Meeting Date	**4th October 2018**	**Agenda Item**	**1b**
Report Title	**Princess of Wales Unit – Exception Report**		
Report Author	Jamie Marchant, Unit Director, Debbie Bennion, Unit Nurse Director and Dr Jonathan Goodfellow Unit Medical Director		
Report Sponsor	Jamie Marchant, Unit Director		
Presented by	Jamie Marchant, Debbie Bennion and Dr Goodfellow		
Freedom of Information	Open		
Purpose of the Report	The paper is a summary of key elements of quality, patient safety and experience indicators within Princess of Wales Service Delivery Unit.		
Key Issues	The paper is a detailed account of the key elements of quality and safety within POW and covers a wide range of areas for noting and consideration by the Committee		

Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
		✓	✓	

Recommendations	The Committee is asked to **note** the contents of the paper as well as the focus and approach of the SDU teams in the hugely important arena of patient safety, quality and experience.

PRINCESS OF WALES UNIT – EXCEPTION REPORT

1. INTRODUCTION

This paper provides a summary and exception report of Princess of Wales Service Delivery Units' quality, safety and patient experience indicators, issues and progress over the period since the last formal update to ABMU QPS Committee in October 2017.

2. BACKGROUND

The triumvirate of Princess of Wales (POW) Service Delivery Unit (SDU) were assembled as a team in late 2015. Over the past 3 years they have worked with clinical and managerial colleagues within the SDU (and wider) to embed approaches which support the values of the Health Board and seek to improve experience, quality and safety of patients. By the end of the first year in post, the enhanced monitoring of the Trusted to Care work by Welsh Government had been closed down and the POW team was active in the final reviews by Welsh Government to provide assurance on the approaches and management of issues on a daily basis.

Approaches to the quality, safety, and experience (QSE) agenda have been maintained and developed further since that time. The triumvirate still hold a weekly meeting with members of the governance team to review all complaints, incidents and other issues in that week. The information for that meeting is shared with the Service Groups. Service Group leads also meet with the governance team to discuss specific details pertinent to their services in the same way.

The SDU operates a Quality and Patient Safety Committee which is co-chaired by the Unit Medical and Unit Nurse Director (with the Service Director also in the membership). The Unit Directors have in the last 6 months reviewed the Terms of Reference for this group and informed by feedback from members of the Committee, members of POW Hospital Management Committee as well as feedback from an Internal Audit report. This has led to the Committee being separated into two forum which alternate each month, namely a "Business" agenda and a "Learning" agenda. There is some consistency across the membership but there is a larger level of medical representation on the "Learning" forum. Terms of Reference for the groups are attached as **Appendix 1 and 2**. Annual work plans for each forum have now been developed. The first meeting of this new arrangement was the Business Meeting held on the 18th September. This session also included representatives from the NHS Wales Delivery Unit in attendance as part of their follow up work.

These two forums under the banner of the one Committee will cover a very wide range of QSE areas as documented in the Terms of Reference. Underpinning this, a monthly report on key quality and patient safety indicators is provided to the POW Hospital Management Committee (HMC). The HMC also receives updates from the Medical Director and Nurse Director on other areas, indicators and issues.

The remainder of this paper seeks to provide information and assurance on a range of areas as well as highlighting key issues in an exception report approach. Whilst the following sections cover a range of indicators, it is the view of the SDU team that an exception report by nature may well focus on the more challenging areas and less so on the wide range of improvements which, in line with Health Board Values are examples of people working together as a team, and striving to always improve. The following is some examples, in no way exhaustive of the excellent work undertaken by teams within the SDU in the last year:

- JAG accreditation for the Endoscopy Unit/service – POW is the first ABMU hospital to gain the national accreditation of JAG for the endoscopy service, and also one of less than a handful in Wales. This has been the culmination of many years of preparation and planning and marks out the SDU as a provider of high quality care and service across a range of indicators
- The Gastroenterology Day Unit which was developed in 2017 continues to thrive and has seen 500 patients since opening 12 months ago. Over half of these patients would have otherwise been treated as inpatients or had to travel to Neath Port Talbot for their follow up treatments. The SDU removed 3 medical beds from the bed stock to deliver this service.
- In September 2018, the SDU has been able to appoint to a Nurse Practice Educator role for the Unit. This has been a structural and support gap and is pivotal in supporting and developing nurses across the SDU in developing their skills and continually improve the care they provide. It is also an aid in recruiting and retaining nurses.
- The Quality Assurance Framework process is in place within POW with 4 wards concluded and a 5th which was undertaken by ABMU corporately. The remaining ward areas are scheduled to be completed before the end of 2018. This approach is embraced by a wide range of colleagues both within the SDU and other services such as therapies and pharmacy.
- Whilst risks remain across a number of medical workforce areas which the SDU work on continually, it is pleasing to note the specific appointments of a joint appointment with Cardiff and Vale UHB of a Consultant Radiologist with special interest in Paediatrics. To support the risks around breast cancer diagnostics the SDU is also working to appoint a Consultant Breast Radiographer part time.
- POW is active in supporting the Learning Disabilities Pathway and is 100% compliant with LD care bundle in 2018 (47/47 patients) compared to 13/47 in 2016
- POW is pleased to be the single site in Wales currently for the Patient Knows Best system of providing patients with electronic access to their information in order to support their self-management of their condition. Initially the SDU is

piloting this within Heart Failure and Movement Disorders, as well as the COPD team and discussions are ongoing regarding the next specialties.

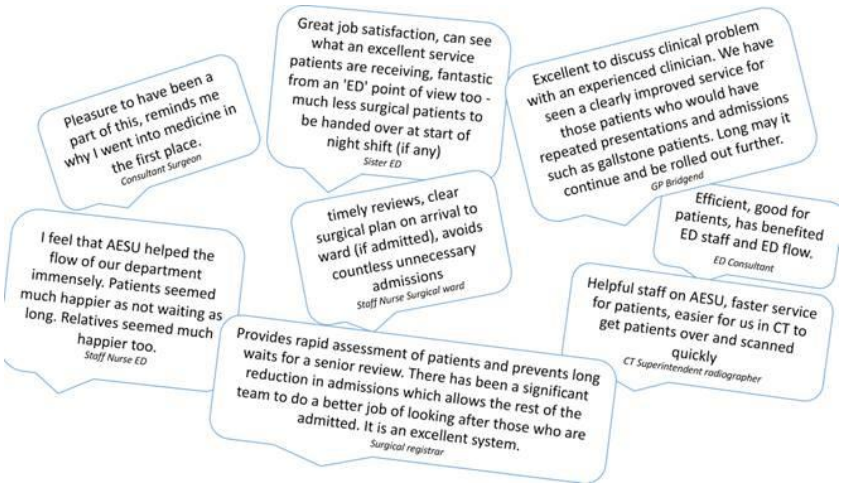
- POW SDU is working with colleagues across ABMU to support the improvement in Cardiac CT imaging as well as the TAVI demand within Morriston. As part of this, POW will recruit to maximise the level of work that can be done locally within the Catheter Lab and thus reduce such demand on Morriston which will be able to direct that time to tertiary work such as TAVI.
- Currently the Pre-operative assessment services provides a high quality service to number of surgical specialties for both Princess of Wales and patients operated on at Neath Port Talbot by surgeons from across ABMU. Building on best practice from elsewhere, Pre-operative assessment screening has been developed and has resulted in a significant increase in the pool of pre-assessed patients as well as more appropriate face to face patients slots with no additional resource required. Further roll out to a wider range of specialties is in progress.
- POW SDU continues to demonstrate active management and containment of the sickness levels across all staffing groups and has been commended at a recent Finance and Performance Committee for its sustained lower levels of sickness. Managing sickness is a key supporting aid of quality and safety as it enables the SDU to minimise any gaps in staffing on rosters and the potential consequences to patient care.
- Similarly the anaesthetic/pre-assessment department has fully embraced evidence based practice from centres of excellence across the UK and is providing a comprehensive Cardio Pulmonary exercise test for patients requiring major abdominal surgery to risk stratify them. This puts the patient at the centre by offering them an informed choice and optimising patients so that risks are reduced and patients are as fit as they can be for the day of surgery. In Quarter 1, 48 patients were put forward for CPET: 4 abnormalities have arisen requiring specialist referral (these would most likely have been cancelled on the day); 10 have been referred for IV iron to correct previously undiagnosed iron deficient anaemia (these would possibly have been delayed or cancelled on the day); 6 Echo referrals (patients had same day as we have a slot reserved) (may have been cancelled); 2 diagnosis of malnutrition and high calorie drinks prescribed (these patients are likely to have had delayed healing / recovery); 1 declined surgery following the consultation and risk assessment. Previously the vast majority would not have had a face-to-face meeting with an anaesthetist and very limited insight into their perioperative risk and little shared decision making
- Princess of Wales Care of the Elderly Team have been redesigning services to better meet the needs of Older People using our services. There have been a number of outputs to date, including the development of an Acute Frailty Ward and a Nurse Led/'Medically Fit' Ward. Ward 20 is now the Acute Frailty ward with effect from January 2017. This has seen patients admitted directly from the front door for management of the acute phase of their admission.

Daily consultant ward rounds and upskilled nursing staff, supported by experienced nurse practitioners have meant all patients receive an inpatient CGA and have allowed for more targeted intervention of acute illness. The aim is for patients to remain on ward 20 for approximately 7 days before either being discharged directly where possible or down streamed to ward 19 or 18 as appropriate. This change has demonstrated a sustainable step change in length of stay (LOS) for patients managed on this ward from 15.2 days in February 2017 to 10.2 days to date, three beds have been removed from the ward to support refurbishment in this time as well, Ward 19 is now the Medically Stable/Nurse Led Ward. A snapshot audit of the Care of the Elderly wards identified a high proportion of inpatients were medically stable and no longer needed routine consultant review. The decision was taken to review clinical management arrangements for ward 19 and move to a nurse practitioner led ward with a named consultant to support if required. The outcome has been a positive impact on culture within the team as well as greater than anticipated reduction in LOS from 43 days to 33 days since January 2018.

- From June 2018 to mid-July 2018 a test of change was undertaken to establish a model for ambulatory emergency general surgery at POW known as an AESU. The AESU was established in one room in the existing fracture clinic area and co-located with the Emergency Department and was overseen by a Consultant General Surgeon with senior Emergency Department staff and/or surgical nursing staff. The six week test demonstrated:
    - 42% reduction in emergency surgical admission equating to the equivalent of 2.3 beds.
    - Reduction in the lead time between attendance and discharge
    - Improvement in 4hr unscheduled care performance of between 2.63% and 5.39% on a daily basis
    - Reduction in the number of 4hr breaches due to senior surgical review to the lowest level since reporting
    - Significant level of positive feedback from staff and patients
- Patient and staff feedback is below. This approach has been proposed by the SDU with discussions for IBG investment. It does require capital investment and would take 6 months to develop but yields not only the benefits above but wider potential for ED to surge at times of demand and take more paediatric patients from Cwm Taf. This will be part of the POW input into the IMTP for 19/20 as well.

Patient Feedback on AESU

Staff Feedback on AESU



2.1 PATIENT FEEDBACK

Data below from 01.10.2017 – 31.08.2018

- Number of PALS contacts made: 2370
- Number of PALS cases turned to complaints: 36 (1.5% of the 2370 contacts made)
- PALS contacts ‘nipped in the bud’: 98.5%
- Number of complaints received in total: 503
- Number of complaints received transferred to redress: 13 (2.6%)
- Number of complaints received transferred to Ombudsman: 2 (0.4%)
- Complaints successfully resolved therefore, 99.6%
- Friends and Family number received: 12,522

- Number of patient contacts (ED attendances, outpatient and admissions as inpatient/daycase): in excess of 235,000

Complaint performance – Formal complaints - Responses within 30 days - % Compliance - HB target 80%

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Number of formal complaints received	**25**	**26**	**29**	**22**	**32**	**19**	**30**	**26**	**22**	**22**	**21**
% compliance of responses sent within 30 days	**72%**	**65%**	**66%**	**55%**	**94%**	**74%**	**73%**	**77%**	**91%**	**64%**	**86%**

The entire SDU team works very hard (as a collective) to prioritise thorough and prompt patient complaints as a natural extension of seeking to provide the best care we can provide. In spite of major pressures in core operational teams and notably in the Governance team (where the Head of Department role has been vacant since February 2018), performance is able to get closer to the target or pass it. The number of complaints does not widely vary but it is noticeable that one success of the PALs team is that less complex issues do not become formal complaints meaning that the complaints that are received, are more complex and thus take longer (and more people) to respond.

The SDU also works closely with the Community Health Council and a representative meets with the CHC Local Committee each month. The SDU has no outstanding actions from CHC reports and strives to respond promptly to all and thus ensuring services and patient care can be improved by the feedback provided by the CHC visits.

2.2 NEVER EVENTS

Disappointingly, the SDU has experienced a number of never events. Reporting processes within ABMU and Welsh Government have been followed consistently and the necessary learning and action have taken place.

Reference	Ward/area	Subject	Date of incident	Current position
72142	Ophthalmology Theatre	Wrong Implant/Prosthesis	03.01.18	Final investigation report and DU/WG approved action plan shared with patient. Incident closed. Learning from incident will be shared at Unit

Reference	Ward/area	Subject	Date of incident	Current position
				QPS on 16.10.18 at the Assurance and Learning Event on 23.10.18
70305	Ophthalmology Theatre	Wrong Implant/Prosthesis	21.11.17	Final investigation report and DU/WG approved action plan shared with patient. Case passed to Redress team for ongoing management under PTR. Learning from incident will be shared at Unit QPS on 16.10.18 at the Assurance and Learning Event on 23.10.18
77950	Ward 7	medication administered via wrong route	21.03.18	Final investigation report and DU/WG approved action plan shared with patient. Incident closed. Learning from incident will be shared at Unit QPS on 16.10.18 at the Assurance and Learning Event on 23.10.18
73314	Surgery	Wrong surgery completed	05.09.17	Investigation report awaited from the Health Board's Serious Investigation team.
75434/75485	Theatres	Retained swab	15.02.18	Investigation report awaited from the Health Board's Serious Investigation team.
76947	Theatres	Wrong Implant/Prosthesis	09.03.18	Final investigation report and DU/WG approved action plan shared with patient. Case passed to Redress team for ongoing management under PTR. Learning from incident will be

Reference	Ward/area	Subject	Date of incident	Current position
				shared at Unit QPS on 16.10.18 at the Assurance and Learning Event on 23.10.18
76951	Theatres	Wrong Implant/Prosthesis	09.03.18	Final investigation report and DU/WG approved action plan shared with patient. Case passed to Redress team for ongoing management under PTR. Learning from incident will be shared at Unit QPS on 16.10.18 at the Assurance and Learning Event on 23.10.18

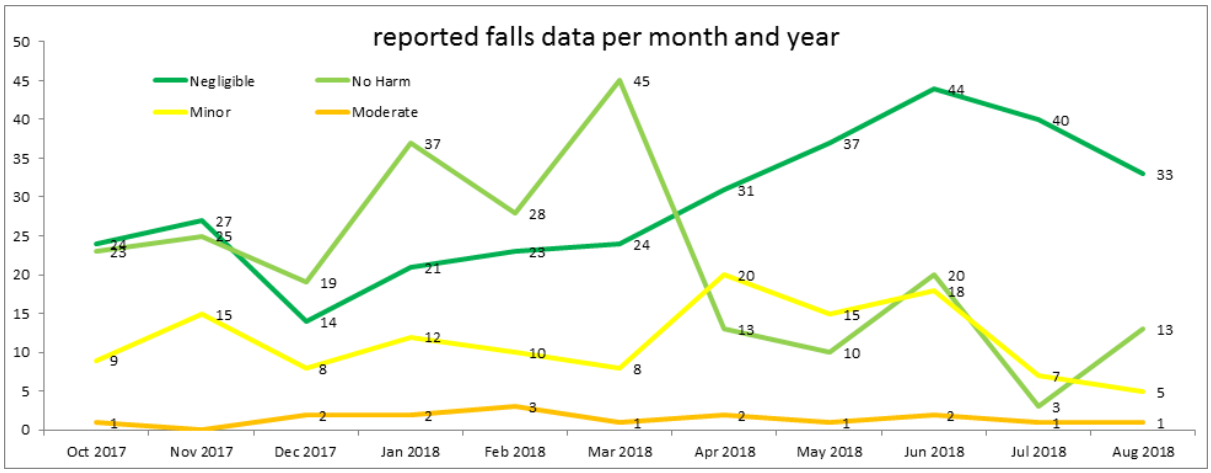
Following on from the investigations and reflection events held with the appropriate personnel. The collective reflection on these events was shared with multi professional attendance at the Audit Day in July for theatre staff, anaesthetists and surgeons to maximise potential for shared learning.

It has been recognised that there are themes around better team working and human factors awareness that could and should be improved upon in our theatres that could help to reduce the likelihood of serious incidents occurring. The Unit Directors have formally written to each Consultant Anaesthetist and Surgeon to remind them of their leadership role and the need for detailed, timely and collegiate team briefs prior to a list commencing to minimise any issues and protect patient safety.

A Team Resource Management Instructor has been appointed to provide human factors and team training for surgical, anesthetics and theatre teams on the 27.11.2018 at a joint audit day.

2.3 FALLS

Data from 01.10.2017 – 31.08.2018



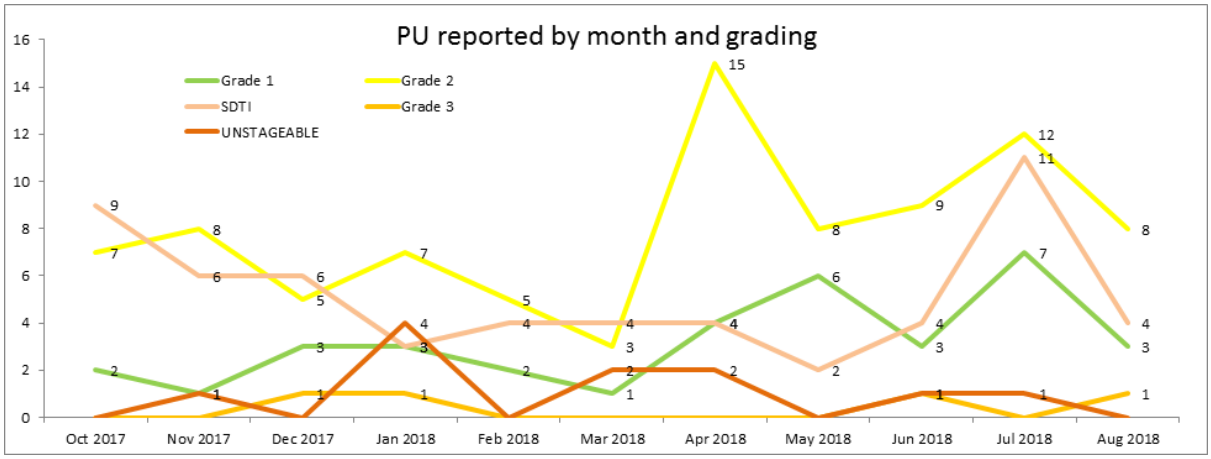
The Health Board has agreed a targeted action to reduce falls causing harm by 10%. The Unit Nurse Director at POW is currently also the Health Board lead for falls. POW has seen the number of falls causing significant harm decreasing by 16% and is also seeing a marked reduction in falls with serious Injury/ moderate harm. The graph above demonstrates spikes where falls that are negligible/no harm have been reported, these are often related to mechanical falls.

The POW SDU Falls Scrutiny Panel has proved invaluable in relation to lesson learnt and sharing of good practice. The panels are clinician led with an overall MDM approach and decision making as to whether the falls were unavoidable/ avoidable.

The revised Falls Policy developed by POW Unit Nurse Director, and Senior Matron was ratified in August 2018 by the Health Board.

2.4 PRESSURE ULCERS

Data below from 01.10.2017 – 31.08.2018



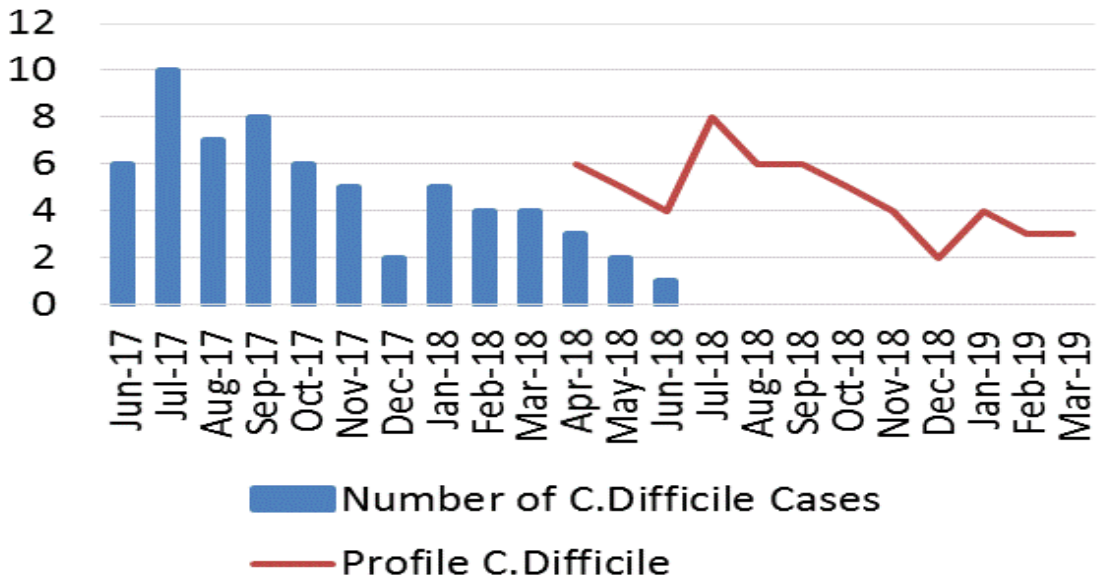
Reporting of Pressure Ulcers (PU) remains high and the graph identifies a significant increase in Suspected Deep Tissue Injury PU within July. There is a current issue with a vacancy within the Tissue Viability service provided to POW as they have normally supported the grading and validation of the Pressure Ulcers. The most recent information and patients need to be reviewed further.

The Scrutiny Panels provide an environment to share good practice and highlight lessons to be learnt but there are plans to develop a more multi-disciplinary approach involving dietetics, physiotherapy and other health professionals to provide a more holistic approach.

2.4 INFECTION CONTROL

C. difficile infection

The cumulative number of inpatients cases of C difficile infection (CDI) in the



Princess of Wales hospital from 1st April 2017 – 30th June 2018 is 61 cases.

Quarter 1 has shown a reduction in C diff rates (to a total of 5). Root Cause Analyses (RCAs) are showing demonstrable multidisciplinary learning, with continued excellent support from Microbiology locally. New Health Board wide antimicrobial guidelines were launched despite short implementation date.

Traditionally C.Diff infection had been detected and diagnosed using a 2 stage test, first the presence of GDH and confirmation with presence of C.Diff toxin. We now use a far more sensitive measure where we detect the DNA from C.Diff using polymerase chain reaction (PCR) technology. As a result of using PCR we are able to detect more cases of C.Diff.

In POW, a patient with a positive PCR result is managed in the same way as a patient with a C.Diff toxin positive result. The use of PCR has increased the detection rate for C.Diff and has led to more wards reaching the threshold for Periods of Increased Incidence (PII). This has resulted in a requirement for enhanced levels of cleaning for these wards in POW. This has been escalated to the Head of Hotel Services.

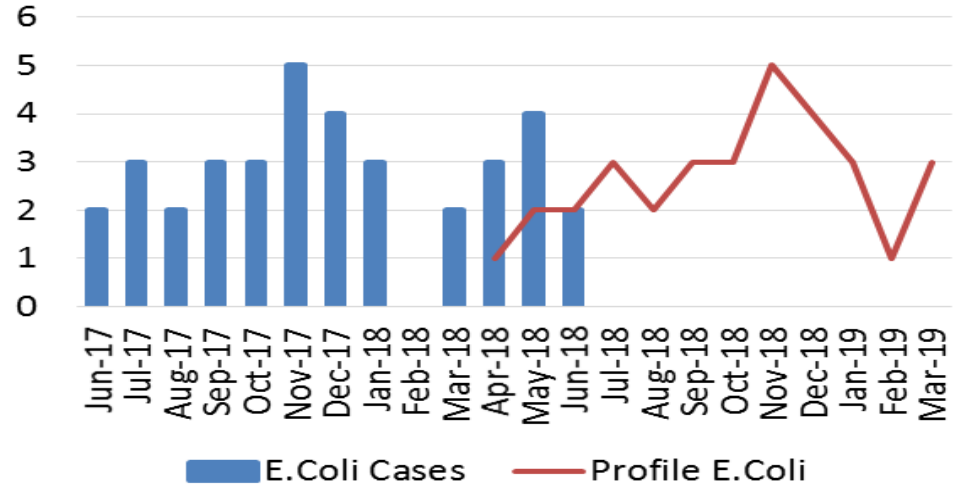
It is an important point to make because the increased detection of C.Diff and enhanced cleaning will reduce the burden of C.Diff spores in the environment and should result in a reduction of cases in the longer term. At present, the corporate infection control team report only the C.Diff toxin positive results to Welsh Government.

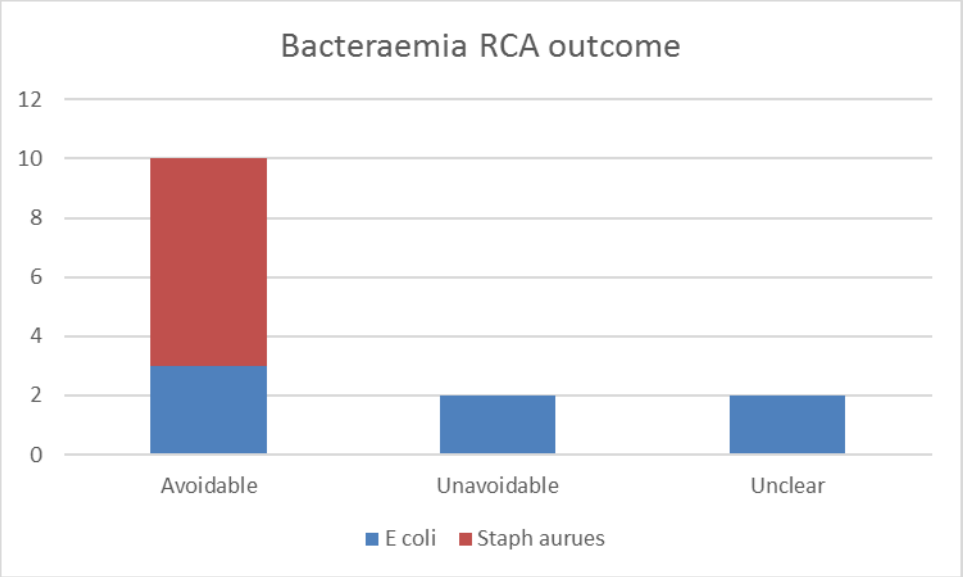
The SDU teams are continuing all existing approaches including early identification of patients with diarrhoea and subsequent isolation and treatment as required. The last year has also seen remedial environmental works completed on Ward 10 and Ward 7 as well as the refurbishment of Ward 20 which was an action committed to in 2014 following the Andrews Report. More recently flooring on Ward 19 which is an infection risk is being undertaken with conclusion this month.

The Unit Directors have flagged up that in their view a Health Board wide review of cleaning hours versus need is required along with a project aimed at standardising cleaning products. The increase in wards managed as in PII's is having significant impact on the support services, particularly the cleaning teams who are struggling to cover the enhanced cleaning required and the SDU has sought escalation of this need as the cleaning team still do not have dedicated (funded) response/outbreak/PII hours.

Ideally the SDU would also benefit from a decant ward to facilitate deep cleaning and more extensive ward refurbishments.

Healthcare acquired E.Coli Bacteraemia cases





The RCA meetings identified a number of cases where the bacteraemia was felt to be avoidable and key themes for learning. These learning points were fed back to the medical and nursing teams. Benefits of the Round the Table Root Cause Analysis meeting are showing demonstrable multi-disciplinary learning. The meetings have also identified a plan to ensure all wards use the bug stop question at Board Rounds

Antimicrobial guidelines

The SDU is active in the anti-microbial stewardship agenda, with the Unit Medical Director chairing the ABMU group. Internally the SDU has taken a multidisciplinary approach to improving the compliance. Reviews demonstrated that a significant proportion of patients were being inappropriately prescribed antibiotics for presumed urinary tract infection. A teaching program has been developed and is being used at ward rounds and board rounds promoting a screening tool. This will be presented at the QPS learning meeting.

All ward pharmacists have received the new additions to the gentamycin guidelines and had face to face teaching from the first week in June 2018. Ward pharmacists have supported the ward level education regarding gentamicin monitoring on a patient by patient basis. Health Board Infection Prevention Control team advised on the new guidelines and laminated copies of key parts of the guidelines have been provided to be displayed on wards.

Doctors (on inductions) have received teaching on the new guidelines. Pharmacy or microbiology are available for advice.

2.5 NURSE STAFFING ACT

A Multidisciplinary review has been undertaken to review compliance with ward establishments covered by the Act to gain an accurate position. This was as a

consequence of both hard and soft intelligence data sources indicating potential variability in operational management, potential risks future sustainability solutions and opportunities. The baseline review and analysis of all the triangulated methods has confirmed a number of facts, identified further improvement areas and established a clear methodology and recording structure to support future reporting responsibilities.

The SDU undertakes monthly reviews of sickness, vacancy, annual leave compliance, and bank and agency usage in line with the rostering policy and KPI's within it. In accordance with RCN guidelines, the SDU has supernumerary status of the ward manager.

The Peer Review findings were that the reviewers concurred with the NSA submission by the SDU for 4 wards within the SDU, but felt the remaining 7 wards submissions would **not** be sufficient to meet the requirements of the Act. All Peer review findings were submitted to the Interim Executive Director of Nursing & Patient Experience in June 2018.

In September 2018, the Health Board approved three wards within POW; of a funded uplift for the increase of Health Care Support Workers (HCSW).The up-lift of HCSW will reduce our risk in staffing levels verses acuity of our patients on those wards. The up-lift will also support the SDU in bridging the gap between the hours required within the act to nurse patients safely in accordance with the all-Wales Levels of Care.

2.6 SHIFT STANDARDISATION

The SDU consulted in the earlier part of 2018 to move to a standardised shift pattern across the SDU. Traditional patterns were also not set and a high level of variance and person specific arrangements were in place. The consultation (and subsequent implementation) moved all wards to a 12 hour shift pattern with the exception of three wards, namely Ward 18 and 19 (COTE) and Ward 11 (Gynae/Medicine). This move provides clarity and consistency for staff but also supports the robust use of rostering and subsequent compliance with KPIs and patient experience/care benefits. This also yielded a substantial financial cost reduction for the SDU and thus Health Board.

2. 7 VIOLENCE AND AGGRESSION WITHIN THE EMERGENCY DEPARTMENT

The SDU has had 2 visits from Health and Safety Executive (HSE) following a staff "concern" relating to violence and aggression in the Emergency Department. The SDU team have been working closely with colleagues from Security and Switchboard, as well as the staff members involved in the original concern to implement some developments and these were reported to HSE at a follow up meeting on 17th September 2018. Violence and aggression training has been implemented using a train the trainers concept and over 60% of staff have now had up to date training. This programme is being actioned at pace. One concern related

to the level of security presence within POW and thus the ability to have presence in ED. The Security team have now increased hours to provide two guards on site with one focused in ED. This presence is a very important step and gratefully received by the staff.

Another issue related to access and egress from the hospital out of hours. Historically, for many years, the access and egress was through ED. This compounded the number of people in and around ED even at the busiest times with no real control of this. In the early summer, following detailed conversations, the access and egress was switched to the main entrance with Switchboard monitoring/allowing access. Additional technology, including cameras was purchased. ED however could still be accessed by use of a code. Sadly code based entries are limited in their effectiveness as people share them even if they should not. This was therefore only the first step in improving demand through ED but this did not provide a secure lock down procedure or prevent inappropriate access. HSE were extremely keen at their recent meeting to see progress to a secure lock down department with swipe card access. The Service Director was able to confirm plans were in place and he needed to secure funding. Since the meeting this has been secured with the quick support of the capital team within ABMU and will now be procured and implemented. HSE have subsequently been briefed on this progress. It is the view of the Service Director following this meeting that progress has been noted by HSE as being positive and the risk of any enforcement action has been lessened substantially.

2.8 BRIDGEND CLINIC

Bridgend Clinic is the private unit within POW and has operated in this capacity for over 20 years. It is a relatively rare situation within NHS Wales to have a formal bedded unit (9 beds) for private work within a District General Hospital and therefore has a number of complications to sit within NHS governance rules. The Unit Medical Director raised a number of issues relating to Bridgend Clinic with the former Medical Director/Chief Information Officer in May 2018 and this was followed up in the subsequent Performance Review. The Executive Medical Director then wrote to the Service Director asking for a review of the governance relating to the Clinic. Meetings have been held within the SDU involving input from Information Governance, Internal Audit and the Director of Corporate Governance. A written update was provided to the Executive Medical Director in late July 2018 but the work of the review continues. The review of all information governance issues is likely to take a number of months as it will need to address governance issues across ABMU for private patient work in other ABMU hospitals but which are not undertaken using an arrangement such as Bridgend Clinic. At this stage the priority is to develop a formal Framework to underpin the governance which will include (not exhaustively);

- Admitting rights
- Suspension of admitting rights

- Fees schedule
- Medical indemnity cover/scope (and that ABMU will check)
- Sharing of information and outcomes
- Full engagement with PHIN
- Role of the new Bridgend Clinic Governance Group (Unit CDs/MD etc.)
- Role of Bridgend Clinic User Group (including representation on the Governance Group)
- Information Governance Roles and Responsibilities (for both the Clinic and individual private practitioners)
- Compliance and sharing with PHIN
- Framework will include the requirements of FCP10 Income & Charges, Section 6 Private Patients.
- Framework will also take into account the Internal Audit recommendations made from previous years.

This new draft framework will be discussed at a meeting on 21st September and then finalised as a high priority.

2.9 HEALTH INSPECTORATE WALES – SURGICAL SERVICES INSPECTION

POW was subject to an unannounced inspection by HIW in May 2018. This inspection was part of the national programme entitled Surgical Services and in the case of POW they decided to review the trauma pathway. This meant the focus was on the orthopaedic team, Ward 10 (the trauma ward) and Theatres within POW.

Following the visit there was a need for immediate assurance on 2 issues which were addressed accordingly. Upon receipt of the formal report the SDU has developed a corresponding Action Plan which has been submitted to HIW and accepted in July 2018. The SDU team are currently undertaking a routine review of the actions to ensure progress is being made (in accordance with the plan) and this will be reviewed formally at the SDU HMC in October. A large majority of the issues and actions are within the gift of the teams to be implemented however one key area has been flagged to ABMU corporately, namely the lack of an ortho-geriatric service. A proposal relating to this, which will require investment, has been submitted by POW to appoint a Consultant Orthogeriatrician (who is a Consultant Physician for Care of the Elderly with a special interest and training in orthopaedic conditions). The lack of a funded consultant ortho-geriatrician has hampered the development of a hip fracture pathway. A lead ortho-geriatrician, lead orthopaedic surgeon and a lead anaesthetist are key requirements in NICE guidance. Lack of ortho-geriatric presence will have a significant impact on perioperative care and subsequent length of stay and is demonstrated in the self-assessment undertaken.

From benchmarking it seems that POW is the only trauma admitting unit in NHS Wales and possibly (NHS within whole UK) which does not have such a supporting

service. This will be discussed formally with Executive Team members imminently to assess the next steps in progressing this.

2.10 GENERAL WARD AREAS

The SDU leadership team continually review all indicators of quality, safety and experience as well as staffing levels and other relevant workforce indicators. Wards which require more focused support are provided that at an individual or Ward level, depending on the need. A new Matron for Trauma and Orthopaedics has commenced in September 2018 and is actively supporting and directing Ward 10 as a focus of her time and the wider team. A new Matron is in place for Care of the Elderly who will provide support to all COTE wards with a specific focus on Ward 20

Ward 6 has been previously been flagged as a Ward with a number of challenges. A new Sister was appointed in 2016 and has led major progress in the Ward which now is fully staffed and performing well on indicators in spite of it being a pressured ward in terms of demand and patient acuity.

2.11 MORTALITY REVIEWS

The last report to HMC covered the period June 17 to June 18. The key findings were that although the number of deaths triggering a stage 2 review were low, there was still a significant delay in getting these completed. The Unit Medical Director has reminded colleagues that the undertaking of stage 2 reviews should be included in consultant job plans and any learning, e.g. presentation of case for discussion in mortality review/governance meeting may be included as evidence in the doctor's annual appraisal.

Following a report from Internal Audit it was noted that POW had 45 outstanding stage 2 mortality reviews from 2014/15. These have almost been completed with only 8 outstanding, with support from colleagues in ED and anaesthetics who volunteered to do these reviews. Any actions/lessons which arise from these reviews will be fed back to the relevant specialty for discussion in the audit/governance meetings and if appropriate discussed in the QPS learning meeting.

3. GOVERNANCE AND RISK ISSUES

The risk register was last formally reviewed by the Unit at the QPS Committee in July 2018. Since that date, and in line with new Terms of Reference the register will next be reviewed formally at the HMC in October. At present, leads for each risk are reviewing the risks to ensure accuracy of position, score and any mitigating management. The SDU will continue to escalate risks which are out with of the SDUs management control or where the risk cannot be contained/managed solely within POW SDU. Recent examples of escalation have been the risk relating to HSDU backlog and availability of surgical trays. This was assessed and scored by

POW SDU and then escalated to Morriston (host SDU for HSDU across ABMU). As a consequence of this action additional staffing hours has been deployed to reduce the score. The SDU has also escalated a risk relating to gaps in the leadership teams within POW at the moment. This is across medical leadership, matron and managerial and is impacting on the SDUs ability to deliver on and progress a range of issues which it would wish to. This is compounded by the Bridgend Boundary change and that is currently also affecting recruitment into these posts.

A risk which is currently escalating within POW is the impact of demand and patient need from HMP Parc Prison. ABMU has recently commented in the media on the issue as it pertains to demand on mental health services but this also impacting severely within POW. Emergency attendances and admissions come through ED and issues such as age profile increasing, drug impacts and impacts of violence within the prison present at ED. Patients who are admitted include an older profile than previously and can lead to very complex discharge planning with the private prison. This issue was discussed at HMC in September and a risk is being reviewed, scored and will be escalated through normal channels. This issue has also been flagged up early to Cwm Taf as one for the commissioning work stream to review

As noted, risks will be managed by the HMC and escalated accordingly. This paper does not in itself impact or increase any risk or governance issues.

The SDU has recently received the Internal Audit report on POW SDU Governance. Whilst the report has limited assurance and will be reported at Audit Committee, the SDU has responded actively to the Action Plan and working at pace to implement the recommendations and actions within the report.

4. FINANCIAL IMPLICATIONS

There are no specific financial implications as a consequence of this paper.

5. RECOMMENDATION

The Committee is asked to note the contents of the paper as well as the focus and approach of the SDU teams in the hugely important arena of patient safety, quality and experience.

Governance and Assurance							
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships		
		✓					
Link to Health and Care Standards ***(please ✓)***	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
		✓	✓	✓		✓	

Quality, Safety and Patient Experience

Whilst the entire content of this paper is related to quality, safety and patient experience, it is not a proposal for service change or development and is a summary of current position. There are no implications as a direct result of the contents of this paper

Financial Implications

This paper is not a proposal for service change or development and is a summary of current position. There are no financial implications as a direct result of this paper

Legal Implications (including equality and diversity assessment)

This paper is not a proposal for service change or development and is a summary of current position. There are no legal implications as a direct result of this paper and no requirement for an equality and diversity assessment

Staffing Implications

Whilst this paper includes an update on staffing factors, this paper is not a proposal for service change or development and is a summary of current position. There are no financial implications as a direct result of this paper

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

In line with the nature of this paper, as an exception report on current and recent indicators on quality and patient safety, this paper has not been reviewed for any long term implications nor the Well-being of Future Generations (Wales) Act 2015

Report History	This paper is presented as part of the cycle of Unit reporting to ABMU Health Board Quality and Patient Safety Committee. Whilst the issues within this report are reviewed in numerous fora within POW Unit, including the Hospital Management Committee and Quality and Patient Safety

	Committee, this paper has not been presented previously to any forum within POW or ABMU. POW Unit previously reported to the Committee in October 2017.
Appendices	Terms of Reference **Appendix 1** - Quality and Patient Safety Committee Business **Appendix 2** - Quality and Patient Safety Committee Learning