Patient Quality, Safety & Outcomes Committee

Tue 16 August 2022, 09:30 - 12:30

Microsoft Teams

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Verbal *Chair*

1.2. Apologies for Absence

Verbal *Chair*

1.3. Declarations of Interest

Verbal *Chair*

1.4. Draft Minutes of the last Meeting held on 7th June 2022

Attachment *Chair*

1.4 Draft PQSOC Minutes 7th June 2022 (Chair Reviewed).pdf (19 pages)

1.5. Committee Action Log

Attachment *Chair*

1.5 PQSOC Action Log August 2022.pdf (7 pages)

09:30 - 09:30
0 min

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

Verbal *Chair*

There are no items requiring Approval/Ratification or Decision

09:30 - 09:30
0 min

3. ITEMS FOR DISCUSSION

3.1. Urgent and Emergency Care Report

Attachment *Director of Operations*

3.1 Urgent & Emergency Care Report.pdf (7 pages)

3.2. Quality and Safety Outcomes Report, July 2022

Attachment *Clinical Executives*

3.2 PQSOC Performance Report - July 2022.pdf (30 pages)

3.3. Clinical Audit Strategy 2022 -2025

Attachment *Medical Director*

3.3 Clinical Audit Strategy 2022-2025.pdf (12 pages)

3.4. Clinical Audit Activity Report (Local and National), Quarter 1, 2022-23

Attachment *Medical Director*

3.4 National Clincal Audit PQSOC Aug 22 v2.pdf (11 pages)

3.5. Psychosis Audit

Attachment *Medical Director*

3.5 National Audit of Psychosis August 22 Final.pdf (6 pages)

3.6. Update on Cancer Services, and associated risks

Attachment *Medical Director*

3.6 Cancer Performance PQSOC- July 2022 0.2 (002).pdf (8 pages)

3.7. National Review of Venous Thromboembolisms (VTE) Report

Attachment *Medical Director*

3.7 VTE review SBAR.pdf (4 pages)
3.7a ABUHB WRP ACTION PLAN FOR IMPROVEMENT July 2022.pdf (8 pages)
3.7b WRP ABUHB Review - Prevention of VTE draft.pdf (47 pages)

3.8. Safeguarding Annual Report 2021/22

Attachment *Interim Director of Nursing*

Supported by Fiona Bullock, Deputy Head of Safeguarding

3.8 PQSOC- Safeguarding Annual Report 2021-22.pdf (5 pages)
3.8a Safeguarding Annual Report - 2021-22 - FINAL.pdf (33 pages)

3.9. Infection Prevention and Control Annual Report 2021/22

Attachment *Interim Director of Nursing*

Supported by Moira Bevan, Head of Infection Control

3.9 PQSOC- IPC Annual Report 2021-22.pdf (5 pages)
3.9a IPAC Annual Report 2021-22 - FINAL.pdf (42 pages)

3.10. LD Directorate Update

Attachment *Interim Director of Primary Care, Community and MH*

3.10 Learning Disability Directorate Update Paper.pdf (7 pages)
3.10a Appendix 1 Table of Recommendations From Improving Care Improving Lives.pdf (2 pages)
3.10b Appendix 2 Primary Health Liaison.pdf (1 pages)
3.10c Appendix 3 Learning Disability Directorate Update Paper.pdf (1 pages)
3.10D Appendix 4 Health Liaison Nurse Patient Stories.pdf (5 pages)
3.10e Appendix 5 Secondary Liasion docx.pdf (2 pages)

3.11. Committee Risk Report, July 2022

Attachment *Director of Corporate Governance*

3.11 PQSO Committee Risk Report Aug2022 V2.pdf (8 pages)
3.11a Master Risk Updates August 2022 V2.pdf (35 pages)

3.12. Committee Annual Workplan 2022-23

Attachment *Director of Corporate Governance*

3.12 PQSOC Work Plan August 2022.pdf (4 pages)

3.12b PQSO_Committee Work Programme 2022-23_Draft(2).pdf (7 pages)

09:30 - 09:30
0 min

4. For Information

4.1. Highlight Report: Patient Quality, Safety & Outcomes Group

Attachment *Director of Therapies & Health Science*

4.1 Patient Quality Safety & Outcomesd Committee Highlight Report from 13 07 2022.pdf (2 pages)

4.2. Healthcare Inspectorate Wales, 2022–2023 Operational Plan

Attachment *Director of Nursing*

4.2 HIW 2022-23 Operational Plan.pdf (2 pages)
4.2a 20220620 -FINAL Operational Plan - EN(2).pdf (22 pages)

4.3. PROMPT Wales Quality Assurance Review

Attachment *Director of Nursing*

4.3 PROMPT Wales Quality Assurance Review.pdf (5 pages)
4.3a ABUHB FINAL PROMPT WALES QA REPORT 220614JUN14.pdf (17 pages)

4.4. WHSSC QPSC Chairs Report to the 12 July 2022 Joint Committee - for information

Attachment *Director of Nursing*

4.4 Chairs Report Quality & Patient Safety Committee (QPSC) June 2022.pdf (26 pages)

09:30 - 09:30
0 min

5. Other Matters

5.1. Items to be Brought to the Attention of the Board and Other Committees

Verbal *Chair*

5.2. Any Other Urgent Business

Verbal *Chair*

5.3. Date of the Next Meeting: 18th October 2022, 9.30am – 12.30pm

Verbal *Chair*

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of Patient Quality, Safety & Outcomes Committee held on Tuesday 7th June 2022 at 9.30am via Teams

Present:

Pippa Britton	- Vice Chair (Chair of Committee)
Shelley Bosson	- Independent Member
Louise Wright	- Independent Member
Paul Deneen	- Independent Member
Helen Sweetland	- Independent Member

In attendance:

Rani Mallison	- Director of Corporate Governance
Rhiannon Jones	- Director of Nursing
James Calvert	- Medical Director
Peter Carr	- Director of Therapies and Health Sciences
Alexandra Scott	- Assistant Director for Quality and Patient Safety
Danielle O'Leary	- Head of Corporate services, Risk and Assurance
Nathan Couch	- Audit Wales
Andrew Doughton	- Audit Wales
Jonathan Thomas	- Directorate Manager, Theatre Services
Martin Silcox	- Senior Practitioner, Theatre Services
Deb Jackson	- Assistant Director of Nursing
Emma Guscott	- Committee Secretariat

Observers:

Rhian Gard	- Principle Auditor, NWSSP
Tracey Partridge Wilson	- Assistant Director of Nursing, Quality, Safety & Patient Experience
Linda Alexander	- Deputy Director of Nursing
Gwawr Evans	- Scheduled Care Manager

Apologies:

Leanne Watkins	- Director of Operations
Glyn Jones	- Interim Chief Executive

1	**Preliminary Matters**
PQSO 0706/01	**Welcome and Introductions** The Chair welcomed those present to the meeting and thanked individuals for their attendance, noting the Director of Corporate Governance would be joining the meeting later.
PQSO 0706/02	**Apologies for Absence** Apologies for absence were noted as above.
PQSO 0706/03	**Declarations of Interest** There were no Declarations of Interest raised in relation to items on the agenda.
PQSO 0706/04	**Draft Minutes of the Committee held on 5th April 2022** The minutes of the meeting held on the 5th April 2022 were agreed as a true and accurate record.
PQSO 0706/05	**Action Sheet of the Committee held on the 5th April 2022** The Committee reviewed those actions outstanding as recorded in the action log and noted the following: **'1910/13 Annual Assurance Report on Health & Care Standards: Nutrition and Hydration-** *An update inclusive of a map of where the facilities are to be received following the review.'* Peter Carr, Director of Therapies & Health Sciences, informed the Committee that the review was being undertaken by the facilities division, with the aim for completion by July 2022. Action to remain with an update to come back to the Committee. **'2112/04 Annual Assurance Report on Health & Care Standards: Nutrition and Hydration-** *Peter Carr informed members that the Health Board was not meeting NICE best practice model regarding a dedicated nutritional support team to include specialist nurses. A business case for a dedicated nutritional*

	support team is being developed and would be presented to the Executive Team for consideration, with an update to the Committee.' Peter Carr informed the Committee that further discussions had taken place with Divisions to establish future implementation of NICE Guidance. Action to remain, with a detailed update to be provided at a later date. The Chair requested a timeline for the remaining outstanding actions, PQSO 0504/06.3 and 0504/06.4. **Action:** Rhiannon Jones, Director of Nursing, highlighted that the Action Log status' column did not follow the 'Agreed Actions' key. This would be updated and amended to reflect the agreed key in readiness for the next meeting. **Committee Secretariat**
2	**Items for Presentation and Discussion**
PQSO 0706/06	**Audit Wales Review of ABUHB's Quality Governance Arrangements and Management Response** Nathan Couch, Audit Wales, provided the Committee with an overview of the purpose of the Quality Governance Arrangements review and its findings. The review had taken place between June and October 2021. The purpose of the review was to determine if the Health Board's operational and corporate governance arrangements supported the delivery of high quality, safe and effective services. To assess this, Audit Wales focussed on the Scheduled Care Division and the General Surgery Directorate, reviewing organisational culture and behaviours, strategies, structures and processes, and information flows and reporting. Key messages from the review were that the Health Board had clear, articulated corporate arrangements for quality governance and key areas of quality and safety; however, further improvement was required at Divisional and Directorate level. As outlined in the report, eight recommendations were made during the review. The recommendations were summarised as: • Risk Management – strengthen the maintenance and oversight of the Divisional Risk Register • Clinical Audit – complete work on the organisational clinical audit strategy, policy, and plan • Values and Behaviours – undertake work to understand why some staff feel they are not treated fairly or given feedback when reporting errors/near-misses or incidents • Patient Experience – ensure there are systematic arrangements for collating and acting upon patient experience • Putting Things Right – ensure the policy is rapidly reviewed and updated

	• Quality and Safety Framework – complete a review of the Quality Assurance Framework and ensure coverage of operational flows • Resources to support governance – undertake an assessment of resources in place for quality and safety across Divisions and determine the capacity of staff to undertake their role effectively • Coverage of quality and safety matters – ensure operational meetings provide coverage for quality and safety alongside finance and performance. All recommendations had been agreed with the Health Board, appropriate actions outlined, alongside agreed completion dates and Executive ownership. Audit Wales thanked the Health Board for the engagement during the review, with a special thanks to Rachel Manley, Corporate Nursing Assistant and the Directorate nursing teams for their support. Shelley Bosson, Independent Member, referenced *'There is also a need to review the extent that operational staff and management have sufficient capacity to effectively support quality governance.'* (Audit Wales, pg. 5) and queried if this linked to job planning and requested assurance if improvements in job planning would therefore have a positive impact. Rhiannon Jones, Director of Nursing, responded that there were designated leads in each Division for quality and safety, and that a review of resources would be undertaken by Clinical Executives and divisional leads to assess any perceived infrastructure gaps. Paul Deneen, Independent Member, requested clarity on how the recommendations would be monitored. Rhiannon Jones indicated that these recommendations would be monitored through the Audit, Risk and Assurance Committee recommendation tracker and the Patient Quality, Safety and Outcomes Committee. It was agreed that a report highlighting progress against each recommendation to be presented to the Committee in October 2022. **Action: Rhiannon Jones/Linda Alexander** The Chair welcomed the report in October and requested a verbal update on progress against each recommendation at the next Committee meeting in August 2022. **Action: Rhiannon Jones/Linda Alexander** The Committee was assured that although the Audit Wales review focused on Scheduled Care, the results would be shared with all Divisions, along with an assessment of capacity and resources across

	all Divisions, to encourage organisational learning and promotion of best practice. Andrew Doughton, Audit Wales, informed members of planned work to produce a National Report scheduled to be published in Autumn 2022, which would address the following: • Key themes and messages taken from reviews across Wales. • National arrangements with Welsh Government (WG) and wider NHS partners. • Progress made against quality improvement, aligning with new Welsh Government legislation, relating to the Duty of Quality and Candour, which was due to be implemented in Spring 2023. The Committee **NOTED** the report for **ASSURANCE** and welcomed an update on progress in October 2022.
PQSO 0706/07	**Theatres Safety Programme Update** Rhiannon Jones, Director of Nursing, informed the Committee that the presentation on the Theatres Safety Programme related to concerns regarding an increase in 'Never Events' in surgical and theatres directorates. Marcus Silcox, Senior Practitioner in Theatre services, and Jonathan Thomas, Directorate Manager for Theatre services, provided an update on the work being undertaken in theatres and scheduled care, relating to theatre safety. The Committee was informed that a 'Never Event' was defined as "a preventable serious incident," and that national guidance and/or safety recommendations should be implemented by all health care providers to avoid such incidents occurring. Since July 2020 there had been 19 'Never Events' within the Health Board; 11 of which occurred in a theatre and within the theatre directorate. As a result of this, several initiatives had been implemented, including a Theatre Safety Group, and a Theatre Safety & Compliance programme, containing 23 workstreams, overseen by programme leads. The workstreams provided assurance through the Health Board by identifying areas of elevated risk and areas that required enhanced or ongoing support. As part of the presentation, the following key points were highlighted to the Committee: • The objective of all workstreams was to reduce the number of Serious Incidents and Never Events. • Through utilisation of audit tools, the Health Board would benchmark its practice against national recommendations and guidelines.

	• Robust processes in relation to incident management and organisational learning would provide the Health Board with an opportunity to produce constructive feedback and support to staff who used the DATIX system to report incidents. The Theatres Directorate was commended for excellent standards and practice during the Health Board's internal audit of Medicine Management, which was undertaken in May 2022. The Committee was informed that the report had determined a reasonable assurance level and would be presented to the Audit, Risk and Assurance Committee in line with due process. Paul Deneen, Independent Member, requested assurance around the following: • In relation to the numbers of patients who had utilised the Health Boards theatre services in comparison to the number of 'Never Events', whether the Health Board was an outlier in this area? Rhiannon Jones informed the Committee that the Health Board was an outlier in 2018/19, and this had triggered the workstreams being undertaken at present. Although there had been a recent spike, feedback from the Delivery Unit did not indicate that the health Board was currently an outlier, with the possibility that the spike could be linked to positive reporting due to the utilisation of the new 'Once for Wales' concerns management system and the revision of the Datix reporting systems. Jonathan Thomas informed the Committee that all patients were logged on the Ormis Theatre Management System. From 2019 to 2020, approximately 41,000 patients were treated in the Health Boards theatres. • Was there an appropriate level of communication and openness between medical professionals and patients in theatres? The Committee were informed that for each Never Event there was a robust process, with an open and transparent line of communication between staff and patients. It was discussed that there was room for improvement around communication across the Health Board, and that work was underway to address this. The Committee noted that some Clinical leads had raised concerns in relation to the increase in 'Never Events', in particular the patient misidentification incidents. Additional communication tools had been put in place to remind staff of the importance of following processes for patient identification to further improve outcomes and promote patient safety. Committee members supported the 'Human Factor Training' workstream as outlined in the presentation. Peter Carr, Director of Therapies and Health Sciences, discussed how theatre safety was a

	team responsibility and welcomed the multi-disciplinary approach, Peter Carr highlighted that the registered workforce in these areas is highly skilled, and that the Health Board had an obligation to provide a learning environment that promoted trust, regular mentoring and support of staff and highlighting training needs and gaps when appropriate. The Chair queried if well-being support for patients and staff was offered when 'Never Events' or Serious Incidents occurred. It was confirmed that each individual case was assessed and if further psychological support were deemed appropriate, a referral would be made for the patient concerned. A formal review process for staff was in place and signposting to well-being services formed an aspect of the template. James Calvert informed the Committee that patients and families are assigned a key link contact for support and that 'lay' summaries and glossaries are produced alongside reports to encourage transparency and enhance understanding. The Committee thanked Jonathan Thomas, Marcus Silcox and the teams for the excellent management response and presentation.
PQSO 0706/08	**Covid-19 Concerns and Claims: The National Framework & Investigative Process** Rhiannon Jones, Director of Nursing, supported by Deb Jackson, Assistant Director of Nursing, provided the Committee with an overview of the Covid-19 investigative framework. The Committee received a presentation of the Health Board's expectations. The following was discussed: • The Covid-19 investigative framework is a national framework. There was a Welsh Government requirement for all incidents of nosocomial (hospital acquired infections) Covid-19 to be investigated. Funding had been received across Health Boards in Wales to support a Covid-19 investigation team, with a two-year timeframe. • A three-stage, Executive led standardised approach for Covid-19 investigation was in place: o identification o assessment, and o investigation • The total number of health acquired incidents from February 2020 to April 2022 was noted as 2317, with the highest numbers recorded between December 2021, to April 2022 (wave 4). • There was a requirement for 15.2 whole time equivalent (WTE) multi-disciplinary staff to support the investigation. The recruitment process had commenced, with interviews held week

	commencing 30th May 2022. A Business and Performance manager had been successfully appointed and would be responsible for the appointment of remaining required staff. • It was noted that the Health Board would be providing additional support for staff and families during this process through a clinical psychologist. Louise Wright, Independent Member, queried if the investigations included staff who had contracted nosocomial Covid-19. Rhiannon Jones informed the Committee that this process was for patients only, however ongoing discussions had taken place and separate investigations would take place for staff members. Paul Deneen, Independent Member, queried the if the three-stage approach for Covid-19 investigation was an All-Wales approach. Deb Jackson responded that this was a National Framework followed throughout Wales. The committee was further advised that if probable harm was identified as part of the investigations, then legal teams would form part of the multidisciplinary scrutiny panel, following the Welsh Risk Pool process. Shelley Bosson, Independent Member, queried if the Health Board was an outlier in relation to anticipated challenges regarding recruitment. Required recruitment numbers varied across Health Boards and to ensure delivery of robust investigations within the two-year required timeframe, Aneurin Bevan University Health Board required a large, multidisciplinary team. Rhiannon Jones discussed that that the relevant number of clinical investigators had been recruited. There was a requirement for investigations to commence prior to all recruitment posts being filled, due to time restraints. Helen Sweetland, Independent member, queried if there had been additional funding given to support the investigation process. Rhiannon Jones informed the Committee that Welsh Government had provided additional funding of approximately £750,000 to support the investigative process. The Chair requested that regular updates on the investigation process and progress would be monitored through the Committee. Rhiannon Jones suggested that a report be presented in January 2023, with regular updates to the Committee to be included as part of the standing item, Patient Quality, Safety and Outcomes Report. **Action: Rhiannon Jones/Linda Alexander/Secretariat** The Committee thanked Deb Jackson for the overview, noting the challenges in relation to recruitment and acknowledged that investigations would commence in June 2022.

PQSO 0706/09	**Learning from Death Report** James Calvert, Medical Director, supported by Alexandra Scott, Assistant Director for Quality and Patient Safety provided the Committee with the report. James Calvert reminded the Committee that the Medical Examiner (ME) role was set up as a national recommendation taken from the Shipman Inquiry 2005, to provide independent scrutiny of deaths. The Committee was informed that by the end of 2022, there would be a statutory requirement for all deaths in Wales, in both primary and secondary care, to be subject to scrutiny by the ME. James Calvert discussed the report, noting it included contextual information of overall performance. Aneurin Bevan University Health Board had received 169 referrals from the ME between 1st December 2021 and the 1st May 2022. The Committee was informed that the Health Board's multidisciplinary Mortality Screening Panels regularly meet to assess all referrals from the ME. Medical Directors from across Wales had also met to discuss the ME service and highlighted how great value can be taken from identifying and themes/clusters. Alexandra Scott highlighted the mortality clusters that had been identified through mortality data. The data indicated that there might have been a correlation between the restart of some elective surgeries, however, Health Board mortality data that related to elective and emergency procedures showed the Health Board was in a good position against peers in Wales. Alexandra Scott informed the Committee that the National Emergency Laparotomy Audit (NELA) had previously identified Royal Gwent Hospital as a mortality rate outlier. Improved, real-time reporting through NELA, now showed the position had significantly improved, supported by the Health Board's Quality Improvement Programme. The Committee was informed of an additional theme that had been highlighted from the ME, with several referrals received for patients with Learning Disabilities cared for in acute hospital settings. As a result of this, a thematic review was underway. The Health Board had taken immediate action and the Learning Disability Steering Group had been reconvened, in order to monitor Health Board compliance with the 1000 Lives care package and promote a more collaborative approach to providing care. The Chair commented that the Committee was assured that recognised themes were being investigated and noted that work was underway to

	improve patient experience and care with all patients, particularly patients with Learning Disabilities (LD). The Committee requested assurance that the learning was shared throughout the Health Board to all staff in a patient care setting. Alexandra Scott informed the Committee that the Learning Disability Steering Group' terms of reference capture an evidence-based approach for caring for patients with a LD in acute settings, and that learning had been taken from the ME referrals. Rhiannon Jones, Director of Nursing, suggested that the issues raised by the ME in relation to LD patients highlighted the need for further monitoring of progress for improvement of patient care for individuals with a LD. A future update on the review of patient care for individuals with a Learning Disability to come back to the Committee. Chair to discuss request with Chris O'Connor outside of the meeting. **Action: Chris O'Connor/Chair/Secretariat** The Committee **NOTED** the report for **ASSURANCE**. The Committee acknowledged this was the final meeting for Alexandra Scott and thanked her for her contribution to quality and patient safety within the Health Board.
PQSO 0706/10	**Healthcare Inspectorate Wales (HIW) Unannounced Visit to the Grange University Hospital (November 2021)** Rhiannon Jones, Director of Nursing, provided an update report for assurance alongside an overview of the HIW unannounced visit findings. An update on progress against each recommendation was also included in the report. A letter had been received (included in papers) from HIW requesting an update on progress against the recommendations. The Committee was advised that this had been triggered by ongoing system pressures in Urgent Care. The Health Board had responded to the HIW letter, providing twenty-five pieces of evidence to support the implementation of the recommendations. The HIW visit took place over a three-day period, during which patients in Urgent and Emergency care for both adults and children were reviewed. Overall, HIW were not assured that all systems and processes in place were sufficient to ensure all patients were consistently receiving acceptable standards of safe an effective care, although the hard work of staff was recognised. It had been identified until the flow of patients had been addressed in the Emergency departments that the Health Board may find it difficult to address the recommendations made. The Health Board acknowledged that Urgent and Emergency care remained a priority and a current significant risk. HIW observed that staff were

	striving to provide safe and effective emergency care for patients within the busy units, although staff survey feedback indicated that some staff felt that they could not deliver the care they wanted to. Of the patients asked, 84% rated their experience as good or very good, notwithstanding significant issues with patient feedback on length of waiting times. The Committee were informed that the immediate assurance letter from HIW was received a few days after the visit, raising concerns around visibility of patients in waiting areas, infection control issues within the Covid corridor and insufficient Resuscitation trolley checks. The report outlined the immediate improvements made, and the Health Board response. This consisted of 12 recommendations and progress against each. HIW had also identified an additional 59 recommendations as part of the improvement plan. Based on the 71 recommendations, there were 112 actions. At the time of the meeting there were 15 actions outstanding, all of which would be completed by October 2022. A further update on the final response to HIW, progress and compliance against actions to come back to the October Committee meeting. **Action: Rhiannon Jones/Linda Alexander/Secretariat** The Chair requested information on the extra waiting space for the Emergency Department at the Grange University Hospital, as outlined in the report. Rhiannon Jones informed the Committee that this has been completed, however there were ongoing discussions and concern raised from clinical teams around the use of the space with current staff deficits. It was agreed that a further discussion to take place at the next Board development session. **Action: Rhiannon Jones/Rani Mallison** Shelley Bosson, Independent Member, queried why the infection control issue and signage issues outlined in the report were not factored into the new build. Rhiannon Jones informed the Committee that the infection control issue was due to system pressures and corridor areas being utilised to accommodate patients; corridor areas were not factored in for patient use in the initial design of the Grange University Hospital. The Health Board had recognised the need for a sink area and a request was in for a sink with the works and estates department prior to the HIW visit. Signage standards were followed, however on reflection the comments have been addressed. Shelley Bosson informed members of an upcoming meeting with Gareth Hughes, Divisional Director of Facilities, during which the concerns around signage would be raised and feedback would be provided to the Committee as part of the progress update at the next meeting. **Action: Secretariat**

	Paul Deneen, Independent Member, queried if staff feedback relating to the Grange University Hospital had improved. Rhiannon Jones informed the Committee that system pressures and recruitment issues continued to influence staff morale; however, progress had been made around nursing recruitment. In addition to this, a recent staff survey had been completed, the results of which would be shared with the People and Culture Committee in due course. **Action: Rhiannon Jones/Secretariat** Paul Deneen discussed the several hundred patients over capacity in hospitals who were awaiting care packages for discharge and the further pressure exerted on staff as a result. James Calvert, Medical Director, reiterated that staff were currently working under immense pressure, and highlighted that this was the case on a national level. The Committee were reminded that the data presented throughout the meeting showed improvements in outcomes for the Health Board, noting the requirement to focus on improvements but also noting the positive changes. The Committee noted the requirement for 'a whole system' approach to further improve patient care. The Committee thanked staff involved for their work and welcomed an update on the final response to HIW to be presented to the Committee at the October meeting.
PQSO 0706/11	**The Independent Review of Maternity Services at SATH (The Ockenden Review)** Rhiannon Jones, Director of Nursing, gave an overview of the final Ockenden Report, produced on the 30th of March 2022. The second, and final report identified several new themes intended for wider sharing across NHS England. The paper outlined the key points from the report and identified actions being taken in Wales to review the report and extract learning. The Chief Nursing Officer for Wales had written to each Health Board requesting an assessment of maternity services, to include relevant elements from the Ockenden Report, the previous review of maternity services conducted by HIW, and in addition, compliance with recommendations and actions from the Cwm Taf Morgannwg maternity review. The self-assessment would be rag rated, with a focus on areas that are red or amber. The Health Board has complied with the Welsh Government (WG) request and submitted a self-assessment. The self-assessment was executive led and involved multidisciplinary members of the Families and Therapies Division. No red rag rated areas were reported in the self-assessment, however, there were several amber areas flagged. The Health Board had requested guidance from WG

	regarding examples of evidence in relation to the amber areas. A report would be provided to the Committee at a future meeting, including the WG feedback to the Health Boards response. **Action: Rhiannon Jones/Linda Alexander/Secretariat** The Committee was informed that there was a national event planned for July, during which the Neonatal and maternity Board, WG and all Health Boards would review the collective finding from the self-assessments and plan the required improvement actions. The Committee was assured that the Health Board had undertaken the self-assessment and were reviewing services locally through the Health Board Maternity Services Assurance Group. It was agreed that a copy of the Health Board's self-assessment would be shared outside of the meeting. **Action: Rhiannon Jones/Linda Alexander** James Calvert highlighted the Health Board's positive culture and open approach to reporting that encouraged clinical staff to speak out when deemed necessary. Rhiannon Jones discussed an example of this when Health Board midwives formally reported their concerns, demonstrating the culture of an open approach to reporting, resulting in clinically driven decisive action. The Committee **NOTED** the report for **ASSURANCE**.
PQSO 0706/12	**Patient Quality and Safety Outcomes Report** Rhiannon Jones, Director of Nursing, provided an overview of the Outcomes report. Reporting within the Health Board continued to adopt a proportionate approach due to sustained challenges and therefore focussed on high-risk matters. The Committee's previous request of using arrows to demonstrate progress on the 'status at a glance' report, and the addition of a glossary at the end of the report had been fulfilled. The Committee was informed that two areas of concern continued to be 'red' RAG rating: Stroke Services and Urgent Care. Two additional red rated areas to note, were Never Events and Cancer Services. There has been an addition to the risk list which related to 'inter-site hospital transfers', falling under the 'safe care' category and currently rated as amber.

	Cancer performance had declined with challenges to manage backlog, compounded by increasing referrals. Cancer harm reviews have commenced to consider the impact of breaches in patients' care. In respect of Infection Prevention and Control there had been a reduction in the number of inpatients diagnosed with Covid with minimal outbreaks on hospital wards and a positive position in care homes. There had been an improvement in the rate in Colostrum Difficile (CDif), noting the occurrence remains above target, mirrored across Wales. Infection control teams were undertaking reviews to further understand this position. The report included options to implement a Child and Adolescent Mental Health crisis hub. A full report on this to come back to a future Committee meeting. **Action: Rhiannon Jones/Linda Alexander/Secretariat** A draft report had been received via Welsh Risk Pool, following their review of the Venous Thromboembolism. The Health Board was undertaking a review of the current position and action plan and an update would be submitted to Welsh Risk Pool by July 2022. It was agreed that an update would be presented to the August Committee meeting. **Action: Rhiannon Jones/Linda Alexander/Secretariat** The Committee was informed that the Urgent Care system remained under sustained and continued pressure. WG has published the requirements for '6 Goals for Urgent and Emergency Care' and an extraordinary meeting of Board members and Executives had been scheduled to discuss this and the Health Board response for June 2022. An ongoing review of the Urgent Care Transformation Board was in progress, and it had been proposed that the meeting would be redesigned to focus on the 6 goals. The system pressures had resulted in detrimental impact on patient experience, with some patient safety risks with lengthy delays on patient flow, together with delayed ambulance response times in the community. Positive improvements were discussed in Urgent and Emergency care, including previous risks identified in the Minor Injuries Units had eased, with increased staffing, fewer reported incidents a decrease in very unwell patients self-presenting. The Committee noted that an extraordinary meeting had been held in May 2022 with Executive leads, to create a plan for improvement for Urgent and Emergency Care. Whilst outcomes had improved, further work was required.

	Peter Carr, Director of Therapies and Health Science, informed the Committee of the current challenges within the Stroke pathway and how this linked to system pressures on the Urgent Care pathway Further progress had been made on protecting the Hyper Acute Stroke Unit (HASU) for stroke patients, noted as a previous challenge when the HASU was utilised to accommodate non-stroke patients. This will enable therapies colleagues to immediately assess patients on arrival at the Grange University Hospital. As part of the learning and improvement work for stroke services, the Health Board had invited an external organisation, 'Getting It Right First Time' (GIRFT) to review services. This review had taken place and the Health Board was awaiting a formal report containing recommendations. The full report and management response would come back to the Committee, **Action: Peter Carr/Secretariat** Additional work would be undertaken to review the provision of stroke services within current resource allocation against best practice. Expansion of the multidisciplinary teams wherever possible would be considered. ***Louise Wright, Independent Member, left the meeting.*** James Calvert, Medical Director, shared an update on cancer services with the Committee. The following key points were noted: • The Health Board was working towards improving the '62 days from referral to treatment' cancer pathway target. Some of the influencing factors were discussed, including staffing issues and a significant increase in referrals. • In comparison to pre-Covid data, there had been an overall increase in cancer referrals of 15-20%, increasing to 30% for some lower GI and Breast cancer services. • Delayed referrals, and patients were presenting with cancers at an advanced stage, had been exacerbated by Covid. To help combat this, the Health Board had introduced a programme called 'See the Signs', providing guidance on possible early signs of cancer to Primary Care teams and the public. • Single cancer pathways provide scans for patients on first point of contact with clinicians. This service had increased demand on cross sectional imaging, causing some delays in reporting, mirrored nationally. Wales's Radiology Academy has been proactive in increasing radiologist training to address increased demand. • The unavailability of sufficient outpatient appointments has also influenced cancer pathways. Work is underway at Directorate level to address this, noting that there has been a slight improvement due to the relaxation of the social distancing guidance.

	• Delays in histopathology, with 30% of samples not reported in time for the multidisciplinary (MDT) meetings. There is a current business case in development, seeking additional funding to improve the histopathology. • Improved metrics indicate clear visibility of cancer performance. Discussions had taken place at the Cancer Board, looking at innovative predictive modelling to help identify future peaks, allowing for forward planning around required resource based on demand. This is currently being piloted in Breast cancer services. • The Health Board had been successful in securing grant funding, looking at raising awareness and improving referral times for Ethnic Minority Groups and clients with Learning Disabilities. Shelley Bosson, Independent Member, requested assurance around the following: • Relating to Urgent and emergency care, had the ambulance delays and 'appendix B' incidents been completed. Rhiannon Jones informed the Committee that there were 6 outstanding 'Appendix B's', and a review was ongoing, alongside WAST, with a target for completion over the following month. It was noted that none of the 26 'Appendix B's' reviewed so far had met the criteria for a nationally reportable incident. An update on this to be covered in The Outcomes report at the next Committee meeting. **Action: Rhiannon Jones/Linda Alexander** • Requested a more detailed update on the current risk relating to Cancer services. An additional report to come back to the next Committee meeting. **Action: James Calvert/Secretariat** • Relating to Patient Reported Experience Measures, a timeframe for the procurement and installation of the Servica System. Rhiannon Jones informed the Committee that funding approval was with the Charitable Funds team and there were plans for rapid implementation, with further updates to come in Autumn 2022. The Committee **NOTED** the report for **ASSURANCE**. ***Rani Mallison, Director of Corporate Governance, left the meeting.***
PQSO 0706/13	**Operation Jasmine and the Coroner's Inquests- further reflection and learning** In December 2021, Care Inspectorate Wales, Caerphilly County Borough Council, the Health Board, and Social Care Wales worked in partnership to facilitate an online reflection and learning event on Operation Jasmine. As well as the multi-agency learning, the Health

	Board had considered further actions to ensure on-going improvements as a result of the inquests. Rhiannon Jones, Director of Nursing, provided an overview to the Committee of the Health Board's approach to continued organisational learning in respect of Operation Jasmine. The Health Board had produced an improvement plan, commencing work on the nine recommended actions for improvement, noting that the recommendation on the Standardised Reflection Tool had been completed. The recommendations had previously been approved by the Board in April 2022, with agreement for oversight via the Committee. The recommended actions were noted as: • "Lets not forget" – a schedule of awareness raising sessions • A standardised Quality Assurance Framework for commissioned work • A review of the Margaret Flynn Action Plan to assess progress • A review for the process of professional reflection • A strengthening of the patient and family voice with meaningful patient experience gathering • Education programmes – sessions on accountability, record keeping standards, raising concerns, reflective practice. • Review of Dignity and Essential Care Inspection (DECI)/Healthcare Associated Covid Infections (HCAI) processes across all areas • Consider safety tools (10 steps for safety) to heighten awareness and positioning of Quality and Patient Safety • Consider an approach of inter-Divisional reviews A further update on the progress of the improvement plan to be presented to the Committee in February 2022. **Action: Rhiannon Jones/Linda Alexander** The Committee **RECEIVED** the report for **ASSURANCE.**
PQSO 0706/14	**Patient Safety, Quality and Outcomes Committee Risk Report** Danielle O'Leary, Head of Corporate services, Risk and Assurance, presented the risk report to the Committee. The following key points were highlighted: • the continued and sustained challenge of the pandemic response continued to influence the risk environment. • The Committee was advised that work was being undertaken around the development and education around risk management, enhanced through the Health Board's Risk Management Community of Practice and would be monitored via the Audit, Risk and Assurance Committee as part of the Risk Management Strategy realisation plan.

	• A Board session around Risk Appetite had been planned for the for June 2022. • Work was underway to further improve assurance mechanisms to the Board on Health Board commissioned services. • The Committee was asked to note the de-escalation of risks, as referenced within the report. • Progress had been made in relation to the CAHMS risk profile (CRR028), and it was anticipated that an improved position would be reflected in the report at the next Committee meeting. Danielle O'Leary provided assurance to the Committee that areas outlined in the Outcomes Report, Urgent Care, Cancer, and Stroke services were reflected in the Corporate Risk Register. This was positive to note and provided a level of evidence that the thematic approach to risk management had started to embed across the Health Board as Operational 'themes' had been captured Corporately. The Committee risk profiles, and Corporate Risk Register would continue to inform the Committee workplan and all Committee priorities in the future. The Committee **NOTED** the report for **ASSURANCE**.
PQSO 0706/15	**Committee Priorities 2022/23** A presentation had been circulated to members of the Committee that outlined the Committee priorities for the next year. Committee members were invited to share comments with Rani Mallison, Director of Corporate Governance, outside of the meeting. It was agreed that this item would be re-scheduled for the next meeting. **Action: Rani Mallison/Secretariat**
3	**Items to be Received for Information**
PQSO 0706/16	**Highlight Assurance Reports:** **a) Maternity & Neonatal Services Assurance Group** The report was **RECEIVED** for **INFORMATION**. **b) Welsh Health Specialised Services Committee (WHSSC) Quality & Patient Safety Committee Chair's Report** The report was **RECEIVED** for **INFORMATION**.
PQSO 0706/17	**An overview of 'Enhanced Care': linking provision, cost, and outcome** The report was **RECIEVED** by the Committee.

PQSO 0706/18	**Internal Audit Report: Facilities (Care After Death) Report- Reasonable Assurance** The report was **RECIEVED** by the Committee.
4	**Other Matters**
PQSO 0706/19	**To Confirm any Key Risks and Issues for Reporting/Escalation to Board and/or other Committees** An oversight of wider maternity services, to include the future of Midwife led Units, to be discussed at Board level. **Action: Rhiannon Jones/Linda Alexander/Rani Mallison**
5	**Date of Next Meeting is Tuesday 16th August 2022 at 09:30 via Microsoft Teams**

Patient Quality, Safety & Outcomes Committee
16th August 2022
Agenda Item: 1.5

Patient Quality, Safety & Outcomes Committee

Action Log - August 2022

Agreed Actions:

Overdue	Not yet due	Due	Transferred	Complete	In Progress

Action Ref	Action Description	Due	Lead	Progress	Status
1910/13 Annual Assurance Report on Health & Care Standards: Nutrition and Hydration	The Committee requested an update, inclusive of a map of where the facilities are, to be received, following the review.	**October 2022**	**Director of Therapies & HS / Secretariat**	**21/12/21** Catering Review: Peter Carr informed the Committee that meetings had taken place with facilities with the view to start immediately. There was an expectation that the duration of the Health Board wide review would be 6 months with the plan to present findings to the	**Not yet due**

Action Ref	Action Description	Due	Lead	Progress	Status
				Executive Team in Summer 2022. Included in the Committee work programme for October 2022.	
2112/04 Annual Assurance Report on Health & Care Standards: **Nutrition and Hydration**	The Committee requested an update in respect of the business case for a dedicated nutritional support team following its presentation to the Executive Team for consideration.	**October 2022**	**Director of Therapies & HS**	**21/12/21** Peter Carr updated the Committee that the Divisions were working on the Nutrition Standards paper, and this would be presented to the Executive Team, with an update to the Committee to follow. Included in the Committee work programme for October 2022.	**Not yet due**
PQSO 0504/06.3 Assurance Report: National Clinical Audit and Local Clinical Audit Arrangements	The Committee requested a detailed response to identified gaps in the Psychosis Audit to come back to a future meeting.	**August 2022**	**Medical Director**	Psychosis Audit item added for discussion at the PQSOC meeting in August 2022.	**Complete**

Action Ref	Action Description	Due	Lead	Progress	Status
PQSO 0504/06.4 Assurance Report: National Clinical Audit and Local Clinical Audit Arrangements	The Committee requested that the Health Board's Local Clinical Audit Plan be presented to the Committee at the earliest opportunity.	**August 2022**	**Medical Director**	Item added for discussion on the PQSOC agenda in August 2022.	**Complete**
PQSO 0706/06.1 Audit Wales Review of ABUHB's Quality Governance Arrangements and Management Response	The Committee requested a progress report on implementation of the recommendations included within the report be scheduled for October 2022.	**October 2022**	**Interim Director of Nursing**	Included in the Committee work programme for October 2022.	**Not yet due**
PQSO 0706/08 Covid-19 Concerns and Claims: The National Framework & Investigative Process	The Committee requested that regular updates on the investigation process and progress would be monitored through the Committee.	**February 2023**	**Interim Director of Nursing**	Included in the Committee work programme for February 2023.	**Not yet due**
PQSO 0706/09	The Committee requested an update on the review of patient care for individuals	**August 2022**	**Committee Chair**	Added as an agenda item for discussion at the PQSOC meeting in August 2022.	**Complete**

Action Ref	Action Description	Due	Lead	Progress	Status
Learning from Death Report	with a Learning Disability. The Chair agreed to discuss this request with the DoPCCMH outside of the meeting.				
PQSO 0706/10.1 Healthcare Inspectorate Wales (HIW) Unannounced Visit to the Grange University Hospital (November 2021)	The Committee requested a further update on the final response to HIW, progress and compliance against actions to come back to its October 2022 meeting.	**October 2022**	**Interim Director of Nursing**	Included in the Committee work programme for October 2022	**Not yet due**
PQSO 0706/10.2 Healthcare Inspectorate Wales (HIW) Unannounced Visit to the Grange University Hospital (November 2021)	The Committee requested a Board discussion regarding extra waiting space for the Emergency Department at the Grange University, in light of concern raised from clinical teams around the use of the space with current staff deficits.	**August 2022**	**Director of Corporate Governance**	Board Briefing Session arranged for 10th August to focus on Urgent and Emergency Care.	**Complete**

Action Ref	Action Description	Due	Lead	Progress	Status
PQSO 0706/11.1 The Independent Review of Maternity Services at SATH (The Ockenden Review)	The Committee requested that the action plan arising from the Health Board's assessment be monitored as part of the Committee's future workplan.	**October 2022**	**Interim Director of Nursing**	Included in the Committee work programme for October 2022.	**Not yet due**
PQSO 0706/11.2 The Independent Review of Maternity Services at SATH (The Ockenden Review)	The Committee requested that a copy of the Health Board's self-assessment be shared outside of the meeting with Members.	**June 2022**	**Interim Director of Nursing**	Initial assessment documents shared with members for information. A final self-assessment, along with a summary of supporting evidence, would also be presented to the Board at its meeting in September 2022.	**Complete**
PQSO 0706/12 Patient Quality and Safety Outcomes Report	The Committee requested an update in respect of implementing a Child and Adolescent Mental Health crisis hub, as set out within the report.	**August 2022**	**Director of Operations**	Pending formal confirmation from Welsh Government of the capital work scheme (expected September 2022), this will be progressed and delivered this financial year.	**Complete**

Action Ref	Action Description	Due	Lead	Progress	Status
PQSO 0706/12.1 Patient Quality and Safety Outcomes Report	The Committee noted that a national review of Venous Thromboembolism (VTE) would be presented to the Committee, following its publication.	**August 2022**	**Medical Director**	Added as an agenda item for discussion at the PQSOC meeting in August 2022.	**Complete**
PQSO 0706/12.2 Patient Quality and Safety Outcomes Report	The Committee noted that the 'Getting it Right First Time' (GIRFT) Stroke Review would be presented to the Committee following its publication.	**October 2022**	**Director of Therapies and Health Sciences**	Formal feedback from the Stroke GIRFT review was received on 4th August 2022, and a management response/action plan will follow. Included in the Committee work programme for October 2022.	**Not yet due**
PQSO 0706/12.3 Patient Quality and Safety Outcomes Report	The Committee noted that an update on the review of WAST's 'Appendix B's', would be covered in The Committee's Outcomes report at the next meeting.	**August 2022**	**Director of Nursing**	Included within the Q*uality and Safety Outcomes Report, July 2022* item for August meeting.	**Complete**
PQSO 0706/12.4	The Committee requested a more detailed update on the	**August 2022**	**Medical Director**	Added as an agenda item for discussion at the PQSOC meeting in August 2022.	**Complete**

Action Ref	Action Description	Due	Lead	Progress	Status
Patient Quality and Safety Outcomes Report	current risk relating to Cancer services.				
PQSO 0706/13 Operation Jasmine and the Coroner's Inquests- further reflection and learning	The Committee requested a further update on implementation of the improvement plan to be presented to the Committee in February 2023.	**February 2023**	**Director of Nursing**	Added to the committee work programme for February 2023	**Not yet due**
PQSO 0706/15 Committee Priorities 2022/23	The Committee noted that the presentation on Committee Priorities 2022/23 would be shared with members outside of the meeting.	**June 2022**	**Secretariat**	Presentation shared with members outside of the meeting.	**Complete**

Aneurin Bevan University Health Board

Urgent and Emergency Care Report, including a focus on outcomes and patient experience

Executive Summary

Welsh Government launched it 'Six goals for urgent and emergency care' policy handbook on 27 April 2022. The document sets out expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place, first time for physical and mental health. It is anticipated that by delivering each of these goals through collaboration and partnership, optimal patient and staff experience, clinical outcomes and value can be achieved.

The Six Goals for Urgent and Emergency Care handbook sets out the clear ambitions of a programme of work that will, when delivered collectively improve the quality, efficacy and efficiency of urgent and emergency care.

In supporting the policy there are requirements to ensure, at a national, regional, and local level that, the component parts of the programme are working towards the desired outcomes. This means connectivity between:

- Clinical leadership – collaboration maximising national and local expertise leading to consistent outcomes across the spectrum of urgent and emergency care.
- Operational management – ensuring through transformation, the design, development, and implementation of new models of care – clinically informed and grounded in best evidence-based practice.
- Investment – having a methodology that gives organisations the freedom to plan and invest over a programme whilst concentrating on key priorities, where robust monitoring will support the realisation of benefits.
- Accountability – through the development of improvement triumvirate teams ABUHB will be able to access clinical leadership, operational and programme management and access to analytical support. It is anticipated that these teams will bridge the gap between national oversight, support and investment and ABUHB delivery. They will also provide the monitoring bridge assuring the national programme that progress is made against the programme objectives.

The 6 goals that will support Urgent and Emergency Care, focussing on outcomes and patient experience are:

Goal 1: Co-ordination planning and support for populations at greater risk of needing urgent or emergency Care
Goal 2: Signposting people with urgent care needs to the right place, first time
Goal 3: Clinically safe alternatives to admission to hospital
Goal 4: Rapid response in a physical or mental health crisis

Goal 5: Optimal hospital care and discharge practice from the point of admission **Goal 6**: Home First approach and reduce the risk of readmission			
The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			x
Executive Sponsor: Leanne Watkins, Director of Operations			
Report Author: Kathryn Smith, Associate Director of Operations			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report:			
Supplementary Papers Attached:			

Purpose of the Report

Provide Patient Quality, Safety and Operational Committee (PQSOC) with an overview of how the Aneurin Bevan initial 'Six Goals' Programme Plan will support the delivery of the areas of focus for Improvement to Urgent and Emergency Care Services for our population, to improve outcomes and patient experience and to deliver on the actions set out in the joint WAST/Health Board action plan to mitigate real time avoidable patient harm in the context of extreme and sustained pressure across the urgent and emergency care system.

Background and Context

Sustained and extreme pressure across the Welsh NHS urgent and emergency care system has negatively impacted patient flow through all hospital sites. This pressure has led to a substantial growth in emergency ambulance handover lost hours.

A range of factors have meant that ambulance response times have deteriorated significantly. Delays in community response and those associated with a delayed transfer from the ambulance on arrival at hospital to a suitable hospital bed have led to a growing number of cases of avoidable harm or death to patients. Whilst there is a focus on ambulance handover delays and WAST concerns it is important to note that these are symptoms of whole system pressure and in terms of balancing patient safety and risk, the urgent and emergency care patient experience and outcomes needs to be considered in this context.

Welsh Government (WG) launched its 'Six goals for urgent and emergency care' policy handbook earlier this year. The document sets out expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place, first time for physical and mental health. It is anticipated that by delivering each of these goals through collaboration and partnership, optimal patient and staff experience, clinical outcomes and value can be achieved.

The key aims of each of the six goals to support the improvement are outlined as follows:

Goal 1: Co-ordination planning and support for populations at greater risk of needing urgent or emergency Care

- Identification of at-risk older people and intervention.
- Accelerated cluster development

- Equal Access to UEC for all
- Reducing High intensity use of AEC services

Goal 2: Signposting people with urgent care needs to the right place, first time

- Maximize utilisation of UPCCs (i.e. 111 / WAST Remote support)
- Increase the number of contacts prior to attendance (Contact First)
- Increase the number of 111 calls
- Develop 111 pathways
- Enhanced Directory of Services
- Develop Neighbourhood Care Networks

Goal 3: Clinically safe alternatives to admission to hospital

- Implement SDEC at the Grange University Hospital
- Develop and implement eLGH SDEC Strategy
- Implement virtual consultation and appointments offering with SDEC
- Develop and improve speciality SDEC services (EFU, RACU)
- Define the model for sustainable flow centre staffing
- Develop flow centre pathways
- Develop 'one source of truth' for flow centre pathways

Goal 4: Rapid response in a physical or mental health crisis

- Quality, Safe Timely care in ED
- Develop optimal 999 pathways
- Identify and Implement patient handover improvements
- Develop services for mental health Crisis response

Goal 5: Optimal hospital care and discharge practice from the point of admission

- Define and implement a discharge improvement group
- Reduce length of stay with a particular focus on 7 and 21 day LOS
- Define and implement 'in-hospital' coordination improvements
- Develop step-up and step-down process
- Develop ED referral process
- Long wait escalation improvements
- Home first approach and reduce risk of admission
- Define and implement plan for ED footprint development

Goal 6: Home First approach and reduce the risk of readmission

- Scale up Step closer to home pathways
- Embed D2RA as an ethos across system
- Improve home first capacity and access points
- Develop Direct admission/transfer pathways
- Develop care home conveyancing process
- Embed reablement service offerings

For each of the goals specific outcome measures have been identified as outlined in the table below:

Goal	Outcomes measures
1	• Number of instances of extremely high service usage (4 in 4 weeks), Number of attendances due to falls
2	• Number of 111 Call received, 111 call abandonment rate, Number of Urgent Primary Care contacts, number of re-directions to another site
3	• Number of calls to flow centre, Assess-out rate, Number of Referrals to SDEC, Rate of admission to an in-patient bed from SDEC, Time spent in SDEC
4	• Number of attendances to ED, Time to Triage, Time to be seen by first clinician, time spent in ED >4 Hours, Time spent in ED >12 hours, Ambulance handover >1 hour, Ambulance lost hours
5	• Site Occupancy levels, Number of patients with Length of stay > 7 / 10 / 21 days, Daily net discharge rate
6	• Number of patients Medically Fit For Discharge, Number of patients awaiting a Package of Care, Number of patients discharged through front door therapy intervention

Patient stories and experience continue to be captured to drive the necessary improvement and ensure that changes will positively impact on the experience our patients and staff will have.

One of the most advanced workstreams which will directly positively influence outcomes, patient experience and respond favourably to WAST concerns is the goal 3 work, looking at alternatives to admission to hospital.
There are several initiatives underway which support this goal:

APP in the Flow Centre
ABUHB intent to run a test of change for one month in October ahead of winter, piloting an Advanced Practice Paramedic (APP) at the Flow Centre to improve patient flow, reduce the conveyance rate of patients to GUH and optimise patient outcomes. Essentially ensuring that the patient is seen at the right time, in the right place by the right person. The test of change will pilot an Advanced Practice Paramedic (APP) at the Flow Centre as part of the workforce model, strengthening the senior decision-making function, providing advanced clinical assessment skills, enhancing advice and support around conveyance and alternatives to conveyance, therefore treating more patients in the community or in their own home rather than hospital.

Initial proposal is for the model to operate 9am-9pm, seven days a week aligned to the demand, 66% of WAST referrals via Flow Centre are between 9am and 9pm, with 33% occurring overnight 9pm - 9am. Draft SOP/MOU to be approved by WAST and ABUHB, with an aim to pilot in October with a view to continuing as part of winter pressures if outcomes are positive.

Scheduling of Urgent Care – RGH AMU
Five scheduled urgent care slots per day have been introduced in the Acute Medical Unit (AMU) at the Royal Gwent Hospital (RGH) for GP referred patients via the Flow Centre. This model has been introduced to improve patient flow, realign workforce with demand and reduce length of stay primarily by avoiding overnight admissions of lower acuity patients. Essentially, realigning the clinical services to the clinical demand via the intake to ensure the patient is seen at the right time, in the right place by the right person. A Pilot commenced on 21st June, progress has been slow due to staffing pressures, however the Flow Centre continue to promote slots via NCNs, and to raise the profile.

Over 65/75 Pathway – Flow Centre
The development of an older person pathway to improve the flow of older patients through our system via the Flow Centre. Essentially ensuring that the patient is seen at the right time, in the right place by the right person. The pathway will aim to stream patients who meet the clinical criteria

to an eLGH site for initial assessment, improving flow and optimising patient outcomes. There are times when older people require care in hospital and this is the right place for them. However, older people are at a greater risk of experiencing significant harm if admitted to hospital as an emergency, particularly if there are delays in the Emergency Department. This pathway organises services around the patient to improve care optimising patient outcomes. A working group has been established, and the test of change will entail a phased approached, operating within controlled parameters to ensure a safe and robust roll out:

- Phase 1 - streaming patients aged over 65 years in a care/residential home or who have a package of care in place, flagging these patients as potentially suitable for an eLGH to be discussed with nurse/consultant, subject to the existing eLGH criteria, implemented on 27TH June.
- Phase 2 – streaming of patients over 75 years, developing pathway/question set based on Bournemouth Criteria and Clinical Frailty Scale, plan to implement late August.

In specific response to delays in ambulance handover, an Ambulance Handover Action plan has been developed which focusses on the 6 goals work steams. Monthly meetings are held with EASC to review and monitor progress against plans.

Same Day Emergency Care
Implementation of SDEC will take a three phased approach at the GUH. The benefit of this approach is that it builds on previous understanding, allows for development through piloting, supports the assimilation of the new workforce and encourages collaborative working:

- Phase 1: Referral from GPs via the Flow Centre (August 2022)
- Phase 2: Referral from ED with oversight (Early 2023)
- Phase 3: Scope expansion: Specialty integration (Mid 2023)
- Phase 4: Direct Streaming from ED

Phase 1 is an Integrated model between Acute Medicine and General Surgery, Monday – Friday between 08:00 – 20:00. In Phase 1 the patient is referred via a GP to the Flow Centre directly or via medicine/Surgery to SDEC, where the patient is reviewed by a consultant with a view for discharge. It is anticipated that between 20 to 35 patients per day will pass through SDEC during phase 1. In Phases 2 and 3, patients will be streamed from ED and directly from WAST with plans to integrate some speciality consultation to SDEC. The clinical model is, by design limited on specific conditions appropriate for SDEC, this is to ensure as many patients as possible can be assessed for SDEC suitability and thus the patients with the higher acuity to have timely access to MAU or SAU beds. There is small set of clinical exclusions to ensure patients who are treated in SDEC are of lower risk/acuity 4/15

In order to deliver on the actions set out on the joint WAST/Health Board action plan to mitigate real time avoidable patient harm across the urgent and emergency acre system, patient flow is critical and this is reliant on the goal 5 workstream. There are a number of sub workstreams underway:

- **Discharge Pathways** – The Delivery Unit (DU) report demonstrated low levels of awareness of D2RA pathways and alternatives to hospital care. This presents a risk of patients deconditioning in hospital. There is work on going to assess extended length (over 21 days) to review knowledge and skills with view to developing training for discharge planning. This work is being led by the Medicine Divisional Nurse. It is anticipated that this will result in lower length of stay and patients placed in most appropriate setting for their stage of care

- **Safer Principles** - There is variable use of the SAFER principles across the Health Board and there is a need to relaunch and embed the principles of SAFER, including the importance of

daily senior review, setting the EDD/MFDD at early stage and to plan discharge from admission

- **Consistent MDT board rounds** – to embed the MDT approach to Board Rounds to ensure that all care is coordinated by the whole team, with the aim to reduce 'waits' for each input to happen. To ensure referrals both internally and externally are made as soon as required to reduce delays

- **LOS review** - Ensure Senior Nurse review for 10 day LOS meetings in place for medically fit patients, with system escalation system to ensure that 'blocks' are addressed

- **Expert discharge team** – to develop support for wards with 'expert' team to increase knowledge base and provide solutions for complex patient needs.

Assessment and Conclusion
The report sets out the Health Board's 'Six Goals' Programme Plan' and actions to address the WAST concerns and details the areas of focus that aim to deliver improvement to Urgent and Emergency Care Services and will improve outcomes and patient experience. The plan will ultimately contribute to an improvement in Ambulance handover performance and address concerns raised by WAST and EASC and respond to the details in the joint HB/WAST handover improvement plan. An initial ambition has been set of a 25% reduction in handover delays (from a baseline of October 2021 to factor in increased demand). The profile is yet to be finalized. Updates to the plan will be provided on monthly basis to the Health Board Six Goals Urgent and Emergency Care Programme Board. Quarterly updates will be provided to the Board and its Committee's via the IMTP reviews.

Recommendation
The Board is asked to note the contents of the paper and the action to improve patient experience and outcomes across the urgent and emergency care system and improve ambulance handover performance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	All schemes referred to in the report have bespoke financial support and governance
Quality, Safety and Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health and Care Standards	This report contributes to the good governance elements of the H & CS

Link to Integrated Medium Term Plan/Corporate Objectives	All objectives are referenced in the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** The Six Goals Programme encompasses both short and long term initiatives to improve Urgent and Emergency Care
	Integration – It is anticipated that Six Goals will have a positive impact upon the well being of staff and population due to being whole system that includes Local Authority partners
	Involvement – Involvement of various internal and external groups is continuous and coordinated through goal workstreams
	Collaboration – Collaboration with various internal and external groups is continuous and coordinated through goal workstreams
	Prevention – Team members have the authority to raise concerns and flag problems
Glossary of New Terms	New terms are explained within the body of the document
Public Interest	Report to be published

Patient Quality, Safety and Outcomes Report

Executive Summary

- Urgent Care remains one of the top organisational risks. Key metrics have been identified, with oversight through the Six Goals – Urgent and Emergency Care Improvement Board.
- Same Day Emergency Unit (SDEC)planned to open August 2022.
- The Stroke Directorate is working with 'Getting it Right First Time' (GRIFT) Team to undertake an extensive review from point of contact through to discharge and post discharge care. The review took place on the 11th May 2022.
- Cancer performance continues to face significant challenges due to increasing cancer referrals. Cancer harm reviews commenced in January 2022 to consider impact of all breaches.
- Welsh Government issued a briefing paper 20th May 2022 in regards the de-escalation of Covid-19 measures in NHS Wales. Following de-escalation, the Health Board has experienced an increase in the number of positive in-patients.
- The number of patients requiring Critical Care or High Care Respiratory intervention remains low.
- Clostridium difficile continues to be above trajectory albeit a slow improvement has been seen.
- Collaboration between IPC, Community Hospitals and the Bladder and Bowel services is underway participating in the HOUDINI project. Preventing catheter associated urinary tract infection.

Patient Quality, Safety & Outcomes 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: Clinical Executives	
Authors: Linda Alexander, Interim Director of Nursing	
Date of the Report: July 2022	
Supplementary Papers Attached: Nil	

Purpose of the Report

The patient quality, safety and outcomes report is produced around the themes of the Health and Care Standards (HCS) and is provided assurance in relation to priority areas that are deemed to be higher risk.

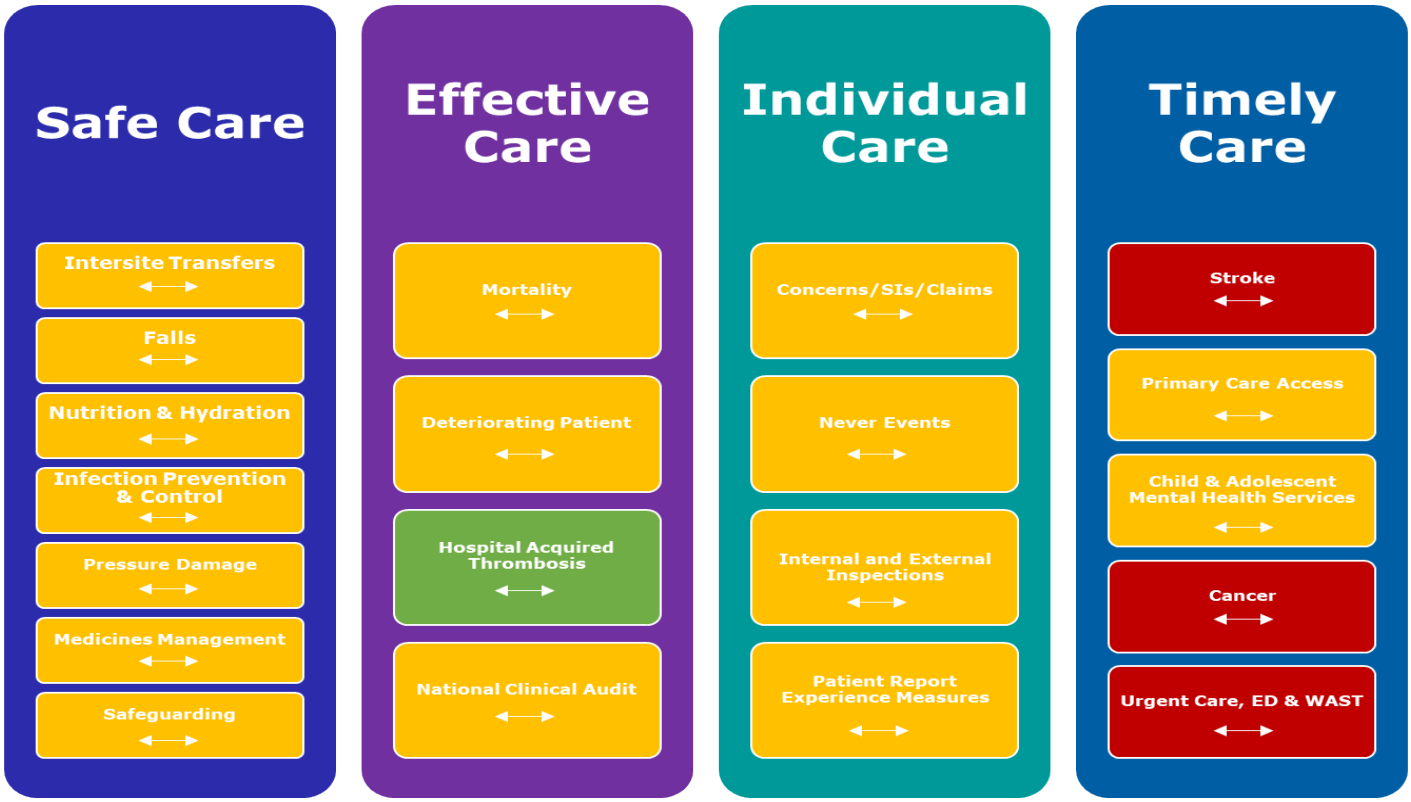
The current outcomes report is a condensed account as agreed by the Chair of the committee.

Background and Context

The report is generated using key performance indicators, information from incident reporting, concerns and complaints and includes escalation from any of the quality & safety-associated groups which report to the Quality, Patient Safety Operational Group (QPSOG) and directly to the Patient Quality, Safety and Outcomes Committee (PQSOC).

The following is an 'at a glance' Red, Amber, Green (RAG) rated summary of key metrics that are regularly monitored, some of which (and notably the 'red' rated areas) are included within this report, providing an overview of the Health Board position from May and June 2022.

KEY:		
	↑	Increase
	↓	Decrease
	↔	Static
	*	New



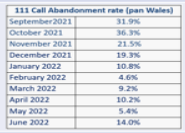
Assessment

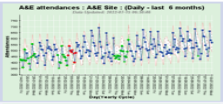
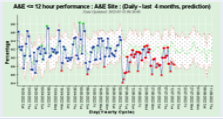
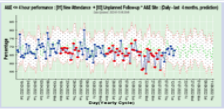
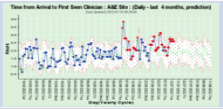
Assessment aligned to Health & Care Standards and ABUHB IMTP priorities

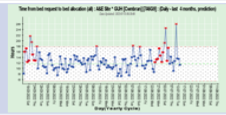
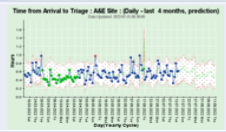
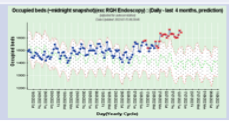
Timely Care IMTP Priority: 1 2 3 4 5

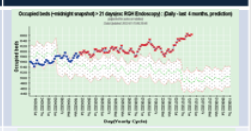
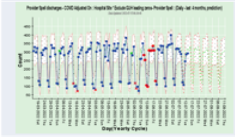
Urgent Care (Standard 5.1 – Timely Access) **RED**

Urgent and Emergency Care remains one of the top organisational risks for ABUHB, an issue mirrored nationally and is receiving significant Ministerial attention. Key metrics have been identified, with oversight through the Six Goals – Urgent & Emergency Care Improvement Board, and weekly analysis via the System Leadership and Response meetings. The following tables illustrate the data collected, analysed and reviewed for drive improvement.

6 Goals	Key Metric	Target	Apr22	May22	Jun22	Signal	Signal explanation/ Comment	Chart/Graph
2	Think 111 calls (both in and out-of-hours)	↑	622	778	621		Improvement in the number of calls since Jan 22.	
2	111 calls abandoned	↓	10.2%	5.4%	14%		Significant reduction in abandonment rates since Sep 21.	 111 Call Abandonment rate (pan Wales) September2021 31.9% October 2021 36.3% November 2021 21.5% December 2021 19.3% January 2022 10.8% February 2022 4.6% March 2022 9.2% April 2022 10.2% May 2022 5.4% June 2022 14.0%
2	Redirections from GUH (Count of both in and out-of-hours)	↓	151	104	96			
2	Redirections from MIU (Count of both in and out-of-hours)	↓	473	544	586			
3	UPCC Consultation / Treatment (monthly totals)	↑	8,674	8,301	7,703			

Goal	Key Metric	Target	Apr22	May22	Jun22	Signal	Signal explanation/ Comment	Chart/Graph
4	ED Attendances (all sites/daily avg)	↓	477	526	544		Increasing trend since Jan.	
4	<12 hours %	↓ 100%	91.7%	91.9%	89.7%		Operating within the lower range and out of range 9 times.	
4	<4 hour %	↓ 100%	68.5%	67.2%	64.9%		Below forecasted levels during May and June.	
4	Waits in ED over 16 hours	↓	447	432	458			
4	Time to be seen by first clinician never above 2 hours	↓ 95%	1.5 hours	1.8 hours	2.2 hours		Out of range during June.	

Goal	Key Metric	Target	Apr22	May22	Jun22	Signal	Signal explanation/ Comment	Chart/Graph
4	Time for bed available from request - 8 hours	↓ 95%	11.5 hours	11.5 hours	12.8 hours		Sustained performance during May.	
4	ED Triage Time	↓ 0.25 hours	0.5 hours	0.5 hours	0.6 hours			
4	Ambulance Handovers >1 hour	↓	45.5%	42.2%	41.7%		Overall increasing trend. 41.7% of handovers >1 hour in Jun 22.	
4	No more than 70 Ambulance hours lost in a day (daily average)	↓ 95%	89 hours	89 hours	*Pending*			
5	Occupied Beds monthly av	↓	1498	1511	1534		Out of range and following forecasted seasonal trends.	

Goal	Key Metric	Target	Apr22	May22	Jun22	Signal	Signal explanation/ Comment	Chart/Graph
5	LOS over 21 days	↓	607	619	610		Out of range and not following forecasted seasonal trend	
5	Ave Daily discharges	↑	234	247	244			
6	Average daily DTOC Patients on Complex List - Acute	↓	98	155	*Pending*		New complex list system commences in May. Therefore some discrepancies may show when comparing prior to May.	N/A
6	Average daily DTOC Patients on Complex List - Community	↓	116	136	*Pending*		New complex list system commences in May. Therefore some discrepancies may show when comparing prior to May.	N/A

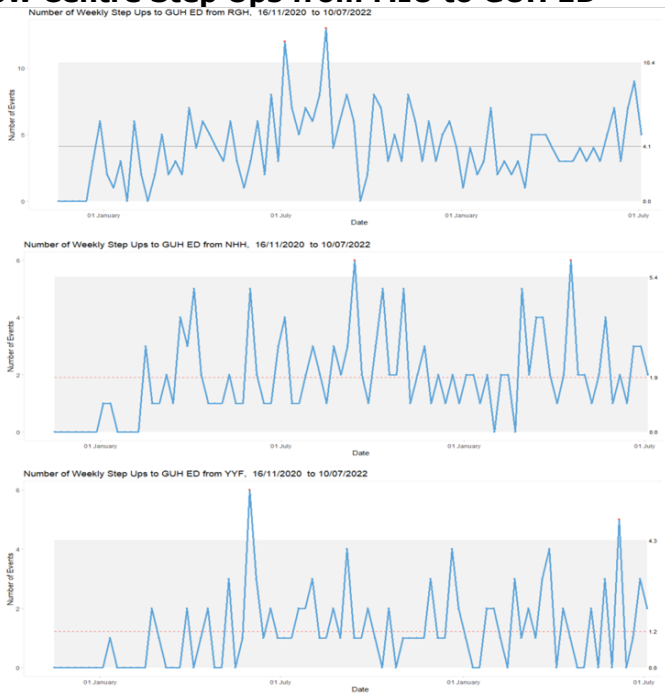
The Minor Injury Units (MIU) continue to see a high number of patients. The Redirection Policy is used robustly to ensure patients are being cared for in the most appropriate environment to manage their clinical condition and risk. The Emergency Nurse Practitioners (ENP) scope of practice has been reviewed and expanded; e.g, to support manipulations. Monthly performance data illustrates a month on month increase in redirections from MIUs in quarter 1 of 2022/2023, suggesting that some patients continue to attend the wrong sites for their condition. Out of area attendances to MIUs were consistently high from February to May 2022, peaking to above expected levels in May 2022, 34% of OOH attendances were from Powys.

Sick, self-presenting patients attending MIUs in the enhanced Local General Hospitals (eLGHs) was a high clinical concern when the GUH first opened. However, focussed work regarding these concerns, especially in relation to establishments has been undertaken, and additional training has been offered following practitioner concerns. For example, there was an increase in the volume of pregnant women attending MIUs. As a result, ENPs on all four MIU sites have accessed midwifery input; these sessions have been well received and well evaluated, especially in relation to confidence-building amongst staff.

Communications with the public have been regularly updated to ensure that key messages, especially in relation to where to attend for what condition or ailment. It is evident that communications in this area will be consistently required. Communication has been highlighted as a priority within the Welsh Government Six Goals of Urgent and Emergency Care Programme, communication is fundamental to accessing the right services first time. There is a dedicated work stream within the Six Goals nationally focusing on communication, linking communication teams locally.

Action Cards, clearly identifying the roles and responsibilities and steps to take if a sick patient attends a MIU have been developed and embedded. These identify access channels to the Emergency Physician in Charge (EPIC – the most senior ED doctor on duty).

Flow Centre Step Ups from MIU to GUH ED

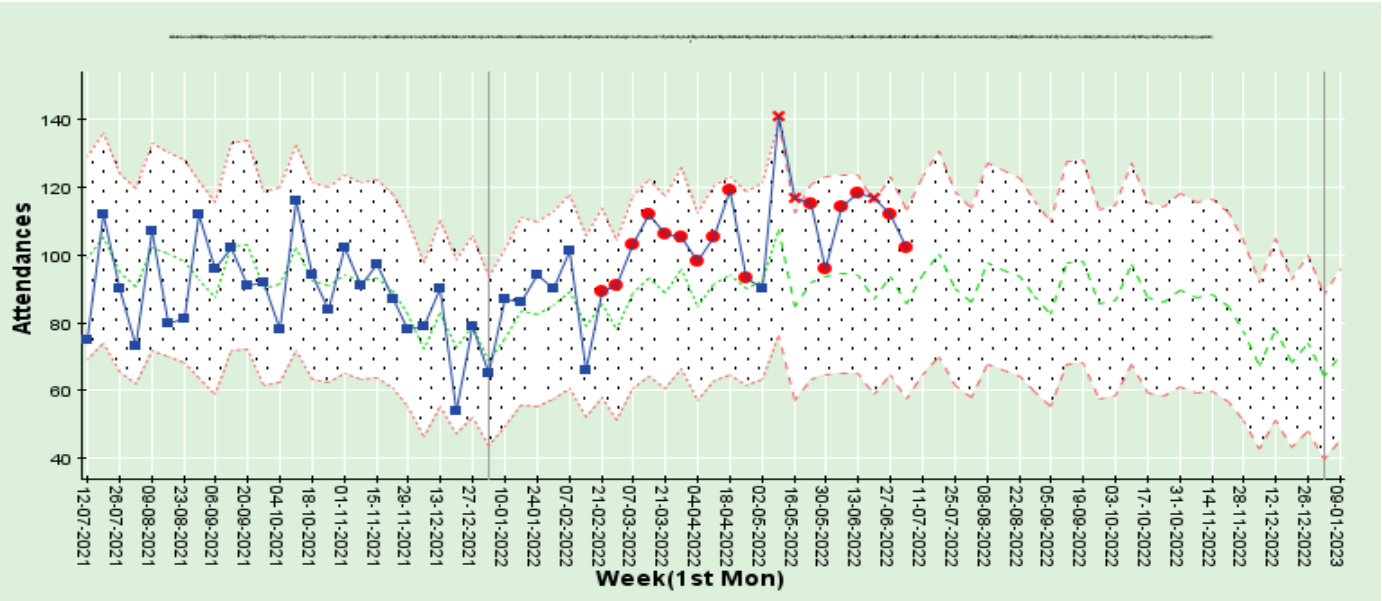


RGH step ups to GUH ED had been increasing in July 2021, but have been more stable since September 2021 at around 4 per week.

NHH step ups to GUH ED had been variable between 1 and 6 each week, they were more stable around 0-2 between September 2021 and February 2022, but have been around 2-6 since then.

YYF step ups to GUH ED have been mostly stable around 0-4 per week.

There have been reports of out-of-area patients attending MIUs and initial data shows that the number of patients attending MIUs (RGH, NHH and YYF) from outside of ABUHB has increased in recent weeks. This volume has been above the expected levels continuously since 21 February 2022 and has exceeded the upper expected range three times since this date in the weeks commencing 9th May, 23rd May and 20th June.



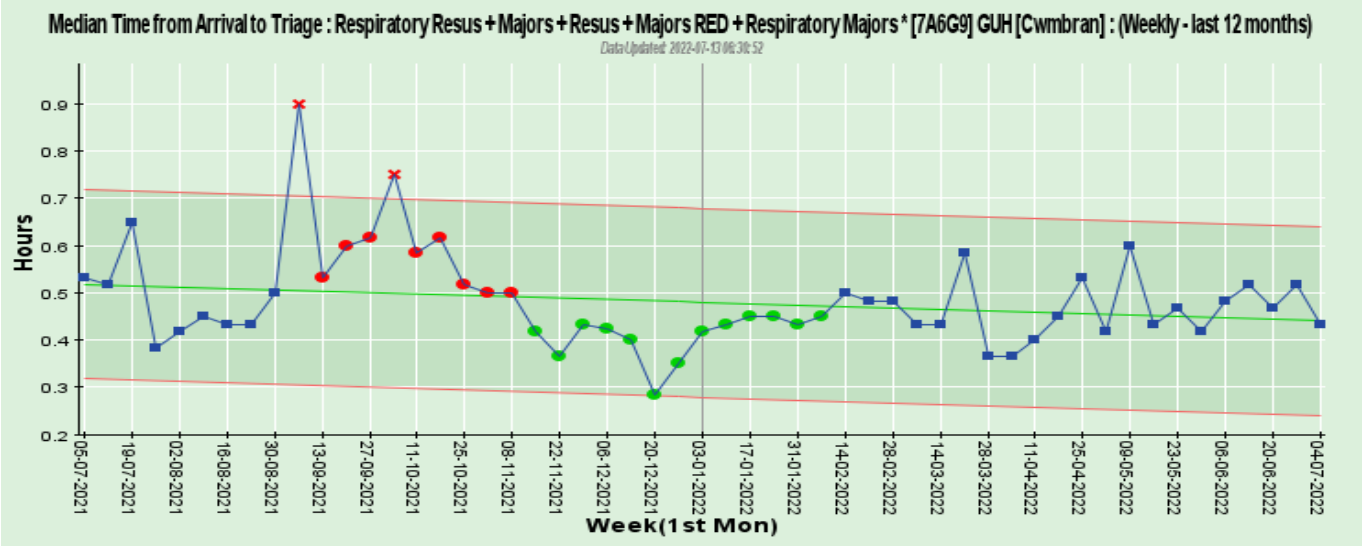
Patients from the areas below being the highest attenders:

Top 80% Attending Areas (Last 6 months)	Attendances
South Powys	787
South Merthyr Tydfil	311
South Cynon	248
South Taf Ely	183
North Taf Ely	147
North Cynon	133
Cardiff East	129
Cardiff North	111
North Merthyr Tydfil	87

In order to inform further work, an additional scoping exercise is being undertaken.

The number of attendances to the GUH ED is also seeing an increasing trend. In order to be able to identify the level of risk within the department, a clear focus has been placed on triage. Triage is a 'sorting' of patients and allocates categories to patients dependent on their presenting complaint and acuity. This then influences a time frame for the patients to be seen by a clinician. Knowing the triage category of patients helps to manage the risk for individuals and the department.

The national target for triage is 15 minutes from arrival in the department. A triage working group led by the Nurse Consultant continues to review triage performance and effectiveness. The triage work has been further supported by our Practice Educator team within the ED, supporting and building confidence in our workforce. The graph below shows the trend in reduced time to triage.



Ambulance Handover times have an overall increasing trend (41.7% of handovers >1hr). A review of criteria, which enable patients to be moved from ambulances to sit within the department has been undertaken. In addition, a Standard Operating Process (SOP) for ED has been developed to ensure the department meets the fundamental needs of the patients.

The SOP clearly references the actions that are required to be taken and by whom when there are off-loading delays for patients and if handover cannot be taken from ambulance crews. The SOP also reinforces that patient investigations and treatment should be commenced, pressure care provided as well as toileting and nutrition and hydration offered. This ensures timely and dignified care for patients.

Patients waiting in ED >16hrs has increased during June with 458 and the average time from bed request to bed allocation remains high at an average of 12.8hrs. Quality metrics are regularly monitored by the Senior Management Team (SMT), the Divisional Management Team (DMT) and escalated accordingly. Patient falls, medication incidents and violence and aggression incidents are reducing. There has been an increase in grade 1 pressure ulcers reported, which is being further analysed and will result in an improvement plan.

To support the 'Right Place First Time' process, there has been an increased focus on the streaming of patients, to improve patient experience by bringing efficiencies into the system. There is Consultant input at the Flow Centre, who advise on options for admission; 45-50% of patients are deemed appropriate for eLGHs (data which has been consistent since the GUH opened). In addition, a test of change has been identified to stream older people who meet the clinical criteria to an eLGH site, improving the flow of older people through our system and optimising patient outcomes. Essentially ensuring the patient is seen at the right time, in the right place by the right person.

To manage patient flow more efficiently, ABUHB are developing a Same Day Emergency Care (SDEC) Unit at the GUH and plan to pilot an appointment-based ambulatory care model in the Acute Medical Unit (AMU) at the RGH. The SDEC unit at GUH is planned to open in August 2022. This will mean patients who meet the criteria can be seen in SDEC rather than being accommodated in ED, AMU or Surgical Assessment Unit (SAU).

There are significant benefits associated with treating people through SDEC services, these include:

Patient experience:

- The ability for patients to be assessed, diagnosed and commence their treatment on the same day, improving patient experience and reducing hospital admissions.
- This has a knock-on effect on the quality of care provided in AMUs, as only patients in need of specialist Acute Medicine care will remain at the GUH.
- Avoiding unplanned and longer than necessary stays in hospitals, resulting in lower risk of infections and patient de-conditioning.
- Providing direct access for some specialties which may avoid the need for patients to return to the hospital for an outpatient appointment.
- The potential reduction in the number of Clinicians patients will see.
- Patients who have already been seen by a GP will not need to be seen by the ED team; they will be seen by the right clinician first time.

Benefits to Staff:

- *Team engagement:*
  There is a considerable amount of positive energy linked to the implementation of SDEC.
- *Recruitment benefits:*
  Recruiting to SDEC will likely be a more attractive proposition than the existing care model.
- *Wellbeing:*
  Seeing the patient journey from start to finish has been noted as a staff wellbeing benefit.
- *Team working:*
  Promoting integrated working especially between Medicine and Surgery even at the planning stages, will become a bigger benefit once integration occurs.

From a nursing perspective, recruitment remains ongoing for all areas, following positive additional financial investment agreed by the Executive Team. The Practice Educator team have increased their establishment to enable provision of a strong preceptorship model for new starters. The student nurse Streamlining recruitment process is very successful for GUH, 10wte have been recruited for ED and 3 WTE for AMU. Recruitment is also ongoing for SDEC.

The Medical workforce is more challenged across all grades. The Consultant roster has not been fully recruited to and there is also constant backfilling of the middle grade tier, which remains a national issue. SHO grades are also under pressure, but these are proving easier to fill at a Locum grade. There are no long-term sickness or absence issues currently.

Stroke (Standard 5.1 – Timely Access) **RED**

The Stroke Directorate is working with the "Getting it Right First Time" (GIRFT) Team to carry out an extensive review from point of contact through to discharge and post discharge care, to recommend areas for improvement. The GIRFT team has successfully reviewed every Stroke Service in NHS England and has now reviewed the

Stroke service across ABUHB. The review took place on 11th May 2022 and the team visited each of the Stroke Rehabilitation wards (RGH, NHH and YYF) and then visited the Hyper Acute Stroke Unit (HASU) at the Grange Hospital. During the visit, the GIRFT Team observed how each of the wards run and documented the stroke patient pathway.

A deep dive review meeting then took place at the GUH with key stroke staff attending either in person and or joining virtually from the other three other sites that had been visited earlier in the day.

The deep dive provided an opportunity for the Stroke Team to voice their ideas to improve the workforce model and also showcase previous work that the GIRFT has been involved in to improve stroke services.

An interim action plan was developed following the deep dive and these actions will be monitored through the Task and Finish group which is next due to meet on 4th August 2022 with the GIRFT Team.

The GIRFT team have now completed their first draft report which has been circulated for comments. It is anticipated that the full report will be available early August in readiness for the meeting on 4th August.

Performance

The Health Board monitors a number of key quality metrics for urgent intervention in stroke that determines whether a patient was able to have a CT scan within 1 hour and be admitted to the HASU within 4 hours of arriving at the hospital. Whilst stroke patients will receive necessary care interventions in the Emergency Department, and often pre-hospital by the paramedics, a timely scan and HASU care are critical for optimal outcomes.

Over the past 6 months, the proportion of patients with a suspected stroke who have a CT within 1 hour of arriving at the Emergency Department has been in the region of 50%, however, for the month of May, we have seen a huge improvement in performance and over 75% of patients reached the CT scanner within 1 hour of arrival. It is anticipated that this rise is due to the increased number of patients presenting within the thrombolysis window, however, further data will demonstrate if this is a sustained change or just fluctuation.

The proportion of patients with a confirmed stroke directly admitted within 4 hours remains low (21.7% in May 2022) which is slightly higher compared to the rest of Wales (14.8.%).

In May 2022, the Health Board achieved full compliance for the percentage of patients assessed by a stroke consultant within 24 hours at 100% (79.7% all Wales).

The proportion of applicable patients assessed by at least one therapist within 24 hrs of clock start remains low at 46.9%, and significantly lower in comparison to All Wales (78.9%). A thorough review of the Stroke Therapy resources has been completed which will form part of the action plan for the Stroke Task and Finish Group.

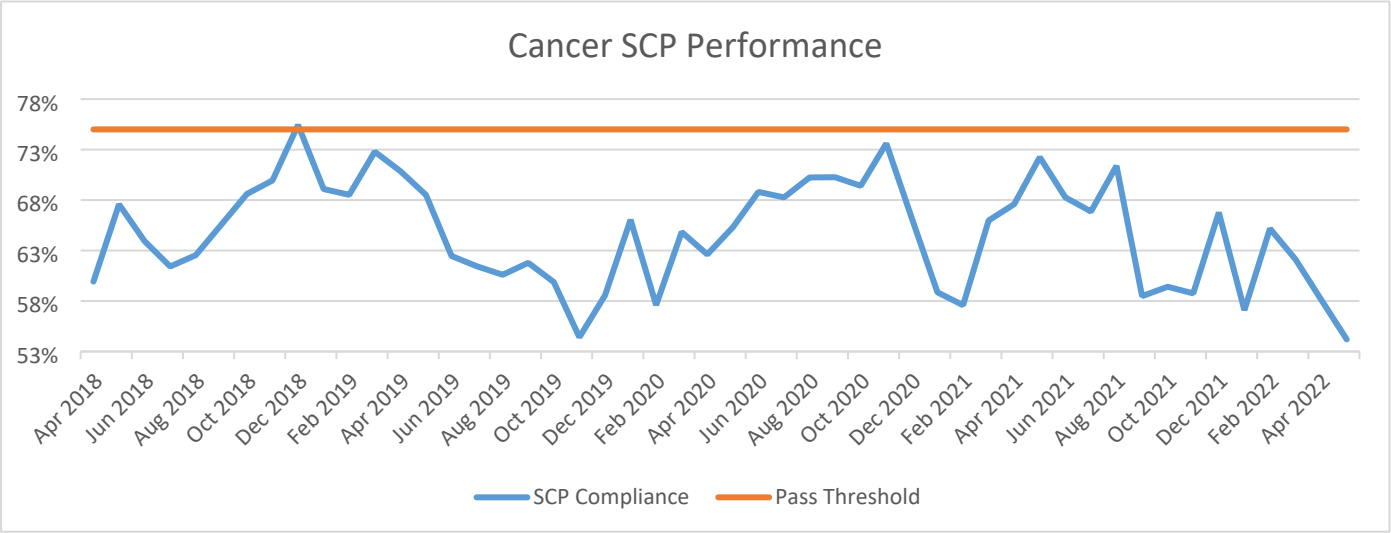
Thrombolysis rates (proportion of stroke patients given thrombolysis) was 18.4% in May 2022. The thrombolysis audit is ongoing to identify any opportunities to improve

thrombolysis performance. An earlier review of the data identified that patients have not arrived at the Grange University Hospital in a timely basis and, in some cases, there have been delays in referral to the HASU and stroke team. It is important to note that 100% of all clinically eligible stroke patients are given thrombolysis.

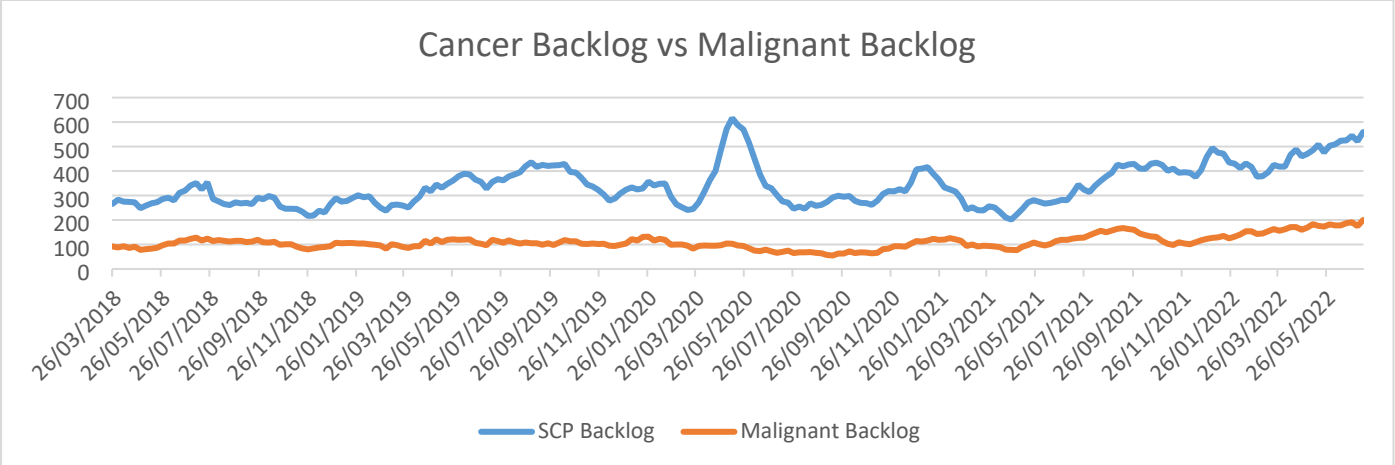
Cancer (Standard 5.1 – Timely Access) **RED**

Performance Overview

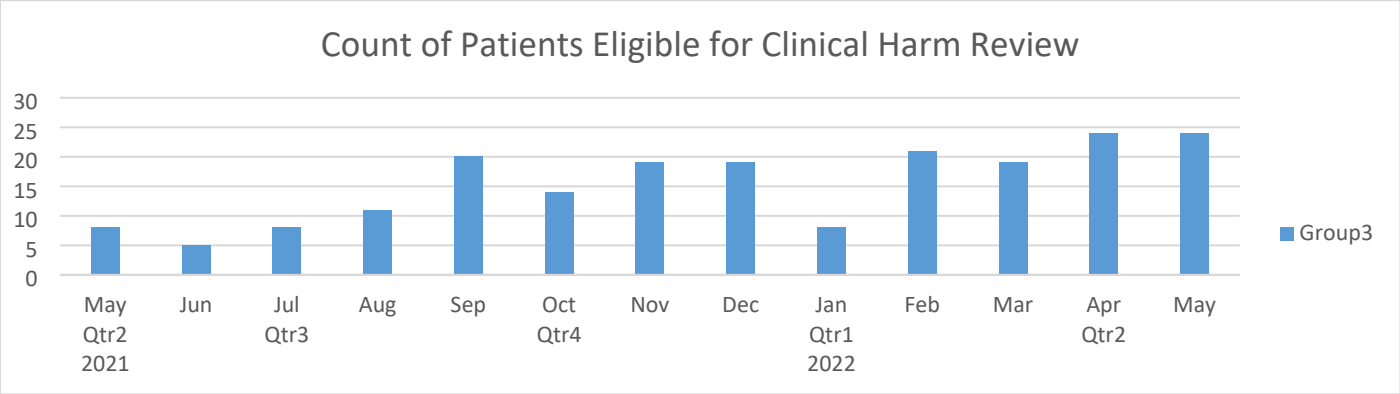
The delivery of cancer care is facing sizeable challenges across multiple aspects of the patient's pathway. To date, the 75% pass threshold, established as an intermediary target to launch the single cancer pathway, has not been met. Furthermore, since February 2020, the monthly compliance position has continued to fall and in May culminated in its lowest position to date of 53.4%. To achieve the current target a 46% reduction in breaches would be required based on current treatment levels, the equivalent of 73 fewer breaches in a single month. Except for skin, all tumour sites are failing to meet the pass threshold.



Concerningly, while performance wavers, the volume of patients actively waiting over 62 days continues to grow and as of mid-July, sits at 559 patients on a cancer pathway having already breached. Whilst most of these patients will reach a benign diagnosis, the numbers of patients in the backlog with a known malignancy is also rising at a comparative rate, suggesting upcoming performance figures are likely to continue to struggle and potentially worsen.



Health Boards are expected to conduct clinical harm reviews on any patient whose pathway has breached 146 days from the point of suspicion. ABUHB started its own harm review process in January 2022, and in this time have seen a monthly increase in the volume of patients breaching this timeline. Consistent themes have been identified through this process of tertiary delays (including screening pathways) and inefficient or capacity restricted pathways. Delays have also been regularly influenced by patient engagement.



Shifting momentum and changing the current trajectory of cancer performance is a big task that is going to require a major change of approach. Embedding this change is almost certainly going to happen at the expense of other areas of care delivery, due to the finite resource currently delivering routine and emergency work in concordance with cancer work.

The difficulties in delivering cancer pathways to a 62-day timeframe is being influenced by a myriad of operational challenges, often being experienced differently by different teams. There are however several broader and more definitive challenges that are having an impact on all tumour sites and have influenced the most recent spike in waiting list and backlog numbers.

Delivery Challenges

Demand

Colorectal are now regularly receiving more than 600 referrals per month. This figure is 46% higher than the pre covid mean, and as a result has prompted a 70% increase in the number of USC endoscopy requests, and 48% increase in USC Radiology requests.

Accommodating this additional demand has been one of the major challenges for diagnostic services, and whilst the workload is being absorbed, has led to delays within the cancer pathway which previously would not have existed.

Whilst colorectal has seen the most severe demand increase, similar patterns are also being experienced in UGI, Urology and Breast.

The increasing demand in these services is creating a major bottle neck at the front end of the pathway, resulting in long delays to first appointments, and initial diagnostics. This challenge can be seen through our 14-day first seen compliance which has fallen to 39.9% across the health board and is as low as 15% in the highest demand

tumour sites. These capacity constraints are subsequently leading to lower rates of diagnosis by 28 days, which in June was 64%, 14% lower than 2019. First outpatient waits are the single biggest breach reason recorded through our breach analysis.
Establishing the necessary capacity to maintain rapid outpatient appointments and diagnostic capacity at the start of the pathway provides the greatest opportunity for performance improvement and is the focus of all cancer working groups, however it is recognised that enabling this capacity is restricted by the need to maintain non cancer activity.

Capacity

Establishing sufficient capacity to maintain wait times against the standards expected to deliver 62-day pathways is a challenge across most tumour sites. The primary challenge is maintaining sufficient capacity in light or workforce shortages, sickness/annual leave, and non-cancer recovery work. There are also limitations associated still with the opening of the Grange, and this is predominantly due to bed capacity for elective high-risk procedures and change to clinical rotas for GUH cover.

Considering staffing difficulties, alternate options are being explored to increase capacity. This includes the increased utilisation of nurse led clinics such as Colorectal, and private providers such endoscopy and pathology. The greatest concern is currently within Colorectal considering the dramatic demand increase and the forecast expansion of screening services which is anticipated to increase the volume of cancer surgeries by 196 by 2025.

Tertiary dependencies

ABUHB are heavily reliant on tertiary providers for both treatment and diagnostics in a variety of tumour sites. This includes all Radiotherapy and chemotherapy treatment, as well as surgical treatment for our UGI, Gynaecological, plastics and some urological patients (partial nephrectomies). PET scanning and genetic pathology testing are also provided externally.

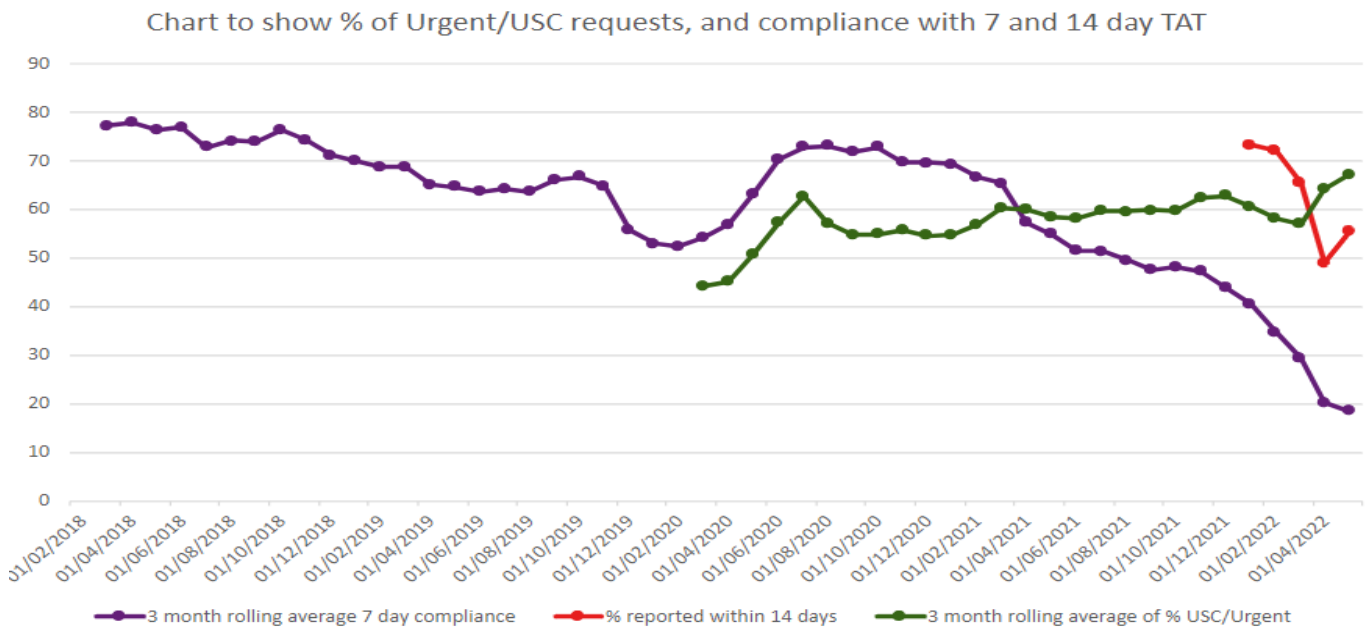
The difficulties being faced currently in ABUHB are also reflected in these tertiary providers and increasingly we are seeing extended waiting times for these procedures. There is currently no form of breach sharing, or waiting time reallocation, and delays at tertiary centres are reflected purely in ABUHB performance.

Breaches are rarely assigned purely to delays at tertiary centres, and this is because we often are not referring for the treatments with adequate time in the pathway for tertiary providers to realistically meet the 62 days. The delays are however regularly contributing to the extended length of wait for some patients, and this is expected to increase due to current staffing challenges within SACT delivery.

Pathology

The demand facing pathology is both increasing in volume and complexity. Since April 2020, the percentage of samples marked as USC or urgent has increased from 45% to 68%, and increasingly samples are needing further work up for genetic testing and re-look. The ability to expand the service is hindered by the available working space, and the ability to recruit specialist staff. As a result, the turnaround time on USC samples has suffered, and the 7-day turnaround time has fallen from 75% to 19% in the same time threshold. 14-day turnaround time has also seen a 24% drop.

Solutions to the estate challenges are being explored with urgency and a business case is currently in the PIP process. Further opportunities are being explored to outsource the routine pathology work, thus alleviating pressure on reporting physicians, however, to date no outsourcing companies have been found.



Patient choice/engagement

When the single cancer pathway was embedded, a change was made to the way pathways are managed that eliminated any ability to apply suspensions to the cancer pathway. As such, performance is now an unadjusted and true representation of waits from suspicion to treatment.

With demand now at a steady state, and COVID impacting pathways less, the scale of patient-initiated delays is now becoming apparent, particularly the impact of non-attendances and repeated cancellations. The 146-day harm reviews have identified patient choice as the third most common reason for long waiting breaches after bowel screening capacity and inefficient or complex pathways.

Addressing this issue is a challenge that is being addressed through 2 fronts, the first being primary care input and the information being provided to patients at the point of referral. It is common for patients on the cancer pathway to be unaware of the urgency and nature of the referral and so persuading patients to prioritise the appointment can be difficult.

Secondly, admin processes are being refined to ensure patient initiated delays are acted on swiftly and appropriately, with minimal time between missed appointments. This is being addressed through a health board wide staff training programme which has now been delivered to over 100 staff and is published within the intranet.

What are we doing to address these challenges?

Recognising the difficult position cancer finds itself in, and the totality of organisational input required to recover the cancer position, a 2-part workshop was established, providing an opportunity to voice the current difficulties within services, establish the roles and responsibilities in managing patient pathways, and pull together a collective

action plan focussed on addressing the challenges that are within scope to begin to improve.

The first of the sessions ran on Wednesday the 29th of June and provided an opportunity for most tumour site teams to demonstrate their current position. The second of the workshops is due to run on Wednesday the 20th of July and will culminate in the production of the action plan which will be the focal point of recovering cancer performance.

From these workshops, work has begun on trialling innovative approaches to the management of patient pathways, utilising dedicated resource to ensure the timely progression of patients. A thorough demand and capacity procedure will also be required within each specialty to accurately demonstrate the current capacity short falls (a request also received from Welsh Government).

Working groups have been established in Breast, Urology, Lower GI, and Gastroenterology focussing pathway improvement. This work is being supported from within Cancer Services utilising a dedicated Macmillan Optimal Pathway Manager as well as the substantive workforce.

Cancer Services are establishing improved methods of communicating with our tertiary providers and have established a collaborative group with Velindre to improve data and information sharing whilst streamlining join work projects. Tertiary tracking meetings are also in place with Cardiff and Swansea to ensure shared patients are given sufficient attention.

Whilst this work focusses predominantly on cancer waiting times, there are further branches of work being undertaken within Cancer Services focussing on patient experience, prehabilitation and holistic support. A project is now underway focussing on the integration of a digital self-assessment tool for all patients at the start of the cancer pathway providing the opportunity for early health optimisation. This is complemented by the wider Prehabilitation project that is due to launch in August 2022 and looks to provide prehab integration for all patients on the suspected cancer pathway.

The breadth of operational challenges discussed during the first cancer workshop demonstrates the challenge currently facing cancer, and the scope of improvement work needed to achieve the 62-day pathway. The greatest improvement to cancer performance will be realised in our ability to efficiently start the cancer pathway with timely appointments and or diagnostics. Supporting services in enabling this will rely on the authority and understanding that prioritising cancer will only be achievable at the deficit of non-cancer work, and in some cases, expansion of the current available workforce.

Safe Care IMTP Priority: 1 2 3 4 5

IP&C (Standard 2.4 – Infection Prevention and Control) AMBER

Monkeypox

Monkeypox is a rare zoonotic infection which is mainly found in parts of Central and West Africa. Recently, there have been cases of the West African clade of Monkeypox detected within the UK, however, the risk of widespread transmission remains low.

Monkeypox infection is usually a self-limiting disease with symptoms lasting from 2 to 4 weeks, as with many infectious diseases, additional precautions may be required for individuals who are at increased risk of more severe illness. Monkeypox is currently classified as a high consequence disease.

To date, there have been 9 reportable cases in Wales. Aneurin Bevan University Health Board (ABUHB) has established an Incident Management Team (IMT) to review the following key components:

- Patient pathways
- Screening and Testing
- Vaccination
- Staff risk assessment
- Communication plan
- Infection Prevention requirements

Covid-19

Welsh Government (WG) issued a briefing paper on the 20th May indicating the steps required, with immediate effect, for the de-escalation of Covid-19 measures in NHS Wales together with a ministerial announcement on the 27th May 2022 abolishing mandatory wearing of face coverings within health and social care settings.

The Reducing Nosocomial Transmission Group (RNTG) reviewed the recommendations, and a briefing paper was prepared outlining the actions (listed below) for ABUHB to achieve the recommendations. Approval was sought via the Executive Team to implement changes with immediate effect.

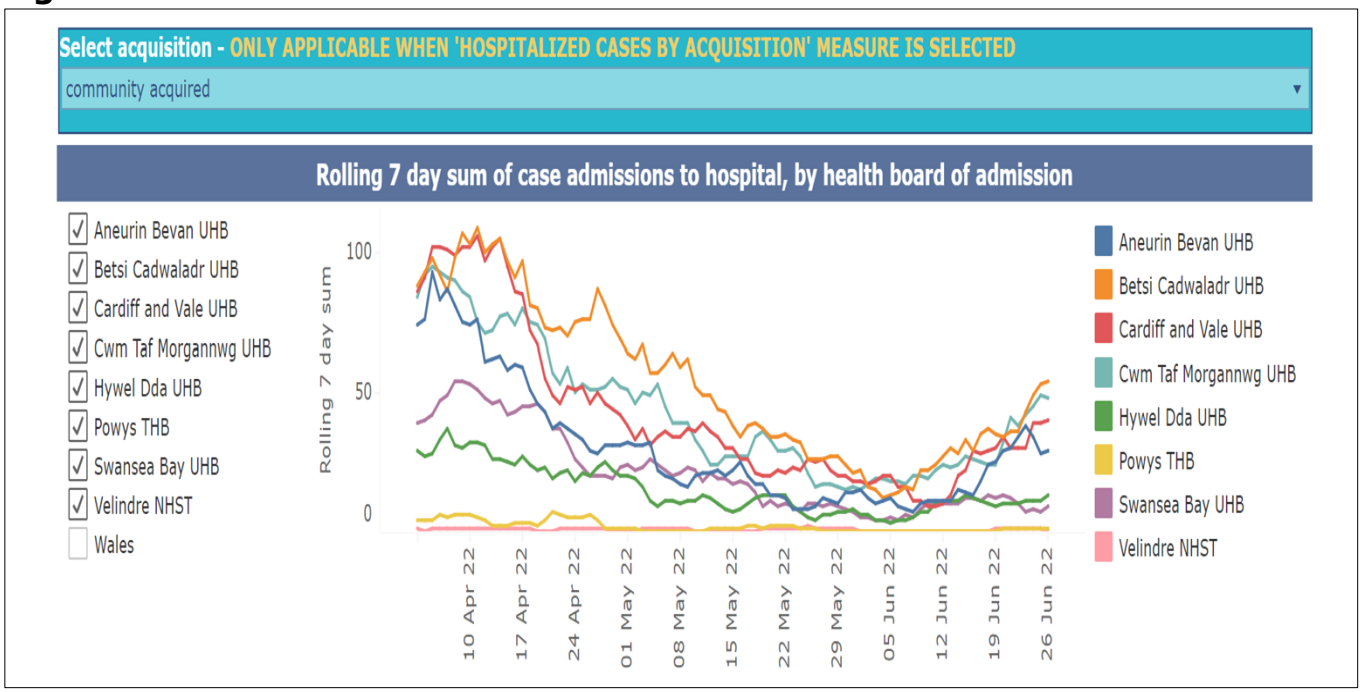
1. Personal Protective Equipment to return to pre pandemic guidance, except for Covid-19 patient pathways.
2. Social distancing to return to pre pandemic measures, except for Covid-19 pathways.
3. Continue triage and testing of patients on admission.
4. Preadmission testing to convert from PCR to LFD testing.
5. Patients to be reviewed for step down at day 7 not day 10 (this had already been implemented within ABUHB).
6. Review visiting restrictions and increase visitors to the Health Board.
7. Staff previously clinically vulnerable to return to work.

8. Ongoing monitoring of cases/outbreaks and community prevalence to continue.

Following the de-escalation of Covid-19 measures, the Health Board has experienced an increase in the number of positive in-patients.

Fig 1: demonstrates the number of inpatients diagnosed with Covid-19 from April 2022 to June 2022 across Wales. ABUHB in-patients with a new Covid infection reduced to as low as 2 by the end of May, June has seen an increase to 81 cases.

Fig 1:



The number of patients requiring critical and high-level respiratory care continues to be significantly lower than previous surges, with a maximum of 2 patients at any one time.

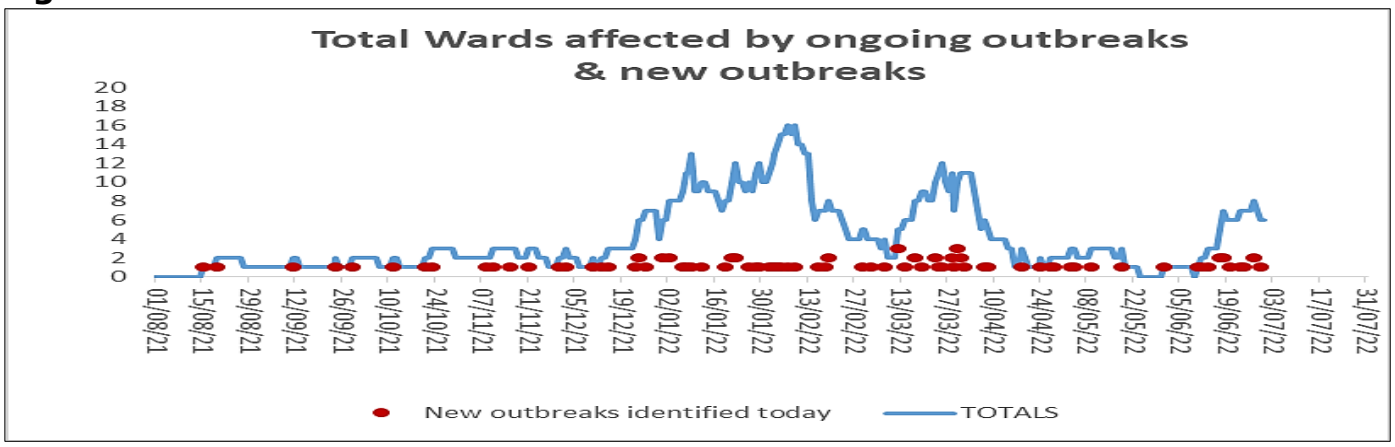
In March 2022, in line with national guidance, the Patient Placement Protocol was amended in line with national guidance resulting in patients being cared for on a ward suitable to their clinical presentation rather than transferring through Covid pathways. There has been no evidence to demonstrate that this has impacted on hospital onset transmission.

Covid-19 Outbreaks

The number of hospital onset outbreaks has increased significantly. Undoubtedly, this is a consequence of reducing Covid safety measures namely use of PPE, social distancing, visiting and reduced patient testing on admission only.

Fig 2 displays the number of new outbreaks identified on a daily basis and the ongoing prevalence of ward closures.

Fig 2:



The Infection Prevention Team (IPT) continue to convene outbreak control meetings to determine route cause. To reduce the risks of transmission of Covid 19, the Executive Team supported a request to ask all staff in the clinical area to resume the practise of wearing face coverings.

Care Homes

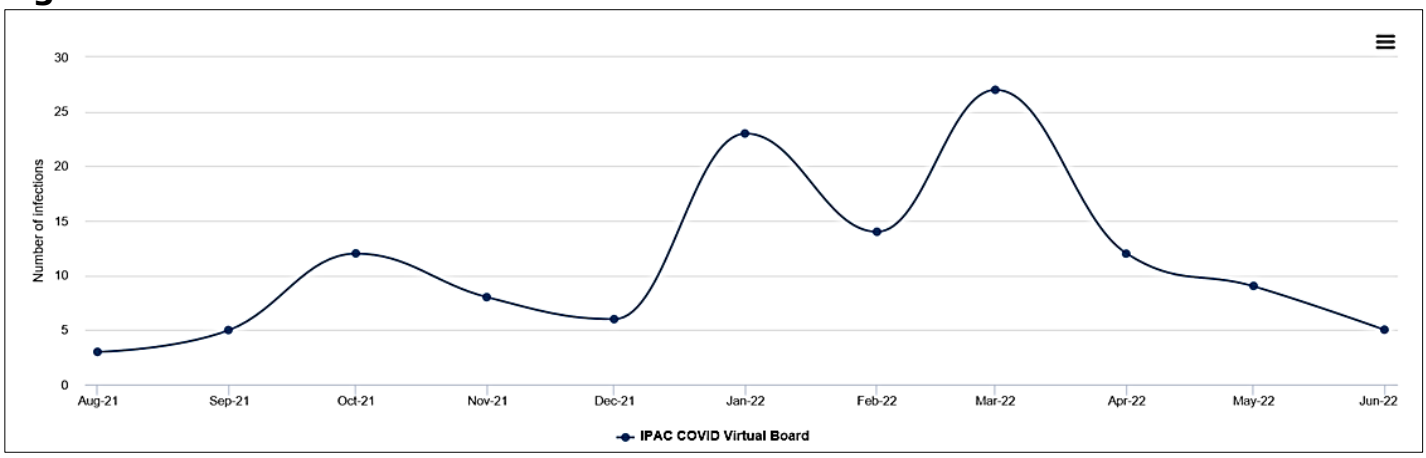
Care Home prevalence (where a resident or a member of staff has tested positive) has remained stable over the reporting period. Safe Patient Discharge passport has been updated to reflect new testing requirements. Primary Care IPT continue to carry out proactive and reactive visits to Enclosed Settings.

Covid-19 Mortality

Deaths associated with Covid-19 are an important measure of intervention success. Throughout the pandemic, the Health Board implemented adjustments to improve patient pathways, management, and healthcare experience. This, together with treatments and effective vaccines, has led to reductions in mortalities.

All patients are followed up for 28 days post Covid-19 positive result. May to June 2022, there have been 14 inpatient deaths associated with indeterminate, probable, or definite healthcare associated Covid infection. **Fig 3** displays the trend of Covid related deaths since August 2021.

Fig 3:



Covid Investigation Team

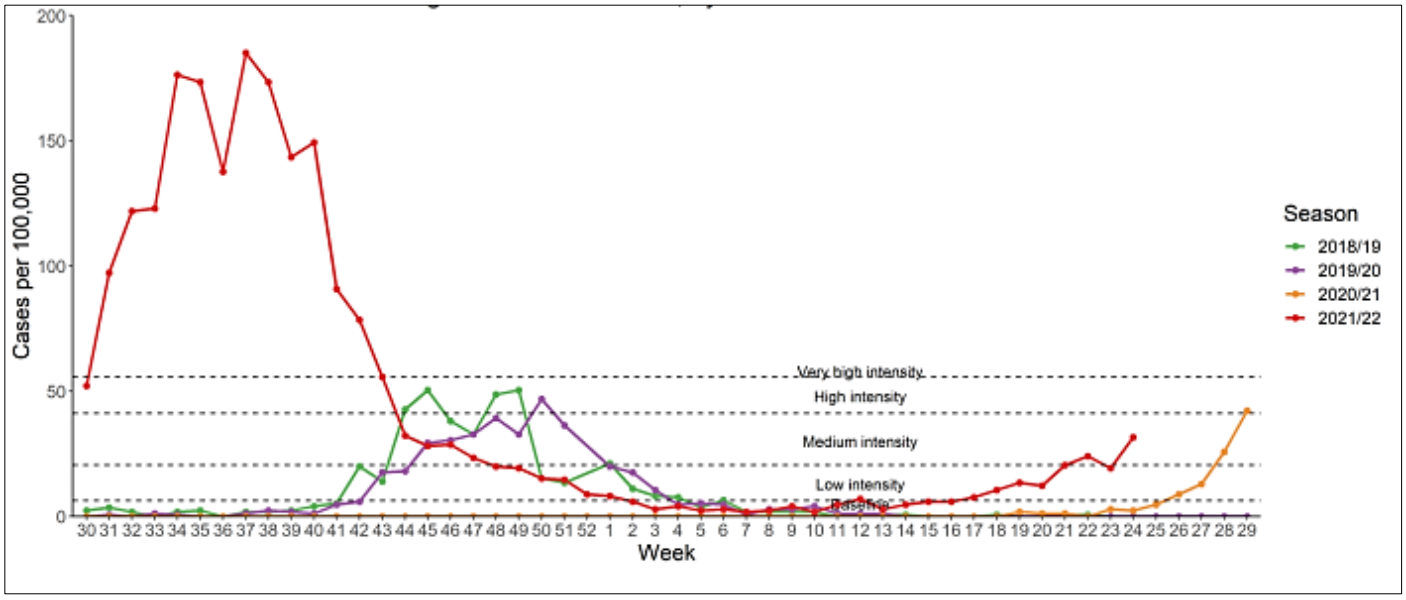
ABUHB are progressing with the necessary requirements to deliver the programme of investigation work in relation to patient safety incidents of nosocomial Covid-19. The Covid Investigation Team will report progress to the QPSOC in January 2023.

Other Respiratory Infections

A Public Health Briefing issued on 23rd June 2022 outlined the usual pattern of circulation of seasonal respiratory viruses and other acute respiratory infections.

Prior to the pandemic (2020) Respiratory Syncytial Virus (RSV) season routinely occurred in Wales in the Autumn. However, there was no significant RSV season during the autumn and winter of 2020/21. RSV season in 2021/22 began at the end of June, much earlier than would usually be expected, the number of inpatients presenting to ABUHB with Influenza and RSV remains low. **Fig 4** shows RSV incidence rate in those aged under 5 in Wales by week.

Fig 4:



Potentially an even earlier start to the 2022/23 RSV season may be occur, although it is too early to predict how long the season will last, when it will peak (and at what level of activity), or whether there may be a subsequent increase in activity later in the 2022/23.

In response Family and Therapy Division are preparing the following: -

- Possible surge in beds.
- Re-iterating the RSV teaching to key staff
- Alerting the paediatric and primary care teams
- Establish reporting mechanisms for PHW surveillance group about the SARI notifications

Welsh Government Antimicrobial (AMR) and Healthcare Associated (HCAI) Improvement Goals

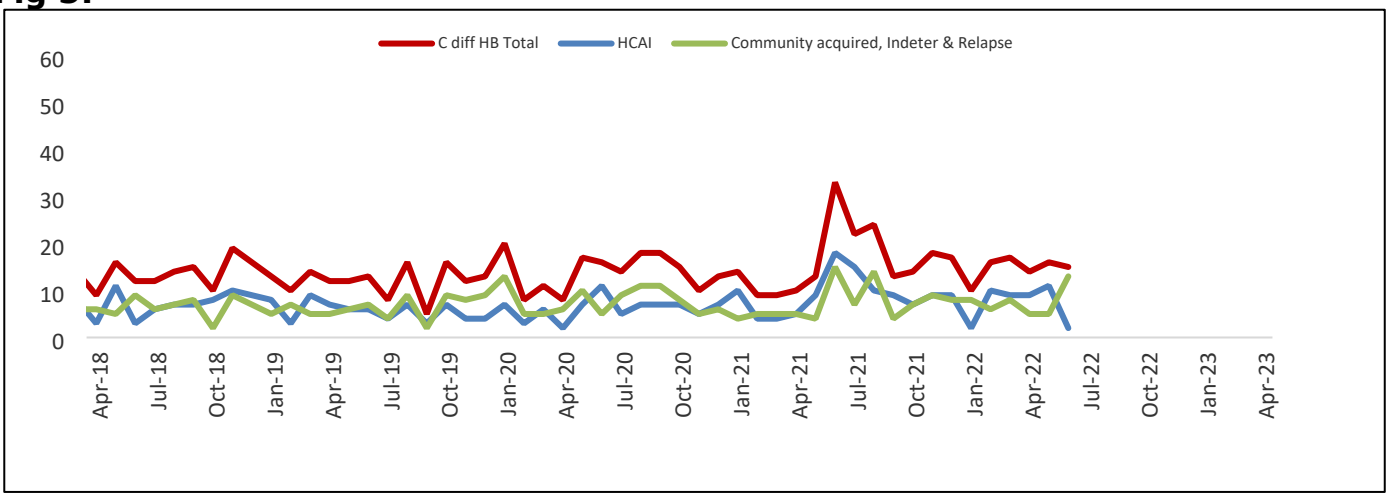
Welsh Health Circular issued on 1st March 2022 outlined the reduction expectations which have been extended until March 2023.

C *difficile*

C *difficile* continues to be above trajectory and remains a concern albeit slow improvement is being seen.

Fig 5 shows HB performance from April 2018 to June 2022. Cases average from 10 to 15 cases per month. The table below displays breakdown of cases for May and June.

Fig 5:



Month	HCAI	CAI	Indeterminate	Relapse	TOTALS
May	11	3 (1 x other HB)	2	1	**17**
June	2	5	4	4	**15**

Analysis of the antibiotic reviews demonstrate:

- 3 did not receive antibiotics
- 11 received antibiotics in line with guidelines, culture results or microbiology advice
- 7 patients received potentially suboptimal antibiotics
- 11 reviews are pending

Learning from route cause analysis includes:

- A recurrent theme associated with piperacillin/tazobactam prescribing in secondary care, this will be fed back to secondary care teams, and primary care learning fed back to the relevant practice.

- One new outbreak linked to B0 at The Grange University Hospital, learning was identified around cleaning of patient equipment and using the incorrect solution for decontamination. This has now been resolved via procurement and staff education.

- Faecal Microbiata transplant was considered for at least one of the relapse cases.

- Laboratory Genotyping from a previous outbreak indicated that cross infection was likely to have occurred locally in Ysbyty Ystrad Fawr hospital.

One of the key preventable measures to reduce HCAI is the Hydrogen Peroxide Vapour (HPV) proactive clean. There has been significant slippage in the delivery of the programme at The Grange and Community Hospitals due to inpatient capacity and the inability to secure decant space.

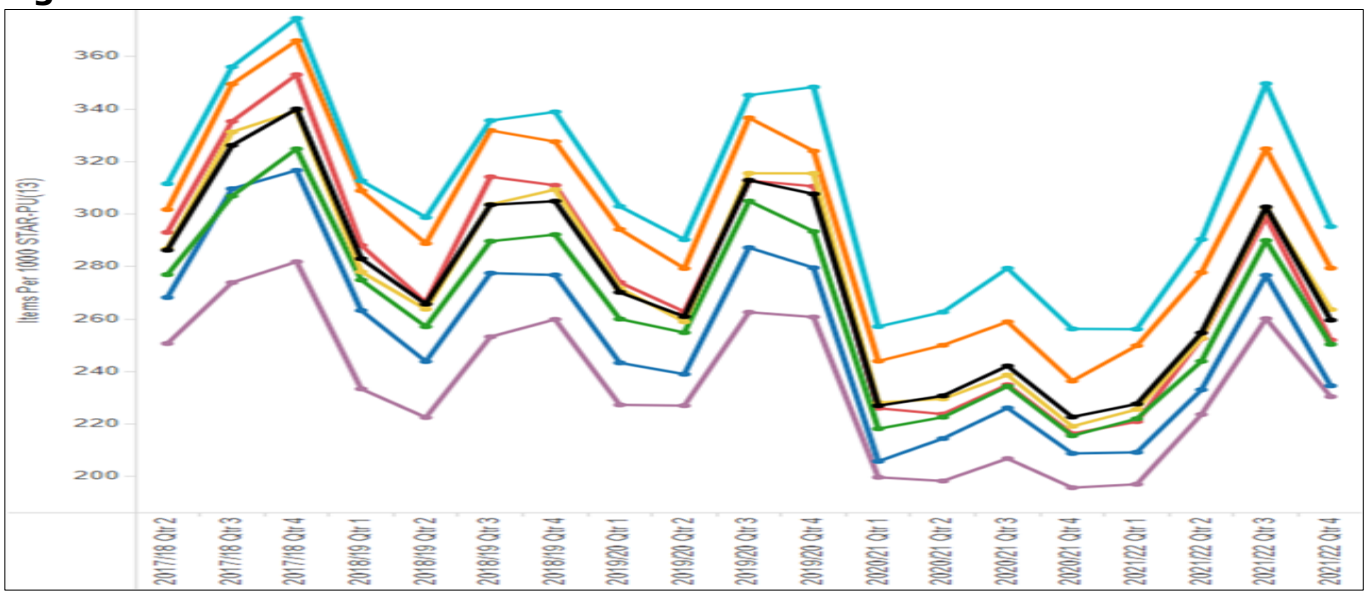
Antimicrobial Resistance

Antibiotics within the WHO 'Access' category are narrow spectrum antibiotics, which carry a lower risk of resistance and other adverse effects. The Welsh Government expectation is that 55% or more of total antibiotic use in secondary care should be in the 'Access' category. ABUHB has exceeded the target, increasing to 63% 'Access' use for Q2 21-22 (GUH 58%, YYF 63.5%, NHH 66.6% & RGH 67.6).

The other secondary care improvement goal is implementation of 'Start Smart Then Focus' (SSTF), the principles of best practice for antimicrobial stewardship, via roll out of the Antibiotic Review Kit (ARK) methodology. This includes a hard stop of all antibiotics at 72 hours, forcing review and, if required, re-prescription of antibiotics. ARK was rolled out to GUH and RGH in June, this completes roll out to acute sites. Next step is to ensure practice is embedded and monitored.

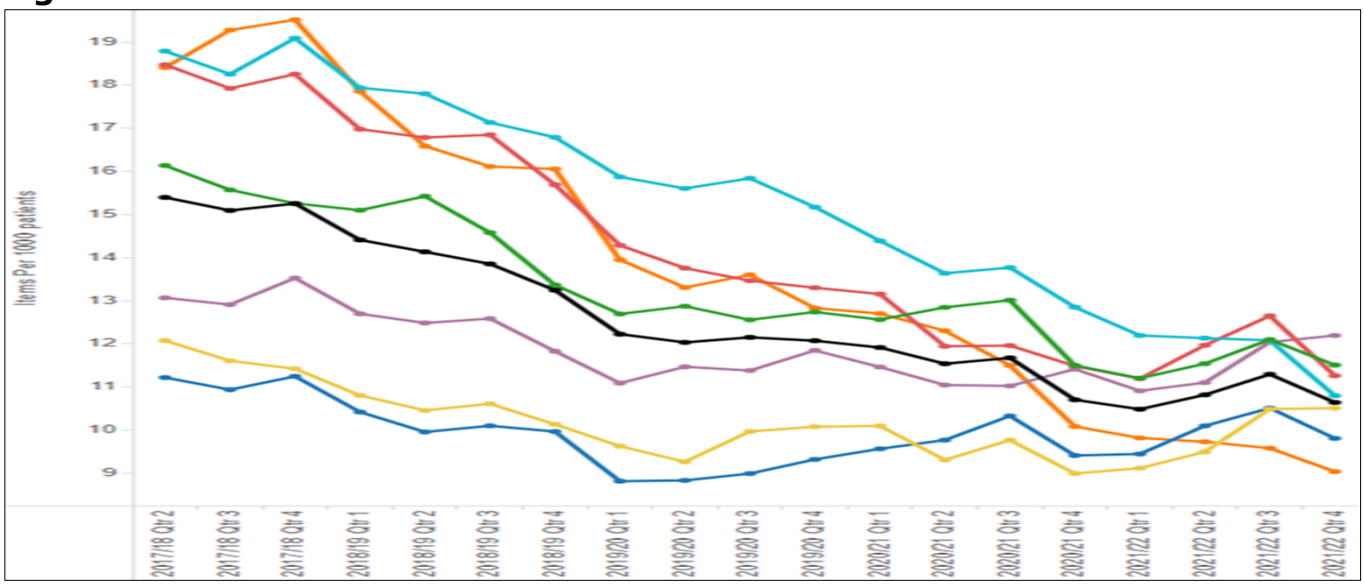
Total antimicrobial use in primary care peaked in Q3 21-22, but reduced again in Q4. Despite this, ABUHB is still on track to meet the WG 2023 reduction target. Of concern is an increase in prescribing in Blaenau Gwent, resulting in the locality now being the highest antibiotic prescribers in Wales. **Fig 6** demonstrates the increase in antibiotic volume. ABUHB is the yellow line, tracking the all-Wales average black line

Fig 6:



Use of 4C antibiotics (higher risk for resistance and *C. difficile* infection) has increased in Blaenau Gwent, indicating this locality is an outlier. ABUHB is only just below the all-Wales average. It is considered these trends may be attributable to staffing issues, as previous changes in antibiotic use have been proportionate to use of locum prescribers. It is hoped that the existing primary care Antimicrobial Pharmacist vacancy will be recruited to imminently, alongside a newly funded post. This additional workforce will ensure a targeted approach within Blaenau Gwent to reverse these trends. **Fig 7** shows ABUHB are amongst the lowest prescribers of 4C agents in Wales, however the increasing trend requires ongoing scrutiny.

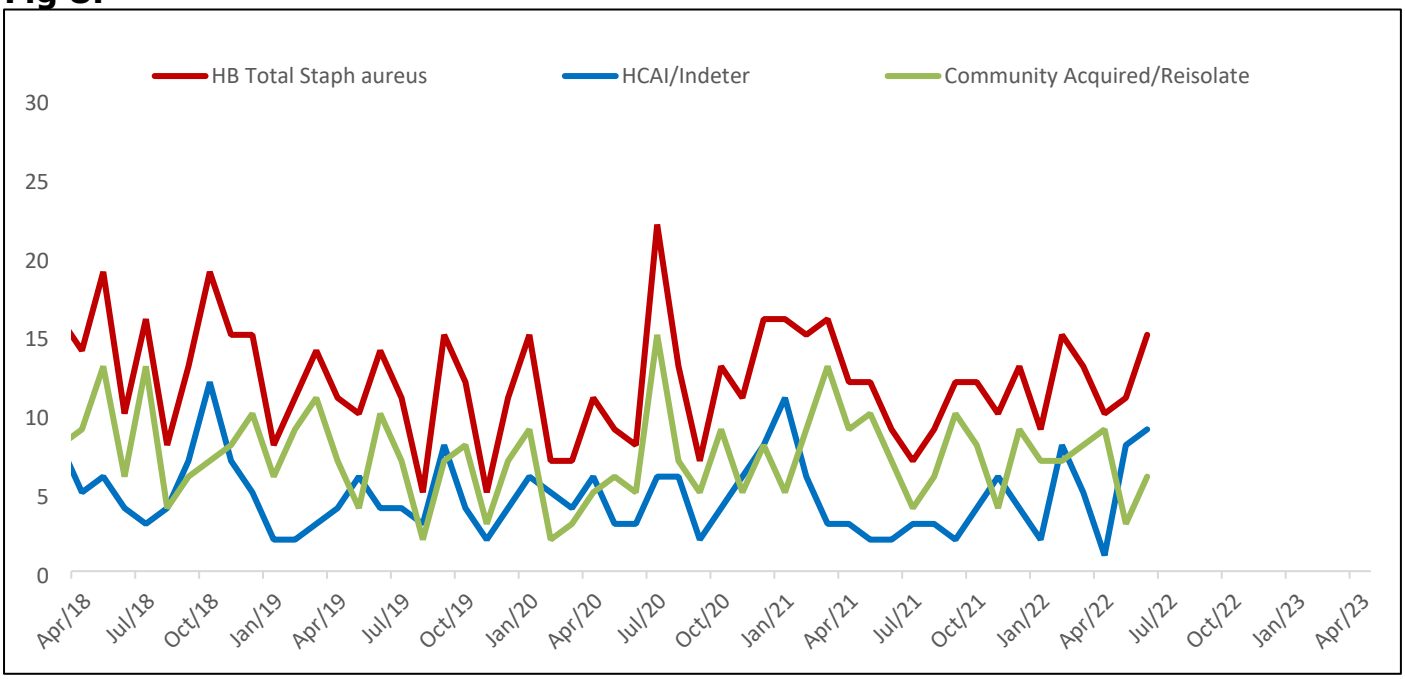
Fig 7:



Staphylococcus aureus bacteraemia

Fig 8 shows HB performance from April 2018 to June 2022. Cases range from 5 to 20 cases per month. The table below displays breakdown of cases for May and June.

Fig 8:



Month	HCAI	CAI	Indeterminate	Reisolate	TOTALS
May	8	3	0	0	**11**
June	9	6	0	0	**15**

Root cause analysis reviews have identified 7 cases linked to line infections over the last two months. Two MSSA cases were linked to Cardiology, potentially linked to a delay in a procedure taking following line insertion. Insertion processes has been reviewed locally and lines will now be inserted in the Cath lab to avoid prolonged delay.

Two cases of MRSA were detected on twins in the neonatal unit. The babies were transferred from Cardiff University Health Board. On arrival, concerns were noted with cannulas already in place. Cannulas were removed, but several days later the twins became unwell. It is considered, the MRSA blood stream infection was secondary to multiple line insertions. Both babies have returned to Cardiff and are improving.

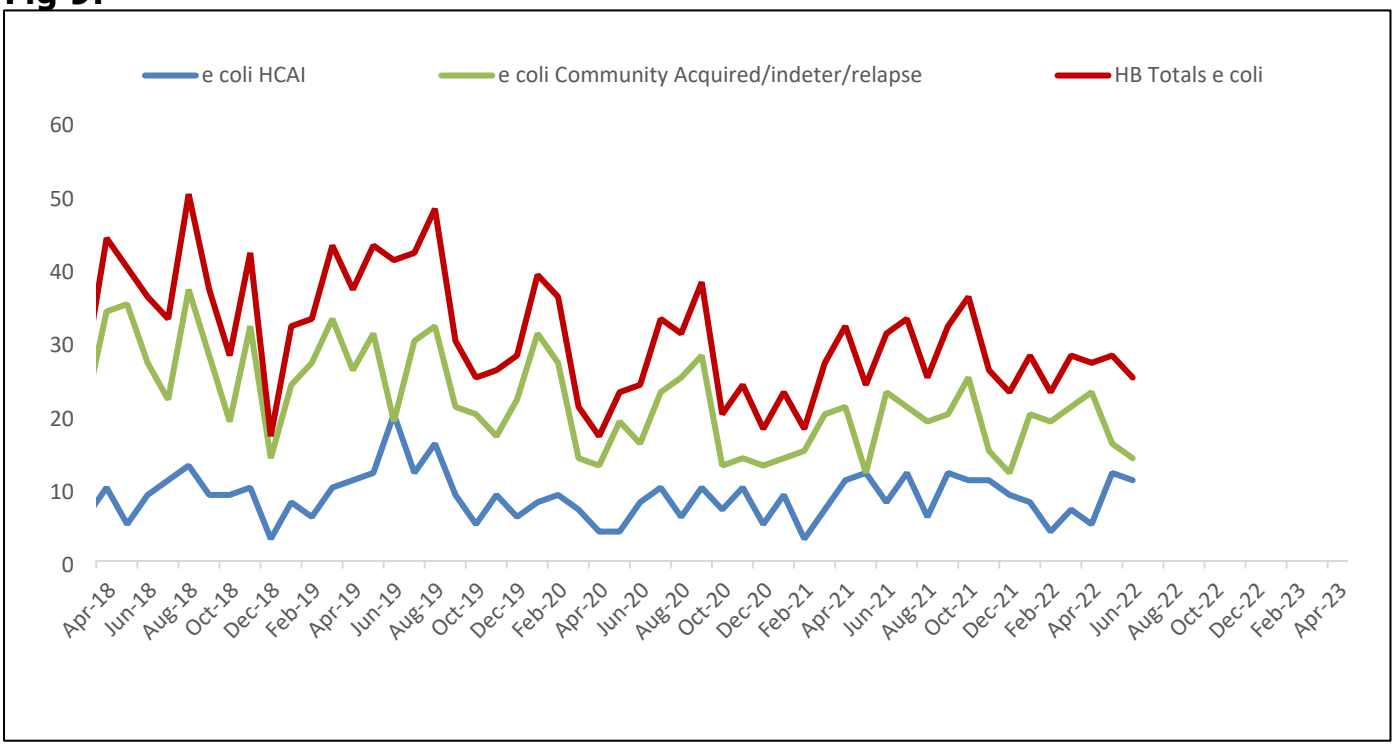
IPT are supporting Divisions to actively promote Aseptic Non-Touch Technique (ANTT). ABUHB ANTT Steering Group is being re-established and refreshed. Radiology is progressing a business case for a Peripherally Inserted Central Catheter (PICC) Line Service which will aim to provide patients with the right line at the right time.

Gram Negative bacteraemia

E coli

Fig 9 shows HB performance from April 2018 to June 2022. Cases range from 17 up to 50 cases per month. Since August 2020, cases average 26 per month. The table below displays breakdown of cases for May and June.

Fig 9:



Month	HCAI	CAI	Indeterminate	Reisolate	TOTALS
May	12	16	0	0	**28**
June	11	14	0	0	**25**

Patients presenting septic on admission continues to be the highest contributing factor to the case rate. The main source of infection remains urinary/respiratory and biliary sepsis. No outbreaks have been identified over the two-month reporting period.

Community IPT are visiting Care Homes to raise awareness of the Care Home UTI Algorithm. The overarching aim is to prevent UTI and to improve practice.

These contact visits include:

- A request for information around how many people living in the care home have experienced a UTI in the last 6 months with a view to collecting this data following the intervention.
- An offer to provide education for care home teams which include the elements of the algorithm, including UTI prevention, recognition of symptoms, diagnosis / sampling and management.
- Distribution of the TARGET UTI leaflet

As at the end of June, the team have undertaken: -

- 26 care home contact visits
- 6 care home education sessions

The IPT are collaborating with Community Hospitals and the Bladder & Bowel Service participating in the HOUDINI Project: "Make that catheter disappear": Preventing catheter associated UTI (CAUTI). The aim is to reduce the number of catheter days and incidence of CAUTI by timely removal of catheters when no longer indicated thus improving catheter care. The initiative is being piloted in County hospital with a plan to scale-up the project to Ysbyty Aneurin Bevan. Other aspects of the initiative include:-

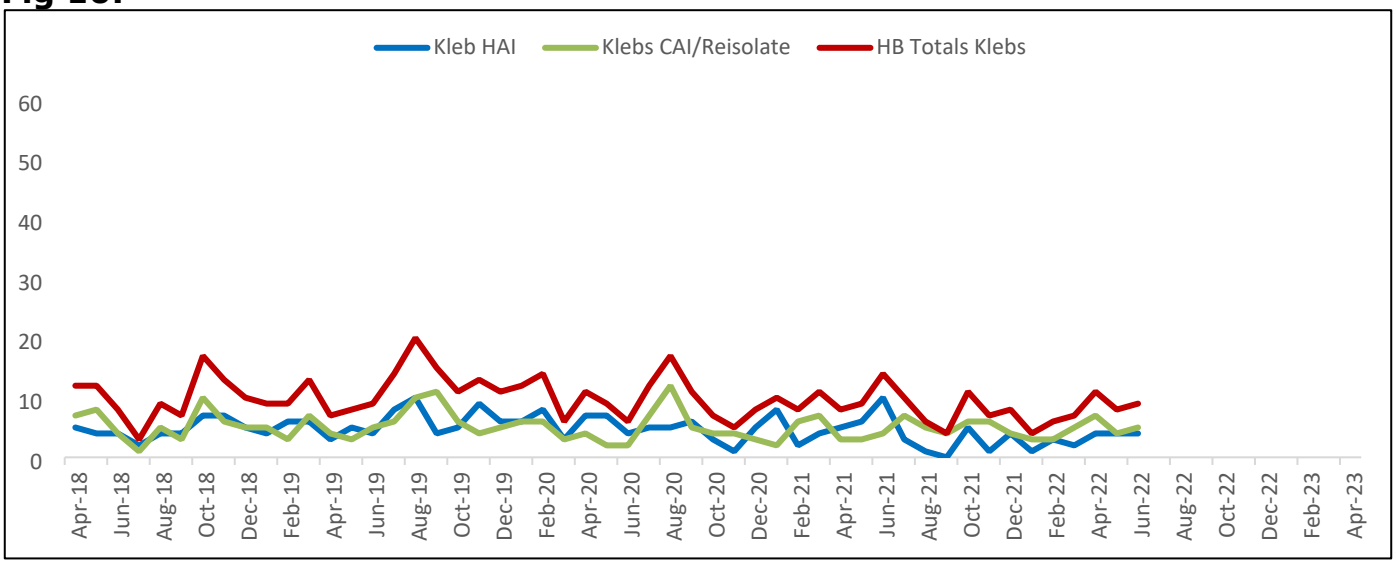
- Catheter care and 'trial without catheter' education to ward teams (5 sessions provided to date)
- Revised catheter care bundle to be piloted
- Daily review of all patients with catheters utilising the 'Patient Safety at a Glance' (PSAG) boards

With the aim to reduce the risk of respiratory infections secondary to Covid-19, an oral hygiene audit tool has been shared with the Divisional Nurses. Poor mouth care has been linked as a risk factor.

Klebsiella

Fig 10 shows HB performance from April 2018 to June 2022. Average cases per month remain below 9. The table below displays breakdown of cases for May and June.

Fig 10:

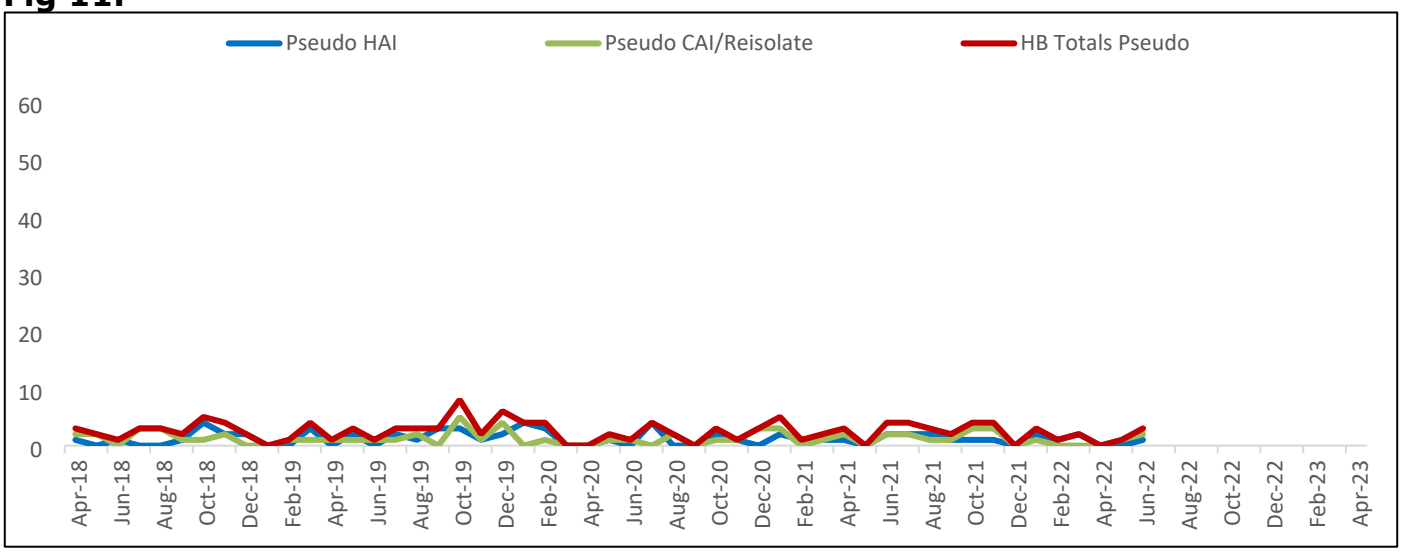


Month	HCAI	CAI	Indeterminate	Reisolate	TOTALS
May	4	2	0	0	**6**
June	4	5	0	0	**9**

Pseudomonas

Fig 11 shows HB performance from April 2018 to June 2022. Cases average 2 per month with some months experiencing zero cases. The table below displays breakdown of cases for May and June.

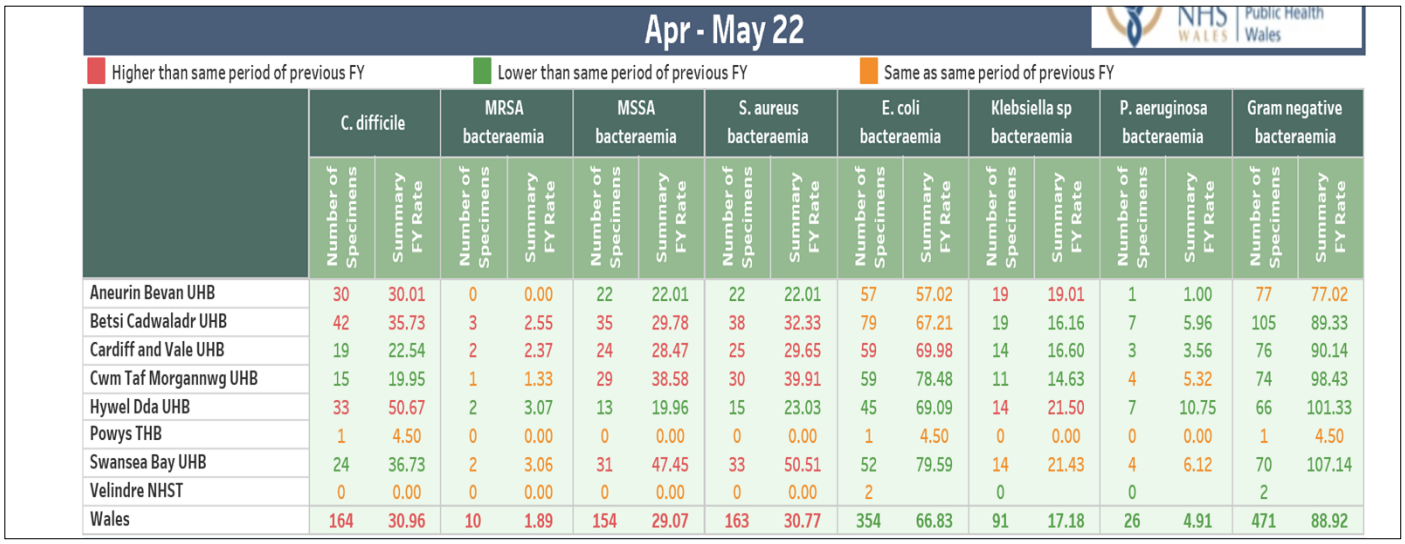
Fig 11.



Month	HCAI	CAI	Indeterminate	Reisolate	TOTALS
May	0	1	0	0	1
June	1	2	0	0	3

All Wales comparisons

With the exception of C *difficile*, ABUHB has the lowest rates for Staph aureus and gram negative bacteraemia in Wales, as can be seen in the following table.



Apr - May 22

NHS Wales | Public Health Wales

Higher than same period of previous FY | Lower than same period of previous FY | Same as same period of previous FY

	C. difficile		MRSA bacteraemia		MSSA bacteraemia		S. aureus bacteraemia		E. coli bacteraemia		Klebsiella sp bacteraemia		P. aeruginosa bacteraemia		Gram negative bacteraemia	
	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate
Aneurin Bevan UHB	30	30.01	0	0.00	22	22.01	22	22.01	57	57.02	19	19.01	1	1.00	77	77.02
Betsi Cadwaladr UHB	42	35.73	3	2.55	35	29.78	38	32.33	79	67.21	19	16.16	7	5.96	105	89.33
Cardiff and Vale UHB	19	22.54	2	2.37	24	28.47	25	29.65	59	69.98	14	16.60	3	3.56	76	90.14
Cwm Taf Morgannwg UHB	15	19.95	1	1.33	29	38.58	30	39.91	59	78.48	11	14.63	4	5.32	74	98.43
Hywel Dda UHB	33	50.67	2	3.07	13	19.96	15	23.03	45	69.09	14	21.50	7	10.75	66	101.33
Powys THB	1	4.50	0	0.00	0	0.00	0	0.00	1	4.50	0	0.00	0	0.00	1	4.50
Swansea Bay UHB	24	36.73	2	3.06	31	47.45	33	50.51	52	79.59	14	21.43	4	6.12	70	107.14
Velindre NHST	0	0.00	0	0.00	0	0.00	0	0.00	2		0		0		2	
Wales	164	30.96	10	1.89	154	29.07	163	30.77	354	66.83	91	17.18	26	4.91	471	88.92

Decontamination – progress update

- Work is ongoing at the Bevan Health and Wellbeing centre located in Tredegar, including the decontamination rooms for General Dental Practitioner (GDP). The handover of the building is anticipated in April 2023 with the aim to operationalise 3 weeks later.
- The Newport East Health & Wellbeing Centre start pre-enabling works mid-July. Current Community Dental Services (CDS) at Clytha Clinic will transfer to the new centre, which will also become a potential centralised decontamination unit for satellite clinics such as Caldicot Clinic. This new build will provide decontamination facilities compliant with required standards Welsh Health Technical Memorandum (WHTM) 01-05.
- The Royal Gwent Hospital (RGH) new endoscopy suite works are commencing mid July with aim of completion in August 2023. A new project team is being developed to support the operational aspects of scope supply to the unit from August 2023 when the existing Endoscopy Unit (including decontamination) will be decommissioned.
- Stage 4 fees for the RGH centralised decontamination unit have been secured. The design is being completed with engagement from the successful Endoscope Washer Disinfector (EWD) manufacturer, Getinge, with aim of contractor tender process commencing in April 2023. The 27 week building works will commence August 2023 once footprint has been vacated. This new facility will initially

provide decontamination services for endoscopy at the RGH followed by other RGH stakeholders such as Urology Directorate as required.

- The Urology OPD Reverse Osmosis (RO) at the RGH has failed resulting in no Endoscopy Washer Disinfector (EWD) facilities at the unit. This is being addressed however single use scopes continue to be used in the meantime to maintain the service.
- 2 out of the 3 newly purchased scope drying cabinets at Endoscopy Ysbyty Ystrad Fawr (YYF) have been installed with 1 in use, 1 awaiting commissioning and 1 to be installed. This will ensure appropriate drying and storage standard compliance.
- The Grange Hospital (GUH) HSDU endoscopy unit has been commissioned for use. from Monday 4th July this will enable all GUH scopes to be decontaminated on site, preventing transport and delay in decontamination. This further supports compliance with required WHTM 01-06 standards.
- Endoscopy YYF continue to strive toward Joint Advisory Group (JAG) accreditation. Frequent meetings have occurred with the relevant task and finish groups, however there are areas of concerns raised by the Authorised Engineer (Decontamination). The whole principle of the JAG process is continual improvement and some of these critical factors will impact on the assessment outcome on the elevation of standards. The Directorate are taking this forward with involvement from the ABUHB decontamination manager and Work & Estates.

Works and Estates have been asked to provide an insight into their Strategy to support decontamination services throughout the Health Board. Specifically concerning Authorised Person (decontamination) provision and support to Endoscopy services who are wanting in reaching compliance with required testing standards.

Water Safety

In line with National Guidance, ABUHB continue with a robust routine water testing programme for early indication of Legionella and Pseudomonas. During the reporting period, there have been no incidences of above normal pathogen counts water testing at The Grange Hospital.

Works & Estates department recently alerted the IPT to a concern at Ysbyty Aneurin Bevan (YAB) with the temperature management of the water systems on site. Water testing was carried out rapidly and subsequently Legionella was identified. To mitigate risks, purifying filters were installed on the taps.

Filters also remain in place on taps in most Family & Therapy wards and posters installed promoting the adequate time for flushing of the units.

ABUHB Water Safety Group is closely monitoring the situation.

Glossary

Health and Care Standards

Safe Care
The principle of safe care is to ensure that the population are protected from harm and supported to protect themselves from known harm. The health, safety and welfare of people are a priority. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it delivers. Although the provision of care has some associated element of risk of harm to service users, safe care identifies, prevents or minimises unnecessary or potential harm. Therefore people will be kept safe and protected from avoidable harm through appropriate care, treatment and support.

Effective Care
Effective Care The principle of effective care is that people receive the right care and support as locally as possible and are enabled to contribute to making that care successful. If people receive the right care and support they will be empowered to improve or manage their own health and wellbeing. Interventions to improve people's health must be based on best practice, derived from good quality research. Data relating to care delivery should be maintained in structured, accurate and accessible records. The ability to manage data and information and to communicate effectively will contribute to the delivery of safe and effective care.

Dignified Care
The principle of dignified care is that the population are treated with dignity and respect and treat others the same. Fundamental human rights to dignity, privacy and informed choice must be protected at all times, and the care provided must take account of the individual's needs, abilities and wishes.

Timely Care
The principle of timely care is that people have timely access to services based on clinical need and are actively involved in decisions about their care. Not receiving timely care can have a huge impact on individuals' experience of health services and their ability to achieve the best health outcomes. To ensure the best possible outcome people's conditions should be diagnosed promptly and treated according to clinical need.

Individual Care
The principle of individual care is that people are treated as individuals, reflecting their own needs and responsibilities. All those who provide care have a responsibility to ensure that whatever care they are providing includes attention to basic human rights. Where people are unable to ensure these rights for themselves, when they are unable to express their needs and wishes as a result of a sensory impairment, a mental health problem, learning disability, communication difficulty or any other reason, access to independent advocacy services must be provided. Every person has unique needs and wishes. Individual needs and wishes vary with factors such as age, gender culture, religion and personal circumstances, and individual needs change over time, respecting people as individuals is an integral part of all care

Patient Safety Solutions
Through analysis of reports of patient safety incidents, Ombudsman and Coroners reports and safety information from other national and international sources, the Welsh Government issues advice and/or guidance for the NHS in Wales that can help to ensure the safety of patients. These are issued as Patient Safety Notices (PSN) or Patient Safety Alerts (PSA).

Intersite Transfer
Transfer of patients between ABUHB inpatient sites as part of their treatment pathway.

Covid-19
Coronavirus is an infectious disease caused by the SARS-CoV-2 virus. Most people infected with the virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Some people will become seriously ill and require medical attention.

Clostridium difficile
(C. *difficile*) is a type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. When someone has C *difficile* infection, it can spread to other people very easily if the bacteria gets onto objects and surfaces.

Gram-negative infections
Include those caused by Klebsiella, Pseudomonas aeruginosa, and E. Coli. Gram-negative bacteria –are enclosed in a protective capsule. This capsule helps prevent white blood cells (which fight infection) from ingesting the bacteria. Under the capsule, gram-negative bacteria have an outer membrane that protects them against certain antibiotics, such as penicillin. When disrupted, this membrane releases toxic substances called endotoxins.

Influenza
A highly contagious viral infection of the respiratory passages causing fever, severe aching, and catarrh, and often occurring in epidemics

Respiratory syncytial (sin-SISH-uhl) virus (or RSV)
A common respiratory virus that usually causes mild, cold-like symptoms.

Staphylococcus aureus bacteria (staph)
Lives on the skin and in the nose of many people. It usually only causes a problem such as MSSA bacteraemia if it gets inside the body. Staph infections can be either methicillin-resistant staph (MRSA) or methicillin-susceptible staph (MSSA). MSSA infections are usually treatable with antibiotics. However, MRSA infections are resistant to antibiotics. Many staph infections are mild, but they can also be serious and life-threatening.

Monkeypox
Monkeypox virus is an enveloped double-stranded DNA virus that belongs to the *Orthopoxvirus* genus of the *Poxviridae* family. There are two distinct genetic clades of the monkeypox virus: the central African (Congo Basin) clade and the west African clade. The Congo Basin clade has historically caused more severe disease and was thought to be more transmissible.

Single Cancer Pathway
A Welsh Government target to support diagnosis cancer and starting treatment within 62 days.

Getting It Right First Time (GIRFT)
A national programme of work to improve the treatment and care of patients through in-depth review of services, benchmarking, and a data-driven evidence base to support change.

Recommendation

The Patient Quality, Safety and Outcomes Committee is asked to:

- **Note** the Health Board position against a range of key quality and safety metrics.
- **Discuss** performance, themes and actions for assurance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	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 and a number of areas are also included within the Covid and Corporate Risk Registers.
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)	NA
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	
Public Interest	Report has been written for the public domain.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality, Safety & Outcomes Committee Tuesday 16th August 2022 Agenda Item: 3.3

Aneurin Bevan University Health Board

Clinical Audit Strategy

Executive Summary

The ABUHB clinical audit policy has been revised and will be ratified in July 2022. The development of an ABUHB clinical audit strategy will support the processes to operationalise the policy and ensure that clinical audit is embedded in the Health Board's assurance and quality improvement function.

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

Executive Sponsor: James Calvert Executive Medical Director			
Report Author: Alexandra Scott Assistant Director of Quality and Patient Safety			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board-**	**Patient Quality, Safety & Outcomes Committee**
Date of the Report: August 2022			
Supplementary Papers Attached: ABUHB Clinical Audit Strategy			

Purpose of the Report

The report has been developed to provide oversight of the ABUHB Clinical Audit Strategy 2022-2025.

Background and Context

ABUHB is committed to delivering safe and effective care to the population of Gwent. Clinical audit is an essential tool in ensuring that services continually evolve and develop and are responsive to quality and safety risks.

When carried out in accordance with best practice standards, clinical audit:

- Provides assurance of compliance with clinical standards
- Identifies and minimises risk, waste, and variation
- Improves the quality of care and patient outcomes

ABUHB has adopted a policy on the governance and practice of clinical audit which applies to all staff, and which has recently been revised and will be ratified at the ABUHB Clinical Policies Group in July 2022.

Assessment and Conclusion

A Clinical Audit Strategy (appendix1) has been developed to support the delivery of a meaningful programme of audit designed to provide assurance and inform quality improvement across the Health Board.

A digital clinical audit management tool has been procured to support delivery of the strategy and provide organisational oversight of all clinical audits and the development and monitoring of improvement plans.

The Clinical Audit Strategy will deliver four key priorities:

- Scrutiny of national clinical audit performance with robust development and monitoring of improvement plans
- Divisions will identify clinical audits that allow scrutiny and assurance associated with quality and safety risk
- Trainees are supported to participate in meaningful clinical audits that support clinical governance
- Groups and Committees across the Health Board will commission clinical audit to support effective assurance as required.

Divisions will start to develop local clinical audit plans designed to provide assurance relating to their quality and safety priorities from July 2022. Progress with the Clinical Audit Strategy 2022-25 will be monitored and progressed through the ABUHB Clinical Standards and Effectiveness group.

Recommendation

The committee is asked to agree the clinical audit strategy.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Clinical audits should support meaningful risk assessment and management of Divisional and Corporate risk registers
Financial Assessment, including Value for Money	Clinical audits can provide assurance of effective and safe clinical care and therefore could reduce medicolegal impact on the organisation

Quality, Safety and Patient Experience Assessment	Clinical audit is an effective tool in supporting quality assurance and quality improvement and the strategy will support the development of Divisional clinical audit plans developed around the quality and safety priorities
Equality and Diversity Impact Assessment (including child impact assessment)	Clinical audit can provide assurance around clinical care and mitigate health inequalities
Health and Care Standards	The clinical audit strategy supports the delivery of standard 3.1 safe and clinically effective care
Link to Integrated Medium Term Plan/Corporate Objectives	The clinical audit strategy should support the delivery of the IMTP priorities
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** providing sustainable and long-term benefits to care and population health
	Integration –cross organisational working to provide safe and effective care
	Involvement – to support Divisional ownership and a systematic approach to clinical audit as a quality and safety approach
	Collaboration – working in partnership with all areas of the health Board
	Prevention – delivering effective health promotion, screening, and early intervention
Glossary of New Terms	
Public Interest	Written for the public domain

Appendix 1

Aneurin Bevan University Health Board

Clinical Audit Strategy

2022-2025

ABUHB is committed to delivering safe and effective care to the population of Gwent. Clinical audit is an essential tool in ensuring that services continually evolve and develop and are responsive to quality and safety risks.

When carried out in accordance with best practice standards, clinical audit:

- Provides assurance of compliance with clinical standards
- Identifies and minimises risk, waste and variation
- Improves the quality of care and patient outcomes

ABUHB has adopted a policy on the governance and practice of clinical audit which applies to all staff

Achieving the objectives set out in this strategy will ensure that the Health Board Clinical Audit Policy is implemented and effective, resulting in sustained improvements and the delivery of safe care.

WHO IS THE STRATEGY RELEVANT TO

- The Board
- Divisional Management Teams
- Clinical Directors
- Chairs of Health Board groups and committees
- Clinical Audit Leads
- Education Leads

THE FOUR PRIORITIES

- There is scrutiny of national clinical audit performance with robust development , monitoring and progression of Improvement plans
- Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk
- Trainees are supported to participate in meaningful clinical audits that support clinical governance
- Groups and committees across the Health Board will commissioning clinical audit to support effective assurance where no other evidence is available.

AMaT
Audit Management and Tracking

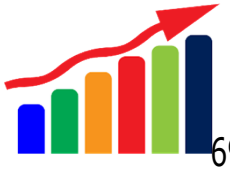
Priority 1

There is scrutiny of national clinical audit performance with robust development and monitoring of improvement plans

The National Clinical Audit and Outcome Review Plan is a comprehensive programme of clinical audit that allows the Health Board to bench mark their delivery of care associated with a board range of evidence based guidance against health organisations across the UK. The National Audit plan can be accessed here .

To ensure an effective and robust approach to considering national audit outcomes and implementing the requisite improvements a systematic approach to the governance of these audits is required.

- On Publication of each national audit the national report and local results will be uploaded to AMaT and the Divisional Triumvirate and the Clinical Lead will be notified of the publication.
- On Publication, all national clinical audits will be reviewed by the Division in partnership with the Clinical Director and Clinical Audit Lead
- An action plan will be developed by the Divisional Triumvirate in partnership with the Clinical Director to support the requisite improvements and uploaded onto AMaT.
- The national audit results and Improvement will be presented to the Clinical Standards and Effectiveness Group within two months of publication by an individual agreed between the Divisional triumvirate and the Clinical Director
- The Divisions will ensure the necessary scrutiny and monitoring of National Audit improvement plans in a Quality and Patient Safety Forum
- All associated risk will be reviewed and where appropriate recorded on the Divisional risk register



Priority 2

Divisions will identify clinical audits that allow scrutiny and assurance associated with quality and safety risk

Quality is the endeavour of continuously, reliably, and sustainably meeting customer, patient or service user needs. This definition places quality at the centre of the health service and as the organisational strategy, not merely a component of the strategy. The Duty of Quality applies to all health service functions in Wales and applies to both clinical and non-clinical functions and the people that deliver those functions.

NHS organisations will be required to ensure that they are routinely using data and information about quality at every layer of the organisation as part of their Quality Management Systems and clinical audit will be an important tool in supporting this function.

Divisional Triumvirates will be required to develop a programme of Clinical Audit that support governance and assurance aligned to the quality and safety priorities of the Division. The quality and safety priorities will include:

- Nationally reportable Incidents
- Patient safety incident themes
- Clinical outcomes
- New Evidence Based Guidance including NICE
- Themes from mortality reviews and M&M

Each Division will be required to present an overview and update of their clinical audit plans at each Clinical Standards and Effectiveness Groups meeting.

- All clinical audits will be registered on AMaT and will have an identified lead.
- All Clinical audits will be monitored at an appropriate and pre-defined quality and safety forum.
- All results will be reported on AMaT
- Where required all actions plans will be recorded on AMaT
- The Divisional Triumvirate will have oversight of all clinical audits and their results and will ensure that the require actions plans are progressed and monitored.
- Clinical Audit will be a standing agenda item on Divisional Quality and Patient Safety Group agendas
- Divisions will be asked to produce a report on a bi annual basis detailing clinical audit activity, results and improvements and present this at the Clinical Standards and Effectiveness Group.

Priority 3

Trainees are supported to participate in meaningful clinical audits that support clinical governance

Where trainees are required to undertake clinical audit as part of their ongoing development, the Directorate and Division have a responsibility to ensure that the necessary arrangements are in place to ensure that they have oversight of these projects, that the results are considered and that were necessary action plans are developed to support the requisite improvements.

Trainees should be supported to undertake meaningful clinical audits that support quality and safety priorities and are involved in the resultant quality improvement.

- All clinical audits undertaken by trainees should be agreed by a clinical supervisor and should contribute to the Divisional Quality and safety priorities
- All clinical audits must be registered on AMaT with the audit supervisor specified.
- All audit results must be uploaded to AMaT if the data is not collected directly onto the AMaT system
- All results will be reviewed by the clinical supervisor
- Where required an action plan will be developed with the support of the Clinical Director with oversight from the Divisional Triumvirate and uploaded to AMaT
- All clinical audits and action plans will be monitored at an appropriate and pre-defined quality and safety forum.
- All Trainees must receive the appropriate acknowledgement of their participation in clinical audit and will be provided with a certificate of participation generated through AMaT .

AMaT Audit Management and Tracking

Priority 4

Groups and Committees across the Health Board will commission clinical audit to support effective assurance as required.

Clinical governance is the systems, processes and behaviours by which organisations lead, direct and control their functions in order to achieve organisational objectives, safety, and quality of service, and in which they relate to patients and carers, the wider community, and partner organisations

The Health Board Quality Assurance Framework Structure comprises a range of groups, each of which forms an essential element of the overall system and controls that are in place within the Health Board; their purpose is to mitigate and manage risk which may occur with regard to the achievement of ABUHB strategic objectives and priorities as set out in the Health Board's Integrated Medium Term Plan. The groups ultimately reporting to the Patient Quality Safety and Outcomes Committee, a sub-committee of the Board.

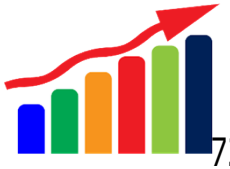
The Quality Assurance Framework support the delivery of a quality management system including

Quality Planning – the health board priorities and plans for the delivery of high quality and safe services

Quality Improvement – The systematic process to implement the improvements required within our services

Quality Control – The processes in place to ensure that the care being delivered

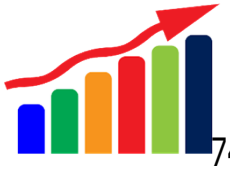
- Every group that forms part of the quality assurance framework will review the evidence available to support its function in overseeing the quality of care provision
- Consideration will be given to implementing clinical audit where no existing evidence is available
- Clinical audit should be considered to provide evidence of improvements here required.
- Clinical audit will be implemented to meet mandated national requirements eg DNACPR audits



Recommendation	Action	Responsible group / Individual	Completion Date
There is scrutiny of national clinical audit performance with robust development and monitoring of improvement Plans	All Clinical Directors, Directorate and Divisional Management Teams, Senior Nurses, Clinical Governance and Quality and Safety Leads will register with AMaT	Divisional Triumvirates	July 2022
	All national audit reports and local data will be disseminated to the Divisions using AMaT	Quality and Patient Safety Team	July 2022
	National audit action plans developed to address requisite improvements will be saved, monitored on AMaT	Divisional Triumvirates	August 2022
	All audits and Improvement plans will be presented at the Clinical Standards and Effectiveness Group	Divisional Triumvirate and Clinical audit lead	September 2022
Divisions will identify clinical audits that allow	Divisions will register two local clinical audits on AMaT that address a current Divisional quality and safety priority	Divisional Triumvirates	July 2022

AMaT Audit Management and Tracking

scrutiny and assurance associated with quality and safety risk	Implement the two registered audits and record the results on AMaT and present the outcomes of these audits at a Divisional Quality and Patient Safety meeting	Divisional Triumvirates	August 2022
	Present overview of local audit activity in Clinical Standards and Effectiveness Groups	Divisional Triumvirates	September 2022
Trainees are supported to participate in meaningful clinical audits that support clinical governance	Provide each cohort of Medical Trainees with registration and training information for AMaT	Medical Education	August 2022
	All clinical supervisors to register with AMaT	Divisional Triumvirates	July 2022
	All clinical audits undertaken by medical trainees to be registered on AMaT and results to be uploaded to AMaT	Directorate Management Teams	From August 2022
	All clinical audits completed by medical trainees to be presented at a clinical audit meeting or quality and patient safety meetings	Directorate Management teams	From August 2022
	All medical Trainees to be issued with a certificate to evidence their involvement in the clinical audit	Directorate Management teams	August 2022



Groups and Committees across the Health Board will commission clinical audit to support effective assurance as required.	All groups and committees that form part of the ABUHB Quality Assurance Framework should review the evidence available to them to identify gaps in assurance and consider commissioning clinical audits to address these gaps.	Chairs of ABUHB groups and Committees	October 2022 2022

Aneurin Bevan University Health Board

National Clinical Audit Activity Report.

Executive Summary

Results for published national audits that have been discussed at the Clinical Effectiveness Committee are provided. Other audits have been reported but not yet discussed. These are listed below.

There were two Diabetes audit reports published during April and May 2022:

- NDA - National Diabetes Audit
- NPDA - National Paediatric Diabetes Audit

The Clinical Lead for NPDA will present at the September 2022 Clinical Standards Effectiveness Group.

In June 2022, the National Cardiac Audit Programme report 'The Heart in Lockdown' was published which incorporates:

- Myocardial Ischaemia National Audit Project (MINAP)
- Heart Failure
- Adult Percutaneous Coronary Interventions (Angioplasty audit) (PCI)
- Cardiac Rhythm Management

The Clinical Leads for these audits have been invited to the September 2022 Clinical Standards Effectiveness Group.

The National Maternity and Perinatal Audit (NMPA) was published June 2022 and the Clinical Lead will present to the Clinical Standards Effectiveness Group in November 2022, along with the Clinical Lead for National Clinical Audit of Psychosis (NCAP) as this report was published July 2022.

Further reports published in July 2022:

- National Asthma and COPD Audit Programme (NACAP) – Pulmonary Rehabilitation/Primary Care
- National Audit of Seizures and Epilepsies (Ep12) – ABUHB not participating
- National Audit of Care at End of Life (NACEL) – TBC

Audits reported to Clinical Standards Effectiveness Group June 2022:

- National Bowel Cancer Audit 2021 annual report Part 1 includes patients diagnosed with bowel cancer between 01 April 2019 and 31 March 2020. To try to minimise any effect of COVID-19 within this audit cohort, we have

included major resections carried out up to March 31st, 2020 (pre-first wave of pandemic).

- National Lung Cancer Audit (NLCA) annual report provides information on the process of care and outcomes for patients diagnosed with lung cancer between 1 January 2019 and 31 December 2019 in Wales. The Welsh audit data are presented separately and are not compared with England due to the differences in data processing between England and Wales.

- National Prostate Cancer Audit Eighth Year Annual Report – Results of the NPCA Prospective Audit in England and Wales for men diagnosed from 1 April 2019 to 31 March 2020 and the Impact of COVID-19 in England during 2020

- National Oesophago-Gastric Cancer Audit (NOGCA) 2021 Annual Report focuses on the care received by patients diagnosed with invasive epithelial cancer of the oesophagus, gastro-oesophageal junction (GOJ) or stomach, or high-grade dysplasia (HGD) of the oesophagus between April 2018 and March 2020. For outcomes of curative surgery among people with OG cancer, data are reported for a three-year period (April 2017 to March 2020) to ensure that enough procedures are included in the analysis to produce robust statistics for individual organisations.

Quality & 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 Director: Dr James Calvert, Medical Director	
Authors: Joanne Stimpson/ Dr James Calvert	
Date of the Report: 29/07/2022	
Supplementary Papers Attached: Nil	

Purpose of the Report

The National Clinical Audit provides oversight of results from National Clinical Audits and Confidential Inquiries and where required gives oversight of the improvements underway to address performance

Background and Context

The National Clinical Audit and Outcome Review Plan (NCAORP) is published by Welsh Government annually, although no NCAORP was published over the Covid-19 pandemic. The NCAORP confirms the list of National Clinical Audits that the Health Board is expected to participate in and confirms how the findings from audits and reviews will be used to measure and drive forward improvements in healthcare in Wales.

Welsh Health Boards and Trusts are required to ensure the resources to enable staff to participate in all audits, reviews and national registries included in the annual plan are available. Health Board's should ensure the full audit cycle is completed and that findings and recommendations from audit link directly into the quality improvement programme and lead to improved patient care and outcomes.

To ensure the maximum benefit is derived from the clinical audit programme Health Boards and Trusts should:

- Ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registries included in the annual Plan.
- Appoint a Clinical Lead to act as a champion and point of contact for every National Clinical Audit and Outcome Review which the Health Board is participating in.
- Ensure Divisional Triumvirates are sighted on all relevant documents as well as the Clinical Lead.
- Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.
- Have clear lines of communication which ensures full Board engagement in the consideration of audit results and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place.
- Facilitate the wider use of data from audit and national registries to be used as supporting information for medical revalidation and peer review.
- Ensure learning from audit and review is shared across the organisation and communicated to staff and patients.

To achieve this in ABUHB; following publication of each National Clinical Audit the audit will be registered on AMaT with an identified Lead. The Clinical Lead in conjunction with the Divisional Triumvirate will review the reports and develop an action plan to address any requisite improvements, within AMAT. Both the results and action plan will be presented to the ABUHB Clinical Standards and Effectiveness Group which reports to Quality and Patients Safety Operational group, a sub group of PQSOC.

Audits presented to Clinical Standards Effectiveness Group:

National Bowel Cancer Audit (NBCA) 2021 - An audit of the care received by people with bowel cancer in England and Wales

The National Bowel Cancer Audit (NBOCA), commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Welsh Government, has been developed by the Association of Coloproctology of Great Britain and Ireland (ACPGBI).

Data for Wales is supplied by the Cancer Network Information System Cymru (CaNISC). The 2021 annual report Part 1 includes patients diagnosed with bowel cancer between 01 April 2019 and 31 March 2020.

Key Points include:

- Data quality at RGH and NHH were of a high standard with several submissions being 100%, case ascertainment over 85%
- Patients seen by keyworker were 97% and 99% for RGH and NHH respectively, better than the National rate of 86%
- Potentially curative cancer resected: both sites comparable to the national average of 83%
- Major resections QA 'at least 12 LN resected' 87% RGH and 83% NHH comparable to NA 86%
- Attempted Lap Surgery is not a Quality Indicator but is recorded and ABUHB is lower than the NA, and this is expected to improve with the increase in the number of surgeons performing laparoscopic surgery – no concerns as not an outlier
- Stage 3 Colon Cancer receiving adjuvant chemotherapy; ABUHB not outliers however rates are lower than the NA; this is impacted on by patient fitness and each patient is discussed in MDT and documented in CANISC
- Rectal Cancer management variances in RGH and NHH due to the number of surgeons operating at each site, Cancer resection margins (CRM) rates recorded for ABUHB higher than NA and CRM Negative rate lower in RGH than NHH however across ABUHB comparable to NA
- APER (resection of rectum) comparable to NA of 39% (RGH 30%/NHH 24%)
- 61% of NHH patients had Permanent Stoma compared to 36% in RGH and NA 36%
- 30-day unplanned admissions RGH and NHH similar to NA of 13.9%
- 30-day unplanned return to theatre 12.8% RGH and 4.3% NHH compared to 12.9% NA.
- 90 day and 2-year mortality rates both comparable to NA
- 18-month stoma unclosed NA 40% with RGH being 40.9% however NHH 56.1%

Actions:

- Closure of de-functioning ileostomy – 25% less theatre lists post-pandemic, and this procedure requires one session (1/2 day list) per patient

- Removing Cancer is higher priority in the reduced theatre capacity than reversal of ileostomy
- Rectal Cancers amalgamated to single site to ensure expertise in one area

National Lung Cancer Audit (NLCA) 2019

The Annual Report data relating to 2019 is pre-pandemic. At the time ABUHB Lung Cancer had two MDT's in RGH and NHH in 2019. Now amalgamated in a single ABUHB MDT. Key points and Actions are based on one MDT. Data for Wales is not directly comparable to England due to the differences in data capture techniques between the two countries.

Key Points include:

- Data capture is excellent due to the support of the Cancer Services and clinicians to ensure robust data collection and vetting.

	N Cases	Performance Status %	Stage %	PS and Stage %	FEV1 %	FEV1 Absolute %	FEV1 in stage I-II and PS 0-1 %	FEV1 Absolute in Stage I-II and PS 0-1 %	CT-Scan %	PET-Scan %	Bronchoscopy %	CT-Scan before Bronchoscopy %
Wales	2240	98.93	99.02	97.99	54.96	54.91	92.29	92.29	93.71	31.43	29.51	95.89
ABUHB	374	100.00	98.40	98.40	67.65	67.65	94.92	94.83	94.92	30.75	30.21	97.27
NHH	127	100.00	97.64	97.64	77.17	77.17	92.91	100.00	92.91	29.92	40.16	97.92
RGH	247	100.00	98.79	98.79	62.75	62.75	95.95	91.43	95.95	31.17	25.10	96.77

- Lung Cancer associated with poor outcomes for patients, the 1-year survival rate was 40.5% (comparable to overall Wales average) and trying to address this is requires large-scale Public Health interventions to optimise pathways.
- The majority of patients are presenting with multiple co-morbidities. The proportion of patients in ABUHB presenting with a good performance status is 38.5% compared to the Welsh Average (WA) 43.7% - treatment options are therefore more limited
- ABUHB Pathological confirmation rate improved 2018 to 2019, 68.5% to 71.93%.

Country First Seen	Number of cases	Pathological diagnosis N	Pathological diagnosis %
Wales	2240	1518	67.77
ABUHB	374	269	71.93
NHH	127	104	81.89
RGH	247	165	66.80

- Challenges to our pathological services need to be addressed as the current situation is not sustainable.
- Lung Cancer Nurse Specialist rates for reviewing patients are better than WA.

Country First Seen	Number of cases	LCNS data completeness %	LCNS assessed %
Wales	2240	94.69	90.36
ABUHB	374	95.45	91.44
NHH	127	100.00	89.76
RGH	247	93.12	92.31

- Anti-Cancer therapy in ABUHB was 56.2% compared to WA 52.2% for 2018 and ABUHB improved to 55.88% for 2019 whilst WA dropped to 50.49%.

Country First Seen	Number of cases	Proportion that had active treatment %
Wales	2240	50.49
ABUHB	374	55.88
NHH	127	63.78
RGH	247	51.82

- PS (performance status) 0-1 with active treatment in ABUHB was 85.42% compared to WA of 77.44%, internal audits have been carried out to ensure that radical treatment is being provided to patients dependant on suitability.

Country First Seen	Number of cases PS 0-1	Proportion of patients with PS 0-1 that had active treatment %
Wales	975	77.44
ABUHB	144	85.42
NHH	57	84.21
RGH	87	86.21

- Surgery recommended rate for resection of patients with early-stage disease and good performance status in England and Wales is 17%. ABUHB was below the WA for 2018 and above the WA for 2019. For some patient's radiotherapy is the preferred treatment and this is not taken into account when assessing surgery rates.
- Advanced stage disease (IIIB/IV) receiving chemotherapy in ABUHB above WA for 2018 & 2019
- Small Cell Lung Cancer (SCLC) SACT rates improved from 58.2% (2018) to 61.4% (2019). Both figures are better than the WA and Chemotherapy for 2019 improved from 2018 for ABUHB, however just under the WA at 64.1% compared to 64.74% - Stage III active treatment for ABUHB for 2019 is 87.5% compared to the WA of 85.37%

Country First Seen	Number of NSCLC cases at stage IIIb, IIIc or IV with PS 0-1	Number of NSCLC cases at stage IIIb, IIIc or IV with PS 0-1 that had chemotherapy	Proportion of NSCLC patients at stage IIIb, IIIc or IV with PS 0-1 that had chemotherapy %
Wales	421	226	53.68
ABUHB	57	35	61.40
NHH	21	16	76.19
RGH	36	19	52.78

- Radical radiotherapy for ABUHB for 2019 is better that the WA at 32.89% compared to 24.9%

	Number of cases	Patients receiving radiotherapy %
Wales	2240	24.91
ABUHB	374	32.89
NHH	127	36.22
RGH	247	31.17

- NSCLC Survival to 30 days for ABUHB is 83.38% comparable to WA of 84.8% - highlighting the often-advanced nature of presentation of patients with this disease.

Country First Seen	Number of cases with NSCLC	NSCLC patients surviving to 30 days after diagnosis %
Wales	2030	84.78
ABUHB	331	83.38
NHH	111	86.49
RGH	220	81.82

- ABUHB has a population presenting with advanced stage disease.
- Early screening of patients has been discussed at HB level and is currently being looked at by NICE for UK roll out. Improved access to smoking cessation services is imperative to develop going forward.
- Higher numbers of patients coming through A&E. This number is expected to rise post-Covid.

Actions:

- Data impacted by CANISC – poor platform for recording data required by the NLCA and a major determinant for the poor data capture and presentation compared to England.
- NHS England had seen a reduction of surgical rates by 5% during 2020 due to the pandemic and we may also see a similar reduction once Wales 2020 data is published
- ABUHB pathologists are under immense pressure. They are looking to relocate to larger premises until they can be sited at GUH. Cannot appoint more staff without increased lab space.

National Prostate Cancer Audit (NPCA) 2019

This 8th NPCA Annual Report covers the diagnostic period between April 1st 2019 and March 31st 2020 in order to bring clinicians and patients up to date with the prostate cancer landscape as it stood just before the pandemic in England and Wales.
ABUHB data from the Annual Report 2021 relating to data from April 19 to Mar 2020.

Key Points:

- 100% performance status recorded
- PSA completed in 76% unsure as to why not higher scoring
- Gleason Score completed in 76%
- TNM completed 77%
- Excellent CNS services
- ABUHB has a sexual function and specialist continence counselling services.
- Risk Group Assigned in 87%
- ABUHB has high risk of men presenting with metastatic disease 19% compared to UK average of 13%
- No national data for treatment to compare, low risk patients receiving radical treatment for ABUHB 13% (surgery or radiotherapy)
- Men diagnosed with advanced disease 66%
- Surgery was halted in 2020 due to the pandemic as treatment was high risk of covid-19
- ABUHB has two surgeons undertaking prostatectomies and there remains uncertainties around the data accuracy identified in NPCA report
- Emergency re-admission rates, 13% (18% in 2018) - many admitted for observation purposes only
- GU complications ABUHB; 11% - about average in comparison to UK average of 8%
- Restrictions in Wales around data quality due to the restrictions in CANISC. This system will soon be obsolete.

Actions:
No actions were noted – suggestions of scrutinising the data to confirm the figures presented within the Annual Report. Concerns over new dataset completion.

National Oesophago-Gastric Cancer Audit (NOgCA) 2021 - An audit of the care received by people with Oesophago- Gastric Cancer in England and Wales

NOGCA Annual Report 2021 for data from 2018-2020. All primary curative treatment is delivered outside of ABUHB.

Key Points:

- Commonest referral route via GP's. Patients discussed at weekly MDT's for determination of curative or palliative care, curative treated outside ABUHB (Velindre/Cardiff)
- 2nd largest HB for number of cases with high Case Ascertainment

Patients diagnosed with OG cancer, 1 April 2018 – 31 March 2020	England	Wales	Betsi Cadwaladr	Hywel Dda	Swansea Bay	Cardiff and Vale	Cwm Taf	Aneurin Bevan
Patient records submitted	19,002	1,317	369	190	227	129	147	255
% case ascertainment	XX%	XX%	85-100%	85-100%	85-100%	65-74%	65-74%	85-100%

- ABUHB above average on CT scan to identify metastatic disease at 91.8% compared to 85.9%

BCUHB	94.3%
Hywel Dda	82.6%
Swansea Bay	91.6%
Cardiff and Vale	89.9%
Cwm Taf	96.6%
Aneurin Bevan	91.8%

- CT-PET for curative treatment; ABUHB identified as a low user of PET at 44.3% - however usage of CT-PET has increased since this data was captured and is now standard practice

BCUHB	80.0%
Hywel Dda	67.6%
Swansea Bay	55.7%
Cardiff and Vale	69.4%
Cwm Taf	78.6%
Aneurin Bevan	44.3%

- Completeness of data on clinical stage is high due to the efforts of the MDT coordinator, 222 of 225 had complete clinical stage data

BCUHB	336 of 369
Hywel Dda	157 of 190
Swansea Bay	202 of 227
Cardiff and Vale	113 of 129
Cwm Taf	140 of 147
Aneurin Bevan	222 of 255

- ABUHB below average at 55.6% compared to 61% of patients with clinical stage 0-3 having plan for curative treatment
- Waiting times are long, over 2 months from referral to treatment for curative treatment– 53% urgent GP refs waited more than the 62 days target while 20% all ref routes waited more than 104 days to primary curative treatment – non curative treatment 12% waited longer than 104 days from ref to treatment – these have improved since with an average of 80 days waiting for curative treatment, non-curative is comparable at 69 days

Curative Treatment

BCUHB	88 days
Hywel Dda	70 days
Swansea Bay	83 days
Cardiff and Vale	64 days
Cwm Taf	74 days
Aneurin Bevan	80 days

Non-Curative Treatment

BCUHB	68 days
Hywel Dda	69 days
Swansea Bay	69 days
Cardiff and Vale	59.5 days
Cwm Taf	59 days
Aneurin Bevan	69 days

- Fewer cancelled clinics now as more surgeons attend from Cardiff which improves referral to treatment rates
- ABUHB has 21% diagnosed via emergency admission; slight outlier compared to some English regions
- OGD capacity impacted by Covid-19 – pre-covid 10-12 OGD's dropped to 4 although now around 7-8
- Increased number of MDT referrals

Actions:

- Investigate ways of reducing number of emergency presentations

Recommendation

The Committee is asked to NOTE the assurance provided by the National Clinical Audit results and the Improvements that are being implemented.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	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 and a number of areas are also included within the Covid and Corporate Risk Registers.
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	
Public Interest	Report has been written for the public domain.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Tuesday 16th August, 2022 Agenda Item: 3.5

Aneurin Bevan University Health Board

National Clinical Audit of Psychosis (2020/2021)

Executive Summary			
The report provides assurance with respect to work undertaken to address improvements in the "Early Intervention in Psychosis Service" following review of results of the National Clinical Audit of Psychosis (2020/2021).			
The Board 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: James Calvert, Executive Medical Director			
Report Author: Sarah Cadman, Head of Quality and Improvement for MH/LD			
Report Received consideration and supported by : Michelle Forkings, Divisional Nurse for MH/LD			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: 04th August 2022			
Supplementary Papers Attached: Nil			

Purpose of the Report

The purpose of the paper is to provide assurance with respect to work undertaken to address requisite improvements highlighted by the National Audit of Psychosis with respect to the Early Intervention Service (2020/2021).

Background and Context

The National Clinical Audit of Psychosis (NCAP) - Early Intervention in Psychosis (EIP) report (2020/2021) provides national and organisation-level findings on the treatment of people by EIP teams in Wales, collected as part of the NCAP. The audit is a 5-year programme, commissioned by the Health Quality Improvement Partnership (HQIP) on behalf of NHS England and NHS Improvement. The first year of the audit examined care provided to people with psychosis by inpatient and outpatient services; in years 2 (2018/2019), 3 (2019/2020) and 4 (2020/2021), the audit examined care provided by EIP services.

EIP services are specialised services providing prompt assessment and evidence-based treatments to people with first episode psychosis (FEP). The report acknowledges that EIP services in Wales and Ireland are in an earlier developmental stage than those in England.

The audit report refers to 'Together for Mental Health', the Welsh Government strategy for Mental Health. The report focuses on the delivery of NICE compliant treatment for 14–25 year olds with an emerging psychosis (NICE quality standard 80 2015; NICE quality Standard 102 2015). Data comprises information relating to timely access, take up of psychological therapies, prescribing, physical health monitoring, employment and education programmes and take up of carer-focused education and support programmes. The report also acknowledges that the audit took place during the pandemic and that services continued to be offered throughout the pandemic by EIP teams.

There is growing evidence for a positive association between treatment provided for first episode psychosis and a favourable prognosis. It is recognised that the longer the psychosis is left untreated the poorer the prognosis.

Assessment and Conclusion

ABUHB provides a standalone multidisciplinary service across the Health Board consisting of a Consultant Psychiatrist, Psychologist, Mental Health Nurses, Peer Support Workers and (in the last year) Occupational Therapist for EIP for people aged 18 and over. 78% of patients known to the service are male with 44.11% between ages 18-35. The Health Board has a caseload of 111 patients compared to the Wales average of 47 patients.

There is wide variation across Wales in relation to timely access, standards met, workforce capacity, staff competencies and resources as well as interventions offered. There have been a number of improvements observed since the previous reported year and most areas of care delivery are comparable or exceed Welsh performance.

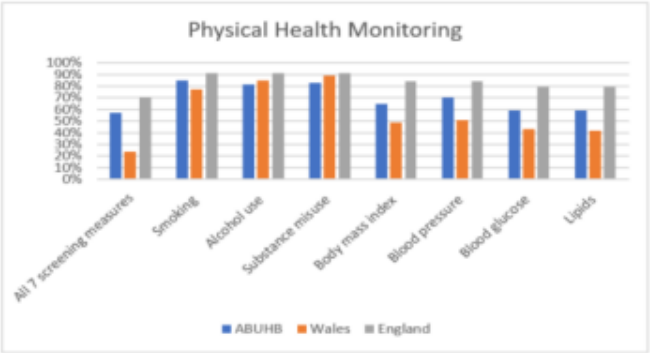
- The evidence suggests that patients should be referred within 2 weeks of onset of a psychotic episode. ABUHB met this standard in 36% of cases.
- 85% of patients were offered cognitive behavioural therapy for psychosis (CBTp) compared to 52% across Wales.
- 35% of patients were offered and started family intervention, with 16% offered and waiting for intervention, compared to 25% across Wales.
- 98% of patients were offered antipsychotic medication, which was comparable with Welsh performance.
- 92% of patients with First Episode Psychosis (FEP) who had 2 adequate but unsuccessful trials of antipsychotics were offered Clozapine compared with 61% across Wales.
- 31% of carers accepted education and support programmes compared with 23% across Wales.
- 70% of patients were offered supported employment programmes, with a further 13% offered and waiting, this compared to 68% across Wales.

There is an increased risk of developing physical health conditions associated with psychosis and as a result screening for physical conditions is an important measure for this patient group. Screening includes, BMI, smoking status, alcohol intake and substance abuse and screening for diabetes and cardiovascular risks.

- 32% of patients in ABUHB received full physical health screening.

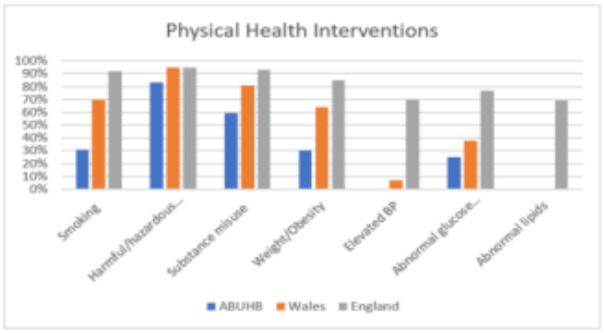
Physical Health Monitoring

	ABUHB	Wales	England
All 7 screening measures	57%	24%	70%
Smoking	85%	77%	91%
Alcohol use	81%	85%	91%
Substance misuse	82%	89%	91%
Body mass index	65%	49%	84%
Blood pressure	70%	51%	84%
Blood glucose	59%	43%	79%
Lipids	59%	42%	79%



Physical Health Interventions

	ABUHB	Wales	England
Smoking	31%	70%	92%
Harmful/hazardous use of alcohol	83%	95%	95%
Substance misuse	59%	81%	93%
Weight/Obesity	30%	64%	85%
Elevated BP	0%	7%	70%
Abnormal glucose control	25%	38%	77%
Abnormal lipids	-	-	69%



Following the audit improvements include:

- Plans to progress the delivery of CBTp to the At Risk Mental State population.
- Development of a strategy to address inequalities in access to the services. Services have been mapped against the 34 service standards using a maturity matrix. This has identified 11 priority standards.
- Development of a Standard Operating Procedure has been developed to support physical health screening. The operational policy is being reviewed to ensure it is current and meets the standards.
- Further work is underway to drive improvements in recording substance misuse and offering interventions.

Action	Progress	Target Date
Delivery of CBTp to the At Risk Mental State Patient Group	The ABUHB EIS team provides a 6-month extended assessment for diagnosis and case conceptualisation for ARMS (suspected FEP) cases, during which time the team provides CBT-p informed intervention as appropriate. A member of the team was supported to commence the three-year training but left their post. The team has attempted to recruit a suitably qualified clinician on three occasions to no avail. The team has now appointed a clinical psychologist who is willing to undertake the training, thus the Health Board will fund this. In the interim, all clinical staff have been supported to attend the Diploma in CBT for psychosis training – a training package specifically designed for EIP - in order that patients benefit from a CBTp-informed approach.	Training to commence this year
Development of a strategy to address inequalities in access to the service	There is a national steering group for EIP services in Wales, led by Improvement Cymru and attended by the Team Lead and others from ABUHB. Work is being taken forward at a national level. Within ABUHB, the EIS works with colleagues in CAMHS to ensure education about FEP and how to access services is in place across other parts of the mental health service (e.g. primary care, primary care mental health support service, in-patient mental health teams) and within schools and colleges.	
Development of a standard operating procedure to support physical health screening	The Team Lead for EIS in ABUHB is chairing the National Physical Health Subgroup to implement service improvement/ guidance across Wales. Additionally, the team successfully recruited to a Nursing post with the remit of supporting physical health screening and intervention.	Started May 22
Development of a framework to drive improvements in recording substance abuse intervention	This work is included in the work above.	

The Cognitive Behavioural Therapy (CBT) for psychosis intervention described by NICE as best practice is a very specific qualification. At the current time, there is one clinician in Wales who holds this qualification. ABUHB is unable to provide the specific Cognitive Behavioural Therapy for

Psychosis (CBTp) for the 'At Risk Mental State' (ARMS) population (people in the prodromal stage of psychosis) described by NICE, however does offer CBTp-informed psychological intervention.

It should also be noted that the 2021/22 National Clinical Audit of Psychosis: Early Intervention in Psychosis Audit Report for Wales was published on 14 July 2022. The report is separate to the English report. Findings will be fed back to CSEG in Autumn however, ABUHB's compliance with the standards is higher than the Total National (Wales) Sample for all but two of the standards.

Recommendation
The committee is asked to note the improvements implemented to address the findings of the National Clinical Audit of Psychosis (2020/2021).

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Constraints in safe and effective care should be risk assessed and adequate mitigation put in place
Financial Assessment, including Value for Money	Effective care delivery could reduce the medicolegal impact on the organisation
Quality, Safety and Patient Experience Assessment	The NCAP is aligned to quality and safety priorities and is a measure of effective care
Equality and Diversity Impact Assessment (including child impact assessment)	The audit seeks to minimise inequalities in health
Health and Care Standards	Effective care standard 4.1: Safe and effective care
Link to Integrated Medium Term Plan/Corporate Objectives	The delivery of all IMTP priorities
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** The delivery of resilient and effective care
	Integration – Working organisations and agencies to meet the population health need
	Involvement – Supporting multi agency and patients involvement in the delivery of care
	Collaboration – Supporting multi agency and patients involvement in the delivery of care
	Prevention – provision of timely and effective interventions to maximise health outcomes
Glossary of New Terms	

Public Interest	Evidence of the safety and efficacy of care delivery in ABUHB

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality, Safety & Outcomes Committee Tuesday 16th August 2022 Agenda Item: 3.6

Aneurin Bevan University Health Board

Cancer Performance

Executive Summary

The delivery of cancer care is facing sizeable challenges across multiple aspects of the patient's pathway. To date, the 75% pass threshold, established as an intermediary target to launch the single cancer pathway, has not been met. Furthermore, since February 2020, the monthly compliance position has continued to fall and in May culminated in its lowest position to date.

As performance wavers, the volume of patients actively waiting over 62 days continues to grow and as of mid-July, 559 patients on a cancer pathway have already breached. The difficulties in delivering cancer pathways to a 62-day timeframe is being influenced by a myriad of operational challenges, often being experienced differently by different teams.

Shifting momentum and changing the current trajectory of cancer performance is a significant task, requiring a major change of approach, likely at the expense of other areas of non-cancer care delivery, due to the finite resource currently delivering routine and emergency work in concordance with cancer work.

Following workshops to fully understand the challenge, work is underway (and gathering momentum) to influence areas and improvements. The breadth of operational challenges discussed during the cancer workshops demonstrates the challenge currently facing cancer, and the scope of improvement work needed to achieve the 62-day pathway.

The greatest improvement to cancer performance will be realised in our ability to efficiently start the cancer pathway with timely appointments and or diagnostics. Supporting services in enabling this will rely on the authority and understanding that prioritising cancer will only be achievable at the deficit of non-cancer work, and in some cases, expansion of the current available work force

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	X
Executive Sponsor: James Calvert, Medical Director	
Report Author: Michael Eastwell, Cancer Services Manager	
Report Received consideration and supported by: Cancer Services	

Executive Team		**Committee of the Board PQSOC**	X
Date of the Report: July 2022			
Supplementary Papers Attached: None			

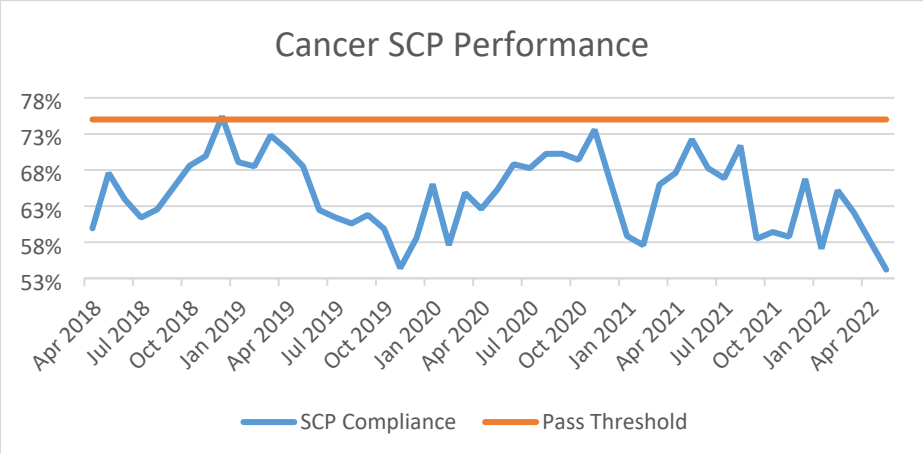
Purpose of the Report

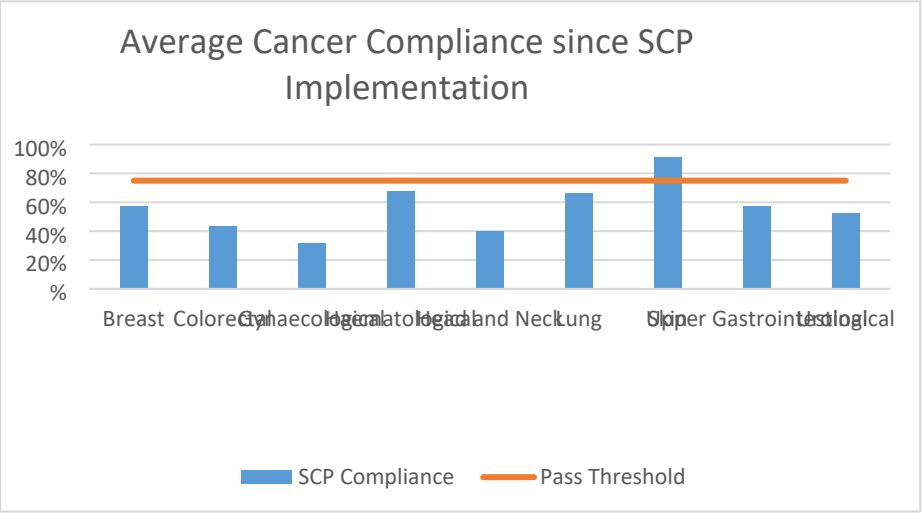
To illustrate the current performance in cancer and identify improvements to address the challenges.

Background and Context

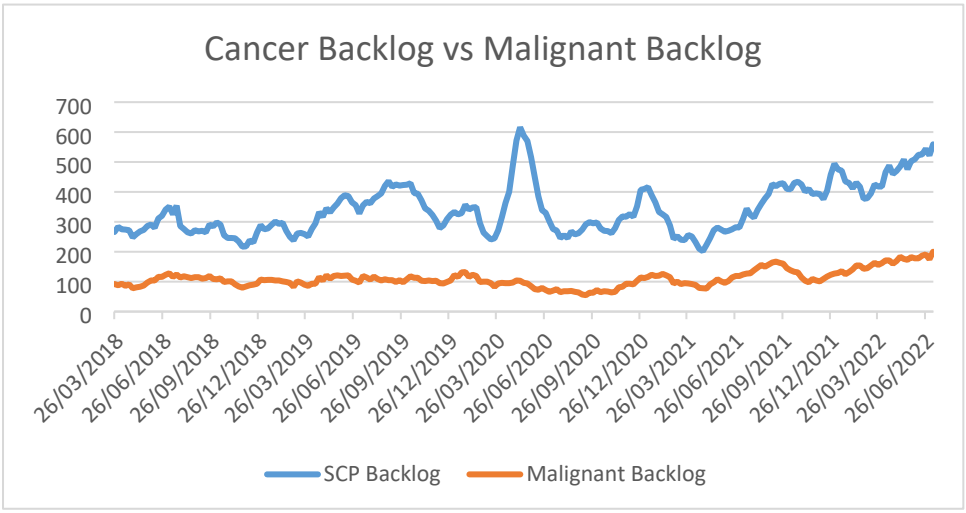
Performance Overview

The delivery of cancer care is facing sizeable challenges across multiple aspects of the patient's pathway. To date, the 75% pass threshold, established as an intermediary target to launch the single cancer pathway, has not been met. Furthermore, since February 2020, the monthly compliance position has continued to fall and in May culminated in its lowest position to date of 53.4%. To achieve the current target a 46% reduction in breaches would be required based on current treatment levels, the equivalent of 73 fewer breaches in a single month. Except for skin, all tumour sites are failing to meet the pass threshold.

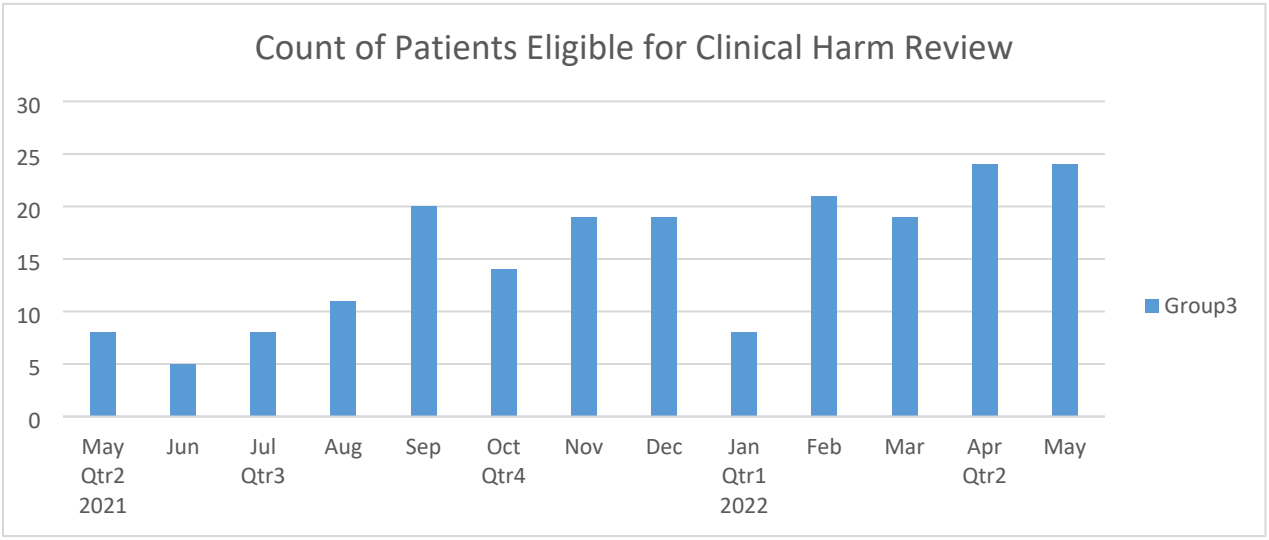




Concerningly, while performance wavers, the volume of patients actively waiting over 62 days continues to grow and as of mid-July, sits at 559 patients on a cancer pathway having already breached. Whilst most of these patients will reach a benign diagnosis, the numbers of patients in the backlog with a known malignancy is also rising at a comparative rate, suggesting upcoming performance figures are likely to continue to struggle and potentially worsen



Health Boards are expected to conduct clinical harm reviews on any patient whose pathway has breached 146 days from the point of suspicion. ABUHB started its own harm review process in January 2022, and in this time have seen a monthly increase in the volume of patients breaching this timeline. Consistent themes have been identified through this process of tertiary delays (including screening pathways) and inefficient or capacity restricted pathways. Delays have also been regularly influenced by patient engagement however to a lesser extent.



Shifting momentum and changing the current trajectory of cancer performance is a big task that is going to require a major change of approach. Embedding this change is almost certainly going to happen at the expense of other areas of care delivery, due to the finite resource currently delivering routine and emergency work in concordance with cancer work.

The difficulties in delivering cancer pathways to a 62-day timeframe is being influenced by a myriad of operational challenges, often being experienced differently by different teams. There are however several broader and more definitive challenges that are having an impact on all tumour sites and have influenced the most recent spike in waiting list and backlog numbers.

Assessment and Conclusion

Delivery Challenges

Demand

Colorectal are now regularly receiving more than 600 referrals per month. This figure is 46% higher than the pre covid mean, and as a result has prompted a 70% increase in the number of USC endoscopy requests, and 48% increase in USC Radiology requests.

Accommodating this additional demand has been one of the major challenges for diagnostic services, and whilst the workload is being absorbed, has led to delays within the cancer pathway which previously would not have existed.
Whilst colorectal has seen the most severe demand increase, similar patterns are also being experienced in UGI, Urology and Breast.

The increasing demand in these services is creating a major bottle neck at the front end of the pathway, resulting in long delays to first appointments, and initial diagnostics. This challenge can be seen through our 14-day first seen compliance which has fallen to 39.9% across the health board and is as low as 15% in the highest demand tumour sites. These capacity constraints are subsequently leading to lower rates of diagnosis by 28 days, which in June was 64%, 14% lower than 2019. First outpatient waits are the single biggest breach reason recorded through our breach analysis.

Establishing the necessary capacity to maintain rapid outpatient appointments and diagnostic capacity at the start of the pathway provides the greatest opportunity for performance improvement and is the focus of all cancer working groups, however it is recognised that enabling this capacity is restricted by the need to maintain non cancer activity.

Capacity

Establishing sufficient capacity to maintain wait times against the standards expected to deliver 62-day pathways is a challenge across most tumour sites. The primary challenge is maintaining sufficient capacity in light or workforce shortages, sickness/annual leave, and non-cancer recovery work. Maintaining sufficient capacity over holiday periods remains challenging. There are also limitations associated still with the opening of the Grange, and this is predominantly due to bed capacity for elective high-risk procedures and change to clinical rotas for GUH cover.

Considering staffing difficulties, alternate options are being explored to increase capacity. This includes the increased utilisation of nurse led clinics such as Colorectal, and private

providers such endoscopy and pathology. The greatest concern is currently within Colorectal considering the dramatic demand increase and the forecast expansion of screening services which is anticipated to increase the volume of cancer surgeries by 196 by 2025.

Tertiary dependencies

ABUHB are heavily reliant on tertiary providers for both treatment and diagnostics in a variety of tumour sites. This includes all radiotherapy and chemotherapy treatment, as well as surgical treatment for our UGI, plastics and some urological and Gynaecological patients. PET scanning and genetic pathology testing are also provided externally.

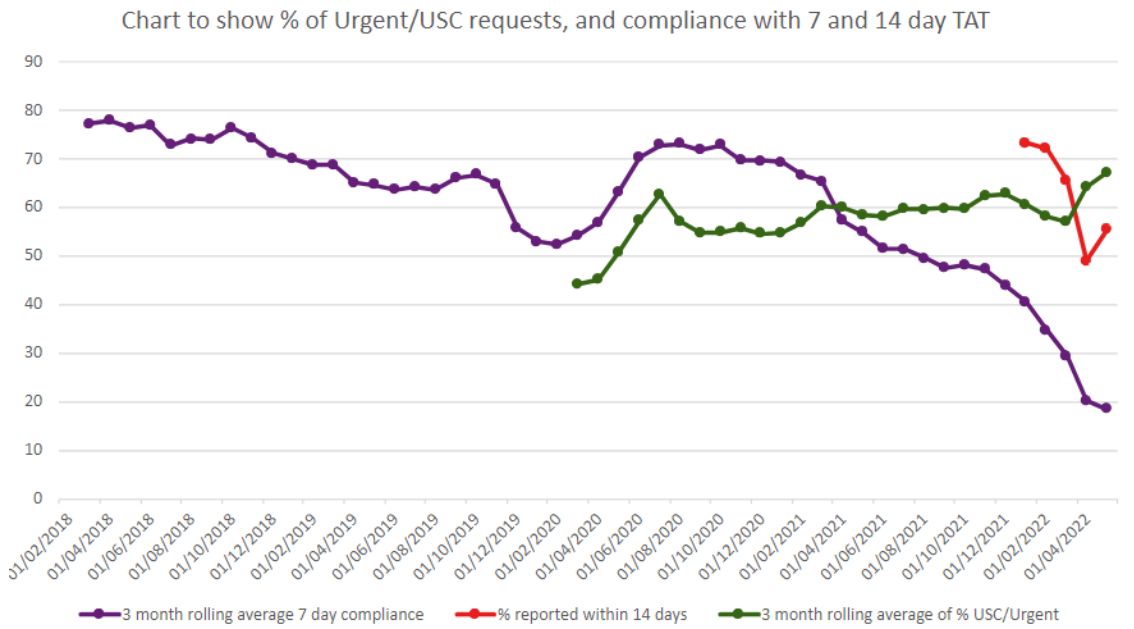
The difficulties being faced currently in ABUHB are also reflected in these tertiary providers and increasingly we are seeing extended waiting times for these procedures. There is currently no form of breach sharing, or waiting time reallocation, and delays at tertiary centres are reflected purely in ABUHB performance.

Breaches are rarely assigned purely to delays at tertiary centres, and this is because we often are not referring for the treatments with adequate time in the pathway for tertiary providers to realistically meet the 62 days. The delays are however regularly contributing to the extended length of wait for some patients, and this is expected to increase due to current staffing challenges within SACT delivery.

Pathology

The demand facing pathology is both increasing in volume and complexity. Since April 2020, the percentage of samples marked as USC or urgent has increased from 45% to 68%, and increasingly samples are needing further work up for genetic testing and re-look. The ability to expand the service is hindered by the available working space, and the ability to recruit specialist staff. As a result, the turnaround time on USC samples has suffered, and the 7-day turnaround time has fallen from 75% to 19% in the same time threshold. 14-day turnaround time has also seen a 24% drop.

Solutions to the estate challenges are being explored with urgency and a business case is currently in the PIP process. Further opportunities are being explored to outsource the routine pathology work, thus alleviating pressure on reporting physicians, however, to date no outsourcing companies have been found, and pathology pressures remain one of the highest concerns.



Patient choice/engagement

When the single cancer pathway was embedded, a change was made to the way pathways are managed that eliminated any ability to apply suspensions to the cancer pathway. As such, performance is now an unadjusted and true representation of waits from suspicion to treatment.

With demand now at a steady state, and COVID impacting pathways less, the scale of patient-initiated delays is becoming apparent, particularly the impact of non-attendances and repeated cancellations. The 146-day harm reviews have identified patient choice as the third most common reason for long waiting breaches after third party delays and inefficient or complex pathways.

Addressing this issue is a challenge that is being addressed through 2 fronts, the first being primary care input and the information being provided to patients at the point of referral. It is common for patients on the cancer pathway to be unaware of the urgency and nature of the referral and so persuading patients to prioritise the appointment can be difficult.
Secondly, admin processes are being refined to ensure patient initiated delays are acted on swiftly and appropriately, with minimal time between missed appointments. This is being addressed through a health board wide staff training programme which has now been delivered to over 100 staff and is published within the intranet.

What are we doing to address these challenges?

Recognising the difficult position cancer finds itself in, and the totality of organisational input required to recover the cancer position, a 2-part workshop was established, providing an opportunity to voice the current difficulties within services, establish the roles and responsibilities in managing patient pathways, and pull together a collective action plan focussed on addressing the challenges that are within scope to begin to improve.

The first of the sessions ran on Wednesday the 29th of June and provided an opportunity for most tumour site teams to demonstrate their current position. The second of the workshops was held on Wednesday the 20th of July, and culminates in the production of an improvement action plan which will be the focal point of recovering cancer performance.

From these workshops, work has begun on trialling innovative approaches to the management of patient pathways, utilising dedicated resource to ensure the timely progression of patients. A thorough demand and capacity procedure will also be required within each specialty to accurately demonstrate the current capacity short falls (a request also received from Welsh Government).

Working groups have been established in Breast, Urology, Lower GI, and Gastroenterology focussing on pathway improvement. This work is being supported from within Cancer Services utilising a dedicated Macmillan Optimal Pathway Manager as well as the substantive work force.

Cancer Services are establishing improved methods of communicating with our tertiary providers and have established a collaborative group with Velindre to improve data and information sharing whilst streamlining join work projects. Tertiary tracking meetings are also in place with Cardiff and Swansea to ensure shared patients are given sufficient attention.

Whilst this work focusses predominantly on cancer waiting times, there are further branches of work being undertaken within Cancer Services focussing on patient experience, prehabilitation and holistic support. A project is now underway focussing on the integration of a digital self-assessment tool for all patients at the start of the cancer pathway providing the opportunity for early health optimisation. This is complemented by the wider Prehabilitation project that is due to launch in August 2022 and looks to provide prehab integration for all patients on the suspected cancer pathway.

The breadth of operational challenges discussed during the cancer workshops demonstrates the challenge currently facing cancer, and the scope of improvement work needed to achieve the 62-day pathway. The greatest improvement to cancer performance will be realised in our ability to efficiently start the cancer pathway with timely appointments and or diagnostics. Supporting services in enabling this will rely on the authority and understanding that prioritising cancer will only be achievable at the deficit of non-cancer work, and in some cases, expansion of the current available work force.

Recommendation

The Committee is requested to note the contents of this paper, and is asked to support the continued multidisciplinary efforts to address the challenges identified

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	This report has no financial consequence.
Quality, Safety and Patient Experience Assessment	This report has been produced for the Committee- mitigation of risks or impact of realised risks.
Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact
Health and Care Standards	This report contributes to the good governance elements of the H & CS.
Link to Integrated Medium Term Plan/Corporate Objectives	Strongly - the objectives will be referenced to the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –**
	Integration – Multidisciplinary approach taken
	Involvement –
	Collaboration – Collaboration with various internal and external groups is continuous
	Prevention – Team members have the authority to raise concerns and flag problems
Glossary of New Terms	New terms are explained within the body of the document.
Public Interest	Report to be published

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality, Safety & Outcomes Committee Tuesday 16th August 2022 Agenda Item: 3.7

Aneurin Bevan University Health Board

A National Review into the Prevention of Venous Thromboembolism (VTE) in NHS Wales

Executive Summary

NHS Wales has conducted a review of VTE care in Wales, with the aim to improve patient safety in relation to the diagnosis and prevention of venous thromboembolisms (VTE). The attached report and action plan has been produced following a patient record review into the administration of prescribed thromboprophylaxis and documentation of a VTE risk assessment for all patient admissions, both medical and surgical. The report outlines recommendations which have been concluded following the review.

The Board 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: James Calvert Executive Medical Director			
Report Author: Leeanne Lewis - Assistant Director of Quality and Patient Safety			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: August 2022			
Supplementary Papers Attached: A National Review into the Prevention of Venous Thromboembolism (VTE) in NHS Wales – WRP paper and ABUHB action plan			

Purpose of the Report

During 2021, 58 cases relating to Venous thromboembolism (VTE) were submitted to the Welsh Risk Pool (WRP) for either approval of a Learning From Events Report (LFER) or reimbursement. The WRP reimbursed health bodies £1.7million for VTE related cases during 2021. 44 of the 58 cases were at the LFER stage and so reimbursement values are not included in the £1.7million; the true figure is likely to exceed £10m. ABUHB submitted three cases to WRP during this time, which equates to a rate of 0.5 per 100,000 population compared with 1.8 per 100,000 population across Wales.

In response WRP commissioned a patient record review across all health boards in Wales with the terms of reference developed in conjunction with the All-Wales Hospital Acquired

Thrombosis (HAT) Committee to assess application of the All-Wales Thromboprophylaxis Policy standards.

Background and Context

The Review established that:

- There was under recording of VTE risk assessment across Wales
- Completion of the VTE section of the adult inpatient medication administration record when thromboprophylaxis was prescribed was excellent.
- Completion of the VTE section of the adult inpatient medication administration record when thromboprophylaxis was not prescribed was unsatisfactory.
- Most health boards had a VTE risk assessment within their clerking proformas but compliance with completion was poor.
- There is no mandatory training relating to VTE within Wales
- All health boards' demonstrated compliance of over 90% in the administration of prescribed thromboprophylaxis within 24 hours of admission or as dictated on the drug chart.

Assessment and Conclusion

The report makes 5 recommendations:

1. **All health boards within Wales adopt the All-Wales Thromboprophylaxis policy**

The ABUHB policy for Thromboprophylaxis for all Hospital Inpatients incorporates the All-Wales Thromboprophylaxis Policy and aims to improve awareness of thromboprophylaxis and patient safety in the hospital setting.

2. **All clinical staff undertake All Wales training, booth in relation to the recognition of patients presenting with symptoms of a VTE and in the prevention of hospital acquired thrombosis**

At present ad hoc training is delivered across the organisation but this will be superseded by the All-Wales training package that will be delivered through ESR which is currently under development. A business case will be developed to support additional resource to support face to face training to address findings from Hospital Acquired Thrombosis (HAT) reviews and patient safety incidents relating to VTE and broader use of anticoagulant.

3. **All patients receive a documented VTE risk assessment using a Department of Health Risk Assessment Tool (or similar) on admission, as part of the initial clerking of patients.**

A compliant VTE risk assessment is incorporated into the general medical and surgical clerking proforma although completion rates are poor. A gap analysis will be undertaken to identify areas where standardised VTE risk assessments are not part of clerking

documentation. Work will be undertaken with the Divisions to support improved completion of the risk assessment.

4. **An All-Wales checklist for the investigation of HAT is developed in order to maintain a uniform investigation approach across NHS Wales**

All potential episodes of hospital acquired thrombosis are subject to review by senior clinicians in the field to establish if they were preventable and to support the identification of modifiable risks. Preventable HAT occurrence has reduced significantly since 2020. ABUHB will amend the review process as required when an All-Wales review tool becomes available.

5. **VTE risk assessment compliance data and HAT data is shared at appropriate health body governance meetings**

Work is underway across ABUHB to standardise the Quality and Patient Safety agenda. VTE will form part of the agenda with consideration given to producing data to support scrutiny, assurance and to inform improvements.

A detailed action plan will be developed to support the delivery of the requisite improvements and will be submitted to WRP in July 2022 and will be presented to the August 2022 PQSOC.

Recommendation
The committee is asked to acknowledge that we are working towards compliance with these recommendations. Work is underway to provide assurance that each of these recommendations will be achieved over the next 12 months, additional resource will involve completion of a business case.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	HAT data and completion of VTE risk assess should be a priority for Divisional and Corporate risk registers
Financial Assessment, including Value for Money	HAT data can provide assurance of effective and safe clinical care to prevent VTE and could reduce medicolegal impact on the organisation. WRP reimbursed health bodies £1.7 million for VTE related cases in 2021.
Quality, Safety and Patient Experience Assessment	VTE risk assessment is an effective tool in preventing harm and long-term co-morbidities from VTE. The QPS team records HAT data monthly providing quality assurance for ABUHB patients.

Equality and Diversity Impact Assessment (including child impact assessment)	VTE risk assessment can provide assurance around minimising the number of HATs and mitigate health inequalities
Health and Care Standards	VTE assessment supports the delivery of standard 3.1 safe and clinically effective care
Link to Integrated Medium Term Plan/Corporate Objectives	The HAT data, compliance with VTE risk assessment and accountability to WRP should support the delivery of the IMTP priorities
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** providing sustainable and long-term benefits to care and population health
	Integration –cross organisational working to provide safe and effective care
	Involvement – to support Divisional ownership and a systematic approach to HAT data and VTE risk assessment as a quality and safety approach
	Collaboration – working in partnership with all areas of the health Board
	Prevention – engagement in the process of HAT prevention leads to lower incidence of VTE and associated comorbidities
Glossary of New Terms	Included within the report
Public Interest	Written for the public domain

ACTION PLAN FOR IMPROVEMENT	
Reference	**A National Review into the Prevention of Venous Thromboembolism (VTE) in NHS Wales**
Health Board	**Aneurin Bevan University Health Board**
Lead Officer for Action Plan (name & title)	**Leeanne Lewis – Assistant Director for Quality and Patient Safety** **Dr Sarah Lewis – Consultant Haematologist – Chair of ABUHB Thrombosis Committee**
Date action plan commenced	**22.07.2022**
Synopsis of Concern	During 2021, 58 cases relating to Venous thromboembolism (VTE) were submitted to the Welsh Risk Pool (WRP) for either approval of a Learning From Events Report (LFER) or reimbursement. The WRP reimbursed health bodies £1.7million for VTE related cases during 2021. 44 of the 58 cases were at the LFER stage and so reimbursement values are not included in the £1.7million; the true figure is likely to exceed £10m. ABUHB submitted three cases to WRP during this time, which equates to a rate of 0.5 per 100,000 population compared with 1.8 per 100,000 population across Wales. In response WRP commissioned a patient record review across all health boards in Wales with the terms of reference developed in conjunction with the All-Wales Hospital Acquired Thrombosis (HAT) Committee to assess application of the All-Wales Thromboprophylaxis Policy standards. The Review established that: • There was under recording of VTE risk assessment across Wales • Completion of the VTE section of the adult inpatient medication administration record when thromboprophylaxis was prescribed was excellent. • Completion of the VTE section of the adult inpatient medication administration record when thromboprophylaxis was not prescribed was unsatisfactory. • Most Health boards had a VTE risk assessment within their clerking proformas but compliance with completion was poor. • There is no mandatory training relating to VTE within Wales • All Health boards' demonstrated compliance of over 90% in the administration of prescribed thromboprophylaxis within 24 hours of admission or as dictated on the drug chart. The report makes report makes 5 recommendations:

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
ONE: All health bodies within NHS Wales adopt the All-Wales Thromboprophylaxis Policy.		The ABUHB policy for Thromboprophylaxis for all Hospital Inpatients incorporates the All-Wales Thromboprophylaxis Policy and aims to improve awareness of thromboprophylaxis and patient safety in the hospital setting. Policy was circulated in Clinical Policy Digest Newsletter on HB intranet and available to all Divisions. All new staff HB wide to be educated in the use of policy and where to locate it.	Policy updated in 2021 and is available in clinical policies on share point. Recirculate Policy via HB wide QPS and governance meetings for clinical and nursing leads Dates for F1 induction for August 2022 for all sites, new F1's included in teaching, face to face or by video link.	Clinical Policy and Standards Group – supported by the Thrombosis Committee Medical Education/ Post Graduate Centre	Leeanne Lewis Dr Sarah Lewis	**Autumn 2022**

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
TWO: All clinical staff undertake All-Wales training, both in relation to the recognition of patients presenting with symptoms of a VTE and in the prevention of hospital acquired thrombosis (HAT).		At present ad hoc training is delivered across the organisation but this will be superseded by the All Wales training package that will be delivered through ESR which is currently under development. A business case will be developed to support additional resource to support face to face training to address findings from Hospital Acquired Thrombosis (HAT) reviews and patient safety incidents relating to VTE and broader use of anticoagulant. All Wales HAT group to set the report for the uptake rate of clinicians successfully completing teaching tool for HB to achieve. VTE teaching becomes part of mandatory ESR learning for ALL clinical staff. HB wide VTE teaching as part of F1 induction.	VTE teaching tool under development with WRP and ESR, due for launch in autumn 2022. Develop business case based on cost avoidance of harm and benefits of training in VTE assessment. WRP to inform HB's of required teaching tool uptake rate, this will be reviewed annually initially. Teaching tied in with clinical staff annual review/ PADR/ ESR.	All Wales HAT group WRP Leeanne Lewis Dr Sarah Lewis WRP Leeanne Lewis QPS WRP	Leeanne Lewis	**Autumn 2022**

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
		ABUHB ESR uptake figures reported monthly to governance and thrombosis committee who will review and report to WRP.	Work with post-grad and Education supervisors to set up VTE teaching via video link/ webinar for all new clinical staff. Compare ESR training figures with HAT rate in clinical areas for organisational learning	Medical Education Post Grad QPS WRP Leeanne Lewis Dr Sarah Lewis	Dr Sarah Lewis	

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
THREE: All patients receive a documented (Full) VTE risk assessment, using a Department of Health Risk Assessment Tool (or similar) on admission, as part of the initial patient clerking.		A compliant VTE risk assessment is incorporated into the general medical and surgical clerking proforma although completion rates are poor. A gap analysis will be undertaken to identify areas where standardised VTE risk assessments are not part of clerking documentation. Work will be undertaken with the Divisions to support improved completion of the risk assessment. Tools must comply with NICE CG89 guidance as per the All Wales TP Policy. Support of CEO, Medical director, clinical directors, Nurse director and senior nurse's essential. Provide TP risk assessment tools on Thrombosis intranet page and available as PDF documents on SharePoint so they are accessible to all clinical areas, where clerking documents are not used.	Currently risk assessment and prescribing of thromboprophylaxis utilising the VTE prescribing section on the in-patient medication chart on each site is excellent. Formal completion of the risk assessment in notes remains a challenge. Work with informatics to look at an electronic solution. Evidence of use of acute and elective risk assessment tools in all sites. Sites who do not use clerking documentation, education needed to signpost. Haematology page being developed and dedicated Thrombosis section will be incorporated to include all Policies and risk assessment	Thrombosis committee Leeanne Lewis Dr Sarah Lewis Informatics Thrombosis Group Thrombosis Committee	Leeanne Lewis Dr Sarah Lewis	**Autumn 2022**

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
		Obstetrics implementing electronic VTE risk assessment for ALL maternity in-patients and out-patients. Task and Finish Group with Clinicians and work with Quality Improvement to increase completion of VTE risk assessment tool in notes. Educate all clinical staff in the rationale behind the risk assessment tool and correct completion. VTE ESR teaching due to launch in Autumn 2022 Continuation of VTE Prophylaxis section on in-patient medication chart	Assurance of accurate completion of electronic VTE risk assessment for number of obstetric patients. Measure improvement of VTE risk assessment completion, working with ABCi. VTE teaching set up with video link / webinar for all new clinical staff in Aug 2022. Audited monthly on hospital thermometer	Thrombosis Committee and Obstetrics Quality Improvement Team(ABCi) Thrombosis Committee Medical Education Post Grad Pharmacy	Leeanne Lewis Dr Sarah Lewis	**Autumn 2022**

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
FOUR: An All-Wales checklist for the investigation of a HAT is developed in order to maintain a uniform investigative approach across NHS Wales		All potential hospital acquired thrombosis are subject to review by senior clinicians in the field to establish if they were preventable and to support the identification of modifiable risks. Preventable HAT occurrence has reduced significantly since 2020. ABUHB will amend the review process as required when an All-Wales review tool becomes available. Business case to include HB Thrombosis Leads to manage service needs and development Grow Thrombosis team - Employ dedicated Local Thrombosis nurse/ pharmacist/ physician's associate on each site Thrombosis nursing Champions in clinical areas Review HAT investigation documentation and ensure fit for purpose	QPS process for HAT data is already readily available, improve feedback to clinicians to develop organisational learning and look at common themes. Business Case to include cost of avoidable harm from preventable HATs and clinical negligence claims. Link with Director of Nurses and Divisional Nursing Leads All Wales HAT investigation check list developed by WAG and All Wales HAT group currently in place	Leeanne Lewis QPS Team Thrombosis Committee Leeanne Lewis Dr Sarah Lewis Thrombosis Committee Director of Nursing Leeanne Lewis Dr Sarah Lewis	Leeanne Lewis Dr Sarah Lewis	**Winter 2022**

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
FIVE: VTE risk assessment compliance data and HAT data is shared at appropriate health body governance meetings.		Work is underway across ABUHB to standardise the Quality and Patient Safety agenda. VTE will form part of the agenda with consideration given to producing data to support scrutiny, assurance and to inform improvements. A detailed action plan will be developed to support the delivery of the requisite improvements and will be submitted to WRP in July 2022 and will be presented to the August 2022 PQSOC. Business case to incorporate HB Thrombosis Lead to share HAT data. Ensure that all learning and recommendations are shared across the organisation.	Disseminate HAT data via QPS leads at a Directorate and Divisional Level. Link in with Putting Things Right to develop a Learning Committee for themes from preventable HATs and clinical negligence claims. HAT data and VTE risk assessment compliance data / briefing to be circulated to Heads of Nursing / Governance Leads for sharing via QPS Governance Committee meetings	QPS Team Leeanne Lewis AB QPS Meeting Putting Things Right / Legal Services Team Medical Director/ Clinical Director's Meeting / Nursing Committees / Therapies / Governance QPS Committee meetings	Leeanne Lewis Dr Sarah Lewis	**Winter 2022**

Status of action:

GREEN	Complete
AMBER	In progress
RED	Missed deadline for completion - escalate

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Cronfa Risg Cymru
Shared Services Partnership
Welsh Risk Pool Services

A National Review into the Prevention of Venous Thromboembolisms (VTE) in NHS Wales

A Report by the Welsh Risk Pool Safety and Learning Team

April 2022

Gwella Diogelwch Cleifion Trwy Ddysgu
Improving Patient Safety Through Learning

A National Review into the Prevention of Venous Thromboembolisms (VTE) in NHS Wales

A Report by the Welsh Risk Pool Safety and Learning Team

April 2022

About this Report

This report is intended for health bodies within NHS Wales, with the aim to improve patient safety in relation to the diagnosis and prevention of venous thromboembolisms (VTE). The report follows a patient record review into the administration of prescribed thromboprophylaxis together with the provision and documentation of a VTE risk assessment for all patient admissions, both medical and surgical.

The report outlines recommendations which have been concluded following the review.

This report outlines the findings from the review as a national perspective. Each health body will receive an individualised report, outlining findings and data specific to their organisation.

Version
ABUHB Report Vdraft1

CONTENTS

1. Executive Summary

1.1 This report has been prepared by the Welsh Risk Pool Safety and Learning Team with the aim to improve patient safety in relation to the prevention of venous thromboembolisms (VTE).

1.2 The national Learning Advisory Panel (LAP) reviews the learning from all clinical negligence claims and redress cases in NHS Wales. In Early 2021, the Panel identified increased numbers of redress and clinical negligence cases relating to VTE.

1.3 Patients who are hospitalised and acutely unwell are widely recognised to be at a higher risk of developing a VTE than people in the general population. Given the increased numbers of hospital admissions of acutely unwell patients with Covid-19, there was concern that the number of cases presenting to the LAP would increase significantly.

1.4 In the most recently available data, the Office of National Statistics shows that 369 people died in Wales, in 2020, from VTE related illness.

1.5 According to the charity Thrombosis UK, 55-60% of VTEs develop during or following hospitalisation and are the number one cause of preventable deaths in hospital.

1.6 The Welsh Risk Pool Committee requested that a patient record review was undertaken across NHS Wales. This was undertaken by the WRP Safety & Learning Team. Contributions were obtained from clinicians working within the VTE and haematology fields and within a range of specialities.

1.7 Criteria for the review were developed following discussion with members of the All-Wales Hospital Acquired Thrombosis (HAT) Committee. These were formulated to assess application of the current All-Wales Thromboprophylaxis Policy standards.

1.8 Patient records were reviewed as part of the fieldwork to identify whether the patient had received a documented VTE risk assessment on admission, whether the VTE section of the Adult In-Patient Medication Administration Record had been correctly completed and whether thromboprophylaxis had been administered as prescribed.

1.9 The review found that compliance with correct completion of the Record for patients where thromboprophylaxis had been prescribed was excellent across all NHS Wales health bodies.

1.10 However, in cases where thromboprophylaxis had not been prescribed, compliance with correct completion of the Record was poor.

1.11 Compliance with the administration of prescribed thromboprophylaxis was excellent across NHS Wales.

1.12 The review found that whilst most health bodies had a VTE risk assessment tool within their clerking documentation, compliance with completion of it was poor. Most patients do not receive a documented VTE risk assessment on admission.

1.13 Initial patient clerking is often undertaken by junior doctors. Completion of a documented risk assessment tool would aid their clinical decision making. We have recommended that all patients receive a documented VTE risk assessment on admission.

1.14 It was identified that there is no mandatory training relating to VTEs within NHS Wales. VTE training at induction was noted to be very variable across NHS Wales and between hospitals within health bodies. Some hospitals provide excellent VTE training at induction. Some hospitals do not provide any at all. All-Wales VTE training is currently being developed. We have recommended that all clinical staff undertake this training.

1.15 We have made five recommendations based on the findings of this review. We hope that they will assist health bodies in improving patient safety relating to this important topic.

RECOMMENDATIONS

ONE All health bodies within NHS Wales adopt the All-Wales Thromboprophylaxis Policy

TWO All clinical staff undertake All-Wales training, both in relation to the recognition of patients presenting with symptoms of a VTE and in the prevention of hospital acquired thrombosis (HAT).

THREE All patients receive a documented VTE risk assessment, using a Department of Health Risk Assessment Tool (or similar) on admission, as part of the initial patient clerking.

FOUR An All-Wales checklist for the investigation of a HAT is developed in order to maintain a uniform investigative approach across NHS Wales.

FIVE VTE risk assessment compliance data and HAT data is shared at appropriate health body governance meetings.

2. Background

2.1 Venous thromboembolism (VTE) is a term referring to a blood clot which has formed within a vein. VTE is a collective term and can include deep vein thrombosis (DVT) and pulmonary embolism (PE).

2.2 Blood clots most commonly form in the deep veins of the legs or arms and are called DVTs. Part of the clot can break off and travel to the lungs resulting in a PE.

2.3 There are multiple factors which can influence and increase a person's risk of developing a DVT/PE. These include (Clarity Informatics, 2020):

- Age
- Overweight
- Previous history of a DVT/PE
- Combined contraceptive pill
- Pregnancy
- Cancer
- Thrombophilia
- Immobility
- Inflammation/infection
- Surgery

2.4 A person is more likely to develop a DVT/PE if they are acutely unwell and hospitalised and also up to 90 days post discharge. This is due to increased venous stasis and hypercoagulability.

2.5 Covid-19 can result in the development of a VTE through immune mediated clot formation. The formation of VTE in Covid-19 infections has been investigated and reviewed, with so far, variable results (Malas et al, 2020) (Tholin et al, 2021). The formation of a VTE is likely related to the severity of the infection and thus the severity

of the immune response. To date, no direct link has been identified between the Covid-19 virus and formation of a VTE.

2.6 Symptoms of a VTE depend on where it has formed. Most common symptoms related to a PE are shortness of breath and chest pain, whilst those with a DVT are a painful, red and swollen calf. However, symptoms are varied and not always typical.

2.7 PE can be difficult to diagnose. If one is not identified, it can cause significant harm and the risk of death is high (Heit et al, 2016).

2.8 A patient has an increased risk of developing a VTE, if they are acutely unwell (Clarity Informatics, 2020).

2.9 It is recognised that the incidence of VTE has decreased over recent years. The Medical Examiner for Wales commented that observationally, the number of deaths relating to VTE had reduced over the last 15 years. However, according to the Office of National statistics (ONS), during 2020, there were 369 deaths in Wales related to VTEs (Appendix 1). The impact of VTE cases generates a significant burden and cost to NHS Wales.

2.10 There are a number of clinical guidelines that relate to the assessment and treatment of blood clots. Further guidelines outline how to assess the risk of a blood clot in a patient who is undergoing a medical treatment or procedure. Prophylactic treatment can be provided with both medication and non-medication interventions available.

3. Contributors to the Review

3.1 The review was undertaken by the WRP Safety and Learning Team on behalf of the Welsh Risk Pool Committee. The fieldwork and data analysis has been led by Helen Bull, Senior Safety & Learning Advisor.

3.2 Whilst regular meetings of the All-Wales HAT Committee had been reduced due to the pandemic, contributions were helpfully provided by the Chair and key members of this important group.

3.3 A patient record review was undertaken across NHS Wales and further contributions were obtained from clinicians working both in a range of roles and specialities,

including anti-coagulation nurses, DVT nurses, governance staff and physicians and surgeons.

4. Decision to undertake a review

4.1 Thematic analysis of cases presented to the Welsh Risk Pool Committee during early 2021 highlighted patient safety risks in relation to the prevention of VTEs. The review commenced in Summer 2021

4.2 The national Learning Advisory Panel were noting increased numbers of redress and clinical negligence cases relating to VTEs. The cases were generally either in relation to the failure to recognise symptoms of patients presenting with a PE or a DVT or cases where there had been a failure to risk assess the patient on admission resulting in the development of a VTE.

4.3 Due to the pandemic, there were increased hospital admissions of patients acutely unwell with Covid-19 (https://coronavirus.data.gov.uk). Data highlights that a patient is at an increased risk of developing a VTE if they are acutely unwell (Clarity Informatics., 2020).

4.4 Increased numbers of HAT have been reported during this period on the quarterly returns to Welsh Government (data provided by Welsh Government for 2020-21).

4.5 The All-Wales Thromboprophylaxis Policy (Appendix 2) states that all patients should be risk assessed within 14 hours of admission or by the initial consultant review.

4.6 This patient safety issue is therefore clearly having an impact on NHS Wales and is a cause of a number of clinical negligence claims and redress cases. In 2020, the ONS showed 369 deaths in Wales relating to VTE (Appendix 1). Research (Howard et al, 2018) has demonstrated 60 to 70 cases of PE per 100,000 of the UK population. Whilst it is recognised that VTE cases numbers are generally decreasing, they still cause significant burden to the NHS.

4.7 In 2019, a National Confidential Enquiry into Patient Outcome and Death (NCEPOPD) within English NHS Trusts identified that there was a delay in commencing anticoagulation therapy for 20% of the 526 cases that it reviewed (National

Confidential Enquiry into Patient Outcome and Death, 2019). Figures for NHS Wales are likely to be similar.

4.8 The Welsh Risk Pool Committee recognised that there is significant learning potential to mitigate the risk of failing to recognise symptoms in patients with a VTE or failing to risk assess on admission to prevent a VTE from developing.

5. Review Methodology

5.1 Analysis of a number of selected patient records was undertaken. The first phase of the review analysed patient records relating to admissions under the medical specialty.

5.2 To achieve a random sample of a suitable size, a list of all medical admissions was requested from each health body for the first weeks of October, November and December 2020. These dates were chosen due to the increased numbers of HAT being reported to Welsh Government for those months and following discussions with members of the All-Wales HAT Committee.

5.3 Each health body chose one hospital to be the focus of the review.

5.4 A random sample of 100 patient records from each health body was requested to be included in the fieldwork of the review.

5.5 The review only included admissions of adult patients. The review team recognise that evidence shows that generally children under 16 years of age are at a much lower risk of developing a VTE.

5.6 The All-Wales Thromboprophylaxis Policy was developed in January 2020. This utilises NICE Guidance 89 and also incorporates recommendations from the Welsh Government's 2012 one day inquiry into VTE prevention in hospitalised patients in Wales. The Policy outlines the following expectations:

All patients admitted to Welsh Hospitals will have their risk of developing a VTE assessed on admission and before the initial consultant review:

- *Using a tool published by a national UK body, professional network or peer reviewed journal e.g., Department of Health VTE Risk Assessment Tool.*

- *Referring to the appropriate treatment intervention as per NICE NG89 and prescribing prophylaxis as appropriate.*

- *Documenting treatment choice on the VTE prophylaxis section of the All-Wales In-Patient Medication Administration Record.*

Where thromboprophylaxis is not required or contraindicated this must be clearly documented on the Adult In-Patient Medication Administration Record and documented in the patient's notes.

5.7 The review utilises a set of questions and the criteria for analysis of the patient records selected for inclusion. The review criteria were developed following discussion with members of the All-Wales HAT Committee and have been formulated to assess application of the All-Wales Policy standards.

- Did the patient receive a fully documented risk assessment within 24 hours of admission?
- Was the VTE prophylaxis section on the Adult In-Patient Medication Administration Record completed in full, whether thromboprophylaxis was prescribed or not?
- Was thromboprophylaxis administered as prescribed?

5.8 The All-Wales Policy states that patients should be risk assessed within 14 hours of admission. In recognising the challenges of out of hours admissions and in order to maintain a uniform approach for all health bodies, and to ensure consistent parameters when reviewing the patient records, the review team decided to set the review criteria to within 24 hours of admission, for determining whether a patient was risk assessed and received thromboprophylaxis.

5.9 After completion of the analysis of patient records medical admissions, the same methodology and criteria were applied for surgical admissions in the second phase of the review.

5.10 The Welsh Risk Pool Safety & Learning Team would like to extend their thanks, to all staff throughout NHS Wales who have provided support. In addition to contributors of the information captured by the review, a number of colleagues have tirelessly supported the review through the preparation of patient records for analysis. This was

achieved despite the protective measures required by the pandemic and all colleagues went above and beyond to support this review – which indicates the strength of patient safety through NHS Wales.

6. Clinical Decision Making

6.1 The review team considered how clinical staff make decisions as to whether a patient is at risk of developing a VTE or is presenting with one.

It is recognised that decision making is challenging in unscheduled care settings – particularly an emergency department. There are particular challenges when patients present with atypical symptoms or history. Initial patient assessment is often the most difficult. Demands on the service and workload can contribute to the challenges faced by clinical staff.

6.2 Initial triage is often undertaken by nurses with different levels of experience, whilst initial clerking is likely to be completed by junior doctors, often Foundation Year 1 or 2. Lack of experience makes a clinician more likely to be unfamiliar with signs and symptoms, typical or atypical. They are also less likely to be able to assess a patient's history in as much detail as more experienced members of staff. Given this, junior staff are more at risk of prescribing thromboprophylaxis as default, even if not needed and risk focussing on preventing VTEs rather than assessing, in addition, the risk of bleeding and whether thromboprophylaxis is actually detrimental.

6.3 The Healthcare Safety Investigation Branch (HSIB) looked at clinical decision making in the diagnosis and treatment of PE in emergency departments in England (Clinical decision making: diagnosis and treatment of pulmonary embolism in emergency departments, 2022) after they identified several incidents where there had been a delay in diagnosis of a PE. The HSIB report concluded that inexperienced clinical staff are more likely to match patients with textbook descriptions e.g., shortness of breath and chest pain for PE and that this risked the clinician not taking into account the complete clinical picture of a patient. HSIB further noted that emergency department pathways did not always prompt clinicians to consider VTE and they also noted that risk assessments to support diagnosis were not often used. There is a risk of a diagnostic bias in inexperienced clinical staff.

6.4 The HSIB report notes that decision making is a skill which requires practice. Novices need to develop heuristics (unconscious mental shortcuts to support decisions where limited time or information) together with structured approaches for rapid decision making. Novices tend to default to following rules. Checklists and risk assessments support rule-based decisions.

6.5 From reviewing the claims caseload, the review team have developed a number of anonymised examples of patient presentations involving challenges associated with VTE risk assessment, prevention, recognition and treatment. These are presented as Patient Stories to highlight the circumstances.

6.6 Patient Story 1

Mary, a 30-year-old female, was admitted to hospital with a two-week history of rectal bleeding. She was diagnosed with an anal fissure and successfully treated.

A documented VTE risk assessment was not undertaken when Mary was admitted.

Seven days post discharge from hospital, she was readmitted via the emergency department and diagnosed with a DVT. As a result, she was prescribed 5 months of anticoagulation therapy which she would likely have avoided, if she had been properly VTE risk assessed on initial admission to hospital.

6.7 Patient Story 2

Jonathan, a 51-year-old male, presented to the emergency department on a number of occasions over a 4-week period, with chest pain and breathlessness. On each occasion he was diagnosed with a chest infection, for which he was prescribed antibiotics.

His condition did not improve and so he re-presented to the emergency department a further time.

A computerised tomography (CT) scan was undertaken which revealed the presence of bilateral pulmonary embolisms.

Before Jonathan could be recalled, he collapsed at home and suffered a cardiac arrest. Resuscitation was unsuccessful and he died.

Findings of the Coroner were an undiagnosed DVT and PE.

6.8 Patient Story 3

Derek, a 35-year-old male, presented to the emergency department after injuring his ankle, playing football. He was diagnosed with an avulsion fracture of the medial malleolus and a fracture of the 5th metatarsal. He was placed in a below knee plaster back slab.

Two days later, he was reviewed in the trauma clinic where it was noted that there was moderate swelling to the ankle and foot. Neurovascular status was intact. A below knee heel weightbearing cast was applied and he was provided with crutches.

Derek represented to the emergency department a week later, complaining that the cast was too tight. The cast was cut to create room and he was discharged home.

Four days later, Derek represented with shortness of breath. A Doppler scan identified an occlusive DVT in both proximal peroneal veins and one in the popliteal vein. A CT scan did not reveal any PEs. He was treated with Warfarin, prescribed 6 months of anticoagulation therapy and discharged home.

Two days later he was readmitted and diagnosed with a PE. Warfarin dosage was adjusted as the levels were found to be sub-therapeutic.

Eight months later, Derek was admitted to hospital with shortness of breath and chest pain. He was diagnosed with a second PE.

After investigation, it was concluded that Derek's leg was not fully examined when he represented with the cast being too tight. A DVT was not considered as a differential diagnosis and consequently anticoagulation therapy was not prescribed.

6.9 NICE Guideline 89 describes the role of interim anticoagulation therapy for patients with a suspected PE/unknown diagnosis. The HSIB report noted that less experienced clinicians often found it easier to prescribe these as they were following guidelines. More experienced clinicians would be more aware of potential risk, especially the risk of bleeding and therefore more able to balance the risk of prescribing against the potential risk of harm.

7. VTE Risk Assessment to Support Clinical Decision Making

7.1 A risk assessment checklist standardises the task, reduces reliance on memory and enhances best practice (Chartered Institute Ergo, 2020). A well-designed checklist/risk assessment tool should support clinical decision making and highlight factors which would influence the decision.

7.2 NICE Guideline 89 states that all patients should be risk assessed for VTE on admission and before the first consultant review, using a tool by a national UK body, professional network or peer reviewed journal. The most commonly used is the Department of Health VTE Risk Assessment Tool (Appendix 3).

7.3 Assessing bleeding risk requires a detailed history. A documented VTE risk assessment would support this.

7.4 This review and the HSIB report identified that clinicians were not using available checklists/risk assessments even though they were available. Reasons given were that they were not suitable for the task, inaccessible and a high workload meaning no time to complete them.

7.5 A well-designed risk assessment tool would provide all of the benefits above and be easily accessible and useable within the time constraints of the consultation.

7.6 The All-Wales Policy recommends the use of a risk assessment derived from the Department of Health Risk Tool for Venous Thromboembolism Prevention, or from a similar nationally recognised body. This risk assessment tool is a checklist guiding the clinical decision maker to consider factors for the prevention of a VTE balanced against the risk of bleeding in a patient. It is a user-friendly risk assessment requiring the decision maker to consider the patient's history and presenting symptoms, tick the appropriate boxes and then sign and date it.

7.7 Most health bodies already have a version of this risk assessment, or similar, within their clerking proformas (Appendix 4).

Use of a risk assessment tool would aid the diagnosis of patients with a suspected VTE and aid the decision to prescribe, or not prescribe, a patient with thromboprophylaxis.

7.8 NHS England made it mandatory to complete a documented VTE risk assessment for all admissions (NHS funded acute care), from June 2010. The data is collected monthly but now published quarterly (from April 2015). The data collection asks for the number and percentage of patients aged 16 and over (prior to April 2019, age 18), admitted in the month, who have been risk assessed for VTE on admission to hospital, using a national VTE risk assessment tool.

7.9 The first data collection for quarter 2, 2010 evidenced 53% compliance with completion of the national VTE risk assessment tool. Overall compliance for 2010-11 was 67.4% (www.england.nhs.uk/statistics/statistical-work-areas/vte/).

7.10 Average compliance for 2011/12 had increased to 88.9%. Overall compliance was exceeding 95% by 2013-14 and continues to do so, though data collection and publishing has been put on hold during the pandemic.

7.11 VTE risk assessment in NHS England, using a national VTE risk assessment tool was included as a National VTE CQUIN (Commissioning for Quality and Innovation) in 2013-14, whereby NHS providers had to demonstrate greater than 95% compliance in completion of the national VTE risk assessment tool, in order to receive financial incentives (CQUIN, 2013-14). Data from NHS England shows that these levels of compliance have been achieved since 2013-14.

8. Hospital Acquired Thrombosis (HAT)

8.1 HAT prevention was promoted as part of the 1000 lives Improvement Programme which was launched in 2008, aimed at avoiding 1000 avoidable deaths across NHS Wales. As outlined in the Programme, a person is 10 times more at risk of developing a clot when being treated for a serious illness in hospital. 1000 lives worked with Thrombosis UK and NHS organisations in Wales to reduce the incidence of HAT.

8.2 In October 2012, the Welsh Government held a one-day inquiry into VTE prevention in hospitalised patient in Wales (National Assembly for Wales, Health and Social Care Committee, 2012).

Following the Inquiry, the All-Wales HAT Committee was formed in 2014 with the aim to:

- Develop and implement processes to reduce the incidence of HATs across Wales.
- Develop a standardised system by which a HAT is reported to Welsh Government.

- Implement a process for learning whenever an avoidable HAT occurs.

8.3 Quarterly submissions of data to Welsh Government commenced in 2015. Criteria for VTE cases associated with a hospital admission and to be included in the quarterly returns are detailed in Appendix 5.

8.4 Since the start of this initiative, the number of preventable HAT has reduced considerably (Croft, 2019).

8.5 Observationally, whilst there are clear criteria as to the inclusion of reportable VTE cases which are hospital acquired, investigation into whether they were preventable or not, has been variable across Wales.

8.6 The Delivery Framework 2021-22 removed the quarterly reporting requirement of HAT to Welsh Government from April 2021. Health bodies are still expected to gather and monitor data locally.

8.7 There is general concern expressed by clinicians and the WRP Safety & Learning Team, that with the removal of this reporting requirement, the number of HAT will increase as local monitoring is reduced due to competing challenges.

9. Findings of the Review

9.1 Data was collated as part of the fieldwork as outlined in section 5.

9.2 The review took place during the Covid-19 pandemic. Most elective surgery was cancelled at this time. This severely impacted on the number and type of surgical cases available for this review. General Surgery and Trauma and Orthopaedics were chosen for inclusion in the review rather than include all surgical specialities, as it was considered that this would have diluted the review data findings. In one hospital reviewed, there were no General Surgery patients during the time period and so an alternative speciality was reviewed. One other health body had no surgery cases at all during the review period.

9.3 Following discussions and observations, it was apparent that across NHS Wales, clinicians work on the basis that if they complete the VTE Prophylaxis section of the Adult In-Patient Medication Administration Record, this implies that they have risk assessed the patient.

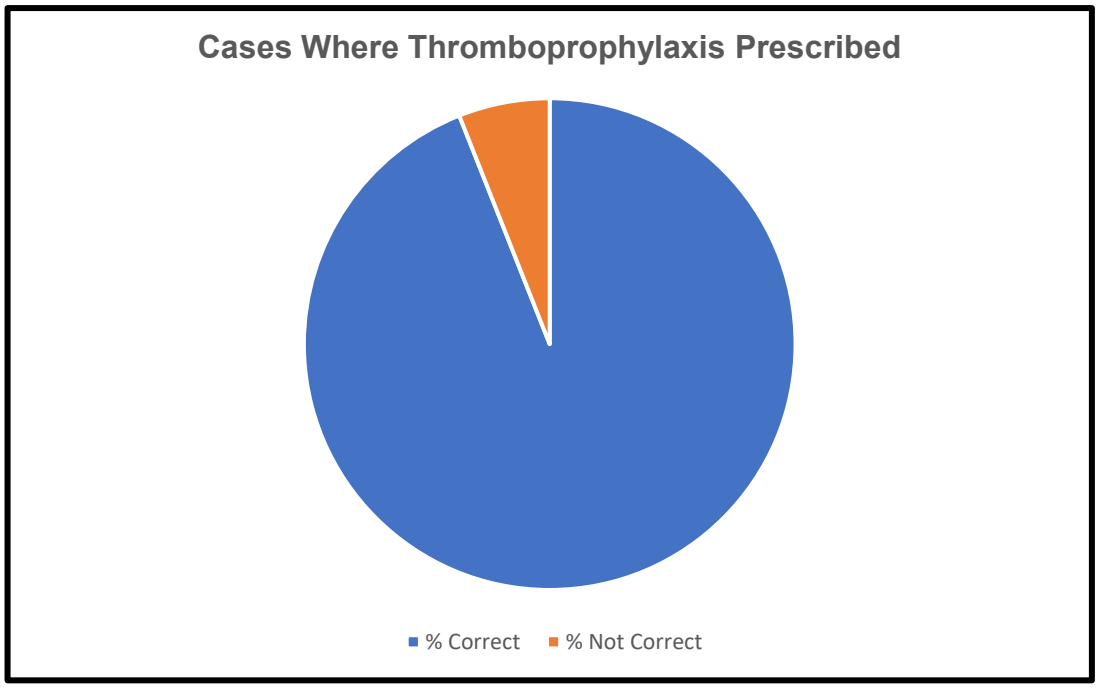
9.4 Completion of the VTE Prophylaxis section could imply that they have considered which drug is appropriate for the patient but it does not confirm that a clinician has comprehensively risk assessed the patient, in particular, for the risk of bleeding.

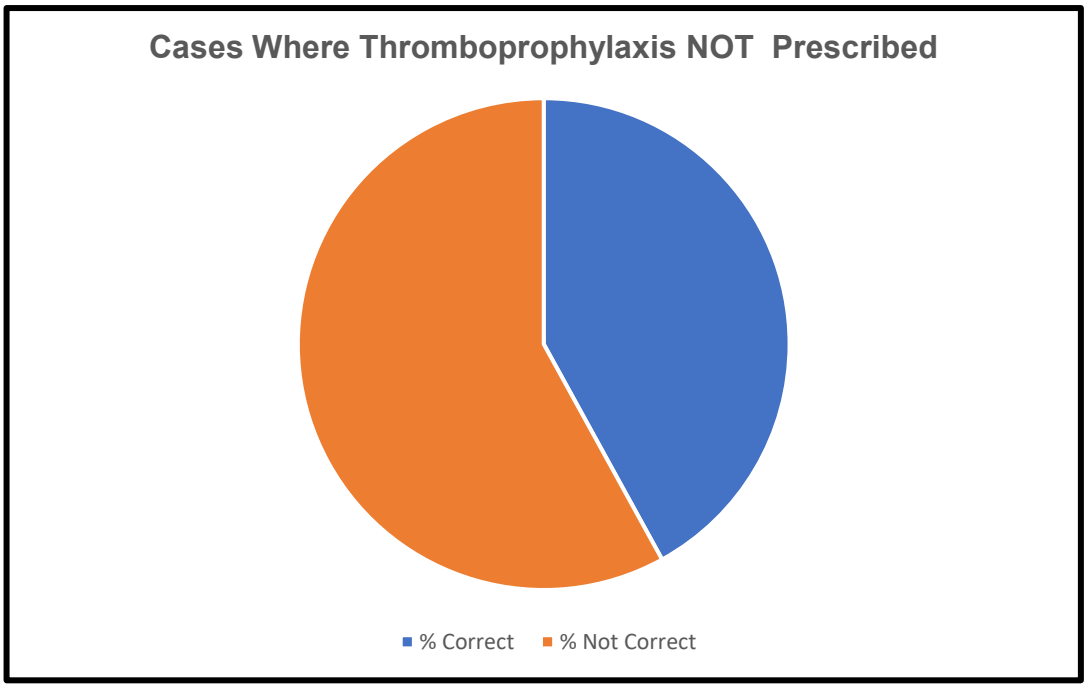
9.5 If the patient risk assessment isn't documented, there is no evidence that it has taken place, regardless of whether there is an implication that the type of drug has been considered. This presents a significant challenge when defending legal claims.

9.6 The review has identified that completion of the VTE section of the Adult In-Patient Medication Administration Record, when thromboprophylaxis was **prescribed,** had excellent compliance across Wales, with all but one health body exceeding 90%, for both surgical and medical cases.

9.7 The review has identified that completion of the VTE section of the Adult In-Patient Medication Administration Record, when thromboprophylaxis was **not prescribed**, was unsatisfactory, with compliance levels for medical admissions averaging 34% and surgical admissions, averaging 8%. Records were either unsigned, undated or the reason for not prescribing thromboprophylaxis was not highlighted on the Record or in the patient records. In some cases, all three reasons were applicable.

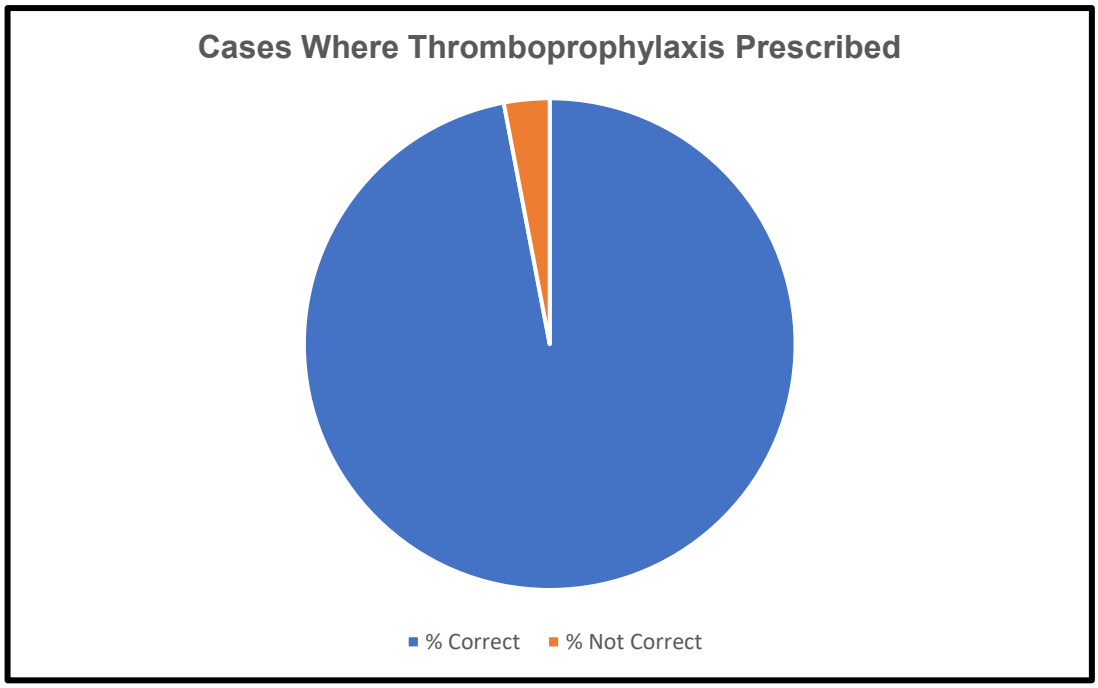
Compliance with Correct Completion of the Adult In-Patient Medication Administration Record at ABUHB – Medicine Cases

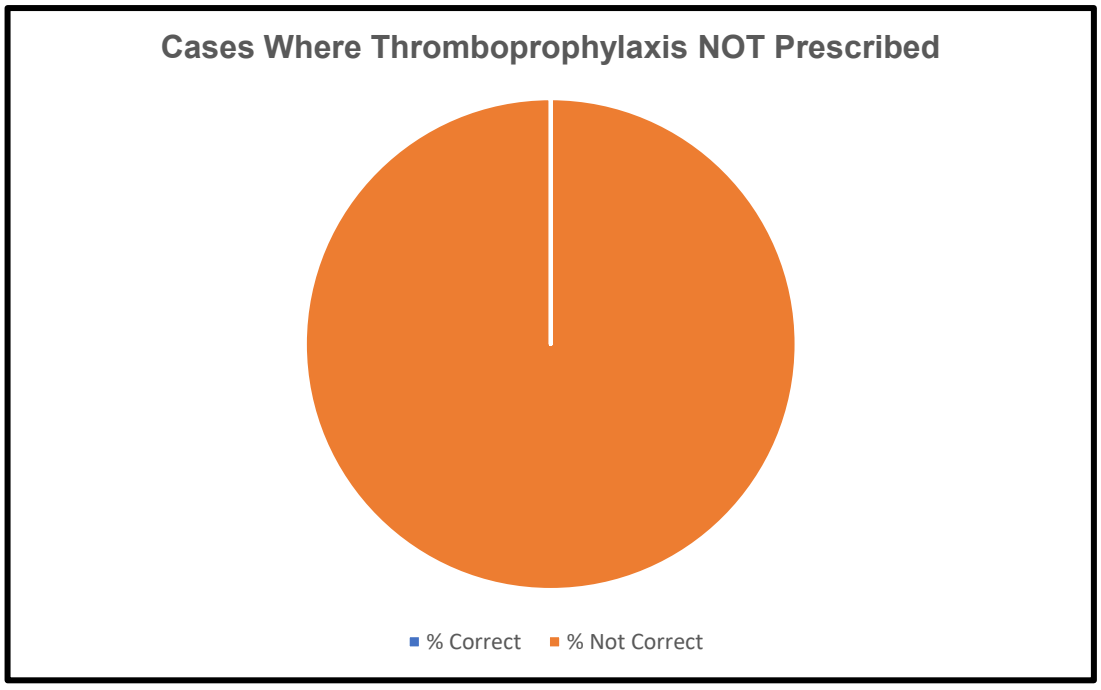




Health Body	Thromboprophylaxis Prescribed % Correct	Thromboprophylaxis NOT Prescribed % Correct
ABUHB	94	42

Compliance with Correct Completion of the Adult In-Patient Medication Administration Record at ABUHB – Surgery Cases

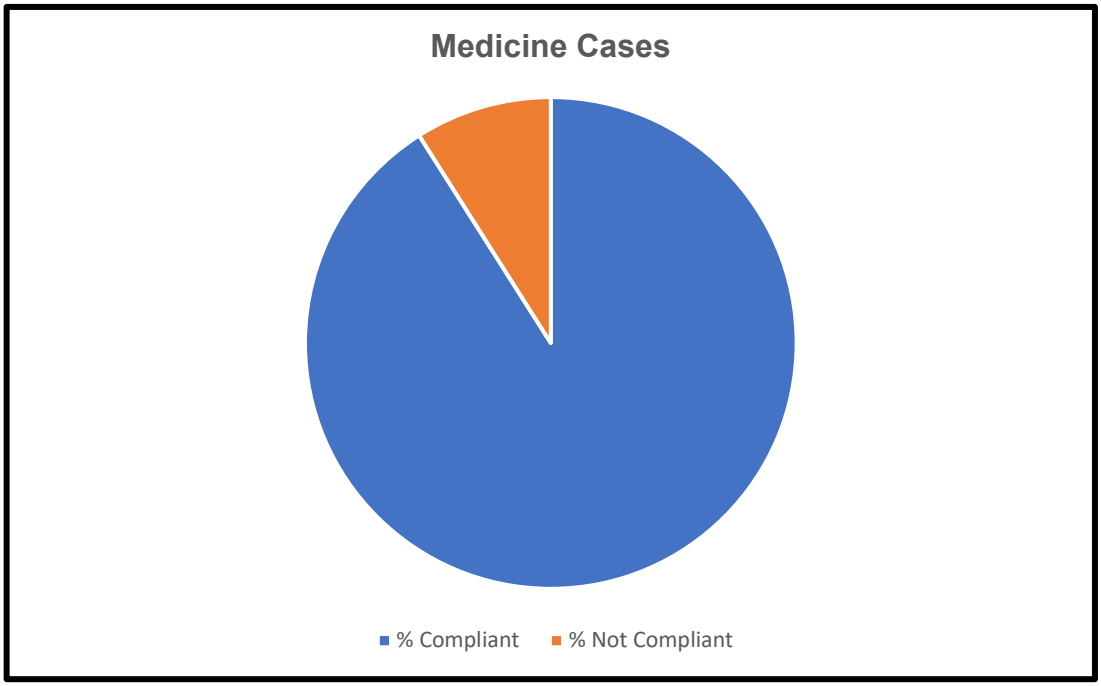


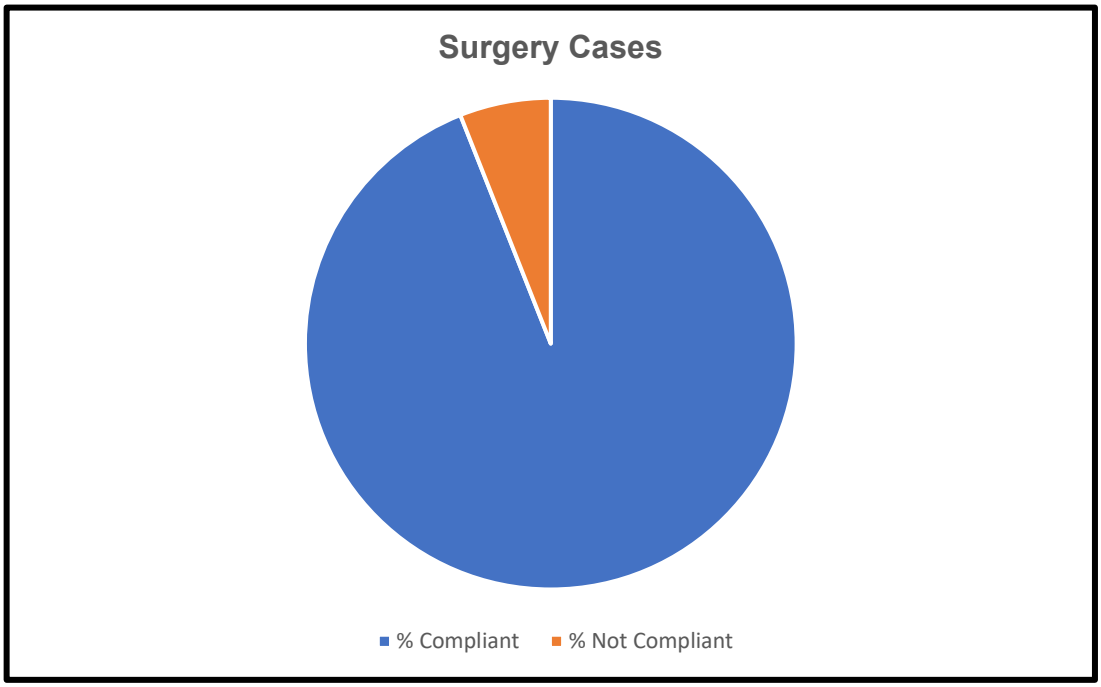


	Thromboprophylaxis Prescribed % Correct		Thromboprophylaxis NOT Prescribed % Correct	
Health Body	General Surgery	T&O	General Surgery	T&O
ABUHB	98	96	0	0

9.8 All health bodies demonstrated over 90% compliance for both medical and surgical admissions, in the administering of prescribed thromboprophylaxis within 24hours of admission or as dictated on the drug chart/records.

Compliance with Administration of Thromboprophylaxis within 24 hours or as Prescribed at ABUHB

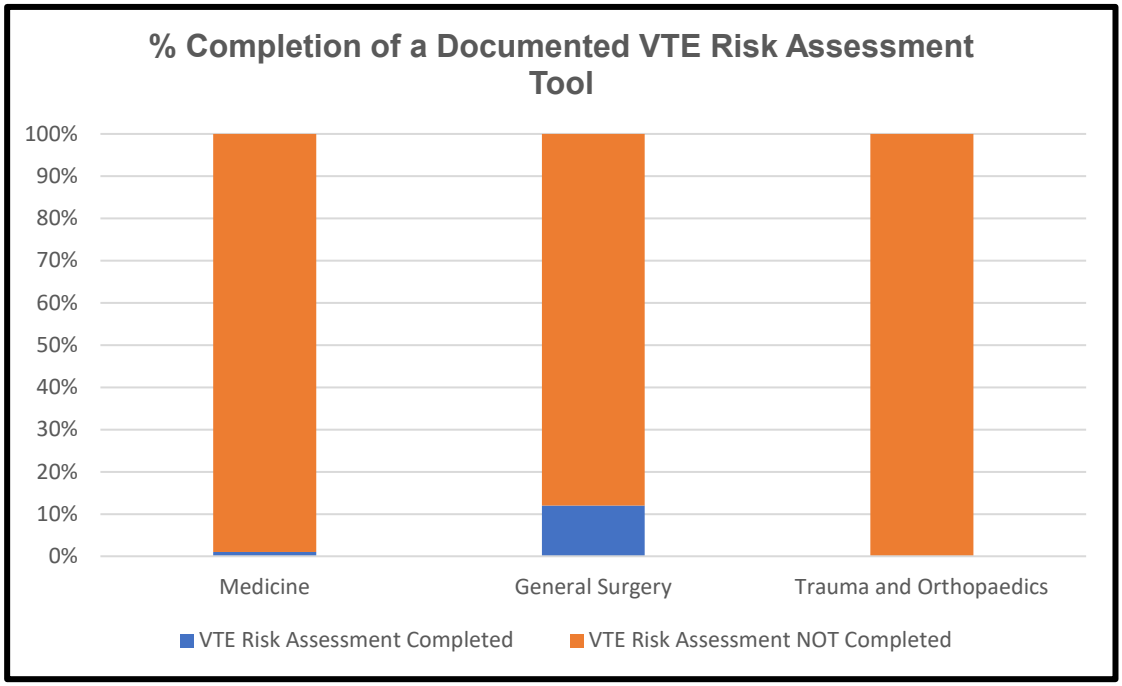




Health Body	All Medical Cases %	All Surgical Cases %
ABUHB	91	94

9.9 All health bodies demonstrated poor compliance with completion of a documented VTE risk assessment tool. Medical admissions averaged 7% compliance and surgical admissions 27% compliance, across NHS Wales.

Compliance with Completion of a Documented Risk Assessment Tool at ABUHB



Health Body	All Medical Cases % Compliance	General Surgery % Compliance	Trauma and Orthopaedics % Compliance
ABUHB	**1**	**12**	**0**

9.10 Whilst compliance with both completion of the VTE Prophylaxis section of the Medication Administration Record and administering thromboprophylaxis, when prescribed, were excellent across Wales, compliance with completion of a VTE risk assessment tool was poor and, in some cases, it was zero percent.

9.11 A VTE risk assessment tool was present within most health bodies' clerking proformas. There were exceptions where some health bodies had one for surgical admissions but not medical, or vice a versa. One health body did not have a VTE risk assessment tool within any of their main medical or surgical clerking proformas.

9.12 Given the presence of these VTE risk assessment tools within most health bodies' clerking, the review team considered potential reasons why they were not being filled in. Considering the analysis of research in this sector (outline in section 4) and the findings of the HSIB report there are likely to be multiple reasons influencing effective completion - such as workload and accessibility.

10. Additional Observations

10.1 The dosage of prophylactic medication to prevent a VTE is linked to a patient's body weight. It is recognised that a patient's weight is often estimated resulting in potential underdosing or overdosing of thromboprophylaxis, when prescribed. This safety risk was identified nationally in 2010 (National Patient Safety Agency, 2010).

10.2 It is widely recognised that a lack of a signature on a Medication Administration Record when thromboprophylaxis was prescribed (or not) could result in confusion as to whether the drug should be administered.

11. Training in Relation to Recognising Symptoms of a VTE and Completion of a VTE Risk Assessment

11.1 Research was undertaken to identify if there was a link between VTE training provided at induction within each health body and the compliance of completion of a documented VTE risk assessment. Health bodies were asked to provided examples of VTE training provided at induction.

11.2 There is no mandatory training in relation to VTE within NHS Wales.

11.3 VTE training provided at induction was considerably variable across each health body and in some cases, between hospitals within the same health body.

11.4 Some health bodies provided very detailed presentations covering all aspects of VTE. One health body was noted as only having '5 minutes' at induction for VTE training. One hospital was noted as providing no VTE training at all at induction.

11.5 Some individual specialities were found to include VTE training at their inductions, however, this was also inconsistent across Wales and often not provided.

12. Impact on NHS Wales and Submissions to the WRP

12.1 Health bodies must submit a Learning from Events Report (LFER) to the WRP within 60 working days of admitting qualifying liability in a redress case or making any admission or agreeing to settle, in a clinical negligence claim. The LFER has be approved by the WRP Committee following scrutiny by the national Learning Advisory Panel before any claim for reimbursement of damages/costs which the health body has incurred will be paid by the WRP.

12.2 During 2021, 58 cases relating to VTEs were submitted to the WRP for either approval of the LFER or reimbursement.

12.3 The WRP reimbursed health bodies £1.7million for VTE related cases in 2021 where the health body had paid out damages in a redress or clinical negligence claim.

12.4 44 of the 58 cases were at the LFER stage and so reimbursement values for these are not included in the £1.7million; with the true figure in the 58 cases likely to exceed £10m.

Number of VTE Related Cases Submitted to the WRP during 2021

Health Body	Number of Cases Relating to VTEs Submitted to the WRP (2021)	Population Served by Health Body	Number of Cases per 100,000 Population
ABUHB	**3**	**598,194**	**0.5**

12.5 Health bodies with higher numbers of redress or clinical negligence case submissions to the WRP, per 100,000 population served (https://statswales.gov.wales), corresponded with lower compliance with completion of a documented risk assessment tool.

12.6 Health bodies with higher numbers of redress or clinical negligence case submissions to the WRP, per 100,000 population served, corresponded with either absent or minimal VTE training at induction.

12.7 Health bodies with either absent or minimal VTE training at induction, corresponded with lower compliance with completion of a documented risk assessment tool and a resultant higher submission of redress or clinical negligence cases to the WRP.

13 Impact on Clinical Staff and Patients

13.1 In addition to the immediate presenting symptoms of a VTE previously discussed (Clarity Informatics, 2020) e.g., shortness of breath and chest chain for a PE or calf swelling for a DVT (amongst others), patients who have suffered from a VTE can suffer long term effects including:

- Post Thrombotic Syndrome (PTS) – long term pain, swelling, discolouration and ulcers on the leg affected by a DVT.
- Chronic Thromboembolic Pulmonary Hypertension (CTEPH) – increased blood pressure resulting in ongoing shortness of breath, fainting and chest pain.

13.2 These long-term conditions reduce the quality of a patient's life and can impact on their mental health (Tran et al, 2021) (Hunter et al, 2019).

13.3 Patients suffering from chronic illness increase the financial burden on NHS Wales and increase the workload for clinical staff.

13.4 It is also apparent that clinical staff who may have missed a diagnosis of a VTE can demonstrate considerable distress which could impact their mental health.

14 Recommendations

Following this review, a number of recommendations are made, in relation to the prevention of VTEs. The recommendations form the basis for a set of proposals to improve patient safety across NHS Wales.

Recommendation 1

All health bodies within NHS Wales adopt the All-Wales Thromboprophylaxis Policy

1. The Policy is based on the National Institute for Health and Care Excellence (NICE) Clinical Guideline 89, which provides clear guidance for national standards and will ensure a uniform and consistent approach to the prevention of VTEs across NHS Wales.

2. It provides guidance in relation to VTE risk assessment tools and clearly defines the criteria for which patients should be risk assessed.

3. It clearly defines the responsibilities of clinical staff in relation to VTEs, when assessing any patient admitted to hospital.

4. Health Bodies should ensure that this policy is formally adopted via their local governance route and that the policy is shared widely with relevant clinical staff.

Recommendation 2

All clinical staff undertake All Wales training, both in relation to the recognition of patients presenting with symptoms of a VTE and in the prevention of hospital acquired thrombosis (HAT).

1. All Wales training has been developed by members of the All-Wales HAT Committee, in conjunction with the WRP. Feedback in relation to its content has been provided by a range of stakeholders across NHS Wales. Two modules have been developed:

   - Recognition of a patient with a VTE. This includes symptoms, causes and risk factors.
   - Prevention of hospital acquired thrombosis. This includes risk assessment, risk factors, symptoms and treatment.

2. All Wales training ensures a consistent approach across Wales in risk assessing and risk assessment tool completion, for all patients on admission.

3. It is proposed that the frequency of training for staff and the associated compliance levels are established by the All-Wales HAT Committee and reviewed on a yearly basis.

4. All health bodies should ensure that they include VTE training within the essential skills training required by clinical staff. It is recognised that as compliance with formalised VTE training is at a very low level, this will take a period of time to reach a more acceptable level of compliance.

Recommendation 3

All patients receive a documented VTE risk assessment, using a Department of Health Risk Assessment Tool (or similar) on admission, as part of the initial patient clerking.

1. Use of a risk assessment tool would aid the diagnosis of patients with a suspected VTE and aid the decision to prescribe, or not prescribe, a patient with thromboprophylaxis as a measure to prevent a VTE from occurring during an admission.

2. A fully documented risk assessment tool provides strong evidence that it has been undertaken and that the patient has been fully assessed for both the risk of clotting and the risk of bleeding.

3. Most health bodies already have a VTE risk assessment tool in their clerking documentation and therefore, in most instances, there would be no requirement to develop a new one. There is an opportunity to introduce a standardised tool through collaboration between health bodies.

4. Using a documented VTE risk assessment tool would reduce the risk of a misdiagnosis, reduce the risk of a patient developing a HAT and thus reduce the overall impact on NHS Wales, including the number of submissions to the WRP.

5. It is recognised that audits and reviews will be required to determine the effectiveness of training and compliance with the use of the tool.

6. It is proposed that compliance levels for completion of a documented VTE risk assessment are set by the All-Wales HAT Committee and reviewed on a yearly basis.

Recommendation 4

An All-Wales checklist for the investigation of HAT is developed in order to maintain a uniform investigative approach across NHS Wales.

1. Following the removal of the requirement for health bodies to submit quarterly HAT data returns to Welsh Government, health bodies are still expected to monitor numbers locally and investigate all HAT to identify whether they were preventable or not.

2. The provision of a checklist for the investigation of HAT would eliminate inconsistencies and therefore help to maintain a uniform approach across NHS Wales.

3. It is proposed that a checklist is developed in conjunction with the All-Wales HAT Committee.

Recommendation 5

VTE risk assessment compliance data and all HAT data is shared at appropriate health body governance meetings.

1. Capturing, analysing, sharing and reviewing of VTE data is an essential tool to promote learning within a health body and share improvements across NHS Wales.

2. Monitoring compliance levels will enable the health body to implement learning interventions and improve patient safety.

15 References

a) Chartered Institute of Ergonomics and Human Factors. (2020) Guidance to help design effective and usable work procedures for health and social care teams [online]. https://ergonomics.org.uk/resource/guidance-on-desinof-effective-work-procedures.html (Accessed February 2022).

b) Clarity Informatics LTD. (2020) Pulmonary embolism: Clinical knowledge summary commissioned and funded by National Institute for Health and Care Excellence. https://cks.nice.org.uk/topics/pulmonary-embolism (Accessed April 2022).

c) Croft, A. (2019) Reducing the incidence of hospital acquired thrombosis - an all-Wales perspective. International Forum on Quality and Safety Healthcare.

d) Healthcare Safety Investigation Branch (2022) Clinical decision making: diagnosis and treatment of pulmonary embolism in emergency departments

e) Heit, J. A., Spencer, F. A. and White, R. H. (2016) the epidemiology of venous thromboembolism. Journal of Thrombosis and Thrombolysis, 41 (1), 3-14.

f) Howard, L. S. G. E., Barden, S., Condliffe, R., Connolly, V., Davies, C. W. H., Donaldson, J., Everett, B., Free, C., Horner, D., Hunter, L., Kaler, J., Nelson-Piercy, C., O-Dowd, E., Patel, R., Preston, W., Sheares, K. and Campbell, T. (2018) British Thoracic Society Guideline for the initial outpatient management of pulmonary embolism. Thorax, 73 (suppl 2).

g) Hunter, R., Noble, S., Lewis, S. and Bennett, P. (2019) Long-term psychosocial impact of venous thromboembolism: a qualitative study in the community. BMJ Open 2019;9(2).

h) Malas, M. B., Naazie, I., Elsayed, N., Mathlouthi, A., Marmor, R. and Clary, B. (2020) Thromboembolism risk of Covid-19 is high and associated with a higher risk of mortality: a systematic review and meta-analysis. Eclinical Medicine, 29, 100639.

i) National Assembly for Wales, Health and Social Care Committee (2012) One day inquiry into venous thromboembolism prevention in hospitalised patients in Wales.

j) National Confidential Enquiry into Patient Outcome and Death, (2019).

k) National Patient Safety Agency (2010) Reducing treatment dose errors with low molecular weight heparins. NPSA/201/RRR014 [online].

l) NHS England (2013) Commissioning services that deliver high quality VTE prevention. A guide for commissioners.

m) NICE Guidance 89 (NG89) Venous thromboembolism in over 16s: reducing the risk of hospital acquired deep vein thrombosis or pulmonary embolism, updated 2019.

n) Tholin, B., Ghanima, W., Einvik, G., Aarli, B., Bronstad, E., Skojonsberg, O.H. and Stavem, K. (2021) Incidence of thrombotic complications in hospitalised and non-hospitalised patients after Covid-19 diagnosis. British Journal of Haematology, 194 (3),542-546.

o) Tran, A., Redley, M. and de Wit, K. (2021) The psychological impact of pulmonary embolism: a mixed-methods study. Research and Practice in Thrombosis and Haemostasis, 5 (2), 301-307.

16 Appendices

Appendix 1 ONS – VTE Deaths in Wales

Appendix 2 All-Wales Thromboprophylaxis Policy

Appendix 3 Department of Health VTE Risk Assessment Tool.

Appendix 4 Examples of risk assessment tools

Appendix 5 HAT reporting criteria

Appendix 1

Office of National Statistics – Number of deaths in Wales, related to VTEs

	2016	2017	2018	2019	2020
All deaths	33066	33248	34406	33183	37399
VTE related deaths	316	311	317	252	369
% VTE related deaths	1	1	1	0.75	1

Appendix 2

All Wales Thromboprophylaxis Policy

This policy is based on National Institute for Health and Care Excellence (NICE) Clinical Guideline (NG) 89 providing clear guidance regarding National Standards. The guideline forms the foundation for thromboprophylaxis risk assessment tools for use in all patient groups in Welsh Hospitals.

Contents *page 1*

1. Overview

This guideline covers assessing and reducing the risk of Venous Thromboembolism (VTE) in people aged 16 and over in Welsh hospitals. It aims to help healthcare professionals identify people most at risk and describes treatments and interventions that can be used to reduce the risk of VTE utilising NICE Guidance 89 (NG89) – Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism

Who is it this policy for?

- Healthcare professionals

Who does this policy cover?

- All patients aged 16 years and over admitted into hospital are at risk of VTE. This includes patients discharged from hospital, including from Accident & Emergency and trauma clinics with lower limb devices, such as plaster casts or braces and pregnant women admitted to hospital or a midwife-led unit including up to 6 weeks after giving birth and patients at high risk of VTE attending hospital for day case procedures including cancer treatment and surgery.

2. Background

Up to 60% of all VTEs are hospital-acquired, accounting for 10% of all hospital deaths and is the number one cause of preventable hospital mortality (thrombosisuk.org/thrombosis-statistics.php). Many deaths are preventable if patients are offered a VTE risk assessment on admission to hospital and when required appropriate thromboprophylaxis. The House of Commons Select Committee Report on the Prevention of Venous Thromboembolism in hospitalised patients first addressed the situation in February 2005. In May 2012, the Welsh Assembly Government Health and Social Care committee held a one-day enquiry into in to Venous Thrombo-embolism Prevention in Welsh hospitals. The All Wales Thrombosis Group manages the implementation of the NICE NG89 clinical guidance, the Welsh Assembly Government (WAG) recommendations and audit of Hospital Acquired Thrombosis (HAT) through a means of continuous Root Cause Analysis (RCA). The group reports directly to WAG.

Five recommendations were made following the one-day enquiry in May 2012:

Recommendation 1: Compliance with relevant NICE guidance.

Recommendation 2: Clinicians are mandated to carry out VTE risk assessment for all hospitalised patients and prescribe thromboprophylaxis as appropriate.

Recommendation 3: Health boards will develop a standardised method of demonstrating their HAT rate.

Recommendation 4: An RCA will be undertaken for all patients who develop a VTE during their hospital stay or within 90 days following discharge to establish if the event is hospital acquired.

Recommendation 5: Welsh Government and health boards work together to raise awareness amongst patients and clinicians of the risks of developing HAT.

NICE NG89 (updated August 2019) was released in 2018 providing clear guidance regarding National Standards. The guideline forms the foundation for thromboprophylaxis risk assessment tools for all patient groups.

3. Policy Statements

All patients aged 16 years and over admitted to Welsh hospitals must be fully assessed for their risk of VTE. The risk assessment should not only consider the individuals risk of VTE but also their risk of bleeding and any other conditions which may affect the appropriateness of administering thromboprophylaxis.

- All patients admitted to Welsh hospitals will have their risk of developing a VTE assessed on admission:
    - Using a tool published by a national UK body, professional network or peer reviewed journal as a reference and / or as a clinical document. For example; Department of Health VTE Risk Assessment Tool
    - Referring to the appropriate treatment intervention as per NICE NG89 and prescribe pharmacological or mechanical prophylaxis as appropriate in accordance with local formulary.
    - Documenting treatment choice on the VTE prophylaxis section found within the All Wales In-Patient Medication Administration Record.

- Where thromboprophylaxis, chemical or mechanical, is **not** required or is contraindicated this **MUST** be clearly documented on the VTE prophylaxis section found within the medication chart and documented in the patient's case notes.

- Reassess medical, surgical and trauma patients for risk of VTE and bleeding at the point of consultant review or if their clinical condition changes. See **recommendations** 1.1.8 Re Assessment of Risk of VTE and bleeding (NICE NG89)

- The clinical notes of all patients who develop a VTE during their current inpatient admission (length of stay to be greater than 24 hours of being admitted) or having had a hospital inpatient admission (length of stay to be greater than 24 hours) in the health board within the previous 90 days following discharge will be reviewed to establish whether:
    - A thromboprophylaxis risk assessment has been completed on admission as per health board policy.
    - Appropriate treatment has been offered.

  Where the answer to either of these questions is 'No' a RCA will be undertaken to establish if the HAT was potentially preventable.

- The number of suspected HAT cases related to a hospital stay are collated by the Health Board monthly and RCA's and associated actions are reported to WAG on a quarterly basis

4. Principles

Consultants and relevant clinicians within their teams, supported by nursing and pharmacy staff, are responsible for the uptake of thromboprophylaxis risk assessment for all patients on admission and for re-assessment during the hospital stay.

All patients receiving thromboprophylaxis will be given a full explanation of the need for treatment, as per NICE NG89, supported by an appropriate patient information leaflet, such as Lowering Your Risk of Blood Clots (Thrombosis UK 2019) or EIDO: Reducing your risk of developing a blood clot (DP01) or a locally developed patient information leaflet professionally or peer reviewed.

5. Scope of Policy

This policy applies to all patients 16 years and over admitted to hospital.

6. Policy Review

The Health Board Thrombosis & Anticoagulation (T&A) committee, Anticoagulation Steering Group or HAT Steering Board are responsible for facilitating, reviewing and ratifying this policy, clinical guidelines and risk assessments 3 yearly or earlier if required.

7. Duties and Responsibilities

Overarching Managerial Responsibility

Clinical Directors / Heads of Nursing / Heads of Midwifery / Heads of Pharmacy are responsible for ensuring that this policy and associated clinical guidance, procedures and risk assessments are available for the relevant staff within their clinical area.

Admitting Doctor / Clinician

It is the responsibility of the clinician:

- To assess each patient as soon as possible within 14 hours after admission to hospital or by the time of the first consultant review using the risk assessment appropriate to the speciality as a reference or as a clinical document and prescribe appropriate treatment on the All Wales In-Patient Medication Administration Record.
- To balance the person's individual risk of VTE against their risk of bleeding when deciding whether to offer pharmacological thromboprophylaxis to medical, surgical and trauma patients.
- If using pharmacological VTE prophylaxis for medical patients, start it as soon as possible and within 14 hours of admission, unless otherwise stated in the population-specific recommendations (see NG89 sections 1.4 to 1.9).
- If using pharmacological VTE prophylaxis for surgical and trauma patients, start it as soon as possible and within 14 hours of admission, unless otherwise stated in the population-specific recommendations (see NG89 sections 1.10 to 1.15).
- To document any decision not to treat or any deviation from the guidelines in the patient case notes.
- To re-assess all hospitalised patients for their risk of VTE at the point of consultant review and/or if their clinical condition changes.
- To inform patient why they are having thromboprophylaxis treatment.

Nurses

It is the responsibility of the qualified nurse to:

- Prompt the responsible clinician to ensure all patients are risk assessed as soon as possible after admission to hospital or by the time of the first consultant review and then re-assessed daily **OR** as their clinical condition changes.
- Ensure the prescribed thromboprophylaxis is administered as required and documented on the All Wales In-Patient Medication Administration Record.
- Support the clinician in informing the patient why they are having or not having thromboprophylaxis treatment.
- Supply each patient on admission or in pre-assessment clinic with a HAT patient information leaflet explaining need for risk assessment on admission, thromboprophylaxis during their hospital stay and VTE prevention advice on discharge from hospital.

Obstetrician / Midwife

It is the responsibility of the obstetrician / midwife to:

- Assess all women on admission to hospital or a midwife-led unit if they are pregnant or gave birth, had a miscarriage or had a termination of pregnancy in the past 6 weeks, to identify their risk of VTE and bleeding. A tool published by a national UK body, professional network or peer-reviewed journal should be used. The Royal College of Obstetricians and Gynaecologists Green-top Guideline No 37a – RCOG (2015), developed the most commonly used risk assessment tool.
- Reassess risk of VTE and bleeding, and assess the need for thromboprophylaxis for all women:
  - within 6 hours of giving birth, having a miscarriage or having a termination of pregnancy or
  - if their clinical condition changes **and** they:
    - are pregnant **or**
    - have given birth, had a miscarriage or had a termination of pregnancy within the past 6 weeks
- Inform the patient why they are having or not having thromboprophylaxis treatment.
- Ensure the prescribed thromboprophylaxis is administered as required and documented on the All Wales In-Patient Medication Administration Record.
- Supply each patient on admission or in ante-natal clinic with a HAT patient information leaflet explaining the need for a risk assessment on admission, thromboprophylaxis during their hospital stay and VTE prevention advice on discharge from hospital.

Pharmacists

It is the responsibility of the pharmacist to:

- Check that patients have appropriate thromboprophylaxis prescribed when reviewing the All Wales In-Patient Medication Administration Record. To support nurses and midwives in prompting the clinical teams to complete VTE risk assessments.
- Support the clinician in informing the patient why they are having or not thromboprophylaxis treatment.

8. Education

- Ensure all clinicians responsible for undertaking VTE prophylaxis risk assessment or re-assessment has the necessary competence to undertake their duties safely.
- Ensure all staff caring for patients undertaking mechanical or chemical VTE prophylaxis treatment has the necessary competences to undertake their duties safely.

9. Audit

- VTE cases associated with a hospital admission, known as HAT, are collated via radiology and Informatics and reported to WAG each month by appointed members of staff from each health board on the HAT reporting template. These cases are validated by a process of RCA to determine if they are potentially preventable HATs and reported quarterly to WAG to establish the number of potentially preventable HAT's in each health board.

- The rate of patients receiving a VTE risk assessment on admission to hospital can be collected from the 'Hospital Thermometer' monthly audit, specifically from the VTE prophylaxis section within the All Wales In-Patient Medication Administration Record, or similar locally agreed method of audit or audit tool.

10. Tools and Documents

- Each Health Board is responsible for the creation of VTE Risk assessment tools and documents associated and complying with this policy.

Considerations for Individual Health Boards

7-day pharmacological thromboprophylaxis in medical patients: The most recent NICE guidance (NG89) recommended that all medical patients receive at least 7 days of pharmacological thromboprophylaxis.
Some health boards and trusts in the UK have recommended against the use of routine extended (i.e. beyond discharge) pharmacological thromboprophylaxis in medical patients. Reasons for this decision include concerns around cost vs benefit ratio, validity of the key studies in modern practice, safety of home LMWH administration.
These concerns are in line with the British Society of Hematology's recent rebuttal to the NICE guidance.
Extended thromboprophylaxis in medical patients is currently not recommended within the American College of Chest Physicians (ACCP 2012) guidelines.
Pharmacological thromboprophylaxis should be regularly reviewed. On discharge, post admission with an acute medical illness, if the patients risk of VTE outweighs the risk of bleeding, NICE recommends considering continuing pharmacological thromboprophylaxis for a minimum of 7 days. If this is deemed necessary, it must be ensured that people who are discharged with pharmacological VTE prophylaxis are able to use it correctly, or have arrangements made for someone to be available who will be able to help them.

Prescribing mechanical thromboprophylaxis: When prescribing mechanical thromboprophylaxis only one device is to be prescribed and fitted at a time – there is no evidence to support the use of more than one mechanical device at the same time.

Prescribing unlicensed medications: At the time of publication (NG89 - March 2018), Low Molecular Weight Heparin (LMWH), Fondaparinux, Apixaban, Dabigatran or Rivaroxaban did not have a UK marketing authorisation for use in patients 18 years and younger for use as thromboprophylaxis medication.

Aspirin does not have a UK marketing authorisation for use as thromboprophylaxis medication. However, it is NICE NG89 approved for use as thromboprophylaxis in patients who have had a total hip replacement or total knee replacement. Within this patient group, the prescriber should follow relevant professional guidance, taking full responsibility for the decision. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

Religious, social and cultural beliefs: Be aware that heparins are of animal origin and this may be of concern to some patients. Discuss the alternatives with patients who have concerns about using animal products, after discussing their suitability, advantages and disadvantages with the person. See Religion or belief: a practical guide for the NHS.

11. NICE NG89 Treatment Intervention links:

Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism (NG 89)

1.1 Risk assessment

1.2 Giving information and planning for discharge

1.3 All patients

1.4 Interventions for people with acute coronary syndromes or acute stroke or for acutely ill patients

1.5 Interventions for people with renal impairment

1.6 Interventions for people with cancer

1.7 Interventions for people having palliative care

1.8 Interventions for people admitted to critical care

1.9 Interventions for people with psychiatric illness

1.10 Interventions when using anaesthesia

1.11 Interventions for people having orthopaedic surgery

1.12 Interventions for people having elective spinal surgery or cranial surgery or people with spinal injury

1.13 Interventions for people with major trauma

1.14 Interventions for people having abdominal, thoracic or head and neck surgery

1.15 Interventions for people having cardiac or vascular surgery

1.16 Interventions for pregnant women and women who gave birth or had a miscarriage or termination of pregnancy in the past 6 weeks

12. Other Links

NHS Risk Assessment Tool

All Wales In-Patient Medication Administration Record

TUK - Lowering Your Risk of Blood Clots: Patient information leaflet

All Wales tissue viability Anti Embolism Stocking (AES) guidance

13. Links to NG 89 – Miscellaneous information

Terms used in this guideline (NG89)

Putting this guideline into practice

Context

More information

Recommendations for research

- 1 Risk assessment
- 2 Dose strategies for people who are obese
- 3 Direct oral anticoagulants for people with lower limb immobilisation
- 4 Aspirin prophylaxis for people with fragility fractures of the pelvis, hip or proximal femur
- 5 Duration of prophylaxis for elective total hip replacement surgery

Update information Recommendations that have been changed

14. Website Links

Thrombosis UK

Anticoagulation UK

e-VTE

Appendix 3

Department of Health VTE Risk Assessment Tool.

RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

All patients should be risk assessed on admission to hospital. Patients should be reassessed within 24 hours of admission and whenever the clinical situation changes.

STEP ONE

Assess all patients admitted to hospital for level of mobility (tick one box). All surgical patients, and all medical patients with significantly reduced mobility, should be considered for further risk assessment.

STEP TWO

Review the patient-related factors shown on the assessment sheet against **thrombosis** risk, ticking each box that applies (more than one box can be ticked).

Any tick for thrombosis risk should prompt thromboprophylaxis according to NICE guidance.

The risk factors identified are not exhaustive. Clinicians may consider additional risks in individual patients and offer thromboprophylaxis as appropriate.

STEP THREE

Review the patient-related factors shown against **bleeding risk** and tick each box that applies (more than one box can be ticked).

Any tick should prompt clinical staff to consider if bleeding risk is sufficient to preclude pharmacological intervention.

Guidance on thromboprophylaxis is available at:

National Institute for Health and Clinical Excellence (2010) Venous thromboembolism: reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital. NICE clinical guideline 92. London: National Institute for Health and Clinical Excellence.

http://www.nice.org.uk/guidance/CG92

This document has been authorised by the Department of Health
Gateway reference no: 10278

Department of Health

1

RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

Mobility – all patients (tick one box)	**Tick**		**Tick**		**Tick**
Surgical patient		Medical patient expected to have ongoing reduced mobility relative to normal state		Medical patient NOT expected to have significantly reduced mobility relative to normal state	
Assess for thrombosis and bleeding risk below				**Risk assessment now complete**	

Thrombosis risk			
Patient related	**Tick**	**Admission related**	**Tick**
Active cancer or cancer treatment		Significantly reduced mobility for 3 days or more	
Age > 60		Hip or knee replacement	
Dehydration		Hip fracture	
Known thrombophilias		Total anaesthetic + surgical time > 90 minutes	
Obesity (BMI >30 kg/m²)		Surgery involving pelvis or lower limb with a total anaesthetic + surgical time > 60 minutes	
One or more significant medical comorbidities (eg heart disease;metabolic,endocrine or respiratory pathologies;acute infectious diseases; inflammatory conditions)		Acute surgical admission with inflammatory or intra-abdominal condition	
Personal history or first-degree relative with a history of VTE		Critical care admission	
Use of hormone replacement therapy		Surgery with significant reduction in mobility	
Use of oestrogen-containing contraceptive therapy			
Varicose veins with phlebitis			
Pregnancy or < 6 weeks post partum (see NICE guidance for specific risk factors)			

Bleeding risk			
Patient related	**Tick**	**Admission related**	**Tick**
Active bleeding		Neurosurgery, spinal surgery or eye surgery	
Acquired bleeding disorders (such as acute liver failure)		Other procedure with high bleeding risk	
Concurrent use of anticoagulants known to increase the risk of bleeding (such as warfarin with INR >2)		Lumbar puncture/epidural/spinal anaesthesia expected within the next 12 hours	
Acute stroke		Lumbar puncture/epidural/spinal anaesthesia within the previous 4 hours	
Thrombocytopaenia (platelets< $75x10^9$/l)			
Uncontrolled systolic hypertension (230/120 mmHg or higher)			
Untreated inherited bleeding disorders (such as haemophilia and von Willebrand's disease)			

2

Appendix 4

Examples of risk assessment tools already found in clerking proformas or available for use alongside the clerking proforma

CT and other Imaging results

Patient Details: (Sticker)

Name: .....

DOB: .....

Hosp No: .....

Information given to Patient / Family or Carers

Suspecting GI bleed?– Use Glasgow-Blatchford Score. If GBS is 0: Consider Discharge with urgent outpatient OGD with in 1 week. If > 1 then complete AIMS65 Score to assess need for urgent endoscopy

Venous Thromboprophylaxis Risk Assessment-

Patients expected to have

1. Reduced mobility: - Yes ☐ No ☐

2. Surgical admission:- Yes ☐ No ☐

Complete in all patients in first 24hrs

If 1& 2 both No = low risk of VTE Risk assessment complete (give patient information)

One or more Yes = Complete full risk assessment

Risk assessment for VTE: GUIDE

STEP 1: Assess Mobility. All surgical patients, and all medical patients with significantly reduced mobility, should have full risk assessment.

STEP 2: Review the thrombosis risk. Any tick for thrombosis risk should prompt thromboprophylaxis according to NICE guidance.

STEP 3: Review bleeding risk. Any tick should prompt clinical staff to consider if bleeding risk is sufficient to preclude pharmacological intervention

	Risk factors for VTE		Risk of bleeding
	Age over 60 years		Active bleeding or at risk of bleeding
	Critical care admission		Acquired bleeding disorders (such as acute liver failure)
	Obesity -body mass index [BMI] > 30 kg/m2		Concurrent use of anticoagulants known to increase the risk of bleeding (such as warfarin with international normalised ratio [INR] > 2)
	Significantly reduced mobility for 3 days or more		
	Fracture		
	Dehydration		Lumbar puncture/epidural/spinal anaesthesia expected within the next 12 hours
	Hip or Knee surgery		
	Known thrombophilias		Uncontrolled systolic hypertension (230/120 mmHg or higher)
	Personal history or first-degree relative with a history of VTE		Untreated inherited bleeding disorders (haemophilia and von Willebrand's disease)
	One or more significant medical co-morbidities		Acute stroke (both ischaemic and haemorrhagic), risk of central nervous system bleed (SAH, head injury)*
	Surgery with significant reduction in mobility		
	Use of hormone replacement therapy		Thrombocytopenia (platelets less than 75 x 109 /
	Use of oestrogen-containing contraceptive therapy		Anaesthesia within the previous 4 hours
	Active cancer or cancer treatment		Neurosurgery, spinal surgery or eye surgery
	Varicose veins with phlebitis		Other procedure with high risk of bleeding.

Clinical decision:

Low risk, no TP required ☐

Clinicians may consider additional risks in individual patients and offer thromboprophylaxis as appropriate (Adapted from Department of Health VTE risk assessment © Crown copyright 2010. 301292 1p March 10. http://www.nice.org.uk/guidance/CG92)

One or more risk Thromboprophylaxis Prescribed ☐

Thromboprophylaxis Contraindicated ☐

***Consider Use IPC in Acute Stroke** ☐

Doctors signature _____ **Bleep** _____

[redacted] [redacted] **Page 9 of 12**

Title: 'Reducing the risk of VTE in patients admitted with acute medical illness'

Authors: [redacted] *Version 1.0* *Ratified by:* [redacted]

[redacted]

Reducing the risk of Venous Thromboembolism (VTE) in patients admitted with Acute Medical illness

UNLESS CONTRAINDICATED: Prescribe pharmacological thromboprophylaxis for all patients who are non -ambulant with an acute medical illness who have ≥1 risk factor for venous thromboembolism.

Mechanical thromboprophylaxis is not routinely used in medical patients.

In **acute stroke patients**, where pharmacological thromboprophylaxis is deemed unsafe, intermittent compression devices are recommended (anti embolic stockings (AES) are contraindicated)

DOES THE PATIENT HAVE RISK FACTORS FOR VENOUS THROMBOEMBOLISM? (VTE)			
Age over 60 years		Obesity (BMI greater than 30kg/m²)	
Acute medical/Critical care admission		Dehydration	
Pregnancy or < 12 weeks post-partum		Varicose veins or active phlebitis	
Active cancer or cancer treatment		Use of oestrogen containing contraceptive therapy	
Personal or first degree relative with history of VTE		Known thrombophilia	

Risk factors for VTE identified?

- If no document on drug chart, reassess regularly
- If yes, assess for contraindications to pharmacological thromboprophylaxis (see below)

DOES THE PATIENT HAVE CONTRAINDICATIONS TO PHARMACOLOGICAL THROMBOPROPHYLAXIS?			
Active bleeding or at risk of bleeding		Thrombocytopenia: platelet count < 75 x 10^9 /l	
Severe renal disease, (<30ml/min see dosing advice below)		Currently receiving therapeutic anticoagulation	
Previous heparin induced thrombocytopenia or allergy		Acute stroke/ICH/SAH	
Neuraxial procedure (e.g. LP) within the past 4h or due in the next 12h		Uncontrolled hypertension (SBP > 180mmHg)	
Admitted for terminal care or end of life pathway		Known bleeding disorder, severe liver disease	

Have any contraindications been identified?

- If no prescribe Enoxaparin on the 'VTE prophylaxis' section of the drug chart, dosing advice is provided below
- If yes, document in the notes (and on the drug chart)
- Reassess risk of bleeding and venous thromboembolism regularly and if clinical situation changes

Weight & CrCl based dosing of enoxaparin thromboprophylaxis	Weight ≤50kg	Weight >50-100kg	Weight 101-150kg	Weight >150kg
CrCl >30 mL/min	20mg **Once** daily	40mg **Once** daily	40mg **Twice** daily	60mg **Twice** daily
CrCl <30 mL/min	20mg **Once** daily	20mg **Once** daily	20mg **Once** daily	40mg **Once** daily

**Cr Cl <30 mL/min . See https://www.mdcalc.com/creatinine-clearance-cockcroft-gault-equation*

***Consider dose adjustment for AKI / declining renal function* *Renal advice:* [redacted]

On discharge, post admission with an acute medical illness, if the patients risk of VTE outweighs the risk of bleeding, NICE (NG89) recommends considering continuing pharmacological thromboprophylaxis for a minimum of 7 days. If this is deemed necessary, it must be ensured that people are able to administer treatment correctly, or have arrangements made for someone to be available who will be able to help them.

Appendix 5

HAT Reporting Criteria

Detailed Specification

The data source for completing Welsh Government's Hospital Acquired Thrombosis data monitoring return are as follows:

- Source of identifying a positive VTE: Patients reported on RADIS.
- Incidents reported via a post mortem (or other mortality tools).
- Source of admission history: Patient Administration Systems (PAS).

A HAT that could have been potentially avoided is determined by identifying a patient (adult only – age 18 plus) who had a positive VTE either:

- Following a hospital admission (length of stay is to be greater than 24 hours) within the previous 90 days post discharge. It does not include patients with a stay of less than 24 hours, outpatients (including endoscopy) or patients who attended A&E or emergency procedures in outpatients (i.e. fracture clinics). A patient with multiple admissions within 90 days should only be reported once.

or

- During his/her current in-patient admission (length of stay is to be greater than 24 hours). This excludes day cases.

Until the collection system is improved, the positive VTE and hospital admission must be within the same health board (e.g. it does not include a VTE diagnosed by one health board and a hospital admission within the previous 90 by another health board). In these instances, the diagnosing health board/trust should make every effort to inform the health board where the HAT was instigated. This principle also applies to patients treated in private hospital.

RADIS procedure codes to be used are:

- CPAUG: CT Angiogram pulmonary - Computed tomography angiography of pulmonary artery (procedure)
- NCHEQ: NM Lung perfusion scan - Pulmonary perfusion study (procedure)
- NCHEV: NM Lung ventilation scan V - Pulmonary ventilation study (procedure)
- ULLVB: US Doppler lower limbs Both - Doppler ultrasonography of vein lower limb (procedure)
- ULLVL: US Doppler lower limb veins Lt - Doppler ultrasonography of vein lower limb (procedure)
- ULLVR: US Doppler lower limb veins Rt - Doppler ultrasonography of vein lower limb (procedure
- ULLCL: US Compression venography lower limb Lt - Ultrasound compression venography of lower limb (procedure)
- ULLCR: US Compression venography lower limb Rt - Ultrasound compression venography of lower limb (procedure)
- ULLCB: US Compression venography lower limb B - Ultrasound compression venography of lower limb (procedure)

The count does not include cases where the following criterion has been met:

- The full Root Cause Analysis confirms that the VTE is not a HAT or a preventable HAT. (A full RCA is to be completed if appropriate thromboprophylaxis has not been provided and a risk assessment is not available or does not support the action taken).

Cases with missing notes or where the relevant information is missing at the time of data submission are not considered for RCA and are not included in the count. When missing notes have been found and audited a retrospective correction is to be re-inputted under the relevant quarter that the positive VTE incident occurred. Any notes not found within a 6 month period should be excluded from the count. (Note: Missing notes is a cause for concern in itself, since it is not possible to identify if a case was potentially preventable or not).

Data is derived from the Welsh Government's collection of management information from health boards and trusts. The standardised approach to reporting the information to Welsh Government was agreed by the National HAT Steering Group. Health boards and trusts complete a standardised proforma and forward it to Welsh Government on a quarterly basis. Please refer to 'Additional Information' for a copy of the reporting proforma.

Data is presented on an all Wales basis and is also available at a health board/trust level. Data will NOT be used to make organisational comparisons.

Reporting Frequency	Quarterly
Time Delay of Reported Data?	3 months Health boards / trusts are to submit their quarterly data as follows: Quarter 1: 14 October Quarter 2: 14 January Quarter 3: 14 April Quarter 4: 14 July Note: In addition to this indicator, NHS organisations are expected to complete: Monthly data on the number of VTE cases associated with a hospital HAT per quarter. These cases are to be validated to determine if they are a HAT. Monthly data is to be reported 10 working days after month end of 14th of the following month. A quarterly or annual summary of lessons learnt to improve delivery and corrective actions agreed. This is to be completed for all HATs that are potentially preventable. This is to be submitted in accordance with the quarterly reporting timetable provided above, or if submitted annually by 14 July.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality Safety and Outcomes Committee Tuesday 16th August 2022 Agenda Item:3.8

Safeguarding Annual Report

Executive Summary
The Safeguarding Annual Report has been prepared to provide an overview of Aneurin Bevan University Health Board's (ABUHB) safeguarding reporting and position for 2021/2022. The report provides information on the progress, performance, risk and learning together with an overview of emerging themes and trends, and a proposed work programme for 2022/'23.

Purpose: **Patient Quality, Safety and Outcomes Committee is asked to:**	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	✓
Executive Sponsor: Linda Alexander - Interim Director of Nursing	
Author: Amy Bucknall – Interim Head of Safeguarding	
Report Received consideration and supported by:	

Executive Team	✓	**Sub-Committee**	
Date of the Report:			

Supplementary Papers Attached:

- **Safeguarding Annual Report 2021/'22**

Background and Context

The annual report outlines strengths and areas for improvement for safeguarding during the reporting period. It aims to provide assurance to the Patient Quality, Safety and Outcomes Committee and external stakeholders that the Health Board is fulfilling its statutory safeguarding obligations.

The report demonstrates the Health Board's commitment to ensure that safeguarding is a key commitment and that **'safeguarding is everyone's business'.** It is acknowledged everyone has a pivotal role in ensuring patients, their families and the public receive high standards of care, which is compliant with UK and Welsh Government safeguarding legislation.

The Covid-19 pandemic has challenged the Health Board and this is the same for the safeguarding agenda. New risks have emerged due to lockdown and subsequent hidden harm, as well as rising austerity in Wales. The report identifies the continued service offered and the improvements made to address the Gwent populations' emerging needs.

Assessment and Conclusion

Initiatives:

- Due to a significant number of child deaths related to asphyxiation, the Health Board worked with Welsh Government on a rapid review. Involvement continued with the development of a suicide and self-harm for young people strategic group within the Gwent Safeguarding Board which health stakeholders are key contributors.

- ABUHB's Early Intervention Safeguarding Hub has been embedded, after it launched in early 2021. It provides single access support for internal and external stakeholders. Data for safeguarding children and adults' activity is now being recorded in the hub which will help with the understanding of activity and themes.

- The Health Board trialled an Independent Domestic Violence Advocate (IDVA) in the Mental Health Division. The pilot supported training assessment and referral for people impacted by domestic abuse and coercive control seeking mental health support.

- A new safeguarding Intranet page has been developed and is much improved from the previous Intranet site with easier access to support, forms, training, supervision, policy, and process for all ABUHB staff.

- A new booking and communication process for requesting safeguarding supervision has been launched.

- The ABUHB Corporate Safeguarding Team chaired the national Single Unified Safeguarding Review Group to support the development of a central repository for practice reviews and domestic homicide reviews (which will be launched in 2022).

- Safeguarding training compliance for Levels 1 and 2 and Ask and Act Training are now available on the ESR platform.
- ABUHB volunteered to pilot a new national safeguarding quality assurance tool (one of only 2 sites in Wales). Work on this has begun with the Corporate Safeguarding Team co-chairing the tools subgroup, with plans to pilot the tool.
- Members of the Corporate Safeguarding Team are Chair and Lead Reviewers on several high-profile Child and Adult Practice Reviews and Domestic Homicide Reviews supporting the critical analysis, health influence and learning from particularly complex cases that resulted in the death or serious harm of persons at risk.
- A shared database has been created for Safeguarding Allegations about Practitioners/ Those in a Position of Trust to enable robust assessment and monitoring of allegations between the Corporate Safeguarding Team and Human Resources.

Challenges:

- The Covid-19 pandemic entered its second year, and this impacted significantly on the Corporate Safeguarding Team. Consequently, the focus in safeguarding has remained on critical aspects of care.
- There have been increases in the number of Duty to Report referrals received from the Unscheduled Care Division. This identified opportunity to establish close links with the Division and to pilot bespoke training and supervision programme and resources such as an evidence-based safeguarding proforma.
- There have been consistently rising rates of Allegations/ Concerns about Practitioners or those in a Position of Trust. Work has started to create a database, but there is an opportunity to further embed learning with a Standard Operation Procedure, Toolkit and Training package for the Health Board.

- Safeguarding supervision for adult specific practitioners was piloted in 2021 for the District Nurses. The pilot has been challenging to evaluate as there was poor attendance due to the pandemic. There needs to be a continued focus on safeguarding supervision for adult colleagues in 2022/23 with wider roll out focused in safeguarding 'high impact' areas.

- There has been an increase in the number of Duty to Reports received regarding patient-on-patient assaults at ABUHB. The root cause needs to be determined with actions identified to minimise the risk.

- Level 3 Safeguarding Children and Adults training compliance is not yet able to be reported. This needs to be addressed in 2022/23 with a complete mapping exercise of the roles that require level 3 training to be completed.

- Compliance for level 1 and 2 safeguarding children and adults training, and for level 1 'ask and act' training has improved in the reporting year. However, improvements are needed to meet the 85% target. A Training Needs Analysis is required to better understand and address the challenges in achieving target compliance in 2022/23.

- Current ongoing Domestic Homicide Reviews have demonstrated there is work needed to understand and address issues relating to older adults who are victims of domestic abuse. Engagement in local and national multi-agency VAWDASV groups is required to ensure the Health Board is included in plans and pilots for this specific area of concern.

- Suicide and self-harm for children and young people has been identified as a theme in multiple Child Practice Reviews. The Health Board will be included in local and national workstreams to ensure a preventative approach to suicide and self-harm is promoted across all Divisions.

- Impending changes to the Mental Capacity Act legislation has faced significant delays. Work needs to continue regarding the Act and the proposed changes that look set to be launched in Autumn 2022. The Mental Capacity Act will be on the workplan for 2022-2023.

Despite the challenges of 2021-2022, progress has made against the Safeguarding Workplan 2021/'22 which is positive when taking into account the operating environment.

Recommendation	
• **NOTE** the Safeguarding Annual Report 2021/22.	
Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Links to relevant Quality, Patient Safety risks outlined within the Health Board's corporate risk profile.

Financial Assessment, including Value for Money	N/A
Quality, Safety and Patient Experience Assessment	Annual reports are central to patients' safety and quality of care given.
Equality and Diversity Impact Assessment (including child impact assessment)	N/A
Health and Care Standards	The Annual Report provides information around standard 2.7.
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP and the quality improvements highlighted.
The Well-being of Future Generations (Wales) Act 2015 – **5 ways of working**	**Long Term –** Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – The quality and patient safety improvements described work across HB's
	Involvement – Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – The quality and patient safety improvements described work across HB's
	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	
Public Interest	Report has been written for the public domain.

2021 - 2022

SAFEGUARDING ANNUAL REPORT

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Contents

1 Aim

This Annual Report presents an overview of the work Aneurin Bevan University Health Board (ABUHB) carried out in 2021/2022. It has the aim to ensure that the children, young people, and adults the Health Board serves are safeguarded from harm.

The report aims to demonstrate the Health Board's commitment to ensure safeguarding is a key commitment and **'safeguarding is everyone's business'**. We acknowledge that we all have a pivotal role to play in ensuring patients, their families and the public receive high standards of care, which is compliant with UK and Welsh Government safeguarding legislation.

This report will outline the work carried out during the reporting period of the 1st April 2021 to 31st March 2022. It will detail the areas of strength and areas for improvement against the previous years' Workplan (2020-2021). It aims to provide assurance to the Executive Board and external stakeholders that the Health Board is fulfilling its statutory safeguarding obligations and that progress is being made in safeguarding.

The Covid-19 pandemic has challenged the Health Board in ensuring that safeguarding processes remain consistent and agile in responding to those at risk of harm. New risks have emerged due to national lockdowns, and there is evidence of explicit and hidden harms that children and adults have faced. This report aims to identify the continued service offered and the improvements made to address the emerging needs of the population as we travel through the second year of the pandemic.

2 Introduction

"I am proud to present the 2021-2022 Safeguarding Annual Report and wish to thank colleagues and partners at all levels who work tirelessly to safeguard children and adults at risk".

Rhiannon Jones
Director of Nursing
Executive Lead for Safeguarding

Welcome to Aneurin Bevan University Health Board's (ABUHB) Safeguarding Annual Report for 2021-2022. This report demonstrates our ongoing commitment to safeguarding the population of Gwent.

Safeguarding is the protection of a person's health, wellbeing, and human rights; enabling them to live free from harm, abuse, and neglect. It is an integral part of providing high-quality health care.

Safeguarding children, young people and adults is a collective responsibility and this report will demonstrate the work across the region with multi-agency

partners, including Local Authorities, Police, Education and Third Sector Agencies to fulfil this responsibility.

NHS organisations have a statutory duty to ensure processes are in place to safeguard those at risk. Safeguarding activity is underpinned by: -

- Health and Care Standards for Safeguarding Children and Adults at Risk (Welsh Government and NHS Wales, 2015)
- The Safeguarding Maturity Matrix (NHS Wales, 2018)
- Social Services and Well-being (Wales) Act (SSWBA) (Welsh Government, 2014)
- Violence Against Women and Domestic Abuse (VAWDASV) Act (2015) (Welsh Government, 2015)

The annual report will demonstrate compliance with legislation by summarising key safeguarding activity across ABUHB during the period 2021-2022. It will also evaluate the performance against the previous years' workplan, whilst also presenting the priorities for 2022/2023.

2.1 Context

Aneurin Bevan University Health Board (ABUHB) is the second largest Health Board in Wales. Its footprint covers Blaenau Gwent, Torfaen, Monmouthshire, Caerphilly, and Newport. This equates to a population of around 630,000 people. The Health Board employs over 16,000 staff.

Due to the scale of the Health Board and the diverse population served, safeguarding activity is consistently high and often very complex. In 2021/'22 cases pertaining to Domestic Abuse, Modern Slavery and Human Trafficking, Gangs and County Lines, Fabricated and Induced Illness, Female Genital Mutilation, to name but a few, were experienced.

There has been much activity locally, nationally and regionally contributing to the wider safeguarding agenda.

Safeguarding is naturally a challenging specialism; however, the last 2 years have been particularly difficult. The Covid-19 global pandemic has changed, and continues to change, risks associated with safeguarding.

The impact on patients has been very apparent and is seen daily by the Corporate Safeguarding Team, who manage the front door of safeguarding reports made by the Health Board. Trends which have emerged locally and nationally include the increasing scale of domestic abuse, impacts on mental ill-health, suicide and self-harm, isolation and poverty.

There is increasing awareness of the hidden harms associated with lockdown or shielding that are likely to emerge in the coming years. The cases seen in England and Wales pertaining to the murders of Logan Mwangi, Arthur Labinjo-Hughes and Star Hobson provide a stark reality of the impacts of children and adults not being seen by professionals and safeguarded from harm.

There have been other crises nationally and internationally. The war in Ukraine has seen refugees come to the UK who require extensive support to continue life after fleeing their homes to live fear-free.

There has also been impact on the economy associated with Covid and the war. This has seen unprecedented and sudden rises in the cost of living, with food, fuel, and energy prices all increasing. In March 2022, inflation was reported to be 7% higher than the year previous (March 2021) (House of Commons, 2022). This impacts on the most vulnerable in society and will adversely impact safeguarding linked to poverty.

Due to the current issues both locally and nationally, as was the case with the 2020-2021 Annual Report, activity of the Corporate Safeguarding Team has been focussed on critical aspects only, due to the ongoing challenge and impact of the Covid pandemic. Despite this there has been positive delivery against the 2021 Safeguarding Workplan, the Safeguarding Strategy and continued organisation pursuit of ensuring people across Gwent are safeguarded from abuse, neglect, and other forms of harm.

ABUHB is committed to ensuring safeguarding is part of its core business and recognises safeguarding children, young people and adults at risk is a shared responsibility with a need for effective partnership working and engagement.

3 Developments and Initiatives (on a page)...

Due to a significant number of child deaths related to asphyxiation, the Board worked with Welsh Government on a rapid review and the development of a strategic group within the Gwent Safeguarding Board, whose work is ongoing to look at prevention regarding suicide and self-harm for young people.

The Corporate Safeguarding Team are Chair and Lead Reviewers on several Child and Adult Practice Reviews and Domestic Homicide Reviews to support the critical analysis, health influence and learning from particularly complex cases that resulted in the death or serious harm of a person at risk.

A new booking and communication process for requesting safeguarding supervision has been launched and has been successful in managing and evaluating supervision across the Health Board.

The Corporate Safeguarding Hub was developed in January 2021 and was one of last year's successes. In 2021-22 we have further improved this by ensuring data collection for the safeguarding children activity which did not exist before.

Development and embedding of the Early Intervention and Prevention Hub within the Corporate Safeguarding Team. The hub provides internal, single access support to the Health Board and external stakeholders. Through this the Health Board better contribute to the identification, collation, and coordination of information to inform initial decision making for safeguarding cases.

Safeguarding training compliance for Levels 1 and 2, and Ask and Act Training are now available on the ESR platform which enable monitoring and risk management.

A new safeguarding internet page has been developed and is much improved from the old intranet site. It is easy to navigate and has data cleansed old information.

The Head of Safeguarding chaired the national Single Unified Safeguarding Review Group to support the development of a central repository for practice reviews and domestic homicide reviews which will be launched in 2022.

One of the Corporate Safeguarding Teams Lead Nurses published an article regarding the impact of the pandemic on child exploitation, particularly relating to online exploitation (Bullock, 2022). She noted poignantly that isolation should be considered an adverse childhood experience.

A database has been created for Safeguarding Allegations about Practitioners/Those in a Position of trust to enable robust assessment, monitoring and of allegations in the Health Board.

ABUHB volunteered to pilot a new national safeguarding quality assurance tool (one of only 2 sites in Wales). Work on this has begun with the Head of Safeguarding co-chairing the tools subgroup, with plans to pilot the tool in Quarter 2 2022-23.

The Health Board trialled an Independent Domestic Violence Advocate (IDVA) in the Mental Health. The pilot supported training assessment and referral for people impacted by domestic abuse and coercive control seeking mental health support.

4 Governance Structure for Safeguarding

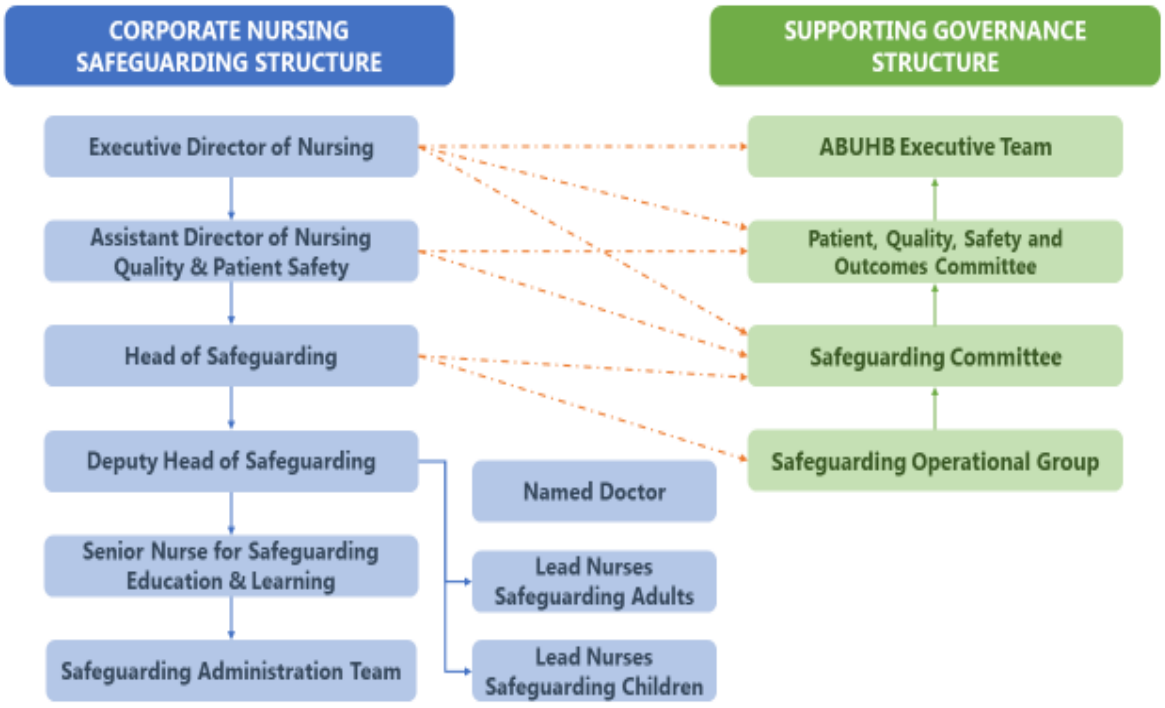
A strong and stable structure ensures that safeguarding is well led and accountable from the Board through to frontline practitioners.

Safeguarding within ABUHB is underpinned by a clear and robust structure. The Chief Executive is accountable for safeguarding with responsibility for executive leadership delegated to the Director of Nursing, supported by the Assistant Director of Nursing – Quality & Safety.

The Health Board's Corporate Safeguarding Team includes a Head of Safeguarding and a Deputy Head of Safeguarding and is part of the Corporate Nursing Team.

Diagram 1 demonstrates the current safeguarding and governance structure.

Diagram 1:



In quarter 3 of 2021, there were some workforce challenges impacting on the Corporate Safeguarding Team and its functioning. The Deputy Head of Safeguarding left post and during the period of recruitment the Head of Safeguarding was absent long term. This presented a significant leadership deficit and risk. Interim arrangements were secured with a temporary Assistant Head of Safeguarding appointed together with supervision support from the National Safeguarding Team, which was welcomed.

4.1 ABUHB Meeting Infrastructure

Meeting Title	Chair	Terms of Reference
Safeguarding Committee	Executive Director of Nursing	• The committee reports to the Executive Team and Patient Quality, Safety and Outcomes Committee (a sub-committee of the Board). • The Safeguarding Committee is multidisciplinary with representation across all Divisions. • The committee provides strategic oversight of the Health Board agenda and gives operational direction in relation to safeguarding in line with national, regional, and local guidance and legislation. • The committee oversees implementation of the Workplan and key safeguarding metrics for assurance and risk mitigation.
Safeguarding Operational Group	Head of Safeguarding	• This group is accountable to the Safeguarding Committee.
Regional Safeguarding Board Meetings	External Partners in the Local Authority	• Safeguarding relies on multi-agency working and there are close ties with the Regional Safeguarding Board, Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Board and the NHS Wales Safeguarding Network. • ABUHB's Corporate Safeguarding Team contributes, at all levels, to the work of these groups which are both regional and national, and includes their respective annual reports to ensure true collaboration.

This year has seen involvement in some new regional and national groups, to include:

- **Single Unified Safeguarding Review Steering Group** - working group to support the development of a central repository for practice reviews and domestic homicide reviews.

- **Suicide and Self Harm Prevention Task and Finish Group** - group to review the current practices relating to suicide and self-harm following a period of increased harm to children and young people.

5 Performance for 2021-2022

ABUHB are committed to ensuring quality assurance of safeguarding is transparent with risks and areas for improvement acknowledged, monitored, and actioned.

5.1 Performance against the 2021-2022 workplan

RAG		
	Green:	Achieved
	Amber	Partial achievement
	Red:	Limited progress

Priority 1	Shared database	Workforce to have access to a shared database for Safeguarding Allegations/ Concerns about Practitioners and those in a position of trust. This was developed in 2020/21 with an implementation date for quarter 2 2021/22.	
Priority 2	Safeguarding Allegations / Concerns about Practitioners and those in a position of Trust	Ensure staff can recognise and manage these concerns, through the development of resources including prompts and training.	
Priority 3	Safeguarding training compliance	VAWDASV Group 3 and Safeguarding Adults and Children Levels 2 will be reported as a percentage compliance figure by the end of Quarter 2. Level 3 Safeguarding Adults and Children will be reportable as a percentage compliance figure by the end of Quarter 3.	
Priority 4	Safeguarding Risk Register	Further refinement of Safeguarding Risk Register by Quarter 4 2021/22.	
Priority 5	Safeguarding Adults concerns	An interim solution is in place for the recording of Safeguarding Duty to Reports on Datix and further work will take place over	

		2021/22 with Once for Wales Concerns Management System Programme whose aim is to bring consistency to the use of the electronic tools used by all NHS health bodies.	
Priority 6	Safeguarding Adults concerns	Ensure staff working with complex safeguarding adults concerns have access to safeguarding supervision, through the implementation of a program of safeguarding supervision.	
Priority 7	Safeguarding Workplan	Ensure actions remain on target and monitored via the Safeguarding Operational Group. The Safeguarding Strategy is entering its final year and the impact of the work undertaken to date will be considered.	
Priority 8	Corporate Safeguarding Team report structure	Review and amend existing performance reports to include practice review summaries. The revised performance report to inform next year's Annual Report.	

5.2 The Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix (SMM) is a quality assurance tool that all Health Boards and Trusts in Wales submit to the NHS Wales National Safeguarding Team on a yearly basis.

The SMM supports Health Boards and Trusts to measure the effectiveness of Safeguarding using self-assessment, identifying strengths and areas for future focus.

The SMM has 5 standards that Health Boards and Trusts benchmark themselves against. Health Boards and Trusts self-assess themselves out of a highest possible score of 5, using set indicators to guide their scoring.

The SMM has been in place since 2018 and ABUHB's Safeguarding Strategy for 2019-2022 has been aligned to the Safeguarding Maturity Matrix standards.

It should be noted that the SMM reporting does not replicate the NHS financial year with the submission being requested by mid-October each year. Consequently, the SMM provides assurance for ABUHB for October 2020 - October 2021.

5.2.1 ABUHB's SMM Submission for 2021

ABUHB's SMM submission for the year demonstrated the progress made against the 5 SMM standards. Table 1 demonstrates the submission, with a column to show the development from previous years SMM's. A rating system demonstrates the advancements made in the Health Board. Green indicates improvement, amber indicates remaining the same and red indicates a decline.

As demonstrated in Table 1, ABUHB has seen improvement in safeguarding in the areas of Governance and Rights Based Approaches and Learning Culture, with the other areas remaining stable. There has been no decline in quality assurance in any area in the year. This is positive giving the context of Covid-19 and the Corporate Safeguarding Team focusing on recovery and maintenance.

Areas that have remained static will be prioritised in the next steps section of this report, which will influence the Workplan for next year.

ABUHB have also been selected by the National Safeguarding Team, who author the SMM, to pilot a new SMM alongside Velindre NHS Trust. Being a part of this pilot will help to strengthen assurance processes. The Gwent Safeguarding Board has also agreed to the pilot using the SMM as a multi-agency quality assurance tool, which will be evaluated next year.

Table 1: SMM Submission October 2020 – October 2021

SMM Standard	Current Position SMM 2021 Submission	Proposed Action SMM 2021 Submission	Score 2021	Score 2020	Score 2019
1 Governance and Rights Based Approach	• Outstanding to scope and implement a model of safeguarding supervision across adult divisions. The ABUHB Policy has been updated to include supervision for adult services • There is a safeguarding supervision offer in place for children's divisions • The implementation of Liberty Protection Safeguards (LPS) has been delayed. Work has started and LPS is now a standing item of the Safeguarding Committee.	• Roll-out of a pilot of adult safeguarding supervision for District Nurses in the Health Board. • To agree a Mental Capacity Act implementation and training strategy to support LPS implementation.	4	3	4
2 Safe Care	• There has been a significant increase in the number of Safeguarding Allegations/Concerns about practitioners and those in a position. • Additional work is required to raise awareness and ensure consistency in the management of these concerns. • A database for the recording of allegations and concerns about practitioners (and those in a position of trust) has been created using Microsoft Teams which has supported the monitoring and understanding of trends and themes.	• ABUHB's Corporate Safeguarding Team to develop resources and training to support staff across the Health Board in understanding their role in managing this process.	3	3	3
3 ACE Informed	• Safeguarding training includes Adverse Childhood Experience (ACE) awareness, and Domestic Abuse. Further targeted work in relation to Domestic Abuse is required. • A pilot of an IDVA within Mental Health and Learning Disabilities (MH/LD) was implemented in the year.	• Safeguarding Operational Group to consider how good practice can be adapted and shared to all areas. There is a need to continue to ensure staff are ACE-aware and that it is incorporated into practice. • Continue to raise awareness of Domestic Abuse through the implementation of the IRIS project in Primary Care and the pilot of an IDVA within the Health Board.	3	3	3
4 Learning Culture	• Delivery of training has been compromised by the Covid pandemic, albeit adaptions have been made with the introduction of training via MS Teams which remains ongoing in the second year of the pandemic. There have been no moves to return to face-to-face training. • Level 1 and 2 safeguarding training can now be recorded via ESR which has improved monitoring. • Work required to ensure skills available within the Corporate Safeguarding Team to develop and maintain intranet pages for safeguarding for the Health Board. • Training compliance data is included within the Safeguarding Performance Reports and shared at each Safeguarding Operational Group and Safeguarding Committee.	• Add learning section on Intranet regarding safeguarding to support ABUHB staff to address their own learning and development needs. • Training compliance recording on ESR Level 3 training remains outstanding. • Need to develop and implement a Level 3 competency learning record for adult safeguarding. • A Training Plan will be developed which will include a suite of training options.	4	3	3
5 Multiagency Partnership Working	• Safeguarding Hub at ABUHB has been a success and is now business as usual for the Health Board. • There is a lack of paediatrician attendance at strategy discussions.	• Work with Public Health Wales and the Regional Safeguarding Board, to explore whether the Duty to Report developed for use on the Datix reporting system, meets the needs of the local population. • Work with paediatric colleagues to increase paediatrician attendance at strategy discussions. • Health Visiting, Mental Health, and District Nursing to support these hubs.	4	4	4

5.2.2 SMM Peer Review

The 2021 Safeguarding Maturity Matrix was submitted in October 2021. In November 2021, the SMM Peer Review process was hosted by the National Safeguarding Team. The Peer Review enables Health Boards and Trusts in Wales to critique each other's submission and improvement plan for the year.

ABUHB was paired with Velindre University NHS Trust. The Peer Review was very productive and proves to be a valuable process.

Through the Peer Review discussion ABUHB strengths included: -

- The improvement in recording of training compliance and safeguarding statistics.
- The significant contribution to the Regional Safeguarding Board.
- The involvement in incidents and Practice Reviews, with a corporate safeguarding team member involved in all processes.
- All Practice Reviews shared at the Safeguarding Committee to identify wider learning.
- The comprehensive evidence of multi-agency working including the Corporate Safeguarding Hub, attendance at Multi Agency Risk Assessment Conferences (MARAC), Multi Agency Child Exploitation Panel and National Referral Mechanism meeting.

Through the Peer Review discussion ABUHB areas for improvement included: -

- Level 3 training compliance not yet able to be measured.
- Exploring options for a more blended approach to training and learning. For example, podcasts to reach wider audiences in informal ways.
- The Liberty Protection Safeguard implementation required more work for preparation of launch.

5.2.3 Summary

The Safeguarding Maturity Matrix identifies actions for the year ahead, which will underpin the Workplan for 2022-2023.

Aligning the Safeguarding Workplan to the SMM output has ensured a focus and a common thread across the various internal and external reporting structures. The deliverables then inform the Workplan which is delivered by the Safeguarding Operational Group and monitored by the Safeguarding Committee.

5.3 Internal Audit

The ABUHB Corporate Safeguarding function was reviewed by Internal Audit in 2020-2021. A 'Reasonable' level of assurance was achieved, meaning the Board could take 'reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively.'

It noted 'some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved'.

There were 3 recommendations all of which have been addressed in 2021/'22.

Recommendation 1:	Implement monitoring tools for safeguarding concerns raised about staff
Update: Practitioner Concerns (Section 5 of the Wales Safeguarding Procedures) are now maintained on a spreadsheet through Microsoft Teams which is accessible by the Corporate Safeguarding Team and the Workforce Division. We are now able to report Practitioner Concerns to the Safeguarding Operational Group and Safeguarding Committee. There is work planned for 2022-'23 for the implementation of a Practitioner Concerns Standard Operation Procedure, Toolkit and Training tools to be launched and communicated to the Health Board.	

Recommendation 2:	Progress the objectives of the Safeguarding Operational Group regarding monitoring and action planning for poor training compliance
Update: Monitoring of training compliance has improved in the year, as the use of ESR is now able to monitor Levels 1 and 2 safeguarding training. Training compliance and risks for the Health Board are discussed at the Safeguarding Operational Group and Safeguarding Committee. There are Divisions in the Health Board who have persistent low compliance and work has been completed this year to address this with the Divisions directly.	

Recommendation 3:	Key risks should be escalated to the Safeguarding Committee
Update: Risk is shared at the Safeguarding Committee and work continues to enable the Divisions that form ABUHB to report their exceptions regarding safeguarding risk, to enable the Corporate Safeguarding Team to support in mitigation. This will continue with restructuring of the Safeguarding Committee through 2022-'23.	

6 Activity for Safeguarding Children & Adults

The Corporate Safeguarding Hub was launched in January 2021. It offers a single point of contact for advice and support to both the Health Board and for external partners. The child function of the hub is supported by 5 (4.6 FTE) expert child safeguarding practitioners who triage, assess, coordinate, and monitor cases relating to children at risk known to the Health Board.

6.1 Safeguarding Children

Due to the newness of the Corporate Safeguarding Hub, data capture for the safeguarding children's activity required adaptation, and has only been in place since November 2021. Consequently, we cannot report on the full data set for 2021-'22 but will be able to do this next year.

Since November 2021, 451 strategy discussions across 5 Local Authority boroughs have been conducted. 378 of the 451 strategy discussions were classified as urgent, demonstrating the level of risk the team are managing.

The data evidences the growth of the safeguarding hub as it progresses into its first year, as in Quarter 3 2021-'22 there were 240 strategy discussions ABUHB attended, compared to 358 in Quarter 4.

The hub has enhanced the way in which ABUHB contribute to the safety planning for children at risk. It also enables staff to better support children, young people and their families due to early intervention and engagement in multi-agency discussion and preparedness.

6.1.1 Child Protection Medicals (CPM)

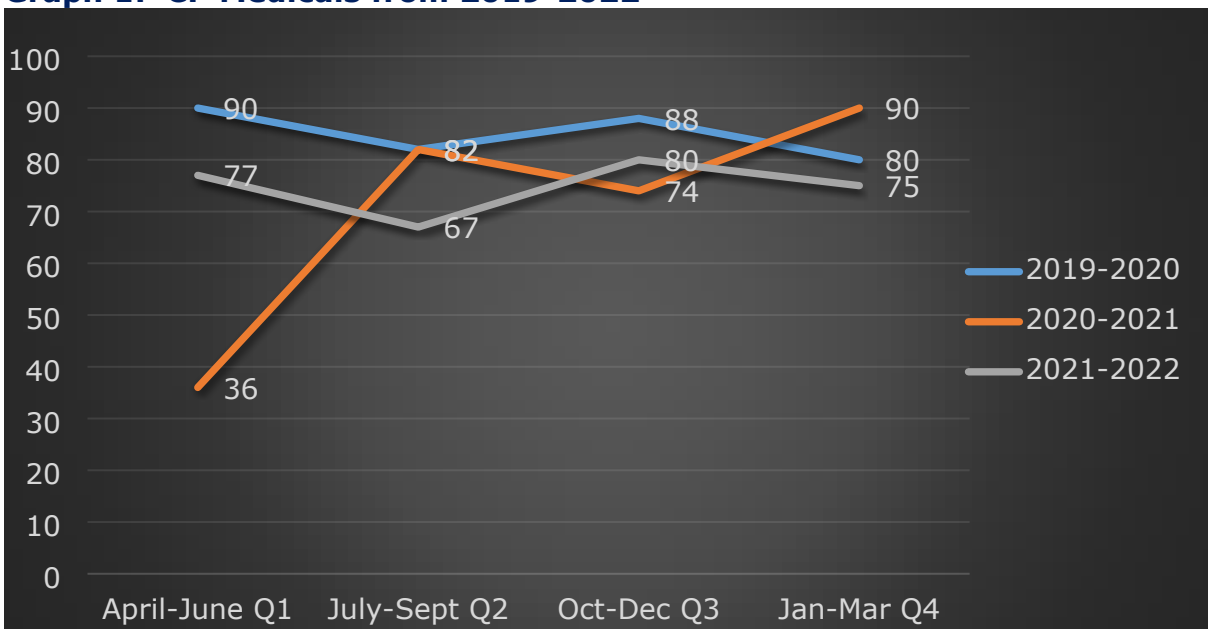
Child Protection Medicals are examinations to look for signs that a child or young person has been neglected or abused (Wales Safeguarding Procedures, 2015, Children Act, 2004).

Despite the impact of Covid-19 and the pandemic spanning its second year, the challenges experienced in 2020-'21 were not replicated this year in terms of Child Protection Medicals. Last year saw an unprecedented reduction in the number of CP Medicals requested and completed in the first 3 months of the pandemic, when national lockdown was implemented.

This was concerning as it indicated children were not being seen by professionals who could identify indicators of neglect or abuse.

The number of CPM for 2021/2022 have been consistent, averaging 73 per quarter compared to 85 per quarter pre-pandemic. The initial concern regarding reduced CPM in quarter 1 first wave has dissipated. There have been 299 CPM during 2021/'22.

Graph 1: CP Medicals from 2019-2022



6.1.2 Demographics of CP Medicals

The highest number of CPM's were under the category of physical harm, at 85%. This is the same for previous years where physical harm is the most common category.

The most common age for CP Medicals is for children aged between 1-2 years (27%) and aged 3-5 years (26%). Under 1 years of age account for 24% of CP Medicals. This is seen across the last 3 years with no variation.

Actions Following CP Medicals:

- Child Protection Medicals are requested internally in the Health Board, or through external partners such as the Police or Local Authority. 83% referrals came from the Local Authority in 2021-2022.

- According to policy these should be conducted within 24 hours of request being accepted. In the reporting year 70% of children were seen for Child Protection Medical within 3 hours. The remaining 30% were seen within 24 hours. We are pleased to report all children were seen within the set timeframe, ensuring they are appropriately and efficiently safeguarded.

6.1.3 Procedural response to Unexpected Death in Childhood (PRUDIC)

Procedural Response to Unexpected Deaths in Childhood (PRUDiC) sets the minimum response and describes the process of communication, collaborative action, and information sharing. The aim of the PRUDiC is to ensure that the response is safe, consistent, and sensitive.

There were 15 child deaths that met the criteria for the PRUDiC process in the boroughs covered by ABUHB in 2021-2'2.

This has remained generally consistent over the last 3 years, with 17 PRUDiC's last year (2020-'21) which was the initial year of the Covid-19 pandemic, and 14 in the year previous (2019-'20).

20% of the child deaths were due to strangulation by hanging and the ages of the children ranged from 9 years to 17 years. This is a similar picture to previous years.

Welsh Government are notified of all PRUDiC'S in accordance with the Putting Things Rights Guidance. Through this communication the patterns and trends pertaining to suicide was noted, which has also been seen across Wales. ABUHB is engaged in local and national workstreams with Welsh Government regarding suicide to ensure that preventative approaches are maximised.

6.1.4 Child Practice Reviews

There are currently 4 ongoing child practice reviews ABUHB are involved in. The children were known to the Local Authority.

They are in the early stages of the review process and learning will be disseminated through the Safeguarding Committee when complete.

6.2 Safeguarding Adults

The adult safeguarding function of the Corporate Safeguarding Team receive Duty to Reports from Divisions enabling assessment and multi-agency referral for adults at risk.

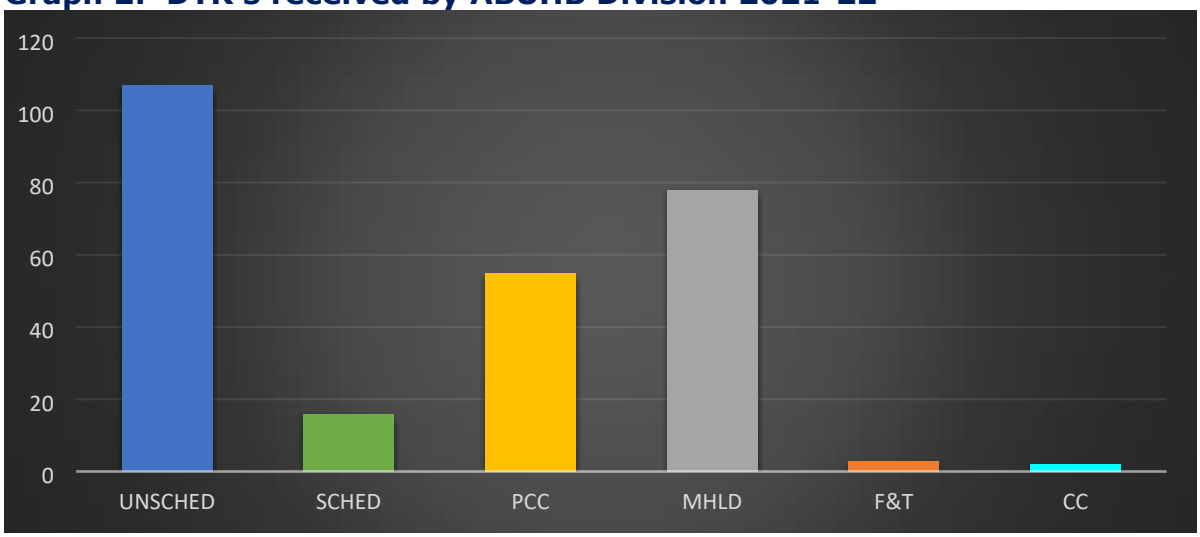
These include cases that pertain to possible safeguarding risk that the Health Board may have contributed to, and cases where external parties (individuals or organisations) are contributors.

6.2.1 Duty to Reports

In 2021-'22 there were 261 Duty to Reports received by the Corporate Safeguarding Team from the Health Board. This has been generally consistent with a gradual increase since 2019, with 231 and 241 reported respectively from 2019-20 and 2020-21.

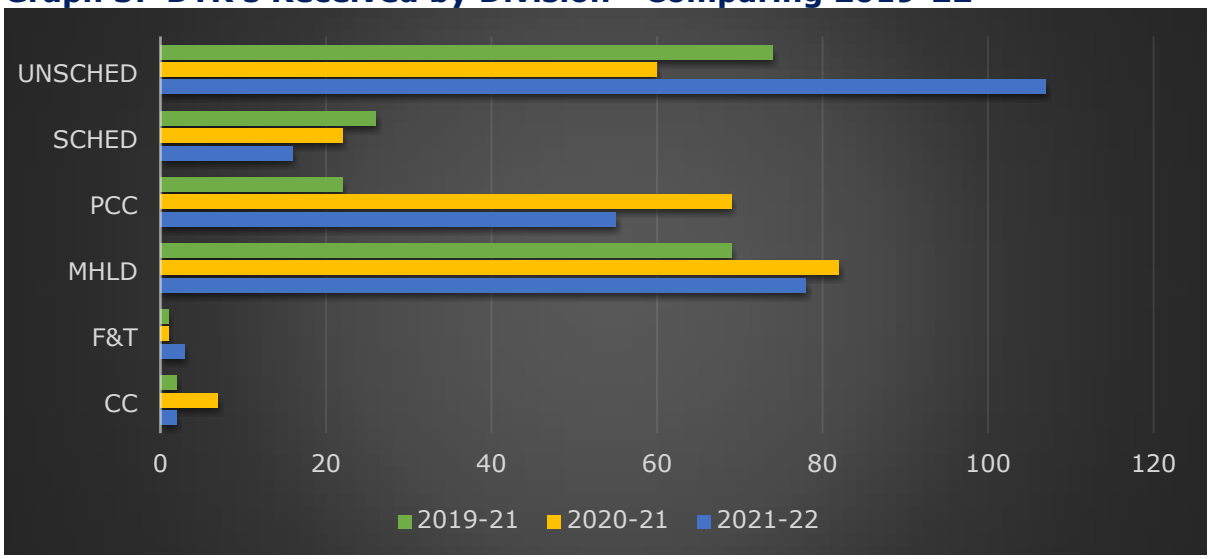
Unscheduled Care reported the highest number of DTR's as demonstrated in Graph 2, with 107 DTR's sent to the corporate adult team. This is expected as this Division covers all Emergency and Assessment Units, seeing many adults in crisis for a variety of reasons.

Graph 2: DTR's received by ABUHB Division 2021-22



Interestingly this trend has changed over the last 3 years. Graph 3 demonstrates the change in the DTR's received from Divisions since 2019. In previous years, the Mental Health and Learning Disability Division typically reported the most DTR's.

Graph 3: DTR's Received by Division - Comparing 2019-22



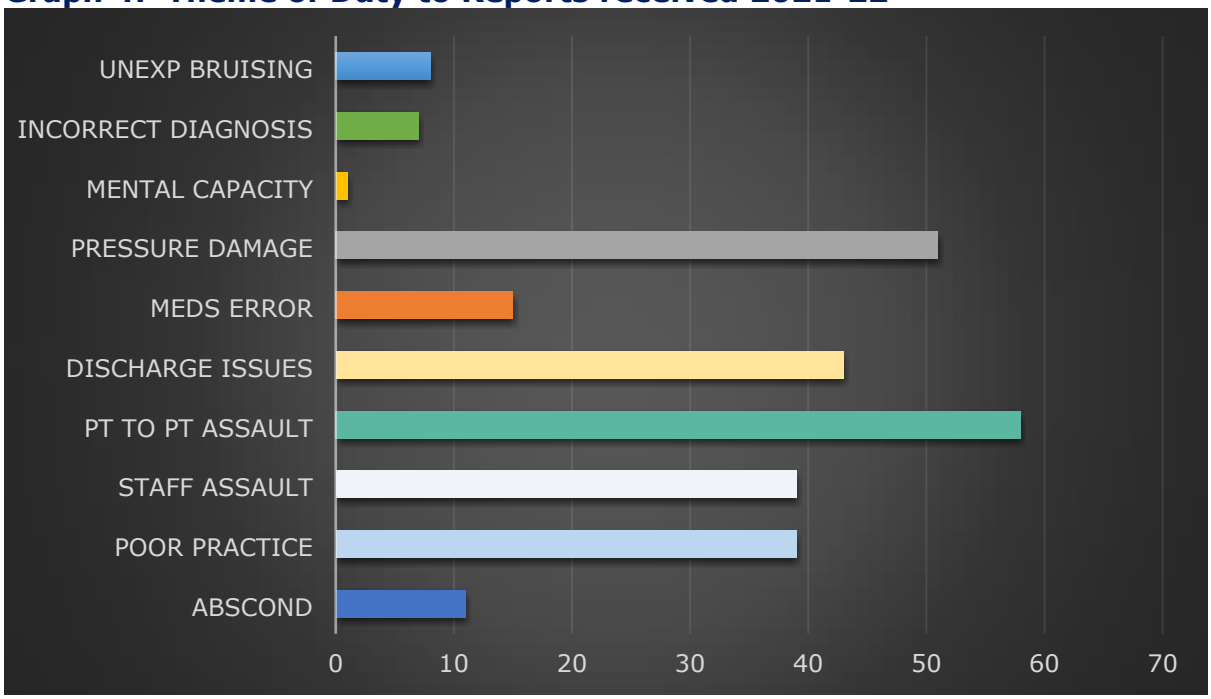
It is possible to surmise that the impact of the pandemic has seen more adults coming to Unscheduled Care settings in crisis due to backlogs in care. The British Medical Association (2022) has said that there is a 'hidden backlog' of patients that is ever increasing, with patients who are currently unknown presenting for care in growing quantities.

Combined with increasing rates of domestic abuse (Welsh Government, 2021) and impacts on mental health (Wales Fiscal Analysis, 2021) it is expected this trend may continue next year and further.

6.2.2 Themes of Duty to Reports

The DTR's received in 2021-22 demonstrated the variety of reasons an adult may be 'at risk'. Graph 4 demonstrates patient to patient assault and pressure damage are the most common reason for a DTR to be submitted.

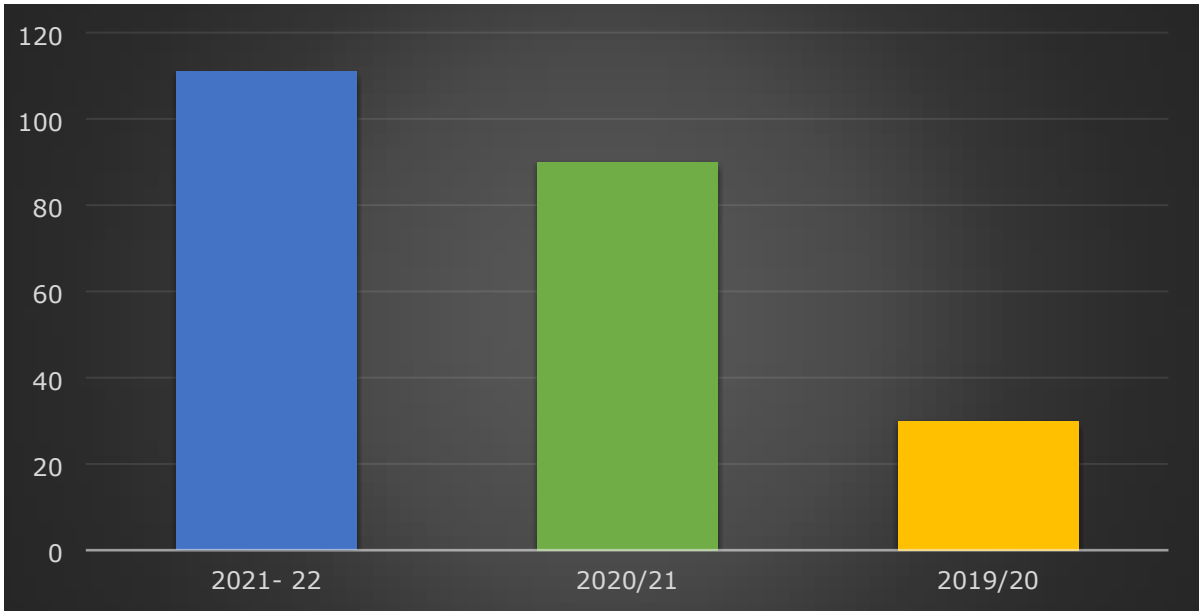
Graph 4: Theme of Duty to Reports received 2021-22



This is expected for pressure damage, as Welsh Government requires Health Boards to report healthcare acquired pressure damage under the Regulation 38 notification guidelines, (NHS Wales, 2018). This was a change because of the Margaret Flynn review (and Operation Jasmine).

For patient-to-patient assaults this is harder to explain and looking at the data for the last three years, it has increased in quantity and remained the highest reported theme of DTR's for the last 2 years. Graph 5 illustrates the increase.

Graph 5: Patient to Patient Assaults 2019-22



It is important that this trend is fully understood by the Health Board and that interventions are considered and implemented by a multiagency group, to attempt to reduce the risk of harm to inpatients at ABUHB.

6.2.3 Outcome of Duty to Reports

The Duty to Reports received by the adult function are all screened and actioned as to what intervention and support the adult at risk may require. There are specific actions that the Corporate Safeguarding Team take in regard to received Duty to Reports. These include:

- **Safeguards in Place:** the team make enquiries to relevant agencies and the adult at risk and it is found that the necessary support is in place so the report can be screened out.

- **No Further Action (NFA):** the report does not meet the threshold for safeguarding adults and is closed to the Corporate Safeguarding Team with communication to the referrer.

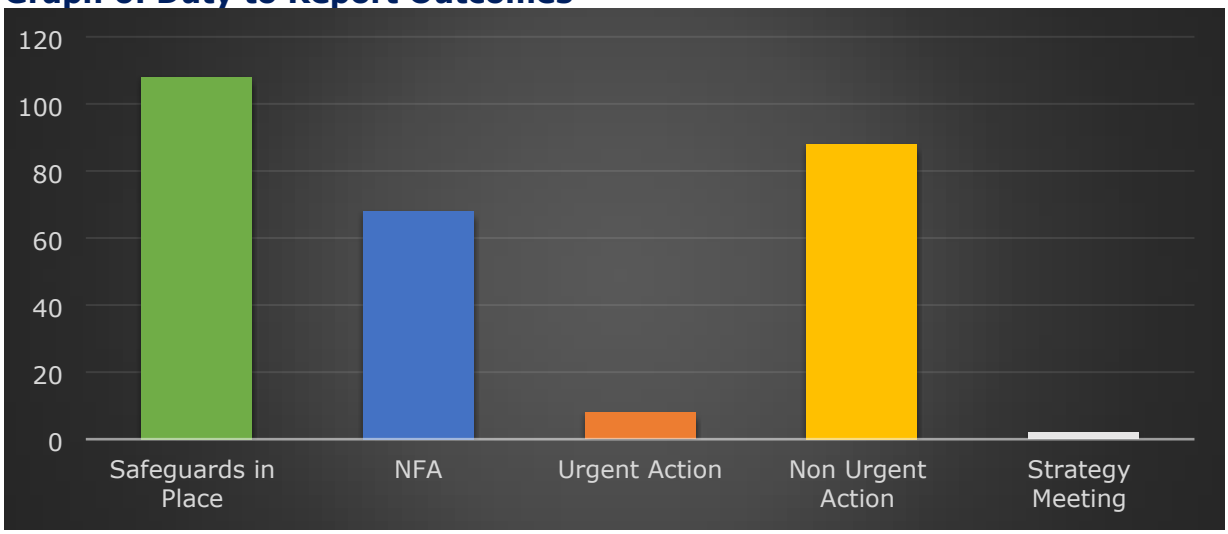
- **Urgent Action:** enquiries are made by the team and it is found that immediate safeguarding actions are required to protect the adult at risk.

- **Non-Urgent Action**: enquires are made by the team and it is found that non-urgent enquiries and referrals for care and support are required.

- **Strategy Meeting:** enquiries find that there are safeguarding concerns requiring formal strategy meeting with the Police and Local Authority.

Graph 6 demonstrates the outcomes of the Duty to Reports. It is able to be summarised most activity in the team relates to non-urgent enquiries and action, and ensuring assurance that safeguards are already in place for the adult at risk.

Graph 6: Duty to Report Outcomes



6.2.4 Adult Practice Reviews

There is currently 1 ongoing adult practice review ABUHB are involved in. This review and its learning will be explored in the ABUHB Safeguarding Committee when complete.

6.3 Domestic Abuse

Domestic Abuse is ***"any incident or pattern of incidents of controlling, coercive or threatening*** *behaviour, violence* ***or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or*** *sexuality"* ***(Welsh Government, 2015).***

Domestic abuse is an increasing issue in the Gwent region. In 2021 the Home Office reported that 8,679 offences were recorded by Gwent Police in 2020-'21, around 18% of all offences recorded that year. Gwent has seen a 100 per cent rise in domestic abuse offences since 4,329 were logged in 2015-'16, when records began. This rise in cases has been seen in the Health Board, where domestic abuse disclosures and concerns are raised every day through the safeguarding hub.

The Corporate Safeguarding Team are involved in work to support victims of domestic abuse who are at high risk, through the inclusion in Multi Agency Risk Assessment Conferences (MARAC). These are multi-disciplinary meetings where cases pertaining to victims who are at risk of serious harm or homicide are discussed, and actions made to safeguard them.

ABUHB attended 143 MARAC's and discussed 1781 cases for high-risk victims of domestic abuse.

In 2021-2022, ABUHB's Corporate Safeguarding Team attended 143 MARAC's and discussed 1781 cases for high-risk adults and their children. Through this process the Corporate Safeguarding Team research all cases prior to attending the MARAC to ensure robust discussions can occur. They also ensure that all health-related actions are co-ordinated through the team and sent to appropriate practitioners for implementation.

6.3.1 Domestic Homicide Reviews

In 2021-22 ABUHB were involved in 3 Domestic Homicide Reviews (DHR's). The reviews are all ongoing and their learning will be explored at the Safeguarding Committee when completed.

The cases all received extensive media attention due to the nature of the offences and highlight the impact of Covid-19 on domestic abuse. The cases are in the public domain.
All three of the DHR's pertained to possible domestic abuse in relationships for older adults aged between 56 and 74 years of age. All of the victims were female and were killed by a spouse or ex-spouse. 2 were killed by stabbing and 1 was killed by strangulation.

The involvement in the DHR's has demonstrated domestic abuse for older adults is a prevalent issue. The NHS Wales Violence against Women Domestic Abuse and Sexual Violence (VAWDASV) steering group have indicated this trend has been seen across Wales and requires targeted attention.

The learning from these reviews will inform future interventions, as a Health Board, to better identify and support older adults who are victims of domestic abuse.

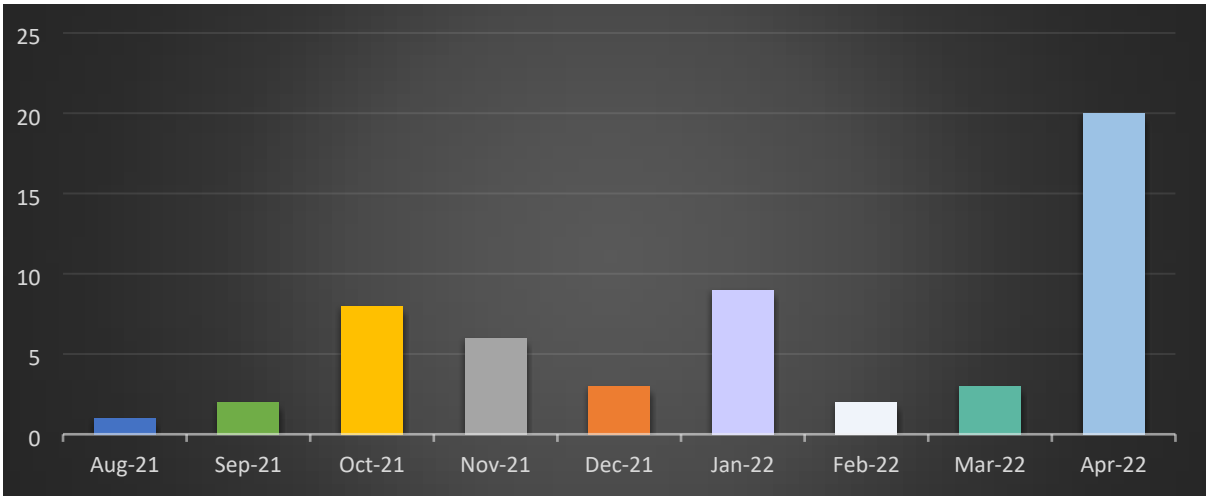
6.3.2 An Independent Domestic Violence Advocate Pilot

During 2021-'22 a pilot was introduced to employ an experienced Independent Domestic Violence Advocate (IDVA) in the Mental Health and Learning Disabilities (MHLD) division. This aimed to improve the awareness, assessment, signposting and referral for patients experiencing domestic abuse (including coercive control) whilst in contact with mental health services.

The pilot was launched in August 2021 and ran until March 2022. Following evaluation, it was identified that although there was some benefit of the IDVA being in the MH&LD Division, the number of referrals and training being requested did not replicate the high levels of domestic abuse being seen in other Divisions.

Graph 7 demonstrates the IDVA referrals received from the MH&LD Division in the 7 month pilot period. The maximum number of referrals in one month being 9.

Graph 7: IDVA Referrals made Aug 2021–Apr 2022



This compared to evidence of Multi Agency Risk Agency Conference (MARAC), which averages 30 referrals per month.

Despite the lower-than-expected level of referrals, the IDVA did deliver a substantial amount of training and liaison across the MH/LD division. This included: 23 training sessions, 18 meeting presentations and supervision sessions, 3 Domestic Abuse Stalking and Harassment (DASH) risk assessment workshops and 2 MARAC workshops. 167 MHLD staff attended these meetings.

It was decided in quarter 4 of 2021-22 the pilot in MH/LD would cease and the IDVA would transfer to the Urgent Care Directorate, based in ED, GUH. The impact of the IDVA in ED will be reported in the 2022/'23 Annual Report.

6.4 Mental Capacity Act

The Mental Capacity Act (MCA) (2005) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. Changes to the Mental Capacity Act have been underway since 2019 and ABUHB have been working tirelessly to prepare for the amendments when they are implemented.

The Mental Capacity (Amendment) Act (2019) amends the Mental Capacity Act (2005) and introduces Liberty Protection Safeguards (LPS). LPS is a new process for authorising deprivations of liberty for persons who lack capacity.

Implementation of the LPS was planned to begin in April 2022, and the MCA Lead at ABUHB had been working towards this implementation date. The Safeguarding Workplan for 2021-2022 embedded the work that had been occurring to ensure preparedness for this date.

Unfortunately, due to the pandemic, the implementation date was delayed by the UK Government. Instead on 17 March 2022, the Government opened a 16-week public consultation on the proposed changes to the Mental Capacity Act Code of Practice, including guidance on the new LPS. This is due to end on 7 July 2022.

Despite delays, ABUHB's Mental Capacity Team did not cease activity and energy was put into ensuring Health Board Divisions would be ready for the implementation, which now is expected in Autumn 2022.

Activity has included: -

- Engagement with the public consultation to deliver Health Board wide responses.
- Conducted engagement events and workshop briefings across ABUHB and the Gwent region.
- The inaugural Mental Capacity and LPS forum was held in Quarter 4 of 2021-2022 with future dates planned in 2022-2023.
- A revised MCA policy had been completed and sent to Executive Nursing Team.
- The MCA training strategy was approved at the MCA forum.
- MCA training and support teams channel is operational to all staff members and provides links to training dates and support.
- Generic and bespoke training and workshops for MCA is available to all Divisions, these have been well attended and evaluated.
- Phase 2 of the funding arrangements for LPS have been released for ABUHB to bid against in collaboration with the consortium partnership.
- ABUHB in partnership with Gwent Regional Partnership Team produced a short animation video explaining the changes to the Mental Capacity Act and the new Liberty Protection safeguards framework.

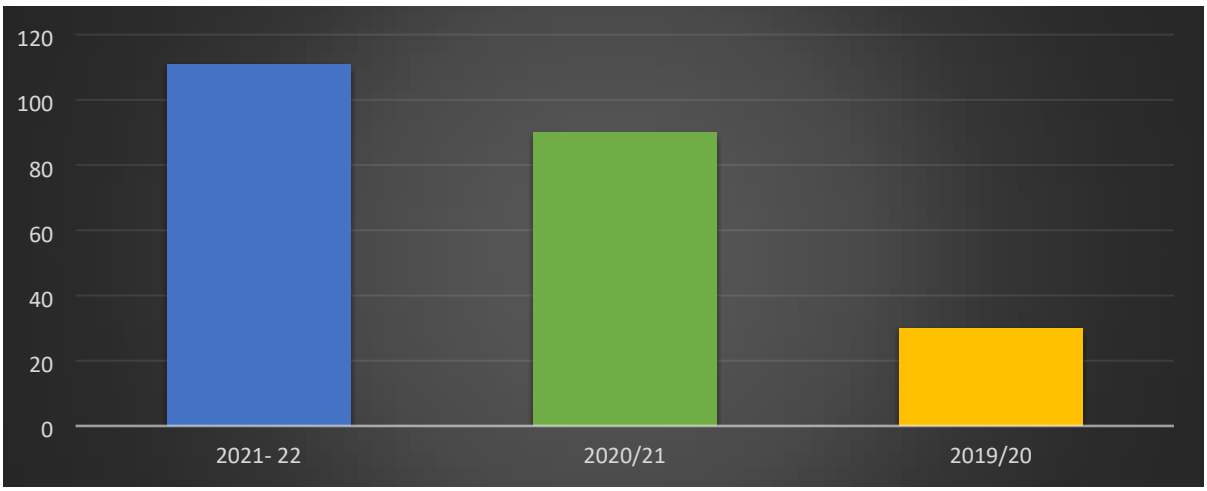
Active work will continue throughout 2022/'23 to ensure organisational preparedness for Act implementation.

6.5 Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust

Section 5 of Wales Safeguarding Procedures provides a framework for how to respond appropriately to safeguarding concerns about people whose paid or voluntary work brings them into contact with children or adults at risk.

There were 111 Safeguarding Allegations or Concerns raised about ABUHB staff in 2021-'22. This has continued to increase year-on-year from 90 in 2020-21 and just 30 in 2019-'21 which Graph 8 depicts.

Graph 8: Safeguarding Allegations about Practitioners 2019-2022



There is no national (Welsh or UK wide) evidence that there is a reason that could explain the increase in numbers in safeguarding allegations regarding staff. It may be explained the implementation of the Section 5 process has increased monitoring and awareness of the cases.

Prior to 2019, concerns relating to those working with adults were managed within the safeguarding process for the adults affected. Concerns relating to children were managed through the Local Authority and Police.

Due to the consistent and significant increase in the numbers of safeguarding allegations about staff members, it is important the Health Board has measures in place to support Divisions in managing cases robustly and safeguarding patients, other staff members and the community.

In 2021-22 work has been ongoing to create a database using Microsoft Teams where allegations about staff are held and can be monitored easily by the whole Corporate Safeguarding Team. The Corporate Safeguarding Team have all received training on the Section 5 process which means the whole team (adult and children specialist nurses) can all manage the concerns from initial concern through to substantiation and decision.

Further work is required in 2022/'23 to embed the same learning across ABUHB to ensure the Divisions can manage allegations to the same standard. Work started in Quarter 4 of this year to create a Standard Operation Procedure, a

Toolkit and training webinars to support, which is referenced in the next steps section.

7 Safeguarding Supervision

Safeguarding supervision is a key part of the Corporate Safeguarding Teams role. It ensures all staff are competent to carry out their responsibilities in safeguarding and feel supported and able to develop by reflection.

Supervision provides a restorative and reflective space for staff to discuss cases and reflect on what went well and what could be done better. It also helps to alert the Corporate Safeguarding Team around the themes being seen by the frontline in ABUHB.

> ***"Thank you for the supervision today - it was really positive and impactful".***
>
> (School Nursing Team)

ABUHB staff have access to supervision in several ways. This includes immediate telephone supervision, debriefs, individual supervision and group supervision.

Regular supervision occurs for child specific specialities including Health Visitors, School Nurses, Child Adolescent Mental Health (CAMHS) Practitioners, Community Paediatric Nurses, Children with Learning Disability Nurses, Sexual Health Outreach, Acute Paediatric Nurses, Health Care Support Workers, Neonatal Intensive Care Nurses and the Neonatal Intensive Care Liaison Team and Midwives.

> ***"Safeguarding supervision was emotionally containing after a really challenging week".***
>
> (Children Adolescent & Learning Disability Nursing Team)

This has continued to be delivered virtually via Microsoft Teams throughout the pandemic. The Corporate Safeguarding Team has recognised the importance that Health Board staff are able to speak to subject matter experts regarding cases and incidents they are involved with.

The Corporate Safeguarding Team has a new electronic booking system for safeguarding supervision, where staff take the lead in their own supervisory needs and are able to book for a date to suit them. They are recommended to receive supervision (from the Safeguarding Supervision policy) twice per year.

Electronic reporting of safeguarding supervision began in January 2022. During this 3 month period there have been 11 safeguarding supervision sessions held by the Corporate Safeguarding Team with 51 delegates attending from Health Visiting, School Nursing, CAMH's, Sexual Health, and Looked After Childrens Nurses. We look forward to reporting the full year's supervision data for 2022-2023.

Evaluation by participants around accessing supervision virtually in the pandemic has been positive and enables them to access supervision easily wherever they are working. Consequently, a blended approach to supervision with virtual and face-to-face methods will be used in the year ahead.

This was demonstrated in several cases discussed in supervision in the year, with the theme of children with gender dysphoria, or identifying as transgender suffering with long waiting lists, mental health issues and turning to the internet for remedies and support online. This was causing staff to feel concerned regarding the need to safeguard children and young people, whilst considering their individual needs, NHS delay impacts and influences from contemporary sources such as social media and online healthcare providers.

Due to supervision the case was taken to the Regional Safeguarding Board, discussed with key Divisions such as CAMH's and shared with Welsh Government to raise awareness and request the creation of a process to support children, young people, and their families, alongside the staff that support them.

Adult safeguarding supervision is still in its infancy and its current offer is being piloted, initially to District Nurses. There have been several sessions arranged by the Corporate Nursing Team in 2021-'22 but uptake has been challenging due to the pandemic impact on staffing in the District Nursing team. Recent sessions have seen more uptake so we are hopeful that this will continue. Work is ongoing to engage the teams in supervision.

Adult services have been particularly strained due to demand and capacity pressures and staffing deficits, so supervision does not appear to have been prioritised. Adult Safeguarding supervision will continue to be promoted. There needs to be a continued focus on safeguarding supervision for adult colleagues in 2022-23 with roll-out to more areas such as Unscheduled Care and Mental Health and Learning Disabilities, where safeguarding concerns have increased.

8 Training

Safeguarding training is a key part of the Corporate Safeguarding Teams role. Safeguarding training is mandatory in ABUHB and compliance is expected to meet Welsh Governments national target of 85%. Training is provided through e-packages and through face-to-face methods.

Safeguarding training compliance has been an area of service provision that has been challenging to maintain throughout the Covid-19 pandemic. This was reported in the last annual report when the initial wave of Coronavirus rendered then 'normal' method of face-to-face safeguarding training unfeasible to continue. This was due to the possibility of spreading the virus in large training groups of staff being required in high-impact areas.

"The knowledge, scenarios and coverage of topic was excellent".

(Community Health Nurse)

Alongside face-to-face training ceasing to be held, high staff sickness and absence, staff turnover, use of agency staff, staff redeployment into clinical areas and staff having to prioritise clinical skills training packages made achieving the Welsh Government target of 85% compliance for safeguarding training even more challenging.

However, ABUHB rose to the challenge and we were committed to ensure the offer of full safeguarding training continued throughout the pandemic. Following the first year of the pandemic where the Corporate Safeguarding Team were reactive to the changes needed in training, in 2021-2022 the safeguarding training sessions have been increased, so there is more availability. All training is now fully virtual for people to attend in a safe way, which is more flexible to their needs and working patterns. This has been positively evaluated.

'"The MS Teams online training session worked well, and the teaching covered many areas in a logical and timely manner".

(General Practitioner)

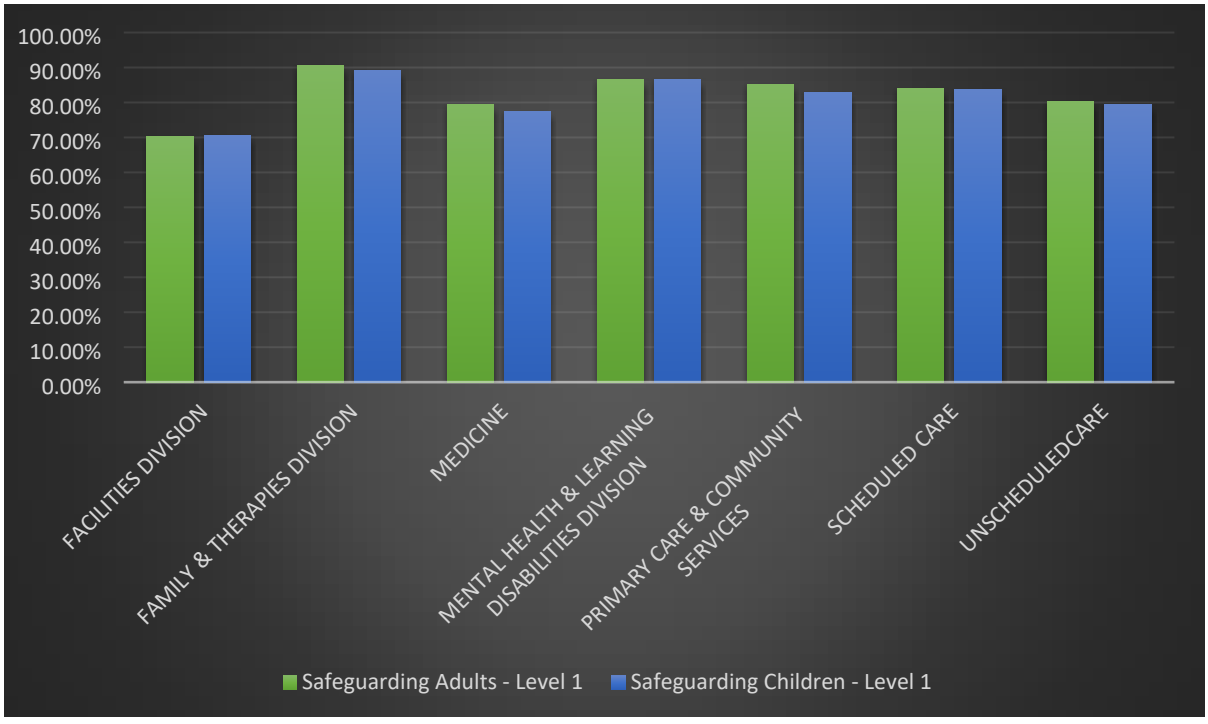
8.1 Level 1 Safeguarding Training

Level 1 safeguarding training is mandatory for all professionals who work within ABUHB. It ensures that all staff can recognise safeguarding concerns for adults and children and are able to take appropriate action to safeguard.

Safeguarding Level 1 training compliance for adults is 83% and Safeguarding Level 1 training compliance for children is 82%. This is an improvement from last year where average compliance was around 75% for Level 1 children and adults training.

The compliance figures demonstrate only minor improvements are required to reach the 85% target. Graph 8 demonstrates the Divisional training compliance for levels 1 & 2.

Graph 9: Level 1 Safeguarding Training Compliance



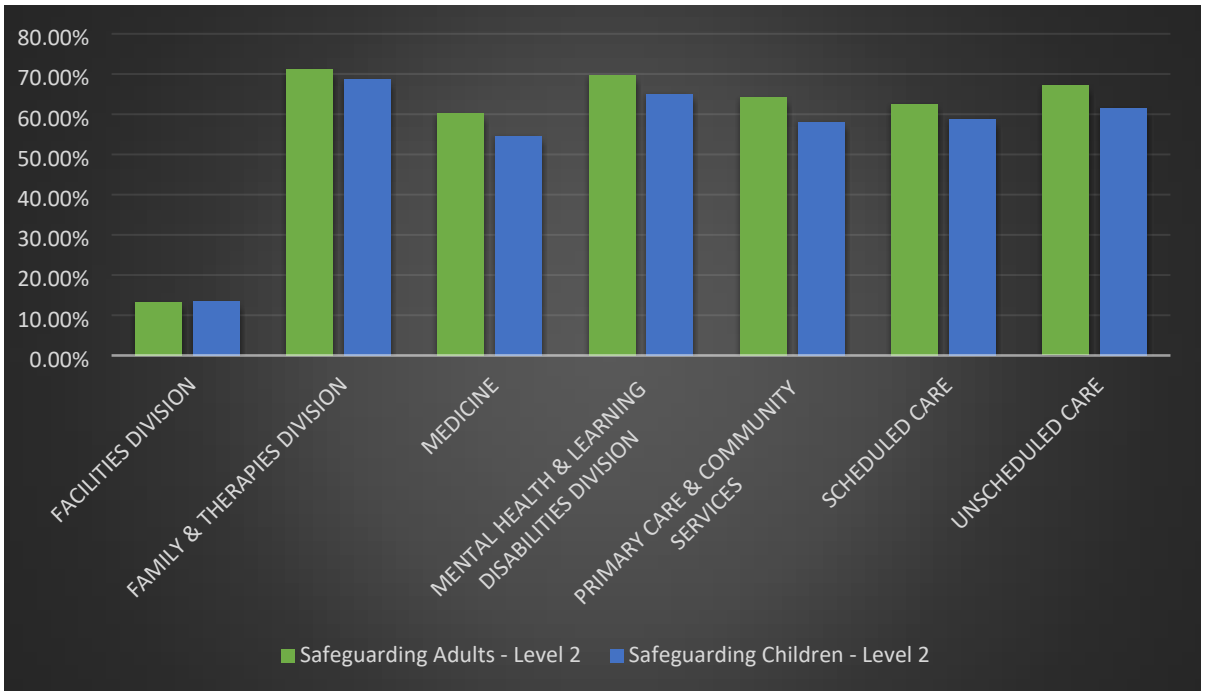
8.2 Level 2 Safeguarding Training

Level 2 safeguarding training is mandatory for professionals who work within ABUHB and have any contact with patients. They should be able to recognise and act on safeguarding concerns by making referrals and advocating for adults and children.

Safeguarding Level 2 training compliance for adults is 71% and Safeguarding Level 1 training compliance for children is 67%. This is the first time that Level 2 training compliance is being reported via ESR so presents the baseline data for future comparison.

The compliance figures demonstrate there is improvement required to reach the 85% target, with greater effort required for Facilities Divison particularly.

Graph 9: Level 2 Safeguarding Training Compliance



8.3 Level 3 Safeguarding Training

Level 3 safeguarding training is for professionals who could potentially contribute to assessing, planning, intervening and/or evaluating the needs of a children or adults with safeguarding concerns.

Level 3 safeguarding training for children and adults is accessed through a 1 full day training course (7.5 hours) which provides the 'building blocks' to Level 3 competency. Additionally, level 3 members are requested to complete a safeguarding competency booklet that demonstrates how they have been involved in the planning, evaluating and reflection of safeguarding over a 3-year period.

Reporting against Level 3 Safeguarding Adults and Children training is not yet complete. When agreeing the target completion date of Quarter 2 2021-2022 it

was hoped that this could be achieved by using the approach of bulk aligning roles titles on ESR. This was the approach taken for Level 2 and allows large numbers of staff to be assigned a competency at any time. However, on meeting with the Divisional Leads it was clear that this would not be possible and a more nuanced approach was needed. An example of this is a Health Visitor would require Level 3 Safeguarding Children but not Level 3 Safeguarding Adults.

This has meant Divisions will need to identify the staff who require these competencies at a local level. To support this, a training needs analysis is required and phased approach to Level 3 Safeguarding training is required. Phase 1 will focus on high impact safeguarding areas such as Family and Therapies, Complex Care, Urgent Care and Mental Health & Learning Disabilities. Phase 2 would include Scheduled Care and Community Care, and Phase 3, Medicine and remaining areas.

The Corporate Safeguarding Team will then be able to support in the identification and alignment of staff.

We can report for 2021-2022 that 124 people were trained to Level 3 safeguarding in the period May 2021 - March 2022.

The completion of the Level 3 safeguarding competency booklet has been challenging in the last 2 years and this is directly attributable to the pandemic. Of 124 people trained at Level 3, only 20 individuals have completed their competency booklet. This needs review in the training needs analysis next year, as to how this can be promoted and audited robustly.

8.4 Domestic Abuse Training

Ask and Act training aims to ensure that professionals are trained to provide an effective response to anyone affected by any form of gender-based violence, domestic abuse, and sexual violence.

Ask and Act training is grouped similarly to standard safeguarding training using level 1, 2 and 3 to indicate the responsibility and learning requirement of the participants. Level 1 being the most basic and is mandatory for all ABUHB staff, and level 3 being for those who actively work with victims and are likely to identify, assess and refer.

In 2021/22 78% of eligible staff at ABUHB were trained to Level 1 in Ask and Act. This is near the 85% target and an improvement from 74% for 2020/2021.

Level 2 Ask and Act training has seen around 600 staff attend Group 2 training in 2021-2022 (3% of the eligible workforce). There remain challenges to extrapolating compliance data due to ESR reporting which will be added to the Training Needs Analysis and Workplan for 2022- 2023 to better understand and report on training compliance for the higher levels of safeguarding training.

9 Conclusion

In conclusion, 2021/22 has been a challenging year for ABUHB as a second year of Covid transpired. The pandemic has identified new risks due to lockdown and hidden harm, which will undoubtedly impact for 2022/'23 and beyond.

Despite the challenges, successes have been secured: -

- Involvement in national pilots and workstreams relating to the Safeguarding Maturity Matrix and the Single Unified Safeguarding Review.
- Innovations in: -
  - Delivering and evaluating safeguarding supervision and training virtually
  - Creation of a Health Board Early Intervention and Prevention Hub
  - Pilot of an Independent Domestic Violence Advocate in the Mental Health Division
  - Database for Safeguarding Allegations about Practitioners/Those in a Position of Trust
- Improvements in multiagency communication and support.
- A new safeguarding internet page to promote safeguarding in-house.

ABUHB is committed to ensuring the safeguarding of children and adults is a priority and continues to improve in 2022/'23. 2021/'22 has demonstrated the need for safeguarding services to be agile, responsive and purposeful as the Covid-19 pandemic continues, and no doubt the recovery period will bring more challenges. Many of these will be hidden harms faced by victims and survivors, who will need safeguarding in different ways to those we have known before.

Work will continue with the community and partners to ensure the development and adaptation according to need, with patients at the heart of everything that we do.

10 Priorities for 2022/2023

ABUHB acknowledges that there is further work required to improve the safeguarding of children and adults at risk. It is important as Health Board that we continue to adapt and enhance the services we offer to meet the needs of contemporary society. The pandemic has escalated the need to communicate and support people differently and we are committed to maintain progress made.

The priorities for ABUHB in 2022/'23 are:

Priority 1

There is a need to address the rising rates of Allegations/ Concerns about Practitioners or those in a Position of Trust. A Section 5 Standard Operation Procedure, Toolkit and Training package will be created, launched and communicated across the Health Board to ensure robust and consistent management of these safeguarding concerns.

Priority 2

There have been increases in the number of Duty to Report referrals received from the Unscheduled Care Division. There will be close work between the Corporate Safeguarding Team and the Division to ensure incidents and risks are co-managed, and safeguarding supervision and safeguarding training packages are in place, are being accessed by staff and compliance is regularly monitored. A pilot of an evidence-based safeguarding proforma will be rolled out in the Emergency and Assessment departments to help guide the initial assessment, triage and referral process for adults at risk.

Priority 3

There has been an increase in the number of Duty to Reports received regarding patient-on-patient assaults in ABUHB. It is important this trend is understood and interventions can be put in place to prevent harm to adults at risk whilst they are in the Health Board's care. Close work with the Divisions who report higher levels of patient-on-patient assault will be required to look at incident monitoring and themes, and to use the Safeguarding Committee and Operational Groups to create an approach that can be piloted in the Health Board.

Priority 4

Safeguarding supervision for adult specific practitioners was piloted in 2021 for District Nurses. The pilot has been challenging to evaluate as there was poor attendance due to the pandemic. There needs to be a continued focus on safeguarding supervision for adult practitioners in 2022-'23 with wider roll-out focused in safeguarding 'high impact' areas, such as Unscheduled Care and Mental Health & Learning Disabilities Divisions.

Priority 5

The pilot of an Independent Domestic Violence Advocate in the Mental Health & Learning Disabilities Division had some success in 2021-'22. However, it was recognised the referrals and training numbers did not match the levels seen in comparative Health Boards such as Cardiff and Vale UHB, and with the levels of domestic abuse reported across the Health Board. Consequently, the IDVA service will be re-piloted in the Unscheduled Care Division to ascertain if the impact is higher. This will be thoroughly evaluated in 2022-'23.

Priority 6

Compliance for Level 1 and 2 Safeguarding Children and Adults Training and Level 1 'Ask and Act' training has improved in the reporting year. However minor improvements are needed to meet the 85% target. A training needs analysis will be produced to better understand and address the challenges in achieving target compliance in 2022/23. Bespoke training for Divisions where compliance is low will be introduced.

Priority 7

Level 3 Safeguarding Children and Adults Training compliance is not yet able to be reported. This needs to be addressed in 2022/'23 with a complete mapping exercise of the roles that require Level 3 training to be completed. The current 'building blocks' approach to Level 3 safeguarding training also requires review, as compliance with the 'Safeguarding Competency Booklet' is challenging to monitor.

Priority 8

Current ongoing Domestic Homicide Reviews that ABUHB are involved in have demonstrated there is work needed to better understand and address routine inquiry and support offered to older adults who are victims' domestic abuse. Engagement in local and national multi-agency VAWDASV groups is required to ensure that the Health Board is included in plans and pilots for this specific area of concern.

Priority 9

Suicide and self-harm for children and young people has been identified as a theme in multiple Child Practice Reviews. It is important that the Health Board is included in local and national workstreams that are ongoing next year, to ensure that a preventative approach to suicide and self-harm is promoted across all divisions. 'High impact' areas such as the Child and Adolescent Mental Health Service, School Nursing and Emergency Departments must be particularly involved in planning and piloting of new approaches.

Priority 10

ABUHB is piloting a new version of the Safeguarding Maturity Matrix in 2022-2023. It is important actions from the new quality assurance tool are incorporated into the annual Workplan and Safeguarding Strategy.

Priority 11

Impending changes to the Mental Capacity Act legislation has faced significant delays in UK Government. Work needs to continue regarding the Act and the proposed changes that look set to be launched in Autumn 2022. The Mental Capacity Act must remain on the Workplan for 2022-2023 to ensure it remains in focus and risks are addressed as they arise.

11 References

British Medical Association (2022). NHS Backlog Data Analysis.
Accessed at: NHS backlog data analysis (bma.org.uk) on the 16.05.22

Bullock, F (2022). *COVID-19 lockdowns and the rise in child exploitation.*
Accessed at: COVID-19 lockdowns and the rise in child exploitation - PubMed (nih.gov) on the 16.05.22

Children Act (2004). HM Government House of Commons (2022). *Rising cost of living in the UK.*
Accessed at: Rising cost of living in the UK - House of Commons Library (parliament.uk) on the 16.05.22

NHS Wales (2018). *Safeguarding Maturity Matrix.*
Accessed at: PHW Safeguarding Maturity Matrix 2019.pdf (wales.nhs.uk) on the 16.05.22

Wales Fiscal Analysis (2021). *Covid-19 in Wales: The Mental Health and Wellbeing Impact: BRIEFING PAPER.*
Accessed at: COVID-19-Mental-health-FINAL-08-07-2021.pdf (cardiff.ac.uk) on the 23.05.22

Welsh Government and NHS Wales (2015). *Health and Care Standards.*
Accessed at: Health standards framework english (gov.wales) on the 16.05.22

Welsh Government (2015). *Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act*
Accessed at: Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 (legislation.gov.uk) on the 16.05.22

Welsh Government (2014). *Social Services and Well-being (Wales) Act*
Accessed at: EN Draft Template (legislation.gov.uk) on the 16.05.22

NHS Wales (2018). Pressure Ulcer Reporting and Investigation All Wales Guidance
Accessed at: Purpose of Document (wwic.wales) on the 23.05.22

Welsh Government (2021). *Violence Against Women, Domestic Abuse and Sexual Violence: National Advisers Annual Plan 2022 to 2023*
Accessed at: Violence against women, domestic abuse and sexual violence: national advisers annual plan 2022 to 2023 [HTML] | GOV.WALES on the 23.05.22

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality Safety and Outcomes Committee Tuesday 16th August 2022 Agenda Item: 3.9

Aneurin Bevan University Health Board

Infection Prevention & Control
Decontamination & Antimicrobial Resistance Annual Report 2021/2022

Executive Summary
The Infection Prevention & Control Decontamination & Antimicrobial Resistance Annual Report summarises infection prevention and control events within the organisation and provides information between April 2021 and March 2022.

Purpose: **Patient Quality, Safety and Outcomes Committee is asked to:**	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	✓
Executive Sponsor: Linda Alexander – Interim Director of Nursing	
Author(s): **Deb Jackson – Assistant Director of Nursing IPC** **Moira Bevan – Head of Nursing IPC**	
Report Received consideration and supported by:	

Executive Team	✓	**Sub-Committee**	
Date of the Report:			
Supplementary Papers Attached: Infection Prevention & Control Decontamination & Antimicrobial Resistance Annual Report 2021/2022			

Situation

The purpose of the Infection Prevention and Control, Decontamination and Antimicrobial Annual Report is to provide an overview of the Aneurin Bevan University Health Board (ABUHB) performance and assurance against the following: -

- Welsh Government Antimicrobial Resistance (AMR) and Healthcare Associated Infections (HAI) Improvements Goals.
- Respiratory Infections (Covid-19, Influenza, Respiratory Syncytial Virus (RSV).
- Decontamination Strategy
- Infection Prevention incidents

Background and Context

The annual report is underpinned by Health and Care Standard 2.4 Safe Care. Within this standard, effective infection prevention and control (IPC) is identified as everybody's business.

Infection Prevention continues to be high priority for the Health Board (HB) and the Infection Prevention Team (IPT) continue to monitor the activity robustly through the ICNET surveillance data which has quickly identified hospital outbreaks.

The purpose of this report is to outline the infection prevention work undertaken in 2021/'22, the management arrangements and progress against performance targets.

The Covid-19 pandemic has resulted in ongoing pressure for the IPC Team and organisation, despite the pressure performance has been reasonable considering the operating environment.

Assessment and Conclusion

A breakdown of the Welsh Government targets: -

- A total of 208 cases of C *difficile* were reported from April 2021 to March 2022. This is a 40% increase in comparison to the equivalent period 2020/21 but mirrors the national position.

- A total of 134 cases of Staph aureus bacteraemia were reported from April 2021 to March 2022, of which 5 patients were identified with MRSA and 129 with MSSA. This is a 15% reduction compared to the equivalent period on 2020/21. The provisional rate is 22.40 per 100,000 population.

- A total of 349 cases of E coli were reported from April 2021 to March 2022. This is a 17% increase compared to the equivalent period 2020/21. The provisional rate is 57.51 per 100,000 population, this is below the Welsh Government reduction expectation and ABUHB has the lowest rate in Wales.

- A total of 96 cases of Klebsiella reported from April 2021 to March 2022. This is -20% fewer than the equivalent period 2020/21. The provisional rate is 15.55 per 100,000 population and the Heath Board has the lowest rate in Wales.

- A total of 36 cases of Pseudomonas were report from April 2021 to March 2022. This is 29% more than the equivalent period 2020/21. The provisional rate is 5.18 per 100,000 population.

- There have been no outbreaks of norovirus.

- Activity of influenza in ABUHB during 2021/21 was low with no ward outbreaks.

The ABUHB Antimicrobial Working Group (AWG) continues to monitor antimicrobial usage and implement strategies to optimise use of antibiotics across the Health Board.

Recommendation

The PQSOC is asked to **NOTE** the Annual Report and: -

- The significant work programme and the impact of Covid-19.
- The achievements of 2021/22.
- The areas of concentration and priorities for 2022/23.

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 include reputation, financial risk due to increased length of stay. This has been identified on the Division 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 RNTG, antimicrobial working group and decontamination group.
Equality and Diversity Impact Assessment	Quality impact assessments are considered in all environmental assessment and action plan.

(including child impact assessment)	
Health and Care Standards	Infection prevention is linked to Standard 2.1 and 2.4 by managing risk and promoting infection prevention must be everyone's 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. Using clinical expertise to deliver evidence-based practice.
	Involvement – Engagement and Divisional ownership for the reduction of healthcare associated infection. Linking with the site-based leadership teams for the delivery of their implementation plans.
	Collaboration – collaborative working across the Divisions and the site-based leadership teams in response to health needs. Linking both externally and internally to improve patient outcomes and risk reduction.
	Prevention – working towards the reduction of healthcare associated infection reviewing themes for improvement goals.
Glossary of New Terms	
Public Interest	Infections can affect everyone the IPT continue to work multi-disciplinary to promote best practice, reducing the risk of hospital transmission. Healthcare associated data published on Public Health webpage data being readily available to the public for assurance, honesty and transparency.

ANNUAL REPORT

Infection Prevention & Control, Decontamination & Antimicrobial Resistance

2021/2022

Aneurin Bevan University Health Board is committed to ensuring that a consistent high standard of infection prevention and control practice is a priority and is an essential requirement of assuring high quality, safe and effective care and minimising avoidable harm.

Contents

1 Purpose

The purpose of the Infection Prevention and Control, Decontamination and Antimicrobial Annual Report is to provide an overview of the Aneurin Bevan University Health Board (ABUHB) performance and assurance against the following: -

- Welsh Government Antimicrobial Resistance (AMR) and Healthcare Associated Infections (HAI) Improvement Goals
- Respiratory Infections (Covid-19, Influenza, Respiratory syncytial virus (RSV)
- Decontamination strategy
- Infection Prevention Incidents

2 Introduction

Aneurin Bevan University Health Board recognises the prevention of infection is fundamental to the quality of care delivered and is committed to ensuring that a consistent high standard of infection prevention and control practice.

The Annual Report is underpinned by Health and Care Standard 2.4 Safe Care. Within this standard, effective infection prevention and control (IPC) is identified as everybody's business and must be part of everyday healthcare practice, based on the best available evidence, so people are protected from preventable healthcare associated infections.

The "Code of Practice for the Prevention and Control of Healthcare Associated Infections" (2014) builds on the 2011 Welsh Government "Commitment to Purpose – eliminating preventable healthcare associated infections (HCAIs)". This framework sets out the minimum necessary infection prevention and control (IPC) arrangements for NHS healthcare providers in Wales, whereby organisations are expected to meet nine core elements.

There are several other guidance documents and standards which outline evidence-based practice to support organisations in the prevention of healthcare associated infection (including Covid-19) and to reduce the burden of antimicrobial resistance, these include: -

- Standard and Transmission Based Infection Prevention Precautions
- Communicable Disease Outbreak Plan for Wales
- All-Wales Infection Prevention and Control Training, Learning and Development framework
- National Standards for Cleaning in NHS Wales
- Aseptic Non-Touch Technique (ANTT)

The consistent implementation and maintenance of these key national standards is vital to prevent the transmission of harmful micro-organisms to patients and staff and minimise harm.

HCAI's have the potential to cause significant harm. As well as the more obvious consequence of a local infection requiring treatment or life-threatening infections such as sepsis and endocarditis. Infections can also cause chronic illness leading

to long term pain and disability. There is also an adverse impact on health service due to extended lengths of patient stay in hospital and time away from home, the costs of diagnosis, treatment and complications of infections coupled with the costs of specific IPC measures. Hence, the prevention and control of infection is a national and organisational priority.

The Covid-19 pandemic has caused widespread disruption to health and care services and consequently the importance of IPC measures has probably never been more important.

ABUHB maintains a zero-tolerance approach toward all preventable HCAIs and is committed to minimising risks to patients. Welsh Government AMR and HCAI Improvement Goals 2021-22 set out 2 main aims namely:

- Optimise the use of antimicrobials
- Lower the burden of infection

Progress against these 'improvement goals' is monitored through the HB Reducing Nosocomial Transmission Group (RNTG).

The table below demonstrates compliance with the goals for the reporting period.

Pathogen	Welsh Government Target per 100,000 population	Health Board Rate
C *difficile*	25.00	**34.27**
MSSA	20.00	**21.73**
MRSA	0.00	**0.67**
E coli	67.00	**58.01**
Klebsiella	10% reduction	**15.55 (20% reduction)**
Pseudomonas	10% reduction	**5.18 (29% increase)**

Recognising ABUHB did not achieve the Welsh Government reduction expectations, it is important to note that with the exception of C *difficile,* the Health Board have the lowest rates across Wales. An overview is provided further in the report.

3 Progress/Performance against 2021/'22 Workplan

Based on the 2020/21 issues, a work programme was developed for focus during 2021/22. The table below outlines progress:

RAG	
Green:	Achieved
Amber	Partial achievement
Red:	Limited progress

Priority 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks the environment and other users may pose, maximising the use of ICNet.	The IPT, along with other key stakeholders, proactively utilise ICNet on a daily basis as a central repository to inform, monitor and manage patient caseloads in relation to healthcare associated infections. The ICNet outbreak module was installed with one further module still under consideration for development on an All Wales basis.	
Priority 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates robust compliance to the prevention and control of infections.	Environmental cleaning is a fundamental principle of preventing infection in the hospital setting. Environmental monitoring via the Symbiotic audit is ongoing to support this essential requirement. Local environmental groups were re-established to include key divisional representation aiming to achieve a clutter free and clean environment.	
Priority 3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	The Health Board remains committed to achieving the improvement goals to combat antimicrobial resistance, which are measured against the five year Welsh Government strategy and via local Root Cause Analysis (RCA) meetings. There are 5 improvement goals associated with the WG reduction expectation for optimising the use of antimicrobials across primary and secondary care. Progress against these improvement goals are monitored via the Health Boards antimicrobial stewardship group and Reducing Nosocomial Transmission Group (RNTG). A key priority for the organisation is Goal 5: 'Start Smart Then Focus' which splits into two themes: junior doctor audits and the Antibiotic Review Kit (ARK) project. ARK has gone live in Ysbyty Ystrad Fawr and Nevill Hall hospitals, with further organisational roll out planned. Given that targets will be set against the audits from next year onwards, these projects need to gather pace to optimise antimicrobial effectiveness for treating infection whilst mitigating the risk of resistance occurring.	

Priority 4	Provide suitable and accurate information on infections for service users.	Patient information leaflets are aligned, adapted and updated in-line with Public Health Wales resources, which are disease specific. Refreshed banner stands and posters were prominently displayed in public areas highlighting the Health Boards position in regards visiting and accessing hospital premises during the pandemic. Internal and external communications are regularly posted to ensure the public and service users are well informed in regards infection prevention measures and any changes relating to Welsh Government ALERT levels.	
Priority 5	Ensure prompt identification of people who have or are at risk of developing an infection so they receive timely and appropriate treatment, to reduce the risk of transmitting infection to other people.	Improved utilisation of ICNet leads to proactive patient identification and intervention at critical moments. There remains in place a continued focus on patient pathways to support both the safe care of patients and restarting of healthcare services. A well-defined pathway is under development to protect those patients who are extremely clinically vulnerable from Covid -19, to ensure they can receive care in isolation facilities. CWS holds an alert message to aid the safe placement and management of patients, who have an infection which may have a significant impact. Systems are in place but this priority is 'amber' due to demand and capacity pressures impacting on flow.	
Priority 6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities through education and training.	The IPC education strategy was updated and ratified via RNTG. Training compliance was monitored via the Site Based Leadership Teams. In addition, an all Wales education framework was developed. The IPT have mapped the current training programme against the recommendations. IPC features as part of the Health Board's Induction Programme and training resources are available via the Intranet. Processes are in place, but this priority is 'amber' due to fluid workforce.	
Priority 7	Ensure all IPC policies are up-to-date and evidence-based.	All IPC policies are reviewed and are up to date. The IPT align all Health Board IPC policies against All Wales National Policy utilising evidence based practice, in turn these are ratified via RNTG.	

Priority 8	Undertake outbreak reviews from Covid surge 1 and 2, together with individual death reviews associated with each outbreak and ensure organisational learning and preparedness for future surges.	Organisational learning from surge 2 Covid-19 outbreaks was shared with the Executive Team, and for wider organisational learning via RNTG. The Health Board participated in the Delivery Unit national review. A Covid Investigation Team has been established.	
Priority 9	Actively contribute to the Covid-claims agenda.	The IPT continue to actively respond to any requests in respect of complaints/claims and investigations as requested by legal services, PTR, Divisional and corporate teams.	
Priority 10	Implement a staph aureus reduction plan.	ABUHB currently has the lowest rates of staph aureus within Wales. There is a continued focus on the ANTT requirement for the risk reduction of blood stream infections. The development and approval of the business case to expand the existing PICC line service will support the insertion and maintenance of PICC lines and ensure the right patient receives the right line.	
Priority 11	Prepare a business case for strengthening of, and investment, in the IPC team and infrastructure.	A successful application to the transformation fund awarded to strengthen the IPC infrastructure.	

The annual report is aligned to the 9 standards within the Code of Practice.

Standard 1:	Appropriate organisational structures and management systems for IPC must be in place.
Standard 2:	The physical environment should be maintained and cleaned to a standard that facilitates IPC and minimises the risk of infection
Standard 3:	Suitable and accurate information on infections must be made available to service users, their visitors and the public.
Standard 4:	Suitable, timely and accurate information on infections must be provided to any person concerned with providing further support or nursing/medical care when a service user is moved from one organisation to another or within the same organisation.
Standard 5:	All staff employed to provide care in all settings are fully engaged in the process of IPC.
Standard 6:	Adequate isolation facilities are provided to support effective IPC.
Standard 7:	Policies on IPC must be in place and made readily accessible to all staff.
Standard 8:	So far as is reasonably practicable, staff are free of and is protected from exposure to infections that can be acquired or transmitted at work.
Standard 9:	All staff are suitably trained and educated in IPC associated with the provision of healthcare.

4 Standard 1: Organisational structures and management systems for IPC

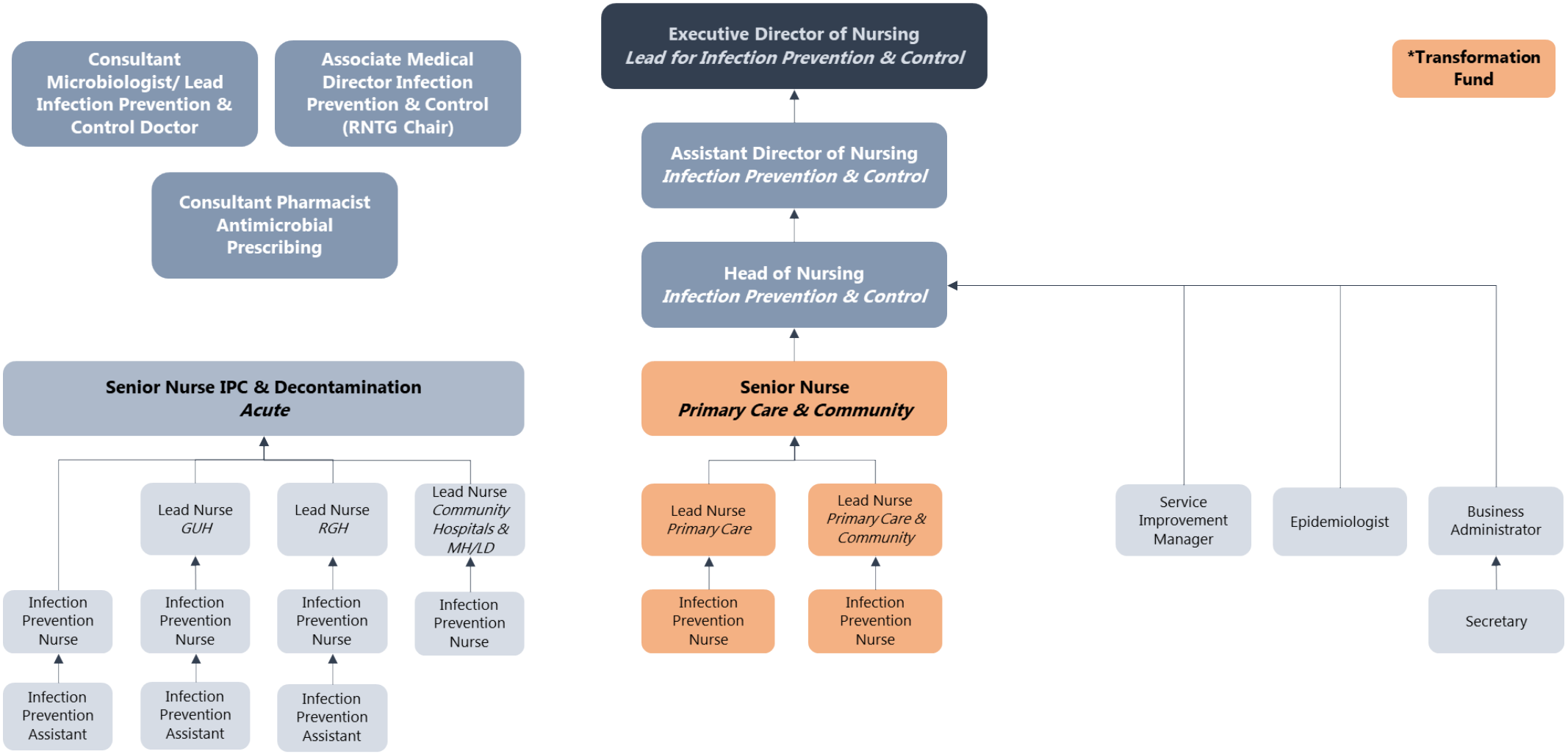
The Covid-19 pandemic has had an enormous impact on the Infection Prevention and Control Team (IPCT), and it is fitting to acknowledge their ongoing resilience and commitment to keeping patients, staff, and visitors safe during the most challenging times. It is recognised that the Infection Prevention service has been predominantly reactive throughout the pandemic, responding to high numbers of incidences and outbreaks in hospitals and community care settings. As the risks associated with Covid-19 are subsiding, there is a commitment to now re-focus on a proactive approach to preventing infection.

The Chief Executive is accountable for IPC with responsibility for executive leadership delegated to the Director of Nursing. The IPCT is nurse-led, with advice and support provided by a Consultant Microbiologist/Designated Lead Doctor.

The pandemic has demonstrated the requirement for additional IPC resources to support community and private settings. In conjunction with the Primary Care and Community Divisions, IPCT successfully secured funding from the Transformation Fund to expand the Community resource to provide an enhanced service for Care Homes, community healthcare teams and private providers.

During the pandemic, the organisation's decontamination programme was significantly limited as the manager was required the Covid response.

Infection Prevention & Control Infrastructure



The previously appointed Covid Safety Advisors have had a role review with the development of Infection Prevention Assistants. They continue to support the Covid agenda, but have a broadened remit, covering wider aspects of IPC.

5 Standard 2: Physical environment should be maintained and cleaned

5.1 Decontamination

Throughout 2021/22, the time the Decontamination Manager was able to dedicate to decontamination was significantly limited as their expertise was redirected to core IPC.

Attempts to resume the decontamination role in March 2021 were short lived due to, again, rising levels of Covid infections in hospitals.

Due to Covid-19 restrictions, only one decontamination audit was undertaken jointly with the Authorised Engineer (Decontamination) for Wales NWSSP (NHS Wales Shared Services Partnership). This took place at the Endoscopy Decontamination Unit Royal Gwent Hospital (RGH) and aligns with 2 previous audits undertaken at the Endoscopy Units in Nevill Hall Hospital (NHH) and Ysbyty Ystrad Fawr (YYF). The review has highlighted further work around traceability of instruments, weekly testing process requirements and chemical monitoring and storage. These will be monitored through the Strategic Decontamination Group.
The Decontamination Manager, when able, 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.

Final plans were agreed for the endoscopy decontamination scheme which will now only support the new endoscopy suite at the Royal Gwent Hospital. Other departments are expected to align later.

Business case for the four-theatre suite endoscopy unit has been sent to Welsh Government and is currently awaiting approval from the Investment Board.

During the reporting year, Nevill Hall Hospital Sterilisation and Disinfection Unit (HSDU) was decommissioned. Surgical instruments from NHH are transported for processing to the new facility at The Grange University Hospital (GUH) except for the Endoscopy department who continue to process on site.

Work continues to improve decontamination processes including:

- The continuation of service and testing contracts for all endoscopy services to ensure compliance with WHTM 01-06 testing criteria with procurement.
- Working in Partnership with Works and Estates Authorised Person for Decontamination.
- The commissioning of the HSDU GUH ensuring compliance with required WHTM standards and the ISO accredited status for HSDU in Wales.

- The purchase of 3 drying cabinets, with installation of 1 at YYF in line with Joint Advisory Group (JAG) accreditation standards and WHTM 01-06.

- Procurement of scopes and implementation of a robust decontamination service across sites to support GUH endoscopy services while HSDU and centralised endoscopy decontamination facilities are built at the GUH.

- Appropriate management of soiled used trays and their timely transport continues to be monitored.

- The purchase of 2 further ultraviolet (UV) decontamination units for decontamination of nasoendoscopes in YYF and NHH. This will allow for efficient disinfection of nasoendoscopes and significantly reduce the amount of single use nasoendoscopes being currently used.

- HSDU departments continue to be monitored as per WG requirement and remain accredited to national ISO standards.

- Ongoing monitoring of facilities/theatres for best practice re tray and decontamination of surgical instruments.

- Ongoing monitoring of weekly water quality sampling through Standard Operating Procedures (SOPs).

Whilst there has been limited external meetings with other NHS organisations across Wales, the decontamination team at NWSSP SES continues to facilitate national discussion on continual improvements throughout Wales during the reporting period.

Next steps include the building and commissioning of Ringland Community Centre (Community Dental Service) and General Dental Practice (GDP) where best practice facilities will be available. It is anticipated that Ringland will support one or two further CDS clinics with decontamination facilities, ensuring compliance with WHTM 01-05 and reflect the CDS strategy of decontamination hubs.

5.2 Facilities

The workforce supply challenges experienced in 2020/21 continued into 2021/22. Throughout the course of the period between April 2021 and March 2022 it became increasingly difficult to align the supply of workforce to the demand required to deliver the cleanliness service. A collaborative review of the workforce requirements to deliver the Standards was undertaken by the Senior Facilities Management Team, Service Improvement Manager for Cleaning Services, Operational Services Managers' and Business Partner Accountant. The group reviewed pre-pandemic cleaning schedules, resource allocation and environmental audit reports to determine the required level of resource to deliver the enhanced Standards.

Following this review a paper was presented to the Executive Team in September 2021 that contained various options to deliver the All Wales Enhanced Cleaning Standards and provide resilience to support surge demand. The Executive Team agreed to support the preferred option. Support for this option enabled the recruitment of 88 whole time equivalents (WTE) to meet Covid and surge

demands, while utilising agency staff to deliver the additional cleans as indicated in the All Wales Enhanced Cleaning Standards.

Workforce and Organisational Development initiated a recruitment drive to raise awareness of working within the division, which has led to 70 candidates being offered an interview. The division were able to offer posts to 18 candidates, the other candidates were unable to work the hours required. As a division it is acknowledged that many candidates were not willing to work only evening shifts i.e. 6 adverts have been promoted last year and still unable to fill evening shifts. This has resulted in a review of working hours undertaken by domestic staff at GUH to assess whether alternative working hours can be explored without compromising service delivery (this review is still ongoing). The division has successfully recruited or increased current staff's hours equating to 38 WTE of the 51.64 WTE.

Facilities have also linked with 6 agencies to recruit to the enhanced cleaning rosters, so far, 66 WTE of the 88 WTE have been recruited. The retention rate is just under 10%.

These workforce issues are recognised and to try and mitigate these Estates & Facilities have developed the career development pathway. This has been created to develop, implement and embed a career development programme to support career pathways which will in turn increase staff retention and succession planning as well as increasing knowledge and skills across a broad range of tasks.

The divisions Transformational Change Programme have been doing large volumes of work speaking to staff and listening to concerns and challenges they have experienced.

Estates and Facilities have taken an innovative approach to providing the cleaning service and overcoming the challenges faced in doing so. In 2021/22 the division has been working to identify new ways of providing services and embracing new technology to assist in the delivery of safe systems of working that will enhance and deliver improved cleaning to wards, departments and communal areas. This has resulted in investment in:

- 10 Ultra Violet (UV) decontamination machines. These machines increase the speed of the sanitation of patient areas following an outbreak. UV decontamination is used in conjunction with Hydrogen Peroxide Vapour (HPV) decontamination. The total investment has been circa £350,000.

- 6 additional HPV decontamination machines. Although HPV machines have been operational for a number of years, the demand for this type of clean continues to increase.

- 2 HPV transport cases. Due to the risks associated with the machinery and chemicals used it has not previously been safe to transport the machines across the estate. This has limited our ability to respond to emerging threats. The two transport cases will address this risk and allow us to move HPV machines around our estate, therefore improving our response. The total investment in HPV is £258,534.

- 4 Eco Bots (robotic cleaning machines). The Eco Bot is an easy to operate robotic scrubber dryer. It takes just 30 minutes to map a 2,000 m² area.

- Thanks to the 20+ sensors, the Eco Bot 50 is able to perceive the environment, avoid obstacles, and prevent collisions. This machine is eco-friendly and efficient; its water is recycled through a 4-stage filtration system to give constant operation during the 2.5-hour run time. Eco Bot 50 cleans on schedule, requiring no human intervention in its cleaning operations, these are used alongside our traditional cleaning methods and allows the ability to clean public corridors out of hours, enhancing the environment and reduces risk to pedestrians due to wet floors. £131,400 has been invested in this range of machinery

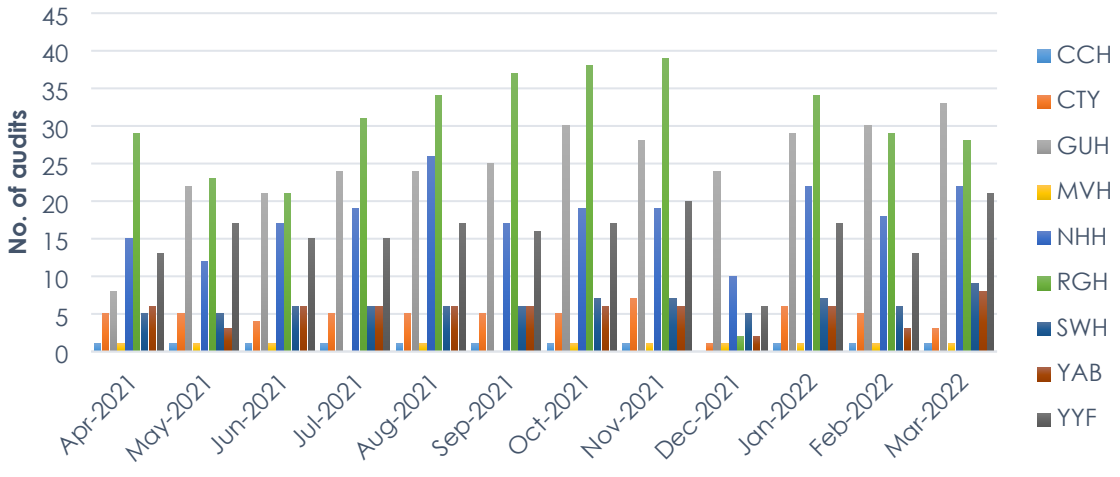
- 5 additional Environmental Cleanliness Auditors. The audit team that sits within the division's Health, Safety and Compliance team has been increased to provide additional assurance regarding the cleanliness of buildings. The Audit team undertake audits of all patient facing and public areas, they audit site cleanliness, Estates, Nursing and IPC, which have 13 elements dedicated to them. In total, 65 elements are audited, and these are reported to senior staff in all areas and are discussed at RNTG.

To ensure robust and consistent cleaning methods are used across all hospital sites Facilities has developed a training programme to ensure all new and existing staff receive updated standardised training. The training covers requirements for cleaning methodology, correct use of equipment, delivery of national requirements on colour coding of cloths and mops and work within defined cleaning schedules and checklists.

With a recognition of workforce supply challenges, Facilities are committed to investing in staff and supporting career development with a focus on career pathways'.

Environmental cleanliness audit feedback can be seen in the following graph, to include number of audits undertaken and site compliance:

Graph 1: Environmental Cleanliness Audits undertaken



Compliance with cleaning standards has been presented at the Patient Quality, Safety and Outcomes Committee (PQSOC) for assurance.

6 Standard 3: Accurate information on infections must be made available

IPT has an Intranet page where staff can access the latest IP guidance, resources and useful information. There is a library of infection prevention policies and patient information leaflets. News items are shared regularly via the new intranet platform.

The team participated in two campaigns throughout the year and due to the ongoing pandemic, the team reached out to employees via social media.

On 5 May 2021, the team supported the World Health Organisation Hand Hygiene awareness day "SAVE LIVES: CleanyourHands".

Infection Prevention Awareness week took place from 18th to 22nd October 2021. The IPT developed a Winter Toolkit to prepare colleagues for seasonal illnesses that impact on infection prevention and patient experience.

The campaign was supported by the Director of Nursing, Medical Director, Lead Antimicrobial Pharmacist and Consultant for IP, who presented key messages via social media. Themes covered throughout the week were: -

- Covid-19
- Respiratory viruses (including influenza) and prevention of hospital acquired pneumonia
- Diarrhoea and vomiting
- *C. difficile*
- Staff Health and well-being

Infection data is presented to the PQSOC via an outcomes report bi-monthly, with publically available reports.

7 Standard 4: Surveillance

The following section covers:

- ICNET
- *Clostridium difficile*
- *E. coli* bacteraemia
- *Pseudomonas* bacteraemia
- Mortality
- Influenza
- Carbapenem resistant organisms
- Covid-19
- *Staphylococcus aureus* bacteraemia
- *Klebsiella* bacteraemia
- Norovirus
- Surgical Site Infections
- Respiratory syncytial virus

7.1 ICNET

ICNET is an electronic infection case management and surveillance software which has been adopted by IPCT's across Wales. The system provides a comprehensive overview of patients' laboratory results and documented IPC interventions. Patient records on ICNET are available to IPC teams across Welsh Health Boards

improving the communication around infections both between and within IPC teams, and the data feeds into local and national surveillance programmes.

Over the last 12 months, ICNET has proved vital in the management and control of Covid-19, enabling the team to manage patients and support clinical teams promptly and efficiently. It has enabled the team to work remotely, which has proved invaluable when needing to provide support over a large geographical area.

The outbreak module has been improved and can now provide a comprehensive timeline to aid outbreak investigation. This function benefits the team significantly for the timely assessment, establishing an index case and identifying potential hypothesis around the transmission of infection, thus contributing to the overall learning and root cause analysis.

Going forward, the IPT will explore the functions within the software to further improve case management and control of a wide range of infections in hospitals and in community settings.

7.2 Covid-19

During this reporting period, the Health Board faced a third and fourth wave of Covid-19 and the highly transmissible Omicron variant swept rapidly through the country.

Whilst the Health Board experienced a rise in the number of people with Covid in hospital, thanks to the rapid roll-out of the population vaccination programme, the infection was less severe than seen in previous waves.

Nonetheless, the sheer volume of people, both patients and staff, testing positive in hospital and in the community meant that the organisation faced unprecedented challenges in service provision.

The infection prevention guidance for the Omicron variant was consistent with other variants in that physical distancing, hand hygiene and environmental cleanliness, ventilation, mask wearing and PPE together with vaccination were the key factors for reducing spread and impact.

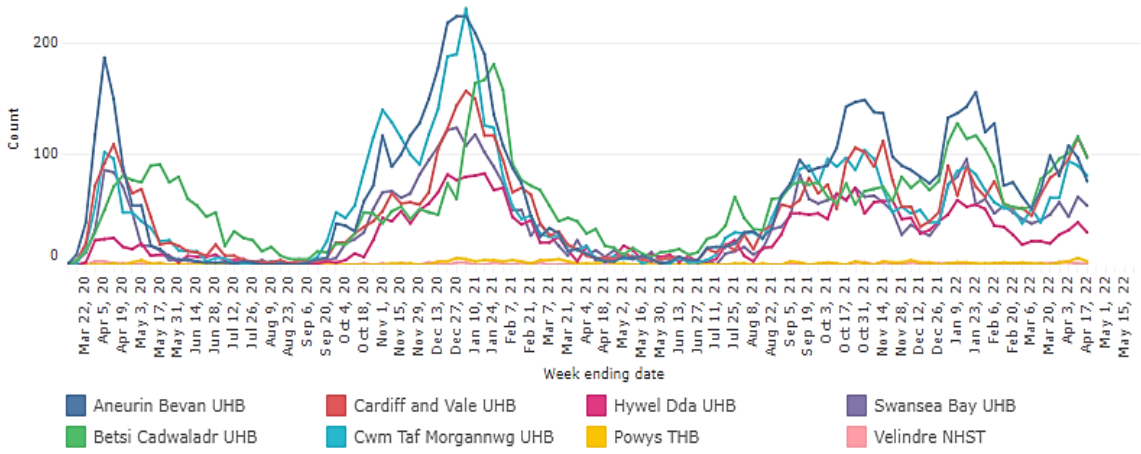
The evidence base around Covid is continuing to grow and we now have a better understanding of how the virus spreads and how to prevent severe infection through vaccines and treatments. What is not certain, however, how the virus itself will behave in the future and the true likelihood of a more transmissible or severe variant is not known.
In waves 3 and 4, most of the healthcare acquired Covid-19 cases across ABUHB were picked up through routine hospital asymptomatic screening. These patients had been admitted to hospital for reasons other than Covid-19, thankfully, most of these patients experienced mild symptoms, or were asymptomatic and did not require treatment or an extended hospital stay for their infection.

The reduced incidence of severe Covid-19 infection due to the successful vaccine campaign and a milder variant meant that mortality rates across Wales following Covid-19 infection reduced from 16.1% (Autumn 2021 Delta variant) to 7.6% (Winter 2021-22 Omicron variant).

As at the end of March 2022, changes to All-Wales testing protocols for Covid-19 removed the requirement for routine asymptomatic screening for hospital in-patients. Patients continue to be tested on admission.

The following graph show the number of inpatients diagnosed with Covid-19 from March 2020 to May 2022. For this reporting period, it can be seen that April 2021 to August 2021 was stable, with volatility from September 201 to March 2022 albeit lower than wave 1 and 2.

Graph 2: All Wales weekly number of inpatient confirmed cases



Rapid development and constant review of SOPs, risk assessments and protocols has been paramount in informing and evolving the safe management of Covid-19 in healthcare and community settings.

The team closely monitor announcements and updates from Chief Medical Officer (CMO), Chief Nursing Officer (CNO), Welsh Government and UK Health Security Agency (UKHSA), updating key documents promptly so they can be scrutinised and ratified by RNTG and the Executive Team without delay to facilitate rapid implementation.

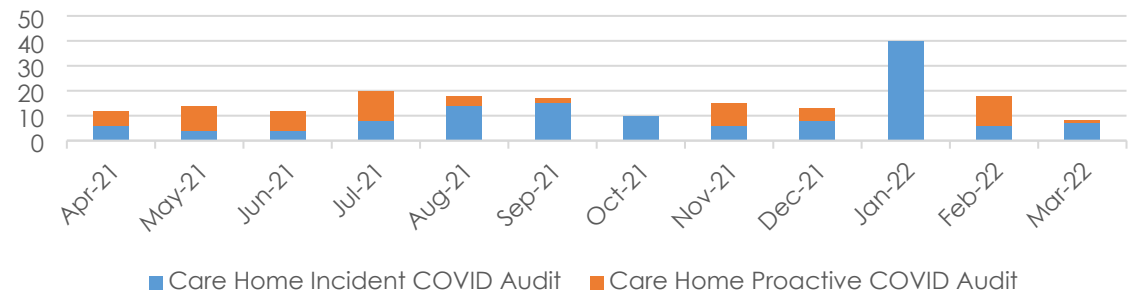
Updates to the 'Staff returning to work following contact with a positive Covid case' risk assessment have been particularly challenging due to the unprecedented volumes of staff cases and contacts and the need to balance this against the risk that staff absences posed to service provision.

ABUHB has continued to have a robust visiting policy advocating "Visiting with a Purpose." Part of the requirement is relatives are tested prior to seeing their loved ones. RNTG frequently reviews the visiting policy and strongly advocates this process to continue considering the increase in cases within the community.

Community IPT provided support for care homes and the locality Incident Management Teams during the pandemic both in response to incidences and outbreaks of Covid. The support has been significant and has stretched the IPCT, albeit the team were boosted via Transformation funding.

The Infection Prevention Team carried out 197 Covid audits in the period April 2021 – March 2022, as shown in the following graph.

Graph 3: Covid audits in Care Homes

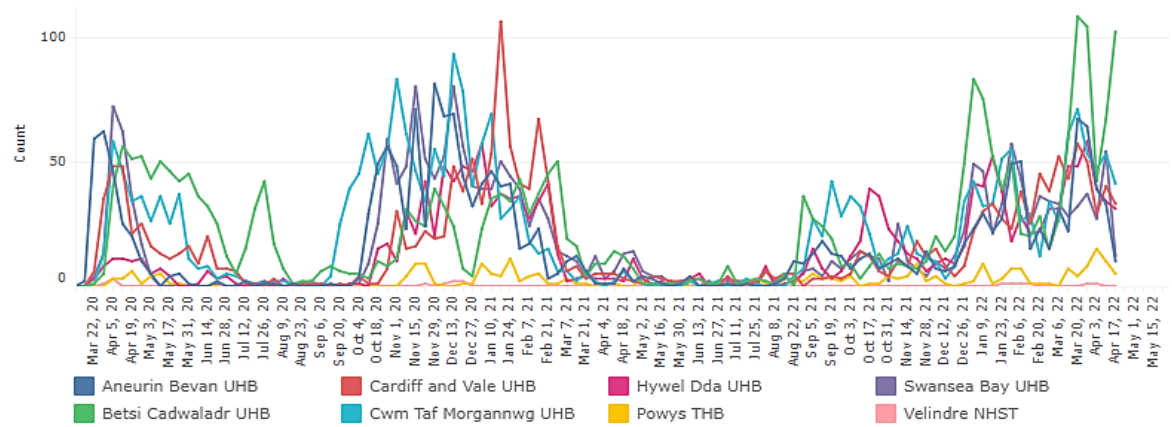


7.2.1 Covid Outbreaks

An outbreak, as defined by Public Health Wales (PHW) is two or more linked cases occurring in the same ward environment within a specific timeframe and is a notifiable incident. High community transmission is inextricably linked to hospital acquired cases and during the Omicron surge, hospitals experienced significant numbers of incidental / asymptomatic cases whereby patients tested positive through routine in-patient screening whilst being treated for another medical condition.

The following graph shows all Wales number of probable and definite cases of healthcare acquired Covid-19.

Graph 4: All Wales weekly number of probable and definite hospital onset



For each outbreak, there is a clear and robust management plan which includes timely infection prevention guidance and support, and an 'Outbreak Control' meeting to determine the root cause, how the infection spread and the management of any ongoing risks.

As has been previously stated, for many of the declared outbreaks in the Omicron wave, a considerable proportion of cases were asymptomatic and only identified through routine in-patient or more frequent testing due to an outbreak being declared.

Through the review process, some themes were identified to include: -

- Aged estate
- Limited cubicle capacity

- Poor ventilation

Hospital ventilation and air changes has been assessed by Works and Estates. The survey concluded that, with the exception of The Grange Hospital, all other sites do not meet the recommended 6 air changes per hour. The Ventilation Group continue to evaluate the use of air scrubbers to enhance air quality.

The care environment (including the availability of cubicles) and ventilation were found to be key factors for reducing the risk of transmission of Covid-19 in hospital sites. Proportionally, far fewer outbreaks were identified in The Grange compared to Nevill Hall, Royal Gwent, and some community hospitals.

7.2.2 Covid Mortality

All in-patient deaths in Royal Gwent, Ysbyty Ystrad Fawr and The Grange hospitals are subject to independent scrutiny from the Medical Examiner. Any deaths that are assessed as being due to 'probable' or 'definite' hospital onset of Covid are referred to the Health Board for further review. Reviews have been undertaken using the national audit tool to understand the route of transmission, and whether there were any modifiable risks, including a review of adherence to the range of infection prevention precautions (e.g. patient placement, hand hygiene and cleaning compliance).

Over the pandemic period, there have been improvements in patient management and treatments for Covid-19 disease, impacting on death rates. Likewise, the development of effective vaccines and their high uptake, would also lead to reductions in deaths. This is demonstrated in Graph 5 where ABUHB had the lowest death rate across Wales during wave 4.

Graph 5: Wales Mortality

	Wave 1		Wave 2		Wave 3		Wave 4		Total	
	Deaths n (%)	Cases n	Deaths n (%)	Cases n	Deaths n (%)	Cases n	Deaths n (%)	Cases n	Deaths n (%)	Cases n
Wales	**622 (34%)**	**1856**	**1428 (27%)**	**5236**	**245 (17%)**	**1476**	**113 (13%)**	**886**	**2408 (25%)**	**9,454**
Aneurin Bevan UHB	97 (40%)	244	255 (29%)	879	35 (18%)	192	6 (7%)	91	393 (28%)	1406
Betsi Cadwaladr UHB	199 (32%)	630	179 (25%)	705	41 (15%)	281	38 (14%)	264	457 (24%)	1880
Cardiff and Vale UHB	95 (31%)	303	210 (27%)	777	29 (18%)	166	12 (13%)	93	346 (26%)	1339
Cwm Taf Morgannwg UHB	115 (33%)	354	317 (28%)	1115	59 (18%)	327	16 (11%)	141	507 (26%)	1937
Hywel Dda UHB	25 (29%)	87	207 (39%)	694	50 (19%)	270	19 (13%)	148	301 (25%)	1199
Swansea Bay UHB	86 (40%)	214	243 (25%)	985	28 (16%)	180	21 (15%)	136	378 (25%)	1515

7.2.3 Covid Investigation Process

ABUHB has received £750K following the Minister for Health and Social Care, pledge that all incidents of hospital acquired nosocomial Covid-19 infections will be investigated within a 2-year timeframe. A national framework for Covid investigations is in place and lessons will be learned to reduce the chances of reoccurrence.

ABUHB are committed to investigating nosocomial Covid infections in line with the Putting Things Right Regulations.

A Nosocomial Covid-19 Patient Safety Incident Investigation Proportionality Decision Tool that considers the level of harm caused either directly or indirectly as a result of the nosocomial infection will be used to review all cases. The tool is in three stages:

Stage 1:	The identification of patients who meet the criteria of nosocomial Covid including those patients who have subsequently been discharged.
Stage 2:	The clinical assessment of each patient to determine the level of harm. Where moderate or severe harm is identified, the process will progress to stage 3 of the investigation tool kit and the patient, their family or representatives are contacted by the Health Board to advise them of the investigation and to allow them an opportunity to contribute to the investigation.
Stage 3:	The Health Board will undertake a proportionate investigation; it is recognised that this approach will vary according to each case investigated and therefore no standardised investigation tool is being mandated. As part of this process the investigation will consider the level of harm.

It is anticipated that the Health Board will require 15.2 WTE multidisciplinary staff to conduct approximately **2317** investigations from Waves 1-4 (and likely to climb in numbers as Omicron continues to impact).

ABUHB have commenced putting in place the necessary resource and infrastructure to deliver the programme of investigation work in relation to patient safety incidents of nosocomial Covid-19. Which includes;

- Establish relevant internal assurance mechanisms such as scrutiny panels.
- Proactively engage with patients and families who have been affected by incidents of nosocomial Covid-19, including advocacy through the Community Health Council.
- Put in place the necessary infrastructure to provide a dedicated point of contact for supporting families for five days a week.
- Develop robust governance structures.
- Engage with colleagues in the Delivery Unit who will have overall responsibility for national leadership and oversight in relation to implementation and application of the national framework.
- Work with the Delivery Unit to develop the national learning plan which will incorporate the lessons learned throughout the pandemic and identified through investigative process.

Recruitment is currently in progress. The Head of Covid Investigations, Covid-19 Clinical Investigators, Project Manager and Administration Support, have been recruited and commence from the 20th June 2022. The Covid Investigation Team will report progress to the QPSOC in January 2023.

7.3 Clostridium *Difficile*

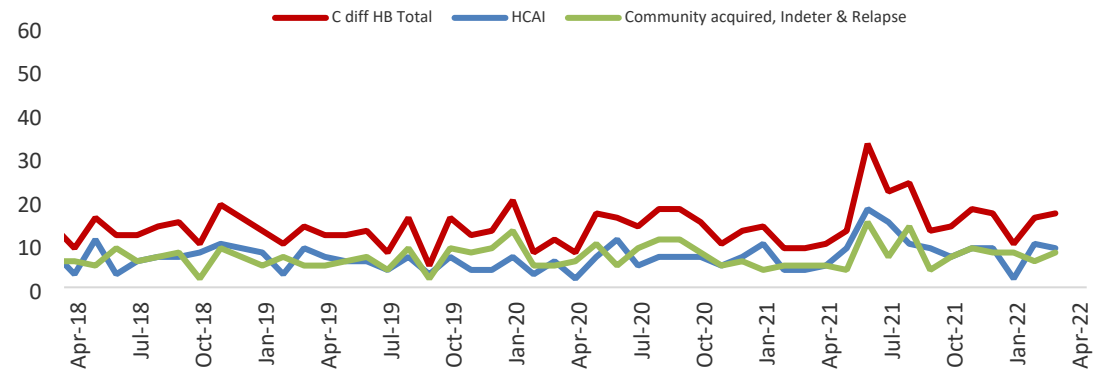
Clostridium difficile is a bacterium that can be found in the lower gastro intestinal tract. The severity of illness can vary from a simple bout of diarrhoea to a severe infection causing potentially life-threatening inflammation of the bowel.

The organism can live harmlessly in the gut of young children and around 3 in 100 of adults. In healthy people it generally causes no harm as its growth is controlled by a healthy gut flora. However, when the natural balance of the intestine is disrupted by antibiotics, other medications or illness, the bacteria can multiply and produce toxins causing acute infection.

C *difficile* can be minimised by good antibiotic stewardship and medicines management, particularly in those people who have specific risk factors (e.g. with previous history of *C. difficile* or chronic illness). The risks of transmission from one person to another in hospital and care settings can be reduced by adherence to infection control precautions such as prompt isolation of people with symptoms, hand hygiene and cleaning of the environment and equipment.

A total of 208 cases of C *difficile* have been reported from April 2021 - March 2022. This is a 40% increase in comparison to the equivalent period 2020/21. The provisional rate is 34.27 per 100,000 population, which has exceeded the Welsh Government Reduction Expectation. Following review, 134 were identified as hospital acquired with the remaining 78 identified as community acquired as illustrated below in the graph.

Graph 6(a): C. *difficile* Performance



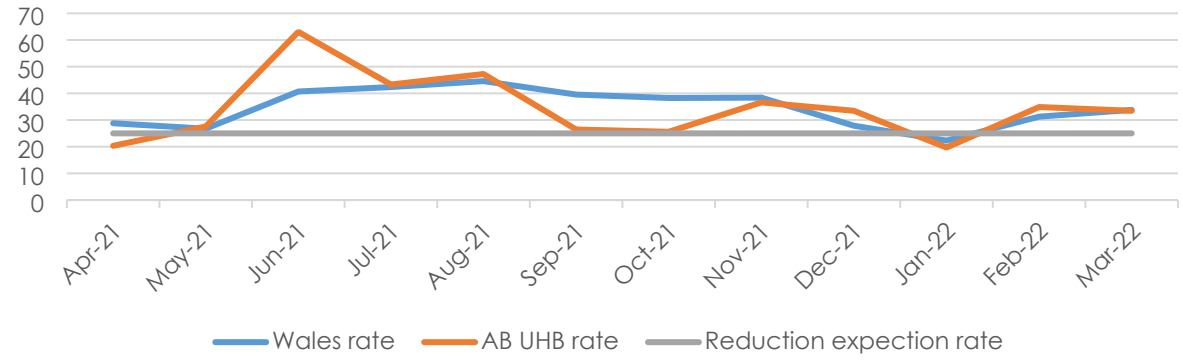
All Health Boards across Wales have seen an increase in C *difficile* infections, potentially associated with the Covid-19 pandemic. It is widely believed that an increased use of broad-spectrum antibiotics (which is known to increase the risk of C *difficile* infection) following secondary infection with Covid-19 is a significant factor.

During June and July, ABUHB witnessed a significant increase in the number of patients developing C *difficile*. Contributing factors to this increased incidence was antimicrobial stewardship, environmental cleanliness, and hand hygiene. Challenge and support meetings were established to improve performance and Divisional ownership in the prevention and management of C. *difficile* with an

overall aim to reduce the risk to patients and return to the decreasing trend seen prior to the pandemic.

The graph below displays ABUHB rate of C difficile infection compared to the all Wales rate. The grey line indicates the reduction expectation up to March 2022. ABUHB did not achieve the reduction expectation.

Graph 6(b): ABUHB rate of C difficile infection compared to the all Wales rate



Each *C. difficile* case is subject to a root cause analysis (RCA). Findings from these RCA's has identified that 28 patients received antimicrobials outside Health Board guidance. The reviews are fed back to the clinicians with the expectation to share learning with the clinical teams. ABUHB has commenced the rollout of the Antimicrobial Review Kit (ARK) project to support prudent antimicrobial stewardship, to help doctors, pharmacists and patients stop antibiotics in hospital when they are no longer needed.

Two key aspects of the care bundle to prevent C *difficile* within a hospital setting is hand hygiene and environmental cleaning. Wards are required to undertake regular hand hygiene and cleanliness audits as optimum compliance is key to minimise cross infection. Data is captured via the Health and Care Monitoring Tool.

There is an expectation for wards to undertaken monthly hand hygiene audits and achieve 95% compliance with the national indicator - 5 moments for hand hygiene namely:-

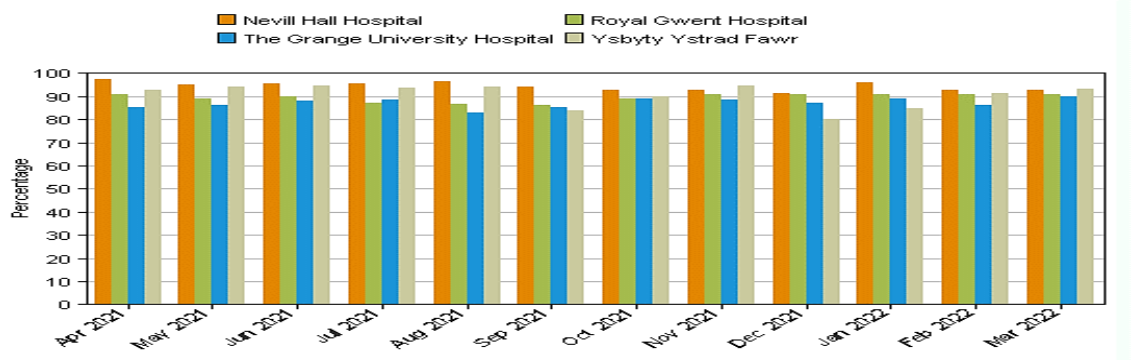
1. Before patient contact
2. Before a clean/aseptic procedure
3. After body fluid exposure
4. After patient contact
5. After contact with patient surroundings

Audit results are fedback locally in a timely manner and all disciplines of staff are encouraged to challenge poor compliance across the multidisciplinary team.

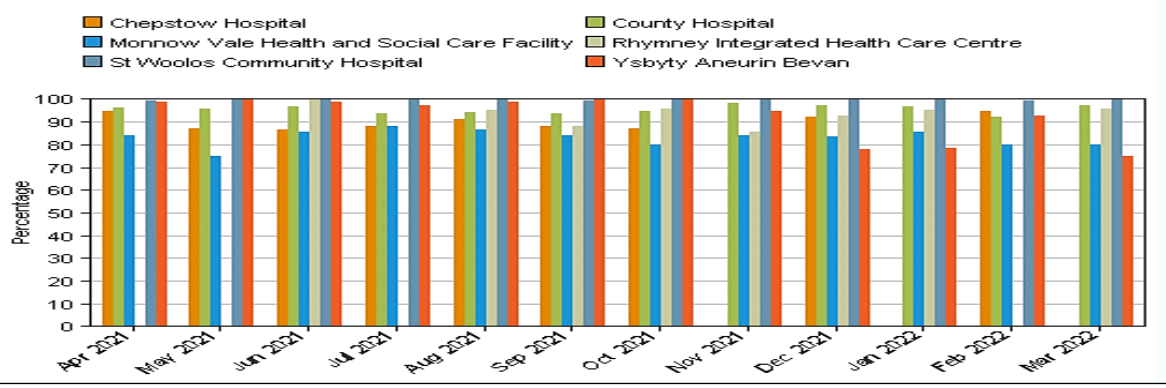
The IPT have supported wards and departments to improve compliance through the World Hand Hygiene Awareness campaign on 5th May 2022. IPT attended a number of wards with the hand decontamination unit to demonstrate effective hand washing technique.

The graphs below demonstrate monthly compliance ranges from 83% to 97% compliance for Nevill Hall, Royal Gwent, The Grange and Ysbyty Ystrad Fawr Hospitals while community hospitals range from 75% to 100%.

Graph 6(c): Hand Hygiene Compliance – Acute Services



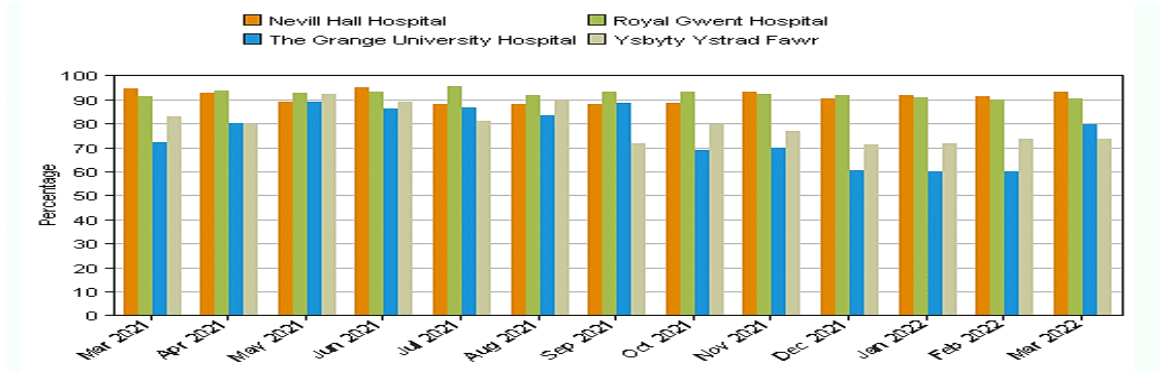
Graph 6(d): Monthly Hand Hygiene compliance – Community & MH&LD



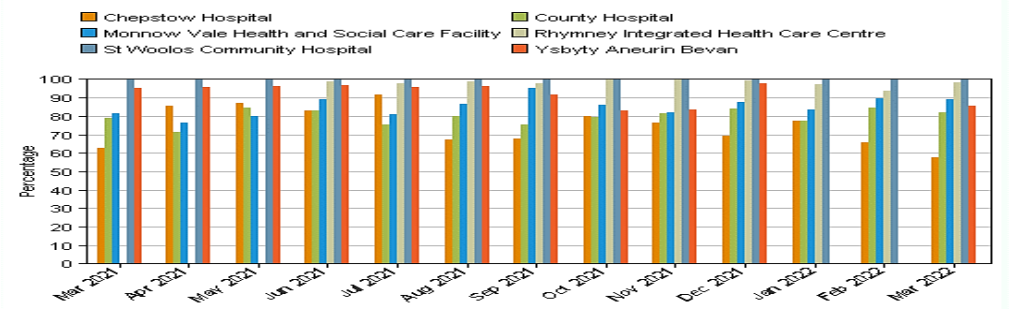
Cleaning schedules have been established in ABUHB for a number of years to support nurses with daily and weekly cleaning responsibilities. Again, there is an expectation for wards to achieve 95% or above compliance with completion of cleaning schedules.

The graphs below display compliance ranging from 65% to 100% across the Health Board.

Graph 6(e): Environmental Cleanliness Compliance – Acute Services



Graph 6(f): Environmental Cleanliness Compliance – Community & MH&LD



Validation and Environmental audits are undertaken by IPT and Facilities. Physically, most ward environments are clean, tidy and free from clutter. However, when documentation was reviewed during the validation audit, it was apparent that cleaning schedules are not being signed. An action for 2022/23 is to explore an electronic system for completion and signing.

ABUHB undertook an annual deep cleaning programme utilising Hydrogen Peroxide Vapour (HPV) Technology. HPV is an oxidising agent. When it comes in to contact with microorganisms, it oxidises the cells or spores, thus deactivating them. HPV is delivered as a vapour at high speed, ensuring distribution to all parts of a room.

ABUHB use HPV machines as part of proactive cleaning on discharge of a patient with certain known infections i.e. C *difficile* and also have a rolling programme of HPV cleans to support the reduction of HAI's.

Despite the pressures caused by the pandemic, the HPV programme was successfully completed, except for County Hospital. The process was slow to progress in some hospitals as they were unable to secure empty beds to decant patients to facilitate the HPV clean. It is important to have vacated areas for patients to move into away from the cleaning activity as this reduces the risk to patients from moving equipment which can disturb dust containing harmful bacteria. In addition, it provides an opportunity to declutter and improve the environment as required (e.g. repair and re-paint etc.). A reduced workforce due to staffing challenges has also hampered the programme.

7.3.1 Clostridium *difficile Outbreaks*

During the reporting period, 16 wards have been affected by periods of increase incidence where two or more patients had been identified as C. *difficile* positive. Laboratory genotyping indicates that cross infection is likely to have occurred on 6 of the wards affected. There is no scientific evidence in the other 10 areas re: patient to patient or staff to patient cross infection. Contributing factors to the outbreaks were environmental cleanliness, contaminated mattresses, hand hygiene and antimicrobial stewardship. In response, a rapid C *difficile* implementation plan was developed, which is monitored via RNTG.

7.3.2 Staph aureus bacteraemia

Staphylococcus aureus bacteria (SA) lives on (or colonises) the skin and in the nose of many people; it can also colonise chronic wounds. Most of the time it does not cause any harm but can cause infection if it multiplies or enters the body (e.g.

via an invasive device or wound). Staph infections can be either methicillin-resistant Staph aureus (MRSA) or methicillin-susceptible Staph aureus (MSSA).

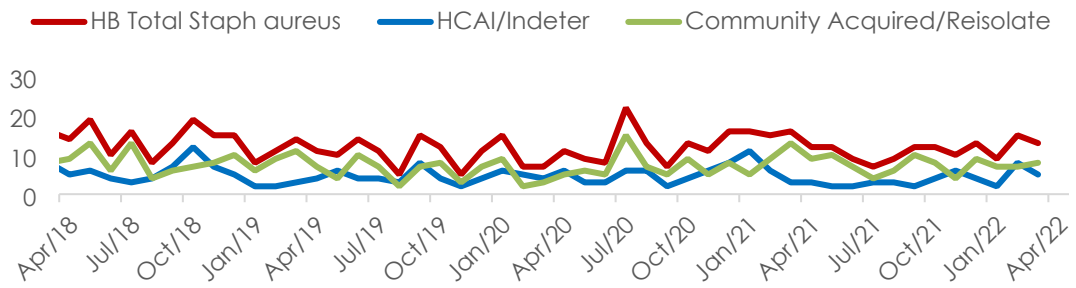
Both types of SA can go on to cause severe infection (e.g. sepsis, endocarditis) particularly in susceptible people vulnerable to infection (e.g. older people, those with acute illness or chronic conditions).

MSSA infections are more easily treatable with antibiotics. However, MRSA infections are resistant to many standard antimicrobials.

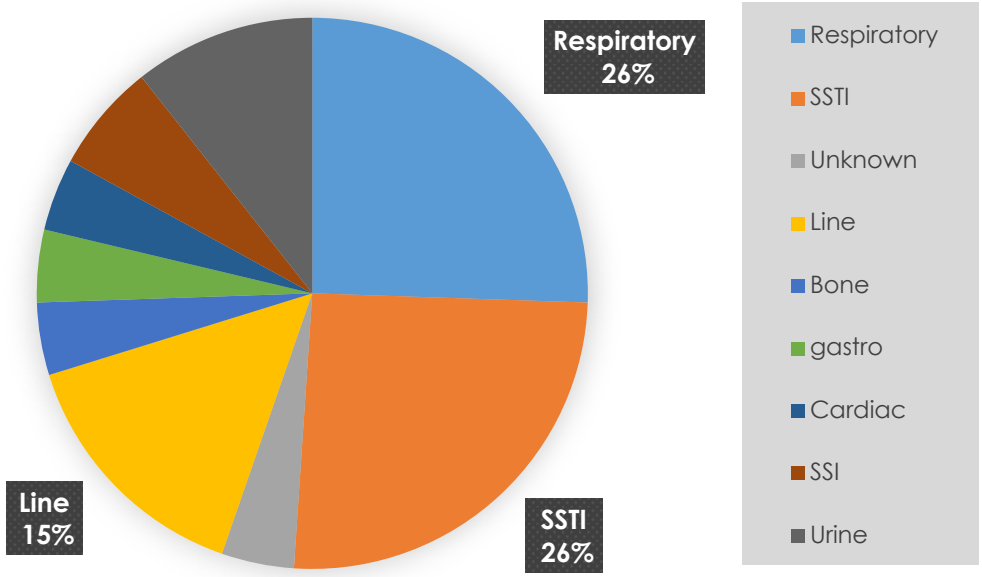
A total of 134 cases of Staph aureus bacteraemia reported from April 2021 – March 2022, of which 5 patients were identified with MRSA and 129 with MSSA. This is a 15% reduction compared to the equivalent period in 2020/21. The provisional rate is 22.40 per 100,000 population. ABUHB has the lowest reported rate in Wales.

A total of 86 cases were attributed to community acquisition with the remaining 48 identified within the hospital setting as indicated below.

Graph 7(a): Staph Aureus bacteraemia – HB performance

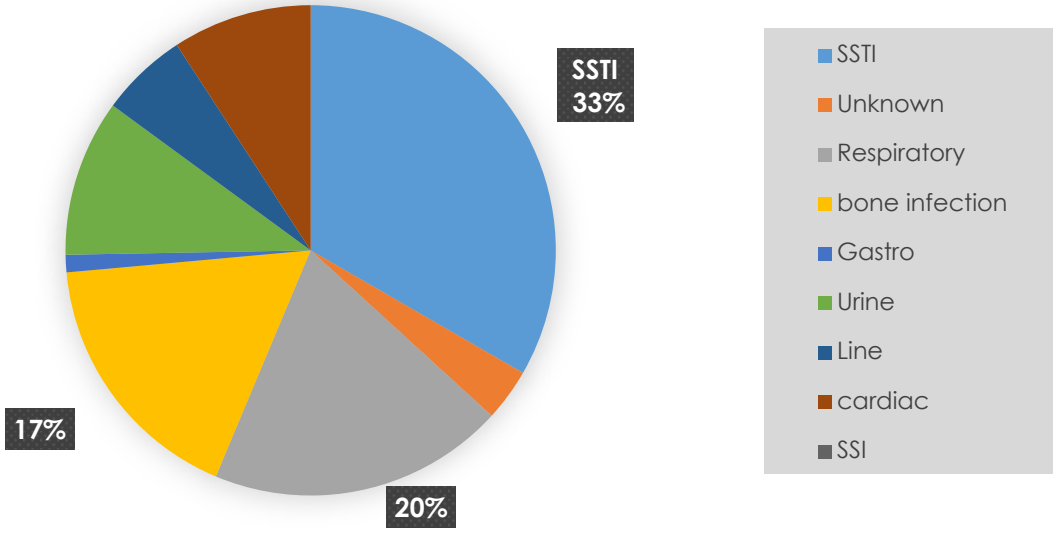


Graph 7(b): Source of infection themes – hospital acquired Staph Aureus



SSTI = skin & soft tissue infection SSI = surgical site infection

Graph 7(c): Source of infection themes – community acquired Staph Aureus



7 cases have been associated with line infection within secondary care which is an improvement on the previous year. The IPT continue to work in collaboration with venous access team and Divisional education leads in the promotion of aseptic non touch technique (ANTT).

Respiratory infections continue to have an ongoing impact on patients, and this is a continued theme throughout the Covid-19 pandemic. ABUHB piloted a care bundle targeting the prevention of hospital acquired pneumonias within County Hospital. This work will be explored further during 2022 appreciating the pilot was small. The aim of the bundle is to reduce the risk of pneumonia by promoting: -

- Oral hygiene
- Speech and Language Therapy assessment
- Physiotherapy assessment to encourage mobility post mealtimes
- Ensuring patients are sat upright to consume their meals

A high number of patients continue to be identified on admission to secondary care with wounds and skin infections being the source of infection, 29 in total.

The Community IP team are engaged in efforts to understand the root causes of community acquired SA bloodstream infections.

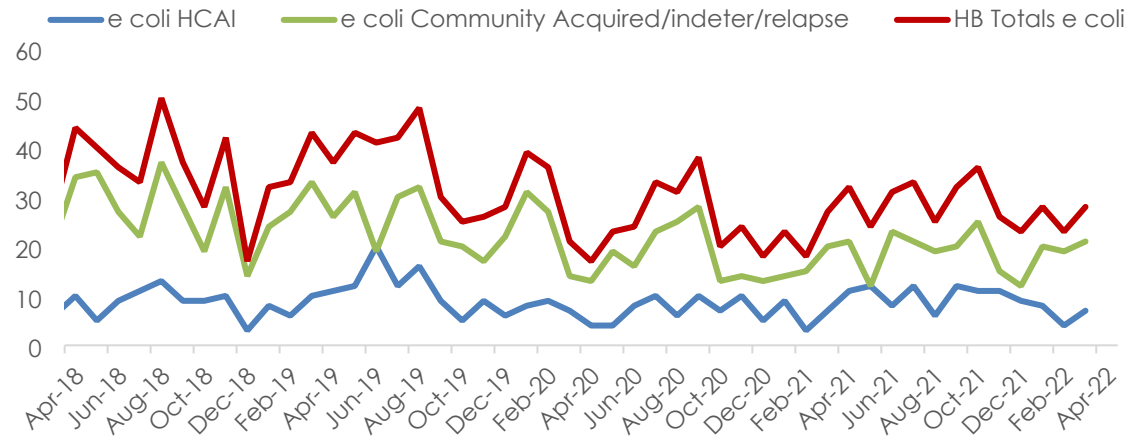
7.4 Gram Negative Bacteraemia

Gram-negative infections include those caused by *Klebsiella sp., Pseudomonas aeruginosa,* and *E. coli*. These are organisms which live harmlessly in the gut but if they grow and multiply in other parts of the body, they can cause a range of infections with varying severity and significant associated mortality.

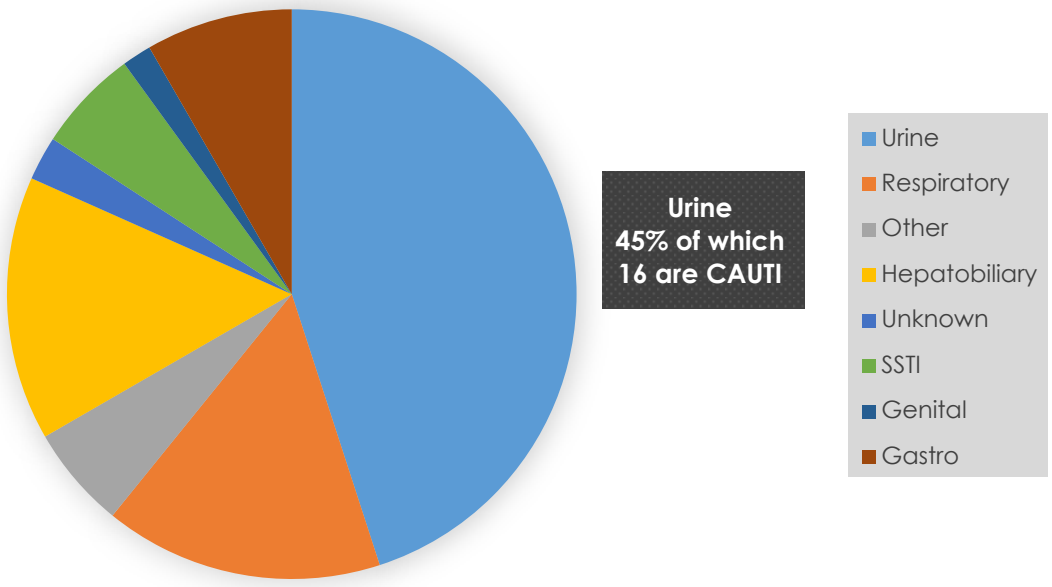
Gram-negative bacteria (GNB) are the leading cause of healthcare associated bloodstream infections. It is known that GNB are becoming increasingly resistant to antibiotics and therefore more difficult to treat. Lowering the burden of infection is key to reducing the development of antimicrobial resistance.

A total of 349 cases of E coli were reported from April 2021 to March 2022. This is a 17% increase compared to the equivalent period 2020/21. The provisional rate is 57.51 per 100,000 population, this is below the Welsh Government reduction expectation and ABUHB has the lowest rate in Wales. A total of 229 patients were identified on admission to secondary care with 120 identified as hospital acquired, as indicated below.

Graph 8(a): E coli bacteraemia HB performance

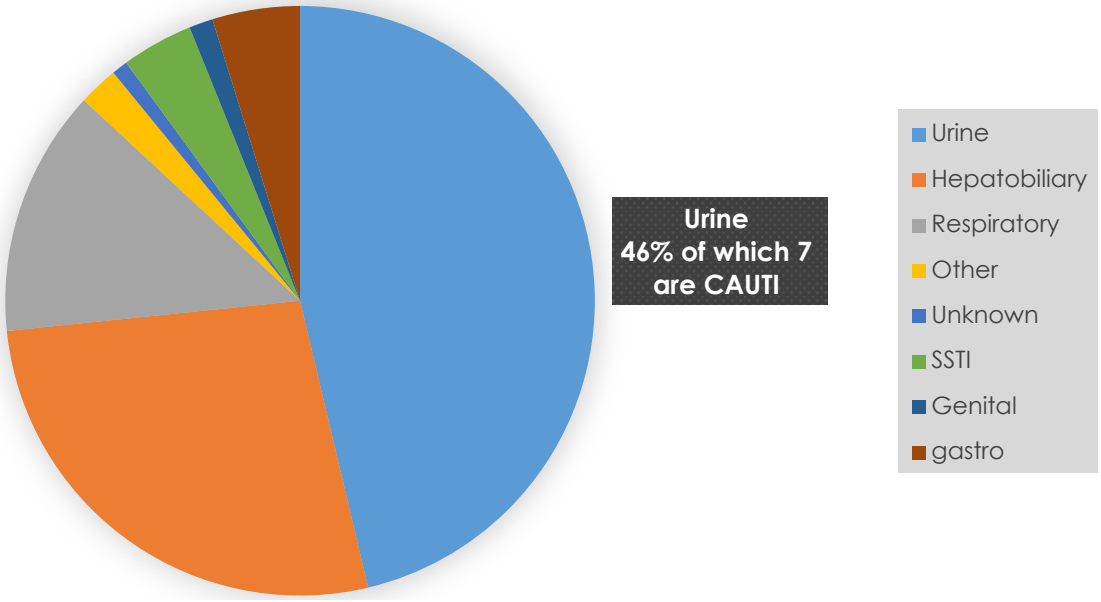


Graph 8(b): Source of infection themes – hospital acquired E coli bacteraemia



CAUTI = catheter associated urinary tract infection

Graph 8(c): Source of infection themes – community acquired E coli bacteraemia



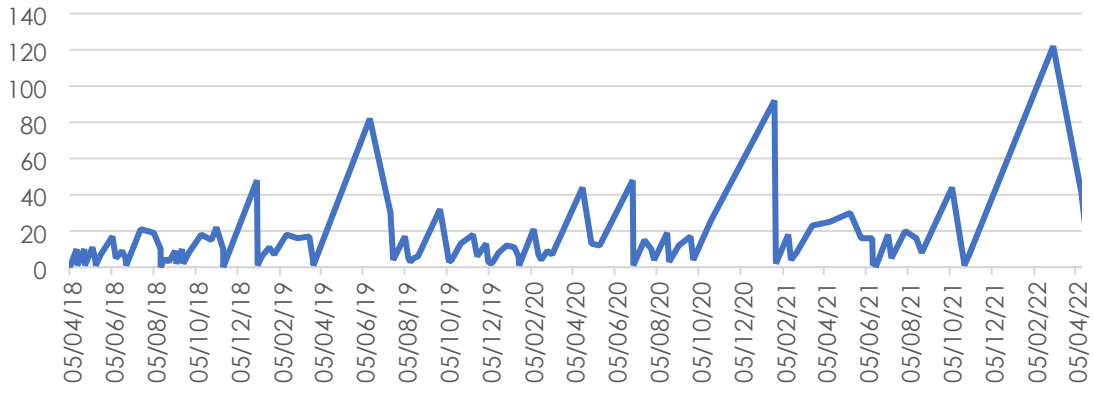
A considerable proportion of cases (61% of the 484 total cases) of Gram-Negative Blood Stream Infection (GNBSI) are community acquired.

IPT continue to review gram negative bacteraemia cases where urinary catheter implications are linked to the source of infection. The largest burden of infection is linked to urine as the source of infection. A total of 160 patients have been identified, of which 23 had long term catheters in-situ.

In 2018 The Bladder and Bowel Service working with District Nursing teams began implementing the community "trial without catheter" (TWOC) initiative.

The IPT has promoted and supported this programme and collects data on the 'days between' catheter associated UTI associated Blood Stream Infection (BSI). It is noted that intervals between such cases are increasing meaning that fewer serious bloodstream infections are resulting from urinary catheters.

Graph 8(d): Community acquired CAUTI associated GNBSI days since last case



A priority for 2022 is the introduction of HOUDINI into the hospitals across the Health Board with the aim to ensure catheters are only in place as long as they need to be, and are removed as soon as they are no longer indicated.

The IPT are currently working with the Bladder and Bowel service and the Primary and Community Care Division to pilot the project on 2 community hospital wards with an ambition to significantly scale-up the project once the pilot is completed.

The following principles apply:-

H	**H**aematuria (clots and heavy)
O	**O**bstruction/Retention (catheterised by Urologist)
U	**U**rological/Major Pelvic/Prolonged Surgery
D	**D**ecubitus/Pressure Ulcer (to aid healing of sacral/perineal wound in incontinent patient – consider alternatives to catheterisation
I	**I**nput/Output (critical for patient management)(haemodynamic instability/acute kidney injury
N	**N**ursing End of Life
I	**I**mmobilisation/Neurogenic bladder (e.g. actual or suspected unstable fracture, multiple traumatic injuries, IABP). Be aware: risk of life threatening Autonomic Dysreflexia if patients with spinal injuries go into retention – seek expert advice).

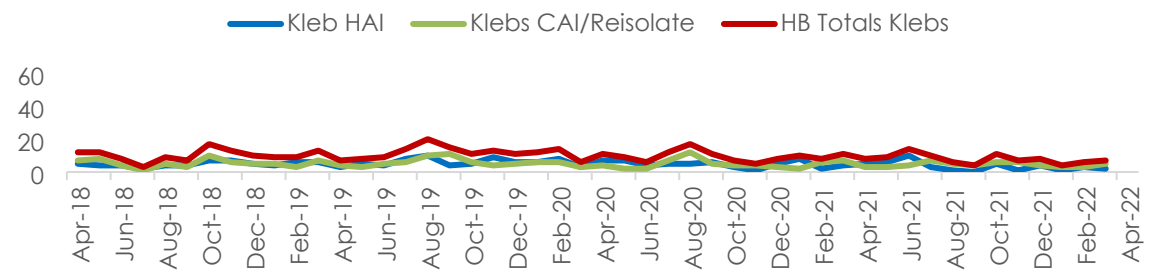
In May 2022, the South-West Newport District Nursing Team were awarded the Chief Nursing Officer Betsi Cadwaladr Foundation Scholarship Award for their Trial without catheter (TWOC) intervention. A new TWOC protocol was developed to guide and support community nurses to undertake trial without catheter safely in patient's homes. The protocol clarified the inclusion and exclusion criteria for those eligible for a TWOC at home in order to prevent all of the TWOC appointments taking place in hospital. The Bladder & Bowel service have since trained District Nurses from four other localities to carry out the TWOC's in the community.

A considerable proportion of gram negative blood stream infections are due to respiratory and hepatobiliary infections. It is thought that this is due to secondary respiratory infections following Covid, and possibly due other pandemic related factors related to people with hepatobiliary risk factors.

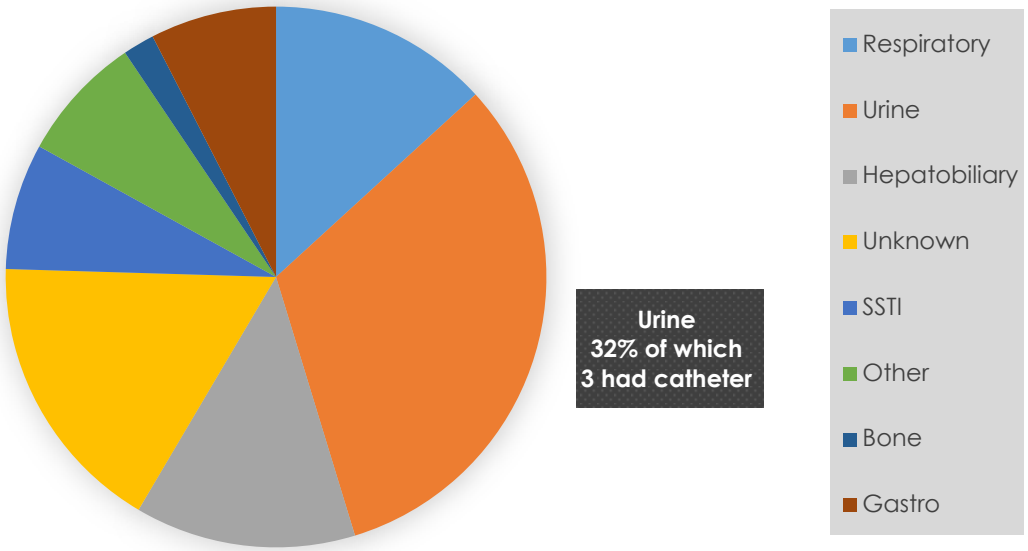
7.5 Klebsiella bacteraemia

A total of 96 cases of Klebsiella reported from April 2021 to March 2022. This is -20% fewer than the equivalent period 2020/21. The provisional rate is 15.55 per 100,000 population and the HB has the lowest rate in Wales. A total of 51 cases were identified on admission and classified as community acquired infection and 45 cases attributed to the hospitals.

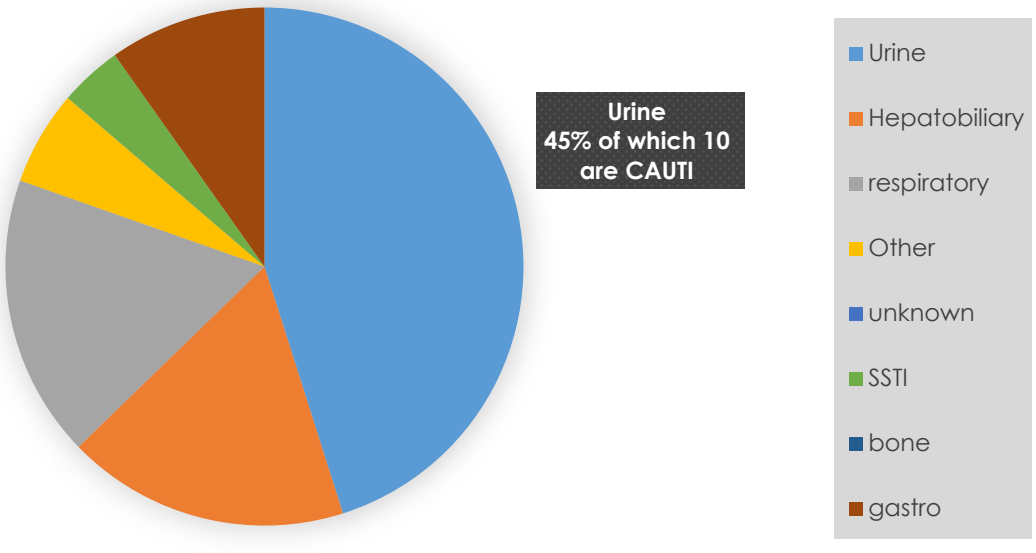
Graph 9(a): Klebsiella bacteraemia – HB performance



Graph 9(b): Source of infection themes – hospital acquired Klebsiella bacteraemia



Graph 9(c): Source of infection themes – community acquired Klebsiella bacteraemia

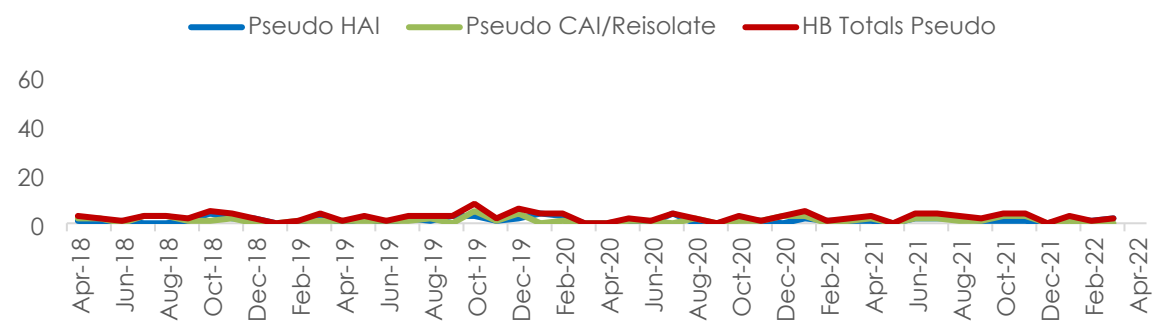


There has been one cluster of cases linked to critical care area where the likely root cause was the doubling up of patients in single rooms transmitted through the patient equipment, staff hands or environmental cleaning.

7.6 Pseudomonas bacteraemia

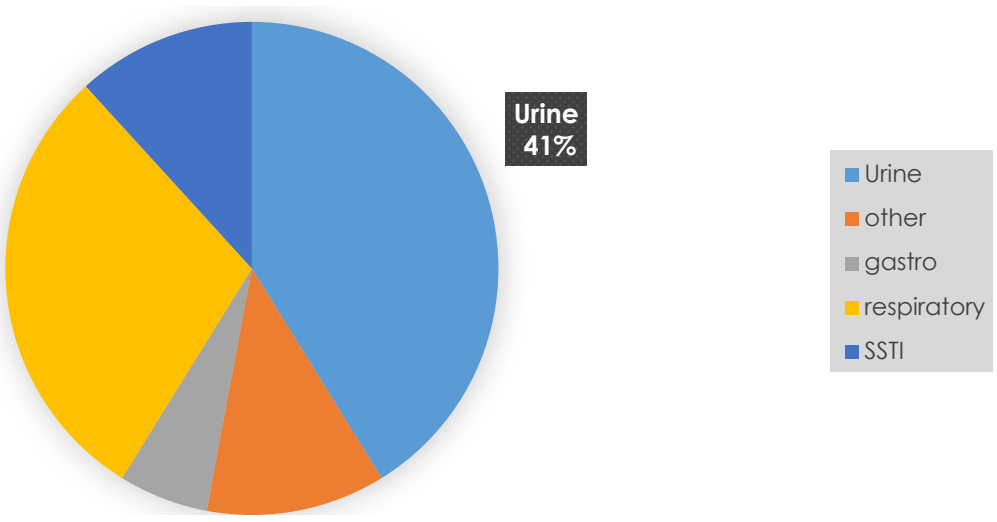
A total of 36 cases of Pseudomonas were reported from April 2021 to March 2022. This is 29% more than the equivalent period 2020/21. The provisional rate is 5.18 per 100,000 population. ABUHB has the lowest rate in Wales. There were 19 cases attributed to the community setting and 17 to hospital acquired.

Graph 10(a): Pseudomonas bacteraemia – HB performance

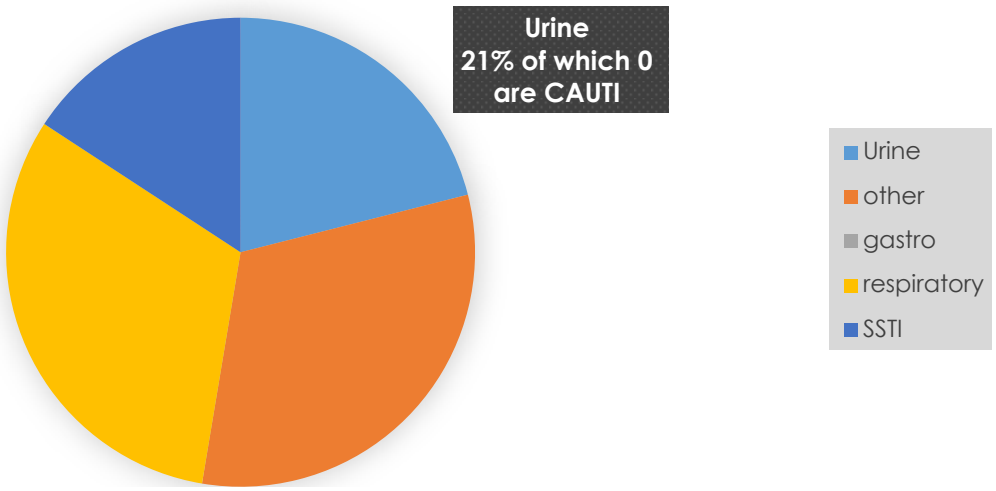


Overall numbers remain small. There have been no clusters and the analysis for the sudden increase is that the same patients are having long hospital stays and recurring infections.

Graph 10(b): Source of infection themes – hospital acquired Pseudomonas bacteraemia



Graph 10(c): Source of infection themes – community acquired Pseudomonas bacteraemia



7.7 Mortality

In collaboration with a Consultant Physician, the Lead Nurse for Infection Control undertakes a mortality review for hospital acquired infections of patients who have died within 28 days where a positive *C. difficile, Staph. aureus* or Gram negative blood stream infection has been identified on the death certificate. Key themes following reviews include:-

- The use of broad-spectrum use of antimicrobials
- Limited fluid balance recording for input and output management
- Delay in septic screening and the collection of blood cultures
- Delay in requesting additional samples to conclude the source of the infection which would support prudent antimicrobial prescribing

Following each review, the Consultant and Senior Nurse is provided with an analysis of the findings and an update is also provided to ABUHB mortality review group for learning. An initiative implemented over the past year was the development of a risk assessment tool for consultants to aid the assessment of hospital acquired infection mortality.

The table below displays the number of deaths were *C. difficile, Staph. aureus* or Gram negative blood stream infection has been identified or contributed to the cause of death.

Infection	No. deaths from April to March
C difficile	3 (1.44%)
Staph aureus	6 (4.47%)
GNBSI	8 (2.29%)

7.8 Norovirus

Norovirus is a self-limiting diarrhoea and vomiting bug that normally lasts 48 – 72 hours and is usually more prevalent in the winter months. It is often referred to as the "Winter Vomiting Bug." There have been no outbreaks in 2021/22. It is thought that that the wearing of face coverings, frequent cleaning and hand hygiene has significantly reduced the risk of the spread of the infection together with reduced social mixing.

7.9 Surgical site infections SSI

A surgical site infection (SSI) is an infection that occurs after surgery in the part of the body where the surgery took place. Surgical site infections are often superficial infections involving the skin or superficial tissue only, however they can cause deep infections leading to sepsis, increased pain, discomfort and general suffering to the patient.

There are two areas for mandatory reporting across Wales; Primary hip and Knee and Caesarean Section. The number of SSI's related to primary hip and knee procedures is usually received in the Health Board each April through the Public Health Wales Annual Report. Due to the pandemic and the cancellation of non-urgent surgery, a report will not be produced this year for orthopaedic procedures. The PHW Caesarean Section report from January 2021 to December 2021 has been issued where the overall average infection rate has returned to base line data of 2.9%. All infections were assessed as superficial with no deep or organ space reported.

7.10 Influenza

Influenza is a viral infection that attacks the respiratory system, nose, throat and lungs. Flu, like other infections, causes minor illness, but can be much more severe in vulnerable people, causing significant morbidity and mortality.

Activity of influenza in ABUHB during 2021-22 was low with lengthy periods of no new cases detected throughout the usual seasonal period when influenza normally circulates. This trend in low or no activity reflects all-Wales trends in influenza activity this seasonal year. There was slightly more influenza detected in 2021-22 than in 2020-21, however prior to this, the last typical season in ABUHB was during 2019-20. From early March, extra-seasonal increases in influenza activity have been identified.

7.11 Respiratory Syncytial Virus

Respiratory Syncytial Virus or more commonly known as RSV is a respiratory virus that usually causes mild, cold-like symptoms. Most people recover in a brief period; however, RSV can be serious, especially for infants under the age of 5 and older adults. RSV is the most common cause of bronchiolitis and pneumonia in children.

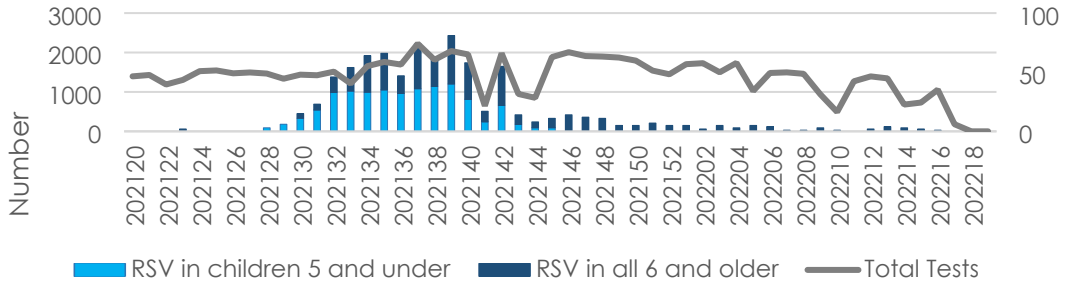
During last winter it was anticipated the NHS would be required to manage increased numbers of patients, in particular children, with RSV presenting to

hospital due to potential decrease in developed immunity. In response, ABUHB implemented a surge plan for the management of RSV. Impact was lower than anticipated.

RSV activity began to increase from week 28, peaked during week 38, and declined after week 42. There was an increased number of cases detected in ABUHB during the 2021-22 RSV season, compared to previous years. Most cases during seasonal activity were in children aged 5 and under. RSV in older adults continued to be detected for an extended period outside of usual seasonal RSV activity, but overall impact was limited.

Activity for RSV is shown in the following graph.

Graph 11: RSV activity



7.12 Carbapenems producing Enterobacterales (CPE)

Enterobacterales are a large family of bacteria that usually live harmlessly in the gut of humans and animals. They include species such as *Escherichia coli*, *Klebsiella* spp. and *Enterobacter* spp. However, these organisms are also some of the most common causes of infections, including urinary tract infections, intra-abdominal and bloodstream infections. Carbapenems are a valuable family of β-lactam (penicillin-like) antibiotics normally reserved to treat serious life-threatening multidrug-resistant Gram-negative infections in hospitals. They include Meropenem, Ertapenem, Imipenem and Doripenem.

Resistance to some or all carbapenems is a natural characteristic of some Gram-negative bacteria. Others can produce carbapenemases, which are enzymes that destroy carbapenem antibiotics, which means that these infections are resistant to standard antibiotic treatment.

The spread of carbapenemase-producing enterbacterales (CPE) will pose an increasing threat to public health and medical treatment pathways in the UK as these resistant bacteria can spread rapidly in healthcare settings. Throughout the twelve-month period, ABUHB has not identified any onward transmission of these bacteria and patients with a known history have been managed in-line with ABUHB policy and national guidelines.

8 Serious Incidents

This section looks at serious incidents that have involved infection prevention intervention (except for Covid-19 and C *difficile* outbreaks).

Incident/Concern	Actions and Learning
Increase of MDRO *Klebsiella* in Critical Care	
A number of cases of multi drug resistant organism (MDRO) *Klebsiella* isolated from samples collected in a short space of time from patients on the ITU (Intensive Treatment Unit). Infection was attributed as 'healthcare associated'	▪ 'Doubling-up' of patients and reduced physical environment ▪ Fundamental cleaning and hand hygiene not robust ▪ Reviewed cleaning process within the department
Increase Staph capitis Neonatal Unit	
10 babies identified in a six-month period	▪ Ensure single use ultrasound gel ▪ Enhanced cleaning of incubators implemented ▪ If failed cannulation to escalate to a senior member of the team ▪ Observation nurse re-established for high-risk procedures on the unit
Patient exposure to Tuberculosis	
TB exposure	▪ Patients contact traced according to National policy

8.1 Water Safety

ABUHB has continued to undertake a six-monthly augmented care water testing regimen which identified *Pseudomonas* and *Legionella* in the Family and Therapies Division clinical areas. In response point-of-use water filters have been placed onto the clinical sinks, systems flushed, reviewed cleaning processes and notification process for when wards/department become vacant. Retesting samples have returned negative. There have been no incidents or transmission of infection to patients or staff and continue to monitor closely.

8.2 Antimicrobial Stewardship

A recent paper in the Lancet stated that in 2019 4.95 million deaths were associated with antimicrobial resistance worldwide, of which 1.27 million were as a direct result of resistant bacteria. This demonstrates that antimicrobial (antibiotic) resistance is already a leading cause of death across the world, causing the deaths of more people than other common infections. Ensuring appropriate use of antibiotics is therefore key to the prevention of many deaths due to untreatable / resistant infections. This is to ensure the effectiveness of antibiotics is preserved.

The ABUHB 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 develop & review local treatment guidelines.

Key achievements for this reporting period include:

- Roll out of the Antibiotic Review Kit (ARK) to Ysbyty Ystrad Fawr and Nevill Hall Hospital. ARK is a toolkit, including an online training tool, decision aid and audit programme, designed to safely stop antibiotics in patients who no longer need them, and change prescriber behaviours. Further roll out to the Grange University Hospital and Royal Gwent Hospital is planned.

- Transfer of all antimicrobial guidance onto a new digital platform.

- A new method of dosing and monitoring one of the high risk antibiotics, to improve patient safety.

- Three members of the team writing national antimicrobial guidelines to standardise practice across Wales

The Consultant Pharmacist for Antimicrobials, who is currently chairing the Welsh Antimicrobial Pharmacists Group, has also visited Malawi, along with two other pharmacists from Wales, as part of a Commonwealth Partnerships for Antimicrobial Stewardship project. The project aims to share expertise with the Pharmaceutical Society of Malawi, and support development of antimicrobial stewardship in two of the largest hospitals in the country using prescribing surveys, training sessions and developing a practical toolkit to guide healthcare professionals.

8.2.1 Antimicrobial Prescribing Performance

Welsh Government improvement goals for antibiotic usage resumed from October 2021:

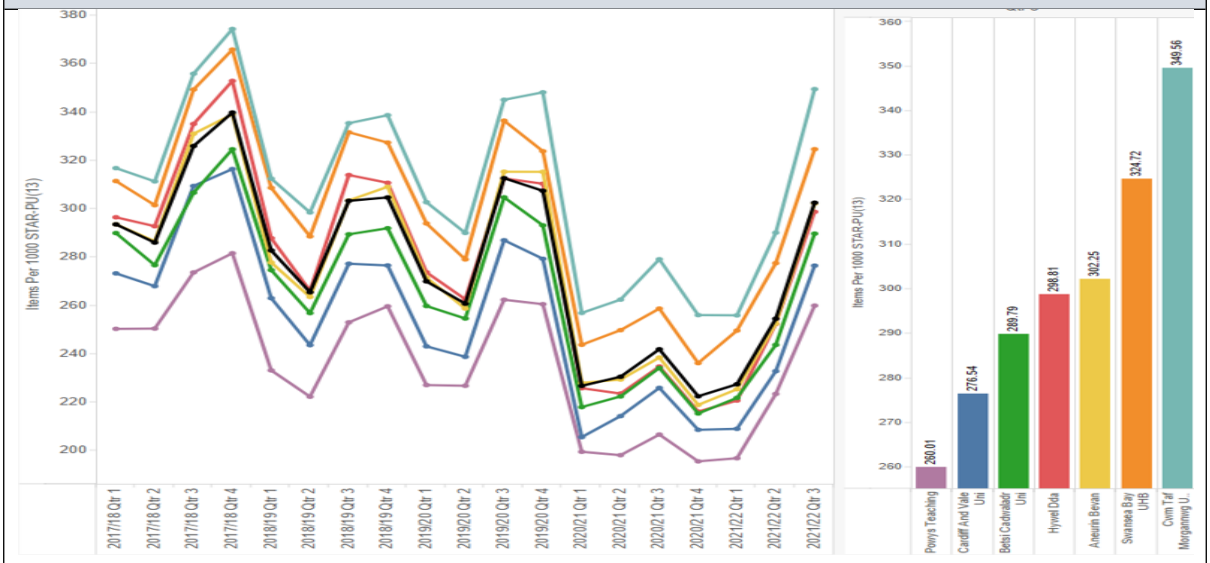
- A minimum 25% reduction in antimicrobial usage in the community from the 2013/14 baseline.

- In secondary care, increase to or maintain the proportion of antibiotic usage within the WHO 'Access' category to ≥55% of total antibiotic consumption

8.2.2 Primary Care Prescribing

Data are only available to the end of Q3, however the following graph demonstrates the significant increase in antibiotic volume in Q3. It is thought that during the pandemic the reduced attendance at GP surgeries resulted in the drop in prescribing, however once more 'normal' behaviours resumed during the latter half of 2021 prescribing reverted back to pre-pandemic levels. On the graph below, ABUHB is the yellow line, tracking the all-Wales average black line:

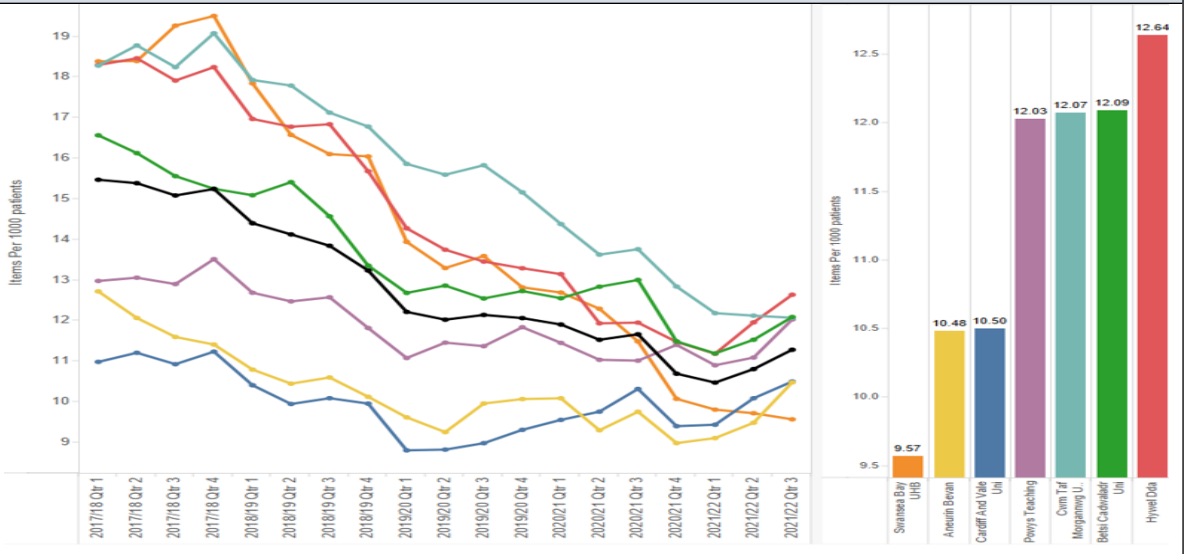
Graph 12(a): Antibiotic volume



The term '4C antimicrobials' refers collectively to four broad-spectrum antibiotics (co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin). Avoidance of these broad-spectrum antibiotics helps minimise development of resistance and reduces the risk of *C. difficile*, MRSA and resistant urinary tract infections.

The following graph demonstrates ABUHB are amongst the lowest prescribers of 4C agents in Wales, however the increasing trend requires ongoing scrutiny:

Graph 12(b): Number of 4C antimicrobials per 1,000 patients



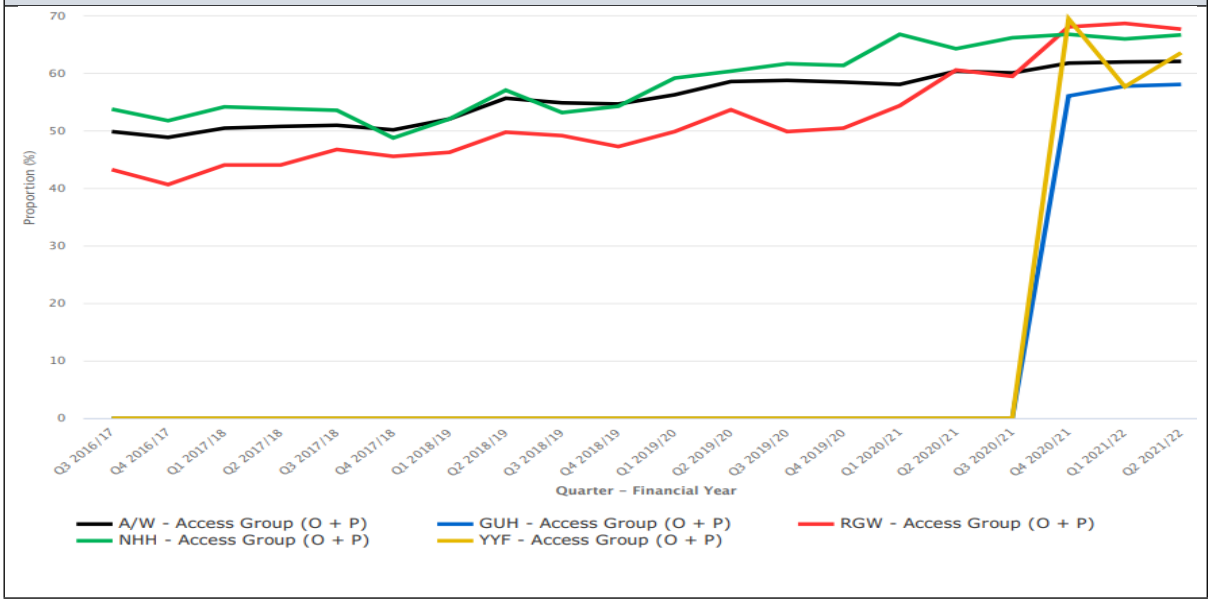
8.2.3 Secondary Care Prescribing

Data for secondary care have now been expanded to cover GUH & YYF, providing a more comprehensive view of prescribing, however data are only available to the end of Q2.

Antibiotics within the WHO 'Access' category are narrow spectrum antibiotics that carry a lower risk of resistance and other adverse effects. The aim is therefore to use as great a proportion of these agents as possible.

Graph 12.3 demonstrates and increase in the proportion of 'Access' use, to the extent all ABUHB sites were above the 55% target.

Figure 12(c): Access group usage as a proportion of total antimicrobial use



9 Standard 5: Governance

The Reducing Nosocomial Transmission Group (RNTG) is chaired by the Associate Medical Director. The purpose of the Group is to oversee the reduction in health care acquired spread of infection. The group actively monitor compliance with the Covid Implementation Plan, and other healthcare associated infections, directing action where necessary and escalating matters to the Executive Team as and when appropriate. The group initially focussed on Covid-19, but the Terms of Reference have been reviewed with inclusion of the wider IPC, antibiotics and decontamination agendas.

The group focuses on the provision of safe services, to include resumption of services, and advises on the implementation of Welsh Government Guidance. Feedback is received from the national Nosocomial Transmission Group, National Infection Prevention & Control and Decontamination meeting updating on guidance including cleaning standards, antimicrobial stewardship, Welsh Government five-year plan, segregation of Covid and non-Covid streams, admission pathways, and patient and staff testing with the overall aim of patient and staff safety.

RNTG horizon scan, review evidence and provide advice, guidance and direction to:

- Minimise transmission of SARS-CoV-2 in hospital and primary care
- Monitor compliance with Welsh Government Reduction expectation for healthcare associated infection and antimicrobial stewardship by providing strategic accurate real time surveillance
- Minimise transmission for all healthcare associated infection across the HB
- Enhance patient and staff experience
- Promote safe environments of care
- Review and endorse policies

RNTG provides each division an opportunity to report exceptions with the fundamental aspects of IPC namely:-

- Hand Hygiene
- Cleaning Schedules
- Antimicrobial audit results
- PSAG boards to monitor antibiotic use
- Infection Prevention training
- HPV programme
- Surgical Site Infections

9.1 Healthcare Inspectorate Wales Audit

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the Emergency Department (ED) and Surgical Assessment Unit at The Grange University Hospital (the hospital) within the Health Board on the 1 – 3 November 2021. There were three recommendations from an infection prevention perspective: -

1. Installation of a clinical hand washing sink within the "red" corridor
2. Additional photocopier within the children's assessment area
3. Minimise staff crossing patient's pathways

The first two recommendations were implemented with immediate effect and the last is not always achievable due to safe staffing. However, the risk is reduced by implementing robust transmission precautions when deficits does not allow for separate staff.

10 Standard 6: Adequate isolation facilities

ABUHB is extremely fortunate to have a high number of isolation facilities available for the safe management of patients. It is recognised within the Royal Gwent, Nevill Hall and Community Hospitals, except for Ysbyty Aneurin Bevan, cubicles are limited. To support the risk assessment, the IPT have been liaising with ward managers for the daily assessment and safe placement of patients.

Additional work is underway to review and improve the ventilation systems within these areas as the Health Board is aware they do not meet the standard of six air changes per hour which reduces the risk of onward transmission of respiratory infections.

11 Standard 7: Policies

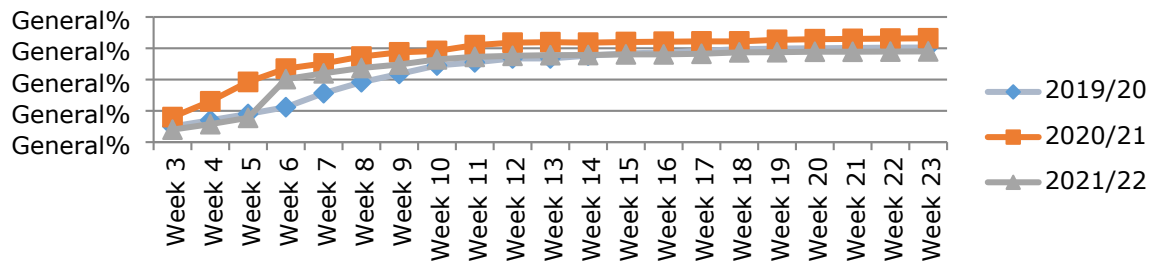
Infection prevention policies are in line with national guidelines. A library of policies is available on the intranet. The team has developed a new policy over this reporting period for the management of Carbapenems Producing Organisms (CPE). This is for the operational management and safe patient placement. The influenza policy has been refreshed in line with change in national guidance for the management of respiratory pathways.

Policies are reviewed every 3 years or updated routinely if new guidance emerges. Reviewed and new policies are approved via RNTG. All policies are currently in date.

12 Standard 8: Occupational Health/Vaccination

IPT continue to work in collaboration with Occupational Health in promoting safe health for employees. Part of this collaboration is to promote staff vaccination in particular influenza. The IPT have actively supported the development of staff risk assessment. The following graph shows a year on year comparison of ABUHB staff flu vaccination uptake.

Graph 13: Staff flu vaccination update



Where respiratory protective equipment (RPE) is used, it must be able to provide adequate protection for individual wearers. RPE cannot protect the wearer if it leaks. Health and Safety have completed a total of 2321 fit tests between April 2021 and March 2022.

There have been some challenges to fit testing:-

- Staff not being released to attend booked Fit Test appointments due to clinical demands on wards.

- Changes to kit requiring further fit testing.

To aid staffing constraints and the ongoing changes in procurement a "Fit Test Train the Trainer" course has been implemented. Compliance will be monitored closely and reported via RNTG and the Health & Safety Committee.

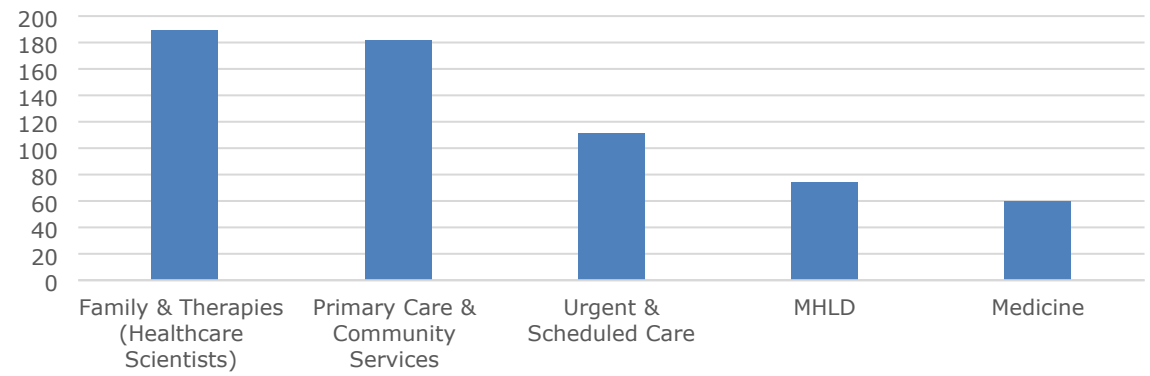
13 Standard 9: Trained and educated in IPC

During 2021 an all-Wales infection prevention and control training, learning and development framework was developed to set a standard used in Wales to inform practice within health and social care. Good compliance with infection control practice is essential for maintaining a safe environment for everyone and reducing the risk of spread of infectious disease.

IPT has reviewed the new framework and incorporated the new elements within the ABUHB Infection Prevention Education Training strategy. Limited face to face sessions has been provided over the twelve-months due to the ongoing Covid-19 constraints therefore the team has continued to promote donning and doffing of personal protective equipment (PPE), promoting e-learning and virtual education sessions via Microsoft Teams.

The data below indicates the Infection Prevention training activity over the past 12 months via Divisions:-

Graph 14: Numbers of staff attended virtual/classroom training



14 Conclusion

Eliminating avoidable healthcare associated infection remains a top priority for NHS Wales and ABUHB. It has been an extremely difficult year for the IPC team with most of the work focused on responding to the Covid pandemic, with IPC playing a central and fundamental role. The Divisions alongside other teams, in particular Health and Safety, Site Operational and Facilities, have supported the team in delivering the IPC agenda.

The achievement of most of the Welsh Government reduction targets during 2021/'22 has been positive, not least against the backdrop of Covid-19 and the pressure this presented across ABUHB.

As the organisation transitions into "business as usual", it is important to refocus on the fundamental principles of IPC, strengthening cleaning and the HPV programme and re-embedding the IPC agenda as being owned by everyone.

15 Work Programme 2022/'23

A work programme has been developed for focus during 2022/23 as follows: -

Priority 1:	Systems to manage and monitor the prevention and control of surgical site infection (SSI). These systems use risk assessments, mapping the patients pathway within secondary and primary care maximising the use of ICNet.
Priority 2:	Provide and maintain a clean and appropriate environment in managed premises that facilitates robust compliance to the prevention and control of infections.
Priority 3:	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance, through the roll out of Antibiotic Review Kit (ARK) project.
Priority 4:	Provide suitable and accurate information on infections for service users.
Priority 5:	Ensure prompt identification of people who have or are at risk of developing an infection so they receive timely and appropriate treatment, to reduce the risk of transmitting infection to other people.
Priority 6:	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities through education and training.

Priority 7:	Ensure all IPC policies are up-to-date and evidence-based.
Priority 8:	Undertake outbreak reviews from Covid/C difficile and other pathogens ensuring learning is shared across the HB.
Priority 9:	Actively support the Covid-19 Investigation Team
Priority 10:	Support the business case for line care with an overall aim to reduce Staph aureus bacteraemia.
Priority 11:	Recruitment and stabilisation of the IPC team supporting Health Board agenda.
Priority 12:	Review evidence and research for electronic hand hygiene monitoring. Develop a cost analysis to implement to support the reduction of hospital acquired infections.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality, Safety and Outcomes Committee Tuesday, 16th August 2022 Agenda Item: 3.10

Aneurin Bevan University Health Board
Learning Disability Directorate Update Paper

Executive Summary

The Learning Disability Directorate have been asked to update the QPSOC across three key areas of work:

- Primary Care Liaison Service & Secondary Health Liaison Service.
- Progress on ABUHB response to the Improving Care, Improving Lives review of specialist learning disability in-patient provision.
- Monitoring the quality of commissioned packages of care in in-patient settings.

The Board 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 Chris O'Connor, Interim Executive Director of Primary Care, Community and Mental Health

Report Author: Lara Homan, Lead Nurse, Learning Disability Directorate
Dr Nicola Lewis, Clinical Director, Learning Disability Directorate
Chris Jones, Senior Practitioner, Mental Health & Learning Disabilities Commissioning

Report Received consideration and supported by: Michelle Forkings, Divisional Nurse for MH/LD

Executive Team		**Committee of the Board [Committee Name]**	**Patient Quality, Safety and Outcomes Committee X**

Date of the Report: 4 August 2022

Supplementary Papers Attached: Appendices 1 – 5.

Appendix 1 Appendix 2 Appendix 3 Appendix 4 Appendix 5

Purpose of the Report

The Learning Disability Directorate have been asked to update the QPSOC across three key areas of work:

- Progress on ABUHB response to the Improving Care, Improving Lives review of specialist learning disability in-patient provision.
- Primary Care Liaison Service & Secondary Health Liaison Service
- Monitoring the quality of commissioned packages of care in in-patient settings.

Background and Context

Welsh Government wrote to Health Boards on 30 June 2021 seeking support to prioritise the implementation of the recommendations of the National Collaborative Commissioning Unit (NCCU) review of learning disability inpatient care (Improving Care: Improving Lives 2020). Welsh Government will be working with stakeholders to support action planning at a national level and,

where appropriate, to take an All-Wales approach to resolving some of the issues identified in the report. The nominated ABUHB Executive lead for this work is Dr Chris O' Connor, Interim Executive Director of Primary Care, Community and Mental Health. The ABUHB Learning Disability Directorate lead is Dr Nicola Lewis, Clinical Director. The Local Authority lead is Jo Williams, Assistant Director for Caerphilly Borough Council.
The Welsh Government Improving Care, Improving Lives report (2020) identified that individuals with a learning disability experience 'worse health outcomes' than those of the general population and identified areas of physical health to focus their review on. The Learning Disability Directorate have responded to these concerns by establishing a Primary Care Liaison service and a Secondary Health Liaison Service for people with a learning disability.

Improving Care, Improving Lives focuses on supporting people with a learning disability to live as independently as possible but recognises the need for hospital admissions for some. When hospital admission is required, it is integral that people with a learning disability receive safe, effective and outcome focused care. To ensure this is occurring monitoring of commissioned in-patient packages is an essential role of the health board.

Assessment and Conclusion

(1) Progress on ABUHB response to the Improving Care, Improving Lives review of specialist learning disability in-patient provision.

Supported by the Gwent Regional Partnership Team, this work was initially led by the Mental Health and Learning Disability Delivery Group. This group consisted of partners from ABUHB, Local Authority, Regional Partnership team, third sector and experts by experience. A series of workshops were held to discuss the recommendations of the report, to explore regional pathways in and out of specialist care, identifying what is working well, where improvements are required and barriers that may require a national approach, and to develop local priorities from the recommendations. The Improving Care, Improving Lives report makes 70 recommendations to be considered by providers, commissioners, and Welsh Government. The Delivery Group recognised the importance of all the recommendations but agreed that a set of key priorities needed to be developed, as a first stage response, to ensure we could remain focussed. Five priority areas were developed covering a range of recommendations. Please see table of recommendations in Appendix 1.

The Mental Health and Learning Disability Delivery Group has recently been disbanded. As such, the Learning Disability Directorate are currently co-ordinating, with partners, the final draft of the action plan to take forward the priority areas. The action plan will be presented to the Mental Health and Learning Disability Strategic Partnership at the meeting planned for the 31/08/22.

A range of additional themes were highlighted through the workshop review of the Improving Care, Improving Lives report which include:

- Improving the transition from child to adult learning disability services including the role of education in understanding needs early within families and education to aid preventative work.

- Developing the community infrastructure to enable individuals to be supported closer to home and within community based provision. This includes:
    - developing the provider workforce to support people with complex behaviours of concern and risk
    - developing appropriate housing options for people with complex behaviours and risk
    - developing community alternatives to admission e.g. crisis support, wrap around services, and respite services.

In May 2022, Natasha Harris, Gwent Regional Partnership Team and Dr Nicola Lewis, Clinical Director, Learning Disability Directorate were invited to present the ABUHB work to date at the National Implementation and Assurance Group. The ABUHB work was received very positively. Most other health boards had not yet started this work. Alongside the priority areas for immediate action, the wider themes were discussed and it was agreed that the National Implementation and Assurance Group would facilitate a workshop event in November 2022. The themes formed the basis to this workshop to support the development of regional/all-Wales approaches to increasing the provision of community based integrated housing, Health, and Social Care models of support.

Finally, Improvement Cymru, the national quality improvement service for NHS Wales delivered by Public Health Wales, are working with organisations to reduce the use of specialist hospital care for people with behaviours of concern over a period of four years with prioritisation to be determined in partnership with organisations and Regional Partnership Boards. As part of this national work, we have recently contributed to an audit for our region of all individuals with a learning disability currently in an inpatient setting. ABUHB are currently reviewing the audit report produced by Welsh Government.

(2) Learning Disability Primary Care and Secondary Health Liaison Services

It is widely recognised that people with a learning disability experience many barriers when accessing healthcare. This has been further compounded by the Covid-19 pandemic which has seen an already marginalised population experiencing additional barriers to accessing healthcare.

Primary Care Liaison Service

The Primary Care Liaison Team have provided education to primary care staff in relation to health inequalities, reasonable adjustments, and easy read information as without these essential interventions it has been found that people with a learning disability do not receive information appropriate to their needs. It is widely recognised that appointments which are lengthy can be anxiety provoking for many people with a learning disability and therefore the team have completed pre-appointment learning disability health checklists to gather important information and to assist in the planning of appointments.

Throughout ABUHB the uptake of the learning disability health checks for people with a learning disability has been poor. With this service going forward primary care liaison will be a point of contact to educate, support and advise in the planning and delivery of LD Health Checks. Research indicates that regular health checks will often identify treatable health conditions. The Neighbourhood Care Network (NCN), and in particular the NCN Lead for learning disabilities have worked in close collaboration with the primary liaison team in establishing relationships with GP surgeries and supporting with the embedding of the learning disability health checks. Appendix 2 outlines the achievements and outcomes achieved over the past 6 months and Appendix 3 outlines the work completed in each quarter of 2021/22.

Barriers to completing Annual Health Checks

There have been some barriers to completing the health checks and gathering data as follows:

- Covid restrictions – Colleagues were unable to use GP surgeries due to restrictions however as restrictions are lifted, we are seeing an increase in GP surgeries reaching out to our Primary liaison team asking for their support.
- Obtaining and checking LD READ codes – It was integral that LD READ codes were obtained and verified prior to health checks being completed. This has been a long process as it requires both Administrative and Clinical input due to conditions such as dyslexia being grouped into an LD READ code.
- Access to data – Currently the Primary Care team are unable to access the number of LD health checks completed by GPs in the ABU Health Board Region. This is due to GP surgeries utilising an IT system that we do not have access too. The Primary Liaison team have requested access to this system and are awaiting a response.

What resources would help?

- Health Care Support Worker within the team to facilitate pre-assessment learning disabilities health check screening and support individuals at their GP appointments.
- Administrative support to assist with LD READ codes alongside clinical input.
- Access to IT system that records completed health checks.

Secondary Health Liaison Service

The Secondary Health Liaison Team have been operational since 2013 and provides specialist intervention for people with a learning disability accessing acute and secondary general healthcare services. The objectives of this team are to assist with the reduction of health inequalities, reduce avoidable and premature deaths through accessible services, ensuring that people with a learning disability living in the Health Board area receive a high quality, safe and equitable service.
The team achieves this through working in collaboration with staff in acute and secondary sectors to provide reasonable adjustments and to support people with a learning disability in accessing mainstream NHS services. A key part or their role is education for staff in acute and secondary services and acting as role models for working with individuals with a learning disability.

The team collected a range of data about their activity from the 1 January 2022 – 29 June 2022 (approx. 6 months) and identified the following:

- No of referrals to team were 84.
- Readmission of patient to hospital within 30 days was 9 (11%).
- Patient discharged without discharge meeting was 14 (17%).

Appendix 4 provides some examples of the work completed by the secondary liaison team in the form of patient
stories.

Appendix 5 identifies themes of concern identified from weekly team meeting discussion documents. In response to some of these concerns the Directorate has commissioned a pilot scheme where the secondary liaison team includes a Consultant Psychiatrist to support multi-disciplinary working and improve communication with medical colleagues within the acute and secondary sectors of the Health Board. The pilot will be evaluated and reviewed after 12 months. The concerns will also be raised and shared at the Learning Disability Steering Group which is attended by Divisional Nurses from across the Health Board.

Currently the secondary liaison team rely on referrals from other health professionals or family and carers. The secondary liaison team have been to all the local hospitals and wards providing leaflets and posters to promote their service. The team also attend training and time out sessions as well as induction days to promote the service and encourage other health professionals to make referrals. Due to current and different systems used the team are only aware of people with a learning disability being admitted to general hospital if they receive a referral.

The effect of the primary health liaison team and their work around annual health checks is key to ensuring equitable and timely care and treatment for individuals with a learning disability and will directly impact upon the number of individuals with a learning disability in acute physical health settings. A recent study completed by the National Centre for Population Health and Wellbeing Research found that health checks are most effective for those who have their first health check at a younger age and that annual health checks increase the survival rate for those with intellectual disabilities, especially those with Autism or Down's Syndrome. As the primary health liaison team continues to establish itself within primary services and continues the education of the importance of annual health checks, we would expect to see less admissions to acute physical health services for adults with a learning disability within ABUHB.

(3) Monitoring the quality of commissioned packages of care in in-patient settings

There are currently 7 individuals in commissioned inpatient settings. All individuals in commissioned placements have a care coordinator allocated under Part 2 of the Mental Health (Wales) Measure 2010 and Care and Treatment Plan (CTP) reviews are undertaken in line with Part 2 including the use of a prescribed CTP template. All 7 individuals are currently detained under the Mental Health Act 1983 and the detention is reviewed accordingly through the hospital managers at the care provision and the Mental Health Review Tribunal for England and Wales.

All inpatients are reviewed through provider MDTs and ABUHB clinical teams are included in reviews and sent minutes of these meetings. Reviews of the CTP are undertaken and updated at least every 6 months. The individualised CTP encompasses all care and support needs including those associated with physical health e.g. general health such as GP, Dental, Optometry etc. and specialist specific appointments e.g. Epilepsy, Diabetes etc.

The Health Board has a service level agreement with the National Collaborative Commissioning Unit (NCCU) to provide governance over the contractual arrangements with providers on the All Wales Framework. The Quality Assurance Improvement Service (QAIS) incidents are reported through the Commissioning Care Assurance and Performance System (CCAPS) database and alerts given to the commissioning team and care coordinator to review the incident. Standards monitored through these arrangements are made explicit in the contract between the NCCU and provider. The NCCU use a Quality Assurance Rating System whereby 3 Q's are allocated to a provider with the expectation that the 3 Q's are maintained throughout the period on the framework. Any performance issue deemed to be an actual risk to the safety, physical or mental health of a patient will constitute a 'level 2 performance issue' resulting the removal of two Qs from the provider. In turn a Performance Improvement Plan will be requested and a timeframe for compliance agreed. Should the provider not meet the requirements they will then be suspended from the framework resulting in the Health Board reviewing the placement and sourcing alternative care provision.

The Commissioning Team undertakes annual clinical audits of placements to ensure that the CTP is in place and meets the holistic needs including Physical Health and Wellbeing (covering physical health, malnutrition and obesity and medical devices / resuscitation equipment). The non-clinical audits undertaken by contracts and performance also ensures that resources and training are in place to meet the specifications identified on the CTP.

All escalations in concern are discussed under the provider performance section of the Divisional Quality Assurance Panel and plans developed. Clinical teams and case managers can also escalate concerns through panel for discussion. The escalating concerns policy would be initiated if required and appropriate Duty to Report procedures followed for safeguarding.

Recommendations
• Note the progress made with the Improving Care, Improving Lives Action Plan and support the continued joint work. • Note the progress made with both secondary and primary liaison services and consider the continued development and strengthening of health liaison teams. • Note the continued work in monitoring the quality of commissioned packages of care in in-patient settings.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Primary liaison team are currently funded through RIF from Welsh Government. The Directorate have made the primary liaison team permanent 'at risk' and therefore if the funding is withdrawn this will affect the directorates financial position.

	There is variable engagement from GP's across the Health Board region, and lack of access to data on completed health checks poses a risk to the demonstration of outcomes achieved by the primary liaison team. There is variable engagement from acute and secondary sectors in relation to guidance and recommendations made by the secondary liaison team that poses a risk to outcomes achievable by secondary liaison. Lack of or limited access to collaborative and partnership working to complete and take forward actions from the Improving Care, Improving lives action plan in a timely manner poses a risk.
Financial Assessment, including Value for Money	Primary liaison team are currently funded through RIF from Welsh Government and equates to £155,272.00
Quality, Safety and Patient Experience Assessment	The project should have a positive impact on the quality of service provided to the service user and for their experience. The project should also reduce health inequalities experienced by people with a Learning Disability.
Equality and Diversity Impact Assessment (including child impact assessment)	An Equality and Diversity Impact Assessment has been undertaken and there are no negative impacts from this project. There are significant benefits for the affected individuals. This project does not relate to children.
Health and Care Standards	The project complies with the Health and Care Standards of: Person Centred Care and Individual Care (Planning Care to Promote Independence and Peoples Rights) and also involves the standards in relation to Staff and Staff resources.
Link to Integrated Medium Term Plan/Corporate Objectives	This project forms part of the Directorate's Integrated Medium Term Plan and links to the Corporate Objectives of: •Providing and commissioning services that focus on the needs of the patient, in their homes, communities and where necessary hospital settings •Improving the efficiency and effectiveness of our services •Focusing on prudent and value based healthcare to ensure clinical value and value for money is improved.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Welsh Government wrote to Health Boards on 30 June 2021 seeking support to prioritise the implementation of the recommendations of the National Collaborative Commissioning Unit (NCCU) review of learning disability inpatient care (Improving Care: Improving Lives 2020). At its heart were the principles that people with a learning disability should live normal lives in the community and not live in hospitals. These principles remain current, and the project aims to enable this and ensure that individuals with a learning disability receive safe, effective and outcome focused care in whatever setting they are living or accessing. The aim of this project also focuses on reducing the health inequalities individuals with a learning Disability currently face and support timely access to the care they require.

	Integration – The aims of the project are aligned with the aims and recommendations of the Welsh Government report Improving Care, Improving lives.
	Involvement – This National Care Review is based on the sourcing of 156 pieces of information on the admission, status, care, treatment, and outcomes for each patient in relation to their current hospital inpatient episode, a total of 26,364 pieces of information. Patients, advocates and the All Wales People First Learning Disability Charity were consulted during this National Care Review.
	Collaboration – This project demonstrates collaborative and partnership working as there will be a requirement to work closely with Local Authorities, commissioned placements and other health professionals including GP's.
	• **Prevention –** This project will enable individuals with a learning disability be supported in less restrictive models of care and will enable them to live more independent lives with increased rights and entitlements. • Maximising patient safety and minimising clinical risk for people with a learning disability contributing to the prevention of premature and avoidable deaths. • Patients with a learning disability and their families/ carers will have facilitated support and better access to mainstream health services, including easy to understand information. • Person centred approaches for vulnerable people. • Improved levels of patient satisfaction/ experience with associated decrease in complaints, Safeguarding concerns and serious incidents. • Improved levels of education, training, and skill development for generic staff. • Closer collaboration between primary, secondary and community learning disability teams meaning that people with a learning disability can be discharged safely. • Length of stay which is appropriate to need and the possibility of reduction in bed days and delayed discharges and reduction in re-admission rates.
Glossary of New Terms	There are no new terms in this report.
Public Interest	

Appendix 1 Table of Recommendations From Improving Care Improving Lives

Recommendation:	(1) Rights – ensuring that those who are inpatients are either under MHA, DOLS or have the capacity to consent to admission – that this is reviewed and that they are aware of their rights (inc. right to advocacy)
11	Providers should ensure that all patients, not subject to detention under the Mental Health Act or to Deprivation of Liberty Safeguards have the capacity to consent to being an inpatient.
12	Providers should ensure that all patients subject to detention under the Mental Health Act or Deprivation of Liberty Safeguards are aware of their rights
13	Commissioners should ensure that all patients subject to detention under the Mental Health Act or to Deprivation of Liberty Safeguards are subject to regular review
14	Commissioners should ensure that all patients in hospital are assigned a care coordinator.
15	Commissioners should ensure that all care coordinators understand their role in ensuring the patient is cared for in a safe and high-quality environment and in planning and expediting the patient's transition.
	(2) Care Plans - outcomes focussed
16	Commissioners should ensure that care plans are reviewed regularly, within a maximum time period of six months.
17	Providers should ensure that hospital support plans are reviewed regularly, within a maximum time period of three months.
19	Providers should ensure that all care plans and hospital support plans are developed with specific objectives, measurable outcomes, and clear timescales.
20	Commissioners should ensure that the desired outcomes for the patient are agreed on admission with the patient, families, provider, and local care team.
21	Commissioners should monitor the achievement of outcomes closely, intervening if outcomes are not being achieved in a timely manner.
22	Providers should ensure that the patient's outcomes are discussed as part of the care plan and hospital support plan reviews.
40	Providers should ensure that the rationale for application and planned duration for any and all personal restrictions should be clearly documented in the patients' hospital support plan and be regularly reviewed.

	(3) Medication
25	Commissioners should ensure the adoption of evidence-based prescribing by all providers
27	Providers must ensure that the patient, local care team and carers and involved in the decision to commence or discontinue any psychotropic medication.
28	Providers should ensure that all patients prescribed psychotropic medication have a recognised side-effect monitoring tool completed.
29	Providers should ensure that patients and families receive information, in an accessible format, on desired effects and possible side-effects of medication.
	(4) Patient Experience
49	Providers should undertake regular patient experience surveys in partnership with independence advocacy services and use the findings of these surveys to improve care.
50	Commissioners should ensure measures of patient satisfaction are obtained and used as indicators of responsive and quality services
	(5) Evidence Based Interventions
59	Providers should ensure that staff are delivering high quality, evidence-based interventions to achieve the patients' outcomes.

Appendix 2 Primary Health Liaison

Achievements and outcomes over the past 6 months include:

- Links with all GP Practices, Local Authorities in Caerphilly, Blaenau Gwent, and Monmouth. Links with GP practices in Torfaen are just being established.

- Provided updated LD-READ CODES for all GP practices in Caerphilly and Blaenau Gwent.

- Verified all GP Lists in Caerphilly and Blaenau Gwent using systems available to LD services and in process of revisiting these practices with final lists of all individuals with a LD living within those areas. (It must be noted that there is a very small number of individuals who were unable to be validated at this time and need further investigative work in collaboration with the GP to understand the current LD READ code given to individuals) Without these checks individuals without a LD will not achieve the correct healthcare and support they need going forward. Public Health Wales recognise this as a valuable part of the service as people with a LD are already marginalised and without services correctly diagnosing them, they would not be called for things such as the COVID Vaccination in the correct JVCI Group.

- Worked in collaboration with children's services.

- Provided education/training/awareness sessions to Primary Care.

- Developed a leaflet to raise awareness of the role and services provided.

- Worked in collaboration with GP's to undertake pre checks in preparation for Annual Health Checks (AHC).

- Worked in collaboration with third party agencies such as Growing Spaces, Paul Ridd Foundation, Learning Disability Wales, Peoples First.

- Worked in collaboration with Public Health Wales to promote the Once for Wales Health Profile.

- Part of the newly formed All Wales Primary Care LD Liaison Network Group.

- Worked jointly to support the COVID vaccination programme.

- Collaboratively developed reasonable adjustment plans prior to AHC and Health Action Plans after AHC.

- Ensured appropriate needs are met by the right service by making referrals on to appropriate teams.

- ABUHB have been praised by Public Health Wales and advised that the model they have developed ideally needs to be rolled out across Wales as the blueprint for Primary Liaison LD Services.

09-Aug-22

Reducing Health Inequalities

Instructions

Please fill in each Quarter and submit in line with the agreed submission deadline.	
Q1 - Submission by	14th July 2021
Q2- Submission by	14th October 2021
Q3 - Submission by	14th January 2022
Q4 - Submission by	15th April 2022
You will only be able to access the cells that must be completed	

Home

Evaluation How Much, How Well, Difference Made in your Project Quarter 1

PLANNED How Much	ACTUAL How Much have you completed so far?	PLANNED How Well	ACTUAL How Well	PLANNED Difference Made	ACTUAL Difference Made
This is pulled through from the overview page	*Q1 Figures*	*This is pulled through from the overview page*	*Q1 Figures*	*This is pulled through from the overview page*	*Q1 % Figures*
Total number of individuals with LD on GP register	528	Number of new individuals with LD registered with GP	1	% of individuals registered with GP receiving annual health check	3.60%
Training sessions provided	3	Number of individuals attending training sessions	60	% of individuals receiving annual health check requiring further intervention	89%
				% of individuals receiving annual health check having Once for Wales health profile and action plan	100%
				% of individuals receiving annual health check receiving LD easyread information	100%

Key Additional Information for Quarter 1

Example of the type of information we require such as: unexpected outcomes / issues or barriers the project has faced in this quarter / exceptional work completed by staff or projects impact.

1. Of the 528 individuals on 13 GP Registers which we have reviewed we have been able to verify that 307 have a diagnosis of LD. The remaining 321 individuals we need to access the GP records to confrim READ codes for these individuals to be able to verify their diagnosis and this work is planned to commence w/c 9th August 2021.
2*. The GP Practices informed the team during a recent meeting that as a consequence of the COVID Pandemic they had been advised by ABUHB to relax the enhanced services so they have not been prioritising Annual Health Checks for people with LD.
3*. In additon as a consequence of COVID the team have not been able to physically access GP Practices and this is required to access the information systems to gather the data regarding the number of Annual Health Checks completed. Therfore the team believe that the figures included in this reporetd of AHC uptake is underestimated.
4. The team also undertook a significant piece of work supporting Primary Care services in relation to the administration of the COVID Vaccine to individuals with LD. The team identified individuals with LD known to CLDT's and Primary Care services across Gwent and identified consent and capacity of the individual and what reasonable adjustments were required (if any) in relation to the COVID Vaccination. This piece of work has ensured that at least 100 individuals with LD have been vaccinated who may not have otherwise received this intervention. This work has also raised the profile of the team

After completing the evaluation for the relevant quarter, please rate the progress of your project choosing from the drop down list.

BRAG Rating	Amber - some risk to delivery

Do any of the following groups benefit from the project?

Group	*Yes / No*	*If yes, How Many?*
Carers	No	
LGBTQAI+	No	
Traveller Community	No	
BAME	No	

Evaluation How Much, How Well, Difference Made in your Project Quarter 2

PLANNED How Much	ACTUAL How Much have you completed so far?	PLANNED How Well	ACTUAL How Well have you achieved outcomes so far?	PLANNED Difference Made	ACTUAL Difference Made
This is pulled through from the overview page	*Q2 Figures*	*This is pulled through from the overview page*	*Q2 Figures*	*This is pulled through from the overview page*	*Q2 Figures*
Total number of individuals with LD on GP register	1,164	Number of new individuals with LD registered with GP	618	% of individuals registered with GP receiving annual health check	
Training sessions provided	13	Number of individuals attending training sessions	36	% of individuals receiving annual health check requiring further intevention	
0		0		% of individuals receiving annual health check having Once for Wales health profile and action plan	
				% of individuals receiving annual health check receiving LD easyread information	

Key Additional Information for Quarter 2

Example of the type of information we require such as: unexpected outcomes / issues or barriers the project has faced in this quarter / exceptional work completed by staff or projects impact.

1. Within this quarter, the number of individuals identified on the base-line (original) GP LD lists that were provided to us has increased to 1164. This is an additional 618 individuals identified on a further 18 (11 BG and 7 Caerphilly) GP LD lists. We have also been able to gather information from additional surgeries in Caerphilly and all surgeries within Blaenau Gwent

2. After accessing surgeries within Caerphilly, we requested that new READ codes as provided to us by PHW were run with each GP practice– this has generated extensive lists with a significant increase in the number of people on GP lists who have been identified as having a LD – we are in the process of verifying the more updated lists. Whilst we are still awaiting some of this

3. Blaenau Gwent practices have been very forthcoming with information and we have been able to book appointments with the surgeries w/c 9th November. We plan to again request new READ codes are run and predict that like Caerphilly, further individuals will be identified.

4. We have added new alerts on Clinical Work Station – 115 individuals in Caerphilly, with more to add and a further 32 in Blaenau Gwent.

5. During visits to 12 Caerphilly GP surgeries, we have been able to discuss health inequalities experienced by people with a learning disability and also discuss and offered our services by LD primary Liaison and CLDT'S within ABUHB. During this visits, we have also clarified with the practice if anyone on their current LD register needs reasonable adjustments for the

6. Caerphilly practices have reported that AHC have been on hold during the Covid-19 pandemic. We have also been informed that some surgeries have continued to offer these however as we have not had access to the data that supports this nor the quality of each AHC. Some practices report these have been carried out over the phone or that the receptionists have gathered some

7. The team have continued to undertake supporting primary care services in relation to the administration of the Covid Vaccine to individuals with LD. A further 61 individuals across the 5 boroughs have been vaccinated/received second vaccine. Requests from GP's, private providers, CLDT'S (including CALDS) and families are still being made frequently. The team were shortlisted for RCN Nurse of the Year Award – for work completed to enable people with

After completing the evaluation for the relevant quarter, please rate the progress of your project choosing from the drop down list.

BRAG Rating	Amber - some risk to delivery

Do any of the following groups benefit from the project?

Group	*Yes / No*	*If yes, How Many?*
Carers		
LGBTQAI+		
Traveller Community		
BAME		

Evaluation How Much, How Well, Difference Made in your Project Quarter 3

PLANNED How Much	ACTUAL How Much have you completed so far?	PLANNED How Well	ACTUAL How Well have you	PLANNED Difference Made	ACTUAL Difference Made
This is pulled through from the overview page	*Q3 Figures*	*This is pulled through from the overview page*	*Q3 Figures*	*This is pulled through from the overview page*	*Q3 Figures*
Total number of individuals with LD on GP register	2104	Number of new individuals with LD registered with GP	80	% of individuals registered with GP receiving annual health check	
Training sessions provided	17	Number of individuals attending training sessions	91	% of individuals receiving annual health check requiring further intevention	
0		0		% of individuals receiving annual health check having Once for Wales health profile and action plan	
0		0		% of individuals receiving annual health check receiving LD easyread information	
0		0		0	
0		0		0	
0		0		0	

Key Additional Information for Quarter 3

Example of the type of information we require such as: unexpected outcomes / issues or barriers the project has faced in this quarter / exceptional work completed by staff or projects impact.

After completing the evaluation for the relevant quarter, please rate the progress of your project choosing from the drop down list.

BRAG Rating	Amber - some risk to delivery

Do any of the following groups benefit from the project?

Group	*Yes / No*	*If yes, How Many?*
Carers		
LGBTQAI+		
Traveller Community		
BAME		

Evaluation How Much, How Well, Difference Made in your Project Quarter 4

PLANNED How Much	ACTUAL How Much have you completed so far?		PLANNED How Well	ACTUAL How Well have you	PLANNED Difference Made	ACTUAL Difference Made
This is pulled through from the overview page	*Q4 Figures*		*This is pulled through from the overview page*	*Q4 Figures*	*This is pulled through from the overview page*	*Q4 Figures*
Total number of individuals with LD on GP register	996	683 people in Caerphilly have been verifed as having a Learning Disability in	Number of new individuals with LD registered with GP	240	% of individuals registered with GP receiving annual health check	GP practice holds this information
Training sessions provided	33	32 Training sessions have been provided 22 in Caerphilly and 11 in Blaenau Gwent	Number of individuals attending training sessions	60	% of individuals receiving annual health check requiring further intevention	GP practice holds this information
0			0		% of individuals receiving annual health check having Once for Wales health profile and action plan	
0			0		% of individuals receiving annual health check receiving LD easyread information	
0			0		0	
0			0		0	
0			0		0	

Key Additional Information for Quarter 4

It is widely recognised that people with a LD experience many barriers when accessing health-care. This has been further compounded by the Covid-19 pandemic which has seen an already marginalised population experiencing additional barriers to accessing health-care.

Many of the GP practices that we have contacted have lacked the expertise and knowledge related to health inequalities that people with a LD experience.

Within our role we have been required to provide education to Primary Care staff in relation to health inequalities, reasonable adjustments and easy read information as without these essential interventions it has been found that people with a LD were not receiving information appropriate to their needs. It is widely recognised that appointments which are lengthy can be anxiety provoking for many people with a LD and therefore we have completed pre- appointment AHC checklists to gather important information and to assist in the planning of appointments.

Throughout ABUHB the uptake of the AHC for people with a LD has been poor. With this service going forward we will be a point of contact to educate, support and advise in the planning and delivery of AHC. Research indicates that regular health checks will often uncover treatable health conditions.

Achievements and outcomes over the past twelve months

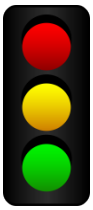
Linked with all GP Practices, Local Authorities in Caerphilly and Blaenau Gwent

After completing the evaluation for the relevant quarter, please rate the progress of your project choosing from the drop down list.

BRAG Rating	Green - on track

Do any of the following groups benefit from the project?

Group	*Yes / No*	*If yes, How Many?*
Carers	NO	
LGBTQAI+	NO	
Traveller Community	NO	
BAME		



5 x Health Liaison Nurse Patient Stories

1. Outpatient – ultrasound scan.
2. Out of area inpatient – complex needs.
3. Out of area inpatient – resident from local CHC funded LD services.
4. Inpatient – potentially prevented an unsafe discharge.
5. Emergency Department patient – Joint assessment of patient which resulted in a protocol being developed.

Patient story 1

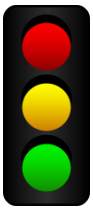
- Mr D. is a 44 year old gentleman with Autistic spectrum disorder.
- He has been referred as he has a possible abdominal hernia and there is parental concern as to if he will be able to tolerate unfamiliarity of environment in the ultra sound department and the procedure itself.
- Mr. D does not vocalise when he has pain and it is identified that there are significant risks to his health if he is not able to access the diagnostic scan.
- Joint home visit (HLN & Community LD Nurse known to the patient and family). Discuss and agree in principle ‘reasonable adjustments’ that may assist him to tolerate the scan procedure.
- Liaise with Radiology appointment scheduling officer for appropriate date of appointment
- Liaise with Consultant Radiographer and Radiology Nursing staff regarding ‘reasonable adjustments’ and negotiate how they could best accommodate this.

The plan:

- Parents were to provide nursing staff with bedding from Mr D’s bedroom so that the examination table could be dressed to resemble his own bed (using his own pillow, duvet and sheets).
- Mr D was allowed to hold his toy monkey throughout the procedure and parents were allowed to stay with him throughout.

Result:

- A successful scan, which enabled the consultant to formulate an appropriate treatment plan for the patient.
- The patient and his family had a positive experience of accessing generic healthcare services.



Patient Story 2

- A 20 year old man with profound and multiple learning disabilities was referred to the Health Liaison Nurse Team, as he needed to be admitted to hospital for insertion of specialist cannula. There were factors of concern raised by his CLDN.
- Maintaining safety: He is physical the size of a six year old child. He has multiple allergies to antibiotics and to latex, where exposure may cause anaphylaxis. He is very prone to infection. He is not able to communicate his needs. He has epilepsy.
- Breathing: He experiences low oxygen levels when asleep and requires the use of oxygen and 1:1 observational monitoring over 24 hours.
- Eating and drinking: He has a PEG in situ and requires all medication to be administered via this route.
- Moving and handling: He needs correct positioning in a specialist seat, although he is able to move his hands shuffle his lower body.

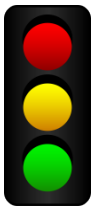
Concerns raised by his mother:

- She would not be allowed to stay with her son during his hospital stay.
- She had been told via a T/C to a Staff Nurse on the proposed ward that as her son was 20 years old, “he should not need his mother with him”
- That he would be allocated a hospital bed with the risk that he might fall out if she was not allowed to stay. He has a large cot at home where he feels safe and secure, and mum was worried that he would feel anxious if he was not in a similar cot.
- That staff would not recognise his allergies.
- That he would not have 1:1 care in hospital, which could result in his oxygen levels falling or seizure activity not being recognised and responded to.

Action plan

- Liaise with ward manager to discuss concerns and develop a plan for meeting his needs through facilitating “reasonable adjustments”.
- Identify risks to him being cared for on an adult ward e.g. due to his physical size he would require paediatric resuscitation equipment.
- Ensure all parties (ward staff and theatre staff) are aware of allergies (which include latex).
- Make arrangements for his mother to stay with him, and for her to have a bed, hot food / drinks throughout the duration of the hospital stay.
- Make arrangements for provision of cot for sleeping in, which is suitable for his size and weight.
- Arrange for his specialist chair and toys to be brought in, to ensure that he is well supported when sitting and that he has opportunity to engage in meaningful activities (which also helps reduce his anxiety).

.



Patient Story 3

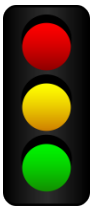
- A middle aged man from a residential home is to be admitted to hospital for a removal of a mass which is suspected to be malignant.
- He has autistic spectrum disorder, and is sensitive to touch, bright lights and noise. He likes his daily routine to be structured and familiar.
- He needs an operation which will result in a sutured wound and a drain post operatively.
- He is also likely to have an intravenous infusion post operatively.

Concerns

- The residential home manager says that the patient will find it difficult to cope in an unfamiliar environment e.g. bright lights, noise, touch of others.
- He may not tolerate the sutures, the wound drain, the intravenous infusion or the dressings post operatively.

Action plan

- Meet with all members of the multi disciplinary team and his brother (NOK) to discuss viable options to address the above concerns.
- Discuss the use of low adhesive dressings to minimise discomfort with the Tissue Viability Nurse.
- Liaise with the manager of the residential home around provision of 1:1 support from familiar staff to provide emotional support and reassurance.



Patient Story 4

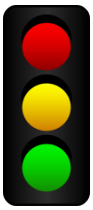
- Mr W is a 53 year old gentleman with a moderate learning disability. He has lived at home with a package of care since his mother passed away (she was his main carer).
- He was referred by the doctor on the ward for assistance with discharge planning.
- He was originally admitted to hospital due to a fall at home.
- He had been lying on the floor over 24 hours before he was eventually found by a relative who called in to see him.
- Although Mr W was deemed medically fit for discharge, when he was reviewed jointly by the 2 Health Liaison Nurses they were in agreement that a discharge back to his current setting may be unsafe unless an OT home assessment was carried out.

The plan:

- An OT home assessment was requested to assist in determining whether it was safe to return home or not.
- Consultation with patient, family and Social Worker regarding possible placement options.
- Liaison with ward staff for discharge planning which included the coordination of meetings.

Result:

- Unsafe discharge was avoided and Mr W's risk of falls was greatly reduced as he was placed in accommodation that was more suitable for meeting his needs.
- He now has a staff team on hand to provide assistance when required and to monitor his well-being.
- His family now have peace of mind that he lives in a safer environment.



Patient Story 5

- Miss A is a 24 year old woman with a mild learning disability. She lives in supported living accommodation and has a history of frequently accessing emergency services / departments (70+ attendances at A&E as an adult).
- She had been transported to hospital via ambulance after reportedly consuming bleach, shampoo and conditioner.
- She was referred for assessment of her current mental state as she has been deemed medically fit for discharge.

The plan:

- Joint assessment made by Health Liaison Nurses prior to discharge from the Emergency Department.
- Liaison between the CLDT, the supported living provider and the hospital department to enable a safe and planned discharge to take place.

Result:

- Miss A was deemed at low risk of further self-harming behaviour and was discharged from the Emergency Department.
- She received support from the Health Liaison Nurses whilst she awaited a taxi to transport her home.
- Her home made arrangements for the taxi and were ready to greet her when she arrived home.
- The CLDT was kept informed of the situation and their advice was taken throughout the planning process.
- A multi-disciplinary meeting was held a week after discharge and a protocol for working with Miss A for when she attends A&E / MAU was developed.

Appendix 5 – Secondary Liaison

Themes of concern identified from weekly secondary liaison team meeting discussion documents

It should be noted that this list is not exhaustive. It should also be noted that in some cases several of the issues may have affected the same patient, but a rough estimate indicates that almost 30% of referrals in the last 6 months have at least one theme of concern associated with them.

1. Feeding Issues.

The team have identified issues with feeding and nutrition that were not being addressed in at least 4 cases.

2. Missing or Inaccessible Health Profiles.

Health profiles are key to adequately supporting people with LD on acute wards, they can be relatively inaccessible if filed in clinical notes – they should be live documents used by all staff caring for a person with LD. An issue has also been identified is that when patients are transferred between wards as often happens in the new GUH and peripheral hospital model that this Health Profiles do not move wards with them. The team have had at least 4 examples of missing or inaccessible health profiles.

3.Decisions not to treat /ceiling of care decisions being made in the absence of a BI meeting.

Obviously in urgent or acute situations decisions not to treat in the best interests of an incapacitated patients sometimes have to be made, however in the last 6 months the team have identified 3 examples where the Secondary Care Liaison Team have had to request a formal best interest decision meeting be convened for non-urgent decisions where a ceiling of care has been set for an incapacitated patient with no best interest discussion.

4. Support with BI decisions, Mental Capacity and Dols

The team have identified at least 6 occasions where the team have needed to suggest BI meetings, advice on capacity assessments and DoLs. On 1 occasion the team had to advocate strongly on behalf of the patient in a BI meeting for further investigation/treatment in a case where there was evidence of diagnostic overshadowing.

5. Support with DNACPR decisions

On 1 occasion the team supported understanding and knowledge about the All Wales DNACPR policy.

6. Discharge without notification

The team have encountered at least 3 cases of discharge without notification of people on our caseload and 1 case where there were concerns expressed by the liaison team over an inappropriately rapid discharge plan.

7. Clinical Review on wards

In 1 case liaison staff identified seizure activity that had not been recognised by ward staff (despite an existing diagnosis of epilepsy and dementia) and in 1 case needed to advise on adequate pain relief to enable the patient to engage in physiotherapy.

8. Concerns from paid carers

The team often receives referrals and enquiries from paid carers and relatives. On 1 occasion there was confusion about whether the patient had been admitted (carers were told the patient had only been admitted to the medics) and who had responsibility to administer the patients medication.

9. Mortality

In 1 case specific concerns were raised by the liaison team regarding the cause of death and the impact that bowel management had had on the patient's death, a datix was raised and the case was referred to the coroner.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient, Quality, Safety and Outcomes Committee Tuesday, 16th August 2022 Agenda Item: 3.11

Aneurin Bevan University Health Board
PQSO Committee - Strategic Risk Report

Executive Summary

This report provides an overview of the profile of the current risks reporting to the Patient, Quality, Safety and Outcomes Committee (PQSOC). Whilst this report articulates the strategic risk profiles for the organisation, operational context is important to note as the Health Board continues to experience the challenges of the pandemic; restart and recovery of previously paused operational services; alongside continued staffing pressures.

This report includes update on progress related to the organisational approach to risk management and continued development and embedding of the risk management strategy 2021.

The PQSO Committee is asked to note this report for assurance.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	
Executive Sponsor:	Rani Mallison, Director of Corporate Governance
Report Author:	Danielle O'Leary, Head of Corporate Services, Risk and Assurance

Report Received consideration and supported by :

Executive Team	**N/A**	**Committee of the Board [Patient, Quality, Safety and Outcomes Committee]**	**As outlined.**

Date of the Report: 3rd August 2022

Supplementary Papers Attached:
Appendix 1 – Assessment of 12 Risk Profiles

Purpose of the Report

This report is provided for assurance purposes and seeks to provide a summary of the current key risks to the Health Board in respect of Quality and Patient Safety.

Background and Context

In conjunction with the revised Board Assurance Framework (BAF) and the revised Risk Management Approach, the Health Board is able to review and assess its strategic risks against achievement of objectives as set out in the IMTP 2022/23.

This report provides the Patient Quality, Safety and Outcomes Committee with an opportunity to review the organisational strategic risks which receive oversight from PQSO Committee.

The Health Board utilises the All-Wales Risk Matrix to assess the potential impact and likelihood of occurrence of all predicted risks to form an overall risk score. Risks may then be tolerated, treated, transferred or terminated in line with the Health Board Risk Management Strategy.

Assessment & Overview of Current Status

The revised risk management approach remains in the embedding phase throughout the organisation and thematic alignment can be evidenced through the Divisional risk reporting and strategic risk reporting. Continued engagement throughout the organisation has taken place and continues to progress to strengthen the utilisation of the Health Board's internal electronic risk management system (DATIX). The risk management system will form one of the key sources of business intelligence in respect of identification and escalation of operational risk, in conjunction with Executive level horizon scanning led risk identification.

This business intelligence and Executive level horizon scanning will be used to inform Board and Committee agendas and thereby, drive the business of the Health Board. This will ensure that an outward facing, strategic and risk focus is adopted. This will also be reflected in Board and Committee work plans and the Board Assurance Framework.

Further development work alongside Divisions is being undertaken to ensure risks are being captured on the system appropriately and consistently in terms of scoring, risk assessment and descriptors. Divisional engagement has continued over recent months and a plan to fully realise the benefits associated with the Risk Management Strategy has been developed and endorsed by the Audit, Risk and Assurance Committee which has the responsibility for overseeing implementation and progress of the plan.

Executive Team continues to support the embedding of the revised risk management approach and strategy provides an overarching position in relation to each risk area. In parallel to horizon scanning, strategic risk identification; the Health Board's risk management approach and infrastructure, is continually improving.

Further work to understand how we provide the Board with assurance on our commissioned services in relation to Continued Health Care (CHC), Looked After Children (LAC) and other Specialist Services for Mental Health is being undertaken. The Health Board recognises the need to take our internal strategic and operational risk management processes into consideration when we seek assurance on the services we commission and provided on our behalf. This work will dovetail with developmental work planned for the next iteration of the Board Assurance Framework.

Assessment

The risks reported to the Committee have been reviewed by risk owners and service leads in relation to risk scoring, descriptions, action plans and updates.

The Committee is asked to note the following updates since the last reporting period:

In relation to risk **CRR028** Access to crisis care beds for children and young people; significant developments in relation to the Health Board management of this risk continues. The Health Board is currently awaiting final approval of funding to develop the dedicated ward for Children and Young People in crisis however, contingencies are in place to progress this work should the funding not be forthcoming. The Committee will receive clarity on this position at the next Committee meeting in October 2022.

A strategic risk in relation to cancer services has also been drafted for the Committee to consider and approve **(CRR039).** This is included within the overview of risks table below, and at ***Appendix 1***.

Current Status

There are currently **27** risks comprising the Corporate Risk Register, of those 12 receive oversight from the Patient, Quality, Safety and Outcomes Committee. The following table provides a breakdown of the 12 risks by their severity:

High	9
Moderate	3
Low	0

There are also 4 risks which continue to be effectively managed within its target score and within the agreed risk appetite level (outlined in the table below). Therefore, the Committee is asked to note the current score, target score, an assessment as to whether the risk is managed within its agreed risk appetite, and trend since the last reporting period:

Risk ref and Descriptor	Current Score	Target Score (informed by Appetite level)	Risk Appetite Level	Managed to Agreed Level Y/N?	Risk Treatment	Date and Trend Since Last Reporting Period	Assurance/ Oversight Committee	Risk Owner
CRR019 Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand. **(re-framed Dec 2021)**	20	15	**Low** level of risk appetite in relation to patient safety risks. **Moderate** levels of risk with regard to innovation around mitigations to prevent demand and better manage the demand.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Board, July 2022)** 	**PQSO**	**Director of Operations**
CRR013 Failure to prevent and control hospital and community acquired infections to include COVID-19	10	10	**Zero or low** due to patient safety and quality of service.	**Yes**	**Treat** the potential impacts of the risk by using internal controls.	**(Board July 2022)** 	**PQSO**	**Director of Nursing**
CRR023 Potential risk to population health in relation to avoidable harm due to priority being given to management of the COVID pandemic.	20	20	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to different ways of working to address backlog. This would include the use of technologies and innovations.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Board, July 2022)** 	**PQSO**	**Director of Operations**
CRR010 Inpatients may fall and cause injury to themselves	15	10	**Zero or low** in the interests of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Board July 2022)** 	**PQSO**	**Director of Therapies and Health Science**

CRR027 Effectiveness of COVID vaccination and booster programme compromised leading to a Variant of Concern	20	20	**Moderate** risk appetite level will need to be applied to this risk profile, given the unpredictability of the potential of variants of concern. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control.	**Yes**	**Treat** the potential impact of the risk with mitigations. **Tolerate** the unpredictable element of the VoC and other mutations.	**(Board, July 2022)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR028 Continued inappropriate admissions of Children and Young People to adult mental health in-patient beds.	20	10	**Low** risk appetite level in relation to patient safety and experience. **Moderate** level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Board July 2022)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**
CRR001 High levels of seasonal influenza	8	8	**Low** level of risk appetite in relation to patient experience. **Moderate** levels of risk appetite can be applied to pursue innovative models and technologies to encourage uptake.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Board July 2022)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR003 Mental Health services will fail to meet the anticipated increased demand of the Health Board population, for Mental Health support, in light of the COVID 19 pandemic.	12	8	**Low** risk appetite level in the interests of patient safety. **Moderate** risk appetite levels will need to be taken to explore further innovations and appropriately reconfigure services and implement new arrangements.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Board July 2022)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**
CRR036 Risk of clinically unsafe and	15	5	Low (averse to risk) Risk Appetite Level 2	**No**	**Treat** the potential impacts of the risk by	**(Board July 2022)**	**PQSO**	**Director of Operations**

inappropriate inter-site patient transfers and into communities					using internal controls.			
CRR037 Risk of an inability to staff acute sites appropriately and provide acceptable levels of care in line with best practice and guidelines. Due to increased acuity of patients presenting.	15	5	Low (averse to risk) Risk Appetite Level 2	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Board July 2022)** 	**PQSO**	**Director of Nursing and Director of Operations**
CRR038 Risk of delays in discharging medically fit patients partly due to delays in accessing packages of care from Partners.	20	10	Moderate (cautious risk taking) Risk Appetite Level 3	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Board July 2022)** 	**PQSO**	**Director of Operations and Director of Primary, Community and Mental Health Services**
CRR039 Risk of delayed cancer treatments delivered to patients due to deteriorated position in cancer performance specifically in relation to 62 day waits.	20	10	Low (averse to risk) Risk Appetite Level 2	**No**	**Treat** the potential impacts of the risk by using internal controls.	**NEW RISK**	**PQSO**	**Medical Director/Director of Operations**

A detailed assessment of each risk profile outlined above is available at **Appendix 1**.

We will be actively working to review risk targets to ensure realistic and as far as possible; set within the context of the Board's appetite for risk.

Recommendation & Conclusion

The Committee is requested to note the content of this report for assurance purposes, recognising that there will be further iterative development work to embed the revised risk management approach with QPSOG and Divisions.

The Committee is asked to acknowledge the de-escalating trajectory of:

CRR010 – Inpatient falls

The Committee is also requested to note the additional risks, previously approved by the Board in July 2022, which receive oversight from this Committee. An update on these risks will be included as part of the strategic risk report to the October 2022 Committee meeting.

The Committee is asked to consider and endorse a new risk in relation to Cancer Services:

CRR039 - Risk of delayed cancer treatments delivered to patients due to deteriorated position in cancer performance specifically in relation to 62 day waits.

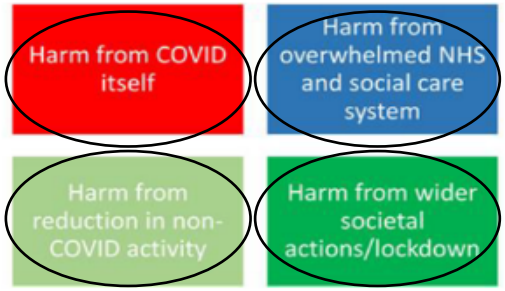
The Committee is also requested to note the 4 risks being effectively managed within agreed risk appetite and target risk score levels and the detail within ***Appendix 1.*** The Committee is encouraged to review the risk profiles in conjunction with other, interlinked risk profiles to ensure consistent understanding of context.

Supporting Assessment & Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment (including value for money)	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.
Quality, Safety & Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality & Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health & Care Standards	This report contributes to the good governance elements of the H & CS.
Linked to Integrated Medium Terms Plan & Corporate Objectives	The objectives will be referenced to the IMTP

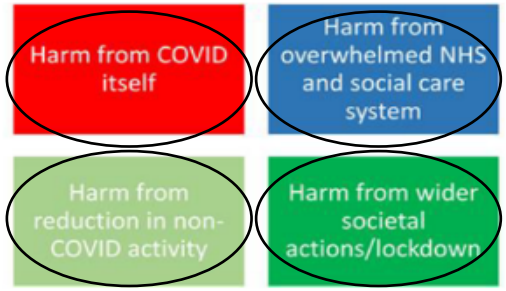
The Wellbeing of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of Terms	None
Public Interest	Report to be published

<table>
<tr><td colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="5">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2">Provide high quality care and support for older adults
Care closer to home
Less serious illness which require hospital care</td><td colspan="5">Risk of clinically unsafe and inappropriate inter-site patient transfers and into communities
Due to lack of availability of safe and appropriate transfer vehicles, staff and skill mix to facilitate the transfers.

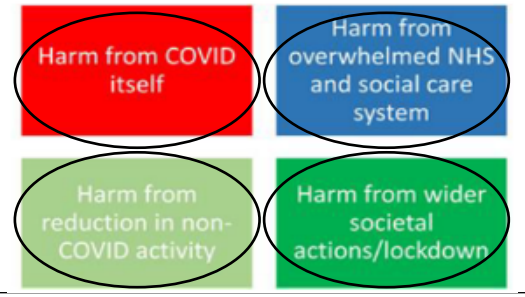
TREAT</td></tr>
<tr><td colspan="2"></td><td colspan="5">Impact
Compounds the Health Board’s inability to discharge into communities and negatively impacts the DToCs position. Poor patient/families and staff experience and outcomes. Potential financial implications and reputational/public confidence damage.</td></tr>
<tr><td>High Level Themes</td><td>Quality and Patient Safety
Patient Outcomes and Experience
Public Confidence
Reputational
Financial</td><td colspan="3">Risk Appetite</td><td colspan="2">Low (averse to risk)
Risk Appetite
Level 2</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="5">Risk Score</td></tr>
<tr><td>Patient Quality, Safety and Outcomes Committee</td><td>Existing Health Board contractual arrangements with WAST</td><td colspan="2">Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td colspan="2">Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
<tr><td colspan="2">Action Plan SMART actions that will positively</td><td>Due Date</td><td>Likelihood</td><td>Consequence</td><td>Likelihood</td><td>Consequence</td><td>Likelihood</td><td>Consequence</td></tr>
</table>

impact on the risk and help achieve the target risk score or maintain it.		4	5	3	5	1	5
		20		**15**		**5**	
Trend	**NEW RISK**	**Executive Owner: Director of Operations**					
Mapping Against 4 Harms of COVID		**Update**					
		**NEW RISK**					

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
• **Provide high quality care and support for older adults** • **Staying healthy** • **Care closer to home** • **Less serious illness which require hospital care**		***Risk of*** an inability to staff acute sites appropriately and provide acceptable levels of care in line with best practice and guidelines. ***Due to*** Increased levels of patient acuity presenting **TREAT** **TOLERATE** ***Impact*** Negative impact on staff morale, patient experience and outcomes. Non-compliance with legislative and statutory requirements, creating exposure to reputational damage.					
High Level Themes	• **Staff well-being** • **Patient experience and outcomes** • **Reputational** • **Public Confidence** • **Quality**	**Risk Appetite**	**Low (averse to risk)** **Risk Appetite** **Level 2**				
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Patient Quality, Safety and Outcomes Committee	• Health Board Recruitment drives • Safer staffing legislation • Pay incentives for Health Board bank staff • Proactive engagement with agencies	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	3	5	1	5

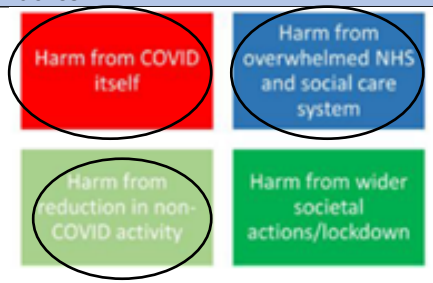
		20	15	
Trend	**NEW RISK**	**Executive Owner: Director of Nursing and Director of Operations**		
Mapping Against 4 Harms of COVID		**Update**		
		**NEW RISK**		

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="3">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2" rowspan="2">• Provide high quality care and support for older adults
• Care closer to home
• Less serious illness which require hospital care</td><td colspan="3">Risk of delays in discharging medically fit patients
Due to partly due to delays in accessing packages of care from Partners - covered in part by CRR019 (unmet demand and ambulance delays) on CRR
TREAT TOLERATE</td></tr>
<tr><td colspan="3">Impact
Deteriorating position in relation to social care crisis significantly impacts on Health Board’s ability to do its business and manage increased demand. Full understanding of partner risk profiles is required to develop new ways of whole system working.</td></tr>
<tr><td>High Level Themes</td><td>• Partnership
• Patient experience and outcomes
• Quality
• Financial
• Reputational
• Public Confidence</td><td>Risk Appetite</td><td colspan="2">Moderate (cautious risk taking)
Risk Appetite
Level 3</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Patient Quality, Safety and Outcomes Committee</td><td>• Multiple internal SOPs to support the timely discharge of medically fit patients
• Existing relationships and professional</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	arrangements with social care • Legislation requirements e.g. S117 etc.						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	4	5	2	5
• RPB review of step closer to home pathway. • Explore options to increase community beds/virtual bed capacity in conjunction with Partners.	Autumn 2022	**20**		**20**		**10**	
Trend	**NEW RISK**	**Executive Owner: Director of Operations and Director of Primary, Community and Mental Health Services**					
Mapping Against 4 Harms of COVID		**Update**					
		**NEW RISK**					

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="3">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2" rowspan="2">Providing high quality care and support for older adults
Less serious illness that require hospital care</td><td colspan="3">CRR010
Risk of: patients causing themselves harm or injury whilst in our services
Due to: lack of training and resources to asses patients

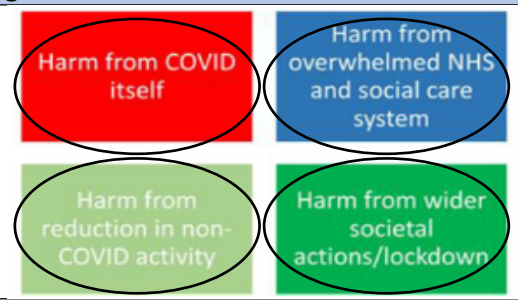
TREAT</td></tr>
<tr><td colspan="3">Impact
Detrimental impact on patient quality and experience, potential impact on staff morale should incidents increase, and potential financial and reputational damage should incidents occur that could have been prevented, leading to litigation action.</td></tr>
<tr><td>High Level Themes</td><td>Patient Outcomes and Experience
Quality and Safety
Reputational
Public confidence
Financial</td><td>Risk Appetite</td><td colspan="2">Low (averse to risk)
Risk Appetite
Level 2</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Patient, Quality, Safety and Outcomes Committee</td><td>Comprehensive corporate inpatient falls prevention action plan agreed. Policy for the management of and reduction of Inpatient Falls is in place.
Multidisciplinary training and support to drive improvement
Reports on inpatient falls provided to Executive Team and Quality, Patient Safety and Outcomes Committee.
Improvement metrics agreed and overall numbers of inpatient falls is within trajectory for improvement.
An ongoing data analysis allows for the identification of shifts and trends associated with falls and activity outside of normal variation.
ABUHB engagement in the ‘All Wales Inpatient Falls Network’ in support of the development of a more consistent,</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	standardised approach to falls management across Wales. ABHUH are also actively engaged in the' 4 Nations Falls Collective'. • The 'Falls and Bone Health Committee' looks to align its work to the National Audits and associated recommendations.						
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	3	5	2	5
• Promoting (through training) the multidisciplinary requirements of the policy including completion of required risk assessments & care plans. ABUHB are actively engaged in the development of a generic level 1-2 falls training platform which will be promoted as a national production on completion and delivered via ESR. • To also include the promotion of the newly developed falls specific medication review tool and falls associated Head Injuries pathway. Further awareness sessions are being delivered. • Learning from serious incidents with audit of agreed actions and expected outcomes. • Evaluation of the falls components of the 'Once for Wales 'incident reporting system to ensure the opportunity to maximise the value of the data sets included. Further work is being undertaken to evaluate and confirm the accuracy of the systems outputs to inform the falls data sets. • Engagement in the planning process for the implementation of the electronic version of the MFRA as part of the WNCR.	Ongoing	**20**		**15**		**10**	
Trend		**Executive Owner: Director of Therapies and Health Science**					
Mapping Against 4 Harms of COVID		**Update**					
		**July 2022** The 'Falls Policy for Hospital Adult Inpatients' was formally launched in July 2021 supported by an extensive awareness raising campaign. Staff training has been aligned to the requirements of the revised Policy. Work continues across ABUHB sites to further promote the MDT approach and requirements. The Falls and Bone Health Committee monitor the progress and impact of this work. A collaborative review of the governance structures in support of the management of falls has been undertaken by the Falls and Bone Health Steering group. This group will be retitled the 'Falls and Bone Health Committee' with the establishment of two new subgroups to undertake work associated with inpatient falls and those in the community setting outside of the hospital environment. The Falls and Bone Health Committee will report directly to the Patient					

	Quality, Safety and Outcomes Committee. The revised governance structure will come into effect from February 2022. The first meetings of the subgroups took place in March 2022 with a focus on defining the 'Terms of Reference' and determining the agreed membership. Both groups are developing programmes of work to further inform the corporate action plan. Whilst the 'Hospital Group' will focus on the inpatient setting the ''Community Group will look at the prevention and transition aspects of the persons pathway. Both groups will be cohesive in coordinating the elements of their programmes activities where commonality exists between both. Representatives from both groups would contribute to the work through a task and finish setting. A group is being established to review the learning processes and actions adopted for those inpatient falls associated serious incidents and injury, including the mechanisms for the monitoring/auditing of associated action plans. The group has identified that further work is required to ensure that learning is being implemented, monitored and audited in a consistent and coordinated way across the Health Board. The development of an incident reporting framework is being considered but would look to take account of those beyond that of falls incidents. From a falls perspective this would be coordinated via the 'Hospital Group' and feed to the Falls and Bone Health Committee for oversight. A meeting to discuss the opportunities to develop a framework is scheduled for the 19th July 2022 and will take account of the ability to adopt a standardised approach. Work continues in light of ongoing system pressures and falls in the Emergency Department, with an Audit/ Pathway working group established to consider opportunities to improve safety in this specific environment. An evaluation of DATIX data is being undertaken to look at the themes that contribute to the numbers of incidents which will be used to inform next steps and subsequent improvement initiatives in this environment. A representative for ABUHB is working with other HBs in Wales to develop a level 1-2 falls training platform which will be delivered via ESR and available to all staff. This is intended to support a guided introduction to falls prevention and management through an interactive learning approach. This will help to inform the development of an ABUHB falls training framework which will take account of the requirements of the hospital and community setting The Health Board continues to participate in the 'All-Wales inpatient falls Network, including engagement in the 4 Nations Falls Collaborative; this provides opportunity for shared learning and benchmarking. National audit outcomes will be presented to the respective Falls and Bone Health Groups and Committee to ensure any recommendations are considered within the context of the programmes of work. Inpatient falls management has been subject to an internal audit for which reasonable assurance has been given. The outcome was subject to several recommendation for which a management response has ben provided. The activities which for the response will be coordinated via the 'Hospital Group' with progress updates provided to the Falls and Bone Health Committee. Work has commenced on the development of standardised questions in support of fulfilling the requirements of the Health and Care Standard 2.3 Falls Prevention. This will underpin falls related specific audits which will look at information gathering from a qualitative and quantitative perspective and will look to include observational audits.

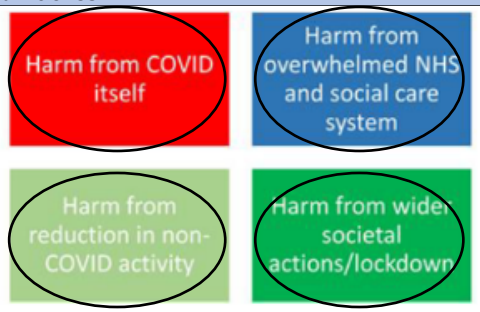
	There is ongoing engagement in the establishment of the implementation plan for the introduction of the electronic version of the MFRA as part of the WNCR. Training will be as a systems approach and will need to be supplemented by the ongoing provision to fulfil the clinical requirements for the completion of the MFRA.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision		
• **Provide high quality care and support for older adults** • **Care closer to home** • **Staying Healthy** • **Dying well**		***Risk of*** *delayed cancer treatments delivered to patients* ***Due to*** *deteriorated position in cancer performance specifically in relation to 62 day waits.* **TREAT**		
		Impact Reduced levels of patient quality, outcomes and experience, public confidence, and potential reputational damage to the Board.		
High Level Themes	• Quality and Patient Safety • Patient Outcomes and Experience • Public Confidence • Reputational • Financial	**Risk Appetite**	**Low (averse to risk)** **Risk Appetite** **Level 2**	
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**		
Patient Quality, Safety and Outcomes Committee	• Cancer Services Board to monitor and review delivery plans associated with cancer targets (KPIs) • Regular reporting on cancer KPIs to Welsh Government. • Cancer Directorate performance meetings. • Use of business intelligence tools (Lightfoot SFN,	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***	**Current** ***Risk level after initial controls/mitigations have been implemented.***	**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***

	Qliksense, Performance warehouse data).						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		5	5	4	5	2	5
• Action plans developed as part of an exceptional cancer services workshop. The Cancer Services Board to monitor and review implementation. • Pro-active medical rota population to mitigate the increased instances of medical annual leave • Development of mitigations for fragile pathology position to target the reduction in performance of 15% in dermatology.		**25**		**20**		**10**	
Trend	**NEW RISK**	**Executive Owner: Director of Operations and Medical Director**					
Mapping Against 4 Harms of COVID		**Update**					
		**NEW RISK** ***The Committee is requested to note that issues identified through the exceptional cancer services workshops are captured via the "Update on Cancer Services, and Associated Risks" paper. ***					

<table>
<tr><td colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="3">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2">Getting it right for children and young adults
Supporting adults in Gwent to live healthy and age well
Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness which require hospital care</td><td colspan="3">CRR003 (March 2017)
Risk of: Mental Health services will fail to meet the anticipated increased demand of the Health Board population
Due to: Continued and sustained Health Board response to the COVID Pandemic
TREAT

Impact:
Levels of population well-being could decline creating enhanced and sustained reliance on mental health services for children and adults. Unmet demand in communities potentially leading to increase in demand for Secondary Care Mental Health Services.</td></tr>
<tr><td>High Level Themes</td><td>Partnership
Research, Innovation Improvement Value
Quality and Patient Safety
Patient Outcomes and Experience</td><td>Risk Appetite</td><td colspan="2">Moderate (cautious risk taking)
Risk Appetite
Level 3</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Patient Quality, Safety and Outcomes Committee</td><td>1. Key transformation programme in place to address: a) A whole system model to meet mental health need with a key focus on developing/strengthening open access foundation tier and mental health support within Primary Care; to enable prevention and early intervention. b) Redesigning crisis services and acute care. c) Redesigning services for people with complex needs.
2. A programme is in place monitoring bed availability and flow through the system, overseen by the Deputy Divisional Nurse.
3. Systems and processes are in place to monitor demand.</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	• 4. Engagement with local academia to continue to monitor the impact of COVID on the wellbeing of the general population. • 5. Securing additional resources both within year, and recurrent.						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	4	3	4	2	4
• Development of new models to meet the mental health needs of the population across all Tiers e.g. Foundation Tier, Primary Care Mental Health, Secondary Care Specialist Mental Health Services	May 2022	**16**		**12**		**8**	
Trend		**Executive Owner: Director of Primary, Community and Mental Health Services**					
Mapping Against 4 Harms of COVID		**Update**					
		**July 2022** No funding for sustainably funding PWP service currently identified although existing service will continue to be funded through NCNs. However, bids were produced for additional funding from WG to fund a range of service improvements including reducing waiting times across IAS, PCMHSS and psychology. WG supported all bids with exception of neurodevelopmental bids. Subsequent follow up meeting held with WG representatives and funding also agreed to support ADHD service development, although IAS bid not supported by WG as new funding expected to be released next year. Risks associated with MAS clinic follow up waiting list in Caerphilly currently being investigated due to concerns about patients being lost to follow up during Covid period. Review of patient notes completed in Caerphilly and remedial action plan has been developed. Initial checks in other boroughs suggest issue contained within one borough, however now confirmed that some issues also identified in Blaenau Gwent MAS and audit to commence in borough shortly. SBAR being finalised and will be considered by Executive Team on 11 August 2022. Work ongoing to review SISU OBC financial costs. SBAR under development for consideration at 18th August Executive Team meeting. OBC now delayed two months and finalised case to be considered at November 2022 Public Board in light of further work required on financial case and benefits. **External Assurance:** In relation to any external sources of assurance and any metrics to indicate whether we have been successful in mitigating any risks; • WG letter confirming initial funding response to funding bids and HB response • SBAR attached regarding introduction of ADHD service supported by Exec Team, Health Board, CHC and LMC.						

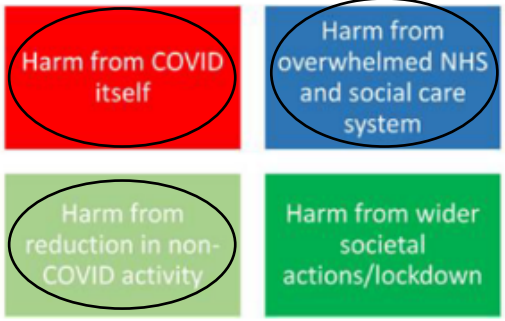
	 FUNDING AWARD LETTER Aneurin Beva  ST Letter - 08.07.2022.docx  Exec Team SBAR template ADHD ...

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="3">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2">Getting it right for children and young adults
Supporting adults in Gwent to live healthy and age well
Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness that require hospital care
Dying well</td><td colspan="3">CRR019 – (Jan 2022) Re-framed
Risk of: Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand.
Due to: Significant delayed transfers of care, domiciliary and care home constraints.

TREAT TOLERATE

Impact
Significant negative impact on patient flow throughout the acute care system in conjunction with a poor patient experience which may in turn produce poor patient outcomes.</td></tr>
<tr><td>High Level Themes</td><td>Patient Outcomes and Experience
Population Health
Quality and Safety
Reputational
Public confidence
Financial</td><td>Risk Appetite</td><td colspan="2">Low (averse to risk)
Risk Appetite
Level 2</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Patient, Quality, Safety and Outcomes Committee</td><td>Health Board Emergency Pressures Escalation Policy (revised Nov 2021)
Health Board surge plans.
Health Board SLA with WAST
System Leadership and Response – whole system planning – meets x2 weekly.
Cross-site meetings to discuss system and flow pressures meets x4 daily.
Emergency Care Improvement Board – meets monthly
Urgent Care Transformation Board</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	4	5	3	5
Short Term:		**20**		**20**		**15**	
• Public messaging including social media to ask the public to consider other options before attending the Emergency Department. These messages have been shared through partner organisations, the Health Board website and social media channels.	Ongoing Ongoing						
• Respiratory Ambulatory Care Unit go live - phase one consultant to identify suitable patients, phase two Flow Navigator	Ongoing						
• Discharge improvement Board – Nurse Led Discharge SOP to be ratified.	Feb 2022						
• GP/HCP - one single point of access for GP to arrange admission and book transport.	Ongoing						
• Continued GP aligned to the Flow Centre triaging patients on the ambulance stack, redirecting patients to appropriate pathways and services following a request for an emergency response by contacting 999	Ongoing						
• Home First service extend focus to ED at the GUH to ensure that those people who are able to be re-directed or are able to use Direct conveyance to community beds	Ongoing						
• Care home conveyance - Highest reasons for calls/conveyance is falls/injury from fall – response will be co-ordinated							
• High Risk Adult Cohort (Venn diagram) – pilot project, multiagency group building on existing compassionate communities framework to ensure that those individuals who have been in hospital in the last year have health review and plan in place							
• Table top exercises have commenced between MIU/UPCC/111 to ensure the 111 Algorithm is directing patients to the right places, this work has suggested there is further improving to the numbers of patients directed towards UPCC , size of opportunity currently being quantify.							
• Implementation of Trauma day unit in GUH site	Ongoing						

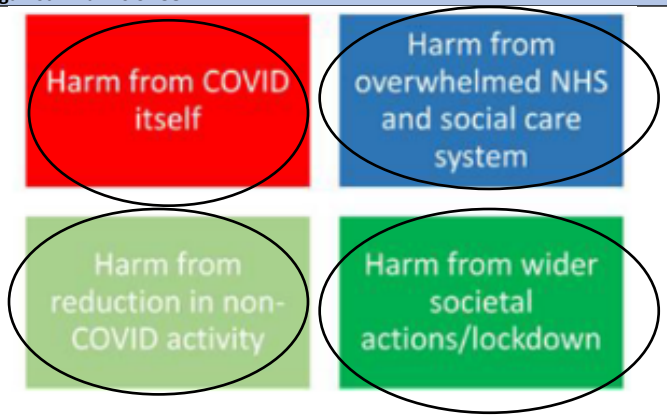
Medium Term (3-12 months) • Development of the SDEC bid on the GUH site • Integrated Front Door proposal at Nevill Hall	Summer 2022 Ongoing		
Trend since last reporting period		**Executive Owner: Director of Operations**	
Mapping Against 4 Harms of COVID		**Update**	
		July 2022 The Health Board continues to work alongside the Delivery Unit to maximise discharges, this includes engagement with Senior Nurses, discharge co-ordinators and relatives/family members. Continued population engagement on accessing most appropriate services, at the right place, at the right time and teams at the GUH are continuing to have sensitive conversations with family members regarding discharges. A number of Health Board initiatives are underway and regular reviews are undertaken to understand benefits and extract learning. SDEC care currently being delivered in Respiratory and Gastroenterology with the potential to increase patients being treated there if pts can be streamed from Flow Centre. Build has commenced for dedicated SDEC in GUH site that will incorporate surgery and acute medicine in Summer of 2022. The Clinical Operating Model for SDEC at GUH is being refined, workforce recruitment and on-boarding plans developed. Orders for the equipping of the facility have been progressed to capitalise on the funding that has been allocated by WG; to be committed this Financial Year. Outcome of System Re-set weekend – significant system benefits were seen over the weekend and this was down to a number of factors. The outcome of the weekend currently in the process of being typed up and to be shared with the Exec team about what we should prioritise for WF supply and embed in our system over winter and beyond. In particular initiatives that work included (but is not exhaustive): • 7 day cover for pharmacy and therapies • Input of home first on the weekend • Growing team of Physicians Associates to support discharge • Focus on discharge not step down • GUH Frailty model Escalation plan agreed at Executive Team December 2021. Continues to embed and implement – table top exercise planned for Spring 2022. Holly Ward – step closer to home facility enabled w/c 24th Jan 2022. It is important to note that this risk profile should be reviewed and considered in conjunction with ***CRR002 (Workforce)*** and cross reference to ***CRR013 (IPAC)***	

	Resource/staffing capacity has been significantly impacted particularly at ED and MAU due to infection outbreaks and ward closures.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22	**Risk Description, Appetite and Decision**
Priority 1 – Every child has the best start in life **Priority 2- Getting it right for children and young adults**	***CRR028 – (June-2021)*** ***Risk of:*** **-** Continued inappropriate admissions of children aged under 18 to acute adult mental health wards. Particularly where admissions are of under 16-year-olds, are for longer than 72 hours and/or are not compulsory detentions under the Mental Health Act. ***Due to:*** Inability to access appropriate acute/crisis beds for this age group in the region **TREAT**
	Impact Ineffective and poor patient experience potentially leading to poorer patient outcomes. Reputational and possible financial damage if Health Board unable to provide adequate levels of service provision for this cohort of patients.

High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Staff Well Being	**Risk Appetite**	**Moderate (cautious risk taking)** **Risk Appetite** **Level 3**
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**	
Patient Quality, Safety and Outcomes Committee	• Policy in place for the use of adult MH beds for up to 72 hours. • Designated bed in Extra Care Area	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***	**Current** ***Risk level after initial controls/mitigations have been implemented.***	**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***

	• C&YP aged under 16 are nursed 1:1 and are prevented from mixing with other patients on the ward. • If YP is detained under the Mental Health Act, the safeguards inherent with this legislation apply.						
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	4	5	2	5
CAMHS is working with partners to develop Crisis support for C&YP which will include crisis beds.	Ongoing	**20**		**20**		**10**	
Trend							
Mapping Against 4 Harms of COVID		**Update**					



Executive Owner: Director of Operations

July 2022

It should be acknowledged that this risk is part of a broader National risk in relation to children who present to acute services in crisis. The Health Board continues to work with Welsh Government on a National level to develop plans to mitigate this risk.

Although it is acknowledged that this is an issue for the Health Board as it has already been realised, it remains a continuing risk not only to the Health Board but across Wales and as a result CAMHS has over the last few years created and extended their liaison response and crisis outreach response which is evidenced to have reduced self-harm and suicide and diverted children, young people from hospital with a reduction in bed use in spite of the increase in crisis presentation. CAMHS is also looking at further enhancements building on weekend cover, particularly boosting the out of hours cover and ongoing work with key stakeholders:

a) At a meeting with Gwent Local Authority Heads of Children's Service on Monday 06 September 2021, we agreed to develop a guide document in relation to the support of Children's Crisis Admission (these are children classed as a delayed discharge from hospital on social grounds).

b) As part of the agreement, CAMHS and the 5 Gwent Local Authority Heads of Children's Service agreed to a shared responsibility for keeping the child/young person safe in hospital (previously this had been the sole responsibility of ABUHB/CAMHS).

c) CAMHS and the 5 Gwent Local Authority Heads of Children's Service also agreed to explore a medium to long term plan of providing psychosocial support to children and young people in the community as an alternative to hospital admission.

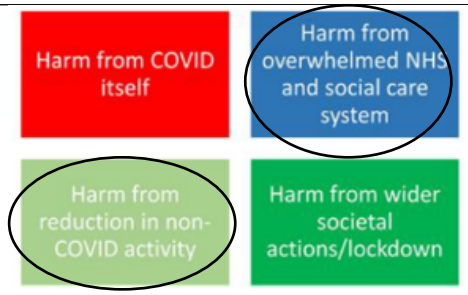
d) CAMHS received an investment of £500k non-recurring in 2021 towards management of crisis admissions that will be utilised in partnership with ABUHB colleagues and Gwent Local Authority Heads of Children's Service, to meet crisis bed requirements.

e) The convening of a pathway group between ED and CAMH's to ensure there is an agreed protocol and escalation should these patients present

	Further developments are underway currently working with Works Estates to establish a CAMHS Crisis Rapid Assessment Centre and Intervention at the St Woolos site. The site will aim to provide: • A safe space for young people struggling with emotional distress to be able to access skilled support on an ad hoc basis, as opposed to attending ED • The Centre will aim to reduce hospital admissions and emergency presentations by providing practical, therapeutic interventions. • Young people who have been assessed by CAMHS emergency liaison team and who are awaiting discharge can attend the centre to wait safely and securely for transport. CAMHS are presently in the early stages of developing a plan with help from Hannah Capel, Capital Projects/Planning and Justin Jones from Works and Estates. A schedule of accommodation has been drafted, identifying the number of rooms, functions, access and specification required to ensure the accommodation is fit for purpose. As the site has been unused for a significant amount of time, it will require a full renovation that is likely to be completed in two phases, 2022/23 onwards. A PPD has been drafted and awaiting further details re costings and proposals for the project Ie tendering works and contractors.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		**Risk Description, Appetite and Decision**	
• **Getting it right for children and young adults** • **Supporting adults in Gwent to live healthy and age well** • **Provide high quality care and support for older adults** • **Staying healthy** • **Care closer to home** • **Less serious illness which require hospital care**		***CRR023 – (May 2020)*** ***Risk of: Unknown or unmet non-COVID harm across population health*** ***Due to: Priority being given to management of the COVID pandemic*** **TREAT**	
		Impact Potential significant longer-term impact across the whole of the healthcare system due to patients presenting with more acute disease/illnesses thereby creating more reliance on the Health Board. Could also lead to higher levels of Health Inequalities and detrimentally impact on patient experience, outcomes and levels of public confidence.	
High Level Themes	• Population health • Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Finance	**Risk Appetite**	**Low (averse to risk)** **Risk Appetite** **Level 2**

Committee Assurance	Internal Controls – Policies/Procedures	Risk Score					
Patient, Quality, Safety and Outcomes Committee	• Departmental repurposing and redesign to accommodate non-COVID activity has occurred. New ways of working adopted e.g. virtual reviews. Nosocomial Group operating, providing advice and support. • Adapt and sustain progress being monitored through Exec Team meetings via Director of Operations. • Plan in place for for green recovery (treatments) RGH – all specialities excluding orthopaedics • Orthopaedic operating at OSU and NHH (P2) • Outpatient Steering Group • Robust escalation reporting and escalation arrangements within primary and community services division.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	4	5	4	5
Early recovery plan agreed focusing on Cancer, 52 weeks, Follow Up waits, Diagnostic and Therapies waiting times, and Eyes Care. Formal recovery plan for 2022/23 being developed as part of the Annual Plan. Focus on new ways of working will be fundamental to the approach. Risk stratification and validation of lists is ongoing and focus is on Urgent and Cancer work. Weekly tracking of recovery plus tracking of new ways of working in place, the priorities outlined above mirror those in F&T with similar work progressing operationally around risk stratification, validation, daily scrutiny of cancer pathways, WLI OPD sessions for clinically urgent patients, maximising PAC and theatres and on a transformational level, redesigning of services.	Mar-22 Mar-22	**20**		**20**		**20**	
Trend		**Executive Owner: Director of Operations and Director of Primary Care, Community and Mental Health**					
Mapping Against 4 Harms of COVID		**Update**					



July 2022

Prioritisation for use of capacity is as follows:

- Cancer, suspected cancer, and urgent, for new outpatients (R1 for ophthalmology) for all surgical and non-surgical specialities including therapies
- Suspected cancer, urgent and routine for diagnostics (due to the number of cancer cases that arise from routine tests)
- New urgent and routine outpatients over 52 weeks
- Patients waiting for a new outpatient appointment over 104 weeks
- 100% delayed Follow-up outpatients
- Adhering to the surgical prioritisation during the coronavirus pandemic (Version 2 – June 2020 – P1a, 1b, 2, 3 and 4), as well as the separate guidance in terms of obstetrics and gynaecology (RCOG) and ophthalmology (RCOphth):

Continued use and expansion of Consultant Connect – Specialist Advice Service.

Trajectories in terms of ministerial target delivery being completed.

Outpatients

Continued contact of patients 26 weeks and over on new outpatient waiting list plan for 22/23 to establish if they still require the appointment.

SoS and PIFU implementation plan developed for 22/23.

Ongoing clerical validation of both outpatient and treatment waiting lists.

Social distancing requirements stopped in opd and templates increased accordingly.

New outpatient one stop treatment unit at RGH – monies obtained from WG for recurring staffing/consumable requirements. Task and finish group in situ to undertake implementation of Unit – Quarter 3.

Use of E:Advice automated system to go live in Quarter 3.

Outpatient speciality transformational plans complete and trackers in place to monitor delivery and impact on activity and financial impacts.

Treatments

Pathway changed from use of PCR to LFDs.

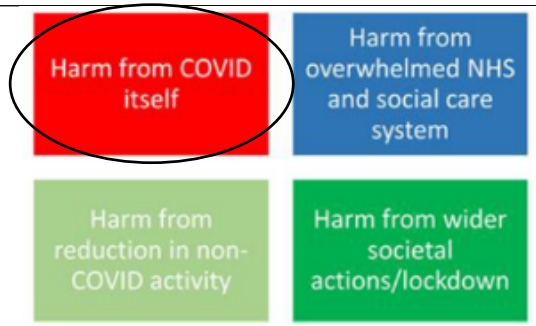
Primary and Community Services

- A Restart & Recovery Programme has been developed in primary care, including prioritising the areas of greatest concern / backlog from a primary care perspective. A Restart & Recovery Working Group has been

	established to oversee the work and now meets fortnightly. This Programme has since widened to include key priorities over winter, where we know that staff time will need to be prioritised but also where continued backlog / suspension of services is likely to have a significant impact if not addressed. The programme plan for this is attached. A mechanism for monitoring and reporting activity in primary care has been developed since the beginning of the pandemic and ABUHB is the only HB in Wales with this level of intelligence. This has now been supplemented with a more detailed assessment of one week's activity in primary care, which is currently being analysed in preparation for being presented to the Executive Team. This information is being used to assess the variation in practice activity / operational models during the pandemic and now. A summary of this data is now included in our weekly performance report and monthly performance briefing – latest versions of both attached for assurance. This shows that activity in primary care has steadily been increasing with more and more F2F contacts being performed.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22	Risk Description, Appetite and Decision
• Less serious illness that require hospital care • Providing high quality care and support for older adults	***CRR013 – (Jul-18)*** ***Risk of:*** Widespread hospital and community harm, with potential increase in demand and acuity of hospital or community acquired infections. ***Due to:*** Failure to effectively manage community and hospital transmission of Health Care Acquired Infections (HCAIs) to include COVID 19. **TREAT**

		Impact Potential impact on staffing, resources and infrastructure of an already pressured acute hospital system. Further potential impact on Primary and Secondary care services if need in communities are not managed.						
High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence	**Risk Appetite**		**Low (averse to risk)** **Risk Appetite** **Level 2**				
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**						
Patient, Quality, Safety and Outcomes Committee	• Robust internal policies • Multiple SOPs	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***		
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	
		3	5	2	5	2	5	
Reducing nosocomial transmission group (RNTG) which is clinically led, reports to Executive Team weekly. COVID hospital transmission implementation plan is in place, recently updated to include the Hierarchy of Controls and with frequent auditing and monitoring. Organisational thermometer updated to reflect community prevalence Ongoing monitoring of the Clostridium Difficile rapid implementation plan via RNTG	Ongoing	**15**		**10**		**10**		
Trend		**Executive Owner: Director of Nursing**						
Mapping Against 4 Harms of COVID		**Update**						



July 2022 COVID-19

There continues to be an ongoing community prevalence of COVID-19, which has impacted on patients presenting to hospitals with COVID-19 and onward hospital transmission. Currently there are 5 wards in outbreak across the ELGH and community hospitals which is a significant reduction. Each outbreak has undergone a thorough root cause analysis, essential to understand the transmission of COVID-19 and focus on improvement. Each outbreak has been reported to Welsh Government, index cases have been identified on five-day inpatient testing. In addition to the outbreak RCA mortality reviews are undertaken for patients who have died within 28 days of a probable and definite hospital acquired Covid-19 acquisition.

The Health Board (HB) has an established Covid pathways supported by single room hospitals. This assists in reducing the risk of COVID-19 transmission and is in-line with the recommendations contained in the hierarchy of control risk assessment.

The HB currently implements admission and inpatient five-day testing to identify asymptomatic carriers. It also supports the testing for other winter respiratory infections such as RSV and Influenza. This will change in April in line with National Guidance and revised National Alert Level

There have been several care/residential homes reporting outbreaks of Covid-19 across the ABUHB footprint. IPT have continued to provide support and advice.

The HB has a robust visiting policy which is regularly reviewed and updated in-line with Welsh Government “visiting with a purpose” guidance. LFD testing for all visitors continues to reduce the risk of COVID-19 transmission, with a revised visiting policy in train.

All standard operating procedures and policies relating to COVID-19 are discussed and ratified at the reducing nosocomial transmission group (RNTG). The isolation period of exposed patients and for outbreak management from 10 to 7 days was recently agreed, recognising a whole system approach to risk is essential.

Staff risk assessments have been developed and are regularly updated in line with WG guidelines, to support safe return to work when exposed to a positive case and have been identified by trace and protect or recent international travel.

Clostridium Difficile

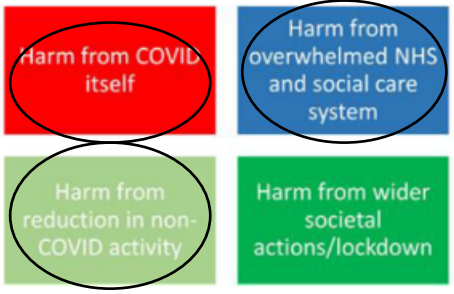
Clostridium Difficile within ABUHB continues to exceed the Welsh Government reduction expectation target which mirrors all Wales trajectory. Recent months have seen a slightly improved picture. Last year an implementation plan was developed incorporating all key principles required for the reduction and management of Clostridium Difficile reflecting national guidelines. This continues to form a key agenda item with RNTG with a particular focus on antimicrobial stewardship, fundamental infection prevention principles and hospital cleaning.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22	Risk Description, Appetite and Decision
• **Getting it right for children and young adults** • **Supporting adults in Gwent to live healthy and age well** • **Provide high quality care and support for older adults** • **Staying healthy** • **Less serious illness which require hospital care**	***CRR001 (Mar-2016)*** ***Risk of:*** co-infection with flu and COVID-19 leading to avoidable illness, hospitalisations and deaths. ***Due to:*** poor uptake of flu vaccination among Health Board staff, primary school-age children, and patients aged 65 and over and people under the age of 65, staff in care homes **TOLERATE** **TREAT**

		Impact Potential impact on all services with increased hospital admissions and primary care presentations if vaccinations are not undertaken in line with guidance and recommendations.						
High Level Themes	• Partnership • Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence	**Risk Appetite**		**Moderate (cautious risk taking)** **Risk Appetite** **Level 3**				
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**						
Patient Quality, Safety and Outcomes Committee	• Seasonal flu action plans implemented in primary care (including care home staff), schools and for Health Board staff. • Community Flu Group meets fortnightly. • Staff flu group meets fortnightly. • Campaign to increase staff uptake launched mid-September involving Flu champions, Divisional Flu Leads, clinical leaders, team managers and team leaders • Flu uptake monitored weekly and Health Board staff uptake newsletter, produced and disseminated weekly. • Staff flu vaccine uptake rate as of 31st March 2022 was 58.16% As at 15th March the flu vaccination uptake among those 65 years and older and in clinical risk groups aged 6 months to 64 years was the highest in Wales at 79.9% and 53.6% respectively compared to All Wales average of 77.9% and 48.2%. Uptake among 2 and 3 year olds was 50.4% which is higher than All Wales average of 47.6%.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	4	2	4	2	4

• An internal audit of the ABUHB Flu vaccine programme was undertaken in March 2022. It provided substantial assurance on two assurance objectives and reasonable assurance on the remaining three objectives. • This audit report identified matters requiring management attention such as reviewing the TORs of the Staff Flu Working Group, more availability of communication materials, and more availability of flu clinics for staff. • The Health Board will be holding annual Staff Flu Vaccine planning event for 2022-23 in May 2022 and the audit recommendations will be considered in the next year planning. • Staff flu immunisation programme 2022-23 will be presented at the Exec Team meeting in August/September 2022. • NCNs will be reviewing this year's flu season to identify effective approaches to maximise uptake through cluster based delivery models in 2022/23. This will focus on 2 and 3 year olds, at risk clinical groups and care home staff. The NCN plans will also be informed by the results of this year's internal audit report. • The PCCS Division will be undertaking a stocktake of vaccine ordering across GP practices and community pharmacy to assess the level of vaccine supply for next year's flu season. There is currently uncertainty from WG about whether the 55 to 64 year old and secondary school aged cohorts will be recommended by the CMO. This may result in delays in ordering and is a current risk within the system as it will result in late delivery dates during next year's flu season. • There are ongoing discussions with LMC in regards to the logistics of the flu and COVID-19 booster campaign which is likely to be a blended approach between primary care and the MVCs during the Autumn 2022 campaign. • During the Spring and Summer 2022 there will be early planning for an on-site delivery model for vaccination of care home staff through liaison between Responsible Individuals, Care Home Managers and Community Pharmacies. • During next year's flu campaign GP practices will be asked to use the personalised letter piloted last flu season to maximise uptake among 2 and 3 year olds • NCNs will be asked to consider alternative delivery models to increase uptake in 2 and 3 year olds which may include working with pre-school providers or an MVC type model to reduce barriers to access for parents. • NCNs will also be asked to consider a more collegiate approach between GP practices and Community Pharmacies to reach those in at risk clinical groups who have not previously taken up the offer for flu vaccination.	Aug-2022	**16**	**8**	**8**

Trend		Executive Owner: Director of Public Health and Strategic Partnerships
Mapping Against 4 Harms of COVID		**Update**



July 2022

Vaccine uptake in primary care

Summary by Health Board and Local Authority (15mar2022)

		Children 2 to 3 years			Clinical risk 6m to 64y			65y and older		
		Denominator	Immunised	Uptake (%)	Denominator	Immunised	Uptake (%)	Denominator	Immunised	Uptake (%)
Aneurin Bevan UHB	Blaenau Gwent	1,526	834	54.7%	11,487	6,026	52.5%	14,462	11,057	76.5%
	Caerphilly	3,829	1,895	49.5%	27,220	13,879	51.0%	37,393	29,273	78.3%
	Monmouthshire	1,752	1,191	68.0%	13,118	8,293	63.2%	25,893	22,154	85.6%
	Newport	3,901	1,811	46.4%	22,049	11,535	52.3%	27,338	21,560	78.9%
	Torfaen	2,046	847	41.4%	14,761	7,744	52.5%	20,021	15,977	79.8%
	AB Total	13,054	6,578	50.4%	88,635	47,477	53.6%	125,107	100,021	79.9%
Wales	Wales	64,785	30,839	47.6%	443,895	213,782	48.2%	690,189	537,721	77.9%

Monmouthshire had the highest uptake across all LAs in wales for all four groups creating an opportunity to learn from and share what worked well through ABUHB NCN networks.
Health Visitors have been actively promoting flu immunisation for those aged 2 and 3 years since January but this has not translated into a significant increase in uptake.

Vaccine uptake in school age children

Final uptake figures are now available. All the school sessions including mop up sessions were completed by the end of January 2022 and numbers submitted. Local figures show the School Health Service have given 50,722 vaccinations across all the schools with 66% uptake in Primary Schools and 57% in Secondary Schools. Evaluation on this year's programme in being undertaken and a staff and school survey received a good response in gathering feedback in order to improve delivery and uptake next year.

Vaccine uptake in Health Board staff

Uptake for ABUHB staff with direct patient contact was 57.4% (as at 15/02/2022) which is in line with the Wales average. A staff flu immunisation programme recovery programme started on 25/01/22 with a 'it is not too late' message to staff yet to have their flu vaccination followed by a range of measures to promote the vaccination and make it easy for staff to access it. Clinics will cease at the end of March.

As at 22/02/22 the 7 day rolling rate of transmission of COVID-19 in the ABUHB area increase to 460.3/100,000 (Wales 416.1 / 100,000) with 8.7% of tests being positive. If rates of COVID-19 remain high and influenza starts to circulate in Wales, as expected by the CMO, there will be an increasing risk of patients being seriously unwell with COVID-19 and

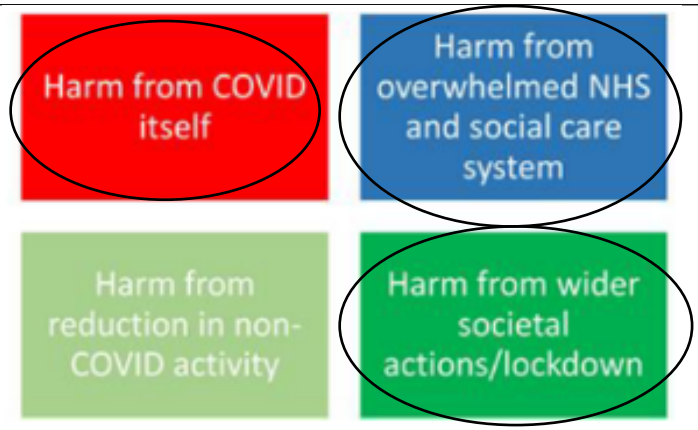
	influenza at the same time. Public messaging about personal behaviours to reduce risk of infection with COVID-19 – hands, face, space, ventilation – will also reduce the risk of infection with influenza. **Welsh Health Circular (WHC) 2021 019 on The National Influenza Vaccination Programme**  04-08-2021_Welsh Government - ...

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22	**Risk Description, Appetite and Decision**
Priority 2- Getting it right for children and young adults **Priority 3 – Adult in Gwent live healthy and age well** **Priority 4 – Older adults are supported to live well and independently**	***CRR027 (June - 2021)*** ***Risk of:*** new COVID variants emerging ***Due to:*** significant and sustained spread of disease culminating in the effectiveness of COVID-19 vaccination and booster programme being compromised **TREAT** **TOLERATE**

		Impact Potential impact on ability to staff services appropriately, also leading to widespread disease and harm in communities, eventually impacting on Health Board services, Primary, Secondary and Tertiary).		
High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Staff Well Being	**Risk Appetite**	**Moderate (cautious risk taking)** **Risk Appetite** **Level 3**	
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**		
Patient Quality, Safety and Outcomes Committee	• Continuation of data, surveillance, and monitoring activities to inform any deterioration from 'Covid Stable' to 'Covid Urgent' (as per WG national policy), as could be triggered by emergence of a new variant, and initiate standing up of IMT arrangements as necessary e.g.: ▪ Local IMTs controlling clusters and outbreaks and keeping cases as low as possible (standing up / frequency of local IMT arrangements are determined by local need – *however, data and surveillance information outlining the epidemiological situation continues to be shared on a routine basis and escalated as necessary).* ▪ Gwent IMT – *a handover and governance certificate has been produced to transfer Gwent IMT's key responsibilities (including ongoing surveillance, analysis and impacts of Covid-19) to the Gwent, Test, Trace Protect*	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***	**Current** ***Risk level after initial controls/mitigations have been implemented.***	**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***

	Leadership Group and the Gwent Local Resilience Forum Human Infectious Diseases Group • Keeping abreast of guidance from WG. • Continuing public messaging on adherence to restrictions. • Vaccination Programme Board monitoring roll-out of programme weekly. Transitioning of the Gwent Test, Trace, Protect Service – with a focus on vulnerable settings including Health and Social Care - into a Health Board and Single Host LA model (Caerphilly County Borough Council) during Q1 2022/23 until at least 31st March 2023. The Health Board component of the Service will be led by a Consultant in Public Health and consist of: ▪ Regional Cell Delivery Team (programme and project management expertise, business support and administration) ▪ Public Health and Protection Team (specialist public health expertise, clinical expertise, and contact tracing teams) ▪ Data & Surveillance Team (epidemiology and data analysis expertise)						
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		5	5	4	5	4	5
When standing, Gwent IMT leads on multi agency response to manage community response. Sit reps (SBAR) to WG are submitted on a routine basis when required *(stood down as of February 2022)* or on an exceptional basis. Gwent IMT involves representatives from 5 x Local Authority Directors of Public Protection, ABUHB Director of Public Health, & Public Health Wales Health Protection.	Monitored weekly at present	**25**		**20**		**20**	

Gwent IMT & Gwent, TTPS delivery and management of National VAMC guidance, regional testing plans etc. Gwent IMT has handed over to GTTPS Leadership and Gwent LRF HIDG as described above under controls. The Wales Outbreak Control Plan and the Gwent Covid-19 Prevention and Response Plan describe the operational 'response model' moving forward and the IMT will be reinstated if necessary in accordance with those arrangements. It is noted that there is a commission from Welsh Government to Public Health Wales to review the Wales Outbreak Control Plan and that the Gwent LRF Human Infectious Diseases Group is to review the Gwent Covid-19 Prevention and Response Plan The Gwent Test Trace Protect Service Leadership Group is the key partnership body established to lead and guide the TTP service established in the face of the Covid-19 pandemic and will continue in this role as the service transitions to an Integrated Health Protection Service. Transitioning of GTTPS to facilitate ongoing Covid-19 response where required, inclusive of Data & Surveillance capabilities to inform the need for any escalation of the Health Board response.				
Trend since last reporting period		**Executive Owner: Director of Public Health and Strategic Partnerships**		
Mapping Against 4 Harms of COVID		**Update**		



July 2022:

The Omicron variant spread rapidly around the world in December 2021 with control measures having little effect on slowing spread down due to it being much more transmissible than previous variants. The easily transmissible sub-variant of Omicron, called BA.2, now appears to be causing most cases. Recent easing of restrictions and waning immunity from the vaccines could be factors behind the rise too.

Experience to date shows that the Omicron variant has resulted in a much lower rates of serious illness than previous waves, due to high levels of vaccine induced population immunity (realised risk) and the variant itself causing less serious illness (inherent risk). However, there has been an increase in hospitalisations in recent week particularly in older age groups. It is hoped that future variants of COVID-19 will also have a lower inherent risk of serious illness and that vaccines will be equally effective (realised risk), but that is by no means certain. The risk of a future variant being both highly transmissible and having a higher inherent risk of serious illness than Omicron remains a very real risk.

On 4th March 2022 Welsh Government published their transition plan 'Together for a Safer Future: long-term COVID-19 transition from pandemic to endemic' which recognises that vaccination and treatments are our best future defence. Together for a Safer Future sets out two future planning scenarios – Covid Stable and Covid Urgent. Covid Urgent is premised on a new variant that has a high level of vaccine escape or other advantages that puts large numbers of people at risk of severe illness (similar to the Alpha wave in Dec 2020). If this scenario were to arise in the future it would require all of us to work together to reintroduce protective measures.

The ABUHB COVID-19 mass vaccination programme has given over 374,337 booster vaccinations. The programme continues to provide first, second and third doses of the COVID-19 vaccination in line with JCVI guidance and WG policy for all relevant age groups. Last month Welsh Government announced the Spring booster programme for over 75s, care home residents and immunosuppressed. The Spring booster has recently commenced through the MVC model for over 75s and immunosuppressed with mobile vaccination crews vaccinating care home residents (starting on 21/03/22). Welsh Government have also confirmed that Wales will be providing a universal vaccination offer to 5-11 year olds which started on the 10/02/2022 and is also being delivered through the MVCs.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality, Safety & Outcomes Committee Tuesday 16th August 2022 Agenda Item: 3.12

Aneurin Bevan University Health Board

PATIENT QUALITY, SAFETY & OUTCOMES COMMITTEE WORK PLAN

Executive Summary			
The Patient Quality, Safety and Outcomes Committee is asked to receive the draft Committee work plan appended to this report. The work plan has been developed to enable the Patient Quality, Safety and Outcomes Committee to fulfil its Terms of Reference as agreed by the Board in March 2022.			
The Board 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: Rani Mallison, Director of Corporate Governance			
Report Author:			
Report Received consideration and supported by :			
Executive Team	**X**	**Committee of the Board**	
Date of the Report: 25th July 2022			
Supplementary Papers Attached: **Appendix 1 – Committee Work Plan**			

Purpose of the Report

The draft Committee work plan outlines the key items for business, legislative requirements as outlined within the Health Board Standing orders which enables the Patient Quality, Safety and Outcomes Committee to discharge its responsibilities appropriately and on behalf of the Board.

Background and Context

The scope of the Patient Quality, Safety and Outcomes extends across the full range of Health Board business and encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and

commissioned services of the Health Board. The Committee embraces the Health and Care Standards as the Framework in which it fulfils its purpose.

In line with good governance practice, a committee work plan has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The work plan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting function.

Assessment and Conclusion
The Committee is requested to approve the Committee work plan as outlined in **Appendix 1** noting that the work plan will be presented at each Committee meeting for oversight and noting. The work plan will be used to inform Committee business alongside the Board Assurance Framework which would seek to highlight areas of limited or reduced gap in assurance.

Recommendation
The Committee is requested to: • **RECIEVE** and **APPROVE** the proposed Committee work plan and **NOTE** that it will be brought forward to each future Committee meeting for oversight. • **AGREE** to reference and utilise the Committee work plan to inform agendas and items for discussion in conjunction with the Board Assurance Framework.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	This report has no financial consequence.
Quality, Safety and Patient Experience Assessment	This report has no QPS consequence.
Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact.
Health and Care Standards	This report contributes to the good governance elements of the H & CS.
Link to Integrated Medium Term Plan/Corporate Objectives	The objectives will be referenced to the IMTP

The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering how the business of the Committee aligns to the WBoFG Act.
Glossary of New Terms	Not required.
Public Interest	Report to be published.

PATIENT QUALITY, SAFETY & OUTCOMES COMMITTEE
PROGRAMME OF BUSINESS 2022/23

The scope of the Patient Quality, Safety & Outcomes Committee extends to the full range of ABUHB responsibilities. This encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. The Committee will embrace the Health and Care Standards as the Framework in which it will fulfil its purpose

This Annual Programme of Business has been developed with reference to:

- the Committee's Terms of Reference as agreed by the Board in March 2022;
- the Board's Assurance Framework (based on its Annual Objectives for 2021/22 and 2022/23);
- delivery of the Board's Experience, Quality & Safety Objectives set out within the IMTP 2022-25;
- key risks identified through the Corporate (Strategic) Risk Register and Operational Risk Registers.
- audit and regulatory reports identifying weaknesses in internal control (following consideration by the Audit, Risk and Assurance Committee); and
- key statutory, national and best practice requirements and reporting arrangements.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	April 2023
Preliminary Matters									
Attendance and Apologies	Standing Item	Chair	✓	✓	✓	✓	✓	✓	✓
Declarations of Interest		All Members	✓	✓	✓	✓	✓	✓	✓
Minutes of the Previous Meeting		Chair	✓	✓	✓	✓	✓	✓	✓
Action Log and Matters Arising		Chair	✓	✓	✓	✓	✓	✓	✓
Committee Requirements as set out in Standing Orders									
Development of Committee Annual Programme of Business 2022/23	Annually	Chair & Director of CG			✓				
Review of Committee Programme of Business	Standing Item	Chair			✓	✓	✓	✓	✓
Annual Review of Committee Terms of Reference 2022/23	Annually	Chair & Director of CG						✓	
Annual Review of Committee Effectiveness 2022/23	Annually	Chair & Director of CG							✓
Committee Annual Report 2022/23	Annually	Chair & Director of CG							✓
Quality Domain: Safe Care									
Pharmacy and Medicines Management Annual Report	Annually	Medical Director						✓	
Internal Audit Review: Medicines Management (Reasonable Assurance) – Update on actions	Annually	Medical Director						✓	
Learning from Death Report	Bi-Annually	Medical Director		✓			✓		
Cleaning Standards Annual Report	Annually	Director of Operations						✓	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	April 2023
Nutrition and Hydration Annual Report **(Oct 2022 to include responses to Actions: 1910/13 & 2112/04)**	Annually	Director of Therapies & HS				✓			
Falls Prevention and Management Report	Bi-Annually	Director of Therapies & HS				✓			✓
Health and Safety Compliance Report	Annually	Director of Therapies & HS				✓			✓
Safeguarding Annual Report	Annually	Director of Nursing				✓			
Safeguarding Group Highlight Report	Quarterly	Director of Nursing			✓		✓		✓
Operation Jasmine Action Plan **(Feb 2023 to include response to Action: 0706/13)**	Bi-Annually	Director of Nursing		✓				✓	
Children's Rights & Participation Forum	Bi-Annually	Director of Nursing				✓			✓
Infection Prevention and Control Annual Report	Annually	Director of Nursing			✓				
Infection Prevention and Control Report	Quarterly	Director of Nursing			✓	✓		✓	
Blood Management Annual Report	Annually	Medical Director					✓		
Organ Donation Annual Report	Annually	Medical Director						✓	
Quality Domain: Effective Care									

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	April 2023
Quality Assurance Framework Annual Review and Evaluation of Progress	Annually	Clinical Executives				✓			
Commissioning Assurance Framework, Development and Implementation	Bi-Annually	Clinical Executives					✓		
Clinical Effectiveness and Standards Committee Report	Bi-Annually	Medical Director				✓			✓
Annual Clinical Audit Plan (prior to ratification) by the Audit, Risk & Assurance Committee	Annually	Medical Director			✓				
Clinical Audit Activity Report (Local and National)	Quarterly	Medical Director			✓		✓		✓
Quality Improvement Annual Report	Annually	Director of Public Health							✓
Research and Development Annual Report	Annually	Director of Public Health							✓
Medical Devices Annual Report	Annually	Director of Therapies & HS					✓		
Point of Care Testing Annual Report	Annually	Director of Therapies & HS					✓		
GIRFT Stroke Review **(Oct 2022, Action: 0706/12.2)**	Ad-hoc	Director of Therapies & HS				✓			
Quality and Safety Outcomes Report	Standing Item	Clinical Executives	✓	✓	✓	✓	✓	✓	✓
Committee Risk Report, including BAF	Standing Item	Director of Corporate Gov	✓	✓	✓	✓	✓	✓	✓
WHSSC QPS Committee Report	Standing Item	Director of Nursing	✓	✓	✓	✓	✓	✓	✓
Quality Domain: Dignified Care & Individual Care									

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	April 2023
Patient Story	Standing Item	Clinical Executives	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Putting Things Right Policy	Every 3-yrs (2022)	Director of Nursing				✓			
Putting Things Right Reporting (complaints, compliments, and redress)	Standing Item[1]	Director of Nursing	✓	✓	✓	✓	✓	✓	✓
Quality & Engagement (Wales) Act, Preparedness and Implementation	Annually	Director of Nursing				✓		✓	
Patient Experience Report	Quarterly	Director of Nursing		✓			✓		✓
Dementia Care Annual Report	Annually	Director of Nursing							✓
Clinical Negligence Claims and Coroners Inquests Report	Bi-Annually	Director of Nursing				✓			✓
Patient Safety Incidents and Learning	Standing Item[2]	Director of Therapies & HS	✓	✓	✓	✓	✓	✓	✓
Covid-19 Concerns and Claims **(Feb 2023 to include responses to Actions: 0706/08)**	Bi-Annually	Director of Nursing		✓				✓	
Service Specific Deep-Dive Assurance Reviews									
Learning Disabilities	Annually	Director of PCCMH			✓				
Urgent and Emergency Care Demand and Impact on Outcomes	Quarterly	Director of Operations			✓		✓		✓

[1] Via Quality and Safety Outcomes Report
[2] Via Quality and Safety Outcomes Report

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	April 2023
Maternity Services: Organisational Self-Assessment and Action Plan	Bi-Annually	Director of Nursing		✓		✓			
Child and Adolescent Mental Health Crisis Hub and Safe Accommodation	Annually	Director of Nursing							
Self-Harm & Suicide - Children & Young People	Annually	Director of Nursing							
Independent Audit, Regulation and Inspection									
Internal Audit Reports relevant to the remit of the Committee	Ad-hoc	Clinical Executives	As scheduled within the Annual Internal Audit Plan						
External Audit Reports relevant to the remit of the Committee	Ad-hoc	Clinical Executives	As scheduled within the Annual External Audit Plan						
Action Plan for "*Review of Quality Governance Arrangements*" Audit, Wales Review (2021/22)	Bi-Annually	Clinical Executives		✓			✓		
Internal Audit Review - Quality Governance arrangements for the commissioning of NHS Continuing Care within the Mental Health & Learning Disabilities (limited assurance) – Action Plan Update	Bi-Annually	Director of Primary, Community Care & Mental Health			✓			✓	
Internal Audit Review – Medical Devices – Action Plan Update	Bi-Annually	Director of Therapies & HS			✓		✓ (linked to Annual Report)		
Overview of Audit Recommendation Tracking (relevant to the Committee)	Quarterly	Director of Corporate Gov			✓		✓		✓
Inspections of Healthcare Inspectorate Wales	Ad-hoc	Director of Nursing	As published						

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	April 2023
Inspections of the Community Health Council	Ad-hoc	Director of Nursing	As published						
Tracking of Improvement Actions Arising from Inspections and Reviews **(Oct 2022 to include response to Action 0706/06.1)**	Quarterly	Director of Nursing		✓		✓		✓	
Healthcare Inspectorate Wales Operational Plan	Annually	Director of Nursing			✓				
Healthcare Inspectorate Wales Annual Report	Annually	Director of Nursing						✓	
ABUHB Final Response to HIW Unannounced Visit to GUH November 2021 and Compliance against actions **(Oct 2022- Action 0706/10.1)**	Ad-hoc	Director of Nursing				✓			
ABUHB Independent Assessment and Action Plan Based Upon findings of the *The Independent Review of Maternity Services at SATH (The Ockenden Review)* **(Oct 2022- Action 0706/11.1)**	Ad-hoc	Director of Nursing				✓			

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:	Patient Quality, Safety and Outcomes Committee
Reporting Period:	From the meeting held 13th July 2022 (held by Teams)

Summary of Key Matters Considered by QPSOG:

COVID-19 Concerns and Claims: The National Framework & Investigative Process

The group received an update summary report on the framework and process that the Health Board will be following.

Divisional Risk Registers/Concerns
The Divisional Quality and Patient Safety Leads were given the opportunity to escalate Divisional risks and concerns related to quality and patient safety.

The group had a specific discussion about challenges staffing additional surge capacity across our hospital sites, especially due to the reliance on non-substantive staff. The group received assurance on the mitigation in place to manage the risk but the Chair agreed to feed this concern into discussion happening at the Executive Team level about managing the current system pressures.

All the Divisional risks and concerns raised are included in the Divisional risk registers with information detailing the mitigation action being taken. The QPSOG was assured that the appropriate action is in place at Divisional level to address and mitigate the current risks to ensure the quality and safety of services. No risks were escalated for additional assistance from the QPSOG.

Quality, Patient Safety and Experience Report
A verbal report was presented and comments invited ahead of the formal report being prepared for presentation to the PQSOC meeting in August 2022.

Nutrition & Hydration Strategy Update
The group received a presentation on the progress made with the Nutrition and Hydration Strategy which sits against Health and Care Standard 2.5. The Chair welcomed the positive progress and informed the meeting that the Committee has requested an update on Standard 2.5 at the October meeting, and to include the outcome of the patient dining review.

Matters Requiring QPSC Level Consideration:
• Quality, Patient Safety and Experience Report (scheduled for PQSOC meeting in August 2022) • Progress Report on Standard 2.5 / Nutrition and Hydration Strategy, including the patient dining review (scheduled for PQSOC meeting in October 2022)
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: 14th September 2022

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality, Safety & Outcomes Committee Agenda Item: 4.2

Aneurin Bevan University Health Board

Healthcare Inspectorate Wales 2022 -2023 Operational Plan

Executive Summary

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. The remit of HIW is to look at the quality, safety and effectiveness of services being provided to people and communities, drawing attention to good practice, and highlighting practice that could cause harm to those who are receiving it.

ABUHB received and acknowledged receipt of the HIW programme of work for 2022 - 2023, defining its key deliverables and how they will be measured.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	√
Executive Sponsor: Linda Alexander	
Report Author: Linda Alexander	
Report Received consideration and supported by :	

Executive Team		**Committee of the Board [Committee Name]**	**PQSOC**
Date of the Report: June 2022			
Supplementary Papers Attached: Healthcare Inspectorate Wales 2022 – 2023 Operational Plan			

Overview

This year HIW have launched a Strategic Plan for the next three years, with the purpose of influencing and driving improvement across healthcare services in Wales.

This Operational Plan outlines priorities and actions over 2022 - 2023 to achieve its strategy effectively and efficiently. The deliverables within this plan set out key measurables of how HIW will meet actions and statutory duties. This includes a focus this year on driving and strengthening engagement, improving, and modernising ways of working and understanding communities better in relation to equality, diversity, and inclusion.

In response to the pandemic, HIW have been committed to evolve and adapt, and this strategic plan builds upon that work, to provide assurance about the quality and safety of the services HIW regulate and inspect.

Recommendation
PQSOC are requested to note contents of report.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

OPERATIONAL PLAN

2022 - 2023

CONTENTS

ABOUT US

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

We look at the **quality, safety and effectiveness** of the services that are being provided to people and communities, **drawing attention to good practice** where we find it and **calling out practice that could cause harm** to those who are receiving it. What matters to people and communities is core to what we do.

Healthcare exists for people and communities, and the work we carry out looks at whether it meets the **needs of a community** and whether it is of a **good quality.** Where we **find inequalities** in healthcare provision, where a service is not designed for the needs of the community it serves, **we will challenge this.**

Equality and diversity is embedded in the work we do and we consider how healthcare services reach those who face the greatest barriers to accessing quality healthcare.

Our responsibilities in relation to mental health span both the NHS and the independent sector. HIW also works with other review and inspectorate bodies to consider the **quality of healthcare** delivered in non-healthcare settings such as prisons.

OVERVIEW

Welcome to our Operational Plan for 2022 - 2023, this document sits alongside our Strategic Plan and outlines our priorities for the next year.

In our plan we will set out our programme of work for 2022 - 2023, defining our key deliverables and how they will be measured. We have set a challenging work programme for the year and, following a period in which there have been extraordinary pressures on our people, we will focus more than ever on supporting their wellbeing to enable them to provide the best possible service.

We welcome feedback, so please get in touch if you have any comments on our work or wish to feedback on healthcare services in Wales.

FOREWORD

Welcome to our Operational Plan for 2022 to 2023

This year we launched our Strategic Plan for the next three years, with the purpose of influencing and driving improvement across healthcare services in Wales.

This Operational Plan outlines our priorities and actions over 2022 - 2023 to achieve our strategy effectively and efficiently. The deliverables within this plan set out key measurables of how we will meet our actions and statutory duties. This includes a focus this year on driving and strengthening engagement, improving, and modernising our ways of working and understanding our communities better in relation to equality, diversity and inclusion. In response to the pandemic, we have continued to evolve and adapt, and this plan builds upon that work, so we can continue to provide assurance about the quality and safety of the services we regulate and inspect.

We have seen a period of significant change and this plan continues to support how we develop, to ensure we continue to monitor and check that people in Wales are receiving good quality healthcare. We have introduced many new ways of working to continue to fulfil our organisational functions, whilst being flexible to any emerging risks. People are at the heart of what we do, and it is important we strive to share lessons learnt, reflect on what has worked well and take forward this learning to continuously improve. We will continue to listen and support the wellbeing of our people to enable them and our organisation to do the best possible job and keep our communities safe and well.

We have set out a varied work programme for the year and we welcome any feedback, so please get in touch if you have any comments on our work or wish to feedback on healthcare services in Wales.

We want to deliver and drive improvements that make a real difference, and I am confident this plan will support us in doing this.

Alun Jones
Interim Chief Executive

PRIORITY 1

We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.

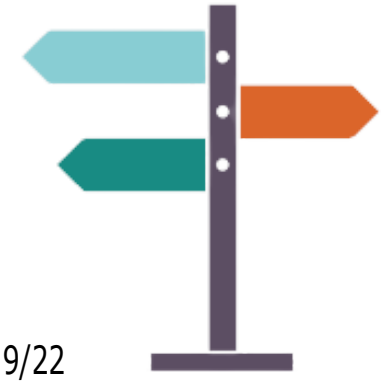
Actions

- We will consider the quality of care given to people during their time on a clinical pathway
- We will seek out opportunities to listen to people about what matters to them on their healthcare journey
- We will build on our approach to exploring care delivered both in and outside of a hospital setting, recognising that many people receive care in the community.

Year 1 Deliverables	Measured By	Outcome
Establish a stakeholder advisory group with diverse and inclusive representation	• Explore, build and maintain new working relationships with stakeholders who champion equality, diversity and inclusion considering the needs of the people who use healthcare services in Wales • Continually review and consult on the diverse representation within the group • Evaluate the impact of the group to ensure we are listening and communicating their views effectively to inform our work.	Stakeholder views will have helped to shape our work programme.
Increase the range of tools we have for engaging with people about our work	• Develop a toolkit exploring the different methods of engagement available • Improve how we establish and run focus groups • Introduce and review new and alternative engagement methods to target new audiences.	Our work will be supported by wider engagement opportunities which will increase our understanding of issues affecting a variety of people from diverse backgrounds.

Year 1 Deliverables	Measured By	Outcome
Develop a new methodology for carrying out onsite inspections of General Practices (GPs) which explores the wider primary care provision that GPs are part of in order to provide patient care	• Implementation of the new methodology framework that reflects the role of GPs within the wider primary care landscape • Roll out training on the new GP methodology for inspectors and peer reviewers • Number of GP inspections carried out using the new methodology • Obtain feedback from GP settings following inspections.	Our assurance work for GP practices will have explored the wider context within which GPs operate, providing HIW with a more holistic understanding of the primary care system and impact on patients.
Design options which enable patient pathways to be built into our inspection and assurance methodology and programme of work	• Produce a set of strategic principles to complement a risk-based approach to planning our programme of inspection and assurance methodology work • Patient journeys are considered at the point of planning.	Our work will have given greater consideration to the care delivered to patients within different parts of the healthcare system and how this impacts on their care overall.

Year 1 Deliverables	Measured By	Outcome
Review our quality assurance process for applications for registrations	• Circulate case studies of good practice and share lessons learnt • Review the quality of applications received against the revised standards.	Our registration work will provide a source of intelligence on the quality of newly registered providers, which will mean we can undertake assurance work on new services in accordance with risk.
Deliver a programme of national and local reviews which explores the quality of care delivered to patients during their time on a pathway.	• Deliver a national review of patient flow • Commence a national review of planned care • Deliver a local review of mental health discharge in Cwm Taf Morgannwg University Health Board • Commence two other local reviews • Commence a further joint review with Audit Wales of Cwm Taf Morgannwg University Health Board, to review progress from 2019 joint report on the health board's quality governance arrangements.	Our work will have explored national issues of high risk and delivered recommendations which improve the care delivered to patients in Wales.



PRIORITY 2

We will adapt our approach to ensure we are responsive to emerging risks to patient safety.

Actions

- We will build on the flexible models of assurance and inspection work that we developed during the pandemic, using all tools available to us to help us carry out our work
- We will use our internal intelligence function and our work with others to direct our work at areas of highest risk
- We will build on our engagement methods, so that we can communicate our messages quickly to drive improvement.

Year 1 Deliverables	Measured By	Outcome
Review our suite of inspection and assurance tools	• Formalise an approach to more complex offsite work • Strengthen our process for offsite assurance work • Evaluate the impact of offsite work.	Our assurance tools will enable us to be agile in the way we deploy our resources, targeting the level of risk with the appropriate assurance tools.
To actively share our findings and recommendations with stakeholders, service providers and the public to influence and drive improvements in healthcare	• Produce and establish a 'Quarterly Insight Bulletin' with a 'learning and insight' section • Develop and embed a new process within core business for the production and circulation of such learning bulletins • Review the number of bulletins issued and their engagement analytics • Development of a partnership section on the HIW external facing website to host such content.	Our findings and recommendations will have been shared regularly and promptly, helping contribute to improvements in healthcare services.
Consult and develop an Engagement Strategy to support us in our work 	• Consult with key stakeholders to obtain a wider understanding of how we can improve our engagement • Produce an initial draft of the strategy.	Our work will be supported by a better understanding of how stakeholders, service providers and the public want us to engage with them.

Year 1 Deliverables	Measured By	Outcome
Ensure all inspection and assurance processes are aligned to any changes to the Health and Care Standards	• Communicate the standards to all HIW service area leads for implementation • Revise and develop assurance methodology to ensure our work aligns with the standards.	Our work will accurately reflect the way in which healthcare services in Wales measure quality within their services.
Ensure all our processes are prepared to reflect the change from Deprivation of Liberty Safeguards (DOLS) to Liberty Protection Safeguards (LPS)	• Review and update the impact assessment for the introduction of LPS • Consider any changes to inspection tools.	Our work programme will be ready to fulfil our statutory responsibilities against the Liberty Protection Safeguards once they are introduced.
Evaluate the Service of Concern (SoC) process for the NHS and update our enforcement approach for independent healthcare services	• Evaluate how the NHS SoC process has been implemented, seeking feedback, with a view to improving it where necessary • Refresh the current enforcement and criminal investigation guidance for the independent sector • Formalise a media and communications process for SoCs in independent healthcare.	Our approach to escalation and enforcement across all healthcare services will be clearly defined and we will be able to confidently apply this to services that are not providing safe patient care.

Year 1 Deliverables	Measured By	Outcome
Continue to deliver a programme of assurance and inspection work to independent healthcare settings in line with our statutory duties and promote the findings	Deliver up to 97 inspections or quality checks to a variety of independent healthcare settings broken down further into: • Up to 9 inspections to private only dental practices (additional work to mixed NHS and private dental practices is accounted for in NHS deliverable) • Up to 45 inspections of laser services • Up to 2 Ionising Radiation Medical Exposure Regulations (IR(ME)R) inspections • Up to 10 mental health hospital inspections • Up to 6 independent hospital inspections • Up to 5 independent hospice inspections • Up to 20 independent clinic inspections • Percentage of reports published within seven weeks of each quality check • Percentage of reports published within three months and one day following each onsite inspection.	We will have checked the quality of care provided to patients at a range of independent healthcare settings across Wales, contributing to improvement in services for patients.

Year 1 Deliverables	Measured By	Outcome
Continue to deliver a programme of assurance and inspection work in the NHS to a range of settings, informed by analysis of risk and promote the findings	Deliver up to a total of 169 inspections or quality checks to a variety of NHS settings broken down further into: • Up to 27 GP inspections • Up to 95 dental inspections (two NHS, 93 to practices providing mixed private and NHS dental contracts) • Up to 5 IR(ME)R inspections • Up to 10 NHS mental health service inspections • Up to 24 NHS hospital inspections • Up to 3 community mental health team inspections • Up to 5 NHS learning disability setting inspections • Percentage of reports published within target time following each inspection and quality check.	We will have checked the quality of care provided to patients at a range of NHS healthcare settings across Wales, contributing to improvement in services for patients.

PRIORITY 3

We will work collaboratively to drive system and service improvement within healthcare.

Actions

- We will work with others to strengthen our understanding of the issues affecting healthcare services and the people and communities who use them
- We will specifically consider the challenges faced by minority groups when using healthcare services, using this understanding to help challenge healthcare inequalities through our work
- We will build on our working relationships with partners so that we increase the impact we can make to the quality of healthcare delivered to the people of Wales
- We will support our staff to make judgements about both service and system level issues.

Year 1 Deliverables	Measured By	Outcomes
Consult on a new Equality, Diversity, and Inclusion Strategy	• Design a consultation process to include key stakeholders • Produce an initial draft of the strategy for circulation • Develop an equality impact assessment toolkit and subsequent training.	Our work will have been shaped by our increased understanding of equality, diversity and inclusion within our work.
Undertake a gap analysis with independent healthcare providers to obtain a wider understanding of their preferred communication methods	• Circulate a survey for providers to 'have their say' on preferred communications methods • Produce a report following the survey to review the best methods of engagement • Identify and evaluate any new suggested methods	Our understanding of what independent healthcare providers need to hear from us will be shaped by what they have told us.
Develop the Independent Healthcare area of the external facing website 	• Increase the information available for Independent Healthcare services and create a bespoke area on HIW's external facing website.	Prospective and existing independent healthcare providers will have easier access to information which will help them to provide safe, effective services. 

Year 1 Deliverables	Measured By	Outcomes
Develop a healthcare summit to address emerging issues and priorities	• Evaluate HIW activity and the impact following each summit.	Our work will be shaped by strong partnership working which will provide us with a greater understanding of risks and issues in healthcare services across Wales.
Invest in the development of our peer and patient experience reviewers to continue developing their skills	• Host a series of development sessions • The number of sessions held • Review completed competency assessment forms • Circulate a feedback questionnaire at the end of year to obtain an assessment of the value the sessions • Introduce a section in the Quarterly Insight Bulletin for developing peer and patient experience reviewers.	Our work will be supported by peer and patient experience reviewers who are up to date and engaged with our work.
 Embed a new governance mechanism for further joint working with key stakeholders	• Review the alignment of our inspection and assurance work plans to collaborate better with key stakeholders • Consolidation of the key findings and emerging themes from our joint work and consider how these can inform our future work programmes.	Our impact on healthcare services will be supported by increased partnership working, providing a more holistic view of the issues facing patients.

Year 1 Deliverables	Measured By	Outcomes
Maximise the value of HIW's bespoke data management system known as 'Pwls' through further training	• Develop and implement a training plan for existing and new staff • Review of the quality of data inputted into the system • Feedback from staff on the effectiveness of Pwls • Review how we use data drawn from Pwls to inform our work.	Our staff will be better able to access up to date information about healthcare settings, contained all in one location so that we work more efficiently.
Continue to deliver a service which provides a responsive approach to handling concerns brought to us by members of the public and stakeholders.	• Evaluate themes and trends of concerns received to inform our work programme • Analyse the outcome of each concern, reviewing the time scale and actions taken.	We will provide a robust process to handling concerns received which will enable us to deal with issues efficiently and effectively.

PRIORITY 4

We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Actions

- We will continue to invest in developing the skills and knowledge of our staff
- We will build on the learning culture we have put in place, ensuring that evaluation and reflection is a core approach to our work
- We will embed our quality governance strategy so that it is at the heart of everything we do.

Year 1 Deliverables	Measured By	Outcomes
To review the scope and role of our People Forum to ensure it contributes most effectively to the needs of our staff and the organisation	• Consult and plan an internal relaunch plan for the forum • Hold an all-staff conference and analyse subsequent feedback forms	Our staff will be involved in shaping the ongoing development of the organisation through an established forum into which they can directly feed their experiences and insight.
To further embed HIW's quality strategy into the organisation	• Review HIW output against the quality strategy's aims and objectives organisation • Review structure of organisation to assist in the implementation of the quality strategy • Allocate specific resources to ensure the strategy is delivered effectively	Our work will be challenged and improved through implementation of a continuous quality improvement approach.
Develop a learning and development plan for the year to support staff and the organisation to develop	• Deliver a regular programme of training and development opportunities for staff • The number of training sessions delivered • Review training feedback forms.	Through a culture of growth and learning our staff will have been given opportunities to develop, this will drive improvements within our own work.

RESOURCING

In line with other public sector organisations, we expect to experience budgetary pressures in the coming years. For 2022 - 2023 we have a budget of approximately £4.3m. This will enable us to continue the delivery of core activity, including work following-up on previous recommendations and the ability to respond to emerging intelligence.

We have posts equivalent to 83 full-time staff as well as a panel of over 200 specialist peer reviewers. We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our second opinion appointed doctor (SOAD) service. We have 35 Patient Experience Reviewers and Experts by Experience who work with us on inspections to capture the views of patients.

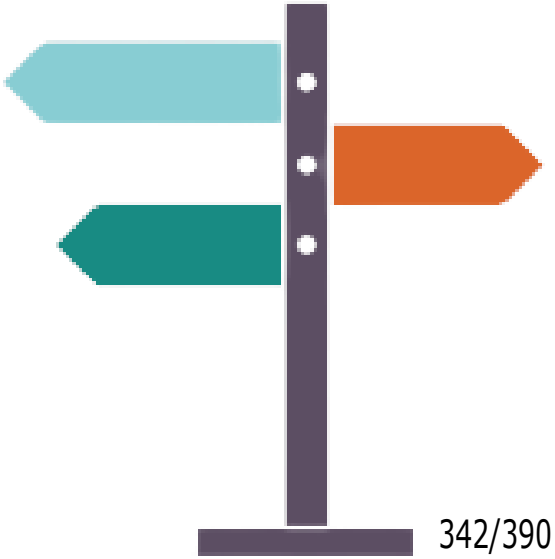
Team	Posts
Senior Executive	3
Inspection, Regulation and Concerns	39
Partnerships, Intelligence and Methodology	14
Strategy Policy and Engagement	5
Clinical advice (including SOAD service)	4
Corporate Services (including business support)	18
Total	83

CONTACT

0300 062 8163

HIW.org.uk

Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ



ISBN: 978-1-80364-404-2

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality, Safety & Outcomes Committee Tuesday 16th August 2022 Agenda Item: 4.3

Aneurin Bevan University Health Board

Quality Assurance visit of PROMPT WALES to Maternity Services
Grange University Hospital

Executive Summary

The PROMPT Wales National Team undertook a quality assurance visit in Aneurin Bevan University Health Board on the 5th April 2022. The purpose of the visit was to observe the PROMPT Wales training undertaken by maternity services at The Grange University Hospital.

The observational team consisted of:

- PROMPT Wales National Midwife
- Consultant Obstetrician CTM UHB
- Practice Development Midwife Swansea Bay UHB.

Following the visit, a report was issued to enable the Health Board to review the information, provide feedback and present an action plan to address the findings. The report and action plan are to be used for internal quality assurance processes.

The report will be shared with the Welsh Risk Pool Committee and Welsh Government to contribute to the evaluation of the PROMPT Programme.

This paper summarises the key points from the report and identifies actions taken within Maternity Services in ABUHB to meet the recommendations.

The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance	√		
Note the Report for Information Only			
Executive Sponsor: Linda Alexander, Interim Director of Nursing			
Report Author: Linda Alexander/ Jayne Beasley			
Report Received consideration and supported by :			
Executive Team	√	**Committee of the Board [Committee Name]**	**PQSOC**
Date of the Report: June 2022			
Supplementary Papers Attached: PROMPT WALES QUALITY ASSURANCE REVIEW FINAL REPORT – 14TH JUNE 2022			

Purpose of the Report

To provide assurance to PQSOC in regards PROMPT training delivery for maternity services at the Grange University Hospital. The report and action plan can be utilised for internal quality assurance processes within the Health Board.

Background and Context

PROMPT is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in outcomes for mothers and babies through improvement in knowledge, clinical skills, and human factors. PROMPT is endorsed by the Royal College of Obstetrics and Gynaecology (RCOG), Obstetric Anaesthetist's Association (OAA) and Royal College of Midwives (RCM).

NHS Wales maternity services must be committed to the highest standard of multi professional training. PROMPT WALES is a maternity safety programme funded by Welsh Risk Pool and has been implemented into obstetric led units across Wales since January 2018.

From April 2022, the National PROMPT Wales team have attended training sites across Wales to ensure a high standard of training and to provide quality assurance to the Welsh Risk Pool, local leadership teams and Welsh Government.

Assessment and Conclusion

Observations and assessment of the National PROMPT Team are as follows:

- The overall impression of the National Team is PROMPT Wales training at the Grange University hospital is well planned, organised and facilitated to a good standard.
- The team understand the overarching purpose of PROMPT, bringing multi-professional teams together to practice clinical skills and human factors in a safe environment.
- The faculty worked well together, and role modelled effective multi-professional working.
- The observed programme is a shortened practical course, supported by on-line learning. This structure was designed to maintain PROMPT Wales training throughout the Covid pandemic. With the publication of the final Ockenden Report it is important NHS Wales Maternity Services remain committed to achieving the highest quality multi-professional training and take heed of the recommendations around on-site training. Health Boards are asked to make steps to return to on-site training with an anticipated return to the clinical area in September 2022.
- It is important to ensure multi-professional representation on all stations wherever possible.
- It was observed that there was an opportunity to provide a more detailed briefing ahead of scenarios to improve team performance.
- The role of observers is an essential component of PROMPT as they observe the clinical management and human factors and provide valuable feedback during debrief. The observers considered this component could be enhanced.

- Whilst there was excellent attention paid to clinical management of the emergencies, the National Team noted that there was more scope to include human factors overall.

- It was recommended that during the eclampsia scenario a scribe should be allocated to complete the proforma and this can be mentioned in the briefing.

The PROMPT Wales National Team noted areas of good practice which can be adopted by other teams and should be shared with other faculties and at national development events.

Several areas of good practice were noted during this Quality Assurance Review:

- Multi professional faculty were supportive and understood the needs of the professional group.

- It was acknowledged the Heath Board had taken great effort in planning course attendance to ensure a suitable mixture of professional groups were in attendance.

- Volume of topics was very good and undertaken following review of local incidents and priorities.

- The faculty used incidental spare time for discussion of local incidents national reports or further learning demonstrating high quality experience.

- There was opportunity for feedback during the day, excellent debriefing, and good time management.

- Patient actors added realism.

- Excellent reference to the key learning points.

- Excellent time management facilitated by the Practice Facilitator who was able to be supernumerary.

Following the Quality and Assurance visit PROMPT Wales made the following recommendations: -

- Plans for full onsite training to commence from September 2022.

- There should be scope to improve briefing and prepare the team for scenarios.

- Reinforce Human factors throughout course.

- Use of emergency boxes trolleys to be used to encourage fidelity to practise.

- Mannequins should be fit for purpose to ensure effective practise of manoeuvres.

- A Midwife and an obstetrician should facilitate shoulder dystocia and breech scenarios.

Conclusion:

The Quality Assurance visit to ABUHB on the 5 April 2022 by the National Team was undertaken to observe and review the training practices within maternity services.

The observational review and subsequent report have highlighted good areas of practice and multi professional training, as well as areas for improvement.

All recommendations have been implemented with the exception of moving all training sessions to the clinical setting.

The bed capacity at GUH is such that accommodating clinical scenarios within the labour ward runs the risk of cancellation of valuable training sessions, therefore a mixed model where the clinical area and the educational centre is utilised will ensure sessions can continue.

Recommendation
The Committee is requested to **NOTE** the review.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Ensure that non-compliance or variance from best practice is properly recorded and audited and any risks identified are managed appropriately. Utilise feedback for internal quality assurance processes.
Financial Assessment, including Value for Money	No financial impact
Quality, Safety and Patient Experience Assessment	Linked to avoidable harm ensuring appropriate care, treatment and information, support and early detection through ongoing training development and education.
Equality and Diversity Impact Assessment (including child impact assessment)	No impact
Health and Care Standards	Safe Care, Effective Care, Timely Care.
Link to Integrated Medium Term Plan/Corporate Objectives	Education and Training – sustaining a skilled workforce
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term** – continuous assessment internal and from independent reviewers.
	Integration – foster a culture of integration supported by learning and self-assessment to support safe and effective patient care.
	Involvement – Mutli-professional approach/ support and feedback from PROMPT external assessors.
	Collaboration – work collaboratively with internal and external providers to ensure the best care possible is delivered to patients.
	Prevention – people will be kept safe and protected from avoidable harm through appropriate care, treatment and support through education and training

Glossary of New Terms	
Public Interest	May of be interest and will provide assurance

PROMPT WALES
QUALITY ASSURANCE REVIEW

CYMRU / WALES
PROMPT
PRactical Obstetric Multi-Professional Training
Hyfforddiant Aml-broffesiynol Ymarferol mewn Obstetreg

ANEURIN BEVAN
UNIVERSITY HEALTH BOARD

The Grange University Hospital

QA VISIT DATE:	**5TH APRIL 2022**
DRAFT REPORT ISSUED:	**26TH APRIL 2022**
CONFIRMED ACTION PLAN:	**24TH MAY 2022**
FINAL REPORT ISSUED:	**14TH JUNE 2022**

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Cronfa Risg Cymru
Shared Services Partnership
Welsh Risk Pool Services

Gwella Diogelwch Cleifion Trwy Ddysgu
Improving Patient Safety Through Learning

QA REPORT STATUS: FINAL

This report is issued following a draft release to enable the Health Board to review the information, provide feedback and present an action plan to address the findings.

The report and action plan can be used for internal quality assurance processes within the Health Board.

The Welsh Risk Pool will use this report as part of future Quality Assurance Reviews and monitoring processes.

The PROMPT Wales National Team hope that the feedback and recommendations in the report are valuable and provide your organisation with useful guidance for further development of your PROMPT Wales training.

REFERENCES

1. Siassakos, D., Crofts, J. F., Winter, C., & Weiner, C. P. (2009). *The active components of effective training in obstetric emergencies*. BJOG, 1028–1032. https://doi.org/10.1111/j.1471-0528.2009.02178.x

2: Ockenden, D. (2022). *Ockenden Report* – Final. https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

PROMPT Wales Quality Assurance visit at Aneurin Bevan University Health Board

Date:

5th April 2022

Location:

Education Centre, Grange University Hospital.

The Welsh Risk Pool observing team:

Sarah Morris - PROMPT Wales National Midwife

Accompanied by:

Dr Aditi Miskin – Consultant Obstetrician, Cwm Taf Morgannwg UHB

Jenilee Harrison, Practice Development Midwife, Swansea Bay UHB

ABUHB PROMPT Wales faculty on date of visit:

Amy Bond, Practice Development Midwife

Amy Shacaluga, Obstetrician

Furat Sankari, Obstetrician

Ellie Morgan, Anaesthetist

Jane Morgan, Midwife

Pauline Summer, Midwife

Hannah McLoughlin, Clinical Supervisor for Midwives

Louise Anderson, Midwife

Rachel Davies, Healthcare Assistant

Diane Mears, Healthcare Assistant

CONTENTS

00 What is PROMPT Wales

00.1 PROMPT Wales is a maternity safety programme funded by the Welsh Risk Pool and supported by the PROMPT Maternity Foundation. PROMPT Wales has been successfully implemented in all obstetric-led units in Wales since January 2018.

00.2 PROMPT Wales is centrally coordinated by a multi-professional National Team who provide oversight of this all-Wales programme and offer support and guidance to local faculty teams. Local PROMPT Wales Leads in each obstetric-led unit are responsible for the planning and organisation of PROMPT Wales training in their unit and are supported by a wider multi-professional faculty who have undergone an accredited PROMPT or PROMPT Wales faculty training course.

00.3 PROMPT Wales aims to meet the needs of Welsh NHS organisations, in making childbirth safer and improving outcomes for women and babies through the provision of high-quality training which meets the PROMPT Wales Standards (2018).

00.4 Commencing in April 2022, the National PROMPT Wales team have coordinated a series of Quality Assurance visits to all training sites to ensure that high standards of PROMPT training are being met across Wales. This report will present the findings of the National Team and will include examples of good practice and recommendations for action before the next scheduled visit. We aim to promote a consistent approach and authenticity to the PROMPT principles throughout NHS Wales and to encourage continuous improvement of PROMPT Wales training through our objective and balanced feedback. The report will be shared with the Welsh Risk Pool Committee and Welsh Government and contribute to the evaluation of the programme.

01 Venue for Training

01.1 Conducting PROMPT Wales Training in the clinical area is considered to be an essential component of effective training[1]. This promotes the principle of 'teams that work together, train together' which underpins PROMPT training and enables the testing of systems and processes - contributing to organisational improvement. There has been some relaxation of the expectation to conduct training within the clinical area due to the challenges associated with the pandemic. It is anticipated that all PROMPT Wales training will be held in clinical areas from September 2022.

01.2 ABUHB's PROMPT Wales courses are currently held in the Education Centre at The Grange University hospital.

01.3 The education centre consists of spacious simulation rooms in which to host PROMPT Wales training and is a suitable alternative to the clinical area on a temporary basis.

02 Organisation of the training

02.1 Structure of the session

02.1.1 The ABUHB training programme is a well-structured programme which consists of six relevant practical sessions of 40 minutes each and runs from 10:00 – 15:00 hours.

02.1.2 Presentations continue to be accessed by delegates before attending and three hours is provided.

02.1.3 Ice-breakers were included once the delegates had been split into the three teams. As some team members were noted not to introduce themselves to each other, this could be instigated by the faculty.

02.1.4 The effectiveness of PROMPT training is underpinned by the multi-professional approach. It was positive to note that the ABUHB session included both multi-professional faculty and multi-professional delegates. The nineteen delegates were split into three multi-professional teams. On the day of the Quality Assurance visit there were six midwives, three obstetricians, three other junior doctors working in obstetrics, four anaesthetists and three healthcare assistants (HCA) in attendance.

02.2 Welcome and introductory talk

Before splitting into three teams, the delegates were welcomed and faculty introduced themselves.

02.3 End of Session Plenary & Feedback

02.3.1 It is useful for delegates to come together at the end of the day as this provides an opportunity for questions and concludes the day nicely. Delegates left from their last station, but we recognise this may still be due to restricting large numbers coming together; although the group were together at the start of the day for introductions.

02.3.2 The Practice Development Midwife has implemented an innovative approach to gathering feedback, using a QR code which links to a feedback form. This has resulted in good response rates for feedback which faculty are able to access rapidly in time for their debrief.

02.4 Faculty Debrief

02.4.1 It is pleasing to see the importance given to a faculty debrief with half an hour timetabled at the end of the programme for this. This provides an opportunity for discussion about the day, to review the feedback and identify any required changes for future courses.

03 Learning Presentations

03.1 The following presentations are accessed by delegates before attending:

- PROMPT Wales Human Factors
- PROMPT Wales/OBS Cymru,
- Locally developed presentation for Sepsis
- Locally developed presentation on fetal physiology and surveillance
- PROMPT Maternity Foundation's Cardiac Arrest COVID 19 Pandemic video.

Presentations continue online due to unavailability of a room large enough to bring all delegates together whilst allowing for social distancing.

03.2 Despite the best efforts of the Practice Facilitator in monitoring the completion of the pre-course learning and with-holding certificates unless there is evidence of completion, some delegates informed the National Team that they had not completed it. Understanding the principles of PROMPT, in particular the human factors, before taking part in scenarios is considered an integral part of PROMPT training and these delegates will have missed out on essential preparation which is likely to have impacted on their learning. From our observations across NHS Wales, we have noted that teams perform more effectively in the scenarios in relation to human factors when they have received the Human Factors presentation face-to-face and on the day.

04 Scenarios

04.1 PPH Scenario

04.1.1 This scenario was facilitated by an Obstetrician, Midwife and 2 HCAs. One HCA was the patient-actor.

04.1.2 All paperwork was available. More than one OBS Cymru checklist would be useful. In one scenario observed, the HCA used it to document measured blood loss (MBL) so there wasn't one available for the lead to read from to guide the team through the management.

04.1.3 The equipment was already laid out. We recommend a training emergency PPH box/trolley to replicate that which is used in practice. A photograph of the 'real' box/trolley can be taped to the box. It is useful to also check that the delegates know where to locate the emergency box/trolley in the clinical area. Props such as a BP cuff and oxygen mask would add to the realism. Whilst blood stained incontinence pads were present, they were noted not to be removed for weighing during the scenario and MBL was provided by the facilitator despite this. To reinforce the importance of measuring blood loss, we recommend the MBL is only provided when the delegate has simulated weighing of the incontinence sheets. This can be explained in the briefing.

04.1.4 Briefing the team together in the room before the scenario is strongly recommended as this orientates them to the environment and equipment, clarifies exactly what actions they should undertake, reminds them to include human factors, and with the intention of putting them at ease. PROMPT Wales has developed a Facilitator's Aide Memoir to guide the facilitator through this. In one PPH scenario the handover was given straight away with no briefing observed. In another, a quick briefing was given outside the room.

04.1.5 The faculty were noted to be supportive throughout and let the scenario unfold without interrupting. It was noted that observation readings were provided without delegates actually 'taking' the blood pressure, pulse rate etc, and the MEOWS chart was not used. Explaining in the briefing that observations need to be acted out, asked for individually, and plotted on the MEOWS chart prepares the delegates for what is expected. It is useful to discuss the importance of using a MEOWS chart as a trigger, to recognise the deteriorating woman and the response to treatment.

04.1.6 It was good to see Facilitator's Aide Memoir used to structure the debrief. The facilitators had completed the clinical and human factors checklists, possibly because all delegates were required to take part. The National Team felt that human factors

could have been reinforced further during the debrief by highlighting examples of SBAR, closed loop communication, use of names etc, and discussing leadership and situational awareness.

04.1.7 Key Learning Points from the PPH chapter in the PROMPT Trainer's Manual brought the scenario to a nice conclusion. Spare time was utilised appropriately with discussion around recent reports and local cases.

04.2 Maternal Collapse Scenario

04.2.1 This scenario was facilitated by an obstetrician, an anaesthetist and a midwife. A simulation manikin was appropriately used as chest compressions were required. A facilitator provided the voice-over until the cardiac arrest occurred.

04.2.2 Very good equipment was available. The algorithm was available and used by the team.

04.2.3 A short briefing took place about how to use the equipment. The Facilitator's Aide Memoir would act as a reminder of what should be included in the briefing as it is useful to remind the teams to practice team-roles and leadership, communication and situational awareness, and provide examples such as 'declare the emergency,' 'use SBAR' etc. The team can also be reminded to allocate a scribe.

04.2.4 RCUK COVID guidance and use of a FFP3 face mask before commencing cardiac compressions was not discussed.

04.2.5 The faculty were noted to be supportive throughout and let the scenario unfold without interrupting. Observations and other information were provided as requested.

04.2.6 The Facilitator's Aide Memoir was used to guide the debrief. Again, the National Team felt that human factors could have been reinforced further by highlighting and exploring examples noted during the scenario. For example, one team were noted to use "somebody" as opposed to using names and this is always worth discussing during the debrief.

04.2.7 Key Learning Points from the Maternal Cardiac Arrest chapter in the PROMPT Trainer's Manual concluded the scenario and ensured all points had been covered.

04.2.8 Spare time was utilised appropriately for further learning.

04.3 Anaphylaxis – Sepsis Scenario

04.3.1 The National Team thought this was a very good scenario which covered two important

subjects in one station. However, some delegates were noted to be a little confused by this as they were unaware from the programme that sepsis was included. This could be alleviated by a detailed briefing setting out the expectations.

04.3.2 This scenario was facilitated by an anaesthetist, an obstetrician and a midwife in a simulation suite using a manikin. A patient-actor would also be appropriate in this scenario.

04.3.3 An emergency trolley and relevant paperwork were available.

04.3.4 A quick briefing which orientated the team to the scene and equipment took place. Whilst use of the algorithm/s was mentioned, it is useful to show them to the team before starting, especially as both the Sepsis Risk Assessment Tool and the Anaphylaxis algorithm were required. The team would have benefitted from a reminder about human factors and what was expected, e.g. declare the emergency, practice closed loop communication, etc. The National Team felt it would be useful to explain the roles of the facilitators, in particular that there would be a voice-over provided.

04.3.5 The faculty were noted to be supportive throughout and let the scenario unfold without interrupting. Observations and information were provided as requested. The algorithm and Sepsis Risk Assessment tool was used by the team, but observations were not plotted on the MEOWS chart - mentioning this in the briefing would explain to the team what is expected.

04.3.6 The Facilitator's Aide Memoir was used to guide the debrief. The facilitators completed the checklists and again - some further discussion around the human factors would have been beneficial.

04.3.7 Key Learning Points from the relevant chapters in the PROMPT Trainer's Manual concluded the scenario and ensured all points had been covered.

04.3.8 Spare time was utilised appropriately for further learning.

04.4 <u>Eclampsia Scenario</u>

04.4.1 This was facilitated by an obstetrician, a midwife and 2 HCAs, one of whom was the patient-actor.

04.4.2 The equipment was laid out in advance. Having the equipment laid out for the delegates does not prepare the team for how to access the equipment in the clinical area or familiarise themselves with the contents. The Health Board should consider

more realistic replication of equipment for future sessions such as a training emergency eclampsia box. A BP cuff is an essential prop for this scenario. Having the eclampsia drugs (Magnesium Sulphate and anti-hypertensives) available would provide an opportunity to practice retrieval and preparation.

04.4.3 A quick briefing took place outside the room. As there are 3 algorithms for this scenario: Severe pre-eclampsia, Eclampsia and Severe Hypertension, we have found that the teams perform better when these have been explained before starting the scenario as the objective is for them to practice using them to guide the management, so they are confident to use them in clinical practice. This can then be reinforced in the debrief.

04.4.4 The faculty were noted to be supportive throughout and let the scenario unfold without interrupting. Observations and information were provided as requested but we suggest waiting until the delegates 'take' the observations first. The scenario was over quickly, and this would keep the timing more real. BP readings should coincide with treatment given. The algorithms were used by the team although there was some confusion evident. The MEOWS chart is an essential part of the care of a woman with eclampsia and this was not used by the team – explaining beforehand that the observations should be plotted would alleviate this.

04.4.5 Sometimes delegates may say they don't need to use an algorithm and it is important that faculty tactfully remind them that algorithms have been adopted in practice in NHS Wales based on the evidence.

04.4.6 The Facilitator's Aide Memoir was used to partly guide the debrief. The facilitators completed the checklists and again, some further discussion around the human factors would have been beneficial, as well as asking the patient-actor for feedback to gain the 'woman's' perspective.

04.4.7 Key Learning Points from the Eclampsia chapter in the PROMPT Trainer's Manual concluded the scenario and ensured all points had been covered.

04.4.8 There was quite a lot of time left and this was utilised appropriately. The delegates found it useful to be guided through the 3 algorithms in some detail as suggested by our team.

04.5 <u>Shoulder Dystocia Workstation</u>

04.5.1 This workstation was facilitated by two midwives. Ideally, we would expect an obstetrician to facilitate with a midwife.

04.5.2 The PROMPT Flex manikin and baby were used, and all delegates had practice with the Force Monitor. The National Team advise that the emphasis should focus on avoiding downward traction per se, as opposed to the numbers recorded.

04.5.3 The perineum of the manikin was noted to be ripped and should be replaced before the next session to ensure effectiveness of training. It is important the correct lubricant is used to maintain the lifespan of the manikin and details for reordering have been shared. We also recommend that delegates use lubricant when performing internal manoeuvres to avoid damage to the perineum.

04.5.4 Leaving the abdominal skin off and holding the baby from underneath so as to demonstrate placement of the impacted shoulder behind the symphysis pubis is recommended so delegates can visualise the impaction and the manoeuvres.

04.5.5 The algorithm was displayed on the large screen which was good, and this was worked through in a structured manner. A few laminated copies would also be useful. We recommend briefly discussing cleidiotomy, Zavanelli manoeuvre and symphysiotomy. This may have been omitted as there was no obstetrician on faculty and the midwives may not have felt confident to explain these procedures.

04.5.6 It is important to also refer to human factors in workstations as well as scenarios. A few minutes explaining the importance of a lead, with the algorithm, who maintains situational awareness whilst those involved are task focussed, will reinforce awareness of how human factors can contribute to the outcome.

04.5.7 It was good to observe that all delegates had time to practice manoeuvres. We would encourage delegates (for whom it is relevant to their practice) to practice the rotational manoeuvres as well as removal of the posterior arm.

04.5.8 The 'Truck and Low Bridge' analogy was used appropriately.

04.5.9 All key learning was included.

04.6 <u>Breech Workstation</u>

04.6.1 This scenario was facilitated by two midwives. As with shoulder dystocia, we would ideally expect this to be facilitated by an obstetrician and a midwife.

04.6.2 The PROMPT Breech module was appropriately followed.

04.6.3 The Flex manikin was used appropriately but was somewhat hindered by the damaged perineum.

04.6.4 All key learning points were covered as per the PROMPT algorithm and RCOG guidance.

04.6.5 The PROMPT breech algorithm was shown to the team. It would be useful to encourage a team member to read through this taking the role of a lead. This would seamlessly introduce the human factors element into the workstation.

04.6.6 It was good to note the team were reminded about the PROMPT Maternity Foundation's Breech Birth training video. This includes a demonstration of application of Forceps so may be more useful in the absence of training Forceps than using hands to simulate this. With an obstetrician as faculty and availability of training forceps, an opportunity would be provided for junior obstetricians to practice application of forceps to the aftercoming head, with the midwife supporting the baby.

04.6.7 We recommend including a demonstration of supra-pubic pressure to aid flexion of the head if required.

04.6.8 All delegates had time to practice manoeuvres and time was utilised appropriately.

05 Overall observations

05.1 The overall impression of the National Team is that PROMPT Wales training at the Grange University hospital is well planned, organised and facilitated to a good standard. The team understand the overarching purpose of PROMPT, bringing multi-professional teams together to practice clinical skill and human factors in a safe environment.

05.2 The observed programme is a shortened practical course, supported by on-line learning. This structure was designed to maintain PROMPT Wales training throughout the COVID pandemic. With the publication of the final Ockenden Report[2] this month it is more important than ever that NHS Wales maternity services remain committed to achieving the highest quality multi-professional training and take heed of the recommendations around on-site training. With this in mind, we are recommending that Health Boards make steps to return to on-site training with an anticipated return to the clinical area in September 2022.

05.3 On the day of the review, the faculty worked well together, and role modelled effective multi-professional working.

05.4 As two obstetricians and an anaesthetist were facilitating on this course, the programme could be organised such that the anaesthetist facilitates with a midwife on

maternal cardiac arrest and anaphylaxis so that the obstetrician is available for breech and shoulder dystocia. It is important to have multi-professional representation on all stations wherever possible.

05.5 There is an opportunity to provide a more detailed briefing ahead of the scenarios. It is important that delegates understand that PROMPT is not about testing their knowledge and clinical management but is an opportunity to understand how human factors impact clinical outcomes. The objective is to practice teamworking and communication and the use of the PROMPT algorithms and other tools, which in turn would be expected to lead to effective clinical management. From our observations teams usually perform well when they have received a detailed briefing.

05.6 The role of observers is an essential component of PROMPT as they observe the clinical management and human factors and provide valuable feedback during the debrief. Team sizes allowing, we recommend allocating at least one observer from the team who should take the PROMPT Wales Human Factors checklist, and this should be prioritised during the debrief. If team sizes do not allow a second observer, a facilitator can complete the clinical checklist.

05.7 Whilst there was excellent attention paid to clinical management of the emergencies, the National Team noted that there was more scope to include human factors overall.

05.8 PROMPT proformas for documentation have been adopted in practice in maternity services in NHS Wales. They are available for eclampsia, cord prolapse, shoulder dystocia and breech. In the eclampsia scenario we would recommend the team allocate a scribe to complete the proforma and this can be mentioned in the briefing. In the workstations the opportunity for familiarisation can be facilitated through discussion.

06 Good Practice Noted

06.1 The PROMPT Wales National Team note areas of good practice which can be adopted by other teams and share this information with other faculties and at national development events. A number of areas of good practice were noted during this QA Review.

06.1.1 Multi-professional faculty

It was pleasing to note the multi-professional nature of the faculty present on this course, all of whom were supportive and understood the needs of each professional

group. However, with three doctors on faculty, the programme could be organised so that a doctor and midwife facilitate on each station.

06.1.2 Multi-professional delegate teams

The Heath Board has undertaken great efforts in planning course attendance to ensure that a suitable mixture of professional groups is attained.

06.1.3 Six relevant stations

The volume of clinical topics included is very good. Selection of the topics covered during the training have been made following a review of local incidents and priorities.

06.1.4 Faculty used any incidental spare time at the end of all scenarios for discussion of local incidents, national reports or further learning relevant to the topic.

This also demonstrates a commitment to provision of a high quality experience as delegates are not released early and waiting around in between stations.

06.1.5 A faculty 'huddle' took place at the beginning and of the day, and a debrief at the end.

This provided an opportunity for the team to review feedback from the last course and have last minute discussions about the running of the day and tips regarding facilitation. The post course debrief facilitated reflection and identified any areas which would benefit from improvement ahead of the next course.

06.1.6 Use of a patient-actors.

This adds realism and provides the opportunity for the patient-actor to feedback to the team providing the 'woman's' perspective on the care received.

06.1.7 Excellent debriefing noted in some of the stations and faculty members were knowledgeable, supportive and welcoming.

06.1.8 Excellent reference to Key Learning Points at the end of each station.

06.1.9 Excellent time management facilitated by the Practice Facilitator who was able to be supernumerary.

07 Our Recommendations for further development

07.1 The PROMPT Wales National Team make the following recommendations to further improve the effectiveness of the training conducted by the Health Board.

PWABU01 ABUHB should be making plans for a return to a full day of on-site training to commence in September 2022.

PWABU02 There is scope to improve the briefing and better prepare the team for the expectations of the scenario. The PROMPT Wales Facilitator's Aide Memoir can be used to guide the facilitator through the briefing in a structured manner.

PWABU03 There is further opportunity to reinforce human factors throughout the course. This would be enhanced by the reintroduction of the PROMPT Wales Human Factors presentation presented on the day and a reminder ahead of each scenario as part of the briefing.

PWABU04 Fidelity to practice could be enhanced through the use of emergency boxes/trolleys, similar to those used in the clinical area, along with the addition of essential props such as BP cuffs.

PWABU05 Manikins should be fit for purpose to ensure effective practice of manoeuvres is possible.

PWABU06 Where possible, an obstetrician and midwife should facilitate on shoulder dystocia and breech stations.

08 Health Board Action Plan

Action Ref	Action title	Action description	Time scale for completion	Progress report
PWAB01	Return to a full day of on site training	Moving towards full day on site training sessions	To commence implement-ation from September 2022 with the new programme. Monthly monitoring	Commitment required from faculty members to run face to face training lectures - e-mail sent to all members circulated. Currently due to workload on the labour ward it would not be feasible to conduct all scenarios in that clinical area as there is a risk of cancelling sessions 2 scenarios in labour room 4 scenarios education centre
PWAB02	Improve the briefing and better prepare the team for the scenarios	Utilise the PROMPT Wales Facilitators Aide Memoir to aid facilitation of the briefing. E-mail via PROMPT leads to be sent to all faculty member as a reminder to use the Aide Memoire to facilitate sessions	May 2022	There is an Aide Memoire for each scenario this has been utilised for debrief but not used at the commencement
PWAB03	Reinforce human factors throughout the course	Use of PROMPT Wales human factors presentation to be undertaken at the start of the day. Reminder to be undertaken prior to each scenario and added to briefing.	May 2022	Complete
PWAB04	Enhancement of fidelity to practice	Utilisation of emergency boxes and essential props to be included in the sessions	May 2022	Complete
PWAB05	Mannequins should be fit for purpose	To check mannequins and order replacement	May 2022	2 LIMS available Mannequin insert broken ordered replacement same arrived along with lubrication
PWAB06	Obstetrician and midwife should facilitate on shoulder dystocia and breech stations	Obstetrician and midwife to be allocated	May 2022	Review of scenarios, obstetrician will need to be removed from another scenario as appropriate.

Reporting Committee	**Quality Patient Safety Committee**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**June 7th 2022**

Summary of key matters considered by the Committee and any related decisions made

Commissioning Team and Network Updates

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below:

1.0 Welsh Renal Clinical Network (WRCN)

The Committee received the report from the network. There were no issues to report.

2.0 Cancer & Blood

The Welsh Centre for Burns and Plastic Surgery, Morriston Hospital, Swansea Bay University Health Board (SBUHB) remained at escalation level 3. Work continued with Swansea around the long-term model, which was dependent on the redevelopment of Morriston's ICU unit, including receipt of capital for a long-term plan. WHSSC continued to monitor the two phase action plan with input and advice from the South West & Wales Burns Network (SW&WBN).

The Positron Emission Tomography Imaging Centre (PETIC) remained in Escalation and monitoring meetings were in place. Another concern around the of the age of the current scanner was also highlighted. There is a procurement process underway to replace this scanner which will mitigate this risk. The service was maintaining turnaround times within the agreed target of 10 working days.

The committee noted that there were long waiting times for plastic surgery within Swansea Bay. A recovery plan had been requested but this had not been received to date.

3.0 Cardiac

Members received an update regarding the two cardiac surgical services in South Wales that remained in escalation. An update was received on the action plan in place in response to the GIRFT report undertaken at SBUHB and the Committee

received assurance that SBUHB was making good progress on its delivery and the level of escalation would be reconsidered shortly.

Cardiff and Vale University Health Board (C&VHB) had recently been re-escalated from Level 2 to Level 3 due to the lack of assurance to engage with WHSSC regarding their GIRFT improvement plan. WHSSC have since received a more detailed action plan with involvement from the Surgical Clinical Board and good engagement at the last escalation meeting. WHSSC have facilitated the engagement of the two Health Boards to share learning and will continue to monitor the service against key indicators.

Despite the services being in escalation the committee noted that the risk for patients waiting for cardiac surgery had been reduced. Cardiac Surgery waiting lists were currently at their lowest for four years. However, there were growing concerns around diagnostics and cardiology clinical pathways within Health Boards as people are not making their way onto cardiac surgery lists.

4.0 Mental Health & Vulnerable Groups

Members received a separate update report regarding Ty Llidiard, which was currently in Escalation Level 4. Members requested that their concerns regarding the length of time that the services had been in escalation and the slow progress be escalated to Joint Committee for further discussion and assurance.

The committee were informed that a stakeholder engagement with NHS England, with the aim of securing a new Perinatal Mother & Baby Unit service for mid Wales and North Wales patients, was ongoing but this was dependent on the securing of capital funding by NHSE.

Following receipt of notice for the termination of the WHSSC contract with Oxford Health NHS Foundation Trust, colleagues in NCCU were scoping alternative providers to ensure ongoing and uninterrupted service provision.

Prior to the Welsh Gender Service (WGS) being set up in 2019, patients were referred to the London GIC in Charing Cross hosted by Tavistock & Portman NHS Foundation Trust (T&PNFT). In 2019, the WGS repatriated a number of patients based on the level of complexity they could manage at that time. The WGS has now completed the repatriation of the remaining validated waiting list of 130 patients. It was also noted that additional funding had been secured in order to set up a satellite clinic for North Wales and Powys patients to reduce the distance to access treatment.

The Committee was informed that work was ongoing with NHS England to consider a clinical model for the Gender Identity Development Service (GIDS) and explore a regional solution given the recommendation from the Cass Review to move away from a single provider.

5.0 Neurosciences

Members noted one significant area of concern about the use of an imaging platform that health boards have been using to transfer images between NHS Wales and thrombectomy providers in North Bristol and the Walton. The issue had been escalated to the Delivery Unit and Welsh Government and work was currently being undertaken to improve stroke pathways.

6.0 Women & Children

Concerns remained with paediatric intensive care beds, as a result of staffing issues, which could potentially result in paediatric patients requiring intensive care being transferred out of Wales. The Committee was assured that work was ongoing and a set of controls was in place to mitigate the risk.

Members were informed that Paediatric Surgery remained a concern. There was a risk that paediatric patients waiting for surgery in the Children's Hospital of Wales were waiting in excess of 36 weeks, due to the COVID-19 pandemic and that, as a consequence, the condition of the patient could worsen. The WHSS team had asked for a recovery trajectory and plan and there is continuous monitoring with the Clinical Board at CVUHB and through SLA meetings.

7.0 Intestinal Failure (IF)– Home Parenteral Nutrition

The Committee was provided with a detailed update on the creation of a temporary IF commissioning team and the on-going review of IF arrangements. The report highlighted some concerns with the current supply issues with Calea and progress with the HPN contract renewal. It was confirmed that WHSSC had formally instructed procurement to act on behalf of WHSSC in raising concerns around the contract performance. The ultimate aim is to move to an NHS provided service in order to mitigate the risk further.

Other Reports Received

Members received reports on the following:

- **Services in Escalation Summary**

WHSSC currently has seven services in escalation. One service had increased its level of escalation and all others remain unchanged; progress and further work was detailed in the commissioning team reports.

- **CRAF Risk Assurance Framework**

Members received a report presenting the updated Corporate Risk Assurance Framework (CRAF) and outline the risks scoring 15 or above on the commissioning teams and directorate risk registers. There were currently 18 risks on the CRAF of which 16 were commissioning risks and two were organisational risks. Four risks were de-escalated during the period between February - May 2022 and work continues with the commissioning teams to address the remaining risks. It was noted that IPFR remained one of the highest risks. The Committee was informed that following a meeting with WG it had been confirmed that WHSSC were able to commence a wider engagement exercise to

consider the ToR and will be referenced in the Joint Committee's Managing Director's Report in July 2022 and a final report will be presented in September 2022.

- **CQC/HIW Summary Update**

- **Quality Newsletter**

Members received a draft copy of the First Quality Newsletter for comment and feedback. This was well received and is an appendix to the report for wider circulation as appropriate.

- **Service Innovation & Improvement Report**

The report which provided an update on the Service Improvement and Innovation Workshops and similar externally organised events that have taken place since the Covid-19 pandemic was received.

- **Policy Group Report**

Items for information

Members received a number of documents for information only, which members needed to be aware of:

- Chair's Report and Escalation Summary to Joint Committee 12 May 2022;
- Datix – Cymru Incident Investigation – User Guide
- QPS Forward Work Plan;
- QPS Distribution List

QPSC Committee Effectiveness Self- Assessment Results and Forward Work Plan

The findings of the self-assessment results were shared and it was confirmed that they had also been presented to IGC and to the JC in July. Overall the comments were positive. It was difficult for some members to comment as there had been a change in membership at the same time as the survey was circulated

Key risks and issues/matters of concern and any mitigating actions

The items highlighted above.

Summary of services in Escalation (Appendix 1 attached)

Quality Newsletter (Appendix 2 attached)

Matters requiring Committee level consideration and/or approval

Members agreed the following would be highlighted in the Chair's Report to Joint Committee.

- Ty Llidard updates and to include paper as Appendix to JC,
- Increased escalation of PICU,
- Intestinal Failure position; and
- CRAF - Concerns around IPFR more specifically the changes to the Terms of Reference and governance review.

Matters referred to other Committees Ensure chairs report are part of health board's agenda items	
Confirmed minutes for the meeting are available upon request	
Date of next scheduled meeting:	9th August 2022 at 13.00hrs

1.0 SERVICES IN ESCALATION

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 31.05.2022	Movement from last month
November 2017	North Wales Adolescent Service (NWAS)	BCUHB	2	• Medical workforce and shortages operational capacity • Lack of access to other Health Board provision including Paediatrics and Adult Mental Health. Number of Out-of-Area admissions	• QAIS report outlined key areas for development including the recommendation to consider the location of NWAS due to lack of access on site to other health board provision – This is being considered in the Mental Health Specialised Services Strategy. • Participation in weekly bed management panel meeting. • Medical workforce issues improved with further appointments made and the issue of GMC registration resolved for 1 clinician.	

					• Level of escalation will be considered following QAIS annual review in June	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 31.05.2022	Movement from last month
March 2018 Sept 2020 Aug 2021	Ty Llidiard	CTMUHB	4	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11 September	• Escalation meetings held monthly, however March 22 meeting stood down for the report on a visit from NCCU into the unit to be published to inform ongoing discussions. • Service spec discussions progressed with work ongoing to consider the requirements of the unit. • Awaiting publication and implementation of Medical Emergency Response SOP by CTM. • Coroner's inquest concluded. Implementation of outcomes of inquest to be incorporated into escalation plan alongside the outcomes of HIW and NCCU visits	

					• Executive meeting held on May 3rd 2022. • Managing Director wrote to CEO CTUHB on 6th May with agreed actions following meeting. • Response received from Health Board 12th May outlining work and jointly agreed improvement plan going forward.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 31.05.2022	Movement from last month
September 2020	FACTS	CTMUHB	3	• Workforce issue	The 12 CQV meetings have now been held. The service remains at level 3. Good progress is being made against the key actions key actions remaining: • Substantive Consultant Psychiatrist job description is with the Royal College of Psychiatrists for approval. • Clinical Lead to be advertised once CAMHS Consultant posts have been appointed. • The service has been asked to submit a revised staffing plan to increase the resilience of the team using underspend. • The FACTS service specification (for CAMHS) is planned to go to policy group on	

					13th July for approval to consult. • FACTS have ongoing issues in Parc Prison linked to offsite system access and personal safety that have been escalated via the appropriate channels.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 31.05.2022	Movement from last month
July 2021	Cardiac Surgery	SBUHB	3	• Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review	• Continued six weekly meetings in place to receive and monitor against the improvement plan. • Although the service was de-escalated on delivery of the immediate actions required by the GIRFT recommendations (per March update), further work is required between SBUHB, C&VUHB and WHSSC to improve the aorto-vascular pathways and develop the preferred options. In the meantime, the pathway will remain unchanged. • Escalation level will	

					be reviewed on provision of six months of data following delivery of GIRFT recommendations.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 31.05.2022	Movement from last month
July 2021 April 2022 (from 2-3)	Cardiac Surgery	C&VUHB	3	• Lack of assurance regarding processes and patient flow which impact on patient experience	• C&VUHB had previously agreed a programme of improvement work to address the recommendations set out in the GIRFT report. • In view of continued failure to provide the GIRFT improvement plan and HEIW report the service has been re-escalated • First level 3 meeting scheduled for 1 June, with subsequent meetings at 6 weekly intervals; these supersede bi-monthly meetings previously agreed for monitoring purposes.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 31.05.2022	Movement from last month
November 2021	Burns	SBUHB	3	• The burns service at SBUHB is currently unable to provide major burns level care due to staffing issues in burns ITU.	• The burns ICU is restored to full capacity (3 beds) with support from general ICU and anaesthetics consultants (stage 1 of the plan). • Mutual assistance is available via the South West and Wales Burns Network and wider UK burns escalation arrangements, should it be required. • The three-stage plan has been agreed following advice and support from the Burns Network and a peer visit to Swansea. • The service re-	

					opened on Monday 14 February with an interim service model delivered with the support of general anaesthetics and general ICU consultants. • The escalation meetings will be led by WHSSC with support and advice from the Burns Network to ensure standards are maintained through the transition process. • An outline scoping case for the capital development of ITU at Morriston Hospital was shared with WHSSC in May. The first escalation monitoring meeting with SBUHB is currently being arranged.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position	Movement from last month
February 2022	PETIC	Cardiff University	3	Concern over management capacity within the service to ensure a safe, high quality timely service is maintained for patients. These concerns include: • Recent suspension of production of PSMA due a critical quality control issue identified during MHRA inspection. Service slow to address impact on service for patients. • Failure to undertake a timely recruitment exercise leading to isotope production failures. • Failure to produce a	• The quality control issue has been addressed and isotope production restarted on 25 February after a three week suspension. • Analysis of the impact of the delays on patients indicates that while it caused patient anxiety and stress, it is unlikely there will be harm to patients' clinical outcomes. • Current waiting times are within the target turnaround time of 10 days. • The first escalation meeting took place on Friday 25 March. • An action plan has	

				business case of sufficient quality in a timely manner for replacement of the scanner.	been agreed with focus on the management and governance arrangements for the service. The next escalation meeting is on Tuesday 7th June 2022.	

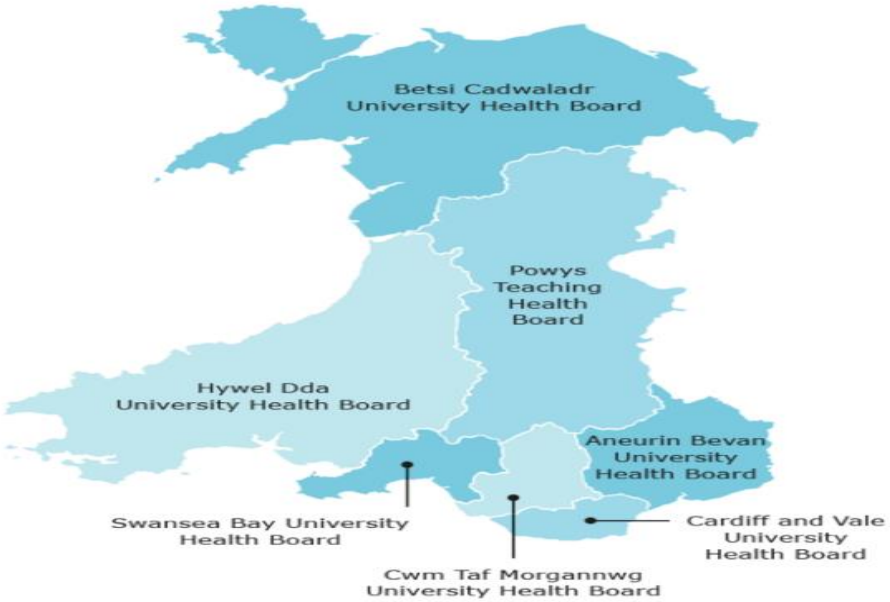
Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WELSH HEALTH SERVICES SPECIALISED COMMISSIONING QUALITY UPDATE



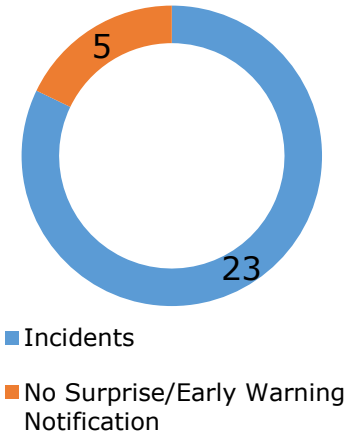
This is the 1st edition of the Quality newsletter from the Welsh Health Specialised Services team in Wales. Our plan is for these to be developed on a quarterly basis to supplement some of the reports and data which already feedback through different forums into the Welsh Health Boards.

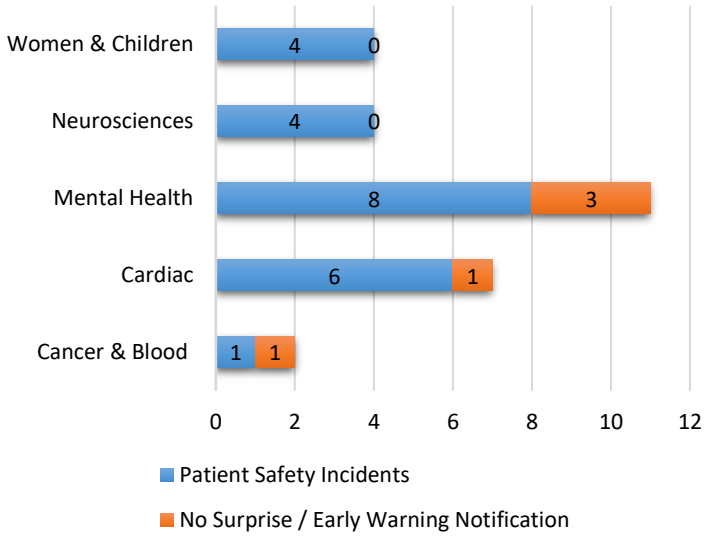
These are some of the highlights and an overview of some of the work we are involved with from a commissioning perspective. The services commissioned from WHSSC are both in Wales and with NHS England this will only provide a very brief snapshot of some of these.

Reporting for the last Quarter

WHSSC do not investigate incidents but are responsible for supporting the investigations into these alongside the monitoring and reporting to the Health Boards. WHSSC are responsible for ensuring the delivery of safe services and any action plans themes or trends arising from concerns are completed and support learning. WHSSC facilitate the continued monitoring of commissioned services and work with providers when any issues arise.

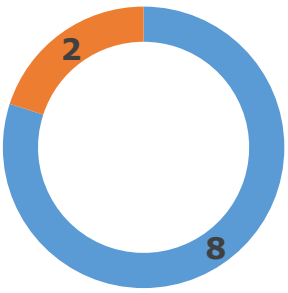
As at March 2022 there are **23** Patient Safety Incidents and **5** No Surprise/Early





Complaints

As at March 2022 a total of **8** Patient Safety Incidents and **2** No Surprise/Early



Service Innovation and Improvement Days
Formerly known as Audit and Outcome Days

During the Covid period these were put on hold but are now back and underway. To date, two days have been held this year one with the Intestinal Failure team and another with the Cancer Network and the Sarcoma specialist teams. A further date is planned for July 2022 with the Cystic Fibrosis team. The days have been really beneficial and the following is an illustration of some of the themes which have emerged:-

These have provided a forum for patient experience to be shared and an opportunity to hear about innovation and different ways of working which

have been adopted to support and deliver services through Covid. They have also provided an opportunity for services to discuss horizon scanning and the development of new services / pathways to support emerging new treatment and therapies. They have facilitated networking opportunities and provided a platform for benchmarking.

The following are some comments received from attendees of the day:-

Whatever the future holds, I am confident that I have received the very best treatment currently available to science to minimise the risk of a re-occurrence. It is reassuring that I am regularly being rechecked and have been made aware of the self-surveillance I need to be undertaking.
Know that I still have the support at the end of the telephone, helps me and my family get answers to questions when they arise, although I try to keep these to a minimum.

Overall having a team that I could have confidence in had a really positive impact on both my mental and physical health.

Thanks for the skills of the medical team and the care I have received. My quality of life is much the same is was pre-sarcoma. I have come through this with as much of a positive mental attitude for the future as I enjoyed in the past.

The fact that to achieve this quality care incurred travelling a greater distance than to my local general hospital has been more than worthwhile. Throughout my treatment, I felt I was more part of the team than just a patient. This was achieved by keeping me well informed and giving me guidance on the options available.

Update from the Patient Care Team
IPFR (Individual Patient Funding Request)

The Patient Care Team receives and manages individual patient funding requests for healthcare that falls outside of agreed range of services.

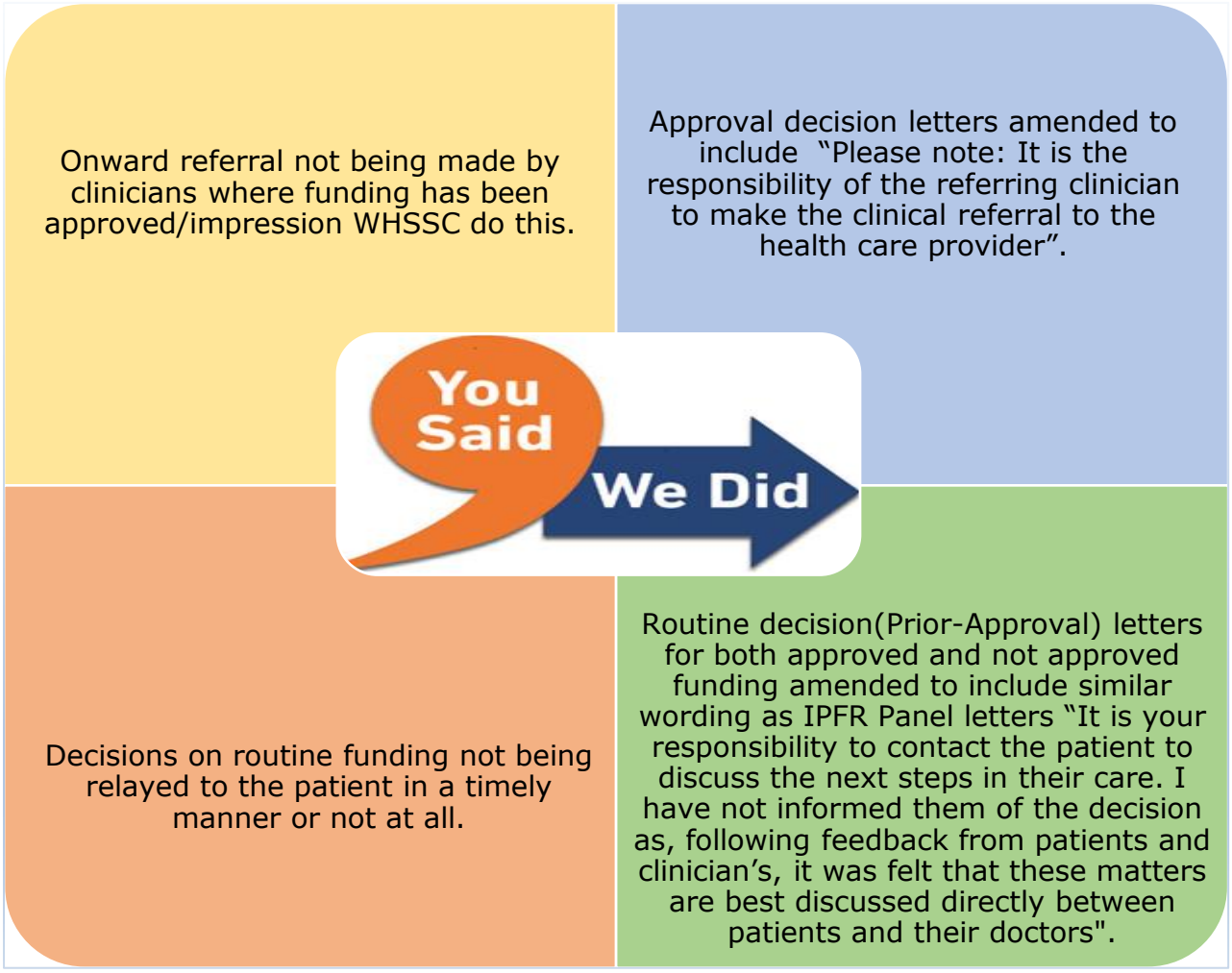
An overview of IPFRs processed 2021 – 2022 (Quarter 1 – 4):

Qtr 1	
April – June	551
Qtr 2	
July – September	449
Qtr 3	
October – December	434
Qtr 4	
Jan – March	603

Total Number of IPFRs 2038

Feedback received to the IPFR team

You Said, We Did – listening to feedback and implementing change:-



Engagement with Patient Experience

Listening and learning from Patient stories and experience provides the team with great insight into the services commissioned by WHSSC. One story shared with the team last year was from the prosthetic team in Cardiff and involved a patient who had received a microprocessor prosthetic knee. The patient was able to demonstrate over Teams the difference this had made to his mobility and the impact and improvement this had on his quality of life. The prosthetic team were also able to demonstrate how important their work is and how individual this had to be to patients requiring their services.

Many teams have had to work in different ways over the last year and have had to be very innovative in their approach. Some of the teams have shared how they have had to adapt to working with SMART phones and apps with their patients to monitor their wellbeing over virtual appointments and how much they have learnt through doing them to this. Some of this has promoted independence in some of their client groups and been enabling for them.

Some data shared with the team form the Clinical Nurses in Adult Congenital heart disease included an evaluation from patients on virtual clinics.

The Survey was undertaken through survey monkey and sent to **64** patients, a total of **35** responses were received resulting in the following summary,

- A blended approach mix of virtual and face to face appointments thought to work well by patients

- Virtual clinics to be offered as video rather than telephone call to improve the patient experience
- Prior to virtual appointment, patients who require tests such as ECG and Echocardiograms beforehand are undertaken prior to the appointment.
- Promotion and support of patient self-management such as Blood pressure self-monitoring, weight management and symptoms, use of fit watches, pulse measurement apps for heart rhythm recognition felt to be helpful and supportive.

It was evident the Team had learnt to respond and manage patients during the pandemic in new and innovative ways. The experience has seen the team and the patients become more confident with the new ways of working and the ongoing approach to be more of a blended approach.

Other surveys and stories which WHSSC have supported have been the impact delays have had on patients in treatment within certain specialties, such congenital cleft lip and palate, , the following are just a few comments from patients into the survey:-

Quick Round up of Commissioning Teams

Mental Health

5 year strategy being developed and well underway with excellent engagement and support from the Welsh Clinical Teams.

Women and Chidren's

Paediatric Strategy is gaining momentum and moving forward with improved engagement

Neurosciences and long term condition

Plan to develop All Wales strategy to improve outcomes and experience of patients receiving specialised rehabilitation

Cancer and Blood

Recent successful Sarcoma Service Improvement and Innovation Day held.

Cardiac

Richard Palmer has joined the commissiong team as a planner . Andrea will be returning to supporting Patient care team after a brief retirement

Intestinal Failure

Ongoing work being undertaken with the recently formed IF commissioning team and as a result of the IF review and Service Improvement and Innovation Day

Recognition of significant events and useful links

Well done to the team Professor Iolo Doull/ Sian Lewis and Andrew Champion on their recent publication:-

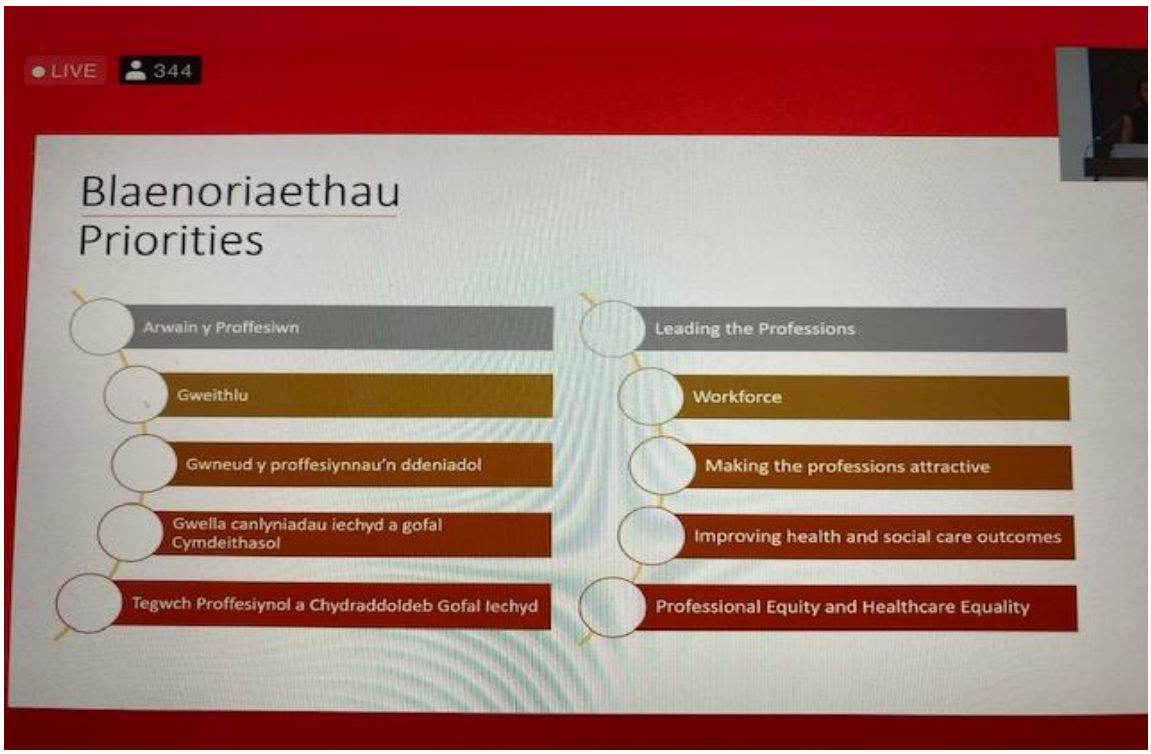
A Case Study on Reviewing Specialist Services Commissioning in Wales:
TAVI for Severe Aortic Stenosis
Applied Health Economics and Health Policy Journal

A Case Study on Reviewing Specialist Services Commissioning in Wales: TAVI for Severe Aortic Stenosis | SpringerLink

Chief Nursing Officer Conference Wales

Sue Tranka, Chief Nursing Officer for Wales

The recent Chief Nursing Officer Conference held in April 2022 saw the launch of the CNO priorities included below. WHSSC team will be supporting and continuing to incorporate these into their practice. The theme of the conference was very much around professional leadership and delivering this with kindness and Compassion.



Developed in collaboration with stakeholders, the five priorities are:

- Leading the profession - invest in and develop nurse and midwife leaders at all levels in health and social care through dedicated leadership programmes;
- Workforce - close the vacancy gap and attract, recruit and retain a motivated, skilled workforce;
- Making the professions attractive - inspire people to enter the nursing and midwifery professions as the most attractive healthcare career choice in Wales;
- Improving health and social care outcomes - deliver equitable, good-quality, person-centred care; and
- Professional equity and healthcare equality - create a nursing and midwifery workforce that reflects the population it serves and addresses inequalities.

220405 Patient Safety Update 5 April 2022 i:

OTHER USEFUL LINKS WHSSC WEBSITE ….

Welsh Health Specialised Services Committee