Patient Quality, Safety and Outcomes Committee

Tue 30 July 2024, 09:30 - 12:30

MS Teams

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

Agenda

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of the last Meeting held on Tuesday 4th June 2024

Attached *Chair*

- 1.4 PQSOC Minutes 4th June 2024 reviewed PB.pdf (7 pages)

1.5. Committee Action Log

Attached *Chair*

- 1.5 final Action Log PQSOC July 2024 RD docx.docx updated version.pdf (2 pages)

2. ITEMS FOR DISCUSSION

2.1. Committee Risk Report

Attached *Director of Corporate Governance*

- 2.1 Committee Risk Report_PQSOC_July 24.pdf (6 pages)
- 2.1 Appendix A PQSOC Strategic Risk Register.pdf (1 pages)
- 2.1 Appendix B Dashboard and Risk Assessments.pdf (4 pages)

2.2. Quality Performance Report

Attached *Clinical Executives*

- 2.2 PQSOC Performace report July 2024.pdf (6 pages)
- 2.2a PQSOC Performance Report - July 2024 (1).pdf (97 pages)

2.3. Mortuary Incident Action Plan

Attached *Director of Therapies and Health Science*

- 2.3 Mortuary Action Plan SI Action Plan Feedback.pdf (6 pages)
- Copy of 2.3a Moruary SI Acton Plan.pdf (1 pages)
- 2.3b Att 2 Mortuary Action Plan SI.pdf (6 pages)
- 2.3c Att 3 Morutary SI Action Plan.pdf (9 pages)

2.4. Commissioning Assurance Framework

Attached *Clinical Executives*

- 2.4 Updated Version SBAR - QAF for Commissioned Services - PQSOC July 2024.pdf (6 pages)
- 2.4a Updated Version Quality Assurance Framework for Commissioned Services - PQSOC - July 24.pdf (12 pages)
- 2.4 Commissioning Assurance Framework Report.pdf (6 pages)
- 2.4 a Appendix 1 Commissioning Assurance Framework - FINAL - 02.07.24.pdf (9 pages)

2.5. Maternity Services: Organisational Improvement and Action Plan

Attached *Director of Nursing*

- 2.5 Maternity Services Improvement Plan 2024-27 - SBAR for Execs.pdf (5 pages)
- 2.5 Appendix 1 - ABUHB Maternity Services Improvement Plan 2024-2027 (002).pdf (19 pages)
- 2.5 ABUHB Maternity Services Improvement Plan - 2024-27.pdf (11 pages)

2.6. Review of Committee Programme of Business 2024/25

Attached *Director of Corporate Governance*

- 2.6 PQSOC FWP cover report July.pdf (4 pages)
- 2.6a Final PQSOC FWP 2024-15 v14 used for July meeting updated following review. docx.pdf (9 pages)

3. ANNUAL ASSURANCE REPORTS

3.1. Pharmacy & Medicines Management Annual Report 2022/23

Attached *Medical Director*

- 3.1 Cover report PQSOC - Pharmacy MM Annual Report FINAL SBAR.pdf (4 pages)
- 3.1a v2 ABUHB - Pharmacy MM Annual Report 22-23 FINAL.pdf (44 pages)
- 3.1b Annual prescribing report 2022-23 - Aneurin Bevan.pdf (6 pages)

3.2. Hospital Transfusion Committee Annual Report

Attached *Medical Director*

- 3.2 PQSOC - HTC Annual Report SBAR.pdf (4 pages)
- 3.2a Annual Report 2023-24 Hospital Transfusion Committee.pdf (19 pages)

3.3. Infection Prevention and Control and Cleaning Standards Annual Report 2023/24

Attached *Director of Nursing*

- 3.3 SBAR - Infection Prevention_ Decontamination Antimicrobial Stewardship Annual Report 2023-24.pdf (7 pages)
- 3.3a IPAC Annual Report 2023-24.pdf (27 pages)

3.4. Safeguarding Annual Report

Attached *Director of Nursing*

- 3.4 Safeguarding Annual Report 2023-24.pdf (4 pages)
- 3.4a Safeguarding Annual Report 2023-24.pdf (18 pages)

4. ITEMS FOR INFORMATION

4.1. Overview of Internal & External Audit Recommendation Tracking

Attached *Director of Corporate Governance*

- 4.1 Internal & External Audit Recommendations Tracker Q1 2024-25 Cover Report.pdf (5 pages)
- 4.1 Appendix A_29 Clinical Recommendations Audit Recc Tracker.pdf (2 pages)
- 4.1 Appendix B_ 16 Recommendations Requiring an Update.pdf (1 pages)

- 4.1 Appendix C_6 Completed Recommendations Audit Recc Tracker.pdf (1 pages)
- 4.1 Appendix D_8 Recommendations with Revised Timeframes.pdf (1 pages)
- 4.1 Appendix E_2 Remaining Overdue Recommendations.pdf (1 pages)

4.2. Children's Rights & Participation Forum

Attached *Director of Nursing*

- 4.2 Children's Rights SBAR July 2024.pdf (3 pages)
- 4.2a Highlight Report Children's Rights Forum 22.07.24.pdf (3 pages)

4.3. Review of Neurodevelopmental Service for Under 18s

Attached *Director of Nursing*

- 4.3 Board and Committee Report for All Wales NH under 18s Review and Response.pdf (4 pages)
- 4.3a Divisional Response to the NHSE Publication of the All-Wales Review of ND Service for under 18s.pdf (8 pages)

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5. OTHER MATTERS

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

Oral *Chair*

5.2. Any Other Urgent Business

Oral *Chair*

5.3. Date of the Next Meeting: 2nd September 2024

Oral *Chair*

Agenda Item – 1.4

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

MINUTES OF THE PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE MEETING

DATE OF MEETING	Tuesday 4th June 2024, 2:00pm
VENUE	Microsoft Teams

PRESENT	Pippa Britton, Independent Member, Committee Chair Helen Sweetland, Vice Chair Paul Deneen, Independent Member Penny Jones , Independent Member
IN ATTENDANCE	Jennifer Winslade, Director of Nursing Rani Dash, Director of Corporate Governance Peter Carr, Director of Therapies & Health Science James Calvert, Medical Director Michelle Jones, Head of Board Business Neil Patrick, Independent Member Leeanne Lewis, Assistant Director of Quality & Patient Safety Rhian Gard, Deputy Head of Internal Audit Sara Utley, External Audit Tracey Partridge-Wilson, Deputy Director of Nursing Jayne Beasley, Head of Midwifery & Gynaecology Moira Bevan, Head of Service Infection Prevention and Control Nurse Richard Morgan-Evans, Deputy Director of Operations Jessica Scurr, Quality Improvement Advisor Scott Taylor, Head of Health, Safety & Fire Margaret Parrott, Cancer Services Manager Tanya Strange, Head of Nursing Person Centred Care Thomas Jaynes, Committee Secretariat
APOLOGIES	None

PQSOC 0406/1	**Preliminary Matters**
PQSOC 0406/1.1	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC 0406/1.2	**Apologies for Absence** There were no apologies for absence to record.

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PQSOC 0406/1.3	**Declarations of Interest** There were no declarations of interest raised to record.
PQSOC 0406/1.4	**Minutes of the previous meeting** The minutes of the Patient Quality, Safety and Outcomes Committee held on 30th April 2024 were agreed as a true and accurate record subject to the following amendment:- PQSOC 3004/3.4 The change in SOP to allow patients with a pre-op mortality of <10% to receive surgical care at RGH had been undertaken as a way of balancing the risk that accrues for patients of being on extended waiting lists. The process of patient selection was clinically led and adverse incidents on the surgical pathway at RGH were reviewed in the surgical M&M meeting and no concerns had been raised to date with respect to altering the risk threshold for surgery at RGH.
PQSOC 0406/1.5	**Committee Action Log** The Committee received the action log and was content with progress made in relation to completed actions and against any outstanding actions, as set out within the paper.
PQSOC 0406/2	**Items for Discussion**
PQSOC 0406/2.1	**Development of Committee Annual Programme of Business 2024/25** Rani Dash (RD), Director of Corporate Governance, provided an overview of the Forward Work Plan and changes since the plan was approved by the Committee in April 2024. *The Committee **NOTED** the updated Committee forward work plan as provided in Appendix 1.*
PQSOC 0406/2.2	**Committee Risk Report** Rani Dash (RD), Director of Corporate Governance, provided the Committee with an overview of the Committee Risk Register for which the Board had delegated responsibility to the Committee. RD advised that since the last report to the Committee, the risk environment had remained relatively stable, with no changes in the risk scores and advised that the following risks were reported as a risk level of High and Extreme:-

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	• **SRR 005** - There is a risk that the Health Board would be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system. (High) • **SRR 008** - There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public. (High) • **SRR 010** - There is a risk that the Health Board would fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974. (Extreme) The Committee was advised that the Committee was previously cited on the risk in relation to the Pharmacy Robot which was included within the corporate risk register and that a risk assessment had been completed and an update on this would be reported to the next Committee meeting in July. *The Committee **NOTED** the following:* • *Delegated strategic risks* • *Delegated corporate risk* • *Work being undertaken to reduce the risks to within appetite level.* • *Work being undertaken to ensure the Committee is sighted on all risks that have the potential to impact patient quality and safety.*
PQSOC 0406/2.3	**Quality Performance Report** Jennifer Winslade (JW), Director of Nursing, supported by, James Calvert (JC), Medical Director, Peter Carr (PC), Director of Therapies & Health Science, Moria Bevan (MB), Head of Service Infection Prevention and Control Nurse, Jayne Beasley (JB), Head of Midwifery & Gynaecology, Jessica Scurr (JS), Quality Improvement Advisor, Scott Taylor (ST), Head of Health, Safety & Fire, Richard Morgan-Evans (RME), Deputy Director of Operations, Margaret Parrott (MP), Cancer Services Manager, provided the Committee with an overview of the patient quality safety outcomes performance report for the period. JW advised the Committee that the Quality Patient Safety Report (QPS) would be reviewed to include learning to secure further improvement on the quality of reporting. JW advised that there was a need to improve the performance of responses to complaints and noted a target of responding to 75% of complaints within 30days by 1st October 2024 and that the satisfaction score for Patient

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Experience was reported at 89%. The Committee was advised that a new test system would be piloted with a view to securing further improvements.

The Committee was advised that a key area of focus within Patient Safety Incidents was relating to human factors. The Committee noted the Health Board would take the learning from the investigations made on incidents reported and that a new governance structure had been put in place to monitor outstanding actions with the support of the divisional team.

JW advised the Committee that since November 2023, the Health Board had not experienced any Never Events. JW confirmed that there had been 29 incidents of duty of candour since April 2024, and that the reported number of Measles cases within Gwent was 17 cases and the incubation period was drawing to a close.

JW reported that Health Inspectorate Wales had undertaken a review at Ty Lafant, Llanfrechfa Grange in April 2024. JW advised that the report was awaited but confirmed that no immediate improvements were required in respect of the unit.

Moria Bevan (MB), Head of Service Infection Prevention and Control Nurse, provided the Committee with an update in respect of infection, prevention and control. MB advised that during the period a high level of C Diff cases had been reported and advised that a multidisciplinary team had been established to address the increase and to return rated to within normal levels.

Paul Deneen (PD), sought assurance as to the actions that were taken in informing patients and families of the implications of infection, and was advised that communication was key and work was ongoing with Public Health for the information to be made available on the internet.

Jayne Beasley (JB), Head of Midwifery & Gynaecology, provided the Committee with an update in respect of the Maternity Unit at GUH. The Committee was informed that a full midwife staffing compliment was in place, and where bank staff had been used this would impact the variable pay spend. JB assured the Committee that improvements in training compliance was evidenced with PROMT training reported at 44%, and CTG training reported at 59%. The Committee sought assurance as to how training

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compliance of locums was recorded, and was informed that from September 2024 where recruitment occurs all staff would receive training as part of the induction programme.

JB advised the Committee that a Community PROMT Quality Assurance review had taken place in March 2024 and the outcome was positive.

JW provided the Committee with an update in respect of the Mental Health & Learning Disabilities performance and noted that engagement with staff was ongoing, that an effective governance and escalation process had been implemented and noted the ongoing improvements in recent months. The Committee requested for a report to be submitted to the October meeting in respect of the challenges that had occurred in securing improvements within the Division.

Action:

- Director of Nursing/Chief Operating Officer to submit a report on the challenges that had occurred in securing improvements within the Division to the October meeting.

Jessica Scurr (JS), Quality Improvement Advisor, provided the Committee with an overview of the the quailty improvement work that had been completed in reducing Never Events within Theatres,with the aim reducing Never Events incdents to less than 1 in 20,000 procedures by January 2026, throught the introduction of a safer surgery checklist. JS informed the Committee of the breadth of the approach deployed which included psychological staff safety surveys and the next steps for the project which included reviewing the barriers with a view to resolving issues and securing improvement.

The Committee thanked JS and the project team for the work undertaken which had resulted in no Never events reported for a significant period of time.

Scott Taylor (ST), Head of Health, Safety and Fire, provided the Committee with an overview of the position of Datix Incidents for the period December 2021 to March 2024 where 70,645 incidents had been reported. The Committee was assured that 95% of the unrejected incidents were closed, with 76% of closed incidents coded as no or low harm.

The remaining 2,905 incidents which were open had 71% coded as patient safety incidents. The Committee noted

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	that an agreement with the divisions was in place for a rapid review of open incidents to be conducted. ST provided the Committee with an overview of the categorisation when reporting incidents which was aligned with the national policy for patient safety. The Committee noted that a benchmarking exercising had been undertaken with other health boards across NHS Wales management of Datix and the resources to support this function would be considered by the Executive Committee. The Committee requested for a report to be presented at a future meeting to discuss the responsibilities and resourcing for the management of Datix. Rani Dash, Director of Corporate Governance, advised that these were responsibilities of the Executive Team and this was planned to be discussed. Richard Morgan-Evans (RME), Deputy Director of Operations, and Margaret Parrott (MP), Cancer Services Manager, provided the Committee with an overview of the suspected Cancer pathway. The Committee was advised that a new pathway had been designed to enable the prompt treatment of cancer patients. The Committee noted that the recent industrial action had impacted upon the performance of the pathway as junior doctors were not able to support, which in turn resulted in delays in patients accessing the pathway with delayed test results and accessing surgery. The Committee noted that a task and finish group had been established in respect of tumour sites and tertiary services with the aim of improving performance. *The Committee **NOTED** the information within the report.*
PQSOC 0406/2.4	**Annual Volunteering report** *Tanya Strange joined the meeting* Tanya Strange (TS), Head of Nursing Person Centred Care, provided the Committee of an overview of the Annual Volunteering report. TS confirmed that the report celebrated the key achievements over the past year and noted the valuable contribution made by volunteers, with the aim of improving the experience for patients, their families, and carers whilst ensuring volunteer experience is also positive. TS advised that as a result of the pandemic the number of volunteers had reduced and that work continued to improve volunteer provision across the Health Board

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	including the end-of-life champions at a community level, and participation in three national pilots. The Committee noted the demand upon coordinator capacity due to the number of volunteers that each coordinator supports. *The Committee **NOTED** the achievements to date and the challenges to expansion and the proposed actions for 2024 onwards*. *Tanya Strange left the meeting*
PQSOC 0406/3	**Other Matters**
PQSOC 0406/3.1	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** Paul Deneen (PD), Independent Member, sought assurance as to how the Health Board was protected from cyber-attacks and was advised that a training session with the Board was scheduled for later this month.
PQSOC 0406/3.2	**Any Other Urgent Business** There was no urgent business.
PQSOC 0406/3.3	**Meeting Reflections** The Committee agreed for the In-Committee meeting to be deferred to the next scheduled meeting in July 2024 9am. **Action: Fern Cook, Committee Secretariat** The Committee reflected and agreed that future agendas would include a maximum of two deeps dives to ensure that meetings do not overrun.
PQSOC 0406/3.4	**Date of the Next Meeting:** Tuesday 30th July 2024

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CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE

Agenda Item – 1.5

Outstanding	**In Progress**	**Not Due**	**Completed**	**Transferred to another Committee**

Committee Meeting	**Minute Reference**	**Agreed Action**	**Lead**	**Target Date**	**Progress/ Completed**
23rd February 2024	**PQSOC 2302/2.1**	**Safeguarding Annual Report** Support was being provided to one local authority, as a result of their additional requirements. The Committee requested that in the next annual report a section outlining the support to staff members be included.	**Director of Nursing**	September 2024	**In Progress** Howard Stanley to provide update on 30th July 2024 Committee Meeting
30th April 2024	**PQSOC 3004/2.1**	**Quality Report** The Committee would be provided with an overview of the actions taken by the Department to reduce the number of never events.	**Medical Director**	September 2024	**Completed** This action was included within the Quality report to the Committee meeting held on 4th June 2024, where a deep dive was completed.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
4th June 2024	**PQSOC 0406/2.3**	**Quality Performance Report** A report on the challenges that had occurred in securing improvements within the Mental Health Division would be provided to a future meeting.	**Director of Nursing/ Chief Operating Officer**	September 2024	**Not Due**

All actions in this log are currently active and are either part of the Committee's forward work programme or require more immediate attention, such as an update on the action or confirmation that the item scheduled for the next Committee meeting will be ready.
Once the Committee is assured that an action is complete, it will be removed. This will be agreed at each Committee meeting.

Agenda No: 2.1

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 July 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

The purpose of this report is to provide a summary of the current strategic risks that have been delegated to the Patient Quality, Safety, and Outcomes Committee (the Committee) for monitoring, on behalf of the Board.

The report also informs the Committee of any significant operational risks identified by the Executive Committee through the Corporate Risk Register that have the potential to impact patient quality and safety.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation & Cefndir / Background

The Committee's last meeting concluded that the Committee Risk Register contained **three** high-level risks with **three** sub-risks, and **one** corporate risk, for which the Board has delegated responsibility for receiving and scrutinising assurances.

Since the last report to the Committee, the risk environment has remained relatively stable, with no changes in the risk score or exposure to the four risks monitored by this Committee.

Asesiad / Assessment

Strategic Risk Register (SRR)

Table 1 displays the status as of July 2024 for the **three** strategic sub-risks delegated to the Committee. The **three** sub-risks have been reviewed and updated to provide the Committee with up-to-date information on the internal control system and sources of assurance for each sub-risk.

The Committee Risk Register is included in **Appendix A** and the Dashboard and individual risk assessments for the **three** sub-risks are included in **Appendix B.**

Table 1

Risk Ref:	Risk Description	Sub-Risk	Risk Level	Within Appetite
SRR 005 **Theme** Service Delivery **Appetite** Open Score 16 and below	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	Due to inadequate arrangements to support system-wide patient flow.	**High** **3 x 4** **(12)**	**Y**
SRR 008 **Theme** Transformation & Partnership Working **Appetite** Open Score 16 and below	There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.	**Moderate** **2 x 4** **(8)**	**Y**
SRR 010 **Theme** Compliance & Safety **Appetite** Minimal Score 8 and below	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974.	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed, and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	**High** **3 x 4** **(12)**	**N**

It should be noted that, while the risks have been updated to include improved control and assurances, the risk score and level for all **three** sub-risks have not changed. **SRR 005** and **SRR 008** remain within the Health Board's risk appetite for the risk domain, therefore the Committee can be assured that these risks are effectively mitigated.

Work will continue with risk owners to manage the risk and ensure that the controls and assurances in place prevent the potential risk from occurring.

SRR 010's risk score and exposure remain outside of the Health Board's agreed-upon risk appetite for the Compliance and Safety risk domain, as shown in Table 1. However, as the Improvement Plan has not been fully implemented, there is potential for the additional planned action to bring the level of risk down to within appetite.

Monitoring of **SRR 010** will remain a key focus of the Committee, and the findings of the scheduled Internal Audit of Health and Safety, planned for quarter 4 of the 2024/25 Plan, will provide the Board and Committee with the evidence needed to determine whether the Improvement Plan has delivered the necessary improvements. In the interim, the Board has been asked to decide whether it is willing to accept the residual risk that is held if the risk score does not move to within appetite. The outcome will be reported in the next iteration of this report to the Committee.

Corporate Risk Register (CRR)

The Committee has been delegated responsibility for oversight of any corporate risk (significant operational risks) relevant to the agenda of the PQSOC.

Table 2 summarises a high-level operational risk that was escalated to the CRR following the established escalation process outlined in the Risk Management Framework. The Pharmacy Directorate manages and updates the risk, with oversight from the Executive Committee due to the potential impact on the organisation and the investment required to eliminate the risk.

Enhanced oversight by the Committee provides an additional layer of control and assurance that the risk is managed appropriately and does not cause significant disruption to the organisation's operations.

Following the recent purchase of a new Robot, which is scheduled for implementation between August and October 2024, the Committee can be confident that the risk will be eliminated after implementation; however, it should be noted that the risk is still outside of appetite, so it will be tolerated at the current level and managed until implementation.

The full risk assessment is attached as **Appendix C.**

Table 2

Risk Ref:	Risk Description	Sub-Risk	Risk Level	Within Appetite
CRR 004 **Theme** Service Delivery **Appetite** Open Score 16 and below	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	Due to the current Pharmacy layout/robot at RGH being over 18 years old and not fit for purpose.	**Extreme** **(20)**	**N**

The CRR remains under development and initial meetings with Directors have been held to discuss any potential high-level operational risks in their areas of responsibility that require the Executive Team's support and management via the Corporate Risk Register. The draft corporate risk portfolio will be discussed at the Executive Time Out session in July, during which a focused assessment of these risks, as well as strategic risks, will be conducted to ensure they are reflective of the operating environment and are recorded and reported at the appropriate level. A full report, including the status of strategic and corporate risks, delegated to the will be presented to the Board at its next meeting in September 2024 for approval. Following that all risks pertinent to the remit of the PQSOC will be presented in the next report to the PQSOC.

The closing position as of July 2024 is that the Committee Risk Register includes **three** high-level risks with **three** sub-risks and **one** corporate risk.

Argymhelliad / Recommendation

The Committee is requested to:

- **NOTE** the delegated strategic risks;
- **NOTE** the delegated corporate risk;
- **NOTE** the work being undertaken to reduce the risks to within appetite level; and,
- **NOTE** the work being undertaken to ensure the Committee is sighted on all risks that have the potential to impact patient quality and safety.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The Strategic Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety Choose an item.

	Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	The Board and respective Committees of the Board have considered risks contained within the Strategic Risk Register

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. N/A

Risk ID	Monitoring Committee	Risk Theme	Risk Owner	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite		Actions to Reduce Risk to Target	Assurance that the Risk is being manged effectively	Target Risk Score				Review of Risk	
							Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Current Risk Score	Risk Level	Current Status Against Appetite	Risk Appetite and Threshold Explained			Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Target Risk Score	Risk Level	Last Reviewed	Next Review
SRR 005	Patient, Quality, Safety and Outcomes Committee	Service Delivery	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	•Avoidable deaths or significant harm •Delays in releasing ambulances from hospital sites back into the community •Delayed discharges from acute and non-acute settings resulting in deteriorating patients •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: Focus Processing power Capacity Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. Regional flow processes not always supported with neighbouring HBs (Health Board)	Medium	3	3	9	Moderate	01/04/2024	01/07/2024
SRR 008	Patient, Quality, Safety and Outcomes Committee	Transformation and Partnership Working	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff, the public and partners	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	•Adverse impact on patient experience •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence •Failure to deliver Duty of Quality	2	4	8	Moderate	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX	Medium	2	2	4	Low	01/04/2024	01/07/2024
SRR 010	Patient, Quality, Safety and Outcomes Committee	Compliance and Safety	Executive Director of Therapies and Health Science	The Health Board will fail to protect the Health and Safety of staff, patients and visitors in line with its duties under the Health and Safety at Work Act 1974	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	• Unintended physical harm; • Punitive actions from the Health and Safety Executive (HSE); • Increased levels of staff sickness; • Loss of estate due to unsafe environments; • Financial implications; • Adverse publicity; and, • Reputational damage	3	4	12	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established.	Negative	2	3	6	Moderate	01/05/2024	01/08/2024

Reference	Risk Owner	Risk Description	Reason For The Risk	Risk Score Matrix											
				2	4	5	6	8	9	10	12	15	16	20	25
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow												
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement												
SRR 010	Director of Therapies and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.												

Assessment of adequacy of assurances	POSITIVE = Identified assurances are deemed robust in telling us that the controls in place are working effectively.
	REASONABLE = Identified assurances are deemed adequate in telling us that the controls in place are working effecively, however some gaps have been identified which need to be addressed.
	NEGATIVE = Identified assurances are deemed insufficent in telling us that the conrols in place are working effectively with substantial gaps identified which need to be addressed.

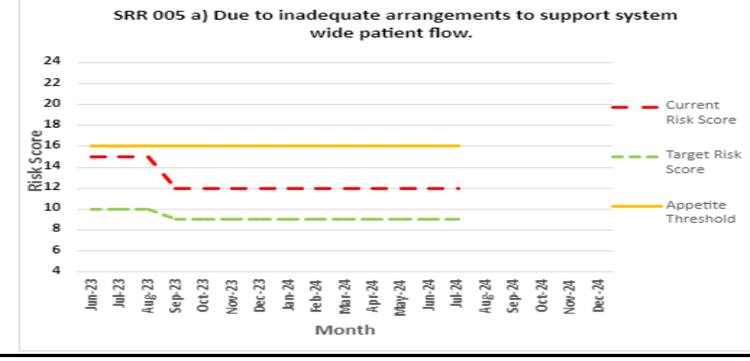
Key	Current Score	●
	Target Score	X
	Appetite Threshold	◊
	Current to Target	◄ –

RISK THEME	SERVICE DELIVERY			
Strategic Risk: SRR 005	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.**			
Strategic Threat	a) Due to inadequate arrangements to support system-wide patient flow	**Publication Status**	**Public**	
Impact	➢ Avoidable deaths or significant harm ➢ Delays in releasing ambulances from hospital sites back into the community ➢ Delayed discharges from acute and non-acute settings resulting in deteriorating patients; ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Catastrophic)*	3 *(Minor)*
Last Reviewed	01 July 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*
Next Review Due Quarterly based on current score	01 October 2024			

Risk Appetite Level - Open
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Open SCORE 17 AND BELOW
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.



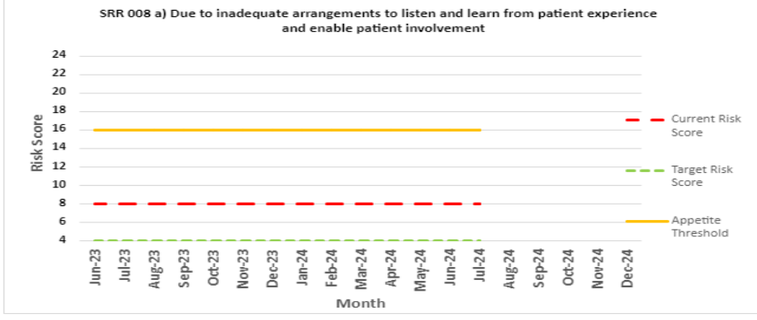
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment)*
• Escalation Policy. • Performance and Accountability Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Enhanced monitoring in place for U&EC • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. • Planned care recovery meetings with the NHS execs. • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. • WG – IQPD meetings to review areas of focus.	• Operational framework – Being revamped through operational framework ahead of next winter. • Improve regional acceptance of flow processes with neighbouring Health Boards. Repatriation meetings established and new Wales-wide protocols due to come in regarding repatriation.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. • Performance report against measures/metrics **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • **Internal Audit Reviews** 1. Intra-site Patient Transfers (Q1) - Not Yet Reported (expected to be received at Audit, Risk & Assurance Committee in February 2024. • External inspections/visits.	**Gaps in Assurance** • Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. • The impact of the Performance and Accountability framework in improving patient flow **Action to Address Gaps in Assurance** • Close monitoring and reporting of the frameworks in practice to support learning and improvements.	**Reasonable Assurance**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
Strategic Risk: SRR 008	**There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.**				
Strategic Threat	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.	**Publication Status**	Public		
Impact	➢ Adverse impact on patient experience ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence ➢ Failure to deliver Duty of Quality				
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	2 (Unlikely) x	2 *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*	
Last Reviewed	01 July 2024	**Risk rating**	**= 8** *(Moderate)*	**= 4** *(Moderate)*	
Next Review Due (Bi-annually based on current risk score)	01 October 2024				

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure

Risk Appetite Threshold – Open SCORE 17 AND BELOW
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

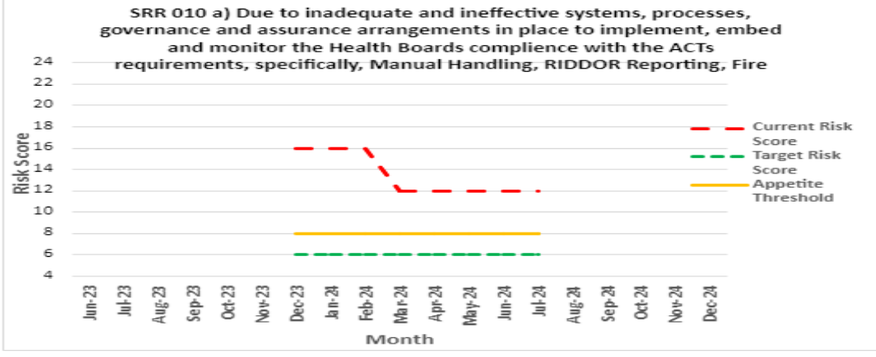
SUMMARY
The current risk level is **OUTSIDE** of target but **WITHIN** the appetite threshold. Target level is **WITHIN** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment)*
• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX • Oversight of Medical Examiner reports to determine patient experience actions • Public Engagement- Big Conversation Bereavement held 20th March 2024 • People Participation Panel ED in Progress	• Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. • PCCT staff training to support Civica data entry and retrieval. • Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. • Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to QPSOG • Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision.- Discussions with VBHC to pilot SMS in ED through DrDoctor • National directives around new national surveys that need to be managed additional to internal roll out programme. • Volunteer feedback to be reviewed to identify themes.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. • Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. • Patient Experience and Involvement Team undertaking Culturally Competent Accreditation • Immediate feedback and escalation to clinical teams following PALS queries and concerns **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee • Implemented PALS DATIX Module **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • LLais Reports • HIW inspections • Advocacy reports	**Gaps in Assurance** • No SMS provision to increase the number of PCC surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. • Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped. • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards. **Action to Address Gaps in Assurance** • Discussions with VBHC team to consider SMS through DrDoctor with pilot at ED • PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Ned to have discussions with facilities around rooms. • Patient experience KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation.	**Reasonable Assurance**

RISK THEME	COMPLIANCE & SAFETY			
Risk No: SRR 010	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974**			
Strategic Threat	**a)** Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	**Publication Status**	Public	**Risk Appetite Level - MINIMAL.** Any risk that has a MINIMAL risk appetite level should be managed to a **Score of 8 or below**. **Risk Appetite Threshold -** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls**.**
Impact	➢ Unintended physical harm; ➢ Punitive actions from the Health and Safety Executive (HSE); ➢ Increased levels of staff sickness; ➢ Loss of estate due to unsafe environments; ➢ Financial implications; ➢ Adverse publicity; and, ➢ Reputational damage			**SUMMARY** The current risk level is **OUTSIDE** of the appetite threshold and target score. The target level to be achieved is **WITHIN** the set appetite threshold.

Lead Director	Director of Therapies & Health Science	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	3 (*possible*) x	**2** (*Unlikely*) x
Initial Date of Assessment	01 December 2023	**Impact**	***4*** *(Major)*	**3** *(Moderate)*
Date Reviewed	01 May 2024	**Overall Risk Rating**	**= 12** *(High)*	**= 6** *(Moderate)*
Date of Next Review Quarterly based on current score	01 August 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Attendance at Divisional Quality & Patient Safety meetings provide a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established. • Board Training / Development (delivered on 24 Apr 2024) • Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern	• Health and Safety Governance and reporting arrangements (Health and Safety Committee) • Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System • Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) • Consultation and communication with the workforce regarding compliance with the Act • New ways of working with Divisions to ensure accountability for health and safety is recognised. • Implement key performance indicators to monitor health and safety compliance. • Review the governance arrangements for the Health & Safety Committee • Health and Safety Policies and Procedures to be reviewed. • Onboard further Manual Handling trainers across the organisation to improve compliance. • Scope for training non-Health Board staff • Learning from events to be documented and communicated to the organisation.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Health and Safety compliance data extracted from ESR and Datix and reported **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Established monitoring of H&S at the Executive Committee • Corporate H&S report risk and assurance to the Health and Safety Committee • Established monitoring of H&S at the PQSO Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Performance reviews at All Wales Health and Safety Management Steering Group • Internal Audit – H&S processes Review to be included in 2024/25 Plan. • South Wales Fire & Rescue Service fire safety audit programme. • Health and Safety Executive reviews/inspections.	**Gaps in Assurance** • Effectiveness of the health and safety plan • Compliance on completion of risk assessments and mitigating actions **Action to Address Gaps in Assurance** • Implement health and safety performance reporting • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan	**Reasonable Assurance**

Agenda Item – 2.2

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 July 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Performance report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Nursing Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety Tracey Partridge-Wilson, Deputy Director Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health and Care Quality Standards provide a clear framework to help the planning, delivery and monitoring of healthcare services in Aneurin Bevan University Health Board.

The Performance report provides data for a set of quality indicators and outcomes that align with the Health Board's priorities and strategic goals. These are mapped to the six domains of quality which the and the six quality enablers. The indicators cover all aspects of care, clinical outcomes, patient safety, patient experience, and efficiency.

Cefndir / Background

The performance report provides current data on quality and patient safety as mapped against the Pillars of quality:

- Patient and staff experience and stories
- Incident reporting – falls, pressure ulcers, medicines management and mortality
- Complaints, concerns and compliments

- Health, safety and security
- Infection Control and Prevention
- Safeguarding

These 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains.

Escalated risks and concerns are also detailed in the report and there is a section on clinical effectiveness. Additional information is also available to provide documentation and evidence of good practice and learning from feedback.

Asesiad / Assessment

Areas of Improvement

- The Health Board is refreshing its approach to Quality Improvement (QI) to create a Faculty approach and to embed Quality Improvement from Ward to Board. Additional QI coach training has been sourced and adapted with a plan to train 75 additional QI coaches per year. The development of a QI strategy is in progress with an aim for organisational approval in the Autumn.
- RAMI - the Health Board has seen improvement in the Risk Adjusted Mortality Indicator with a focus on Learning from Deaths reporting based on the English model.
- The PALS service continues to develop and to focus on early intervention and support for patients and their families when they have concerns, the service will develop to further support the PTR process
- The themes from PALS is enriching our learning from feedback by providing qualitative data. This is allowing the Health Board to take action and make positive improvements in a timely manner. It is evident that we are reaching out to our 'unheard' patients and enabling them to provide feedback, which may not have been the case if relying on complaints or concerns to drive changes
- Civica satisfaction rate remains over the 85% benchmark albeit, a text solution to increase uptake is being explored.
- There have been no new Never Events since November
- Improved uptake of Level 1 and Level 2 Safeguarding training and increased safeguarding referrals demonstrating greater awareness of safeguarding thresholds
- Developments in the bereavement offer continue with a focus on early advice and support for families. The new Health Board approach to bereavement 'GRACE' will be launched shortly
- Improved Health and Safety assurance
- The operational approach to Quality Assurance is developing with standardised agendas and standardised data sets built upon the Quality Pillars and the STEEP principles promoting Ward to Board assurance
- Ward Accreditation is currently being rolled out across a number of Divisions
- A further workshop on the Quality Outcomes Framework has been held with plans for a revised QOF for the September Board

Areas of Focus

There are a number of issues, risks and concerns which are discussed in the report and reflect areas requiring improvement in terms of quality outcomes. For Committee consideration the areas are summarised below.

- Additional assurance on the timeliness of incident investigations will be developed, this will include data on reason for delay i.e external processes and early learning.
- Review of Serious Incident Policy.
- Infection rates continue to rise, an improvement plan is in development and an enhanced monitoring process will be put into place. In relation to Clostridum difficile infection the majority of suboptimal prescribing related to piperacillin/tazobactam (Tazocin) use in secondary care. This is part of the ongoing work around co-amoxiclav in the secondary care.
- Continued focus on the quality of care within Mental health and Learning Disability Services demonstrated in the updated improvement plan.
- Level 3 enhanced monitoring for performance and outcomes related to Urgent and emergency care pathways at the GUH ED. Quality outcomes and timeliness of care within urgent care. This relates to a number of metrics including Ambulance Handover times, 12 and 24 hour waits in ED and system flow.
- Falls remain an area of focus and scrutiny. Falls data is available for review and discussion at ward level. Any areas of concerns are flagged to QPS leads for investigation. Falls with fractures are presented at the weekly Executive Huddle. These discussions are informed by a weekly data review.
- Safeguarding Level 3 training remains an area for improvement, to be complaint with the intercollegiate guidance Level 3 training is required for clinical staff.
- Themes from incidents continue to include the deteriorating patient, which is part of the safer care collaborative, and the impact of extended waits.
- Putting Things Right (PTR) the compliance with closure of PTR concerns within 30 days remains of concern. There has been steady improvement in aged complaints over 12 months however the Health Board has developed a plan to return to the required level of compliance which will be 75% of PTR concerns closed within 30 days.

Next steps will also include a programme of work on sepsis, which will include implementing the updated NICE guidance and sepsis recognition and early assessment from primary care to acute. There will be a focus on sepsis awareness, patient information and safety netting advice.

The Patient Engagement and Involvement Team have reviewed the current Enhanced Care Framework and undertaken an audit of 54 cases in relation to patient safety and patient experience. The recommendations from the review have been supported by the Value and Sustainability Board and an improvement plan with implementation of the new framework and associated actions is underway.

For the Health and Care Quality Standards that are limited in reporting e.g. Equitable, these will be reviewed to establish what else is being reported that can be inserted into the QOF and what additional measures should be included (i.e. more data is required in relation to safeguarding & domestic violence and children and young people's outcomes).

As part of this work, we will continue to strengthen our governance structures through Board-to-Floor connections that promote cross directorate and multi-professional working. We have initiated work to ensure that the implementation, measurement and monitoring of our strategy is hardwired through our governance and integrated performance reporting.

Listening and Learning

The Health Board recognises that organisational learning plays a vital role in the continuous improvement and development of healthcare organisations therefore the work will focus on:

- Implementation of the Health Board's Listening and Learning Framework which demonstrates our commitment to promote a culture that values, facilitates, and embeds learning and in which the lessons learned are used to improve the quality of patient care, safety, quality and experience.
- This framework demonstrates how learning will be identified, triangulated, disseminated, and implemented into practice, to facilitate and embed a culture of appreciative enquiry, continuous improvement in health care services.
- We continue to strive for a Just culture of shared learning and a triangulated approach to quality, patient safety and experience.
- A bi-monthly learning and improvement forum is developing with its first meeting in May 2024.
- The learning repository is being tested in July 2024, which will allow us to collate, store and utilise this learning, enabling us to share knowledge, shape change, embrace innovation, implement quality improvement and create opportunities to develop excellence in practice.

Key priorities for the next six months include automation and revision to the Quality Outcomes Framework, development of Integrated reporting with Finance, Workforce and Planning, strengthening of Quality Patient Safety structures within Divisions, refreshing the Quality Improvement Plan and strengthening assurance and reporting.

Argymhelliad / Recommendation

The Patient Quality, Safety and Outcomes Committee is requested to note the progress of the quality performance report.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

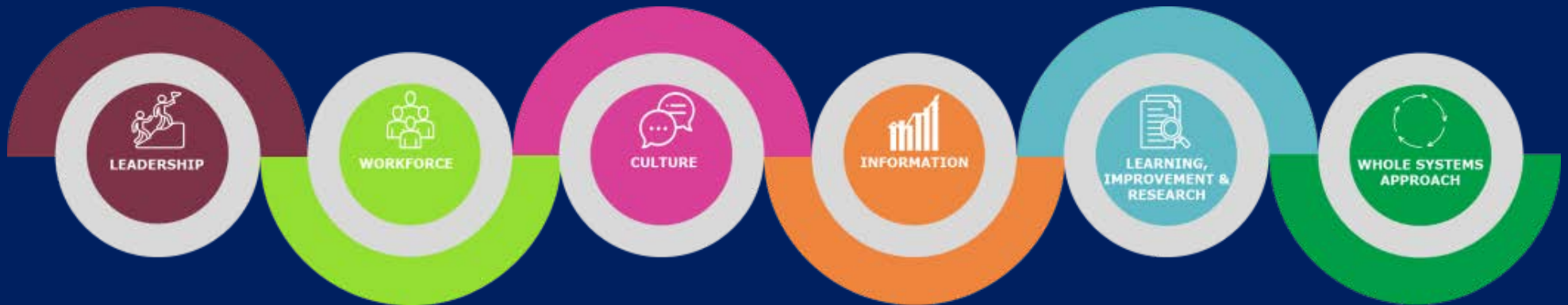
Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

Patient Quality, Safety and Outcomes Committee

Performance Report

July 2024



Overview

The Patient, Quality and Safety performance report provides the Board with an overview of the Health Board's quality and safety metrics and summary of performance. It is aligned to the Ministerial priorities and key challenges, which are:

Quality and Safety Pillars

- Patient Experience and Staff Feedback
  - Civica and PALS update
- Incident reporting
  - Patient Safety Incidents
  - National Reportable Incidents
  - Near Misses
  - Duty of Candour
- Complaints and concerns
  - Continue to focus on closure of historical complaints over 6-12 months
- Health, Safety and Security
- Infection Prevention and Control
- Safeguarding

Escalated Risk Concerns

Clinical Effectiveness

Information

Urgent Care

QPS Update

The changes made by centralising the Quality Patient Safety (QPS) teams are delivering several benefits including: -

- Increased engagement and collaboration with Divisional teams.
- Development of standardised agendas to facilitate discussion within the Divisions aligned to the six pillars or quality as in the quality strategy. This will drive the Health Board's Quality, Patient Safety and Experience assurance meetings. The agenda is currently being tested.
- We will continue to review bespoke training to support staff undertaking investigations.
- The QPS team leads are undertaking the Affina Team Building Programme with the Head of QPS supported by WOD to improve team effectiveness and performance across the organisation.
- QPS workplan has been developed which is aligned to ABUHB Quality Strategy and Quality Priorities to support QPS leads to deliver key objectives.
- The patient engagement and involvement strategy continue to progress the delivery of person-centred care, which includes patient participation panels, a 6 month progress report on PALS and bereavement services.
- The Patient Safety Incident team are continuing to review The Health Board's processes for managing incidents and are ensuring effective triangulation of incidents. This will ensure improved quality, timeliness and person-centred response.
- There is continued work on improving the backlog of complaints in line with PTR regulations.
- Following the end of the Safer Care Collaborative the Health Board is reviewing the Faculty to facility and support the ongoing work and projects within Quality Improvement.
- We are refining our quality outcomes framework to make the indicators more succinct and working with the data, digital and technology team to develop automated reporting and develop our Quality Management System to ensure 'always on' reporting.
- Working in collaboration with divisional and central teams to develop a QPS Accountability Framework.
- Draft Commissioning Assurance Framework (CAF) to be discussed at the end of July.
- We are in the process of writing our annual quality report.

Learning and Improvement Update

- The Health Board recognises that organisational learning plays a vital role in the continuous improvement and development of healthcare organisations.
- Implementation of the Health Board's Listening and Learning Framework demonstrates our commitment to promote a culture which values, facilitates, and embeds learning and in which the lessons learned are used to improve the quality of patient care, safety, quality and experience.
- This framework demonstrates how learning will be identified, triangulated, disseminated, and implemented into practice, to facilitate and embed a culture of appreciative enquiry, continuous improvement in health care services.
- We continue to strive for a Just culture of shared learning and a triangulated approach to quality, patient safety and experience.
- A bi-monthly learning and improvement forum started in May 2024.
- Our learning repository is being tested in July 2024, which will allow us to collate, store and utilise this learning, enabling us to share knowledge, shape change, embrace innovation, implement quality improvement and create opportunities to develop excellence in practice.

Good Practice and Learning from Feedback

Section 1

Patient Experience - ED

- Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. Discussions with VBHC to pilot SMS in ED through Dr Doctor.
- People Participation Panel ED (neurodiversity)
- Themes from concerns are shared with the wider team for improvement and learning
- To enhance patient experience we are now utilising volunteers within the department

British Red Cross Emergency Department (ED)

- Wellbeing and Home Safe Service – Grange University Hospital
- Support the patient experience whilst in ED
- A team of staff and volunteers have a presence within the ED department itself to enhance the patient experience by supporting patients and their families while they are waiting for, during, or between treatments and examinations by providing emotional and practical support to help reduce anxiety and promote their mental well-being.
- Emotional support such as sitting with someone who is confused, distressed, or disorientated (providing supervision to minimise risk); talking to someone about their concerns; being a friendly face or a supportive listening ear.

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Patient Feedback: Listening and Learning

Patient Experience Feedback
1 April 2024 – 30 June 2024
Emergency Department Survey

Location/Department	Responses	1 - Did you feel that you were listened to?	2 - Were you able to speak in Welsh to staff if you needed to?	3 - From the time you realised you needed to use this service, was the time you waited:	4 - Did you feel well cared for?	5 - If you asked for assistance, did you get it when you needed it?	6 - Did you feel you understood what was happening in your care?	7 - Were things explained to you in a way that you could understand?	8 - Were you involved as much as you wanted to be in decisions about your care?	9 - Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall exp	Overall
		Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	
Emergency Department	79	75	44	39	75	72	69	72	72	69	68
	Overall	**75**	**44**	**39**	**75**	**72**	**69**	**72**	**72**	**69**	**68**
	Benchmarks	**85**	**85**	**85**	**85**	**85**	**85**	**85**	**85**	**85**	85

Was there anything particularly good about your experience that you would like to tell us about?	Was there anything that we could change to improve your experience?
Top 3 themes	**Top 3 themes**
15 comments around **Compassion**	**24** comments around **Comfort**
10 comments around **Emotional & Physical support**	**21** comments around **Waiting**
9 comments around **Helpfulness**	**4** comments around **Emotional & Physical support**

Escalated Risk Concerns

Section 2

Mental Quality, Mental Health & Learning Disabilities Quality, Safety & Governance Update

Overall Status Summary

- Since July 2023 the MH&LD Division has been subject to internal escalation
- A number of quality improvement actions were identified, and these were prioritised into a 30, 60, and 90-day improvement plan.
- The Plan has also addressed broader efforts in workforce modelling, leadership, clinical engagement, performance, risk management, and service transformation.
- NHS Exec Oversight – Cathy Dowling and Dave Semmens
- Appointment of an Improvement Director – Gareth Marr – in post (currently acting Divisional Director)
- Appointment of a Divisional Director – Louise Turner – starts in May
- Progress on quality, safety, and governance in MHLD has been routinely reported through the Executive Committee, Patient Quality Safety & Oversight Committee the Board, and externally through IQPD.
- NHS Exec Colleagues have agreed to co-produce a paper for the Quality Delivery Board and will continue to monitor delivery of improvements through IQPD and JET meetings
- Feedback from the NHS Executive on the improvement plan has been addressed, and there is a commitment to aligning better with the Health Board's Quality Strategy and the new accountability/escalation framework.

Progress / Achievements

What went well this period and upcoming Deliverables

Progress/Achievements:

- Setting The Scene workshop to engage with staff on the setting the vision and ideas for service improvement.
- Ongoing support from the QPS team to better align the division with the Quality Strategy and embed processes.
- A strong focus on improved safety governance in line with HB processes from the Nursing Team
- Multi-professional clinical leadership opportunities developing
- Wider Team support to Implement a process to systematically assess workforce risks and incorporate them into the risk register and the IMTP process.
- Models of care: The teams are keen to look at doing things differently and will start having discussions with the directorates.
- Increased corporate divisional governance in place – fortnightly.
- Improved learning from deaths processes.
- With the ongoing challenges associated with WCCIS, we are now using technology that leverages software, or "bots," to automate the transfer of data between applications, thereby optimising processes and conserving staff time.

Deliverables and Focussed pieces of work

- Thematic review process
- Ward accreditation in line with HB processes
- Audit strategy
- Daily briefings and escalation processes further embedded at BAU
- A review of serious incidents is ongoing, and the Executive Director for Nursing and Chief Operating Officer continue to monitor ongoing issues with safeguarding, serious incident reporting, and disciplinary processes
- Embed Right Care right person and the new rolling out the new model of police and health partnership for mental health crisis response.

Challenges

- The Divisional Director has assumed their role, and although some interim Senior Leadership Team members are still present, the team is stabilising and progressing with several important initiatives.
- Efforts are ongoing to establish robust governance and assurance processes concerning the quality and safety of patient care and monitored through the Divisional Assurance fortnightly meetings.
- Ongoing focus on patient safety and safeguarding, staff engagement, cultural and improvement initiatives.
- Some of these measures will necessitate a long-term cultural enhancement program to maintain the changes, yet staff are increasingly involved and contributing to the strategic vision and the generation of ideas for service improvements.
- Ongoing issues with WCCIS (patient information system) and the necessary work to support validated information. Some work around methods are now in place to support data collection such a RPA 'bots' to transfer data.
- Continued focus on 1A/1B performance and the necessary actions to address the waiting list issues, such as validation, triage and rules.
- Continue to review staff engagement and communication across the Division.

MH/LD Position of the 90 Day Plan

Plan Progress

The improvement plan, originally intended to be completed by the end of December, has been delayed due to the need for additional scrutiny and provision of evidence. Suitable revised target dates have been established.

Below is a current summary of the progress made with the improvement plan and outstanding actions:

30 Day Actions	**18 Completed**	**Outstanding 1 action:** • Missing Persons Policy - currently out for Health Board consultation
60 Day Actions	**16 Completed**	**Outstanding 2 actions:** • Strengthening OOHs arrangements • Safe staffing in-patient SBAR to Execs
90 Day Actions	**2 Completed**	**Outstanding 2 actions:** • Commissioning Arrangements • Missing persons policy in commissioned services

Ongoing

- The 90 day plan has been largely executed with advancements in consolidating the actions and the developments in certain areas.
- Divisional assurance meetings have been increased, with one of the bi-weekly meetings dedicated to discussing the improvement plan and the wider strategic work programmes.
- The wider large scale programme of improvement is led by the Improvement Director with a clear focus on governance and assurance, quality, safety, modernisation and wider service redesign.
- Ongoing piece of work on patient search, observation policy and practice, safeguarding reporting and escalation.
- The process for identifying recurring safety issues will be incorporated into the safe care collaborative and disseminated through patient safety learning forums.
- Oversight by Board/Executive and support from NHS Executive colleagues.

Urgent & Emergency Care

Issue	Cause	Remedial Action	Who	When
Medical Staffing: Medical Staffing to support the Emergency Department (Demand & Capacity modelling showing deficit for demand)	• Increased activity	• Locum processes in place and reviewed weekly with management team and monthly within Directorate • Ongoing recruitment • Demand & Capacity modelling completed	General Manager / Divisional Director / Divisional Management Team	Ongoing
	• Vacancies	• Regular review of medical rotas to match demand within financial envelope are in place with site leads.		
	• Implementation of different models of care	• Explore alternative roles e.g. Physicians Assistants, ANPs etc.		
Nurse Staffing: Vacancies with increased number of patients causing additional staffing pressures and associated governance and costs.	• National shortage of registered nurses • Emergency Department Establishment was increased following the move to the GUH • Challenging place to work due to increased attendances, increased acuity, environmental challenges, inadequate flow	• Recruitments drives for Registered Nurses and HCSWs • Student streamlining • Recruitment of internationally trained nurses • Robust sickness management • Practice Educators working clinically alongside junior staffing • Senior Nurse Point of Contact (POC) • Block-booking of staff secured and robust processes in place to manage roster • Progress alternative roles	Divisional Nurse / Divisional Management Team	Ongoing
Patient Flow: Congestion within the ED (and Assessment Units). Increased presentations / Long lengths of stay / Ambulance delays	• Increased demand • Poor patient flow • Pathways of Care • Increased Delayed Discharges of Care	• Escalation plan in place to support movement of patients • Full Capacity Protocol (FCP) in place • Expansion of ED Main Wait in progress with anticipated completion date of May 2025. • SDEC in GUH open. Predominantly scheduled care utilising but medicine usage increasing along with other pathways such as ED direct referrals and WAST direct access • Full utilisation of the Flow Centre to maximise alternative pathways to ED • Acute Frailty Response team within ED to facilitate early discharge or transfer to appropriate care setting	General Manager / Divisional Director / Divisional Nurse / Divisional Management Team	Ongoing

External Assessments – Q1 2024/25

Health Inspectorate Wales – Inspections and National Reviews

Ty Lafant, Llanfrechfa Grange – April 2024
No immediate improvements identified
Draft Inspection Report received 10/07/24
Division to review factual accuracy and provide a response to recommendations highlighted in improvement plan

Llais Gwent Region Visits

No inspections have been undertaken during Q1

Winter Patient Experience Report received May 2024
4 recommendations identified
Improvement Plan developed and shared with Llais

Health Inspectorate Wales – Immediate Assurance Letters

Month	No. of Immediate Assurance Letters	Ward/Area of concern
April	3	3 x GUH
May	4	C7 East, RGH SAU, RGH ED, GUH Carn y Cefn, YAB
June	5	Talygarn, County D5 West, RGH ED, GUH Beechwood Wood, SCH Staff member MH/LD

6 Pillars of Quality
1
Patient and staff experience and stories
2
Incident Reporting, Falls, Pressure Ulcers, Medicines Management and Mortality
3
Complaints, Concerns and Compliments
4
Health, Safety and Security
5
Infection Control and Prevention
6
Safeguarding

Section 3

Pillars of Quality

1. Patient and staff experience and stories
2. Incident Reporting – falls, pressure ulcers, medicines management, mortality
3. Complaint, concerns and compliments
4. Health, Safety and Security
5. Infection Control and Prevention
6. Safeguarding

These 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains. Providing data in these Pillars of Quality will review our performance.

We must put the quality and safety of our health services above everything else. This strategy signals our intention to progress these six pillars of quality to establish our level of performance. The pillars will be our Quality Markers in our Quality management system. Strengthening our quality management system helps us make sure our decision-making focuses on improving the quality of health services.

These measures of quality will allow standardised agendas for Divisions to report on quality measures.

PATIENT AND STAFF EXPERIENCE AND STORIES

Through the introduction of CIVICA – an electronic Citizen Feedback platform that will help people who are using our services to tell us what they think about their care. Providing feedback on our services will help us learn, make changes where we need to and celebrate what we do well. Staff will also be able to feedback on a regular basis, helping them to make improvements in their areas.

Analysis of patient experience data including complaints and compliments will provide a comprehensive picture of areas of positive performance and areas for improvement.

COMPLAINTS, CONCERNS AND COMPLIMENTS

Our commitment to patients is, wherever possible, to respond to their complaints timely and provide the information requested in an open and transparent way. Where it is not possible to provide immediate resolution, we commit to agree an appropriate investigation and to carry out that investigation to a high standard and on time. To ensure that all complainants have access to an investigating officer and are contact regularly.

INFECTION PREVENTION AND CONTROL

The Health Board is committed to zero tolerance of preventable Healthcare Associated Infections (HCAIs). Welsh Government sets reduction expectations for healthcare acquired infections which are achieved via collaboration from experts across healthcare. The Health Board are committed to providing clear programmes of work and evidence-based Policies which sets the expectation on the organisation. Our workforce will be skilled and trained to deliver against national, local and organisational objectives. We will monitor outcomes and reporting compliance/ learning through the Reducing Nosocomial Transmission Group (RNTG), Patient Safety Operational Group and Committee.

INCIDENT REPORTING

Through our 'Pillars of Quality' Programme, we will continue to focus on incident reporting as a key enabler of organisational learning and improvement. We will co-ordinate a comprehensive rolling Programme of quality improvement initiatives which strive to reduce avoidable harm with a focus on falls, pressure ulcers, deteriorating patients, mortality, end of life care, medicines management, discharge and safe transfers of care.

Our commitment to staff is to have a **just** culture, where staff feel safe to report concerns, incidents and near misses, knowing this will result in a timely, fair, comprehensive investigation. Our incident reporting system 'Datix' is a key component in providing insights to data gathering and learning actions.

HEALTH, SAFETY AND SECURITY

We are committed to ensuring that the fundamental standards of health, safety and security are continuously improved. We have a committed workforce of operational leaders who we will educate to ensure they have the advanced skills to deliver safe services. We will support the development of local policies and practices through our Health, Safety and Security Practitioners. We will conduct reviews of all sites and an annual snapshot of health and safety. Our focus for the duration of this strategy will be to reduce staff harm from lifting and handling, violence and aggression and slips, trips and falls.

SAFEGUARDING

Safeguarding is everybody's responsibility. We will demonstrate reasonable steps to ensure the safety of children and adults at risk. The Health Board's Strategy and Policy sets the expectation of accessing services. The workforce will be skilled and trained to deliver national, local and organisational objectives. The Health Board will support and enable operationalisation through provision of tools and direct support from the corporate safeguarding team, as the workforce undertakes its duties in relation to safeguarding. We will monitor outcomes and report effectiveness through effective audit and clear governance processes.

PILLAR 1

Patient and staff experience and stories

- Civica
- Bereavement Collaboratives
- Patient Stories
- IPAC Dashboards
- Volunteer to Career
- Chaplaincy
- Volunteering
- Patient Advice and Liaison Service (PALS)
- Leadership, Accountability and Culture
- Deprivation of Liberty Safeguards/ Mental Capacity Act
- Cultural Competence Accreditation Scheme
- Dementia Standards
- Listening Meetings

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Patient Feedback: Listening and Learning

CIVICA & PALS

April - June 2024 Update

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Patient Feedback: Listening and Learning

Patient Experience Feedback
1 April 2024 – 30 June 2024

All Surveys

Number of Responses
Health Board Wide - 01/04/2024 to 30/06/2024
All Questions (Care Closer to Home (11 years and upwards), Care Closer to Home (4-11 years), Care Closer to Home (Parents/Carers questionnaire) , Emergency Department Survey, Health Visiting Feedback Questionnaire, National Nosocomial COVID-19

1663
Responses

Export Options

Satisfaction Score ALL
Health Board Wide - 01/04/2024 to 30/06/2024
All Questions (Care Closer to Home (11 years and upwards), Care Closer to Home (4-11 years), Care Closer to Home (Parents/Carers questionnaire) , Emergency Department Survey, National Nosocomial COVID-19 Programme Investigation Survey, Palliative Care

90%
Satisfaction

Export Options

Emergency Department Survey

Number of Responses
Health Board Wide - 01/04/2024 to 30/06/2024
All Questions (Emergency Department Survey - Standard)

79
Responses

Export Options

Satisfaction Score
Health Board Wide - 01/01/2024 to 31/05/2024
All Questions (Emergency Department Survey - Standard)

60%
Satisfaction

Export Options

Responses Trend Graph
Health Board Wide - 01/04/2024 to 30/06/2024
All Questions (Emergency Department Survey - Standard)

Response Trend

Person Centred Care (PCC) Survey

Number of Responses
Health Board Wide - 01/04/2024 to 30/06/2024
All Questions (Person Centred Care - Standard)

1557
Responses

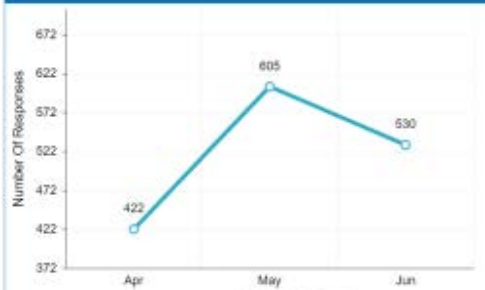
Export Options

Satisfaction Score PCC
Health Board Wide - 01/04/2024 to 30/06/2024
All Questions (Person Centred Care - Standard)

91%
Satisfaction

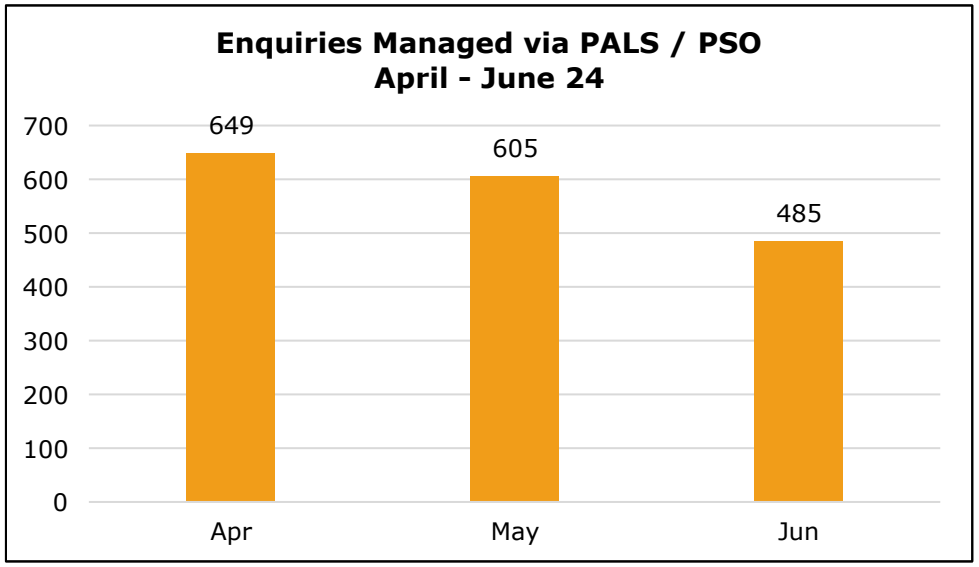
Export Options

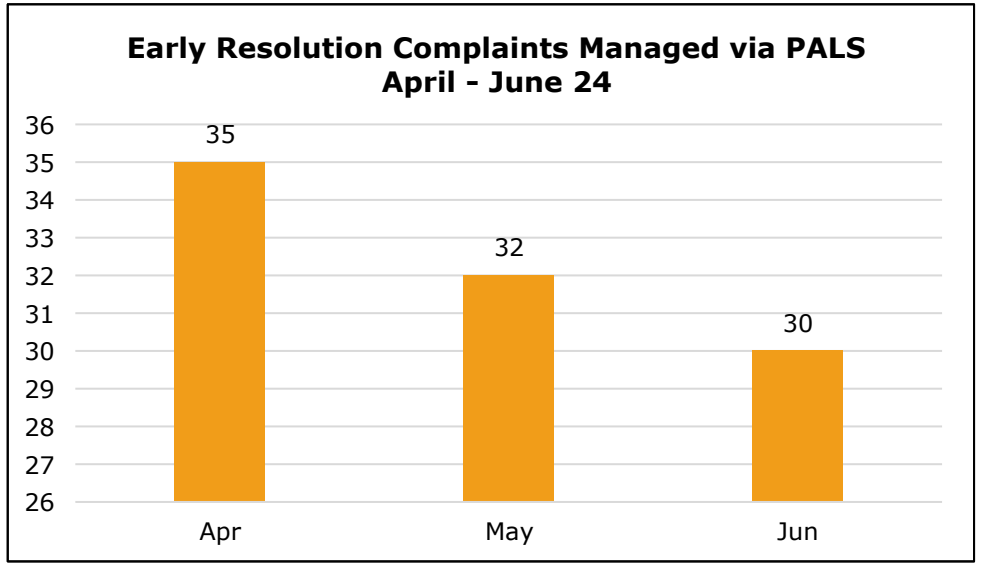
Responses Trend Graph
Health Board Wide - 01/04/2024 to 30/06/2024
All Questions (Person Centred Care - Standard)

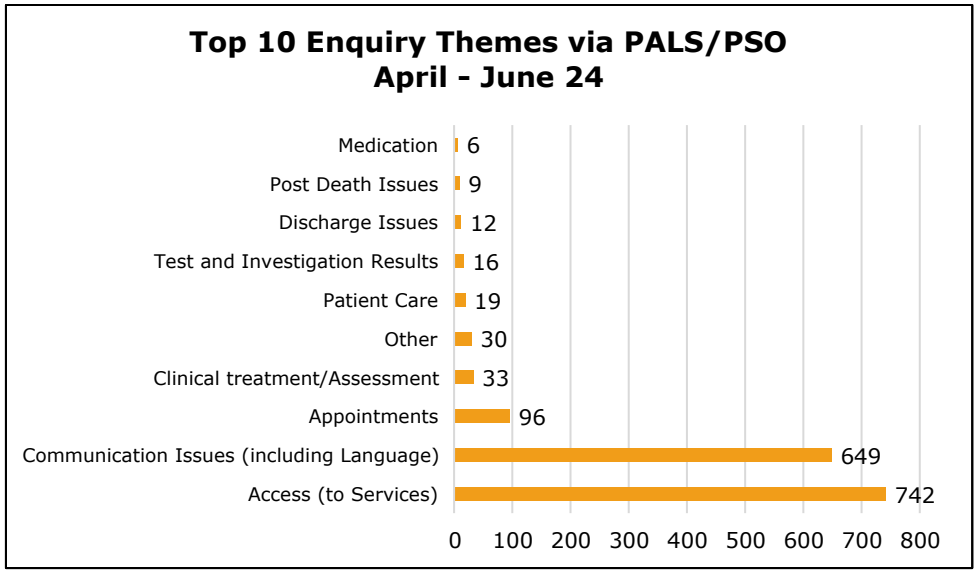


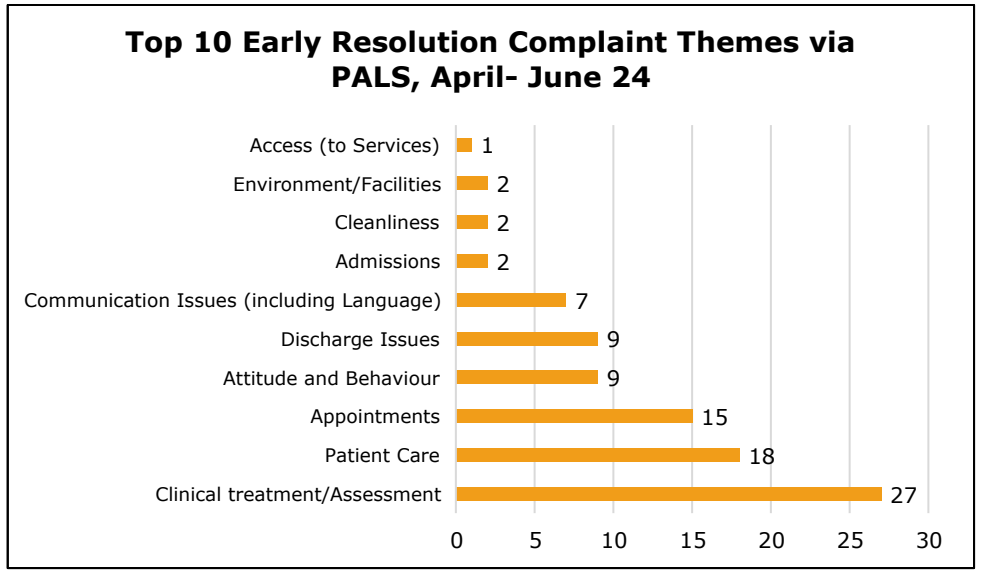
Response Trend

Patient Advice & Liaison Service – Quarter 1 2024/25

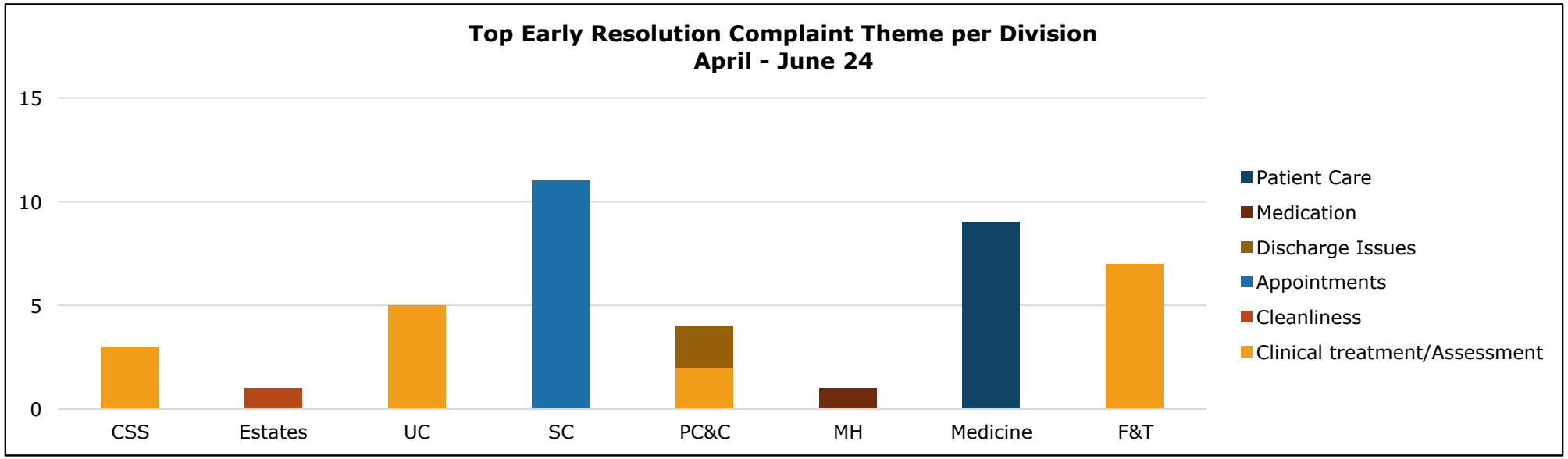


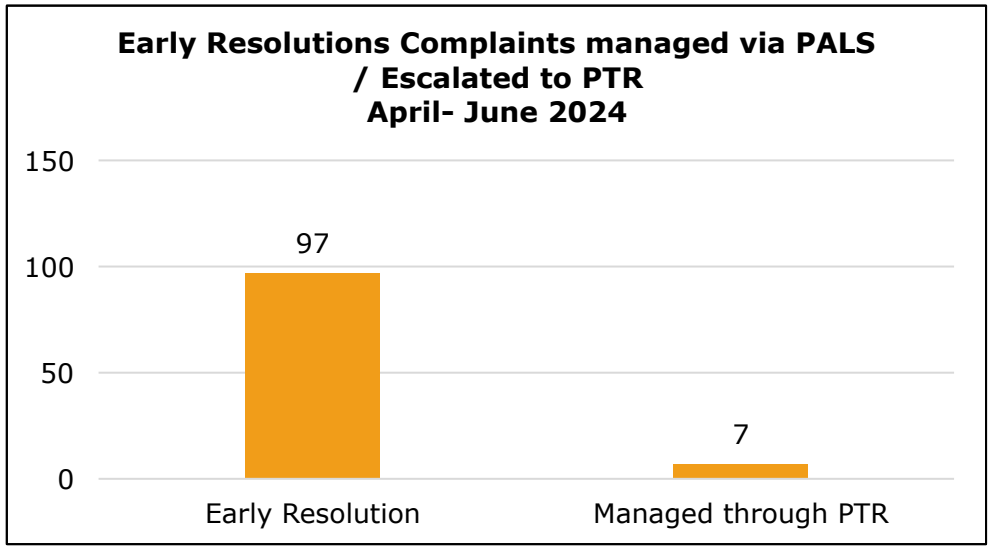


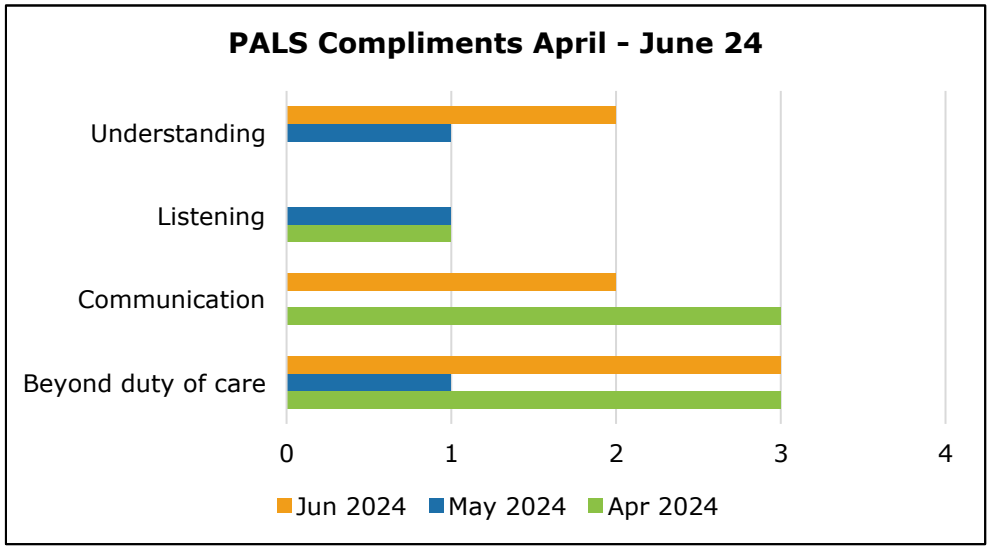




Patient Advice & Liaison Service – Quarter 1 2024/25







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Patient Feedback: Listening and Learning

Patient Experience Feedback
1 April 2024 – 30 June 2024

Division	Responses	2 - I felt listened to	2 - I was able to make my own decisions about my care	2 - I had care and support from staff who understood my needs and respected my choices	2 - I had the support of my family (or friends) when I needed them	2 - I felt safe	2 - I felt physically comfortable	2 - I was given information and advice that I could understand to help me keep well	2 - I was told who to contact if I need care and support in the future	Overall
		Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	
Family and Therapies	37	96	91	95	96	97	95	95	99	95
Medicine	772	87	77	90	93	93	87	86	75	86
Primary Care & Community	69	88	80	95	91	92	88	89	75	87
Urgent Care	19	89	84	92	94	89	72	89	81	87
Complex & Long Term Care	15	80	79	89	90	100	86	93	87	88
Surgery	480	98	95	99	98	99	97	98	96	97
Clinical Support Services	99	99	92	100	97	100	97	99	96	98
Mental Health and Learning Disabilities	54	94	83	96	86	96	90	91	80	90
	Overall	91	84	94	94	96	91	91	84	91
	Benchmarks	85	85	85	85	85	85	85	85	85

Person Centred Care (PCC) Survey – Questions 1-8

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Patient Feedback: Listening and Learning

Top 3 Themes from PCC Survey

What did we do well? Q9	What could we have done better? Q10
Top 3 themes	**Top 3 themes**
268 comments around **Emotional & Physical support**	• **60** comments around **Food & Beverages**
•**252** comments around **Compassion**	•**40** comments around **Waiting**
•**208** comments around **Friendliness**	•**24** comments around Facilities

Top 3 Themes from PCC Survey

Positive Themes	Negative Themes
Emotional and Physical Support (268)	**Food & Beverages (60)**
Compassion (252)	**Waiting (40)**
Friendliness (208)	**Facilities (24)**

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Patient Feedback: Listening and Learning

Patient Comments from PCC Survey

Positive

encouragement li stened to everything i needed. support was always there

extremely pleased how my father has been treatedwith dignity and compassion

friendly and helpful staff. nothing too much trouble. efficient but very caring this

Not So Positive

some meals were awful especially breakfast

i sometimes ring my call bell but have to wait a long time for someone to come to attend to my needs.

i am in a day room with another patient there is no bathroom to use for personal use plus no call bell if i need assistance from staff

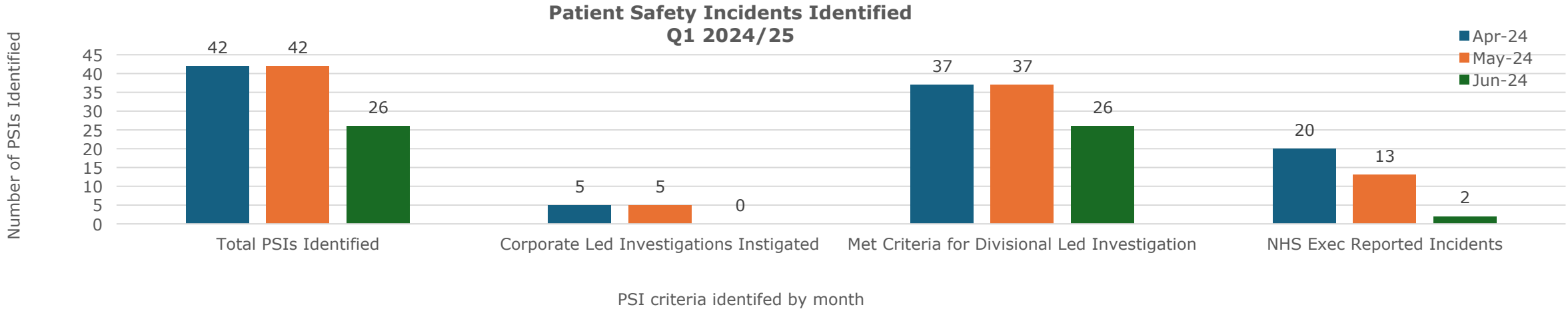
PILLAR 2

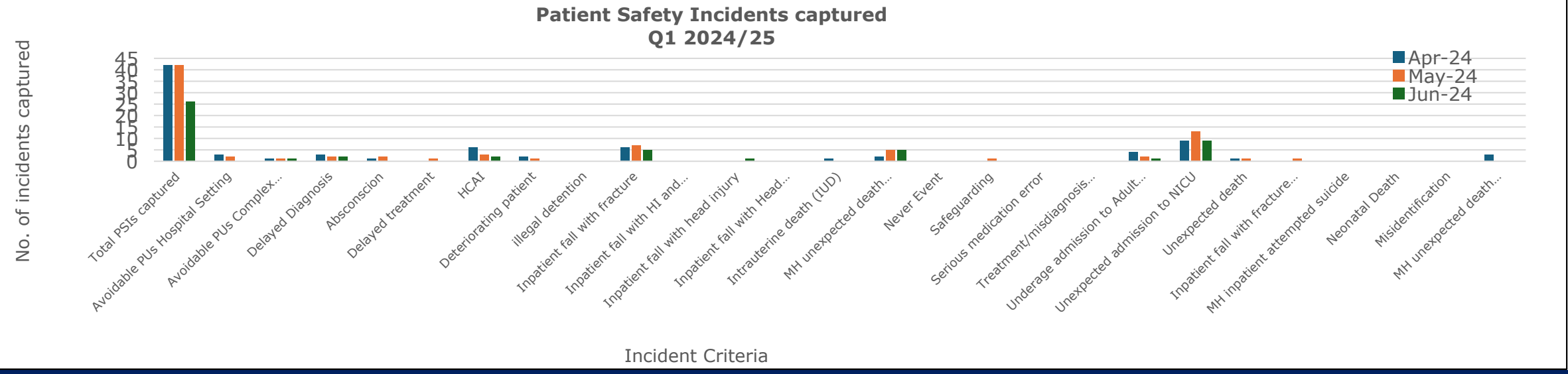
Incident Reporting, Falls, Pressure Ulcers, Medicines Management and Mortality

Leadership, Accountability and Culture	Never Events	Deteriorating Patient	Patient Safety Incident process	QPSE Dashboards
Pressure Ulcers / Medicines Management	Staff Training	Datix (validation)	Falls Panel	Duty of Candour
Learning, Monitoring & Assurance	Just Culture/ Psychological Safety	Mortality	Risk Registers	Human Factors

Patient Safety Incidents

A total of **110** Patient Safety Incidents (PSIs) (moderate and above harm) met the criteria for either Corporate or Divisional led Investigation were identified during Quarter 1 2024/25. This is in comparison to **109** in Q1 of 2023/24.

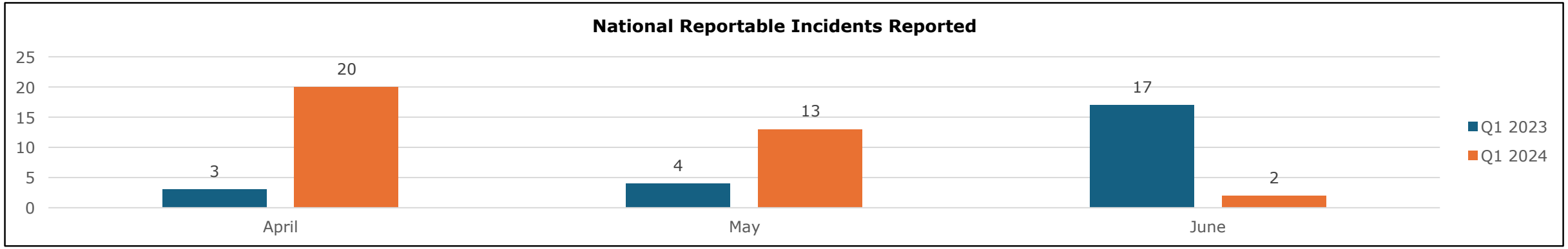




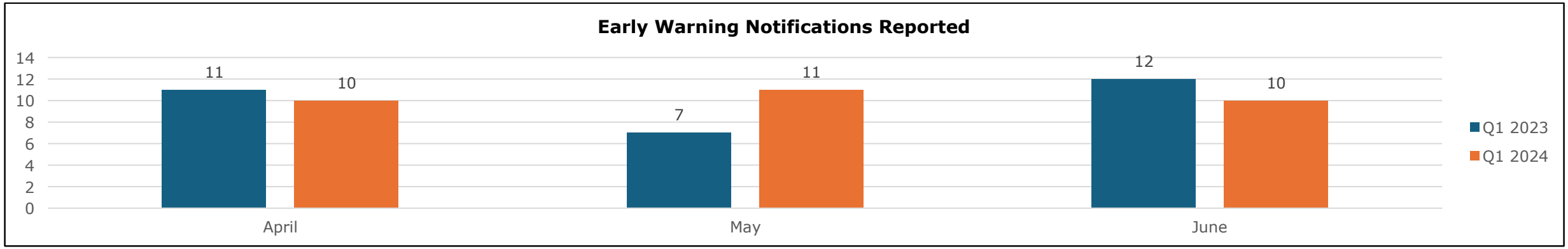
Patient Safety Incidents

Not all PSIs under investigation were reported as National Reportable Incidents (NRIs). This could be because some NRIs are submitted to the NHS Executive prior to the decision making regarding the proportionality of the investigation (Divisional or Corporate Led). Also, NRI reporting can occur retrospectively after the investigation has been commenced and once further intelligence is received.

In May 2023, the Health Board met with NHS Executive colleagues, to discuss the reporting criteria. As a result, the number of reported NRI's saw a significant increase in June 2023. We have since seen stabilisation of reporting, and continue to monitor.



There were **31** Early Warning Notifications (EWNs) reported to Welsh Government (WG) during Q1 2024/25. Themes included Safeguarding concerns, patient absconsions, misidentification of patients and PRUDICs. This is in comparison to **30** in Q1 of 2023/24.



Never Events

- **0 Never Events reported during Quarter 1.**
- **2 Never Events were closed in Quarter 1.**
- **0 Never Events have been reported since November 2023 .**

Improvement Work

Key changes to Dermatology Patients accessing services through 'see and treat' route to mandate marking of lesions in marker pen with arrow, and recording number of lesions present and marked. Procedure not conducted if lesion not marked and has been clarified with the patient and the requesting clinician in clinic. *N.B NatSIPPs 2 recommends circling areas to be excised but not recommended in Dermatology due to need to visualise clearance margins.*

Ongoing spot audits to be carried out in 'see and treat' Dermatology clinics to monitor compliance with marking of lesions.

Identification of a dedicated block bay within each hospital site where anaesthetic blocks can be performed safely with adequate resources.

Design of a Local Safety Standard for Invasive Procedures (LocSSIP for Regional Anaesthesia/ Nerve blocks, focusing on the Prep, Stop Block process. Standardised LocSSIP used by all specialities who perform nerve blocks (including Anaesthesia, Orthopaedics, and Interventional Radiology). Education of all staff groups on new LocSSIP once developed.

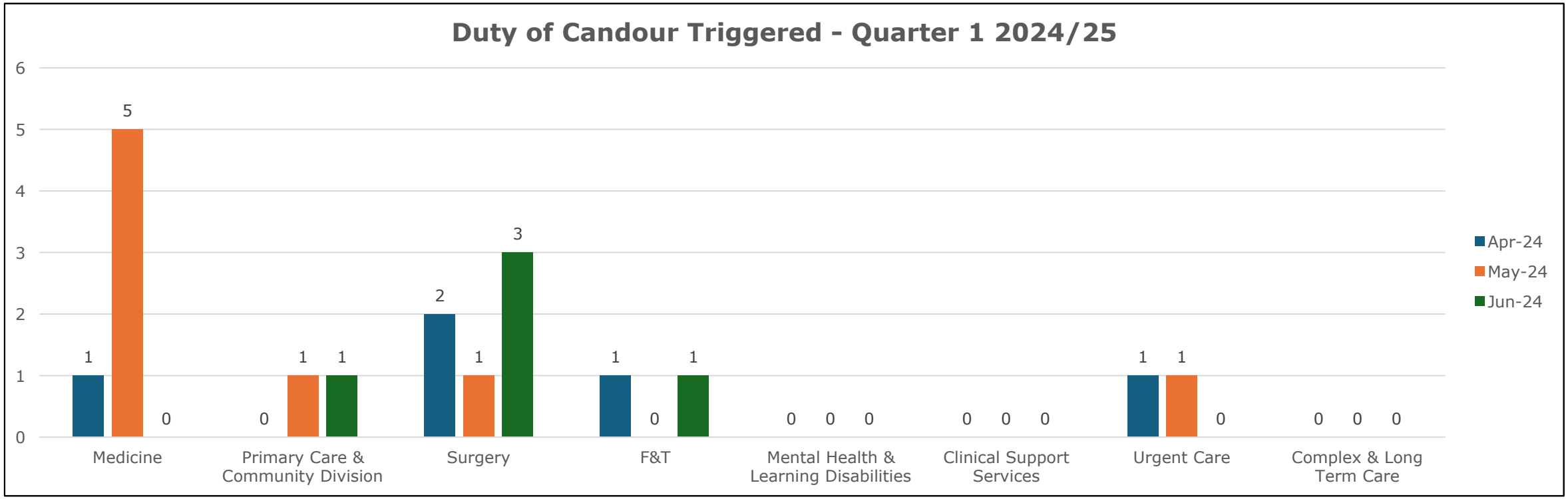
To provide standardised and formalised training for all Regional Anaesthesia assistants through a mixture of electronic learning and / or lectures. Stop before you block teaching is being included in 'back to basics' teaching programme. E-learning resource created and currently final edit stage.

Provision of a dedicated Regional Anaesthesia assistant on all Health Board sites.

Duty of Candour

In Quarter 1 2024/25 there were **6170** incidents affecting patients reported on the Datix Cymru system.

There have been **18** incidents that have triggered Duty of Candour. *This figure is based on the question* - ***Was Healthcare provided a factor?***



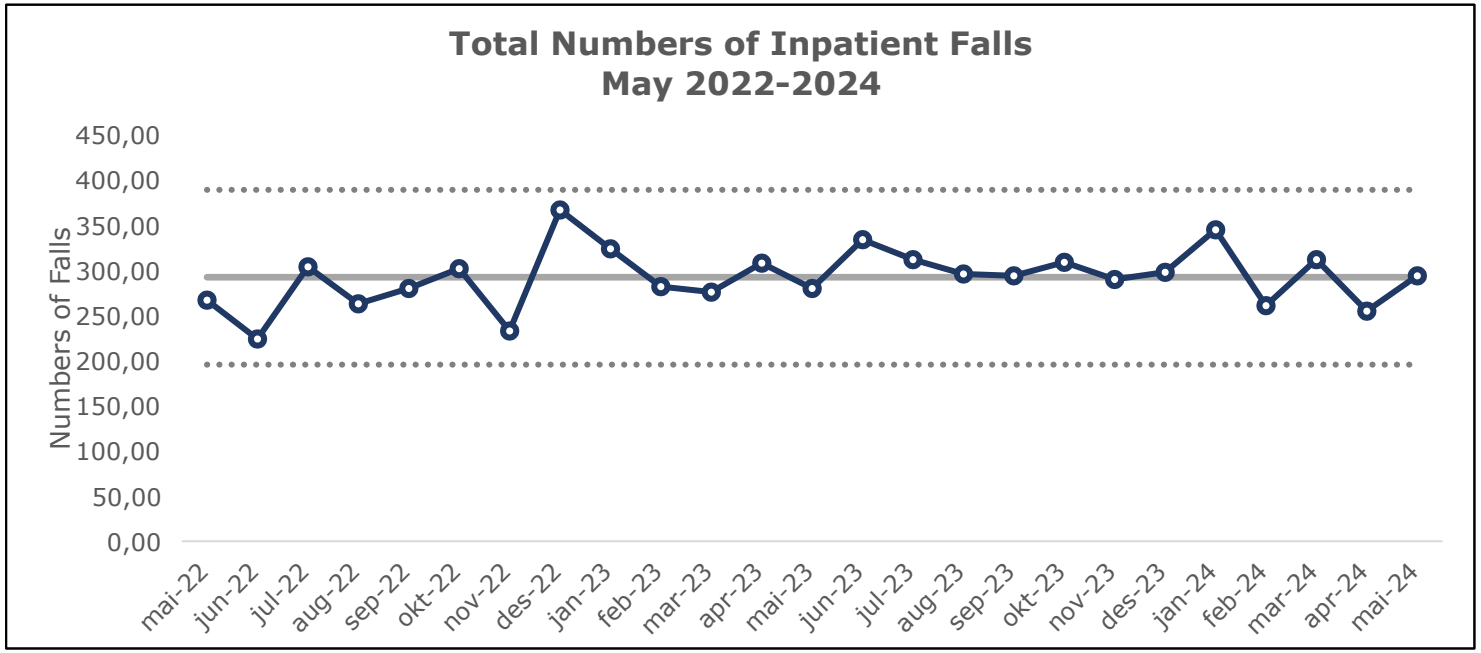
The Duty of Candour was introduced in April 2023. The way in which Duty of Candour is captured on RL Datix, and reporting criteria has been refined for 2024/25. Due to this change, we are unable to provide comparative data.

Human Factors

Update on current activities and progress:

- Human Factors Sim Sessions in Elective Obstetric theatres have commenced, on a monthly basis.
- Safety culture surveys in theatres are ongoing.
- Basic Human Factors training being rolled out in eLGH theatres by Practice Educators.
- Paeds sessions have commenced.
- Ophthalmology sessions are commencing July 2024.
- Human Factors session at AHP conference on 12 July 2024 and poster submitted.

Total Number of Inpatient Falls



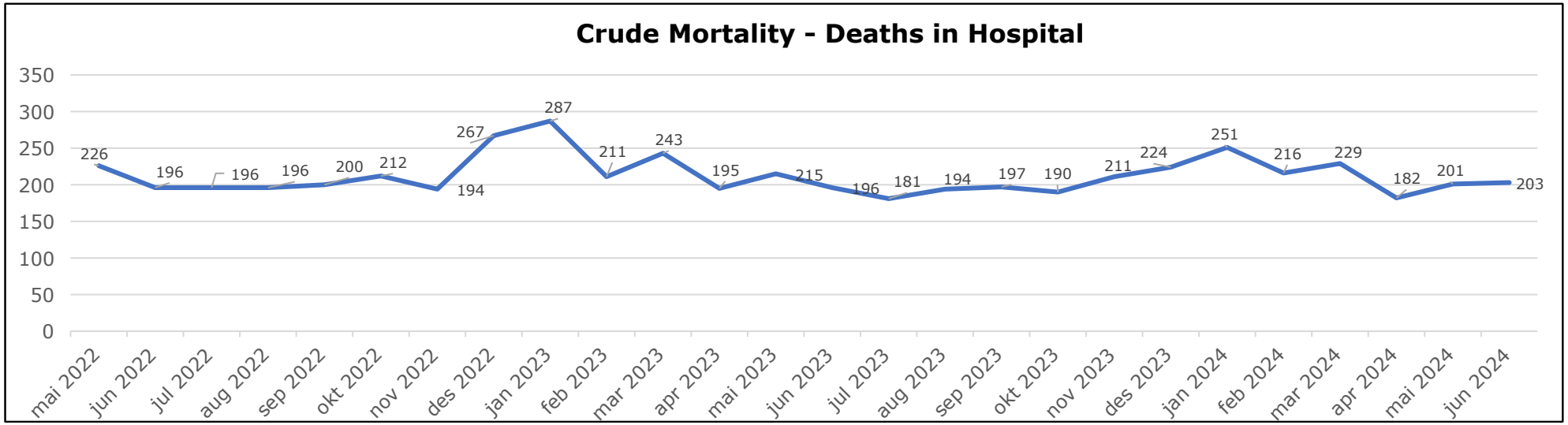
July 2024 - Context

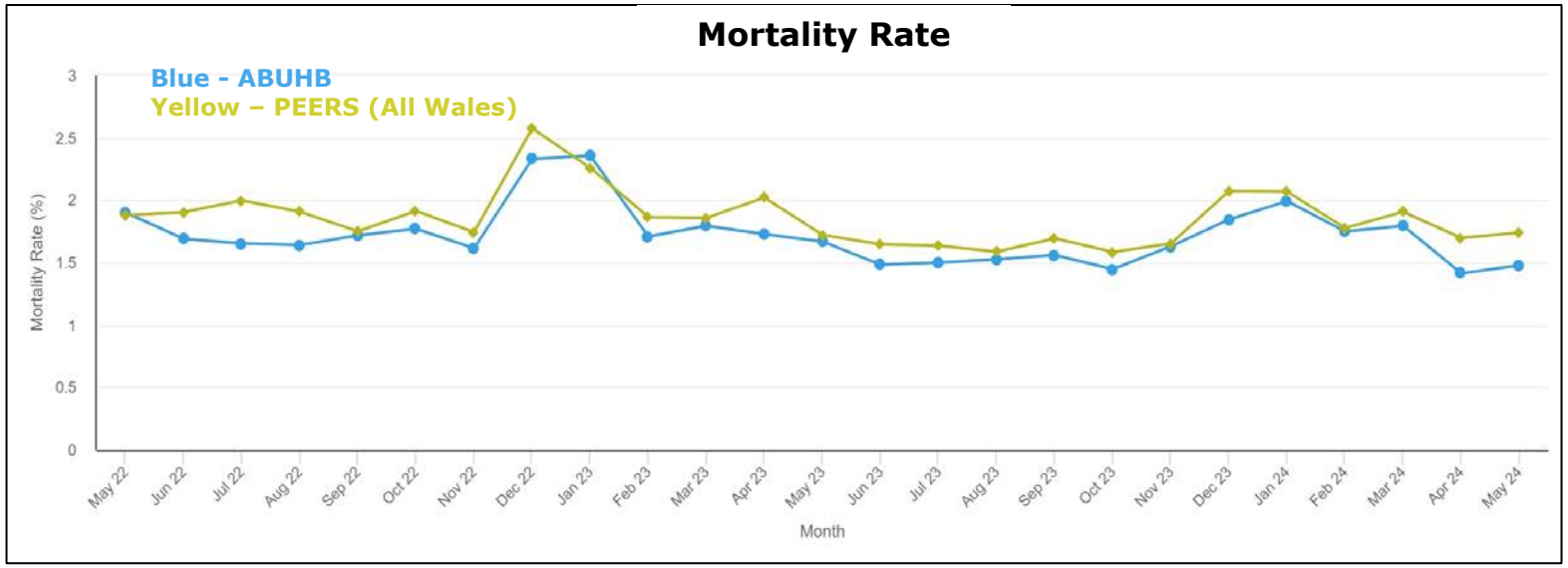
The data used in this chart has been retrieved from RLDatix.

The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period May 2022-2024. This period length for this data is selected to ensure the analysis is statistically valuable.

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	• For the given period of analysis, the mean average of fall incidents is 276 which represents a decrease since the last report presented in March 2024 • Following a downwards trend from January 2024 the months of February and April 2024 have seen the lowest recorded values for falls incidents since November 2022.	Although January to May 2024 have seen increased levels of variation as compared to the preceding months some of the values are a positive representation of a decrease in the numbers of reported inpatient falls.

RAMI/ Crude Mortality in Hospital



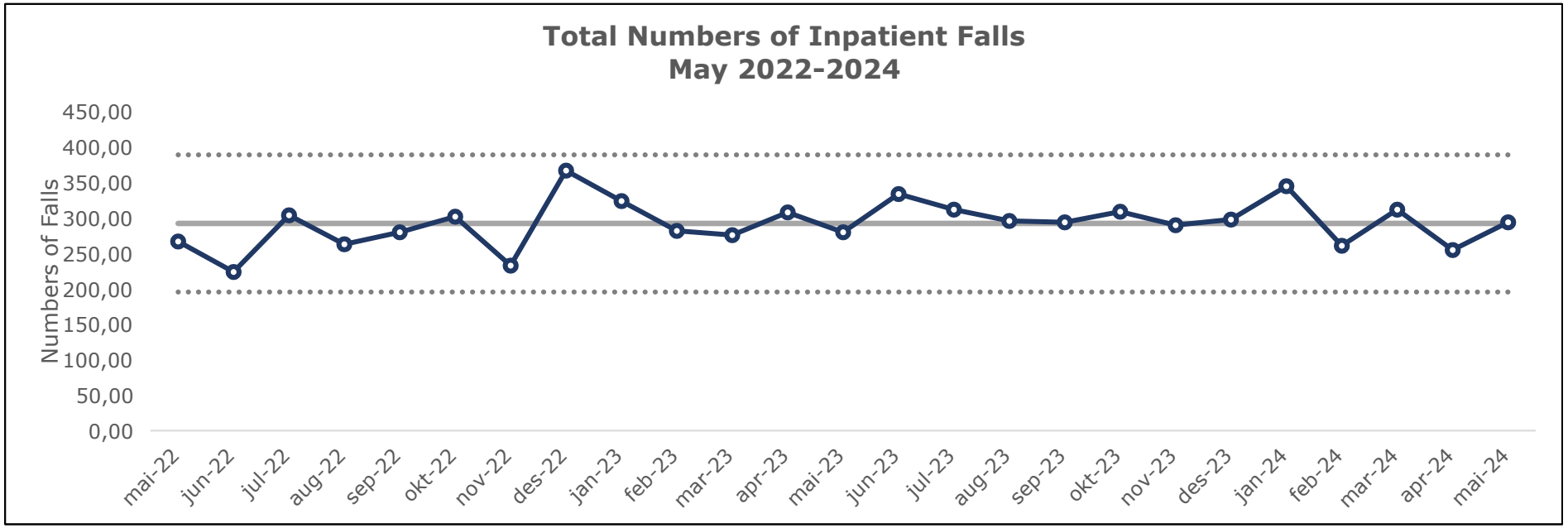


RAMI has dropped below the All Wales peer but continues to vary. Crude mortality and the mortality rate are flat and consistent. Individual mortality reports will enable Directorates to undertake deep dives in high mortality specialties.

Mortality Actions

Issue	Cause	Remedial Action	Who	When
Understanding mortality data and how we implement learning from mortality	There is a need to understand what is reported to PQSOC and to Board for mortality. England produce a Learning from Death framework which enables a standardised mortality report.	Mortality report presented at April PQSOC. Will be reported every 6 months. Includes development of Learning from Death Framework. Includes learning from the Medical Examiner service and the mortality review screening panel. Reviewing our end to end mortality process.	Medical Director's QPS team	On-going
Reliability of mortality data	Consistency of mortality reporting and data.	Mortality framework developed for reporting mortality indicators. This describes the approach: Tier 1 – Health Board level, Tier 2 – Divisional level and Tier 3 Directorate level. The QOF currently reports RAMI and crude mortality. There is an All Wales Mortality review group working to standardise reporting of mortality.	QPS Team and Information Manager	Ongoing
Clinical coding	The national target for clinical code is 95% coding completion one month post episode discharge. We are currently coding at 80% because of increasing activity.	Working with coding team to improve coding rate and depth and understand the variation in RAMI compared to the consistent and flat mortality rate over time.	QPS Team, DDT team and Information Manager	Ongoing
Mortality Data and Clinical Outcomes	Developing a governance process around mortality outliers	QPS Team and Information Manager currently drafting a Standard Operating Procedure for Mortality Outliers and investigation.	Information Manager, DDT and QPS Team	On-going
	Develop process for when to undertake a review of case notes	Develop a deep dive SOP to allow scrutiny of notes for review. This will help to interrogate the notes assessing for accuracy of coding and clinicians input for learning from deaths. This will include processes e.g. for MHLD deaths and suicide.		
	Mortality indicators not available to all	Once mortality indicators are agreed, the team will develop as a QLIK app to provide instant access to data.		

Total Number of Inpatient Falls



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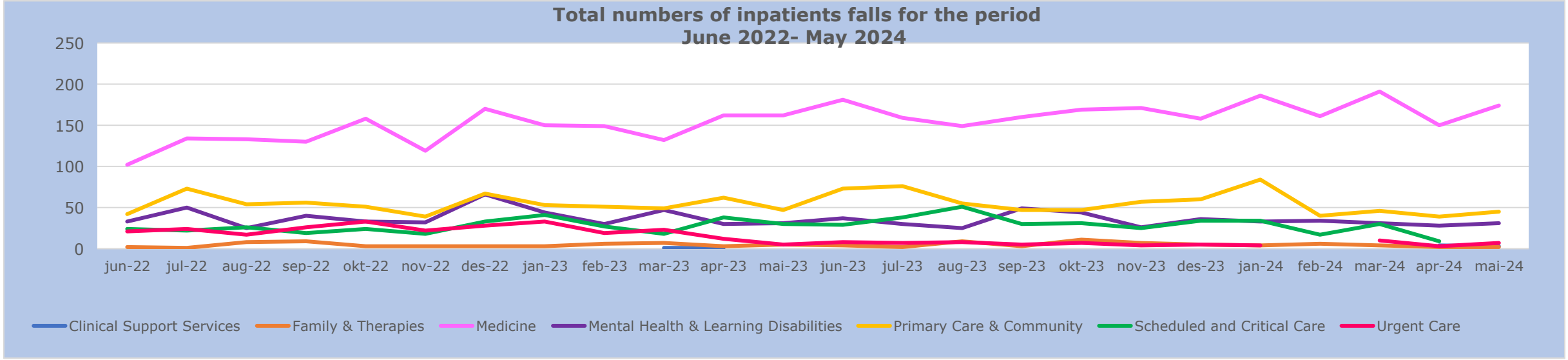
Inpatient Falls Data by Division



Data Sharing

All data is available to ward level for review and discussion.

Any areas of concern are flagged to QPS Improvement and Development Managers for investigation.

Falls with fractures are presented at the weekly Executive Huddle. These discussions are informed by a weekly data review.

What the chart tells us Key Variations By Division

Primary Care and Community

- Following the peak in January 2024 (86 falls incidents) the Division has sustained the 50% reduction in numbers of incidents with April recording the lowest value for this reporting period (39).

  January – May 2024 Average Value = 50

Medicine

- Following a peak value seen in January 2024 (186) the subsequent downward trend has been followed by a further peak in March 2024 (191) this represents the highest value since June 2023 January – May 2024 Average Value = 172

Scheduled and Critical Care

Due to changes in Divisions true values are only represented to March 2024.

No significant statistical variation January to March 2024 Average Value =26

Clinical Support Services

- Following the 3 incidents of falls in February a further 3 /4 falls incidents have been recorded for April and May, respectively. The falls are associated with patients attending foe diagnostics.

Mental Health & Learning Disabilities

- Following the peak value in the latter months of 2023 the values represented are those of a steady trajectory.

  January to May 2024 Average Value =31

Surgery

- As of April 2024, Surgery will be represented as a data set. To date values of 20 and 32 have been recorded for April and May, respectively.

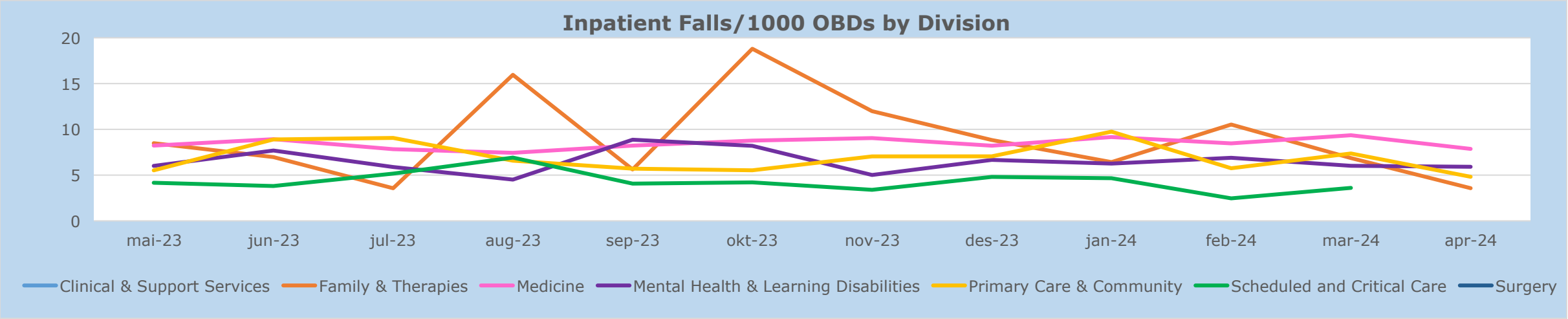
July 2024 - Context

The data used in this chart has been retrieved from RLDatix.

As expected, the highest numbers of falls remain linked with those ward that are populated by our frailer and older patients.

To Note the Emergency Department and Clinical Support Services do not hold a bed base.

Inpatient Falls Data by Division



What the chart tells us Key Variations By Division

The information provided represents Inpatients Falls per 1000 Occupied Bed Days (OBD's) per Division for the period May 2023 to April 2024.

For 2024 to April four out of five Divisions saw a downward trend as aligned to the National average of 6.6, with the month of April seeing significantly lower values. Although Medicine has a value of 7.9 this is also representative of a downwards trajectory.

This trend appears to correlate with corresponding peaks in falls incidents across several Divisions.

It is important to recognise in the advent of the change in Divisions data for Scheduled care is to March 2024 and although is seen as proceeding in an upwards direction this value is again significantly below the National average (3.6).

Key Variations

The latter months of this data analysis has seen some of the lowest values of falls per 1000 ODB's for the Health Board.

April 2024
Families & Therapies = 3.6
Mental Health and Learning Disabilities =5.9
Primary and Community Care =4.8
Medicine =7.9

March 2024
Scheduled Care = 3.6

Surgery is represented by a limited data set with current values for March and April being 3.9 and 4.2, respectively.

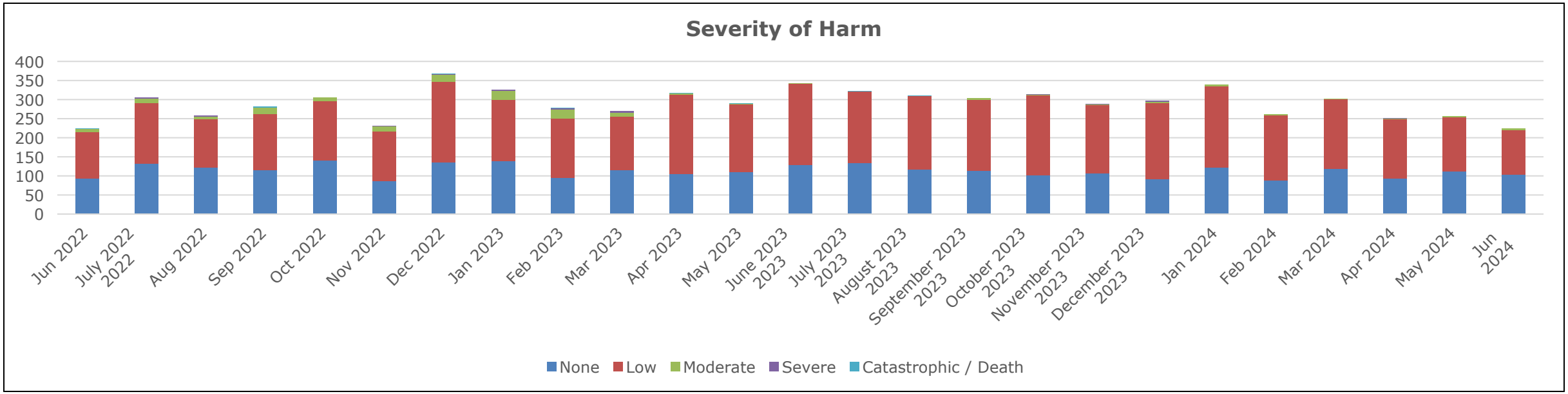
July 2024 - Context

The data used in this chart has been retrieved from RLDatix.

It is important to consider these values in the context of numbers of patients in hospital within a given service.

For note a value for Urgent Care is no longer calculated as this previously represented a Division which has been subject to change and does not hold a bed base.

Inpatient Falls Data Severity of Harm



Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	Of the total numbers of falls incidents reported for which the the severity of harm is categorised for the given period is 6537. Of this figure the following is identified. • 97% No or low harm. • 2.5% - Moderate harm • 0.4% Severe harm • 0.1% Catastrophic	The severity data is now reflective of the identified level of harm recorded post investigation. As compared to previous reports the % no or low harm is significantly higher than previously represented with a % reduction in the other associated categories of harm.

July 2024 - Context

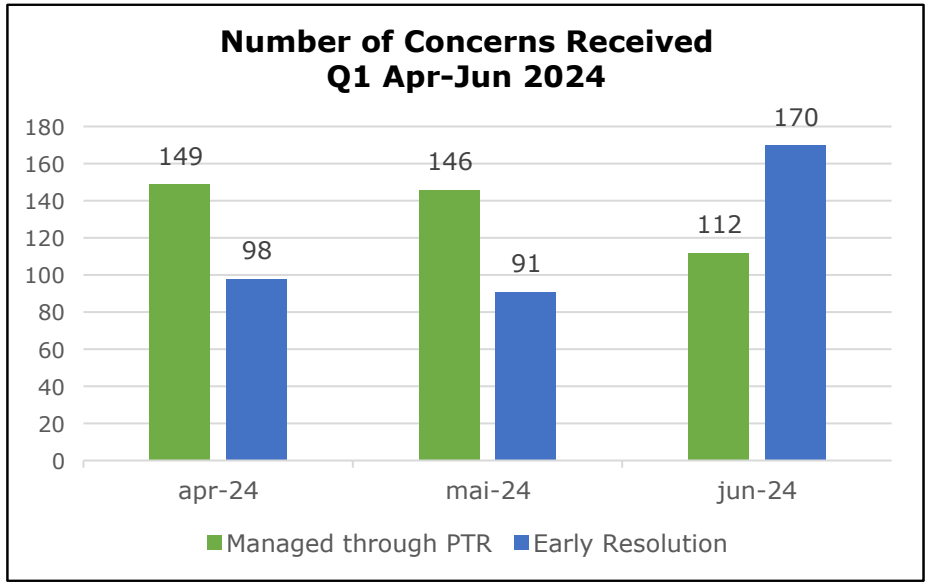
The data represents the collective information for ABUHB and refers to the severity of reported falls incidents for the period June 2022- 2024.

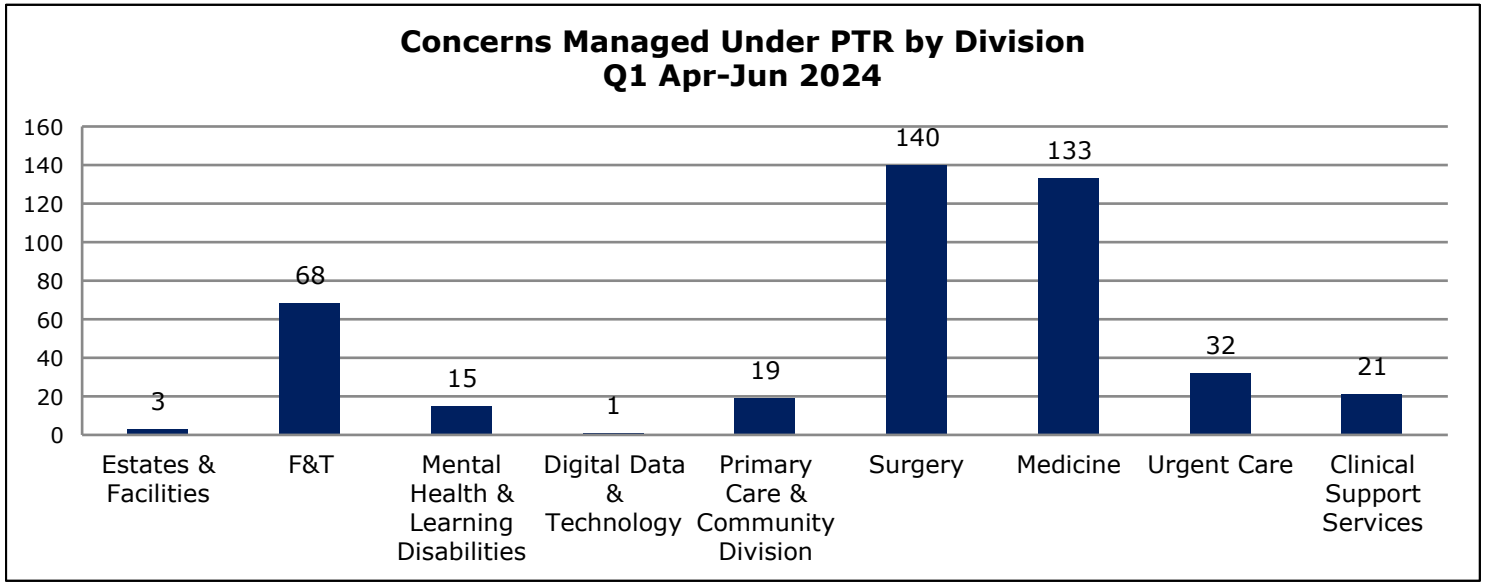
PILLAR 3

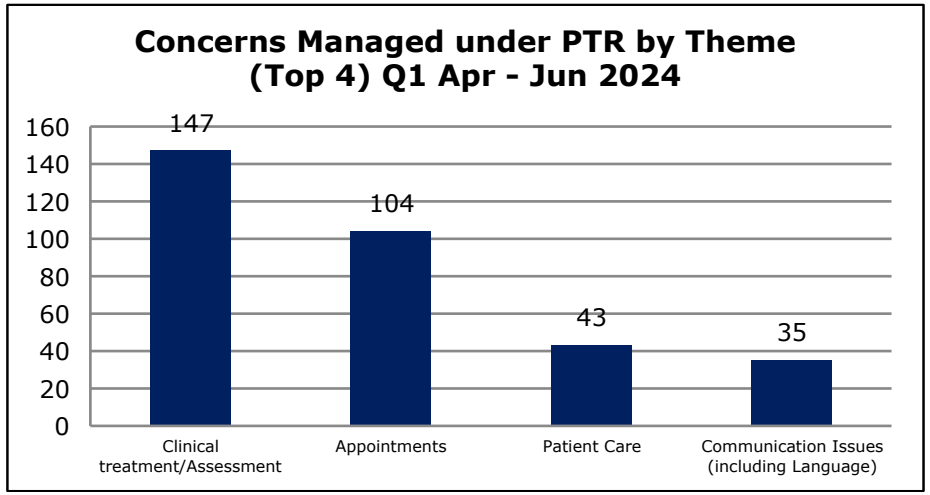
Complaints, Concerns and Compliments

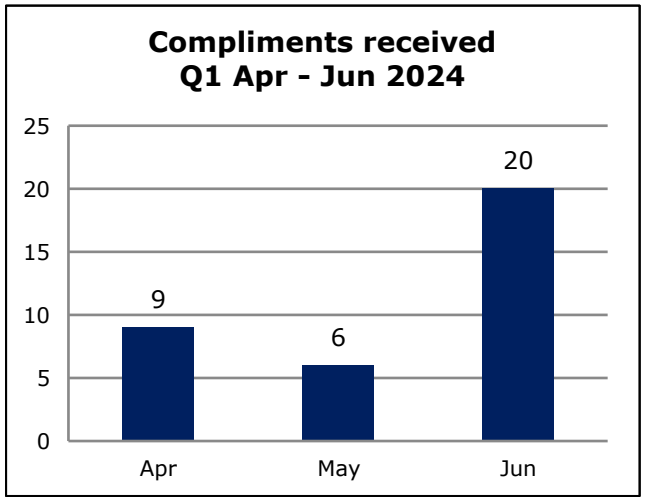
- QPSE Dashboards
- PTR Regulations
- Patient and Staff Feedback
- Complaints – Themes and Learning
- PSOW – Themes & Learning
- Psychological Safety
- Leadership, Accountability and Culture
- Collaborative Forums
- Staff Training and Mentorship (IO)
- Early and Regular Contact
- Speaking up Safely

Complaints







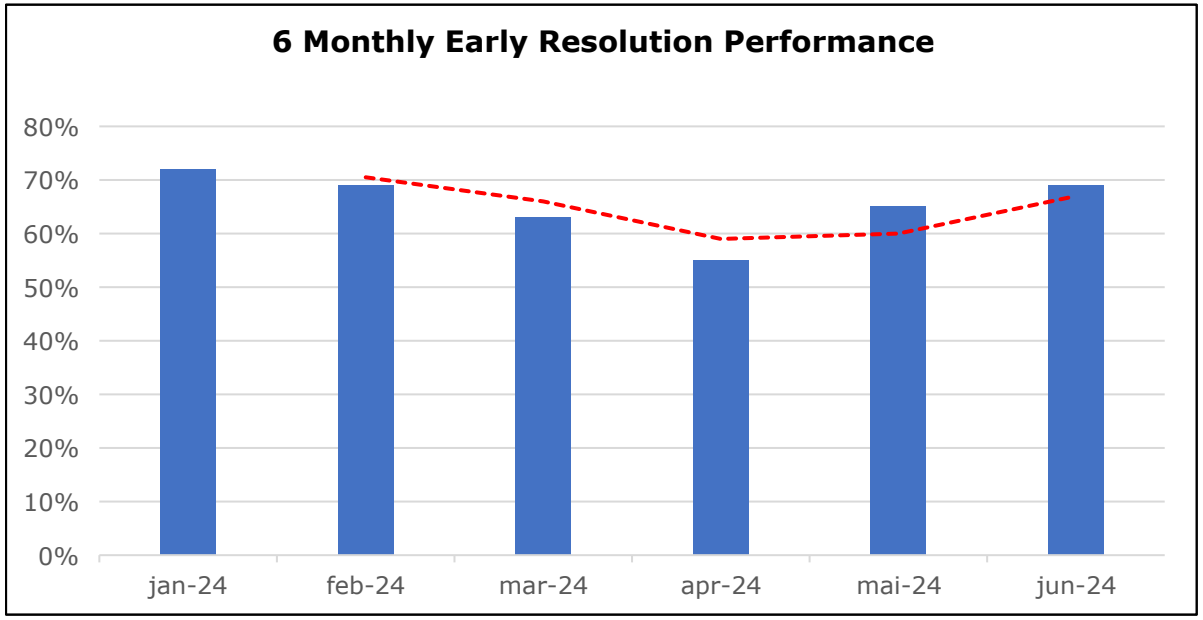


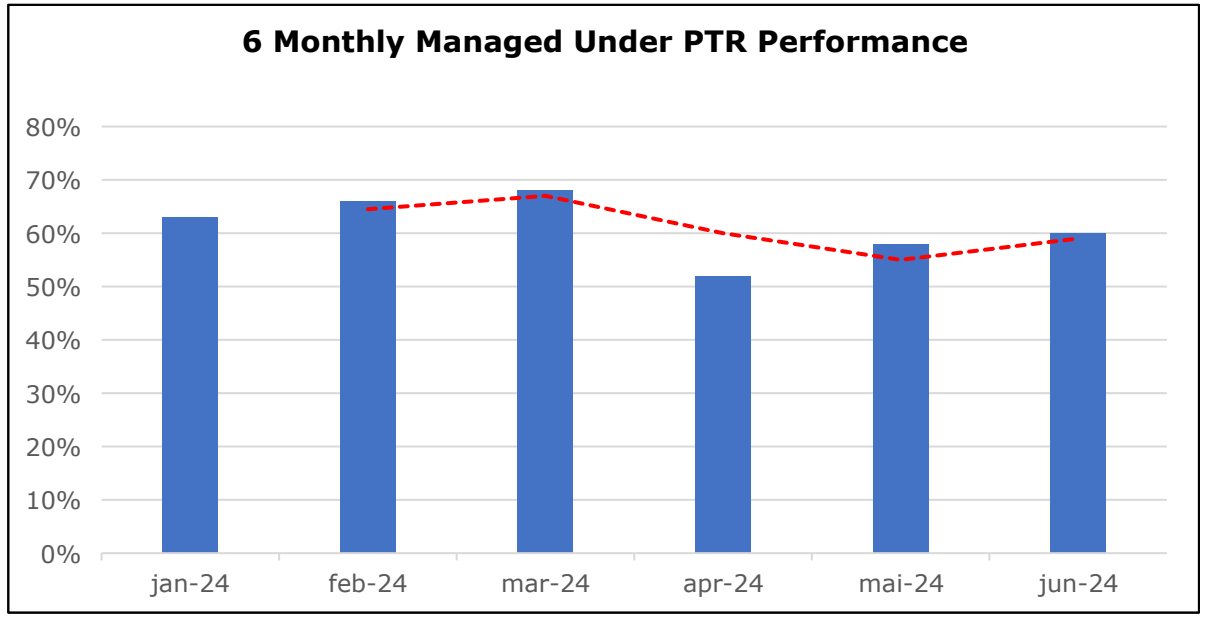
Q1 saw the inception of the Acknowledgement Team in May 2024, the aim is to ensure early and meaningful contact with complainants.

The number of concerns received both Managed through PTR and via Early Resolution has increased by approximately 40% on the same reporting period 2023-24. The themes for the period remain unchanged from Q3 and Q4.

This will pinpoint what concerns are being raised and these will be confirmed via telephone with the complainant. The central team have assumed responsibility for beginning the Datix form and bullet pointing the questions ahead of allocation of an IO to ensure focused direction to assist with expediency. This approach has been very well-received and welcomed by stakeholders such as PSOW during our quarterly meetings and by WRP during a very positive assessment in June.

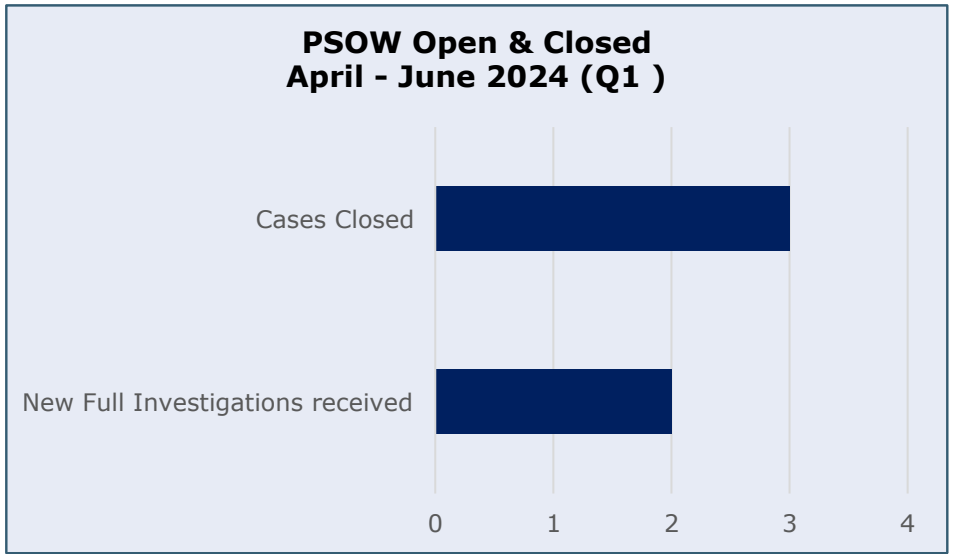
Complaints

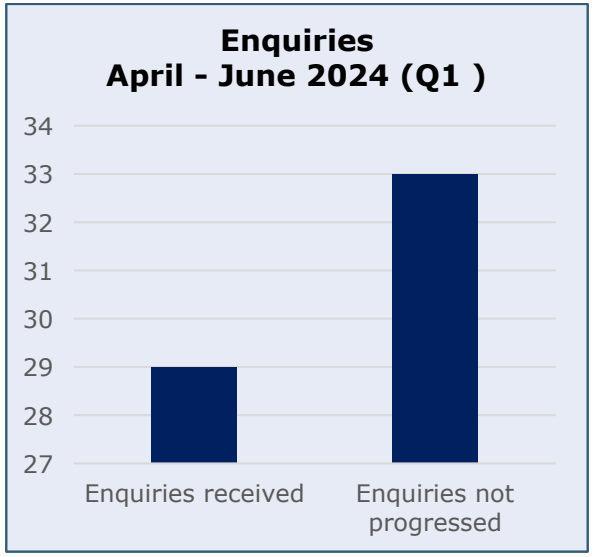


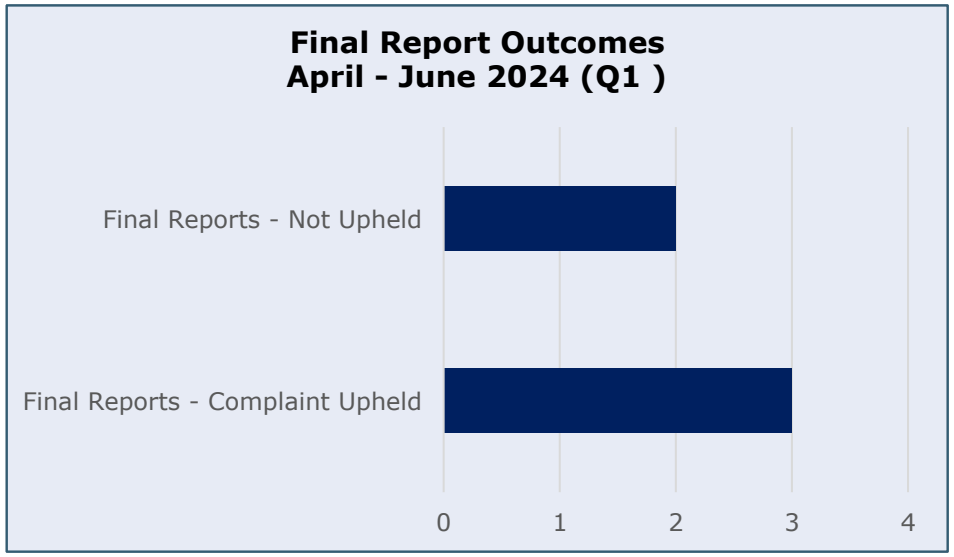


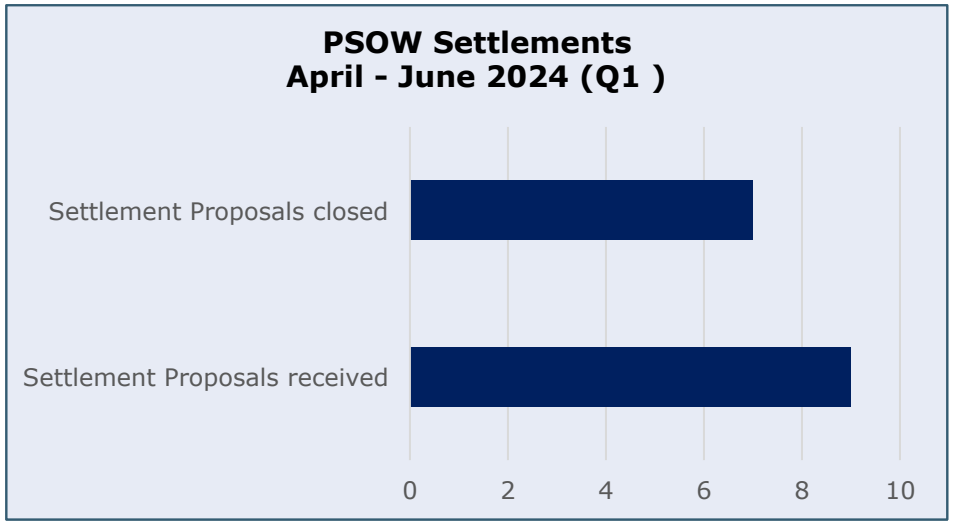
- Weekly complaints meetings are fully embedded to ensure a collaborative approach to cross-divisional concerns and the ability to escalate for advice and support to the central concerns team as required.
- With regards to reduction of complaints exceeding the WG 30-day timeframe, dedicated resource is being utilised to identify, monitor and assist with concerns investigations that may require additional support in order to conclude.
- **At the end of Q1 the number of concerns exceeding 12 months has reduced to 6, which is a positive decrease from 11 at the end of Q4.**
- Strategy meetings are now considered for all grade 4 and 5 complaints (if they are not managed as a PSI moderate to severe harm) facilitated by the Complaints Manager or the Senior Complaints Manager within 2 working days. This prevents delays and ensures that complaints sit with the right team, first time, rather than bouncing between teams.
- PALS are now engaged with grade 1+2's. PTR teams and PALS are supporting with reviewing all open grade 1's and 2's to try and resolve the complaint verbally, this has aided with closure of some of the more outstanding concerns.

Ombudsman (PSOW)

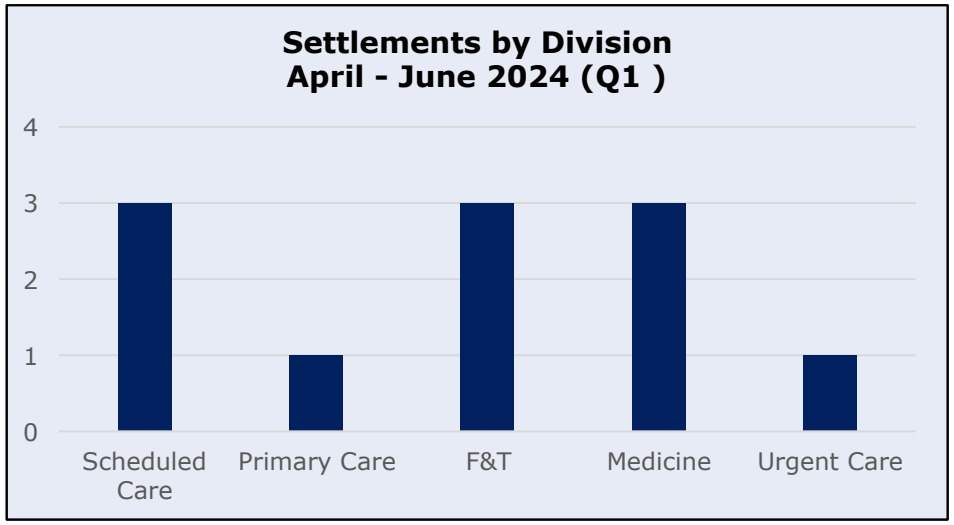








Positively, although the number of enquiries received has been higher, the number progressed by PSOW has been lower. Indicating that the PSOW has been satisfied following receipt of evidence from the Health Board. Overall settlements and final reports upheld has reduced across the period. The Health Board continues to perform above average and the target performance timescales when providing evidence to PSOW.



Claims, Redress and Inquests – Q1 Update

April – June 2024

Activity over 1st Quarter

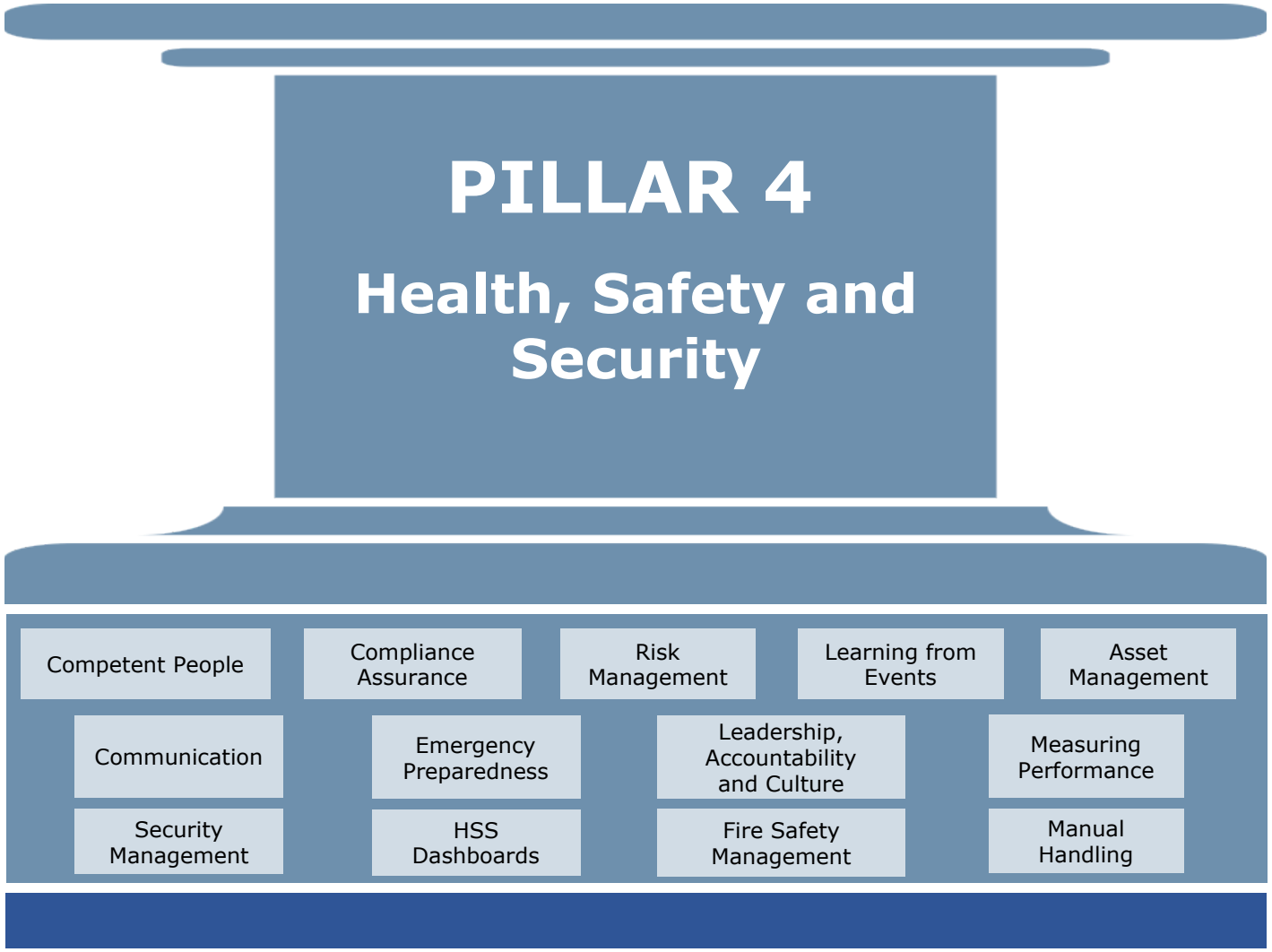
- Clinical Negligence claims remain steady
- Personal Injury claims remain at historic low
- Coroner work remains high
- 80 new inquests received
- 26.6 month on month this quarter

Reg 28: Prevention of Future Deaths Reports

- Only **1** Reg 28 report issued this quarter
- The Health Board were not a party to the inquest
- Community death. Update requested on patient flow and ongoing work to improve handover delays across hospital sites

Coroner meetings

- Constructive meetings held with members of the Executive Team – CEO, Medical Director, and scheduled Director of Nursing
- Head of Legal Services continues as daily point of contact, with
- Regular 1:1 meetings with Coroner to maintain good operations and direct lines of communication for effective inquest management, latest meeting held 28 June 2024.


PILLAR 4
Health, Safety and Security
Competent People
Compliance Assurance
Risk Management
Learning from Events
Asset Management
Communication
Emergency Preparedness
Leadership, Accountability and Culture
Measuring Performance
Security Management
HSS Dashboards
Fire Safety Management
Manual Handling

Health and Safety Executive Engagement

There have been no new concerns raised by the Health and Safety Executive (HSE) during quarter 1 of 2024/25.

The Health and Safety Executive (HSE) have one active case with the Health Board relating to an investigation of a patient fall at Nevill Hall Hospital, which occurred in 2019.

South Wales Fire & Rescue Service Activity

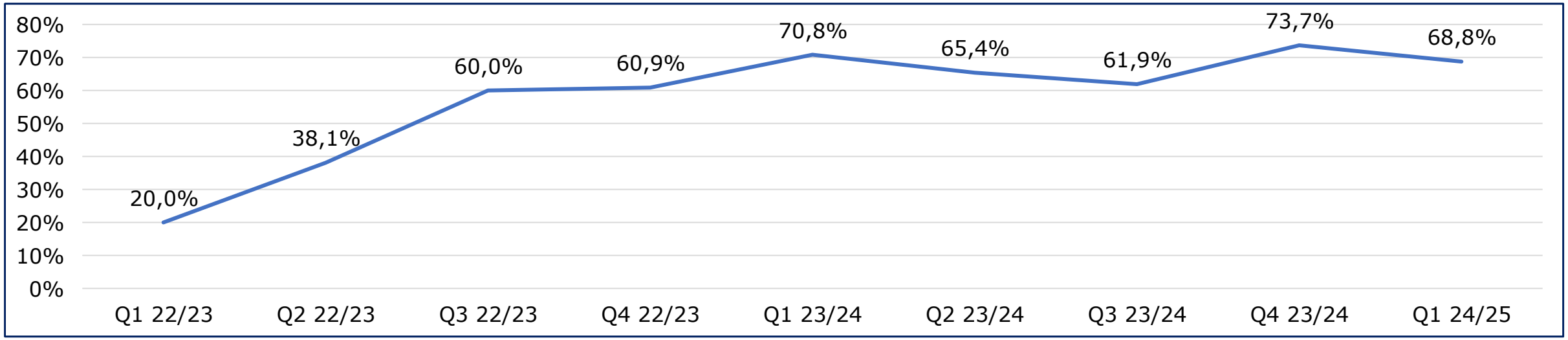
The Health Board are progressing the recommendations of the two enforcement notices relating to fire safety at Residences at Nevill Hall Hospital (Gerylyn and Bron Haul).

Positive improvements have been made to address the storage and housekeeping. Capital funding has been secured to address the enhancements required to the fire alarm systems and fire resisting doors.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During Q1 (April to June 2024) the Health Board have reported **16 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

68.75% of these cases were reported within the legal timeframes within the legislation.



Health, Safety and Security

Health and Safety Statutory and Mandatory Training

At end of May 2024 training compliance for the Health Board was reported as:

There has been **no change** in the compliance with health and safety compared with the previous report, however, the compliance with Fire Safety, Violence & Aggression and Manual Handling have all increased.

Health & Safety	**87%**
Fire Safety	**84%**
Violence & Aggression	**86%**
Manual Handling	**58%**

Health and Safety Training for Senior Leaders

Board Development session held on 24 April 2024 provided a focus on health and safety legislation, including Corporate Manslaughter. The session was delivered by Solicitors from NWSSP Legal & Risk Services.

IOSH Safety for Executives and Directors being planned for Q3 2024/25.

Health and Safety Committee

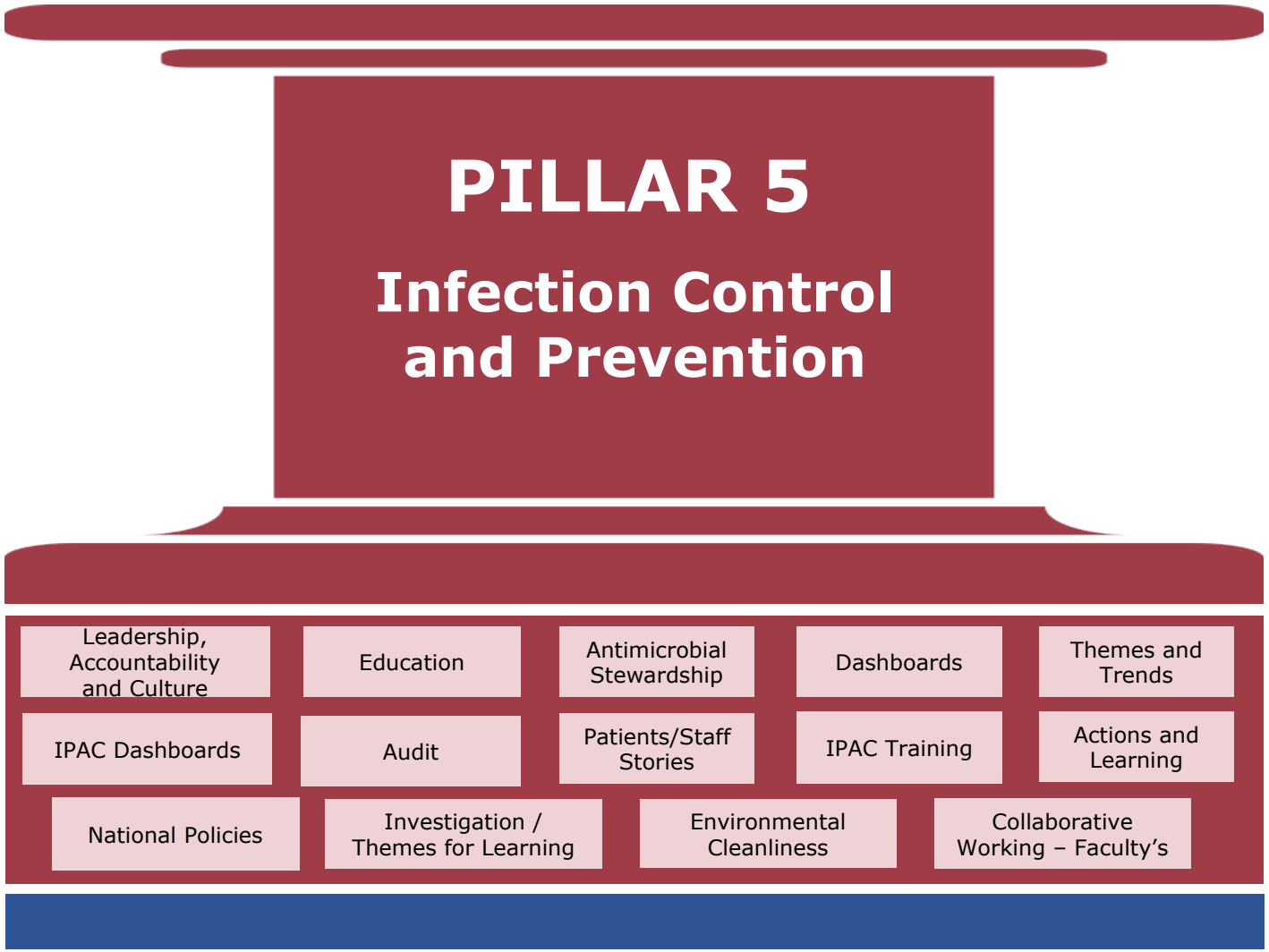
The revitalised Executive led Health and Safety Committee met in June 2024.

The Committee will be developing a work programme to improve compliance with health and safety.

Health, Safety & Fire Annual Report 2023/24

The health, safety and fire annual report 2023/24 is in development.

This will be ratified at the Health and Safety Committee and approved by the Executive Committee by the end of September 2024.


PILLAR 5
Infection Control and Prevention
Leadership, Accountability and Culture
Education
Antimicrobial Stewardship
Dashboards
Themes and Trends
IPAC Dashboards
Audit
Patients/Staff Stories
IPAC Training
Actions and Learning
National Policies
Investigation / Themes for Learning
Environmental Cleanliness
Collaborative Working – Faculty's

Infection Prevention & Control

Healthcare Associated Infections

Table 1. Current FY rate per 100,000 population of specimens by HB, Apr - Jun 24

Additional filters for Table 1.

Select month or FY

Current FY

Select organism group

All organisms

< than same period last FY

= same period last FY

> than same period last FY

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	49.51	1.36	31.2	59.01	21.7	7.46
Betsi Cadwaladr UHB	47.21	1.75	23.31	83.93	12.82	1.17
Cardiff and Vale UHB	45.22	0.79	36.49	53.15	24.59	6.35
Cwm Taf Morgannwg UHB	37.94	0.9	34.33	77.68	24.39	3.61
Hywel Dda UHB	56.24	3.12	29.16	90.62	20.83	9.37
Powys THB	23.97	0	3	0	0	0
Swansea Bay UHB	63.81	1.05	26.15	54.39	35.57	1.05
Velindre NHST						
Wales	48.16	1.41	28.82	67.11	21.77	4.48

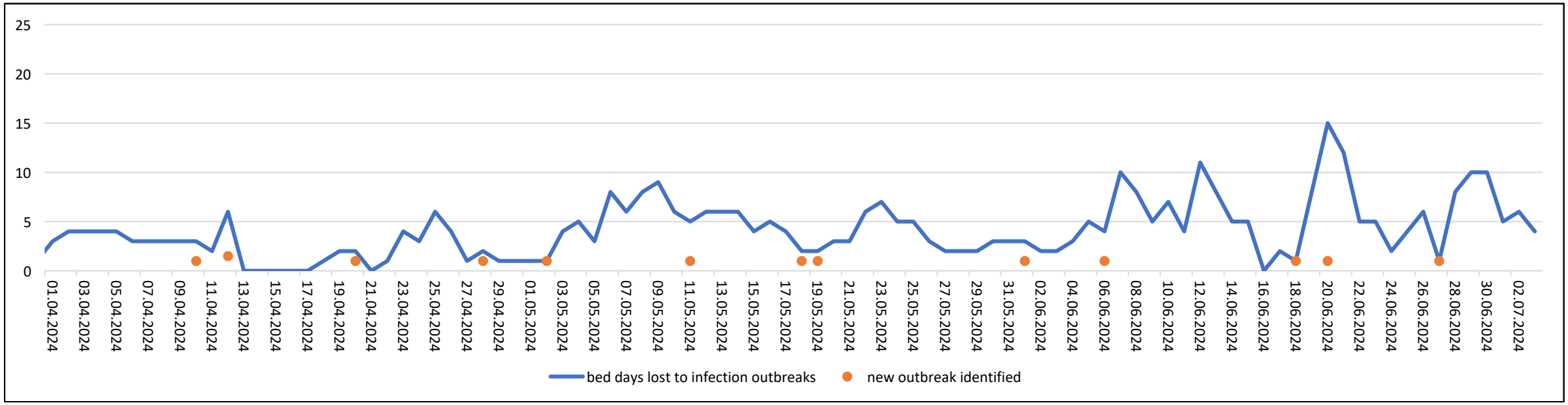
Issue	Cause	Remedial Action	Who	When
3 wards closed due to outbreak of Covid infection D5W, 4/4 & Monnow Vale	• Visitor Covid positive • Symptomatic staff – no longer testing	• Cohorted affected patients • Covid safety measures assurance completed by ward managers – good compliance	Infection Prevention Ward Managers	June 2024
Increase in C difficile infection June Total = 24 HAI = 8 CAI = 9 Relapse = 7	• Antimicrobial stewardship • Compliance with fundamental IP measures	• Enhanced cleaning strategy approved & HPV programme commenced		Ongoing
Increase in Staph Aureus Blood stream infections. June Total = 22 HAI = 8 CAI = 14	• 6 skin & soft tissue • 5 bone & joint • 5 respiratory • 2 line associated • 2 urinary • 1 Gastro • 1 unknown	• Promoting ANTT • Reviewing standardisation devices available via Procurement • QI project for admission screening • TVN Wound assessment and management training now available for staff to book via ESR • Viewing skin preparation products	Ward Managers Senior Nurses Tissue Viability	Ongoing
Increase with Gram Negative blood stream infections – fewer cases in June. June Totals E coli = 23 (3 HAI – 20 CAI) Klebsiella – 7 (2 HAI – 5 CAI) Pseudomonas = 3 (3 HAI)	• 18 urinary tract • 9 Hepatobiliary • 2 respiratory • 2 gastro • 1 unknown • 1 skin & soft tissue	• Revisiting the 9 key standards for UTI prevention • Study session arranged for 13th August • Promoting Start Smart then Focus Antibioitic audits • Rapid roll out of the HOUDINI "make the catheter disappear initiative • Review adult antimicrobial guide in line with resistance patterns	Infection Prevention Bladder & Bowel Service Antimicrobial Pharmacists	Ongoing

WG Targets – Healthcare Associated Infections (HAIs)

Issue	Cause	Remedial Action	Who	When
Above Welsh Government trajectory for reportable incidents	Increase in community acquired cases and hospital transmission	➢ Refreshed organisational HAI Action Plan ➢ Visit from Public Health Wales Consultant to review Action Plan ➢ Divisional Assurance reported via Infection Prevention & Antimicrobial Stewardship Committee ➢ Refresh internet page with information for public ➢ Re-established root cause analysis meetings	Infection Prevention Public Health Wales Divisions Infection Prevention/Comms Infection Prevention/Divisions	June 2024 July 2024 July 2024 Ongoing Ongoing
C difficile - Current rate per 100,000 population is 49.51% (73 cases compared to 45 cases the equivalent period 2023/24) 6 wards affected by period of increased incidence	➢ Antimicrobial stewardship ➢ Compliance with fundamental infection prevention measures ➢ Increase in community acquired and relapse cases ➢ 3 patients linked to onward transmission via geno-sequencing	➢ Ongoing Quality Improvement project within Medicine ➢ Enhanced cleaning paper approved & operational ➢ Raised awareness of mattress checking process with support from Facilities ➢ Targeted training & education	Unscheduled Care Facilities & Divisions Facilities & Infection Prevention Infection Prevention	Ongoing June 2024 June 2024 Ongoing
Staph Aureus – MRSA current rate per 100,000 population is 1.36 & MSSA 31.2% (48 cases compared to 22 for the equivalent period 2023/24)	➢ 3 line infections ➢ Largest burden is skin & soft tissue damage	➢ Deep dive to identify themes ➢ Promoting ANTT & Wound Care education ➢ Reviewing skin preparation ➢ QI project to improve admission screening ➢ Link with Procurement to standardise medical devices	Infection Prevention Infection Prevention & TVN Infection Prevention Infection Prevention/Admission Units Infection Prevention/Procurement	July 2024 Ongoing Ongoing August 2024 July 2024
Gram negative blood stream infections - Current rate per 100,000 population is **Ecoli** – 29.01% (87 cases compared to 91 cases the equivalent period 2023/24) **Kleb** – 21.7% (32 cases compared to 29 cases the equivalent period 2023/24) **Pseudo** – 7.46% (11 cases compared to 6 cases the equivalent period 2023/24)	➢ Over 50% linked to urinary tract infections ➢ Increase in antimicrobial resistance	➢ Established a working group for the 9 standards for UTI prevention ➢ Arranged a study session in collaboration with Bowel Services, Dieticians, Microbiology & Pharmacy linked to the 9 standards ➢ QI for oral hygiene ➢ Reviewing AMR guidance ➢ Promoting ANTT ➢ Developed an intranet resource page ➢ Raised awareness of Correct sample collection	Infection Prevention, Bladder & Bowel services, Dieticians, Micro & Pharmacy Medicine/Carolyn Joyce Infection Prevention/Divisions Infection Prevention Infection Prevention/Micro	June 2024 August 2024 Ongoing Ongoing Ongoing

Infection Prevention & Control

Bed Days Lost



April = 70
May = 135
June = 171

- 6 wards affected by C difficile
- 8 wards closed with Covid outbreaks

Refreshed the Patient Placement SOP & use of the Respiratory Assessment Zone

Infection Prevention & Control

Decontamination

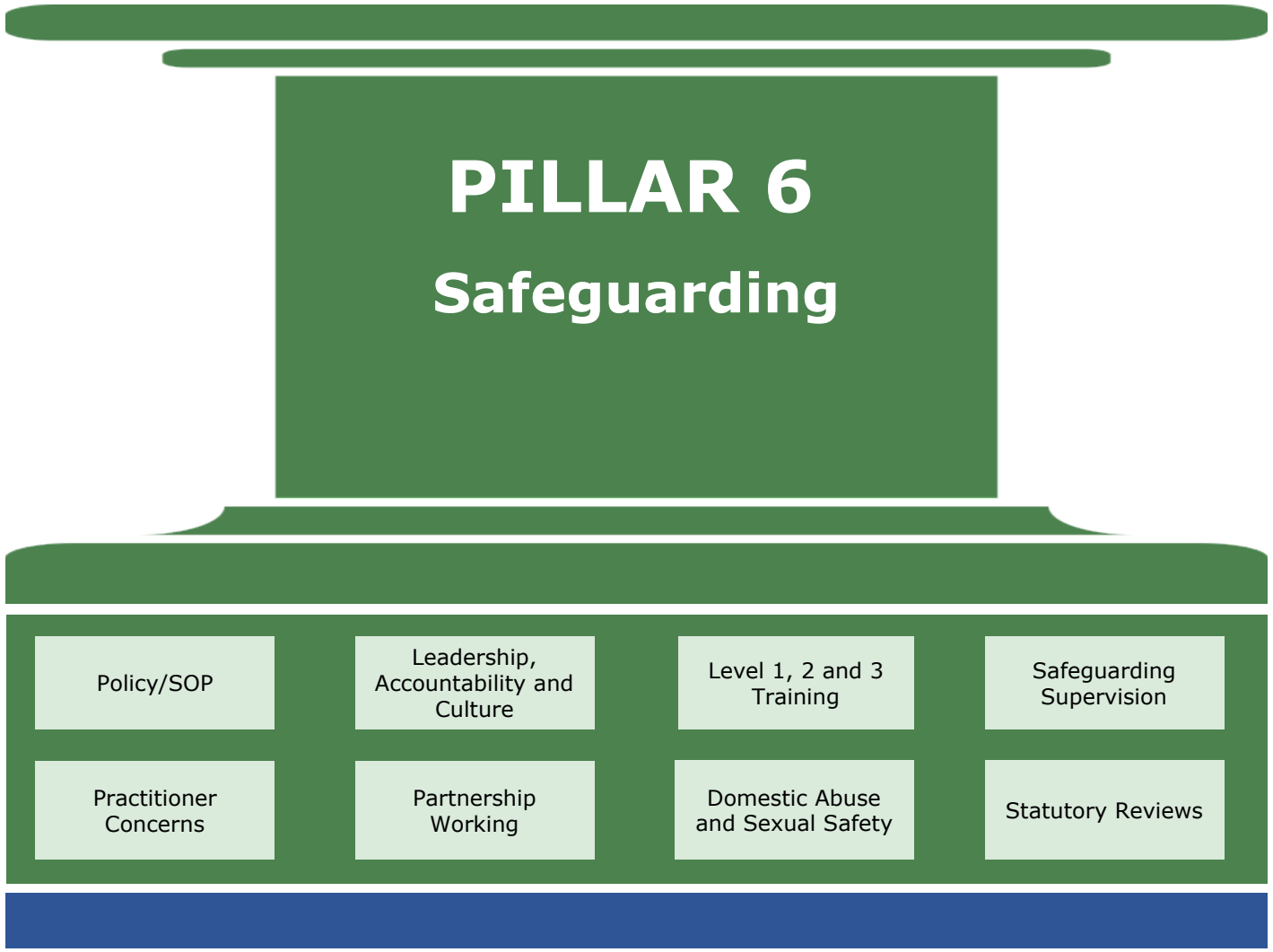
Issue	Cause	Remedial Action	Who	When
Community Dental Service (CDS) washers have been tested but not serviced, indicating non compliance with required standard.	Lack of works and estates trained staff to undertake the role and their focus on other decontamination testing, e.g. HSDU.	All Wales Authorised Engineer (Decontamination) AE(D) aware.	Authorised Person (D) Works & Estates lead	July 2024
		Waiting CDS agreement on release of monies for band 5 Works personnel.	CDS Directorate	July 2024
Delay in centralised endoscopy unit project build at the Royal Gwent Hospital (RGH) have led to increased demand on the interim unit with breakdowns occurring.	Non agreement of revenue costs initially created delay however this has since been approved by ABUHB Board and awaits decision for funding by Welsh Government.	The interim decontamination unit continues to decontaminate scopes however has failings on recent Bowel Screening Wales (BSW) audit.	Welsh Government funding review	August / September 2024
		Action plan produced to address issues.	HSDU lead	July 2024
Endoscopy YYF achieved amber rating on Joint Advisory Group (JAG) audit undertaken by AE(D) on behalf of BSW.	Identified issues showing little progress since 2022 year audit, including works and estates input, electronic track & trace (T&T), report governance.	Updated action plan indicates some progress on aspects such as T&T. Action plan review by Directorate in readiness for BSW July review where need to demonstrate required BSW standards.	Directorate Manager & Senior Nurse	July 2024
AP(D) role not fully functioning from a governance aspect.	Lack of AP(D)s and decontamination works trained staff. Currently under review and progress toward AP(D)	Decontamination manager continues to support AP(D)with joint report review and submission.	General Manager Facilities / Works & Estates	August 2024

C.Difficile Antibiotic Root Cause Analysis Themes Q1 2024/25

Antibiotic findings	HCAI	CAI	Relapse	Grand Total
No suboptimal antibiotics	17	5	4	26
Awaiting GP response		10	6	16
Possible suboptimal use - increased risk of *C.diff*	11	1	1	14
No antibiotics received	1	2	2	5
Possible suboptimal use - no increased risk	4	2		5
Grand Total	**33**	**20**	**13**	**66**

- The majority of suboptimal prescribing related to piperacillin/tazobactam (Tazocin) use in secondary care. This will be investigated as part of the ongoing work around co-amoxiclav in the main hospital sites.

- 8/50 patients did not have their acid-suppressing medicine held whilst on antibiotics.


PILLAR 6
Safeguarding
Policy/SOP
Leadership, Accountability and Culture
Level 1, 2 and 3 Training
Safeguarding Supervision
Practitioner Concerns
Partnership Working
Domestic Abuse and Sexual Safety
Statutory Reviews

Safeguarding

Training and Development

Training Module	Compliance %
Adult Safeguarding Level 1	87%
Children Safeguarding Level 1	86%
Adult Safeguarding Level 2	90%
Children Safeguarding Level 2	88%

Safeguarding Training continues to be provided and monitored, in line with the recommendations of the Intercollegiate Documents for Safeguarding of Children and Adults.

All training for Safeguarding level 1 and 2 is now above the required 85% compliance.

Level 3 Children's and Adults training continues to be a challenge and further work is required across the Health Board to ensure that this is mandated to staff appropriately via ESR and that compliance data can then be analysed.

Safeguarding

Current Risks/Challenges

Issue	Cause	Remedial Action	Who	When
Safeguarding Level 3 Training Non Compliance	Delays in being mandated via ESR	Due to the inability to formally mandate the training a number of targeted sessions are in place and training is being delivered in areas of higher risk.	Head of Safeguarding	Q2 2024/25
Decommissioning of Specialist Domestic Abuse Service in General Practice	Funding is not sustainable for 2024/25 to enable the continuation of the IRIS Programme	Due to the absence of any funding to support beyond a transition period, there will be a significantly reduced service available to support survivors of Domestic Abuse presenting in General Practice.	Public Health	Q2 2024/25
Significant increase in safeguarding referrals and strategy meetings for vulnerable children and adults	It is unclear if there is any singular cause for this increase in activity, though improved staff awareness will be a contributory factor	A temporary increase in staffing has been agreed, from existing budget to manage current work load. Deep dive to be completed to understand more regarding cause and to determine if workload can be reduced without compromising safety.	Head of Safeguarding	Q2 2024/25
Staff feeling unsupported or poorly prepared hen asked to give evidence in court proceedings	Increase in requests to attend Court which are being supported by staff who have had limited exposure to this role	Working Group established to clarify roles and responsibilities and to develop training on what to expect when giving evidence.	Deputy Head of Safeguarding	Q3 2024/25

GP Engagement in Child Protection Processes

- The Monmouthshire NCN has identified that General Practice is not always made aware regarding Children entering or coming off the Child Protection Register.

- Corporate Safeguarding have engaged with the LA Leadership Team for Safeguarding in Monmouthshire to understand why GP's are not invited to meetings or sent relevant updates.

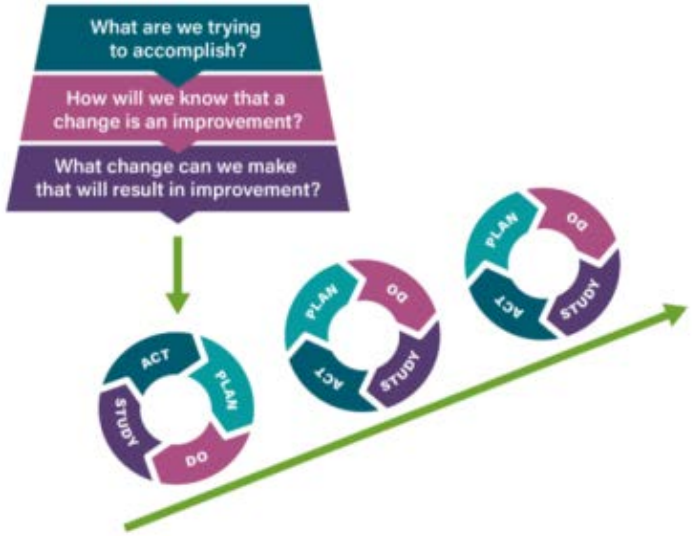
- Reviews of GP Records and LA Records highlighted that the LA often do not have the correct details to notify GP.

- Corporate Safeguarding are commencing a trial in Monmouthshire which will:

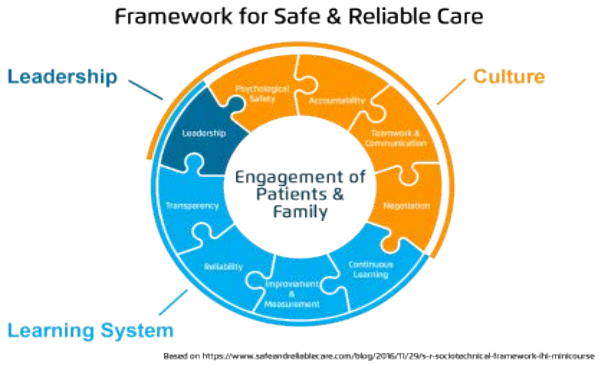
  - Act as a point of contact to ensure meting invitations are forwarded to the correct GP Practice.
  - Undertake a quarterly review with the LA to ensure that GPs are made aware of all children that came on to or exited the register in that reporting period.

- The trail will be reviewed by the Corporate Safeguarding Team, Monmouthshire County Borough Council and the NCN to evaluate its impact prior to making recommendations regarding how a similar process can be applied in the other four LA areas.

Quality Improvement



Safe Care Collaborative: Final Update



Score	IHI - Stage of Project Scoring summary
2	Activity but no changes
2.5	Changes tested but no improvement
3	Modest improvement
3.5	Improvement
4	Significant improvement
4.5	Sustainable improvement
5.0	Outstanding sustainable improvement

Organisational Update: Stage-Collaborative Closed in May 2024

- **Learning Session, May 14th**– Face to Face Learning Session held at the ICC focussing on 'Sustaining Successful Improvement'
- **ABUHB Deteriorating Patients Collaborative –** Review to be undertaken around what is next for a local collaborative, reflecting ABUHB strategic direction and the forthcoming National Programme. 'Improvement Cymru', who led SCC, now forms part of the 'Quality, Safety and Improvement' directorate within the NHS Executive are identifying their national priorities.
- **Leadership programme of work** –Executive Safety walkarounds set up for 2024, some cancelled at the start of the year but more completed during April/May.
- **Quality Outcomes Framework**–Maxine Power facilitated session around development of the QOF measures. Aim to reduce these to up to 5 measures per component of STEEEP. Qtr 4 QOF reported.
- **QI Skills Development**– Spread & Scale aim: *'To unleash a million minutes of quality improvement coaching to enable our people to improve their services over the next 4 years'*. Cohort 1 of new QI Coach programme in Autumn focussing on QPS staff, Primary Care and others. 3 programmes 2025 onwards aiming to develop 75 QI Coaches embedded in divisions each year.
- **QI/Nursing Directorate –** ABCi QI Unit moved to QPS/Nursing

Teams Update

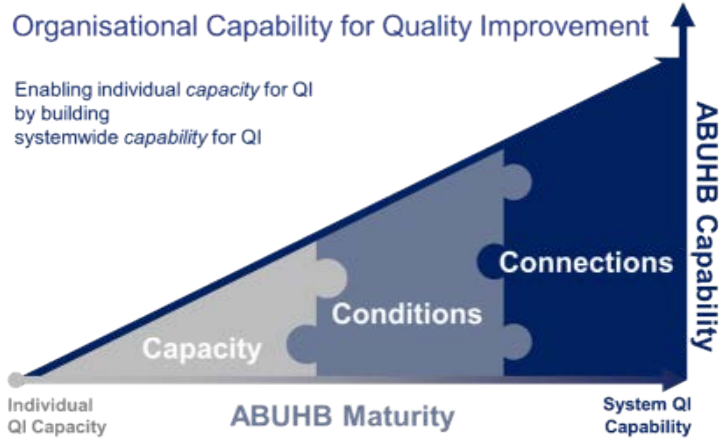
- **Storyboards** - Updated for Learning session 6
- **Ward C0 –**Up until the end of April, there hasn't been a Cardiac Arrest for 155 days. Next stage of visual management, screen accessible for full MDT at handover between shifts.
- **Monmouthshire** – Invited to present as spotlight session at final learning session. Reduction in Package of Care hours for medically optimised patients. Reduction in median LOS. Exploring potential to spread Mon integrated model.
- **AMU** – Workforce changes in AMU leadership/ team/coach. Ongoing support for QI within AMU under consideration
- **OT Early Intervention** – Invited to present as spotlight session at final learning session. 6 week Home Based Memory Rehabilitation (HBMR) programme reduced from 770-670 minutes for each patient, allowing for an extra patient to undertake the programme each month. Testing pre-hab memory strategy leaflet for patients on waiting list & planning for spread.
- **Theatres –** Up until the end of May, there hasn't been a Never Event in theatres for over 195 days, equating to 3.9 events avoided. Improvement Advisor in post whose work is aiming to reduce retained material/wrong sided block Never Events in theatres. Work focussing on two areas: Developing Safety Culture via Human Factors training/simulation and QI, plus reliable introduction of NatSSIPS 2. Testing Safety Culture survey as part of Human Factors, updated WHO checklist and 'Pause for the Gauze' being tested and spread across theatres.

Workstream	ABUHB Team	Score
Acute	Medical Assessment Unit at GUH	2.5
	Ward C0 (ENT surgical ward) at GUH	3.5
	Theatres – Human Factors	2.5
Ambulatory	North Monmouthshire Integrated Team	3.5
Community	OT/MH Early Intervention for Cognitive Impairment Team	3
Leadership	Executives, Leaders for Safety, Faculty	3.5

April - June 2024
Prepared by ABCi team

Quality Improvement

*"**Quality improvement** is about giving the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them. It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement."*



April - June 2024
Prepared by ABCi team

Our QI Capability strategy is to build:

Capacity for QI – knowledge, skills, experience

- **QI Coaches integrated into divisions**
- QI Knowledge and Skills Development Framework

Conditions for QI – Enablers for QI

- Clinicians as QI Leaders
- Data systems supporting QI
- Resources to support teams working to improve services
- Patient involvement in QI
- **Human Factors and Safety Culture**

Connections for QI – QI Networks sharing learning

- QI Networks, both internal and external
- Strategic Partners
- **Safe Care Partnership/ Collaborative**
- QI Collaboration

Progress:

ABUHB NHS IMPACT Self Assessment survey - initial results

Spread and Scale Integrated QI Coaches – 90 Day Plan

Aim - "To unleash a million minutes of quality improvement coaching to enable our people to improve their services over the next 4 years"

QI Coach development programme (click for more info)

- **Plan** – Each year x 3 Cohorts x 25 participants = 75 participants each year = 300 QI Coaches in 4 years
- Celebration event for pilot QI Coach Programme in June
- 27 booked on Cohort 1 planned for Autumn 2024 targeted at key staff e.g. QPS, Primary Care, QI Project teams.
- 2025 dates for QI Coach Programme booked
- 16/300 QI Coaches trained in ABUHB
- 4140/1,000,000 minutes of QI Coaching delivered to QI teams between April – May 2024

Human Factors and Safety Culture

- ABCi Improvement Advisor supporting work to reduce Never Events in Theatres – presented to PQSOC
- 195 days since last Never Event in theatres (data to May) equating to 3.9 events avoided
- Testing SCORE safety culture survey
- Updated WHO checklist and 'Pause for the Gauze' being tested and spread across theatres

Safe Care Partnership (SCP)/Collaborative(SCC)

- Safe Care Collaborative ended in May 2024
- Improvement Cymru part of NHS Executive 'Quality, Safety & Improvement Directorate scoping priorities for next stage of SCP work

Questions

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For Information
Clinical Effectiveness

Section 4

Audit Title:	National Oesophago-Gastric Cancer (NOGCA) Audit **State of the Nation Report** Data -1 Apr 2020 – 31 Mar 2022 Published January 2024	Clinical Lead: Miss Tamsin Boyce, Consultant, Surgery
Rationale:	NOGCA is commissioned by Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP).	
Objectives:	It aims to promote quality improvement in patient outcomes, and to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales.	
Presented at Clinical Standards and Effectiveness Group 23rd May 2024		

Upper GI cancer treatment is not delivered in ABUHB. Treatment centralised within Cardiff and Vale UHB (CVUHB). Radiotherapy undertaken at Velindre Cancer Centre (VCC). The Health Board is only responsible for the front end of the patient pathway. Referral to Treatment times (RTT) has increased over the last 10 years due to improved staging and diagnostics as well as an increase in demand.

	ABUHB	National
Patients diagnosed after an emergency admission (lowest rate in Wales SBUHB 20.4% & CVUHB 21.6%)	14.1%	13.1%
% of patients who waited >62 days form urgent referral to 1st treatment	83.3%	
Patients having a treatment plan for curative treatment	32.4%	37.2%
Patients having a treatment plan for non-curative treatment	67.6%	62.8%
Patients with non-curative plans having chemotherapy or radiotherapy	42.8%	34.7%

100% of ABUHB patients completed Radiotherapy

Key Success and Concerns

Report Successes:	
1	Doing well with CT Staging, (96.9%) higher than the national rate.
2	Of the patients with a plan for non-curative treatment, 42.8% are having chemotherapy or radiotherapy, nationally this is 34.7%.
3	With higher diagnosis rate in the Health Board compared to the rest of Wales, the Health Board maintained face to face contacts and MDT's during the pandemic.
4	Lower rates of diagnosis after emergency admissions than other organisations across Wales, although not as good at the UK national rate. ABUHB 14.1% v National 13.1%.
5	Straight To Test endoscopy CT scans done same day if applicable.

Report Concerns:	
1	Lower rates of patients having a plan for curative treatment than the national rate, the Health Board being 32.4% and nationally 37.2%.
2	The Health Board has a lower rate for patients having a plan for non-curative treatment at 67.6% compared to nationally 62.8%
3	Increase in RTT 62-day measure, form 80 days in 201/-2020 to 82.5% in 2020/2022.

Assurance Level

Limited - The project did not achieve the standards or criteria being audited against

Risk Level

Major - Non-compliance with national standards/Significant risk to patients if unresolved

Not on Risk Register within the Health Board as much of the pathway is outside of the Health Boards control - Upper GI cancer treatment delivered in CVUHB and radiotherapy in VCC.

	Report Recommendations:	S.M.A.R.T Actions: Responsible: Due Date: Progress:
1	Cancer Alliances and Wales Cancer Network should review patient pathways in their region to identify opportunities to intervene and reduce high and variable rates of diagnosis following emergency admission and late-stage diagnosis. *Action by*: Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Ongoing work across Wales (National Optimal Pathway) to reduce late-stage diagnosis.
2	Review oesophago-gastric (OG) cancer care pathways against best practice guidance to identify ways to reduce the proportion of patients with OG cancer waiting more than 62 days from urgent referral to first treatment. *Action by*: Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Ongoing work with National Optimal Pathway. Update to Service Level Agreement (SLA) in progress and obtain 2022/2023 data to see accurate performance
3	Explore reasons for non-completion of palliative chemotherapy regimens, including review of patients with OG cancer who died within 90 days of starting treatment, and review patient selection for palliative chemotherapy where appropriate. Action by: Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Specialist OG dietician already present in clinic, there is definitely the workload for further input, there is also OG Dietetic cover in the MDT.

	Report Recommendations:	S.M.A.R.T Actions: Responsible: Due Date: Progress:
4	Given the often profound impact of OG cancer on patients' nutritional status, Cancer Alliances and Wales Cancer Network should review specialist dietetic provision across their region, and ensure OG cancer units are resourced according to national specifications to ensure that all patients have access to appropriate dietetic input. *Action by*: Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Specialist OG dietician already present in clinic, there is definitely the workload for further input, there is also OG Dietetic cover in the MDT.
5	In Cancer Alliances with low rates of active treatment for high-grade dysplasia (HGD), review reasons for non-treatment and determine if more patients with HGD could be eligible for endoscopic therapy Action by: Cancer Alliances	Numbers are so small it is difficult provide a comment. There have been issues, 2 patients delayed pathways for HGD due to uncertainties regarding funding. This is delivered by Cardiff and not specifically covered in the SLA. This caused delays in treatment resulting in more advanced disease at treatment. This has since improved, and processes are less complicated and protracted. Long term funding and workforce remains fragile.

Audit Title:	State of the Nation Report 2024 An audit of care received by patients diagnosed with Lung Cancer in England and Wales during 2022 National Lung Cancer Audit (NLCA)	Clinical Lead: Dr Mat Jones Medical Consultant
Rationale:	Aim of NLCA is to evaluate the patterns of care and outcomes for patients with lung cancer in England and Wales. To support services to improve the quality of care for these patients.	
Objectives:	Management of patients with lung cancer is informed by various national guidelines. The NLCA evaluates current patterns of care against standards. These standards were defined in publications from: The National Institute for Health and Care Excellence (NICE) QS17, Roy Castle Lung Cancer Foundation's national commissioning guidance, the National Optimal Lung Cancer Pathway and the 2022 "Getting it Right First Time" (GIRFT) report. The NLCA has developed a set of indicators to reflect these and encourages healthcare professionals to review the findings of this report and to understand why unwarranted differences in practice exist.	
Presented at Clinical Standards and Effectiveness Group – 23rd May 2024		

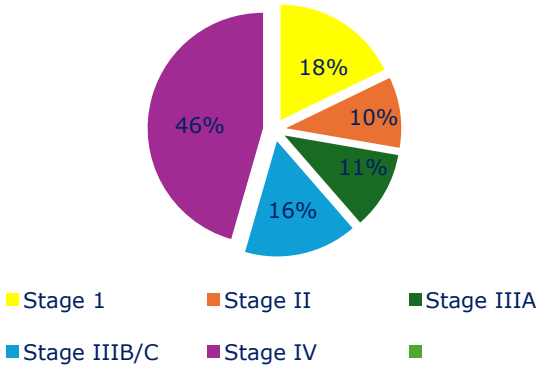
The Health Board has the largest number of patients with 100% data quality on key data items:

- 100% for basis of diagnosis,
- 100% for tumour morphology,
- 100% for disease stage, and
- 100% for performance status.
- 100% of records had data on whether a lung cancer nurse specialist was present at diagnosis.

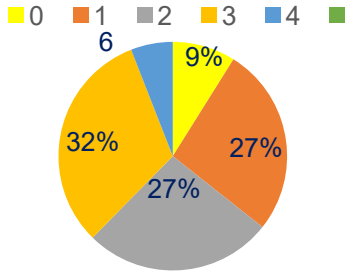
There are two cohorts: a) Small Cell Cancer – 12%, b) Non-Small Cell Lung Cancer (NSCLC) – 88%. There are 5 stages of disease:

- Stage I – 18%
- Stage II – 10%
- Stage III – 27%
- Stage IV – 46%

Unfortunately, the highest numbers are in the late stage of lung cancer disease due to late presentation or being asymptomatic at the time of detection.



There are 4 Performance Status (PS) levels, which is based on patients' daily capabilities from independent to bed bound. Low numbers present with a low PS.



ABUHB Performance status (per cent of known values)

ECOG PERFORMANCE STATUS

ECOG Performance Status

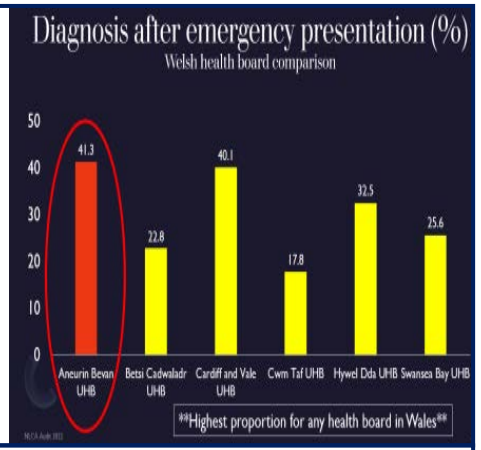
Developed by the Eastern Cooperative Oncology Group, Robert L. Comis, MD, Group Chair.*

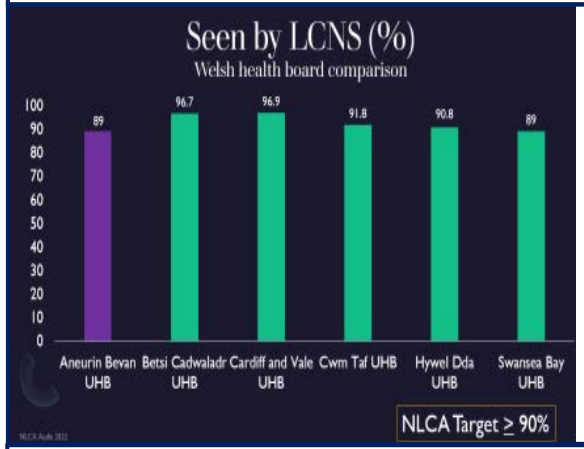
GRADE	ECOG PERFORMANCE STATUS
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours
3	Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any selfcare; totally confined to bed or chair
5	Dead

*Oken M, Creech R, Tormey D, et al. Toxicity and response criteria of the Eastern Cooperative Oncology Group. *Am J Clin Oncol.* 1982;5:649-655.

- The Health Board has a lower proportion of PS 0/1 compared to All Wales data, above the average proportion of patient in PS 3 & 4, 38% compared to 35.3%. These are not often suitable for curative treatments and more suited to palliative management as have higher rates of co-morbidities with increased risk of side effects from treatments. This ultimately impacts the HB treatment rates. PS 2 for the Health Board is 27% compared to Wales mean of 23.5%.
- Patients with Stage I/II with PS 0-1 - Confirmed pathological staging NLCA target is >90% within the Health Board was 89.4% (74.5% in 2021) compared to a Wales mean of 89.1%.
- NSCLC patients having surgical resection NLCA target > 17%, the Health Board 15.5% (adjusted for co-morbidities and deprivation), increased from 10.9 & in 2021 and above the Wales mean of 14.3%. In NHS England this is around 18% due in part to increased diagnosis at the early stage through lung cancer screening which is not yet carried out across Wales outside of a pilot Lung Health Check in CTUHB. Ambitions should be to achieve 20%.
- NSCLC patients Stage I/II with PS 0-2 having curative treatment is not always possible due to many factors. These include patient choice, co-morbidities, deterioration during investigation and factors relating to the tumour. The NLCA target >80%, the Health Board rate is 77.9% and improved from 2021 (66.7%) and higher than the Wales mean of 75.8%.
- For SCLC (more aggressive tumours) patients having chemotherapy ,the Health Board treatment rate was 50% in 2021 and in 2022 increased to 61.7% compared to Wales mean of 71.2%. The NCLA target is set at >70%. The Health Board had a high proportion of patients, 47 in total, which was 12% of our whole cohort who presented with small cell cancer. This is a higher-than-average proportion, and these patients are very challenging, often very co-morbid and often present through hospital and emergency settings.
- For NSCLC patients Stage IIIA with PS 0-2 (more advanced disease associated with further spread to Lymph Nodes) the Health Board is pushing boundaries with regards to cancer management. For those achieving curative treatment in this group, the Wales mean is 59.3% with the Health Board achieving 57.1% in 2022 compared to 31.7% in 2021, possibly linked to the pandemic and restriction in treatments during that time.
- NSCLC patients Stage IIIB/IV with PS 0-1 (advanced disease spread to outside the lung) having Systemic anti-cancer treatments (SACT) improved from 2021 rate of 56.6% to 57.8% in 2022 with a Wales mean of 61.8%. This suggests that people are potentially being missed due to challenges such as pathology waiting times and being reliant upon oncology services outside of the Health Board.

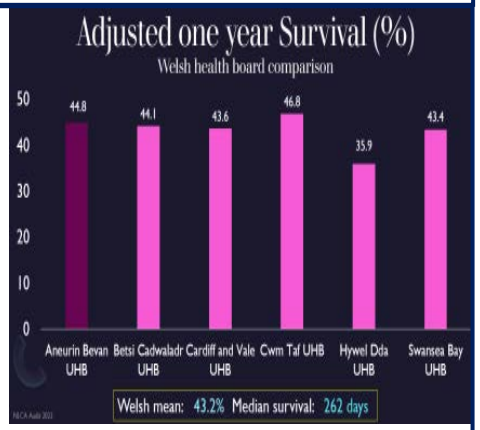
The Health Board has the highest proportion of diagnosis after emergency presentation across Wales with 41.3% presenting in this way, which was interesting compared to the emergency admission rate for NOGCA. However, lung cancer patients generally present with a higher bulk of disease, more co-morbidities, advanced age and poorer PS status when they present in this way. In England, emergency presentations are reduced due to the screening programme. Last year's data was low at 6.3%, but the data was inaccurate and since then the data recording has been managed carefully to ensure the data was robust this year.





The NCLA target for patients being seen by a Lung Cancer Nurse Specialist (LCNS) is 90% and the Health Board is at 89%. This is an improvement on the previous year's data however this is impacted upon by patients presenting as an emergency. This is being addressed to try and bring LCNS into seeing inpatients, to support patients and aid decision making, as the LCNS are pivotal in the management of lung cancer patients and without them the service would not be able to run efficiently. There are plans to develop the LCNS roles going forward.

Looking at how all this impacts patient survival, we know that lung cancer outcomes have been poor in recent years, and with developments in detection and treatments, survival rates have increased. In the Health Board although 1 year survival is still low at 44.8% it is above the Welsh mean at 43.2%, second only to Cwm Taf UHB who do have a screening programme at pilot stage, which may be impacting on survival outcomes. The Welsh median survival in days is 262 which is less than England 327 potentially due to the emergence of screening and reduced deprivation indices as a whole. The chart demonstrates the survival associated with disease stage, highlighting the importance of early detection.



Successes
Introduction of Physician of the week to prioritise lung cancer patients
Improved curative rates for early-stage disease and excellent pathological confirmation rates for early-stage disease and good PS.
More patients with SCLC having chemotherapy
Large increase from 31.7% to 57.1% of NSCLC with stage IIIA and PS 0-2 receiving curative treatment.
Lung Cancer Nurse Specialist input very good with plans to seen inpatients.
Adjusted one year survival rate is second best in Wales at 44.8%.

Concerns
Below target treatment rates for surgical resection in NSCLC, SCLC chemotherapy and NSCLC advanced stage good PS treated with SACT (but all improved from 2021). Concerning numbers presenting as emergency admissions.
Many of the HB patients have high PS and present with advance disease making curative treatment less viable.
Surgical resection rates are under target, although have improved since 202, under the 17% target set by NLCA.
High rate of emergency presentations (41.3%).

Key Messages ABUHB compared to Wales	Wales (n=2211)	ABUHB (n=400)
Curative treatment rates of NSCLC patients with stage I/II and good performance status (0-2)	76.2%	77.9% ↑
Curative treatment rates of NSCLC patients with stage IIIA and good performance status (0-2)	61.2%	57.1% ↓
Surgical resection rate (adjusted) for patients with NSCLC	14.3%	15.5% ↑
Proportion of patients with lung cancer diagnosed after an emergency presentation	29.4%	41.3% ↑
Proportion of patients seen by a Lung Cancer Nurse Specialist	92.4%	89% ↓
Use of systemic anti-cancer therapy for stage IIIB/IIIC–IV NSCLC patients (PS 0–1)	60.1%	57.8% ↓

Conclusions

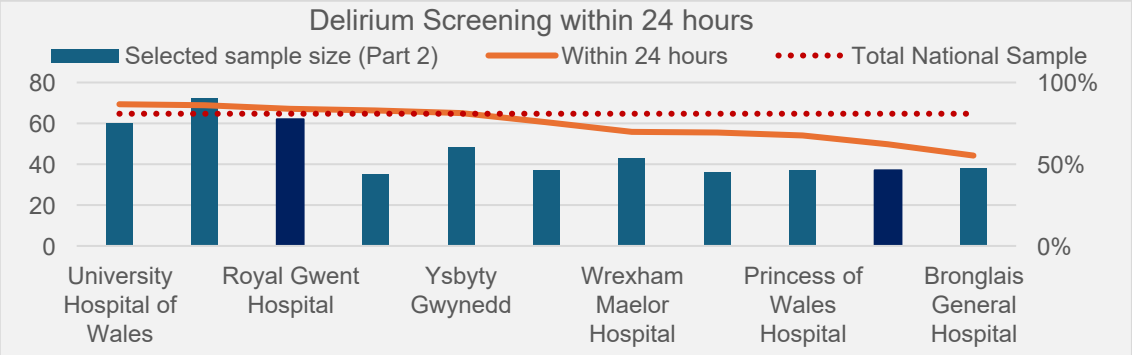
- The ABUHB lung cancer service diagnoses 400 cases of lung cancer per annum [>1 per day]
- The service also deals with abnormal imaging, large numbers of suspected malignancy and metastatic disease
- It is an expanding service with ever changing challenges including a population with severe co-morbidities/ frailty
- Improving indices compared to 2021 data
  - Better curative rates for early-stage disease
  - Excellent confirmation pathological confirmation rates for early stage, good performance status (PS)
- Below target treatment rates for surgical resection in NSCLC, SCLC chemotherapy and NSCLC advanced stage good PS treated with SACT (*but all improved from 2021)*
- Concerning number presenting as emergency admissions – more advanced disease, frailty

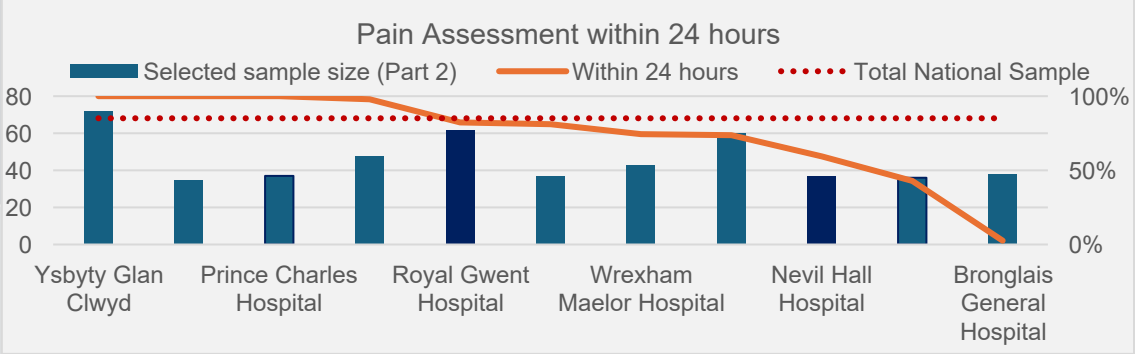
	Report Recommendations:	Progress:
1	Ensure services are implementing targeted lung cancer screening for people aged 55 to 74 who are at high risk of lung cancer.	Lung Health Check Pilots No imminent HB plans
2	Ensure providers have thoracic surgery capacity to meet both current demand for curative surgery and to accommodate the increase in activity caused by the national rollout of the Targeted Lung Health Check programme. Wales: 14% of NSCLC patients diagnosed in 2022 had a lung resection, compared with 16% in 2019	Surgical resection rate below NLCA target No issues with access – but waiting times >4 weeks
3	Ensure NHS hospitals have the necessary resources and capacity (1) to reduce the proportion of patients waiting more than 21 days from diagnosis to first treatment, and (2) for biomarker testing and the timely delivery of results for patients considered for systemic anti-cancer therapy (SACT) Wales: For patients with stage IV NSCLC, the median time from diagnosis to SACT was 52 days (47 days in 2021). For patients with SCLC, the median was 21 days (16 days in 2021).	Ongoing oncology and surgical delays Improved pathological services – PD-L1 in-house from next month, QuicDNA ctDNA project pioneers
4	Ensure at least 70% of patients with NSCLC stage IIIB-IVB and PS 0-1 receive systemic anti-cancer therapy (SACT) in line with NICE guidance. Wales: 60% of patients with NSCLC stage IIIB-IVB and PS 0-1 had SACT, increased from 57% in 2021 - ABUHB: 57.8%	SACT for advanced stage disease below NLCA target Complex patients, frail, multi-morbidity, patient choice
5	Aim to achieve high levels of data completeness in the cancer registration datasets, particularly the Rapid Cancer Registration Dataset and Cancer Outcome and Services Dataset (COSD) in England. Wales: Completeness of data was excellent overall, 98-100%, in key data items (97-100% in 2021)	The only Data Quality measure that the Health Board is not meeting is Morphology (all Patients) 69% Likely transposition error – rates of NSCLC not specified (NOS) remains small

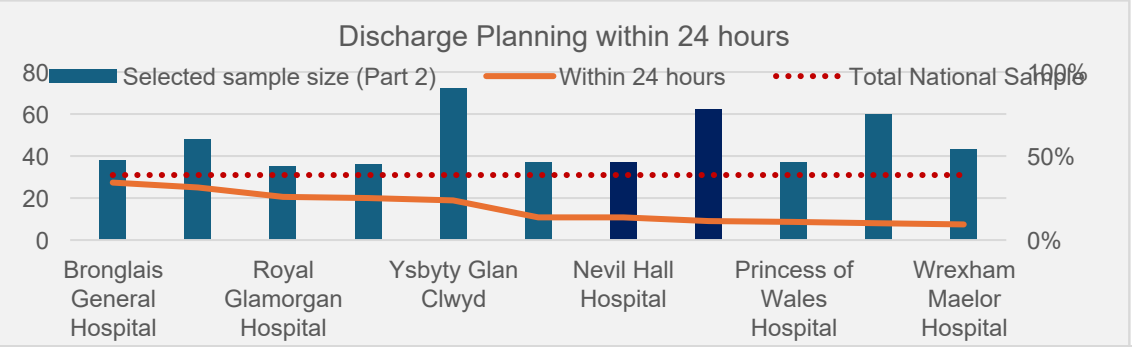
Audit Title:	National Audit of Dementia (NAD) Care in General Hospitals 2022-2023 Round 5 Audit Report **Published August 2023**	**Clinical Lead: Dr Inder Singh** **Site Leads:** **Dr Sheriff (RGH)** **Dr Subhan (YYF)** **Dr Adel (NNH)**
Rationale:	Report presents results of the 5th round of the NAD. Improving dementia care remains a key national priority for health services in England and Wales, highlighted in the Prime Ministers Challenge on Dementia 2022 and the Welsh Government Dementia Action Plan. An extremely high proportion (92%) of eligible hospitals participated in this important audit once again. For the first time the audit was undertaken prospectively, enabling hospitals to take earlier action to improve patient care and experience.	
Objectives:	NAD measures the performance of general hospitals in England and Wales against standards relating to care delivery which are known to impact people with dementia while in hospital. Standards include NICE Quality Standards and guidance, the Dementia Friendly Hospitals Charter, and reports from the Alzheimer's Society, Age Concern and Royal Colleges. Standards are updated for every round of audit.	

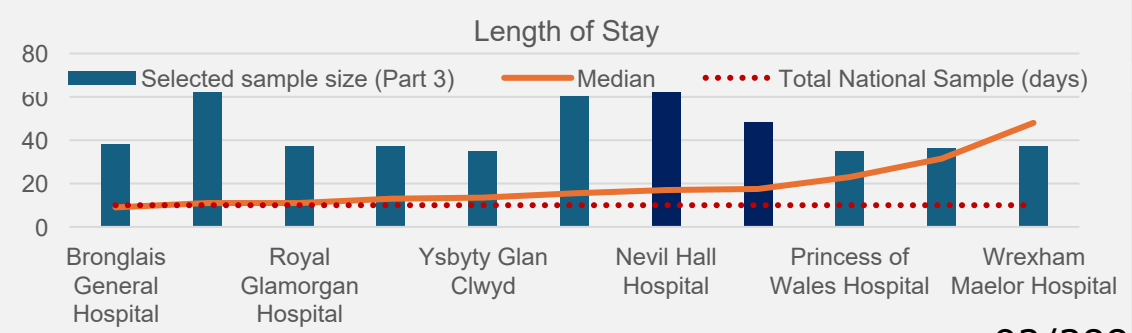
Presented at Clinical Standards and Effectiveness Group – 23rd May 2024.

Key Metrics National Round 5	National	RGH	NHH	YYF
% Delirium screen (inc. noted on admission)	87%	98%	70%	94%
% Pain assessment	92%	100%	69%	82%
% Pain reassessment	92%	100%	59%	22%
% Pain tool – question only	61%	0%	100%	100%
% Initiation of discharge plan in first 24 hours*	45%	11%	14%	19%
Carer rating overall care quality	66%	100%	75%	85%
Carer rating communication	60%	67%	72%	88%









Discharge Planning

"The hospital put in place things to make sure my friend was discharged safely and with a package of care in place. They were fantastic really" CARER

72% patients had named staff coordinate their discharge

64% patients had an expected date of discharge

86% patients received a discharge plan

39% patients received a discharge plan within 24 hours of admission

discharge planning within 24 hours ranged between 0% - 100% across all hospitals

Reasons discharge planning not initiated

"I was contacted out of the blue and told my [AGE] [RELATIVE] would be discharged to a Travelodge... The discharge team did not take into account her night time needs and I was distraught" CARER

Discharge Information

86% patients were discharged by the end of audit period

92% patients were on the right ward for their consultant specialty at point of discharge

81% patients who died received an end of life care plan

Length of stay in weeks

10 Median days length of stay

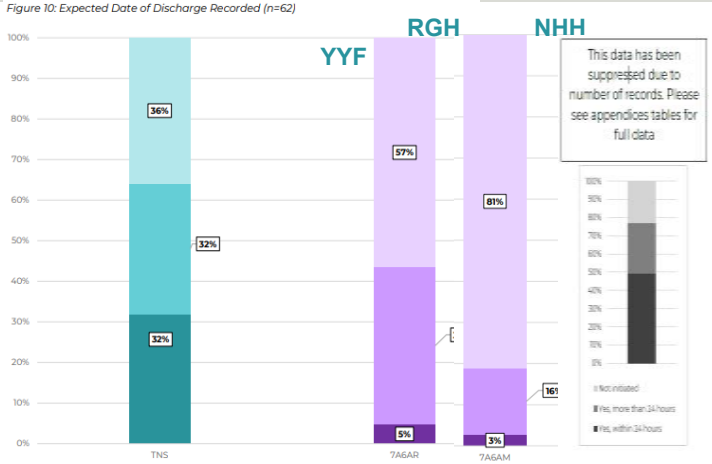
Median length of stay ranged between 4 - 48 days across all hospitals

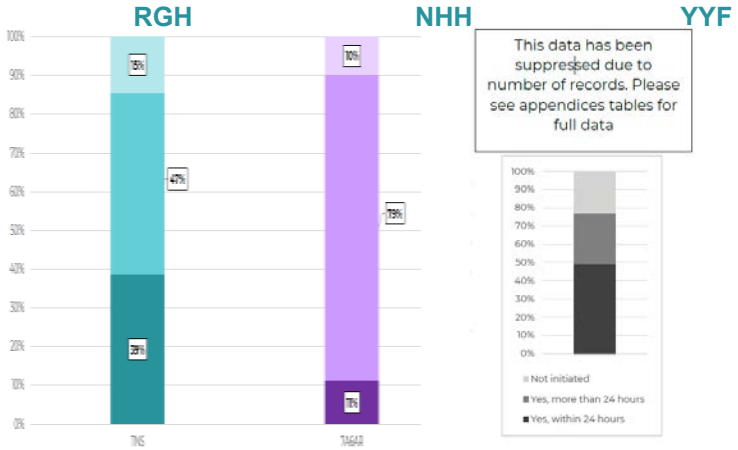
Change of Place of Residence/Care

13% patients had a change in care location after discharge from own home/short term to long term care compared to 8% in 2019

60% patients were discharged to their own home or short term care

Figure 10: Expected Date of Discharge Recorded (n=62)





Assurance level	
Limited	The project did not achieve the standards or criteria being audited against

Risk level	
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Not in risk register as actions and improvement work remain ongoing

Discharge Information RGH

National R5 Median Length of Stay (days):	7A6AR R5 Median Length of Stay (days):
10	17

National R5 Patients discharged by end of audit period:	7A6AR R5 Patients discharged by end of audit period:
86.4%	88.7%

National R5 Patients were on the right ward:	7A6AR R5 Patients were on the right ward:	National R5 Patients who received an end of life care plan:	7A6AR R5 Patients who received an end of life care plan:
92.5%	88.7%	80.6%	100%

NB. EOL care plan information was only collected for patients who died during admission

Discharge Information NHH

National R5 Median Length of Stay (days):	7A6AM R5 Median Length of Stay (days):
10	13

National R5 Patients discharged by end of audit period:	7A6AM R5 Patients discharged by end of audit period:
86.4%	45.9%

National R5 Patients were on the right ward:	7A6AM R5 Patients were on the right ward:	National R5 Patients who received an end of life care plan:	7A6AM R5 Patients who received an end of life care plan:
92.5%	100%	80.6%	83.3%

NB. EOL care plan information was only collected for patients who died during admission

Discharge Information YYF

National R5 Median Length of Stay (days):	7A6AV R5 Median Length of Stay (days):
10	33

National R5 Patients discharged by end of audit period:	7A6AV R5 Patients discharged by end of audit period:
86.4%	64.3%

National R5 Patients were on the right ward:	7A6AV R5 Patients were on the right ward:	National R5 Patients who received an end of life care plan:	7A6AV R5 Patients who received an end of life care plan:
92.5%	100%	80.6%	66.7%

NB. EOL care plan information was only collected for patients who died during admission

Report Successes:	
1	Pain Assessment and re-assessment in RGH at 100% and YYF pain assessment 82%
2	Delirium Screening noted on admission - RGH 98% and YYF 94% compared to national 87%

Report Concerns:	
1	Expected discharge date (EDD) - RGH - 5% within 24 hours, 39% more than 24 hours, 57% initiated NHH - 3% within 24 hours, 16% more than 24 hours, 81% not Initiated - difficulties with EDD due to patient complexities and delays in social measures YYF - not enough data to analysis
2	Pain Assessment NHH 69% (outlier notification received for NHH data)
3	Lack of use of the Abbey Pain Score tool
4	Discharge planning not carried out within 24 hours for RGH and not completed in NHH - lack of data for YYF
5	Length of Stay median: RGH 17 days, NHH 13 days, YYF 33 days
6	Pain re-assessment for YYF 22%
7	Delirium Screening NHH - 70%

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	•Progress:
Carer feedback	Improve Carer questionnaire completion across the HB	Use the teams currently across the wards (volunteers, PALS etc.) to encourage the carers to complete the questionnaire	Sonya Foley	31/03/2024	
End of Life	End of life care for patients with Dementia	Regular teaching sessions for doctors and nurses across all sites, by palliative care team – Dr Subhan has discussed this option with Palliative Care Consultant. Palliative care team is interested to provide this focused teaching as part of their palliative care teaching	Dr Subhan	31/03/2024	Ongoing

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date/Progress:
1	**Integrated Care Boards/Welsh Government should seek assurance from Trusts/Health Boards regarding their actions and progress with recommendation one.**	Reported to Clinical Standards and Effectiveness Group and Patient Quality and Safety Group	Dr Inder Singh	Ongoing
2	**<u>Comprehensive pain assessment</u>** **The National Report recommends the Medical Director and Chief Nurse should ensure that staff are trained and supported in the use of appropriate tools for comprehensive pain assessment (e.g. e-lfh Pain Management Programme)** **This should include:** • Understanding the need for structured pain assessment. • How pain interacts with symptoms of dementia, and that people with dementia may not articulate pain. • The regular use of an appropriate pain tool for assessing people with dementia on the ward.	Need to introduce and improve structure pain assessment across HB sites (use of the ABBEY if clinically indicated) Link with Education team to review current training	Dr Inder Singh, Sue Pearce (Divisional Nurse), Amanda Whent	Ongoing

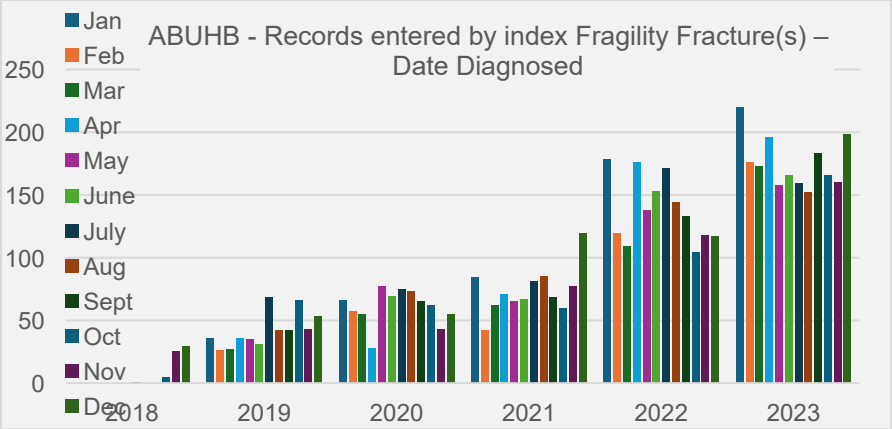
	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
3	The Chief Executive Officer should ensure that the Trust/Health Board has a nominated Board member responsible for dementia in addition to the clinical lead, whose responsibilities will include:		Dr Inder Singh – Clinical Lead Amanda Whent – Dementia Lead Nurse Sue Pearce – Senior Divisional Nurse	6 months	All ongoing
	• Establishing and implementing hospital systems capable of 1) identifying people with dementia admitted to the hospital and 2) showing the proportion of people with dementia affected by falls, delayed discharges, readmissions, pressure ulcers and incidents of violence/aggression, so that accurate figures may be supplied to NHS England Emergency Dashboard and other national dashboards.	Dementia alert on CWS in practice and currently linking with Improvement Cymru in establishing a benchmark (once achieved CL will be establishing other metrics inc. IP Falls)			
	• Monitoring the proportion of ward-based staff who have received Tier 2 level training in dementia, and assessing the impact this has on quality of care, as experienced by patients and carers. • Scrutinising feedback from patients and carers and reports of NAD.	Dementia training and awareness is ongoing. Good Work Learning and Development Framework level 1. • Informed level 86% on ESR • Skilled level bi-annual reporting to WG • Influencer level presenting on boards, meetings and conferences			
	• Tabling the Trust/Board Annual Dementia Statement for review.	Feedback review is led by Sue Pearce.			
	• Providing regular reports to the Integrated Care Board/Welsh Government relating to the appropriate governance and monitoring of care of people with dementia.	Dr Singh and Amanda Whent report to the Board			
	• Developing action plans based on areas identified for improvement in care and patient experience, including ensuring that personal information about their care preferences and needs has been gathered and is available at the bedside; regular review of the environment against "Dementia Friendly" criteria using a standardised tool (e.g. Enhancing the Healing Environment, The King's Fund (kingsfund.org.uk); Patient-Led Assessments of the Care Environment (PLACE) – NHS Digital)	Dementia care plan and environment – Sue Pearce and Amanda Whent			

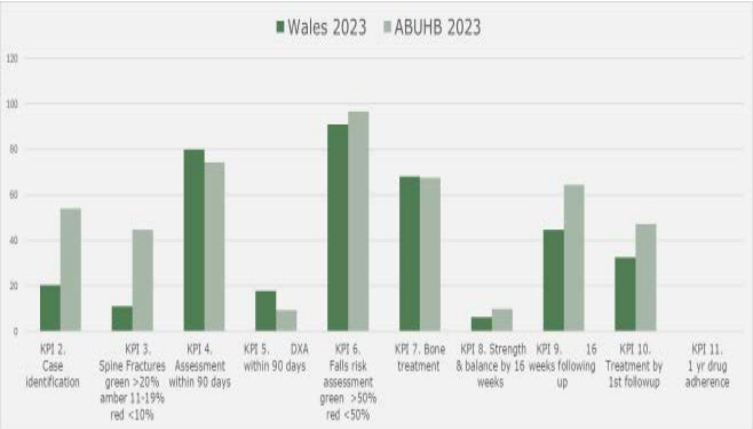
Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
Dementia alert	To promote the use of dementia alert (136) in Welsh PAS (Myrddin)	• Promote Ward Clerks entering the Dementia Code (136) into WPAS	• Sue Pearce	31/08/2024	Ongoing
Delirium screening and care plan	ABUHB - Quarterly point prevalence audit for the duration of 1 week on assessed for Delirium screening on patient with Dementia	• To provide LoS on the Delirium Audit carried out quarterly	• Dr Singh	31/08/2024	Ongoing
		• Review the if diagnosis of delirium also have dementia and assess for:- EDD was established, DC planning commenced within 24 hrs, and time (total number of days) away from home.	• Dr Singh	31/08/2024	Ongoing
	Improve nursing attendance and engagement with Delirium training – SQID, 4AT	• Continuing with Delirium teaching every 8 weeks (led by Dr Z Subhan) – target audience doctors, staff nurses, HCSW	• Kertrina Collins, Natalie Webb, Helen Price	31/08/2024	Ongoing
		• Involve senior nurses for individual sites to encourage nurse attendance	• Dr Subhan	31/08/2024	Ongoing
		• To deliver focused delirium teaching (SQID) in the ward settings – Dr Subhan to explore this with senior nurses	• Dr Subhan	31/08/2024	Ongoing
	Measure the outcome of Delirium teaching and training	• Encourage Delirium Champions from each ward in YYF, who will help with the teaching and training for the nurses	• Dr Subhan	31/08/2024	Ongoing
		• A QIP on Delirium Time Bundle has already commenced – to complete the first cycle and present the result to the stakeholders			
		• Delirium training attendance certificate to help with re validation - using AMaT certificate function	• Joanne Stimpson	Ongoing	Ongoing
	Measure the outcome of Delirium teaching and training Improving assessment of delirium in hospital and communication of diagnosis to all teams/carers	• Compliance of recording delirium diagnosis on quarterly basis using IT (WPAS) - link with Kathleen Hyde.	• Joanne Stimpson	Ongoing	Ongoing

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
Pain assessment/ Re-assessment	Quarterly one day Audit all patients who scored on pain assessment	• Proportion of patients who had dementia to be assessed for pain using a recommended ABBEY pain scales	• Dr Singh	31/10/2024	Ongoing
	Improve pain assessment and re-assessment	• Training and teaching of Abbey Pain score for nurses Dr Subhan has already discussed this with Palliative care Consultant, Dr Patten. Dr Patten has agreed to deliver this training with the help of Palliative care CNS. Dr Patten to discuss with her CNS and update Dr Subhan	• Dr Subhan/Dr Patten	31/03/2024	Ongoing
		• To continue with pain assessment using Care Flow question only assessment	• Dr Subhan/ Dr Adel	31/03/2024	Ongoing
		• After standard clinical assessment and pain score assessment should be used for patient who cannot communicate pain - has been Further work needed to decide on what pain score screening tool is going to be used across the HB - to ensure continuity.	• Dr Singh	31/03/2024	Ongoing
Dementia training	Look at compliance figures on ESR for mandatory All Wales dementia module by site.	• To be looked at in the senior nurse monthly/cross divisional nurse meetings to see if this is beneficial information	• Sue Pearce	31/03/2024	Ongoing
Discharge planning/EDD	Improve compliance in completing the Estimated Discharge Date (EDD)	• DISCHARGE PLANNING TO BE COMMENCED IN 80% OF PATIENTS WITHIN 24 HOURS - to prevent de-conditioning in the hospital (goal 5 and goal 6). To encourage all staff to agree EDD in the post take round/MAU board rounds. Discharge coordinators/ward managers to take the initiative in putting an EDD for every patient during board rounds. This should also be discussed in the weekly MDT.	• Dr Subhan/Dr Adel/Dr Sheriff	31/03/2024	Ongoing
	Look at HB LoS wide rather than episode	• Compare LoS from episode to HB LoS	• Dr Singh	31/04/2024	Ongoing

Audit Title:	Annual report – Improved Fracture Liaison Service (FLS) identification with gaps in monitoring: a call to action for national and regional planners Data - Jan 2022 to 31 Dec 2022 Published - Feb 2024	Clinical Lead: Dr Inder Singh
Rationale:	FLS ensures that patients aged 50 and over who sustain a broken bone after a fall have their bone health and falls risk checked and managed to lower their risk of a subsequent fracture. The FLS is made up of a team of healthcare professionals led by a Clinical Lead who liaise with wider teams to provide bone health care plan. FLSs bring clear benefits to the patient and the system in the long term and have been shown to be clinically and cost-effective.	
Objectives:	Fractures after a fall from standing height or less in adults aged 50 years and over often indicate osteoporosis and increased falls risk. Without urgent management, the risk of serious fractures due to osteoporosis will increase. Fracture liaison services (FLSs) deliver secondary fracture prevention using clear pathways to identify those with potential osteoporotic fractures, deliver systematic assessment, treatment recommendations in line with national guidelines, and monitoring to ensure recommendations are initiated and adhered to. The delivery of this pathway is mapped across key performance indicators (KPI) to support local FLSs to check and improve their local services.	
Presented at Clinical Standards and Effectiveness Group – 23rd May 2024		

The Health Board has improved on all but one KPI from 2022 to 2023 with two of the KPI's moving up into the higher metric grouping:	
KPI 2	Case Identification has increased from 22.6% in 2021 to 42.6% in 2022 with a further increase in 2023 to 54.1%, and from 2022 to 2023 increased from red into amber and is performing better than Wales and National average.
KPI 3	Spine Fractures metric is >20% is green, and in 2021 was 26.1%, in 2022 the increased to 35.4% and a further increase in 2023 to 44.6%
KPI 4	Assessment within 90 days has increased from 21.3% and red in 2021 to 60.3% and amber in 2023 remained amber but increased to 74.2% and although worse than the Wales average is better than the National average
KPI 5	Dexa scan with 90 days was 23.3% in 2021, this decreased in 2022 to 12.4% and a further decrease in 2023 to 9.4%
KPI 6	Falls risk assessment was 34.7% in 20021 however significantly increased to 80.2% in 2022 and a further increase in 2023 to 96.6%, this measure green if over 50%
KPI 7	Bone treatment has a lesser growth although all years are in the green at 57.7% in 2021, 65.7% in 2022 and 67.5% in 2023
KPI 8	Strength and balance by 16 weeks is red for all years at 4.8% in 2021 and 9.1% in 2022 and 10% in 2023 which is increasing and is performance better than the Wales and National average
KPI 9	16 week follow up have significantly improved from 1.4% in 2021 to 19.1% in 2022 and a significant increase to 64.4% in 2023 and performing considerably better than the Wales and National averages
KPI 10	Treatment by 1st Follow up although remains in the red, the performance has increased from 8.3% to 18.1% to 47.3%
KPI 11	1 Year drug adherence for 2022 the Health Board is under performing compared to the Wales and National average at 13.6%. No comparison data for 2023 is available to date





National, Wales and ABUHB data for all KPI's for 2021, 2022 & 2023

green as 80%		KPI 2. Case identification	KPI 3. Spine Fractures green >20% amber 11-19% red <10%	KPI 4. Assessment within 90 days	KPI 5. DXA within 90 days	KPI 6. Falls risk assessment green >50% red <50%	KPI 7. Bone treatment	KPI 8. Strength & balance by 16 weeks	KPI 9. 16 weeks following up	KPI 10. Treatment by 1st followup	KPI 11. 1 yr drug adherence
amber as 50-79%											
red as <50%											
National Average 2023	68341	34.7	23	65.5	31.7	61.7	56.9	7.8	28.6	29.2	Not applicable
National Average 2022	80015	40.6	22.5	63.2	29.2	62	56.6	6.8	27.1	28.9	21.9
National Average 2021	74647	37.9	20.3	66.5	31.2	60.8	55.2	5.6	24.5	29	22.3
Wales 2023	3403	20.4	11.1	79.9	17.8	90.9	68.2	6.2	44.6	32.6	Not applicable
Wales 2022	3152	18.9	10.1	77.8	33.5	86.3	62.5	6	21.4	16	24.9
Wales 2021	2030	12.2	6.6	65.2	22.9	61.6	56.7	3.9	13.8	10.3	30.3
ABUHB 2023	2097	54.1	44.6	74.2	9.4	96.6	67.5	10	64.4	47.3	Not applicable
ABUHB 2022	1649	42.6	35.4	60.3	12.4	80.2	65.7	9.1	19.1	18.1	13.6
ABUHB 2021	875	22.6	26.1	21.3	23.3	34.7	57.7	4.8	1.4	8.3	18.4

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Resource and Costs by Staff Band

	WTE required				Annual cost £				
	Nursing	Admin	Radiology	Consultant	Nursing	Admin	Radiology	Consultant	Total
Band 1									£0
Band 2									£0
Band 3		2.5				£77,581			£77,581
Band 4			0.4				£13,518		£13,518
Band 5									£0
Band 6	2.0		0.2		£96,489		£9,649		£106,138
Band 7	2.7				£158,438				£158,438
Band 8a									£0
Band 8b									£0
Band 8c									£0
Band 8d									£0
Band 9									£0
Consultant				0.2				£21,705	£21,705
Total Staff	4.7	2.5	0.6	0.2	£254,927	£77,581	£23,167	£21,705	£377,380
Overheads					£38,239	£11,637	£3,475	£3,256	£56,607
Total	4.7	2.5	0.6	0.2	£293,166	£89,218	£26,642	£24,961	£433,987

Financial benefits

	Year	Hip fracture (inpatient)	Other fracture site (inpatient)	Other fracture site (outpatient)	Clinical vertebral	Total	Average benefit per year
Acute care	2024	£585,330	£34,599	£7,961	£19,780	£647,670	
	2025	£995,061	£52,809	£12,151	£35,604	£1,095,625	
	2026	£1,424,303	£67,377	£15,503	£49,450	£1,556,633	
	2027	£1,697,457	£80,124	£18,436	£57,362	£1,853,379	
	2028	£1,873,056	£87,408	£20,112	£63,296	£2,043,872	
	All years	£6,575,207	£322,317	£74,163	£225,492	£7,197,179	£1,439,436

Estimate of service costs

The Royal Ostoporosis Society has a separate tool to help clinicians, managers and commissioners accurately calculate the costs of your FLS service for the number of patients shown in this FLS Benefits Calculator. The costs shown below are an approximation of the likely range of a what a service would cost for the number of patients expected in your service. **These are approximations only and must not be used in a business case.** For an accurate calculation using local salary, tariff activity, MFF and prescribing data please talk to your Royal Osteoporosis Society contact. All costs are for year 1 only.

	Lower estimate	Upper estimate
Estimate of staffing costs	£378,810	£635,559
Trust overhead charge of 15% applied to staff costs	£56,822	£95,334
Estimate of additional prescribing costs*	£14,744	£152,595
Total costs of FLS	£450,376	£883,488

* Prescribing costs will increase as the number of patients on osteoporosis therapy increases cumulatively each year

National, Wales and ABUHB data for all KPI's for 2021, 2022 & 2023

green as 80% amber as 50-79% red as <50%		KPI 2. Case identification	KPI 3. Spine Fractures green >20% amber 11-19% red <10%	KPI 4. Assessment within 90 days	KPI 5. DXA within 90 days	KPI 6. Falls risk assessment green >50% red <50%	KPI 7. Bone treatment	KPI 8. Strength & balance by 16 weeks	KPI 9. 16 weeks following up	KPI 10. Treatment by 1st followup	KPI 11. 1 yr drug adherence
National Average 2023	68341	34.7	23	65.5	31.7	61.7	56.9	7.8	28.6	29.2	Not applicable
National Average 2022	80015	40.6	22.5	63.2	29.2	62	56.6	6.8	27.1	28.9	21.9
National Average 2021	74647	37.9	20.3	66.5	31.2	60.8	55.2	5.6	24.5	29	22.3
Wales 2023	3403	20.4	11.1	79.9	17.8	90.9	68.2	6.2	44.6	32.6	Not applicable
Wales 2022	3152	18.9	10.1	77.8	33.5	86.3	62.5	6	21.4	16	24.9
Wales 2021	2030	12.2	6.6	65.2	22.9	61.6	56.7	3.9	13.8	10.3	30.3
ABUHB 2023	2097	54.1	44.6	74.2	9.4	96.6	67.5	10	64.4	47.3	Not applicable
ABUHB 2022	1649	42.6	35.4	60.3	12.4	80.2	65.7	9.1	19.1	18.1	13.6
ABUHB 2021	875	22.6	26.1	21.3	23.3	34.7	57.7	4.8	1.4	8.3	18.4

Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Resource and Costs by Staff Band

	WTE required				Annual cost £				
	Nursing	Admin	Radiology	Consultant	Nursing	Admin	Radiology	Consultant	Total
Band 1									£0
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	Report Recommendations:	S.M.A.R.T Actions:	Responsible: Due Date: Progress:
1	More FLSs are now delivering over 80% identification rates for non-spine fractures. FLS that have prioritised improvement in KPI 2 and 3 should contact these services to share best practice for funding and identification pathways.	Based on the annual activity/no. of fragility fractures ABUHB FLS of 4209, The HB needs • 4.7 - WTE nursing staff • 2.5 - admin • 0.6 - radiology staff (dexa scan) • 0.2 consultant. The total annual cost for this is £433,987. The Medical Division has invested 2 WTE CNS and 1 WTE Administrator (147K). Over the period of 5 years the total annual cost for ABUHB FLS including staff cost, overhead charge of 15% and prescribing costs be approx. £450,376 to £883,488. The annual benefits across acute care is equal to £1439,436 and all benefits inclusive of community and social care will be 2.1 Million.	Dr Inder Singh Ongoing
2	To meet the healthcare recovery targets from the pandemic, FLS funding should be prioritised based on expected number of avoided fractures from a comprehensive service. FLSs should describe their capacity gaps and the expected benefit vs effort from re-organising pathways to ensure that at least 80% of higher risk patients are checked within 16 weeks of their fracture. *This may result in lower rates of identification for lower fracture risk patients.*		
3	FLSs should work with their local DXA providers to ensure access to DXA is based on patient need. This may require FRAX before DXA pathways, increasing follow up based on evidence and using FRAX only recommendations to clear backlogs of patients that are unlikely to be cleared in the next four months.		
4	FLS care pathways should acknowledge that specific patient groups need a personalised approach to assessment, decision-making and support. This includes providing patient-facing materials that reflect the languages of their local population.		
5	All senior executive decision-makers should hold a key stakeholder meeting to explore how local needs for fragility fracture patients can be met. Patient representatives and members of the Royal Osteoporosis Society should be invited to the meeting, and it should plan for effective and sustainably resourced FLSs based and designed on the KPIs from the FLS-DB.	FLS is regularly discussed in the Falls and Bone Health Committee but with Patient representation and ROS representation	Peter Carr 8th April 2024 To be discussed

	Clinical Leads Local Recommendations: (if applicable)	Responsible:	Due Date:	Progress:
1	FLS for the ABUHB continues to be a centralised service and this is already achieved, however this needs to be continued.	Dr Singh	Ongoing	Improving
2	Wider partnership with Community Team, Primary Care and third sector.	Dr Singh	Ongoing	Improving

Background Information

Section 5

Quality Strategy

- Quality Strategy and Patient Experience and Involvement Strategy being fully implemented.
- QOF report being refined for 2024/25. To include a smaller number of metrics which demonstrate assurance and compliance. Reconciliation to be carried out with current QOF. Working with Digital, Data and Technology to automate reporting. Ensure triangulation of data.
- Continue to develop Quality operating framework, and assurance framework. Safe Care Collaborative ongoing and moving inhouse.
- Commissioning Assurance Framework going to Executives in July 2024.
- QI refresh – mapping of QI expertise in the organisation, identifying Quality champions. Focus on creating capacity and develop capability.
- Plan for engagement with ward-based teams and clinical areas to consider local collection of quality data.

Quality pillars as defined in the Quality Strategy:

These 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains. Providing data in these Pillars of Quality will review our performance.

Framework for Speaking up Safely in the NHS

- Following the publication of NHS Wales Speaking up Safely Framework, the Health Board have undertaken a self-assessment in relation to the framework standards and developed an action plan in support of its implementation.

- A Speaking up Safely initial engagement and awareness event was held in October 2023.

- Workforce & OD have launched an internal raising concerns bespoke email address with migration to an externally provided Employee Assistance Programme and Speaking Up service with the aim of going live at the end July 2024.

- Cross organisation and multi-profession steering group has been established with the inaugural meeting held in March 2024 to determine Terms of Reference and organisational approach.

- Shaping a two year plan, with strong emphasis on evaluation.

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Sensory Loss **(PALS)**	Feedback from patient who is Deaf expressing concerns about reasonable adjustments when attending outpatient department.	Met with patient at home. Patient invited members of the Patient Experience Team to the Deaf Club. The PALS team attended a Deaf Club meeting in the community. The PALS Officer listened to the feedback and suggestions in order to feedback to the health board and be a catalyst for awareness and change.	The PALS team have formed a good relationship with members of the "Deaf Club" and are taking their suggestions forward to improve services for those who are deaf and hard-of-hearing. Linked with Assistive Technology, GP practice managers, internal departments and Equality, Diversity and Inclusion team.	To reach out to more communities who struggle to navigate Health Board services due to their disabilities.
Families Who Are Distanced **(PALS)**	PALS were contacted by a lady living in Ireland. Her son was very unwell and presented at GUH. He told her he would be leaving without being seen, as he couldn't face waiting any longer.	While the PALS Officer provided reassurance on the phone, the PSO on duty went to ED and spent time with the patient and reassured he would be seen soon.	The next morning, the PALS officer called the mother, as they could see that her son had an appendectomy during the night. *The Mother said "I am so grateful you were on the other end of the phone; it was such a weight lifted off me and I was able to sleep last night when I had originally thought about booking the next flight to Wales."*	Raising awareness of our PSOs and PALS' team. That our team can provide reassurance to patients in the hospital whilst they await further investigations.

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Learning Disabilities: Care in a general hospital **(PALS)**	The sister of a patient with a learning disability diagnosis contacted PALS, as her brother was being transferred to NHH instead of RGH. Their mother had died in NHH and the sister felt it would be difficult for her brother to stay there and felt he should have been transferred to RGH.	A PALS Officer visited NHH and met with the patient. They had a sensitive conversation about the patient's past experiences, and the patient expressed that he was no longer scared of being at NHH – in-fact, he was happy to stay for the remainder of his care. PALS also arranged for regular volunteer visits.	The sister was overcome with relief. She knew her brother was being cared for and that he would be having some well-needed company from the volunteer team.	PALS kept an eye on patients progress and that he was still receiving company from volunteers. Sister knew she had our details if any further issues needed to be addressed.
On-Going Support **(PALS)**	PALS were approached by a gentleman who had concerns regarding an interaction with a member of the team caring for him. His confidence in his care and been shaken.	A PALS Officer was able to meet the gentleman at his next appointment and provide comfort and a plan of on-going PALS support. Future appointments have - and will - be accompanied by a member of the PALS or volunteer team	This support has transformed the patient's experience and increased their confidence to communicate with the Health Care Team.	The case remains open due to the active contact with PALS.
Patient Dignity **(PALS)**	Patient supported by PALS told us she had no night clothes to wear in hospital, and her family were unable to bring her any because of distance.	A PALS Officer contacted wards across the Health Board to source some night clothes. They obtained a bag of clean clothing in different sizes and provided the patient with night clothes for the duration of her stay.	Patient felt dignified in having night clothes on the ward. The family were very appreciative.	The PALS team now have a supply of night clothes for patients in the office, and are able to provide to patients if required.

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
End Of Life Companionship **(PALS)**	PALS were asked to provide support to a patient admitted to the Emergency Department. They were receiving End of Life care and a request for an End-of-Life companion had been made but they had not yet arrived at the hospital.	The PALS team provided interim support. One of the Patient Support Officers attended the ward and sat with the patient, held her hand and provided comfort until family had arrived.	Patient had companionship and support during her time in hospital.	The PALS team have arranged for their Patient Support Officers to attend End of Life Companion training, so they are able to offer support on the wards whilst End of Life Volunteers are requested.
Mental Health Support Signposting. **(PALS)**	The PALS team were contacted by a lady who felt she had nowhere to turn, and she was struggling to come to terms with her Stoma and felt unworthy of care. Her anxiety was becoming overwhelming.	The PALS team arranged for contact from the Stoma team, but also signposted the patient to free face-to-face counselling in their area as well as Mental Health support apps such as Calm Harm, Beat Panic and Headspace.	Patient felt more equipped after speaking with PALS, and the knowledge that there is a team available, 7 days a week, to offer support and guidance comforted them.	The PALS team to link in more with community Mental Health groups so we're aware what support patients can access in their area.
Non-Health Related Guidance **(PALS)**	The PALS team were contacted by a lady who was struggling, financially as her husband's pension had been frozen whilst he'd been in hospital.	The PALS officer contacted Department of Work & Pensions (with consent) and was able to confirm that only the Attendance Allowance should have been suspended, and that the impact to State Pension would be rectified.	The lady told us we had managed to alleviate all anxieties regarding her financial worries.	Create strong links with External Health Board teams.

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Mental Capacity Act **Staff Development and Confidence**	Concerns raised relating to compliance with the Mental Capacity Act (MCA) across the Health Board	The MCA team have developed a training programme which is accessible to all staff across the Health Board. • ESR • Awareness sessions • Workshop • Bespoke sessions on request Bespoke sessions • SALT • Vaccination staff • Children Services (CCC) • Mental Health services MCA team have attended training provided by EDGE training consultancy and this was also offered to other teams where it was relevant to their practice. • MCA and young people • DoLS and young people • Community DoLS MCA Team are actively involved with the Enhanced Care Initiative at YYF and provide MCA and DoLS training. Updated MCA Policy, Mental Capacity Assessment and Best Interest form developed and now in circulation.	Application for MCA/DoLS training to be mandatory accepted by the Health Board. This will support staff confidence in being able to apply the MCA principles in practice.	To continue to deliver training on rolling programmes as and when requested. MCA Practitioners continue to be visible within clinical areas, to develop working relationships with staff, offer practical guidance and support

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Supporting Carers **Principles of the Mental Capacity Act and Consent**	Informal carers have little knowledge of the MCA and the meaning of consent.	MCA team have been invited to attend and deliver information sessions at carer awareness sessions organised by Mapping, Education and Carers Service. This will enhance carer understanding of the MCA. Worked with animation company to develop a Consent animation.	To provide an insight of MCA for carers on the process for decision making when a person is deemed to lack capacity for a specific decision. Consent animation will increase awareness of consent for the pubic, patients, carers and staff	Launch consent animation by September 2024. Review public information relating to consent and include the role of informal carers.
Volunteering in the Community	Feedback from the volunteer team about an increasing number of community volunteering visits. These are time consuming needing risk assessments, introductory meetings and ensuring the right	Additional questions now asked of volunteers including: Would you prefer to visit a Male, Female or both: What day/time of day will you be available to volunteer? Do you drive: If not, are you happy to use public transport:	Asking more relevant questions upfront means that volunteers can be appropriately matched with those they support in the community.	Increased community volunteer visits.

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
	volunteer match. Considering the complexity and needs of people living in the community, there was a need to gather more information to ensure volunteer availability.	Would you be happy to visit a client living with Dementia: Would you be happy to visit a client with Mental Health: On Commencement Community Volunteers will be supported with an Introduction Visit and then be expected to volunteer independently.		
Supporting a patient with behaviours that challenge	Referral to support a patient who is blind at RGH. Patient also living with Dementia. Ward staff contacted; team were not made aware that this patient was receiving enhanced care. On arrival volunteers were left alone with patient who was quite agitated, witnessed him being verbally aggressive to staff.	Linked in with Dementia Team who visited this patient. Informed volunteers who offered to support this patient of diagnosis of dementia and to support with befriending and meaningful activities. Advised them to speak to the staff for support and guidance if required. Team contacted volunteers for regular updates and support.	Challenging behaviours reduced when patient engaged in meaningful activity. Volunteers felt more comfortable with knowing who they are going to support. Knowing more about the patients such as hobbies and interests allows the volunteer to engage more at each visit.	To ensure Volunteers are provided with proactive support and are informed of the needs of the person they are supporting. Link meaningful activity into the Enhanced Care programme.

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Supporting Volunteers with Sensory Loss	Volunteers attending Teams Volunteer Core Training with hearing impairment advised that they are not always able to hear the conversations clearly.	The volunteer advised the team of the transcription service, which helped him with his impairment. The following sentence was added to the generic email link for training: There is a function on Teams for text translation, for those who may require this service: **Select More... / Language and Speech / Turn on live captions**	Volunteers have additional resources to help them engage and interact as part of training but also volunteer support sessions and additional training available to them	To continue to link in with volunteers for additional advice on how we can improve the volunteer experience.
Loss after Miscarriage	Contacted by senior nurse to say that a patient had lost a baby before 20 weeks, and she was struggling with coming to terms with her loss.	Patient Experience leads met with senior nurse and patient. She outlined her experience and the changes she wished to see from a service perspective. This included women being fully informed of what may happen if they choose termination when the child's chance of survival is unlikely. This patient also wanted to see the bereavement offer for women who lose babies under 20 weeks improved.	Patient invited to Big Conversation Bereavement event. Engaged in child loss round table conversation. Has now told of her experience on film which will be taken to a listening and learning event. Patient has agreed to be part of the bereavement collaborative and wishes to volunteer to help	To be introduced to the Volunteer Manager to explore volunteering opportunities. To be invited to the bereavement collaborative. Edited film to be presented to Executive Committee, to the gynaecology senior leadership teams and possible in-person

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
			other women who may experience traumatic loss. Patient story will be used to improve experiences for all women who lose babies under 20 weeks.	attendance at Board. Operational procedures to be reviewed.
Raising Awareness about Consent	Issues raised locally and nationally about people's awareness of consent.	Meeting with QPS leads and Medical Lead for Consent. Worked with animation company and animation about consent developed. This is bilingual.	Members of the public and staff will be able to access the animation as an 'easy guide' to consent.	Animation will be launched by Clinical Executive. Female voice over version being created to promote use in female services.
Theme	**Feedback**	**Action Taken**	**Impact**	**Next Steps**
Bereavement	Feedback from bereaved people concerned due to lack of support and information.	Big Conversation: Bereavement held on 20/03/24. Attended by 170 people including people who have been bereaved, public, staff and stakeholders.	Extremely well evaluated. 50 people have expressed an interest in joining the bereavement collaborative. Peoples feedback	Publish Big Conversation evaluation report. Invite people to the Bereavement Collaborative. Roll out Big Conversations

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
			will inform the new bereavement model.	across all 5 boroughs May-July 2024.
Dementia Advanced Care Planning.	Feedback from the Advanced Care planning group, Memory assessment services and the dementia citizens feedback has identified a need to adapt and improve the information, understanding and skill for Future care planning in dementia care.	2 workshops have taken place, specifically considering Dementia care. 1 in May and the second in June. Expressions of interest to attend was sent out from each workstreams under the All Wales Dementia Standards programme as well as the Gwent Care home Governance meetings the workshops were attended by representatives from across agencies in Gwent who provide care for people with dementia.	The workshop feedback will be themed into areas of improvement and best practice. This feedback will provide the support for the actions within the ACP subgroup.	An evaluation and next steps will be produced and presented at the Dementia Hospital steering Group, EOLC Borad and ACP group. This information will also feed into a Gwent regional Future Care Planning workshop which is being planned for November.
Dementia-Communication following Diagnosis at Memory Assessment Clinics	Feedback from the Community Engagement events have indicated that the current process of receiving communication following formal diagnosis from the MAS (Memory Assessment Service) should be reviewed.	A review of the current process of delivering a diagnosis of dementia as well as information will be led by the MAS clinics in Gwent through the Older Adult Mental Health MAS managers meeting. The standards of expectations will be agreed and audited. Theis will be monitored by the Workstream 2a group.	Following the scoping of current practice a template letter will be drafted for consideration by the Citizens listeners and the MAS work streams.	Evaluated via Workstream 1 and 2a and B.

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Meaningful Engagement and Activities	Reviews reports such as the Community Health council dementia review highlighted the need for improvements in dementia engagement in hospitals and care homes. The first phase of the improvements in care took place in the 42 wards across the hospitals in Gwent. Following a review of the Meaningful Engagement and Activities in Hospital programme the feedback was positive. A second phase of delivery started in April 2024 with care homes and the Prison health care units.	A Improvement of care funding case was made to NHS Charities to support the extension of the hospital Engagement and activities programme into these areas as well as prison health care units. This bid was successful, and a steering group has now been formed to lead on this implementation programme. 2 staff members have been recruited for the 18-month period to support the programme.	A series of measures will be considered as part of the evaluation at 6 monthly reporting periods. 16 Care Homes identified for phase 1 of the programme. Currently carry out scoping surveys with Residents, Carers and Staff to shape what support is required in each area.	Evaluated via the Meaningful Engagement steering group, reported to the Workstream 4 Dementia Hospital Charter Group and NHS Charities.

Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Activity Coordinators programme	Through the Meaningful Engagement programme working with Activity co-ordinators in post that it was identified that there was a lack of structure and support for staff in these roles and further work is required to streamline this role and provide adequate for the staff in post. There are plans for further posts to be created in Gwent and an induction and development plan needs to be arranged.	A Task and Finish group has now been formed with a Senior Nurse led to address concerns raised by activity co-ordinators. This is supported by the Specialist Dementia Practitioner and Regional Activities co-ordinator. Job description, Induction programme and uniform as well as communication of the role are all actions that have been discussed at first few meetings. Also a support group for the staff in post to allow them to share experiences and help shape the support required.	It is expected that the staff in post will be better supported. Creating capable, competent and confident staff who will deliver quality engagement to patients with Dementia.	A steering group is leading on this work and will report to the Dementia Hospital steering group with updates to the Dementia Board and QPSOG.

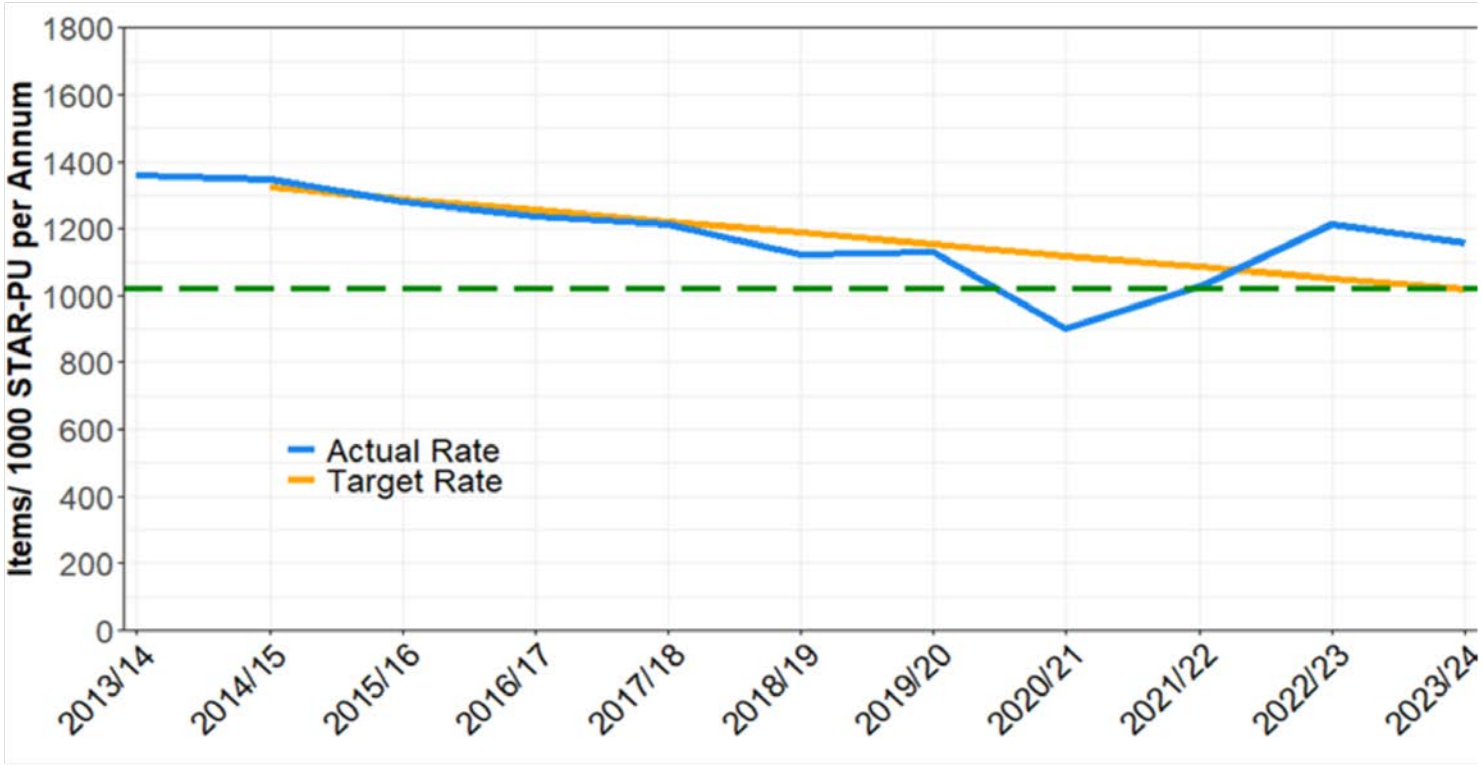
Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Engaging with Ethnic Minority Communities around dementia.	Feedback from people in ethic minority communities is that they would like more information and support around dementia. Many people report that they do not know where to go and for some not being able to speak English is a barrier.	There have been a number of Health Fayres in different locations in Newport to bring information about many health topics including dementia and the risk factors for dementia. These fayres have seen partners from different health departments and the third sector working together to provide information and support. Muslim Doctors Cymru (MDC) have also been present to provide various screening and to translate when needed.	Having an ongoing presence in the community has increased awareness of dementia and the risk factors and now the community is reaching back and inviting us to attend events to provide further information about dementia. Dementia has been identified has a priority in the Heritage in Health workstream. The 3 priorities are Menopause, Diabetes and Dementia. The Programme Manager is part of the workstream and meeting with other partners to plan how we continue to reach the community and provide relevant information to support them to access services. Diabetes is a risk factor for dementia – thus there is an opportunity to raise awareness of the risk factors for dementia and discuss brain health and the modifiable risk factors.	A dementia café specifically for ethnic minority communities is being set up in the community – this will be in a venue where the community currently attend. We will have a presence to discuss dementia and the risk factors for dementia. People working and living in the community will be available to translate. This work will be carried out over many weeks to cover different aspects of dementia and to allow for questions and to explore cultural experiences around dementia and brain health.

Listening and Learning from Feedback

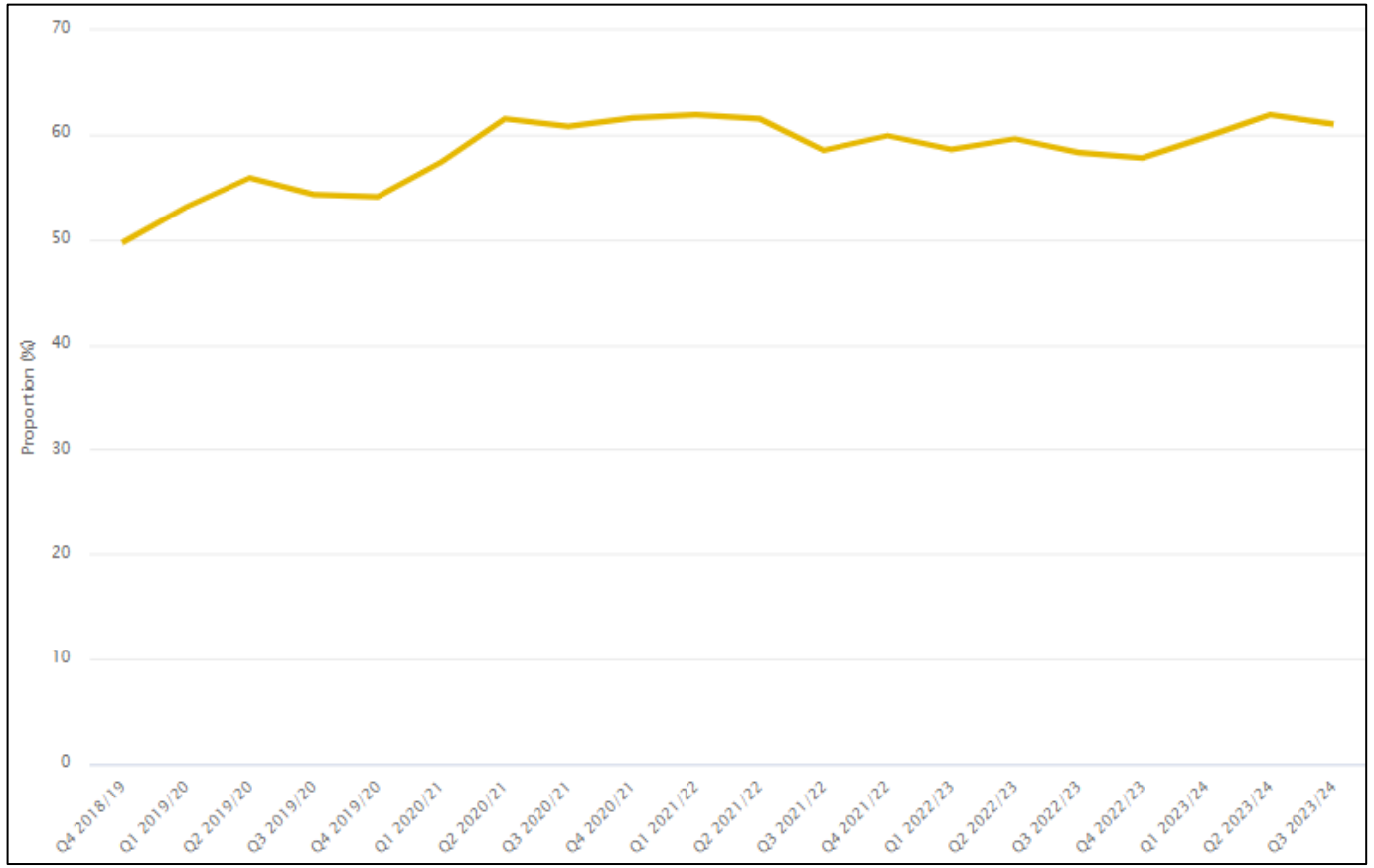
Theme	Feedback	Action Taken	Impact	Next Steps
Spiritual Care **Baby Loss**	Families have expressed sadness and pain at loss when they were preparing to celebrate. Some ask for prayers / blessing following loss.	Signposting to on-going support. Annual Memorial Service and Bereavement Care Session.	On-going care available as families are ready to take up. Huge gratitude for active support from those attending. Event held on 2nd June with 80+ in attendance.	Memorial Service has been an annual event for a number of years.
Wellbeing Activities for Staff	Chaplaincy finding new ways of offering wellbeing support to a wider audience of staff, especially outside of the main hospital sites.	Great feedback, letters of thanks from staff who work in smaller sites and clinics who have enjoyed wellbeing activities.	Request for on-going support.	Changes in staffing may mean changes in priorities and activities. Looking at what might be possible with a smaller team.
Pastoral care / spiritual care	Some reoccurring issues of staff not referring patients who make requests for chaplaincy support.	Where problems have been identified a greater spread of information made available to ward / unit. Offer of Spiritual Care training session. Where there is little engagement from staff, escalated to senior nurse.	Improvements and change can be slow to filter through. Staff often express a lack of time and forgetting to follow up patients requests because of volume of work and things to keep in mind.	Supportive approach to staff often has a more positive affect.

WG Targets – Antimicrobial Prescribing: Primary Care



- ABUHB has not achieved the minimum 25% reduction in antimicrobial usage in primary care from the 2013/14 baseline. Whilst ABUHB made good progress in previous years, prescribing rates have not recovered since the Invasive Group A Strep (IGAS) outbreak in 22/23, when widespread messaging from the UKHSA encouraged people to seek antibiotics. At 23/24 FYE ABUHB had achieved a 14.7% reduction across in-hours GP services.
- The antimicrobial team have successfully influenced the 2024-25 Clinical Effectiveness Prescribing Programme (CEPP) for GP practices, which will include a heavy weighting on reducing antimicrobial prescribing, to encourage all practices to engage with the AMS agenda.
- Blaenau Gwent and Caerphilly remain the highest prescribing localities in Wales, with Torfaen in 4th position in Q4 23/24.
- The new 0.4WTE pharmacist is now in post, allowing acceleration of targeted audit & feedback cycles with high-prescribing practices.

WG Targets – Antimicrobial Prescribing: Secondary Care



Data is only available to the end of Q3 however ABUHB continues to achieve proportion of antibiotic usage within the WHO 'Access' category to ≥55% of total antibiotic consumption

Following publication of the new 5-year National Action Plan for AMR on 8th May, Welsh Government antimicrobial targets are anticipated to change significantly. It is likely that challenging targets will be set for both primary and secondary care that will require intensive work to achieve.

Internal Alerts relating to medication

- **Time Critical Medication: Desmopressin for Diabetes Insipidus**

Desmopressin is a life sustaining medication for patients with cranial insipidus, and within the last 12 months there have been four incidents of delayed or omitted doses. An internal alert was cascaded to raise awareness of the condition and treatment pathways, to highlight what preparations are available and how to obtain stock within and out of hours.

- **Dalteparin & Fondaprinux pre-filled syringe: potential for severe allergic reactions in patients with latex allergy**

The needle shield for Fragmin® (dalteparin) and Arixtra® (fondaparinux) are no longer latex free and severe allergic reactions may be caused if these PFS are used in patients with latex allergy. A number of policies will need to be updated to reflect this new information and ensure safe alternatives are selected. An internal alert has been issues to highlighted this risk in the interim.

- **Risk of coring the bung of Piperacillin/ Tazobactam 4.5g vials with 18 gauge blunt needles**

Multiple incidents of bung coring have been reported across the HB when using the fresenis kabi (FK) brand of Piperacillin/ Tazobactam 4.5g. A different brand has been sourced to resolve the issue, and advice has been issued to use a 21 gauge sharp green BD needle on the FK brand. Staff are reminded to inspect the reconstituted solution for particulates prior to administration.

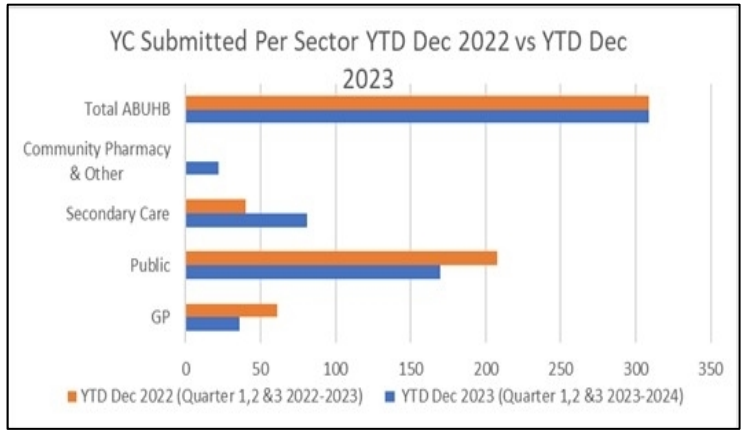
- **Adrenaline pre-filled syringe: failure to deploy**

Three incidents reported of failure of adrenaline pre-filled syringes to deploy in an emergency situation. Incompatible connected were a root cause in all reported incidents and work in underway to source and roll out compatible connectors to all resus trolleys.

Medication Safety Group: Reporting

Yellow Card (YC) Scheme

- Significant increase in YC reporting from the Secondary Care
- Public and GP reporting down 41% and 18% respectively.
- Rolling training programme in place which includes junior doctors, pharmacists, advance nurse practitioners, vaccinators, practice nurses.
- Cross-sector group working with Yellow Card Centre Wales to improve reporting



MHRA and Genomics Biobank

- The goal is to improve understanding of how patients genetic makeup may increase their risk of harm from side effects of medications.
- By collecting genetic samples from patients who have experienced suspected side effects they aim to discover if this side effect is caused by a genetic trait.
- The biobank is currently recruiting patients who have experienced side effects for specific medicines, these include:
  DOACs - severe bleeding (potentially serious and life threatening)
  Allopurinol - severe skin reactions (including SJS, TENS and DRESS)
- Focused approach in ABUHB to ensure these ADRs are identified and reported to support the work on making these medications safer.

Medication Safety Group: Action Plan

Issue	Cause	Remedial Action	Who	When
Defective medication	Unplanned issue, often unknown cause.	Report each defect to manufacturer and to Yellow Card scheme to notify MHRA. Mitigating plan of action and monitoring of situation until resolved.	All areas handling drugs should notify pharmacy team when a defect is noticed.	Ongoing as required
Yellow Card Scheme – not currently achieving KPIs	Multifactorial, reporting often not part of the process when discontinuing a medication due to a side effect/ adverse drug reaction.	Continue to work to increase awareness and educate all staff who prescribe and assess patients.	Cross-sector YC group	Ongoing

All Wales Patient Safety Solutions: Compliance Status

Alert	Compliance Deadline	Action to achieve compliance	Status
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	Sep-23	This project is being lead by Peggy Edwards. Work is still on-going.	In-progress

Agenda Item:2.3

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 July 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Mortuary Serious Incidents – Action Plan Feedback
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr, Executive Director of Therapies and Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Simon Hoad, Pathology Directorate Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report constitutes a formal update on Pathology Directorate progress against the action plans submitted as part of the Patient Safety Incident (PSI) investigation relating to the Datix incidents referenced ABU58687 and ABU68393. These are the two historical cases of incorrect release of deceased to funeral directors and are being presented to the Patient Quality, Safety and Outcomes Committee for consideration.

Cefndir / Background

In November 2023 it was discovered that a deceased patient had been released incorrectly to a funeral director resulting in their subsequent cremation. This patient is known as Patient A. The intended deceased patient for release is referred to as Patient B.

The death of patient A had not been registered.

This error was identified internally when the Care after death team called the funeral director responsible for the onward care of Patient B to enquire as to when collection could be expected. They informed that Patient B had already been collected and their funeral held.

A failure to follow existing release processes within the Mortuary in the Grange University Hospital led to this incident.

The incident was reported internally and to all relevant external stakeholders – Welsh Government, the Human Tissue Authority (HTA) and the UK Accreditation Service (UKAS).

The HTA are responsible for issuing the Health Board with the licence to carry out Post-mortem activity on health board sites and assessing ongoing compliance with the code of practice and standards. Any incident involving the release of the wrong deceased is classified as an HTA reportable incident (HTARI). The HTARI reference number is CAS-69585-W4T6, PSI reference ABU58687.

Another incident was subsequently identified in March 2024 whereby a second release of an incorrect deceased patient had occurred. Again, this deceased patient is referred to as Patient A (intended release of Patient B). The identification was of the error was noted by our releasing Anatomical Pathology Technician (APT) when the funeral director service attended to collect Patient A who had remained with us in long term storage. The release was ceased and again reported internally and to all relevant external stakeholders. The HTARI reference number is CAS-70618-N7W5, PSI reference ABU68393.

Both incidents originated in November 2023 and similarities are noted with the administration, procedural errors and staff involvement.

Following the second incident, colleagues from UKAS arrived to the Mortuary facility to conduct an unannounced assessment on 04/04/2024. The outcome of the visit has been to suspend the mortuary service from the current scope of accreditation under the Cellular Pathology Department ISO 15189:2012, Medical Laboratories – Requirements for quality and competence.
The Cellular Pathology UKAS reference number is 10338.

Asesiad / Assessment

Current position

- 19 recommendations were made following on from the PSI investigations that took place. Of these 8 were generated from ABU58687 and a further 11 from ABU68393.

- Two of the action points feature in both PSI action plans.

- Reciprocal actions 1312 and 1978 - to ensure that representation is always present at the National Pathology Programme Anatomical Pathology Compliance and Workforce Group. This has occurred for the past two meetings and relevant staff members have dates held in their calendars for meetings scheduled over the next year.

- There are three outstanding actions remaining.

Datix ref	Action	Update as of 09/07/24
1981	To share the outcomes and actions of the report with the Funeral Directors Association	IO in process of obtaining permission to share redacted report with FDA - 26/06/2024
1973 & 1310	Review of the daily occupancy updates, gathering and sharing with the Mortuary staff and the Care after Death staff. This is to be combined with a review of the systems used within the Mortuary and the Care after Death team to accurately collate the information of the deceased within the department. Mortuary/Body store occupancy levels for all sites to be updated in real time. Mechanism for this to be agreed and implemented in reviewed procedures. Full review and functionality of LIMs to be undertaken and outcome reported back via Mortuary Incident Task and Finish Group.	Remains under discussion at the Mortuary Incident Task and Finish Group. Until a permanent IT solution is sought, Mortuary staff could be asked to update CAD database in real time as admissions/releases occur in addition to LIMS. Consider rotating a member of the CAD team to the Mortuary to conduct releases and real time admin updates/a currently redeployed staff member so they can be supported

All actions have been amalgamated and can be seen in Attachment One.

External agency actions

Having raised HTARI's with the HTA immediate actions were defined and implemented internally.

HTA immediate actions: ABU58687 / HTARI CAS-69585-W4T6

- A copy of the latest Standard Operating Procedure (SOP) and risk assessment for release of the deceased
- A summary of the discussion held with the family concerned
- A summary of the discussion with the Coroner –the deceased released was still under the authority of the Coroner and had not yet had a death registration
- Summary detail of which identifiers of the deceased were provided by the funeral director and what identifiers were checked against the body at the point of release – this is for further understanding of how the incident arose.

This was all completed as requested and submitted on 07/12/2023.

HTA immediate actions: ABU68393 / HTARI CAS-70618-N7W5

- To review the use of the toe tags on the deceased and to consider a more robust method of ensuring information on the body is accessible and legible. There is a possibility that staff are relying on the notification of death forms

as the sole information in identification procedures as this is readily accessible rather than fully opening the body bag to review toe tags.

- To implement a two-person crosscheck (establishment staff) of all information when bodies are being released for the immediate future.

- To review the use of and mitigate the risk of notification of death forms being placed on the wrong bodies following Post Mortem (PM) examination. The SOP and risk assessment for PM examination should be reviewed as a matter of urgency

- Evidence of the full body traceability audit to ensure that all bodies currently in storage are fully traceable and all information on the deceased matches between the notification of death form, toe tags / ID bracelets and information in your mortuary register and electronic database to be submitted by 13/05/2024.

This was all completed as requested and full body traceability audits conducted across all licenced sites.

In addition to the action plans produced as a result on the internal Patient Safety Investigation describing corrective and preventative actions (CAPA), the HTA also issued a CAPA plan, mapped to the relevant HTA standards for the licence. A deadline for submission of evidence to demonstrate that all prescribed resolutions had been implemented.

A copy of this plan is provided as Attachment Two.

The Regulation Manager confirmed that this CAPA plan covered actions required to evidence implementation of corrective/preventative actions for both of the incidents.

Information was received on 10/06/2024, confirming that the CAPA plan issued has been resolved and the cases closed on their system.

Following the second incident, colleagues from UKAS arrived to the Mortuary facility to conduct an unannounced assessment on 04/04/2024. The outcome of the visit has been to suspend the mortuary service from the current scope of accreditation under the Cellular Pathology Department ISO 15189:2012, Medical Laboratories – Requirements for quality and competence.

The Cellular Pathology UKAS reference number is 10338 – outcome report is provided as Attachment Three.

Argymhelliad / Recommendation

In summary, the Pathology Directorate has identified the following action to take forward:

- Resolve outstanding actions 1981 and 1973 as soon as possible

- Continue with embedding actions defined in the action plan regarding good governance processes – training/competency/document reviews/risk review
- Maintain performance of audits in line with the audit calendar and fostering continuous improvement through swift management of findings
- Prioritise ensuring wellbeing of workforce and cultivating good working relationships across the mortuary/care after death teams.
- Determine whether to re-apply to restore mortuary service to UKAS scope of accreditation under Cellular Pathology. This will need to be in line with ISO 15189;2022 standards.
- Maintain continued compliance to HTA standards as defined in Code B Post-mortem examination licensing standards and guidance to safeguard the Health Boards licence status.

The Committee is asked to note the briefing for the purpose of assurance.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	4. Dignified Care 6.3 Listening and Learning from Feedback 3.5 Record Keeping 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Not Applicable
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	

Rhestr Termau: Glossary of Terms:	APT - Anatomical Pathology Technician CAPA – Corrective/Preventative Action Plan HTA – Human Tissue Authority PSI – Patient Safety Incident UKAS – United Kingdom Accreditation Service
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Incident reference	Status	ID	Start date	Module	Synopsis of action	Due date	Comments	Action Owners
58687	Completed	1307	08.01.2024	Incidents	Updated release of deceased SOP circulated to staff within Mortuary and body stores at ABUHB	08.01.2024	/	
58687	Completed	1305	15.01.2024	Incidents	Reminder poster clear and evident in the Mortuary and Body stores	22.01.2024	/	
58687	Completed	1306	22.01.2024	Incidents	Quick reference guide for existing and new staff	22.01.2024	/	
58687	Completed	1308	08.01.2024	Incidents	Currently there is no Mortuary Collection form in use. The Pathology team are adapting an existing form that is a national exemplar template from theGOV.UK webpage for local adoption and adaptation. This is intended to be used toauthorise the release the body of a deceased person from a hospital. This has been modified to suit ABUHB Mortuary and CAD services and is to be incorporated into administrative and releasing standard operating procedures. Additionally, suggestions from the CO - OP FD service have been included	30.03.2024	/	
58687	Completed	1309	08.01.2024	Incidents	Review current process for highlighting deceased patients of same/similar names and incorporate into current process	30.03.2024	/	
58687	Completed	1310	18.12.2023	Incidents	Mortuary/Body store occupancy levels for all sites to be updated in realtime. Mechanism for this to be agreed and implemented in reviewed procedures * **as Action ID 1973**		Remains under discussion at the Mortuary Incident Task and Finish Group. Until a permanent IT solution is sought, Mortuary staff could be asked to update CAD database in real time as admissions/releases occur in addition to LIMS. Consider rotating a member of the CAD team to the Mortuary to conduct releases and real time admin updates/a currently redeployed staff member so they can be supported	Julia Hemming Simon Hoad Paul Miller Lucy Bennett
58687	Completed	1311	22.01.2023	Incidents	Incorporation of regular meetings between Mortuary and CAD colleagues to be implemented There will also be a review of the current management structure within Pathology to ensure a clear structure for the Mortuary and CAD team.	30.03.2024	/	
58687	Completed	1312	29.02.2024	Incidents	Nominate a representativeto represent on the APT and HTA group and commence regular attendance * **as Action ID 1978**	30.03.2024	/	
68393	Completed	1971	06.03.2024	Incidents	Conduct a full review of the Procedure for Post Mortem examinations ensuring that the requirements for deceased in a state of decomposition are detailed	25.03.2024	/	
68393	Completed	1970	06.03.2024	Incidents	Confirmation that the review of safety checks and 2-person check for the release of the deceased has been completed. Continue the auditing of the process for admitting and releasing the deceased within the Mortuary at GUH.	15.04.2024	/	
68393	Completed	1979 (&1980 - accidental duplicated entries)	06.03.2024	Incidents	Investigation outcomes and follow up report to be shared with the Human Tissue Authority. The follow-up report for this incident should be submitted on the HTA Portal no later than 17 May 2024. The follow up report must include detail of corrective and preventative actions taken and completed to date to mitigate risk of a similar incident.	17.05.2024	/	
68393	Active	1981	06.03.2024	Incidents	To share the outcomes and actions of the report with the Funeral Directors Association	30.06.2024	SH in process of obtaining permission to share redacted report with FDA - 26/06/2024	Sally Heal
68393	Completed	1972	06.03.2024	Incidents	Ensure Post Mortem tables are numbered for clarity	30.06.2024	/	
68393	Active	1973	06.03.2024	Incidents	Review of the daily occupancy updates, gathering and sharing with the Mortuary staff and the Care after Death staff. This is to be combined with a review of the systems used within the Mortuary and the Care after Death team to accurately collate the information of the deceased within the department. Mortuary/Body store occupancy levels for all sites to be updated in real time. Mechanism for this to be agreed and implemented in reviewed procedures. Full review and functionality of LIMs to be undertaken and outcome reported back via Mortuary Incident Task and Finish Group * **as Action ID 1310**	30.06.2024	Remains under discussion at the Mortuary Incident Task and Finish Group. Until a permanent IT solution is sought, Mortuary staff could be asked to update CAD database in real time as admissions/releases occur in addition to LIMS. Consider rotating a member of the CAD team to the Mortuary to conduct releases and real time admin updates/a currently redeployed staff member so they can be supported	Julia Hemming Simon Hoad Paul Miller Lucy Bennett
68393	Completed	1974	06.03.2024	Incidents	Review of admission process of deceased from the community and labelling provided prior to arrival and as applied by staff receiving the deceased. Benchmarking of processes across Health Boards in Wales to be undertaken and outcome reported back via Mortuary Incident Task and Finish Group	30.06.2024	/	
68393	Completed	1975	06.03.2024	Incidents	Demonstrate implementation of new Mortuary and Care After Death portfolio of ongoing training and competency. Two new staff members are imminently joining the CAD team.	30.06.2024	/	
68393	Completed	1976	06.03.2024	Incidents	All new starters and existing staff to undertake Human Factors training if not yet completed already.	30.06.2024	/	
68393	Completed	1977	06.03.2024	Incidents	Regular meetings to be held with the Mortuary staff to ensure ongoing communication and assurance of wellbeing.	30.06.2024	/	
68393	Completed	1978	06.03.2024	Incidents	Continue representation at National Pathology Programme Anatomical Pathology Compliance and Workforce Group * **as Action ID 1312**	30.06.2024	/	

HTA Human Tissue Authority

Corrective and preventative action (CAPA) plan

12036 - Roberts, Sarah - Grange University Hospital

Please complete the blanks below

HTA Standard	GQ1a - 5/4/2024	**Level of Shortfall (major or minor only)**	Minor
Short Description	Standard Operating Procedures (SOPs)		
Inspection finding: Following an incident of the release of the wrong body, the SOP for release of the deceased from the mortuary is to be updated to include further clarification for staff regarding the procedure.			
Deadline for completion of corrective and preventative action:	05/04/2024		

HTA Use Only

Action for HTA:	Submission of evidence of compliance.
Compliance information to be submitted: • A copy of the implemented SOP for release of the deceased form the mortuary. • Evidence that all relevant staff have read and acknowledged the updated SOP.	

Corrective and preventative action (CAPA) plan

12036 - Roberts, Sarah - Grange University Hospital

Please complete the blanks below

HTA Standard	GQ3a GQ3c - 5/4/2024	**Level of Shortfall (major or minor only)**	Major (Cumulative)
Short Description	Staff training and competency assessment		
Inspection finding: Following a release of a wrong body incident , the establishment are required to demonstrate that relevant staff are up-to-date with training and competency in the release of the deceased from the mortuary procedure using the new competency framework developed as a result of the incident.			
Deadline for completion of corrective and preventative action:	05/04/2024		

HTA Use Only

Action for HTA:	Submission of evidence of compliance.
Compliance information to be submitted: • A copy of the competency assessment framework developed as an outcome of the incident. • Evidence that all relevant staff have now completed training and have been assessed as competent in the release of the deceased procedure.	

APPROVED TEMPLATE

Corrective and preventative action (CAPA) plan

12036 - Roberts, Sarah - Grange University Hospital

Please complete the blanks below

HTA Standard	**GQ6b - 5/4/2024**	Level of Shortfall (major or minor only)	**Major**
Short Description	Risk assessment - release of the wrong body.		
Inspection finding: The risk assessment to mitigate the risk of release of the wrong body is not sufficiently detailed to ensure all control measure in place are captured for understanding by staff involved in the procedure.			
Deadline for completion of corrective and preventative action:	05/04/2024		

HTA Use Only

Action for HTA:	Submission of evidence of compliance
Compliance information to be submitted: • An updated risk assessment mitigating risk of release of the wrong body. • Evidence all relevant staff have read and acknowledged the updated risk assessment.	

APPROVED TEMPLATE

HTA Human Tissue Authority

Corrective and preventative action (CAPA) plan
12036 - Roberts, Sarah - Grange University Hospital

Please complete the blanks below

HTA Standard	T1c - 19/4/2024	**Level of Shortfall (major or minor only)**	Major
Short Description	The use of three identifiers in the release of bodies procedure.		
Inspection finding: Following a release of a wrong body incident, the establishment are required to evidence the actions taken to mitigate risks of a similar incident.			
Deadline for completion of corrective and preventative action:	19/04/2024		

HTA Use Only

Action for HTA:	Submission of evidence of compliance.

Compliance information to be submitted:

- A copy of the updated SOP for release of the deceased from the mortuary (as per GQ1(a).
- A copy of the release form implemented for use by funeral directors - including dates of implementation.
- A copy of the poster implemented to remind staff of the use of three identifiers at the point of release.
- Two audits of the release procedure - this should focus on the effectiveness of the updated procedure and the newly implemented release form. The audits should include observational assessments of the use of three identifiers in practice at the point of release. The number of bodies audited must be sufficient to provide assurance that procedures have embedded.

HTA Human Tissue Authority

Corrective and preventative action (CAPA) plan
12036 - Roberts, Sarah - Grange University Hospital

Please complete the blanks below

HTA Standard	- 5/4/2024	**Level of Shortfall (major or minor only)**	Major
Short Description	Same / Similar name procedure		
Inspection finding: Following a release of the wrong body incident, the establishment are required to provide evidence of how the same / similar name procedure has been strengthened.			
Deadline for completion of corrective and preventative action:	05/04/2024		

HTA Use Only

Action for HTA:	Submission of evidence of compliance
Compliance information to be submitted: • A copy of the updated same / similar name procedure. • Evidence that relevant staff have read and acknowledged the updated procedure. • Two audits of the same / similar name procedure which evidences effectiveness of the updated procedure.	

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ASSESSMENT REPORT

Name & Address of Organisation	Aneurin Bevan University Health Board Headquarters St Cadoc's Hospital Lodge Road Caerlon Newport NP18 3XQ	**Type of Assessment**	Unannounced visit
		UKAS Reference Number	10338
		Date(s) of Assessment	04/04/2024
Assessment Location(s)	Mortuary The Grange University Hospital Caerleon Road Llanfrechfa Cwmbran NP44 8YN	**Project References**	309983-01-03
Assessment Standard / Criteria	ISO 15189:2012	**Schedule Issue No(s)**	006
Name & Role of UKAS Assessment Team	Assessment Manager: Georgina Meachen Lead Assessor: Rachel Bradley Technical Assessor: Pradeep Agrawal	**Date(s) of Assessment Plan**	22/03/24
		No. of (M) Findings: Action Mandatory	8
Name of Organisation Representative(s)	Sarah Rogers Simon Hoad	**No. of (M) Findings: Require Evidence to UKAS**	8
Report Issued By	Rachel Bradley	**No. of (R) Findings: Action Recommended**	1
Report Issued Date	08/04/2024	**Method of Reviewing Evidence**	Remote
Report Acknowledged By		**Quote for Reviewing Evidence**	___Days Quote to follow
Report Acknowledged Date	Return email	**Agreed Action Completion Date**	
Report Acknowledged Method	Return email	Please return evidence to: Assessment Portal	

AREAS SAMPLED AT ASSESSMENT (*marked as '* **X***'*)			
ORGANISATION		**IMPARTIALITY & INTEGRITY**	
Legal Status	**X**	Independence, Impartiality & Integrity	
Liability Cover (CB / IB only)		Confidentiality	
Management of Finances (CB/IB only)	**NA**	**EVALUATION PROCESSES**	
Resources	**X**	Design & Development of Methods / Schemes	
Organisation Structure	**X**	Enquiries, Tenders, Contracts	
Responsibility & Authority	**X**	Planning & Resource Allocation	
MANAGEMENT		Testing/ Calibration/ Inspection/ Audit *	
Management System Including Documented Policies & Procedures	**X**	Reports & Certificates	
Roles & Responsibilities for Quality		Decisions/ Opinions	
Control of Documents and Records	**X**	Certification & Maintenance of Certification (CB only)	**x**
Management of Sub Contractors and Purchases		**TECHNICAL COMPETENCE**	
Service to Clients (Test / Cal only)		Personnel	**X**
Handling of Complaints / Appeals / Disputes	**X**	Methods / Schemes	**X**
Control of Nonconforming Items Dealing with Corrective & Preventive Actions and Improvements	**X**	Facilities / Equipment (Test/Cal/IB only) / Environmental conditions (Test/Cal only)	**X**
Internal Audit and Management Review	**X**	Assurance of Quality of test / calibration Cooperation (IB only)	**NA**
Supervision & Monitoring of Staff	**X**	Witnessed Activities	**X**
Conditions for Granting & Maintaining Certification (CB only)	**x**	***OTHER (specify)**	

*Delete as applicable

Executive Summary

This was an unannounced assessment to the mortuary at the Grange University Hospital (GUH) within the Aneurin Bevan University Health Board, to assess the service provision following the submission of 2 significant non-conforming work incidents. Activities were assessed against the requirements of UKAS accreditation including ISO 15189:2012 for ongoing conformity and compliance.

Key Strengths identified:

- Engaged and knowledgeable trainee APT's interviewed on the day
- Action taken to address the incidents using HTARI form and CAPA for HTA

Areas for improvement:

- Traceability of patient transfer to and from other body stores can be difficult
- Manual process with the use of forms and LIMS could lead to points of failure without risk assessment for mitigation available
- Lack of security audits carried out and lack of documented list of authorised personnel with access
- The use of the unaccredited body store at the Gwent hospital
- Backlog of post mortems has not been captured within the QMS
- No formal quality indicators implemented to ensure any breaches are addressed
- No evidence of continual improvement captured within the QMS

There is evidence of active ongoing risks and significant areas of concern identified during this visit. The lack of security measures in place or regular audits carried out do not provide assurance of patient safely and protection of confidential records. The processes involved from patient receipt to release have not been evaluated for points of failure, risk, and inclusion of appropriate mitigation where relevant. There is evidence of a lack of QMS oversight in relation to mortuary activities.

Recommendation

It is recommended that an imposed suspension of accreditation under ISO 15189:2012 is for the mortuary services including the body store at the Grange University Hospital is carried out. A draft schedule 007 will be submitted to document the removal of this service. The suspension of accreditation is subject to:

- Agreement from an independent decision maker at UKAS
- Submission of electronic evidence of improvement action to address all mandatory (M) findings of non-conformity raised at this assessment to be reviewed on site.
- Satisfactory close out of all mandatory findings.

During the onsite visit for the review of evidence submitted to address the mandatory findings, a technical assessor and a lead assessor will assess all mortuary activities and the QMS areas which were not covered during the unannounced visit, to provide assurance of conformity for the department. Any findings identified during this assessment will be evaluated using a risk based approach to reinstatement of the service. If any findings are deemed low risk then recommendation to reinstate will be submitted if the findings can be cleared within one month. If there are findings raised which are considered high risk in relation to patient safety, clearance of these findings will be required before reinstatement can be recommended. This will be subject to review and agreement by an independent decision maker at UKAS.

It is expected that suspensions last no more than six months and the following has been agreed with the Laboratory as a plan for managing the re-instatement of accreditation.

In the event that findings remain open after two rounds of further evidence submission, a review of the recommendation will be made.

Recommended (R) findings are not mandatory and are proposed as quality improvement opportunities or indicate possible future non-conformity.

Scope

An unannounced visit was carried out to assess conformity with the requirements of ISO 15189 following two incidents of significant non-conforming work which were reported to the HTA at the end of 2023. The Customer failed to notify UKAS of the first incident, which is a deviation from the signed UKAS Customer Agreement clause 3.4, the second incident was reported to UKAS in accordance with the agreement. A visit plan provided by the Assessment Manager provided a guide for the documents and processes to be reviewed during the day. On arrival at the mortuary there were two Trainee APT's present who provided a walk round of the facility and requested documentation. The senior management team and the Senior APT were not available until lunchtime due to the Health Board investigation of the recent incidents at the Royal Gwent Hospital. The assessment followed the process of patient receipt to release and the potential areas of failure.

The documentation throughout the receipt to release process was reviewed in tandem by the lead assessor and the technical assessor and this report will capture the findings from this review alongside a review of the facilities carried out by the technical assessor.

Organisation

Legal Entity

The legal entity for the department is Aneurin Bevan University Health Board, and the mortuary services situation at the Grange University Hospital sits within the cellular pathology department accreditation.

Responsibility, Authority, and Interrelationships

The department Pathology Governance Manager is Sarah Roberts who is responsible for the quality manager activities for the cellular pathology department. The departmental manager for cellular pathology is Julia Hemming, who the senior APT, Paul Millar reports to. Simon Hoad is the pathology services manager who has responsibility for all departments within pathology. There is a new department 'CAD' which is the bereavement service for the Trust which previously sat within the facilities and estates division, has now moved within the clinical services division. This is a recent move, and the reporting structure and organogram was not reviewed during this assessment. This will be followed up at reinstatement, to ensure that roles and responsibilities between CAD and the mortuary are clearly defined.

Significant non-conforming work

Prior to this visit a review of 2 incidents was carried out by the Assessment Manager following UKAS process. The department has recorded these incidents using the HTARI form for notification to HTA, which is open awaiting submission of evidence to address findings raised by HTA. The pathology governance manager was able to show the HTARI reports, however due to time constraints these were not reviewed during the day and will be followed up when closed by the HTA. The department have recorded the events within the Datix system, and the health board is carrying out their own internal investigation, which was ongoing at the time of this assessment. Evidence was seen of implemented actions to address the defined root causes, which includes the fridge magnets to identify when a patient is stored with a similar or the same name. This was seen in action and is working satisfactorily. To accompany this process the department use a list which is generated daily from the LIMS which identifies the location of each body in storage and is highlighted if similar or the same name. This form is present within the office area and used for patent release as an additional check. SOP's have been updated to reflect the changes in process and were reviewed on site. The full CAPA plan and effectiveness check is to be reviewed during the reinstatement visit, alongside the HTA report.

Review of the receipt to release process

There is evidence of a lack of standardisation through the receipt of patients to release process identified during the review. Community patients are labelled using toe tags with a different set of paperwork and delivery to the mortuary, whereas hospital deaths the bodies are identified using wristbands and different documentation. The Porters collect the trolleys from the body store and return with a member of ward staff who complete the register, and the bodies are stored in the fridges which do not open into the post mortem room.

The main source of information is the mortuary register which uses a unique identification number which is included within the input of patient details into LIMS. There is evidence of inconsistency with information added into the register. Evidence was seen when a release of patient was being performed, where the APT entered information related to the release which involved transfer to the Gwent, within the LIMS, however not all staff do this, and sometimes this information is entered only into the register, this action is not included within the SOP. There is a form which is used by the department which also can include information of transfer; however this is not always completed. The APTs have to email the Care of Death Team (CAD) each day with a list of released patients and the CAD input this information into the dashboard for all body stores within the health board. This information is not real time and may not be accurate representation of the current location of the patient, it is not clear whether this is used by the department for patient location, or what the purpose the dashboard has for the CAD team. This unique identifier is not used for the patient identification process, only name, date of birth and address is used, however this is the reference which is used within the department. It is recommended that the lab consider using this unique identification number throughout the process of patient management which could provide additional traceability especially when patients are transferred to other locations and returned.

There are different methods for recording the condition of the body in relation to the requirements stated in MO 007, where the condition checks should be carried out at 14 days, and thereafter at 21 days. There is no accurate record of this, and traceability of the previous check isn't apparent (Finding raised). This issue is compounded when patients are transferred to other body stores as there is a lack of traceability regarding whether condition checks have been carried out or recorded. The Gwent site is used as a body store when there are capacity issues at the Grange, and the transfer process is captured within the register and the patients released using the LIMS. There is a lack of consistency when completing the LIMS release as not all staff with provide information related to why the patient has been released or to which location. The Gwent is currently not included within the current scope of accreditation, and there is no assurance that the other body store meets the requirements of the standard (Finding raised). There is evidence that patients are returned to the Grange from the Gwent, again the traceability for this process is not clear and the amount of detail recorded in the register varies.

The root cause associated with the incorrect release of patients which resulted in the incidents, was related to failure to follow procedure for the identification checks prior to release. A number of different forms were identified during the process review, some which look very similar dependant on whether the patient has had a post mortem prior to release. The lack of awareness when similar or the same names were on site at the same time may have been an issue, which has been addressed. It is not possible to identify if there have been any near misses in relation to the individual who was responsible for the mix up of bodies, as there is a lack of information being fed into the QMS in relation to deviations. Error logs and incident records were not reviewed during this visit due to time constraints and will be followed up at reinstatement.

A risk assessment for the receipt to release process was not available and it is unclear from discussion if one was established, to indicate that there had been consideration given to the points of potential failure, with the inclusion of mitigating actions. The manual process with inconsistent completion of forms, registers and LIMS poses a significant risk of failure which could result in incidents which could have been prevented. The lack of quality indicators means that any breaches of HTA guidance are not detected, a non-conformance report is not raised and the QMS is unable

provide information for trending analysis, preventive action which in turn indicates there is no continual improvement noted.

There is a backlog of postmortems which could mean some patients are exceeding 30 days in storage and unable to move to a fridge due to the requirements of a post mortem, however there was no evidence for prioritising the patients or risk assessment carried out available for review. As there are no quality indicators including this target, there are no deviations recorded and subsequently no non-conformance records to capture this situation within the QMS (Finding raised).

A review of currently competency status was carried out by the technical assessor and there is evidence that all mortuary staff have overdue competency records, some up to 2 years out of date. This is another area of concern in relation to the recorded incidents, as there is no assurance that personnel carrying out duties are competent to perform tasks (Finding raised). The competency status of the designated Individual for HTA will be followed up at a reinstatement visit

Security arrangements within the department were reviewed by the technical assessor, which indicates that an audit of authorised personnel has not been carried out since November 2023. In addition there is no list of personnel within the Trust who have access to the mortuary to carry out a suitable audit (Finding raised). There is CCTV within some areas of the department, however, there has not been an audit of this footage carried out (Finding raised). There are no CCTV cameras within the body store and lack of a justification how patient safety and confidentiality requirements have been met (Finding raised).

Technical competence report from Pradeep Agrawal

Summary

There are serious concerns on security and safe patient management in The Grange University Hospital, Cwmbran (GUH) – Mortuary/body store. A number of findings have been raised (included in this report) and discussed with lab management to be addressed urgently.

- Although there are SOPs for receipt, storage, and release of patients it is noted these are not adhered to 'fully' in practice e.g. lack of condition checks as specified in the SOP
- Staff and porters are expected to be trained in mortuary/body store procedures and competency assessed annually. There is no list of personnel with access authorised by mortuary management to assure staff trained in mortuary/body store procedures access the mortuary/body store. Majority of competency assessments are out of date and there is no evidence of CPD of mortuary staff.
- Audit of security using swipe card access was last carried out Nov 2023 and there is no audit of CCTV footage at the entrance/exit doors. There is no CCTV in body fridge room to assure safety and security of patients.
- Today, 5 April 2024, noted a number of patients stored in fridge for over 30 days due to delay in post mortem. There is no Datix or risk assessment to urgently mitigate this breach of HTA guidance.

Background

This unannounced visit was triggered due to 2 serious incidents which took place in November 2023, when on each occasion a wrong body was released to the families. Due to time constraints a review of the SUI and HTARI reports was not carried out, and this assessment followed a review of the patient receipt to release process. Lab management verbally (during the unannounced site visit) provided some detail and the current status of the incidents. HTA have been informed and a CAPA plan is being submitted. Key finding on both incidents is the failure to check patient identifiers (particularly similar names) at release.

Area/activities assessed

Mortuary/body store - MO 002 (receipt); MO 0092 (storage); MO 007 (release)

Personnel including competence, training records, performance reviews, CPD and qualifications

There is an establishment of 5.0wte APT in mortuary/body store for post mortem and admit/release patients and 1.0wte Mortuary Technician to admit/release patients. Workload/staffing level for technical staff appears to be satisfactory evidenced by completion of various examination processes. There is an excellent team work in place.

Porters and ward staff admit hospital deceased patients and Mortuary/body store staff admit community deceased patients (in and out of hours).

Mortuary/body store staff and CAD team release deceased patients using 3 PID identifiers – name, DOB, and ward (if hospital) and address (if community) in hours. Mortuary/body store APT staff release patients out of hours (MO 007)

There is no documented list of authorised access of personnel in Mortuary body store, to ensure patient safety and security of confidential records and there is no evidence of training of these personnel (Finding raised)

Competency of mortuary staff is out of date by up to 2 years (Finding raised)

Improvement required to show compliance for the competence and training records.

Accommodation and environmental conditions

GUH Mortuary/body store is located on the ground floor (south side) of the hospital. The body store has a capacity of 165 storage spaces which includes standard, bariatric and super-bariatric fridge spaces. There are freezer spaces for standard and some bariatric patients. Today the body store is approx. 70% full.

Mortuary/body store space is limited noted by the regular transfer of patients to the Royal Gwent hospital body store by a named funeral director (SLA not witnessed/assessed). Contingency arrangements across the Heath board not assessed and to be followed up during the reinstatement visit.

There is a viewing room. Viewing patients in the Mortuary is by appointment service only, facilitated by Mortuary Staff.

There is no evidence of CCTV footage audit for the mortuary body store and the last audit of swipe card access took place in November 2023. There is no CCTV in the body fridge area to ensure patient safety (Finding raised).

There are major accommodation and environmental concerns which do not meet the requirement of the standard.

Equipment including calibrations, acceptance testing and associated records

Calibration and metrological traceability to ISO17025 of temperature monitoring system to assure satisfactory storage (integrity) of patients in fridges and freezers and alert mechanism should there be deviation in temperature of these equipment not assessed. Service reports and acceptance testing records of equipment not assessed, to be reviewed during the reinstatement visit.

Pre-examination procedures including information for users and request forms

Mortuary user information including contact details and opening hours not assessed and will be reviewed at the reinstatement visit. Mortuary notification sheet includes name, DOB and ward (hospital patient)/address (community patient) - 3 PID identifiers used to admit and release patients.

Sample transportation

Deceased are received from hospital (GUH, Royal Gwent and Nevill Hall hospitals) and community. Porters bring in deceased from GUH wards using trolleys from the mortuary. Funeral directors bring in patients from Royal Gwent and Nevill Hall hospitals and community. Patient returned from RGH for post mortem and/or release from GUH site is 'not always' recorded in the mortuary register, as stated above there are inconsistences in relation to the completion of paperwork and the LIMS.

Sample reception
Deceased are admitted with a patient record form and PID identifiers is tied on wrist (hospital patient) and toe (community patient). Mortuary/body store - body reception and storage - Patient details from mortuary notification are entered by mortuary staff in mortuary register and later on LIMS TrackCare (using unique mortuary register number) at earliest possible convenience by the mortuary staff. A separate mortuary database is maintained (and updated) by CAD. The release procedure MO 007 states the use of 3 Identification points - name, dob and address, the unique mortuary registration number is not included on the patient. It is recommended if this identifier is used for patient management that it is included as one of the checks carried out and included on the body (Recommended finding raised)

Overall, the pre-examination processes are fit for purpose.

Examination processes including procedure documentation, validation, verification and uncertainty
SOPs covering the admission, storage and release of deceased were witnessed. There were clearly written and easy to follow. The content adhered to 5.5.3. All were document controlled and available on Q-pulse. Staff are aware of the SOPs witnessed evidenced by their knowledge and understanding of the processes. Body store staff have access to Q-pulse for SOPs and mortuary related documents in the mortuary.

Mortuary/body store use mortuary register and LIMS TrackCare to maintain patient details of patients admitted/released and storage location.

SOP MO 0092 states that condition checks of patients should take place at 14 days and 21 days thereafter, there is no documented evidence that this is being carried out (Finding raised)

Improvement required to show compliance with the standard.

Advisory services
This advice is provided at Pathology governance level by pathology governance manager, clinical lead, department manager, operational manager, senior APT and quality lead.

Mechanisms to periodically review examinations provided to ensure that they are clinically appropriate
There is currently a 3-week backlog of patients awaiting post mortem, this has an adverse effect on the condition of the patient. Evidence of prioritisation and a risk assessment has not been seen during this assessment (Finding raised).

Record control
Patient records in Mortuary are maintained in mortuary register and LIMS TrackCare. CAD team also maintain/update deceased patient records.

Next Step

Assessment Manager – Submit report for decision making to ratify the recommendation to suspend the mortuary service from the current scope of accreditation

Customer – Submit evidence to address the mandatory findings

Assessment Manager – Carry out a review of current status at 3 months

Assessment Manager – Carry out on site review of evidence to address mandatory findings and to carry out an assessment of all mortuary activities and the QMS to review suitability to reinstate accreditation

References

BS EN ISO 15189:2022: Medical Laboratories – Requirements for Quality and competence (ISO 15189:20122)

TPS 47: UKAS Policy on Participation in Proficiency Testing (Edition 5 - January 2023)

EPTIS: European PT Information System: Inventory of regularly operated PT schemes in EPTIS-participating countries

Office for Product Safety and Standards: Accreditation Logo and Symbols: The National Accreditation Logo and Symbols: Conditions for use by UKAS and UKAS accredited organisations. Guidance – February 2024 (Department for Business, Energy, and Industrial Strategy; DBEIS)

GEN 6: Reference to Accreditation and Multilateral Recognition Signatory Status by UKAS Accredited Bodies (Edition 2 - December 2022)

F044: UKAS Customer Agreement (Issue 4, November 2022) clause 3.4

Report End

Agenda Item 2.5 (New Version)

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 July 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	An Approach to Developing a Quality Assurance Framework for Commissioned Services
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing Dr James Calvert, Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Ann-Marie Matthews, Lead for Clinical Commissioning/IPFR Tracey Partridge-Wilson, Deputy Director of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper seeks to introduce the proposed approach to developing a Quality Assurance Framework for Commissioned Services to the Patient Quality, Safety and Outcomes Committee, and explain the current limitations, and proposed further development work required.

Cefndir / Background

Aneurin Bevan University Health Board has a statutory responsibility to provide healthcare services that meets the needs of our population. Our strategic aim is to ensure there is equitable access to safe, effective, and sustainable services, as close to a patient's home as possible, within available resources. We achieve this by directly providing healthcare or by commissioning healthcare from other service providers.

Aneurin Bevan University Health Board, like many health boards, have had to respond to more challenging performance and financial positions, as well as changes within the commissioning landscape, particularly since the COVID pandemic.

Commissioning plays a critical role in driving quality and improvement and setting out longer term goals with providers by way of setting standards, focussing on improvement in effectiveness, whilst ensuring that patients are at the forefront.

This approach to developing a Quality Assurance Framework for Commissioned Services (QAF-CS) sets out the key principles and approach to commissioning for quality, providing a structure which should be used to support the development of consistent, high quality commissioning practices and associated improvements in outcomes to ensure the Health Board is operating effectively to commission safe, high-quality and sustainable services for our residential population – including the ability to recognise any early action and systematic deterioration in care within a provider organisation.

Asesiad / Assessment

The Health Board is primarily a provider organisation; however, a proportion of its budget is devoted to securing healthcare services, including unscheduled and planned care from neighbouring NHS Wales Health Boards and NHS Trusts in England. This in part is due to our geographical location and cross-border arrangements. The QAF-CS) seeks to describe a continuous assurance process to ensure that the services we commission are safe, personal, effective and continuously improving.

What is commissioning

In basic terms, commissioning is often described as the purchasing of NHS services from other organisations to meet the health needs of a local population. Aneurin Bevan University Health Board aims to commission services that improve the health and wellbeing of our residential population using a continual process of planning, agreeing, and monitoring our healthcare services. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

This shift towards a more collaborative approach to planning and improving services means that, instead of focusing on procurement and contract management, we will continue to work closely with key partners across the system (including providers) to understand population needs, determine key priorities, and design, plan, and resource services to meet those needs.

Commissioning for Quality

Quality should be at the heart of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales.

Poor quality care can also be costly in terms of harm, waste, and variation. The Health Board needs to ensure that we are operating effectively to commission safe, high-quality, and sustainable services within the resources available, delivering on our statutory duties whilst driving continuous improvement in the quality of services and outcomes achieved for patients.

NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these quality governance arrangements is

to help organisations and their staff both monitor and where necessary, improve standards of care.
The Health Board already has a clear commitment to ensure the provision of safe and high-quality services, supported by corporate frameworks and improving risk management. Value and behaviours are well established, and the introduction of the new Quality Strategy is further strengthening the Health Boards operational governance. The synergy between these two documents therefore ensures that quality and safety is at the forefront of all we do.

Record of providers and Quality Assurance Data
NHS Long Terms Agreement (LTAs) and Service Level Agreement (SLAs) between NHS bodies for healthcare in relation to NHS statutory functions are embedded in the NHS (Wales) Act 2006. They are not legally enforceable contracts. Within Wales the arbitration process is through the Welsh Government.

Where there is private sector involvement, contracts are legally binding, and procurement is via the NHS shared Services Partnership in line with Standing Financial Instructions. All Wales Frameworks should therefore be used where available.

The commissioning arrangements for some healthcare services are on a collective all-Wales basis. The Joint Commissioning Committee (JCC) is responsible for the joint planning and commissioning of specialised and tertiary services on behalf of all Health Boards in Wales.

Where Aneurin Bevan University Health Board is the commissioner, the principles of good contract management remain an important part of the wider commissioning process. However, commissioning is about more than ensuring providers meet their agreed obligation as it can not only help the Health Board identify and manage its own and its providers risks but can help achieve saving and continuous improvement.

Each Division is responsible for ensuring the services that fall within their service areas are commissioned appropriately and effectively and have adequate monitoring arrangements in place. Further work however may be required by some Divisions to strengthen these arrangements following agreement of this approach to a QAF-CS. As such, whilst the fundamental principles underpinning this approach should be adhered to, we recognise that due to the diversity of each service area, the implementation frameworks for each Division will need to be tailored to drive forward the quality assurance and quality improvement of their respective service areas.

The Central Financial Commissioning team are responsible for agreeing the Health Boards larger LTAs and SLAs, with regular monitoring and performance meetings taking place with providers to ensure adherence to the contracts.

There are currently several ways in which Divisions receive and feedback information regarding commissioned services. This includes inspection reports and both qualitative and quantitative feedback. Whilst some Divisions have developed registers and systems to aid their commissioning processes, it is recognised that the

Health Board does not have a standardised register of commissioned services and some Divisions hold better records than others.

Further development

Further work is required to identify what information is currently available in relation to commissioned services, such as what documented agreements are available, and what areas require further detailed work including whether adequate monitoring processes are in place. However, there may be challenge in terms of acceptance by the Divisions A working group should therefore be developed to review commissioning for quality processes within each Division and to consider processes for testing change and implementation.

In relation to patient experience, the Datix system provides an option to record which organisation the concern relates to and who is leading on that concern. Further work is required to ascertain whether Divisions are reviewing the numbers of concerns/incidents reported for providers in order to detect any potential deteriorating quality in service provision.

Discussions have taken place between the Lead for Clinical Commissioning/IPFR and the Finance Business Partner – Commissioning, and work has commenced with the Divisions to create a central map/register of commissioned services across the Health Board.

Development of a small commissioning working group is also proposed to identify any areas where further support is required to wider aspect of commissioning, including the development of best practice guides and thus developing a pool of 'experts' by building knowledge in this area.

Argymhelliad / Recommendation

The Patient Quality, Safety and Outcomes Committee is asked to discuss this approach to developing a Quality Assurance Framework for Commissioned Services and to note the progress and direction for further areas of development in relation to quality for commissioned services.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.3 Quality Improvement, Research and Innovation Governance, Leadership & Accountability 3.1 Safe and Clinically Effective Care Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Regional Solutions
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	N/A
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives

Quality Assurance Framework for Commissioned Services

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

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1 INTRODUCTION

Aneurin Bevan University Health Board has a statutory responsibility to provide healthcare services that meets the needs of our local population in accordance with the NHS (Wales) Act 2006, the Well-being of Future Generations (Wales) Act 2015, Social Services and Wellbeing (Wales) Act 2014 and Cross Border Healthcare Services (April 2013). Our strategic aim is to ensure there is equitable access to safe, effective, and sustainable services, as close to a patient's home as possible, within available resources. We achieve this by either directly providing healthcare or by commissioning healthcare from other service providers.

Commissioning is defined as the continual process of planning, agreeing, and monitoring our healthcare services. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

Quality assurance is the responsibility of all who work in healthcare, and dependent on our role, we become accountable in different ways for the decisions we make. At the heart of those decisions is the need to ensure that the Health Board is operating effectively to commission safe, high-quality, and sustainable services within the resources available, delivering on our statutory duties whilst driving continuous improvement in the quality of services and outcomes achieved for patients.

This Quality Commissioning Assurance Framework sets out the key principles and the approach to commissioning and should be used to support the development of consistent, high quality commissioning practices and associated improvements in outcomes for our residential population.

This document does not seek to dictate every step taken in commissioning, given the wide scope of service commissioning across the Health Board. **Rather, it is a compass to guide our work and decision-making**, recognising the professional expertise and vital systems we already have in place throughout the organisation.

We will be able to fully meet our ambitions for quality health and care services by collaborative commissioning in partnership with external local and regional providers and partners, with our patients, with colleagues from across the Health Board, and with other colleagues supporting public services. This framework sets out a shared set of principles and practical guidance for actions, responsibilities, and expectations for commissioning.

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain. These are set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020;
- A Healthier Wales.

The development of our Health Board's Quality Strategy supports the new legislative requirements.

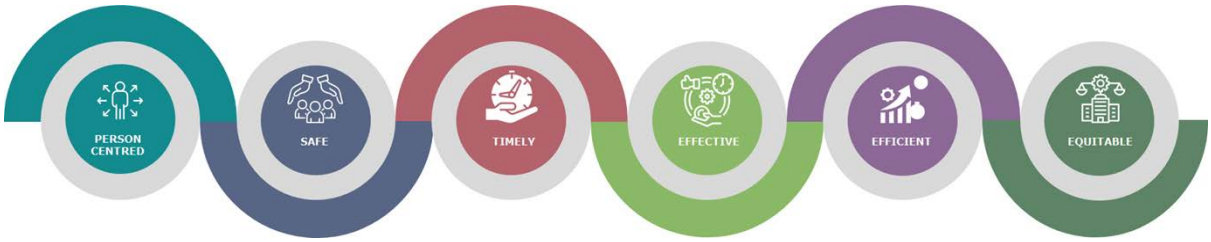
The Health Board's Quality Indicators have been aligned to the six domains of quality: person-centred, safe, timely, effective, efficient and equitable. These outcomes and indicators collaboratively establish a set of quality indicators that align with the Health Boards priorities and strategic goals. The indicators cover all aspects of care, clinical outcomes, patient safety, patient experience, and efficiency.

This framework does not sit in isolation and should be read in conjunction with both the Health Boards wider strategies and any National Frameworks in place in relation to the service area.

2 QUALITY

Numerous definitions of quality relating to health and care services have been described by various global organisations, including the Institute for Healthcare Improvement and World Health Organisation. However, *The Duty of Quality Statutory Guidance and Health and Care Quality Standards 2023 WG23-12*, issued by the Welsh Government on 1st April 2023 serves a dual purpose of providing statutory guidance which helps NHS bodies in Wales deliver the requirements of the duty of quality, and also sets out the new Health and Care Quality Standards issued under section 47(1) of the Health and Social Care (Community Health and Standards) Act 2003.

Quality is considered to be defined as continuously, reliably, and sustainable meeting the needs of the population that we service. In order to achieve this, Aneurin Bevan University Health Board needs to ensure that the health services we provide, and commission are in line with the six domains of quality outlined in our Quality Strategy - **S**afe, **T**imely, **E**ffective, **E**fficient, **E**quitable and **P**erson-Centred. These quality dimensions provide a framework to assess quality and guide improvement and will be at the forefront of the services we provide.



3 QUALITY IN COMMISSIONED SERVICES

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The framework is not introducing any new concepts for the Health Board but builds on the foundations of current practice. We recognise that the Health Board is operating under a changing environment, with considerable challenge to both the Health Board and the patients we support.

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as early as possible, with the aim of working in partnership to improve the services commissioned.

Reasons for escalation could be triggered by a single event or a combination of factors which may relate to, but are not limited to: -

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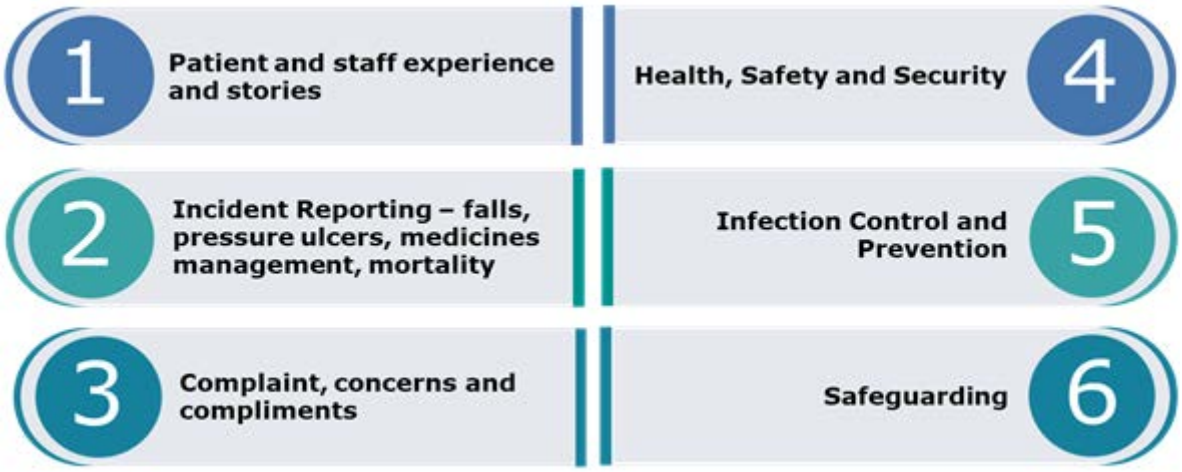
- Repeated failure to deliver agreed improvement plans and/or an inadequate response to address the concerns raised.
- Financial management.
- Serious concerns raised by Healthcare Inspectorate Wales, Care Inspectorate Wales, Llais, Welsh Government intervention processes or other professional bodies.

Routine monitoring should be undertaken for all commissioned services and is the terms used when there are no identified concerns with delivery of the service. These are currently mapped to the pillars of quality and include: -



Where there are concerns, and a lack of assurance in terms of improvement, the escalation process takes place. This process is structured to allow engagement with providers, local and regional commissioners, and regulators where necessary. It is a system whereby there is continuous service improvement or decommissioning if necessary.

Whilst we recognise each service will have its own escalation process in place based on the services commissioned, these should be aligned to a tiered approach

similar to the Welsh Government (NHS Wales Escalation and Intervention Arrangements 2014): -

- Routine monitoring
- Escalated monitoring
- Escalated intervention
- Escalated measures
- Decommissioning

Risks should be reported within Divisional Risk Registers and shared with the Patient Safety and Quality Operational Group.

The approach to escalation and intervention where there are matters of concern that need to be addressed should also be aligned to the organisations Operational Framework.

ESCALATION METHODOLOGY

Each Division should have in place processes for the routine monitoring of commissioned services to ensure they are effective and deliver quality and safe care to patients, including performance monitoring. A critical gap in the system of oversight of quality and safety was identified in the Francis report, which arose from the inability of commissioners to collect information on provider quality and to understand and make use of contractual mechanisms that were available to them. This methodology outlines the process for managing the escalation process in response to such concerns.

The escalation process should be a 'step-up, step down' process. There should be a proportionate approach which considers the degree of risk for Gwent patients. For example, a small number of Gwent residents may attend a large organisation in Special Measures, but the specific service used by Gwent residents may not be a cause for concern.

ESCALATED MONITORING

The Division must demonstrate that it is taking a pro-active response to put in place effective processes to address the issue(s) and drive improvement. Monitoring will be more frequent than that carried out under routine arrangements and may also take a wider variety of forms, including regular communication and meetings in addition to written progress updates and submission of evidence, including updated action plans and qualitative and quantitative data.

The investigation will lead to one of three possible outcomes: -

- No further action necessary. Concerns and finding logged and routine monitoring continue.
- Action and review date agreed. Concern(s), findings and action plan logged, and monitoring of the action plan arranged. Consideration should be given as to whether a risk assessment is required.
- Commissioning quality visit required i.e. further escalation required

ESCALATED INTERVENTION
The nature and focus of a commissioning quality visit will vary depending upon the circumstances of the issue in question. In instances where there is insufficient evidence available to make a judgment on the degree of concern further evidence collection may be required prior to the visit. This might include an external review, collection of patient experience data, a self-assessment report from the provider etc.

The visiting representatives from the HB will be in line each Divisions Implementation Framework. Where sufficient evidence already exists to support the concerns raised, it is likely that the visit will take the form of an action planning meeting. These meeting will typically utilise a flexible agenda based around developing an action plan for addressing the issue(s) with agreed timescales and responsibilities.

The visit may lead to one of the following outcomes: -

- No further action necessary. Concerns and finding logged and routine monitoring continue.
- Action and review date agreed. Concerns, findings and action plan logged and monitored.
- Risk assessment undertaken and logged on the Divisional Risk Register.
- Insufficient progress leading to a serious concern regarding on-going patient care at the provider. The provider will be designated to 'escalated measures.'

Dependent on the seriousness of the issue(s), the Deputy Chief Operation Officer will arrange a meeting between the Medical Director of the Health Board and the provider organisation. The Health Boards Commissioning Team should also be notified.

ESCALATED MEASURES
Where there is evidence that the Action Plan emanating from the escalated intervention has failed to meet the required outcomes as agreed by the Division, the following should be considered: -

- Further action planning
- Penalties
- Decommissioning

Issues to be raised with Chief Executive Officer and with the Executive Committee if necessary. An update should also be provided to the Patient Quality Safety and Outcomes Committee.

	Level of monitoring	**Escalation**	**Meeting frequency**
Level 1 Green	Routine monitoring – Evidence and data should be provided through quality schedules, national assessments and usual data sources and information	None – routine monitoring	As per Divisional implementation plan

	Level of monitoring	Escalation	Meeting frequency
Level 2 **Amber**	Escalated monitoring – Enhanced monitoring via exception and associated remedial actions and trajectory for improvement agreed.	Enhanced Monitoring	As per Divisional implementation plan – Enhanced monitoring
Level 3 **Red**	Escalated intervention Commissioning Quality visit required. Escalated performance monitoring requiring detailed action plans for exceptions	Commissioned Quality Visit required. Escalate to Medical Director and Director for Commissiong if required	As per Divisional implementation plan – Enhanced monitoring
Level 4 **Red**	Escalated measures for performance monitoring and requirement for detailed action plan. As a minimum monthly meeting to review areas where commissioners have serious concerns about quality and patient safety	Escalate to Chief Executive Officer / Executive Committee. Reported to Patient Quality Safety Outcomes Committee	AS per Division implementation plan. CEO led escalated meetings if there are significant and persistent concerns.

7 DE-ESCALATION PROCESS

As the performance improves and the risk assessments indicate a reduction in the level of intervention required, de-escalation should be considered. Discussions should take place within Divisions and an update provided to the Patient Safety and Quality Operational Group.

DECOMMISSIONING

The withdrawal from or closure of an internal or external service by ceasing funding or ending a contract is defined as decommissioning and is an integral part of the commissioning cycle. It is most likely to occur at the end of a contractual agreement, however, could occur during the contract term due to unforeseen circumstances. It is vital that the process of reviewing contracts, including quality of provision, value for money and strategic relevance begins before the contract is due for renewal.

Factors that may lead to the decommissioning of a service may include evidence of poor-quality services; services not aligning to our strategic priorities; the level and type of demand for services has changed; the introduction of alternative or

innovative delivery models, service failing to comply with legislative requirements e.g. safeguarding. A natural end to the contract may also lead to the decommissioning of a contract/service.

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

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 July 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality Commissioning Assurance Framework
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing Dr James Calvert, Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Ann-Marie Matthews, Lead for Clinical Commissioning/IPFR Tracey Partridge-Wilson, Deputy Director of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper seeks to introduce the proposed Commissioning Assurance Framework to the Patient Quality, Safety and Outcomes Committee, and explain the current limitations, and proposed further development work required.

Cefndir / Background

Aneurin Bevan University Health Board has a statutory responsibility to provide healthcare services that meets the needs of our population. Our strategic aim is to ensure there is equitable access to safe, effective, and sustainable services, as close to a patient's home as possible, within available resources. We achieve this by directly providing healthcare or by commissioning healthcare from other service providers.

Aneurin Bevan University Health Board, like many health boards, has had to respond to more challenging performance and financial positions, as well as changes within the commissioning landscape, particularly since the COVID pandemic. Commissioning plays a critical role in driving quality and improvement and setting out longer term goals with providers by way of setting standards, focussing on improvement in effectiveness, whilst ensuring that patients are at the forefront.

This Commissioning Assurance Framework (CAF) sets out the key principles and approach to commissioning for quality, providing a structure which should be used to support the development of consistent, high quality commissioning practices and associated improvements in outcomes to ensure the Health Board is operating effectively to commission safe, high-quality and sustainable services for our residential population – including the ability to recognise any early action and systematic deterioration in care within a provider organisation.

Asesiad / Assessment

The Health Board is primarily a provider organisation; however, a proportion of its budget is devoted to securing healthcare services, including unscheduled and planned care from neighbouring NHS Wales Health Boards and NHS Trusts in England. This in part is due to our geographical location and cross-border arrangements. The CAF seeks to describe a continuous assurance process to ensure that the services we commission are safe, personal, effective and continuously improving.

What is commissioning

In basic terms, commissioning is often described as the purchasing of NHS services from other organisations to meet the health needs of a local population. Aneurin Bevan University Health Board aims to commission services that improve the health and wellbeing of our residential population using a continual process of planning, agreeing, and monitoring our healthcare services. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

This shift towards a more collaborative approach to planning and improving services means that, instead of focusing on procurement and contract management, we will continue to work closely with key partners across the system (including providers) to understand population needs, determine key priorities, and design, plan, and resource services to meet those needs.

Commissioning for Quality

Quality should be at the heart of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales.

Poor quality care can also be costly in terms of harm, waste, and variation. The Health Board needs to ensure that we are operating effectively to commission safe, high-quality, and sustainable services within the resources available, delivering on our statutory duties whilst driving continuous improvement in the quality of services and outcomes achieved for patients.

NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these quality governance arrangements is to help organisations and their staff both monitor and where necessary, improve standards of care.

The Health Board already has a clear commitment to ensure the provision of safe and high-quality services, supported by corporate frameworks and improving risk management. Value and behaviours are well established, and the introduction of the new Quality Strategy is further strengthening the Health Boards operational governance. The synergy between these two documents therefore ensures that quality and safety is at the forefront of all we do.

Record of providers and Quality Assurance Data

NHS Long Terms Agreements (LTAs) and Service Level Agreements (SLAs) between NHS bodies for healthcare in relation to NHS statutory functions are embedded in the NHS (Wales) Act 2006. They are not legally enforceable contracts. Within Wales the arbitration process is through the Welsh Government.

Where there is private sector involvement, contracts are legally binding, and procurement is via the NHS Wales Shared Services Partnership in line with Standing Financial Instructions. All Wales Frameworks should therefore be used where available.

The commissioning arrangements for some healthcare services are on a collective all-Wales basis. The Joint Commissioning Committee (JCC) is responsible for the joint planning and commissioning of specialised and tertiary services on behalf of all Health Boards in Wales.

Where Aneurin Bevan University Health Board is the commissioner, the principles of good contract management remain an important part of the wider commissioning process. However, commissioning is about more than ensuring providers meet their agreed obligation as it can not only help the Health Board identify and manage its own and its providers risks but can help achieve saving and continuous improvement.

Each Division is responsible for ensuring the services that fall within their service areas are commissioned appropriately and effectively and have adequate monitoring arrangements in place. Further work however may be required by some Divisions to strengthen these arrangements following agreement of the CAF. The Central Financial Commissioning team are responsible for agreeing the Health Boards larger LTAs and SLAs, with regular monitoring and performance meetings taking place with providers to ensure adherence to the contracts.

There are currently several ways in which Divisions receive and feedback information regarding commissioned services. This includes inspection reports and both qualitative and quantitative feedback. Whilst some Divisions have developed registers and systems to aid their commissioning processes, it is recognised that the Health Board does not have a standardised register of commissioned services and some Divisions hold better records than others.

Further development

Further work is required to identify what information is currently available in relation to commissioned services, such as what documented agreements are available and what areas require further detailed work including whether adequate monitoring

processes are in place. A review of commissioning for quality processes for each Division is therefore recommended.

In relation to patient experience, the Datix system provides an option to record which organisation the concern relates to and who is leading on that concern. Further work is required to ascertain whether Divisions are reviewing the numbers of concerns/incidents reported for providers in order to detect any potential deteriorating quality in service provision.

Discussions have taken place between the Lead for Clinical Commissioning/IPFR and the Finance Business Partner – Commissioning, and work has commenced with the Divisions to create a central map/register of commissioned services across the Health Board.

Development of a small commissioning working group is also proposed to identify any areas where further support is required.

Argymhelliad / Recommendation

The Patient Quality, Safety and Outcomes Committee is asked to support the adoption and format of the Quality Commissioning Assurance Framework and to note the progress and direction for further areas of development for commissioned services.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.3 Quality Improvement, Research and Innovation Governance, Leadership & Accountability 3.1 Safe and Clinically Effective Care Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Regional Solutions
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	N/A
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives

Quality Assurance Framework for Commissioned Services

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

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1 INTRODUCTION

Aneurin Bevan University Health Board has a statutory responsibility to provide healthcare services that meets the needs of our local population in accordance with the NHS (Wales) Act 2006, the Well-being of Future Generations (Wales) Act 2015, Social Services and Wellbeing (Wales) Act 2014 and Cross Border Healthcare Services (April 2013). Our strategic aim is to ensure there is equitable access to safe, effective, and sustainable services, as close to a patient's home as possible, within available resources. We achieve this by either directly providing healthcare or by commissioning healthcare from other service providers.

Commissioning is defined as the continual process of planning, agreeing, and monitoring our healthcare services. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

Quality assurance is the responsibility of all who work in healthcare, and dependent on our role, we become accountable in different ways for the decisions we make. At the heart of those decisions is the need to ensure that the Health Board is operating effectively to commission safe, high-quality, and sustainable services within the resources available, delivering on our statutory duties whilst driving continuous improvement in the quality of services and outcomes achieved for patients.

This Quality Commissioning Assurance Framework sets out the key principles and the approach to commissioning and should be used to support the development of consistent, high quality commissioning practices and associated improvements in outcomes for our residential population.

This document does not seek to dictate every step taken in commissioning, given the wide scope of service commissioning across the Health Board. **Rather, it is a compass to guide our work and decision-making**, recognising the professional expertise and vital systems we already have in place throughout the organisation.

We will be able to fully meet our ambitions for quality health and care services by collaborative commissioning in partnership with external local and regional providers and partners, with our patients, with colleagues from across the Health Board, and with other colleagues supporting public services. This framework sets out a shared set of principles and practical guidance for actions, responsibilities, and expectations for commissioning.

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain. These are set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020;
- A Healthier Wales.

The development of our Health Board's Quality Strategy supports the new legislative requirements.

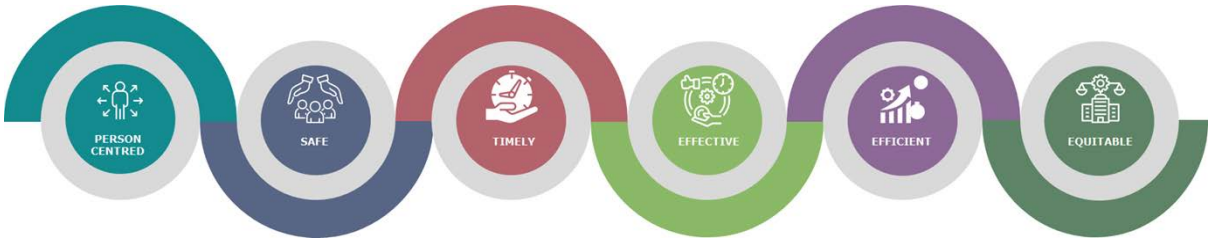
The Health Board's Quality Indicators have been aligned to the six domains of quality: person-centred, safe, timely, effective, efficient and equitable. These outcomes and indicators collaboratively establish a set of quality indicators that align with the Health Boards priorities and strategic goals. The indicators cover all aspects of care, clinical outcomes, patient safety, patient experience, and efficiency.

This framework does not sit in isolation and should be read in conjunction with both the Health Boards wider strategies and any National Frameworks in place in relation to the service area.

2 QUALITY

Numerous definitions of quality relating to health and care services have been described by various global organisations, including the Institute for Healthcare Improvement and World Health Organisation. However, *The Duty of Quality Statutory Guidance and Health and Care Quality Standards 2023 WG23-12*, issued by the Welsh Government on 1st April 2023 serves a dual purpose of providing statutory guidance which helps NHS bodies in Wales deliver the requirements of the duty of quality, and also sets out the new Health and Care Quality Standards issued under section 47(1) of the Health and Social Care (Community Health and Standards) Act 2003.

Quality is considered to be defined as continuously, reliably, and sustainable meeting the needs of the population that we service. In order to achieve this, Aneurin Bevan University Health Board needs to ensure that the health services we provide, and commission are in line with the six domains of quality outlined in our Quality Strategy - **S**afe, **T**imely, **E**ffective, **E**fficient, **E**quitable and **P**erson-Centred. These quality dimensions provide a framework to assess quality and guide improvement and will be at the forefront of the services we provide.



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as early as possible, with the aim of working in partnership to improve the services commissioned.

Reasons for escalation could be triggered by a single event or a combination of factors which may relate to, but are not limited to: -

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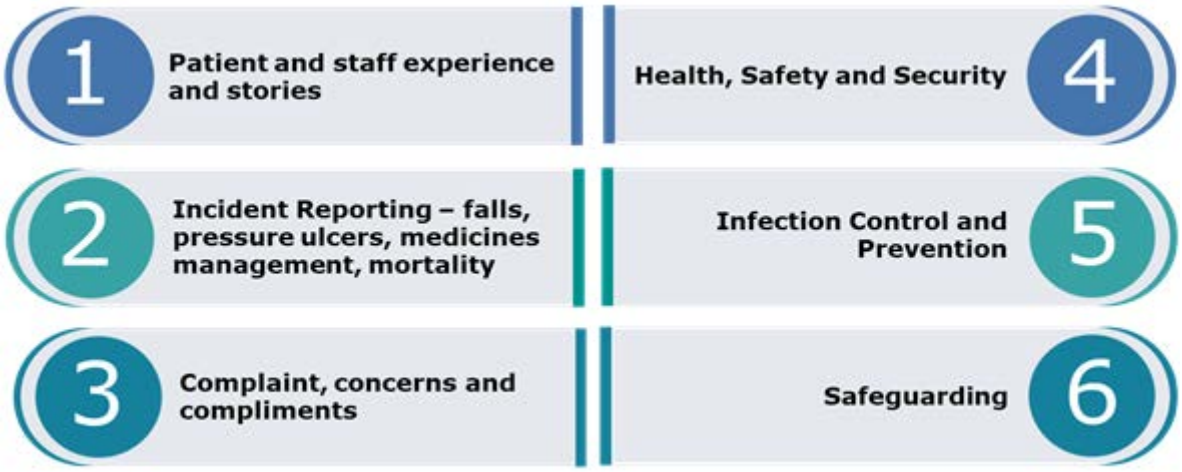
- Concerns arising from the examination of qualitative and quantitative data. For example, raised mortality rates, deteriorating infection profiles, or concerning patient harm reports.
- Alternatively, a worrying set of workforce metrics (for example in relation to Nurse Staffing Levels (Wales) Act 2016, or credible soft intelligence which is not readily accounted for by the provider.
- Repeated failure to deliver agreed improvement plans and/or an inadequate response to address the concerns raised.
- Financial management.
- Serious concerns raised by Healthcare Inspectorate Wales, Care Inspectorate Wales, Llais, Welsh Government intervention processes or other professional bodies.

Routine monitoring should be undertaken for all commissioned services and is the terms used when there are no identified concerns with delivery of the service. These are currently mapped to the pillars of quality and include: -



Where there are concerns, and a lack of assurance in terms of improvement, the escalation process takes place. This process is structured to allow engagement with providers, local and regional commissioners, and regulators where necessary. It is a system whereby there is continuous service improvement or decommissioning if necessary.

Whilst we recognise each service will have its own escalation process in place based on the services commissioned, these should be aligned to a tiered approach

similar to the Welsh Government (NHS Wales Escalation and Intervention Arrangements 2014): -

- Routine monitoring
- Escalated monitoring
- Escalated intervention
- Escalated measures
- Decommissioning

Risks should be reported within Divisional Risk Registers and shared with the Patient Safety and Quality Operational Group.

The approach to escalation and intervention where there are matters of concern that need to be addressed should also be aligned to the organisations Operational Framework.

7 DE-ESCALATION PROCESS

As the performance improves and the risk assessments indicate a reduction in the level of intervention required, de-escalation should be considered. Discussions should take place within Divisions and an update provided to the Patient Safety and Quality Operational Group.

Agenda Item – 2.5

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

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 July 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Maternity Services Improvement Plan 2024-27
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade – Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Jayne Beasley - Head of Midwifery

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to advise on the Maternity Improvement Plan which aims to determine how Aneurin Bevan University Health Board maternity service will achieve high quality maternity care and details their approach to providing individualised care, reductions in health inequalities, improves, innovates and develops to meet the needs of those who access the service and those who work in it.

Cefndir / Background

Aneurin Bevan University Board maternity services serves a diverse population with high levels of socio-economic deprivation across a wide geographical area. Maternal deprivation is linked to disparities in health with 29.5% of Aneurin Bevan births being from the most deprived areas. In conjunction with levels of deprivation there is an increase in the complexity of women and babies, increasing births via caesarean section, rising rates of obesity, smoking, perinatal mental health and low levels of breast feeding are evident. Midwives are key to providing education, information and targeted intervention to increase life chances for babies and improve health outcomes and birth experience for women.

A number of key strategic reports have been developed to drive change to improve health, health outcomes and reduce inequalities, and to ensure safe practice is at the heart of health care. It is with these reports in mind that the maternity improvement plan has been developed.

- Maternity Care in Wales a 5-year vision 2019
- Healthier Wales 2018
- The maternity and neonatal safety programme 2022
- CNO priorities 2022-2024
- Nursing, Midwifery, SCPHN workforce strategy 2023-2026
- ABUHB IMTP
- Anti-Racist Wales by 2030 action plan Welsh Government
- 5 Year vision for breastfeeding

Asesiad / Assessment

The improvement plan details how care will be delivered through a number of key themes. Focussing on women babies and families through the life course, pregnancy, birth and the postnatal period, and on those that are working to provide care. The improvement plan includes a multidisciplinary review and this has been compiled into a priority plan, around improvement work, including timeframes covering a 3-year period 2024-2027.

Improvements and high-quality care will be delivered through several key themes:-

1) The Population – Women, Families and Babies
With a commitment to delivering improvements in antenatal care through targeted public health intervention, supporting choice, continuity and building.

2) Safe Effective Care
Maternity services will ensure a robust governance structure where continuous learning is in place to aid improved outcomes and multidisciplinary teams are work within a safe supportive working environment.

3) Workforce
We will commit to a positive work environment where a positive learning culture is fostered, whereby multi professional teams train and work in a culturally safe environment.

4) The Future of the Service
Maternity service will be involved in innovation improvement, research and development to ensure safe effective high-quality care.

Within these key themes are a number of work streams. The following table articulates a number of actions under specific work streams.

Workstream	No. of Actions
Antenatal Care	9
Public Health	7
Infant Feeding	8
Patient Experience	4
Governance	7
Bereavement care	4
Infection prevention	6
Training	8
Intrapartum care and birth	5
Culture	11
Staff development	5
Workforce	8
Digital technology	4
Pathways of care	4
Environment	2
Research and Development	3
Total	**95**

A number of these workstreams are already in progress for 2024 and form part of maternity services IMTP.

Quarter 1	Completed
Care delivered through trauma informed model	√ introduced to mandated training
Women supported re birth plan	√
Healthy lifestyle	√
Inform all parents (bereaved) review take place	√
Daily emergency checks	Ongoing monitoring
Cleaning hand hygiene audits	Ongoing monitoring
90% MBRRACE reported <7days	√ linked in with NICU
Caesarean section SOP	Work ongoing
4 hours mandated CSfM	√
Wellbeing peer supporters across all areas	√ Audited through CSfM
Support flexible working arrangements	√
Leadership academy band 7 & 8	√
Birth rate plus compliance	√ additionality not included
Education for midwives Bsc and Msc	√
Recruitment drive & improvement	√
Positive public promotion	√
Implementation of safe care	
Digitised process for training records	In progress
Dedication to research	√

Quarter 2	Completed
Caring for you campaign	√
100% women signposted healthier together	√
Early access to specialist care for women with underlying conditions	√
100% women informed re hygiene and wound care	√ ongoing audit via badgernet signposted healthier together
100% women low risk able to chose birth in any setting pathway	√ push notification via badgernet
Audit entenox in environment	√ first pilot results for review

Argymhelliad / Recommendation

The Patient Quality, Safety and Outcomes Committee is asked to note the ongoing work to implement and embed improvements within maternity services.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 7. Staff and Resources 7.1 Workforce Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Workforce and Culture Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	

Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

ABUHB MATERNITY SERVICES IMPROVEMENT PLAN 2024-2027

WOMEN, FAMILIES AND BABIES

RECOMMENDATIONS :-

There will be a commitment to informed choice, respect and compassion in care provision for women and their families. Decision making, which places women, families and babies at the centre of care provision is paramount to building trusting relationships and empowering parents. Choice and personalised care will be provided according to women's need and wishes. Health promotion will be embedded through care to improve outcomes.

Maternity services will work in partnership with women and families, care will be personalised to provide women with choice and the ability to make informed decisions regarding their care.
We will commit to: -

- Providing choice
- for place of birth
- Providing excellent experience for women families and babies
- Supporting women to make informed choices, based on good quality information and the best available evidence.
- Improve women's health through public health messaging
- Safer pregnancy campaign
- Ensuring a positive care experience
- Improving equity of access and a reduction in health inequalities
- Working in co-production with other health professionals
- Acting on and seeking out feedback
- Working in line with maternity network re midwifery led care standards

Ante-Natal Care

Action	Measurement of Success	Progress	Lead	Quarter	Year
Develop a pregnancy registration form to ensure women can book with community	80% of women who will have been booked for their pregnancy by 10/40.		SMM community	4	2024

midwife via direct access to maternity service from 6/40 gestation.	Early access to specialist antenatal care for women with underlying health conditions.	Diabetic clinics in place with early access		2	2024
Community Midwives to ensure health messaging and choices for birth are provided in the antenatal period	100% of women are sign posted to Healthier together website. 100% of women are supported to write their birth plan by 36/40 gestation Increase options for outpatient induction at all LGH sites	Monitored via badgernet for audit Available at all sites	SMM Community	2 1 4	2024 2024 2024
Mandatory training to incorporate trauma informed care to acknowledge the lived experience and support the premise of choice, safety, collaboration, empowerment, culture and trust.	Care will be delivered through a trauma informed model.	Planned for mandated training Sept 24	Consultant Midwife	1	2024
Development and implementation of the Midwife led diabetes pathway for women with gestational diabetes.	Women with GDM will follow a pathway of care supported by the lead midwife for diabetes.	Appointment of lead midwife for diabetes	Diabetic Lead Midwife	1	2026
Support midwifery sonography training for 24/25 to optimise scanning across service	All at risk women receive USS in line with GAP and GROW & SFGA guideline	3 midwives undergoing training 24/25	Head of Midwifery	4	2025
Adoption of the All-Wales Family Engagement Framework	Positive patient experience and collaborative working with robust governance processes	All Wales work - In development and in draft	Head of Midwifery	4	2026

Public Health					
Action	**Measurement of Success**	**Progress**	**Lead**	**Timescale Quarter**	**Year**
MECC training incorporated into mandatory training	95% midwives will have completed MECC training.	Monitored via PDM	Public Health Midwife	3	2024
	100% women will have Carbon monoxide monitoring	PPD request for additional Carbon monoxide monitors		4	2025
	100% of eligible women offered/signposted to vaccination	For Audit 2024		4	2024
	Women will be encouraged to maintain a healthy lifestyle and all women who smoke will be offered specialist smoking cessation support, good quality health information	In place		1	2024
	Delivery of brief advice/intervention by midwives to all pregnant women with a BMI of 25+	In place		4	2025
Weight management support will be offered for those women with a BMI 30-35. Specialist one to one support for those with a BMI greater than 35. With Weight Management postnatal support groups	Improved outcomes for birth and breast feeding rates	Waiting confirmation of funding	Public Health midwife	4	2025

Increase volunteer service within black and Asian communities and learning from experience.	There will be an inclusive service which targets improved outcomes for global majority women	Ongoing work to recruit from within communities	Consultant Midwife	3	2025

Infant Feeding					
Action	**Measurement of Success**	**Progress**	**Lead**	**Quarter**	**Year**
Midwives will encourage all mothers and babies who are able to be kept together and ensuring skin to skin contact following birth.	100% compliance with skin to skin where able	Auditable via digitised records	SMM	4	2024
	100% Women who wish to breast feed offered support to breast feed/ express within an hour of birth.	New training in development for 2024/25		2	2024
Improve midwifery support and education regarding infant feeding	Implementation of 3 tiers of support for infant feeding support There will be peer support groups in all areas and a champion team of midwives with additional skills in breastfeeding.	Working group in place with HV services to undertake	Lead Midwife for Infant Feeding	2	2024
	5 midwives complete train the trainer BFI course.	Names sought		4	2025
	Achieve Baby friendly accreditation.			3	2026
	100% of women with GDM are offered support to harvest breast milk.	Supported through ANC		4	2024

Lead midwife for infant feeding and public health midwife are supported to undergo training in frenectomy	Establishment of Tongue Tie Pathway	Training commenced	Head of Midwifery	1	2025
Patient Experience					
Action	**Measurement of Success**			**Quarter**	**Year**
Adoption of CIVICA across the service	Measurement of patient experience through patient reported outcome measures.	Civica in place but limited usage currently	Head of Midwifery	4	2024
Inform all parents of babies who have died that a review will take place with feedback.	100% of families have a completed review of their care via PMRT.	PMRT embedded into service – feedback provided	Lead Midwife for Bereavement	1	2024
Collaboration of maternity and neonatal voice partnership with a focus on health inequalities and ensuring that the voices of people with protected characteristics are represented.	This will be achieved through formal MNVPs, BABI roadshow and the maternity volunteer service.	Partnership working commenced	Consultant Midwife	4	2025
Women will have access to a consultant midwife or to the perinatal mental health service where their needs are more complex.	100% of women who feel that they require support after birth are offered a debrief	After birth services implemented REWIND training completed	Consultant Midwife	1	2025
Monthly monitoring of all concerns within the directorate	The 30-day response times for formal concerns to increase to 80%, with majority of	Reduction in formal concerns increase in debrief	Head of Midwifery/Lead Midwife for Concerns	4	2024

	concerns responded to informally within 48 hours.	informal resolution			

SAFE & EFFECTIVE CARE

RECOMMENDATIONS:-

We will aim to deliver multi professional, timely, equitable, high-quality evidence-based care using continuous improvement as well as learning from concerns, incidents, trend's themes, experience and feedback.

Maternity services will ensure a robust governance structure where continuous learning is in place to aid improved outcomes and multidisciplinary teams are work within a safe supportive working environment. We will commit to: -

- Transparent governance system, with identification of themes and trends
- Evidence based learning culture
- A reduction in avoidable harm
- Standardised guidelines policies and processes
- Risk assessment during pregnancy
- Monitoring and fetal wellbeing
- MDT training incorporating human factors

Governance

Action	Measurement of Success	Progress	Lead	Quarter	Year
Working group to review the mat/neo dashboard and reporting mechanisms to include IT neonates and maternity	Implementation of combined maternity and neonatal dashboard with accurate data reporting of real time clinical outcome measures.	Ongoing work with IT	Service Improvement Manager	4	2024
Thematic analysis of ATAIN data and monthly shared learning through MDT perinatal meeting	Reduction in term admissions.	Reviewed as part of MDT risk meetings	Safety champion	4	2024

Review of governance structure and support in maternity	Dedicated governance team with allocated sessional time lead midwife, governance lead midwife, consultant and admin support.	Admin support sourced, lead midwife in post and consultant	Head of Midwifery	3	2024
All investigators trained to undertake their roles.	Timely, compassionate and thorough investigative reports All adverse outcomes investigated sensitively within time frames and in collaboration with families.	Training dates shared	Head of Midwifery /Clinical Director	4 3	2025 2025
Maternity staff engaged in the All-Wales group reviewing the MEOWS chart.	Adoption of the All-Wales Meows chart. Standardisation of care across Wales	Draft Meows circulated for comment – shared with staff	Safety Champion	4	2024
Daily emergency equipment checks and fridge temperature compliance	100% compliance with daily equipment checks and fridge checks	Monitored via SMM team weekly	SMM	1	2024
Bereavement					
Action	**Measurement of Success**	**Progress**	**Lead**	**Quarter**	**Year**
There will be a MDT commitment to PMRT review, to include external review.	100% of all stillbirths and all babies who died in the Health Board will have a formal review 90% MBRRACE reporting within 7 days.	Monthly review in place Joint meeting with neonatal service to determine requirement	Lead Midwife for Bereavement	4 1	2025 2024

	Adoption of the Bereavement care pathway.	and increase uptake		4	2026
Monitoring of staff who can undertake Post mortem consent training to ensure adequate staff trained	Ensure all women whose baby died unexpectedly are offered a post-mortem.	Monitored monthly extra dates submitted for band 7 midwives	Lead Midwife for Bereavement	2	2024
Infection Prevention					
Action	**Measurement of Success**	**Progress**	**Lead**	**Quarter**	**Year**
Implementation of caesarean section reducing SSI SOP.	Reduction in SSI 4.5%.	SOP in development	Head of Midwifery	4	2025
	Cleaning hand hygiene audit 100% compliance.			1	2024
	100% women informed hygiene and wound care.			2	2024
	85% staff compliant with ICP & ANTT			4	2024
	WHO surgical safety lists completed for all surgical events.			2	2024

Training					
Action	**Measurement of Success**	**Progress**	**Lead**	**Quarter**	**Year**
Commitment to MDT training with monthly monitoring	95% MDT Prompt training compliance	Review of 2024 compliance data to be undertaken – Mw compliance 95% 2023	PDM Obstetric & Anaesthetic leads	3	2024
	Adoption of IFS standards with monthly MDT IFS training target 95% compliance.	Commenced April 24		3	2024
	100% midwives working in HDU undertaken critical care prompt.			3	2024
	100% midwives working in intrapartum care trained in neonatal life support.			3	2024
Midwives to be trained in safeguarding	80% community staff completed Level 3 safeguarding for community staff.	Bespoke dates circulated	Safeguarding Lead Midwife and corporate safeguarding	4	2025
	85% all staff completed level 2 safeguarding.	Complete		3	2024
Increase in numbers of midwives able to undertake NIPE	25% midwives able to undertake NIPE.	6 additional midwives undergoing training 2024	Head of Midwifery	1	2026

Mandated training for perinatal mental health training.	100% maternity staff receive perinatal mental health training	Incorporated into mandatory training	Lead Midwife for Perinatal Mental Health	3	2024
Labour and birth					
Action	**Measurement of Success**	**Progress**	**Lead**	**Quarter**	**Year**
Optimisation of the pre term infant through commitment to Periprem	85% mothers receive magnesium sulphate, 85% babies will receive breast milk-optimisation 85%	Periprem embedded into practice monitoring in place - 84% compliance magnesium suphate 38% early breast milk – optimisation 66%	Periprem Lead	3	2025
Implementation of Induction of labour pathway	Improve information, communication and reduce delays in transfer to labour ward. Monitored via DATIX	Update of IOL guideline – IOL forum in place	Obstetric leads	4	2024
Midwives to ensure health messaging and choices for birth are provided in the antenatal period	100% of women who have low risk for complications in labour are enabled to consider birth in any setting.	Ongoing	SMM	2	2024
Movement of pool from RGH to GUH	Increased pool usage in GUH midwife led unit	Awaiting W&E	Service improvement manager	4	2024
Embed All Wales guidelines to include All Wales Normal labour pathway and the All-Wales Transfer Policy, through cascade	Adoption of the All Wales pathway across the service.	All Wales Guideline and transfer document shared	Consultant Midwife	2	2025

training, teaching aids and training videos.					

OUR PEOPLE

RECOMMENDATIONS:-

We will continue to invest in our teams, enabling flexibility, developing skilled midwifery staff and leaders of the profession. There will be workforce planning and evidence-based tools to determine staff and appropriate skill mix to meet the needs of the population. Midwives will have continued professional development and specialist roles to develop practice. Support workers will be trained and supported to contribute to care.

Women are listened to and are central to care, listening to their experience will inform service change and delivery. This starts with prioritising staff wellbeing fostering a safe and caring culture within the work place. Maternity staff will feel valued and will work together to improve health and wellbeing.

We will commit to a positive work environment where a positive learning culture is fostered, whereby multi professional teams train and work in a culturally safe environment. Birth rate plus is the current tool utilised to assess appropriate midwifery staffing levels. In April 2023 an updated report concluded the following levels of staffing for The Grange University Hospital, community and outpatient services, Band 3-7 plus specialist midwives and management of 269.47 wte.

To note:

- The service has a 94/6% registered to non-registered staff which could be increased to 90/10% split for postnatal care
- There was a negative variance of – 0.51wte with traditional birth rate plus calculation this increased to 7 wte if calculating additional care provision for training student supervision and births outside of guideline
- Specialist and management roles should account for 26.7 wte the service has 18.6 a deficit of 8.1 wte
- There will be a sustainable workforce with appropriate staffing at all levels.

This will be evidenced by: -

- Psychological safe culture
- Emphasis on a positive health and wellbeing culture
- Create a culture that allows people to speak up
- Visible compassionate leadership
- Provide a positive learning environment
- Ensure staff health and wellbeing is embedded
- Health board values and behaviours

- Develop of new roles, flexible working patterns and career succession opportunity's

Culture					
Action	**Measurement of Success**	**Progress**	**Lead**	**Quarter**	**Year**
Undertake Diverse Cymru's Cultural Competence Certification Scheme : to support good and fair working practices	Cultural competency accreditation.	Work ongoing – working towards	Consultant Midwife	4	2025
There will be a commitment to fostering a safe working environment	95% maternity staff undertake civility saves lives training.	Forms part of mandatory training	SMM team	3	2024
	Human factors incorporated into mandated training.			3	2024
	Refresh and revisit - Caring for you campaign.	Complete		2	2024
	Wellbeing peer supporters across all areas of the service.	Complete		1	2024
	4 hours mandated Clinical supervision for all midwives	Embedded into practice		1	2024
	Safeguarding supervision embedded into practice.	Supported through community only		1	2025
	Succession planning and coaching sessions for all grades.			3	2026

	Implementation of Swartz rounds.	Safety huddle implemented Swartz rounds via Clinical governance		3	2024
	Support for flexible working arrangements	All requests reviewed		1	2024
	Undertake a yearly psychological safety survey			4	2026

Development

Action	Measurement of Success	Progress	Lead	Quarter	Year
All Maternity staff supported to achieve their potential with commitment to retention of all staff	Band 7 & 8 Midwives undertake Leadership academy	Staff supported to attend leadership academy	Head of Midwifery	1	2024
	100% preceptor midwives to undergo Once for Wales preceptorship programme.	Embedded	PDM/CsfM	3	2024
	85% staff have a meaningful PADR, regular catch ups.	66% current	SMM Team	3	2024
	100% midwives have undertaken Student	Complete	PEF	3	2024

	Supervision and Assessment training. 100% staff have an exit interview.	Complete	SMM team	2	2025
Workforce					
Action	**Measurement of Success**	**Progress**	**Lead**	**Quarter**	**Year**
3 yearly Birth rate plus assessment	Birth rate plus compliance.	Completed 2022	Head of Midwifery	1	2024
Workforce review of band 3 and 4 maternity support workers and skill mix	90/10% skill mix split of registrants to non-registrants.	T&F in place to review	Head of Midwifery /Workforce business partner	2	2025
Adoption of safe care	Maternity service to align with health board re ward staffing levels.		Head of Midwifery	3	2025
Undertake a review of the management structure to include Director of midwife consultant midwife and specialist midwifery team, to include succession planning.	Band 6 to band 7 development into specialist roles. Supporting midwives with educational development BSc MSc.	Complete	Head of Midwifery	4 2 1	2024 2025 2024

Proactive management of recruitment through engagement in local community and schools, living the life of a midwife. Open days and careers events and road shows	Reduction in vacancies and turnover of staff	Living the life of a midwife dates for 2024/25	SMM Team	1	2024
Promotion of maternity services	Positive public reception, sharing good news stories, abstracts for conferences.	complete		1	2024

OUR FUTURE

Recommendations :-

Long term sustainable service will be achieved through transformation and quality improvement work. There will be an investment in technology to improve information, education and clinical care and outcomes.

Maternity service will be involved in innovation improvement, research and development to ensure safe effective high-quality care. We will commit to reduce the environmental impact of climate change to reduce emissions. We have an active maternity research service with dedicated research midwives and multiple open randomised control trials and observational studies. We will further embed research within maternity services and midwifery practice, to give all midwives the opportunity to participate in research and subsequently improve outcomes from women and families

We will endeavour to commit to: -

- Digital solutions to support staff to undertake their role
- Ensuring safe working environments
- Wellbeing hubs
- Data collection systems for visible timely learning
- Research and development
- Quality improvement programs
- Improve accuracy of information

Digital

Actions	Measurement of Success	Progress	Lead	Quarter	Year
Maternity records will be digitalised	Digitised records embedded into practice Bespoke reports will be available via Badgernet and real time accessible data collection.	Implemented 2024	Digital Lead Midwife /Project Team	4 4	2024 2024

Digitalised central process for recording training.	All training will be recorded as a rolling year on digitised easy to follow format	Digital lead midwife working on	Digital Lead Midwife	4	2024

Pathways of Care					
Action	**Measurement of Success**	**Progress**	**Lead**	**Quarter**	**Year**
Implement IBSOT.	Improved assessment and triaging of women through the maternity triage unit used		Assistant Head of Midwifery	2	2025
Introduction of PLGF	Reduce length of stay and admissions/ treatment for women with pre-eclampsia.		Lead Obstetrician	4	2026
Development of community HUBS in LGH	Care will be delivered close to home with increased public health awareness	Care delivered in LGH	SMM	2	2025
Review environmental footprint at GUH to optimise capacity	Increase patient flow and reduction in reportable delays in care	Virtual baby ward introduced, IOL pathway, ELCS lounge	Head of Midwifery	4	2024
Environment					
Action	**Measurement of Success**	**Progress**	**Lead**	**Quarter**	**Year**
Audit Entonox exposure within the environment	Recordable levels monitored	Nitrous oxide environment testing commenced	Safety Champion	4	2024

	Ensure safer working environments through nitrous oxide destruction	1x Nitrous oxide destruction machine in place		2	12024
Research & Development					
Action	**Measurement of Success**	**Progress**	**Lead**	**Quarter**	**Year**
Commitment to research projects in collaboration with R&D and quality improvement programmes	Research projects embedded into practice	Complete	Consultant Midwife	1	2024
	Quality improvement programmes embedded through service to address patient flow and pathway.	Ongoing		4	2024
	Monthly QI and research forums embedded in practise and QI training incorporated into mandatory training study days.	Ongoing		4	2024

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

ABUHB Maternity Services

Improvement Plan

2024-2027

Supporting healthy pregnancies, improving maternity care and health outcomes

Important note: We recognise that not all pregnant people will identify as women. When referencing pregnant women throughout this document, this is intended to be inclusive of pregnant and birthing people of all genders.

Foreword

Pregnancy and birth are life changing events for women and their families. Evidence based, person centred, safe and high-quality care during pregnancy, birth and following birth can have a positive impact on the health and life chances of women and babies as well as the healthy development of children throughout life. This can help to reduce the impact of inequalities which can have long term health consequences for families, securing the best possible outcomes for mothers' babies and communities.

This document sets out the vision for achieving high quality maternity care in Aneurin Bevan University Health Board and details our approach to ensuring maternity service provides individualised care, reduces inequalities, improves, innovates and develops to meet the needs of those who access our services and those who work in it.

The Maternity Plan aligns to: -

01 Maternity Care in Wales 5-year Vision 2019

02 Health Wales 2018

03 The Maternity & Neonatal Safety Programme 2022

04 CNO priorities 2022-2024

05 Nursing, Midwifery, SCPHN Workforce Strategy 2023-2026

06 ABUHB IMTP

07 Anti-Racist Wales by 2030 Action Plan, Welsh Government

Introduction

Aneurin Bevan University Health Board Maternity Service provides care during pregnancy, birth and the postnatal period for approximately 6000 women and their families per year. All 4 choices for birth are offered, to include home, freestanding birth unit, alongside midwife led unit and obstetric unit, whilst outpatient services are provided in the Local General Hospitals in line with care close to home.

GRANGE UNIVERSITY HOSPITAL

- Obstetric Unit
- Triage
- High Dependency
- Bereavement Room
- Antenatal & Postnatal Ward
- Midwife Led Unit
- Elective and Emergency Theatres
- Induction Ward

YSBYTY YSTRAD FAWR YSBYTY ANEURIN BEVAN

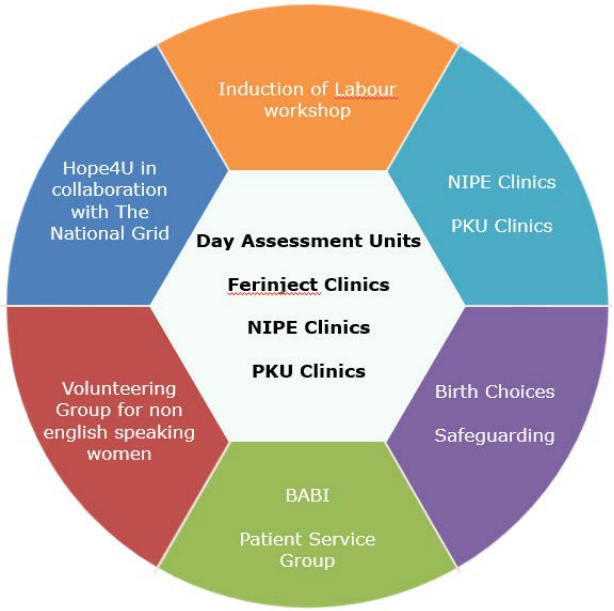
- Midwife Led Birthing Unit
- Outpatient Services

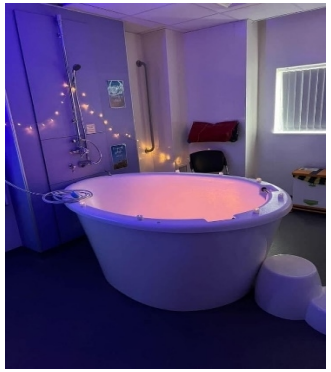
ROYAL GWENT COUNTY NEVILL HALL HOSPITALs

- Outpatient Services
- Community Hubs

What do we provide at ABUHB	Which Hospital site is this offered
Routine Antenatal Clinics	NHH, RGH, County, YAB, YYF
Fetal Medicine Clinics	NHH, RGH
Haematology Clinics	NHH, RGH,
Diabetes Clinics	NHH, RGH, YYF
Sonography Clinics	NHH, RGH, County, YAB, YYF
Epilepsy Clinics	NHH, RGH,
Weight Management Clinics	NHH, RGH, YYF, YAB, County
Perinatal Mental Health Clinics	YYF
Asthma Clinic	RGH
Obstetric Anaesthetic clinic	RGH, NHH
Substance Misuse Clinics	NHH, RGH
Smoking Cessation	NHH, RGH, County, YAB, YYF
Debrief rewind service	Virtual and Face-to-Face
Glucose Tolerance Test (GTT) & Anti D clinics	NHH, RGH, County, YAB, YYF
Maternal Medicine Clinics	NNH, RGH, YYF
FGM Clinic	RGH

Outpatient Services





Acute Services

Emergency Theatres

Elective Theatres

High Dependency Unit

Triage

Alongside Birth Centre

Induction of Labour Ward

Antenatal Ward

Postnatal Ward

Post-op Ward

Free Standing Birth Centre and POD

Population

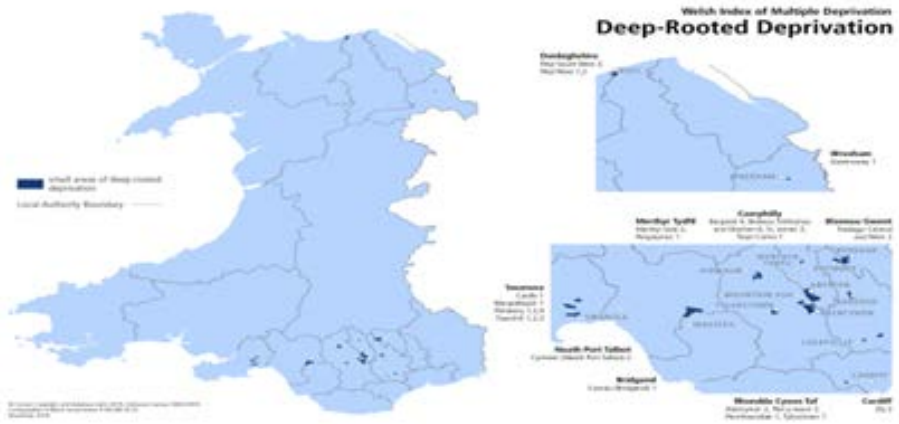
The total population in the Health Board catchment areas is 591,396 people. Those eligible to access Maternity Care ages: -

Age 16-25 = 53,384
Age 25-44 = 84,234

Caerphilly	170,615	169,546	178,782	177,610	177,277	176,735	176,805	175,999	176,130
Blaenau Gwent	72,666	70,000	68,812	67,829	67,566	67,382	67,219	66,989	67,014
Torfaen	90,961	90,912	91,190	90,638	91,130	91,685	92,337	92,454	92,860
Monmouthshire	80,209	84,984	91,508	91,791	91,834	91,370	92,456	93,163	93,886
Newport	135,479	137,642	145,785	153,234	155,222	156,773	158,438	159,687	161,506

Deprivation

Aneurin Bevan University Board serves a diverse population with high levels of socio-economic deprivation across a wide geographical area. Maternal deprivation is linked to disparities in health and an increased risk of adverse maternal and perinatal outcomes. 29.5% of Aneurin Bevan births are from the most deprived areas compared to a UK average of 20%.



Areas shown on the map with deep deprivation in our catchment locality.

Deprivation is linked to: -

- Substance and alcohol misuse
- Raised safeguarding problem
- Increased BMI, and poor nutrition
- Mental Health problems

Risk Factor	Preconceptions+	In Pregnancy	
		Early	Late
Tobacco Smoke	✓	✓	
Bacterial Vaginosis		✓	
Young Maternal Age	✓	These factors can only be impacted preconception	
Birth Interval	✓		
Periodontal Infections	✓	✓	
Sexually Transmitted Infections	✓	Little evidence on intervention available	
Low/High BMI	✓		
Nutrient Deficiency	✓	✓	

+ Preconception intervention includes postnatal interventions within an inter-pregnancy period

Midwives are key to providing intervention over the life course.

Maternity Services has specialist midwives in place to support families to provide safe and effective care. With their professional knowledge and guidance, they encourage and improve wellbeing before, during and after pregnancy, relating to all public health indicators.

- Public Health Lead Midwife & Lead for Substance Misuse
- Perinatal Mental Health Lead Midwife
- Safeguarding Lead Midwife
- Breastfeeding Midwife

Public Health Data ABUHB 2022

Smoking	15.1%
Body Mass Index >35	14.4%
Alcohol Substance Misuse	0.6%
Mental Health – Referral for PNMH	4.5%
Low Birth Weight Babies	6.1%
Breastfeeding	10 days: 47% 6 months: 17%

Summary of Statistics from Antenatal Care

Initial Assessment/Bookings

The percentage of pregnant women receiving their initial assessment by their 10th completed week of gestation decreased by four percentage points in 2022, falling from 71.5% to 67.5%. The percentage was lower for women in the youngest and oldest age groups.

Year (2022)

Area		Number										Percentage							
		Within 10 weeks	11-15 weeks	16-20 weeks	21-25 weeks	26-30 weeks	31-35 weeks	36-40 weeks	41-45weeks	Not stated	Total women	Within 10 weeks	11-15 weeks	16-20 weeks	21-25 weeks	26-30 weeks	31-35 weeks	36-40 weeks	41-45we
Wales		19,822	3,896	518	323	282	259	574	70	821	26,565	77.0	15.1	2.0	1.3	1.1	1.0	2.2	
Wales	Betsi Cadwaladr	4,370	745	108	50	37	31	200	39	10	5,590	78.3	13.4	1.9	0.9	0.7	0.6	3.6	
	Powys	290	56	13	2	4	5	0	0	0	370	78.4	15.1	3.5	0.5	1.1	1.4	0.0	
	Hywel Dda	2,447	300	44	31	23	19	23	1	2	2,890	84.7	10.4	1.5	1.1	0.8	0.7	0.8	
	Swansea Bay	2,225	620	48	32	22	34	17	1	1	3,000	74.2	20.7	1.6	1.1	0.7	1.1	0.6	
	Cwm Taf Morgannwg	3,329	455	82	80	100	62	207	9	28	4,352	77.0	10.5	1.9	1.9	2.3	1.4	4.8	
	Aneurin Bevan	3,014	1,115	102	45	38	37	95	20	774	5,240	67.5	25.0	2.3	1.0	0.9	0.8	2.1	
	Cardiff & Vale	4,147	605	121	83	58	71	32	0	6	5,123	81.0	11.8	2.4	1.6	1.1	1.4	0.6	

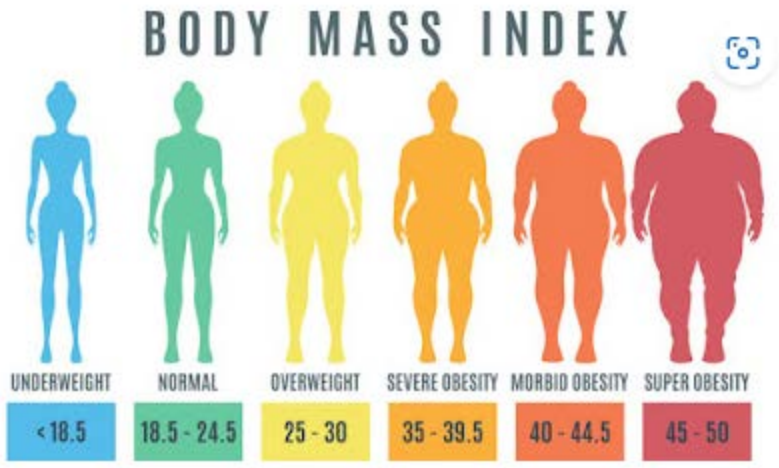
Percentage of Women with a BMI of 30+ at initial assessment, by individual Health Board 2022

Area		Number						Percentage					
		BMI 10 < 18.5	BMI 18.5 < 25	BMI 25 < 30	BMI 30+	Not stated	Total women	BMI 10 < 18.5	BMI 18.5 < 25	BMI 25 < 30	BMI 30+	Not stated	Total women
Wales		491	8,704	6,625	7,132	589	23,541	2.1	37.9	28.9	31.1	2.5	.
Wales	Betsi Cadwaladr	121	1,951	1,400	1,555	58	5,085	2.4	38.8	27.8	30.9	1.1	.
	Powys	4	141	103	93	0	341	1.2	41.3	30.2	27.3	0.0	.
	Hywel Dda	63	1,018	765	778	112	2,736	2.4	38.8	29.2	29.6	4.1	.
	Swansea Bay	52	1,049	798	854	62	2,815	1.9	38.1	29.0	31.0	2.2	.
	Cwm Taf Morgannwg	56	1,167	1,011	1,372	161	3,767	1.6	32.4	28.0	38.0	4.3	.
	Aneurin Bevan	89	1,518	1,156	1,244	70	4,077	2.2	37.9	28.8	31.0	1.7	.
	Cardiff & Vale	106	1,860	1,392	1,236	126	4,720	2.3	40.5	30.3	26.9	2.7	.

Obesity

Close to a third of pregnant women were classed as obese by their BMI score at initial assessment. This proportion has increased every year since data was first collected in 2016 and was similar for all age groups between 20 to 24 and 45 or older.

The percentage of obese pregnant women at initial assessment from Black or White ethnic backgrounds was close to double the percentage of obese pregnant from Asian backgrounds. Just over a quarter of all women gained the recommended amount of weight during pregnancy, based on their BMI group at initial assessment.



Summary of Statistics from Antenatal Care

Smoking

The percentage of pregnant women recorded as smokers at initial assessment and birth decreased slightly in 2022 to their lowest levels on record. Just over a quarter 'stopped smoking' between their initial assessment and birth, also the highest on record. However, during COVID 19 smoking data has been self-reported rather than tested through a carbon monoxide test, from 2022/2023 onwards carbon monoxide monitoring has been reinstated.

Smoking rates at both initial assessment and birth decreased as the mother's age group increased. Rates were also markedly higher in mothers from White and Mixed ethnic backgrounds, with very few mothers from Black or Asian backgrounds recorded as smokers.

Number and percentage of women who 'stopped smoking' during pregnancy, by health board providing the service 2022

Area		Total women	Number of women with valid smoking status at initial assessment AND birth	Number of women smoking at initial assessment	Number of women smoking at initial assessment but not at birth	Percentage of women who 'stopped smoking'	Percentage of women with complete data
Wales		26,565	21,233	2,892	773	26.7	79.9
Wales	Betsi Cadwaladr	5,590	5,537	1,012	142	14.0	99.1
Wales	Powys	370	272	20	6	30.0	73.5
Wales	Hywel Dda	2,890	10	4	1	25.0	0.3
Wales	Swansea Bay	3,000	2,496	0	0	0.0	83.2
Wales	Cwm Taf Morgannwg	4,352	2,912	635	316	49.8	66.9
Wales	Aneurin Bevan	5,240	5,079	766	216	28.2	96.9
Wales	Cardiff & Vale	5,123	4,927	455	92	20.2	96.2

Mental Health

Three out of ten pregnant women reported a mental health condition at initial assessment. Younger pregnant women were more likely to report a mental health condition than older pregnant women.

The percentage of pregnant women from Mixed ethnic backgrounds and White ethnic backgrounds reporting a mental health condition was more than three times higher than pregnant women from Black or Asian ethnic backgrounds.

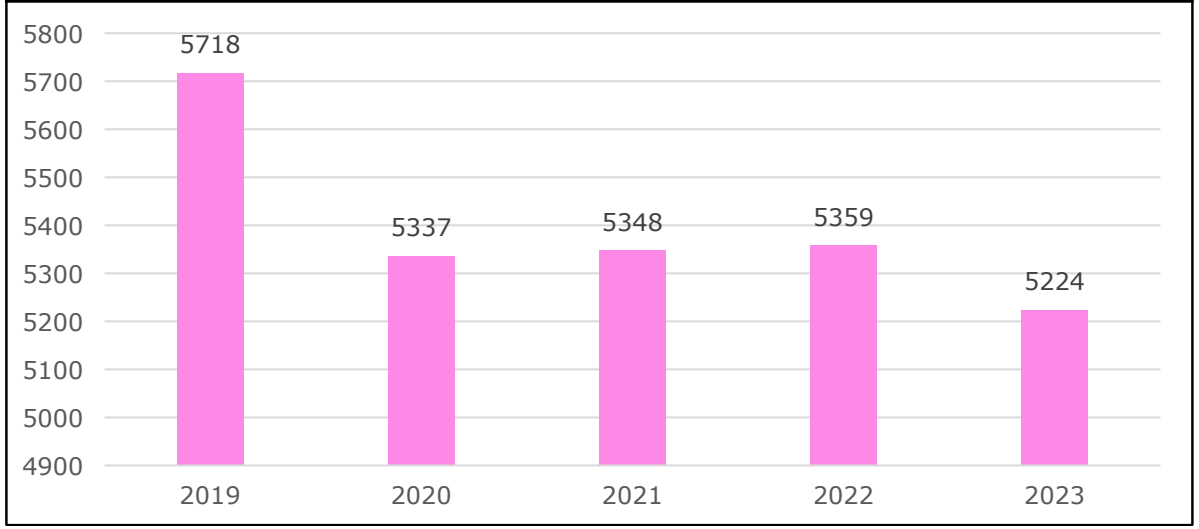
Number and percentage of women at initial assessment who had reported a mental health condition, by Health Board providing the service 2022

Area		Number				Percentage			
		Mental health condition reported	Mental health condition not reported	Not stated	Total women	Mental health condition reported	Mental health condition not reported	Not stated	Total women
Wales		4,808	11,119	696	16,623	30.2	69.8	4.2	.
Wales	Betsi Cadwaladr	.	.	.	.	.	.	.	.
Wales	Powys	95	266	9	370	26.3	73.7	2.4	.
Wales	Hywel Dda	795	1,885	210	2,890	29.7	70.3	7.3	.
Wales	Abertawe Bro Morgannwg	.	.	.	.	.	.	.	.
Wales	Swansea Bay	1,123	1,778	99	3,000	38.7	61.3	3.3	.
Wales	Cwm Taf	.	.	.	.	.	.	.	.
Wales	Cwm Taf Morgannwg	.	.	.	.	.	.	.	.
Wales	Aneurin Bevan	1,212	3,693	335	5,240	24.7	75.3	6.4	.
Wales	Cardiff & Vale	1,583	3,497	43	5,123	31.2	68.8	0.8	.

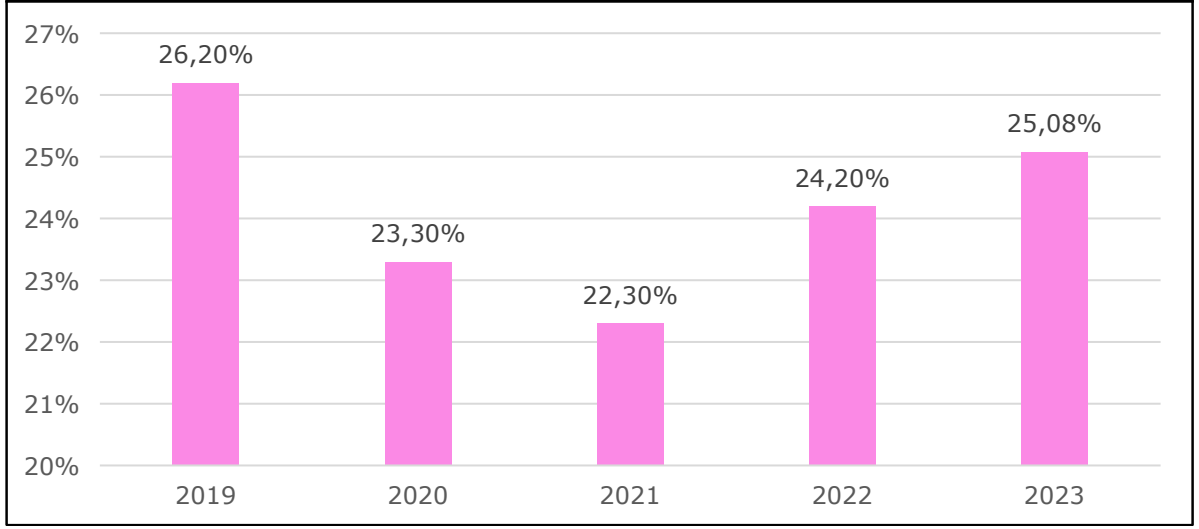
Summary of Statistics for Labour and Births

- Fewer than half of labours began spontaneously in 2022, continuing the longer-term downward trend.
- An epidural was administered in just under a quarter of all births.
- A third of babies were born via caesarean section, the highest percentage on record. One in five born via emergency caesarean section and close to one in seven arrived via elective caesarean section.
- The number of live births decreased, in 2022, there were 15% fewer singleton live births and 39% fewer multiple (twins and triplets) births than there were ten years prior.
- 9 out of 10 births were from White ethnic backgrounds, a decrease by 2 percentage points from five years ago. Percentage of births from Black and Asian ethnic backgrounds has increased by 0.8 and 0.6 percentage points respectively, over the same period.
- The percentage of younger mothers birthing in the year continued to fall, and just over half of all mothers birthing in the year were aged 30 or older. There were more mothers birthing aged between 35 and 39 than there were aged 20 to 24 for the second year in a row.
- Close to one in fifty births were at home in 2022, the lowest proportion of home births since 2002.
- Close to one in twelve births arrived pre-term. This proportion has been largely unchanged for the past seven years.
- The percentage of low birthweight babies increased slightly to 6.1%. While there are year-to-year variations, this percentage has been on a marginal upward trend over the past eight years. A slightly higher percentage of female babies had low birthweights than males.
- The average birthweight for a singleton birth was a little more than one kilogram heavier than a multiple birth. Just over half of births at gestations between 32 and 36 completed weeks had low birthweight, compared to 3% of births at gestations between 37 and 41 completed weeks.
- While it is expected that a higher percentage of births from women of Asian ethnic backgrounds would have low birthweight compared to other ethnic groups, the percentage of low birthweight babies from Asian backgrounds increased to its highest rate on record, while rates for all other ethnic groups remained broadly in line with longer-term trends.

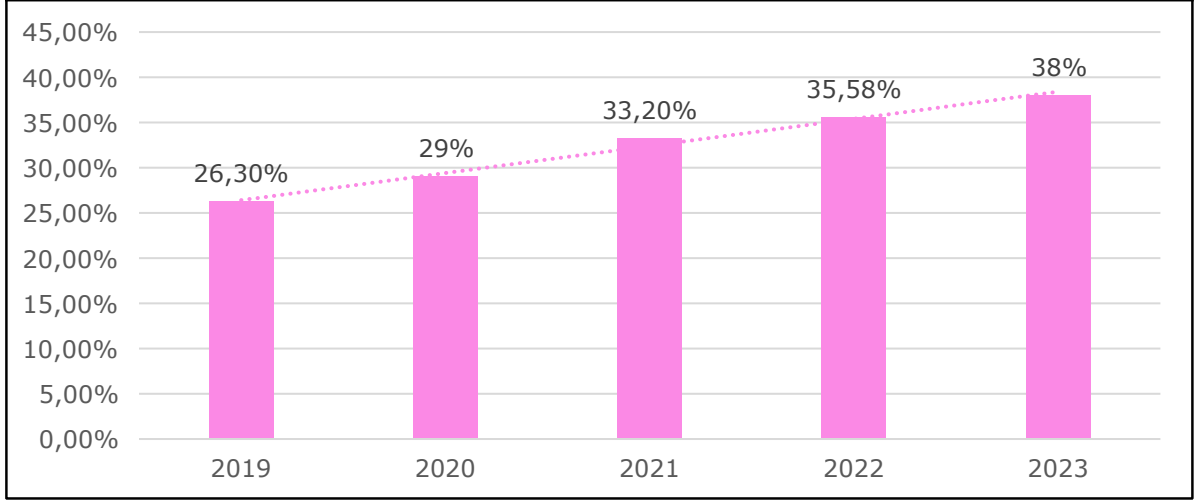
Total Births 2019 - 2023



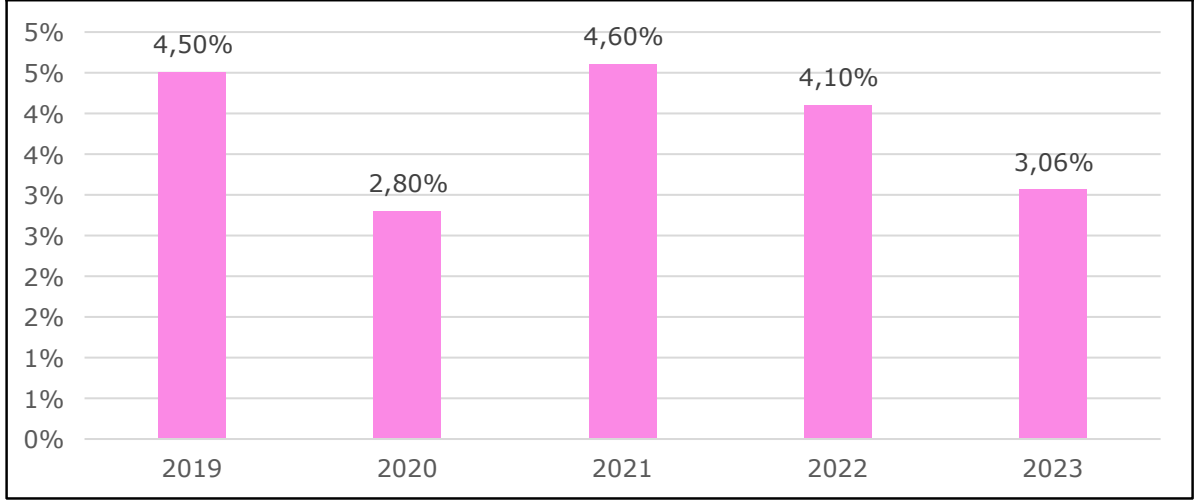
Total % of IOL's 2019 - 2023



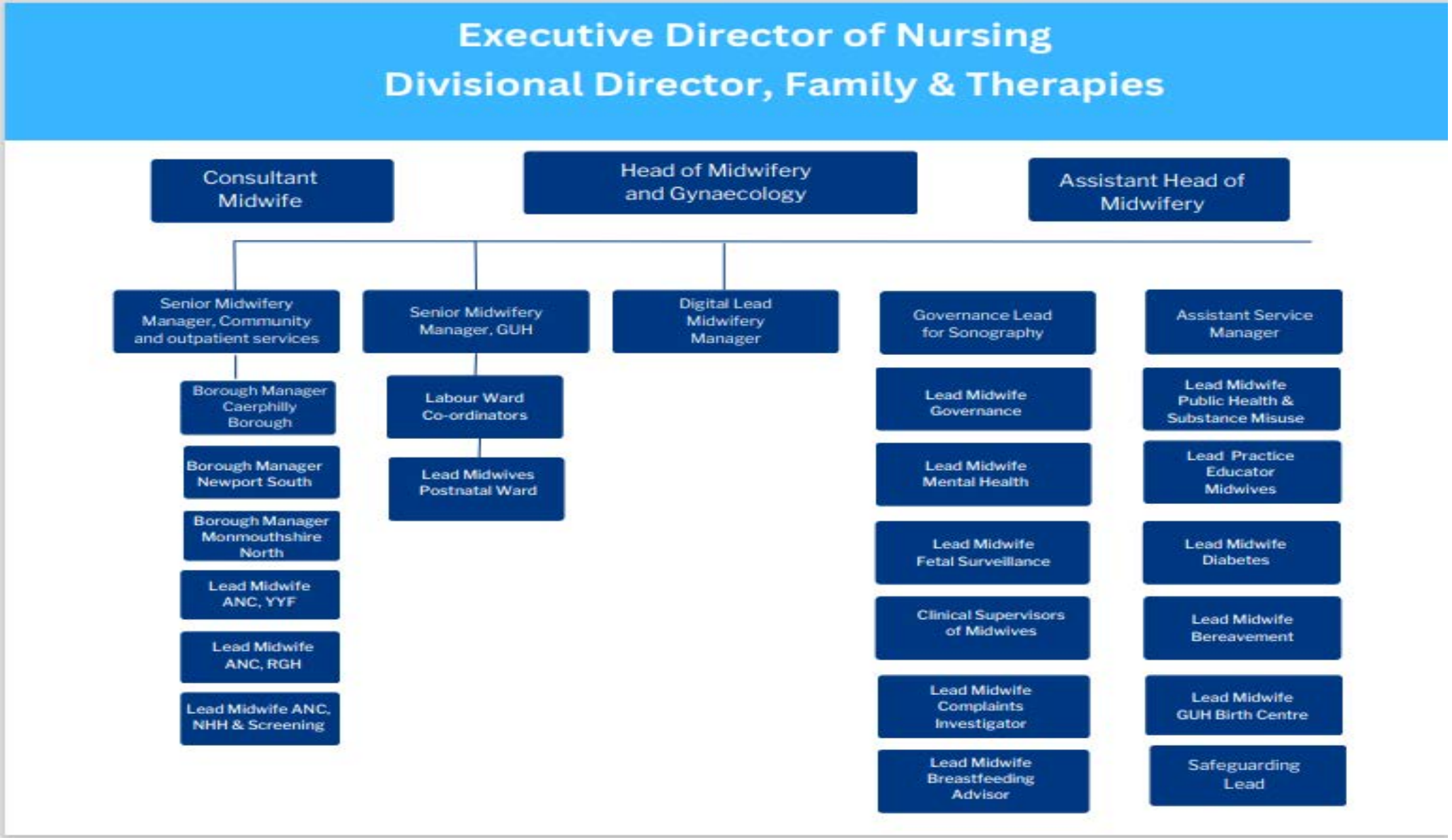
C Section Rates 2019 - 2023



Comparison of Stillbirth rate per 1000 births 2019 - 2023



Our Structure



Delivering the Vision, our Aims…

We believe that every child deserves the opportunity to have the very best start in life. Early childhood experiences, including before birth, are key to ensuring improved health outcomes, better learning, access to good work and a fulfilled life. To deliver this priority, we will challenge traditional practices, introduce new ways of working and forge greater alliances with local authorities and the third sector.

GOOD HEALTH IN PREGNANCY

- Increase in successful births to healthy babies including reduction in miscarriages, premature births and low birth rates

MIDWIFERY AND NEONATAL SERVICES

- Promoting and encouraging normal births wherever safe and practical and reduce use of induction of labour and caesarean intervention

HEALTHY CHILD WALES PROGRAMMES

- Improved access to breastfeeding and nutrition support
- Establishing fully integrated working between midwifery, health visiting, school nursing and Flying Start teams

CHILDHOOD IMMUNISATION

- Improved uptake and compliance with national measures to achieve population immunity

Women, Families and Babies

There will be a commitment to informed choice, respect and compassion in care provision for women and their families. Decision making, which places women, families and babies at the centre of care provision is paramount to building trusting relationships and empowering parents. Choice and personalised care will be provided according to women's need and wishes. Health promotion will be embedded through care to improve outcomes.

Safe and Effective Care

We will aim to deliver multi professional, timely, equitable, high-quality evidence-based care using continuous improvement as well as learning from concerns, incidents, trend's themes, experience and feedback.

Our People

We will continue to invest in our teams, enabling flexibility, developing skilled midwifery staff and leaders of the profession. There will be workforce planning and evidence-based tools to determine staff and appropriate skill mix to meet the needs of the population. Midwives will have continued professional development and specialist roles to develop practice. Support workers will be trained and supported to contribute to care.

Women are listened to and are central to care, listening to their experience will inform service change and delivery. This starts with prioritising staff wellbeing fostering a safe and caring culture within the work place. Maternity staff will feel valued and will work together to improve health and wellbeing.

Our Future

Long term sustainable service will be achieved through transformation and quality improvement work. There will be an investment in technology to improve information, education and clinical care and outcomes.

Agenda Item: 2.6

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 July 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Patient Quality, Safety and Outcomes Committee – Review of Committee Forward Work Plan 2024/25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Board Business

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Patient, Quality Safety and Outcomes Committee is asked to review the agreed Committee Forward Work Plan appended to this report. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2023/24 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

In line with good governance practice, the committee has a forward work plan that was developed to ensure statutory requirements for items of Committee business

are scheduled in across the year. The forward work plan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting process.

To aid the committee when reviewing its programme of business, the forward work programme captures the timing of when reports are to be submitted, identifies items that have been deferred and captures new requests for reports and enables the Committee to monitor and review its business at each meeting.

During the period the following requests and/or changes to the forward work programme have been included:

Items brought forward on the Forward Work Programme:

- Safeguarding Annual Report – brought forward to July meeting (from September) due to other Annual Reports being deferred
- Pharmacy and Medicines Management Annual Report – brought forward to September meeting (from December) as the report covers the 2022/23 period

Items deferred on the Forward Work Programme:

- Falls and Bone Health Annual Report deferred to September due to ongoing work
- Health and Safety Compliance Report deferred to September due to ongoing work
- Quality Outcomes Framework 2024/25 deferred to September.

Amendments to the Forward Work Programme:

- Blood Management Annual Report – Included on the agenda as Hospital Transfusion Committee Annual Report. FWP updated to reflect amended title.
- Pharmacy Robot Risk Assessment – included within the Committee Risk Report

Additions to the Forward Work Programme:

- Review of neurodevelopmental service for U18s - included due to the external report being received in the reporting period.

Argymhelliad / Recommendation

The Committee is requested to **NOTE** the updated Committee forward work plan as provided in **Appendix 1**.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

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

Annual Programme of Business for 2024-25

Patient, Quality, Safety and Outcomes Committee

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2023/24
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

Area of Focus as per the Committee's Terms of Reference:
The scope of the Patient Quality, Safety and Outcomes Committee encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on: a. The robustness of the Health Board's Clinical Quality Governance arrangements; b. the experience of patients, citizens and carers ensuring continuous learning; c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services; and d. the effectiveness of arrangements in place to support Improvement and Innovation.

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

2

MATTERS TO BE CONSIDERED	Lead	Frequency of Report	Schedule of Meetings					
			QTR 1		QTR 2	QTR 3		QTR 4
			30th April	4th June	30th July	2nd Sept	10th Dec	4th Feb
Preliminary Matters								
Attendance and Apologies	Chair	SI	√	√	√	√	√	√
Declarations of Interest	All members	SI	√	√	√	√	√	√
Minutes of the Previous Meeting	Chair	SI	√	√	√	√	√	√
Action Log and Matters Arising	Chair	SI	√	√	√	√	√	√
Committee Governance								
Development of Committee Annual Programme of Business 2025/26	Chair & DoCG	AN					√	
Review of Committee Programme of Business 2024/25	Chair	SI	√	√	√	√	√	√
Annual Review of Committee Terms of Reference 2024/25	Chair & DoCG	AN					√	
Annual Review of Committee Effectiveness 2024/25	Chair & DOCG	AN					√	
Outcome of Annual Review of Committee Effectiveness 2024/25	Chair & DOCG	AN						√
Committee Annual Report 2023/24	Chair & DOCG	AN	√					

Committee Annual Report 2024/25	Chair & DOCG							√
Committee Risk Report	DOCG	SI	√	√	√	√	√	√
NHS Wales Joint Commissioning Quality Committee Report	DOCG	SI	√	√	√	√	√	√
Pharmacy Robot Risk Assessment	DOCG	Action			√ (incl. in risk report)			
Quality Governance Framework								
Quality Strategy - Quality Outcome framework	DoN	Quarterly			**D**	√ **D**	√	
Quality Annual Report 2023/24	DoN	AN				√		
Quality Assurance Framework Annual Review and Evaluation of Progress	Clinical Executives	AN						√
Primary Care Quality Report	COO	Bi-AN				√		
Performance Report on the Pillars of Quality, to include:- • Patient experience and stories • Incident reporting - falls/ pressure ulcers medicines management and mortality • Healthcare Inspectorate Wales Operational Plan • Complaint, concerns and compliments • Health Safety and Security • Infection Prevention and Control	DoN /MD & DOTHS	Quarterly		√	√		√	√

• Safeguarding
• Clinical Negligence Claims and Coroners Inquests Report
• Quality & Engagement (Wales) Act, Preparedness and Implementation
• Tracking of Improvement Actions Arising from Inspections and Reviews
• Cleaning Standards Annual Report
• Infection Prevention and Control
• MCA & DOLs
• Child and Adolescent Mental Health Quality Outcomes Report, including self-harm and suicide
• Operational Quality updates on:
  ○ Cancer
  ○ U&EC
  ○ Planned Care								

Pillars of Quality Interim Report	DoN	Bi-Annual	√			√		
Mental health and learning disabilities assurance - included in performance report	DoN	SI	√	√	√	√	√	√
Healthcare Inspectorate Wales Annual Report	DoN	AN	√					

Report on National Review of Consent to examination and treatment standards in NHS Wales	MD	Annually					√	
Stroke Delivery Group Annual Report	DOTHS	Annual					√	
Commissioning Assurance Framework, Development, and Implementation	Clinical Executives	AN		**√D**	√			
Commissioning Outcomes Report	Clinical Executives	Bi-An				√		√
Putting Things Right Annual Report 2023/24	DoN	AN				√		
Maternity Services: Organisational Improvement and Action Plan	DoN	Bi-An			√			√
Learning from Death Report	MD	Bi-AN	√				√	
Listening and Learning Framework	DoN	An	√					
Listening and Learning Framework Outcomes report	DoN	Bi-an				√		√
IPC and Cleaning Standards	DoN	Annually		**√D**	√			
Annual Volunteering Report	DoN	Annually		√				
Mortuary Incident Action Plan	DoT&HS	Annual		**√D**	√			

Never Event Incidents Report	MD	Annual				√		
Covid-19 Nosocomial Investigations Report	DoN	Annual		**√D**	**√ D**	√		
Challenges in securing improvements within the Mental Health & Learning Disabilities	DoN	Action				√		
Safe Care								
Medical Devices Annual Report	DoT&HS	AN					√	
Radiation Protection Group Annual Report	DoT&HS	AN					√	
Falls and Bone Health Management Annual Report	DoT&HS	AN		**√D**	**√D**	√		
Health and Safety Compliance Annual Report	DoT&HS	AN			**√D**	√		
Human Tissue Act Group Annual Report	DoT&HS	AN				√		
Pharmacy and Medicines Management Annual Report	MD	AN			√			
Safeguarding Annual Report	DoN	AN			√			
Effective Care								
Research and Development Annual Report	MD	AN				√		
Hospital Transfusion Committee Annual Report	MD	AN			√			
Organ Donation Annual Report	MD	AN				√		

Annual Report on Clinical Audit Activity 2023 – 2024	MD	AN		√				
Clinical Audit Outcomes Report (Local and National)	MD	Quarterly		√		√		√
Overview of Audit Internal & External Recommendation Tracking (relevant to the Committee)	DoCG	Quarterly	√		√		√	
Nutrition and Hydration Committee Annual Report	DoT&HS	AN					√	
Clinical Effectiveness and Standards Committee Report	MD						√	
Review of neurodevelopmental service for U18s	DoN				√			
Patient Centred Care								
Children's Rights & Participation Forum	DoN	Bi-AN			√			√
Dementia Care Annual Report	DoN	AN				√		
Children and Young Peoples Board Minutes	DoN	SI				√	√	√

Lead Officer	
Key	
CEO	Chief Executive
DoCG	Director of Corporate Governance
DoF&P	Director of Finance & Procurement
DoSP&P	Director of Strategy, Planning & Partnerships
COO	Chief Operating Officer
DPH	Director of Public Health
DoT&HS	Director of Therapies & Health Science
DoW&OD	Director of Workforce & Organisational Development
DoN	Director of Nursing
MD	Medical Director
DOD	Director of Digital
Chair	Chair

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	1/2 yearly
Schedule of Meetings	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

Agenda Item: 3.1

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 July 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Pharmacy and Medicines Management Annual Report 2022-23
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Jonathan Simms, Clinical Director of Pharmacy

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA / SBAR REPORT

Sefyllfa / Situation

The term 'medicines management' covers all the processes and behaviours that influence the clinical and cost-effective use of medicines.

The Annual Report, together with the enclosure published from the All Wales Therapeutic and Toxicology Centre, provides an update on pharmacy services, medicines management, primary care prescribing and homecare medicines services in ABUHB.

The Welsh Government requires that a report showing progress in priority areas of safe prescribing, antimicrobial stewardship and value is scrutinised by the Board or the Patient Quality, Safety and Outcomes Committee annually.

These areas together with other key developments have been mapped to the Health and Care Standards.

Cefndir / Background

In 2016 the Wales Audit Office (WAO) published a report on 'managing medicines in primary and secondary care'[1]. The report was subsequently considered by the Public Accounts Committee and recommendations published[2], which have been considered by Welsh Government.

One of the original recommendations identified in the WAO report was the need for prescribing and medicines management to have a higher profile within Health Boards and to have an annual agenda item at the Board to discuss an annual report.

Asesiad / Assessment

The Annual Report highlights:

1. The introduction of reforms to the Community Pharmacy contractual framework with the introduction of 'Presgripsiwn Newydd' in April 2022. This seeks to drive additional clinical service delivery with all pharmacies providing the Clinical Community Pharmacy Service, comprising of the common ailment service, emergency medicines service, emergency contraception and the provision of influenza vaccination. This programme of work has seen the expansion of the pharmacist independent prescribing service providing additional access to community services.
2. The contribution of pharmacy services to improved patient safety and medicines governance through direct patient care and the work of the Medicines and Therapeutics Committee, Medicines Safety Group, and the Controlled Drugs Local Intelligence Network (CDLIN).
3. The report describes progress with the goals identified in the Medication Safety Strategy which was launched in March 2022.
4. Internal Audit undertook a review of governance arrangements for the management, administration, and storage of controlled drugs which also included the role of the CD LIN. Adequate assurance was demonstrated, and subsequent management actions have been completed.
5. Service developments included the approval of the Emergency Department business case in November 2022, a further expansion of the Community Response Team Pharmacy service and the repatriation of clozapine dispensing requiring additional investment.
6. The performance of the Health Board against the variety of national prescribing indicators identified in the Annual Prescribing Report 2022-2023.

Argymhelliad / Recommendation

The Committee is asked to note the contents of the Pharmacy and Medicines Management Annual Report, which provides assurance on the delivery of Pharmacy and Medicines Management services including primary care prescribing performance against the National prescribing indicators.

[1] https://www.audit.wales/news/medicines-management-needs-higher-profile-health-bodies
[2] https://senedd.wales/laid%20documents/cr-ld11478/cr-ld11478-e.pdf

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	NA
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.6 Medicines Management 1.1 Health Promotion, Protection and Improvement 2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Medicines Management Programme Board Executive Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities;

	and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item. Choose an item.

Aneurin Bevan University Health Board

Pharmacy and Medicines Management Annual Report 2022-23

"Our service aims to provide safe, home to home, timely, patient focused care, to empower patients to stay healthy, to improve health, to reduce harm and maximize efficiencies from medicines."

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1 Executive Summary

In 2016 the Wales Audit Office (WAO) published a report on 'Managing medicines in primary and secondary care | Audit Wales following individual Health Board reviews in acute hospitals and primary care. The report was subsequently considered by the Public Accounts Committee and recommendations published, which have been considered by Welsh Government cr-ld11478-e.pdf (senedd.wales)

One of the original recommendations identified in the WAO report was the need for prescribing and medicines management to have a higher profile within Health Boards and to have an annual agenda item at the Board to discuss an annual report covering pharmacy services, medicines management, primary care prescribing, homecare medicines services and progress in addressing the issues identified in Trusted to Care.

Welsh Government has subsequently commissioned the Welsh Analytical Prescribing Support Unit (WAPSU) to develop an Annual Prescribing Report for Health Boards showing progress in four priority areas (safe prescribing; antimicrobial stewardship; cost efficiency; and access to medicines). Annual Prescribing Reports 2022–2023 - All Wales Therapeutics and Toxicology Centre (nhs.wales)

2022/23 has seen a number of key strategic influences across pharmacy services in Wales:

- In October 2022, Welsh Government announced updated goals as part of a new 3 year plan for 'Pharmacy: Delivering a Healthier Wales' to transform pharmacy in Wales. To support this, ABUHB held a Pharmacy Event: Pharmacy Delivering a Healthier Wales – 2025 Goals, the 2030 Vision for Wales presented by Jonathan Simms, ABUHB Clinical Director of Pharmacy and Chair of the Welsh Pharmaceutical Committee together with Elen Jones, Director of the Royal Pharmaceutical Society Wales.

  Next three year plan launched to transform pharmacy in Wales | GOV.WALES

  Pharmacy: Delivering a healthier Wales (rpharms.com)

- All Wales Medicines Strategy Group (AWMSG) produced All Wales Guidance for Prescribing Intervals (Nov 2022) which concluded that, there would be a benefit to pharmacies, GPs and patients if dispensing intervals were extended awttc.nhs.wales/files/guidelines-and-pils/all-wales-guidance-for-prescribing-intervalspdf/. WAPSU, has developed a dashboard to report on progress for increasing the interval of prescribing durations for prescriptions issued within primary care.

- November 2022, Welsh Government announced it had commissioned The Royal Pharmaceutical Society to undertake an independent review of the future of clinical pharmacy services in NHS hospitals in Wales. (To be published later in 2023)

- Health Education and Improvement Wales (HEIW), produced a consultation document Developing a Strategic Pharmacy Workforce Plan (February 2023). Eng Pharmacy Workforce Plan Consultation Document Final.docx (live.com)

- Community pharmacy contractual reforms, 'A New Prescription: The future of community pharmacy in Wales' was introduced April 2022, to ensure the long-term sustainability of the sector. Presgripsiwn Newydd - A New Prescription (gov.wales).

This annual report provides an update on the 2021/22 Annual Prescribing Report plus an update of the events undertaken during 2022/23. Additional key developments have been identified and mapped to the Health and Care Standards.

2 Introduction

2.1 Pharmacy and Medicines Management

2.1.1 *Pharmacy Services*

The pharmacy directorate is in a unique position with responsibility for services across the whole care pathway, with pharmacy professionals working in the managed sector in primary and secondary care together with responsibility for the pharmacy contract and the development of services across 130 community pharmacies.

There are approximately 300 staff comprising of pharmacists, pharmacy technicians, pharmacy assistants and clerical staff working across four acute hospital sites, community hospitals, intermediate care, GP practices and NCNs to support safe and cost-effective prescribing, dispensing and administration of medicines.

2.1.2 *Medicines Management*

'Medicines management' covers much more than the purchase of drugs. The term covers all the processes and behaviours that influence the clinical and cost-effective use of medicines as well as positive outcomes for patients.

Medicines are the most common therapeutic intervention used in healthcare.

- It is estimated that between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended. This represents not only an economic cost due to the wasted medicine, but also to the cost arising from increased demands for healthcare and is detrimental to patient's quality of life due to non-adherence and worsening of the condition. The common reason for poor compliance is patients do not have an opportunity for appropriate support in understanding how to utilise their medication and optimise the effect of their medication.
- The safety of medicines is an important consideration as unsafe medication practices and medication errors are a leading cause of injury and harm to individuals. It is estimated that 6.5% of all admissions are medication-related and evidence suggests that 72% of these are deemed avoidable. Up to 50% of hospital admissions may involve a prescribing error. In 2017 the World Health Organization (WHO) issued a medication safety challenge to reduce the level of severe, avoidable harm related to medications by 50% over the next five years
- The financial pressure on prescribing will continue to grow across all sectors due to an ageing population and the introduction of new and innovative medicines. It is therefore important that the focus continues to ensure a prudent approach to effective medicines management, through the delivery of savings opportunities across all Divisions, supported by Pharmacy.

3 Staying Healthy

3.1 Standard 1.1 Health Promotion, Protection and Improvement

3.1.1 *Community Pharmacy Services*

There are 130 community pharmacies across the Health Board which provide a range of clinical services, dispensing and support for self-care as part of their NHS "contract".

In 2022/23:

- Dispensing rates increased by 2.1% compared to 2021-22 with over 16.3 million items dispensed.
- The Common Ailments Service (CAS) has seen a significant increase in provision with 37,178 consultations provided. An increase of 65% compared with 21/22.
- Influenza vaccine delivery decreased from a peak of nearly 29,000 to a 24,764 in 22/23.
- The Emergency Hormonal Contraception (EHC) service provided 4,017 consultations.
- 26,468 medicines were supplied in response to 14,475 requests from patients who were unable to obtain a prescription from their GP before their next dose using the Emergency Supply Service.
- 883 Smoking quit attempts were supported by the HMQ at Community Pharmacy services
- 2,212 Discharge medication reviews were provided
- 408 Supplies of palliative medication were made via the community pharmacy out of hours service.
- The Pharmacist Independent prescriber service provided 5,077 consultations from 28 commissioned pharmacies.
- Medicines shortages and concession prices had an impact on patient services, pharmacy workload and viability.
- 2022-23 continued to see staff shortages across all pharmacy team roles and there has been a significant rise in the number of temporary closures.

Below is a summary of key community pharmacy issues for 2022/23.

3.1.1.1 Community Pharmacy Essential Services

The essential services are the "core" services that patients have traditionally expected from community pharmacies. They include dispensing, provision of advice and non-prescription sales. Community pharmacies across Gwent dispensed 16.3 million prescription items in 2022/23. Equating to around 313,000 items a week, this vital workload presents a challenge to community pharmacy teams in the changing face of pharmacy as both "*Pharmacy : Delivering a Healthier Wales*" and "*Presgripsiwn Newydd*" seek to drive additional clinical service activity. As can be seen from the activity data above, pharmacy contractors are embracing the challenge to deliver, but we can't ignore the continued need to better manage the volume.

Medicines shortages have been increasingly problematic over the last few years and resulted in escalating drug costs for community pharmacies contributing to financial difficulties within businesses.

3.1.1.2 Clinical (additional) Services

The introduction of the Clinical Community Pharmacy Service bringing together an all or nothing approach to provision of the Common Ailments Service (CAS), Emergency Medicines Supply (EMS), Emergency Contraception (EC) and Seasonal Influenza has meant that all pharmacies in ABUHB now provide all these services improving patient access.

Common Ailments Service (CAS)

All of the pharmacies in ABUHB provide the Common Ailments Service, which was first piloted in October 2013 and enables pharmacists to treat a range of common illnesses, e.g. vaginal thrush, conjunctivitis, athlete's foot etc. in patients registered with the scheme through the Choose Pharmacy IT system. The CAS is open to anyone living in Wales or registered with a GP in Wales.

Around 80% of patients accessing the service would have otherwise booked an appointment with their GP so the service has potentially saved around 29,500 GP consultations.

Smoking Cessation Services

92 community pharmacies in ABUHB delivered smoking cessation services Level 3 and 127 community pharmacies delivered Level 2. These services are fully integrated with the Help Me Quit National Programme providing good access to services across ABUHB. The Health Board Community Pharmacy team work closely with local Public Health Wales practitioners to develop this service year on year. In 2022-23 the effects of the pandemic and the lack of face-to-face consultation has diminished service provision, and PHW colleagues continue with engagement to regain lost ground. The level 3 service has delivered a 40% Quit Rate which is in line with National targets.

Influenza Vaccination Services

The aim of the service is to increase access to flu vaccination for patients, GMS provision is recognised as the major provider within primary care. In recent years domiciliary care workers and care home staff have been added to the cohort of clients that pharmacies are able to vaccinate.124 Community Pharmacies actively provided this service to adult patients and although the eligible group remained the same as 2021/22 vaccine there was a reduction in the number of patients vaccinated via this route. Vaccine supply issues may have played a factor.

Emergency Hormonal Contraception Services (EHC)

Community pharmacies are recognised providers of EHC. All pharmacies in ABUHB now provide the service.

Emergency Supply Service (EMS)

The EMS service removes the cost barrier accessing medicines via the "emergency supply" arrangements within the Human Medicines Regulations and helps patients obtain previously prescribed medicines if they cannot visit their

GP or OOH services. The Choose Pharmacy platform affords access to the Welsh GP Record providing an additional safety net for supply.

The 14,475 requests managed by community pharmacies would otherwise have presented as urgent requests to OOH or GPs.

3.1.1.3 Other enhanced services from pharmacies

These include

- Supervised consumption of opiate substitution
- Out of Hours Palliative Care Service
- MAR chart Service
- Inhaler Review Service
- Care Homes Service

3.1.1.4 Pharmacist Independent Prescriber Services (PIPS)

The PIPS service provides a framework and funding for Pharmacist Independent Prescribers to manage a range of acute clinical conditions and contraception services in a community pharmacy setting. In 22/23 28 pharmacies were commissioned for the service and provided more than 5,000 patient consultations. There continue to be challenges with implementation as prescribers and contractors fit the service in amongst the daily demands, but interest and activity continues to grow.

3.1.2 *Prison Services*

ABUHB is responsible for overseeing healthcare and pharmacy services at HMP Usk and Prescoed. In response to the inspections by HM Chief Inspectors of Prisons and Denise Farmer on behalf of the Andrew Evans (Chief Pharmaceutical Officer Wales) an increase in pharmacy provision was agreed to be of benefit to the prisoners and to ensure equitable healthcare.

Summer 2022 saw a new Clinical Pharmacist join the team (0.4 WTE) they implemented pharmacist led clinical reviews helping to optimise medications. The new Clinical Pharmacist has started to implement new services such as the creation of a training programme for pharmacy technicians to complete Medicines Reconciliation. Preliminary work has begun on the creation of a Health Bar for prisoners, with the aim that the prisoners will have better access to medications for self-treatment.

The Lead Pharmacist remained redeployed to the Mass Vaccination programme until March 2023 when a new Lead Pharmacist came into post. In response to Welsh Governments 'Pharmacy Service Review in HMP Usk/Prescoed an action plan was created and submitted. This plan will improve pharmacy provision in the prisons by the creation and implementation of new polices, reviewing existing policies and continued review of staffing levels and training.

3.1.3 *COVID Mass vaccination programme*

In July 2022 the Primary care pharmacy team, Neighbourhood care network (NCN) pharmacists and academy pharmacists who were redeployed to support the COVID vaccination programme were released to go back to their posts. The new structure for MVC pharmacy staff was put in place. This consists of 5 WTE

Band 4 Senior Technical Officer staff, managed by a Band 6 Senior Pharmacy Technician, with a Band 8b Lead Pharmacist leading the team.

Responsibilities include updating standard operating procedures from national templates, ordering of the vaccine, monitoring of stock levels, storage, delivery, handling and dilution of the vaccine for use in the mass vaccination centres (MVC), community vaccination centres (CVC), GP practices, pop up clinics, care homes and prison.

There are now only two mass vaccination centres, in Newport and Ebbw Vale. Vaccination in Caerphilly borough is done in pop-up clinics, and in Torfaen there is a community vaccination centre in Cwmbran.

In addition to delivering COVID vaccines, the vaccination programme also delivered influenza vaccines in MVCs between December 2022 and March 2023. Childhood immunisation clinics have also been run in February and August 2023, for children who were unable to be vaccinated at their GP practice, or who missed their routine vaccination dates in school.

The pharmacy departments at The Royal Gwent (RGH), and Ysbyty Ystrad Fawr supported the vaccination programme by receiving our COVID vaccines, until we were able to receive direct deliveries in Spring 2023, and also with ordering and supplying vaccines for our childhood immunisation clinics.

4 Safe care

4.1 Standard 2.1 Managing Risk and Promoting Health and Safety

4.1.1 *Medication Safety*

The Medicines Safety Group (MSG) is a multidisciplinary group with representation from all divisions, pharmacy, and corporate teams. During March 2022, the MSG launched a Medication Safety Strategy with endorsement from the Medicines and Therapeutic Committee (MTC) and the Quality and Patient Safety Operational Group (QPSOG). The Medication Safety Strategy set out the ambitions of the MSG over a three-year period and focuses on five priority goals, each of which has their own set of objectives and measures to support their delivery:

4.1.1.1 *Goal 1: Improve reporting and learning from medication incidents*

Omitted medication

Several work streams have been completed to reduce incidents relating to omitted and delayed medication including updating the time critical medication policy, improving access and training to Omnicell, reviewing stock lists and increasing awareness in clinical areas with promotional work e.g., posters, medication safety campaign.

The Chief Nursing Officer for Wales and the NHS Wales Executive Assistant Director of Quality and Safety wrote to all Executive Directors of Nursing in NHS Wales asking them to undertake a benchmarking exercise in their respective organisations against the 10 recommendations in the 'Time Critical Medication' campaign promoted by Parkinson's UK.

A multi-professional response identified the following:

- Training videos incorporated into mandatory Medication Management training for nurses and doctors.
- Alert added to patient profiles on Clinical Work-Station (CWS) which states "Patient taking time-critical medication" to alert Health Care Professionals (HCP) to ask patients about their medicines.
- National poster developed to empower patients to report to HCP that they are on time-critical medication and to support HCP to enquire about time-critical medication.

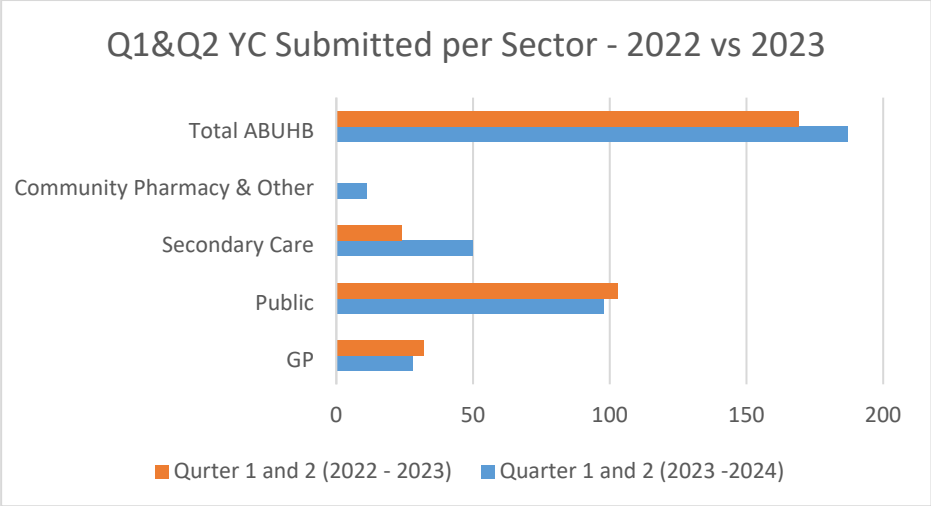
- Divisions to consider local risk and add to risk register accordingly.
- Self-administration policy currently under review to support timely administration of PD medication.
- Within the tender for an Electronic Prescribing and Medicines Administration solution, capability to flag time-critical medication was an essential criterion. The ability to pull accurate reports on timing of administration will aid future improvement work. Audits looking at all time critical missed doses will be conducted to identify areas requiring support.

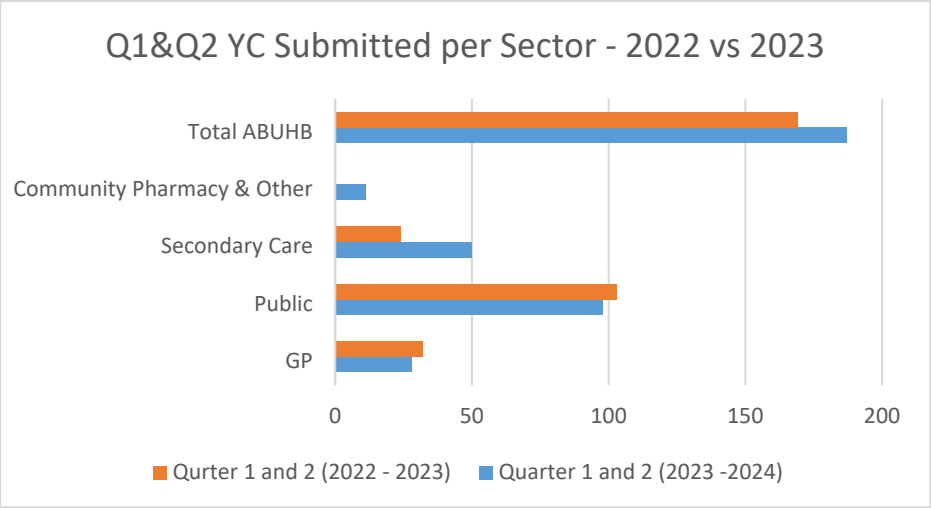
Medication reconciliation

Following a serious incident in which a patient received medication intended for another patient, a scoping activity was carried out to look at other similar incidents searching for key themes and learning opportunities. Fourteen incidents were reported since December 2021 with a peak in incidents in December 2022. Most incidents occurred in the Emergency Department and contributory factors varied significantly, and no patters or common themes were identified. One potential severe harm was intervened by the pharmacy team. Internal alert produced to remind staff to use two sources for a medication history, one being the patient (if an appropriate source).

Yellow Cards

A cross-sector group was re-established to look at opportunities to improve yellow card reporting. This group focused on activities to increase awareness, increase training and education and encourage more groups of HCP to report e.g., physician associates, pharmacy technicians. The graph shows a significant increase in reporting from secondary care and an overall growth of 11%.





4.1.1.2 *Goal 2: Support the safe and secure storage of medication*

All clinical areas are expected to submit annual audit data on the safe storage of medication in line with Patient Safety Notice 055 (released October 2020). Any concerns highlighted triggers an action plan and where necessary, an in-depth risk assessment is carried out resulting in a RAG rated action plan.

A series of incidents relating to patient's accessing their own medication from a locked medication locker, and in one case, accessing another patients' medication highlighted a security risk which required intervention. Engagement with divisional nursing teams identified a preferred option of changing the locker codes to the same code within each clinical care at an appropriate frequency e.g., monthly. Staff were reminded to take care to shield the code from patients and relatives to ensure the secure storage of medication.

4.1.1.3 *Goal 3: Reduce harm from high-risk medication and transition of care*

Vancomycin

Trend analysis highlighted an increase in vancomycin incidents during September 2022. A thematic review did not identify a clear theme and incidents were of all types with multi-factorial contributory factors. The antimicrobial team collaborated nationally to agree new vancomycin guidelines, and these were rolled out in January 2023. The main changes included loading doses to enable patients to reach peak concentration more timely, increased range for creatinine clearance to determine a maintenance dose and a table to ease dose adjustment following vancomycin levels. Vancomycin incidents will be monitored following the roll out, however early indicators suggest the roll out has been a success.

Insulin

A multi-professional group undertook a thematic review for insulin incidents and identified an array of contributory factors. This group identified current work streams that would facilitate safer insulin prescribing and administration. These included:

- Training and education – The diabetes team has received funding from Value Based HealthCare to appoint a nurse to deliver on training and education for nurses and prescribers across GUH and to undertake valuable audits aimed at improving safety.
- Resource files rolled out to all clinical areas within ABUHB with instructions for administration, signposting to resources and contact details for the diabetic teams.
- New insulin charts contain pertinent information on initiation and discharge of patients on insulin to standardise care.
- Insulin Bulletin developed and cascaded out to all HCP.
- The Community Nursing Team in Blaenau Gwent completed a survey of primary care nursing staff to seek opinions on what was required to improve insulin safety. The outcome was the development of portable boxes for training purposes which included DKA, hypoglycaemic, hyperglycaemia action cards including administration demonstration kits. Initial feedback from nursing teams positive and improved confidence amongst staff. Consideration of further roll out is currently underway.

Paracetamol

Risk of overdose of oral paracetamol in patients who are frail, elderly, have liver disease or on interacting medication was highlighted by the Healthcare Safety Investigation Branch (HSIB) and an audit was carried out to seek assurance from local prescribing practices. The findings of the audit showed that 28% (13) had a documented body weight less than 50kg. Five patients had already had their dose adjusted due to weight and two others required dose adjustment due to frailty. No weight was documented for 19% of patients.

An alert was produced to share good prescribing guides for patients requiring paracetamol and a poster to remind nurses of the importance to weight their patients weekly. Further work will look at whether medication dosed by weight is an issue that requires further action.

4.1.1.4 *Goal 4: Learn from and contribute to the national medication safety agenda*

Patient Safety Notices and Alerts

During 2022-23, seven patient safety notices and alerts relating to medicines were issues or ongoing from the previous year. The status of each is demonstrated in Table 1 below.

Table 1. PSNs and PSAs issued or ongoing during 2022-23

30/09/22	PSN055	Safe Storage of Medicines: Cupboards	Compliant
31/01/22	PSN057	Emergency Steroid Therapy Cards: Supporting Early Recognition & Management of Adrenal Crisis in Adults and Children	Compliant

20/12/22	PSN060	Reducing the risk of inadvertent administration of oral medication by the wrong route	Compliant
25/02/22	PSN062	Elimination of bottles of liquefied phenol 80%	Compliant
28/02/22	PSN061	Reducing the risk of patient harm - standardised strength of phenobarbital oral liquid	Compliant
31/03/22	PSN063	Deployment of NRFit (ISO 80369-6) compliant devices in Wales (2021)	Compliant
27/01/2023	PSA015	Safe use of oxygen cylinders in areas without medical gas pipeline	Compliant

Internal Safety Alerts and Communication

Several internal alerts, memos and communication posters were cascaded out with Medication Safety sign off to ensure the safe use and storage of medication. These are outlined in Table 2 below.

Table 2. Table listing the internal alerts, memos and ERASE posters produced and cascaded during 2022-23

Internal Alert	Rationale	Cascade mechanism
Taking an accurate drug history	SI: patient prescribed medication intended for another patient	Corporate QPS, central cascade
Coring issue	National issues relating to needles/ technique	Corporate QPS, central cascade
IV fluids/ VRIII fluid shortage	Switch of product agreed by endocrine, anaesthetic and pharmacy directorates to enable a reliable and ongoing supply.	Corporate QPS, central cascade
Alteplase shortage	High risk shortage requiring input from multiple directorates to protect stocks from depletion and enable treatment of ischemic stroke.	Corporate QPS, central cascade
Oxygen cylinder shortage	Safe use of oxygen cylinder in practice and a NAMDET oxygen cylinder duration chart to estimate amount of time left in cylinder.	Corporate QPS, central cascade

Paracetamol	Risk of overdose of oral paracetamol in patients who are frail, elderly, have liver disease or on interacting medication.	Corporate QPS, central cascade
Memo		
No self-administration	Self-administration (except insulin) to be stopped until a review of the practice is carried out and a policy developed to support safe assessments.	Corporate QPS, central cascade
Safe storage of medication	In line with PSN 055, summary of key recommendations and good practice to keep medication secure in clinical areas.	MSG, central cascade
ERASE poster		
Midazolam	Risk of selecting the incorrect prescription of midazolam e.g., dose and route different for seizures and anxiety.	DQPS, MSG, central cascade
Allergy	Reminding staff to check allergy status before administering mediation, in particular antibiotics.	DQPS, MSG, central cascade

4.1.1.5 *Goal 5: Develop and implement strategies to improve the medicines safety culture*

Welsh Pharmacy Awards

The Grange University Hospital Pharmacy team won an award in the Patient Safety in Secondary Care category in the Welsh Pharmacy Awards. A summary of the nomination reads: *"GUH pharmacy staff have strived to put patients and their safety first in line with NHS Wales values. Through the training and education of our staff, we have ensured that patients are prescribed the correct medication and they are available for administration in a timely manner. Development of staff has ensured job satisfaction which has proven to improve patient safety and reduce medication related harm. We have shown a commitment to working in partnership within multi-disciplinary teams and have been given praise*

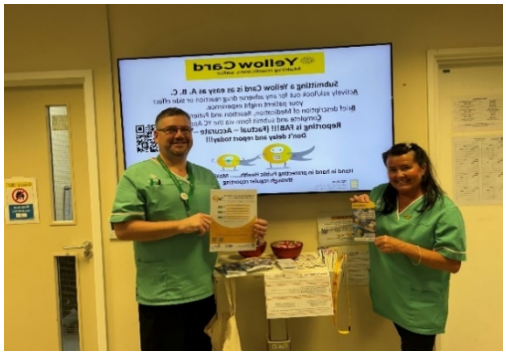
by multiple teams on how valued the pharmacy teams input is in keeping patients safe. Overall, GUH pharmacy staff have collaborated, pioneered and adapted practice to ensure high quality, efficient and safe patients care in a challenging and fast paced environment".

Community Resource Team (CRT)

The pharmacy team fed back to MSG on their work on reducing polypharmacy and the risk of falls, reducing waste, and embedding the pharmacy teams within the multi-professional CRT team. Their work was shared with members of the Health Committee at the Senedd and Assembly Members have visited the CRT team to see the great work they deliver.

Medication Safety Campaigns

World Patient Safety Day (17 Sept 2022) and Medication Safety Week (7-13 November 2022) were celebrated across the Health Board with a series of informative lunch time talks, promotion tables and a social media presence. These campaigns are an opportunity to share topical issues e.g., timely medication and promote the use of reliable and reputable resources when prescribing and administering medication. Reporting Yellow Cards for adverse drug reactions is a message we regularly promote, using examples of how this influences medication licencing and safety.



Non-Medical Prescribing

Wider engagement with the Non-Medical Prescribers (NMP) saw a new NMP policy written with multi-professional input and a new method for capturing annual scope of practice declaration by all NMPs. A register of all NMPs in the Health Board has been created and maintained and work is ongoing work to ensure all supplementary prescribers are captured also. A standardised approach to the allocation of prescription pads and associated paperwork has been agreed

and a platform on SharePoint was developed for sharing of prescribing patient safety incidents / MHRA alert and sharing of good practice set up. The Health Board had input into the development of All-Wales Competence Standards for Non-Medical Prescribers from HEIW.

Electronic Prescribing and Medicines Administration (EPMA)

As part of the Digital Medicines Transformation Portfolio, a local procurement exercise was undertaken to identify the specific requirements within an EPMA capabilities for ABUHB. A preferred supplier has now been identified and work is underway to submit a business care to Welsh Government to secure ongoing funding for a roll out and maintenance programme. The significant contribution to medicines safety and management is well recognised and we look forward to rolling out this programme in 2025.

4.2 Standard 2.6 Medicines Management

4.2.1 *Homecare Medicines*

A pharmacy homecare service is one that delivers supplies of medicinal products, together with care delivered by suitable healthcare professionals where appropriate, direct to a patient's home with their consent under the management of a hospital or other specialist prescriber. The majority of patients are those with chronic disease and stable treatment regimens that do not require acute care input on a regular basis, offering choice to patients for their ongoing treatments. Homecare is now a well-established service and supports Welsh Government strategy of moving care closer to home through direct medicines and nursing supply: thus removing the need for patients to attend the hospitals solely to collect/access their medicine. This service has been subject to Internal Audit and was last reviewed in 2017/18.

The total number patients treated via homecare in 2022/23 was 2,106 – an increase of 5% on the previous year, with a total value of £11m, representing 21% of all Secondary Care drug expenditure.

The monthly average number of patients registered for a homecare service has risen from 1,624 to 1,854; an increase of 14%.

Due to the migration of all pharmacy services from EDS to the new IT system Careflow (Wellsky/JAC), we are currently unable to pull data in the appropriate format to enable us to provide detailed reports on financial expenditure. This deficiency has been escalated, and we are working with DHCW to develop new reports which will enable us not only to provide accurate data on historical spending, but also assist with the identification of future savings potential. This work also includes a review of the processes around Out-of-Area drug recharging, where existing processes are inadequate.

Following other software updates, and the implementation of O365 across NHS Wales, we have also been unable to report on the initiation of specialist Secondary Care homecare medications to the practice pharmacists within the Primary Care teams. This work is a valuable patient-safety initiative which has worked well for the past two years, and ensures that the patients' Primary Care Record is maintained with a list of specialist therapies which are only to be

prescribed by Secondary or Tertiary care. It was proposed that this project be taken forward by the Hospital Pharmacy Services Management Board for further development.

4.2.2 *Medicines Governance*

4.2.2.1 Controlled Drugs

Controlled Drug Local Intelligence Network (CDLIN)

The Controlled Drug Local Intelligence Network (CD LIN) met quarterly during 2022/23. The meetings were held via Teams. These were chaired by our Medical Director who is appointed as the Accountable Officer for the Health Board.

An area of focus for 2022/23 has been monitoring use of Controlled Drugs (CDs) in GP practices. GP Practices were sent a CD self-declaration to complete. Improvements were seen in all areas of the audit with more practices having processes and procedures in place for the use of CDs and greater awareness on the importance of reporting CD incidents and concerns. Only dispensing practices in Monmouthshire stock CDs.

A review of Independent Prescribers in GP practices who prescribe CDs identified, 70% were nurses, 27% pharmacists, 3 paramedics and 1 podiatrist. No concerns were identified. Schedule 2 CDs account for 11% of CD prescribing for indications of pain, substance misuse, and ADHD.

CD internal audit report

In June 2022, Internal audit published their report confirming ABUHB had adequate governance arrangements in place for the management, administration and storage of CDs. Areas identified requiring attention were, frequency of ward CD stock checks and updating of the ABUHB CD policy. All concerns raised have been addressed.

Pregabalin Prescribing

The drug related death group raised concerns over the increased involvement of pregabalin (Schedule 3 CD) in drug related deaths. ABUHB is the second highest prescriber in Wales. In response, the chronic pain group and pharmacy team developed a toolkit to support GP practices review their pregabalin patients. High use GP practices were identified and next steps included auditing high risk patients, and training sessions for GPs and secondary care clinicians.

Home Office CD licences

In February 2023, the Home Office and Chief Pharmaceutical Officer for Wales wrote to all Health Boards requesting that they should as a matter of priority, review all services where they possess controlled drugs and arrangements where they supply controlled drugs to different services within their organisation, or to other organisations and assure themselves of compliance with the requirements for controlled drugs licensing.

In response, the Health Board reviewed all services and identified where licences were required. This includes the pharmacies at The Royal Gwent Hospital, The Grange University Hospital, Ysbyty Ystrad Fawr as well as offsite substance misuse and dental services. Applications were submitted to the Home Office in 2023.

4.2.2.2 Patient Group Directions

The Patient Group Direction (PGD) approval group met 7 times during this period and 42 PGDs were signed off. The group members include a senior primary care pharmacist, clinical informatics and prescribing support lead pharmacist, physiotherapist, lead nurse and a consultant in acute care. The group meets to review existing PGDs, assess requests for new PGDs and audits the use of existing PGDs.

The PGDs have helped improve access to medicines in out of hours, dental, mental health, sexual health, dental, endoscopy, radiology, ophthalmology, occupational health and the accident and emergency department. UKHSA and Public Health Wales PGD templates are used for all the Health Board immunisation PGDs as determined by national guidance and immunisation programmes. This has also included the PGDs for the COVID vaccination programme. The scope of the Mass Vaccination Centres has been widened to allow wider delivery of immunisation programme for children.

The new antivirals for the treatment of positive COVID cases are included in the list of PGDs for patients at high risk.

The PGD approval group has extended its terms of reference and now reviews homely remedies protocols. Homely remedies are medicines used to treat minor ailments, which can be purchased over the counter and do not need to be prescribed e.g. Antihistamine used in Prison and Mass Vaccination Centre.

4.2.2.3 Policy review and development

The pharmacy team continues to review and update its policies and standard operating procedures to meet the needs of the service and align with national guidance. Policies/procedures that were updated and ratified by the Clinical Standards Policy Group during 2022/23 include:

- Reduced Harm from omitted and delayed medicines in hospital - Critical Medicines list Issue
- Remote prescribing in community hospitals and Rapid Medical Community Resource Teams pilot 2022
- Guidelines for use and administration of intravenous Iloprost in adults
- Intravenous Ocrelizumab Administration Chart for adult patients
- Intravenous Alemtuzumab Administration Chart for adult patients
- Protocol for use and administration of intravenous ferric derisomaltose in adults
- Clinical Use of PGDs Policy
- Controlled Drugs Standard Operating procedure (GPs & Dentists)

Following the Internal Audit review, the Policy of Management of Controlled Drugs had an addendum added in October 2022

The Clinical Standards Policy Group agreed to extend the Medicines Management Policy: Code of Practice to give the department time to undertake a more formal review.

4.2.3 *Antimicrobial stewardship*

The Antimicrobial Stewardship team continues to monitor antimicrobial usage and implement strategies to optimise use of antibiotics across the Health Board, including development & review of local treatment guidelines.

Key achievements for 2022/23 include:

- Completion of roll out of the Antibiotic Review Kit (ARK) to the Grange University Hospital (GUH) and Royal Gwent Hospital (RGH), meaning all four main sites are now live. ARK is a toolkit, including an online training tool, decision aid and audit programme, designed to safely stop antibiotics in patients who no longer need them, and change prescriber behaviours. Work is now ongoing to embed the audits as a rolling programme, fed back via divisional quality & patient safety groups, with audit completion rates fed back at Reducing Nosocomial Transmission Group (RNTG) for oversight.
- Ongoing antimicrobial ward rounds at key sites, where complex infection cases are reviewed by a Consultant Microbiologist and an Antimicrobial Pharmacist. Since these ward rounds were introduced in December 2020 over 2,000 patients have been reviewed and over 3,000 interventions made, including stopping treatment in 21% of patients.
- New vancomycin guidelines to improve dosing and monitoring for this high-risk antibiotic.
- Introduction of AMS education sessions for 5th year medical students & pharmacy technicians.
- Introduction of an app to ensure last-line antimicrobials are only supplied with appropriate authorisation for use, including a QI project to monitor implementation.
- Collaboration with the lymphoedema team to identify patients with repeat antibiotic courses that are then followed up by a specialist nurse.
- Contribution to development of various national strategy documents, including the UK Start Smart Then Focus best practice guidelines for secondary care, the Welsh *C. difficile* strategy, and the next National Action Plan for antimicrobial resistance.

The team has carried vacancies for the majority of the past year but has restructured and successfully recruited to two vacancies by FYE, including the primary care vacancy. In addition to ongoing workstreams the team has also spent significant time implementing COVID-19 therapies, and supporting the Strep A outbreak in Q3.

The Consultant Pharmacist for Antimicrobials is also one of three Welsh members of the Malawi-Wales Antimicrobial Pharmacy Partnership, who were highly commended in the Best New Partnership category of the Hub Cymru Africa awards 2022. The partnership has successfully bid for almost £100k to expand the work in Malawi across over the next 18 months from April 2023.

4.2.4 *MHRA Inspections*

Manufacturer's Specials MHRA Licence:

The Pharmacy Production Unit at the Royal Gwent Hospital (RGH) has held a Manufacturer's Special (MS) licence since 1999. This is a Medicines and Healthcare Regulatory Agency (MHRA) assigned licence to manufacture aseptically prepared and 'packed-down' medicines for the patients of ABUHB. In order to keep this MS licence, high standards of good manufacturing practice and product quality must be maintained. The MHRA perform inspections of the MS licence sites every 2-3 years. The most recent inspection at RGH was performed on 10-11th March 2020. The inspectors gave the unit a risk rating of 3 (zero is the highest risk and 5 is the lowest), and assigned fewer deficiencies (seven) than at the 2017 inspection. All seven deficiencies have now been addressed by the implementation of robust actions (shown in the table below), as agreed by the MHRA.

Deficiency	Action
Agar plates (used for monitoring the environment in the pharmaceutical isolators and clean rooms) were incubated at a single temperature only.	Rectified by introducing the gold standard of dual-temperature incubation
The method for the validation of the transfer and decontamination of starting materials into the cleanroom and pharmaceutical isolators was not robust enough.	The method was redesigned in light of MHRA recommendations
The method for the validation of the aseptic manufacturing process was not complex enough to reflect the products that were being manufactured.	The method was redesigned in light of MHRA recommendations
The SOP for 'Change Controls' (i.e. how to safely implement changes) did not require a check on the effectiveness of the change introduced during the 'post implementation' phase.	The procedure for following up changes was updated to include the need to state specific outcomes in the post implementation phase.
The SOP for complaints did not require a consideration of whether the complaint had been caused by a falsified medicine.	The procedure for complaints was updated to require the need to consider whether a complaint was caused by a falsified medicine.
One ambient storage area was not temperature mapped.	Thorough temperature mapping of the storage area was performed following the inspection.

There was no control over the photocopying of worksheets used during re-packaging manufacturing.	A new process and associated SOPs for re-packaging manufacture was designed following the inspection. The process is now more robust with master copies of worksheets controlled digitally with access limited to senior pharmacy production staff.

Unlicensed Medicines:

During 2022-23 there was the redesign of the process for the procurement and risk assessment of unlicensed medicines (ULMs) to ensure safer and better-quality medicines are being supplied to patients in secondary care in ABUHB.

Aseptic preparation:

The role of the pharmacy assistant in aseptic services was redefined. In the past 12 months, our Senior Pharmacy Assistant for Pharmacy Production has become the first pharmacy assistant in ABUHB to perform critical volume checks in the aseptic preparation of injectable chemotherapy at the Pharmacy Production Unit at RGH.

Wholesale Distribution Authorisation MHRA Licence:

In November 2018, following a significant amount of preparation work and a successful MHRA site inspection, the Pharmacy department at Nevill Hall Hospital (NHH), obtained a Wholesale Distribution Authorisation (WDA) Licence from the MHRA. In doing so, ABUHB become only the third Health Board in Wales to hold a WDA licence. The WDA licence has allowed the distribution team at the Pharmacy department at NHH to safely and legally supply the Welsh Ambulance Trust, Powys Teaching Health Board, St David's Hospice and the Longtown Mountain Rescue charity with the critical medicines they require for their patients. A follow up virtual 'office based Responsible Person' inspection from the MHRA was conducted on 6th May 2022. The inspector was complimentary regarding the quality systems in place and officially authorised the approval of another senior ABUHB Pharmacist to be named as a Responsible Person on the licence.

4.2.5 *Prescribing Efficiency Opportunities*

The Pharmacy Directorate are instrumental in identifying and facilitating the delivery of efficiency saving across all Divisions within the Health Board. The table below identifies the savings delivered.

ABUHB Medicines Management Savings Performance 3 Year Trend

Division	2020-21 Savings Delivered £'000	2021-22 Savings Delivered £'000	2022-23 Savings Delivered £'000
Primary Care	1,533	2,301	2,661
Family & Therapies	43	93	49
Mental Health	0	0	0
Scheduled Care	996	273	1,515
Clinical Support Services	0	0	0
Medicine	416	460	0
Urgent Care	0	11	0
All other Divisions	0	0	0
sub-total	1,455	836	1,564
Total ABUHB	**2,988**	**3,137**	**4,226**

Due to the need to prioritise clinical services, the time available for directorate and divisional pharmacists to contribute to the savings plan is limited. The directorate continue to deliver savings department despite the current limited resource.

In 2022-2023 the Medicine Division made the decision to recruit an 'invest to save' Divisional Programme Pharmacist following the ongoing success of the role in the Scheduled Care Division. This WTE post has been recruited and development of a Medicine savings plan for 2023/2024 financial year is in progress.

4.2.6 *Clinical Informatics*

Since the creation of a new post of Lead Pharmacist, Clinical Informatics, there have been several developments within the secondary care pharmacy setting that have improved medicines governance. The most significant implementation for 2022-23 has been the adoption of electronic ward handovers. These have been designed as a prioritisation tool for all staff across all secondary pharmacy sites, allowing the patient with the greatest need to be seen first.

The data that is continually collected via the e-handovers is then available for senior staff to review. Giving oversight of the levels of activity across all sites. This data can then be utilised to ensure staffing resources are allocated correctly.

5 Effective Care

5.1 Standard 3.1 Safe and Clinically Effective Care

5.1.1 *Medicines and Therapeutics Committee (MTC)*

- In 2022-23, the MTC met six times, with meetings taking place in May, July, September, November, January, and March. October 2022 saw the Formulary and Clinical Effectiveness Pharmacist leave post with the replacement starting in position in January 2023. Table 3 provides a summary of items considered by the MTC at their meetings.

Table 3: Summary of items considered at MTC meetings during 2022/2023

Item	Outcome	Examples
New drug/formulary application	7/8 approved 1/8 rejected	Grazax oral lyophilisate immunotherapy as TLS Red for grass pollen in children as TLS red. Otigo ear drops for Acute Otitis Media rejected (on the basis of lack of evidence)
License extensions for existing formulary drugs	7/7 approved	Melatonin for short term insomnia in older adults
New or revised Shared Care Protocols (SCPs)	5/5 approved	Denosumab for the treatment of osteoporosis in post-menopausal women and in men at increased risk of fractures (revision)
Traffic Light Status (TLS) Change	7/8 approved 1/8 rejected	Ryeqo approved from red to Amber for control of moderate to severe symptoms of uterine fibroids GLP-1 agonists to remain amber for Type II Diabetes Mellitus
ABUHB Prescribing guidelines (new or revisions)	7/7 approved	Hay fever and Cow's Milk Protein Allergy Guidelines
Subgroup formularies	1/1 approved	Dietetic formulary reviewed by Clinical Nutrition/Dietetic group and revision approved by MTC

- A newsletter is circulated after each MTC meeting to prescribers at ABUHB containing headlines and useful information regarding formulary decisions and prescriber issues at ABUHB. MTC Newsletters can be found here.

- Minutes from the MTC meetings are available from the MTC Secretary on request.
- 32 x requests to prescribe non-formulary medications were considered by the MTC Chair/deputy.
- 97 drugs were approved by NICE or AWMSG, 80 and 17, respectively. MTC agreed the appropriate formulary status for each, which was then recorded on the formulary. The implementation process for these drugs at ABUHB was via the High Cost Drugs Implementation Planning Group (HCDIPG) a sub-group of MTC.

5.1.2 *National Prescribing Indicators*

The All Wales Medicines Strategy Group (AWMSG) has developed and endorsed National Prescribing Indicators (NPIs) since 2003 as a means of promoting safe and cost-effective prescribing. The indicators identify the therapeutic priorities for NHS Wales and focus on safety, stewardship or efficiency the methodology for establishing the NPI targets is based on the principle of encouraging all Health Boards, local cluster groups and practices to achieve prescribing rates in the best quartile. The threshold for achievement is based on the prescribing rate of the best performing 25% of practices in Wales, for the quarter 3 of the preceding financial year. The target is therefore not an absolute value and can be achieved if there is movement towards the threshold set.

National Prescribing Indicators 2022-2025 - All Wales Therapeutics and Toxicology Centre (nhs.wales)

For 2022-2025, the National Prescribing Indicators: Supporting Safe and Optimised Prescribing focus on the following priority areas:

- Analgesics (including opioids, tramadol, and gabapentin and pregabalin)
- Anticoagulants in atrial fibrillation
- Antimicrobial stewardship (including total antibacterial items and the '4C antimicrobials': co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin)
- Decarbonisation of inhalers

These four priority areas were supported by additional indicators:

- Safety
  - Prescribing safety indicators
  - Hypnotics and anxiolytics
  - Yellow Cards
- Efficiency
  - Best value biological medicines
  - Low value for prescribing

In order to support the implementation of National priorities, the Health Board operates a Clinical Effectiveness Prescribing Programme (CEPP) which incentivises practices to improve performance. The approach taken is to focus

on a few priority indicators rather than to include all of them. For 2022-23 the areas of focus are shown below.

1	Total antibacterial items per 1,000 STAR-Pus
2	Number of 4C antimicrobial items per 1000 patient
3	Hypnotic & anxiolytic ADQs per 1,000 STAR-PUs
4	Gabapentin & pregabalin DDDs per 1,000 patients
5	High strength opioids ADQs per 1,000 patients
6 Either	Low Global Warming Potential inhalers as % all inhaler items. Available to all practices- supports QAIF
Or 7	The number of patients with AF and a CHA2DS2- VASC score of 2 or more who are currently prescribed an anticoagulant, as a percentage of all patients with AF and CHAD2DS2-VASC =>2

5.1.2.1 Summary of overall HB position against the national prescribing indicators (March 2023)

The table below shows the extent to which practices in each Health Board met the target or indicator thresholds.

Health boards/practices achieving the indicator targets/thresholds – Quarter ending March 2023

Indicator Description	Aneurin Bevan	Betsi Cadwaladr	Cardiff And Vale	Cwm Taf Morgannwg	Hywel Dda	Powys	Swansea Bay
Opioid burden (UDG) ADQs per 1,000 patients	12 17%	20 21%	43 75%	5 11%	9 19%	6 38%	10 20%
High strength opioids (UDG) ADQs per 1,000 patients	23 32%	21 22%	30 53%	7 15%	6 13%	4 25%	18 37%
Tramadol DDDs per 1,000 patients	21 30%	21 22%	31 54%	8 17%	12 25%	7 44%	14 29%
Gabapentin and pregabalin DDDs per 1,000 patients	12 17%	24 25%	37 65%	3 7%	15 31%	4 25%	7 14%
Antibacterial items per 1,000 STAR-PUs	✗	✗	✗	✗	✗	✗	✗
4C antibacterial items per 1,000 patients	✗	✓	✗	✓	✓	✗	✓
DPIs and SMIs as a percentage of all inhalers	44 62%	18 19%	41 72%	29 63%	34 71%	4 25%	8 16%
Hypnotics and anxiolytics ADQs per 1,000 STAR-PUs	20 28%	22 23%	38 67%	8 17%	9 19%	7 44%	15 31%
Low Value for Prescribing (UDG) spend (£) per 1,000 patients	6 8%	43 45%	24 42%	4 9%	8 17%	8 50%	15 31%

Percentage of practices meeting threshold: 0% – 100%

- The figure in the cell is the number of practices in each Health Board meeting the target or indicator threshold.
- The percentage figure and cell colour represent the proportion of practices in each Health Board meeting the target or indicator threshold.
- The target for antibacterial items per 1,000 STAR-PUs is by Health Board, therefore a tick demonstrates achievement.

It should be noted that the table provides the % of practices achieving the threshold target. This is established in the December quarter of the preceding year and is based on the best performing quartile of all GP practices in Wales. Therefore, at the baseline only 25% of practices in Wales will be achieving the threshold target.

This information needs to be seen in the context of the trends in prescribing performance. Further information is provided in the Annual Prescribing Reports 2022–2023 - All Wales Therapeutics and Toxicology Centre (nhs.wales), which accompanies this report, together with a brief summary below, which outlines the specific actions taken to improve performance.

- Opioid Burden

  This indicator is decreasing consistently and is comparable with other Health Boards.

- High strength opioids

  This indicator is decreasing and is comparable with other Health Boards. It has been included in the ABUHB CEPP for 2022-23. Practice education has been carried out on the limited benefit of doses of 120mg morphine equivalence or more. The Medicines Management team developed a search to identify patients prescribed 120mg morphine equivalence or more, which has been circulated to practices. Practices have been encouraged to review patients identified by this search. A decrease has been seen in ABUHB prescribing in 2022-23 for this indicator.

- Tramadol

  Feedback from practices highlights the difficulty with tramadol deprescribing in established patients and the focus is to limit initiation to new patients. Work is ongoing to deprescribe, albeit slowly, and decreasing trends are evident. Targeted work at an outlier practice Abersychan, North Torfaen has seen a steep and sustained decrease in tramadol prescribing.

- Gabapentinoids

  This remains a priority indicator in the CEPP. Whilst this report covers 2022-23, it should be noted that the CEPP for 2023-24 had a particular focus on this area. This included mandatory attendance at two online training sessions for GP practices, presented by Dr Sue Jeffs (Pain consultant) and Dr Julia Lewis (Consultant in Addiction). This highlighted the risks and concerns with the overuse of opioids and gabapentinoids; and promoted the gabapentinoid toolkit (developed by the chronic pain group) which provides support materials to aid patient reviews and dose reduction plans.

  All practices were asked to undertake a pregabalin audit on Audit Management and Tracking (AMaT) to identify the indication, initiator (primary or secondary care), high dose use and high risk patients. Practices were asked to develop an action plan following their audit. Furthermore, the top high use practices had a face to face meeting with a pharmacist and Pain consultant to discuss their specific prescribing issues. These actions have resulted in a decrease in prescribing for Q4 2023-24. Further details will be provided in the 2023-24 annual report.

- Antibacterial items

  This remains a priority indicator in the CEPP. The prescribing trend is in line with other Health Boards. It should be noted that antibiotic use peaked in winter 2022-23 due to the invasive Group A Strep outbreak, during which the UKHSA, via national media outlets, encouraged patients to present for antibiotics. This has undone many years of public health messaging around antibiotic-seeking behaviours and will require significant efforts to reverse this.

- 4C Antibacterials

  This remains a priority indicator in the CEPP. It is apparent that performance has deteriorated from the lowest prescribing Health Board Q2 2021/22 to the third highest Q4 2022/23 and now second highest in Q4 2023/24. The primary care antimicrobial pharmacist post has been vacant for more than 18 months until January 2023. The main focus of the new 0.7 WTE appointee is audit and feedback cycles with high-prescribing practices, which has proven an effective intervention to reduce both antibiotic volume and 4C use in other Health Boards. The remaining 0.4WTE vacancy was recruited to in 2023-24.

  Evidence of benefit has been demonstrated in both Blaenavon Medical Centre and Abersychan following support from the primary care antimicrobial pharmacist and both have seen a subsequent decrease in 4C prescribing since Q4 2022/23.

- Dry powder inhalers /soft mist inhalers (DPIs/SMIs) % of all inhalers

  This was an optional indicator in the CEPP for 2022/23. This supported practices with the decarbonisation agenda and the Green inhaler QI initiative which is included in the GMS contract. This indicator is increasing consistently in ABUHB and has exceeded the NPI target.

- Hypnotics and Anxiolytics

  This remains a priority indicator in the CEPP. Practices are encouraged to use the AWTTC toolkit to audit patients and deprescribe. There is a steady decrease in prescribing which is similar to other health boards.

- Low Value for Prescribing

  The increasing trend in 2022-23 has been explored. Practices with high prescribing have been identified and discussions held. One area of focus has been the prescribing of lidocaine patch prescribing. This has led to work reviewing our local guidelines and reiterating the position to all clinicians. The use of chloral hydrate has been discussed at MTC and the formulary status updated to 'RED' specialist only prescribing in 2024. Further progress will be reported in subsequent annual reports.

5.1.2.2 Secondary Care Antimicrobial Performance

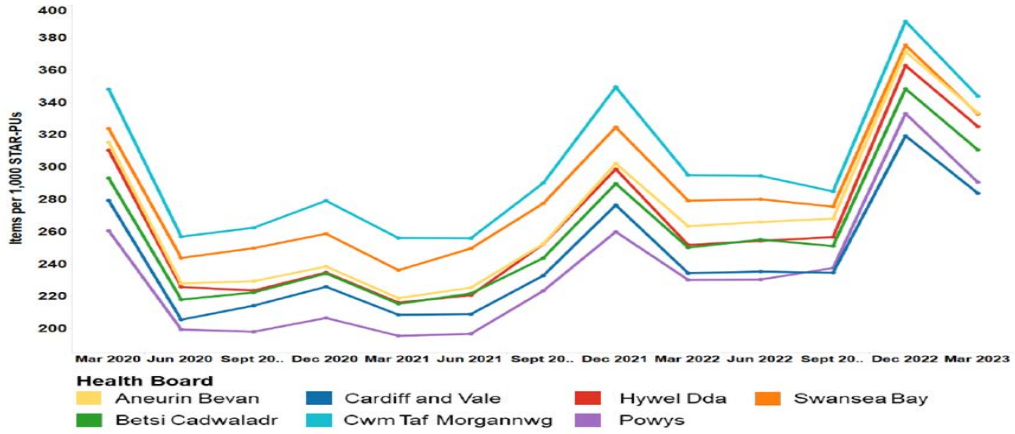
Increase the proportion of antibiotic usage within the WHO Access category to ≥55% of total antibiotic consumption (as DDD).

'Access' category antibiotics are antibiotics that cover a narrower range of bacteria and carry a lower risk of resistance and other adverse effects. To achieve this target many guidelines have been amended to encourage use of combinations of Access category agents instead of single broader-spectrum antibiotics. Since the implementation of the Wellsky pharmacy system in 2020, data issues within DHCW has meant that PHW is unable to provide performance against target. This issue has now been resolved. Local antimicrobial usage data suggest that all main ABUHB hospitals had achieved the 55% target, with most achieving around 60% of total antibiotics in the access group.

5.1.2.3 Total Antibiotic Prescribing (Items per 1000PU)

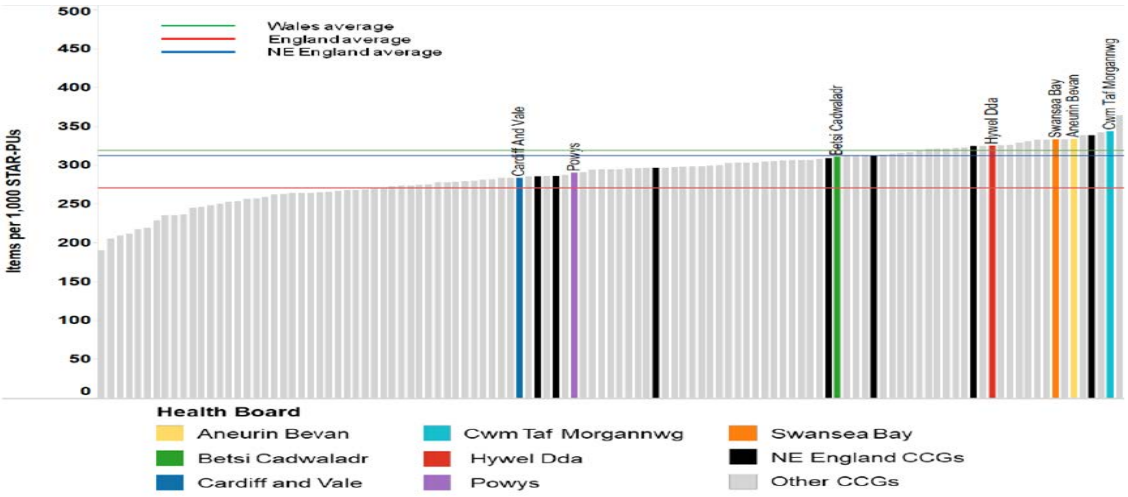
The target for this measure is based on Health Board rather than practice performance, with an expectation of a quarterly reduction of 5% against a baseline of April 2017–March 2018.

Trend in antibacterial prescribing items per 1,000 STAR-PUs



ABUHB is ranked sixth in terms of overall performance.

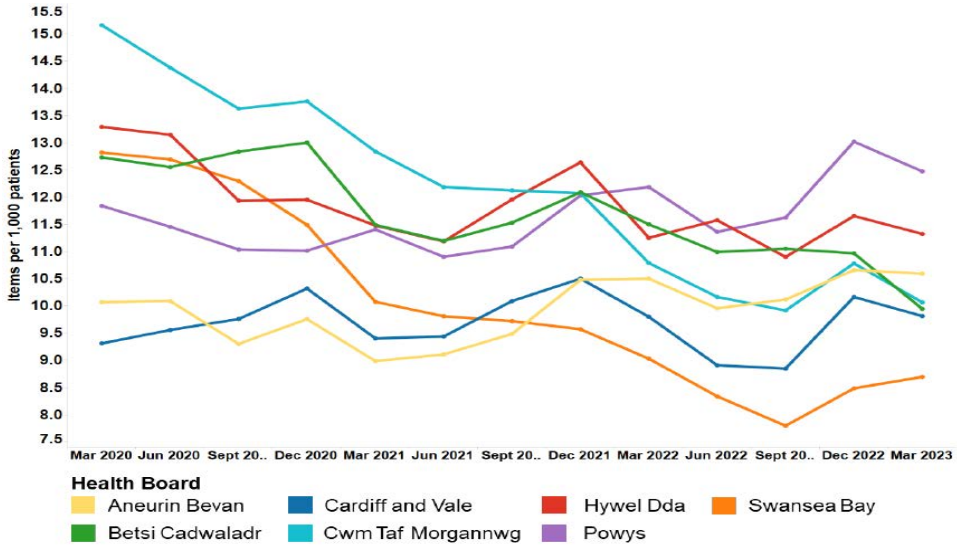
Antibacterial prescribing in Welsh Health Boards and English CCGs – Qtr. ending March 2023



5.1.2.4 4C Antimicrobial Prescribing (items per 1000PU)

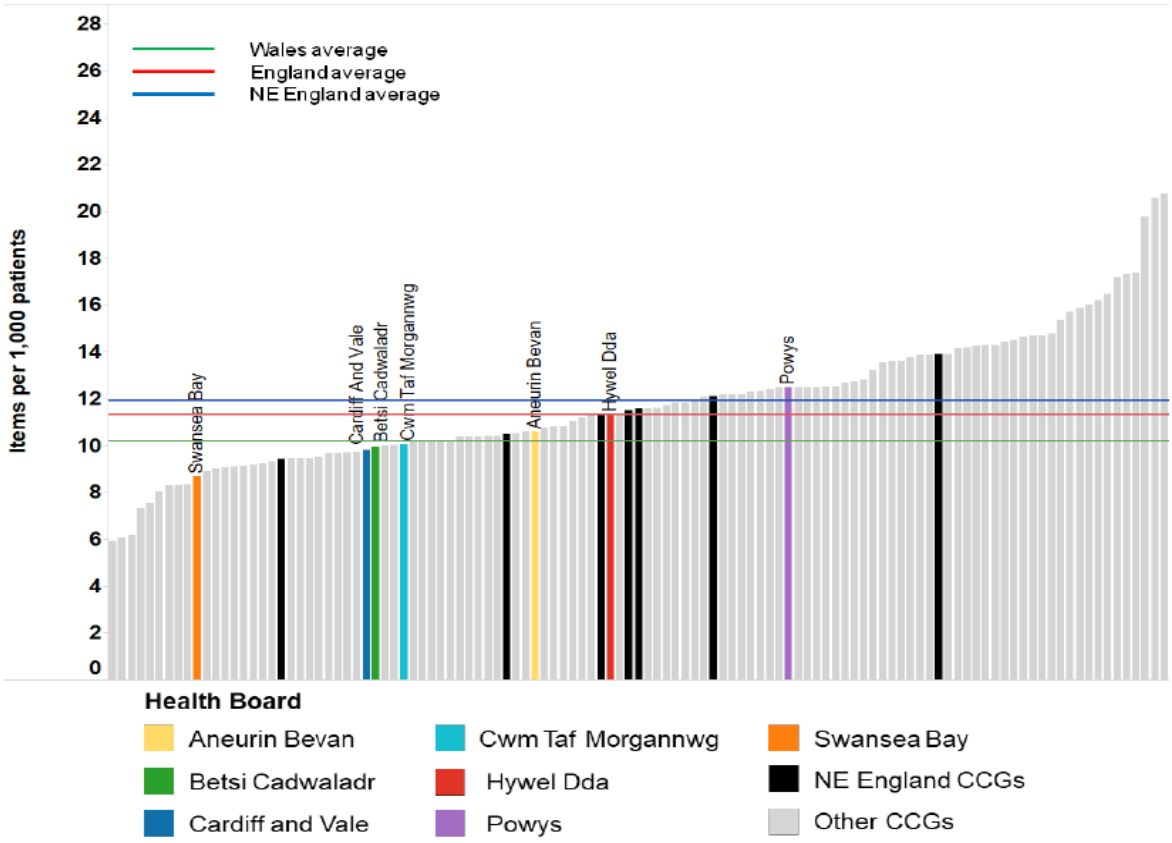
Broad spectrum antibiotics are associated with an increased risk of healthcare associated infections. ABUHB is ranked fifth in terms of overall performance.

Trend in 4C antimicrobial items per 1,000



As can be seen in the CCG comparison, ABUHB is below the English average.

4C antimicrobial items per 1,000 in Welsh Health Boards and English CCGs – Qtr. ending March 2023

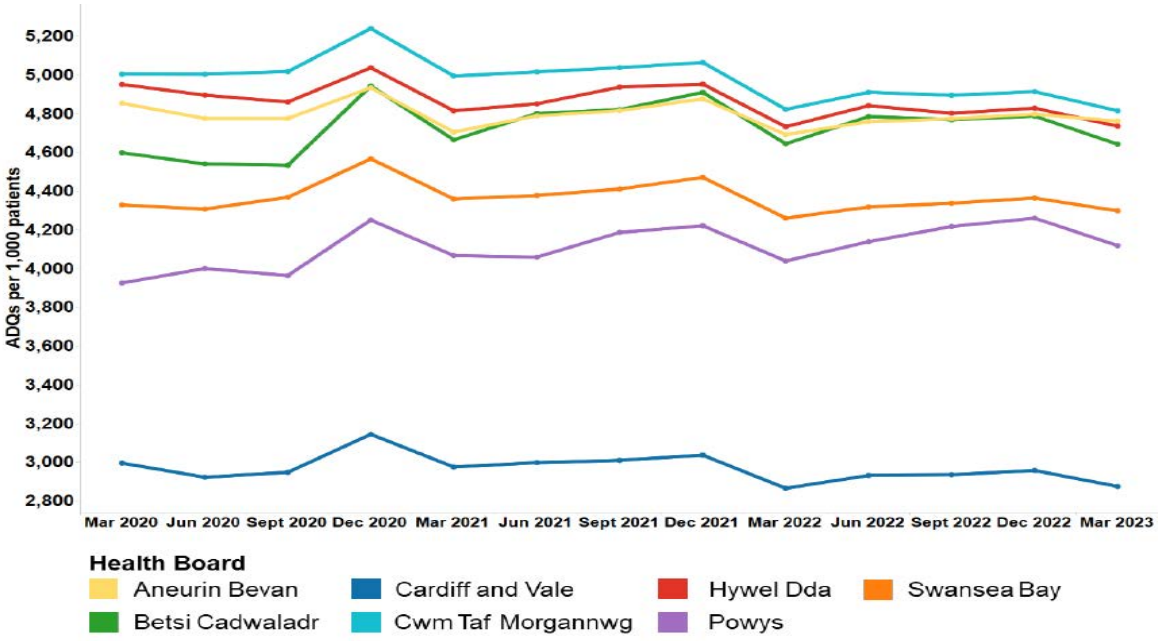


5.1.2.5 Opioid Burden

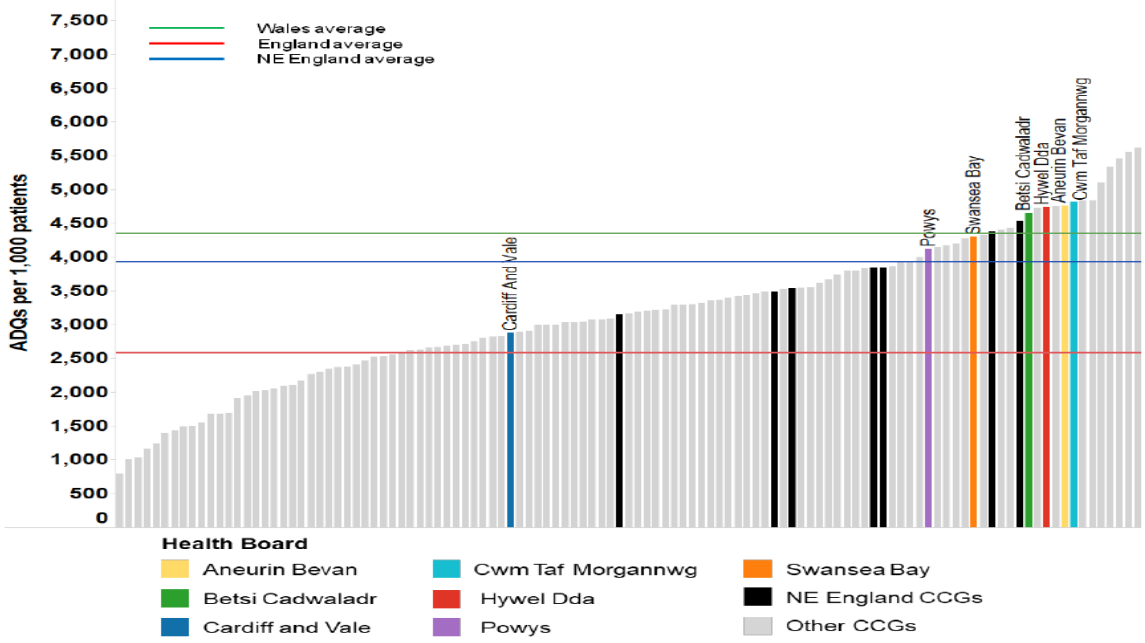
This prescribing indicator recognises the use of opioids for non-cancer pain in primary care and encourages a timely review of patients.

This includes all opioid analgesics including tramadol and co-codamol. Whilst there is a downward trend in prescribing, ABUHB is ranked sixth in terms of overall performance.

5.1.2.6 Trend in opioid burden UDG ADQs per 1,000 patients



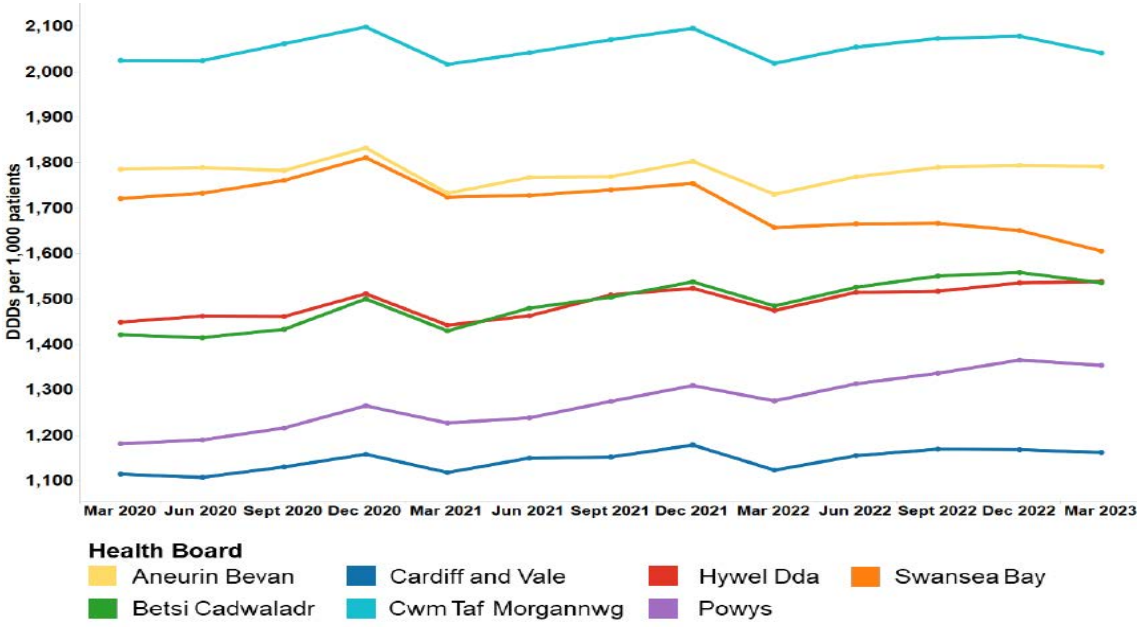
Opioid burden prescribing in Welsh Health Boards and English CCGs – Qtr. ending March 2023



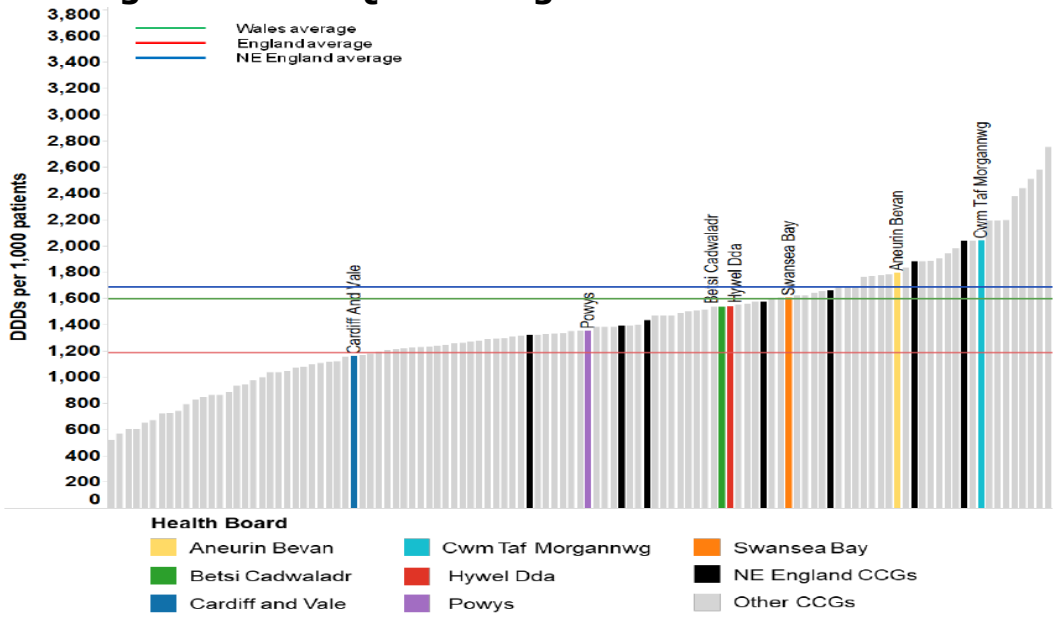
5.1.2.7 Gabapentin and Pregabalin

ABUHB has historically had a high use of these agents for neuropathic pain. As can be seen in chart below, the use of these has increased in all Health Boards, although the rate of increase is flattening out. These medicines became schedule 3 controlled drugs in April 2019 which may have resulted in a further reduction in use. ABUHB is ranked sixth in terms of overall performance.

Trend in gabapentin and pregabalin prescribing DDDs per 1,000 patients



Gabapentin and pregabalin prescribing in Welsh Health Boards and English CCGs – Qtr. ending March 2023



5.2 Standard 3.3 Quality Improvement, Research and Innovation

ABUHB has always recognised the value of Research and Development and the need to invest in the service in order to produce a robust strategy. In 2022, the Executive Board approved the R&D Strategy for 2022 – 2027 *(Delivering and developing research that is core to clinical services and meets the needs of our population)* which details the issues facing R&D with regards to the delay in investment in instrumental support services such as Pharmacy. The R&D strategy highlights Pharmacy specifically as an area that needs developing to enhance the overall HB capacity to provide a robust clinical trial service.

During 2022-23, a variety of quality improvement projects have been undertaken across the department, to optimise the service offered by pharmacy and streamline processes. This year the department has established an R&D peer support group to develop a culture where R&D becomes business as usual. This aims to support individuals to develop their service improvement research question, and write up the findings for dissemination.

2022-23 saw an important milestone, with the Lead Pharmacist for Critical Care becoming first pharmacist Principal Investigator within ABUHB, for a clinical trial.

In addition, ABUHB was selected as the only Welsh site for the NIHR funded study by the London School of Hygiene & Tropical Medicine to evaluate the 2019-2024 UK Antimicrobial Resistance National Action Plan. The Consultant Pharmacist for Antimicrobials was the local collaborator for this important study, which will inform development of the next 5-year 4 nation National Action Plan.

In July 2022, AWTTC hosted a virtual Best Practice Day focused on the environmental impact of medicines. Presenters shared examples of some of the excellent medicine's optimisation work going on in Wales to support NHS Wales Decarbonisation Strategic Delivery Plan. ABUHB pharmacy team presented one of the ten presentations on the day.

The Health Board pharmacists from primary and secondary care who lead on respiratory medicines presented their work done on reducing the over-use of short acting beta agonists (SABA) inhalers. The work resulted in significant potential carbon savings. They also spoke about a related project to develop an app that simplifies and supports inhaler reviews.

6 Timely Care

6.1 Standard 5.1 Timely Access

6.1.1 *Pharmacy Emergency Department Service*

A pharmacy service is provided to the emergency department at GUH following the successful pilot in 2019/20; which demonstrated that the pharmacy support improved flow by expediting discharges, reviewing acutely unwell patients and resolving issues at the front door.

The business case to fund additional pharmacy resource within GUH ED was approved in November 2022 and there has been successful recruitment of staff to establish a team with the following structure:

- 8B Lead Pharmacist
- 4 x 8A Clinical Pharmacists
- 3 x Band 5 Pharmacy Technicians
- 0.3 x Pharmacy Assistant

This team will provide a 12 hour per day, 7 day a week service. There will be an ongoing review and evaluation of the service with the intention to expand the service to the Medical Admission Units. The service is on track to deliver its expected benefits of enhancing patient safety, the release of ED staff time and to highlight potential savings through more cost-effective use of medicines.

The Medical Admissions Unit (MAU) at GUH receives a pharmacy service of 9am to 5pm Monday to Friday. This service was transferred from RGH MAU upon the opening of GUH at Acute Medicine Clinician request. This has left the MAU at RGH vulnerable with the pharmacy service being reduced to that of a minimum of 2 hours cover per day. The pharmacy cover to the MAUs at NHH and YYF also receive the same 2-hour clinical cover.

A full evaluation of the service will be undertaken with further information provided in subsequent annual reports. Some immediate observations have confirmed that compliance with the NICE recommendation of medicines reconciliation within 24 hours has increased since the service was introduced. This ensures the patient is receiving the correct medication and allows for the optimisation of medications in the acutely unwell patient. This has been proven to reduce medication errors thereby reducing the risks to patient safety and inadvertent wastage of medicines.

The number of missed doses for critical medicines has greatly reduced and this directly correlates to a reduced length of stay and improved patient experience. Prescribing pharmacists have also ensured high risk medicines are prescribed in a timely fashion, for example insulin and antiepileptics, but have also ensured that patients do not receive medications that would cause significant harm due to their acute clinical condition.

The multi-disciplinary team have benefited through ease of access to specialist clinical knowledge and advice over extended hours and weekends. This ensures that the patient receives the right medicine at the right time. Patients are counselled to ensure they are taking their medicines correctly and ensures the maximum benefit is received from the intervention thereby reducing the risk of

preventable medicines-related hospital admissions. The pharmacy team are also involved in the review of policies, procedures, guidance and PGDs. Patient / MDT feedback has praised the service, and all feel it is invaluable in improving patient safety and experience.

6.1.2 *Repatriation of Clozapine service*

Following a successful business case for additional pharmacy resource, NHH Pharmacy and YYF Pharmacy have repatriated the pre-dispensing of Clozapine for over 300 patients. Pre-dispensing clozapine for point of care testing clinics improves patient experience. This enables the patient to attend the clozapine clinic for a health review, blood tests and receive their medication supply during one visit.

7 Individual Care

7.1 Standard 6.1 Planning Care to Promote Independence

7.1.1 *Pharmacy Service to the Community Resource Teams*

The CRT Pharmacy team has had a positive year – now with all our posts as permanent positions, we have been able to build on the service with the staff settled and most undertaking further training. The extra training has allowed us to skill-mix and our pharmacy technicians are taking on more complex clinical roles, allowing the pharmacists to be more involved in work such as clinical MDTs with external consultants, prescribing and support to the Community Falls service.

We now have a comprehensive pharmacy service to 3 boroughs: Newport; Torfaen; Caerphilly funded by the Regional Integration Fund (RIF) and *a separately funded* limited service to another borough: Blaenau Gwent.

Within those 3 boroughs in particular, we have established close links with colleagues working in community pharmacy, practice pharmacy/NCNs and secondary care pharmacy. This ensures that we are able to take on, or pass on, patients with pharmacy management plans in need of close follow up, meaning that the closest and most appropriate pharmacy service is in place to follow up on issues.

In Torfaen CRT, we have established a pilot whereby we in-reach onto the local community hospital wards to help nursing staff prepare patients better for taking their medicines post discharge – the scheme is called 'Your Medicines' and aims to promote patients' awareness of medicines regimes leading to confidence and independence with medicines post discharge

In Caerphilly CRT, the pharmacy service has led increased involvement with microbiology to ensure early review of IV antimicrobials and has worked closely with the T&O Directorate to establish better referrals and better communication with the Rapid Nursing service who administer IV antimicrobials at home.

The Newport pharmacy service has been diminished due to sickness and maternity leave during this financial year. The service continues to support the Rapid Medical, Rapid Nursing and Re-ablement service despite this.

As a team across the boroughs the CRT Pharmacy service has delivered training on medicines administration to Blaenau Gwent CRT HCSWs – using the Policy previously written by the pharmacy team in previous years. They have also delivered training to care workers and managers within the Newport CRT. This aims to move the service away from administration reliant on dosettes (i.e. medicines packed into blister packs by community pharmacies which is not sustainable and causes delays and confusion particularly at discharge).

Three pharmacy technicians are currently studying for their BTEC level 4 Pharmacy Clinical Services qualification. All are already demonstrating clinical interventions that contribute to the improved safety of the frail elderly patients in this cohort. These pharmacy technicians continue to contribute to patient care, in the absence of their regular pharmacist, with remote pharmacist support. One of those pharmacy technicians has recently produced a poster on her work within the Community Falls team in Caerphilly showing improvement in

outcomes such as bone health prescribing and deprescribing of medicines associated with a risk of falls. The poster was accepted for the Association of Pharmacy Technicians UK conference in September.

During 2022/23 this initiative supported 1555 patients through Rapid Medical/Rapid Nursing (including IV at home services) and 277 through the Community Falls service. 186 patients were referred from the Reablement teams; an average of 61% of these referrals resulted in either reduced care calls or patients taking their medicines independently. 547 medicines were deprescribed by the pharmacy team within the Rapid Medical and Community Falls service over this 12-month period; many of these medicines are associated with an increased risk of falls.

Further service evaluation is being undertaken as part of the additional funding secured as part of the Regional Integration Fund. Progress will be provided in subsequent annual reports.

8 Staff and Resources

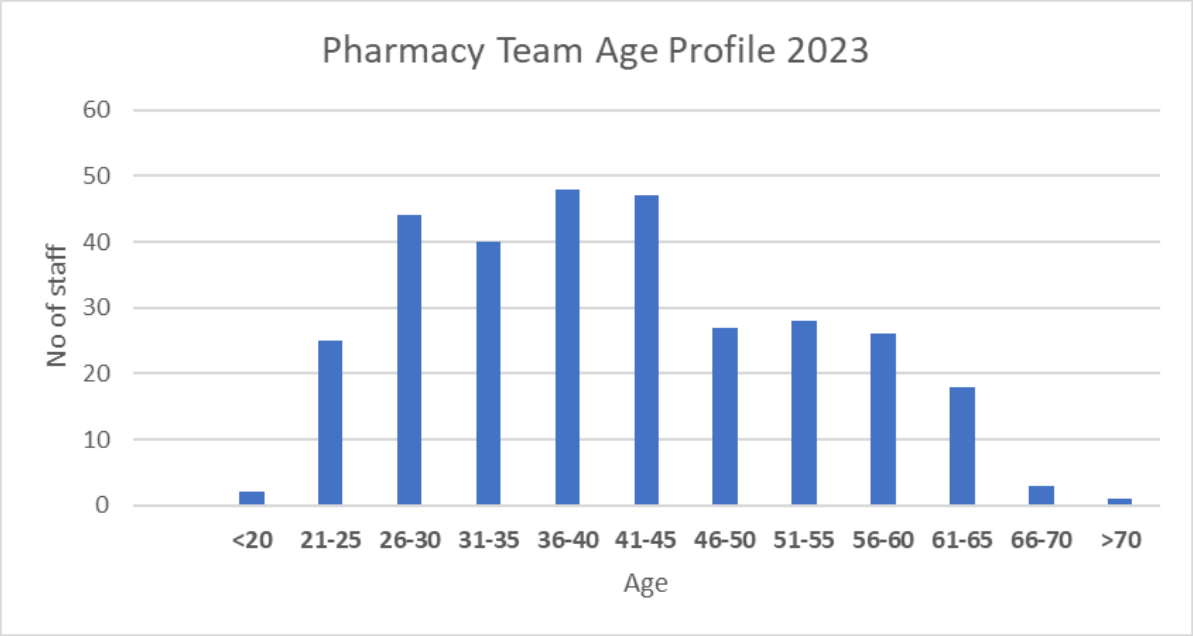
8.1 Workforce

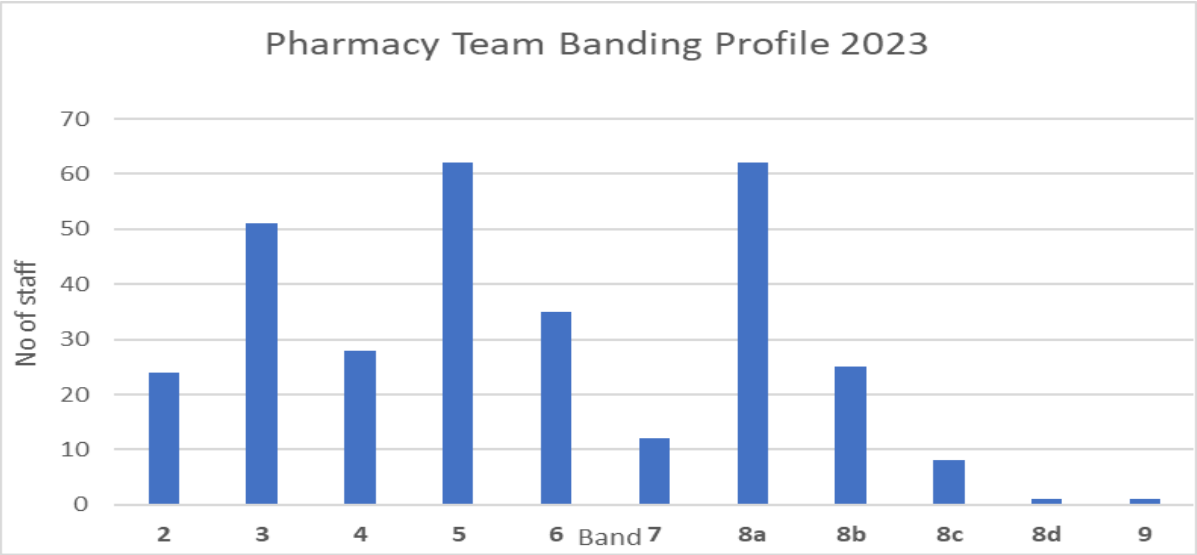
The department has developed its workforce in all sectors in line with the Pharmacy Clinical Futures workforce plan ensuring that skills are developed in line with local demographic needs. This has included advanced practice for both pharmacists and pharmacy technicians including developing the role of clinical pharmacy technician and further pharmacist independent prescribers in intermediate, primary, and secondary care.

Benchmarking of Pharmacy Services (data from HEIW extrapolated from ESR data) demonstrates that, compared with all other Health Boards in Wales, ABUHB continues to have a lower number of pharmacy staff (hospital and primary care) per 10,000 population across all pay bands.

The ABUHB pharmacy workforce is experiencing unprecedented demands and vacancies in all sectors. Several factors have contributed towards the issue including increased demand for roles e.g. transcribing and loss of staff e.g. retirements. It is anticipated that this will continue and will potentially worsen during the next few years for several reasons. The pharmacy workforce is on the national staff shortage list and faces major challenges in the recruitment and retention of highly skilled and trained staff. This is a particular risk for pharmacy technicians.

The age profile of the pharmacy team across all sectors shows 25% of the team are over 50





8.1.1 *Secondary Care*

The secondary care pharmacy workforce is on the national staff shortage list and faces major challenges in the recruitment and retention of highly skilled and trained staff. This is a particular risk for pharmacy technicians who represent the majority of band 4, 5 and 6 in the staffing profile.

Due to difficulties in procuring a course, there will be a fallow period for pharmacy technicians in Wales between Spring 2023 and February 2024, where there will be no new registrants during this period.

The demand for pharmacy technicians is anticipated to increase in both primary and secondary care. The department are developing new pharmacy assistant roles (band 2 and 3) to reduce the staffing gap and to enable the release pharmacy technicians to undertake more advanced roles.

Retention of band 7 pharmacists continues to be an issue in secondary care as pharmacists move for promotion to 8a posts in other sectors or to neighbouring Health Boards.

8.1.2 *Primary Care*

In primary care, the majority of pharmacy staff were re-deployed to run the vaccination programme during 2020-2022. As the programme reduced, some returned to their substantive posts, whilst others moved to other roles within the Health Board or direct employment in GP practices. 2022-23 has seen a change in over 70% of the technicians and pharmacists in primary care medicines management team. This has given the Clinical Director the opportunity to restructure the primary care team.

Neighbourhood Care Networks (NCNs) have also seen a reduction in the number of their band 8a practice-based pharmacists. Some NCNs have chosen not to backfill the posts as their pharmacists have moved to other posts or left for direct GP practice employment.

8.2 Training programmes

To meet the developing needs of patients, the General Pharmaceutical Council have introduced new Initial Education and Training for Pharmacists (IETP) standards for pharmacists and pharmacy technicians. New programmes will need to be implemented in all sectors. To correspond with introducing the new standards for future trainees, existing staff (legacy staff) will also need to be upskilled.

8.2.1 *Pharmacists*

The new IETP standards for pharmacists will ensure that those qualifying in 2026 will be independent prescribers (IPs). Clinical placements will increase in both quality and quantity in all sectors to ensure the outcomes. HEIW will co-ordinate the changes across Wales. It is anticipated that the first changes will be implemented in Academic year 2022-23 and will be progressively increased. This will be an opportunity for pharmacists as there is currently limited placements (mainly observational) available but will have a significant impact on the workforce in implementing the new programmes.

As part of the implementation of the new standards, all foundation pharmacists that will be trained in ABUHB will be undertaking the HEIW 4/4/4 programme (4 months in primary care, secondary care and community pharmacy).

Post foundation training for pharmacists will change from August 2023. A new programme has been commissioned by HEIW to replace the traditional Clinical Diploma programme. The new programme will be available in all sectors and will have a different output and funding model. This will provide additional funding for contractors for training. However, it will have a significant impact on secondary care as there will be a significant loss of income which unless funded additionally will mean a reduction in headcount of staff and a reduction in training posts that the HB are able to train. Following agreement with the executive team in February 2023, it was agreed to recruit our 2023 cohort at risk.

The current Clinical Diploma course offers further training in therapeutics which will be reduced in the new course. Changing the course content will impact on the service that the staff are able to deliver for patients and the department will need to plan how this shortfall can be managed e.g., additional courses.

The skills of all tutors and trainers will also need to be developed in line with the standards this will include the development of Pharmacist Designated Prescribing Practitioners to ensure capacity to deliver IP training for all pharmacists.

The department continues to upskill all clinical patient facing pharmacists to become independent prescribers. However, this is limited by current staffing vacancies.

8.2.2 *Pharmacy Technicians*

For pharmacy technicians, new registrants will already be qualified to undertake medicines reconciliation and accuracy checking on registration. A first intake of the new programme in ABUHB was introduced in February 2022 with a registration date of February 2024. The department are currently upskilling all existing pharmacy technicians to the same level. Whilst the programme is being

initially implemented, only single sector programmes are being run. This will be reviewed in line with the HB's previous ambition of multi-sector programmes.

In primary care, two of our experienced pharmacy technicians attained their BTEC Level 4 Professional Diploma in Clinical Pharmacy Services through Bradford College. It is the only BTEC programme offering an academically recognised award in pharmacy clinical services within the UK.

8.2.3 *Academy*

Over the past 3-4 years, ABUHB has run a successful primary care training academy. Pharmacy has been an integral part of the academy delivering a primary care post foundation programme for pharmacists and supporting a multisector pre-registration programme for pharmacy technicians. Both workstreams were instrumental in succession planning for the HB. Further funding for the Academy has not been agreed (Business case pending) and as a result from May 2022, there has been no infrastructure to deliver pharmacy training and no pharmacy training posts in primary care. This is likely to have a significant impact on future Pharmacy staffing in primary care.

8.3 Continued Professional Development

In 2022, a new "learning @ lunch" program was set up; this is aimed at all pharmacy staff across both primary and secondary care. Sessions are run monthly over teams, with each session recorded and then uploaded to the central "learning @ lunch" pharmacy page within SharePoint, along with supplementary resources.

The sessions are organised by primary and secondary pharmacy links, covering a range of topics relevant to both sections. The library of recorded sessions also provides a resource for new staff joining the Health Board.

9 Risks

Top risks on the Pharmacy directorate risk register March 2023:

Risk	Comments	RAG Rating
Community Pharmacy Closures across ABUHB	**Temporary suspensions and breach notices of pharmaceutical services continue to affect patients in Gwent**. The frequency with which they occur has reduced from the summer high but remains well above previous years. High rates of temporary closures continues to see neighbouring contractors workload increase significantly – impacting on their ability to provide clinical and additional services and potentially affecting their viability.	Amber/ Red
Community Pharmaceutical Service Provision:	**Staffing levels continue to be a concern across the community pharmacy network as pharmacists and support staff seek out new roles away from employed community pharmacy positions.** Pressure of work seems to be main driver. – HEIW has produced a report, but many of the factors cited are outside the direct control of the Health Board. **Increase in applications to reduce overall opening hours by (initially) a reduction in supplementary hours.** The HB is unable to influence this. Additionally, there's an increasing reluctance to take part in rota provision in some areas. Service provision is being managed by expanding rota boundaries and time periods.	Red
Sale of Lloyds Pharmacies	**Lloyds Pharmacy Ltd has 19 pharmacies in ABUHB, 18 of which are for sale and 1 is withdrawing from our list.** 7 pharmacies have yet to have a transfer of ownership application made for them. The contractor is unable to state what will happen or if there is a deadline for the sales process. Should there be a deadline, the pharmacies may close.	Amber

	Additionally, as the sales process draws out, staff may leave and affect service provision. Contractor will not share information re sales Mitigation – none available Potential impact: patients can access pharmacy services elsewhere. Other pharmacy services may be stretched or unable to cope in the short term	
Reduced community pharmacy service provision.	**When the ownership transfers from Lloyds to the new owner.** A new NHS identifier will be created for the pharmacy. As payments and service access are linked to this identifier, it's possible that the transfer of ownership may disrupt the provision of the services reducing patient access. Conversation with SSP to continue existing services and access to the new provider. Allow a grace period for formal commissioning with the new contractor. Potential impact: patients can be signposted to other pharmacies should service provision pause, core dispensing service will be unaffected	Amber
Medicines Distribution across South Gwent: failing robot and distribution process across South Gwent	Significant pressure on ability to continue to deliver safe and effective distribution of medicines across all South Wales wards, departments and hospitals due to lack of progress of RGH department refurbishment including installation of new robot. Current department layout/robot is over 18yrs old and service is not fit for purpose. Robot has a constantly high number of breakdowns, rendering supply erratic and leading to medication stock issues across South Gwent. RGH department not fit for purpose and significantly inferior to other sites, consequently unable to perform role as Medicines Distribution Hub. A new robot is now on order and scheduled for replacement in Q2/3 2024.	Red

Pharmacy workforce: Lack of clinical staff in secondary care	Significant Pharmacy workforce risk across the HB. Essential services not being delivered due to lack of staff, causing a significant risk to patient care. Current vacancy rate over 40 WTE across all staffing groups affecting all core services. All non-patient facing activities stopped, essential services reduced/removed (Meds Safety, Medicines Information, AMS, E&T), Site Leads being utilised as clinical so unable to provide any support to other issues. Unfunded areas have had Pharmacy clinical service removed. Areas of high risk that are not serviced include Transfer Lounge/Fox Pod at GUH, YYF MAU, RGH MAU. Unable to take on any additional Clinical Trials and have had to stop recruitment into existing schemes. Some areas are not having discharges processed and are utilising WP10HPs. Clinical Prioritisation SOP produced for ward-based teams, as unable to cover bed base at each site. Some wards are not being visited every day due to staff shortages. Recent concern over recurrent funding which had been approved for transcribing case has subsequently been removed. Need to clarify how this can be covered in the ongoing budget. Recent increase in vacancies and failure to recruit to vacancies continue to impact on services	Red

Key:

Red	Highly problematic - requires urgent and decisive action.
Amber / Red	Problematic - requires substantial attention, some aspects need urgent attention.
Amber / Green	Mixed - aspect(s) require substantial attention, some good.
Green	Good - requires refinement and systematic implementation.

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Annual prescribing report 2022-2023

AWTTC
All Wales Therapeutics & Toxicology Centre

This report has been developed by:
WAPSU
Welsh Analytical Prescribing Support Unit

Aneurin Bevan

KEY

- Aneurin Bevan
- Cardiff and Vale
- Hywel Dda
- Swansea Bay
- Betsi Cadwaladr
- Cwm Taf Morgannwg
- Powys

This logo is displayed alongside sections of the report where further data are available on the Server for Prescribing Information Reporting and Analysis (SPIRA). Find out more at **awttc.nhs.wales**

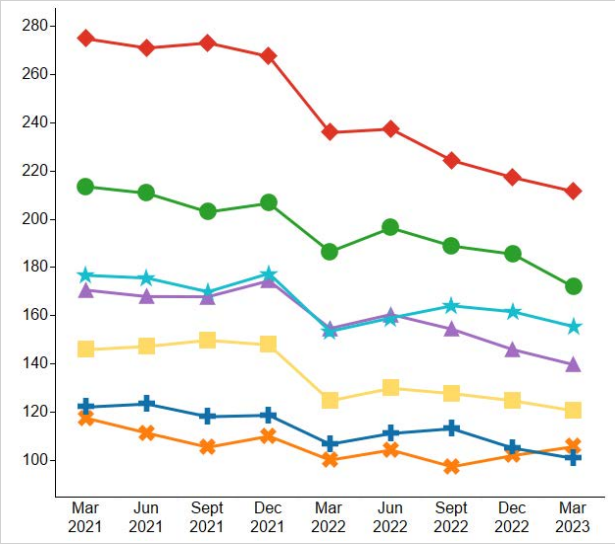
Analgesics

High-strength opioid prescribing

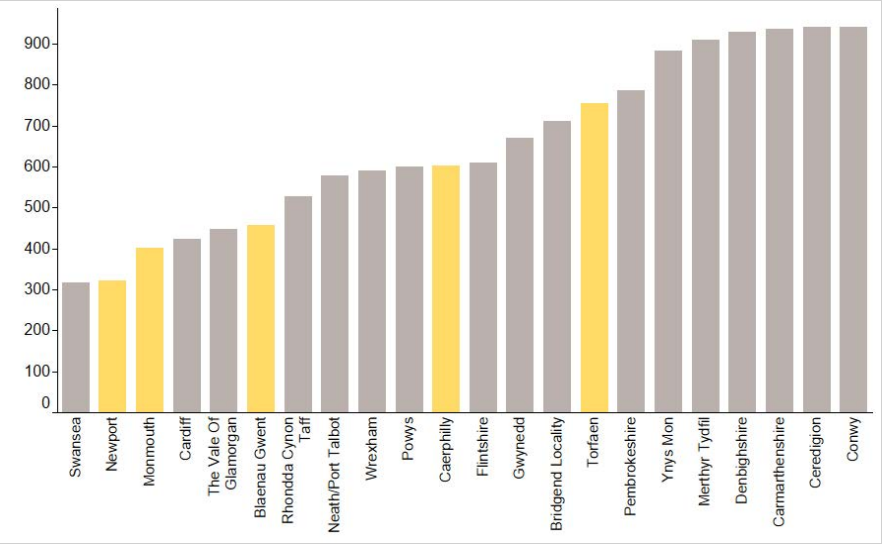
National Prescribing Indicator 2022–2025

Due to a lack of evidence of effectiveness, opioids are not recommended as a treatment option for the management of chronic primary pain. The British Medical Association briefing paper, *Chronic Pain: supporting safer prescribing of analgesics*, notes that too many chronic pain patients are prescribed opioids at high doses. The aim of this measure is to encourage the appropriate use and review of opioids, minimising the potential for dependence, diversion, misuse and adverse drug reactions.

High-strength opioid prescribing (ADQs per 1,000 patients) - Quarterly trend up to March 2023



High-strength opioid prescribing (ADQs per 1,000 patients) - Locality data - Financial year 2022-2023



When compared with the previous year, Aneurin Bevan's performance **IMPROVED**

High-strength opioid prescribing decreased by **11.7%** in 2022–2023

Out of the 7 health boards, Aneurin Bevan is ranked:

% change from last year : **2nd**

Current overall performance : **3rd**

GLOSSARY

ADQs – average daily quantity – a measure of prescribing volume based upon prescribing behaviour in England. It represents the assumed average maintenance dose per day for a medicine used for its main indication in adults. ADQ is not a recommended dose but an analytical unit to compare prescribing activity.

DDDs – defined daily dose – a unit of measurement developed by the World Health Organization whereby each medicine is assigned a value within its recognised dosage range. The value is the assumed average maintenance dose per day for a medicine when used for its main indication in adults. A medicine can have different DDDs depending on the route of administration.

STAR-PUs – specific therapeutic group age–sex related prescribing units – designed to measure prescribing weighted for age and sex of patients. There are differences in the age and sex of patients for whom medicines in specific therapeutic groups are usually prescribed. To make such comparisons, STAR-PUs have been developed based on costs of prescribing or items within therapeutic groups.

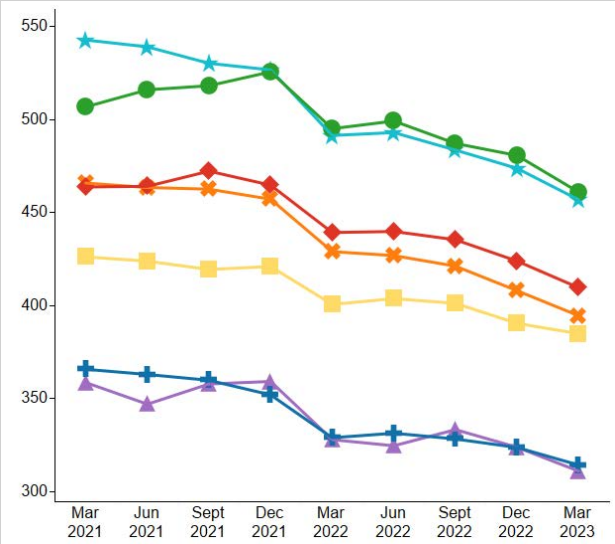
Analgesics

Tramadol

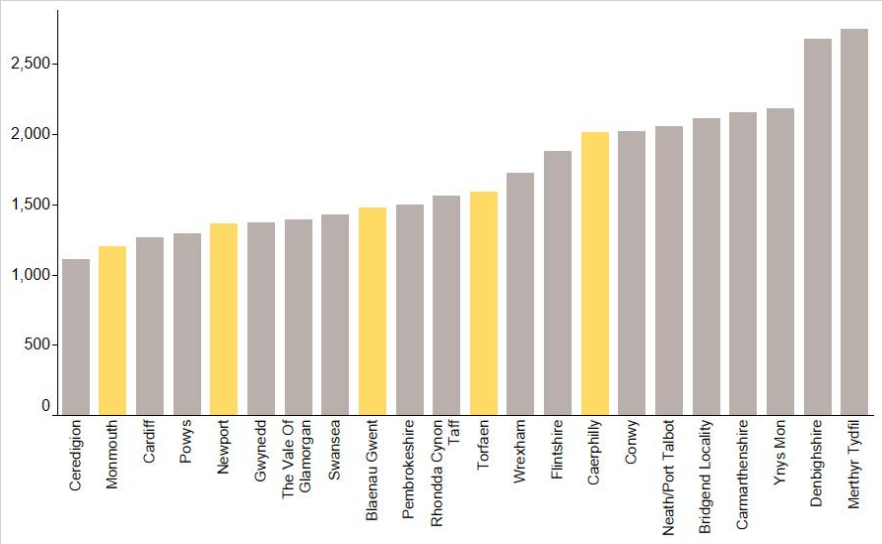
National Prescribing Indicator 2022–2025

While there is a recognised place in pain management for tramadol, there are concerns regarding the risks associated with dependence, diversion, misuse and adverse drug reactions. The aim of this measure is to promote a prudent approach to prescribing tramadol, taking into account the risks and benefits, and to encourage timely review.

Tramadol prescribing (DDDs per 1,000 patients) - Quarterly trend up to March 2023



Tramadol prescribing (DDDs per 1,000 patients) - Locality data - Financial year 2022-2023



When compared with the previous year, Aneurin Bevan's performance **IMPROVED**

Tramadol prescribing decreased by **5.1%** in 2022–2023

Out of the 7 health boards, Aneurin Bevan is ranked:

% change from last year : **7th**

Current overall performance : **3rd**

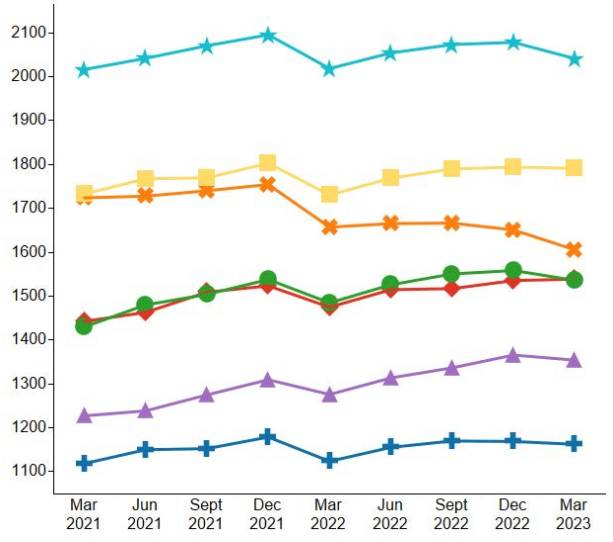
Analgesics

Gabapentin and pregabalin

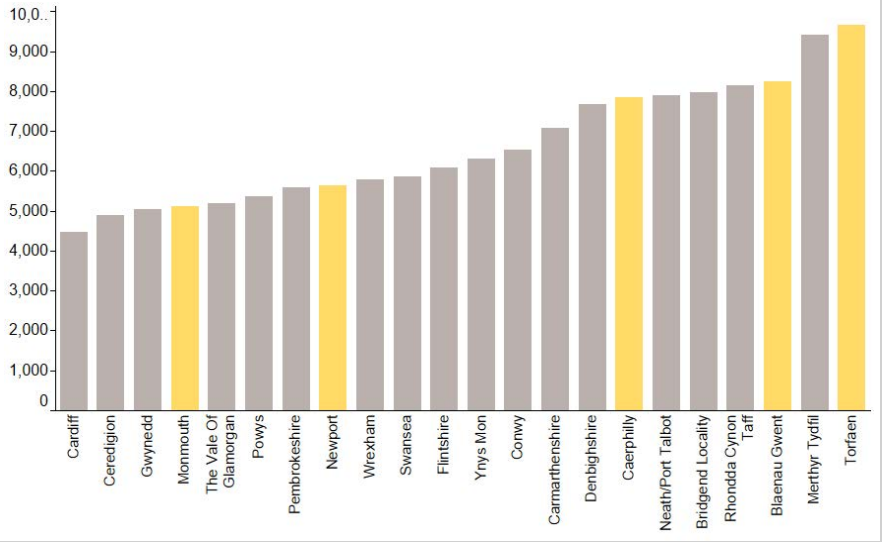
National Prescribing Indicator 2022–2025

Both gabapentin and pregabalin may cause depression of the central nervous system. When used in combination with other depressants, they can cause drowsiness, sedation, respiratory failure and death. Their potential for misuse, abuse and dependence also exists. The aim of this measure is to encourage the appropriate use and review of gabapentin and pregabalin in primary care, minimising the potential for dependence, diversion, misuse and adverse drug reactions.

Gabapentin and pregabalin prescribing (DDDs per 1,000 patients) - Quarterly trend up to March 2023



Gabapentin and pregabalin prescribing (DDDs per 1,000 patients) - Locality data - Financial year 2022-2023



When compared with the previous year, Aneurin Bevan's performance **DETERIORATED**

Gabapentin and pregabalin prescribing increased by **1.0%** in 2022–2023

Out of the 7 health boards, Aneurin Bevan is ranked:

% change from last year : **3rd**

Current overall performance : **6th**

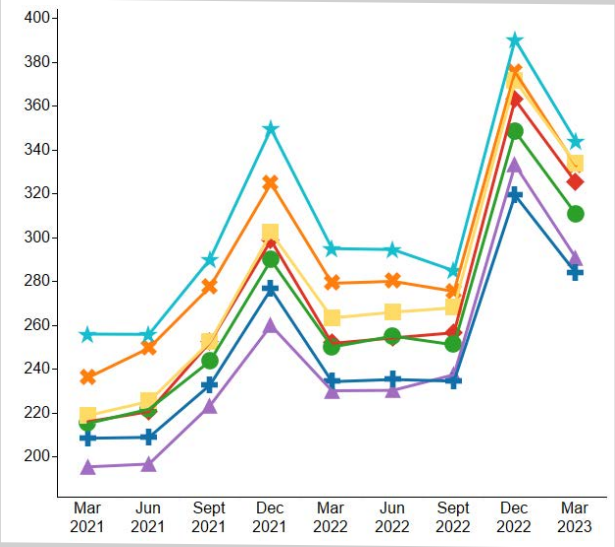
Antimicrobials

Total antibiotic prescribing*

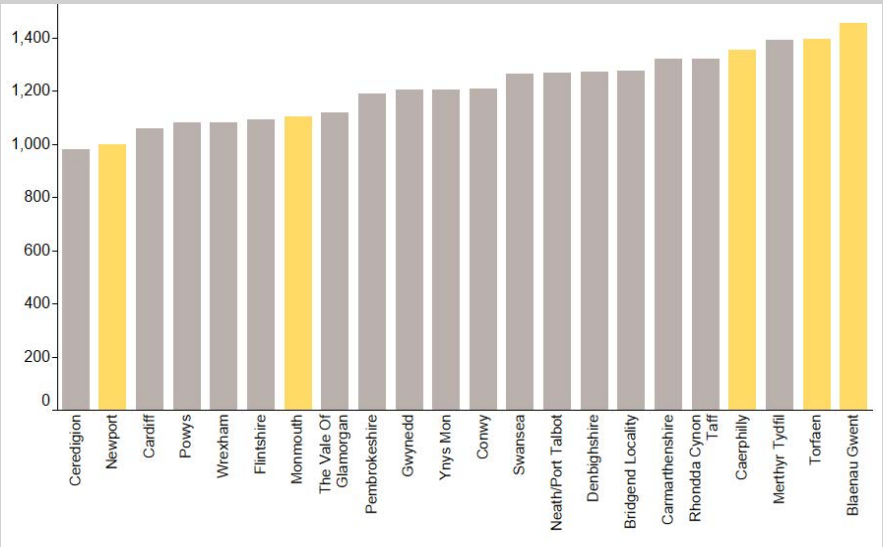
National Prescribing Indicator 2022–2025

The widespread and often excessive use of antimicrobials is one of the main factors contributing to the increasing emergence of antimicrobial resistance. The aim of this measure is to encourage the appropriate prescribing of all antibiotics in primary care.

Total antibiotic prescribing (items per 1,000 STAR-PUs) - Quarterly trend up to March 2023



Total antibiotic prescribing (items per 1,000 STAR-PUs) - Locality data - Financial year 2022-2023



When compared with the previous year, Aneurin Bevan's performance **DETERIORATED**

Total antibiotic prescribing increased by **18.8%** in 2022–2023

Out of the 7 health boards, Aneurin Bevan is ranked:

% change from last year : **6th**

Current overall performance : **5th**

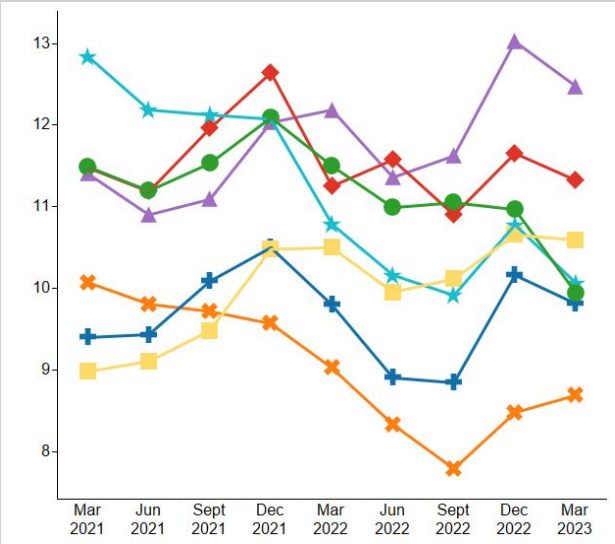
Antimicrobials

4C antimicrobial prescribing

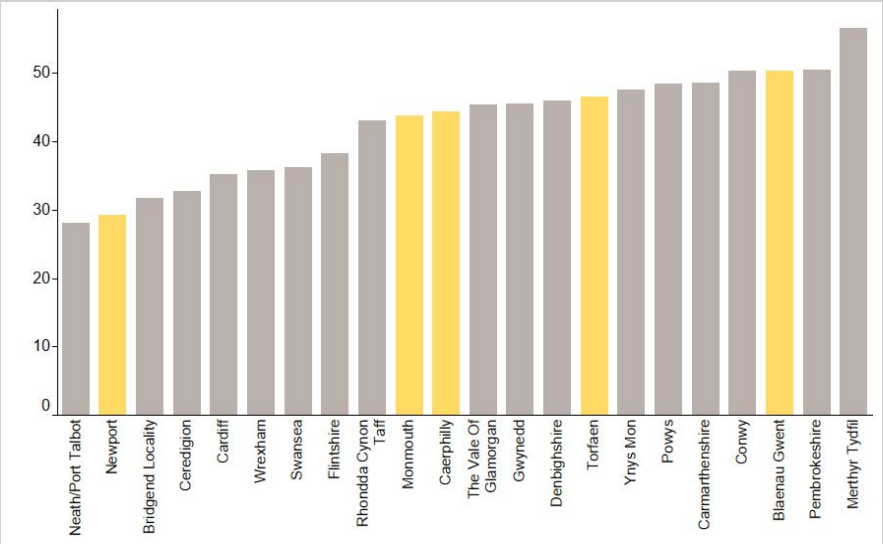
National Prescribing Indicator 2022–2025

The use of the broad spectrum antibiotics known as 4C antimicrobials (co-amoxiclav, cephalosporins, clindamycin and fluoroquinolones) when narrow spectrum antibiotics remain effective increases the risk of healthcare associated infections (e.g. *Clostridioides difficile*, methicillin-resistant *Staphylococcus aureus* and resistant urinary tract infections). The aim of this measure is to reduce variation in and overall prescribing of the 4C antimicrobials in primary care.

4C antimicrobial prescribing (items per 1,000 patients) - Quarterly trend up to March 2023



4C antimicrobial prescribing (items per 1,000 patients) - Locality data - Financial year 2022-2023



When compared with the previous year, Aneurin Bevan's performance **DETERIORATED**

4C antimicrobial prescribing increased by **4.4%** in 2022–2023

Out of the 7 health boards, Aneurin Bevan is ranked:

% change from last year : **6th**

Current overall performance : **4th**

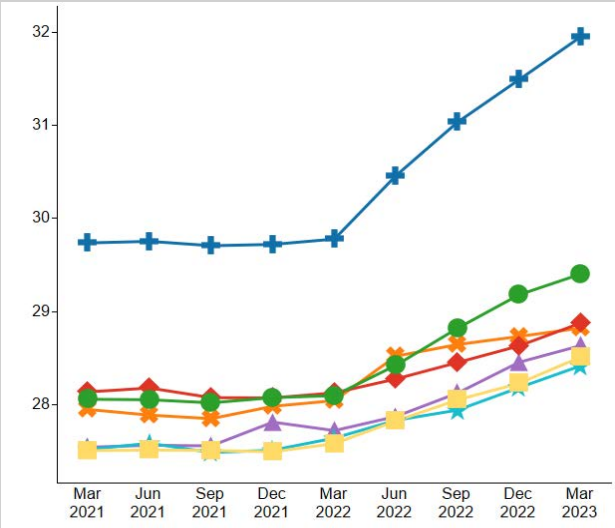
*The higher rate of Group A *Streptococcus* infections seen during the quarter ending December 2022 will have likely contributed to the increased use of antibiotics, compared to the same quarter of the previous year

Creating capacity

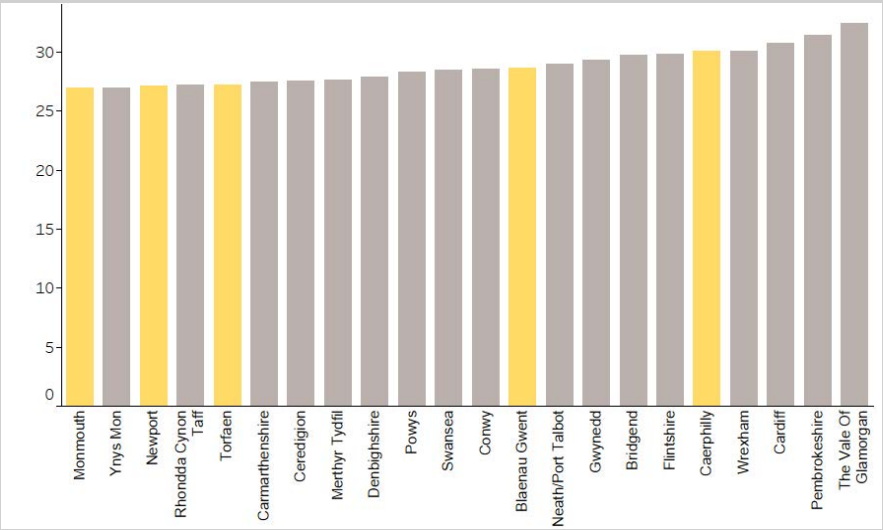
Prescribing intervals

Increasing the 28 day prescribing interval (where appropriate) will release capacity for community pharmacists to deliver clinical services and reduce the administrative burden within GP practices. The average quantity dispensed, of a group of once daily medicines, can provide an indication of change.

Perscribing intervals (Average quantity dispensed per item) - Quarterly trend up to March 2023



Perscribing intervals (Average quantity dispensed per item) - Locality data - Quarter ending March 2023



When compared with the previous year, Aneurin Bevan's performance **IMPROVED**

Average quantity dispensed per item increased by **2.3%** in 2022–2023

Out of the 7 health boards, Aneurin Bevan is ranked:

% change from last year : **4th**

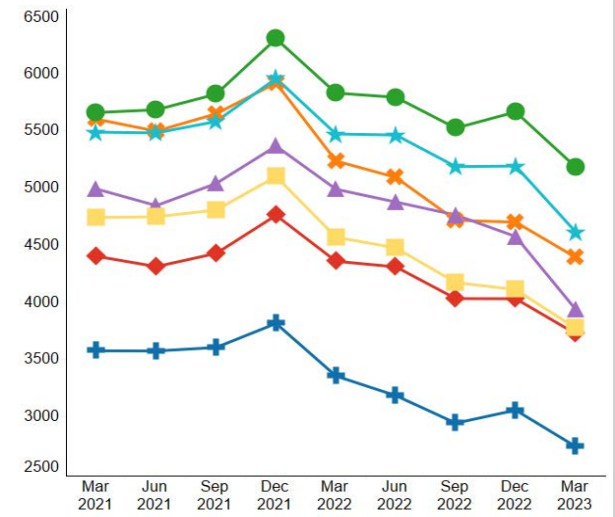
Current overall performance : **6th**

Decarbonisation

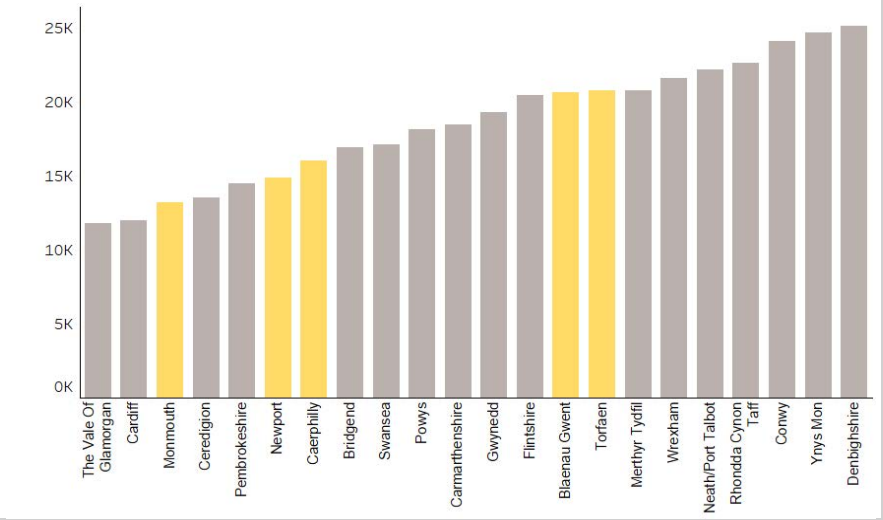
Inhaler carbon footprint

Hydrofluorocarbons are powerful greenhouse gases used in metered dose inhalers (MDIs). Low global warming potential (GWP) inhalers, including dry powder inhalers (DPIs) and soft mist inhalers, have a lower carbon footprint than MDIs. The National Prescribing Indicator Decarbonisation of Inhalers aims to encourage an increase in the use of low GWP inhalers, to reduce the carbon footprint of inhaler prescribing in Wales.

Indicative carbon footprint of inhalers (CO_2 tonnes per 1,000 patients) - Quarterly trend up to March 2023



Indicative carbon footprint of inhalers (CO_2 tonnes per 1,000 patients) - Locality data - Quarter ending March 2023



When compared with the previous year, Aneurin Bevan's performance **IMPROVED**

Carbon footprint decreased by **14.0%** in 2022–2023

Out of the 7 health boards, Aneurin Bevan is ranked:

% change from last year : **3rd**

Current overall performance : **3rd**

Safety

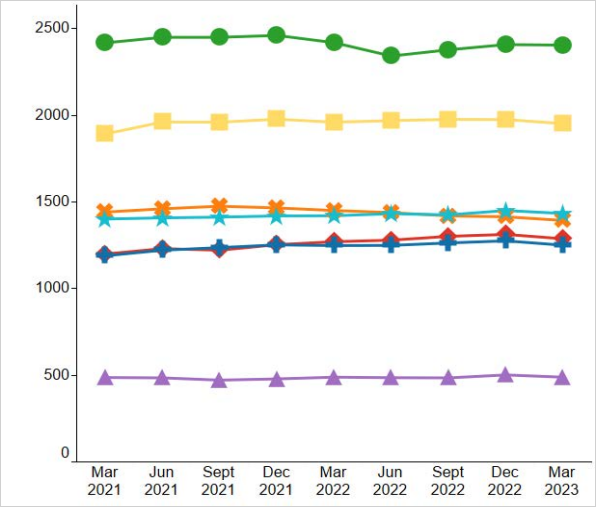
Prescribing Safety Indicator*

Patients aged ≥ 65 years old prescribed an antipsychotic

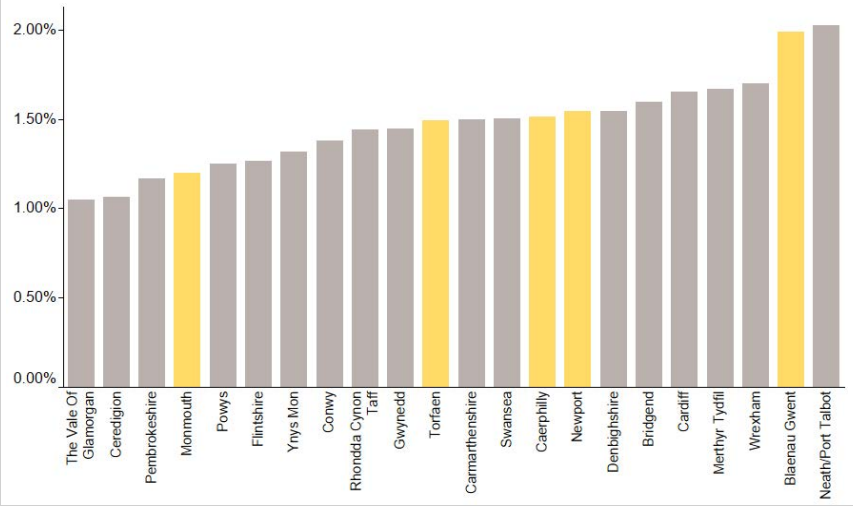
National Prescribing Indicator 2022–2025

Antipsychotics should be avoided in patients with dementia unless the person is at risk of harming themselves or others, or experiencing agitation, hallucinations or delusions that are causing them severe distress. Patients identified by this indicator should be reviewed and/or monitored as appropriate.

Number of patients ≥ 65 years old prescribed an antipsychotic - Quarterly trend up to March 2023



Number of patients ≥ 65 years old prescribed an antipsychotic as a percentage of all patients ≥ 65 years old - Locality data - Quarter ending March 2023



Comparing number of patients identified, quarters March 2023 vs March 2022

Aneurin Bevan's performance **IMPROVED**

Number of patients identified decreased by **0.4%**

Comparing number of patients as a % of patients ≥ 65 years old, quarters March 2023 vs March 2022

Out of the 7 health boards, Aneurin Bevan is ranked:

% change from March 2022 : **2nd**

Current overall performance : **5th**

Safety

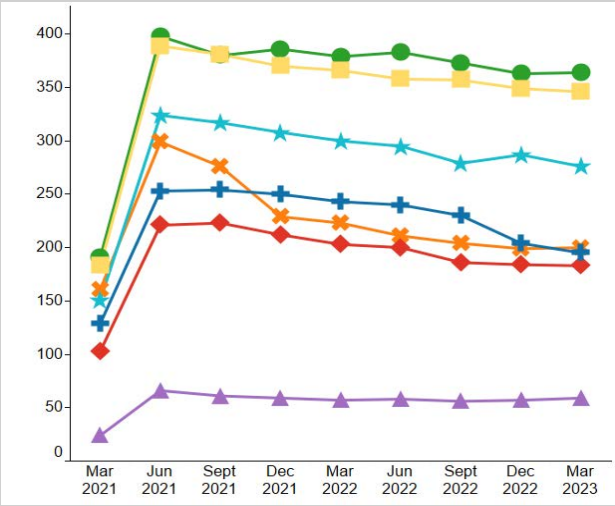
Prescribing Safety Indicator*†

Female patients aged 14–55 years old with a prescription for sodium valproate

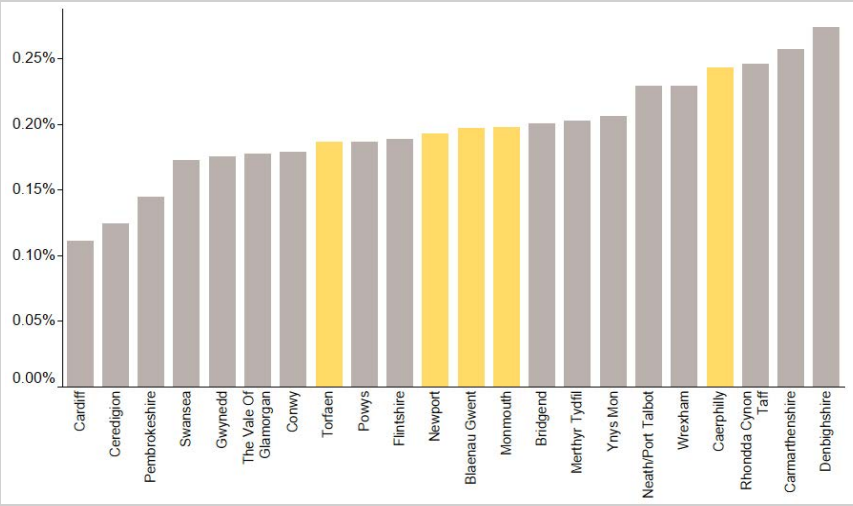
National Prescribing Indicator 2022–2025

Due to the high risk of malformations and developmental problems associated with exposure of babies to valproate medicines in the womb, they must no longer be used in women or girls able to have children unless they have a Pregnancy Prevention Programme in place. Patients identified by this indicator should be reviewed.

Number of female patients aged 14—55 years old with a prescription for sodium valproate - Quarterly trend up to March 2023



Number of female patients aged 14—55 years old with a prescription for sodium valproate as a percentage of female patients aged 14—55 years old - Locality data - Quarter ending March 2023



Comparing number of patients identified, quarters March 2023 vs March 2022

Aneurin Bevan's performance **IMPROVED**

Number of patients identified decreased by **5.5%**

Comparing number of patients as a % of female patients aged 14—55 years old, quarters March 2023 vs March 2022

Out of the 7 health boards, Aneurin Bevan is ranked:

% change from March 2022 : **4th**

Current overall performance : **6th**

* Prescribing Safety Indicators will not pick up instances where a patient has been reviewed and prescribing has been found to be appropriate.

† The search for this Prescribing Safety Indicator was amended from the quarter ending June 2021 to include female patients aged 14–55 years. Data prior to this includes female patients aged 14–45 years only.

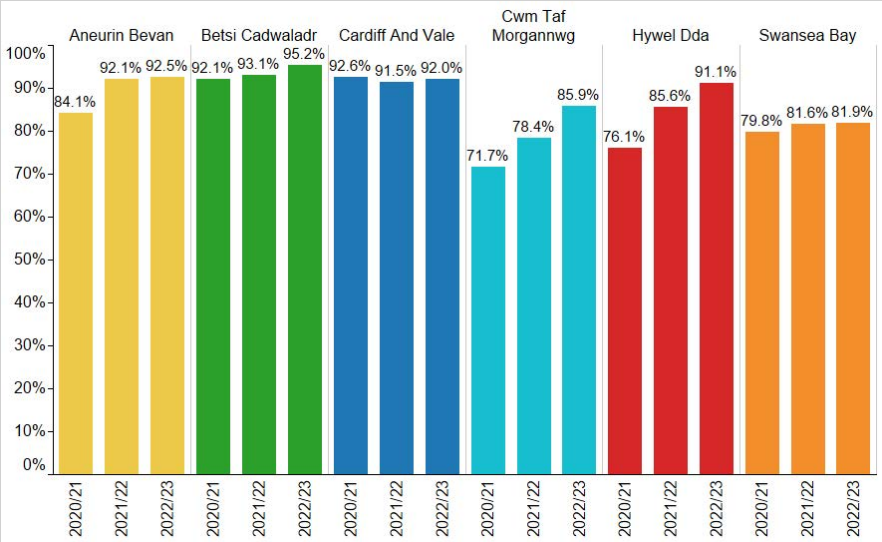
Value

Best value biological medicines

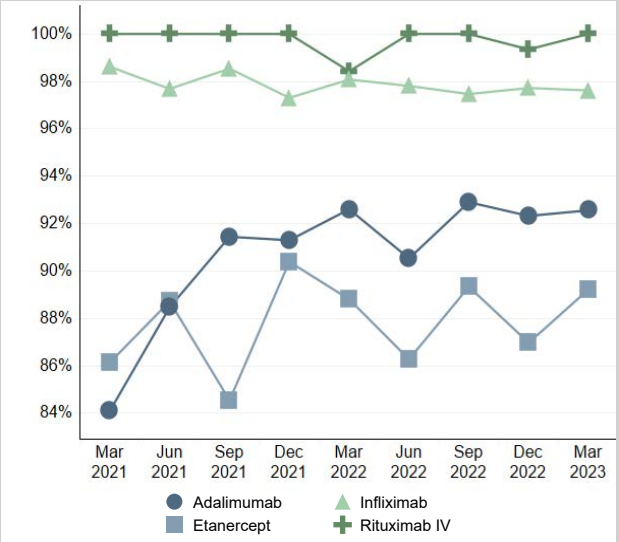
National Prescribing Indicator 2022–2025

A biosimilar medicine is a biological medicine that is developed to be highly similar and clinically equivalent to an existing biological medicine. They increase choice for patients and clinicians and drive commercial competition. The aim of this measure is to ensure prescribing of best value biological medicines supports cost-efficient prescribing in Wales.

Biosimilar prescribing (as a % of total biologic)



Biosimilar usage in Aneurin Bevan (as a % of total biologic) - Quarterly trend up to March 2023



Please note: These data are extracted via a central mapping of individual items. This is reviewed on a regular basis and therefore differences may exist between various data sets.

When compared with the previous year, Aneurin Bevan's performance **IMPROVED**

Biosimilar prescribing (as a % of total biologic) increased by **0.4%** in 2022–2023 ↑

Out of the 6 health boards*, Aneurin Bevan is ranked:

% change from last year : **5th**

Current overall performance : **2nd**

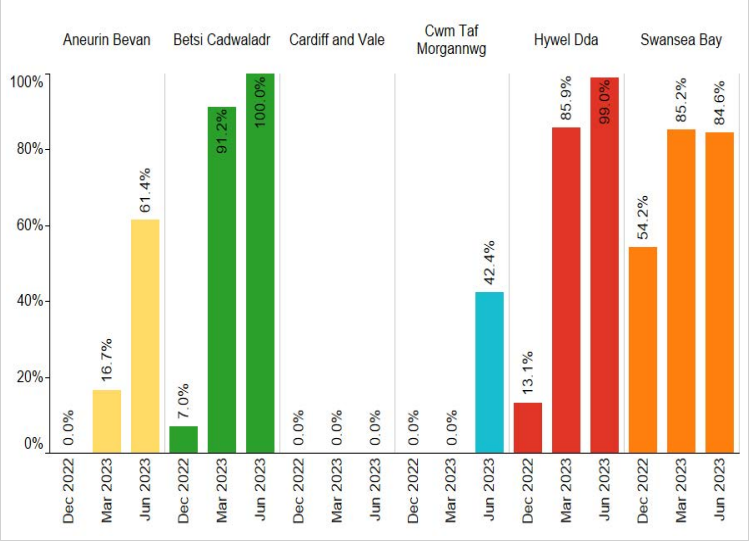
*Powys is not included in this measure.

Annex - Value

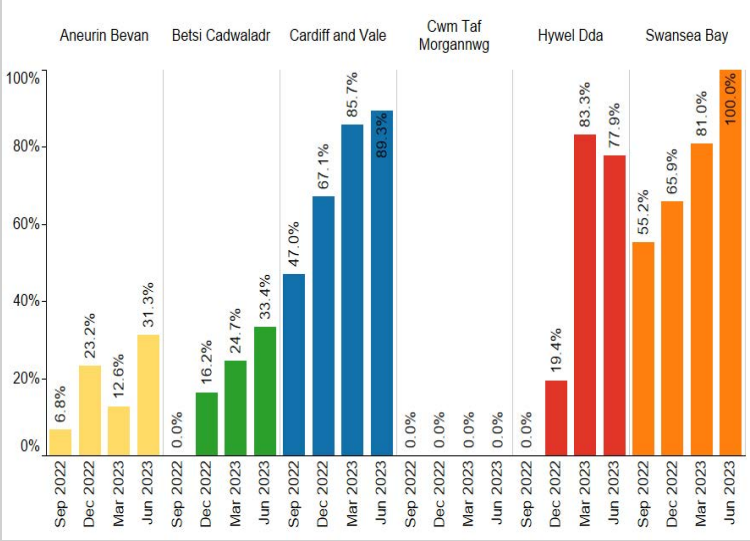
Prescribing of generic lenalidomide and biosimilar ranibizumab

Generic versions of lenalidomide and biosimilar versions of ranibizumab are now available. To provide a baseline measure for improvement in 2023-2024, an early indication of their use has been included below. It is anticipated that switching to the generic or biosimilar versions of these medicines will produce significant financial savings for the NHS in Wales.

Generic lenalidomide purchases (as a % of total lenalidomide)



Biosimilar ranibizumab purchases (as a % of total ranibizumab)



Agenda Item:3.2

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 July 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Hospital Transfusion Committee: Annual Assurance Report 2023-24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Hospital Transfusion Committee (HTC)

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA / SBAR REPORT

Sefyllfa / Situation

This report provides information about the Hospital Transfusion Committee activities for the year 2023-24 and provides assurance of the Health Board's management of blood and its various components against the Health and Care Quality Standards.

It also sets out the priorities and actions which will be progressed through the Hospital Transfusion Committee (HTC) through 2024-25.

Cefndir / Background

The Hospital Transfusion Committee (HTC) has oversight and responsibility for Health and Care Standard 2.8 Blood Management; ensuring that people have timely access to a safe and sufficient supply of blood components and blood products when needed.

The HTC produces an Annual Assurance Report detailing the Health Board position in relation to each component of the Health and Care Standard and provides exception reports if required throughout the rest of the year.

Asesiad / Assessment
At its 7th June 2024 meeting the HTC was satisfied that the Health Board's approach to the management of blood and its various components against the Health and Care Quality Standards is effective. It recognised that improvements can continue to be made and that plans are in place to undertake the improvements. The HTC believes that the Health Board has robust governance systems in place to maintain a safe sufficient supply of blood, blood components and blood products to support timely, appropriate and effective use for all. It is also satisfied that the Health Board complies with legislation and national guidance on the supply and appropriate use of blood, blood components and products. The Chair of HTC is a Consultant Haematologist with responsibility for transfusion, Welsh Blood Service (WBS). The HTC membership consists of, Haematology / Transfusion Department Manager, Transfusion Laboratory Manager, Transfusion Practitioner, Anaesthetist, Risk Management and invites representation from Finance, Senior Nursing & Midwifery teams and clinical high users of blood components. A number of actions have been agreed for 2024/25 and progress against the actions will be reported at each HTC meeting. Patient Safety Incidents are identified and comparisons are made against past performance to ensure improvements are made. The potential of clinical incidents are included in the HTC Risk Register. In 2023 there were 7 "Wrong Blood in Tube" (WBIT) incidents. An additional module of the Haemonetics digital system is being introduced in July 2024 which allows bedside patient identification and verification of blood components prior to transfusion and this is believed to improve patient safety.
Argymhelliad / Recommendation
The Committee is asked to note the contents of the Hospital Transfusion Committee: Annual Assurance Report 2023-24, which provides assurance on the Health Board's management of blood and various components.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	NA
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.6 Medicines Management 1.1 Health Promotion, Protection and Improvement 2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Medicines Management Programme Board Executive Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities;

	and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item. Choose an item.

HOSPITAL TRANSFUSION COMMITTEE: ANNUAL ASSURANCE REPORT 2023-24

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1. Purpose

This report provides information about the Hospital Transfusion Committee activities for the year 2023-24.

As such, it provides assurance of Health Board's management of blood and its various components against the Health and Care Quality Standards.

It also sets out the priorities and actions which will be progressed through the Hospital Transfusion Committee (HTC) through 2024-25.

2. Background

The Aneurin Bevan University Health Board Quality Assurance Framework forms an essential element of the overall system of controls with the aim of identifying, mitigating and managing risks to the achievement of our strategic objectives and priorities as set out in the Health Board's Integrated Medium-Term Plan. This framework is aligned to the Board Assurance Framework and with inherent links to the Risk Management Strategy.

The Health Board Quality Assurance Framework Structure comprises a range of groups, each of which focus on an aspect of quality and safety reporting to the Patient Quality Safety and Outcomes Committee (PQSOC) a sub-committee of the Board, via the Quality and Patient Safety Operational Group (QPSOG), which reports to the Executive Team.

The Hospital Transfusion Committee has oversight and responsibility for Health and Care Standard 2.8 Blood Management; ensuring that People have timely access to a safe and sufficient supply of blood components and blood products when needed.

The HTC produces an Annual Assurance Report detailing the Health Board position in relation to each component of the Health and Care Standard and provides exception reports if required throughout the rest of the year.

3. Assurance Assessment

Health services have robust governance systems in place to maintain a safe sufficient supply of blood, blood components and blood products to support timely appropriate and effective use for all.
There is compliance with legislation and national guidance on the supply and appropriate use of blood, blood components and products.

Aneurin Bevan University Health Board Blood Management is governed by the Hospital Transfusion Committee (HTC), a subgroup of the QPSOG that reports into the PQSOC.

The HTC membership consists of Chair, Consultant Anaesthetist, Welsh Blood Service; Haematology Consultant with interest in transfusion; Haematology / Transfusion Department Manager; Transfusion Laboratory Manager; Transfusion Practitioner; Risk Management representative and invited representation from Finance, Senior Nursing & Midwifery teams and clinical high users of blood components.

Action 2023: Invite Finance, Quality and Patient Safety (QPS) and Primary Care (or equivalent) representative to HTC – complete.

The HTC agenda is developed to encompass all components of Health and Care Standard 2.8 Blood Management, including compliance with legislation, stock management, education and training and patient safety incidents.

The HTC is responsible for the implementation and review of all Blood Component and Blood Product Policies, procedures and clinical guidelines developed to ensure that the Health Board delivers care in line with national legislation. The format of the agenda has been amended to accommodate clinical and QPS representatives.

The Health Board Policies and Procedures reinforce legislation and national guidance including:

i. Blood Transfusion Policy

The HTC is responsible for the content and review of the policy and monitors compliance through the Hospital Transfusion Team.

The Policy is currently under review.

The Policy:

- Informs clinical and laboratory staff of the blood components available, their appropriate use and any alternative strategies that should be considered and underpins Administration of Blood Components, British Society of Haematology (BSH) (2015).
- Sets out the responsibilities of the Health Board and staff groups with respect to the storage and distribution of human blood components for transfusions in line with the UK Blood Safety and Quality Regulations (BSQR) (2005) and safe transfusion, particularly with respect to correct patient identification, correct documentation including traceability of all blood components and communication of information.

- Is explicit in defining the responsibility of the Transfusion Laboratory in accounting for all blood components issued including their final fate and the requirement to report all serious adverse events and reactions to the Medicine and Health Care products Regulatory Agency (MHRA).
- Clearly defines training and competency requirement of all staff involved in transfusion processes.
- Provides information to support informed consent and the provision of patient information.

ii. Clinical Standard Operating Procedure (CSOP): Transferring Blood Components with Patients

The CSOP provides transfer principles and methods unique to each Health Board site and standardises the process to ensure that:

- All transferred patients who have, or are at risk of, immediate, life-threatening bleeding, have definitive care in transit.
- To minimise the detrimental effects of hypothermia, acidosis and coagulopathy due to inappropriate or unavailable treatment.
- the correct Patient Identification and Component Administration procedures are followed.
- compliance with legislation relating to Traceability, Cold Chain and Safe Handling of Blood Components.

iii. The Blood Transfusion Sample Acceptance Policy

The policy details the procedure for the correct labelling of pre-transfusion request forms and samples and the correct identification of samples for screening prior to the release of blood components and blood products and underpins Pre-Transfusion Compatibility Procedures in Blood Transfusion Laboratories, BSH (2012).

The collection and labelling of samples is a critical step in the blood transfusion process. Errors can range from minor discrepancies in the core patient identifiers to the complete mislabelling of sample and form with details from another patient – 'Wrong Blood in Tube' (WBIT). If undetected prior to transfusion, there is an increased risk of a fatal ABO incompatible haemolytic reaction.

A National Audit of UK Serious Hazards of Transfusion (SHOT) Haemovigilance Scheme report on the type and prevalence of errors and provide guidance on how they may be prevented with an emphasis on training and competency assessment to standardised procedures.

A recent audit of sample acceptance, within the Health Board shows an 8.2% sample rejection rate due to errors in labelling. Sample rejection, however, is variable across sites and departments.

The risk to patient safety has been reduced by the 'Zero Tolerance' process whereby any sample that does not meet the labelling requirements specified in the policy is not accepted.

Also, there is a 'Check Sample' protocol which requires at least two identical blood group results available before group-specific blood can be issued by the Hospital Transfusion Laboratory.

Staff who take blood transfusion samples require training and competency assessment in positive patient identification and how to label the samples in compliance with this Policy. Continued compliance is essential for safe transfusion and minimising the risk of serious adverse events.

iv. The Management of Major Haemorrhage Protocol

An updated Protocol has been approved by HTC and has been submitted to the Clinical Policies and Standards Group for final ratification in May 2024.

The early recognition of major blood loss and effective, appropriate action is vital if hypovolemic shock and its adverse consequences are to be avoided. The rapid provision of blood and blood components is integral to successful management.

The protocol provides an evidence-based algorithm for the transfusion management of major haemorrhage in adult and paediatric patients.

Implementation supports the Health Board in meeting the requirements of the National Patient Safety Agency Rapid Response Report on emergency availability of blood and blood components.

The Protocol has been adapted from the NHS Blood and Transplant (NHSBT) NW Region's Toolkit for the management of major haemorrhage (2013) and underpins Haematological Management of Major Haemorrhage, BSH (2022). The guidance is intended for use within Aneurin Bevan University Health Board in The Grange University Hospital (GUH), Royal Gwent Hospital (RGH), Nevill Hall Hospital (NHH) and Ysbyty Ystrad Fawr (YYF).

v. The Blood Shortage Clinical Management Plan

The Blood Shortage Clinical Management Plan details the Health Board's contingency plans to ensure the effective use of available red cells and platelets when stocks have fallen to very low levels and is essential in ensuring transfusion support remains available for patients who need it most.

The Health Board may be required to activate its Emergency Planning Group arrangements for short term shortages, caused by e.g. inclement weather or an influenza outbreak, or very acute shortages caused by e.g. security issues which stop donors coming forward to donate blood, and prolonged blood shortage which could result from a number of circumstances, e.g. the introduction of further measures to reduce the risk of disease transmission by transfusion or a future pandemic.

The plan aims at ensuring the shortages are handled in a fair and effective way and covers all adult transfusion. Clinical staff will be aware of their responsibilities and accept that a decision-making process is necessary when the supply of red cells is limited.

The HTC is responsible for the overall management of the plan.

In addition, policies exist to support the safe and effective use of specific blood products including, intravenous Immunoglobulin and recombinant activated human coagulation factor VII and VIIa, fresh frozen plasma and platelets.

The Health Board transfusion service submits an annual Blood Compliance Report to the MHRA and is subject to periodic inspection. The last inspection was undertaken at GUH in March 2022 and incorporated a review of the quality management system including, documentation, complaints, component recall, training and competency, validation and calibration, traceability, storage and distribution and review of serious adverse incidents.

(a) Effective schemes and systems are in place to actively manage stock, minimise wastage, and plan effectively for shortages.

The Blood Health National Oversight Group (BHNOG) was established in 2017 to oversee the implementation of the NHS Wales National Blood Health Plan (BHP). BHNOG is an All-Wales body authorised by the Welsh Government to lead on all matters relating to the BHP and relevant blood health related issues.

The remit of the BHP is to initiate and implement transfusion based best practice to ensure safe and appropriate transfusion. The BHNOG is responsible for leading these changes in Wales working collaboratively with Health Boards and Welsh Government.

A monthly dashboard of blood component usage by site is produced by WBS to support effective and prudent use of blood products and to support its monitoring and management. The dashboard is accompanied by an exception report when exceptions occur (see attached), based on non-compliance with KPIs for Health Boards to review and discuss mitigating actions. Dashboards and exception reports are discussed at HTC – see Appendix 1 (ABUHB Monthly Data Report) and Appendix 2 (Hospital Red Cell Wastage Report) for examples of reports.

The Health Board Blood Shortage Plan sets out a clear line of communication between WBS and the Health Board Executive team and clear clinical guidance on appropriate transfusion and prioritisation of blood products in the case of blood shortages.

(b) Continuous innovative programme of education, training and competence assessment covers all staff involved in the transfusion process in line with national strategy.

An All-Wales Transfusion Competency Package is used to assess staff in the critical areas of:

- Taking of Pre-Transfusion Blood Samples
- The Administration of Blood Components to the Patient.

Pre-transfusion sampling and administration competencies are transferable within Wales with suitable evidence of completion. Competency assessment can be completed by ward-based assessors or the Transfusion Practitioners.

The collection and transport of blood components competency assessments in the handling and storage of blood components is a legal requirement under Blood Safety and Quality Regulations (BSQR) 2005. This is achieved through a locally agreed programme of assessment of compliance with Good Manufacturing Practice (GMP) as monitored by the MHRA. This applies to staff who transport blood components (e.g., Porters, clinical & non-clinical staff, and Couriers).

A register of training and competency assessment is maintained by the Transfusion Practitioner Team that records the delivery of training and competency assessments.

In the absence of a formal training needs analysis there is no current method of defining the denominator and therefore capturing the actual numbers of staff who require training. Ward managers and Health Board staff are also advised to keep local transfusion training records.

During 2023, the Blood Health Team at Welsh Blood Service implemented 9 transfusion training modules which are now available on ESR.

An application has been submitted to the Health Board Core Learning Committee (CLC) for the inclusion of the Essential Transfusion Practice module on ESR as mandatory for all registered staff who may be involved in the transfusion process. Should this be approved, it will support in defining the denominator and providing a record of transfusion training undertaken. There will be a phlebotomy module available later in 2024.

However, this should be seen as the minimum, essential training undertaken, with further training in all-Wales and Aneurin Bevan specific processes and protocols in pre-transfusion sampling, administration and haematological management of a major haemorrhage. This bespoke training is provided by the TP team along with remedial training for members of staff involved in transfusion-related incidents.

Action 2024: Progress application for Essential Transfusion Practice module to become mandatory on ESR

Scrutiny of all patient safety incidents associated with transfusion is undertaken to understand if lack of compliance with training or competency assessment was a contributory factor in any incident.

In 2023 there were several reported incidents that relate to lapsed or failure to complete training and competency assessment.

Transfusion Practitioners across Wales provide transfusion education to Year 5 Medical Students during their Senior Student Assistantship (SSA) within local Health Boards. Audit has shown that greater than 50% of students leave Wales to take posts elsewhere which has prompted discussion around inclusion on the local induction programmes for Foundation Practitioner 1 (FP1) doctors.

This reduction in students proceeding on to medical practice in Wales has prompted a review of the SSA transfusion training programme to determine whether it can achieve a significant tangible outcome for Wales or whether resources would be better focussed on FP doctors who will be practicing in Wales for at least 2 years. The BHNOG

Education Strategy Group has arranged a meeting with HEIW to determine if transfusion education can be included in the FP1 induction programme rather than ad hoc. The Health Board Medical Education Lead is in support of the proposal.

Action 2024: Progress discussions with HEIW and Health Board Medical Education Leads to introduce transfusion training to FP1 Induction Programme.

(c) Processes are in place that enhance the safety of blood transfusion and support the recognition and reporting of, and shared learning from, all incidents, adverse blood events and reactions.

A register is maintained to detail all transfusion Serious Adverse Events (SAE) and Serious Adverse Reactions (SAR) to support the extrapolation of themes and trends and to record national reporting to MHRA and Serious Hazards of Transfusion (SHOT) the UK's independent, professionally led haemovigilance scheme.

SHOT recently introduced an additional category for acknowledging continual excellence (ACE) which acknowledges exceptional transfusion practice by a team or department, that was above and beyond routine practice and has widespread learning opportunities. The Health Board submitted one such ACE event for a project undertaken for the implementation of Prothrombin Complex Concentrate into the Emergency Department without the initial need for Consultant Haematologist approval. This was in response to a SHOT / Central Alerting System (CAS) Alert published in January 2022.

The project was presented at the British Blood Transfusion Society (BBTS) Annual Conference and at the BHNOG Annual Conference where it won the category for Service Improvement.

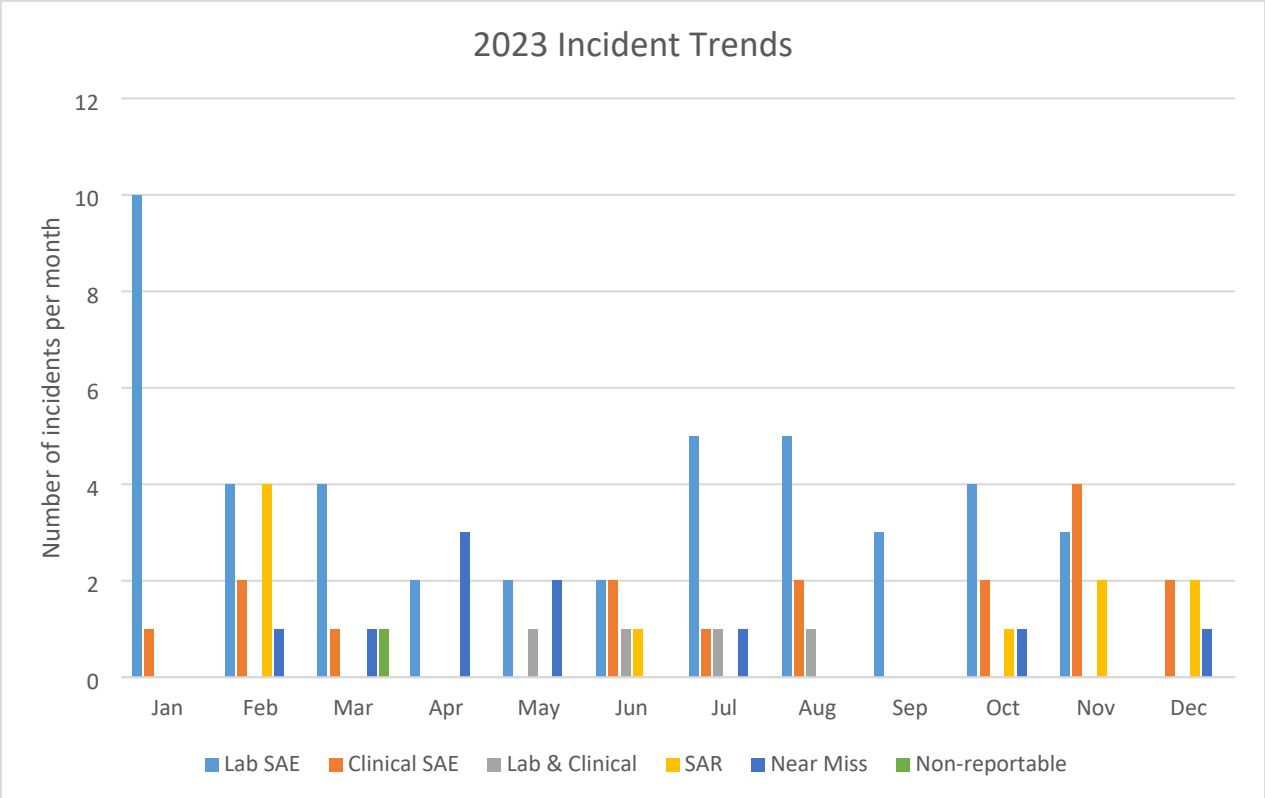
An SAE & SAR notification report must be made within 5 working days of receipt to MHRA who will share the report with SHOT. SHOT collect and analyse anonymised data relating to adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood components and blood products in the United Kingdom. Where risks and problems are identified, SHOT produces recommendations to improve patient safety. The recommendations are collected into its annual report, a summary of which is then circulated to all the relevant organisations including the four UK Blood Services, the Departments of Health in England, Wales, Scotland and Northern Ireland and all the relevant professional bodies as well as circulating it to all of the reporting hospitals.

(The SHOT Annual Report is available July 2024 as a hard copy to purchase or freely available via the SHOT website and the SHOT app. SHOT-REPORT-2022-FINAL-Bookmarked-1.pdf (shotuk.org))

As haemovigilance is a continuing exercise, SHOT can also monitor the effect of the implementation of its recommendations.

4. Patient Safety Incidents

Patient Safety incidents relating to transfusions are grouped into three categories, clinical, Laboratory and shared clinical and laboratory incidents (see graph below).



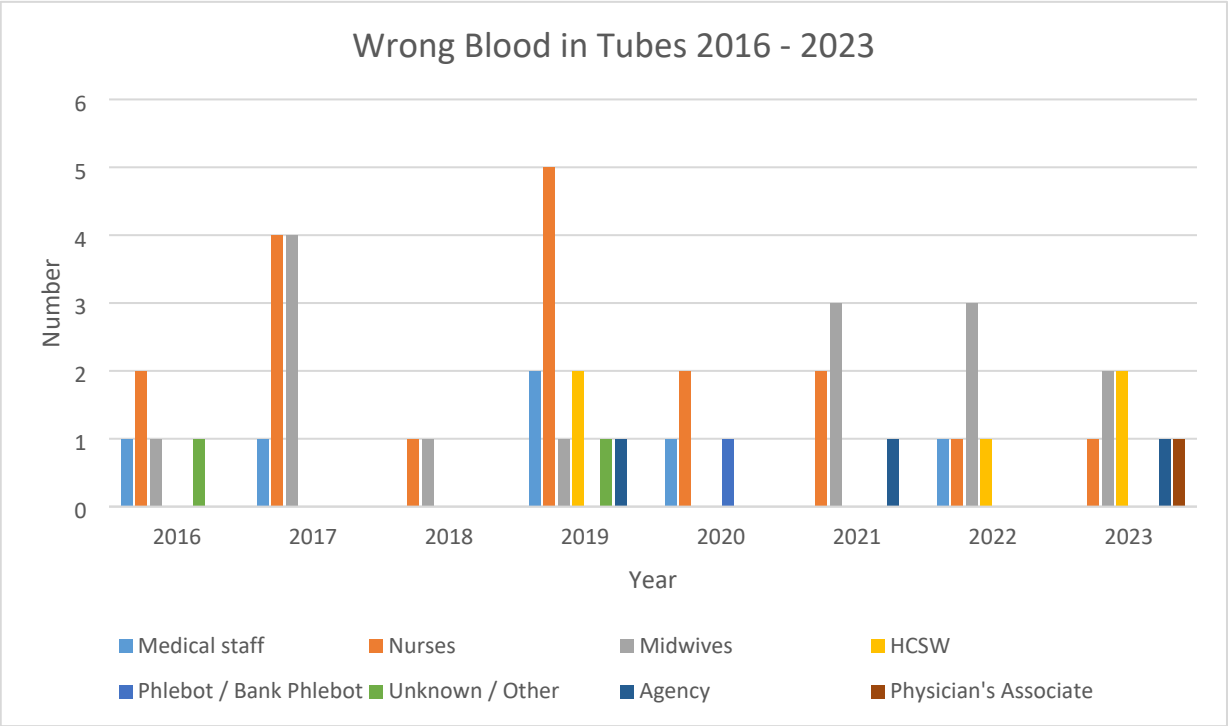
i. Clinical Errors

The more commonly reported clinical error is "Wrong Blood in Tube." (WBIT). The graph below provides the number of incidents of wrong blood in tube events from 2016 – 2023.

Seven WBIT incidents were reported in 2023.

The check sample protocol aims to mitigate the risk of WBIT. A check sample protocol requires at least two identical blood group results available before group-specific blood can be issued by the Hospital Transfusion Laboratory.

When a patient does not have an historical blood group recorded on the laboratory system the clinician is required to take a second pre-transfusion sample in a separate phlebotomy episode. The specifics of what constitutes a second phlebotomy episode are 2 separate venepunctures with 2 separate patient identification checks.



In 2023, the TPs investigated an event where the first and confirmatory sample were taken in one phlebotomy event. Corrective and preventative action included education and a sampling competency assessment for the individual and education session for wider group of staff (Physician's Associates). Had the patient required red blood cells, this would have resulted in an ABO incompatible transfusion which is a Department of Health Never Event.

Action 2023: All-Wales project to implement a bedside sample collection system across Wales aiming to reduce the incidence of WBIT.

The All-Wales project has not progressed. See action for 2024 below.

The introduction of remote issue Haemobank blood fridges is complete within the four main sites of Aneurin Bevan University Health Board.

The Haemonetics system is used to check the patient's blood group, the availability of a valid sample with the results fully validated and no reason for exclusion from electronic issue. The Haemobank will

communicate with the lab IT system and identify the correct blood component and issue labels to be attached to the blood unit that include the unique patient identifiers and donor identification number.

This will minimise the risks associated with issue of incorrect blood.

A further module for the Haemonetics system allows bedside patient identification and verification of blood components prior to transfusion which will greatly improve patient safety. This was originally to be implemented as part of the LINC LIMS project on a Wales NHS basis. However, this project was terminated without the module being implemented.

Implementation of this module would have prevented a serious incident (SI) where an incorrect patient was transfused a platelet component meant for a different patient due to lack of patient identification. Therefore, independently, the Health Board is progressing development and implementation of a digital transfusion application and this is expected to be in place in January 2025.

In addition, under the NHS Wales "Scan4Safety" programme ABUHB is developing a business case for procuring GS1 compliant wristbands which will link with ABUHB clinical applications.

Action 2024: All Wales project has not progressed.

Application to implement in Aneurin Bevan University Health Board as a recommendation from a serious incident (SI).

The project requires the introduction of GS1 compliant barcoded ID bands and cannot progress until these have been implemented across the Health Board.

ii. Laboratory & Clinical Incidents

As previously reported, clerical errors account for a significant proportion of laboratory errors and can include misspelling or incorrect digits in patient details on the pre-transfusion sample which was then accepted and passed at all stages of lab testing, validation & issue of blood component. Should the blood component be transfused in the clinical area, this becomes a joint lab and clinical incident. Clerical incidents continue to be prominent in the 2023 data.

iii. Loss of traceability incidents

The BSQR 2005 defines "traceability" as "the ability to trace each individual unit of blood or blood component from the donor to its final destination (whether this is a recipient, a manufacturer of medicinal

products or disposal) and from its final destination back to the donor and is a legal requirement. This has previously been achieved by returning a label attached to the blood unit to the laboratory indicating the outcome of the blood product. The transfusion lab reported 22 loss of traceability events throughout 2023 where the traceability label was not returned to the transfusion lab and there was no evidence of transfusion in the patient notes / All Wales Transfusion Record.

Traceability during 2023 was therefore 99.8%. The legal expectation is to achieve 100% traceability at all times.

Traceability has been placed on the Risk Register (Risk ID 6700).

Implementation of Haemonetics BloodTrack Enquiry for confirming traceability electronically once the transfusion has commenced is intended to significantly improve traceability across the 4 main sites of the Health Board.

Action 2024: TPs to continue providing training on BloodTrack Enquiry system to clinical staff to facilitate ward fating of red blood cells to improve traceability with the support of newly appointed post of Transfusion Support Officer.

iv. Management of Major Haemorrhage

The management of major haemorrhage is governed by a Major Haemorrhage protocol to ensure early recognition and timely and effective action to prevent hypovolemic shock.

Every major haemorrhage activation within the Health Board is audited internally by the TP team and MHPs across Wales are subject to ongoing audit by WBS who designed a monitoring tool to capture data from major haemorrhage activations. It produces a quarterly report to support appropriate use of O RhD negative red cells & major haemorrhage management.

The report and the Health Board's compliance with the quality indicators are reviewed and discussed at the quarterly HTC (examples of reports are shown in Appendix 1 and Appendix 2 and the SHOT Annual Report is available in July 2024 as a hard copy to purchase or freely available via the SHOT website).

5. Collective Approach to Optimal Blood Management

The Welsh Blood Service provides All Wales leadership around the use of blood and related products across Wales ensuring more effective and efficient use.

All Health Boards work in collaboration with WBS to support the delivery of the NHS Wales Blood Health Plan.

6. Conclusion

The Hospital Transfusion Committee is satisfied that the Health Boards approach to the management of blood and its various components against the Health and Care Quality Standards is effective.

It recognises that improvements can be made and plans are in place to improve the service.

Appendix 1: ABUHB HTC Monthly Data Report

Grŵp Goruchwylio Iechyd Gwaed Cenedlaethol
Blood Health National Oversight Group

Monthly Data Report

Report for: ABUHB
For the period of: 1st Jan 2023 – 31st Dec 2023
Date Issued: 24/01/2024
For the attention of: TLMs/TPs/Consultant Haematologists/HTT/HTC Chairs

O D Neg Issues
All Wales Data: December saw a decrease in O neg Issues to 11.7% total issues and a slight reduction in rolling issues to 12.22%
HB/Hospital Data: HB saw a reduction in overall O D Neg issues to 11.10% for December with rolling % issues below KPI at 11.10%. However, both Royal Gwent and Nevill Hall hospitals saw O D Neg issues above the 12% KPI at 15.12% & 14.18% respectively for December. Action: Continue to monitor stock sharing across HB to ensure maximum use of O D Neg units
Hospital Response: Checked how many O Neg units RGH & NHH issued compared to November and it had increased by 13 units, they were all transfused to O Neg patients. NHH O Neg issues: Nov 11 units Dec 14 units RGH O Neg issues: Nov 19 units Dec 29 units
O D NEG WAPI
All Wales Data:

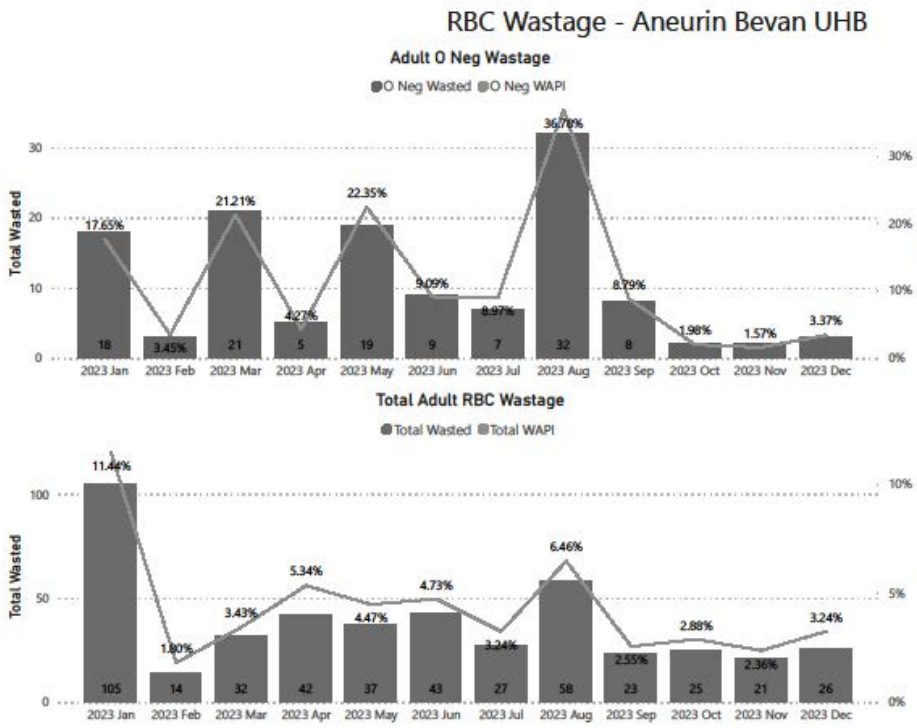
HB/Hospital Data: No action
Hospital Response:
Platelet WAPI
All Wales Data:
HB/Hospital Data: No Action
Hospital Response:

Actions:

HTTs/HTCs are requested to discuss report & propose any remedial actions/key messages as appropriate. This report is designed to celebrate both good practice and areas for improvement.
The HTC chair (or designated deputy) should ensure they are familiar with the data and actions/messages identified locally in preparation for the BHNOG meetings where verbal feedback may be requested.
Feedback from HTTs/HTCs is welcomed and can be provided by completing the '*hospital response*' section in the table and returning to WBS.bloodhealthteam@wales.nhs.uk.

Please Note: The data provided in these reports relies on the accuracy and timeliness of data input. This data may be subject to change if amendments are made after the data submission date.

Appendix 2: Hospital Red Cell Wastage Report



DateCompleteTo

31/12/2023

Year	Month	Total Wasted	Total WAPI	O Neg Wasted	O Neg WAPI
2023	December	26	3.24%	3	3.37%
2023	November	21	2.36%	2	1.57%
2023	October	25	2.88%	2	1.98%
2023	September	23	2.55%	8	8.79%
2023	August	58	6.46%	32	36.78%
2023	July	27	3.24%	7	8.97%
2023	June	43	4.73%	9	9.09%
2023	May	37	4.47%	19	22.35%
2023	April	42	5.34%	5	4.27%
2023	March	32	3.43%	21	21.21%
2023	February	14	1.80%	3	3.45%
2023	January	105	11.44%	18	17.65%
Total		**453**	**4.38%**	**129**	**11.10%**

Agenda Item: 3.3

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 July 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Overview of the Infection Prevention, Decontamination and Antimicrobial Stewardship Annual Report 2023/2024
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade – Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Moira Bevan – Head of Nursing, Infection Prevention

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

The purpose of the report is to provide the Patient Quality, Safety and Outcomes Committee with an overview of key achievements and concerns from the Infection Prevention, Decontamination and Antimicrobial Stewardship annual report 2023/2024.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The annual report provides an overview of key achievements, risks and organisational learning encompassing:-

- Infection Prevention Team Governance
- Welsh Government Reduction expectation target
- Respiratory infections
- Caesarean section
- Education and Audit
- Covid Investigation Team
- Outbreaks
- Decontamination
- Cleaning standards
- Incident management

Cefndir / Background

Each year, an annual report is submitted to provide assurance on the key principles of infection prevention across the Health Board for the financial year (FY) March to April. The report also provides an update on progress against FY 2023/24 priorities and identifies key objectives for the new financial year.

Asesiad / Assessment

Throughout the year, the Infection Prevention Team have strived to support Divisions promoting best practice for infection prevention. The team continues to be financially subsidised by Regional Integration Funds (RIF) which enables the team to work collaboratively across Primary and Secondary Care. This funding is reviewed annually with a potential risk around service provision if not successful in 2025.

Welsh Government Reduction Expectation Goals While the Health Board were below the national average rate for all reportable organisms, it is disappointing to report that the Health Board experienced an increase compared to the equivalent period 2022/2023: -

Reportable Organism	% increase	Equivalent period 22/23
C difficile	19%	36 cases more
E coli	11%	31 case more
Klebsiella	14%	13 cases more
Pseudomonas	39%	7 cases more

Contributing factors include antimicrobial resistance and suboptimal prescribing, patient acuity, compliance with fundamental infection prevention measures i.e. hand hygiene, cleaning schedules, boarding and movement of patients.

Antimicrobial Stewardship

The Health Board continued to achieve the Welsh Government target for antimicrobial use in secondary care. In hospital settings, joint ward rounds with Microbiology have reviewed 1,263 patients on complex antimicrobial therapy, making 1,782 recommendations to optimise treatment.

The Antimicrobial Pharmacy team have provided 65 hours of education, reaching 1,123 healthcare professionals across all sectors, including rolling out antibiotic workshops to all final year medical students, and reaching new groups such as Physicians Associates.

Point Prevalence Survey demonstrated an increase in secondary care prescribing rate from 29.5% in 2022 to 34.3% in November 2023. Working with QPS team to add antimicrobial stewardship audits to assurance dashboards, continuing with weekly ward rounds and introducing interventions to optimise antimicrobial prescribing.

World Antibiotic Awareness Week saw the launch of a new checklist for prescribers to support prudent use of high-risk 'quinolone' antibiotics, which has supported the Health Board response to a subsequent warning from the MHRA. The team have also opened the UK Antimicrobial Registry trial within the Health Board, to collect data on the effectiveness of new antimicrobial drugs.

Primary care did not achieve the Welsh Government reduction target for antimicrobial prescribing. Whilst Aneurin Bevan University Health Board made good progress in previous years, prescribing rates have not recovered since the Invasive Group A Strep (IGAS) outbreak in 2022-23, when widespread messaging from the UKHSA encouraged people to seek antibiotics.

However, work in primary care is now underway, with an initial five audit and feedback cycles being completed with high-prescribing practices. Recruitment to additional vacancies will enable quality improvement work such as this to accelerate in 2024/25. Additionally, the antimicrobial team have successfully influenced the 2024-25 Clinical Effectiveness Prescribing Programme (CEPP) for GP practices, which will include a heavy weighting on reducing antimicrobial prescribing, to encourage practices to engage with the agenda.

Respiratory Infections

Covid-19, Influenza and RSV were in line with seasonal variation. The Health Board had one of the lowest rates of hospital onset in Wales. Contributing cause to hospital acquired infections were patients sharing facilities, cared for in open bays, enhanced level of care, visitors and staff. The Health Board continued to promote best practice and patient placement guidance was updated and made available to staff via the intranet to support local risk assessments.

C section Surgical Site Infection

Health Board rate of 3.9% which returned to pre pandemic levels. Unfortunately, due to a data error, it was not possible to compare rates with other Health Boards.

Audit & Education

A significant amount of time and resource was devoted to undertaking audits (1,538) and delivering training (1,294 staff trained) across the Health Board including Primary Care settings (Care Homes).

The team continue to focus their efforts in healthcare settings where increase incidences have occurred.

Quality Improvement

The team supported the introduction of QI projects within medicine; one supporting a reduction of healthcare associated C difficile and one linked to oral hygiene with the aim to reduce hospital acquired pneumonia. Staff have been engaging in this process and a resource for all is being developed on the intranet.

Outbreaks

During the winter period, the Health Board was not only affected by outbreaks of respiratory illnesses, but periods of increase incidence of norovirus and C difficile also impacted on the service. The team worked seamlessly providing support to minimise disruption to bed days lost whilst balancing whole systems risks.

Decontamination

The team corroborated with clinical teams to achieve JAG accreditation within endoscopy. An area of concern was the number of Authorised Persons for Decontamination AP(D) within Works and Estates. An interim measure has been for staff working in local units to be trained to undertake weekly water sampling to minimise risk with this hazard.

Another area of risk is the interim decontamination unit in place in readiness for the new endoscopy unit at the Royal Gwent Hospital. Current infrastructure is inadequate to serve the ever-expanding clinical capacity. A capital project is being submitted as Phase 2 of the overarching development.

National Cleaning Standards

A gap analysis of the 2009 standards demonstrated partial compliance with most domains and non-compliance for a local cleaning strategy. Priority for Facilities Team going forward is to reintroduce a Service Improvement Manager whose primary role will be to develop a strategy, redesign training and competencies for staff and establish a tracking system for areas consistently falling below the agreed standard.

Water Safety

There was an increase in water counts within the augmented care areas. The likely cause was lapse with staff running taps in areas infrequently used. Works and Estates reviewed training, placed filters on taps and chlorinated the tanks. A water safety plan has been reviewed and approved via the Water Safety Group which covers the HTM national standards.

Critical Incidents

There were 7 unusual events outside national reportable incident requirements. All incidents were reviewed and supported by clinical teams internally and referred to Public Health Wales where necessary. Where required, patients and families were notified, appropriate treatment, staff education and promotion of vaccinations have been actioned.

Priorities for 2023/24

Good progress achieved with 2023/24 priorities with the exception of the introduction of a surgical site infection module on ICNET. This was due to a delay with all Wales IT development and interface.

One Health Board policy (Blood Borne Viruses) was out of date for review due to changes in national guidance and requiring clarity around roles and responsibilities within Primary Care for inoculation exposure.

Roll-out of Aseptic Non-Touch Technique (ANTT) accreditation began via the ward accreditation process.

Eliminating avoidable healthcare associated infections remains a top priority for NHS Wales and Aneurin Bevan University Health Board. It has been an extremely challenging year for the Infection Prevention Team with the majority of work absorbed responding to ongoing respiratory infections, increase in C difficile and other Welsh Government reduction expectations.

Recognising the Health Board did not achieve all the targets, the accomplishment of reducing rates in most areas of the Welsh Government expectation goals during 2023/2024 has been encouraging, reporting lower averages in all areas of measurement.

The Infection Prevention Team acknowledge collaboration with Divisions, Facilities, Occupational Health, Health and Safety and Site Operational Teams to deliver the

infection prevention agenda by sustaining a mask fit testing programme, promptly placing patients safely in the best environment for their clinical need, keeping hospitals clean, tidy and well-organised aiding the provision of safe patient care.

It is important to promote fundamental principles of infection prevention and control alongside strengthening environmental cleanliness, effective decontamination and antimicrobial stewardship to ensure infection prevention is perceived as being everyone's business. This can be enhanced by sharing local ownership and infection prevention and control becoming holistic to everyday practice.

The Infection Prevention Team are committed to delivering a proactive strategy for risk reduction of healthcare associated infections.

Argymhelliad / Recommendation

Aneurin Bevan University Health Board acknowledge that there is further work required to improve infection prevention and reduce the risk of hospital acquired infection. It is important as a Health Board that we continue to adapt and enhance the services we offer to meet the needs of patient's, staff and families.

The priorities for ABUHB in 2024/2025 are:

1. Review the proactive enhanced cleaning strategy
2. Develop the business case for infection prevention team
3. Undertake a quality improvement work for the reduction of health acquired infection
4. Staff engagement
5. Actively support other specialities in their business cases
6. Surgical site infection (SSI) module of ICNET.
7. Upscale audit & feedback cycles in high antibiotic-prescribing GP practices
8. Align ABUHB antimicrobial stewardship action plan to the new UK 5-year AMR National Action.
9. Environmental cleanliness by Developing local strategies and focus on education.

The Patient Quality, Safety and Outcomes Committee is requested to acknowledge the key achievements from 2023/2024 and support the priorities for 2024/2025.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Choose an item. 2.4 Infection Prevention and Control (IPC) and Decontamination Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Experience Quality and Safety Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Infection Prevention, Decontamination & Antimicrobial Stewardship

Annual Report 2023/24

Infection Prevention and Control Team
Aneurin Bevan University Health Board

Introduction

Aneurin Bevan University Health Board is committed to ensuring that a consistently high standard of infection prevention and control practice is a priority and is an essential requirement of assuring high quality, safe and effective care and minimising avoidable harm.

ABUHB maintains a zero-tolerance approach toward all preventable Healthcare Associated Infections and minimising risks to patients. Healthcare associated infections are infections acquired by patients during their stay in hospital or another healthcare setting. Welsh Government Antimicrobial Resistance and Healthcare associated infections Improvement Goals 2023-24 sets out 2 main aims namely:

- Optimise the use of antimicrobials
- Lower the burden of healthcare associated infection

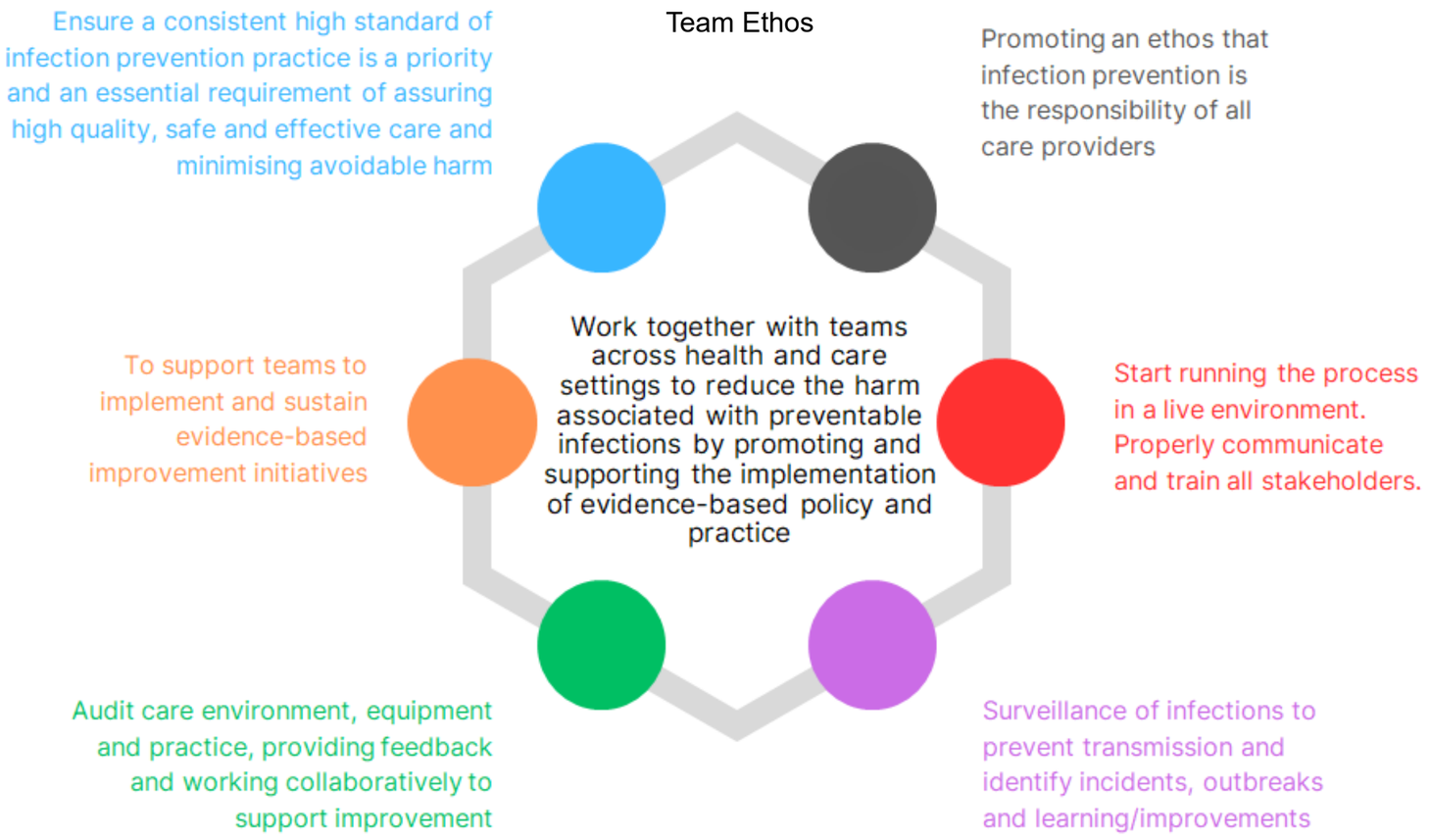
Progress against these 'improvement goals' is monitored through the Health Board's Infection Prevention & Antimicrobial Stewardship Group (formerly the Reducing Nosocomial Transmission Group).

Antimicrobial Stewardship is a co-ordinated approach that promotes the appropriate use of antibiotics to reduce resistance and decrease the spread of infections cause by mutli-drug resistant organisms.

Reusable medical devices are used throughout the Health Board. An understanding of decontamination practices and medical device management needs to be maintained and monitored against current standards. Decontamination is the combination of processes, including cleaning, disinfection and /or sterilization, used to render a re- useable item safe for further use.

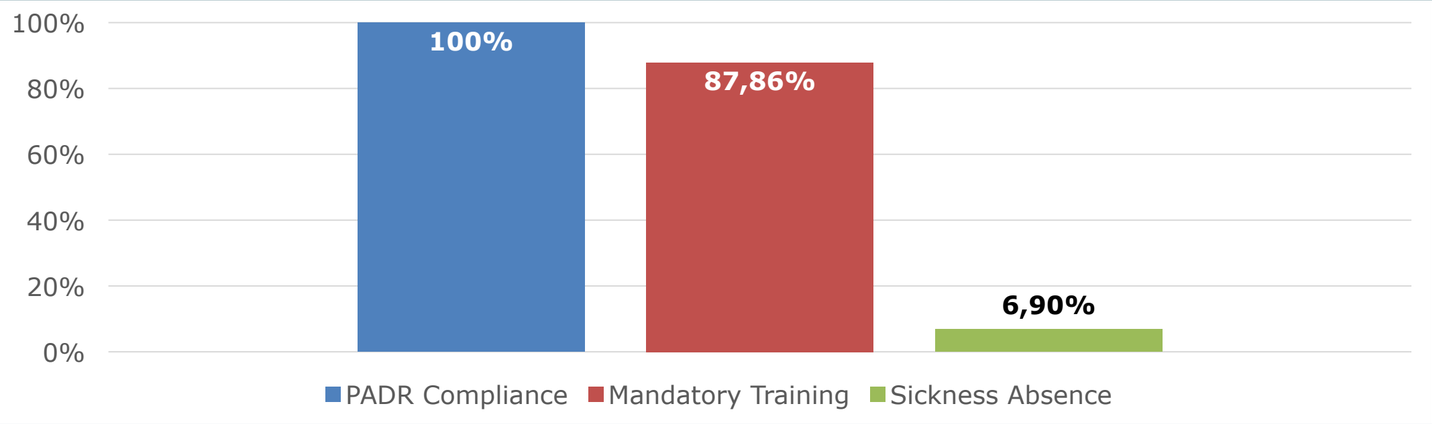
The Infection Prevention Team continued to use the ICNET electronic case management system to monitor in-patient activity. The system enables a comprehensive overview of patients' laboratory results and provides a platform for documenting infection prevention interventions. Patient records are visible to Infection Prevention Teams across Wales and this system supports wider communication.

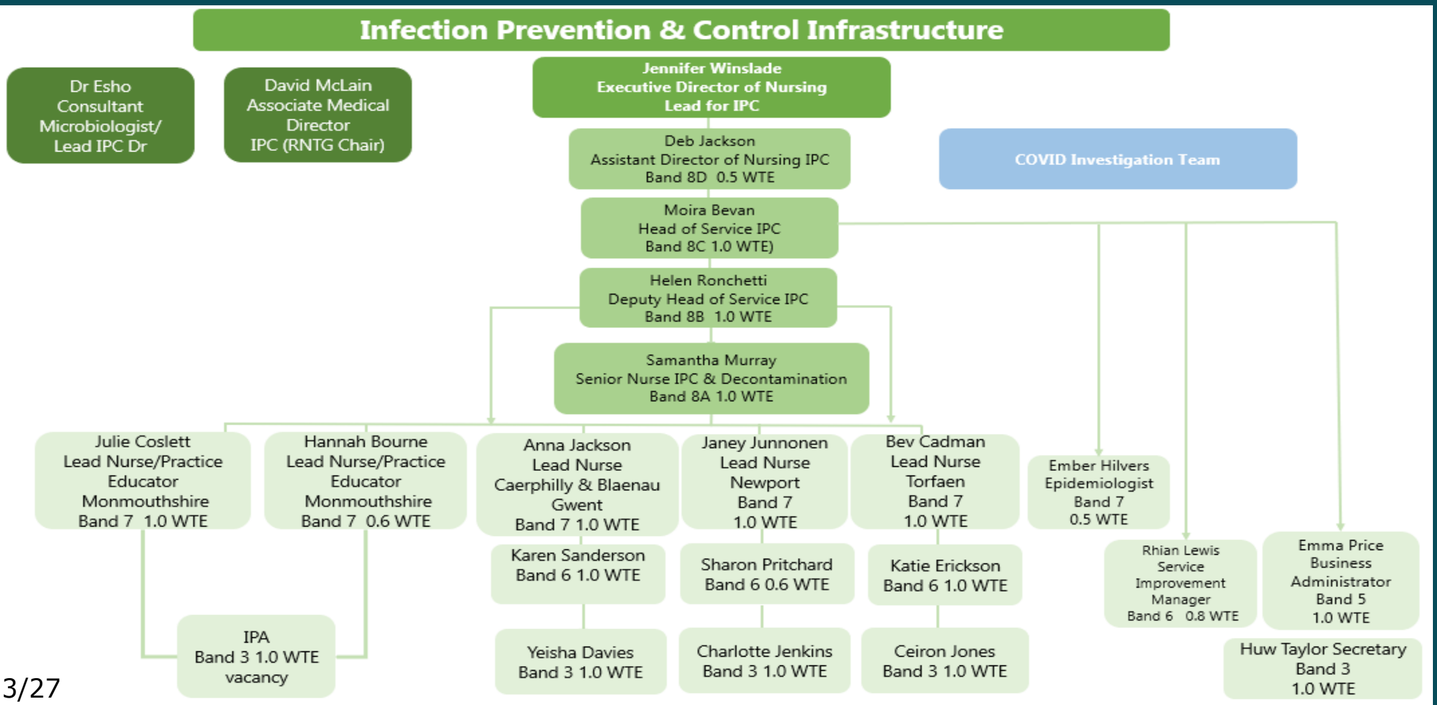
Over the last 12 months, ICNET has proved vital in the management and control of Covid-19, enabling the team to manage patients and support clinical teams promptly and efficiently. It has enabled the team to work remotely, which has proved invaluable when needing to provide support over a large geographical area.



Staffing and Governance

- Funding continue to be supported by the Regional Integration Fund which supports service provision within Primary Care





The Infection Prevention and Antimicrobial Stewardship Committee was established to oversee the reduction of healthcare acquired infections (HAI) and antimicrobial resistance. The group monitor compliance with the Health Board's Welsh Government Healthcare associated infections and Antimicrobial Resistance goals action plan, directing action where necessary and escalating matters to the Executive Team as appropriate. Overall aims include:

- Enhance patient and staff experience
- Promote clean, safe environments for the delivery of patient care
- Minimise transmission for all healthcare associated infections across the Health Board and review learning from outbreak management
- Update and review Health Board risk register
- Promote adherence to antimicrobial stewardship/infection prevention national policies, guidelines and improvement interventions
- Review and endorse new and existing policies
- Review and endorse the annual programme of work and educational strategy
- Develop and dissemination of guidance to assist services for local implementation
- Receive reports or exceptions from:-
  - Cleanliness Group
  - Ventilation Operational Group
  - Decontamination Operational Group
  - Water Safety Group
  - Antimicrobial Working Group
  - Health Protection Programme Board

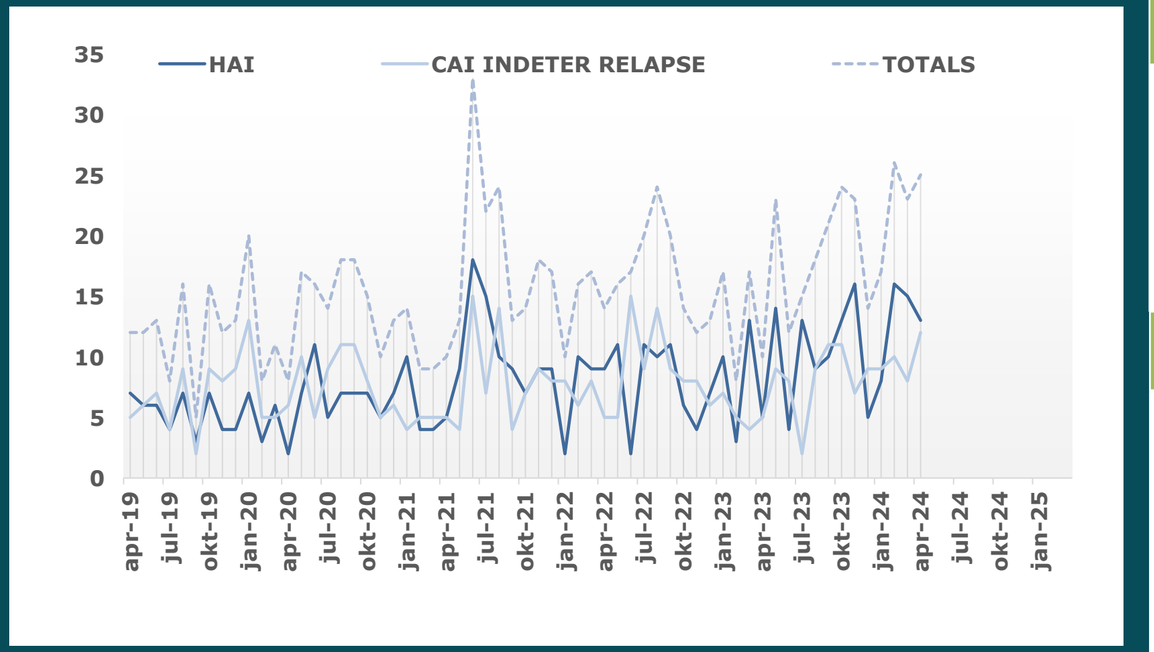
Healthcare Associated Infections – All Wales Comparison

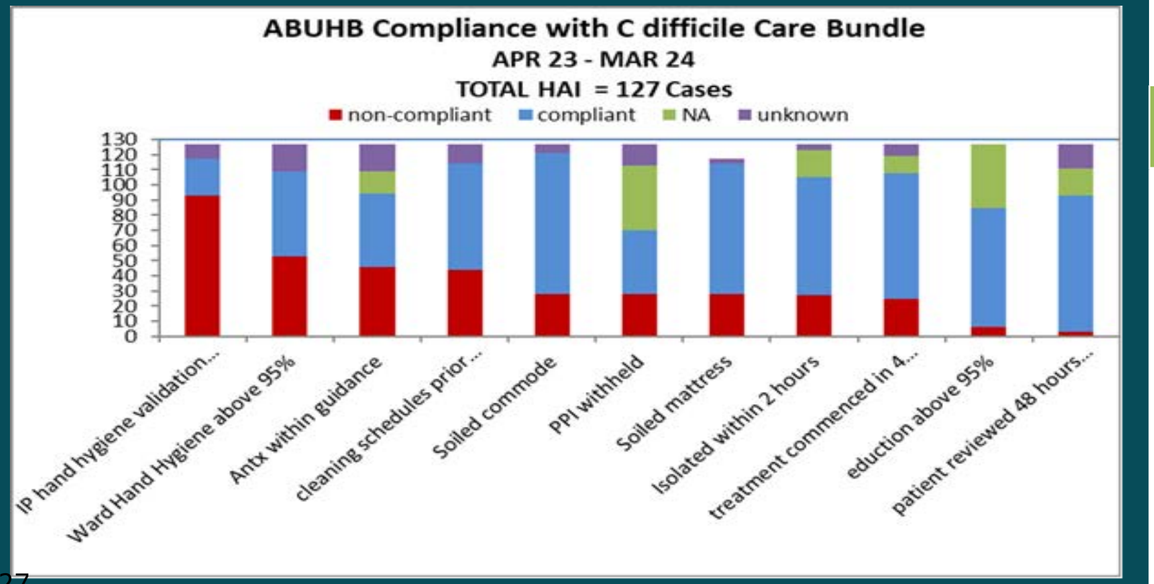
	Count of cases April 2023 to March 2024					
	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. Aeruginosa bacteraemia
Aneurin Bevan UHB	228	9	120	351	134	25
Betsi Cadwaladr UHB	287	8	172	548	156	32
Cardiff and Vale UHB	113	13	146	345	120	18
Cwm Taf Morgannwg UHB	126	9	129	378	118	21
Hywel Dda UHB	182	10	100	387	108	29
Powys THB	25	0	1	2	0	0
Swansea Bay UHB	250	7	134	257	94	20
Velindre NHST	7	1	0	6	6	0
Wales	**1218**	**57**	**802**	**2274**	**736**	**145**

	Rate of cases per 100,000 population April 2023 to March 2024					
	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. Aeruginosa bacteraemia
Aneurin Bevan UHB	38.55	1.52	20.29	59.35	22.66	4.23
Betsi Cadwaladr UHB	41.7	1.16	24.99	79.63	22.67	4.65
Cardiff and Vale UHB	22.35	2.57	28.88	68.24	23.74	3.56
Cwm Taf Morgannwg UHB	28.38	2.03	29.05	85.13	26.57	4.73
Hywel Dda UHB	47.26	2.6	25.97	100.49	28.05	7.53
Powys THB	18.67	0	0.75	1.49	0	0
Swansea Bay UHB	65.2	1.83	34.95	67.02	24.51	5.22
Velindre NHST						
Wales	**38.89**	**1.82**	**25.61**	**72.61**	**23.5**	**4.63**

	< than same period last FY
	= same period last FY
	> than same period last FY

Welsh Government Goals: C difficile Infection (CDi)





Reduction

228 cases of c difficile were reported from Apr 2023 - Mar 2024. This is 36 cases more (19% increase) than the equivalent period 2022/23. The Health Board rate of 38.55 per 100,000 population is above the Welsh Government (WG) target of 25 per 100,000 population. Both healthcare associated and community acquired cases have increased.
Healthcare associated/indeterminate = 159
Community acquired/relapse cases = 69

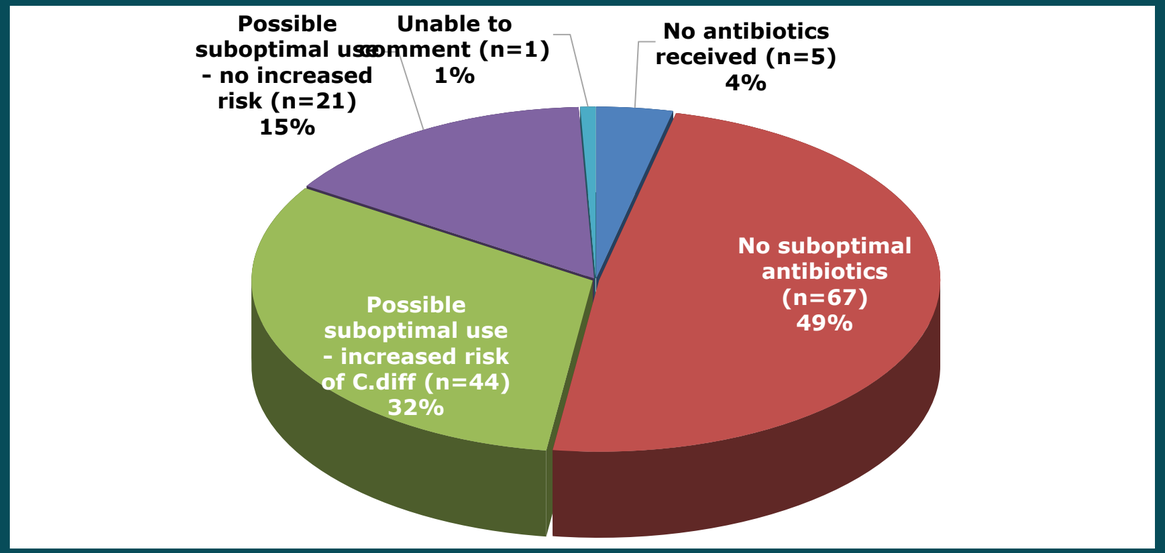
Learning from incidents and outbreaks

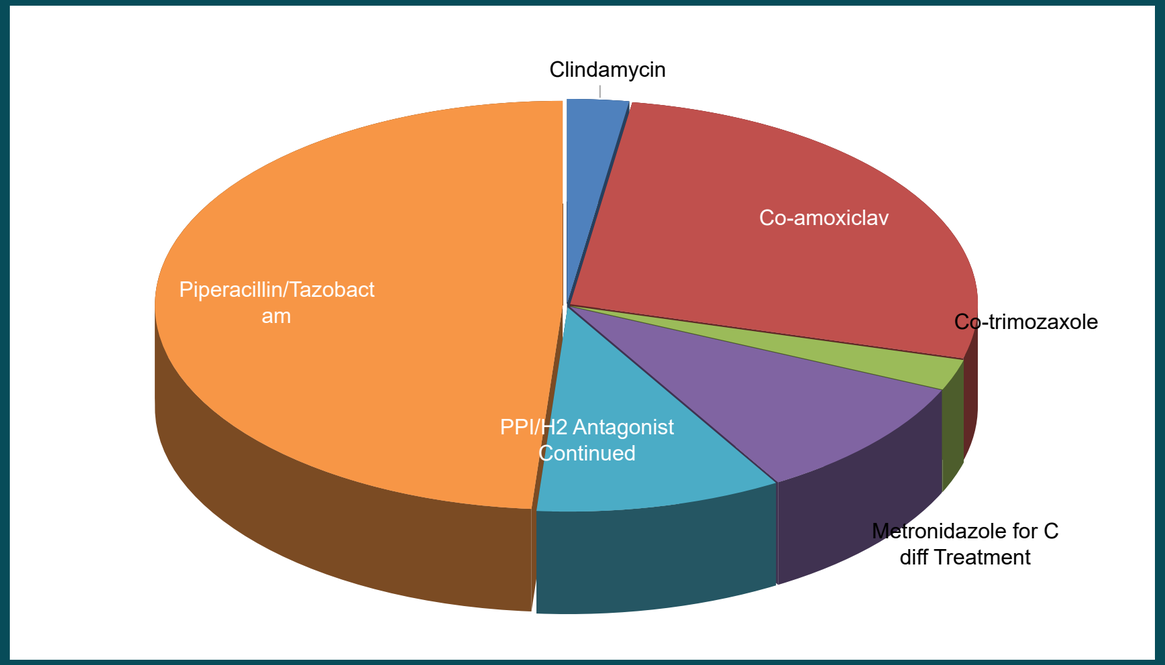
- 23% patients received suboptimal antibiotics that may have increased the risk of C difficile infection within the past 3 months, the majority of which were in secondary care. 10% patients received no antibiotics within the 3 months prior to infection.
- 16 of the HAI cases were linked genomically indicating onward hospital transmission.
- All HAI cases are reviewed and analysis has indicated some learning around fundamental infection prevention practices (as indicated in the chart)
- 14% of Catheter Acquired Infection (CAI) cases were linked to sub-optimal (not the most appropriate) antibiotic prescribing
- Return rates from GP practices have declined, with 25/60 CAI root cause analyses still outstanding

Remedial Actions

- Medicine Quality Improvement Faculty in place to improve awareness and infection prevention practices
- Ward-based practical training
- Organisational Action Plan monitored via the Infection Prevention and Antimicrobial Stewardship Committee
- Proactive Hydrogen Peroxide Vapour cleaning programme undertaken albeit with some slippage in the programme at Ysbyty Ystrad Fawr, The Grange and County Hospital.
- Themes around unnecessary co-amoxiclav or piperacillin/ tazobactam use (these are anti-biotics) were identified in Quarter 3 and 4. Audits are planned at all sites to investigate the extent of the problem.
- Feedback provided to General Practitioners and Quality Patient Safety Forums around community acquired cases associated with sub-optimal prescribing.

Welsh Government Goals: Antimicrobial Stewardship – Secondary Care





Analysis of suboptimal antibiotic usage

Nearly a third of patients with health care acquired C difficile received potentially sub-optimal treatment resulting in increased risk of C difficile. Reasons for suboptimal prescribing resulting in increased c difficile risk were varied.

Piperacillin/tazobactam was used inappropriately for respiratory tract infections and urinary tract infections. Similarly co-amoxiclav was used inappropriately for respiratory tract infections and urinary tract infections as well as biliary and gastrointestinal infections. Antibiotic guidance is available on the intranet and directs prescribers to the most appropriate choice for specific infections rather than using broad spectrum (antibiotics that act against a wide range of disease).

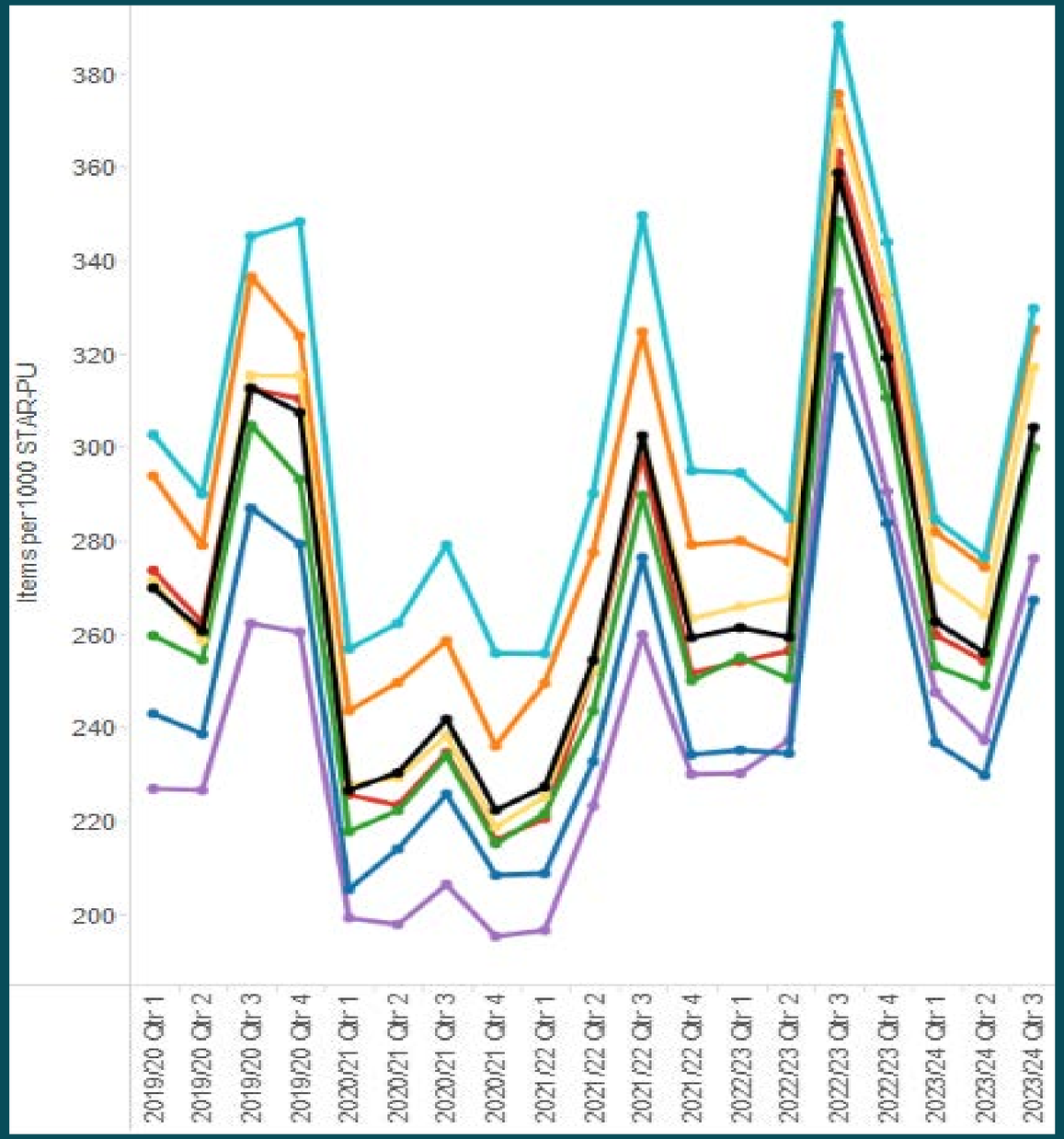
Learning

Majority of learning identified related to the suboptimal use of the broad-spectrum antibiotics piperacillin/tazobactam and co-amoxiclav.

Additional learning included not withholding gastric acid suppressing agents whilst being treated with antibiotics and treatment of c difficile infection with the antibiotic metronidazole, which is no longer recommended as a first line option

Piperacillin/tazobactam and co-amoxiclav prescribing is now being audited to identify areas of inappropriate use. Antimicrobial stewardship education and antimicrobial resistance awareness sessions are planned for areas identified. Prescribing is a key driver within the faculty for medicine where pharmacy have been supporting Improvement cycles.

Welsh Government Goals: Antimicrobial Stewardship (AMS) – Primary Care



Reduction

- Data is only available to end of Quarter 3, but the Health Board will not achieve the minimum 25% reduction in antimicrobial usage in primary care from the 2013/14 baseline (Aneurin Bevan University Health Board is the yellow line on the graph, tracking above the black all-Wales average).
- Caerphilly has joined Blaenau Gwent and Torfaen as the three highest prescribing localities in Wales.

Remedial Actions

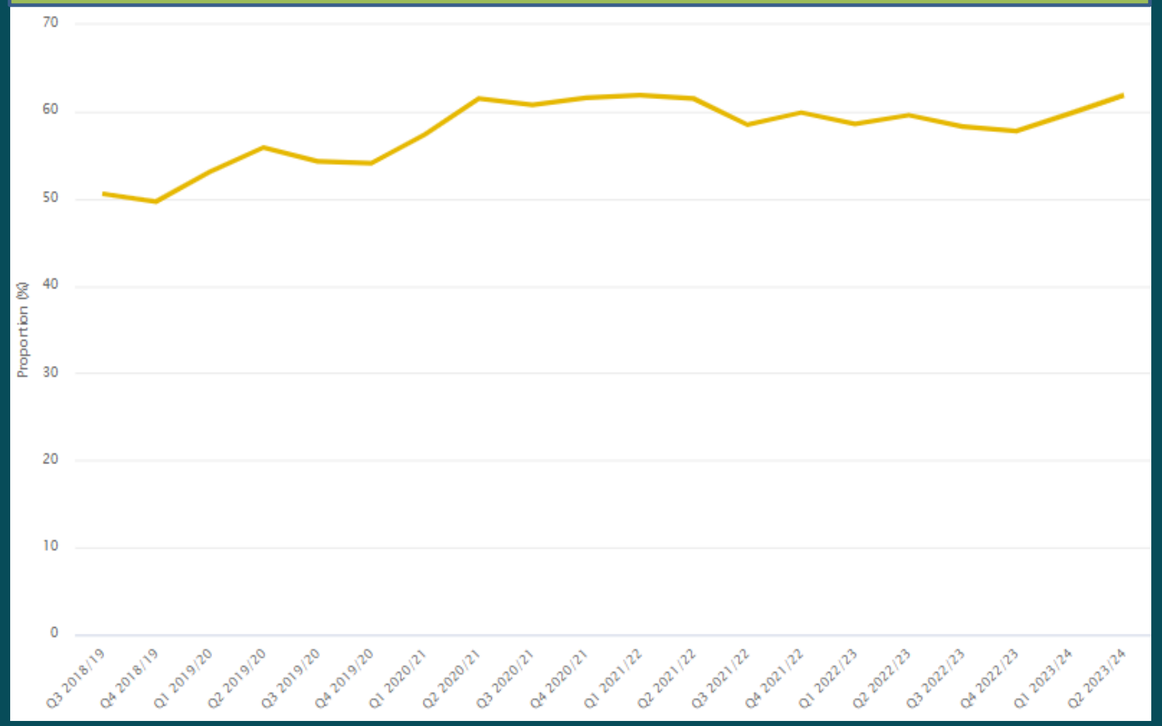
- Recruited to 0.4 whole time equivalent primary care antimicrobial pharmacist and 0.39 senior project support officer (new posts).
- Audit & feedback cycles have been completed in 5 high-prescribing practices, and the audit undertaken in a 6th practice, awaiting feedback. Cycles to be scaled up from April 2024 when new pharmacist in post.
- Project to investigate use of doxycycline in high prescribing practices

Activities of note

- Antimicrobial Stewardship team have delivered 65 hours of education to 1123 multi-professional individuals across primary and secondary care, including new groups such as Physician Associates. 5th year medical student teaching rolled out to all postgraduate centres.
- Collaborative working with lymphoedema team, identifying patients with multiple episodes of cellulitis to be reviewed in clinic.
- Team provide clinical support to the COVID-19 therapies service.

Welsh Government Goals: Antimicrobial Stewardship (AMS) – Secondary Care

Proportion of antibacterials in the 'access' category



Reduction

- Data is only available to the end of Quarter 2, however the Health Board continues to achieve proportion of antibiotic usage within the World Health Organisation 'Access' category to greater than 55% of total antibiotic consumption
- Point Prevalence Survey demonstrated an increase in secondary care prescribing rate from 29.5% in 2022 to 34.3% in November 2023. Survey also demonstrated deficiencies in urinary tract infection diagnosis and management.
- Completion of antimicrobial stewardship audits by medics remains poor

Remedial Actions

- Working with Quality Patient Safety team to add antimicrobial stewardship audits to assurance dashboards
- Urinary tract infection educational sessions planned for secondary care teams
- Working with electronic prescribing team to ensure Antimicrobial stewardship functionality incorporated during build so that best practice is established at go live

Activities of note

- Weekly antimicrobial ward rounds at the four sites reviewed 1263 patients, making 1782 interventions to optimise antimicrobial prescribing, including stopping treatment in 15% patients.
- Quinolone (a type of anti-biotic) safety checklist launched for World Antimicrobial Awareness Week, which has supported response to MHRA alert in January 2024.
- Opened UK Antimicrobial Registry study in March 24, to collect real world data on outcomes with newer antimicrobials. Running as an independent research

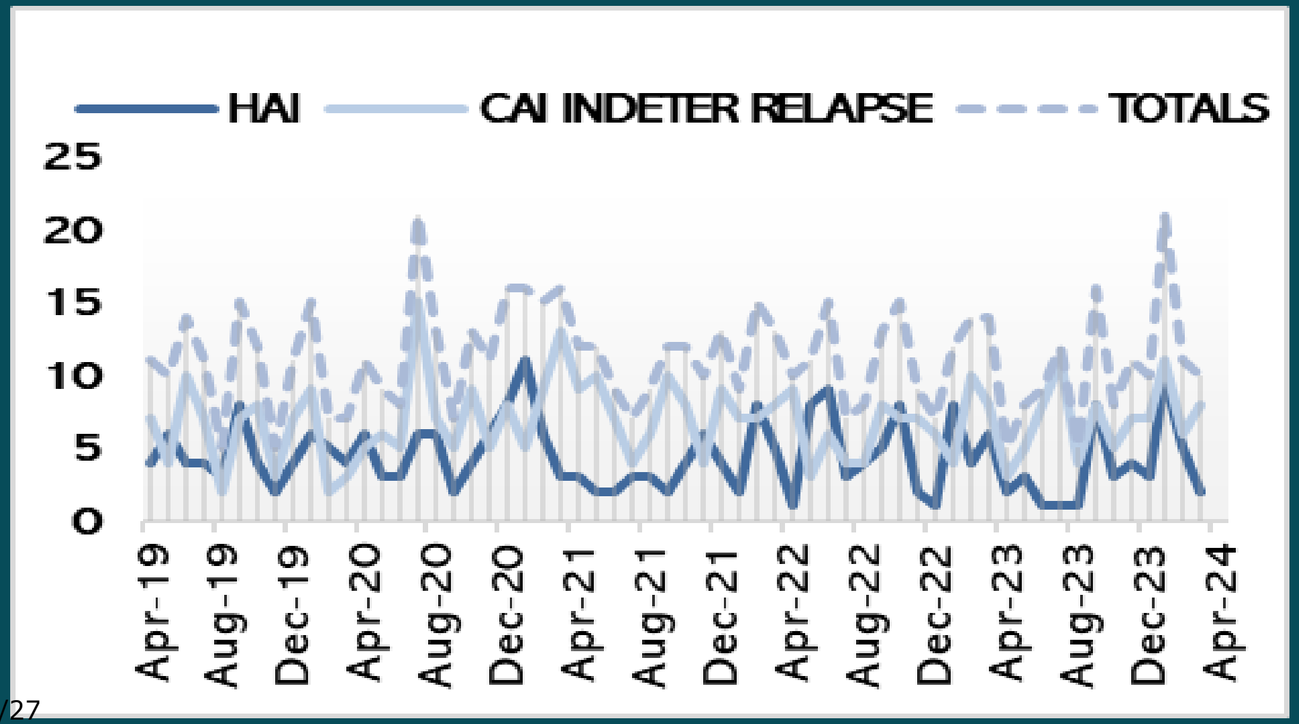
Welsh Government Goals: Staph Aureus Blood stream infections

Reduction

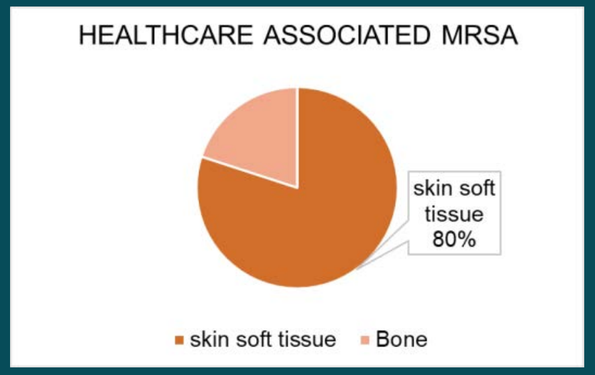
- 128 cases of Staph aureus blood stream infections reported from Apr 2023 - Mar 2024. This is 8 fewer cases (6% lower) than the equivalent period 2022/23. Health Board rate per 100,00 population is 21.81%. Of which 9 are Methicillin Resistant Staph Aureus (MRSA) all others are Methicillin Sensitive Staph Aureus (MSSA) and, compared to the rest of Wales, Aneurin Bevan University Health Board has the lowest rate.
- Healthcare associated = 48 (5 MRSA)
- Community acquired/reisolate = 80 (4 MRSA)

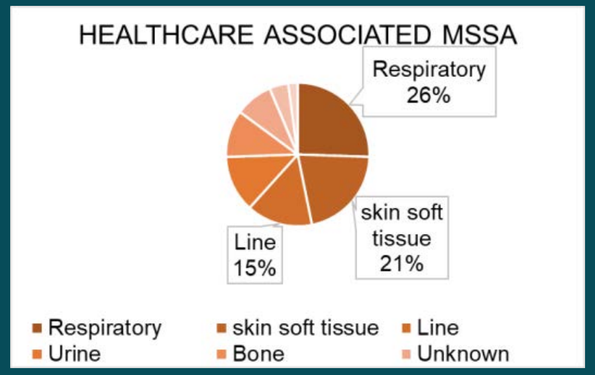
Remedial Actions

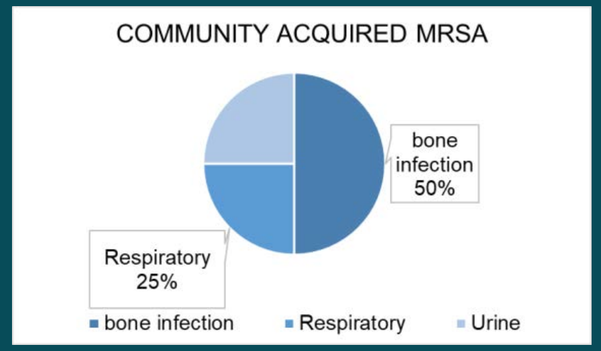
- Root cause analysis for all cases of MRSA blood stream infections and intravascular device associated cases
- Quality Improvement project for Oral Care with the aim to reduce hospital acquired pneumonia
- Invasive device audits
- Promotion of aseptic procedure packs
- Active promotion of Aseptic Non Touch Technique throughout the Health Board
- Pressure ulcer collaborative review of wounds
- MRSA Admission screening audits

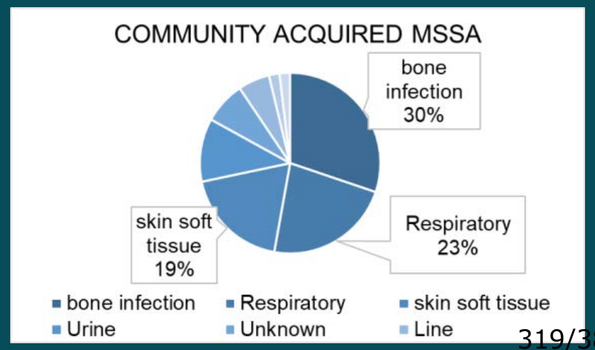


Source of Infection









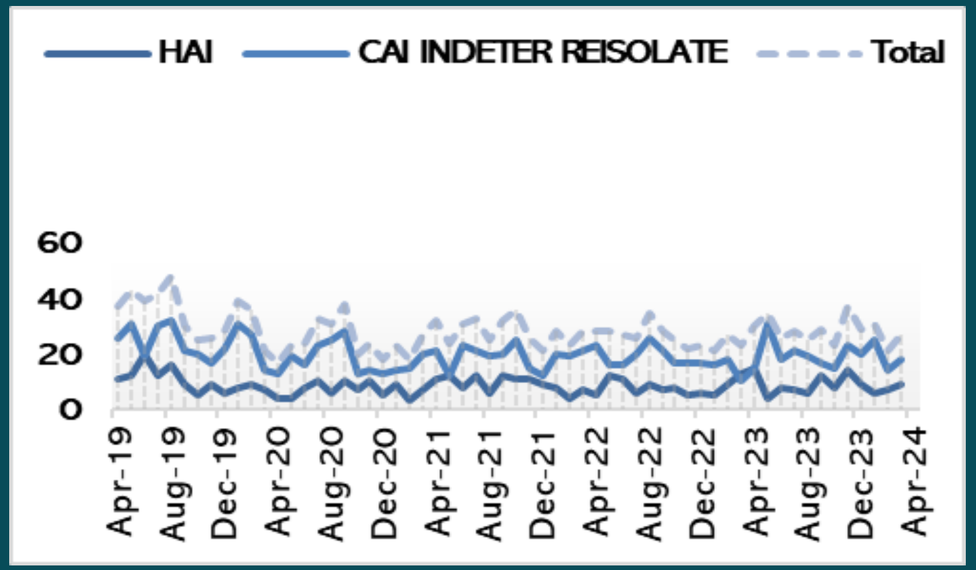
Welsh Government Goals: E Coli blood stream infection

Reduction

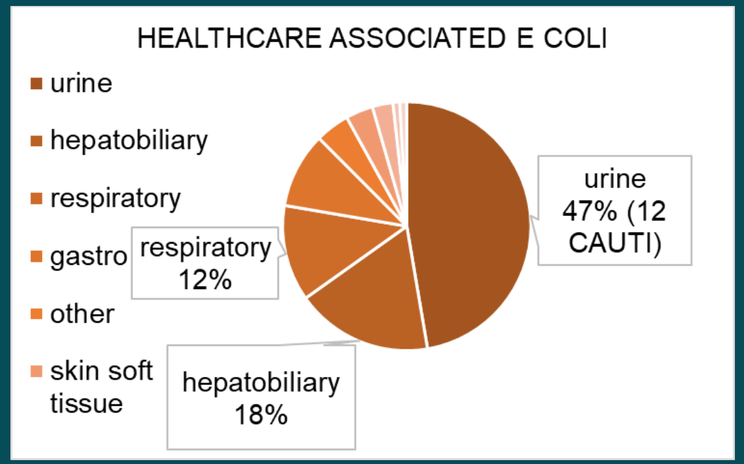
- 350 cases of E coli reported from Apr 2023 - Mar 2024. This is 31 cases more (11% higher) than the equivalent period 2022/23. Health Board rate of 59.35 per 100,000 population and remain significantly lower than the rest of Wales.
- Healthcare associated/indeterminate = 112
- Community acquired/reisolate = 238

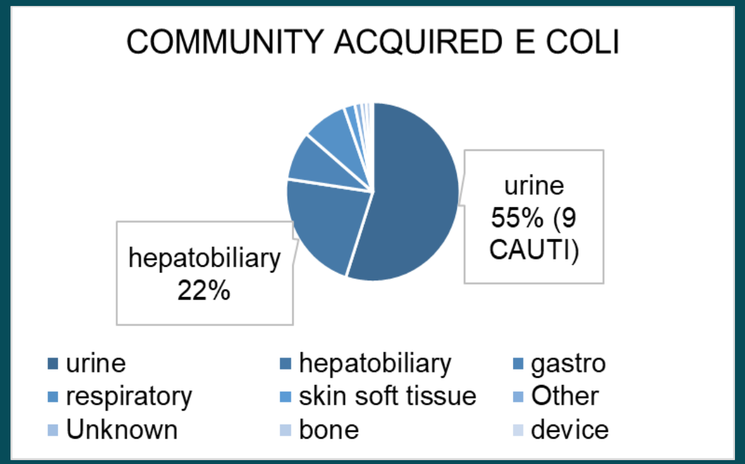
Remedial Actions

- Urine is the largest burden of infection. Root cause analysis process implemented for urinary catheter associated cases
- Promote the 9 key standards for urinary tract infections management
- Roll out of the project HOUDINI – "Make the catheter disappear" which aims to remove a catheter more quickly.
- Hospital acquired pneumonia/oral hygiene faculty commenced in stroke pathway



Source of Infection





*CAUTI is a catheter associated urinary tract infection

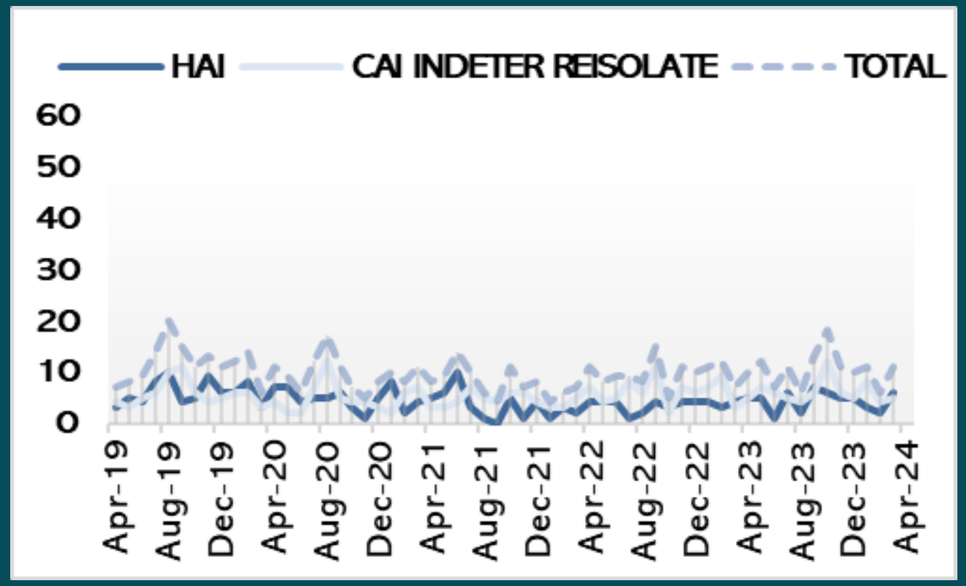
Welsh Government Goals: Klebsiella blood stream infection

Reduction

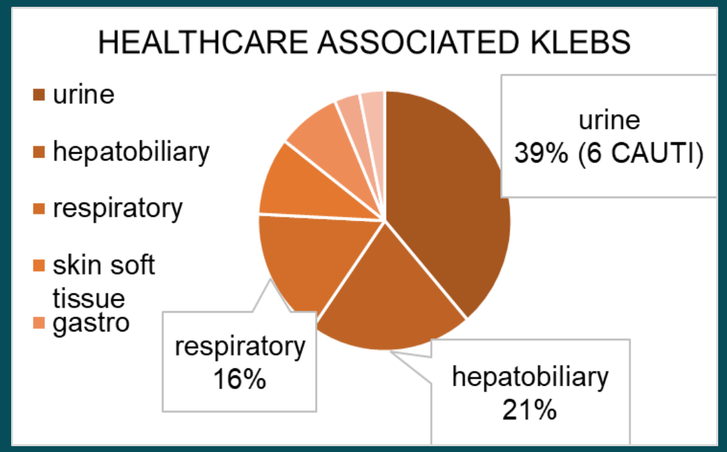
- 131 cases of Klebsiella reported from Apr 2023 - Mar 2024. This is 13 cases more (14% higher) than the equivalent period 2022/23. Health Board rate 22.66 per 100,000 population lowest rate in Wales. Many Klebsiella blood stream infections occur in individuals already colonised with the bacteria and cause infection opportunistically. There are several risk factors which increase the risk for klebsiella infection. There are also strains of klebsiella, labelled as hypervirulent strains, which are significantly more likely to cause infection in younger, healthier patients. Hypervirulent strains are more likely to cause pneumonia, meningitis, and/or liver abscesses compared to less virulent klebsiella infections.
- Healthcare associated/indeterminate = 62
- Community acquired/reisolate = 73

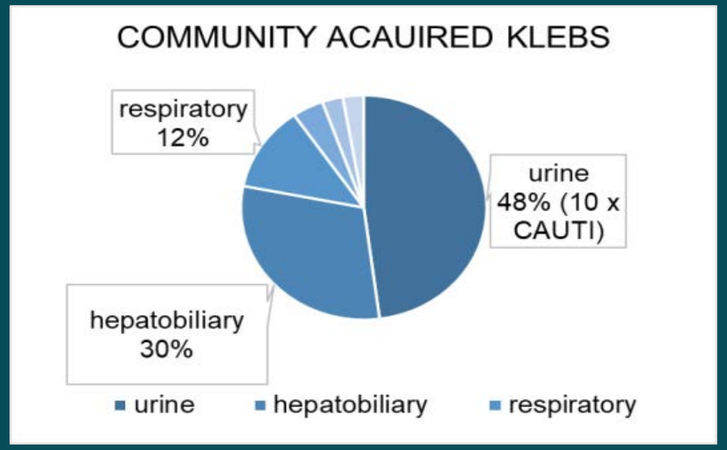
Remedial Actions

- Reviewed resistance rates and discussed at the antimicrobial working group to ensure first choice of treatment remains appropriate.
- Promote 9 standards for Urinary Tract Infection management and catheter reviews implemented



Source of Infection





*CAUTI is a catheter associated urinary tract infection

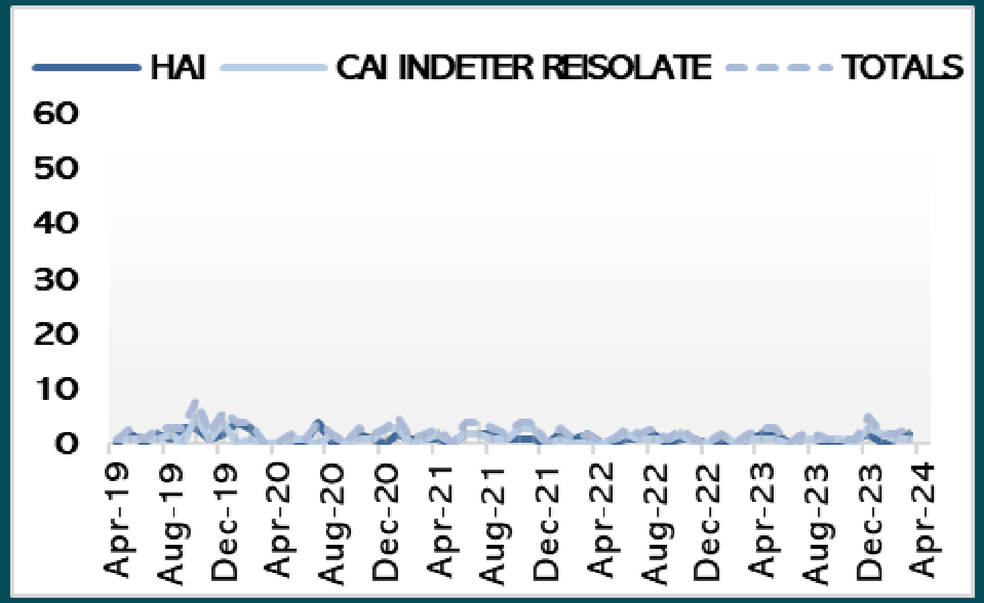
Welsh Government Goals: Pseudomonas blood stream infection

Reduction

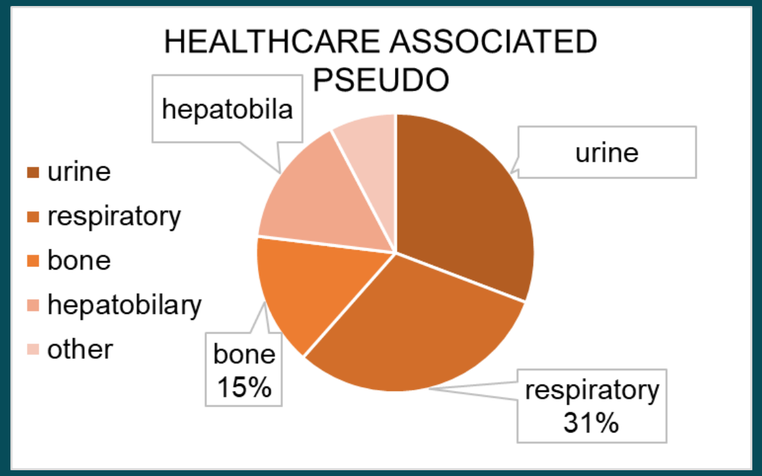
- 25 cases of Pseudomonas reported from Apr 2023 - Mar 2024. This is 7 cases more (39% higher) than the equivalent period 2022/23. Health Board rate 4.23 per 100,000 population.
- Healthcare associated/indeterminate = 13
- Community acquired/reisolate = 11

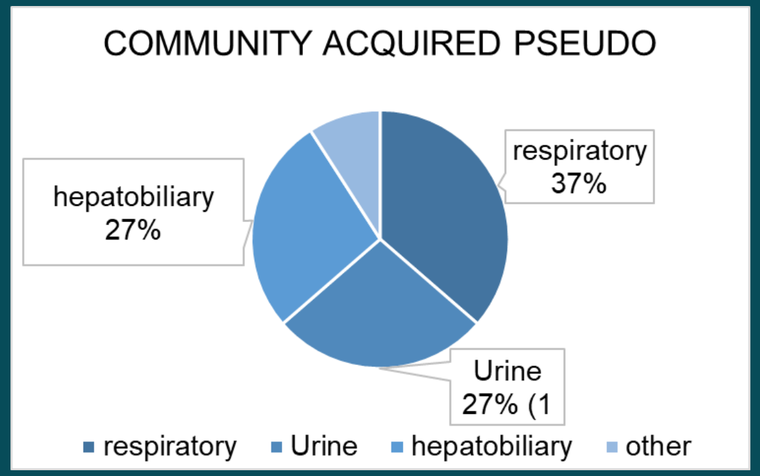
Remedial Actions

- Numbers remain small with the largest burden of infection linked to urinary infections in hospital.
- The Health Board are participating in the HOUDINI Project: 'make the catheter disappear which aims to remove a catheter more quickly
- The project entails monitoring the number of catheter days per week, an education programme and introduction of a new catheter care bundle.
- A total of 34 catheter reviews for all Gram-negative blood stream infection in community undertaken which has resulted in a provision of education and team feedback re learning.



Source of Infection

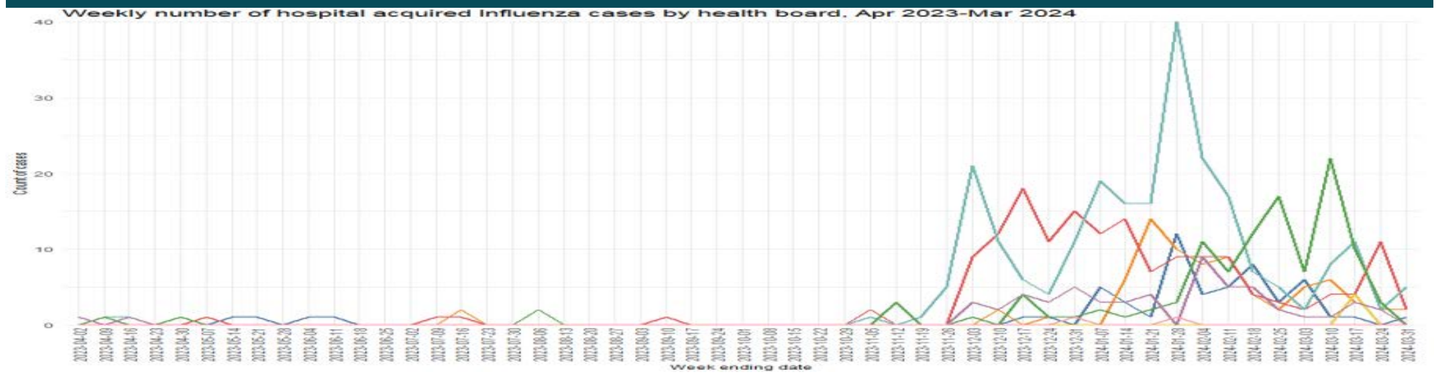




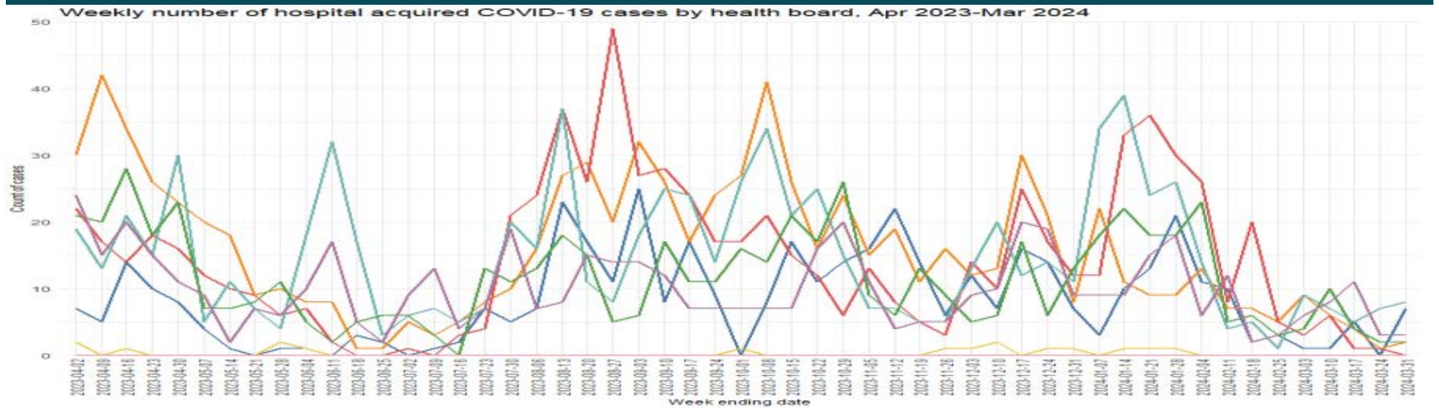
*CAUTI is a catheter associated urinary tract infection

Respiratory

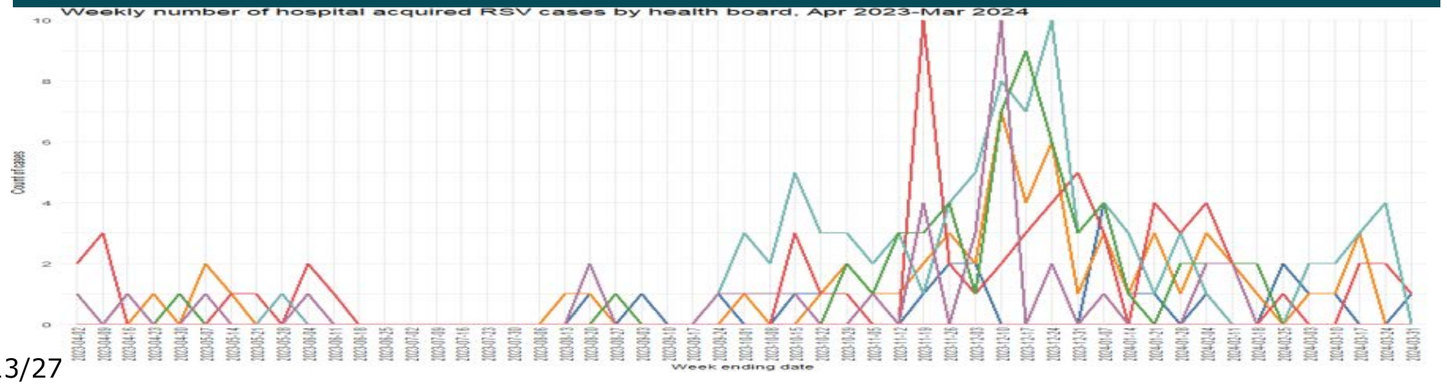
Hospital onset Influenza



Hospital onset Covid-19



Hospital onset RSV



The majority of hospital acquired respiratory infections and outbreaks have occurred within the local general hospitals where patients are sharing facilities. Other contributing factors are the acuity of patients, level of enhanced care, workforce constraints and visitors.

Patient placement protocols have continued to support local risk assessment based on system organisational whole system risks.

The Infection Prevention Team has continued to support local teams for mask fit testing, patient placement and validation of fundamental infection prevention measures to minimise onward transmission. This approach has resulted in the Health Board having lower rates of onward transmission for most of the year compared to other Health Boards.

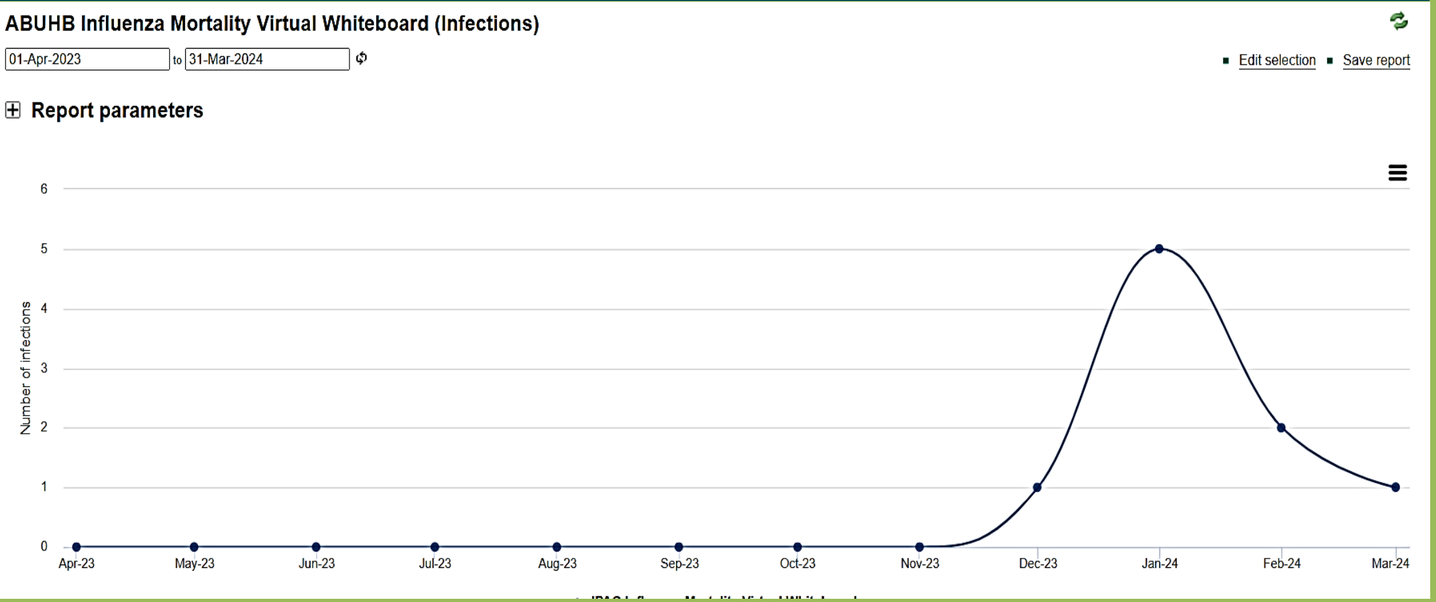
Respiratory

- The Infection Prevention Team review all patients who have died within 28 days of an indeterminate, probable and definite healthcare associated Covid-19/influenza infection
- Many patients reviewed have died of other causes, but Covid or influenza has been cited on the death certification
- There have been **610** healthcare associated Covid-19 cases throughout the FY 23/24
- Of these, **86** patients died within 28 days of acquiring Covid-19
- **7** of these cases were reported as a National Reportable Incident where Covid-19 had been cited on the death certification
- Aneurin Bevan University Health Board has a lower mortality rate (127 per 1,000 bed days) than the all Wales average (134 per 1,000 bed days)

- There have been **52** healthcare associated Influenza cases
- Of these, **17** patients died with 28 days of acquiring influenza
- **One** of these were reported as a National Reportable Incident where influenza was cited on the death certification
- Aneurin Bevan University Health Board has a lower mortality rate (90 per 1,000 bed days) than the all Wales average (137 per 1,000 bed days)

Covid-19 - Mortality

Influenza



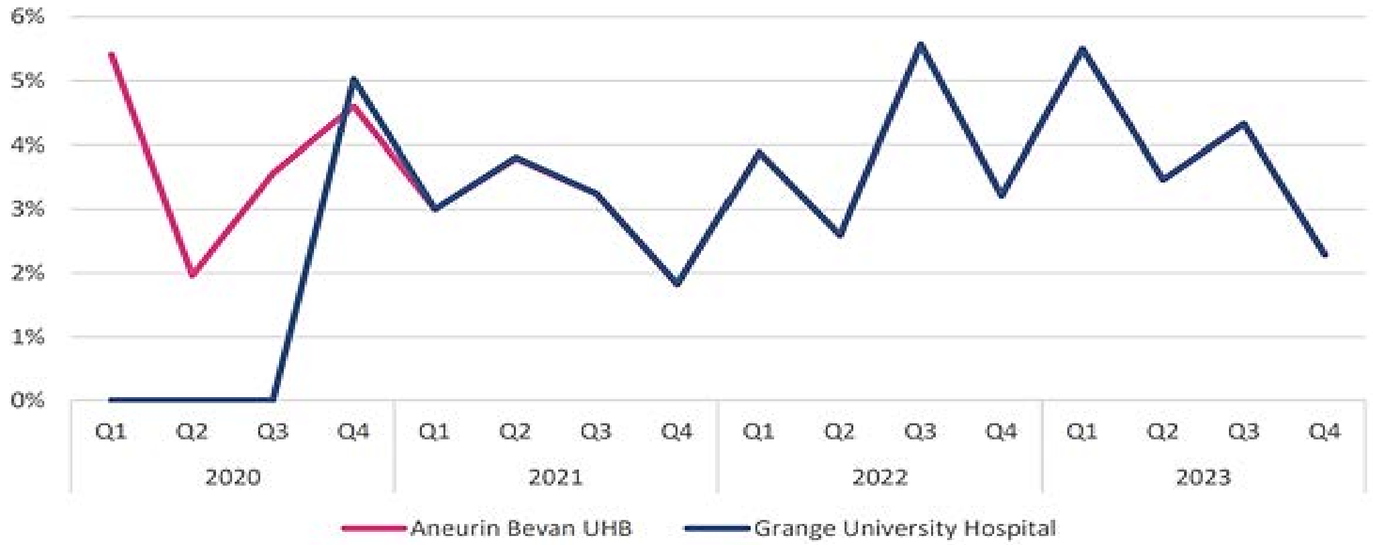
Caesarean Section Surgical Site Infections (SSI)

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Rates

This section contains a summary of SSI rates, including quarterly rates, overall SSI rates and infection types for the year.

Quarterly rates

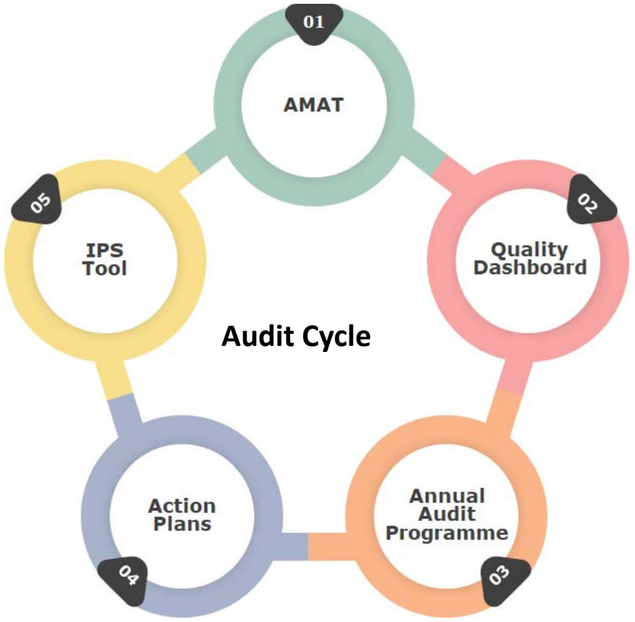


Areas of most significant concern	Action to address
Increased number of hospital acquired wound infections with maternity	➢ Small Task & Finish group established and Health Board action plan developed ➢ Review of data - over reporting identified and submitted an application to Public Health Wales for an amended Report ➢ Review of patient pathways, observational audit in theatres ➢ Education package delivered to maternity with a focus of

Audit & Education

AUDIT CYCLE
- Timely feedback
- Action plan via Audit Management and Tracking system (AMAT)
- Local ownership & monitoring

THEMES FOR LEARNING
- 5 Moments for hand hygiene awareness
- Correct use of personal protective equipment
- Poor documentation
- Lapse with fundamental measures



Infection Prevention Education: Objectives and Compliance

To increase the awareness of clinical staff of their personal responsibilities towards the prevention and control of infection. At the end of the session the learner will understand:

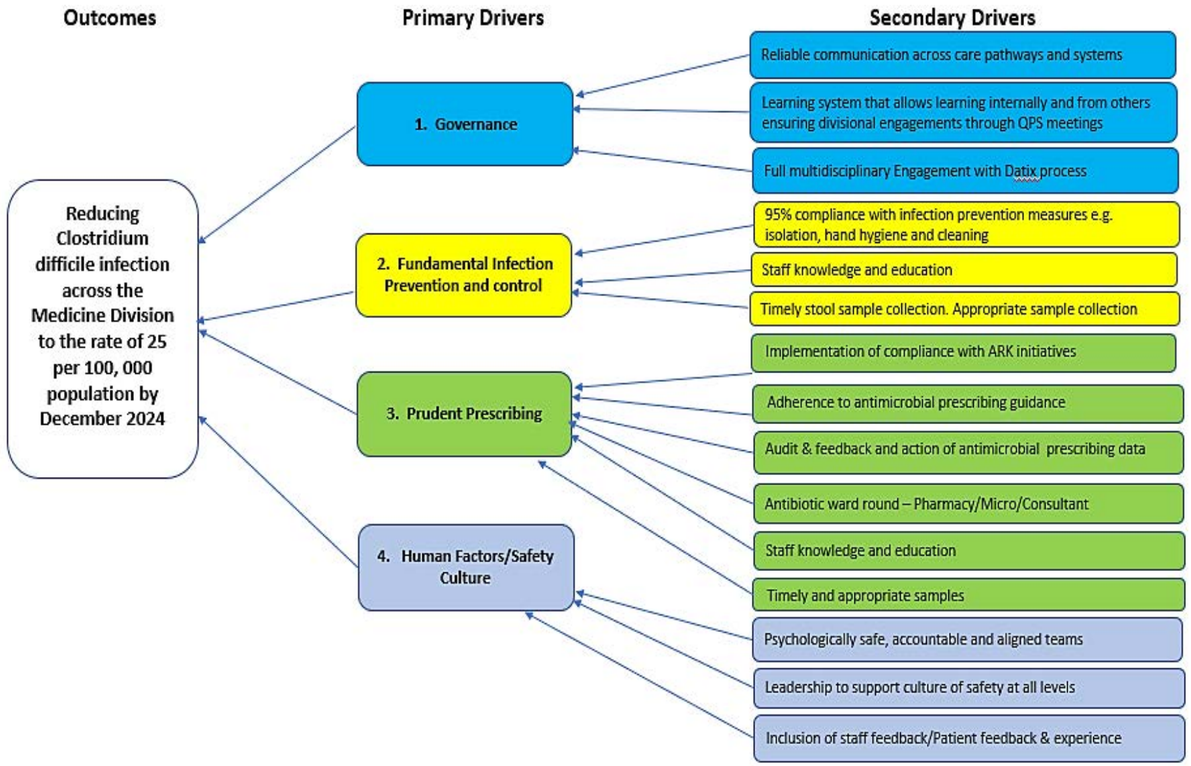
- The need to protect patients and staff from the risk of healthcare associated infections
- Importance and application of infection prevention practices
- How to maintain your health and protect yourself from occupational exposure to infection
- How to recognise the increased incidents and outbreaks of infection

Type of audit	Number undertaken
Isolation Precautions	42
Hand Hygiene Audit	206
Covid safety measures	109
Dashboards	351
Peripheral venous catheter bundles	408
Urine catheter bundles	301
Care Homes undertaken	54
Care homes audit offered	65
Community dentistry	2

Infection Prevention Training

Division	Staff Trained
Medicine	283
Urgent Care	24
Scheduled Care	250
Family & Therapies	368
Mental Health & Learning Disabilities	77
Primary & Community Care	84
Facilities	116
Bank	43
Other	49

Quality Improvement

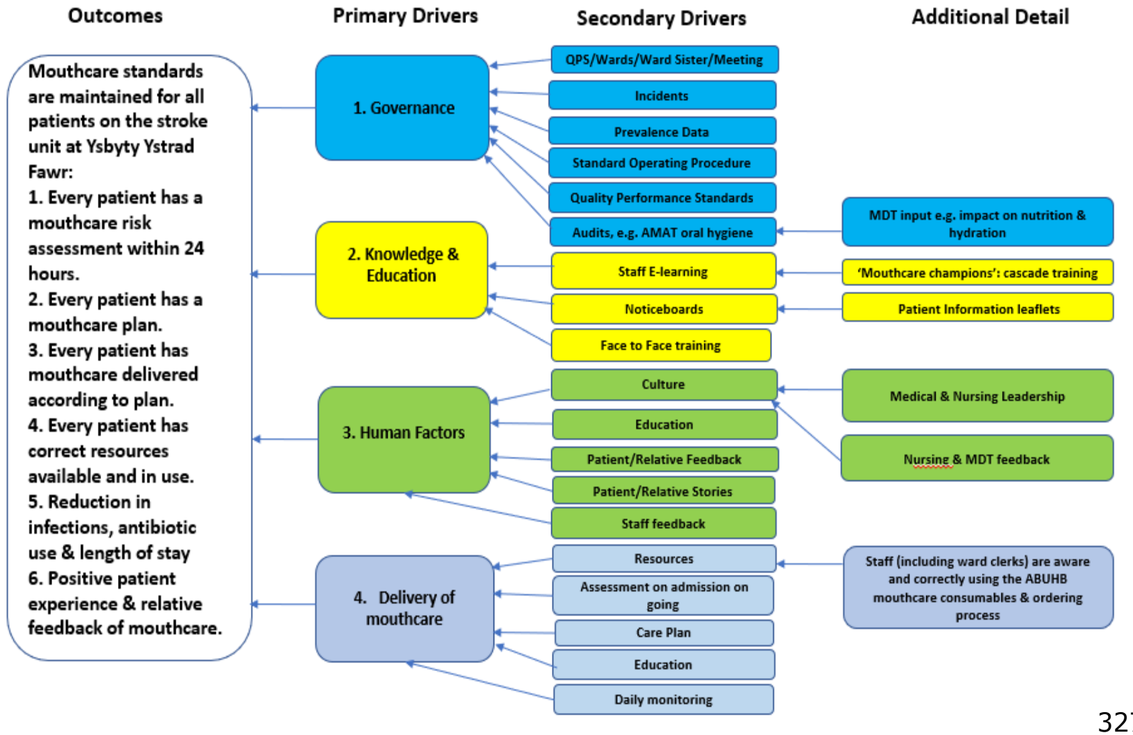


C Difficile Faculty – Medicine

- 4 wards participating one on each Nevill Hall, Royal Gwent, Ysbyty Ystrad Fawr and The Grange
- Ongoing improvement cycles for change to be implemented on the primary drivers (actions)
- Outcome measure is the days between cases which averages 22 days.

Mouthcare Stroke Pathway

- Two wards participating at Ysbyty Ystrad Fawr
- Outcome measures monitored via diagnosed hospital acquired pneumonia
- Improvement cycles focus on education
- Assessment of oral care being validated via Audit Management and Tracking platform and Welsh Nursing Care Record
- Intranet resource page developed



Covid-19 Investigation Team

Programme Highlights

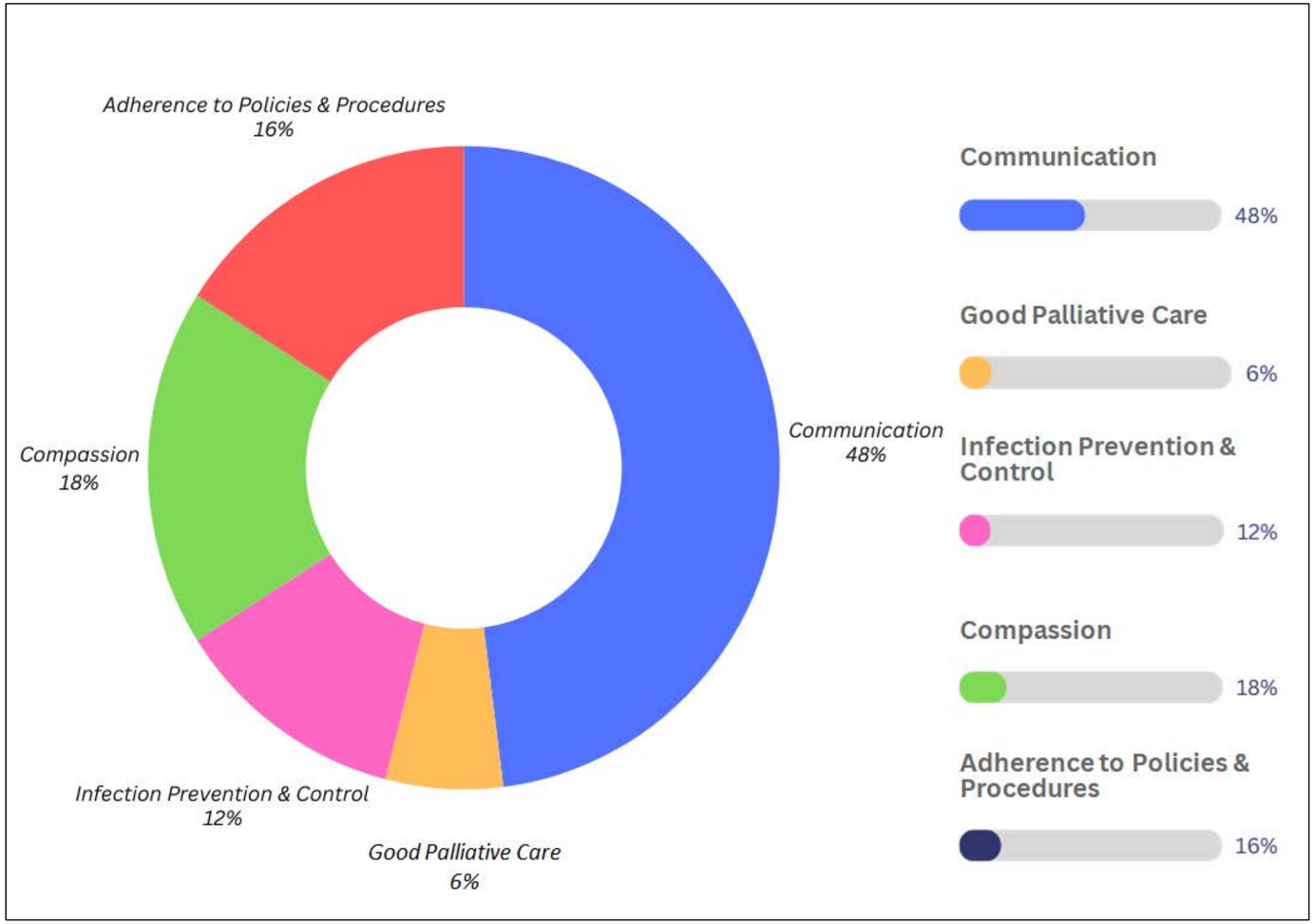
- Programme completed on time and within budget
- 2883 Nosocomial COVID-19 investigations concluded
- No cases referred to Legal & Risk
- Bereaved relative digital story produced for National learning
- Assisted to aide closure for many bereaved families
- Scale of review & evidence to inform and drive Clinical, Corporate & Quality Patient Safety Improvements

Outcome Snapshot

- 1357 Definite Health Care Acquired Infections
- 534 Probable Health Care Acquired Infections
- 321 Indeterminate cases
- 713 Deceased cases
- 47% Death Part of Causal Sequence or Sole Contribution
- 47% of cases in Royal Gwent Hospital
- 23% of cases in Nevil Hall Hospital
- 9% of cases in Grange University Hospital/Ysbyty Ystrad Fawr
- 2006 cases linked to outbreaks

Good Practice

Themes of Good Practice identified across 2883 cases, where documented



Decontamination

Area of most significant concern	Action to address
The Endoscopy unit at Ysbyty Ystrad Fawr continue to strive toward Joint Advisory Group accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the criteria set out in the Joint Advisory Group standards.	➢ An action plan developed by Gastroscopy highlighted areas of focus to achieve Joing Advisory Group accreditation with specific issues being electronic track & traceability and weekly testing on the Endoscope washers. ➢ Ysbytty Ystrad Fawr Endoscopy staff have been trained to undertake part of the required weekly testing for the interim period, within their abilities, taking the department further toward Joint Advisory Group compliance.
Works & Estates strategy to support decontamination services throughout the Health Board with limited Authorised Person leaving the Health Board in a vulnerable position. An Authorised Person (Decontamination), or AP(D), qualified person offers a range of specialist services and capabilities to help facilities maintain the highest standards of sterilisation and decontamination	➢ A full review of the Health Board Works & Estates Authorised Persons is already underway. This includes the only Authorised Person who is unable to fulfil his role & responsibilities as indicated by the Authorised Engineer Decontamination Wales. ➢ Ysbyty Ystrad Fawr Endoscopy staff have been trained to undertake part of the required weekly testing for the interim period to support Works & Estates.
Chemical compatibility issues with some non lumen scope / probe decontamination.	➢ A review of suitable options is near completion by the decontamination manager, with final checks being made, involving ultrasound and scope manufacturers. This is an 'all UK' issue involving numerous scope manufacturers and decontamination process looking at compatible decontamination processes.

Decontamination

Area of most significant concern	Action to address
Community Dental Services decontamination equipment have been tested once within the last year, however there is no planned testing & servicing for the forthcoming year.	➢ Works staff have undertaken the testing and servicing for years as part of an Service Level Agreement. As part of the works review, a decision will be made as to external contract or continue with discussion between Community dental and Works & Estates.
The decontamination of mattresses process has been raised as a significant concern.	➢ Since Drive DeVilbiss took over the contract on 1st October, immediate improvements have been instilled following collaborative working with the decontamination manager, Infection prevention teams and key facilities management. A more robust mattress management process is required with facilities mattress lead, decontamination manager and local site nursing teams.
Safe storage concerns of disinfectant peracetic acid in endoscopy units at Ysbyty Ystrad Fawr & Royal Gwent Hospital was raised and has since been resolved.	➢ In line with Control Of Substance Hazardous to Health requirements and Welsh Health Technical Memorandum 01-06, environmental cupboards fit for purpose had been purchased, however remained unused due to space constraints at Royal Gwent Hospital. Ysbty Ystrad Fawr had relocated but ventilation remained an issue. This has since been addressed.
The **interim** decontamination unit for the new endoscopy unit's arrival had been delayed until October causing a delay in training staff. The unit became live January 2024. Breakdowns forced the implementation of contingency plan for decontamination work to be undertaken at the Grange Hospital Sterilisation Disinfection Unit.	➢ Staff actioned an interim solution utilising existing decontamination units for training and in actioning a contingency plan required purchase of accessories required for the decontamination process. ➢ Risk of breakdowns remains real as demand on the **interim** decontamination unit has increased with the new 4 theatre endoscopy suite now active, with 50% less decontamination capacity.
A decision awaits from Welsh Government for the new Royal Gwent centralised endoscopy decontamination. Bowel Screening Wales will be reliant on the Joint Advisory Group audit outcome to be undertaken in April 2024 as to whether the interim decontamination unit is satisfactory.	➢ The project has been on hold whilst awaiting Executive approval and for Welsh Government agreement funding. This new facility will initially provide decontamination services for bowel screening Wales endoscopy unit at the Royal Gwent Hospital and other stakeholders such as Urology Directorate.

Cleaning Standards

	Fully Compliant	Partially Compliant	Non-Compliance
Management of environmental cleanliness – Local Health Boards are able to demonstrate clear management arrangements for environmental cleanliness linked to corporate and clinical governance			
Local cleanliness strategies – a consistently high standard of environmental cleanliness is delivered			
Education and development – staff are trained to undertake their duties in ensuring that the national cleanliness standards are met			
Risk-based analysis for service provision – the most appropriate cleaning methods and frequencies are applied to specific functional areas within healthcare facilities			
Facility Management – Local Health Board owned buildings and fixtures are maintained to an acceptable condition to enable to effective and safe cleaning of the patient environment			
Monitoring of cleaning outcomes – the standard of cleanliness of the healthcare environment is assessment by both internal and external audit			

Priorities

- Develop local cleanliness strategy to move non-compliance out of the red
- Redesigning cleaning induction and competency training and apprenticeships.
- Re-introduction of the Cleaning Service Improvement Manager post (realignment of duties).
- Introducing and tracking environmental cleanliness recovery plans for areas falling below the agreed standard.
- Review all functional areas in Synbiotix to ensure correct risk ratings are applied.
- Introduce paperless cleaning schedules via Synbiotix. The scheduler function has the ability to have all staff cleaning schedules i.e. all elements that are required to be cleaned and their frequency can be accessed via a hand held device as observed from a site visit to Yeovil.

Water Safety Group

Issue	Cause	Remedial Action	Who	When
Raised water counts within Augmented Care at The Grange and Royal Gwent Hospitals	Taps not frequently run within the clinical area	• Increased staff awareness • Filters placed on taps • Retesting with the aim for clearance • Flushing poster developed • Training video for cleaning of clinical hand washing sink	Infection Prevention Works and Estates	March 2024
No standardisation for requesting water coolers within clinical environments	Previously been able to order via procurement without a standard operating procedure	• Standard Operating Procedure developed which indicates clear roles and responsibilities, local risk assessment and sign off for accountability	Works and Estates Infection Prevention Local Manager	Ongoing
Robust governance for water safety	Changes with key staff	• Terms of reference reviewed • Water safety plan developed • Increased ownership across the Division • Incidents recorded via Datix	Water Safety Committee Works and Estates Infection Prevention Team	Throughout 2023/24

Critical incidents

Issue	Cause	Remedial Action	Who	When
Shingles exposure	Patient with confirmed shingles on Gwanwyn ward	➢ Contact tracing exercise undertaken to identify staff and patient immune status	Infection Prevention	Completed 25th January 2024
Suspected Pertussis (whooping cough) – Emergency Department, Grange Hospital	Index case in the waiting area for 12 hours on 22nd – 23rd January 2024	➢ Contact tracing exercise undertaken to identify patients exposed for at least one hour ➢ Warn & Inform letter sent to 51 parent's & GP	Infection Prevention	Completed 9th February 2024
Suspected Pertussis (whooping cough) Minor Injuries Unit Nevill Hall & Children's Emergency Assessment Unit, Grange Hospital	Index case presented at GP out of hours Nevill Hall on 11th Feb & 12th Feb, transferred to Children's Emergency Assessment Unit, Grange Hospital on 12th Feb	➢ 2 patient contacts – checked for vaccination status ➢ Staff contacts wearing personal protective equipment	Infection Prevention	Completed February 2024
Patient with healthcare associated invasive group A strep on D4E, Royal Gwent Hospital	• Possible staff member working with symptoms of sore throat	➢ Staff and patient contacts risk assessed for signs of infection- sore throat, skin soft tissue infection or concerns about infection at any site ➢ Staff member visited GP for treatment ➢ 4 patient contacts received prophylaxis antibiotics ➢ Warn & inform letters sent to patient contacts	Infection Prevention Ward Manager Senior Nurse	Completed February 2024
Invasive group A strep identified on admission to Acute Medical Unit	• Patient admitted with worsening skin rash for 2 days prior to admission. considered vasculitic rash secondary to bacteraemia	➢ Patient commenced antibiotic treatment ➢ Patient isolated ➢ No patient or staff contacts	Infection Prevention	March 2024
Measles exposure within GP Out of hours and Children's emergency assessment unit	• Child not isolated on presentation to the department	➢ Contact tracing of patients and staff (71) ➢ Public Health Incident Management Team - meeting ➢ Under 6 month children offered HNIG ➢ Warn and inform letters sent ➢ Increased comms ➢ Review MMR status ➢ Promote mask fit testing	IMT	March 2024

National Reportable Incidents

Issue	Cause	Remedial Action	Who	When
Ward closures due to outbreaks:- ▪ 21 Covid ▪ 12 diarrhoea & vomiting/norovirus ▪ 1 influenza	• Lapse with use of personal protective equipment – staff, visitors & patients • Sub standard cleaning • Staff knowledge of infection prevention measures • Visitors attended with known symptoms • Additional capacity and boarding	➢ Encouraged correct use of appropriate personal protective equipment ➢ Enhance cleaning & recording ➢ Bespoke ward based practical training ➢ Restricted access posters displayed at ward entrance ➢ Comms circulated for visiting	Infection Prevention Ward Manager/ Senior Nurse	At time of outbreak
Healthcare associated infections patient mortality:- ▪ 3 C difficile associated ▪ 7 Covid associated ▪ 1 influenza associated	• Multiple co morbidities • Antimicrobial treatment • Exposed within Healthcare • Shared facilities	➢ Antimicrobial resistance review ➢ Education ➢ Promotion of personal protective equipment ➢ Mask fit testing ➢ Hand hygiene promotion ➢ Patient placement standard operating procedure	Infection Prevention Ward Manager/ Senior Nurse	At time of outbreaks
Two patients underwent thyroid surgery at Royal Gwent Hospital Theatres (Theatre 14) on 26.10.2023 both had swabs sent from their surgical site infection and both grew *Streptococcus disgalactiae*.	• Small theatre environment • Use of masks for all theatre personnel within the theatre suite and surrounding clinical area • Thoroughfare of theatre staff accessing the suite during a procedure	➢ Review staff risk assessment for respiratory infections ➢ Staff wellbeing included in theatre WHO risk assessment ➢ Cleaned vents in theatres ➢ Consider type of procedure being undertaken due to small environment	Theatre Personnel Consultant	Completed

Review of Priorities for 2023/24

1	Systems to manage and monitor the prevention and control of surgical site infection. These systems use risk assessments, mapping the patients pathway within secondary and primary care maximising the use of ICNet.	Unable to progress due to the all Wales development and interface with Ormis. Team have linked with internal IT and is on the Health Board agenda.
2	Review the enhanced technology available to our facilities teams to ensure patients are cared for in a clean environment.	Ultra Violet light and Hydrogen Peroxide Vapour available across the Health Board ensuring consistency for enhanced level of decontamination.
3	Commence antimicrobial audit and feedback cycles for high prescribing, outlying, GP practices.	Implemented.
4	Modernise the resources ensuring suitable and accurate information on infections for service users/staff and residents within the Aneurin Bevan University Health Board area.	Refreshed intranet pages, personal protective equipment posters updated.
5	Ensure prompt identification of people who have or are at risk of developing an infection so they receive timely and appropriate treatment, to reduce the risk of transmitting infection to other people.	Ongoing via ICNET and 7 day working.
6	Aim to achieve Aseptic Non Touch Technique bronze accreditation for the Health Board.	Gained permission to submit wards/departments rather than Health Board, several areas will achieve early 2024 and now incorporated into ward accreditation.

Review of Priorities for 2023/24

7	Ensure all Infection Prevention policies are up-to-date and evidence-based.		One policy out-of-date due to change in national guidance plus needing clarity re roles and responsibilities for management of sharp injuries for the general public from primary care.
8	Undertake Route Cause Analysis and outbreak reviews from reduction expectation, Surgical Site Infections and respiratory pathogens and other pathogens ensuring learning is shared across the Health Board.		Implemented via Datix.
9	Actively support the Covid-19 Investigation Team.		Achieved.
10	Support the business case for infection prevention team with an overall aim to supports sustainability/succession planning and reduce health care associated infection across the Health Board.		Gained Regional Integration funding for 2024/25.
11	Support a business case to enhance ventilation with the overall aim to reduce healthcare associate infection that is transmitted via the air		Infection Prevention Team active member of the ventilation group, capital bid in progress.
12	Undertake a quality improvement project for the reduction of hospital acquired pneumonia.		Implemented on the stroke pathway at Ysbyty Ystrad Fawr.

Conclusion

Eliminating avoidable healthcare associated infection remains a top priority for NHS Wales and Aneurin Bevan University Health Board. It has been an extremely challenging year for the Infection Prevention Team with most of the work focused on responding to the ongoing respiratory infection increase in C difficile and other Welsh Government reduction expectations.

Recognising the Health Board did not achieve all the targets, the accomplishment of reducing rates within most areas of the Welsh Government expectation goals during 2023/24 has been encouraging, reporting lower averages in all areas of measurement.

The Infection Prevention Team acknowledge the support from the Divisions, facilities, Occupational Health, Health and Safety and the site operation team to deliver the infection prevention agenda. This has supported the mask fit testing programme, prompt patient placement keeping hospitals clean and providing a safe patient environment.

It is important to focus on the fundamental principles of infection prevention and control, strengthening cleaning, decontamination, antimicrobial stewardship and fundamental principles embedding the infection prevention agenda as being everyone's business by sharing local ownership and by becoming holistic to everyday practice.

Priorities for 2024/25

Aneurin Bevan University Health Board acknowledges that there is further work required to improve the infection prevention and reduce the risk of hospital acquired infection. It is important as Health Board that we continue to adapt and enhance the services we offer to meet the needs of the Health Board.

The priorities for ABUHB in 2024/25 are:

Priority 1:
Review the proactive enhanced cleaning strategy with facilities as decant wards are unavailable and there are constraints on capacity to ensure patients are cared for in a clean environment.

Priority 2:
Develop the business case for infection prevention team with an overall aim to support sustainability/succession planning and reduce health care associated infection across the Health Board

Priority 3:
Undertake a quality improvement work for the reduction of health acquired infection based on surveillance findings.

Priority 4:
Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection and have the education knowledge and tools.

Priority 5:
Actively support other specialities in their business cases for reduction of healthcare acquired infection.

Priority 6:
Develop systems to manage and monitor the prevention and control of surgical site infection. These systems use risk assessments, mapping the patients pathway within secondary and primary care maximising the use of ICNet. This is dependant on an all Wales process and interface with theatre IT systems

Priority 7:
Upscale audit & feedback cycles in high antibiotic-prescribing GP practices, focusing on those with high volume and high use of higher-risk '4C' antibiotics.

Priority 8:
Align Health Board antimicrobial stewardship action plan to the new UK 5-year Antimicrobial Resistance National Action Plan, due to be published May 2024.

Priority 9:
Environmental cleanliness - develop local strategies and focus on education. Review service accordingly to any new published national standards.

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CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 July 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Safeguarding Annual Report 2023-2024
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Howard Stanley - Head of Safeguarding

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Safeguarding Annual Report has been prepared to provide an overview of the 2023/2024 position in terms of how Aneurin Bevan University Health Board (ABUHB) has managed its statutory responsibilities in regard of safeguarding. It will provide information on progress, performance as well as an overview of emerging themes and trends, including lessons learnt and the subsequent vision for 2024/2025.

Cefndir / Background

The Report focuses on, and describes the successes and challenges related to, "Safeguarding" during the reporting period. It will encompass the strategic work of the Safeguarding Committee and the responses to operational safeguarding.

Asesiad / Assessment

2023/24 has been a year of significantly increased activity within safeguarding, both in terms of the volume of cases and their complexity.

To summarise the organisational 2023/24 position is as follows: -

Partnership Working
ABUHB continues to engage actively with the Safeguarding Board and Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV), as well as with its subgroups, fulfilling our statutory responsibility.

Learning Reviews
One Child practice review has been published and ABUHB is supporting the implementation of recommendations.

Training
There continues to be substantial challenges with an effective mandate and uptake of Level 3 Safeguarding Training and Ask and Act Training

Assurance
Areas for improvement have been identified via the Safeguarding Maturity Matrix (SMM) tool and clear plans are in place to address these, which are monitored via Safeguarding Committee.

Operational
With a marked increase in activity, ongoing monitoring is required to ensure standards are maintained and staff wellbeing is not adversely impacted.

To summarise, the following are the eight key priorities that will frame the Safeguarding Annual Work Programme 2024/2025: -

1. To work with Senior Leadership Team in Primary Care to ensure that those working within primary care have the training and resources to ensure compliance with the Wales Safeguarding Procedures
2. To ensure delivery of appropriate Safeguarding Adult Supervision to teams within the Mental health and learning Disability Division who are holding caseloads.
3. To develop and launch a suite of documents in relation to sexual safety, including a Chaperone Policy, a standard operating procedure for referral to Sexual Abuse Referral Centre (SARC) and guidelines on internal reporting.
4. To revise the model for delivery and monitoring of Level 3 Safeguarding training
5. Launch of the DATIX Safeguarding Module to facilitate better case management of cases open to the safeguarding processes
6. To rewrite the ABUHB Section 5/Practitioner Concerns Guidance to reflect internal processes and to strengthen local application of the national threshold for referral
7. To develop a set of internal assurance measures, which can contribute to Ward Accreditation, in regard of Safeguarding and Domestic Abuse
8. To establish operational subgroups of the safeguarding committee with a focus on embedding learning from statutory reviews and driving quality improvement

Argymhelliad / Recommendation

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

- **APPROVE** the Safeguarding Annual Report 2023/2024
- **NOTE** the eight key priorities of the Safeguarding Annual Work Programme
- **NOTE** the challenges associated with an increase in referral activity.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care 6.3 Listening and Learning from Feedback 7. Staff and Resources
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Work in partnership to reduce the inciende of domestic abuse, 'honour' based violence and elder abuse Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.

	If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves

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Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Safeguarding Annual Report 2023/24

Introduction

NHS organisations have a statutory duty to ensure processes are in place to safeguard those at risk, as outlined by: -

- Health and Care Standards for Safeguarding Children and Adults at Risk (Welsh Government and NHS Wales, 2015)
- Social Services and Well-being (Wales) Act (SSWBA) (Welsh Government, 2014)
- Violence Against Women and Domestic Abuse (VAWDASV) Act (2015) (Welsh Government, 2015)

This annual report will demonstrate compliance with legislation and inform the Aneurin Bevan University Health Board of the Safeguarding activity during the period 2023 to 2024. In doing so, the report aims to:

- Provide assurance to the Board that the organisation is fulfilling its statutory obligations
- Assure external organisations, partners and regulatory bodies that there is effective work in progress to prevent abuse and reduce harm to vulnerable service users
- To inform the Board, its workforce, partners and regulatory bodies of the activities and function of the Safeguarding & Vulnerabilities Team
- Demonstrate that governance and assurance arrangements within Safeguarding are robust.
- Identify and describe the key risks that were managed during the year, as well as any highlighting current risks and their management.
- Provides a summary of some the key activities undertaken throughout the year, both locally and nationally.
- Set out priorities and areas identified for improvement in relation to safeguarding activity for implementation during 2023/2024.

Local Partnership Arrangements

The Aneurin Bevan University Health Board Safeguarding Team are statutory members of both the Gwent Joint Children and Adult Safeguarding Board and the Gwent VAWDASV Partnership Board, as well as supporting work at a range of sub groups and committees.

The Gwent Joint Children and Adult Safeguarding Board is a multi-agency partnership board responsible for making sure safeguarding is at the core of all services provided across the region. It is supported in its work by a number of sub groups that manage the core business and other more specific pieces of work which deliver on the strategic priorities set each year.

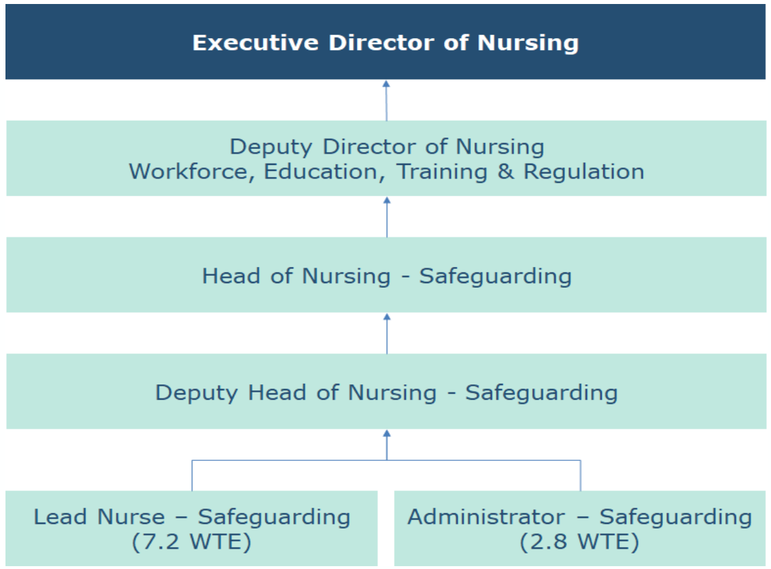
VAWDASV Partnership Board is a multi-agency collaboration working together across Gwent to prevent violence against women, domestic abuse and sexual violence, with the objective of improving the outcomes for individuals experiencing or at risk of harm, along with those of their families and support networks.

Staffing and Governance

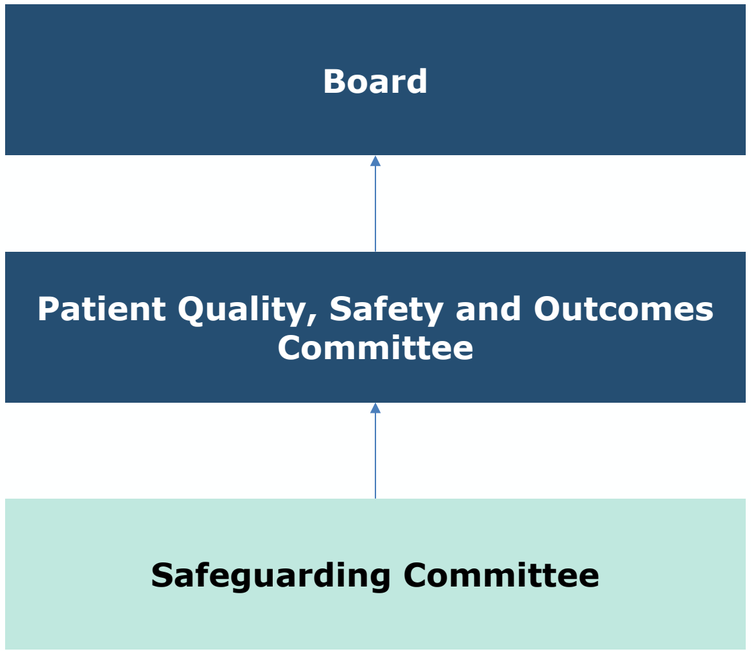
ABUHB is accountable for ensuring that its own safeguarding structure and processes meet the needs of the service. Safeguarding within ABUHB is underpinned by a clear and robust structure, with the Chief Executive accountable for safeguarding and responsibility for executive leadership delegated to the Executive Director of Nursing, supported by the Deputy Director of Nursing. A Head of Safeguarding, supported by a Deputy, is in place to provide strategic assurance for Safeguarding, as well as being the representative on partnership boards.

As strategic lead, the Head of Safeguarding has delegated responsibility for development of appropriate systems including development and implementation of policy, provision and monitoring of training, support with operationalisation of safeguarding practice and ensuring there is a process for monitoring both quality and effectiveness of safeguarding, across the organisation.

Due to some significant increases in activity throughout the last year, some changes to the establishment have been agreed. As of 7 June 2024 the Safeguarding Team has three vacancies for Lead Nurses, one of which is fixed term due to non-recurrent funding, which is out to advert.



The Safeguarding Committee is a formally constituted Committee within the Heath Boards governance structure and reports to Patient Quality and Safety Outcomes Committee, having delegated authority to oversee and monitor the Safeguarding of Adults, Children and Young People.

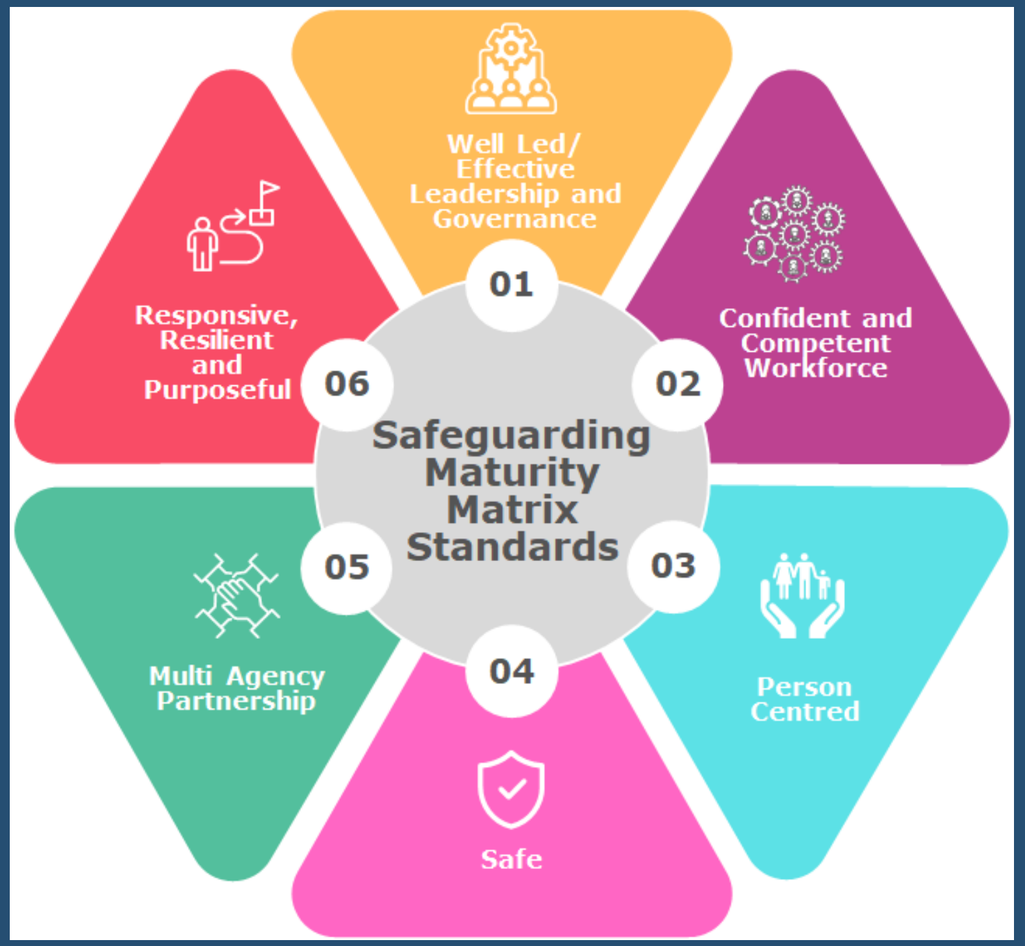


This committee sets out the Health Boards Safeguarding Strategy and sets objectives to encourage continuous improvement, as well as compliance with national and local policies. It is further tasked with responsibility to develop and implement systems for quality monitoring that are robust, auditable and effective, as well as raising the awareness of safeguarding agenda.

Safeguarding Maturity Matrix

Assurance

The Safeguarding Maturity Matrix is a quality assurance tool that all Health Boards and Trusts in Wales submit to the NHS Wales National Safeguarding Team on a yearly basis, used by Health Boards to measure the effectiveness of Safeguarding using self-assessment, identifying strengths and areas for future focus. This tool has 6 standards and a total of 41 indicators across the categories of:



The most recent Safeguarding Maturity Matrix completed and evaluated highlighted one area of non-compliance, four areas of partial compliance and twenty-five areas of full compliance. This contrasted with three areas of non-compliance and fourteen areas of partial compliance in the previous year.

It is highlighted that the one area of non-compliance related to the way in which services commissioned by the Health Board are monitored to ensure compliance with all relevant safeguarding legislation, policies and guidance, where this is local and not a national commissioning contract. In this area it was noted that there are some strong processes in place in regard of Complex Care, but that there were some gaps in assurance regarding some specialist providers. It is anticipated, following work regarding a quality framework for commissioned services, that this issue will be resolved.

Of the indicators where we were partially compliant, these were related to the themes of training, safeguarding supervision and service user feedback. The concerns related to both supervision and training are covered elsewhere in this report.

In relation to service user feedback, specific to the safeguarding process, it is noted that there is no formal route through which we seek feedback from patients who have experienced the safeguarding process. However, reviews of documentation did evidence that the wishes of the patients are sought directly or from their representatives at the time of the referral. One of the challenges regarding providing feedback is that the patients have often left our care prior to conclusion of the safeguarding process. In these instances, feedback is often provided via parallel processes such as complaints management or duty of candour, as well as from the Local Authority as lead agency for safeguarding.

Audit

A Safeguarding Audit was undertaken by NHS Wales Audit and Assurance Services in August 2023, which achieved reasonable assurance overall. Substantial assurance was achieved in regard of governance arrangements and multi-agency co-operation.

In respect of the area of compliance with policy, procedure and legislation overall performance was good. However, due to evidence of some Duty to Reports (DTR) not having been completed within recommended timescales a level of reasonable assurance was achieved. Significant work is ongoing with a variety of areas where a delay in reporting has been identified as a theme and this issue has been partially resolved through enabling digital referrals from emergency care areas.

The fourth and final domain of the audit related to training and reasonable assurance was achieved, as we were unable to evidence the way Level 3 Safeguarding Training is mandated and compliance monitored. This concern is addressed in a separate section of this report.

Activity for Safeguarding Children and Adults

Safeguarding Children

In 2023/24 there have been 3736 duty to reports made by ABUHB in relation to suspected abuse or neglect of children across the five boroughs. This is compared to 1944 referrals made in the previous year, showing an increase of 92%. Alongside this increase in referral volume there has also been an increase in complexity of these cases, with 55% of these progressing to strategy meetings. The volume of strategy meetings for this year being just under 2000 and being a 78% increase on the previous year.

Whilst some of the increases in activity can be put down to better resourcing within Local Authority Safeguarding Teams and better training/awareness in relation to safeguarding, this does not account for such a sharp rise in activity.

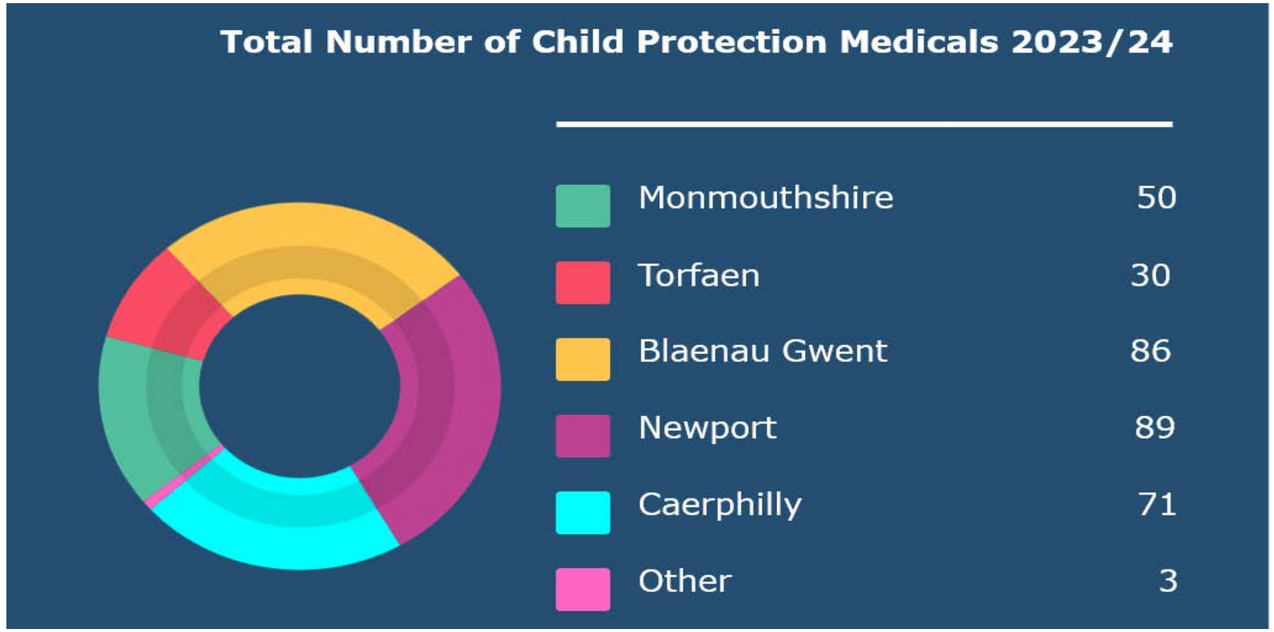
In 2024/25 the Corporate Safeguarding Team will continue to work with partner agencies, both responsively in regards of individual cases but also proactively, via the Safeguarding Board, to ensure the increase in activity is fully understood.

The effectiveness of our safeguarding hub in contributing to the safety planning for children at risk, enables staff to better support children, young people and their families at an early stage, as a result of engagement in multi-agency discussion.

Child Protection Medicals (CPM)

Child Protection Medicals are examinations to look for signs that a child or young person has been neglected or abused.

Throughout 2023/2024 there were 329 Child Protection Medicals undertaken, which is approximately a 10% increase on the volume conducted in previous years.



The above shows a breakdown of Child Protection Medicals by Local Authority Area, though no conclusions can be drawn from this data in isolation.

In previous years there have been concerns related to differences in opinion between radiologists within ABUHB and those in other Health Boards. Extensive work has taken place regionally, with stronger processes io place to facilitate peer or more specialist review in cases where there are concerns or professional differences.

According to policy a CPM should be conducted within 24 hours of request being accepted. In the reporting year all children were seen within the set timeframe.

Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

Procedural Response to Unexpected Deaths in Childhood (PRUDiC) sets the minimum response and describes the process of communication, collaborative action, and information sharing. The aim of the PRUDiC is to ensure that the response is safe, consistent, and sensitive.

There were 12 child deaths that met the criteria for the PRUDiC process in the boroughs covered by ABUHB in 2023-24. This has remained generally consistent over the last 3 years: -

Welsh Government are notified of all PRUDiC'S in accordance with the Putting Things Rights Guidance. Through this communication the patterns and trends are noted.

Child Practice Reviews

Assurance

In 2023/24 there was one Child Practice Review published by Gwent Safeguarding Board and learning from this has been disseminated via the Safeguarding Committee.

This review was undertaken following the death of a 4-year-old male in December 2021 who is referred to as Stanley as requested by the family. Stanley was born in 2016 and there had been previous service involvement as the family lost another child who was 6 months old in 2018. At the time of his death, Stanley had been staying with his father and was returned home on the morning of his death due to being very unwell. The cause of Stanley's death is unexplained; however, it was noted that his bowels were impacted.

Within the review there were no specific areas where it was identified that there had been any oversights or that there were any specific areas for improvement in relation to ABUHB provided or contracted services. However, some of the wider learning points regarding effective models of both safeguarding and management supervision for staff working with complex cases provided some useful learning internally.

Background

1 This Review followed the tragic death of a 4 year old male child in December 2021. Stanley was born in 2016 and there had been previous service involvement with the family as they lost another child who was 6 months old in 2018. At the time of his death, Stanley was residing with his mother and younger half-brother. He had been staying with his father and paternal grandmother the night prior to his death, and was returned home on the morning of his death due to being very unwell. The cause of Stanley's death is unexplained; however, it was noted that his bowels were impacted. The review period for Stanley falls within the parameters of the Covid 19 pandemic where agencies were working under various pressures; however, statutory obligations in respect of safeguarding remained the same and there was an expectation these continued to be met.

Diogelu Gwent
Gwent Safeguarding

Context

2 At the time of Stanley's death, he and his younger brother were subject to Child Protection Registration. This was primarily due to his mother being in a relationship with a registered sex offender, however there had been other concerns regarding domestic abuse, the mental health of both parents, and a disclosure by Stanley's father that he had sexually abused his niece. This was later retracted but was investigated by Polic with no further action being taken.

During the period of involvement with Children's Services, Stanley was noted to have ongoing health concerns in respect of constipation, he had been prescribed medication by his GP. In the days preceding Stanley's death, there had been no concerns that he was unwell. An ambulance was called upon his return home to his mother's address and Stanley was found to be in cardiac arrest; medical attention was provided at the home before Stanley being conveyed to hospital where he sadly died.

Recommendations

7 Children's Duty to Report Threshold Guidance to be shared with multi agencies. Each agency to consider the implementation of this guidance within their own organisation.

Gwent MAPPA unit to provide training for Gwent IDVA Services to ensure they understand what is expected of them when attending MAPPA meetings.

Gwent MAPPA Unit to provide briefings to all MAPPA chairs regarding the importance of accurate recording of disclosures agreed in MAPPA meetings.

7-minute briefing on Independent Domestic Violence Advisor (IDVA) Services to be formulated (including what the service can provide and the referral process) and shared with organisations.

Theme 1: Quality of Safeguarding Assessments

3 There were concerns that vulnerabilities of Stanley's mother were overlooked when responding to referrals submitted. Stanley's voice was missing from early safeguarding assessments and home visits were not carried out due to the covid pandemic and domestic abuse concerns were overlooked. Similarly, concerns regarding Stanley's father's mental health were not fully acknowledge in respect of his parenting capacity.

Decisions were made without multi-agency strategy meetings taking place despite the threshold being met and there was a lack of information sharing which meant that risk assessment was likely to have been compromised. It is felt that the case should have progressed to S47 enquiries at an earlier stage. There was also a lack of clarity as to the rationale for case closures and concerns that timescales specified within the Wales Safeguarding Procedures were not adhered to.

Recommendations

6 Gwent Safeguarding Board to develop business continuity guidance for agencies to follow in an event or situation whereby service delivery is impacted. Regional guidance will ensure that all agencies are working to an agreed set of standards ensuring that the safeguarding of children, young people and adults is not compromised.

Gwent Safeguarding Board to develop a Quality Assurance framework to ensure the correct process is being followed when closing cases and to ensure Wales Safeguarding Procedures are adhered to.

Local authorities to increase availability and effectiveness of training for frontline practitioners to improve awareness and understanding of engaging meaningfully with fathers.

Strategy Discussion attendance should comply with recommendations set out in the Wales Safeguarding Procedures.

Theme 3: Domestic Abuse being Overlooked

5 Concerns were identified regarding domestic abuse within Stanley's mother relationship and her partner had an extensive history of domestic abuse. However, the focus was on the risk of sexual offending and that the risk of domestic abuse was overlooked. Although it was recorded that disclosures made by Management of Sexual or Violent Offender (MOSOVO) Officers included domestic abuse concerns, it is not clear what extent of information was shared and no disclosures were made under Claire's Law, thus it is unclear if Stanley's mother was fully aware of the risk in this context.

A referral was not made to Independent Domestic Violence Advocates Services (IDVA) in a timely fashion and when it did take place, did not progress due to an administrative error. This was despite IDVA representatives being present at Multi-Agency Public Protection Arrangement (MAPPA) meetings where risk was highlighted.

Theme 2: Missed Opportunities to Submit Safeguarding Referrals

4 Stanley's father shared concerns with the Health Visitor regarding his appearance and general health; He was advised to discuss with Stanley's mother and contact Children's Services if these continued. A visit was then undertaken where the Health Visitor also noted some concerns, however, a Duty to Report was not submitted. It is important that practitioners take ownership for any concerns shared with them and are not reliant upon family members or members of the public to contact Children's Services.

There were also concerns that the National Probation Service were not clear about the capacity of Stanley's mother to supervise contact with her partner, a Registered Sex Offender, however, did not submit a Duty to Report for clarification, despite being aware of a high level of contact.

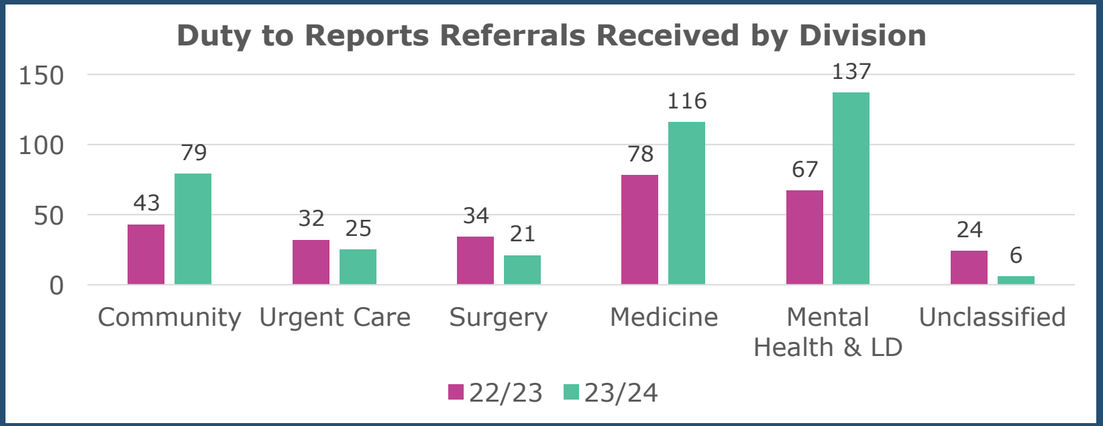
Safeguarding Adults

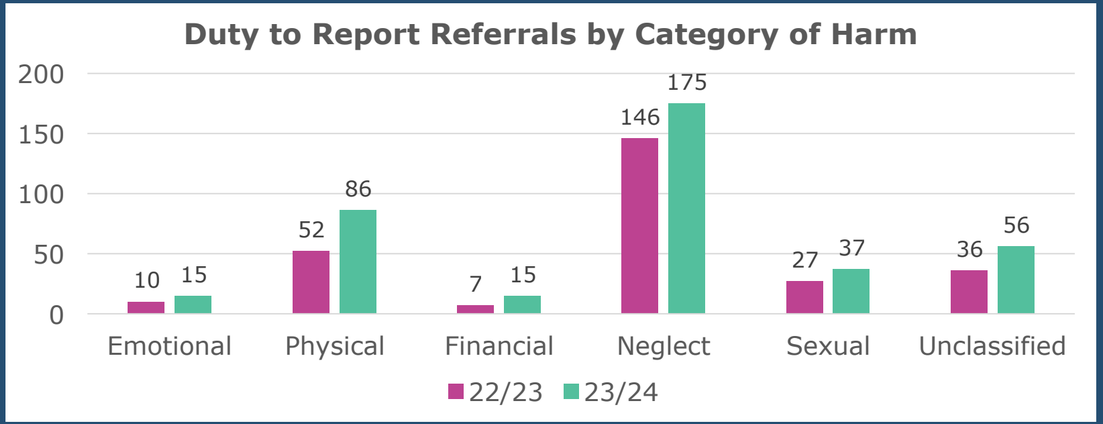
The Adult Safeguarding function of the Corporate Safeguarding Team receive Duty to Reports from Divisions enabling assessment and multi-agency referral for adults at risk.

These include cases that pertain to possible safeguarding risk that the Health Board may have contributed to, and cases where external parties (individuals or organisations) are contributors.

In 2023/24 there were 362 Duty to Reports received by Corporate Safeguarding. This has been a significant increase on the 263 received in 2022/23 and represents an increase of 38%.

The following graphics show the referrals broken down by Division and Category of Harm.





The information provided by Division is reported for information purposes only and is not utilised for comparison, as often the Division reporting will be reporting a concern that is not related to the care and treatment that they are delivering.

When reviewing the data categorised by type of harm, it is clear that Neglect is by far the most prevalent. This category includes allegation of neglect with sub themes including poor discharge, pressure ulcers and medication errors.

On closer analysis of the data relating to physical harm, it is noted that a bulk of these incidents are patient upon patient assaults, which on investigation have nearly always been unavoidable.

Of significant concern is the figure of reported in relation to sexual assault, which was also highlighted in the Annual Report for 2022/23. Considerable work has been undertaken to review these incidents and whilst the volume remains concerning, the incidents have not been of a type that would meet the definition of serious sexual harm.

It is noted that the figures highlight a sharp increase in referrals from the Mental Health and Learning Disability Division. This can be attributed to some targeted work in ensuring that incidents were reported when they met the threshold, acknowledging that historically they may have been normalised.

Adult Practice Reviews

In the period 2022/23 there were no Adult Practice Reviews published by the Gwent Safeguarding Board.

Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust

Section 5 of Wales Safeguarding Procedures provides a framework for how to respond appropriately to safeguarding concerns about people whose paid or voluntary work brings them into contact with children or adults at risk.

There were 129 Safeguarding Allegations or Concerns raised about ABUHB staff in 2023/24, this figure having been 102 in 2022/23.

Of these 129 referrals into the process, 36 these were substantiated, with 29 proceeding to criminal investigation. In the previous year only 10 were substantiated and 10 moved to formal Police investigation.

When reviewing this report, it is important to recognise that the process in place means that staff are considered under this process, regardless of whether the allegation made against them relates to their work for ABUHB or is related to an incident or occurrence within their private lives.

To offer some context on the figures for 2023/24, 76 related to allegations made regarding incidents in the workplace and a further 53 were related to incidents reported whilst not at work. Furthermore, it should be noted that these cases are not all related directly to employed ABUHB staff, with a number relating to independent contractors in Primary Care.

In each individual case there are timely risk assessments undertaken, supported by Divisional Teams and Workforce, that look at strategies to ensure that patients are not placed at risk and that the staff member is supported through the process until its conclusion.

Given the increase in reporting and the increase in action, a working group has been established to look at these incidents in more detail with a view to updating our Policy, clarifying the threshold for referral and to determine any themes and trends. There has been a commitment of senior representation on this workstream from the Execs responsible for Nursing, Therapies, Medicine and Workforce. Early work undertaken by this group has identified that referrals made into the process by us have met the threshold, however it has further noted that referrals made by other agencies do not appear to meet the threshold and could have been managed through other routes

Modern Slavery

Modern Slavery is defined as slavery, servitude and forced or compulsory labour.

In 2023/24 local multi agency processes were strengthened in relation to Modern Slavery, with the launch of a formal risk assessment conference to look at how risk to identified individuals can be reduced and to ensure that they are properly supported following their exposure. During this period there were 16 individuals identified as victims of Modern Slavery.

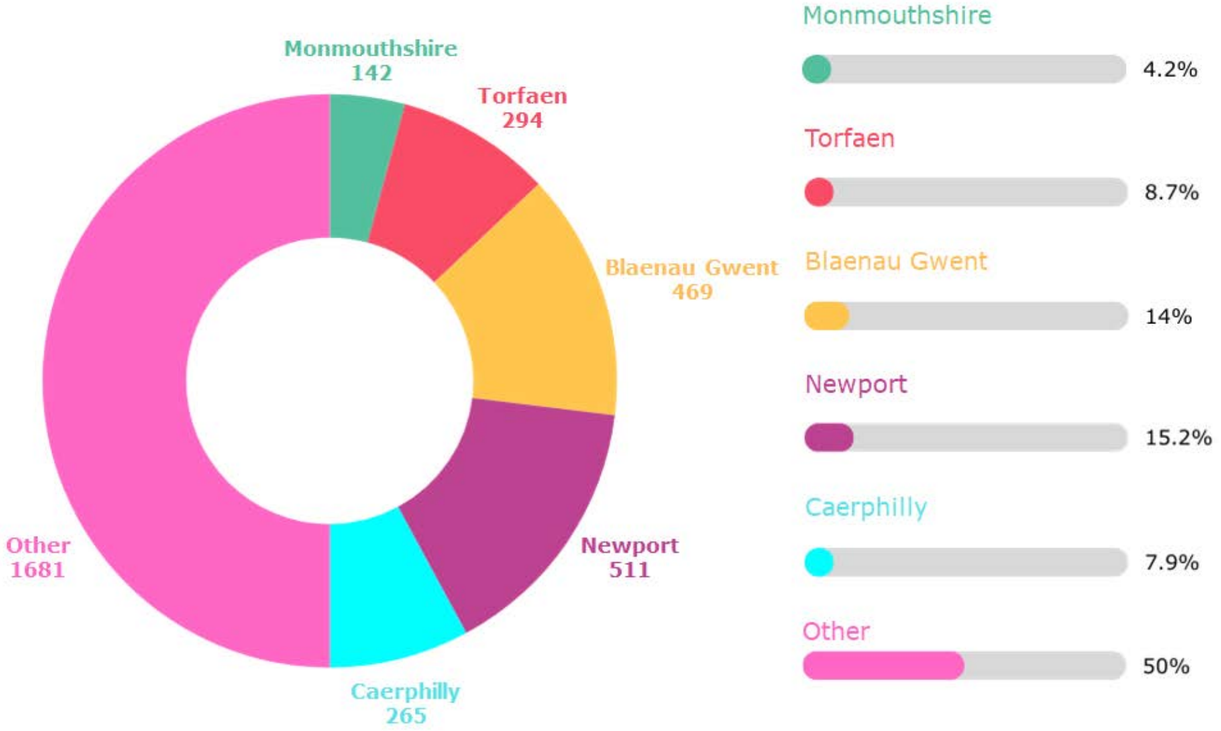
Domestic Abuse

Domestic Abuse is "any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality" (Welsh Government, 2015).

Multi Agency Risk Assessment Conference (MARAC)

The Corporate Safeguarding Team are involved in work to support victims of domestic abuse who are at high risk, through supporting the Multi Agency Risk Assessment Conferences (MARAC). These are multi-disciplinary meetings where cases pertaining to victims who are at risk of serious harm or homicide are discussed, and actions made to safeguard them.

In 2023-2024, following repeated requests from partners and in line with best practice, ABUHB's Corporate Safeguarding Team recommitted to attend MARAC. Prior to this point we had supported the process through submission of reports. This was a considerable new undertaking for the team, with each Local Authority holding a MARAC Panel on a fortnightly basis.



The above shows the volume of cases discussed in MARAC and therefore highlights the volume of individuals experiencing Domestic Abuse that would be considered Medium or High risk utilising a nationally accredited risk assessment tool. In addition to this significant cohort, there are a high volume of individuals that use our service who will be experiencing domestic abuse where the risk assessment has indicated a standard risk and are supported by a single agency, which in many cases can be ourselves or our independent contractors.

Domestic Homicide Reviews

In 2023-24 the Corporate Safeguarding Team supported six Domestic Homicide Reviews (DHR's), which are yet to be published, with two of these having been started in the previous year and one dating back to 2020.

Having reviewed the early findings of these reviews, it is evident that the support provided to patients has been of a high standard. However, there are some identified areas of improvement in relation to how domestic abuse and associated vulnerability are recorded within patients notes, to ensure that it can be seen as an active concern for those that may also have contact with the patient. Compared to many historic DHR, there is evidence of much better professional curiosity and good practice in relation to ensuring that patients are seen alone.

Historically the Health Board has represented all health agencies within the DHR process, but with the three current reviews there has been active engagement with the process by General Practice. This has facilitated a far richer flow of information and enabled more meaningful discussion, resulting in clearer and most importantly achievable recommendations being made.

The learning from these reviews will inform future interventions, as a Health Board, to better identify and service users who are victims of domestic abuse, as well as those who are supporting them.

Independent Domestic Violence Advisers (IDVA)

The IDVA Service is commissioned Gwent Wide and is currently hosted by Newport City Council, though funding is provided by the five Gwent Local Authorities, ABUHB and the OPCC. This role aimed to improve the awareness, assessment, signposting and onward referral for patients experiencing domestic abuse (including coercive control) who are in contact with Health Board Services.

Alongside this education role, the IDVA works directly with patients who have experience Domestic Abuse, supporting them with risk assessments, safety planning, reporting their experiences to the Police and introducing them to other services such as Housing or specialist support.

Throughout the reporting period 2023/24 the IDVA service available to health was based in the Grange University Hospital, though supports patients and staff across the whole ABUHB inpatient and urgent care footprint. Over the course of this period our IDVA supported 305 survivors of Domestic Abuse

Safeguarding Supervision

Safeguarding supervision is a key part of the Corporate Safeguarding Teams role. It ensures all staff are competent to carry out their responsibilities in safeguarding and feel supported and able to develop by reflection.

Supervision provides a restorative and reflective space for staff to discuss cases and reflect on what went well and what could be done better. It also helps to alert the Corporate Safeguarding Team around the themes being seen by the frontline in ABUHB.

ABUHB staff have access to supervision in several ways. This includes immediate telephone supervision, debriefs, individual supervision and group supervision.

Child Safeguarding Supervision

Regular supervision continues for child specific specialities including Health Visitors, School Nurses, Child Adolescent Mental Health (CAMHS) Practitioners, Community Paediatric Nurses, Children with Learning Disability Nurses, Sexual Health Outreach, Acute Paediatric Nurses, Health Care Support Workers, Neonatal Intensive Care Nurses and the Neonatal Intensive Care Liaison Team and Midwives.

The Corporate Safeguarding Team has recognised the importance that Health Board staff are able to speak to subject matter experts regarding cases and incidents they are involved with. They are recommended to receive supervision (from the Safeguarding Supervision policy) twice per year.

Compliance with safeguarding supervision is monitored locally by operational managers, though it is evident that the safeguarding team have provided close to 100 formal supervision sessions over the year and that these have been actively engaged with by operational staff within our children's services.

Adult Safeguarding Supervision

Adult safeguarding supervision does not have the same clear mandate within the intercollegiate guidance as that which exists for our workforce supporting children. In part this is due to a national view that those working with adults do not hold formal cases loads and that their interactions with service users is more transitory.

However, there is evidence within the Health Board that there are teams that work with complex and vulnerable people over prolonged periods, so a model is being developed to ensure that there are formal options available for safeguarding supervision.

To date, the Corporate Safeguarding Team has already implemented a safeguarding supervision model with the Complex Care Team and the High Impact Service. In addition to this, there are plans to explore more formal offers of Safeguarding Supervision with District Nursing and the Community MH/LD Teams.

Training

Safeguarding training is a key part of the Corporate Safeguarding Teams role. Safeguarding training is mandatory in ABUHB and compliance is expected to meet Welsh Governments national target of 85%. Training is provided through e-learning and face-to-face teaching methods.

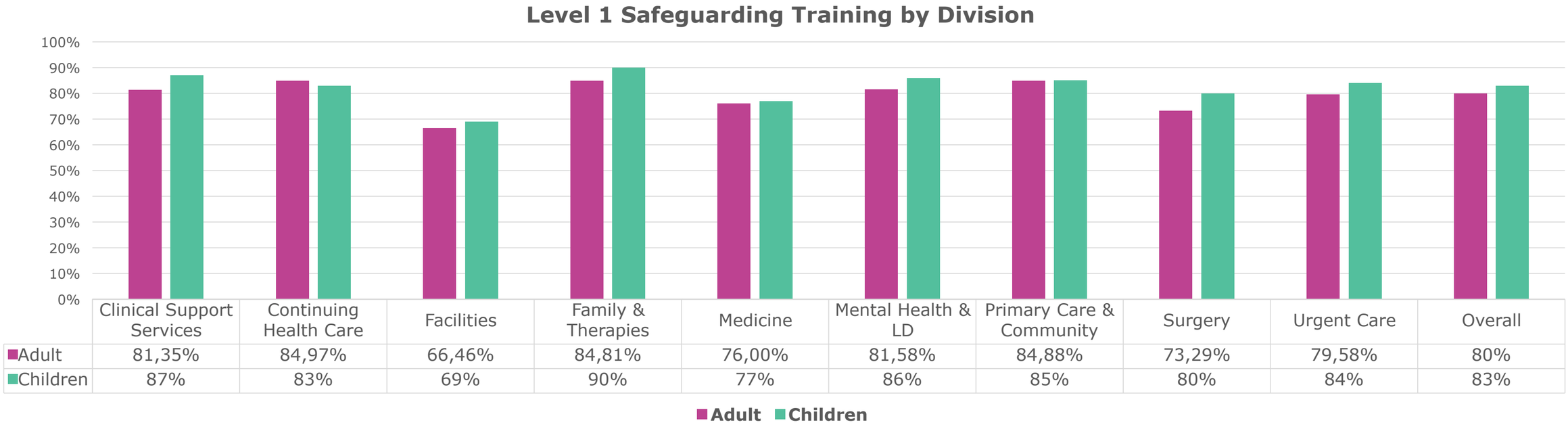
Safeguarding training compliance has improved between 2023-2024, and improved engagement from divisions has been noted and appreciated. Level 3 training for both children and adults was re-launched in April 2023 and throughout the year 780 training places were offered for each discipline.

Level 1 Safeguarding Training

Level 1 safeguarding training is mandatory for all professionals who work within ABUHB. It ensures that all staff can recognise safeguarding concerns for adults and children and are able to take appropriate action to safeguard.

Safeguarding Level 1 training compliance for adults was 80% and Safeguarding Level 1 training compliance for children was 83% on March 31st 2024.

The compliance figures demonstrate only minor improvements are required to reach the 85% target. The graph below shows level 1 compliance for both adult and children by division.



	Clinical Support Services	Continuing Health Care	Facilities	Family & Therapies	Medicine	Mental Health & LD	Primary Care & Community	Surgery	Urgent Care	Overall
Adult	81,35%	84,97%	66,46%	84,81%	76,00%	81,58%	84,88%	73,29%	79,58%	80%
Children	87%	83%	69%	90%	77%	86%	85%	80%	84%	83%

Training

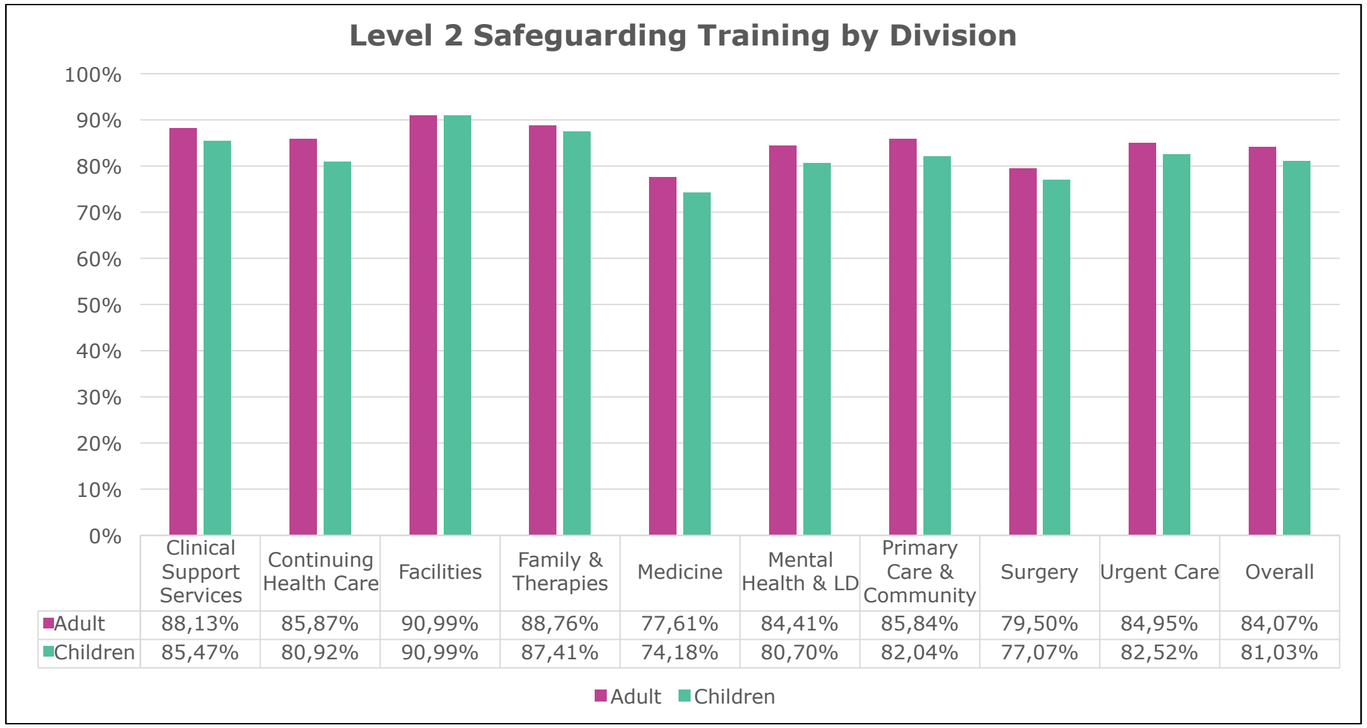
Level 2 Safeguarding Training

Level 2 safeguarding training is mandatory for professionals who work within ABUHB and have any contact with patients. They should be able to recognise and act on safeguarding concerns by making referrals and advocating for adults and children.

Safeguarding Level 2 training compliance for adults is 84% and Safeguarding Level 1 training compliance for children is 81%. Which is unchanged from 2022-2023 figures.

The compliance figures demonstrate only minor improvements are required to reach the 85% target. The graph below shows level 2 compliance for both adult and children by division.

The graph shows level 2 compliance for both adult and children by division.



	Clinical Support Services	Continuing Health Care	Facilities	Family & Therapies	Medicine	Mental Health & LD	Primary Care & Community	Surgery	Urgent Care	Overall
Adult	88,13%	85,87%	90,99%	88,76%	77,61%	84,41%	85,84%	79,50%	84,95%	84,07%
Children	85,47%	80,92%	90,99%	87,41%	74,18%	80,70%	82,04%	77,07%	82,52%	81,03%

Level 3 Safeguarding Training

Level 3 safeguarding training is for professionals who could potentially contribute to assessing, planning, intervening and/or evaluating the needs of a children or adults with safeguarding concerns.

Level 3 safeguarding training for children and adults is accessed through a 1 full day training course (7.5 hours) which provides the 'building blocks' to Level 3 competency. In addition to this, staff are asked to keep a personal record of further completed Safeguarding training and supervision which contributes to the hours required for completion

Reporting against Level 3 Safeguarding Adults and Children training remains incomplete due to difficulties in recording mandatory requirements on ESR for different staff groups. It was hoped that this could be achieved by using the approach of bulk aligning roles titles on ESR. This was the approach taken for Level 2 and allows large numbers of staff to be assigned a competency at any time. An example of this is a Health Visitor would require Level 3 Safeguarding Children but not Level 3 Safeguarding Adults. Contact has been made with ESR and discussions on how this can be achieved are ongoing. Once achieved the Corporate Safeguarding Team will then be able to support in the identification and alignment of staff.

In 2023-2024 780 staff members completed the level 3 training combined for adults and children. In addition, a further 247 staff attended bespoke training in relation to their specific discipline.

Training

Domestic Abuse Training

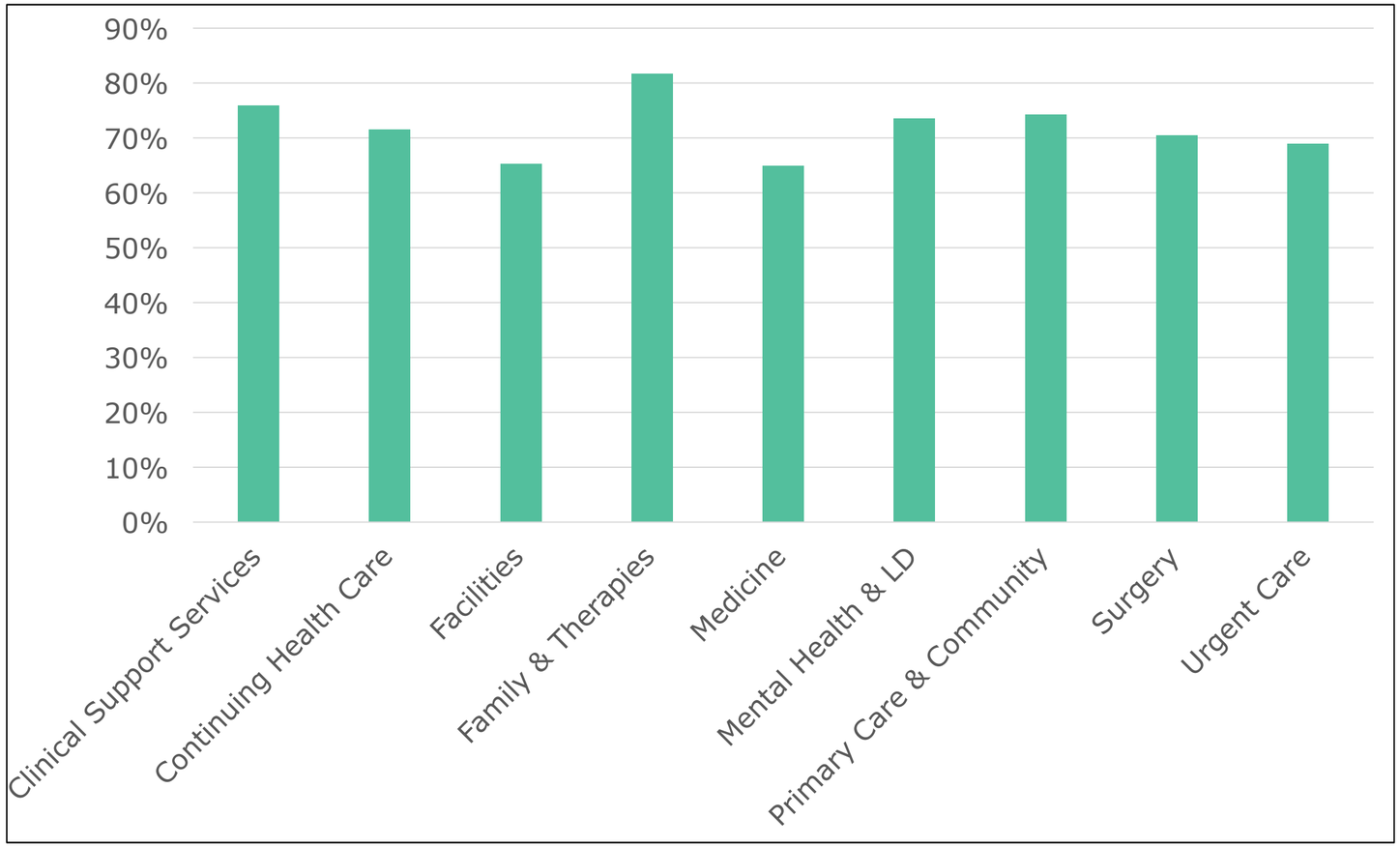
Ask and Act training aims to ensure that professionals are trained to provide an effective response to anyone affected by any form of gender-based violence, domestic abuse, and sexual violence.

Ask and Act training is grouped similarly to standard safeguarding training using group 1, 2 and 3 to indicate the responsibility and learning requirement of the participants. Level 1 being the most basic and is mandatory for all ABUHB staff, and level 3 being for those who actively work with victims and are likely to identify, assess and refer.

In 2023/24 74% of eligible staff at ABUHB were trained to Level 1 in Ask and Act. This figure remains static from 2022/23's compliance percentage.

Level 2 Ask and Act training continue to remain a challenge to extracting compliance data due to ESR reporting which will be remain on the Training Needs Analysis of 2024/25.

The graph shows Group 1 compliance by division.



Review of Priorities for 2023/24

1	Level 3 Safeguarding Training is not yet mandated via ESR and therefore is unable to be monitored at either an operational or strategic level. Therefore, ongoing work will be needed to ensure that this is remedied, to able better monitoring of compliance.	This challenge has not been able to be overcome with the current ESR system in place. As such, alternate ways of monitoring compliance will need to be considered in partnership with workforce.
2	Divisional Reporting to Safeguarding Committee is not yet established as standard practice. As the bulk of the operational work relating to safeguarding takes place at an operational level, divisions need to be able to demonstrate an awareness of themes, trends and risk. As such, the Corporate Safeguarding Team will work with Divisional leadership Teams to ensure that a mechanism is in place for reporting to committee.	Divisional reporting is now an integral part of the Safeguarding Committee, with reports including updates on learning from reviews, training, current challenges, supervision and risk.
3	Feedback from partners has highlighted some delays in referrals being made to local authorities where a child in urgent care may present with a need that meets the threshold for referral to safeguarding. Work will be undertaken to ascertain how IT can be utilised to minimise the impact on staff and enable more timely referral, this will be the subject of monitoring to ensuring improvement and to monitor quality.	Significant work has been undertaken in developing and reviewing the implementation of digital referrals via urgent care areas. Feedback from local Authorities has highlighted that this has significantly improved both the quality and the timeliness of reports. The longer term objective is to extend this to other clinical areas, through the implementation of the DATIX Safeguarding Module.
4	ABUHB has a statutory duty to engage with local multi agency work focussed on reduction of serious violence. As such, the Safeguarding Team will work internally with Public Health and externally with partners to ensure that we are first recording/ reporting appropriate data and then to utilise this to direct strategies to reduce violence.	Statutory duty has been met through active contribution to the strategic needs profile and through provision of activity data to inform the local profile.
5	To undertake a thematic review of PRUDiC to understand any themes and ensure that these drive improvements both internally and externally to our organisation.	An annual review of PRUDiC was undertaken and presented to the Safeguarding Committee. Given the small number of cases and the variations in the types of patients, it was not possible to identify any specific learning or themes.
6	To work with partners regionally to understand the variance in reporting of skeletal surveys that form part of the Child protection Medical Process, looking at how peer support and review may facilitate consistency.	Extensive work has taken place regionally, with stronger processes io place to facilitate peer or more specialist review in cases where there are concerns or professional differences.
7	To engage with the partners regarding the review and recommissioning of the IDVA service, to ensure that it meets the needs of the ABUHB population and that the way in which it meets these can be evidenced both quantitively and qualitatively.	The review and recommissioning exercise for the IDVA service identified some benefits to this service remaining within the public sector. Therefore the service will continue to be hosted by Newport County Borough Council
8	To review internally the way in which reports of sexual harassment and sexual harm are reported and managed, both in respect of individual cases and wider thematic learning.	A task and finish group was established to undertake this work and has identified the need to update the Chaperone Policy, develop standard operating procedure for referral to the sexual abuse referral centres (SARC) and to develop guidance on how cases should be reported and classified via DATIX.

Conclusion

In conclusion, 2023/24 was another challenging year for the Corporate Safeguarding Team, impacted by staff vacancy and a significant increase in safeguarding activity.

The challenges of increased operational activity has meant there has been some delays in fulfilling aspects of quality assurance and service improvement work.

Despite the challenges, successes have been secured in the following areas: -

- Improved outcomes in the Safeguarding Maturity Matrix
- Delivery of Level 3 Safeguarding Training
- Widening the scope of safeguarding supervision
- Reasonable assurance in Safeguarding Audit
- Longevity Independent Domestic Violence Advocate role based in urgent care
- Establishing a well-attended and productive Safeguarding Committee
- Active support of the MARAC process

ABUHB is committed to ensuring the safeguarding of children and adults is a priority and continues to improve in 2023/24, tackling both exiting and new challenges, many of which will be from hidden harms faced by victims and survivors, who will need safeguarding in different ways to those we have known before.

Work will continue with the community and partners to ensure the development and adaptation.

Priorities for 2024/25

ABUHB acknowledges that there is further work required to improve the safeguarding of children and adults at risk. It is important as Health Board that we continue to adapt and enhance the services we offer to meet the needs of contemporary society.

The priorities for ABUHB in 2023/24 are:

Priority 1:
To work with Senior Leadership Team in Primary Care to ensure that those working within primary care have the training and resources to ensure compliance with the Wales Safeguarding Procedures.

Priority 2:
To ensure delivery of appropriate Safeguarding Adult Supervision to teams within the Mental health and Learning Disability Division who are holding caseloads.

Priority 3:
To develop and launch a suite of documents in relation to sexual safety, including a Chaperone Policy, a standard operating procedure for referral to SARC and guidelines on internal reporting.

Priority 4:
To revise the model for delivery and monitoring of Level 3 Safeguarding training.

Priority 5:
Launch of the DATIX Safeguarding Module to facilitate better case management of cases open to the safeguarding processes.

Priority 6:
To rewrite the ABUHB Section 5/Practitioner Concerns Guidance to reflect internal processes and to strengthen local application of the national threshold for referral.

Priority 7:
To develop a set of internal assurance measures, which can contribute to ward accreditation, in regard of Safeguarding and Domestic Abuse.

Priority 8:
To establish operational subgroups of the safeguarding committee with a focus on embedding learning from statutory reviews and driving quality improvement.

Agenda Item: 4.1

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 July 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit Recommendations Tracker
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report is presented to the Patient Quality, Safety, and Outcomes (PQSO) Committee to provide greater transparency and oversight into the implementation of internal and external recommendations resulting from planned audit reviews that fall under the purview of the PQSO Committee's agenda.

The full Audit Tracking Report was received by the Audit, Risk and Assurance Committee on 09 July 2024 for assurance of actions to complete recommendations.

Cefndir / Background

Following the previous report to the PQSO Committee in June 2024, which included an update on overdue recommendations up to the end of March 2024, the closing position was reported as **three** recommendations remained 'Overdue' with a further **23** 'Not Yet Due' an update, as the implementation date was still within the agreed timeframe for completion.

Since then, a further **three** have been added to the Tracker following finalisation of Medical Equipment and Devices (Ultrasound) received at the Audit, Risk and Assurance Committee on 21 May 2024.

In total the Tracker holds **29** recommendations across **eight** audit reports that are linked to the quality and safety agenda.

Asesiad / Assessment

At the end of June 2024 there were **29** active recommendations across **eight** audit reports owned by the Clinical Executives, listed below: -

- 2017 - Medical Equipment and Devices
- 2021 - Medicines Management
- 2022 - Monitoring Action Plans
- 2022 - Discharge Planning
- 2022 - Dementia Services
- 2022 - Structured Assessment
- 2022 - Putting Things Right: Advisory Review
- 2023 - Medical Equipment and Devices (Ultrasound)

Table 1 provides information in relation to the **29** recommendations by 'Year,' 'Executive Lead,' and 'Priority Rating'. The colour coding within the tables is explained below. Further detail regarding the **29** recommendations can be found in **Appendix A**.

Key – Recommendation Priority Rating			
N/A	Low	Medium	High

Table 1

All Recommendations by Year,' 'Executive Lead,' and 'Priority Rating								
Year	Lead Director							Total
	Director of Nursing				Medical Director	Director of Therapies & Health Science		
2017	-				-	2		2
2021	-				1	-		1
2022	1*	7	7	4	-	-		19
2023	2		2		-	2	1	7
Total	23				1	5		29

*Denotes one external audit recommendation. The remaining 28 are internal audit recommendations.

Of the **29** recommendations, **16** required an update as these had triggered as 'Overdue' during Quarter 1 (Table 2). Overdue represents recommendations that have passed their original or revised implementation date. Further detail regarding the **16** recommendations can be found in **Appendix B**.

Table 2

Number of Overdue Recommendations by Lead Director Pre Update				
Year	Lead Director			Total
	Director of Nursing	Medical Director	Director of Therapies & Health Science	
2017	-	-	2	2

2022	**2**	**5**	**4**	**1**	**-**	**12**
2023	**1**		**1**	**-**	**-**	**2**
Total	**13**			**1**	**2**	**16**

The updates received concluded the following position as outlined in Tables 3 -5 with further information found in **Appendices C, D and E** respectively.

Table 3

Audit Report	Number of Completed Recommendations		
	Director of Nursing		Medical Director
2021 Medicines Management	**-**		**1**
2022 Discharge Planning	**1**	**2**	**-**
2022 Dementia Services	**1**	**1**	**-**
Total	**5**		**1**

Table 4

Audit Report	Number of Recommendations with Revised Timeframes		
	Director of Nursing		Director of Therapies & Health Science
2017 Medical Equipment and Devices	**-**		**2**
2022 Discharge Planning	**3**	**1**	**-**
2023 Putting Things Right	**1**	**1**	**-**
Total	**6**		**2**

Table 5

Audit Report	Number of Overdue Recommendations
	Director of Nursing
2022 Monitoring Action Plans	**1**
2022 Discharge Planning	**1**
Total	**2**

While it is important for the Committee to be reassured that work is underway to implement the **two** overdue recommendations, there are **eight** recommendations where the original deadlines as specified in the final reports have passed, and these recommendations should receive equal scrutiny.

The Audit Risk and Assurance (ARA) Committee reviewed the Audit Recommendation Tracker for the Quarter 1 (April 2024 – June 2024) reporting period at its meeting on 09 July 2024. The closing position, which included the status of the recommendations in this report, was approved. However, the ARA Committee has requested supplementary information from Lead Directors for any recommendations that are still outstanding. The Director of Nursing is responsible

for one recommendation (Discharge Planning) that necessitates additional detail to be provided to the ARA Committee.

Furthermore, any recommendation that surpasses the approved threshold of more than two revised deadlines will be required to submit an assurance note for each meeting and attend the meeting to provide an explanation for why the recommendations are still outstanding. This approach will be implemented until the Committee is satisfied that either external factors are affecting implementation, in which case the Committee will determine whether the challenges need to be raised with the auditing body; or the Committee is satisfied that the recommendations have been implemented and there is sufficient evidence to approve completion.

This approach will ensure there is greater rigour and accountability in the implementation of recommendations and will be implemented for the next report to the ARA Committee in September.

Argymhelliad / Recommendation

- **NOTE** the closing position of the **29** audit recommendations; and,
- **NOTE** the approach being implemented by the Audit Risk and Assurance Committee to ensure a higher level of scrutiny for longstanding recommendations and high-rated recommendations that exceed the threshold for revised deadlines.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. Integral to the delivery of the IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	All terms are explained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including new request	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?
2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	N/A	High	R1	R1 Register should be maintained to operational management of medical devices and equipment in each area/ site department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	-74.85	30/06/2024	0.00		Overdue	Overdue	4		June 2024: The Estate Service will be in a position to roll out the user guide for the Medusa Customer Portal following the delayed major update to the Medusa database that is scheduled to be implemented on 12th July 2024. The ward and departmental audit of non-electrical medical equipment has been implemented. The output will be a local inventory/register of installed medical equipment not captured in	January 2024: The Estate Service is in a position to roll out the user guide for the Medusa Customer Portal following the delayed major update to the Medusa database that is scheduled to be implemented on 12th July 2024. The ward and departmental audit of non-electrical medical equipment has been implemented. The output will be a local inventory/register of installed medical equipment not captured in technical aspects of attaching RFID tags and entering the related data into the Medusa, the Asset Register and the Paragon RFID databases for all equipment has restricted the people conducting the task to skilled and available EBME and Finance staff. Physically accessing equipment, which by design and necessity is mostly in utilisation on patients, has restricted the tagging operation to points of contact with	January 2024: The dominant risk factor related to this recommendation is the unbalanced investment in equipment, this is assessed as a having a current risk exposure level of 12 (high). The following mitigation actions are identified: Work is in progress to assure that within the medical equipment and devices register, lists of medical equipment and devices located in our wards and departments are up-to-date and accurate.	Whilst the aim is to tag all medical equipment & devices throughout the the hospital we are focused on completing one major site. This being the GLH and to date out of 3242 assets listed on our database 1341 devices have been tagged, which represents 41.3% of assets on site at the GLH. In total we have RFID tagged over 4100 medical devices to date across our HB sites. Its difficult to commit to a completion date giving the ongoing service pressures, but this work is a daily ongoing process and when time
2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	N/A	High	R2	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/03/2018	-74.85	31/08/2024	2.03		Overdue	Overdue	4		June 2024: A system of providing bedside training to cascade infusion device trainers has been established and training is in now workstream. A system of categorisation of the degree of training required against groups of equipment types has been developed. Reflection of this in the Medusa equipment management database is pending the major update that is scheduled to be implemented on 12th July 2024. Update Aug 2023:	January 2024: Ward and departmental managers need appropriate resources to engage in the identification and the making available of staff for training Obtaining a match with an appropriate level of quality for the Health Board's needs from the training that can be provided by the manufacturer needs scrutiny Lack of manufacturer personnel limiting ability to respond with support to run training sessions on a large scale	January 2024: The dominant risk factor related to this recommendation is that infusion therapy delivered by infusion device is unable to be provided if an insufficient number of trained staff are present on a given shift roster, this is assessed as a having a current risk exposure level of 9 (high). The following mitigation actions are identified: Follow up on seeking responses to the infusion training questionnaire originally sent out to ward and departmental managers in January 2023 and update	New QPS Infusion Device Service Training Manager now in post.Consolidation of the infusion device training records aim to be achieved by end of Sept 23, Development of a dashboard to indicate compliance levels aim to be achieved by December 2023.Piloting migrating the infusion device training records to HealthRoster/ESR dependant on outside agencies.
2021.20	Medicines Managment	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R2	R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	The CD Policy is due for review during 2023/24. At the previous review a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version.The use of red pen on the wards is to make stock checks morevisible. The practicality of this will be reviewed.Keeping patients own CDs on a	31/03/2023	-14.98		-1490.92		Completed /Closed	Completed /Closed	2		Policy extended with review date 31st May 2024. Revised policy due to be provided to Clinical Policy & Standards Group 9th May 2024. Update Aug 2023: The review date of the current policy is November 2023. Progress to review and update it was delayed to ensure compliance with the Welsh Government notification to ensure HB	Delay due to HMRC licencing requirements		ABUHB_Clinical_0552 Management of Controlled Drugs Policy_Issue 6 Policy reviewed and update approved at CSPG 9th May 2024
2022.18	Monitoring Action Plans	Reasonable	Director of Nursing	Assistant Director of Nursing (PT Safety)	Low	R2	Management should review the number of actions raised within the HIW reports and the number of actions noted within the reports sent to committees for accuracy. Management should ensure no actions have been missed from the HIW report	The Health Board agrees with this recommendation. An update to the SOP will be developed to ensure a Quality Assurance check is undertaken, confirming that all actions have been captured and referenced	01/05/2023	-13.97	31/10/2024	4.03		Overdue	Overdue	3		January 2024: In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."This will be implemented across the HB in April 2024. August 2023: SOP updated to include the undertaking of Quality Assurance checks. In process of moving all inspections onto AMAT. The system will automatically generate			
2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R2	We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended.	The Health Board has a work programme for discharge to be overseen by the newly created Discharge Improvement Board, chaired by the Executive Director of Nursing. This will strategically co-ordinate the current workstreams and include oversight of the roll out of the 'optimising discharge framework' issued by the NHS delivery unit. All workstreams currently form part of the goals 5 & 6 for improving urgent care and this will now form part of the overarching discharge programme. Embedding the optimising discharge framework will be a key priority of the Discharge Improvement Board, with a launch event hosted by a number of Health Board	01/04/2024	-2.95		-1490.92		Completed /Closed	Completed /Closed	0					Discharge programme of work through the Integrated Discharge Board is embedded through the defined work streams to support the safe and timely discharge in line with the 6 goals programme. The optimising discharge framework is rolled out and embedded cross divisionally and ongoing education is supported by key groups, events, workshops and ward based champions The Health Board continues to take forward a Discharge Improvement Programme, aligned to the WG Six Goals for Urgent
2022.19	Discharge Planning	Limited	Director of Nursing	Medical Director/Assistant Medical Director for Planning/ Director of Nursing	High	R3	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day.	01/04/2024	-2.95		-1490.92		Overdue		0					
2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	High	R3	Where an expected, standard processes is assessed as not required, for example discharge meetings held to discuss needs and establishment of care packages, that the assessment and conclusion be evidenced.	The Health Board acknowledges that there is inconsistency in the documentation of MDT meetings. The introduction of the Welsh Nursing Care Record (WNCR) may provide an opportunity to capture the content of discharge meetings as a digital record which clinical and admin staff can access and will formally record the actions agreed. The Health Board's Chief Nurse for Information has been engaged in this process. In the interim, the Head of Discharge will work with ward staff to introduce a consistent approach to documentation and evidence in the notes. It should be acknowledged that discharge arrangements will vary considerably	01/04/2024	-2.95		-1490.92		Completed /Closed	Completed /Closed	0					Welsh Nursing Care Record (WNCR) is established and embedded in all in patient areas and that include discharge documentation. Discharge documentation is audited to ensure compliance and standardisation. Audit results and areas for improvement will feed in to the safer discharge group, a cross divisional group to ensure that safer discharge principles are adhered to and that learning is evident from any examples of poor discharge. Board rounds and MDT rounds are a daily practice on in patient areas
2022.19	Discharge Planning	Limited	Director of Nursing	Assistant Medical Director for Planning	High	R3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site	01/04/2024	-2.95	31/08/2024	2.03		Overdue		1		June: SBAR documentation is embedded and used as standard in all inter site transfers. SBAR has review periods to make sure it is current and user friendly to ensure the correct information is on the document . The SBAR was reviewed May 2024 and new version will be rolled out August 2024			
2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R4	A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported	Analysis of patient data from discharges that are not complex and which have a longer than expected length of stay is being used to explore the feasibility of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and the Health Board will be embedding these principles as 'business as usual'. The framework will	01/04/2024	-2.95	30/09/2024	3.02		Overdue		1		June 2024: the new A8 Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days', the Health Board has focused on implementing these principles and the new electronic management tool will enable collation of data to demonstrate the impact. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded however the electronic data system is currently being rolled out .			
2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R5	Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded.	Discharge checklists are used by most wards; however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy.	01/04/2024	-2.95	30/09/2024	3.02		Overdue		1		June 2024: The Welsh Nursing care records are rolled out to all areas and the discharge documentation is audited to ensure compliance. Further work is ongoingthrough the Integrated Discharge board and focus groups to ensure that the checklist and discharge documentation is embedded meaningful and robust. This includes discharge champions in inpatient areas and a learning focus with the safer discharge group			
2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	High	R6	We recommend that the Health Board ensure that the monitoring programme is reinstated and lessons learnt from reviewing each service areas are shared throughout	The Health Board acknowledges that the monitoring as set out in the policy has not taken place. When drafting the new discharge policy we will consider the most appropriate audit mechanism to ensure that compliance is monitored and reported. The lessons learnt will be reported through the new Discharge Improvement Board and through to the 6 Six Goals Programme Board. Reporting will also be provided to the Executive Committee and PQSOC	01/04/2024	-2.95		-1490.92		Completed /Closed	Completed /Closed	0				The Integrated discharge board and the 6 goals programme board, alongside the focus group has a learning and improvement focus. Safer discharge group and the discharge group discuss and implement improvement and change as needed through patient experience and learning. Data and Audit supports the improvement and learning.	
2022.19	Discharge Planning	Limited	Director of Nursing	Planning Director / Head of Performance	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of readmission supported by Lightfoot data and linked to goals 1 and 2 of the 6 Goals for Urgent & Emergency Care programme.	01/10/2023	-8.95	30/09/2024	3.02		Overdue	Overdue	2		June 2024: An initial meeting has been held and a scoping document is being prepared to develop a business case for a new data capture system to enable greater depth of analysis on discharge data and infromation March: There is work ongoing to streamline data analysis, to ensure data is more meaningful and will enable the monitoring of trends. The Executive Director of Nursing and Digital have a meeting to review this in April. Progress will be monitored on an ongoing basis via the Integrated Discharge Board. January 2024: A review of the data and audit requirements for discharge is planned, the systems and processes have been revised and data and audit opportunities can now be reviewed including case review			
2022.27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care	Medium	R1	Formal deadlines should be set by the Health Board to ensure the timely delivery of actions to maintain compliance with the Standards. Performance against these deadlines should be monitored and reported on.	The standards have been developed and published by Improvement Cymru. There are no national deadlines set for the Standards. This is continuously evolving and will help all Health Boards/regions to influence, shape and improve dementia care over coming years. These are the first 20 Standards and we anticipate that new standards will be introduced by Improvement Cymru over the coming years. We have updated the Board and Quality Patient Safety and Outcomes Committee of work undertaken during the readiness year. The Regional Dementia Board consider all the standards which are part of the dementia action plan, and this is also fed back	01/07/2024	1490.95		0.00		Not yet due		0					
2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse Dementia	Medium	R2	There should be a programme of work implemented, to undertake an assessment of the environmental suitability of wards that provide beds for patients with dementia	This will be discussed at the In-Patient Hospital Group on 28th of June and confirm who leads on this	01/06/2023	-12.95		-1490.92		Completed /Closed	Completed /Closed	1		March 2024: GMAMH dementia wards completed the Kings Fund audits on the three dementia wards. They are piloting the ABUHB Accreditation audits on Cedar Park which will be rolled out on al OAMH wards which include environmental audits. Ligature risk assessment audits are part of the ward OAMH yearly review. General hospital wards do not routinely use the Kings fund audits on wards, but the tool has been used to			Older Adults have this process of Audit in place, other sites across ABUHB are requesting support with Audit as required.
2022.27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care / Lead Nurse Dementia with Associated Standards Workstream Leads	Low	R2	Consideration should be given to digitalise the "this is me" document and use it as a dementia passport document. Also, make it as a live document which could be further used for home care and nursing home settings	This is me is not a mandatory/Once for Wales NHS tool. There are numerous documents/versions of information that would identify a person needs etc. We shall discuss this and other documents at the next Dementia Board and suggest that Workstream 2a and Workstream 3 leads on this recommendation and determine the feasibility of adding this document to the newly developed patient information portal.	01/06/2023	1477.97	30/09/2024	1493.93	16/04/2024	Overdue	Not Yet Due	1		March 2024: The challenge of raising awareness of the benefits of this biographication is part of an ongoing programme of improvements through the Meaningful Activities and engagement training delivered monthly from the patient Experience and Involvement team. The national Improvement Cymru team are facilitating an All Wales Biographical tool discussion and implementation group which will help support this message of this tool. Dates unconfirmed as being led by Improvement Cymru. Review September 2024			June 2024: Patient stories continue to be collected and shared at relevant meetings. The PALS 6 monthly evaluation report contains a number of case studies for onward sharing and learning. Listening and learning from feedback is reported through QPSOC.
2022.27	Dementia Services	Reasonable	Director of Nursing	Informatic Programme Manager - WCCIS	Medium	R3	It should be clearly defined and communicated in what circumstance alerts should be used. In addition, staff should be trained on how to add alerts to the system	We will review the training and electronic filing requirements for 'alerts' and ensure that clear messages are communicated to the relevant staff	01/07/2023	1478.95	01/10/2024	1493.97	16/04/2024	Overdue	Not Yet Due	1		March 2024: Applying an Alert so WCCIS was the developed. The system is not live also and time limited. As part of the National Audit of Dementia and the Dementia Hospital Steering group and alert has been introduced for the CWS (Clinical Work Station). An alert will be displayed on patient record using an input code of 136. A briefing document, flow chart and review process is in place to monitor the impact of this as a measurement of people with dementia on our inpatient wards and attending out patient departments. The GP read codes			
2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse for OAMH / Informatics Programme Manager - WCCIS	Low	R3	Training should be provided to ensure a consistent approach for the electronic and paper records completion	We will review the training components and update where required, to ensure a consistent approach is adopted	01/07/2023	1478.95	31/07/2024	1491.93	16/04/2024	Overdue	Not Yet Due	1		March 2024: No further action via WCCIS. Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit partnership under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospital admission and discharge work.	Nov 2023: This action needs to be part of the wider patient flow and discharge in ABUHB. Invites to the Dementia workstream 4 meetings will help us understand the challenges and solution and future measurements.	Nov 2023: Recorded and reviewing the membership of work stream 4 and action plan from the National Audit of Dementia.	
2022.27	Dementia Services	Reasonable	Director of Nursing	Programme Manager	Low	R4	Consideration should be given to formally monitor (e.g. set KPIs) and report on • patients hospitalised outside of their catchment areas; and • moved from one hospital site to another one over their treatment time.	Workstream 5b (measurement) will consider appropriate KPI's and will extend an invitation to the Patient Flow Team to be members of the workstream	01/08/2023	1479.97	31/10/2024	1494.95	16/04/2024	Overdue	Not Yet Due	1		March 2024: The Dementia Hospital Steering Group implements the All Wales Dementia Hospital Charter and as such are reviewing the KPI for measurement. The CWS Alert will help us to provide a framework to capture, admission, discharge, hospital moves and incidents. This Alert has been introduced in March 2024 and will be monitored and actions evolve as information is reviewed. The patient flow team have a regular invite to participate in the Dementia Hospital Steering Group.			
2022.27	Dementia Services	Reasonable	Director of Nursing	Programme Manager linking in with Patient Flow Leads	Low	R4	Where operationally and clinically possible, a patient's locality should be considered as part of the admission / transfer process.	Patient Flow Team to consider this specific aspect, linked to the developed KPI's above	01/09/2023	1480.98	31/07/2024	1491.93	16/04/2024	Overdue	Not Yet Due	1		March 2024: Invitations have been sent to the Patient Flow Team to join the Hospital Dementia group. Still awaiting representation to be confirmed. Nov 2023: The Welsh language team are invited to the Dementia Workstream 4 Hospital Dementia group. The have a dedicated Pulse page to enable staff to access resources and information to support patients to communicate in the welsh language. the person centred team also have a dedicated e mail address and can signpost people to the the Welsh Language			Nov 2023: Pulse Welsh Language and engagement pages on the intranet as well as a Welsh Language team who we collaborate with closely.
2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse Dementia	Low	R4	There should be easily available information / training for staff to ensure patients can communicate with Welsh speaking staff.	The Workstream 4 (Hospital Charter) to link with the Welsh Language Lead and Workforce and Organisational Development leads to identify the number of Welsh Speaking Staff, identify how we can better identify Welsh Speakers and ensure access to Welsh Speakers as part of our Person Centred Care Dementia Care work programme.	01/09/2023	1480.98	31/08/2024	1492.95	16/04/2024	Overdue	Not Yet Due	1		March 2024: Colleague from the Welsh language team are members of the Dementia Hospital steering Group. Language preference and choice have been included on the patient bedside boards introduced to the COTE and medicine wards. The patient Experience and involvement Team are participating in the Cultural Competency accreditation programme to ensure all activities supported through the team consider cultural awareness and accessibility. Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient			Nov 2023: We have 15 wards who are adopting the VIP programme. We capture patient feedback and use patient experience to inform our improvements in care. recent example was the Anticipatory Grief learning module and Dementia Conference. The patient experience is an ongoing agenda item on our PCCT monthly team meetings. This information is included in QPS reports and annual reviews.
2022.27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care / Lead Nurse Dementia with Associated Standards Workstream Leads	Low	R5	Local initiatives with success stories should be channelled and discussed at existing forums.	Patient Stories are used at MDT learning events, at Board, through the Quality and Patient Safety Operational Group (QPSOG) and Board. Discussions have taken place within the Person-Centred Care Team to develop a digital portal for all patient stories. Listening and Learning is reported at QPSOG. There are also early discussions around establishing a Community of Practice for patient experience to share learning and celebrate success/best practice (September 2023). The Dementia Specialist Practitioner through the VIPS work will be key to sharing best practice/success stories across all hospital wards.	01/09/2023	-9.93		-1490.92		Completed /Closed	Completed /Closed	1		This is an ongoing action, monthly team meetings facilitate an opportunity to share feedback and consider how we use this feedback to influence practice and services. Patient feedback is used as a basis of QPS, Internal and external reporting. A 1 year reporting of VIPS will take place in April 2024.			June 2024: Patient stories continue to be collected and shared at relevant meetings. The PALS 6 monthly evaluation report contains a number of case studies for onward sharing and learning. Listening and learning from feedback is reported through QPSOC.
2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	N/A	Medium	R1	A timeline plan for the path to the closure of the case should be prepared and shared with all persons involved in the case, in order that participants can plan and prepare for their input and schedule time to do so.	A review of the complaint process will be undertaken following the OCP process to realign Quality Patient Safety resourses to the Nusing Directorate. A new Quality Patient Safety Manager has been appointed who will be responsible for the complaints process. Since period of review the PTR, Legal and QPS teams are aligning under one structure, this will bring together enchanced knowledge and skills of the PTR regulations, legal tests and required timelines. The new structure will triangulate the whole complaint process, beinging improved quality and timeliness to concern responses.	31/03/2024	1487.93	30/09/2024	1493.93	16/04/2024	Overdue	Not Yet Due	1		March 2024: The OCP has now concluded on 9th February 2024. Centralising all PTR teams to ensure PTR regulations are adhered to. Trajectory has been devised for all divisons the Health Board has comitted to be within the 75% Welsh Government target by September 2024.			
2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	N/A	High	R4	Current barriers that are leading to poor resolution target and complience rates require identification and resolution urgently.	An urgent review of any immediate barriers and quick winds will be undertaken. The PALS service was launched in November which will aim to resolve more complaints through early engagement with families	31/12/2023	-5.97	31/10/2024	4.03		Overdue	Overdue	2		June 2024: PALS team are now actioning all grade 1 and 2 concerns. 6 monthly evaluation report in progress. Closer liason between PALS and PTR team. March 2024: The QPS resource centralised on 15th February 2024. We are in the process of reviewing and remapping the entire concerns pathway which will identify and address the barriers that are leading to poor compliance. The PALS service are now managing all grade 1 and 2 concerns.			
2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	N/A	Medium	R5	Complaint case analysis detail level should be sufficiently granular, to provide learning to recipients and to prevent reoccurance.	Review of all QPS resourses being undertaken via an OCP will include learning. A review of divisional QPS structures and asurance mechanisms will be require following OCP this will form part of a wider delivery plan for the Quality Strategy and a clear accountability framework between the ursing Directorate and the Operational Divisons for QPS.	31/12/2023	-5.97	31/10/2024	4.03		Overdue		1		June 24: A Centralised Learning Repository is also being developed which will provide a live bank of actions undertaken, updates. This will be supported by the utilisation of the actions functionality in Datix Cymru, which supports monitoring, ownership and accountability. March 2024: The organisational OCP has now concluded and the QPS teams have moved centrally. Job Titles and Descriptions are being reviewed to include Learning and Quality Improvement. Learning captured onto action plans and held on datix. QPS and divisional leads			
2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	Chief Operating Officer	High	R6	Actions to address the circumstances that have led to individual complaints and those that have been identified to address complaint themes through boarder learning pathways should be captired in actions plans. The delivery of the plans should be monitored by appropriate oversight groups.	Review all QPS resourses being undertaken via an OCP which will include learning.	31/12/2023	1484.95	30/09/2024	1493.93	16/04/2024	Overdue	Not Yet Due	1		March 2024: The organisational OCP has now concluded and the QPS teams have moved centrally. Job Titles and Descriptions are being reviewed to include Learning and Quality Improvement. Learning captured onto action plans and held on datix. QPS and divisional leads to be trained by ABCI team to become Quality Improvement Coaches via spread and scale approach. High level themes identified and learning and QI to focus on the specific themes and learning shared widely accross the organisation. Governance reporting and assurance processes			

2022.03	Structured Assessment 2022	Not Rated	Director of Nursing	N/A	N/A	R3	R3 There is limited use of patient and staff stories at Board. The Health Board should consider how it can increase and maximise the benefit of patient and staff stories in Board and committees to help centre and focus meetings on the things that matter most, and to help triangulate this intelligence with formal agenda items.	A Digital Story Protocol for staff and patient stories is currently under development and once approved an electronic digital repository of stories will be created. Digital Story Telling training has been commissioned. The CIVICA Citizen Feedback System now allows people to leave narrated stories. A selection of these will be played at the start of every Board meeting. The Executive Team will agree a programme of staff and patient stories that help triangulate intelligence with formal agenda items.	31/03/2023	1475.93	31/12/2024	1496.95	16/04/2024	Overdue	Not Yet Due	2		March 2024: Digital Story repository now being considered on an all Wales basis. In the meantime, the Patient Experience Team will oversee all digital stories and manage in person attendance at Board. Where possible these will align to presented papers . June 23: A Patient Experience & Involvment Strategy has been developed which includes Digital Patient Narratives and Stories. A patient story has been presented at a Board Development Session and PQSOC this year. All Wales Experience Team reviweing. Review December 2024 Update July 2023: The Digital Story Protocol is drfated but is now being revised due to recent decisions to support 'in-person' patient experiences at Board. To date, a patient story has been played at each Board during 2023. Additionally, digital stories are being used at listening and learning events and development days. There is all Wales discussion around a digital toolkit. The CIVICA system is being rolled out with a specific focus on supporting teams with training to retrieve their own data. Patient verbal narratives are not yet on the system. The first CIVICA report will be presented at Executive Team in September 2023.			
2023.16	Medical Equipment & Devices - Ultrasound	Reasonable	Director of Therapies and Health Science	Risk manager Quality and Patient Safety	High	R1.1	We recommend that a periodic physical verification control process is implemented across the Health Board to confirm the existence of ultrasound equipment and the accuracy of its listing in the MEDUSA database. This may be done by adopting the asset management RFID tagging process underway across all assets.	Medusa currently holds information relating to ultrasound equipment highlighting the location and owner department. A rolling 12-month programme of staggered audit will be implemented to ensure that departments visually check the ultrasound assets against the Medusa list, reporting any issues or potential faults with the equipment to EBME. A 6-month implementation period has been assigned to this action given the need to engage with ultrasound equipment owners, design the audit process, ensure audits are recorded in an appropriate electronic format. The Ultrasound Governance Committee will represent the strategic oversight forum to review progress against the defined actions documented within the management response in support of raising assurance levels. Completing the management response to fully meet the recommendation will require Health Board employees to comply with the policy; failure by any individual to have not followed the policy will be escalated to the relevant Divisional Director.	01/11/2024					Not Yet Due		0						
2023.16	Medical Equipment & Devices - Ultrasound	Reasonable	Director of Therapies and Health Science	Head of Capital Finance	High	R1.2	We recommend that the Health Board carry out periodic alignment / reconciliation checks between the MEDUSA equipment database and the finance owned fixed asset register with respect to ultrasound equipment. This may also be completed via an electronic interface with the asset databas	An electronic interface exists between the fixed asset register and MEDUSA equipment database however there is a current known fault with this interface. It is currently being addressed between EBME, Capital Finance and IT. Medusa also requires a software update to the latest revision which is also in progress. A rolling programme of audit will then be implemented to ensure reconciliation between MEDUSA and the fixed asset register (only applicable to assets where RFID has already been implemented). A 6-month period has been assigned to this recommendation given the uncertain nature of implementing the solution as well as designing an audit process and recording in an appropriate electronic format.	01/11/2024					Not Yet Due		0						
2023.16	Medical Equipment & Devices - Ultrasound	Reasonable	Director of Therapies and Health Science	EBME Manager	Medium	R2	We recommend that services using ultrasound equipment ensure all items are covered by appropriate service or maintenance contracts and are tracked centrally.	Monitoring of service and maintenance contracts is managed through individual departments as well as the EBME service. The physical verification audit will be utilised to ensure equipment has a current maintenance contract as well as evidence that maintenance has taken place within the prescribed period. EBME will investigate potential for MEDUSA to hold contract information centrally on MEDUSA. The system can be set up to provide Alerts. The alert can be used as an early warning indicator for both EBME and the owner that equipment is approaching a maintenance period. If, after investigation, the potential is not viable or investment required not available, then this particular set up on the system will not be implemented; this is not critical to the Health Board meeting the recommendation. The Ultrasound Governance Committee will represent the strategic oversight forum to review progress against the defined actions documented within the management response in support of raising assurance levels. Completing the management response to fully meet the recommendation will require Health Board employees to comply with the policy; failure by any individual to have not followed the policy will be escalated to the relevant Divisional Director.	01/11/2024					Not Yet Due		0						

ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recomme n-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including new request
2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	N/A	High	R1	R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	31/03/2018	-74.85	30/04/2024	-2.00	16/04/2024	Overdue	Overdue	3
2017.00	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	N/A	High	R2	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/03/2018	-74.85	31/05/2024	-0.98		Overdue	Overdue	3
2021.20	Medicines Managment	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R2	R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version. The use of red pen on the wards is to make stock	31/03/2023	-14.98	31/05/2024	-0.98	16/04/2024	Overdue	Overdue	2
2022.18	Monitoring Action Plans	Reasonable	Director of Nursing	Assistant Director of Nursing (PT Safety)	Low	R2	Management should review the number of actions raised within the HIW reports and the number of actions noted within the reports sent to committees for accuracy. Management should ensure no actions have been missed from the HIW report	The Health Board agrees with this recommendation. An update to the SOP will be developed to ensure a Quality Assurance check is undertaken, confirming that all actions have been captured and referenced	01/05/2023	-13.97	30/04/2024	-2.00	08/02/2024	Overdue	Overdue	2
2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R2	We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended.	The Health Board has a work programme for discharge to be overseen by the newly created Discharge Improvement Board, chaired by the Executive Director of Nursing. This will strategically co-ordinate the current workstreams and include oversight of the roll out of the 'optimising discharge framework' issued by the NHS delivery unit. All workstreams currently form part of the goals 5 & 6 for improving urgent care and this will now form part of the overarching discharge programme. Embedding the optimising discharge framework will be a key	01/04/2024	-2.95		-1490.92		Overdue		0
2022.19	Discharge Planning	Limited	Director of Nursing	Medical Director/Assistant Medical Director for Planning/ Director of Nursing	High	R3	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same	01/04/2024	-2.95		-1490.92		Overdue		0
2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	High	R3	Where an expected, standard processes is assessed as not required, for example discharge meetings held to discuss needs and establishment of care packages, that the assessment and conclusion be evidenced.	The Health Board acknowledges that there is inconsistency in the documentation of MDT meetings. The introduction of the Welsh Nursing Care Record (WNCR) may provide an opportunity to capture the content of discharge meetings as a digital record which clinical and admin staff can access and will formally record the actions agreed. The Health Board's Chief Nurse for Information has been engaged in this process. In the interim, the Head of Discharge will work with ward staff to ensure, or capture, relevant primary healthcare conversations and evidence in	01/04/2024	-2.95		-1490.92		Overdue		0
2022.19	Discharge Planning	Limited	Director of Nursing	Assistant Medical Director for Planning	High	R3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that	01/04/2024	-2.95		-1490.92		Overdue		0
2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R4	A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported	Discharge delays can affect both simple and complex discharges and therefore emphasis should be improving the process for all patients. Length of stay data is available to explore the feasibility and the benefits of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and	01/04/2024	-2.95		-1490.92		Overdue		0
2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R5	Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded.	Discharge checklists are used by most wards, however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy.	01/04/2024	-2.95		-1490.92		Overdue		0
2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	High	R6	We recommend that the Health Board ensure that the monitoring programme is reinstated and lessons learnt from reviewing each service areas are shared throughout	The Health Board acknowledges that the monitoring as set out in the policy has not taken place. When drafting the new discharge policy we will consider the most appropriate audit mechanism to ensure that compliance is monitored and reported. The lessons learnt will be reported through the new Discharge Improvement Board and through to the 6 Six Goals Programme Board. Reporting will also be provided to the Executive Committee and PQSOC	01/04/2024	-2.95		-1490.92		Overdue		0
2022.19	Discharge Planning	Limited	Director of Nursing	Planning Director / Head of Performance	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless	01/10/2023	-8.95	31/03/2024	-2.98	08/02/2024	Overdue	Overdue	1
2022.27	Dementia Services	Reasonable	Director of Nursing	Lead Nurse Dementia	Medium	R2	There should be a programme of work implemented, to undertake an assessment of the environmental suitability of wards that provide beds for patients with dementia	This will be discussed at the In-Patient Hospital Group on 28th of June and confirm who leads on this	01/06/2023	-12.95	31/01/2024	-4.95	12/09/2023	Overdue	Overdue	1
2022.27	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care / Lead Nurse Dementia with Associated Standards	Low	R5	Local initiatives with success stories should be channelled and discussed at existing forums.	Patient Stories are used at MDT learning events, at Board, through the Quality and Patient Safety Operational Group (QPSOG) and Board. Discussions have taken place within the Person-Centred Care Team to develop a digital portal for all patient stories. Listening and Learning is reported at QPSOG. There are also early discussions around establishing a Community of Practice for patient experience to share learning and celebrate success/best practice (September 2023). The Dementia Specialist Practitioner through the VIPS work will be key to sharing best	01/09/2023	-9.93	30/06/2024	0.00	16/04/2024	Overdue	Overdue	1
2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	N/A	High	R4	Current barriers that are leading to poor resolution target and complience rates require identification and resolution urgently.	An urgent review of any immediate barriers and quick winds will be undertaken. The PALS service was launched in November which will aim to resolve more complaints through early engagement with families	31/12/2023	-5.97	30/06/2024	0.00	16/04/2024	Overdue	Overdue	1
2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	N/A	Medium	R5	Complaint case analysis detail level should be sufficently granular, to provide learning to recipients and to prevent reoccurance.	Review of all QPS resourses being undertaken via an OCP will include learning. A review of divisional QPS structures and asurance mechanisms will be require followng OCP this will form part of a wider delivery plan for the Quality Strategy and a clear accountability frameowrk between the ursing Directorate and the Operational Divisons for QPS.	31/12/2023	-5.97		-1490.92		Overdue		0

Risk and Assurance Team												Lead Executive to Update			
Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommen-dation No.	Recommendation	Managment Response	Agreed Deadline Date	Last Progress Update	New Progress Update	Is this recommendation completed/Closed (Yes or No)	If completed please provide a small summary of what has been implemented	If NOT completed please provide a date in which you expect to complete
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R2	We recommend that Health Board management ensure that formal discharge planning training is provided to both clinical and administrative staff engaged in the pathway, including updates if the process is amended.	The Health Board has a work programme for discharge to be overseen by the newly created Discharge Improvement Board, chaired by the Executive Director of Nursing. This will strategically co-ordinate the current workstreams and include oversight of the roll out of the 'optimising discharge framework' issued by the NHS delivery unit. All workstreams currently form part of the goals 5 & 6 for improving urgent care and this will now form part of the overarching discharge programme. Embedding the optimising discharge framework will be a key priority of the Discharge Improvement Board, with a launch event hosted by a number of Health Board Executives held in January 2023. Local training has already commenced with sessions delivered across the acute sites and with plans for roll out to the other hospital sites within the next 6 months. This will be supported by the national training programme to be delivered by the NHS delivery unit. The lack of procedural documentation will be addressed through the new discharge policy formation.				yes	Discharge programme of work through the intregrated discharge board is embedded through the defined work streams to support the safe and timely discharge in line with the 6 goals programme. The optimising discharge framework is rolled out and embedded cross divisionally and ongoing education is supported by key groups, events, workshops and ward based champions The Health Board continues to take forward a Discharge Improvement Programme, aligned to the WG Six Goals for Urgent and Emergency Care Programme, under Goals 5 & 6 – Return and Stay Well at Home. The focus over the last three months includes, roll out of a new D2RA digital solution alongside an education and training programme, supporting capturing meaningful data including red to green days, medically optimised discharge status and D2RA pathways to support patient flow across sites. The function and performance of the Discharge Lounges at RGH and NHH have been reviewed to support timely patient discharge. The RGH Discharge Lounge has relocated and is now aligned with the RGH Discharge Hub and the NHH Discharge Lounge has introduced a new transport booking system. Further works is ongoing	
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Director of Nursing	High	R3	Where an expected, standard processes is assessed as not required, for example discharge meetings held to discuss needs and establishment of care packages, that the assessment and conclusion be evidenced.	The Health Board acknowledges that there is inconsistency in the documentation of MDT meetings. The introduction of the Welsh Nursing Care Record (WNCR) may provide an opportunity to capture the content of discharge meetings as a digital record which clinical and admin staff can access and will formally record the actions agreed. The Health Board's Chief Nurse for Information has been engaged in this process. In the interim, the Head of Discharge will work with ward staff to introduce a consistent approach to documentation and evidence in the notes. It should be acknowledged that discharge arrangements will vary considerably depending on the assessed requirements of the individual.				yes	Welsh Nursing care record (WNCR) is established and embedded in all in patient areas and that include discharge documentation. Discharge documentation is audited to ensure compliance and standardisation. Audit results and areas for improvement will feed in to the safer discharge group, a cross divisional group to ensure that safer discharge principles are adhered to and that learning is evident from any examples of poor discharge. Board rounds and MDT rounds are a daily practice on in patient areas to facilitate a safe and timely discharge and ensures documentation and communication with patient and family	
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Director of Nursing	High	R6	We recommend that the Health Board ensure that the monitoring programme is reinstated and lessons learnt from reviewing each service areas are shared throughout	The Health Board acknowledges that the monitoring as set out in the policy has not taken place. When drafting the new discharge policy we will consider the most appropriate audit mechanism to ensure that compliance is monitored and reported. The lessons learnt will be reported through the new Discharge Improvement Board and through to the 6 Six Goals Programme Board. Reporting will also be provided to the Executive Committee and PQSOC				yes	The Intregrated discharge board and the 6 goals programme board, alongside the focus group has a learning and improvement focus. Safer discharge group and the discharge group discuss and implement improvement and change as needed through patient experience and learning. Data and Audit supports the improvement and learning.	
Internal	2022.3	Dementia Services	Reasonable	Director of Nursing	Lead Nurse Dementia	Medium	R2	There should be a programme of work implemented, to undertake an assessment of the environmental suitability of wards that provide beds for patients with dementia	This will be discussed at the In-Patient Hospital Group on 28th of June and confirm who leads on this		March 2024: "OAMH dementia wards complete the Kings Fund audits on the three dementia wards. They are piloting the ABUHB Accreditation audits on Cedar Park which will be rolled out on al OAMH wards which include environmental audits. Ligature risk assessment audits are part of the ward OAMH yearly review. General hospital wards do not routinely use the Kings fund audits on wards, but the tool has been used to support individual ward improvement plans as part of the VIPS hospital dementia Friendly Hospital Charter implementation programme. UPDATE JULY 2023. Audit recommendations discussed at meeting. Agreement that a review of the in-patient action plan will be undertaken in September 2023. A dedicated inpatient workshop focussing on the All Wales Dementia Friendly Hospital Charter will be held in November 2023. This will include a review of the resources required to undertale an environmental audit of in patient wards.		yes	Older Adults have this process of Audit in place, other sites across ABUHB are requesting support with Audit as required.	
Internal	2022.3	Dementia Services	Reasonable	Director of Nursing	Head of Nursing Person Centred Care / Lead Nurse Dementia with Associated Standards Workstream Leads	Low	R5	Local initiatives with success stories should be channelled and discussed at existing forums.	Patient Stories are used at MDT learning events, at Board, through the Quality and Patient Safety Operational Group (QPSOG) and Board. Discussions have taken place within the Person-Centred Care Team to develop a digital portal for all patient stories. Listening and Learning is reported at QPSOG. There are also early discussions around establishing a Community of Practice for patient experience to share learning and celebrate success/best practice (September 2023). The Dementia Specialist Practitioner through the VIPS work will be key to sharing best practice/success stories across all hospital wards.		This is an ongoing action, monthly team meetings facilitate an opportunity to share feedback and consider how we use this feedback to influence practice and services. Patient feedback is used as a basis of QPS, Internal and external reporting. A 1 year reporting of VIPS will take place in April 2024.		yes	June 2024: Patient stories continue to be collected and shared at relevant meetings. The PALS 6 monthly evaluation report contains a number of case studies for onward sharing and learning. Listening and learning from feedback is reported through QPSOC.	
Internal	2021.2	Medicines Managment	Reasonable	Medical Director	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services	Medium	R2	R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version.The use of red pen on the wards is to make stock checks morevisible. The practicality of this will be reviewed.Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock.The policy will also include a description of the audit framework that will provide assurance the policy is being followed.	31/05/2024	Update March 2024: Policy extended with review date 31st May 2024. Revised policy due to be provided to Clinical Policy & Standards Group 9th May	Update 29/05/24: Ratified at CSPG 9th May 2024. Ref - CSPG 0905/05	Yes	Policy reviewed and update approved at CSPG 9th May 2024	

Risk and Assurance Team												Lead Executive to Update			
Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommen-dation No.	Recommendation	Managment Response	Agreed Deadline Date	Last Progress Update	New Progress Update	Is this recommendation completed/Closed (Yes or No)	If completed please provide a small summary of what has been implemented	If NOT completed please provide a date in which you expect to complete
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Assistant Medical Director for Planning	High	R3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.			SBAR documentation is embedded and used as standard in all inter site transfers. SBAR has review periods to make sure it is current and user friendly to ensure the correct information is on the document . The SBAR was reviewed May 2024 and new version will be rolled out August 2024	no		Aug-24
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R4	A method for identifying delays during the discharges of 'simple' cases should be introduced, monitored and reported	Discharge delays can affect both simple and complex discharges and therefore emphasis should be improving the process for all patients. Length of stay data is available to explore the feasibility and the benefits of such an approach. The Health Board continually seeks to identify the factors that delayed discharge and this work forms part of the workstream for goal 5 of the Welsh Government '6 Goals for Urgent and Emergency Care' programme. As part of this programme, the Delivery Unit has recently released the 'optimal patient flow framework', and the Health Board will be embedding these principles as 'business as usual'. The framework will also feature in the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days'. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded within our policy.			the new All Wales Discharge Policy, to include the introduction of the SAFER principles, D2RA and 'red & green days', the Health Board has focused on implemeting these principles and the new electronic management tool will enable collaltion of data to demonstrate the impact. These concepts have the potential to reduce LOS and improve discharge planning, so will be embedded however the electronic data system is currently being rolled out .	no		Sep-24
Internal	2022.19	Discharge Planning	Limited	Director of Nursing	Director of Nursing	Medium	R5	Determining whether to make the use of the discharge checklist mandatory (including which aspects to include) or not and if so, the document should be consistently completed. Performance should be monitored until fully embedded.	Discharge checklists are used by most wards; however, we acknowledge there is an inconsistent approach in their use. The Welsh Nursing Care Record is currently being rolled out across the Health Board and may provide the opportunity to make the checklist part of the digital record as part of a standardised approach. In the interim, the use of checklists will be reviewed as part of the Discharge Improvement Board workstreams. The use of checklists will be further defined in the new discharge policy.			The Welsh Nursing care records are rolled out to all areas and the discharge documentation is audited to ensure compliance. Further work is ongoingthrough the Intregrated Discharge board and focus groups to ensure that the checklist and discharge documentation is embedded meaningful and robust. This includes discharge champions in inpatient areas and a learning focus with the safer discharge group	no		Sep-24
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Planning Director / Head of Performance	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide		March: There is work ongoing to streamline data analysis, to ensure data is more meaningful and will enable the monitoring of trends. The Executive Director of Nursing and Digital have a meeting to review this in April. Progress will be monitored on an ongoing basis via the Integrated Discharge Board. January 2024: A review of the data and audit requirements for discharge is planned, the systems and processes have been revised and data and audit opportunities can now be reviewed including case review	An initial meeting has been held and a scoping document is being prepared to develop a business case for a new data capture system to enable greater depth of analysis on discharge data and infromation	no		Sep 24 for the business case
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	N/A	High	R4	Current barriers that are leading to poor resolution target and complience rates require identification and resolution urgently.	An urgent review of any immediate barriers and quick winds will be undertaken. The PALS service was launched in November which will aim to resolve more complaints through early engagement with families		March 2024: The QPS resource centralised on 15th February 2024. We are in the process of reviewing and remapping the entire concerns pathway which will identify and address the barriers that are leading to poor complaince. The PALS service are now managing all grade 1 and 2 concens.	June 2024: PALS team are now actioning all grade 1 and 2 concerns. 6 monthly evaluation report in progress. Closer liaison between PALS and PTR team.	no		Oct-24
Internal	2023	Putting Things Right; Final Advisory Review	Reasonable	Director of Nursing	N/A	Medium	R5	Complaint case analysis detail level should be sufficently granular, to provide learning to recipients and to prevent reoccurance.	Review of all QPS resourses being undertaken via an OCP will include learning. A review of divisional QPS structures and asurance mechanisms will be require followng OCP this will form part of a wider delivery plan for the Quality Strategy and a clear accountablility frameowrk between the ursing Directorate and the Operational Divisons for QPS.		March 2024: The orgaisational OCP has now concluded and the QPS teams have moved centrally. Job Titles and Descriptions are being reviewed to include Learning and Quality Improvement. Learning captured onto action plans and held on datix. QPS and divsional leads to be trained by ABCI team to become Quality Improvement Coaches via spread and scale approach. High level themes identified and learning and QI to focus on the specific themes and learning shared widely accross the organisation. Goverance reporting and assurance processes are under review ro ensure consistency accross the system. Working with datix team to ensure that actions are assigned on the datix system.	June 24: A centralised Learning Repository is also being developed which will provide a live bank of actions undertaken, updates. This will be supported by the utilisation of the actions functionality in Datix Cymru, which supports monitoring, ownership and accountability.	no		Oct-24
Internal	2017	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	N/A	High	R1	R1 Registers should be maintained for operational management of medical devices and equipmenton each ward and department, which should record relevant equipment details.The register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed.Each areashould ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record itupon theirregister. Discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded. Going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues.	The Health Board to consider investing in an overarching equipment database register with staff resources to ensure regular updating and management.	30/04/2024	March 2024: The Health Board is compliant with the parts of the recommendation that, (a) registers should be maintained for operational management of medical devices and equipment on each ward and department, which should record relevant equipment details, (b) that the register format should be consistent and overseen centrally, with periodic reviews / scrutiny completed, (d) discrepancies that are identified can be updated / amended on the register, so all items are correctly recorded, and (e) going forward, relocation of equipment, disposals, additions etc. should be updated promptly to ensure an accurate record continues. The Health Board is currently partially compliant concerning the part of the recommendation that (c) each area should ascertain the total number of devices held, by reviewing each and every item (including non-electrical equipment) physically and record it upon their register. "A centrally managed industry standard pan-organisation medical equipment register (Softpro Medusa) is in place and operational. The database records medical equipment management information on each item of equipment, including the location where each item is deployed. Reports can be produced filtered by ward/ department though the on-line Customer Portal. Ward and departmental managers can access a list of equipment in the register that is allocated to their work area from the centralised register via an on-line Customer Portal. The	The EBME Service will be in a position to issue the user guide for the Medusa Customer Portal following the delayed major update to the Medusa database that is scheduled to be implemented on 12th July 2024. The ward and departmental audit of non-electrical medical equipment has been implemented. The output will be a local inventory/register of installed medical equipment not captured in other databases. This is generally non-electrical equipment	No		End of July 2024
Internal	2017	Medical Equipment and Devices (2017/18)	Limited	Director of Therapies and Health Science	N/A	High	R2	R2 A clear robust control mechanism should be established by the divisions / directorates demonstrating the consideration and delivering of applicable training,aligned to medical equipment and devices. Training records should also be uploaded onto ESR.The poor mandatory training compliance rates with regard to infusion devices / pumps should be addressed as a matter of urgency.	From a Divisional perspective, the cascade training provided at ward level has not raised any particular safety issues, although with the increasing use of bank and agency staff, consideration should be given to accessible on site training for these members of staff. The Health Board to consider establishing a catalogue of equipment that needs specific training to operate, alongside a database of staff compliance.	31/05/2024	Aug 2023: • New infusion device service and training manager now in post. • New database formed to record training compliance and process of inputting historical data in progress, plan to work this into HealthRoster/ESR once up to date, providing a compliance dashboard. • Audit sent out to ward managers and divisional senior nurses to determine current training compliance throughout ABUHB. • Training sessions delivered and open to substantive and bank staff to book. • Strategic plan to incorporate cascade trainers into the training provision to increase compliance.	A system of providing centralised training to cascade infusion device trainers has been established and training is in now workstream. A system of categorisation of the degree of training required against groups of equipment types has been developed. Reflection of this in the Medusa equipment management database is pending the major update that is scheduled to be implemented on 12th July 2024. Representation of the centralised essential-for-job-function training competencies in ESR is pending engagement sought from the ESR team.	No		End of August 2024

Risk and Assurance Team												Lead Executive to Update			
Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommen-dation No.	Recommendation	Managment Response	Agreed Deadline Date	Last Progress Update	New Progress Update	Is this recommendation completed/Closed (Yes or No)	If completed please provide a small summary of what has been implemented	If NOT completed please provide a date in which you expect to complete
Internal	2022.2	Monitoring Action Plans	Reasonable	Director of Nursing	Assistant Director of Nursing (PT Safety)	Low	R2	Management should review the number of actions raised within the HIW reports and the number of actions noted within the reports sent to committees for accuracy. Management should ensure no actions have been missed from the HIW report	The Health Board agrees with this recommendation. An update to the SOP will be developed to ensure a Quality Assurance check is undertaken, confirming that all actions have been captured and referenced		Januray 2024: In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."This will be implemented across the HB in April 2024. August 2023: SOP updated to include the undertaking of Quality Assurance checks. In process of moving all inspections onto AMAT. The system will automatically generate reports, to include number of actions identified."	Not yet complete, further training on AMAT required	no		
Internal	2022.2	Discharge Planning	Limited	Director of Nursing	Medical Director/Assistant Medical Director for Planning/ Director of Nursing	High	R3	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day						

Agenda Item – 4.2

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD COMMITTEE MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 July 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Children and Young People's Rights and Participation Forum Meeting
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Kavitha Pasunuru- Assistant Director, Families and Therapies Division
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rebecca Stanton- Regional Children and Families Transformation Lead

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This briefing to the PQSOC is because Children's Rights needs to be a focal point of our work with Children and Families through all aspects of healthcare within Aneurin Bevan University Health Board. The Children's Rights and Participation Forum strives to keep Children's rights on the agenda of services, supporting information sharing and examples of good practice.

Cefndir / Background

The Forum's work is an important subject for the Health Board to keep appraised of and in Wales, there are currently the following National policies and legislation in place underpinned by the UNCRC;

Rights of Children and Young People (Wales) Measure 2011,
Social Services and Well-being (Wales) Act 2014,
Well-being of Future Generations (Wales) Act 2015.

All of these policies establish duties on public authorities that contribute towards the realisation of Children's rights.

Asesiad / Assessment

There is currently a regular group that takes place every quarter to ensure the Health Board keeps the subject of Children and Young People's rights firmly at the front of people's minds. The Children & Young People's Rights & Participation meeting has a mix of representatives from various areas across Aneurin Bevan University Health Board, but the membership is still being built in order to raise the awareness of Children's Rights and how this can be implemented within daily practice.

The Children & Young People's Rights & Participation Forum was held on the 22nd July 2024. The group membership still needs building, so we held an open workshop session to discuss our priorities as a group and how we intend to raise the profile of this important subject area. We have engaged with the Director of Nursing and Chief Operating Officer to gain their support, and we have a plan that includes the following;

-Engaging new members from across other divisions and/or organisations within the wider partnership
-The group reporting into the new Children and Young People Strategic Board in September
-Redeveloping a communications strategy to raise awareness
-Plan for a potential event in September to launch new priorities

Argymhelliad / Recommendation

The Patient Quality, Safety & Outcomes Committee is asked to **NOTE** the contents of the report.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	6.2 Peoples Rights Governance, Leadership & Accountability Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life Getting it right first time for children and young people
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

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

Highlight Report

Group Name:	**ABUHB Children's Rights & Participation Forum**		
Group Aim:	The Forum is led by the Family & Therapy Division on behalf of Aneurin Bevan University Health Board on the area of children's rights and participation. This is the key children's rights and participation forum for Aneurin Bevan University Health Board. The group will inform and drive a children's rights approach, placing the UNCRC at the core of planning and service delivery, influencing the integration of children's rights into every aspect of decision-making, policy and practice.		
Date Completed:	22.07.24	**Date of last meeting**	22.07.24
Completed By:	Dr Kavitha Pasunuru (Chair) Rebecca Stanton, Head of Transformation Programme		
Distribution List:	PQSOC		
Summary:	Due to a dip in attendance to these meetings, today's session was an open agenda to consider how we might refresh the group moving forward and consider our priorities. Jenni Winslade mentioned the new Children and Young People Strategic Board and how this forum will be feeding into the strategic group moving forward.		

Priorities and Action Plan

There are many members within the forum, but consistent membership at meetings has been challenging, probably due to pressures individuals are facing within their day jobs. The open session today was an opportunity for members to share their ideas and vision for the group.

Priorities identified for the group were as follows;

- Involving Young People (particularly within recruitment and/or volunteering and shadowing within the NHS)
- Awareness Raising around Children's Rights
- Advocacy for Children and Young People
- Inclusion; ensuring we are representing all Children and Young People

- Measure improvements for how we are doing things/examples of good practice
- Accountability
- Collaboration between colleagues/teams/services
- Making an improvement to how we offer services for Children and Young people

Jo Foley from Public Health shared a helpful presentation around the strategic needs assessment, and it was agreed the links with this will be important moving forward.

Need to seek support from our Communications colleagues to support our agenda and exploring Children/Young people's sections on Healthier together and/or other NHS websites.

Comment from Chair / Items for Escalation
Kavitha asked for expressions of interest in the Chairing role moving forward.

Actions / Next Steps
Becky to open up membership invites to colleagues across the partnership. Link in with BG youth forum regarding mapping and Children/Young People's feedback around accessing Health. Link in with ABUHB communications colleagues to locate a representative to support the agenda. Reviewing of the membership and TOR to link in with the strategic meeting in September.

Agenda Item: 4.3

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 July 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Review of Neurodevelopmental Service for Under 18s
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Leanne Watkins, Chief Operating Office Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sara Garland, General Manager, Family & Therapies

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Neurodevelopmental Service for Under 18s Divisional response to the NHSE Publication of the All Wales Review of the Neurodevelopmental Service for Under 18s is being shared with the Patient Quality, Safety and Outcomes Committee for information.

Attached as an appendix 1 is the detailed response and the corresponding action plan. The Committee is requested to acknowledge the report and to be assured that the progress of this action plan will be monitored bi-weekly with the CAMHs lead.

Cefndir / Background

The final report of the Neurodevelopmental (ND) Review focuses on our current management of the ND triage backlog, the ND recovery plan, and the ND transition arrangements. These issues have either been resolved or are being addressed with comprehensive plans, including a strategy to enhance collaboration between Mental Health & Learning Disabilities (MH+LD) and Children and Young People's ND services moving forward.

Asesiad / Assessment

Report highlights:

- **What is working well**

  The comprehensive findings of the Review indicate that our teams are maintaining good standards of ND service delivery, with four of the All-Wales ND standards being fully met and two described as partially met.

  The team is performing well under challenging conditions (with a rising demand for ND assessments). To manage the increased demand and mitigate risks, they have taken time and effort to enhance parental involvement and co-production, inclusive practices and outcomes, progress and achievement, the quality of assessments, and collaborative efforts with educational and other partners.

- **Areas for improvement**

  To address the ND triage backlog and improve waiting times, a range of processes have been implemented, including increased investment and service redesign. This effort is supported by the Family & Therapies Division and the Executive Committee, with additional investments and the development of a new Under 5 ND pathway, which became operational on May 7, 2024.

  In terms of enhancing service user experience, particularly parental engagement and co-production, a transformation has occurred in how parents and carers are engaged. An engagement forum has been established, fostering openness and partnership. This approach has been well-received by families, who have expressed feeling heard, supported, and satisfied.

  Furthermore, an intuitive tracker is being developed in collaboration with Paul Solloway, ABUHB Director of Digital, to allow service users to better monitor progress along the ND pathway. This tool aims to simplify system navigation for parents and clarify available support mechanisms

  Improvements in the ND assessment timeline are also underway, with the adoption of the Portsmouth model and the development of the Under 5 ND pathway. These changes are expected to expedite the ND assessment process, enhance its quality, and make it more child-focused. The goal is to better meet needs by understanding them more clearly, ensuring families can connect with the right individuals at the right times to support their children.

Argymhelliad / Recommendation

The Committee is provided with this response for information. The proposed method for monitoring the action plan will include bi-weekly updates in collaboration with the CAMHs/Family & Therapy leads and at the Monthly Divisional Assurance meeting with Strategic Oversight through the Children and Young People's Strategic Board.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	5. Timely Care Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	• Improve the access, experience and outcomes of those who require mental health and learning disability services • Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers • Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	

Rhestr Termau: Glossary of Terms:	CAMHs (Child and Adolescent Mental Health Services)
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Divisional Management Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	• Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves • Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies

Divisional Response to the NHSE Publication of the All-Wales Review of Neurodevelopmental Service for Under 18s

Divisional Response

- The Neurodevelopmental (ND) Review final report's recommendation is looking specifically at how we are managing our ND triage backlog/ND recovery plan and ND transition arrangements; all of which have either resolved or we have a fully formed plan underway to address including a focus on how MH+LD and CYP ND can work more closely together moving forward.

Report Highlights: What is working well

- The overall Review findings showed that our Teams are committed to the very highest standards of ND delivery and 4 out of the All-Wales ND standards are met with 2 described as partially met.

- It's clear that the team are doing an exceptional job in very difficult circumstances (with increasing demands for ND assessments) and to help address the surge in demands/mitigate risks, they have invested time and efforts in improving parental engagement and co-production, inclusive practice and outcomes, progress and attainment, the quality of assessments, joint collaborative work with education and other partners.

Report Highlights: Areas for Improvement

- ***ND wait time recovery and clearing the triage backlog***; we have adopted a range of improvements focused on reducing waiting times through a process of greater investment and service re-design which is supported by the Family & Therapies Division and the Executive Board through additional investments and development of a new Under 5 ND pathway that is now operational (with effect from 7 May 2024).

- ***Better service user experience (Parental engagement and co-production)***; we have transformed the way that we engage with parents and carers through the development of an engagement forum that is based on openness, partnership and co-production; working with parents and carers on the forums. Families have shared that working with them in a spirit of genuine transparency, partnership and co-production made them feel listened to, supported and happy.

We are working on an intuitive tracker with Paul Solloway, ABUHB Director of Digital for use by our service users to better track CYP's progress along the ND pathway. This will also make it easier for parents to better navigate our systems and understand the support mechanisms that are available.

- ***Improving ND assessment timeline***; our adoption of the Portsmouth model and development of an Under 5 ND pathway will make ND assessment process faster, better quality, more child focused. We will improve how we are meeting needs by better understanding the needs we are trying to address and families can reach the right people at the right time to support their children.

ABUHB Neurodevelopmental Service Review Action Plan (2024-25)

Following the NHSE publication of the All-Wales Review of ND Service for under 18s and following engagement with the Service leads, the following key actions for improvement have been identified:

NHSE Review Indicator	Aim of Action / Outcome	Actions and Milestones	Accountable Lead	Timeframe	RAG Rating
The HB should continue to monitor and implement the plan to reduce the number of children and young people waiting to commence an ND assessment with a focus on those waiting the longest.	This review indicator is RAG rated as red as whilst the ND RTT recovery for the 0-18 years is prioritised for the next 12 months. The focus will be on screening of referrals, ensuring capacity of core ND team to undertake additional assessments and chronological appointment of the current waiting list ND aims to evidence improvement in waiting list from 127 weeks longest wait as at end April 2024 to 26weeks in-line with national ND targets by the end of April 2025. This review indicator should be re-graded as amber in December 2024 once improvements are achieved before going green for the overall 0-18 years ND 80% RTT in April 2025.	To implement weekly review/ audit of the ND assessments demand and service capacity to better understand how needs continue to be met and ensure full delivery of the under 18 ND recovery by April 2025.	ND Service Delivery and Improvement Manager/ ND Operational and Clinical Lead	April 2024 to March 2025	
The HB should review the current triage backlog position and ensure that	This is graded as amber as the plans for screening are underway. *This should be graded*	New referral processes currently are being developed and will be	ND Service Delivery and Improvement	Sept 2024	

NHSE Review Indicator	Aim of Action / Outcome	Actions and Milestones	Accountable Lead	Timeframe	RAG Rating
referrers and families receive a timely outcome and response to their referral.	*as green by September 2024,* by which time ND would have screened and cleared backlog of 450 referrals by the end of August 2024.	rolled out/adopted fully in the new academic year (September 2024). Implementation of the new 'Portsmouth profiling tool' is aimed for September 2024. In the intervening period concerted efforts will be made (via school face to face meetings booked in before end of summer term in July 2024 to meet with ALNCO to discuss bulk referral management. The ND clinical lead and the ND operational lead are focussing on referral screening and additional support from the CAMH Service The Schools In reach team over the summer months) will screen and clear all referrals backlogs to be able to begin accepting referrals on a needs-based direction. Backlog referrals have continued to come down (from a previous number	Manager/ ND Operational and Clinical Lead		

NHSE Review Indicator	Aim of Action / Outcome	Actions and Milestones	Accountable Lead	Timeframe	RAG Rating
		of 700 backlog in January 2024 to 450 as at end April 2024).			
Arrangements for transition between children's and adult ADHD assessment services should be clarified to ensure young adults are not disadvantaged in relation to access, waiting time, or age-appropriate skills and expertise.	Where it's clinically indicated that an assessment is needed, the under 18 ND service will now accepts referrals up to age 18 for ADHD assessments.	Internal fast track process and redesigned of under 18 ND pathway to ensure if an assessment is indicated, this would be carried out before the YP's 18th birthday	ND Consultant / ND Operational and Clinical Lead	April 2024	
Reporting and data validation arrangements should be reviewed to ensure that referrals received, accepted, and rejected, are reported in line with the definitions. The HB may wish to engage with the NHS Executive for further clarification of reporting requirements.	Under 18 ND service since reviewed its official reporting of rejected referrals; which is now captured on Welsh Patient Administration System (WPAS)/to WG.	To input rejected Single Point of Access (SPACE ND) referrals into the WPAS system for official reporting into WG as part of the monthly ND activity / previously this information was captured manually and retained by SPACE ND data as they were deemed not suitable for ND assessment.	ND Service Delivery and Improvement Manager	April 2024	
It would be beneficial for the HB to review access to clinical rooms to ensure suitable clinical space is available to undertake face	An interim arrangement to use the Children's Centre space for ND assessments is underway, however, there is need to identify dedicated ND clinic space.	To designate a suitably clinic environment for ND assessments working with the Divisional Accommodation Group (taking into account the	ND Service Delivery and Improvement Manager / Service Group Manager	March 2025	

NHSE Review Indicator	Aim of Action / Outcome	Actions and Milestones	Accountable Lead	Timeframe	RAG Rating
to face consultations and assessments.	At the moment, ND clinics are booked across the 3 children's centres and Ty Bryn / White Valley Centre in St Cadocs. This is graded as amber as the CAMHS SMT are aware of the need to ensure the suitability of booking in ND assessments to suit the children / families and this is on their agenda. This will remain as amber over the next 12 months	need of the Neurodiverse CYP).			
The HB should continue to support the service to engage with opportunities to contribute to national planning and practice sharing forums.	Evidence of ongoing engagement and contribution to national planning/practice: • Most recently an assessment of the ND Evaluation tool 'QB Test' was shared with the National Clinical Working Group at a Community of Practice event demonstrating value added to the diagnostic Pathway with use of QB Test. • ND roll out of the Portsmouth ND toolkit as a way of transforming ND Pathway into 'Needs Led Approach' was demonstrated at a Stakeholder event with ALNCO followed by training attended by 300 Gwent	The Co-Production Parent group' work is nationally recognised including recognition by the NHS Wales who awarded first prize to ABUHB ND under the 'Empowering Communities Through their Care' category. The overall offer and schemes supported by ND is appreciated by the national forum and groups; and feedback received showed the regular training/workshops/co-production groups complements the assessment Pathway and	ND Consultant / ND Operational and Clinical Lead	April 2024	

NHSE Review Indicator	Aim of Action / Outcome	Actions and Milestones	Accountable Lead	Timeframe	RAG Rating
	practitioners from all Agencies. • ND continue to facilitate regular training and workshops with Social Care colleagues and Education that is well-subscribed as an access to expert advice/support, and to discuss the needs of CYP. • 'Nurturing ND service Co-Production Parent group' is also facilitated and have engaged in the development of resources / supporting Parents to be Peer mentors and ensuring extended support to Parent and Carers since March 2022.	overall service user experience.			