Patient Quality, Safety & Outcomes Committee

Tue 08 February 2022, 09:30 - 12:30

Microsoft Teams

Agenda

09:30 - 09:45
15 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 21st December 2021

Attachment *Chair*

1.4 Approved PQSO Minutes 21st December 2021 (PB approved).pdf (15 pages)

1.5. For Discussion: Committee Action Log

Attachment *Chair*

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

09:45 - 11:55
130 min

2. Items for Presentation and Discussion

2.1. Update on Compliance with Cleaning Standards

Verbal *Director of Operations/Divisional Director of Facilities*

2.2. Assurance Report: Infection Prevention and Control Management during COVID Pandemic (to include Local Options Framework)

Attachment *Assistant Director of Nursing*

2.2 QPSOC - An Overview of Covid-19 (Rhiannon Jones (Aneurin Bevan UHB - Nursing)).pdf (9 pages)

2.2.1. COMFORT BREAK- 10 MINUTES

2.3. Assurance Report: Quality and Safety Outcomes Committee Risk Report

Attachment *Clinical Executives*

2.3 PQSOC Performance Report - december 2021-IT0077825.docx V3.pdf (22 pages)

2.4. Patient Quality, Safety and Outcomes Committee Risk Report

Attachment *Board Secretary*

- 2.4 PQSO Committee Risk Report Feb2022 V1.pdf (7 pages)
- 2.4a Appendix 1 Master PQSO Risks.pdf (26 pages)

11:55 - 12:30
35 min

3. Other Matters

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

Verbal *Chair*

12:30 - 12:30
0 min

4. Date and Time of the Next Committee Meeting is 09:30am on Tuesday 5th April 2022 via Microsoft Teams

Verbal *Chair*

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of Patient Quality, Safety & Outcomes Committee held on Tuesday 20th December at 9.00am via Teams

Present:

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

In attendance:

Rani Mallison	- Board Secretary
Rhiannon Jones	- Director of Nursing
Peter Carr	- Director of Therapies & health Science
James Calvert	- Medical Director
Leanne Watkins	- Director of Operations
Gareth Hughes	- Divisional Director of Facilities
Janice Jenkins	- Interim Assistant Director of Digital Programmes
Emma Guscott	- Committee Secretariat

Observers:

Nathan Couch	- Audit Wales
Alexandra Scott	- Assistant Director Patient Safety
Katija Dew	- Independent Member
Alan Davies	- Aneurin Bevan Community Health Council
Tracey Partridge-Wilson	- Assistant Director of Nursing, Quality & Patient Safety

Apologies:

Nicola Prygodzicz	- Director of Planning, Digital & IT

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1	**Preliminary Matters**
PQSO 2112/01	**Welcome and Introductions** The Chair welcomed those present to the meeting and thanked individuals for their attendance.
PQSO 2112/02	**Apologies for Absence** Apologies for absence were noted as above.
PQSO 2112/03	**Declarations of Interest** There were no Declarations of Interest raised in relation to items on the agenda.
PQSO 2112/04	**Draft Minutes of the Committee held on 19th October 2021** The minutes of the meeting held on the 19th October 2021 were agreed as a true and accurate record. Shelley Bosson requested that the following, taken from the minutes, be recorded on the Action log: **PQSOC 1910/09:** *Rhiannon Jones advised that a Senior Nurse for Safeguarding Education had been appointed and would be making direct contact with teams reporting low compliance. Rhiannon Jones would link with the Board Secretary to arrange bespoke training for Board members that did not attend the previous focussed Development session*. **Rhiannon Jones/Rani Mallison** Rhiannon Jones informed the Committee that a full review of training was being undertaken, and this would come back to the Committee at a later date. **PQSOC 1910/13:** *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** 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.
PQSO 2112/05	**Action Sheet of the Committee held on the 19th October 2021** The Committee reviewed those actions outstanding as recorded in the action log and noted the following:

	1910/13 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. Rhiannon Jones updated the Committee on the following actions: **1910/06 Dementia Companions and Meaningful Occupation mode:** An update on the evaluation had been included in the Outcomes Report. Action complete. **1910/08 Putting Things Right - update against 2021/2022 priorities:** Circulated outside of the meeting. Action complete. **1910/13 Annual Assurance Report on Health & Care Standards; Nutrition and Hydration:** • Peter Carr to update and recirculate the Equality Impact Assessment. • The committee was assured that the use of different assessment tools in mental health and community settings was as a result of tools being developed for different categories of patients. Action complete. **1910/17 Highlight Reports; Urgent Care Transformation Board:** Rhiannon Jones had shared the Primary care update on Graduated Care with Shelley Bosson. Action complete.
2	**Presentations/Reports for Assurance**
PQSO 2112/06	**Urgent and Emergency Care Update** Leanne Watkins, Interim Director of Operations, provided an update on Urgent and Emergency Care, presenting the previously circulated paper. It was reported as a multi-agency issue. A review was taken across the whole system in order to understand interdependencies and create a coordinated approach. An Urgent Care structure had been put in place, overseen by the Urgent Care Transformation Board. It was noted that the work programme initially focused on Winter pressures. A 'System Reset' weekend was conducted on the 21st November to replicate seamless system conditions that were needed to improve the flow. The reset had been positive and addressed the congestion in departments and patient safety during the exercise. Leanne Watkins shared the significant areas of concern to the Committee. These were outlined as follows:

DRAFT

	• Over 21-day length of stay in excess of 500 patients (normal average range was noted as 200 patients). • Fragility of staffing driven by COVID and recruitment issues, to include the increased use of agency doctors and nurses. • Access to urgent care, particularly 111 services. Long wait times when accessing 111 telephone services were highlighted, along with high abandonment rates. • The impact on the Minor injuries Units and Emergency Departments (ED) as a result of the inability to access the 111 service in a timely manner was discussed. It was noted that departments were not currently equipped for the volume of self-presenters, however, the Committee was assured that plans we in place to mitigate these issues (see dedicated agenda item 2112/07) Leanne Watkins reported areas that had seen a positive impact on service delivery. An emergency reconfiguration of the respiratory model had taken place in response to fragility of staffing. Condensing the respiratory support had allowed for daily consultant support in the Emergency Department, resulting in a reduction waiting times and an improved patient experience, via Ambulatory Care. The Chair queried if Mass Vaccination redeployment had impacted on Primary Care and system pressures. It was reported that redeployment had affected all areas; whilst recognising the mass vaccination booster programme was an important step towards addressing winter pressures and the response to the emerging Omicron variant. Rhiannon Jones, Director of Nursing, flagged that staffing deficits and increased acuity were impacting on length of stay, with an average of 250 patients who were fit for discharge. Plans were being put in place to mitigate this. James Calvert, Medical Director informed the Committee that 59% of consultant posts remained vacant in Wales, which was a significant concern. Paul Deneen, Independent Member, requested assurance that patients' needs were being met when waiting for care in ED and that families were able to contact clinical staff for updates. Rhiannon Jones assured the Committee that Standard Operating Procedures were followed and that the fundamentals of care for patients with delayed handover were robust. Food and hydration were provided to patients and the HIW National report outlined the positive support ABUHB provided for delayed patients. The Committee noted that communications remained an issue. Investments had been made to address the ongoing issue by

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	employing ward clerks and patient liaison officers. Further support was still required, however, and there was a current bid for a Patient Advice and Liaison Service to improve communication with patients and families, but recurring funding was required. Paul Deneen requested further information on the 'long term strategic changes for the Emergency Department' as outlined in the report. Leanne Watkins informed the Committee that work was being undertaken to support Same Day Emergency Care (SDEC). Plans for a SDEC Ambulatory Care area in the Grange University Hospital (GUH) were in development. The Health Board's Flow Centre was noted as supporting pathways, with a bespoke integrated front door model, as a fundamental model to support patients. Shelley Bosson, Independent Member, requested opinion on the more than 500 patients waiting in hospitals for more than 21 days and whether Local Authority (LA) care packages were influencing the inability to discharge. Leanne Watkins stated that delayed transfers were at approximately 250-300 in acute and community hospitals. The Health Board had been liaising with LA colleagues, commissioning additional care home beds and trying to secure adequate care packages for patients. The ability to transfer patients into the correct care setting was noted as very challenging. Some LA services were in 'business continuity', and it was noted that some care providers were handing back contracts to LA partners. Shelley Bosson queried if the weekend trial of holding additional assessment trolley space in the ED was successful, and if so, was it now implemented on a permanent basis. Leanne Watkins stated that the test of change was positive but achievement was variable if flow became compromise demand was increased the assessment space needed to be utilised. The Committee received the update and the Chair thanked the teams for the report.
PQSO 2112/07	**Minor Injuries Units (eLGHs)** Rhiannon Jones, Director of Nursing, provided the Committee with a presentation and update on the work she had been leading with James Calvert, Medical Director, in respect of Minor Injuries Units (MIU). The work was undertaken in response to the opening of GUH and unwell patients self-presenting at Minor Injury Units in both the Royal Gwent Hospital (RGH) and Nevil Hall Hospital (NHH). Rhiannon Jones presented the update on the risks and mitigated actions to the Committee. The following points were noted:

DRAFT

	• Some patients had been misdirected through the 111 service, highlighting the inadequate local knowledge of some call handlers. A positive tabletop exercise had taken place with WAST, amending the narrative used by the call handlers. • Site specific action cards had been produced to inform staff of correct pathways if a misdirected patient arrives at an MIU. • The Royal College of Physicians (RCP) report highlighted the concerns of medical staff in minor injury units; providing care to clinically unwell self-presenting patients. The report from Health Education and Improvement in Wales (HEIW) also indicated the use of medical SPR's to care for unwell presenters was inappropriate. The risk to patient care and staffing required action, especially with the possibly of having medical staffing trainees removed from MIU. • The moral injury to staff working in the MIU was flagged as a concern. Staff shared issues around the expectation placed upon them. Meetings had taken place to support staff and provide assurance around their roles, responsibility, accountability and protection in terms of vicarious liability. Further support through staff surveys and People First engagement events, undertaken by the Executive Team, was in place to listen and act on concerns raised by staff. • Staffing numbers had been based on Clinical Futures modelling, however, the actual attendances in the MIU in comparison to predicted data was between 20-50% higher. It was stated that the MIU' were not designed to cope with the numbers currently presenting. • Mitigation to address the MIU issues was discussed. It was flagged that stabilisation rooms had been introduced to allow for virtual contact with the Emergency Physician in Charge (EPIC) at the GUH, thus improving patient care and providing support to the nursing staff in MIU's prior to transfer. • The increase of Transfer Practitioners to a 24/7 service had been approved by the Executive Team, with on-going appointment. • Staffing levels in NHH more widely were flagged as a concern. An ongoing stabilisation group led by the Medical Director was in place. • 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. James Calvert informed the Committee that ongoing issues with WAST triage and patient transfers was a potential risk. Meetings had taken place with WAST and additional meetings with medical staff to pull

DRAFT

	together a Standard Operating Procedure for delayed ambulance transfers had been developed. Paul Deneen requested clarification as to why clear information did not identify GUH as a Critical Care Centre. It was confirmed that there had been significant communication outlining the role of GUH and eLGH's and this continued. **Action:** The Chair requested further information on patient transfers and any challenges to come back to a future meeting. **Rhiannon Jones/James Calvert**
PQSO 2112/08	**External inspections & Reviews: Healthcare Inspectorate Wales (HIW) & the Aneurin Bevan CHC- HIW National Ambulance Review, HIW GUH ED & Assessment Units, CHC 7 Days in Ed, HIW Mental Health St Cadocs and Wales Neonatal Network Peer review** Rhiannon Jones provided an update on the outlined reports, which had been previously circulated to the Committee. The Committee was informed that the HIW Welsh Ambulance Service NHS Trust (WAST) and Health Board review was conducted in April/May 2021. A full report had been received and published and a response submitted by the Health Board. It was noted that there were twelve national recommendations, relevant to ABUHB, outlined in the report. Three areas of ongoing Health Board action were noted as follows: • Patient Flow and the impact on delayed patient handover to be discussed in the Urgent and Emergency Care Update. • Appropriate representation at WAST meetings, including the Serious Clinical Incident Forum. Previously there had been representation from the nursing and Putting Things Right (PTR) teams. The Committee was assured that future meetings would include operational team representation. • Consistent approach in providing timely investigations and treatment for patients waiting for Ambulances. The Committee was informed that the Community Health Council (CHC) had spent seven days in the emergency department at GUH during August 2021. Patient surveys were undertaken, alongside staffing experience discussions and observations. As a result of the report, there had been five recommendations for the Health Board. The Health Board had produced an action plan as a result of the published findings, addressing all recommendations that had been made. The Committee was informed that the outlined report and action plans had been amalgamated to facilitate oversight and to support the operational teams. The Urgent Care Transformation Board

DRAFT

	would be overseeing the reported actions. Regular updates on actions were being provided to HIW and CHC. In September 2021 there was an unannounced inspection undertaken by HIW on wards in the Mental Health Division at St Cadoc's Hospital. As a result of the inspection, three immediate assurances were requested by HIW. The concerns were noted as follows: 1. The segregation of patients in the Psychiatric Intensive Care Unit. 2. Concerns around an individual wound care plan. 3. There was a requirement for a Divisional policy addressing long term segregation. The Committee was advised that an immediate update had been provided to HIW, since which, a full report had been received from HIW stating that they had been assured by the Health Board's actions. The Committee was assured that immediate recommendations one and two were actioned, and the third was in progress and on track to meet the December deadline. Further updates will come back to the Committee as part of the HIW actions and inspection reports. HIW undertook an unannounced visit to the Emergency Department (ED) and assessment units in GUH in November 2021. As a result of the visit, there were four immediate assurances. These were noted as; • Visibility of patients in the ED waiting room area (also flagged in the CHC report). • Infection Control measures in the Covid corridor. • Regular and systematic checking of Resuscitation trolleys (issue previously identified by HIW). • Concerns around workforce experience, based on feedback from the staff surveys and interactions conducted during the visit. The Committee was informed that a response had been provided to HIW and that HIW was assured with the actions taken. The Health Board were awaiting the final report from the HIW visit to GUH. The Neonatal Network peer review took place early 2021. The Divisions submitted a comprehensive self-assessment in response to the review. It was noted that the panel identified several areas of good practice and achievements in the GUH Neonatal Unit. Some areas were identified as areas for improvement, concerns were noted within the report. An action plan had been produced in response to concerns raised. The Committee was assured that actions were being undertaken to address recommendations within the reports. Shelley Bosson queried 'Golden Drops' as outlined in the Neonatal Network Peer Review. Rhiannon Jones agreed to provide an

DRAFT

	explanation outside of the meeting. **Action:** Information to be shared with committee members. **Rhiannon Jones** Louise Wright, Independent Member, requested assurance that recommendations would not be repeated in future inspections, noting that daily checking of the Resuscitation trolleys in ED inspection had been a previous HIW recommendation. Rhiannon Jones assured the Committee that policies and training were in place to ensure these issues were monitored accordingly, but could not give outright assurance they would not reoccur. Helen Sweetland, Independent Member, queried the meaning of the acronym HALO, included in the HIW National Ambulance Review. The Committee was informed that HALO stands for a Hospital Ambulance Liaison Officer. The Health Board has two HALO roles in the Emergency Department; these are ambulance personnel acting as a liaison between the department and patients waiting on ambulances with a delayed handover. The Chair noted the pressures that staff were working within and requested that associated workforce and staff well-being issues highlighted in these reports be considered by the People & Culture Committee. **Action: Secretariat** Rhiannon Jones noted concern in relation to the significant pressure and impact on staff during the external inspections at such a difficult and challenging time with system pressures and the pandemic. These concerns had been raised with the Chief Nursing Officer for Wales. The Committee acknowledged the additional pressure these reviews placed on staff. The Committee received the reports and associated updates provided. The Chair extended her thanks to Rhiannon Jones and respective teams, recognising the work undertaken.
PQSO 2112/09	**Learning From Death Report** James Calvert, Medical Director, presented the previously circulated report which provided assurance in respect of ABUHB's process to review and scrutinise inpatient mortality; and to outline the learning and improvements that are being implemented where required. The Committee noted the introduction of the Independent Medical Examiner (ME), with the aim that all deaths that occur in the ABUHB area will be scrutinised by the ME by summer 2022.

DRAFT

	James Calvert discussed how the Risk Adjusted Mortality Index (RAMI) enabled the Health Board to measure co-morbidity and enabled comparison with other health care settings. The ME referred a quarter of the deaths reviewed back to the Health Board; these deaths were then reviewed by the Mortality Group chaired by Steve Edwards, Deputy Medical Director. The group completes a thematic analysis which is predicted to be impactful over time at improving systems by identifying patterns. The report included patterns that had been flagged by the ME. One item of note was issues around communication. Infection control restrictions due to the pandemic had highlighted the importance of informal contact with patients' families, further supporting the need to strengthen patient advice and liaison services. The Risk Adjusted Re-Admissions Index indicated a deterioration in 2020, which was now showing improvement. The initial deterioration may be attributed to system flow issues. The Committee was assured that a Discharge Improvement Board had been established to improve system flow and standardise processes. In addition, a 'Step up-Step Down' group has been established to ensure processes were followed for inter-site transfers. **Action:** The Chair requested 6 monthly updates for the Committee. **James Calvert/secretariat** James Calvert highlighted the good progress made by Peter Carr, Director of Therapies and Health Science, and respective teams in relation to the reduction in numbers of patient falls when in hospital. The Committee received the report and noted the findings as outlined within.
PQSO 2112/10	**Cleaning Standards Report- performance against standards** Leanne Watkins, Interim Director of Operations, supported by Gareth Hughes, Divisional Director of Facilities, presented the previously circulated paper which provided an update in respect of Enhanced Cleaning Standards. Leanne Watkins informed the Committee that a paper had been presented to the Executive Team in September 2021, during which, an agreement was made to appoint additional staff to support delivery against the All-Wales Cleaning Standards. Delivery of the standards was a joint effort with Facilities, Infection Prevention and Control

DRAFT

	(IPAC) and Nursing teams. The current challenges with recruitment into facilities roles was identified. Gareth Hughes reported that since the opening of GUH and with the enhanced cleaning requirements, extra facilities posts had been required. The funding agreed at Executive Team had enabled the use of a mix of fixed term and agency staff. It was stated the agreed funding was not recurrent, foreseeing possible challenges. It was noted that recruitment was moving at pace. Flexibility of current teams allowed cover of risk-based cleaning requirements, by providing transport for staff to move around sites as required. The Committee was assured that the Division are addressing recruitment and strengthening staff retention. Gareth Hughes reported that, as a result of an audit completed by the Compliance and Health Safety Teams, collaborative work was being undertaken alongside NHS Wales Shared Services Partnership (NWSSP) Welsh Government (WG) to explore further National Cleaning Standards. The Chair requested assurance of continued training and quality. Gareth Hughes assured the Committee that an electronic system, called Simbiotic, produced live data on audit and performance, enabling robust audit and assessment of compliance. If an audit flagged a training issue, this could be rectified with staff training within 24-48 hours. Alongside this, each zone had a supervisor overseeing all facilities staff, further facilitating coordination. Gareth Hughes invited Independent members to participate in 'walk arounds' at a date deemed safe to do so. Shelley Bosson requested assurance around current cleaning compliance. Gareth Hughes reported that standards were not being met in totality, however based on risk, the Health Board was delivering in high-risk areas. Latest guidance from WG had changed cleaning standards and the teams were working on amending the audit process to reflect this. The Committee requested an update on compliance at the next meeting. **Action:** A detailed report on the organisational compliance to cleaning standards will be presented to the next committee. **Leanne Watkins** The Committee received and noted the information and update contained within the paper. The Committee was assured that the Health Board were using all avenues of recruitment to address current staffing issues and managing risk accordingly. The Committee highlighted the important role that facilities staff play in the Health

DRAFT

	Board and expressed appreciation to the staff in facilities for their hard work.
3	**For Consideration**
PQSO 2112/11	**Update of QPSOG** Peter Carr, Director of Therapies and Health Science presented the previously circulated paper. Paul Deneen, Independent Member, requested assurance on the mitigation of the ongoing risk of children being admitted to adult acute Mental Health Units and requested the numbers of children and young adults this affected. Peter Carr reported that this was an ongoing risk and there was no improved position at the time of the meeting. The Committee was assured that this had been escalated to the Executive Team and that part of the redesign work at GUH was looking at adequate space for young people when arriving at the hospital. Rhiannon Jones stated that, although the numbers of patients were small, it was having an adverse impact on children and young people's experience. **Action:** The Chair requested further updates to come back to the Committee. **Leanne Watkins**
PQSO 2112/12	**Quality and Safety Outcomes Report** Rhiannon Jones, Director of Nursing, presented a previously circulated report which highlighted the current position against a range of key quality indicators, identified emerging themes, areas of concern and mitigation as well as good practice. The following key issues were noted: • An improved position of falls, at the lowest level in the last two years at 5 per 1000 bed days. • Infection Prevention and Control remains at red rag rating- noting that ABUHB is performing the best in Wales in 4/6 targets. • The stroke position remained a concern. • Urgent and Emergency care remained a significant risk due to demand and capacity pressures. Associated with Infection, Prevention and Control the following was discussed: • Current low levels of Flu and RSV were noted. A revised plan for Flu immunisations had been agreed by the Executive Team, utilising the Local Options Framework. • There had been a gradual increase in COVID presentations and nosocomial transmission. Independent Members were due to be briefed on COVID outside of the meeting. The Committee was

DRAFT

	assured that all patient deaths associated with nosocomial outbreaks received a full root cause analysis. The COVID Implementation Plan had been updated to include further changes to national IPAC guidance. The Omicron variant and current isolation guidelines were noted as a risk and possibly detrimental in terms of staffing. • Clostridium Difficile was improving but remained a concern. • HPV cleaning had been maintained but proved challenging due to demand and capacity pressures. IPAC teams had met with Divisions to address issues and develop improvement plans. The Committee noted that Deb Jackson would be replacing Liz Walters as Infection Control Lead. A Meaningful Activities pilot had been undertaken in Ysbyty Aneurin Bevan. A full report would be rolled out throughout the Health Board. It was noted as a positive pilot with a good outcome for patients. Rhiannon Jones noted significant pressures within the Putting Things Right Corporate team due to staff sickness, which was in turn impacting performance. Actions were being undertaken to address departmental issues. The new Datix system had been implemented across Wales. Comparative data indicated an increase of complaints, with two main themes noted as communication and waiting times for treatment. A 'Test of Change' had been approved by the Executive Team around the management of complaints. Investigating Officers would be employed to process low level complaints. There had been two Never Events during October and November 2021. Actions were being taken to address these. An anonymous concern had been made to HIW in relation to theatre safety. A response had been sent to HIW and a response from HIW was awaited. Peter Car provided an update on the Stroke pathway and mitigations. An updated action plan addressing challenges had been reported to the Executive Team. A new effective Triage Criteria had been implemented in the ED. Since the opening of GUH and the implementation of the ideal model, the Health Board had a dedicated Stroke facility. An updated escalation plan for Stroke capacity had been completed providing a framework for staff around demand and capacity for the Hyper Acute Stroke facility. It was stated that the under performance around stroke therapies was as a direct impact of the loss of the Therapies Assessment room. The Health Board did intend to reinstate the Therapies Assessment room. Demand and capacity work had been undertaken, with support of the corporate planning team, to determine if current capacity matched demand. Peter Carr stated that an external review had been commissioned across all therapy services, resulting in recommendations. The findings

	would be aligned with work undertaken in 2022 with 'Getting Things Right First Time' to produce a strategic plan for Stroke services. It was noted that HIW were completing a review of Stroke services and pathways across Wales and the recommendations would feed into the Health Boards action plan. The Committee was assured that a Stroke Delivery Group, reporting to the Executive Team, was providing oversight of the actions outlined. Shelley Bosson requested that the outcomes report be mapped to the priorities in the Annual Plan. **Action:** Future reports to cross reference the Annual Plan and IMTP. **Rhiannon Jones** The Committee received and noted the report and thanked teams for the work underway.
PQSO 2112/13	**WCCIS Implementation** Janice Jenkins, Interim Assistant Director of Digital Programmes, presented a previously circulated paper which provided an update on the risk exposure for the Health Board due to the postponement of the implementation of WCCIS for MH&LD services. The Committee was assured that the Health Board was pursuing urgent discussions with EMIS to establish extended support arrangements post March 2022. WCCIS performance had stabilised and there was a possibility of a rescheduled WCCIS 'go live' date of March 2022. Further discussions would take place at the Strategy, Planning, Partnerships and Well-being Group (SPPWBG). **Action:** The Chair requested an update be provided to the SPPWBG. **Nicola Prygodzicz/secretariat** 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. **Action:** Draft report to be shared with Independent Members once published. **Rani Mallison**
4	**Items for Quality Assurance- for information**
PQSO 2112/14	**Highlight Reports:** The Committee noted the following reports: • **Safeguarding Committee** A Child practice review was reported, highlighting lessons learned for multiple agencies. The Outcomes Report flagged low compliance with level 2 training, a particular concern of note was Children's Safeguarding training. Divisions were looking at ways to improve this shortfall in safeguarding compliance. Children's

DRAFT

	services remained a protected service in terms of redeployment. The Chair requested assurance that this was flagged as a risk. The Committee were assured that low training compliance is on the Corporate Risk Register, and that direct engagement from the Divisions had seen positive improvements in compliance from some teams. • **Urgent Care Transformation Board** The Committee received the report for information.
5	**Items for Board Consideration**
PQSO 2112/15	**Strategic Risk Report (Key Risks)** Rani Mallison noted that further work was underway on presentation of risks and how these risks should influence the Board and Committee agendas. **Action:** Update on risk management approach to be provided at the next meeting. **Rani Mallison** **Confirm Key Risks and items for Board Consideration** None Noted.
6	**Date of Next Meeting is Tuesday 8th February 2021 at 09:30 via Microsoft Teams**

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Agenda Item: 1.5

Patient Quality, Safety & Outcomes Committee

Action Log - February 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	Not yet due

Action Ref	Action Description	Due	Lead	Progress	Status
				ensuring the delivery of Strategic Objectives.	
1506/07	**Assurance Process for Complex Care and CHC** An update be scheduled for a future Committee to report on the outcomes of the Brithdir reflection sessions with ABUHB, CCBC & CIW	Closed	**Rhiannon Jones/ Secretariat**	**21.01.22** update from Rhiannon Jones. The families have confirmed they no longer wish to meet with ABUHB, WG, CCBC & CIW. The national reflection is therefore closed.	Complete
0109/11	**Medical Devices** Peter Carr, agreed to circulate the detailed action plan with members	Closed	**Peter Carr**	Action Plan has been circulated to the Medical Devices Committee for ratification. Once approved this will be provided to PQSOC. Circulated with members 31/01/2022	Complete
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

Action Ref	Action Description	Due	Lead	Progress	Status
	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	**Safeguarding Annual Report 2020/2021** **Shelley Bosson requested the following be added as an action (original action PQSOC 1910/09)** Rhiannon Jones advised that a Senior Nurse for Safeguarding Education had been appointed and would be making direct contact with teams reporting low compliance. Rhiannon Jones would link with the Board Secretary to arrange bespoke training for Board members that did not attend the focussed Development session.		**Rhiannon Jones/** **Rani Mallison**	**21/12/21** Rhiannon Jones informed the Committee that a full review of training was being undertaken, and this would come back to the Committee at a later date. **21/1/22** Update from Rhiannon Jones: Safeguarding has been added to the Board Development Programme for 2022/23.	Complete

Action Ref	Action Description	Due	Lead	Progress	Status
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 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**	**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.	In progress

Action Ref	Action Description	Due	Lead	Progress	Status
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.	Not yet due
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	Due
2112/12	**Quality and Safety Outcomes Report**		**Rhiannon Jones**	**21/1/22** Update received from Rhiannon Jones: The report will include HCS and IMTP going forward.	Complete

Action Ref	Action Description	Due	Lead	Progress	Status
	Shelley Bosson requested that the outcomes report be mapped to the priorities in the Annual Plan. Future reports to cross reference the Annual Plan and IMTP.				
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.	Not yet due
2112/15	**Strategic Risk Report (Key Risks)** Rani Mallison noted that further work was underway on presentation of risks and how these risks should influence the Board and	08/02/2022	**Rani Mallison**	Committee risk report included as a standing agenda item. Report included on the agenda for Committee meeting 08/02/22.	Complete

Action Ref	Action Description	Due	Lead	Progress	Status
	Committee agendas. Update on risk management approach to be provided at the next meeting.				

PATIENT QUALITY, SAFETY & OUTCOMES COMMITTEE

An Overview of Covid-19

Executive Summary

In discussion with the Chair of PQSOC it was agreed for the Committee to receive an update on the impact and management of Covid-19, specifically Omicron, in the context of Winter pressures.

Omicron is a variant of SARS-COV-2 first reported to the World Health Organisation by South Africa on the 24th November 2021. It has subsequently become a dominant strain with recognition of its highly transmissible nature but with disease impact of less severity. This variant transversed the world in the space of a month.

Research is continuing world-wide to greater understand Omicron to include the performance of vaccines, effectiveness of treatments, mutational impact and viral behaviour.

The advice regarding Omicron is consistent with other strains in that physical distancing, hand hygiene, environmental cleanliness, ventilation, mask wearing and PPE together with vaccination are the key factors for reducing spread and impact.

Hundreds of thousands of cases of the Omicron variant of Coronavirus have been detected in the UK and whilst there has been a rise in the number of people in hospital with Covid-19 the severity of illness is less, undoubtedly impacted by high rates of vaccination. Nonetheless, the sheer volume of people testing positive is forcing huge numbers to isolate, presenting significant risks for service provision.

This report outlines 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 Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	X
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	
Executive Sponsor: Rhiannon Jones, Executive Director of Nursing	
Report Author: Moira Bevan, Head of Infection Prevention & Control	
Date of the Report: 27th January 2022	
Supplementary Papers Attached: Nil	

Purpose of the Report

To provide an overview of Covid-19 specifically the Omicron variant and its impact on patients, staff and Health Board services for assurance purposes.

Context

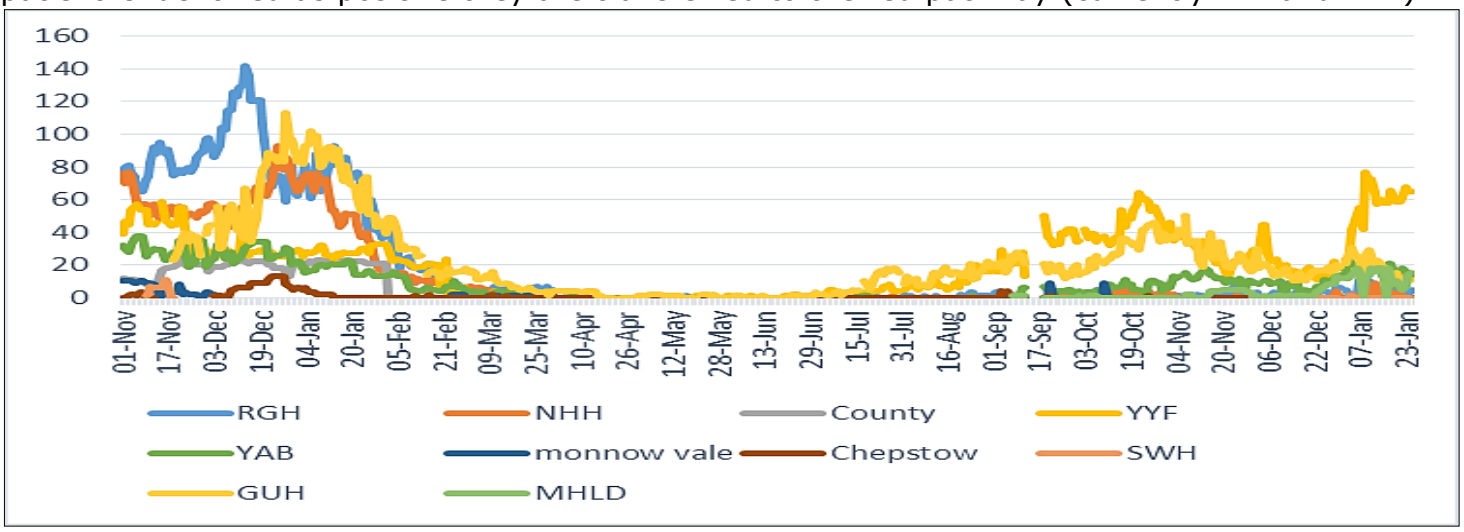
Covid-19 continues to have significant impact across the footprint of Gwent with community spread, hospital acquisition and high staff isolation and absence rates. That said, it has been reported by Welsh Government that the peak has now occurred in Wales, based on positivity and infection rates and the national Alert level has now decreased to Level 0.

Assessment

Inpatient Covid Rates

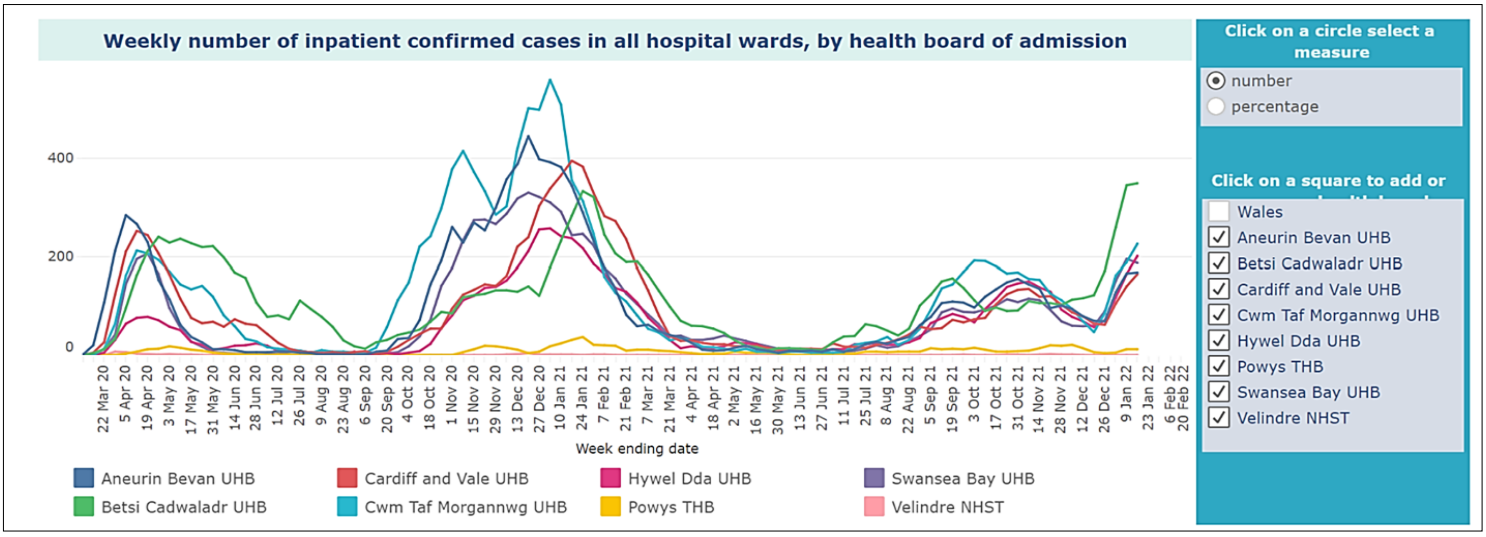
Throughout December 2021 and January 2022, the number of patients with Covid has increased. The inpatient Covid positive figures include those presenting with Covid and those being confirmed as positive through in-patient testing (asymptomatic).

The following graph shows the positive patients by hospital site up to 23rd January 2022. When a patient is identified as positive they are transferred to the red pathway (currently YYF and YAB).



The next graph shows the number of patients confirmed positive by Health Boards, across Wales. The numbers are as a proportion of total inpatients, up to mi-January, with an uptick noted from December 2021 across all Health Boards, excluding Powys.

It can be seen that the majority of Health Boards are following a similar trajectory.



The pressure on Critical Care services observed in the first and second wave of Covid has not been observed during this Omicron wave. This is likely to be the impact of the Covid Vaccination Programme, and uptake within the general population.

The following graphs show ITU admissions across the UK together with a picture of the vaccination status. The graphs are produced by the Intensive Care National Audit and Research Centre (ICNARC).

National ITU Covid admissions since June 2020

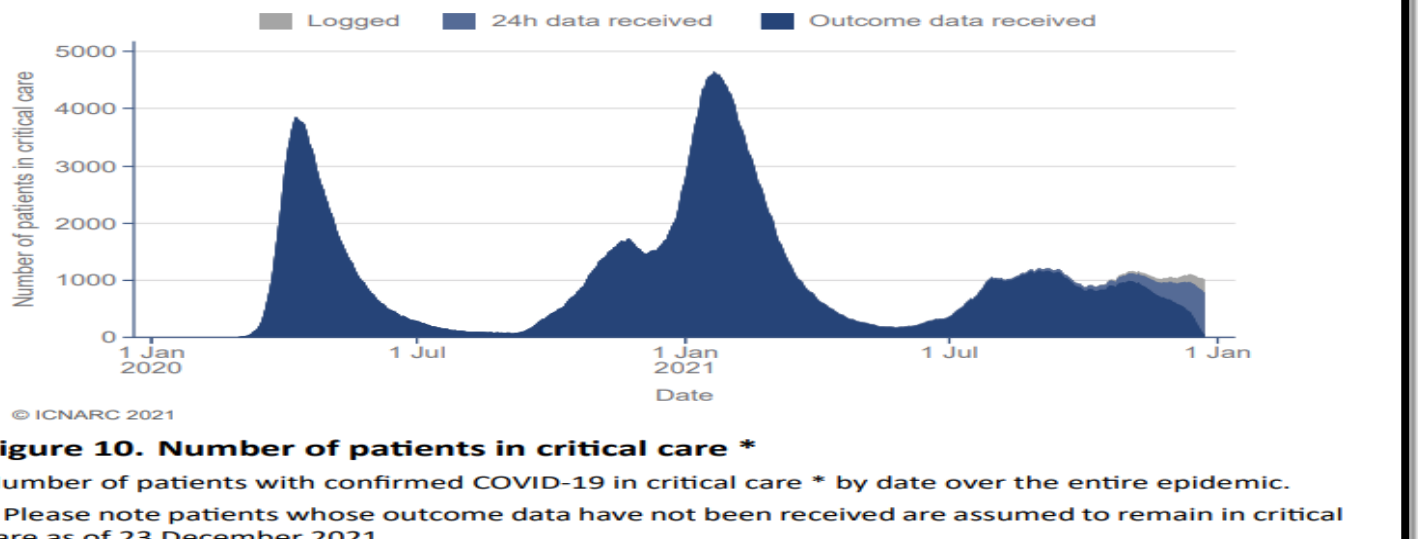


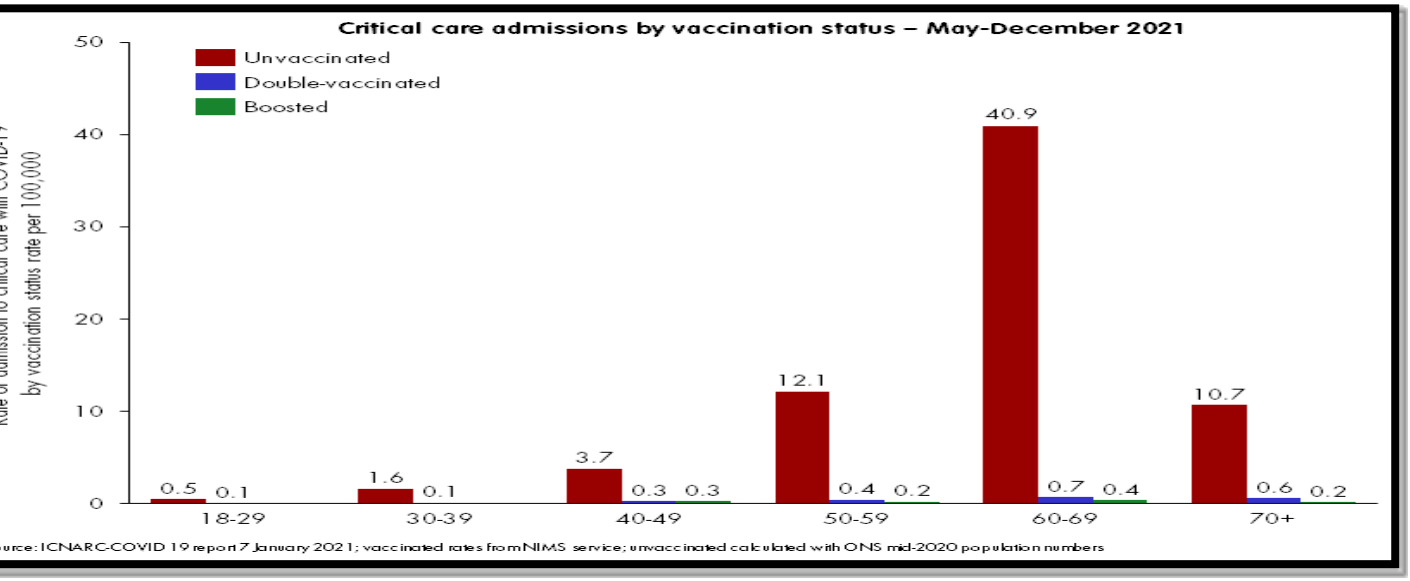
Figure 10. Number of patients in critical care *

Number of patients with confirmed COVID-19 in critical care * by date over the entire epidemic.

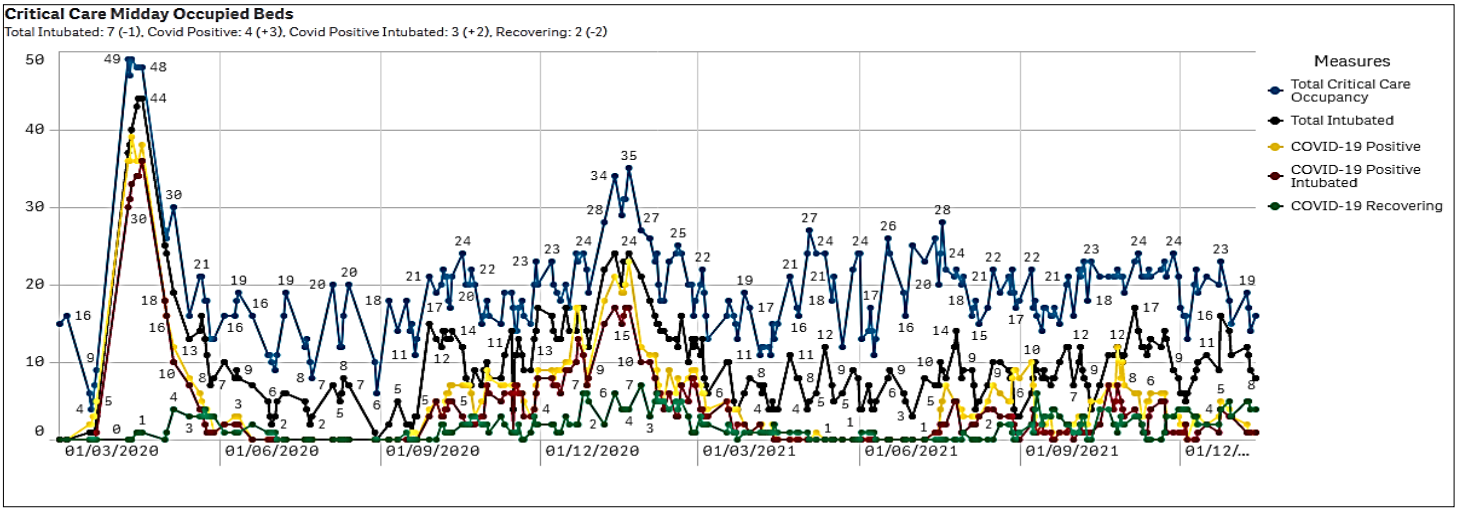
* Please note patients whose outcome data have not been received are assumed to remain in critical care as of 23 December 2021.

ICNARC critical Care admissions by age and vaccination status

This graph illustrates the higher number of patients in ITU are in the unvaccinated group, with 60-69 age group the greatest.



The following graph depicts the picture for ABUHB, from the start of the pandemic to January 2022. The numbers for the Omicron surge are lower than previous waves with the commissioned bed-base maintained since Summer 2021. It can be seen the numbers of Covid-positive patients are low for December 2021 (and continue to be so).

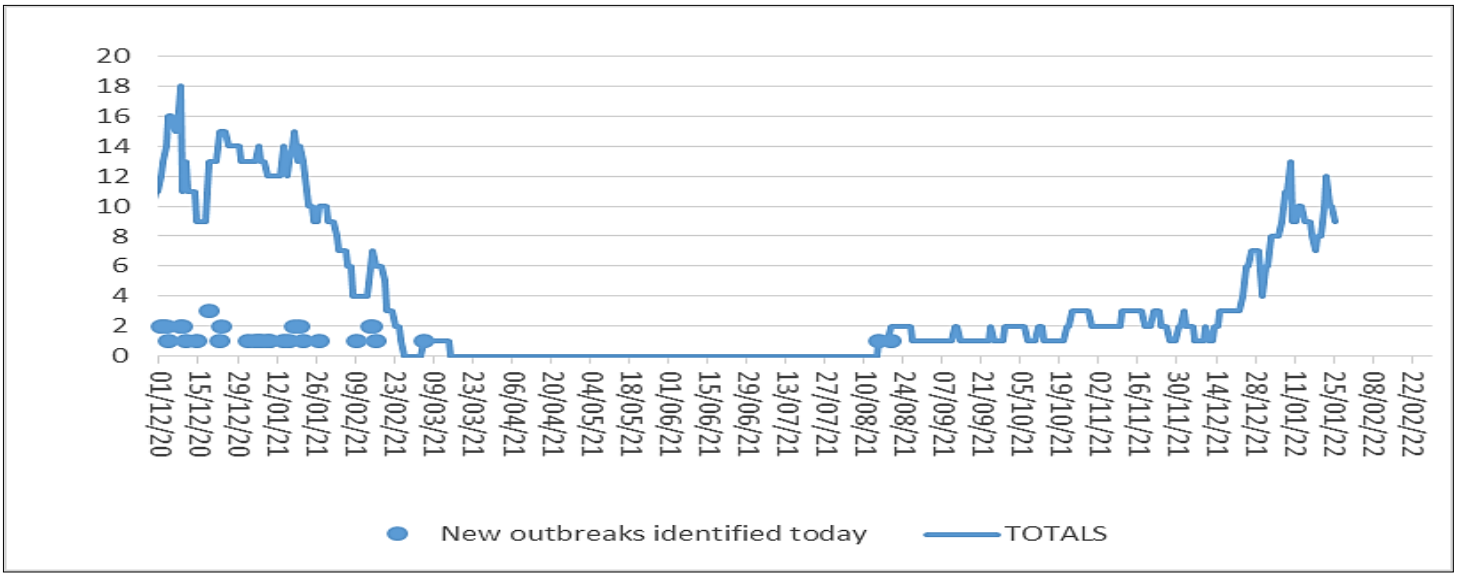


Covid Outbreaks

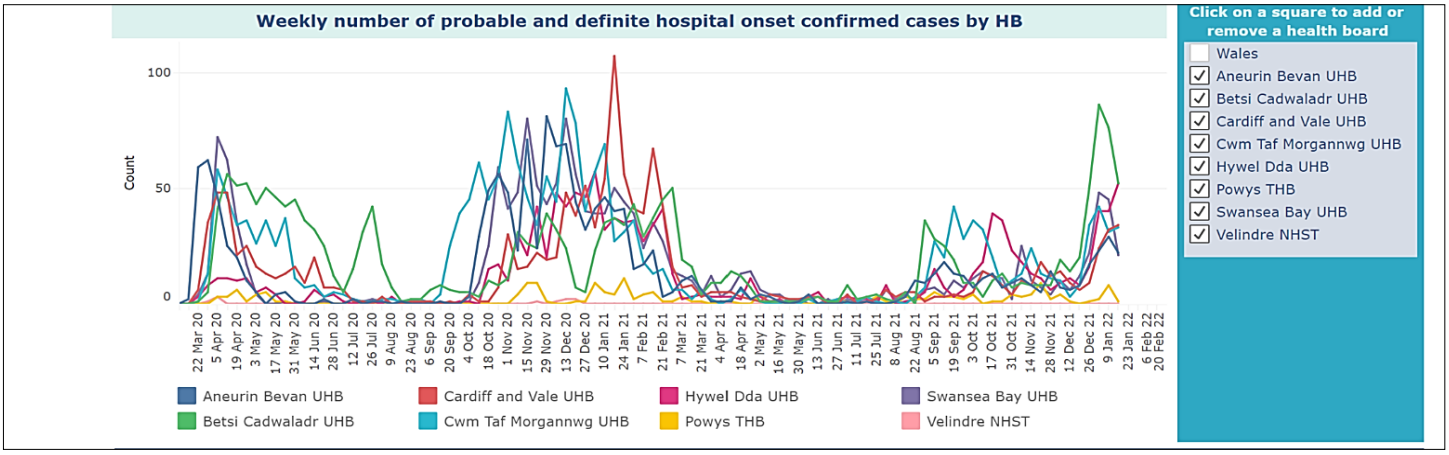
An outbreak, as defined by Public Health Wales, is 2 or more cases occurring in the same ward environment within a specific time period and is a notifiable incident. High community transmission is inextricably linked to hospital acquired cases. During the Omicron surge, hospitals have been experiencing increasing numbers of incidental cases. (Incidental cases are where patients test positive through routine screening whilst being treated for another ailment or medical condition).

For each outbreak, there is a robust process followed in terms of management, as set out in the outbreak management plan. This includes a root cause analysis to try and ascertain cause of acquisition and spread. For the majority of the declared outbreaks, asymptomatic carriers have been identified mostly through routine testing. There are some specific challenges in the eLGHs and Community Hospitals associated with aged estate, limited cubicles and ventilation.

The below graph shows the number of wards declared in outbreak mode from the beginning of December 2020 to mid-January 2022. Outbreaks have been declared in RGH, NHH and YYF with RGH the most significantly impacted. It shows a peak of 13 outbreaks mid-January which is impacting on the flow of patients due to ward closures.



The next graph shows ABUHB's probable and definite hospital onset Covid. 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 is 1% of all Covid infections across Wales with similar rates noted for all Health Boards in Wales.



Mental Health Services

There have been a number of outbreaks across Mental Health services presenting operational challenges, including the implication of isolating positive patients whilst optimising their Mental Health care, in addition patients have had to be cared for out of area to manage ward closures. To mitigate the risk of Covid infection, all patients admitted to acute adult mental health services were admitted to a single receiving area where they remained for 5 days when they were retested and then transferred to another clinical area for the remaining period of their admission. The "Patient Leave" policy was reviewed to minimise the risk of community exposure and onward transmission of Covid.

ELGHs

The number of wards impacted has undoubtedly affected patient flow with varying numbers of beds lost due to ward closures. The IPC team, together with microbiology, provide advice and guidance on management, considering whole system risk. In some instances, patient experience has been impacted by multiple transfers to ensure they are cared for on the appropriate Covid pathway. Occasionally, this has resulted in patients being cared for in a different speciality to their initial clinical presentation. This inevitably impacts on their experience, their speciality treatment and length of stay.

Pragmatic decision making has been implemented for Mental Health and acute services to mitigate risks to patient experience and inpatient capacity. These have included reducing the ward closure time, from the date of the last identified case, from 14 to 10 days (which is now national guidance).

Outbreak investigations have identified, in the majority, the index case has been an asymptomatic individual. In order to mitigate this risk, all inpatients are PCR tested every 5 days and all staff are requested to undertake a pre shift LFD test every day. This strategy has meant increased identification of asymptomatic patients and staff and has therefore led to increased outbreak reporting. The early identification of these outbreaks has meant that measures, including daily LFD tests, are started earlier reducing further transmission and enabling earlier re-opening of wards. To note at the end of January revised guidance has been received regarding changes to daily LFT testing for staff.

Despite pressures and operational challenges the Health Board is only managing 2 complaints that are Covid-associated currently.

Care Homes

There has been a significant increase in the number of care homes either in Covid incident (where a resident or a member of staff have tested positive) or in outbreak (where multiple residents and staff test positive) across Gwent. The following graph is an example of the reporting used for Care Homes, indicating staff and residents affected. The care home position impacts on patient flow as transfers and admission may be reduced if a home is in outbreak mode. This has a direct impact on hospital length of stay.

Care Home status report a snapshot (January 2022)

Local Authority	Status	No of Staff affected	No of residents affected
Blaenau Gwent	Outbreak = 7	30	21
	Incident = 4	9	0
Caerphilly	Outbreak = 9	92	38
	Incident = 9	35	1
Monmouthshire	Outbreak = 8	60	30
	Incident = 8	20	12
Newport	Outbreak = 13	137	48
	Incident = 6	14	1
Torfaen	Outbreak = 9	82	86
	Incident = 6	15	5

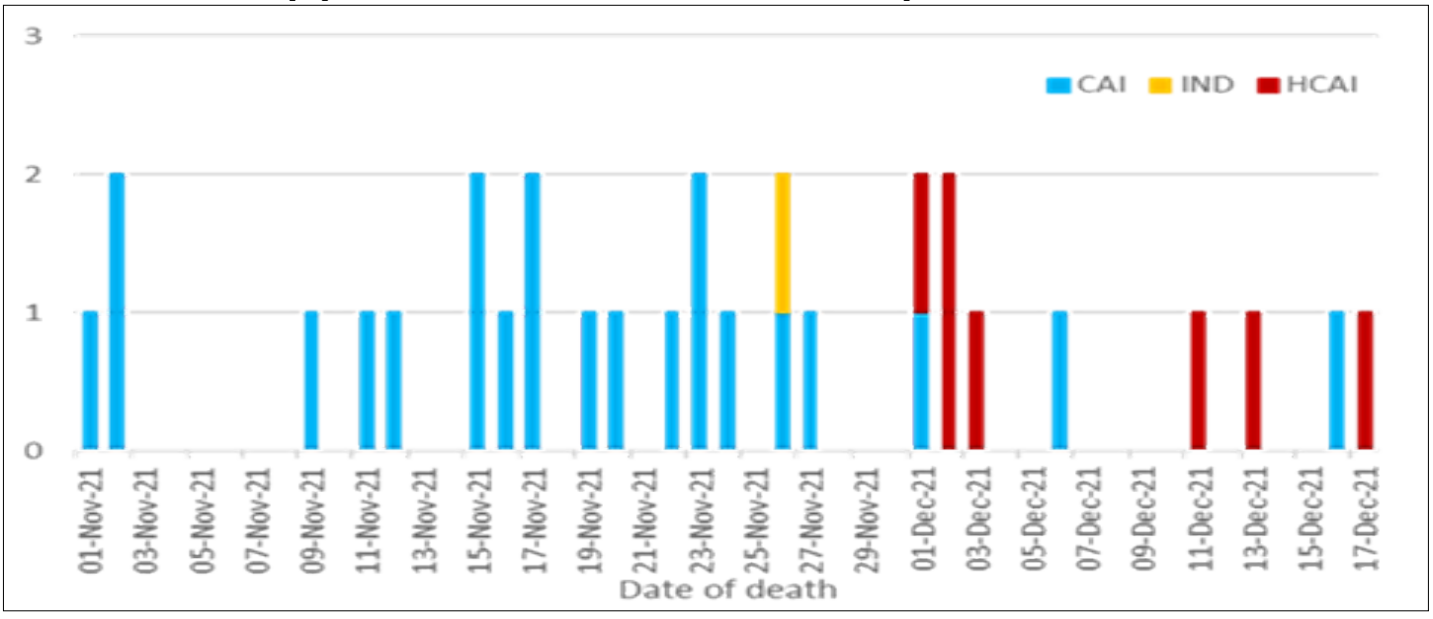
Covid-19 Mortality

From November to December 2021, there have been 30 inpatient deaths within 28 days of testing positive from Covid. 22 deaths have been associated with community acquired onset, where the patient was admitted with Covid. 7 deaths were as a result of probable or definite hospital onset and one death was indeterminate.

All inpatient deaths in RGH YYF and GUH are subject to independent scrutiny from the Medical Examiner. Any deaths that are assessed as probable or definite hospital onset are referred back to the Health Board to further consider. Reviews have been undertaken using the national audit tool to understand where the patient acquired the infection and if there were any modifiable risks. Causes of outbreaks within ABUHB have included exposure to asymptomatic carriers, sharing communal facilities, aged estate, limited cubicles and inadequate ventilation. As a result of these investigations a number of actions have been undertaken including: -

- Ventilation of inpatient areas at NHH and RGH has been reviewed by an external company and a report is pending.
- Enhanced cleaning requirement have been published by Public Health Wales. These have been reviewed and the facilities directorate has provided assurance that current processes are compliant with the recommendations. The facilities team are undertaking regular environmental audits.

Covid-19 Mortality (November 2021 → December 2021)



Up until the beginning of December 2021 there were no hospital acquired cases, which aligns to the start of the Omicron impact.

National Guidance

There have been multiple changes to national guidance from December 2021 to January 2022, to include:-

- Infection Prevention and Control seasonal respiratory infection
- Testing of healthcare workers
- International travel
- Health and Social Care Workers
- Self-isolation
- Omicron briefing
- Personal Protective Equipment for Social Care
- Reduction to isolation days for exposure and outbreak
- Discharge service for Care Homes

Key changes include:-

1. The importance of a risk assessment linked to the Hierarchy of Controls, to further support organisations/services to maximise workplace risk mitigation.
2. A recommendation for universal use of face masks for staff and face masks/ coverings for all patients/visitors to remain as an IPC measure within health and care settings over the winter period.
3. A recommendation that physical distancing should be at least 1 metre, increasing whenever feasible to 2 metres across all health and care settings and physical distancing should remain at 2 metres where patients are suspected or have confirmed respiratory infection.

In addition, Welsh Government have advised discontinuation of a low, medium and high pathway approach, but ABUHB are continuing with pathways currently due to:-

- The risk of onward Covid transmission
- Protecting the elective surgical pathway due to other non-Covid-19 harm.

In terms of hospital visiting, restrictions remain in place due to the number of outbreaks and rates of community transmission. This is being closely monitored in line with national alert levels and the local infection position. Restricted visiting has a natural impact on patients and relatives but it is currently important to minimise hospital footfall and risk of transmission of Covid.

There have been a number of changes to testing, namely:-

- From the 17 December 2021 Welsh Government guidance for all public-facing health and social care staff changed from twice weekly LFT testing to a recommendation that LFTs should be taken each day staff attend for work.

- From 31 December 2021 changes were made to the regulations and guidance in Wales for the self-isolation of positive cases for the general public. Those who test positive should now isolate for 7 days and should take LFTs on day 6 & 7 of their isolation. Isolation should continue if either test is positive. This has been incorporated into the ABUHB staff risk assessment.

- Staff returning from international travel no longer require additional testing requirements for health and social care staff above that of the general public. This has been reflected in the ABUHB staff risk assessment.

- The required isolation period for Covid cases in hospital settings can be reduced from 14 days to 10 days in most situations, subject to a local risk assessment.

Local Options Framework

In enabling Health Board and Trusts in Wales to balance activity for emergency and elective care with the challenges of Coronavirus, Welsh Government introduced a Local Options Framework. This presents flexibility in the system to make adjustments based on demand and capacity and pause services dependent on a risk and impact assessment. The Health Board reports to Welsh Government weekly on any decisions made.

Based on the direct impact of Covid on staffing levels, a number of decisions have been made by the Executive Team using the Local Options Framework, to include:

- Temporary closure of Midwifery-led Units and Home Births and centralisation of services at GUH for 2 weeks.
- Temporary suspension of some orthopaedic elective services, enabling deployment of clinicians to essentials services.
- Temporary suspension of some OPD services, enabling deployment of clinicians to essential services.
- Rationalisation of Primary Care Mental Health Services, with staff deployment to support significantly challenged in-patient services.

Conclusion
Covid-19 continues to have significant impact on Health Board services with direct and indirect effect on patients, staff and public. The Health Board is utilising national guidance with monitoring of the Covid Implementation Plan via the Reducing Nosocomial Transmission Group and oversight via Executive Team.

Recommendation
The PQSOC is asked to NOTE the report and RECEIVE the update for assurance purposes.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Covid-19 has significant risk to patient/staff and HB safety, the infection prevention guidance advocates within the hierarchy of controls, a risk assessment approach in the management of suspected or confirmed Covid-19 cases.
Financial Assessment, including Value for Money	Direct of indirect impact on finance.
Quality, Safety and Patient Experience Assessment	Healthcare associated infection has an impact on patient experience and this is discussed via Divisional Quality and Patient Safety forums. Learning is shared within the RNTG.
Equality and Diversity Impact Assessment (including child impact assessment)	Equality Impact Assessments are considered in all environmental assessment and action plans.
Health and Care Standards	2.4 promoting infection prevention must be everyone business and part of everyday holistic healthcare
Link to Integrated Medium Term Plan/Corporate Objectives	The reduction of healthcare acquired infection is incorporated into the Annual Plan and so aligns to all priorities (1-5)

The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** The winter planning strategy incorporates the covid-19 plan to balance the associated risks.
	Integration – The HB has implemented national guidance for the management of Covid-19 across the HB. Guidance is reviewed regularly and shared with key partners.
	Involvement – Multidisciplinary representative at RNTG from across the HB enabling open and transparent discussions
	Collaboration – The Covid-19 agenda is featured within all the Divisions, with the overarching aim working together to promote best practice and implement HB polices.
	Prevention – The HB has developed and endorsed guidance and standard operating procedures based on national policies
Glossary of New Terms	
Public Interest	Information within the paper is reflective of National reporting available via Public Health Wales webpage

Patient Quality, Safety and Outcomes Report

Executive Summary

- As agreed with the Chair of PQSOC the performance report has been scaled back to focus on risk areas, taking a proportionate approach to reporting in recognition of the significant pressures across the UHB. The two areas of main focus being stroke and urgent care for this reporting period.
- Inpatient falls are 6.6 per 1000 bed days, so remain at a positive state.
- ABUHB has declared compliance with 5 patient safety solutions in the past 2 months
- There are continued pressures on the urgent care system with variable performance against national targets
- There is ongoing improvement work for stroke services with 87% of patients assessed by a consultant within 24 hours

Quality & Patient Safety Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	X
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: 28 January 2022	
Supplementary Papers Attached: Nil	

Purpose of the Report

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

The key reporting areas have also been mapped to the Annual Plan as requested in December 2021 by members of the PQSOC aligned to the priorities of:

- Every child has the best start in Life
- Getting it right for children and young adults
- Adults in Gwent live healthily and age well
- Older adults are supported to live independently and age well
- Dying well as a part of life

Background and Context

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

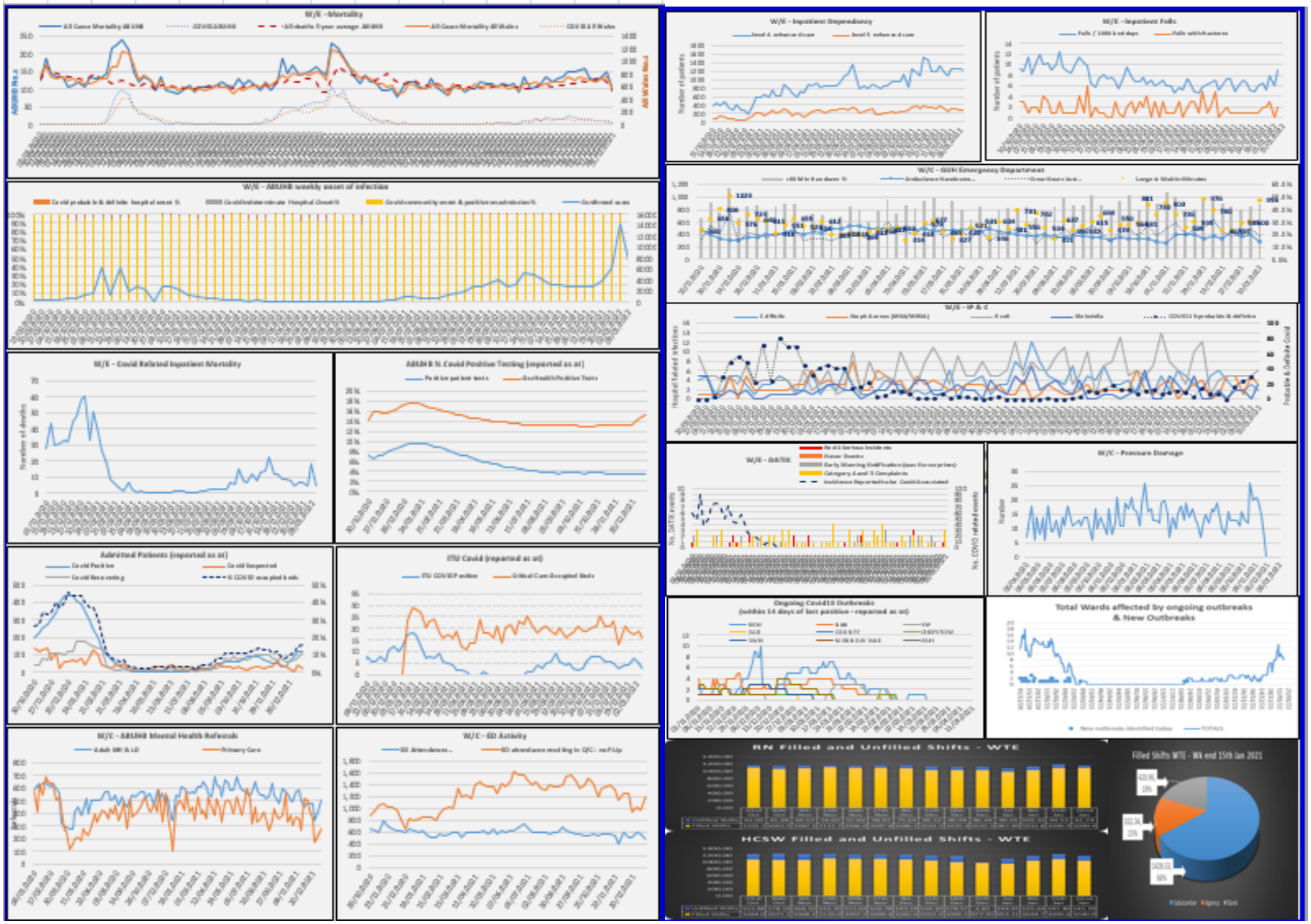
The following is an 'at a glance' Red, Amber, Green (RAG) rated summary of key metrics that are regularly monitored, some of which (and notably the 'red' rated areas) are included within this report, providing an overview of the Health Board position for this reporting period.

Assessment and Conclusion

Leadership and Governance

To support a prudent and effective response to the increased winter pressures and further wave of Covid, specifically the Omicron variant of concern, all non-essential meetings have been postponed or cancelled.

The normal monitoring of the harms from Covid has continued to support governance and assurance. A briefing continues to be provided to the Executive Team weekly. A snapshot of the Covid Dashboard is provided for assurance that this robust diverse process remains in place.


W/E - Mortality
W/E - ABUHB weekly assen of infection
W/E - Covid Related Inpatient Mortality
ABUHB % 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 Dependency
W/E - Inpatient Falls
W/C - GGH Emergency Department
W/E - IP & C
W/E - DATIX
W/C - Pressure Damage
Ongoing Covid19 Outbreaks
(within 14 days of last positive - reported as at)
Total Wards affected by ongoing outbreaks
& New Outbreaks
RN Filled and Unfilled Shifts - WTE
HCSW Filled and Unfilled Shifts - WTE
Filled Shifts WTE - Wk end 15th Jan 2023

Staying Healthy. Annual Plan Priorities : 2,3,4

The principle of staying healthy is to ensure that people in Wales are well informed to manage their own health and wellbeing. Organisations and people in Wales will work together to protect and improve health and wellbeing and reduce health inequalities. People will be empowered to make decisions about their own health, behaviour and wellbeing that impact positively throughout their lives.

Covid Vaccination Programme Standard 1.1 Health Promotion, Protection and Improvement

Mass Vaccination Programme

Up to 12 January 2022, 471,768 first doses and 445,835 second doses, 12,323 third doses of Covid-19 vaccinations had been given across the Health Board area, through a blend of mass vaccination centres, GP practices and mobile team delivery. In addition to this, 345,208 residents in Gwent have received their booster dose. 89.3% of over 80's, 89.8% of those aged 75-79, 89.6% of 70-74 years, and 86.3% of over 50s have received their booster.

The Health Board currently has four Mass Vaccination Centres in operation. The opening hours for the mass vaccination centres are available to view on the Health Board's website. Through a combination of Mass Vaccination Centres, GP Surgeries, Mobile Vaccination Teams, and pharmacies administering vaccinations, since the Programme's rollout, the successful delivery of this ambitious Vaccination Programme is testament to the hard work and dedication of all staff, including the invaluable support received from the Local Authorities, Leisure Trusts, the Military, redeployed healthcare staff, volunteers, nursing students and Gwent Police.

Safe Care Annual Plan Priorities: 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.

Once for Wales Concerns Management System (Standard 2.1 Managing Risk and Promoting Health and Safety)

The Committee are aware of the introduction of a new system known as RLDatix 'Once for Wales Concerns Management System' (OfWCMS) currently being implemented across NHS Wales.

Within the Health Board the following modules have been implemented successfully to date:

- Claims
- Redress
- Feedback, including complaints
- Incidents

The incident module was implemented on 1 December 2021 and within the first month a total of 2,104 incidents were reported. The monthly average reported from January to November 2021 was 2,300 incidents.

There is positive engagement across the organisation to develop sustainable processes to manage incident records, to ensure quality and learning.

The Health Board OfWCMS Project Group is engaging with Divisions to support the cleansing of records within the Datix Web system (Old Datix) with a plan being considered to migrate records from the old Datix system to the new platform. This is being led by the Corporate Health and Safety Department, who operationally manage the system.

The above update is to purely provide to PQSOC with a situation summary progress and confirm the organisational approach.

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

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

The Health Board has declared compliance with the following Patient Safety Alerts and Notices in the past 2 months, as required:

PSN060 Reducing the risk of inadvertent administration of oral medication by the wrong route.

Errors involving the administration of medication by the incorrect route can result in serious patient harm including death. Between 2013 and 2018, 14,149 medication errors involving the wrong route were reported to the National Reporting and Learning System across the UK with an annual increase in the number of these errors noted. Approximately 12% of errors involving the wrong route of administration resulted in patient harm.

In response to the PSN a review of procured enteral syringes has been undertaken to confirm that the devices are compliant with PSN060. All Divisions have provided assurance that these syringes are routinely used for oral medications and that medications administered by different routes are stored separately. Audit is ongoing to ensure sustained compliance.

Patients who are self-administering medications using oral syringes are provided with specific devices for the administration of each drug with information on the safe use of each device.

PSN059 Eliminating the risk of inadvertent connection to medical air via a flowmeter.

Air flowmeters attached to piped medical air outlets are primarily used to drive the administration of nebulised medication; typically for short periods to manage respiratory conditions. Most other uses of piped medical air do not require an air flowmeter. Due to the proximity of the piped medical air and oxygen outlets at the bedside, and the similarity in design of flowmeters, there is a significant risk when using air flowmeters that patients may be inadvertently connected to medical air instead of oxygen.

ABUHB has previously declared compliance with the previous Patient Safety Notice which sought to minimise the risk of inadvertent connection of oxygen tubing to airflow meters. All areas were risk assessed and medical air outlets were capped off where this was deemed safe and appropriate. A programme of ad hoc audits to ensure that there are no untethered medical air regulators in use provides ongoing assurance in relation to this and the previous alert. A review of medical equipment registers undertaken in response to the publication of PSN059, demonstrates that all nebulisers were exchanged for electrically powered devices that were not reliant on medical air.

PSN056 Foreign body aspiration during intubation, advanced airway management or ventilation

Loose items unintentionally introduced into the airway during intubation, ventilation or advanced airway management (known as foreign body aspiration [FBA]) can lead to partial or complete airway blockage or obstruction. In response to the PSN a review of current purchasing was undertaken and it was established that ECG electrodes procured were compliant with the safety requirements. A Protocol and Procedure for preparing equipment for intubation and advance airway management has been developed to provide a standardised, structured and safe approach to preparing equipment used for resuscitation, intubation and airway management which mitigates the risk of FBA.

PSN058 Urgent assessment/treatment following ingestion of 'super strong' magnets
Small powerful magnets are sold as toys, decorative items and fake piercings and are becoming increasingly popular. The power of the magnetism means that if two super strong magnets are swallowed separately or swallowed with a metallic item they can be strongly attracted to one another from different parts of the intestine. This compression of bowel tissue can lead to necrosis and perforation.

In response to the publication of PSN058, ABUHB has adopted the Royal College of Emergency Medicine protocol, Ingestion of Super Strong Magnets in Children to support the effective and safe identification and management of patients and clinical management of this patient group. Guidance has been disseminated across the Emergency Department.

PSA061 Inappropriate anticoagulation of patients with a mechanical heart valve
Early in the Covid -19 pandemic, published guidance supported clinical teams to review patients with a mechanical heart valve and treated with vitamin K antagonist (VKA) and, where appropriate, to change their medication to an alternative anticoagulant (eg a low molecular weight heparin (LMWH) or a direct oral anticoagulant (DOAC)). This was partly to reduce the frequency of clinic attendance for monitoring, and thus reduce the risk of harm to patients. The guidance listed exceptions where specific patients should not be switched from a VKA, including patients with a mechanical heart valve. In response to the publication of the PSA, a search of all ABUHB General Practice registers was undertaken to establish patients who had a mechanical heart valve and their prescribed anticoagulants were viewed. In addition, the Haematology Directorate, undertook a search of the DAWN database and identified 350 patients who had mechanical heart valves and prescribing of their anticoagulation was reviewed.
The response to PSA061 did not identify any patients who were prescribed inappropriate anticoagulation.

There are two outstanding patient safety solutions which the Health Board have yet to declare compliance with.

PSA008 Nasogastric (NG) Tube misplacement: continuing risk of death and sever harm.
The Health board is compliant with all elements of the PSA including the provision of local policies, the supply of safe equipment and the delivery of competency based training relating to NG tube insertion. However, an All Wales announcement on the standardised PH strip used to confirm correct placement of the NG tube is pending from the Surgical Materials Testing Laboratory (SMTL) and until this has been announced ABUHB is unable to declare full compliance with this alert.

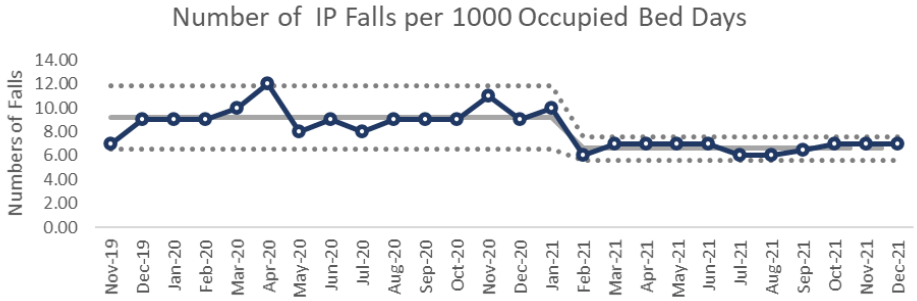
PSN055: Safe Storage of Medicines
The PSN states that all new builds and refurbishments commissioned after April 2016 must ensure that medicine storage areas must comply with a significant number of standards to ensure the secure and safe storage of medications.

A programme of clinical audit is being undertaken to review all areas where medications are stored in ABUHB sites. The audit has extended to all sites not just those refurbished and built after 2016. The audit results are now being reviewed to consider just those applicable to establish if the Health Board is now compliant. The work will continue across all Health Board sites regardless of the age of the estate.

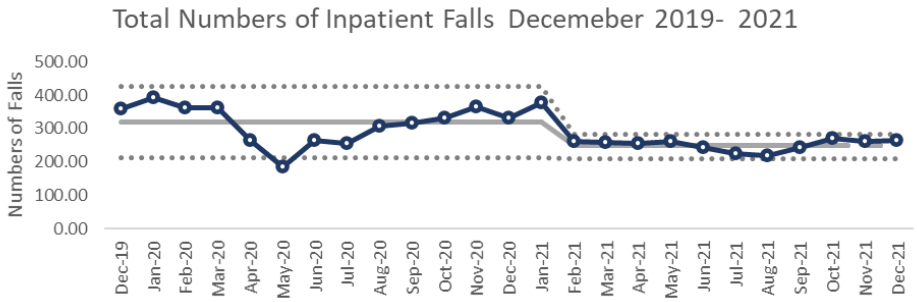
Safe Care (Standard 2.3 – Falls Prevention)

The process for monitoring Inpatient falls continues on a weekly basis and with the establishment of monthly control charts which identify shifts and trends associated with the numbers of reported falls incidents. An evaluation of the complete data sets demonstrates no significant statistical variation for falls incidents across AHUHB.

The graph below demonstrates the Inpatients falls per 1000 occupied bed days OBD's for the period December 2019-21. It is important to note that although as of August 2021 there has been a minimal upwards trajectory the values remain below or aligned to the National average. Each incident in which a fracture has occurred continues to be presented at 'Falls Review Panel' and accompanied by an associated action plan with identified learning. As of February 2021, a change in the average value was seen with a decrease to 6.6 from that of 9.2 for the period November 2019 to January 2021.



In relation to the total numbers of inpatient falls the information below up to December 2021 demonstrates the sustained reduction in reported falls incidents as compared to the same period for 2019/2020. There is minimal variation around the mean average of 249 up to 31st December 2021 as compared to a previous value of 319 for the period December 2019 to January 2021.



The complete data sets will going forwards be monitored by the 'Hospital Falls and Bone Health Group' reporting to the Falls and Bone Health Committee through its newly established governance structure.

Safe Care (Standard 2.4 – Infection Prevention and Control) Annual Plan Priorities: 1 2 3 4

A separate report relating to Covid-19 has been provided for the Committee

Nutrition and Hydration (Standard 2.5 – Nutrition and Hydration)

An annual assurance report was presented to the PQSOC in October 2021 that identified a number of recommendations. An action plan was developed which is being monitored by the Nutrition and Hydration group and an update will be presented to the PQSOC in April 2022.

Safeguarding (Standard 2.7 – Safeguarding Children & Adults at Risk)

A highlight report was presented to the PQSOC in December 2021 which remains current. No further meetings of the Safeguarding Committee have been held in this reporting period.

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.

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

A standalone paper detailing National Clinical Audit results and improvements has been produced but has been deferred to the April PQSOC meeting.

Patient and Family Communication (3.2 Communicating Effectively)

The Omicron variant has significantly increased community infection rates and in accordance with infection prevention guidance, visiting is restricted. Staff absence levels are high, impacting on their ability to answer telephone calls and deal with queries. Inevitably, this has led to an increasing number of complaints being received through switchboard, PTR and social media relating to relatives inability to contact wards.

Due to increased complaints from members of the public, particularly relatives who have been unable to contact wards, an interim service is being introduced across the 3 main sites (RGH, NHH and GUH) in January 2022. Working 8am-8pm the Patient Liaison Officers (PLO's) will answer calls and follow up queries from relatives.

They will be proactive in visiting the wards and speaking to clinicians, providing a ring back update service for the relatives which aims to improve communication and to reduced anxieties. This service was extremely valuable during the height of the pandemic in surge 1 and 2, with complaints relating to telephones not being answered reducing significantly. Additionally the presence of PLO's also reduced the volume of related calls going through to Switchboard out of hours. The reintroduction of the service and its impact is being closely monitored.

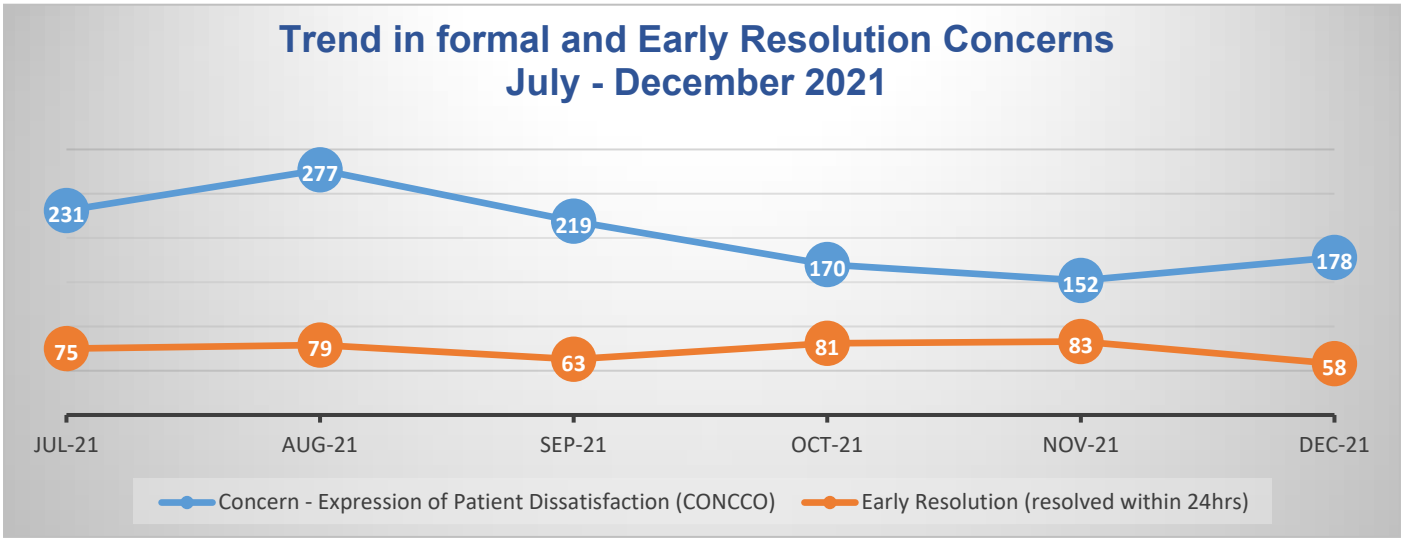
Individual Care Annual Plan Priorities: 1 2 3 4 5

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.

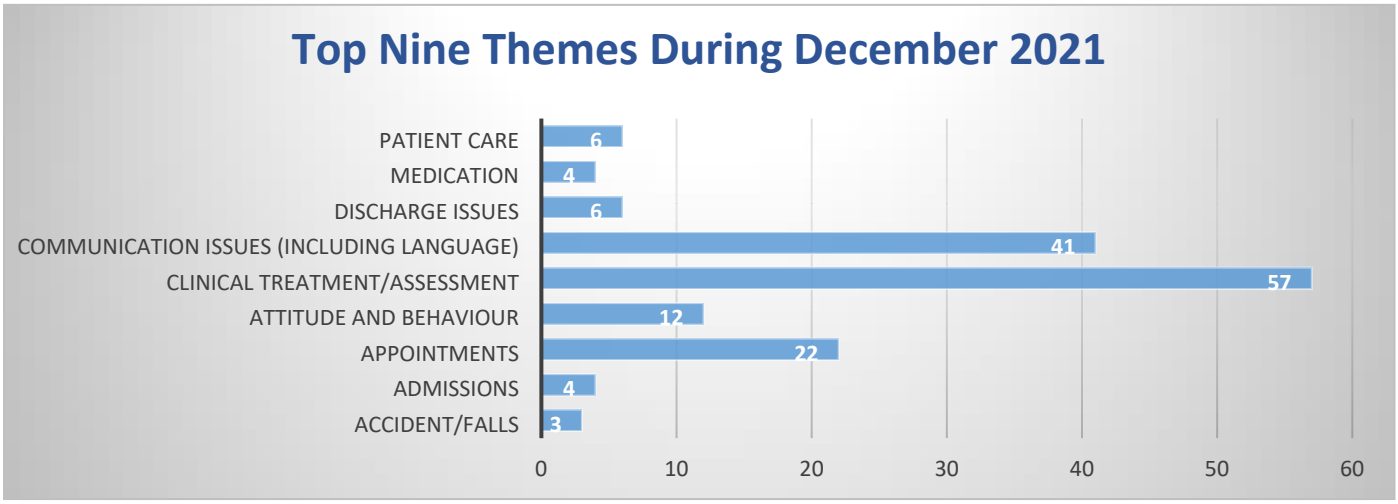
Complaints/Concerns and Serious Incidents (Standard 6.3 Listening and Learning from Feedback)

The 'Once for Wales' Feedback Module went live on the 1 October 2021. This is still being embedded within the organisation and there remain issues extrapolating data. This issue is being worked through with the national team.

The number of formal complaints received during December 2021 was 178. During the same reporting period in 2020, 190 were received a decrease of 6%.



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



The top three themes are

1. Clinical treatment /Assessment (57)
2. Communication Issues (Including Language) (41)
3. Appointments (22)

These are comparable themes with data reported during October and November 2021, with the exception of communication now being the second highest and appointments third. The PLO service should help to reduce complaints associated with communication.

The test of change for the proportionate management of complaints described in the last report has also commenced. An update will be produced for the April PQSOC Committee.

Public Services Ombudsman for Wales (PSOW)

In December the Health Board received 6 new queries, 5 new investigations and 1 settlement proposal. Two Final Reports have been received in January, 1 Upheld and 1 not upheld.

Throughout December 12 cases were closed.

At the end of December 2021, there were 36 open PSOW cases at various stages in the process which is a reduction by 10 from November 2021.

A meeting was held with the PSOW, CEO and Executive Director of Nursing in January to discuss ABUHB performance. The meeting was positive and affirmed organisational responsiveness.

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

The following table provides quantitative data in relation to incidents, including those reported nationally.

2021	**All SIs**	**Reported to the DU**	**Early Warning Notification**	**Never Events**	**Red 1**	**Red 2**
December	24	2	9	1	1	23
2022	**All SIs**	**Reported to the DU**	**Early Warning Notification**	**Never Events**	**Red 1**	**Red 2**
January as of 18.1.22	10	0	0	0	1	9

Two incidents were reported to the Delivery Unit (DU) in December 2021 and related to;

1. Homicide by patient known to MH Services.
2. One Never Event- Misplaced Nasogastric Tube, Critical Care

There have been no reported incidents to the DU to date (18 January 2022).

As of 31 December 2021, there were 37 open SIs (reported to Delivery Unit) and 1 PRUDiC. In comparison to December 2020, there were 117 open SIs and 11 PRUDiCs. The reduction in the number of open investigations with the DU reflects the amended reporting criteria through COVID from early March 2020 and the changes to the National Reporting Framework from June 2021. The majority of PRUDiC investigations continued to be managed via the PRUDiC process as opposed to the Serious Incident process.

PRUDiCS
Of the PRUDiCs reported, two of these related to suicide. Further correspondence by Welsh Government has confirmed that the Health Board is not the only organisation to have reported these incidents. A study has been commissioned to ascertain the effect of Covid on the mental health of young people due to isolation and school closures. This is being led nationally.

External Inspections and Peer Review - Internal and External Inspections (Standard 6.3 – listening and learning from feedback)

The final HIW reports for Radiology and the Emergency Department remain pending and will be reported at an appropriate PQSOC.

Sensory Loss (standard 6.3 Listening and learning from feedback)

Sign Live: in recognition that people who are deaf are not always able to have a British Sign Language (BSL) interpreter with them, a trial of 'Sign Live' is due to commence in designated areas (ED department, Out Patients, Booking Centre, PTR, Mass Vaccination Centres, Testing Centres and a GP practice. Sign Live is a video relay service that provides access to an online BSL Interpreter 7 days a week 24/7. The trial will go live at the end of January and will be evaluated to determine improvements in accessibility.

Patient Experience (standard 6.3 Listening and learning from feedback)

Virtual Third Party Feedback: In partnership with the Community Health Council (CHC), a number of 'virtual buddying' visits have been made to wards. Supported by the Person Centred Care Team, patients are able to have a confidential discussion with members of the CHC through FaceTime or Teams meetings. Feedback reports are disseminated to service areas for action and any concerns raised at the time of the discussion are escalated to staff to address. 5 reviews have been undertaken and 2 reports have been received with feedback including:

- Patient environment in inpatient Mental Health Services including environmental temperature
- Support provision at meetings for patients in a mental health setting
- Meaningful activity
- Menu choices
- Introduction of Dementia Champions
- Provision of colourful walking frames
- Use of the red tray system to support optimisation of nutritional support

An improvement plan has been developed to address all recommendations and the requisite actions are either in progress or complete and will be reported in full at the April PQSOC.

Digital Patient Stories: A number of digital patient stories have been made to support listening and learning. Staff have attended digital story training which will enhance capacity to undertake digital stories going forward. These stories have included:

- The experience of a patient within cancer services and the emotional support she received
- The experience of a patient who died alone during the pandemic when visiting restriction were in place.
- The experience of living with long Covid
- A patients experience of dignified care
- A patient experience of Covid in ITU

End of Life Companions

The End of Life (EoL) Companion volunteer service commenced at the very start of the pandemic. 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 lives. 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, but they did not want their relative to be alone.

The EoL companion role was explained to the family, she then arranged for 3 Companions to visit the following day so that the family could have some much needed rest. The Clinical Skills Trainer also met with the ward staff so that they were aware of the support that had been put in place.

The Companions know they may be contacted at short notice and were very pleased that they could support both the patient and the relatives. It was during one of the Companion visits that the patient peacefully died and importantly they were not alone which was a comfort to both the patient and their relatives. The Health Board are so grateful to the End of Life Companions who provide a very special and unique companionship in the final hours and moments of peoples' lives, ensuring patients do not die alone.

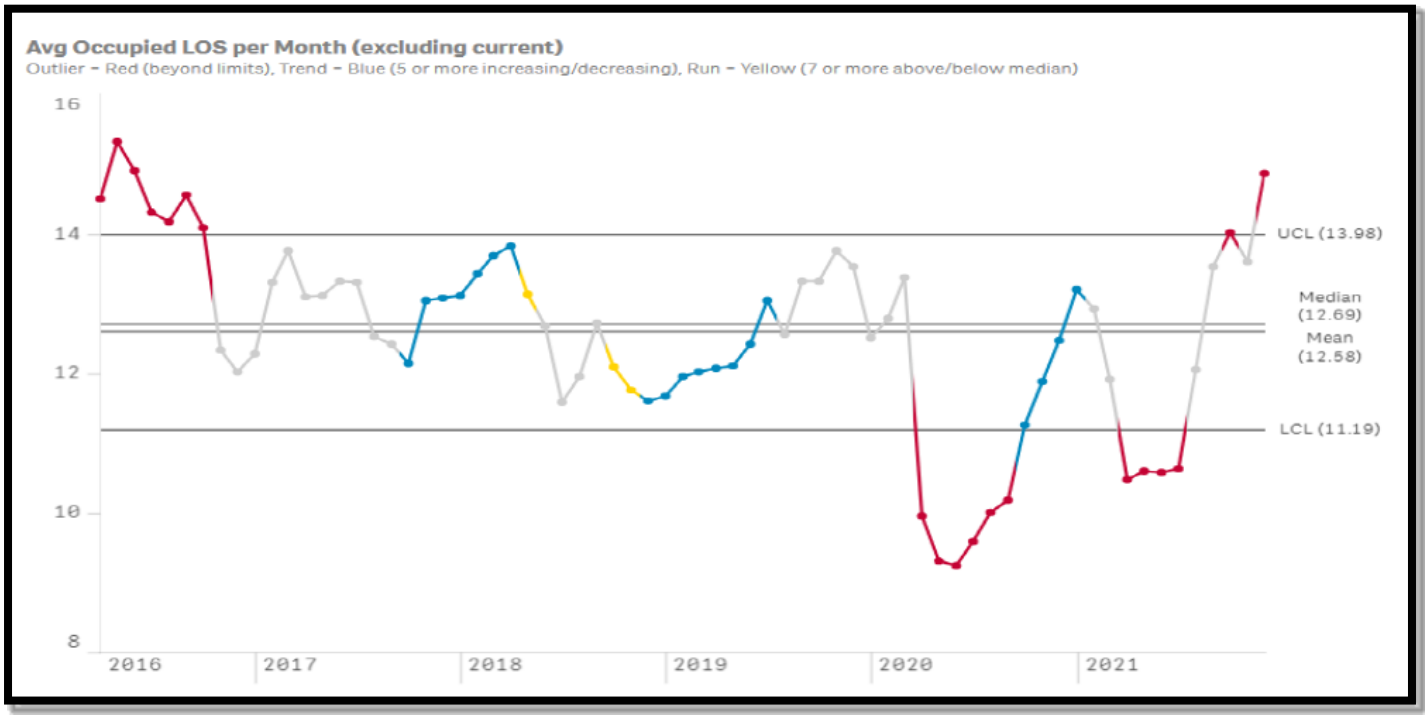
Timely Care. Annual Plan Priorities 1 2 3 4 5

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.

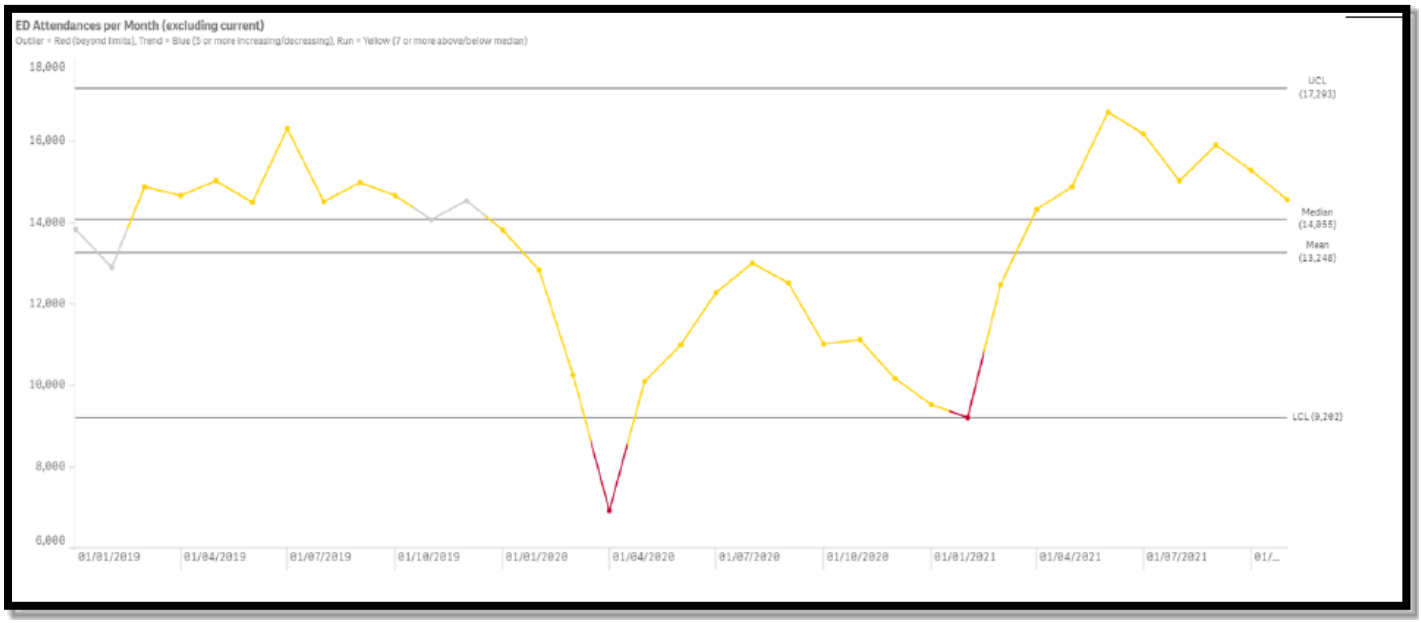
Urgent Care (Standard 5.1 – Timely Access)

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 Departments and Minor Injury Units, increased acuity potentially 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 increasing presentations of Covid-19 and the need to maintain appropriate streaming of patients and increasing levels of elective work as part of the recovery programme.

Currently the average length of stay for patients admitted as a medical emergency is at its highest point since June 2016. The following chart illustrates the monthly average length of stay for patients admitted as an emergency



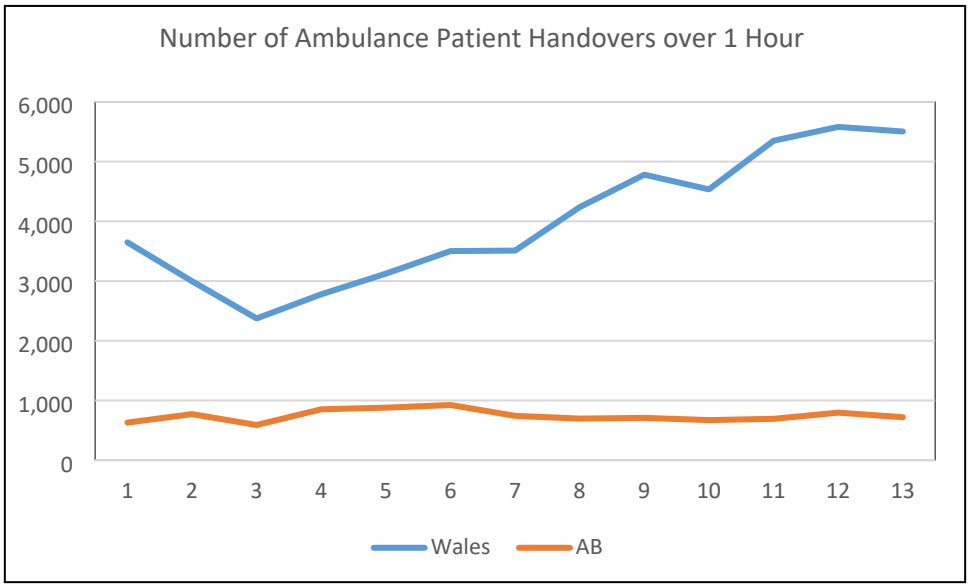
Attendance at the Health Board's Emergency Departments (ED) had been increasing since the start of February 2021, with just over 14,500 attendances in November 2021, higher than pre-pandemic monthly figures. The graph below provides an overview of the overall monthly ED attendances across the Health Board since April 2019. 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. The typical rate is 21% compared to 25% at the Grange University Hospital. This higher admission rate reflects the higher acuity of patients attending The Grange University Hospital Emergency Department, which consequently results in more patients staying longer than 12 and 24 hours.



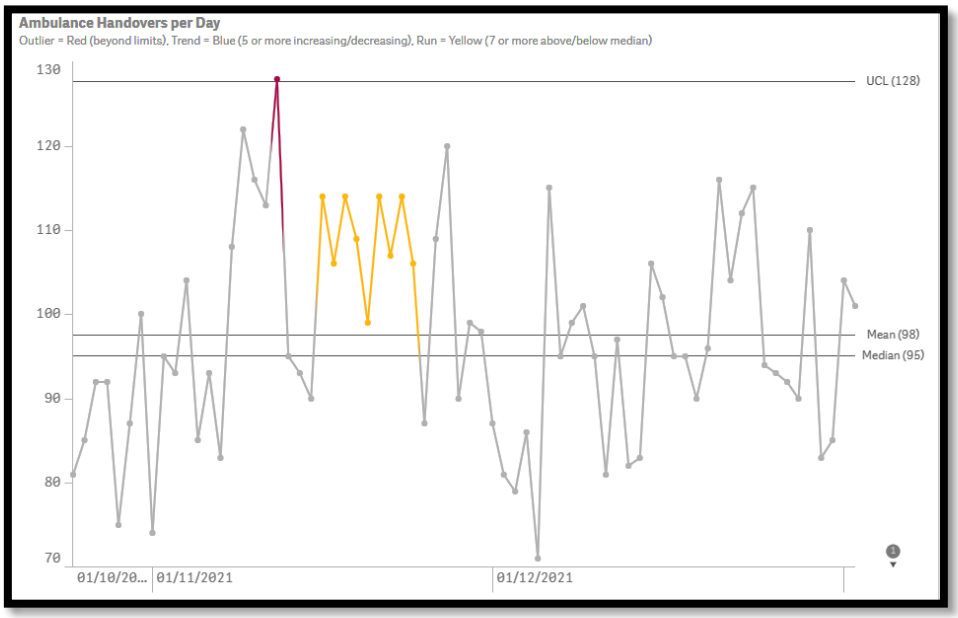
There are 3 key Emergency Department metrics which are nationally reported:

- The number of ambulance handovers over 1 hour
- 4 hour performance
- 12 hour performance

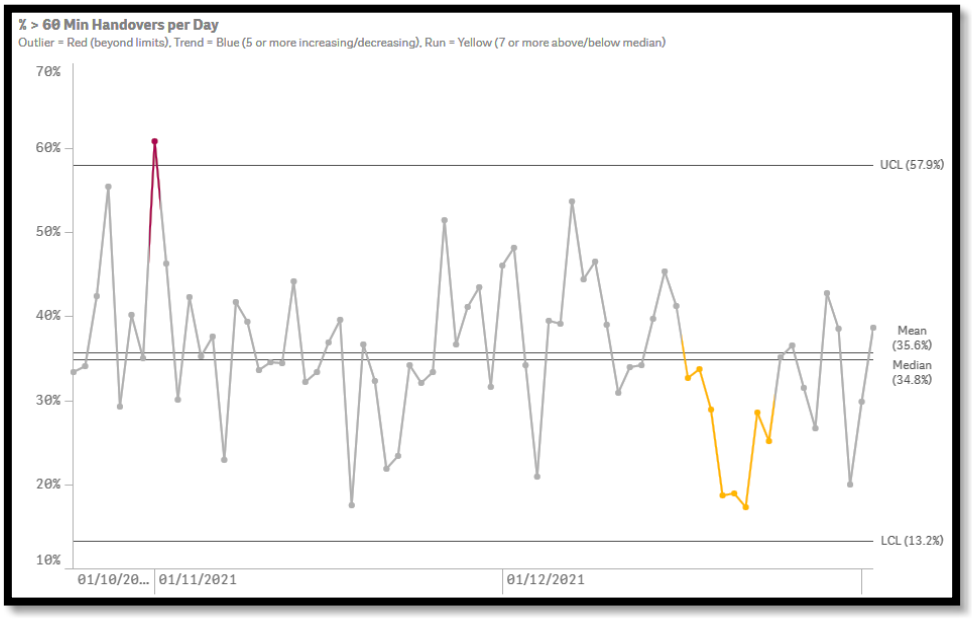
Despite a stable trajectory in relation to the number of ambulance handovers, the Health Board is ranked 4th out of 6 University Health Boards (UHB). Performance is rated on handover numbers as opposed to handovers per head of population. The way this information is reported is being reviewed nationally to allow benchmarking and comparison.



Ambulance handovers greater than 60 minutes has increased in the previous 2 months. In December, 720 patients waited over 60 minutes and in November 2021, 797 were reported compared to the October position, where 693 were reported. The graph below show the number of handovers a day with significant variation, between 72-131 and the average was 98 handovers.

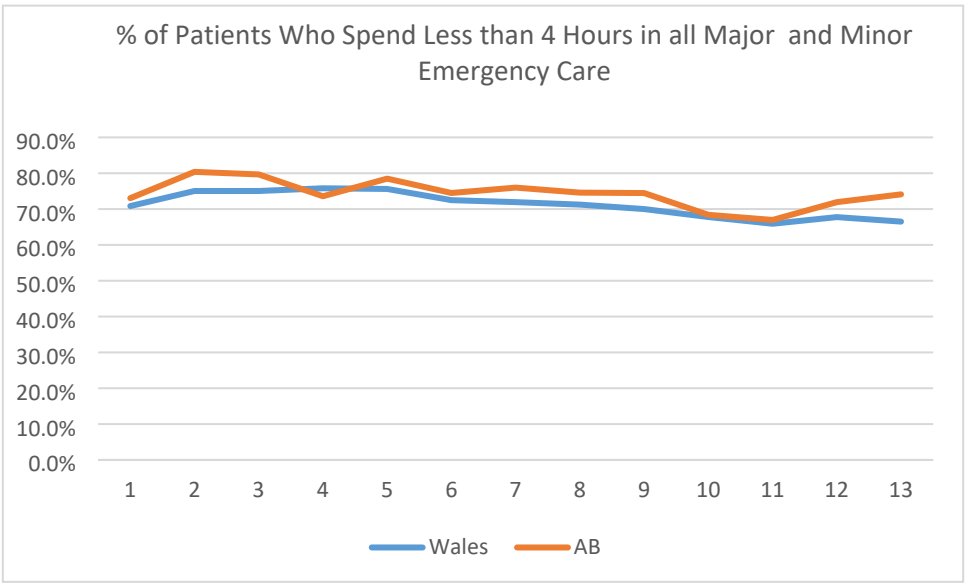


The Graph below illustrates the number of handovers greater than 60 minutes. Again significant variation can be seen with up to 63% exceeding 60 minutes at peak at the beginning of November 2021 and 18% in December 2021. The average is 35%

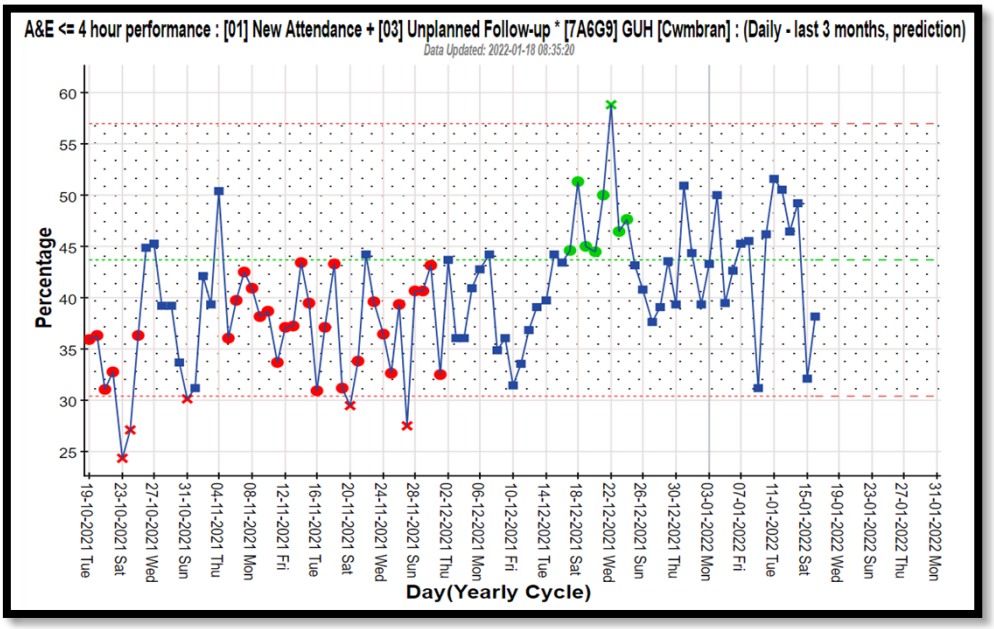


The number of arrivals per day together, with time of arrival and numbers arriving in batches impacts on the organisational ability to respond in a timely manner particularly when the department is under pressure and/ or is overcrowded. All patients delayed on an ambulance receive fundamentals of care.

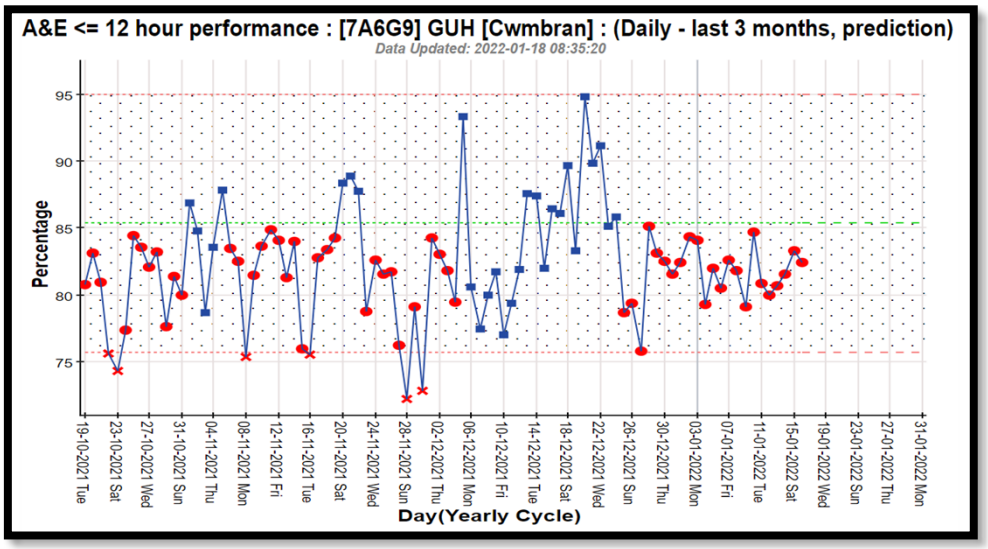
Within Wales, transit time targets for ED remain in place. The targets sets out the expectation that patients attending ED should be admitted, transferred or discharged within 4 hours with an achievement of 95%. The standard also states no patients should wait longer than 12 hours before being admitted to a ward from the point of a decision to admit. The graph below demonstrates the Health Board performance against the 4 hour target, compared to the rest of Wales for the past 12 months, up until January 2022. It shows ABUHB is comparatively performing well in the circumstances.



The following graph shows transit time for 4 hours from October 2021- mid January 2022. The average is a 43% over a four month period with peak performance at 60% during Christmas week and poorest performance at 25% in October 2021. Performance in January 2022 dipped to low 30%

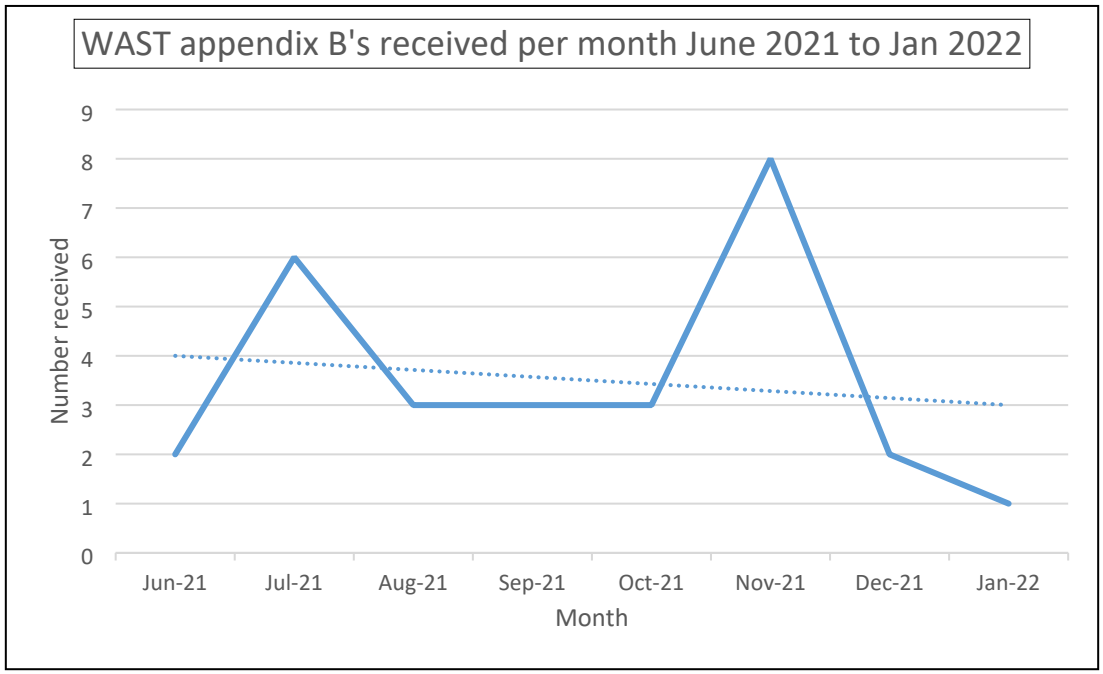


This next graph illustrates the performance against the 12 hour target which is also variable and reflective of 4 hour performance. Mid December saw performance at 95% with Christmas week seeing a significant decrease to circa 75%, with an average of 85% over the 4 month period.



1 incident was reported nationally by the Emergency Department between June 2021 and January 2022. The incident did not relate to any of the three ED performance metrics.

The graph below illustrates the number of Welsh Ambulance Service Trust (WAST) incidents, (referred to as appendix B) when delayed handovers are considered to have been a contributory factor. The Health Board works with WAST to support the investigation by providing details relating to the site position at time of the incident and the Operations Team consider the outcomes of all investigations.



Stroke (Standard 5.1 – Timely Access)

Stroke Care

The Hyper Acute Stroke Unit (HASU) at the Grange University Hospital (GUH) opened on 16th November 2020 with 15 beds plus 1 therapy room. The entire ward has 32 beds, with the other 16 beds are normally occupied with Haematology and Surgical patients. Since opening the HASU at GUH, the main challenge has been maintaining available acute stroke capacity when a patient with a stroke is first admitted and then providing timely transfers onto the e-LGHS. The urgent pressures have made it particularly difficult to protect beds for acute patients with a stroke and the performance has been severely impacted.

The proportion of patients with a stroke directly admitted within 4 hours dropped to 8.2% in November 2021 compared with 20% in October. The service has identified several challenges that continue to impact on flow through the stroke pathway. Transferring patients from GUH to the eLGHs on a timely basis has been persistently difficult, due to availability stroke rehabilitation capacity. The service is working to take forward some rapid actions in order to create additional capacity.

In November 2021, the Health Board maintained its reasonable performance with the percentage of patients assessed by a stroke consultant within 24 hours at 87.1%. The percentage of stroke patients receiving the required minutes for speech and language therapy deteriorated in November with 25.8% compared with earlier in the year where figures were approximately 45% compliance. A 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 where hyper-acute and rehabilitation are not delivered on the same site. The detailed findings of the report will be discussed at the Health Board Stroke Delivery Group, which is chaired by the Executive Director of Therapies and Health Sciences. The review forms 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.

Thrombolysis rates were higher than usual in November at 16.1%. The improvement in compliance can be attributed to a higher number of patients presenting within the thrombolysis window. 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.

As part of the ongoing improvement work the Stroke Directorate has engaged with an external provider called "Getting it Right First Time" 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 first meeting is scheduled for the end of January 2022 and will include representatives from all of the Stroke Multidisciplinary Team. The findings of the review will be discussed and taken forward in the Stroke Directorate Meeting and progress will monitored through the Stroke Delivery Board with reporting to the Executive Team.

A new programme of education has been set up by the Community Neurological Rehabilitation Service "Stroke Pathway Connections", for people working on the Stroke Pathway based on the principles of connecting people and learning from service users. Anyone working in stroke services can attend including people working in Hyper Acute Stroke Unit, Rehabilitation Stroke Wards, Community Hospitals, Community Neuro Rehab Service, Community Resource Teams, voluntary sector, Ambulance Service, Primary Care and Emergency departments.

The idea is for staff to have the opportunity to step out of busy work schedules for a short time and think about specific areas of work and most importantly how the people experience our services so that the service can continue to improve.

In December 2021 a thematic review of stroke services was undertaken following increased patient safety incident reporting. A number of themes emerged:

- The majority of cases presenting to ED were out of Hours with variation between in hours and out of hour's services
- There was inconsistent resources relating to the stroke pathway available for staff to refer to.
- The opening of GUH and the development of the new stroke pathway had highlighted a number of concerns including the impact of the Covid pandemic.

A number of recommendations were made as part of the review including:

- Clarification of pre streaming pathway and updating and circulating the stroke pathway
- Education of the ED triage staff and reception staff to raise awareness of atypical stroke presentations
- ED medical staff to be aware of the need to have early involvement of the stroke team if within thrombolysis window and not wait for a CT brain scan to be performed.
- Reinforcing Patients within the thrombolysis window must be discussed with the stroke team.

A task and finish group has be convened to implemented the recommendations and to reintroduce the audit of patients presenting with a stroke.

Recommendation

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

- **Note** the Health Board's position against a range of key quality and safety metrics, notably Urgent and Emergency Care and Stroke, which continue to be red-rated.

- **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)	Not applicable to the purpose of this summary report.
Health and Care Standards	Health and Care Standards form the quality framework for healthcare services in Wales. The issues focussed on in the report are therefore all within the Health and Care Standards themes, particularly safe care, effective care and dignified care.
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP and the quality improvements highlighted here are within the Plan.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being Objectives and should also indicate to which Objective(s) this area of activity is linked.*
	Long Term – Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Involvement –Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	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, 8th February 2022 Agenda Item: 2.4

Aneurin Bevan University Health Board
PQSO Committee - Strategic Risk Report

Executive Summary

This report provides an overview of the profile of the current risks reporting to the Patient, Quality, Safety and Outcomes Committee (PQSOC). Whilst this report articulates the strategic risk profiles for the organisation, operational context is important to note as the Health Board continues to experience the challenges of the pandemic; restart and recovery of previously paused operational services; ongoing uncertainties related to Variants of Concern (VoC) alongside current significant staffing pressures due to sickness and isolation requirements.

The PQSO Committee is asked to note this report for assurance.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	
Executive Sponsor:	Rani Mallison, Board Secretary
Report Author:	Danielle O'Leary, Head of Corporate Services, Risk and Assurance

Report Received consideration and supported by :			
Executive Team	**N/A**	**Committee of the Board [Patient, Quality, Safety and Outcomes Committee]**	**As outlined.**

Date of the Report: 12th January 2022

Supplementary Papers Attached:
Appendix 1 – Summary of 10 Risk Profiles

Purpose of the Report

This report is provided for assurance purposes and seeks to provide a summary of the current key risks to the Health Board in respect of Quality and Patient Safety.

Background and Context

In conjunction with the revised Board Assurance Framework (BAF) and the revised Risk Management Approach, the Health Board is able to review and assess its strategic risks against achievement of objectives as set out in the Annual Plan 2021/22.

This report provides the Patient Quality, Safety and Outcomes Committee with an opportunity to review the organisational strategic risks which receive oversight from PQSO Committee.

The Health Board utilises the All Wales Risk Matrix to assess the potential impact and likelihood of occurrence of all predicted risks to form an overall risk score. Risks may then be tolerated, treated, transferred or terminated in line with the Health Board Risk Management Strategy.

Assessment & Overview of Current Status

The revised risk management approach remains in the embedding phase throughout the organisation and thematic alignment can be evidenced through the Divisional risk reporting and strategic risk profile reporting. Continued engagement throughout the organisation has taken place and continues to progress to strengthen the utilisation of the Health Board's internal electronic risk management system (DATIX). The risk management system will form one of the key sources of business intelligence in respect of identification and escalation of operational risk, in conjunction with Executive level horizon scanning led risk identification.

This business intelligence and Executive level horizon scanning will be used to inform Board and Committee agendas and thereby, drive the business of the Health Board. This will ensure that an outward facing, strategic and risk focus is adopted. This will also be reflected in Board and Committee work plans and the Board Assurance Framework.

Further development work alongside Divisions is being undertaken to ensure risks are being captured on the system appropriately and consistently in terms of scoring, risk assessment and descriptors. It is anticipated that one of the mechanisms for undertaking this development work will be the Risk Managers Community of Practice.

This work is underpinned and supported by Executive Team which provides an overarching position in relation to each risk area. In parallel to horizon scanning, strategic risk identification; the Health Board's risk management approach and infrastructure, is continually improving.

Current Status

During January 2022, Executive Team undertook a review of all risks held on the Corporate Risk Register. It was recommended by the respective Executive risk owners to de-escalate or realign risk profiles to more appropriate Committees, the risks outlined below. This decision was then endorsed by the Board at the January 2022 meeting:

- ***CRR007 Inability to reflect demands of an increasingly aging population*** – It was agreed that this risk profile needed to be monitored and reviewed within a planning and strategic capacity.
- ***CRR031 Initial modelling work from the southern hemisphere indicates that a potential double cohort of bronchiolitis could be expected Winter 2021/22 creating a significantly increased demand in Paediatric Services*** – It was agreed that the impact of this risk had not been fully realised and

therefore should be de-escalated and managed at a local/Divisional level with escalation routes enabled, if necessary.

- ***CRR020 Failure to implement WCCIS leading to inaccessibility of essential patient information –*** It was agreed that this risk would report to the Audit, Finance and Risk Committee as a matter of course. Concerns relating to specific Patient Quality and Safety would be deferred to the PQSO Committee whenever necessary.

The table below provides a high level view of the **10** risk profiles that receive oversight from the Patient, Quality, Safety and Outcomes Committee; by their severity:

High	8
Moderate	2
Low	0

Therefore, the Committee is asked to note the current score, target score, an assessment as to whether or not the risk is managed within its agreed risk appetite, and trend since the last reporting period:

Risk ref and Descriptor	Current Score	Target Score (informed by Appetite level)	Risk Appetite Level	Managed to Agreed Level Y/N?	Risk Treatment	Date and Trend Since Last Reporting Period	Assurance/ Oversight Committee	Risk Owner
CRR019 Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand. **(re-framed Dec 2021)**	20	15	**Low** level of risk appetite in relation to patient safety risks. **Moderate** levels of risk with regard to innovation around mitigations to prevent demand and better manage the demand.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Board, Jan 2022)** 	**PQSO**	**Director of Operations**
CRR013 Failure to prevent and control hospital and community acquired infections to include COVID-19	15	10	**Zero or low** due to patient safety and quality of service.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Board Jan 2022)** 	**PQSO**	**Director of Nursing**
CRR023 Potential risk to population health in relation to avoidable harm due to priority being given to management of the COVID pandemic.	20	20	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to different ways of working to address backlog. This would include the use of technologies and innovations.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Board, Jan 2022)** 	**PQSO**	**Director of Operations**
CRR010 Inpatients	15	10	**Zero or low** in the interests of patient	**No**	**Treat** the potential impacts	**(Board January**	**PQSO**	**Director of**

may fall and cause injury to themselves .			safety.		of the risk by using internal controls.	**2022)** 		**Therapies and Health Science**
CRR027 Effectiveness of COVID vaccination and booster programme compromised leading to a Variant of Concern	25	20	**Moderate** risk appetite level will need to be applied to this risk profile, given the unpredictability of the potential of variants of concern. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control.	**No**	**Treat** the potential impact of the risk with mitigations. **Tolerate** the unpredictable element of the VoC and other mutations.	**(Board, January 2022)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR028 Continued inappropriate admissions of Children and Young People to adult mental health in-patient beds.	20	10	**Low** risk appetite level in relation to patient safety and experience. **Moderate** level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Board January 2022)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**
CRR030 Limited contact with public and NHS services in addition to clinical deployment to support Public Health Mass Vaccination programme contributing to a compromised Safeguarding position (**re-framed to reflect DoLs position**)	16	5	**Low** risk appetite in this area due to potential impact on quality, experience and patient outcomes.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Board January 2022)** 	**PQSO**	**Director of Nursing**

***links to Workforce risk – CRR002**								
CRR001 High levels of seasonal influenza	8	8	**Low** level of risk appetite in relation to patient experience. **Moderate** levels of risk appetite can be applied to pursue innovative models and technologies to encourage uptake.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Board January 2022)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR003 Mental Health services will fail to meet the anticipated increased demand of the Health Board population, for Mental Health support, in light of the COVID 19 pandemic.	12	8	**Low** risk appetite level in the interests of patient safety. **Moderate** risk appetite levels will need to be taken to explore further innovations and appropriately reconfigure services and implement new arrangements.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Board January 2022)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**
CRR026 Risk to the general population and patients already within our services, due to less than adequate surge capacity to address any further exponential increase in pandemic response. ***links to Workforce risk – CRR002**	20	5	**Low** risk appetite level will be applied.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Board January 2022)** 	**PQSO**	**Director of Operations**

A detailed assessment of each risk profile outlined above is available at **Appendix 1**.

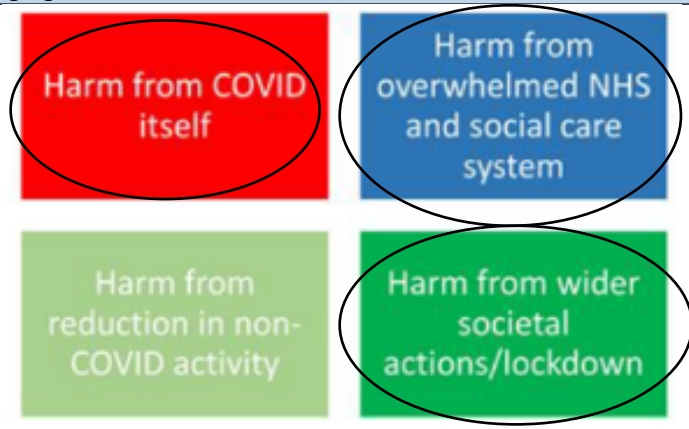
We will be actively working to review risk targets to ensure realistic and as far as possible; set within the context of the Board's appetite for risk.
Recommendation & Conclusion
The Committee is asked to note the content of this report for assurance purposes, recognising that there will be further iterative development work to embed the revised risk management approach with QPSOG and Divisions. The Committee is also requested to note the detail within **Appendix 1** and is encouraged to review the risk profiles in conjunction with other, interlinked risk profiles to ensure consistent understanding of context.
Supporting Assessment & Additional Information

Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment (including value for money)	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.
Quality, Safety & Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality & Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health & Care Standards	This report contributes to the good governance elements of the H & CS.
Linked to Integrated Medium Terms Plan & Corporate Objectives	The objectives will be referenced to the IMTP
The Wellbeing of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of Terms	None
Public Interest	Report to be published

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
Priority 2- Getting it right for children and young adults **Priority 3 – Adult in Gwent live healthy and age well** **Priority 4 – Older adults are supported to live well and independently**		***CRR027 (June - 2021)*** ***Threat Event: Effectiveness of COVID-19 vaccination and booster programme compromised*** ***Threat Cause: - New Variants emerge*** **TREAT** **TOLERATE**					
High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Staff Well Being	**Risk Appetite**	Given the unpredictability of the potential of variants of concern, a flexible, moderate risk appetite level will need to be applied to this risk profile. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control. Therefore an element of this risk will need to be tolerated.				
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Patient Quality, Safety and Outcomes Committee	• IMTs controlling clusters and outbreaks and keeping cases as low as possible. • Gwent IMT with SBAR (reported weekly to Executive Team) • Keeping abreast of guidance from WG. • Continuing public messaging on adherence to restrictions. • Vaccination Programme Board monitoring roll-out of programme weekly.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		5	5	5	5	4	5

Gwent IMT leads on multi agency response to manage community response with weekly sit reps (SBAR) to WG. Gwent IMT involves representatives from 5 x Local Authority Directors of Public Protection, ABUHB Director of Public Health, & Public Health Wales Health Protection. Gwent IMT & Gwent, TTPS delivery and management of National VAMC guidance, regional testing plans etc. Continual review and updating of Gwent Covid-19 Prevention and Response Plan, transition to Recovery Coordination Groups inclusive of VoC related exercises.	Monitored weekly at present	**25**	**25**	**20**

Trend since last reporting period	↑
Executive Owner: Director of Public Health and Strategic Partnerships	
Mapping Against 4 Harms of COVID	**Update**



January 2022:

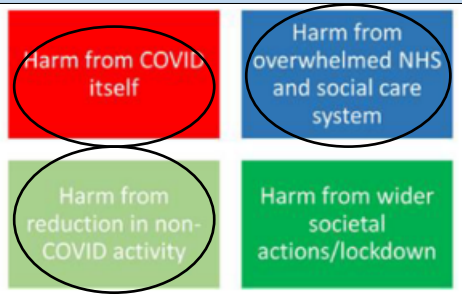
The Omicron variant spread rapidly around the world in December2021 with control measures having little effect on slowing spread down due to it being much more transmissible than previous variants. There is now a high level of confidence that the wave of the Omicron variant has resulted in a much lower rates of serious illness than previous waves, due to high levels of vaccine induced population immunity (realised risk) and the variant itself causing less serious illness (inherent risk). It is hoped that future mutations (variants) of COVID-19 will also have a lower inherent risk of serious illness and that vaccines will be equally effective (realised risk), but that is by no means certain. The risk of a future variant being both highly transmissible and having a higher inherent risk of serious illness than Omicron remains a very real risk.

The ABUHB COVID-19 mass vaccination programme has given over 350,000 booster vaccinations with over 100, 000 given during the three week period of accelerated delivery in December 2021. By 31/12/21/ everyone eligible for a booster vaccination had been offered an appointment. The programme continues to provide first, second and third doses of the COVID-19 vaccination in line with JCVI guidance and WG policy for all relevant age groups.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
• **Getting it right for children and young adults** • **Supporting adults in Gwent to live healthy and age well** • **Provide high quality care and support for older adults** • **Staying healthy** • **Less serious illness which require hospital care**		***CRR001 (Mar-2016)*** ***Threat Cause: Poor uptake of flu vaccination among Health Board staff, primary school-age children, and patients aged 65 and over and people under the age of 65, staff in care homes*** ***Threat Event: Risk of co-infection with flu and COVID-19 and potential delays in vaccine availability.*** **TOLERATE** **TREAT**					
High Level Themes	• Partnership • Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence	**Risk Appetite**	Low level of risk appetite in relation to patient experience. However, moderate levels of risk can be taken to pursue innovative models and technologies to encourage update through communication and engagement. Mass vaccination clinics.				
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Patient Quality, Safety and Outcomes Committee	• Seasonal flu action plans being developed for primary care (including care home staff), schools and staff. • Flu Delivery Group meets weekly. • Transformative approach through Flu Group. • Staff flu group meets regularly. • Campaign to increase uptake launched mid-September involving Flu champions. • Flu uptake monitored weekly and Health Board staff uptake newsletter, produced and disseminated weekly. • Staff uptake at 53% week of 02 November continue with actions to sustain progress and monitor via DPH and Deputy Medical Director and Director of Primary Care.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	4	2	4	2	4

• Continued to work with NCN leads on effective approaches to maximise uptake through cluster based delivery models • Circulated correspondence to GP practices requesting number of vaccines ordered and delivery dates in order to carry out a gap analysis of what the shortfall would be for the HB to pick up in light of the CMO letter • Following the review of practice flu data submitted engaged in discussion with LMC in regards to the logistics of the flu and COVID-19 booster campaign • Agreed on-site delivery model for vaccination of care home staff through liaison between Responsible Individuals, care home managers and community pharmacies • Encouraged GP practices to use the personalised letter piloted last flu season to maximise uptake among 2-3 year olds	Aug-2021	**16**	**8**	**8**

Trend	⟺
Executive Owner: Director of Public Health and Strategic Partnerships	
Mapping Against 4 Harms of COVID	**Update**



January 2022 Update:

Influenza is circulating in Europe and the CMO has written to Health Boards encouraging renewed efforts to increase flu vaccination uptake after focus switched to the accelerated COVID-19 booster programme in December 2021.

The uptake rates for ABUHB as at 18/01/22 were:

ABUHB had the highest uptake rate of all Health Boards in Wales for patients aged 65 years and older at 78.9% (Wales average = 76.9%); 65% of patients aged 50-64 at risk (Wales = 60.2%); 37.9% of patients aged 50-64 with no risk factors (Wales = 33.2%) and 39.8% of patients aged 6 months – 49 years at risk (Wales = 33.7%)

76.7% (56 of 73) ABUHB GP Practices had an uptake of 75% or over (Wales = 64.8%)

Monmouthshire had the highest uptake across all LAs in wales for all four groups creating an opportunity to learn from and share what worked well through ABUHB NCN networks.

Uptake in 2-3 year olds at 47.0% is higher than the Wales average (45.6%) but lower than some other HBs. Health Visitors are actively promoting flu immunisation for those aged 2-3 years who have not yet had it.

Uptake in primary school children aged 4-10 years in school immunisation sessions delivered by ABUB is 66.4%, below the Wales average (67.0%) as is the uptake for secondary school children aged 11-15 years at 56.9% compared with a Wales average of 57.1%, The data is from school sessions delivered so far and the ABUHB programme continued to be delivered when schools returned this term.

Uptake for ABUHB staff with direct patient contact was 55.4% in line with the Wales average of 55.3% but below the highest rate of 60.9%. A staff flu immunisation programme recovery programme started on 25/01/22 with a 'it is not too late' message to staff yet to have their flu vaccination followed by a range of measures to promote the vaccination and make it easy for staff to access it.

As at 24/01/22 the rate of community transmission of COVID-19 in the ABUHB area remained high at 580.5/100,000 (Wales 483.7 / 100,000) with 35.4% of tests being positive (Wales 33.6%). If rates of COVID-19 remain that high as

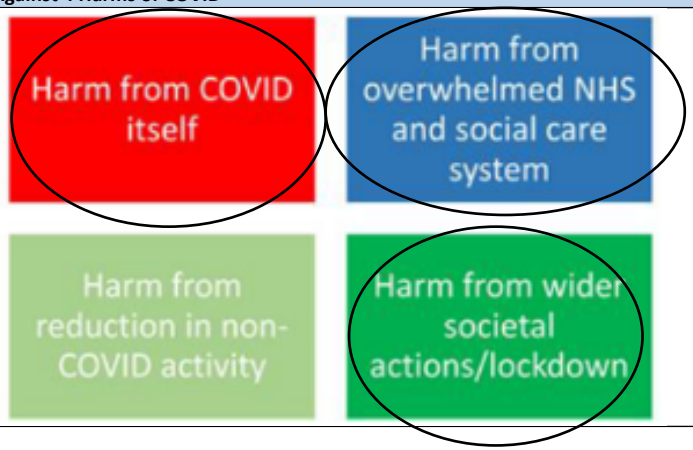
	influenza starts to circulate in Wales, as expected by the CMO, there will be an increasing risk of patients being seriously unwell with COVID-19 and influenza at the same time. Public messaging about personal behaviours to reduce risk of infection with COVID-19 – hands, face, space, ventilation – will reduce the risk of infection with influenza too. **Welsh Health Circular (WHC) 2021 019 on The National Influenza Vaccination Programme**  04-08-2021_Welsh Government - ...

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22	Risk Description, Appetite and Decision
Priority 3 – Adult in Gwent live healthy and age well **Priority 4 – Older adults are supported to live well and independently** **Priority 5 – Dying well as part of life**	***CRR026 – (June 2021)*** ***Threat Event: Inadequate surge capacity to address service demand*** ***Threat Cause: Substantial increase in pandemic levels.*** **TREAT**

High Level Themes	Risk Appetite
• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Staff Well Being • Financial	Recognising the importance of the patient quality and experience aspects of this risk profile, a low to moderate level will be applied however, the Health Board will need to understand the risk profile of its partners to ensure robust plans continue to be developed to proactively manage this risk area.

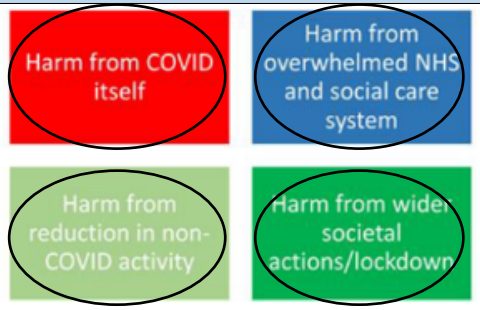
Committee Assurance	Internal Controls – Policies/Procedures	Risk Score
Patient Quality, Safety and Outcomes Committee	• Weekly Tactical Meeting in place to oversee operational model and implementation of surge capacity. • Monitored through the RNTG weekly thermometer to ensure resilience against any rise in community cases and subsequent hospital impact. • Factored in additional capacity to bed planning for the remainder of the financial year.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***
		Current ***Risk level after initial controls/mitigations have been implemented.***
		Target ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***

Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	Due Date	Inherent Likelihood	Inherent Consequence	Current Likelihood	Current Consequence	Target Likelihood	Target Consequence
		3	5	2	5	1	5
Bed planning has been remained dynamic with core Covid-19 capacity of 60 beds in the Winter Plan with surge plans beyond this, 58 additional beds allocated in the Winter plan with the ability for a further 123 additional beds to support acute medical need with consequent impact on scheduled care delivery. Flexibility to zone beds appropriately to meet need.	Action plans are reviewed weekly.	**15**		**10**		**5**	

Trend		Executive Owner: Director of Planning Digital and ICT
Mapping Against 4 Harms of COVID		**Update**
		Jan 2022 Surge capacity is being utilised across sites in line with Winter and surge planning. Daily operational views coordinated via site Bronze teams are monitoring staffing, safety, and appropriate zoning of surge areas. The Tactical Group oversee the system and make decisions on coordination across sites to ensure appropriate use of surge capacity. System pressure remains high and surge capacity occupancy is predominantly supporting medically fit for discharge patients.

<table>
<tr><td colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="4">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2">Getting it right for children and young adults
Supporting adults in Gwent to live healthy and age well
Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness which require hospital care</td><td colspan="4">CRR003 (March 2017)
Threat Cause: Continued and sustained Health Board response to the COVID Pandemic
Threat Event: Mental Health services will fail to meet the anticipated increased demand of the Health Board population
TREAT</td></tr>
<tr><td>High Level Themes</td><td>Partnership
Research, Innovation Improvement Value
Quality and Patient Safety
Patient Outcomes and Experience</td><td colspan="2">Risk Appetite</td><td colspan="2">Risk appetite in this area is low in the interests of patient safety. However, further managed risk will need to be taken to explore further innovations and appropriately reconfigure services and implement new arrangements in the interests of service users.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="4">Risk Score</td></tr>
<tr><td>Patient Quality, Safety and Outcomes Committee</td><td>1. Key transformation programme in place to address: a) A whole system model to meet mental health need with a key focus on developing/strengthening open access foundation tier and mental health support within Primary Care; to enable prevention and early intervention. b) Redesigning crisis services and acute care. c) Redesigning services for people with complex needs.
2. A programme is in place monitoring bed availability and flow through the system, overseen by the Deputy Divisional Nurse.
3. Systems and processes are in place to monitor demand.
4. Engagement with local academia to continue to monitor the impact of COVID on the wellbeing of the general population.</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td colspan="2">Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	• 5. Securing additional resources both within year, and recurrent.						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	4	3	4	2	4
• Development of new models to meet the mental health needs of the population across all Tiers e.g. Foundation Tier, Primary Care Mental Health, Secondary Care Specialist Mental Health Services	May 2022	**16**		**12**		**8**	
Trend	⇔	**Executive Owner: Director of Primary, Community and Mental Health Services**					
Mapping Against 4 Harms of COVID		**Update**					



January 2022:

There is growing evidence from surveys that the pandemic has had considerable impact on population mental wellbeing with the impact being greatest for young people. Mental Health services are seeing well above pre-pandemic numbers of patients with a high level of acuity of mental illness.

Good progress is being made with the roll out of of open access Foundation Tier interventions, introduction and Psychological Wellbeing Practitioners within the Primary Care MDT.

The extension of Shared Lives across ABUHB is providing an alternative to in-patient admission,. Tender awarded and mobilisation process commenced for Sanctuary Provision and Support House,

Outline Business case for Specialist In-Patient Services Unit delayed due to the Omicron wave of COVID-19 needing the full attention of the MH&LD Divisional Leadership Team. It will restart at the point normal business resumes.

The Division is also implementing a number of additional actions, including use of WG Recovery funding to externally commission additional capacity, to address waiting times for core areas of service where waiting lists grow during Covid e.g. Psychological Therapies, Integrated Autism Service, Memory Assessment Services, Primary Care Counselling

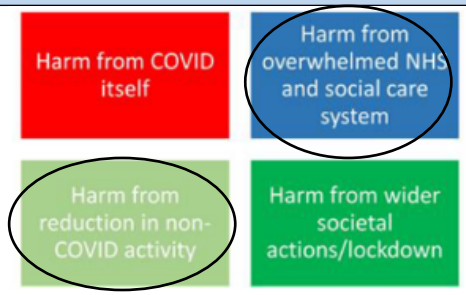
External Assurance:

In relation to any external sources of assurance and any metrics to indicate whether we have been successful in mitigating any risks;

- An audit undertaken by Shared Services that was presented to the Audit Committee regarding a review of the governance arrangements in place to take forward the transformation of Mental Health Services across ABUHB.
- A paper that was presented to the Board providing an update on the engagement and consultation that has been undertaken regarding the transformation of our Mental Health Services across ABUHB.
- An initial evaluation of the PWP service that was presented to the Community Health Council demonstrating that we are actively evaluating some of the new models of care that we are introducing to meets the mental health needs of the population.

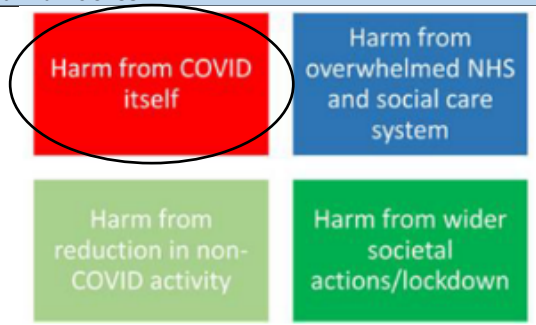
	 ABUHB 2020-21 MHLD Divisiona...  AB CHC update report June 2021...  Transforming Adult Mental He...

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
• **Getting it right for children and young adults** • **Supporting adults in Gwent to live healthy and age well** • **Provide high quality care and support for older adults** • **Staying healthy** • **Care closer to home** • **Less serious illness which require hospital care**		***CRR023 – (May 2020)*** ***Threat Cause: Priority being given to management of the COVID pandemic*** ***Threat Event: Risk to population health in relation to non - COVID harm*** **TREAT**					
High Level Themes	• Population health • Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Finance	**Risk Appetite**		Zero or low level of risk in terms of protecting patient safety and the quality of services however, innovative means of tackling backlogs of waiting lists and working SMARTER in the future needs to be considered and in this case, a higher risk appetite will be applied.			
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Patient, Quality, Safety and Outcomes Committee	• Departmental repurposing and redesign to accommodate non-COVID activity has occurred. New ways of working adopted e.g. virtual reviews. Nosocomial Group operating, providing advice and support. • Adapt and sustain progress being monitored through Exec Team meetings via Director of Operations. • Plan in place for for green recovery (treatments) RGH – all specialities excluding orthopaedics • Orthopaedic operating at OSU and NHH (P2) • Outpatient Steering Group • Robust escalation reporting and escalation arrangements within primary and community services division.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	4	5	4	5
Early recovery plan agreed focusing on Cancer, 52 weeks, Follow Up waits, Diagnostic and Therapies waiting times, and Eyes Care. Formal recovery plan for 2022/23 being developed as part of the Annual Plan. Focus on new ways of working will be fundamental to the approach. Risk stratification and validation of lists is ongoing and focus is on Urgent and Cancer work.	Mar-22	**20**		**20**		**20**	

Weekly tracking of recovery plus tracking of new ways of working in place, the priorities outlined above mirror those in F&T with similar work progressing operationally around risk stratification, validation, daily scrutiny of cancer pathways, WLI OPD sessions for clinically urgent patients, maximising PAC and theatres and on a transformational level, redesigning of services.	Mar-22			
Trend		**Executive Owner: Director of Operations and Director of Primary Care, Community and Mental Health**		
Mapping Against 4 Harms of COVID		**Update**		
		**Jan 2022** Prioritisation for use of capacity is as follows: ➢ Cancer, suspected cancer, and urgent, for new outpatients (R1 for ophthalmology) for all surgical and non-surgical specialities including therapies ➢ Suspected cancer, urgent and routine for diagnostics (due to the number of cancer cases that arise from routine tests) ➢ New urgent and routine outpatients over 52 weeks ➢ Patients waiting for a new outpatient appointment over 104 weeks to be reviewed ➢ 100% delayed Follow-up outpatients ➢ Adhering to the surgical prioritisation during the coronavirus pandemic (Version 2 – June 2020 – P1a, 1b, 2, 3 and 4), as well as the separate guidance in terms of obstetrics and gynaecology (RCOG) and ophthalmology (RCOphth): Continued use and expansion of Consultant Connect – Specialist Advice Service. A number of staff have recently been appointed, and a communication plan drafted, enabling patients to have one point of access. The team will be able to advise on issues such as waiting times, or assist with obtaining the information about treatments or rehabilitation actions. **Outpatients** Patients who are waiting over 52 weeks for a new outpatient appointment have been contacted as part of the validation expectation This will progress to new patients who are waiting 36-52 weeks, this commenced with ENT in January 2022, and other services will follow. Ongoing clerical validation of both outpatient and treatment waiting lists.. Capital Conversion of estate to create a one stop OPD Treatment Centre (completion date 21st February). It will consist of two theatres. The procedures currently looking to be undertaken are: ➢ Iron Infusions - colorectal, rheumatology, neurology, nephrology ➢ Neurology – one stop lumbar punctures ➢ Minor ops – Max Fax, training lists		

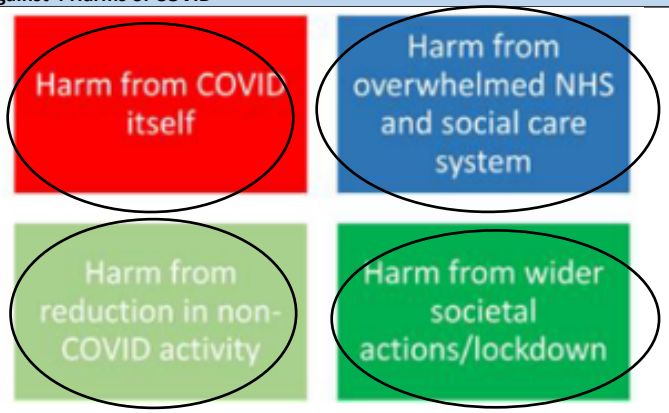
	➢ General Surgery minor ops –lumps and bumps, cysts, lipomas ➢ Minor breast lists – cysts ➢ Dermatology Approximately 6,982 patients per annum to be undertaken within the unit (social distancing requirements still apply). **Treatments** Recommenced Paediatric day case lists for General Surgery, ophthalmology and ENT site. The Performance Team are working on a pilot with Orthopaedics using 'Quick Question' to contact patients to establish if they still require their appointment. This will be targeted at P4 patients. Aim to commence end of Jan/beg Feb. Outcomes to be reviewed prior to roll out to other specialities. **Primary and Community Services** • A Restart & Recovery Programme has been developed in primary care, including prioritising the areas of greatest concern / backlog from a primary care perspective. A Restart & Recovery Working Group has been established to oversee the work and now meets fortnightly. This Programme has since widened to include key priorities over winter, where we know that staff time will need to be prioritised but also where continued backlog / suspension of services is likely to have a significant impact if not addressed. The programme plan for this is attached. A mechanism for monitoring and reporting activity in primary care has been developed since the beginning of the pandemic and ABUHB is the only HB in Wales with this level of intelligence. This has now been supplemented with a more detailed assessment of one week's activity in primary care, which is currently being analysed in preparation for being presented to the Executive Team. This information is being used to assess the variation in practice activity / operational models during the pandemic and now. A summary of this data is now included in our weekly performance report and monthly performance briefing – latest versions of both attached for assurance. This shows that activity in primary care has steadily been increasing with more and more F2F contacts being performed.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
• Less serious illness that require hospital care • Providing high quality care and support for older adults		***CRR013 – (Jul-18)*** ***Threat Cause: Failure to effectively manage community and hospital transmission of Health Care Acquired Infections (HCAIs) to include COVID 19.*** ***Threat Event: Widespread hospital and community harm leading to increase in demand and acuity.*** **TREAT**					
High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence	**Risk Appetite**		Zero/Low Appetite			
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Patient, Quality, Safety and Outcomes Committee	• Robust internal policies • Multiple SOPs	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		3	5	3	5	2	5
Reducing nosocomial transmission group (RNTG) which is clinically led, reports to Executive Team weekly. COVID hospital transmission implementation plan is in place, recently updated and with frequent auditing and monitoring. Clostridium Difficile rapid implementation plan developed and monitored via RNTG	Ongoing	**15**		**15**		**10**	
Trend		**Executive Owner: Director of Nursing**					

Mapping Against 4 Harms of COVID	Update
	**January 2022 COVID-19** Overall cases of COVID-19 and test positivity continues to increase in our communities, resulting in an increase in patients presenting to our hospitals with COVID-19. The Health Board is reporting an increased trend in hospital admissions. Omicron as the new VoC, and deemed highly contagious, is placing significant pressure on hospital sites in regards isolation, ward closure and outbreak management control. Several wards within the acute and mental health setting are in outbreak mode. Each outbreak has undergone a thorough root cause analysis, essential to understand the transmission of COVID-19 and focus on improvement. Each outbreak has been reported to Welsh Government, index cases have been linked to asymptomatic carriers and have been identified on five day inpatient testing. The Health Board has an established red patient pathway supported by single room hospitals. This assists in reducing the risk of COVID-19 transmission and is in-line with the recommendations contained in the hierarchy of control risk assessment. The HB continues to implement admission and inpatient five day testing to identify asymptomatic carriers. It also supports the testing for other winter respiratory infections such as RSV and Influenza. The HB has a robust visiting policy which is regularly reviewed and updated in-line with Welsh Government guidance. Due to the challenges being faced with the new Omicron variant an update on the 9th January reinforced the message of visiting with a purpose. LFD testing for all visitors is in place to reduce the risk of COVID-19 transmitting into the Health Board setting. All standard operating procedures and policies relating to COVID-19 and VoC are discussed and ratified at the reducing nosocomial transmission group (RNTG). Site based leadership representation is core to RNTG in order to provide assurance on the implementation and monitoring of the Covid-19 implementation plan. Staff risk assessments have been developed and are regularly updated in line with WG guidelines, to support safe return to work when “Ping” or in close contacted to a positive case and have been identified by track and trace or have recently returned from an amber country. **Clostridium Difficile** Clostridium Difficile within ABUHB continues to exceed the Welsh Government reduction expectation target. USC and the Community Divison are currently the areas of concern. Recent months have seen a slightly improved picture however the trajectory remains above the WG target. In response a rapid implementation plan has been developed to incorporate all key principles required for the reduction and management of Clostridium Difficile in line with national guidelines. This now forms a key agenda item with RNTG. Challenge and support meetings have been undertaken in order to ensure improved performance and divisional ownership in the prevention, management and reduction of clostridium difficile. **Respiratory syncytial Virus (RSV)** There is an expectation that the health board will receive an increased number of patients, in particular children, with RSV due to limited community immunity. In response, the Family and Therapies Division, in collaboration with key members, have implemented a surge plan for the management of RSV. Regular updates are provided to ET and Welsh Government.

	The expected significant surge expected has not currently translated into hospital admissions. To date the HB has had no incidents of cross transmission and is currently managing within the existing footprint. The HB continues to routinely test water within our augmented care areas as required by national guidelines. Within the neonatal area a count of pseudomonas was identified. In response a local disinfectant of the water systems was implemented, filters placed on taps, cleaning of the clinical hand washing sinks revisited. Repeat samples have identified no counts of pseudomonas. No negative impact for babies was noted.

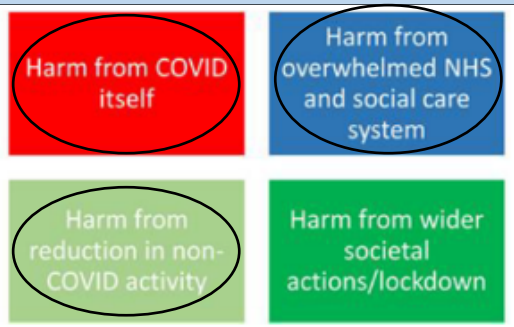
Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision		
Priority 1 – Every child has the best start in life **Priority 2- Getting it right for children and young adults** **Priority 3 – Adult in Gwent live healthy and age well** **Priority 4 – Older adults are supported to live well and independently** **Priority 5 – Dying well as part of life**		***CRR030 – (Re-framed Jan 2022) *this risk has interdependencies with CRR002 Workforce Risk**** ***Threat Event: Safeguarding incidents to include all forms of abuse, domestic violence and radicalisation, now being realised where they had previously been 'masked' due to lockdown, placing additional pressures on the Health Board Safeguarding services compounded by limited contact with clinical professionals and restricted visiting.*** ***Threat Cause: Limited contact with public and NHS services - COVID restrictions in addition to clinical deployment to support Public Health Mass Vaccination programme.*** **TREAT**		
High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Staff Well Being • Financial • Public Health - COVID	**Risk Appetite**	Risk Appetite is low in this area due to potential impact on quality, experience and patient outcomes however, tolerances could be flexible as the Health Board develops innovative ways to mitigate this risk.	
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**		
Patient Quality, Safety and Outcomes Committee	• Training in VAWDASV and Safeguarding has been delivered to the Board in June 2021 as a development session. • Robust monitoring of activity through the Safeguarding Committee • Monthly practitioner concerns data shared with Divisions to review and manage • Safeguarding work programme for 2021/22 developed • Safeguarding Strategy in place	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***	**Current** ***Risk level after initial controls/mitigations have been implemented.***	**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***

	• Risk management re: workforce deployment to mass vaccination clinics at Strategic level in response to WG request. • DoLs consortium overseeing activity e.g. Waiting lists, compliance monitored via the QPSOG and PQSO Committee. • Local escalation framework for DoLS.						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		5	5	4	4	2	5
• Weekly review of safeguarding staff currently redeployed to support mass vaccination programme. • Agreement of clinical sessions for Best Interests Assessors to support mass vaccination clinics, mitigated by commissioning agency BIAs. • Regional consortium will continue to monitor the DoLS action plan and escalate as required. • Safeguarding positon continues to be monitored at Safeguarding Committee with escalation to Executive Team as required.	Weekly 31st Jan 2022 Monthly Monthly	**25**		**16**		**10**	
Trend		**Executive Owner: Director of Nursing**					
Mapping Against 4 Harms of COVID		**Update**					
		Jan 2022 – The following training compliance data was presented to the last Safeguarding Committee: **Level 1 Safeguarding Adult Training** - Overall compliance 69%. **Level 1 Safeguarding Children Training** - Overall compliance 77%. **VAWDASV Group 1 Training** - Overall compliance 69%. It was agreed that the Corporate Safeguarding Team would consider how it could further support training compliance within the Health Board. Safeguarding was subject to an Internal Audit and a ***reasonable assurance*** was achieved. One of the recommendations was the establishment of a Safeguarding Operational Group. This was established in Quarter 3 to support the delivery of the Safeguarding Strategy through the Work Plan. This is achieved through collaboration working with the Divisions. Based on the 2020- 2021 Annual Safeguarding Report, a work programme has been developed for 2021/22 which outlines 8 priority areas. The Health Board will measure success against the 8 priority areas and monitoring of progress will take place at the Safeguarding Committee and as necessary to the Patient Quality, Safety and Outcomes Committee.				

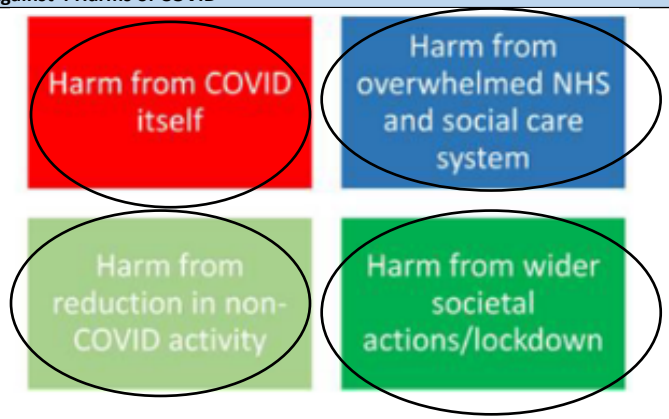
	Progress has made against the Safeguarding Work Plan and alternative ways of working have been employed to mitigate and ensure actions are delivered on time. The Safeguarding Strategy will now enter its final year and work is underway to consider how this can be evaluated. Members of the Safeguarding Committee had been asked to consider the Safeguarding annual report and the impact for divisions and their priorities for QTR 4 2021-2022. The themes presented: • Training, particularly Level 2. • Aligning Safeguarding Level 3 training • Awareness of when Duty to Report Required • Using case examples and scenarios to raise awareness • Continuing Health Care funded placements and links to Safeguarding The Health Board reports to WG on DoLS activity annually and significant waiting lists are experienced consistently across Wales, this continues to be an issue Nationally. Workforce risk assessment around staff redeployment to the mass vaccination programme to continue to be robustly monitored weekly and any necessary escalations made available to staff.

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="3">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2">Getting it right for children and young adults
Supporting adults in Gwent to live healthy and age well
Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness that require hospital care
Dying well</td><td colspan="3">CRR019 – (Jan 2022) Re-framed
Threat Cause: Significant delayed transfers of care, domiciliary and care home constraints.
Threat Event: Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand.
TREAT TOLERATE</td></tr>
<tr><td>High Level Themes</td><td>Patient Outcomes and Experience
Population Health
Quality and Safety
Reputational
Public confidence
Financial</td><td>Risk Appetite</td><td colspan="2">Low level of risk appetite in relation to patient safety risks. However, moderate levels of risk with regard to innovation and changing models of care and roles to prevent demand and better to demand. Therefore the Health Board will seek to Treat and Tolerate this risk within agreed and specified tolerance/capacity levels.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Patient, Quality, Safety and Outcomes Committee</td><td>Health Board Emergency Pressures Escalation Policy (revised Nov 2021)
Health Board surge plans.
Health Board SLA with WAST
System Leadership and Response – whole system planning – meets x2 weekly.
Cross-site meetings to discuss system and flow pressures meets x4 daily.
Emergency Care Improvement Board – meets monthly
Urgent Care Transformation Board</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	4	5	3	5
Short Term:		**20**		**20**		**15**	
• Public messaging including social media to ask the public to consider other options before attending the Emergency Department. These messages have been shared through partner organisations, the Health Board website and social media channels.	Ongoing Ongoing						
• Respiratory Ambulatory Care Unit go live - phase one consultant to identify suitable patients, phase two Flow Navigator	Ongoing						
• Discharge improvement Board – Nurse Led Discharge SOP to be ratified.	Feb 2022						
• GP/HCP - one single point of access for GP to arrange admission and book transport.	Ongoing						
• Continued GP aligned to the Flow Centre triaging patients on the ambulance stack, redirecting patients to appropriate pathways and services following a request for an emergency response by contacting 999	Ongoing						
• Home First service extend focus to ED at the GUH to ensure that those people who are able to be re-directed or are able to use Direct conveyance to community beds	Ongoing						
• Care home conveyance - Highest reasons for calls/conveyance is falls/injury from fall – response will be co-ordinated							
• High Risk Adult Cohort (Venn diagram) – pilot project, multiagency group building on existing compassionate communities framework to ensure that those individuals who have been in hospital in the last year have health review and plan in place							
• Table top exercises have commenced between MIU/UPCC/111 to ensure the 111 Algorithm is directing patients to the right places, this work has suggested there is further improving to the numbers of patients directed towards UPCC , size of opportunity currently being quantify.							
• Implementation of Trauma day unit in GUH site	Ongoing						
Medium Term (3-12 months)							
• Development of the SDEC bid on the GUH site	Summer 2022						
• Integrated Front Door proposal at Nevill Hall	Ongoing						
Trend since last reporting period		**Executive Owner: Director of Operations**					

Mapping Against 4 Harms of COVID		**Update**
		Jan 2022 The Health Board continues to work alongside the Delivery Unit to maximise discharges, this includes engagement with Senior Nurses, discharge co-ordinators and relatives/family members. Continued population engagement on accessing most appropriate services, at the right place, at the right time and teams at the GUH are continuing to have sensitive conversations with family members regarding discharges. A number of Health Board initiatives are underway and regular reviews are undertaken to understand benefits and extract learning. SDEC care currently being delivered in Respiratory and Gastroenterology with the potential to increase patients being treated there if pts can be streamed from Flow Centre. Build has commenced for dedicated SDEC in GUH site that will incorporate surgery and acute medicine in Summer of 2022. The Clinical Operating Model for SDEC at GUH is being refined, workforce recruitment and on-boarding plans developed. Orders for the equipping of the facility have been progressed to capitalise on the funding that has been allocated by WG; to be committed this Financial Year. Outcome of System Re-set weekend – significant system benefits were seen over the weekend and this was down to a number of factors. The outcome of the weekend currently in the process of being typed up and to be shared with the Exec team about what we should prioritise for WF supply and embed in our system over winter and beyond. In particular initiatives that work included (but is not exhaustive): • 7 day cover for pharmacy and therapies • Input of home first on the weekend • Growing team of Physicians Associates to support discharge • Focus on discharge not step down • GUH Frailty model Escalation plan agreed at Executive Team December 2021. Continues to embed and implement – table top exercise planned for Spring 2022. Holly Ward – step closer to home facility enabled w/c 24th Jan 2022. It is important to note that this risk profile should be reviewed and considered in conjunction with CRR002 (Workforce) and cross reference to CRR013 (IPAC) Resource/staffing capacity has been significantly impacted particularly at ED and MAU due to infection outbreaks and ward closures.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
Priority 1 – Every child has the best start in life **Priority 2- Getting it right for children and young adults**		***CRR028 – (June-2021)*** ***Threat Event: - Continued inappropriate admissions of children aged under 18 to acute adult mental health wards. Particularly where admissions are of under 16 year olds, are for longer than 72 hours and/or are not compulsory detentions under the Mental Health Act.*** ***Threat Cause: Inability to access appropriate acute/crisis beds for this age group in the region*** **TREAT**					
High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Staff Well Being	**Risk Appetite**		The risk appetite in this area is low however, a moderate level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.			
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Patient Quality, Safety and Outcomes Committee	• Policy in place for the use of adult MH beds for up to 72 hours. • Designated bed in Extra Care Area • C&YP aged under 16 are nursed 1:1 and are prevented from mixing with other patients on the ward. • If YP is detained under the Mental Health Act, the safeguards inherent with this legislation apply.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	4	5	2	5
CAMHS is working with partners to develop Crisis support for C&YP which will include crisis beds.	Ongoing	**20**		**20**		**10**	

Trend		Executive Owner: Director of Operations
Mapping Against 4 Harms of COVID		**Update**
		Jan 2022 It should be acknowledged that this risk is part of a broader National risk in relation to children who present to acute services in crisis. The Health Board continues to work with Welsh Government on a National level to develop plans to mitigate this risk. Although it is acknowledged that this is an issue for the Health Board as it has already been realised, it remains a continuing risk not only to the Health Board but across Wales and as a result CAMHS has over the last few years created and extended their liaison response and crisis outreach response which is evidenced to have reduced self-harm and suicide and diverted children, young people from hospital with a reduction in bed use in spite of the increase in crisis presentation. CAMHS is also looking at further enhancements building on weekend cover, particularly boosting the out of hours cover and ongoing work with key stakeholders: a) At a meeting with Gwent Local Authority Heads of Children's Service on Monday 06 September 2021, we agreed to develop a guide document in relation to the support of Children's Crisis Admission (these are children classed as a delayed discharge from hospital on social grounds). b) As part of the agreement, CAMHS and the 5 Gwent Local Authority Heads of Children's Service agreed to a shared responsibility for keeping the child/young person safe in hospital (previously this had been the sole responsibility of ABUHB/CAMHS). c) CAMHS and the 5 Gwent Local Authority Heads of Children's Service also agreed to explore a medium to long term plan of providing psychosocial support to children and young people in the community as an alternative to hospital admission. d) CAMHS received an investment of £500k non-recurring in 2021 towards management of crisis admissions that will be utilised in partnership with ABUHB colleagues and Gwent Local Authority Heads of Children's Service, to meet crisis bed requirements. e) The convening of a pathway group between ED and CAMH's to ensure there is an agreed protocol and escalation should these patients present Further developments are underway currently working with Works Estates to establish a CAMHS Crisis Rapid Assessment Centre and Intervention at the St Woolos site. The site will aim to provide: • A safe space for young people struggling with emotional distress to be able to access skilled support on an ad hoc basis, as opposed to attending ED • The Centre will aim to reduce hospital admissions and emergency presentations by providing practical, therapeutic interventions. • Young people who have been assessed by CAMHS emergency liaison team and who are awaiting discharge can attend the centre to wait safely and securely for transport. Further updates on this development will be presented as and when they become available.

<table>
<tr><td colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="6">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2">Providing high quality care and support for older adults
Less serious illness that require hospital care</td><td colspan="6">CRR010 –
Threat Cause: Patients will fall whilst they are in our services
Threat Event: Patients will be harmed or injured.

TREAT</td></tr>
<tr><td>High Level Themes</td><td>Patient Outcomes and Experience
Quality and Safety
Reputational
Public confidence</td><td colspan="2">Risk Appetite</td><td colspan="4">Risk appetite in this area is zero or low in the interests of patient safety.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="6">Risk Score</td></tr>
<tr><td>Patient, Quality, Safety and Outcomes Committee</td><td>Comprehensive corporate falls prevention action plan agreed. Policy for the Reduction of Inpatient Falls in place.
Multidisciplinary training and support to drive improvement
Reports on inpatient falls provided to Executive Team and Quality, Patient Safety and Outcomes Committee.
Improvement metrics agreed and overall numbers of inpatient falls is within trajectory for improvement.
An ongoing data analysis allows for the identification of shifts and trends associated with falls and activity outside of normal variation.
ABUHB engagement in the ‘All Wales Inpatient Falls Network’ in support of the development of a more consistent, standardised approach to falls management across Wales.
The ‘Falls and Bone Health Committee’ looks to align its work to the National Audits and associated recommendations.</td><td colspan="2">Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td colspan="2">Current Risk level after initial controls/mitigations have been implemented</td><td colspan="2">Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
<tr><td colspan="2">Action Plan SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.</td><td>Due Date</td><td>Likelihood</td><td>Consequence</td><td>Likelihood</td><td>Consequence</td><td>Likelihood</td><td>Consequence</td></tr>
<tr><td colspan="3"></td><td>4</td><td>5</td><td>3</td><td>5</td><td>2</td><td>5</td></tr>
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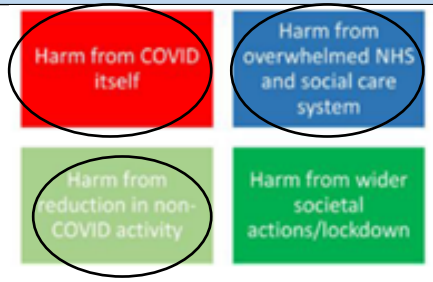
• Promoting (through training) the multidisciplinary requirements of the policy including completion of required risk assessments & care plans. • To also include the promotion of the newly developed falls specific medication review tool and falls associated Head Injuries pathway. • Learning from serious incidents with audit of agreed actions and expected outcomes. • Evaluation of the falls components of the 'Once for Wales' incident reporting system to ensure the opportunity to maximise the value of the data sets included.	Ongoing	**20**	**15**	**10**

Trend		**Executive Owner: Director of Therapies and Health Science**

Mapping Against 4 Harms of COVID	**Update**
	January 2022 The 'Falls Policy for Hospital Adult Inpatients' was formally launched in July 2021 supported by an extensive awareness raising campaign. Staff training has been aligned to the requirements of the revised Policy. Work continues at our Community sites to further promote the MDT approach and requirements. The progress and impact of this work is monitored by the Falls and Bone Health Committee. A collaborative review of the governance structures in support of the management of falls has been undertaken by the Falls and Bone Health Steering group. This group will be retitled the 'Falls and Bone Health Committee' with the establishment of two new subgroups to undertake work associated with inpatient falls and those in the community setting outside of the hospital environment. The Falls and Bone Health Committee will report directly to the Patient Quality, Safety and Outcomes Committee. The revised governance structure will come into effect from February 2022. A group was been established to review the learning processes and actions adopted for those inpatient falls associated serious incidents and injury, including the mechanisms for the monitoring/auditing of associated action plans. The group has identified that further work is required to ensure that learning is being implemented, monitored and audited in a consistent and coordinated way across the Health Board. This action will be overseen by the Falls and Bone Health Committee. Work continues in light of continued system pressures and falls in the Emergency Department, with an Audit/ Pathway working group established to consider opportunities to improve safety in this specific environment. The Health Board continues to participate in the all-Wales inpatient falls Network, including engagement in the 4 Nations Falls Collaborative; this provides opportunity for shared learning and benchmarking.