Patient Quality, Safety & Outcomes Committee

Tue 05 April 2022, 09:30 - 12:30

Microsoft Teams

Agenda

09:30 - 09:40
10 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. For Approval: Draft Minutes of the Committee Meeting held on the 8th February 2022

Attachment *Chair*

1.4 Updated Approved Draft PQSOC Minutes 8th February 2022 (Chair approved).pdf (9 pages)

1.5. For Discussion: Committee Action Log

Attachment *Chair*

1.5 updated PQSOC Action Log April 2022.pdf (7 pages)

09:40 - 12:00
140 min

2. Items for Presentation and Discussion

2.1. Assurance Report: National Clinical Audit and Local Clinical Audit Arrangements

Attachment *Medical Director*

2.1 National Clincal Audit 20220303.pdf (36 pages)

2.2. Assurance Report: Compliance with Cleaning Standards, including Bench-marking Data, and Actions underway to address associated issues and risks

Attachment *Director of Operations/Divisional Director of Facilities/Senior Facilities Manager*

2.2 Enhanced Cleaning standards.pdf (8 pages)

2.3. Dementia Services Update, including a Patient Experience Story

Presentation- to follow *Director of Nursing*

2.4. Committee Annual Work Plan/Priorities 2022/23

Presentation- to follow *Director of Corporate Governance*

2.4.1. 10 MINUTE COMFORT BREAK

2.5. Healthcare Inspectorate Wales, Inspections Update

Attachment *Director of Nursing*

2.5 HIW Inspections Report for PQSOC.pdf (6 pages)

2.6. Patient Quality and Safety Outcomes Report

Attachment *Clinical Executives*

2.6 PQSOC Performance Report - March 2022 - FINAL.pdf (34 pages)

2.7. Patient Quality, Safety and Outcomes Committee Risk Report

Attachment- to follow *Director of Corporate Governance*

2.8. Assurance Report: Access to Primary Care Services

Attachment *Director of Primary, Community Care and Mental Health Services/Head of Primary Care*

2.8 Assurance report cover paper- Access to Primary Care Services.pdf (4 pages)
2.8a Assurance Report- Access to Primary Care Services.pdf (12 pages)

12:00 - 12:25
25 min

3. Items to be Received for Information

3.1. Highlight Assurance Reports:

3.1.1. Quality, Patient Safety and Outcomes Group

Attachment *Director of Nursing*

3.1.1 QPSOG report from 01 03 2022.pdf (2 pages)

3.1.2. Children's Rights & Participation Forum

Attachment *Director of Nursing*

3.1.2 CRP Forum Highlight Report - Jan 2022.pdf (3 pages)

3.1.3. WHSSC Quality & Patient Safety Committee

Attachment *Director of Nursing*

3.1.3 Q&PS Chairs Report January 2022.pdf (16 pages)

3.2. Transition and Handover- Children's and Adults Health Care Services

Attachment *Director of Operations*

3.2 2022- 02-28 JP to CEs re transition between children_s and adult healthcare services(1).pdf (2 pages)

3.3. Investigating and Learning from Cases of Nosocomial Covid-19

Attachment *Director of Nursing*

3.3 20220301 - Funding letter - Investigation and learning from Nosocomial Cases - Aneurin Bevan University Health Board.pdf (2 pages)

3.4. Internal Audit Reports:

3.4.1. GUH Quality Assurance Report

Attachment *Director of Corporate Governance*

3.4.1 ABUHB_2021-22_GUH Quality Assurance_Final Report.pdf (21 pages)

3.4.2. Falls Management Report

Attachment *Director of Corporate Governance*

3.4.2 AB 2021-22 - Falls Management FINAL Internal Audit Report.pdf (15 pages)

3.5. Committee Terms of Reference 2022/23

Attachment *Director of Corporate Governance*

3.5 Terms of Reference PQSO Committee_March2022.pdf (12 pages)

12:25 - 12:30
5 min

4. Other Matters

4.1. To confirm any key risks and issues for reporting/escalation to Board and/or other Committees

Verbal *Chair*

12:30 - 12:30
0 min

5. Date of the next meeting; Tuesday 7th June 2022 at 09:30 via Microsoft Teams

Verbal *Chair*

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of Patient Quality, Safety & Outcomes Committee held on Tuesday 8th February 2022 at 9.30am via Teams

Present:

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

In attendance:

Glyn Jones	-	Interim Chief Executive
Rani Mallison	-	Board Secretary
Tracey Partridge-Wilson	-	Assistant Director of Nursing
Peter Carr	-	Director of Therapies & health Science
Alexandra Scott	-	Assistant Director of Quality and Patient Safety
Gareth Hughes	-	Divisional Director of Facilities
Emma Guscott	-	Committee Secretariat

Observers:

Nathan Couch	-	Audit Wales
Laura Howells	-	Principle Auditor, NWSSP
Alan Davies	-	Aneurin Bevan Community Health Council

Apologies:

Rhiannon Jones	-	Director of Nursing
James Calvert	-	Medical Director

1	**Preliminary Matters**
PQSO 0802/01	**Welcome and Introductions** The Chair welcomed those present to the meeting and thanked individuals for their attendance.
PQSO 0802/02	**Apologies for Absence** Apologies for absence were noted as above.
PQSO 0802/03	**Declarations of Interest** There were no Declarations of Interest raised in relation to items on the agenda.
PQSO 0802/04	**Draft Minutes of the Committee held on 21st December 2021** The minutes of the meeting held on the 21st December 2021 were agreed as a true and accurate record. Shelley Bosson, Independent Member, queried what was meant by 'moral injury' on page 6 of the minutes. Peter Carr, Director of Therapies and Health Science, informed the Committee that this referred to something falling below basic moral standards. The Health Board encouraged all clinicians and staff to work within their boundaries and share their experiences. Shelley Bosson discussed the following on page 6 of the minutes; *A rapid review of nurse staffing had taken place. As a result, £800k additional investment had been approved by the Executive Team for additional nursing and health care support workers. Active recruitment was underway, noting that if recruitment was unsuccessful other options would need to be considered to mitigate risk.* Shelley Bosson queried how long the Health Board would follow the plan before considering other options. Tracey Partridge-Wilson, Assistant Director of Nursing, informed the Committee that the recruitment process had been successful. **Action:** The Chair requested an update on the number of staff that had been appointed to come back to the next Committee meeting, for assurance. **Tracey Partridge-Wilson**
PQSO 0802/05	**Action Sheet of the Committee held on the 21st December 2021** 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 *Update the Equality Impact Assessment and recirculate the paper.* Peter Carr, Director of Therapies and Health Science, informed the Committee that this would be shared outside of the meeting. **2112/04 Annual Assurance Report on Health & Care Standards:** **Nutrition and Hydration** *Peter Carr informed members that the Health Board is 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 exploratory work was taking place within the Health Board and any recommendations would go to the Executive Team, with a Nutrition and Hydration Compliance report coming back to the Committee. Louise Wright, Independent Member, requested information on how the Health Board monitored patients requiring assistance to eat. Tracey Partridge-Wilson informed the Committee that the Health Board was utilising 'red trays' to identify patients at risk and this was being audited. Peter Carr informed members that the Health Board were working towards raising standards for both specialised and general nutrition, and recognised more work was required to improve nutrition on the wards. The Chair requested that staff food also be considered, aligning to the 'Healthy Weight, Healthy Wales' strategy. Gareth Hughes, Divisional Director of Facilities, informed members that the Health Board were compliant with All Wales standards for patient and staff nutrition and that any further updates would come back to the Committee.
2	**Items for Presentation and Discussion**
PQSO 0802/06	**Update on Compliance with Cleaning Standards** Gareth Hughes, Divisional Director of Facilities, provided an update on progress with compliance with cleaning standards. The following was outlined: • Through the Innovation Capital programme, the Health Board had purchased and successfully piloted three robots for cleaning, out of hours. • Additional Hydrogen Peroxide Vapour (HPV) machines had been purchased. • The facilities teams implemented staff training through the Health Board's Centre of Excellence.

	• ABUHB is the only Health Board in Wales with an Internal Audit team for facilities; this team had recently increased to 11 staff. • In relation to recruitment, the Health Board had recruited 33 out of the 52 intended positions. Staff feedback indicated retainment had been positively influenced by increased training and support. • NTG Audit Scores were discussed, with cleaning standards data above 95%. • Risks are manged against the All-Wales Cleaning Standards. One identified risk was the frequency of cleans. This was due to low staffing levels as a result of sickness and gaps in recruitment. The Committee were assured that this risk was being mitigated through recruitment and the utilisation of the Simbiotic data, enabling robust audit and assessment of compliance. Louise Wright, Independent Member, queried what could be done to uplift the grading for staff, to address the recruitment issue of staff leaving cleaning roles for higher paid employers outside of the Health Board. Gareth Hughes informed the Committee that the Health Board could not change current NHS based job descriptions. The Facilities teams were implementing a number of things to improve staff experience, outlined as follows: • 'You said, we did' initiative, managers were completing regular walk-arounds, listening to staff and acting on feedback. • Employing a Recruitment and Retention Manager, as part of improving staff experience and investing in staff well-being. • Based on staff feedback, the Facilities Team were also recruiting a Communications Officer to ensure Health Board messaging gets to those staff who do not have regular access to the intranet as part of their daily role. • Creating a pathway for staff to progress, supporting staff to develop if they wish to do so, through PADR discussions and support. Shelley Bosson, who is an observer at the Facilities PMO, informed the Committee of the impressive work being undertaken by the Facilities Division and was encouraged by the enthusiasm of the staff. **Action:** Full report to come back at the next Committee meeting. **Gareth Hughes** The Committee thanked Gareth Hughes for the comprehensive update.
PQSO	**Assurance Report: Infection Prevention and Control**

0802/07	**Management during the COVID Pandemic (including the Local Options Framework)** Tracey Partridge-Wilson, Assistant Director of Nursing, provided the Committee with an overview of the report and an update on the impact and management of the COVID pandemic. The Committee were informed that an update on vaccinations would be discussed in the outcomes report further along in the agenda. The report outlined data in terms of hospital rates, ITU activity, outbreaks, the care home position, and mortality together with an overview of the changes to national IPAC guidance from December 2021 to January 2022 and implementation of the Local Options Framework. The Committee were informed that the Alert Level for Wales remains at zero. As of February 8th, 2022, the number of ABUHB hospital COVID outbreaks was 15, which was having a significant impact on system flow, particularly in the Royal Gwent Hospital. The changes in IPAC guidance were discussed, with December 2021 changes outlining that ABUHB continue with the pathways in place, protecting the 'Green' pathways for elective patients. Tracey Partridge-Wilson gave an overview of the Local Options Framework as outlined in the paper. It was discussed that the framework enabled Health Boards in Wales to present flexibility based on demand and capacity. Paul Deneen queried how the Local Options Framework was reviewed by the Health Board. Rani Mallison, Board Secretary, informed the Committee that decisions were agreed and regularly reviewed through the Executive Team Meetings. Any plans to reintroduce 'business as usual' would come forward to the Executives for approval. Paul Deneen questioned how the Health Board managed communications to staff and the community. Tracey Partridge-Wilson stated that messages were communicated through the Community Health Council (CHC), Social Media platforms, the ABUHB Internet page and regular staff emails via the Communications team. Glyn Jones, Interim Chief Executive, stated that staff who are directly impacted by any decisions are part of the decision-making process. Shelley Bosson queried how the Health Board managed the pressures relating to community transmission of COVID. Alexandra Scott discussed that the report presented to the Committee in December outlined the impact of COVID on Primary Care services. Two metre distancing remains in GP surgeries, additional clinical resources have been made available, including Allied Care and Clinical Nurse Specialists, to alleviate pressures. It was noted that COVID continues

	to impact Primary Care Services. The Chair discussed the importance of continuing the communication of best practice in Primary Care settings, particularly infection control in Care Homes. The Committee requested that any future COVID updates include Primary Care Services. The Committee thanked Tracey Partridge-Wilson for the update and received the report for assurance.
PQSO 0802/08	**Patient Quality and Safety Outcomes Report** Peter Carr, Director of Therapies and Health Science, provided an overview of the report. It was noted that the report included the previous Committee recommendations of mapping it against the Health Board's Annual Plan. The presentation focused on two areas that were of 'red' rag rating: Stroke Services and Urgent Care. The Committee was informed that in Urgent Care, there were significant pressures in the Emergency Departments (ED). It was discussed that the Omicron wave was impacting on both workforce and presentation of patients, causing disruption, and affecting the ability to achieve normal flow and capacity. System flow blockages contributed to the inability to discharge, with Care in the Community and Care Homes being a limiting factor. Attendance at the hospital front door was higher than pre-pandemic, contributing the increased length of stay (LOS) in the ED. Ambulance handover times were discussed. The Health Board's target for transit times was 95% of patients to be admitted, transferred, or discharged within 4 hours based on individual care requirements. Although ABUHB performance was in line with All Wales performance, it was not achieving this target at present. Delayed handovers were being closely monitored and teams were working alongside Welsh Ambulance Service NHS Trust (WAST) to improve services and share any learning and outcomes from incidents. Emergency department teams and WAST work together to ensure that the fundamentals of care are provided for patients awaiting treatment. Shelley Bosson questioned what would be considered as an incident. Peter Carr informed the Committee that a WAST incident is where delayed handovers have been a contributing factor in patient care. The Health Board then investigates and shares outcomes and learning with WAST. Paul Deneen requested assurance around current challenges with 111 services. Glyn Jones, Interim Chief Executive, informed the Committee that the Health Board were involved with the national 111 programme.

	There were capacity and handover issues in December 2021 due to unprecedented demand, resulting in high call abandonment rates. More recently, the 111 service has added additional telephone capacity and recruited staff, with early data showing a positive impact with lower abandonment rates. There is an intention to roll out the '111 service' across Wales by the end of March 2022. The Chair requested data on the number of patients being taken to hospital in an Ambulance, where the Ambulance transport was not required. The Committee were informed that pre-hospital streaming and intelligent diverts take place, alongside WAST, to determine the best care for patients. **Action:** Relevant data to be shared in future Urgent Care reports. **Peter Carr** The Committee encouraged conversations with Welsh Government (WG) relating to clear signage for the new hospital sites, as data indicates that patients are attending incorrect sites for treatment. The Committee was informed of the current challenges within the Stroke pathway and how these linked to system pressures on the Urgent Care pathway. Quality metrics were discussed; patients arriving in the Emergency Department and moving through to the Hyper Acute Stroke Unit (HASO) at GUH within the recommended 4 hours was at 8.2% during November 2021. The lack of capacity within the HASO was largely attributed to system pressures and the need for HASO beds to be used to accommodate non-stroke patients. The following plans to mitigate risk were discussed: • A Standard Operating Procedure (SOP) for a protected Stroke pathway was being assessed by the Executive Team. • Stroke treatment training has been provided for clinical staff within the triage and Emergency Departments. • The Executive Team have invested in Speech and Language therapy services in GUH, and recruitment is underway. • ABUHB, alongside the Stroke Association and the Community Health Council, have updated communications to educate and support the population to recognise early signs of Stroke. The Stroke Directorate were working alongside 'Getting It Right First Time', who were completing an external review. Recommendations from this engagement will support the Health Board in improving future Stroke services. This review was being overseen by the Stroke Recovery Group, chaired by Peter Carr. Louise Wright, Independent Member, discussed the large amount of Datix concerns raised around the use of the HASU therapy room in GUH. The Committee requested assurance on what the Health Board was doing to address this, and information on any clinical areas that

	were protected and not used to alleviate system pressures. Peter Carr informed the Committee that due to extreme system pressures the Health Board had to make daily decisions to mitigate risk, ensuring patient safety and sufficient clinical staffing. It was noted that the Therapy room on the HASU was an important clinical area to enable therapies services to provide care to patients. The Committee was assured that any breach of the Therapies room was being monitored daily, by the Executive Team, through the HASU utilisation update and ABUHB Situation Report (SITREP). Several spaces within GUH and across eLGHs were being repurposed as additional capacity to address system pressures, ensuring that correct medical and clinical staffing cover was available for each area. Paul Deneen, Independent Member, requested assurance of sufficient 24 hour cover on the HASU and that there was no variation of service in and out of hours. The Committee was informed that there is a Stroke consultant on-call 24 hours a day. Further investigation into variation of service between in hours and out of hours would be looked into, alongside the 'Getting it Right First Time' external audit. **Action:** The Chair requested an update of the external audit to come back to the Committee. **Peter Carr** The Chair discussed early hearing tests for older adult pathways such as Dementia and Stroke and questioned if this could be incorporated into the Health Board's Stroke pathway. **Action:** A further look at the pathway capacity to support this. **Peter Carr** The Committee discussed the excellent work undertaken and thanked the teams. Shelley Bosson, Independent Member, noted the 'End of Life Companion' initiative and requested further information of the availability across all hospital sites. **Action:** Numbers to be circulated to members outside of the meeting. **Tracey Partridge-Wilson** The Chair congratulated Peter Carr and the teams on the huge improvement in the number of falls, as outlined in the report. The Chair discussed complaints from patients and families around communication. The Committee requested information on the temporary patient liaison service, noting its success in facilitating communication and supporting patients and families. The Committee was advised that the Health Board were looking at a longer-term solution for a patient liaison service, and currently recruiting extra staff.

	The Committee received the report provided. The Chair extended her thanks to Peter Carr and respective teams, recognising the work undertaken.
PQSO 0802/09	**Patient Safety, Quality and Outcomes Committee Risk Report** Rani Mallison, Board Secretary, presented the previously circulated risk report to the Committee. The Committee were advised that the report included risks that had recently been reported to the Board as part of the Corporate Risk Register. The report was used to inform the Committee agenda, therefore all outlined associated risks would have been discussed during the meeting. Shelley Bosson requested that the threat cause of the risk *Inadequate surge capacity to meet surge demand, pg.66* be reviewed to ensure the threat cause of *Increase in pandemic levels* was still relevant. **Action:** Board Secretary to look into request. **Rani Mallison** The Committee discussed that inpatient falls were listed as a high risk and questioned if the risk score was accurate due to the number of inpatient falls dropping significantly. The Committee were informed that the aim for the Health Board was to get below All-Wales comparisons and were looking to reduce the risk score from 15 to an inherent risk score of 10. **Action:** The Chair requested further discussing around managing pandemic risks at the next Committee meeting. **Rani Mallison/secretariat**
3	**Other Matters**
PQSO 0802/10	**To Confirm any Key Risks and Issues for Reporting/Escalation to Board and/or other Committees** None Noted.
4	**Date of Next Meeting is Tuesday 5th April 2021 at 09:30 via Microsoft Teams**

Agenda Item:

Patient Quality, Safety & Outcomes Committee

Action Log - April 2022

Agreed Actions:

Overdue	Not yet due	Due	Transferred	Complete

Action Ref	Action Description	Due	Lead	Progress	Status
1304/05	A Matrix of Committee Duties to come to a future meeting (1102/17)	April 2022	**Rani Mallison**	The Board and its Committees will undertake an assessment of its effectiveness during Feb/March 2021. In doing so, the Board will review its Committee structure, roles and responsibilities and priorities. Board and Committee workplans will therefore be developed to take effect from 1st April 2022, informed by strategic risk/board assurance framework, emerging issues and assurance needs based on regulatory and compliance requirements. The Board and Committee workplans will be aligned to ensure the Board, via its Committee, is focussed on ensuring the delivery of Strategic Objectives.	Not yet due

Action Ref	Action Description	Due	Lead	Progress	Status
1910/13	**Annual Assurance Report on Health & Care Standards: Nutrition and Hydration** Update the Equality Impact Assessment and recirculate the paper		**Peter Carr / Secretariat**	**21/12/21** Peter Carr to update and recirculate the Equality Impact Assessment.	In progress
	An update inclusive of a map of where the facilities are to be received following the review	July 2022	**Peter Carr / 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 Executive Team in Summer 2022.	Not yet due
2112/04	**Annual Assurance Report on Health & Care Standards: Nutrition and Hydration** **Shelley Bosson requested the following be added as an action (PQSOC 1910/13)** Peter Carr informed members that the Health Board is	**TBC**	**Peter Carr**	**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. 08/02/22 Peter Carr informed the Committee that exploratory work was taking place within the Health	In progress

Action Ref	Action Description	Due	Lead	Progress	Status
	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.			Board and any recommendations would go to the Executive Team, with a Nutrition and Hydration Compliance report coming back to the Committee.	
2112/07	**Minor Injuries Units eLGHs** The Chair requested further information on patient transfers and any challenges to come back to a future meeting.		**Rhiannon Jones/** **James Calvert**	**21/1/22** Update received from Rhiannon Jones: An update will be provided to the April 22 Committee meeting. Added to the Forward work plan. **10/03/22** In place of an agenda item, a brief note to be shared with members. Update to be provided at the meeting.	Not yet due

Action Ref	Action Description	Due	Lead	Progress	Status
2112/10	**Cleaning Standards Report- performance against standards** A detailed report on the organisational compliance to cleaning standards will be presented to the next committee.	08/02/2022	**Leanne Watkins/** **Gareth Hughes**	Included as a verbal item on Committee meeting agenda for 08/02/22 **0802/06** Full report added to April 2022 agenda on request of Chair. **Added to April agenda.**	Complete
2112/13	**WCCIS Implementation** A strategic review was underway by WG of WCCIS national programme. The results of the report will influence how the Health Board utilises the system. A draft report would be completed by WG in January 2022. Draft report to be shared with Independent Members once published	Feb 2022	**Rani Mallison**	Report not yet received.	Due

Action Ref	Action Description	Due	Lead	Progress	Status
0802/08	**Patient Quality and Safety Outcomes Report** The Chair requested data on the number of patients being taken to hospital in an Ambulance, where the Ambulance transport was not required. **Action:** Relevant data to be shared in future Urgent Care reports.		**Peter Carr**		Complete
0802/08.1	**Patient Quality and Safety Outcomes Report** The Chair discussed early hearing tests for older adult pathways such as Dementia and Stroke and questioned if this could be incorporated into the Health Board's Stroke pathway. **Action:** A further look at the pathway capacity to support this.		**Peter Carr**	Range of actions being taken within older adult pathways, and not exclusive to stroke, to support people with hearing loss and dementia, including the following: · Audiology has been leading on a screening assessment with the OAMH Memory Assessment Services as part of the Dementia diagnosis and assessment pathway. · Training, including "Sign live" is being advertised on the Intranet. · The DoL Team lead has been arranging BSL training.	Complete

Action Ref	Action Description	Due	Lead	Progress	Status
				· Facilities has developed a menu picture card prompt. · Ffriend I Mi provides a communication session which includes hearing loss for their volunteer services and hearing aid care. · As part of the Dementia awareness 1 day training, for all staff and dementia Volunteer companions, we include hearing loss and importance of using the "This is me" document that identified patient centred care needs. · In the process of developing patient bedside boards which include communication needs which include hearing impairment and changes in sensory issues.	
0802/08.3	**Patient Quality and Safety Outcomes Report** Shelley Bosson, Independent Member, noted the 'End of Life		**Tracey Partridge-Wilson**	We currently have 45 End-of-Life Companions covering all hospital sites, with an additional 10 in the recruitment process	Complete

Action Ref	Action Description	Due	Lead	Progress	Status
	Companion' initiative and requested further information of the availability across all hospital sites. **Action:** Numbers to be circulated to members outside of the meeting.			10/03/22 Information shared with Committee Members and IM's present at the meeting	
0802/09	**Patient Safety, Quality and Outcomes Committee Risk Report** Shelley Bosson requested that the threat cause of the risk *Inadequate surge capacity to meet surge demand, pg.66* be reviewed to ensure the threat cause of *Increase in pandemic levels* was still relevant. **Action:** Board Secretary to look into request.		**Rani Mallison**	Update to be provided at meeting.	

Committee:	Patient Quality, Safety & Outcomes Committee 5th April 2022
Agenda Item:	**2.1**
Document Title:	**National Clinical Audit**

National Clinical Audit

Summary

- ABUHBs compliance with diabetes care processes and treatment equals Welsh performance but is generally lower than English performance furthermore Welsh performance is declining gradually.
- ABUHB performance in the National Audit of Psychosis is comparable to or exceeds Welsh performance.
- This is the first Fracture Liaison service annual report that ABUHB has contributed to. Data provides some performance information but is not robust enough to provide assurance across the entire FLS pathway in 2019.
- There was some variation noted in inpatient heart failure care between NHH and RGH during 2019/20. The implementation of an inpatient pathway will now ensure that all patients admitted with heart failure will have specialist review during their admission.
- RGH was notified of outlier status with respect to adjusted mortality in 2019/20 following emergency laparotomy surgery. Crude mortality data suggests the rate has fallen since single siting at GUH. Ongoing quality improvement work has resulted in improvements against several key performance indicators.
- Nationally significant ethnic and socio-economic inequalities have been demonstrated to lead to poorer maternal and perinatal outcomes. ABUHB have specialist perinatal mental health services and obstetric / medical pathways and participate in the Gap and Grow Programme to monitor small for gestational age babies.
- The Neonatal peer review highlighted good practice and recognised the success of relocating to GUH and merging two neonatal teams. An improvement plan is in place to address a number of recommendations and a significant central line infection improvement plan is in place and has been successful in reducing infection rates in 2021.

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

Patient Quality, Safety and Outcomes Committee is asked to: Discuss the results detailed in the paper and to Note the assurance provided by the actions

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality Safety and Outcomes Committee Tuesday 5th April 2022 Agenda Item:2.1

Approve the Report			
Discuss and Provide Views			x
Receive the Report for Assurance/Compliance			x
Note the Report for Information Only			
Executive Sponsor: James Calvert Executive Medical Director			
Author(s): Joanne Stimpson, Quality and Safety Lead for Clinical Audit and Alexandra Scott Assistant Director of Quality and Patient Safety			
Report Received consideration and supported by:			
Executive Team		**Sub-Committee**	
Date of the Report: 22.03.2022			
Supplementary Papers Attached: Nil			

Situation

The National Clinical Audit and Outcome Review Plan (NCAORP) is a mandated programme of national audit commissioned by Health Quality Improvement Partnership (HQIP) designed to help assess the quality of healthcare and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data.

Background and Context

Welsh health boards and trusts are required to ensure the resources to enable staff to participate in all audits, reviews and national registers included in the annual plan. They should ensure the full audit cycle is completed and that findings and recommendations from audit link directly into the quality improvement programme and lead to improved patient care and outcomes.

To ensure that maximum benefit is derived from the clinical audit programme health boards and trusts should:

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

- Facilitate the wider use of data from audit and national registries to be used as supporting information for medical revalidation and peer review.
- Ensure learning from audit and review is shared across the organisation and communicated to staff and patients.

Following publication of each national clinical audit the clinical lead in conjunction with the Divisional Director reviews the reports and develops an action plan to address any requisite improvements. Both results and action plans are presented to the ABUHB Clinical Standards and Effectiveness Group which reports to Quality and Patients Safety Operational Group a subgroup of PQSOC.

Assessment and Conclusion

The National Diabetes Audit (NDA) provides a comprehensive view of diabetes care in England and Wales. It measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards.

The audit comprises Care Processes and treatment targets for Type 1 and Type 2 Diabetes, with data ranging from 2015 to 2020.

Care Processes
All people with Diabetes age 12 and over should receive all of the eight NICE recommended care processes and attend a structured education programme shortly after diagnosis. The care processes are:

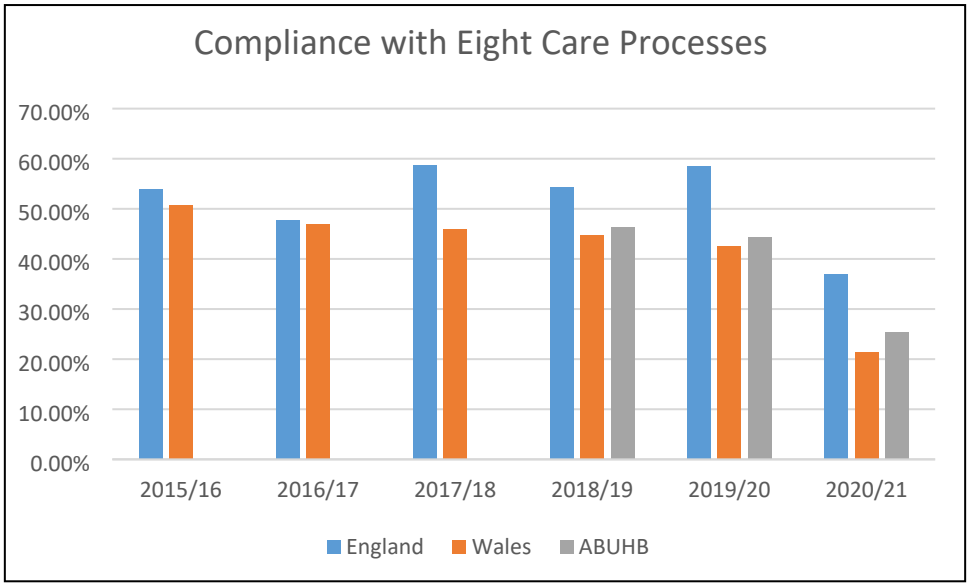
- HbA1c (Glucose control)
- Blood Pressure
- Serum Cholesterol
- Serum Creatinine
- Urine Albumin Creatinine Ratio (UACR)
- Foot Risk Surveillance
- BMI
- Smoking History

(England has a 9th process commenced in 2019/2020 relating to retinal screening not yet reported for Wales).

Type 2 Diabetes
Generally, compliance with six of the eight care processes is reasonable sitting at 80% or above, however much poorer compliance is observed with respect to Urine Albumin /Creatinine Ratio and foot surveillance in England and Wales which reduces the portion of patients receiving all eight care processes significantly and a gradual but sustained decline in performance has been noted in Wales since 2015/16.

- Wales compliance with eight care processes **42.6%**
- England compliance with eight care processes **58.5%**
- ABUHB compliance with eight care processes **44.3%**

Wales reports sustained lower compliance with completion of all eight care processes than England with 42.6% of patients with type 2 diabetes having all eight care process compared with 58.5% in England. ABUHB reports compliance in each of the eight care processes in line with Wales or slightly above the national rate and for comparable numbers of patients receiving all eight care processes.



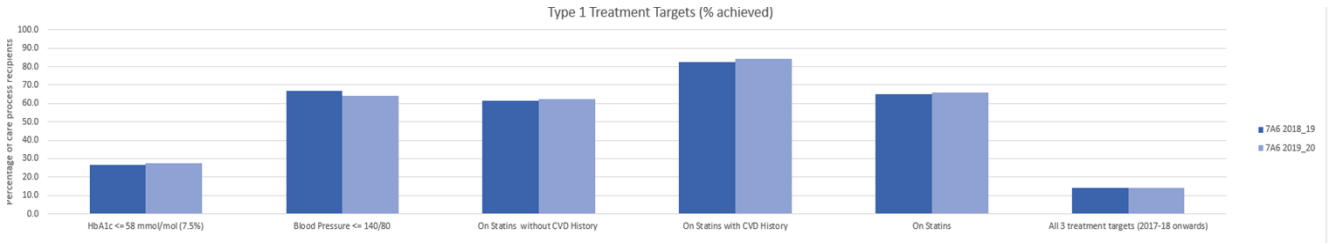
Reduction in compliance has been noted in the next reporting period (2020/21) reflecting the impact of COVID -19 and access to non-urgent care during this period.

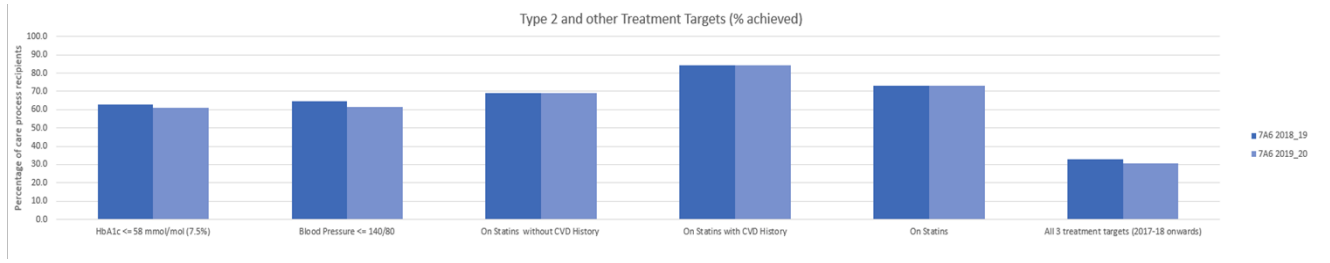
Treatment Targets

As well as recording compliance with care processes the National Diabetes Audit measures effective diabetes management in line with NICE guidelines. A number of treatment targets are applied, and performance is measured as the proportion of the Health Board population meeting these targets.

	England Type 1	Wales Type 1	ABUHB Type 1	England Type 2	Wales Type 2	ABUHB Type 2
Treatment targets of HbA1c <58 mmol/mol	31.6%	26.3%	27.6%	65.6%	61.1%	61.2%
BP <140/80	73.9%	65.9%	64.3%	73.6%	64.6%	61.3%
Statins for primary prevention of CVD	66.2%	62.9%	62.2%	72.3%	67.5%	69.1%
Statins for secondary prevention of CVD	85.1%	84.1%	84.2%	86.4%	84.2%	84.1%
Satins for combined prevention of CVD	69.4%	66.5%	66.1%	76.1%	72.0%	73%
Meeting all three treatment targets	20%	14.2%	14%	40.1%	31.5%	30.6%

The two charts below demonstrate little variation between ABUHB 2018/19 and 2019/20 performance against the treatment targets for both Type 1 and Type 2 diabetes.





Structured Education – Offered and Attended

The offer of structured education within one year of diagnosis has been increasing year on year with ABUHB performance (50.5%) in line with Wales (59.8%), however the numbers of patients recorded as attending structured education within a year of diagnosis is significantly lower with 3.2% of Welsh patients diagnosed with type 2 diabetes and 0.5% of ABUHB patients attending the structured education.

Consideration is being given to a more centralised approach to chronic disease management including focusing initially on respiratory disease and then moving toward diabetes management using a community hub approach. There has been some assurance provided by Localities that the intial resource freed up by moving respiratory disease to community hubs would allow a greater focus on diabetes management until this can migrate to a centralised model.

It was anticipated that both compliance with care processes, but also diabetic control, has declined significantly over the period of the pandemic and moving towards a centralised model will allow a more efficient use of the community diabetes specialist nurse resource.

Compliance with the care processes and several of the treatment targets including BP cholesterol and HbA1c have been identified by Welsh Government as a priority delivery measure and will be subject to national scrutiny.

In Summary

- ABUHB performance is largely comparable with Welsh performance.
- Urine Albumin Creatinine Ratio (UACR) and Foot Risk Surveillance are the two care processes of lowest compliance.
- A centralised chronic disease management model will allow efficient use of clinical nurse specialist resource to drive improvement in treatment targets.
- A centralised model will support the delivery of structured education and care delivery.
- Initially the delivery of centralised chronic disease management, specifically respiratory disease will allow resource to be focused towards diabetes in General Practice.

National Clinical Audit of Psychosis (NCAP) - Wales national report for the early intervention in psychosis (EIP) audit 2020/21

This Welsh report into Early Intervention in Psychosis (EIP) provides information on the treatment of people by EIP teams in Wales, collected as part of the NCAP. EIP services are specialised services providing prompt assessment and evidence-based treatments to people with a first episode of psychosis (FEP). 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.

There is growing evidence for a positive association between treatment provided for first episodes of psychosis and a favourable prognosis. In particular it is recognised that the longer the psychosis is left untreated the poorer the prognosis.

ABUHB provides a standalone multidisciplinary service that consists of consultant psychiatrists and psychologists, mental health nurses, peer support workers and occupational therapists 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 compared to the Wales average of 47 patients.

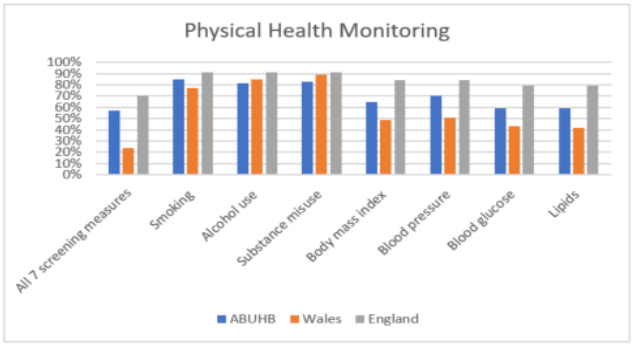
There is wide variation across Wales in relation to timely access, standards met, workforce capacity, staff competencies and resources as well as interventions offered. The evidence suggests that patients should be referred within 2 weeks of onset of a psychotic episode. ABUHB met this standard in 36% of cases

- 85% of patients were offered CBTP compared to 52% across Wales.
- 35% were offered and started family intervention with 16% offered and waiting for intervention compared to 25% across Wales.
- 98% were offered antipsychotic medication, which was comparable with Welsh performance.
- 92% with 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.

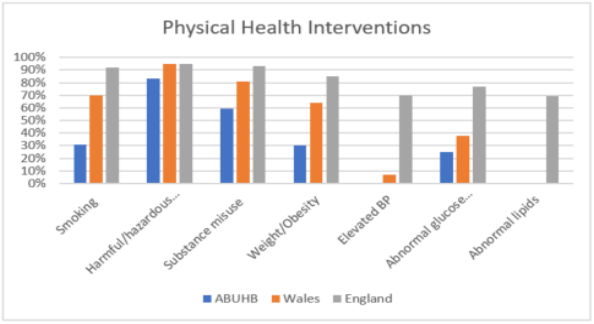
There is an increased risk of developing physical health conditions associated with psychosis and as a result screening for physical conditions is an important measure for this patient group. Screening includes, BMI, Smoking status, alcohol intake and substance abuse and screening for diabetes and cardiovascular risks. 32% of patients in ABUHB received full physical health screening

	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%



Currently ABUHB is unable to provide Cognitive Behavioural Therapy for Psychosis (CBTP) for at risk mental states population (ARMS) (those people in the prodromal stage of psychosis).

In Summary

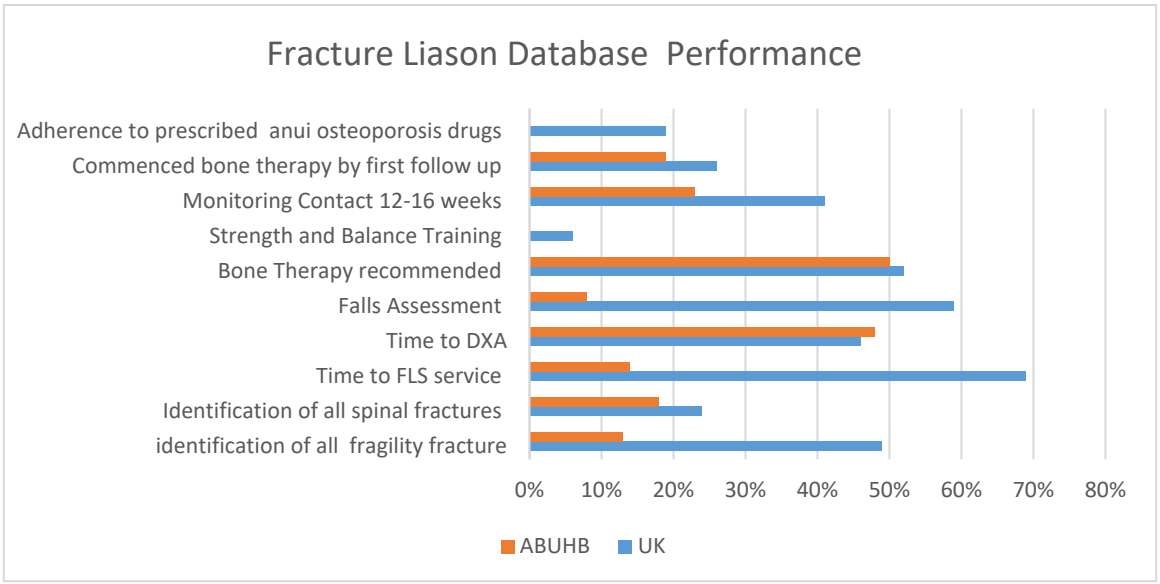
- There have been a number of improvements since the previous year.
- Most areas are comparable or exceed Welsh performance.

- There are plans to progress the delivery of CBTP to the At-Risk Mental State population and to develop 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.
- 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.

Fracture Liaison Service Database (FLS-DB) 2021 (2019 data)

Data collection to support the Fracture Liaison Service database commenced in 2019 and 50% data completeness was achieved compared with a national rate of 69%.

At the time of data collection ABUHB Fracture Liaison Services were delivered by the Rheumatology Directorate to patients under 75 years with a confirmed diagnosis of osteoporosis and those presenting with low trauma fractures. Many patients over 75 years (approximately 75% of the FLS cohort) were referred back to primary care for initiation of bone health treatment, falls assessment and referral to strength and balance training with no data captured to support scrutiny of care delivery for this patient group.



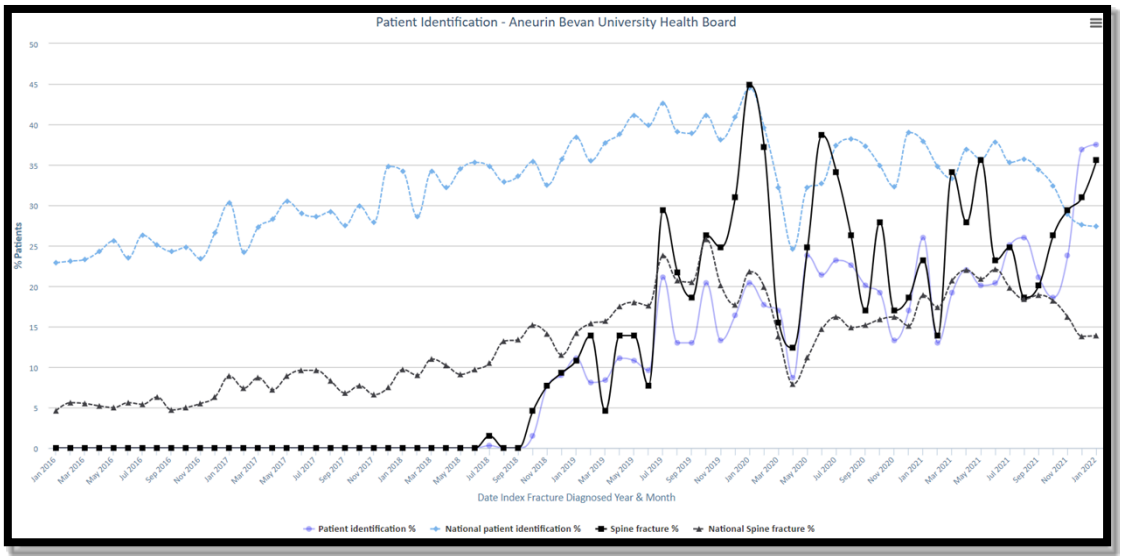
In November 2021, as part of the Welsh Government Recovery Scheme, the Care of the Elderly (COTE) service secured temporary funding to pilot 2.0 WTE Bone Health Clinical Nurse Specialists to manage the Bone Health Service for ABUHB.

Two band 7 Clinical Nurse specialists (CNS) – Falls and Bone Health were appointed to support wider work and the FLS medical team have dedicated time included in the job plans.

Joint working and wider integration among COTE, Rheumatology, Radiology and Community Resource Team (CRT), has enabled services to work in partnership to meet the current evidence-based recommendations and to assess all patients with fragility fracture within 90 days of their fracture and to intervene as required. In addition, the CRT Frailty team is supporting a higher number of falls assessments in the community.

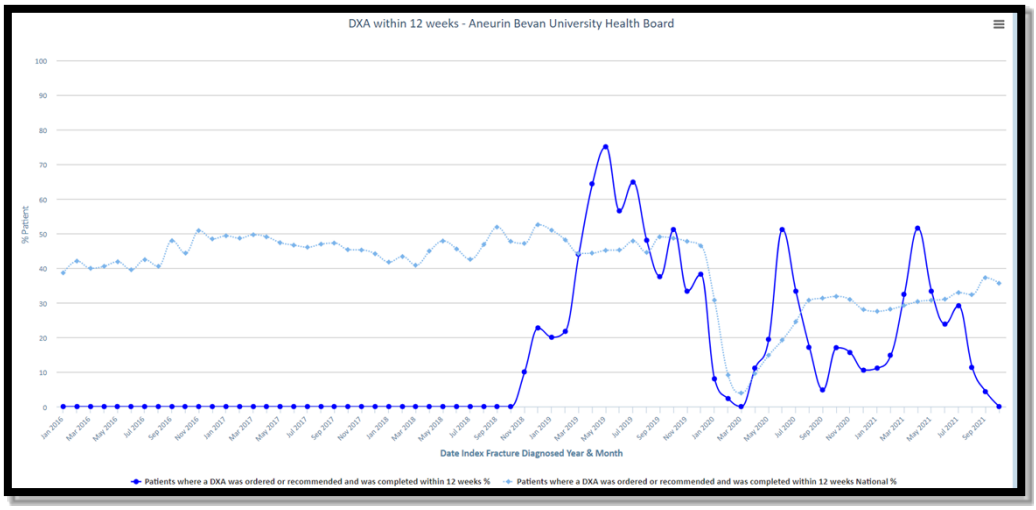
The Radiology directorate review weekly data on fragility fractures and generate a report on weekly basis to support allocation of patients to the appropriate service dependant on their age. The aim is to jointly assess a further 10% more patients in the year 2022 as compared to the year 2021.

The graph below demonstrates the increase in patient identification between 2018 – 2022.



The graph below illustrates the decline in performance relating to DXA scan within 12 weeks of referral since the beginning of the pandemic, due to the redeployment of staff and the requirement to social distance in radiology departments. Current ABUHB DXA scanning for patients who are reviewed in the fracture liaison service

means that patients receive scans within 5 weeks of referral, although provision of DXA reports are subject to delays of up to 12 weeks from referral.



In Summary

- Limited data collection in 2019 means that the 2021 FLS audit report does not reflect care provision for the entire patient cohort.
- The delivery of fracture liaison services has been subject to significant change since November 2021 with the development of a falls and bone health service.
- Routine reporting by radiology ensures that all patients are referred to the fracture liaison service or the falls and bone health service dependant on age.
- The falls and bone health service is providing a holistic approach to assessment and intervention and that extends beyond the KPIs included in the FLS audit for patients over 75 years.

National Heart Failure Audit 2021 (2019-20 data).

The National Heart Failure Audit reports on inpatient care; including investigations, treatments, and access to specialist care for patients admitted with Heart Failure. There is also a focus on discharge and follow up. The audit aims to improve perfromance against 5 KPIs.

Nationaly data was entered on 69,556 heart failure related admissions. A target of 70% case ascertainment is set for each organisation contributing to the audit to ensure that the data accurately reflects the true epidemiological picture of heart failure care. ABUHB achieved 77% case ascertainment in the 2019/20 reporting

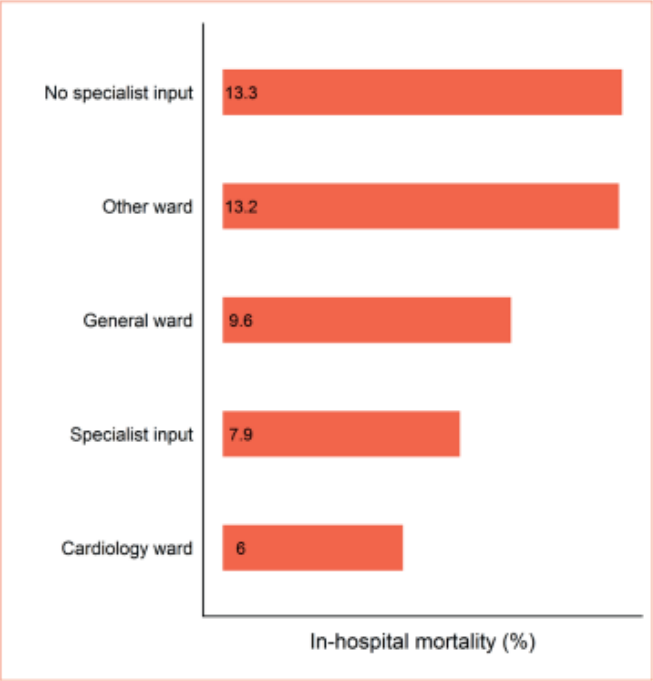
period. A significant and sustained improvement in performance has been seen for the last three years.

The five performance indicators and targets are:

- 90% use of ECG and echocardiogram as diagnostic tools
- 85% specialist team input during admission
- 60% patients being admitted to a cardiology care
- 85% of heart failure admissions with reduced left ventricular ejection fraction on discharge on all 3 disease modifying drugs
- 50% have a 2 week follow up

Access to specialist heart failure care and admission to a cardiac ward is associated with improved performance in relation to the key performance indicators and with improved outcomes for patients. The graph below demonstrates the impact on mortality of cardiology input or admission to a cardiology ward nationally.

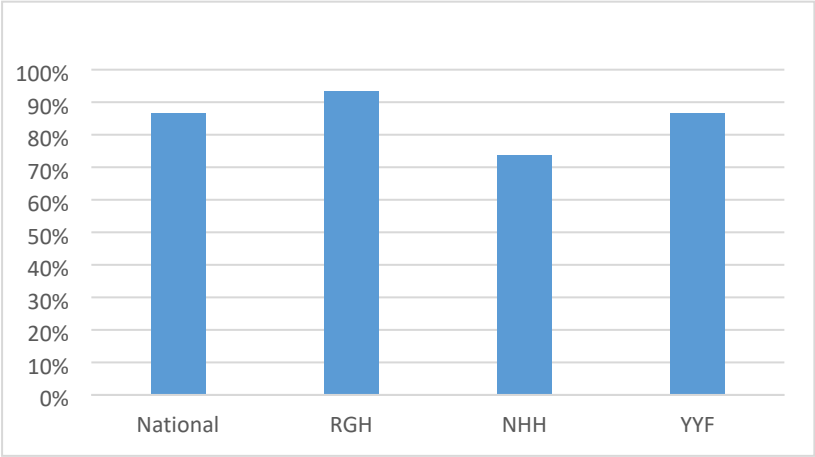
In-hospital mortality 2019/20



KPI: 90% use of ECG and echocardiogram as diagnostic tools

Attempting a diagnosis of heart failure on clinical symptoms and signs alone will result in an incorrect diagnosis 50% of the time. An accurate diagnosis requires an investigation to confirm an underlying structural or functional abnormality of the heart. Nationally echocardiography is performed in 86% of patients. Patients

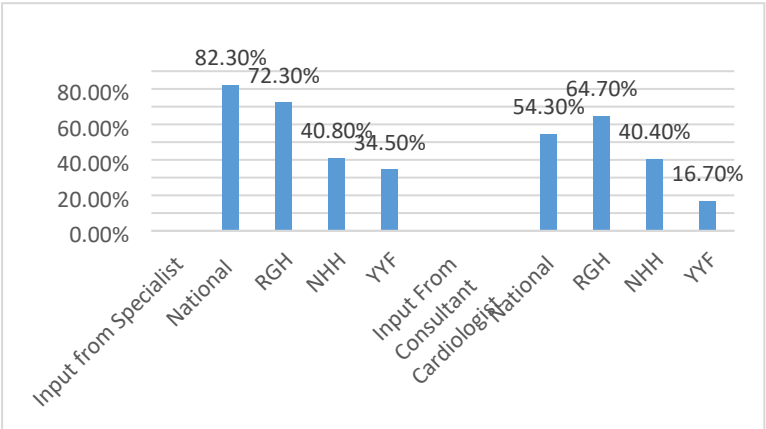
admitted to cardiology wards were more likely to have echocardiography than those admitted to general medical wards (93% versus 82%). However, it should be noted that patients receiving specialist input to their care, no matter where they are admitted, have higher rates of echocardiography (90%). ABUHB met the target in 84% of cases in 2019/20, however there was variation in performance between RGH and NHH, with NHH achieving the target in over 90% while RGH achieved 73%.



KPI: 85% specialist team input during admission & 60% patients being admitted to a cardiology care

In 2019/20 just over 50% of patients in ABUHB had some form of cardiology input and 40% were admitted to a cardiology ward with little improvement noted over the previous three reporting periods. There was significant variation noted in the proportion of patients seen by the Heart Failure Team across the three sites participating in the audit.

Input from Heart Failure Specialist team 2019/20

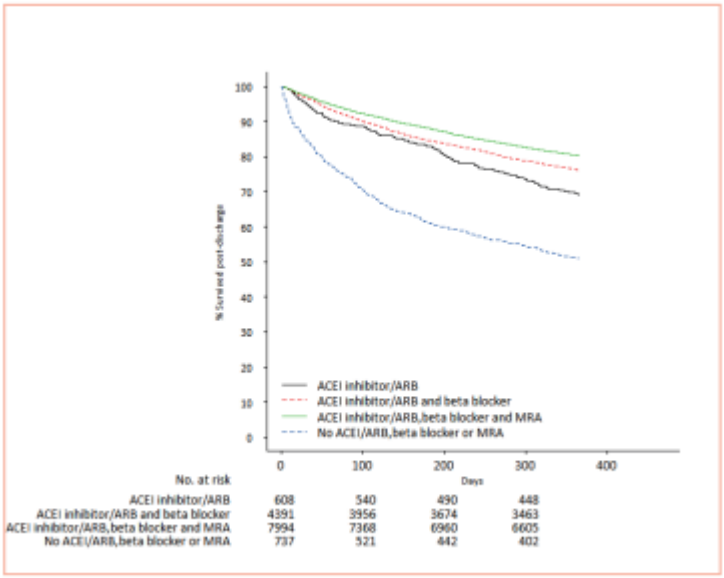


KPI: 85% of heart failure admissions with left ventricular ejection fraction on discharge on all 3 disease modifying drugs

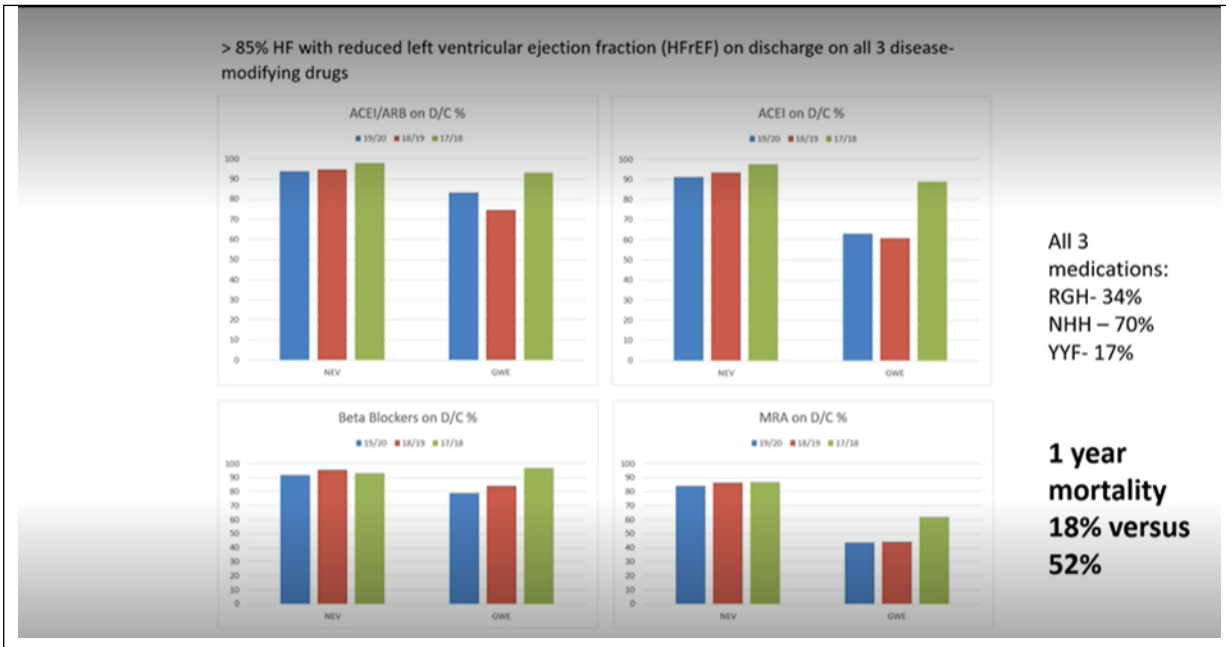
Admission to a cardiology ward or input from a specialist heart failure team is associated with improved prescribing of disease modifying drugs. With rates of applicable patients prescribed all three drugs increasing from 49% to 56% nationally when admitted to a cardiology ward.

Those discharged on all three disease modifying drugs had a 1-year mortality rate of 18% compared to 52% for those leaving hospital without any of the three drugs.

Mortality post-discharge associated with prescribing for patients with HFrEF, 2019/20



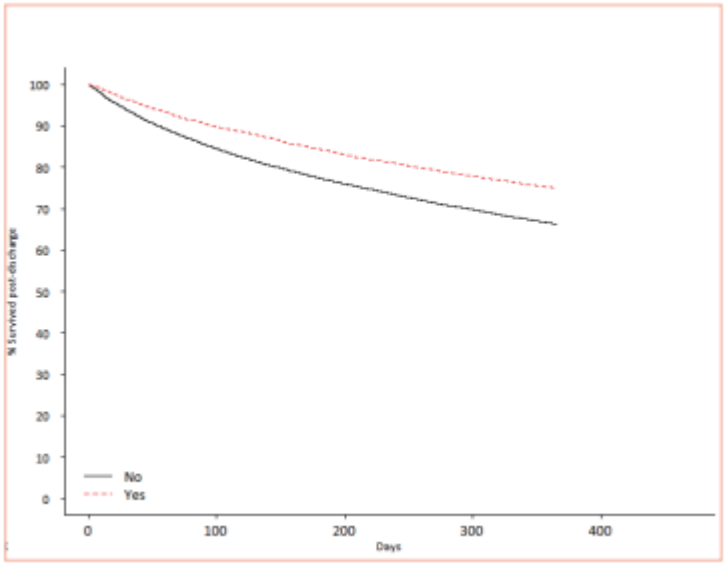
There was significant variation noted in prescribing of disease modifying drugs between the three audit sites with NHH prescribing all three drugs to 70% of patients on discharge compared with 34% at RGH and 17% in YYF.



KPI: 50% of patients should have a 2 week follow up

People admitted to hospital because of heart failure should be discharged only when stable and should receive a clinical assessment from a member of a multidisciplinary heart failure team within 2 weeks of discharge (NICE quality Standard 103). This is a 'high-risk' period, when the patient is at increased risk of hospital readmission and is in danger of falling between hospital and community care. Specialist cardiology and heart failure nurse follow-up and access to cardiac rehabilitation improves morbidity and mortality in heart failure.

One year mortality stratified by referral to cardiac rehabilitation, 2019/20



Patient Reported Outcome Measures (PROMS) and Clinical Reported Outcome Measures (CROMS) were introduced in ABUHB four years ago and allowed the reconfiguration of the heart failure services within existing resources. The changes have been successful in reducing the follow up time from 63 days to 14 days of discharge and all patients receive two appointments within the first 35 days following discharge. This improvement in follow up has resulted in the time to optimisation of medication reducing from 79 weeks to 22 weeks.

Recent funding has increased the nurse workforce to the recommended level of 2 whole time equivalent nurses per 100 000 population, which has supported the Heart Failure Team to introduce an inpatient pathway across GUH, RGH, NHH and YYF. It is anticipated that this will significantly increase the proportion of patients who have input from the specialist heart failure services. The nurses will form a link with cardiology services. It is intended that the nurses will support increased prescribing of the disease modifying drugs and to support optimisation of these medications prior to discharge.

Historically there has been no funding for a cardiac rehabilitation service across the Health Board, despite the associated improved outcomes. Short term funding for twelve months has now been provided and a heart failure hub with cardiac rehabilitation has been set up in the Caerphilly borough area. There have been no readmissions within 30 days for the cohort of patients who have received input from this service. Patients receiving usual care are having two follow up appointments within the first 12 weeks following discharge, those being cared for in the heart failure hub have 6 appointments as are those receiving cardiac rehabilitation. In addition, a number of co-production workshops have been undertaken with patients to understand what is important to them. Areas identified as priorities included prompt follow up, collaborative working with primary care and a clear and honest plan of care.

In Summary:

- ABUHB case ascertainment is above the national target.
- There is variation in the care delivered between NHH and RGH with respect to the key performance indicators. This included variation in prescribing compliance and in ECG.
- 50% of patients received care from a specialist heart failure team as an inpatient and 40% were admitted to a cardiology ward.
- The development of an inpatient pathway now means that the majority of heart failure patients will have specialist input.
- The reporting of PROMS and CROMS has led to follow up time reducing from 63 to 14 days post discharge.

- The development of a heart failure hub has prevented 30 days readmissions for the patients seen there and delivers cardiac rehabilitation.

National Emergency Laparotomy Audit (NELA) 2021 (December 2019-November 2020)

Emergency laparotomy has one of the highest associated rates of death of all types of surgery performed, almost ten times greater than that of major elective gastrointestinal surgery. Despite this, historically, emergency perioperative care pathways have fallen short of the clinical standards, organisational structures and care processes that benefit most elective patients (NELA, 2017). Care organisations are now using NELA to review performance in emergency surgical and perioperative care, and the data are used to drive development in emergency surgery and perioperative care.

During the 2019/20 reporting year, mortality rates were risk adjusted based on factors included in the NELA risk prediction model to take into account confirmed Covid-19 infection amongst the patients whose data was submitted to the audit. Nationally 30-day mortality fell to 8.7%- and 90-day mortality to 12.6%, NHH reported a 30-day mortality rate of 8.7%, however the Health Board received notification that adjusted mortality rates in RGH during the 2019/20 reporting year were 14.4%, in the top 5% of mortality rates in England and Wales.

Risk-Adjusted Mortality

National mean 8.7%
Number of patients included 255

In response to the alert, the year 7 data was reviewed, and it was established that RGH care did not meet the required standard in three domains,

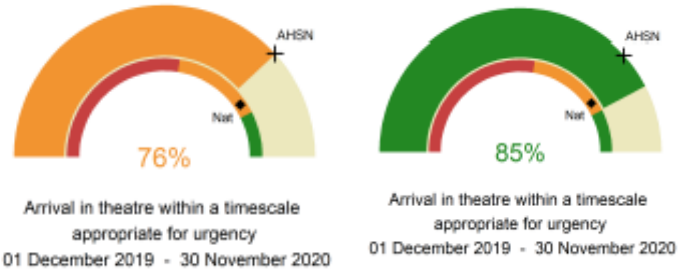
- The proportion of patients with a predicted mortality score of >5% who had a consultant surgeon and anaesthetist in theatre;

- The proportion of patient being admitted to critical care when predicted mortality was >5%;
- Timely provision of antibiotic treatment to patients with suspected sepsis.

In response an Emergency General Surgery Group was convened to monitor performance against these indicators to support ongoing improvements and the unadjusted year 8 mortality data suggests that there has been a significant reduction.

The proportion of patients arriving in theatre in a timescale appropriate for the urgency of surgery (minimum standard 85%)

RGH **NHH**



Arriving in theatre in a timescale appropriate for the clinical urgency of surgery is an important factor in determining patient outcomes. To inform improvements relating to this KPI the theatres booking form is being amended to capture additional data which will support the identification of trends in delayed time to surgery.

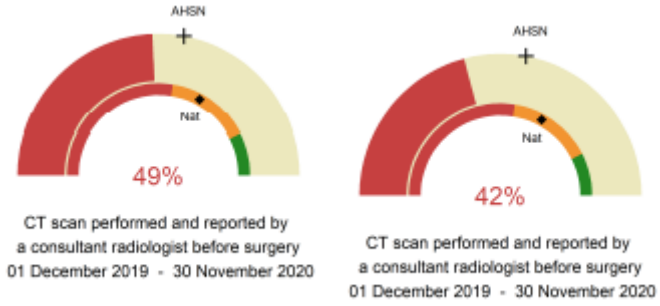
Proportion of patients arriving in theatre within an appropriate time	
Year 7	77%
Year 8	74.7%

The proportion of patients who received a CT scan which was reported by an in-house consultant radiologist before surgery (minimum standard 85%)

16% of patient who underwent a laparotomy with normal findings did so without a preoperative CT scan. NELA demonstrates that the use of outsourced radiology reporting services has increased to 19% nationally. The anticipated discrepancy rate

between CT reports and surgical findings is 5% regardless of who reports the CT scan, however there is an increased discrepancy rate noted in outsourced CT scans. The Health Board discrepancy rate was 5.7% with a lower than national in-house CT reporting rate.

RGH **NHH**



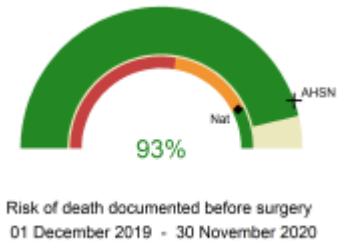
Sepsis

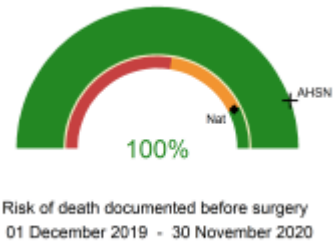
27% of all NELA patients have sepsis suspected on admission, and more than half of these patients are documented preoperatively as being high-risk (56.8%). Around 1 in 5 of those patients have antibiotics within an hour (21.6%) whilst 1 in 10 have their first dose of antibiotics in theatre (9%), with median time from admission to decision to operate 9.8 hours and admission to theatre 15.3 hours. The Health Board successfully provided antibiotics within 1 hour of when sepsis was suspected in 29% of cases. A standalone audit of antibiotic prescribing from emergency laparotomy patients in the Emergency Department has been undertaken, in addition the Health Board is forming an expert advisory panel to advise on the uptake and implementation of the 2021 revised sepsis and septic shock guidelines. Since the opening of GUH an Emergency Department NELA lead has been appointed to support Quality improvement work in relation to the early identification of NELA patients and work is underway to support the proactive management of the patients prior to requesting a surgical review.

The proportion of patients for whom a risk assessment was documented before surgery (minimum standard 85%).

Risk assessment prior to surgery dictates the appropriate time to surgery and the post-operative care including planned admission to Critical Care. A target of 85% is set by NELA and this was achieved nationally and exceeded on both NHH and RGH sites.

RGH **NHH**

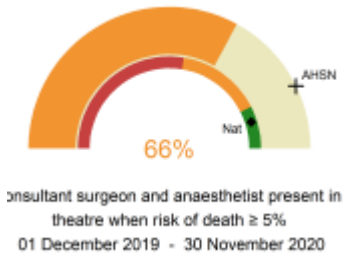




Each high-risk patient should have a consultant surgeon, anaesthetist present in theatre during surgery RGH NHH

Nationally 90.1% of patients who had a risk of death of 5% or over had both a consultant anaesthetist and surgeon present in theatre. In RGH this standard was achieved for 66% of patients and for 100% in NHH during 2019/20. This is an area of increased focus to support the requisite improvements in mortality and the year 8 data suggests that there is a significant improvement in compliance.

RGH **NHH**

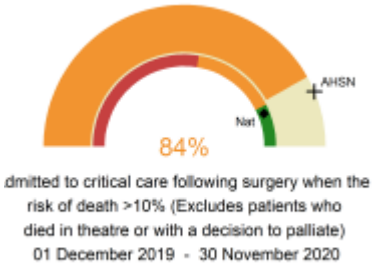


Consultant surgeon and anaesthetist present in theatre when risk of death >=5%	
Year 7	75.5%
Year 8	97.0%

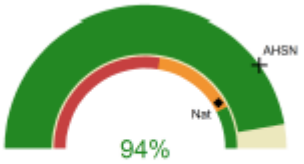
The proportion of patients who were admitted directly to critical care when risk of death ≥5% (minimum standard 85%).

Nationally 87.6% of patients who had a risk of death of 5% or more were admitted directly to critical care following surgery. This standard was exceeded in NHH with 94% of patients admitted directly to Critical Care however it was only achieved in 84% of cases in RGH during 2019/20.

RGH NHH



dmitted to critical care following surgery when the risk of death >10% (Excludes patients who died in theatre or with a decision to palliate)
01 December 2019 - 30 November 2020



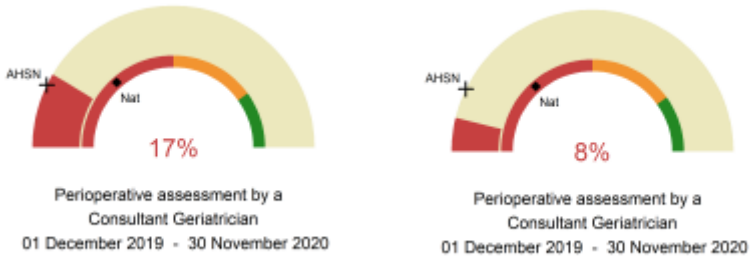
Admitted to critical care following surgery when the risk of death ≥ 5% (Excludes patients who died in theatre or with a decision to palliate)
01 December 2019 - 30 November 2020

COTE assessment

Older patients may suffer from multi-morbidity and may be frail. Frailty is defined as a syndrome of physiological decline in older people which makes them particularly vulnerable to adverse outcomes and deterioration in physical health after major stressors (such as emergency laparotomy). The Royal College of Surgeons and British Geriatric Society recommend that all patients over the age of 65 should have frailty assessed, and if found to be frail, the patient should be considered high-risk and should be reviewed by geriatricians.

Nationally this is achieved in 27% of cases but in 2019/20 was only achieved in 17% of cases in RGH and 8% in NHH. A Perioperative Care for Older Patients undergoing surgery (POPS) service commenced in November 2021 which now means that all patients over the age of 65 are being reviewed on a twice weekly basis on a consultant led ward round.

RGH **NHH**



All emergency laparotomy surgery has been centralised since the opening of GUH in November 2020 and is reflected in the year 8 reporting to date. Since opening GUH there has been an emergency department lead appointed to support the early recognition of acute abdominal pathology including triage, assessment and investigation.

In Summary:

- RGH mortality was 14.4% in 2019/20 compared to a national rate of 8.7%
- Unadjusted mortality rates suggest a significant improvement to date
- There was variation noted in the time to theatre between NHH and RGH. Improvement work is underway to capture reasons for delays
- 29% of applicable patients had antibiotics in 1 hour, above the national rate but well below the target set by NELA
- Variation in the presence of a consultant surgeon and anaesthetist in theatre was noted between NHH and RGH with significant improvements noted in year 8 in GUH
- The development of a perioperative service for older people undergoing surgery (POPS) in late 2021 will mean all patient over the age of 65 will be reviewed by a COTE consultant.

Mothers and Babies Reducing Risk Through Audits and Confidential Enquiries (MBRRACE) – Saving Lives and Improving Mothers Care 2017-2019 and the **National Maternal and Perinatal Audit (NMPA) 2021 (2015-2018) Ethnic and socio-economic inequalities in NHS maternity and perinatal care for women and their babies**

The confidential enquiry into maternal deaths and morbidity report includes surveillance data on women who died up to 12 months after the end of their pregnancy between 2017-2019. The report identified that nationally 17% of women

received good care, however in 37% of cases improvements in care might have changed the outcome for these women.

The MBRRACE report highlights the disparity in maternal mortality rates between black and Asian ethnic groups and white women. Maternal mortality rates are four times higher amongst Black women and two times higher amongst Asian women. The NMPA inequalities report derived from the NMPA dataset provides results for a number of measures of maternity and perinatal (the period around the time of birth) care, with a specific focus on presenting the results for women according to their ethnicity and level of socio-economic deprivation.

MBRACCE and NMPA key message included:

- 8% of women who died were classed as experiencing severe and multiple disadvantages due to mental health / substance misuse or domestic abuse.
- Cardiac disease is the largest indirect cause of maternal death.
- Neurological disease is the second largest indirect cause of maternal death.
- Thrombosis is the leading cause of death in the first 6 weeks after the end of pregnancy.
- Suicide is the leading cause of maternal death in the first 12 month after the end of pregnancy.
- Rates of smoking at birth were significantly higher in the most deprived quintile.

The ethnic disparity reflected in the MBRACCE report is also highlighted in the National Maternal and Perinatal Audit (NMPA) 2021 (2015-2018) Ethnic and socio-economic inequalities in NHS maternity and perinatal care for women and their babies, which noted that

- Women from south Asian or Black ethnic groups are more likely to have small for gestational age babies.
- Babies born to Black women are more likely to have low apgar scores.
- Babies born to south Asian women are less likely to have low apgar scores than white babies but more likely to be admitted to a neonatal unit.
- Babies born to women living in the most deprived areas are more likely to be born early and be small for gestational age and have low apgar scores, be admitted to a neonatal unit or be stillborn.

ABUHB has undertaken a number of initiatives to support more vulnerable women. A recent Stand up to Racism Day included the development of a resource pack to highlight issues and enhance skills relating to equality and diversity. This work was shortlisted by the Royal College of Nursing for the Nurse of the Year award. A pilot

project is being developed to support individualised antenatal care for these women. ABUHB has participated in the QUIDS study to predict risk of premature births and the Affirm trial to consider reductions in still birth rates. ABUHB participates in the Gap and Grow programme which targets low for gestational age babies and provides additional monitoring and scans. Maternity services include a named community midwife to support continuity of care in the antenatal and post-natal period.

Care of older women

The importance of 'post-pregnancy' counselling is equal to pre-pregnancy counselling for future pregnancies and for joining up obstetric and medical care to optimise a woman's long-term health. In order to ensure equitable access to information and advice the Health Board has developed a Healthier Together platform that includes preconception advice about age, smoking and substance abuse, BMI and physical activity. A Public Health Midwife leads on contraception training for the Health Board.

The annual report highlights the importance of avoiding delays in consultant appointments and evidence-based effective preventive interventions such as aspirin pending the results of investigations such as prenatal diagnosis. The Health Board has joint Medical and Obstetric care pathways in place and has developed pathways to ensure timely risk assessment and treatment; including a patient group directive to ensure the timely review and appropriate prescribing of aspirin and anticoagulation therapy to women.

Improving Mental Health Care

Mental illness is one of the leading causes of maternal death and the report highlights the importance of clear pathways to support joint working and sharing of information between GPs, Mental health Services and Maternity Services and the need for health professionals to monitor regularly for symptoms throughput pregnancy and the perinatal period in line with NICE guideline CG 192.

ABUHB has a dedicated Perinatal Mental Health Team (PNMH) and facilitates specialist perinatal mental health clinics. The PNMH team includes a Psychiatrist, Perinatal Mental Health Nurse and Peer support workers and the team is supported by a dedicated Obstetrician and Midwife. The PNMH team will support all women with moderate or severe mental illness. In addition, services are being developed to support women with mild to moderate mental illness, which includes education for midwives to help them to support vulnerable women.

The annual report also highlights the importance of pathways for women who required secondary care as a result of mental illness. These women are able to access the crisis support team and there is a WHSSC commissioned Mother and Baby unit in Swansea.

ABUHB undertake a multi-disciplinary investigation into all maternal deaths including those associated with mental illness.

Cancer Care

The report has highlighted the importance of ensuring that the cancer care of women should not be compromised because they are pregnant or post-partum. ABUHB provides care in line with the recommendations including that all women who have recently had cancer should be seen by an obstetrician in their first trimester and that all symptoms of cancer are followed up postnatally.

Prevention and Treatment of thromboembolism

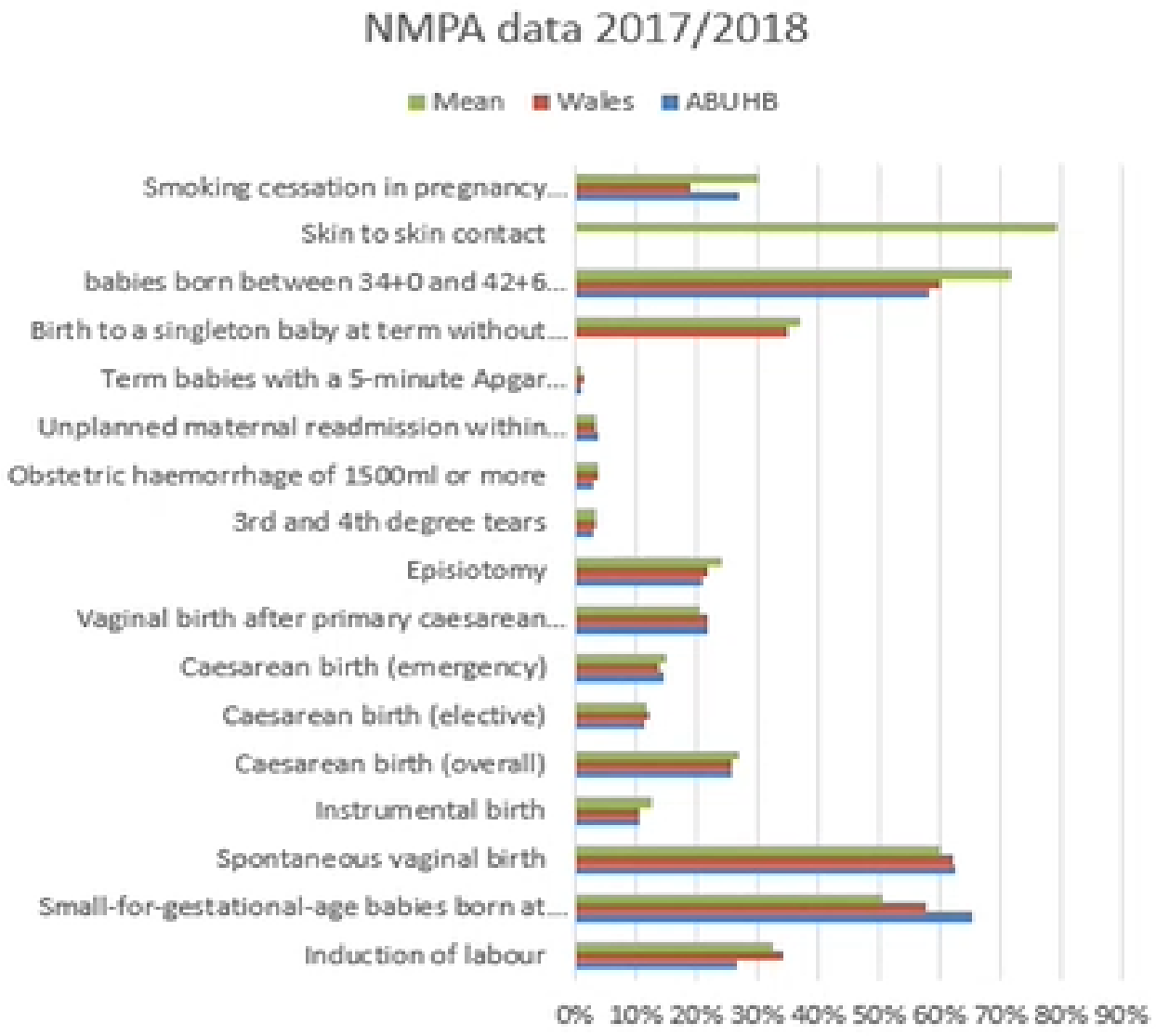
The importance of VTE prevention including the use of a VTE risk assessment consistent with national guidance and re-weighing women to establish if their VTE score has changed is highlighted in the report as well as the requirement to assess and review adherence with thromboprophylaxis. The Health Board review all women up to 12 weeks postnatally, to ensure they are provided with support from a midwife and are supported to learn how to administer their medication. Where this is not possible the midwife will attend to administer treatment as required.

In Summary:

- Both reports highlight significant ethnic and socio-economic inequalities that lead to increased maternal and perinatal morbidity and mortality.
- The ABUHB Healthier Together website provides preconception advice on subjects including age, smoking, BMI, Substance abuse and physical exercise.
- A joint Medical and Obstetric pathway is in place to care for pregnant women with existing Health conditions.
- A dedicated Perinatal Mental Health team support all pregnant women with moderate and severe mental illness.
- A stand up to Racism Day event was held to raise awareness of health inequalities.

National Maternal and Perinatal Audit (NMPA) Clinical Report 2021 (2017-2018)

The NMPA presents measures of maternity and perinatal care based on births in English, Scottish and Welsh NHS services between 1 April 2017 and 31 March 2018. The report also provides contextual information describing the characteristics of women and babies cared for during this time period whose data have been included in this report.



ABUHB performance was comparable with Wales for many of the indicators considered within the NMPA clinical report.

The Saving Babies' Lives initiative launched in 2016 includes identification and surveillance of growth restricted babies as a priority to reduce stillbirth in England. 17 Reports on the implementation of the care bundle at 19 trusts demonstrated that antenatal detection of small-for gestational-age (SGA) babies has improved. In Wales, the National Stillbirth Working Group (NSWG) endorses the implementation of the Welsh Initiative for Stillbirth Reduction, which includes improved surveillance and monitoring of suspected SGA babies in its aims. Since inception the Welsh rate has reduced from 62.2% to 57.7% but remains higher than the UK mean. ABUHB reported that 65.4% of babies were small for gestational age at 40 weeks' gestation compared to Wales (57.7%). ABUHB implemented the gap and grow programme which offers serial growth scans for women who present with certain risk factors including raised BMI, a previous SGA pregnancy or chronic maternal diseases eg diabetes. The women are scanned every three weeks or as deemed clinically appropriate by the obstetric team. Women who have a fundal height measurement below the 10th centile will be offered a scan within 3 working days and as clinically appropriate thereafter. The Gap and Grow programme is subject to ongoing audit and monitoring.

Data reporting has been restricted in some areas but the commissioning of a new data collection platform within the next 9 months will support scrutiny of other variables such as skin to skin contact and births without intervention.

ABUHB performs very well compared to the rest of Wales and comparably with the UK mean in relation to smoking cessation with 27.1% of women recorded as stopping smoking compared to 19.10% nationally. The Health Board employs a Public Health midwife who leads on smoking cessation.

In Summary:

- ABUHB compares favourably with many of the NMPA indicators when compared with national performance.
- Smoking Cessations rate are particularly good (27%) and exceed the national rates 19%.
- Wales National Still Birth Working Group oversees the Welsh initiative for still birth reduction.
- In ABUHB all pregnant women with small for gestational age babies are offered serial scans and undergo systematic ongoing monitoring .
- A new data reporting tool will be procured this year and will result in additional data set to support improvement e.g. births without intervention and skin to skin.

Welsh National Neonatal Peer Review

In April 2021 the Welsh Neonatal Peer review was undertaken to consider care under the following categories:

- Patient Centeredness and care of the baby and family
- Safe and effective care
- Equitable and efficient care
- Timeliness

The review included self-assessment against standards plus a virtual peer review.

Patient Centeredness

The neonatal team felt the merger of two teams onto the new GUH site and the designing and opening of the new unit had been a great success and this was recognised through the peer review; with the family facilities praised as well as the posters and information displayed on the unit. At the onset of Covid when visiting was subject to significant restrictions and parents were required to alternate visiting, a system called V-create was introduced which enabled parents to interact with their babies via video and to FaceTime the nurses on the unit.

An initiative called Family Integrated Care was introduced to encourage parents to look after their babies. Support groups continued through the pandemic.

The peer review did highlight inadequate shower facilities for parents which is currently being addressed and the review praised the involvement of parents in the ongoing design of the environment. They recognised that the parent accommodation is not yet open but will provide accommodation for 11 parents on the site of GUH once opened.

Safe and Effective Care

The peer review recognised effective network working, adherence with evidence-based guidelines and evidence of good practice and innovation. They did however note the lack of psychology input. The department had benefited from 6-month psychology input to support bereavement work prior to Covid but this had subsequently ceased. The review noted previous high rates of Central Line Associated Blood Stream Infection (CLABSI) identified in a previous audit report. Quality Improvement work relating to the reduction of Central Line Associated Blood Stream Infections continues and 2021 rates were reduced. A quality and safety group supported by a lead nurse and consultant was established to progress QI work including thermoregulation and breast feeding and to consider emergent

themes and trends. Educational and teaching modules continued throughout covid by moving to virtual teaching methods

The Review also noted the difficulties in accessing Post-mortem counselling training for consultants over covid however this has been resolved and all appropriate staff have now accessed training.

Equitable and Efficient Care

The peer review noted a high level of special care activity which was above the recommended 80% and at its highest the unit was at close to 300% occupancy; however, it was noted that since relocating to GUH recommended special care levels have been more closely maintained. The lack of funded transitional care was the cause of additional demands and has often meant that babies were unnecessarily separated from the mothers. A business case is being developed to progress this.

In Summary

- The peer review praised the new NNU facilities and noted the success of the merger of two teams.
- It was noted that the family facilities were yet to open at the time of the review.
- The neonatal team had used technology to support families staying in contact with the unit and to monitor the babies over the pandemic.
- Previously higher rates of Central Line Associated Blood Stream Infection were noted but it was also noted that quality improvement initiatives had been successful in reducing rates.
-

National Audit Improvements

Audit	Action	Who	Progress	
National Diabetes Audit	• A centralised chronic disease management model will allow efficient use of clinical nurse specialist recourse to drive improvement in treatment targets • A centralised model will support the delivery of structured education at the source of care delivery. • Initially the delivery of centralised chronic disease management, specifically respiratory	Primary Care		

	disease will allow resource to be focused towards diabetes in General Practice			
National Fracture Liaison Service Audit	The Falls and bone health service pilot will be subject to a review at 6 month and then a further review in November 2022 to consider ongoing funding	Rheumatology / COTE	Falls and bone health service is currently running in YYF and all applicable patients are directed to either the Fracture liaison service of Falls and bone health service	
National Audit of Psychosis	Delivery of CBT to the At-Risk Mental State Patient Group	MHLD		
National Audit of Psychosis	Development of a strategy to address inequalities in access to the service	MHLD		
National Audit of Psychosis	Development of a standard operating procedure to support physical health screening	MHLD	This is complete and the operational policy is now being reviewed to ensure it is current and meets the necessary standards	
National Audit of Psychosis	Development of a framework to drive improvements in recording substance abuse and interventions	MHLD		
National Heart Failure Audit	The development of an inpatient pathway now means that the majority of heart failure patients will have specialist input	Heart Failure Team	The service is now fully operational	
National Heart Failure Audit	The development of a heart failure hub has prevented 30 days readmissions for the patients seen there and delivers cardiac rehabilitation	Heart Failure Team	This service is operational and subject to ongoing review	

National Emergency Laparotomy Audit	Monthly emergency General Surgery Meetings Are underway to Monitor Performance against the KPIs	General Surgery	Underway and chaired by the COO	
National Emergency Laparotomy Audit	The development of a NELA dashboard is underway to support scrutiny of prospective performance	General Surgery / Quality Patient Safety	Currently in development	
National Emergency Laparotomy Audit	Appointment of A NELA specialist nurse	General Surgery	Currently recruiting	
National Emergency Laparotomy Audit	The development of a perioperative service for older people undergoing surgery (POPS) in late 2021 will mean all patient over the age of 65 will be reviewed by a COTE consultant.	General Surgery	Operational since November 2021	
National Emergency Laparotomy Audit	Development of a revised theatre booking form	General Surgery	The booking form is currently being amended to identify if there have been delays in clinical decision making	
MBRRACE / NMPA	A new data reporting tool will be procured this year and will result in additional data set to support improvement eg births without intervention and skin to skin.	Maternity Services	A business case is currently under development to support the new fata platform	
Neonatal Peer Review	Increased parental shower resources required in	NNU	Converting toilet unit to additional shower	
Neonatal Peer Review	Resumption of Post-mortem Counselling training for consultants	NNU	Complete	
Neonatal Peer Review	Opening of parental accommodation on GUH site	NNU	The opening is imminent	
Neonatal Peer Review	Development of transitional care service to allow babies to remain with mothers		A business case is under development and will require 5.6WTE nursery nurses	

Neonatal Peer Review	Delivery of antibiotics to babies on the post-natal ward to avoid unnecessary transfer	NNU / post-natal ward	Training is underway to support this	
Neonatal Peer Review	BAPM compliant therapy provision	NNU	A business case is under development to provide details of the allied health professional requirements	
Neonatal Peer Review	Reduction of central line infections	NNU	A Central line action plan has been established which includes: • Relaunch of central line bundle • Adherence to procedure checklists • Adherence to Two to care approach for sterile procedures • RCA for all cases • Antibiotic stewardship • Education • Daily review of central line requirements CLABSI rates per 1000 line days have reduced in 2021.	

Recommendation

The Committee are asked to discuss the assurance performance detailed in each of the audit reports and NOTE the assurance provided by the reports and associated actions.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report reviews National Clinical Audit and peer review outcomes which can be used 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. Issues identified are included on the Divisional risk register 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 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 all within the Health and Care Standards themes, particularly safe care, effective care. All national audits are reported through the clinical standards and effectiveness group, part of the ABUHB quality assurance framework aligned to the health and care standards.
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP and the quality improvements highlighted here are within the Plan.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being*

	Objectives and should also indicate to which Objective(s) this area of activity is linked.
	Long Term – Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Involvement –Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	See section 4.
Public Interest	Report has been written for the public domain.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality, Safety and Outcomes Committee Tuesday 5th April 2022 Agenda Item: 2.2

Aneurin Bevan University Health Board

Implementation of All Wales Enhanced Cleaning Standards

Executive Summary

This report provides an overview of the implementation of the All Wales Enhanced Cleaning Standards across the Aneurin Bevan University Health Board's estate.

The report details the challenges faced in recruiting the level of workforce required for full delivery of the Standards and some of the approaches used to overcome this challenge. Furthermore, it provides assurance that an increased number of agency staff have become available in recent weeks to support the programme.

The report also demonstrates the positive environmental cleanliness audit scores achieved in February 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: Leanne Watkins			
Report Author: Gareth Hughes, Divisional Director of Estates & Facilities			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	**PQSOC**
Date of the Report: 11th March 2022			
Supplementary Papers Attached: None			

Purpose of the Report

Following the introduction of All Wales Enhanced Cleaning Standards in response to the Covid 19 pandemic a paper was presented to the Executive Team on the 22nd September 2021.

The original paper asked the Executive Team to consider three options to support ABUHB's delivery of standards. The Executive Team supported Estates & Facilities preferred option, to Support fixed term recruitment to COVID/Surge demand for 12/24 months and utilise agency for Enhanced Cleaning Standards.

This paper provides assurance regarding the progress made delivering the implementation of the Standards and further steps being taken.

Background and Context

Prior to the start of the Covid pandemic, cleaning standards were completed in accordance with the National Standards for Cleaning in NHS Wales. The Standards, first published in 2003 and revised in 2009 provide a framework from which each Health Board should develop a Cleanliness Strategy, Operational Cleaning Plan and agreed frequencies of cleaning. The document sets out the minimum standards of cleanliness that should be achieved across the NHS Wales estate.

From the onset of the pandemic a review of services was carried out. The review identified that an additional workforce was required due to; COVID, surge demands, bed configuration and reintroduction of service models (patient feeding, cleaning and portering). This equates to an additional 51.64WTE domestic staff (total across all facilities services 172.04WTE). This requirement was being met by agency staff.

Covid-19 Changes to Cleaning Standards

In October 2020, a specific Covid-19 Addendum to the 2009 Standards was implemented, to ensure appropriate level of environmental cleaning across the NHS Wales estate. In total the addendum included 9 standards of cleanliness. The most significant change from the core Standards was Standard 2 – cleaning frequencies. Standard 2 included three tiers of cleaning frequencies listed as 'red', 'amber' and 'green' pathways. Overall, each pathway provided increased cleaning frequencies (from the core 2009 Standards) that varied by pathway and area (refer to Appendix 1). The pathway system has recently been updated but the workforce requirements remain the same.

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.

In considering the likelihood of all areas presenting a red pathway, this was deemed as low and would subsequently present a high recruitment risk. Therefore, using a pragmatic and risk based review of the workforce modelling across the three pathways, it is assumed that the demand will be 100% of the green pathway (88WTE) with the remaining (39WTE) for amber and red pathway requirements which will be flexed according to demand. Total requirement is 127WTE.

The full year cost of providing the Enhanced Cleaning Standards on a fixed term basis is £3.9m consisting of £3.574m for 127wte Band 2 staff and £357k for cleaning consumables. At present, Welsh Government have not confirmed a continuation of the amended standard or an allocation of funding to ABUHB beyond 2021/22 financial year.

This workforce requirement was benchmarked and aligned to other NHS organisations in Wales and accounted for the number of single bedded rooms and subsequent additional cleaning requirements across ABUHB sites.

It is important to note that this is an estimate of where we are now based upon current modelling and informed assumptions and will require a continual review to account for any unforeseen changes.

Assessment and Conclusion

Innovation

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 our wards, departments and communal areas. This has resulted in investment in:

- 10 Ultra Violet decontamination machines. These machines increase the speed of the sanitation of patient areas following an outbreak. The ultra Violet decontamination is used in conjunction with Hydrogen Peroxide Decontamination. The total investment has been circa £350,000.

- 6 additional Hydrogen Peroxide Vapour (HPV) decontamination machines. Although HPV machines have been for a number of years, the demand for this type of clean has continues to increase.

- 2 Hydrogen Peroxide Vapour 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 also 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 our buildings. The Audit team undertake audits of all Patient facing and public areas, they audit site cleanliness, and also audit Estates, Nursing and Infection Prevention and Control, 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 the Health Boards, Reducing Nosocomial Transmission Group (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 our staff and supporting career development with a focus on career pathways' the division has worked with the Bevan Commission to formalise this process. Career development has been supported with the creation of a transformational change team that takes the ideas generated by staff and turns them into viable workstreams that both drive improvement and values staff input. This is part of wider investment into our workforce that also includes visible and compassionate leadership. All managers from Director level, through to assistant operational services managers, undertake routine "Back to the Floor" exercises, this enables the management team to understand how the daily life and the working environment of our staff is affected and what we can do as a management team to support them and how we can do things differently.

Management coverage has also been reviewed and ensures that all staff have access to a manager, including those who work unsociable hours.

In recognition of workforce supply challenges this approach has looked to improve the retention of existing staff, make Domestic roles more attractive to candidates and utilise technology to support the cleaning operation.

Recruitment

Workforce & OD had initiated a recruitment drive i.e. the NHS recruitment bus, to raise awareness of working within the division, which has led to 70 candidates being offered an interview, unfortunately the uptake for interview was 38. The division was 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 (ie 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 whilst not 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. In addition, the recruitment bus has also recently given members of the public the link to apply for the remainder of the posts along with existing agency staff.

We have also linked in with 6 agencies to recruit to the enhanced cleanings rosters, so far, we have recruited 40.99 wte of the 88wte, the retention rate is just under 10%. Again, we believe the slow uptake is because the enhanced cleaning hours are evenings, which is required due to the frequencies of cleans. The agencies currently have adverts for these positions on all recruitment platforms. We have seen the biggest placement of agency staff during the week of 7 March 2022 (10 wte). Recruitment agencies have anticipated this increased flow of agency staff should continue as staff previously assigned to the vaccination programme are seeking alternative employment.

We recognise these workforce issues 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 the development of career pathways and succession planning 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 all our staff and listening to concerns and challenges they have experienced. There were challenges that staff spoke about in terms of communication and as a result Estates & Facilities have funded a communication and media lead to promote success and ensure that staff are listened to, informed, and feel valued within the division.

Compliance

The Estates & Facilities audit and compliance team have been working hard ensuring that local and national standards are adhered to. Robust procedures have been put in place to ensure that at risk areas are identified and maintained to the high standard required.

In addition to the cleaning schedules element the Synbiotix System has also been added. Synbiotix is a transformative software which complements existing hospital operating environments. These electronic tools help automate and streamline operational audits including large-scale cleaning, catering and workforce management systems.

The Compliance team submit and circulate monthly compliance/exception reports to the Division which provides a multitude of audit scores. This includes the single element report which provides additional information on all direct patient care elements. Also, the environmental

exception and single element reports are monthly agenda items for the Reducing Nosocomial Transmissions Group.

Audits undertaken in February show that:

- Nineteen areas received 100% compliance

Hospital	Ward	Nursing Score	Cleaning Score
County Hospital	Talygarn ward	100.00%	
Grange University Hospital	Ward B3 - Antenatal - DMT	100.00%	
Grange University Hospital	Ward B3 - Post Op Support - DMT		100.00%
Grange University Hospital	Ward C3 - HDU - DMT	100.00%	100.00%
Grange University Hospital	Ward C3 - MDU - DMT	100.00%	100.00%
Grange University Hospital	Ward B4 (Haematology) - DMT	100.00%	
Nevill Hall	Minor Injuries Unit	100.00%	
Nevill Hall	OPD2 Windsor Suite		100.00%
Royal Gwent Hospital	B5 Birthing Centre	100.00%	
Royal Gwent Hospital	C5 West		100.00%
Royal Gwent Hospital	Eye Ward	100.00%	
Royal Gwent Hospital	Urology Day Case	100.00%	
Royal Gwent Hospital	Main Theatre - ENT - Theatre 4&5		100.00%
Royal Gwent Hospital	Main Theatre - Orthopaedics - 1,2 & 3		100.00%
Royal Gwent Hospital	Main Theatre - Recovery		100.00%
Royal Gwent Hospital	Max Fax - Lab Technician	100.00%	100.00%
St Woolos Hospital	Dermatology Ward	100.00%	
Ysbyty Ystrad Fawr	Magnetic Resonance Imaging (MRI)	100.00%	
Ysbyty Ystrad Fawr	Midwifery LED Unit - Birthing	100.00%	

- Eight areas received a red rating

Hospital	Ward	Date of Audit		After Resolved	
		Nursing Score	Cleaning Score	Nursing Score	Cleaning Score
Grange University Hospital	Assessment Medical Unit (AMU)		92.54%		92.54%
Grange University Hospital	Emergency Department		92.81%		
Nevill Hall	4/2 Crickhowell		92.31%		
Royal Gwent Hospital	B3 E/W		88.26%		88.26%
Royal Gwent Hospital	Main Theatre - General - Theatres 6,7,8 & 9	90.00%		90.00%	
Royal Gwent Hospital	New Cardiology Department		92.62%		
St Woolos Hospital	Gwanwyn		91.60%		91.60%
Ysbyty Ystrad Fawr	LEC - MAU		90.72%		

- 97% (103 of 106 audits undertaken) compliance was achieved following submission of all resolve data

	Nursing					Cleaning				
Site	# of Audits	Wards Compliant at day of audit	Wards compliant after resolved data	% Wards compliant at day of audit	% Wards compliant after resolved data	# of Audits	Wards Compliant at day of audit	Wards compliant after resolved data	% Wards compliant at day of audit	% Wards compliant after resolved data
CCH	1	1	1	100%	100%	1	1	1	100%	100%
CTY	5	5	5	100%	100%	5	5	5	100%	100%
GUH	30	30	30	100%	100%	30	28	29	93%	97%
MVH	1	1	1	100%	100%	1	1	1	100%	100%
NHH	18	18	18	100%	100%	18	17	18	94%	100%
RGH	29	28	28	104%	97%	29	27	28	93%	97%
SWH	6	6	6	100%	100%	6	5	5	83%	83%
YAB	3	3	3	100%	100%	3	3	3	100%	100%
YYF	13	13	13	100%	100%	13	12	13	92%	100%
ABUHB	**106**	**105**	**105**	**99%**	**99%**	**106**	**99**	**103**	**93%**	**97%**

Data figure criteria:-

Very High Risk	
= > 98%	Green
Between 88% - 98%	Amber
= < 88%	Red
High Risk	
= > 95%	Green
Between 85% - 95%	Amber
= < 85%	Red
Significant Risk	
= > 85%	Green
Between 75% - 85%	Amber
= < 75%	Red
Low Risk	
= > 75%	Green
Between 65% - 75%	Amber
= < 65%	Red

Furthermore, staff are being trained on the latest PPE guidance prior to undertaking audits in all risk pathways.

A recent meeting has taken place with the IPaC Team regarding introducing the use of the ATP swabs, fluorescent markers to supplement visual inspection which would give assurances of the cleaning processes.

Cleaning frequencies have increased across all sites. The consistency and sustainable delivery of the frequencies set out in the Standards is reliant on workforce supply. While it is acknowledged that the recruitment of the full requirement has been a challenge, workforce shortages have been offset by existing staff and the innovative approach used. The recent increased supply of agency staff provides confidence that the division are on track to recruit the full number of staff required.

Recommendation
The Committee is asked to note both the success to date and the plans in place to overcome the workforce supply challenges that have been experienced.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risks detailed with the Estates and Facilities Divisional Risk register
Financial Assessment, including Value for Money	Financial commitment is in line with the Executive Paper (September 2021)
Quality, Safety and Patient Experience Assessment	Risks detailed with the Estates and Facilities Divisional Risk register
Equality and Diversity Impact Assessment (including child impact assessment)	N/A
Health and Care Standards	Health and Care Standards April 2015 • Standard 1.1 Health Promotion, Protection and Improvement • Standard 2.2 Managing Risk and Promoting Health and Safety • Standard 2.4 Infection Prevention and Control (IPC) and Decontamination
Link to Integrated Medium Term Plan/Corporate Objectives	Divisional IMTP is being developed and this will be included
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The all Wales Enhanced Cleaning Standards (Covid 19 Addendum) compiles with the Well-being of Future Generations (Wales) Act 2015 – 5 ways of working
	Long term – Having made significant investment in cleaning equipment, software systems and additional staff resources we are able to demonstrate a long-term service improvements, which has promoted consistent and robust cleaning regimes, additional staff training and development for staff. Resulting in service improvements able to react should possible future COVID scenarios.

	Integration – Through the implementation of the All Wales Enhanced Cleaning Standard we can demonstrate our integrated approach by maximising the effective use of NHS resources in achieving planned outcomes for services and patients, along with an appropriate system for monitoring and improvement.
	Involvement – Through involvement of our staff, in jointly owned decisions regarding wider service planning and evaluation, we deliver the outcomes that matter most to patients and staff. Involving all levels of staff from across the Division through consultation in the development of our implementation plan and by "Back to the Floor" exercises, facilities operational managers have gained an understanding of key issues that has helped to improve the service, communication and staff well-being.
	Collaboration – By collaborating with others from across the Division and external partners we have been able to promote a diverse workforce and developing our staff towards being the best they can be. With recruitment partners we are working proactively to overcome recruitment and retention issues.
	Prevention – The Divisions response to the requirements of the All Wales Enhanced Cleaning Standards demonstrates a holistic approach to service improvement which works towards preventing negative impacts on the Health Boards well-being objectives in terms of maximising the use of NHS resources and maximising the benefits to patients and staff.
Glossary of New Terms	
Public Interest	Written for the public domain

Committee:	Patient Quality, Safety & Outcomes Committee
Date:	**5th April 2022**
Agenda Item:	**2.5**
Document Title:	**Health Inspectorate Wales' Reviews: An update on the current position with their reviews**

Patient Quality, Safety and Outcomes Committee

HEALTH INSPECTORATE WALES' REVIEWS: AN UPDATE ON THE CURRENT POSITION WITH THEIR REVIEWS

Summary

This report is to update the Patient Quality, Safety & Outcomes Committee (PQSOC) of the progress with the delivery of recommendations and actions from HIW inspections conducted across Aneurin Bevan University Health Board from 2018 to current day. Inspections prior to 2018 have been closed.

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 and Discuss	✓
Executive Sponsor: Rhiannon Jones – Executive Director of Nursing	
Report Received consideration and supported by:	

Executive Team		**Sub-Committee**	

Date of the Report: 26 March 2022
Supplementary Papers Attached: N/A

Situation

The PQSOC will be aware there has been significant attention to the effective internal management of HIW reviews, with a strengthening of oversight and control. There has been continued attention and focus throughout the pandemic, illustrating a positive position in terms of the closure of a number of historical reviews, with actions completed.

Background and Context

The Director of Nursing has delegated lead responsibility for HIW relationships, co-ordinating inspections, maintaining a corporate tracker, monitoring compliance with improvement plans, and managing constraints.

A robust organisational process is in place to ensure coordinated support during a HIW inspection. A database is maintained, which includes all HIW correspondence, dates for submission of evidence, action plans and evaluation dates. The corporate nursing team review every draft report prior to submission to HIW, through the portal.

When correspondence is received from HIW it is managed as per the below:

- As soon as correspondence comes into the CEO office from HIW it is immediately sent to the Assistant Director of Nursing, Quality and Safety and the Corporate Nursing Assistant, with a cc to the Director of Nursing.
- Through Corporate Nursing, the correspondence is reviewed and directed appropriately, providing the receiving teams with clear instructions as to the expectations and deadlines.

All correspondence is entered on the HIW database, with a flagging mechanism to ensure deadlines are achieved.

Assessment and Conclusion

Current Position within ABUHB

ABUHB have been compliant with all deadlines set by HIW, with timely submission of information, despite often challenging timescales.

The Assistant Director of Nursing (ADoN) meets regularly with key stakeholders in Divisions to review all HIW inspections and progress. The ADoN is also working with Divisions to ensure their responses to HIW are succinct and to the point, addressing the recommendations made, as well as encouraging a robust approach to evidence collation and recording.

The current position with inspections and recommendations can be seen in the below table, extracted from the Tracker. ABUHB have received three Immediate Assurance notices, which have been responded to; there are 245 recommendations from the inspections resulting in 192 actions of which 60 are outstanding (31%).

Division	Hospital/Ward/Area	Date of Inspection	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	No. of Recommendations identified by HIW	Total No. of ABUHB Actions Identified	Total No. of Actions Outstanding
Primary Care & Community	Redwood Hospital	16/09/2020			1	1	0
	Cas-Gwent Unit, Chepstow Community Hospital	17/05/2021			0	0	0
Unscheduled Care	Ward 3/4, Nevill Hall Hospital	29/09/2020			2	2	0
	Ward D6W, Royal Gwent Hospital	13/04/2021			0	0	0
	Ward 3/2, Nevill Hall Hospital	21/04/2021			2	2	0
	ED, Grange University Hospital (unannounced)	1-3/11/21	Yes	4	12	18	12
Child & Family	National Review of Maternity Services	Issued 18/11/20			32	11	0
	Review of Healthcare Services for Young People	Issued 11/09/20			37	69	5
Scheduled Care	Ward C7W, Royal Gwent Hospital	07/10/2020			2	3	0
Mental Health & LD	Adferiad Ward, St Cadoc's Hospital	07/10/2020			5	11	0
	Ty Lafant, Llanfrechfa Grange	01/12/2020	Yes	2	6	6	0
	Ty Skirrid, Maindiff Court Hospital	25/11/2020			2	3	0
	Twyn Glas, Caerphilly	20/04/2021			2	2	1
	Adferiad Ward, St Cadoc's Hospital (unannounced)	13-14/09/21	Yes	2	26	33	6
	National Review of Mental Health Crisis Prevention in the Community	2021			19	Due to be submitted to HIW in April 2022	
Joint thematic inspection of the progress of individuals who have mental health problems through the criminal justice system		w/c 19/04/21				Report received - no factual accuracies reported	
Mass Vaccination Centres	HB Wide	Mar-21			4	4	0
Nuclear Medicine	Royal Gwent Hospital	2-3/02/21			27	27	11
Joint WAST & HB	HB Wide	April & May 2021			12	ABUHB position on each finding identified and response provided. Improvement Plan is monitored via Urgent Care Board.	
Covid-19 National Review	HB Wide				16	ABUHB position on each finding identified and reported to Executive Team & PQSOC.	
Patient discharge from Hospital to General Practice	HB Wide	2018			12	24	2
Diagnostic Imaging Department	Grange University Hospital	16-17/11/21			26	30	23
National Review - Patient Flow (Stroke) Pathway	HB Wide	Review taking place between February and June 2022					
		Total	3		245	192	60

Recommendations
The PQSOC are asked to: • **Note** the progress with the closure of historical actions plans and the position with implementation against all recommendations; • **NOTE** the approach to managing HIW correspondence and ensuring compliance with timescales.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of inspections, reviews and actions are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	Direct or indirect impact on finance.
Quality, Safety and Patient Experience Assessment	This report is central to the safety and quality of care provided to patients and it provides a Six month update of HIW (Healthcare Inspectorate Wales) inspections, reports, and outstanding actions across the Health Board.
Equality and Diversity Impact Assessment (including child impact assessment)	Not applicable to the purpose of this summary report.
Health and Care Standards	This report provides information around standard 2.1, 3.1, 3.2, 3.3, 3.5,4.2,5.1, 6.3 and 7.1
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP. This report refers to the work of Healthcare Inspectorate Wales (HIW) in both their planned and unplanned work which is referenced in the IMTP.

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 directorates and divisions within the HB.
	Involvement – Many improvement initiatives are developed using feedback from the population using the service.
	Collaboration – The quality and patient safety described work across directorates and divisions within the HB.
	Prevention – Improving patient safety will prevent. Patient harm within our services.
Glossary of New Terms	
Public Interest	Report has been written for the Health Board.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality, Safety & Outcomes Committee Tuesday 5th April 2022 Agenda Item: 2.6

Patient Quality, Safety and Outcomes Report

Executive Summary

- Improvement in infection rates and compliance to national expectation targets has seen the RAG rating for IPAC reduced from red to amber.
- The Health Board has declared compliance with three National Patient safety solutions to ensure safe provision of care associated with the prescribing and use of Phenobarbital and Phenol and the assessment of children who have handlebar trauma injuries.
- The management of inpatient falls has been subject to Internal Audit review and awarded "reasonable assurance".
- A programme of Health Board wide audit is underway to measure compliance with the Nutrition and Hydration action plan presented to PQSOC in October 2021.
- A two week improvement programme is underway in the Emergency Department in GUH with some resultant improvement in 12 hour performance noted.
- Three community Health Council reports are outlined in this paper, with associated recommendations and actions.
- In response to increased death from Suicide in children and young people a Gwent wide Self-Harm and Suicide Prevention Task and Finish Group has been set up, attended by the Deputy Head of Safeguarding to address the current Immediate Response Group process (that runs parallel to PRUDiC).

Patient Quality, Safety and Outcomes Committee is asked to:	
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: Alexandra Scott, Assistant Director of Quality and Patient Safety Tracey Partridge-Wilson, Assistant Director of Nursing – Quality, Safety and Patient Experience Karen Hatch, Assistant Director of Therapies and Health Science	
Date of the Report: 23 March 2022	
Supplementary Papers Attached: Nil	

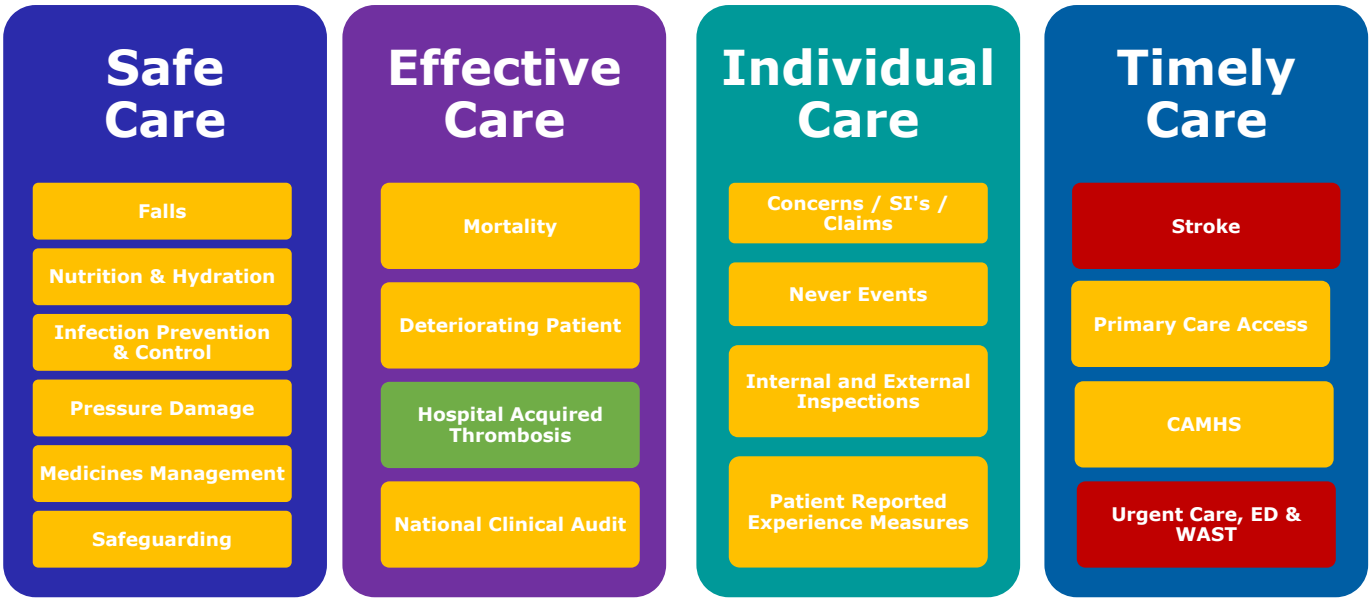
Purpose of the Report

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

Background and Context

This 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 for Quarter 4 (where information is available).

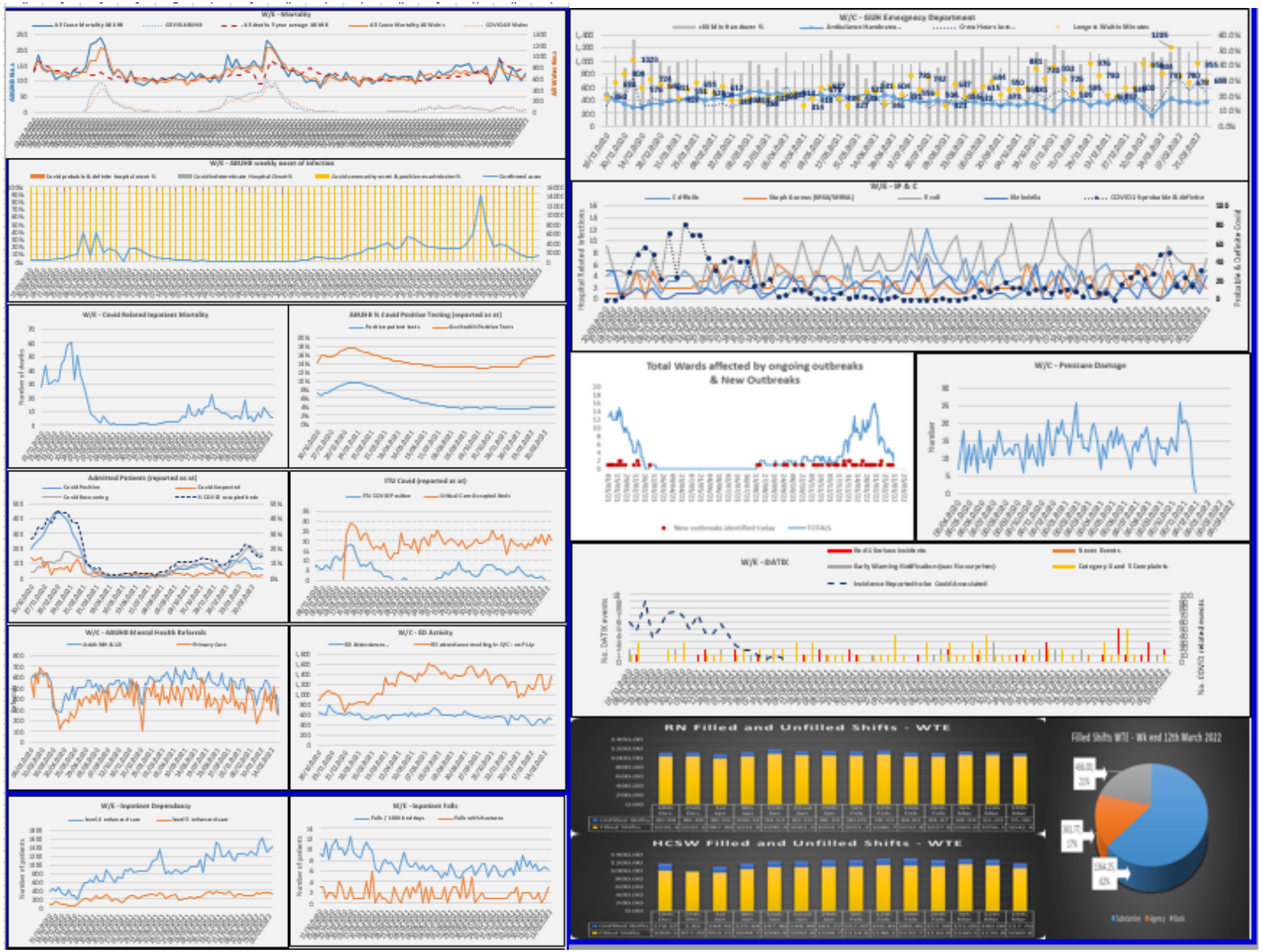


Assessment and Conclusion

Leadership and Governance

To support a prudent and effective response to the increased pressures across NHS Wales and the Health Board due to Covid, a reviewed approach to report remains in place.

The routine monitoring of the harms from Covid has continued, supporting governance and assurance. A briefing continues to be provided for the Executive Team weekly. A snapshot of the Dashboard is provided overleaf to visually demonstrate data collection and reporting for committee assurance.


W/E - Mortality
W/E - ABUHB weekly onset of infection
W/E - Covid Related Inpatient Mortality
ABUHB N. Covid Positive Testing (reported as at)
Admitted Patients (reported as at)
ITU Covid (reported as at)
W/C - ABUHB Mental Health Referrals
W/C - ED Activity
W/E - Inpatient Dependancy
W/E - Inpatient Falls
W/C - ABUHB Emergency Department
W/E - IP & C
Total Wards affected by ongoing outbreaks & New Outbreaks
W/C - Pressure Damage
W/E - DATIX
RN Filled and Unfilled Shifts - WTE
HCSW Filled and Unfilled Shifts - WTE
Filled Shifts WTE - Wk end 12th March 2022

Safe Care: Annual Plan Priority 1 2 3 4 5

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.

Patient Safety Solutions (Standard 2.1 Managing Risk and Promoting Health and Safety)

Through analysis of reports of patient safety incidents, Ombudsman Reports and Coroners Inquests and safety information from other national and international sources, the Welsh Government issues advice and/or guidance for the NHS in Wales to ensure the safety of patients. These are issued as Patient Safety Notices (PSN) or Patient Safety Alerts (PSA). PSNs are issued to ensure that healthcare staff are made aware of a potential patient safety issue. An assessment can then be made and actions taken if necessary. A Notice may be subsequently re-issued as an alert. PSAs require prompt action with a specified implementation date. The Health Board are required to confirm they have implemented the required actions.

The Health Board has declared compliance with the following Patient Safety Alerts and Notices Since February 2022:

PSN062 – Elimination of bottles of liquefied phenol 80%
Phenol is a caustic compound used for its antimicrobial, anaesthetic, and anti-pruritic properties and is highly corrosive and toxic. It can cause burns, severe tissue injury and is rapidly absorbed causing systemic toxicity. High strength Phenol is generally used in podiatry and orthopaedic foot surgery for destroying the nail matrix.

A review of patient safety incidents associated with high strength phenol evidenced occurrences of miss-selection of phenol preparations and harm from use and accidental spills.

In response to these risks PSN062 required the removal of liquefied Phenol and replacement with safer alternatives and the removal of the preparation from formulae to ensure that it cannot be prescribed or dispensed. The Health Board has declared compliance with the actions specified within the notice and the assurance includes:

- A review of all ABUHB stock was undertaken and demonstrated that Phenol was not stocked in any clinical areas.
- An alert was enabled on Primary care prescribing systems in the event that practitioners attempt to prescribe Phenol.

PSN061 – Standardised strength of phenobarbital Oral liquid
Phenobarbital is an anti-epileptic drug used to treat a variety of seizure types in both adults and children. It has a narrow therapeutic index and patients must receive the

correct dose to prevent adverse effects or death from loss of seizure control or toxicity. The drug is available in a number of different doses and some preparations are not considered appropriate for children because of the alcohol content. The Royal College of Paediatrics and Child Health (RCPCH) and Neonatal and Paediatric Pharmacists groups (NPPG) guidance, endorsed by the All Wales Medicines Safety Strategy Group recommend that the unlicensed alcohol free phenobarbital 50mg/5ml oral liquid is given to children.

National incidents of patient harm have occurred because of the inadvertent interchanging of different strengths and preparations of the drug. Factors contributing to these errors include the availability of multiple strengths and preparations of Phenobarbital on electronic prescribing systems, on pharmacy software and dispensary shelves. The Health Board has declared compliance with the actions specified within the notice and assurance includes:

- All patients newly initiated on phenobarbital oral liquid are now prescribed the alcohol free 50mg/5ml preparation.
- Phenobarbital alcohol free 50mg/5ml preparation is prescribed for all paediatric patients.
- An alert has been enabled on all GP prescribing systems to alert them to the risk of alternative prescribing.
- Pharmacy IT systems have been updated to hide alternative strength and preparations of oral liquid and this can only be dispensed by a senior pharmacist in exceptional circumstances.
- All inpatients who are prescribed an alternative strength or preparation of phenobarbital oral liquid are reviewed to establish if it is appropriate to change their prescription to 50mg/5ml.

PSN064- Handlebar injuries in the paediatric abdomen

Handlebar injuries in children have a known association with major internal injuries. As well as pancreatic injuries, injuries to the liver spleen and hollow viscera are well described. PSN064 highlights the importance of considering intra-abdominal injuries in any child presenting with a handlebar injury, particularly if accompanied by significant pain, vomiting, deranged vital signs or visible abdominal wall bruising.

PSN064 requires the review of relevant protocols to ensure that if a child presents with a handlebar injury there is a low threshold for surgical review and CT imaging and or admission for observation. In addition children presenting to a Minor Injuries Unit should be reviewed by a Clinician trained to examine the abdomen or refer to the Emergency Department. The Health Board has declared compliance with these actions specified within the alert and assurance includes:

- A Navigation Policy to ensure that patients receive care in the most appropriate setting for their clinical presentation and includes the process to transfer patients to the Emergency Department from a Minor Injuries Unit, as appropriate.
- Handlebar injuries to the abdomen and lower chest are considered a red flag and the appropriate management and treatment of these injuries are included in training for all Emergency Nurse Practitioners and Triage Nurses within the ED.
- The South Wales Trauma Network have are facilitating a study day for Welsh MIUs regarding the 'red flags of major injury, including 'handle bar.'

PSN057 Emergency Steroid Therapy Cards: Supporting Early Recognition and Management of Adrenal Crisis in Adults and Children

Adrenal insufficiency is a rare disorder which can lead to adrenal crisis and death if not identified and treated immediately. All patients with conditions that cause primary or secondary adrenal insufficiency are physically dependant on daily steroids therapy as a critical medicine. Omission of steroid therapy in these patients can lead to adrenal crisis.

Analysis of incident data submitted to the National Reporting and Learning System identified four patient deaths, four patient admissions leading to critical care and another 320 incidents associated with steroid replacement therapy. Work in ensuring compliance with this Notice is ongoing.

- The dissemination of the Welsh Health Circular WHC 2001/008 to support the provision of a steroid card and to advise patients to seek medical attention during illness.
- An NHS Wales emergency steroid card has been developed for all applicable patients.
- Wales have commissioned emergency hydrocortisone therapy kits to support swift and standardised approach to emergency hydrocortisone therapy.
- Work continues around the arrangements for Emergency Department Clinicians to refer patients with adrenal insufficiency to endocrinology services.

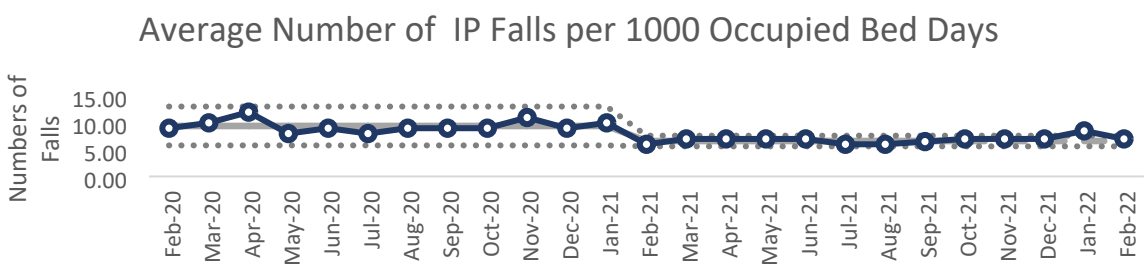
An update on actions associated with PSN057, will be reported the June PQSOC to provide assurance.

Safe Care (Standard 2.3 – Falls Prevention)

The information provides overview of inpatient falls as of February 2022, which is subject to continuous monitoring and review through multiple quality and governance forums to include the 'Falls and Bone Health Committee' and the associated 'Hospital Falls and Bone Health Group'. The data period of 24 months is used to support the establishment of control charts, which identify shifts and trends associated with the numbers of reported falls incidents.

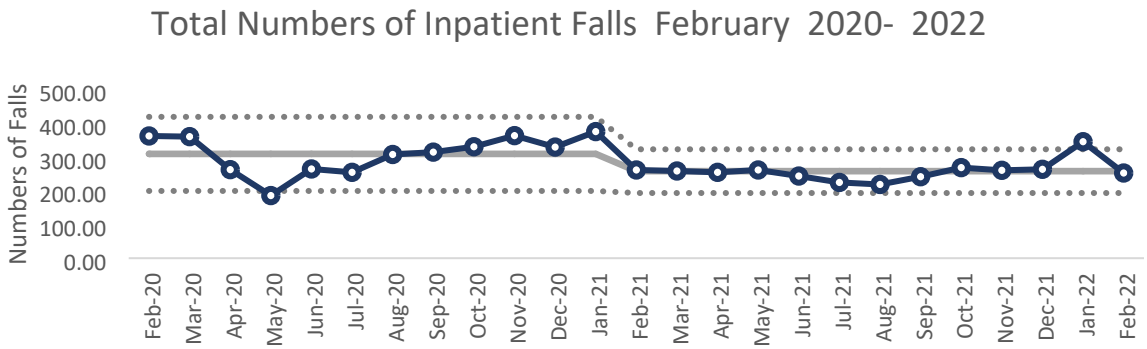
Chart 1 demonstrates the average number of inpatients falls per 1000 Occupied Bed Days (OBD's) February 2020-22. For the period February to December 2021 there has been a sustained period in which the numbers of falls have been aligned to the average value or the lower control limit with minimal variation. January 2022 has seen a change in trajectory with an increase in the average value from 6.6 to 8.1. February 2022 has seen a subsequent downwards trajectory with the average value returning to 7.2.

Chart 1: Average Number of Falls per 1000 OBD's February 2020-2022



Aligned to the above, chart 2 depicts a similar change in which January 2022 has seen an increase in the total numbers of reported falls incidents. The numbers represent a value which is marginally above the upper control limit of 323. February 2022 has seen numbers return to the sustained values seen throughout 2021.

Chart 2: Total number of reported falls incident 2022-2022



January 2022 saw an increase in falls across all Divisions with those areas of most significance being Urgent Care and Medicine. From a site perspective both the GUH and NHH have demonstrated upwards trends in falls incidents whilst all other sites demonstrate limited variation. For February, GUH is the only site which has not seen a reversal in the trajectory. It is important to note that the changes for January and February 2022 represent two single data points and that the process of ongoing monitoring will provide a greater insight into any significant changes in shifts and trends.

In response to the increase in numbers for both Urgent Care and Medicine a focussed review of the incidents is being undertaken to support the provision of information trends and to inform change initiatives. This includes an in-depth analysis of ward level data.

Falls Action updates:

- Falls management has been subject to Internal Audit, the outcome of which provides the Health Board with reasonable assurance. The recommendations within the report will further inform the work of the 'Falls and Bone Health Committee' and that of the 'Hospital Falls and Bone Health Group'.
- The 'Hospital Falls and Bone Health Group' had its first meeting on the 10th March 2022 and is in the process of agreeing it 'Terms of Reference' and associated membership together with identified programmes of work.
- ABUHB have representation at an 'All Wales's' forum in which a level 1-2 generic platform for falls management training is being developed and will represent a national product to be delivered through ESR.
- Meetings of the National Falls Taskforce and 4 Nations Collaborative were held on the 21st March 2022, the outcomes of discussions of which will be used to embed consistent standards across Wales and inform the work of ABUHB.
- The Health Board have received a Regulation 28 from the Coroner (prevention of future deaths report). A response is currently being prepared.

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

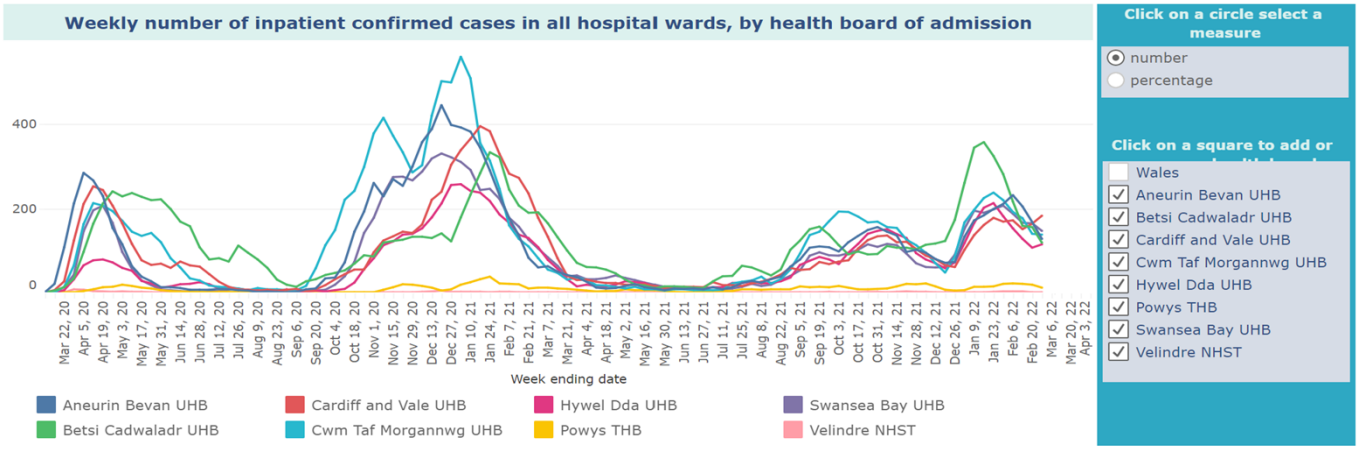
Inpatient Covid

From May 2021, the number of patients with Covid in hospital started to reduce until September 2021, when cases began to rise again peaking in January 2022.

The following graph shows the number of positive patients in each hospital up to 7th March 2022. At the end of January 2022, there was a requirement for additional red capacity to be established on the Royal Gwent site to cope with inpatient demand. In March 2022, the Health Board were in a much better position and red pathways returned to single hospital sites only (Ysbyty Ystrad Fawr and Ysbyty Aneurin Bevan).

The following graph illustrates ABUHB weekly confirmed inpatient Covid cases compared to other Health Boards in Wales. The graph demonstrates that the numbers of patients with confirmed Covid as a proportion of total inpatient beds is between 1% and 4% (27th February 2022). The graph shows Health Boards are following a similar trend.

Confirmed inpatient Covid compared with Welsh HBs:



The number of patients requiring critical care and high-level respiratory care is significantly lower than previous surges.

Covid-19 Outbreaks

An outbreak, as defined by Public Health Wales is 2 or more cases occurring in the same ward environment, within a specific time period and is a notifiable incident. The ongoing community transmission is inextricably linked to hospital acquired cases.

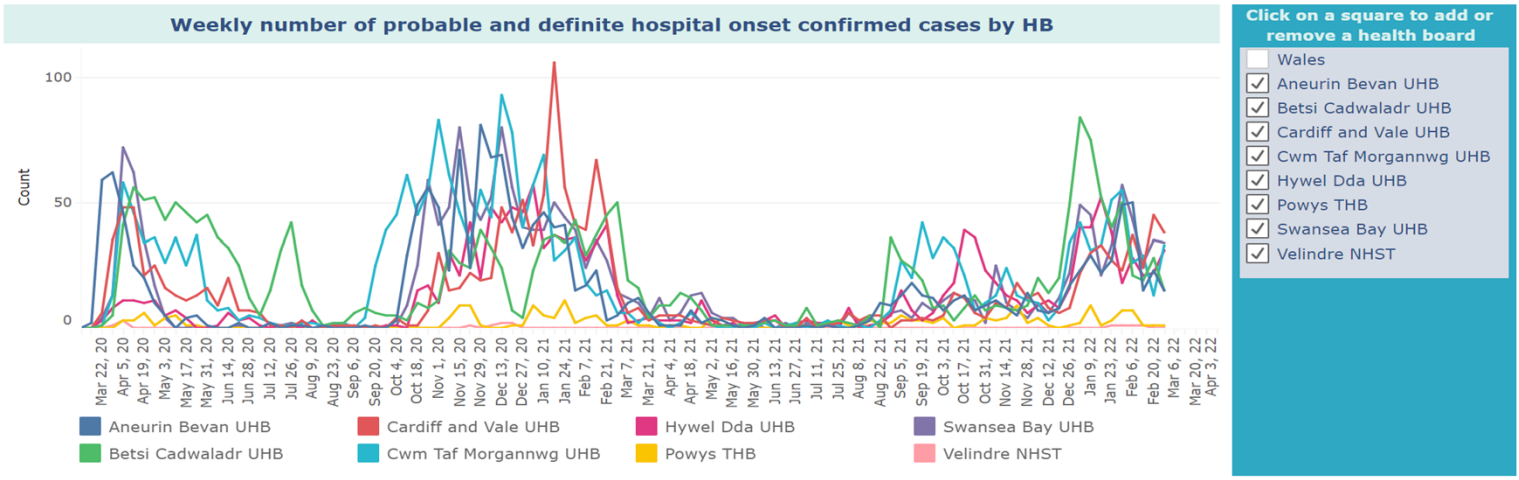
At its highest point in February 2022, 16 wards across the health board were affected and closed due to outbreaks of Covid-19 placing significant pressure on bed capacity, workforce, and staff wellbeing. Royal Gwent Hospital has been most severely affected with a mixture of 10 bays and/or wards closed during the peak in early February. The Mental Health Division have also experienced several ward closures, creating pressure to outsource specialist beds.

The Health Board has a robust Standard Operating Procedure for outbreak management which includes an outbreak control meeting to explore the possible root cause, hypothesis for index case and compliance with Covid-19 safety measures. The core

agenda has been reformatted to steer the outbreak control group towards a whole systems risk assessment approach rather than concentrating on the purist infection prevention measures. This is in line with the proposed Covid 19 investigation process (nationally described).

The following graph demonstrates ABUHB probable and definite hospital onset of Covid-19. Probable hospital onset is defined as a positive test 8-14 days after admission and definite hospital onset is post 14 days following admission. The rate of probable and definite hospital onset within ABUHB is 1% compared to all Wales rate of 2%.

All Wales Hospital Onset:



Themes continue to be associated with asymptomatic carriers identified via routine inpatient testing. There are some specific challenges in the eLGHs and Community Hospitals associated with aged estate, limited cubicles, and ventilation.

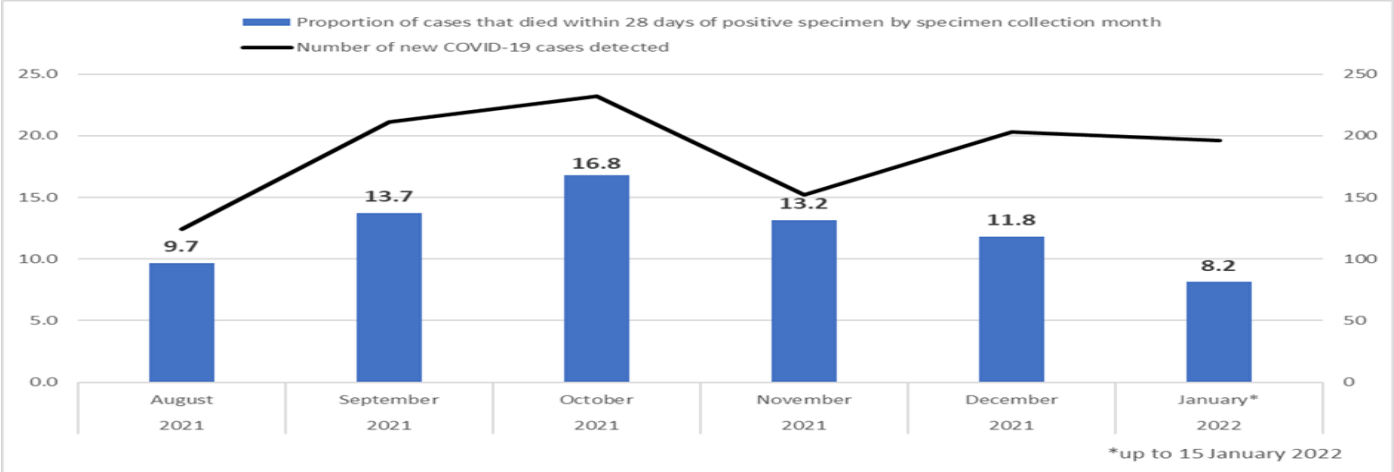
Care Homes

Care Homes have endured considerable episodes of Covid incidence (where a resident or a member of staff have tested positive) or outbreaks. The care home position impacts on patient flow from secondary to primary care as transfers and admission are restricted when a care home is in outbreak mode. In collaboration with Public Health Wales, the Infection Prevention and Control Team has developed a Patient Discharge passport to support a risk assessed approach for safe discharge, to reduce hospital length of stay.

Covid-19 Mortality

From January 2022 to March 2022, there have been 15 inpatient deaths associated with probable or definite healthcare associated Covid infection. A further 18 patients with community onset of Covid-19 have died within 28 days of testing positive.

Health Board Mortality data:



The trend is suggestive of a decline in mortality linked with the Omicron variant compared to the Delta variant, which is mirrored across Wales.

At the beginning of February 2022, a national approach to the investigation and management of Covid-19 nosocomial infection was agreed. This is a significant and complex piece of work, with a Welsh Government expectation this proceeds at pace

The Health Minister has confirmed circa £4.5M for Wales. ABUHB portion of this funding has been confirmed and can be seen in the letter, included in the agenda, for information.

National Guidance

Current UK Infection prevention and control guidance first issued in November 2021 and revised in January 2022, remains in place for the management of seasonal respiratory infections in health and care settings (including SARS-CoV-2) with provision for a respiratory pathway and other care pathways to be defined locally. There is a steer from Welsh Government to move to a business-as-usual arrangement. The Reducing Nosocomial Transmission Group (RNTG) has reviewed this recommendation and advocated a phased transition of the three areas, through a monitored and proportionate approach: -

- Testing - reduce inpatient to day 1, 3 and 5 only and reduce staff testing to twice weekly for patient facing.
- Patient pathways- a transition to acute respiratory, acute non-respiratory and protected elective pathways by the end of March 2022.
- Gradually relax visiting restrictions.

These recommendations are based on the following: -

- Sustained reduction of number of Covid-19 inpatients
- Falling rate of hospital acquired infection
- Community prevalence
- Mortality rate

In summary, RNTG have proposed a phased and controlled relaxation of the Covid-19 rules. This gradual change will be monitored via RNTG and reported to Executive Team.

Other Respiratory Infections

The number of inpatients presenting with Influenza and Respiratory Syncytial Virus (RSV) has been unusually low. The Health Board has a robust winter plan where patients who are identified as influenza or RSV positive are isolated or cohorted following the appropriate pathway. It can be concluded from the data below that RSV and Influenza is not circulating within the ABUHB community.

Welsh Government Reduction Expectation Goals

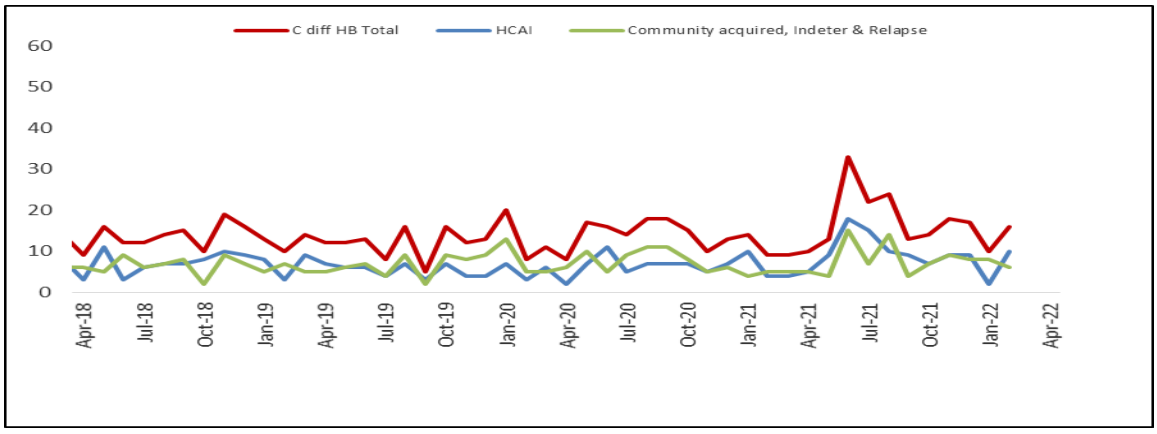
To support best practice, reduce healthcare associated infections and provide a clean, safe environment for patients, staff and visitors, the Infection Prevention and Control Team, in collaboration with Leadership Teams, report any exceptions, barriers and challenges with care bundle compliance through the Reducing Nosocomial Transmission Group (RNTG) for action, monitoring and follow up.

The Health Board are in the process of planning the annual Hydrogen Peroxide Vapour (HPV) cleaning programme, which will enhance the ward environment.

C *difficile*

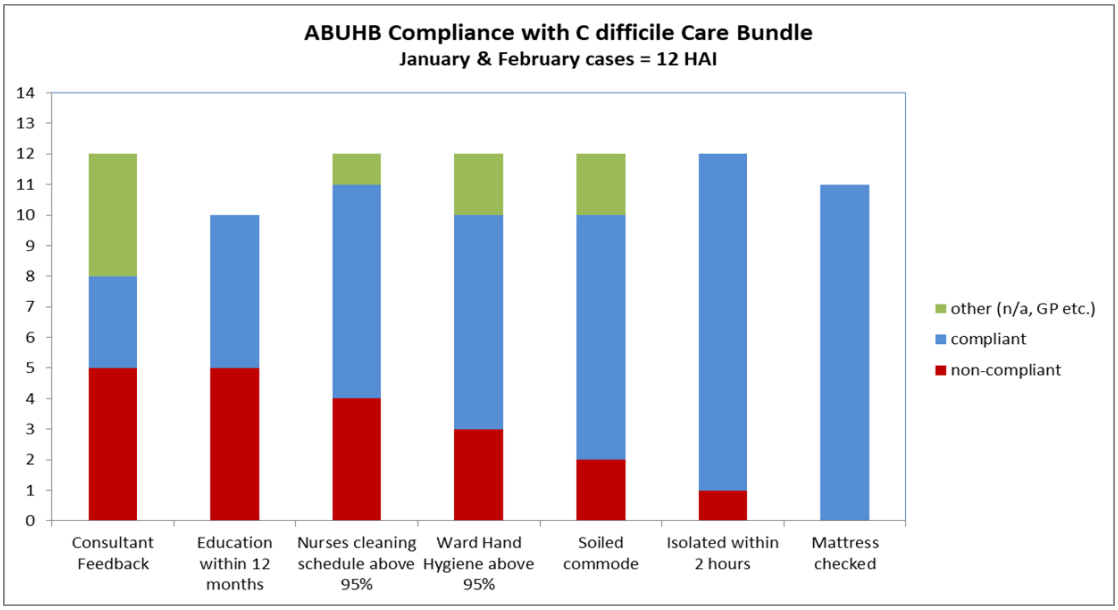
Clostridium difficile (C. *difficile*) is a type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. When someone has C *difficile* infection, it can spread to other people very easily if the bacteria gets onto objects and surfaces. There have been 188 cases of C *difficile* reported from April 2021 - February 2022. This is 37% more than the equivalent period 2020/21 equating to a rate of 34.34 per 100,000 population. C *difficile* continues to be above trajectory and remains a concern albeit an improvement is being seen. There were 10 reportable cases for January 2022 and 17 cases in February as per graph below:

C difficile Prevalence:



The following is a breakdown of compliance with key elements of the C *difficile* care bundle for healthcare associated cases discussed at root cause analysis meetings in January and February. Consultant engagement remains challenging and it has been challenging to deliver a programme of education during the pandemic. As there is a move towards business as normal, it is timely to inject some targeted focus to these key elements, to drive down the burden of C *difficile* infection and promote local ownership.

Compliance with Infection Prevention fundamentals:



There has been one outbreak identified at Ysbyty Ystrad Fawr. Laboratory Genotyping indicates cross infection has likely occurred. Other contributing factors were environmental cleanliness and antimicrobial stewardship. A new ward sister has been appointed and is rapidly establishing robust processes to enhance compliance with fundamentals of infection prevention. Facilities resources have increased with a focus on cleaning near patient equipment and frequently touch areas points.

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; data to the end of Q1 21-22 demonstrate ABUHB has exceed the target and is running at 62% 'Access' use.

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, which includes a hard stop of all antibiotics at 72 hours, forcing review and, if required, re-prescription of antibiotics. ARK was successfully implemented in YYF over the autumn, and NHH went live on 1st March. The antimicrobial team are currently planning roll out to RGH then finally GUH. It is hoped the roll out will be complete at the beginning of July to ensure it is standard of care by staff changeover in August.

Total antimicrobial use in primary care has rebounded to pre-pandemic levels in Q2 21-22, however use of the high-risk '4C' agents remains lower than both the Welsh and English average.

Staphylococcus Aureus Bacteraemia

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.

120 cases of Staph aureus bacteraemia have been reported from Apr 2021 - Feb 2022. This is 15% fewer than the equivalent period 2020/21 equating to a provisional rate of 21.92 per 100,000 population. Within the month of January 8 cases were reported and 14 cases in February.

Over the two month reporting period, 10 cases were associated with hospital admissions. Normally, each incident undergoes a root course analysis review to establish the source of infection and any associated learning.

There have been no clusters identified and initial analysis has highlighted one infection associated with a peripheral line. Robust monitoring around Peripheral Venous Catheter (PVC) care was implemented as an action.

There have been two cases of MRSA bacteraemia reported within this time period. One associated with an exacerbation of psoriasis. The other associated with a wound to a patient's ankle.

Two area of focus over the next quarter include:

- Aseptic Non Touch Technique (ANTT)
- Working in collaboration with primary care for the ACT project (this is a project where all healthcare professionals encourage and offer people who inject drugs wound care packs).

Gram Negative Bacteraemia

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.

Patients presenting septic on admission continues to be the highest contributing factor to the case rate. Overall, there has been an increase in reportable cases compared to the equivalent period 2020/21, but the rate of admissions has been lower during this period. Bench marking from the previous year (2019/20), shows a significant reduction in the overall rate of Gram-Negative Bacteraemia

There have been 316 cases of E coli reported from Apr 21 to February 2022. This is 17% more than the equivalent period 2020/21. There have been 29 cases in January and 24 cases in February.

Pseudomonas

There have been 3 reportable cases of pseudomonas in January and 2 in February equating to a rate of 5.30 per 100,000 per population. There have been 29 cases of Pseudomonas reported from Apr 21 to Feb 22. This is 29% more than the equivalent

period 2020/21 and the analysis is that the same patients are having recurring infections.

Klebsiella

86 cases of Klebsiella reported from April 21 to February 2022. This is 18% fewer than the equivalent period 2020/21, a provisional rate of 15.71 per 100,000 population. There were 5 cases in January and 6 cases reported in February.

There have been no clusters identified across the Health Board and the main source of infection is urinary tract. The Infection Prevention and Control Team and Continence Service are incorporating the principles of the HOUDINI project into the urinary catheter care bundle. This is daily risk assessment tool to determine if the patient still requires a urinary catheter.

The "trial without catheter" (TWOC) initiative has been introduced supported by District Nursing which has resulted in catheter days reduced. Contributing to a decline in urinary catheter associated infection. This work has been shortlisted for the Betsi Cadwaladr Scholarship.

All Wales comparison Welsh Government Reduction Expectation

ABUHB has the lowest rates across Wales for bacteraemia infections and are the only Health Board on target to achieve a marginal reduction.

None of the Welsh Health Boards are likely to achieve a reduction against the C *difficile* expectation.

All Wales comparison for Welsh Government Reduction Expectation:

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	188	34.34	3	0.55	117	21.37	120	21.92	316	57.73	86	15.71	29	5.30	431	78.74
Betsi Cadwaladr UHB	202	31.38	10	1.55	161	25.01	171	26.57	407	63.24	127	19.73	36	5.59	570	88.56
Cardiff and Vale UHB	145	31.41	8	1.73	111	24.04	119	25.78	284	61.52	110	23.83	31	6.72	425	92.06
Cwm Taf Morgannwg UHB	136	33.04	2	0.49	105	25.51	107	25.99	366	88.91	74	17.98	28	6.80	468	113.69
Hywel Dda UHB	141	39.54	15	4.21	100	28.04	114	31.97	332	93.10	74	20.75	29	8.13	435	121.98
Powys THB	10	8.21	0	0.00	0	0.00	0	0.00	3	2.46	0	0.00	0	0.00	3	2.46
Swansea Bay UHB	178	49.76	10	2.80	118	32.98	128	35.78	267	74.63	87	24.32	22	6.15	376	105.10
Velindre NHST	4		0	0.00	3		3		4		3		1		8	
Wales	1,004	34.62	48	1.65	715	24.65	762	26.27	1,979	68.23	561	19.34	176	6.07	2,716	93.64

Decontamination

The new endoscopy suite at the Royal Gwent Hospital is progressing on time. A Project Team continue to work alongside the endoscopy team, to develop a new centralised decontamination unit on site in readiness to support service delivery, including Gastroscopy, Urology and ENT. The procurement has reached its final two manufacturers for the purchase of scope washer disinfectors.

The Endoscopy Unit at Ysbyty Ystrad Fawr is aiming for accreditation via the Joint Advisory Group (JAG) this year. Significant developments in striving for this recognition include chemical monitoring and storage, new upgraded sinks in the washroom and the purchase of two new drying cabinets.

The Family and Therapies Directorate have purchased three Trophon decontamination units, ensuring validated decontamination of probe scanners. Training has been given and their introduction demonstrates commitment to improving standards rather than its essential requirements.

Commissioning of the newly built Central Sterilisation Department (CSD) at The Grange University Hospital is near completion, with an aim to open fully in April 2022. In the meantime, surgical instruments are transported to the Royal Gwent Hospital and Nevill Hall Hospital CSDs. The benefits of this development will improve service delivery and state of the art decontamination technology.

The above actions will reduce the risk of hospital infection associated with reusable medical devices, whilst maintaining an adequate level of decontamination and promoting best practice. There have been no incidents associated with decontamination over this reporting period.

Water Safety

In line with National Guidance ongoing water testing areas across the Health Board has identified raised counts of Legionella and Pseudomonas within the Family & Therapies areas. Works & Estates have installed filters onto the taps, disinfected the water tanks and revisited the cleaning protocol of clinical handwashing sinks to minimise risk to patients. This has not resulted in onward transmission of infection to patients and is closely monitored by the Water Safety Group.

Nutrition and Hydration (Standard 2.5 – Nutrition and Hydration)

Further to the previous paper (October 2021) to the committee, the following provides an update on progress with the nutrition and hydration action plan.

Auditing is being conducted which will quantify the following:

- WAASP Nutritional Screening
- Beverages and snacks
- The Fundamentals of Care
- Observations for mealtimes
- Patient satisfaction surveys

The organisation continues to look at models for nutritional support, this work remains ongoing. A 'Patient Dining Service' review commenced in February 2022 led by Estates and Facilities, with an identified project plan which consists of a four-phase approach to include:

- Data capture
- Qualitative and quantitative data analysis
- Appraisal in support of identifying potential service models for further consideration
- Development of a final report for consideration and consultation

The associated timelines are identified as concluding in June 2022. The project is supported by a formal project governance process managed through the 'Estates and Facilities Programme Management Board'. Key deliverables have been identified against each phase of the project plan. The Community Health Council have been engaged.

The Nutrition and Hydration review will be agendered for the June PQSOC.

Medicines Safety (Standard 2.6 medicines Management)

The use of medicines is the most common type of healthcare intervention. Most medicines are used safely and effectively, but sometimes, incidents happen that can lead to harm to patients. By identifying areas of particular risk, NHS organisations and healthcare professionals can take action to significantly improve the safety of patients receiving and taking medicines· Studies have shown that 6.5% of hospital admissions may be related to harm from medicines and around 7% of inpatients may experience harm from medicines, much of which is deemed preventable.

The introduction of an ABUHB Medication Strategy Group that extends over three years that aligns to the NHS Patient Safety Alert: Improving medication error incident reporting and learning. This recommends Health Boards identify a Board level Director to oversee medication incident reporting and learning, identify a Medication Safety Officer to support local medication error reporting and learning and identify a multi professional group to review incident reporting. The NICE guidance on medicine optimisation makes reference to the impact of safety of medicines and focuses specifically on medication incident reporting, transfer of care and medicines reconciliation and review. The World Health Organisation (WHO) launched their Global Medications Safety challenge in March 2017 to reduce severe avoidable harm due to medication incidents by 50% over 5 years. The key priorities are high risk situation, polypharmacy and transfer of care.

There are five goals prioritised within the strategy:-

1. Improve reporting and learning from medication incidents and good practice
2. Support the safe and secure storage and use of medicines
3. Reduce harm from high risk medication and tasks
4. Learn from and contribute to the national medication safety agenda
5. Develop and implement strategies to improve the medicines safety culture across the Health Board

An action plan has been developed to support the delivery of the above goals, between 2022 -2025, and an update will be provided to the PQSOC on an annual basis, as part of a broader medicines management assurance report.

Effective Care: Annual Plan Priorities 1 2 3 4 5

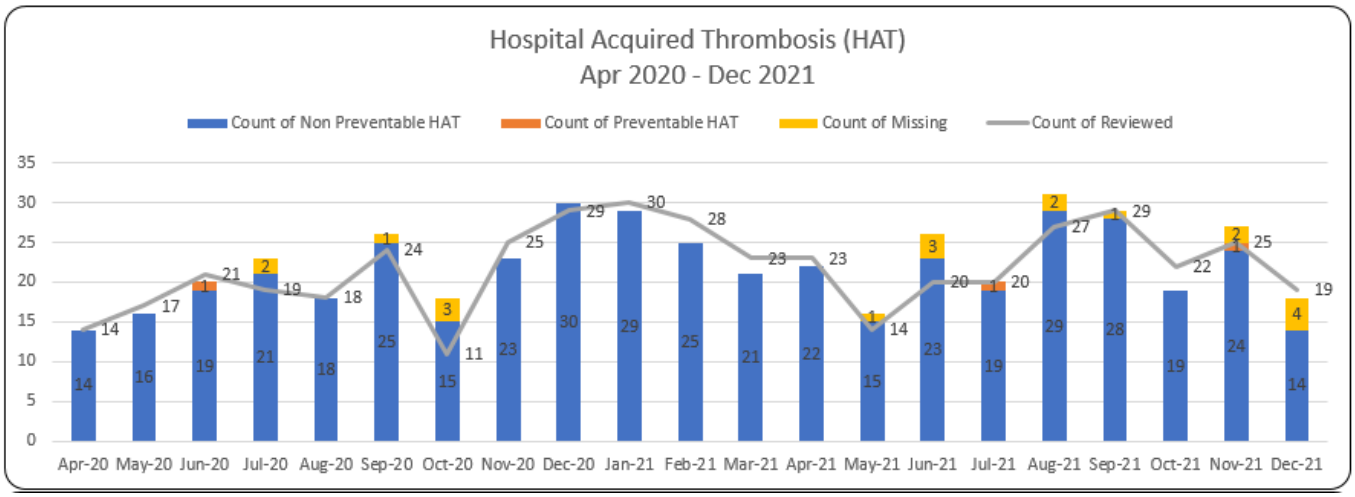
The principle of effective care is that people receive the right care and support as locally as possible and are enabled to contribute to making that care successful. If people receive the right care and support they will be empowered to improve or manage their own health and wellbeing. Interventions 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.

Thrombosis (Standard 3.1 Safe and Clinically Effective Care)

All Hospital Associated Thrombosis (HAT) are subject to a process of reviews facilitated by the Haematology Directorate and undertaken by the Lead Consultant for each patient.

Between April 2019 and April 2020, 9 potentially preventable Hospital Acquired Thrombosis (HAT) occurred. As a result of robust reviews, targeted education and feedback, occurrences reduced significantly to 1 potentially preventable HAT in the 2020/21 reporting year.

Between April and December 2021 there has been continued good practice, with 2 potentially preventable cases identified, where there were omissions in prescribing that may have been contributing. In both cases there was an omission to prescribe the necessary thromboprophylaxis despite this being identified and flagged by a reviewing Pharmacist. A national review of venous thromboembolism (VTE) risk assessment and prescribing is currently underway and is likely to result in a revised All Wales Risk Assessment. Communication is being circulated to all prescribing Clinicians of the importance of completing a VTE risk assessment and prescribing accordingly.



Mental Capacity Act (MCA) (Standard 3.1 Safe and Clinically Effective Care)

A recent Mental Capacity Act audit undertaken by Internal Audit provided "reasonable assurance". The audit identified best interest discussions were not adequately documented and records of mental capacity assessment were frequently not recorded when completing a DNACPR decision, for patients without mental capacity.

The Person-Centred Care Team have appointed two MCA Specialist Practitioners who commenced post on 28th February. As well as providing training, these post holders will work side by side with clinical teams, advising and guiding on the implementation of the MCA in everyday clinical practice.

A number of initiatives to raise staff awareness and professional development have taken place over the past 3 months:

- Practice Educator for both Dementia and Deprivation of Liberty (DoLS) has been secured until the end of March 2022. These Educators have developed and delivered training programmes. Further consideration of the sustainability of these posts is taking place.
- MCA training programme developed.
- The DoLS Team are undergoing British Sign Language training in order to better communicate with people who are deaf and who may lack capacity.
- MCA training has been arranged for GP's.
- 3 training videos outlining how to practically undertake and complete DNACPR, Capacity and Best Interest Decisions are in development.
- DNACPR training incorporating MCA has been delivered through the Grand Round.
- A training strategy to support MCA and implementation of the Liberty Protection Safeguards has been agreed through the Workforce and Organisational Development Steering Group.

Clinical Audit (Standard 3.1 - Safe and Clinically Effective Care)

A standalone Paper is being reported to the Committee to provide an overview of the national clinical audit results and associated improvement plans.

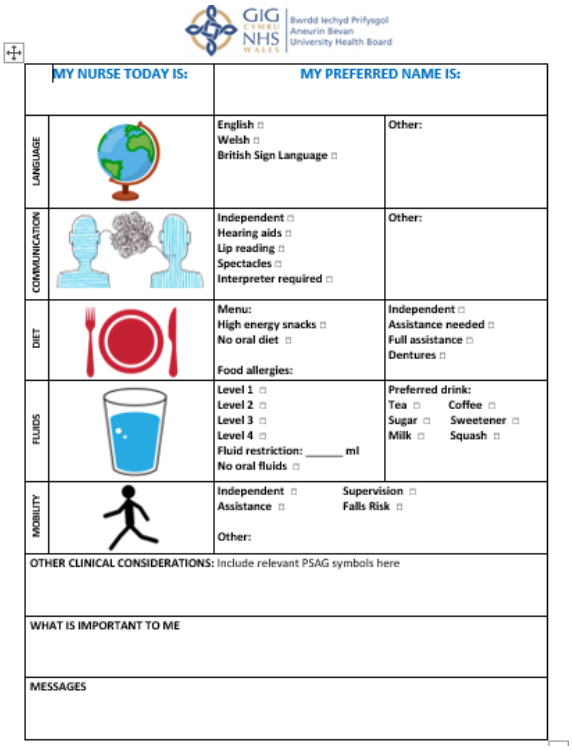
Dignified Care: Annual Plan Priorities 1 2 3 4 5

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.

Meaningful Activity (Standard 4.1 - Dignified Care)

A Proof of Concept and Service Evaluation has been undertaken at Ysbyty Aneurin Bevan. This demonstrated that engaging patients in meaningful activity can significantly reduce behaviours that challenge. A suite of meaningful activities are now available for staff to download. Monies have been secured to purchase a substantial amount of meaningful activity kit that will support people who are living with dementia and those who have sensory impairment. A training programme has been established that aims to improve dementia care, and the importance of engaging people in meaningful activity is included within that programme. Roll-out across the Health Board has commenced. The meaningful activities consider sensory loss and the provision of activities in Welsh.

Patient Bedside Boards (Standard 4.1 Dignified Care)



MY NURSE TODAY IS:		MY PREFERRED NAME IS:	
LANGUAGE		English □ Welsh □ British Sign Language □	Other:
COMMUNICATION		Independent □ Hearing aids □ Lip reading □ Spectacles □ Interpreter required □	Other:
DIET		Menu: High energy snacks □ No oral diet □ Food allergies:	Independent □ Assistance needed □ Full assistance □ Dentures □
FLUIDS		Level 1 □ Level 2 □ Level 3 □ Level 4 □ Fluid restriction: _____ ml No oral fluids □	Preferred drink: Tea □ Coffee □ Sugar □ Sweetener □ Milk □ Squash □
MOBILITY		Independent □ Supervision □ Assistance □ Falls Risk □ Other:	
OTHER CLINICAL CONSIDERATIONS: Include relevant PSAG symbols here			
WHAT IS IMPORTANT TO ME			
MESSAGES			

The In-Patient Hospital Dementia Group has identified the need to ensure that patient bedside boards are designed to capture key safety considerations relevant to each patient.

This includes the need ensure that staff can see 'at a glance' whether a person has dementia and be able to immediately recognise the support patients may need, including nutrition and hydration, falls risks etc.

A review of the current patient bedside boards has resulted in the development of a more detailed magnetic board that will enable key risks and symbols to be added. Additionally, space is allocated on the Boards to identify what is important to the patient and to enhance relative to staff communication and vice versa.

These Boards are being ordered and priority areas identified to pilot the Boards.

Timely Care: Annual Plan Priorities 1 2 3 4 5

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.

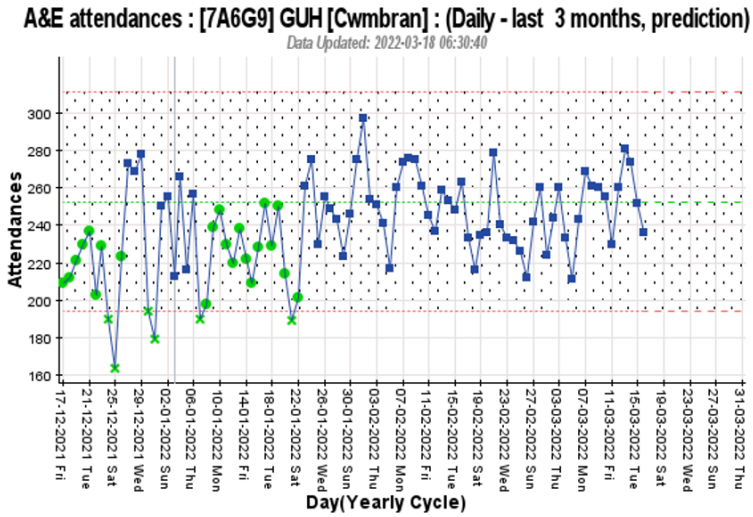
Urgent Care (Standard 5.1 – Timely Access)

The urgent care system continues be under significant pressure both nationally, regionally and locally. This is in the context of significant workforce challenges, increasing demand for urgent primary care, increased ambulance call demand, increasing self-presenters at Emergency Department (ED) and Minor Injury Units (MIU), increased acuity linked to post lockdown impact, increased bed occupancy for emergency care and high levels of delayed discharges linked to significant social care workforce challenges. All of this is also in the context of ongoing presentations of Covid-19 and the need to maintain appropriate streaming of patients, and the increasing levels of elective work as part of the recovery programme.

Attendance at the Health Board's Emergency Departments (ED) had been increasing since the start of February 2021; however, December and January attendances decreased with just over 13,100 in January 2022 compared with over 14,500

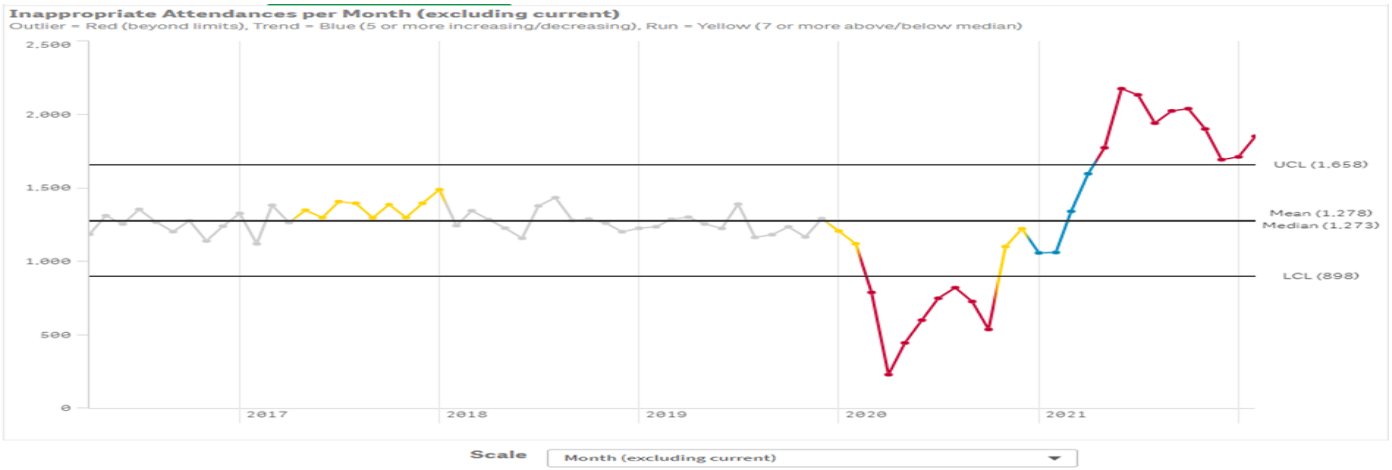
attendances in November 2021, slightly lower than pre-pandemic monthly figures. Attendances are expected to follow the typical seasonal trends in the coming months.

The Grange University Hospital continues to see a higher rate of patients being admitted than is the case for other Emergency Departments, with 25% observed in GUH compared to 20% in other departments. This higher admission rate reflects the higher acuity of patients attending the Emergency Department, which consequently results in more patients staying longer in the department (and in wards).

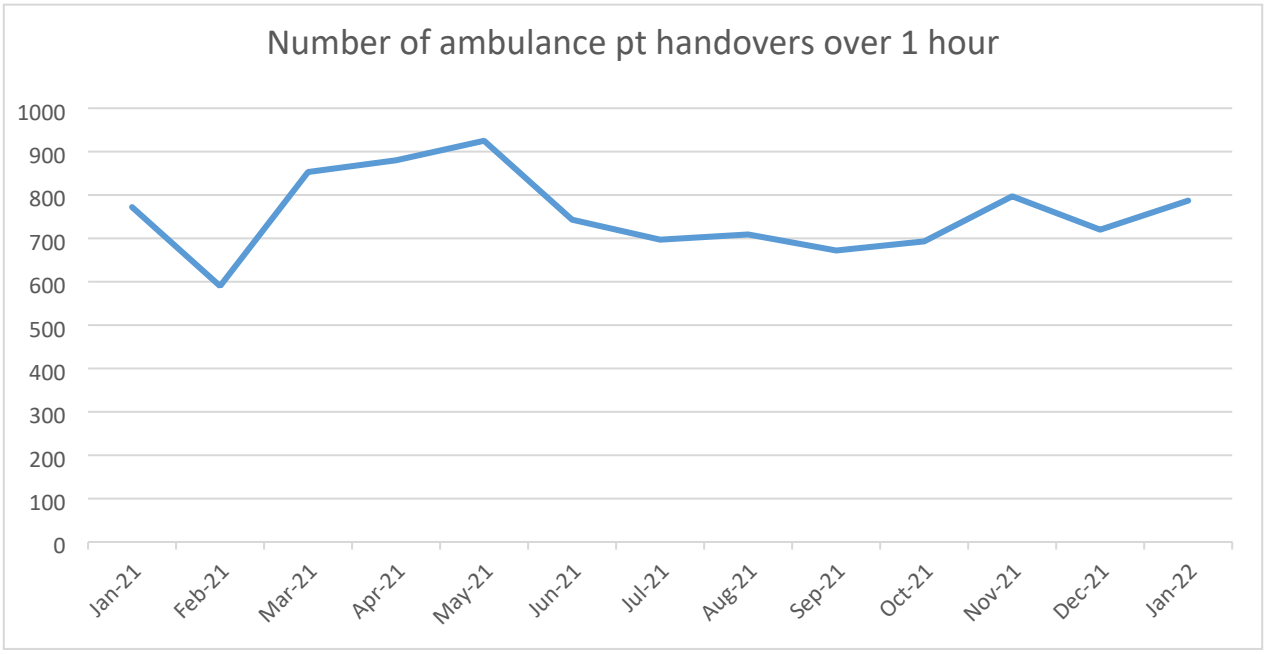


Significant and sustained demand in the Emergency Department has a detrimental impact on quality, safety and experience with resultant prolonged stays in the ED and delayed handover of care between ambulances and ED staff, leading to subsequent delays in ambulance response within the community.

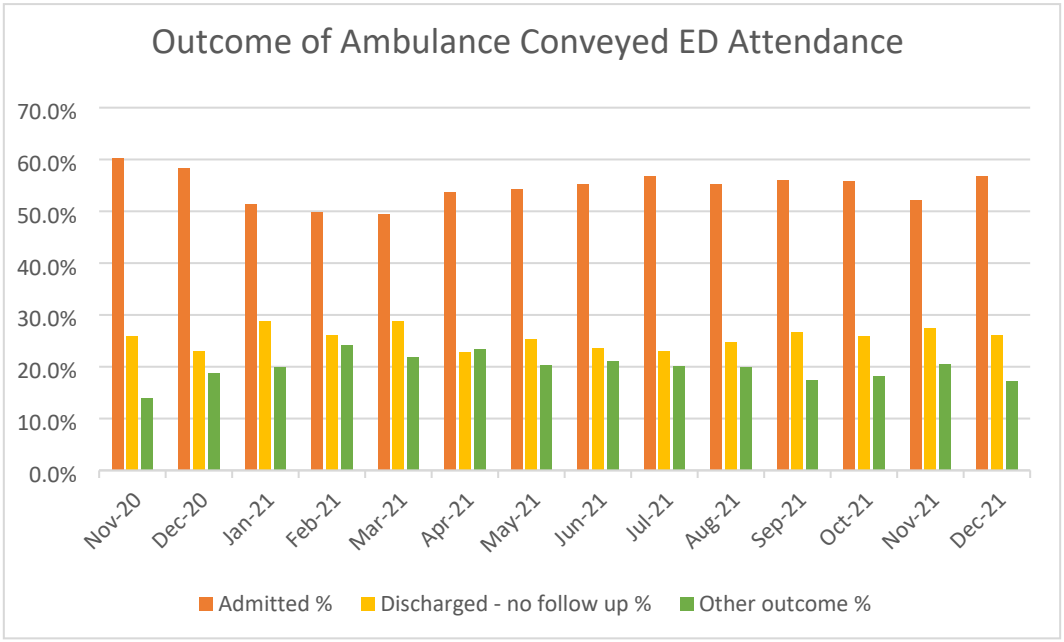
While the acuity of the patients attending GUH ED remains high, there is also a proportion of patients who could be seen more appropriately in other health settings. The graph below illustrates the number of patients attending the Health Boards Emergency Departments (including MIU's) each month who are deemed 'inappropriate'. An inappropriate attendance is when the patient has been reviewed by a Clinician and the condition the patient is presenting with is deemed as more appropriate to be seen in another health care setting. This number has increased significantly from the typical monthly median of 1250 prior to April 2021, to approximately between 1800 and 2000 each month since April 2021.



The number of patients conveyed by ambulance whose handovers occur 60 minutes or longer after arriving at GUH have remained static with an average of 757 delayed handovers each month, between 590 in February 2021 and 925 in May 2021.

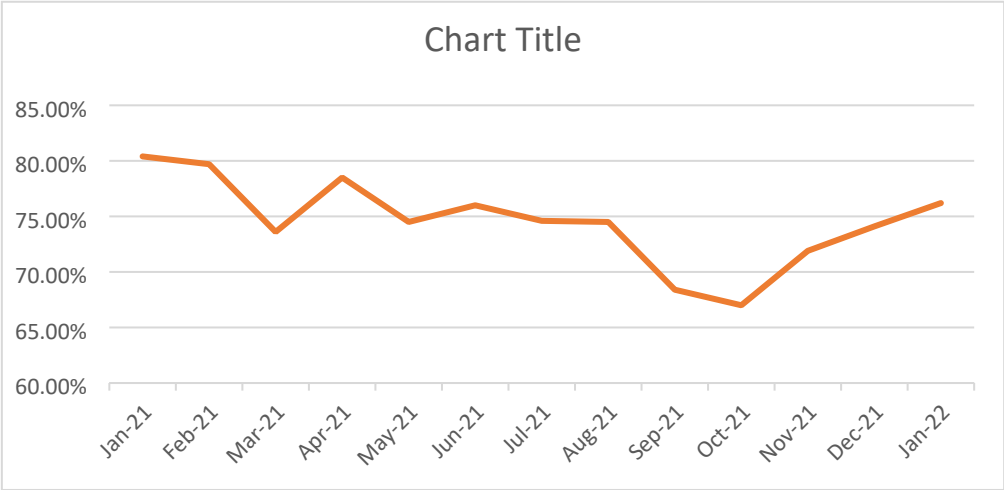


Ambulance attendances at GUH from November to December average 1486 and each month, varying between 1268 and 1897 with an average of 54.2% of patients conveyed by ambulance being admitted and 25.7% being discharged with no further follow up required. An average of 20.1% being subject to a different outcome. It should however be noted that 25% of the patients who are discharge without follow up spend over 12 hours in the ED, frequently receiving care and treatment in this environment.



Improving performance has been observed in relation to the proportion of patients being discharged, admitted or transferred within 4 hours of presenting at ED, with ABUHB rated as second in Wales for this performance. Two periods of poor performance

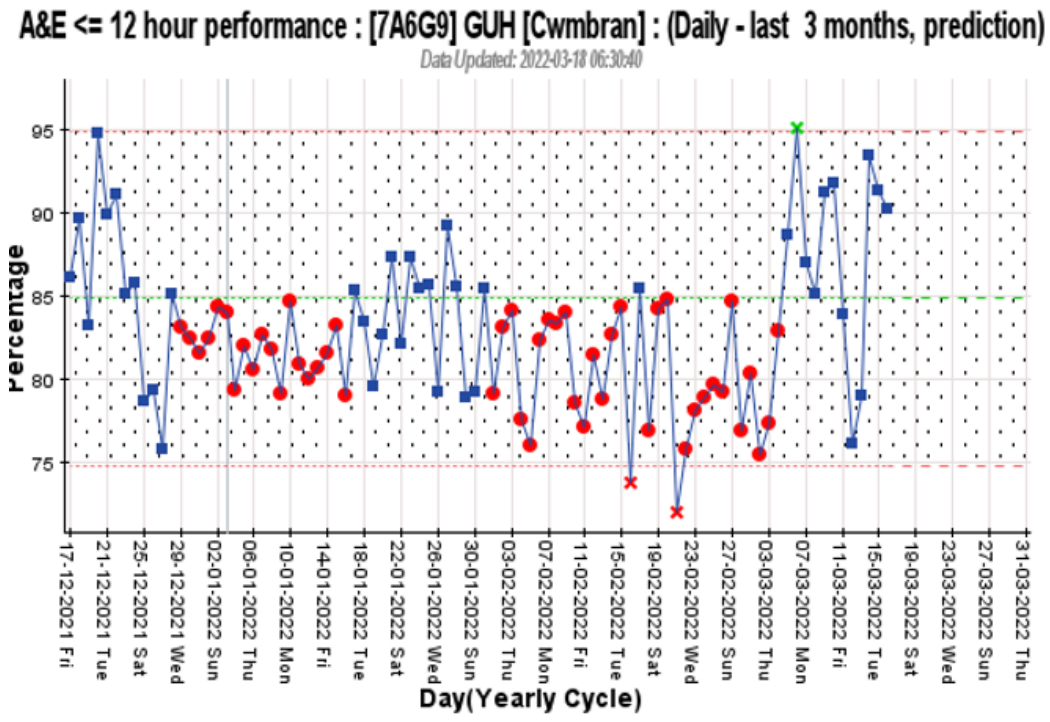
relating to discharge admission or transfer within 12 hours of presentation was noted in the first two weeks in January 2022 and throughout February 2022.



A two week system reset has been conducted nationally to address high ambulance response times, delays in handover, waits in the ED, extended lengths of stay and waits for hospital discharge.

The improvement programme included a focus on a reduction in variation in referrals from primary to secondary care, additional clinical support in the Flow Centre to include WAST support and a focus on the intersite transfer process from ELGHs to GUH. In addition there is a focus on a falls response unit and refinement of escalation arrangements.

The following graph demonstrates an improvement in 12 hour performance observed since the initiation of the two week sprint, with 12 hour performance above the 85% target, with a weekend reduction in performance noted.



An evaluation of the 2 week system reset is being conducted and ABUHB will join a national learning event to share feedback.

Stroke (Standard 5.1 – Timely Access)

As an unscheduled, urgent care pathway, the Health Board's stroke pathways are directly impacted by the continued urgent care system wide pressure that is being seen nationally, regionally and locally; this is especially evident with regard to the access related stroke quality metrics.

The Health Board benefits from having a modern, purpose designed Hyper Acute Stroke Unit (HASU) at the Grange University Hospital (GUH) which provides urgent intervention at the most acute stage of the stroke. Since opening the GUH, and in the context of the continued urgent care system pressures, the Health Board has been unable to fully protect this HASU capacity to maintain access and timely flow. Similarly when a patient with a stroke is ready to move on from the HASU, to the sub-acute rehabilitation facilities (currently at the Royal Gwent, Nevill Hall and Ystrad Mynach hospitals), the transfer can be delayed due to lack of capacity at those sites, again directly related to system wide pressures in all parts of the urgent care pathway (including community social care that supports discharge for patients with increased dependency). Flow through the pathway is effectively stalled as a result of the pressurised and congested system, which has been further restricted by repeated COVID-19 outbreaks that can cause ward closures and delayed discharges to closed settings.

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 region of 50% (48.8% in February 2022) which reflects a similar performance across Wales. This can be partly explained by the very congested Emergency Departments that lead to logistic and processing delays.

The proportion of patients with a confirmed stroke directly admitted within 4 hours has remained stubbornly low over the past 6 months (14% in February 2022) which also reflects a similar performance across Wales (17.6%).

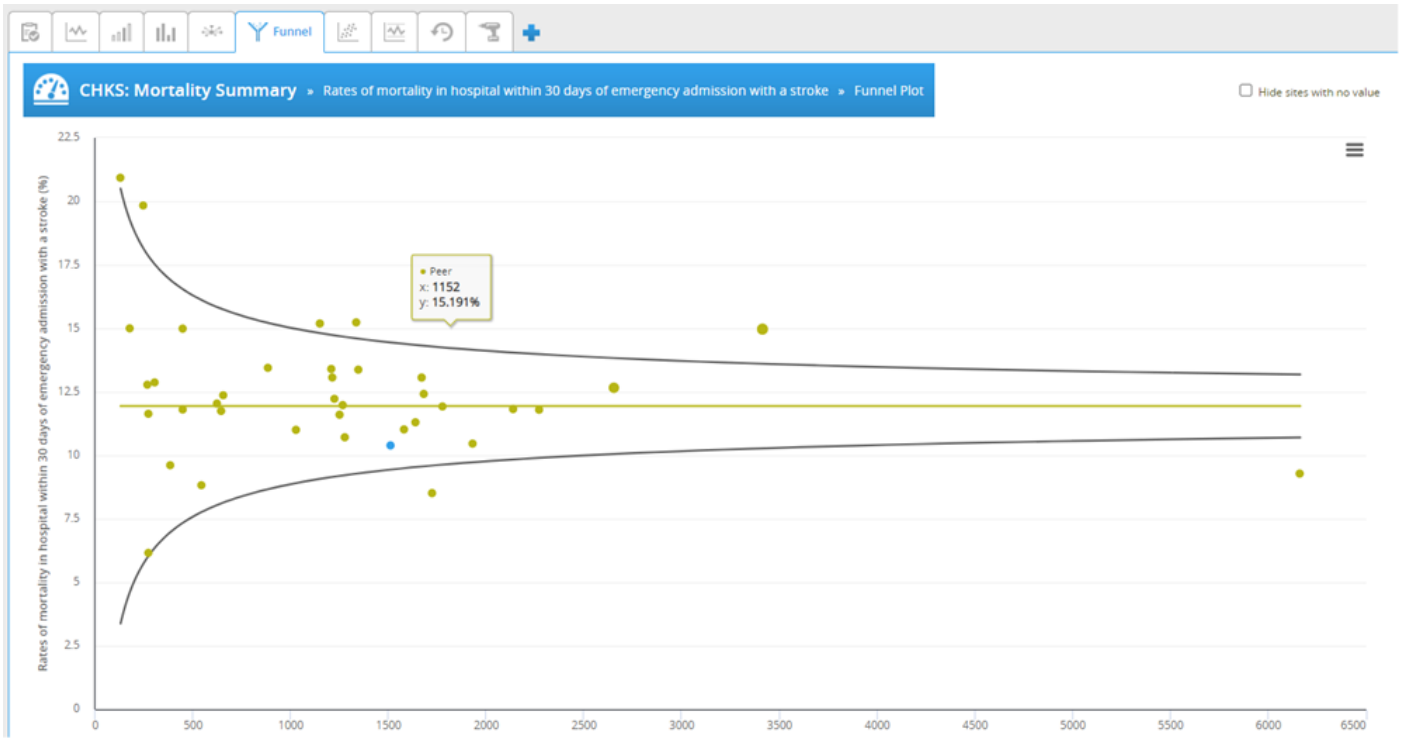
In February 2022, the Health Board recovered its previously good and best in Wales performance for the percentage of patients assessed by a stroke consultant within 24 hours at 93% in February 2022 (73% all Wales).

The proportion of applicable patients assessed by at least one therapist within 24 hrs of clock start improved with 53.5% in February 2022, up from 28.6% in January 2022, though still low in comparison to previous best performance over 75%. The impact of the urgent care system pressures has resulted in decisions being taken to use the HASU

therapy assessment room as additional bed capacity; whilst this assessment facility is unavailable then it is not possible to undertake the required level of therapy assessment for stroke patients during the critical acute phase.

Thrombolysis rates (proportion of stroke patients given thrombolysis) was 9.3% in February 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.

Notwithstanding concerns about timely access to stroke care, the reported mortality summary (comparison with top peers in the UK from Jan 2020 to March 2022) as shown in the funnel plot below, indicates that the Health Board is not an outlier for rates of mortality in hospital within 30 days of emergency admission with a stroke.



Whilst the urgent care system pressures are a major contributing factor to the access performance with the stroke care, there are also workforce factors (medical, nursing and AHPs) that must be considered. In recent years, the service has struggled to recruit into Stroke Consultant vacancies. However, it has been agreed for the service to develop a joint post to cover Acute Medicine and Stroke with the view to attracting a wider interest from applicants and will support both the Stroke service and the Medical Assessment unit.

An external review of therapy services across the stroke pathway has been undertaken to map the existing therapy workforce across the Health Board against clinically recommended levels in each setting. The report highlighted that gaps in specialist stroke therapy cover varied between professions and between sites, which is further complicated by those staff having to travel between sites. The review will form part of the stroke recovery plan and the focus will be to ensure that there is equitable therapy

provision and determination of the best use of limited resources and the requirement for future stroke therapy provision.

As part of the stroke recovery plan and ongoing improvement work the Stroke Directorate has engaged with an external provider called "Getting it Right First Time" (GIRFT) for a specialty review. The specialty review will involve a local data pack being produced detailing ABUHB's stroke performance data, followed by a series of meetings with members of the Stroke MDT including Senior Operational Managers and Divisional Leads. The review will examine a wide range of factors, from length of stay, access to the HASU and rehabilitation sites, patient mortality, sharing of best practice, and areas for improvement and individual service costs through to overall budgets.

The GIRFT first meeting happened at the end of January 2022 and included representatives from all of the Stroke Multidisciplinary Team and the peer review will be conducted in May 2022. The findings / recommendations of the review will be feed into and be taken forward as part of the stroke recovery plan, with a planning task & finish group being established and progress monitored through the Stroke Delivery Board with reporting to the Executive Team.

In summary, a range of action being taken forward to address performance issues with stroke quality metrics as part of the recovery plan:

- Utilising public communication opportunities to promote the importance of seeking immediate help at the signs of stroke (F.A.S.T.) by working in partnership with the CHC and the Stroke Association;
- Continued work with Emergency Department to ensure timely identification of stroke patients and expedite CT scans and transfer to the HASU;
- Work with the Director of Operations to put in place protection of the critical stroke pathway capacity as part of the Health Board's escalation procedures;
- Address workforce sustainability (medical, nursing and AHPs), aligned to a review of the entire stroke pathway, considering rehabilitation capacity and configuration, innovative roles, and most prudent use of limited resources;
- Support the GIRFT review process and establish a task & finish structure to respond to any recommendations as part of the recovery plan, with oversight by the Stroke Delivery Board.

Individual Care: Annual Plan Priorities 1 2 3 4 5

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.

End of Life Companions (Standard 6.2 People's Rights)

The Person-Centred Care Team has recruited 50 End of Life Companions. Companions support people who are at risk of dying alone. They will also support relatives, sitting with patients where relatives are unable to always be at the person's side.

Example of impact:
The End of Life (EoL) Companion volunteer service commenced at the very start of the pandemic, March 2020. Companions were recruited and trained so they were ready to support any patient that was at the end of their life and at risk of dying alone. End of Life Companions have supported patients both as befrienders and also provided support to patients who are in the last days of their life.

Late last year, the Person-Centred Care Team had a request for the EoL Companions to support a family in providing some additional company for their relative. The family members were exhausted. They had been sitting with their relative 24-hours a day and they needed some rest. However, they did not want their relative to be alone.

3 Companions visited the following day so that the family could have some much needed rest. The patient died with a companion present.

Patient Experience Feedback (Standard 6.3 Listening and Learning from Feedback)

Capturing the patient experiences of care in ABUHB health systems is an invaluable source of information that supports understanding of the quality and safety of care delivery. Failure to capture and triangulate this information with other quality and safety data was key in a number of national sentinel patient safety events. Currently patient experience surveys are predominately undertaken manually, requiring members of the Person-Centred Care Team and/or clinical staff to attend clinical areas to gather feedback. This is resource intensive and does not provide the organisation with real time patient feedback.

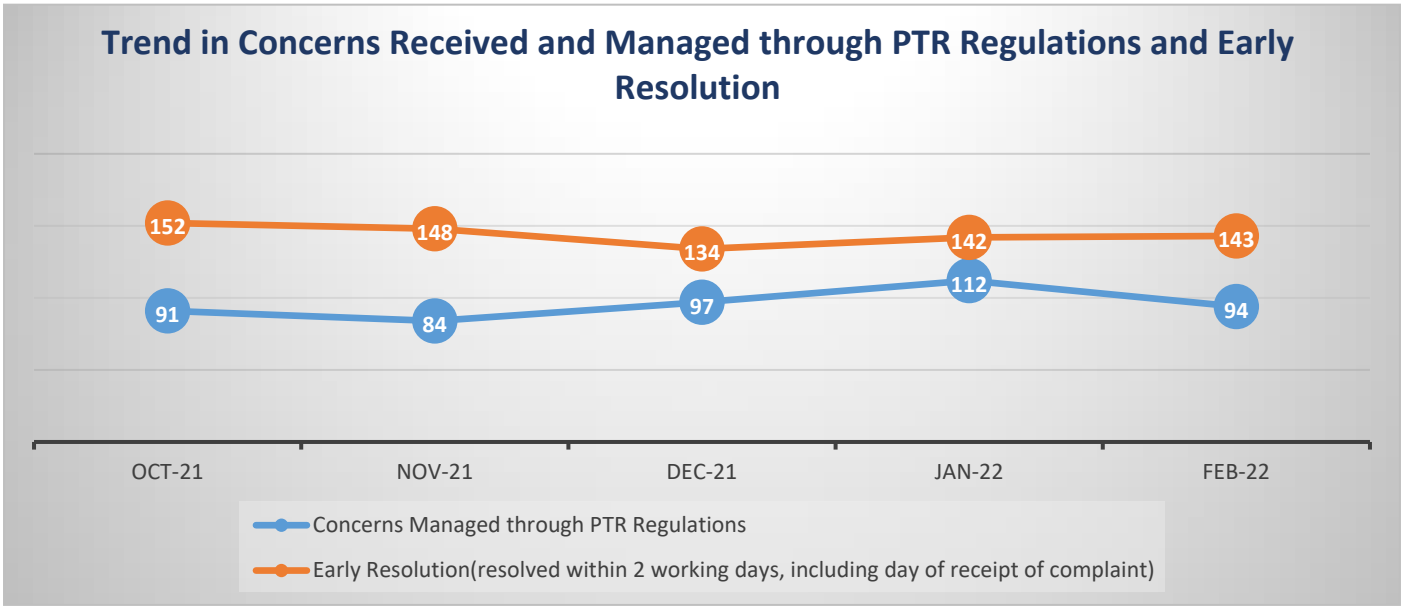
There are ongoing discussions to support the implementation of a digital platform to gather patient experience across the Health Board. A business case is being prepared to inform the consideration of the Once for Wales Citizen Feedback Platform, provided by CIVICA as the preferred system.

Complaints/Concerns and Serious Incidents (Standard 6.3 Listening and Learning from Feedback)

The 'Once for Wales' Feedback Module in RL Datix went live on the 1 October 2021 and is still being embedded within the organisation. Validation has been undertaken to ensure accuracy. It is anticipated that performance data will be available by the end of April 2022.

The number of formal complaints and those managed via 'early resolution' during January and February 2022 was **491**. The following graph illustrates an increase each month in the number managed through early resolution.

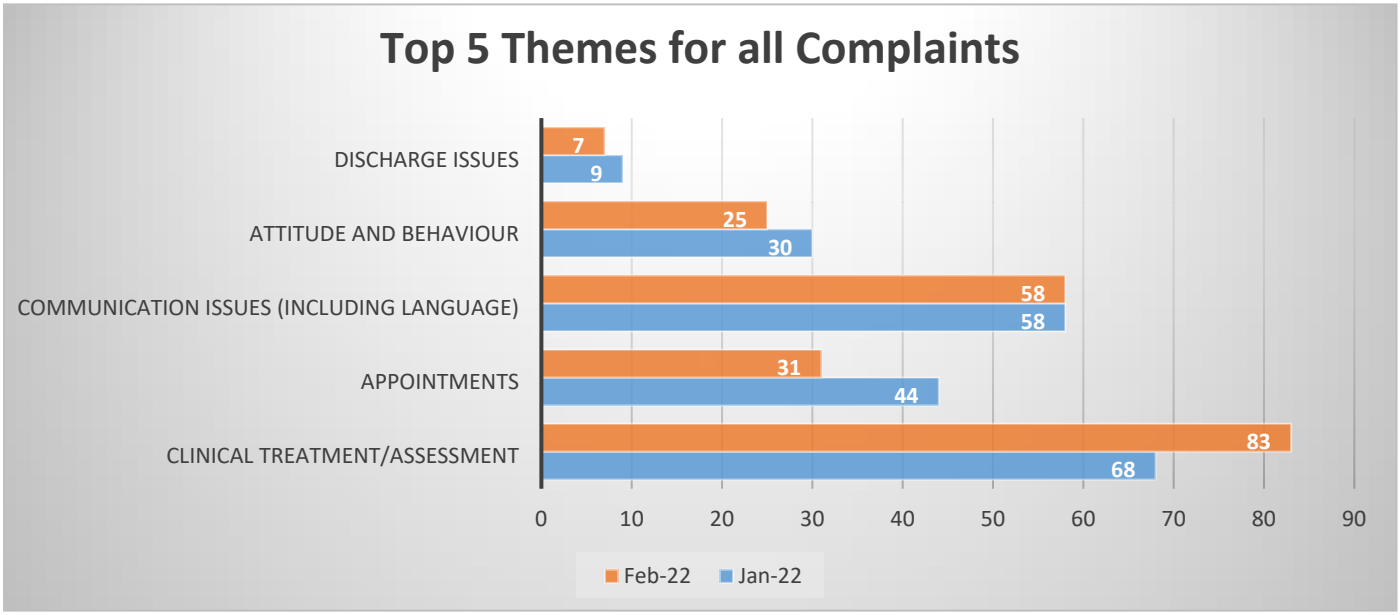
To note there is ongoing discussion at an All Wales level around the interpretation of the guidelines set out by Welsh Government re: complaints data submission definitions and supporting information regarding the timeframes for early resolution.



The following table illustrates performance of both early resolution and complaints managed through PTR that were closed within the agreed Welsh Government target.

	Complaints received in January 22	% Performance closed within target	Complaints received in February 22	% Performance closed within target
Early Resolution complaints received	142	75%	143	83%
Received and managed through PTR Regulations	112	74%	94	55%

The top five reported themes are illustrated in the following graph.



Clinical treatment/assessment remains the top theme, which is consistent with previous months. A further review of concerns managed through 'early resolution' identified that communication issues (including language) as the top theme.

To assist with communication, the Health Board has received a number of calls and complaints from relatives who have been unable to contact wards. This has led to an increased anxiety for relatives who are unable to visit loved ones. During discussions with Switch Board leads, it was discovered they indicated a significant increase in calls from relatives, especially during times when families would have been visiting.

The Health Board identified the need to provide additional support to the wards, especially with clinical staffing deficits, and actively recruited ward clerks and ward assistants. To manage the escalating concerns from families, the Health Board agreed two immediate measures to support relative communication:

1) Patient Liaison Officers (PLO's) were employed working 8am-8pm, 7 days a week at the 3 acute sites, linking in with the other hospitals. They act as a link between the relative and the wards. Relatives are encouraged to telephone the wards first and if no response to ring a dedicated telephone line.

2) To support with increased calls during late afternoon/evenings, 30 additional hours at band 3 were secured to supplement the current Switchboard Team.

This service has been extended until June 2022.

Sign Live Update:
There are ongoing issues with the Sign Live pilot that was due to be implemented in February 2022 and it is unlikely that this will go live before the 31st March 2022. The aim of this system was to provide a dedicated British Sign Language interpretation that is available 24/7, every day of the year. This 'on demand' service enables connection to a qualified and experienced interpreter. The IT department are continuing to explore Cloud access to source a solution.

Public Services Ombudsman for Wales (PSOW):
At the end of February 2022, there were a total of 32 open PSOW cases at various stages within the process, a reduction in one case.

The Health Board is notified of cases which remain anonymous to the Health Board, and which the PSOW has decided not to take forward. For this 2 month period, the Health Board was notified of 8 such cases.

During this reporting period a case that had been previously deemed as a Public Interest Draft Report was downgraded to Non-Public Interest following extensive comments from the Health Board. This demonstrates how appropriate engagement with the PSOW office can result in more favourable outcomes for the Health Board.

One Final Upheld Report was received throughout this period. The Ombudsman upheld the failure to diagnose the patient's life limiting condition, lack of communication with the patient and his family about the investigations undertaken and a probable diagnosis, failure to meet the patient's nutritional needs, dietician reviews and NG feeding, and concerns around the management of how the complaint was handled.

The Health Board shared the report with the relevant clinicians enabling reflection on its findings and to identify learning points. The case was also shared with the Health Board Equalities Lead for review and identification of any additional learning.

Patient Safety Incidents (Standard 6.3 Listening and Learning from Feedback)

The 'Once for Wales' Incident Module went live on the 1 December 2021 and is still being embedded within the organisation. An Incident Module Operational Group has been established with representatives from across the divisions and which will report to the RLDATIX project group.

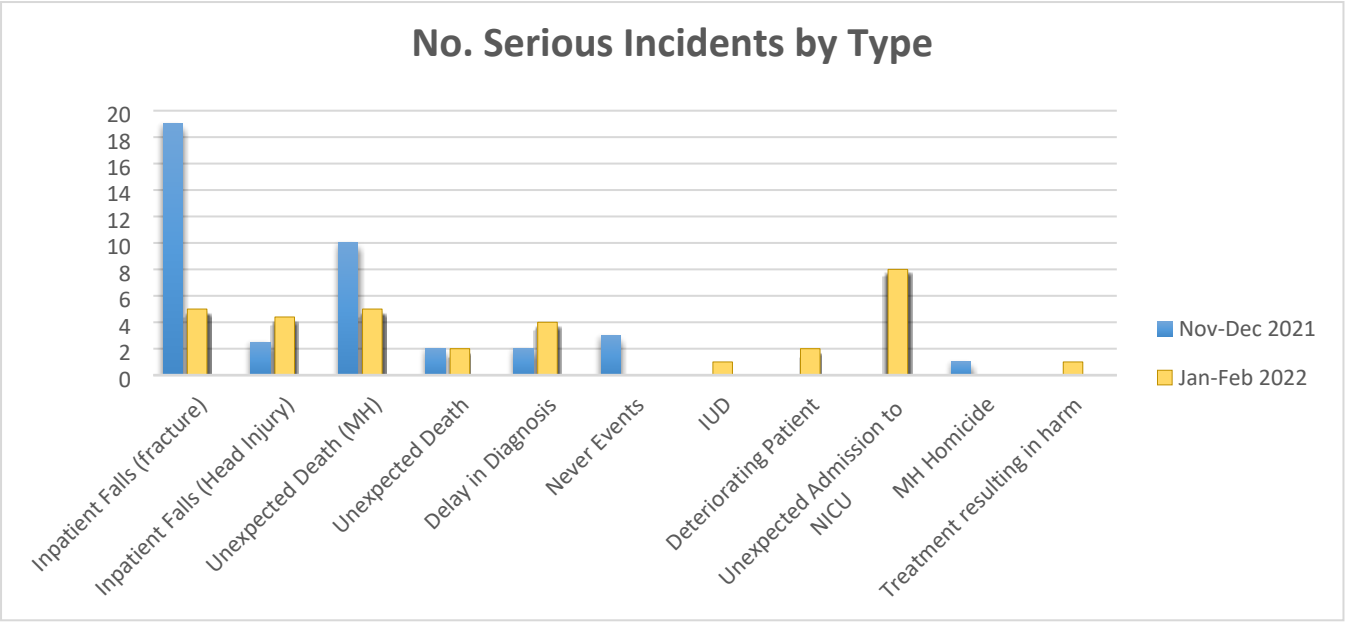
During January and February 2022, 40 incidents were identified as meeting the Serious Incident criteria requiring a Red 1 Corporate led investigation or a Divisionally led Red 2 investigation.

The Table below shows the number of open incidents during the reporting period, in comparison to 2021.

Number of Open Serious Incidents (2021 and 2022)				
Division	**January 21**	**January 22**	**February 21**	**February 22**
Scheduled Care	2	3	3	1
Unscheduled Care	6	12	5	7
Mental Health & LD	5	6	10	5
Community	2	0	5	2
Primary Care	0	0	1	0
CHC	0	0	0	0
F&T	4	6	4	5

The above table demonstrates the number of incidents open as opposed to new incidents. Some incidents open in January and February last year are still open for the same period this year. Overall, it demonstrates that progress is being made with the closure of incidents.

The following table shows the number of serious incidents by type during the reporting period.



A total of 10 incidents met the criteria to trigger a Red 1 Corporate led investigation.

One incident met the revised National Reporting criteria and was submitted to the Delivery Unit.

Inpatient falls with fracture comprise the largest proportion of Serious Incidents. 15 have been captured within this reporting period.

There was a total of 6 inpatient falls whereby a significant head injury was sustained. Out of these 6 incidents, 3 met the criteria for a Red 1 investigation. 5 out of the 6 patients who sustained a significant head injury because of the fall died subsequently.

Four serious incidents met the criteria of delayed diagnosis. Three of these incidents were related to radiology concerns and the reporting and follow up of investigation results. Two out of the four incidents met the criteria for a Red 1 Corporate Led investigation.

Two incidents met the Serious Incident Criteria of deteriorating patient, one of these incidents met the criteria for a Red 1 Corporate Led investigation.

There were 5 unexpected deaths of Mental Health Service Users within the community setting. These deaths meet these criteria as having occurred within 12 months of a service user accessing mental health services.

Eight unexpected admissions to Neonatal Intensive Care Unit (NICU) have been identified during this reporting period. To date only one of the incident meets the criteria for a R1 investigation and one is being managed as a red 2. Of the remaining six cases initial review is that there was no deviation from expected practice. As this is an increase in the amount of unexpected NICU admissions, in comparison to data for the same period in previous years, the Division is conducting local concise reviews.

Finally for this reporting period, 2 unexpected deaths were identified, which occurred in a clinical setting.

One case on initial review has not identified any patient safety concerns.

The Second case was flagged by the Medical. Following the first R1 meeting the incident has been stepped down to a R2.

PRUDiCS
There have been 10 PRUDiCs during Q3 and Q4 (minus March).

- 3 of the child deaths pertained to suicide for children aged between 9 and 17 years of age. This is unusual and has been shared with Welsh Government.
- A Gwent wide Self-Harm and Suicide Prevention Task and Finish Group has been set up and is attended by the Deputy Head of Safeguarding to address the current Immediate Response Group process (that runs parallel to PRUDiC)
- Current PRUDiC processes are well embedded in the Health Board.
- A Standard Operating Procedure was developed for PRUDiC in November 2021 and is in use by the Corporate Safeguarding Team.

Never Events
There were no Never Events reported during January and February.

Training:

1. Investigating Officer Training
When an adverse event occurs, the aim of effective incident investigation is to identify the multitude of factors that may have contributed to it**.** Yet, these are notoriously complex within healthcare. Skilled Investigating Officers (IOs) with specialist knowledge and expertise are key to this process so that each investigation can become a springboard for learning and improvement. Training which targets critical investigative skills, systems thinking, and an analytical approach is pivotal to preparing staff for the IO role.

The aim is to:

- Increase numbers of Health Board trained IOs to meet demand of SIs requiring investigation.
- Enhance standard of SI investigations and reports.

2. Report Writing Training
To assist with quality, timey reports funding has been provided to secure an external company to provide bespoke training days, which will encompass report writing and writing complaint responses. Fifty colleagues from across all Divisions will have opportunity to attend this training, scheduled for April and May.

3. PSOW Training
Dates are being arranged to restart training facilitated by the Public Services Ombudsman for Wales. This elementary training will be widely offered to staff across the Heath Board. Previous sessions have been well evaluated.

External Inspections Community Health Council (Standard 6.3 – Listening and Learning from Feedback)

A standalone paper is being reported to the Committee, regarding HIW inspections.

Since the last PQSOC, the Health Board has received three CHC reports.

The first relates of which relates to people's experiences of being admitted to the Grange University Hospital for planned surgery. For this engagement exercise, individuals who had received services from the Grange University Hospital's Maxillofacial Service for Head and Neck Cancer between April and October 2021 were sent a CHC paper survey directly to encourage engagement participation and to share feedback about their experiences. The survey received responses from 27 individuals. It was encouraging to hear overall people had a positive experience with the team and the majority of people said they were either satisfied or very satisfied with their care.

CHC findings include:

- Individuals who waited longer than expected to be admitted to the ward on the day of their procedures.
- On occasion, patients have been asked to wait in locations outside the ward before being admitted.
- On occasion, patients have encountered poor/lack of communication when attempting to contact the staff.
- Regarding a patient having to change in toilet prior to their operations due to capacity constraints.
- Comments they received regarding those with special needs or learning disabilities.

The Health Board has responded to the recommendations and developed an action plan to implement and monitor. There is only one outstanding action which relates to the provision of ring-fenced beds and ward areas for Head and Neck patients. This has been delayed due to organisational demand and capacity pressures but should be resolved by the end of April 2022.

The second report related to people’s experience of accessing the Outpatients Diabetic Services support they needed before and during the pandemic and since the restrictions have eased in 2021.

This included 20 responses.

18 people shared their experiences with CHC via the online diabetes service survey over a 3 month period and 2 people shared their experience via the CHC “Care during the Coronavirus” survey during 2021 to date.

It was encouraging to hear a range of positive comments across all aspects of peoples’ experience. The participants said they had accessed the Diabetes Service over a period ranging from 1–46 years. A recurring theme throughout the feedback was people’s frustration with the lack of communication from the diabetes team, particularly about the reinstatement of face-to-face appointments and the difficulties experienced when trying to make appointments or get advice over the telephone.

The Health Board has responded to the recommendations and developed an action plan to implement and monitor. There is only one outstanding action relating to difficulties some people have experienced when attempting to make contact with the team. A system is being introduced where patients will have a return call within 1 working day. This is being audited for assurance.

The third report explored inpatient experiences at RGH, YYF and NHH hospitals during the Covid-19 pandemic. A small number of CHC members spoke with people virtually (via an iPad and video calling), with the support of the Person-Centred Care Team. The video calls took place between 17th November 2021 and 24th November 2021. 14 patients were involved. It was positive to hear that overall most people were happy with the treatment and care they received. Some mixed feedback was received from people at the Royal Gwent Hospital. It was encouraging to hear that in most cases staff were polite and respectful. The CHC heard that some people had less positive experiences with staff during the night time and that wards could be noisy.

The CHC heard a mix of positive and negative views about meal times; some people felt the menu choices were limited, particularly for those who have specific dietary requirements and others were happy with the meals.

There was feedback about feelings of isolation when patients were staying in single rooms.

The Health Board has responded to the recommendations and developed an action plan for implementation and monitoring. A number of actions are outstanding but Divisions have provided assurance that the actions will be implemented in-time.

Recommendations

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

- **Note** the Health Board position against a range of key quality and safety metrics, notably compliance with patient safety solutions and Emergency Department performance.

- **Discuss** performance, themes and actions.

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

PATIENT QUALITY, SAFETY & OUTCOMES COMMITTEE

REVIEW OF ACCESS TO GMS SERVICES UPDATE

Document Title:	Patient quality, safety & outcomes committee Review of Access to GMS Services UPDATE		
Date of Document:			
Executive Sponsor:	Chris O'Connor – Interim Director of Primary, Community and Mental Health		
Purpose: **Patient Quality Safety and Outcomes Committee is asked to:**	Approve change		Comment:
	Approve funding		
	Provide a view	✓	

Summary / Situation:

The purpose of this report is to provide the Patient Quality, Safety and Outcomes Committee with an update following the review of Access Arrangements in General Practice that was undertaken in June 2021.

The Health Board undertook an in-depth review of Access arrangements across all 72 GP practices, to determine the impact of new ways of working in response to the pandemic, and to seek assurance in respect of access to services for patients.

3 key measures were identified that directly impact upon patient care, for benchmarking purposes and outliers in these measures were identified, prompting targeted practice discussions.

Individual practice reports and NCN level reports were produced to support and inform discussions.

The findings of the report have informed the development of schemes to support GMS access.

Background:

The attached report provides the details of the steps taken following the review and the rationale informing those and planned next steps.

Assessment

Primary care access remains challenging, with an exhausted workforce and unknown backlog of patient need.

GP practices have embraced the schemes developed designed to support access, with an additional 917.5 hours of reception/ admin time (24 wte) and approximately an additional 3,200 GP equivalent appointments per week during this time.

The Primary Care Contracting team will continue to work closely with practices, Local Medical Committee, Community Health Council and Health Board colleagues to ensure access to GMS services is maintained in a safe and timely manner for patients and staff, which will involve ongoing monitoring and evaluation.
Recommendation & Conclusions:
The attached report provides an overview of the review of access arrangements in General Practice and the positive outcomes. The Health Board will continue to actively monitor and support GMS access in line with contractual requirements, and current WG guidance in order to meet the needs of the registered patient population.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Patient perception that practices are closed. Backlog due to the suspension of services during the pandemic, patients have not been presenting for routine care. Unknown quantity of backlog of routine treatments / referrals etc. and secondary care delays. All of which has an impact on access.
Financial Assessment, including Value for Money	This will depend on any required investment to support access. Funding for additional session as part of restart and recovery and re-purposed ES funding.
Quality, Safety and Patient Experience Assessment	Ensure appropriate and safe level of access to GMS provision
Equality and Diversity Impact Assessment (including child impact assessment)	N/A - All patients will be treated equally.
Health and Care Standards	Standard 1: Staying Healthy Standard 3: Effective Care Standard 4: Dignified Care Standard 5: Timely Care
Link to Integrated Medium Term Plan/Corporate Objectives	▪ Ensuring safety, excellence and quality in all our services at all times.

	▪ 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**	*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.
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	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

Access to General Medical Services

March 2022 Update

Content

1. Introduction

The Health Board is responsible for ensuring the provision of General Medical Services (GMS) to residents throughout Aneurin Bevan University Health Board and commissions services from independent contractors through The National Health Service (General Medical Services Contracts) (Wales) Regulations 2004. It also directly manages the provision of services in four practices where it has been unable to secure an independent contractor.

The Covid-19 pandemic has necessitated new ways of working, with practices adapting the way they offer and provide clinical services with a greater degree of flexibility to meet patient and service needs, and now as services resume, many of these changes are being taken forward.

The Health Care system as a whole remains under unprecedented pressure, and it remains vital that we are able to clearly gauge, articulate, understand, and influence the delivery of GP services and the impact on the wider system and vice versa.

2. Background

There are 72 General Practices that are responsible for providing care to patients between 8.00 am and 6.30 pm Monday to Friday. Outside of these "core hours", access to medical care is provided by the Health Board's Out of Hours Service, which operates between 6.30 pm and 8.00 am each weekday evening and throughout weekends and Bank Holidays.

Approximately 90% of all Healthcare contacts take place in the primary care setting.

It is well rehearsed that General Practice adapted very quickly to new ways of working in response to the pandemic. With national guidance continuing to advocate *telephone first*, practices have now adopted a blended approach to patient consultations, offering both face to face and remote consultations, as appropriate. The number of face-to-face appointments is increasing, however there are challenges with this, especially in relation to managing social distancing and throughput of patients. Although Wales has reverted to level 0, several measures remain in place within Health Care settings in order to protect staff and patients and it's important to recognise that this does still have an impact on patient throughput.

Practices continue to manage competing demands, whilst still often facing criticism of service delivery and a misconception that practices have been closed or are not providing care.

There continues to be ongoing workforce challenges with teams being exhausted from their continued efforts during the pandemic and also a high number of staff needing to isolate due to testing positive as COVID-19 continues to circulate in the community and restrictions ease.

3. Current position

As restrictions began to ease and services resumed, the Health Board acknowledged the need for these new ways of working to be reviewed and ensure patients have appropriate, safe and timely access to their GP services, whilst adhering to national guidance. In June 2021, the Health Board worked closely with practices and other partners including Gwent Local Medical Committee (LMC) and Aneurin Bevan Community Health Council (ABCHC) to undertake a comprehensive review of access arrangements which was previously reported on in August 2021.

An in-depth review and analysis of all data captured was undertaken at practice level, alongside the access standards and other data available including A&E attendance, Urgent Primary Care, Minor Injuries and Out of Hours activity and an individual overview report was produced for each practice as well as an NCN level report for each NCN, to inform directed conversations with practices and provide benchmarking information for NCN based discussions.

The Health Board identified three key measures, with a direct impact on patient care and how they access services, that were used to inform benchmarking.

- Clinical Sessions – shortfall of 15% or more.
- Telephone Lines – less than 1 line per 1,000 patients
- Face to Face Consultations – less than 25% face to face

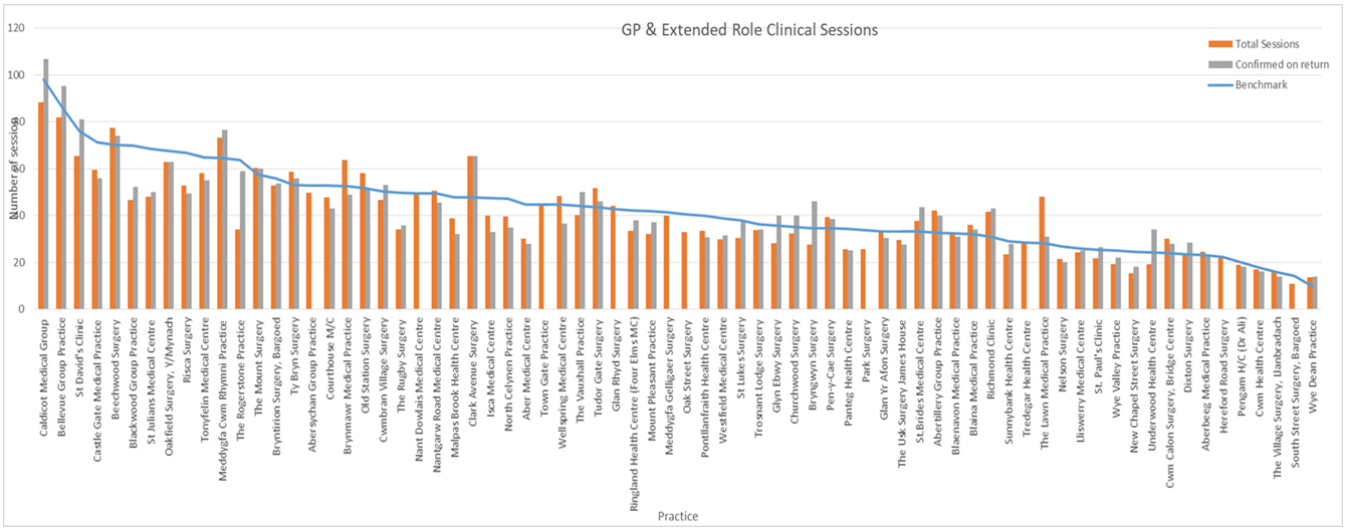
Clinical sessions

In the absence of a national position, the Health Board has a locally agreed benchmark of 1 clinical session per week, per 200 registered patients. Using this benchmark, practices with a shortfall of 15% or more were identified as outliers.

The graph below shows what was reported by practices during the review period with approximately 58% of practices reporting that they were meeting, or exceeding, the 1:200 clinical sessions.

Many practices expressed that this was not an accurate reflection of usual core provision due to planned and unplanned absences. Therefore, a

confirmation process was undertaken to confirm 'usual' provision and only those that still had a shortfall of 15% or more were identified as outliers in this measure.



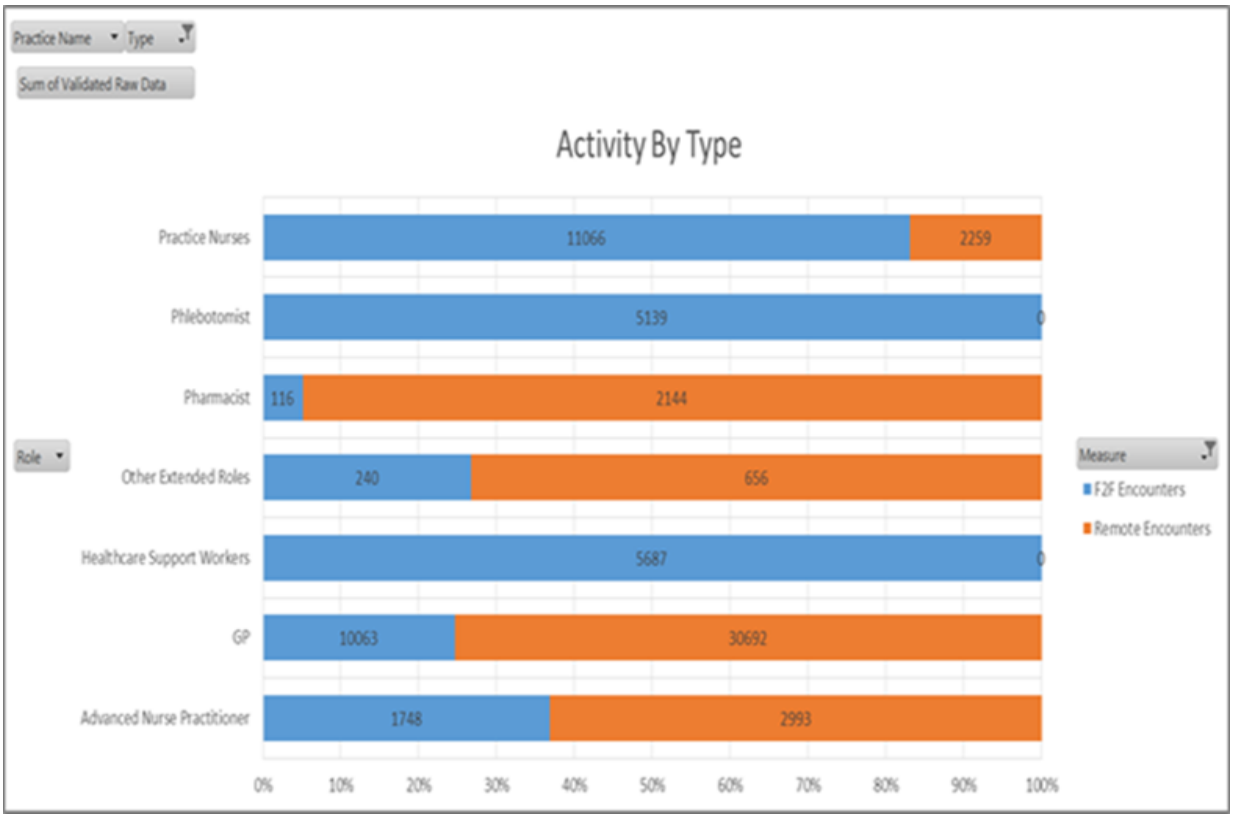
Telephone lines

In 2019-20 practices received an investment of £3.7m into the Global Sum to support practices in securing and implementing the necessary infrastructure in order to achieve the Access Standards with a particular focus on telephony. 92% of practices have reviewed their call demand, of which 88% have implemented changes as a result. 83% of practices confirmed that they had already upgraded their telephone systems.

Again, there is not a national position on the recommended number of lines per registered patients. However, the Health Board implemented a local guide of 1.5 lines per 1,000 registered patients, and 40% of practices achieve this. As this is only a guide, practices with less than 1 line per 1,000 registered patients were identified as outliers in this measure.

Face to face consultations

Practices have adopted a blended approach to patient consultations, offering both face to face and remote consultations, as appropriate. The number of face-to-face appointments has increased, however there are challenges with this, especially in relation to managing social distancing and throughput of patients. The findings of the access review indicated that across ABUHB, there was a split of 25% face to face and 75% remote GP consultations.



In England, for July 2021, 57% of consultations were face to face. There is not a nationally agreed position in Wales in respect of face-to-face consultations. Therefore, practices with a face-to-face consultation rate of less than 25% were identified as outliers. Given that the review was undertaken in June, we asked practices to complete this aspect of the data capture again for the week commencing 27th September to ensure we were reflecting an accurate and current position.

By reviewing these three key measures 19 outliers in two or more measures were identified,

- 4 practices that have a clinical session shortfall of 15% or more AND are below 25% face to face consultation rate,
- 5 practices with less than 1 telephone line per 1,000 patients AND below the 25% face to face consultation rate,
- 7 practices with less than 1 telephone line per 1,000 patients AND a clinical session shortfall of 15% or more and,
- 3 practices identified in all three measures.

In addition to practices resubmitting their face-to-face activity for the week of September 27th 2021, practices were also asked to confirm their usual core clinical sessions. Following this, there were 9 practices still identified as outliers in two or more measures.

As a result, it was agreed that those 9 practice would receive a visit to discuss this in more detail. These visits would be led by a Primary Care Clinical Directors, supported by the Primary Care Contracting Team. Unfortunately, due to competing priorities, including Primary Care supporting the delivery of the Covid-19 booster programme, these visits have been delayed. 2 visits have been completed and the remainder are now scheduled to be completed by the end of April 2022.

LMC has supported this approach and where requested by the practice, have attended to be part of the discussions. Practices will be advised of the expectations in each key area and discussions on what support is available, where appropriate e.g., financial support through sustainability framework or recruitment support. In some cases, it may be necessary for practices to develop and improvement plan. For those practices that are identified in just one measure, this has been highlighted to them.

4. Outcomes

The Access Review has demonstrated that in many cases, practices are meeting the 1:200 benchmark for clinical sessions and yet are still unable to meet demand for a number of reasons.

As part of the Restart and Recovery Programme several schemes have been developed and designed to support practices with additional capacity/resource to meet some of these pressures and to support with addressing the back log of care.

Non-Recurrent Funded Schemes

Restart & Recovery Additional Clinical Sessions

The Health Board has developed an Additional Clinical sessions Scheme to provide support for GP practices by funding additional Clinical sessions from December 2021 to March 2022.

Summary

- Only those Practices meeting **the minimum requirement of one clinical session per 200 registered patients weekly** will be eligible for additional clinical sessions
- This scheme supports an additional clinical session per week, per 2,000 registered patients, per practice
- The additional clinical session can be provided by either a GP or an Extended Role Clinician with Independent Prescriber status.
- The additional clinical session must deliver a minimum of 50% face to face appointments and a maximum of 50% remote appointments and should be available for pre-booking.

Restart & Recovery Additional Reception Hours
The Health Board has developed an Additional Reception Hours Scheme, which has been agreed with the LMC, to provide support for GP practices by funding additional reception hours from December 2021 to March 2022.

Summary
- Practices must have a minimum of 1 telephone line per 1000 patients to apply to participate in this scheme.
- The scheme offers reimbursement of 100% of the total cost (salary / sessional fee & on-costs) of either additional posts upon appointment or additional hours worked by existing post holders.
- The scheme offers up to 5 additional reception hours per 1000 patients per week.

Restart & Recovery Additional Cervical Screening
The Health Board commissioned additional weekend cervical screening clinics through Sexual Health team, in order to support the backlog in Primary Care.

Summary
- Dedicated booking line for patients to ring and book appointment
- Must be in receipt of screening invite

Out of Hours NES - National Scheme issued by WG
As part of the Covid-19 strategy WG issued a NES for the provision of **essential** General Medical Services, outside of core hours, during the period 17 December 2021 to 31 January 2022. The purpose of this Enhanced Service is to cover the provision of essential GMS to patients requesting advice, a consultation or other essential service, outside of GMS core hours.

Summary
- All Practices can apply
- Can be delivered by individual practice or as a cluster solution
- Supports GMS contractors to provide *essential* general medical services but not *additional* services.
- GP Practices have the opportunity to participate in the above Enhanced Service on *weekends and bank holidays* commencing on Saturday 25/12/21 through to Sunday 30/01/22
- The GMS contractor may deliver the Enhanced Service either by
  - Opening the main surgery with GP clinical triage, telephone and video consultation, face to face patient consultation as clinically necessary and with appropriate practice staffing including a receptionist, or
  - Remote GP clinical triage, telephone and video consultation and, where appropriate, face to face patient consultation as clinically necessary, which may be arranged for a period later in the day at a practice premise site.

Restart & Recovery Care Home Winter Pressures
The Health Board has developed a Care Home Ward Rounds Scheme to fund practices to deliver weekends and/or Bank Holiday Ward rounds over the winter months. This will ensure continuity of care and has the potential to reduce demand on both the GP Out of Hours Service and a reduction in onward referral outside of core hours.

Summary

- There are two schemes on offer; Practice can apply for either of both schemes.

Option 1: To provide a payment to practices to undertake a care home ward round on Saturday or Sunday for the months of December, January, February and March 2021/22.

Option 2: To provide a payment to practices to undertake a care home ward round on either:

- Monday 27th December 2021 **or** Tuesday 28th December 2021
- Monday 3rd January 2022

Recurrent Funded Schemes

Additional Capacity - National Scheme agreed with Welsh Government/GPCW as part of the GMS Contract 2021/22
£2m has been made available during this year (2021-22) to support additional capacity within GMS, with particular emphasis on winter pressures this year.

Summary

- Practices will be eligible for pro rata funding @ 61p per patient based on their capitation list size as at 1st October 2021.
- All practices can apply for funding
- The scheme offers reimbursement of 100% of the total cost (salary / sessional fee & on-costs) of either additional posts upon appointment or additional hours worked by existing post holders.
- ALL staff groups are covered by this scheme - clinical and non-clinical
- If posts/hours continue after April 2022 they may be eligible for 50% match funding under the new 2022-23 scheme**

**Awaiting confirmation of detail of 22-23 scheme from WG.

Additional Clinical Sessions Local Enhanced Service (LES)
The Health Board commissioned a new Local Enhanced Service to fund additional clinical sessions. This LES supports an additional clinical session per week, per practice where the practice determined by practice list size

Summary

- Only those Practices meeting the minimum requirement of one clinical session per 200 registered patients weekly will be eligible for additional clinical sessions
- 0-10,000 registered patients = 1 additional clinical session per week
- 10,001-20,000 registered patients = up to 2 additional clinical sessions per week
- The additional session(s) need to be provided by either a GP or Extended Role with Independent Prescriber session and need to offer a minimum of 50% face to face appointments and a maximum of 50% remote appointments and should be available for pre-booking.

The table below details the uptake and additionality provided by each scheme**:**

Scheme	Number Participating	Additionality	Scheme runs
Additional Winter Capacity funding	61 practices commissioned (68p per patient)	Awaiting evaluation of funding utilisation plans to determine	01/12/2021 – 31/03/2022 (Awaiting detail for 22/23 scheme)
NES GMS outside of contracted hours	9 practices commissioned originally (Dec – Jan) 8 practices commissioned for Feb 22	113 GP equivalent sessions (approx. 1,600 appt)	17/12/21 – 28/02/22
R&R Additional reception hours	25 practices commissioned	917.50 hours per week	01/12/2021 – 31/03/2022
Winter Pressures Care home ward rounds	3 practices commissioned	46 ward rounds provided to date	01/12/2021 – 31/03/2022
R&R Additional clinical sessions	26 practices commissioned – 2 in progress (need further detail from practices)	80 weekly GP equivalent sessions (approx. 1,200 appt per week)	01/10/2021 – 31/03/2022
LES Additional clinical sessions	19 practices commissioned	27 weekly GP equivalent sessions (approx. 405 appt per week)	Ongoing
Cervical Screening additional clinics	Commissioned service from Sexual Health	586 additional appointments taken to date	06/11/2021 – 31/03/2022

Practices in ABUHB are asked to submit their activity data on a weekly basis, detailing total number and type of encounters, this is combined into a dashboard with other data such as ED and assessment unit attendances and UPC contacts which is then used for monitoring and benchmarking purposes. This is also a pre-requisite for some the schemes detailed above.

Submission rates vary, currently approximately 70% of practices submit on a weekly basis. However, the data shows an overall increase in face-to-face activity to 35.4% as at week commencing 7th March 2022.

5. Summary

The Health Board recognises the ongoing challenges regarding access in Primary Care, specifically to General Medical Services. The Access Review has prompted and supported discussions at practice and NCN level. There were immediate changes, such as doors being unlocked, changes to appointment systems and staffing rotas and the development of schemes both nationally and locally to support practices to try to meet the demand and ensure access to services for patients, in a safe and timely manner. It is clear that face to face consultations are increasing and practices and patients are adapting to the new blended approach to consultations.

It is important that some of the changes that have been made during the pandemic, where they are still appropriate, are not lost. The need to maintain a safe environment for staff and patients remains paramount and, whilst the pandemic continues, a level of remote consultations will remain in place for those patients who would benefit from such a service. Additionally, a blended approach to consultations in the future will ensure that all patients have access to their local GP services in a way that is right for them. However, there is a need for further national public and patient communication and engagement to support with this.

It is important to recognise the role of the public in making the right choice when seeking help and advice. A cultural shift is also required to recognise that a GP, or the GP surgery, is not always the most appropriate professional or location for every issue that doesn't require hospital attendance.

Practice teams have responded and worked tirelessly throughout Covid-19 and continue to do so in trying to manage the unknown backlog and have embraced the schemes on offer to support them to do so providing an additional 917.5 reception hours (24 wte) and approximately 3200 additional GP equivalent appointments. The Health Board will continue to work with practices to maintain safe and appropriate levels of access to GMS services in line with current guidance.

6. Next Steps

Complete visits as identified and summarise findings.

It has been agreed by the Health Boards Access Group to complete the data collection elements of the access review as part of the Annual Contract Review process, which will be issued to practices in the first quarter of 2022/23.

Achievement against the 21/22 access standards will be confirmed and analysed in June 2022. The Health Board will support practices to maximise achievement for 22/23.

Roll out of 22/23 Additional Capacity funding (pending confirmation of detail from WG).

Encourage participation in the Additional Clinical Sessions LES.

Practices will continue to be encouraged to complete the weekly activity dashboard.

Practices will be supported to complete the mandatory Quality Improvement (QI) project element of Quality Assurance and Improvement Framework (QAIF) in respect of Activity/Appointment Data introduced for 21/22 which is designed to support collaborative measures for managing demand and standardising good practice as well as improving the validity of appointment book data and informing patient communications.

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 1st March 2022 (held by Teams)

Summary of Key Matters Considered by QPSOG:

Health & Social Care (Quality and Engagement) Act 2020

The group considered the Health Board requirements for implementing the act, specifically the Duty of Quality section. An immediate action was agreed to develop a template agenda and data set for Divisional and Directorate QPS governance fora, and which would also be used to structure feedback from Divisions into the QPSOG for assurance and escalation.

Divisional Risk Registers/Concerns

The Divisional Quality and Patient Safety Leads were given the opportunity to share Divisional risks and concerns related to quality and patient safety.

The group had a specific discussion about the safety concerns associated with the requirement to board patients during times of high system escalation. Assurance was provided that these risks are managed at ward level and that the Standard Operating Procedure for boarding is being reviewed by the Director of Operations and senior clinical leads.

All the Divisional risks and concerns 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 April 2022.

RLDatix Once for Wales Concerns Management System
The group received an update about the roll out of the RLDatix modules.

Neonatal Annual Report
The group received a presentation on the Neonatal Annual report for 2020.

Medication Safety Strategy
The group received a presentation on the draft Medication Safety Strategy which has been developed by the Medication Safety Group and invited comments.

Paper/Electronic Radiology Reporting SBAR

The group received an update on work to address safety concerns associated with Radiology reporting and learning from recent serious incidents. In order to make the system more robust, CWS electronic requesting has been set up, with dual running alongside paper. A plan is in place to now switch off paper reports, ensuring all results in the system have been seen and acted upon appropriately. The QPSOG has asked for further updates and assurance on this plan.

Matters Requiring QPSC Level Consideration:

- Quality, Patient Safety and Experience Report (scheduled for PQSOC meeting in April 2022)
- Neonatal Annual Report, for information.

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: 4th May 2022

Highlight Report

Group Name:	**ABUHB Children's Rights & Participation Forum**		
Group Aim:	The Forum is led by the Family & Therapy Division on behalf of Aneurin Bevan Health Board on the area of children's rights and participation. This is the key children's rights and participation forum for Aneurin Bevan University Health Board. The group will inform and drive a children's rights approach, placing the UNCRC at the core of planning and service delivery, influencing the integration of children's rights into every aspect of decision-making, policy and practice.		
Date Completed:	3rd March 2022	**Date of last meeting**	25th January 2022
Completed By:	Dave Williams (Chair) Sian Thomas, Consultant Nurse Child Health		
Distribution List:	PQSOC		
Summary:	A varied agenda for the January Forum which included: – Review of Terms of Reference, which included a discussion on a new Chair, the need for subgroups and resources to deliver elements of ToR. – Involving Young People in the Recruitment Process project (update). – Engagement with the Regional Youth Forum in relation to CAMHS. – Establishing Health Ambassadors within ABUHB. – National Youth Advocacy Service update.		

Children's Rights & Participation Forum - Terms of Reference (ToR)

Discussion around future Chair role and need for subgroups and resources to deliver elements of ToR.

It was felt that the revised ToR described the progress made in this area and key areas that need focus; it was noted that resources will be required to achieve the objectives set around children's rights training and audit. The resources identified were for the following tasks – leading and developing the work, managing and updating social media and web-based materials (School nursing have a potential model) and recompensing young people for their input similar to all user participation work for coproduction. The ToR should be seen as a recommendation of forum development.

It was suggested within the first year, need to establish the best system for achieving outcomes, through bringing items to the committee for agreement/approval and members owning the tasks. Consideration will need to be given to frequency of meetings and membership.

It was suggested that National Youth Advocacy Service (NYAS) and SNAP Cymru will be invited to become members with the potential of NYAS to work with the young people/person to work towards a young person becoming a joint Chair.

Involving Young People in the Recruitment Process project (update)

Having developed a Health Board guidance for Involving Young People in the Recruitment process, it was recognized that there was a need for resources for staff and young people resources, to support implementation, prior to progressing to the pilot stage.

Sian Thomas provided a project update (on behalf of working group) and the social media and communications manager for public health nursing shared the leaflet and video that have been developed for young people. In light of the positive work that the social media and communications manager role has undertaken for public health nursing in relation to children's participation, the forum will focus on 'Technology enabled participation/information' at a future meeting. Other examples include, using VR tech within the neurodevelopmental health team and the potential opportunity to consider how the Additional Learning Needs one-page profile may be animated.

It was highlighted that there is a need for a Divisional/Health Board budget allocation for vouchers, to acknowledge young people's involvement.

Engagement with the Regional Youth Forum (RYF)

Engagement with the Regional Youth Forum in relation to CAMHS

Rebecca Stanton provided an update on work that she is doing with RYF as part of the Transformation Programme in relation to CAMHS; further engagement will take place during half term. Mental health is one of the priority areas for the RYF.

Discussion took place on previous engagement work (external to the Health Board) that was undertaken with the RYF as part of the ALN Act that lead to a mentoring qualification for the young people. It was noted that if funding became available within the Health Board, that this could be very beneficial both for the HB to hear the voice of young people as well as for the young people themselves to gain a qualification.

Establishing Health Ambassadors within ABUHB

Discussion on how the Health Board hears the voice of CYP and the potential benefits of requesting members of the RYF to become Aneurin Bevan Health Ambassadors/ youth forum, working alongside the RYF. It was felt that potentially it would be beneficial to invite YP who have accessed health services across AB to be members. It was felt that this would be beneficial and that it should be a target to be achieved within the next year; Youth Forum leads were happy to support progressing this action.

NYAS project update

Kevin Crewe (NYAS) reported that NYAS are not receiving many referrals via the contract and highlighted the current constraints of the HB contract with NYAS as its focus is around concerns; it would be more helpful if they were commissioned as a resource for CYP to go to if they have something to say about the service.

Kevin was asked to share the themes of young people's concerns from other projects in order that target the services where we need to hear the young people's voice.

Comment from Chair / Items for Escalation

Dave Williams and Sian Thomas to meet with Executive Director of Nursing to discuss ToR and request a Board Development Session on Children's Rights & Participation.

Actions / Next Steps

- NYAS and SNAP to be invited to attend Forum.
- Gap in relation to the resources required to progress the children's rights and participation agenda to be highlighted as part of IMTP (next round).
- Focus on 'Technology enabled participation/information' at a future meeting.
- Involving young people in the Recruitment process to be piloted (Summer 2022).
- To progress establishing Health Ambassadors, working alongside Regional Youth Forum.

Reporting Committee	**Quality Patient Safety Committee**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**18 January 2022**

Summary of key matters considered by the Committee and any related decisions made

Presentation/Patient Experience

Members received a presentation from the Major Trauma Network (MTN). Four patient stories were presented by the MTN illustrating how the patient journey has changed since the inception. It was noted that the MTN would be peer reviewed in March 2022 by NHS England with a report due in June 2022 and the findings would be presented to the August 2022 QPS meetings. PROMS and PREMS were being built in across the network in partnership with Value in Health Wales and it was confirmed that patient information was available bilingually and a proactive app was being developed.

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

The Committee received the report and took questions by exception. Congratulations were passed onto the Renal Network Team who had recently won a prestigious Nursing Times Award for Learning Disabilities Nursing for their home haemodialysis care of patient with learning difficulties.

2.0 Cancer & Blood

The Committee received an update regarding the burns services at SBUHB that is currently in escalation level 3 because of the closure of the Morriston Hospital Burns ITU due to staffing constraints. Extensive discussions with the South West and Wales Burns Network around the development of an action plan are ongoing and SBUHB have confirmed their commitment to re-opening the full burns service.

3.0 Cardiac

An update was received on GIRFT. In addition, the Committee received assurance that SBUHB was making good progress on the Action Plan relating to cardiac mitral valve surgery and noted that, once resolution was achieved on the vascular

pathway issues, consideration would be given to de-escalate the service from level 4 to level 3.

4.0 Mental Health & Vulnerable Groups

Members received a presentation on Mental Health Specialised Services. It was noted that the Coroner's Inquest following the death of a Young Person in Ty Llidiard back in March 2017 would commence on 17 January 2022 and was expected to last 10 days. An update on the judgment would be provided at the next meeting.

5.0 Neurosciences

Members received the Neurosciences Commissioning Team Update and noted the progress made.

6.0 Women & Children

The Committee was informed that the WHSSC Joint Committee had approved the extension at the request of SBUHB for the OCN for Neonatal Transport because of operational pressures caused by the COVID-19 pandemic.

Development Day

The Development Day was scheduled to take place on the 10 February 2022. A draft agenda was discussed and circulated prior to the event.

Other Reports Received

Members received reports on the following:

- **Services in Escalation Summary**

Members noted that the cochlear services in Bridgend had been de-escalated and removed from the report. No new services had been added since the last report.

- **WHSSC Policy Group**

The Committee was reassured by the work undertaken by the policy group and requested a development session with members to fully understand the position in order be able to support any future work to align with the Committee's work plan.

- **CRAF Risk Assurance Framework**
- **CQC/HIW Summary Update**
- **Incidents and Complaints Report**

Items for information

Members received a number of documents for information only which members needed to be aware of:

- National Reporting and Learning System Letter from Welsh Government;
- Chair's Report and Escalation Summary to Joint Committee 12 October 2021;
- Q&PS Forward Work Plan;

• Q&PS Circulation List.
Key risks and issues/matters of concern and any mitigating actions No specific items were identified requiring reporting in addition to the above updates.
Summary of services in Escalation (Appendix 1 attached)
Matters requiring Committee level consideration and/or approval Members noted that the Neonatal Network Transport was already on the agenda to be discussed by Joint Committee on 15 March 2022
Matters referred to other Committees None identified
Confirmed minutes for the meeting are available upon request

Date of next scheduled meeting:	30 March 2022 at 13.00hrs

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 05/01/2022	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 ongoing. Registrar due to start January 22. Consultant post still awaiting GMC/Royal College approval – appointed to in January 2021 so 12	

					months ago.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 05/01/2022	Movement from last month
March 2018 September 2020 August 2021	Ty Llidiard	CTMUHB	4	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11th September	• Escalation meetings held monthly, however Dec 21 meeting stood down due to operational pressures at CTM. • Funding from WG approved in Dec 21 to meet needs of gap analysis. CTM to conduct gap analysis against the service spec. • CTM UHB to finalise the SOP for Medical Emergency Response– discussions have been concluded. Awaiting publication and implementation of SOP by CTM. • Follow-up meeting to be arranged to discuss CTM OD report to agree any	⟺

					additional elements and the time frame for delivery – Meeting scheduled for Dec 21 stood down due to operational pressures at CTM. • CTM UHB to share maturity matrix and agree a timeframe for the action plan. CTM to map against Ty Llidiard and report progress accordingly. • Coroner's inquest 17 January for 10 days • HIW unannounced visit 11 November – awaiting publication full report	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 05/01/2022	Movement from last month
September 2020	FACTS	CTMUHB	3	• Workforce issue	• 7 CQV meetings have now been held and the service will remain at level 3 until all key actions are met. • The CQV meeting planned for December was stood down and re-scheduled for 3rd February 2022. • CTMUHB ILG have been asked to submit a Clinical Leadership Plan to address the substantive Consultant Psychiatrist post and Clinical Lead role. • The FACTS service specification is being finalized subject to input from CAMHS	

					colleagues.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position	Movement from last month
September 2019	Cochlear Implant Service	South Wales	4	• Quality and Patient Safety concerns from C&V Cochlear Implant team, from the patients who were immediately transferred to the service in Cardiff following the loss of audiology support from the Bridgend service.	• C&VUHB treating all patients. • Interim CHC arrangements agreed. • WHSSC Corporate Directors agreed that an initial key piece of work, which was started prior to the concerns raised about the Bridgend service should be re-established before the commencement of the engagement process. • 2 workshops took place in September. The first workshop concluded with the potential service models for appraisal. The second workshop undertook an option	Risk removed November 2021 

					appraisal on the models. The next steps are to undertake a financial option appraisal and consultation and engagement. • This risk was reassessed at the Neurosciences and Complex Conditions Commissioning Team meeting held in November 2021. It was agreed that because the required mitigating action is in place i.e. that service is being delivered by C&VUHB, that this risk can be closed and removed from the CRAF.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position	Movement from last month
July 2021	Cardiac Surgery	SBUHB	4	• Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review	• 6 weekly meetings in place to receive and monitor against the improvement plan. • Plan to de-escalate to Level 3 following an agreed pathway for aorto-vascular cases. Initial meeting held but further clarity being sought in regards to best practice and cardiac team having sight of additional quality outcome data at the meeting planned for February 2022. Plan to de-escalate to level 3 will then be reviewed.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position	Movement from last month
July 2021	Cardiac Surgery	C&VUHB	2	• Lack of assurance regarding processes and patient flow which impact on patient experience	• C&VUHB have an agreed programme of improvement work to address the recommendations set out in the GIRFT report. • Bi- monthly meetings agreed for monitoring purposes. WHSSC have not yet received an action plan from C&VUHB that outlines the programme of work and this has subsequently been escalated to Clinical Board for action.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position	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.	• Mutual assistance in place via the South West and Wales Burns Network and wider UK burns escalation arrangements. Patients will be stabilised at Swansea and transferred to another centre if appropriate to their care needs. • Network and peer visit to Swansea has taken place to advise on interim and longer term solution. • SBUHB has confirmed its	

					commitment to re-opening the service. • The plan for re-opening burns ITU and commencing major burns level care is expected by end of January.	

Services in Escalation

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

All Health Board and Trusts Chief Executives

Our ref: JP/LH/SB

28 February 2022

Dear all

The transition between children's and adult healthcare services for young people with long-term health needs is an important time for children and young people and one which needs careful management to ensure continuity of care and services.

We have developed new guidance which has been co-produced with NHS colleagues,[1][2] during an extensive period of consultation with stakeholders from across the NHS and Third sector organisations. Collaboration with key healthcare colleagues across Wales has been key to the development of this work, in order to improve the care young people, aged 16 to 25, receive during this period. The guidance covers the time before, during and after they move from children's to adult services. It aims to ensure young people and their carers have a better experience of transition by improving the way care is planned and carried out.

The guidance supports consistent implementation of National Institute for Health and Care Excellence (NICE) guidance. We expect that guidance to be underpinned by robust governance arrangements and administrative processes and procedures locally.

Our expectation from all NHS organisations is as follows:

1. Health boards and trusts must have a clear accountability and delivery mechanism in place, which includes identifying and designating a senior lead reporting to the Quality and Safety Committee, who will have accountability for ensuring implementation and quality of the transition and handover guidance across all primary, secondary, tertiary and community services.

   The senior lead will be responsible for championing transition and handover at a strategic level. The identified senior lead will be crucial to the effective and coordinated operation of transition and handover between children's and adults services.

   The health board and trust should ensure that the designated senior lead:

[1] *Pontio a throsglwyddo o wasanaethau iechyd plant i wasanaethau iechyd oedolion | LLYW.CYMRU*
[2] *Transition and handover from children's to adult health services | GOV.WALES*

- has appropriate clinical experience (for example in a field such as Medical, Nursing, Midwifery, Allied Health Professional, or Public Health);
- is capable of providing overall strategic direction with a view to ensuring the Health Board or Trust meets the requirements of the guidance;
- has an ability to secure strong partnership working across both children and adult services;
- is able to identify and solve problems and conflict at the earliest opportunity between children's and adults services;
- produce an annual report to the Health Board's Quality and Safety Committee
- is able to escalate issues to the Health Board's Executive Board, as appropriate.

2. That every child and young person transferring from children to adult services will have a documented Transition and Handover Plan (THP), or equivalent.

3. A Handover Named Worker is appointed from the NHS Body's children's or adult services to support the transition and handover of healthcare for every child and young person.

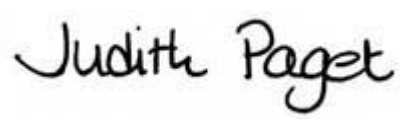
4. The health board or trust must ensure that there are suitable and effective monitoring arrangements in place.

5. There should be a mechanism put in place to capture the child and young person/family/carer's impression of the transition and handover process after 6 months and 12 months to help inform future service provision. In addition, a mechanism to capture how many people have made a representation under Putting Things Right.

6. Health boards and trusts should monitor implementation of the transition and handover guidance using service user feedback, service standards, recognised national audit outcomes, and undertake a review of structures, processes and outcomes after 2 years to ensure it remains fit for purpose and key services user outcomes have been achieved.

After two years of implementation, Welsh Government will undertake annual reviews of these arrangements to ensure quality and consistency across the NHS in Wales.

Yours sincerely



Judith Paget CBE

Professor Chris Jones
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer

Llywodraeth Cymru
Welsh Government

To: Glyn Jones
Interim Chief Executive Officer
Aneurin Bevan University Health Board

(Glyn.jones7@wales.nhs.uk)

cc: Robert Holcombe
Interim Director of Finance and Procurement

(Robert.holcombe@wales.nhs.uk)

1st March 2022

Dear Glyn

Investigating and learning from cases of Nosocomial Covid-19

Further to the Minister's written statement of 26 January 2022 (Written Statement: Investigating and learning from cases of hospital-acquired Covid-19 (26 January 2022) | GOV.WALES) announcing funding to support the delivery of the programme of investigation work into cases of nosocomial Covid-19, I can now confirm your funding package as detailed below:

Aneurin Bevan University Health Board will have access up to £753,155.00 per annum for 2 years. The resource uplift to allocate the first year of funding will be actioned for the start of the 2022-2023 financial year.

The conditions of funding are set out below.

Aneurin Bevan University Health Board will be expected to:

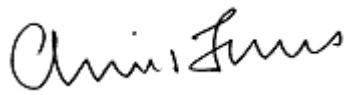
- Put in place the necessary resource and infrastructure to deliver the programme of investigation work in relation to patient safety incidents of nosocomial COVID-19. Investigation work must be completed in line with the *NHS Wales national framework – Management of patient safety incidents following nosocomial transmission of COVID-19* (national framework). This includes investigating cases where a person has acquired nosocomial COVID-19 in a care setting while receiving NHS funded care and when individuals were transferred from hospital into a care home and subsequently contracted COVID-19, within 14 days of transfer. The national framework is currently being updated to provide further clarity of these requirements for NHS funded care.

Parc Cathays, Caerdydd CF10 3NQ Cathays Park, Cardiff CF10 3NQ
Ebost/Email:PSChiefMedicalOfficer@gov.wales

- 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 CHC.
- 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, including:
    - internal mechanisms to ensure your Board is fully appraised of progress with investigations; and
    - reporting mechanism to update NHS Wales Delivery Unit (DU) on progress. Monthly reporting against an agreed reporting framework will be required. Further details on this will be provided by the DU.
- Engage with colleagues in the DU who will have overall responsibility for national leadership and oversight in relation to implementation and application of the national framework.
- Work with the DU to develop the national learning plan which will incorporate the lessons learned throughout the pandemic.

This funding has been provided to ensure the programme of investigation work can be delivered at pace. I am aware that activity is already taking place and I am grateful for your continued support with this important and challenging work.

Yours sincerely



PROFESSOR CHRIS JONES

Grange University Hospital: Quality Assurance

Final Internal Audit Report

January 2022

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

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Auditors:	Audit & Assurance: Specialist Services unit
Executive sign-off:	Nicola Prygodzicz, Executive Director of Planning, Digital & IT
Distribution:	Robert Holcombe, Deputy Finance Director Hannah Capel, Interim Associate Capital Projects Director Neil Miles, Clinical Futures Programme Director Rachel Savery, Senior Programme Manager Rani Mallison, Board Secretary
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

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Executive Summary

Purpose

The agreed audit brief sought to provide assurance in the area of Quality Assurance, focussing on an assessment of the delivery Grange University Hospital (GUH) building against the key business case objectives.

Overview

A reasonable assurance has been determined in this area.

It was evident that the build of the GUH substantially provides the ability to deliver enhanced services, in accordance with the objectives of the business case. However, the delivery of capital investment benefits has been impacted by Covid-19, and accordingly it may be appropriate for revised targets to be put in place. These were being reviewed by management to amend accordingly.

The matters requiring management attention include:

- Reporting against the aspirations of the business case; and
- Review and monitor of targets for the capital investment benefits in accordance with ongoing utilisation of the facility.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary [1]

Assurance objectives		Assurance
1	Functionality	Reasonable
2	Capital Investment Benefits	Reasonable
3	Performance	Substantial
4	Feedback	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1, 1.2	Post opening and re-baselined benefits	*1, 2, 4*	Operation	Medium
2.1	Ongoing monitoring	*2*	Operation	Medium

1. Introduction

1.1 The agreed Grange University Hospital (GUH) integrated audit plan for 2021/22, sought to provide assurance across a number of areas including the quality of the delivered build.

1.2 Accordingly, this audit sought to determine whether the GUH provision, had been reviewed against the objectives of intended functionality, and capital investment objectives, as specified at the business case.

1.3 The GUH, as the specialist critical care facility for the Aneurin Bevan University Health Board (the UHB) forms part of a major reorganisation of health delivery within Gwent. Delivery has therefore encompassed not only delivery of services from a new build, but a switch to a new delivery model across the county. The UHB has reported that the facility:

- is the first Gwent hospital directly accessible for Welsh Air Ambulance patients;
- is one of the busiest hospitals for ambulance demand in Wales; and
- has the third biggest Maternity Unit in the United Kingdom.

1.4 The GUH was originally targeted to open in Spring 2021, but opening was brought forward to Autumn 2020 recognising impending winter and Covid-19 pressures. Practical completion and handover of the entire facility was achieved on 12 November 2020, and the hospital subsequently opened on 17 November 2020.

1.5 A report prepared by the UHB '*The Grange University Hospital – Reflection on the First Six Months*' noted benefits of the new building to include:

- improved access to diagnostics / equipment;
- closer working of services such as respiratory, cardiology and critical care due to close proximity and location of services;
- new services e.g. Cardiac MRI, a new lung biopsies service; and inpatient cardiac MR service (the first in Wales);
- improved access to cardiology;
- additional Catheter laboratory capacity;
- more Emergency Department and Medical Assessment Unit capacity; and
- management of hospital acquired infections (HAI's) due to the single rooms at the site and the ability to contain any infection e.g. GUH had a total of 17 HAI's since opening compared to 493 at the Royal Gwent Hospital within the same timeframe.

1.6 The potential risks considered at this review were:

- failure to achieve the required quality or anticipated benefits from the build;
- the build does not provide required functionality;
- anticipated benefits are not realised;
- parties performed poorly in delivering contractual obligations; and

- lessons are not learnt.

1.7 Where the objectives to be delivered by the build were impacted by Covid (as indicated by management), this has been noted at **Appendix D** , with analysis of full Covid data ongoing at the time of audit. Therefore, this audit does not represent an assessment of delivery in the context of Covid-19.

1.8 Further, an assessment of the quality of services provided at the GUH was outside the scope of this audit.

1.9 Noting the ongoing impact of Covid 19, the delivery of the integrated audit plan for 2021/22 included an increased element of remote working.

2. Detailed Audit Findings

Functionality: Review of the functionality of the delivered build against the objectives of the business case and the cost implications of any issues or risks which remained post completion.

2.1 Key intended benefits specified at the Full Business Case (FBC), relating to functionality i.e. delivery enabled by the building itself were stated as:

a) delivered capacity / occupancy; and
b) delivered schedule of accommodation.

Delivered capacity / occupancy

2.2 Bed capacity (being the intended number of beds to support the clinical model of the FBC) was reviewed as a measure of functional provision at the project: A summary of the capacity is as follows:

	FBC Target	Actual[1]
GUH	462	464 Nov 20 – March 21 471 recurrent
Other (other hospital sites / community beds)	(625)	Not published
Whole Health Board	(163)	Not published

[1] *The "actual" figures at the above table were as reported to the Executive Board in September 2020 (two months prior to opening), and remain the most recent data (recognising the fixed nature of the build at this point). Covid pressures have impacted on the wider utilisation of beds across the UHB, details of which remain to be confirmed.*

2.3 Management confirmed that a one-year review will be undertaken, based on data to November 2021, and reported to the UHB Board in March 2022. While the terms

of reference for the review had yet to be published, it was evident that analysis to provide a more complete data set was ongoing at the time of audit.

2.4 Targets (in this case, bed targets) were originally set in 2015, yet the required bed numbers evolved up to the date of opening.

2.5 It is further acknowledged that the handover point represented early opening which was required to meet Covid demand. As a result, the UHB did not require a field hospital facility to be opened as at other Health Boards. Bed provision and services delivered were affected, and remain as such whilst the UHB strives to manage the ongoing impact of the pandemic.

2.6 Accordingly, to better understand the impact of the GUH facility and its optimum level of performance (amended given the current circumstances), there is a need to assess data pre- and post-handover to better inform management (**MA1**).

Delivered schedule of accommodation

2.7 The schedule of accommodation was reviewed to compare accommodation provided at GUH against that specified at the FBC. Audit analysis has shown that the accommodation was in line with that originally specified (see **Appendix B**)

2.8 A review of the functional changes, as requested by the UHB (see **Appendix C**) also indicated that no significant changes to the original functionality had been requested during the construction phase of the project.

2.9 A *'Lessons Learnt Review'* was published by the Executive Director of Planning, Digital and IT in July 2021. This reported that it remains relevant to re-evaluate the building's facilities and spatial requirements in light of evolving usage (additionally noting the impact of Covid) (**MA1**).

2.10 It was noted that the agreed build had been subject to a value engineering process, and that it may now be relevant to re-validate this exercise. Also noting the passage of time since the approval of the FBC (approved 2015), certain changes have been instructed from the project under-spend e.g. in relation to doctor's rest facilities, external footpaths and additional car parking. Consideration of further works (additional to these) was ongoing, notably:

- conversion of Level 1 agile working space to a Same Day Emergency Care Unit; and
- conversion of ground floor Grange House single storey block into a Wellbeing Centre.

2.11 However, these changes do not relate to delivery as determined at the FBC, and accordingly have not been assessed at this audit.

Functionality - conclusion

2.12 It is recognised that the UHB are undertaking a wider review to provide more comprehensive assessment of delivery against the FBC expectations. However,

based on the data that was available at the date of the reporting, **reasonable assurance** has been determined with regard delivery of the intended functionality.

Capital Investment Benefits: Assurance that the capital investment benefits identified at the business case have been realised.

2.13 This section focussed on the targeted benefits arising from the construction specific elements outlined at the FBC (see **Appendix D**). The FBC specified the core aim of providing a facility to attain English upper quartile performance (based on benchmarking against the Northumbria Specialist Emergency Care Hospital, which opened in 2015). The associated capital investment benefits arising from the new development included:

- Facilities;
- Efficiencies facilitated by the design e.g. adjacencies;
- Quality, and compliance;
- IT utilisation;
- Estate rationalisation / economy; and
- Sustainability

2.14 It is recognised that a number of indicators await data while some others have been impacted by Covid, e.g. indicator D4 (**Appendix D**), in relation to use of high tech assets. It is also recognised that data included the pre-handover period (2015 – November 2020).

Facilities

2.15 Facilities were delivered in accordance with the specified Schedule of Accommodation (see **Appendix C**).

2.16 A report prepared by the UHB '*The Grange University Hospital – Reflection on the First Six Months*' noted benefits to include:

- new provisions – e.g. Cardiac MRI, a new lung biopsies facility; and inpatient cardiac MR facility (the first in Wales);
- an additional Catheter laboratory capacity; and
- more Emergency Department and Medical Assessment Unit capacity.

2.17 Improved provision has also included enhanced ratios of parking, staff changing and sanitary facilities. Delivery facilities, as tested by the audit was evidenced to be in accordance with the aspirations of the benefits plan.

Efficiencies facilitated by the design

2.18 The build has optimised departmental adjacencies in accordance with its design. As a result, the *'Reflection on the First Six Months'* report was able to document positive impacts of the build on working models including:

- ability to meet Covid demand within its own footprint;

- co-located CT and MRI scanners (rare in the UK);
- close working between respiratory, cardiology and critical care due to close proximity and location of departments;
- an embedded psychology well-being facility within Critical Care; and
- the only UK facility to have 24 in-shift and post shift day / night rest rooms.

Quality and compliance

2.19 The build now provides a facility, compliant with NHS Wales Technical and Building requirements (e.g. for space provisions). The building was certified as free of defects that would prevent use at handover, and there has been timely resolution of snagging remediation. It has also obtained full building certification.

IT Utilisation

2.20 The facility utilises new/enhanced IT systems e.g. remote patient monitoring (to provide safer care for single bed wards) and real time patient and bed information (which enhances effective delivery of care). However, the use of an effective communication system for clinicians remains under review, therefore full compliance with the aims of the benefits realisation plan remains to be demonstrated.

Estate rationalisation / economy

2.21 It is recognised that revisions in service models since 2015 will have impacted on estate rationalisation (2015 being the date at which business case targets were set). Impact on the Estates backlog maintenance requirement across the wider Health Board also remains to be assessed. A review of benefits such as estates rationalisation and reduction in backlog maintenance has therefore been recommended at a later date (**MA1**).

Sustainability

2.22 The Building Research Establishment's Environmental Assessment Method (BREEAM) provides a sustainability assessment tool. The GUH obtained a BREEAM "*Excellent*" rating in accordance with NHS requirements for new buildings (*NHS Wales Infrastructure Investment Guidance WHC 2018-043 9.6)*.

2.23 Ongoing monitoring and reporting of both UHB energy and sustainability to Welsh Government are subject to defined arrangements. However, noting the additional need for ongoing monitoring of the GUH performance against the specified benefits of the business case, management should determine an appropriate forum to provide appropriate scrutiny (**MA2**).

Capital Investment Benefits – conclusion

2.24 There remains a need to further assess a number of key outcomes (in part, due to the impact of Covid). However, where data was available, objectives were met. **Reasonable assurance** has therefore been determined in this area.

Performance: Assurance that the performance of all parties involved in the delivery of the contract have been appropriately assessed and reported.

2.25 The *'Lessons Learnt Review'* reported that good relationships with the Supply Chain Partner (the contractor) and external advisers had been key to the success of the build.

2.26 Snagging issues were appropriately addressed in a timely fashion and in accordance with the requirements of the contract.

2.27 Additionally, Key Performance Indicators (KPIs) were actively monitored by the external Project Manager, with reporting to Project Board on an exception basis only The KPIs were also utilised as a return to NWSSP: SES to monitor performance by parties appointed to the NHS: Building for Wales framework. These recorded excellent performance by the parties, including the UHB, as assessed by other contracted parties.

2.28 Substantial assurance is therefore determined in this area.

Feedback: Assurance that user feedback or other technical post-project evaluations, have identified causality in relation to any issues identified to inform lessons learnt.

2.29 The *'Reflection on the First Six Months'* report included patient, staff and visitor feedback; and positively assessed a range of issues.

2.30 *The 'Lessons Learnt Review'* assessed a wider range of performance including, project governance; programme management, contractor and adviser performance; equipping; workforce planning; financial planning; communication; handover; service delivery; and IT; deriving 26 key lessons to be learnt for future UHB capital projects, and sharing with other health bodies.

2.31 As *previously* noted, management have confirmed that a one-year review will take place, based on data to November 2021, and a full appraisal of the GUH facility will be facilitated by NWSSP: SES 15 months post-handover (in accordance with Welsh Government guidance).

2.32 Post *project* reviews undertaken to date, have not been supported by comprehensive data (see **MA1**). However, noting the range of feedback both planned and undertaken, **reasonable assurance** is determined.

Appendix A: Management Action Plan

Matter Arising 1: Post opening and re-baselined benefits (Operation)	**Impact**
Included in the *'Lessons Learnt Review'* (published July 2021), is the section "Scope Creep". This states that: *"The bed plan to enable savings system-wide has not been implemented - some of this is a result of Covid-19 but particularly in an environment where demand is ever increasing. Benefits realisation as a concept was accepted in the project but could be seen as subjective and rarely included sufficient metrics… To conclude, the revenue implications of opening the GUH have resulted in significant changes to the original …models included for the FBC. The GUH should act as a key enabler to improve system efficiency and patient outcomes for ABUHB patients".* The business case benefits were set in 2015 (and recognising the passage of time that has elapsed) it would be informative to report data pre and post opening against objectives for the facility (i.e. up to and post November 2020). Following such appraisal, there will be a need to re-baseline relevant objectives for building functionality.	Potential risks that: • Management are not appropriately informed • Planning in not appropriately informed

Recommendations	**Priority**
1.1 Management should confirm available data and conclusions relating to functionality of the GUH, by comparison to business case objectives pre and post opening.	**Medium**
1.2 Management should re-baseline relevant, objectives for the facility based on current information in order to inform revised functional models.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 Agreed.	At relevant reporting	Director of Planning, Digital and IT

1.2 Agreed.	The one year, and NWSSP:SES delivery reviews.	Director of Planning, Digital and IT

Matter Arising 2: Ongoing monitoring (Operation)		**Impact**
On an ongoing basis, monitoring of Energy usage, will be reported via the annual Estates & Facilities Performance Management System (EFPMS) return. This is monitored by NWSSP: SES on behalf of Welsh Government. Defined arrangements for monitoring sustainable use of the facility are also in place. Sustainability reporting is also now a requirement for all health bodies direct to Welsh Government; and sustainability planning is also required as part of the UHB within its annual report, against objectives specified at its (three yearly) Integrated Medium Term Plans. However, noting the additional need for ongoing monitoring of the GUH build performance against the specified benefits of the business case, management should determine an appropriate forum to provide appropriate scrutiny.		Potential risk that: • Appropriate scrutiny is not applied to ongoing performance
Recommendation		**Priority**
2.1 Management should confirm an appropriate forum to which to report on-going monitoring of the investment benefits derived from the GUH facility .		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 Agreed. The reporting of the energy efficiency benefits of GUH will be picked up as part of the broader energy review and discussed at the Strategic Capital & Estates Group.	At relevant reporting	Director of Planning, Digital and IT

Appendix B: Schedule of Accommodation

Areas specified at the final business case for delivery			Delivered ?
Main Entrance (including restaurant)			✓
Emergency Department (including Adult, Paeads, & Medical & Surgical Assessment)			✓
Emergency Diagnostics	Radiology	Radiology / CT / support	✓
		Ultrasound	✓
		MRI	✓
	Cardiac	Non-invasive	✓
		Vascular	✓
Interventions suite (including Theatres & anaesthetics)			✓
Critical Care Unit (ICU / HDU/ CCU & including inpatient CCU Levels 2 / 3)			✓
Adult Inpatient unit (including inpatients, acute ward & support)			✓
Maternity & neo-natal	Maternity	Incl obstetrics & wards	✓
	NICU	NICU EGAU & support	✓
Children's services (including inpatients, PAU & ED)			✓
Clinical support	Pathology	Inc. hispathology, cytology & blood services	✓
		Mortuary	✓
	Pharmacy	Total Pharmacy	✓
	Others	CSSD	✓
Whole hospital services		Offices / other	✓
	Education & training Centre	Meetings, conference, skills lab	✓
		Library	✓
		Staff change	✓
		Catering & FM	✓
Circulation			✓
Plant			✓
Total net room area			✓

Note: data was extensive, and in some cases could not be precisely matched within the time frame of the audit, due to differences in classification e.g. inclusion of corridors or remote storage.

Appendix C: Major changes requested to the build contract

Major changes requested to build provision	COST	Totals
	£	£
Major functional changes to handover		
Radiology redesign	£998,148	
Radiology additional equipment	£687,887	
Radiology - other technical changes	£115,487	
8 nr new rest rooms on Level 2 Zone 30, and 22 nr study beds (4nr elsewhere)	£381,296	
Pathology redesign including a Discharge Lounge	£352,035	
Mobile Telephony and IT workspace rooms	£216,680	
Omit en-suite bariatric hoists	-£85,132	
Omit endoscopy storage from Room CAU.01.010	-£17,789	
TOTAL		**£2,648,612**

% of original build contract of £206,457,458 1%

Appendix D: Capital Investment Benefits

(as sampled by audit from the GUH Business Case - Benefits Realisation Plan)

Key

Blue	Data not available
Red	Data impacted by Covid

CLINICAL FUTURES BUSINESS CASE – BENEFITS REALISATION PLAN
APPENDIX 3A

Investment Objective 1 : A65 **To provide by 2019 a configuration of services that supports clinical outcomes and standards of patient care equivalent to English upper quartile performance delivered in appropriate and modern health care environments.**						**Out-turn**		
REF	**Benefit Descriptor**	**Improvement Indicators**	**Specified Information Source**	**Performance Measure**		**Data**	**Target Met ?**	**Comments**
				Baseline	**Target**			
A4	Provides safe and appropriate settings for modern specialist health care delivery.	Ensuites and increased ratio of sanitary facilities.		Design Spec at Full Business Case	Delivered to budget specification	Schedule of Accommodation	✓	
		Adequate car parking		Design Spec at Full Business Case	Delivered to budget specification	Delivered specification	✓	The contract originally provided: 57 Accessible parking 239 Visitor 652 Staff 20 Emergency An additional 274 spaces were provided by

								Compensation Event 274C at a cost of £228k, plus £126k for 18 electric charging points.
		Provision of staff change		Design Spec at Full Business Case	Delivered to budget specification	Schedule of Accommodation	✓	
		New builds meet AEDET (Achieving Excellence Design Evaluation Toolkit) Key Performance Indicators (KPI's) to ensure building quality and functionality is designed within a commonly agreed framework	AEDET report	Design Spec at Full Business Case	Delivered to budget specification	Building control certificate	✓	
A6	Evidenced based design supports more efficient and effective working practices	Improved utilisation of IT e.g. Vocera (staff communication system / patient Flow management system)						While use of Vocera by clinicians remains under review, other systems such as Careflow (a real time patient status tool), Mindray (a remote monitoring system), and Qlik (a reporting tool) have successfully been commissioned.
		NHS Wales Health Technical Memorandum (HTM) / Health Building Notice (HBN) compliance.		Design Spec at Full Business Case	Delivered to budget specification	Building control certificate	✓	

		Compliant clinical spaces, designed for modern healthcare.		Design Spec at Full Business Case	Delivered to budget specification	Schedule of Accommodation	✓	
		Departmental adjacencies minimising travel distances.		Design Spec at Full Business Case	Delivered to budget specification	As build drawings / "six month on" document	✓	
		Designed & Built to be easily cleaned and maintained.	C4C	Design Spec at Full Business Case	Delivered to budget specification	Health & Safety file	✓	
Investment Objective 4: **To deliver a configuration of services and supporting infrastructure by 2019 that optimises financial effectiveness and delivers efficient use of available resources.**						**Out-turn**		
REF	**Benefit Description**	**Indicator/Measurement**	**Information Source**	**Performance Measure**		**Data**	**Target Met ?**	**Comments**
				Baseline	**Target**			
D3	Improved functionality and inter relationships between sites and individual departments	Outline interdependencies with other depts./physical adjacencies. Measure through team working/mortality rates/staff sickness/infection rates/risk reduction			Improvement	As build drawings / six month on document	✓	

D4	Improved utilisation of high tech assets	Improved utilisation of high tech assets : improved theatre utilisation MRI utilisation CT (computerised tomography) utilisation Increased Catheter laboratory capacity		Current usage	Increased usage				**Data significantly impacted by Covid** Both scheduled and emergency use of high tech assets has been significantly impacted by Covid, and accordingly, management have deferred publication pending more robust / steady state data.
D5	Allows rationalisation of the existing estate / release of existing estate	Existing sites rationalised i.e. Neville Hall Hospital/ Royal Gwent Hospital/ St. Woolos Hospital (NHH/RGH/SWH)	EFPMS (Estates and Facilities Performance Management System)	Current Gross Internal Floor Area (GIFA) of rationalised sites	Reduced GIFA of rationalised sites		No. of sites		**Data significantly impacted by Covid.** Site rationalisation plans were significantly impacted by Covid, and accordingly, management have deferred publication pending more robust / steady state data.
D6	Backlog Maintenance reduced	Change from Baseline	EFPMS	Current data	Reduction in Backlog maintenance				Data not yet available, also noting that defects at GUH within its first year of operation are contractually rectified at £0 cost.
D7	Improved sustainability / energy efficiency	Carbon Emissions/BREEAM Excellence (Building Research Establishment's Environmental Assessment Method)	EFPMS	Design Target at Full Business Case	Actual after 12 month operational use		BREEAM Excellent certification obtained	✓	

Appendix E: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Falls Management
Final Internal Audit Report

March 2022

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

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Executive sign-off:	Peter Carr, Director of Therapies and Health Science
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Committee:	Audit, Finance and Risk Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

We sought to provide assurance that the Falls Policy for Hospital Adult Inpatients was being adhered to by staff and monitored appropriately.

Overview

We have issued reasonable assurance on this area.

Overall, we found that the number of inpatient falls declined following the introduction of the revised multi-factorial risk assessment (MFRA) and policy.

Within the sample tested, we also found the completion rate of the assessment forms to be consistent with our previous audit of Falls Management.

However, we did identify the following exceptions:

- Six of 30 patients sampled, where a fall had occurred, did not have a completed MFRA recorded prior to the fall.
- 12 of a separate sample of 29 patients tested did not have a MFRA completed within the timeframe required. However, we recognise this was within a pandemic environment.
- Three of the same sample of 29 patients tested did not have a MFRA recorded, when one should have been completed.

We only selected patients for our sample where a MFRA was required to be documented.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Trend

2018/19 – reasonable assurance

Assurance summary[1]

Assurance objectives		Assurance
1	Falls Management Policy	Substantial
2	Policy Application and Adherence	Reasonable
3	MFRA completion	Limited
4	Oversight and Monitoring	Substantial

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	MFRA completion	2	Operation	High
2	Datix entries	2	Operation	Medium

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 The review of Falls Management was completed in line with the 2021/22 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board'). The review sought to provide the Health Board with assurance that falls management procedures are appropriately implemented and monitored within the Health Board.

1.2 The Health Board recognises that the prevention of falls, and effective management of patients following a fall, is an important patient safety challenge for the Health Board, in common with all Health Boards.

1.3 To minimise falls, and as far as possible their impact on patients and staff the Health Board has adopted the National Institute of Health and Care Excellence (NICE) clinical guidance. This guidance provides recommendations for the assessment and prevention of falls in older people for use by healthcare and other professionals and staff who care for older people who are at risk of falling.

1.4 During July 2021, the Health Board issued a revised Falls Policy for Hospital Adult Inpatients (the 'Policy'), which was accompanied by an awareness raising campaign. Alongside this process, the governance arrangements have been restructured with the re-establishment of the Falls and Bone Health Steering Group, but now entitled the Falls and Bone Health Committee (the 'Committee'). The Committee reports directly to the Patient Quality, Safety and Outcomes Committee.

1.5 Supporting the Committee within the newly established structure are two sub-groups, the Hospital Falls and Bone Health Group and Community Falls and Bone Health Group.

1.6 The key risks considered in this review were:

a. failure to properly risk assess patients leading to increased falls and patient harm;

b. lack of appropriate monitoring of falls leading to missed opportunities to identify weakness and implement improvements;

c. reputational risk from negative publicity arising from increased or serious falls; and

d. financial loss to the Health Board.

1.7 Due to the pandemic, we did not visit wards to complete our testing. Instead, we reviewed electronic copies of the clinical notes, to determine if multi-factorial falls risk assessments (MFRAs) had been fully completed.

2. Detailed Audit Findings

Audit objective 1: to ensure that there are adequate policies / procedures in place, detailing processes to support minimising inpatient falls incidents and embedding the requirements of NICE CG161.

2.1 We confirmed that the updated Policy is hosted on the intranet site, with supporting links to the document correctly referenced.

2.2 We tested to ensure that the Policy continues to encompass the requirements of NICE CG161. We also selected a sample of best practice guidance and ensured the contents of the Policy incorporated relevant details.

2.3 We found the revised Policy to be comprehensive, with a multi-disciplinary approach adopted, additional medication review tools, a head injury pathway, nutritional risk screening tool and frailty referral forms included. Each of these have the potential to improve inpatient falls management.

2.4 The Policy includes a MFRA, which is more detailed than the previous version. However, when interviewing staff over their awareness of the Policy and supporting documents, we were informed that the length of the MFRA was considered overly detailed. Furthermore, the total amount of time to complete the assessments and the frequency was also a concern raised throughout the audit. We tested the completion of a sample of MFRAs under audit objective three.

Conclusion:

2.5 We confirmed that the Policy is readily accessible and provides detailed tools to assist with the management of falls. In addition, the requirements of NICE CG161 and supporting best practice has been incorporated into the documentation. Therefore, we have provided substantial assurance for this objective.

Audit objective 2: to ensure, that the applicable policies / procedures are adhered to by staff within the Health Board as appropriate.

2.6 We tested adherence to the Policy through sample testing, with our findings detailed below under audit objective three. However, we also tested the following controls, which are in place to assist with compliance to the Policy and supporting procedures:

- the launch of the new policy;
- falls management training;
- the content of the operating procedure; and
- controls in place following the completion of the MFRA.

New policy launch

2.7 We found that the revised Policy was launched with an awareness campaign and supporting communications. Alongside this an update to the falls management training programme was completed.

Falls Management Training

2.8 A programme of falls management training was commenced when the Grange University Hospital (GUH) opened. This was to assist with the different nursing practices required for single rooms, as opposed to the multiple occupancy bays predominantly used at the other hospital sites.

2.9 We found that the training has continued since the opening of the GUH. Alongside the delivery of the training and the introduction of the Policy there has been a noticeable decline in the number of falls recorded. This has continued month on month in the total number of falls and the number of falls per 1,000 bed days. Further detail is provided under audit objective four. We also reviewed the training feedback provided by the participants and found this to be positive.

2.10 However, as mentioned above, some of the feedback did focus on the MFRA detail required and the amount of time to complete it. We have raised this within **matter arising one.**

Procedural Documentation

2.11 Paragraphs 6.0 to 8.0 of the Policy form the Standard Operating Procedure (SOP) sets out the requirements for a member of staff to complete an assessment. We found that it covers adult inpatients from admission to discharge and sets out the actions required to apply the policy.

Operational Controls

2.12 We were advised that there is no 'universal' admissions control checklist that requires confirmation and sign-off of a MFRA, nor any other required documentation. We have raised this within **matter arising one.**

2.13 The operational controls covering MFRA completion are:

- MFRAs are quality checked via DECis (Dignity and Care Inspections);
- 1P1D – one patient, one day checks by a registered nurse, ward manager or a senior nurse; and
- ward managers also visually inspect their documents (but this is not recorded).

2.14 We reviewed examples of the inspections detailed above and confirmed that they are designed as one-off reviews with immediate feedback to ward staff. Common improvement areas identified include incomplete or missing documentation. We have raised this within **matter arising one.**

Conclusion:

2.15 There is a significant reduction in the number of falls recorded, following the introduction of the updated Policy and supporting falls management training. However, we feel that there are still further control improvements to be introduced to ensure the MFRAs are fully completed. We have provided reasonable assurance for this objective.

Audit objective 3: to determine for a sample of applicable patients that a risk assessment has been completed and where required, appropriate action taken to reduce the risk a fall.

2.16 We reviewed two samples to establish if the MFRAs were being completed, in accordance with the Policy. The first sample (of 30) was selected from falls data recorded on Datix, where a patient fall had occurred. The second sample (of 29) was selected from patients admitted to a hospital. To consider the effect of the updated policy and the new MFRA, we looked at admissions and falls from August and September 2021. For both samples, we only included patients that should have had a MFRA completed i.e. they met the requirements as outlined within the Policy.

2.17 As we did not visit wards to complete our testing, we utilised Clinical Workstation (CWS) to locate the MFRAs and the assistance of the Health Board, where documents were absent.

2.18 Whilst the Policy requires a MFRA to be completed within six hours of admission, we applied a tolerance parameter to this requirement, due to the impact of the pandemic and the exceptional pressures that staff were facing. As such, we tested to determine if a MFRA had been completed on the same date that the patient was admitted. However, we did not identify any instances within our sample where the impact of the pandemic was directly attributable.

Datix Falls Sample

2.19 We selected a sample of 30 patients recorded onto Datix that had suffered a fall whilst in hospital during August and September 2021. For seven of the sample we found that no MFRA had been documented, prior to the fall.

2.20 In addition, we found that for six of the seven exceptions identified that the falls prevention section within Datix did not record 'no falls risk assessment was completed' following an investigation - in spite of this question being presented to the user. Instead, the falls were marked as 'unexpected'. We have raised this within **matter arising two.**

Admissions Sample

2.21 We also selected a sample of 29 patients that were admitted to hospital, to determine if a MFRA had been completed, in accordance with the Policy.

2.19 For each of this sample, the completion of a MFRA was a requirement, however, we found that for three patients MFRAs had not been completed. We have raised this within **matter arising one.** However, we have been informed that one of the missing falls assessments may not have been required.

2.20 Furthermore, we found that nine of the 29 within the sample had not been completed within the time limit set out within the Policy (taking into account the points raised within paragraph 2.18). We have raised this within **matter arising one.**

Conclusion:

2.21 The MFRA is a key tool for the management of inpatient falls, so should be completed for all relevant patients, in a timely manner. Due to the number of exceptions identified and compared to our previous audit findings from 2018/19[2], we have provided limited assurance for this objective.

Audit objective 4: to ensure that there is appropriate oversight and monitoring over the management of patient falls throughout the Health Board.

2.22 We obtained the falls data for recent years for the months August to December and ensured that action was undertaken to achieve a downward trend of falls. We found that the data is utilised to provide oversight of falls from the 'ward to Board'. Overall, we found a suite of active reporting in place, with continuing improvement accompanying key actions introduced (training programmes and the revised MFRA / Policy).

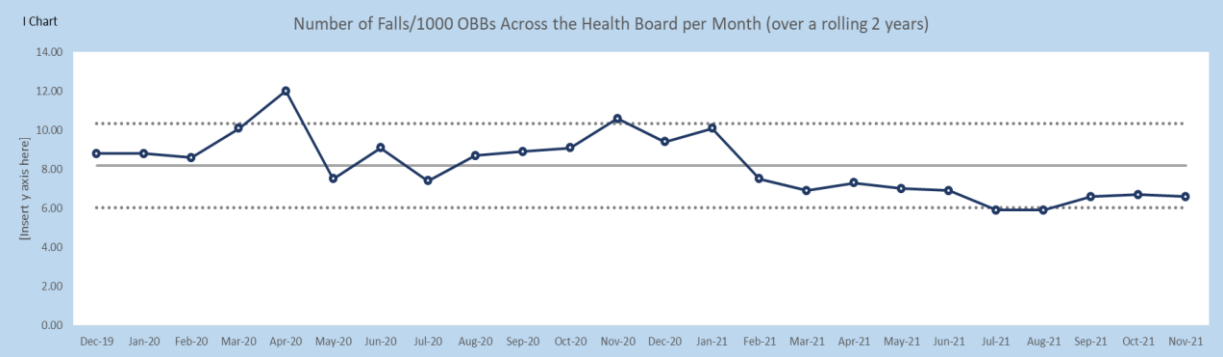
2.23 The latest falls volume information is detailed below in total numbers and per 1,000 bed days.

Falls Volume

	August	September	October	November	December
2017	349	323	302	343	337
2018	348	318	303	285	272
2019	345	304	328	294	359
2020	308	315	331	364	330
2021	219	242	269	261	264

[2] Our 2018/19 Falls Management audit found that two from 39 patients, where a MFRA had not been completed, but should have been.

Falls volume per 1,000 bed days



2.24 We confirmed that there is appropriate oversight of falls management within the Health Board, via the Falls and Bone Health Committee, which reports directly to the Patient Quality, Safety and Outcomes Committee. Whilst there is formal reporting to the Executive Team, which takes place on a quarterly basis, there is also regular reporting and feedback to individual wards.

2.25 We also noted that there is Health Board representation within the Welsh Government initiative, 'The National Inpatient Falls Network'. This is a forum for the sharing of best practice, which has taken place with the medicine review tools and the head injury pathway.

Conclusion:

2.26 We found good reporting mechanisms in place across all levels of the Health Board. We have provided substantial assurance fort his audit objective.

Appendix A: Management Action Plan

Matter arising 1: MFRA completion controls (Operation)	Impact
In spite of a rolling training programme, an updated policy and a revised multi-factorial risk assessment (MFRA) we identified non-completion of falls risk assessments. We selected a sample of 30 patients that had experienced a fall whilst in hospital, to determine if a MFRA had been completed. In all instances the patients should have had a multi-factorial risk assessment (MFRA) documented. However, we found that for seven of the patients a MFRA had not been completed. We also selected a sample of 29 patients that were admitted to hospital, to ensure a MFRA was completed on the same date of admission. However, we found three instances (although we were informed that one MFRA may not have been required) where a MFRA had not been completed and a further nine patients where the MFRA was not completed on the same date / shortly after admission.	Potential risk of: • Patient harm from a failure to properly assess the risk of an unexpected fall • Reputational damage due to non-adherence to the Policy • Financial loss to the Health Board

Recommendations	Priority
1.1 The Health Board should: a. Identify any underlying reason for the non-completion of MFRAs and the impact of the pandemic. b. Review the MFRA documentation to determine if it can be rationalised / updated to be more concise. For example, a permanent section and an ongoing care plan that is periodically revised. c. Continue with the falls management training, but target the programme towards areas of poorer compliance rates. d. Remind staff of the falls management requirements. e. Where 1P1D/DECi inspections identify failures an immediate correction of the patient record and a rerun of the check (and potentially training) should be completed.	**High**

Management response	Target Date	Responsible Officer
1.1 a. It is recognised that the non-completion of the falls risk assessment is multifactorial and the challenges have been heightened during the Covid pandemic. This is both in association with the changing levels of comorbidities for our patient cohort and the availability of staff resources due to competing demands in support of the Health Boards response to the pandemic. Some wards were also	July 2022	Karen Hatch

	subject to changes in their functions with the redistribution of patients in support of the management of the pandemic. The Health Board through its falls management structure will continue to utilise both qualitative and quantitative information to identify themes and trends to instigate the necessary quality improvement initiatives. This will look to include a broader remit of evaluating compliance with the completion of the MFRA through the development of an audit suite aligned to and extending the existing methods being adopted by the wards. The outcomes will look to define any change requirements and will be communicated at all levels within the organisation structures.		
b.	The MFRA represents one assessment within the suite of the Welsh National Care Records (WNCR). This is due to be adopted in its intended electronic format in ABUHB in the Summer of 2022 and will provide a more streamlined systematic MFRA. Although currently being used in a paper format ABUHB as part of the process have submitted a number of change requests, which have been accepted. The detail held within the MFRA is reflective of the many factors which influence the risks of falls and likewise contribute to the wider understanding of the patient's condition. ABUHB is represented at National level and will continue to contribute to the discussions.	Summer 2022	Peggy Edwards
c.	It is recognised that training is a key component in supporting the ABUHB's approach in minimising inpatient falls. The aim is to build on what has already been established. The evaluation of data will look to underpin a focussed approach where areas of concern are identified and will look to inform the training strategy going forward. Aligned to the work of ABUHB we are also represented at an 'All Wales's level in discussions to develop a generic learning platform linked to ESR to support all staff who have a role in falls management. It is intended that this will translate into a national product and provided consistency of approach across Wales. This platform will support enhancing knowledge and skills from both an inpatient and community perspective. The learning package will provide a level 1-2 education upon which additional modules will be developed.	ABUHB - Commencing April 2022 Timelines will be defined at National Level for the ongoing development and implementation of a generic level 1-2 platform.	Karen Hatch

d. Through the newly established structure in support of falls management an ongoing awareness campaign is to be established. The further development of the intranet pages through SharePoint will the provide enhanced communication approaches. This will be looked at in the context of falls from a Hospital and Community perspective. This will be used to develop a falls network, provide a platform to share good practice, research and act as a resource depository. The concept of falls champions will be promoted. All will look to support quality improvement initiatives across the falls pathways. The agendas set for the fall's forums will look to ensure such good practice, learning and necessary change initiatives continue to promote the requirements to manage falls.	Ongoing	Karen Hatch Tracey Partridge Wilson
e. Should non-compliance concerns be identified the findings are shared with the Nurse in Charge, Ward Manager along with the Senior Nurse and QPS Lead. The outcomes are relayed to the member of staff responsible for the care of the patient and the wider team as a means of learning. The responsible member of staff looks to action any requirements to rectify non-compliance. The QPS Lead subsequently undertakes a more extensive focussed audit to identify any systemic concerns within the given ward and to inform the Divisional 'deep dive' discussions. Work is underway to look at how the data can be cross referenced with the overarching falls management data and on the reinstatement of the Health and Care Standards Audits. This approach will look to be supported by the training strategy.	Ongoing	Tracey Partridge Wilson Karen Hatch

Matter arising 2: DATIX Completion (Operation)	Impact
We found six instances where a MFRA for a patient had not been completed, but that patient had experienced a fall. We also found that the identification of the fall was marked as 'unexpected', but yet no MFRA was completed when it should have been. In the previous version of Datix there was a section to identify if a MFRA was not completed when a fall incident has occurred. Consequently, where there is no record of a MFRA completed pre-fall (when one was required) it is incorrect to mark a fall as 'unexpected'.	Potential risk of: • Incorrect data entered onto national systems • Incorrect assumptions on the effectiveness of controls

Recommendations	Priority
2.1 The falls investigation and Datix recording process should reference the MFRA and confirm its completion in relation to the fall event. A fall should not be identified as 'unexpected' if a MFRA had not been completed, when it should have been (e.g. over the age of 65 years).	**Medium**

Management response	Target Date	Responsible Officer
2.1 An ongoing audit process will be established aligned to evaluating the completion of DATIX incidents and the associated completion of the MFRA and will be included as an element of an audit cycle Due consideration will need to be given to the format of the incident reporting criteria within the new system.	September 2022	Scott Taylor Karen Hatch

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
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Prioritisation of Recommendations

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4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Patient Quality, Safety and Outcomes Committee

Terms of Reference – 2022/23

Version: Approved

Date: March 2022

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1. INTRODUCTION

1.1 Section 2 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

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

1.2 The Health Board has established a committee to be known as the **Patient Quality, Safety & Outcomes Committee** (referred to throughout this document as 'the Committee'). The Terms of Reference and operating arrangements set by the Board in respect of this committee are provided below.

2. PURPOSE

2.1 The scope of the 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:

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

2.1 ADVICE

The Committee will provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the development of the following matters, consistent with the Board's overall strategic direction

- Citizen Experience; and
- Quality and Safety of directly provided and commissioned services.

2.2 ASSURANCE

In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on:

a. The robustness of the Board's Clinical Quality Governance Arrangements;
b. the experience of patients, citizens and carers ensuring continuous learning;
c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services; and
d. the effectiveness of arrangements in place to support Improvement and Innovation.

3 DELEGATED POWERS AND AUTHORITY

3.1 With regard to the powers delegated to it by the Board, the Committee will:

A. Seek assurance that the Health Board's **Clinical Quality Governance Arrangements** remain appropriate and aligned to the National Quality Framework and is embedded in practice.

B. Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:

- the delivery of the Patient Experience Plan; and
- the implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned.

C. Seek assurance that arrangements for **the provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:

- the systems and processes in place to ensure efficient, effective, timely, dignified and safe delivery of directly provided services;
- the commissioning assurance arrangements in place to ensure efficient, effective, timely, dignified and safe

delivery of those services commissioned for delivery on ABUHB's behalf;
- the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities;
- the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;
- the arrangements in place to ensure that there are robust infection prevention and control measures in place in all settings;
- the development of the Board's Annual Quality Priorities; and,
- performance against key quality outcomes focussed indicators and metrics.

D. Seek assurance on the arrangements in place to support **Research and Development** and **Improvement and Innovation**, including:
   - an overview of the research and development activity within the organisation;
   - alignment with the national objectives published by Health and Care Research Wales (HCRW);
   - an overview of the quality improvement activity within the organisation.

E. Seek assurance that arrangements for **compliance with Health and Safety Regulations and Fire Safety Standards** are sufficient, effective and robust, including:
   - the operating practices in respect of: staff health and safety; stress at work; patient health and safety, i.e., patient falls, patient manual handling; violence and aggression; fire safety; risk assessment processes; safe handling of loads; and hazardous substances

3.2 The Committee will consider and recommend to the Board for approval those policies reserved for the Board and delegated to this Committee for review, in-line with the Board's Policy Management Framework and Scheme of Delegation and Reservation of Powers.

3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Corporate Risk Register.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate.

The Committee may seek any relevant information from any:

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

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

3.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

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

Committee Programme of Work

3.10 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Assurance Framework and Corporate Risk Register. This approach will ensure that the Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Committee's annual programme of work and is not an exhaustive list for full coverage.

This approach recognises that the Committee's programme of work will be dynamic and flexible to meet the needs of the Board throughout the year.

4 MEMBERSHIP

Members

4.1 Membership will comprise of five (5) members:

Chair:	Independent member of the Board
Vice Chair:	Independent member of the Board
Other Members:	Three other independent members of the Board *[one of which should be the Vice Chair of the Health Board and the Chair of the Audit, Risk and Assurance Committee]*

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

Attendees

4.2 In attendance: The following Executive Directors of the Board will be regular attendees:

- Director of Nursing
- Director of Therapies and Health Science
- Medical Director
- Director of Primary, Community Services and Mental Health

4.3 By invitation:
The Committee Chair extends an invitation to the ABUHB Chair and Chief Executive to attend committee meetings.

The Committee Chair will extend invitations to attend committee meetings, dependent upon the nature of business, to the following:

- other Executive Directors not listed above;
- other Senior Managers and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The Office of the Director of Corporate Governance will provide secretariat services to the Committee.

Member Appointments

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

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of ABUHB.

Support to Committee Members

4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5 COMMITTEE MEETINGS

Quorum

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

5.2 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than **bi-monthly (six times yearly)**, and in line with the Health Board's annual plan of Board Business.

5.4 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.5 Section 3.1 of ABUHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and
- through ABUHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.6 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions (as set out within these terms of reference), the Board retains overall responsibility and accountability for all matters relating to performance and resources.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- applicable escalation of concerns.

In doing so, this contributes to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

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

7.3 The Director of Corporate Governance shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of

the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.