A meeting of the Aneurin Bevan University Health Board
Quality and Patient Safety Committee
will be held on Wednesday 16th October 2019, commencing at 09:30am
in Conference Rooms 1 & 2, Headquarters,
St Cadoc's Hospital, Caerleon

AGENDA

Preliminary Matters		**Attachment**		**09:30**
1.1	**Welcome and Introductions**	Verbal	**Chair**	**15 mins**
1.2	**Apologies for Absence**	Verbal	**Chair**	
1.3	**Declarations of Interest**	Verbal	**Chair**	
1.4	**Draft Minutes of the Committee held on 12th June 2019**	Attachment	**Chair**	
1.5	**Action Sheet of the Committee held on 12th June 2019**	Attachment	**Chair**	
Governance				**09:45**
2.1	**Revised Draft Committee Terms of Reference**	Attachment	**Rachel Williams**	**10 mins**
Presentations				**09:55**
3.1	**Winter Plan – Reflections and Planning for Winter 2019/20**	Presentation	**Claire Birchall/ Alexander Crawford/Mel Laidler**	**20 mins**
3.2	**Quality and Safety in Theatres**	Presentation	**Stephen Edwards/ Liz Waters**	**20 mins**
For Consideration				**10:35**
4.1	**Quality, Safety and Performance Overview** • Fractured Neck of Femur • ABUHB Safeguarding Maturity Matrix • ABUHB HIW Maternity Inspection – findings and actions	Attachment Attachment Presentation	**Dr Paul Buss/ Stephen Edwards** **Rhiannon Jones/ Deb Jackson**	**15 mins** **20 mins**
4.2	**Risk Assessment Overview**	Attachment	**Chair**	**10 mins**
Break (10 mins)				**11:20**

Items for Quality Assurance				
5.1	**QPSOG Assurance Report from Meeting held on 6th September 2019**	Attachment	**Peter Carr**	**10 mins**
5.2	**Women and Children's Services Sustainability**	Attachment	**Peter Carr**	**10 mins**
5.3	**Infection Control Annual Report**	Attachment	**Moira Bevan/ Ceri Phillips**	**10 mins**
5.4	**Putting Things Right Report** • Public Services Ombudsman for Wales Annual Report and Accounts 2018/19	Attachments	**Rhiannon Jones**	**10 mins**
Final Matters/For Information				**12.10**
6.1	**Any Other Business**	Verbal	**Chair**	**5 mins**
6.2	**Items for Board Consideration** To agree items for Board consideration and decision	Verbal	**Chair**	**5 mins**
Date of Next Meeting				**12.20**
Thursday 5th December 2019, 09:00am, Conference Rooms 1 & 2, ABUHB Headquarters, St Cadoc's Hospital				**Chair**

Quality and Patient Safety Committee
Wednesday 16th October 2019
Agenda Item: 1.4

Aneurin Bevan University Health Board
Minutes of the Quality and Patient Safety Committee held on Wednesday 12th June 2019

Present:

Prof Dianne Watkins	-	Chair, Independent Member (University)
Frances Taylor	-	Independent Member
Louise Wright	-	Independent Member

In Attendance:

Judith Paget	-	Chief Executive
Paul Buss	-	Medical Director
Peter Carr	-	Director of Therapies and Health Sciences
Phil Robson	-	Special Advisor to the Board
Martine Price	-	Interim Director of Nursing
Kate Hooton	-	Associate Director, Patient Quality and Safety
Stephen Chaney	-	Deputy Head of Internal Audit (Observer)
Nathan Couch	-	Wales Audit Office (Observer)
David Thomas	-	Assistant Director, ABCi
Kath Smith	-	Interim Associate Director of Operational Delivery
Linda Alexander	-	Interim Assistant Director of Nursing
Lin Slater	-	Deputy Director of Nursing
Deb Jackson	-	Head of Midwifery and Associate Director of Nursing
Sue Bale	-	Research and Development Director
Jemma McHale	-	Community Health Council
Lynne Wilde	-	Head of Transformation
Claire Barry	-	Committee Secretariat

Apologies:

Emrys Elias	-	Vice Chair
Claire Birchall	-	Director of Operations
James Quance	-	Head of Internal Audit
Pippa Britton	-	Independent Member

QPSC 1206/01 Welcome and Introductions

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

QPSC 1206/02 Declarations of Interest

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

QPSC 1206/03 Minutes of the Meeting held on 4th April 2019

The minutes of the meeting held on 4th April 2019 were agreed as a true and accurate record of the meeting.

QPSC 1206/04 Action Sheet – 4th April 2019

The Committee considered the Action Sheet from the meeting held on the 4th April 2019 and noted that all actions had been completed or were progressing.

QPSC 1206/05 Winter Pressures Formal Report 2019

Kath Smith and Linda Alexander gave a presentation on the Winter Pressures Formal Report 2019.

The presentation highlighted the increased demand of attendances at the front door over the last four years, and the Committee was asked to note that whilst there had been an increase in urgent care the Health Board had managed to sustain its elective activity. It was also reported that compared to last winter, Out of Hours contacts had been around the same level, and it was advised that the Health Board had performed well in seeing patients within defined times. This was due mainly to much better clinical shift fill rates.

It was noted to the Committee that in order to plan for winter and to manage bed capacity the Health Board had to try to target the length of stay where possible to support limited bed capacity. It was advised that ABCi provided support to the department on how the Health Board could manage the length of stay for patients in order to achieve the greatest patient turnover and improve bed capacity. It was advised that as a result of the modelling work the expected targets for the Royal Gwent Hospital's length of stay was around 6.6 days and 6.2 days for Nevill Hall Hospital. Unfortunately, the Health Board did not achieve these targets due to the complexity of patients; acuity was higher and as a result patients were not always able to be discharged in a timely manner.

It was highlighted that although there were no significant peeks over the winter period in healthcare acquired infections, the Health Board remained above the target to achieve a reduction. The Committee was asked to note the mechanisms and pathways that had been put into place to improve these areas going forward.

The committee was informed that the HB had reached their target of reducing the number of inpatient falls by 10%, and had indeed exceeded this target.

It was reported that this year the Health Board had collated patient feedback differently and had captured live data. The Community Health Council (CHC) had visited service areas to gain patient opinion and the Committee was advised that any issues that had been raised as a concern by CHC, had been responded to quickly to improve patient experience.

The Committee was advised that the Health Board's first Winter Planning meeting was scheduled for two weeks' time to implement the pathways that were to be put into place to support the winter pressures.

QPSC 1206/06 Quality, Safety and Performance Overview

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

Mortality Rate

It was reported that although the mortality rate had increased going into the 2018-19 winter period, it still remained below the Welsh average. It was highlighted that the mortality rate for Nevill Hall Hospital had increased in November and December, and in December-February was above the Welsh average. It was advised that the mortality reviews completed in December to March had not shown any concerning trends, and the number of second reviews was consistent with the usual level.

National Clinical Audit (NCA)

It was advised that the Wales National Clinical Audit (NCA) and Outcome Review Programme (NCAORP) lists the National Clinical Audits that Health Boards must participate in. It was reported that there was more than 40 NCAs on the programme and Aneurin Bevan University Health Board (ABUHB) aimed to participate fully in all of the NCAs listed. It was noted to the Committee that there was a further 2 that ABUHB did not enter any data for, and 4 in which data entry was not in place for all hospitals, or was limited in some way.

National Audit of Care at the End of Life
It was reported that the NCA of Care at the End of Life took place in 2018. The audit indicates that ABUHB was below the UK National Average in all areas apart from the governance process for End of Life Care.

It was noted to the Committee that the audit demonstrated the need for a Bereavement Service to support the needs of families when a loved one passed away in hospital. It was advised that the Bereavement Service was being progressed using Welsh Government funding initially and a business case was being developed for long term funding of the Service. In addition, actions had been proposed by the Clinical Director for Palliative Care and considered at End of Life Care Board for inclusion in the ABUHB End of Life Care Action Plan.

The Committee agreed that they would like the End of Life Care Action Plan to be brought back to a future Committee meeting. **ACTION: Paul Buss/Kate Hooton/Secretariat**

Sepsis
It was reported that Aneruin Bevan Collaborative on Sepsis (ABC Sepsis) was working well in defined clinical areas, to improve the recognition and response to sepsis and therefore eliminate avoidable deaths and harm from sepsis. It was advised that ABC Sepsis had been collecting data from the sepsis screening tools completed for patients triggering with sepsis in the Emergency Departments. This had been extended to wards in acute hospitals. This data is fed back to the wards and departments at the weekly DRIPS (Data, Review, Improvement, Plot the dots, Share) meetings.

Stroke
The Committee was advised that the most challenging area for the Health Board was adherence to the 'front door' of the pathway, recognising that any patients that were confirmed as having had a stroke were to be admitted to a hyper acute stroke unit bed ward as soon as possible. The acute bed situation means that it is not always possible to adhere to this. It was highlighted that work was ongoing to ensure patients are seen and admitted to a stroke unit bed within a four hour time scale. It was noted to the Committee that there had been an improvement in this area throughout the year.

Coding

It was reported that the Clinical Coding Team was under increasing pressure to provide assurance for the organisation and for the Welsh Government on coding completeness and quality. It was highlighted that the coding completeness target was changed from 95% complete three months after discharge to 95% complete one month after discharge.

The Committee noted that the number of uncoded completed episodes had increased. It was advised that although coding completeness does not impact on the number of deaths or the mortality rate values, it was important for detailed analysis of the variation in the numbers or rates and condition specific mortality rates to be investigated and coded. It was reported that the Clinical Coding Department had now filled its vacancies which will address the issue of completing the coding, but it would be some time before the new staff were working at full effectiveness.

The Committee received the report.

QPSC 1206/07 Risk Assessment Overview

The Committee received the risk register and noted that there were no changes in overall risk scores. The Committee discussed the content of the Risk Register and noted that the risks were consistent with the Committee's work programme.

The Committee received the report.

QPSC 1206/08 QPSOG Assurance Report

The Committee received the assurance report from the Quality and Patient Safety Operational Group (QPSOG) meeting which was held on 21st May 2019.

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

The Committee was assured by the report.

QPSC 1206/09 Quality Dashboard

Lynne Wilde provided an update on the implementation of the Quality Dashboard.

It was reported that the Business Intelligence department had developed the first iteration of the Quality dashboard in Qlik Sense, which was the Health Board's (HB) newly procured Business Intelligence platform. The key metrics which had been included in the dashboard are;

- Healthcare Acquired Infections
- Pressure Ulcers
- Falls
- Fractures
- Medication Errors
- Serious Incidents
- Never Events

It was noted by the Committee that the technical components of the dashboard were all complete with a daily feed from the agreed data source for all these measures which was DATIX. This system was used to record all incidents in relation to the agreed measures and was used by a wide variety of users across the HB. It was advised that the dashboard now displayed the raw numbers, direct from Datix as advised by a Quality Dashboard Development Group. From this main group, small focused groups had started to look in detail at how DATIX is used to ensure the accurate recording and reporting of each of the measures. There is a validation process undertaken by the relevant staff that include and exclude the incidents e.g. location, data quality issues. Clinical validation is also undertaken to determine if e.g. a reported case of pressure damage is actual damage.

It was noted to the Committee that since working with the relevant staff, the Information Department had now replicated these non-clinical exclusions therefore narrowing any discrepancies. The work had been completed with Falls, Fractures and Health Care Acquired Infections with the dashboard numbers now correlating with those being reported. Work on validating serious incidents and 'never events' data was well underway and would be complete in the next couple of months. It was highlighted that the validation process for Pressure Ulcers and Medication Errors was more complex and clinical in nature.

It was highlighted that it had therefore become apparent that some changes to the reporting process were required to enable the accurate population of the dashboard. Principally this would involve incorporating a way by which a reported incident can be identified as being validated and reportable on DATIX. This would then allow the Dashboard to be able to distinguish between validated/non validated incidents and reportable/non-reportable incidents. The daily refresh of data from DATIX would mean that the data would be up to date. Preliminary meetings have been held with DATIX and nursing colleagues and this is being progressed over the next few months.

Lynne Wilde left the meeting.

QPSC 1206/10 Learning from Cwm Taf Morgannwg University Health Board – Report on Maternity Services

The committee received a report and presentation setting out the assessment undertaken of the Aneurin Bevan University Health Board's (ABUHB) Maternity Services, following the review of Cwm Taf Morgannwg University Health Board's Maternity Services. It was reported that the assessment was completed by the Clinical Director and Head of Midwifery/Associate Director of Nursing drawing on the multi-disciplinary team and existing evidence relating to the governance and learning structure of maternity services. The assessment was reviewed and tested by the interim Director of Nursing and Medical Director.

It was advised that ABUHBs Maternity Services had well-established clinical governance arrangements in place that were multi-disciplinary, and a learning culture was well developed with a number of forums and ways that learning from concerns, clinical incidents and feedback were shared.

It was noted to the Committee that family engagement was well established within the maternity services. There were clear mechanisms in place for women and families to give feedback, and it was advised that there was a nominated point of contact person who provided support and updates to families on concerns and serious incident investigations. Social media also contributed to patient and family feedback received, although it was suggested by the Committee that a systematic approach to feedback should be considered for all women in receipt of maternity services.

It was also highlighted that staff engagement was fundamental and support and development of leadership capability at all levels had been a focus for many years, and midwives had been supported to undertake key leadership and management courses.

The Committee discussed the maternity dashboard clinical outcomes and key risks currently. The key risk relating to service sustainability in line with clinical futures. Actions and mitigation in place were noted and the mechanisms to ensure regular review and escalation as required.

Deb Jackson left the meeting.

QPSC 1206/11 Tawel Fan – A Lesson for Learning

Lin Slater provided an update on the independent investigation into the care and treatment provided on Tawel Fan Ward.

It was advised that the Minister for Health and Social Services had requested that all Health Boards undertake an internal review of their services following the recommendations from the Report.

The Deputy Director of Nursing confirmed that a regional Dementia Action Plan has been developed by the Dementia Board and the Dementia Board had also commissioned a mapping exercise across the Health Board's area to determine what services were provided.

The Committee discussed the report recognising that there had been significant activity to support improvement to care and services for this vulnerable group of patients, and acknowledged that much of the improvement work required further development to ensure that this was embedded and sustained.

Lin Slater left the meeting.

QPSC 1206/12 Putting Things Right Report

The Committee received an updated report on the performance and actions that were underway to improve quality and performance through implementation on a Putting Things Right/Organisational Learning Service Improvement Programme and Action Plan.

It was advised that the Health Board had responded to a total of 166 formal complaints during the period March and April 2019, with an overall performance against the 30 day target in March being 38% and improving in April 2019 to 65%.

It was noted to the Committee that the implementation of this plan had contributed to the improved performance on complaints in April 2019, which was now at the highest level since January 2018. It was advised that further focussed work was required to ensure that this performance was sustained and to also pro-actively support and enhance the timeliness and effectiveness of investigations into Serious Incidents.

QPSC 1206/13 Annual Quality Statement

Kate Hooton provided a report on the Annual Quality Statement (AQS). The Committee was asked to receive the report for assurance/compliance and any comments about content/format would be noted and carried forward into the 2019-20 AQS.

It was reported that all NHS Organisations were required to publish an Annual Quality Statement (AQS) as part of the Organisation's annual reporting process. The AQS is the Health Board's statement to the public to let them know what the Health Board had done to improve the quality in relation to delivering services.

It was advised that the AQS had been produced to meet the requirements of the Welsh Health Circular/2019/007 (WHC) which was refreshed every year. It was highlighted that the process starts with a request to the Health Board's Divisions for ideas for the content. All stories are drafted, based on the information that had been provided, and were checked with experts on the subject. Every year the Internal Audit Service undertakes an audit of the content to ensure that it was consistent with information reported to the board over the year, and complies with the WHC/2019/007.

The Committee received the report.

QPSC 1206/14 Items for Board Consideration

There were no items for Board Consideration.

QPSC 1206/15 Date of Next Meeting

The next meeting will be held on Wednesday 16th October 2019 at 09:30am in Conference Rooms 1 & 2, ABUHB Headquarters, St Cadoc's Hospital, Caerleon.

Quality & Patient Safety Committee
Wednesday 12th June 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 12th June 2019

Minute Reference	Agreed Action	Lead	Progress/ Completed
QPSC 1206/06	**Quality, Safety and Performance Overview – National Audit of Care at the End of Life** The Committee agreed that they would like the End of Care Action Plan to be brought back to a future meeting.	**Paul Buss/ Kate Hooton/ Secretariat**	This item has been added to the forward work programme.

2.1

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Finance and Performance Committee Wednesday 16th October 2019 Agenda Item: 2.1

Aneurin Bevan University Health Board

Quality and Patient Safety Committee Terms of Reference

Executive Summary

This report provides for the Quality and Patient Safety Committee the revised Committee Terms of Reference. It is good governance practice for the Terms of Reference to be reviewed annually. This review has also been undertaken as part of arrangements to renew all Health Board Terms of Reference following the updating of the Health Boards committees and membership in May 2019.

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

Executive Sponsor: Richard Bevan, Board Secretary

Report Author: Richard Bevan, Board Secretary

Report Received consideration and supported by :

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

Date of the Report: 2 October 2019

Supplementary Papers Attached: Terms of Reference

Purpose of the Report

The purpose of this report is to present the revised Terms of Reference for the Quality and Patient Safety Committee and seek the committees support prior to approaching the Board.

Background and Context

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

Terms of Reference for all committees have been reviewed and updated by their respective Chairs and Lead Executives. These updated Terms of Reference are currently being considered by committee in this autumn round of meeting in readiness for approval by the Board in November 2019.

Assessment and Conclusion

The attached Terms of Reference for the Quality and Patient Safety Committee have been reviewed and a small number of suggested amendments have been made. The Committee is asked to review and the Terms of Reference and propose any further

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

2.1

Aneurin Bevan University Health Board

Quality and Patient Safety Committee

Terms of Reference

QUALITY AND PATIENT SAFETY COMMITTEE TERMS OF REFERENCE

1. INTRODUCTION

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

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

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

2. PURPOSE

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

- evidence based and timely **advice** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and
- **assurance** to the Board in relation to the Health Board's arrangements for:
- Safeguarding and improving the quality and safety of patient-centred healthcare
- The health and safety of staff, and citizens on the Board's premises
- The protection of vulnerable people in accordance with its stated objectives

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

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

3. DELEGATED POWERS AND AUTHORITY

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

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

b) that the organisation, at all levels (corporate/directorate/ division/clinical) has a citizen centred approach, putting patients, patient safety, well-being and safeguarding above all other considerations;

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

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

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

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

g) that there is an ethos of continual quality improvement and that there are regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation;

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

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

j) that there is continuous improvement in the standard of quality and safety across the whole organisation, which is guided and continuously monitored through the use of national and professional standards and in line with regulatory frameworks and that there is an effective system of clinical audit in place across the organisation and this is reported to the Committee.

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

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

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

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

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

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

Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so,

the Committee shall have the right to inspect any books, records or documents of the Board and primary care practitioners relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

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

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

Access

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

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

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

Sub Committees

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

4. MEMBERSHIP

4.1 Members

A minimum of five members, comprising:

Chair	Independent member of the Board
Vice Chair	Independent member of the Board

Members	At least 2 other independent members of the Board, to include the Chair of the Health Board Audit Committee and the Vice Chair of the Health Board.

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

4.2 Attendees

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

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

Deputies for Executive Directors will be allowed to attend meetings of the Committee in exceptional circumstances only by invitation and agreement with the Chair.

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

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

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

Secretariat

Secretariat - As determined by the Board Secretary.

4.3 Member Appointments

4.3.1 The membership of the Committee shall be determined by the Board, based on the recommendation of the Board Chair – taking

account of the balance of skills and expertise necessary to deliver the committee's remit and subject to any specific requirements or directions made by Welsh Government.

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

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

4.4 Support to Committee Members

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

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

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

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank

discussion of particular matters.

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of committee minutes and written reports, as well as the presentation of an annual report;

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

9. REVIEW

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

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality & Patient Safety Committee Wednesday 16th October 2018 Agenda Item: 4.1

Aneurin Bevan University Health Board

QUALITY AND PATIENT SAFETY REPORT
OCTOBER 2019

4.1

Executive Summary

Summary of Key Points

The number of deaths and mortality rate have risen going into winter, but the decrease into the Spring has not been as marked as usual, particularly at RGH. (section 1.1.).

An overview of participation in National Clinical Audits (NCAs) is provided. The results of the National Audit of Intensive Care are given in section 2.2. The results of the audit are discussed by the Directorate Teams, and there is a robust morbidity and mortality review process for ICU. In addition to this, changes are being made to the data entry process, as there are concerns about "underscoring" in the acuity of the patients.

The front door departments have struggled to maintain the compliance with the sepsis 6 bundle within one hour of recognition of sepsis during the winter, and in to the first 6 months of 2019. (section 3.1.).

Data is showing a decrease in the number of potentially preventable Hospital Acquired Thrombosis (HATs) in the Health Board. (section 3.3)

There has been an increase in the number of in-patient falls in the first 6 months of 2019, which appears to be leading to an increase in the fractures resulting from falls. The Falls Steering Group has broadened its remit to Falls and Bone Health, to ensure that the bone health of our population is as good as possible so that fewer people fracture a bone when they fall.(section 3.8)

A new section has been added to the report with data on quality issues within Maternity Services. This report gives data on Caesarean Section Surgical Site Infection Rates. (section 3.11).

The Quality and Patient Safety Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	
Executive Sponsor: Dr Paul Buss, Medical Director	
Report Author: Kate Hooton, Assistant Director	
Report Received consideration and supported by :	

Executive Team		**Committee of the Board [Quality and Patient Safety Operational Group]**	**X**
Date of the Report: September 2019			
Supplementary Papers Attached:			

Purpose of the Report

The Quality and Patient Safety Report for the Quality and Patient Safety Committee provides information on the ABUHB main priorities in this area, as set out in the Integrated Medium Term Plan and the Annual Quality Statement.

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

Background and Context

This report provides data in the following areas in relation to quality and patient safety:

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

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

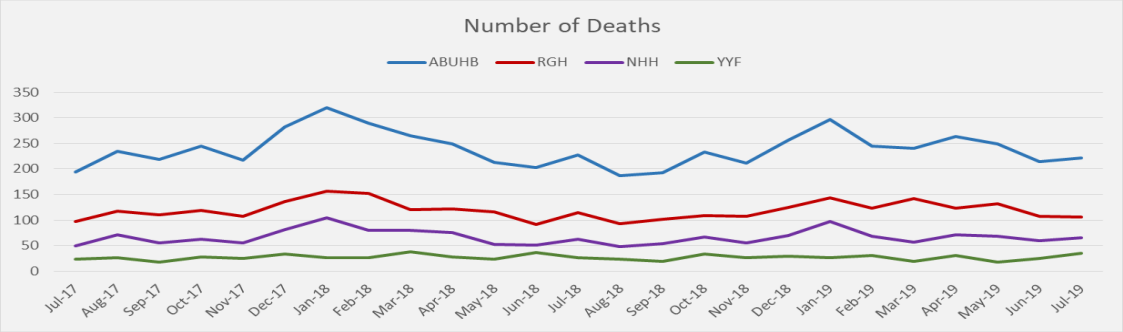
Assessment and Conclusion

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

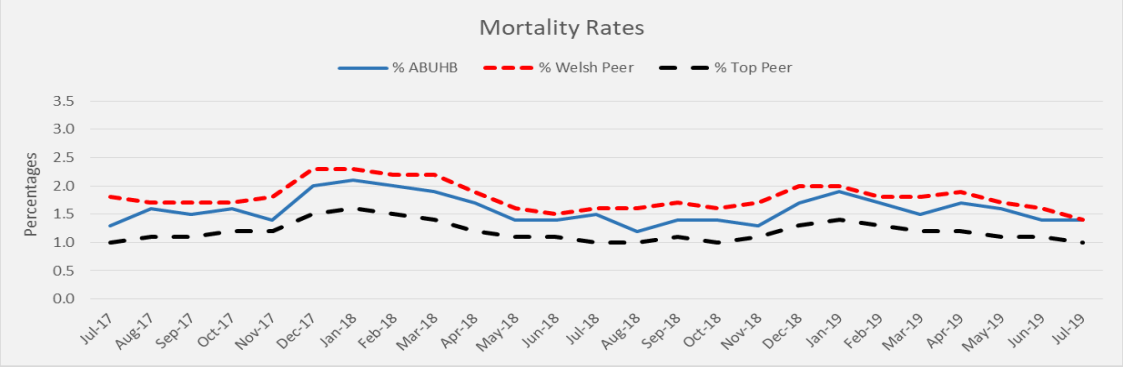
1. High Level Outcomes

1.1 Crude Mortality and Mortality Rate

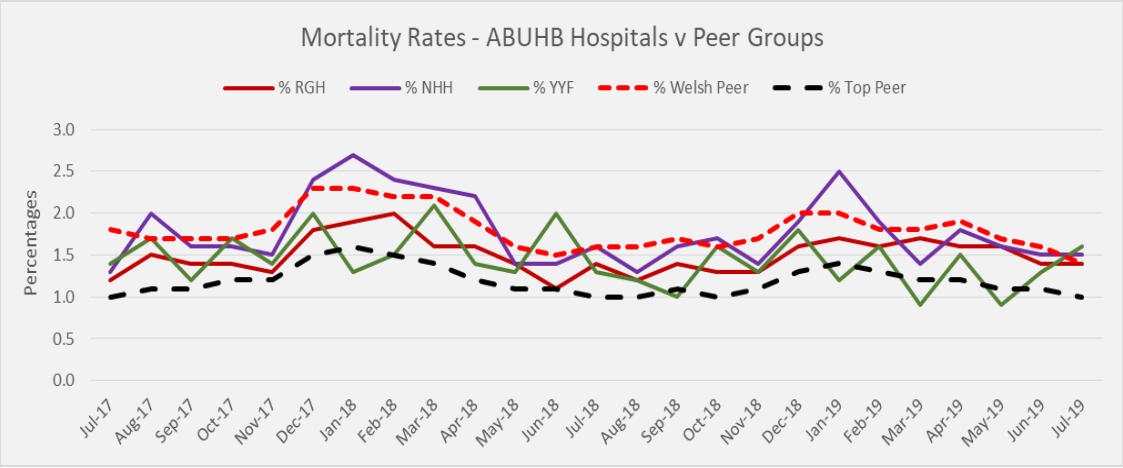
ABUHB and Hospital Crude Mortality July 17 – July 19



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



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



1.2. Narrative on Mortality Data

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

The Crude mortality (number of deaths) in ABUHB and NHH and RGH increased going into the winter period. The crude mortality has then decreased at NHH, but remained high at RGH until June. Crude mortality at YYF has remained relatively consistent throughout the whole winter period and first part of 2019.

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

The mortality rate for NHH has increased sharply in November and December, and in December-February was above the Welsh Average, decreasing below the Welsh Average from March onwards. Mortality reviews completed for December-March at NHH, including a targeted review of the casenotes of 40 deaths, have not shown any concerning trends. However, this rise in the mortality rate at NHH is still of concern until it is understood and changes made if necessary. It is possible that a higher mortality rate is indicative of good practice – using the virtual ward and ambulatory care to keep the less unwell patients out of hospital, and admitting those with higher acuity. NHH has been using the virtual ward for longer than RGH, and a greater percentage of surgical presentations at NHH are managed through the virtual ward than at RGH. However, NHH has a high proportion of registered nurse vacancies on some wards and it is difficult to see the impact of this on care in reviewing the case notes.

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

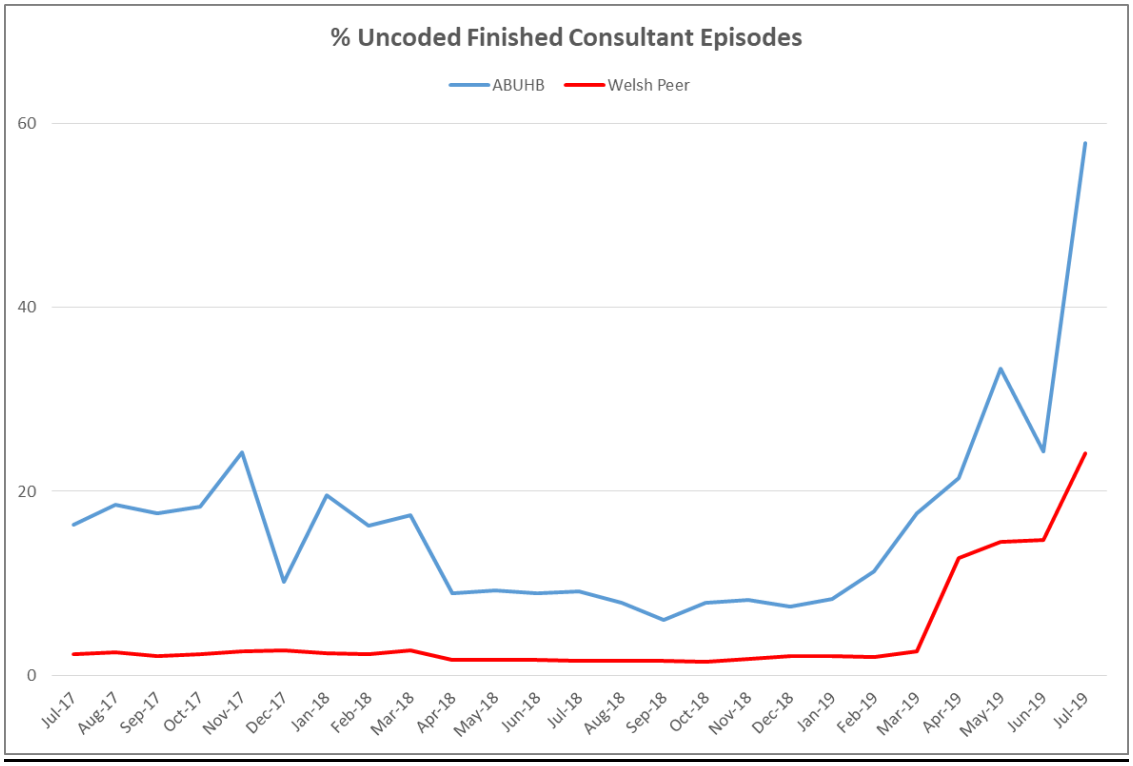
over of staff and it is some time before the new staff are working at full effectiveness.

Completeness of Coding

ABUHB Coding Completeness (02 October 2019, CHKS):

Jan 19	91.7%
Feb 19	88.7%
March 19	82.4%
April 19	79.2%
May 19	68.1%
June 19	79.0%

Uncoded Finished Consultant Episodes July 17 - July 19



2. Surveillance and Review

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

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

2.1 Mortality Review

Percentage Completion of Mortality Reviews –The Welsh Government plan is that, when, in line with the recommendations of the Shipman review, the Medical Examiner role is introduced, the Medical Examiner will undertake the first level of the mortality review. This is part of their role, as they agree the cause of death with the responsible medical team and high light any concerns they have about treatment and care from their review of the clinical record. They also talk to the relatives of the deceased person to ensure that they agree with the cause of death and were satisfied with the care provided. The Health Board will undertake a more in depth, second level review into any deaths highlighted because of concerns by the Medical Examiner. The new role is being introduced from April 2019 on a non-statutory basis for deaths in acute hospitals. In Wales, the Medical Examiners (ME) and the Medical Examiner Officers (MEO) who support them, will be employed by Shared Services. The Health Board is therefore not implementing the role itself, but will ensure it will work alongside the bereavement service, as it is developed. Shared Services will now appoint to the ME and MEO roles, as the lead ME for Wales has been appointed.

The Welsh Government has set the standard that 100% of the notes of patients that die in our hospitals are reviewed. In ABUHB, we have funding for 4 sessions of senior clinician time to complete mortality reviews, with a focus on learning. The number of deaths is higher in the winter, and therefore even when same number of reviews are completed, the percentage of reviews completed will drop. Other HBs in Wales achieve a higher percentage of mortality review completion, as most require their junior doctors to complete the review when they do the discharge summary, rather than a review by an impartial, senior clinician.

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

Percentage of Mortality Reviews completed for ABUHB

	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	March 19	April 2019	May 2019	June 2019	July 2019	Total
No. Reviewed	129	153	168	122	117	175	152	180	207	151	142	98	1794
2nd Stage Review	12	17	14	19	13	13	12	17	29	23	21	14	204
Total Deaths	182	172	233	208	253	294	244	237	261	242	210	218	2754
% Reviewed	71%	89%	72%	59%	46%	60%	62%	76%	79%	62%	68%	45%	65%

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

2.2 National Clinical Audit (NCA)

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

The results of one of these National Clinical Audits are included in this report. The first Report of the National Audit of Care at the End of Life is the NCA included in this report. The results of all the National Clinical Audits are now being reported to the Quality and Patient Safety Operational Group.

The Wales National Clinical Audit and Outcome Review Programme (NCAORP) lists the National Clinical Audits that Health Boards must participate in. There are more than 40 National Clinical Audits (NCAs) on the Programme. ABUHB aims to participate fully in all the NCAs listed below, but there are a further 2 that we do not enter any data for, and 4 that data entry is not in place at all hospitals, or is limited in some way.

The National Clinical Audits that ABUHB participates in on the NCAORP are:

National Joint Registry
National Emergency Laparotomy Programme
Case Mix Programme – Intensive Care
National Diabetes Inpatient Audit
National Diabetes Footcare Audit
National Pregnancy in Diabetes Audit
National Core Diabetes Audit
National Diabetes Transitions Audit
National Diabetes Paediatric Audit
Pulmonary Rehabilitation
All Wales Audiology Audit
Stroke Audit (SSNAP)
Inpatient Falls
National Hip Fracture Database
National Dementia Audit
National Audit of Breast Cancer in Older People
National Audit for Care at the End of Life
Cardiac Rhythm Management
National Audit of Percutaneous Coronary Interventions
Myocardial Ischaemia National Audit project
National Vascular registry Audit
Cardiac Rehabilitation Audit
National Lung Cancer Audit
National Prostate Cancer Audit
National Oesophago-gastric Cancer Audit
National Neonatal Audit Programme Audit
National Maternity and Perinatal Audit
Epilepsy 12 Children and Young People NCA
National Clinical Audit of Psychosis
NCEPOD audits
Mental Health Programme
Maternal Newborn and Infant Clinical Outcome Review programme

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

NCA	Case Ascertainment	Narrative	Update
Trauma Audit Research Network	Participation started	Registered for the audit and clinical staff trained	Lead administrator for NCA now trained on

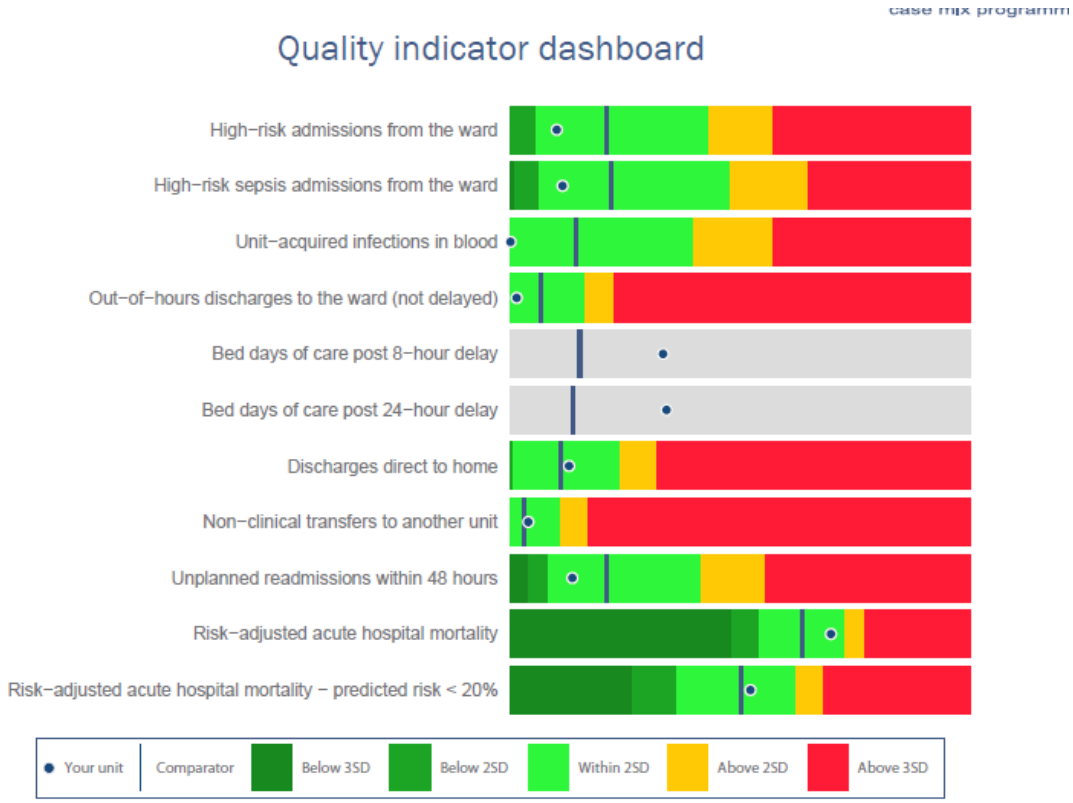
		for the audit but clinical staff unable to complete data entry within their working day.	TARN and entering some data. A member of staff has been appointed to enter data for this audit, and a further member is awaiting financial approval.
National Ophthalmology Audit (Adult Cataract Surgery)	No Participation	Electronic Records systems for Ophthalmology required as this uploads the audit data automatically.	The procurement of an electronic medical record system for Wales is to be expedited, based on the Cardiff model. It is predicted to be ready in March 2020.
NACAP – National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: COPD audit and Adult Asthma Audit and Children and Young People Asthma Audit	Full participation at NHH in COPD and Adult asthma. Participation at RGH and YYF in COPD initiated, with MDST support for data entry. No participation in Children and Young People Asthma Audit	The COPD NCA has recently moved to continuous data entry and the Asthma NCAs are new. The Respiratory Service has struggled to complete the data entry due to the high volume.	A process has been developed at NHH between the clinical staff and the MDST for COPD data entry. RGH Consultant is identifying primary COPD patients and MDST administrative staff are entering the RGH data. YYF clinical staff are now entering data for COPD and Adult Asthma. Paediatricians are unable to enter data for the Asthma audit.
Heart Failure	Full Participation at NHH. Improving participation at RGH and YYF.	Process for data entry working well to date for 2019-20.	It is expected therefore that case ascertainment for ABUHB will achieve 70% in 2019-20.
Early Inflammatory Arthritis	Limited participation	Process agreed between the Consultants and MDST	Two vacancies in the Consultant Team have limited participation.
Fracture Liaison Service	Limited Participation	ABUHB has just registered for this NCA. Process to initiate data entry agreed between service and MDST	Data entry has just started and is being monitored. It is progressing well, but a review is needed to ensure that we are identifying all the required cases.

ICNARC (Intensive Care National Audit and Research Centre)

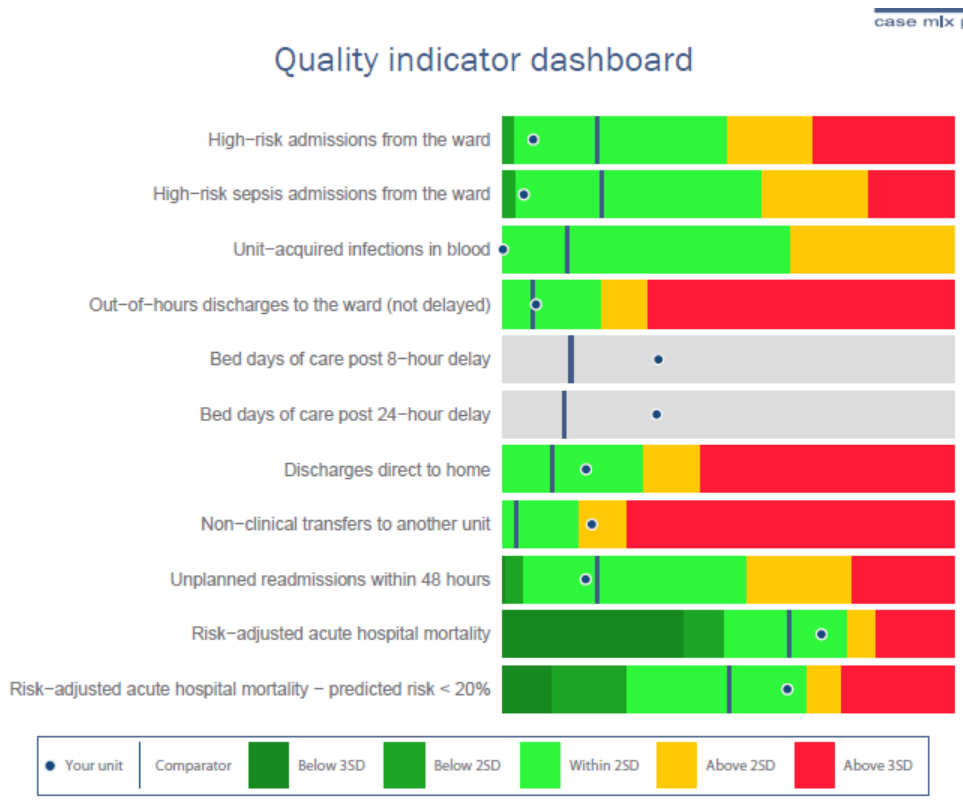
National Audit/Registry Title:	ICNARC (Intensive Care National Audit and Research Centre)
Clinical Lead:	Mike Martin (NHH) and Jack Parry Jones (RGH)
Date of last data capture:	Continuous
Date of last Annual Report:	2018/2019 data in June 2019

Results

RGH



NHH



3. Optimising Care Delivery

3.1. Deteriorating Patient/Sepsis – ABC Sepsis

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

The Collaborative's outcome measures are:

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

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

The process measure for the collaborative is:

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

3.1.1. Review of Results from ABC Sepsis

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

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

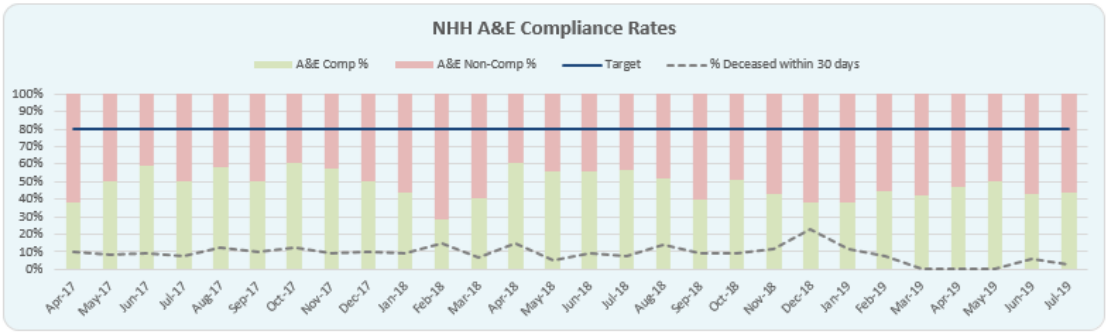
The data for the Emergency Departments is all from the ABC Sepsis database. It should be noted that ABC Sepsis applies the criteria for compliance with the sepsis 6 bundle within 1 hour robustly.

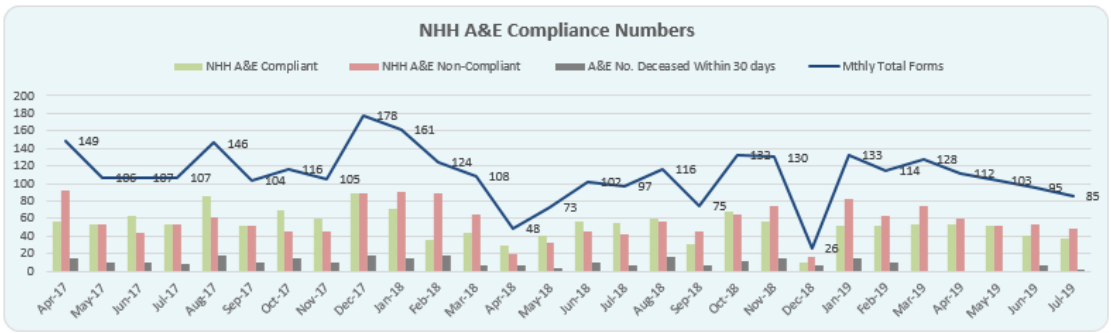
This data is reported to the WG on a monthly basis.

Emergency Departments:

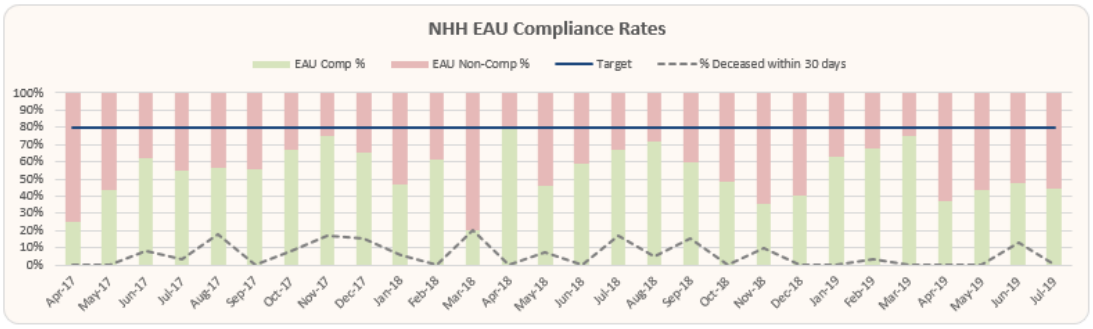
***Nevill Hall Hospital A and E*:** The number of forms at NHH and compliance with the bundle in 1 hour has decreased over the first 6 months of the year. The compliance is normally addressed within the department through discussion with the nurses about completing the form with all the necessary information, and with the doctors about the delays in the prescribing of antibiotics. However, it has been challenging to hold the DRIPS meetings every week in the A and E department during and since the winter period, due to the number of vacancies and therefore agency staff and the pressures within the department.

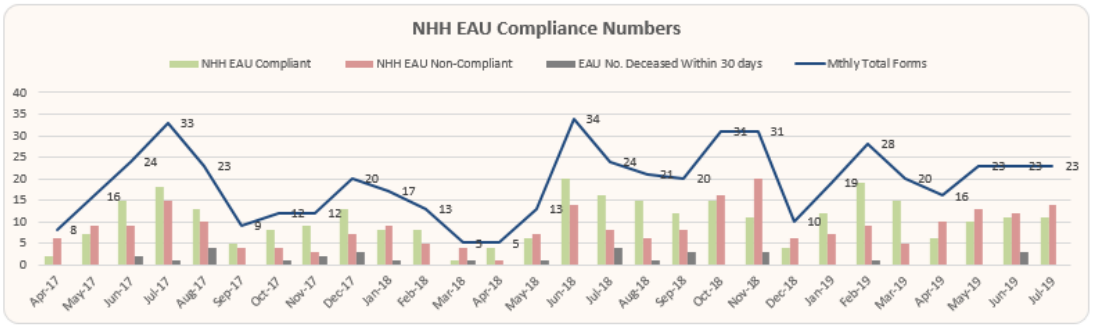
Compliance within 1 hour of recognition of sepsis



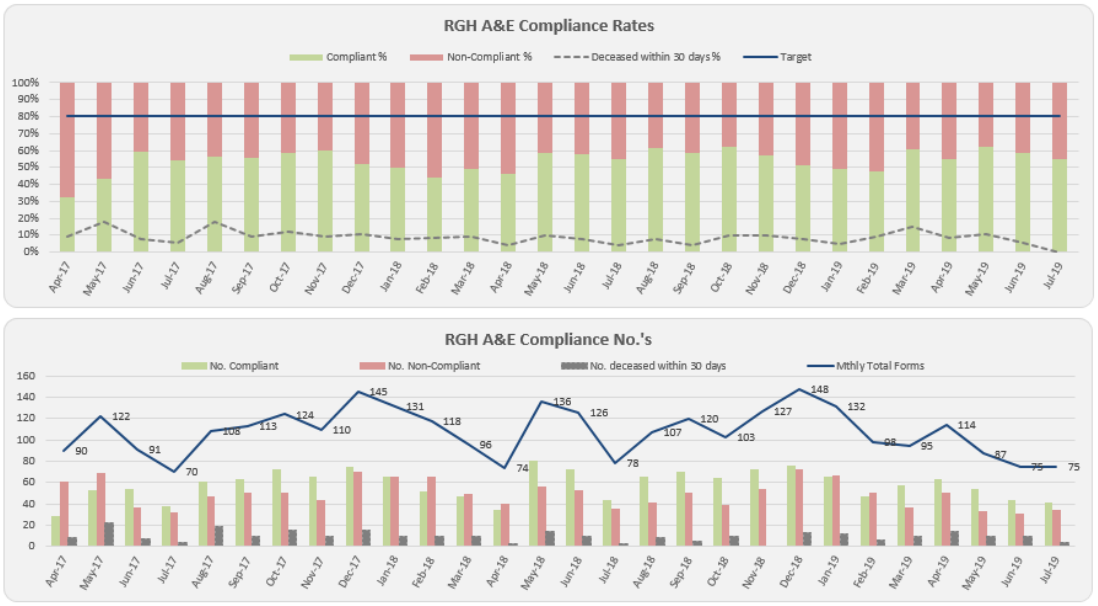


EAU at NHH is engaged with ABC sepsis. Both the recognition and response to sepsis have improved overall in the department, although they vary week to week. The DRIPS meetings have been well attended.



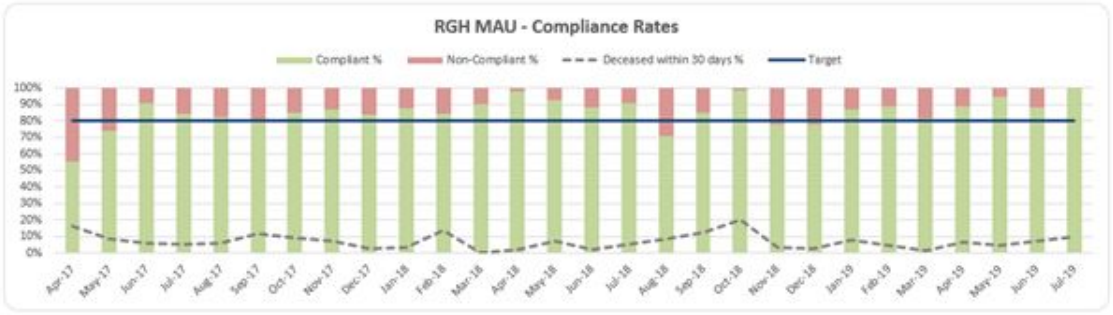


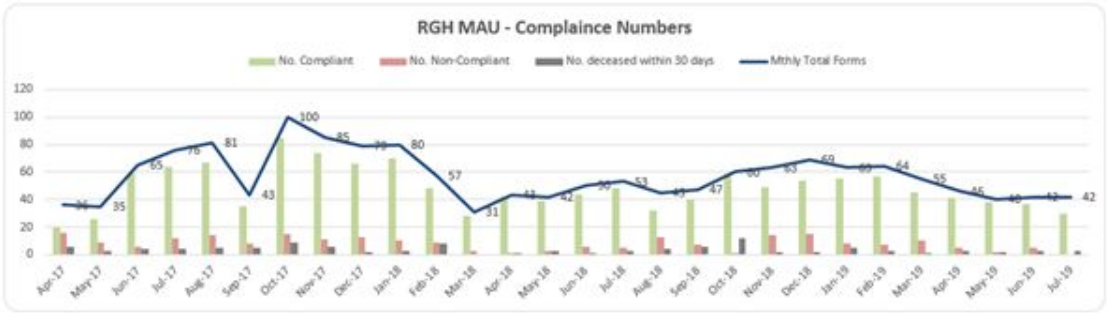
***Royal Gwent Hospital A and E*:** The number of forms from RGH A and E was high over the winter, but has since dropped off. There have been regular meetings with one member of senior staff, but it has not always been possible for many front line nurses to attend the meetings because of the level of vacancies and the pressures in the department. This means learning about the purpose and correct completion of the forms is not being passed on to new staff.



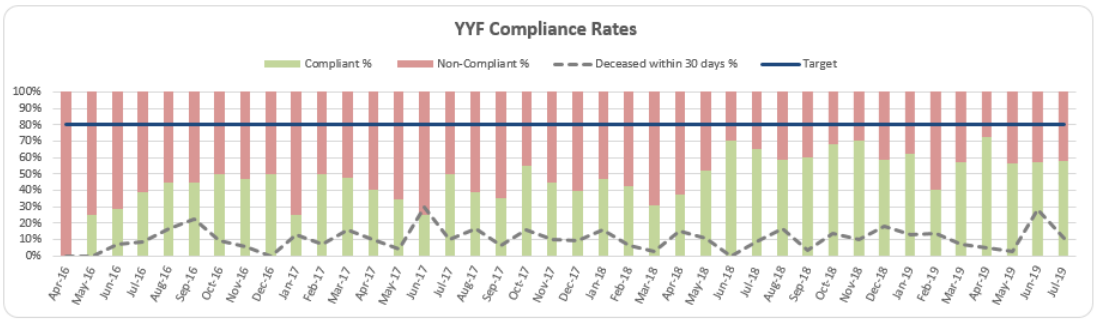
The bar charts below show the number of forms completed in 2 hours and 3 hours, as well as those completed in an hour. This shows that most patients are getting good care.

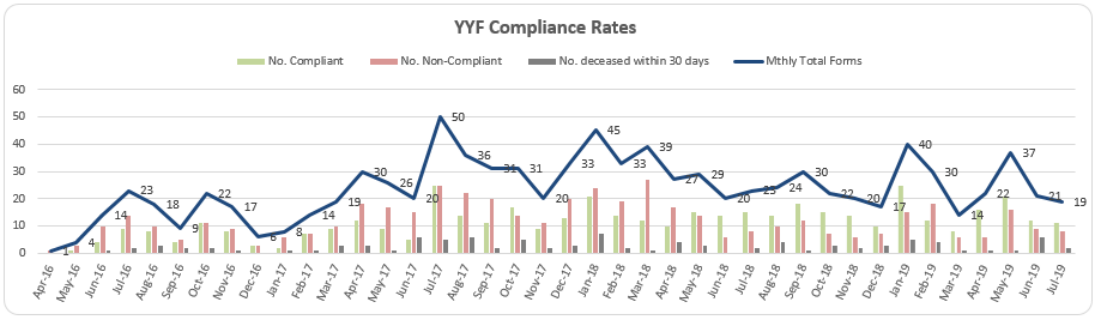
MAU at RGH is fully engaged with ABC Sepsis. The number of forms completed has decreased over the summer period but the compliance has remained high. ABC Sepsis will capture learning from MAU about how they achieve the high compliance and discuss with the other front door departments how the MAU approach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





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





Community:

Work is continuing in a range of areas within the community to implement a change in practice to use NEWS as a common language. This has included providing equipment to enable healthcare District Nurses to take observations, and doing additional training.

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

Wards at NHH and RGH:

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

The ABC Sepsis Lead Nurse regularly compare the sepsis trigger tools received with both data in the Outreach Team data base on the patients seen with sepsis and with patients with a high NEWs score recorded in data pack. The discrepancies are discussed with the ward manager.

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. The ABC Sepsis Steering Group is now taking forward aspects of the action plan from the peer review, but the whole plan is the responsibility of the Acute Deterioration Steering Group. The work in the Community is being incorporated into the existing plan, to ensure that the workstreams continue to work together.

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

3.2 Reducing C Diff and Healthcare Associated Bacteraemia

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

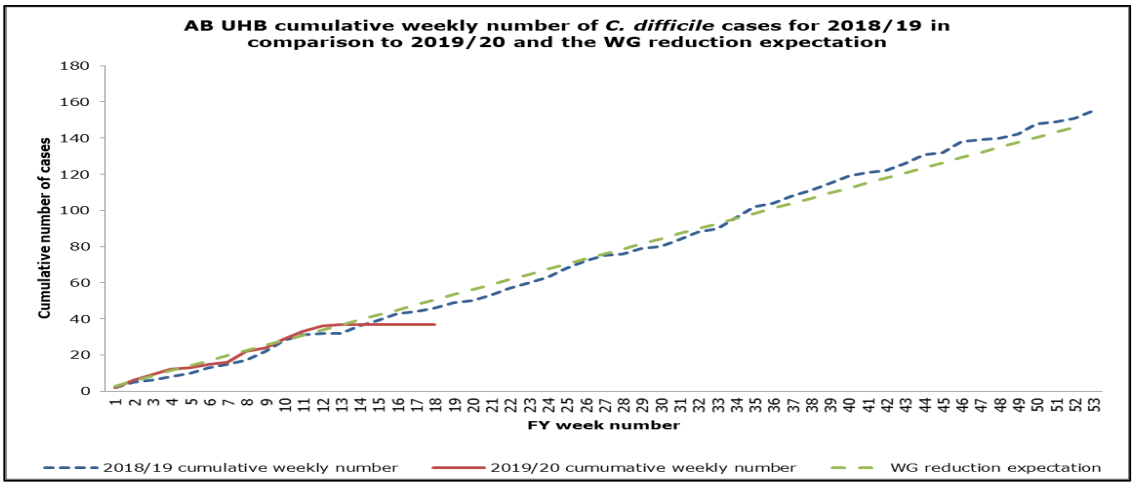
- **C difficile - 25 per 100,000 population**
- **Staph aureus – 20 per 100,000 population**
- **E Coli – 67 per 100,000 population**

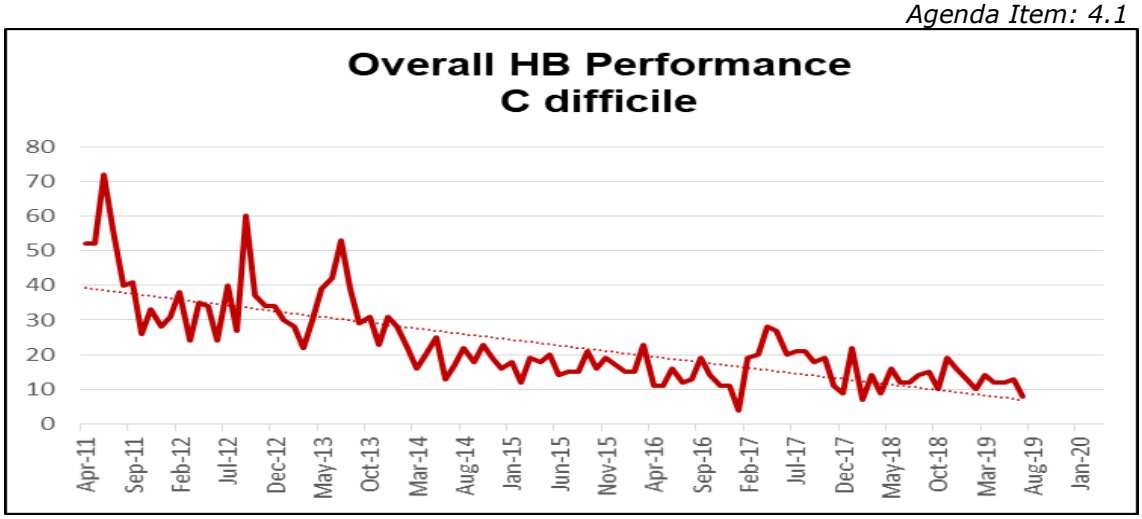
Two new targets were added in 2018/19 by Welsh Government:

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

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

3.2.1. Total C diff. Cases



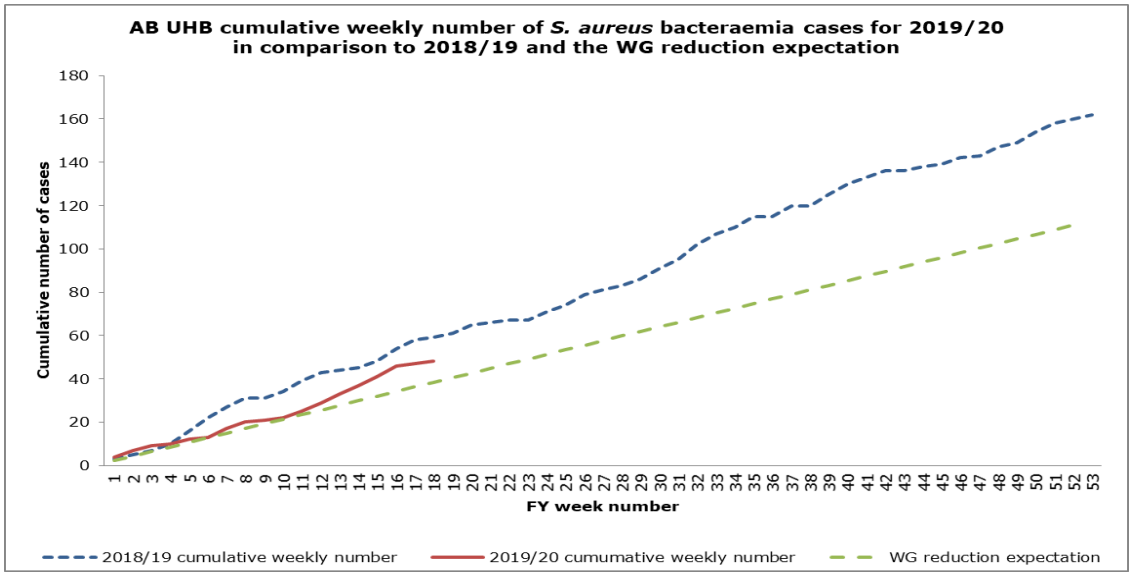


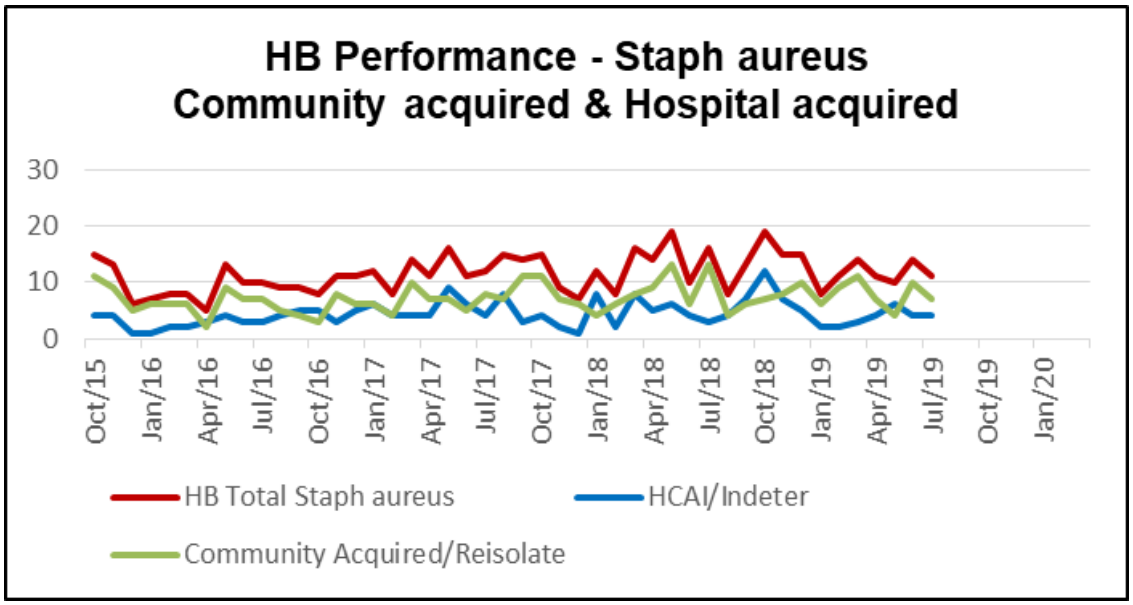
C.*difficile* – ABuHB narrowly missed the 2018/19 reduction target of 26.00 per 100K population with the final figure standing at 26.37. Despite disappointing numbers in August the Health Board is on target to achieve the 2019/20 reduction with the current rate running at 24.28 per 100K population. Only one other Health Board in Wales has a lower rate.

Deep cleans utilising Hydrogen Peroxide Vapour continue along with close monitoring of antibiotic prescribing. The recent appointment of an Infection Prevention & Control Nurse dedicated to Primary Care means that community acquired C.difficile is scrutinised closely for themes and resulting action.

A second important intervention relates to antibiotic guidelines. A change of guidelines utilising co-trimoxazole as the broad spectrum antibiotic of choice was introduced in Cardiff & Vale and Cwm Taff UHBs approximately 2 years ago – which may have contributed to a further reduction in *C. difficile* cases. Co-trimoxazole use is now being encouraged by one of the Welsh Government Tier 1 antimicrobial prescribing targets, therefore a programme of guideline review is under way by the Antimicrobial Guideline Group. Uptake of existing guidance is good with co-trimoxazole now being the second most widely used broad-spectrum antibiotic in ABUHB. Further moves to co-trimoxazole have been made in 2019 with further changes planned.

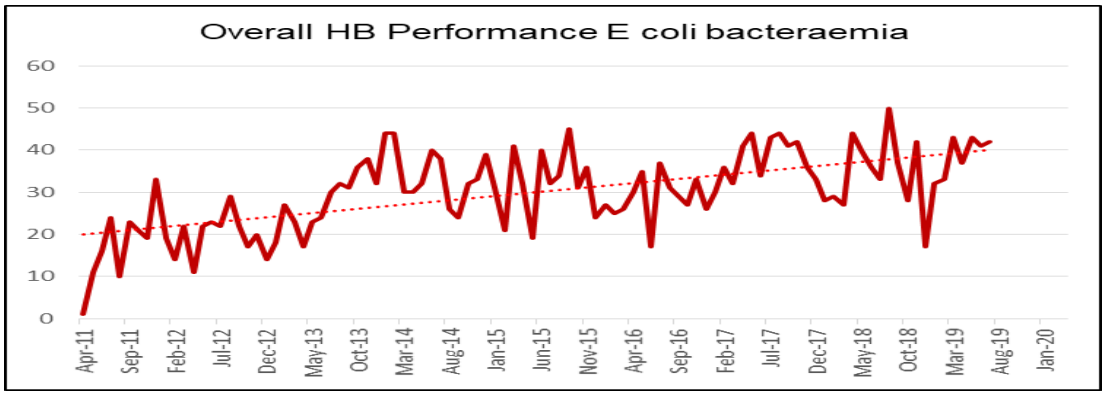
3.2.2. Total MRSA and MSSA Cases

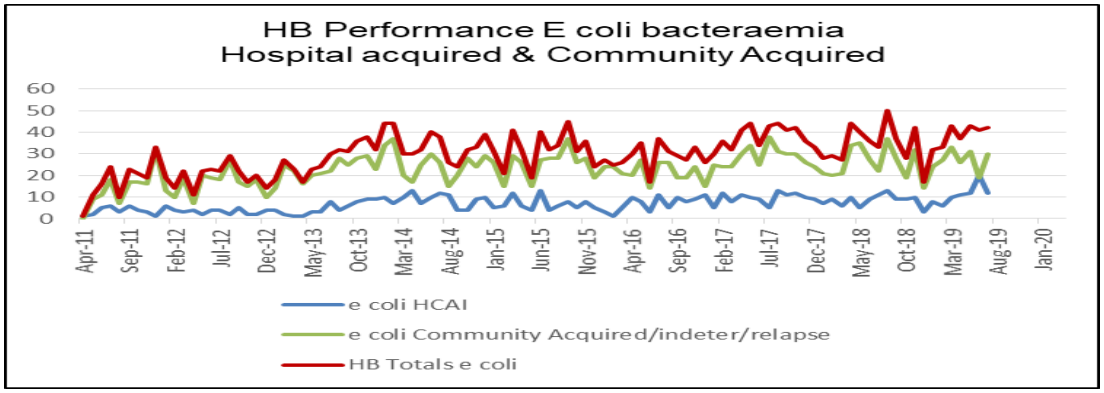




Staph *aureus* bacteraemia – The Health Board currently has the lowest rate in Wales running at 20.64 per 100K population – just above the reduction target of 20 per 100K population. This is a result of focussed work on preventing blood culture contaminants. Numbers of MRSA bloodstream infections are exceptionally low – only 1 case since April 2019.

3.2.3. E Coli





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

3.2.4. Klebsiella – Number of cases

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

Klebsiella species are the most frequently found agents in hospital outbreaks due to multidrug-resistant Gram-negative bacteria. *Klebsiella* species may reside in the bowel, nose, and trachea and on the skin, and are readily transmitted between patients. Contamination of gloves and gowns occurs in 14% of healthcare worker–patient interactions and the organisms survive for more than 2 hrs on hands. In the environment, *Klebsiella* species have been detected from sources such as sinks, room

surfaces, door handles, thermometers and liquid soap. Factors for transmission include length of stay, urinary catheter use and high degree of dependency. Whilst much has been written in peer review journals about this bacteria, the articles relate to hospital outbreaks.

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

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

3.2.5. Pseudomonas *aeruginosa* – number of cases in

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

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

Antibiotic Prescribing Performance

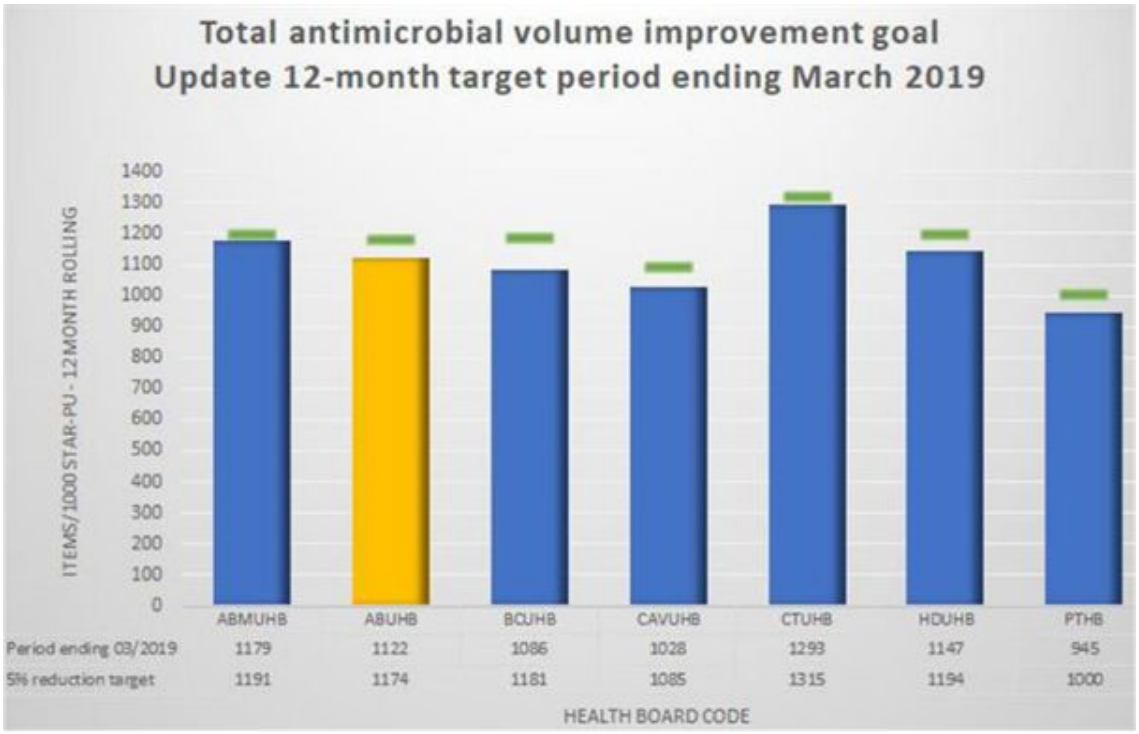
Tier 1 targets for antibiotic usage were introduced in 2018-2019 to minimise the risk of antimicrobial resistance at both an individual and a population level. These are in addition to National Prescribing Indicators that focus on usage in primary care. The 2018-19 year end position is reported below; results for 2019-20 Qtr 1 have not yet been reported.

Primary Care Prescribing

Welsh Government Tier 1 target

- Target for 2018–2019: reduce the total volume of antimicrobial use by 5% compared with the baseline 2016-17 year.
- The green bars on the graph below show the 5% reduction target. The Health Board achieved this target, reducing overall total antimicrobial volume by 9.2%. Every cluster achieved at least the 5% target reduction, with Blaenau Gwent East achieving a 19% reduction.

- Target for 2019–2020: To reflect the UK AMR strategy target, Health Boards are expected to achieve a 25% reduction in antimicrobial prescribing compared with the baseline year of 2013 by 2024. The year on year requirements for reduction by ABUHB will be produced by the Public Health Wales but have not yet been received.



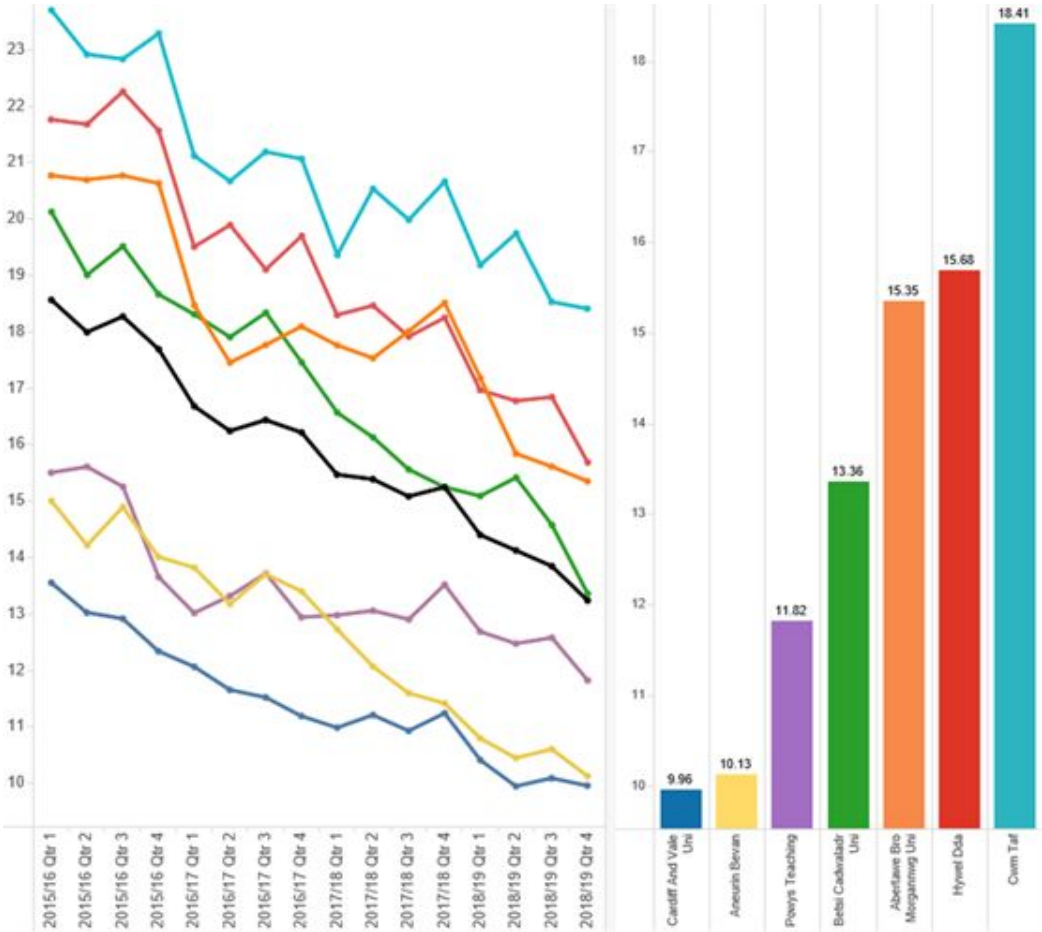
<u>National prescribing indicators</u>

1. Total antibacterial items per 1,000 STAR-PUs (Specific Therapeutic group Age-sex Related Prescribing Unit)
   - Target for 2018–2019: A reduction of 5% against a baseline of data from April 2016–March 2017.
   - This is the same as the Welsh Government target above, so was achieved.
   - Target for 2019-20: a reduction of 5% against a baseline of data from April 2017–March 2018.

2. Number of 4C antimicrobials per 1,000 patients
   - The term '4C antimicrobials' refers collectively to four broad-spectrum antibiotics (co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin). The use of simple generic antibiotics and the avoidance of these board-spectrum antibiotics

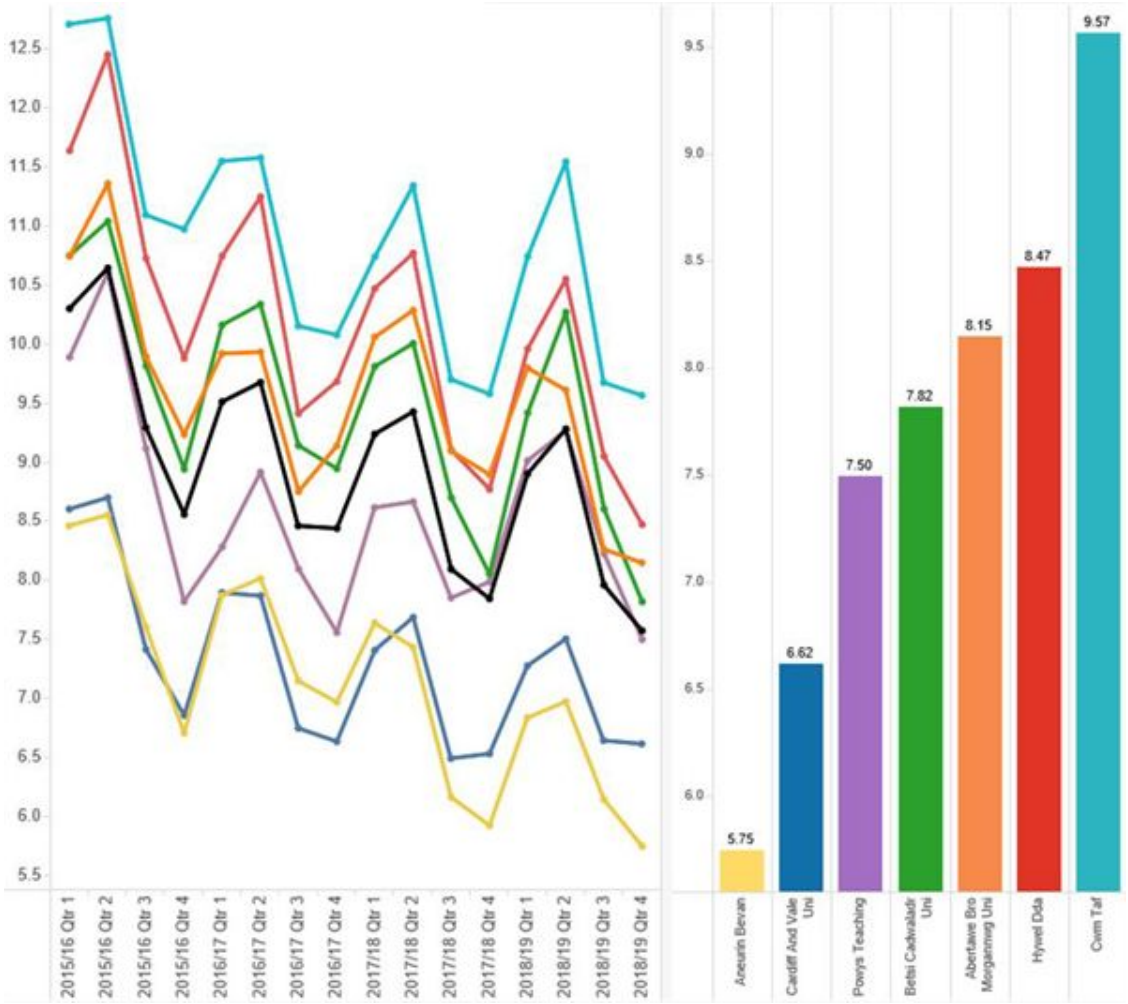
preserve them from resistance and reduce the risk of *C. difficile*, MRSA and resistant urinary tract infections.

- Target for 2018–2019: Absolute measure ≤7% or a proportional reduction of 10% against a baseline of data from April 2016–March 2017.
- The data for Qtr 4 below demonstrate the Health board has the second lowest 4C prescribing in Wales. ABUHB achieved the largest reduction in Wales, with a 24.4% reduction in 4C usage in Qtr 4.
- Target for 2019-20: a reduction of 10% against a baseline of data from April 2017–March 2018.



3. 4C antimicrobials as a % of Antibacterial Items.
   - Target for 2018–2019: Absolute measure ≤7% or a proportional reduction of 10% against a baseline of data from April 2016–March 2017.

- It should be noted that seasonal variation is demonstrated in the data for Qtr 4 below although there is a downward trend. ABUHB has the lowest use of these antibiotics in Wales and achieves the absolute target of ≤7% with a rate of 5.75%.
- This indicator has been retired for 2019-20.

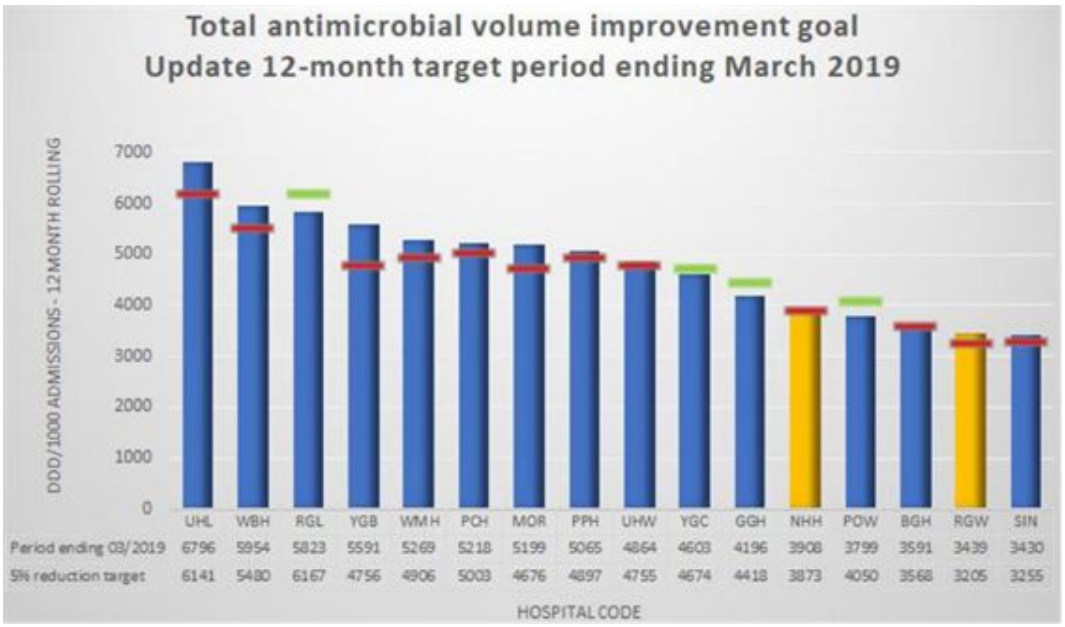


Secondary Care Prescribing

Welsh Government Tier 1 targets

1. Secondary care reduction in total volume measured as Defined Daily Doses (DDDs)/1000admissions

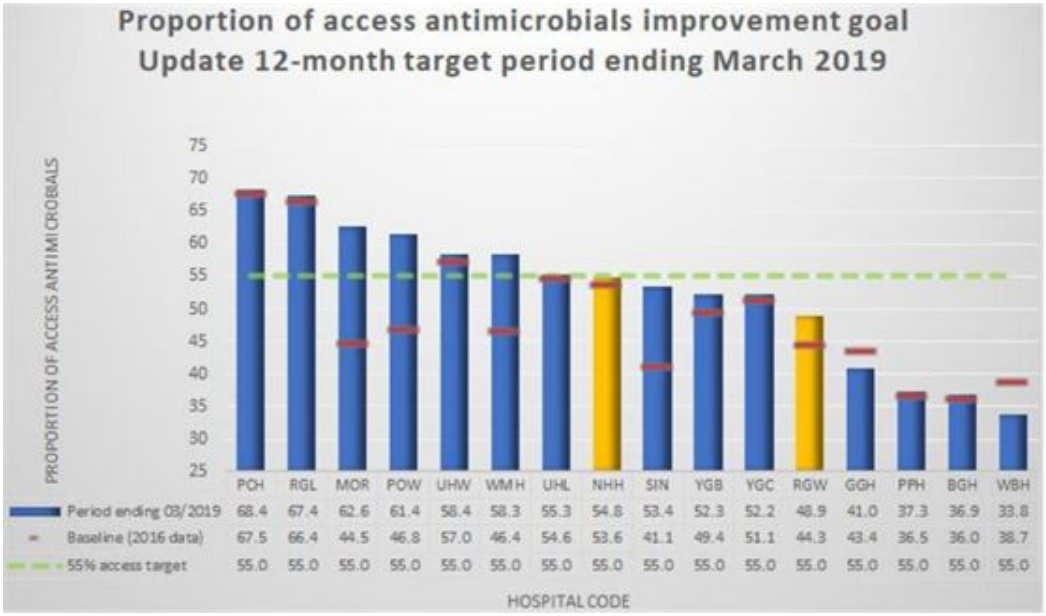
- Target for 2018–2019: reduce the total volume of antimicrobial use by 5% compared with the baseline 2016-17 year.
- The yellow columns in the graph below show the ABUHB acute hospitals (data are not produced for YYF). The red bars show the 5% reduction target demonstrating that neither RGH nor NHH achieved the target, in common with the majority of Welsh hospitals. NHH achieved a 4.1% reduction and RGH a slight increase in use, due to the move in guidelines towards more combination therapy rather than using single broad-spectrum antibiotics. Both RGH & NHH remain lower than average prescribers.
- Target for 2019-20: This target has been recognised as challenging therefore the target for 19/20 has been revised to a 1% reduction in total antimicrobial usage in hospital care against 2018-19 consumption figures.



2. Increase the proportion of antibiotic usage within the WHO Access category to ≥55% of total antibiotic consumption (as DDD) OR increase by 3% from baseline 2016 calendar year
   - Antibiotics within the WHO 'Access' category are narrow spectrum antibiotics, which carry a lower risk of resistance and other adverse effects. The yellow columns in the graph below show the proportion of access antimicrobial usage for the acute hospitals in ABUHB for the financial year 2017/18.

The red bars shows the 2016 calendar year baseline data and the green line the 55% target.

- RGH achieved the target of a 3% increase from baseline, demonstrating a 4.6% increase. NHH almost achieved the 55% target, at 54.8%, a 1.2% increase from baseline.
- Target for 2019-20: Increase the proportion of antibiotic usage within the WHO Access category to ≥55% of total antibiotic consumption (as DDD).



3.3 Hospital Acquired Thrombosis

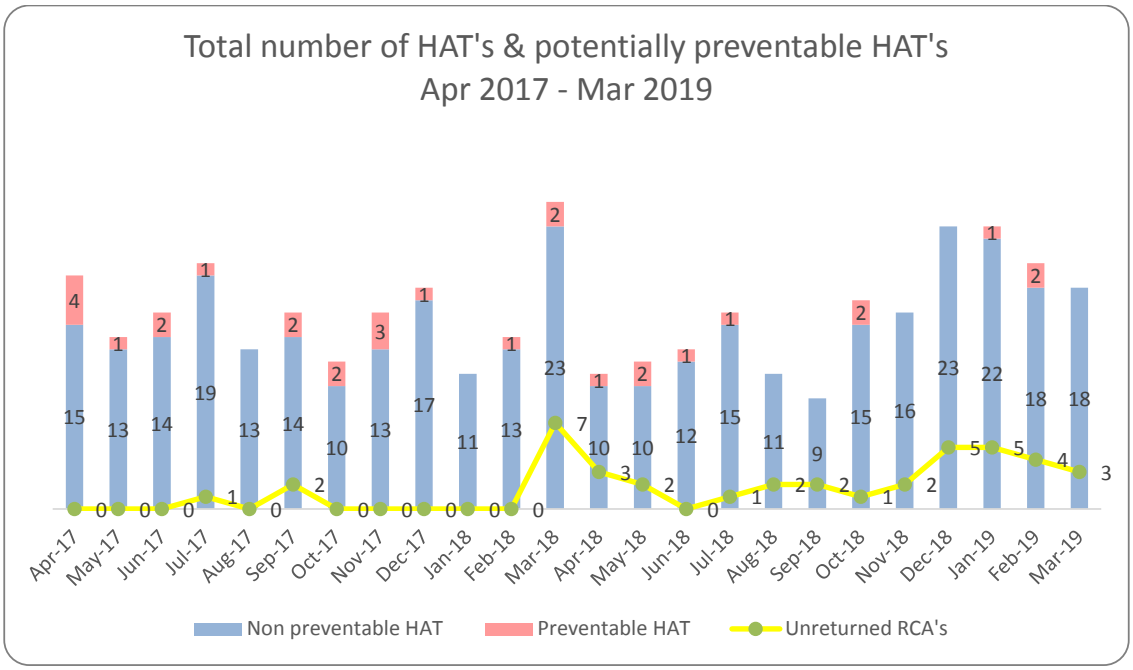
A Hospital Acquired Thrombosis (HAT) is defined as:

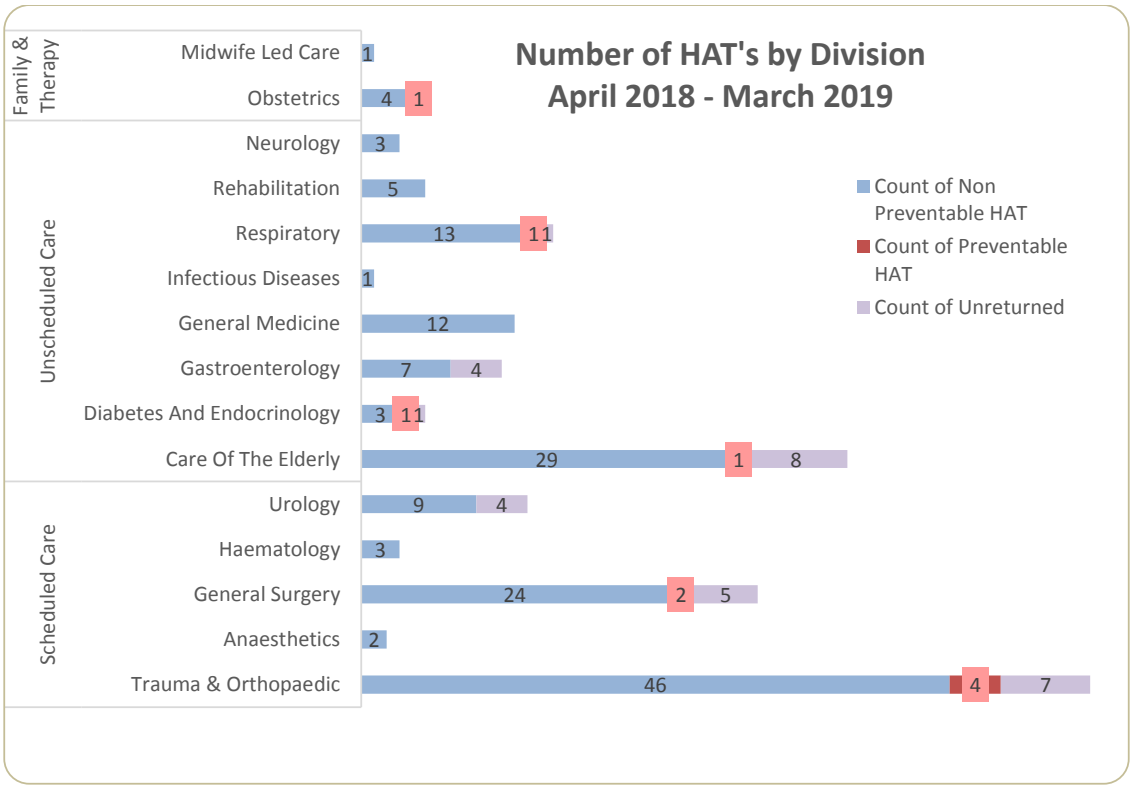
> ***"Any venous thromboembolism (VTE) arising during a hospital admission and up to 90 days post discharge".***

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

All cases of HAT that are identified are sent to the patient's Consultant for review. The number of reviews completed by the Consultants has increased greatly over the last year, through improvements to the process, which means the data is now more robust. All cases that are

identified as potentially preventable, as the correct thromboprohylaxis was not given, are taken to the Thrombosis Group, to ensure that learning happens at all levels from the individual, to the team, to the organisation.





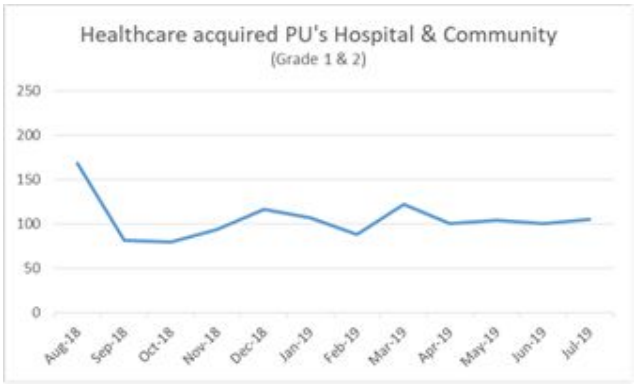
The data for the Trauma and Orthopaedic HATS has been analysed by Consultant and by procedure. This data has been anonymised and sent out to all T and O Consultants. Each Consultant was told which line represents their individual data, so that they can see how they compare to other Consultants. This exercise will now be undertaken for Care of the Elderly and then General Surgery.

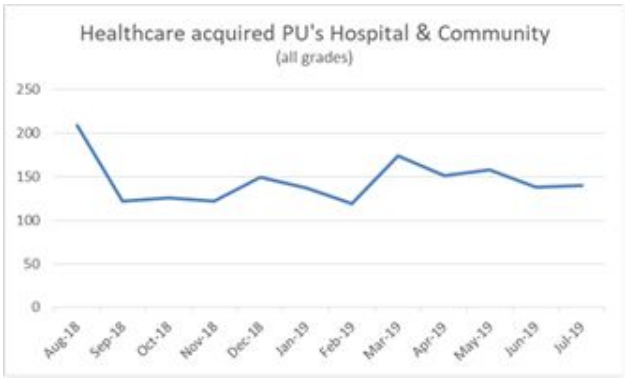
The data below shows the number of cases of HAT in ABUHB in 2018/19 and 2019/20 to date. The data is derived from combining RADIS data with discharge data.

April 2018	May 2018	June 2018	July 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Total
13	12	14	16	12	9	19	17	25	26	22	20	**205**
Quarter 1 Total		**39**	**Quarter 2 Total**		**37**	**Quarter 3 Total**		**61**	**Quarter 4 Total**		**68**	
April 2019	**May 2019**	**June 2019**	**July 2019**	**Aug 2019**	**Sept 2019**	**Oct 2019**	**Nov 2019**	**Dec 2019**	**Jan 2020**	**Feb 2020**	**Mar 2020**	**Total**
17	13	19	18									
Quarter 1 Total		**49**	**Quarter 2 Total**			**Quarter 3 Total**			**Quarter 4 Total**			

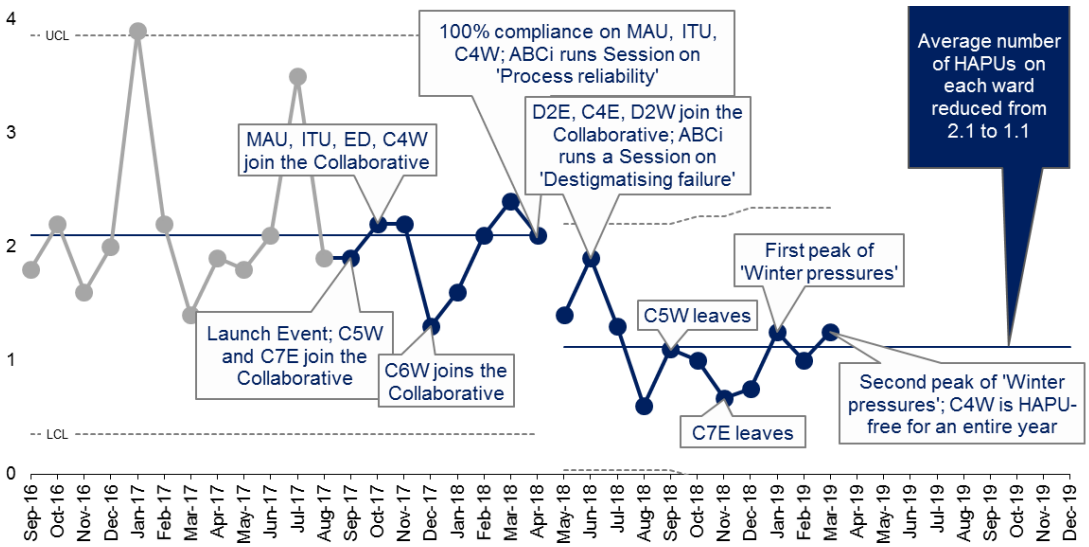
3.4 Pressure Damage

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





Royal Gwent PU Collaborative



Pressure Ulcer Reduction

The total number of pressure ulcers reported through datix across the organisation has disappointingly remained unchanged – the data does not reflect the results of an improvement collaborative on 12 wards at the Royal Gwent Hospital.

Prior to the collaborative the Health Board undertook a significant piece of work to ensure nurses have access to fit for purpose pressure relieving equipment. Additionally, a root cause analysis review identified recurring themes. An improvement collaborative introduced by ABCi across 12 wards resulted in the prevention of 162 pressure ulcers. The reduction of serious pressure ulcers on the RGH site has also been confirmed via data overseen by an Associate Nurse Director.

It should be noted that large numbers of pressure ulcers reported on Datix are often inaccurate – either misclassified or not deemed pressure ulcers at all. A significant piece of work is therefore underway to ensure pressure ulcers are reported appropriately in the first place along with datix reviews to confirm accuracy.

3.5 Stroke Care -

Quality Improvement Measures Summary **August 2019**

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

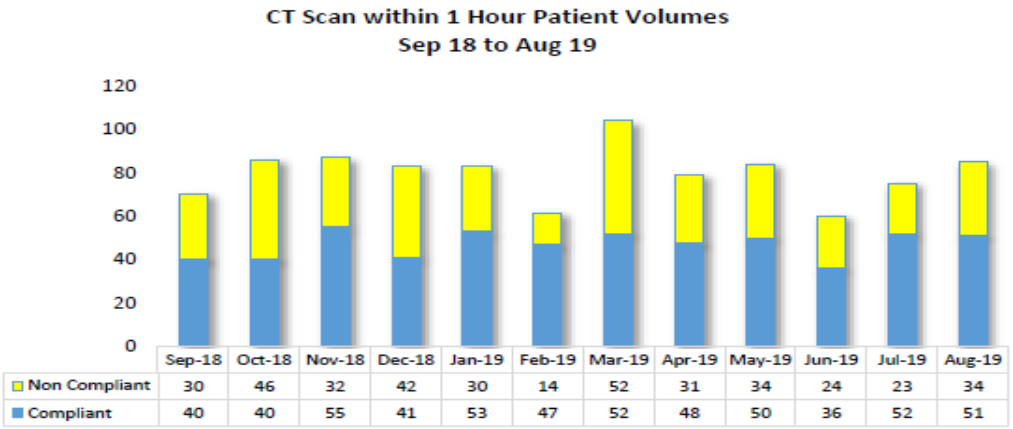
Bwrdd Iechyd Aneurin Bevan Health Board

Quality and Patient Safety Report
Quality and Patient Safety Committee
Agenda Item: 4.1

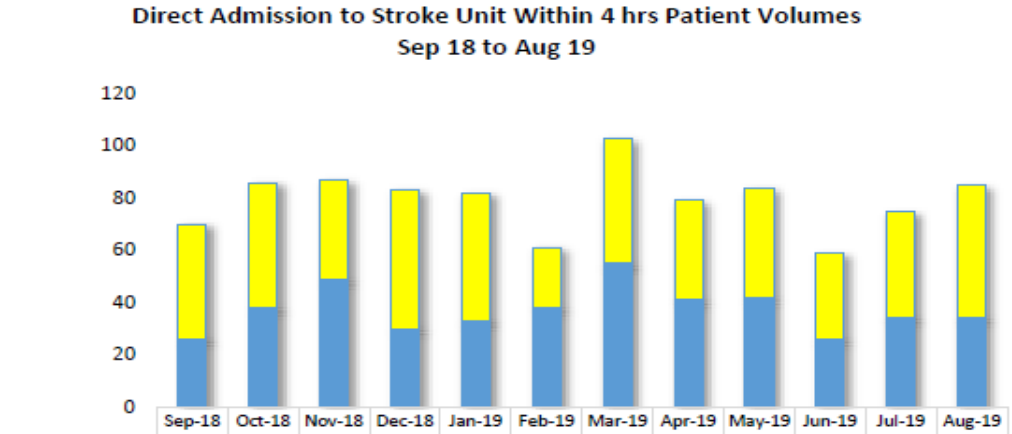
Quality Improvement Measures Summary — August 2019

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

RGH Performance

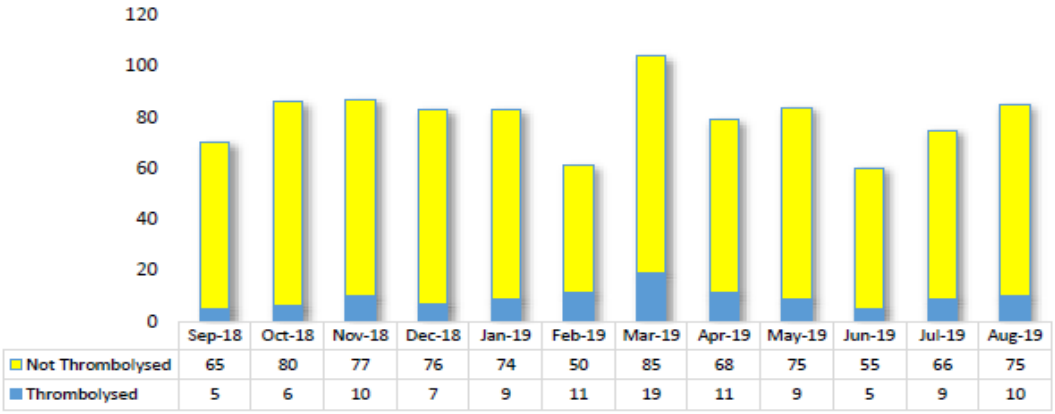


	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Non Compliant	30	46	32	42	30	14	52	31	34	24	23	34
Compliant	40	40	55	41	53	47	52	48	50	36	52	51



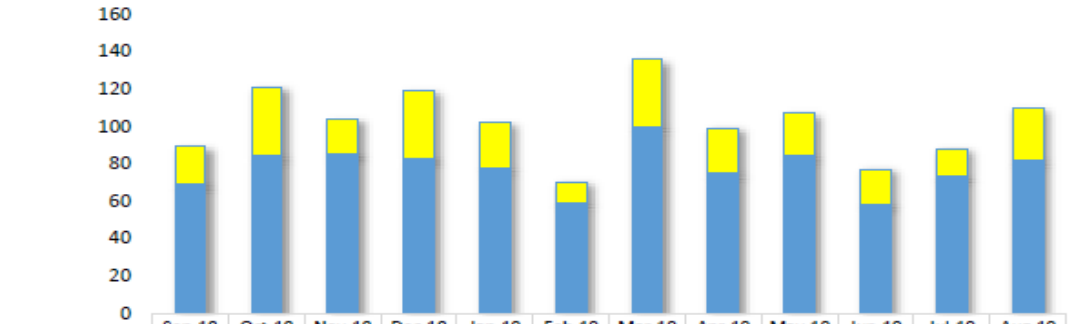
	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Non Compliant	44	48	38	53	49	23	48	38	42	33	41	51
Compliant	26	38	49	30	33	38	55	41	42	26	34	34

Thrombolysed Patient Volumes
Sep 18 to Aug 19



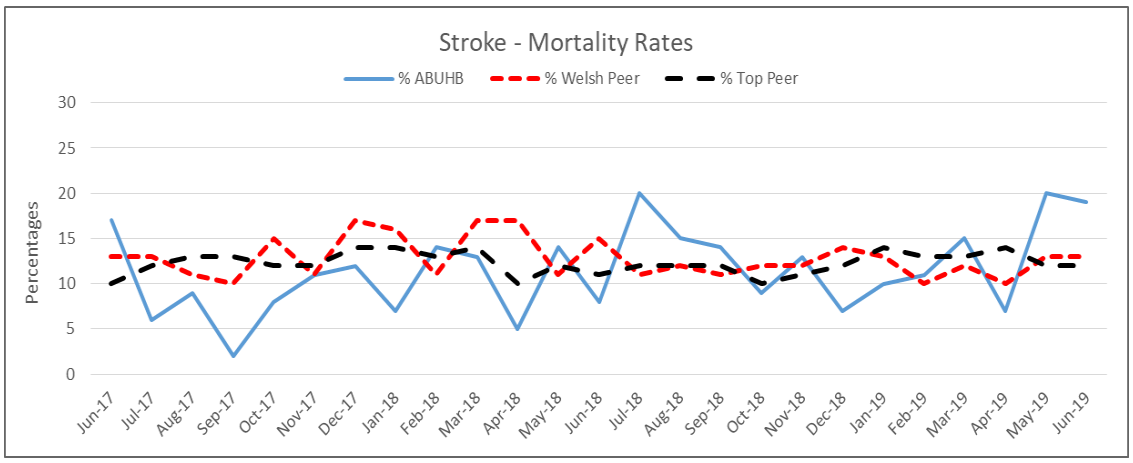
	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Not Thrombolysed	65	80	77	76	74	50	85	68	75	55	66	75
Thrombolysed	5	6	10	7	9	11	19	11	9	5	9	10

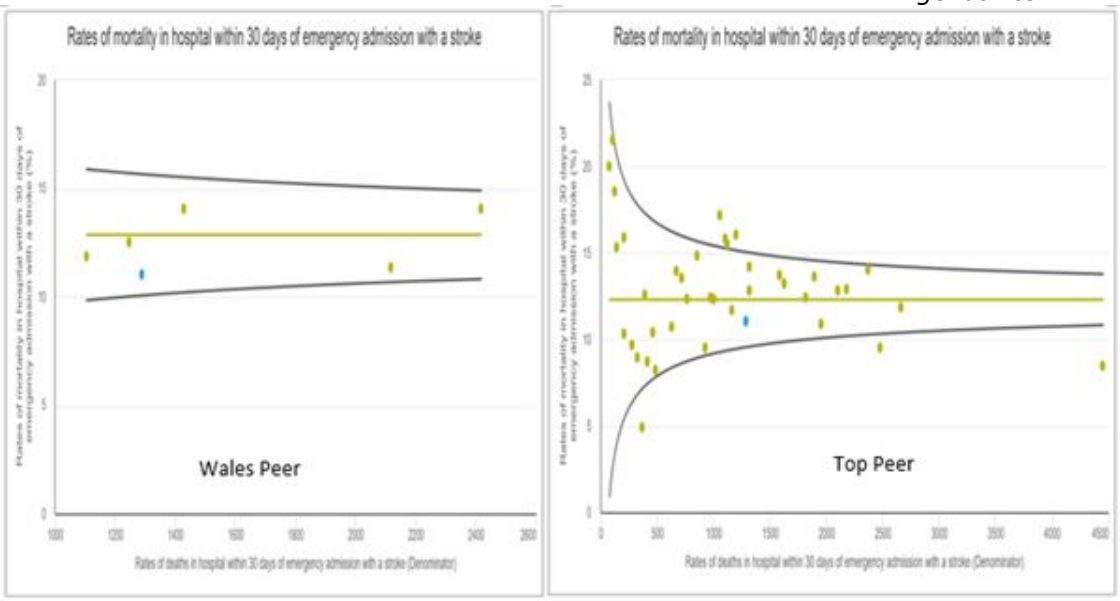
Swallow Screen within 4 hrs Patient Volumes
Sep 18 to Aug 19



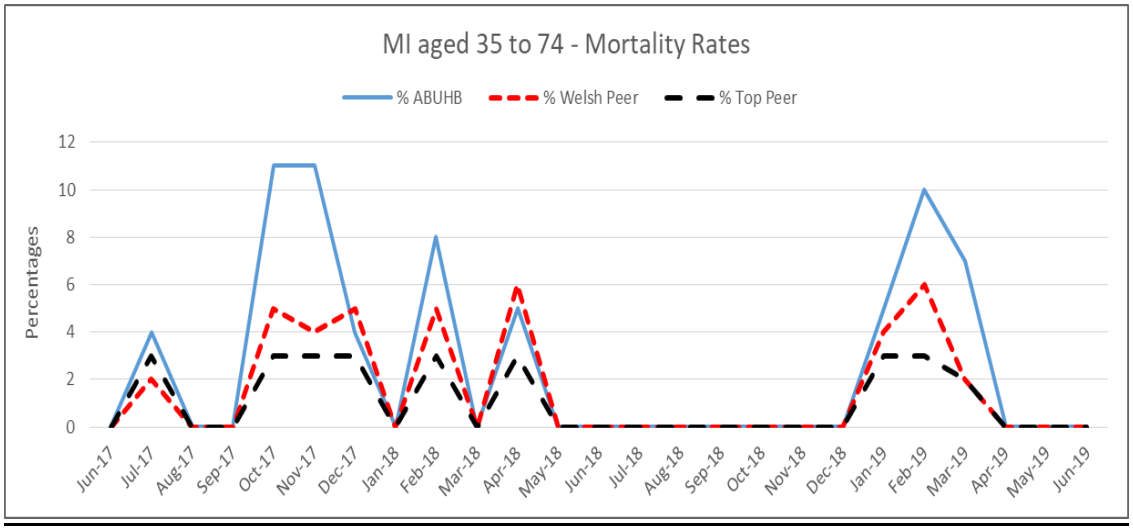
	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Non Compliant	20	37	19	36	24	11	36	24	23	19	15	28
Compliant	69	84	85	83	78	59	100	75	84	58	73	82

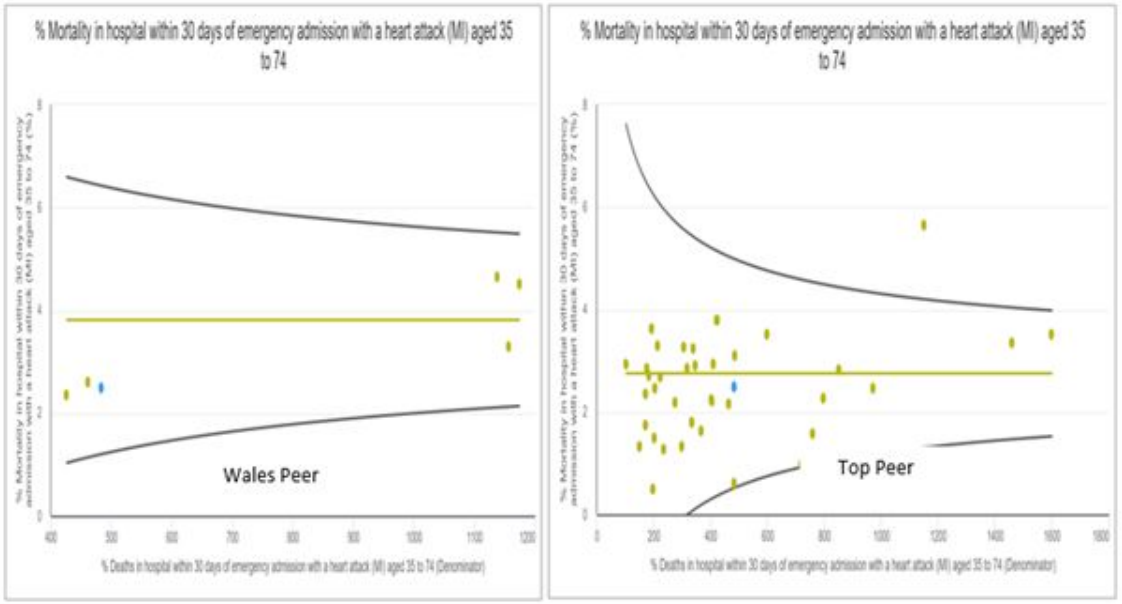
Stroke 30 day mortality against Top Peer





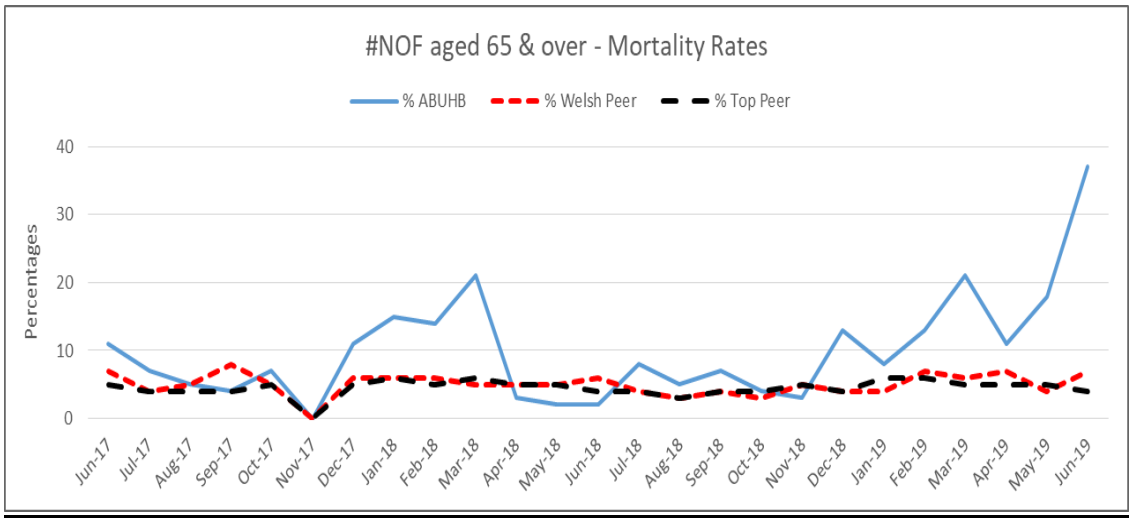
3.6 Myocardial Infarction 30 Day Mortality Ages 35-74 against Top Peer

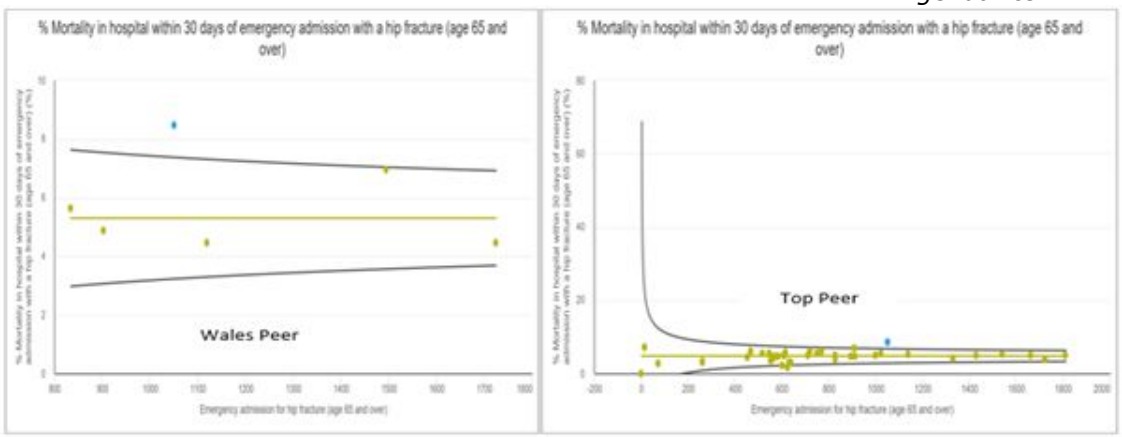




The CHKS data for this measure is under review because of the 6 month period with no deaths.

3.7 Fractured Neck of Femur 30 Day Mortality against Top Peer



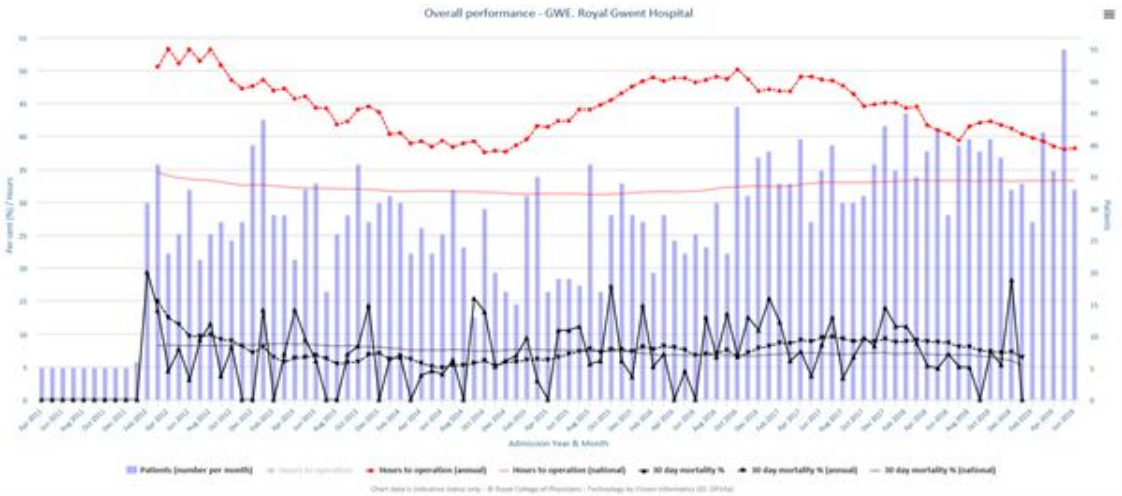


The above data is taken from CHKS, and uses the coded data. As deaths are coded as a priority, and our overall coding completeness is lower than it should be, the higher % mortality recently is in part due to a lower denominator (admissions coded with a fractured neck of femur).

The mortality rate for RGH and NHH for fractured neck of femur is higher than the average for the UK, but improving. Close monitoring of the KPIs and mortality rate will continue, and further changes will be made to improve the KPIs with the aim of bringing the mortality rate in line with or below the UK average.

The Medical Director is liaising with the RCP to see if they can help us understand how we can have a higher mortality rate than the average in the UK but be performing relatively well in the KPI.

RGH National Hip Fracture Database Results



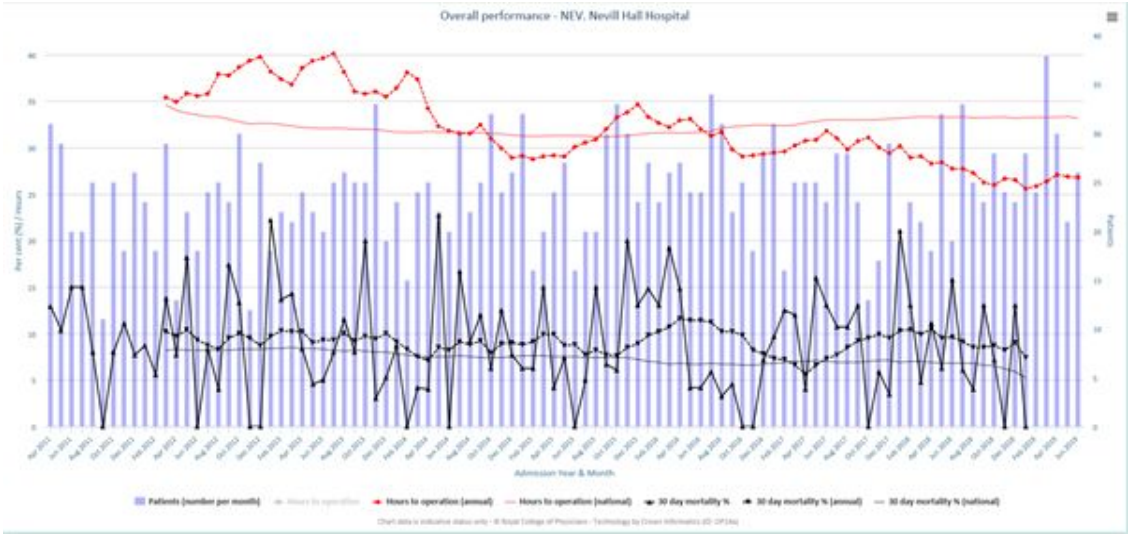
KPI overview: GWE. Royal Gwent Hospital

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

1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery
96%	54%	79%
NHFD overall: 91%	NHFD overall: 69%	NHFD overall: 75%

4. Prompt mobilisation	5. Not delirious post-op	6. Return to original residence
80%	78%	76%
NHFD overall: 81%	NHFD overall: 71%	NHFD overall: 71%

NHH National Hip Fracture Database Results



KPI overview: NEV. Nevill Hall Hospital

Annualised values based on 317 cases averaged over 12 months to the end of June 2019.

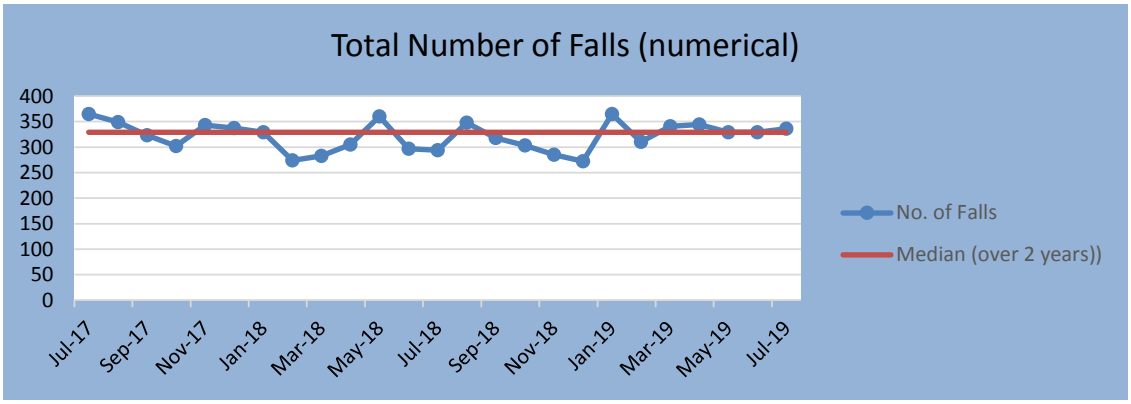
1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery
95%	80%	76%
NHFD overall: 91%	NHFD overall: 69%	NHFD overall: 75%

4. Prompt mobilisation	5. Not delirious post-op	6. Return to original residence
83%	75%	77%
NHFD overall: 81%	NHFD overall: 71%	NHFD overall: 71%

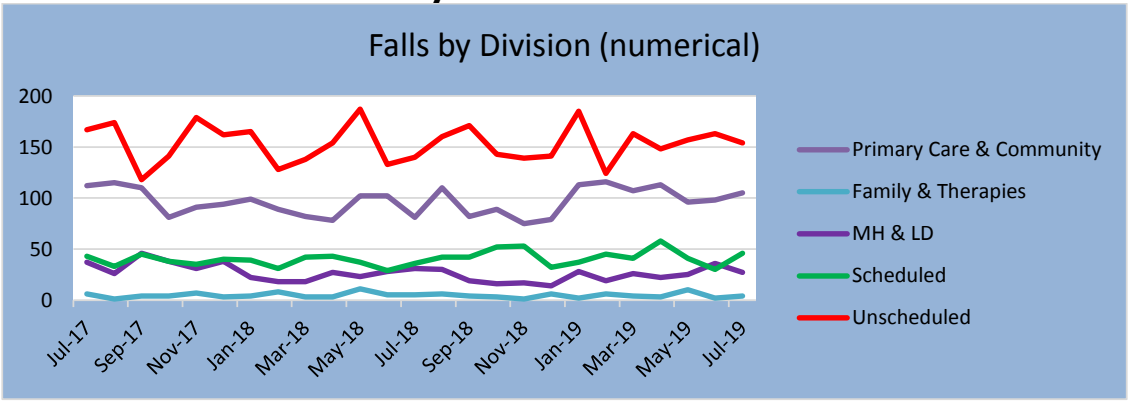
3.8. Preventing Falls

3.8.1. In-patient Falls Data

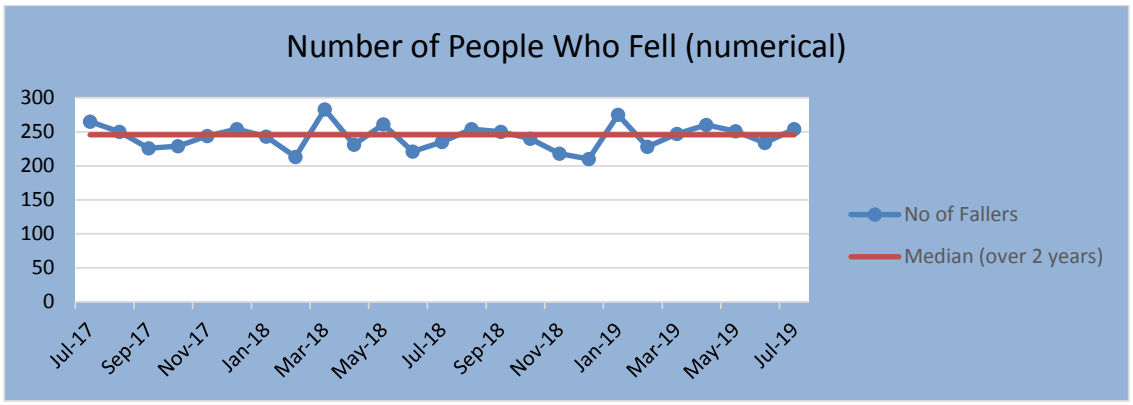
ABUHB Total Number of Falls



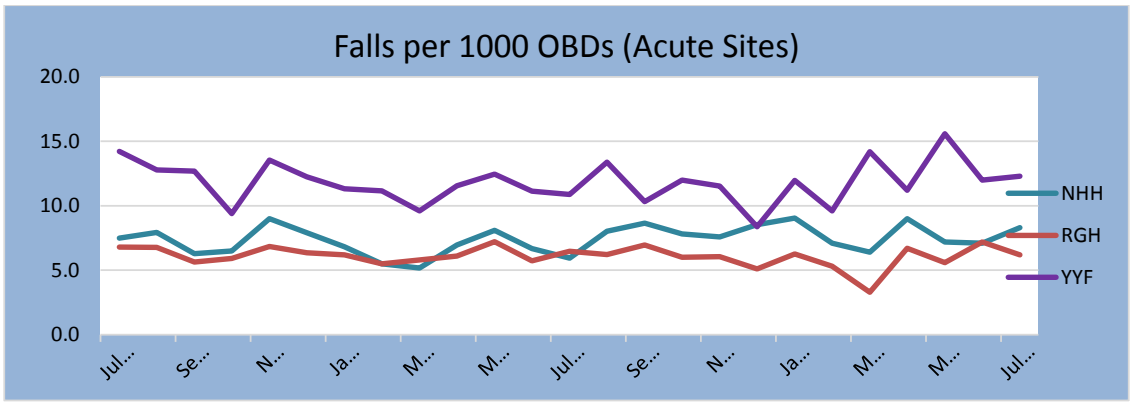
Number of Patient Falls by Division



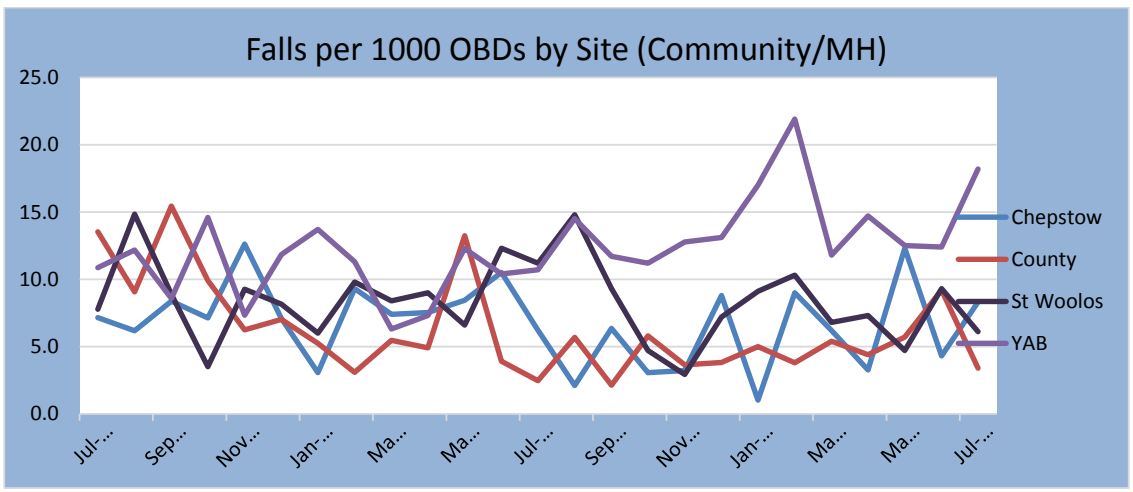
Number of people who fell



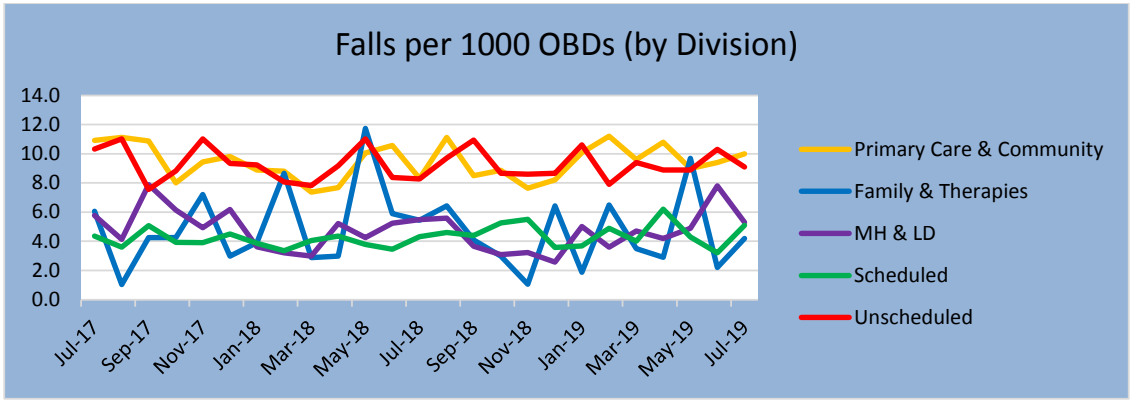
Number of Falls per 1000 Occupied Bed Days by Acute Site



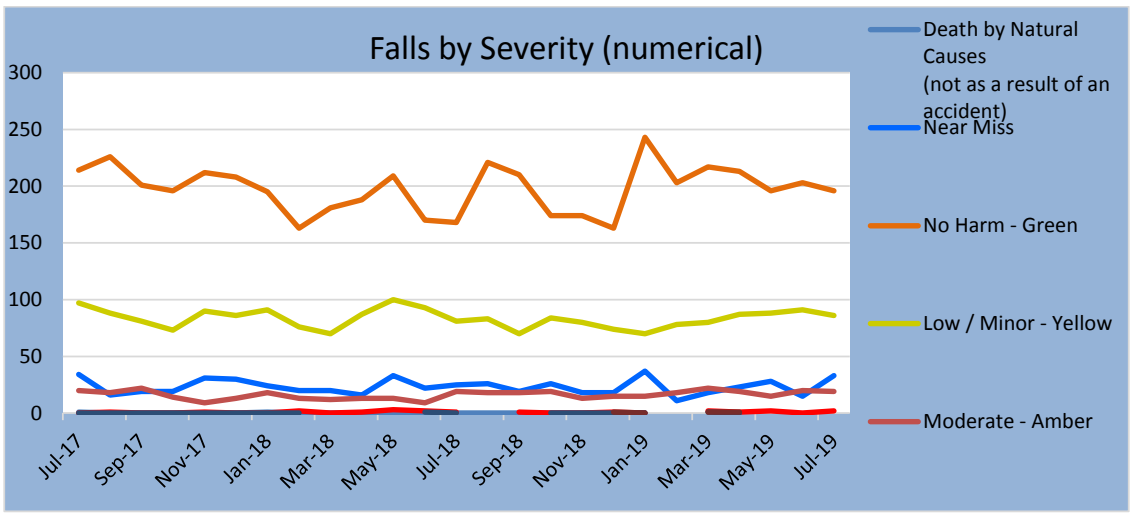
Number of Falls per 1000 Occupied Bed Days by Community/Mental Health Site



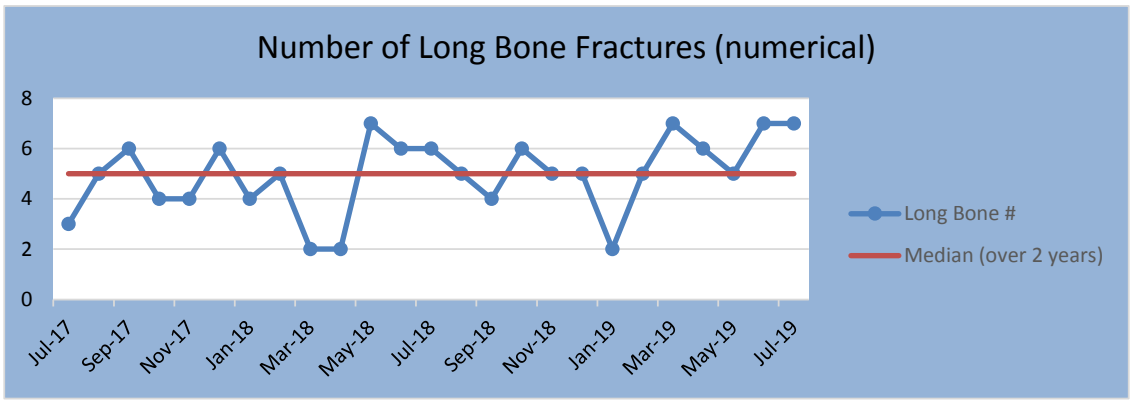
Number of Falls per 1000 Occupied Bed Days by Division

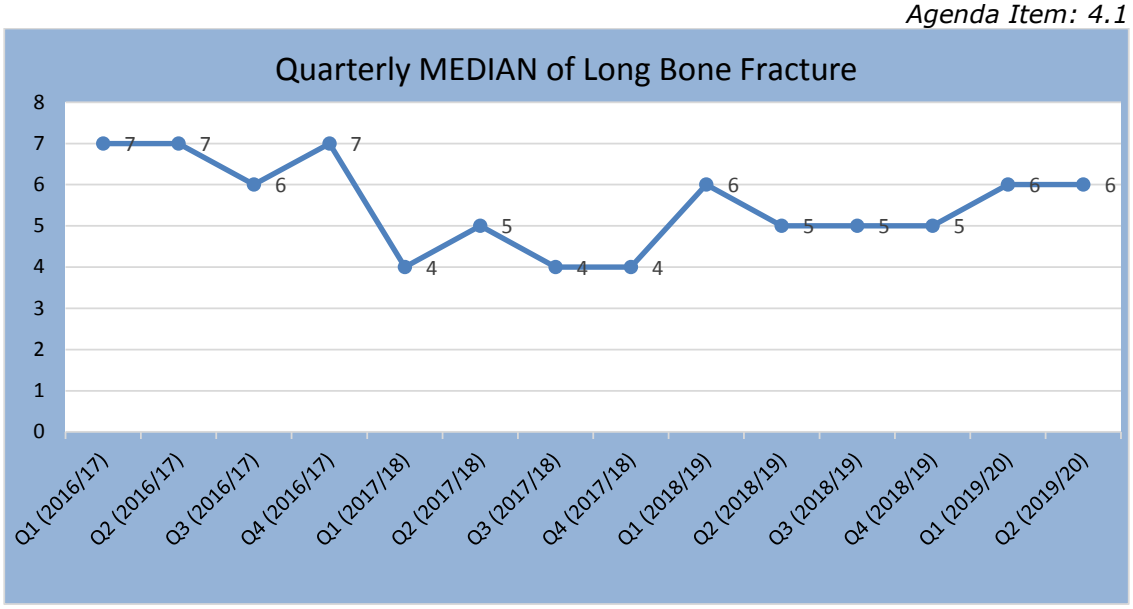


Number of Falls by Severity



Number of Long Bone Fractures





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

The Falls Steering Group has widened its remit to falls and bone health, in order to reduce the number of people that sustain a fracture when they fall as it is not always possible to prevent falls, and therefore improving the bone health of our population will reduce the risk of fracture, even if a person does fall.

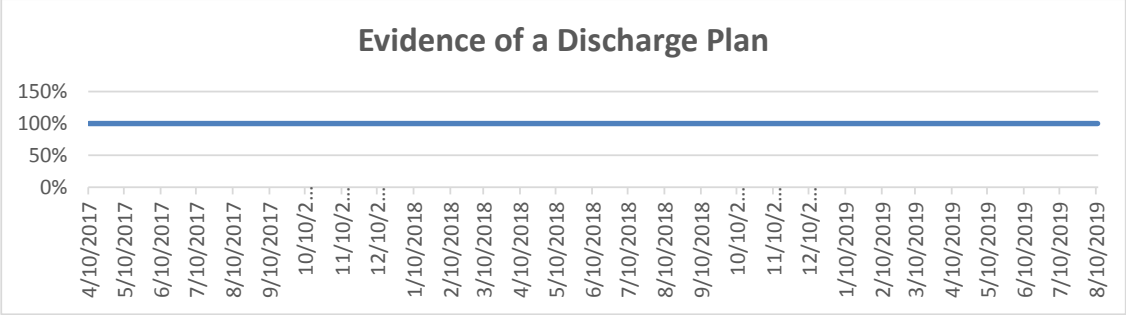
The Falls and Bone Health Steering Group is reviewing the Policy for Prevention and Management of Inpatient Falls to ensure it has captured all the changes that have been made to processes recently. In addition, the Group's action plan is being reshaped to ensure it covers both the hospital and the community,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

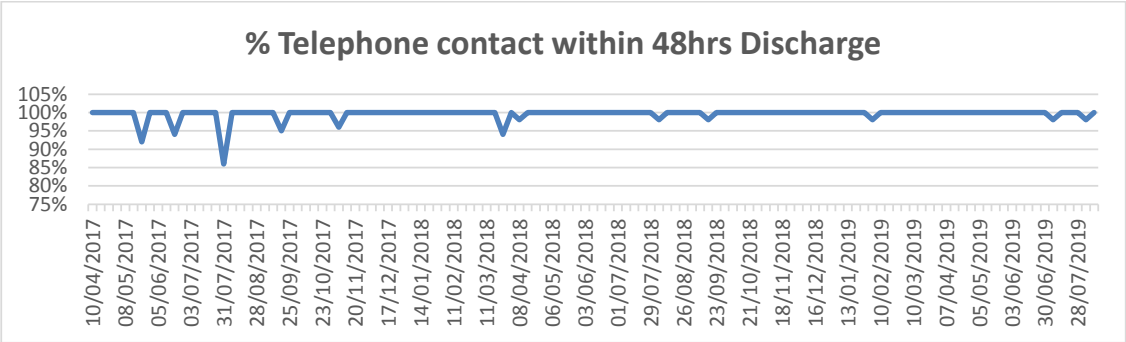
3.9. Mental Health – Compliance with Discharge Plans

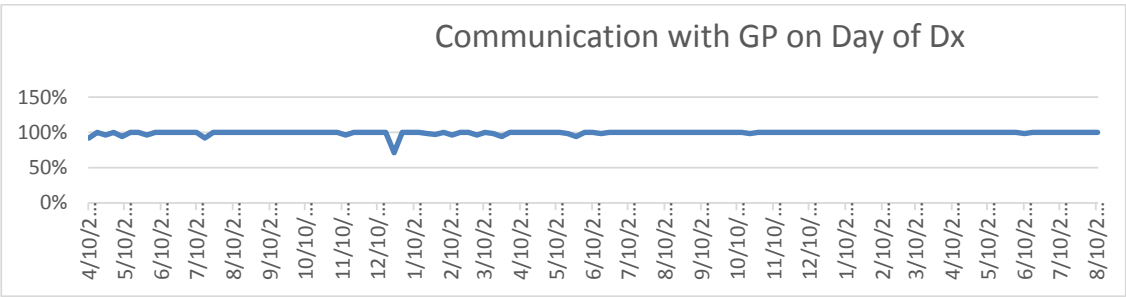
In December 2016 the Coroner issued a Regulation 28 report to the Health Board following the inquest for the death by suicide of a patient on discharge from one of the health board's acute mental health wards. These reports are issued when a Coroner believes that action should be taken to prevent future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

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

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







The Mental Health Division monitors all three elements very closely, and follows up on each instance where the standard is not met, in order to learn and make changes to processes if required. In the case of the telephone

contact, the patient is followed up by a CPN if they can not be contacted by telephone.

3.10. Primary Care – Referrals to Secondary Care

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

Objective	Measure		Latest data	Latest period	Target	Tolerance	Trend - last 24 months
Secondary Care Demand							
ABUHB A&E Activity	New A&E Attendances - Patients Aged >65 Years	Grand Total	1457	Aug 2019	1,476	1,552	
		Blaenau Gwent East	153		128	135	
		Blaenau Gwent West	128		153	161	
		Caerphilly East	171		177	186	
		Caerphilly North	87		93	98	
		Caerphilly South	141		103	108	
		Monmouthshire North	154		149	157	
		Monmouthshire South	85		81	85	
		Newport East	78		102	107	
		Newport North	113		133	140	
		Newport West	106		113	119	
		Torfaen North	137		124	131	
		Torfaen South	104		119	125	
A&E Attendances: The latest reported position as at Aug 2019 was reported as 1457 which is a variance of -95 compared to the same period the previous year which equates to an Decrease of -6.1%. For NCN benchmarking please see table at foot of this report.							
ABUHB Assessment Unit Activity	GP Referrals to Assessment Units	Grand Total	3066	Aug 2019	3,012	3,171	
		Blaenau Gwent East	164		156	164	
		Blaenau Gwent West	226		210	221	
		Caerphilly East	376		390	411	
		Caerphilly North	225		229	241	
		Caerphilly South	253		243	256	
		Monmouthshire North	209		215	226	
		Monmouthshire South	212		181	190	
		Newport East	257		262	276	
		Newport North	285		290	305	
		Newport West	334		284	299	
		Torfaen North	289		294	309	
		Torfaen South	236		259	273	

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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	1789	Aug 2019	1,782	1,876	
		Blaenau Gwent East	129		115	121	
		Blaenau Gwent West	152		144	152	
		Caerphilly East	182		176	185	
		Caerphilly North	79		68	72	
		Caerphilly South	157		142	149	
		Monmouthshire North	173		201	212	
		Monmouthshire South	139		133	140	
		Newport East	119		140	147	
		Newport North	174		190	200	
		Newport West	156		140	147	
		Torfaen North	198		176	185	
		Torfaen South	131		158	166	

Assessment Units: The latest reported position as at Aug 2019 was reported as 3066 which is a variance of -105 compared to the same period the previous year which equates to an Decrease of -3.3%.

Admissions: The latest reported position as at Aug 2019 was reported as 1789 which is a variance of -87 compared to the same period the previous year which equates to an Decrease of -4.6%.
For NCN benchmarking please see table at foot of this report.

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

ABUHB Provider Data	A&E (>65Yrs) Attendances	Assessments (>65Yrs)	Admissions (>65Yrs)	Prescribing
Grand Total	-6%	-3%	-5%	-10.6%
Blaenau Gwent East	13%	0%	7%	15.4%
Blaenau Gwent West	-20%	2%	0%	8.4%
Caerphilly East	-8%	-9%	-2%	-0.5%
Caerphilly North	-11%	-7%	10%	2.9%
Caerphilly South	31%	-1%	5%	-20.7%
Monmouthshire North	-2%	-8%	-18%	-27.3%
Monmouthshire South	0%	12%	-1%	-38.0%
Newport East	-27%	-7%	-19%	-19.6%
Newport North	-19%	-7%	-13%	-8.6%
Newport West	-11%	12%	6%	-24.3%
Torfaen North	5%	-6%	7%	0.7%
Torfaen South	-17%	-14%	-21%	2.9%

3.11 Maternity Services

Caesarean Section Surgical Site Infection Surveillance 1.1.2018-31.12.2018

The most recent data for Caesarean Section Surgical Site Infections (SSIs) is shown below, for RGH and NHH. This is a measure that has been monitored for some time, with some changes to reporting which have impacted on the rates achieved.

Following an inspection by the Healthcare Associated Infections, Antimicrobial Resistance and Prescribing Programme in 2015, the Health Board was advised that it should report all cases of surgical site infection with organisms present (including mixed organisms). This increased the rate of SSIs in 2016. However, in 2017, we were advised to stop reporting cases with mixed organisms present. In 2018, the period within which the development of an infection had to be reported was reduced from 30 days to 14 days, bringing Wales in line with NHS Scotland. It should be noted that most SSIs develop around day 10, so the majority of SSIs will be captured within this timeframe.

NHH has a lower SSI rate than RGH. This is impacted by the RGH taking the more complicated cases, which therefore can have a higher acuity.

ABUHB uses electronic data capture, whereas the other Health Boards in Wales use paper data capture. This explains the higher percentage data capture for ABUHB compared to NHS Wales

RGH

Data from January to December 2018

	SSI Rate[a]	(95% CI)	Total forms received[b*]	Valid post-discharge forms[b**]
Royal Gwent	2.89%	(1.91% - 4.17%)	98%	98%
Aneurin Bevan UHB	2.68%	(1.92% - 3.64%)	97%	97%
NHS Wales	4.01%	(3.57% - 4.48%)	87%	85%

NHH

Data from January to December 2018

	SSI Rate*	(95% CI)	Total forms received[b**]	Valid post-discharge forms[b***]
Nevill Hall	2.34%	(1.25% - 3.97%)	96%	96%
Aneurin Bevan UHB	2.68%	(1.92% - 3.64%)	97%	97%
NHS Wales	4.01%	(3.57% - 4.48%)	87%	85%

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

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The initial section of the report reviews high level data in order to highlight clinical risks in the system. The quality improvement initiatives in this report are being undertaken to improve patient safety and therefore reduce the risk of harm to our Patients. Improved patient safety also reduced the risk of litigation Issues are part of Divisional risk registers where they are seen as a particular risk for the Division.
Financial Assessment, including Value for Money	Some issues highlighted within the report will require additional resources to support further improvement. These will be subject to individual business cases which will contain the full financial assessment. In many cases, improving the quality will reduce harm to patients and/or waste, but this will also be highlighted in the business cases.

Quality, Safety and Patient Experience Assessment	The report is focussed on improving quality and safety and therefore the overall patient experience.
Equality and Diversity Impact Assessment (including child impact assessment)	Advice will be obtained from the Workforce and OD Directorate about how the Impact Assessment is carried out for this report.
Health and Care Standards	Health and Care Standards form the quality framework for healthcare services in Wales. The issues focussed on in the report are therefore all within the Health and Care Standards themes, particularly safe care, effective care and dignified care.
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP and the quality improvements highlighted here are within the Plan.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being Objectives and should also indicate to which Objective(s) this area of activity is linked.*
	Long Term – Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Involvement –Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	The terms are all used routinely in the report, which is presented at every meeting.
Public Interest	Report has been written for the public domain.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality & Patient Safety Committee Wednesday 16th October 2019 Agenda Item: 4.1

4.1

Aneurin Bevan University Health Board

Strategic Framework for Safeguarding 2019 – 2022
Safeguarding Maturity Matrix Assessment 2019

Executive Summary

The NHS Safeguarding Maturity Matrix addresses three interdependent strands regarding safeguarding: service quality improvement, compliance against agreed standards and learning from incidents/reviews. The NHS Safeguarding Maturity Matrix is underpinned by the Health and Care Standards, Wales Future Generations Act 5 Ways of Working and 7 Well-Being goals and the 4 Principles of Prudent Healthcare.

From this, 5 standards have been developed with indicators for each of the standards.

1. Governance and Rights Based Approach
2. Safe Care
3. ACE informed
4. Learning Culture
5. Multiagency Partnership Working

The Safeguarding Maturity Matrix has been adopted by all Health Board and Health Trusts and a self-assessment and plan is completed annually supported by a Peer Review event for Wales to allow sharing of good practice.

The ABUHB Strategic Framework for Safeguarding 2016 - 2019 was developed using the Health and Care Standards (Welsh Government 2015). The 4 Strategic Aims were distilled from the theme of Safe Care of which standard 2.7 is Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

Locally 4 Strategic aims were agreed: -

1. Conforming with legislation and guidance
2. Ensuring effective multi-professional and multi-agency working and co-operation
3. Training and supporting staff
4. Demonstrating assurance of safeguarding across all levels of the organisation

The ABUHB Strategic Framework for Safeguarding has been updated and aligned to the NHS Safeguarding Maturity Matrix. The updated Strategic Framework has been developed in partnership and agreed at the Safeguarding Committee in September 2019. A work plan is being developed and will be presented at the December meeting.

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

Executive Sponsor: Rhiannon Jones - Executive Director of Nursing			
Report Author: Ann Hamlet - Head of Safeguarding			
Report Received consideration and supported by: ABUHB Safeguarding Committee - September 2019			
Executive Team		**Committee of the Board: Quality and Patient Safety Committee**	✓
Date of the Report: 14 October 2019			
Supplementary Papers Attached: **Appendix 1 – ABUHB Strategic Framework for Safeguarding 2019 - 2022** **Appendix 2 – Public Health Wales Safeguarding Maturity Matrix 2019**			

4.1

Purpose of the Report

This report sets out the ABUHB Strategic Framework for Safeguarding 2019 – 2022 and the Safeguarding Maturity Matrix assessment 2019.

The Strategic Framework has been developed in line with the Health and Care Standards (Welsh Government 2015) and builds on the previous ABUHB Framework 2016 - 2019.

An annual plan of work is being developed to take forward the framework. The priorities have been identified following the assessment undertaken of the Safeguarding Maturity Matrix. The work plan based on this assessment will be presented at the December 2019 Safeguarding Committee

The Strategic Framework for Safeguarding 2019-2022, the Safeguarding Maturity Matrix and assessment 2019 are included in the report for information. Both documents have been considered and approved at the Safeguarding Committee on 5th September 2019.

Background and Context

The ABUHB Strategic Framework for Safeguarding 2016 - 2019 was developed using the Health and Care Standards (Welsh Government 2015). The 4 strategic aims were distilled from the theme of Safe Care of which standard 2.7 is health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

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The NHS Safeguarding Maturity Matrix addresses three interdependent strands regarding safeguarding: service quality improvement, compliance against agreed standards and learning from incidents/reviews. The NHS Safeguarding Maturity Matrix is underpinned by the Health and Care Standards, Wales Future Generations Act 5 Ways of Working and 7 Well-Being goals and the 4 Principles of Prudent Healthcare.

From this, 5 standards were developed with indicators for each of the standards: -

1. Governance and Rights Based Approach
2. Safe Care
3. ACE informed
4. Learning Culture
5. Multiagency Partnership Working

In March 2018, the Chief Nursing Officer's Nurse Directors Forum agreed the final version of the Safeguarding Maturity Matrix. It was agreed that it would be used by Health Boards and NHS Trusts to self -assess and obtain a safeguarding maturity score on 'how well they are doing'. The improvement plans and scores were submitted to the National Safeguarding Team to inform the national picture report through the NHS Wales.

Highlight Achievements 2016 -2019

Having completed the Safeguarding Maturity Matrix in 2018, ABUHB developed a work plan that complemented the existing Strategic Framework 2016–2019.

Some of the key achievements from previous framework are: -

Conforming with legislation and guidance

- Following the implementation of the Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) (Wales) Act 2015 the Health Board have been a member of the Regional Partnership Board and contributed to the development of a Gwent wide strategy.

- We currently have 13692 staff and 72% of our staff have undertaken the Group 1 VAWDASV training overall. In the period July to September 2019 online training was completed by 781 people.

- The Corporate Team now has a Head of Safeguarding post in line with other Health Board areas and the safeguarding team are now a Corporate Team. A review of the structure following led to an increase in support for adult safeguarding.

- Awareness raising sessions for the United Nations Convention on the Rights of the Child (UNCRC) were delivered to the Safeguarding Committee.

Ensuring effective multi-professional and multi-agency working and co-operation

- Last year the Gwent Safeguarding Adults Board and South East Wales Safeguarding Children's Board moved to a Single Board with co-chairs.

- The Safeguarding Team contribute to the development and delivery of joint training with the Boards and key partners in the delivery of Multi-agency supervision.

- The Safeguarding Team work with Board partners in the co-production of Regional guidance.

Training and supporting staff

- The Safeguarding Team developed a Level 3 Safeguarding Children Competency booklet which has been shared with other Health Boards.
- The Head of Safeguarding Chaired a Task and Finish group that developed an All Wales Ask and Act package.
- The Safeguarding Team reviewed the training programme for safeguarding children and based on feedback changed the programme to allow more level 3 and bespoke level 2 courses based on feedback from managers.
- The Safeguarding Team co-production training with Gwent Safeguarding Board and the NHS Wales Safeguarding Network.

Demonstrating assurance of safeguarding across all levels of the organisation

- All Wales Guidance for Pressure Ulcer reporting and investigating has been implemented and Scrutiny Panels in place.
- The Safeguarding Team undertook an Audit against the supervision guidance for H/V, School Nurses and LAC. The Supervision models was seen as positive and based on the feedback minor changes made e.g. the booking process and venues used.

Strategic Framework for Safeguarding 2019 – 2022 and Safeguarding Maturity Matrix Assessment 2019

- Consultation for the updated Framework and assessment for the Safeguarding Maturity Matrix 2019 was led through the Safeguarding Committee which includes membership of all divisions. The revised framework was also informed by Welsh Government Statutory Guidance; Working Together to Safeguard People Volumes 5 & 6.
- Our assessment found that we have made progress. Where there is a safeguarding concern within a Serious Incident Report a member of the Corporate Safeguarding Team will now be part of the panel, ensuring learning across. All reviews are shared at the safeguarding Committee with a 7 minute briefing that staff can disseminate in their area. For this year we are building on the work started and actions agreed as part of the assessment will be included in the work plan that will support delivery of the Strategic Framework for Safeguarding.
- In September 2019 the Health Board submitted the Maturity Matrix Assessment that was approved at the Safeguarding Committee to the National Safeguarding Team in preparation for the Peer Review event in November 2019.

Safeguarding Maturity Matrix Improvement Plan

Insert Health Board/NHS Trust Name: ABUHB

Standard	Maturity Score	Current Position	Proposed Action to Improve
1. Governance and Rights Based Approach	4	Progress made in the last year and more embedded in SI process	*To implement safeguarding supervision for Lead Practitioners (Old DLM) *To update training strategy in line with Intercollegiate documents and work with Divisions to improve reporting around compliance
2. Safe Care	3	Examples of good practice identified and agreed priority areas for action.	*Update the Safeguarding Adults Page *Agree a data set of core information for adults and children for use with the Regional Boards *Ensure the implementation of the updated professional concerns in line with Wales Procedures
3. ACE Informed	3	Feel that staff understand what this means but the language of ACEs not embedded	*All safeguarding training to be reviewed to ensure the language of ACES reflected
4. Learning Culture	3	Good structure for dissemination for learning in place but would like to make reports more accessible to front line staff.	*To add a learning section into Safeguarding Intranet pages.
5. Multiagency Partnership Working	4	This is well embedded at a senior level but further work needed with partners in relation to attendance at Strategy Meetings	*To hold a Gwent Wide workshop with partners and paediatricians to agree how they can best inform the strategy meeting *Agree and adapt the Powys Threshold document. *Implementation of Handling Individual Cases across all partners
SMM score:	3		

Assessment and Conclusion

The Strategic Framework for Safeguarding 2019 – 2022 has been developed through consultation. It meets requirements of National Policy and builds on the previous strategy. A key element informing the focus for the work plan to deliver the framework has been the outcome of the Safeguarding Maturity Matrix assessment 2019.

Key strengths following the assessment relate to some of the work undertaken within the Divisions in relation to Pressure Ulcer management and the implementation of scrutiny panels. The actions agreed include the implementation of Welsh Government Statutory Guidance; Working Together to Safeguard People Volumes 5 & 6 which will support staff in meeting their safeguarding responsibilities.

The implementation of the framework and work plan is overseen and monitored by the ABUHB Safeguarding Committee.

Recommendation
The Quality and Patient Safety Committee is asked to: • **Note and endorse the Strategic Safeguarding Framework 2019-22 and associated Safeguarding Maturity Matrix assessment 2019.**

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Reputational risk to the Health Board in not meeting statutory responsibilities Any risks identified by the Safeguarding Committee are escalated to QPS by the Divisional representative.
Financial Assessment, including Value for Money	No financial implications have been identified as actions have been developed using existing infrastructures.
Quality, Safety and Patient Experience Assessment	Will enhance the delivery of Quality, Safety and Patient Experience
Equality and Diversity Impact Assessment (including child impact assessment)	Addresses statutory responsibilities for safeguarding children and adults at risk
Health and Care Standards	Safeguarding Children & Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019 Adult Safeguarding: Roles and Competencies for Health Care Staff First edition: August 2018 Social Services & Well-being (Wales) Act 2014; Social Services & Well-being (Wales) Act 2014 Working Together to Safeguard People Volumes 5 & 6 Handling Individual Cases to Protect Children at Risk and Handling Individual Cases to Protect Adults at Risk. Mental Capacity Act (MCA) (2005); Violence Against Women, Domestic abuse and Sexual Violence (Wales) Act (2015)
Link to Integrated Medium Term Plan/Corporate Objectives	Fully linked to IMTP
The Well-being of Future Generations (Wales) Act 2015 5 ways of working	Fully compliant with the 5 ways of working.
Glossary of New Terms	None
Public Interest	Report to be published in public domain

Appendix 1

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

KEEPING PEOPLE SAFE:

Aneurin Bevan University Health Board Strategic Framework for Safeguarding 2019 - 2022

Contents

The catchment area for Aneurin Bevan University Health Board (ABUHB) for healthcare services contains a population of approximately 600,000. The Health Board is responsible for the health services both provided and commissioned on its behalf. Acute, Intermediate, Primary and Community Care and Mental Health Services are provided by the Health Board and delivered across a network of Primary-Care Practices, Community Clinics, Health Centres, one Learning Disability Hospital, a number of Community Hospitals, Mental Health Facilities, one Local General Hospital and three District General Hospitals. Prison Healthcare Services are also well established. The Health Board employs 16,000 staff, two thirds of whom are involved in direct patient care in hospital, community and care home environments.

ABUHB has developed a comprehensive organisational approach toward patient and client care, which clearly identifies both corporate and clinical accountability and leadership whilst taking full account of all statutory requirements and partnership arrangements.

The Strategic Framework for safeguarding integrates all safeguarding processes, whether concerning a child or adult at risk, recognising the inter relationship and inevitable links between child protection, adults at risk and domestic abuse. It includes proactive measures to keep people safe and working with partners where there are concerns about a persons' welfare.

The purpose of the Strategic Framework for Safeguarding is to set out the current arrangements and build on that already achieved to ensure that ABUHB and all contracted services fully meets its responsibilities for preventing harm and acting on concerns about welfare in the delivery of services for people who live in, work in or visit Gwent.

Definitions

- Vulnerable groups include children, young people and adults who may be at risk of abuse, neglect or exploitation.
- The definition of a child as defined by the Children Act 1989 is a child or young person up to their 18th birthday.
- An adult at risk is defined in Section 126 of the Social Services and Well-being (Wales) Act 2014 as an adult who: -
  - Is experiencing or is at risk of abuse or neglect.
  - Has needs for care and support (whether or not the local authority is meeting needs) **and**;
  - As a result of those needs is unable to protect him/her against the abuse or neglect or the risk of it.
  - Section 197 of the Social Services and Well-being (Wales) Act provides definitions of abuse and neglect.

- 'Abuse' means physical, sexual, psychological, emotional or financial (and includes abuse taking place in any setting, whether in a private dwelling, an institution or any other place).
- 'Neglect' means a failure to meet a person's basic physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being (for example, an impairment of the person's health or, in the case of a child, an impairment of the child's development).

NHS Wales Safeguarding Maturity Matrix

NHS Wales has an essential role in ensuring that all adults and children receive the care, support and services they need in order to promote a healthy, safer and fairer Wales. Measuring the effectiveness of health services in the contribution to safeguarding adults and children is difficult and complex.

The Safeguarding Children Quality Outcome Framework (QOF) was developed in October 2012 and reported annually for three years 2013-2016. In 2017 it was agreed at the Chief Nursing Officer's Nurse Directors Forum, that an all age revised document be developed via the NHS Wales Safeguarding Network. This opportunity to refocus the purpose of self-assessments and to modernise the tool, led to the development of the NHS Safeguarding Maturity Matrix (SMM). It addresses interdependent strands regarding safeguarding: service quality improvement, compliance against agreed standards and learning from incidents and reviews they are doing'.

The Health Board priorities will be aligned to the five standards which are:

STRATEGIC AIM 1

Governance and Rights Based Approach

Legislation and associated guidance details the roles and responsibilities of agencies for safeguarding. This includes levels of accountability; responsibilities and duties of staff; the skills and competencies required by staff to perform their duties; handling individual cases and effective interagency working at all levels.

This includes: -

- Children Act 1989
- Children Act 2004
- United Nations Convention on the Rights of the Child UNCRC
- All Wales Child Protection Procedures (2008) [*currently under review*]
- Safeguarding Children 'Working Together under the Children Act (2004) (2006)
- Protecting Children & Young People, GMC (2012)
- Safeguarding Children & Young People Intercollegiate Document: Roles & Responsibilities for Health Care Staff – January 2019 4th Edition
- Adult Safeguarding: Roles and Competencies for Health Care Staff – August 2018 1st Edition
- Social Services & Well-being (Wales) Act 2014
- All Wales Interim Adult Protection Policy and Procedures in Wales(2010) updated (2013) [*currently under review*]
- NSF, Health Inspectorate Wales, Vulnerable Groups Act (2006)
- NICE 16, Standard 13 (Vulnerable Groups)
- In Safe Hands (2000) [*currently under review*]
- Mental Capacity Act 2005 & Mental Capacity (Amendment) Bill 2019 (Liberty Protection Safeguards)
- Dignified Care: Two Years On (2014): Older Peoples
- Violence Against Women, Domestic abuse and Sexual Violence (Wales) Act 2015
- Mental Health Act, 1983
- Health and Care Standards (April 2015) Standards 2.7
- Counter Terrorism and Security Act 2015

GOVERNANCE AND RIGHTS BASED APPROACH

What has been achieved?

ABUHB has in place clear lines of communication, responsibility and accountability. Whilst the Chief Executive has the overall responsibility for Safeguarding, the Director of Nursing is the lead Executive Officer in taking forward strategic direction and policy implementation and reports on safeguarding matters to the Board.

Senior representation from the Health Board is provided the statutory South East Wales Safeguarding Children Board, Gwent-Wide Adult Safeguarding Board, the Strategic Management Board for Multi-Agency Public Protection Arrangements (MAPPA) and the Violence Against Women, Domestic Abuse and Sexual Violence Board.

An established ABUHB Safeguarding Committee, chaired by an Independent Board Member with divisional representation ensures the implementation, monitoring and audit of relevant guidance reporting directly to the Quality and Patient Safety Committee. The Safeguarding Committee provides a strategic link between ABUHB and the Regional Safeguarding Boards and receives the reports of Domestic Homicide Reviews, Adult and Child Practice Reviews undertaken, monitoring the implementation of recommendations and ensuring that lessons are learnt across the organisation.

ABUHB action plans and work streams are in accordance with the Welsh Government's Strategy for safeguarding children and adults at risk including female genital mutilation (FGM); domestic abuse; child sexual exploitation and children missing from home.

Quality assurance and governance processes including All Wales processes have been developed to ensure that the assessed needs of individual patients who have complex and longer term care needs are regularly reviewed in health board commissioned placements or through commissioned services including:

- Nursing care homes
- Domiciliary care settings
- Learning Disability and Mental Health settings

Going Forward…

All staff working across ABUHB will be empowered and support to meet their duties and responsibilities for safeguarding and public protection. The onward work plan recognises the need to comply with statutory and policy guidance including the Social Services and Well-Being (Wales) Act 2014; the Violence Against Women, Domestic Abuse and Sexual Violence [Wales] Act [2014] Regulation and Inspection Bill 2014 and evolving case law in respect of the Mental Health Act 1983 and Mental Capacity [Amendment] Bill [2019], which concerns Liberty Protection Safeguards.

Priority Actions 2019 – 2022

1 To evidence clear schemes of delegation and transparent governance arrangements across the Health Board.
2 To adopt a Children's Charter in line with UNCRC.
3 Full implementation of Liberty Protection Safeguards.

STRATEGIC AIM 2

Safe Care

Safeguarding is everybody's responsibility and is an integral component of providing high quality clinical services. This is reflected in professional codes of conduct, the ABUHB Values and Behaviour Framework and in job descriptions. This includes having a safe recruitment process that takes into account the risks to vulnerable groups and systems to ensure that staff are able to raise concerns and be heard.

Aneurin Bevan University Health Board (ABUHB) has a statutory duty to ensure the health and safety of NHS patients is maintained where services are commissioned on behalf of the NHS as in a care home. Quality assurance and governance processes have been developed to ensure that the assessed needs of individual patients who have complex and longer term care needs are regularly reviewed in health board commissioned placements or through commissioned services.

Service specifications developed for services commissioned will have in place operational procedures and guidelines in respect of placements to ensure monitoring and escalation of concerns in these circumstances.

SAFE CARE

What has been achieved?

There are clear lines of communication, responsibility and accountability at the Board and throughout the divisions of the organisation to support the delivery of national and local policy.

A Safeguarding Committee is in place Chaired by an Independent Board member, with divisional representation. It ensures the implementation, monitoring and auditing of relevant guidance reporting directly to the Quality and Patient Safety Committee. This committee provides a strategic link between ABUHB and the Regional Safeguarding Boards and receives the reports of Domestic Homicide Reviews, Adult and Child Practice Reviews undertaken; monitoring the implementation of recommendations and ensuring that lessons are learnt across the organisation.

Safeguarding leads are in place in GP and dental practices.

Safeguarding data and activity is collated and reported to the Safeguarding Committee to inform practice, audit and training.

A self-assessment of safeguarding is undertaken annually and reported to Welsh Government.

Going Forward...

ABUHB aims to provide safe and effective care and to ensure full compliance with all Wales procedures for safeguarding children, adults at risk, those at risk from domestic abuse, violence, and exploitation developed under new legislation, and where there are deprivations of liberty.

Priority Actions 2019 – 2022

4 To ensure the Mental Capacity Act (2005) is embedded in practice across the Health Board ensuring a culture of Human Rights.

5 To foster a culture where staff raise concerns about the care provided or commissioned by the Health Board knowing these will be acted upon.

6 Review and further develop the ABUHB training strategy to support staff to meet their responsibilities for safeguarding including; MCA, VAWDASV and to monitor compliance.

7 Develop systems to ensure that safeguarding data informs the Quality and Patient Safety agenda.

STRATEGIC AIM 3

ACE Informed

Adverse Childhood Experiences (ACEs) such as exposure to domestic abuse, substance misuse and mental illness are known to have a direct and immediate effect on a child's health. The safety of the child and the safety of the vulnerable adult are intrinsically linked; preventing early exposure can reduce the impact on children and future generations.

ACE INFORMED

What has been achieved?

ACE indicators and impact have been incorporated into mandatory safeguarding children training.

There is a Regional Violence Against Women, Domestic Abuse and Sexual Violence strategy in place.

Routine enquiry in embedded within Maternity services. Children and young people attending sexual health services are routinely screened for sexual exploitation, and health staff attend CSE strategy meetings.

Going Forward...

ABUHB recognises the importance of staff in all areas being ACE informed to support the development and delivery of services.

Priority Actions 2019 – 2022

8 To ensure services engaged in the provision of care for adult Mental Health, substance misuse and alcohol services are aware of the potential impact on children and young people.

9 Ensure there is a pathway for Domestic Abuse in place and embedded in practice.

10 Ensure information governance systems and internal and external information sharing protocols support new ways of working in safeguarding and for public protection.

STRATEGIC AIM 4

Learning Culture

By promoting a positive culture of multi-agency learning to generate new learning organisations can support continuous improvements in service delivery and practice.

LEARNING CULTURE

What has been achieved?

A Safeguarding Training Strategy was developed supporting staff and their managers to understand the levels of training required appropriate to their role and responsibilities and how to achieve this through a range of learning opportunities.

The organisation actively contributes to the child practice (CPR), adult practice (APR) and domestic homicide review (DHR) processes in the Region and was part of a Home Office approved pilot using the APR methodology to conduct a DHR.

Going Forward...

ABUHB recognises the importance of education and training to support staff with their safeguarding responsibilities. Flexible learning opportunities will be further developed to enable staff to access the levels of training that they need.

Priority Actions 2019 – 2022

11 To ensure that learning from Safeguarding processes including feedback from service users is embedded within the Health Boards learning processes.

12 Ensure systems and processes are in place that the Health Board learns from significant events external to the Health Board.

13 To ensure that opportunities for sharing learning across the Health Board, Commissioned services and multi-agency partners are recognised and supported.

STRATEGIC AIM 5

Multi-Agency Partnership Working

The protection and safeguarding of adults and children relies on multi-agency working and effective information sharing; working together to improve services and outcomes for all.

MULTI-AGENCY PARTNERSHIP WORKING

What has been achieved?

A Safeguarding Team of professionals ensure that expert advice, guidance and support are provided to the divisions; health expertise is available to other agencies; and understanding and contribution to the safeguarding agenda is promoted.

A single point of contact for referrals into the organisation has been developed where there are safeguarding concerns about the welfare of a patient. This ensures a robust response and informs quality assurance processes.

A multi-agency Missing Children Teams is now well established and aims to respond effectively to children missing from home or care placements. This has been expanded to identify and provide a robust response to children at risk of sexual exploitation.

Regional Partnership Boards for Adults, Children and VAWDASV are well established with a supporting infrastructure.

Going Forward...

ABUHB will build on robust multi-agency arrangements and continue to develop and strengthen relationships in order work collaboratively and through integrated services to safeguard vulnerable groups from abuse and neglect.

Priority Actions 2019 – 2022

14 Implementation of the Wales Safeguarding Procedures.

15 Ensure continued senior representation on strategic boards and ensure congruency of strategic action plans across partnerships and the Health Board.

16 ABUHB will work in partnership with other agencies to develop service models to meet the safeguarding needs of vulnerable groups.

Conclusion

This Strategic Framework for Safeguarding sets out the context within which the ABUHB can develop, with its partners, the shared aim of safeguarding those most vulnerable citizens.

The Framework emphasises that safeguarding is everybody's business and requires commitment from every division of ABUHB as well as staff at all levels across the organisation.

Patterns of family life for children and care arrangements for adults vary and there is no one perfect way of bringing up children or caring for vulnerable individuals. Good parenting and good care involve attention to basic and fundamental needs such as warmth, love, stability, consistency, privacy and dignity. ABUHB has the responsibility to ensure that the health contribution to safeguarding is effective in all health services it provides or commissions in order that people whatever their age or ability feel safe and protected.

SUMMARY OF PRIORITY ACTIONS 2019-2022

Strategic Aim 1	Priority Actions	
	**1)**	To evidence clear schemes of delegation and transparent governance arrangements across the Health Board.
	2)	To adopt a Children's Charter in line with UNCRC.
	3)	Full implementation of Liberty Protection Safeguards.

Strategic Aim 2	Priority Actions	
	**4)**	To ensure the Mental Capacity Act (2005) is embedded in practice across the Health Board ensuring a culture of Human Rights.
	5)	To foster a culture where staff raise concerns about the care provided or commissioned by the Health Board knowing these will be acted upon.
	6)	Review and further develop the ABUHB training strategy to support staff to meet their responsibilities for safeguarding including; MCA, VAWDASV and to monitor compliance.
	7)	Develop systems to ensure that safeguarding data informs the Quality and Patient Safety agenda.

Strategic Aim 3	Priority Actions	
	**8)**	To ensure services engaged in the provision of care for adult Mental Health, substance misuse and alcohol services are aware of the potential impact on children and young people.
	9)	Ensure there is a pathway for Domestic Abuse in place and embedded in practice.
	10)	Ensure information governance systems and internal and external information sharing protocols support new ways of working in safeguarding and for public protection.

Strategic Aim 4	Priority Actions	
	**11)**	To ensure that learning from Safeguarding processes including feedback from service users is embedded within the Health Boards learning processes.
	12)	Ensure systems and processes are in place that the Health Board learns from significant events external to the Health Board.
	13)	To ensure that opportunities for sharing learning across the Health Board, Commissioned services and multi-agency partners are recognised and supported.

Strategic Aim 5	Priority Actions	
	**14)**	Implementation of the Wales Safeguarding Procedures.
	15)	Ensure continued senior representation on strategic boards and ensure congruency of strategic action plans across partnerships and the Health Board.
	16)	ABUHB will work in partnership with other agencies to develop service models to meet the safeguarding needs of vulnerable groups.

GIG CYMRU NHS WALES

Safeguarding Maturity Matrix

2019

Purpose and Summary of this Document

The National Health Service (NHS in Wales) is committed to protecting and safeguarding the welfare of vulnerable adults and children.

NHS Wales has an essential role in ensuring that all adults and children receive the care, support and services they need in order to promote a healthy, safer and fairer Wales. Measuring the effectiveness of health services in the contribution to safeguarding adults and children is difficult and complex.

The Safeguarding Children Quality Outcome Framework (QOF) was developed in October 2012 and reported annually for three years 2013-2016. In 2017 it was agreed at the Chief Nursing Officer's Nurse Directors Forum, that an all age revised document be developed via the NHS Wales Safeguarding Network. This opportunity to refocus the purpose of self assessments and to modernise the tool, led to the development of the NHS Safeguarding Maturity Matrix (SMM). It addresses interdependent strands regarding safeguarding: service quality improvement, compliance against agreed standards and learning from incidents and reviews they are doing'.

The improvement plans and scores should be submitted to the National Safeguarding Team to inform the national picture report through the NHS Wales Safeguarding Network to Chief Nursing Officer in Welsh Government. The aim of capturing and collating a national SMM is to provide assurance, share practice and drive improvements towards a 'Once for Wales' consistent approach to safeguarding across Wales.

Using the NHS Safeguarding Maturity Matrix for Self-Assessment

Each area of the Matrix is supported by a number of example indicators which should be considered in order to decide which score fits with the position of the organisation for the reporting period.

An organisation may fit within a particular score if there is evidence available to support the self assessment score. The evidence required for some indicators may be readily available and routinely collated in order to inform other audits. For some areas this may be challenging and systems may not be fully in place to capture data.

Whilst the Safeguarding Maturity Matrix is not intended to performance manage the organisation, a number of examples of evidence have been listed below to support the organisation in agreeing their Safeguarding progress and achievement. In addition to this it is expected to provide a guide in developing the improvement plan.

It is not necessary to provide the evidence for the completion of the SMM, however it would be expected that the evidence would be available within the organisation to support future inquiries by Welsh Audit Office and Healthcare Inspectorate Wales. Completion of the Safeguarding Maturity Matrix will test the concept for a digital solution in the future.

Following the submission of the Improvement plans, the Peer Review process will be used to drive continuous quality improvement involving self-assessment, enquiry and learning between organisations. Peer Review provides a way to focus, in a holistic way, on the quality of a service and the outcomes and experience it delivers.

Reviewers can examine compliance with standards and benchmarking with others, including engagement in service/quality improvement and research. The process will enable safeguarding leads from Heath Boards and Trusts across Wales to undertake the role of a critical friend with each other whilst reviewing and discussing the plans for improvement.

Health Boards and Trusts will be able to build on the concept of working together more closely in relation to fulfilling their safeguarding responsibilities, for example by arranging site visits to respective organisations, sharing pertinent information and attending corresponding safeguarding committees to build on sharing practice and formalise the collaborative approach.

	Progress Levels	Basic Level Score: 1	Early Progress Score: 2	Results Score: 3	Maturity Score: 4	Exemplar Others learning from our reliable achievements Score: 5
Key Elements	1 Governance and Rights Based Approach	Principle accepted, committed to delivery. Less than 25% of the indicators can be evidenced.	Early progress in implementation. 25% or more of the indicators can be evidenced.	Initial achievements are evident. 50% or more of the indicators can be evidenced.	Comprehensive assurance is in place. 75% or more of the indicators can be evidenced.	Clear schemes of delegation and transparent governance arrangements in place. Strong and effective Safeguarding leadership driving a culture of continuous learning and improvements. Can demonstrate safe environments which promote a culture of Human Rights, Children's rights, dignity and respect throughout the organisation.
	2 Safe Care	Principle accepted, committed to delivery. Less than 25% of the indicators can be evidenced.	Early progress in implementation. 25% or more of the indicators can be evidenced.	Initial achievements are evident. 50% or more of the indicators can be evidenced.	Comprehensive assurance is in place. 75% or more of the indicators can be evidenced.	There is a safe and competent workforce to provide prudent care across all services, for example exemplary practice regarding a zero tolerance for avoidable tissue damage. Robust and clear examples can be evidenced.

	Progress Levels	Basic Level Score: 1	Early Progress Score: 2	Results Score: 3	Maturity Score: 4	Exemplar Others learning from our reliable achievements Score: 5
Key Elements	3 ACE Informed	Principle accepted, committed to delivery. Less than 25% of the indicators can be evidenced.	Early progress in implementation. 25% or more of the indicators can be evidenced.	Initial achievements are evident. 50% or more of the indicators can be evidenced.	Comprehensive assurance is in place. 75% or more of the indicators can be evidenced.	Arrangements are in place to consider and mitigate the impact on people living in an environment where they are exposed to Adverse Childhood Experiences (ACEs) such as Domestic Abuse, Mental Illness and Substance Misuse. Robust and clear examples can be evidenced.
	4 Learning Culture	Principle accepted, committed to delivery. Less than 25% of the indicators can be evidenced.	Early progress in implementation. 25% or more of the indicators can be evidenced.	Initial achievements are evident. 50% or more of the indicators can be evidenced.	Comprehensive assurance is in place. 75% or more of the indicators can be evidenced.	Embedded learning culture, committed to learning lessons from reviews and 'concerns raised'. Evidence of organisation wide dissemination of learning and system wide improvements in service and practice shared across the Safeguarding Network. Robust and clear examples can be evidenced.
	5 Multiagency Partnership working	Principle accepted, committed to delivery. Less than 25% of the indicators can be evidenced.	Early progress in implementation. 25% or more of the indicators can be evidenced.	Initial achievements are evident. 50% or more of the indicators can be evidenced.	Comprehensive assurance is in place. 75% or more of the indicators can be evidenced.	Highly developed effective multi agency partnerships to safeguard adults and children. Evidence of improvement, innovation and use of best practice in multiagency working. Robust and clear examples can be evidenced.

1 Governance and Rights Based Approach

Rationale

There should be a clear line of accountability, without doubt or ambiguity about who is responsible at every level for the well-being and protection of children and vulnerable adults.

The UNCRC states that children should be free from abuse, victimisation and exploitation. The environments where children and vulnerable adults are treated should be safe, secure and child friendly.

Example Indicators

- The organisation has a clear Scheme of Delegation for Safeguarding with an Executive member and an Independent Member/ Non-Executive Director who has responsibility for Safeguarding.
- The organisation has a Sub-Committee of the Board with strategic oversight, scrutiny of organisational safeguarding risks and safeguarding assurance. This is supported by a cross organisational arrangement for monitoring and ensuring efficiency of Safeguarding arrangements across all services and function areas.
- Safeguarding policies, aligned to national guidance, are in place and have been formally agreed by the Board (or a Sub-Committee of the Board in line with the Scheme of Delegation).
- Mandatory training is completed by all staff on Equality, Diversity, Human Rights and Child Rights.
- The organisation has a process by which concerns (including complaints and incidents) in relation to safeguarding can be raised, recorded, reported and investigated appropriately.
- Adults and children can communicate in the language of their choice and there is access to independent advocacy and translation services.
- The organisation positively engages with the NHS Wales Safeguarding Network and its sub groups.
- There is a designated person acting as liaison with the Children's and the Older People's Commissioners for Wales.

2 Safe Care

Rationale

All organisations must have a safe recruitment process that takes into account the risks to children and vulnerable adults. There should be a system by which safeguarding concerns about employees should be raised and addressed. Departments and professionals delivering services must take full consideration of their safeguarding responsibilities. Assurance of safeguarding services and processes is evident across all levels within organisations.

Example Indicators

- There is a safe recruitment process and the organisation is compliant with the Disclosure and Barring Service requirements.
- A policy to manage professional abuse allegations and the NHS Wales Procedure for NHS Staff to Raise Concerns (whistle-blowing) has been formally adopted by the Board (or a Sub-Committee of the Board in line with the Scheme of Delegation).
- All staff are made aware of and have access to all policies relating to Safeguarding and Safeguarding information is readily available to all staff via the organisation's Intranet.
- There is a Safeguarding Training Programme agreed within the organisation, consistent with the Intercollegiate Documents as a minimum standard, outlining the various levels of training and target groups.
- All staff working with children and families are supported by regular Safeguarding Supervision and peer review arrangements are in place for paediatricians.
- The Female Genital Mutilation (FGM) Pathway is in place and there is a system in place to ensure that data in relation to FGM as requested by Welsh Government is submitted quarterly.
- There is clear guidance and procedures are in place to ensure that all preventable hospital acquired Grade 3 and 4 pressure ulcers are referred in line with national and local policy.
- There is evidence that the Mental Capacity Act is integral to the organisation's safeguarding processes, including consideration of the wishes, feelings and views of all children aged 16 and 17 years regarding capacity and consent.

3 ACE Informed

Rationale

Adverse Childhood Experiences (ACEs) such as exposure to domestic abuse, substance misuse and mental illness are known to have a direct and immediate effect on a child's health.

The safety of the child and the safety of the vulnerable adult are intrinsically linked; preventing early exposure can reduce the impact on children and future generations.

Example Indicators

- ACE indicators and impact are incorporated into mandatory safeguarding adults and safeguarding children training.
- The organisation has a local Violence Against Women, Domestic Abuse and Sexual Violence strategy specifying objectives, timescales and actions under the requirements of the Act. This has been jointly prepared with the local authority.
- Children and young people attending sexual health services are routinely screened for sexual exploitation.
- The organisation can evidence that children are referred when there are Child Sexual Exploitation (CSE) and Child Sexual Abuse concerns and that an appropriate health professional attends CSE strategy meetings.
- The All Wales Domestic Abuse Routine Enquiry is carried out and monitored within Maternity Services and Health Visiting Services.
- All staff working in Adult Mental Health Services receive training in safeguarding issues and there is a policy in place in relation to children visiting patients in a mental health setting.
- Staff treating adults with mental health concerns consider the risk to children and there are established communication systems in place between mental health and substance misuse services.
- Advice and information on drugs and alcohol services for young people and families is accessible to staff and patients.

4 Learning Culture

Rationale

By promoting a positive culture of multi-agency learning to generate new learning organisations can support continuous improvements in service delivery and practice.

Feedback from patients and clients in the NHS must be used to monitor and improve the quality of services.

Example Indicators

- The organisation actively contributes to the child practice, adult practice and domestic homicide review processes in the Region.
- The recommendations for health from national child practice, adult practice and domestic homicide reviews are acknowledged and changes to current safeguarding systems are made as required in a timely manner.
- As a member of the Regional Safeguarding Board, the organisation monitors and challenges arrangements in implementing agreed changes following a child, adult or domestic homicide review.
- Best practice, learning and new systems or processes implemented following a child, adult or domestic homicide review are shared with others across NHS Wales via the NHS Wales Safeguarding Network.
- There is a mechanism in place to support staff before, during and after a practice review learning event.
- There are opportunities for feedback from vulnerable adults, children and their families in all service areas.
- Information gained from safeguarding concerns and user involvement are used to support learning through audits and improve service delivery.
- Learning from safeguarding concerns, practice and domestic homicide reviews is included in the Annual Quality Statement.

5 Multiagency Partnership Working

Rationale

The protection and safeguarding of vunerable adults and children relies on multi agency working and effective information sharing; working together to improve services and outcomes for all.

Example Indicators

- There is a clear referral process to Social Services, in line with national guidance, with evidence of regular audit and implementation of findings.
- There is evidence of appropriate participation in the Regional Safeguarding Boards and Regional Subgroups.
- There are arrangements in place to fulfil the statutory requirements for Looked After Children resident in the Health Board area with evidence of audit of the effectiveness of this service provision.
- The organisation contributes to the responsibilities of Multi Agency Public Protection Arrangements (MAPPA) and Multi Agency Risk Assessment Conferences (MARAC).
- The organisation contributes to the Procedural Response to Unexpected Deaths in Childhood (PRUDiC) process and there is evidence that information is shared with the National Child Death Review Programme.
- The organisation actively contributes to the multi-agency approach to Modern Slavery Regional working.
- The organisation actively contributes to the multi-agency approach to the duty of PREVENT through Regional working.
- There is evidence of appropriate participation at Public Service Boards in line with the Well Being of Future Generations (Wales) Act.

Examples of Evidence

Governance and Rights Based Approach

- Organisational Structure
- Safeguarding Accountability Structure
- Reporting Framework
- Safeguarding Policies
- Policy ratification process
- Access to Legal Support
- Corporate Safeguarding Meetings
- Safeguarding Practice Guidance
- Serious Incident (SI) Reporting Compliance
- Information Sharing Agreements
- Communication/Media Strategy
- Admission and Discharge Policies
- Intranet Knowledge Hub
- Risk Assessment Tools
- Access to Translation Services
- Access to Advocacy Services

Safe Care

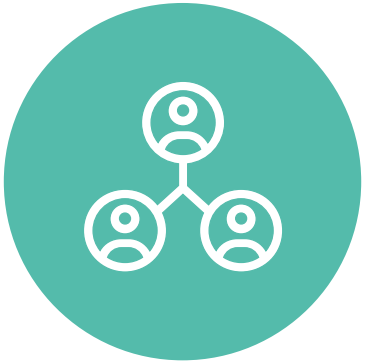
- DBS Compliance
- Safe Recruitment Process
- Complaints/Concerns Policy
- Professional Concerns Policy
- Compliance with FGM reporting
- Safeguarding Job Descriptions
- Children's Charter
- Supervision Policy
- Statutory/Mandatory Training
- Safeguarding Training Strategy
- Pressure Damage reporting
- Child/Adolescent Friendly Services
- Consent Policy
- Mental Capacity Act arrangements

ACE Informed

- DA Routine Enquiry Compliance
- CSE strategy meetings/panels
- CPR/APR/DHR processes
- Ask and Act Compliance
- CSERQ Compliance
- Drug and Alcohol Misuse Policies
- Adult Mental Health Standards
- Adult Mental Health Visiting Policy
- CAMHS Liaison
- LAC Arrangements
- MAPPA Arrangements
- MARAC Arrangements

Learning Culture

- Child Practice Reviews
- Adult Practice Reviews
- Domestic Homicide Reviews
- Sharing Best Practice
- Learning Events
- Annual Quality Statement
- Regional Sub group
- Implementation Plans Compliance
- Stakeholder Feedback
- Putting things right
- DATIX Reporting
- Service delivery audits



Multiagency Partnership Working

- Regional Referral Processes
- Regional Safeguarding Board
- Collaborative Working
- PRUDiC process
- Modern Slavery Statement
- PREVENT arrangements
- CPR/APR/DHR
- Child Death Review Programme
- MASH
- LAC Health Assessments Compliance
- LAC Health Service Audits
- Public Service Boards

Safeguarding Maturity Matrix Improvement Plan

Standard	Maturity Score	Current Position Where a need for improvement has been identified	Proposed Action to Improve
1 Governance and Rights Based Approach			
2 Safe Care			
3 ACE Informed			
4 Learning Culture			
5 Multiagency Partnership Working			
Overall SMM score:			

References and Evidence Base

Adoption and Children Act (2002)

Adult Safeguarding: Roles and Competences for Health Care Staff. Intercollegiate Document (2018)

Adverse Childhood Experiences and their impact on health-harming behaviours (2015)

A Guide to Safeguarding Children and Adults at Risk in General Practice (2016)

A Healthier Wales: our plan for Health and Social Care (2018)

All Wales Child Protection Procedures (2008)

All Wales Clinical Pathway – Female Genital Mutilation (FGM) (2018)

All Wales Pathway Antenatal Routine Enquiry – Domestic Abuse (2006)

All Wales Policies and Procedures for Safeguarding Vulnerable Adults (2000)

Children Act (1989)

Children Act (2004)

Child Sexual Exploitation Prevention Strategy for the NHS in Wales 2016-2019 (2016)

Counter-Terrorism and Security Act (2015)

Data Protection Act (1998)

Female Genital Mutilation Act (2003)

Health and Care Standards (2015)

Human Rights Act (1998)

In Safe Hands - The protection of vulnerable adults from Financial Abuse (2009)

Looked after children: Knowledge, skills and competencies of health care staff. Intercollegiate Role Framework (2015)

Mental Capacity Act (2005)

Modern Slavery Act (2015)

NHS Wales Notification Pathway for Looked After Children (2016)

NICE Guidance Domestic Violence and Abuse: multi-agency working (2014)

NICE Guidance 89: When to suspect child maltreatment (2009)

Putting Things Right (2013)

Rights of Children and Young Persons (Wales) Measure (2011)

Safeguarding and Protecting Children in the NHS – Aylward (2010)

Safeguarding Children and Young people: Roles and Competences for Healthcare Staff. Intercollegiate Document (2019)

Safeguarding Children: Working Together Under the Children Act 2004 (2006)

Safeguarding Training Framework NHS Wales (2019)

Serious Case Review Winterbourne View Hospital (2012)

Serious Crime Act (2015)

Sexual Offences Act (2003)

Social Services Well-being (Wales) Act (2014)Standards for Child Protection Paediatric Services in Wales (2014)

Statutory Guidance on escalating concerns with, and closures of, Care Homes providing services for Adults (2009)

Substance Misuse Service and System Improvement (2011)

Taking Wales Forward 2016-2021 (2016)

The Parliamentary Review of Health and Social Care in Wales (2018)

The Right to Choose Multi agency Statutory Guidance for Dealing with Forced Marriage June (2014)

The Victoria Climbié Inquiry (2003)

Too Serious a Thing - The Carlile Review (2002)

Trusted to Care (2014)

United Nations Convention on the Rights of the Child UNCRC (1989)

Using the gift of complaints - A review of concerns handling in NHS Wales (2014)

Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act (2015)

Wales Interim Policy and Procedures for the protection of Vulnerable Adults from Abuse (2013)

Well-Being of Future Generations (Wales) Act (2015)

You're Welcome: quality criteria for young people friendly Health Services (2011)

Author: NHS Wales Safeguarding Network Email: NST@wales.nhs.uk **April 2019**

NHS Wales Safeguarding Network
Email: NST@wales.nhs.uk
April 2019

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee Wednesday 16th October 2019 Agenda Item: 4.2

4.2

Aneurin Bevan University Health Board

STRATEGIC RISK REPORT FOR QUALITY AND SAFETY

Executive Summary			
This paper provides an overview of the profile of the current risks for which the Quality and Patient Safety Committee is responsible for monitoring, at the end of August 2019. The risk profile of the Health Board is continuing to be revised and reworked. Further rationalisation and redevelopment work continues and will further developed prior to the next Committee meeting. This report is provided for assurance purposes for the Quality and Patient Safety Committee.			
The Quality and Patient Safety Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance	✓		
Note the Report for Information Only			
Executive Sponsor: Paul Buss, Medical Director, Peter Carr, Director of Therapies and Health Science, Rhiannon Jones, Director of Nursing			
Report Author: Rachel Williams, Corporate Services Manager			
Report Received consideration and supported by :			
Executive Team	N/A	**Quality and Patient Safety Operational Group**	✓
Date of the Report: 30th September 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

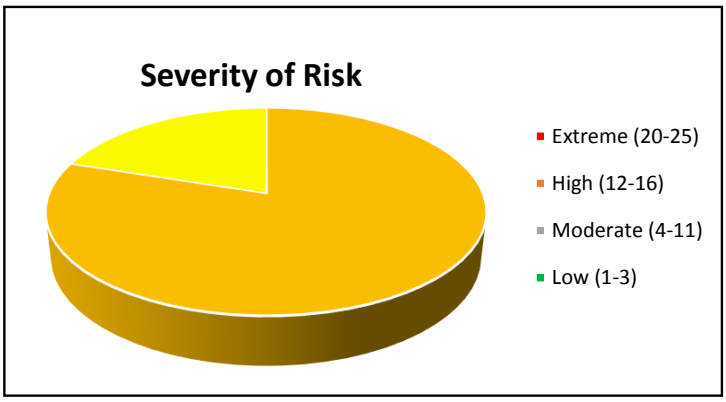
The dashboard reports are generated from the Health Board's Corporate Risk Register. The reports seek to provide in-overview:

- 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.

There are currently 5 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)	4
Moderate (4-11)	1
Low (1-3)	0



There has been 1 risk removed from the Quality and Patient Safety risk register since the last meeting which related to Crisis services in Mental Health not meeting the needs of our population which was scored as 12, high risk. Further details on the specific risks are outlined at the Risk Dashboard which is appended to this report.

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

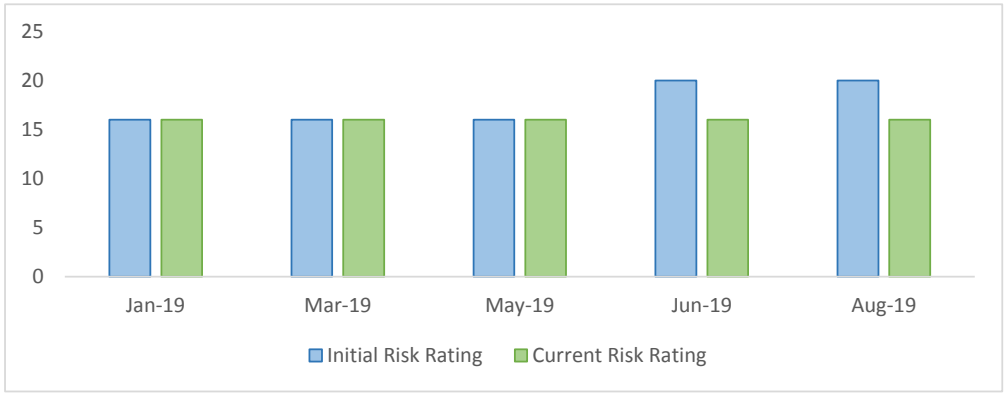
Recommendation
The Quality and Patient Safety Committee is asked to consider this report and note the identified risks as the current quality and patient safety risks for the Health Board as at August 2019.

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

The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to this specific report, however WBFGA considerations are included within the consideration of individual risks
Glossary of New Terms	None
Public Interest	Report to be published

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

CRR015	**Director Lead:** Director of Nursing and Medical Director	**Date Opened:** July 2018
	Assuring Committee: Quality and Patient Safety Committee	**Date Last Reviewed:** August 2019
	Risk: Poor patient experience, deterioration of patient outcomes and quality of care in hospital and community settings due to staff shortages and patients not able to access services on a timely way in both primary and secondary care.	**Target Risk Review Date:** Monthly review undertaken
	Impact: Deteriorating patient experience/outcomes and quality of care.	



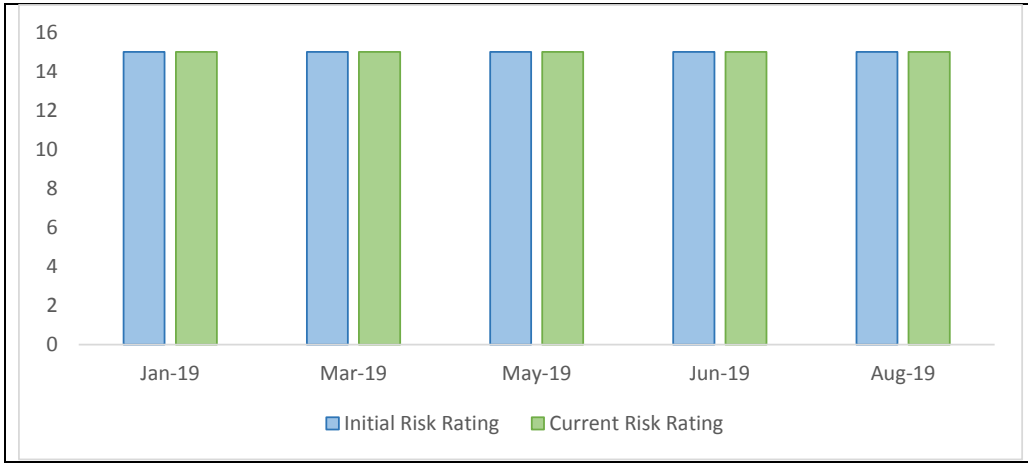
	Consequence	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in July 2019	Risk remained unchanged ⇔		

Controls in place	**Action taken to mitigate the risk**
• Monitoring of quality measures via Quality and Patient Safety Committee; • Patient experience is being captured and specific spot checks are being undertaken • Pressure Ulcer Collaborative and ED turnaround programme • Continued monitoring of HIW/CHC/Complaints/incidents to identify any areas of concern and lessons learnt reported to Executive Team • Workforce planning, planned use of temporary staffing and recruitment strategies in place with regular review • Weekly Clinical Executive Huddles take place and are reported to the Executive Team • A Winter Review and learning has been undertaken and will be reported to the Board in May 2019 and Quality and Patient Safety Committee June 2019	• Reduction in Length of Stay to achieve right patient in right place right time. • Recruitment strategy to be further developed • Real time quality reporting with Cliksense will assist assessment and scrutiny • Further work being undertaken to effectively deliver waiting lists/access targets in light of current demand levels and capacity issues.

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

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

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



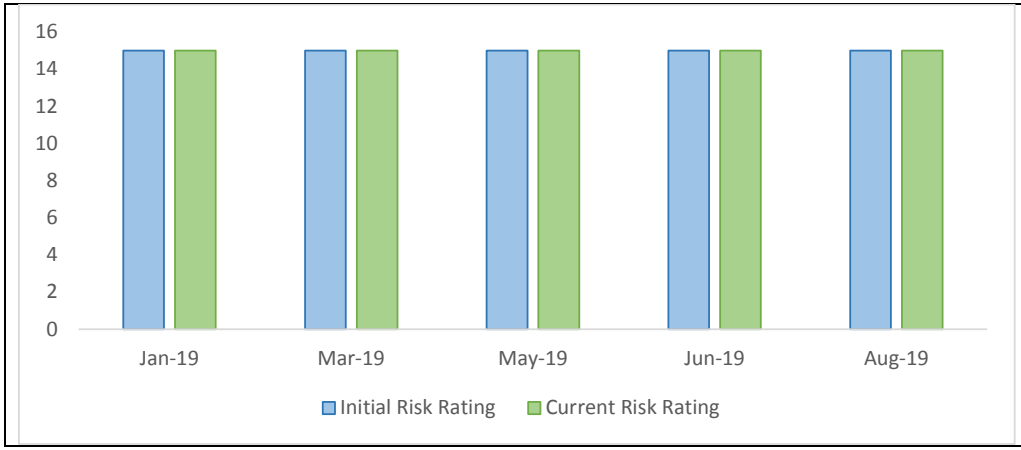
	Consequence	Likelihood	Score
Initial Risk Rating	5	3	15
Current Risk Rating	5	3	15
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in July 2019	Risk remained unchanged ⇔		

Controls in place	**Action taken to mitigate the risk**
• There is an annual programme of HPV cleaning for clinical areas at risk. • An active ward refurbishment programme is in place. • Root cause analysis undertaken for all HCAIs associated with Tier 1 target. • Deep Dives carried out for primary and community acquired infection have been undertaken and an action plan is in place. • Further investment in antimicrobial pharmacy agreed and have recently appointed. Investment in new HPV equipment agreed and procured.	• The Antibiotic Strategy has been reviewed by the Medical Director and key changes made • Antimicrobial prescribing audits have been completed and reported through the Infection Prevention and Antimicrobial Resistance Committee (IPARC). • Development and dissemination of KPIs, with monitoring of outcomes via IPARC.

Assurances	**Links to**
• HIW Reports • Working the Delivery Unit and Reporting • Community Health Council Reports • Internal Audit and Wales Audit Office Report • Reports from the Learning Committee and Lessons Learnt Reports • Divisional Reports including assessments of Health and Care Standards	**Strategic Priorities in the IMTP** This risks links to a range of priorities, but particularly priority 8.

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

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



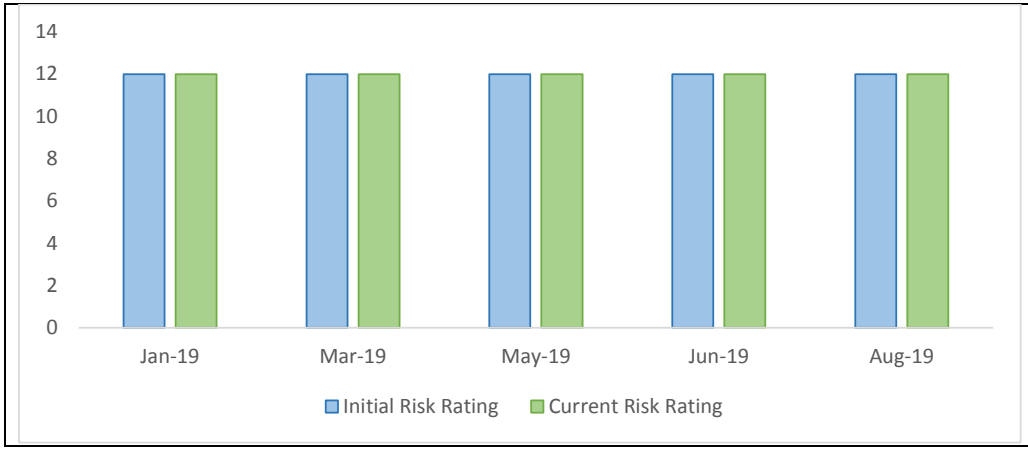
	Consequence	Likelihood	Score
Initial Risk Rating	5	3	15
Current Risk Rating	5	3	15
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in July 2019	Risk remained unchanged ⇔		

Controls in place	Action taken to mitigate the risk
• 'Prevention and Management of Inpatient Falls' Policy has been updated and disseminated widely across the Health Board. • Training ongoing on wards/sites targeting hot spot areas in the first instance. Monthly Falls Scrutiny Panel review and learning from all inpatient falls resulting in a fracture. Numbers of fractures from inpatient falls is reducing.	• The Falls Steering Group is exploring resources for consistent delivery of falls prevention training for all inpatient areas.

Assurances	Links to
• Internal Audit and Wales Audit Office Report • Divisional Reports including assessments of delivery • Reports from Divisional Assurance Meetings • Delivery Framework updates • Executive Team Meetings	**Strategic Priorities in the IMTP** Links to Priority number 8.

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

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



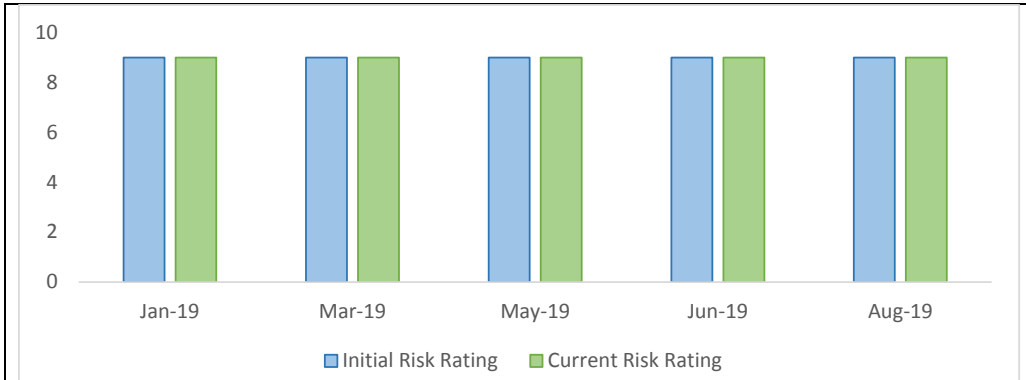
	Consequence	Likelihood	Score
Initial Risk Rating	4	3	12
Current Risk Rating	4	3	12
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in July 2019	Risk remained unchanged ⇔		

Controls in place	**Action taken to mitigate the risk**
• Compliance monitored by the Health and Safety Committee. • Access to on-line training has been simplified via ESR and training compliance rates are steadily improving. • Each Division has received latest data and produce improvement plans.	• Continued staff awareness raising and communication with regard to requirement for compliance and ensuring requirements are a key feature of Division and Corporate Department compliance and assurance reviews.

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

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

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



	Consequence	Likelihood	Score
Initial Risk Rating	3	3	9
Current Risk Rating	3	3	9
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in July 2019	Risk remained unchanged ⇔		

Controls in place	**Action taken to mitigate the risk**
• The Health Board has an approved IMTP, which identifies the key priorities regarding the improvement of health for its population and the allocation of resources to support this. • Budgets are delegated through the organisation based on the priorities set out in the IMTP. • Key IMTP delivery risks, including service, workforce and financial performance are scrutinised at the Finance & Performance Committee. The Finance & Performance Committee will also periodically review the allocation and shift in resources to support the Health Board's priorities. • The Executive Board/Team and monthly Divisional assurance meetings monitor delivery and progress against key risks, including service, quality/safety, workforce and financial performance. • The Health Board's Value Based Health Care Programme aims to improve outcomes for patients making best use of available resources (improving value). This Programme reports to the Quality Patient Safety Committee.	• Continuing focus on IMTP delivery risks • Maximising the opportunities presented by value based healthcare approach.

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

Aneurin Bevan University Health Board

Health Board Committee Update Report

Name of Group:	Quality and Patient Safety Operational Group (QPSOG)
Chair of Group:	Peter Carr, Executive Director of Therapies and Health Science
Reporting to:	Quality and Patient Safety Committee
Reporting Period:	Two QPSOG meetings held in this period, on: 18th July 2019 and 6th September 2019

Summary of Key Matters Considered by QPSOG:

Divisional Risk Registers/Concerns
The Divisional Quality and Patient Safety leads presented the Divisional reports on key risks and concerns related to quality and patient safety.

All the risks and concerns are included in the Divisional risk registers with information detailing the action being taken. The QPSOG was assured that the appropriate action is in place to mitigate the highlighted risks to ensure the quality and safety of services.

To highlight the long standing risk related to workforce (medical and nursing) supply, which features in all operational Division reports.

Corporate Quality and Patient Safety Risks
At the September meeting the Corporate QPS Risks were shared. These risks have been collated following the Divisional Reviews and each having an Executive Lead. The risks will be reviewed routinely and discussed quarterly at the Executive Team and will continue to be shared at the QPSOG. The risks are:

- Outlier for 30 day mortality rate in national hip fracture database
- Management of the Critically ill child Pathway
- Deteriorating patient and Hospital at Night
- Medical Tier 2 Rotas
- GI bleed pathway
- Nurse Staffing on USC Wards
- Staffing at NHH
- Paediatric, Neonatal, and Obstetric services sustainability
- Use of Day Surgery Unit (DSU) for outlying inpatients

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

Putting Things Right (PTR)/ Organisational Learning Report
QPSOG received the PTR report. The report included information about formal and informal complaints received, Ombudsman cases and serious incidents notified. This report will be presented to the QPSC in October 2019.

National Clinical Audit Annual Report
In ABUHB, National Clinical Audit is one of the three main areas of clinical audit activity that is undertaken:

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

The draft report shared with QPSOG provides an overview of all the NCAs. The Medical Director's Support Team will support the audits and make visible to the Clinical Effectiveness Group. A report on each NCA will be submitted to Welsh Government. It was noted that ABUHB intended to improve the profile of clinical audit across the Health Board and better understand how they improve outcomes.

National Clinical Audit Results Overview
The QPSOG received an update on recent National Clinical Audits which focussed on:

- Breast cancer in older people – the main issues identified around diagnostics. An action plan is in place.
- National Vascular Registry – established to provide information on the performance of NHS vascular units and support local quality improvement.

Health Board Wide Clinical Audit Programme
The QPSOG received an update report on the current programme.

QPSOG had previously been invited to make suggestions for the future Health Board Wide Clinical Audits Programme and these had now been added and include Readmissions and Start Smart and Focus. Audits included in the current programme are:

- Implementation of NatSSIPs – to ensure that invasive procedures comply with standards. The pilot audit has been completed, this has been huge and it has been suggested that maybe the focus should be more on never events.

- Antimicrobial Stewardship – to assess adherence to the principles of start smart and focus antimicrobial prescribing, with the All Wales audit tool.
- Informed Consent – to assess whether the completion of the Consent to Treatment Form and Consent process meets the standards in the Consent Policy.
- Readmissions – to assess whether the Discharge Policy was adhered to in DTOC patients that are readmitted in less than 7 days.
- DNACPR – to assess whether clinical practice in relation to the DNACPR process meets the standards set out in the All Wales DNACPR Policy.

QPSOG was informed that in future the Clinical Effectiveness Group will be set up for approval of these audits.

Nurse Staffing Act
QPSOG received a presentation on the Nurse Staffing Act from the Assistant Nurse Director. The presentation provided an overview of the Act and assurance on the action taken in the Health Board to achieve compliance.

Monthly Strategic Workforce /Staffing Act meetings are held within the Health Board with representation from all Divisions, to oversee the implementation of the Nurse Staffing Levels Act across the Health Board and monitor key workforce and staffing metrics.

Incidents due to staffing levels are reported on a weekly basis to the Executive Team. A report on Nurse Staff Act compliance will be provided to QPSOG on a quarterly basis.

Credits 4 Cleaning
The QPSOG received an update report. 37 audits were undertaken in June – 21 wards reached compliance on the day of audit. Assurance of improvement is provided to the Facilities Division.

Choking/Aspiration Guidelines
A draft set of guidelines was shared with QPSOG seeking comments. The guidelines are being developed in response to a clinical incident and confusion about using first aid in the event of choking for patients with a DNACPR. Subject to comments received the draft guidelines will be finalised by Legal Services for approval by the Clinical Policy forum.

HIW – Arrangements for Governance and Learning Following Inspections
The group agreed that reports and agreed action plans / learning from HIW inspections (and any other external body inspections related to

QPS) will be presented to QPSOG in future. The QPSOG agenda format has been restructured to allow time for this.

Radiology Action Plan Following the HIW IRMER Inspection
The HIW inspection took place in October 2018. The regulations were first published in 2000 and rewritten in 2017 with the Health and Safety Regulations included. ABUHB was the first organisation to be inspected under the new regulations and received a good review outcome with no enforcement notices. Licencing, employer's procedures and training documentation are all looked at. 12 protocols and procedures had to be changed and minor improvements made on the ward policy updates. 7 training records out of 3750 were not signed. Recognition of good practice was received. The final report was received and an action plan developed with internal monitoring arrangements agreed and in place. The full report is available on the HIW website.

Patient Identification Issues in Radiology
QPSOG requested an update from Radiology on action taken following issues found in serious incident investigations that involved patient identification concerns. An identification procedure has been implemented. Radiographers now have to ask the patient why they are receiving the radiation. Datix incidents are now logged when the wrong information is found on the form and a four point check is carried out before the examination.

Urinary Catheters
Karen Logan presented on the collaborative approach to reducing harm from Urinary Catheters. A new collaborative approach is being taken, working with the infection prevention team and the wider MDT.

The collaborative meet every three months with the MDT and infection prevention. Clinical incidents are reported on Datix and lessons are learnt about what went wrong. The aim is to reduce unplanned admissions, improve catheter care overall and improve awareness across the Health Board.

Success and progress to date has been to implement a nurse led prescribing service. Also, process mapping what is happening with catheters and listening to the nurses, who welcomed it and as such this has been very successful. Datix reporting has also been very successful. New discharge pathways have been developed to improve discharge arrangements and the catheter passports have been launched across the Health Board. New guidelines for catheter patency solutions have been adopted on an all Wales basis.

The neighbourhood nursing team in Newport are currently trialling TWOC (Trial Without Catheter). Also, Blaenau Gwent are trialling self-catheterisation for patients who need to use them.

A campaign will be launched in November – 'No Catheter November'. There will also be an all Wales Public Health CAUTI/UTI collaboration.

Claims and Litigation Annual Reports 2017/18 and 2018/19
QPSOG members were asked to comment on the two draft reports in advance of being finalised for QPSC.

Quality and Patient Safety Strategy and Assurance Framework
The QPSOG noted the Health Board requirement to develop a Quality and Patient Safety Improvement Strategy and update the QPS Assurance Framework. Time was dedicated on the QPSOG agenda to discuss this in a workshop style session to inform the development of the strategy and framework. This will be brought back to a future QPSOG and QPSC.

Matters Requiring QPSC Level Consideration:

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

- Putting Things Right (PTR)/ Organisational Learning Report (scheduled for QPSC meeting in October 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: 28th November 2019

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 16th October 2019 Agenda Item: 5.2

Aneurin Bevan University Health Board

Sustainability of Women and Children's Services (Paediatric, Obstetrics & Gynaecology and Neonatal Services)

5.2

Executive Summary

This paper provides an overview of the current situation with regard to the sustainability of the medical workforce in Paediatric, Obstetrics & Gynaecology and Neonatal Services during the transition period before the opening of the Grange University Hospital. The paper describes the approach adopted by the Health Board in managing the situation and mitigating the associated risks.

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

Executive Sponsor: Peter Carr, Executive Director of Therapies and Health Science

Report Author: Peter Carr, Executive Director of Therapies and Health Science

Report Received consideration and supported by :

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

Date of the Report: 6th October 2019

Supplementary Papers Attached:

Appendix 1, Report – Review of Paediatric, Obstetric and Maternity Services by the Faculty of Medical Leadership and Management

1. Purpose of the Report

The purpose of the report is to:

- Update the Committee on the current situation regarding the sustainability of paediatric, obstetrics and gynaecology and neonatal services within the Health Board arising from recurring workforce pressures.
- Provide an overview and assurance to the Committee of the approach being taken to manage the sustainability issues described and mitigate the associated risks.

2. Background

The sustainability of a number of acute specialties will ultimately be achieved through their centralisation at The Grange University Hospital in spring 2021, including inpatient care for paediatrics, obstetrics, gynaecology and neonatal services. The case for change for most services in Gwent was first developed in 2005 and resulted in the approval of the Gwent Clinical futures Strategy following consultation in 2007.

The relevance of the Health Board's strategy was reinforced by the outcome of the South Wales Programme consultation, which recommended for Gwent that consultant-led maternity and neonatal care and inpatient paediatric services be centralised at the planned Specialist and Critical Care Centre (SCCC). The capital case for the SCCC was approved by Welsh Government in October 2016.

The foundations of the Clinical Futures strategy are:

- Reduction in inequality
- A focus on prevention
- Integrated care and partnership working
- Safe services as locally as possible
- A refresh of the Local General Hospital (LGH) service model
- A Specialist and Critical Care Centre

For maternity services, this means the Health Board will:

- Provide and develop antenatal and community midwifery services ensuring good access to advice and support throughout the pregnancy
- Offer women and families the options of a home birth or delivering their baby at a midwife-led unit
- Concentrate 24/7 consultant-led services on a single site in order to ensure safe services provided by safe staffing levels and strong clinical teams

For Paediatric Services:

- The majority of children will be seen in out-patient clinics by community paediatricians
- Concentrating 24/7 consultant-led inpatient paediatric services on a single site to ensure safe clinical care at safe staffing levels

In advance of the opening of the Grange University Hospital, in 2015/16 the Health Board was required to implement new workforce models to sustain paediatrics, obstetric and neonatal services at Nevill Hall Hospital. This was the result of Deanery requirements to centralise medical trainees at the Royal Gwent Hospital and to quickly introduce a new workforce model at Nevill Hall Hospital. The impact was to effectively remove a middle grade tier of medical cover. This required the additional appointments and the subsequent loss of Deanery neonatal trainees in neonatal services. In March 2017 this had a similar impact at the Royal Gwent Hospital, requiring additional posts to sustain services. The Health Board has invested circa £2m in additional workforce in sustaining the current configuration of maternity and paediatric services.

While services have been sustained across the two sites, it has not always proven possible to recruit and retain staff to posts as required and as a consequence these services are partially reliant upon medical agency staff to cover vacant posts and the rotas are increasingly fragile. This is despite considerable efforts having been made to recruit staff, including a dedicated international recruitment exercise.

The following summarises the current workforce position for the respective specialties across both Nevill Hall and Royal Gwent Hospitals.

2.1 Obstetrics and Gynaecology Medical Workforce

The pressure is most acute on the middle grade rota at Nevill Hall Hospital, where half the posts are covered by non-substantive staff (agency locum doctors). Whilst there has been initial success in filling these middle grade posts, they have not been retained with staff moving internally and externally to non-resident Consultant posts. As a consequence, we continue to cover these gaps with locums (in addition to our substantive doctors). Recent successful recruitment of Consultant posts has provided additional stability to support this position and reduce the risk.

At Royal Gwent Hospital the middle and junior doctor rotas are filled by Deanery posts. Whilst there are gaps on the junior doctor tier, the Health Board is sustaining its rotas.

Previously, there had been a turnover of experienced midwives because of uncertainty with the sustainability of obstetric services at Nevill Hall Hospital in advance of the opening of the Grange University Hospital. In the past six months this situation has resolved, with some midwives returning to ABUHB and the Directorate having been successful in filling midwifery vacancies. ABUHB remains compliant with Birthrate Plus standards.

2.2 Neonates

Medical cover for the Special Care Baby Unit at Nevill Hall Hospital is provided by the Nevill Hall Hospital paediatricians with outreach support from Neonatologists at the Royal Gwent Hospital.

By way of contrast, the Neonatal Service has successfully implemented a recruitment and retention strategy to sustain services without Deanery trainees. As a tertiary unit, it is able to offer specialist training to international doctors and in this regard has an advantage compared with the Health Board's Paediatric and Obstetric Services.

2.3 Paediatrics

In NHH, an innovative model of Tier 3 Hybrid Consultants doing resident nights reduces the burden on agency and creates a more sustainable environment. Seven consultants work half of their jobs out of hours on the middle grade rota. This is further supplemented by two regular agency locum doctors and a substantive specialty doctor.

A reduction in number of trainees allocated to the health board has meant that the tier 2 (middle grade) doctors are centralised on the RGH site and since September 2019 have been reduced further. Training numbers allocated by HEIW have been cut to less than the number required to maintain the rota as they include doctors on maternity leave and some have given notice. Currently the Directorate is covering the rota gaps by using agency locum doctors. The Directorate is also pursuing the recruitment of additional Hybrid Consultant posts with a middle grade component to their job plan; this will benfit both RGH and NHH. The Health Board continues in negotiation with HEIW on the middle grade training allocation.

In the RGH, there are gaps in the acute rota at RGH at consultant level as consultants have moved to community paediatric posts (not involved in the on call rota). While this contributes to a more viable community paediatric model (we have used vacancy monies to fund 2 WTE to fulfil safeguarding section 47 work, serve the ISCAN project and support the pressured statutory roles such as fostering and adoption medicals), it creates further pressures for the acute tier 3 rota. In the past six months there has also been some planned sickness absence in the RGH Consultant team which has added further strain on the team covering their rota. The recruitment of the additional Hybrid Consultants (described above) will also provide additional stability for the Consultant team.

With recognition that the position regarding paediatric and obstetric medical staffing remains challenging, the Health Board has continually reviewed the situation should the current configuration not prove sustainable until the opening of The Grange University Hospital in spring 2021.

In summary, the workforce pressure points are in obstetrics and gynaecology and paediatrics where middle grade rotas are partially reliant on medical locums, which often are difficult to secure.

2.4 Understanding and Managing the Risks with the Current Clinical Models

The continued reliance on locums in both paediatric and obstetric services has an adverse effect on the continuity of care, with an inability to provide consistent teams, and as a result of turnover, unpredictable and variable competencies. Senior medical staff, and in particular consultant staff, are working harder and harder to maintain safe standards but this can be to the detriment of their wellbeing.

The continued and increasing gaps in the trainee tier of the rota is also having a detrimental impact on the training experience, evidenced by recent GMC surveys for Paediatric training.

In January 2019, the Health Board commissioned the Faculty of Medical Leadership and Management to undertake an independent review of the key risks related to Paediatric,

Obstetric and Maternity Services. This review consisted of interviews conducted over two days with a variety of clinical and non-clinical staff from the services under review, across the two sites and associated services such as ED and anaesthetics, and a review of background documents provided. The full review report is at Appendix 1; the final recommendations and observations are as follows:

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

Since this review was undertaken, the Faculty of Medical Leadership and Management have been further commissioned to undertake the review of the current policy and pathways, on the two sites, for the management of the critically ill child; this review is expected to conclude by December 2019.

The status of the rotas and the related impact on the service, including any clinical incidents or concerns, is closely monitored by the Family and Therapies Division, with a weekly Service Impact Assessment report being completed for Executive scrutiny.

While no significant issues or adverse clinical outcomes have occurred related to the medical workforce fragility, continued monitoring of the risks and oversight of the mitigation action continues at Executive level.

Because of this ongoing situation, for the past 12 months, the Paediatric, Neonatal, and Obstetric services, has received a higher level of scrutiny, management and planning. The Women and Children's Transition Board has been established and weekly assurance meetings are held with the Division, all chaired by the Executive Director of Therapies and Health Science as Senior Responsible Officer. The Board and Executive Team have received regular updates during this period on a routine and exception basis. These governance and assurance arrangements are further described in more detail below.

3. Approach to Managing and Reducing the Risk

Whilst the supply of medical workforce for Paediatric and Obstetric services has been challenging for a number of years, the approach adopted by the health board has been close monitoring of the rota sustainability and associated risk, with the view to maintaining the current two site acute configuration until the opening of the Grange University Hospital.

To address service delivery risks, the volume and activity of obstetric activity at Nevill Hall Hospital continues to fall, with the activity in the last year <2000 births with the majority of premature babies <34 weeks delivered at the Royal Gwent Hospital along with an increasing proportion of complicated obstetric cases. Also, since 2017, the Paediatric take

(urgent GP referrals) has been transferred to the Royal Gwent Hospital from Friday evening until Monday morning; during which time Paediatric inpatient beds are retained at Nevill Hall Hospital and self presenting patients are still accommodated.

3.1 Future Opportunities to Sustain Services

The emphasis currently is maintaining the two site model until it is centralised at the Grange University Hospital. Recognising the increasing pressures in Paediatric services, Executive agreement has been given to recruit additional medical posts, such as hybrid Paediatric consultants to further bolster the middle grade rotas. This option has proven successful at Nevill Hall Hospital in the past but is dependent on suitable applicants, which remains a risk. Also, there will be further negotiation with HEIW on the Paediatric tier 2 trainee allocation.

Recognising the current pressures and the recommendations of the FMLM, the Executive Team has carefully considered the option to centralise these services in advance of the opening of the Grange University Hospital; the following issues have been taken into account in this consideration:

The basis of an early centralisation option being that by bringing together medical teams from the two sites would resolve the current rota gaps. However, a centralised service, particularly in Paediatrics would require an additional Tier 3 rota (Consultant level) because of the amount and acuity of the activity. It is understood that the individuals who have currently taken Hybrid Consultant posts at NHH would not choose to transfer their posts to RGH. Considering these Hybrid Consultants also contribute to the middle grade rota then this benefit would also be lost with centralisation. Furthermore, it is understood that some of the current locum doctors working at NHH would also choose not to work at RGH. It should be noted that some of these issues would prevail with centralisation at GUH but it is not anticipated to lose the Hybrid Consultants. The Division continues to plan and confirm the rotas for GUH.

Importantly, an early centralisation of these services at RGH does not change the function of the Emergency Department (ED) at NHH, which would still receive sick children who present in an emergency, whether by emergency ambulance or walk-ins. This is fundamentally different to the model that will be in place when the GUH opens. An early centralisation model at RGH, that removes Paediatricians from NHH, presents a significant risk for the management of sick children presenting at NHH.

The Executive Team has also considered the critical interdependency of Paediatrics with Obstetric and Neonatal services; centralisation of Paediatrics also requires centralisation of these service. The impact of centralising Obstetrics at RGH in advance of GUH would mean that some women then choose Prince Charles Hospital for their delivery. The Executive Team has not been able to get assurance that this capacity at Prince Charles Hospital would be available to allow centralisation at RGH. This has been an important factor in decision making on the plans for sustaining these services in advance of GUH.

Considering the above, the Executive Team has concluded that an early centralisation in advance of GUH would not resolve the current risks to the service in terms of workforce sustainability and could actually introduce greater risks in terms patient safety and capacity.

3.2 Regional Considerations

Senior planning managers and clinicians from Health boards within South East Wales continue with collaborative regional planning in response to service fragility in all Health Boards, related to medical workforce supply. ABUHB continues to review and secure assurance with the service we commission from neighbouring health boards, not just in terms of sustainability and capacity but also in terms of quality, safety and patient experience.

The Health Board is proposing working jointly with Powys Health Board on an approach to commissioning assurance and this work is being led by the Nurse Director.

4. Governance Arrangements

In 2016 the monthly Paediatric Sustainability Board was established, but with the increasing deterioration in the medical workforce rotas with Obstetrics and Gynaecology through 2018, the remit and scope of this group expanded. In November 2018, in light of the escalated risk of the workforce sustainability, a weekly assurance and planning meeting was put in place instead of the monthly Sustainability Board.

The weekly assurance group has been meeting since November 2018 and is chaired by the Executive Director of Therapies and Health Science. The weekly meeting includes representation from the Executive Director of Planning; the Deputy Director of Planning; the Family & Therapies Divisional Director and Assistant Divisional Director, and further representation from the Divisional Management Team. The group also has input from Workforce and OD, Finance, Corporate Communications and the Associate Director of Engagement. This weekly meeting seeks assurance from the Division on the current situation with the medical rotas, clinical risk and issues, and staff wellbeing; it also provides opportunity for further escalation if required.

In May 2019, the Clinical Futures programme appointed a Programme Manager to support the transition planning for Paediatrics, Obstetrics and Neonates. At the request of the Executive Director of Therapies and Health Science a new programme and governance structure was implemented to provide continued leadership and oversight to the transition planning of these services. A six weekly Women & Children's Service Transition Board has been established to provide the strategic oversight of the work programme with the Executive Director of Therapies and Health Science as Chair and programme SRO. The Women & Children's Service Transition Board reports to the Clinical Futures Service Transformation Board and provides regular updates to the Executive Team. The weekly assurance meeting continues so as to provide the timely assurance on safety and staff wellbeing and the delivery of the programme actions.

5. Communication and Engagement

Community Engagement

Conversations and engagement in respect of the vulnerability of services have already taken place with political stakeholders, Community Health Councils and Leaders of the Councils. The challenges described in this paper, and the future strategic direction for these services with Clinical Futures has also been shared in community engagement events over the past 12 months.

Workforce engagement
The staff from Paediatrics, Neonates, Obstetrics and Maternity have had ongoing engagement with the Divisional management, which has increased in intensity over the past 12 months. Members of the Executive Team also regularly meet with the clinical teams to hear concern and provide reassurance of the action being taken.

Recommendation

The Committee are asked to:

- Note the update on the current situation regarding the sustainability of paediatric, obstetrics and gynaecology and neonatal services within the Health Board arising from recurring workforce pressures and associated clinical risks.
- Receive and note an overview and assurance of the approach being taken to manage the sustainability issues described and mitigate the associated risks.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The sustainability of the current two site paediatric, obstetric and neonatal service has been subject to detailed risk assessments by the Division. The risks have been further assessed and confirmed by external consultants.
Financial Assessment, including Value for Money	An assessment of financial flows has been undertaken
Quality, Safety and Patient Experience Assessment	Throughout the planning process, quality, safety and patient experience is evaluated and used to inform the service models.
Equality and Diversity Impact Assessment (including child impact assessment)	As part of the work to consider a centralisation option, a desktop EIA has been completed.
Health and Care Standards	Informed by relevant HaCS: 2- Safe Care; 3- Effective Care; 5- Timely Care, 7- Staff and Resources
Link to Integrated Medium Term Plan/Corporate Objectives	Aligns with Service Change Plan 7: Sustainable Services and Regional Planning.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** A safe and sustainable service provision supports and ensures the longer term health and wellbeing of women and children in Gwent.
	Integration – Women and children's services in Gwent span acute and community, bringing together health and social care. Ongoing sustainability of the acute service is essential to ensure an integrated pathway of care.

	Involvement – planning women and children's services as part of the Clinical Futures strategy has involved engagement with a wide range of internal and external stakeholders, including service users.
	Collaboration – Development of women and children's services is a collaboration between health boards, WAST and local authority partners, at a local and regional level.
	Prevention – The provision of women and children's services has an important focus on prevention and self-management.
Glossary of New Terms	There are no new terms.
Public Interest	None identified

5.2

Review of Paediatric, Obstetric and Maternity Services

Aneurin Bevan University Health Board

About FMLM

FMLM is the UK professional home for medical leadership and an independent charity. The fundamental objective of the organisation is to improve patient care through better medical leadership and FMLM takes the broad view that all practicing doctors need leadership and management skills commensurate with the level at which they work. This is underpinned by research evidence and supported by our *Leadership and management standards for medical professionals*.

FMLM Applied, the organisational support arm of FMLM, provides bespoke support to healthcare teams, organisations and systems to improve outcomes for patients and populations through effective medical leadership.

Introduction

This review was commissioned to address key clinical risk issues relating to the current configuration of paediatric, obstetric and maternity services within the Aneuran Bevan University Health Board (ABUHB).

The paper summarises discussions and informal interviews conducted over a two-day period by a team led by a Senior Associate of the Faculty of Medical Leadership and Management (FMLM) with key support from members of staff, clinical and non-clinical[1].

The strategic, financial and demographic issues associated with any eventual re-configuration are addressed elsewhere. The FMLM team had sight of documentation deemed relevant by ABUHB in the commissioning of this work, such as Board papers from January 2017 to November 2018; however, the terms of reference called for specific focus on service re-design options, with observations and recommendations that would secure safety of practice within ABUHB.

Recommendations have been made on the basis of interviews conducted over two days with a variety of clinical and non-clinical staff from the services under review across the two sites and associated services such as ED and anaesthetics, and a review of the background documents provided by ABUHB.

Final Recommendations and Observations

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

[1] FMLM team: Dr Andy Mitchell (lead), Dr Adam Januszewski and Ms Claire Hobson

Context

The key contextual matters relate to the current workforce pressures within paediatric, neonatal, obstetric and maternity services in particular, although it is likely that such pressures also extend to other service lines.

All services are currently provided across two sites, Royal Gwent Hospital, Newport (RGH) and Nevill Hall Hospital, Abergavenny (NHH). Within approximately two years all services will be co-located in a single new build, the Grange Hospital (GH).

Workforce pressures are such that services which have been difficult to sustain, may require centralisation prior to the new hospital being ready, a time frame which could easily be prolonged.

The planned centralisation of services has been subject to public consultation in recent years with the proposal that there be a reduction in the number of hospitals in South Wales. There has not been any formal public notification of potential change prior to the opening of the GH in 2022.

Key issues for staff

The review team interviewed 18 members of staff across the two sites, including two Divisional Directors, three Clinical Directors, Consultants, Senior Nurses and Service Managers from the services under review, and consultants from ED and anaesthetics.

Staff expressed remarkably consistent views. They spoke with passion about their respective services and voiced absolute commitment to ensuring safety and quality of service delivery. They also spoke candidly about the pressures that they and the services were currently facing. Most cogently and repeatedly expressed was the view that many years of uncertainty was sapping morale, potentially having a negative impact on quality of patient care and causing drift of staff to other local organisations. There was a strong sense that urgent decisions were needed before further erosion occurred.

The Review Team heard telling comments from staff:
'*We cannot continue with a patch up job'*
'No change is not an option'
'The current situation is wholly unacceptable'
'Unless urgent action is taken, we will see the collapse of a house of cards'
'Things are about to keel over'
'People can only give so much'
'*We need a planned move; we can't continue with sticking plasters'*

Most were of view that the service was running on 'good will' and that whereas this was unlikely to change, service pressures were causing inordinate strain resulting in adverse effects on staff members physical and mental health.

There was acknowledgment, however, of the fact that many would still prefer to see the status quo maintained if at all possible, and that both hospitals are much loved by the local community with a desire for each to maintain the same level of service.

There was concern that because of uncertainty about the future there had not been any concerted communication either with the public or staff groups, and this was adding to the overall sense of anxiety. There was sympathy for the challenging position in which the ABUH Board found itself.

Key areas of risk

The areas where risk is most evident are:

- Neonatal services
- Midwifery and obstetric services
- Services for acutely sick children.

Neonatal services

Neonatal services are currently provided on both Health Board sites.

RGH offers level 3 services for all gestational ages and functions as a member of the neonatal network that spans South Wales. The unit plays an important role in providing regional capacity and absorbs overflow work from Cardiff and Swansea.

There is a fully staffed neonatal consultant rota. The service has had trainees withdrawn in recent years because of insufficient deanery numbers and preferential staffing of other South Wales neonatal intensive care (NIC) services. In spite of this, the unit has been successful in international recruitment; new recruits undertake resident shifts as 'hybrid' consultants[2]. Although currently reasonably secure with an innovative staffing model, there is concern about sustainability into the future.

NHH has hitherto offered level 2 services. It has recently been agreed that it would reduce its scope of practice to 36 weeks gestation and above, providing short term ventilation if required prior to transfer to RGH or elsewhere dependent on cot availability.

Medical care is provided by the general paediatricians who have neonatal experience, with educational support from the RGH neonatologists. Should there be any shift of consultant staff from NHH to RGH there would be no expectation that these individuals would join the neonatal rota.

Nursing staff play a vitally important role, working as a single cohesive team across both sites. The unit has supported the training of neonatal nurse practitioners. Assurance was provided that in the event of any increase in activity on the RGH site, it could be accommodated provided there was additional capacity for transitional care.

[2] A hybrid consultant is a consultant-level doctor who, unlike 'full' consultants, has greater on-call commitments and fewer clinic sessions. They have been created in some parts of the UK to help fill gaps in the mid-tier rota.

Serious concern about the safety of practice was expressed by several individuals. Locum middle grade paediatricians are often reported to be insufficiently skilled at practical procedures such as intubation and line insertion; in addition, because of the low volume of work the general paediatric consultants have experienced skill fade. Nursing staff have been in situations where they have had to lead resuscitations but feel professionally exposed in doing so.

This is a common and worrying phenomenon in small neonatal services and leaves staff and infants compromised. Recent incidents, currently under investigation, were raised where just such compromise may have occurred.

This is an urgent risk that should be addressed. Prompt, safe and skilled management of neonatal resuscitation is crucial. Failure to achieve this can have significant long-term sequelae.

There is a compelling case for prompt centralisation of neonatal practice to a single larger unit on the RGH site, with gains in both quality and safety of care.

Midwifery and Obstetric services

Consultant lead obstetric and maternity services are provided on the two main hospital sites with an additional free-standing maternity service.

Medical obstetric services would appear to be under similar pressure to the paediatric services in terms of workforce, with growing numbers of rota gaps. Currently there is limited cross site working. Differences in clinical views were alluded to, as was concern about possible de-skilling in the smaller less intense environment of NHH. Although there have been very active attempts at recruitment, uncertainty with regard to future configuration was hampering efforts. A difference in the 'culture' of practice was highlighted, with a less acute and lighter workload on the NHH site. This evoked concern that there would be reluctance on the part of some consultants to move site because of exposure to a more intense and high-pressured role.

Midwifery services on the NHH site were described as being in a state of emergency, albeit with contingency plans. Evidence was provided of decline in service quality, with a rising rate of complaints, a rising caesarean section rate and a falling instrumental delivery rate. The culture of practice was described as being one of 'non-attendance'.

The problem has arisen acutely because of depletion of significant numbers of midwives (4.8WTE), their leaving reportedly precipitated by uncertainty over the future of the services, and the reduction in acuity at NHH.

Whereas recruitment is not difficult, a very experienced cadre has been lost, to be replaced by comparatively junior midwives. This adds risk to a fraught situation. Views were very strongly expressed that a single larger unit would secure service quality and lead to greater resilience. As was noted with neonatal nursing, midwives work co-operatively across both sites and have already maximised the benefits to be gained from more flexibility of working patterns.

The uncertainty with regard to the future service offering will create unexpected difficulties of choice for expectant mothers who currently may anticipate delivering at NHH.

There was a unanimous view from those interviewed that consolidation of maternity and obstetric services onto a single site would enhance resilience and safeguard quality. The Board has implicitly acknowledged this by enhancing capacity within the labour ward to cope with increased demand. The case for change appears compelling, and when set alongside a pressing requirement to improve neonatal provision leads to a recommendation for change to occur as soon as is practically possible.

There is a very strong case for consolidation of obstetric and midwifery services onto a single site at RGH, with potential gains in quality and safety of service, as soon as is practically possible, namely whenever there is infrastructural capacity to meet additional demand.

Services for sick children

Securing safe, high quality services for children is perhaps the most complex challenge of any change programme, not only because of the breadth of clinical inter-dependencies, but also because of: wide ranging statutory requirements; the expectation that services will encompass community as well as acute hospital provision; a reducing threshold for referral from primary care; lack of popularity for potential recruits into the specialty, to name but a few of the pertinent issues.

This report focuses on children with acute problems, initially those with the most severe illness, and subsequently those with minor undifferentiated illness.

Children with severe illness

The sickest children need expert support. As with all other regions there is a paediatric intensive care retrieval service that will transfer children to Cardiff in the first instance, and further afield if capacity issues demand.

The two sites adopt differing approaches to such management. Whereas on the NHH site children of any age are accepted on to the adult ICU with the support of the anaesthetic team, for management prior to transfer, such children cared for in RGH are denied access to ICU as a matter of historic policy. Care is provided in a cubicle in the anaesthetic recovery area with responsibility for care being taken jointly by an anaesthetist and the on-service paediatrician.

Although in the circumstances clinical staff work together well to meet the children's needs, the policy derived by the RGH intensivists is unacceptable, and falls below the standards that would be expected. It carries a reputational risk for the organisation, and potentially has a 'knock-on' effect on care of other patients as key medical and nursing personnel are drawn away from other pressing clinical responsibilities, possibly for prolonged lengths of time.

This issue was raised by several senior clinicians, who have already proposed an external independent review. This is supported. However, the outcome of any such review is easily predictable, namely that the policy must change in order to meet standards.

The policy with regard to management of very sick children prior to transfer should be reviewed by the most appropriate means either internally or externally.

Services for children with minor undifferentiated illness

Currently there are comprehensive services on both hospital sites for sick children; both are witnessing rising referral rates for problems that could mostly be catered for in primary care. Evidence was provided of RGH being the busiest hospital in South Wales.

As with other similar services, the review team was made aware of significant pressure on paediatric staffing and was provided with evidence of large number of vacancies and locum usage. The problem is evident on both sites but significantly more acute at NHH, with exceptionally high locum rates, and concern about variable quality and experience of individuals.

Morale was described as uniformly low, and in some circumstances dire, but there remained a commitment to maintaining the quality and safety of the services. A difference in the 'culture' of practice between the two sites was alluded to, with the perception that RGH focused predominantly on specialist services and lacked overall 'ownership'. By way of contrast, paediatricians at NHH were more thought to be more cohesive.

Concern about sustainability of the NHH acute service has been expressed for many years, dating back particularly to the time of withdrawal of trainees in 2014, although there was fragility prior to this.

NHH has 11 consultants, 4 non-resident and 7 'hybrid' who provide resident on call cover on weekdays and daytime weekend cover. The 'hybrid' jobs are reported to be 'the most unpopular jobs in Wales'. Two doctors are leaving in the near future, with no planned replacements as yet. The locum rate for the non-hybrid posts is 90%.

The service was reported to have survived on good will and cohesive, co-operative team functioning with a collective responsibility for maintaining the service, and a high level of personal commitment. Examples were cited of consultants working in isolation or committing to on-call responsibilities at short notice.

The review team were assured that all potential sources of middle-grade workforce had been explored, including the up-skilling of nursing staff.

The RGH has a consultant of the week model with two consultants providing cover at all times. Four of twelve consultants undertake this specific commitment, with a further consultant providing a 1:5 commitment. The remainder of the consultants provide approximately a 1:7.5 commitment. All consultants contribute to ward weeks and out of hours care

The prevailing view of all paediatricians is that the current service at NHH is unsustainable, and that change is needed with consolidation on the RGH in advance of eventual consolidation on the GH site.

Based on the evidence presented, the review team supports the case for re-configuration.

This support is dependent on the development of an interim model of care that would require negotiation between paediatricians and all other stakeholders in the service. The paediatric team will need to offer a maximal level of support and incorporate cover for NHH services in collective job plans.

The option of maintaining the status quo would meet with:
- increasingly frequent locum failure
- repeated episodes of closure by default in an emergency
- increasing staff disillusionment with adverse impact on morale
- increasing risk of care provision.

Senior clinicians have expressed significant concern, however, about the safety of practice in the event of diminished paediatric support, particularly with regard to the possibility and risk of sick children presenting to A&E. Concerns are as follows:
- unskilled A&E staff because of traditionally high level of support from paediatric services
- greater travel time for public to A&E services
- delayed transfer of unwell patients significantly impacting on A&E capacity
- lack of paediatric facilities in A&E
- potential adverse effect on training recognition and recruitment of A&E trainees with loss of paediatric experience
- responsibility for supervision of transfer drawing anaesthetic staff away from service
- capacity of RGH A&E to absorb increased patient numbers
- capacity issues in the NHH A&E service in the event of a delayed transfer
- current lack of awareness of the general public of potential change.

Every effort needs to be made to mitigate the inherent risk involved in this level of service change.

Broadly speaking, the two relevant options for an interim model of care include:
- downscaling of provision to a paediatric assessment unit at NHH providing care ‘8 ‘til late’ either 5 or 7 days per week
- diversion of all paediatric cases from NHH to RGH or other local units with no dedicated on-site provision at NHH, other than outpatient services.

Either option will result in a reduction of paediatric presence and support within the hospital.

Paediatric Assessment Unit

Paediatric assessment units are generally very successful in dealing rapidly and effectively with sick children when lead by senior decision makers, usually within the short time frame that PAUs allow. A significant number of such children fall into the primary care category.

There are some children however, who need to remain under observation overnight or for longer periods, and who therefore need transfer to an inpatient unit. This is a practical proposition when there is either co-location, or relatively close proximity of units; the greater the distance the more likely it becomes that the PAU adopts the function of an inpatient unit, with similar staffing requirements both medical and nursing.

In the circumstances pertaining to NHH it is questionable whether the model will be effective in dealing with staffing issues, but there would be benefit gained from further detailed modelling.

In summary, 'down-scaling' provision to PAU status would entail:
- consolidation of medical staff rotas on RGH site
- continued medical and nursing staff requirements in NHH PAU
- regular transfers of children remaining as in-patients at the end of routine working hours
- lack of immediacy of support to A&E services overnight.

Diversion of all paediatric care

The second option would result in there being no dedicated service provision for children on the NHH site, with re-direction to either RGH or other local units. This option is even more challenging, and strong reservations were expressed about the safety of such practice.

Diversion of all paediatric cases to RGH or other local units would result in:
- lack of immediacy of support for any children presenting to A&E through 24hrs
- no requirement for PAU
- consolidation of paediatric medical staff rotas on the RGH site
- re-direction of all GP referrals
- re-direction of all blue light ambulance conveyances.

Change to the model would require a concerted public education programme. Nevertheless, for as long as there is a designated A&E service there will still be parents with children who present, and who need treatment and observation, or transfer. This responsibility would fall predominantly on A&E and anaesthetic services. Mindful of clinical concerns expressed, a system of comprehensive educational and advisory support would be essential.

To mitigate the risk of a child requiring rapid transfer and having to wait for an emergency ambulance, the option of either a dedicated vehicle or additional funded resource within the ambulance service should be considered.

Conclusion

FMLM was requested to offer experienced observation on the current configuration of obstetric and paediatric services in ABUHB and offer suggestions for future patterns of service delivery.

Change to such services is highly emotionally charged and invokes passionate responses from the public and staff alike. However, the arguments in favour of change are very strong, and FMLM supports these. Change should happen by design rather than by default, patient safety being paramount. There has been the prospect of change within ABUHB for many years; continued uncertainty is having detrimental effects on staff morale.

Change will require concerted public and staff engagement, with significant visible leadership from senior clinicians and managerial staff.

Change should be phased over a realistic period of up to six months, and should begin with neonatal and maternity services, with gradual transition to a free-standing unit, provided capacity issues have been resolved.

Prior to any change in services for sick children there should be a negotiated agreement between paediatricians and other relevant specialties on an interim model of care that offers the maximum possible levels of support, incorporating cover for NHH within job plans where appropriate. The practicalities of establishing a paediatric assessment should be fully explored.

There should be a review of the policy for providing care for very sick children needing intensive care.

Care for sick children should be centered on the RGH site, provided capacity is adequate for the increased flow both in A&E and the PAU.

Appendix 1:

Associates

Andy Mitchell

Dr Andy Mitchell's early years were spent in the Armed Services. As Joint Service Clinical Director he was responsible for widely distributed paediatric services, and for worldwide intensive care retrieval of sick children. He has been clinical lead for the Hampshire & Isle of Wight Maternity and Children's Network, worked with the DH on collaborative policy development, and both the MA and CSIP as a national clinical network lead offering advice to SHAs and PCTs on network development. He has undertaken many service reviews, and has been appointed as a member of the National Clinical Advisory Team. From April 2009-November 2016 he was Medical Director, NHS London.

Adam Januszewski

Dr Adam Januszewski is a Douglas fellow at FMLM and a National Medical Director's clinical leadership fellow at the Department of health and social care. Adam graduated from Imperial College London with honours, completing his general medical training as an academic clinical fellow in London. He is currently a medical oncology trainee working in North-West London (Imperial College Healthcare and Chelsea and Westminster Hospitals) having completed his PhD at the Royal Marsden Hospital.

Adam is the chair of the trainees committee of the Association of Cancer Physicians (ACP) and a member of the Joint Speciality committee, Joint Collegiate Committee for Oncology and Joint Royal Colleges of Physicians Training Board (recruitment). Adam has an interest in medical education, where he has been a personal tutor, mentor and a member of the curriculum oversight development group for oncology. He is currently overseeing a project mapping clinical leadership development and integrating it with pathways of clinical progression.

Claire Hobson

Claire has over twenty years' experience of strategic operational and business-facing policy roles in the public and private sector. She has spent the majority of her career in central government, in various management and senior leadership positions where she gained an interest and experience in talent assessment and development. She has been an indepedent panel member for recruitment interviews, an assessor for the Civil Service Fast Stream, a mentor and performance improvement coach. Claire is studying for a Masters degree in Occupational and Business Psychology at Kingston University and is a Fellow of the Chartered Management Institute. She is Deputy Chief Operating Officer at FMLM.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality & Patient Safety Committee Wednesday 16th October 2019 Agenda Item: 5.3

Aneurin Bevan University Health Board

Infection Prevention & Decontamination Annual Review April 18-March 19

5.3

Executive Summary			
Tackling infections is a key priority for Aneurin Bevan University Health Board (ABUHB) and our goal is to stop any preventable infection from developing and causing harm to patients. This report stipulates the management structures, standards, policies and procedures supporting the prevention and control of infections. Data on key healthcare associated infections (HCAI) are reported as part of the surveillance programme mandated by Welsh Government (WG).			
The Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			x
Executive Sponsor: Rhiannon Jones – Director of Nursing			
Report Author: Moira Bevan/Dr Abrishami/Liz Waters/Ceri Phillips			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board: Quality & Patient Safety Committee**	**x**
Date of the Report: April 18 – March 19			
Supplementary Papers Attached: Annual programme of work, Tier 1, antimicrobial and endoscopy action plan			

Purpose of the Report
The purpose of this report is to provide an update on the Infection Prevention Service, and demonstrate progress against the reduction expectation indicated by Welsh Government Healthcare Associated Infection Strategy. The review summarises significant infection prevention and control events within the organisation and provides information on the Infection Prevention Service between April 2018 and March 2019

Background and Context

The purpose of this report is to inform patients, public, staff and Aneurin Bevan University Health Board (ABUHB) of the infection prevention work undertaken in 2018/19, the management arrangements and progress against performance targets.

Assessment and Conclusion

- C difficile a total of 115 cases equates to HB rate of 26.37 per 100,000 population which is 28% fewer cases
- MRSA bacteraemia a total of 12 cases equates to HB rate of 2.04 per 100,000 population which is 37% fewer cases
- MSSA bacteraemia a total of 144 cases equates to HB rate of 24.50 per 100,000 population which is an increase of 9%
- Combined MSSA/MRSA bacteraemia a total of 156 cases equates to HB rate of 26.54 per 100,000 population which is an increase of 3%
- E coli bacteraemia a total of 428 cases equates to HB rate of 72.82 per 100,000 population which is 5% fewer cases
- Klebsiella bacteraemia a total of 122 cases equates to HB rate of 20.76 per 100,000 population which is an increase of 21%
- Pseudomonas bacteraemia a total of 20 cases equates to HB rate of 5.10 per 100,000 population which is the same number reported compared to the previous year
- Surgical Site Infections (SSI) - Orthopaedic primary joint 0.4% at NHH, 0% at RGH all Wales rate 0.2%
- Surgical Site Infections (SSI) - C section all Wales rate 4.01%, HB rate at NHH is 2.34% and RGH 2.89%, both sites lower than the Welsh rate
- Ventilator Associated Pneumonia (VAP) all Wales rate 1.86% HB rate 1.51% which is lower than the Welsh rate

Recommendation

The Quality and Patient Safety Committee are asked to receive the annual report from the Infection Control Committee and note:-

- The significant work programme for 2018/2019
- The achievements of 2018/19
- The areas of concentration in 2018/2019

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Healthcare associated infection has a patient risk in relation to mortality and morbidity. Risk to the organisation includes reputation, financial risk due to increased length of stay. This has been identified on the Divisional and corporate Risk Registers.
Financial Assessment, including Value for Money	Healthcare associated infection has significant risk to patient safety, thus resulting in not only a cost to the patient but the Health Board. Each C.difficile case and MRSA bacteraemia is estimated at £10K
Quality, Safety and Patient Experience Assessment	Healthcare associated infection has an impact on patient experience and this is discussed via Divisional Quality and Patient Safety forums. Learning is shared within the infection prevention committee.
Equality and Diversity Impact Assessment (including child impact assessment)	Equality impact assessments are considered in all environmental assessment and action plan
Health and Care Standards	Infection prevention is linked to standard 2.1 and 2.4 by managing risk and promoting health and safety, promoting infection prevention must be everyone business and part of everyday holistic healthcare
Link to Integrated Medium Term Plan/Corporate Objectives	Linked to WG reduction expectations for healthcare associated infection and the antimicrobial strategy
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Continue to review evidence based practice to work reactively and proactively to reduce the risk of infection
	Integration – *Working with public health wales/Welsh Government, CHC, 1000 lives with an overall aim to provide safe care around the prevention of infection*
	Involvement – Engagement and Divisional ownership for the reduction of healthcare associated infection
	Collaboration – Collaborative working across the Divisions in response to health needs
	Prevention – Working towards the reduction of healthcare associated infection reviewing themes for improvement goals
Glossary of New Terms	N/A
Public Interest	Infections can affected everyone the IPT continue to work multidisciplinary to promote best practice. IP data available to the public for assurance

5.3

INFECTION PREVENTION & DECONTAMINATION

ANNUAL REVIEW April 2018 to March 2019

June 2019

CONTENTS

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June 2019

Executive Summary

Tackling infections is a key priority for Aneurin Bevan University Health Board (ABUHB) and our goal is to stop any preventable infection from developing and causing harm to patients.

This report stipulates the management structures, standards, policies and procedures supporting the prevention and control of infections. Data on key healthcare associated infections (HCAI) are reported as part of the surveillance programme mandated by Welsh Government (WG). From April 2018 to March 2019, key points were as follows:-

- C difficile a total of 115 cases equates to HB rate of 26.37 per 100,000 population which is 28% fewer cases
- MRSA bacteraemia a total of 12 cases equates to HB rate of 2.04 per 100,000 population which is 37% fewer cases
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June 2019

Introduction

The purpose of this report is to inform patients, public, staff and ABUHB Executive Board of the infection prevention work undertaken from April 2018 to March 2019, the management arrangements and progress against performance targets.

The ABuHB Infection Prevention service is based on the Code of Practice (2014) for the prevention and control of healthcare associated infection and builds on the Welsh Government publication - Commitment to Purpose – Eliminating preventable healthcare associated infections – An action plan for Healthcare Organisations in Wales (2011). The Code highlights the need for "all staff" to understand the impact of infection control practices to enable them to discharge their personal responsibilities to patients, other staff, visitors and themselves. The move away from infection control being seen solely the domain of the specialist infection prevention team to infection control becoming "everyone's business" is a stance taken by ABuHB along with a culture of "zero tolerance" where one avoidable infection is considered too many.

This statement is also reflected within the Health and Care Standards 2015 indicating that infection prevention must form part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections. This has been supported by local ownership of infection prevention across Divisions and Directorates.

The Antimicrobial Resistance (AMR) Delivery Plan issued in March 2016 recognised the importance of effective infection prevention and control in all health and social care settings. Core aims ensure that care is provided in a safe environment, infections are diagnosed quickly and the right treatment given.

In light of non-compliance with HCAI targets across all Health Boards, an All Wales 1000 Lives collaborative was launched in 2017 focussing on HCAI reduction and Antimicrobial Resistance with 5 focus areas:-

- C difficile,
- Staph aureus bacteraemia
- Ecoli bacteraemia
- Surgical Site infection (SSI) and
- Leadership

Tackling HCAIs requires a holistic approach that links with antimicrobial stewardship, decontamination of medical devices, estates and facilities, cleaning and laundry, clinical and managerial leadership, in addition to its own monitoring of patient incidents and harm. The Infection Prevention Annual Programme of Work **(Appendix 1)** has driven the Infection Prevention service during 2019/20 and includes the subject areas outlined above. The main issues that have dominated the annual programme are:-

- Reduction Expectations from Welsh Government for C *difficile*, Staphylococcus *aureus* (MRSA and MSSA bacteraemia) and gram negative bacteraemia
- The implementation of the 3 year plan for Aseptic Non Touch Technique (ANTT) across the HB following a CMO/CNO Welsh Healthcare circular
- The implementation of the Infection Prevention and Control Strategic Action plan **(Appendix 2)**
- The implementation of the Antimicrobial Resistance (AMR) action plan **(Appendix 3)**
- The implementation of the decontamination action plan **(Appendix4)**
- Monitoring of mandatory surveillance programmes for surgical site infection and taking appropriate action where required.

Progress and Concerns

The major actions that have dominated the infection prevention programme from April 2018 to March 19 are:

- Root cause analysis of C *difficile* and MRSA/MSSA/gram negative bacteraemia cases and associated learning which is returned rapidly to the clinical area.
- The control and management of Influenza. The numbers of cases Primary and Secondary care was of concern this year.
- Outbreak management for C *difficile*
- The control and management of norovirus (diarrhoea & vomiting) which has significant impact on bed capacity if not controlled effectively.
- The implementation and monitoring of infection prevention related care bundles.
- Mortality reviews relating to C *difficile* and Staph aureus/gram negative bacteraemia.
- The implementation of a decontamination action plan following an All Wales audit in June 2018.
- The active promotion of antimicrobial stewardship.
- Supporting divisions to implement mandatory surgical site infection surveillance namely C section and orthopaedics.
- Support Critical Care to implement the mandatory surveillance for ventilator associated pneumonia
- The implementation of Aseptic Non Touch Technique (ANTT) a national initiative as stipulated in the Welsh Health Circular
- The implementation of ICNET a surveillance programme for the IPT
- Implementation of the 1000 lives collaboration for HCAI and antibiotic stewardship
- Monitor and support the HPV programme

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- Supporting sepsis work stream
- Supporting the Divisions for mask fit testing

Infection Prevention Team

It is the policy of ABUHB to prevent and control infection wherever possible. The Infection Prevention Team (IPT) has responsibility for the prevention and control of infection providing advice across the HB.

The Executive Director of Nursing is the designated executive lead for Infection Prevention and Control in ABuHB

The Infection Prevention Team consists of:

- Lead Clinician for Infection Prevention – Consultant Microbiologist 2 sessions per week
- Associate Nurse Director/Consultant Nurse – 1WTE
- Lead Nurse for Infection Prevention – 1 WTE
- Senior Nurses for Infection Prevention - 2.25 WTE
- Senior Nurse/Decontamination Manager - 0.75 WTE
- Infection Prevention Nurses covering sites - 4.WTE
- Administration team - 1.6 WTE

In line with All Wales Consultant Nurse “rules” the Consultant Nurse does not operationally manage the Infection Prevention Team. The Consultant Nurse links with Cardiff University and using specialist expertise influences and informs the development of strategic plans for HCAI in ABuHB and across Wales. It should be noted that the role was extended to support the main nursing agenda hence the dual role of Associate Nurse Director and Consultant Nurse for Infection Prevention and Control.

The IPT is supported by Consultant Microbiologists/Infection Prevention Doctors based in the Royal Gwent Hospital. However, since May 2016 following the retirement of the Lead Infection prevention Doctor, an interim Consultant Microbiologist has taken on the role. Unfortunately, there have been no successful applicants to replace the post. This risk has been highlighted to Scheduled Care Division (as microbiology falls under this directorate) and microbiology work patterns adjusted. Nevertheless, this issue is impacting on the level of advice that can be accessed by clinical staff, especially outside of the Royal Gwent Hospital. This risk should be resolved for 2020 as appointment made in the summer of 2019.

In addition to the Monday to Friday service, the senior members of the team supported a weekend on call service during the winter period. This was supported by securing additional funding reacting to infection control related winter pressure issues, such as flu and viral gastroenteritis, which has received positive feedback with a plan to mirror the service for 2019/20.

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It should be noted that cases of HCAI identified in Primary Care is contributing to non-compliance with Welsh Government Goals. In light of this, the *hospital based* Infection Prevention Team has extended their remit to scrutinise cases acquired outside of hospital. Nevertheless the risk of hospital based nurses providing a service in Primary Care presents a risk to cases acquired in hospital. A business case was successful in March to employ a band 7 Infection Prevention and Control Nurse to cover Primary Care. One of the roles of this new post will be to undertake root cause analysis reviews of Primary Care cases and instigate appropriate action. In addition to the band 7 post an epidemiologist has been appointed as a job share opportunity within Public Health Wales with an honorary contract with ABUHB.

Welsh Government Reduction Expectation for Infection Prevention

NHS patients have the right to expect high quality care and services in a safe environment. Healthcare Associated Infections can be a significant threat to patient safety and also incur considerable financial cost to health boards/trusts. Since 2011, the Welsh Government and NHS Wales have been stipulated a zero tolerance to all preventable HCAIs and a wealth of guidelines, policies and tools on infection prevention have been available to assist in infection reduction measures.

It should be noted – unlike England – that Health Boards in Wales are performance managed on the target pathogens whether they have been acquired in the community or hospital. The vast majority of those considered “hospital acquired” can be attributed to failings but community acquired pathogens are more complex. Sometimes it can be attributed to healthcare – poor antibiotic prescribing by GP’s or infection control practice in nursing homes for example. However a not insignificant number have been acquired without any healthcare input at all.

The use of antimicrobials plays a significant role in the Healthcare Associated Infection agenda both in community and hospital settings. Additionally, the overuse of antimicrobials is a national concern because of ongoing resistance. In light of this the Health Board has recently appointed a Consultant Antimicrobial Pharmacist, plus 3 additional antimicrobial pharacist to promote and oversee the implementation of antibiotic policies across the Health Board in secondary and primary care. The Consultant Pharmacist priorities are:

Secondary Care

- Establishing the junior doctor Start Smart Then Focus audit programme: this is a national audit, which aims to teach desired behaviours through undertaking the audit. There is a protocol and an online data collection tool which produces graphs and run charts and also allows trainees to print off a certificate once they’ve entered 20 patients in a given month. Directorates have been asked to ensure one audit is undertaken per site per month, but uptake thus far has been limited.
- Rolling out the new all-Wales medication chart, which has a dedicated antimicrobial section

- Undertake further work around de-escalation, targeting patients started on antibiotics for sepsis in conjunction with 1000 lives
- Continuing the programme of guideline review, moving away from use of co-amoxiclav, piperacillin/tazobactam and quinolones towards more combination treatment and co-trimoxazole

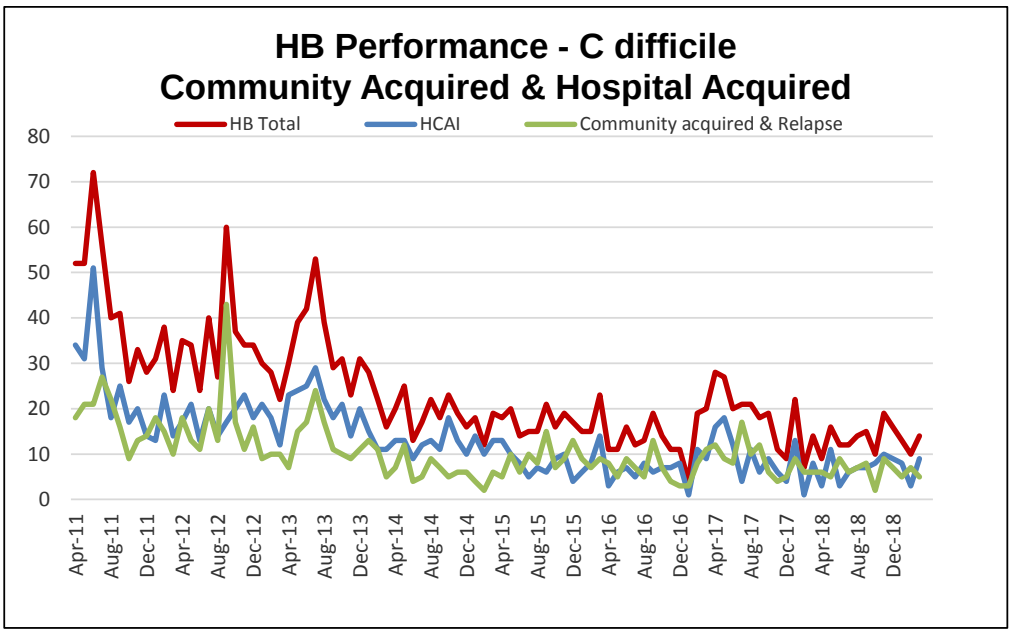
Primary care

- Targeted work in high-prescribing areas to support the CMO letter, potentially involving audit and feedback cycles which have proven beneficial in BCUHB
- Antimicrobial prophylaxis review work
- Supporting implementation of CRP point of care testing

As antimicrobial pharmacy plays such a crucial role in the Healthcare Associated Infection agenda – the Infection Prevention Committee will now be called Infection Prevention & Antimicrobial Resistance (IPARC) Committee.

C difficile

The C difficile rate across the HB for 2018/19 equated to 26.37 per 100,000 population it was slightly disappointing in that the target was missed by .37 per 100,000 population. The HB had a total of 155 cases from April 2018 to March 2019 this equates to 28% of fewer cases than the previous year. Within Nevill Hall Hospital 18 cases were reported which is 27 fewer cases than the previous financial year. The Royal Gwent had 45 reported cases within 2018/19 which is also 18 cases less to the previous year. The remaining cases are associated as being acquired within the community and often these patients have not received intervention within healthcare or antibiotics within the previous 6 months.



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As previously indicated antimicrobial stewardship plays a significant impact on C difficile therefore there is also a need to assess compliance with the use of Co-trimoxazole a broad spectrum antibiotic considered to reduce this risk. This antibiotic has been robustly implemented in C&V and Cwm Taff with what appears to be good results. A workshop is planned for May 2019 to gain support from the Medical Director in taking this work forward.

It should be noted that the number of outbreaks across the year has had a significant impact on the overall number of cases acquired and if these could have been prevented the HB would of achieved their reduction expectation and patient safety preserved. The table below indicates the number of periods of increase incidence/outbreaks reported on following wards. Beds closed to allow HPV cleans to take place.

WARD	DATE REPORTED	NO. OF PATIENTS AFFECTED
C6W	13/04/18	2
B6N	16/05/18	2
D2W	28/05/18	2
2:1 OAKDALE	07/06/18	2
D2W	24/08/18	2
Rowan	25/09/18	2
D4W	09/10/18	2
3:2 Penallta	19/12/18	3
3:1 Risca	23/12/18	2

Learning for the RCA case reviews and outbreak meetings are identifying issues with nurses cleaning compliance – related to the high number of staff vacancies. The resulting high number of bank and agency nursing is impacting on nurses cleaning responsibilities. Ward Sisters and Senior Nurses have been asked to make cleaning responsibilities explicit to bank and agency nurses at the start of each shift.

Poor quality of equipment in that it is unable to be cleaned to a satisfactory level, again urgent replacement of the equipment required has been advocated.

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Finally antibiotic stewardship is another theme that requires improvement within the following areas:-

- Prescribing in line with HB guidance
- 72 hour reviews
- IV to oral switch
- Documentation

In light of the number of relapse cases there has been a move to ***prioritise*** the use of faecal microbiota transplant (FMT) which is a therapy to replace the gut flora, or microbiota, of patients with *C. difficile* infection with that of a healthy donor. This should in turn prevent further relapses.

The number of hospital acquired cases is concerning as numbers over the summer period were low. It is reassuring that no outbreaks were identified as all ten hospital acquired cases were sporadic and not linked to one particular area. Discussions with Royal Wolverhampton NHS Trust revealed that they too had issues with sporadic cases across their hospitals – resolved by increased cleaning in Emergency Departments and Medical Assessment Units. Winter pressure monies supported an initiative to introduce a 24 hour cleaning regime in ABUHB for a six week period, therefore the impact of this invention is unable to be determined due to the short period of time implemented.

Over the next twelve months the Infection Prevention team recommend:

- Funding is sourced for 24 hour cleaning in “front door” areas at Nevill Hall and the Royal Gwent over the winter period. As well as the benefits to the Healthcare Associated Infection agenda – there will be an aesthetic benefit too.
- Metrics associated with the Co-trimoxazole policy should be urgently developed and disseminated to clinicians.
- Continue to promote the use of FMT to prevent relapses.
- Trial facilities replacing nurse cleaning at NHH ward assistant to be appointed

Although the HB missed the target the Divisional ownership and response to the recommendations have been absolutely key in achieving the HB reduction and reducing the risk to patients.

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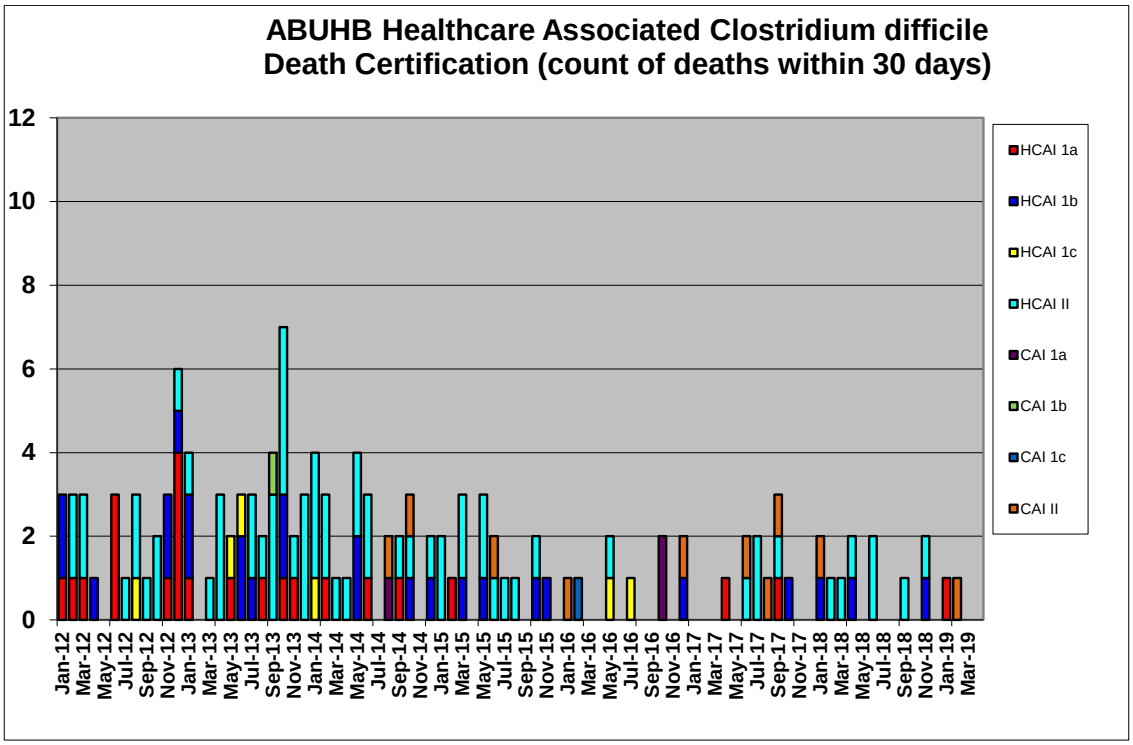
Deaths associated with C difficile

There is a requirement by WG that all deaths within 30 days associated with C difficile is reported via a serious incident. An additional mortality review is conducted on these patients by the Associate Nurse Director. It is often concluded that antimicrobial stewardship and environmental contamination is a contributing factor in these patients' deaths.

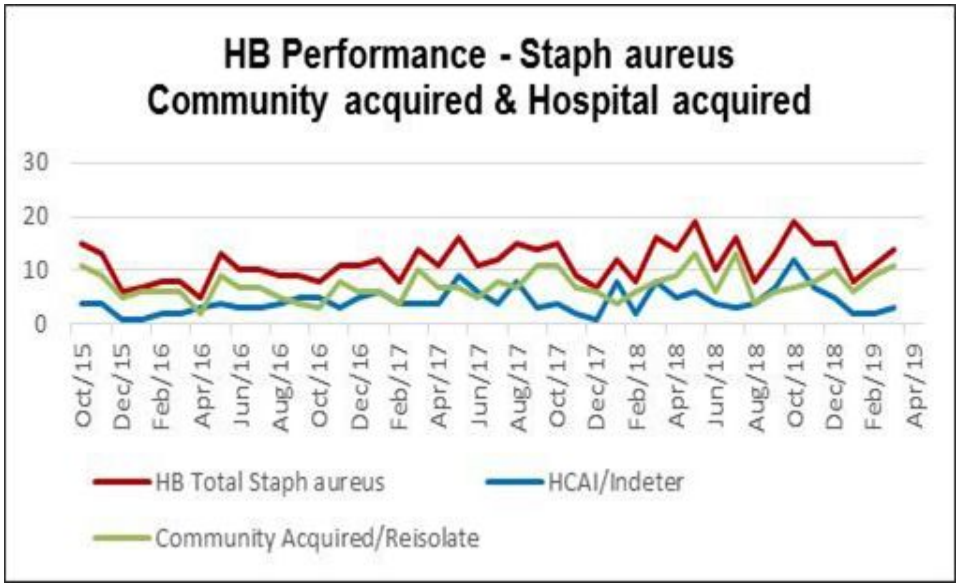


Staph aureus bacteraemia

The HB rate for staph aureus bacteraemia for 2018/19 is 26.54 per 100,000 population this is 3% more than the previous financial year. Breaking this down across the acute sites Nevill Hall identified 38 cases between 2018/19 which equates to 3 less than the previous year. The Royal Gwent reported 102 cases which is an increase of 11 more cases during the financial year. The remaining patients have been identified as community acquired and most months equate to more patients than in secondary care.

This is a combined target and the number of MRSA cases has reduced and a total of 12 was identified across the HB this equates to a rate of 2.04 per 100,000 population which is a 37% reduction compared to the previous year.

June 2019



Staph aureus cases are often associated with poor vascular device management, so education is fundamental. Delivery of this education was under the remit of Training and Development but was passed over to divisions some time ago. However the following education issues have been identified:

- Lack of standardisation across Divisions with the number of sessions being delivered, support by practice educators / ANPs etc.
- Lack of provision per se within Divisions.
- Lack of equipment / substandard equipment.
- Large number of patients who need cannulation / venepuncture / IV medications.
- No central programme for cannulation / venepuncture / IV medications.

In response, a meeting with practice educators will be convened to urgently identify a robust standardised strategy for the delivery of a robust venous access education programme. In the meantime, the IPT team has identified clinical areas which can be targeted with appropriate education.

Aseptic non touch technique (ANTT) also contributes to exemplary venous access. Mandatory training and assessment is ongoing, with excellent compliance by nurses but the Health Board is struggling to engage medical colleagues. This is an all Wales requirement and a Health Circular advocated this is a must for all professional groups. Compliance is monitored via the Divisional highlight reports at the IPAR committee.

Following the learning noted above a successful business case for a venous access nurse will also positively contribute to the prevention of infections related to venous devices, funding has been agreed however the post will be appointed to in 2019.

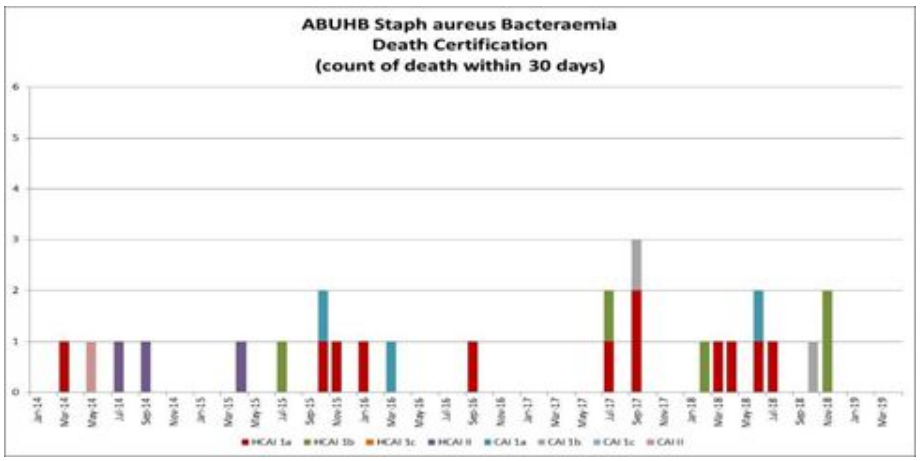
June 2019

The Infection Prevention Team recommend:

- Urgent attention to the development of a robust venous access education strategy.
- In the interim the Infection Prevention Team will target key clinical areas with venous access and blood culture training.
- Progress the venous access nurse & primary care infection control nurse posts.

Staph aureus death

The IPT review all cases of Staph aureus bloodstream infection and any cases where it has been identified as the main or contributory cause of death within 30 days mortality review is undertaken. These cases are reported via the putting things right team and learning shared with the Divisions. An area of improvement from these reviews have included in the development of a vancomycin monitoring chart thus to ensure the patient received the correct therapeutic dose.



June 2019

Gram Negative Bacteraemia

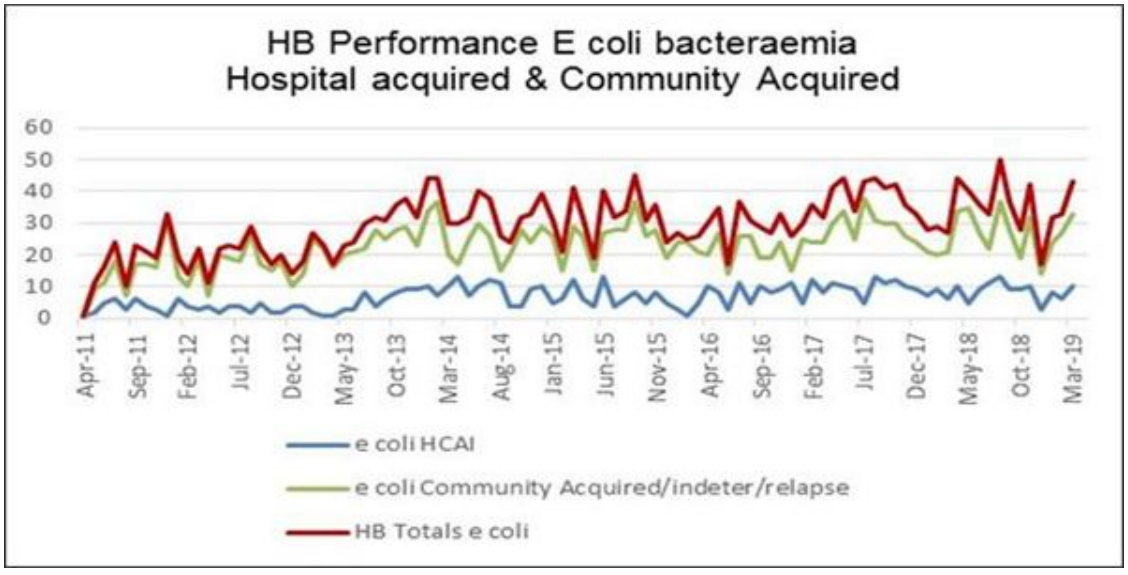
E Coli, Klebsiella and Pseudomonas (collectively known as gram negatives) is a relatively new target with a vast majority of cases acquired in the community. Gram negative bloodstream infections are mostly associated with urinary tract infections and urinary catheters but a significant amount are related to the hepatobiliary and respiratory tract. A recent conference has indicated that the UK infection control community are on a steep learning curve with this particular pathogen.

Emerging evidence is suggesting that only 20% can be avoided so to that end the Health Board is focussing on gram negative infections associated with the urinary tract and catheter associated urinary tract infections.

A significant piece of work around urinary catheters is resulting in the improved management of these devices – but is yet to show a positive impact on the gram negative target. A Trial without Catheter protocol is under review which will give Divisions clear guidance on how to manage patients who have been discharged home with urinary catheters. Additionally further engagement with the surgical directorate is needed to ensure that patients are catheterised appropriately at time of operation as case reviews are identifying patients who have been catheterised with no indication to do so.

In terms of urinary tract infection further work is needed to ensure GP's are appropriately prescribing antibiotics. Urinary tract antibiotic guidelines have been updated following publication by Public Health Wales and circulated. Discussions have commenced with Primary Care as to how compliance will be monitored.

Evidence is also suggesting that gram negatives infections are prevalent in the summer and are associated with dehydration. Indeed graphs related to E Coli indicate a "summer" issue.



June 2019

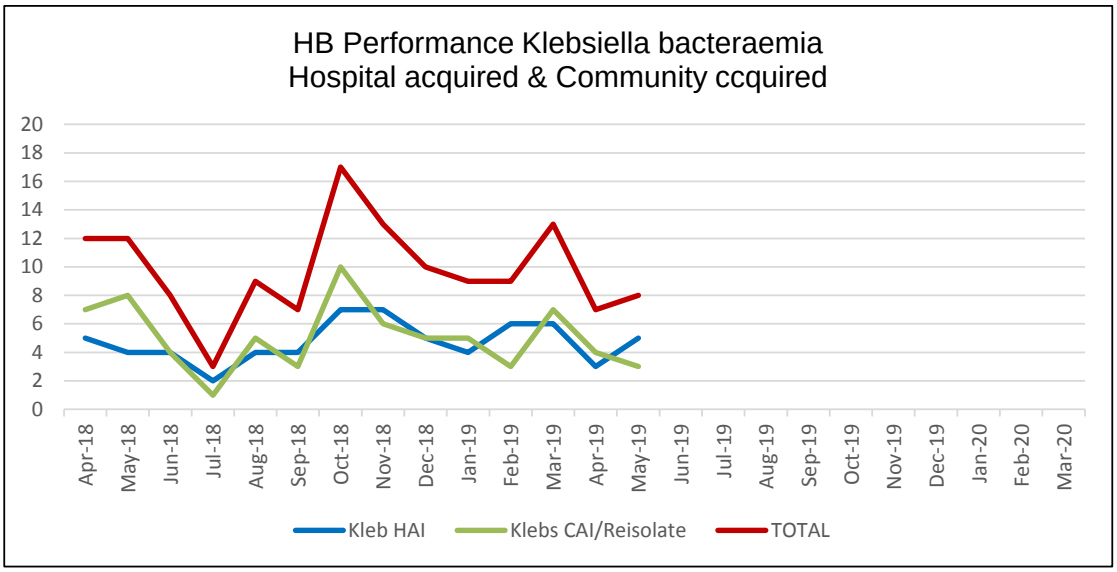
Within the HB 428 cases were identified over the 12 month reporting period this is 5% fewer cases than the previous year which equates to a rate of 72.82 per 100,000 population. Recognising that we didn't achieve the target however improvement was noted overall.

Nevill Hall reported 137 cases of E coli bacteraemia which is an increase of 2 cases than the previous year. A total of 251 cases identified within the Royal Gwent Hospital which is 28 fewer cases to the previous year. Again it's important to note that again patients are often associated as community acquired and present into secondary care with symptoms.

Klebsiella Bacteraemia

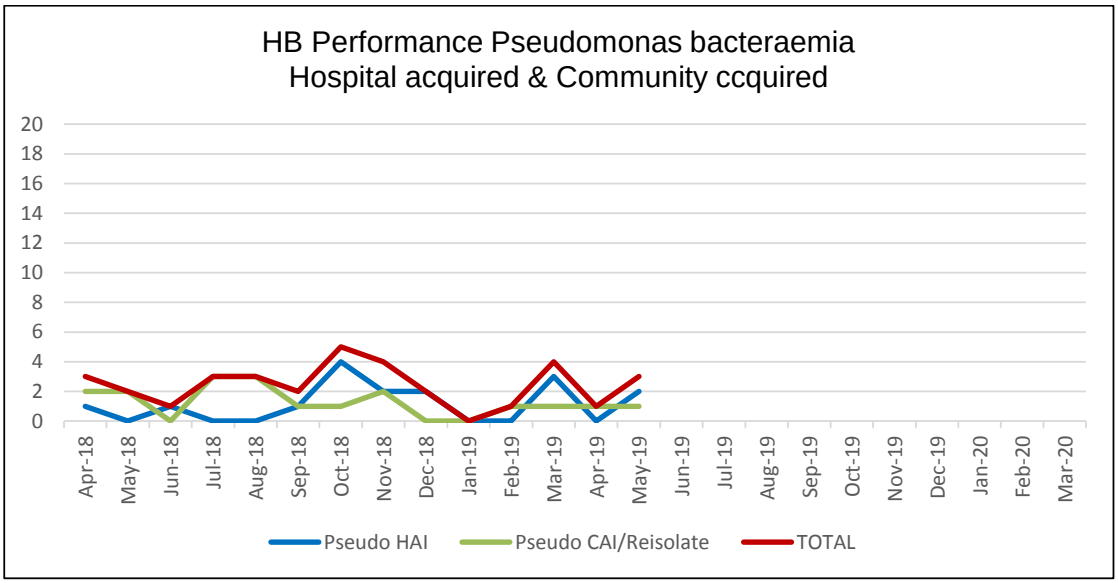
A total of 122 cases reported over the financial year this is 21% more than the previous year, the WG target was to reduce by 10% which was not achieved within the HB. A total of 37 cases reported in Nevill Hall for 2018/19, this equated to 4 fewer cases than the previous year. The Royal Gwent 78 cases identified however disappointing to note this is 25 more cases than the previous year.

Previously it was assumed that this is a hospital acquired concern however the graph below indicates that a number of patients are presenting into secondary care with this resistant organism.



Pseudomonas Bacteraemia

A total of 30 cases reported throughout the HB which equates to 5.10 per 100,000 population. Nevill Hall 7 cases reported during the financial year this is the same number compared to the previous year. A total of 22 cases reported in the Royal Gwent this equates to 4 more cases than the previous fanatical year.



The Infection Prevention Team recommend over the next 12 months via the newly appointed infection prevention nurse for primary care with the epidemiologist and working in collaboration with the Division will

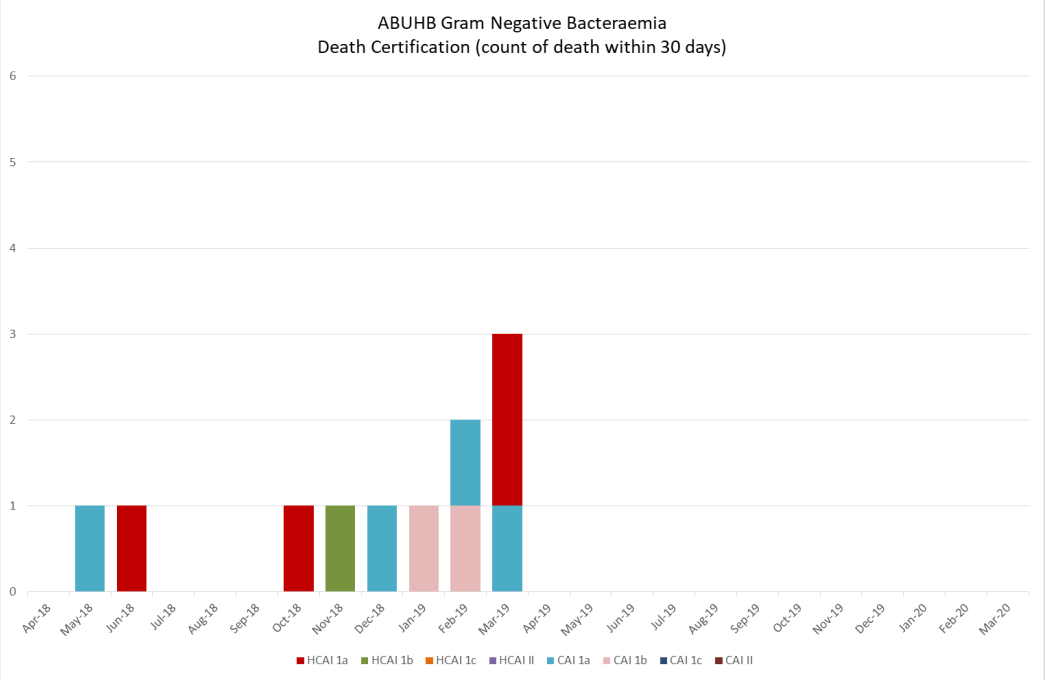
- Develop metrics to monitor GP's compliance with urinary tract guidelines.
- Progress and ratify the Trial without Catheter Protocol.
- Engage surgical directorate in further assessing the need for surgical patients to have urinary catheters.
- Plan a hydration campaign across the Health Board to include the general public in June

Overall, the IPT have made significant progress towards the WG HCAI Goals. Following the 2 new appointments in Pharmacy and Corporate Nursing Team, the service going forward is in a much better position to identify themes and work on recommendations to reduce HCAI to improve patient safety.

June 2019

Gram Negative deaths

Within 2018/19 a new initiative for the IPT is working with the Divisions reviewing gram negative deaths within 30 days of the positive results where there has been indication on the death certificate. To date minimal learning has been established in that patient had received the correct antimicrobial treatment prior to their death, however further work is required around robust process for the management of urinary catheters.



Surgical Site Infections (SSI)

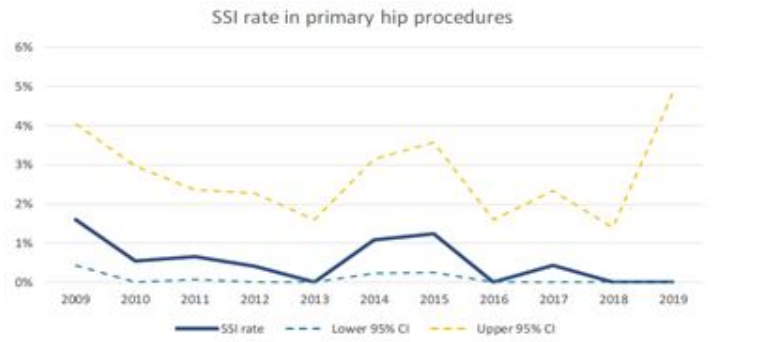
SSIs are defined as infections that occur in a wound following invasive surgical procedures. SSI's are one of the most common causes of HCAI accounting for 23.7% of inpatient infection within acute hospitals in NHS Wales. SSIs cause excess morbidity and mortality and are estimated on average to double the cost of treatment, mainly due to an increase in hospital length of stay. SSIs have serious consequences for patients as they can result in pain, suffering and additional surgical intervention on occasions. On rare occasions they can be associated with deaths. There are two mandated schemes.

June 2019

Orthopaedic SSI Rate breakdown (last 12 months)

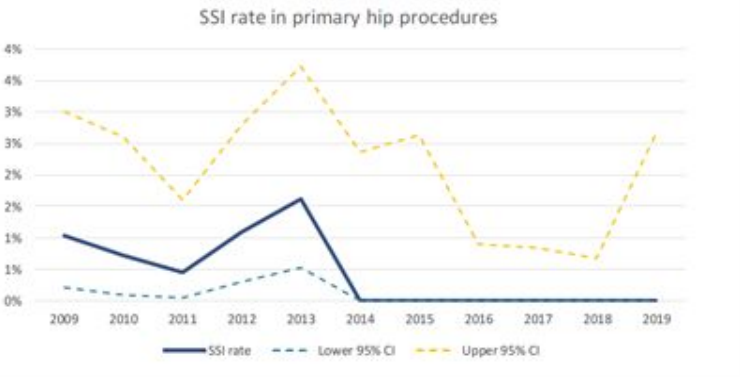
	Nevill Hall	Royal Gwent
Overall Procedures	717	1283
Total Hip	293	550
Total Knee	371	500
Partial Knee	2	186
Other/unknown	51	47
SSI Rate	**0.4%**	**0.0%**

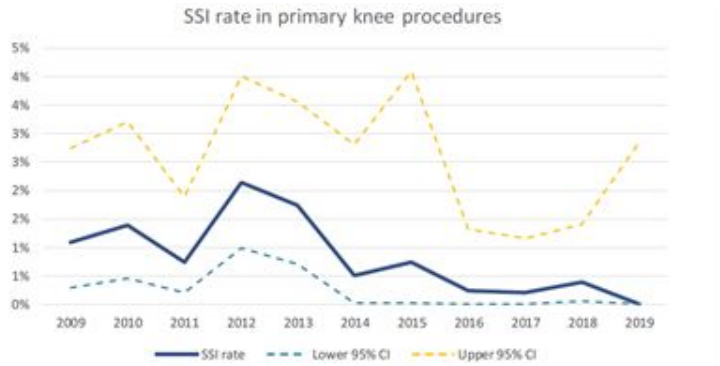
SSI rate primary hip & knee – Nevill Hall



June 2019

SSI rate primary hip & knee – Royal Gwent Hospital





The all Wales rate for primary joint replacements is 0.2% which equates to the same as our HB rate, within NHH we have a rate of 0.4% and RGH 0%. This is a reduction compared to the previous year both from a Welsh prospective plus and HB. During 2018 there has been three primary knee infections identified within NHH. In response to this the theatres has undergone a declutter and HPV programme.

In addition to the above the IPT is working closely with the Maternity and Orthopaedic Directorate to implement a number of interventions:-

- Aseptic Non Touch Technique (ANTT)
- Participation in the all Wales 1000 lives collaboration for SSI
- Promote the E learning package for Caesarean sections SSI reduction
- Review patient information leaflets and identify roles and responsibilities linked to the all Wales public health promotion
- Observational audit within theatre
- Standardise the SSI care bundle and data collection on theatre processes
- Root cause analysis process identified for SSI for inpatient infection, infection identified in the community will be reviewed in line with the new appointment within IP for primary care

June 2019

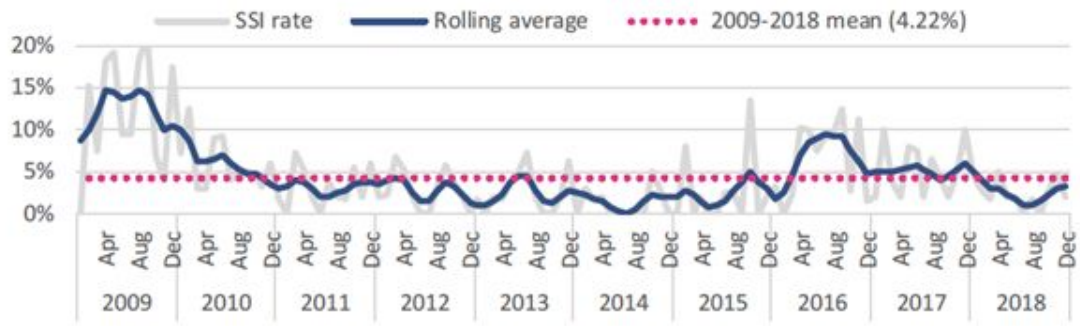
The IPT are also supporting the General Surgery Directorate for the implementation of SSI on bowel surgery. This is a recommendation of the 1000 lives collaborative and is in very early stages of development. A task and finish group has been established and will review pre, inter and post-operative care in line with national recommendations

Caesarean Section SSI Rate breakdown (last 12 months)

The rate of C section rate for ABUHB is 2.68% from Jan – Dec 2018, NHH has a rate of 2.34% and RGH 2.89% which is lower than the all Wales rate of 4.01%. This is an improvement compared to last year's rate of 5.8% for the HB.

	Nevill Hall	**Royal Gwent**
Total forms received	96%	98%
Valid post-discharge forms	96%	98%
SSI Rate	**2.34%**	**2.89%**

Nevill Hall



Royal Gwent

June 2019

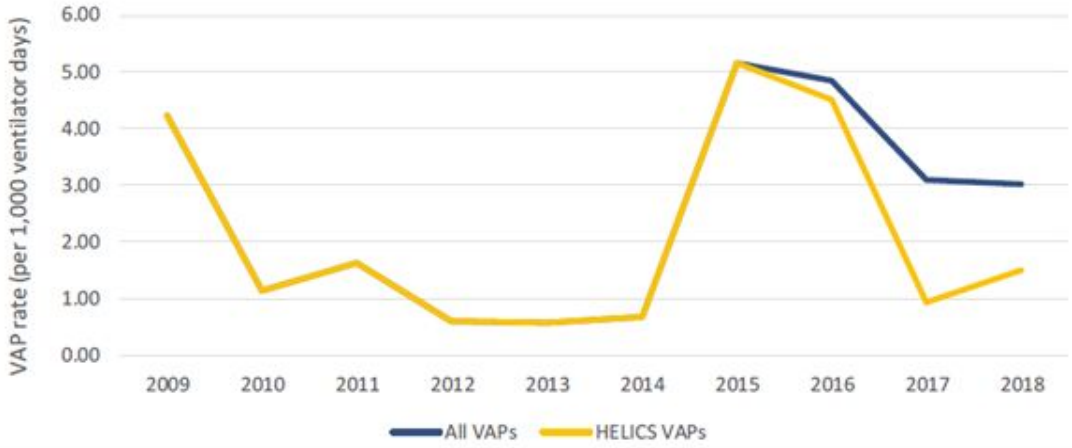
During 2018 the HB participated in an external review with Public Health Wales and they concluded that previously the HB had been over reporting their SSI rate. Another indication for the significant reduction in SSI is that PHW only report infections up to 14 days post-operative and not 30 days in line with other nations in the UK, however the Directorate agreed for assurance to continue to monitor patients up to 30 days within ABUHB.

Two other interventions were the standardisation of the wound dressing for ladies having a c section and all Midwives received infection prevention education with a particular focus on the SSI bundle during 2018.

June 2019

Ventilator-Associated Pneumonia

Ventilator-associated pneumonia (VAP) is a type of lung infection that occurs in people who are on mechanical ventilation breathing machines in intensive care units. VAP is a major source of increased illness and death. Persons with VAP have increased lengths of ICU hospitalisation and have up to a 20-30% death rate.



The Welsh rate for ventilator associated infection is 2.93 per 1,000 ventilator days ABUHB rate for 2018 equated to 1.51. A total of 5 patients across the HB was identified during 2018, the directorate continue to monitor the VAP care bundle and review each positive sputum sample contributing to the patient risk. Disappointing to note this slight increase compared to the previous year however remain below the Welsh average.

A meeting was held to discuss the variance across Wales as ABUHB system of utilising experienced clinical input to identify VAP cases is most likely to have produced robust and accurate reporting of VAP rates. There was some discussion as to whether Public Health Wales should look at a different system of bacteraemia data collection, however it was concluded that the current system if used accurately provides good data both on organisms identified and identifying and intervening on those patients most at risk. There are ongoing discussions on how ABUHB can cascade our data collection methods, to improve Wales wide reporting.

Antimicrobial Stewardship

Infection prevention is key in minimising emergence of antimicrobial resistance, by preventing the need to use antibiotics in the first place. Similarly good antimicrobial stewardship is vitally important to try and prevent a future in which antibiotics no longer

work and simple infections, which are easily spread, can be fatal. A new team of antimicrobial pharmacists across primary and secondary care, led by the Health Board's first Consultant Pharmacist, has been recruited during the year and are starting work to scale up work previously undertaken in this area.

Antimicrobial Pharmacists attend healthcare associated infection review meetings, identifying any sub-optimal prescribing and taking steps to address this. The Antimicrobial Working Group (AWG) continues to monitor antimicrobial usage and implement strategies to optimise use of antibiotics across the Health Board. The Antimicrobial Guideline Group has continued its programme of work to review local treatment guidelines to minimise course durations where possible, encourage IV to oral switching, and encourage use combinations of antibiotics rather than 'one-size fits all' options.

Prudent antimicrobial use is also discussed at the monthly IPARC meetings, which are jointly chaired by the Executive Medical Director and the Executive Director of Nursing. A member of AWG will be in attendance to provide an update on:

- performance against national prescribing indicators and Welsh Government antimicrobial reduction goals
- progress against the ABUHB AMR action plan (see appendix 3)
- Start Smart Then Focus audit results

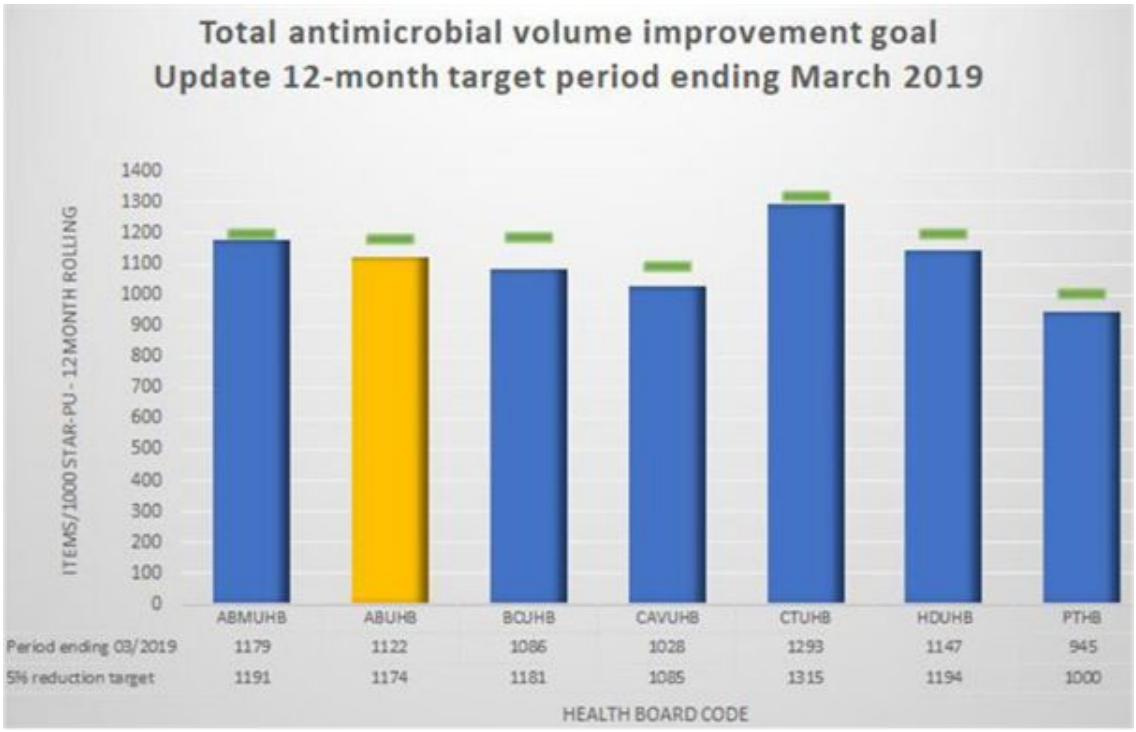
Antibiotic Prescribing Performance

Tier 1 targets for antibiotic usage were introduced in 2018-2019 to minimise the risk of antimicrobial resistance at both an individual and a population level. These are in addition to National Prescribing Indicators that focus on usage in primary care. The 2018-19 year end position is reported below.

Primary Care Prescribing

Welsh Government Tier 1 target

- Target for 2018–2019: reduce the total volume of antimicrobial use by 5% compared with the baseline 2016-17 year.
- The green bars on the graph below show the 5% reduction target. The Health Board achieved this target, reducing overall total antimicrobial volume by 9.2%. Every cluster achieved at least the 5% target reduction, with Blaenau Gwent East achieving a 19% reduction.



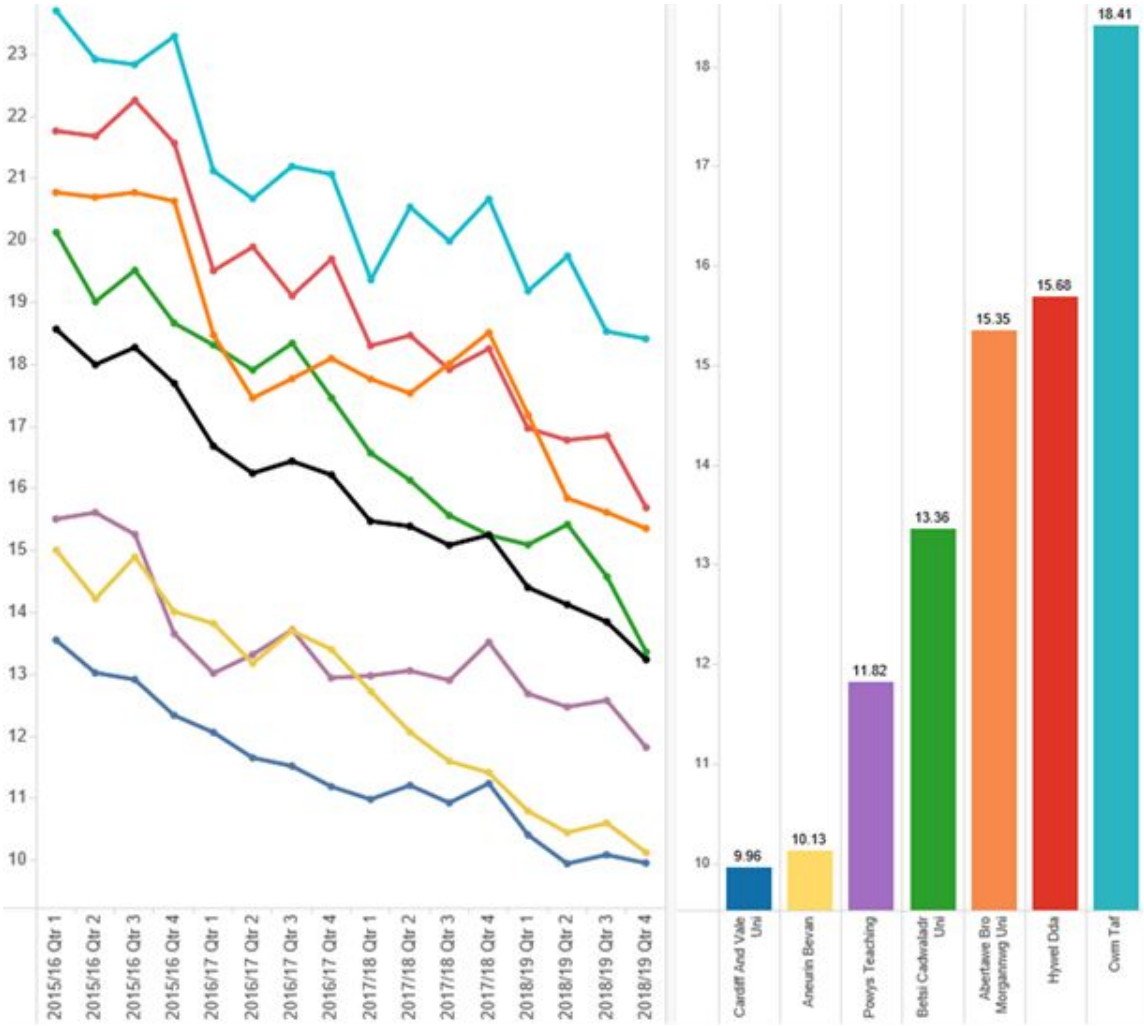
National prescribing indicators

1. Total antibacterial items per 1,000 STAR-PUs (Specific Therapeutic group Age-sex Related Prescribing Unit)
   - Target for 2018–2019: A reduction of 5% against a baseline of data from April 2016–March 2017.
   - This is the same as the Welsh Government target above, so was achieved.

2. Number of 4C antimicrobials per 1,000 patients
   - The term '4C antimicrobials' refers collectively to four broad-spectrum antibiotics (co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin). The use of simple generic antibiotics and the avoidance of these board-spectrum antibiotics preserve them from resistance and reduce the risk of *C. difficile*, MRSA and resistant urinary tract infections.

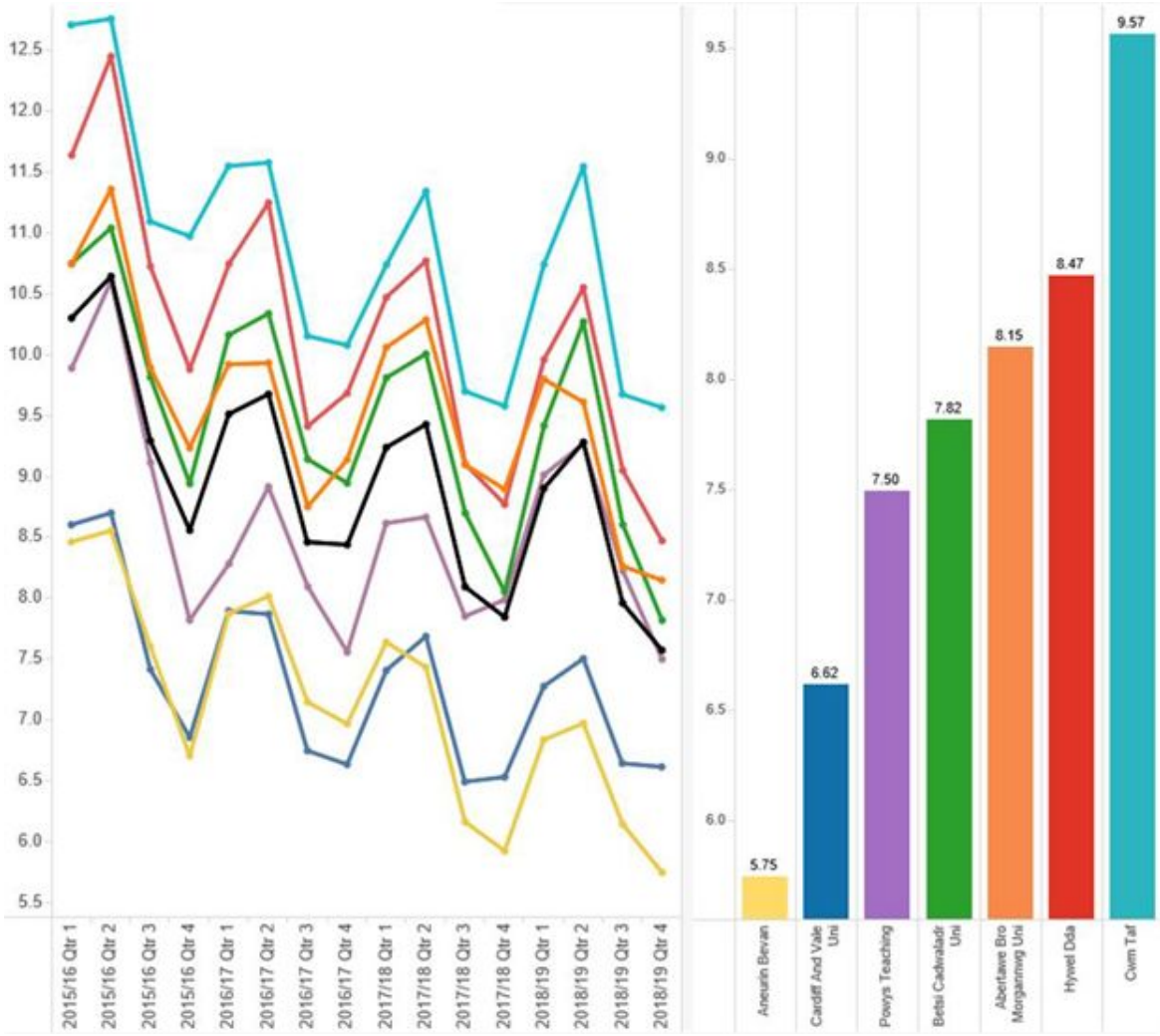
   - Target for 2018–2019: Absolute measure ≤7% or a proportional reduction of 10% against a baseline of data from April 2016–March 2017.
   - The data for Qtr 4 below demonstrate the Health board has the second lowest 4C prescribing in Wales. ABUHB achieved the largest reduction in Wales, with a 24.4% reduction in 4C usage in Qtr 4.

June 2019



3. 4C antimicrobials as a % of Antibacterial Items.
   - Target for 2018–2019: Absolute measure ≤7% or a proportional reduction of 10% against a baseline of data from April 2016–March 2017.
   - It should be noted that seasonal variation is demonstrated in the data for Qtr 4 below although there is a downward trend. ABUHB has the lowest use of these antibiotics in Wales and achieves the absolute target of ≤7% with a rate of 5.75%.

June 2019

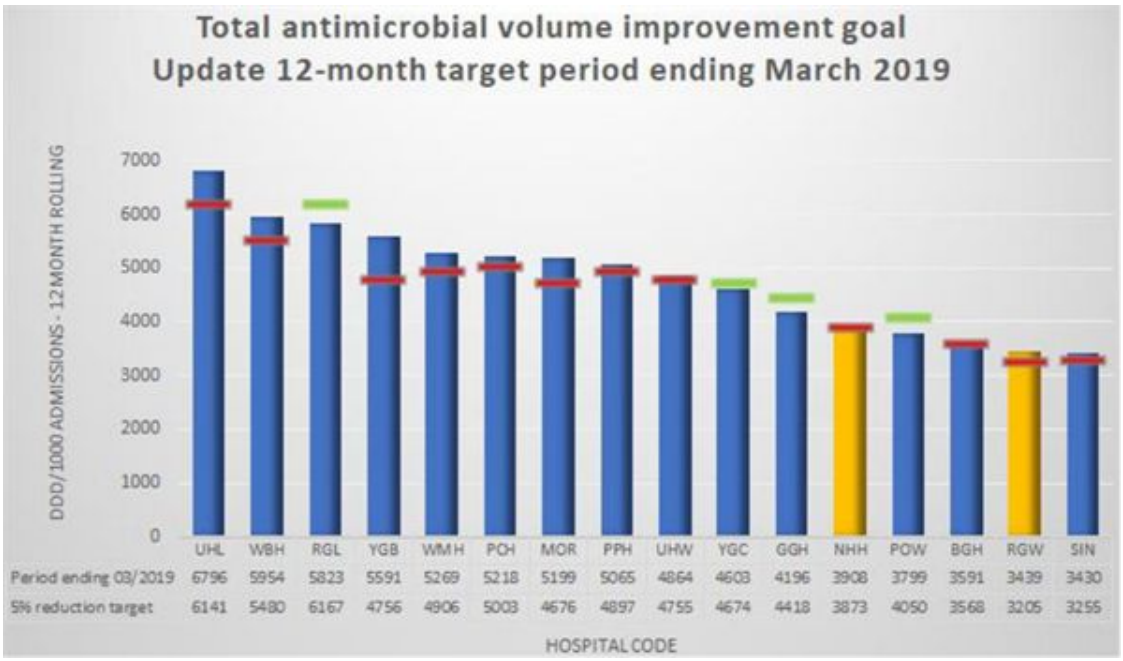


Secondary Care Prescribing

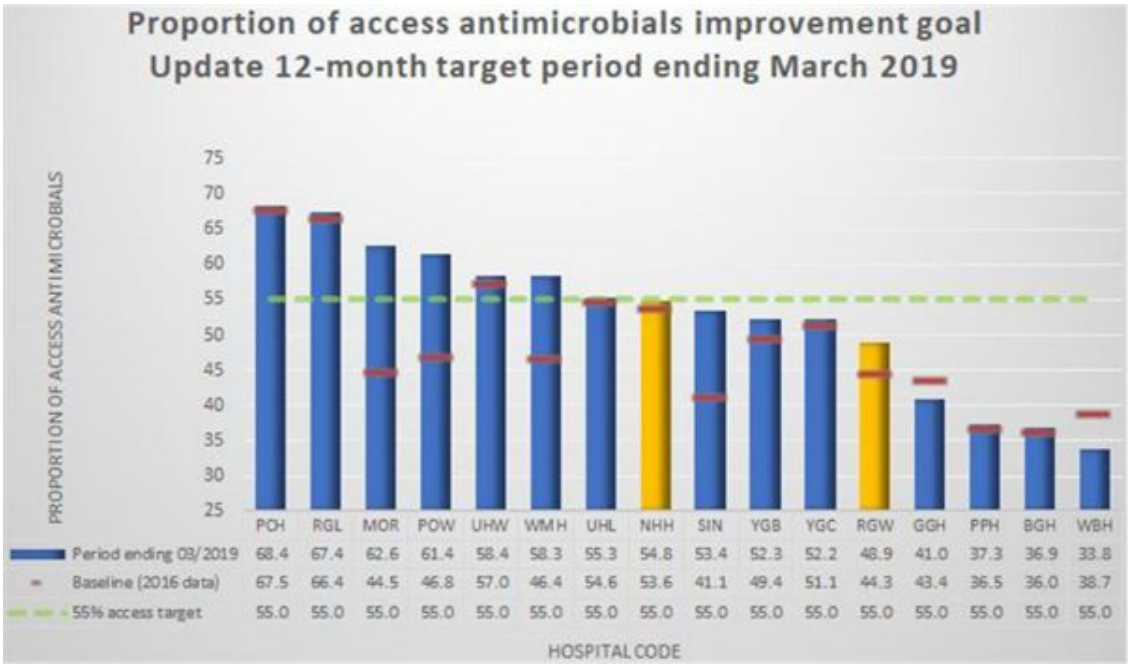
Welsh Government Tier 1 targets

1. Secondary care reduction in total volume measured as Defined Daily Doses (DDDs)/1000admissions
    - Target for 2018–2019: reduce the total volume of antimicrobial use by 5% compared with the baseline 2016-17 year.
    - The yellow columns in the graph below show the ABUHB acute hospitals (data are not produced for YYF). The red bars show the 5% reduction target demonstrating that neither RGH nor NHH achieved the target, in common with the majority of Welsh hospitals. NHH achieved a 4.1% reduction and RGH a slight increase in use, due to the move in guidelines towards more combination therapy rather than using single broad-spectrum antibiotics. Both RGH & NHH remain lower than average prescribers.
    - This target has been recognised as challenging therefore the target for 19/20 has been revised to a 1% reduction in total antimicrobial usage in hospital care against 2018-19 consumption figures.

June 2019



2. Increase the proportion of antibiotic usage within the WHO Access category to ≥55% of total antibiotic consumption (as DDD) OR increase by 3% from baseline 2016 calendar year
    - Antibiotics within the WHO 'Access' category are narrow spectrum antibiotics, which carry a lower risk of resistance and other adverse effects. The yellow columns in the graph below show the proportion of access antimicrobial usage for the acute hospitals in ABUHB for the financial year 2017/18. The red bars shows the 2016 calendar year baseline data and the green line the 55% target.
    - RGH achieved the target of a 3% increase from baseline, demonstrating a 4.6% increase. NHH almost achieved the 55% target, at 54.8%, a 1.2% increase from baseline.



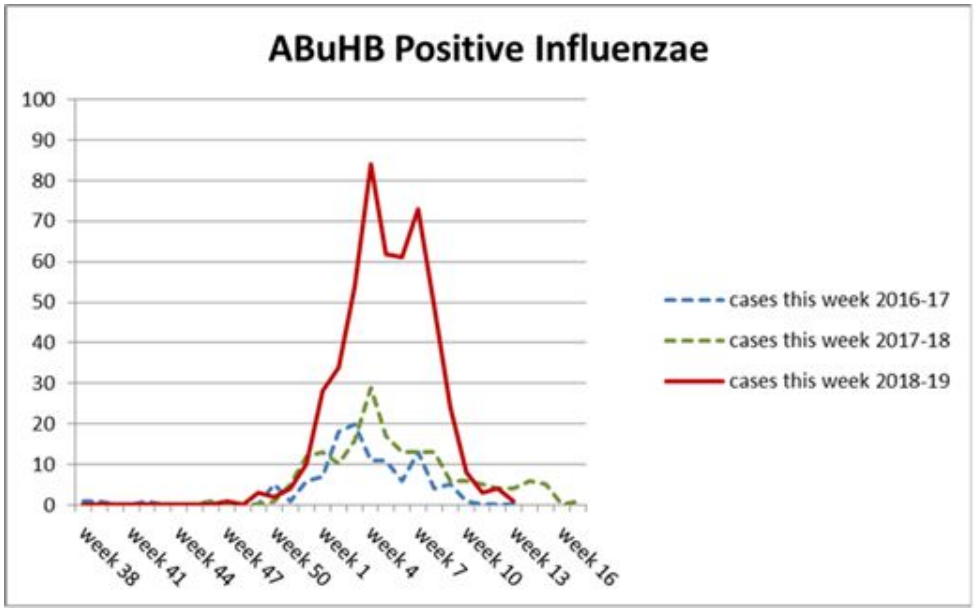
Influenza

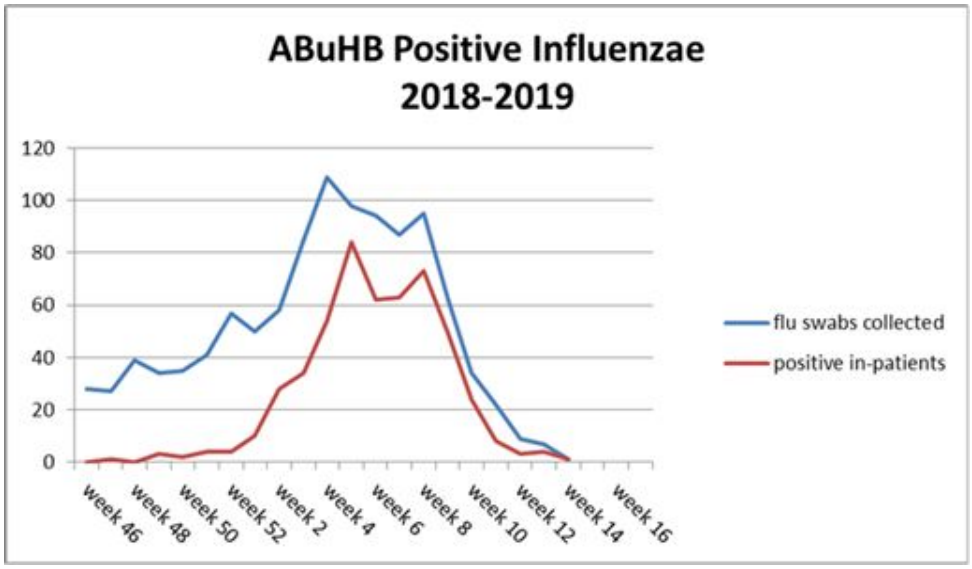
Influenza, commonly known as flu, is an infectious disease caused by the influenza virus. Symptoms can be mild to severe. The most common symptoms are high fever, runny nose, sore throat, muscle pain, headaches, coughing and feeling tired. These symptoms typically begin two days after exposure to the virus and most last less than a week.

The most vulnerable group of patients are those with morbidity risk factors such as diabetes, heart/lung/liver/kidney/blood/metabolic/ brain or spinal conditions, asthmatic, immunocompromised, obesity and children under the age of five, adults over the age of sixty five, pregnant women.

The 2018/19 flu season proved to be challenging with significant number of patients presenting with influenza like symptoms. The HB screened over 1814 patients of which 629 tested positive. The HB invested in PCR testing as a diagnostic tool which allowed for the majority of cases the result was confirmed with 2 hours this aid appropriate patient placement and risk assessment.

June 2019



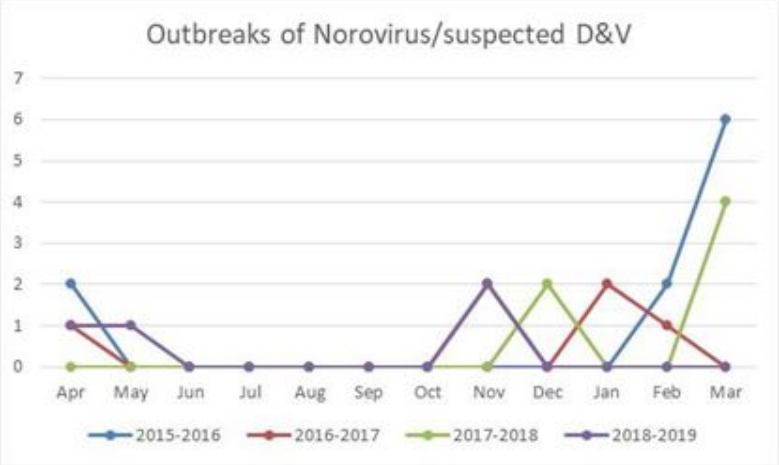


Through ongoing robust surveillance this resulted in the HB experiencing very few issues with influenza, however an outbreak was noted on D4W at the Royal Gwent. The IPT undertook a deep dive and themes for learning was around patient screening as numerous patients was asymptomatic carriers and in response to this standard operating procedure is being developed

Norovirus

Norovirus, which causes diarrhoea and vomiting, is one of the most common gastrointestinal infections in the UK. It is also known as the winter vomiting bug because it is more common in the winter period, although it can be picked up at any

time of the year. Norovirus can be very unpleasant but symptoms usually resolve in a few days, however the outcome to vulnerable patients can be significant. The IPT identified 4 wards during the reporting period which is a reduction to previously year. The ongoing support of the Executive team re ward closures significant helps in reopening quicker and less patients become affected.



Decontamination

An All Wales audit undertaken in 2018 identified improvement within ABUHB. Endoscopy decontamination facilitates within Nevill Hall Hospital has been centralised within the existing HSDU facilities which was a recommendation from WG survey 2018. This will eliminate the risk of the consistent failings within Llanwenarth suite for the standard rinse water tests.

Following recommendations, further discussions are underway to establish the future plans for endoscopy which will include JAG accredited endoscopy units at both Nevill Hall and the Royal Gwent Hospitals and also centralised endoscopy decontamination unit at the Royal Gwent Hospital.

In relation to other issues identified in July 2018 excellent progress has been made in implementing the decontamination action plan with good evidence of widespread divisional ownership. This action plan is monitored via the decontamination strategic group with any exceptions reported to infection prevention committee.

The Decontamination Manager continues to support the Divisions to promote best practice and compliance with national standards; Welsh Health Technical Memorandums (WHTMs) and ISO EN BS standards. The WHTMs is an indicator that decontamination processes are compliant within an organisation.

Work has been ongoing across the HB to improve decontamination processes including:

- The negotiation of Single Tender Agreement for 1 year pan Gwent service and testing contract for all endoscopy services to ensure compliance with WHTM 01-06 testing criteria with procurement.
- Third W&E authorised person (decontamination) has been appointed and trained within the HB
- Washer disinfectors have been purchased and since commissioned sited within all community dentistry service clinics, ensuring compliance with WHTM01-05
- Robust SOPs have been introduced within respiratory and critical care with decontamination of diagnostic equipment
- Procurement and implementation of designated gastroscope practice for required flexible endoscopy use within endoscopy thus ensuring no cross infection
- Approval has been granted for 2 new washer disinfectors at YYF endoscopy unit.
- Vac a scope has been implemented into the endoscopy Unit at Royal Gwent Hospital
- A UV decontamination unit has been purchased for decontamination of nasoendoscopes in Nevill Hall hospital ENT Unit
- HB service users attend external meetings for endoscopy with aim of sharing best practice across Wales
- HSDU departments accredited to national standard
- HSDU basket replacement ongoing which is in partnership with theatre re standardisation
- Ongoing review with facilities/theatres for best practice re tray and decontamination of surgical instruments
- Ongoing monitoring of weekly water quality sampling and act according to results

All the above interventions has been implemented with evidence based practice aiming to reduce the risk to patients and staff from inadequate decontamination of scopes. Also services have been sustained ensuring reduced patient cancellations.

A decontamination resource information pack has been developed by the lead nurse for decontamination due to limited expertise within practice. The pack is accessible to not only the IPT but directors as well which can be accessed out of normal work hours to preserve safety and service needs.

Next steps will include and external review of dentistry in 2019, ongoing monitoring and the development of the services in line with Clinical futures and The Grange hospital.

June 2019

Serious Incidents

The Infection Prevention Team often encounter extraordinary circumstances that require interventions over and above normal IP practice and precautions. A number of incidents investigated and followed up during 2018/19 are:

1. **REUSE OF MEDICAL DEVICE** The IPT supported Scheduled Care Division with the investigation of an isolated incident whereby a medical device (syringe) was used more than once on different patients. Follow up screening has indicated that no patient has acquired a blood borne virus from this incident however that doesn't take away the psychological aspect of the patient's wellbeing. Themes for learning:-
    - Dr education from an IP
    - Through put within theatres
    - Governance re trainees and observation from theatre

2. **BACTERAEMIA INFECTIONS** During October 2018, the neonatal unit at Royal Gwent Hospital had an increase of babies with differing bacteraemia infections. In response to this an action plan was developed in collaboration with the clinical team and IPT, with a particular focus on line care and blood culture collection. Public Health were informed and were satisfied the inventions implemented.

3. **MEASLES EXPOSURE** Patient presented at ED query pneumococcal, query flu and a rash of unknown origin. Initially, thought to be antibiotic related as visited GP 2 day's prior and prescribed antibiotics. Following discussion with Microbiology and Public Health Wales, patient was swabbed for measles which subsequently tested positive. On review of the patient administration system in ED (Symphony), it was not clear if the patient had been isolated appropriately. This resulted in contact tracing 122 potentially exposed patients and 24 staff contacts.

   Learning from this incident was around improving communication and effective documentation. Also, recognition that ED is extremely busy and a very difficult area to manage in terms of infection control precautions. To support this, it was agreed that Public Health concerns would be discussed at handover to raise awareness.

4. **CHICKEN POX EXPOSURE** Staff member with immunity to chicken pox was experiencing a period of reduced immunity during a shift in ED potentially exposing 74 patients. Letters circulated to patient GP and staff followed via occupational health. No contacts required additional interventions.

5. **RSV NEONATES** Four neonates tested positive for RSV during December 2018. All babies were nursed in cots in the same area. Parents of index case had reported symptoms of cough and cold. There has also been staff members working with symptoms. It is therefore likely that cross infection occurred.

Raised awareness with staff to avoid working with symptoms. Developed an all Wales screening tool for parents visiting the unit with respiratory symptoms.

6. **TB** Bedwas ward at Ysbyty Ystrad Fawr were heavily involved with managing a complex case of infective TB. The case required a multi-disciplinary approach to safely manage the patient and public. The event triggered an alert within the Newport homeless community and an outbreak debrief and management review will be undertaken in July 2019.

Infection Prevention Training Compliance

The Infection Prevention Team undertake training throughout the year supporting Divisions at events such as away days. Staff can also access IP training via the ESR Learning catalogue.

1701 individuals received training via these methods. In addition, 1275 individuals accessed the IP online training.

Divisional uptake of training is monitored at the Infection Prevention and Antibiotic Resistance Committee via their highlight reports.

The team has also supported the Divisions in developing a strategy to implement aseptic non-touch technique (ANTT) training. To date, a total of 328 assessors have been trained across the HB. Again, divisional uptake is monitored via the Infection Prevention Committee.

Emerging Organisms

There is a concern across the UK with regard to infections caused by a Gram-negative bacteria such as Carbapenemase producing enterobacteriaceae(CPE) and CPA Carbapenemase producing Acientobactor which has caused multiple outbreaks across other HB in the UK.

Over the reporting period the HB has seen an increase of number of sporadic cases with this organism, either identified on admission to ABuHB premises or via routine samples or known carriers being readmitted. The IPT have continue to promote the following interventions to reduce the risk to the patients and HB:-

- Screening of patients who have had an overnight stay in other hospitals across the UK or abroad
- Reviewing the cleaning strategy for inpatient daily requirements and on discharge
- Ensure all patients who acquire CPE/CPA are discharged with an alert card so that patients can be appropriately managed in the future
- Ensure patient equipment is in good working order and fit for purpose
- Developed a SOP for the management of inpatients
- Staff education

June 2019

- Process to identify repatriation of patients from other hospitals
- Daily linkage with wards when identified positive patients
- Linkage with Primary Care for patient access other HB services

ICNET

ICNET is an electronic infection case management and surveillance software. This will provide a standardised approach across Wales within IPT, ensuring a comprehensive overview of patient's infection control history within Wales, improving patient flow and outcome by standardisation of workflow and provide a national picture of healthcare associated infection.

During 2018/19 module 1 & 2 implemented and the next stage is implement the following modules

- Third module is for the surveillance and management of MDRO due to the increasing concern with antibiotic resistance across the world - awaiting
- Forth module is either the management of outbreaks and Surgical Site Infection SSI both areas are a mandatory requirement for national reporting within Wales – awaiting

Conclusion

Eliminating avoidable healthcare associated infection remains a top priority for the public, patients and staff. In response, a robust annual programme of work has been implemented over 2018/19, owned by the Divisions but supported by an experienced and highly motivated Infection Prevention and Control Team.

Non-compliance with targets has been disappointing, but good progress has been made this year with C. difficile reductions in particular. The 2019/20 the annual programme of work will rise to the challenge of resistant organisms which will be a focus in 2020.

Infection Prevention and Control is the responsibility of all HB staff and the Infection Prevention and Control Team do not work in isolation. The considerable success over the last year has been possible because of the commitment for infection prevention and control - demonstrated at all levels of the organisation.

Sponsored by: Martine Price – Director of Nursing

Prepared by: Moira Bevan - Lead Infection prevention Nurse

Liz Waters – Consultant Nurse Infection Prevention/Associate Nurse Director

Dr Mohammad Abrishami – Lead Infection Prevention Doctor

June 2019

Annual Programme of Work

April 2019- March 2020

INFECTION PREVENTION & DECONTAMINATION

Author: Moira Bevan, Lead Nurse, Infection Prevention

CONTENTS

Introduction

Infection Prevention remains everybody's business. There is a zero tolerance to all preventable healthcare associated infections (HCAI) within Aneurin Bevan University Health Board (ABUHB) and within the NHS in Wales.

Within Wales a code of practice was published in 2014, building on previous documents such as the 2011 Welsh Government Commitment to Purpose – Eliminating Preventable Healthcare Associated Infections ((HCAI) A framework of Actions for Healthcare Organisations in Wales. The code refers to nine standards that are required to be implemented providing a foundation on which to build high quality and innovative systems of infection prevention and control.

NHS patients have the right to expect high quality care and services in a safe environment. HCAIs can be a significant threat to patient safety, increase mortality and morbidity and also incur considerable financial cost to health boards

Tackling HCAIs requires a holistic approach that links with antimicrobial stewardship, decontamination of medical devices, estates and facilities, cleaning and laundry and clinical and managerial leadership. In addition to our own monitoring of patient incidents and harm, health boards from healthcare associated infections is absolutely key to achieve learning and prevent further harm.

ABUHB remains committed to this and it is reflected in the infection prevention annual programme of work.

It will also reflect other drivers within Wales to include:-

- Annual Quality Framework – Tier 1 targets
- Health and Care Standards
- Fundamentals of Care
- 1000 lives programme
- All Wales Decontamination Strategy
- Public Health Wales – Mandatory Surveillance
- Together for Health talking antimicrobial resistance and improving antibiotic prescribing 2016
- Infection Prevention Code of Practice

The overall aim of the Infection Prevention Team (IPT) will be to provide up to date evidence based practice, protecting the patient, staff and public. Promoting safe, high quality, dignified care in a professional manner, aiming for excellence in all we do

Objectives

By April 2019 the Infection Prevention Team (IPT) will:-

- Liaise with the Divisions and Localities in implementing action plans based on the above, promoting local ownership.
- Monitor compliance with all Wales drivers i.e. ANTT
- Monitor the Executive Infection Prevention Committee (IPC), working on the agreed action plan following learning from RCA
- Reduction expectation indicated by Welsh Government for the reduction of C. *difficile* of a rate of 25 per 100,000 and Staph *aureus* bacteraemia of a rate of 20 per 100,000 and Gram negative bacteraemia to include E coli bacteraemia of a rate of 61 per 100,000 and a 10% reduction for Pseudomonas and Klebsiella bacteraemia by undertaking root cause analysis in collaboration with the Divisions
- A focus urinary assessment within primary and secondary care and CAUTI reviews sharing lessons learnt with the Divisions.
- Promote the all Wales guidelines for UTI management
- Work in collaboration with Tissue Viability for the reduction of MSSA in chronic wounds
- Validate practice at an operational level ensuring standards are maintained around healthcare setting environment, cleaning and hand decontamination and feedback accordingly.
- Outcome data from Ward to Board to be reported on quarterly basis, monitoring progress against Welsh Government reduction expectation and mandatory surveillance as indicated by Public Health Wales.
- Liaise with the Divisions and Public Health to continue to strengthen the Influenza vaccine campaign.
- Ensure influenza patients are managed appropriately and follow the agreed pathway.
- Enhance the Link Champions programme with study sessions twice yearly
- Annual audits supporting the Divisions and the Environment Committee through local reviews of the Healthcare setting ensuring it is of an acceptable standard from an infection prevention perspective and that the recommendations incorporated into local action plans.
- Embed the strategy for the early identification and monitoring of Carbapenamase producing Enterobacteriaceae (CPE) and other resistant pathogens
- Promote and ensure that accurate information is communicated to all relevant individuals in an appropriate and confidential manner.
- Implement the ICNET package into the IPT in line with other HB in Wales
- Support the antimicrobial reduction strategy
- Implement a teaching strategy across the HB for all staff

- Infection prevention and control in both acute and community settings will be improved through the implementation of clear, unambiguous and easily accessible policies and procedures

Mandatory Surveillance – WG targets plus alert organisms

The Infection Prevention Team (IPT) will feedback surveillance data from Ward to Board and act upon any identified increased incidents or outbreaks.

Routine surveillance data across the organisation will include:-

- C. *difficile*
- Staph aureus bacteraemia
- Ecoli bacteraemia
- Other bacteraemia i.e pseudomonas and klebsiellia
- Deaths relating to healthcare associated infections within 30 days of diagnosis
- Influenza
- Alert organism i.e CPE
- Surgical site infection (SSI)
- Mandatory surveillance via WHAIP – Orthopaedic SSI in primary joints and C sections infections, Ventilator associated pneumonia and central lines within critical care
- Outbreaks of diarrhoea and vomiting
- Outbreaks or increased incidents of alert organisms
- Antibiotic stewardship via review meetings
- 1000 lives drivers as indicated

The team will liaise with the wards on a daily basis providing real time feedback and to the Divisions on a monthly basis via the quality dashbaord unless a concern is identified and feedback will be given immediately. Reports will be submitted to the Infection Prevention Committee and the Quality and Patient Safety Committee.

Work in collaboration with the Divisional Leads and Head of Facilities in the development of an annual Hydrogen Proxide Vapour (HPV) clean in response to local surveillance data and as part of a rolling programme proactive clean.

Audit

By April 2020 the IPT will:-

- In collaboration with facilities annual Infection Prevention Society (IPS) environmental audit on all acute areas and feedback accordingly.
- Every 3 months undertake a validation audit of the quality dashboard for infection prevention and feedback accordingly.

- Every 3 months undertake MRSA screening compliance and to feedback compliance via the quality dashboard.
- Every 3 months undertake a validation hand hygiene audit and feedback via the quality dashboard and fundamentals of care and present to the IPAR committee.
- In collaboration with the venous access nurse undertake CAUTI/PVC/CVC audits for bundle compliance and feedback accordingly.
- Undertake specific audits as required when an issue is identified i.e. following a cluster or outbreak or in response to a complaint.
- Support wards and departments in local audits for hand hygiene and environment.
- Undertake isolation audits annually and feedback accordingly. This will also be monitored via the root cause analysis for C.*difficile* and MRSA bacteraemia.
- Liaise with Works and Estate with their audit requirement for the water quality in augmented care areas.
- Collaborate with the antibiotic pharmacist with antibiotic stewardship
- Work in collaboration with Primary Care with auditing nursing and residential homes.

Isolation Facilities

- Work in collaboration with Works and Estates in implementing the Welsh Health Circulars from the Welsh Government and facilitate the introduction of such recommendations.
- Ongoing review of the current lack of respiratory isolation facilities available and support the Divisions in local risk assessments until the Grange Hospital is available
- Promote the daily assessment of cubicles within the Division to aid prompt isolation for patients who have been risk assessed as needing a cubicle
- Support Divisions with the assessment of cubicles, especially in outbreak management or when the organisation is at a red escalation

Decontamination

By April 2020, the Decontamination Manager will continue to work with local lead individuals in the Divisions who have responsibility to:-

- Implement and monitor relevant Welsh Heath Technical Memorandum (WHTM) guidance and European National (EN) Standards.
- Implement a training plan and Divisions to report compliance via status reports at the Infection Prevention committee.
- Implement an audit programme and report findings to the Divisions and via the Strategic Decontamination Group.

- Monitor in collaboration with the Divisions a quality dashboard for endoscopy
- Liaise with external bodies promoting best practice.
- Implement the decontamination strategy.
- Receive external reports and act upon recommendations.
- Develop and maintain a decontamination manual accessible on the intranet.
- Identify and assess decontamination risks within the Organisation ensuring escalation through the Divisions and at the Strategic Decontamination Group
- Promote a standardised approach to decontamination across the Health Board
- Support the Divisions with a centralised approach to decontamination with a particular focus on the Royal Gwent site
- Participate in the all Wales dental audit 2019/20

Training and Education

Infection Prevention training is available to all HB staff via an E Learning programme, within Learning at NHS Wales

By April 2020 the IPT will:-

- Promote the Infection Prevention Education Strategy for providing training to staff/visitors/volunteers/contractors within ABUHB.
- Offer annual training to all acute/community hospitals/residential/nursing home either via face to face or via E learning.
- Link with the Localities Leads for infection prevention reviewing current training for GP practices.
- Provide study sessions for link champions to include an opportunity for staff across the organisation to uptake the influenza vaccine.
- Collaborate with colleagues across Wales in formulating a standardised approach to infection prevention training.
- Implement ad hoc training if an area of concern identified or increased incidents of infections.
- Promote the use of Aseptic Non Touch Technique (ANTT).
- IPT to support the Divisions in the training and assessment of ANTT
- Promote staff responsibilities with regard to vaccine preventable diseases and work in collaboration with the Occupational Health Department and Public Health Wales.
- A member of the IPT to become a champion for flu vaccine
- Support the continence team in the promotion of urinary catheter training
- A representative from the infection prevention team on the HB strategic educational group
- Support facilities with the development of educational package

- Promote hand hygiene on the 5th of May in line with World Health Organisation
- Promote infection prevention on National awareness week in October
- Link with external bodies i.e. IPS re National campaigns
- Work in collaboration with Health & Safety/Occupational Health colleagues to provide mask fit test training

Clinical Futures

By April 2020 the IPT will:-

- Engage with the clinical futures team providing infection control advice on the new builds and refurbishments.
- Review the team structure and scope in readiness for the change in service and apply for additional funding

Team Development

By April 2020 the IPT will:-

- All infection prevention nurses will progress with their own personal development utilising the IPS competency as a framework working within their code of practice NMC
- All members of the infection prevention team will have regular one to ones with an annual PADR.
- Each team member will attend at least two study days within the period 2019/2020.
- The team will be encouraged to collaborate with other organisations across the UK horizon scanning for best practice.
- The Consultant Nurse for infection prevention will raise the profile of the service internally and externally to the organisation.
- Each team member will be encouraged to promote and publish good practice and achievements.
- Team members to be encouraged to register or sustain their subscription with the IPS.

Service Development

By April 2020 the IPT will:-

- All acute and community in patient areas will be implementing ANTT
- Acute wards will be implementing the care bundle for central lines.

- Work with acute medicine to develop a care bundle to prevent hospital acquired pneumonia.
- Work with the sepsis team to review hospital acquired sepsis and lessons learnt to promote best practice.
- Attend Public Health Wales meetings sharing best practice and ensuring learning is returned to ABUHB.
- Lead Nurse to attend all Wales Lead Nurse meeting sharing best practice and returning learning to ABUHB.
- Decontamination manager to attend all Wales decontamination meetings sharing best practice and returning learning to ABUHB.
- Review of the current team structure in line with new recommendations or changes within existing team structures.
- Review organisational policies for infection prevention / decontamination and adopt any new policy accordingly.
- Develop the IP service to cover the Grange Hospital successfully with the proposed business case
- Develop a winter strategy to support the HB with the management of influenza and outbreaks

Public/Patient Involvement

By April 2020 the IPT will:-

- Work closely with members of the CHC with regard to the hospital environment and cleanliness
- Update the intranet page with local data to keep the public informed and up to date
- Update and develop patient/relative information leaflets and signage, indicating best practice and public responsibility to infection prevention
- Link with the CHC re local campaigns and initiatives to aid the reduction of healthcare associated infections
- Collaborate with CHC to engage re hospital outbreaks
- Link with the Communication Team re any local concerns or re new/ongoing initiatives

Research & Development

By April 2020 the IPT will have:-

- Collaborated with Cardiff University to undertake research relating to:
  - Competency based infection control education
  - Effectiveness of UV light in environmental decontamination
- Submit abstracts of good practice within infection prevention and decontamination, both internally and externally to the organisation

- A successful initiative will be submitted for publication

Annual Report

By April 2020 the IPT will have:-

- Submitted an annual report reflecting the annual programme of work and evaluation of the service

Aneurin Bevan University Health Board

Infection Prevention – Tier 1 Target – Performance Plan

Reduction Expectation 2019/20

Introduction

Healthcare associated infections (HCAIs) cause avoidable harm and remain a key patient safety issue and result in significant financial cost to the NHS in Wales. The target indicated by Welsh Government for the Health Board is:-

- C difficile – 25 per 100,000
- Staph Aureus bacteraemia – 20 per 100,000 with Zero tolerance to MRSA bacteraemia
- Gram Negative bacteraemia – 61 per 100,000

ABUHB must remain vigilant to all types of healthcare associated infections. Continuing to set clear national reduction expectations in response of *C. difficile, S. Aureus (MRSA and MSSA bacteraemias), Gram Negative (E Coli, Pseudomonas and Klebseilla) will:*

- Reinforce the Welsh Government commitment to zero tolerance of preventable HCAIs;
- Underpin Prudent Health and Care's do no harm and minimise inappropriate variation principles;
- Continue as a key marker of success in the multi-interventional approach needed to tackle HCAIs; and
- Encourage Health Boards to take all steps to prevent and manage better frequently occurring HCAIs – whether in hospital of the community

The new action plan will help keep the focus on this priority area; this action plan in conjunction with the AMR and will encourage the Health Board to make incremental improvements building on progress to date and ensure progress is consistent throughout Wales in line with the 1000 lives collaboration. There are five work streams to the HCAI 1000 lives collaborative, C difficile, Staph aureus and Gram Negative bacteraemia, Surgical Site Infection (SSI), and leadership.

Actions are RAG-rated according to the following criteria:

Green	On target for completion by deadline date or completed.
Amber	Delay or risk of delay but some progress is being made. Escalation may be required to CPG, Site and/or Executive Lead.
Red	Progress not being made, or very significant delay in progress. Escalation to Executive Lead required.

Core Membership		
Initials	**Name**	
RJ	Rhiannon Jones	Director of Nursing
PB	Paul Buss	Medical Director
SE	Stephen Edwards	Deputy Medical Director
LW	Liz Waters	Consultant Nurse/Associate Nurse Director
MB	Moira Bevan	Lead Nurse, Infection Prevention
PE	Paul Edwards	Consultant Surgeon
JS	Jonathon Simms	Clinical Director of Pharmacy
CP	Ceri Phillips	Antibiotic Pharmacist
MA	Mohammad Abrishami	Consultant Microbiologist/Lead Infection Prevention Doctor
DNs	Divisional Nurses	Nursing Representation
IJM	Ian Morris	Deputy Director of Planning
DW	David Wells	Head of Facilities South/Strategic Cleanliness Manager
RS	Rhianwen Stiff	Consultant in Communicable Disease Control
EL	Elaine Lewis	Occupational Health Manager
EP	Eryl Powell	Consultant in Public Health
SM	Samantha Murray	Decontamination Manager/Senior Nurse, Infection Prevention
Co-opted Members		
CB	Claire Birchall	Associate Director Operations
ML	Martin Lane	Assistant Director, Quality & Patient Safety
WW	Wendy Warren	Head of Planning/Civil Contingencies
AE	Aled Evans	Consultant/Clinical Director, Trauma & Orthopaedics
GE	Gareth Edwards	Consultant Obs & Gynae/Assistant Divisional Director
NP	Neil Pearce	Head of Estates, Maintenance & Operations
DDs	Divisional Directors	

Theme	Action	Lead	Timetable (End of)	Verification	Progress	RAG rating
Hand Hygiene	Key Hand hygiene messages to be published on the Intranet Carousel & Screensaver.	MB/Communications Team	Throughout 2019/20	Infection Prevention & Control Committee Divisional QPS		
	Divisional nurses to provide assurance that senior nurses are monitoring hand hygiene via the Senior Nurse Infection Prevention dashboard	DNs	Throughout 2019/20	Infection Prevention & Control Committee Divisional QPS	Monthly monitoring and circulated via IPT	
	Infection Prevention Team (IPT) to monitor Hand Hygiene compliance via the Fundamentals of Care Audit tool	IPT	Throughout 2019/20	Infection Prevention & Control Committee Divisional QPS		
	HB to participate in National Hand hygiene awareness	IPT	May 2019	Refreshed hand hygiene campaign		

Cleanliness & Estates	UHB discretionary capital programme to include a minimum of one ward upgrade each financial year, to include isolation & en-suite facilities (acute & community hospitals)	LW	September 2019	Infection Prevention & Control Committee	Ward 3-3 2019 commenced July	
	DNs to provide a robust plan for the implementation of the agreed HPV cleans ensuring wards of highest priority are cleaned & monitor progress against scheduled	DNs	May 2019 2018	Infection Prevention Committee	Identified wards 10 RGH – in progress 8 NHH - completed 1 SWH- completed 2 County – completed 1 Chepstow completed 1 YAB Completed 1 YYF in progress 30.09.19 3 wards left within RGH	
	C4C compliance scores subject to monthly review with escalation of exceptions to IPC via Divisional highlight reports	DW/DNs	Bi Monthly	Infection Prevention Committee Exceptions reported to IPC		

	Develop a business case to introduce ultra violet light decontamination for alert organisms	DW/MB	July 2019	Infection Prevention Committee	Dragon den to review products being implemented in Oct/Nov All Wales group developed Wales linking with Scotland re what clean for what	
	Vacancies & long term sickness to be reported monthly & to be included within facilities highlight report with clarity on whether vacancies have been backfilled with bank/agency	DW	Monthly	Infection Prevention Committee	To be incorporated into Divisional highlight reports	
	The percentage of outstanding job requests to be reported monthly & to be included within facilities highlight report	NP	Monthly	Infection Prevention Committee	To be incorporated into Divisional highlight reports	
	Position Statement to be provided annually to identify end of life macerators and compliance with annual service.	NP	July 2019	Infection Prevention Committee	Divisional responsibility	

	Facilities to review the escalation of job requests to ensure any requests that include sewage/drainage are high priority & acting on promptly.	NP	July 2019	Infection Prevention Committee		
	To increase the cleaning hours within the assessment areas at RGH and NHH to a 24 hours service to be included in the HPV paper	GH/DW/CB	May 2019	Infection Prevention Committee	To be reviewed in line with winter planning 30.09.19 Ward assistant JD developed and advertised to be piloted	
	To increase the cleaning resource in areas where nursing staffing is significantly compromised to be included in the HPV paper	GH/DW/CB/DN	May 2019	Infection Prevention Committee	Paper presented to the Board 22nd July approved Divisional funding required	
Medical engagement & patient care	Junior doctor engagement in C.difficile & S. aureus reduction & AMR Stewardship including hand hygiene & audits. Develop a champion role.	DDs	Throughout 2019/20	Divisional Status Reports to IPC	Start smart and focus audits	

	Consultant & junior doctor engagement with background & root cause analysis reviews to increase to 95%. Audit via database	DD	Ongoing throughout 2019/20	Infection Prevention Committee Divisional QPS	Monitored via RCA dashboard	
	Lead Clinician to attend outbreak meetings for increased c difficile within a ward & learning to be shared within Directorate QPS	DD	When required	Meeting minutes	Attended Neonatal 3-4 Chepstow	
	Lead Clinician to feedback learning following outbreaks at the IP&C Committee & Divisional QP&S.	DD	When required	Infection Prevention Committee Divisional QPS	Discussed at QPS Neonatal attended IPC	
	GP engagement - via written feedback - with C.difficile reviews to increase to 95%. Audit via C.difficile database	AP	Bi monthly	Infection Prevention Committee Divisional QPS		
	Job plan of ICD to be reviewed, together with that of Consultant Medical Microbiologist to address outstanding recommendation of Duerden Report.	MA/DD	Jan 2016 and ongoing	Job Plan		

Additional actions to support all work streams	Divisions to provide assurance that a weekly mattress inspection process is in place with validation by the infection prevention team. Record on IC dashboard.	DNs	Bi monthly	Divisional QPS & Divisional Status Reports to the Infection Prevention Committee	Monitored via quality dash board	
	Divisional nurses to provide assurance that senior nurses are monitoring crucial infection prevention interventions – including commode cleanliness - via the Senior Nurse Infection Prevention dashboard & HCAI	DN	Throughout 2019/20	Quality Dashboard for IP C4C audits	Discussed with Divisional nurses to improve gaps July 2019 Ongoing monitoring HACI and deep dives	
	Patients with unexplained diarrhoea to be isolated within 2 hours of developing symptoms & monitored through a process developed by Infection Prevention Team & Patient Flow Teams.	DN/Patient Flow Team	Throughout 2019/20	Divisional QPS & Infection Prevention Committee	Reviewed via the IPT results process	
	Divisional Management Teams (DMT) to provide a plan to release staff for infection prevention & control education. Monitored via Divisional highlight reports	DMT	Throughout 2018/19	Infection Prevention Committee Divisional QPS	Training compliance monitored via the Divisional highlight report	

Leadership	Executive Team walk arounds to include infection control. Major issues to be reported to IP&C committee.	RJ	Throughout 2019/20	Feedback correspondence		
	Develop a HB Vision for Infection Prevention & Control	MB	August 2019	Infection Prevention Committee	Review in line with the grange strategy	
Surgical Site Infection (SSI)	DMT to provide assurance that the care bundle for SSI is robust. Present ORMIS report at IP&C committee	DMT	Bi monthly	Infection Prevention Committee via highlight reports	Review criteria in line with national standards ormis/ICNET availability meeting arranged 15.08.19 Ipt linked with ormis awaiting new software to be updated	
	Map current patient pathways for surgical procedure to ensure compliance with National guidelines exceptions to be reported	DMT/MB	Throughout 2019/20	Infection Prevention Committee via highlight reports	40 patients reviewed in line with new colorectal SSI surveillance to be presented in August 30.09.19 Abci mapping processes	

	Support the implementation of ICNET to allow for robust 30 day follow up for SSI	MB/LW/BS	August 2019	Infection Prevention Committee	Linked with IT re ormis and ICNET interface 30.09.19 discuss next module to be implemented	
	Monitor SSI rates in relation to colorectal surgery task and finish group established	DMT/KS	May 2019	Infection Prevention Committee and Divisional QPS	Bimonthly meeting 40 cases reviewed As base line data monitor via ICNET	
	Refresh the STOP campaign to be implemented across the HB	MB/Communication team	September 2019	Infection Prevention Committee	CAUTI implemented in June Plan PVC Oct 30.09.19Link Champion arranged for Oct No catheter November covering district nurse and nursing homes	
	PVC & CAUTI bundle compliance to be monitored monthly by the Divisions & validated 3 monthly by IPT. Observational audit for insertion & maintenance to provide assurance of evidence to practice.	DMT/MB	Throughout 2019/20	Infection Prevention Committee	Monitored via quality dash board	

	All relevant staff to undertake ANTT assessment every 3 years compliance monitored via highlight reports	DMT	Throughout 2019/20	Infection Prevention Committee	Ongoing monitoring	
	Divisional Management Teams to provide a plan to release staff for training on blood culture collection Dr Abrishami to provide 2 session each year at RGH,NHH and YYF	DMT/MB	Throughout 2019/20	Infection Prevention Committee	NHH induction provided by MB RGH planned for March YYF planned for Dec	
	Scope the provision of wound care & assessment across the HB & update the committee with findings	TV/MB/LW	July 2019	Infection Prevention Committee	IPT member of the wound care group support re RCA linked to chronic wounds	
Staph aureus & Gram Negative bacteraemia	Establish & implement RCA process for Community acquired staph aureus & feedback themes for learning	LL/MB	June 2019	Infection Prevention Committee & Divisional QPS	Biliary sepsis deep dive implemented and feedback July IPAR Urinary catheter reviewed Next Resp	
	Implement RCA process for gram negative bacteraemia that is a consequence of urinary catheter & feedback themes for learning	DMT/MB/Continence Leads	Throughout 2019/20	Infection Prevention Committee & Divisional QPS		

	Promote the all Wales E learning package for urinary catheter once developed across the DMT where appropriate & monitor compliance	Continence Lead & DMT	Throughout 2019/20	Infection Prevention Committee & Divisional QPS	Division aware e learning available	
	A 4 year competence assessment for those inserting urinary catheters is required as well as ANTT assessment DMT where appropriate & monitor compliance	DMT/Continence lead	Throughout 2019/20	Infection Prevention Committee & Divisional QPS	Divisions monitoring compliance via highlight reports	
	Promote & implement the Key Standards for UTI Prevention.	DMT/CP/MB/LW/Continence leads	Throughout 2019/20	Infection Prevention Committee & Divisional QPS	Ongoing Review re antimicrobial stewardship Key messages re urine sample shared in June 2019 30.09.19 UTI Leaflet funded for circulation	
	Review and promote blood culture training to all key members of staff across HB. Monitor compliance plus monitor via contaminant blood cultures	DMT	Throughout 2019/20	Infection Prevention Committee & Divisional QPS	Included in IP training MAU focus in June/July	

	Review provision for TWOC clinics across the HB	DMT	June 2019	Infection Prevention Committee & Divisional QPS		
	Implement a hydration campaign in collaboration with dieticians and Public Health Wales	LW/Dieticians/KN	April 2019	Nutrition and Hydration working group		
	IPT to work in collaboration with substance misuse team of the reduction of MSSA linked to PWID	Mental Health Division/IPT	Sept 2019	Infection Prevention Committee & Divisional QPS		
	IPT to work in collaboration with TVN and Professor Harding reviewing patient pathway for the management of wound and chronic ulcer management	ITP/Liz Waters/Professor Harding/TVN/Vascular team/Radiology	Sept 2019	Infection Prevention Committee and chronic leg ulcer meeting	IPT member of the working group	

	IPT to work in collaboration with respiratory medicine for the prevention of respiratory infections with a particular focus on:- Oral care Immunisation against flu COPD management	Moira Bevan/community lead	Sept 2019	Infection Prevention Committee	Email sent re the lead for primary/secondary care Vaccine programme established COPD pathways available Oral care next focus	
	Implement the oral health programme in dentistry (designed to smile)	Dr Jones	Sept 2019	Infection Prevention Committee	Implement annual report requested	

WG Survey 2018 Action Plan						
Theme	**Action**	**Lead**	**Timetable (End of)**	**Verification**	**Progress**	**RAG rating**
Environment / Facilities	NHH endoscopy: Centralisation of services as priority as current layout inadequate	Denise Cressey	March 2019	Working group minutes Regular updates at Strategic Decontamination Group meetings	Business case approved Working group established Nov 2018 – successful appointed company Denise to feedback.	
	RGH endoscopy theatre D decontamination room: Interim install of sink to meet WHTM 01-06 requirements to improve scope decontamination flow Install of sink thermometers	Gareth Blandford Ivor Jones AP(D) Angela Ball	March 2019	SOPs in place Regular updates at Strategic Decontamination Group meetings	Audits undertaken of SOP to mitigate risk Request for costing undertaken	
	Urology OPD: Assurance regarding decontamination automated door system required	Ivor Jones AP(D) / Martin Munday AP(D) / Ceri Badham	Sept 2018	Service contract or SLA in place to ensure remains in working order	Complete Works confirm SLA in place	

WG Survey 2018 Action Plan						
Theme	**Action**	**Lead**	**Timetable (End of)**	**Verification**	**Progress**	**RAG rating**
	Cleanliness of departments	Departmental manager Sam Murray	Monthly	Quality dashboard 3 monthly validation by IPN	Ongoing audit plan Local manager & Senior nurse engagement Equipment aspect	
	Clutter within departments reduce to an acceptable level	Departmental managers	Monthly	Quality dashboard 3 monthly validation by IPN	Ongoing audit plan Local manager & Senior nurse engagement Equipment aspect	
	Review the air flow and cooling systems of the departments	W&E	Quarterly	Service Records	Stand alone units	
Traceability	Convert from a manual trace-ability to an electronic system to increase awareness and reduce human error	Department mangers	April 2019	Minutes of T&F group Centralisation of services meetings Capital group meeting minutes	Denise Cressey will be ordering as part of coordinated order	
Storage	All unscheduled activity is covered by using vacuum packed innovation	Departmental Managers	Dec 2018	Evidence of purchase	PPD developed. Needs changing as nil able to utilise for ENT YYF Gareth to action	

WG Survey 2018 Action Plan						
Theme	**Action**	**Lead**	**Timetable (End of)**	**Verification**	**Progress**	**RAG rating**
	Review the storage of scopes within Theatre C in main endoscopy at RGH	Angela Ball	Dec 2018	Audit	2 Drying cabinets ordered. 1 in situe 1 this weekend Nov 2018 Completed	
	Review the chemical storage so that it meets COSHH standards	Departmental Managers	Dec 2018	Purchase of relevant cupboards	Divisions to update re ordered. Need expensive cabinets as part of ongoing improvement. Mitigate risks by removing	
Training	Departmental update for the manual decontamination of Trophen	Sam Murray	Dec 2018	Training records	Training dates arranged Updates undertaken	
	Review the equipment used for manual cleaning ensuring single use equipment is uterlised for scopes	Sam Murray/ Ceri Badham	Dec 2018	Training records Observational audits	As part of audit. Sister aware and actioned	

WG Survey 2018 Action Plan						
Theme	**Action**	**Lead**	**Timetable (End of)**	**Verification**	**Progress**	**RAG rating**
	Introduce a manual clean at YYF ENT followed by the use of Tristel 3 between each patient	Unit Manager/Sam Murray	Nov 2018	Training records Observational audits	Actioned. Will be monitored as part of dashboard	
PPE	Standardise the PPE used throughout the endoscopy unit	Sam Murray	Dec 2018	Training records Observational audits		
Documentation	Ensure all SOP are updated and current Promote the use of the HB intranet	Sam Murray/Departmental Leads	Dec 2018	Question staff awareness Audit	As part of audit process	
	Evidence of required water testing	Departmental managers W&E Sam Murray	Weekly	Documented results	Process undertaken and evident. Will be monitored as part of dashboard	
Equipment	Replacement programme for all equipment is adequate	Departmental managers	Ongoing	Equipment register	Capital risk register. Updated regularly.	

WG Survey 2018 Action Plan						
Theme	**Action**	**Lead**	**Timetable (End of)**	**Verification**	**Progress**	**RAG rating**
	Ensure SLA for all AER and scopes accordingly	Departmental managers	Annual or on new purchase	Evidence of contracts	Renewed as required. All inclusive service and testing OQ PQ	

ABUHB Antimicrobial Tier 1 Targets Action Plan

In May 2018 Welsh Government issued a Welsh Health Circular (link) which set out improvement goals for antimicrobial prescribing for the first time. The 2019-19 targets are:

Primary Care and Secondary Care: 5% reduction against the baseline year of April 2016 – March 2017:

- Primary care reduction in total volume measured as Items / 1000 STAR-PU.
- Secondary care reduction in total volume measured as DDD/1000admissions

Secondary Care:

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

In addition to the targets further quality improvement expectations are outlined:

- **ALL PRESCRIBERS** should document indications for all antimicrobial prescriptions, facilitating effective audit and review of antimicrobial prescribing.
- **In Primary Care**, an appropriate Read code should be entered whenever antimicrobials are prescribed.
- **In Hospital practice** indications and course duration must be documented on the prescription chart and a review of antimicrobial prescriptions must be undertaken by a senior clinician at 48 – 72hours. The "Start Smart then Focus" standard.
- Health Boards will be expected to embed a scheme of regular audit against the "Start Smart Then Focus" standard, both to better understand, and improve the quality of antimicrobial prescribing.

Welsh Government will expect that Health Boards and Trusts report on progress against these improvement goals at the Quality and Delivery Meetings.

This document constitutes the ABUHB action plan to address the actions required of the health board. Progress will be monitored by the Antimicrobial Working Group, Medicines Management Programme Board and Infection Control Committee. Actions are RAG-rated as follows:

Green	Completed or on target to be completed by deadline
Amber	Progress made but some actions still outstanding
Red	No progress, or very significant delay. Escalation to executive lead required
Grey	Awaiting clarification or action by Public Health Wales (PHW) or other external group before can proceed with action

PE	Paul Edwards	Consultant Surgeon, Associate Medical Director, Chair of Antimicrobial Working Group
NB	Nidhika Berry	Consultant Microbiologist
JS	Jonathan Simms	Clinical Director of Pharmacy
JM	Jean Matthews	Primary Care Pharmacist
CP	Ceri Phillips	Consultant Pharmacist – Antimicrobials
VD	Victoria Dixon	Antimicrobial Pharmacist – Primary Care from March 2019
SH	Sian Heaton	Antimicrobial Pharmacist – RGH from April 2019
SB	Sara Boyle	Antimicrobial Pharmacist – NHH
CL	Cerys Lockett	Antimicrobial Pharmacist – YYF from March 2019
MSCO	Martha Scott	Consultant Respiratory Physician
DN	Divisional Nurses	
IPARC	Infection Prevention & Antimicrobial Resistance Committee	
PHW	Public Health Wales	

Theme	Action	Lead	Deadline	Progress	Evidence
Staffing	Increase number of Antimicrobial Pharmacists to deliver one of outstanding recommendations of the Duerden Report	JS	Dec 2018	Consultant Pharmacist started October 2018 Team recruited November 2018 but will not all be in post until April 2019	Staff in post
	Improve clinical representation at the AMR Delivery Board	JS	Sept 2018	JS has discussed with Paul Buss. Tessa Lewis attending in NICE capacity. CP (or NB when CP on leave) are only other ABUHB representatives	Meeting minutes
Metrics	Use PHW web portal for primary care (practice level) and secondary care (hospital level) data	CP	Autumn 2018	Awaiting publication of web portal. Use broad-spectrum antibiotic usage as surrogate in interim	
	Expand secondary care usage reports to include divisional reports for Family & Therapies and Community	SB	Q3 2018/19	In progress; will be in place for Q4 18/19 reports	Reports
	Antimicrobial stewardship to be included in Divisional highlight reports for Infection Prevention & Antimicrobial Resistance Committee (IPARC)	Divisional Nurses	Q3 2018/19	Dec 18 & Jan 19 IPARC meetings cancelled so no reports yet received	Highlight reports

Public engagement	European Antibiotic Awareness Day/World Antibiotic Awareness Week	CP/JM	November 2018	Public-facing campaign focusing on self-care; engagement stands in secondary care: 270 Antibiotic Guardian pledges made, 192 of which were members of the public. Communications team cancelled primary care engagement stands. Healthcare-professional campaign focused on review of antibiotics by 72 hours & used screensavers, intranet messages, emails to prescribers and doctors' teaching.	
		VD	November 2019	Preliminary reports suggest PHW will not be running a national public engagement campaign in 2019. Local materials to be developed when Primary Care Antimicrobial Pharmacist in post	
	Identify alternative means of engaging with public, e.g. mother & baby groups, U3A, WI etc. and develop material to use with groups	VD	Jan 2019	Awaiting start of Primary Care Antimicrobial Pharmacist	Sessions delivered
Primary Care specific actions					
Diagnostics	CRP point of care testing (POCT)	NB	September 2018	Asked Nadia El-Farhan for list of practices with machine: none are listed with POCT team	
		CP	March 2019	NCN expressed interest in local pilot, but POCT team had refused based on previous LMC decision to take a coordinated approach. CP has discussed with Liam Taylor who supports an NCN pilot approach. CP to discuss with POCT team.	
	Care home urine dipstick algorithm based on Nottingham model	CP	August 2018	PHW UTI algorithm for care homes finalised. Tick-box version developed for care homes to file in patients' notes and send to GP to support diagnosis. Consultation ends 8th March 2019	Feedback from GPs & care homes
Education & Training	Update GPs regarding HCAI & UTI management	JM	October 2018	JM re-emphasised messages prescribing leads meeting	Feedback forms
		VD	?	Unable to progress UTI work further until all-Wales guidance reviewed in light of new NICE guidance	
	STAR (Stemming the Tide of Antimicrobial Resistance) blended learning programme for GPs	PHW	?	National STAR+ programme business case now being progressed by AMR Delivery Board	
Antimicrobial guidelines	Implement All-Wales Antimicrobial Guidance Group (AWAGG) output as available	CP	Ongoing	Awaiting further guidance	RxGuidelines

	Implement NICE common ailment guidelines	CP	Ongoing	Acute sinusitis (NG79): complete March 2018 Acute sore throat (NG84): complete March 2018 Otitis media (NG91): complete July 2018	RxGuidelines
				Awaiting review by All-Wales Antimicrobial Guideline Group: • Lower UTI (NG109) • Acute prostatitis (NG110) • Acute pyelonephritis (NG111) • Recurrent UTI (NG112) • Catheter-associated UTI (NG113) • Acute exacerbation of COPD (NG114) • Acute exacerbation of bronchitis (non-CF) (NG117) • Acute cough (NG120)	
	Review guidance around azithromycin prophylaxis in light of recommendations in NG114	Respiratory	September 2019	CP emailed respiratory pharmacists Feb 2019	
Miscellaneous	Consider incentive scheme for high-prescribing practices	JS	December 2018	URTI CEPP audit submitted for consideration; outcome pending	
	Letter to high-prescribing GP practices	PHW	October 2018	CMO wrote to relevant practices, benchmarking prescribing against peers & outlining primary care reduction expectation and audit advice. JS requested NCNs produce an action plan in response to the letter. Majority of NCNs produced plan; JS sent chasing email for remainder Feb 19	Letter
	Investigate feasibility of adding link to GP system to print 'Manage my Infection' leaflet in one click	JM	September 2018	System change pending	

Secondary Care specific actions					
Diagnostics	Out-patient clinic letters requesting urine sample	PE MB	August 2018 September 2018	Wrote to Clinical Directors to ascertain if urine samples are required for their pre-admission appointments. Urology and nephrology require routinely; gynaecology require if patients are presenting with urinary symptoms. Linked with clinics to ensure messages removed	Clinic letters
	Investigate feasibility of running BATCH trial in ABUHB examining impact of procalcitonin measurement on infection management in children	CP	March 2019	CP has met with R&D who are able to support. Attending Child Health Clinical Governance day to discuss 20.03.19	
	Scope penicillin-allergy de-labelling work	CP/MSCO		Unable to progress at present	
Antimicrobial guidelines	Implement All-Wales Antimicrobial Guidance Group (AWAGG) output as available	CP	Ongoing	Community-acquired UTI guidelines implemented August 2018	RxGuidelines
	Review empirical antimicrobial guidelines to minimise recommendation of broad-spectrum agents, shorten course lengths where possible & improve IV-Po switch information	CP	April 2019	Diabetic foot guidance nearing completion which will impact both medical and surgical areas CAP guidelines are remaining source of most co-amoxiclav use. Awaiting all-Wales guidance	RxGuidelines
	Implement NICE guidelines	CP	Ongoing	Pending further guidelines	RxGuidelines
	Clinical directors to support circulation of new guidelines to their directorate & increase medical engagement	PE	Ongoing	Pending next set of guidelines	e-mails
	Develop paediatric antimicrobial guidelines	CP	October 2019	CP attending Child Health Clinical Governance day to discuss 20.03.19	
Start Smart Then Focus audit	Engage with relevant stakeholders	CP PE	Jan 2019 August 2018	Promoted at F1 & F2 teaching sessions and Junior Doctor Quality Improvement Forum Consensus reached at Antimicrobial Working Group (AWG) that one audit should be undertaken per directorate per site per month by trainees, using a quality improvement approach. Results should be presented at directorate meetings and run-charts and summary of learning sheet fed back to AWG. Expectation communicated to Clinical Directors August 2018	e-mails
	Audit implementation	CP	May 2019	Only 4 audits undertaken to date. Strategy to be discussed further at IPARC PHW/1000 lives launch event planned for May 2019	Number of audits undertaken

	Antimicrobial audit communication plan to include frequency of audit feedback via email and presentation to relevant clinical groups such as Clinical Directors' Forum, Grand Round etc	PE/CP		Pending implementation of audit	Feedback to Antimicrobial Working Group
Point Prevalence Survey (PPS)	Undertake annual point PPS	CP	November 2018	Complete. Results awaited from PHW	Quality Measures report
	Circulate 2017 PPS results	CP	September 2018	Final report received circulated to clinicians	e-mails
Miscellaneous	Implement all-Wales antimicrobial medication chart across acute secondary care settings	CP	September 2018	Awaiting final all-Wales chart; decision made with Principal Pharmacist Patient Services to wait for new chart rather than rolling out old chart. Antimicrobial pharmacists supporting roll out March/April 2019	Use of chart at ward level
	Review stock lists to ensure broad-spectrum agents only stocked at ward level where necessary	CP	October 2018	Awaiting additional pharmacist resource	Stock lists
	Antibiotics/PPI/Laxatives to be discussed in PSAG board rounds and include reason for prescription, duration, iv to oral change, narrow spectrum considered on culture results	DN		New model of antibiotic review agreed by deputy medical director. Details of the new model to be circulated to divisional directors for onward circulation to consultants 2018 Implemented in areas where PSAG boards available symbol for oral and IV	Infection Prevention Nurse validation
	Investigate feasibility of introducing coded approval for restricted antimicrobials	CP	February 2019		

GIG CYMRU NHS WALES – Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality & Patient Safety Committee Wednesday 16th October 2019 Agenda Item: 5.4

Aneurin Bevan University Health Board

'Putting Things Right' Report

5.4

Executive Summary

The purpose of this report is to appraise the Committee of the performance during July and August 2019 in terms of both formal and informal Complaints, Public Service Ombudsman for Wales cases, Serious Incidents and Never Events.

Key Achievements:	**Issues:**
• Compliance of 70% achieved for August against a target of 65% - 30 day turnaround for complaints.	• Fragility of the PTR Team
Forthcoming Plans / Priorities:	**Areas for Discussion / Areas of Concern:**
• Continued improvement against the performance trajectory, with a particular focus on SI's.	• Never Events – Theatres (subject to a separate presentation as part of the QPSC Agenda)
Actions Required from the Committee:	**Financial Implications:**
• Nil	• Nil
Other Information:	
• Public Service Ombudsman for Wales Annual Report and letter to the Chair, ABUHB.	

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	x
Note the Report for Information Only	
Executive Sponsor: Rhiannon Jones - Executive Director of Nursing	
Report Author: Jane Rowlands-Mellor - Assistant Director PTR and Martine Price - Deputy Director of Nursing	

Report Received consideration and supported by :			
Executive Team		**Committee of the Board: Quality & Patient Safety Committee**	**x**
Date of the Report: October 2019			
Supplementary Papers Attached:			

Purpose of the Report
The purpose of this report is to appraise the Committee of the performance during July and August 2019 in terms of both formal and informal Complaints, Public Service Ombudsman for Wales cases, Serious Incidents and Never Events.

5.4

The papers is aligned to the delivery of the following strategic objective(s) and Health and Care Standard(s):		
Health and Care Standards	1. Staying Healthy	
	2. Safe Care	
	3. Effective Care	
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	
	8. Governance, Leadership & Accountability	

Background and Context
This report provides an update on Concerns, Ombudsman and Serious Incidents performance during July and August 2019. The underlying principles of 'Putting Things Right' are that whatever concerns are raised through a complaint, claim or clinical incident, those involved will be dealt with candour. They must also receive a through and appropriate investigation, a timely acknowledgment and a prompt response. Significant work has been undertaken to improve both turnaround time performance and quality of concerns handling and responses. The Health Board responded to a total of 225 formal complaints during July and August 2019, with the overall performance against the 30 day target in July being **65%** and in August 2019 **70%**, both of which are on or above trajectory. The majority of Divisions exceeded their trajectories for August, which is positive. **Tables 1 and 2** illustrate the number of formal and informal complaints received during July and August 2019. It includes the number of complaints received, the subject of complaints and the performance against the 30 day target for the Health Board and the individual Divisions.

Table 1

Compliance Figures – July 2019											
Division	Formal complaints received	Total Formal Complaints Closed	WG Target Formal Complaints Closed Within 30 Working Days	30 day Response in Month Actual Performance	Total Open Complaints	Total Overdue Complaints	Overdue < 3 Months	Overdue > 3 Months	Overdue > 6 Months	Overdue > 12 Months	July 19 Trajectories %
Scheduled Surgical & Critical Care	67	66	48	73%	110	33	15	8	9	1	60%
Unscheduled & Acute Care	42	41	28	68%	65	25	14	8	2	1	55%
Family & Therapy Services	14	12	5	42%	37	11	7	3	1	0	75%
Facilities	0	1	0	0%	0	0	0	0	0	0	0%
Primary Care & Community	22	9	6	67%	49	22	14	5	3	0	60%
Mental Health & Learning Disabilities	11	12	4	33%	22	4	3	0	1	0	50%
Complex Health Care	1	1	1	100%	1	0	0	0	0	0	0%
Health Board	**157**	**142**	**92**	**65%**	**284**	**95**	**53**	**24**	**16**	**2**	**58%**

Table 2

Compliance Figures – August 2019											
Division	Formal complaints received	Total Formal Complaints Closed	WG Target Formal Complaints Closed Within 30 Working Days	30 day Response in Month Actual Performance	Total Open Complaints	Total Overdue Complaints	Overdue < 3 Months	Overdue > 3 Months	Overdue > 6 Months	Overdue > 12 Months	July 19 Trajectories %
Scheduled Surgical & Critical Care	66	57	41	72%	121	40	22	6	13	0	60%
Unscheduled & Acute Care	46	32	25	78%	79	32	18	7	6	0	60%
Family & Therapy Services	22	24	13	54%	37	12	8	4	1	0	75%
Facilities	2	3	3	100%	0	0	0	0	0	0	0%
Primary Care & Community	11	14	9	64%	43	23	15	4	4	0	60%
Mental Health & Learning Disabilities	7	8	5	63%	18	5	4	0	1	0	50%
Complex Health Care	0	0	0	0%	1	0	0	0	0	0	0%
Health Board	**154**	**138**	**96**	**70%**	**299**	**112**	**67**	**21**	**25**	**0**	**62%**

Early Resolution

A change in Welsh Government Legislation was instigated from 30 May 2019. Informal complaints criteria was changed and are now classified as Early Resolution. These complaints are to be addressed 'on the spot' or within 24 hours (previously this was 48hrs) and all complaints responded to after this time will now be logged as a formal complaint, but some of these do not require a written response from the Chief Executive.

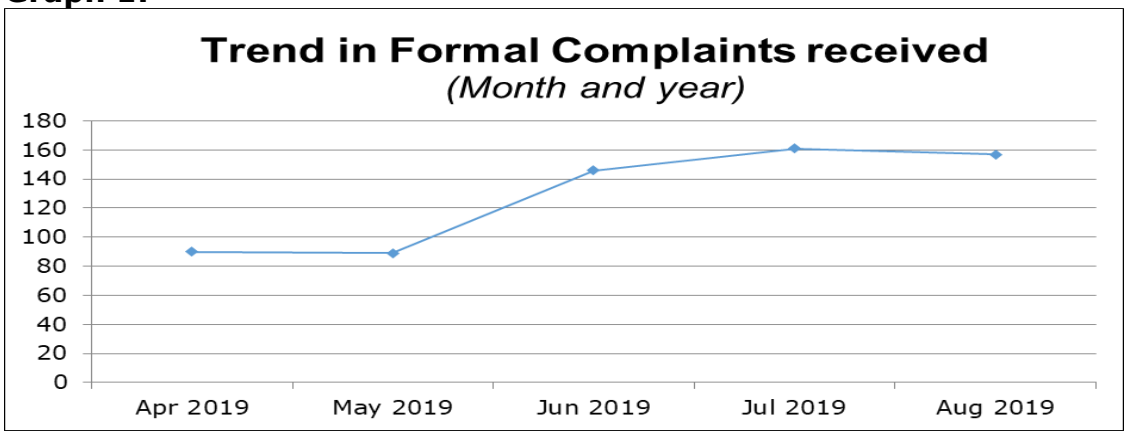
PTR Team Update

A new Assistant Director joined the team in August 2019 and a new Senior Concerns Manager has also been recruited, commencing in post during October 2019. This will bring stable senior leadership and management to PTR.

The Assistant Director has reviewed the current infrastructure and much work is on-going to ensure substantive appointments within the team, as currently the majority of team members are in secondment positions.

Trends

Graph 1:

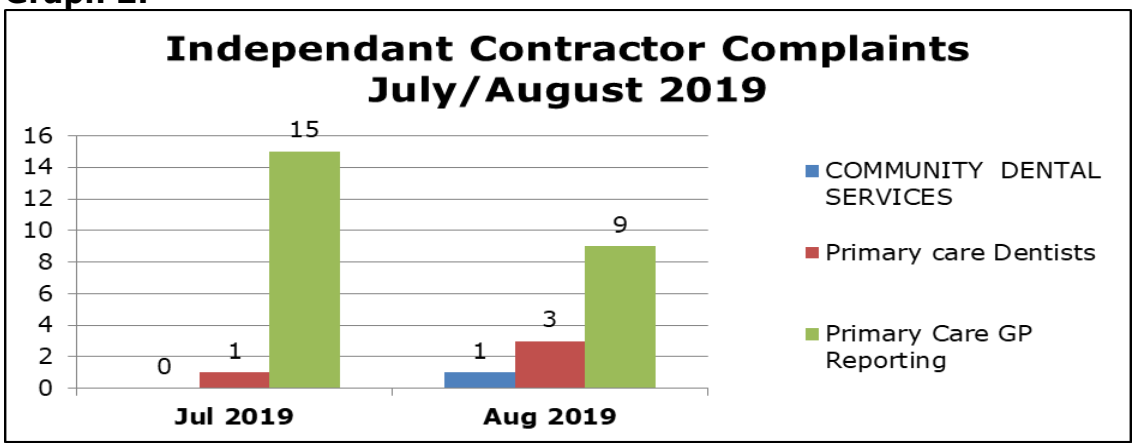


The increase in formal complaints illustrated in the above graph is attributable to the change in reporting and categorisation.

Independent Contractor Complaints

During July and August 2019, the Health Board received 29 complaints about independent contractor services, of which 24 were forwarded to the appropriate practice for investigation, as shown in Graph 2. Complaints raised directly with independent contractors, which are not submitted via the Health Board, are not included in this report.

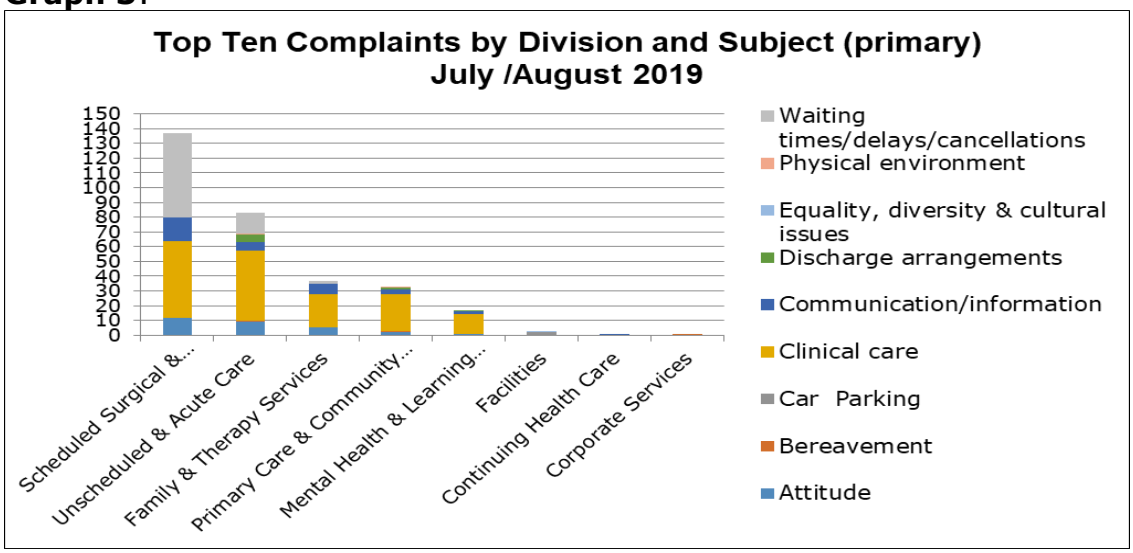
Graph 2:



Formal Complaints received by Division and Subject for July and August 2019

The majority of formal complaints received in July and August 2019 were related to Clinical Care and Waiting Times /Delays/Cancellations.

Graph 3:



Scheduled Care received the highest number of formal complaints. 47 in Trauma and Orthopaedics, which were 19 clinical care, 18 waiting times, 8 communication and 2 attitude. The next highest was 32 in Accident and Emergency the majority of which were complaints about clinical care. There were 26 complaints regarding staff attitude across Scheduled Care, Unscheduled Care and Family and Therapies.

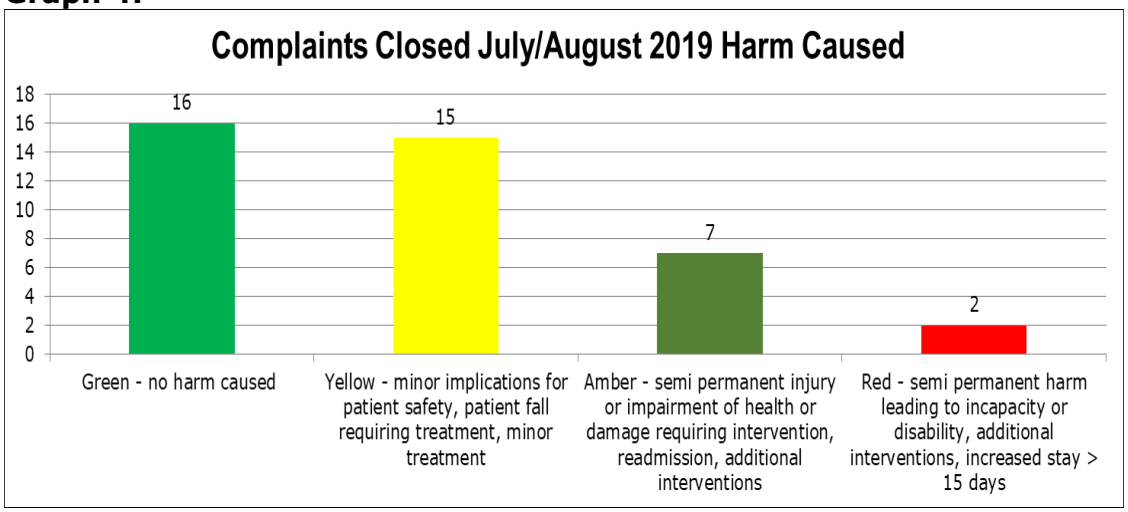
Grading of Complaints

Complaints are graded on receipt in accordance with the seriousness of the concerns raised and the level of harm reported. Following investigation, the grading may need to be amended to reflect the actual level of harm caused as shown below in the graph of formal complaints closed by harm caused. Cases where the investigation has shown harm has been caused by a breach of duty of care are presented to the Redress Panel and these are presented in a separate report.

Serious Complaints closed in July and August 2019

Of the **40** formal complaints which received a response in July and August 2019, 2 were serious complaints graded 4 (Red). None were Grade 5's e.g. catastrophic.

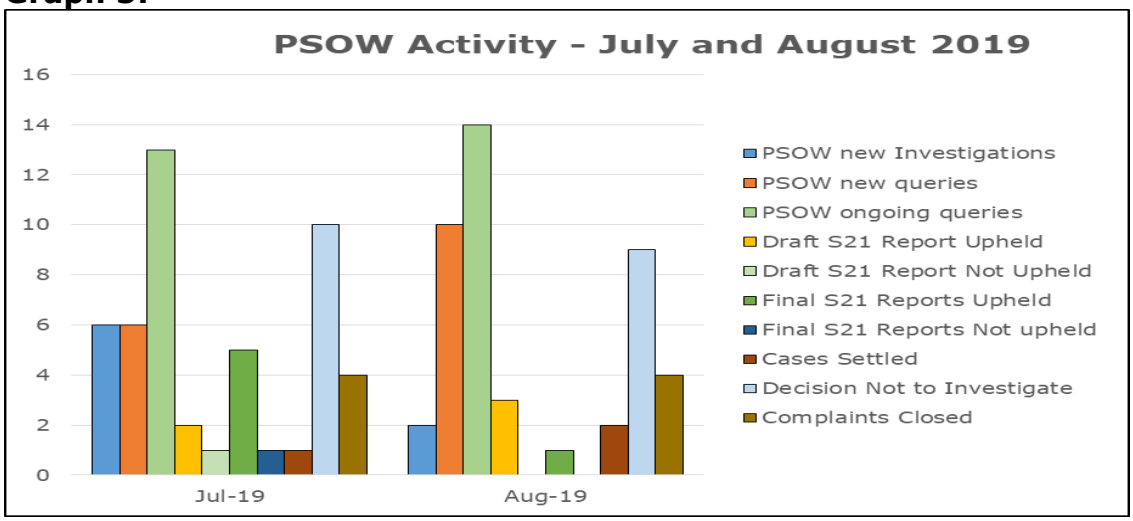
Graph 4:



Public Services Ombudsman for Wales (PSOW) Complaints

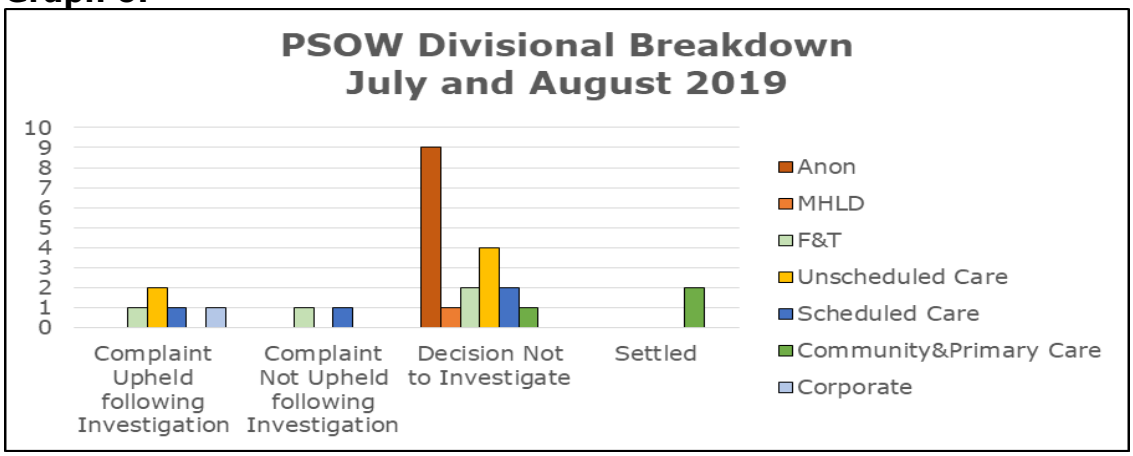
During July and August 2019 the Health Board received 16 new complaint queries, together with notification of 8 new complaint investigations, which was an increase on the previous two month period (14 and 5 respectively). The chart below provides an overview of PSOW activity during July and August 2019.

Graph 5:



The following chart provides a breakdown by Division of final investigations that were Upheld, Not Upheld, together with cases Not to Investigate (NTI) and Settled over the 2 month period.

Graph 6:



Never Events during August

During August there were two Never Events reported. These cases are still undergoing investigation. As a result of the reporting a detailed review of Datix for the past three years across Theatre Services has been conducted. A meeting with the Delivery Unit has been set up to review the Never Events and provide assurance as to ABUHB actions.

Serious Incidents – monthly compliance figures for July and August 2019

There have been improvements in the management and resolution of Serious incidents. The performance against 60 day turnaround was just below the improvement trajectory for August at 59% against a target of 60%.

The number of open Serious Incidents has decreased from 104 in July to 92 in August 2019.

Table 3:

SI Compliance Figures – July 2019				WG target for investigation – 60 working days						
Division	**Number reported to WG in month**	**Description**	**Total Open SI's**	**Number in Date**	**Overdue 0-3 Months**	**Overdue 3-6 Months**	**Overdue 6-12 Months**	**Overdue >12 Months**	**% Compliance with 60 Day Target**	**% Trajectory**
Scheduled Care	0		17	6	2	5	3	1	100% (1/1)	55%
Unscheduled Care	4	2 #NOF 1 fall & C2 fracture 1 fall & head injury	20	10	4	2	4	0	71% (5/7)	50%
Family & Therapies	2	1 IUD 1 MRSA on SCBU	11 plus 15 PRUDiCs	4	3	3	1	0	57% (4/7)	100%
Mental Health & LD	8	4 unexpected deaths 1 susp sui 2 absconsions 1 self harm	33	14	7	6	2	4	50% (2/4)	50%
Community	4	3 #NOF 1#tibia	16	9	5	0	0	2	27% (2/7)	N/A
Primary Care	0		5	0	1	2	1	1	N/A	N/A
Complex Health Care	0		2	0	0	2	0	0	N/A	N/A
Facilities	0		0						N/A	N/A
Corporate	0		0						N/A	N/A
Total	**18**		**104**	**43**	**22**	**20**	**11**	**8**	52%	**55%**
			*119 with PRUDiCS							

Table 4:

SI Compliance Figures – August 2019				WG target for investigation – 60 working days						
Division	**Number reported to WG in month**	**Description**	**Total Open SI's**	**Number in Date**	**Overdue 0-3 Months**	**Overdue 3-6 Months**	**Overdue 6-12 Months**	**Overdue >12 Months**	**% Compliance with 60 Day Target**	**% Trajectory**
Scheduled Care	4	2 never events – wrong implant 2 unexpected deaths	17	6	3	3	4	1	25% (1/4)	58%
Unscheduled Care	5	1 delay in treatment 1cdiff death 1 bacteraemia death 2 #NOF	22	12	3	3	3	1	80% (4/5)	55%
Family & Therapies	1	1 IUD	12*	4	4	0	4	0	0% (0/1)	100%
Mental Health & LD	2	2 unexpected deaths	18	8	4	2	3	1*DHR	100% (4/4)	50%
Community	0		15	6	6	1	0	2	33% (1/3)	N/A
Primary Care	1	Medication issue	6	1	1	1	2	1**	N/A	N/A
Complex Health Care	0		2	0	0	0	2	0	N/A	N/A
Facilities	0		0						N/A	N/A
Corporate	0		0						N/A	N/A
Total	**13**		**92**	**37**	**21**	**10**	**18**	**6**	59%	**60%**
			*108 with PRUDiCS					** ongoing Police investigation		

Recommendation
The Committee is asked to review and discuss the report.

Next Steps:
Next Steps: • Continued improvement in 30 day turnaround for Complaints and 60 day turnaround for Serious Incidents • To establish a Learning Committee • To stabilise the PTR Team infrastructure • To produce an Improvement Plan for Safety in Theatres

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality & Patient Safety Committee Wednesday 16th October 2019 Agenda Item: 5.4

Aneurin Bevan University Health Board

Public Services Ombudsman for Wales Annual Report and Accounts 2018/19

5.4

Executive Summary

The Public Services Ombudsman for Wales (PSOW) Annual Report 2018/19 gives an overview of the work of the Ombudsman over the year. It provides the Health Board with information relating not only to ABUHB but the complaints about public service providers across Wales. This presents an important learning opportunity for the Health Board and informs improvement work via the Putting Things Right Team and Divisions

Key Achievements:	**Issues:**
• The performance of concerns meeting the Welsh Government target of 75% has seen improvement. August 70% of concerns were responded to within 30 days.	• Further focussed work is required to reduce the number of complaints the PSOW receives from ABUHB.
Forthcoming Plans / Priorities:	**Areas for Discussion / Areas of Concern:**
• A meeting was held with our improvement officer of the PSOW on the 8 October. • The PTR improvement action plan is being reviewed and updated.	• Attached is the ABUHB Annual Letter
Actions Required from the Committee:	**Financial Implications:**
• To note the annual report and letter.	• NIL

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

Receive the Report for Assurance/Compliance			
Note the Report for Information Only			x
Executive Sponsor: Rhiannon Jones - Executive Director of Nursing			
Report Author: Martine Price - Deputy Director of Nursing			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board: Quality & Patient Safety Committee**	**x**
Date of the Report: October 2019			
Supplementary Papers Attached: PSOW Annual Letter 2018/19 PSOW Annual Report and Accounts 2018/19			

5.4

Purpose of the Report
The Public Services Ombudsman for Wales (PSOW) Annual Report 2018/19 gives an overview of the work of the Ombudsman over the year. It provides the Health Board with information relating not only to ABUHB but the complaints about public service providers across Wales. This presents an important learning opportunity for the Health Board and informs improvement work via the Putting Things Right Team and Divisions.

The papers is aligned to the delivery of the following strategic objective(s) and Health and Care Standard(s):		
Health and Care Standards	1. Staying Healthy	
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	
	6. Individual Care	✓
	7. Staff and Resources	
	8. Governance, Leadership & Accountability	

Background and Context
The Health Board has reviewed the annual letter and provided a formal response to the Ombudsman. During 2018/19 the Health Board was issued with two public interest reports. Both reports have been carefully considered and action taken. The action plan relating to case ref: 201707515 has been completed with learning embedded. The action plan relating to ref: 201704489 is under final review, noting that the All Wales Thromboprophylaxis Policy is currently going through consultation. The Health Board had an increase of 18 cases requiring PSOW intervention, compared with last year.

A new Assistant Director, who leads PTR, commenced in August and the new PTR Team Leader commences early October. There has been investment in both the concerns resource and ombudsman work, with substantive appointments underway. This investment in the team will enable further progress with improvement work and support for Divisions.

Complaint themes have been reviewed. Whilst recognising improvement is required across all divisions , the scheduled care division has the highest number of upheld concerns with themes of clinical care relating to waiting times and complaint handling being the highest reasons for concern. This division has seen a significant improvement in recent months with their performance in complaint response times. In August the Health Board achieved 70% response to the 30 day target. Alongside turnaround performance, work on the quality of the response and the contact with complainants remains key and this is being progressed .

All divisions are focussed on improving complaint handling. ABCi have undertaken a pathway mapping of a concern to ensure consistency and a more person centred approach to concerns handling.

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

Next Steps:
• To continue improvements with concerns responses and learning from patient experience.

Recommendation
The Committee is asked to NOTE the content of the Annual Report, the Annual Letter for ABUHB.

Ombudsman Ombwdsmon
PUBLIC SERVICES OMBUDSMAN FOR WALES
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU

Our ref: NB

Ask for: Communications

01656 641150

Date: 7 August 2019

communications
@ombudsman-wales.org.uk

5.4

Ms Ann Lloyd
Chair of the Board
Aneurin Bevan University Health Board

By Email Only
ann.lloyd@wales.nhs.uk

Dear Ms Ann Lloyd

Annual Letter 2018/19

I am pleased to provide you with the Annual letter (2018/19) for Aneurin Bevan University Health Board. This year I am publishing my Annual Letters as part of my Annual Report and Accounts. I hope the Board finds this helpful and I trust this will enable it to review its own complaint handling performance in the context of other public bodies performing similar functions across Wales.

As you will note from my Annual Report, Aneurin Bevan UHB is one of the four health boards in Wales which has continued to receive the highest number of complaints. Whilst the number of complaints investigated is consistent with those investigated last year, you will note that there has been a significant increase in the number of complaints which were upheld, 31 this year compared with only 17 last year, with the number of complaints where intervention from this office was necessary increasing from 31 to 49 this year; this is a worrying trend. You will also note that this year, of the ten public interest healthcare-related reports I issued, two (20%) concerned care and treatment delivered by your Health Board. I consider this to be of some concern as, before this year, I had only issued two public interest reports relating to your Health Board since I took up my post in 2014.

Public Services Ombudsman For Wales | Ombwdsmon Gwasanaethau Cyhoeddus Cymru, 1 Ffordd yr Hen Gae, Pencoed CF35 5LJ
www.ombudsman-wales.org.uk | www.ombwdsmon-cymru.org.uk
01656 641150 01656 641199 ask@ombudsman-wales.org.uk | holwch@ombwdsmon-cymru.org.uk

We agreed last year that the Health Board would work with an Improvement Officer to target poor complaint handling. I note that my Improvement Officer met your Contact Officer on a number of occasions and delivered a training session to a Complaints Workshop at the Health Board in January of this year. I am pleased to note an improvement in communication between the Health Board and my office. This work is ongoing and sadly is not reflected in the statistics for this year, but I am hopeful that with the continued support provided to you by my Improvement Officer and, in due course, the Improvement Team, we should see an improvement in complaint handling practice over time.

The Public Services Ombudsman (Wales) Act 2019 has now been introduced. I am delighted that the Assembly has approved this legislation giving the office new powers aimed at:

- Improving access to my office
- Providing a seamless mechanism for complaint handling when a patient's NHS care is inextricably linked with private healthcare
- Allowing me to undertake own initiative investigations when required in the public interest
- Ensuring that complaints data from across Wales may be used to drive improvement in public services for citizens in Wales.

I am very much looking forward to implementing these new powers over the coming year.

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
- Reflect upon the findings in the Public Interest reports I have issued and positively act upon my recommendations to improve services
- Work to reduce the number of cases which require intervention by my office
- Work with my Improvement Officer to improve complaint handling, particularly in the parts of the Health Board which generate most complaints about complaint handling
- Inform me of the outcome of the Health Board's considerations and proposed actions on the above matters by **31 October 2019**.

This correspondence is copied to the Chief Executive of your Health Board and to your Contact Officer. 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
Anita Davies, Contact Officer

Factsheet

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

Health Board	Complaints Received	Average	Complaints Investigated	Average
Aneurin Bevan University Health Board 2018/19	134	146	38	36
Aneurin Bevan University Health Board 2017/18	121	140	43	49
Abertawe Bro Morgannwg University Health Board	139	132	35	32
Betsi Cadwaladr University Health Board	194	173	44	42
Cardiff and Vale University Health Board	102	123	28	30
Cwm Taf University Health Board	75	74	22	18
Hywel Dda University Health Board	109	96	20	23
Powys Teaching Health Board	26	33	3	8

B. Complaints Received by Subject with Health Board average

Aneurin Bevan University Health Board	Complaints Received	Average
Health - Complaint Handling	9	12
Health - Appointments/admissions/discharge and transfer procedures	3	4
Health - Clinical treatment in hospital	96	70
Health - Clinical treatment outside hospital	7	8
Health - Confidentiality	2	1
Health - Continuing care	1	4
Health - Other	11	5
Health - Patient list issues	2	3
Housing - Other	1	0
Various Other - Poor/no communication or failure to provide information	1	0
Various Other - Rudeness/inconsiderate behaviour/staff attitude	1	0

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

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 Reports	Grand Total
2018/19									
Aneurin Bevan University Health Board	19	15	33	18	1	11	29	2	128
Health Board average (adjusted)	23	18	38	29	2	12	29	2	153
2017/18									
Aneurin Bevan University Health Board	19	10	26	14	2	6	17	0	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	% intervention
Aneurin Bevan University Health Board 2018/19	49	128	38%
Aneurin Bevan University Health Board 2017/18	31	94	33%
Abertawe Bro Morgannwg University Health Board	54	139	39%
Betsi Cadwaladr University Health Board	86	210	41%
Cardiff and Vale University Health Board	37	107	35%
Cwm Taf University Health Board	27	82	33%
Hywel Dda University Health Board	48	115	42%
Powys Teaching Health Board	10	17	59%
Powys Teaching Health Board – All-Wales Continuing Health Care cases	7	16	44%

Appendix

Explanatory Notes

Section A compares the number of complaints against the Health Board which were received and investigated by my office during 2018/19, 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 2018/19, 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 2018/19, with the average outcome (adjusted for population distribution) during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

Section D provides the numbers and percentages of cases received by my office 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 via email to communications@ombudsman-wales.org.uk

Ombudsman Ombwdsmon
PUBLIC SERVICES OMBUDSMAN FOR WALES
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU

INNOVATION IMPROVEMENT INFLUENCE

Annual Report & Accounts

of

The Public Services Ombudsman for Wales
for the year ended
31 March 2019

Laid before the National Assembly for Wales
under paragraphs 14,16 and 17 of Schedule 1
of the Public Services Ombudsman (Wales) Act 2005

Contents


Performance
Report

Ombudsman's Review of the Year

Innovation, Improvement and Influence: A Review of 2018/19

This is the final year covered by my corporate plan ***Innovation, Improvement*** and ***Influence***. In terms of ***innovation*** I am delighted that new legislation has now been passed by the National Assembly for Wales. The new Act draws on best practice from Ombudsman schemes across the world, from Scotland and Ireland to Catalonia and Ontario.

The increasing number of health complaints coming to the office continues to be a challenging concern. This year the overall number of complaints about public bodies increased by 11%. Complaints about Health Boards increased by 4% compared with the previous year, though the rate of increase has slowed. Complaints about GPs and Dentists increased significantly, meaning that overall complaints about NHS bodies increased by 9%.

The performance of the four health boards that we have continued to designate as ***improvement*** bodies has been disappointing. Hywel Dda University Health Board's complaint figures were the same as for the previous year and the increase in complaints about Betsi Cadwaladr Health Board matched the all-Health Board average. There were substantial increases in complaints about both Abertawe Bro Morgannwg and Aneurin Bevan Health Boards of 15% and 11% respectively.

A significant number of the complaints about NHS bodies were principally about complaint handling (9%). This suggests that there is a cultural issue within Health Boards, which I hope the additional powers provided under the new Public Services Ombudsman (Wales) legislation can help address.

Despite the continued pressure and strain on the office as a result of increased numbers of health complaints, my staff have succeeded in increasing case closures substantially, compared with the previous year; a fantastic achievement.

However, as well as the number of complaints going up, the proportion of cases where I found maladministration or service failure has also increased during the year, with 67% of investigated complaints upheld or settled. Early resolution continues to play an important part in providing administrative justice, accounting for 57% of positive outcomes for complainants.

Fourteen complaints resulted in public interest reports in the course of the year. The majority were health-related though there were significant local government cases, too. I also issued one special report, under Section 22 of the Public Services Ombudsman (Wales) Act 2005, in respect of Wrexham County Borough Council. The Council failed to complete the actions it had agreed with me to address shortcomings in its service provision in the Welsh language.

In order to meet the ever-increasing demands on my office, we can only function successfully by getting the best from the talented staff we employ. During the year, we were able to further develop support for staff and we are working to improve wellbeing. I was absolutely delighted that, during 2018/19, our staff survey revealed that 93% of staff were proud to work in the office.

My office has continued to have *influence* within Wales and outside Wales. I was pleased to host visits to the office from the Republic of Korea's Anti-Corruption and Civil Rights Commission, while I also hosted a delegation from the Jiangsu Government Action Supervision Training Program. Additionally, I participated in a Council of Europe seminar with delegates from Georgia and Abkhazia. I also met with new colleagues taking up their roles as Older People's Commissioner for Wales, Welsh Language Commissioner and Auditor General.

I participated fully in International Ombudsman Institute events and Public Service Ombudsman Group meetings, including meetings in Gibraltar in December. In September I was pleased to be at Aberystwyth University to address the Standards Conference. In terms of broader stakeholder engagement, I was delighted that my office had a stand at the National Eisteddfod in Cardiff.

During the course of the year I met with Assembly Members from across the political spectrum and also gave evidence to the Equality, Local Government and Communities Committee, the Public Accounts Committee and the Finance Committee of the National Assembly for Wales.

As Chair of the Ombudsman Association (OA) I also attended the launch of the All-Party Parliamentary Group on Consumer Protection Report following their Ombudsman Inquiry.

The new legislation governing my work provides for a more proactive role for my office. I want this to provide a voice for the voiceless, ensuring that our services are accessible and allowing my office to initiate investigations proactively rather than waiting for a complaint to arrive at my door.

During the year, our Welsh Language Policy has been reviewed and revised. Changes to our case management systems have improved our recording of language preferences and I look forward to working with the Welsh Language Commissioner in the year ahead to develop formal language standards as required under the new legislation governing my work.

The combination of a challenging complaints context, our experience of improvement activities and the additional legislative powers will inform our strategic focus for the next three years ahead. My next Corporate Plan, Delivering Justice, will focus on delivering our key complaint service, promoting learning and improvement and using resources wisely so that we are as fit as we can be to face future challenges.

Who we are, what we do

Role of the Public Services Ombudsman for Wales

As Ombudsman, I have two specific roles. The first is to consider complaints about public services providers in Wales; the second is to consider complaints that members of local authorities have broken the Code of Conduct. I am independent of all government bodies and the service that I provide is free of charge.

Complaints about public service providers

Under the Public Services Ombudsman (Wales) Act 2005, I consider complaints about bodies providing public services where responsibility for their provision has been devolved to Wales. The types of bodies I can look into include:

- local government (both county and community councils)
- the National Health Service (including GPs and dentists)
- registered social landlords (housing associations)
- the Welsh Government, together with its sponsored bodies.

I am also able to consider complaints about privately arranged or funded social care and palliative care services.

When considering complaints, I look to see whether people have been treated unfairly or inconsiderately, or have received a bad service through some fault on the part of the service provider. Attention will also be given to whether the service provider has acted in accordance with the law and its own policies. If a complaint is upheld I will recommend appropriate redress. The principal approach taken when recommending redress is, where possible, to put the complainant (or the person who has suffered the injustice) back in the position they would have been in if the problem had not occurred. Furthermore, if, from my investigation, I see evidence of a systemic weakness, recommendations will be made with the aim of reducing the likelihood of others being similarly affected in future.

Code of Conduct Complaints

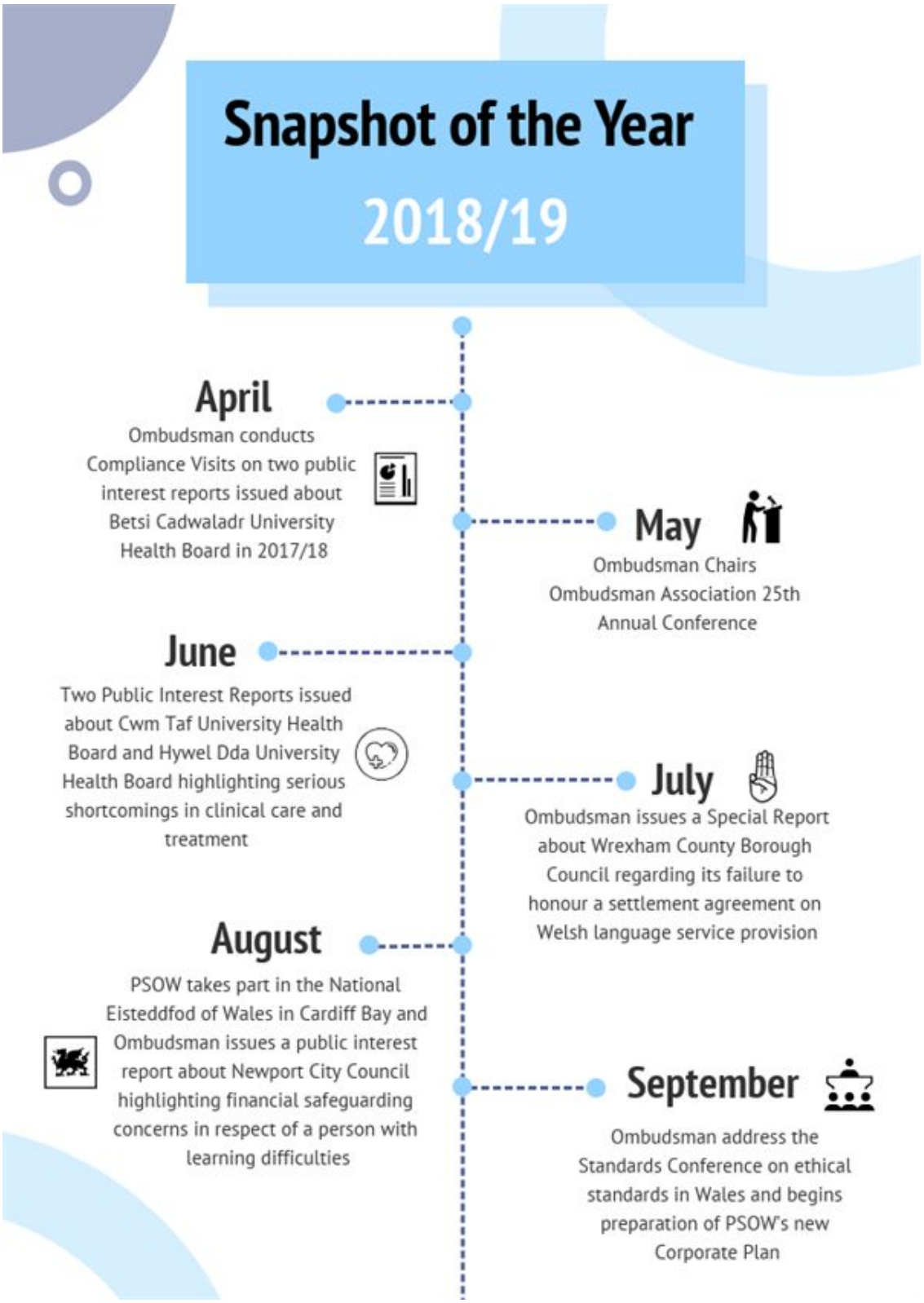
Under the provisions of Part III of the Local Government Act 2000, together with relevant Orders made by the National Assembly for Wales under that Act, I consider complaints that members of local authorities have breached their authority's Code of Conduct. I am also a "prescribed person" under the Public Interest Disclosure Act for raising whistleblowing concerns about breaches of the Code of Conduct by members of local authorities. I can consider complaints about the behaviour of members of:

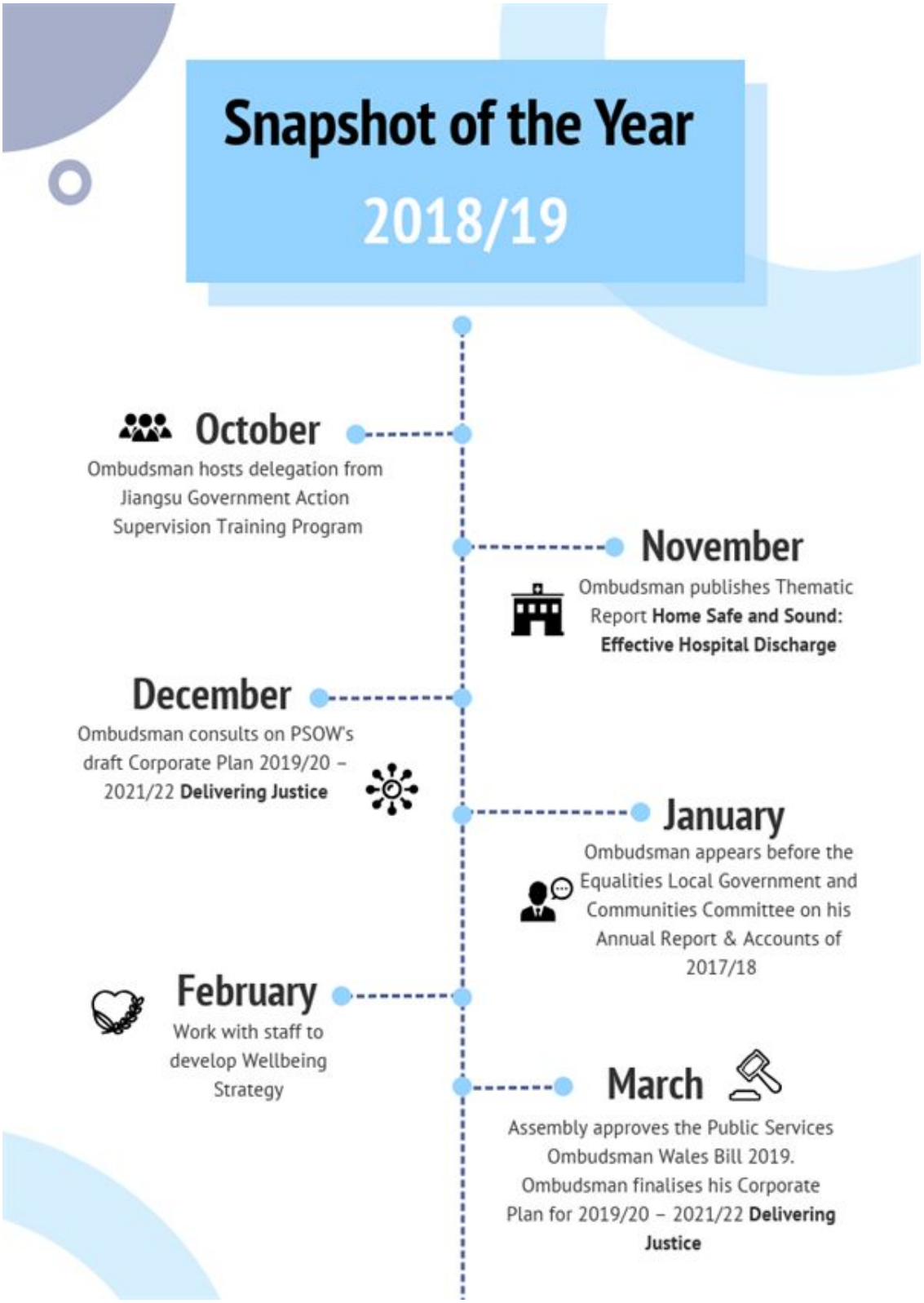
- county and county borough councils
- community councils

- fire authorities
- national park authorities and
- police and crime panels.

All these authorities have a code of conduct which sets out in detail how members must follow recognised principles for behaviour in public life. If a county councillor wishes to make a complaint about another county councillor within their own authority, I expect them first to make their complaint to the authority's Monitoring Officer, as it may be possible to resolve the matter locally without my involvement.

Snapshot of the Year 2018/19

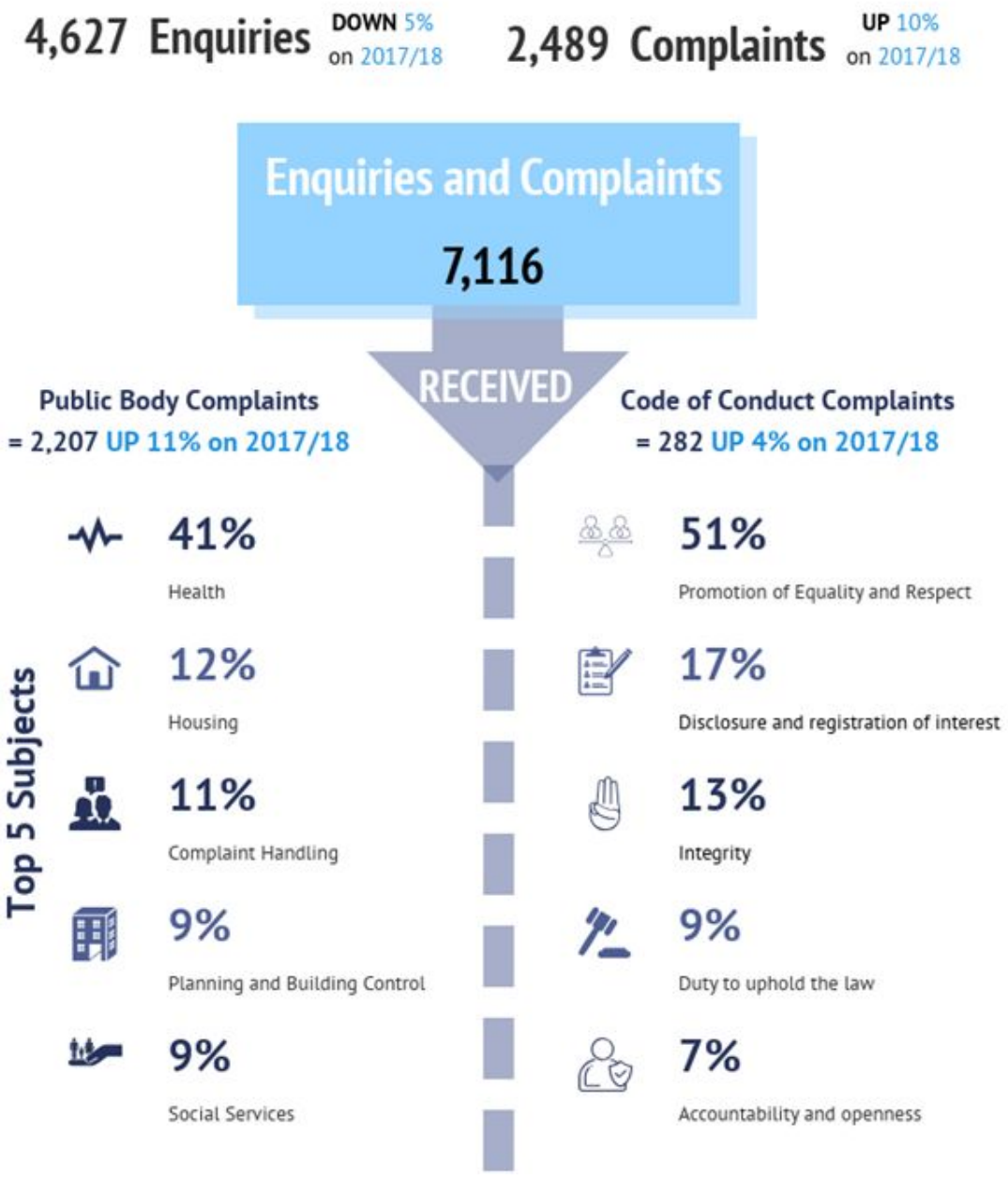



Snapshot of the Year
2018/19
October
Ombudsman hosts delegation from Jiangsu Government Action Supervision Training Program
November
Ombudsman publishes Thematic Report **Home Safe and Sound: Effective Hospital Discharge**
December
Ombudsman consults on PSOW's draft Corporate Plan 2019/20 – 2021/22 **Delivering Justice**
January
Ombudsman appears before the Equalities Local Government and Communities Committee on his Annual Report & Accounts of 2017/18
February
Work with staff to develop Wellbeing Strategy
March
Assembly approves the Public Services Ombudsman Wales Bill 2019. Ombudsman finalises his Corporate Plan for 2019/20 – 2021/22 **Delivering Justice**

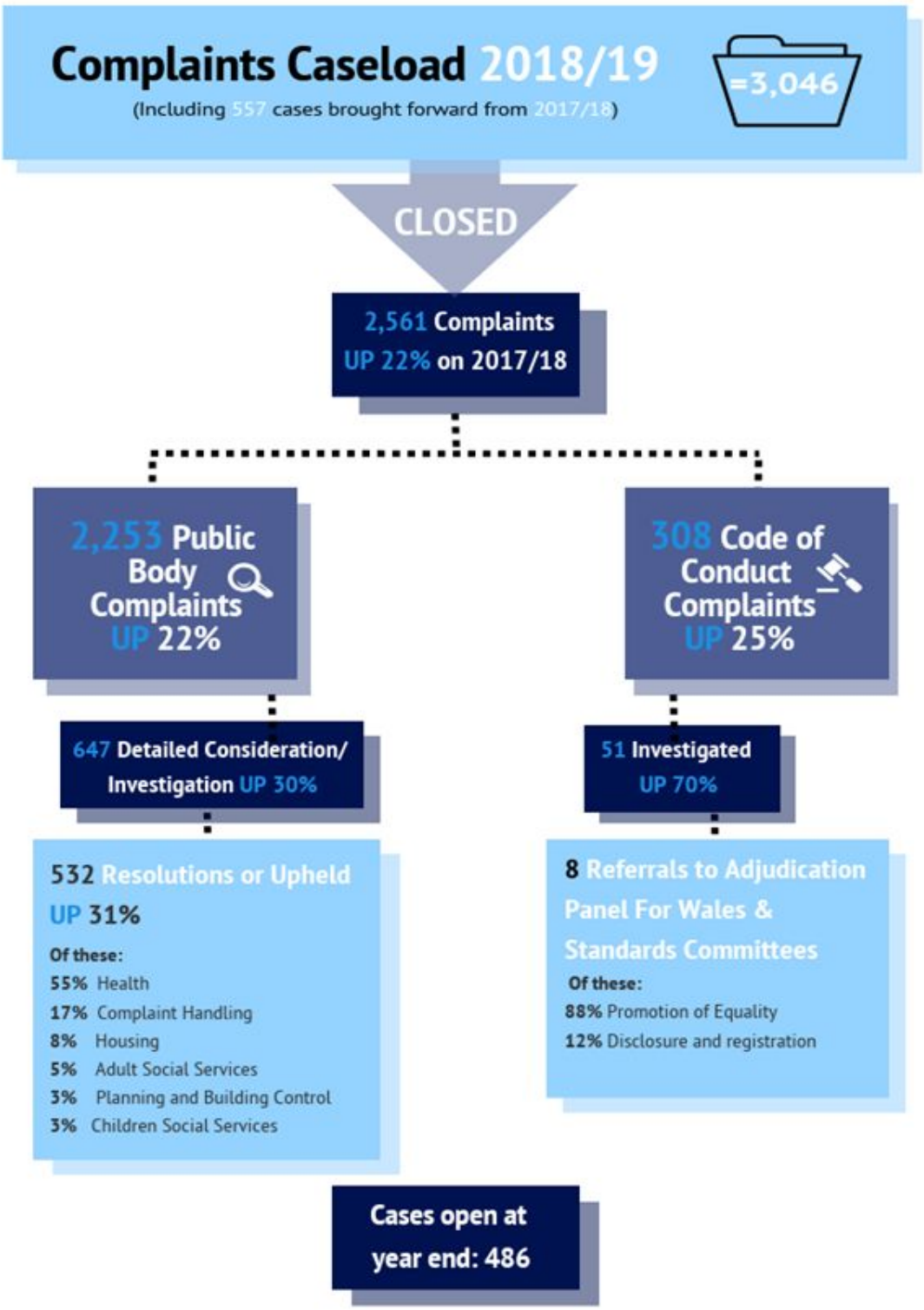
The Complaints Service

Information on the complaints service is presented in two sections. The analysis firstly reflects the complaints **received** during the year and then shows complaints **closed** during the year.

The year in summary: Complaints Received



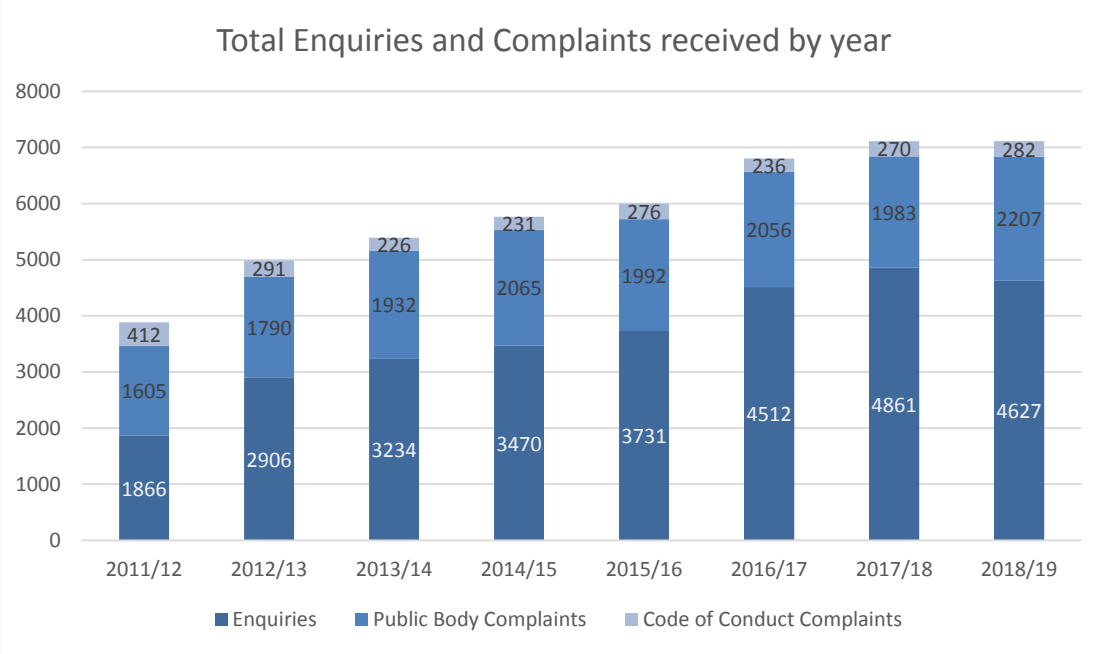
The year in summary: Complaints Closed



Strategic Aim 1 – A high quality, proportionate and effective complaints service

Public Body Complaints Received

During 2018/19 we received 2,207 complaints about public service providers, a considerable 11% increase compared to the previous year. This is the highest number of complaints received by the office since it was established. Unsurprisingly, it is the number of complaints (and particularly complaints about health care) that is the prime driver of the workload of the office.



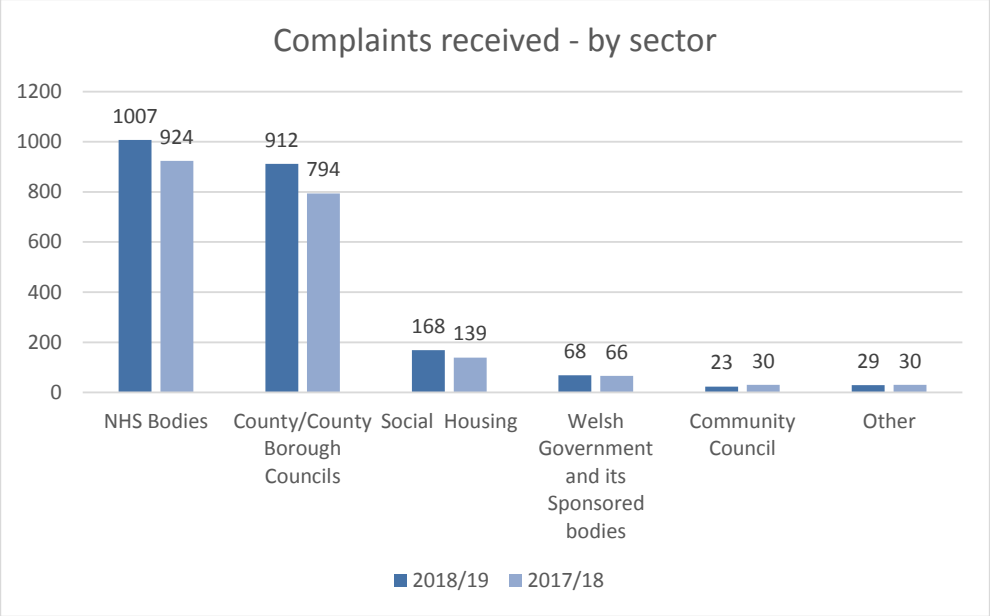
Graph 1.1

Sectoral breakdown of complaints received

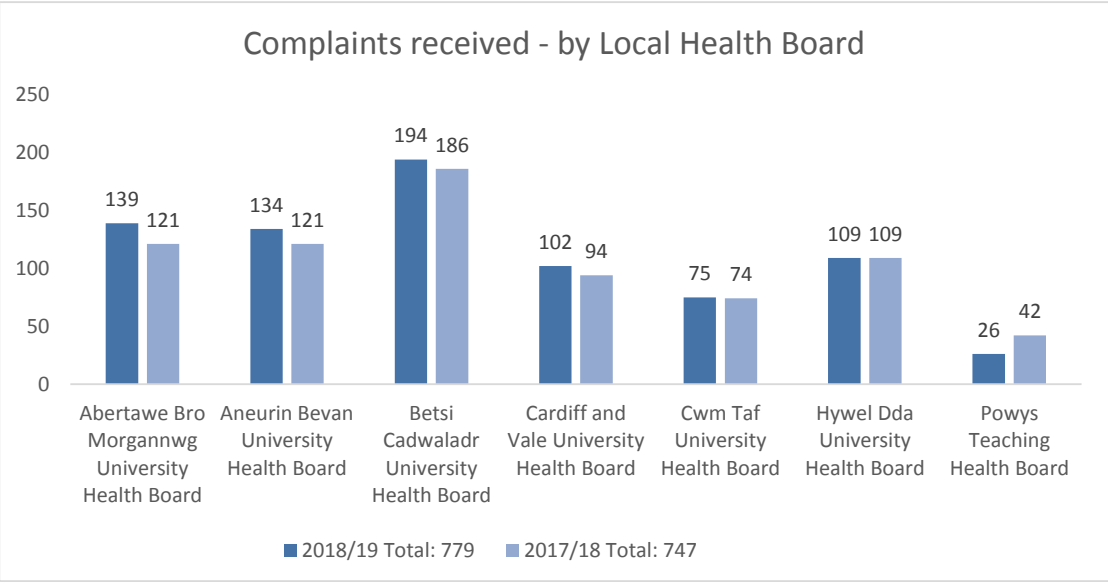
The sectoral breakdown of the complaints received can be found in Graph 1.2 below. Complaints about NHS Bodies have increased by 9% on the previous financial year – 1,007 in 2018/19 compared to 924 in 2017/18. This is the first time that the number of complaints about NHS bodies has exceeded 1,000 in one year.

Betsi Cadwaladr, Abertawe Bro Morgannwg, Aneurin Bevan and Hywel Dda remain the Health Boards about which the Ombudsman has received the highest number of complaints. Of these, the Health Board with the largest year-on-year increase in complaints was Abertawe Bro Morgannwg. I received 139 complaints about Abertawe Bro Morgannwg in 2018/19 compared to 121 in 2017/18; an increase of 15%.

In last year's Annual Report, I reported that complaints about health care are five times more likely to require investigation than complaints about other public services. This remains the case because we are less likely to be able to resolve a complaint or reach a decision without securing additional information, including medical records. It also continues to be the case that they can be complex and time-consuming to investigate because, since I am able to consider professional judgement in health complaints, I frequently need to seek professional clinical advice to inform my decision making.



Graph 1.2



Graph 1.3

Complaints received about public bodies by subject

Analysis of complaints by subject, rather than sector, shows that, as in previous years, health complaints make up the largest part of our caseload – 41%. Housing (12%), Complaint Handling (11%) Social Services and Planning and Building Control (9% each) remain other areas where there are significant numbers of complaints.

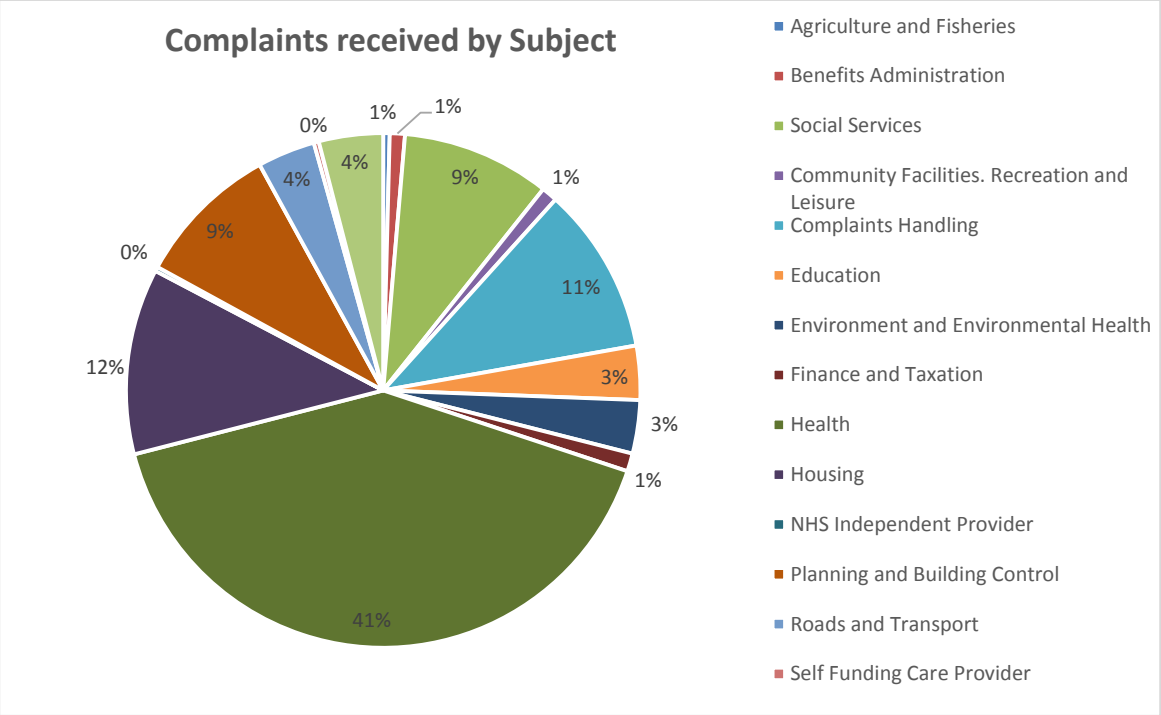


Chart 1.1

Outcomes of public body complaints considered – cases closed during 2018/19

During 2018/19 we closed 2,252 cases. Despite the competing pressures arising from the continuing increases in health-related complaints made to my office, we achieved a significant increase in the number of cases closed - a 22% increase compared to the previous year. This is testament to the hard work and commitment of my staff.

Cases closed per sector

Sector	2018/19	2017/18
NHS Bodies	1,040	812
County/County Borough Councils	905	766
School Appeal Panels	23	13
Social Housing	167	140
Welsh Government and its sponsored bodies	68	65
Community Council	22	30
Other	27	28
Total cases closed	2,252	1,854

Table 1.1

A detailed breakdown of the outcomes can be found below.

Complaint about a Public Body	2018/19	2017/18
Closed after initial consideration	1604	1357
Complaint settled voluntarily (2018/19 – includes 302 Early Resolutions)	322	257
Investigation discontinued	12	8
Investigation: complaint not upheld	103	84
Investigation: complaint upheld in whole or in part	196	144
Investigation: complaint upheld in whole or in part - public interest report	14	4
Special report under Section 22 of the PSOW Act – public body failed to carry out actions it had previously agreed with the Ombudsman	1	0
Total Outcomes – complaints	2252	1854

Table 1.2

Upheld complaints and voluntary settlements of complaints are interventions by my office that provide positive outcomes for complainants. These increased markedly in 2018/19. Table 1.3 below shows the numbers and percentages of complaints, about the seven Health Boards and the 22 local authorities in Wales, in which my office has intervened (whether in upholding a complaint or settling a complaint) and delivered a positive outcome for complainants.

	No. of complaints with PSOW intervention	Total number of closed complaints	% interventions
Abertawe Bro Morgannwg University Health Board	54	139	39%
Aneurin Bevan University Health Board	49	128	38%
Betsi Cadwaladr University Health Board	86	210	41%
Cardiff and Vale University Health Board	37	107	35%
Cwm Taf University Health Board	27	82	33%
Hywel Dda University Health Board	48	115	42%
Powys Teaching Health Board[1]	10	17	59%
Powys Teaching Health Board – All-Wales Continuing Health Care cases	7	16	44%
Total	318	814	39%

1. Powys Teaching Health Board figures exclude complaints relating to All-Wales Continuing Health Care cases which are shown separately.

Table 1.3a

	No. of complaints with PSOW Interventions	Total number of complaints closed	% of cases with PSOW intervention
Blaenau Gwent County Borough Council	2	7	29%
Bridgend County Borough Council	6	36	17%
Caerphilly County Borough Council	8	68	12%
Cardiff Council	19	110	17%
Cardiff Council – Rent Smart Wales	1	3	33%
Carmarthenshire County Council	4	48	8%
Ceredigion County Council	5	24	21%
Conwy County Borough Council	5	39	13%
Denbighshire County Council	4	30	13%
Flintshire County Council	16	56	29%
Gwynedd Council	6	35	17%
Isle of Anglesey County Council	5	31	16%
Merthyr Tydfil County Borough Council	0	14	0%
Monmouthshire County Council	0	23	0%
Neath Port Talbot County Borough Council	4	40	10%
Newport City Council	7	43	16%
Pembrokeshire County Council	6	33	18%
Powys County Council	11	64	17%
Rhondda Cynon Taf County Borough Council	4	34	12%
Swansea Council	11	81	14%
Torfaen County Borough Council	1	12	8%
Vale of Glamorgan Council	7	30	23%
Wrexham County Borough Council	8	44	19%
Total	138	905	15%

Table 1.3b

Early Resolutions and Settlements - Positive outcomes for complainants

We adopt a proportionate approach to our complaint handling and aim to provide effective resolutions to complaints whenever possible. Below are examples of such resolutions which have provided complainants with appropriate remedies without the need for my office to fully investigate the complaint.

Loss of medical records by Health Board

Mr A complained about the care and treatment provided to his late mother, Mrs A, during the hospital admission before her death and that the medical notes relating to the admission had been mislaid by Cwm Taf University Health Board.

My office contacted the Health Board to express concern that the records were missing and that this would deny Mr A the opportunity to have his complaint reviewed by my office. The loss was a serious matter and evidence of maladministration on the Health Board's part that

had resulted in a significant injustice to Mr A. The Health Board agreed to provide Mr A with an appropriate apology and a payment of £1750 in recognition of the uncertainty and distress caused to Mr A due to its administrative failing.

Loss of education as a result of school exclusion

Mrs X complained, following her son's permanent exclusion from school in November 2018, that her local authority had not arranged education for him until February 2019. A gradual integration into the child's new school was to start early in March, but only for one hour a day. The complainant said that her son was depressed as a result of being out of his educational routine and she had been unable to go to work.

The child had missed a substantial number of hours of his education following his exclusion and the local authority had acted contrary to Welsh Government guidance which says that all learners should receive education 15 days after an exclusion for 5 hours a day.

The Council agreed to apologise to the family, consider any systemic issues identified from the failings in this case, provide the child with extra tuition to allow him the opportunity to catch up with the education he had missed and provide a plan for the child to receive the five hours a day education he is entitled to.

Failure to provide financial assistance to a family member whose niece had been placed in her care

Mrs T complained that she had not received financial assistance from the Council following her niece's placement with her in November 2016. She said she was informed that she would receive the same payments as a foster parent. However, despite contacting the Council about this and chasing the matter for over one year, the Council had not responded to her request.

I was satisfied that financial assistance should have been provided. The Council agreed to apologise to Mrs T for the failure to respond to her request for financial assistance; to provide Mrs T with a payment of £250 in recognition of the time and trouble caused to her due to the failure to respond to her request; to calculate the amount of financial assistance due to Mrs T and provide her with this backdated payment of approximately £20,000.

Failure to fulfil duties owed to Special Guardians for two young people

Mr C and his wife were Special Guardians for two young people. Mr C complained that the Council had failed to fulfil its duties to them and the young people, both during and on expiry of the Special Guardianship Orders.

The investigation into this complaint was discontinued when the Council agreed to settle the complaint by making the payment of £32,275 in respect of guardianship and lodgings payments. The Council also agreed to write to Mr C to inform him of the learning areas identified as a result of his case.

Performance - Decision times

Time taken to tell the complainant if I will take up their complaint

We have set ourselves target times within which we will decide and tell complainants whether or not we will take up their complaints.

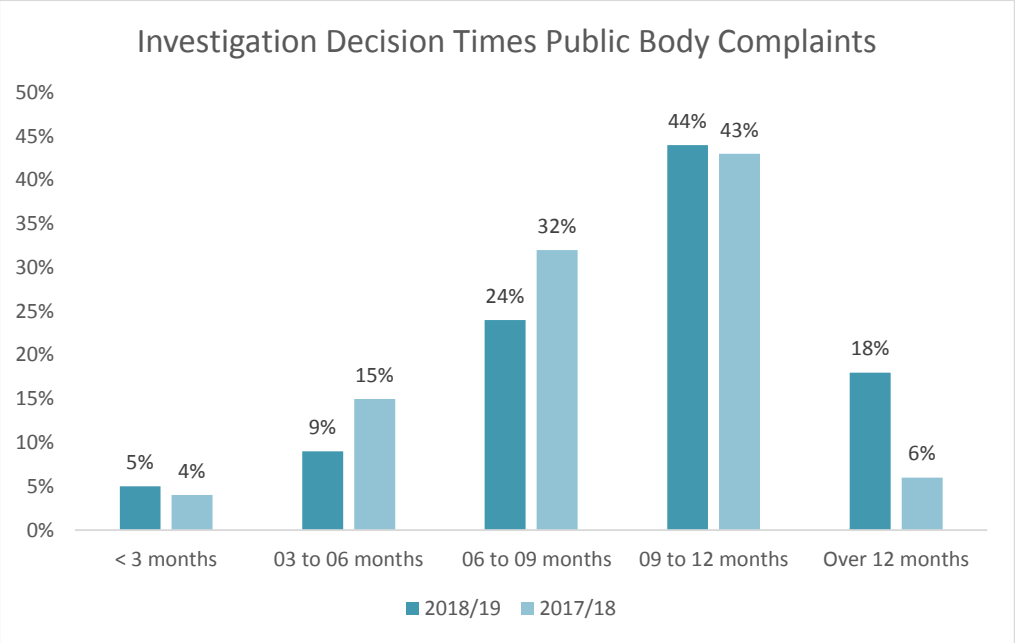
We aim to achieve the following times:

- Decision on whether complaint is within jurisdiction/premature - within 6 weeks.
- Decision on whether or not to investigate, following detailed assessment – within 6 weeks.
- Resolution of complaint, where we seek early resolution without the need to investigate – within 9 weeks.
- Investigation start, where investigation is required – within 6 weeks of the Date Sufficient Information is Received (DSIR).

The following table shows the percentage of cases where we met these targets.

	Percentage 2018/19	Percentage 2017/18
Decision on whether complaint within jurisdiction/premature – within 3 weeks	83%	92%
Decision on whether or not to investigate, following detailed assessment - within 6 weeks.	84%	89%
Where decision to seek early resolution without need to investigate, resolution achieved – within 9 weeks	85%	91%
DSIR to Investigation start date – within 6 weeks	55%	74%

Table 1.4



Graph 1.4

Decision Times

It is very disappointing that our performance against our target decision times to inform a complainant whether we will take up their complaint fell significantly. We carried over a high number (557) of open cases into 2018/19 compared with the previous year. A significant number of these cases were open investigations. We also appointed a number of new members of staff to cover maternity/adoption leave and the time taken for induction, training and development meant that they were not immediately as productive as the colleagues they were covering.

In view of the pressures of an increasing caseload on our casework staff, we needed to 'queue' new cases received in the office between May and September 2018, to prevent staff from having a caseload that was too high to progress effectively. Each case was generally queued for one month. Whilst the queuing of new cases gave our investigative staff an opportunity to make progress on, and close, a high number of cases during this period, the inevitable consequence of the queue was that we did not meet our 6 weeks decision timescale for informing complainants we were starting investigations in 45% of cases last year.

It is also disappointing that, in 2018/19, we completed 82% of investigations within 12 months, compared with 94% in 2017/18. This is despite the fact that we closed 30% more cases after detailed consideration or investigation during 2018/19 compared with the previous year. Many of the 557 open cases we carried over into 2018/19 from the previous year were open investigations. Health cases account for 80% of the cases we fully investigate, so many of those cases from 2017/18 were complex, with multiple heads of complaint, requiring clinical advice from more than one adviser.

The introduction of the 'queue' for the five-month period, together with the dedication of my staff and managers, helped us complete many of the older cases and alleviated some of the casework pressures. Since we closed more cases in 2018/19, fewer open cases (486) have been carried over into 2019/20. This remains a high and demanding caseload, but is more manageable. Whilst I am disappointed with the time it took us to close some cases, I am pleased that we are in a better position and we will work to improve decision times.

Code of Conduct Complaints received

The total number of Code of Conduct complaints received increased slightly by 4% from 270 to 282. Within this, complaints against members of Town and Community Councils increased significantly, by 14%.

Code of Conduct complaints received

	2018/19	2017/18
Town and Community Councils	190	167
Local Authorities	91	102
National Parks	1	1
Total	**282**	**270**

Table 1.5

As in previous years, the majority of Code of Conduct complaints received during 2018/19 related to matters of 'promotion of equality and respect'. These accounted for 51% of complaints. 'Disclosure and registration of interests' (17%), 'Integrity' (13%), 'Duty to uphold the law' (9%) and 'Accountability and openness' (7%) were the other common subjects of complaints. Chart 1.2 below shows a breakdown of the nature of Code of Conduct complaints received:

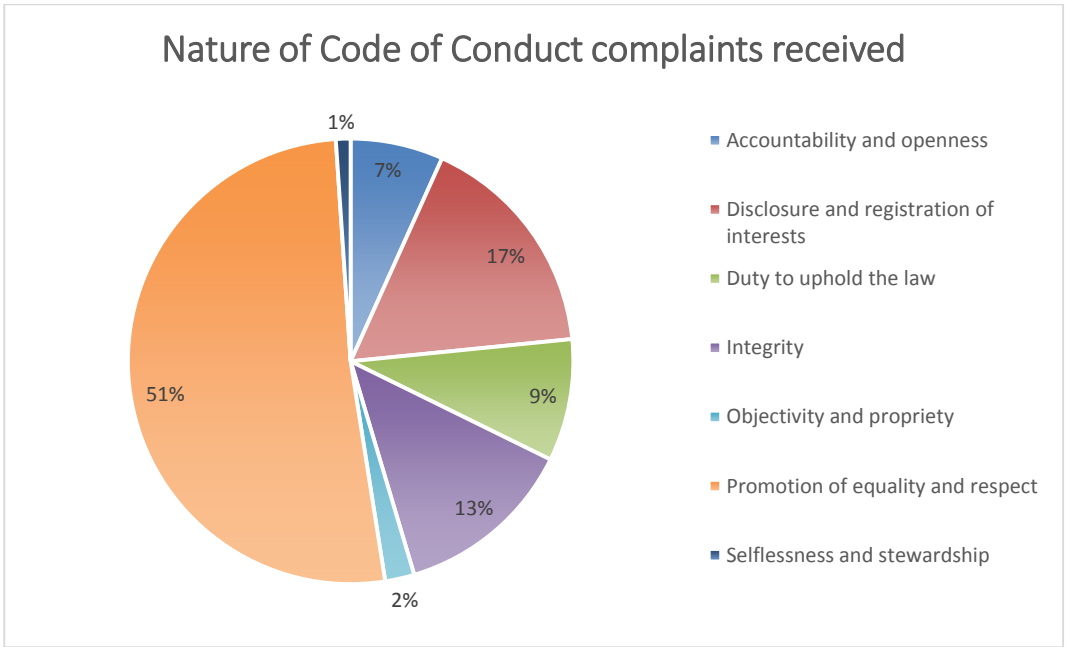


Chart 1.2

Code of Conduct complaint outcomes

My staff carefully consider the details of complaints on receipt to consider whether there is evidence suggesting the Code may have been breached and whether it is in the public interest to investigate. 255 of the 308 Code of Conduct complaints concluded during the year were closed after this initial consideration. In this way my investigative resources are directed to the more serious complaints where an investigation is required in the public interest.

In 2018/19, I saw a further rise in complaints made about members of Town and Community Councils. Concerningly, many of these alleged a failure to uphold the principle of 'promotion of equality and respect'. I have noted an increase in the number of these complaints from Clerks or staff members of such councils. These complaints often pose some evidential difficulties and must be considered carefully in the context of the relevant case law. Such complaints are often indicative of a breakdown in the employment relationship, as opposed to true Code of Conduct issues. However, where I have found conduct suggestive of a failure to show respect and consideration or bullying and harassing behaviour, I have referred such behaviour for consideration by the appropriate Standards Committee. I have also committed to assisting the representative organisations in their production of guidance for employees of Town and Community Councils to assist them in understanding my role and jurisdiction and in distinguishing between employment and conduct matters.

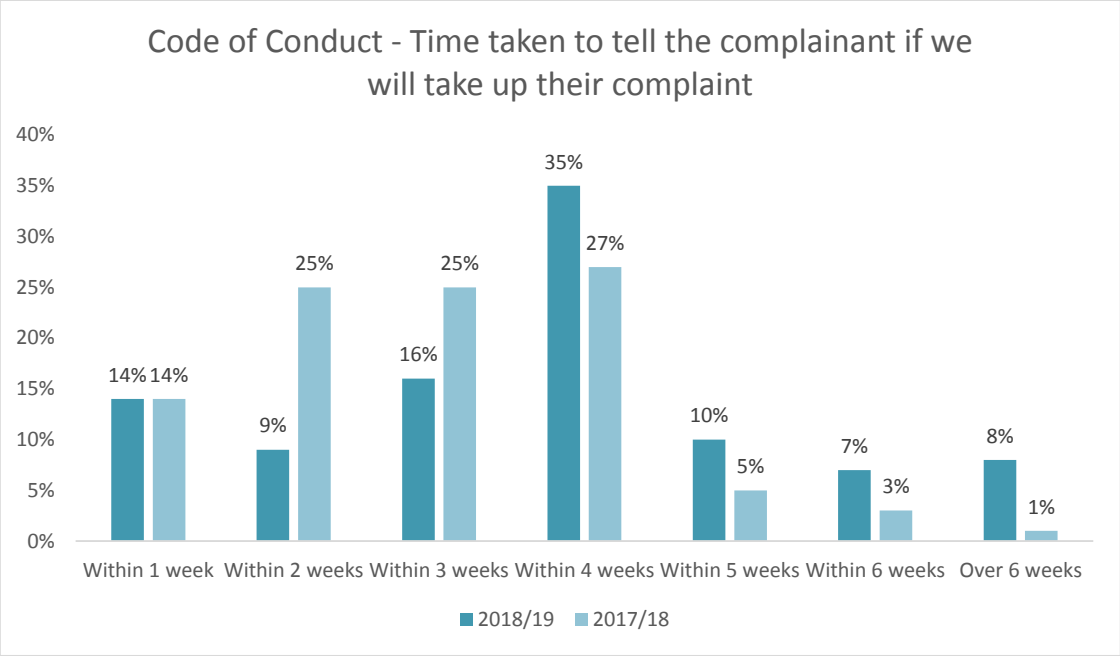
A significant percentage of the cases I have referred to the Adjudication Panel for Wales this year focus on the principle of the promotion of equality and respect. This is not representative of a wider decline in member conduct. Two of referrals made featured a single serious allegation of disrespectful behaviour towards a fellow member. The third related to the way in which that particular member responded to the complaint and its subsequent investigation. The fourth referral was made due to disreputable conduct of a member which came to my attention as a result of an investigation. These matters are yet to be determined by the Adjudication Panel for Wales.

	2018/19	2017/18
Closed after initial consideration	255	213
Complaint withdrawn	2	4
Investigation Discontinued	15	4
Investigation completed: no evidence of breach	9	13
Investigation completed: no action necessary	19	10
Investigation completed: Refer to Standards Committee	4	0
Investigation completed: Refer to Adjudication Panel	4	3
Total Code outcomes	308	247

Table 1.6

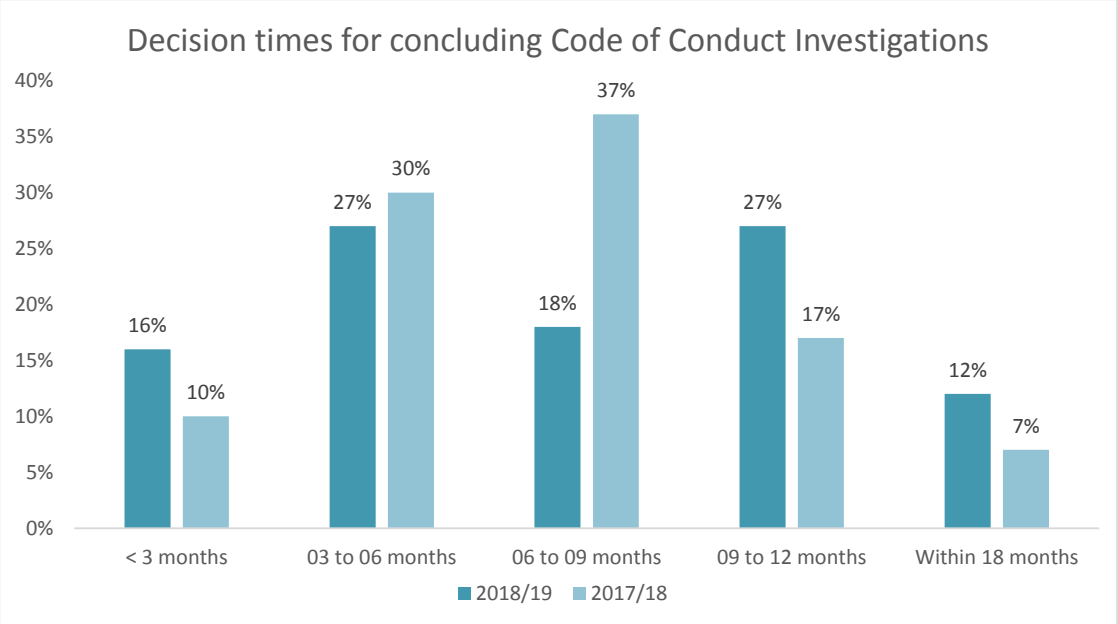
Code of Conduct Investigation Decision Times

In respect of Code of Conduct complaints, 75% of complainants were informed whether I would take up their complaint within 4 weeks of the date I received sufficient information and 92% within 6 weeks. The casework pressures explained above, contributed to this decline in performance in meeting the 4-week target.



Graph 1.5

Graph 1.6 below shows decision times for investigated complaints. 43% of Code of Conduct investigations were completed within 6 months and 88% within 12 months.



Graph 1.6

5.4

Whistleblowing disclosure report

Since 1 April 2017, as the PSOW, I am a 'prescribed person', and required to report annually on whistleblowing disclosures made in the context of Code of Conduct complaints.

The Public Interest Disclosure Act 1998 provides protection for employees who pass on information concerning wrongdoing in certain circumstances. The protection only applies where the person who makes the disclosure reasonably believes:

1. that they are acting in the public interest, which means that protection is not normally given for personal grievances; and
2. that the disclosure is about one of the following:

    - criminal offences (this includes financial improprieties, such as fraud),
    - failure to comply with duties set out in law,
    - miscarriages of justice,
    - endangering someone's health and safety,
    - damage to the environment, or
    - covering up wrongdoing in any of the above categories.

In 2018/19, I received seven complaints which raised potential whistleblowing concerns about alleged breaches of the Code of Conduct. Most of these complaints were received from employees of local authorities and raised issues relating to alleged criminal offences and a perceived failure to comply with equality duties, as set out in law. The remainder were received from staff or former staff of Town and Community Councils and raised concerns primarily relating to the duty to comply with the law in the context of financial impropriety and confidentiality of information.

Of the number of potential whistleblowing cases received, I determined that two of the complaints did not meet my criteria for investigation. Of those investigated, two were subsequently discontinued as the circumstances were such that the continuation of the investigation was no longer in the public interest. The investigations in respect of the remaining three complaints are continuing.

Strategic Aim 2 – Use knowledge and insight to improve complaint handling, improve public services and inform public policy.

Public Interest Reports

Issuing a public interest report is one of the key ways I can highlight learning from complaints and help to ensure that listed authorities are accountable for the services they provide.

The **public interest** factors the I consider include wide ranging values and principles relating to the public good, for example: to ensure that there is transparency, accountability and good decision-making by public bodies and ensure justice and fair treatment for all.

The factors which I consider when deciding whether to issue a public interest report include cases where there are wider issues from which others can learn; what went wrong is significant or is ongoing and the investigation has highlighted systemic problems; the failures identified are ones my office has identified previously and lessons haven't been learned or when a public body has refused to agree to my recommendations.

During 2018/19, I issued **14** public interest reports. While the majority of these related to service failure in our hospitals, there were some notable reports regarding maladministration in local government.

In July, I issued my second special report. This related to Wrexham County Borough Council breaking an undertaking to correct Welsh language errors in its council tax notices. The notice contained errors in its Welsh version for three consecutive years and, despite previously agreeing with my office to correct the matter in time for the 2018/19 financial year, it failed to do so.

An unusual complaint received by my office, which resulted in a public interest report, involved a gentleman who, after returning home from hospital following surgery, found that Flintshire County Borough Council had wrongly classified his vehicle as abandoned and had destroyed it.

The vehicle also contained valuable tools and these were destroyed with the car. This was as classic case of maladministration as I have witnessed as Ombudsman and the report generated media coverage across the UK.

One of the most tragic cases of this year concerned the care and treatment of a young mother and her new born baby, by Glangwili and Withybush General Hospitals in West Wales.

Sadly, the baby died in hospital after delays in treatment and attendance by medical staff. My investigation unearthed a catalogue of serious failings; the family will never know if the baby would have survived if there had been no delay in treatment.

Another report which was deeply disturbing was that of a young boy who was forced to wait for three years to have his kidney removed. This had a serious impact on his life and it is likely his human rights were compromised because of the impact on both his physical and mental wellbeing and the extent of suffering he endured.

You can read all our public reports here. While the standard of service received by those featured in public interest reports is not typical of that provided by Welsh public services, it is important that lessons are learned to ensure the same mistakes are not repeated.

Compliance Visits

In April 2018, I undertook a compliance visit following two public interest reports I issued about Betsi Cadwaladr University Health Board in 2017/18. The first report was about inadequate post-operative care following surgery at Ysbyty Glan Clwyd, when a patient died from sepsis. During my compliance visit, I found that guidelines to clinical staff, especially junior doctors, now emphasises that middle and consultant grades are available over weekends and bank holidays. This was pleasing, as it addressed the recommendations in my public interest report, but it also responds to the wider concerns about out of hours care I highlighted in my Thematic Report Out of Hours: Time to Care which was published in March 2016.

The second public interest report concerned delays by the Urology Service in diagnostic investigations and the scheduling of surgery in respect of a patient who had an aggressive form of prostrate cancer. At the time of my visit, I found that the Health Board had significantly reduced diagnostic waiting times in the service (from nine months to eight weeks) and that it was investing to improve future access to diagnostic tools.

Thematic report

In 2018, I issued a Thematic Report Home Safe and Sound: Effective Hospital Discharge which identified five primary areas in which service providers fall short when conducting discharging patients. These include the lack of effective communication or planning between hospitals and community services and a failure to involve family members in the process. I highlighted a number of matters for Health Boards, GPs and local authorities to consider for future improvement.

Annual letters for health boards and local authorities

Each year I issue Annual letters to the health boards and local authorities in Wales which generate the majority of the complaints which come to my office. In these letters I draw attention to any learning points which have arisen from complaints in the previous year, including any public interest reports. I also draw attention to the percentage of complaints resulting in 'intervention' by my office, as outlined in Table 1.3 above.

A number of Health Boards and Councils responded positively to my 2017/18 Annual letters during the course of last year, by confirming that they had reflected upon the issues which I had drawn to their attention. For example, one Health Board shared learning from reports I upheld with staff via its Listening & Learning Feedback Newsletter and another had worked to improve its performance in complying with the recommendations I made in my reports.

Annual letters can be found here.

Strategic Aim 3 – Plan for a new Public Services Ombudsman (Wales) Act.

The PSOW Bill 2019 was approved by the National Assembly for Wales in March. During the course of last year, my office began initial preparatory work for the new powers contained within the new Act.

Complaints other than in Writing

Processes have been devised for the staff who will be taking oral complaints. The criteria to apply to requests for oral complaints have been set and plans made to store complaints received in this way.

Private Health Care

The private bodies affected by the new Act have been identified and plans have been made to alert them to PSOW's new powers.

Own Initiative Investigations

Internal processes have been drafted which outline how subjects for 'Own Initiative' investigations will be identified and how the investigations will be undertaken. The process for consulting on the draft criteria I intend to apply will begin in summer 2019.

Complaints Standards Authority

The format of the Complaints Standards Authority (CSA) has been devised and the principles for complaint handling drafted. The structure of the CSA has been planned in readiness for a recruitment programme to begin in summer 2019.

Staff Training

Plans are under way to ensure PSOW staff are trained in the work that is necessary under PSOW's new powers. Regular updates to staff on the progress being made towards preparing for the new powers have been undertaken.

Communications Strategy

PSOW's Communications staff will be based within the team responsible for the new powers. Work is ongoing to prepare for the challenges faced in promoting the various new aspects of PSOW's work.

Strategic Aim 4 – Be accountable for the service we provide and the money we spend.

This Annual Report & Accounts forms a key part of my accountability arrangements. The Corporate Governance Report, included in the Accountability Report section of this document, sets out the structures and mechanisms in place to secure accountability.

Corporate Plan

Last year, I consulted widely on our new Corporate Plan for 2019/20 – 2021/22 Delivering Justice. This focuses on delivering our key complaints service, promoting learning and improvement and using resources wisely so that we are equipped to face future challenges.

Service user satisfaction

In the past, I gathered information on service user satisfaction through hard-copy survey forms sent by post. The response rate declined and, in most cases, responses were submitted at an early stage of the process, so did not reflect satisfaction or otherwise with investigations and decisions. To address this, I introduced an on-line satisfaction form and asked complainants to complete the form at any stage of the process, including the conclusion of the case. Disappointingly, response rates have not been high.

The results are summarised below. The responses and comments show that there are mixed levels of satisfaction, with those whose complaints are not investigated likely to respond less positively than those whose complaints are investigated.

It was easy to find out how to contact the Ombudsman	84% agree or strongly agree
The service was helpful and sensitive	51% agree or strongly agree
I was given a clear explanation of what would happen	71% agree or strongly agree
Staff understood my query or complaint	49% agree or strongly agree

Table 4.1

A number of positive comments were made by those responding. These included:

'most comprehensive and helpful' *'efficient and swift'*
'My family and I now have a better understanding of the events … are very pleased with the recommendations …' *'helpful and sensitive'*
'clear and helpful' *'highly useful and highly recommended'*
'excellent service' *'… impressive. Correspondence was clear…'*
'I found the service very good in every way. All extremely professional and competent'
'helpful and courteous' *'very empathetic to my cause'*
'an exemplary service … polite, efficient and professional'
'I was kept informed of developments. Extremely thorough … and … sensitive'

There were, however, a number of less positive comments, generally where complaints have not been taken forward for investigation or have not been upheld. Some comments indicate that the complainant considers that the evidence provided by the public body is given greater weight than their evidence, or that our staff have not fully engaged with and understood the complaint. Whilst the nature of the work, and the fact that complainants reaching my office have generally exhausted the public body's complaint process without getting the outcome they seek, means that the outcomes will always disappoint some complainants, we will be working with staff in the year ahead to address some of the less positive responses and improve the service.

I have published my Service Standards, which reflect the service standards recommended by the Ombudsman Association. These are:

- We will ensure that our service is accessible to all
- We will communicate effectively with you
- We will ensure that you receive a professional service from us
- We will be fair in our dealings with you
- We will operate in a transparent way

The Public Services Ombudsman for Wales website provides more details of what these standards mean in practice. The website also helps service users to make a complaint about the service my staff have provided and to ask that a casework decision taken by my office is reviewed. More detail of this is provided below.

Reviews of casework decisions

Where a service user (generally the complainant) considers that a decision made by my staff, in respect of a complaint about a public body or a councillor, is flawed, they can request a review of that decision if there is additional information, or if some of the information they provided has not, in their view, being properly considered. Reviews are then undertaken by the Review Manager who has not been involved in the case previously. During the year 213 requests for a review were received. 88% of these were considered and responded to within 20 working days. In 23 reviews (11%), the outcome was that the case would be re-opened for further consideration and/or investigation.

Complaints about our service

If a service user is unhappy about the service they have received, they can make a formal complaint about our service. During the year, 30 new complaints were received.

Cases brought forward from 2017/18	5
Received during the year	30
Closed during the year	32
Open at year-end	3
Responses within 20 days	30 (94%)
Responses outside 20 days	2 (6%)

Table 4.2

In 94% of cases, responses were sent within the timescale we set. However, where 'Easy Read' (a combination of words and pictures to help those with a learning disability understand documents) responses are required, it has proved difficult to comply with timescales, as Easy Read translation can take up the full time allowed for a response. Efforts will be made to speed up this process during 2019/20.

The outcomes of the complaints about our service were as follows:

Fully or partially upheld	9
Not upheld	15
Not upheld – disagreement with investigation matter	7
Withdrawn	1
Total	32

Table 4.3

In nine cases, the complaints were fully or partially upheld. These included a failure to update the complainant regularly, typographical errors in a letter and mishandling of a changed telephone number. In one case, which was re-opened as a result, we had not properly engaged with comments received on a draft report. Wherever possible, learning points are drawn from complaints and shared with staff.

Independent External Review of Complaints About our Service

To ensure that we are open and accountable, when we respond to complaints about our service, we include an option to refer to an Independent External Reviewer of Complaints About our Service. There was a change of reviewer during the course of the year.

During the year, eight cases referred to the External Reviewer were concluded. Two cases were partially upheld. In one case the External Reviewer concluded that we should have sought a further apology from a Health Board as part of a complaint settlement. In another case, the External Reviewer concluded that, by accepting a service complaint from a complainant who wanted a different decision in respect of their complaint about a public body, we had given them false hope.

Learning points from these cases have been shared with staff.

Staff survey

During the year, a staff survey, open to all staff, was conducted. 86% of staff responded. The results showed 93% of those staff are proud to work for PSOW; 89% say it is a good place to work and 87% consider that their managers communicate effectively with them. Areas generating the most negative responses were around resources and workload. Work to improve in the least positive and most negative areas has commenced and will continue in 2019/20.

Annual Sustainability Report

I am continuing to develop sustainable practices throughout the organisation. Efforts are ongoing at local and national level to ensure that protecting the environment remains a priority. Where possible, PSOW will make changes to reduce the impact of the office on the environment and operate in a sustainable and responsible manner.

Our Building

We currently have one office in Pencoed, near Bridgend. We originally took up the lease for the ground floor in 2005 and have, since then, expanded to occupy part of the first and second floors to accommodate approximately 70 staff and visitors in a largely open plan office space.

Electricity is the only energy supply used and this provides lighting and heating/cooling as well as powering normal office equipment. The building is leased, which limits our ability to make substantial changes to the energy efficiency of the building. However, we are making changes within our office space where we can, for example with the introduction of LED lighting – see below.

We will be opening a small office in Bangor during 2019/20.

Building Statistics

The table below provides key information about our offices in Pencoed, heating arrangements and energy usage for the year.

Building	Constructed	No. of Floors	Total Usable Floor Area (ft²)	Heating Type	Electricity usage (kWh)
1 Ffordd yr Hen Gae	2004	3	16,460	Air Handling Units	106,701

Table 5.1

Accessibility

The offices have reasonable transport links. The railway station at Pencoed (less than one mile away) together with bus services to/from the site, provide public transport options for staff and visitors. Our offices are also easily accessed by car from the M4 motorway.

Travel, emissions and suppliers

We consider sustainability, as well as cost and practicality, in determining the most appropriate means of travel to meetings and training, with preference given to public transport. Staff are

encouraged to travel sustainably, and showers and bicycle stands are provided at our offices. A number of staff now work at home as part of their normal working pattern. Opening a small office in Bangor during 2019/20 will accommodate staff who reside in North Wales.

Local suppliers are used where possible to help reduce carbon emissions.

Lighting & Energy

New LED lighting was fitted across the whole of the ground floor offices and part of the first floor in March 2018. Staff have also been encouraged to turn off lights and heating/air conditioning when not in use. This has resulted in an average electricity usage reduction of 16%. During the year, our remaining office space was fitted with LED lighting, with a view to reducing energy usage further.

Waste management

Individual desk bins have been removed, with recycling and waste bins placed throughout the office to encourage staff to recycle what they can. We recycle all waste paper confidentially and recycle general waste such as plastic, cardboard and tins, along with batteries and toner cartridges.

We produce little food waste, but coffee grounds and used tea bags are offered to staff for use in compost. Office newspapers are recycled in the paper recycling.

Office waste continues to be collected by two different companies, one for general waste and mixed recycling and one for confidential waste.

Reduction in the use of plastic

The UK government aspires to eliminate all avoidable plastic within 25 years. We do not use disposal cups for hot drinks, with staff and visitors using ceramic cups and mugs. With the removal of bottled water coolers, disposal plastic cups are no longer purchased. Staff and visitors have access to reusable cups/glasses.

Current Waste Figures

The table below shows the amount of waste, of different types, we produce annually.

Type	Total Waste (kg)	Trees Saved	Landfill Saved (m3)	KwH Saved	CO2 Saved (kg)	Water Saved (L)
Recycled Paper & Confidential Waste	**8,860**	150.62	2.05	37,212	5,316	283,520
Mixed Recycling	**2,250**					
General Waste	**20,000**					

Table 5.2

We will be working to reduce the amount of waste sent to landfill in 2019/20.

Annual Equality Report

Staff Equality Data Gathering/Monitoring

Our staff are asked annually to complete and return a monitoring form seeking information in respect of each of the protected characteristics. That disclosure is, of course, on a voluntary basis. 49 staff responded to the survey.

Age	The composition of staff ages is as follows: Under 25: 6% 25 to 34: 12% 35 to 44: 29% 45 to 54: 33% 55 to 64: 20%
Gender	69 % of staff stated they were female and 31% male. When asked if the gender staff identify with was the same as described at birth, 100% of the staff who answered the question said yes.
Disability	94% of staff said they were not disabled, 4% of staff said that they were a disabled person and 2% staff preferred not to say. However, when asked if their day-to-day activities were limited because of a health problem or disability which had lasted, or was expected to last, at least 12 months, 4% said that they were limited a lot, 6% said they were limited a little, 88% said their day to day activities were not limited (2% preferred not to say)
Nationality	In describing their nationality, 50% said they were Welsh; 39% said British, 10% said they were English (1 person did not answer).
Ethnic group	The ethnicity of staff is: 96% White (Welsh, English, Scottish, Northern Irish, British); 4% Black (African, Caribbean, or Black British/Caribbean).
Language	When asked about the main language of their household, 87% of staff said this was English; 13% said Welsh (2 people did not answer).
Religion or Belief	Responses to the question asking staff about their religion were as follows: No religion: 53%; Christian: 43%; Other: 2% (2% preferred not to say)
Marriage/Civil Partnership	56% of staff stated they were married; 4% were in a civil partnership; 27% were single; 9% replied other, 4% preferred not to say (1 person did not answer)
Sexual Orientation	Responding on this, 96% said that they were heterosexual or straight, 2% said gay or lesbian (2% preferred not to say)

Table 6.1

Staff Training

Staff training is provided to support staff in their specific job roles and for their ongoing development. Significant developments have been made during the year, with the introduction of a new training and development process which accommodates the whole organisation's training needs from induction through to continued professional development. Other activities during the year include:

- A training plan is now created at the start of every year which details the organisation's training requirements with costings. The training budget is carefully managed to meet these needs.
- A comprehensive induction programme has been set up so that new members of staff are integrated well into the organisation.
- Online training has been set up for a number of mandatory topics. These will be repeated at agreed frequencies.
- Staff are required to identify and undertake a target number of hours of continued professional development each year.
- Good practice seminars are held for internal training and are also recorded so they can be used to refresh knowledge and are available for new staff.
- All training is evaluated to ensure its effectiveness and value for money.

Pay and Gender – data as at 31 March 2019

As at 31 March 2019, there were 67 members of staff employed. The table below provides an analysis by grade and gender. 73% of the overall workforce is female. Whilst women are well represented at the higher pay scales within my office, making up 60% of senior managers, this remains slightly lower than their proportion of the overall workforce. At the most junior level, 84% of staff are female.

Under the specific Equality Act duties, we are required to set an equality objective for gender and pay, or explain a decision not to do so. To support staff development and progression, a number of staff were supported to complete a management development programme during the year. In addition, an external review will be undertaken during 2019/20 to identify any actions that should be taken to support equality in the workplace, with a view to achieving greater equality. In a relatively small organisation, individual recruitment outcomes can make apparently large differences – for example one senior manager equates to 20% at that level.

Considerable flexibility is available to all staff, with flexitime, limited core hours and a flexible working policy. As at 31 March 2019, there was one member of staff on a fixed term contract, with all other staff on permanent contracts. 17 members of staff work part time (15 female, 2 male).

Head count (not Full Time Equivalents)	Male No.	Female No.	Total No.	Male : Female ratio
Frontline and Administrative staff	3	16	19	16:84
Investigation Officers and Support Service Managers	6	21	27	22:78
Improvement Officers and Managers	7	9	16	44:56
Senior Managers	2	3	5	40:60
Total	**18**	**49**	**67**	**27:73**

Table 6.2

Recruitment

During the past year, five members of staff have left. There has been recruitment to replace departing staff, for a new post and for fixed term cover for maternity leave and a secondment. Eight new employees were recruited on permanent contracts and one on a fixed term contract.

We ask all applicants to complete anonymous equality questionnaires, which are not shared with those who are shortlisting and/or interviewing.

Analysis of the recruitment equality questionnaires indicates that all age ranges are broadly appropriately represented (though no applicants said they were over 65). Around 70% of applicants are female. Although many applicants did not complete the equality questionnaire, we are concerned that recruitments do not always attract a proportionate number of applicants from non-white backgrounds (compared with the all-Wales or more local populations). We are reviewing our recruitment advertising and looking at where to advertise opportunities.

Applications forms are anonymised before they are passed to those who are shortlisting and/or interviewing. Staff involved in recruitment decisions have undertaken equality and recruitment training, to support equality in recruitment.

Disciplinary/Grievance

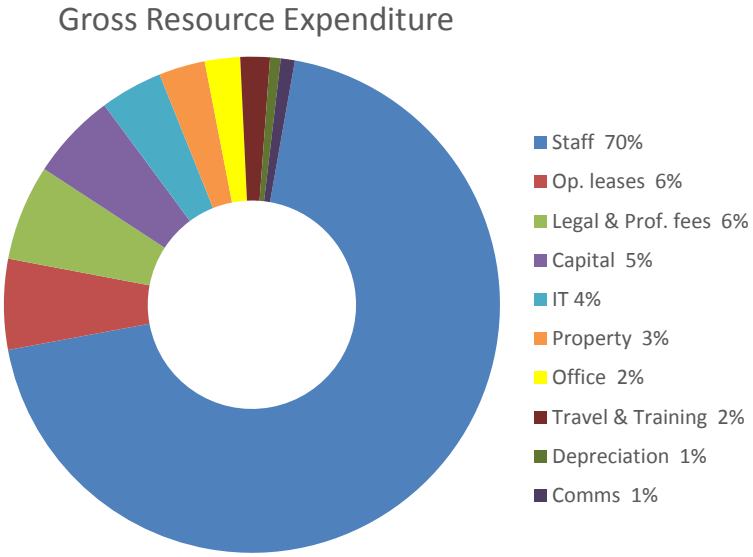
Due to the small number of staff working in the office and the very small number of instances of disciplinary/grievance, it is not considered appropriate to report on equality data for this category, due to the risk of identification of individual staff. I remain satisfied that there are no identifiable issues in this area that would cause concern.

Procurement

Our procurement policy refers to the relevant equality requirements that we expect our suppliers to have in place.

Financial Management

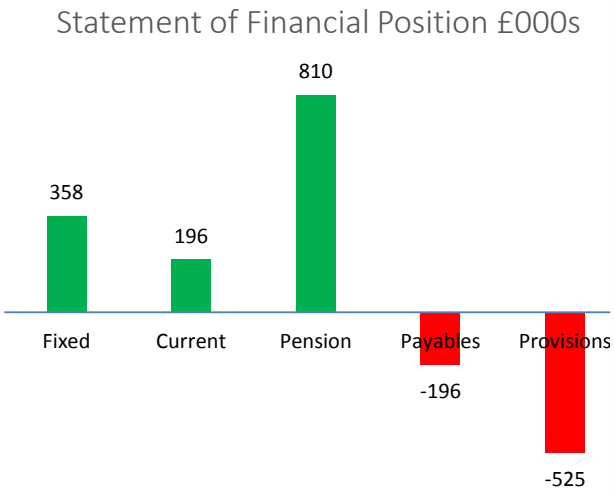
Resource Out-turn	£000s	£000s	Change
	2018/19	2017/18	£000s
Total Resource	4,445	4,210	+235
Cash Requirement	4,390	4,178	+212

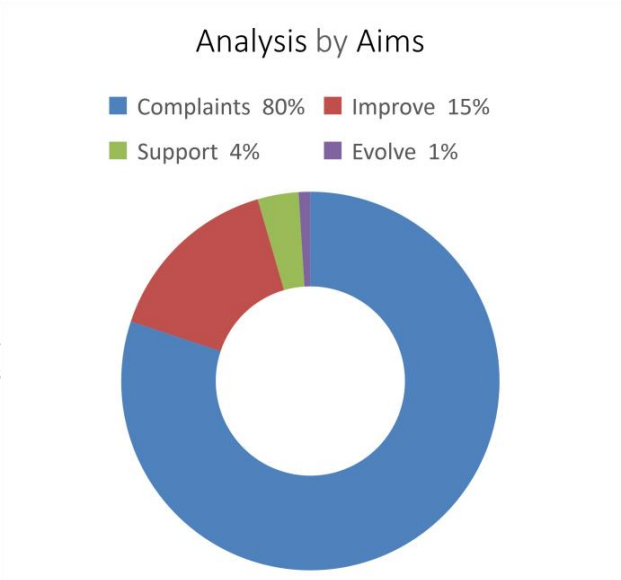


Overall, resource expenditure has increased compared to the same period last year.

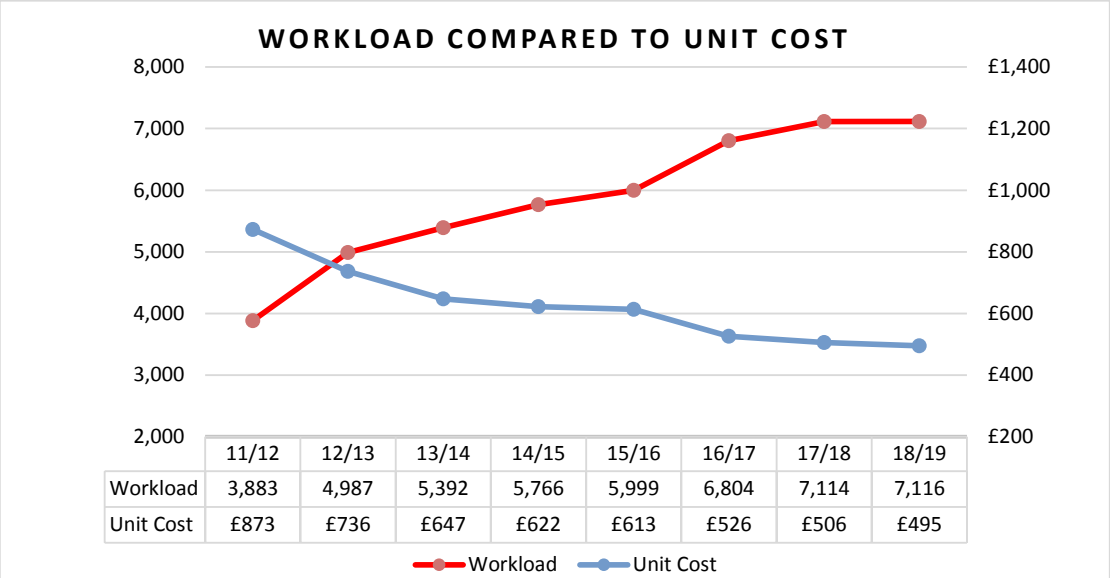
This can be attributed to an increase in employment costs due to pay awards, increments and an increase in frontline staffing numbers and significant capital investment in both an IT infrastructure upgrade project and further development of the Case Management system. There was a cash underspend of £20k.

Fixed assets have increased by £130k from the same period last year as a result of the large capital investment. £43k provisions have been utilised in the year, and the pension fund surplus is now £810k following an actuarial re-measurement. An analysis of spending by aim shows that the majority of resources continued to be applied to complaints handling and investigation.



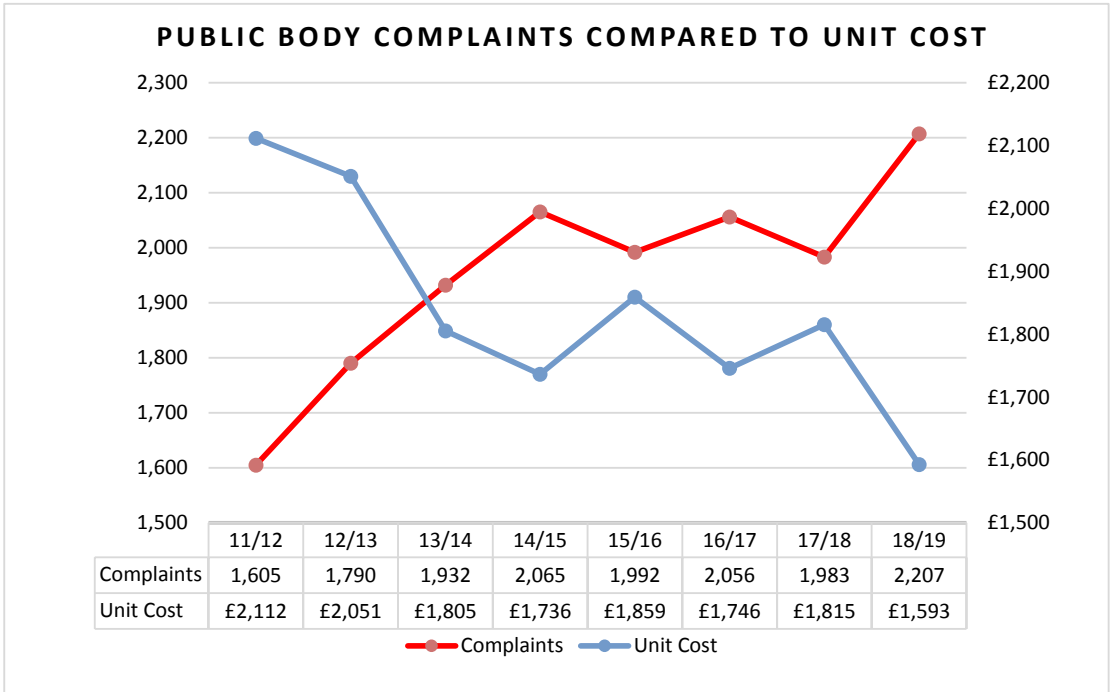


Unit Costs



	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19
Workload	3,883	4,987	5,392	5,766	5,999	6,804	7,114	7,116
Unit Cost	£873	£736	£647	£622	£613	£526	£506	£495

Total workload has increased by 83% whilst unit costs has reduced by 43% when adjusted for CPI inflation.



	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19
Complaints	1,605	1,790	1,932	2,065	1,992	2,056	1,983	2,207
Unit Cost	£2,112	£2,051	£1,805	£1,736	£1,859	£1,746	£1,815	£1,593

Public body complaints have increased by 38% with a corresponding reduction in unit cost of 25%.

Expenditure to 31 March 2019 compared to previous year

	2018/19	2017/18	Reasons for significant changes
	£000	£000	
Salaries	2,389	2,194	
Social Security costs	221	210	2% pay award, increments and increased staffing levels in complaints handling
Pension costs	480	439	
Pension fund charges	42	55	
Total Pay	**3,132**	**2,898**	
Rentals under operating leases	264	265	
External Audit fee	18	18	
Legal and professional fees	261	319	Reduced legal costs
Other property costs	135	205	Reduced rates and maintenance
Computer services	182	239	Website development 2017/18
Office costs	103	98	
Travel and subsistence	31	36	
Training and Recruitment	55	55	
Communications	41	45	Reduced translation costs
Depreciation	31	43	Aged assets fully depreciated
Total Other Administration Costs	**1,121**	**1,323**	
Gross Costs	**4,253**	**4,221**	
Income	(61)	(31)	Secondment to HIW
Net Expenditure	**4,192**	**4,190**	
Capital	253	20	New IT infrastructure and Case Management System development
Net Resource	**4,445**	**4,210**	

More detailed financial information can be found in the notes that support the accounts.

Nick Bennett
Accounting Officer
Public Services Ombudsman for Wales

2 July 2019


Accountability
Report

Corporate Governance Report

Ombudsman's Report

Background

Under the Government of Wales Act 2006, the office is financed through the Welsh Consolidated Fund (WCF) with any unspent cash balances repaid into the WCF after a certified copy of the accounts has been laid before the National Assembly for Wales. This creates a further control in that there is a need to effectively manage the budget on both a cash and a resource basis. The salary of the office holder of the Public Services Ombudsman for Wales and the related costs are a direct charge on the WCF and are administered through the National Assembly for Wales.

As at 31 March 2019, the Office comprised 68 staff based in Pencoed, Bridgend including the Ombudsman, Chief Operating Officer, Director of Policy, Legal and Governance, as well as investigation and support staff.

The National Assembly for Wales provided cash of £4.4 million for the funding of the Office, although £20k of this is due to be returned to the WCF being the unused cash balance at the year end. The sum of £20k is within the accepted year-end balance criteria of 3% funding. The Office has achieved a level of spending in line with the Estimate agreed in November 2017 and amended by Supplementary Budgets during 2018/19.

Great strides have been made over recent years in improving efficiency in the way we consider complaints. This has been essential in view of the ever-increasing caseload. The table below shows that, over the past eight years, the Office has seen an increase of over 83% in all contacts (that is, in enquiries, complaints about the conduct of members of local authorities and public body complaints), whilst unit costs have reduced by 43% when adjusted for CPI inflation.

Workload	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	Change
Enquiries	1,866	2,906	3,234	3,470	3,731	4,512	4,861	4,627	148%
Code of Conduct Complaints	412	291	226	231	276	236	270	282	-32%
Public Body Complaints	1,605	1,790	1,932	2,065	1,992	2,056	1,983	2,207	38%
Total	3,883	4,987	5,392	5,766	5,999	6,804	7,114	7,116	83%
Unit Cost	£873	£736	£647	£622	£613	£526	£506	£495	-43%

Remuneration and Pension Liabilities

Details of the pay and related costs of the Ombudsman and the Office are shown in the Remuneration Report.

Pension obligations to present and past employees are discharged through the Principal Civil Service Pension Scheme (PCSPS), the Local Government Pension Scheme administered through the Cardiff and Vale of Glamorgan Pension Scheme and the pensions paid directly to former Commissioners or their dependants.

Further details are given in the Pensions Disclosures.

Corporate Governance

The office holder of the Public Services Ombudsman for Wales is a Corporation Sole. In addition, upon taking up my role as Ombudsman, I was appointed by the Treasury as the Accounting Officer for the public funds with which the National Assembly entrusts me to undertake my functions. The Audit & Risk Assurance Committee supports the Ombudsman by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report. Further details are set out in the Annual Governance Statement.

Register of Interests

A register of interests is maintained for the Ombudsman, Directors and members of the Advisory Panel and Audit and Risk Assurance Committee.

Accounts Direction

Under the Accounts Direction issued by HM Treasury dated 21 December 2006, I was required to prepare accounts for the financial year ended 31 March 2019 in compliance with the accounting principles and disclosure requirements of the edition of the Government Financial Reporting Manual (the FReM) issued by HM Treasury which was in force for 2018/19.

The accounts have been prepared to:

(a) give a true and fair view of the state of affairs at 31 March 2019 and of the net resource outturn, resources applied to objectives, recognised gains and losses and cash flows for the financial year then ended

(b) provide disclosure of any material expenditure or income that has not been applied for the purposes intended by the National Assembly for Wales or material transactions that have not conformed to the authorities that govern them.

Auditors

The Auditor General for Wales is the External Auditor of the accounts of the PSOW as laid down in paragraph 17 of Schedule 1 to the Public Services Ombudsman (Wales) Act 2005. The cost of the audit for 2018/19 was £18k, with no increase since 2017/18.

As far as I am aware, I have taken all the steps necessary to make the auditors aware of any relevant audit information.

Nick Bennett
Accounting Officer 2 July 2019
Public Services Ombudsman for Wales

Statement of Accounting Officer's Responsibilities

Under the Public Services Ombudsman (Wales) Act 2005, as Public Services Ombudsman for Wales, I am required to prepare, for each financial year, resource accounts detailing the resources acquired, held or disposed of during the year and the use of resources by the PSOW during the year.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the PSOW and its net resource outturn, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, as the Accounting Officer, I am required to comply with the requirements of the *Government Financial Reporting Manual* and in particular to:

- observe the Accounts Direction issued by the Treasury including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed and disclose and explain any material departures in the accounts
- prepare the accounts on a going concern basis
- confirm that the Annual Report and Accounts as a whole is fair, balanced and
- understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

My relevant responsibilities as Accounting Officer include the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the PSOW's assets, as set out in Managing Welsh Public Money and the Public Services Ombudsman (Wales) Act 2005.

As the Accounting Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that PSOW's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Annual Governance Statement 2018/19

Status of the Public Services Ombudsman for Wales

As laid down in Schedule 1 paragraph 2 of the Public Services Ombudsman (Wales) Act 2005, the Ombudsman is a Corporation Sole holding office under Her Majesty and he discharges his function on behalf of the Crown. Schedule 1 paragraph 18 states that the Ombudsman is the Accounting Officer for the Office of the Ombudsman.

Scope of Responsibility

In undertaking the role of Accounting Officer, I ensure that the Office operates effectively and to a high standard of probity. In addition, I have responsibility for maintaining a sound system of internal control that supports the achievement of PSOW's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in "Managing Welsh Public Money".

I am independent of the National Assembly for Wales, but am accountable to its Public Accounts Committee for the use of resources made available to support my statutory functions. In determining the level of resources available to the Office, the PSOW's budget proposals are considered by the Finance Committee of the National Assembly for Wales in accordance with the process laid down in the Act. I produce a combined Annual Report and Accounts for consideration by the Equality, Local Government and Communities Committee and the Finance Committee.

I am required to include this statement with my annual report and accounts to explain how the governance of my Office works and to ensure it meets the requirements of the Corporate Governance Code. To enable me to satisfy these requirements, I have established appropriate structures, systems and procedures that are comprehensive and provide me with evidence that the governance arrangements are working as intended across the whole organisation and its activities. Such arrangements include my Governance Framework, a comprehensive internal control environment, effective internal and external audit arrangements and robust financial management, risk planning and monitoring procedures.

Strategic Planning and Performance Monitoring

In my Strategic Plan for the three years 2016/17 to 2018/19, I established the following:

Vision: A public service culture that values complaints and learns from them to improve public service delivery.

Mission: by considering complaints, to put things right for service users and contribute to improved public service delivery and standards in public life.

Whilst individual teams within the Office are charged with implementing the actions identified, the Management Team monitors progress made against targets and the outcomes achieved via monthly reports. I was very pleased that all key activities for 2018/19 had been delivered by the end of the financial year.

System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable, and not absolute, assurance of effectiveness. It is based on an ongoing process designed to identify and prioritise the risks to the achievement of my policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system has been in place in the Office of the PSOW for the year ended 31 March 2019 and up to the date of approval of these accounts and accords with HM Treasury guidance. No significant areas of internal control weaknesses have been identified from audit work and steps to improve controls further are implemented promptly and monitored by the Audit and Risk Assurance Committee.

Corporate Governance arrangements

Governance arrangements include an Audit & Risk Assurance Committee (ARAC). The Committee's responsibilities are:

Audit & Risk Assurance Committee

(a) Terms of Reference

Following a review of governance arrangements, the Terms of Reference of ARAC were amended so that it is now a stand-alone Committee. The Committee supports the Ombudsman by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

(b) Membership

Membership comprises up to six independent external members. Three new independent members joined ARAC during the year and attended their first meetings in June and September 2018. They are Mrs Anne Jones, former Assistant Information Commissioner; Mr Trevor Coxon, former Monitoring Officer of Wrexham County Borough Council and Mr Ian Williams, former Group Chief Executive of Hendre Limited. The other members are Dr Tom Frawley CBE, former Northern Ireland Assembly Ombudsman and Commissioner for Complaints; Mr Jim Martin,

former Scottish Public Services Ombudsman and Mr Jonathan Morgan, former Assembly Member and former chair of the National Assembly's Public Accounts Committee. Mr Morgan continues to Chair the Committee.

(c) Training

Members of the Committee are invited to assess their training needs annually. An induction programme is provided for all members of the Audit & Risk Assurance Committee. Ian Williams attended an induction day on 18 September 2018.

In June 2018, all members at that time took part in a bespoke Governance and Accountability training programme. In addition, in October 2018, the Chair attended a joint Sector Update meeting, run by Deloitte LLP and held at the Future Generations Commissioner's Office. The Ombudsman, Chief Operating Officer and Financial Accountant also attended.

In November 2018, the Audit & Risk Assurance Committee Chair and the Financial Accountant attended a workshop held for chairs of Audit & Risk Assurance Committees and facilitated by the Wales Audit Office. This was useful for networking and sharing best practice and information.

(d) Meetings

The Committee sets itself an annual work programme. There were four meetings of the Committee during the year.

The Ombudsman attends ARAC Meetings and the Chief Operating Officer acts as Secretary to the Committee. The meetings were also regularly attended by internal and external auditors and appropriate members of the PSOW's Management Team.

At each meeting, the Committee received a number of standing agenda items. These include declarations of any identified fraud or losses, including any data losses. At each meeting, the Committee received a copy of the latest Budget Monitoring report considered by the Management Team. This is intended to provide the Committee with an assurance that there is regular scrutiny of the financial position within the Office.

During the year, the Committee also received reports on a number of other appropriate matters within its Terms of Reference. They included the 9 and 12-month accounts, internal audit plans, a review of the Whistleblowing Policy, a review of governance arrangements, updates on major IT developments and the development of a Strategic ITC Plan and relevant financial and corporate governance matters issued by HM Treasury. The Committee considered the PSOW review of the Cabinet Office Counter-Fraud Framework to satisfy itself that appropriate arrangements are in place.

The Committee provided advice to the Ombudsman to ensure that the 2018/19 Annual Governance Statement included appropriate information and complied with best practice.

The Committee also considered risk management at each meeting. A new approach to the risk register was adopted in 2017, with the aim of securing focus on key risks. The main principle of the current risk management report format is that there are five key risk horizons, and that an assessment is made by the PSOW Management Team, on a regular basis, for each of these risk horizons:

- Core Function
- Data Privacy/information security
- Financial
- Operational & Support
- Governance

The Committee is presented with a risk summary table and assessment of the five risk horizons as a method of ensuring that they are kept aware of key risks and can review risk management and risk mitigation.

Attendance was as follows:

Membership:

Jonathan Morgan (Chair)	4
John Williams (until June 2018)	1
Tom Frawley	4
Jim Martin	4
Anne Jones	4
Trevor Coxon	4
Ian Williams (from September 2018)	3

(e) Internal and External Audit

The Committee received regular reports from both the internal and external auditors. The work of Deloitte as Internal Auditors during the year was planned based on their overall needs assessment and carried out through their third annual programme. Their reports highlighted the satisfactory internal control framework within the organisation and made recommendations for improvement where necessary.

The rolling audit programme covering the other aspects of the Office's work and controls also noted the satisfactory internal control framework within the Office and made recommendations for improvement where necessary. The overall assessments were as follows:

Information Security	SUBSTANTIAL assurance
Financial Systems:	
Budgetary Control	SUBSTANTIAL assurance
Revenue & Receivables	SUBSTANTIAL assurance
Payroll	SUBSTANTIAL assurance
Pension arrangements	SUBSTANTIAL assurance
Corporate Governance/Risk Management	SUBSTANTIAL assurance

In all audits, the level of assurance was considered 'Substantial', the highest assurance level. A number of low priority recommendations were made and these have either been completed or will be completed in accordance with agreed timescales.

The internal auditors' Annual Report for 2018/19 stated: 'Based on the work we have undertaken during the year we are able to conclude that the Ombudsman has a basically sound system of internal control, which should provide substantial assurance regarding the achievement of the Ombudsman's objectives.' These findings provide assurance that the arrangements in place are reducing the Office's exposure to risk. The Committee noted the thoroughness of the audit work, practicality of recommendations and the open and positive response of management to the recommendations made.

The role of external audit is undertaken by the Wales Audit Office (WAO). The Committee considered the Annual Report and Accounts that included the Governance Statement of the Office for 2017/18 together with the External Audit of Financial Statements Report and Management Letter. The audit conclusions for the 2017/18 financial year were reviewed at the September 2018 meeting of the Committee.

An unqualified opinion was given on the 2017/18 Accounts on 17 July 2018 with no recommendations arising from the Audit.

Both Internal and External Auditors have the right, if considered appropriate, to raise any matter through an open access policy to the Chair and through that right to bring any matter to the attention of the Committee. The Committee, by reviewing the programmes of both the External and the Internal Auditors, ensured that they were co-operating effectively with each other. The quality of the audit work and that of the Committee has been evaluated during the year through consideration of the audit reports and recommendations and dialogue at meetings between Committee Members and the Auditors.

To ensure that appropriate matters can be raised in confidence, the Chair of the Committee holds an annual meeting with representatives of the External and Internal Auditors. Such a meeting was held on 27 March 2019.

(f) Monitoring processes

At each meeting during 2018/19, the Committee received a report on progress made on the implementation of External and Internal Audit recommendations. The Committee members were satisfied that all the recommendations made had been implemented or will be implemented by the first quarter of 2018/19.

(g) Annual Review and Assessment

This annual review is undertaken to ensure that the work of the Audit and Risk Assurance Committee continues to comply with the Good Practice Principles set out in the HM Treasury Audit Committee Handbook. To assist the Committee in determining that it was complying with good practice, each member was invited to complete the National Audit Office's 'The Audit Committee self-assessment checklist.'

Comments received from Committee members were considered in preparing the Annual Report for 2018/19.

The report concluded that it had received comprehensive assurances and information that was reliable and sufficient to enable it to carry out its responsibilities. Those assurances demonstrated a satisfactory overall internal control environment, financial reporting and the management of risk and of the quality of both the Internal and External Audit work undertaken.

The Committee was therefore able to provide assurances to effectively support me as the Public Services Ombudsman for Wales to comply with my Accounting Officer responsibilities in providing evidence to assist in the preparation of this Annual Governance Statement.

Advisory Panel

The Advisory Panel is a non-statutory forum whose main role is to provide support and advice to the Ombudsman in providing leadership and setting the strategic objectives of the office of the Public Services Ombudsman for Wales. The Panel also brings an external perspective to assist in the development of policy and practice.

The Panel provides specific advice and support to the Ombudsman on:

- vision, values and purposes
- strategic direction and planning.

The Advisory Panel is an advisory-only body to the Ombudsman and does not make decisions in its own right.

Reporting of Personal Data Related Incidents

All incidents involving personal data are reported to the Audit and Risk Assurance Committee, regardless of whether the PSOW is at fault. Where PSOW is at fault, guidance issued by the Information Commissioner's Office (ICO) is considered to establish whether it is necessary to report the incident to that office. PSOW's process for handling such incidents has been amended to reflect the requirements of the Data Protection legislation and updated guidance issued by the ICO. During 2018/19, there were no incidents that required reporting to the ICO.

The Risk and Control Framework

As required by "Managing Welsh Public Money", I am supported by a professionally qualified Financial Accountant who carries out the responsibilities of a Finance Director as set out in that document.

Risk management and the risk register are standing Agenda items for the Audit and Risk Assurance Committee.

I am continuing to enhance the robust internal control arrangements to ensure that the Office has the capacity to identify, assess and manage risk effectively. In undertaking this responsibility during the year ended 31 March 2019, I have been supported by a Chief Operating Officer to whom some of the Ombudsman's responsibilities have been delegated. In addition, the Management Team which I chair has responsibility for overseeing risk management. I am satisfied that the systems in place identify potential risks at an early stage and enable, through active management, the appropriate action to be taken to minimise any adverse impact on the office. As already stated the Audit and Risk Assurance Committee receives regular reports on the Risks relating to this Office.

Risks are considered across a number of key areas or risk horizons. These are:

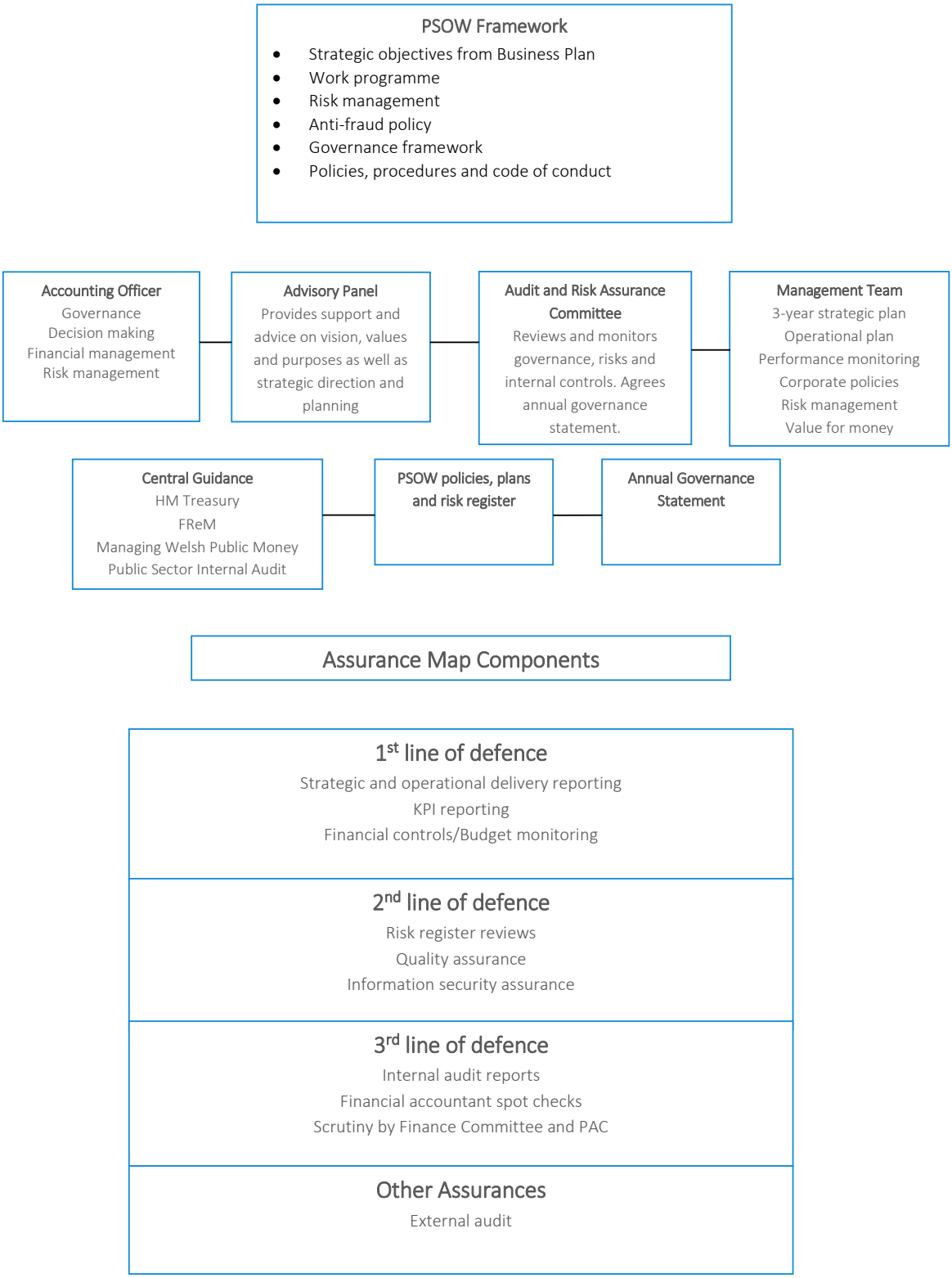
- risks that could affect my ability to fulfil my core functions
- risks affecting data security
- financial risks
- governance risks
- risks affecting facilities and support arrangements (such as premises and IT services).

Key risks at the financial year-end were identified as follows:

Risk horizon	Risk affects:	Risk management and mitigation:	Residual risk:
Core function	Suitable and reliable facilities and systems - the risk arises specifically from concerns about external IT support provision and repeated systems outages	Complete the upgrade of IT infrastructure as soon as practically possible. Pro-active contract management of IT Support provider	Unreliable IT systems could affect service delivery and ability to handle caseload effectively. It could also give rise to reputational damage. The residual risk is therefore considered RED
Data Security	System security – physical and cyber security	Robust, documented and audited IT controls, password controls, back up arrangements, external IT support, penetration testing, regular software updates	IT security is a high priority with controls in place, but the risk of cyber security attacks remains real for everyone and for all organisations. The residual risk is therefore considered RED

I and my Management Team will continue to work to manage and minimise the risks in these key areas in the year ahead and the risks will be considered at each meeting of the Audit & Risk Assurance Committee.

Risk Assurance Framework Arrangements



Budgeting Process

As Accounting Officer, I ensure that I have in place arrangements for tight control of the public money entrusted to me. The Management Team receives a monthly budget monitoring report setting out details of actual against budgeted expenditure. Any unexpected expenditure issues that may arise during the year are considered and actions required to ensure that the office remains within its budgeted expenditure are agreed. No major issues arose in respect of the PSOW's budget for 2018/19.

As far as the process of producing the PSOW's financial estimate for 2019/20 is concerned, a paper setting out initial budget criteria was considered by the Advisory Panel in June 2018. Following on from this, a draft budget estimate paper was considered at the meeting in September 2018. That paper set out in full the financial resources that the PSOW sought to discharge its functions and develop its improvement work with public service providers. It allowed for some pay and price inflation and sought largely to absorb, through greater efficiency, the continuing and significant growth in the number (and complexity) of complaints. The Estimates paper, seeking a 3.8% cash increase, was submitted to the Finance Committee of the National Assembly for Wales. The Finance Committee considered the paper in October 2018 and I was pleased to be able to attend the meeting to answer Assembly Members' specific questions on the submission. Following that meeting, the Finance Committee Chair wrote to the Ombudsman, requesting that the submission be modified and resubmitted, with the increase limited to 1.6% and the proposals to support improvement work in public service providers deleted. A revised estimate was submitted and subsequently approved.

A supplementary budget for 2019/20 will be submitted in April 2019 to fund:

- The Civil Service Pensions increase in employer contributions of 6%, and
- The additional costs associated with the new Public Services Ombudsman (Wales) Bill

Conclusion

I can report that there were no significant weaknesses in the Office's system of internal controls in 2018/19 which would affect the achievement of the Office's policies, aims and objectives and that robust Corporate Governance is in operation with no breaches of the Corporate Governance Code.

Nick Bennett
Accounting Officer 2 July 2019
Public Services Ombudsman for Wales

Remuneration Report

Public Services Ombudsman for Wales

The Government of Wales Act 2006 provides for my remuneration and associated national insurance and pension costs to be met from the Welsh Consolidated Fund, rather than being paid directly. These costs are included, for transparency, in the remuneration report.

Remuneration

The following sections provide details of the remuneration and pension interest of the most senior management of the Office: Nick Bennett - Ombudsman, Chris Vinestock - Chief Operating Officer and Director of Investigations and Katrin Shaw - Director of Policy, Legal and Governance.

Single Total Figure of Remuneration

Officials	Salary (£'000)		Bonus payments (£'000)		Benefits in Kind (to nearest £100)		Pension benefits (to nearest £1,000)		Total (£'000)	
	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18
Nick Bennett	145-150	145-150	-	-	-	-	58,000	57,000	205-210	200-205
Chris Vinestock	95-100	90-95	-	-	-	-	34,000	27,000	125-130	120-125
Katrin Shaw	75-80	75-80	-	-	-	-	29,000	30,000	105-110	105-110

Nick Bennett's pension benefits for 2017/18, disclosed as £56,000, were recalculated by MyCSP due to a salary underpayment in that financial year.

Salary

Salary includes gross salary, overtime and any other allowances to the extent that they are subject to UK taxation.

Benefits in kind

The monetary value of benefits in kind covers any expenditure paid by the PSOW and treated by HM Revenue and Customs as a taxable emolument. There was no such expenditure.

Bonuses

No bonus was paid during the year to me or to any staff within my office, as no bonus scheme is in operation.

Pay multiples

The banded remuneration of the highest-paid director in the financial year 2018/19 was £145,000-£150,000 (2017/18 = £145,000-£150,000). This was 3.5 times (2017/18 = 3.6) the median remuneration of the workforce, which was £41,847 (2017/18 = £41,025). In 2018/19, no employee received remuneration in excess of the highest-paid director (2017/18 = none).

Remuneration ranged from £18,000 to £150,000 (2017/18, £17,000-£150,000). Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Pay awards

Staff pay is linked to the pay awards made to employees within Local Government in England and Wales. In line with that procedure, a 2% pay increase was awarded to staff that covered the year April 2018 to March 2019.

Pensions

Pension entitlements for the persons shown above are detailed below:

Name	Accrued pension at pension age as at 31/03/19 and related lump sum	Real increase in pension and related lump sum at pension age	CETV at 31/03/19	CETV at 31/03/18	Real Increase in CETV	Employer contribution to partnership pension accounts
	£000	£000	£000	£000	£000	Nearest £100
Nick Bennett	40-45	2.5-5	495	395	29	-
Chris Vinestock	55-60	0-2.5	822	706	19	-
Katrin Shaw	30-35	0-2.5	476	403	14	-

Pension Liabilities

The pension obligations to present and past employees are discharged through:

(a) the Principal Civil Service Pension Scheme (PCSPS)
(b) the Local Government Pension Scheme administered through the Cardiff and Vale of Glamorgan Pension Scheme (the Fund) and
(c) the pensions paid directly to former Commissioners or their dependants.

Further details are given in the Pensions Disclosures.

Sickness

During the year, an average of 3.3 days per employee were lost through sickness, compared with 5.6 days in 2017/18. This is the equivalent of 1.2% (2.1% in 2017/18) of total possible workdays.

Reporting of Civil Service and other compensation schemes

No exit packages were paid in 2018/19 (2017/18 Nil).

Advisory Panel and Audit and Risk Assurance Committee

The following non-pensionable payments, based on a daily rate, were made to members of the Advisory Panel and Audit and Risk Assurance Committee:

	2018/19	2017/18
	£	£
Jonathan Morgan	3,789	1,565
Anne Jones	2,488	846
Jim Martin	2,799	622
Tom Frawley	2,488	622
Trevor Coxon	2,799	-
Ian Williams	1,866	-
Margaret Griffiths (left during year)	282	564
John Williams (left during year)	282	904
William Richardson (left 2017/18)	-	1,263
Sharon Warnes (left 2017/18)	-	622
Beverley Peatling (left 2017/18)	-	622

Due to the late timing of the March 2018 meeting only 3 payments were made to committee members in 2017/18, with the fourth payment being made in April 2018.

For staff reporting issues see the Annual Equality Report.

Nick Bennett
Accounting Officer
Public Services Ombudsman for Wales

2 July 2019

National Assembly for Wales Accountability and Audit Report

In addition to the primary statements prepared under **International Financial Reporting Standards (IFRS)**, the Government Financial Reporting Manual (FReM) requires the Ombudsman to prepare a statement and supporting notes to show resource outturn against the Supply Estimate presented to the Assembly, in respect of each request for resource.

Summary of Net Resource Outturn

for the year ended 31 March 2019

	Revised Estimate			Outturn				2017/18
	Gross Expenditure	Income	Net Total	Gross Expenditure	Income	Net Total	Net total outturn compared to estimate	Net Total
	£000	£000	£000	£000	£000	£000	£000	£000
Revenue	4,313	(62)	4,251	4,253	(61)	4,192	59	4,190
Capital	229	-	229	253	-	253	(24)	20
Net Resource	**4,542**	**(62)**	**4,480**	**4,506**	**(61)**	**4,445**	**35**	**4,210**
Net Cash Requirement	**4,472**	**(62)**	**4,410**	**4,451**	**(61)**	**4,390**	**20**	**4,178**

The Ombudsman is paid directly from the Welsh Consolidated Fund and not by the Office and is not included in the PSOW accounts.

For transparency, the Ombudsman's remuneration continues to be disclosed in the Remuneration Report.

Reconciliation of Net Resource to Net Cash Requirement

for the year ended 31 March 2019

	Note	2018/19 Revised estimate	2018/19 Net total Outturn	Net total outturn compared to revised estimate	2017/18 Outturn
		£000	£000	£000	£000
Net Revenue	2-4	4,251	4,192	59	4,190
Net Capital	6	229	253	(24)	20
Net Resource		**4,480**	**4,445**	**35**	**4,210**
Movement in provisions	10	(20)	12	(32)	7
Capital charges	6	(70)	(31)	(39)	(43)
Movements in working capital	7-9	20	(16)	36	24
Pension charges (LGPS)	Pensions Disclosures	-	(20)	20	(20)
Net cash requirement		**4,410**	**4,390**	**20**	**4,178**

Nick Bennett
Accounting Officer
Public Services Ombudsman for Wales

2 July 2019

The Certificate and Independent Auditor's Report of the Auditor General for Wales to the National Assembly for Wales

Report on the audit of the financial statements

Opinion

I certify that I have audited the financial statements of the Public Services Ombudsman for Wales For the year ended 31 March 2019 under paragraph 17 (2) of Schedule 1 of the Public Services Ombudsman (Wales) Act 2005. These comprise the Summary or Net Resource Outturn, Statement of Comprehensive Net Expenditure, Statement of Financial Position, Consolidated Statement of Cash Flows, Statement of Changes in Taxpayers Equity and related notes, including a summary of significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. The financial reporting framework that has been applied in their preparation is applicable law and HM Treasury's Financial Reporting Manual based on International Financial Reporting Standards (IFRSs) as adopted by the European Union/United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

In my opinion the financial statements:

- give a true and fair view of the state of Public Services Ombudsman for Wales affairs as at 31 March 2019 and of its net cash requirement, net resource outturn and net operating cost, for the year then ended; and
- have been properly prepared in accordance with HM Treasury directions issued under the Public Services Ombudsman (Wales) Act (2005).

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)). My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report. I am independent of the body in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

I have nothing to report in respect of the following matters in relation to which the ISAs (UK) require me to report to you where:

- the use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The Accounting Officer is responsible for the other information in the annual report and financial statements. The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies, I consider the implications for my report.

Opinion on regularity

In my opinion, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the National Assembly for Wales and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Report on other requirements

Opinion on other matters

In my opinion, the part of the Remuneration Report to be audited has been properly prepared in accordance with HM Treasury directions made under the Public Services Ombudsman (Wales) Act (2005).

In my opinion, based on the work undertaken in the course of my audit:

- the information given in the Annual Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and the Governance Statement has been prepared in accordance with HM Treasury guidance;
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements and has been prepared in accordance with the Public Services Ombudsman (Wales) Act (2005).

Matters on which I report by exception

In the light of the knowledge and understanding of the body and its environment obtained in the course of the audit. I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- proper accounting records have not been kept;
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records and returns;
- information specified by HM Treasury regarding the remuneration and other transactions is not disclosed; or
- I have not received all of the information and explanations I require for my audit.

Report

I have no observations to make on these financial statements.

Responsibilities

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for preparing the financial statements in accordance with the Public Services Ombudsman (Wales) Act 2005 and HM Treasury directions made there under, for being satisfied that they give a true and fair view and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the body's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless deemed inappropriate.

Auditor's responsibilities for the audit of the financial statements

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Responsibilities for regularity

The Accounting Officer is responsible for ensuring the regularity of financial transactions.
I am required to obtain sufficient evidence to give reasonable assurance that the expenditure and income have been applied to the purposes intended by the National Assembly for Wales and the financial transactions conform to the authorities, which govern them.

Adrian Crompton
Auditor General for Wales
3 July 2019

24 Cathedral Road
Cardiff
CF11 9LJ


Financial
Statements

Statement of Comprehensive Net Expenditure

for the year ended 31 March 2019

	Note	2018/19	2017/18
		£000	£000
Administration costs			
Staff costs	2	3,132	2,898
Other non-staff administration costs	3	1,121	1,323
Gross Administration Costs		**4,253**	**4,221**
Operating Income	4	(61)	(31)
Net Administration Costs		**4,192**	**4,190**
Net Revenue Outturn		**4,192**	**4,190**

All activities commenced in the period are continuing.

Notes 1 to 18 and the Pensions Disclosures form part of these statements.

Statement of Financial Position

as at 31 March 2019

	Note	2018/19 £000	2017/18 £000
Non-current assets			
Property, Plant and Equipment	6a	185	128
Intangible assets	6b	172	7
Receivables due after more than one year	7	1	3
Pension fund surplus	Pensions Disclosures	810	30
		1,168	**168**
Current Assets			
Trade and other receivables	7	175	186
Cash and cash equivalents	8	20	32
		195	**218**
Total assets		**1,363**	**386**
Current liabilities			
Trade and other payables	9	(172)	(177)
Provisions less than one year	10	(44)	(43)
		(216)	**(220)**
Total assets less current liabilities		**1,147**	**166**
Non-current liabilities			
Trade and other payables due after one year	9	(24)	(28)
Provisions greater than one year	10	(481)	(494)
		(505)	**(522)**
Total assets less liabilities		**642**	**(356)**
General Fund		**642**	**(356)**

Notes 1 to 18 and the Pensions Disclosures form part of these statements. The significant change to the pension fund surplus is clarified in the Pensions Disclosures on page 88.

The financial statements were approved by the Accounting Officer and authorised for issue on 2nd July 2019 by:

Nick Bennett
Accounting Officer
Public Services Ombudsman for Wales

2 July 2019

Statement of Cash Flows

for the year ended 31 March 2019

	Note	2018/19	2017/18
		£000	£000
Net cash outflow from operating activities	11	(4,137)	(4,158)
Net cash flow from investing activities	12	(253)	(20)
Financing from National Assembly for Wales	13	4,410	4,210
Prior year cash balance repaid		(32)	(34)
Net increase (decrease) in cash equivalents after adjustments for payments to Welsh Consolidated Fund		**(12)**	**(2)**
Cash and cash equivalents at the beginning of period		**32**	**34**
Cash and cash equivalents at the end of period		**20**	**32**

Notes 1 to 18 and the Pensions Disclosures form part of these statements.

Statement of Changes in Taxpayers' Equity

for the year ended 31 March 2019

	General Fund 2018/19	General Fund 2017/18
	£000	£000
Balance as at 1 April	(356)	(354)
Net operating costs	(4,192)	(4,190)
Funding by National Assembly for Wales	4,410	4,210
Due back to Welsh Consolidated Fund	(20)	(32)
Actuarial re-measurement of LGPS pension fund	800	10
Total recognised income and expense for year	998	(2)
Balance as at 31 March	642	(356)

Notes 1 to 18 and the Pensions Disclosures form part of these statements.

An actuarial re-measurement under paragraph 64 of IAS 19 has resulted in a significant surplus of £800k to be recognised in the 2018/19 financial accounts. Further details can be found in the Pensions Disclosures.

Notes to the Financial Statements

1. Statement of Accounting Policies

These financial statements have been prepared in accordance with the Government Financial Reporting Manual (the FReM) issued by HM Treasury which is in force for 2018/19. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS), as adopted or interpreted for the public sector. Where the FReM permits a choice of accounting policy, the accounting policy which has been judged to be most appropriate to the particular circumstances of the PSOW for the purpose of giving a true and fair view has been selected. The particular accounting policies adopted by the PSOW are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for any revaluation of fixed assets, where material to their value to the business, by reference to their current costs.

1.2 Property, Plant and Equipment

Expenditure on property, plant and equipment is capitalised where the purchases are expected to have a useful life extending over more than one year and the cost exceeds £1k. Assets costing less than £1k may be capitalised providing they are capital in nature and are part of a larger scheme that is, in total, more than £1k. Assets are shown at cost less an allowance for depreciation. On initial recognition, fixed assets are measured at cost, including such costs as installation, which are directly attributable to bringing them into working condition for their intended use. In reviewing the costs of the fixed assets previously acquired and the prices paid for the new acquisitions during the year, there is no material difference between the historic net book value of the assets and their replacement cost, less depreciation.

1.3 Depreciation

Assets are depreciated at rates calculated to write them down to zero or, if applicable, estimated residual value on a straight-line basis over their estimated useful life following an initial charge of a full month's depreciation in the month of purchase. Assets in the course of construction are depreciated when the asset is brought into use. Except where otherwise noted, asset lives are assumed to be the following:

Plant	10 years or the lease term if shorter
Furniture and other fittings	10 years or, in the case of fittings, the lease term
Computers and other equipment	3 to 10 years

1.4 Intangible assets

Purchased computer software licences and developed software are capitalised where expenditure of £1k or more is incurred and the useful life is more than one year. Intangible assets costing less than £1k may be capitalised, providing they are capital in nature and are part of a larger scheme that is, in total, more than £1k. Intangible assets are reviewed annually for impairment and are stated at amortised historic cost. Software licences are amortised over the shorter of the term of the licence and the useful economic life of the computer equipment on which they are installed. This would usually be from 3 to 5 years. Developed software is amortised over the estimated useful life. In the year of acquisition, following an initial charge of a full month's depreciation in the month of purchase, the balance is amortised on a straight-line basis over the balance of the estimated life.

1.5 Value Added Tax

The PSOW is not registered for VAT. Expenditure is therefore disclosed gross of VAT.

1.6 Pensions

The pension obligations to present and past employees are covered by the provisions of the Principal Civil Service Pension Scheme (PCSPS), the Local Government Pension Scheme administered through the Cardiff and Vale of Glamorgan Pension Scheme (the Fund) and by direct payment to previous Commissioners for Local Administration in Wales and any surviving beneficiaries. Full details are disclosed in the Pensions Disclosures at the end of the Financial Statements. The costs of providing these pensions are charged through the Statement of Comprehensive Net Expenditure with actuarial gains and losses relating to the Cardiff and Vale of Glamorgan Pension Scheme being recognised in the year in which they occur.

1.7 Early departure costs

Where the PSOW is required to meet the additional cost of benefits beyond the normal benefits payable by the appropriate pension scheme in respect of employees who retire early, these costs are charged to the Statement of Comprehensive Net Expenditure in full when the liability arises.

1.8 Operating Leases

Expenditure on leased property is charged in the period to which it relates. Operating lease charges for equipment are spread equally over the life of the lease.

1.9 Staff Costs

In line with IAS, 19 short-term employee benefits, such as wages, salaries and social security contributions, paid annual leave and paid sick leave, as well as non-monetary benefits for current employees, are recognised when an employee has rendered services in exchange for those benefits.

1.10 Provisions

These are sums which are of uncertain timing or amount at the balance sheet date and represent the best estimate of the expenditure required to settle the obligations. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the recommended HM Treasury discount rate.

1.11 Income

All income is recognised in the Statement of Comprehensive Net Expenditure in accordance with IAS 18.

1.12 Impact of Standards Not Yet Effective

Standard	Effective date	Further details
IFRS 16 Leases	2020/21	IFRS 16 will replace the current leases standard IAS 17. The key change is that it largely removes the distinction between operating and finance leases for lessees by introducing a single lessee accounting model that requires a lessee to recognise assets and liabilities for all leases with a term of more than 12 months, unless the underlying asset is of low value. It will lead to all leases being recognised on the balance sheet as an asset based on a right of use principle with a corresponding liability for future rentals. This is a significant change in lessee accounting.

2. Staff Costs and Numbers

The aggregate employment costs were as follows:

	2018/19 £000	2017/18 £000
Permanent staff:		
Salaries	2,389	2,194
Social Security costs	221	210
Pension costs	480	439
Pension fund charges	42	55
Total	3,132	2,898

There were no temporary staff employed by the PSOW.

The average number of whole-time equivalent persons employed (including senior management and fixed term appointments) during the year was as follows:

	2018/19 No.	2017/18 No.
Directors	2	2
Complaints Handling	49	45
Corporate Services and IT	8	7
Communications and PA	3	3
Total	62	57

3. Non-Staff Administration Costs

	2018/19 £000	2017/18 £000
Rentals under operating leases	264	265
External Audit fee	18	18
Legal and professional fees	261	319
Other property costs	135	205
Computer services	182	239
Office costs	103	98
Travel and subsistence	31	36
Training and Recruitment	55	55
Communications	41	45
Sub-total	**1,090**	**1,280**
Depreciation	24	32
Amortisation charge	7	11
Loss on disposal	-	-
Sub-total	**31**	**43**
Total Other Administration Costs	**1,121**	**1,323**

4. Operating Income

	2018/19 £000	2017/18 £000
Seconded staff	(60)	(30)
Interest receivable	-	-
Other – Future Generations Commissioner	(1)	(1)
Total	**(61)**	**(31)**

5. Operating Costs by Strategic Aims

The costs of providing a first class Ombudsman service to Wales are set out below. We have identified four new strategic aims for delivering our mission and the allocation to each of the aims has been based on the following:

- An estimate of the staff time spent on the objective
- Direct allocation of expenditure where applicable
- Apportionment of other costs pro rata to the estimate of staff time

	2018/19		2017/18	
	£000	%	£000	%
Strategic Aim 1: To provide a complaints service that is of the highest quality, proportionate and effective.	3,356	80.1	3,307	78.9
Strategic Aim 2: To use the knowledge and insight obtained from the complaints we consider to improve complaint handling by public services providers and to have an impact in improving public service delivery and informing public policy.	651	15.4	661	15.8
Strategic Aim 3: To continue to evolve and grow as an office, specifically planning for implementation of the Ombudsman's new powers should the National Assembly for Wales create a new Public Services Ombudsman (Wales) Act.	40	1.0	52	1.2
Strategic Aim 4: To be accountable for the service we provide and the public money we spend.	145	3.5	170	4.1
Net operating costs	**4,192**	**100.0**	**4,190**	**100.0**

6a. Property, Plant and Equipment

2018/19	Plant	Computers and other equipment	Furniture and other fittings	Total
	£000	£000	£000	£000
Cost or valuation at 1 April 2018	156	150	430	736
Additions	-	66	15	81
Disposals	-	-	(17)	(17)
At 31 March 2019	156	216	428	800
Depreciation At 1 April 2018	(156)	(131)	(321)	(608)
Charged in the year	-	(8)	(16)	(24)
Disposals	-	-	17	17
At 31 March 2019	(156)	(139)	(320)	(615)
Carrying amount as at 31 March 2019	-	77	108	185
Carrying amount as at 31 March 2018	-	19	109	128

2017/18	Plant	Computers and other equipment	Furniture and other fittings	Total
	£000	£000	£000	£000
Cost or valuation at 1 April 2017	156	182	415	753
Additions	-	5	15	20
Disposals	-	(37)	-	(37)
At 31 March 2018	156	150	430	736
Depreciation At 1 April 2017	(156)	(152)	(305)	(613)
Charged in the year	-	(16)	(16)	(32)
Disposals	-	37	-	37
At 31 March 2018	(156)	(131)	(321)	(608)
Carrying amount as at 31 March 2018	-	19	109	128
Carrying amount as at 31 March 2017	-	30	110	140

6b. Intangible Assets

2018/19	Information Technology £000	Software Licences £000	Total £000
Cost or valuation at 1 April 2018	328	52	380
Additions	172	-	172
Disposals	-	-	-
At 31 March 2019	500	52	552
Amortisation as at 1 April 2018	(321)	(52)	(373)
Amortisation charged in the year	(7)	-	(7)
Disposals	-	-	-
At 31 March 2019	(328)	(52)	(380)
Carrying Value as at 31 March 2019	172	-	172
Carrying Value as at 31 March 2018	7	-	7

2017/18	Information Technology £000	Software Licences £000	Total £000
Cost or valuation at 1 April 2017	328	71	399
Additions	-	-	-
Disposals	-	(19)	(19)
At 31 March 2018	328	52	380
Amortisation as at 1 April 2017	(310)	(71)	(381)
Amortisation charged in the year	(11)	-	(11)
Disposals	-	19	19
At 31 March 2018	(321)	(52)	(373)
Carrying Value as at 31 March 2018	7	-	7
Carrying Value as at 31 March 2017	18	-	18

In the opinion of the Public Services Ombudsman for Wales, there is no material difference between the net book value of assets at current values and at their historic cost.

7. Trade and other Receivables

	2018/19 £000	2017/18 £000
Amounts falling due within one year		
Prepayments	175	186
Trade debtors	-	-
Amounts falling due after more than one year		
Prepayments	1	3
Total	**176**	**189**

8. Cash and Cash Equivalents

Any bank balance held at the year-end must be returned to the Welsh Consolidated Fund. A figure of £20k (£32k in 2017/18) has been included within the accounts, being the net balance at the year end on all the bank accounts operated by the PSOW, irrespective of whether the individual account is in debit or credit. This balance will have to be repaid to the Welsh Consolidated Fund in 2019/20 under the Government of Wales Act 2006.

9. Trade Payables and other Current Liabilities

	2018/19 £000	2017/18 £000
Amounts falling due in one year		
Untaken annual leave	61	70
Deferred rent reduction	5	5
Welsh Consolidated Fund - unspent balances	20	32
Trade payables	15	24
Accruals	71	46
	172	**177**
Amounts falling due in more than one year		
Deferred rent reduction	24	28
Total	**196**	**205**

10. Provisions for Liabilities and Charges

	2018/19				2017/18
	Pensions for Former Commissioners	Dilapidation Costs	Other Costs	Total	Total
	£000	£000	£000	£000	£000
Balance at 1 April	260	277	-	537	544
Additional provision required	24	9	-	33	75
Discount rate movement	(2)	-	-	(2)	1
Provisions utilised in the year	(43)	-	-	(43)	(83)
Balance at 31 March	**239**	**286**	**-**	**525**	**537**

Analysis of expected timings of payment of provisions:

	2018/19	2017/18
	£000	£000
Payable within one year	44	43
Payable within 2 to 5 years	157	172
Payable in more than 5 years	324	322
Balance at 31 March	**525**	**537**

Pension provisions are calculated based on the National Life Tables for England and Wales issued by the Office of National Statistics. Later year pension increases are in line with GDP deflator information issued by HM Treasury. The discount factor has been amended to 0.29% for the financial year (0.10% in 2017/18) in line with the guidance issued by the Treasury. Two surviving spouses of former Commissioners remain as a pension liability.

Dilapidations were increased in 2018/19 in line with BCIS building indices for general building costs provided by PSOW's building consultants.

11. Reconciliation of Operating Cost to Operating Cash Flows

	Notes	2018/19 £000	2017/18 £000
Net operating cost		**(4,192)**	**(4,190)**
Adjust for non-cash items	3	51	63
Decrease /(Increase) in trade and other receivables	7	13	(26)
Increase/(Decrease) in trade and other payables	9	(9)	-
Movement in provisions	10	(12)	(7)
Movement in cash repaid to Welsh Consolidated Fund	8	12	2
Net cash outflow from operating activities		**(4,137)**	**(4,158)**

12. Non-Current Asset Expenditure and Financial Investment

	2018/19 £000	2017/18 £000
Purchases of property, plant and equipment	(81)	(20)
Proceeds of disposals of property, plant and equipment	-	-
Purchases of intangible assets	(172)	-
Net cash outflow from investing activities	**(253)**	**(20)**

13. Reconciliation of Net Cash Requirement to Increase/(Decrease) in Cash

	2018/19 £000	2017/18 £000
Net Cash Requirement:		
Operating activities	(4,137)	(4,158)
Capital Expenditure	(253)	(20)
	(4,390)	**(4,178)**
Financing from National Assembly for Wales	4,410	4,210
Repayment to Welsh Consolidated Fund	(32)	(34)
Increase /(Decrease) in cash and cash equivalents	**(12)**	**(2)**

14. Commitments under Operating Leases

	2018/19	2017/18
	£000	£000
Total future minimum operating lease payments on Building:		
Payable within one year	183	183
Within two and five years	732	732
More than five years	250	433
	1,165	1,348
Other:		
Payable within one year	12	20
Within two and five years	-	12
More than five years	-	-
	12	32
Total – all operating leases	1,177	1,380

15. Contingent Liabilities

None.

16. Capital Commitments

There were no capital commitments at 31 March 2019 (2017/18 Nil).

17. Related Party Transactions

The PSOW is headed by the Public Services Ombudsman for Wales and was established under the Public Services Ombudsman (Wales) Act 2005. The Ombudsman is independent of Government and the funding arrangements of the Office are set up to ensure that the independence of the Office is secured. The PSOW has had a number of material transactions with the National Assembly for Wales, HM Revenue and Customs (Tax and National Insurance payments) and the Cabinet Office (payments in respect of the Principal Civil Service Pension Scheme). During the year, no directors, key members of staff or their related parties have undertaken any material transactions.

18. Events after the Reporting Period

None.

Pensions Disclosures

Two pension schemes are operated on behalf of current staff – The Principal Civil Service Pension Scheme (PCSPS) and the Cardiff and Vale of Glamorgan Pension Fund (the Fund). There also remains an ongoing liability to meet the unfunded pensions of two dependant relatives of former Local Government Commissioners.

Civil Service Pensions

Pension benefits are provided through the Civil Service pension arrangements. From 1 April 2015, a new pension scheme for civil servants was introduced – the Civil Servants and Others Pension Scheme or alpha, which provides benefits on a career average basis with a normal pension age equal to the member's State Pension Age (or 65 if higher). From that date, all newly appointed civil servants and the majority of those already in service joined alpha. Prior to that date, civil servants participated in the Principal Civil Service Pension Scheme (PCSPS). The PCSPS has four sections: three providing benefits on a final salary basis (classic, premium or classic plus) with a normal pension age of 60 and one providing benefits on a whole career basis (nuvos) with a normal pension age of 65.

These statutory arrangements are unfunded with the cost of benefits met by monies voted by Parliament each year. Pensions payable under classic, premium, classic plus, nuvos and alpha are increased annually in line with Pensions Increase legislation. Existing members of the PCSPS who were within ten years of their normal pension age on 1 April 2012 remained in the PCSPS after 1 April 2015. Those who were between ten years and thirteen years and five months from their normal pension age on 1 April 2012 will switch into alpha sometime between 1 June 2015 and 1 February 2022. All members who switch to alpha have their PCSPS benefits 'banked', with those with earlier benefits in one of the final salary sections of the PCSPS having those benefits based on their final salary when they leave alpha. (The pension figures quoted for officials show pension earned in PCSPS or alpha – as appropriate. Where the official has benefits in both the PCSPS and alpha the figure quoted is the combined value of their benefits in the two schemes.) Members joining from October 2002 may opt for either the appropriate defined benefit arrangement or a 'money purchase' stakeholder pension with an employer contribution (partnership pension account).

Employee contributions are salary-related and range between 4.6% and 8.05% for members of classic, premium, classic plus, nuvos and alpha. Benefits in classic accrue at the rate of 1/80th of final pensionable earnings for each year of service. In addition, a lump sum equivalent to three years initial pension is payable on retirement. For premium, benefits accrue at the rate of 1/60th of final pensionable earnings for each year of service. Unlike classic, there is no automatic lump

sum. **classic plus** is essentially a hybrid with benefits for service before 1 October 2002 calculated broadly as per **classic** and benefits for service from October 2002 worked out as in **premium**. In **nuvos**, a member builds up a pension based on his pensionable earnings during their period of scheme membership. At the end of the scheme year (31 March) the member's earned pension account is credited with 2.3% of their pensionable earnings in that scheme year and the accrued pension is uprated in line with Pensions Increase legislation. Benefits in **alpha** build up in a similar way to **nuvos**, except that the accrual rate in 2.32%. In all cases members may opt to give up (commute) pension for a lump sum up to the limits set by the Finance Act 2004.

The **partnership** pension account is a stakeholder pension arrangement. The employer makes a basic contribution of between 8% and 14.75% (depending on the age of the member) into a stakeholder pension product chosen by the employee from a panel of providers. The employee does not have to contribute, but where they do make contributions, the employer will match these up to a limit of 3% of pensionable salary (in addition to the employer's basic contribution). Employers also contribute a further 0.5% of pensionable salary to cover the cost of centrally-provided risk benefit cover (death in service and ill health retirement).

The accrued pension quoted is the pension the member is entitled to receive when they reach pension age, or immediately on ceasing to be an active member of the scheme, if they are already at or over pension age. Pension age is 60 for members of **classic**, **premium** and **classic plus**, 65 for members of **nuvos**, and the higher of 65 or State Pension Age for members of **alpha**. (The pension figures quoted for officials show pension earned in PCSPS or alpha – as appropriate. Where the official has benefits in both the PCSPS and alpha the figure quoted is the combined value of their benefits in the two schemes but note that part of that pension may be payable from different ages.)

Further details about the Civil Service pension arrangements can be found at the website www.civilservicepensionscheme.org.uk

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity, to which disclosure applies.

The figures include the value of any pension benefit in another scheme or arrangement which the member has transferred to the Civil Service pension arrangements. They also include any additional pension benefit accrued to the member as a result of their buying additional pension benefits at their own cost. CETVs are worked out in accordance with The Occupational Pension Schemes (Transfer Values) (Amendment) Regulations 2008 and do not take account of any actual or potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are taken.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Compensation for loss of office

No staff left under Voluntary Exit or Voluntary Redundancy terms during the financial year.

Cardiff and Vale Pension Fund - Local Government Pension Scheme

The disclosures below relate to the funded liabilities of the Cardiff and Vale of Glamorgan Pension Fund (the Fund) which is part of the Local Government Pension Scheme (the LGPS). The funded nature of the LGPS requires the PSOW and its employees who are members of the scheme to pay contributions into the Fund, calculated at a level intended to balance the pension's liabilities with investment assets.

The PSOW recognises gains and losses in full, immediately through the Statement of Comprehensive Net Expenditure. In accordance with International Financial Reporting Standards, disclosure of certain information concerning assets, liabilities, income and expenditure relating to pension schemes is required.

No further employer contributions are required to be paid to the Fund by the PSOW.

Disclosure under IAS19 (LGPS funded benefits)

Introduction

The figures below relate to the funded liabilities within the Fund which is part of the Local Government Pension Scheme (LGPS).

Results under IAS 19 (LGPS funded benefits)

Date of the last full actuarial valuation	31 March 2016
Expected employer contributions next year (£M)	-
Duration of liabilities	12.8 years

Key assumptions (% per annum)

	31 March 2019	31 March 2018	31 March 2017
	%	%	%
Discount rate	2.40	2.60	2.50
RPI Inflation	3.30	3.20	3.10
CPI Inflation	2.20	2.10	2.00
Pension increases	2.20	2.10	2.00
Pension accounts revaluation rate	2.20	2.10	2.00
Salary increases	3.20	3.10	3.00

Mortality assumptions

The mortality assumptions are based on actual mortality experience of members within the Fund based on analysis carried out as part of the 2016 valuation, and allow for expected future mortality improvements. Sample life expectancies at age 65 resulting from these mortality assumptions are shown below:

Assumed life expectancy at age 65	31 March 2019	31 March 2018
Males		
Member aged 65 at accounting date	22.4	23.1
Member aged 45 at accounting date	23.0	24.2
Females		
Member aged 65 at accounting date	24.8	25.8
Member aged 45 at accounting date	25.9	27.2

Asset allocation

	Value at 31 March 2019			Value at 31 March 2018
	Quoted %	Unquoted %	Total %	Total %
Equities	0.0	0.0	0.0	0.0
Property	0.0	0.0	0.0	0.0
Government bonds	100.0	0.0	100.0	100.0
Corporate bonds	0.0	0.0	0.0	0.0
Cash	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0
Total	**100.0**	**0.0**	**100.0**	**100.0**

Reconciliation of funded status to Statement of Financial Position

	Value at 31 March 2019 £M	Value at 31 March 2018 £M
Fair value of assets	7.00	6.84
Present value of funded defined benefit obligation	5.26	5.32
Funded status	**1.74**	**1.52**
Unrecognised asset	(0.93)	(1.49)
Asset/(Liability) recognised on the balance sheet	**0.81** [1]	**0.03**

[1] The increase in asset value is as a result of a change in the LGPS regulations in May 2018. This permits the refund of a surplus on exiting the Fund which has been reflected in the calculations this year. The actuary's opinion is that this is a "one off" event and any adjustments in future years should be relatively small, particularly given that PSOW has a "gilts based" investment strategy which will reduce any volatility.

The split of the liabilities at the last valuation between the various categories of members is as follows:

Active Members	6%
Deferred Pensioners	12%
Pensioners	82%

Amounts recognised in Statement of Comprehensive Net Expenditure

	Period ending 31 March 2019 £M	Period ending 31 March 2018 £M
Operating cost		
Current service cost	0.02	0.02
Past service cost (incl. curtailments)	0.00	0.00
Settlement cost	0.00	0.00
Financing Cost		
Interest on net defined benefit liability (asset)	0.00	0.00
Pension expense recognised in profit and loss	**0.02**	**0.02**
Remeasurements in Other Comprehensive Income		
Return on plan assets (in excess)/below that recognised in net interest	(0.21)	0.12
Actuarial (gains)/losses due to change in financial assumptions	0.19	(0.01)
Actuarial (gains)/losses due to changes in demographic assumptions	(0.20)	0.00
Actuarial (gains)/losses due to liability experience	0.01	0.04
Adjustments due to the limit in paragraph 64	(0.59)	(0.16)
Total amount recognised in other comprehensive income (OCI)	**(0.80)**	**(0.01)**
Total amount recognised in profit and loss and OCI	**(0.78)**	**0.01**
Allowance for administration expenses included in current service cost (£M)	0.00	0.00

Changes to the present value of the defined benefit obligation

	Period ending 31 March 2019 £M	Period ending 31 March 2018 £M
Opening defined benefit obligation	**5.32**	**5.35**
Current service cost	0.02	0.02
Interest expense on defined benefit obligation	0.14	0.13
Contributions by participants	0.00	0.00
Actuarial (gains)/losses on liabilities – financial assumptions	0.19	(0.01)
Actuarial (gains)/losses on liabilities – demographic assumptions	(0.20)	0.00
Actuarial (gains)/losses on liabilities – experience	0.01	0.04
Net benefits paid out	(0.22)	(0.21)
Past service cost (incl. curtailments)	0.00	0.00
Net increase in liabilities from disposals/acquisitions	0.00	0.00
Settlements	0.00	0.00
Closing defined benefit obligation	**5.26**	**5.32**

Changes to the fair value of assets

	Period ending 31 March 2019 £M	Period ending 31 March 2018 £M
Opening fair value of assets	**6.84**	**7.00**
Interest income on assets	0.17	0.17
Re measurement gains/(losses) on assets	0.21	(0.12)
Contributions by the employer	0.00	0.00
Contributions by participants	0.00	0.00
Net benefits paid out	(0.22)	(0.21)
Net increase in assets from the disposals/acquisitions	0.00	0.00
Settlements	0.00	0.00
Closing fair value of assets	**7.00**	**6.84**

Actual return on assets

	Period ending 31 March 2019 £M	Period ending 31 March 2018 £M
Interest income on assets	0.17	0.17
Remeasurement gain/(losses) on assets	0.21	(0.12)
Actual return on assets	**0.38**	**0.05**

Funded Benefits

The following data was provided by the Fund Administering Authority and/or the Employer and has been used to produce the IAS 19 results in this report. Details of the split of assets between the various asset classes were also provided by the Fund Administering Authority and are shown above. We have also shown some of the intermediate calculations used in evaluating the figures in this report.

Active Members as at 31 March 2016

	Number	Total Pay £(M)
Total	1	0.05

Pensioner and deferred pensioner members as at 31 March 2016

Type	Number	Total Pension £(M)
Deferred members	5	0.02
Pensioners and dependants	11	0.23

Funded cash-flow data provided

	Months Provided	Amount Provided (£M)	Amount Used (£M)
Employer – Normal contributions	12	0.00	
Employer – Additional capital contributions	12	0.00	
Employer – Early retirement strain on fund payments	12	0.00	
Total contributions by the Employer			**0.00**
Employee – Normal contributions	12	0.00	
Employee – Added years contributions	12	0.00	
Total contributions by participants			**0.00**
Transfers in	12	0.00	
Other income	12	0.00	
Transfers out	12	0.00	
Retirement lump sums	12	0.00	
Other outgoings	12	0.00	
Death in service lump sums *	12	0.00	
Benefits paid (i.e. pension paid)	12	0.22	
**Net benefits paid out ** **			**0.22**

*	We have calculated the expected death in service lump sums over the year to be (£M)	0.00
**	The 'Net benefits paid out' figure includes an allowance for expenses of (£M)	0.00

Annualised pensionable payroll over the accounting period

Type	(£M) *
Period ending 31 March 2019	0.05
Period ending 31 March 2018	0.05

* The annualised pensionable payroll has been derived from the contributions paid over the relevant accounting period

Fund return

The overall Fund return over the accounting period has been calculated as 5.7%.

The asset return over the accounting period for the Employer has been taken as the index return on the published FTSE Index Linked UK Gilts over 5 years total return index, to reflect the notional low risk investment strategy which has been put in place with effect from 1 December 2016, in respect of the Employer.

Pensions for former Ombudsmen

With the agreement of the Secretary of State for Wales in 1991 and subsequent confirmation by Statutory Instrument 1993 No. 1367, Local Government Commissioners became eligible to join the Local Government Pension Scheme. However, the pensions of the three previous Local Government Commissioners remained the responsibility of the Public Services Ombudsman for Wales and are met through the Statement of Comprehensive Net Expenditure. At 31 March 2019 two surviving spouses of former Commissioners continued to receive a pension.

Pensions are increased annually in line with other pension schemes within the Public Sector. The basis of calculations of the Annual Pensions Increase has been changed from using the annual movement based on the Retail Price Index (RPI) to the Consumer Price Index (CPI). The amount of the uplift applied is normally set out in the Statutory Instrument Pensions Increase (Review) Order. This uplift for 2018/19 was 3%.

The total payments during 2018/19 were £43k (£41k in 2017/18). The liabilities arising out of the obligation to finance these pensions together with any dependant pensions has been calculated to be £239k (£260k in 2017/18). The calculation to determine the overall liability has been carried out internally using life expectancy tables for males and females in Wales obtained from the website of the Government Actuary's Department. A discount rate, from PES (2018), of 0.29% (0.10% in 2017/18) has been applied in accordance with the Treasury guidance that all pension liabilities should be discounted.

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