Patient Quality Safety and Outcomes Committee

Tue 25 April 2023, 09:30 - 12:30

Microsoft Teams

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 7th February 2023

Attached *Chair*

1.4 Draft Minutes PQSOC Committee 07_02_23 Chair Approved.pdf (10 pages)

1.5. Committee Action Log

Attached *Chair*

1.5 PQSOC Action Log April 2023.pdf (4 pages)

2. Items for Approval/Ratification

2.1. Committee Annual Report 2022/23

Attached *Director of Corporate Governance*

2.1 PQSOC Annual Report 2022-23.pdf (3 pages)
2.1a 2022-23 PQSOC Annual Report v2.pdf (29 pages)

3. Items for Discussion

3.1. Patient Quality and Safety Outcomes Measures Report, March 2023

Attached *Clinical Executive Directors*

3.1 PQSOC Performance Report - April 2023 - DRAFT (002) (002).pdf (56 pages)

3.2. Committee Risk Report, April 2023

Attached *Director of Corporate Governance*

3.2 PQSOC_Strategic risk report_Apr2023.pdf (6 pages)
3.2a Appendix 1_PQSOC Risk Regsiter Overview April 2023.pdf (4 pages)

3.2b Appendix 2 Committee Risk Report April 23 V3.pdf (78 pages)

3.3. Annual Reports

3.3.1. Blood Management

Attached *Medical Director*

3.3.1 Blood Management document FINAL JMC(1).pdf (15 pages)

3.3.2. Pharmacy and Medicines Management

Attached *Medical Director*

3.3.2 Pharmacy MM Annual report 21-22_(1).pdf (4 pages)
3.3.2a Pharmacy and Medicines Management Annual report 21-22 final (002).pdf (35 pages)

3.3.3. Research and Development

Attached *Medical Director*

3.3.3 Research and Development v3 april 2023(1).pdf (4 pages)
3.3.3a ABUHB R & D Strategy (3).pdf (28 pages)

3.3.4. Dementia Care

Attached *Director of Nursing*

3.3.4 PQSOC DEMENTIA ANNUAL REPORT.pdf (6 pages)
3.3.4a Dementia Standards Pathway document-English - Final.pdf (20 pages)
3.3.4b Regional Dementia Board Annual Report 2022-23 DRAFT.pdf (24 pages)

3.3.5. Falls and Bone Health Committee

Attached *Director of Therapies and Health Sciences*

3.3.5 Falls and Bone Health Report April 2023.pdf (36 pages)

3.3.6. Nutrition and Hydration Group

Attached *Director of Therapies and Health Sciences*

3.3.6 Board and Committee Report N&H April 23.pdf (7 pages)
3.3.6a Nutrition & Hydration.pdf (2 pages)
3.3.6b Nutrition & Hydration.pdf (4 pages)

3.4. National Audit of Care at the End of Life (NACEL) Management

Attached *Director of Nursing*

3.4 PQSOC NACEL April 2023 Final.pdf (12 pages)

3.5. National Review of Consent to Examination and Treatment Standards in NHS Wales: Welsh Risk Pool Report and Management Response

Attached *Medical Director*

3.5 A National Review of Consent to Examination Treatment Standards in NHS Wales PQSOC FInal April 2023.pdf (7 pages)
3.5a Consent action plan March 2023.pdf (8 pages)
3.5b Welsh Risk Pool Letter to ABUHB- March 2023.pdf (2 pages)
3.5c WRP National Review - Consent to Examination & Treatment Final ABUHB (With Action Plan).pdf (21 pages)

3.6. Clinical Audit Activity Report - March 2023

Attached *Medical Director*

3.6 Clincial Audit Activity Report Final March 2023 v2.pdf (19 pages)

4. Items for Information

4.1. Highlight Reports

4.1.1. Quality & Patient Safety Operational Group

Attached *Clinical Executive Directors*

4.1.1 QPSOG report from meeting 15 03 23.pdf (4 pages)

4.1.2. Children's Rights Participation Forum

Attached *Clinical Executive Directors*

4.1.2 ABUHB Children and Young People's Rights & Participation Forum - 28.02.23.pdf (3 pages)
4.1.2b Children's Rights Highlight Reports Feb 2023.pdf (6 pages)
4.1.2a Platfform - Gwent4YP.pdf (11 pages)

4.1.3. Safeguarding Group Highlight Report

Attached *Clinical Executive Directors*

4.1.3 Safeguarding Highlight Report - December 2022.pdf (4 pages)

4.1.4. Clinical Effectiveness and Standards Committee

Attached *Clinical Directors*

4.1.4 CSEG Jan 23 meeting notes for Mar 2023.pdf (11 pages)

4.1.5. WHSSC QPS Committee Report

Attached *Clinical Directors*

4.1.5 WHSSC QPSC Chairs report.pdf (10 pages)

4.2. PQSO Committee Workplan 2022/23

Attached *Director of Corporate Governance*

4.2 MASTER PQSO_Committee Work Programme 2022-23_Draft(5).pdf (7 pages)
4.2a PQSOC Workplan update April 2023.pdf (1 pages)

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 Next Meeting - Wednesday 20th June 2023

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

MINUTES OF ANEURIN BEVAN UNIVERSITY HEALTH BOARD PATIENT, QUALITY, SAFETY & OUTCOMES COMMITTEE MEETING

DATE OF MEETING	7th February 2023
VENUE	MS Teams

PRESENT	Pippa Britton, Independent Member (Chair) Louise Wright, Independent Member Paul Deneen, Independent Member Helen Sweetland, Independent Member
IN ATTENDANCE	Jennifer Winslade, Director of Nursing Rani Dash, Director of Corporate Governance Peter Carr, Director of Therapies & Health Science Leanne Watkins, Director of Operations Tracey Partridge-Wilson, Assistant Director of Nursing Bryony Codd, Head of Corporate Governance Paul Underwood, General Manager Stephen Chaney, Deputy Head of Internal Audit, NWSSP Linda Alexander, Deputy Director of Nursing Paul Mizen, Clinical Lead/Assistant Medical Director Danielle O'Leary, Head of Corporate Services, Risk and Assurance Jonathan Simms, Clinical Director of Pharmacy Steve Bonser, Head of Transformational Change Lucy Kings, Head of Nursing, Primary Care Leeanne Lewis, Assistant Director of Quality & Patient Safety Scott Taylor, Head of Health & Safety Rhys Fulthorpe, Health & Safety Manager Trish Chalk, Assistant Director of ABCi & Interim Deputy Director of Planning Ian Jenkins, Head of Systems Planning Unscheduled Care Linda Joseph, Deputy Chief Officer, CHC Krisztina Kozlovszky, Internal Audit Manager, NWSSP Catherine Currier, Meeting Secretariat
APOLOGIES	James Calvert, Medical Director Karen Hatch, Assistant Director of Therapies & Health Sciences

PQSOC/0702/1.	**PRELIMINARY MATTERS**
PQSOC/0702/1.1	**Welcome and Introductions** Pippa Britton (PB), Committee Chair welcomed and noted the guests attending for specific agenda items.
PQSOC/0702/1.2	**Apologies for Absence** The Committee noted the above apologies.
PQSOC/0702/1.3	**Declarations of Interest** There were no Declarations of Interest.
PQSOC/0702/1.4	**Draft Minutes of the last Meeting held on 6th December 2022** The minutes of the meeting held on 6th December were accepted as an accurate record.
PQSOC/0702/1.5	**Committee Action Log** Members noted the updated action log. It was confirmed that the Psychosis Audit had been presented to Clinical Standards & Audit Group and would be included within the Clinical Audit Report. An update on the Patient Charter would be included in the Quality Strategy Update. Peter Carr (PC), Director of Therapies & Health Science confirmed the Service was on track to deliver the Nutrition & Hydration update to the April 2023 Committee meeting. A request was made that the Nutrition & Hydration Report included a deep dive in Dementia. **Action: Director of Therapies and Health Science** The Patient, Quality & Safety Outcomes Committee **NOTED** the updates.
PQSOC/0702/2.	**ITEMS FOR APPROVAL/RTATIFICATION/DECISION**
PQSOC/0702/2.1	There were no items for inclusion in this section.

PQSOC/0702/3.	**ITEMS FOR DISCUSSION**
PQSOC/0702/3.1	**Patient Quality and Safety Outcomes Measures Report, January 2023** Jenny Winslade (JW), Director of Nursing introduced a presentation, which aimed to provide an update on the Workforce Nursing Staffing Levels (Wales) Act 2016, Quality & Safety Pillars, Urgent Care, Planned Care and Cancer Care. Linda Alexander (LA), Deputy Director of Nursing provided an overview of the Nursing Staffing Levels Wales Act 2016, the Health Board's compliance and actions being undertaken. Currently an annual update was provided and it was noted that in future, it was planned to provide a bi-monthly update in line with Welsh Government submissions to ensure the Committee received the appropriate ongoing assurance. JW took the Committee through the work being undertaken on the development of Pillars of Quality and the development of a Quality Strategy Structure. Trish Chalk (TC), Assistant Director of ABCi & Interim Deputy Director of Planning provided an update on the Safe Care Collaborative and the joint work with Improvement Cymru and the Institute of Healthcare Improvement. Paul Deneen (PD), Independent Member requested an update Duty of Candour training for staff. Leeanne Lewis (LL), Assistant Director of Quality & Patient Safety explained that the All-Wales Training Pack had not been released by Welsh Government yet but confirmed that Divisional Readiness Assessments were being undertaken. The Committee felt it would be beneficial to gain and understanding of how much Mandatory & Statutory Training Health Board staff were required to undertake and how long in hours this takes. Peter Carr (PC), Director of Therapies & Health Science confirmed a review of Mandatory & Statutory Training across the organisation was being undertaken. A report should be provided to the People & Culture Committee with a cross-over into this Committee's statutory duty to be assured regarding IPC and training etc. The Committee noted that the delay in Welsh Government releasing the All Wales Duty of Candour training package would impact on the Health Board's ability to implement and be compliant with the Act which comes in force 1st April 2023. JW highlighted that the risks from the volume and

	complexity of work required to comply with the Duty of Candour Act had been escalated to Welsh Government. Tracey Partridge-Wilson (TP-W), Assistant Director of Nursing provided an update on work regarding National Reportable Incidents including learning from the incidents and events. Helen Sweetland (HS), Independent Member asked if, due to the size of the Health Board, we were confident all events were reported and respond to. TPW noted that further consideration was needed and work was ongoing with the Delivery Unit. A request was made for future reports to include yearly figures to allow for comparison. TPW provided an update on Complaints and Serious Incidents (SIs) including a review of Divisional Quality Patient Safety resources to ensure timely responses. The Committee noted the protracted SIs and the delays in providing information to the Coroner. TPW explained the issue of protracted investigations was being considered as part of the Divisional Resource Review. It was confirmed Coroner information was being provided following an internal Quality Review and submitted just before deadline to ensure best information was provided. The Clinical Executives participated in the submission and monitoring of information submitted to the Coroner, who was kept aware and updated. The Committee noted the increased impact on clinicians following changes to Coroner processes. TP-W provided an update on CIVICA, how it was used to obtain feedback from families, carers etc in real time. A request was made for a briefing note to be circulated after the meeting. PC provided an overview of Health, Safety & Security data and the positive impact of work of the Health & Safety Team with the Police. An update on RIDDOR Reporting compliance was provided and actions being undertaken. LA provided a high level overview of Infection Prevention Control and Healthcare Acquired Infections (HCAIs). A patient story was shared, relating to hospital acquired COVID. It was noted the Health Board was in the process of investigating all cases of hospital acquired COVID to ensure learning and as part of the process patients/families are offered the opportunity to share their story. Pippa Britton (PB), Committee Chair requested the thanks of the

Committee was passed on to the family for being willing to share their story.

The Committee discussed the importance of hearing from families and providing them with an opportunity to share their experience; of learning from these incidents and the care of Dementia patients including the need to maintain contact with their families. The Committee requested that when the Dementia Deep Dive was undertaken it included undiagnosed dementia in the community.

LA provided an overview of COVID-19 investigations. It was noted a review was ongoing in relation to Safeguarding Training and an update was provided on the roll out of an online Children's Safeguarding form. The Committee requested a brief was provided at the April Committee meeting on the roll out of the Children's Safeguarding Online Form including rollout timeline.

PC provided an overview of falls across the Health Board including statistics and reviews undertaken. The Committee discussed if there were any patterns and PC provided feedback on the response to trends.

JW presented an update on Urgent Care highlighting key messages relating to Medical Staffing, Nurse Staffing and patient flow. The Committee discussed capacity in the Community to provide Rehabilitation Support and an update was provided on the work with CRT Teams, Redesigning Services For Older People and the development of a Rehabilitation Strategy in collaboration between hospital and community therapists.

Trish Chalk left at 11:16.
Ian Jenkins, Head of Systems Planning Unscheduled Care joined the meeting.

Ian Jenkins (IJ), Head of Systems Planning Unscheduled Care provided an overview of Planned Care activity, performance and expected activity levels.

Paul Mizen (PM), Assistant Medical Director provided an update on cancer performance, backlog recovery, projected activity and recovery challenges. The Committee asked how the Health Board benchmarked to other Health Boards across Wales. It was agreed this information would be shared with the Committee. Helen Sweetland (HS), Independent Member noted the pressures affecting all Welsh Health Boards and this was not unique to ABUHB.

	PB thanked all the contributions and those who pulled the information together and noted the assurance provided to the Committee. *Linda Alexander left at 11:31.* **Action**: • **Assistant Director of Nursing** to include yearly figures for SI's and Never Events in future reports. • **Director of Nursing** to circulate briefing note on CIVICA following the meeting. • **Director of Nursing/Director of Therapies & Health Scientists** to include undiagnosed dementia in the Community, as part of the Dementia Deep Dive. • **Director of Nursing** to arrange for a briefing on the roll out of the Children's Safeguarding Online Form to be provided to the April Committee meeting. • **Assistant Medical Director** to request the Planning Team share with the Committee the Health Board's Cancer Performance benchmarked against other Welsh Health Boards. The Committee **RECEIVED** an overview of the Health Boards Quality, Safety Metrics and Summary of Performance **for ASSURANCE.**

PQSOC/0702/3.2	**Committee Risk Report, January 2023** Danielle O'Leary (DO'L), Head of Corporate Services, Risk & Assurance provided an overview of the Committee's Strategic Risk Report. DO'L highlighted two risks CR013 and CR023 and provided an update on each risk. DO'L explained that at a recent Audit Risk & Assurance Committee a deep dive was undertaken of the Committee's strategic risks, and it was proposed a similar exercise was undertaken for the PQSOC Committee. The Committee agreed with the proposal. **Action:** • **Head of Corporate Services, Risk & Assurance** to undertake a deep dive of the strategic risks on behalf of the Committee. The Committee **RECEIVED** the overview of the Strategic risks which routinely report to the PQSO Committee and **NOTED** the update in respect of risk CRR028 as requested by the Committee.
PQSOC/0702/3.3	**Healthcare Inspectorate Wales Inspection Review, to include Tracking of Improvement Actions Arising from Inspections and Review** Tracy Partridge-Wilson (TP-W), Assistant Director of Nursing introduced the report, which provided an update on HEIW visits undertaken since December 2022 and ongoing actions. It was noted that the management of Independent Contractors was being discussed with Clinical Executives to ensure the Health Board received appropriate assurance. The Committee raised the issue of patient photographs and completion of documentation. TP-W explained the inconsistency in having patient photographs, as part of their medical record, was due to patient preference and was being worked through with HEIW. The variety of patient documentation systems across the Health Board was noted as a barrier and the transition to WICIS. Pippa Britton (PB), Committee Chair agreed to discuss with the Chair a review of the different patient record systems and which Committee this should be reported to. It was noted that the appointment of the Chief Digital Officer would be key to resolving this issue. The Committee NOTED the Operation Jasmine Report with no questions.

	Jonathan Simms (JS), Clinical Director of Pharmacy provided an overview of Controlled Drug Management and highlighted the amount of testing undertaken, compliance, reconciliation and actions being progressed. The Committee discussed Omnicell and how the Health Board ensured the right staff had completed the training. It was confirmed that each ward had a Superuser and guidance was being developed to ensure staff understood the benefits of the technology to operational delivery. **Action**: • **Committee Chair** to discuss with the Chair a review of the different patient record systems and which Committee this should report to. The Committee **NOTED** the findings of the Medicines Management Internal Audit report, the actions that have been taken to address the recommendations and the update provided on HEIW Reviews and actions being taken.
PQSOC/0702/3.4	**Clinical Audit** *Peter Carr left the meeting at 12:03 due to a fire alarm.* Leeanne Lewis (LL), Assistant Director Patient & Quality Safety provided an overview via a presentation summarising the reports and highlighting key messages. The Committee noted that the limited assurance reports had provided an opportunity to review and improve current processes and approach. The Committee discussed the resources required to implement the AMaT and to support Clinical Audits, which were currently being reviewed, as part of the Quality Strategy. The Committee Chair requested the outcome of the Clinical Audit Resource Review was provided to a future Committee meeting. The Committee **NOTED** the findings of the Medicines Management Internal Audit report and **NOTED** the actions taken to address the recommendations. The Committee **NOTED** the assurance provided by the Clinical Audit Team in developing an Internal Audit Report - Clinical Audit Plan January 2023 for the next twelve to twenty-four months. The Committee **NOTED** the assurance provided by the Clinical Audit Team to develop a Clinical Audit Programme for the next 12-24 months.

	The Committee **NOTED** the Clinical Audit Activity Report.
PQSOC/0702/3.5	**Annual Reports: Health Board Organ Donation Report** Paul Mizen (PM), Assistant Medical Director presented the Health Board's Annual Organ Donation Report and highlighted that the Organ Donation Committee had been re-established following the pause during the pandemic. The Committee noted that the Terms of Reference states the National Organ Annual Report would be submitted to the Committee in August/October 2023 and it was requested this was added to the Committee's Froward Work Plan. **Action:** • **Meeting Secretariat** to update Committee Forward Work Plan to include the National Organ Annual Report. The Committee **NOTED** the latest Organ Donation Performance Report and the work programme.
PQSOC/0702/4.	**ITEMS FOR INFORMATION**
PQSOC/0702/4.1	**Highlight Reports** The Committee received the following reports for information: a) QPSOG Highlight Report 18th January 2023 b) ABUBH Children's Rights & Participation Forum December 2023
PQSOC/0702/4.2	**Assurance Reports to the Finance & Performance Committee, January 2023** The Committee received the following reports for information: a) **Stroke GIRFT Update** b) **Six Goals Urgent & Emergency Care** The Committee noted the GIRFT Stroke Action Plan was missing timeframe/target dates and Bryony Codd (BC), Head of Corporate Governance agreed to highlight this to Peter Carr (PC), Director of Therapies & Health Sciences. **Action**: • **Head of Corporate Governance** to highlight to the Director of Therapies & Health Sciences the missing timeframes in the GIRFT Stroke Action Plan.

PQSOC/0702/4.3	**Committee Workplan 202/23** The Committee noted the additional of the National Organ Annual Report to the Committee Workplan, which was received for information.
PQSOC/0702/5.	**OTHER MATTERS**
PQSOC/0702/5.1	**Items to be Brought to the Attention of the Board and Other Committees** • The People & Culture Committee to receive a report on the review of Mandatory & Statutory Training.
PQSOC/0702/5.2	**Any Other Urgent Business** The Committee noted the quality of information and presentation style helped to support the Committee and in providing assurance.
PQSOC/0702/5.3	**Date of Next Meeting** The date of the next Patient Quality & Safety Outcome Committee was noted as 25th April 2023.

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

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
6th December 2022	**PQSOC 0612/14**	**Health & Safety Compliance Report:** Members requested a detailed report on violence and aggression, including comparative data across Wales and the impact of negative social media comments on the health and safety of staff members.	**Head of Health and Safety/ Secretariat**	**Q1, 2023/24**	To be added to the PQSO Committee Workplan for 2023/24 – June 2023 meeting.
19th October 2021	**1910/13**	**Annual Assurance Report on Health & Care Standards: Nutrition and Hydration:** An update, inclusive of report from Patient Dining Review.	**Director of Therapies & Health Science**	February 2023	To be included within the Nutrition & Hydration Group Annual Report 2022/23, scheduled to be presented to the Committee in April 2022.
7th February 2023	**PQSOC 0702/3.1**	**Patient Quality & Safety Outcomes Measures Report, January 2023**: Health Board's Compliance of Nursing Staffing Wales Act 2016 to be presented bi-monthly.	**Director of Nursing**	June 2023	To be included within the PQSO Committee workplan for 2023/24 as a routine bi-monthly assurance report.

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
7th February 2023	**PQSOC 0702/3.1**	**Patient Quality & Safety Outcomes Measures Report, January 2023:** An update on a review of Mandatory & Statutory Training to be provided to the PQSOC Committee and the overall report to be submitted to the People & Culture Committee.	**Director of Therapies & Health Sciences**	June 2023	In discussion with the Committee Chair, this action has been transferred to the People & Culture Committee with its delegated responsibility to seek assurance on training and development.
7th February 2023	**PQSOC 0702/3.1**	**Patient Quality & Safety Outcomes Measures Report, January 2023:** The Committee Chair requested the results of the Dementia Deep Dive included undiagnosed dementia in the Community was added to the next PQSOC Committee agenda.	**Director of Nursing/Meeting Secretariat**	June 2023	To be included within the Dementia Annual Report 2022/23, scheduled to be presented to the Committee in April 2022.
7th February 2023	**PQSOC 0702/3.1**	**Patient Quality & Safety Outcomes Measures Report, January 2023:** The Independent Members requested an update was provided on the rollout of the Online Children's Safeguarding Form.	**Director of Nursing**	June 2023	To be addressed within the PQSO Outcomes Report presented to the Committee in April 2023.
7th February 2023	**PQSOC 0702/3.3**	**HIW Inspection Review to include Tracking of Improvement Actions Arising from Inspections and Review**: Committee Chair to discuss with Health Board Chair if a review of different patient record	**Committee Chair**		Discussion held with Chair. Board briefing to be scheduled to discuss quality of clinical record keeping.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		systems was required and if this should be presented to the Board.			
7th February 2023	**PQSOC 0702/3.4**	**Clinical Audit**: The Committee Chair requested this report is provided at each PQSOC Committee meetings.	**Director of Nursing/Meeting Secretariat**	June 2023	To be included within the PQSO Committee workplan for 2023/24 as a routine assurance report.
7th February 2023	**PQSOC 0702/3.5**	**Annual Reports – Health Board Organ Donation Report**: In line with the ToR the National Organ Annual Report will need to be presented to the August/October PQSOC	**Medical Director/Meeting Secretariat**	June 2023	To be scheduled within the PQSO Committee workplan for 2023/24.
7th February 2023	**PQSOC 0702/3.1**	**Patient Quality & Safety Outcomes Measures Report, January 2023:** Following an update on CIVICA. It was agreed a Briefing Note would be circulated on CIVICA and the planned roll out.	**Director of Nursing**	March 2023	Complete. Email sent 13th February 2023
7th February 2023	**PQSOC 0702/3.1**	**Patient Quality & Safety Outcomes Measures Report, January 2023:** Following an update on the Health Board's Cancer Performance it was agreed Benchmarking Information would be shared with the Independent Members.	**Medical Director**	March 2023	Complete. Email sent 28th February 2023

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

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.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	25 April 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Patient Quality, Safety and Outcomes Annual Report 2022 - 23
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper presents the Patient, Quality, Safety and Outcomes Committee Annual Report 2022-23, referred to as the Annual Report throughout this paper.

The Annual Report (Appendix A) is provided for endorsement prior to submission to the Board on 24th May 2023.

Cefndir / Background

Section 2 of Aneurin Bevan University Health Board's Standing Orders states that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

The scope of the Patient Quality, Safety and Outcomes extends across the full range of Health Board business and encompasses all areas of patient experience,

quality and safety relating to patients, carers and service users, within directly provided services and commissioned services of the Health Board. The Committee embraces the Health and Care Standards as the Framework in which it fulfils its purpose.

Each Committee is responsible for developing an annual report for submission to the Board via the Chair within 6 weeks of the end of the reporting year, setting out its activities during the year and including the review of its performance.

The Board shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Board Development Programme, as part of an overall Organisation Development framework; and
- The Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

The Annual Report seeks to provide a comprehensive evaluation on the business undertaken by the Committee over the course of the 2022-23 financial year including any issues, and gaps in assurance that have required escalation to the Board.

Argymhelliad / Recommendation

The Patient Quality, Safety and Outcomes Committee is asked to **CONSIDER** and **ENDORSE** its Annual Report 2022-23 prior to submission to the Board on 24th May 2023.

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):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The objectives will be referenced to the IMTP

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. 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. There is no Equality and Diversity impact.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Not required
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. Not applicable to the report, however, considerations will be included in considering how the business of the Committee aligns to the WBoFG Act

Patient Quality, Safety and Outcomes Committee

Annual Report for 2022-23

April 2023

CONTENTS

Foreword

Chair's Foreword

I am pleased to present the Patient Quality, Safety and Outcome Committee's (the Committee's) Annual Report for the year ended 31 March 2023.

In this report we provide an overview of the work of the Committee, which extends to the full range of Health Board responsibilities; and encompasses all areas of patient experience, quality and safety relating to patients, carers and service users.

In particular, I welcome the approval of the Quality Strategy by the Board in March 2023, which will ensure that quality is embedded in our culture and that we are delivering the highest quality healthcare to our local communities and putting Quality, Safety and Learning at the heart of everything we do.

In addition, the Patient Experience and Involvement Strategy, which will help drive our teams and our staff members passion to improve people's experiences within our services.

Finally, I would like to express my personal appreciation to all who contributed to the patient quality, safety and outcomes agenda over the last 12-months.

Diolch yn Fawr / Thank you

Pippa Britton
Chair
Patient Quality, Safety and Committee

1. Introduction

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

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

1.2 The Term of Reference of the Patient Quality, Safety and Outcomes Committee (referred to throughout this document as 'PQSO' or the 'Committee') were approved by the Board in March 2022 (see **Appendix 1**). These were not changed during the reporting year.

1.3 The Committee formally adopted its Terms of Reference, following the Board's approval, on 05 April 2022.

The purpose of the PQSOC is to provide: evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

1.4 This report describes how the PQSOC discharged its role and responsibilities during the period 1 April 2022 to 31 March 2023. This was a year of change for the Committee, it being a first full year in role for some committee members and a year in which there were both interim and permanent changes in the executive team supporting PQSO Committee in meeting its responsibilities.

2 2022-23 Work Programme

2.1 ABUHB Standing Orders require the Board Secretary to produce an Annual Plan of Board business. This should incorporate formal Board meetings, regular Board Development sessions and, as appropriate, planned activities of the Board's Committees and Advisory Groups. The Work Programme adopted for PQSOC in 2022-23 is attached to this report (see **Appendix 2**).

2.4 A Work Programme is designed to align to its terms of reference and the requirement for it to seek information to be able to give advice or gain assurance for itself and on behalf of the Board. The Work Programme is, however, a framework rather than a prescriptive agenda. This gives PQSOC flexibility to identify changing priorities or any need for further assurance or information.

3 PQSO Committee Meetings and Membership

3.1 During 2022-23, PQSOC met five times via Microsoft Teams- in April 2022, June 2022, August 2022, December 2022 and February 2023. The meeting scheduled to take place in October 2022 was cancelled due to systems pressures at that time, however all reports were received at the December 2022 meeting. Detail of the members and executive directors who attended these meetings is provided at **Appendix 3**.

3.4 The Committee comprised the following Independent Members:

- Pippa Britton Chair
- Louise Wright Vice Chair
- Paul Deneen
- Helen Sweetland
- Shelley Bosson (until 1.11.22)

3.3 In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the organisation is required to meet in public. As a result of the public health risk linked to the pandemic there have been limitations on public gatherings, and it has not therefore been possible to allow the public to attend committee meetings throughout 2022/23. This has therefore meant that the Health Board has not complied with its Standing Orders in this regard.

To ensure business was conducted in as open and transparent manner as possible during this time the meeting agenda packs have been published to the Health Board's website in advance of meetings.

3.5 The Committee's agenda and papers were made public, save where it was necessary to meet 'in private', which it did on two occasions in 2022-23. Private meetings are held where it would not be appropriate to discuss a matter in public, due to issues of patient or staff confidentiality, commercial confidentiality, or discussion of serious incidents or escalated concerns which would not be in the public interest.

Issues discussed in private session include calling black escalation and a specific incident and investigation outcome.

4 PQSOC Reporting Arrangements

4.1 Following each meeting, the PQSOC submits an Assurance Report to the following Board meeting, outlining topics discussed, areas of concern and areas of risk. All Board papers can be accessed via the following link.

5. PQSOC Work Programme: 2022-23

5.1 The PQSOC Work Programme for 2022-23 is set out in **Appendix 2**.

5.2 During the year, PQSOC received internal presentations or annual reports on:

- An overview of the new **Dementia Standards** and the launch, on the 6th April 2022, of the All-Wales Hospital Dementia Charter
- Overview of compliance and performance against **National Clinical Audit and Local Audit Arrangements**
- Compliance with **Cleaning Standards,** including Benchmarking Data, and Actions underway to address associated issues and risks
- An update of progress following the initial presentation in September 2021 of the review of **Access Arrangements in General Medical Services (GMS)** undertaken in June 2021
- An update on the work being undertaken in theatres and scheduled care, relating to **theatre safety**, following concerns regarding an increase in 'Never Events' in surgical and theatres directorates.
- An overview of the **Covid-19 investigative framework**
- **Learning from Death Report** and the statutory requirement for all deaths in Wales, in both primary and secondary care, to be subject to scrutiny by the Medical Examiner.
- Health Board's approach to continued organisational learning in respect of **Operation Jasmine.**
- Overview of Enhanced Care: linking provision, cost and outcomes
- The Health Board's plan and progress in response to the Welsh Government **'Six Goals for Urgent and Emergency Care'** and how these plans have now been aligned within the Health Board's 'Six Goals' Programme Plan
- Assurance of work undertaken to address required improvements outlined in the **National Clinical Audit of Psychosis** with respect to the Early Intervention Service (EIS) (2020/2021).
- **Cancer performance** including identified improvement actions to address the current challenges.

- Report outlining the Health Board's action plan in response to the **national review of Venous Thromboembolisms**.
- **Safeguarding Annual Report**, including progress, performance, risk and learning together with an overview of emerging themes and trends.
- **Infection Prevention and Control Annual Report,** outlining the infection prevention work undertaken in 2021/22, management arrangements and progress against performance targets.
- An update on the review of care for individuals with **Learning Disabilities**
- Overview of the Health Board's contractual arrangements for **WAST inter-site transfers**.
- Health Board's current position and governance arrangements in relation to **Health and Safety Compliance**.

Together, these provided the Committee with an overview of how the PQSOC agenda was being implemented at a local level.

The Committee also received various external reports, including:

- Regular reports outlining progress of the delivery against recommendations and outstanding actions from **HIW inspections** conducted across the Health Board.
- GUH Quality Assurance Report
- Falls management
- **Audit Wales Review of ABUHB Quality Governance Arrangements**, which concluded that the Health Board had clear, articulated corporate arrangements for quality governance and key areas of quality and safety; however, further improvement was required at Divisional and Directorate level.
- **HIW Unannounced visit to GUH**, triggered by ongoing pressures in the urgent care system. Overall, HIW were not assured that all systems and processes in place were sufficient to ensure all patients were consistently receiving acceptable standards of safe an effective care, although the hard work of staff was recognised.
- Discussion of the key points from the **Ockenden Review** and identified actions being taken in Wales to review the report and extract learning.
- **HMP Prison Services Self Assessment,** based upon recommendations taken from HIW' review of the Quality Governance Arrangements within Swansea Bay University Health Board, for the delivery of healthcare services to Her Majesty's Prison Swansea.

5.3 The Committee approved

- **Clinical Audit Strategy**- to support the delivery of a meaningful programme of audit designed to provide assurance and inform quality improvement across the Health Board.

6. Patient Centred Care

6.1 The Committee has sought assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust.

6.2 Presentation of a Patient-Staff Story at a Board meeting continued in 2022-23, on topics such as:

- Long COVID Service - staff member shared their experience of using the service and the impact of long-COVID on their health and wellbeing.
- Virtual Ward - a place based structured, face-to-face or virtual multi disciplinary team (MDT) conversation between a range of multi-disciplinary and multi-sector professionals, where people/patients with a variety of complex and inter-related issues are discussed and care planning takes place.
- 'Bob's Story' -What Matters to Me - which highlighted the importance of dignity and respect for patients.

7. Assurance and Improvement

7.1 The Committee receive a performance Report at each meeting, this has continued to develop during the year and provides an overview at each meeting 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:

- **Workforce Nursing Staffing Levels (Wales) Act 2016**
- **Quality and Safety Pillars** (incident reporting, patient experience and staff feedback, complaints and concerns, health and safety, infection prevention and control, safeguarding)
- **Urgent Care**
- **Planned Care**
- **Cancer**

8 Committee Oversight of Risk

At each Committee meeting during 2022/23 the Committee received a strategic risk report. An overview of the risks that are reported to the Committee is provided with detailed risk assessments of the risks that receive direct oversight from the Committee. The Committee also has an opportunity to highlight any areas of concerns or significant risk, as appropriate.

There has been an increased synergy between the risk report, the patient outcomes report and Committee agenda items over the year. This was informed by the work of the Audit, Risk and Assurance Committee (ARAC) when in July 2022, the ARA Committee received an internal audit review on the BAF. The purpose of the review was to "*evaluate the BAF process and supporting arrangements that are embedded within Aneurin Bevan University Health Board governance structure*." The report concluded a reasonable level of assurance could be taken and made 4 recommendations (2 medium, 2 low) to further develop, embed and strengthen the BAF to ensure Board and Committee business focused on the areas of weakest assurance and highest risk. The findings of the report were used as a baseline to inform the revised approach for 2023/24.

At a further meeting of ARAC in August 2022, a presentation from the Director of Corporate Governance outlined an updated approach to development of the BAF allowing for closer alignment and reporting with the Corporate Risk Register. It was also proposed that enhanced assurance mapping would be included to replicate the Three Lines of Defence Model The three lines of defence for assurance and reassurance GGI as highlighted as best practice for evidencing sources of assurance and reassurance through the Good Governance Institute (GGI).

It was agreed that a system of assurance would be developed and would focus on the following:

- **Board Assurance Framework (Risk Based)**
  - Aligned to Corporate Risk Register, focussed on Strategic Risks and Strategic Priorities
- **Assurance Mapping (Process Based)**
  - Organisational assurance mapping to review system-wide internal control.
- **Quality Assurance Framework**
  - To ensure a systematic, continued, and sustained improvement in the quality of care

The first steps to achieving this revised approach to the BAF have been taken and at the March 2023 Board meeting, the Board received the

first iteration of the report, complete with assurance mapping and action plans identified to address gaps in assurances. Further development of the presentation of the report is expected to align with a rationalisation of the currently held strategic risks and a revised Risk Management Strategy. This is expected to be presented to the May 2023 Board.

8.2 **Themes of Risks Reported**

At the time of writing the Committee had responsibility for oversight of **10** organisational risks that relate to various aspects of Patient, Quality, Safety and Outcomes. A breakdown of the current risks is depicted below:

High	**8**
Moderate	**2**
Low	**0**

A high-level breakdown of the themes that have been consistently reported to the Committee are as follows:

- **Patient flow and discharge**
- **Inter-site patient transfers**
- **Mental Health service provision**
- **Increased levels of patient acuity**
- **Increase in Putting Things Right (PTR) complaints and incidents.**
- **Safeguarding**

At the October 2022 Committee meeting, members were advised of the Risk Management Strategy Benefits Realisation Plan. This made clear links to the objectives contained within the Health Board Risk Management Strategy and how each objective would be measured and monitored and the intended outcomes of each.

A further update on Health Board commissioned arrangements was provided at the October 2022 meeting, following an internal audit review into the Mental Health and Learning Disabilities Commissioning arrangements. Members were advised that to align with the proposed system of assurance to support the Board and Risk Assurance Framework, an organisational mapping exercise to determine sources of assurance would be undertaken. It is anticipated that this work will conclude and be reported back to the Committee during 2023/24.

9. Self-assessment and Evaluation

9.1 The Board has undertaken an overall assessment of its effectiveness during 2022/23 using the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for Leadership and Governance Developmental Reviews.

The Well-led Framework supports boards to maintain and develop the effectiveness of their leadership and governance arrangements and has a strong focus on integrated governance and leadership across quality, finance and operations as well as an emphasis on organisational culture, improvement and system working.

From 2023/24, Committees will undertake a mid-year self-assessment of their effectiveness to inform the Board's end of year assessment.

10. Key Areas of focus in 2023-24

10.1 Arrangements to ensure focus on and, where necessary, strengthen Board and committee oversight on patient experience, quality and safety, in line with the six domains of quality outlined in the Health Board's Quality Strategy:

- Person-centred care
- Safe care
- Timely care
- Efficient care
- Effective care
- Equitable care

11. Conclusion

11.1 This report provides a summary of the diverse and often complex work undertaken by the PQSOC during 2022-23, and demonstrates that the Committee has complied with its Terms of Reference as approved in March 2022.

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

Patient Quality, Safety and Outcomes Committee

Terms of Reference – 2022/23

Version: Approved
Date: March 2022

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1. INTRODUCTION

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

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

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

2. PURPOSE

2.1 The scope of the Committee extends to the full range of ABUHB responsibilities. This encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. The Committee will embrace the Health and Care Standards as the Framework in which it will fulfil its purpose:

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

2.1 ADVICE

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

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

2.2 ASSURANCE

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

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

3 DELEGATED POWERS AND AUTHORITY

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

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

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

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

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

- the systems and processes in place to ensure efficient, effective, timely, dignified and safe delivery of directly provided services;
- the commissioning assurance arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of those services commissioned for delivery on ABUHB's behalf;
- the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities;
- the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;

- the arrangements in place to ensure that there are robust infection prevention and control measures in place in all settings;
- the development of the Board's Annual Quality Priorities; and,
- performance against key quality outcomes focussed indicators and metrics.

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

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

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

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

Authority

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

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

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

Access

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

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

Sub Committees

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

Committee Programme of Work

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

4 MEMBERSHIP

Members

4.1 Membership will comprise of five (5) members:

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

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

Attendees

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

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

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

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

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

Secretariat

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

Member Appointments

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

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

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

Support to Committee Members

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

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

5 COMMITTEE MEETINGS

Quorum

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

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

Frequency of Meetings

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

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

Openness and Transparency

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

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and

- through ABUHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

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

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

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions (as set out within these terms of reference), the Board retains overall responsibility and accountability for all matters relating to performance and resources.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- applicable escalation of concerns.

In doing so, this contributes to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

9. CHAIR'S ACTION ON URGENT MATTERS

9.2 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee – after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Appendix Two

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	25th April
Preliminary Matters									
Attendance and Apologies	Standing Item	Chair	✓	✓	✓	✓	✓	✓	✓
Declarations of Interest		All Members	✓	✓	✓	✓	✓	✓	✓
Minutes of the Previous Meeting		Chair	✓	✓	✓	✓	✓	✓	✓
Action Log and Matters Arising		Chair	✓	✓	✓	✓	✓	✓	✓
Committee Requirements as set out in Standing Orders									
Development of Committee Annual Programme of Business 2022/23	Annually	Chair & Director of CG			✓				
Review of Committee Programme of Business	Standing Item	Chair			✓	✓	✓	✓	✓
Annual Review of Committee Terms of Reference 2022/23	Annually	Chair & Director of CG						✓	
Annual Review of Committee Effectiveness 2022/23	Annually	Chair & Director of CG							deferred
Committee Annual Report 2022/23	Annually	Chair & Director of CG							✓
Quality Domain: Safe Care									
Pharmacy and Medicines Management Annual Report	Annually	Medical Director							✓
Internal Audit Review: Medicines Management (Reasonable Assurance) – Update on actions	Annually	Medical Director						✓	
Learning from Death Report	Bi-Annually	Medical Director		✓			✓		
Cleaning Standards Annual Report	Annually	Director of Operations						deferred	
Nutrition and Hydration Standards and Strategy'	Annually	Director of Therapies & HS							✓
Falls Prevention and Management Report	Bi-Annually	Director of Therapies & HS							✓

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	25th April
Health and Safety Compliance Report	Annually	Director of Therapies & HS					✓		
Safeguarding Annual Report	Annually	Director of Nursing			✓				
Safeguarding Group Highlight Report	Quarterly	Director of Nursing			✓		✓		✓
Operation Jasmine Action Plan	Bi-Annually	Director of Nursing		✓				✓	
Children's Rights & Participation Forum	Bi-Annually	Director of Nursing				✓			✓
Infection Prevention and Control Annual Report	Annually	Director of Nursing			✓				
Infection Prevention and Control Report	Quarterly	Director of Nursing			✓	✓		PQSO report	
Blood Management Annual Report	Annually	Medical Director						deferred	
Organ Donation Annual Report	Annually	Medical Director						✓	
Quality Domain: Effective Care									
Quality Assurance Framework Annual Review and Evaluation of Progress	Annually	Clinical Executives						✓	
Commissioning Assurance Framework, Development and Implementation	Bi-Annually	Clinical Executives					✓		
Clinical Effectiveness and Standards Committee Report	Bi-Annually	Medical Director				✓			✓
Annual Clinical Audit Plan (prior to ratification) by the Audit, Risk & Assurance Committee	Annually	Medical Director			✓				
Clinical Audit Activity Report (Local and National) Feb 23 to include Annual Clinical Audit Draft Internal Audit Report	Quarterly	Medical Director			✓			✓	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	25th April
Quality Improvement Annual Report	Annually	Director of Planning							deferred
Research and Development Annual Report	Annually	Medical Director							✓
Medical Devices Annual Report	Annually	Director of Therapies & HS					✓		
Point of Care Testing Annual Report	Annually	Director of Therapies & HS					✓		
Quality and Safety Outcomes Report	Standing Item	Clinical Executives	✓	✓	✓	✓	✓	✓	✓
Committee Risk Report, including BAF	Standing Item	Director of Corporate Gov	✓	✓	✓	✓	✓	✓	✓
WHSSC QPS Committee Report	Standing Item	Director of Nursing	✓	✓	✓	✓	✓	✓	✓
Quality Domain: Dignified Care & Individual Care									
Patient Story	Standing Item	Clinical Executives	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Putting Things Right Policy	Every 3-yrs (2022)	Director of Nursing				✓			
Putting Things Right Reporting (complaints, compliments, and redress)	Standing Item[1]	Director of Nursing	✓	✓	✓	✓	✓	PQSO report	PQSO report
Quality & Engagement (Wales) Act, Preparedness and Implementation	Annually	Director of Nursing					✓		PQSO report
Patient Experience Report	Quarterly	Director of Nursing		✓			✓		✓
Dementia Care Annual Report	Annually	Director of Nursing							✓

[1] Via Quality and Safety Outcomes Report

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	25th April
Clinical Negligence Claims and Coroners Inquests Report	Bi-Annually	Director of Nursing				✓			PQSO report
Patient Safety Incidents and Learning	Standing Item[2]	Director of Therapies & HS	✓	✓	✓	✓	✓	PQSO report	PQSO report
Covid-19 Concerns and Claims	Bi-Annually	Director of Nursing		✓				✓	
Service Specific Deep-Dive Assurance Reviews									
Learning Disabilities	Annually	Director of PCCMH			✓				
Urgent and Emergency Care Demand and Impact on Outcomes	Quarterly	Director of Operations			✓		✓		deferred
Maternity Services: Organisational Improvement and Action Plan	Bi-Annually	Director of Nursing		✓		✓			
Child and Adolescent Mental Health Crisis Hub and Safe Accommodation	Annually	Director of Nursing							
Self-Harm & Suicide - Children & Young People	Annually	Director of Nursing							
Primary Care Quality	Bi-Annually	Director of PCCMH							deferred
Independent Audit, Regulation and Inspection									
Internal Audit Reports relevant to the remit of the Committee	Ad-hoc	Clinical Executives	As scheduled within the Annual Internal Audit Plan						
External Audit Reports relevant to the remit of the Committee	Ad-hoc	Clinical Executives	As scheduled within the Annual External Audit Plan						
Action Plan for "*Review of Quality Governance Arrangements*" Audit, Wales Review (2021/22)	Bi-Annually	Clinical Executives		✓			➲	✓	
Internal Audit Review - Quality Governance arrangements for the	Bi-Annually	Director of Primary,			✓			✓	

[2] Via Quality and Safety Outcomes Report

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	25th April
commissioning of NHS Continuing Care within the Mental Health & Learning Disabilities (limited assurance) – Action Plan Update		Community Care & Mental Health							
Internal Audit Review – Medical Devices – Action Plan Update	Bi-Annually	Director of Therapies & HS			✓		✓ (linked to Annual Report)		
Overview of Audit Recommendation Tracking (relevant to the Committee)	Quarterly	Director of Corporate Gov			✓		✓		✓
Inspections of Healthcare Inspectorate Wales	Ad-hoc	Director of Nursing	As published						
Inspections of the Community Health Council	Ad-hoc	Director of Nursing	As published						
Tracking of Improvement Actions Arising from Inspections and Reviews	Quarterly	Director of Nursing		✓		✓		✓	
Healthcare Inspectorate Wales Operational Plan	Annually	Director of Nursing			✓				
Healthcare Inspectorate Wales Annual Report	Annually	Director of Nursing						✓ Included in Dec 22	
WRP Report and Management Response/Action Plan: National Review of Consent to examination and treatment standards in NHS Wales		Medical Director							✓

Appendix 3

Patient Quality, Safety and Outcomes Committee: Attendance at meetings in 2022-23

Attended | **Did Not Attend** | **Not a Member/Required Attendee**

Meeting Dates	5th April	7th June	16th August	18th October	6th December	7th February
Independent Members						
Pippa Britton (Chair)				Meeting Cancelled		
Louise Wright (Vice Chair)						
Paul Deneen						
Helen Sweetland						
Shelley Bosson						
Executive Directors						
James Calvert				Meeting Cancelled		
Jenny Winslade						
Peter Carr						
Rhiannon Jones						
Leanne Watkins						
Chris O'Connor						
Rani Dash						
Glyn Jones						

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Patient Quality, Safety and Outcomes Committee

Performance Report

APRIL 2023

Overview

The Patient, Quality and Safety performance report provides the Committee 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:

- **Workforce Nursing Staffing Levels (Wales) Act 2016**
- **Quality and Safety Pillars**
- **Urgent Care**
- **Planned Care**
- **Cancer**

Nursing Staffing Levels Wales Act 2016

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical/surgical and paediatric inpatients wards					
Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	**Total number of incidents/ complaints - Sept/Oct 2022**	**Number of closed incidents/ complaints – Sept/Oct 2022**	**Total number of incidents/ complaints <u>not closed</u> and to be reported on/during the <u>next</u> reporting period**	**Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained**	**Number of incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor**
Hospital acquired pressure damage (grade 3, 4 and unstageable)	Nov - 5 Dec - 5 Jan - 7 **Total 17**	Nov - 1 Dec - 3 Jan - 4 **Total 8** (4 avoidable)	9 open	Closed HAPU's related to staffing = 2	**2**
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents)	Nov - 0 Dec - 4 Jan – 5 **Total 9**	Nov – n/a Dec -1 Jan – 1 **Total 2**	7 open	Closed falls related to staffing = 0	**0**
Medication errors never events	0	0	0	0	0
Any complaints about nursing care	Nov - 0 Dec - 3 Jan – 8 **Total 11**	Nov - 0 Dec - 0 Jan – 0 **Total 0**	11	All complaints remain open-only 1 where staffing questions answered - **1 (not maintained)**	1 not a contributing factor
Infiltration/ extravasation injuries	0	0	0	0	0

Nursing Staffing Levels Wales Act 2016

Issue	Cause	Remedial Action	Who	When
Incorrect categorisation of HAPU's resulting in inaccurate reporting.	Following RCA – categorisation not revisited and re-categorised to reflect outcome of RCA.	Further education and training for divisions on correct process. Continuous evaluation to ensure processes are embedded.	Divisional Nurses Nurse Staffing Programme Lead	Commenced Jan 2023 – on-going
Focused review not been undertaken to determine nurse staffing levels and route cause of metric reported.	Staff unfamiliar with requirements of the new system to meet NSLWA requirements. Continue to populate RCA which requires manual pull through.	Further education and training for divisions on correct process. Move from paper RCA to electronic datix focused review	Divisional Nurses Nurse Staffing Programme Lead	February 2023 - ongoing
Requirement to report nurse staffing levels aligned to complaints is ambiguous. Not a consistent approach across Wales	Complaints often multifaceted, spanning different wards, specialities, divisions and hospitals.	Staff reminded of the requirement to determine the root cause of a complaint and to complete the NSLWA component on Datix to determine nurse staffing levels and whether this was considered a contributing factor.	Divisional Nurses Nurse Staffing Programme Lead	February 2023
Validation of metrics in a timely manner.	The nature of the level of harm relating to the NSLWA means there is often a delay in validating the data as each incident requires a thorough RCA.	Divisions asked to review incidents in particular HAPU's and falls at the earliest opportunity whilst the patient is still an inpatient to improve accurate and timely validation.	Divisional Nurses Nurse Staffing Programme Lead	On-going

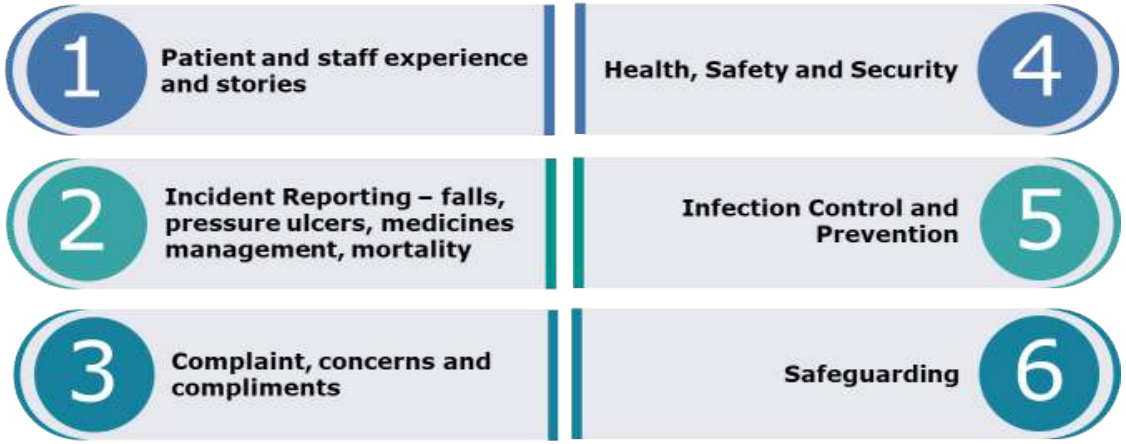
Pillars of Quality

- Define measurements for quality
- Incident reporting (this include falls, next steps pressure ulcers and medicines management).
- Patient Experience and Staff Feedback (await Civica). This will include compliments.
- Complaints and concerns
- Health and Safety (encompass security)
- Infection Prevention and Control
- Safeguarding

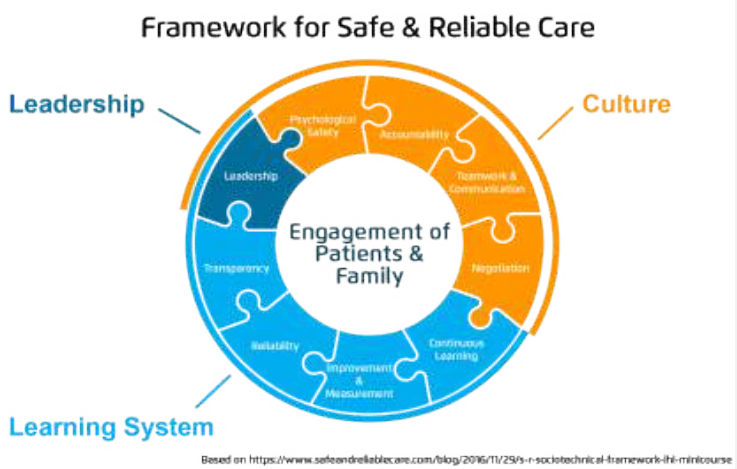
Quality Strategy Implementation Plan

- Quality & Engagement Act from 1st April 2023 encompassing Duty of Candour and Duty of Quality.
- Approved - Quality Strategy and Patient Experience & Involvement Strategy.
- Board session delivered in March 2023.
- Implementation plan underway.
- Workplan being refined, including deteriorating patients, NRIs and never events in theatres and radiology.
- Patient experience and involvement forms part of the pillars of quality, using Civica to include stories and thematic experience data.
- Establish a forum for learning from triangulation of data, including thematic reviews, develop action plans and shared learning.
- Safe Care Collaborative ongoing.

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.



Safe Care Collaborative - update

Organisational Update

- Learning Session 1.2 – March
  - Stage – Action Period 3
- Presentations at Learning Session 1.2
  - Faculty / infrastructure to support Safe Care Collaborative at ABUHB
  - AMU to Acute Workstream session
- Data lead working with coaches and teams to aid with understanding the current system and above
- Monthly reports for each team set up

Teams Update

- All teams working to identify specific SMART aim for their respective workstreams
- All teams have undertaken process mapping / fishbone sessions to understand current system
- Key family of measures to be updated by next Learning Session – June. Includes outcome, process and balancing measures
- Review of primary and secondary drivers, include initial change ideas
- Operational pressures and end of year leave has impacted progress

Workstream	ABUHB Team	IHI Score
Acute	Medical Assessment Unit at GUH	1.0
	Ward C0 (ENT surgical ward) at GUH	1.5
Ambulatory	Gastro-intestinal Ambulatory Care Unit (GACU) at RGH	1.0
	Monmouthshire Integrated Team	1.5
Community	Clinical Assessment & Treatment in Care Homes (CATCH) at County	1.5
	Mental Health OT Team	1.0
Leadership	Executives, Leaders for Safety, Faculty	1.0

0.5 Intent to participate	Project identified, charter/contract of intent not yet complete, team still forming.
1.0 forming team	Team forming (key individuals assigned) or formed; aim or charter/contract of intent, focus determined; initial plans made.
1.5 Project plan begun	Project Planning documentation (rationale, aims, scope, resources, timescales, measures, expected outcomes, initial focus) begun and project team formed. Team have met.
2.0 Activity but no changes	Initial cycles for team learning begun. Project planning, measurement, data collection, obtain baseline data, study of processes, current state capture.

ABUHB Quality Strategy Delivery Plan

- A Quality Governance Day with Exec Leads and QPS, and QI (ABCi) has taken place.
- Quality strategy delivery plan for 23/24 with an associated Quality Outcomes Framework in progress
- Governance and reporting subject to review with streamlined reporting
- Quality Based Management System being developed access to data in real time & development of a standardised annual quality plan for each Directorate using pillars of quality
- Further work on Patient experience using Civica to include stories and thematic experience data.
- Triangulated learning data to be published to include actions taken and an evaluation of the impact.
- Standardised format of reporting for Directorate and Divisions to report Patient Safety and Quality outcomes.
- Understanding capacity and knowledge gaps, and where capability is needed to implement the strategy.

Next steps

- Person centred approach - directly involve our patients and staff
- Review and monitor WG Quality & Engagement Act deliverables
  - Duty of Candour
  - Duty of Quality
- Implementation of both Quality strategy and Patient Engagement and Involvement Strategy
- Key objectives for Quality & Safety outlined for the next twelve months for monitoring, review and evaluation
- Workplan as part of Quality Strategy will map goals and timeframes with SMART objectives and a Quality Outcomes Framework
- Safety walk arounds being reinstated
- Review of QPS resources
- PTR and QPS teams working together to develop a plan for learning and sharing of incidents
- Strengthened Divisional learning / reporting through Governance structures and standardised agendas
- Data and reporting for improvement to be strengthened from ward to board working with external expertise where appropriate
- Embed an open and transparent learning organisation, with a Just culture, incorporating psychological safety, human factors and wellbeing

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Diversity and Inclusion	Person with Autism wanted support to volunteer.	• Coordinator met with the young person the hospital site to talk through and guide him in the recruitment process. • Volunteer Engagement Strategy has been revised to ensure inclusive opportunities. • Contact made with Autistic Minds to support other young people to take up volunteering opportunities.	Person is so keen to become a volunteer and very happy that we have agreed to him doing this. Positive impact to persons sense of purpose. Volunteer Framework reviewed to ensure inclusion and opportunities are extended to those with additional needs.	His recruitment will be divided into small steps to enable him to complete his documentation and checks with our support. Establish with Autistic Minds how to further promote volunteering opportunities for people with Autism.
Dementia and Hospital Care	Relatives distress around poor communication and visiting.	• Relaunched Johns Campaign and posters for wards. • Hospital Charter Animation developed - public awareness • 16 wards involved in VIPS dementia Improvement Pilot • Dementia Champions • Training in place • PLO service in GUH • Business case for PALS being developed.	Flexible and improved visiting for carers. Public awareness of Hospital Charter and commitment of ABUHB to improve inpatient dementia care. Dementia Charter animation for the public developed.	Increased public engagement events. Promotion of 'Experts by Experience' to increase the number of people we can discuss dementia care with.
Mental Capacity Act	Staff concern around capacity assessments and relative/auditors concerns around DNACPR.	• Staff awareness films developed which take staff through what needs to be considered. Memo to staff around DNACPR and dedicated staff training video produced. • Rolling programme of MCA training now in place, including Best Interest Assessments.	More staff now have access to educational resource. Dedicated team of MCA Specialist Practitioners employed following successful bid to Welsh Government. These Practitioners support clinical staff in clinical practice.	Continued MCA training and support. Animation to be produced specifically around consent. Training for staff in Mass Vaccination Centres- best interests.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Patient Education (Options, Advice and Knowledge-OAK)	Patients with Osteoarthritis of the Knee (OAK) and Menopause unable to access self management education during COVID.	• Online patient education sessions established. • Advertised through pharmacy, GP practices and via Social Media.	Online education sessions has enabled more people to access self-management education. 50 people have attended OAK Menopause sessions to date in 2022-23. 61 people have attended the OAK Knee sessions from April 2022 – Jan 2023.	Continue with online sessions and explore community venues for face to face. Continuing to promote with posters sent electronically to GP Practices and laminated posters sent to Pharmacies and Leisure Centres. Consideration of an OAK session for people needing information regarding MCA and consent (to be discussed).
Volunteer to Career	National drive to value the contribution of volunteers and opportunities for paid employment for volunteers. Volunteers have requested opportunities to gain paid employment.	• Partnership with Helpforce. First Health Board in Wales to pilot Volunteer to Career initiative. • Funding for 1 WTE administrator to support Volunteer to Career initiative. Job Description for Patient Wellbeing.	First Volunteer to Career paid post now recruited at RGH. Another volunteer has secured a WTE HCSW position in Mental Health Services due to volunteer experience. Reporting via Bevan Commission later in 2023. A Patient Wellbeing Assistant post was funded via Charitable Funds and ring fenced for volunteers to apply for based on their volunteering experience should they not have the required qualifications.	Engagement with Job Centres to encourage those who may be unemployed to apply for Volunteer to Career Opportunities. This VtC pathway is now developed and consideration is being paid to this initiative being 'business as usual' especially for groups of people who may be more challenged in finding employment. We are already working with Autistic Minds and one of their members is also on the pathway.
Pharmacy Student 'Experience' Placements	Request from University for Pharmacy Students to gain experience in communication with patients.	• Worked with University. Pharmacy student placements on wards engaged with patients in meaningful activity.	Students have a better awareness of the art of communication that they will be able to take with them in professional practice.	Continue to explore ways to offer students 'experience' placements that support and compliment professional education.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Boredom and Isolation	Feedback from patients around boredom during hospital stays.	• Meaningful activities resource provided to all ward areas, secured through Charitable Funds and Dementia Monies. • Training programme developed and being rolled out.	All inpatient wards now have access to meaningful activity resource. More staff trained in the benefits of meaningful activities. More Dementia Champions trained across wards. Less boredom for patients.	To explore how meaningful activities would better support those with behaviours that challenge (often requiring enhanced care). Audit of impact in progress. Dedicated recruitment drive for more volunteers to support meaningful activities.
Loss and Dementia	Feedback from staff about managing and anticipating loss.	• Partnership with Cruse to develop Anticipatory Loss education for staff. Piloted and successful. Training being delivered.	Staff will be able to better support patients and families/carers of those with dementia to anticipate and deal with loss.	To roll out Anticipatory Loss training and consider e-learning module.
Dying Alone in Hospital	Concerns from relatives that loved ones may be dying alone, particularly during the pandemic	• Secured funding from Helpforce to develop end of life Companion service • 60 End of Life Companions recruited.	Companions have supported people on hospital wards who are dying. Provision of 'respite' for carers who may be unable to visit or need a break. Opportunities for those at risk of dying alone to have access to a Companion. Increased use of technology to connect patients and families. I-Pads have been used for patients to say goodbye.	Ongoing promotion with need to increase staff and direct referrals.
Patient Feedback	There has been no structured, coordinated real-time method of collecting and managing patient feedback.	• The Once for Wales Patient Feedback System (Civica) is now live and being rolled out across the HB. Staff are invited to training and an initial Person Centred Care survey has been designed and will be shared to all appropriate sites on the hierarchy.	Patients will have an opportunity to give anonymous feedback and staff will be able to access this in real time. This will allow staff to respond and take appropriate actions on a continual process.	The roll out of the system is ongoing until all staff are familiar with it. Further surveys can be designed as a result of the initial PCC survey results. Other bespoke surveys can be created for areas where needed.

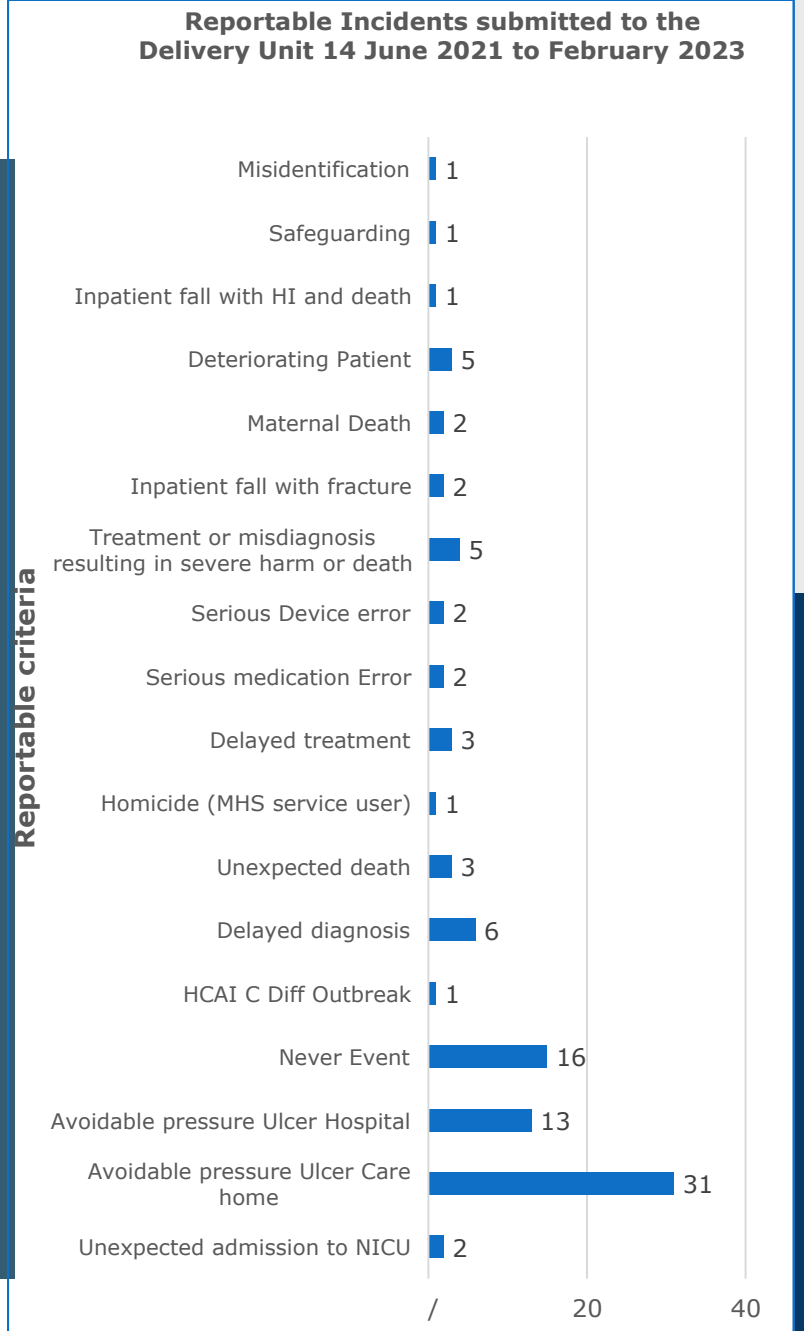
Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Support during Cancer Investigations and Treatment	Patient feedback around lack of psychological support when going through diagnosis and treatment.	• £300,000 secured from NHS Charities Together to develop psychological support service. Person Centred Care Team working with Cancer Leads on new volunteer roles. Currently in discussion about supporting 5 of the cancer pathways with volunteers. Diversity and inclusion considered throughout and working to develop Peer Support for people from diverse backgrounds or with additional needs. • SignLive implemented across cancer services, improving BSL access for people who are Deaf and accessing cancer services.	New in development. People will have better access to psychological support prior to diagnosis, at the point of diagnosis, when going through treatment and in recovery.	Continue to develop the psychological wellbeing service. Focus on diverse groups going forward especially those people who identify as LGBTQ+, Black and Minority Ethnic Groups and people who are Deaf.
Dementia- Citizen Engagement	People have told us that they are not always aware of how to access dementia care and some are expressing concerns around how to seek support.	• Series of Webinars held for the public, patients and staff. • Dedicated dementia email address for people to contact- aids better signposting • Developed Expert by Experience group of people living with or caring for someone with dementia- to inform Health Board of what needs to change.	Improved point of contact access for patients and better signposting when people have concerns. Better awareness of National Dementia Standards with ongoing promotion. Increased communication via Social Media which encourages people to help us shape and influence dementia care. 2 x dedicated Community Listening events in Maindee and Caerleon (supports Wales Listens Campaign).	To recruit members of the public as 'Community Listeners' across all boroughs- 2 year programme needed to support. Expand 'Expert by Experience' and community listening events.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Dementia-Citizen Engagement	People have told us that they are not always aware of how to access dementia care and some are expressing concerns around how to seek support.	• Series of Webinars held for the public, patients and staff. • Dedicated dementia email address for people to contact- aids better signposting • Developed Expert by Experience group of people living with or caring for someone with dementia- to inform Health Board of what needs to change.	Improved point of contact access for patients and better signposting when people have concerns. Better awareness of National Dementia Standards with ongoing promotion. Increased communication via Social Media which encourages people to help us shape and influence dementia care. 2 x dedicated Community Listening events in Maindee and Caerleon (supports Wales Listens Campaign).	To recruit members of the public as 'Community Listeners' across all boroughs- 2 year programme needed to support. Expand 'Expert by Experience' and community listening events.
Patient Narratives/ Stories	We have heard several stories from patients or their relatives as a result of their experience in our care. These have been made into films to be shared at learning events.	• Films have been shared with the senior staff who have shown these films to clinical staff so that learning and responsive actions may be taken. The people who have told the stories have been updated on any actions and responses.	Patients/carers have been give an opportunity to share their experience journey. Patients/family are updated on actions taken. Some families are now part of the 'Expert by Experience' Group. Staff have given positive feedback about impact of the stories and are able to learn from peoples lived experience.	To continue to offer people the opportunity to discuss their experiences. To develop a Community of Practice for staff, patients and families to share and promote best practice.

National Reportable Incidents



From the 14 June 2021, the reporting framework was changed whereby only incidents categorised as severe harm were required to be reported.

Data captured is from 14 June 2021 when phase 1 of the new reporting framework was introduced to 24 March 2023.

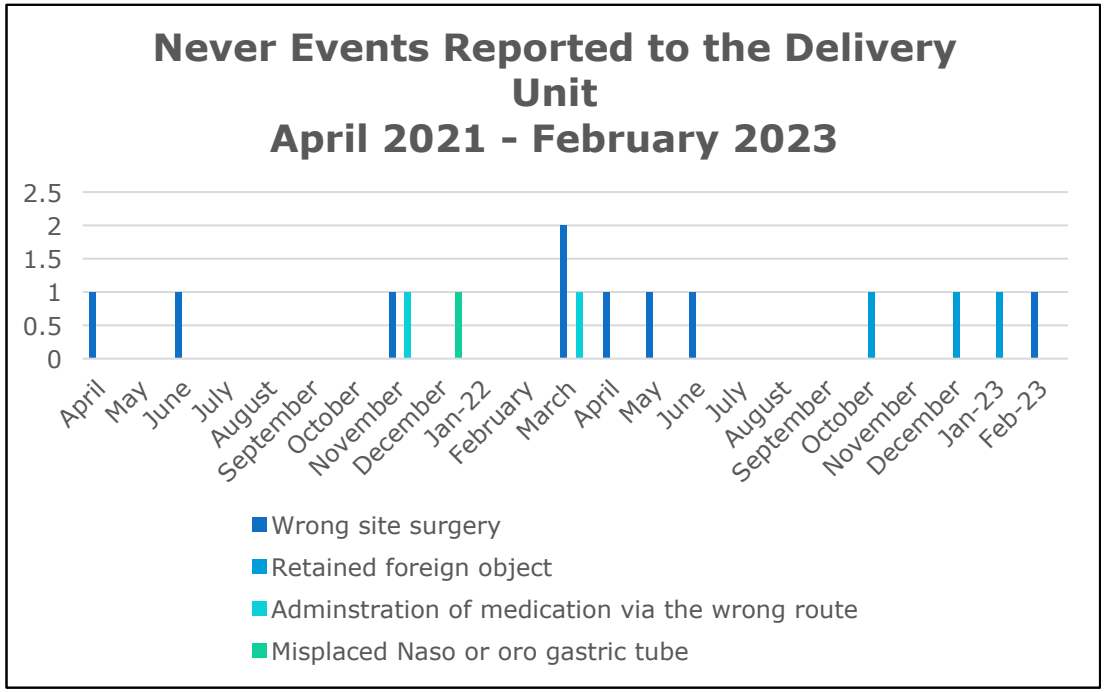
A total of **97** incidents were considered to meet reporting criteria and were submitted during this period.

Currently ABUHB benchmarks below comparator organisations for reporting of NRIs. Data has been supplied by the DU and an internal benchmarking and review exercise is underway to review decision making and reporting against the new reporting framework

Learning and Improvement

- Despite ongoing public engagement some members of the public and staff from partner agencies (social services) are unaware that eLGHs do not have an Emergency Department.
- Site teams are expected to respond to unwell self-presenters in the Minor Injury Units (MIU) and to be reminded of their role and responsibilities when patients present. Self-presenting deteriorating patient Action Cards to be reinforced with the medical teams. Roles and responsibilities are discussed at medical induction and are repeated at each changeover.
- Lack of familiarity with AKI policy especially in relation to the use of IV contrast
- Urea as a stand-alone option on e-blood test requesting led to a full electrolyte profile not being performed. This option has now been removed.
- Lack of recognition of new confusing being a sign of clinical deterioration
- Investigation has highlighted that there is no security presence at YYF which would have been helpful in supporting AMU with a sectioned patient that kept absconding. Also highlighted is a need for there to be better understanding or referral and escalation process for medical patients requiring MH input, especially in moments of crisis, and also better all-round links between MH and acute. Although this incident was at YYF, the process issues could have occurred anywhere on our acute sites.

Never Events



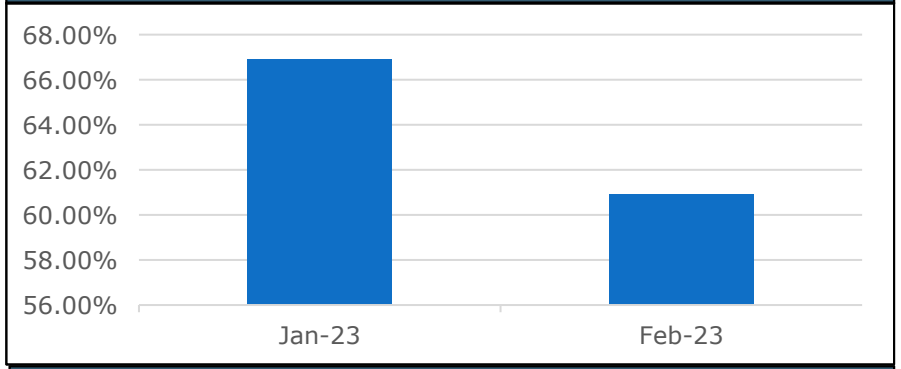
- 2 x new NE were reported during this period - retained swab and wrong site surgery
- NRIs - 12 out of the 15 reported NEs are surgical related (highest reporters of wrong site surgery & NEs comprise 5% of NRIs nationally).
- ABUHB aware of its high number of wrong site procedure Never Events. A large amount of improvement work has gone into making processes more robust, using systems thinking lens for investigations, training IOs using Human Factors and the introduction of the Theatre Safety Collaborative Group for education, sharing and learning.
- There is a Health Board wide wrong site procedure action plan.
- In response to thematic reviews around deteriorating patients, Never Events, and missed/unacted upon radiological findings, these themes have been assigned Senior Exec leads to oversee improvements.

Issue	Cause	Remedial Action	Who	When
Since July 2022 NHS Wales Never Event reporting criteria have changed	Directive from Welsh Government in line with NHS England Removed incidents: Wrong tooth extraction Oesophageal intubation Intravenous administration of medicines intended for epidural route - during implementation of NRfit	SI Team still monitor DATIX for these incidents	PTR SI Team	Ongoing
		Improved search capability on DATIX for key words in these incidents	ABUHB H&S Team	
		Liaise with Divisions when these incidents are identified	Divisional QPS leads	
Embedding of organisational learning from Never Events/SIs and complaints	Organisational memory Turnover of staff	Meeting TBA with Clinical Execs to discuss Never Events and thematic reviews to identify overarching risks and recurrent incidents.	PTR and Clinical Execs	Complete
	Learning from Never Events not embedded within the organisational culture.	Explore a repository of completed and appropriately redacted investigations and action plans – Intranet page.		
		Undertake a review of most recent Never Events focusing on learning. Additionally, a meeting is to be arranged with Theatre Senior Management Team.	Medical Director	Complete
		Monthly Theatre Safety Meetings have been reinstated.	Scheduled Care Triumvirate	Ongoing

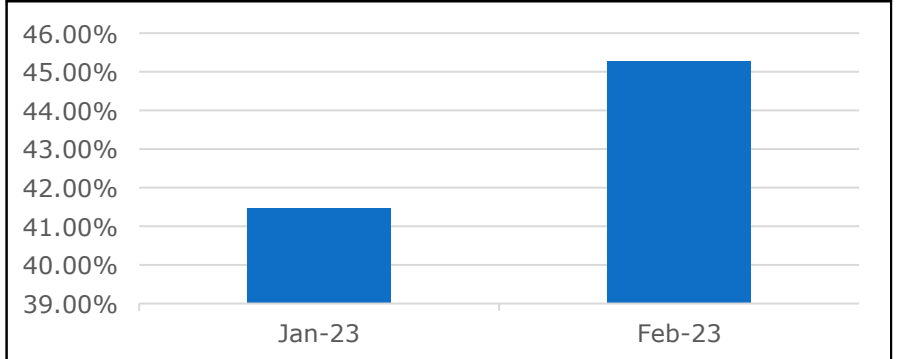
JANUARY– FEBRUARY 2023

Complaints and SIs

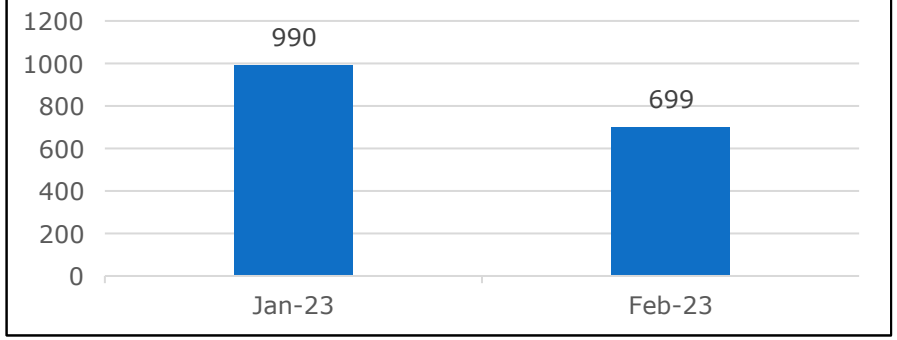
Early Resolution Performance



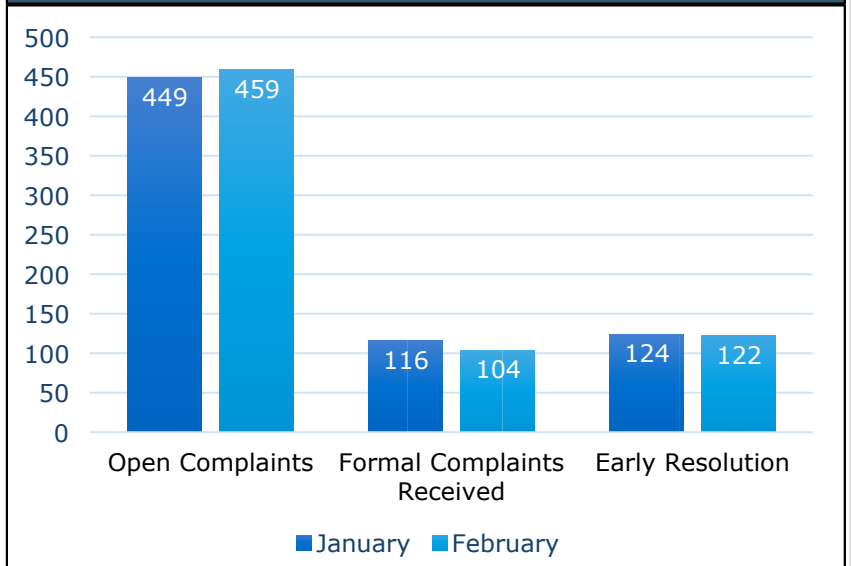
Performance



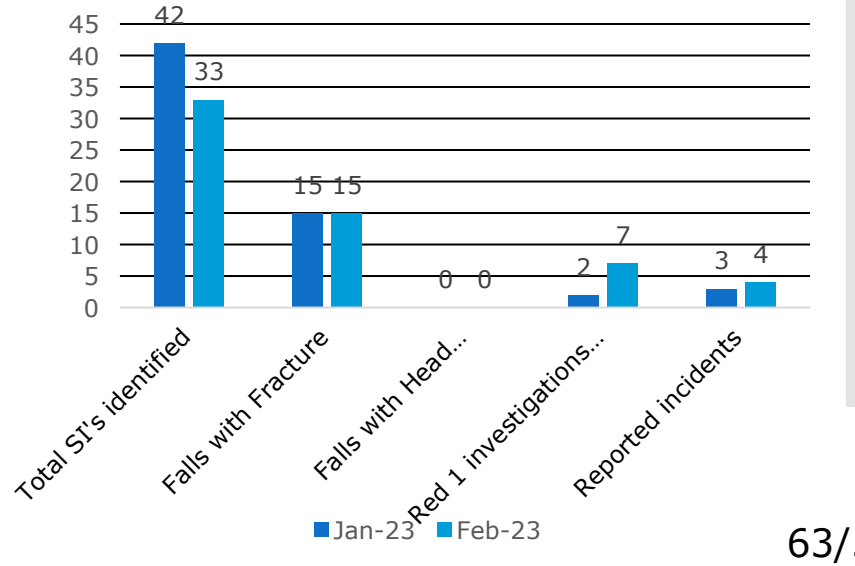
Enquiries Recorded by Patient Liaison Officers



Complaints Data January to February 2023



Serious Incidents captured January to February 2023



Complaints and SIs

Issue	Cause	Remedial Action	Who	When
Reduced compliance in closure of formal concerns within 30 working days	Divisional operational pressures resulting in reduced prioritisation of Complaints and SI process.	▪ Meetings undertaken with Divisional Triumvirates, QPS leads and Complaints Coordinators to revisit process and expectations. ▪ Face to face training commenced February.	Assistant Director of Nursing /PTR Senior Team	Ongoing
Reoccurrence of similar incidents –including Never Events, Deteriorating Patients and missed/unacted upon radiological findings	Inconsistencies across organisational teams/sites in processes undertaken	▪ An Executive has been assigned and is taking the lead on the individual work streams ▪ Two sessions being undertaken on the Delivery Plan for the Quality Strategy.	Executive Directors/ ADQ&PS and Senior PTR Team	27 March and 20 April 2023/ongoing
Unable to consistently achieve compliance for completion of Patient Safety Incidents	Challenges for key colleagues to attend diarised meetings Operational pressures of IO's in completing investigations Ongoing sickness in Corporate SI team	▪ Multi disciplinary Team meetings to establish level of investigation. ▪ Closures dates discussed weekly at the Exec Safety Huddle. ▪ Clear pathway for escalation for delayed processes. ▪ Face-to-face training commenced February.	ADON /Senior PTR Team	Ongoing

Claims, Redress & Inquests

ABUHB Legal Services oversee the management of clinical negligence claims, personal injury claims, concerns progressed under the PTR Redress Scheme, and Coroner inquests.

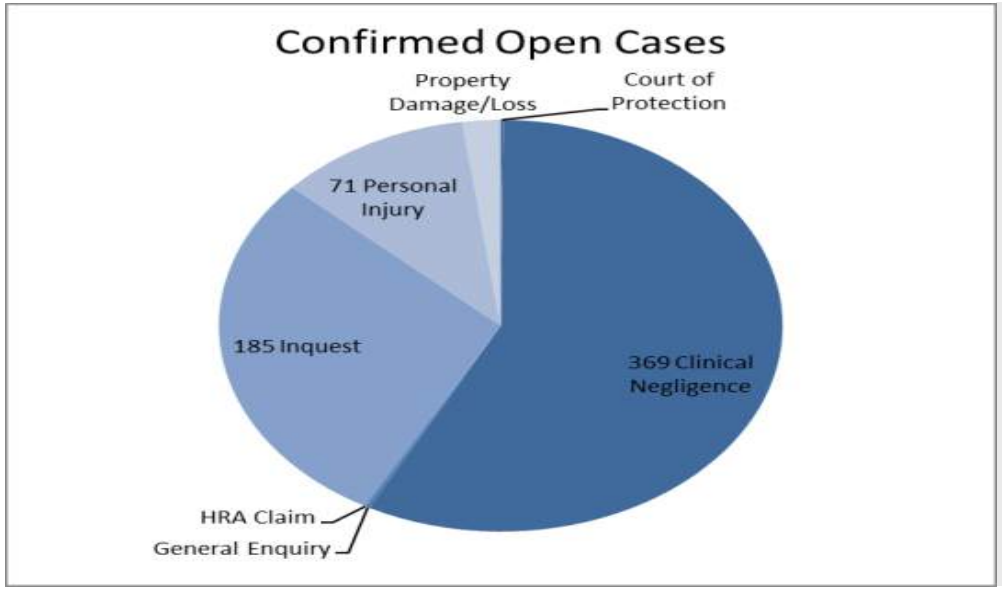
Clinical negligence claim numbers remain steady at **369 (60%)**.

Personal injury claims continue a year on year reduction, currently at a **10 year low**, representing only **10%** of the claims portfolio.

ABUHB Redress Panel determines if a **'Qualifying Liability'** exists in concerns up to £25,000. Two Panels were held in January and February 2023 with a total of 11 cases determined.

'Live' Coroner inquests remain high at **185**, this being **30%** of the overall portfolio.

There were 3 'live' Coroner **Regulation 28 Reports** during the period January-February 2023.

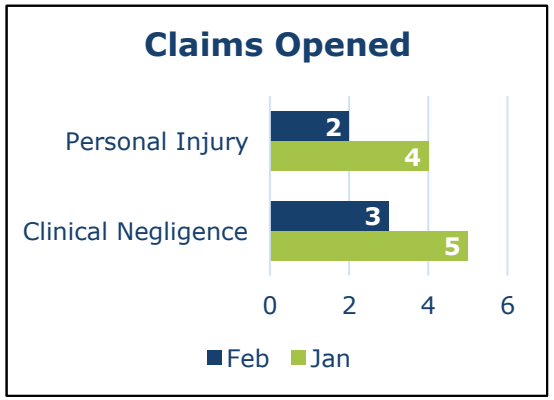


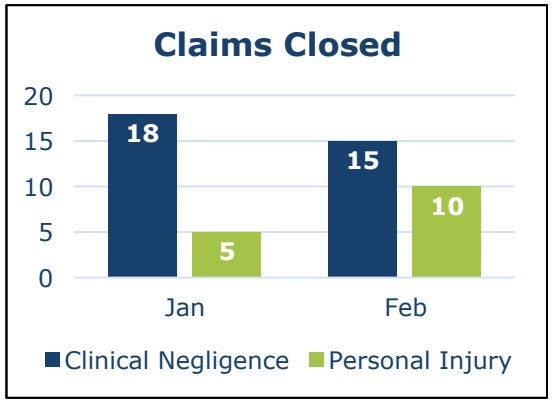
For the period to **31 March 2023** there are **641** live claims/ inquests across the Health Board.

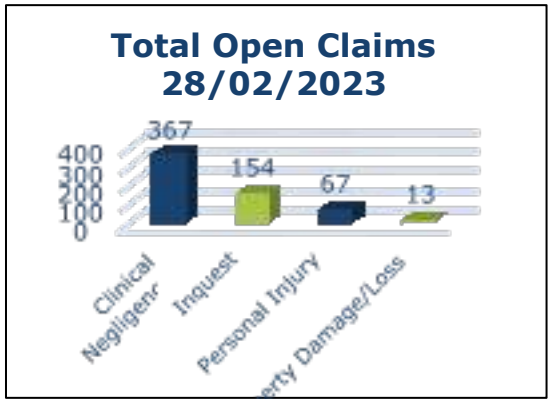
Clinical negligence (**60%**) continues to be the highest followed by inquests (**30%**).

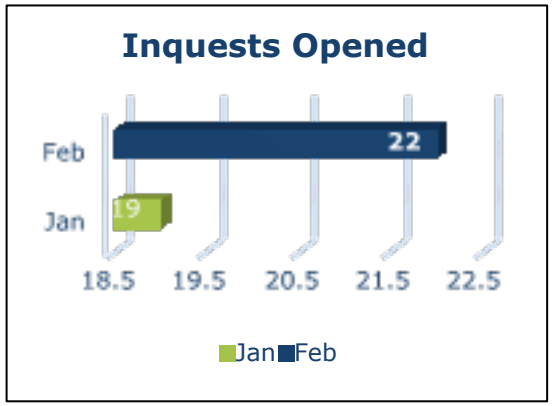
January - February 2023

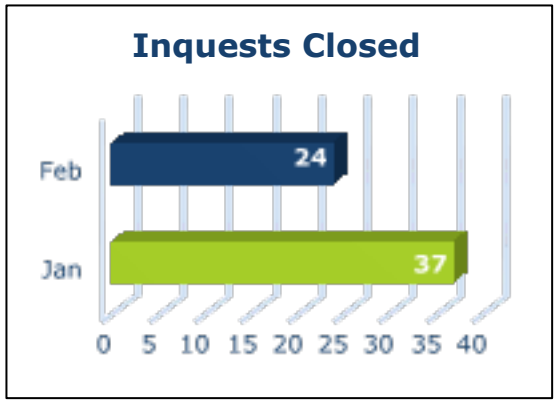
Claims, Redress & Inquests

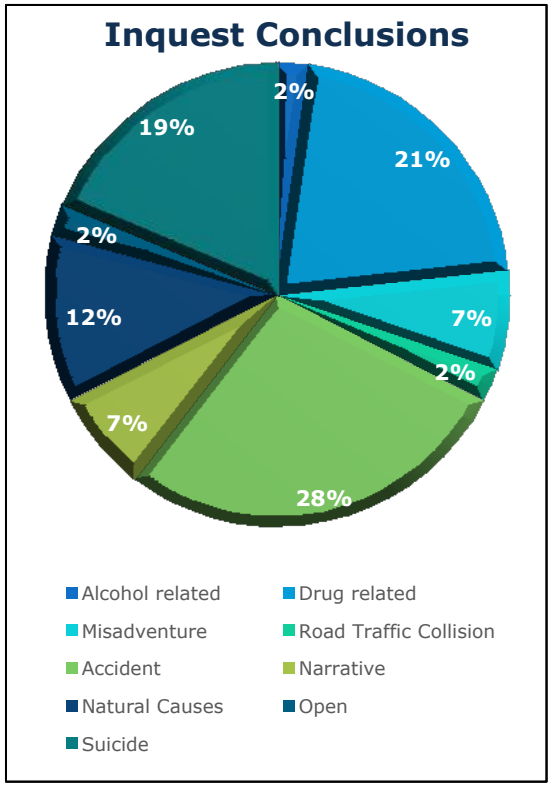


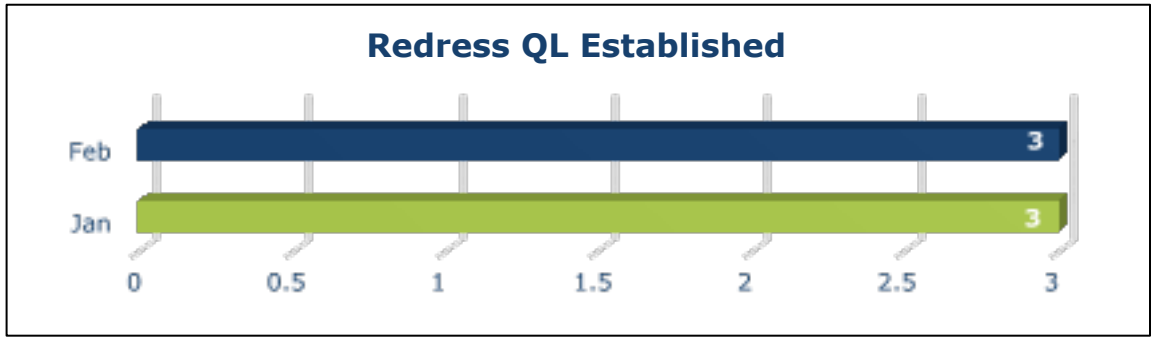












Claims, Redress & Inquests

Learning and Improvement

- HM Coroner for Gwent has commented positively on the significant improvement in quality of witness statements and Serious Incident reports from the Health Board, leading to timely answering of questions from families, and reducing the number of staff required to attend inquests in person.
- All Claims and Redress matters require submission of *Learning From Events Reports* to the Welsh Risk Pool. Our learning/assurance/actions are scrutinised by a clinically led *Learning Advisory Panel.* WRP have recently reported positively, confirming no financial penalties to the Health Board for failure to comply with submission of learning/requested additional evidence.
- NWSSP Legal & Risk services have reported significant improvement in timeliness and responsiveness of ABUHB Legal Services team. There were minimal delays on cases/instructions and no late submission of new case referrals.

Issue	Cause	Remedial Action	Who	When
Regulation 28 Reports issued by HM Coroner: Health Board assurance as to prevention of future deaths	On conclusion of inquest Coroner has identified areas of concern that could give rise to future patient harm/deaths requiring attention/assurance from the Health Board	• Submission of detailed learning/Actions Plans ahead of inquest; identify suitable witnesses to give evidence at inquest • Process introduced for timely internal management and QA following receipt of Coroner report • Monitor and Tracking Report to ensure compliance	Head of Legal Services	Ongoing
Responsiveness to Coroner requests; timely submission of witness statements & SI reports; meeting expectation of Coroner and families; risk of reputational harm	ABUHB has high numbers of Coroner requests and inquests held within the Gwent area. This has a significant impact on staff numbers involved in an inquest, time and resources.	• Members of team have been dedicated to Coroner work to reduce backlog and provide timely responses. • Support provided to staff across the Health Board during their inquest journey • Regular meetings with Coroner to address issues and work constructively together	Head of Legal Services	Ongoing
Learning and Financial Reimbursement submissions to Welsh Risk Pool within prescribed timeframes. Financial penalty and/or risk of refusal to reimburse	Every claim requires submission of learning. Financial reimbursement only granted once full vetting and assurance of all learning/actions	• LFER status tracked on rolling basis to meet deadlines • Monthly reporting to track all payments made • Monthly updates on upcoming submission deadlines	Head of Legal Services	Ongoing
Full adoption of RL Datix case management modules / migration to electronic management/ development of Dashboards	Historically matters managed via Datix rich client and paper files. WRP emphasis on RL Datix for management & reporting, with information held electronically.	• Ongoing migration to full RL Datix adoption • In house RL Datix training sessions to aid ongoing adherence • Trialling of move from paper to electronic in sectors of work	Head of Legal Services	Ongoing/ October

Health, Safety & Security

The Health and Safety Executive (HSE) have **two ongoing cases** within the Health Board.

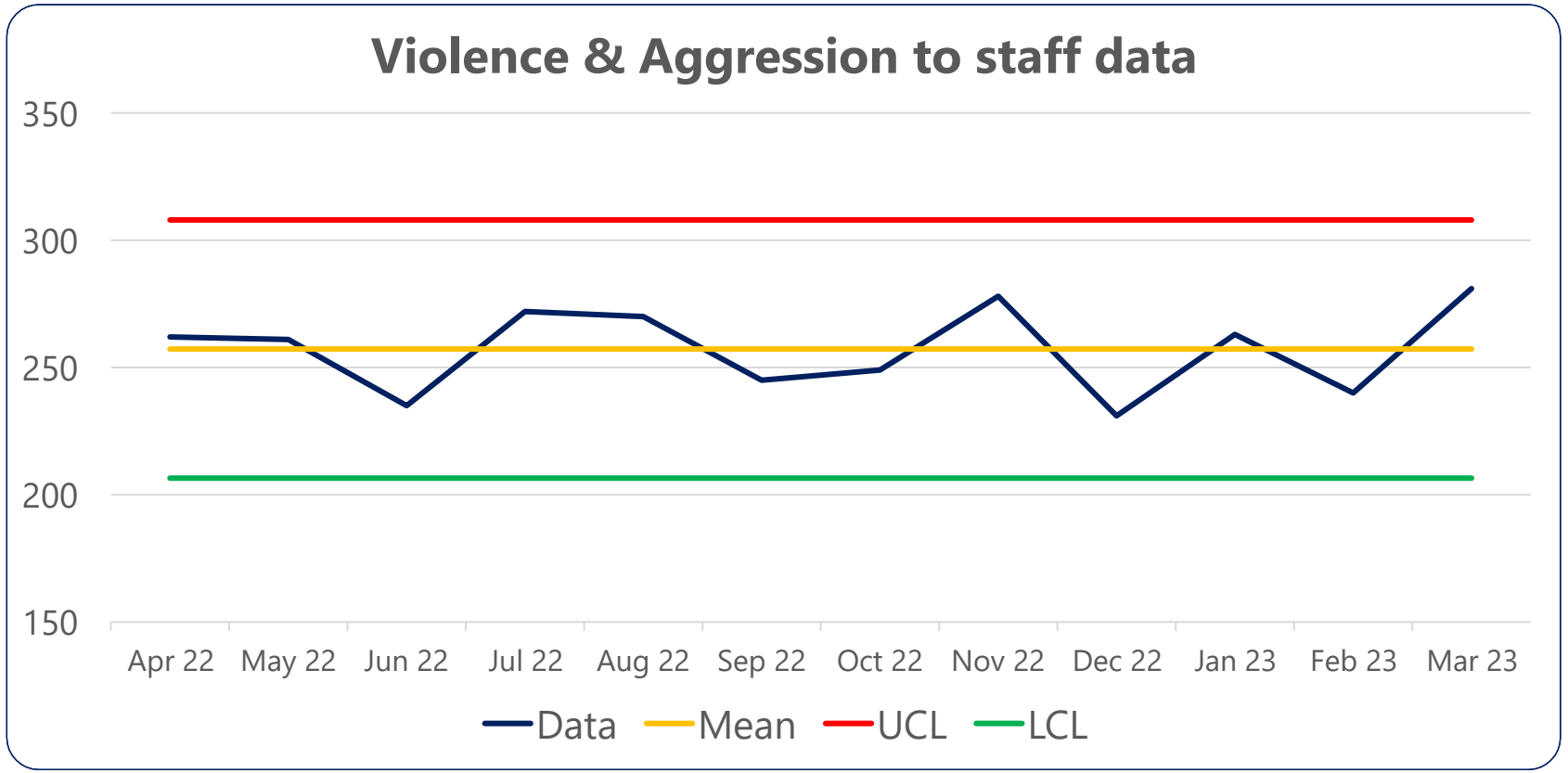
A patient fall at Nevill Hall Hospital and an inspection of Pathology at Royal Gwent Hospital.

During 2022/23 the Health Board reported **79 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

49% of these cases were reported within the legal timeframes within the legislation.

Health, Safety & Security

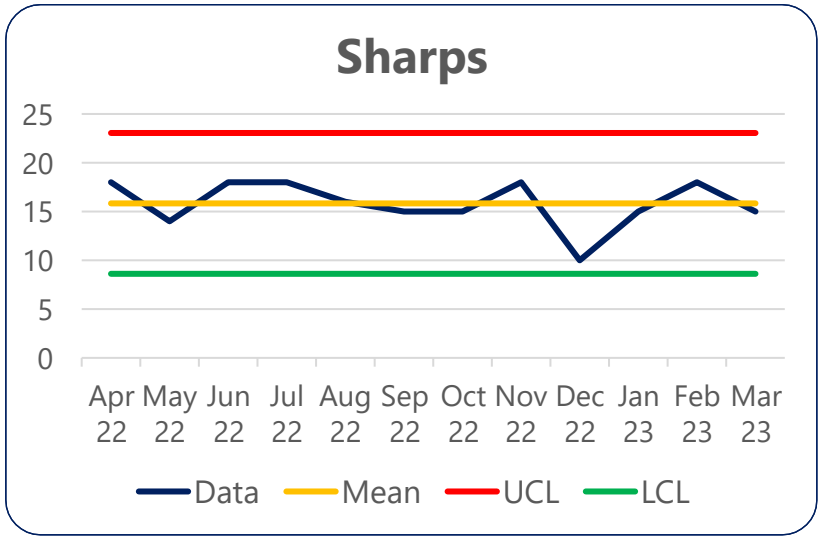
During the period **April 2022 to March 2023** there have been approximately **2,500 incidents** affecting staff. **Violence & aggression** continues to be the highest reported staff incident

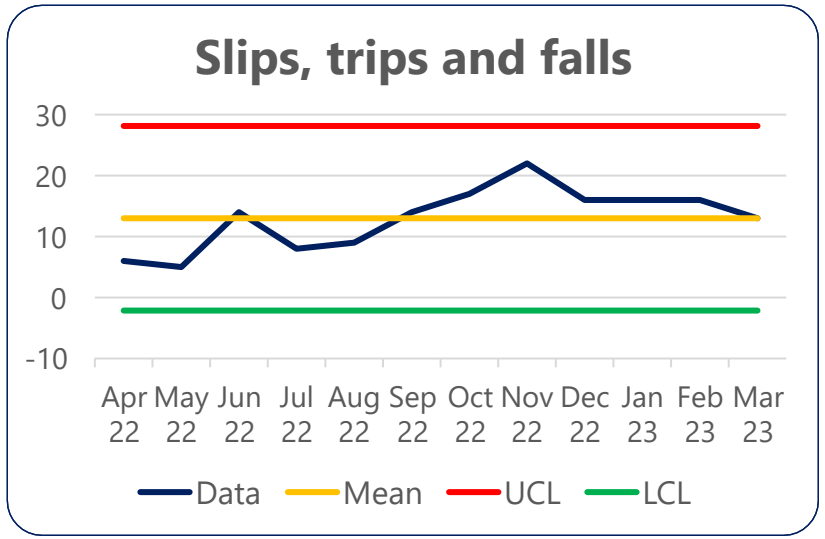


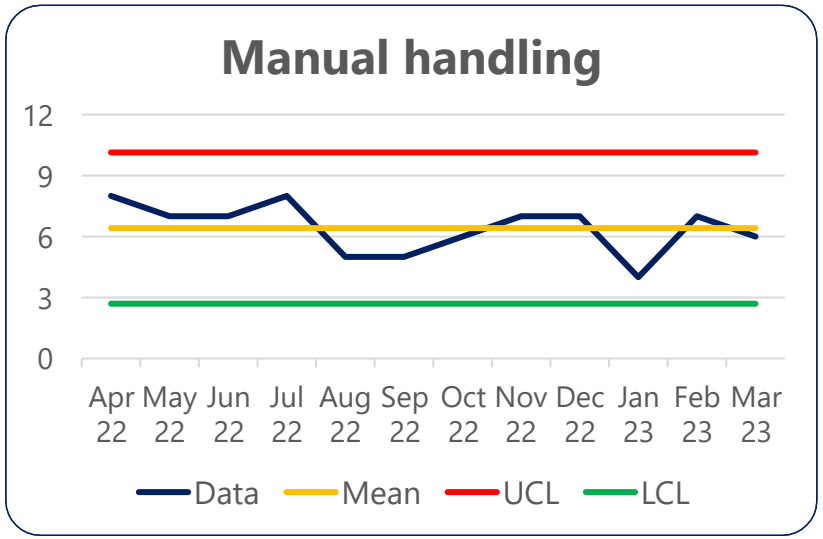
Health, Safety & Security

The graphs represent staff related incidents during 2022/23

Manual handling training compliance is currently **50%**







Health, Safety & Security

Issue	Cause	Remedial Action	Who	When
Reporting cases to the Health and Safety Executive within the legal timeframes. Compliance for 2022/23 is £49%	Failure to obtain intelligence to support the decision to report incidents to the HSE	• Conduct an audit to identify the gaps in compliance • Raise awareness regarding the reporting of incidents in accordance with RIDDOR via a health and safety information sheet • Monitor RIDDOR compliance regularly via the ABUHB Health and Safety Committee	Head of Health, Safety & Fire	April 2023
Violence and aggression towards staff	Abuse to staff continues to be the highest health and safety reported incident towards our workforce	• Plan to benchmark data across NHS Wales • #BEKIND Campaign • Delivery of face-to-face training for targeted areas	Head of Health, Safety & Fire	May/June 2023
Manual handling training compliance. Compliance at February 2023 is 50%	Limited resource within the Corporate Health and Safety Team to meet the demands	• Develop a plan to deliver a sustainable manual handling education programme	Head of Health, Safety & Fire	April 2023

Infection Prevention

ABUHB – Reduction Expectation Goals

Wales 2022/23 HCAI mandatory surveillance summary, Apr 22 - Feb 23

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

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

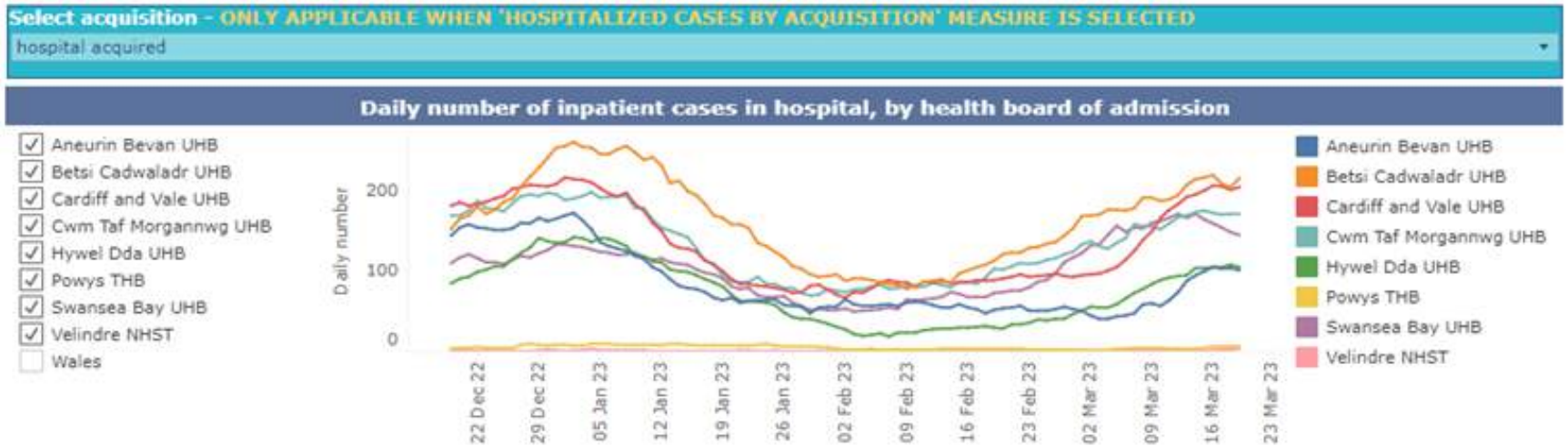
	C. difficile		MRSA bacteraemia		MSSA bacteraemia		S. aureus bacteraemia		E. coli bacteraemia		Klebsiella sp bacteraemia		P. aeruginosa bacteraemia		Gram negative bacteraemia	
	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate
Aneurin Bevan UHB	174	31.79	11	2.01	114	20.83	125	22.84	290	52.98	110	20.10	16	2.92	416	76.00
Betsi Cadwaladr UHB	267	41.48	15	2.33	154	23.93	168	26.10	460	71.47	133	20.66	35	5.44	628	97.57
Cardiff and Vale UHB	131	28.38	11	2.38	117	25.34	126	27.29	278	60.22	111	24.04	23	4.98	412	89.25
Cwm Taf Morgannwg UHB	98	23.81	4	0.97	134	32.55	138	33.53	351	85.27	77	18.71	35	8.50	463	112.48
Hywel Dda UHB	190	53.28	12	3.36	89	24.96	101	28.32	303	84.96	107	30.00	26	7.29	436	122.26
Powys THB	12	9.86	0	0.00	0	0.00	0	0.00	1	0.82	1	0.82	1	0.82	3	2.46
Swansea Bay UHB	180	50.32	11	3.07	126	35.22	137	38.30	241	67.37	96	26.83	40	11.18	377	105.38
Velindre NHST	3		0	0.00	2		2		10		1		0		11	
Wales	1,055	36.37	64	2.21	736	25.38	797	27.48	1,934	66.68	636	21.93	176	6.07	2,746	94.68

Current Position

E Coli	E coli a total of 291 cases of E coli reported from Apr 2022 to Feb 2023. This is -8% fewer than the equivalent period 2021/22. Provisional rate is 53.16 per 100,000 population.
C diff	C difficile a total of 175 cases of C diff reported from Apr 2022 - Feb 2023. This is -7% fewer as than the equivalent period 2021/22. Provisional rate is 31.97 per 100,000 population
Klebisella	111 cases of Klebsiella reported from Apr 2022 to Feb 2023. This is 29% more than the equivalent period 2021/22. Provisional rate is 20.28 per 100,000 population
Staph aureus	Combined MSSA and MRSA a total of 124 cases of Staph aureus bacteraemia reported from Apr 2022 - Feb 2023. This is 4% more than the equivalent period 2022/22. Provisional rate is 22.84 per 100,000 population
Pseudomonas	A total of 16 cases of Pseudomonas reported from Apr 22 to Nov 22. This is -42% fewer than the equivalent period 2021/22. Provisional rate is 3.11 per 100,000 population

Infection Prevention

ABUHB – Covid-19



Current Position

Inpatients	Currently 58 however range over the past month is from 29 to 103.
Outbreaks	1 ward and 4 bays under observation which is a significant improvement from 6 wards and bays affected.
Care Homes	7 in outbreak, 10 with incidents of Covid and 100 Covid free – remained reasonable stable throughout reporting period.

Infection Prevention

Reduction Expectation Goals

Issue	Cause	Remedial Action	Who	When
Reduction of healthcare associated infections	• Antimicrobial stewardship & resistance • Slippage with proactive deep clean • Fundamental Infection Prevention measures not sustained at 95% • High acuity of patients • Secondary infections post Covid-19 • Increase in patients presenting septic in secondary care • Increase in waiting times for elective surgery for biliary conditions • Increase in capacity and boarding patients	• Action plan developed ongoing monitoring via RNTG • Roll out of Antimicrobial risk kit (ARK) • Aseptic Non Touch Technique (ANTT) roll out • Focus on care bundles & device management • Deep Dives re: MRSA indicated learning re admission screening and decolonisation treatment • Draft proactive HPV programme developed	Divisional Management Team Antimicrobial pharmacist Infection Prevention Team	Monthly review via Reducing Nosocomial Transmission Group
Respiratory virus Covid/Influenza The number of hospital outbreaks 17 areas affected during this reporting period	• Shared facilities in eLGH sites • High acuity and level of care for patients • Patients grouped together to support safe staffing • National trends, influenza activity is still increasing • Increased visitors	• Inpatient and staff testing for symptomatic only • Ongoing promotion of prudent Infection prevention measures • Continual review of patient pathways • Step down guidance updated • Promote vaccine programme “its not to late” • Continue to promote face coverings within patient areas	Divisional Management Team Infection Prevention Team	Monthly review via Reducing Nosocomial Transmission Group

COVID-19 Investigations

Part A

	Wave 1 (27/2/2020 - 26/7/2020)	Wave 2 (27/07/2020 - 16/05/2021)	Wave 3 (17/05/2021 - 19/12/2021)	Wave 4 (20/12/2021 - 30/04/2022) **	Live 01/05/2022 -
Total Incidents	316	1111	321	1023	1647
Investigation Not Started	0	993	186	770	1226
Under Investigation	0	34	1	21	96
Downgraded / Recategorised	32	24	105	187	325
Referred to Scrutiny Panel	0	30	1	0	0
Completed Investigations	284	30	28	45	0
Check +/-	0	0	0	0	0
Deaths	147	372	50	116	157

Part B

Care provided was not deemed reasonable	0	0	0	0	0
Cases referred to Legal and Risk	0	0	0	0	0

No. cases referred to Legal & Risk

- **Wave 1 - 100% complete**
- **Wave 2 – 7.56% complete**
- **Wave 3 – 41.74% complete**
- **Wave 4 – 22.68% complete**

****Note: Live wave data represents only to 30 March 2023**

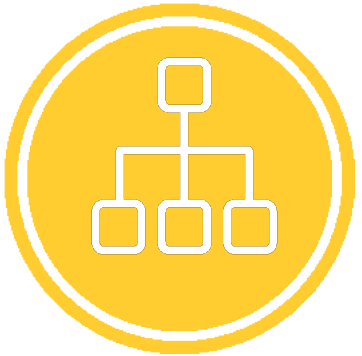
COVID-19 Investigations Programme Risks

Issue	Cause	Remedial Action	Who	When
Delayed start to programme & resource to complete programme on time.	High FTC resource & high risk of losing resource prior to 31 March 2024.	Requested 3 Month extension (to 30 June 2024) for critical resource to secure programme completion.	COVID-19 Investigation Team (CIT)	On going
Investigation resource to undertake live wave in line with Duty of Candour.	Out of scope of the NNCP framework.	Actions with IP&C	IP&C	On going
Availability & time to locate clinical notes.	Clinical notes sparse for COVID-19 identification & management. Locating pertinent notes due to non-chronological back scans. Mental Health notes in off-site storage facilities.	N/A N/A Liaising with Health Records colleagues	COVID-19 Investigation Team (CIT)	On going

Early Learning Themes from COVID-19 Investigative Process Wave 1

Good Practice - Top 3 Themes

IP&C



Adherence to Policies & Procedures

Communication

Learning - Top 3 Themes

Record Keeping

Testing

Isolation Difficulties

Safeguarding

Current Practice Review

The Corporate Safeguarding team are currently supporting Safeguarding Boards with: -

- 3 Child Practice Reviews
- 2 Domestic Homicide Reviews
- 1 Adult Practice Review

In addition to this we are looking at the learning from a high profile Child Practice Review in CTMUH - **Logan Mwangi**. His life was tragically cut short at the hands of his mother, stepfather and a teenage boy; all of which are now serving custodial sentences.

Key learning for Health is in relation to a previous admission to his local A&E, where his injuries were not shared with the local Authority.

Safeguarding is a thread that must run through all our patient interactions. Consideration for sharing information with Childrens services is sometime necessary. Health has a statutory requirement to report child concerns to the Local Authority, in ABUHB that is a Duty to Report.

Safeguarding

Training and Development

- ABUHB is required to provide Safeguarding Training in relation to Children and Adults in line with national standards.
- Current training compliance:

Level	Adult	Children
1	84%	83%
2	84%	81%

- Safeguarding Level 3 training packages have been re-written to include current themes and up-to-date evidence. Training dates have been planned and are available for booking.
- Roll-out of training to commence in April 2023, with a recovery plan to achieve compliance. Support from Divisions is required to allow staff adequate time to undertake.

Safeguarding

Data Analysis

The Corporate Safeguarding Team have developed a number of data analysis tools, to capture themes and trends. Areas of need can then be identified for focused learning and education.

These include: -

- Child and Adult Duty to Reports
- Child Protection Medicals
- PRUDiC's
- Child Strategy Discussions
- Section 5 Practitioner Concerns

Safeguarding System Assurance

- At this current time there are not robust processes in place to monitor systems in place to safeguard individuals in receipt of ABUHB independent contractor services.
- Conversations are already underway with colleagues in Primary Care to determine how we set expectations and monitor compliance.
- Consideration will need to be given to similar processes for all other independent contractors.

Safeguarding

Issue	Cause	Remedial Action	Who	When
Barriers for Health Board workforce to report children's safeguarding concerns to Local Authorities. Quality of referrals been highlighted by LA's	Despite the introduction of the new online DTR forms, individual practitioners have not been completing forms, whilst the child is in department. Resulting in poor quality and no consent	• DATIX raised to log concern. • Remedial plan offered by Senior nurse in ED. • Education and support continuing from CST. • Highlighted the importance of information sharing, re-enforced learning from Child Practice review, with communications assistance.	Corporate Safeguarding Team Emergency Care Team	ongoing
Poor uptake of adult level 3 training dates	• Staff shortages • Understanding the value of the training for staff groups identified in the intercollegiate document • Awareness of training dates	• Comms engagement with awareness raising • Mapping of staff groups requiring level three safeguarding training • Email out to the divisional leads to raise awareness and encourage participation. • Discussions with ESR to have level three training added to this platform.	Corporate Safeguarding Team	Training will commence in April 2023
CST members attending MARAC meetings Feedback from MARAC co-Ordinator that health opinion was missing.	Due to workload pressures and shortages in the team, a trial was arranged to share MARAC research, but not attend the meetings.	• Planning about how we can resource the 40hr per week it takes to complete all MARAC work. • Reallocate admin budget to employ extra hours, allowing 28hr per week to band 7 core work.	Corporate Safeguarding Team	Ongoing

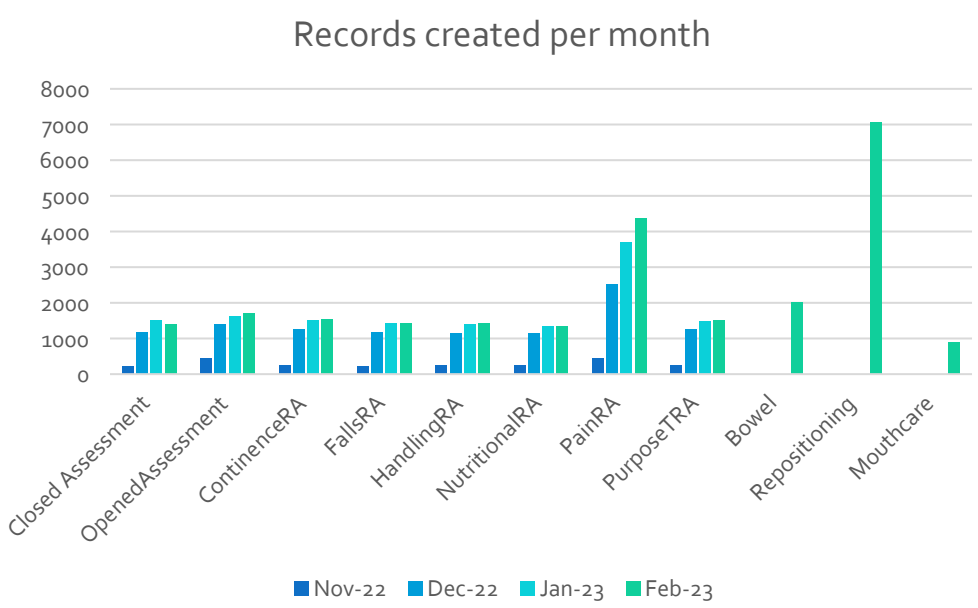
Welsh Nursing Care Record

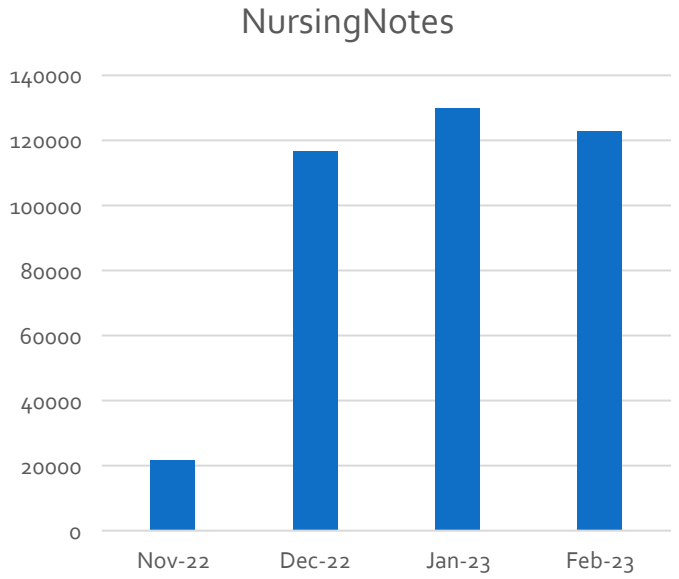
Live in GUH for all adult in patient areas.

Funding available for devices to support the roll out to RGH / St Woolos / YYF.

Rollout planning started for RGH to commence during May 2023.

Version 2.2 released Feb 2023 with bowel, repositioning and mouthcare charts.





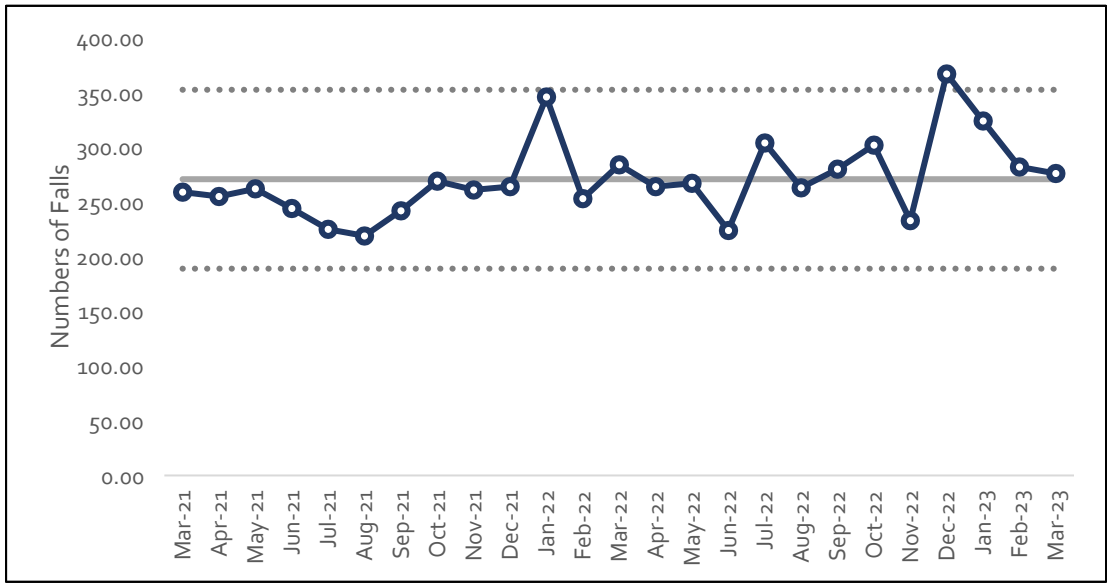
Welsh Nursing Care Record

Issue	Cause	Remedial Action	Who	When
Delay in getting a WNCR record started on two wards	Two wards have issues where the patient pathway on WPAS is not completed for semi-elective patients	Training has been provided to support WPAS pathway selection when booking patients	CNIO	Asap
Dual running across the health board of paper and digital system	The digital patient assessment is only available via Welsh Clinical Portal upon step down	Digital Health and Care Wales are to provide integration with the documents data base (delayed) WCP provided for all nursing staff	DHCW	Q3
Not currently providing qualitative data to ward managers	Work not started on creating dashboard output from data warehouse	Requirements gathering ongoing and mechanisms to provide dashboard being explored	CNIO	Q1
Need a business case for final health board in patient areas	Funding only provided in phases	Business case for equipment for final roll out areas (NHH, Community estate)	Project Manager	Q2

Total Numbers of Inpatient Falls

March 2021-’23

Total = Sum of the falls related incidents reported for the given period



April 2023 - Context

The data used in this I chart has been retrieved from Datix.

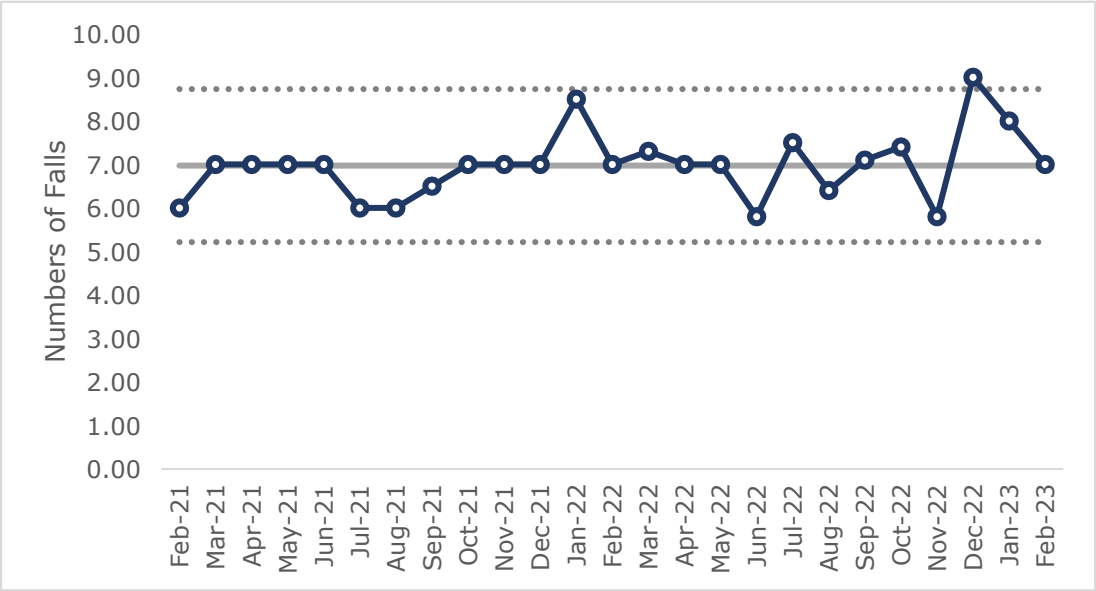
The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period March 2021-2023.

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from Datix as the information source.	• The mean average number of monthly falls for ABUHB has seen a marginal decrease to 270. • For the year 2022-23 incident reporting numbers have been subject to a greater degree of variation as compered to 2021-22 with December of 2022 being marginally above the upper control limit. • January – March 2023 has seen a return to a downward tend with values for February and March being more closely aligned to the mean average.	December 2022 saw the highest numbers of reported falls incidents since January 2022 at 369.

Average Number of IP Falls per 1000 Occupied Bed Days (OBD)

February 2021-'23

OBD = The sum of the number of beds occupied for the given period



April 2023 - Context

The data used in this I chart has been retrieved from Datix.

The data represents the collective information for ABUHB and refers to the average numbers of Inpatient falls per 1000 Occupied Bed Days (OBD).

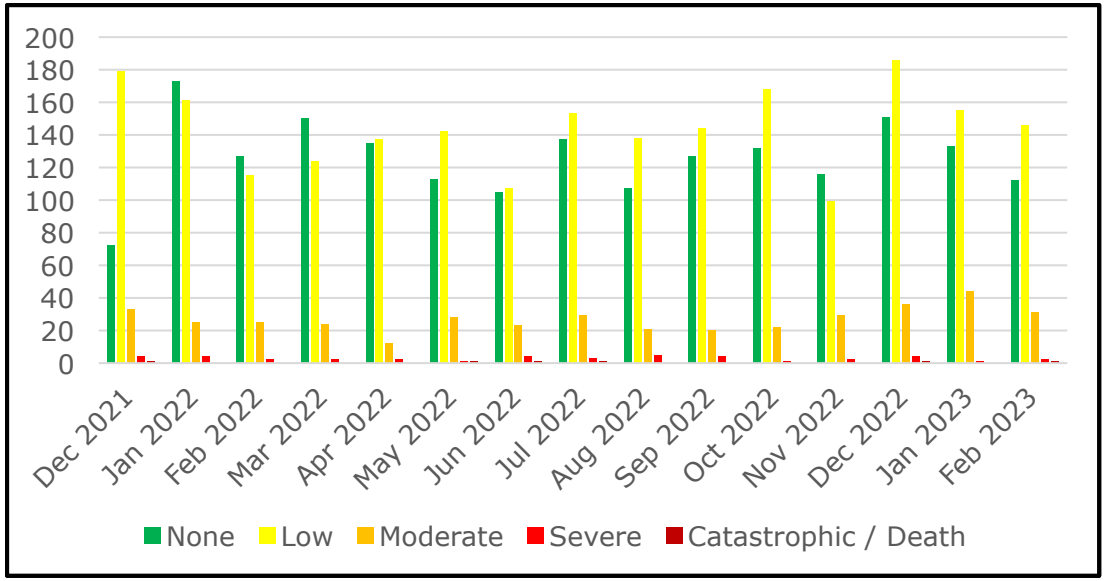
1000 OBD's represents a national standard unit of measure.

December 2022 figure is the highest since January of the same year.

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from Datix as the information source.	• The mean average number of monthly falls for ABUHB per 1000 OBD's for the period March 2021- 2023 was 6.97 which is marginally above the National average of 6.6. • Aligned to the National average for the given period the following is demonstrated: 29% above National Average 29.% below National Average 42% Aligned to the value of 6.6 • November 2022 saw a downward trajectory to the lowest value of 5.8 since June 2022.	Again 2022-23 saw a greater degree of variation as compared to 2021 across the corresponding periods. There has been a reduction in the number of months in which the incident rate was above the national average from 26% to 29%. A peak was seen in December , it is important to consider this in the context of the overall trend. A subsequent decrease has been seen to a value aligned to the National value.

Falls Data

Severity of Harm



April 2023 - Context

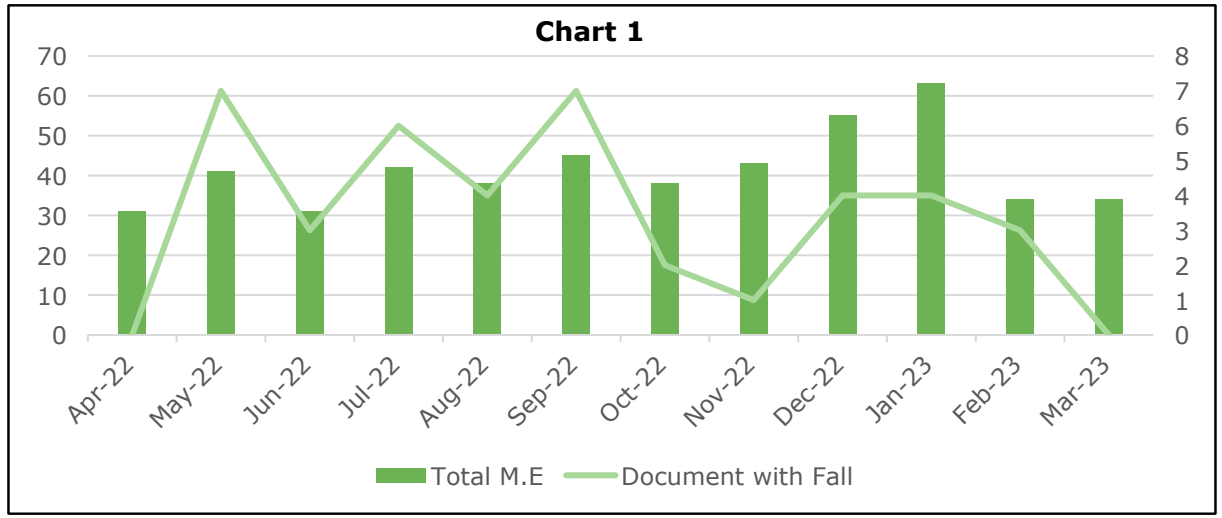
The data used in this chart has been retrieved from Datix.

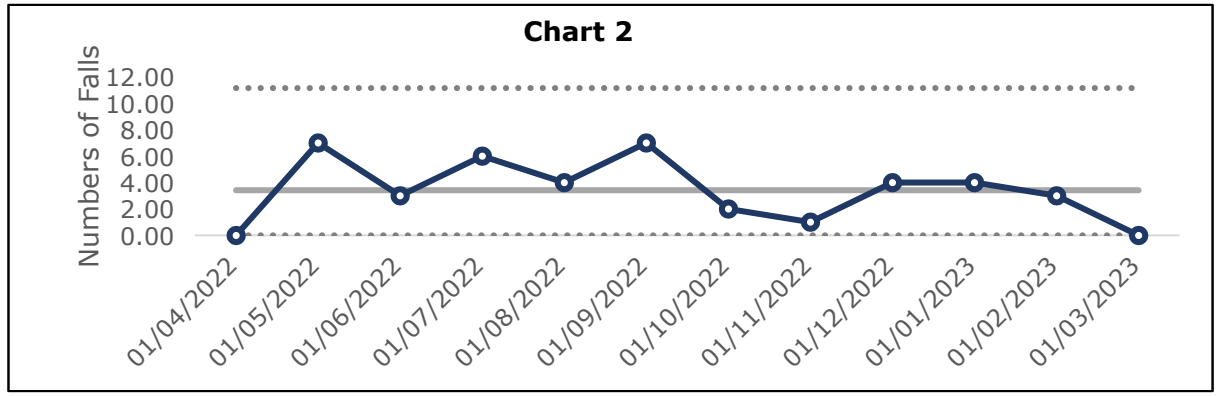
The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period December 2021 to February 2023

The data is reflective of the identified level of harm recorded.

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from Datix as the information source.	The information provided details the distribution of the levels of severity of harm as reported for falls incidents a period of 15 months to February 2023. Of the total numbers of falls incidents reported the severity of harm is categorised as follows: • 44% - no harm • 47% - low harm • 8% - moderate harm • 0.9 % Severe harm • 0.1 Catastrophic	

Medical Examiner (ME) Referrals - Falls





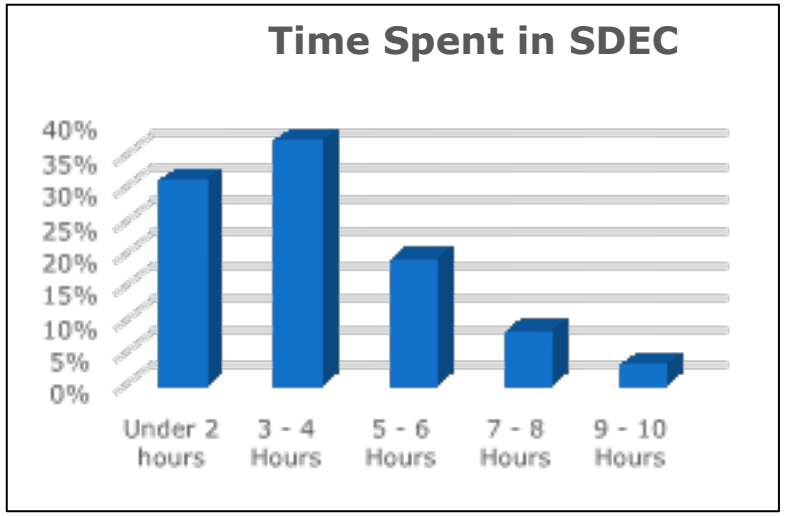
April 2023 - Context

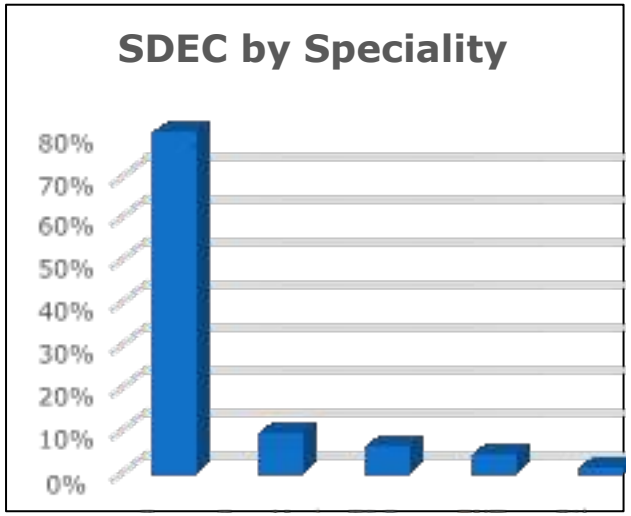
The data represents the collective information for ABUHB and refers to the total numbers of incidents reported to the ME and those numbers which referenced falls within the documentation.

The information is for the period April 2022 to March 2023.

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB) This data source is information extracted from files sent to the ME.	Chart 1 - Of the total numbers referred to the ME 8% had falls referenced within the documentation. This represents 41 of 495 instances . It is however important to recognise that this may not however have been the primary reason for the referral or cause of death. Chart 2 – This demonstrates the trajectories for the numbers of falls reported with a mean average value of 3.4 for the given period. April 2022 to March 2023.	Chart 2 demonstrates the variation around the mean average value of 3.4 with the months May, July and September 2022 being above or more closely aligned to this value. September saw a subsequent downwards trend to values of 2 and 1 respectively (October & November 2022). The months of December 2022, January and February 2023 saw values marginally above the 3.4 with a fall to zero for March 2023.

SDEC GUH at a Glance 8/8/22 – 31/3/23





3579 Patients seen

Average 26 Patients per day

348 Next day Returners

Median time 4 hours

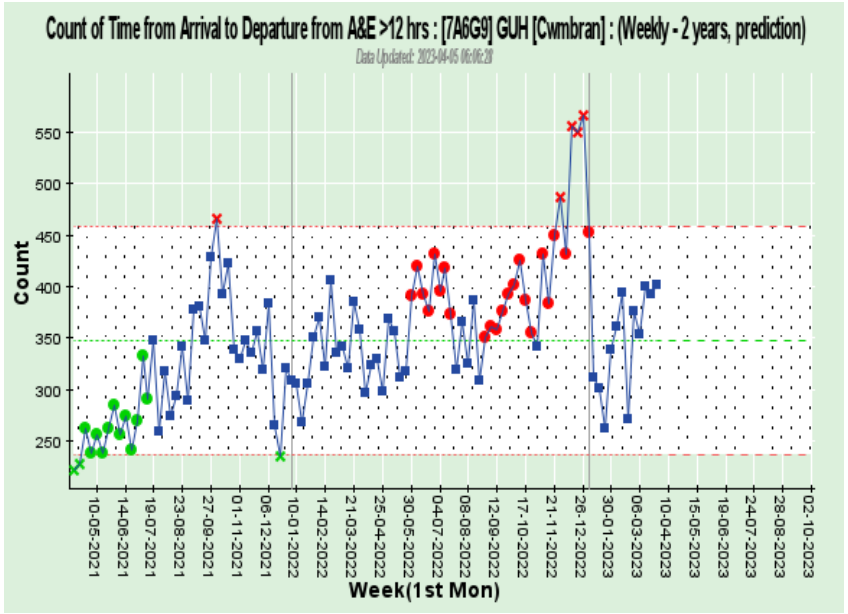
2956 patients Discharged Same Day (83%)

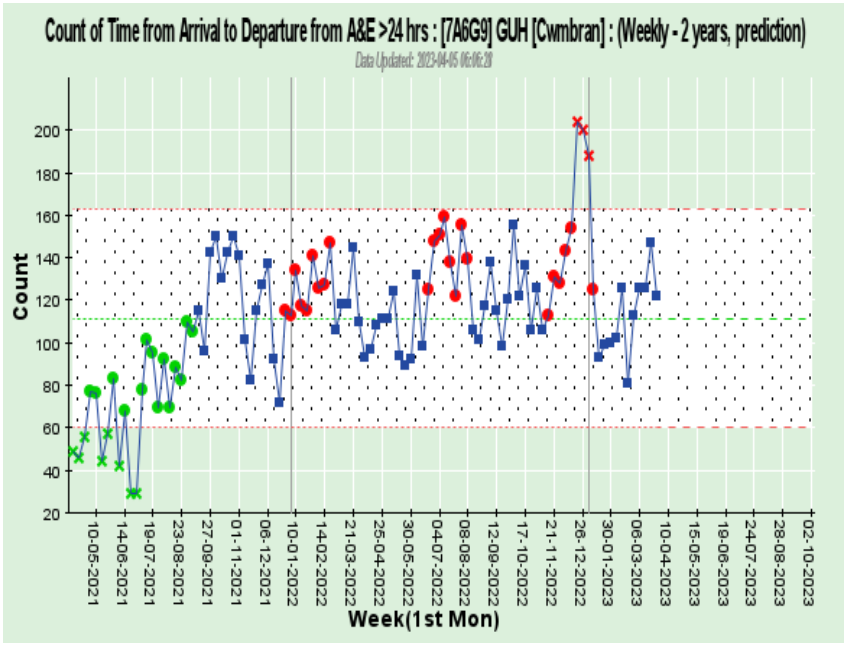
623 Admissions

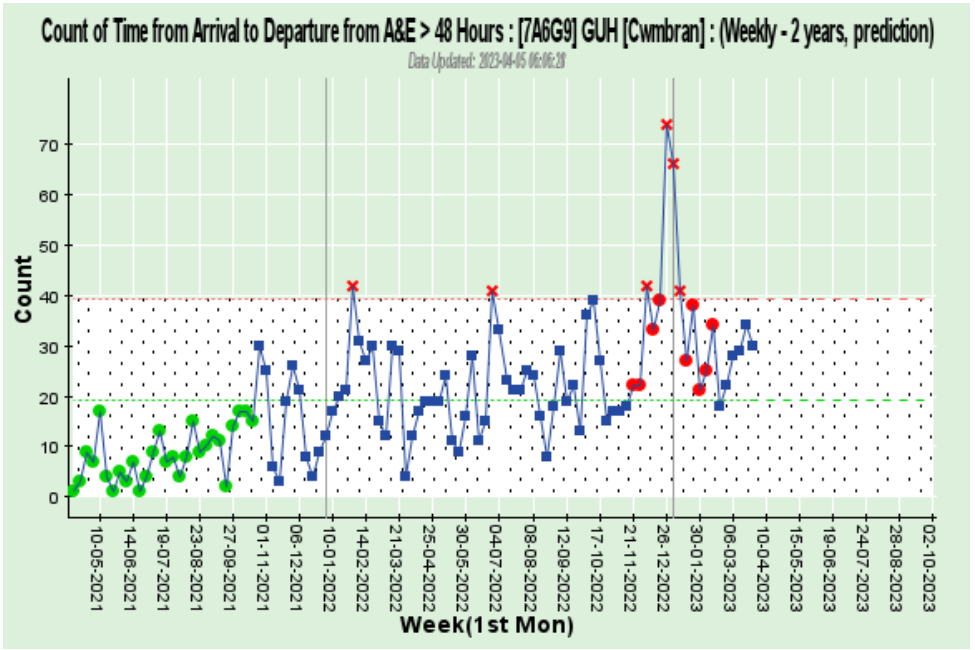
Progress Summary

- Average daily patient throughput up from 19 to 26 (Jan 23)
- Surgical model working very well:
  - Established GP referral process via Flow Centre
  - T&O and ENT pathways developing
- Consistent Positive feedback from patients and SAU staff
- General medicine utilization continues to increase since Jan 23
- Plans to utilize for Acute Oncology from April 23
- Ad-hoc utilization for Maxfax, Gynae and Gastro
- SDEC has never been used for in-patient capacity

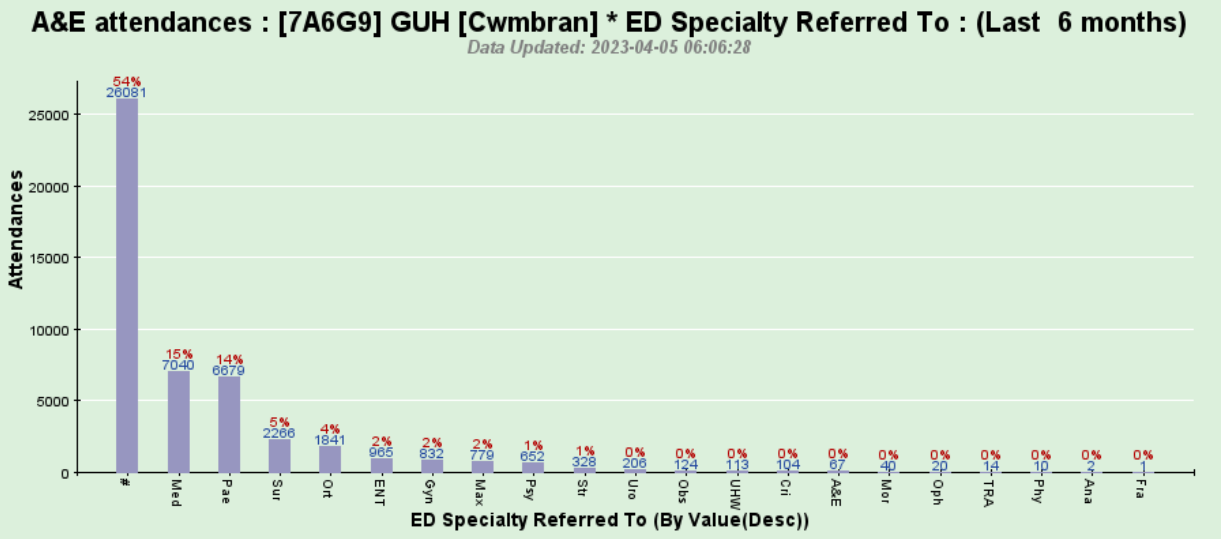
Urgent & Emergency Care



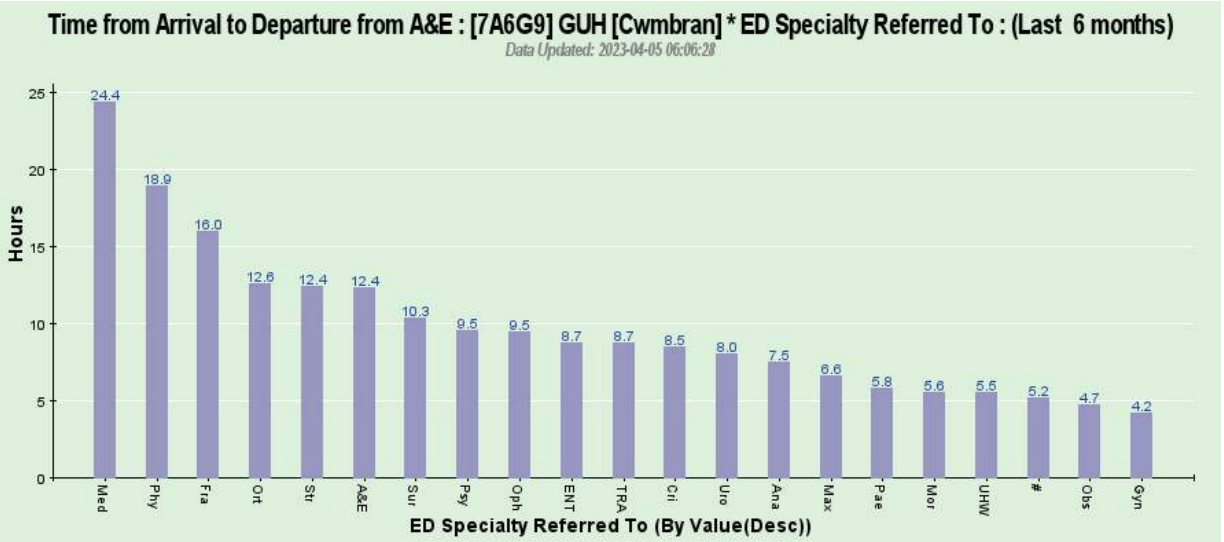




Urgent and Emergency Care

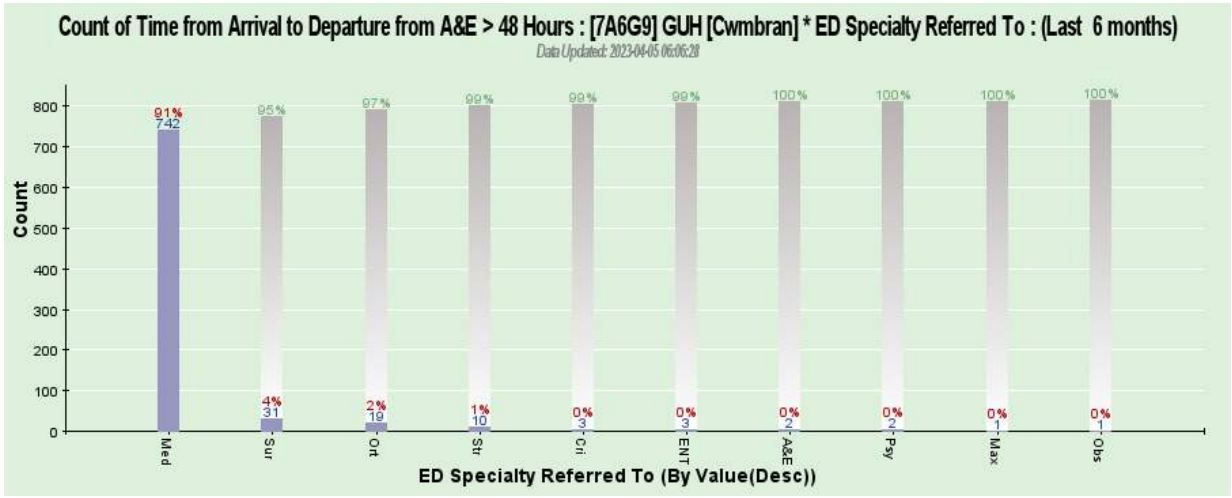


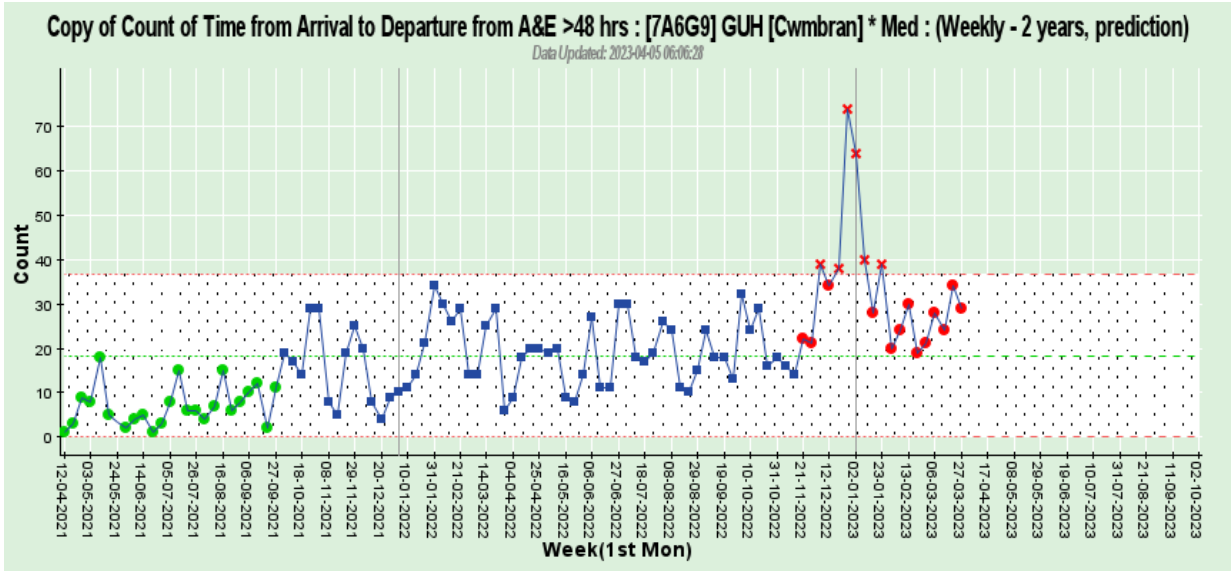
54% of attendances have no specialty recorded, assumed to be patients assessed out. Of the patients attending ED who are referred to a specialty, the demand in the last 6 months is highest for Medical (32%) and Paeds (30%).



Average time for Medical Specialties from arrival to departure in ED is 24.4 hours. There was a reduction after the December peak back to normal expected levels.

Urgent and Emergency Care



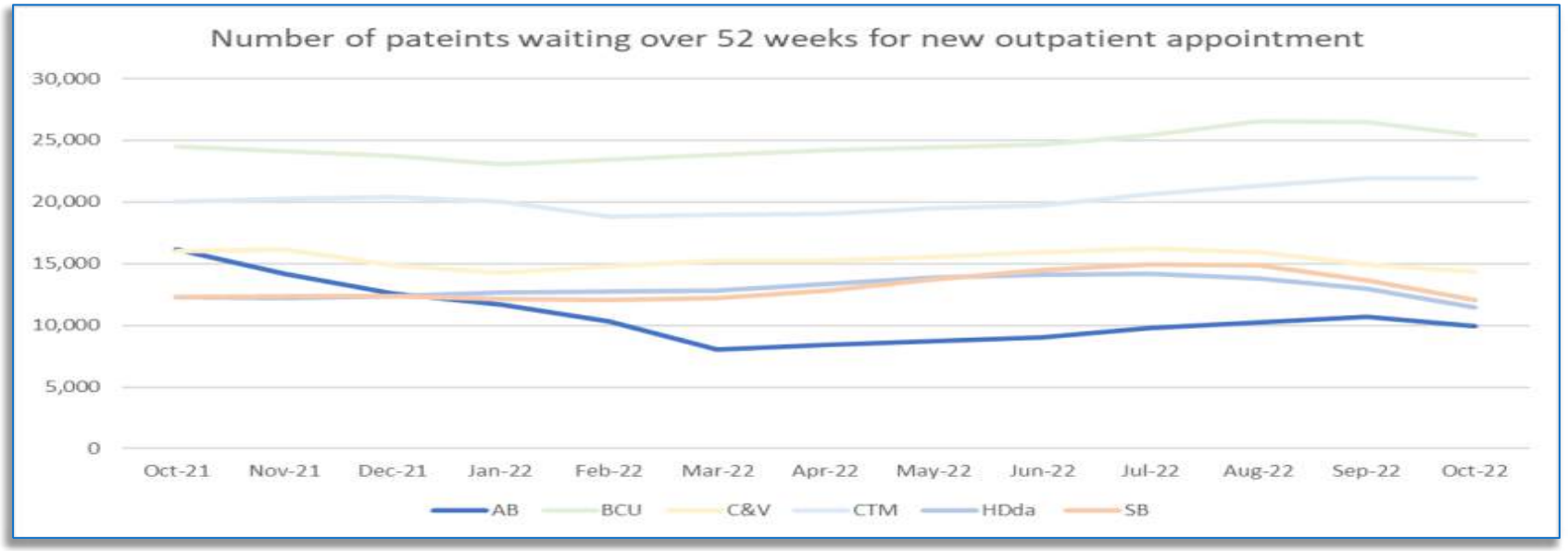


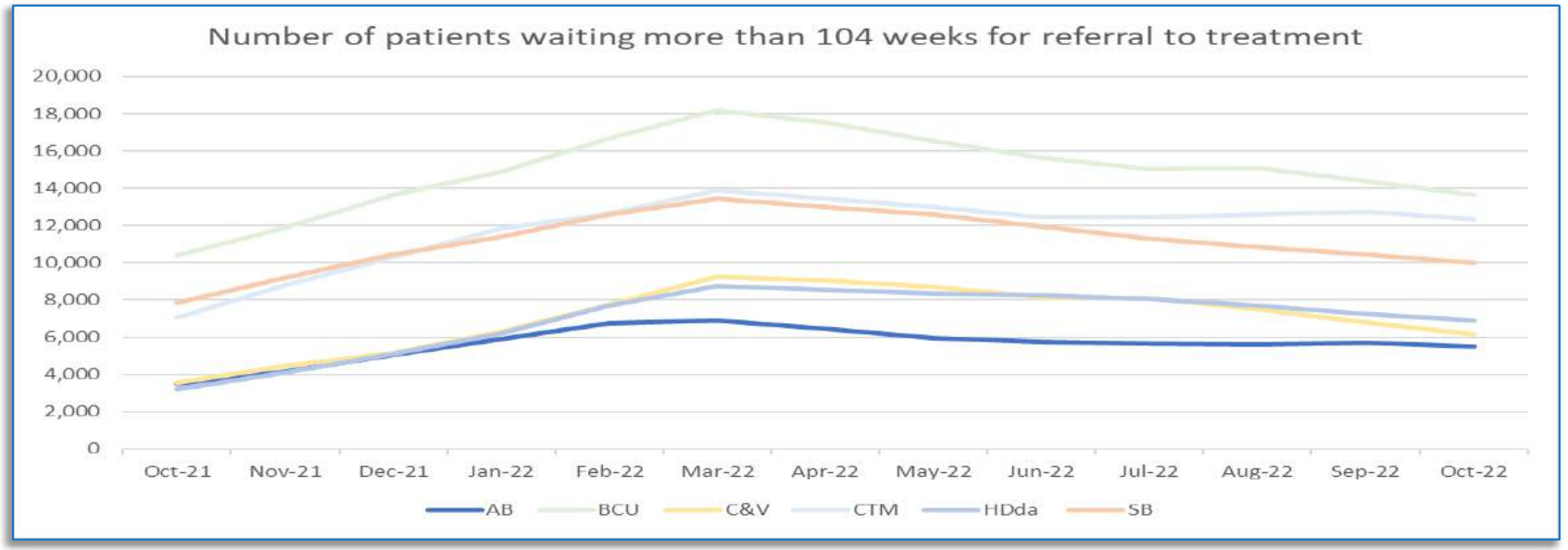
91% of the 48+ hour waits in ED are for medical specialties. The time to departure for medical specialties over 48 hours are normally occurring at around 20 per week but have settled back to 20-35 per week since the peak over Christmas.

Urgent & Emergency Care

Issue	Cause	Remedial Action	Who	When
Medical Staffing: Consultant Medical Staffing to support the Assessment Units, Ambulatory Care, Same Day Emergency Care, Ward A1, Flow Centre and Emergency Department	The opening of the Grange University Hospital (GUH) predicated the need to consolidate the medical workforce, however, medical staffing rosters remain lean.	Locum processes in place and reviewed weekly with management team and monthly within Directorate.	General Manager / Divisional Director / Divisional Management Team	Ongoing
	Increased activity	Ongoing recruitment within acute medicine.		
	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. • Explore models of care across the Assessment Units		
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	Divisional Nurse / Divisional Management Team	Ongoing
Patient Flow: Congestion within the ED and Assessment Units / Increased presentations / Long lengths of stay / A1 / Ambulance delays	• Increased demand • Poor patient flow • Pathways of Care • Increased Delayed Discharges of Care	• Escalation plan in place to support movement of patients • Comprehensive review of available spaces with Capital Planning colleagues at GUH (Main Wait, Sub-wait and SDEC) • Expansion of ED Main Wait being progressed through Capital Bid Application with Welsh Government • A1 reconfiguration work • SDEC commissioned but only being used for Scheduled Care and ad hoc Specialty involvement at present due to deficits in the Acute Medicine workforce	General Manager / Divisional Director / Divisional Nurse / Divisional Management Team	Ongoing

A note on the AB model and its success for Planned Care during Urgent Care pressures

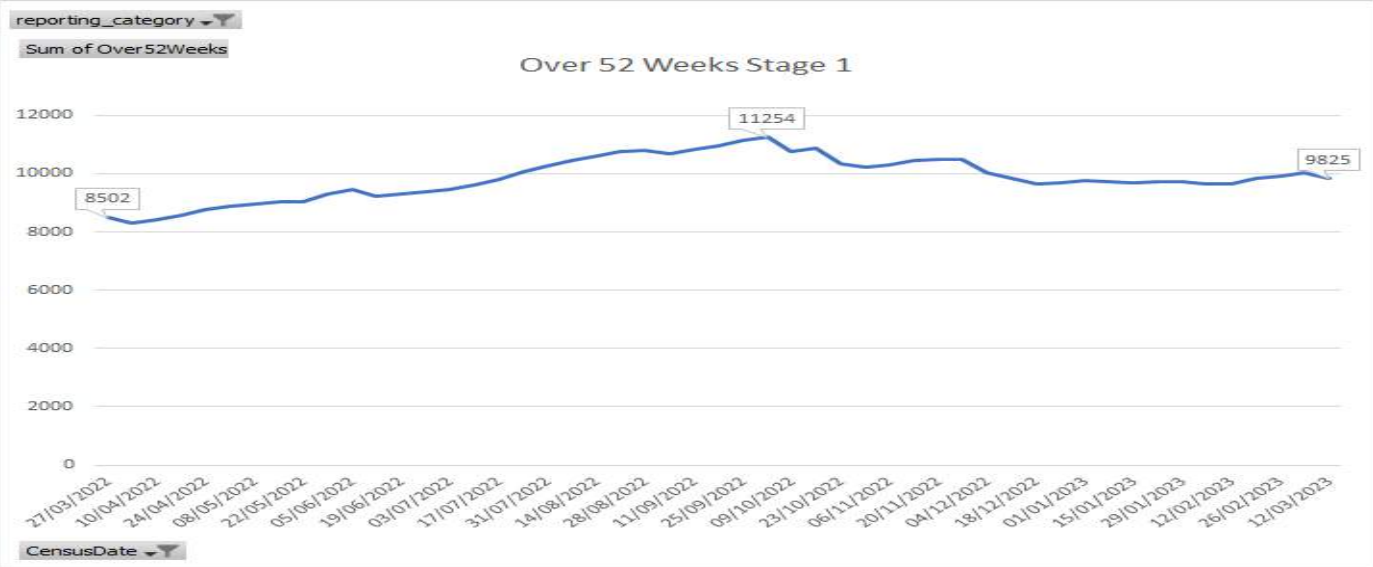




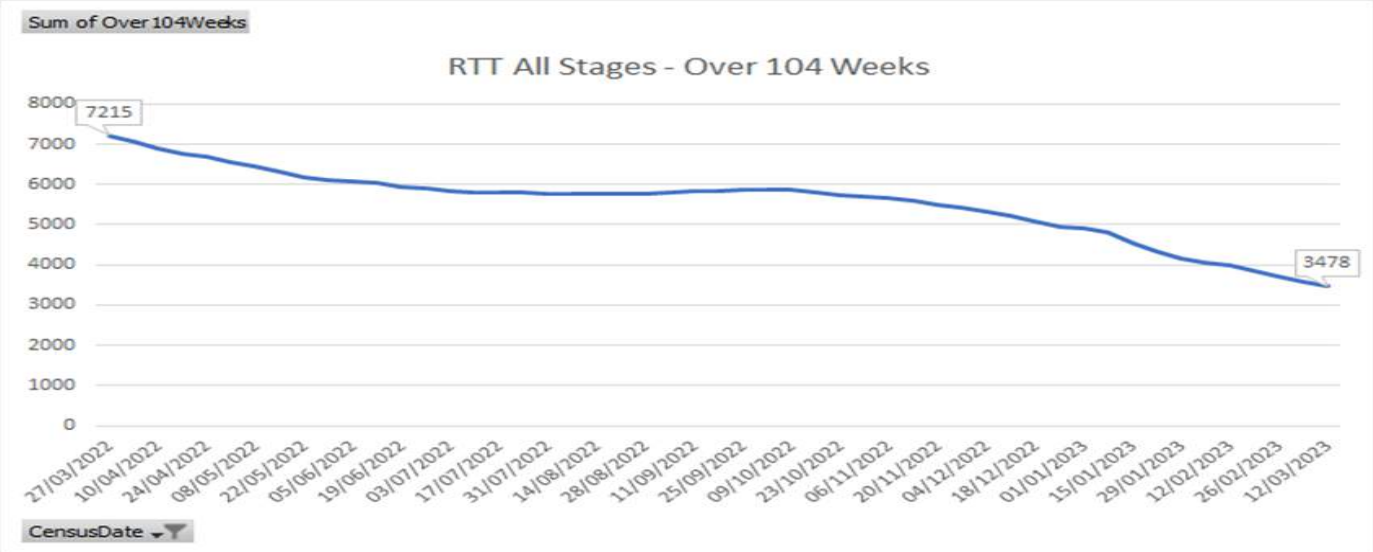
Planned Care

RTT Weekly Snapshot *(reportable activity only)*

RTT – Stage 1 (New Outpatients) Over 52 Weeks



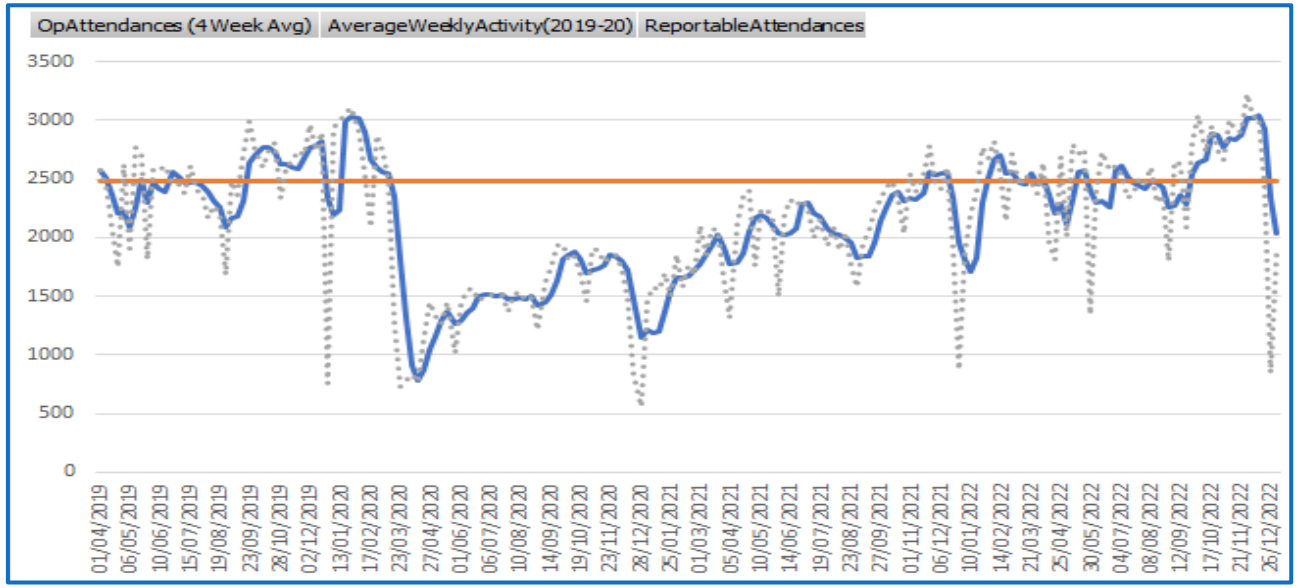
RTT – All Stages Over 104 Weeks



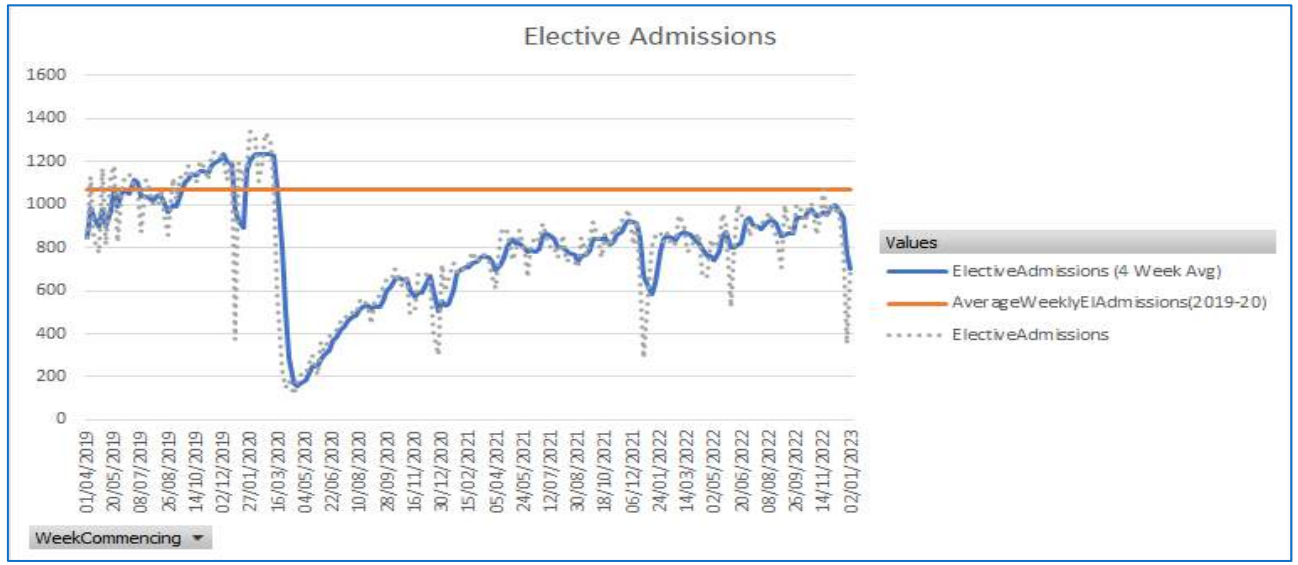
Planned Care

Activity Summary

Outpatients

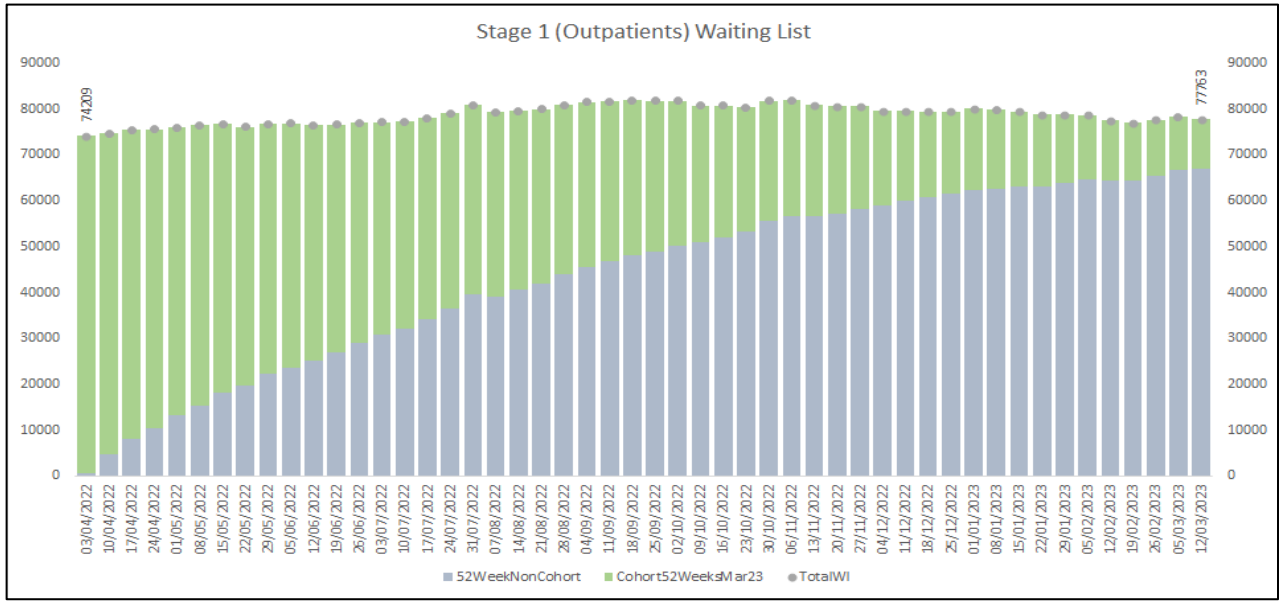


Elective Admissions



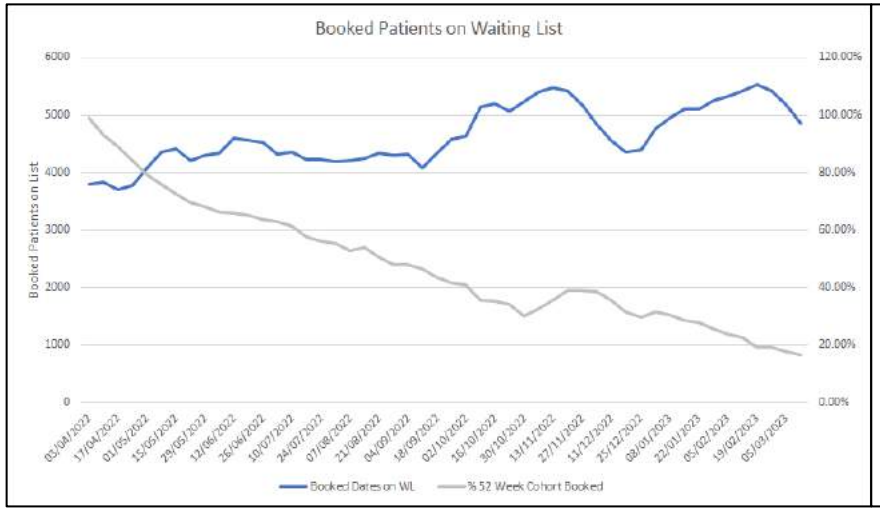
Planned Care

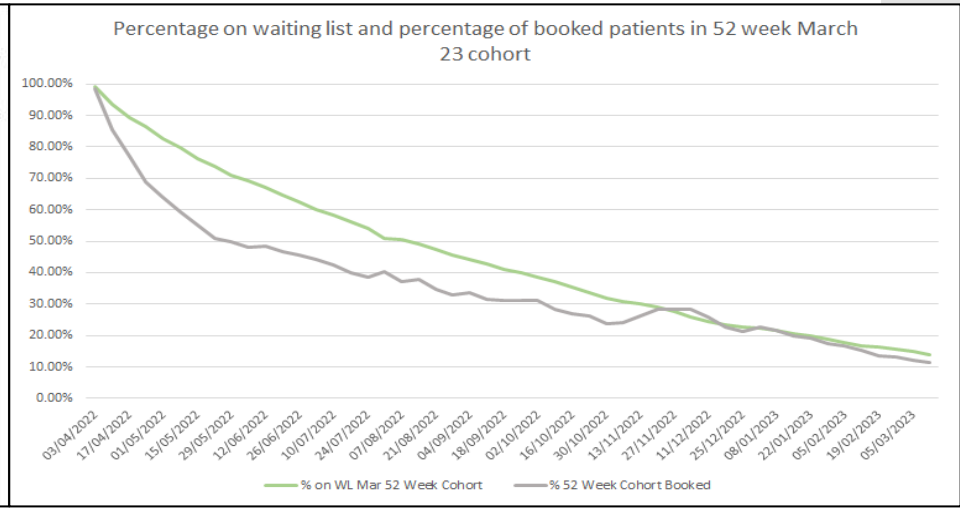
Outpatient Waiting List and 52 Week Cohort



Outpatient waiting list and 52 week cohort

- The number of patients on the outpatient waiting list has increased by just under 3.5k since the start of the financial year.
- Of the patients currently on an outpatient waiting list, **14%** are within the March 52 week cohort.





Planned Care

Performance Overview – Waiting List Snapshot *(unvalidated) as at 12/03/23*

Outpatients

Over 52 Weeks Stage1(Current Week)	Change Stage 1 Over 52 Weeks (past 5 weeks)	Model Forecast Over 52 Weeks St 1 (FYE)
9825	161	10617
		-792

Over 104 Weeks Stage1 (Current Week)	Change Stage 1 Over 104 Weeks (past 5 weeks)	Model Forecast Over 104 Weeks St 1 (FYE)
826	-84	683
		143

Row Labels	Over 52 Weeks Stage1 (CurrentWeek)	Change Stage 1 Over 52 Weeks (past 5 weeks)	_Status	Over 104 Weeks Stage1 (CurrentWeek)	Change Stage 1 Over 104 Weeks (past 5 weeks)	Status
Clinical Support Services						
Chemical Pathology	43	-7		0	0	
Family and Therapies						
Gynaecology	111	-111		0	0	
Medicine						
Gastroenterology	10	5		0	0	
Diabetes & Endocrinology	5	5		0	0	
Scheduled Care						
Ear Nose & Throat	3295	135		558	12	
Ophthalmology	3198	286		0	0	
Trauma & Orthopaedic	1934	-67		253	-63	
Urology	737	-88		15	-33	
Maxillo-Facial	338	3		0	0	
Orthodontics	152	9		0	0	
General Surgery	2	-9		0	0	
Grand Total	**9825**	**161**		**826**	**-84**	

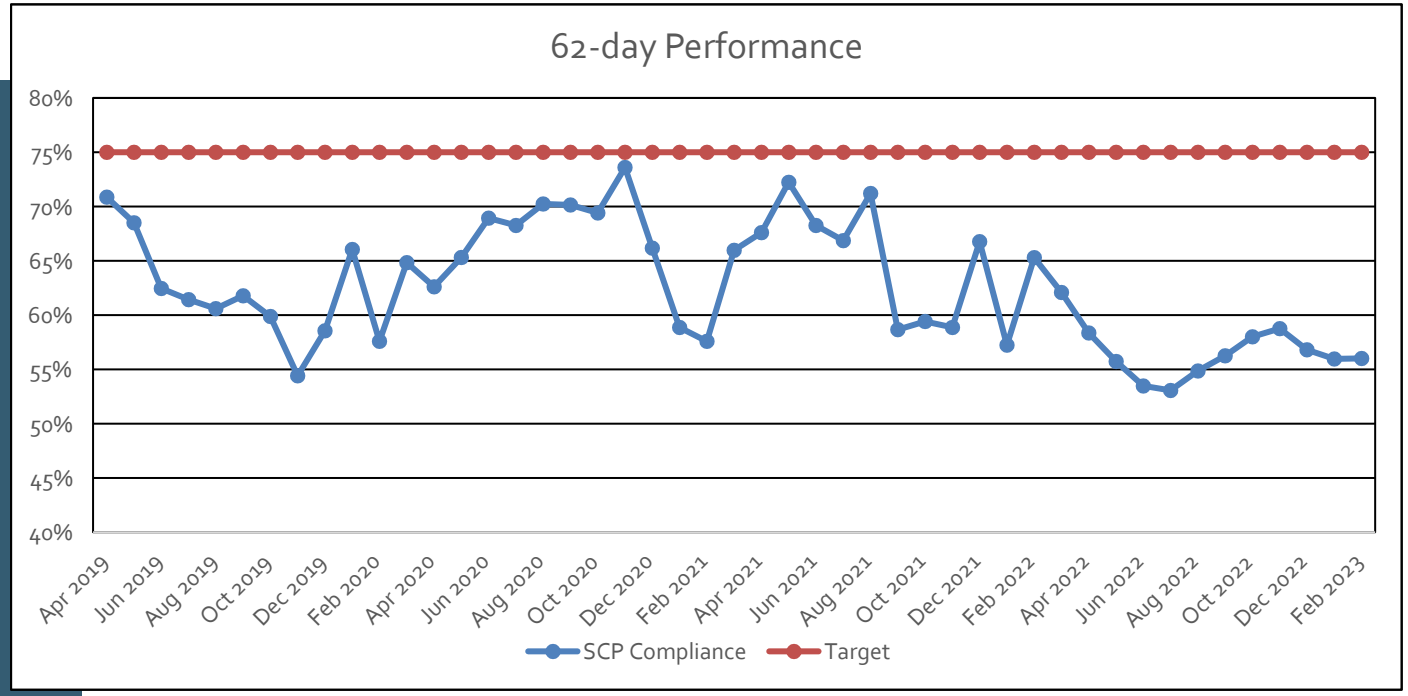
Total RTT Waits

Over 104 Weeks (Current Week)	Change Over 104 Weeks (past 5 weeks)	Model Forecast Over 104 Weeks (FYE)
3478	-581	3549
		-71

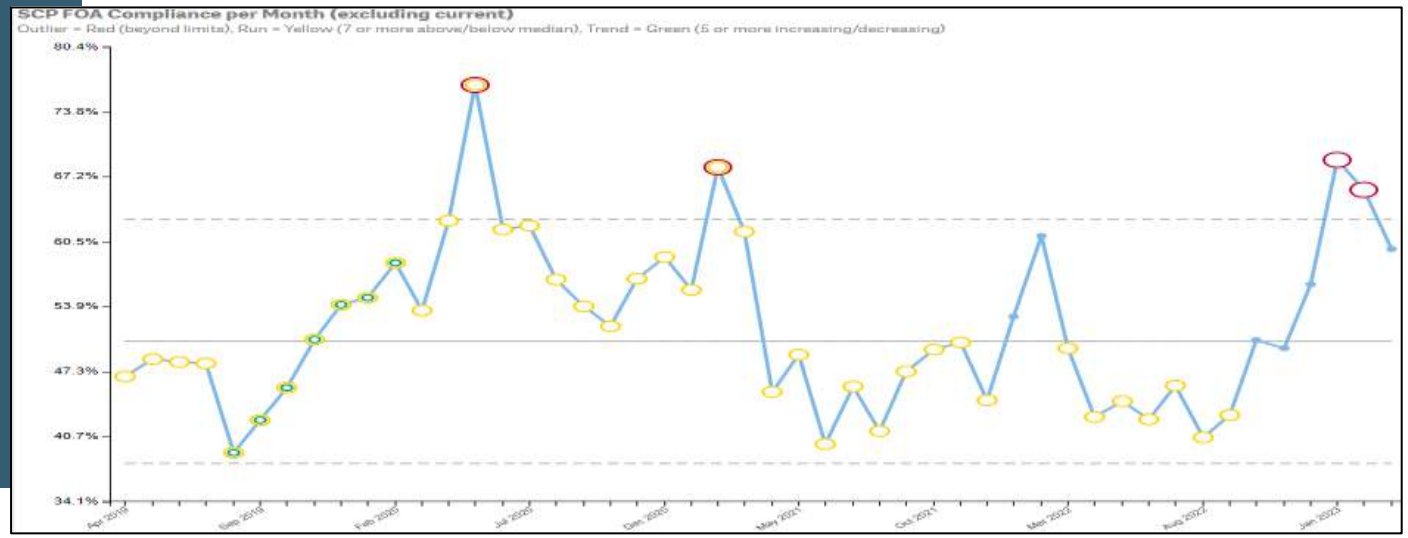
Over 156 Weeks (Current Week)	Change Over 156 Weeks (past 5 weeks)
905	-94

Row Labels	Over 104 Weeks (Current Week)	Change Over 104 Weeks (past 5 weeks)	Status	Over 156 Weeks (Current Week)	Change Over 156 Weeks (past 5 weeks)	Status
Medicine						
Gastroenterology	1	1		1	1	
Scheduled Care						
Trauma & Orthopaedic	2133	-373		692	-63	
Ear Nose & Throat	920	-58		135	-14	
Urology	305	-88		72	-12	
General Surgery	99	-30		3	-1	
Maxillo-Facial	12	-3		1	-2	
Ophthalmology	8	-30		1	-3	
Grand Total	**3478**	**-581**		**905**	**-94**	

Cancer – 62 day Performance



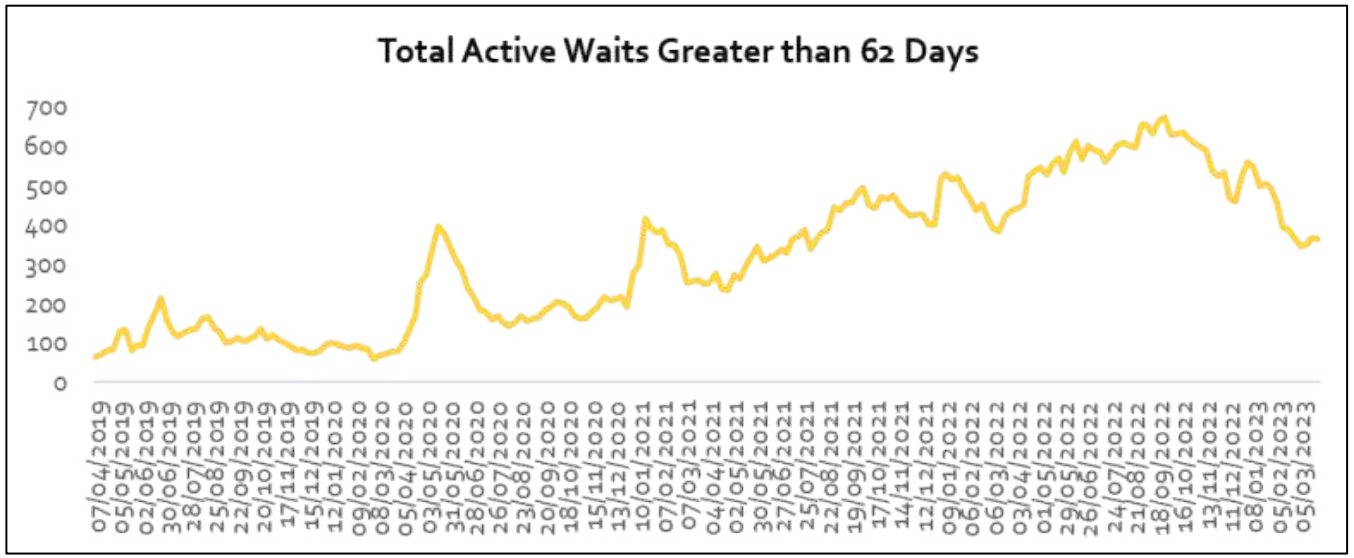
The provisional view of March performance suggests a compliance improvement of up to 10%. This is this result of the improvement to first appointment achieved in January (below).



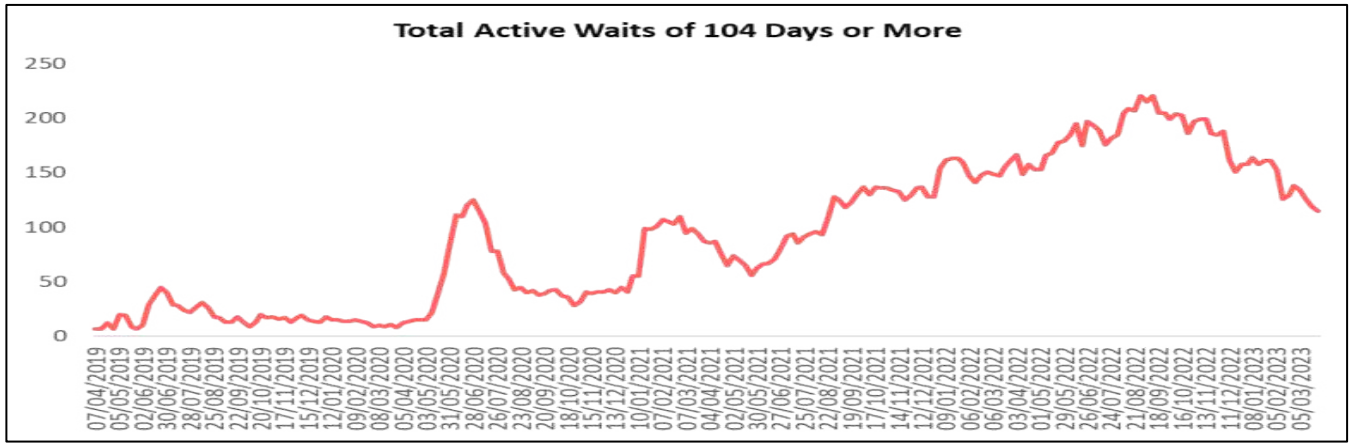
The volume of patients starting their pathway within 14 days has dropped since January due to leave, sickness and ongoing demand increases.

Cancer Backlog

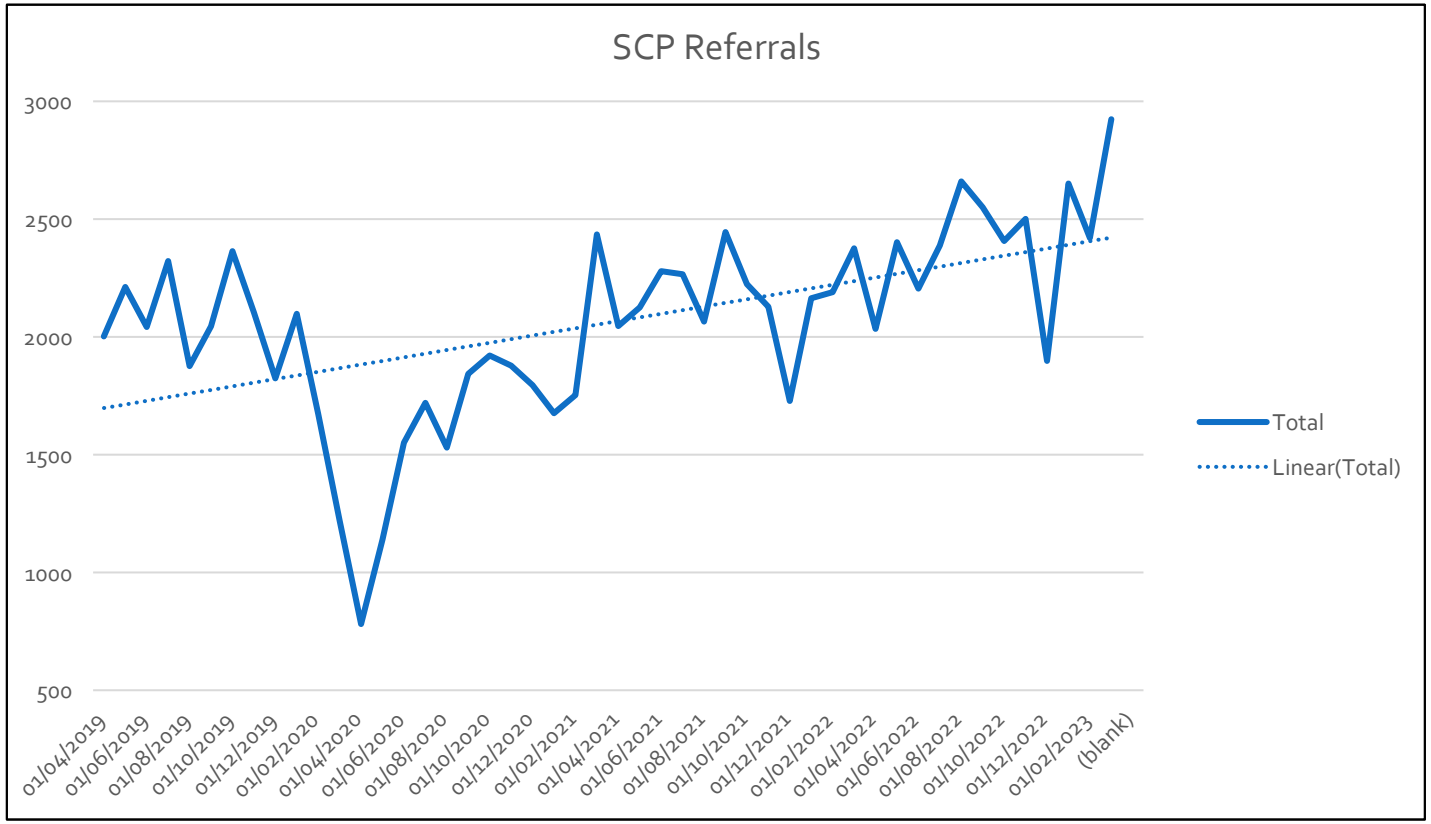
Reducing the active patients waiting over 62 and 104 days remains the priority laid out at the March 2023 ministerial cancer summit.



Backlog now increasing again due to lost activity over end of Q4



SCP Demand



SCP demand continues to increase with further forecast rises. Maintaining this level of activity and improving on cancer performance is going to require more dedicated USC capacity potentially at the expense of RTT capacity.

Recovery Challenges

Issue	Cause	Remedial Action	Who	When
Falling compliance against start of pathway 14 day target: 14 day first appointment compliance has dropped 10% since January peak. This has subsequently led to an increasing back position which will have an adverse impact on 62 day compliance	Annual leave in LGI STT team. Time to first investigation increasing by >25 days	All additional capacity being explored within team to bring down waiting times but anticipated slow recovery. Further options to be explored to streamline start of pathway	Dawn Baker-Lari	30/04/2023
	Delayed CT waiting times due to scanner replacement	New scanner now in place increasing available CT capacity. All options being explored to expedite CT scanning.	Arvind Kumar	30/04/2023
	Haematuria 1 stop clinic waiting times continue to struggle due to available nurse endoscopist capacity. Loss of cancer activity due to emergency consultant leave.	Emergency contingency plans required to maintain and recover urology waiting times.	Mike Hague	30/04/2023
Rising Cancer Backlog	Loss of activity over end of financial year + holidays.	Backlog scrutiny exercised being undertaken in all major tumour sites. Renewed push on start of pathway to prevent further growth	Cancer services + all tumour sites	30/05/2023
Colorectal theatre waiting times	Demand/Capacity shortfall	New job plans created to redistribute cancer workload evenly amongst clinicians. Additional locum consultant surgeon out to advert	Dawn Baker-Lari	30/05/2023

Questions

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	25 April 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Strategic Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Services, Risk and Assurance

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

Er Sicrwydd/For Assurance

This report seeks to provide a summary of the current risks which receive oversight from the Patient Quality, Safety and Outcomes Committee (PQSOC) and feature on the corporate risk register.

The report also provides a first iteration of a proposed new format of report that maps the entire risk profile for the Committee across a diagram. This would provide the Committee with a view of the risk exposure of the organisation in respect of patient, quality, safety, and outcomes risks.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides an overview of all **10** strategic risks described within the corporate risk register and which, require scrutiny and oversight from the Committee.

The sustained demand for services, compounded by the residual impact of the pandemic and significant workforce constraints continue to represent the most significant risks to the Health Board's delivery and the achievement of the objectives outlined within the IMTP. A high-level overview of the PQSOC risks currently captured on the corporate risk register are attached to this report at ***Appendix 1***.

The delegated authority of the Committee in respect of risk management arrangements, as articulated in the Committee Terms of Reference (ToR) is:

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

In recognising this specific area of delegated authority from the Board, this report seeks to provide the Committee with an overarching position of the risks for which it is responsible.

Additional capacity and resource are expected to be in place within the Corporate Governance Team from Summer 2023 when sustainable progress can be made to ensure the revised approach to the Board Risk and Assurance Framework becomes embedded and used to inform and drive Board and Committee business and allow for the Committee to take an active role in evaluating assurances and the internal system of control.

Internal Audit has recently undertaken a review into Risk Management arrangements within the Health Board. The result of this audit was a *reasonable level* of assurance however, further improvement actions have been identified and are addressed in the management actions of the report itself. The report can be accessed on the Health Board website as part of the Audit, Risk and Assurance papers for 18th April 2023.

Cefndir / Background

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

At the March 2023 Board meeting, members received an updated version with enhanced risk assessments for each risk profile. The report included an assessment of the internal controls used to manage each risk and an assessment on levels of assurance that could therefore be taken.

Internal controls were identified and rated (red, amber, green[1]) RAG in relation to their effectiveness. Where gaps were identified, clear actions aligned to SMART methodology were developed and tracked through respective Executive risk owners. Sources of assurance could then be established and similarly, where gaps are identified, clear SMART actions were developed to address the gaps to drive progress to mitigate the risk and reduce either the likelihood, consequence, or both. Committees are then responsible for the active monitoring and review of all risks which receive oversight from each respective committee.

Risk Management ensures that the Health Board focuses on the risks and concerns that may impact on the Health Board's ability to deliver its objectives as stated within the agreed IMTP. Whilst active risk management is performed daily at an operational level, the Health Board's risk management strategy and process

[1] For clarity, Red would indicate no assurances available, Amber would indicate satisfactory sources of assurance available, and Green would indicate a considerable level of assurance with clear evidence that the risk is being managed effectively.

ensures that the Board is informed, engaged, and assured about the approach that Health Board uses to identify and manage perceived risks.

An Executive Committee session is planned for 27th April 2023 to provide an opportunity for Executives to rigorously review the Corporate Risk Register and potentially reframe, de-escalate and redefine risks already captured.

At the time of writing, a further Board Development Session is scheduled to take place on 26th April 2023, focused on defining and setting the Board's risk appetite, based on feedback received at the last session. The outcome of this work will be pivotal in informing the updated Risk Management Strategy, due to be presented to the Board in May 2023.

Asesiad / Assessment

Current Organisational Risk Profile:
There are currently **10** strategic level risks that report to the PQSO Committee, of which **8** are classified as high risks due to the scoring being 15 or greater. The following table provides a breakdown of the risks and level of severity:

High	**8**
Moderate	**2**
Low	**0**

In preparation for the March 2023 Board meeting, the risks that comprise the corporate risk register were subject to Executive risk owner scrutiny, challenge, and review. Robust assessments of the Health Board's internal control system were undertaken, alongside a review of all sources of assurance related to each risk. Based on a calculation of averages methodology, an initial indication on each risk was given a **RAG** rated assurance level. This is in line with Internal Audit methodology when determining assurance levels for audit reviews.

An over-arching, high-level indication of the level of assurance the Committee could derive from the assessment is set out below:

Nil	Satisfactory	Considerable
	X	

This meant that the Committee can take an overall level of ***satisfactory*** assurance that the strategic risks which comprise the corporate risk register, and which represent significant risks to non-delivery of the IMTP, were being managed effectively. The Committee can also take assurance that the system of internal control to manage these risks was deemed to be ***satisfactory***.

Risk Profile and Risk Exposure [2]

Following the Risk Management Board Development Session on 22nd March 2023, it was agreed that for future reporting, Board members would like the opportunity to review the Health Board's risk exposure as a visual representation. The following diagram has been developed for this purpose and is informed by the current risk scores which comprise the PQSO Committee risks:

The diagram clearly demonstrates that the current risk exposure features heavily in the upper limits of the scoring matrix. This is not unusual for strategic level risks and best practice indicates that we would expect to see corporately reported risks as high/significant level as they pose the most significant threat to the organisation and therefore should be reported to the Board and its Committees.

Argymhelliad / Recommendation

The Committee is requested to:

- **DISCUSS and NOTE** the overview of the Committee risks, as contained within the Corporate Risk Register.

[2] The result of the risk analysis process can be used to produce a risk profile which gives a significance rating to each risk and provides a tool for prioritising risk treatment efforts. This ranks each identified risk so as to give a view of the relative importance. **Institute of Risk Management** (IRM)

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The Corporate 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 Corporate 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:	Respective committees of the Board have considered risks contained within the Corporate 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 ref and Descriptor	Current Score	Target Score (informed by Appetite level)	Risk Appetite Level	Managed to Agreed Level Y/N?	Risk Treatment	Date and Trend Since Last Reporting Period	Assurance/ Oversight Committee	Risk Owner
CRR019 Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand. **(re-framed Dec 2021)**	20	15	**Low** level of risk appetite in relation to patient safety risks. **Moderate** levels of risk with regard to innovation around mitigations to prevent demand and better manage the demand.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**March 2023 Board** 	**PQSO**	**Director of Operations**
CRR013 Failure to prevent and control hospital and community acquired infections to include COVID-19	10	10	**Zero or low** due to patient safety and quality of service.	**Yes**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board** 	**PQSO**	**Director of Nursing**
CRR023 Potential risk to population health in relation to avoidable harm due to priority being given to management of	20	20	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to different ways of working to address backlog. This	**Yes**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board** 	**PQSO**	**Director of Operations**

the COVID pandemic.			would include the use of technologies and innovations.		**Tolerate** the impacts of some mitigations and acknowledge that some may not work.			
CRR027 'Effectiveness of COVID vaccination and booster programme compromised resulting from the emergence of a Variant of Concern[1]	20	20	**Moderate** risk appetite level will need to be applied to this risk profile, given the unpredictability of the potential of variants of concern as recognised by Welsh Government in its Winter Modelling Update for 2022-23. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control.	**Yes**	**Treat** the potential impact of the risk with mitigations. **Tolerate** the unpredictable element of the VoC and other mutations.	**March 2023 Board** ⟺	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR028 Continued inappropriate admissions of Children and Young People to adult mental health in-patient beds.	20	10	**Low** risk appetite level in relation to patient safety and experience. **Moderate** level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board** ⟺	**PQSO**	**Director of Operations**
CRR003 – Inadequate and clinically unsafe Mental Health Service provision due to operational impact of WCCIS	12	8	**Low** risk appetite level in the interests of patient safety. **Moderate** risk appetite levels will need to be taken to explore further innovations and appropriately reconfigure services and implement new arrangements.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**March 2023 Board** ⟺	**PQSO/PPH PC**	**Director of Primary, Community and Mental Health Services**
CRR036 Clinically unsafe and inappropriate inter-site patient	15	5	**Low** risk appetite in this area in respect of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board**	**PQSO**	**Director of Operations**

[1] This risk to incorporate clinical to describe an overarching population health vaccination risk for the next Board meeting.

transfers and into communities								
CRR038 Increased levels of patient acuity presenting resulting in an inability to staff appropriately and provide acceptable levels of care in line with best practice and guidelines.	15	5	**Low** risk appetite in this area in respect of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board** 	**PQSO**	**Director of Nursing/Director of Operations**
CRR040 Putting Things Right (PTR) – Continued and sustained non-compliance with The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011	20	8	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board** 	**PQSO**	**Director of Nursing**

Safeguarding *CRR030 – (re-framed Nov 2022) *this risk has interdependencies with CRR002 Workforce Risk** **Risk of:** 'Hidden Safeguarding Harms' experienced by patients in their homes and communities due to the COVID-19 pandemic and significantly increased demand on Health Board services.	16	8	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls.	**March 2023 Board** 	**PQSO**	**Director of Nursing**

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR013 Director of Nursing

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety • Partnership First • Research, Innovation, Improvement, Value • Workforce & Organisational Development • Finance • Digital, Data, Intelligence • Estate • Regional Solutions • Governance	X X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TOLERATE

Overall Level of Assurance (RAG):

	X	

Risk of: *Widespread hospital and community harm, with potential increase in demand and acuity of hospital or community acquired infections.*

Due to: *Failure to effectively manage community and hospital transmission of Health Care Acquired Infections (HCAIs) to include respiratory pathogens.*

Likelihood of Current Occurrence: 2 = Do not expect it to happen / recur but it is possible it may do so

Impact if Occurred: *Potential impact on staffing, resources and infrastructure of an already pressured acute hospital system. Further potential impact on Primary and Secondary care services if need in communities are not managed. Impact on individual patients by increased morbidity and mortality.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X – risk appetite – low adverse to risk		**X – current score** **X – target score**
				X – capacity score

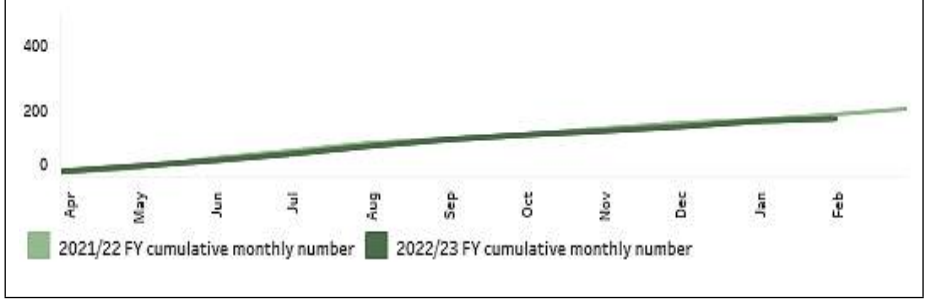
Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

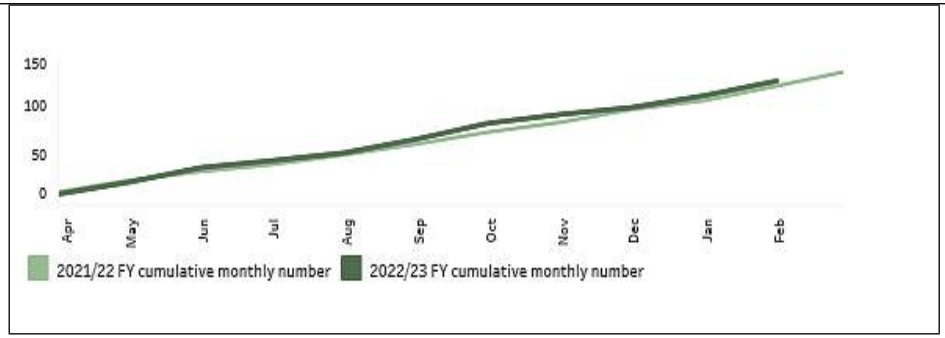
Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophi**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

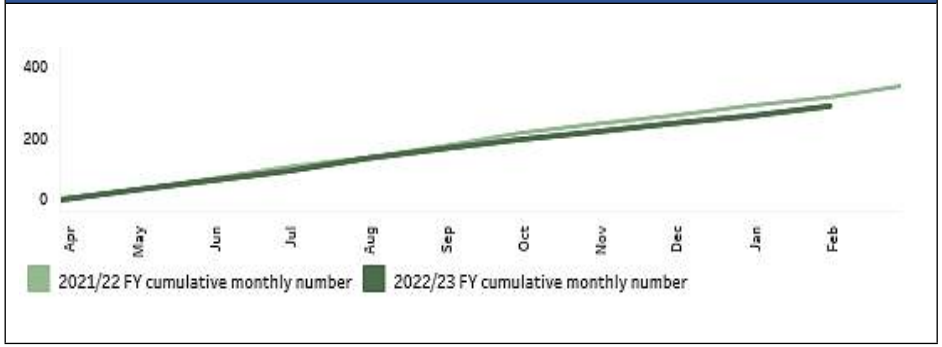
Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
3	***5***	***2***	***5***	***2***	***5***
15		***10***		***10***	

Justification for Risk Appetite and Risk Capacity Level & Target Score:

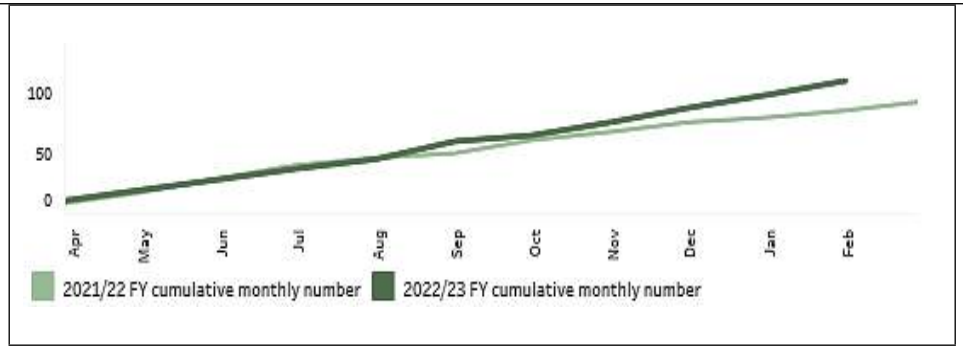
	The risk appetite level is low in this area in the interests of patient safety and experience. The risk capacity level reflects the level at which the Health Board can ultimately tolerate this risk and is in line with the inherent risk score. The target score reflects the current score and therefore, the Board is requested to **TOLERATE** this risk, subject to on-going monitoring, evaluation and review. ***Risk Trend:*** **C difficile**  **Staph Aureus**



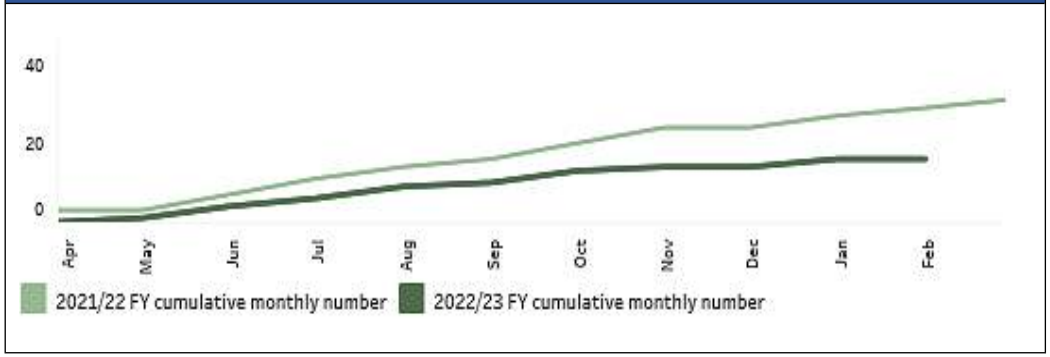
E coli



Klebsiella



Pseudomonas



Current Controls:

- *Daily surveillance of infection data with RCA across the Health Board*
- *Annual program of work*

	• *Ongoing education program and audit monitoring* • *Receive national alerts associated with infection and share accordingly* • *Ongoing policy reviews and updated in line with changes in national guidance* • *COVID hospital transmission standard operating procedures is in place, to include the Hierarchy of Controls and with frequent auditing and monitoring via RNTG* • *Annual HPV proactive enhanced cleaning program* • *IPT support and advise in Divisional Quality and Patient safety forums* • *Consultant Microbiology support and advise across Organisational programs* • *Antimicrobial wards rounds and the roll out of ARK* *Reported via* • *Reducing nosocomial transmission group (RNTG) which is clinically led, reports to Executive Team monthly* • *Quality and patient safety operational group* • *Quality and patient safety outcomes committee* • *Ongoing monitoring of Welsh Government reduction targets action plan via RNTG* • *Monthly Divisional data*

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Review alternative technology to undertake	**Rhys Shorney/Moira Bevan**	**June 2023**	**Ongoing**	

deeps cleans that's has less impact on capacity				
Review ventilation within ELGH	**Mark Ascott/Moira Bevan**	**Oct 2023**	**Dependant on business case**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Monthly IPAC reporting to Executive Committee (via RNTG)	**X**				
Organisational Action Plan to monitor Welsh Government Reduction targets and respiratory		**X**			**95% compliance not sustained within all areas**

pathways monitored via RNTG					
RNTG reporting via Quality and Patient Safety operational and outcomes committee.		**X**			

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Continue IPT support and monitoring via the Divisional quality and safety forums	**Moira Bevan**	**March 2024**	**Ongoing**	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR030 Director of Nursing

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety • Partnership First • Research, Innovation, Improvement, Value • Workforce & Organisational Development • Finance • Digital, Data, Intelligence • Estate • Regional Solutions • Governance	X X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *The risks associated with poor level 3 training compliance means that the practitioner may miss a safeguarding concern or not understand the process to report, work with a Safeguarding plan or escalate safeguarding concerns. Risk of us failing in our duty to report.*

Due to: *No level three adult or child safeguarding training was available in quarters 2,3 & 4 of 2022/23 in ABUHB.*

Likelihood of Current Occurrence: 3 = Possible - Might happen or recur occasionally

Impact if Occurred: *Level three safeguarding training is mandated for register health and care practitioners, who engage in assessing, planning, intervening, and evaluating the needs of children and adults at risk of harm and abuse. The training needs to be completed every three years whilst a practitioner is in the above roles. safeguarding laws and legislations change all the time in response to real-life events, and as such, you will typically need to refresh your training. There is an associated risk to the population and organisational reputational risk.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X – risk appetite – low adverse to risk		**X – target score**
				X – current score
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***4***	***5***	***2***	***5***
25		***20***		***10***	

	Justification for Risk Appetite and Risk Capacity Level & Target Score: *The risk appetite level for this risk is low in the interests of patient safety, experience and outcomes.* *The risk capacity level reflects the level at which the Health Board can ultimately tolerate this risk and is in line with the inherent risk score.* *The target score for this risk (2x5)10 aims to decrease the likelihood of this risk manifesting.* *The remainder of the risk assessment demonstrates how the Health Board will seek to realise the target score.* ***Risk Trend:*** *The risk has now been re-framed to provide a focus on training, therefore previous trend not yet available.* **Current Controls:** • Safeguarding Training offered at level 1 & 2 via ESR. (Current compliance data - adult & child level 1 -81%; Children level 2 55.7% Adult level 2 58.0) • Supervision and case review available. • Robust monitoring of safeguarding activity through the Safeguarding Committee via quarterly reporting. • Good use of the adult and child safeguarding hub facility for ad hock advise from a band 7 safeguarding lead nurse; Monday – Friday 09.00 – 17.00 • Utilising all communication methods available to promote completing safeguarding training.
Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*	

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Updated training packages	**Fiona bullock**	**March 2023**	**Complete. Both have been trailed and evaluated well**	
Training sessions booked for children and adult level three safeguarding training	**Fiona Bullock**	**March 2023**	**Complete. (Monitoring of uptake ongoing, with plans to add additional dates where needed)**	
Communication with practitioners, via share point intranet pages, emails to divisional nurses.	**Fiona bullock**	**ongoing**	**Direct contact with Communications team, to maximise exposure**	
Level 2 safeguarding training compliance levels below expectation of 85%	**Fiona Bullock**	**ongoing**	**Email sent to all divisions to ask for compliance focus**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map					
Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**
Health Board- safeguarding level three adult and child training		**X**		**Mapping has taken place, using the Royal College of nursing intercollegiate document; which is backed up by the Welsh Government safeguarding training guidance.** **Training packages for child and adult level 3 training have been reviewed and made current.** **A training schedule has been advertised across the health board.** **Barrier to compliance monitoring removed. (competency booklet) Additional ways of knowledge assurance being considered.**	**As level three training is mandated every three years. The expectation is that we will not see acceptable level of compliance until 2026**
Safeguarding training compliance	**x**			• **To improve safeguarding training compliance practitioners require management support to complete**	.

				level 2 safeguarding training on ESR and book onto level three safeguarding training dates on share point. Uptake for adult safeguarding training sessions remains low.	**Uptake for adult safeguarding training sessions remains low. Poor compliance with level 2 ESR safeguarding training.**

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR037 Director of Nursing

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X
	• Finance	
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	X
	• Governance	X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Inability to provide safe and adequate levels of care in line with good practice and guidance.*

Due to: *High registered nurse vacancies and absenteeism, increased levels of patient acuity presenting to hospitals, cared for in single occupancy environments.*

Likelihood of Current Occurrence: 2 = Do not expect it to happen / recur but it is possible it may do so

Impact if Occurred: *Negative impact on staff morale, patient experience and outcomes. Non-compliance with legislative and statutory requirements, creating exposure to reputational damage.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

				X – target score
		X – risk appetite – low adverse to risk		
				X – current score
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

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4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
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Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
4	***5***	***4***	***4***	***1***	***5***
20		***16***		***5***	

	Justification for Risk Appetite and Risk Capacity Level & Target Score: Nurse staffing levels remains one of the most significant risks within the Health Board with potential to impact on patient safety, quality of care and experience. If all mitigation and actions come to fruition, there is the ability to reduce the risk substantially hence the score of 5 has been applied as the target risk level. ***Risk Trend:*** The risk level has remined at level 15 (after all controls and mitigation is applied) over the last 6 months. **Current Controls:** • Nurse Staffing Levels (Wales) Act 2016- recalculation of roster establishments. • Monthly Strategic Nurse Workforce Meetings – monitor and manage trends. • On-going local and international recruitment of registered nurses and HCSW's. • Pro-active recruitment via streamlining. • Review of skill mix to include Assistant Practitioners. • Prudent RN approach – introduction of new roles to release registered nurse's time. • Implementation of local bank incentives and specialist bank rates of pay. • Daily site meetings to ensure appropriate allocation of staff to manage risk across all sites. • Bespoke recruitment events • Recruitment wheel for RN's and HCSW's • Roll out of SafeCare
Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*	

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Develop Nursing Workforce Strategy.	Linda Alexander	March 2023	Completed – awaiting Exec approval 23.3.23	
Focused recruitment campaigns (local and national) tailored too hard to fill areas. Speciality driven campaigns.	Sian Bigmore in collaboration with Divisional Nurses	March 2023 - ongoing	Annual recruitment wheel cycle established; first event completed.	
Enhance existing nurse resource bank.	Ann Bentley/Sian Bigmore	March 2023 - ongoing	Annual recruitment wheel cycle established; first event completed. Existing bank nurses to be offered substantive contracts.	
International recruitment	Linda Alexander/Shelly Williams	May 23-Sept23	Paper to be received at Execs 23rd March 2023	
Improve recruitment service by streamlining the process to ensure timely commencement and improved on-boarding process.	Sian Bigmore	May 2023	KPI's being developed to track and monitor improvement in reducing time to hire	
Increased focus on retention.	Shelley Williams	May 2023	Review current flexible working offer. Ensure all marketing material support flexible working opportunities.	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Nurse Staffing Levels (Wales) Act 2016 – compliance with the Act monitored annually.		X			
Nurse Staffing Escalation Framework	X				
Strategic Nursing Workforce Meetings		x			

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR040 Director of Nursing

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X
	• Finance	
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	X
	• Governance	X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Lack of public confidence, reputational and financial damage/impact.*

Due to: *Continued and sustained non-compliance with The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011*

Likelihood of Current Occurrence:
4 -Likely - Will probably happen/recur, but is not a persisting issue but consequence 3 Moderate therefore Risk = 12

Impact if Occurred: *Adverse impact on patients, complainants, carers, staff, along with organisational reputational damage, ultimately effecting levels of public confidence. Potential financial impacts for complaints and clinical negligence claims.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X – risk appetite – moderate/cautious risk taking **9 – target score**	**12 – current score**	
			X – capacity score	

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
4	***4***	***4***	***3***	***3***	***3***
16		***12***		***9***	

Justification for Risk Appetite and Risk Capacity Level & Target Score:

	A moderate risk appetite level has been applied to this risk, accepting that the Health Board will need to adopt a cautious approach to seeking risks to realise optimal opportunities in management of the risk. The risk capacity level has been set at (4x4)16 and aligns with the inherent risk score. The target risk score seeks to decrease the likelihood from the current score but maintain the impact of the risk being realised. ***Risk Trend:*** *Maintained.* **Current Controls:** • Putting Things Right Procedure for the Management of Concerns (Complaints) • Procedure on the management of Public Services Ombudsman for Wales (PSOW) investigations • Putting Things Right Policy (Complaints, Claims and Patient Safety Incidents) • Policy and Procedure for the Management of Patient Safety Incidents (Including Nationally Reportable Incidents) • Toolkits on PTR webpages • IO Face to Face training • Corporate ADN meeting with Divisional SMT • Fully established Corporate Concerns Team and increased QPS support in Divisions • Yorkshire Contributary Factors Framework • Quality Strategy (currently in draft) • The Health and Social Care (Quality and Engagement) (Wales) Act 2020 • Patient Experience and Involvement Strategy

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Further promotion of empowering staff to report incidents and concerns where appropriate – supported by a 'Just Culture' e.g., no blame	Divisional Triumvirate teams PTR team Organisational Workforce	Ongoing	Compassionate leadership Programme Compassionate Leadership in Investigating Officers Quality Strategy Patient experience and involvement strategy	
Triangulation of data to further understand contributing factors relating to Never Events, Patient Safety Incidents and serious concerns	Assistant Director of Nursing, Assistant Director for Quality and Patient Safety and Assistant Director of ABCi	1st April 2023	Governance away day Quality Strategy Thematic reviews Delivery plan for the quality strategy -27th March 2023 Theatre safety collaboration group re-established for education, sharing and learning Theatre safety meeting have been reinstated Review of SI process	

			The current divisional QPS resource is being reviewed and it is anticipated that some of this resource could support this compliance	
To increase compliance with PTR regulations	Divisional Triumvirate teams PTR team	Ongoing	Toolkits on PTR webpages IO Face to Face training Corporate ADN meeting with Divisional DMT Fully established Corporate Concerns Team and increased QPS support in Divisions Patient Experience and Engagement Strategy The current divisional QPS resource is being reviewed and it is anticipated that some of this resource could support this compliance Advisory review in progress	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of* ***operational***, ***organisationa****l and* ***independent*** *assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider*: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**
Putting Things Right Policies		X			Under review
Internal Audit on PTR – reasonable level of assurance gained September 2021			X		
Compliance with Putting Things Right Regulations –		X			

report to WG and PSOW quarterly stats on compliance					

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Updating and reviewing Putting Things Right Policies in line with up to date legislative requirements	Executive Director of Nursing	April 2023	Await confirmation from WG	

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
None identified by the ICT Directorate				

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?

Assurance Map					
Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**

Cyber Security remedial action plan against NIS CAF Assessment		Establishment of HB office of the SIRO	Oversight from NHS Wales Cyber Resilience Unit		Amber as HBOTS inaugural meeting still to take place
Templar Report		Establishment of HB office of the SIRO	Oversight from NHS Wales Cyber Resilience Unit		Amber as HBOTS inaugural meeting still to take place
Cyber Security support at all relevant stake holder groups	Governance and Assurance Groups	Establishment of HB office of the SIRO	Oversight from NHS Wales Cyber Resilience Unit		Amber as HBOTS inaugural meeting still to take place
Monthly Cyber report to include patching and O/S compliance					

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance.*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
HBOTS inaugural meeting to take place.	**Director of Digital**	**Q2 2023**	**Remains in progress.**	

ABUHB Director of Therapies is the National SRO			There is likely to be confidential national mitigations (plans) being worked through that would support mitigation of this risk		It is unknown what these mitigation or plans may be due to the sensitive and confidential nature

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR019 Director of Operations

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	X
	• Workforce & Organisational Development	X
	• Finance	X
	• Digital, Data, Intelligence	X
	• Estate	X
	• Regional Solutions	X
	• Governance	X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand.*

Due to: *Significant delayed transfers of care, domiciliary and care home constraints.*

Likelihood of Current Occurrence: 4 = Likely - Will probably happen/recur but it is not a persisting issue

Impact if Occurred: *Significant negative impact on patient flow throughout the acute care system in conjunction with a poor patient experience which may in turn produce poor patient outcomes.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X – risk appetite – low risk taking		
				X – target score
			X – current score X – capacity score	

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***4***	***5***	***3***	***5***
25		***20***		***15***	

	Justification for Risk Appetite and Risk Capacity Level & Target Score: *This risk has a **low-risk appetite** in respect of quality and patient safety.* *The **risk capacity** for this area is **high** due to the nature of the consequence of the risk being catastrophic, if realised.* *The **target score** has been set at **15** due to an inability to reduce the consequence but some ability to reduce the likelihood albeit, this is informed by external factors outside of the Health Board's control.* ***Risk Trend:** Maintained* **Current Controls:** • Health Board Emergency Pressures Escalation Policy (revised Nov 2021) • Health Board surge plans. • System Leadership and Response – whole system planning – meets x2 weekly. • Cross-site meetings to discuss system and flow pressures meets x2 daily – reduced to release clinical staff. • Escalation meetings as required. • Executive escalation for any crew delayed for over 2 hours, and 2 hourly thereafter. • Emergency Care Improvement Board – meets monthly. • Urgent Care Transformation Board • Lightfoot data being used to inform plans. • Community Division seeking to accept acute transfers pre-mid-day to mitigate late transfers to community and to release capacity in emergency department.

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Implement the AB safety flow model	**Clinical Executives**	**Implemented**	**Enable moves through the system to manoeuvre patients through the system and zero tolerance of 4 hour waits on ambulance (local target) outputs are being actively monitored by EASC dashboard.**	
Pathways of care – collaborative acute, community and being led by Welsh Government	**Annie Lewis**	**Ongoing implementation**	**Reviewing number of patients in acute hospitals who are able to be discharged and not solely reliant on social care input. Data being reported to Welsh Government monthly, in place for the last 3 months.**	
Reviewing care pathways related to hospital admissions. To	**Owain Sweeting/Flow Centre**	**April 2023**	**Early nominations and discussions are being**	

establish care pathways where patients can be most appropriately managed in collaboration with the flow centre.			**undertaken and update to Divisional DMT.**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Health Board Escalation Policy (under review)		**X**			**Policy under review currently to ensure robust and cohesive policy in place.**

Local Business Continuity Plans (BCPs) including the testing of the plans.	**X**				**BCPs in place in most areas but further testing needs to take place.**
Urgent Care Transformation Board – responsible for monitoring and implementation of plans associated with 6 goals of urgent and emergency care.		**X**			**Due to the vast nature of the business of the 6 goals of emergency care, further focus is required in the smaller workstreams to achieve green in this area overall.**

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Reviewing the Health Board Escalation Policy	**Wendy Warren**	**April 2023**	**Information being collated to inform red escalation cards, identification of triggers and actions required.**	
Further testing of BCPs across the operational team.	**Andy Goodenough/Wendy Roberts**	**June 2023**	**Some testing has been undertaken. A planned exercise Euclid from Welsh**	

			Government will test our ability to respond to a major incident and therefore test the strength of BCPs. ICT BCPs have been tested successfully, specifically for the operational team.	
Review of governance arrangements for urgent care transformation board including the workstreams that comprise it.	**Paul Underwood**	**Ongoing**	**Initial reporting to operational DMT has commenced however, further work is required to ensure reporting is consistent and drives forward change and patient outcomes.**	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR023 Director of Operations

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	X
	• Workforce & Organisational Development	X
	• Finance	X
	• Digital, Data, Intelligence	X
	• Estate	X
	• Regional Solutions	X
	• Governance	X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TOLERATE

Overall Level of Assurance (RAG):

	X	

Risk of: *Unknown or unmet non-COVID harm across population health*

Due to: *Priority being given to management of the COVID pandemic.*

Likelihood of Current Occurrence: 4 = Likely - Will probably happen/recur but it is not a persisting issue

Impact if Occurred: *Significant impact on demand for primary, secondary and tertiary care services with patient acuity increasing and patients waiting longer to access appointments. Patient safety and outcomes, levels of public confidence, reputational and financial will be impacted adversely.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X – risk appetite – low risk taking		
				X – current score X – target score
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophi**
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2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***4***	***5***	***4***	***5***
25		***20***		***20***	

	Justification for Risk Appetite and Risk Capacity Level & Target Score: *The risk appetite for this risk is set at a low level, due to impacts on patients' safety and outcomes and unknown harm.* *The risk capacity level for this area is 25 as this is the level at which the risk has been tolerated previously before local mitigations were put in place.* *The target risk score for this area is (4x5)20 and the risk is reported as achieving its target. The challenge for the Health Board remains to maintain this position and identify any other actions that could further reduce the risk and align to risk appetite level. Therefore, the Board is asked to* ***TOLERATE*** *this risk, above risk appetite but within risk capacity level.* ***Risk Trend:*** *Maintained* **Current Controls:** • Planned Care Recovery Plan – Ministerial priority. • Early recovery plan agreed focusing on Cancer, 52 weeks, Follow Up waits, Diagnostic and Therapies waiting times, and Eye Care. • Risk stratification and validation of lists is ongoing, and focus is on Urgent and Cancer work. • Weekly tracking of recovery plus tracking of new ways of working in place • WLI OPD sessions for clinically urgent patients, maximising PAC and theatres and on a transformational level, • Adapt and sustain progress being monitored through Exec Team meetings via Director of Operations. • Plan in place for green recovery (treatments) RGH – all specialities excluding orthopaedics. • Orthopaedic operating at OSU and NHH (P2) • Outpatient Steering Group • Robust escalation reporting and escalation arrangements within primary and community services division.

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Application of INNU Policy	**LW/RME/JP/CM**	**Ongoing**	**Current policy circulated. Quarterly review of statistics for each speciality – currently only able to view at treatment stage. WPAS being adapted to record 'rejection due to INNU' this will enable HB to monitor at front end of pathway All Wales review of INNU Policy to take place**	
Hospital cancellations under six weeks	**LW/JP/CM**	**Ongoing**	**Task and finish group in situ. Action Plan developed. Reasons for cancellations identified by speciality. Main reason is approval of annual leave/study leave under six weeks. Annual leave policy re-issued to Divisions and Directorates. X 3 hospital cancellations – policy being developed.**	

Decrease DNAs	**LW/JP/CM**	**Ongoing**	**Task and finish group in situ.** **DNA rates monitored.** **Action plan developed.** **Focused work on DNAs within tumour sites.** **Use of Dr Doctor to contact patients to establish why they have DNAs with analysis of outcomes.** **Patient focus groups to be organised (working with CHC).**	
Increase use of clinic space/increased utilisation	**LW/JP/CM**	**Ongoing**	**Fortnightly meetings in place with sisters of OPD areas.** **Requests for space directed through this forum** **Specification for outpatient booking system completed and business case underway. Aim of system is to optimise use of clinics space, enable services to request/book space for both ad hoc and longer-term requirements**	
	LW/JP	**Ongoing**		

Patient Contact of new outpatients to establish if they still wish to have their appointment, to ensure the HB has 'clean' and up to date waiting lists **Contact of patients on P4 treatment lists being contacted (agreed specialities only)**			**Monthly programme in place to contact patients with agreed SOPS** **ENT and GS commenced, with timetable for other agreed specialities**	
SoS (see on symptom) and PIFU (patient -initiated Follow-ups)	**LW/JP/CM**	**Ongoing**	**New pathways identified for helping to manage follow-up demand. First element is in terms of ensuring that patients are discharged from follow-up waiting lists where appropriate. In terms of SOS/PIFU - particular concentration on surgical specialities where waiting lists are longer, such as: ENT/GS/T&0/Urology/Gynae/ Derm etc.** **This helps towards ensuring that capacity is used for those patients who need to be seen.**	

			These pathways enable the patients to be managed	
Outpatient Speciality Plans	**LW/JP/CM**	**Revised plans to be completed by 30th April**	**Plans to capture outpatient transformational plans by speciality. Informs programme plan for 23/24.**	
E: Advice	**LW/JP/CM**	**31st March 2023**	**Launch of E: Advice within HB** **To assist with decreasing referral demand into the HB**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	**1st Line of Defence**	**2nd Line of Defence**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**

	(Operational)	(Organisational)			
Application of INNU Policy		**Re-issue of Policy** **Monitoring mechanism in place**	**All Wales Review of INNU Policy**		**Updated policy required. Potential for more categories to be added to the Policy.**
Hospital Cancellations Under six weeks		**Annual Leave and Study Leave Policy** **Monitoring mechanism in place**			**Divisions/directorates to adhere to the policy**
Decrease DNAs		**Re-issue of Policy** **Monitoring mechanism in place**	**All Wales RTT Policy which includes management of DNAs**		**Divisions/directorates to adhere to the policy**
Increase use of clinic space/increased utilisation		**Bi-weekly meetings**			**Funding for booking system**
Patient Contact of new outpatients to establish if they still wish to have their appointment, to ensure the HB has 'clean' and up to date waiting lists		**Programme plan in situ**			

Contact of patients on P4 treatment lists being contacted (agreed specialities only)					
SoS (see on symptom) and PIFU (patient -initiated Follow-ups)		**Task and finish group**	**All Wales target of 20%**		**Continued discussions with directorates and clinical leads. Review pathways from other HBs to establish whether they are suitable for specialities within ABuHB**
E: Advice		**Working with Informatics Team**			**To be launched by end of March 2023. However only partial implementation with further work required to implement the process fully.**
Outpatient Speciality Plans		**DM meetings**			**Being refreshed for 23/24**

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Automated booking system – completion of business case	**Julie Poole**	**May 2023**	**Partially complete. Budget costs obtained. Scoping exercise completed and draft specification.**	
E Advice	**Julie Poole/John Frankish**	**TBC**	**Work with informatics team to identify priority and timeline to complete full process**	
Outpatient speciality plans	**Julie Poole/Directorates**	**May 2023**	**New template developed. Meetings held with AGMs for all Divisions. Meetings organised with DMs**	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR039 Director of Operations and Medical Director

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety • Partnership First • Research, Innovation, Improvement, Value • Workforce & Organisational Development • Finance • Digital, Data, Intelligence • Estate • Regional Solutions • Governance	X X X X X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Delayed cancer treatments delivered to patients.*

Due to: *Deteriorated position in cancer performance specifically in relation to 62 day waits.*

Likelihood of Current Occurrence: *4 = Likely - Will probably happen/recur but it is not a persisting issue*

Impact if Occurred: *Reduced levels of patient quality, outcomes and experience, public confidence, and potential reputational damage to the Board.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X - risk appetite - low (averse to risk)		**X – target score**
				X – current score
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophi**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***4***	***5***	***2***	***5***
25		***20***		***10***	

	Justification for Risk Appetite and Risk Capacity Level & Target Score: *Cancer performance has been clearly outlined as a key operational target by Welsh Government with an expectation to have achieved 70% and reduced long waiting patients (>104 days) by the end of March 2023.* *104 days on cancer pathway has been set as the threshold at which harm should be considered for the patient. We currently have 130 patients actively waiting over this threshold.* ***Risk Trend:*** *Maintained* **Current Controls:** • Cancer Services Board to monitor and review delivery plans associated with cancer targets (KPIs) • Regular reporting on cancer KPIs to Welsh Government. • Cancer Directorate performance meetings. • Use of business intelligence tools (Lightfoot SFN, Qliksense, Performance warehouse data).

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Cancer Assurance meeting recommencing from February 2023 focussing	**Richard Morgan-Evans**	**February 2023**	**In progress, meetings commenced 20/02/2022**	

on backlog reduction, 62 day and 14-day compliance as key metrics for supporting faster treatment.				
Pathology outsourcing to continue. Improvements in USC TAT are expected to improve once routine backlog cleared, and urgent samples begin to be outsourced.	**Arvind Kumar**	**Feb/March 2023**	**Outsourcing has successfully reduced total turnaround times for USC. Further reduction in waiting times required plus additional capacity requirement for expected demand growth**	
14 days first seen measure remains as priority to ensure rapid access to diagnostics. 75% target set for April 2023	**Leanne Watkins**	**April 2023**	**February 14 day compliance was 64.4%**	
Optimal Cancer Pathway manager to begin in post 13.02 with early focus on H&N and Urology	**Michael Eastwell**	**August 2024**	**Manager in post. Awaiting imminent launch of pathway project**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Cancer Services Assurance meetings to act as key metric operational review.	**x**				Meetings currently running fortnightly and by exception. Likely gap in employment of the Cancer Service Manager role monitoring metric trajectories.
Regular reporting on cancer KPIs to Welsh Government.			**X**		Monitoring of ABUHB quality metrics regularly fed back through operational cancer meetings. Potential gap in method of feedback from

					delivery unit to Health Board
Cancer PTL tracking meetings	**X**				Weekly patient level meetings held between Cancer Services and tumour site teams to resolve patient level blockages.
Use of business intelligence tools (Lightfoot SFN, Qliksense, Performance warehouse data).		**X**			Assurance required that Qlik information is being regularly utilised within operation teams.

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Cancer delivery quality metrics to me agreed and disseminated amongst tumour-site teams and monitored through fortnightly assurance meetings.	**Richard Morgan-Evans/Michael Eastwell**	**31/03/2023**	**In progress**	

Cancer Services operational structure to be agreed and implemented.	**Leanne Watkins**	**31/04/2023**	**In progress**	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR028 Director of Operations

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	X
	• Workforce & Organisational Development	X
	• Finance	X
	• Digital, Data, Intelligence	X
	• Estate	X
	• Regional Solutions	X
	• Governance	X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Continued inappropriate admissions of children aged under 18 to acute adult mental health wards. Particularly where admissions are of under 16-year-olds, are for longer than 72 hours and/or are not compulsory detentions under the Mental Health Act.*

Due to: *Inability to access appropriate acute/crisis beds for this age group in the region.*

Likelihood of Current Occurrence: 4 = Likely - Will probably happen/recur but it is not a persisting issue

Impact if Occurred: *Significant impact on demand for primary, secondary and tertiary care services with patient acuity increasing and patients waiting longer to access appointments. Patient safety and outcomes, levels of public confidence, reputational and financial will be impacted adversely.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

				X – target score
		X - Moderate (cautious risk taking)		
				X – current score
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophi**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***4***	***5***	***2***	***5***
25		***20***		***10***	

Justification for Risk Appetite and Risk Capacity Level & Target Score:

	The risk appetite for this risk is set at a moderate level, advising cautious risk taking. The rationale for this is to identify innovative actions of mitigating this risk that has not previously been undertaken. Also, the frequency of this risk recurring is low, therefore, it allows for a higher threshold of risk appetite in seeking the rewards of the mitigations. *The risk capacity level for this area is 25 as this is the level at which the risk has been tolerated previously before local mitigations were put in place.* *The target risk score for this area is (2x5)10 as the Health Board seeks to reduce the frequency of this risk recurring through the mitigations identified through this risk assessment.* **Current Controls:** • Health Board Policy is in place for the use of adult Mental Health beds for up to 72 hours. • Designated bed in Extra Care Area • Children and Young People aged under 16 are nursed 1:1 and are prevented from mixing with other patients on the ward. • If Young Person is detained under the Mental Health Act, the safeguards inherent with this legislation apply.

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
CAMHS is working with partners to develop enhanced Crisis support	**Kolade Gamel**	**Ongoing**		

for Children and Young People which will include crisis beds.				

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Health Board CAMHS Crisis Flow Policy		**X**			**Further assurances required in determining if the Policy remains fit for purpose and if staff are aware/have received the appropriate training and guidance.**

The Health Board was successful in obtaining capital funding for the proposal to repurpose former Bettws Ward, St Cadocs hospital to become a CAMHS crisis suite.		**X**			**Full plan to be developed and reported to Executive Committee, Partnerships, Population Health and Planning Committee and finally, the Board.**

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
A review of the policy to be undertaken to ensure clear staff guidance is provided.	**Kolade Gamel/Leanne Watkins**	**May 2023**		
A robust plan to be developed and reported to relevant groups/Committees to provide Board with assurance the mitigation for this risk is progressing.	**Kolade Gamel/Leanne Watkins**	**Q4 2023/24**		


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Potential Impact of Risk on IMTP Priorities:		Risk Reference and Executive Owner: CRR003 Director of Primary, Community and Mental Health Services

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	
Enablers	• Experience, Quality & Safety • Partnership First • Research, Innovation, Improvement, Value • Workforce & Organisational Development • Finance • Digital, Data, Intelligence • Estate • Regional Solutions • Governance	X X X X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Mental Health services will fail to meet the current and future demand of the Health Board population.*

Due to: *Current WCCIS system implementation, impacting on the ability to understand and report performance, inability to monitor demand and the negative impact of this on patient outcomes.*

Likelihood of Current Occurrence: *4 Likely - Will probably happen/recur but is not a persisting issue.*

Impact if Occurred: *Levels of population well-being could decline creating enhanced and sustained reliance on mental health services for children and adults. Unmet demand in communities potentially leading to increase in demand for Secondary Care Mental Health Services. Inability to provide assurance and reporting under mandatory Mental Health Measure and Psychology Waiting time compliance, resulting in an increase in waiting times for treatment across all services.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

			X – target score	
		X – risk appetite – moderate, cautious risk taking	**X – current score**	
			X – capacity score	

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
4	***4***	***3***	***4***	***2***	***4***
16		***12***		***8***	

Justification for Risk Appetite and Risk Capacity Level & Target Score:
A moderate risk appetite level has been applied to this risk to demonstrate the Health Board's intention to innovate the electronic service whilst maintaining patient safety, experience, and outcomes levels. The Health Board recognises that it may need to seek risks in this area to optimise opportunities.
The risk capacity level is (4x4) 16 which is the level at which the Health Board can tolerate this risk manifesting and is in line with the inherent risk score.
The target score for this risk is (2x4)8. This recognises the Health Board's ambition to reduce the likelihood of the risk being realised and the remainder of the actions within this risk assessment outline the way in which the Health Board can achieve the target score.

Risk Trend: *Maintained.*

Current Controls:

- 1. WCCIS Programme in place, with clear and identified risk and issue escalation protocols within ABUHB, and in conjunction with Advanced and DHCW national programme team.

	• 2. Dedicated performance support within MHLD Division and monthly progress and monitoring meetings to work through dedicated WCCIS reporting timeframes and progress. • 3. Dedicated resource within Informatics in the development of a new Qlik application for all MHLD reporting, which will include dedicated KPI monitoring and MHM reporting dashboards. • 4. Bi-weekly WCCIS steering group in conjunction with WCCIS Programme team and MHLD Divisional partners to monitor and review ongoing performance and backlog issues and potential risks across the programme. • 5. Dedicated resource to support operationalising data to support teams with current waiting list views and the support to cleanse and audit current migrated and new data within the WCCIS system.

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Ending of current designated contract with Qlik developer, seek	Lorna Allcock / Lynne Wilde	31st March 2023	Funding currently sought, confirming extension of	

further funding for extension to ensure full completion of all MHM compliance dashboards on Qlik.			contract with developer and contracting agency.	
Seek additional funding to support agency and overtime of staff to complete team backlog across referrals and appointments.	Divisional Senior Management Team & Directorate Leads	31st March 2023	Currently no funding sought to cover additional staffing resource past March 31st. Emails sent to Informatics manager to see if funding previously designated can be extended past March 31st. Emails and risk logged around the lack of post arch funding for backlog activities.	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of* ***operational***, ***organisationa****l and* ***independent*** *assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider*: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map					
Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**
WCCIS Programme Board	**X** Programme Board	**X** Executive Board	**X** Advanced / WCCIS National Programme Board (WG)		Potential opposing priorities across parties, Advanced priorities and MHLD Divisional priorities.
Dedicated performance support from MHLD Division, Service Improvement and Support Manger and Data Analyst.	**X** MHLD Divisional Manager	**X** Interim Executive for Mental Health			Independent assurance.
Dedicated resource for Qlik Development.	**X** Informatics Manager ABUHB	**X** Executive Director for Informatic Services.			Independent Assurance

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**


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Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR027 Director of Public Health

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X X
	• Finance	X
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	
	• Governance	

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TOLERATE

Overall Level of Assurance (RAG):

	X	

Risk of: New COVID variants emerging
Due to: Significant and sustained spread of disease culminating in the effectiveness of COVID-19 vaccination and booster programme being compromised.
Likelihood of Current Occurrence: *4 = Likely - Will probably happen/recur but it is not a persisting issue*

Impact if Occurred: Potential impact on ability to staff services appropriately, also leading to widespread disease and harm in communities, eventually impacting on Health Board services, Primary, Secondary and Tertiary).

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X - risk appetite - moderate (cautious risk taking)		
				X – current score **X – target score**
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophi**
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5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***4***	***5***	***4***	***5***
25		***20***		***20***	

Justification for Risk Appetite and Risk Capacity Level & Target Score: *The risk appetite level for this risk is set at moderate level recognising that there are several factors related to this risk which are out of the Health Board control.*

	The risk capacity is set at maximum (5x5)25 as this is the level at which the Health Board tolerated the risk when it was first identified. *The risk target score is in alignment with the current risk score; therefore, the Board is requested to* ***TOLERATE*** *this risk above risk appetite but in line with target score, recognising it is being managed within the capacity limits.* ***Risk Trend:*** *Maintained.* **Current Controls:** • Continuation of data, surveillance, and monitoring activities to inform any deterioration from 'Covid Stable' to 'Covid Urgent' (as per WG national policy), as could be triggered by emergence of a new variant and initiate standing up of IMT arrangements as necessary. • Development of Health Board Public Health Plan (to supersede the previous Pandemic Plan) • Health Board Vaccination Programme

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map					
Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR036 Director of Operations

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	
Priority 3	• Adults in Gwent Live Healthily and Age Well	
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	X
	• Workforce & Organisational Development	X
	• Finance	X
	• Digital, Data, Intelligence	X
	• Estate	X
	• Regional Solutions	X
	• Governance	X

Assurance/Oversight Committee: Patient Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: Clinically unsafe and inappropriate inter-site patient transfers and into communities.

Due to: Lack of availability of safe and appropriate transfer vehicles, staff and skill mix to facilitate the transfers.

Likelihood of Current Occurrence: 3 = Probable - Might happen or recur occasionally

Impact if Occurred: *Compounds the Health Board's inability to discharge into communities and negatively impacts the DToCs position. Poor patient/families and staff experience and outcomes. Potential financial implications and reputational/public confidence damage.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

				X – target score
		X – low risk appetite – adverse to risk		
				X – current score
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophi**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
4	***5***	***3***	***5***	***1***	***5***
20		***15***		***5***	

	Justification for Risk Appetite and Risk Capacity Level & Target Score:
	The risk appetite for this risk is set at a low level, which confirms that the Health Board is averse to seeking risks in this area. The rationale for this is to minimise harm to patients.
	
	The risk capacity level for this area is 20 as this is the level at which the risk has been tolerated previously before mitigations were put in place. This
	
	*The target risk score for this area is (1x5)5. Actions identified throughout this report aim to provide a pathway through which the Health Board could achieve the target score. Therefore, the Board is asked to **TREAT** this risk above the appetite, noting it is currently scored below the capacity level.*
	
	Current Controls:
	
	• Ministerial direction on 6 goals of urgent and emergency care and Health Board Programme to achieve the objectives set out within.
	• Contractual obligations between the Health Board and WAST.
	• Same Day Emergency Care Model implemented at GUH.
	• Local handover improvement plan being coordinated by Corporate Operations including:
	  ○ Refresh Full Capacity Protocol (Q3 2022)
	  ○ Review of HALO/PFC role in ED (Q4 2022)
	  ○ Over 65 Pathways (Q1 2023)
	  ○ SDEC (Q4 2022)
	  ○ Scheduling of Urgent Care @ RGH MAU (Q4 2022)
	  ○ Flow Centre APP (Q4 2022)
	  ○ PRU Business Case continuation (Q3 2022)
	  ○ Discharge Pathways (Q3 2022)
	  ○ SAFER Principles(Q3 2023)
	  ○ Consistent MDT Board Rounds (Q1 2023)
	  ○ Provision of an extra 1000 community beds pan Wales by Winter 2022 (Q3 2022)

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Handover Improvement Plan actions & timelines added.	**Steve Bonser**	**Achieved**	**Governance arrangements added to demonstrate measurement and management of WAST contracts. Number of Inter-Site vehicles and skill mix added to highlight appropriateness of ambulance type and clinician available to safely transfer patients between sites.**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map					
Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**
Internal Health Board policies and procedures in place.		**X**			**Regular review of policies and procedures**
Operational criteria and checklists for patients to be transferred.	**X**				
Handover improvement plans.	**X**				**Further testing of improvement plans to demonstrate improvements.**

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Further testing of improvement plans against performance data to demonstrate improvement.	**Steve Bonser**	**Q2 2023**	**Ongoing**	

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:	25 April 2023
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Blood Management
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr James Calvert, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Stacey Wetherell- Haematology Department Manager

Pwrpas yr Adroddiad Purpose of the Report
Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT
Sefyllfa / Situation The Paper provides assurance of the Health Board's delivery of Health and Care Standard 2.8 Blood Management and its various components and sets out the priorities and actions which will be progressed through the Hospital Transfusion Committee (HTC).
Cefndir / Background The Aneurin Bevan University Health Board Quality Assurance Framework (QAF) forms an essential part of the systems and controls in place in the Health Board. The purpose of the QAF is to identify and manage risks to the Health Board achievement of our strategic objectives and priorities as set out in the Health Board's Integrated Medium-Term Plan 2020-2023. This framework is aligned to the Board Assurance Framework and 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. Day to day oversight is via the Quality and Patient Safety Operational Group (QPSOG), which reports to the Executive Team.

The HTC has oversight and responsibility for 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 will produce an annual assurance report detailing the Health Board position in relation to each component of the Health and Care Standard and will provide exception reports if required throughout the rest of the year.

Asesiad / Assessment

Standard 2.8 requires that "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 overseen by the HTC, a subgroup of the QPSOG that reports to the PQSOC.

The HTC comprises a Chair, Consultant Haematologist with responsibility for transfusion, Welsh Blood Service (WBS), Haematology / Transfusion Department Manager, Transfusion Laboratory Manager, Transfusion Practitioner, Anaesthetist, Risk Management and invites representation from Senior Nursing & Midwifery teams and clinical high users of blood components. The HTC will seek to gain representation from finance and Primary Care or equivalent during 2023.
Action 2023: Invite finance and Primary Care (or equivalent) representative to HTC

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 Health Board Policies and Procedures reinforce legislation and national guidance including:

<u>The Blood Component Transfusion Policy</u>
The policy is currently under review and 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). The HTC is responsible for the content and review of the policy and monitors compliance through the Hospital Transfusion Team.

It sets out the responsibilities of the Health Board and its staff 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). The policy 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).

The policy sets out the responsibilities of staff groups across the Health Board in safe transfusion, particularly with respect to correct patient identification, correct documentation including traceability of all blood components and communication of information.

The policy clearly defines training and competency requirement of all staff involved in transfusion processes.

The policy provides information to support informed consent and the provision of patient information.

Clinical Standard Operating procedure (CSOP) Transferring Blood Components with Patients.

The CSOP 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.
- To ensure that the correct Patient Identification and Component Administration procedures are followed.
- To ensure that legislation relating to Traceability, Cold Chain and Safe Handling of Blood Components is complied with.

The CSOP provides transfer principles and methods unique to each Health Board site.

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.

National Audit e.g., 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. Having undertaken a recent audit of sample

acceptance, within the Health Board there is currently an 8.5% sample rejection rate due to errors in labelling. 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 cannot be 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.

<u>The Management of Major Haemorrhage Protocol</u>
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.

This Protocol has been adapted from NHS Blood and Transplant (NHSBT) NW Region's Toolkit for the management of major haemorrhage (2013) and underpins Haematological Management of Major Haemorrhage, BSH (2017). 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).

<u>The Blood Shortage Clinical Management Plan</u>
The Blood Shortage Clinical Management Plan provides 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, very acute shortages caused by, e.g. security issues which stop donors coming forward to donate blood, 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 should be aware of their responsibilities as appropriate and be willing to 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 particular 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 will be 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.

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). 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. 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.

A monthly dashboard of blood component usage by site is produced by WBS to support effective and prudent use of blood products to supporting monitoring and management.

The dashboard is accompanied by an exception report when exceptions occur (see below for examples), based on non-compliance with KPIs for Health Boards to review and discuss mitigating actions.

Dashboards and exception reports are also discussed at HTC.

Hospital Monthly Key Performance Indicator (KPI) Exception Report

Report For:	ABUHB
Period of:	1st January 2022 – 31st December 2022
Date issued:	19.01.23
For the attention of:	Transfusion Laboratory Managers (TLMs)/Transfusion Practitioners (TPs)/ Consultant Haematologists/Hospital Transfusion Committee (HTC) Chairs

O D Neg as a percentage of issues (KPI 12%)

Nothing to Report

O D Neg Wastage as a Percentage of Issues (KPI 10%)

Health Board O D Neg wastage data saw increase in December 2022 to 14.29% although the rolling 12-month KPI was only 7.54%

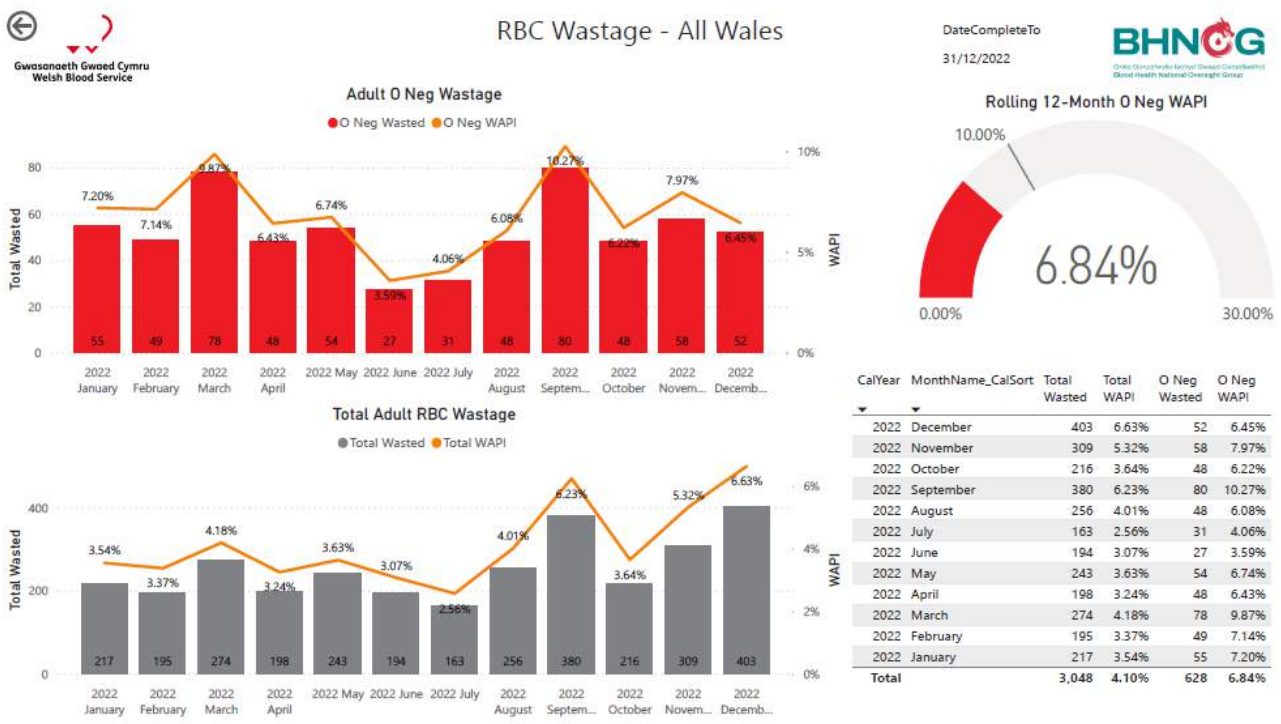
The Grange O D Neg wastage for December showed a large increase at 34.48%. This has contributed to a rolling 12-month KPI of 13.16%. It was noted that there have been ongoing discussions between the Grange TLM & BHT regarding the issue of short dated units and the impact this will have on wastage data.
Action – ongoing review of expiry dates

Platelet Wastage as a Percentage of Issues (KPI 12- 15%)

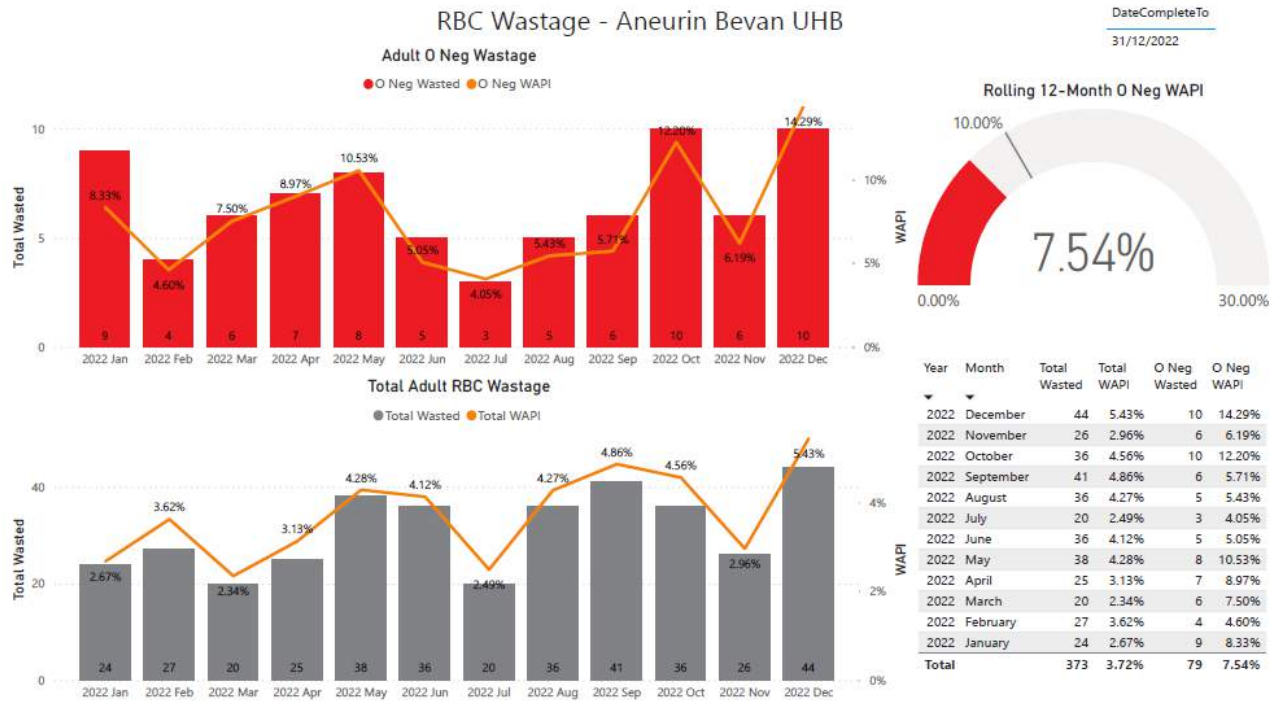
Nothing to Report

KPI reports to be discussed within HTT/HTC & propose any remedial actions/key messages as appropriate. The HTC representative at the BHNOG should ensure they are familiar with the actions/messages identified at the HB.

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.



CalYear	MonthName_CalSort	Total Wasted	Total WAPI	O Neg Wasted	O Neg WAPI
2022	December	403	6.63%	52	6.45%
2022	November	309	5.32%	58	7.97%
2022	October	216	3.64%	48	6.22%
2022	September	380	6.23%	80	10.27%
2022	August	256	4.01%	48	6.08%
2022	July	163	2.56%	31	4.06%
2022	June	194	3.07%	27	3.59%
2022	May	243	3.63%	54	6.74%
2022	April	198	3.24%	48	6.43%
2022	March	274	4.18%	78	9.87%
2022	February	195	3.37%	49	7.14%
2022	January	217	3.54%	55	7.20%
Total		3,048	4.10%	628	6.84%



Year	Month	Total Wasted	Total WAPI	O Neg Wasted	O Neg WAPI
2022	December	44	5.43%	10	14.29%
2022	November	26	2.96%	6	6.19%
2022	October	36	4.56%	10	12.20%
2022	September	41	4.86%	6	5.71%
2022	August	36	4.27%	5	5.43%
2022	July	20	2.49%	3	4.05%
2022	June	36	4.12%	5	5.05%
2022	May	38	4.28%	8	10.53%
2022	April	25	3.13%	7	8.97%
2022	March	20	2.34%	6	7.50%
2022	February	27	3.62%	4	4.60%
2022	January	24	2.67%	9	8.33%
Total		373	3.72%	79	7.54%

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.

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

- Collection and Transport of Blood Components Competency assessment in the handling and storage of blood components is a legal requirement under Blood Safety and Quality Regulations (BSQR) 2005 and 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).

Initial Training should be delivered by the Transfusion Practitioner Team and follow up biennial training can either be completed as an on online resource currently accessible through LearnPro NHS (contract ends on 31/03/2023) or via the Transfusion Practitioner Team. Competency assessment can be completed by ward-based assessors or the Transfusion Practitioners.

A standalone Excel Spreadsheet 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 are required to be trained.

Scrutiny of all patient safety incidents associated with transfusion is undertaken to understand if compliance with training or competency assessment was a contributory factor in the incident. Again in 2022 there were a small number of incidents reported that relate to lapsed or failure to complete training and competency assessment.

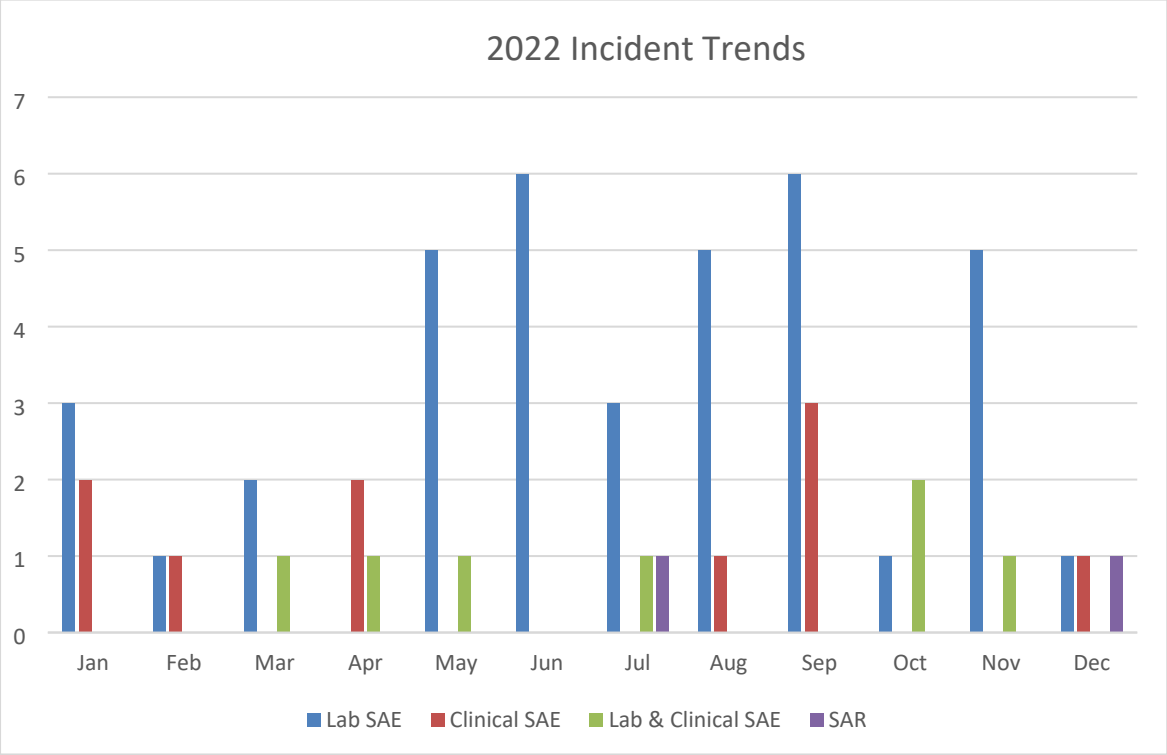
2023 Action: The Blood Health Team at WBS are working to implement an online All-Wales transfusion training package which will be available via ESR. This will seek to improve transfusion training compliance with relevant staff across the Health Board with the aim of being transferable Wales-wide.

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.

An Excel Spreadsheet 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).

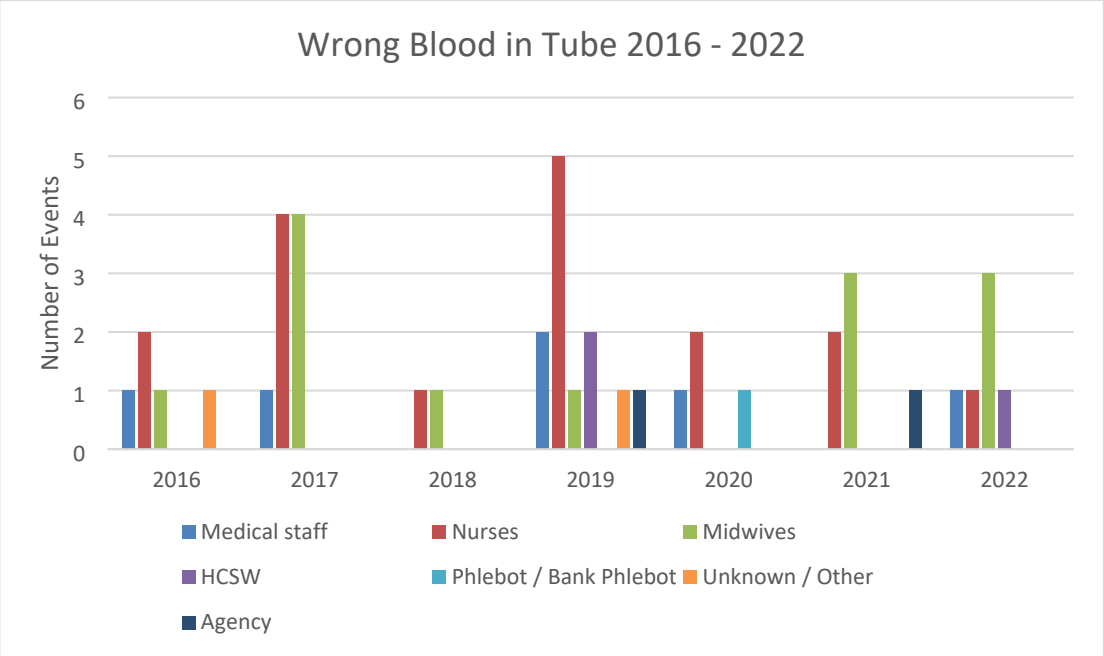
An SAE & SAR notification report must be made within 7 days of receipt to MHRA who will share the report with SHOT, the UK's independent, professionally led haemovigilance scheme. SHOT collect and analyse anonymised data relating to adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood products and blood components in the United Kingdom. Where risks and problems are identified, SHOT produces recommendations to improve patient safety. The recommendations are put 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 as a hard copy to purchase or freely available via the SHOT website and the SHOT app. As haemovigilance is an ongoing exercise, SHOT can also monitor the effect of the implementation of its recommendations.

The SHOT 2021 Annual Report can be read here:
SHOT-REPORT-2021-FINAL-bookmarked-V3-November.pdf (shotuk.org)
Patient Safety incidents relating to transfusions are grouped into three categories, clinical, Laboratory and shared clinical and laboratory incidents (see graph below).



Clinical Errors

The more commonly reported clinical error is "Wrong Blood in Tube." The graph below details incidents of wrong blood in tube events from 2016 – 2022.



Six WBIT incidents were reported in 2022. 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.

Action 2023: Ongoing project looking to implement a bedside sample collection system across Wales aiming to reduce the incidence of WBIT.

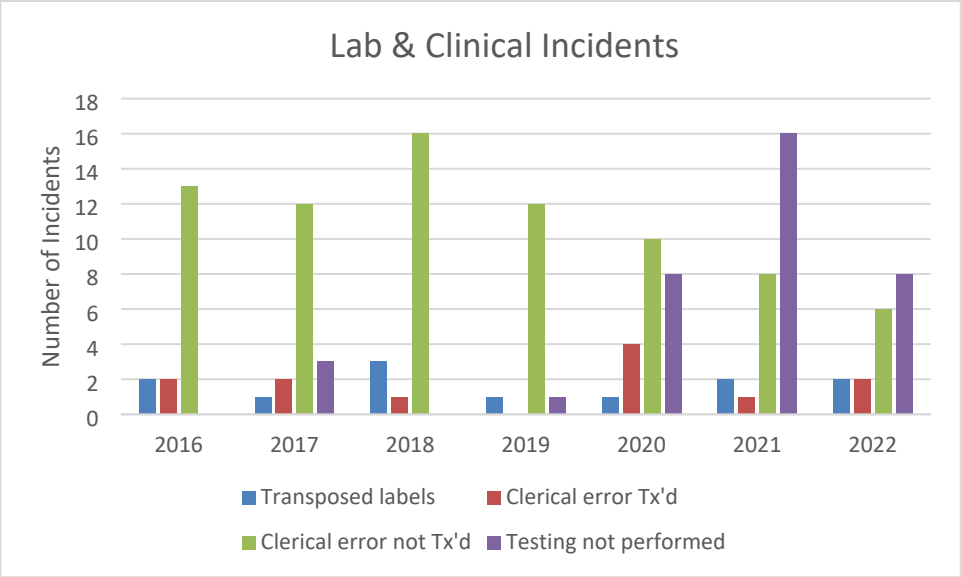
The introduction of new remote issue Haemobank blood fridges is ongoing within Aneurin Bevan University Health Board and has been implemented across the eLGH sites with GUH to follow early 2023. The Haemonetics system is used to check the patient's blood group, the availability of a valid sample with 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 for the blood unit that include the unique patient identifiers and donor identification number. This will minimise the risks associated with issue of incorrect blood.

Laboratory & Clinical Incidents

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 are again prominent in the 2022 data.

Incidents where testing was not performed have been more prominent over recent years as demonstrated in the graph below. A contributory factor is thought to be the introduction of a new transfusion request form where the Kleihauer request is less obvious than the previous form.



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. 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 12 loss of traceability events throughout 2022 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 2022 was therefore 99.5%.

Implementation of a revised process (Haemonetics BloodTrack Enquiry) for scanning blood labels on receipt of a unit of blood into the clinical area and confirming traceability electronically once the transfusion has commenced is underway and it is anticipated that this will significantly improve traceability across the 4 main sites of the Health Board.

Action 2023: TPs to continue providing training on BloodTrack Enquiry system to clinical staff to facilitate ward fating of red blood cells to improve traceability.

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.

The protocol is subject to ongoing audit by WBS who designed a monitoring tool to capture data from major haemorrhage activations. They produce a quarterly report of major haemorrhage management to support compliance with 4 quality indicators which were developed in response to the findings and recommendations of the National Comparative Audit of Blood Transfusion (NCA) 2018 Audit of the Management of Major Haemorrhage along with the BH NOG 2018 recommendations on the use of group O RhD negative red cells (see examples below). The Transfusion Practitioners also audit every major haemorrhage activation within the Health Board and performance of both audits is discussed at the HTC.

Appropriate Use of O D Negative Red Cells & Major Haemorrhage Management; Sept. 2022

Grŵp Goruchwylio Iechyd Gwaed Cenedlaethol
Blood Health National Oversight Group

KPI 1: O D Neg issue as a percentage of total red cell issues

KPI Target: ≤12%

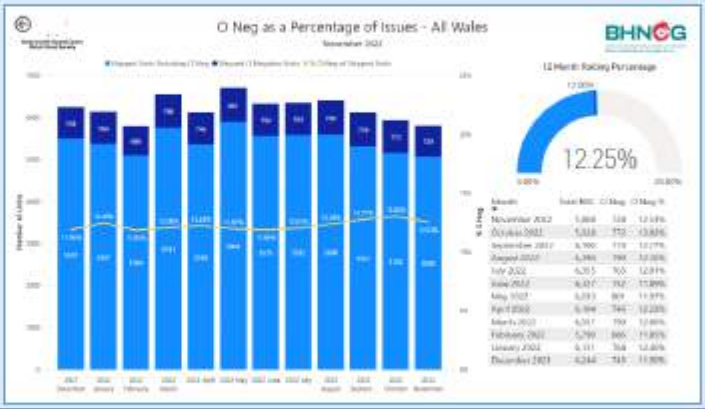
Data for 12 months to end of Nov. 2022:

All Wales KPI: 12.3%

ABUHB: 10.5% BCUHB: 12.4%
C&VUHB: 13.1% CTMUHB: 14.2%
HDUHB: 11.3% SBUHB: 12.0%

All Wales KPI for 12 months to end of:

October 2022: 12.2%
September 2022: 12.2%
August 2022: 12.2%
July 2022: 12.2%
June 2022: 12.3%



Comment & Actions: *All Wales issues appear to have plateaued just above KPI target (12%); a trended graph of the 12 month rolling data point has been produced at Health Board (HB) level and is being sent out to all HBs; BHT to engage with the two notable outlier HBs to discuss further possible action.*

KPI 2: O D Neg wastage as a percentage of O D Neg issues

KPI Target: ≤10%

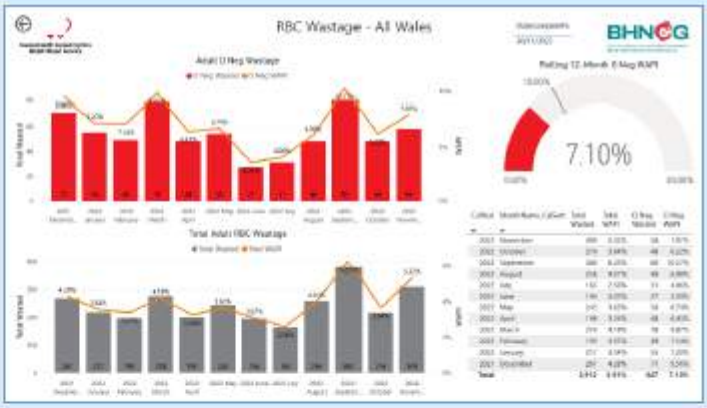
Data for 12 months to end of Nov. 2022:

All Wales KPI: 7.1%

ABUHB: 6.8% BCUHB: 10.8%
C&VUHB: 6.5% CTMUHB: 7.3%
HDUHB: 3.9% SBUHB: 5.4%

All Wales KPI for 12 months to end of:

October 2022: 7.5%
September 2022: 7.4%
August 2022: 7.3%
July 2022: 7.6%
June 2022: 9.0%



Comment & Actions: *All Wales wastage continues to drop well below KPI target (10%); a trended graph of the 12 month rolling data point has been produced at Health Board (HB) level and is being sent out to all HBs to highlight success here.*

KPI 3: O D positive ONLY is used as emergency red cells in adult males for management of major haemorrhage

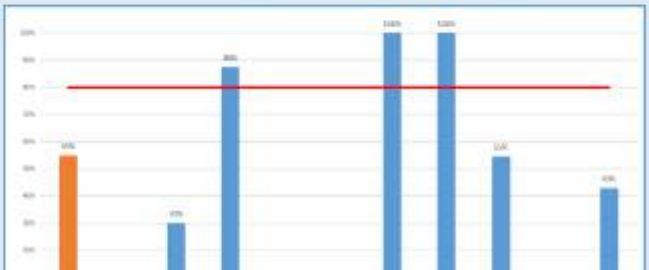
KPI Target: ≥80%

Data for Q2 2022-23 (Jul.-Sep.):

All Wales KPI: 55%
(n=45/82)

Q2 2022-23 (Jul.-Sep.):

No Male MHPs reported for:
NHH
UHL
PCH
PPH
WGH



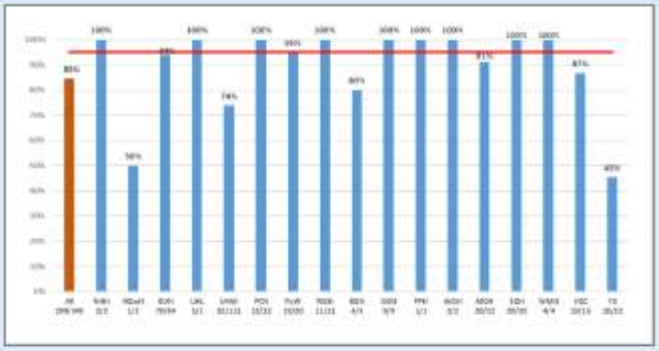
Appropriate Use of O D Negative Red Cells & Major Haemorrhage Management; Sept. 2022

Grŵp Goruchwylio Iechyd Gwaed Cenedlaethol
Blood Health National Oversight Group

KPI 4: A pre-transfusion sample is taken, or valid group available prior to administration of the first unit of blood component

KPI Target: ≥95%
Data for Q2 2022-23 (Jul.-Sep.):
All Wales KPI: 85%
(n=290/343)

Q2 2022-23 (Jul.-Sep.):



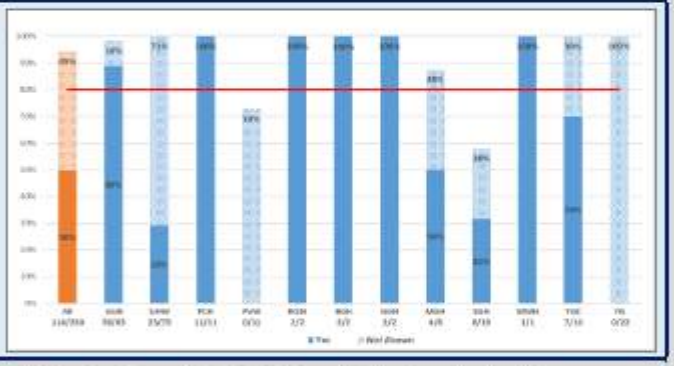
Comment & Actions: *All Wales data staying steady a little below the KPI target; a trended graph of quarterly data has been produced at HB level and will be sent to all HBs. BHT to carry out review of the O- recommendations gap analysis from 2022 (reported compliance and planned actions linked to this KPI), incorporating this long-range quarterly data.*

KPI 5: Tranexamic Acid is given as part of the management of major haemorrhage in Trauma & Obstetrics

KPI Target: ≥80%
Data for Q2 2022-23 (Jul.-Sep.):
All Wales KPI: 50%
(n=114/230)

Q2 2022-23 (Jul.-Sep.):

No Trauma or Obstetric MHPs reported for:
NHH
RGwH
UHL
PPH
WGH

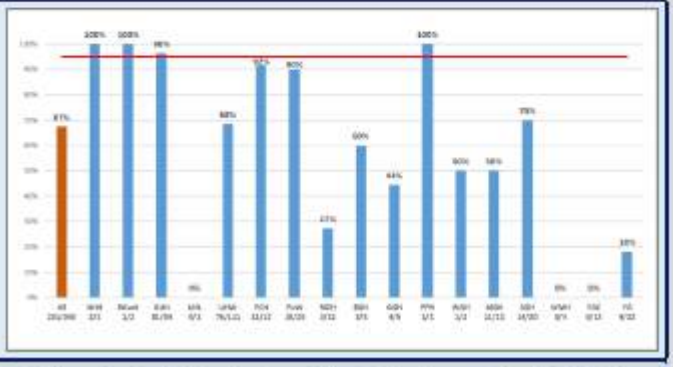


Comment & Actions: *Data capture for this KPI continues to be challenging for hospitals; BHT to liaise with Obs. Cymru lead and Trauma Network lead with regards to their confidence in the use of tranexamic acid being established routine practice in the management of major haemorrhage in obstetrics and trauma respectively.*

KPI 6: Hospital transfusion laboratory team are informed that the major haemorrhage (MHP) was stood down

KPI Target: ≥95%
Data for Q2 2022-23 (Jul.-Sep.):
All Wales KPI: 67%
(n=231/343)

Q2 2022-23 (Jul.-Sep.):



Comment & Actions: *All Wales data see-sawing and well below KPI target; a trended graph of quarterly data has been produced at HB level and will be sent to all HBs. BHT to discuss issues around this with notable outliers as part of the review of the O- recommendations gap analysis from 2022.*

There is a collaborative approach to optimal blood management
The WBS provide 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.

Argymhelliad / Recommendation

It is recommended that the Patient Quality, Safety and Outcomes Committee accept this report as assurance against the Health & Care Standard 2.8 Blood Management.

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):	2.8 Blood Management Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Links to all IMTP priorities as this report provides an assessment against standards that impact all patients.
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. N/A Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Included in main report.
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	N/A

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. Links to all as this report provides an assessment against standards that impact all patients.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	25 April 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Pharmacy and Medicines Management Annual Report 2021/2022
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Chris O'Connor Interim Executive Director of Primary Care, Community and Mental Health
SWYDDOG ADRODD: **REPORTING OFFICER:**	Jonathan Simms Clinical Director of Pharmacy

Pwrpas yr Adroddiad Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Audit Wales (previously Wales Audit Office) recommended that health bodies should have an annual agenda item at the Board (or relevant committee) 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.

There is also an expectation from Welsh Government that an annual prescribing report showing progress in the four priority areas of safe prescribing; antimicrobial stewardship; cost efficiency; and access to medicines is scrutinised by the Board or the Quality and Safety committee.

This annual report therefore provides an update on these areas together with other key developments which have been mapped to the Health and Care Standards.

Cefndir / Background

In 2016 Audit Wales published a report on 'managing medicines in primary and secondary care'[1] following individual health board reviews in acute hospitals and primary care. The report was subsequently considered by the Public Accounts

[1] https://www.audit.wales/news/medicines-management-needs-higher-profile-health-bodies

Committee and recommendations published[2], which have been considered by Welsh Government.

One of the original recommendations identified in the Audit Wales 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

As the report covers the period 2021-22, it should be recognised that the delivery of pharmacy services across primary and secondary care were not operating under normal business as usual arrangements, due to the ongoing pandemic response. Despite ongoing challenges during this time, the whole 'Pharmacy Team' were recognised with the Chief Executive's award in 2021.

The Committee is asked to specifically note the following areas identified within the annual report.

1. The high risk action identified in the Audit Wales report regarding the legal and safety risks associated with the bulk storage of IV fluids at the Royal Gwent Hospital (RGH) remains. This will continue to be the case until alternative storage facilities are identified. This is dependent on the approval of the capital case for the refurbishment of the RGH Pharmacy department and replacement of the robot, which will see the fluids store moving within the department. It should also be noted that the existing robot is no longer fit for purpose due to its age and repeated mechanical breakdowns. The robot is responsible for the distribution of medicines to all wards across South Gwent including the Grange University Hospital. A critical failure will therefore result in significant disruption to the timely access of medicines with potential impact on patient safety and flow. This case is currently considered as an emerging project without All Wales Capital Funding.

2. Pharmacy staff were redeployed to the COVID Mass Vaccination Programme throughout this period and only returned to normal duties in August 2022. This involved the management, governance and logistics of vaccine supplies and the dilution process of the Pfizer vaccine at mass vaccination centres. In addition, secondary care staff supported the packing down of vaccine supplies and the provision of supplies to support the GP practice vaccination programme.

3. 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.

4. The development of a 5-year Medicines Safety Strategy.

[2] https://senedd.wales/laid%20documents/cr-ld11478/cr-ld11478-e.pdf

5. The performance of the health board against the National prescribing indicators.

Argymhelliad / Recommendation

The Patient Quality, Safety and Outcomes 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.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks identified for pharmacy are reported as part of the Primary care and Community divisional risk register. The top 3 risks have been included in the annual report.
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
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. 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

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.

Aneurin Bevan University Health Board

Pharmacy and Medicines Management Annual Report 2021-2022

"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."

Table of contents

1 Executive Summary

In 2016 the Wales Audit Office (WAO) published a report on 'managing medicines in primary and secondary care'[1] following individual health board reviews in acute hospitals and primary care. 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 covering pharmacy services, medicines management, primary care prescribing, homecare medicines services and progress in addressing the issues identified in Trusted to Care.

Welsh Government have 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). It is expected that the Board or Quality and Safety committee are given the opportunity to scrutinise its content. It should be noted that the Annual Prescribing Report for 2020-21 was not produced due to the pandemic and therefore local prescribing data has been used to replicate this within this document.

This annual report therefore provides an update on the Annual Prescribing Report together with an update on actions identified as priority areas within the WAO report. Additional key developments have been identified which have been mapped to the Health and Care Standards.

As this report covers 2021-22, it should be noted that delivery of pharmacy services across primary and secondary care were not operating under normal business as usual arrangements due to the ongoing pandemic response.

The significant efforts of the wider 'Pharmacy Team' across the managed sector and commissioned services during this period were recognised as part of the staff recognition awards with the presentation of the CEO's Award in 2021. This is something that the service is extremely proud to have achieved.

[1] Audit Wales
[2] https://senedd.wales/laid%20documents/cr-ld11478/cr-ld11478-e.pdf

As always it was a tremendous privilege to be on the Judging Panel with so many wonderful nominations and I add my personal congratulations and thanks to you all. My award goes to a service that received 9 separate nominations across the four different categories of: 'leadership', 'partnership working', 'improving patient experience' and 'team of the year'. Before and during the Pandemic they are a service that has demonstrated tremendous resilience both in the community and hospital settings. They have proved themselves critical to the wellbeing of our hospital patients and our wider community. They are 'unsung heroes' of our frontline services. They have introduced new ways of working, implemented new systems in a new hospital and responded creatively and flexibly to innumerable challenges in our hospital and community settings. Whatever part of the service they work in, whatever role they have, and whatever setting they are in – they can all be tremendously proud of the contribution they have made and will continue to make. You make a difference every day

Judith Paget

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 131 community pharmacies.

There are 250 staff comprising of pharmacists, pharmacy technicians, pharmacy assistants and clerical staff working across three 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.

2.2 Wales Audit Office Medicines Management in Acute Hospitals

2.2.1 *Background and context*

The 2015 WAO report on Medicines Management in Acute Hospitals set out recommendations for improving corporate arrangements, pharmacy facilities, prescribing processes and monitoring arrangements as well as reviewing levels of pharmacy staff and service delivery models.

The key finding from the original report for ABUHB concluded that

"Despite low staffing levels and high workload, we identified good relationships on wards together with effective aspects of corporate arrangements and some medicines management processes. The Health Board now needs to develop its strategic approach, address storage issues, minimise some process risks and enhance the way it monitors its services".

In December 2019 a follow up report was published following, a self-assessment, a review of documentary evidence and interviews to determine issues and challenges.

2.2.2 *Update on Progress 2021*

The report concluded that the health board has made good progress in addressing the original recommendations. Out of the 26 original recommendations, 4 actions were considered to be of high risk where there have been no or limited action taken.

Only one of these actions remains outstanding and remains on the directorate's risk register.

R3b. Minimise the current legal and safety risks associated with bulk storage of intravenous (IV) fluids and other bulk items at Royal Gwent Hospital by ensuring items are not publicly accessible and are stored in temperature regulated room.

There has been ongoing dialogue with Facilities to determine whether there is any opportunity to expand storage space at the RGH site without any resolution. Previous mitigating actions have been taken, such as provision of direct delivery of IV fluids to wards, but with limited ward storage availability this will not be a complete solution. A temperature monitoring system has been installed in the bulk fluid room and corridor so that storage conditions can be monitored and appropriate actions taken should this be necessary.

The original risks remain that IV fluids continue to be stored in a non-temperature controlled environment, (similar to the situation on many wards without air conditioning) and that tampering of bulk fluids could occur due to the public accessibility on the area.

A capital case for the refurbishment of the RGH Pharmacy department and replacement of the robot would have seen the fluids store moving into the Pharmacy footprint which is temperature controlled. The case was identified in Draft Capital Programme – 2022/2023 Board Paper presented in March 2022 as an emerging project without approved All Wales Capital Funding. This has not progressed due to lack of capital budget.

Action	*Lead*	*Timescale*
Continue to monitor temperature excursions in the bulk fluid room and corridor and take necessary mitigating actions according to the planned updated guidance from the National QA Group on 'Managing Temperature Excursions in Clinical Areas'. *Progress dependent on capital investment for RGH Pharmacy Refurbishment and Robot Replacement.*	*Clinical Director of Pharmacy*	*Ongoing*

3 Staying Healthy

3.1 Standard 1.1 Health Promotion, Protection and Improvement

3.1.1 *Community Pharmacy Services*

There are 132 community pharmacies across the health board which provide a range of self-care and health and lifestyle advice as part of the contract, established enhanced and advanced services, as well as the provision of dispensing services.

In 2021/22;

- Dispensing rates are increased currently at 1.8% compared to 2020-21 with over 12.3m items being dispensed up until December 2021.
- The Common Ailments Service (CAS) has operated right through the pandemic utilising phone and video consultations, although rates were lower at the start of the pandemic, an increase has been seen and currently there is an increase of 43% in activity with 15,874 consultations (April 21-Jan 2022)
- Influenza vaccine delivery increased by 77% with over 29,000 vaccines being delivered in community pharmacies during 20/21 Flu season.
- Provision of Emergency Hormonal Contraception (EHC) activity has increased by 11% with 3612 consultations (April 21-Jan 2022)
- The Emergency Medicines Service (EMS), designed to improve patient access to regularly prescribed medicines has increased by 131% with over 15,000 supplies (Apr20-Jan21)
- 6046 Smoking quit attempts were supported April 2021-Jan 2022
- 2097 Discharge medication reviews were provided
- 132 Supplies of palliative medication out of hours April 2021-March 2022
- Enhanced service commissioning ranges between 98-61%
- Pharmacy independent prescriber pathfinder services are underway. In response to the Welsh Government strategy for Community Pharmacy developed in 2021, the HB pharmacy team has successfully introduced 15 pharmacists delivering an extended prescriber led Common Ailments service including treatments for lower Urinary Tract infection, Impetigo and Otitis Media. So far in 2021, 2597 consultations have been delivered (April 2020-Dec21) negating the need for a GP.

- Medicines shortages and concession prices had an impact on patient services, pharmacy workload and viability.
- Four community pharmacies were involved in the provision of Covid-19 vaccinations to improve access for patients and support practices.
- Social Distancing, Personal Protective Equipment and Infection Control processes had a huge effect on the delivery/dispensing of medicines to patients with increased levels of aggressive behaviour towards pharmacy staff.
- 2021-22 has seen professional staff shortages and isolation absence hit community pharmacies, some of whom have taken advantage of the flexibility arrangements that Welsh Government introduced to the contract to alleviate pressure on staff. The number of temporary pharmacy closures are increasing significantly disrupting services to patients.

Below is a summary of key community pharmacy issues for 2021/22.

3.1.2 *Community Pharmacy Essential Services*

This relates to the accurate and safe dispensing of medicines by our community pharmacy contractors which are distributed throughout our communities allowing good access for patients to medicines and healthcare advice close to home. From April 21 – Jan 22, our community pharmacies dispensed 13.7m items, this amounts to around 340,000 items per week in Gwent. The volume of prescribing presents a challenge in terms of workload to both pharmacies in dispensing medicines, but also to GP practices in producing prescriptions in a timely and efficient fashion. Welsh Government are developing electronic delivery of prescriptions, which will provide an audit trail in this process and enable the processing of these prescriptions more efficiently. There are concerns that electronic transfer of prescriptions might lead to the establishment of internet pharmacies threatening the existence of local community pharmacies by actively competing for this business. Medicines shortages have been increasingly problematical over the last few years and have resulted in escalating drug costs for community pharmacies which has contributed to financial difficulties within businesses.

A key development in 2021-22 was the reimbursement of Non-Discount Not Deducted expensive medicines which are issued on hospital WP10HPs. ABUHB contractors are much more exposed to these medicines due to ABUHB prescribing policy and the Health Board has acted with help from NHS Shared Services to calculate and reimburse losses on dispensing these products.

At the end of 2021 “A New Prescription” was published by Welsh Government to provide a framework for change within community pharmacy aimed to maximise and fund clinical activity for pharmacists and reduce dependency on dispensing volume as a generator of income. In April 2022, treatment durations can be extended to reduce the number of dispensed items, freeing up pharmacist time, Medicines Use Reviews have been withdrawn but Discharge Medication Review limits have been removed. The provision of standardised Enhanced Services where the contractors commit to providing EHC, CAS, EMS and Influenza vaccination will now drive income, as will a funding stream around Independent Prescriber Services providing for example a more expansive Common Ailments service. ABUHB has been developing the latter aspect of this service eg. Independent Prescriber treatment of lower UTI. Although this is a new service, patient testimonies have been positive eg.

“This is an excellent service, as well as being innovative, thorough, and timely; F.... was offered an appointment within the hour and J..... prescribed the medication that F…….

required. I just wanted to share with you my brief reflections as well as my thanks to J.....– I feel that this is definitely a service that warrants expansion across our boroughs."

3.1.3 *Enhanced Services.*

3.1.3.1 Common Ailments Service (CAS)

99% of the pharmacies in ABUHB provide the Common Ailments Service, which was first piloted in October 2013 and enables pharmacists to treat 26 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.

In 2020-21, so far there are 15,874 consultations in community pharmacies in ABUHB (Jan2022), this represents a 43%increase in activity compared to 2020-21**.** The purpose of this service is to reduce GP consultations for common ailments, in previous studies 80% of patients have indicated that they would have attended GP practices if they had not attended a pharmacy for a CAS consultation, potentially therefore this service has "avoided" over 12,500 GP consultations within ABUHB in 2021-22. The main areas for supply are hay fever, conjunctivitis, vaginal thrush, and threadworm.

3.1.3.2 Smoking Cessation Services

92 community pharmacies in ABUHB deliver smoking cessation services Level 3 and 127 community pharmacies deliver Level 2. These services are fully integrated with the Help Me Quit National Programme. This provides good access to services across ABUHB. The health board Community Pharmacy team work extensively with local Public Health Wales practitioners to develop this service year on year. In 2021-22 community pharmacies supported 6046 quit attempts, a 30%. The level 3 service, which has been developed to include the provision of Varenicline via a patient group direction (PGD) has delivered a 40% Quit Rate which is in line with National targets.

3.1.3.3 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.101 Community Pharmacies provided this service to adult patients 50yrs and older (extended cohort) representing around 93% of all pharmacies within ABUHB. Due to the perception that this service is in competition with GMS service provision, there are still some contractors that do not wish to offer this. However, Influenza vaccine delivery increased by 77% compared with 2019-20, with over 29,000 vaccines being delivered in community pharmacies during 20/21 Flu season. This represents 19% of the total immunisations delivered.

3.1.3.4 Emergency Hormonal Contraception Services (EHC)

Community pharmacies are recognised providers of EHC. There have been significant changes to advice over the last few years, which has meant modifying the service. In ABUHB, 129 providers have provided 3612 EHC consultations (April 21-Jan 2022) which compares similarly with 2019-20.

3.1.3.5 *Emergency Supply Service (EMS)*

EMS was designed to help patients obtain medicines in extremis so that they would not necessarily have to visit their GP practice or OOH services. Using the Choose Pharmacy platform, pharmacists can feel confident in making an emergency supply to patients due to the Choose platform giving access to a limited GP record including prescribing history, and also history of previous EMS made. It has been successfully used in adverse weather episodes e.g. "Beast from the East" where practices have been experiencing difficulties and more frequently during the COVID-19 pandemic. It has consistently avoided calls to Gwent OOH services especially on weekends. 131 pharmacies have delivered this service (100% of all pharmacies), amounting to 15,000 consultations (Apr21-Jan22).

3.1.3.6 *Other enhanced services from pharmacies include*

- Supervised consumption of opiate substitution
- Out of Hours Palliative Care Service
- MAR chart Service
- Independent Prescribing (IP) Pharmacist pilots

3.1.4 *Prison services*

ABUHB are responsible for overseeing healthcare and pharmacy services at HMP Usk and Prescoed. The prisons currently fund a 0.2WTE Pharmacist and 1WTE pharmacy technician.

HMP Usk and Prescoed Healthcare Dept were the subject of two separate inspections during 2021 by HM Chief Inspectors of Prisons and Denise Farmer on behalf of the Andrew Evans (Chief Pharmaceutical Officer Wales). Both reports highlighted benefits to prisoner outcomes if staffing levels and pharmacy team skill mix could be reviewed, especially in view of the current HB Prison Lead Pharmacist being deployed to support the Mass Vaccination Programme. On review a significant uplift of the pharmacy team has been agreed, with an additional 0.4 WTE Clinical Pharmacist and 0.5WTE Pharmacy technician planned to join the team during Summer 2022. This will support the deployment of additional pharmacy lead services across both sites, such as;

- Medicines reconciliation
- Pharmacy shop for prisoners "Health Bar"
- Pharmacist led clinical reviews.

3.1.5 *COVID Mass vaccination programme*

Throughout 2021/22 the Primary care pharmacy team, Neighbourhood care network (NCN) pharmacists and academy pharmacists were redeployed to support the covid vaccination programme. The team was headed up by a senior and lead pharmacist who were key members of the National covid vaccination logistics group and Health Board mass vaccination programme board. Responsibilities included updating patient group directions and standard operating procedures from national templates for ordering of the vaccine, monitoring of stock levels, storage, delivery, handling and dilution of the vaccine for use in the mass vaccination centres (MVC), GP practices, pop up clinics, care homes and prison. To provide additional support to the MVCs and care home team, several pharmacists were also trained to vaccinate.

Each MVC clinic had a pharmacist controller in charge who worked closely with the clinic and admin controllers. This was to ensure quality control of the vaccine including overseeing the use of the vaccine on site, ensuring stock usage matched patient numbers, monitoring fridge temperatures and minimising waste of vaccine at the end of clinic.

The pharmacy department at The Royal Gwent (RGH), Nevill Hall and Ysbyty Ystrad Fawr supported the GP practice vaccine delivery programme by receiving, storing, and managing stock collections for them. To assist the stock management of vaccine across the health board the pharmacy production unit at RGH packed down the Pfizer and Astra Zeneca vaccines into smaller quantities for use in care homes and prison to minimise waste.

4 4 Safe care

4.1 . Standard 2.1 Managing Risk and Promoting Health and Safety

4.1.1 *Medication Safety*

The Medicines Safety Group is multidisciplinary with representation from all divisions, pharmacy, and corporate teams. This met on four occasions during 2021/22, with the focus being the development of a 5 year Medicines Safety Strategy by the Medicines Safety Officer (MSO) with the support of a task and finish group. The strategy has 5 key goals; to improve incident reporting, promote the safe use of medicines, reduce harm, improve learning and to meet the med safety agenda. It recognises the National Strategy: Delivering a healthier Wales along with the WHO global challenge which launched a new strategy in 2021.

Regular medicines safety group agenda items included national and local drug safety alerts, medicines safety audits, medicines and prescribing policies and a review of medicines related incidents identified from DATIX. The group has produced a Medicines Safety newsletter summarising medicines safety incidents, key safety messages, along with bulletins and internal alerts to support training sessions for pharmacy and nursing staff, junior doctors, and GPs.

During 2021/22 there have been 5 National patient safety notices and 1 National patient safety alert

- PSN055 Medicines storage
- PSN057 Emergency Steroid Therapy cards
- PSN060 Inadvertent administration of oral medication by the wrong route
- PSN061 Standardised strength of phenobarbital oral liquid
- PSN062 Elimination of bottles of liquefied Phenol 80%.
- PSA061 Inappropriate anticoagulation of patients with a mechanical heart valve

Safety notices and alerts are discussed before being disseminated through the health board to implement an action plan. Pharmacy work with the Quality and Patient Safety team to look

at ensuring the health board is compliant with those patient safety notices that specifically relate to medicines.

4.1.1.1 Internal alerts

3 Internal alerts were circulated to improve medicines management and safety during 2021/22

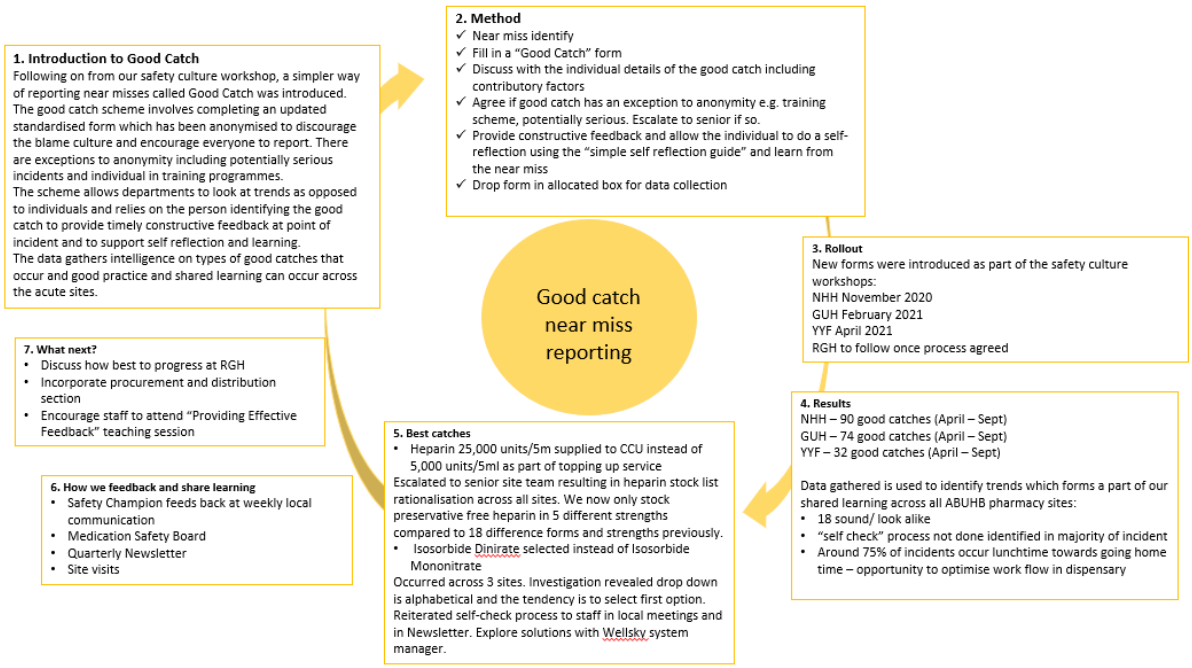
- Metaraminol pre-filled syringes - Metaraminol 2.5mg in 5ml solution for injection in pre-filled syringes (PFS) are available to Theatres, Recovery and POCU across ABUHB for use in the management of intraoperative hypotension. This licensed PFS is in a ready to use concentration (0.5mg in 1ml) and device for bolus doses. Several benefits were identified, including it negates the need to dilute concentrated solution for injection, reduces risk of inadvertently administering an unintended dose, supports rapid access, reduces risk of contamination during dilution process and reduces waste from discarded pre-drawn metaraminol.

- Standard Variable Rate Insulin Infusion Fluid switch - the “standard” fluid at ABUHB is Sodium Chloride (NaCl) 0.45% with Dextrose 5% containing Potassium Chloride (KCl) 0.15%. This fluid was no longer available to procure from a sole manufacturer within the UK. A decision was made by the endocrine, anaesthetic and pharmacy directorates to switch this “standard” fluid to Sodium Chloride (NaCl) 0.9% with Dextrose 5% containing Potassium Chloride (KCl) 0.15% to enable a reliable supply.

- Taking an accurate drug history - An alert was sent out following several patients being prescribed medication intended for another patient. All prescribers should undertake a drug history when a patient is admitted to hospital as part of the clerking process, using two independent sources of information, and whenever possible, the patient should be the primary source of information. Where the Welsh Clinical Portal is the second source of information, prescribers should be familiar with how to access and interpret the list of mediation on the GP record.

4.1.1.2 Safety Culture Workshop

In April 2021 the medication safety team ran multiple safety culture workshop with pharmacy technicians and assistant operational technicians across all major acute sites. Key areas for improvement were identified, including improve reporting rates, timely and appropriate feedback to individuals involved in incidents, better communication when errors occur. The team have since rolled out a new near miss reporting programme known as “Good Catch”.



4.1.1.3 Reflection

Pharmacy team members will reflect following a "good catch" or a medication safety incident. During 2021-22 the medication safety team re-vamped the reflection forms to align with evidence-based John's Reflection Cycle and produced an at-a-glance guidance to accompany the form for both reflectors and line managers. An interactive session was run to assist managers to support staff when they have been involved in a medication incidence. This introduced staff to different types of reflection tools as well as how to use clinical based shadowing and feedback/ coaching sessions to best support staff.

Bi-annual medication safety newsletters for secondary care staff, feedback on Good Catches and Datix reports to support development and reduce harm form medication. Junior doctors receive training in high-risk prescribing, palliative care prescribing and prescribing incidents and adverse drug reactions to help equip them with information and resources to prescribe high risk drugs safely.

4.1.1.4 Quality Improvement projects

- Improving the transfer of medications between ward areas to ensure safe patient care

Medications are not always transferred with patients as they transfer between wards and hospitals within the health board potentially leading to poorer patient outcomes and patient harm. The objective of the QI project was to increase the percentage of patients being transferred with 100% of their medication by 50% in a 3-month period. After the opening of GUH this had dropped to 30%. Following the 12 week QI project, the percentage of patients transferred with all of their medicines increased to 75%. This improved drastically due to a number of factors including the interventions introduced by the improvement project and also

staffing differences. The work has highlighted the importance of pharmacy staff in the transfer of patients to improve patient outcomes.

- Improving Switching of Intravenous to oral Antibiotics at The Royal Gwent Hospital

Delayed switching of IV to PO antibiotics increases the risk of secondary infections, prolonged hospital stays and overall cost of antibiotics. The project showed a team-based approach and a simple aid in the form of a sticker has shown to improve overall switching of IV to PO antibiotics. Future projects should focus on other interventions such as education of junior doctors on Antimicrobial Stewardship principles.

- Improving the process of weighing hospital inpatients, to ensure safe prescribing of weight-based medications

Poor measurement and documentation of hospital inpatient weights puts patients at risk of harm from the unsafe prescribing of weight-based medications. This QI project aimed to refine the weighing process for patients. The results of the project showed an improvement in the number of patients weighed and an advancement in the overall weighing process. The percentage of new patients admitted that had a weight documented within 24 hours, increased from 8.3% to 58.6%. This was due to staff education and training, poster displays and use of patient status boards. Consequently, the project has reduced the risks to patients from incorrect and unsafe prescribing of weight-based medications, and improved patient safety.

4.1.1.5 Yellow Card Reporting

ABUHB have five yellow card champions based across primary and secondary care and work to deliver on key performance indicators (KPIs) and topics cascaded from the Yellow Card Centre Wales and MHRA.

4.1.1.6 Medication Safety Poster Submissions

The following poster was accepted at the annual conference for Yellow Card Centre Wales: Primidone and Apixiban – a case in practice (Dr D Kandhai, Lucy Higgins).

4.1.1.7 Medication Safety Campaigns

During 2021-22 we celebrated 100 years of insulin and raised awareness of sepsis. As part of World Patient Safety Day, we shared vital information on keeping pregnant women and newborn babies safe and extended this message during medication safety week to include reporting of adverse drug reaction during pregnancy

4.2 Standard 2.6 Medicines Management

4.1.2 *Medicines Storage – PSN055*

Patient Safety Notice (PSN) 055, The Safety Storage of Medicines was released in October 2020 to all organisations providing NHS-funded care. It specifies that all new build and refurbishments commissioned after issue of the notice comply with the specifications and that all existing clinical areas are risk assessed and remedial action undertaken proportionate to identified risk.

Risk assessments of clinical areas were carried out by each division during August 2021 and action plans complied and actioned accordingly. Work will continue in 2022/23, with a task and finish group to review ongoing compliance with the PSN and to review policies and procedures that relate to the safe storage of medication. This work is ongoing and an update to the delivery unit is expected by September 2022.

4.1.3 *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 2021/22 was 2,106 – an increase of 5% on the previous year.

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 report 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. We have therefore proposed that this project

be taken forward by the Hospital Pharmacy Services Management Board for further development.

4.1.4 *Medicines Governance*

4.1.4.1 Controlled Drugs Local Intelligence Network (CDLIN)

The Controlled Drug Local Intelligence Network (CD LIN) met twice during 2021/22 rather than the quarterly meeting due to COVID and change of Medical Director. The meetings were held via Teams. These were chaired by our new Medical Director who was appointed as Accountable Officer for the Health Board. A review of Controlled drug (CD) incidents raised concerns over the use of syringe drivers. A working group has been set up and met in January 2022 to review all syringe driver errors. Key issues and themes were identified, and an action plan has been developed. Contributing factors include education and training, communication, documentation, medicines omission and failure to follow procedure.

An area of focus for 2021/22 has been monitoring use of CDs in Dental practices. Practices were sent a CD self-declaration to complete. CD prescribing, requisitions for stock and CD destruction were monitored. A number of issues were identified with advice sort from the dental advisers, GDC and HIW.

4.1.4.2 Patient Group Directions

The Health Board policy for Patient Group Directions (PGD) was reviewed and updated during 2021/22. The PGD approval group met 7 times during this period and sixty three PGDs were signed off. The group members include a senor 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, respiratory, sexual health, endoscopy, ophthalmology, occupational health and the accident and emergency department. Public Health England 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 and which are signed off by the Deputy Medical Director and the mass vaccination programme board. The new antivirals for the treatment of positive COVID cases have been added to list of PGDs for patient at high risk.

4.1.4.3 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 2021/22 include:

- Use and administration of intravenous omeprazole policy
- Thromboprophylaxis for all hospital inpatients policy
- Policy for safe prescribing, dispensing and administration of intrathecal chemotherapy
- Policy for managing potential excessive and inappropriate prescribing policy in primary care

- Thromboprophylaxis for all hospital inpatient policy
- Use and administration of intravenous omeprazole policy
- Issue and use of WP10 HP prescription pads
- Standard operating procedure Safe storage of medicines: refrigerators

One new protocol was developed and ratified for the use and administration of intravenous ferric derisomaltose (Monofer) to standardise the prescribing and administration of IV iron preparations in a timely manner throughout ABUHB.

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.

Two further policies have been updated and await ratification at the policy group. These include the Use of PGD policy and Controlled drug standard operating procedures for GP and Dental practices.

4.1.5 *Antimicrobial stewardship*

The Antimicrobial Working Group (AWG) continues to monitor antimicrobial usage and implement strategies to optimise use of antibiotics across the health board. This includes developing & review local treatment guidelines.

The antimicrobial team have implemented numerous guideline changes, including new gentamicin dosing and monitoring methodology including an online dosage calculator to reduce the risk of patient safety incidents.

Key achievements this year include:

- Roll out of the Antibiotic Review Kit (ARK) to Ysbyty Ystrad Fawr (YYF) & Nevill Hall Hospital (NHH). ARK is a toolkit, including an online training tool, decision aid and audit programme, designed to safely stop antibiotics in patients who no longer need them, and change prescriber behaviours. Further roll out to the Grange University Hospital (GUH) and Royal Gwent Hospital (RGH) is planned.
- Transfer of all antimicrobial guidance onto a new digital platform
- A new method of dosing and monitoring one of the high-risk antibiotics, to improve patient safety
- The team supported development of new All-Wales primary care antimicrobial guidelines, published by AWMSG.

The ABUHB Consultant Pharmacist for Antimicrobials, who chairs the Welsh Antimicrobial Pharmacists Group, visited Malawi, along with two other pharmacists from Wales, as part of a Commonwealth Partnerships for Antimicrobial Stewardship project. The project aims to share expertise with the Pharmaceutical Society of Malawi, and support development of antimicrobial stewardship in two of the largest hospitals in the country using prescribing surveys, training sessions, and developing a practical toolkit to guide healthcare professionals.

The team have also implemented numerous new covid therapeutics, including fifteen new commissioning policies and CMO letters over the year. This involved setting up the pre-hospital service to deliver neutralising monoclonal antibody infusions to highly vulnerable COVID-19 patients, in collaboration with key stakeholders in the division.

4.1.6 *MHRA Inspections*

4.1.6.1 Manufacturer's Specials MHRA Licence:

The Pharmacy Production Unit at the Royal Gwent Hospital (RGH) has held a Manufacturer's Specials (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, as agreed by the MHRA.

The 2017 MHRA inspection highlighted concerns with the facilities and equipment at the RGH aseptic unit. As a result the health board approved £500,000 of capital funding for an extensive refurbishment of the unit. This refurbishment took place from January to September 2019 and upgraded the facilities and equipment significantly, improving the quality and safety of the aseptic medicines prepared for ABUHB's patients. The MHRA inspectors commented on the marked improvement of the facilities during the 2020 inspection and were satisfied that previous facilities concerns had now been addressed.

4.1.6.2 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.

4.1.7 *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 across the healthboard.

ABUHB Medicines Management Savings Performance (Month 12)

Division	2021-22 IMTP Plan Savings £'000	2021-22 Actual Savings £ '000	Over / (Under) Achievement £ '000
Primary Care	2,302	2,217	(85)
Family & Therapies	0	93	93
Mental Health	0	0	0
Scheduled Care	55	273	218
Medicine	2	460	458
Urgent Care	0	11	11
sub-total	57	836	779
Total	**2,359**	**3,053**	**694**

5 Effective Care

5.1 Standard 3.1 Safe and Clinically Effective Care

5.1.1 *Medicines and Therapeutics Committee (MTC)*

In 2021/22 MTC meetings were held in April, May, July, September and November in 2021 and February and March in 2022.

- The committee considered 14 new drug applications and discussed changes to the formulary status of 8 other products.
- 29 individual requests to prescribe were considered by the MTC Chair/deputy
- 15 pieces of prescribing guidance were considered- for example guidance on prescribing in perinatal mental health, hayfever, hyperlipidaemia and statin intolerance, restless legs syndrome and children's eczema.
- 3 shared care protocols were reviewed and updated.

- 105 new drugs were approved by NICE or AWMSG. MTC agreed the appropriate formulary status for each, which was then recorded on the formulary; the ABUHB implementation process for these drugs was via the High Cost Drugs Implementation Planning Group.

5.1.2 *National Prescribing Indicators*

The All Wales Medicines Strategy Group (AWMSG) has developed and endorsed NPIs since 2003 as a means of promoting safe and cost-effective prescribing. The indicators identify the therapeutic priorities for NHS Wales and have a focus on safety, stewardship or efficiency[3] 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

For 2021-2022 the National Prescribing Indicators (NPI): Supporting Safe and Optimised Prescribing, have been refreshed with a focus on three priority areas, supported by safety and efficiency domains. This continues with the philosophy of Prudent Healthcare, enabling higher quality and value through reducing variation, waste and harm, in addition to contributing to two themes in the Quadruple Aim of A Healthier Wales, Welsh Government's plan for health and social care.

Professor Ceri Phillips (the former Chair of AWMSG) wrote to all health boards in December 2019 to highlight the variation in practice achievement against the NPI targets for the quarter ending June 2019 and to seek assurances on actions that would be taken to improve performance and outcomes for patients. Following analysis of individual practice performance, a programme of additional prescribing visits was proposed in outlier practices, focusing on gabapentinoids and opioid burden (as more practices are further from targets compared to other NPIs). COVID-19 delayed the implementation of this programme, but it will still be progressed with the aim of demonstrating targeted improvement in. This has been suspended since March 2020 as the Medicines Management Team and NCN Practice pharmacists have been redeployed to the Mass Vaccination Centres.

There are two strategies for to support practices to make improvements.

- NPIs are included within the health board's Clinical Effectiveness Prescribing Programme (CEPP). This is a framework which incentivises GP practices for improving prescribing performance in quality, safety and efficiency. Prescribing advisors meet with each practice to review prescribing performance and agree potential areas of performance.
- In 2021 a 3 year Medicines Optimisation Strategy was agreed, which includes a focus on two NPI: gabapentinoids and hypnotics.

[3] National Prescribing Indicators 2021–2022
National Prescribing Indicators 2021-2022 - All Wales Therapeutics and Toxicology Centre (nhs.wales)

5.1.2.1 *Summary of overall HB position against the national prescribing indicators (March 2022)*

The table below shows the extent to which practices in each health board met the target or indicator thresholds:

- 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.

Health boards/practices achieving the indicator targets/thresholds – Quarter ending March 2022

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	14 19%	23 24%	45 76%	7 14%	11 23%	8 50%	10 20%
Tramadol DDDs per 1,000 patients	21 29%	18 19%	34 58%	8 16%	13 27%	8 50%	12 24%
Gabapentin and pregabalin DDDs per 1,000 patients	13 18%	23 24%	39 66%	3 6%	14 29%	6 38%	9 18%
Antibacterial items per 1,000 STAR-PUs	✓	✓	✓	✓	✓	✓	✓
4C antibacterials items per 1,000 patients	✗	✗	✗	✓	✓	✗	✓
Proton pump inhibitors DDDs per 1,000 PUs	17 24%	16 16%	36 61%	7 14%	11 23%	1 6%	13 27%
Hypnotics and anxiolytics ADQs per 1,000 STAR-PUs	24 33%	30 31%	44 75%	12 24%	13 27%	8 50%	15 31%
Long-acting insulin analogues as a percentage of long- and intermediate-acting insulin analogue prescribing	37 51%	11 11%	27 46%	25 51%	4 8%	2 13%	0 0%
Low Value for Prescribing (UDG) spend per 1,000 patients	9 13%	47 48%	20 34%	1 2%	10 21%	8 50%	19 39%

Percentage of practices meeting threshold 0% 100%

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 have meant that PHW are unable to provide performance against target. 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.

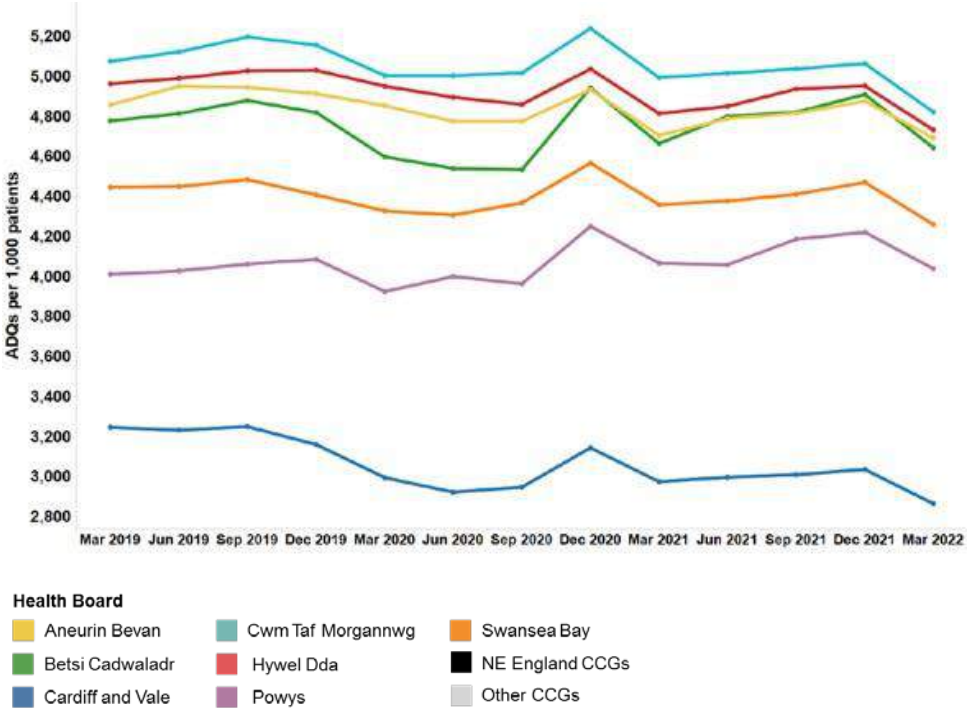
The following summary relates to performance metrics obtained on the National Prescribing Indicators (NPIs). Data is also presented showing the comparative position with English CCGs. North East of England CCGs are highlighted, as these areas have similar socioeconomic and demographic criteria allowing appropriate benchmarking.

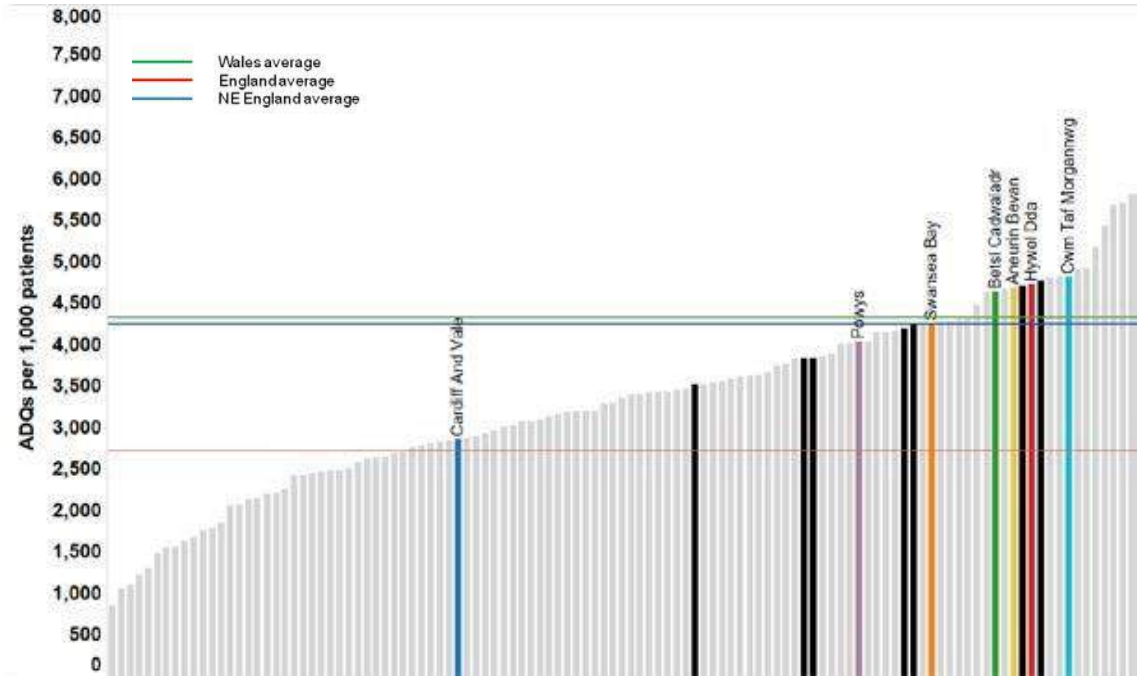
5.1.2.2.1 Opioid Burden

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 fifth in terms of overall performance.

Trend in opioid burden UDG ADQs per 1,000 patients

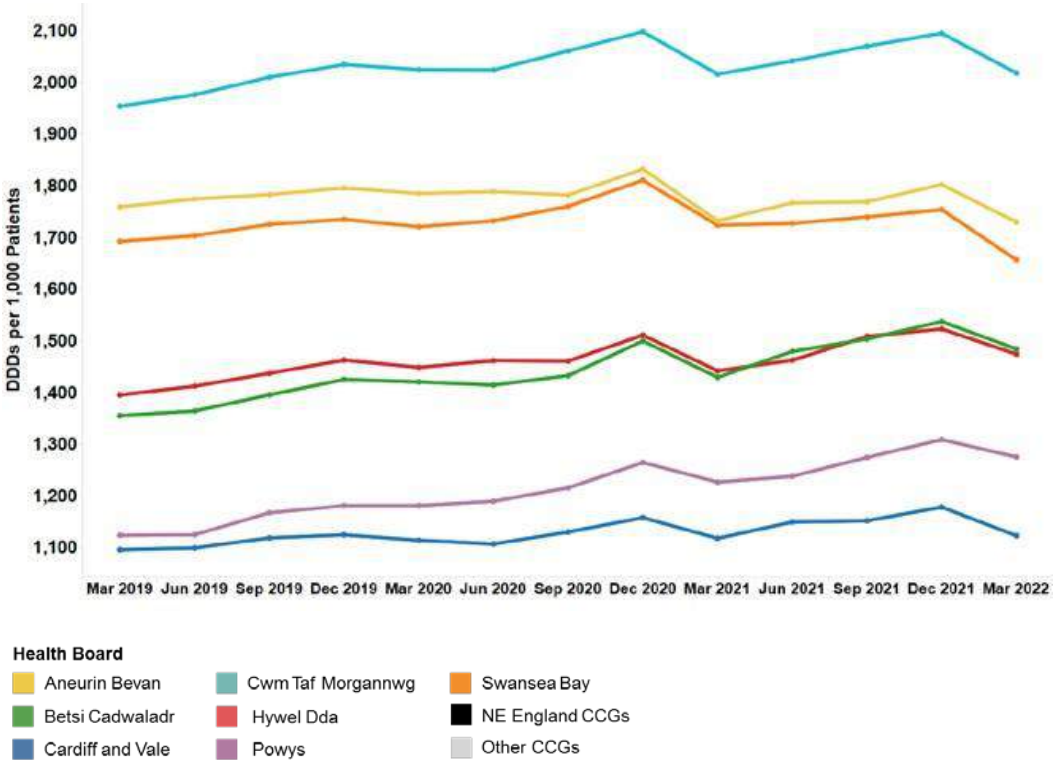




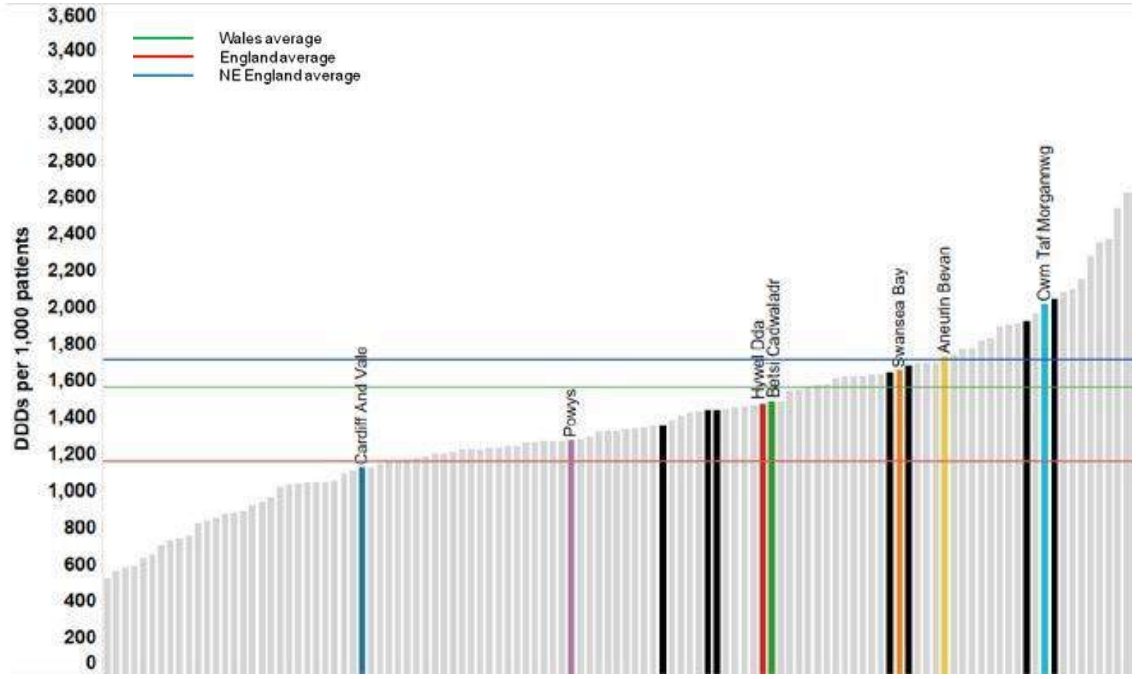
5.1.2.3 *Gabapentin and Pregabalin*

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



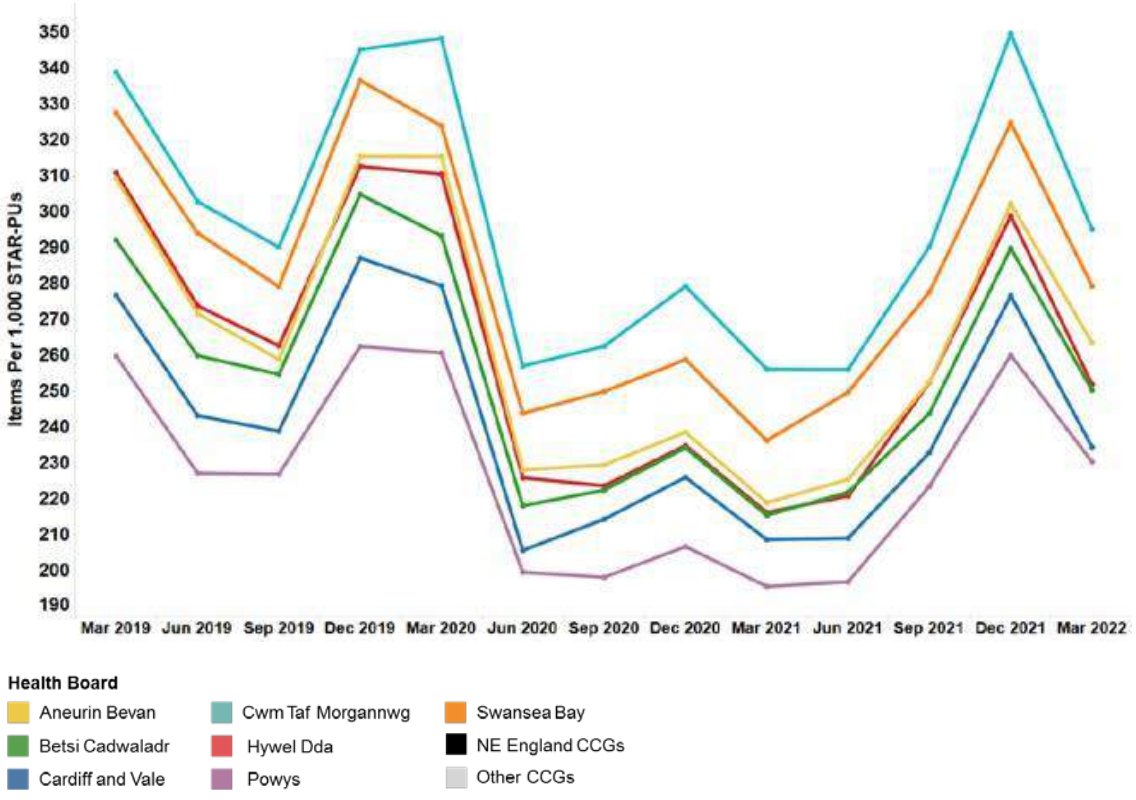
Gabapentin and pregabalin prescribing in Welsh health boards and English CCGs – Qtr ending March 2022



5.1.2.4 *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.

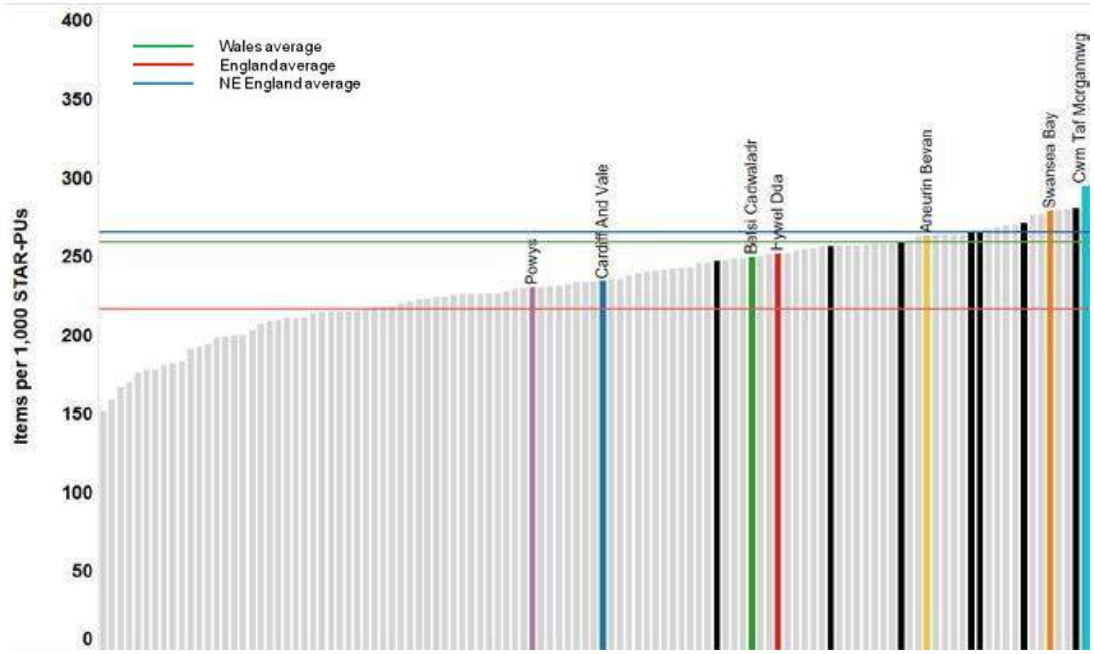
Trend in antibacterial prescribing items per 1,000 STAR-PUs



Overall there is a downward trend in antibiotic prescribing (including the expected seasonal variation) as shown above.

ABUHB is ranked fifth in terms of overall performance.

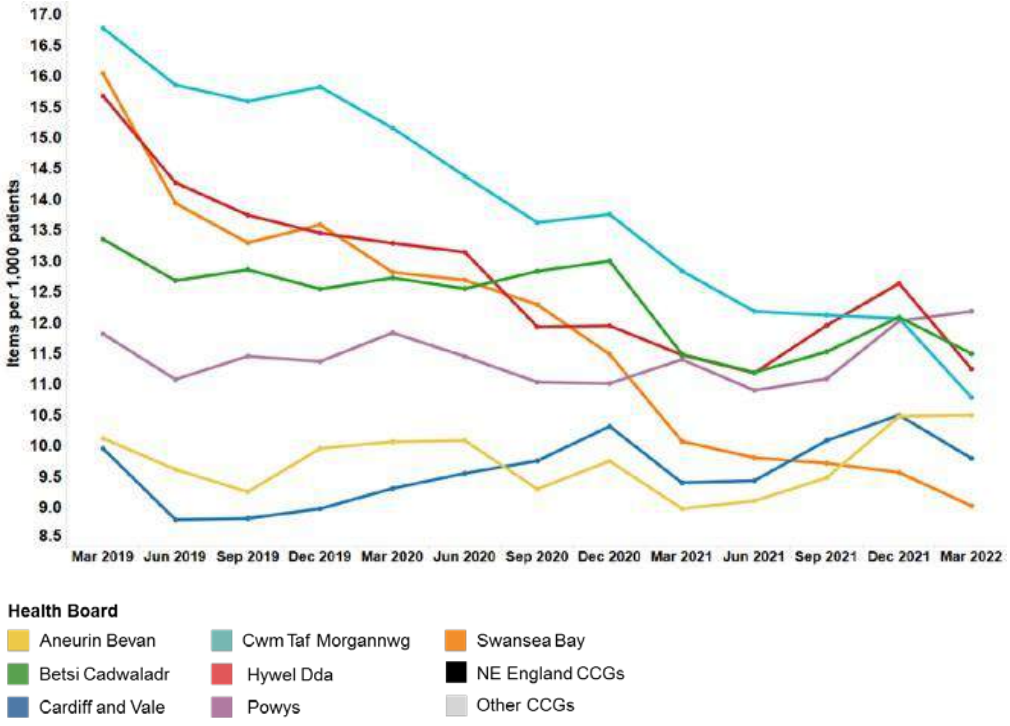
Antibacterial prescribing in Welsh health boards and English CCGs – Qtr ending March 2022



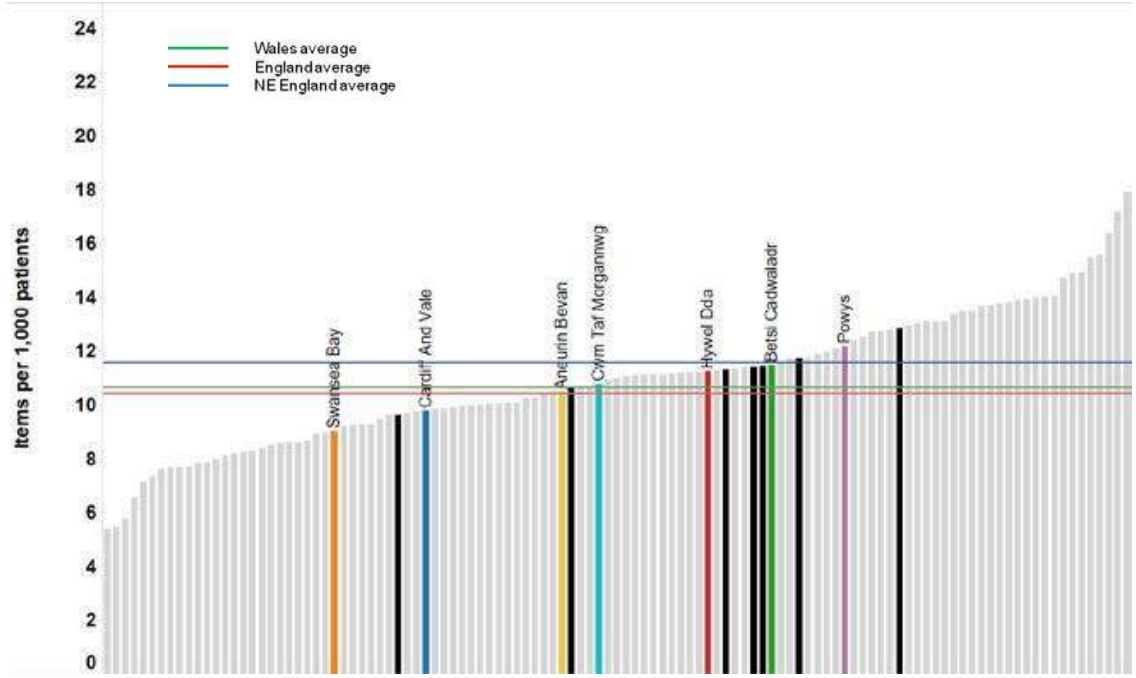
5.1.2.5 *4C Antimicrobial Prescribing (items per 1000PU)*

Broad spectrum antibiotics are associated with an increased risk of healthcare associated infections. ABUHB is ranked 3rd 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.



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.

At the start of 2022, following on from the opening of GUH and multiple COVID-19 pandemic waves, it was evident that the Pharmacy staffing had considerable deficiencies and was not able to provide the required level of support to run an appropriate clinical trial service. As a means to highlight this concern, the Head of Pharmacy and Assistant Director of R&D wrote an Executive paper to highlight what was needed in order to build a sustainable Pharmacy workforce to support clinical trials. The risk was also added to both the R&D and Pharmacy's IMTP.

As an interim measure, ABUHB R&D provided temporary staffing budget to allow appointment of locum staff to help support the service for 2021/22. It is hoped that in following years, the Pharmacy staffing case will be considered and supported by the ABUHB Executive Team on a more permanent basis and allow the HB to strive forward in this agenda.

6 Timely Care

6.1 Standard 5.1 Timely Access

6.1.1 *Pharmacy Emergency Department Service*

A limited pharmacy service of 2 hours per day was provided to the emergency department at GUH throughout 2021/22 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 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 recent business case has been successfully approved by PIP to fund additional pharmacy resource within GUH ED with to provide numerous benefits including enhancing patient safety, the release of ED staff time and to highlight potential savings through more cost-effective use of medicines. This business case is currently being submitted to the Executive Team.

7 Individual Care

7.1 Standard 6.1 Planning Care to Promote Independence

7.1.1 *Pharmacy Service to the Community Resource Teams (CRTs)*

The service has continued to expand and develop due to the continued funding from the Integrated Care Fund during 2021/22. At the end of 2021/22 all current posts are permanent leading to a more settled team and development through longer term training courses. All pharmacists are independent prescribers allowing release of medical time within the teams and an improved co-ordination of medicines supply during patients' episodes of care. An area much improved since the pharmacists have been in post is bone protection with many prescriptions being initiated during patient episodes of care within the Rapid Medical and Falls services.

Two pharmacy technicians are currently studying for their BTEC level 4 Pharmacy Clinical Services qualification. Both 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.

Three of the five boroughs have pharmacy input on a regular basis with continued regular support to MDTs in areas across the CRTs: Rapid Medical; Falls; Reablement. Clinical interventions, de-prescribing of medicines, many associated with falls prevention and national indicator priorities, continue to be recorded and fed back through the ICF scheme. Approximately 70% of patients referred by the Reablement service to pharmacy either become independent with their medicines or care calls are reduced through medicines optimisation. This has been critical at a time when social care capacity has been under pressure.

Torfaen CRT has a much more settled pharmacy service since posts were made permanent. The pharmacy technician has been developing a pilot with staff on Rowan ward in County Hospital, 'Your Medicines', where CRT Pharmacy and nursing staff will work together to ensure that selected patients are discharged with an increased understanding of their medicines regimen.

The agreement of Gwent wide principles for social care administration of medicines in the domiciliary setting have led to less demand on dosettes/MDS provision which anecdotally smooths the discharge process. Pharmacy has opened the conversation with social care agencies and social workers to ensure that these principles are adhered to. Pharmacy in Newport CRT are set to train the Social Care/Reablement service using a new policy for administration of medicines where dosettes/MDS are no longer required. This should improve the discharge process particularly in RGH.

Within the three CRT boroughs the pharmacy input has developed due to strong links with our pharmacy colleagues in primary and secondary care as well as community pharmacy. Home visits to re-evaluate the use of a dosette/MDS has proved successful and the use of a medicines reminder chart has been a regular alternative. The need for an addition of a template for a medicines reminder chart on Community Pharmacy systems has been highlighted. It would also be a priority to have a similar template on the Pharmacy system/CWS within the health board as many patients have been shown to benefit from this approach at/post discharge.

A two year pilot of pharmacy technician input into the Place Based Care initiative in East Newport NCN has just come to an end with successful outcomes and positive feedback from those in the GP practices. These outcomes have been fed back to Welsh Government.

Secondary care pharmacy are encouraged to refer patients at discharge who they feel would benefit from input to support their medicines taking. Currently one of the pharmacy technicians is undertaking a QI project to improve the number of referrals.

Pharmacy have supported the remaining boroughs' CRTs where possible providing remote pharmaceutical advice to the newly formed Rapid Medical team in Chepstow and providing medicines administration training to HCSWs in the Blaenau Gwent Reablement service. A three month pilot of a part-time pharmacist input in Blaenau Gwent occurred during January to March 2022. This focussed on support to the Rapid Medical team and a review of the medicines management of selected patients from the High-Risk Adult Cohort. This initial pilot has led to further funding for the year ahead which will hopefully demonstrate the same benefits as the other boroughs.

7.1.2 *Listening and Learning from Feedback*

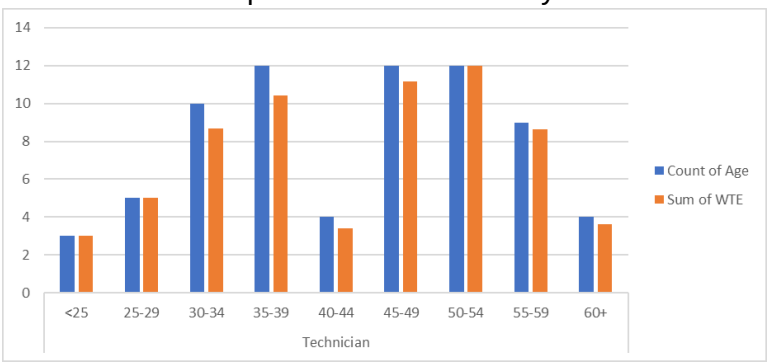
A flow chart for ward pharmacy staff to ensure that the provision of medicines supply at discharge is appropriate for the patient and their environment is currently being developed by a short term working group in response to feedback questionnaire from care homes and CRTs.

8 Staff and Resources

The 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 so 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.

In 2023, 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 retirement profile for Pharmacy technicians shows an ageing population.



The demand for Pharmacy Technicians is anticipated to increase in both primary and secondary care. The department are developing new Pharmacy Assistant roles to reduce the staffing gap and to enable the release Pharmacy technicians to undertake more advanced roles.

8.1 Changes to training programmes

To meet the developing needs of patients, the General Pharmaceutical Council have introduced new initial education and training standards (IETP) 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.

The new IETP standards for Pharmacists will ensure that Pharmacists qualifying in 2026 will be Independent prescribers. 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. This will further impact vacancies. 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.

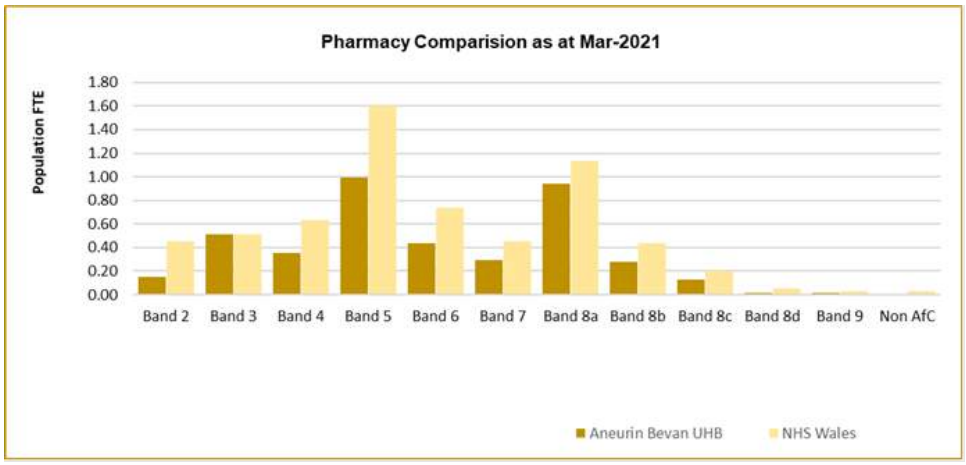
For Pharmacy technicians, new registrants will already be qualified to undertake medicines reconciliation and accuracy checking on registration. A first intake of the new programme in ABUHB was introduced in February 2022 with a registration date of February 2024. The department are currently upskilling all existing Pharmacy technicians to the same level. Whilst the programme is being initially implemented, only single sectors programmes are being run. This will be reviewed in line with the HB's previous ambition of multi-sector programmes.

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 Pharmacists independent prescribers in intermediate, primary, and secondary care.

Over the past 3 years the HB has run a successful Primacy care training academy. Pharmacy have 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 will be 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.

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 department participated in an All Wales exercise to review ESR to increase the quality of ESR data and as a precursor to linking ESR data with the GPhC data base (this went live Dec 2022)



This issue was also identified in the Wales Audit Office review of Medicines Management for ABUHB[4]. The low staffing levels impact on the ability to deliver services and also limit opportunities for staff training and development. This limits the opportunities to train more students and trainees, reduces the opportunities to develop staff and as a result staff retention. As a result, the Health Board are undertaking a Workforce gap analysis in secondary care. This will include defining shortfall of funding required to deliver services using a verified calculator (Stoke calculator) and a review of skill mix for Clinical Services.

The majority of primary care staff were re-deployed to run the Vaccination programme during 2020-22. As the programme has reduced, many are returning to their substantive posts and will need a re-induction and support. A project to standardise the NCN pharmacist role is currently being undertaken.

Many staff worked from home during the pandemic. There is a need to review the roles in line with the Health Board's agile working policy.

[4] https://www.audit.wales/publication/aneurin-bevan-university-health-board-medicines-management-acute-hospitals-update

9 Risks

Top 3 Risks identified on borough/directorate risk register

Risk	Action being taken or planned to mitigate	Support from QPS	RAG Rating	
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 15yrs 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. Without the RGH refurbishment and robot case progressing, this service will continue to deteriorate and lead to missed doses at ward level, delay TTHs and have a negative effect on patient flow throughout ABUHB.	Support capital bid	RED	
Pharmacy workforce: Lack of clinical staff in secondary care	Significant Pharmacy workforce risk across the HB. Currently carrying over 30 vacancies across all staffing groups across all job roles affecting all core services from clinical ward work, homecare, invoicing etc. All non-essential work stopped – no Prescribing Support, meetings stopped, site leads being utilised fully operationally. Any unfunded areas do not have a clinical service provided. Areas of high risk that are not serviced by Pharmacy include Transfer Lounge/Fox Pod at GUH, YYF MAU, RGH MAU (only able to see half beds). Unable to take on any additional Clinical Trials and have had to stop recruitment into existing schemes. Clinical Prioritisation SOP produced for ward-based teams, as unable to cover bed base at each site. This means that patients are prioritised but are not seen every day by the team. Recent funding approved for GUH front door and transcribing case. Staff not yet in post to take service forward.	Monitor	RED	
Transfer lounge: Transfer of Medicines and storage: failure to transfer medications with patients	Medicines not being transferred with patients during step ups and step downs between sites, leading to missed doses and additional financial costs from resupplying these. The recent introduction of the transfer lounge has added a further layer of complexity.	Monitor	Amber/red	

who have inter-ward and hospital transfers.	Message communicated from Director of Nursing to reiterate that transfer of medicines during patient moves is an important nursing responsibility. Pharmacy have reiterated the issue via memos and regular communication. With flow through the system being crucial to patient discharge we are seeing patients moved to the discharge lounge and staying longer. Some are being moved without a take home written and have resulted in patients going home without any prescribed medicines. Datix incidents are being completed and completed and escalated to senior nurses. Pharmacy have tried to ensure the lounge has a designated area for safe storage of medicines. Currently there is nowhere secure to supply a small stock list and the area does not have a controlled drugs cabinet (one has been ordered). This may result in omitted medicines for patients.			

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	25 April 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Research and Development Strategy: Research - A Core Activity 2022-2027
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr James Calvert Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Professor Sue Bale and Mrs Jeanette Wells R&D Director

Pwrpas yr Adroddiad
Purpose of the Report

Er Gwybodaeth/For Information

To update the Committee on the recently approved R&D Strategy.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The last R&D Strategy has expired and the new ABUHB R&D Strategy was approved by the Board in November 2022. It is being brought to the Committee's attention by way of an update for information.

The Committee is being asked to accept the new ABUHB R&D Strategy for information.

In future years the Annual Report, which is presented to PQSOC, will be an opportunity to provide an update on implementation of the strategy and to receive input on the future strategic development.

Cefndir / Background

Aneurin Bevan University Health Board has always recognised the value of 'the research effect': NHS organisations who are more research active have been shown to provide a better care experience and improved outcomes for patients and increased recruitment and retention of high quality staff.

In March 2021, the four nations of the UK published a 10-year vision for research - *Saving and Improving Lives: The Future of UK Clinical Research Delivery* - which sets out an ambition to create a world-leading UK clinical research environment.

The ABUHB Strategy presented today '*Research – a core activity 2022-2027*' aligns to that UK vision.

Summary
Welsh Government's expectation is that research should be a core function of a University Health Board. The R&D Strategy: *Research - A Core activity 2022-2027,* provides three high level strategic objectives and 8 strategic actions. The aim is to develop an infrastructure where research can flourish and where the Health Board can maximise the benefits of its investment in the new Clinical Research Centre at the Royal Gwent Hospital.

Issues of significance to the Health Board
The income the Health Board receives from Health and Care Research Wales (HCRW) provides the core funding for the Health Board's research activity. Historically however NHS Wales spends proportionally 10% of the equivalent budget spent by NHS England. The HCRW budget is therefore under significant pressure and in recent years, HCRW has shifted its criterion for funding to one key performance indicator, which is to recruit participants into studies within an agreed time and target (RTT). Achieving this demonstrates that Wales can deliver what is promised and gives sponsors and commercial companies the assurance they need to bring their studies to Wales.

National/local objectives involved
HCRW and Welsh Government's expectation is that research should be a core function of a University Health Board. As such, research needs to be an integral part of delivering the Health Board's Clinical Futures Strategy and achieving the Health Board's mission to reduce health inequalities across Gwent. We aim to develop a traditional research portfolio in secondary care but also to develop research portfolios delivered by the full range of registrants employed by the health board alongside developing expertise in primary care and public health research.

Asesiad / Assessment

The HCRW and Welsh Government expectation is that the development of research capability and capacity should be a core function of a University Health Board. This strategy sets out how that intention will be achieved.

The Health Board has contributed to the R&D Department through Capital Funding resulting in the new Clinical Research Centre at RGH. Funding for staff and running costs for the centre come from HCRW (c80%) with the remainder received through grant income, commercial income and capacity building.

As research becomes a core activity in ABUHB it is anticipated the benefits of research (where NHS organisations who are more research active have been shown to provide a better care experience and improved outcomes for patients and increased recruitment and retention of staff) will be realised.

Argymhelliad / Recommendation

The Committee is asked to note the report for information.

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):	Governance, Leadership and Accountability 1.1 Health Promotion, Protection and Improvement 3.1 Safe and Clinically Effective Care 7. Staff and Resources
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 The R&D strategy directly references all five Health Board priorities, linking them in to phase two of the implementation plan: the development of a streamlined, efficient and innovative research programme.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Research, Innvoation, Imprevement, Value
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 Improve the experience of lesbian, gay, bisexual and trans (LGBTQ+) service users and staff 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 Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers

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:	ABUHB Executives. ABUHB Board.

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**	Yes, outlined within the paper
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**Yes Attached** All research studies are evaluated at the time of development for equality and diversity. It is also a criterion for most funding bodies that equality and diversity have been taken into account. 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 Choose an item.

YMCHWIL & DATBLYGIAD
Bwrdd Iechyd Prifysgol Aneurin Bevan
Aneurin Bevan University Health Board
RESEARCH & DEVELOPMENT

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

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

Research and Development Strategy

Research – A Core Activity

2022–2027

YMCHWIL & DATBLYGIAD
Bwrdd Iechyd Prifysgol Aneurin Bevan
Aneurin Bevan University Health Board
RESEARCH & DEVELOPMENT

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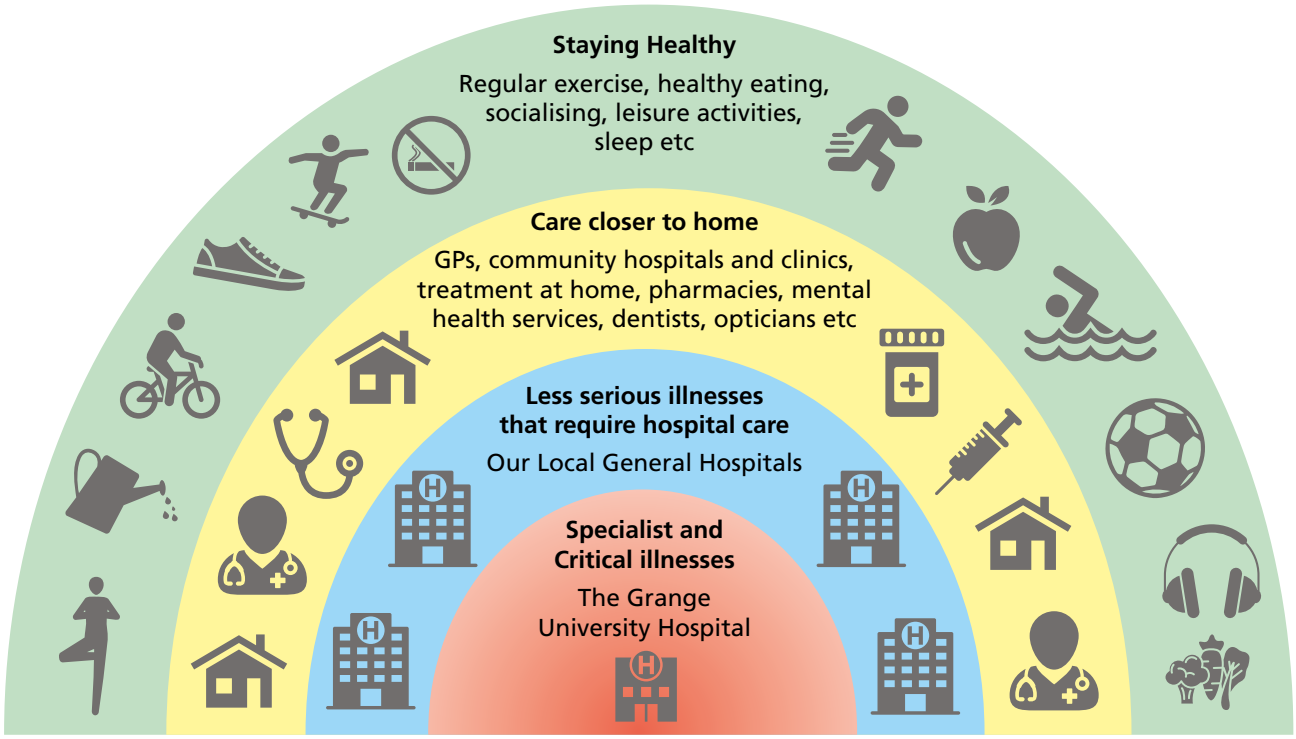


Delivering and developing research that is core to clinical services and meets the need of our population

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

1853
Invention of aspirin

Aspirin, also known as acetylsalicylic acid (ASA), is a medication used to reduce pain, fever, or inflammation.

A precursor to aspirin found in leaves from the willow tree has been used for its health effects for at least 2,400 years. In 1853, chemist Charles Frédéric Gerhardt treated the medicine sodium salicylate with acetyl chloride to produce acetylsalicylic acid for the first time. For the next 50 years, other chemists established the chemical structure and devised more efficient production methods.

Clinical trials and other studies from the 1960s to the 1980s established aspirin's efficacy as an anti-clotting agent that reduces the risk of clotting diseases. The initial large studies on the use of low-dose aspirin to prevent heart attacks that were published in the 1970s and 1980s helped spur reform in clinical research ethics and guidelines for human subject research and US federal law. They are often cited as examples of clinical trials that included only men, but from which people drew general conclusions that did not hold true for women.

Aspirin is one of the most widely used medications globally, with an estimated 50 to 120 billion pills consumed each year, and is on the World Health Organization's List of Essential Medicines.

Contents:

Foreword

Research, a Core Activity 2023- 2028

Aneurin Bevan University Health Board's Research and Development Strategy

"I did not invent penicillin. Nature did that. I only discovered it by accident."

Alexander Fleming, a Scottish physician-scientist recognised for discovering penicillin.

There has never been a more exciting time in the world of research. With advancements in technology, innovation and creativity enabling diseases to be cured; supporting people in recovery and to live longer, research has never been more important.

As we look to the future, our strategy aims to put research and innovation at the core of the Health Board using our newly built, state of the art research facility, as we strive to innovate and improve lives of people in Gwent, across Wales, and as we did in the pandemic, the world.

Our efforts and priority continues to focus on diversifying our research offer so that the Health Board is able to realise its full potential as a leading research organisation. This research strategy, our most ambitious and dynamic to date, signals the start of an exciting new chapter as we strive to embed research into NHS operational services by focusing on three high level strategic objectives and eight strategic actions.

Strategic objective 1: developing a sustainable research workforce. Supporting, nurturing and building on research in areas of strength will provide staff with the tools and opportunity to take part in the delivery of research at a local level.

Strategic objective 2: investing in staff and infrastructure will ensure support is in place for the right people to deliver the right research, at the right time, in the right place.

Strategic objective 3: aims to develop a streamlined, efficient and innovative research programme, fully integrated at an operational level. The research programme will support the delivery of our three-year plan by conducting research that aims to address health inequalities and meet the needs of our local population.

The strategy aligns to the "*Health and Care Research Wales support and delivery strategic framework*", *"CReSt: cancer research strategy for Wales"* and the "*UK 10-year vision for research: Saving and Improving Lives: The future of UK clinical research delivery".*

How did we get here?

In 2022, set against the background of the global pandemic, the Health Board invested in and opened the doors to a state-of-the-art new clinical research facility on the Royal Gwent site. Future plans will see the research infrastructure grow on both the Nevill Hall and Grange University Hospital sites.

Over the next five years we will take full advantage of the opportunities and resources available to us, both within the organisation and externally. Our collaborations will ensure we build strong foundations that support the development of local talent from early career researchers up to Chief Investigator status. We will continue to play our full part in delivering research opportunities developed at a national level as well as those developed at a local level that are aligned to our organisational priorities.

Our new research facility and dedicated team of research specialist nurses will be central to enabling us to maximise income opportunities and growth as we engage in more industry sponsored research and aspire to becoming a preferred partner for commercial trials.

Nicola Prygodzicz
Chief Executive Officer

James Calvert
Medical Director

Comirnaty (BNT162b2)

Spikevax (mRNA-1273)

COVID-19 Vaccine AstraZeneca (AZD1222)

Sputnik V

Sputnik Light

COVID-19 Vaccine Janssen (JNJ-78436735; Ad26.COV2.S)

CoronaVac

BBIBP-CorV/NVSI-06-07

EpiVacCorona

Convidicea (PakVac, Ad5-nCoV)

Covaxin (BBV152)

WIBP-CorV

CoviVac

ZF2001 (ZIFIVAX)

QazVac (QazCovid-in)

COVIran Barekat

Abdala (CIGB 66)

Soberana 02/Soberana Plus

MVC-COV1901

ZyCoV-D

Spikogen (COVAX-19)

FAKHRAVAC (MIVAC)

Nuvaxovid

Turkovac (ERUCOV-VAC)

Corbevax

Covifenz (CoVLP)

2020
COVID-19 vaccines

First identified in December 2019, COVID-19 is a contagious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The disease spread worldwide, leading to a pandemic.

The structure and function of coronaviruses was known prior to the COVID-19 pandemic, and by January 2020, the SARS-CoV-2 virus genetic sequence was discovered and shared worldwide. A global effort led to the development of several vaccines which were first given to human volunteers.

In 2020, the Aneurin Bevan University Health Board, Clinical Research Centre participated in the Oxford, AstraZeneca vaccine trial. The team, supported by Health and Care Research Wales, Public Health Wales and the Centre for Trials Research, recruited over 500 participants, contributing to a better understanding of the vaccines efficacy and safety.

As of March 2022, more than 10 billion doses of COVID-19 vaccines had been administered worldwide.

1 Introduction

Much has changed in the five years since the last Aneurin Bevan University Health Board (ABUHB) Research and Development (R&D) strategy was approved by the Board. The COVID pandemic focused hearts and minds and raised the profile of research not just in ABUHB but worldwide. Finding treatments, vaccines and genetic links was of paramount importance and ABUHB made a significant and impactful contribution to that effort.

The lesson from the pandemic is ABUHB achieved high levels of recruitment to high impact studies when research was part of normal clinical care and not seen as an additional activity requiring time and capacity for research. As we recover from the pandemic, the time is right to develop and implement a strategy that fully embeds research into core ABUHB NHS service delivery.

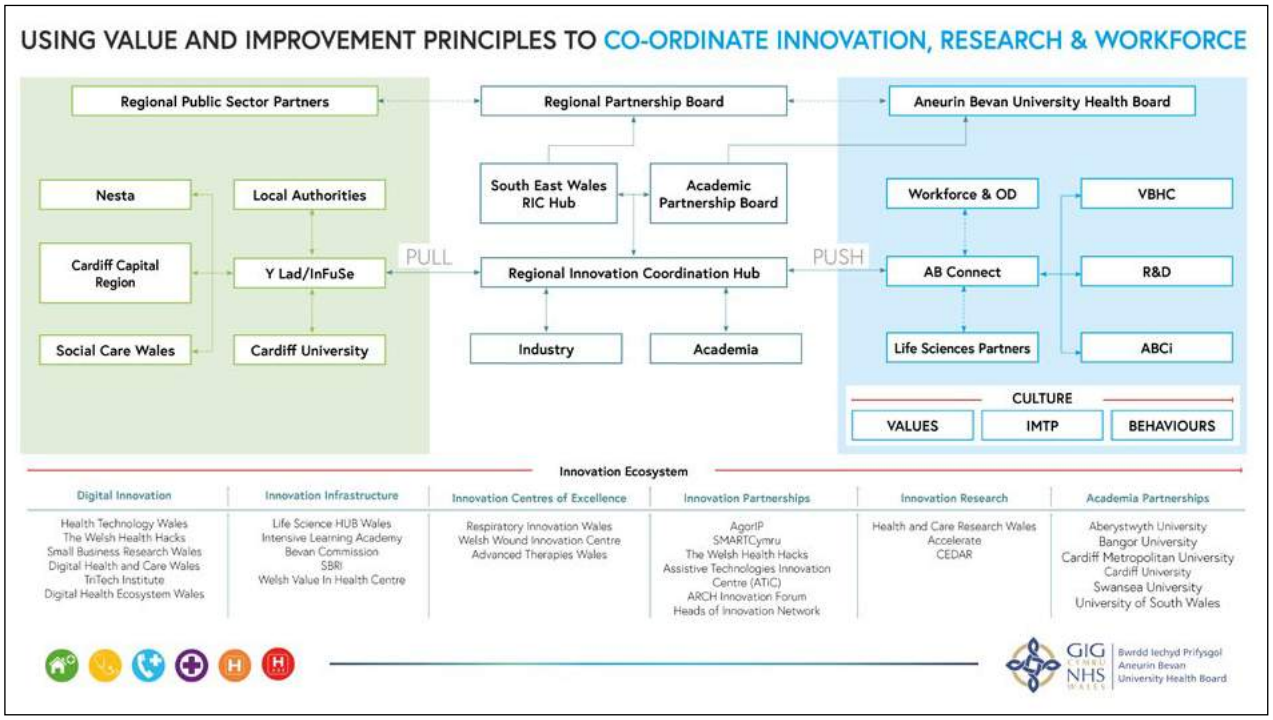
In March 2021, all four nations of the UK published a new 10-year vision for research - *Saving and Improving Lives: The Future of UK Clinical Research Delivery* - which sets out the ambition to create a world-leading UK clinical research environment. This Aneurin Bevan UHB Strategy *'Research – a core activity'* aligns to both the UK vision and the HCRW Support and Delivery Strategic Framework.

Welsh Government's expectation is that research should be a core function of a University Health Board. As such, research needs to be an integral part of delivering the ABUHB Clinical Futures Strategy and achieving the Health Board's mission to reduce health inequalities across Gwent.

2 Background

Reports from bodies such as the Academy of Medical Sciences[1] and the Royal College of Physicians[2] have emphasised the value of research to the NHS. NHS organisations who are more research active have been shown to benefit from 'the research effect'. Those benefits include a better care experience improved outcomes for patients and increased recruitment and retention of staff.

ABUHB has always recognised the value of research working with local, national, and international university partners to design research projects, gain grant funding, and build research workforce capacity and capability to meet the needs of our population. The Health Board has strong partnerships with Health and Care Research Wales (HCRW), university partners, trials units, industry partners, Public Health Wales (PHW) and the voluntary sector.

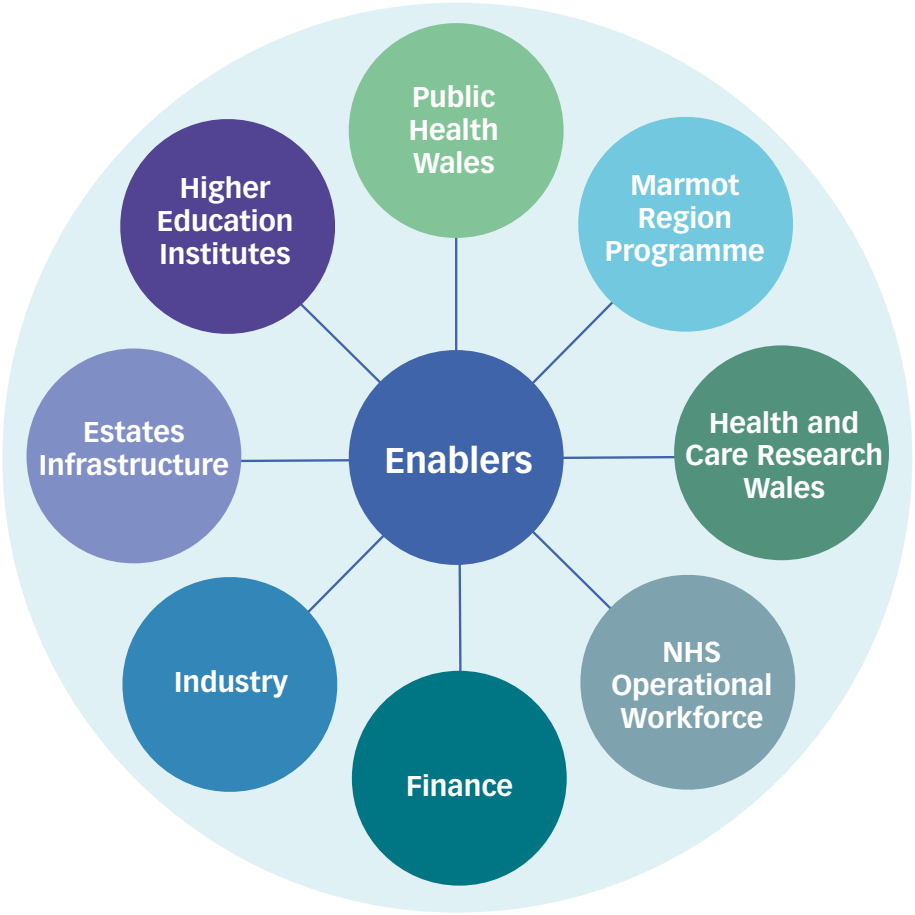


This strategy should be read in conjunction with the ABUHB IMTP. Together these documents demonstrate R&Ds involvement in wider networks that enable research and innovation to be developed, delivered, and outcomes put into practice through service improvement.

1 https://acmedsci.ac.uk/policy/policy-projects/nhs-academia-interface
2 https://www.rcplondon.ac.uk/projects/outputs/research-all-developing-delivering-and-driving-better-research

The income ABUHB receives from HCRW provides the core funding for the Health Board's research activity. The HCRW budget is under significant pressure and in recent years, HCRW has shifted its criterion for funding to one key performance indicator, which is to recruit participants into studies within an agreed time and target (RTT). Achieving this demonstrates that Wales can deliver what is promised and gives sponsors and commercial companies the assurance they need to bring their studies to Wales.

The HCRW and Welsh Government expectation is that the development of research capability and capacity should be a core function of a University Health Board and should be funded accordingly. The shift in HCRW funding criterion away from developing Health Board research capability and capacity has led to a reduction in HCRW income to support core ABUHB R&D team staffing in recent years.



It is important that the Health Board diversifies its income sources for research to their full potential. The ABUHB R&D team are restarting research that was stopped during the pandemic and opening new studies across all healthcare areas whilst still supporting COVID follow up studies.

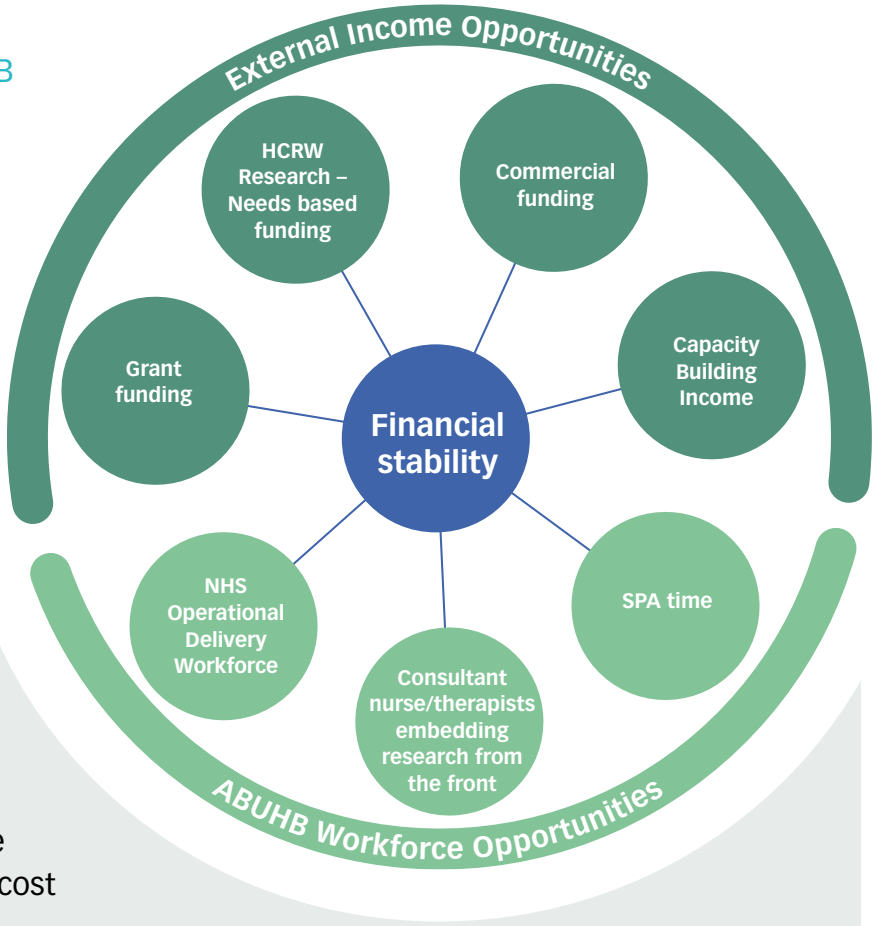
The new Clinical Research Unit in the Royal Gwent Hospital and ABUHB's strong track record of recruitment to internationally important COVID-19 research provide a strong foundation on which to build. This strategy sets out how that intention will be achieved.

STRATEGIC OBJECTIVE 1:
A sustainable and supported research workforce

The research delivery workforce in ABUHB has grown with more specialist research staff employed than ever before. In the last year, despite the reduction in grant and commercial income due to the pandemic halting many studies, the Health Board were able to spend over £2.2m on research delivery. The funding was made up of HCRW Research-Needs Based funding model (including an award from the COVID Vaccine funding stream), commercial capacity building income, charitable funds and capital funding.

Strategic Action 1:

For research to grow ABUHB must fully exploit potential external funding streams and develop the capability and capacity of ABUHB staff to embed research in core service delivery.



External Income Opportunities

- Increase Commercial Trials: pays for research, adds to capacity building income and can be a source for cost avoidance.
- Harness Grant Income: where ABUHB is the Sponsor organisation, grant bids should direct income towards development and funding of an ABUHB Trial Management team.
- HCRW Research-Needs Based funding: a limited resource that in real terms across Wales has decreased significantly over the last ten years. In ABUHB it currently pays for around 80% of the specialist Research and Development Team.

ABUHB Workforce Opportunities

- The Health Board together with its university partners should work together to promote joint working opportunities across NHS and Universities (not just medical consultants but across the whole spectrum of research posts). Stripping out duplication and utilising each other's resources to develop and deliver trials that are set up in alignment with clinical practice and thereby more efficient and effective to run.

- AB Connect:
  - aligning research to the ABUHB Innovation Strategy and the all-Wales Intellectual Property Policy
  - sharing research outcomes to inform service improvement
- Incorporate research sessions into the job plans of research active medical consultants: research active can be defined as:

Either, working in an official capacity as a Principal or Chief Investigator on:

- HCRW/(NIHR) National Institute for Health Research Portfolio studies
- Pathway to portfolio studies
- Pathway to portfolio studies
- Commercially funded research

Or, undertaking developmental activity that leads to one of the above, usually in conjunction with a university.

Embedding research into NHS Operational Delivery

The pillars of university designation: education, innovation and research are everyone's business. As research is embedded further into ABUHB operational delivery; directorates involved in research (supported by the specialist Research & Development team) should ensure open studies are discussed at: directorate meetings, appropriate MDTs or quality meetings to align the research with clinical pathways. All eligible patients should be offered the opportunity to participate (regardless of which clinician is Principal Investigator (PI)/Chief Investigator (CI)) and all staff involved in the specific area of care should be afforded the opportunity to become involved.

The complexity of research activity will determine the level of specialist R&D Team support a directorate will need to run a particular study. The R&D Team maintain oversight of all research activity and will raise the level of support if necessary. The levels of specialist R&D support include:

- **Low complexity, low risk:** Directorate operational team with light touch research specialist team.
- **Medium complexity, medium to low risk:** Research specialist team working alongside directorate operational team in tandem.
- **Complex research requiring specialist knowledge with low-risk elements that can be undertaken by directorate operational team:** Specialist research team with light touch directorate operational team.
- **Highly complex, medium to high risk.** Specialist team supporting PI: Trial runs by specialist research team.

Education

The specialist Research & Development Team will lead an awareness and education programme for the wider ABUHB workforce to engage, explain and encourage recruitment of patients into existing research plus participation in and development of new research.

Strategic Action 2:

Develop and deliver a training programme for all research active staff and those aspiring to become researchers. Including:

International Conference on Harmonization Good Clinical Practice

International Conference on Harmonization Good Clinical Practice (ICH GCP) training is mandatory for anyone involved in clinical research that involves human subjects. It is the international ethical and scientific quality standard for designing, conducting, recording and reporting such trials. ICH-GCP aims to provide a unified standard for the ICH regions to facilitate the mutual acceptance of clinical data by the regulatory authorities in these jurisdictions.

Both the Health Research Authority (HRA) and the Medicines and Health Products Regulation Agency (MHRA) advocate a proportionate approach to the application of GCP to the conduct of research and the appropriate training of staff involved, including those seeking consent from potential participants. [3]

The ABUHB specialist research delivery team members will be trained to facilitate and deliver bespoke, proportionate GCP training for ABUHB staff leading/participating in clinical research activities.

Research Apprenticeship

The aim of research apprenticeships is to support the integration of clinical research into NHS clinical care by offering opportunities for nurses and Allied Health Professionals (AHPs) to step into clinical research within their chosen specialty, supported by a specialist research delivery team member. Through continuing to develop this scheme, clinical research capacity will be built in specialist areas, in turn increasing the opportunities for patients to participate in research and embed clinical research into ABUHB clinical care.

3 Joint Statement on the Application of Good Clinical Practice to Training for Researchers (HRA, MHRA, Devolved Administrations for Northern Ireland, Scotland and Wales) 10 Feb 2020

CPD Events

CPD events are aimed at current and potential researchers. Training is proportionate to the research experience of the participant and aims to provide them with the knowledge and skills required to progress their research careers. That may be at ward level, supporting the specialist research team and local PI, getting involved in a simple evaluation, progressing to PI or taking on the more senior role of CI. Participants will be introduced to the research and development framework, the local infrastructure, available tools and signposted to the most appropriate training opportunities, for example HCRW Clinical Research Time Awards.

- Participation in senior leader education programmes including the Senior Clinician CPD sessions and Physicians Associate CPD sessions.
- Bimonthly Principal Investigator Training programme. Supporting new and established Principal Investigators through taught content and facilitated group learning.
- Bespoke consent training for multi-disciplinary teams new to research. Building quality research capacity through training and development.

Student placements

One of the pillars of university designation is to educate our future workforce. The R&D team regularly provide placements for student nurses, who through training and mentorship are made aware of research as a career pathway. The benefits are that the student will grow to understand what being involved in research means not only to them but also to their patients. Students who do not choose a career in clinical research but go on to work in clinical areas will be able to put their learning into practice working alongside the specialist research team as research is embedded into routine clinical care.

- Active student placement in the Registered Nurse Training Programme - Cardiff University and University of South Wales.
- Opportunities to explore Allied Health Professionals Training programmes - Cardiff University and University of South Wales.
- Working with MSc students.

NIHR Associate Principal Investigator (PI) Scheme

The Associate PI Scheme is a six month in-work training opportunity, providing practical experience for healthcare professionals starting their research career. Staff who would not normally have the opportunity to get involved in clinical research in their day-to-day roles have the chance to experience what it means to work on and deliver an NIHR portfolio trial under the mentorship of an enthusiastic local PI.

- The local research delivery facilitator will raise awareness and provide support for both potential learners and mentors to participate in the NIHR Associate PI scheme.

NIHR Clinical Research Practitioner (CRP) professional registration programme

The NIHR CRP programme provides the opportunity to develop the research workforce by upskilling non-registered practitioners to perform clinical roles. Participation in the all-Wales CRPs registration and accreditation working group (HCRW). 'CRPs are working in research delivery roles that involve direct contact with patients or other study participants. CRPs are now identified as an occupational group in health and care in the UK by the UK Professional Standards Authority (PSA). The PSA is the body that sets the standards for accredited registers of people who work in health and social care. In April 2020 accredited registration for CRPs was approved by the PSA as part of the Academy for Healthcare Science (AHCS) Accredited Register'.

- Participate in the HCRW steering group aimed at developing career pathways for CRPs.

Enhanced skills – specialist delivery team

The Health Boards investment in a new clinical research centre provides facilities for research, clinical trials and interventions to be managed on site. The specialist research team can perform clinical tests; for example, phlebotomy, spinning and processing of samples; treatments; for example, infusion or chemo therapies and also specialist tests; for example, spirometry, ECG, and ultrasound scanning. Enhancing the skill set of the specialist research team enables the Health Board to take full advantage of the new facility and opens up opportunities for R&D to offer a wider range of studies, treatments and interventions to our patients.

- Developing the specialist delivery team to ensure research nurse competencies in infusion, chemotherapy and pump skills are in place and maintained to deliver phase II – IV clinical trials.

Develop the research officer role; either within the specialist team or within the NHS operational teams to take observations, venepuncture and ECGs to support the research team.

STRATEGIC OBJECTIVE 2: Investment in staff and infrastructure

Specialist Research Team

Strategic Action 3:

Align research delivery and governance to consolidate knowledge and expertise to ensure the ABUHB workforce are fully supported to develop and deliver research and to ensure timely study set-up.

Delivering trials within the framework of ICH GCP and following good governance is critical to the quality and integrity of the research undertaken across the Health Board.

As the Health Board move towards fully integrating research into routine care the specialist research team will:

- work seamlessly to support the strategic objectives and actions within this strategy, and
- work with the HCRW support and delivery centre to ensure ABUHB works within the standard required for clinical research

Research Active Consultant Time

Strategic Action 4:

The R&D Director will work alongside the Medical Director to oversee the SPA infrastructure provided through SPA sessions and additional responsibility sessions awarded through job planning. The R&D Director will be aware of all SPA and additional responsibility sessions awarded for research and will be able to align and supervise that work to ensure clinical research is supported and enabled to flourish.

It is often the case that only one or two consultants within a Directorate undertake ‘true’ research; That is working in an official capacity as Principal Investigator or Chief Investigator on:

- HCRW/NIHR Portfolio studies
- Pathway to portfolio studies
- Commercially funded research

Or working with a university:

- Undertaking developmental activity that leads to one of the above

To undertake research in a *Principal Investigator (PI) or Chief Investigator* (CI) role or to develop studies in partnership with the HEIs often requires more time than is awarded through a single or half of an SPA. To address this in discussion with the R&D Director:

- Job plans for research active consultants will be include 1 research SPA.
- where 1 SPA is insufficient the job plan review for the research active consultant should include directorate funded additional responsibility sessions/research sessions.
- directorates may consider employing a consultant research lead who has less clinical sessions and more dedicated research sessions to lead the directorate research portfolio.

NHS Support Services

Strategic Action 5:

develop new and innovative systems to enhance the capacity of pathology, radiology, and pharmacy services to support research and development.

Pathology, Radiology and Pharmacy are support services within the NHS that are crucial to the delivery of clinical trials.

- Limited availability of these resources impedes capacity to open and deliver trials. In addition, as services are moved or redesigned it is important to factor in the impact that the move/change will have on the ability of that service to run clinical trials and the impact that would have on patients.

Increased capacity of support services will be achieved by drawing on a pool of skills to streamline the way trials are set up and delivered through support services. Research specialists currently employed within the support services (who have the knowledge of the trial protocol and the governance that needs to be in place), and the wider directorate support service team (who have the knowledge of the disease area/medication/test) will work together supported by the research senior management team to break down barriers and enable directorates to run clinical trials as part of their operational service.

- Pharmacy: An example being explored in Haematology will involve the directorate specialist pharmacist working alongside the research pharmacist, unpicking new research protocols to establish mechanisms of enabling the study to run. By working together and streamlining the review process duplication can be avoided, valuable time saved, and it can be determined much more quickly if the study is able to run in ABUHB. If successful, this process will roll out to other directorates.

Developing joint appointments between the NHS and HEIs

Strategic Action 6:

ABUHB will work with Higher Education Institutions, Health Education & Improvement Wales and Welsh Government to remove barriers and open opportunities for joint appointments.

It has long been recognised that joint consultant posts are of benefit to NHS organisations and Higher Educational Institutes (HEIs) alike. There are not enough joint consultant posts, and it is important that the Health Board works with the universities to find ways to develop that valuable resource.

Opportunities for joint posts, however, should not be limited to consultant posts and the Health Board together with its university partners need to explore the whole spectrum of research posts across the NHS and HEIs:

Example: Trial Manager.

- Combining the role of an NHS trial manager and a university trial manager would realise the following benefits:
  - career and education development opportunities in the NHS and university. (Employee job satisfaction)
  - access to specialists in both sectors broadening the shared knowledge and expertise. (Better understanding across sectors)
  - trials would benefit from an informed coordinated design and set up meeting the needs of the NHS and HEIs.
  - potential for grant funding to go further as overhead costs are reduced

A Healthier Wales looks towards a future where barriers to working across sectors are broken down. In 2022, at the University Designation Showcase joint NHS/HEI posts were discussed. This discussion identified a number of barriers: (contracts, pensions, salaries, IT connectivity) and suggested an enabler would be an all-Wales joint NHS/HEI strategy looking at the benefits of joint posts and how to remove barriers.

Infrastructure

Strategic Action 7:

align the estate strategy to the research strategy to create an infrastructure that will support research delivery across multiple sites.

In 2021/22 the Health Board opened the doors of its new clinical research centre in Royal Gwent Hospital (RGH) supported by a satellite unit in Nevill Hall Hospital (NHH) and a small team working out of the Grange University Hospital (GUH). The unit enables trial participants to visit and/or have their treatments in one department. This benefits the patients and the research team in maximising value for money, saving time and ensuring trial participants are cared for in a comfortable environment. This development will be key to enabling the delivery of this strategy. Whilst taking full advantage of the new facility the specialist research team continue to work out of clinical facilities on all sites and in the community where this remains the best way to deliver the research.

Community of Practice

Strategic Action 8:

develop a multi professional community of practice where individuals can come together to share ideas and support the implementation of this strategy in conjunction with the ABUHB IMTP and Innovation Strategy.

STRATEGIC OBJECTIVE 3: A streamlined, efficient, and innovative research programme

Patients and members of the public should:

- be given the opportunity to be involved in research regardless of location.
- be offered specialist research opportunities through referral to specialist centres, equally referrals from other areas are accepted by the health board R&D team where the specialist research is hosted by ABUHB.
- expect that research developed locally will utilise a full community of practice including university partners, AB Connect, HCRW Faculty, HCRW Centres and Units and funding opportunities to ensure the studies developed meet the needs of our population.

The specialist research team will work alongside NHS operational teams across all sites constantly working to remove barriers.

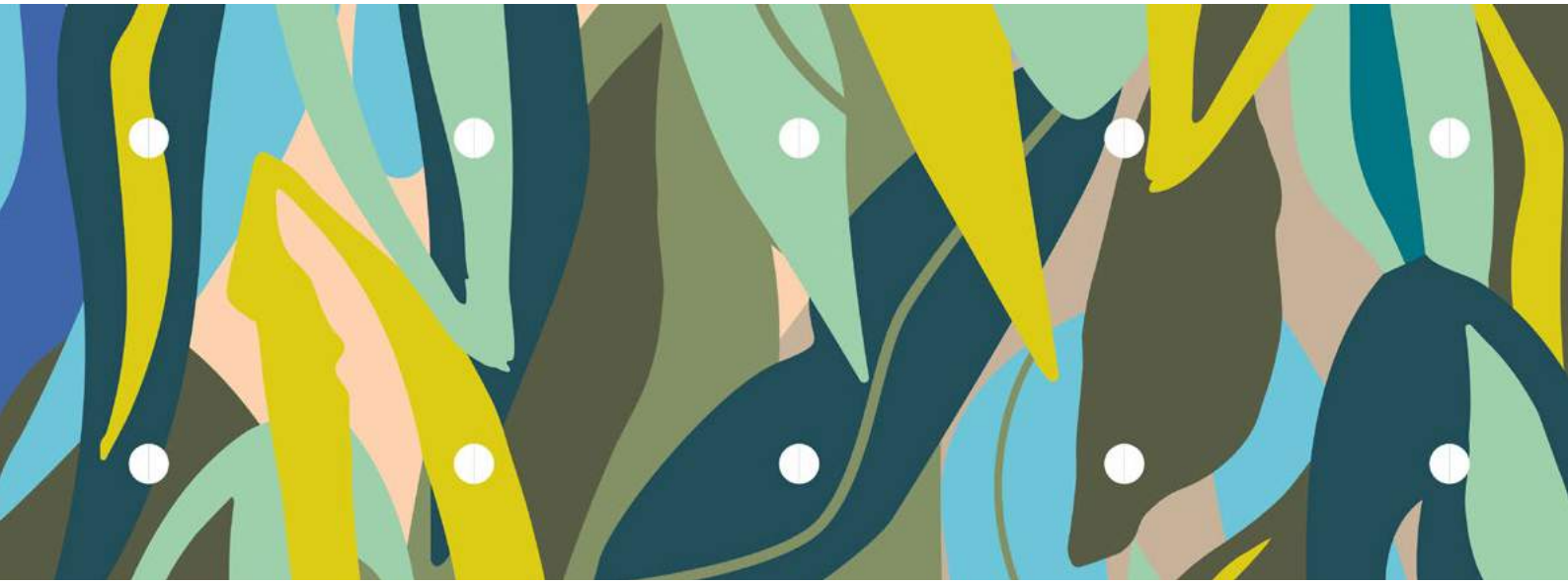
The Health Board drive to realise strategic objective 3; developing a streamlined, efficient, and innovative research programme will be implemented in three phases.

Phase 1: Areas of strength and opportunity

Cardiology: Critical Care: Haematology (and cancer services generally): Midwifery: Neurology: Respiratory: Public Health: Rheumatology: Surgery

Strengths:

- established research portfolios
- commercial and non-commercial
- directorate funding in Haematology for a Research Nurse
- Research Officer in cardiology funded through commercial income
- critical care and midwifery integrate research into jobs throughout the teams and have widespread ICH GCP training in place
- critical care and surgery – running apprentice Research Nurse scheme
- innovative ways of working – haematology specialist pharmacist working with research pharmacist



Weaknesses:

- dedicated time for research active consultants
- support services pathology, radiology and pharmacy often unable to support studies
- shared posts with universities
- clinicians developed to Chief Investigator level

Opportunities:

- map and monitor SPA and additional responsibility sessions awarded for research in these areas
- reach out to directorate pharmacists
- capitalise on the reputation already established running commercial trials and the new research unit to develop commercial portfolios across all areas of strength
- feed research priorities into the pharmacy workforce strategy
- promote a midwifery research portfolio that is delivered as an integral operational service overseen and supported by the Research Midwives
- roll out apprentice Research Nurse scheme to all areas of strength
- develop the research portfolio to fully utilise the day case infusion suite and ward space available within the Royal Gwent Clinical Research Facility

Phase 2: Health Board Priorities

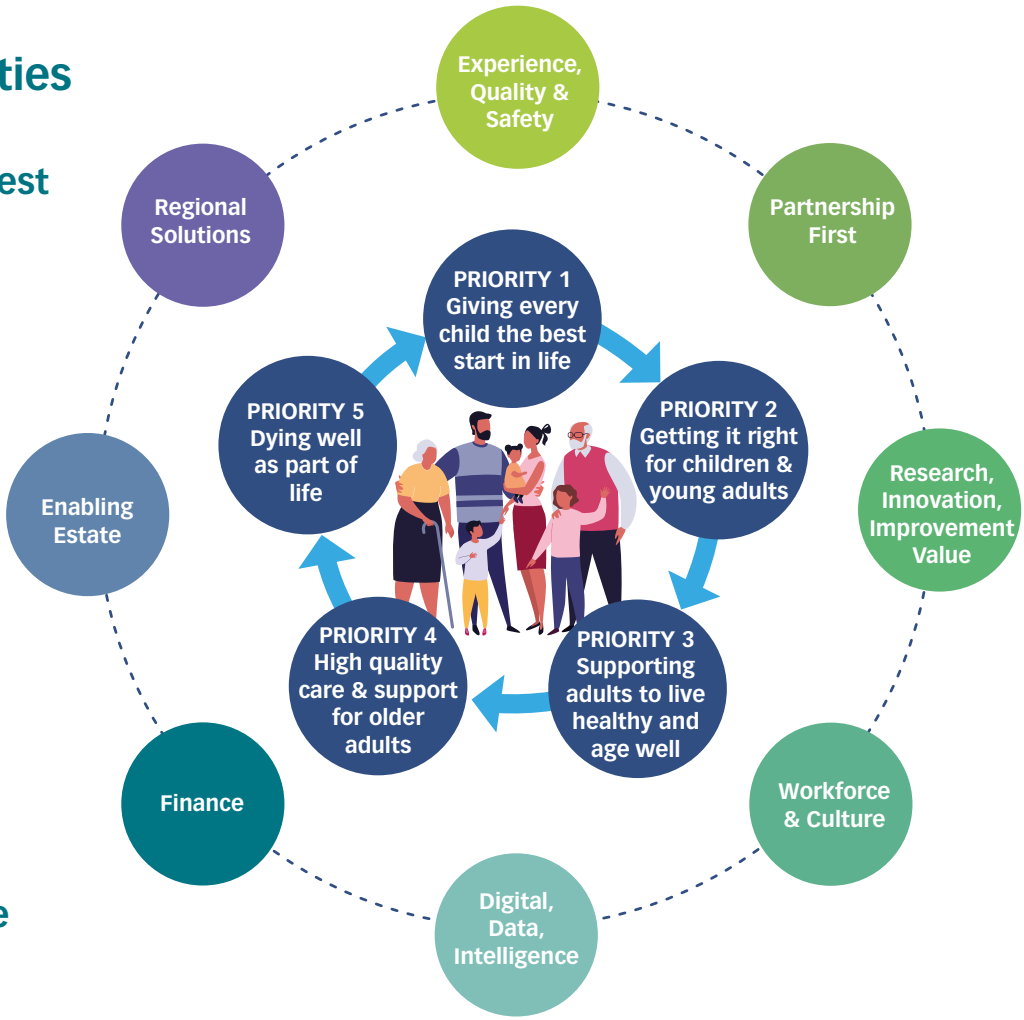
Priority 1: giving every child the best start in life

Priority 2: getting it right for children and young adults

Priority 3: adults in Gwent live healthier and age well

Priority 4: older adults are supported to live well and independently

Priority 5: dying well as part of life



Strengths:

- Midwifery
- The Marmot Region programme
- Public Health
- Palliative care (cancer)
- Research Nurse apprenticeship scheme
- CAMHS
- Mental Health

Weaknesses:

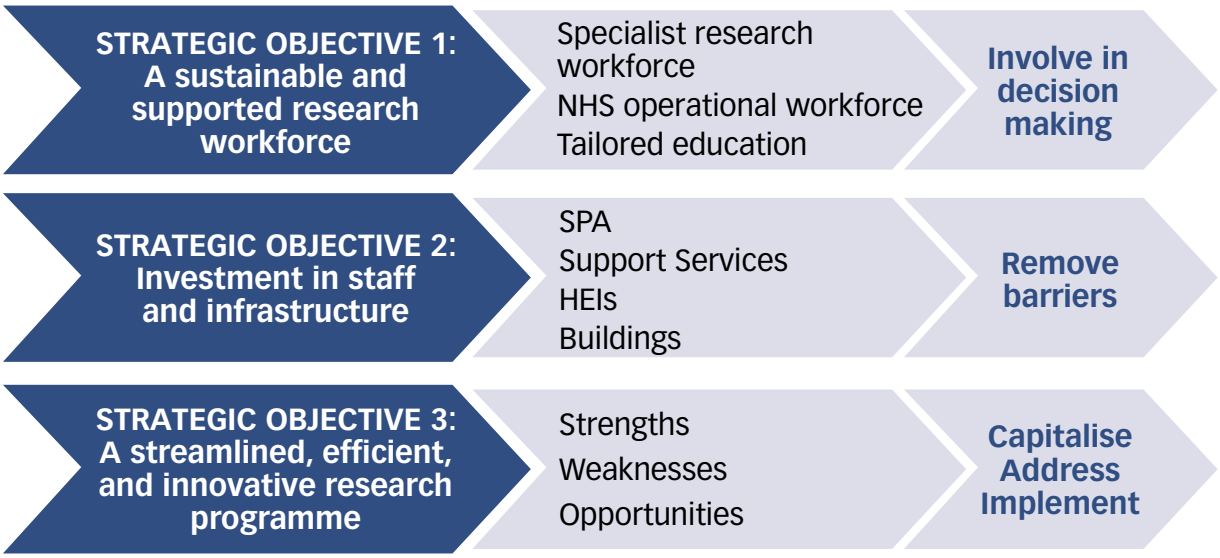
- Priorities 4 and 5 would benefit from research developed and delivered alongside our social care and third sector partners: whilst there are robust processes in place to ensure research in the NHS is set-up and carried out in accordance with ICH GCP there is no process in place to govern social care research or third sector research. This currently means that the Health Board are unable to easily run clinical trials across all sectors. HCRW are working towards addressing this and ensuring processes are developed so that this important phase of research can begin.

Opportunities:

- Midwifery as an exemplar from phase 1 will:
  - lead the way for Priority 1: giving every child the best start in life
  - be a role model for how further services can operationalise research
- The Health Board Marmot Region programme will focus initially on the early years promoting family centred interventions and improved long-term outcomes for children. The aim of the project is to reduce health inequalities across the five priority areas.
- Public Health Wales and ABUHB have worked together to research vaccines and diabetes
- Building on palliative care in cancer research palliative care for everyone

Extend the research nurse apprenticeship scheme to primary care

Phase 3:
Research Delivery – a fully integrated operational service



3 Conclusion and Summary

- In March 2021, all four nations of the UK published a new 10-year vision for research - Saving and Improving Lives: The Future of UK Clinical Research Delivery - which sets out the ambition to create a world-leading UK clinical research environment. This ABUHB 'Research – A Core Activity' strategy aligns to that UK vision.

- On the 21st July 2022, the Chief Medical Officer (CMO) wrote to Health Boards and Trusts in Wales referring to the UK vision for research. In his letter, the CMO outlined the influential role Health Boards and NHS organisations can play in supporting this work programme.

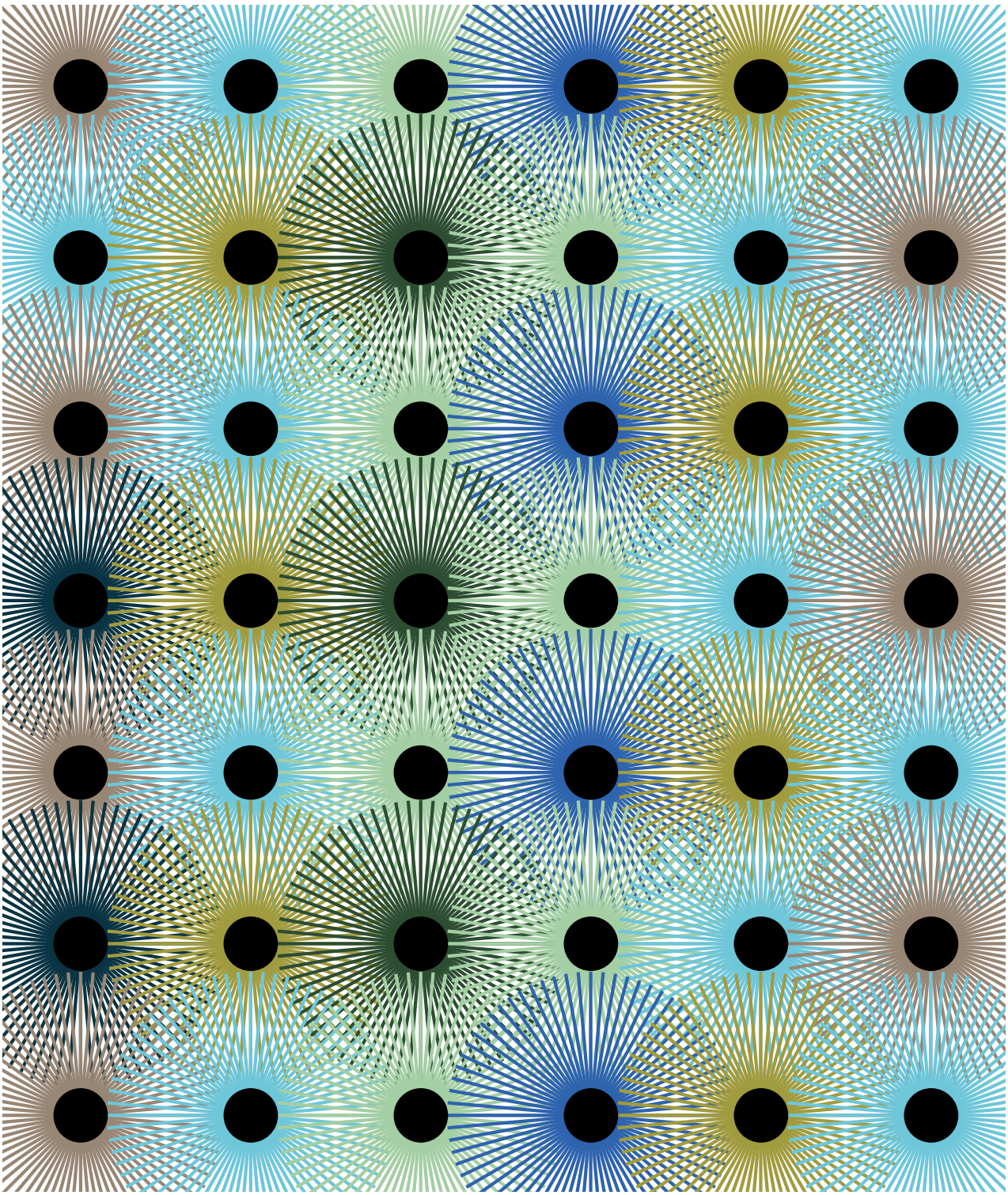
- The income the Health Board receives from Health and Care Research Wales (HCRW) provides the core funding for the Health Board's research activity. The HCRW budget is under significant pressure and in recent years HCRW funding to Health Boards has been reduced.

- It is important therefore, that the Health Board diversifies its income sources for research to achieve the Health Board's full potential as a research organisation.

- This strategy 'Research A Core Activity 2022-2027' sets out how ABUHB will achieve that intention through three high level strategic objectives and 8 strategic actions.

- The aim is to develop the Health Board's infrastructure to be an organisation where research can flourish and where the Health Board can maximise the benefits of its investment in the new Clinical Research Centre at the Royal Gwent Hospital.

- The final document will be published on the Health Board's website in English and Welsh and produced as a high specification booklet that promotes the new Clinical Research Centre and ABUHB as an organisation where research is a core activity.



1911–1979
Josef Mengele

Josef Mengele, also known as the Angel of Death, was a German SS officer and doctor during World War II. He performed deadly experiments on prisoners at Auschwitz concentration camp and showed no consideration for the victims' health, safety, or physical and emotional suffering.

Mengele used Auschwitz as an opportunity to research into heredity, using inmates for human experimentation. Specifically, in identical twins, people with heterochromia iridium (eyes of two different colours), dwarfism, and physical abnormalities. For example he injected chemicals into the eyes of living people in attempt to change the eye colour.

Through history, there are examples of human atrocities undertaken in the name of clinical research. Following on from the Nuremberg trials after World War II, the Nuremberg Code and later the 1964 Declaration of Helsinki provide protection for participants in clinical research. The elements of the declaration described as Good Clinical Practice, form the basis of law in the UK and much of the world.

YMCHWIL & DATBLYGIAD
Bwrdd Iechyd Prifysgol Aneurin Bevan
Aneurin Bevan University Health Board
RESEARCH & DEVELOPMENT

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

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:**	25 April 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Dementia Standards Annual Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jenny Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tanya Strange, Head of Nursing, Person Centred Care

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 Dementia Action Plan for Wales sets out the Welsh Government's commitment to promoting the rights, dignity and autonomy of people living with dementia and the people who care for them. An established Regional Dementia Board has developed a Regional Strategy and Action Plan to drive forward improvement actions against the 6 key aims of the National Plan. In 2021, Improvement Cymru published the *All-Wales Dementia Care Pathway Standards: High Level Standard Descriptors.* These Standards must be reflected in Regional Dementia Strategies and Action Plans. Each region was afforded a 'year of readiness' to prepare for the implementation of the Standards.

The Dementia Annual Report April 2022- March 2023 (attached) outlines the key actions the Regional Dementia Board and associated Workstreams have taken during the readiness year. The Patient Quality, Safety and Outcomes Committee is asked to note the report for assurance.

Cefndir / Background

The Dementia Action Plan for Wales (2018) sets out the Welsh Government's commitment to promoting the rights, dignity and autonomy of people living with dementia and the people who care for them. The Regional Dementia Board is well established and provides a forum for strategic and clinical leadership, engagement, consultation, and joint decision making across the health, social care and third sector agenda for dementia care in the five local authority areas of

Blaenau-Gwent, Caerphilly, Monmouthshire, Newport and Torfaen, and the Aneurin Bevan University Health Board. The Dementia Board aligns and reports to the Regional Partnership Board (RPB). Through its membership the Dementia Board is aligned to the work of the regional Carers Board; End of Life Care Board; Mental Health and Learning Disability Partnership Board and the Gwent Adult Strategic Partnership Board. Five Dementia Friendly Community Implementation groups are represented by each local authority. The Board aims to harness the partnership working in the region to meet the priorities identified by people living with dementia and their carers and in the Dementia Action Plan for Wales and associate guidance.

In March 2021, Improvement Cymru published the 'All Wales Dementia Care Pathway Standards' (attached).

The 20 standards indicate what people believe will make a positive difference to dementia care in Wales. The Standards have been 'wrapped' around the person and, with 'kindness and understanding' at its core, consist of 4 broad themes:

- Accessible
- Responsive
- Journey
- Partnerships and Relationships

Each standard applies to all people being assessed, diagnosed and living with dementia and their carers', recognising people with dementia as a vulnerable group, together with individuals with special characteristics such as Learning Disability and Black Asian and Minority Ethnic Groups. The overriding approach for implementation of the Standards is one of multi-agency responsibility with the Standards supporting the Dementia Action Plan (DAP) and laying the foundation for what the National DAP will look like for the next 5 years and beyond.

To support the implementation of the Standards, the Regional Dementia Board reviewed its action plan to reflect the Standards and established Regional Workstreams that mirror the National Workstreams.

April 2022- March 2023 has been a 'year of readiness' for the Regional Dementia Board, with each Workstream taking forward actions that will support the implementation and embedding of the Standards across health and social care services from 2023 onwards.

Asesiad / Assessment

The attached Dementia Annual Report outlines the key actions taken during the readiness year (2022-2033) and identifies what needs to be actioned during the implementation stage (2023 onwards). In summary:

Workstream 1- Engagement: A number of engagement events have been held with people living with dementia, carers, staff, partners and wider communities to both raise awareness of the standards and to gain people's views on how we can collectively influence, shape and improve dementia care across the region. We have offered 'bespoke' webinars for people who are Deaf, people from ethnic minority communities, carers, people who identify as LGBTQ+ etc, facilitating

evening and daytime enragement opportunities. We have established our first 'Expert by Experience' group. These are people who predominately care for relatives living with dementia. To support the Wales Listens Campaign, we have used our Population Needs Assessment data and Stakeholder discussion to identify 2 areas of Newport to undertake focused dementia listening events. At these events, there has been collective discussion around what dementia care looks like in their communities, what would make dementia care better, what community support is available and how communities wish to be kept informed and involved. We aim to recruit 'Community Listeners' and follow up discussions will be arranged.

Workstream 2a- Memory Assessment: During the readiness year, the workstream have been proactively reviewing service provision and models of service to ensure they are better aligned with the Dementia Standards. Data Measurement Sets are being established. Workstream membership has been refined and now includes key partners to develop this work. Models of best practice are being identified. Proactive engagement has identified the need to establish a Community of Practice to shape and develop Memory Assessment Services (MAS). A dedicated webinar to influence and shape MAS has been arranged for May 2023.Workstream partners are currently speaking to people living with dementia, families, and carers to encourage them to join the Community of Practice. A scoping exercise is being completed around third sector community support.

Workstream 2b- Carers Education: The Workstream has developed a Gwent wide Carers Information Course Model that now runs in six-week blocks in all Five Gwent region boroughs. These are face to face courses with provision for virtual courses also. As part of these courses, Carers are also offered Positive Approaches to Care training, which focusses on person-centred approaches and interventions in dementia care. A resource pack for Carers has been developed and is available in hard print and digital formats. We are positively working towards increasing the number of carers attending courses, by developing a poster to be displayed in all GP Surgeries, all Hospital Entrances/Restaurants/Inpatient Units. This has already seen an increase in referrals. We are currently developing a Padlet for all Carers to access a wide variety of up-to-date information. We have introduced Carers Champions in all Memory Assessment Clinics to be a conduit of information and advice.

Workstream 3- Dementia Connector: A Community of Practice has been established to look at good practice and provision of Dementia Connector models across the UK. Data collection around local connector models has commenced and proactive meetings held with leads across Gwent to gather job specifications and salary information. Dementia Hwb meetings with local partners have been held to look at a community information and signposting hub, and ongoing discussions into potential venues and accessibility are in progress. A bid is being prepared for Dementia Hwb funding. The aim is to pilot in one area as a 'proof of concept' with the local Hwb model being informed by people living with dementia, carers, communities and staff.

Workstream 4- Dementia Friendly Hospital Charter: During the readiness year, the Aneurin Bevan University Health Board adopted the Dementia Friendly Hospital Charter for Wales. To promote awareness of the charter, a brief public animation of the Charter principles and the ABUHB's commitment to improving

dementia care has been produced and publicised. Using Twitter, Facebook, intranet and external web pages we have described the improvement plans that support the Dementia Friendly Hospital Charter. Key highlights include:

- Re-launch of John's Campaign
- Revised patient bedside boards
- Recruitment of dementia volunteer companions
- Introduction of meaningful activities, resources for every ward and a programme of staff learning
- Increase in ward-based Dementia Champions
- Establishment of a continence faculty

The in-patient Hospital Dementia Action Plan has been significantly revised based on feedback and what matters to people.

Workstream 5a- Learning and Development: During the readiness year this Workstream has scoped the current learning available and identified gaps against the GoodWork Framework. A regional approach to shared learning has resulted in the production of a specification for learning resources prior to going to market. Funding has been secured from the Regional Integration Fund to support the commissioning of resources and the supply of assistive technology for use in the learning environment. Engaging with carers, a Gwent Wide Carers Information Course has been developed and is available across all boroughs. The Health Board has committed to the 040 All-Wales Dementia Awareness Module on ESR for all staff. This is a mandatory requirement with the current compliance figures for the workforce being 82.83%. Dementia Friends sessions are now delivered at induction and is mandatory training for all our volunteers.

Workstream 5b- Monitoring: To date, there is no national monitoring tool. Locally, much of the readiness year has been used to scope and identify what data is already collected and identification of data gaps. Connections have been made with performance and measurement leads within quality assurance departments, Local authority, the Health Board and our Dementia Friendly communities, to support this work. Engagement has also taken place with other leads in Wales, to determine what they are doing to identify data in their area and share good practice and learning. We have set up a regional database on excel to capture data, both quantitative and qualitative, which we are continuously updating.

Regional Support

The Regional Dementia Board have been successful in securing funding for a Programme Manager. This post holder (due to start April 2023) will be pivotal in supporting all workstream leads/teams in driving forward their programme plans. They will have a crucial role to play in developing the monitoring data sets to evidence progress across the Dementia Standards and in developing our regional programme to implement the Standards.

Argymhelliad / Recommendation

In April 2023, the Regional Dementia Board will consider Workstream progress to date and will set priorities for 2023/2024, to be reflected in the Regional Dementia Action Plan. This will be reported at the Regional Leadership Group and through to the Regional Partnership Board.

The Dementia Annual Report (attached) outlines the actions the Regional Dementia Board has taken to prepare for implementation of the Standards from April 2022 - March 2023. The Patient Quality, Safety and Outcomes Committee is asked to consider the Annual Report for 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):	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 4.1 Dignified Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Older adults are supported to live well and independently
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 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 Improve the access, experience and outcomes of those who require mental health and learning disability services Improve the wellbeing and engagement of our staff

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	National Dementia Action Plan National Dementia Pathway of Standards Dementia Friendly Hospital Charter Patient Experience Strategy Quality Strategy
Rhestr Termau: Glossary of Terms:	

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Dementia 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	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/	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 Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

GWELLIANT CYMRU IMPROVEMENT CYMRU

All Wales Dementia Care Pathway of Standards

High Level Standard Descriptors

www.phw.nhs.wales

Llywodraeth Cymru
Welsh Government

All Wales Dementia Care Pathway of Standards

The standards for dementia care have been scoped over the past two years with over 1800 people ranging from people living with dementia to voluntary sector organisations to practitioners across Wales and the UK.

This work has been led by Improvement Cymru as part of the Dementia Care Programme and directed by the requirements of the Dementia Action Plan for Wales, overseen by the Welsh Government Dementia Oversight Implementation and Impact Group (DOIIG).

There are twenty standards narrowed down from over one hundred potential standards and they drill down to the detail of what people believe will make a positive difference to dementia care in Wales. They are designed to be dynamic and by responding to evaluation and supporting evidence, standards can be added or subtracted. The twenty standards sit within four themes:

Accessible, **Responsive**, **Journey**, **Partnerships & Relationships** underpinned by **Kindness & Understanding**

The standards have been developed using the Improvement Cymru Delivery Framework. Part of this work has involved developing a two year Delivery Framework for the regions across Wales to cover the period 2021 – 2023.

This Delivery Framework will assist the regions in adopting and implementing the standards by offering support and assistance in year one to undertake engagement, coproduction, scoping, readiness and self-assessment. Year two will focus on implementing the standards into practice.

The standards are person centred and provide a proactive approach to meet each person's language needs. For Welsh speakers, the Active Offer is used to provide services that meet their language needs as a natural part of their care and to ensure relevant patients and carers are truly involved, and receive the best possible care and treatment.

Helping people from all communities to engage and get the support they need, for example people from different cultures and backgrounds such as Black, Asian, and minority ethnic groups.

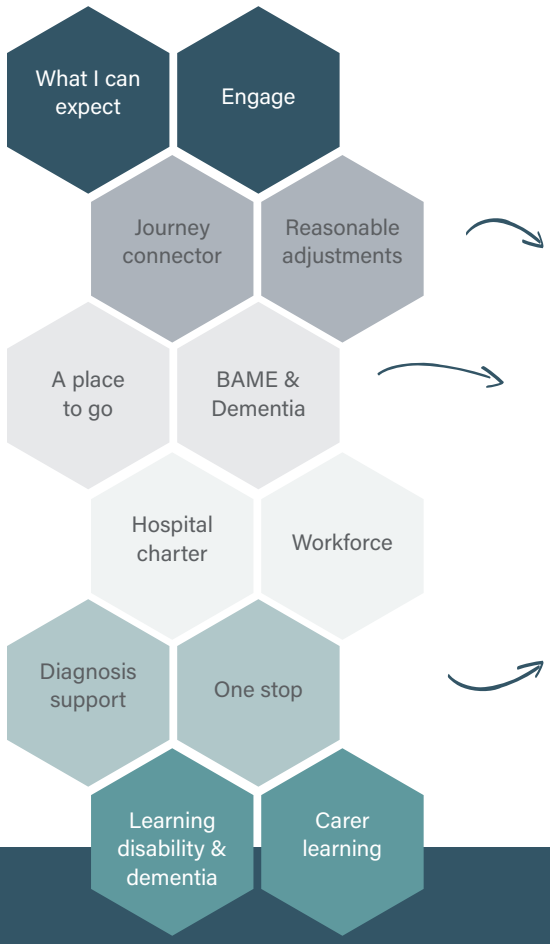
4 Themes 20 standards wrapped around the person

Accessible

Responsive

Journey

Partnerships & Relationships



Kindness & Understanding

Introduction to the standard descriptors

- The standards have been prioritised from over 100 that could have been developed to the 20 described here
- The standards are dynamic, not static, meaning the set of standards will be evolving, when each standard is achieved across Wales it can be replaced with a new one. This means following a robust review standards can be added and subtracted
- There is a brief rationale provided to support understanding the context and evidence for each standard
- Each standard applies to all people being assessed, diagnosed and living with dementia and their carers recognising dementia as a vulnerable group, together with individuals with special characteristics such as Learning Disability, Black Asian and Minority Ethnic groups
- Regions should consider the standards in their entirety as they align with each other
- Identifying the high level responsibility for delivery will be included against the standards, however the key message is one of promoting partnership between agencies and stakeholders to drive the standards forward. At local level the Regional Partnership Board (RPB) and Dementia Forum will decide what agencies have responsibility against the standards and what that responsibility entails e.g. what actions. However, the overriding approach is one of multi-agency responsibility
- Reporting and measurement requirements align to a range of existing audit and reporting streams such as the Royal College of Psychiatrists and Health Care Standards with additional measurement definitions developed as necessary. Reporting and measurement will commence during the implementation phase and will be the responsibility of the RPB and the dementia forum
- Standards support the Dementia Action Plan (DAP) by focusing on a defined set of interventions determined to improve dementia care and will take the DAP core items forward over the next two to three years. This will assist in laying the foundation of what the DAP will look like for the next 5 years and beyond

Accessible

01.

Phase One: This standard is about community engagement using one locality within a region working in partnership, taking 6-12 months to engage with that community to learn, evidence, and analyse what people and agencies have identified it needs e.g. Identify 'what dementia care and intervention looks like around here.' This will produce a vision and growth (delivery) plan. **Due to COVID19 there will have to be a strong emphasis on all means of contact type and service provision that will follow the national guidance.

Phase Two – Year two onwards: support and assistance will be provided as part of the two year delivery framework. Each region will focus on implementing the agreed vision and growth (delivery) plan in year two, with a focus on measurement and assurance.

The focus for this standard **emphasises the phase one** component:

- **Identify one community in a region** e.g. Cwmbran, Carmarthen. Working in partnership demonstrating real engagement and coproduction to develop a plan for what dementia care means to that community – what it looks like – create a community vision that includes meeting places, centres or hubs. Coproduction will be robust, meaningful, evidenced and this will be demonstrated throughout the initiative. Taking this time to engage will ensure that the planning will fit with the community's needs
- A physical place for connection may be provided or it may not – this standard is about what the community states they need
- This meeting place, centre or hub will be accessible and offer a safe, friendly environment for people to go to and start a conversation about their cognitive health. This conversation may be about being forgetful, feeling lonely, feeling down, isolated, struggling with everyday living and stressors or could be a place for people with dementia, their carers and families who may be struggling day to day to access the right care and support. It will offer a place to connect with people, the community and services, to assist with maintaining and maximising skills to enable people to live with dementia
- This meeting place, centre or hub includes digital / telephone connection and access to offer information, support, advocacy, peer support, social and physical health interventions and assistance for people living with cognitive health difficulties including dementia as a point of access and intervention.

**The resulting vision and implementation plan forms part of phase two for this standard

Brief Rationale

Through coproduction regions can be informed by intelligence from its users to improve the quality of services, better design services and pathways based on users' experiences and expertise.

Throughout the consultation people told us that they didn't know where to go when they started to struggle with their cognitive health. People told us that they were not ready to have a formal conversation with their GP when they first started to have cognitive difficulties. Community cognitive health centres will support a safe place and the first step to start the conversation about cognitive health difficulties.

Accessible integrated community cognitive health centres will provide a dual function in supporting individual care services for people experiencing cognitive health difficulties along with providing active health promotion services to improve the population health within the community. This standard aligns to all other standards within this pathway in creating 'how dementia care looks around here.'

02.

Services at the points of contact will provide reasonable adjustments to care that is meeting the person's needs and personal preferences. This will include all people that access community and inpatient services, recognising that people with dementia are a vulnerable group.

- Reasonable adjustments include: translating information so that it's easily understandable, adapting appointment times and venues to enable access and engagement, ensuring Did Not Attend (DNA) is not because people cannot process and act on information provided.
- Recognising that there is a need to have accurate data about who this population is in each region will evidence a progressive action plan to work towards making reasonable adjustments for all people living with a dementia (connects with standard one, three, and eleven).

Brief Rationale

The Equality Act 2010 outlines that a person has a disability if the person has a physical or mental impairment and the impairment has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities. This Act recognises dementia as a disability under these terms and therefore, reasonable adjustments need to be made for all people who are living with dementia based on their individual needs.

Person-centred reasonable adjustments will support the person to live well by maximising their independence and ability to participate in their communities.

Article 5 of the Human Rights Act (1997) notes the importance of making sure that the most and least vulnerable people in our care are treated equally and that reasonable adjustments are made to ensure that all people can make informed decisions. This may include ensuring appropriate use of advocacy, ensuring the voice of the person is heard and appropriately responded to. For people subjected to Deprivation of Liberties Act safeguards, family and significant others (where appropriate) are informed.

This standard looks at the macro and micro level – how the care system responds to reasonable adjustments for all vulnerable groups, individualised approaches to support person-centred care and connects with standard one, asking do we have a robust implementation plan, a work stream for accessible information across all settings and a community.

03.

- Memory Assessment Services (MAS) and Primary Care (GP) will adopt the READ Codes (coded clinical terminology thesaurus) to capture diagnosis of dementia and mild cognitive impairment and work together to promote early intervention and support (connects with standard one)
- Those diagnosed with dementia within settings outside of MAS (including primary care, community resource teams, psychiatric liaison and neurology) will provide the GP and MAS the specific READ Code within two weeks of a diagnosis
- MAS will evidence activity using the agreed data collection tool
- Regions will evidence increasing diagnostic rates by undertaking improvement cycles supported by the Increasing Diagnostic Rates resources when completed

Brief Rationale

Assurance is needed to ensure equity of service access and provision across Wales, no matter where a person is diagnosed, or what type of dementia diagnosis is given. MAS and primary care have access to the oversight of the diagnostic profile in their area. The mechanism to achieve standard three will be agreed locally as this will encourage partnership working to ensure that MAS and primary care are offering a partnership approach to all people and their carers, families with a diagnosis. Partnership arrangements will ensure that those only being seen by a GP will still be offered:

- Dementia coordinators or support workers
- Post diagnostic support, where necessary and signposting to post diagnostic support (cognitive centres could offer this intervention)

Wales can expect:

- an increase in the proportion of people with dementia receiving a formal diagnosis
- an increase in the proportion of people with dementia receiving a diagnosis when they are in the early stages of the illness
- an increase in the number of patients and carers who receive a positive experience of receiving cognitive health services
- reduced risk of crises later in the course of the illness.

The calculation of the estimated dementia diagnosis rate is described by StatsWales. Improvement Cymru and the National Wales Informatics Service(NWIS) are working jointly to develop the availability of monthly data as part of the MAS work stream and will also explore the breakdown of data e.g age range.

As part of the MAS work stream we are scoping the development of a dashboard that provides monthly updates on the estimated dementia diagnosis rate using GP registered populations to produce the denominator. This is further outlined in standard twenty and will be useful for supporting improvement in a more timely fashion.

04.

Learning Disability (LD) services will define a process to capture the total population of people living with a learning disability and specifically Down Syndrome to offer a cognitive wellbeing check. This will include people known to all services including health, social and primary care services that include the GP and MAS. Learning Disability services are joined into the regional dementia care planning initiatives.

- Phase one: concentrate on Down Syndrome as the highest risk group
- Phase two: the wider population and those identified as at risk

Brief Rationale

People living with Down Syndrome are a high risk to develop dementia. It is widely recognised that early identification of symptoms that may indicate the onset of dementia, will enable the person to access an early diagnosis and thus, appropriate advice and support which will enable the person to live with dementia

Phase one:

- There will be an offer of a cognitive health wellbeing check at 30 years to ascertain a baseline assessment.
- A cognitive health wellbeing check will be offered to all people with Down Syndrome aged 40 years

This check will be provided by LD health services working with primary care, LD liaison and MAS in a joined up approach.

There are examples where a triangulation of data from primary care, LD health service and social care has taken place with good results in identifying people that potentially can have a cognitive wellbeing discussion. This improvement cycle will be used to scale and spread across regions.

This standard will support further work in identifying and reaching other populations such as BAME.

Responsive

05.

Health and social care services should provide the outcomes of an agreed set of completed assessment and interventions (listed) when referring to MAS (where the presenting need is indicated). This will assist MAS when they undertake assessments and in providing diagnosis. This will also support the person to manage any identified daily living difficulties.

Brief Rationale

There will need to be a joining of information and services to respond to this standard as per standard one. If information is already available use it, (connect MAS to other systems) if people have not had eye tests for years, suggest it and this links with population cluster work regarding the primary care response to aging and higher risk groups in how to engage them, get the basic interventions done, look at how people can be supported to attend opticians, audiology and the dentist etc. It is a whole systems approach.

Agreed set of completed assessments and intervention:

- Basic physical health tests as a baseline: BP / weight / height / routine blood tests
- Audiology referral / assessment / use of current hearing test (current equals within past two years unless difficulties identified)
- Dentist referral/ assessment / use of current oral health check (current equals annual unless difficulties identified)
- Ophthalmology referral / assessment (sight test) / use of current test (current equals annual unless difficulties identified)
- Cognitive Screening – tools used by primary care for screening for cognitive health issues

Medical History:

- Social History – routine history as a baseline of social support and connections
- Scans – as appropriate as not all people will require a scan for cognitive health issues
- Activities of daily living profile – to gather a baseline of everyday activities that the person currently participates in, is able to do and or also finding difficult

This standard:

- Aids diagnosis in a timely manner
- Avoids diagnostic overshadowing - avoids unnecessary referrals to MAS for assessment of cognitive health as it will pick up underlying predominant physical health needs
- Provides baseline for a number of functions which is important to measure deteriorate against going forward.
- Defines partnership arrangements, expectations and support
- Supports structured referral
- Promotes access to online investigations
- Encourages prudent practices

Where GPs are unable to offer items, an exploration of the support required to achieve this standard will take place. Partnership and positive relationship working between MAS and GP practices maybe key to achieving integrated streamlined services which are both cost and clinically beneficial to all stakeholders.

The key to this standard will be to determine the process for completion and who is responsible for delivery, including the person and their carers. A region will need to scope this and test it as per the delivery framework. MAS assessing a person presenting with a complex picture, therefore, need as much information as possible.

06.

Memory Assessment Services, within a 12 week period from point of referral, will provide a range of interventions (listed) to support diagnosis. Digital platforms and other adaptions and approaches may need to be considered.

Brief Rationale

This standard:

- Aids diagnosis in a timely manner
- Avoids diagnostic overshadowing by ruling out any underlying predominant physical health needs
- Addresses any underlying senses difficulties
- Ensures support and advice around emotional and psychological adjustment to diagnosis for the persons, carer and family
- Ensures support and advice around managing cognitive impairment and the effect this has in managing everyday living activities, roles and relationships
- Ensures a key person supports the individual, their carer and family through uncertain times when exploring whether the person has a terminal condition
- Supports various options for people living with dementia: a telephone contact, the named clinic contact, 3rd sector coordinators

MAS within a twelve week period from point of referral will provide:

- Activities of Daily Living Functional Skills Assessment
- Cognitive assessments: ACE-111 and MoCA
- Scans i.e. CT, PET (as appropriate for those identified)
- Physical health review – using baseline information provided by primary care where appropriate as clinical need determines
- Assessment of carers needs and specific support related to adjusting to role and maintaining carers health and wellbeing
- Social history – including social isolation assessment and signposting, accommodation and financial
- Emotional support – during the assessment period and when providing a diagnosis provided by a practitioner or staff member that best knows the person, their carer and or family
- Pre diagnostic counselling offered
- Named contact: people receiving a cognitive health assessment will have a point of contact to discuss concerns, the process of assessment and potential outcomes throughout the assessment period
- Cognitive functional Interventions & Strategies – (delivered in the home environment or other settings as appropriate to support everyday functional difficulties resulting from the cognitive impairment difficulties)
- Senses assessments (using baseline assessment provided by primary care as these may not be needed to be repeated within this twelve week period)

Physical health review within MAS: The purpose of the delivery framework is for a region to determine what they have already in practice and what they need to meet the standard. There are opportunities to work in partnership across agencies to meet areas such as physical health and also identify a gap in skills.

Cognitive interventions, strategies and post diagnosis intervention. It is assumed that intervention is not needed before diagnosis, when we know that it is important to take every opportunity to engage the person in strategies that can help them throughout the assessment period. This may help address some of the immediate issues they are facing e.g. functioning.

07.

People will have access to a contact that can provide emotional support throughout the assessment period and over the next 48 hours after receiving a diagnosis and ensure following this period, it is offered as required.

Brief Rationale

During the consultation, we heard from people and their carers that they need support when going through the assessment period and when receiving a life changing, life limiting terminal diagnosis of dementia. Some of the experiences highlighted:

- Diagnosis can be given on a day when no core services are operating the following day
- Adjusting to this terminal diagnosis can potentially be devastating and traumatic to people and their families – appropriate support mechanisms need to be in place to support people through this period.

How we manage giving a life limiting diagnosis and the support that we give to help the person adjust to this, has been evidenced to show the impact on a person and their family's ability to make sense of what is happening and therefore, make appropriate lifestyle changes and plans for the future.

This standard offers the detail around the emotional support required during and post diagnosis and how we also manage giving a life limiting diagnosis to the person and their family.

08.

People living with Mild Cognitive Impairment (MCI) will be offered a choice of holistic services monitoring their physical, mental health and wellbeing, with reviews taking place as a minimum six monthly. This will include a range of options including peer support. Signposting and community resources should be at the centre of all intervention (connects to standard one and three).

Brief Rationale

Evidence suggests that 10-15% of people with a diagnosis of MCI develop dementia. Other studies have put this figure as low as 5-10% of people diagnosed with MCI will go on to develop dementia (Alzheimer's Research, January 2018).

For people diagnosed with MCI, early intervention approaches to monitor cognitive decline is important and advice around the six steps risk reduction messages will improve the understanding of health promotion and prevention activities to maximise their wellbeing.

There are a range of individual and group based physical activity interventions and opportunities within a community, that people can be signposted to or delivered by statuary and non-statuary services.

Journey & Navigation

09.

Within 12 weeks of receiving a diagnosis, people living with dementia will be offered education and information on the importance of physical health activities to support and promote health. (connects to standard one).

Brief Rationale

People told us that that there is a lack of information about the importance of physical health promoting activites

There is an increasing evidence base to show that physical exercise interventions to improve strength, balance, mobility and endurance levels has a positive effect on preventing falls in older adults with cognitive impairment. Evidence also suggests that physical exercise experienced together can also have benefits for the person with dementia and their carer by maintaining and where able improving their physical, cognitive, social and emotional functioning, relationships and quality of life.

There are a range of individual and group based physical activity interventions and opportunities within a community that people can be signposted or delivered by statuary and non-statuary services.

MCI: A range of interventions and guidance for those diagnosed (with dementia and MCI) will be available as part of this standard and there will be access to interventions that are also tailored to meet the next steps for those diagnosed with MCI.

10.

People living with dementia, carers and families will be offered learning, education and skills training. This offer will be stage appropriate and will be provided at significant parts of a person's journey. It will include a range of peer support and shared experience opportunities, (connects to standard one).

Brief Rationale

Receiving a dementia diagnosis and having the time and support to adjust to this diagnosis is very important. The individual may need support and advice on a number of key areas from friends, family, peers, experts by experience or with a health or social care professionals, or others in a field that understands dementia. Key areas of learning to support adjustment and living well may include information and advice on treatments and ways to stay active and healthy, financial matters and planning ahead, employment (if the person is still working), driving, practical, emotional and relationship support to live well.

Throughout the consultation people told us that learning and support opportunities must also be offered throughout the person's journey therefore, a chance to receive stage appropriate, needs appropriate information and skills sessions at the right time is important.

It is recognised that there should be a strong emphases for family and care partners to be included in all opportunities to ensure they can access the necessary support, advices, skills and information to perform their role. Cognitive functional interventions and strategies are to be included and there will be a national resource available that includes a range of programmes to acknowledge carer needs and skills.

11.

Wales will adopt the Dementia Friendly Hospital Charter with a regular review of implementation and outcomes.

Brief Rationale

Principles for practice in the Dementia Friendly Charter reflect the aspirations in the Dementia Action Plan for Wales 2018-2022. These cover a number of person centred, rights based approaches including:

- Providing choice around meal times
- Letting people sleep and wake at their own pace
- Allowing flexible visiting times
- Ensuring that care and treatment is culturally sensitive and that where Welsh is a person's first language, care and treatment is provided in Welsh
- Facilitating families and carers to continue to support a person with dementia whilst they are in hospital if they wish
- Adapting environments so they are more 'dementia supportive' such as considering the layout and signage.

By establishing a Wales version of the Dementia Friendly Hospital Charter that is used in England will mean there is a clear focus for the development of robust dementia care provision.

Wales will take learning from the approach in England and build upon it by using a Regional Taskforce approach. This will ensure commitment from professionals, policy makers and people living with dementia and their carers. Having a taskforce in place to work with the region will help the sustainability of the work and regular meetings will ensure that the work continues.

There will be a readiness and self-evaluation tool supporting a peer review approach for care settings to gauge its own performance against the standards outlined in the Charter. Linking and sharing of practice will support equitability and quality improvement nationally, as well as creating and maintaining relationships with the Welsh health board regions.

The Charter aligns to key audit programmes such as health care standards and the Royal College of Psychiatry dementia hospital audit, plus others. Audit items have been cross referenced with the charter principles. It is important to use existing audits as supporting evidence against the charter, however, the focus of the charter will look at how the information is used locally to improve dementia care to meet the principles of the charter.

12.

People living with dementia and their carers will have a named contact (connector) to offer support, advice and signposting, throughout their journey from diagnosis to end of life.

Brief Rationale

A named contact will ensure that people are connected to available local support networks, which may including peer support options, enable access to other financial and practical advice and information on what adjustments could be made to their lifestyle or environment to help them remain as fit and healthy as possible.

There will be a phased approach to meeting this standard:

Phase one:

This will include all newly diagnosed people with a dementia being provided with a named contact (connector)

Phase two:

Identify existing people diagnosed with dementia and provide a named contact (connector)

The dementia connector role will be defined nationally and it is the intention that the role function will help the person and carer to coordinate care. Many people diagnosed with dementia are not being seen by the core statutory dementia services however the function of this role must link with Social Service and Wellbeing Act (Wales) 2014 requirements of coordination and Mental Health (Wales) Measure 2010 care coordinator.

13.

People living with dementia will have access, when needed, to relevant (and when accessing mental health services) dedicated services post diagnosis no matter their residence. This identifies with the care and team wrapped around the individual, (connects to standard one, three and twelve)

Brief Rationale

People in the consultation told us that despite accessing specialist mental health services like MAS, or secondary services there was limited access to a range of professional and voluntary groups working in partnership that can provide a range of treatment and intervention modalities.

Identified dedicated services include:

- Speech and Language Therapy
- Dietician
- Audiology
- Dentistry
- Ophthalmology
- Physiotherapy
- Palliative care from day of diagnosis
- Occupational Therapy
- Psychology
- Mental health nurses
- Social worker
- Mental health specialist services
- Podiatry

Every person's experience of their dementia will be unique. Dementia can affect people in many different ways and therefore a range of skills and professions are required to match people's needs. Dedicated services built around the individual will support timely access to address a range of needs so that the person can live well.

As an example: Community Resource Teams would be included in a team round the individual approach along with other services that people may need, including virtual means of engagement and face to face through a range of different approaches to connect e.g. how services work together as a one stop option within the agreed way that a local community has determined what dementia support looks like (as per standard one).

Dedicated services are services with the ability to respond to the needs of people with dementia and may not need to be dedicated staff working in dementia care within mental health services for example. The service e.g. community dietetics or physiotherapy has suitable funding to provide dementia care support within a community with an ability and resource to respond to need. This will mean core services scope what investment is needed to respond to dementia care as per the focus of standard one.

14.

People living with dementia will have a current face to face appointment where a physical health review will be delivered in partnership by primary and secondary care. Where there is justifiable reason for not providing a face to face appointment, a physical health review will be delivered by other approaches i.e. digital platforms, telephone consultation.

Brief Rationale

People living with dementia are considered as a vulnerable group and therefore people with a dementia may be at risk of health and social inequalities. Health inequalities for people with a dementia can be exampled by the evidence that suggests people with dementia receive less primary, preventative healthcare than people without dementia.

Evidence suggests by increasing the numbers for health checks for people living with a dementia may improve health outcomes. There is also a direct associated with people receiving regular health checks needing fewer unplanned hospital admissions, (Cooper C, 2017).

Ensuring a health check becomes part of the annual care review for people living with a dementia will safeguard against any health inequalities that could potentially be experienced.

Partnership approaches to delivering the health checks maybe appropriate and would support the aim of care around the individual and provide easier access to care. Aligning with standard twenty and the measurement workbook, will capture how many people with a dementia received a face to face review to inform improvement.

15.

People within 12 weeks of being diagnosed with dementia will be offered support to commence planning for the future, including end of life care. This offer will include the opportunity to revisit and update this plan throughout the person's journey. Where appropriate, representation and the use of advocacy will ensure the rights of the person are upheld.

Brief Rationale

Planning for the future and making key decisions is important for every person as there maybe times when the person living with a dementia may not be able to communicate what is important to them, their wishes and needs in regards to daily living, health, social care, finance, housing and end of life decisions.

The important use of advocacy, when appropriate, during the consultation was strongly highlighted. This will ensure the rights of the person are upheld.

During the extensive scoping exercise for the standards, people described a need for support and introduction to support following diagnosis. People will know when they are ready to engage and will have had conversations about what needs to happen next. The consensus was: within a three month period, many people will be ready to engage acknowledging that there will be people who want to take longer or may never want to engage with future planning. This avoids the current situation of people receiving little support following diagnosis or support coming too late and the person cannot engage with their own planning.

16.

Organisations and care settings providing intensive dementia care (this includes mental health and learning disabilities inpatient settings) will provide the framework and structure for Dementia Care Mapping (DCM) to become routine practice, supporting clinical reasoning and decision making. Mental health DCM services will offer DCM support to acute care, prisons and care homes settings.

Brief Rationale

Within the consultation, people told us that this was an important tool to evaluate and learn about person-centred enabling practice. By embedding this tool will help us to improve care across services. This tool will support evidence that ensures services are meeting and responding appropriately to people's needs at all stages of the person's journey. A DCM strategy for Wales will support this standard.

17.

All staff delivering care at all levels within all disciplines and settings, will have the opportunity to participate in person centred learning and development with support to implement into daily practice. This will be a joint regional approach to identifying a range of learning and development opportunities including quality improvement.

Brief Rationale

The Good Work (2016) is a framework with the intention to support all people within all areas and stages of the dementia care field to be able to reflect and identify their individual person-centred learning development strengths and needs.

The effectiveness of any learning and development opportunities needs to be measured by the impact that it has had on care delivery not by the number of people that have been trained.

Understanding and incorporating improvement methodologies will support to provide the tools to evaluate and understand the detail and impact of learning and development opportunities on the outcomes of care delivered.

This standard supports the Goodwork Framework by detailing practical approaches and opportunities that can be classed as learning and development. It enhances the spirit of the framework moving from a set of criteria to practical application. What is classed as evidence of learning and development can be agreed and will therefore improve upon the basic reporting currently in place. It puts a responsibility on regions to focus on a range of learning and development opportunities including supervision.

18.

People living with dementia, their carers and families will have support and assistance to engage with appointments. This will avoid receiving multiple health and social care appointments that can overwhelm, confuse and isolate the person.

- Reasonable adjustments to ensure coordinated effective offers are made to the person
- The organisation can review the offer of appointments and the way appointments happen e.g. digital technology, home visits, multidisciplinary review sessions, to ensure a coordinated response (connects with standard one, two and twelve)

Brief Rationale

Within the consultation, this was an area of frustration for people and carers. Practical streamlining of operational processes will support the service to avoid duplication and maximise opportunities to exercise prudent principles to service delivery. This may include exploring opportunities within roles, partnership working arrangements and developing integrated assessments, protocols and processes.

Access and appointments: A whole systems approach not just care coordination. Look at how the organisation / system supports vulnerable people and provides options for how people can access appointments when engaging with all settings and professionals across health and social care.

At a micro level, the person must have individualised reasonable adjustments made and this can be through and supported by care coordination, dementia connector roles and via team around the individual.

Partnerships & Relationships

19.

Services will ensure that when a person living with dementia has to change or move between any settings or services, care with supportive interventions will be appropriately coordinated to enable the person to consider and adapt to the changed environment. This will ensure that all care partners will communicate and work jointly with each other to support a seamless transition.

Brief Rationale

Transition includes a transfer of communication: care and support plans, intervention plans and 'Getting to know you' type documents. In this standard consider relationship building and partnership working to foster smooth transitions of care.

Ensuring that all services recognises and supports reasonable adjustments for both the individual and their carer during this time will improve the success of the person and their carer adapting and adjusting to change in their circumstances.

This standard is about the system of care being coordinated as well as making individual decisions. For example, avoiding numerous transfers between wards that can confuse and disorientate the person. This is a focus on system growth by reviewing, planning and implementation of how care can be delivered to the person, people with dementia at a systems and person level.

20.

Working in partnership, the region will deliver on the requirements of the agreed data items (measurement workbook) for reporting and assurance.

Brief Rationale

The collection of the agreed data items will provide an overview of the types of services and resources that are currently available to deliver dementia care. The standard will build upon existing items used for measurement within the regions and offer new items, where relevant. This will assist to detail a picture of the landscape of care that is being provided for people living with a dementia and their carers in Wales.

The extensive scoping exercise for the standards also consulted on measurement providing many examples of performance reporting not supporting practice. Usually reporting is undertaken without the purpose described to the workforce and therefore it becomes divorced from improvement in practice or data is asked for with short reporting turnaround times. This standard will offer a workbook approach – one workbook detailing all the requirements (with a rationale and definitions) provided on day one to the region and accessible to the workforce for that reporting year e.g. April 1st.

The workbook will detail all monthly, bi-monthly, quarterly, 6 monthly and annual reporting required highlighting what is needed to work towards etc. It will be part of the delivery framework for implementation in phase 2 and guidance will be provided for the regions on how to use the workbook.

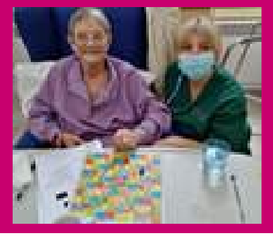
Thank you to all the people across Wales and beyond involved in developing the dementia standard descriptors. Your passion, expertise, lived experience and commitment has enabled these high level descriptors to be developed in support of the forthcoming Dementia Pathway of Standards and Delivery Framework.

GWELLIANT CYMRU IMPROVEMENT CYMRU

Learn Improve and Assure

Llywodraeth Cymru
Welsh Government



All Wales Dementia Care Pathway of Standards

Regional Dementia Board Annual Report 2022 - 2023

Introduction

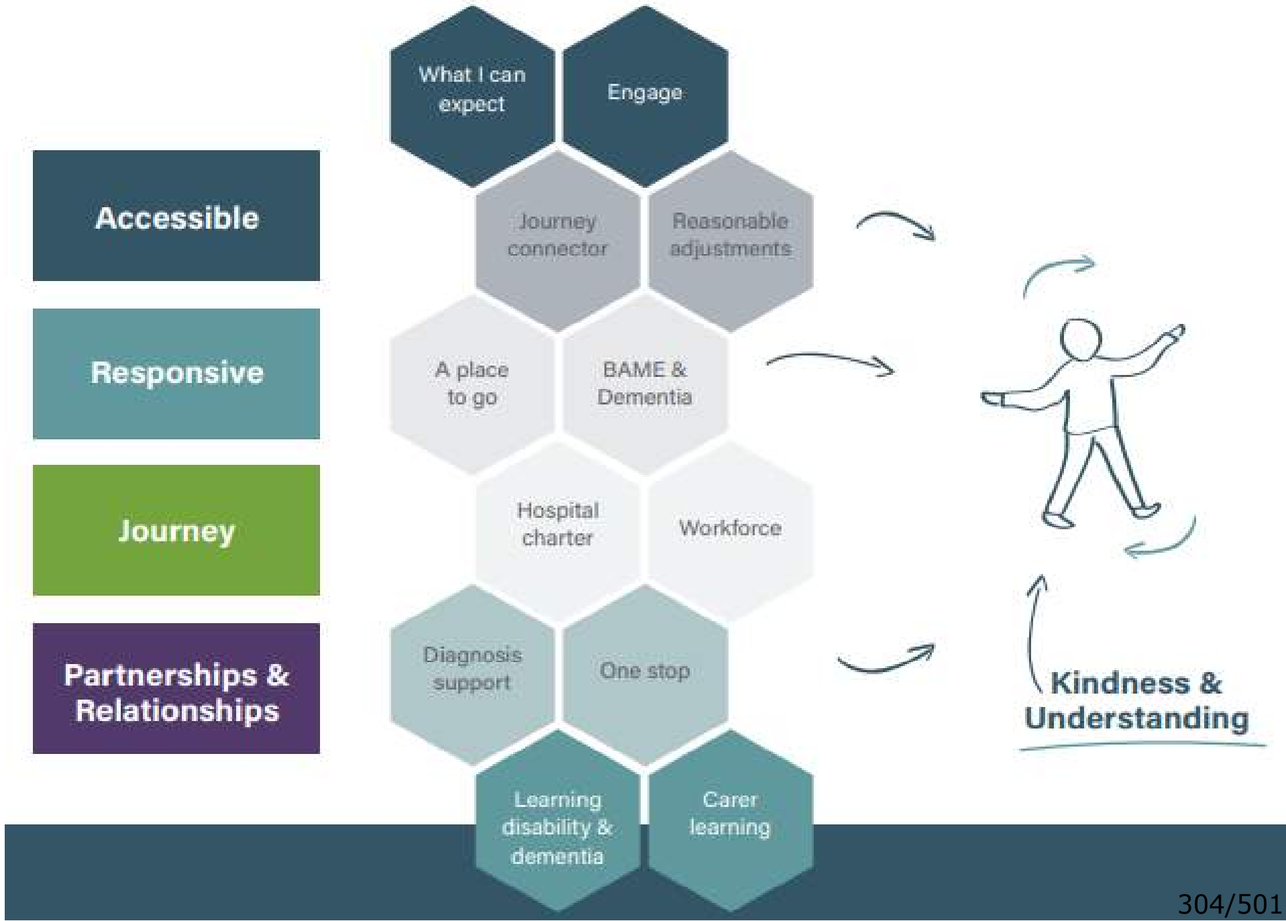
The All-Wales **Dementia Care Pathway of Standards** have been developed by Improvement Cymru and support the Dementia Action Plan for Wales (2018-2022). Prior to the publication of the Standards, a 2-year scoping exercise, which saw the engagement and involvement of 1,800 people and partners, identified what people living with dementia believed would make a real difference to their lived experience.

Over 100 standards were identified. These were analysed and produced **4 overarching themes**:

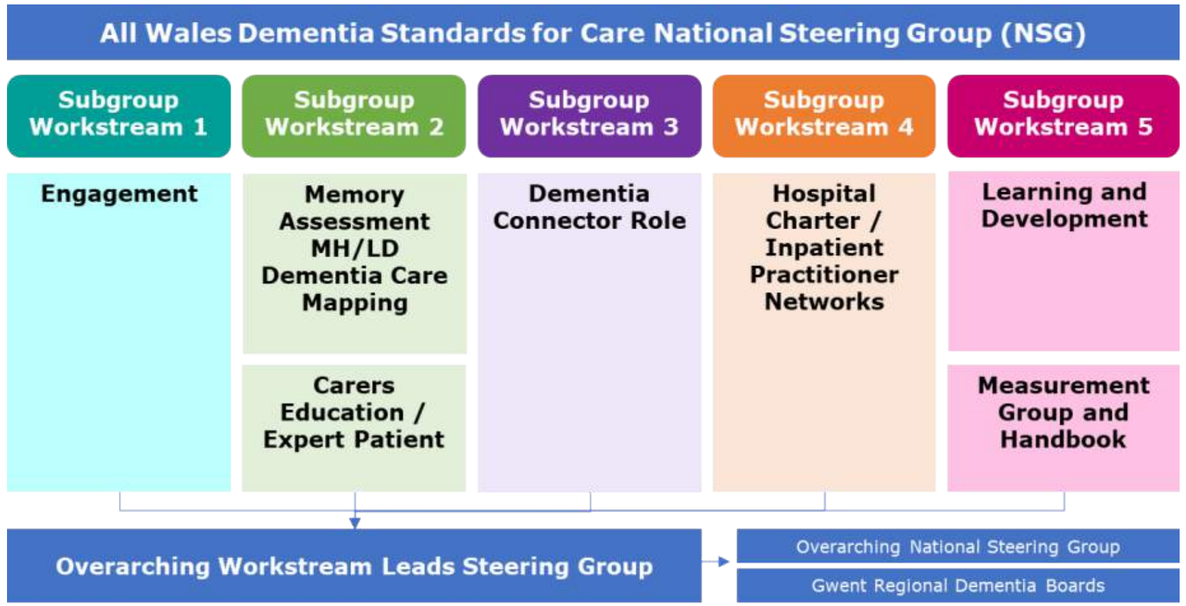
1) Accessible
2) Responsive
3) Journey
4) Partnerships and relationships

From these themes, **20 standard descriptors** were produced (see Appendix 1), all intended to 'wrap around' the person. Each of these standards embeds the ethos of **kindness and understanding.**

In 2022, Regional Dementia Partnership Boards had been afforded a **'readiness year'** to establish Workstreams that would support implementation of the Standards. This annual report outlines the progress the Gwent Regional Dementia Board has undertaken during the readiness year.



National and Regional Workstreams: Supporting Infrastructure to Embed Standards



The Regional Dementia Board meets every 2 months and highlight reports from each of the workstreams are presented to the Board. On a local level, each workstream proactively considers citizen engagement and involvement, ensuring peoples voices help **inform**, **shape** and **influence** local actions to embed the Standards and improve dementia care and support across the Region. Additionally, Executive Directors at Aneurin Bevan University Health Board have been identified across each workstream to support workstream leads as required. This ensures senior level ownership across the Health Board.

To support implementation of the Standards across Wales, **7 National Workstreams** have been established. Members of the Regional Partnership Board attend the national workstream meetings.

Locally, the **Regional Dementia Board** has mirrored this structure with each work stream being inclusive of partners (including citizens).

Workstream Highlights: The Year of Readiness (April 2022 – March 2023)

Workstream 1

Community Engagement

The Dementia Pathway of Standards highlights the need to enhance and develop better dementia care across Wales. **Workstream One** has a focus on community engagement and understanding what a person with dementia needs to continue to live fully within their community. **Standard 1** is about community engagement using one locality within a region working in partnership, taking 6-12 months to engage with that community to learn, evidence, and analyse what people and agencies have identified it needs.

What we've achieved during the 'readiness' year:

Although Standard 1 asks regions to look at one specific community, regionally we agreed that we would also focus on 3 other 'communities' with distinct characteristics to determine their experience of dementia care and support. These are:

- People who are deaf/hard of hearing.
- People from ethnic and minority groups.
- Carers who have had experience of loved ones being in hospital.

Thank you for holding these engagement events and recognising us as the experts. Its really important that our voices are heard. (Carer)

Over the past 12 months a number of **engagement events** have been held with people living with dementia, carers, staff, partners and wider communities. These have included both face to face meetings and **webinars** to both raise awareness of the standards and to seek people's views on how we can collectively **influence, shape** and **improve** dementia care across the region. Through an annual programme of webinars, we have raised awareness of the Standards and informed the audiences of what the Regional Dementia Board wish to do collectively to improve dementia care. We have been conscious to be inclusive and aimed to reach areas of the community who may not be reached through general webinars. We have offered 'bespoke' webinars for people who are Deaf, people from ethnic minority communities, carers, people who identify as LGBTQ+ etc, facilitating evening and daytime enragement opportunities. We have been supported to engage with diverse groups by **British Sign Language** interpreters, **LGBTQ+** national leads, **ethnic minority** champions and **Welsh Language** Leads. 150 people participated in the Webinars to date, and more are planned for 2023.

Each webinar has asked people how they wish to be informed and involved in the work programmes and from these discussions we have now established our first **'Expert by Experience'** group. These are people who predominately care for relatives living with dementia and some have already been involved in **recruitment stakeholder panels.**

Wales Listens Campaign:

Improvement Cymru has launched a ***Wales Listens Campaign***, which encourages regions to engage with specific communities and work with those communities to identify what they feel is important to ensuring good dementia care and support.

What we've achieved during the 'readiness' year:

Using the **Regional Population Needs** assessment data and a Stakeholder discussion at the Newport Partnership Engagement event in November 2022, we were able to identify 2 areas of Newport to introduce the Wales Listening Campaign. These communities are very similar in population sizes but very different in regard to population 'make up' e.g. age profiles, diversity etc. Two events have been held to date enabling us to engage with people who work, live or visit the communities of **Maindee and Caerleon.**

At these events, there has been collective discussion around what dementia care looks like in those communities, what would make dementia care better, what community support is available and how communities wish to be kept informed and involved. There will be follow up meetings to scope out and consider this information in more detail formulating objectives to support a dementia friendly community. The ultimate aim is to recruit '**Community Listeners'**, members of the public who will champion Dementia Care and speak to others in their communities, creating a dementia social movement.

Training for Community Listeners has been developed in partnership with Improvement Cymru and Citizens UK.

A particular focus on **equality, diversity and inclusion** during the readiness year has enabled us to better connect and include those whose voices are **seldom heard**. Although there is so much more to do, and so many more people whose voices are seldom heard to reach, we are confident that this inclusive approach will enable us to connect with more people affected by dementia over the coming years.

Workstream 2(a): Memory Assessment

The aim of **Workstream 2(a)** is to ensure the development and creation of a seamless and **robust pathway** for people diagnosed with Dementia, their carers and others engaged with people living with Dementia.

What we've achieved during the 'readiness' year:

During the readiness year, the workstream have been proactively reviewing service provision and **models of service** to ensure they are better aligned with the Dementia Standards. Data Measurement Sets are being established. Workstream membership has been refined and now includes key partners to develop this work.

Models of best practice are being identified. Proactive engagement has identified the need to establish a **Community of Practice** to shape and develop Memory Assessment Services (MAS). A dedicated webinar to influence and shape MAS has been arranged for May 2023.

Workstream partners are currently speaking to people living with dementia, families and carers to encourage them to join the Community of Practice. A scoping exercise is being completed around third sector community support.

Workstream 2(b) aims to ensure that people living with dementia, carers and families will be offered learning, education and skills training. This offer will be 'stage of condition' appropriate and will be provided at significant points of a person's journey.

What we've achieved during the 'readiness' year:

During the readiness year we have:

- Developed a Gwent wide **Carers Information Course** Model that now runs in six-week blocks in all Five Gwent region boroughs. These are face to face courses. Also, we have developed the same course which is held virtually. These courses are available in all **Boroughs**.
- As part of these courses, Carers are also offered **Positive Approaches to Care** training, which is person-centred approaches and interventions in dementia care.
- A **resource pack** for Carers has been developed and in use. This is in both paper and digital formats.
- We are positively working towards increasing the number of carers attending courses, by developing a poster to be displayed in all GP Surgeries, all ABUHB Hospital Entrances/Restaurants/Inpatient Units. This has already seen an increase in referrals.
- We are currently developing a **Padlet** for Carers to access a wide variety of up-to-date information.
- We have introduced **Carers Champions** in all Memory Assessment Clinics who are conduits of information and advice.

Workstream 2(b): Carers Education

Workstream 3

Dementia Connector Role

Workstream 3 focusses on the development of a **Dementia Connector** model. This role will help a person **navigate** their care journey, being a consistent presence alongside the person living with dementia and their carers/ families and enable timely assistance to prevent people going into crisis. Connectors will **intervene early** to help and support people, which aims to reduce or delay the need for longer term care. This role links to the Social Services and Wellbeing Wales Act, underpinning the principles of, voice and control, prevention and early intervention, wellbeing, co-production and multi-agency working.

What we've achieved during the 'readiness' year:

We have established a **Community of Practice** to look at good practice and provision across the UK. An Improvement Cymru Regional Workshop was held to discuss the Dementia Connector role and collect feedback on how the role should look. Data collection around local connector models has commenced and proactive meetings held with leads across Gwent to gather job specifications and salary information.

Dementia Hub meetings with local partners have been held to look at a community information and signposting hub, and ongoing discussions into potential venues and accessibility are in progress. A bid is being prepared for Dementia Hwb funding. The aim is to pilot in one area as a **'proof of concept'** with the local Hwb model being informed by people living with dementia, carers, communities and staff.

Workstream 4:

Dementia Friendly Hospital Charter

During the readiness year, the Health Board adopted the Dementia Friendly Hospital Charter for Wales. The purpose of the **Hospital Charter** is to improve the experience of people living with dementia when they are in hospital. This experience must recognise an individual's personhood, diversity and preferences, shaped by recognising the importance of dignity respect and kindness.

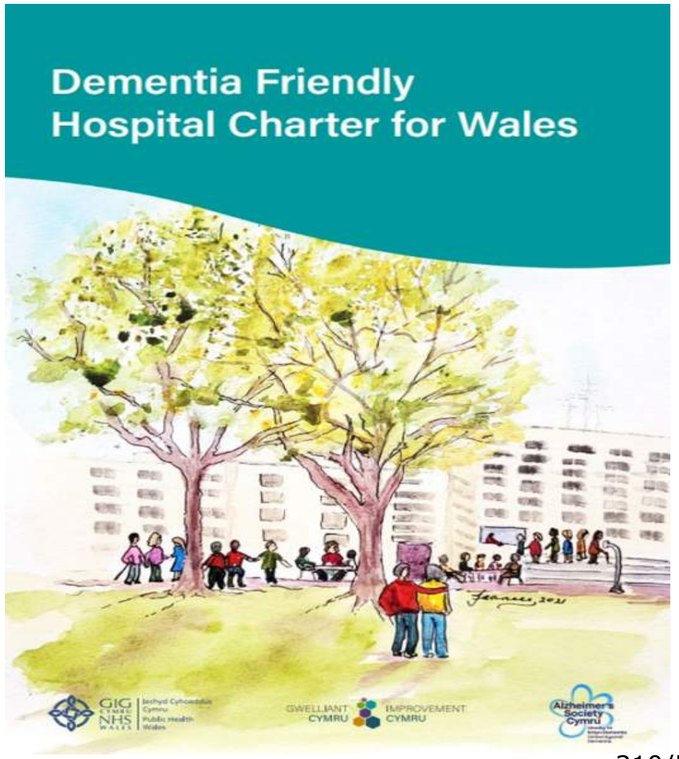
The Charter **builds** on the foundation offered by the Royal College of Nursing's Staffing, Partnership, Assessment, Care and Environment (SPACE) principles. It acts as a short, clear statement of the key principles that contribute to a **dementia friendly hospital**. It provides a **set of principles and indicators** that focus on the needs of people with dementia and their families, carers and supporters and offers an **improvement guide** to assist hospitals in their self-assessment against the dementia friendly principles. Importantly, the Charter **informs people** of what to expect when they receive care and visit a dementia friendly hospital.

What we've achieved during the 'readiness' year:

To promote awareness of the charter, a brief public **animation** of the Charter principles and the ABUHB's commitment to improving dementia care has been produced and publicised. We have been supported by the Communication and Engagement team to promote the Hospital Charter over a weeklong promotional multimedia plan. Using Twitter, Facebook, intranet and external web pages we have described the improvement plans that support both the Dementia Friendly Hospital Charter and overall dementia care including John's Campaign, patient bedside boards, dementia volunteer companions, Dementia Champions, and carers information.

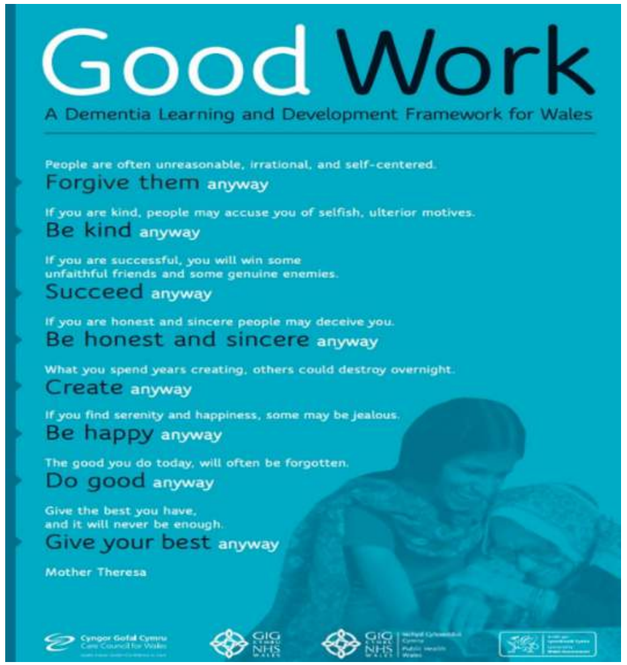
Since Covid and restricted visiting, the distress and concerns from carers around in-patient hospital care has been highlighted through a number of complaints, through webinars and 'patient stories'. Locally, feedback about people's lived experience of dementia care when they are in hospital has been used to influence, shape and improve dementia care across our hospital wards. Our Hospital Dementia Action Plan has been significantly revised based on feedback and **what matters to people**.

What we've achieved will be further highlighted later in this report, under the heading ***Improving In-Patient Person-Centred Dementia Care***.



Workstream 5(a)

Learning and Development



At the heart of the **GoodWork Learning and Development Framework** is what matters to people living with dementia, and aims to empower patients, carers and health and social care staff to ensure dementia care is person centred.

Local dementia training strategies adopt the values that gets to the heart of what matters to people (**compassionate practice**), ensures staff are technically competent and 'fit for practice' (**competent practice**), are personally engaging and contextualised (**wise practice**), fundamentally resulting in a workforce that are **informed, skilled influencers**.

What we've achieved during the 'readiness' year:

Over the past year we have:

- Scoped the current learning available and **identified gaps** against the GoodWork Framework.
- Taken a regional approach to shared learning. There is a learning and development plan for 2018-2022 that is linked directly to the **Dementia Action Plan for Wales** and regional dementia action plan to enable all workforces to engage and achieve the associated aspirations goals and plans.
- Developed a **specification** for learning resources prior to going to market.
- We have a system of developmental groups and workshops for **dementia education** and learning whereby everyone from all stakeholder groups is involved.
- Secured funding from the Regional Integration Fund to support the commissioning of resources and the supply of examples of **assistive technology** for use in the learning environment.
- Identified the **dataset** for measuring impact.
- Engaged with carers networks to promote the availability and **access** to learning.
- Developed a Gwent wide Carers Information **Course.**
- Piloted an ***experiencing dementia*** event provided by the award winning Re-Live organisation. 60 places were made available via the members of the workstream group to enable multi-partner participation.

ABUHB have committed to the 040 **All-Wales Dementia Awareness Module** on ESR for all staff. This is a mandatory requirement and monitored through the PADR process. The current compliance figures for the Workforce is **82.83%**.

We have established and delivered a **Meaningful Engagement and Activities training course** (1 day training) aimed at demonstrating the importance of meaningful activities for wellbeing and to provide staff with the confidence to include meaningful activities in care planning and personalised care.

Recognising workforce development needs, we have **secured funding** to employ 3 Mental Capacity Act (MCA) Specialist Practitioners. As well as working side by side with staff and teams, these Specialist Practitioners have developed a rolling programme of training to help staff better understand the principles of MCA and how to apply these principles when assessing, gaining consent, delivering care and considering best interests. Over **60 sessions** have been held in the past year. These sessions have been attended by numerous professions including nursing, doctors, occupational therapists, psychologists, consultants, theatre staff etc. Training has been both virtual and face to face. Bespoke sessions have been delivered for specialist/ clinical areas. Feedback to date is demonstrating real benefits to staff knowledge, skills and confidence to enable them to apply the principles in everyday practice which will make a real difference to patient care and experience. Additionally, we have developed two **staff educational films** based on what to consider when considering Do Not Attempt Cardiopulmonary Resuscitation **(DNACPR)** and how to undertake **capacity and best interest assessments.** These have been shared with patient experience leads across Wales.

Dementia Friends
An Alzheimer's Society initiative

We have delivered the Alzheimer's **Dementia Friend's** session at all new staff induction programmes. Informed level Dementia awareness sessions have been delivered through the Journey of Excellence new nursing registrant and international nursing programme and the Nursing Apprentice programme.

Our **Volunteer Training** Programme includes dementia awareness as mandatory. All our volunteers are Dementia Friends. For our Dementia Companions and Dementia Champions, additional training is provided. Digital patient stories have been developed to support listening and learning.

A Mapping and Education and Carers Team **(MECS)** has been developed within the Older Adult Mental Health Division. This team will be scoping developing and delivering a series of learning opportunities throughout 2023. This training is based on the carer education programme.

3D's (Depression, Delirium and Dementia) is being delivered in general hospitals. These sessions need to be reflected and recorded on ESR for future reporting.

Workstream 5(b)

Monitoring

There is much discussion across Wales around what the National Dataset for monitoring should contain. A national monitoring proforma to evidence implementation of the Standards has not yet been established.

What we've achieved during the 'readiness' year:

Locally, we are supporting our workstream leads to identify what **data** we already collect and where there are gaps. We have also connected with performance and measurement leads within quality assurance departments, Local authority, ABUHB and our Dementia Friendly communities, to collaborate on this work. Separate engagement has also taken place with other leads in Wales, to find out what they are doing to identify data in their area and share good practice and learning. We have set up a **regional database** on excel to capture data, both quantitative and qualitative which we are continuously adding to. The database holds all the data we have in the following areas:

- Engagement
- Assessment and Diagnosis journey
- Carers
- Learning and Development
- Highlighting gaps in data
- How the standards links to national drivers and RPB objectives
- Separate database highlighting services and resources that are currently available within third sector

We are working closely with the **Alzheimer's Society** to capture quarterly data for the work done across Dementia Friendly Communities. There is a delay with this, due the Dementia Champion Model changing to the Ambassador Model (aligning with England). However, going forward, we will still be able to capture the following data:

- How many Dementia Friends have been trained (Regionally and within each of the 5 LA's)
- How many Dementia Friends sessions have been delivered (Regionally and within each of the 5 LA's)
- How many new Dementia Ambassadors we have. (Regionally and within each of the 5 LA's)

Capturing local data is key to ensure we are **commissioning the right services** in the right places, and we can see where resources are being used. We have already identified some areas where data is not available, and this has been highlighted at the National Workstream. Once we have populated the database with all the information partners are providing, we will meet with our workstream 5b members, to discuss and focus on next steps and inform the National Workstream of any progress.

The Regional Dementia Board have been successful in securing funding for a **Programme Manager**. This post holder (due to start April 2023) will be pivotal in supporting all workstream leads/teams in driving forward their programme plans. They will have a crucial role to play in developing the monitoring data sets to evidence progress across the Dementia Standards.

Improving In-Patient Person-Centred Dementia Care

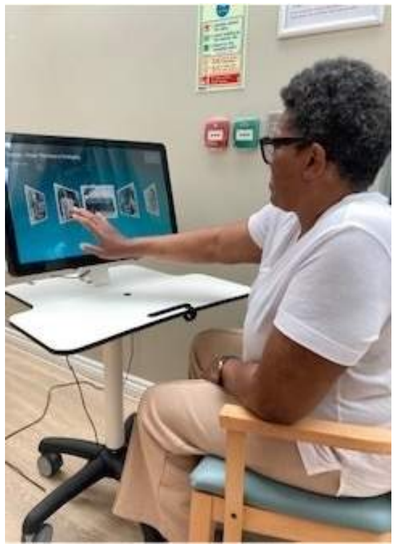
Since the launch of the Standards and the Dementia Friendly Hospital Charter in 2022, much has been done across Aneurin Bevan University Health Board to improve people's lived experiences when they are in **hospital**, including better support for, and inclusion of carers. Wards have proactively engaged in Ward Improvement Plans to help improve **patient experience** in their areas. Professional case discussions and the visibility of the Person-Centred Care Team at ward level are having a very positive impact. **Staff feedback** suggests that having the dedicated dementia intranet pages and access to expert advice through the dedicated e-mail address has significantly helped. Below are some of the initiatives that are having positive impacts on patient care, carer and staff experience. Many of these initiatives have been informed by feedback.

Responding to Patient and Family Feedback

Over the past year we have **listened** to the views of our communities, patients, carers, staff and stakeholders (including dedicated Dementia surveys undertaken by the community Health Council). Our involvement strategies have included either face to face discussions or discussions via webinars and, coupled with a review of written communication, including the Covid recovery reports, are now better able to identify and drive forward both what we do well and action the improvements needed.

Feedback specifically from people in hospital, carers and staff has identified negative experiences, with the main themes including:

- Boredom and isolation
- Restricted visiting
- Staff knowledge around dementia/identification of people living with dementia
- Staff knowledge around capacity and consent
- Lack of recognition of needs
- Poor communication
- Limited involvement of families
- Poor signposting
- General care including continence care/ oral care/nutrition and hydration
- Multiple ward moves



People's feedback has given us real traction in our efforts to improve in-patient dementia care. Additionally, over the past year, have undertaken a number of Kings Funds **Dementia Audits** on wards and ward staff have proactively engaged in ward improvement plans.

Meaningful Activity and Engagement:

Listening to the experiences of those in hospital, particularly around boredom and isolation, we have identified that significant changes were needed to improve the lived experience. We have sourced funding to secure dedicated meaningful activity and engagement resources and have provided every in-patient ward with a variety of activities and resources. These have included items such as large print crosswords, board games, electronic cats and dogs and RITA (Reminiscence interactive therapeutic activity) units. This is reducing boredom and increase cognitive stimulation for patients on our wards. We have also provided wards with a meaningful activity toolkit and dedicated meaningful activity training to over **200** staff.

We have recruited dedicated **Dementia Companions**, who spend meaningful time with patients, engaging them in activities that matter to them. These Companions have additional training in order to better understand dementia, and how to support those who may have behaviours that challenge. Many of the Companions support patient's ability to connect with families through FaceTime.

A dedicated recruitment campaign to increase the number of Dementia Companions across our wards will take place in May 2023.

Dementia Specialist Practitioner:

We have been successful in recruiting a Dementia Specialist Practitioner funded in part through Charitable Funds for two years. This practitioner works alongside clinical teams to embed a culture of person-centred dementia care. They deliver training to Teams around dementia care and meaningful activities and are supporting multiple wards in the **VIPS** pilot.

Since giving up work, volunteering has given me a way to contribute to society. I find it rewarding to be able to help people in even small ways, such as company, conversation or provision of enrichment activities. I also enjoy the company of the people I meet, many of whom have very interesting stories to tell. I am very grateful to have this as part of my life.

(Volunteer)

Care Fit for VIPS:

To support implementation of the Dementia Friendly Hospital Charter, we have introduced **VIPS** into our hospitals. VIPS will support clinical teams to deliver person-centred care through:

- **V**aluing and promoting the rights of the person.
- **I**ndividuals needs- provision of individualised care according to needs.
- **P**erspective: staff understanding care from the perspective of the person with dementia.
- **S**ocial-social environment enables the person to remain in relationship.

VIPS provides a framework with **25 improvement indicators** to help staff to improve dementia care. This year we have **26 wards** engaged in VIPS who will test the framework prior to roll out to other wards.

I was asked to visit as the patient was very low, crying and feeling confused. I face videoed her daughter which made a massive difference as she felt cut off due to her daughter (her main carer) being poorly and unable to visit.

(Dementia Companion)

Dementia Champions:

We have increased the number of ward-based Dementia Champions across our hospitals.

We now have **170 staff** who are identified Dementia Champions. Champions act as role models for other staff members as well as 'connectors' between the wards and the Person-Centred Care Team. They offer inspiration, feedback, suggest actions needed to improve the patient and carer experience as well as how the ward environment may be improved. Dementia Champion Networks are held quarterly, in addition to bitesize learning sessions on specific subjects that promote **patient safety** such as good dental and oral care, consent and capacity, nutrition and hydration, audiology etc.

Dementia Champions attend Dementia Awareness and Meaningful Activity training to improve their knowledge, skills and inclusive practice. **Posters** have been developed to identify who the ward-based Dementia Champion is.

Patient Safety Bedside Boards:

Relatives have **told us** that we need to improve the recognition of people in hospital who have dementia. In order for multi-disciplinary staff and extended ward staff to recognise **'at a glance'** whether a person on the ward has dementia and to improve **patient safety**, we have produced new bedside boards. The boards identify whether someone may have dementia (symbolized by the Dementia Daisy) and additionally identify whether they need additional support or are at risk of, for example poor dietary intake, falls etc. The board helps support person centred care, focus on people's personhood, likes, dislikes and preferences.

Additional PSAG board symbols are being produced which will include whether the person has issues with capacity, whether their first language is Welsh etc.

Families are able to write on the boards improving 2-way communication with clinical teams and identify what matters to the person. The bedside boards have been very well received by ward staff and the bi-lingual template has been **shared across Wales**. The use of these boards both in terms of improving patient safety and the ability of staff to better recognise if a patient has dementia will be evaluated in April 2023.

John's Campaign:

We have relaunched Johns' Campaign across all in-patient wards. *John's Campaign* recognises the importance of **involving carers** who wish to support people living with dementia when they are in hospital. Carers have the right to ask to be involved. The principle of the Campaign means that staff should recognise the importance of carers and maintain a positive attitude to the involvement of carers, demonstrating sensitivity to their needs and recognising their value to care. Leaflets have been prepared for patients and carers and a guide to implementing the Campaign has been produced for staff. The Campaign has been relaunched internally and through social media.

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

Well, I've just come across a wonderful member of staff at NHH doing just this…. she has certainly put my mind at rest. His dementia has been taken into consideration prior to his treatment and the flexibility shown so far gives me more confidence. Thank you.

(Comment on Social Media about the Campaign)

"The Virtual Dementia Tour – Your Window into Their World"

We have secured a training opportunity for staff to provide dementia experience and learning, to enable them to better support people living with dementia.

The Virtual Dementia Tour is all about understanding what a person living with dementia experiences daily to gain a greater understanding.

The tour will visit GUH on the 18th May 2023 providing 36 training spaces.

Coloured Walking Frames

People living with dementia do not always see the colour grey, A Proof of Concept has been tested with the physiotherapy team at Ysbyty Aneurin Bevan to explore if the use of coloured walking frames supports improvement in mobilising and helps people with dementia (and those with visual impairments) better identify their walking frames. This is due to be evaluated in April 2023 at the Dementia Hospital Steering Group.

Intergenerational Practice:

During the Pandemic, much of the established intergenerational work ceased due to visiting restrictions. When restrictions lifted, County Hospital developed an initiative to support **social isolation** across the generations which included the development of a meaningful intergenerational activities programme. The psychological wellbeing of the older inpatients, in particular patients with dementia within County hospital, became a priority. The ward was experiencing an increased number of elderly patients requiring enhanced care needs, visiting by family had been restricted and communication became a challenge with PPE.

We are aware that intergenerational practice has significant wellbeing impacts for both children and the older generation. At County Hospital, the benefits have included:

- Reduction in loneliness/isolation
- Reduction in behaviours that challenge
- Increased creativity
- Increased knowledge about person-centred dementia care
- Reduction in falls
- Positive patient and staff feedback
- Increased staff engagement
- Reduction in staff sickness

Intergenerational activities are now in place at County and Ysbyty Aneurin Bevan. We shall link with all schools and colleges from May 2023 with the aim of resuming intergenerational activity across our wards and care homes from September 2023.

Promoting Welsh Language:

To promote learning of the Welsh Language, a Welsh card game has been designed and produced by the PCCT which forms part of the meaningful activity resources. This encourages people to learn the language, is particularly helpful in engaging people with dementia who speak Welsh and promotes the use of peoples preferred language. This has been developed and promoted through the Welsh Language Team.

The Happiness Programme:

We have introduced the Happiness Programme. This programme blends interactive, sensory light technology delivered through a collection of interactive games, quizzes and mindful immersive content.

HUG by LAUGH:

We have introduced the Hug by Laugh, a sensory device with weighted arms and legs along with an optional beating heart and music within its soft body. Although designed for people living with Dementia the product is being trialled in different settings and early indications are showing a positive impact for children and young people living with **Autism** and people living with mid to later-stage Dementia. The device has been rolled out to care settings across the region and an evaluation has been commissioned with TEC Cymru.

Technology for Wellbeing:

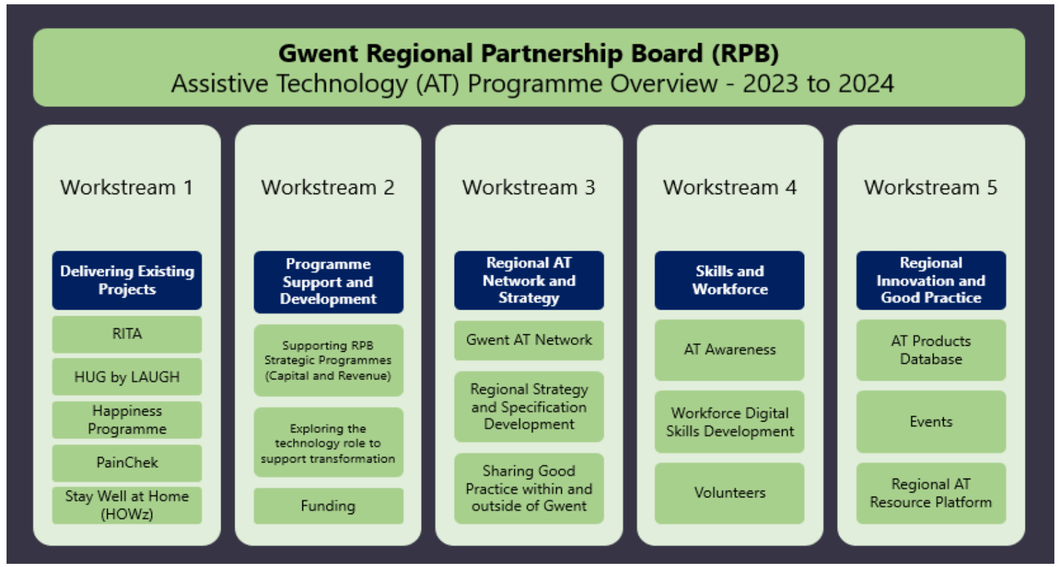
The regional Assistive Technology (AT) Programme was developed to assess the current activity across the region, 'join the dots' and implement several AT projects previously funded by the RPB including the Happiness Programme, HUG by LAUGH, RITA, PainChek, Stay Well at Home and the AT Challenge.

The AT Programme significantly aids **improvements** in dementia care and wellbeing and, evolving over the last year, it now includes 5 workstreams. Dementia workstream leads attend the AT workstreams.

Significant progress has been made to deliver the projects supported through RPB funding. Workstream 1 aims to maximise the impact and benefits of the two largest projects funded - **RITA** (Reminiscence and Interactive Therapies Activities) and the Happiness Programme. Both products are now available in health and social care settings across the region and aim to support people living with **dementia, mental health conditions, and learning difficulties** to support and reduce agitation, isolation, depression and delirium.

RITA provides a range of meaningful activities through a touchscreen device and interactive screens to blend entertainment with therapy to assist patients. This technology is also being trialled as '**RITA for Kids**'.

Workstream 3 was established at the end of 2022 and is looking at an AT strategy and specification with the aim to share good practice across and beyond the region. Workstream 4 aims to ensure the **digital competencies** of the workforce and workstream 5 has seen the development of a resource **Padlet** accessible to partners.



As part of the Assistive Technology Programme regional approach, a single source of AT information is being developed to reduce duplication and maximise information collation and sharing.

Research and Development: Dignity in Continence Care:

There is little research examining how continence care is organised and delivered to people living with dementia across an acute hospital admission, despite the prevalence of this patient population and their **vulnerability** within these settings.

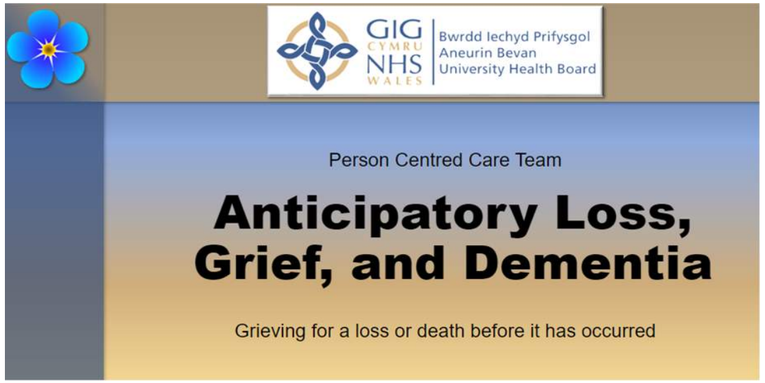
Aneurin Bevan University Health Board have participated in a research project to explore how continence care is delivered to people living with dementia during an acute hospital admission. This was an **ethnographic study** undertaken by Dr Katie Featherstone and took place in hospitals across England and Wales. The results of this research indicated that continence care for people living with dementia in acute hospital wards is significant and a key concern associated with poor experience and outcome for people.

As a result of these findings, we have established a **Continence Faculty** and are working with a pilot ward and ABC*i* to agree a quality improvement plan that ensures improvements in continence care and is informed by patient, carer and staff feedback. A patient and staff survey is in development.

Our ultimate aim is to improve dignity and continence promotion for people with dementia whilst on our wards.

Anticipatory:

Feedback has indicated that people living with dementia and their carers need support from pre-diagnosis through to end of life.



What we've heard is that people need to be supported when faced with the reality that dementia can lead to people experiencing loss of the person they know as the disease progresses. We have developed a training programme for staff which focusses on anticipatory loss and grief in dementia. The training includes the voice and feeling of people and their carers. The aim of the module will be to increase the knowledge and understanding of anticipatory loss of a person living with dementia and their carer.

Dementia Web Page for Online Information:

We have improved our public facing dementia information web page to enable people to better access dementia resources and information. Based on feedback from the Webinars relating to signposting, we have established a dedicated **dementia email address** where people can contact the Person-Centred Care Team if they are unsure of who else to contact. The Team then signposts to the most appropriate person or community resource.

People's Stories:

We have listened to people's experiences of dementia care, developed patient and carer stories/films and have used these to improve learning.

Nutrition and Hydration:

We have developed a short film informed by people's experience of nutrition, hydration and oral care and used this film at dedicated training sessions and as part of safety collaboratives.

Dementia Friendly Communities:

As Newport is our chosen area for initial engagement, we are currently working across all primary schools in the area, supporting **Dementia Friends** sessions and helping schools set up carers and parents' sessions where required. We also connect schools to local hospitals/supported living and other community venues, to encourage intergenerational activities to promote emotional wellbeing. We are working with organisations across Gwent to build further awareness and understanding, **tackle stigma** and help support communities with setting up activities/ services to achieve more inclusive dementia friendly environments.

We are working with **employment services** and continue our work with the DWP to raise awareness of people who might be working and needing extra support. As part of this work, we encourage organisations to look at their own employment policies to help support people living with dementia, their families, and carers in the workplace.

What we want to achieve going forward

Although much has been done during the readiness year, we do not underestimate how much more there is to do. Our priority actions for 2023-2024 will include the following, supported by a monitoring and outcomes framework.

People First:

We will continue to take all opportunities to engage with people living with dementia, carers, staff and communities. We will focus engagement with those whose voices are seldom heard, linking in with experts in the field to ensure our engagement activities are inclusive and accessible.

Listening and Learning:

Feedback from people living with dementia and their carers has been used to support learning. Feedback has been reflected in our dementia training programmes and we will continue to capture feedback to compliment learning provided within ABUHB and across organisations.

Experts by Experience:

We will continue to work with people to extend our Expert by Experience groups across the community and ensure our Experts are representative of those with seldom heard voices.

Dementia Audits:

We will continue to work with clinical teams to undertake in-patient dementia audits across our hospital sites and will link these with the VIPS.

Partnerships:

We will continue to build our partnerships and agree a shared vision to improving the lived experience for people and develop the health and social care workforce. Collectively, we shall develop a monitoring and outcomes framework.

In-Hospital Ward Transfers:

We will work with clinical and operational leads to develop initiatives aimed at minimising ward moves for people with dementia.

Enhanced Care:

We will support the review of enhanced care and work with teams to support alternatives to 1-1 care and restrictive practice, including the spread of person-centred meaningful activities.

Hospital Hubs:

We will work with clinical and operational leads to develop hospital hubs with provision for drop in for people to talk about dementia care. This will be aligned to PALS.

Assistive Technology (AT):

We want to maximise AT to enhance people's wellbeing. The Workstream 2 AT programme supports the work of the RPB and Dementia workstream leads will engage in future developments to ensure AT is considered through all Dementia programmes of work. Workshops to consider the role of technology to support the RPB and prevention and well-being agenda will be held to scope existing progress and direction of travel.

Community of Practice:

We want to develop a Community of Practice across to ensure people's voices and views shape and influence service provision across **Memory Assessment Services**. An engagement event has been arranged for May 2023. We will ensure that carers are part of meetings/interviews etc and develop a leaflet for carers that will be distributed at diagnostic appointment with MAS to explain the service and referral process.

Improving Nutrition and Hydration:

Working with the Nutrition and Hydration team we will develop a dedicated 'bite size' learning session for roll out across wards.

Carers Education:

We will progress carer education sessions across each geographical area, using feedback to improve dementia care and support.

Anticipatory Loss:

We will roll out anticipatory loss training module for staff and consider how this may be available on ESR.

Falls Awareness and Prevention Book:

Following the success of *Billy the Superhero* and *The Elephant in the Room*, we will work with publishers, storytellers, therapy staff and schools to produce a falls awareness book. This book will aim to raise awareness of all the risks associated with falls and the importance of falls prevention **across the ages**, highlighting increased risks when people have a cognitive impairment. This book will be launched in September 2023.

Regional Dementia Conference:

On 24 May 2023 we will be hosting the Regional Dementia Conference. The focus will be how we are working collaboratively to implement the All-Wales Dementia Standards of Care and how these improvements have positively impacted on the experience of people living with dementia, their carers and staff.

Mental Capacity Act:

Based on feedback and the success of training on staff confidence and service improvements, the MCA Specialist Practitioners will have a particular focus in 2023 of promoting the principles of the MCA within the following programmes/initiatives:

- Journey of Excellence
- Quality and Patient Safety
- Medical Lunchtime talks
- Grand Round
- Rotational Doctors
- Dementia Champions
- Assistant Practitioner

Intergenerational Practice:

Building on the pre-Covid success in demonstrating the benefits of intergenerational practice, we will recommence engagement with schools, universities, colleges, ward and care homes to reinvigorate intergenerational practice across our communities and care settings.

Dementia Connector Model:

We will continue to scope and collect details of connector roles we already have in the region as we have a range of community and wellbeing connectors (not dementia specific) that already support people in Gwent. We are establishing the remit of these roles, qualifications required and salary to identify what we already have available. OAMH are reviewing their Service Level Agreements with third sector parties, to consider how the connector model can be constructed within the OAMH structure. There will need to be high levels of joint working and engagement required, as well as clinical governance and accountability factors, so it has been agreed this is the best model of service to use.

Dementia Hub:

A Task and Finish group has been developed and a building identified for the pilot of the hub. We are liaising with the owner of the premises and the funding bid is almost finalised, which will allow us to apply for funding through the Regional Integration Fund or other funding streams. The pilot is supported by many partners, including the Regional Partnership Board, Heads of Adult Service, Elected Members, Local Authority, ABUHB and Third Sector Leads. It has been agreed that a 3-month pilot will not be sufficient to evaluate the service, and a year's funding would be more beneficial to identify the impact of the hub to the lives of people in the community.

GoodWork Learning and Development:

We will aim to develop a database to capture the learning being delivered across ABUHB which will be considered via the Regional GoodWork learning and development group (Work stream 5a). ABUHB workforce have recently agreed to support a subgroup to identify a framework and operational plan to deliver on this aim. We will take forward the learning and development plan that is linked directly to the dementia action plan for Wales and regional dementia action plan to enable all workforces to engage and achieve the associated aspirations goals and plans. The plan will reflect a long-term sustainable approach to ongoing development of dementia related skills and knowledge.

Community Listeners:

We want to engage with, train and support more members of the public to become Community Listeners. We shall evaluate the listening events at both Maindee and Caerleon with a view to developing the model for all boroughs.

Prison Services:

The population of our local prison is an ageing one. HMP Usk has been identified as having a significant number of older prisoners and some of these prisoners have been identified as having, or are likely to develop, dementia and or are living with Dementia. The Person-Centred Care Team and the Mental Capacity Act Specialist Practitioners will support a learning and development improvement plan and assist with improvements for dementia friendly environment.

Dementia and Sport:

We wish to better understand the impacts of contact sports on a person's risk to developing dementia. We have linked with sport clubs and will showcase this risk at the annual Dementia Conference in May 2023 and this will enable us to identify learning to inform projected risk analysis, awareness and service models.

Dementia Companions:

We will increase the number of Dementia Companions across all our wards to better support people living with dementia when they are in hospital. A dedicated recruitment campaign will take place in May 2023. We will work with our communities and partners to determine how we can extend this model to other care settings, such as care homes.

Cultural Competence Certification:

The Person-Centred Care Team will be working with Diverse Cymru over the next year to achieve cultural competence certification. Learning from the assessment and associated training will be used to inform how we approve dementia care in diverse communities.

Meaningful Activities:

We will continue to work with clinical teams to promote the benefits of meaningful activity. We will consider further how meaningful activities can be used to enhance person centred care and experience and reduce behaviours that challenge. We will proceed with a proposal for Grant funding to develop a Meaningful Activity Strategy that will support both hospitals and the wider community including care homes and a person's own home.

Carers Education:

We want to develop internet / intranet space and IT support for carers to access relevant education/resources online. We will further promote carers education sessions across Gwent, also within care homes and plan how this will be achieved as a long-term goal. We will create more face to face and online education which will include out of hours session availability for carers education. We will further explore joint working with the Alzheimer's Society and further develop links/networking with care providers to promote carers education and Person-Centred Care.

Dementia Connectors:

We want to develop and embed the Dementia Connector Model across the region to ensure more timely support and signposting for people living with dementia and their carers.

3rd Sector SLA's:

ABUHB Older Adult Mental Health Service(OAMH) are in process of reviewing SLA's held with 3rd sector partners to ensure alignment with the Standards.

Conclusion

In 2022, Regional Dementia Partnership Boards had been afforded a **'readiness year'** to establish Workstreams that would support implementation of the Standards. This Annual Report outlines the actions the Gwent Regional Dementia Board has undertaken during the readiness year.

The Regional Dementia Board and associated Workstreams have been involved in numerous initiatives to prepare for implementation of the **Standards** and improve the way in which we better engage with patients, relatives, carers, staff and communities. People's feedback is really important in order that we ensure that what matters to people is used to help **influence, inform and shape** dementia care across the region. Actions taken as a partnership thus far will support the implementation of the Standards during the coming year. Whilst good progress has been made during the readiness year, we do not underestimate what still needs to be done. As well as enhancing what is already in place, key areas of focus for 2023/24 have been identified under *'what we want to achieve'.*

As a Regional Dementia Board, we are committed to focusing on **listening** to our communities with an emphasis on diversity and inclusion, using people's feedback to improve the lived experience. This will be embedded throughout our Workstream Programmes.

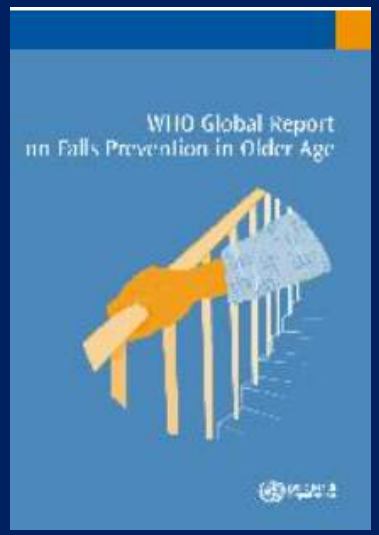
In April 2023, the Regional Dementia Board will review progress to date and will set its priorities for 2023-2024. It is likely that funding will be required to develop some of the new developments mentioned, for example, the Dementia Hwb, and we shall identify resources required through the Dementia Board and Regional Leadership Group.

The appointment of a Regional Programme Manager with an emphasis on supporting all Workstream Leads is a pivotal post and we look forward to being able to prioritise our actions to embed the Standards and fundamentally, **improve the lives** of people living with dementia and their carers for many years to come.

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

Falls and Bone Health Report April 2023

Background Overview



World Context:

Falls prevention and management remains a key issue in the improvement of the health and wellbeing amongst our older people, as falls represent 'a major cause of injury disability, morbidity and mortality' (World Health Organisation: 2018). Globally, falls represent a major public health concern and remain the second most common cause of unintentional injury and death. Approximately 28-35% of people aged 65 years and over fall each year increasing to between 32-42% for those over 70 years of age. Each year it is estimated that 684,000 individually die globally from falls.

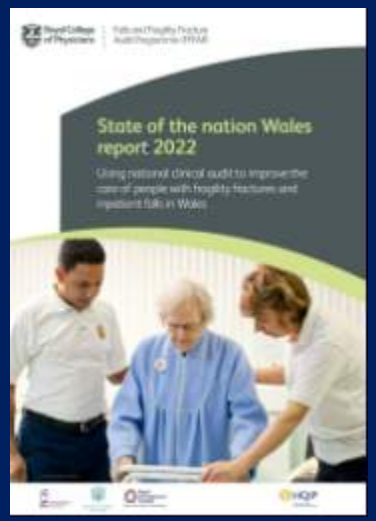
Falls represents a challenge to population ageing with the numbers increasing in magnitude. It is predicted that if preventative measures are not taken in the immediate future the numbers of injuries caused by falls is projected to be 100% higher by 2030 (WHO Global Report).

UK Context:

In the UK around 1 in 3 adults over 65years and half of the population over 80 years will have at least 1 fall per year. This means that each year in the UK at least 5 Million people will experience at least one fall.

Falls remain the most commonly reported patient safety incident with more that 240,000 reported in the acute and mental health setting in England and Wales in 2022.

Background Overview



Wales Context:

The Strategy for Older People in Wales, 2013-23' (Welsh Government: 2013) identified the prevention of falls as an emerging area for policy development and initiatives. Within the context of the document, 'Ageing Well in Wales's identified the importance of reducing the impact and number of falls as a national issue, as well as the contribution to an individual's social isolation.

'The State of the Nation Wales Report 2022' (Royal College of Physicians: 2022) was published as part of the Falls and Fragility Fracture Audit Programme (FFFAP) and looked to use clinical audit as a means to improve the care of people with fragility fractures and inpatient falls in Wales. This summary report examined how the care of inpatient falls and fragility fracture has changed since 2020, showing what the audit reveals about the quality of patient care, and the impact of the COVID-19 pandemic.

A key component of the latest report relates to the National Audit of Inpatient Falls (NAIF) which identified that there were approximately 12,500 Inpatient falls in 2021.

Placing this in the context of Aneurin Bevan University Health Board (ABUHB) we saw 3613 and 3579 as a total number of patient falls in hospital for 2021 and 2022 respectively.

Background Overview

With the implementation of the 'Duty of Quality' (Health and Care Engagement Act, Welsh Government: 2022) which came into force on the 1st April 2023, the management of falls remains a key component under the newly defined quality standards. This is reflected likewise in the recently developed Health Boards Quality Strategy. This serves to further promote and build upon what has already been accomplished with quality, safety and learning at the heart of everything we do.

This report looks to provide a summary of work being undertaken which is underpinned by a plethora of activities across the Health Board in support of reducing the risk of falls across the many settings in which we serve the population of Gwent. It looks to detail the key actions both completed and ongoing with associated recommendations.

Patient falls in Hospital

a. Context – Inpatient Falls.

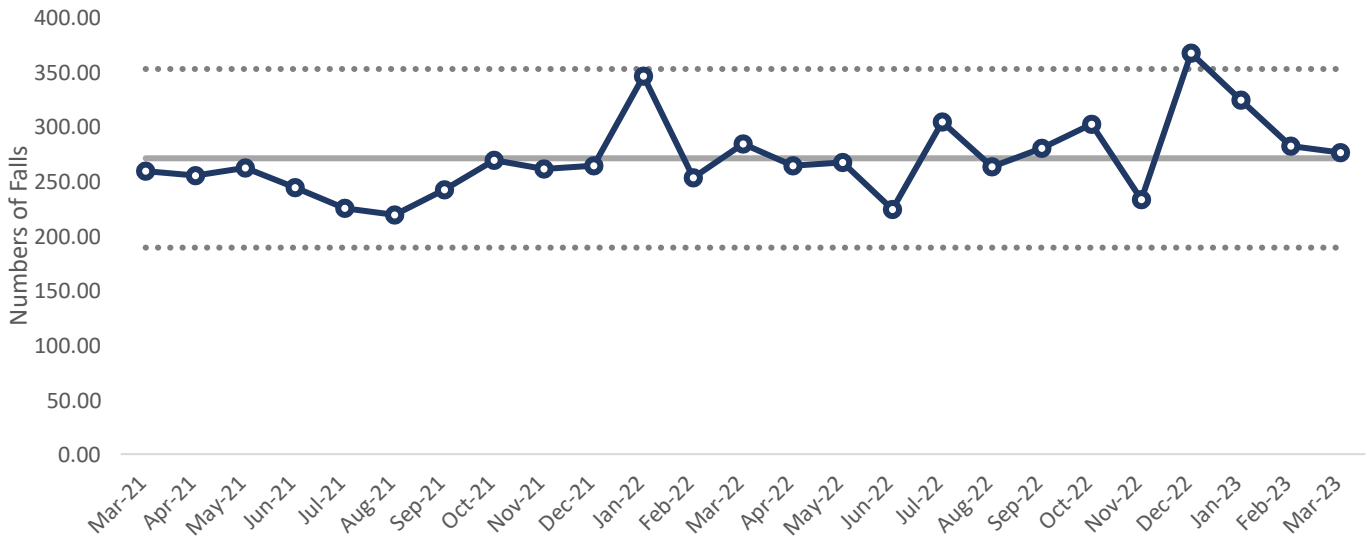
All patients, of all ages, have a heightened risk of falling when admitted to hospital, either due to their past medical history, their current condition or by the very fact that they are within an unfamiliar environment. It is therefore important to ensure that all patients admitted to hospital are systematically assessed for 'falls risk', and effective preventative measures are put in place to reduce the risk of an initial or further fall, whilst promoting enablement.

Prevention, reduction and management of falls within the hospital setting is complex and changes according to individual circumstances, clinical specialties and clinical environments.

The monitoring of falls incident data represents one of the many key factors in understanding the themes and trends and subsequently how this informs the interventions required from ward to Health Board level. The monitoring process is actively managed by individuals wards/ Divisions and by means of the both the Falls and Bone Health Committee and the Hospital Group through its governance structures. A weekly analysis of falls with fractures is a key component of updates to the Clinical Executive Huddle.

Total Numbers of Inpatient Falls March 2021-23

Total = Sum of the falls related incidents reported for the given period



April 2023

Context

The data used in this I chart has been retrieved from Datix.

The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period March 2021-2023

Definitions

Reported fall incidents in Aneurin Bevan University Health Board (ABUHB).

This data was retrieved from Datix as the information source.

What the chart tells us

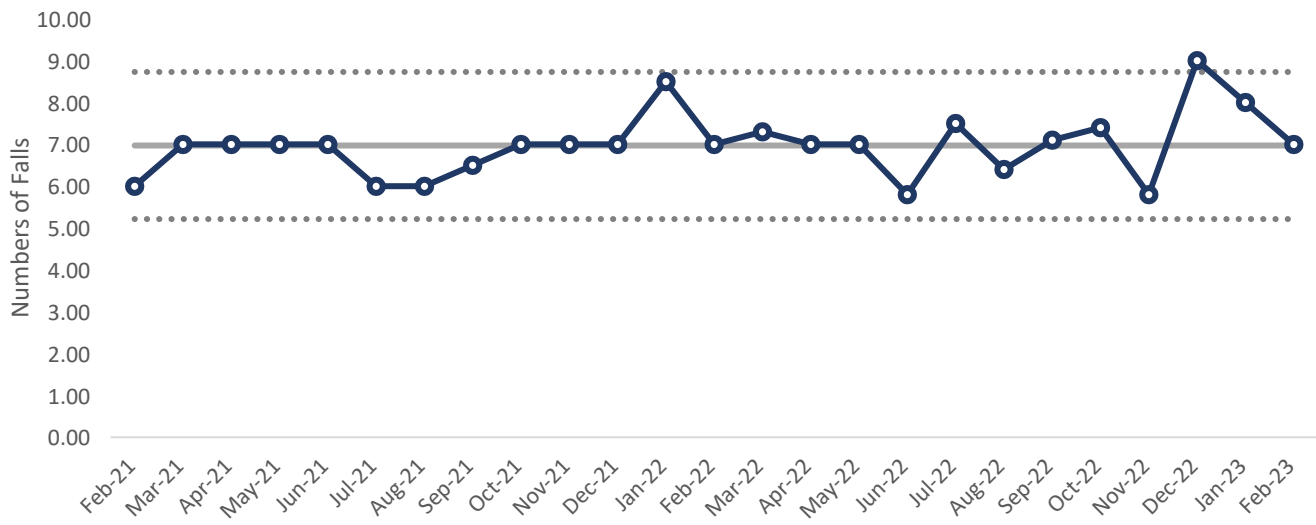
- The mean average number of monthly falls for ABUHB has seen a marginal decrease to 270.
- For the year 2022-23 incident reporting numbers have been subject to a greater degree of variation as compered to 2021-22 with December of 2022 being marginally above the upper control limit.
- January – March 2023 has seen a return to a downward tend with values for February and March being more closely aligned to the mean average.

Variation

December 2022 saw the highest numbers of reported falls incidents since January 2022 at 369.

Average Number of IP Falls per 1000 Occupied Bed Days (OBD). February 2021-23

OBD = The sum of the number of beds occupied for the given period



April 2023

Context

The data used in this I chart has been retrieved from Datix.

The data represents the collective information for ABUHB and refers to the average numbers of Inpatient falls per 1000Occupied Bed Days (OBD).

1000 OBD's represents a national standard unit of measure.

December 2022 figure is the highest since January of the same year.

Definitions

Reported fall incidents in Aneurin Bevan University Health Board (ABUHB).

This data was retrieved from Datix as the information source.

What the chart tells us

- The mean average number of monthly falls for ABUHB per 1000 OBD's for the period March 2021- 2023 was 6.97 which is marginally above the National average of 6.6.
- Aligned to the National average for the given period the following is demonstrated:
  - 29% above National Average
  - 29.% below National Average
  - 42% Aligned to the value of 6.6
- November 2022 saw a downward trajectory to the lowest value of 5.8 since June 2022. A

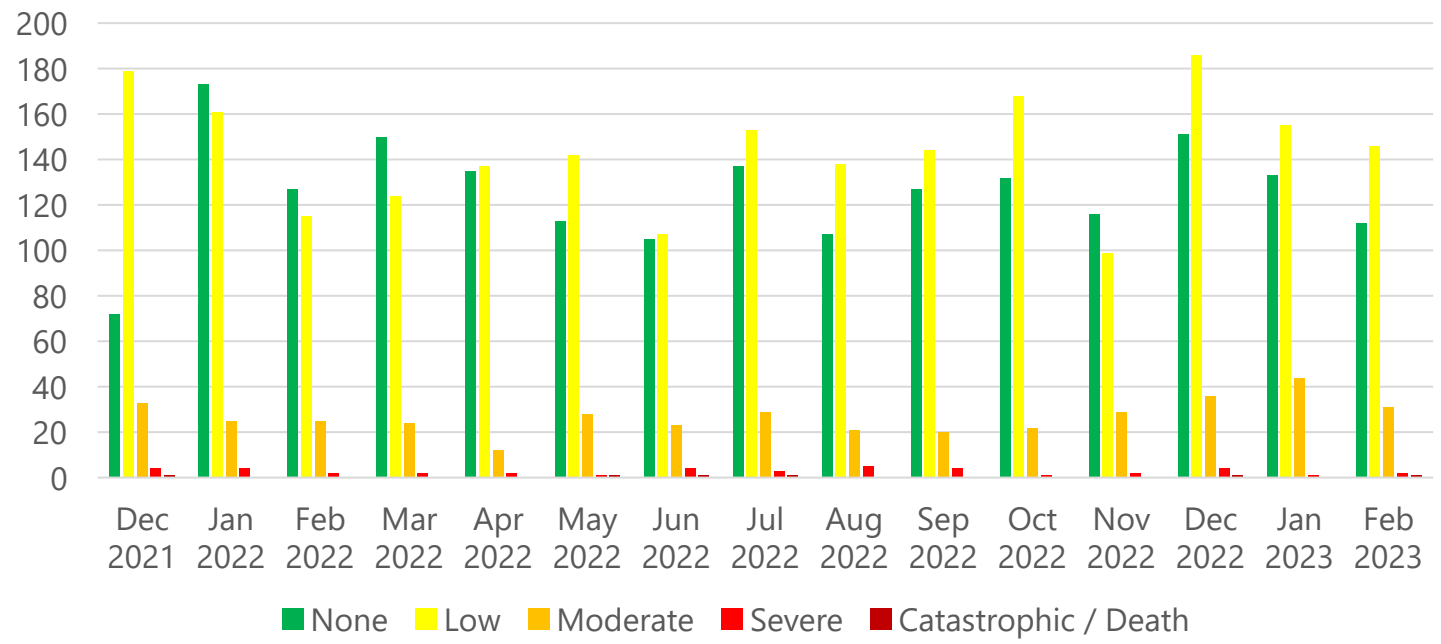
Variation

Again 2022-23 saw a greater degree of variation as compared to 2021 across the corresponding periods.

There has been a reduction in the number of months in which the incident rate was above the national average from 26% to 29%.

A peak was seen in December , it is important to consider this in the context of the overall trend. A subsequent decrease has been seen to a value aligned to the National value.

Severity of Harm



April 2023

Context

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

The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period December 2021 to February 2023

The data is reflective of the identified level of harm recorded.

Definitions

Reported fall incidents in Aneurin Bevan University Health Board (ABUHB).

This data was retrieved from Datix as the information source.

What the chart tells us

The information provided details the distribution of the levels of severity of harm as reported for falls incidents a period of 15 months to February 2023.

Of the total numbers of falls incidents reported the severity of harm is categorised as follows:

- 44% - no harm
- 47% - low harm
- 8% - moderate harm
- 0.9 % Severe harm
- 0.1 Catastrophic

Variation

Medical Examiner (ME) Referrals – Falls

April 2023

Chart 1

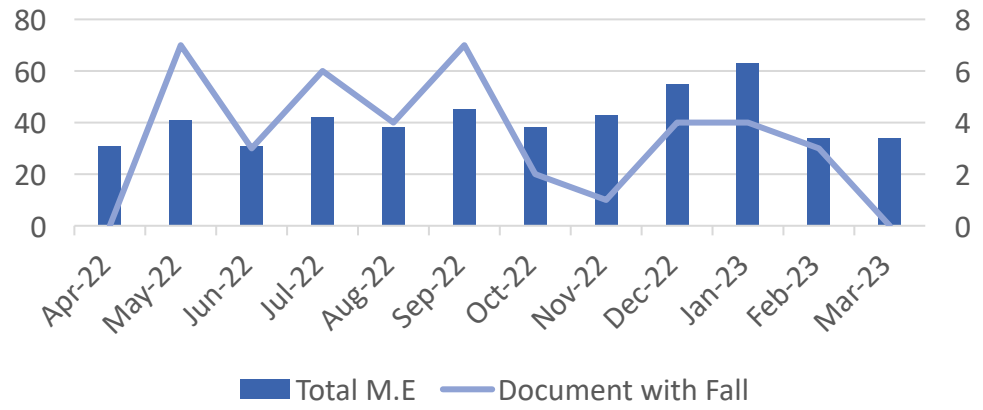
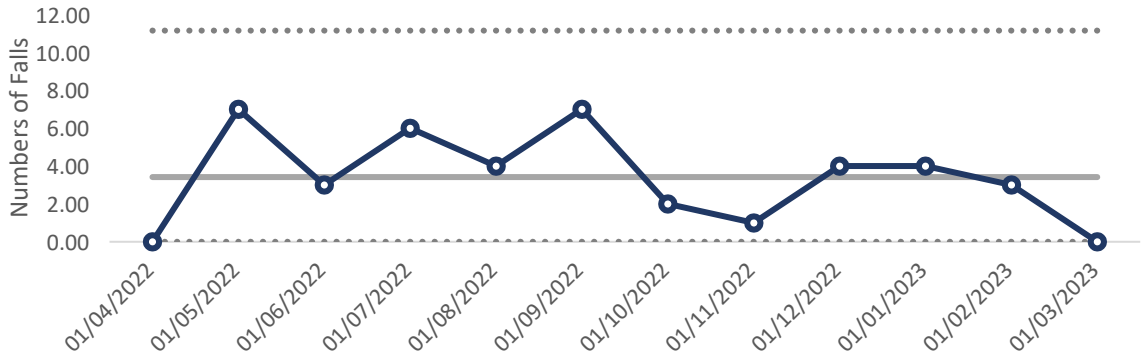


Chart 2



Context

The data represents the collective information for ABUHB and refers to the total numbers of incidents reported to the ME and those numbers which referenced falls within the documentation.

The information is for the period April 2022 to March 2023.

Definitions

Reported fall incidents in Aneurin Bevan University Health Board (ABUHB)

This data source is information extracted from files sent to the ME.

What the chart tells us

Chart 1 - Of the total numbers referred to the ME 8% had falls referenced within the documentation. This represents 41 of 495 instances . It is however important to recognise that this may not however have been the primary reason for the referral or cause of death.

Chart 2 – This demonstrates the trajectories for the numbers of falls reported with a mean average value of 3.4 for the given period. April 2022 to March 2023

Variation

Chart 2 demonstrates the variation around the mean average value of 3.4 with the months May, July and September 2022 being above or more closely aligned to this value. September saw a subsequent downwards trend to values of 2 and 1 respectively (October & November 2022). The months of December 2022, January and February 2023 saw values marginally above the 3.4 with a fall to zero for March 2023.

Patient falls in Hospital

Key Actions:

- A pilot commenced 3rd April 2022 on Oakdale ward to implement a MDT SWARM huddle led by the Medicines Division as a quality improvement project. SWARM represents a safety huddle which takes place as close to the time of incident as possible. The pilot will be informed by the PDSA methodology and will look to incorporate both qualitative and quantitative measures to evidence change and any associated improvements.

- Health and Safety have commenced an evaluation of the availability of flat lifting equipment across ABUHB in support of falls management. Audit outcomes have instigated the following:

  a. The requirements to establish a central database of equipment as n asset register.
  b. To evaluate the associated maintenance contracts and designated ownership with ABUHB.
  c. To undertake a gap analysis and subsequently identify any additional needs.
  d. To establish training to ensure we have the capabilities for the equipment use.

Patient falls in Hospital

Key Actions:

- Aligned to the evaluation of flat lifting equipment work is being undertaken to look at the opportunity to implement a dedicated response team in support of using equipment to lift patients post fall.
- As a aspect of work being undertaken by the National Inpatient Falls Network due consideration is being given to the effectiveness of the use of sensor equipment in reducing the incidents of falls. The consensus at present is such that such equipment should be considered based on the needs of the person and not as an approach for all. Aligned to this an audit of sensor equipment will be undertaken in ABUHB to inform decision making and to gain a greater insight in to the use.
- ABUHB representation is engaged in the National Inpatient Falls Network discussions on the development of the WNCR Immediate post falls risk assessment.
- The DATIX Cymru system provides the opportunities within the incident reporting for falls to allow for the undertaking of a focus review. Currently Medicine has adopted its use for all falls, whilst SC is undertaking the review through a discretionary process. A request was presented to the Falls and Bone Health Committee to ratify an agreement to adopt an all encompassing approach across the Health Board for use in relation to all falls incidents.

Patient falls in Hospital

Key Actions:

- Training is a fundamental element in supporting the delivery of the complexity of components held within the MFRA to minimise the risk of falls. Work has been initiated developing an MDT approach in which individuals professional expertise can provide a greater depth of knowledge and skills within our workforce. This will be reflective of the components held within the MFRA.
- In support of the Inpatient rehabilitation agenda Physiotherapy are providing two Clinical Lead secondment opportunities within their service with a focus being placed on progressing work associated with falls.
- Work is being undertaken to explore how Physiotherapy and Occupational Therapy can further promote patients mobility in terms of "Getting Up, Getting Moving and Getting Dressed'.
- A pilot project is being designed in which visual assessments can be undertaken at the bedside. The proposed ward is C5E at the Royal Gwent Hospital.

b. Context - Falls Management Internal Audit Report March 2022

Internal Audit

March 2022

During the period December 2021 to March 2022 falls management was subject to internal audit with reference to Inpatients. The review was undertaken in order to provide the Health Board with an assurance that falls management procedures were being appropriately implemented and monitored.

The key points for consideration were in recognition of the following:

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

- During July 2021, the Health Board issued a revised Falls Policy for Hospital Adult Inpatients which was accompanied by an awareness raising campaign. Alongside this process, the governance arrangements had been restructured with the re-establishment of the Falls and Bone Health Steering Group, now entitled the Falls and Bone Health Committee together with two sub groups those being the Hospital and Community Falls and Bone Health Groups.

Internal Audit

March 2022

Falls Management Internal Audit Report March 2022

The key risks considered in the review were:

- The failure to properly risk assess patients leading to increased falls and patient harm;
- The lack of appropriate monitoring of falls leading to missed opportunities to identify weakness and implement improvements;
- The reputational risk from negative publicity arising from increased or serious falls
- The financial loss to the Health Board.

As this was undertaken during the C-19 pandemic ward visits were not feasible and therefore a review of electronic copies of clinical notes was undertaken to determine if the Multi- Factorial Risk Assessment (MFRA) had been completed.

Internal Audit

March 2022

Assurance summary[1]

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

Report Outcome – Reasonable Assurance

The above summary was underpinned by the following:

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

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

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

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

Internal Audit

March 2022

Audit Recommendations and Associated Actions:

- **Identify any underlying reason for the non-completion of MFRAs and the impact of the pandemic.**

1	MFRA completion	2	Operation	High

Action to Date:

It was recognised that the non-completion of the falls risk assessment was multifaceted and that the challenges were heightened during the C-19 pandemic. This was associated with the changing levels of comorbidities of our patient cohort and the availability of staff resources due to competing demands in support of the Health Boards response to the pandemic. Some wards were also subject to changes in their functionality.

The Health Board through its falls management structure continues to utilise both qualitative and quantitative information to identify themes and trends to instigate necessary quality improvement initiatives. Compliance with the completion of the MFRA is subject to audit through 1Patient, 1 Day and subsequent deep dives as defined by the findings. All audits are subject to an evaluation of the themes and trends to support informing change this includes scrutiny at the falls review panel.

Internal Audit

March 2022

Audit Recommendations and Associated Actions:

- **Review the MFRA documentation to determine if it can be rationalised / updated to be more concise. For example, a permanent section and an ongoing care plan that is periodically revised**

Action to Date :

The MFRA represents one assessment within the suite of the Welsh National Care Records (WNCR). At the time of the audit the Health Board were at the stage of planning the implementation of the WNCR, MFRA which would translate the existing document into an electronic format. As of November 2022 this has been implemented at the Grange University Hospital (GUH) with further rollout to the Enhanced Local General Hospitals during 2023. The digital format will enhance the opportunities for data gathering on completion of the MFRA.

A current challenge is that within the Health Board we are operating both a paper and digital system.

Audit Recommendations and Associated Actions:

Internal Audit

March 2022

- **Continue with the falls management training, but target the programme towards areas of poorer compliance rates**.

Action to Date:

It is recognised that training is a key component in supporting the ABUHB's approach in minimising inpatient falls. As such we have continued to build on what has already been established. The evaluation of data has looked to underpin a focussed approach where areas of concern are identified has further informed the approach.

Aligned to the work of ABUHB are engaged in the development of a platform for falls training to be established as a module in ESR. This represented a generic learning platform as a National product. It is anticipated that this will be made available to ABUHB staff by the end of July 2023.This platform will support enhancing knowledge and skills from both an inpatient and community perspective. The learning package will provide a level 1-2 education upon which additional specialist modules may be developed.

Internal Audit

March 2022

Audit Recommendations and Associated Actions:

- **Continue with the falls management training, but target the programme towards areas of poorer compliance rates**.

Action to Date (continued):

To date training has had a significant focus on the completion of the MFRA. Work is underway to look at the opportunities to provide practical falls awareness training with engagement of Therapies in the specifics around mobility, nutrition & hydration etc.

Training is also now being delivered via the JOE programme which will look to support newly qualified professionals joining the organisation.

Following agreement by the membership of the Falls and Bone Health Committee work is underway to establish falls training as mandatory requirement within the Health Board.

ABUHB are engaged in the development of a digital platform for the delivery as part of ESR. This has been developed as a National product facilitated by the National Falls Taskforce. This is also being advocated as an opportunity to delivery consistency across the four Nations and is part of discussions within the 4 Nation Falls Collective.

Internal Audit

March 2022

Audit Recommendations and Associated Actions:

- **Remind staff of the falls management requirements.**

Action to Date:

Through the newly established structure in support of falls management an ongoing awareness campaign remains ongoing. The development a falls management specific intranet pages through SharePoint allows for the sharing of resources with further work being undertaken to establish a falls network and to enhance the opportunities for sharing learning as well as acting as a research depository. The agendas set for the fall's forums look to ensure good practice, learning and necessary change initiatives continue to promote the ongoing requirements to manage falls.

Internal Audit

March 2022

Audit Recommendations and Associated Actions:

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

Priority status

Datix entries	2	Operation	Medium

Action to Date:

With the advent of DATIX Cymru this system allows for enhanced opportunities to extract data and to provide field specific audit information. It includes the 'Focus Review' which has been adopted by Medicine as a pilot across all falls incidents whilst Scheduled Care are attributing to fall with fractures. A request to the Falls and Bone Health Committee is to adopt as per Medicine. A subsequent re-evaluation of the investigation document associated with FRP will be undertaken to further streamline processes to maximise the resources available.

WAST

Summary Overview ABUHB for the period January 2022 to February 2023

- 59,288 calls to WAST in ABUHB were attended.
- 12% of all attended calls were falls related as categorised under the nature of the incident. This represented 6747 responses to falls.
- ABUHB. 28% of the represented a the average specialised falls response contribution to demand. Current for 2023 this is at 35% for given months of this year.
- Calls to WAST from Care Homes = 4701 with a related conveyance rate =40

c. Context - Falls and Frailty Response Model

In 2018, the Welsh Ambulance Services NHS Trust (WAST), developed The Falls Framework which included the Falls Response Model. The Framework has led to significant improvements and innovation within the Trust, across Health, Social Care, Local authorities and within the independent sector. Within ABUHB the response model has been supported by WAST with the provision of level 1 response resource and an integrated WAST/ABUHB Level 2 falls and frailty response resource (FFRS - Calls sign FRS01)

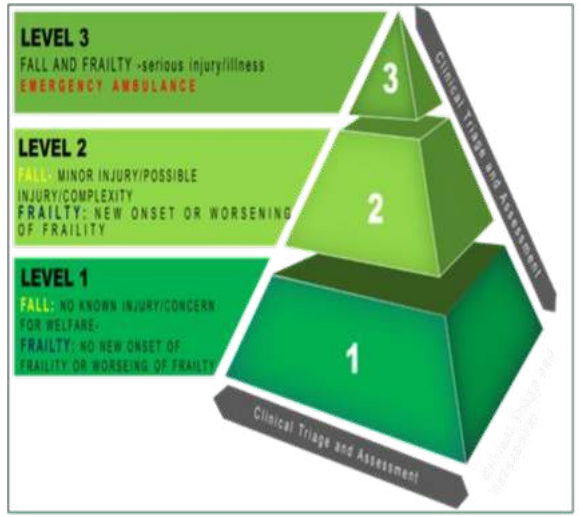
Response levels are broadly defined as follows:

Level 3 Emergency Ambulance

Fall: Serious Injury Frailty/ Serious Illness.

Level 2 Response.
Fall-Minor Injury/Possible Injury/Complexity.
Frailty: New onset or worsening of a frailty symptom.

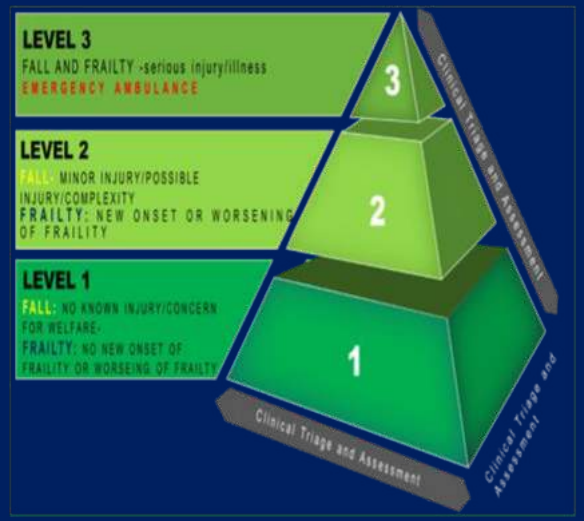
Level 1 Response.
Fall/ concern for welfare-no known injury.
Frailty: No new onset or worsening of a frailty symptom.



Falls and Frailty Response Model

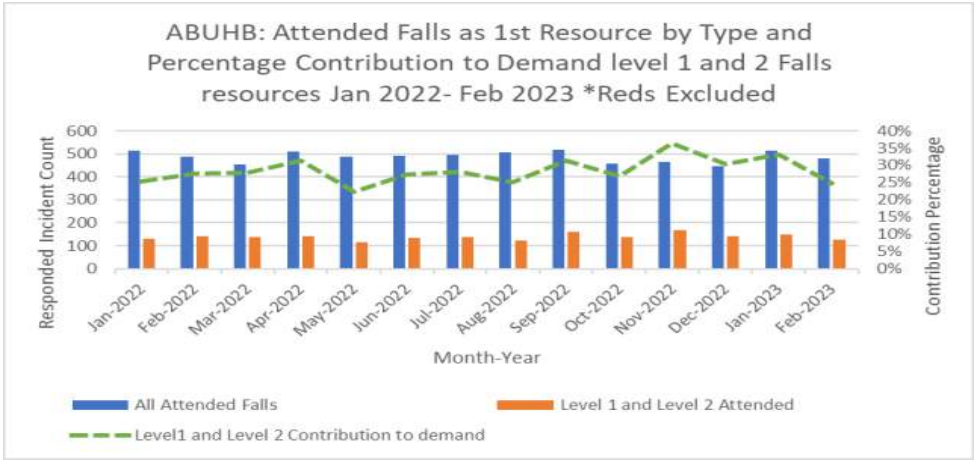
WAST

Falls Response Model



Falls and Frailty Response Model

Falls and Frailty Response Model



For the given period the Level 1, Falls Assistants (FA) contributed to 21% of the overall demand on average for the period, this includes support from other HB Level 1 FA's . When level 1 and level 2 are combined a 28% contribution is seen in response to falls demand. (For Level 2 only 1 resource is operational 12hrs /day)

In 2021 Level 1 FA's responded to 470 Falls in ABUHB, in 2022 due to increased regional resourcing this increased by 39% to 1,190.

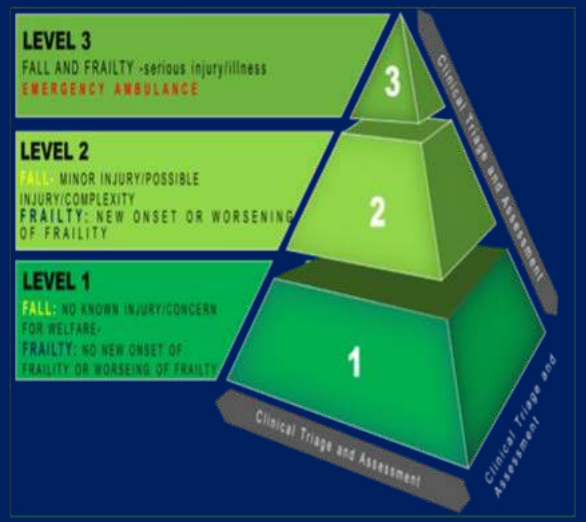
For the given period the Level 2 resource responded to 1000 calls of which 64% were falls by nature of the incident (640). The average conveyance rate was 16%.

All other resources average conveyance rate for falls was 58% (2,842).

WAST

Falls Response Model

FRS



Falls and Frailty Response Model

Key Actions:

At a recent meeting of the Community Falls and Bone Health Group WAST presented two newly developed dashboard.

The WAST dashboard allows for deep dive analysis of the following:

- Incident locality.
- Prioritisation
- FRS Allocations and responses
- FRS level of response
- FRS% conveyance rates.
- Average Time at scene

Outcomes information available as aligned to the above includes as to whether the person was treated at the scene and any referrals into the falls pathway.

A second dashboard related to the incident data portal for care homes developed by the National Collaborative Commissioning Unit. This remains in development and discussions have commenced in relation to its availability to support information sharing in relation to falls within ABUHB.

Discussions continue in relation to how FRS may be used as a sustainable wider opportunity in falls management.

Falls in the Community Setting

d. Context – Falls in the Community Setting

The Gwent Frailty Programme launched in 2011 was delivered by the Health Board and five local authorities and advocated both the vision and several of the principles depicted in the document 'A Healthier Wales: Our Plan for Health and Social Care (Welsh Government:2019).

At that time the programme was designed to bring partners together with the provision of time and resources to improve the outcomes for the frail, elderly population. The design was evidence based and took account of intermediate care, therapy support and additional reablement care supporting a defined cohort of the population. The programme was designed as operating around Community Resource Teams (CRT). One component of the service provision was centred on falls.

The aim of the service was to provide a coordinated approach to assessment and intervention.

Since the inception of the frailty programme several national and strategic policy documents have identified the need for change in order to support the growing population.

'The Strategy for older people in Wales 2013-2023' (Welsh Government:2013) references the prevention of falls with a recognition of the importance of reducing the impact and numbers of falls as a National issue

Falls in the Community Setting

Context – Falls in the Community Setting

The publication of *A Healthier Wales* (2019) described the challenges facing the NHS in Wales and highlighted the needs of the aging population and recommended the need for redesign of services and the importance of information technology.

The Establishment of the programme for redesigning Services for Older People seek to to create a single unifying vision for Gwent and a series of deliverable milestones.

Although this is all encompasses falls represented a key challenge to be met in terms of early intervention and prevention, opportunities to provide rapid assessment, the effective use of our Community beds in support of effective graduated care and early supported discharge. With reference to the six goals programme admission avoidance as appropriate is also key.

As a driver for change the Health Board has seen the establishment of the 'Falls and Bone Health Community Group' as a part of its governance structure. Its aim is to coordinate, support and facilitate the range of activities which contribute to the work on minimising the risk of falls and the overall prevention agenda.

The group remains in its infancy but has multiagency representation. It associated action plan is reflective the need to gain a greater understanding and insight into the scope of work being undertaken and to establish the baseline position.

Falls in the Community Setting

Key Actions:

A process mapping exercise was undertaken in October 2022 to review the Community falls provision to provide information as to the current status and to support future decision making.

- This work provided an evidenced insight into how the services within the Five boroughs have evolved differently and as such have variation in resources, differing models, service scope and provision.

Associated Challenge:

- Variation in management structures with the CRT's
- An absence of a standardised approach was seen in terms of use of referral criteria, screening, assessments and documentation.
- Variation in waiting times and differing offers of interventions.
- Limited and inconsistent data.

It is important that we consider this in relation to the programme for the development of the Older Person Pathway and the wider CRT .

Falls in the Community Setting

Associated Recommendations :

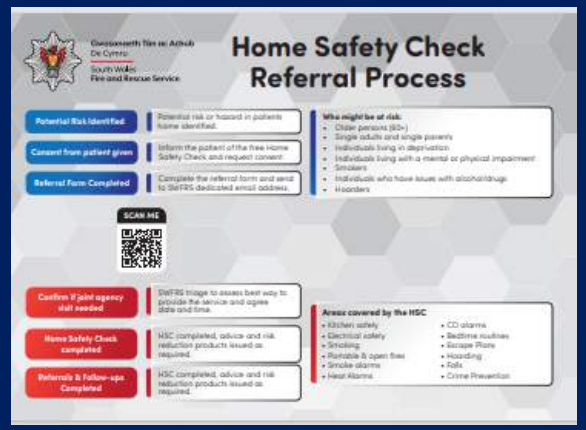
- Standardisation of the data capture across CRT in order to provide consistent measures of activity and outcomes.
- A further analysis of the systems data and to work with other agencies to define and correlate what is available in support of a whole systems approach.
- Extract learning from other models of service delivery in use across the UK and to undertake a gap analysis to support defining a preferred model.
- Optimise the operational leadership structure for falls management.

Key Actions:

- Work has already commenced with CRT's in collaboration with performance teams to move towards developing standardised data capture across all five localities. This will support informing any future single falls model approach.

Standardisation of the data capture across CRT would look to provide consistent measures of activity and outcomes.

Falls in the Community Setting



Further analysis of systems data in relation to falls will look to create the evidence base to provide an assurance as to whether we are effectively reaching the at risk population. This will contribute to the work being undertaken as part of the proactive frailty workstream during 2023. This will assistant in defining the optimum model for operational leadership within the CRT structure for falls within the Community setting and the strategic direction for falls management.

Multi agency engagement will look to promote and proactively advance a whole systems approach.

Key actions : The information represents a few examples of locality Specific initiatives: (this is by no means exhaustive and represents information made available at the time of collating the report).

All Boroughs:

Referrals from the South Wales Fire and Rescue Service (SWFRS) are now being received by falls teams in support of falls management in the home setting. Likewise the teams can refer patients directly to SWFRS for home safety checks with the collaborative development of the referral pathway.

Falls in the Community Setting

Torfaen:

- New links with Pharmacy have been established this year to provide an education session to the falls class patients and also 1:1 advice. This has really benefited patients to understand the reasons behind their prescribed medications and the importance of adhering. Further consideration is being given to how this could be extended into the falls clinics setting in the future.

- Discussions are underway as to how leisure facilities can support the ongoing exercise regimes for fallers who have completed the 8 week programme delivered within CRT services.

Monmouthshire

Work is being undertaken to scope differing models to support admission avoidance for those that experience a fall.

Key actions:

- Following an evaluation of available data to undertake a benchmarking exercise with Hereford NHS Trust (Connexus Falls Response).
- Exploration of opportunities of the benefits of delivering a household cavalry model and the associated funding requirements.

Fracture Liaison Service (FLS).

e. Context:

Osteoporosis is also considered as a serious public health problem due to a very high prevalence and it is estimated that over 200 million people worldwide have suffered osteoporotic hip fractures. About 30% of postmenopausal women in the United States and Europe suffer from this condition and the overall prevalence based on low bone mass is 43.9%.

'In the UK over 3 million people are estimated to have osteoporosis'.

The incidence of osteoporotic fracture increases exponentially with age; particularly over 50 years of age, the lifetime probability of sustaining an osteoporotic fracture is one in every two women and one in five men. In the UK, every two minutes, a person above the age of 50, sustains a fragility fracture, resulting in more than 300,000 osteoporotic fractures per year.

A fracture liaison service (FLS) provides secondary prevention for fragility fractures (defined as a fracture following a fall from standing height or less). These services systematically identify and assess the patient's risk of subsequent fractures, then treat and refer the individual to other specialties in order to reduce the risk of further fractures and falls.

Fracture Liaison Service (FLS).

Key Successes:

FLS's with ABUHB continue with its aim to prevent secondary fractures by ensuring prompt identification, investigation, and treatment through consistent, high-quality care to all patients with fragility fractures above 50 years. The work is based on the national recommendations.

Recent work has been undertaken adopting a quality improvement methodology of Plan-Do-Study-Act cycles to implement change initiatives whilst strengthening the evidence base. This work has been supplemented with a process mapping exercise. This saw the establishment of ownership by the Division of Medicine with cross Divisional engagement with key stakeholders through Clinical Leads for Rheumatology, Care of the Elderly (COTE), and Radiology.

Partnership working with the Royal Osteoporosis Society (ROS) has also facilitated the FLS economic benefit calculations.

Fracture Liaison Service (FLS).

Key Successes (continued).

Process mapping has seen the establishment of the two FLS-DB pathways: Rheumatology team to provide care for patients under 75 with the current Clinical Nurse Specialist (CNS) and COTE team to assess all patients above 75 years. In support of this collaboration with Radiology has seen the establishment of a system in which weekly fracture data lists are generated to aid proactive identification of patients at risk.

The Medical Division has supported the FLS pilot with a further 12 months funding for two new Clinical Nurse Specialists (CNS).

The service continues to be engaged in the submission of patient data to inform the FLS data base (FLS-DB). For ABUHB this showed the following:

- 42.6% (n=1651) of patients identified in the year 2022, an 88% increase as compared to the year 2021.
- Significant improvement observed in relation to spinal fractures as compared to previous years and the National benchmark.
  26% to 35% (National average=21%);

Fracture Liaison Service (FLS).

Key Successes (continued):

- Completion of the Falls assessment has demonstrated as improved from 35% to 81% (National average=61%).
- Delivery of Bone treatment improved from 58% to 66% (National average=54%).

KPI Challenges as recommended in FLS-DB Report 2022 :

- **KPI 2 & 3** – These relate to the requirements to identify 80% identification of all fragility fractures and those of the spine**.**
- **KPI 7 -** Bone therapy recommended with a minimum compliance of 50%
- **KPI 10 - To c**ommence bone therapy by first follow up (80%)
- **KPI 11 -** Adherence to prescribed anti-osteoporosis medication at 12 months post fracture (80%).

Key Service Challenge:

Although the service has demonstrated some successes it is important to recognise that its resources are supported through interim funding provided by the Medicines Division for a limited period. The service is therefore subject to unsustainability into the future**.**

Fracture Liaison Service (FLS).

Key Actions:

- To develop a full business case in support of funding the necessary resources to provide a sustainable FLS with an ability to deliver quality outcomes for the population of Gwent.
- Continued collaboration with the Royal Osteoporosis Society (ROS) in support and delivery of the Health Board strategic plan for FLS's.
- To promote the wider partnership working with ROS and to further strengthen the cross Divisional engagement whilst broadening stakeholder involvement, awareness and knowledge.
- To seek substantive funding for the roles of the CNS and to develop an associated business case. This pilot has had the added benefits of highlighting the importance of improving the culture and multi-professional awareness of fragility fractures and FLS.

The National FLS Quality and Assurance Group

This group was established in 2022 with the overall purpose to improve and support the delivery of care across Wales and reduce the risk of subsequent fractures for patients. ABUHB are actively participating in informing the development of a National standardised approach to delivering equitable services to the population of Wales.

Falls Awareness Week 18th -22nd September 2023

Falls awareness week represents the collective opportunities for the four nations to raise the profile of falls management. In the context of Wales this is coordinated and organised by the National Prudent Healthcare Falls Prevention Taskforce and is underpinned by the principles of ‘Steady on, Stay Safe’.

This year this will focus on health promotion activity relating to falls risks across the generations.

ABUHB has already commenced work on its approach to this week with the inclusion of developing a children's book with the aim of engaging whole families in the conversations in relation to falls.

The Health Board is also engaged in the developing promotion materials at a National level in readiness.

A key message is ‘ Falls is everyone’s business’

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	25 April 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Nutrition and Hydration Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr
SWYDDOG ADRODD: **REPORTING OFFICER:**	Clare Norris/Helen Ward

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

The purpose of this report is to illustrate the Health Board performance in respect of Nutrition and Hydration standards for health care.

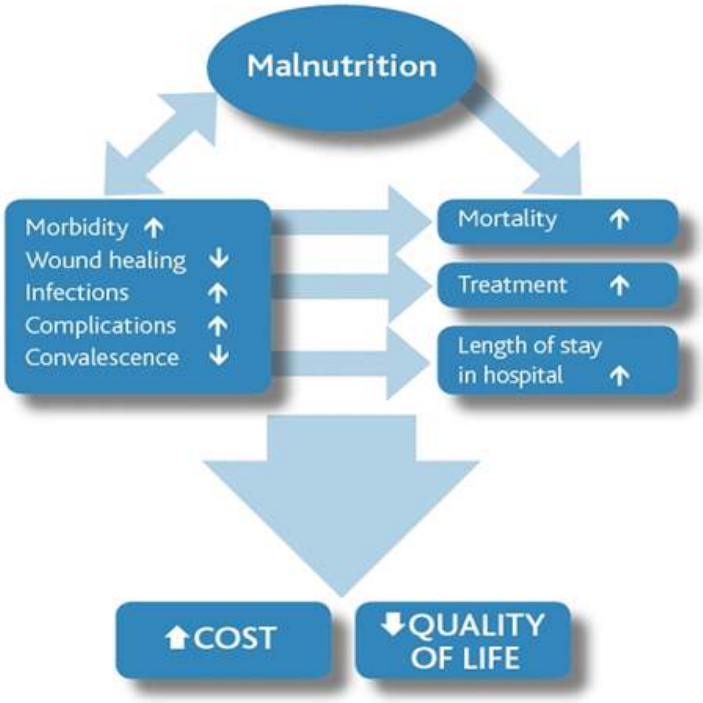
A range of issues for improvement are identified in an action plan to be prioritised according to risk.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Nutrition and Hydration of hospital inpatients is a fundamental component of inpatient care which will affect patient recovery and rehabilitation, complications, length of stay, morbidity, and mortality. It can be considered as a pyramid of 3 levels:

1 the food and beverage service for all patients
2 the provision for patients with additional therapeutic/special diet needs
3 clinical/artificial nutrition (enteral or parenteral) for patients unable to take any or sufficient nutrition and hydration orally.



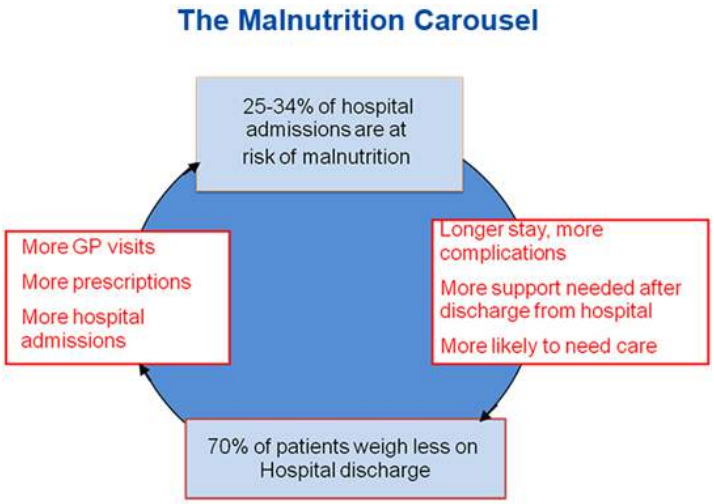
Following discussion of Health Board compliance with Welsh Government Nutrition and Hydration standards at QPSOG (Sept 2021) it was agreed that a review of patient dining services would be undertaken (Jan – May 2022). More recently a range of nutrition and hydration issues were discussed at an informal executive meeting and at their request these are presented as an action plan.

This is report covers: -

- Nutrition and Hydration Standards
- Patient Dining review
- Ward based nutrition support workers.
- Nutrition support team
- Revision of nutrition and hydration committee structure

The committee is asked to note the action plan at appendix 1.

Cefndir / Background



It is well documented that there is a significant incidence of malnutrition in the community with many patients malnourished on admission to hospital; evidence also shows that patients become more malnourished when hospitalised. This is particularly significant (but not limited to) the frail and elderly population and has implications for length of stay and patient flows.

Nutrition and Hydration standards

The relevant standards are: -

- The Health and Care Standards 2.5: Nutrition and Hydration
- All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients. WalesNutritionCateringStandardsHospitalInpatients.pdf (bapen.org.uk)

The all-Wales standards were published in 2012 and it is understood that the Nutrition Lead within Welsh Government is to commission an update of the standards this year. It is expected that this will bring Wales into line with the standards put in place by NHS Scotland.
https://www.nss.nhs.scot/media/1097/1479818118-food-in-hospitals-revised-march-2016.pdf

Food provided for patients needs to be familiar, appealing and available at appropriate times. Above all it needs to be eaten and enjoyed. Fundamental to improving consumption is the delivery of quality and choice of suitable foods and fluids available; maximising opportunities for patients to eat and drink requires the provision of substantial snacks, out-of-hours service provision, on-ward provisions in addition to mealtimes.

Patient Dining Review

The aims of the review:

- To use the information from the Service Review to make recommendations to the Executive Team on how to improve the Patient Dining Experience
- Ensuring that patients are served tasty, nutritionally balanced, and well-presented meals that offer a good range of choice.
- Assess the catering service delivery against the All-Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients, as well as identifying means of improving compliance against them.

Aneurin Bevan University Health Board compliance with the standards relating to Nutrition and Hydration for inpatients remains an area for improvement which is reflected in the action plan.

Ward Based Nutrition Support Worker (WBNSW)

A 10-month, Ward Based Nutrition Support Worker (WBNSW) project undertaken on the hip fracture ward at RGH involved challenging the traditional boundaries of working practices with the aim of delivering comprehensive and co-ordinated nutritional care practises, maximising patient experience and outcomes. The WBNSW focused on accurate and timely identification of those patients at risk of malnutrition, providing greater opportunities for patients to eat and drink, enhancing the eating environment and delivering better patient experience.

The driver for this intervention has been the poor performance of the Health Board in the National Hip Fracture Database/morbidity and mortality rates.

Nutrition Support team

NICE CG 32 (revised) 'Nutritional Support in Adults - Oral nutrition support enteral tube feeding and parenteral nutrition' recommends that all acute hospitals and community should have a multidisciplinary nutrition support team.

The Health Board does not have a fully functioning nutrition support team to organise complex nutrition support to patients in a safe and coordinated manner. A nutrition support team provides the focus point for a multi professional approach to artificial nutrition and will deliver safe, coordinated medical, pharmaceutical, nursing and dietetic advice and support on request across the Health Board.

Since the opening of the Grange University Hospital the delivery of parenteral and enteral nutrition and hydration to patients has become increasingly unsafe and represents the top risk documented on the dietetic risk register. This is evidenced by an increasing number of patient concerns being received and Datix incidents being reported.

Patients to whom we have a duty of care whilst inpatients are exposed to malnutrition with all its attendant complications and associated costs; the failure to provide appropriate and timely nutrition increases the risk of death due to the electrolyte abnormalities associated with refeeding syndrome. This is a risk for patients, for clinical staff involved in their care, reputational and litigation risk for the Health Board.

Revision of Nutrition and Hydration committee structure

The current structure is deemed unfit for purpose. It is proposed that two sub-groups are established – Food and Nutrition and Clinical Nutrition, with membership and terms of reference to be agreed. The reconfigured Nutrition and Hydration committee will be responsible for reporting to QPSOG on the implementation of the action plan.

Asesiad / Assessment

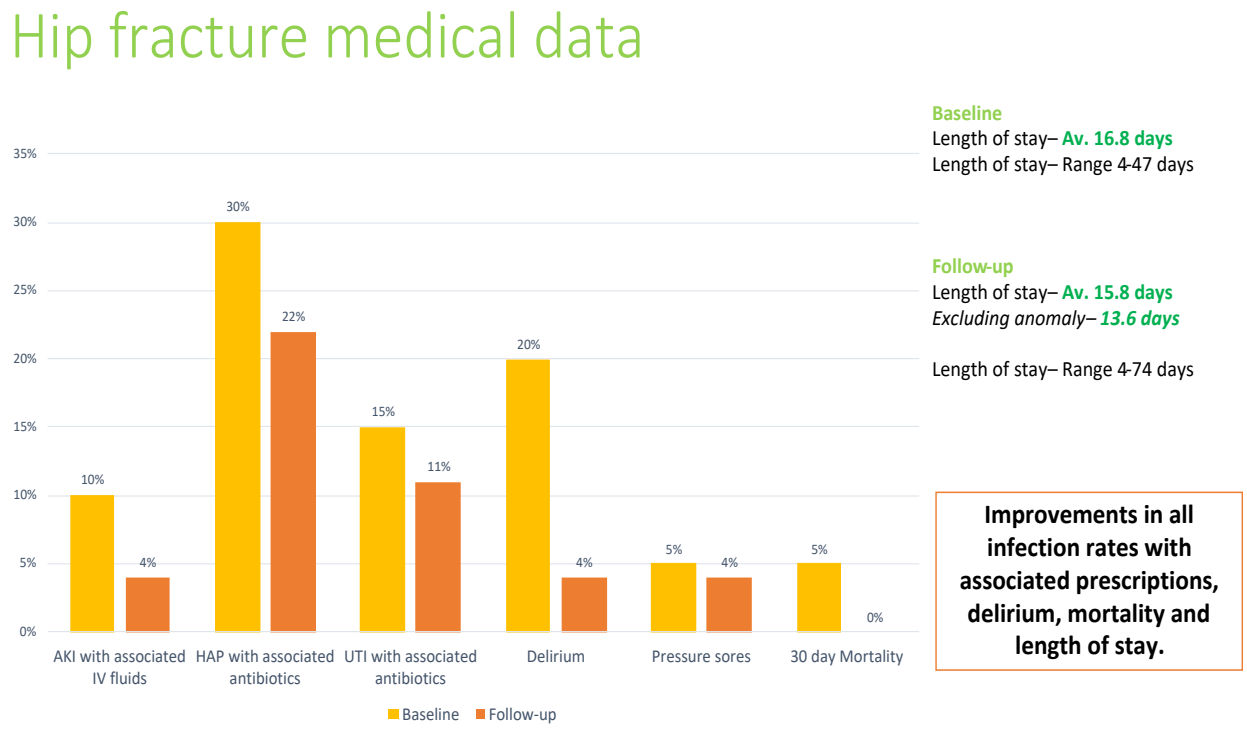
Patient Dining Review

This was undertaken by Facilities Management Catering in conjunction with Dietetics in January to May 2022. It involved a series of engagement events with each of the divisions within the Health Board which identified a wide range of actions to improve compliance with the standards and enhance patient care (summarised in the action plan at appendix 1).

The action plan highlights those improvements which it has been possible to implement to date through service modification and changes or, "just do it"; actions which are 'in progress' and those requiring additional work or resource, potentially re-engineering of service delivery and investment.

WBNSW

Audits undertaken at the start and throughout the project showed improvements in a range of nutritional and clinical parameters. It is estimated that the band 3 WBNSW undertakes duties which relieve the equivalent of 1.00 wte band 5 nurse and potentially can reduce variable pay costs, particularly in respect of agency staff bought in to meet enhanced care needs of patients with delirium. A survey of ward nursing and medical staff indicated they valued the role and acknowledged the improvement in patient care.



Following the success of this project the Scheduled Care Division has committed to fund 1wte WBNSW's for each of the 3 T&O wards in the Health Board for 2023-24. This will provide further evaluation of the role and its value in terms of patient outcomes and flow. See action plan Appendix 1

Nutrition Support Team

A lack of MDT working, clinical leadership and decision-making results in failure to address and treat nutritional risk promptly. This impacts negatively on patient care and recovery leading to increased length of stay and inefficient use of resources.

Examples include:

- Failure to provide/delay in providing artificial nutrition.
- Patients receiving no nutrition for extended periods of time (12 days plus)
- Lack of nutrition support to patients due to lack of tube placement
- Lack of staff training in placement of feeding tubes and nasal bridles
- Displacement of tubes in the community resulting in prolonged admission to hospital
- Delay in placement of PEG tubes due to lack of endoscopy slots
- Inappropriate use of Parenteral Nutrition (PN)/ placement of PICC lines

- Where PN is being delivered - increased infection rates of PICC lines and problems identified with staff skill set delivering PN.

This can be evidenced in the frequency of datix incidents relating to delays in providing clinical nutritional support for complex patients, also in morbidity and mortality reports, serious incidents, and coroner's inquest.

Argymhelliad / Recommendation

The committee is asked to note the action plan appended to the report.

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):	Nutrition and Hydration 2.5 Safe and clinically effective care 3.1 Timely access 5 Choose an item. Choose an item. Choose an item. Choose an item.
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	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. 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. 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)**	
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**	Choose an item.
• **Service Activity & Performance**	Choose an item.
• **Financial**	Choose an item.
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. Collaboration and Prevention

Patient Quality, Safety & Outcomes Committee: Action Plan

Issues	Action plan	Update (RED AMBER GREEN)	Futher action	Quality Metrics (Evaluation)	Lead responsible officer	Timeframe
Nutrition and Catering Standards: Patient Dining Review						
What we've already done/ are working on?						
*Menu not suitable for varying patients' groups (Elderly, Mental Health & Learning disability, Long stay patients)	*Establish a menu review group that support each patient group	*Mental Health and Learning disability menu review task and finish group established *New menu has been finalized and rolled out in January 2023 *Guidance around increased fibre and sugar free, caffeine free, reduce takeaway is also been reviewed within the group. *Seasonal menus are being developed switch up menu choices *New fingerfood menu introduced to paediatric menus *Introduction of new IDDSI Menu	*To have more variety on the IDDSI Menu, storage space to be reviewed * roll out finger food menu to further adult wards	*Patient surveys *Monitor uptake via Synbiotix	Senior Mental Health nurses, FM Service Improvement Manager, N&H Dietitian, SLT lead	9-12 months
Create 5 minute training videos to educate ward - based caterers	*To establish set portion sizes for patients and train catering staff on these *Ward- based caterers need regular food service and nutritional training	Training videos for staff created and being rolled out onto their I-pads to watch at the start of a shift	*Procure bespoke serving utensils required * updates to training videos in response to current events and patient satisfaction surveys	*Number of staff viewing videos *Patient surveys	Mobile Services lead, FM Service Improvement Manager, Operations managers on all sites	Apr-23
Lack of equipment and process to enable provision of hot meal during out of hours in all sites	* Agree process & training need to meet this standard across all sites * Contact procurement on cost of equipment required	*Sites now have access to cook freeze meals by Appetito which can be used OOH	To ensure this is available across all sites and that microwave ovens are in place	*number of hot meals provided OOH per site	Operations Managers across all sites	3 months
Requirement for frequent planned menu reviews	*Process mapping of the current process and responsibilities * Discuss the responsibility of dietitian in this process	Standardized review process of menus using patient feedback surveys and usage of data collected from Synbiotix of popular menu items	MDT planned reviews of menus	*patient surveys *Monitor uptake via Synbiotix *waste monitoring	FM Service Improvement Manager, Nutrition and Hydration lead dietitian	9-12 months
What Can be progressed?						
Better utilisation of Synbiotix System	*Reduce risk of patients being given the wrong snack type or drink because patient allergy and dietary requirement are not readily available. *Lack of patient details on Synbiotix *Communication about patients changing needs – improve how ward and kitchen/Ward based caterers communicate	Electronic sign off of special diets trialled on 3 sites, use of patient names. Being linked to CWS so patients can be followed from admission to discharge.	Once CWS Link has been completed , to roll out electronic sign off across all sites. Awaiting software update from Synbiotix (July)which will allow menus to be changed once clinical sign off has been completed.	Reduced Datix reports	Informatics Team, including lead Nurse for Informatics, Synbiotix, N&H Lead Dietitian	9 months
Patients lack knowledge of menu options before Ward-based caterers request meal orders and lack awareness of hospital catering service provision on admission	*Create a QR Code patient can scan to provide list of menu options and laminated bed side Menus * Create a booklet with information on catering service provision	Trial rolled out at YYF	To roll out across the Health Board	*QR codes /laminated bed side menus available across all sites * Patient satifaction	Digital communications officer, FM Service Improvement Manager, N&H Lead Dietitian	12 months

Procurement -supply chain challenges.	*Create an agreed alternative list of products to order. With the right allergens information	*Alternative product list for out-of-stock items has been created with the right allergen information. *This has streamlined back up ordering options	Standardised back up options needed	monitor out of stock via ORACLE	Procurement, Nutrition and Hydration lead Dietitian, FM Service Improvement Manager	6 months
Catering equipment & Kitchen space outdated.	* Facilities to develop a robust asset register of equipment with life cycles and regular service contracts. * Review divisional process of reporting equipment breakdown			availability of asset register	Senior Facilties Manager	12 months
* Inclusivity of drink options; limited to basic tea, coffee and squash. Same for Milk, condiments *No kosher meals. *Limited snack choice/range; Snacks served mainly Biscuits, cake, fruit.	* Engage with (Equality, Diversity and inclusion Specialist) on inclusive drinks, milk and condiment options and Kosher meals *Contact procurement for variety of specialist teas/coffees, alternative plant milk and costings	*Various additional options have been suggested by Equality, Diversity and Inclusion Specialist * Procurement have been contacted to provide costing these additional items	Approriate range of snack items to include routine, high energy and texture modified options to be available on all wards and ordered via Synbiotix; HB wide agreement needed re funding of snacks. Costings and affordibility to be agreed and options introduced	Range and service of snacks to be audited. Variety and service of drinks to be audited	FM Service improvement manager, Procurement, Nutrition and Hydration lead dietitian	12 months

Report to Quality and Patient Safety Outcomes Committee:

Nutrition and Hydration Standards

Collaboration between Dietetics and Facilities Teams

Nutrition and Hydration Standards

Health and Care standard 2.5: Nutrition and Hydration

People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury

All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients

Nutrient and food based standards which provide for the needs of a diverse hospital population of all ages, both nutritionally at risk and nutritionally well, and those with particular therapeutic and cultural requirements

All Wales Menu Framework

Provides the hospitals of Wales with a wide range of recipes to choose from. These portion specific recipes are designed to help hospitals reduce food costs whilst still producing a high quality meal for their patients

All Wales Hospital Nutrition Care Pathway

NICE CG 32 (revised) 'Nutritional Support in Adults - Oral nutrition support enteral tube feeding and parenteral nutrition'

Recommends that all acute hospitals and community should have a multidisciplinary nutrition support team.

The Journey

- September 2021 report to QPSOG on compliance to standards
- October 2021 Catering review to be undertaken, project manager to be recruited
- January – May 2022 review undertaken: Engagement events with each division led by Senior FM Manager and Facilitator
- Focus Patient Dining Services - range of issues identified see action plan
- Feb 2023 presentation to informal exec identifying nutrition and hydration themes

Themes to take Forward

- Implementation strategy to achieve compliance with the Nutrition and Catering Standards, as per Patient Dining Review action plan
- Approach to rolling out the Ward Based Nutrition Support Workers
- Corporate approach to establishing a dedicated NST

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	25 April 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	National Audit of Care at the End of Life (NACEL) Management
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Before the publication of the fourth round of the National Audit of Care at the End of Life (NACEL) outputs, Aneurin Bevan University Health Board was flagged as a potential outlier under the NACEL Management of Outliers Policy, relating to the Community data submission.

The policy being followed is in-line with Healthcare Quality Improvement Partnership (HQIP's) 'Detection and management of outliers for National Clinical Audits'. This outlines the process for identifying and dealing with outliers within the NACEL dataset.

Cefndir / Background

The National Audit of Care at the End of Life (NACEL) was commissioned by HQIP on behalf of NHS England and the Welsh Government (WG) in October 2017 and the first round of the audit took place in 2018. NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person (18+) and those important to them during the last admission leading to death in acute, community hospitals and mental health inpatient facilities in England, Wales and Northern Ireland.

NACEL is managed by the NHS Benchmarking Network (NHSBN), supported by the Clinical Leads, the NACEL Steering Group, and wider Advisory Group. The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the *five priorities for care* set out in *One Chance To Get It Right, 2014* and *NICE Guideline (NG31) and Quality Standards (QS13 and QS144).*

Currently there is no nominated Clinical lead for the NACEL audit. Therefore, the Clinical Audit Lead from Aneurin Bevan University Health Board's Clinical Audit Team was notified of the outlier status on the 16th November 2022. The data was reviewed and the Health Board were asked to identify any data errors or justifiable explanations for this result and respond via email within 25 working days. A written response was provided by the Executive Director of Nursing on 16th December 2022, which confirmed the data as accurate, thus confirming the initial designation of 'alert' outlier status for the following metric:

METRIC 2: The proportion of Category 1 deaths where there was documented evidence that the patient who was dying had an individualised plan of care addressing their end-of-life care needs, out of all Category 1 deaths.

Asesiad / Assessment

A bespoke dashboard summarised the results of the fourth round of NACEL for the Health Board's submission under eleven key themes (see Appendices). The report includes the Health Board's summary scores for each of the key themes, compared to the whole sample results. NACEL has published information of comparative performance on the NACEL Summary Scores that will identify providers. The 'alert' level status will be noted in the Health Board's bespoke dashboards which was circulated to participants in February 2023.

NACEL has proceeded to stage five of the Management of Outliers Policy. The next steps involve Welsh Government and HQIP being notified of the organisation's confirmed 'alert' status. Unlike for 'alarm' level outliers, the Welsh Government and HQIP are not mandating a formal NHS Health Board notification or response process for alert level.

Health Inspectorate Wales (HIW) does not act as regulator and cannot take regulatory action in relation to NHS providers. However, HIW can request information on the actions taken by organisations to ensure safe services are being delivered. The expectation is that Health Boards should use 'alert' information as part of their internal quality monitoring information. No further action will be required of alert level providers by NHS Benchmarking Network.

These steps were further outlined on a call between the NACEL team and the Assistant Director for Quality and Patient Safety on the 26th January 2023. The Management of Outliers process has now been closed.

Aneurin Bevan University Health Board have acknowledged the outlier status in the recent round of NACEL data publication. The Health Board's Standard Operating Procedure 'To standardise the approach to reviewing, investigating and responding to outlier notification' has been followed. The Health Board is confident

that the data accurately reflects the standard of documentation of the care provided to the patients included in the cohort. The outlier element is in regards to the lack of Individualised Care Plans within the Community.

We have recognised that Aneurin Bevan University Health Board are not currently using the Care Decision Tool routinely to capture the quality of care delivered. We are working towards implementing this throughout the Heath Board. This has had a detrimental impact on the quality of the data submitted as part of the audit. At our End-of-Life Care Board (EOLCB) discussions have confirmed that we do not believe this reflects the standard of care provision at the end of life.

The Health Board's EOLCB has recognised that this is a priority for the organisation in the coming year. The Executive Nursing Director is now chairing the EOLCB and will be working closely with the operational Divisions to roll this out and to provide training around the use of this tool. Once this has been achieved, we are confident that this will have a significant impact on the standard of documentation which will be reflected in the next submission for NACEL.

The fourth round of the audit summary report covering England and Wales, acute and community hospital providers, will be published in July 2023 following approval by the audit funders, NHS England and WG. This report will contain the NACEL recommendations. As part of the NACEL data publication, organisations are encouraged to share learning. Following publication in July, a full report will be produced with an action plan for remedial action. Work is underway with palliative care, Care After Death, bereavement services, primary care and clinicians to develop a task and finish group to progress this work, the gap in clinical leadership will also be considered

There will be a pause on data collection during 2023, whist the audit undergoes a period of redesign. Data collection will commence in 2024. A pause on data collection during 2023 will provide time for the Health Board to develop and implement an action plan to improve outcome data for future years and improve compliance with the NACEL audit.

A revised and reenergised audit will commence in 2024. NHS Benchmarking Network will continue to deliver NACEL for a further three years. The audit will be delivered under a new contract, with plans to focus the audit on quality improvement (QI). NACEL 2024 will:

- focus on ten key metrics to minimise data burden,
- draw attention to health inequalities in relation to specified measures,
- introduce more frequent reporting so providers can monitor developments more regularly and respond quicker to change
- have revised outputs to deliver one concise national report comprising five national recommendations, as well as hosting an online interactive QI tool, regional events and case studies.

Argymhelliad / Recommendation

Note the assurance provided by the ongoing work by the EOLCB and the Corporate Audit Team.

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):	4.1 Dignified Care 6. Individual care 5.1 Timely Access 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Dying Well as part of life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item.
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 Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	For information, an Excel spreadsheet containing the national mean, the Health Board's mean, the standard deviation limits and a copy of the individual responses for each of your submission's Case Note Reviews for this metric is attached.
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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Choose an item.

Appendix One - Project outputs

This bespoke dashboard presents the results for the Health Board's submission. The table shows the components of the audit in which Aneurin Bevan University Health Board participated, together with the number of Case Note Reviews, Quality Surveys and Staff Reported Measures which were completed for the submission.

Acute

Submission code	Submission name	Hospital/ Site	Case Note Review	Staff Reported Measure	Quality Survey	Audit Summary
NC478	Aneurin Bevan University Health Board - Acute	Yes	50	7	13	Yes

Community

Submission code	Submission name	Hospital/ Site	Case Note Review	Staff Reported Measure	Quality Survey	Audit Summary
NC460	Aneurin Bevan University Health Board - Community	Yes	35	0	0	Yes

This dashboard compares the results for the Health Board submission to all acute and community hospitals in England and Wales taking part in the fourth round of NACEL. Results from the four elements of the audit are presented together. The following key is used in the chart titles to show the source of each indicator:

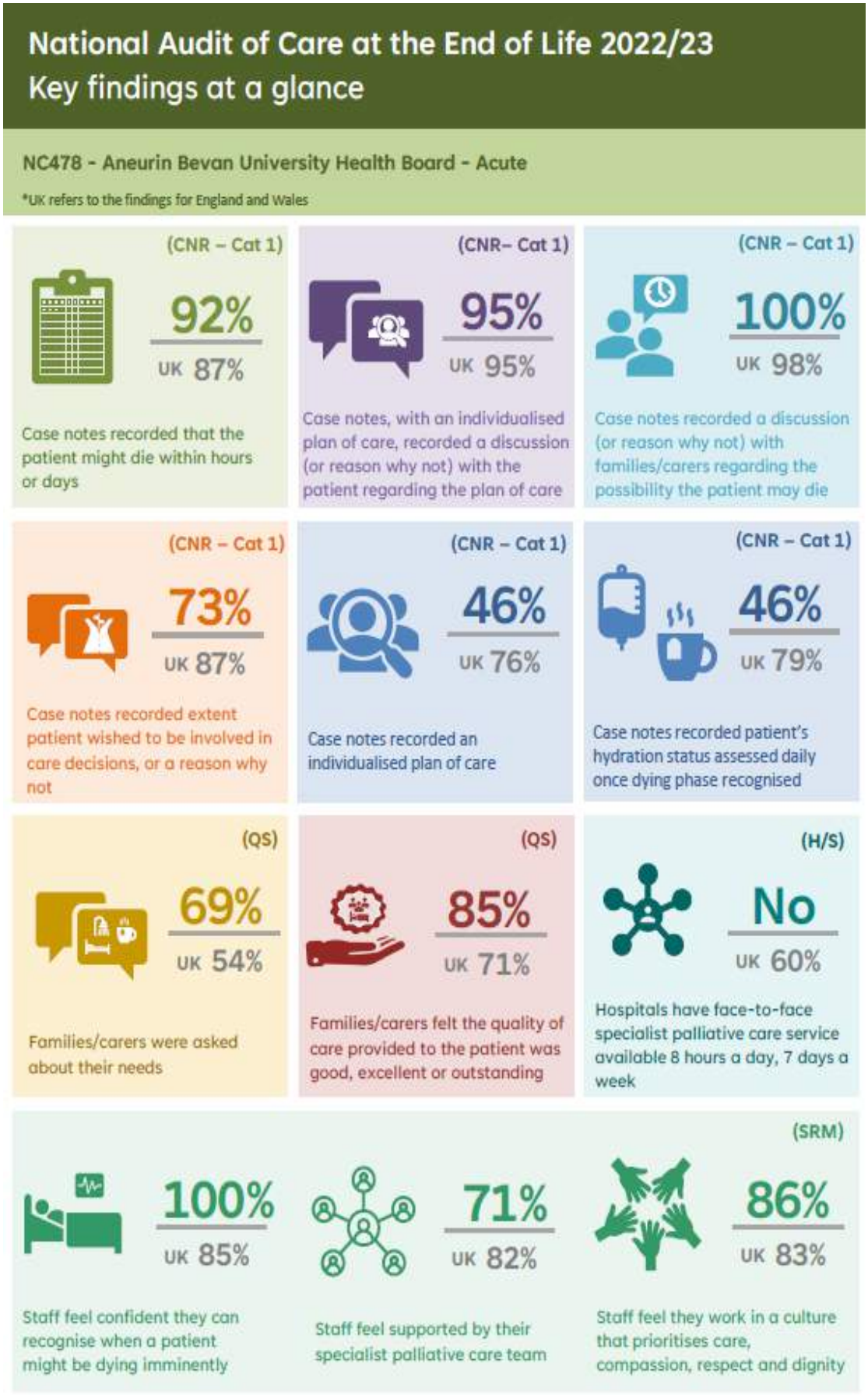
- H/S = Hospital/site level questions included in the organisational level audit
- CNR = Case Note Review
- QS = Quality Survey
- SRM = Staff Reported Measure

The information is presented thematically in eleven sections, covering the *five priorities for care* and other key issues. The themes are**:**

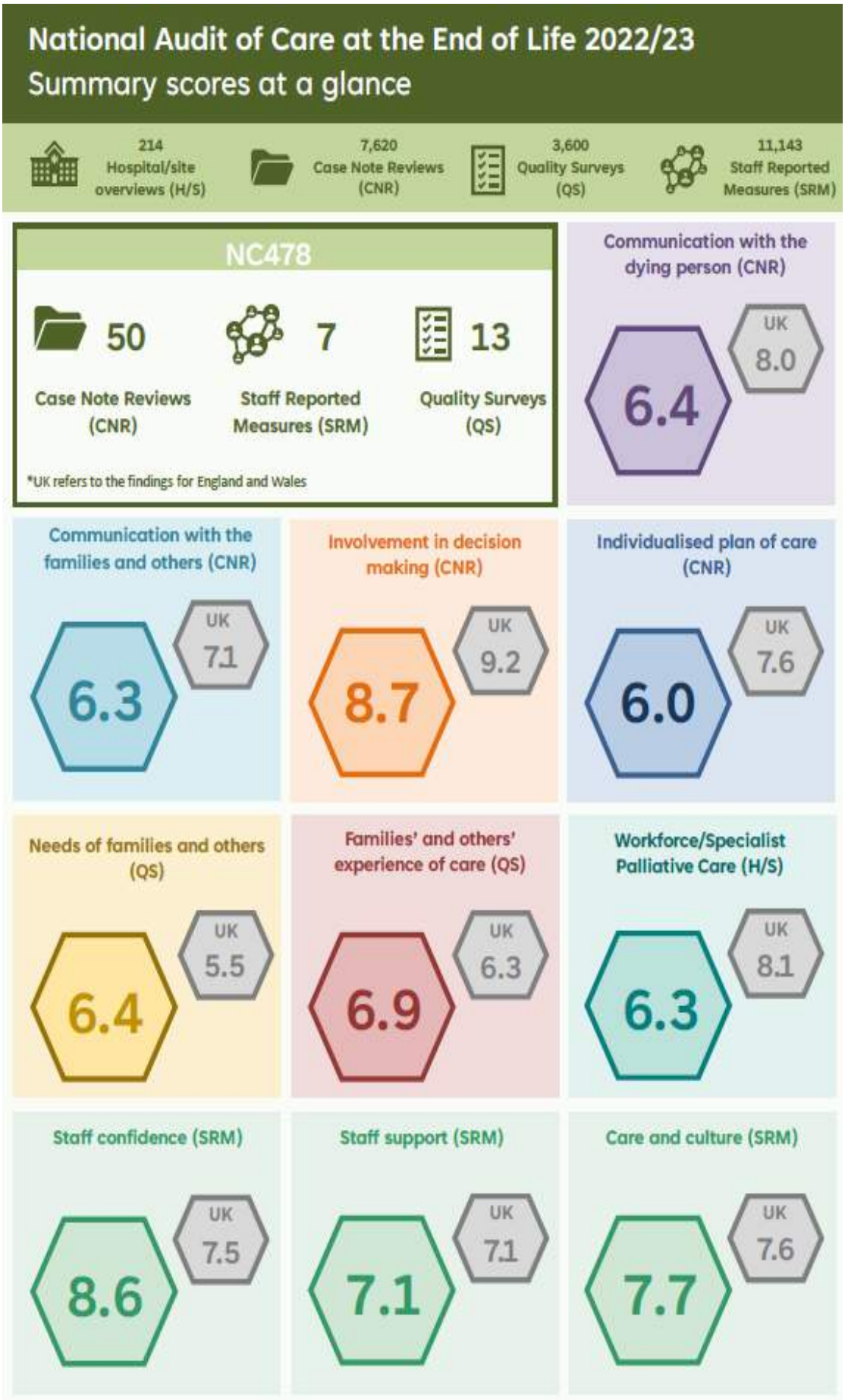
1. **Recognising the possibility of imminent death**
2. **Communication with the dying person**
3. **Communication with families and others**
4. **Involvement in decision making**
5. **Individualised plan of care**
6. **Needs of families and others**
7. **Families' and others' experience of care**
8. **Workforce/specialist palliative care**
9. **Staff confidence**
10. **Staff support**
11. **Staff care and culture**

Appendix Two – Key findings at a glance (Acute)

Appendix Two – Key findings at a glance (Acute)

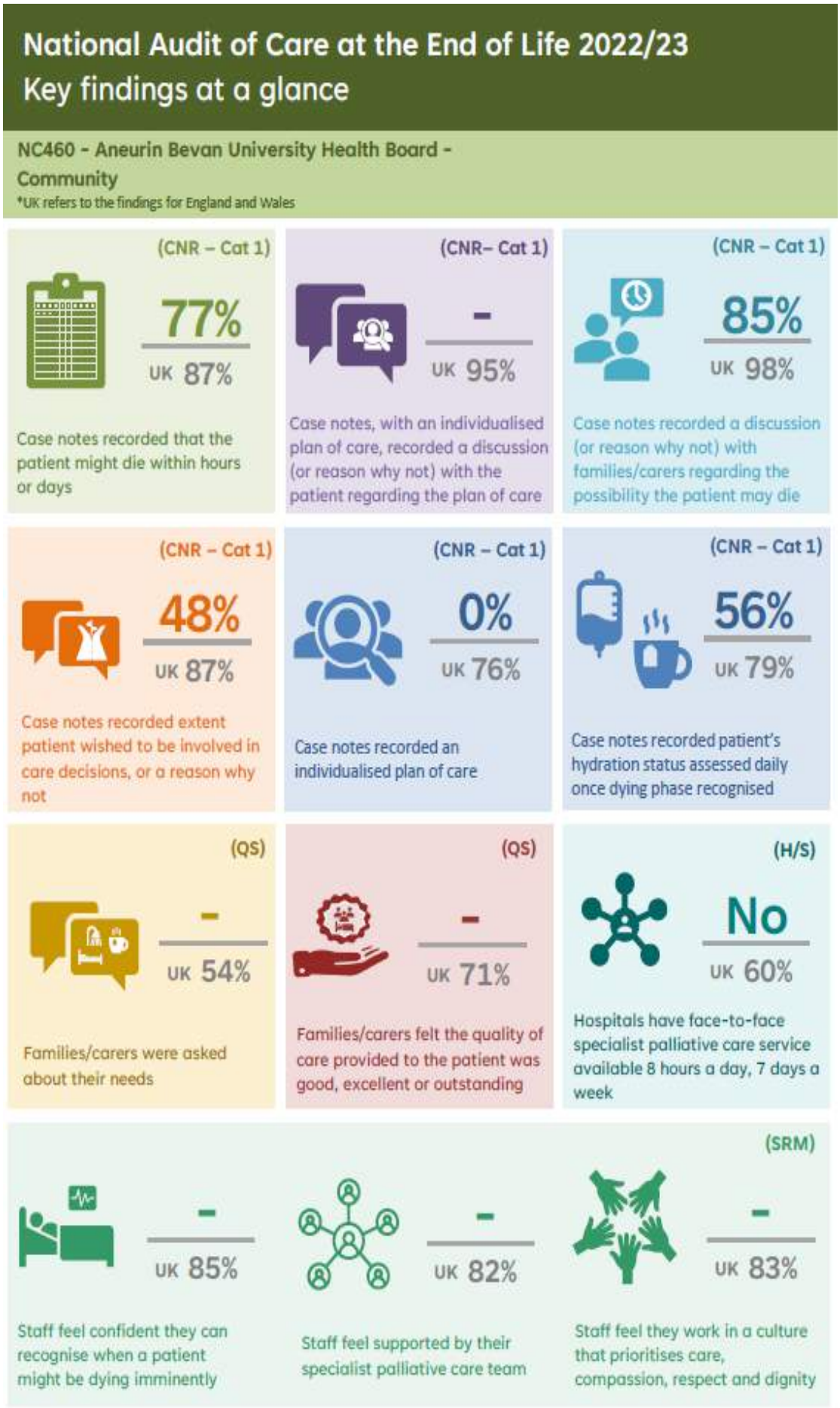


Appendix Two – Key findings at a glance (Acute)



Appendix Three – Key findings at a glance (Community)

Appendix Three – Key findings at a glance (Community)



Appendix Three – Key findings at a glance (Community)

National Audit of Care at the End of Life 2022/23
Summary scores at a glance

214 Hospital/site overviews (H/S)

7,620 Case Note Reviews (CNR)

3,600 Quality Surveys (QS)

11,143 Staff Reported Measures (SRM)

NC460

35 Case Note Reviews (CNR)

0 Staff Reported Measures (SRM)

0 Quality Surveys (QS)

*UK refers to the findings for England and Wales

Communication with the dying person (CNR)

2.4 | UK 8.0

Communication with the families and others (CNR)

3.6 | UK 7.1

Involvement in decision making (CNR)

8.4 | UK 9.2

Individualised plan of care (CNR)

5.9 | UK 7.6

Needs of families and others (QS)

- | UK 5.5

Families' and others' experience of care (QS)

- | UK 6.3

Workforce/Specialist Palliative Care (H/S)

- | UK 8.1

Staff confidence (SRM)

- | UK 7.5

Staff support (SRM)

- | UK 7.1

Care and culture (SRM)

- | UK 7.6

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	25 April 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	A National Review of Consent to Examination & Treatment Standards in NHS Wales
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

A number of significant clinical negligence claims have been submitted to the Welsh Risk Pool Committee (WRP) relating to failures to provide patients with information and failures to document what information was provided. This included discussions that took place regarding the benefits and risks (including material risks) of the proposed treatment and the benefits and risks of any available alternative treatments (including no treatment).

The WRP committee requested that the WRP Safety & Learning Team undertake a review of organisational policies and their clinical application, for obtaining informed consent to examination or treatment with a particular focus on identified areas. An All-Wales summary report has been produced for the outputs from these assessments. Recommendations have been provided to enable organisations to develop an improvement plan to address areas for development.

Cefndir / Background

The scope of the review aimed to assess Health Board policies and their clinical application against the All-Wales Consent to Examination or Treatment Model policy. In May 2021, WRP produced an assessment tool that outlined areas for assessment, starting with collection by the organisations of the evidence outlined in the assessment tool. When completing the assessments, organisations were required to scrutinise and interrogate their consent processes. This enabled local teams to familiarise themselves with the WRP Standard and identify source

evidence which demonstrated compliance or achievement against each area for assessment.

Clinical areas selected for the focus of the assessment in acute organisations were unscheduled orthopaedics, elective endoscopy and elective gynaecology. Due to the impact of the pandemic this work was disrupted and recommenced in September 2022. WRP Consent Assessment Team reviewed the information supplied by each organisation and provided the assessment material back to designated contacts for their further analysis, augmentation where required and final submission.

This report aims to improve patient safety and compliance in relation to the process for sharing information and obtaining informed consent to examination and treatment. The report followed an evidence-gathering exercise against the published WRP Standard. Aneurin Bevan University Health Board provided evidence against each Area of Assessment. This report provides draft findings for the Health Board and has been circulated for comments and factual accuracy considerations. A final copy of the report will be shared with the relevant action plan included to assist with future reviews. The final report is anticipated to be published in March 2023.

Asesiad / Assessment

Aneurin Bevan University Health Board provided an honest reflection of our current position and submitted comprehensive evidence covering the topics required in the standards. As this assessment was supported by the Assistant Director for Quality and Patient Safety, the Health Board asked WRP to acknowledge this post remained vacant for four months throughout the assessment period. The new post holder has been reviewing and improving consent to examination and treatment processes and will work with Divisions to implement the findings in this report.

The report has identified a number of proposed recommendations. These have been used to develop an action plan which addresses the findings and supports the prioritisation of improvement activity in this topic area. Having considered the evidence submitted against each area for assessment, the Review Team have determined an overall limited assurance rating for the Health Board. The following themes have been highlighted in the report and will be used to improve consent to examination and treatment processes.

Policy Content
WRP declared compliance with this standard as the Health Board's Policy for consent to examination or treatment was updated in April 2022 and adapted to follow the standard All-Wales Model Policy. Good practice was acknowledged that consent to examination and treatment documentation and governance forms part of the Clinical Standards and Effectiveness Group (CSEG) agenda, thus ensuring there is an accountable governance structure which covers all clinical and support services.

Consent Forms
The current practice in obtaining a patient's consent for treatment was reviewed and this standard was given partial compliance. Consent forms were being utilised throughout the Health Board and there are current principles in practice for obtaining a patient's consent prior to treatment or intervention within departments and services. Whilst CSEG is responsible for consent documentation, WRP highlighted the lack of a formal documented governance process for the development and

approval of locally produced procedure specific consent forms (PSCF's). It was noted the consent intranet page on PSCF's needed to be updated to reflect the up-to-date position in Wales and the organisation.

Following the recommendations, the WRP standard regarding use of PSCF's will be cascaded to Divisional Triumvirates and Clinical Specialities. A formally approved procedure will be produced which will set out the governance process in relation to the development and approval of local procedure specific consent forms (PSCF's). This will include developing a supporting document detailing the process for development and approval of local patient information leaflets, working with the Patient Experience Team and via CSEG. This will be produced by September 2023. The website will be updated to reflect this immediately.

Training in Consent

The new e-learning module on consent in Wales has been made accessible to all appropriate staff groups and can be accessed via ESR. The report recognised training on consent was covered in the Junior doctor induction programme. The Health Board provides training within the Mental Capacity Act as part of its consent programme. The report noted there is a lack of evidence of induction and ongoing training of all appropriate staff groups on consent issues specifically relating to patients who are deemed to have capacity and documented partial compliance with this standard.

WRP have advised the need to implement a requirement for all clinicians who take consent from patients to evidence completion of a recognised training programme. It is recommended that the frequency of this training should be at least once per revalidation cycle for the relevant professional group (e.g., every five years for doctors). It being accepted that such training is more relevant to some groups than others and could be either via the national e-learning consent training package or an approved in-house face to face training session.

The consent intranet page will be updated to reflect access to EIDO Educate. Health Board representatives will attend the formal launch of the NHS Wales Consent to Examination & Treatment e-learning programme event in March 2023. The e-learning module will be promoted and embedded as part of the consent training throughout Aneurin Bevan University Health Board. It has been advised that completion of the e-learning module should form part of appraisal and revalidation. Divisions will need to plan how all employees who are involved in consent will complete the online training and monitor compliance.

Work to meet this assessment is already underway with Medical Education Leads. The Junior doctor teaching programme includes a session on consent led by the GMC. Training is underway at all sites as part of the teaching and induction programme using the new e-learning training. Consent training is carried out in foundation programmes. A Grand Round training session has taken place with GMC. Compliance with online MCA level 1 and 2 MCA training to be monitored and reported to relevant corporate committee.

Consent Process for Adults

The organisation has adopted the All-Wales Model Policy for consent to examination or treatment and adapted it into organisational format. There are a number of speciality guidelines which underpin the Consent Policy and require urgent review

and this has been escalated to CSEG. Partial compliance was granted for this standard.

Consent Process for Children & Young People
The specific guidance for obtaining consent involving children and young people adult patients is included in the Health Board's policy. Partial compliance with this standard will be improved by ensuring any additional guidance on paediatric issues that are covered in separate documents and checklists, are reviewed and ratified. This includes working with Public Health School nursing.

As part of the recommendations there will be an immediate review of speciality guidelines for adults, children and young people which underpin the Consent Policy. This will involve engaging with Divisions to carry out a scoping exercise and review current consent processes within their specialities. Divisions will be asked to update their consent process in accordance with the new Aneurin Bevan Health Board Policy: Policy for Consent to Examination or Treatment (in line with the All-Wales Model Policy). Clinicians who provide care for Children and young people (CYP) fully consider whether a child is Gillick/Fraser competent (depending on circumstances). Wherever possible clinicians work jointly with both the CYP and person with parental responsibility to gain consent.

Patient Information
Partial compliance was declared for this standard. It was noted there is a clear link to the Health Board's EIDO patient information platform from the consent intranet page. In February 2021, the Corporate QPS team carried out a gap analysis to identify the documentation used by directorates during the consent process; EIDO leaflets, Professional Body and locally developed patient information leaflets. Usage reports produced by EIDO confirmed which specialties are using EIDO patient information leaflets. The exercise has demonstrated compliance with EIDO usage or suitable National alternatives but highlights the need for further consideration of compliance with Welsh Language standards where leaflets other than EIDO are used.

Although CSEG oversees the development of locally produced patient information leaflets, WRP stated there needs to be a formally documented and approved governance process for developing and approving such local leaflets. Currently, the organisation does not have a database of patient information leaflets. WRP highlighted the risk of non-compliant leaflets entering circulation and increase the risk of harm and associated litigation.

It was noted that EIDO patient information leaflets are compliant with Welsh Language Standards, but it was unclear how locally developed patient information leaflets were translated into the Welsh Language. Evidence demonstrated that patient information leaflets were available for staff to give to patients, but lack of audit data did not allow measurement of the usage.

The Health Board will implement a process to comply with the 'Criteria for use of Procedure-specific Patient Information Leaflets'. A document will be developed detailing the process for the development and approval of local patient information leaflets by working with the Patient Experience Team. Further work will include implementing a database used for patient information leaflets. This will be carried out over the next six months.

As an ongoing process, if there is a need to deviate from the use of an EIDO patient information leaflet, or where no EIDO leaflet or compliant alternative is available, we will ensure we are notifying WRP. We will ask Divisions to monitor and address any shortfalls in the use, provision of and documentation of patient information leaflets. The Corporate Quality & Patient Safety (QPS) gap analysis will be updated to capture this shortfall of leaflets and report to CSEG for monitoring.

Monitoring of the Consent Process

Past audits and reviews of the consent process were submitted to WRP. However, during the last twelve months there was a lack of evidence of any consent audits, which resulted in partial compliance with this standard. The Health Board has identified how future audits will be undertaken using the Audit Management and Tracking system (AMaT). Reports will be presented via CSEG and reported to Patient Safety and Quality Outcome Committee. Identified shortfalls will form part of an action plan using AMaT.

WRP have advised to undertake a peer review of the organisation's consent process using the peer review tool developed on an All-Wales basis. This will be implemented using AMaT and in addition to monitoring the organisation's consent process it will enable the organisation to comply with Consent to Treatment - monitoring of compliance with the requirements of consent to treatment documentation (which may be in patient records or on a consent form) of the provision of procedure specific patient information leaflets.

The Clinical Audit Team are working with Divisions to produce a Clinical audit plan, which will include Consent Audits, providing assurance that the Health Board's Consent Policy is being implemented. The standardised audit proforma available on AMaT will be used to conduct consent to treatment audits. This will be completed throughout 2023. The corporate QPS team can support an annual peer review and report using the All-Wales peer review tool.

WRP noted the Health Board's consent intranet page contained useful information for healthcare professionals. Following many of the findings in this report, the intranet page will be updated to reflect the findings and recommendations.

Following the report recommendations, these additional actions will take place over the next six months to improve compliance with all of the standards:

- Work with the Health Board's communication team and develop the intranet page to ensure that the EIDO Healthcare link is easy to find and a prominent feature on our intranet Website under Patient Information Leaflets.
- A memo will be produced to signpost how to access EIDO patient information leaflets. This will also give the appropriate advice; the minimum standard is the use of the EIDO Healthcare published Patient Information Leaflet facilitated through the All-Wales download centre or professionally recognised procedure specific leaflets including leaflets from the Royal Colleges or Professional Associations.
- EIDO download reports will be used to identify Health Board usage across specialities and reported back to Divisions.
- Divisions to feedback lack of availability of an EIDO leaflet or the unsuitability of its use, so this can be reported back to WRP.
- A newsletter is being produced by the Corporate Quality & Patient Safety Team to raise awareness of the new Health Board Consent Policy and link to the

updated Consent Page. It will include the process for development of PSCF's and governance arrangements via CSEG.
- Update the consent intranet page's information on training to make reference to the new e-learning training on consent in Wales and include the link.
- Update the gap analysis of all patient information leaflets used in the two-stage consent process.
- An action plan has been developed to address shortfalls identified in this assessment and implement the recommendations from this preliminary report. These actions will need to be carried out by Divisions within the Health Board.
- A follow up meeting has been arranged with the WRP Consent Assessment Team in May 2023, to discuss the internal report's findings at length and look at best practice.
- The Assistant Director for Quality and Patient Safety is now a member of the All-Wales Consent to Treatment Group and will continue to keep up to date with WRP advice and recommendations.
- There is a Consultant Surgeon with an interest in consent who will facilitate and support the recommendations from this report within clinical specialities.
- Work collaboratively with WRP, other Welsh Health Boards and Trusts to progress an electronic solution for consenting patients.

A detailed action plan has been completed and sent back to WRP in February 2023 following the preliminary report. This has been attached to the document and will be updated to reflect the actions in this report.

Argymhelliad / Recommendation

The Committee is asked to note the assurance provided by the ongoing work on Consent to Examination & Treatment Standards. All themes with partial compliance with standards are being worked through as part of the detailed action plan to ensure recommendations are being implemented.

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):	Governance, Leadership and Accountability 3.1 Safe and Clinically Effective Care 6.2 Peoples Rights 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 prioritise areas where evidence shows take up of services is lower or outcomes are worse

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	A National Review of Consent to Examination & Treatment Standards in NHS Wales. A Report by the Welsh Risk Pool Safety and Learning Team. Draft Report Jan 2023.
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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs 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

ACTION PLAN FOR CONSENT	
Reference	**A National Review of Consent to Examination & Treatment Standards in NHS Wales**
Health Board	**Aneurin Bevan University Health Board**
Lead Officer for Action Plan	**Leeanne Lewis – Assistant Director for Quality and Patient Safety**
Date action plan commenced	**16th February 2023**
Synopsis of Concern	Significant clinical negligence claims have been submitted to the Welsh Risk Pool Committee (WRP) relating to failures to provide patients with information and failures to document what information was provided. This included discussions that took place regarding the benefits and risks (including material risks) of the proposed treatment and the benefits and risks of any available alternative treatments (including no treatment). The WRP committee requested that the WRP Safety & Learning Team undertake a review of organisational policies and their clinical application, for obtaining informed consent to examination or treatment with a particular focus on the areas identified above. An All-Wales summary report has been produced for the outputs from these assessments. Recommendations have been provided to enable organisations to develop an improvement plan to address areas for development. The scope of review was to assess Health Board policies and their clinical application against the All-Wales Consent to Examination or Treatment Model policy. In May 2012, WRP produced an assessment tool that outlined areas for assessment, starting with collection by the organisations of the evidence outlined in the assessment tool. When completing the assessments, organisations were required to scrutinise and interrogate their consent processes. This enabled local teams to familiarise themselves with the WRP Standard and identify source evidence which demonstrated compliance or achievement against each area for assessment. Clinical areas selected for the focus of the assessment in acute organisations were: unscheduled orthopaedics, elective endoscopy and elective gynaecology. Due to the impact of the pandemic this work was disrupted and recommenced in September 2022. WRP Consent Assessment Team reviewed the information supplied by each organisation and provided the assessment material back to designated contacts for their further analysis, augmentation where required and final submission. The following table details the recommendations from the WRP report with an action plan that needs to be carried out by Divisions within Aneurin Bevan University Health Board.

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	Deadline date for completion & insert date of completion
THEME – Consent Policy Undertake an immediate review of speciality guidelines for adults, children and young people which underpin the Consent Policy		Engage with Divisional triumvirates to carry out scoping exercise and review current consent process within their specialities. Divisions to update consent process in accordance with the new Aneurin Bevan Health Board Policy: Policy for Consent to Examination or Treatment (in line with the All-Wales Model Policy). Divisional Clinical audit plan to include Consent Audits, providing assurance that the Health Board's Consent Policy is implemented. Update gap analysis for consent audit carried out.	AMaT implemented. Directorate consent to treatment audits, to be reported via AMaT. Results presented to Clinical Standards and Effective Group. Clinicians who provide care for Children and young people (CYP) fully consider whether a child is Gillick/Fraser competent (depending on circumstances). Wherever possible clinicians work jointly with both the CYP and person with parental responsibility to gain consent.	Divisional Triumvirates and Governance Leads	August 2023

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	Deadline date for completion & insert date of completion
THEME – Patient consent forms Develop a formally approved document setting out the governance process for the development and approval of local patient information leaflets. Develop a formally approved procedure setting out the organisation's governance process in relation to the development and approval of local procedure specific consent forms (PSCF's). Develop a database of patient information leaflets used within the consent process. Thereafter monitor and address any shortfalls in the use, provision of and documentation of patient information leaflets.		Cascade WRP standard regarding use of PSCF's to Divisional triumvirates. A document will be developed detailing the process for the development and approval of local patient information leaflets. Development and approval of local PSCF's is via Clinical Standards and Effective Group (CSEG). A database will be developed for PCSF's approved by this Group. Consent audits conducted by Directorates. Corporate Quality & Patient Safety (QPS) gap analysis to be updated to monitor shortfall of leaflets, report to Clinical Standards and Effectiveness Group for monitoring.	Newsletter being produced by Corporate Quality & Patient Safety Team to raise awareness of new Health Board Consent Policy and link to updated Consent Page. It will include the process for development of PSCF's and governance arrangements via CSEG. Update gap analysis of all patient information leaflets used in the two-stage consent process. The exercise has demonstrated compliance with EIDO usage or suitable National alternatives but highlights the need for further consideration of compliance with Welsh Language standards where leaflets other than EIDO are used.	Divisional Triumvirates and Governance Leads Clinical Standards and Effective Group (CSEG).	August 2023

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	Deadline date for completion & insert date of completion
THEME – Patient information leaflets Put a process in place to comply with the 'Criteria for use of Procedure-specific Patient Information Leaflets following publication of RMA2020-01' namely - Where an organisation wishes to deviate from the use of an EIDO patient information leaflet, or where no EIDO leaflet or compliant alternative is available, this will need to be notified via email to consenttreatment@wales.nhs.uk Monitors and addresses any shortfalls in the use, provision of and documentation of patient information leaflets.		Work with the Health Board's communication team and Intranet team to ensure that EIDO is an easy to find / prominent feature on our intranet Website under Patient Information Leaflets. Update the intranet info on EIDO and produce a memo for how to access it and ensure it is easy to see on the webpage (pulse and QPS webpages) Divisions to feedback lack of use of an EIDO leaflets used for consent and report to QPS team and WRP.	Memo being produced to signpost EIDO patient information leaflets and how to access. EIDO download reports are available to identify Health Board usage across specialities. Update gap analysis of all patient information leaflets used in the two-stage consent process	Corporate QPS team Divisional Triumvirates and Governance Leads	May 2023 September 2023

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	Deadline date for completion & insert date of completion
THEME – Health Board's Intranet page Update the consent intranet page PSCF guidance information. Update the consent intranet page's information on training to make reference to the new e-learning training on consent in Wales.		Corporate Quality and Patient Safety team will update the Health Board's Consent Page. This includes updated advice on PSCF guidance information. The consent page will be updated to include the link to the new e-learning training on Consent in Wales. Work with communication team and Intranet team to ensure that EIDO is an easy to find / prominent feature on our intranet Website under Patient Information Leaflets. Update the intranet info on EIDO and produce a memo for how to access it and ensure it is easy to see on the webpage (pulse and QPS webpages)	Newsletter being produced by Corporate Quality & Patient Safety Team to raise awareness of new Health Board Consent Policy and link to updated Consent Page, once it has been updated, it will include the process for development of PSCF's and links to training. Memo being produced to signpost EIDO patient information leaflets and how to access.	Corporate QPS team Health Board Comms Team	September 2023

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	Deadline date for completion & insert date of completion
THEME – Training Implement a requirement for all clinicians who take consent from patients to evidence completion of a recognised training programme. It is recommended that the frequency of this training should be at least once per revalidation cycle for the relevant professional group (e.g., every 5 years for doctors), it being accepted that such training is more relevant to some groups than others. This could be either via the national e-learning consent training package or an approved in-house face to face training session.		The online training module on ESR (NHS Wales – Informed Consent to Examination or Treatment Course) is available to all Health Board employees. All employees who are involved in consent are required to complete the online training Compliance to be monitored via Divisions. Completion of e-learning module to form part of appraisal and revalidation. Attend the formal launch of the NHS Wales Consent to Examination & Treatment e-learning programme event in March 2023. Raise further awareness of the e-learning module following the launch. Embed this as part of the consent training throughout Aneurin Bevan University Health Board.	The Junior doctor teaching programme includes a session on consent led by the GMC. Training is underway at all sites as part of the teaching and induction programme using the new ESR training. Consent training in foundation programmes. A Grand Round training session has taken place with GMC. Compliance with online MCA level 1 and 2 MCA training to be monitored and reported to relevant corporate committee.	Work with Medical Education Leads to continue training programmes. Divisions to review how training is recorded on ESR.	September 2023

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	Deadline date for completion & insert date of completion
THEME – peer review Undertake a peer review of the organisation's consent process using the peer review tool developed on an All-Wales basis. In addition to monitoring the organisation's consent process it will enable the organisation to comply with requirement number 6 of the WRP RMA 2020-01 Consent to Treatment - monitoring of compliance with the requirements of consent to treatment documentation (which may be in patient records or on a consent form) of the provision of procedure specific patient information leaflets. Provides feedback on the audit results to both individuals and more generically in order to initiate improvements.		Action plan for audits to be developed for 2023 to include Consent to Treatment audits for directorates, reported via AMaT and results presented to Clinical Standards and Effective Group. Using All Wales Peer Review Tool. Corporate QPS team to conduct annual audit to carry out an annual peer review and report using the All-Wales peer review tool.	Corporate QPS audit conducted in 2020. Audit to be carried out locally by Directorates. Results, actions and improvements to form part of quality improvement plans from local audits for Directorates.	Divisional Triumvirates and Governance Leads	August 2023

Status of action:

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

Cydsynio i Archwiliad a Thriniaeth
Consent To Examination & Treatment

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Nicola Prygodzicz
Chief Executive
Aneurin Bevan University Health Board

via email only

Date: 28th March 2023

Your Ref:

Our Ref: Final WRP Consent Report

Dear Nicola,

We are pleased to provide a final copy of the National Review of Consent to Examination & Treatment Standards in NHS Wales. This includes any amendments made following comments received after publication of the draft report. It also includes a copy of the action plan submitted by your organisation in response to the draft recommendations.

We would like to take this opportunity of thanking all members of staff within your organisation who have supported the collation and submission of evidence to the review team.

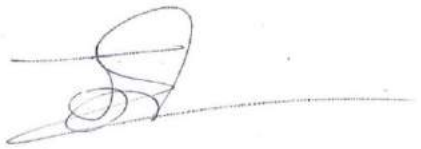
Issues relating to consent to examination & treatment continue to represent a significant proportion of the litigation profile seen in NHS Wales claims and redress cases. Therefore, the Welsh Risk Pool will continue to monitor progress and developments in this area.

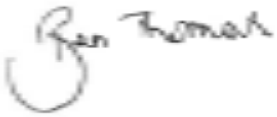
An overarching all-Wales report, outlining the national findings, will be shared with Welsh Government and other national stakeholder bodies. This report is intended to be published in May 2023 after ratification by the Welsh Risk Pool Committee.

Your organisation is already represented on the All-Wales Consent to Examination & Treatment Group and we hope that you find this group beneficial in supporting your quality improvement work in this area. During 2023 and 2024, following the successful launch of the Consent E-learning training programme, the national team will be considering the options available to support digital consent.

If you would like Dr Thomas, or one of the national team, to attend a committee or group meeting within your organisation in relation to the topic of consent, please contact the team directly via email at consenttreatment@wales.nhs.uk.

Yours faithfully,





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

A National Review of Consent to Examination & Treatment Standards in NHS Wales

A Report by the Welsh Risk Pool Safety and Learning Team

Aneurin Bevan University Health Board

Report March 2023

Cydsynio i Archwiliad a Thriniaeth
Consent To Examination & Treatment

Gwella Diogelwch Cleifion Trwy Ddysgu
Improving Patient Safety Through Learning

A National Review of Consent to Examination & Treatment Standards in NHS Wales

A Report by the Welsh Risk Pool Safety and Learning Team

March 2023

About this Report

This report is intended for health bodies within NHS Wales, with the aim to improve patient safety and compliance in relation to the process for sharing information and obtaining informed consent to examination and treatment.

The report follows an evidence-gathering exercise against the published Welsh Risk Pool Standard. Each health body was invited to provide evidence and populate a structured template against each Area of Assessment.

This report provides draft findings for each health body and is circulated for comments and factual accuracy considerations.

The report identifies a number of proposed recommendations. These are shared to enable each organisation to develop an action plan which addresses the findings and supports the prioritisation of improvement activity in this topic area.

This final copy of the report has taken account of comments and points of factual accuracy submitted by the organisation. Additionally, the action plan submitted by the organisation to address the recommendations has been included.

Evidence Gathering	May 2021 – Sep 2021
Pause due to pandemic	Oct 2021 – Sep 2022
Evidence Gathering Update	Oct 2022 – Dec 2022
Draft Findings shared	January 2023
Action Plans Received	February 2023
Final Report Published	March 2023

Version
ABUHB Report VFinal1

CONTENTS

1 Purpose of Review

1.1 A number of significant clinical negligence claims submitted to the Welsh Risk Pool Committee (WRP) relate to failures to provide patients with information and failures to document what information was provided.

1.2 In particular, the discussions that took place regarding the benefits and risks (including material risks) of the proposed treatment and the benefits and risks of any available alternative treatments (including no treatment).

1.3 The WRP committee has requested that the Welsh Risk Pool Safety & Learning Team undertake a review of the organisations policies and their clinical application, for obtaining informed consent to examination or treatment with a particular focus on the areas identified above.

1.4 Outputs from the assessment will be an All-Wales summary report and individual reports for each of the organisations assessed. The reports will provide recommendations to enable organisations to develop an improvement plan to address areas for development.

2 Scope of Review

2.1 The aim is to assess the policies and their clinical application in Health Bodies against the All-Wales Consent to Examination or Treatment Model policy. The WRP has produced an assessment tool that outlines the areas for assessment. This was circulated to the organisation's executive and operational leads for consent to assist organisations in identifying the evidence required to be submitted as part of the assessment.

2.2 The assessments commenced in May 2021 starting with the collection by the organisations of the evidence outlined in the assessment tool. The terms of reference included the opportunity for site visits and staff interviews to consolidate evidence.

2.3 By completing the assessments, organisations were required to scrutinise and interrogate their consent processes. This enabled local teams to familiarise with the WRP Standard and identify source evidence which demonstrated compliance or achievement against each area for assessment.

2.4 The evidence submitted by all organisations was comprehensive and covered the topics required in the standard. Audits on consent provided an honest reflection of each organisations' own current position. This meant that further site visits were not required.

2.5 The clinical areas selected for the focus of the assessment in acute organisations were:

- Unscheduled Orthopaedics
- Elective Endoscopy
- Elective Gynaecology

2.6 The review was disrupted due to the impact of the pandemic and the WRP Committee agreed to recommence the work in this area on 21st September 2022. The Welsh Risk Pool Consent Assessment Team subsequently reviewed the information supplied by each organisation and provided the assessment material back to designated contacts for their further analysis, augmentation where required and final submission. The team did not apply an overall outcome for each standard at that time, as the process was intended to be formative. Several comments were made from the team making suggestions for change or alternative sources of evidence.

2.7 A number of organisations have managed to improve their compliance with the areas of assessment since the original evidence was submitted in 2021 and it is clear that all organisations have been working on improving consent to examination and treatment processes.

3 Assessment Team

3.1 The Welsh Risk Pool assembled a team of specialist practitioners with experience in the topic area:

Sponsor:	Jonathan Webb, Head of Safety & Learning
Field Work:	Susan Derbyshire, Clinical Assessor
	Isobel Smith, Clinical Assessor
Clinical Lead:	Ben Thomas
	National Lead - Consent to Examination & Treatment
Legal Advice:	Sarah Watt, Solicitor
	Gavin Knox, Solicitor
Oversight:	Manon Gwilym, Principal Safety & Learning Advisor
	Eleri Wright, Safety & Learning Advisor

4 Review Findings

4.1 Policy Content

The organisation has now adopted the All-Wales Model Policy for consent to examination or treatment and adapted it into organisational policy format. The approved organisational policy was formally approved in July 2021 and issued in April 2022 with a review date in 3 years. This policy is available via the organisation's consent intranet page.

It is noted as good practice that consent to examination and treatment documentation and governance now forms part of the Clinical Standards and Effectiveness Group agenda, thus ensuring there is an accountable governance structure which covers all clinical and support services.

Compliance with Standard: COMPLIANT

4.2 Consent Forms

The Review of the current practice in obtaining a patient's consent for treatment – Draft Report November 2020 identifies the use of Consent forms 1 and 4 whilst the organisation's table dated February 2021 provides an overview of the current principles in practice for obtaining a patient's consent prior to treatment or intervention within its departments and services. This document also makes reference to use of Consent Forms 1,2 and 4 (the assessment team assume that these are the 'All Wales consent forms') together with some professional body and locally produced procedure specific consent forms (PSCF's). There is reference to a Form 3 being used. The organisation should note that Consent Form 3 has been discontinued in Wales.

The All-Wales consent forms are compliant with Welsh Language Standards. Locally produced PSCF's should be available bilingually e.g. the organisation has developed its own PSCF's in Ophthalmology. Although the Clinical Standards and Effectiveness Group is responsible for consent documentation, there is no formal documented governance process for the development and approval of such PSCF's. The consent intranet page on PSCF's also needs to be updated to reflect the up-to-date position in Wales and the organisation.

Compliance with Standard: PARTIAL

4.3 Training in Consent

Training on consent is contained in the Junior doctor induction programme.

The organisation states that it is using the new e-learning on consent in Wales that can be accessed via ESR. This is accessible to all appropriate staff groups. However, the consent intranet page needs to be updated as it signposts healthcare professionals to the old EIDO be INFOrMED training on consent that was discontinued in Wales some time ago and which was replaced by EIDO Educate a couple of years ago. These previous training programmes have also now been discontinued in NHS Wales and replaced by the new e-learning package developed by SoundDoctor. This was communicated to all organisations by the Welsh Risk Pool.

The organisation highlights that it provides training within the Mental Capacity Act as part of its consent programme. Whilst it is appreciated that training on the MCA is undertaken and that this training will enable a clinician to assess a patient's capacity and whether to use All Wales Consent Forms 1 or 4, such training is unlikely to address in detail the important elements required when consenting a capacious patient. It is felt that there is a lack of evidence of induction and ongoing training of all appropriate staff groups on consent issues specifically relating to patients who are deemed to have capacity.

The consent intranet page contains useful information for healthcare professionals.

Compliance with Standard: PARTIAL

4.4 Consent Process for Adults

The organisation has adopted the All-Wales Model Policy for consent to examination or treatment and adapted it into organisational format. The specific guidance for obtaining consent involving adult patients noted in Area for assessment 2 is included the organisation's policy.

There are a number of speciality guidelines which underpin the Consent Policy. These require urgent review and this has been escalated to the Clinical Standards and Effectiveness Group.

Compliance with Standard: PARTIAL

4.5 Consent Process for Children & Young People

The organisation has adopted the All-Wales Model Policy for consent to examination or treatment and adapted it into Health Board format. The specific guidance for obtaining consent involving children and young people adult patients noted in Area for assessment 3 is included in the organisation's policy.

The newly appointed Assistant Director for Quality and Patient Safety now intends to ensure that any additional guidance on paediatric issues that is covered in separate documents and checklists, are reviewed / ratified. This includes working with Public Health School nursing.

Compliance with Standard: PARTIAL

4.6 Patient Information

The organisation's gap analysis and table dated February 2021 identify that the organisation is using, EIDO, Professional Body and locally developed patient information leaflets within the consent process. EIDO usage reports also confirm which specialties are using EIDO patient information leaflets.

There is a clear link to the organisation's EIDO patient information platform from the consent intranet page.

The organisation's choice of leaflets to use is now set out in the WRP Risk Management Alert and is outlined in the document 'Criteria for use of Procedure-specific Patient Information Leaflets following publication of RMA2020-01'. Although the Clinical Standards and Effectiveness Group oversees the development of locally produced patient information leaflets, there is no formally documented and approved governance process for developing and approving such local leaflets. This places a risk that non-compliant leaflets may enter circulation and increase the risk of harm and associated litigation.

There is no evidence that the organisation has a database of patient information leaflets used within the consent process.

EIDO patient information leaflets are compliant with Welsh Language Standards. Locally developed patient information leaflets require translation into the Welsh Language. It is unclear whether this is done.

Evidence provided shows that the patient information leaflets are available for staff to give to patients. However, audit reports identify that compliance with confirmation that these have been provided is very low. The consent report (November 2020) shows low compliance in

confirmation of patients being given information enabling them to make an informed choice in consenting.

Compliance with Standard: PARTIAL

4.7 Monitoring of the Consent Process

Although audits or review of the consent process have been undertaken in the past, there is no evidence of an audit / review within this important topic being carried out during the last 12 months.

However, the organisation has now identified how audits will be undertaken (specialties using AMaT), how reports will be produced (specialties to Clinical Standards and Effectiveness Group), how they will be reported at Board level (Patient Safety and Quality Outcome Committee), how they will feedback to staff (Governance and Quality and Patient Safety Leads, at Directorate meetings and via Quality and Patient Safety Operational Group and how they will identify shortfalls in an action plan (using AMaT). The Assistant Director for Quality and Patient Safety is developing an action plan to address shortfalls identified in this assessment which will include undertaking audits in 2023.

The audits and reports that have been provided show low compliance with risk and benefit discussion and the distribution of patient information leaflets.

Compliance with Standard: PARTIAL

5 Assurance Rating

5.1 Having considered the evidence submitted against each Area for Assessment, the Review Team have determined an overall assurance rating. This utilises the NHS Wales Internal Audit Framework outlined in Appendix 1.

LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

6 Main Themes

6.1 The Consent Policy is now in place. This policy addresses specific guidance in relation to consenting adults, children and young people. Patient information leaflets are used, however documentation of this needs to be addressed.

6.2 Junior staff are receiving training on consent and all appropriate staff groups can access training on consent via ESR, although uptake does not appear high. An effective system to monitor compliance with the consent process has been identified as an area which requires addressing and the organisation reports that this will be actioned in 2023, with an action plan in development to address all identified shortfalls.

7 Recommendations

It is recommended that the organisation:

7.1 Undertakes an immediate review of speciality guidelines for adults, children and young people which underpin the Consent Policy

7.2 Develops a formally approved procedure setting out the organisation's governance process in relation to the development and approval of local PSCF's

7.3 Updates the consent intranet page PSCF guidance information

7.4 Updates the consent intranet page's information on training to make reference to the new e-learning training on consent in Wales.

7.5 Implements a requirement for all clinicians who take consent from patients to complete a recognised training programme. It is recommended that the frequency of this training should be at least once per revalidation cycle for the relevant professional group, it being accepted that such training is more relevant to some groups than others. This could be either via the national e-learning consent training package or an approved in-house face to face training session.

7.6 Develops a database of patient information leaflets used within the consent process.

7.7 Develops a formally approved document setting out the governance process for the development and approval of local patient information leaflets

7.8 Puts a process in place to comply with the 'Criteria for use of Procedure-specific Patient Information Leaflets following publication of RMA2020-01' namely - Where an organisation wishes to deviate from the use of an EIDO patient information leaflet,

or where no EIDO leaflet or compliant alternative is available, this will need to be notified via email to consenttreatment@wales.nhs.uk.

7.9 Monitors and addresses any shortfalls in the use, provision of and documentation of patient information leaflets and addresses any shortfalls

7.10 Undertakes a peer review of the organisation's consent process using the peer review tool developed on an All-Wales basis. In addition to monitoring the organisation's consent process it will enable the organisation to comply with requirement number 6 of the WRP RMA 2020-01 Consent to Treatment - monitoring of compliance with the requirements of consent to treatment documentation (which may be in patient records or on a consent form) of the provision of procedure specific patient information leaflets.

7.11 Thereafter monitors and addresses any shortfalls in the use, provision of and documentation of patient information leaflets and addresses any shortfalls.

7.12 Provides feedback on the audit results to both individuals and more generically in order to initiate improvements.

8 Conclusion

8.1 Aneurin Bevan University Health Board can take limited assurance in respect of the processes relating to Consent to Examination & Treatment.

8.2 The organisation is aware of the shortfalls identified in the consent and governance processes and has indicated a commitment to address this.

8.3 The Welsh Risk Pool wish to thank the NHS organisations and the staff who were involved in this assessment. The effort involved for those who participated is much appreciated.

9 Appendices

Appendix 1 NHS Wales Assurance Framework

Appendix 2 Organisational Action Plan

Appendix 1

NHS Wales Assurance Framework

SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.
REASONABLE ASSURANCE		The organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.
LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.
NO ASSURANCE		The organisation has **no assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. Action is required to address the whole control framework in this area with high impact on residual risk exposure until resolved.

Appendix 2

Organisational Action Plan

A copy of the action plan received from the organisation in response to the draft recommendations has been included here.

ACTION PLAN FOR CONSENT	
Reference	**A National Review of Consent to Examination & Treatment Standards in NHS Wales**
Health Board	**Aneurin Bevan University Health Board**
Lead Officer for Action Plan	**Leeanne Lewis – Assistant Director for Quality and Patient Safety**
Date action plan commenced	**16th February 2023**
Synopsis of Concern	Significant clinical negligence claims have been submitted to the Welsh Risk Pool Committee (WRP) relating to failures to provide patients with information and failures to document what information was provided. This included discussions that took place regarding the benefits and risks (including material risks) of the proposed treatment and the benefits and risks of any available alternative treatments (including no treatment). The WRP committee requested that the WRP Safety & Learning Team undertake a review of organisational policies and their clinical application, for obtaining informed consent to examination or treatment with a particular focus on the areas identified above. An All-Wales summary report has been produced for the outputs from these assessments. Recommendations have been provided to enable organisations to develop an improvement plan to address areas for development. The scope of review was to assess Health Board policies and their clinical application against the All-Wales Consent to Examination or Treatment Model policy. In May 2012, WRP produced an assessment tool that outlined areas for assessment, starting with collection by the organisations of the evidence outlined in the assessment tool. When completing the assessments, organisations were required to scrutinise and interrogate their consent processes. This enabled local teams to familiarise themselves with the WRP Standard and identify source evidence which demonstrated compliance or achievement against each area for assessment. Clinical areas selected for the focus of the assessment in acute organisations were: unscheduled orthopaedics, elective endoscopy and elective gynaecology. Due to the impact of the pandemic this work was disrupted and recommenced in September 2022. WRP Consent Assessment Team reviewed the information supplied by each organisation and provided the assessment material back to designated contacts for their further analysis, augmentation where required and final submission. The following table details the recommendations from the WRP report with an action plan that needs to be carried out by Divisions within Aneurin Bevan University Health Board.

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	Deadline date for completion & insert date of completion
THEME – Consent Policy Undertake an immediate review of speciality guidelines for adults, children and young people which underpin the Consent Policy		Engage with Divisional triumvirates to carry out scoping exercise and review current consent process within their specialities. Divisions to update consent process in accordance with the new Aneurin Bevan Health Board Policy: Policy for Consent to Examination or Treatment (in line with the All-Wales Model Policy). Divisional Clinical audit plan to include Consent Audits, providing assurance that the Health Board's Consent Policy is implemented. Update gap analysis for consent audit carried out.	AMaT implemented. Directorate consent to treatment audits, to be reported via AMaT. Results presented to Clinical Standards and Effective Group. Clinicians who provide care for Children and young people (CYP) fully consider whether a child is Gillick/Fraser competent (depending on circumstances). Wherever possible clinicians work jointly with both the CYP and person with parental responsibility to gain consent.	Divisional Triumvirates and Governance Leads	August 2023

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	Deadline date for completion & insert date of completion
THEME – Patient consent forms Develop a formally approved document setting out the governance process for the development and approval of local patient information leaflets. Develop a formally approved procedure setting out the organisation's governance process in relation to the development and approval of local procedure specific consent forms (PSCF's). Develop a database of patient information leaflets used within the consent process. Thereafter monitor and address any shortfalls in the use, provision of and documentation of patient information leaflets.		Cascade WRP standard regarding use of PSCF's to Divisional triumvirates. A document will be developed detailing the process for the development and approval of local patient information leaflets. Development and approval of local PSCF's is via Clinical Standards and Effective Group (CSEG). A database will be developed for PCSF's approved by this Group. Consent audits conducted by Directorates. Corporate Quality & Patient Safety (QPS) gap analysis to be updated to monitor shortfall of leaflets, report to Clinical Standards and Effectiveness Group for monitoring.	Newsletter being produced by Corporate Quality & Patient Safety Team to raise awareness of new Health Board Consent Policy and link to updated Consent Page. It will include the process for development of PSCF's and governance arrangements via CSEG. Update gap analysis of all patient information leaflets used in the two-stage consent process. The exercise has demonstrated compliance with EIDO usage or suitable National alternatives but highlights the need for further consideration of compliance with Welsh Language standards where leaflets other than EIDO are used.	Divisional Triumvirates and Governance Leads Clinical Standards and Effective Group (CSEG).	August 2023

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	Deadline date for completion & insert date of completion
THEME – Patient information leaflets Put a process in place to comply with the 'Criteria for use of Procedure-specific Patient Information Leaflets following publication of RMA2020-01' namely - Where an organisation wishes to deviate from the use of an EIDO patient information leaflet, or where no EIDO leaflet or compliant alternative is available, this will need to be notified via email to consenttreatment@wales.nhs.uk Monitors and addresses any shortfalls in the use, provision of and documentation of patient information leaflets.		Work with the Health Board's communication team and Intranet team to ensure that EIDO is an easy to find / prominent feature on our intranet Website under Patient Information Leaflets. Update the intranet info on EIDO and produce a memo for how to access it and ensure it is easy to see on the webpage (pulse and QPS webpages) Divisions to feedback lack of use of an EIDO leaflets used for consent and report to QPS team and WRP.	Memo being produced to signpost EIDO patient information leaflets and how to access. EIDO download reports are available to identify Health Board usage across specialities. Update gap analysis of all patient information leaflets used in the two-stage consent process	Corporate QPS team Divisional Triumvirates and Governance Leads	May 2023 September 2023

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	Deadline date for completion & insert date of completion
THEME – Health Board's Intranet page Update the consent intranet page PSCF guidance information. Update the consent intranet page's information on training to make reference to the new e-learning training on consent in Wales.		Corporate Quality and Patient Safety team will update the Health Board's Consent Page. This includes updated advice on PSCF guidance information. The consent page will be updated to include the link to the new e-learning training on Consent in Wales. Work with communication team and Intranet team to ensure that EIDO is an easy to find / prominent feature on our intranet Website under Patient Information Leaflets. Update the intranet info on EIDO and produce a memo for how to access it and ensure it is easy to see on the webpage (pulse and QPS webpages)	Newsletter being produced by Corporate Quality & Patient Safety Team to raise awareness of new Health Board Consent Policy and link to updated Consent Page, once it has been updated, it will include the process for development of PSCF's and links to training. Memo being produced to signpost EIDO patient information leaflets and how to access.	Corporate QPS team Health Board Comms Team	September 2023

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	Deadline date for completion & insert date of completion
THEME – Training Implement a requirement for all clinicians who take consent from patients to evidence completion of a recognised training programme. It is recommended that the frequency of this training should be at least once per revalidation cycle for the relevant professional group (eg every 5 years for doctors), it being accepted that such training is more relevant to some groups than others. This could be either via the national e-learning consent training package or an approved in-house face to face training session.		The online training module on ESR (NHS Wales – Informed Consent to Examination or Treatment Course) is available to all Health Board employees. All employees who are involved in consent are required to complete the online training Compliance to be monitored via Divisions. Completion of e-learning module to form part of appraisal and revalidation. Attend the formal launch of the NHS Wales Consent to Examination & Treatment e-learning programme event in March 2023. Raise further awareness of the e-learning module following the launch. Embed this as part of the consent training throughout Aneurin Bevan University Health Board.	The Junior doctor teaching programme includes a session on consent led by the GMC. Training is underway at all sites as part of the teaching and induction programme using the new ESR training. Consent training in foundation programmes. A Grand Round training session has taken place with GMC. Compliance with online MCA level 1 and 2 MCA training to be monitored and reported to relevant corporate committee.		

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	Deadline date for completion & insert date of completion
THEME – peer review Undertake a peer review of the organisation's consent process using the peer review tool developed on an All-Wales basis. In addition to monitoring the organisation's consent process it will enable the organisation to comply with requirement number 6 of the WRP RMA 2020-01 Consent to Treatment - monitoring of compliance with the requirements of consent to treatment documentation (which may be in patient records or on a consent form) of the provision of procedure specific patient information leaflets. Provides feedback on the audit results to both individuals and more generically in order to initiate improvements.		Action plan for audits to be developed for 2023 to include Consent to Treatment audits for directorates, reported via AMaT and results presented to Clinical Standards and Effective Group. Using All Wales Peer Review Tool. Corporate QPS team to conduct annual audit to carry out an annual peer review and report using the All-Wales peer review tool.	Corporate QPS audit conducted in 2020. Audit to be carried out locally by Directorates. Results, actions and improvements to form part of quality improvement plans from local audits for Directorates.	Divisional Triumvirates and Governance Leads	August 2023

Status of action:

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	25 April 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Clinical Audit Activity Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Stimpson – Clinical Audit Lead Leeanne Lewis, Assistant Director for Quality & Patient Safety

Pwrpas yr Adroddiad **Purpose of the Report**
Er Sicrwydd/For Assurance

ADRODDIAD SCAA **SBAR REPORT**
Sefyllfa / Situation

National Clinical Audit Reports are presented to the Clinical Standards Effectiveness Group (CSEG) following publication. Clinical Lead(s) for the service(s) are informed of the report due date on publication. The Quality and Patient Safety (QPS) clinical audit team register the audit in the Clinical Audit Area via the web-based Audit Management and Tracking system (AMaT). The relevant documentation is provided to Clinical Leads, who provide CSEG with an analysis of local performance benchmarked against national recommendations. They then provide a "SMART" improvement plan for the Health Board which is available in AMaT so completion deadlines can be tracked.

NCEPOD studies also form part of the National Clinical Audit Outcome Review Plan (NCAOPR) within the Clinical Outcome Review Programme (CORP) and are designed to help assess the quality of healthcare and stimulate improvement in safety and effectiveness by enabling learning from adverse events and other relevant data.

CSEG also review governance arrangements for introduction of new clinical practices/procedures, not previously undertaken within the Health Board, as set out in the Policy for Implementation of New Clinical Procedures. The Group makes an assessment of the safety and effectiveness of the proposed procedure, taking into

account known benefits/ risks and proposed arrangement for training/supervision, informed consent and clinical audit.

Cefndir / Background

Clinical audit is an essential tool in ensuring that services continually evolve and develop and are responsive to quality and safety risks. The results of clinical audit are one input into a wider Quality Management System designed to achieve continuous organisational learning and improvement in delivery of safe and effective care. When conducted in accordance with best practice standards, clinical audit provides assurance of compliance with clinical standards, identifies and minimises risk, waste, and variation in clinical practice from guidelines and defined standards of care. It also improves the quality of care and patient outcomes.

CSEG is held bi-monthly. On 26th January 2023, the audit reports reviewed were:

- National Hip Fracture Database 2021: Improving Understanding
- National Early Inflammatory Arthritis Audit year 4 2021/2022
- National Vascular Registry 2022 Annual Report
- National Diabetes Audit 2020/2021 Care Processes and Treatment Targets
- National Confidential Enquiry into Patient Outcome & Death
- New Procedures Policy request: Orbital atherectomy

Reports reviewed on the 23rd March 2023 will include:

- National Emergency Laparotomy Audit Annual Dec 2020-Nov 2021 (8th report)
- National Neonatal Audit Programme (NNAP) Summary report on 2021 data
- National Asthma and COPD Audit Programme - Paediatric Asthma Secondary Care & Primary Care
- New Procedures Policy request:
  - SEM Scanner
  - Trans-Nasal Endoscopy (TNE)

For future meetings, Clinical Leads have been asked to ensure that Audit reports include a summary of areas of practice that already meet guideline/audit standards and an action plan for areas requiring improvement that are specific, measurable, achievable, realistic and time bound so that their implementation can be tracked. Divisional governance teams are required to oversee the formulation of audit action plans by directorates for approval at CSEG.

Asesiad / Assessment

National Hip Fracture Database (NHFD) 2021: Improving Understanding Report Recommendations

Quarterly governance meetings are recommended to discuss quality and outcomes, including participation from all disciplines. The Health Board are undertaking quarterly fracture neck of femur (#NOF) Improvement Group (IG) meetings. Orthopaedic Governance meetings are held monthly, with Ortho-geriatrician input. All Quality Improvement projects are discussed in these groups. The Health Board works closely with Gloucester Royal Infirmary (comparable in bed base and activity) for peer support and sharing of best practice.

Fast-tracking of patients to appropriate wards following hip fracture is recommended. The Health Board is submitting a business plan for a ring-fenced

bed for patients with #NOF's once they are admitted to hospital. In the IG, the use of Bone Medication (KPI 7) to avoid further fragility fractures is discussed. Patients and their families are encouraged to use the NHFD resources. The review of policies and protocols are on the next #NOF IG agenda. Providing information in various formats and languages for our patients is an area of work outstanding for the Health Board.

Key points:
The Health Board is performing well in:

Key Performance Indicator (KPI)	Measure	Health Board Score	National Audit (NA) Score
1	Prompt orthogeriatric review	93%	86%
3	NICE compliant surgery	72%	69%
5	Not delirious Post-Op – Prompt delirium assessment after operation	79%	62%
6	Return to original residence	72%	70%
7	Bone Medication – given suitable bone strengthening treatment with a 120-day follow-up	62%	34%

Comparable in:

- KPI 0 – Admission to a specialist ward –The Health Board Score was 5% and nationally 6%, reflective of the current pressure on the NHS.
- KPI 2 – Prompt surgery 57% for both The Health Board and the NA.

Not performing well:

- KPI 4 – Prompt mobilisation. The Directorate raised that this needs to be improved as the Health Board Score was 74% compared to NA 80%.

Actions:

- Ortho-geriatrician Governance meeting to commence.
- Ring fenced one bed for #NoF.
- Review of Policies and Protocols with comparison to other units.
- Review the inequalities in healthcare relating to the information literature available to patients.
- Directorate to develop plan with therapies for earlier mobilisation.

National Early Inflammatory Arthritis Audit year 4 2021/2022
Recommendations:
The report recommends a timely process for referral from Primary Care (PC) to Secondary Care (SC) for patients to be seen by a specialist and commenced on treatment. Education for patients and treatment targets are monitored along with.

Key points:
QS 1 - Communication with GP's has improved referral rates with 69% of Health Board patients being referred within three working days from PC to SC with the National Average (NA) being 54%.

However, QS 2 - only 22% of patients are seen within three weeks compared to NA of 42%, due to the clinic booking processes.

Patients commencing on Conventional Disease-modifying anti-rheumatic drugs (cDMARD), QS 3, within six weeks within the Health Board is 83% despite the delays in being seen, NA is 65%.

As soon as the patient has a confirmed diagnosis, education and information is provided, which is QS 4, the NA is 95% with The Health Board 87% at baseline and 100% at 3-month review.

QS 5 – Requires patient to have treatment targets set and agreed, the Health Board is 77% compared to NA 95%.
QS 7 - Emergency advice provided to patients is comparable to the NA (95%) - Health Board 94%. There has been a reduction in twelve month follow ups in the Health Board, seeing a 50% decline, to 25%.

The Directorate raised that consultant shortages would have affected previous performance. It is felt that audit participation is time consuming and does not consider scenarios where a patient has chosen to wait longer.

Actions:

- Improve clinic booking processes – to be discussed at Directorate and Divisional meetings and with British Society for Rheumatology (BSR) Regional Audit Champion.
- Report booking issues for DATIX entry.
- CNS and registrar to be involved in audit follow up.

National Vascular Registry 2022 Annual Report
Recommendations:
The Health Board's Length of stay (LoS) for patients with Abdominal Aortic Aneurysm (AAA) procedures is good at seven 7 days in comparison to C&V which is 9 days LoS.

Data entry issues are believed to affect the results of time to anaesthetic review as the Health Board Clinical Lead states ALL are reviewed at MDT, whilst the report shows 93%.

Target for revascularisation is within five days. The Health Board achieves this in 61% of cases.

Angioplasties carried out as day cases for The Health Board was lower than the NA of 60% at 44%. The Health Board's angioplasty suite remains functioning in GUH, therefore are supporting Cardiff with these cases.

Bypass Case Ascertainment (CA) for the Health Board saw an increase form 58 cases in 2020 to 88 cases in 2021. The Health Boards mortality rates for the period 2019-2021 was higher than the NA of 1.8% at 3.2% and the re-admission within 30 days for the Health Board was 14% compared the NA of 11.5%.

Amputation time and decision for surgery, often can't be done too quickly as patients need to be prepared for such an outcome, however waiting too long can lead to further medical issues. The Health Board's delay was eight days to amputation and

Cardiff is significantly higher at 11 days, with a much higher LoS of 21 days compared to The Health Board 11 days LoS. The Health Board saw 100% patients' amputation within 30 days and Cardiff are at 76%.

Referral within 7 days for The Health Board is better than the NA, with receiving surgery within 7 days of referral also significantly better in the Health Board.

Key points:

- Data for the Health Board is pre-centralisation of vascular services held within Cardiff.
- The Health Board pre-centralisation was performing well with good outcomes.
- Since centralisation issues have been seen with Cardiff Theatre capacity and radiology capacity which are being worked through
- There are concerns regarding delayed repatriation of patients back to their locality Health Board to free up bed capacity on vascular ward – escalated to operations.
- Vascular ward dedicated nursing is excellent.
- There are concerns regarding the numbers of Junior Dr's. – HEIW have declined additional training posts.

Actions: The Directorate have been asked for an action plan

National Diabetes Audit (NDA) 2020/2021 Care Processes and Treatment Targets

Recommendations:

- Achievement of care process in the Health Board has returned to pre-pandemic levels. There is a new:
    - Focus on individualised targets.
    - Focus on frailty and hypoglycaemia.

Key Points:

- This report shows that in all treatment targets for Type I (T1) and Type 2 (T2) diabetes the Health Board is performing better than the All Wales. T1 for the Health Board is 16.5% compared to Wales 11.8% and for T2 the Health Boards 25.4% compared to 21.4% all results for the Health Board and All Wales have reduced form the previous report 2019/2020.
- HbA1c results for the Health Board, across all the measurements (mmol/mol) has improved in 2020/2021 compared to 2019/2020.
- The Primary Care (PC) Specialist Nurse service has done a lot of work to improve the care provided and to participate in the Diabetes Enhanced Service.
- PC Nurse Specialists providing education programmes for other Healthcare professionals.
- Data is gathered direct from the PC Information Portal which means we can get live data.

Actions:

- Diabetes service to continue to promote and support Diabetes National Enhanced Services (NES) and improvement of diabetes care.
- Diabetes service to continue education for HCSW's and Diatips (diabetes theory into practice).
- Discuss NDA and ongoing achievement of outcomes with NCN leads and generate strategies to reduce variation.

National Confidential Enquiry into Patient Outcome & Death (NCEPOD)
NCEPOD studies currently underway within the Health Board, as part of the National Clinical Audit Outcome Review Plan (NCAOPR) within the Clinical Outcome Review Programme (CORP) include.

Current studies:

- Community Acquired Pneumonia - deadline February 2023.
- Testicular Torsion – deadline January 2023.
- Transition from child to adult health services - deadline October 2022
- Crohn's Disease - deadline October 2022.

Commenced studies:

- Endometriosis – with NCEPOD
- Juvenile Idiopathic Arthritis – with NCEPOD

Upcoming studies:

- Rehabilitation following critical illness - Data collection due Summer/Autumn 2023
- End of Life Care - Spring/Summer 2023

The Quality and Patient safety Team (QPS) have devised Standard Operating Procedures (SOPs) for the processes required for the studies. As each study commences the required management team are being asked to provide a clinical lead, so that the Health Board has a better strategy for engagement moving forward. For 2023, all studies will be following the new processes. NCEPOD audits, have been raised at CSEG and it has been agreed that we need to make a commitment to participating in these audits and require full engagement from clinicians.

As part of our Health Board's Clinical Audit Plan, we are working on ensuring full participation in the National Clinical Audit and Outcome Review Plan (NCAORP). This is published by the Welsh Government (WG) annually and is one of the cornerstones in the drive to improve the quality and safety of healthcare in Wales. It sets out in detail how findings from national clinical audit projects and outcome reviews are to be used to measure the quality and effectiveness of the healthcare provided to patients and to assess year on year improvements. The Clinical Audit Team have met with Divisions to discuss Audit plans and are sharing this to ensure the full list of national audit projects that all healthcare organisations must fully participate in, where those services are provided. (See Appendix for more information).

New Procedures Policy request:
The new procedure of Orbital atherectomy was submitted for approval following divisional director and clinical director approval. The group heard the evidence for the new procedure and approval for the implementation plan was given. The consent process was to be discussed with the Directorate.

Argymhelliad / Recommendation

Assurance is given by all Clinical Leads presenting specialty data that Quality Improvement work is always at the forefront and to improve the quality of care for the patients across the localities. All recommendations, successes, concerns and action plans will be added to AMaT.

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):	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management 2.9 Medical Devices, Equipment and Diagnostic Systems 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults Choose an item.
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 Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	NA – National Average CA – Case Ascertainment
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Clinical Standards and Effectiveness Group

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**	Yes, outlined within the paper
• **Financial**	Not Applicable
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/	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 Choose an item.

Appendix One

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2023/03/09	PICANet - Paediatric Intensive Care Audit	PICANet: State of the Nation Report 2022	https://www.hqip.org.uk/resource/picanet-mar-2023/#.ZAoBEnbP1PY	The Health Board is not included in this report; however, our Paediatrics do have an invested interest the key metrics when relevant to HB services. Due to present May 2023 CSEG
2023/03/09	NPDA - National Paediatric Diabetes Audit	NPDA: Report on Care and outcomes 2021/22	https://www.hqip.org.uk/resource/npda-mar-2023/#.ZAruxHbP1PY	Clinical lead for Paediatric Diabetes has presented to CSEG in 2022 data from the 2020/2021 report and is invited to present the 2021/2022 to the May 2023 CSEG.
2023/03/09	CVDPREVENT-Cardiovascular Disease Prevention Audit	CVDPREVENT: Third Annual Audit Report	https://www.hqip.org.uk/resource/third-annual-report-cvdprevent/#.ZAoBAnbP1PY	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2023/03/09	Mental Health Clinical Outcome Review Programme	NCISH: Annual Report: UK patient and general population data 2010-2020	https://www.hqip.org.uk/resource/ncish-mar-2023/#.ZAoBDXbP1PY	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2023/03/09	NACAP - National Asthma and COPD Audit Programme	NACAP: Clinical outcomes Summary report	https://www.hqip.org.uk/resource/nacap-mar-2023/#.ZAoBBnbP1PY	QPS team liaising with Secondary Care Asthma and COPD leads to attend CSEG in May 2023.
2023/02/09	NELA - National Emergency Laparotomy Audit	NELA: Eighth Patient Report of the National Emergency Laparotomy Audit	https://www.hqip.org.uk/resource/eighth-patient-report-emergency-laparotomy-nela/#.Y-S6cXbP1PY	Presented at CSEG March 2023 – update in QPSOC Clinical Audit Report April 2023.
2023/01/12	NACAP - National Asthma and COPD Audit Programme	NACAP: Drawing breath - The state of the nation's asthma and COPD care and recommendations for improvement	https://www.hqip.org.uk/resource/drawing-breath-jan23/#.Y7_neHbP1PY	Primary Care and Children's Asthma presented at CSEG March 2023 – update in QPSOC Clinical Audit Report April 2023
2023/01/12	NPCA - National Prostate Cancer Audit	NPCA Annual Report 2022 Prostate Cancer services during the COVID-19 Pandemic (published January 2023)	https://www.hqip.org.uk/resource/npca-annual-report-2022/#.Y8AUB3bP1PY	QPS team arranging with clinical Lead to present to the CSEG May 2023.
2023/01/12	NOGCA - National Oesophago-Gastric Cancer Audit	NOGCA: An audit of the care received by people with oesophagogastric cancer in England and Wales	https://www.hqip.org.uk/resource/oesophago-gastric-cancer-2022/#.Y8APwHbP1PY	QPS team arranging with clinical Lead to present to the CSEG May 2023.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2023/01/12	NBoCA - National Bowel Cancer Audit	NBoCA: Annual Report 2022	https://www.hqip.org.uk/resource/nboca-annual-report-2022/#.Y8AZ1XbP1PY	QPS team arranging with clinical Lead to present to the CSEG May 2023.
2022/12/08	Medical and Surgical Clinical Outcome Review Programme	Disordered Activity? A review of the quality of epilepsy care provided to adult patients presenting to hospital with a seizure	https://www.hqip.org.uk/resource/ncepod-disordered-activity-2022/#.Y5G0IHbP1PY	QPS Team working with Divisional Triumvirates to ensure NCEPOD studies receive full participation.
2022/12/08	NVR - National Vascular Registry	National Vascular Registry: Short Report - Use of implantable medical devices in aortic aneurysm repair	https://www.hqip.org.uk/resource/nvr-short-report-dec22/#.Y5G0CnbP1PY	The Clinical Lead presented local data to CSEG in January 2023, an update is in the QPSOC Clinical Audit Report for April 2023.
2022/11/10	SSNAP - Sentinel Stroke National Audit Programme	The Road to Recovery: The Ninth SSNAP Annual Report	https://www.hqip.org.uk/resource/sentinel-stroke-audit-programme-annual-report-2022/	Report discussed at Stroke MDT
2022/11/10	NVR - National Vascular Registry	National Vascular Registry 2022 Annual Report	https://www.hqip.org.uk/resource/national-vascular-registry-2022-annual-report/#.Y2z-v3bP1PY	The Clinical Lead presented local data to CSEG in January 2023, an update is in the QPSOC Clinical Audit Report for April 2023.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2022/11/10	FFFAP - Falls and Fragility Fracture Audit Programme	National Audit of Inpatient Falls (NAIF) Annual report 2022: Working together to improve inpatient falls prevention	https://www.hqip.org.uk/resource/national-audit-of-inpatient-falls-annual-report-2022/#.Y2z-knbP1PY	Report discussed at Falls panel
2022/11/10	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal, Newborn and Infant Clinical Outcome Review Programme : Saving Lives, Improving Mothers' Care Report 2022	https://www.hqip.org.uk/resource/maternal-newborn-and-infant-clinical-outcome-review-programme-saving-lives-improving-mothers-care-report-2022/	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/11/10	NNAP - National Neonatal Audit Programme	National Neonatal Audit Programme (NNAP): Summary report on 2021 data	https://www.hqip.org.uk/resource/national-neonatal-audit-programme-summary-report-on-2021-data/	Presented at CSEG March 2023 – update in QPSOC Clinical Audit Report April 2023.
2022/10/13	NEIAA - National Early Inflammatory Arthritis Audit	National Early Inflammatory Arthritis Audit - Year 4 Annual Report	https://www.hqip.org.uk/resource/national-early-inflammatory-arthritis-audit-year-4-annual-report/	The Clinical Lead presented local data to CSEG in January 2023, an update is in the QPSOC Clinical Audit Report for April 2023.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2022/10/13	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance Report	https://www.hqip.org.uk/resource/mbrrace-uk-perinatal-mortality-surveillance-report-2020/	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/09/30	PMRT - Perinatal Mortality Review Tool	PMRT - Learning from Standardised Reviews When Babies Die	https://www.hqip.org.uk/resource/perinatal-mortality-review-tool-annual-report/#.YzahI3bMJPY	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/09/08	FFFAP - Falls and Fragility Fracture Audit Programme	Improving understanding: The National Hip Fracture Database report on 2021	https://www.hqip.org.uk/resource/the-national-hip-fracture-database-report-on-2021-improving-understanding/	Presented at Falls Panel
2022/09/08	NPCA - National Prostate Cancer Audit	NPCA Short Report 2022: Patient and Tumour Characteristics Associated with Metastatic Prostate Cancer at Diagnosis in England	https://www.hqip.org.uk/resource/national-prostate-cancer-audit-short-report-patient-and-tumour-characteristics-associated-with-metastatic-prostate-cancer-diagnoses-in-england/	England only – no local data
2022/08/11	NAD - National Audit of Dementia	National Audit of Dementia - Memory Assessment Services Spotlight Audit 2021	https://www.hqip.org.uk/resource/national-audit-of-dementia-memory-assessment-services-spotlight-audit-2021/	QPS team linking with the Divisional Triumvirate to commence Clinical Audit

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
				processes. Further updates to follow.
2022/08/11	NOGCA - National Oesophago-Gastric Cancer Audit	NOGCA short report - Postoperative nutritional management among patients with oesophago-gastric cancer in England	https://www.hqip.org.uk/resource/national-oesophago-gastric-cancer-audit-short-report-2022-postoperative-nutritional-management-among-patients-with-oesophago-gastric-cancer-in-england/	England only – no local data
2022/07/14	NDA - National Diabetes Audit	National Diabetes Audit, 2020-21 Report 1: Care Processes and Treatment Targets	https://www.hqip.org.uk/resource/national-diabetes-audit-2020-21-report-care-processes-and-treatment-targets/	The Clinical Lead presented local data to CSEG in January 2023, an update is in the QPSOC Clinical Audit Report for April 2023.
2022/07/14	NDA - National Diabetes Audit	Non-Diabetic Hyperglycaemia, 2020-21 Diabetes Prevention Programme	https://www.hqip.org.uk/resource/national-diabetes-audit-diabetes-prevention-programme-non-diabetic-hyperglycaemia-report-2020-21/#.Ys_lY3bMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/07/14	NDA - National Diabetes Audit	National Diabetes Inpatient Safety Audit-England and Wales	https://www.hqip.org.uk/resource/national-diabetes-inpatient-safety-audit-an-annual-survey-of-girft-recommended-staffing-	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
			systems-and-pathways/#.YtAzkHbMKUk	
2022/07/14	NACEL - National Audit of Care at the End of Life	National Audit of Care at the End of Life - Third round of the audit (2021/22) report, England and Wales	https://www.hqip.org.uk/resource/national-audit-of-care-at-the-end-of-life-third-round-of-the-audit-2021-22-report/#.Ys_lQHbMKUk	Presented at EoLB
2022/07/14	NACEL - National Audit of Care at the End of Life	Mental Health Spotlight Audit Summary Report, England and Wales (2021/22)	https://www.hqip.org.uk/resource/national-audit-of-care-at-the-end-of-life-mental-health-spotlight-audit-summary-report-2021-22/#.Ys_WVXbMKUk	Presented at EoLB
2022/07/14	Ep12 - National Audit of Seizures and Epilepsies	National Clinical Audit of Seizures and Epilepsies for Children and Young People	https://www.hqip.org.uk/resource/national-clinical-audit-of-seizures-and-epilepsies-for-children-and-young-people-epilepsy12-report-england-and-wales-2019-21/#.Ys_WO3bMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/07/14	NACAP - National Asthma and COPD Audit Programme	Pulmonary rehabilitation 2021 organisational audit - Summary report	https://www.hqip.org.uk/resource/pulmonary-rehabilitation-2021-organisational-audit-summary-report/	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2022/07/14	NACAP - National Asthma and COPD Audit Programme	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) Wales primary care clinical audit 2021	https://www.hqip.org.uk/resource/national-asthma-and-chronic-obstructive-pulmonary-disease-audit-programme-wales-primary-care-clinical-audit-2021/#.YtAjz3bMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/07/14	NCAP - National Clinical Audit of Psychosis	Early Intervention in Psychosis Audit - National report for England 2022	https://www.hqip.org.uk/resource/national-clinical-audit-of-psychosis-early-intervention-in-psychosis-audit-report-england/#.Ys_lkHbMKUk	England only
2022/07/14	NCAP - National Clinical Audit of Psychosis	National report for Wales - Early Intervention in Psychosis Audit	https://www.hqip.org.uk/resource/national-clinical-audit-of-psychosis-early-intervention-in-psychosis-audit-report-wales/#.Ys_lfHbMKUk	The Clinical Lead presented local data to CSEG in November 2022, an update was given in QPSOC Clinical Audit Report for the February 2023.
2022/07/14	NCMD - National Child Mortality Database	National Child Mortality Database: The Contribution of Newborn Health to Child Mortality across England	https://www.hqip.org.uk/resource/national-child-mortality-database-the-contribution-of-newborn-health-to-child-mortality-across-england/#.Ys_WJ3bMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2022/06/16	NMPA - National Maternity and Perinatal Audit	National Maternity and Perinatal Audit Annual Clinical Audit Report	https://www.hqip.org.uk/resource/national-maternity-and-perinatal-audit-clinical-report-2022/#.YrCOjXbMKUk	The Clinical Lead presented local data to CSEG in November 2022, an update was given in QPSOC Clinical Audit Report for the February 2023.
2022/06/16	NACAP - National Asthma and COPD Audit Programme	Adult Asthma and COPD Organisational Audit Report	https://www.hqip.org.uk/resource/adult-asthma-and-copd-2021-organisational-audit-summary-report/#.YrCDmHbMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/06/16	NACAP - National Asthma and COPD Audit Programme	Children and Young People Asthma Report	https://www.hqip.org.uk/resource/child-and-young-person-asthma-2021-organisational-audit-summary-report/#.YrCJVnbMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/06/16	CVDPREVENT-Cardiovascular Disease Prevention Audit	Cardiovascular Disease Prevention Audit 2022 Annual Report	https://www.hqip.org.uk/resource/cvdprevent-second-annual-report/#.YrCOr3bMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/06/16	NICOR - National Cardiac Audit Programme	National Cardiac Audit Programme Annual Report	https://www.hqip.org.uk/resource/national-cardiac-audit-programme-2022-report-the-heart-in-lockdown/#.YrCO1HbMKUk	PCI & MINAP – Nov 2023 CSEG and update Feb 2023 QPSOC. Heart Failure – Sept 2022 CSEG Cardiac Rhythm – not presented

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2022/06/16	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme Acute Organisational Audit	https://www.hqip.org.uk/resource/sentinel-stroke-national-audit-programme-acute-organisational-audit-2021/#.YrCO-nbMKUk	Stroke Board
2022/06/16	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme Stroke Mimics Report	https://www.hqip.org.uk/resource/sentinel-stroke-national-audit-programme-mimic-audit-2021-short-report/#.YrCPGHbMKUk	
2022/06/16	NDA - National Diabetes Audit	National Diabetes Audit Transition Audit Report	https://www.hqip.org.uk/resource/national-diabetes-audit-2017-21-adolescent-and-young-adult-type-1-diabetes/#.YrB2w3bMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/06/16	NDA - National Diabetes Audit	National Diabetes Audit (Type 1 Diabetes) Audit Report	https://www.hqip.org.uk/resource/national-diabetes-audit-2020-21-type-1-diabetes/#.YrB31XbMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/05/12	Medical and Surgical Clinical Outcome Review Programme	A Picture of Health Bridging the gap between physical and mental healthcare in adult mental health inpatient settings	https://www.hqip.org.uk/resource/national-confidential-enquiry-into-patient-outcome-and-death-a-picture-of-health/#.YnzWpNrMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.

Date Published	PROJECT NAME	FULL REPORT TITLE	HQIP WEBLINK TO REPORT & INFOGRAPHIC(S)	Update
2022/05/12	NABCOP - National Audit of Breast Cancer in Older Patients	National Audit of Breast Cancer in Older Patients 2022 Annual Report	https://www.hqip.org.uk/resource/national-audit-of-breast-cancer-in-older-patients-2022-annual-report/#.YnzNwdrMKUk	Clinical lead presented the 2021 Annual Report in February 2022 and is invited to present the 2022 report to the CSEG in May 2023.
2022/05/11	NDA - National Diabetes Audit	National Diabetes Foot Care Audit Interval Review: July 2014 - March 2021	https://www.hqip.org.uk/resource/national-diabetes-foot-care-audit-interval-review/#.YnzN5trMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/04/14	NPDA - National Paediatric Diabetes Audit	National Paediatric Diabetes Audit Annual report 2020-21: Care processes and outcomes	https://www.hqip.org.uk/resource/national-paediatric-diabetes-audit-annual-report-2020-21/#.Ylfc0ejMKUk	The Clinical lead presented the 2020/2021 Annual Report to the Sept 2022 CSEG 2020/2021.
2022/04/14	Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Safety in Mental Health	https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-safety-in-mental-health-annual-report/#.YlflwujMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.
2022/04/14	Child Health & Medical and Surgical Clinical Outcome Review Programmes	How data captured by NCEPOD supports the identification of Healthcare Inequalities: A review - 2022	https://www.hqip.org.uk/resource/national-confidential-enquiry-into-patient-outcome-and-death-review-of-health-inequalities-short-report/#.YlgQ1ujMKUk	QPS team linking with the Divisional Triumvirate to commence Clinical Audit processes. Further updates to follow.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	25 April 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Highlight Report from the Quality and Patient Safety Operational Group meeting 15/3/2023
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr, Executive Director of Therapies and Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Peter Carr, Executive Director of Therapies and Health Science

Pwrpas yr Adroddiad **Purpose of the Report**
Er Gwybodaeth/For Information

ADRODDIAD SCAA **SBAR REPORT**
Sefyllfa / Situation The Committee is asked to note the information contained in the highlight report from the Quality and Patient Safety Operational Group meeting held on 15/3/2023.
Cefndir / Background The Quality and Patient Safety Operational Group meets bimonthly and has cross-Divisional and multidisciplinary membership. This highlight report is part of routine reporting to the Committee.
Asesiad / Assessment **Divisional Risks and Issues** The Divisional Quality and Patient Safety Leads were given the opportunity to share / update by exception on Divisional risks and issues related to quality and patient safety, with an explanation of action being taken. Written reports from each Division were also shared in advance of the meeting.

All Divisions noted the continued issue of unfilled vacancies (nursing, medical, AHPs, and Healthcare Scientists) which in some areas is mitigated with temporary staff, which brings its own issues. Examples of mitigating action include successful recruitment of Health Care Support Workers by the Medicine Division, who are due to start in April. The Urgent Care Division reported the increased use of Physicians Associates, being employed at The Grange, Nevill Hall and Royal Gwent hospitals. In the Community Division there has been increased recruitment in nursing and targeted recruitment in GMS, dentistry and optometry. In the Mental Health and Learning Disability Division there is ongoing discussion about specialist rates and some progress with nurse recruitment.

The poor condition of some Health Board infrastructure also featured as an issue of concern that is being escalated to Health & Safety and to Facilities departments. Congestion in the Emergency Department waiting room was also raised, with options for expansion being explored.

All the Divisional risks and issues raised are included in the Divisional risk and issue registers with information detailing the mitigation action being taken. The QPSOG was assured that the appropriate action is in place at Divisional level to address and mitigate the current risks to ensure the quality and safety of services. No new risks were escalated for additional assistance from the Operational Group.

Patient Quality and Safety Outcomes Measures Report
A verbal report was presented, and comments invited ahead of the formal report being prepared for presentation to the Committee meeting in April 2023.

It was agreed to agenda an item at the next meeting to discuss assurance and learning around complaints.

It was also reported that safeguarding level three training is now available, and this will also be open to GP practices. The Divisional Quality and Patient Safety Leads were asked to encourage staff to take up the training.

Corporate Health and Safety
The group received an update on key matters related to all functions of corporate health and safety, which will also feed into the Patient Quality and Safety Outcomes Measures Report.

COVID Investigation
The group received an update on the COVID investigation.

Liberty Protection Safeguards.
The Group were updated on the implementation of the Liberty Protection Safeguards. There is still no confirmed implementation date although this is anticipated to be 2024.

Research and Development Strategy
The group were updated that the strategy was approved by the Board in November 2022. Of note is the Health Board's significant role in finding a COVID vaccine and informed the meeting that we were currently working on antibody responses. The Group were informed that the Research & Development department has moved to a new unit at the Royal Gwent Hospital and colleagues were invited to visit the department. It was agreed to explore establishing a staff

community of practice for those interested in being more involved in Research & Development.

Argymhelliad / Recommendation

The Committee is asked to note the information contained in the highlight report from the Quality and Patient Safety Operational Group meeting held on 15/3/2023.

Matters requiring Committee consideration:

- Patient Quality and Safety Outcomes Measures Report (scheduled for the Committee meeting in April 2023)

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):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. 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:	

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.

Highlight Report

Group Name:	**ABUHB Children and Young People'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 and Young People'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:	01/03/23	**Date of last meeting:**	28/02/23
Completed By:	Dr Kavitha Pasunuru (Chair) Sian Thomas Consultant Nurse Child Health Rebecca Stanton, Head of Transformation Programme		
DistributionList:	PQSOC		
Summary:	A packed agenda for our first forum of the new year, and we piloted a new approach of providing department updates in the form of highlight reports (attached below). The agenda included: • Welcome and Introductions Update and feedback from December workshop (shared in previous highlight report) • Two external presentations from: Luke Rees at Platfform 4YP around their youth forum and approach to participation/engagement and Nadia Lovell from NYAS regarding their parent advocacy project. • Highlight report updates (from various departments)		

	• Task and Finish Mapping Group • Update around Guidelines for involving young people within recruitment • Update on the All-Wales Children's Rights Group

External Presentations	
Platform Youth Forums:	Platfform - Children's Rights an
NYAS Parent Advocacy:	An active discussion emerged after the guest presentations with ideas on how members could collaborate outside of the meeting to continue shared learning and practice. There was also a request to explore how we share young people's experiences within a wider arena.

Piloting Department Updates

The department update template was piloted in preparation for this meeting as a mechanism to share good practice and build evidence around the work being undertaken across ABUHB. Within the meeting, departments were able to use these updates to share further about the work being undertaken and an opportunity for others to ask questions and learn from each other. A copy of all the departments updates we received is attached below;

Children's Rights Highlight Re...

Task and Finish Mapping Group

We have a meeting in the diary for the 10th March to start our Task and Finish Mapping group. The group will help us identify activity across ABUHB and areas we may need to strengthen moving forward.

Update around involving young people in recruitment

As previously mentioned in earlier reports, this area has been a particular success. Sian is currently identifying a 'home' for the policy and the suite of resources that have been devised. Further, Sian is seeking ABUHB endorsement for the guideline, with the aim that the process for involving young people in the recruitment process can be used for key roles where appropriate. The workforce and OD department are currently being explored as a potential option. Some of the future aspirations to build upon this work is to have our own Health Youth Forum and widening the model to include work experience or placement opportunities for young people.

National Meeting Update

Feedback around the National meeting that has been pulled together by North Wales. The meeting has direct links with the Children's Commissioner's office and exploring the options for a Wales wide youth summit. Again, this is an opportunity to share good practice and build ideas across Wales.

AOB

Rebecca has met with the Children's Commissioner's office regarding the idea of creating a Children's rights module for ESR, and the office are keen to develop this. The scope has been widened to include the NEST framework as this aligns with Children's rights and supports professional's thinking around using Children's rights at the heart of their planning for young people. Further, conversations have taken place with HEIW to explore using the module on their platform to extend the reach beyond Health/ESR. The module should be in draft in the next month and will go through a period of review and testing. The Family and Therapies Division have kindly offered to be a part of this pilot.

Comment from Chair / Items for Escalation

N/A

Action / Next Steps

- Change of forum name to include 'Young People' in addition to Children.
- Explore setting up a Teams channel for people to share good practice between meetings.
- Task and Finish mapping group: 10th March 2023.
- Find a location for the recruitment policy and ensure its accessibility for further use.
- Explore how we share our 'stories' of young people- Rebecca to liaise with Tanya Strange.
- Continue with developments of the ESR Children's Rights module.

Children's Rights Forum: Highlight Reports- February 2023

Department Feedback Form	
Name of Department:	Speech and Language Therapy – Children's Teams
Name of Representative:	Liz Rees
Highlights this quarter:	Young person involved in Tec Cymru event, sharing her patient story. Young people involved in the national transparent mask trial providing feedback from a service user perspective -are they fit for purpose from a listening, lip reading and communication perspective? Patient story from a child and his mum.
Ideas for ongoing work:	Include on meeting agendas (e.g. seniors meetings) to raise awareness amongst the team and where ideas can be shared, discussed and actioned.

Department Feedback Form	
Name of Department:	Aneurin Bevan University Health Board Communications and Engagement Team
Name of Representative:	Adele Skinner
Highlights this quarter:	Face to face engagement programme continuing (Children specific: session with Flying Starts Tiny Talkers session at Shaftesbury Community Centre, Newport, session at Little Dino's Play Centre, Usk, Bettws Baby Shower, Newport and attendance at Coleg Gwent Health and Well-being Events in Cwmbran, Ebbw Vale, Newport and Cross Keys Email sent to Schools across Gwent to commence engagement with them. As a result, attendance at parents evening planned in Caerphilly and Monmouthshire. Facebook Live: Children's Mental Health Week Facebook Live
Ideas for ongoing work:	Recruit Nye's Community Champions with specific links to children's groups

Department Feedback Form	
Name of Department:	National Youth Advocacy Service
Name of Representative:	Kevin Crewe

Children's Rights Forum: Highlight Reports- February 2023

Highlights this quarter:	Provision of crisis grants, through their allocated advocate for Children and Families experiencing cost of living hardship. Monthly Advocacy drop-in sessions at Serennu Centre have been attended. Advocates continue to sit on SPACE panels in Blaenau Gwent and Caerphilly (in the period October – December 23 young people were supported with advocacy because of this participation). Development of Advocacy leaflet for use with Unaccompanied Asylum-seeking Children. This quarter the NYAS Young People's Advisory Group (YPAG) Worked with national organisation Missing People to share their thoughts on branding and promotion of two of their services. A young person was supported to successfully apply to be part of the UK Civil Service Care Leaver Internship Scheme. The internship provides opportunities to enable care leavers to experience working in central Government and to develop skills and competence to strengthen their future career prospects. The YPAG contributed to the Toolkit that was developed for the All-Wales Protocol on reducing the criminalisation of care experienced children and young people. They have provided positive feedback further to their attendance as Young Ambassadors at the Voices from Care Cymru facilitated Care Experienced Summit. This event provided attendees with an opportunity to describe their experiences directly to the First Minister for Wales and other Ministers including the Education Minister and Deputy Minister for Social Services. The children and young people worked together to develop a Declaration setting out what a reformed care system would look like, this will be published later in 2023. Parental Advocacy continues to support children through providing Advocacy for their parents at meetings throughout Gwent (subject to criteria). The NYAS Unity Project supports Care Experienced Young mums in Gwent and is a Wales wide project.

	NYAS were awarded the Partnership Award at the National Children and Young People's Awards. For the My Things Matter Campaign. It was also announced that NYAS has been awarded The Queen Elizabeth II Platinum Jubilee Volunteering Award. The Jubilee Award, has been given to 20 national charities that work with young people aged between 16 and 25. The award showcases the charities and volunteers who have shown exceptional efforts in supporting and empowering young people across the country.
Ideas for ongoing work:	To work with Teams / Departments within ABUHB so that we can raise awareness of Independent Advocacy and the services NYAS offer so that they can be of use to health practitioners and the families that they work with. To develop an Advocacy, drop in at the other Childrens Centres in Gwent to raise awareness in area.

Department Feedback Form	
Name of Department:	NYAS Cymru – Parent Advocacy
Name of Representative:	Nadia Lovell
Highlights this quarter:	We have seen an increase of referrals into the project across the 5 Local Authority areas. The referral theme is primarily to support parents who are involved in the child protection process with the aim of keeping children in the family home when it is safe to do so. We continue to work closely with our key partners and regularly invite organisations to our team meetings. During this period we met with Safe Families, VAWDASA and SPACE Panel Coordinators from Aneurin Bevan Health Board. We recognise the importance of joint working to ensure there is no duplication of services and to better enable our advocates to signpost parents to the most appropriate services. NYAS has launched a new website which is extremely user friendly and very easy to navigate. NYAS Cymru has its own page with a page dedicated to Parent Advocacy. This page gives a wealth of information on the Pan Gwent service and includes

	the service criteria and leaflet for the project. There is also a link to the parent advocacy interim research report. The new website is proving to be an excellent resource and assists with helping to promote and provide easily accessible information about the project. We have continued to develop relationships with key personal across the 5 Local Authorities to both promote the project and to ensure referral pathways are firmly established. Our primary referral source is Social Services however during this reporting period as awareness of the project expands, we have received referrals from Barnardos, GATA, Primary Mental Health and our Children's Advocacy Projects. We are working alongside Dr Clive Diaz and his team from the Cascade Department at Cardiff University to undertake phase 2 of a research project to look at the impact of parent advocacy on families whose children are involved with social services. We have been part of consultations with Welsh Government in relation to their discussions regarding the radical reform of social services particularly how parent advocacy can support families to prevent children entering the care system. NYAS Cymru have been in a position to provide crisis grants, through their allocated worker for families experiencing cost of living hardship.
Ideas for ongoing work:	To continue to promote the project across all 5 Local Authorities and to both statutory and third sector organisations. To be involved in discussions with Welsh Government around the rollout of Parent Advocacy across Wales.

Department Feedback Form	
Name of Department:	ABUHB General Paeds
Name of Representative:	Buddug Eckley /Marion Schmidt

Children's Rights Forum: Highlight Reports- February 2023

Highlights this quarter:	Healthier Together : Cost of living support
Ideas for ongoing work:	Identify poverty champions in each area to ensure families are aware of support available Change practice wherever possible to improve health care access for families struggling

Department Feedback Form	
Name of Department:	Maternity
Name of Representative:	Emma Mills
Highlights this quarter:	Recruitment drive to encourage young parents to attend our service user forum (BABI) Development of beautiful birth boxes (to ensure a more relaxed and oxytocin friendly birth environment) for all parents but especially helpful for teenage mothers. (Also, aromatherapy service and hypnobirthing) Ran an event called living the life of a midwife to encourage young people/ young carers (generally age 16-18) to learn more about the role of the midwife and advocacy Developed an online survey asking teenage parents about their experiences and how they feel maternity care could be improved.
Ideas for ongoing work:	Would like to include more young people in the interview panel for roles within midwifery.

Children's Rights Forum: Highlight Reports- February 2023

Department Feedback Form	
Name of Department:	Paediatric Dietetics
Name of Representative:	Rebecca Coles
Highlights this quarter:	Ongoing development work with Paediatricians to improve availability to evidence-based resources to promote self-management via Healthier Together. Update of resources available on external ABUHB website- Paediatric Dietetics Review of feedback received via inpatient audit data to improve catering services and paediatric nutrition.
Ideas for ongoing work:	Obtain feedback from children/service users on resources available. Obtain further feedback on modifications made to inpatient menus.

Platfform - Gwent4YP

Children's Rights and Participation Forum

Luke Rees – Service Manager

PLATFORM

For mental health and social change
Dros iechyd meddwl a newid cymdeithasol

Who we are

Platfform is the mental health and social change charity. We are a platform for connection, transformation and social change.

We work with young people in Gwent between the ages of 14 and 18 who are experiencing challenges with their mental health, and with communities who want to create a greater sense of connection, ownership and wellbeing in the places that they live.

We live by our values of being connected, compassionate, brave, and curious in everything we do and believe deeply in our vision of sustainable wellbeing for all.

PLATFORM

Where it all started?

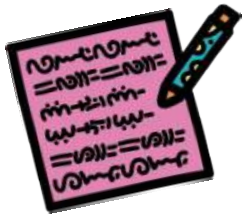
1. We researched what else was being offered
2. We asked young people what did they know about managing their mental health
3. We asked them how they manged their mental health
4. We asked them what would a service could look like and how would it work best
5. We wrote down all of their needs and planned how it could look
6. We then took it into those same young people and delivered it with them and evaluated it at the end of every session
7. Young people signed off on the final content of the programme….

Our approach

Whole person, whole system
Improving resilience and wellbeing by addressing social determinants of distress

People centred & co-production
Building trust and basing support on what is important to the person

Strengths based
Drawing on individual's skills and community assets



Recovery
Through feeling heard and validated – creating agency, hope and direction

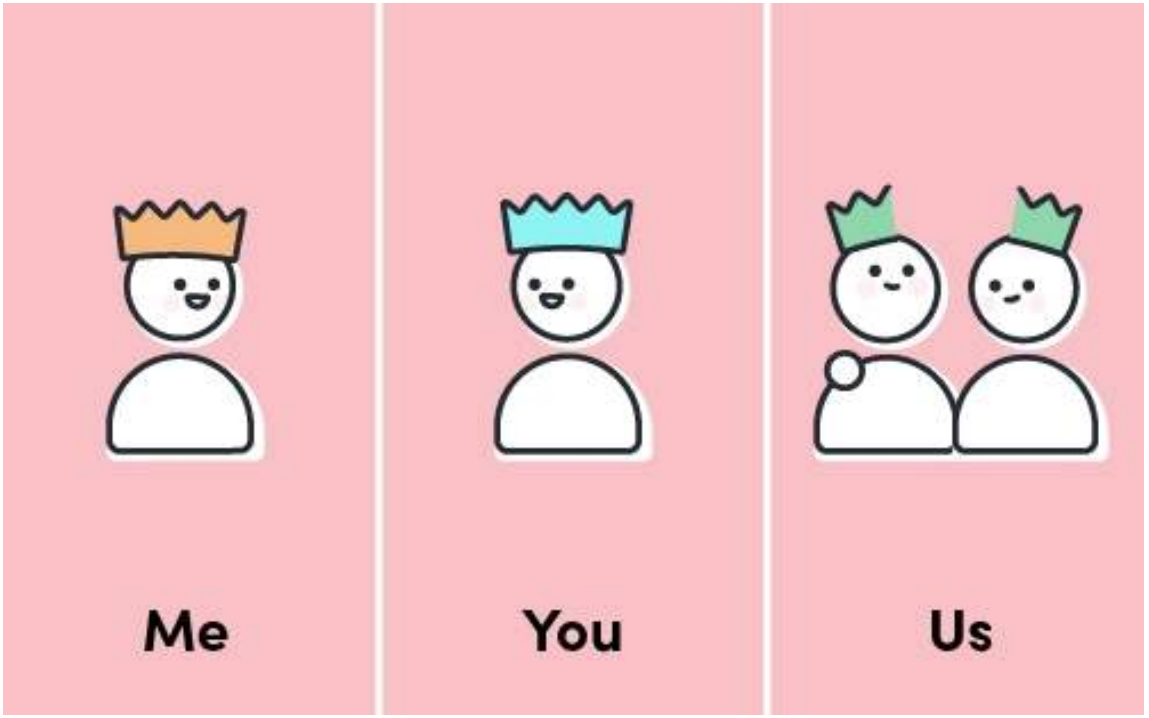
Trauma informed + relational
Understanding people's stories, building relationships, creating connections

Community focussed
People and services being embedded in the community – creating meaning, purpose and feeling valued

Collaboration + integration
With partners in Health, Local Authorities and Third Sector

Our way of working

No more “them” and “us" – we are in this together



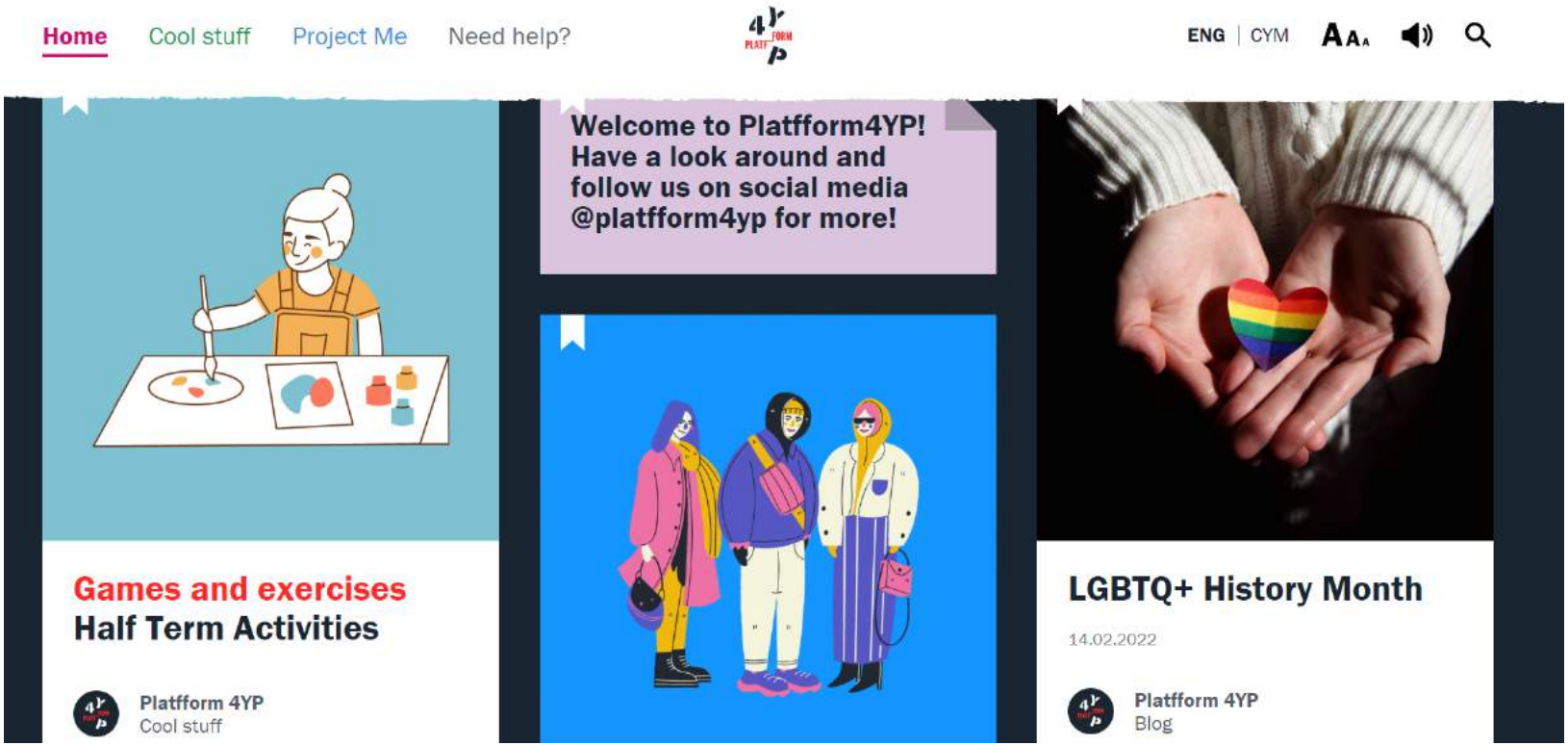
Being told to
Just get over it
or to just
cheer up

Listen to me
more,
don't palm
me off

Young people
being told
they have
nothing to be
depressed about
not listened
too.

Being told I
was milking
the system
when I was
feeling depressed

Youth led website – Platfform4yp.org



A range of co-produced resources


#CardiffsWinterWonderland


FORM


PLATE

Platfform Youth Board

The youth board aims to give a voice to young people from every corner of society and is responsible for these three areas:

- **Advisory** - advise on the direction of our work and how to best engage with young people
- **Development** – inform, influence, and engage with Platfform so that we do the best we can for all young people.
- **Communications** - showcase the work of the Platfform through key communication channels.

Get in touch

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@platfform4yp

All doodles illustrated by Tammie,
part of the Young People's team at Platfform.

PLATFFORM

For mental health and social change
Dros iechyd meddwl a newid cymdeithasol

Highlight Report

Group Name:	**ABUHB Safeguarding Committee**		
Group Aim:	The Safeguarding Committee has delegated authority to establish and implement the strategic direction of safeguarding activity across the Health Board, providing assurance that legal requirements and national guidance are incorporated into policy.		
Date Completed:	19 April 2023	**Date of last meeting:**	14 December 2022
Completed By:	Howard Stanley – Head of Safeguarding		
Distribution:	PQSOC		
Summary:	This highlight report contains a brief summary of discussions at the ABUHB Safeguarding Committee, with particular focus on learning from reviews and the challenges of delivering Safeguarding Training to a large internal workforce and across our independent contractors.		

Safeguarding Maturity Matrix

The NHS Safeguarding Maturity Matrix (SMM) is a self-assessment tool which considers 42 indicators and is utilised by Public Health Wales to determine how well Health Boards are performing in regard of their statutory safeguarding duties.

This self-assessment identified compliance in 25 of these areas, partial compliance in a further 14 areas and non-compliance in 3 areas.

Non-compliance was related to Training, which is discussed later in this highlight report.

Multi Agency Risk Assessment Conference (MARAC) and Health Involvement

A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

In March 2022, a decision was made that ABUHB Safeguarding Team would cease to attend MARAC. Our non-attendance has led to significant concerns being raised by partner agencies.

Following discussion at Safeguarding Committee, internal resources have been identified to enable ABUHB to re-engage with the MARAC process.

Safeguarding Training Compliance and Recovery

ABUHB is currently non-compliant in its duty to ensure that staff have received safeguarding training at the level appropriate to their role, in line with the Wales National Safeguarding Training Standards.

Compliance with Levels 1 and 2 is very close to the expected level of compliance and a programme has now been put in place to deliver Level 3 Training to a large cohort of staff.

A timetable for delivery of Level 3 Training will be presented to the April 2023 Safeguarding Committee, after which the training will be mandated via ESR.

Non-compliance with training is already an open risk on the corporate risk register and is subject to regular review.

Non Recent Abuse Case

Non Recent Abuse is also known as historic abuse. It is classified as an allegation of neglect, physical, sexual or emotional abuse, this can be made on behalf of someone or from the victim themselves.

A case was presented that outlined an incident where an independent contractor had experienced some challenges with timely and appropriate disclosure if an allegation of historic abuse by a former employee. These challenges were in relation to the disclosure being made by a third party, an inability to obtain consent to share from the victim and a view by the independent contractor that they could not override consent in the wider public interest, as the alleged perpetrator had long since retired and ceased practicing.

Discussion of this case highlighted its complexity and potential gaps in knowledge of health care professionals when dealing with cases of such complexity.

A recommendation was approved to ensure that non recent abuse forms a core part of ABUHB internal safeguarding training. Furthermore, provision of training to independent contractors will be identified and these contractors will be prompted to access it.

Child Practice Review "Elena"

A Concise Child Practice Review was commissioned by Gwent Safeguarding Board, in accordance with the 'Working Together to Safeguard People', which considered the circumstances of a child aged 8 months, known hereafter as Elena.

In August 2020, Elena was taken to bed the evening before her death but when checked on the next morning, she was found unresponsive and was deceased when paramedics arrived. Both Elena and her family had a significant history of involvement with agencies. The context of which is domestic abuse, violence and aggression in the community, poor parental mental health, use of illicit and prescribed drugs, ownership of weapons, exotic pets and poor home conditions.

Whilst a number of learning points were identified for partner agencies, the pertinent issue to ABUB was in relation Health Visiting services requirement to undertake sleep environment assessments in line with current practice guidance.

Discussion at Safeguarding Committee highlighted that this is standard practice, but it was agreed that an Audit would be undertaken to determine compliance. Finding of this audit will be presented at the April 2023 Safeguarding Committee.

Health Inspectorate Wales (HIW), Safeguarding and General Practice Preparedness

Health Inspectorate Wales (HIW) have recently refreshed their inspection regime for Primary Care, which was brought to the Health Board's attention following an inspection in one of our local practices, after which HIW contacted the Chief Executive's Office to raise significant concerns.

This new inspection regime includes a significant focus on Safeguarding Policy, Training and Practice. Speaking with GPs in the system, there appears to be mixed levels of preparedness in relation to safeguarding.

It was agreed ABUHB Safeguarding Team would look to produce a "GP Toolkit" which could contain:

- Policy Templates
- Standards for record keeping and flagging
- Terms of Reference for Safeguarding Meetings
- Advice Regarding maintaining a Safeguarding Register
- Links to Regional Safeguarding Board Policy and procedure
- Training Matrix

The Safeguarding Team will also look to scope the training available to General Practice to meet the required hours and work with Primary Care Team to determine if an "offer" can be made to provide Level 3 Training and how this can be resources.

Items for Escalation

- Ongoing monitoring of Safeguarding Training Compliance.

Aneurin Bevan University Health Board

Clinical Standards Effectiveness Group

Minutes of the Meeting of the Clinical Standards Effectiveness Group held on Thursday, 26th January 2023 at 14:00-16:00, via Microsoft Teams

In attendance:
Dr Leo Pinto (LP) - Asst Medical Director for Clinical Effectiveness (Chair)
Leeanne Lewis (LL) – Asst. Dir. Of Quality & Patient Safety (Vice Chair)
Joanne Stimpson (JS) - Quality & Patient Safety Lead for NCA
Anita Goff (AG) - Lead Nurse H&C Standards, Quality & Patient Safety
Stephen Edwards (SE) – Consultant Anaesthetist, & Deputy Med. Director
Seema Sindhakar (SS) – Consultant Anaesthetist
Tom Grace (TG) - MCA Lead / Head - Deprivation of Liberty Safeguarding
Glenys Mansfield (GM) – General Manager, Scheduled Care
Richard Stubbs (RS) – Risk Manager, Corporate QPS Team
Dr Clifford Jones (CJ) - Primary Care Clinical Director Division

Apologies:
Tracy Morgan - General Manager, Acute Medicine
Chris OConnor – Interim Executive Dir. Of Primary Care, Community and MH
Sarah Cadman - Head of Quality & Improvement, MH&LD
Jonathan Sims - Clinical Director of Pharmacy
William Batten - Clinical Effectiveness & Formulary Pharmacist

Guests:
Non Pugh (NP) - Consultant Rheumatologist, Clinical Lead NEIAA
Mr David McLain (DMcL) – Consultant Vascular Surgeon, Clinical Lead NVR
Gavin Williams (GW) - Deputy Directorate Manager, Trauma and Orthopaedics
Dr Allen Wilson (AW) – Consultant, Care of the Elderly

CSEG 2601/01 Welcome and Introductions
The Chair welcomed everyone to the meeting and updated the group on the importance of clinical audit to ensure quality and effectiveness in healthcare, to assess and monitor our own performance in terms of service delivery.

The Group were happy for the meeting to be recorded via Microsoft Teams.

Apologies for Absence

As above.

Declarations of Interest
There were no declarations made of potential conflicts of interest by those attending the meeting.

Draft Minutes of the Meeting held on 24th November 2023

The draft minutes of the meeting held on 24th November 2023 were considered by the group and agreed as an accurate record and outstanding actions discussed.

From the presentations held in November – no actions identified have been updated.

CSEG 2601/02 - National Hip Fracture Database (NHFD) 2021: Improving Understanding

AW provided the group with a visual display of the KPI's held in the NHFD and stated this was 12 months of data up to November 2022. ABUHB is in line with the National Average (NA) and mostly performing better than the other Welsh Health Boards (HB). It was stated that GUH is one of the biggest Trauma Units in the UK.

Compliance	Total Cases	0. Admission to Specialist Ward	1. Prompt Orthogeriatric Review	2. Prompt Surgery	3. NICE Compliant Surgery	4. Prompt Mobilisation	5. Not delirious post-op	6. Return to original residence	7. Bone medication
Wales	4388	4%	66%	54%	72%	74%	63%	72%	37%
Grange University Hospital	717	5%	93%	57%	72%	74%	79%	72%	62%
Morriston Hospital	616	1%	94%	25%	73%	76%	76%	71%	50%
University Hospital of Wales	508	1%	87%	57%	77%	73%	60%	73%	72%
Princess of Wales	277	5%	45%	46%	77%	71%	49%	70%	12%
Prince Charles Hospital	207	2%	0%	58%	39%	64%	11%	73%	1%
NHFD		6%	86%	58%	69%	80%	79%	70%	34%

Annualised values based on total cases averaged over 12 months to the end of November 2022

Report Recommendations:
The emphasis in this NFHD report relate to governance structures and the current structures in ABUHB are a monthly orthopaedic governance afternoon which covers morbidity and mortality, theatre cancellations etc. attended by Orthogeriatricians. Quarterly Fractured Neck of Femur (#NoF) attended by a wider range of stakeholders and designed to guide the service going forward.

The step-down system in ABUHB has previously caused a blind spot for governance, a minority of mortality in the eLGH's had not been captured until recently however now with 4 WTE orthogeriatricians in post it is planned to commence an orthogeriatrician governance structure. Also, a facilities audit from NHFD emphasises governance structures.

Recommendations		*ABUH position*
R1	Hip fracture teams should use quarterly governance meetings to review the quality and outcome of the care they provide	*#NoF Improvement Group (IG) meet quarterly & Orthopaedic Governance meet monthly*
R2	Where performance is significantly below average (red in the caterpillar plots), units should formally discuss possible reasons for this within their regular MDT meeting and plan a QI project to address it	*Viewed and acted upon in #NoF IG*
R3	Quarterly governance meetings should be taken as an opportunity for team members and trainees from all disciplines to make use of the NHFD website as a driver for QI; the new Quarterly Governance Tool is designed to help them do this	*ABUHB is compliant to this within the #NOF IG & Orthopaedic Governance monthly meeting*
R4	The NHFD recommends that governance meetings of surgical, orthogeriatric, anaesthetic, nursing, therapy and management leads should take place on at least a monthly basis	*Above Quarterly and monthly meetings and planning for orthogeriatrician governance meeting now up to 4 WTE*
R5	Monthly governance meetings should be used to plan appropriate QI interventions, and to monitor the impact of these using the real time data reported in the NHFD run charts	*NHFD data reviewed at #NoF IG and established Clinical Governance meeting*
R6	Hip fracture teams should use their KPI caterpillar plots to identify better-performing neighbouring units, so they can share best practice and network with them in designing QI work.	*NHFD data reviewed at #NoF IG and benchmarked against compatible providers in Wales and England - Gloucester Royal Infirmary (GRI) similar to GUH and Dr Wilson visited GRI, and has ongoing collaboration*
R7	Hip fracture teams should use KPI 0 as a marker of initial care and a driver to improve the provision of local anaesthetic nerve blocks and fast-tracking of patients to an appropriate ward. Performance should be considered alongside the figures for their unit in the Anaesthesia run chart and Assessment benchmarking table	*Ring fencing a bed would be ideal, however with current pressures at the front door, this is challenging, but do-able, a business plan being submitted, which is looking favourable. ABUHB on average 3 NoF's a day, one bed would need to be regenerated quickly*
R8	To help patients avoid further fragility fractures, hip fracture team governance meetings should review KPI 7 alongside their Bone Medication Table and arrangements for 120-day follow-up	*#NoF IG review this KPI. ABUHB not the best in Wales however above NA. NA - 34% ABUHB - 62%, UHW - 72%*
R9	Hip fracture teams should signpost patients, their families, and carers to the NHFD website resources designed to help	*This is in the public domain – families can be signposted to this,*

	them understand their care and recovery following a hip fracture	*and this is on the agenda for the next #NoF IG*
R10	Hip fracture teams should use monthly governance meetings to review their policies and protocols, and to compare these with those in other units as described in the Facilities Survey	*On agenda for next #NoF IG*
R11	Hip fracture teams should minimise inequalities in health care; specifically, by reviewing whether support and information are provided in formats and languages appropriate to their patients	*Further work required regarding this KPI*

Recommendations 1, 3, 4, & 5 relate to governance structures.

Key points:

ABUHB is performing well in:

- KPI 1 – Prompt Orthogeriatric review – 93% ABUHB, 86% NA
- KPI 3 – NICE compliant surgery ABUHB 72%, compared to NA 69%
- KPI 5 – Not delirious Post-Op – Prompt delirium assessment after operation ABUHB 79, NA 62%
- KPI 6 – Return to original residence, ABUHB 72%, NA 70%
- KPI 7 – Bone Medication – given suitable bone strengthening treatment with a 120-day follow-up, 62% ABUHB and NA 34%

Comparable in:

- KPI 0 – Admission to a specialist ward – 5% ABUHB and 6% nationally, reflective of the pressure on the NHS
- KPI 2 – Prompt surgery 57% ABUHB and NA

Not performing well:

- KPI 4 – Prompt mobilisation isn't where we want it to be 74% compared to NA 80%

Actions:

- Orthogeriatrician Governance meeting to commence
- Ring fenced one bed for #NoF
- Review of Policies and Protocols with comparison to other units
- Review the inequalities in healthcare relating to the information literature available to patients.

Please note that the NFHD notes have not been approved by the presenting clinician.

CSEG 2601/03 – National Early Inflammatory Arthritis Audit (NEIAA) year 4 2021/2022

NP presented the HB position with regards to the NEIAA report published October 2022 relating to data from April 2021-March 2022 and focuses on 7 key metrics of the NICE QS 33.
NP informed the group of the main requirements for the HB in relation to Early Arthritis Treatment, being:

Key Metrics	Quality Statements	ABUHB performance
How quickly do primary care and other health professionals refer people suspected to have inflammatory arthritis?	**QS1** - Nationally 54% of patients were referred within three working days,	ABUHB – 69 % referred within 3 working days.
How soon after referral are people seen in specialist secondary care services?	**QS2** - Nationally 42% of patients referred with suspected EIA were seen within three weeks. Wales is below the national	ABUHB is below the national and Welsh average at 22%
How long does it take to start treatment?	**QS3 -** Nationally 65% of patients with a diagnosis of RA pattern EIA were established on a cDMARD within six weeks of referral. The Welsh rate is approx. 65%	ABUHB is performing well at 83 %
Do patients receive prompt education about their condition?	**QS4** - Nationally, 95% of patients with confirmed EIA were offered access to education and information on self-management.	ABUHB Baseline: 87% ABUHB 3 months: 100%
Are treatment targets set and agreed?	**QS5** - Nationally 90% of patients with confirmed EIA had a treatment target set and agreed.	Wales along with ABUHB under the NA at 77%.
Do patients have access to emergency advice?	**QS6** - Nationally 95% of patients were provided with access to rheumatology specialist advice (e.g., a telephone advice line).	ABUHB – 94%

	Wales is performing well, above the national average.	
Are annual reviews taking place?	**QS7** – Delays in 3 and 12 month follow up appointments in ABUHB.	12-month target for ABUHB 25% - 50% reduction on previous years

Quality standard	ABUHB 2020	ABUHB 2021	ABUHB 2022	2022 national	2022 wales
QS1 %	72	72	69	54	59
QS2 %	29	74	22	42	34
QS3 %	73	91	83	65	66
QS4 %	92	92	87	95	95
QS5 %	75	75	77	90	88
QS6 %	92	92	94	95	96
QS7 %	75	75	25	no data	no data

Only 4 Health boards in Wales have data for all QS

NP informed the group that the data for ABUHB by site is no longer accurate, it is currently displayed as RGH, NHH and YYF which is no longer the correct sites for the clinics, so the audit has been asked to combine as ABUHB.
NP also informed the group that ABUHB has the highest number of patients across the UK.

Key points:

- Communication with GP's has made an improvement in accurate referrals and earlier referrals
- Outlier status for QS2 EA patients seen within the 3 weeks due to many varying issues with clinic booking
- Establishing patients on cDMARD within 6 weeks is going well, as although late referrals, medication being commenced at first appt
- Education and information on self-management can be delayed due to not always knowing the correct diagnosis, however the correct education is sent to the patient on knowledge of diagnosis
- Unsure as to why QS5 'treatment targets set and agreed' in ABUHB is underperforming
- Good access in ABUHB to QS6 'availability of access to emergency care'
- Consultant shortages previously affecting performance
- Audit time consuming to participate
- Audit does not take into account patients' choice to wait longer i.e. for specific site or date (DNA/CNA)

Actions:

- Improve clinic booking processes – to be discussed at Directorate/DPSQ meetings and with BSR Regional Audit Champion
- Report booking issues for DATIX entry
- CNS and registrar to be involved in audit follow up

CSEG 2601/04 – National Vascular Registry (NVR) 2022 Annual Report

DMcL informed the group that the NVR is mandatory in England however, not in Wales. The data presented relates to 2021 and due to COVID-19 the consultant level data is not available as per usual.
The local data covers 4 areas:

- **Aneurysm repair**
- **Amputation**
- **Carotid endarterectomy**
- **Infer inguinal bypass**

DMcL stated that there are no real issues for ABUHB or Cardiff, Cardiff highlighted because Cardiff historically hasn't permed well and as all ABUHB services were transferred to Cardiff in June 2022. Mr McLain is the Clinical Governance Lead for the Vascular Network of South-East Wales.

Report results:

ABUHB has good case ascertainment compared to Cardiff for Abdominal Aortic Aneurysms (AAA) with ABUHB Length of Stay (LoS) more efficient that the National Average and Cardiff and outcomes are good.

Trust Name	Trust code	NVR Cases	No. of EVAR	Median (IQR) length of stay for open repairs (days)	Median (IQR) length of stay for EVAR (days)	Risk-adjusted in-hospital mortality (2019-2021)
Aneurin Bevan University Health Board	7A6	25	11	7 (6 - 11)	1 (1 - 5)	2.6%
Cardiff and Vale University Health Board	7A4	13	6	9 (8 - 16)	5 (2 - 6)	2.3%

DMcL highlighted that here were some data entry issues with regards to the 2021 data, as some fields are not mandatory on the dataset however the metric are completed, i.e., Anaesthetic review shows 93% when ALL are reviewed by an anaesthetist in MDT meetings.

DMcL highlighted that having low rates of events is difficult to demonstrate if a significant outlier status.

Revascularisation is an ambitious target at within 5 days, however ABUHB at approx. 61% in target compared to Cardiff at 31%.

Angioplasties carried out as day cases for ABUHB was lower than the NA of 60% at 44% whereas Cardiff were at 0% due to organisational issues. ABUHB angioplasty suite remains functioning in GUH, therefore are supporting Cardiff with these cases. Case ascertainment was low due to not being mandatory.

Bypass case ascertainment for both ABUHB and Cardiff are good, and both good outcomes with ABUHB patients having a reduced LoS, although ABUHB mortality rate was slightly higher but not a concern and lower re-admission rates.

Trust Name	Trust code	NVR cases 2021	NVR cases 2019-2021	Median (IQR) length of stay (days) 2021	% Adjusted in-hospital mortality 2019-2021	Readmission within 30 days 2021
Aneurin Bevan University Health Board	7A6	88	198	6 (3 - 12)	3.2%	14%
Cardiff and Vale University Health Board	7A4	55	196	15 (7 - 27)	2.2%	18%
NATIONAL		5,817	17,700	8 (4 - 16)	1.8%	11.5%

Ascertainment interpretation
85% or more
70% to 84%
Below 70%

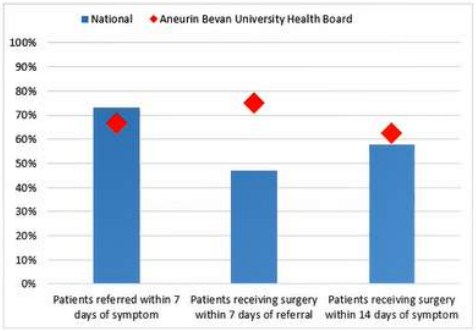
Amputation time, decision to surgery, often can't be done too quickly as patients need to be prepared for such an outcome, however waiting too long can lead to further medical issues. ABUHB delay was 8 days to amputation and Cardiff significantly higher at 11 days, with a much higher LoS of 21 days compared to ABUHB 11 days LoS. Cardiff issues due to theatre usage. ABUHB 100% patients' amputation within 30 days and Cardiff are at 76%. No issues with outcomes for either site.

Data issues with Carotid Endarterectomies (CEA) in Cardiff so no result, however ABUHB Symptom to Surgery rate is 12 days with NA being 13 days

Trust Name	Trust code	NVR cases	Symptomatic cases	Patients referred within 7 days of symptom	Patients receiving surgery within 7 days of referral	Patients receiving surgery within 14 days of symptom	% Adjusted Stroke and/or death rate (2019-2021)	Median delay and IQR from index symptom to surgery (days)	Median (IQR) length of stay (days)
Aneurin Bevan University Health Board	7A6	24	24	67%	75%	63%	3.5%	12 (6 - 18)	1 (1 - 3)
Cardiff and Vale University Health Board	7A4	6	6	N/A	N/A	N/A	3.9%	N/A	6 (3 - 9)
NATIONAL		3,403	3,038	73%	47%	58%	2.2%	13 (8 - 22)	2 (1 - 5)

Ascertainment interpretation
85% or more
70% to 84%
Below 70%

ABUHB v's National shows a slightly lesser ate of referral within 7 days but significantly better rate for patients receiving surgery within 7 days of referral and slightly better than NA in patients receiving surgery with 14 days of symptoms, with a much lower LoS than Cardiff at 1 days compared to 6.



Overall ABUHB performing well in 2021 compared to Cardiff, so moving services there without additional radiology support. Mr McLain noted that the radiology services that were provided at GUH were outstanding. Cardiff has lesser theatre capacity, relaying on emergency theatre space, which is causing delays. This will be evidenced in the next report.

DMcL stressed that Cardiff has a solely vascular ward with dedicated vascular nurses, which is proving better for the patients, however repatriation causes issues with bad availability in Cardiff, also a bottleneck moving patients to the lakeside wing of Cardiff from the acute vascular ward. Theatre provision and hyrd-theatre has no progress and junior Dr's ratio is the single highest risk for the network, losing more Dr's in February 2023. IT co-ordination remains challenging between the 3 HB involved. 6/7 months into the centralisation and it is going well. Medical Director involvement to ensure governance and

management is progressing. Glenys Mansfield stated Directorate meet with Cardiff to raise issues to ensure patients from ABUHB are not being offered a lesser service.

Radiology in GUH still providing an excellent service all round for patients being seen in GUH.

Key points:

- Data for ABUHB is pre-centralisation of vascular services held within Cardiff
- ABUHB pre-centralisation was performing well with good outcomes
- Since centralisation issues with Cardiff Theatre capacity and radiology capacity
- Concerns regarding repatriation of of patients back to their locality HB to free up bed capacity on vascular ward
- Vascular ward dedicated nursing is excellent
- Concerns regarding the volumes of Junior Dr's

Actions:
Please note that the NVR notes have not been approved by the presenting clinician and no actions have been provided.

CSEG 2601/05 – National Diabetes Audit 2020/2021 Care Processes and Treatment Targets

CJ reported the results of the 2020-2021 data to the group. In previous audits, ABUHB outperformed the Wales average in most indicators. However, Wales lags NHS England. ABUHB was performing equally of slightly above other HB's in most targets.

Last NDA covered 2019/20 pre-pandemic and this data is during the height of COVID -19, it was noted that there was a gradual downward trend in achievement across most of Wales.

The national audit report highlighted 3 key findings:

Key Finding 1
During the COVID-19 pandemic, care process completion declined everywhere but there was greater geographical variation than usual. The greatest impacts were on foot examination, weight measurement, and retinal screening. Urine albumin checks remain lowest.

Key Finding 2
During the COVID-19 pandemic: glucose control improved in people with type 1 diabetes but deteriorated in those with type 2 and other types of diabetes; blood pressure deteriorated in all; and use of statins was relatively unchanged.

Key Finding 3
2.0% of people with type 1 diabetes and 5.3% of people with type 2 or other types of diabetes have severe frailty. 65,970 people with type 2 diabetes have both severe frailty and HbA1c ≤ 53 mmol/mol. 18,690 people with diabetes with severe frailty and HbA1c ≤ 53mmol/mol are on insulin or sulphonylurea or both. These people may be at particular risk of harm due to hypoglycaemia.

Geographical variation increased nationally however the drop off in achievement due to COVID-19 was more noticeable in certain areas of ABUHB.
Treatment target achievement worsened and Co-existence of frailty and DM1/DM2 highlighted as a potential risk

Report Recommendations:

1. Although not included in this audit data, achievement of care process in ABUHB has returned to pre-pandemic levels
2. Focus on individualised targets
3. Focus on frailty and hypoglycaemia

Key Points:

- Treatment Targets for ABUHB have mostly seen a reduction, HbA1c, 58mmol/mol has increased slightly for Type I from 2019/20 to 2020/21. The same pattern is demonstrated at a Welsh National level.
- Blood pressure treatment target achievement is on a long-term downward trend but HbA1c shows steady improvement.
- All 3 treatment targets saw a downward turn across Wales
- Primary Care (PC) Specialist Nurse service have done a lot of work to improve the care provided and to participate in the Diabetes Enhanced Service.
- PC Nurse Specialists providing education programmes for other Healthcare professionals
- Data is gathered direct from the PC Information Portal which means we can get live data

Aneurin Bevan University Local Health Board			
		Q1 20/21	Q2 22/23
Measure	Measure Description	Percentage	Percentage
ND01	All newly diagnosed diabetics referred to/attended structured education programme	47.87	50.28
NDA01	HbA1c recorded within last 15 months	87.07	89.17
NDA02	Blood Pressure recorded within last 15 months	87.24	88.25
NDA03	Cholesterol recorded within last 15 months	78.30	81.63
NDA04	Serum Creatinine recorded within last 15 months	87.51	89.60
NDA05	Urine Albumin recorded within last 15 months	50.92	56.71
NDA06	Foot Surveillance recorded within last 15 months	62.48	67.10
NDA07	Body Mass Index recorded within last 15 months	75.98	77.92
NDA08	Smoking Status recorded within last 15 months	72.35	72.00
NDA09	**All 8 Care Processes Completed**	**35.30**	**40.27**
PR01	8 Measures Recorded	35.30	40.27
PR02	7 Measures Recorded	24.07	23.29
PR03	6 Measures Recorded	11.59	11.25
PR04	5 Measures Recorded	7.02	6.39
PR05 PR06 PR07 PR08 PR09	4 or Less Measures Recorded	4.41	3.76
TT01	HbA1c<48 mmol/mol (6.5%)	21.63	17.64
TT02	**HbA1c<=58 mmol/mol (7.5%)**	**50.74**	**49.12**
TT03	HbA1c<=86 mmol/mol (10.0%)	79.31	80.81
TT04	**Latest blood pressure <=140/80**	**52.41**	**54.16**
TT05	Cholesterol<4 mmol/L	29.58	34.46
TT06	Cholesterol<5 mmol/L	57.07	62.17
TT07	All Treatment Targets Met	21.21	21.95

Actions:

- Diabetes service to continue to promote and support Diabetes NES (national Enhanced Services) and improvement of diabetes care
- Diabetes service to continue education for HCSW's and Diatips (diabetes theory into practice)
- Discuss NDA (National Diabetes Audit) and ongoing achievement of outcomes with NCN leads and generate strategies to reduce variation

CSEG 2601/06 – National Confidential Enquiry into Patient Outcome & Death (NCEPOD)

JS gave the group a brief introduction to the NCEPOD studies which form part of the National Clinical Outcome Review Plan (NCAORP). JS gave an update on the position of the current studies and the studies due during 2023. The processes within the HB were provided, stating that once details of which specialties are expected to participate in a study, the QPS team will liaise with the divisional triumvirate, requesting clinical representation to support study completion.

Current studies:

- Community Acquired Pneumonia - Deadline extended to 17/02/2023 - 25/32 cases incomplete
- Testicular Torsion – not complete and deadline extended to 27/01/2023 - 6/8 cases incomplete
- Transition from child to adult health services - not completed at deadline date 28/10/2022
- Crohn's Disease - not completed at deadline date 28/10/2022
- Endometriosis - Patient data provided to NCEPOD awaiting cases on website
- Rehabilitation following critical illness - Data collection due Summer/Autumn 2023
- End of Life Care - Spring/Summer 2023
- Juvenile Idiopathic Arthritis – TBC
- Prison Healthcare Study - Data from Prison Service

CSEG 2601/06 - New Procedures Policy request

LL informed the group that any new procedure/new equipment applications need to come through the CSEG for discussion and approval. Each application requires a completed form from the 'Application for the introduction of a new clinical procedure or technique' policy ABUHB/Clinical/1091. LL informed of an application from Cardiology to use a different device called Orbital Atherectomy and the cardiovascular team will provide training and a competency metrics and align to NICE guidance. This will go through a triumvirate approval process.

Next meeting Thursday 23rd March 2023 @ 14:00 – 16:00

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**24 January 2023**

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

Presentation – Mental Health Deep Dive

The committee received an informative Mental Health (MH) presentation which covered the following key areas:

- Mental Health Strategy – Consultation Feedback
- Secure Services Review
- Single Commissioner
- CAMHS
- Eating Disorders
- Mother and Baby Unit
- Governance and Incident Reporting

Dai Roberts (DR) explained that the majority of HBs had submitted consultation feedback and from the initial review of responses there was no firm opposition to the key elements of the MH strategy. The consultation responses would be used to inform the development of the final strategy and an implementation plan for the strategy was also under development.

Shane Mills (SM) provided a detailed overview of the Secure Mental Health review which he conducted and highlighted the general differences between High, Medium and Low Secure Services, the average lengths of stay as well as other classifications by gender, sexual orientation etc. for patients in each sector.

DR explained that the Single Commissioner Model had been to the WHSSC Joint Committee on 10 January 2023 and that Secure Mental Health Services in Wales should be commissioned by WHSSC. More detailed work needed be done to define the appropriate timescales, but the programme of work is unlikely to be completed before April 2024 at the earliest.

DR provided an update on the positive progress in relation to CAMHS and the de-escalation of Ty Llidiard to Escalation Level 3. The service had been in Escalation Level 4 for a considerable length of time. There will be a piece of work undertaken on referral management, which will be undertaken by NCCU.

In relation to Eating Disorders, interim arrangements are currently in place with

the Priory to ensure access to Eating Disorder beds for adults. A tender process is underway to secure a medium-term solution for the next 2-3 years. The long-term solution will be considered as part of the Specialised Services Strategy for Mental Health.

Several recommendations were made following the review of Tonna Mother and Baby Unit (MB) and an analysis of a permanent option is being conducted in line with the Mental Health Strategy Work.

Welsh Kidney Network (WKN)
QPS members were provided with an update around the two risks documented as they scored above 15, the first being around the financial element and possible inability to meet demands through the current budget. The second high level risk was around the limited outpatient capacity in Morriston Hospital, where there is a plan to establish two new satellite units around the Swansea area which should be running early 2024. The funding for these dialysis units had been approved by the Joint Committee during January 2023.

Ashraf Mikhail (AM) provided an update on the peer review process and gave details on the Quality Statement that was released by WG in 2022, which summarised the aims and objectives for the WKN.

Commissioning Team and Network Updates
Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below:

Cancer & Blood
Within the Cancer & portfolio and in relation to the Burns service, WHSSC were notified this week that the Mutual Aid arrangements through the Burns Network had been triggered due to a nurse staffing issue and all the arrangements with the Burns network worked appropriately.

The Corporate Directors Group Board (CDGB) had also agreed to de-escalate the PETIC service.

Neurosciences
There was a performance issue that had been a pre-COVID issue within the Neurosurgery Service, but that had now been de-escalated. Nicola Johnson (NJ) highlighted the good progress that had taken place in terms of access.

The single-handed Consultant within the Neuroendocrine Tumour service (NETS) has taken a leave of absence, but WHSSC have received assurance that contingency arrangements are in place. A Consultant from another accredited Centre is providing support and cover for these clinics.

Within the Neurosciences Commissioning Team, the Cochlear and Baha engagement was launched in December 2022 and this will close on 14 February 2023.

Cardiac
Within the Cardiac surgery services, unfortunately the escalation status has remained at the same level in both C&VUHB and SBUHB.

Following receipt of the Royal College of Surgeons (RCS) Report, it was not considered appropriate to de-escalate the service in SBUHB. WHSSC will be meeting again with the HB at an escalation meeting in February to consider the Action Plan that they have put in place to address the issues highlighted in the report. The position will then be considered again under the Escalation Framework processes.

C&VUHB has reported that hood discussion had taken place around their strategic issues and cultural changes. The provider had expressed the view that the escalation process has helped to maintain the focus of the Health Board on these issues. There will be a further meeting in April 2023.

NJ commented that the RCS Report had been written on the basis of a visit to the HB in March 2022 and the HB had undertaken significant action as a result. WHSSC had written to the HB outlining the areas of concern and the evidence required to provide WHSSC with the necessary assurance. NJ explained that she and Sian Lewis had also met with the Medical Director and Chief Executive of the Health Board and explained the progress that was expected by the next Escalation meeting.

Women & Children
During the winter there had been increased pressure within the paediatric intensive care service. This was anticipated post Covid with a return to children mixing on top of the usual respiratory pressures during the winter months.

AR reminded the Committee that WHSSC continued to attend the Paediatric Intensive Care SitRep meetings. There continues to be high demand for PICU beds.

In response to a query around Paediatric activity levels in C&VUHB, NJ explained that WHSSC had received assurance from the HB that they would be able to deliver the contract for 2022/23, but throughout the year due to pressures of theatre and staffing allocation across other Paediatric surgical disciplines the HB has not been able to deliver the level of planned contract activity. This has remained a focus of the performance meetings with the HB. NJ highlighted that, in conjunction with the JC, WHSSC would be reviewing the contract for next year and the provision for Paediatric Surgery. Outsourcing options remain on the table.

Mental Health & Vulnerable Groups
NJ explained that details around the NWAS and Ty Llidiard Services had been covered within the Mental Health presentation.

Adele Roberts (AR) felt it was important to add to the Mental Health update that WHSSC received a report on 7 November 2022, jointly undertaken by NHS Wales and NHS England, relating to a serious incident, which had led to the death of a patient on 20th April 2022. There were 12 recommendations, which will be considered by the Mental Health and Vulnerable Groups Commissioning Team. The

date of the Inquest has not yet been confirmed. The final report and findings of the inquest will be reported to the Quality and Patient Safety Committee once concluded. An update will be provided to the Joint Committee through the Chair's report.

Intestinal Failure (IF) – Home Parenteral Nutrition
The action on the Intestinal Failure (IF) invoices had been closed and an update has been provided within the report. Some new IF risks will be added onto the CRAF in January 2023 mainly around the financial and contractual arrangements.

4.0 Other Reports Received
Members received reports on the following:

- **Services in Escalation Summary**
  WHSSC currently has 6 services in escalation to report, although this will be reduced to 4 as 2 services are scheduled to come out of escalation. One service has also reduced its level of escalation and there are no new services in escalation. The table at the end of this paper provides a summary of each of those services.
- **CRAF Risk Assurance Framework**
  Members were provided with an updated position regarding the WHSSC CRAF. Members noted the updated Risk Appetite Statement that had recently been approved by the JC.
- **Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update**
  AR provided a briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period October to December 2022.

It was acknowledged that the structure of the CQC had recently changed and may have had an impact on the structure for producing the reports. However, going forward WHSSC will continue to work closely with the CQC on their action plans and meet with them regularly.

Incident and Concerns report
An update report was noted and received by the Committee for assurance. The Chair asked for the content of the report to be considered with perhaps some additional information added to the next report.

5.0 Items for information:
Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee 8 November 2022,
- QPSC Distribution List; and
- QPSC Forward Work Plan.

Key risks and issues/matters of concern and any mitigating actions Key risks are highlighted in the narrative above.	
Summary of services in Escalation (Appendix 1 attached)	
Matters requiring Committee level consideration and/or approval None	
Matters referred to other Committees As above	
Confirmed minutes for the meeting are available upon request	
Date of next scheduled meeting:	21 March 2023 at 13.00hrs

SERVICES IN ESCALATION

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
September 2020	FACTS	CTUHB	2	• Workforce issue	• Last escalation meeting was held on 14/12/22 • Assurance was provided for the remaining key requirements • The service was formally de-escalated to level two on 16/12/22 Service will continue to be monitored through an improvement plan for further de-escalation (confirmation of clinical leadership and recruitment of remaining psychology posts)	**To be removed from escalation** 

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
March 2018 Sept 2020 Aug 2021	Ty Llidiard	CTMUHB	3	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11 September	• Escalation meetings held monthly, Exec Lead identified from Health Board. Last escalation meeting 5th December 2022 • Improvement Board established to oversee delivery of an integrated improvement plan • Emergency SOP has been fully implemented • Majority of posts recruited to or start dates agreed. • Improved leadership evident via escalation meetings • Progress against de-escalation action plans, and a favorable report following the latest quality visit provided assurance to support de-escalation of service to Level 3 • Further audit being conducted around the referral processes to enable consideration of further de-escalation.	
July 2021	Cardiac Surgery	SBUHB	3	• Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review	• Continued six weekly meetings in place to receive and monitor against the improvement plan. • The service was de- escalated on delivery of the immediate actions required by the GIRFT recommendations (per March update), but remained in level 3 whilst the impact of these actions is ascertained. • The escalation level was discussed at the most recent	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
					meeting in October 2022 and, although significant progress towards the GIRFT benchmarks was noted, it was agreed that WHSSC would need to review the final report of the Royal College of Surgeons of England (RCS England) Invited Service Review to be prior to any potential further de-escalation. • This report was received in November 2022 and was subsequently reviewed by the Cardiac Commissioning Team. As a result of the report's urgent recommendations to address patient safety risks, and in view of a small number of new concerns identified by the RCS, WHSSC concluded that further assurance was required further assurance before de-escalation could be taken forward, and the service remains in Level 3 escalation.	
July 2021 (original escalation) April 2022 (escalated from 2-3)	Cardiac Surgery	C&VUHB	3	• Lack of assurance regarding processes and patient flow which impact on patient experience	• C&VUHB had previously agreed a programme of improvement work to address the recommendations set out in the GIRFT report. • In view of a failure to provide the requested GIRFT improvement plan and HEIW report, the service was re-	⟷

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
					escalated in April 2022. • The service has since provided both a GIRFT improvement plan and HEIW report (and action plan), and WHSSC has developed de-escalation criteria based on the GIRFT recommendations and action plans. • The de-escalation criteria were discussed at the November 2022 escalation meeting. It was agreed that there was no expectation that the criteria would need to be delivered in full to facilitate de-escalation, but that the service would need to evidence demonstrable progress as a result of targeted actions • A further escalation meeting has been scheduled for April 2023.	
November 2021	Adult burns	SBUHB	3	• At the time of initial escalation, the burns service at SBUHB was unable to provide major burns level care due to staffing issues in burns ITU. An interim model was put in place allowing the service to reopen in February 2022. The current escalation	• Escalation monitoring meetings held on 12th August, 27th September and 1st December 2022. • The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023. • The capital case remains on target with the planned timeline. • The next escalation monitoring	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
				concerns the progress of the capital case for the long term solution and sustainability of the interim model.	meeting is arranged for 3rd March 2023.	
February 2022	PETIC	Cardiff University	1	Concern over management capacity within the service to ensure a safe, high quality timely service is maintained for patients. These concerns include: • Recent suspension of production of PSMA due to critical quality control issue identified during MHRA inspection. Service slow top address impact on service for patients. • Failure to undertake a timely recruitment exercise leading to isotope production failures. • Failure to provide a business case of sufficient quality in a timely manner for replacement of the scanner	PETIC has taken forward the agreed actions with regard to increasing management capacity within the service and clarifying the governance arrangements for the service. PETIC has been de-escalated and therefore removed from the table of services in escalation. WHSSC corporate directors agreed to de-escalate PETIC following confirmation on 5th December 2022 that the actions in the escalation action plan had been completed. The service has returned to routine monitoring.	**To be removed from escalation**

PATIENT QUALITY, SAFETY & OUTCOMES COMMITTEE
PROGRAMME OF BUSINESS 2022/23

The scope of the Patient Quality, Safety & Outcomes Committee extends to the full range of ABUHB responsibilities. This encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. The Committee will embrace the Health and Care Standards as the Framework in which it will fulfil its purpose

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

- the Committee's Terms of Reference as agreed by the Board in March 2022;
- the Board's Assurance Framework (based on its Annual Objectives for 2021/22 and 2022/23);
- delivery of the Board's Experience, Quality & Safety Objectives set out within the IMTP 2022-25;
- key risks identified through the Corporate (Strategic) Risk Register and Operational Risk Registers.
- audit and regulatory reports identifying weaknesses in internal control (following consideration by the Audit, Risk and Assurance Committee); and
- key statutory, national and best practice requirements and reporting arrangements.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	25th April
Preliminary Matters									
Attendance and Apologies	Standing Item	Chair	✓	✓	✓	✓	✓	✓	✓
Declarations of Interest		All Members	✓	✓	✓	✓	✓	✓	✓
Minutes of the Previous Meeting		Chair	✓	✓	✓	✓	✓	✓	✓
Action Log and Matters Arising		Chair	✓	✓	✓	✓	✓	✓	✓
Committee Requirements as set out in Standing Orders									
Development of Committee Annual Programme of Business 2022/23	Annually	Chair & Director of CG			✓				
Review of Committee Programme of Business	Standing Item	Chair			✓	✓	✓	✓	✓
Annual Review of Committee Terms of Reference 2022/23	Annually	Chair & Director of CG						✓	
Annual Review of Committee Effectiveness 2022/23	Annually	Chair & Director of CG							deferred
Committee Annual Report 2022/23	Annually	Chair & Director of CG							✓
Quality Domain: Safe Care									
Pharmacy and Medicines Management Annual Report	Annually	Medical Director							✓
Internal Audit Review: Medicines Management (Reasonable Assurance) – Update on actions	Annually	Medical Director						✓	
Learning from Death Report	Bi-Annually	Medical Director		✓			✓		
Cleaning Standards Annual Report	Annually	Director of Operations						deferred	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	25th April
Nutrition and Hydration Standards and Strategy'	Annually	Director of Therapies & HS							✓
Falls Prevention and Management Report	Bi-Annually	Director of Therapies & HS							✓
Health and Safety Compliance Report	Annually	Director of Therapies & HS					✓		
Safeguarding Annual Report	Annually	Director of Nursing			✓				
Safeguarding Group Highlight Report	Quarterly	Director of Nursing			✓		✓		✓
Operation Jasmine Action Plan	Bi-Annually	Director of Nursing		✓				✓	
Children's Rights & Participation Forum	Bi-Annually	Director of Nursing				✓			✓
Infection Prevention and Control Annual Report	Annually	Director of Nursing			✓				
Infection Prevention and Control Report	Quarterly	Director of Nursing			✓	✓		PQSO report	
Blood Management Annual Report	Annually	Medical Director						deferred	
Organ Donation Annual Report	Annually	Medical Director						✓	
Quality Domain: Effective Care									
Quality Assurance Framework Annual Review and Evaluation of Progress	Annually	Clinical Executives						✓	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	25th April
Commissioning Assurance Framework, Development and Implementation	Bi-Annually	Clinical Executives					✓		
Clinical Effectiveness and Standards Committee Report	Bi-Annually	Medical Director				✓			✓
Annual Clinical Audit Plan (prior to ratification) by the Audit, Risk & Assurance Committee	Annually	Medical Director			✓				
Clinical Audit Activity Report (Local and National) Feb 23 to include Annual Clinical Audit Draft Internal Audit Report	Quarterly	Medical Director			✓			✓	✓
Quality Improvement Annual Report	Annually	Director of Planning							deferred
Research and Development Annual Report	Annually	Medical Director							✓
Medical Devices Annual Report	Annually	Director of Therapies & HS					✓		
Point of Care Testing Annual Report	Annually	Director of Therapies & HS					✓		
Quality and Safety Outcomes Report	Standing Item	Clinical Executives	✓	✓	✓	✓	✓	✓	✓
Committee Risk Report, including BAF	Standing Item	Director of Corporate Gov	✓	✓	✓	✓	✓	✓	✓
WHSSC QPS Committee Report	Standing Item	Director of Nursing	✓	✓	✓	✓	✓	✓	✓

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	25th April
Quality Domain: Dignified Care & Individual Care									
Patient Story	Standing Item	Clinical Executives	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Putting Things Right Policy	Every 3-yrs (2022)	Director of Nursing				✓			
Putting Things Right Reporting (complaints, compliments, and redress)	Standing Item[1]	Director of Nursing	✓	✓	✓	✓	✓	PQSO report	PQSO report
Quality & Engagement (Wales) Act, Preparedness and Implementation	Annually	Director of Nursing					✓		PQSO report
Patient Experience Report	Quarterly	Director of Nursing		✓			✓		✓
Dementia Care Annual Report	Annually	Director of Nursing							✓
Clinical Negligence Claims and Coroners Inquests Report	Bi-Annually	Director of Nursing				✓			PQSO report
Patient Safety Incidents and Learning	Standing Item[2]	Director of Therapies & HS	✓	✓	✓	✓	✓	PQSO report	PQSO report
Covid-19 Concerns and Claims	Bi-Annually	Director of Nursing		✓				✓	
Service Specific Deep-Dive Assurance Reviews									
Learning Disabilities	Annually	Director of PCCMH			✓				
Urgent and Emergency Care Demand and Impact on Outcomes	Quarterly	Director of Operations			✓		✓		deferred

[1] Via Quality and Safety Outcomes Report
[2] Via Quality and Safety Outcomes Report

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	25th April
Maternity Services: Organisational Improvement and Action Plan	Bi-Annually	Director of Nursing		✓		✓			
Child and Adolescent Mental Health Crisis Hub and Safe Accommodation	Annually	Director of Nursing							
Self-Harm & Suicide - Children & Young People	Annually	Director of Nursing							
Primary Care Quality	Bi-Annually	Director of PCCMH							deferred
Independent Audit, Regulation and Inspection									
Internal Audit Reports relevant to the remit of the Committee	Ad-hoc	Clinical Executives	As scheduled within the Annual Internal Audit Plan						
External Audit Reports relevant to the remit of the Committee	Ad-hoc	Clinical Executives	As scheduled within the Annual External Audit Plan						
Action Plan for "*Review of Quality Governance Arrangements*" Audit, Wales Review (2021/22)	Bi-Annually	Clinical Executives		✓			➲	✓	
Internal Audit Review - Quality Governance arrangements for the commissioning of NHS Continuing Care within the Mental Health & Learning Disabilities (limited assurance) – Action Plan Update	Bi-Annually	Director of Primary, Community Care & Mental Health			✓			✓	
Internal Audit Review – Medical Devices – Action Plan Update	Bi-Annually	Director of Therapies & HS			✓		✓ (linked to Annual Report)		
Overview of Audit Recommendation Tracking (relevant to the Committee)	Quarterly	Director of Corporate Gov			✓		✓		✓

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	25th April
Inspections of Healthcare Inspectorate Wales	Ad-hoc	Director of Nursing	As published						
Inspections of the Community Health Council	Ad-hoc	Director of Nursing	As published						
Tracking of Improvement Actions Arising from Inspections and Reviews	Quarterly	Director of Nursing		✓		✓		✓	
Healthcare Inspectorate Wales Operational Plan	Annually	Director of Nursing			✓				
Healthcare Inspectorate Wales Annual Report	Annually	Director of Nursing						✓ Included in Dec 22	
WRP Report and Management Response/Action Plan: National Review of Consent to examination and treatment standards in NHS Wales		Medical Director							✓

Report title as scheduled within Workplan – Not included on agenda	Lead	Update
Quality Assurance Framework Annual Review and Evaluation of Progress	Clinical Executive Directors	Quality Strategy submitted to the Board March 2023
Cleaning Standards Annual Report	Director of Operations	Deferred due to capacity issues within the Facilities Division
Annual Review of Committee Effectiveness 2022/23	Director of Corporate Governance	The Board has undertaken an overall assessment of its effectiveness during 2022/23. A mid year review of Committee effectivess, to inform the Board's year end review, to be included in the FWP for October.