Patient Quality, Safety and Outcomes Committee

Tue 07 February 2023, 09:30 - 12:30

Via Microsoft Teams

Agenda

1. Preliminary Matters

📄 AGENDA 07.02.23.pdf (3 pages)

1.1. Welcome and Introductions

Verbal   Chair

1.2. Apologies for Absence

Verbal   Chair

1.3. Declarations of Interest

Verbal   Chair

1.4. Draft Minutes of the last Meeting held on 6th December 2022

Attachment   Chair

📄 1.4 DRAFT PQSOC Minutes 6.12.22 bc approved PB.pdf (11 pages)

1.5. Committee Action Log

Attachment   Chair

📄 1.5 Action Log Revised Template Jan 2022 (003).pdf (5 pages)

2. Items for Approval/Ratification/Decision

There are no items for inclusion in this section

3. Items for Discussion

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

Presentation   Clinical Executive Directors

📄 3.1 PQSOC Performance Report - FINAL.pdf (43 pages)

3.2. Committee Risk Report, January 2023

Attachment   Director of Corporate Governance

📄 3.2 a FINALPQSOC_Strategic Risk Report Cover paper_Feb23 (002).pdf (4 pages)
📄 3.2 b Appendix1 PQSOCCommitteeRisk Register OverviewFeb2023.pdf (5 pages)
📄 3.2 c Appendix 2 Risk Updates Feb2023.pdf (46 pages)

3.3. Healthcare Inspectorate Wales Inspection Reviews, to include Tracking of Improvement Actions Arising from Inspections and Reviews, including

Attachment   Director of Nursing / Medical Director

a) Healthcare Inspectorate Wales Reviews
b) In Search of Accountability, Operation Jasmine
c) Internal Audit Review: Medicines Management (Reasonable Assurance) - Update on Actions

- 3.3 Health Inspectorate Wales - Quarterly Update for PQSOC.pdf (15 pages)
- 3.3 b Operation Jasmine-Coroner Inquests - Actions for Improvement - Update for PQSOC February 2023.pdf (5 pages)
- 3.3 c 1 MM Internal Audit Report CHECKED (002).pdf (8 pages)
- 3.3 c 2 ABHB 2021-22 Medicines Management Final Report for client.pdf (17 pages)

3.4. Clinical Audit

Attachments   Medical Director

a) Internal Audit Review of Clinical Audit (Limited Assurance) and Management Response
b) Clinical Audit Plan 2022-24
c) Audit Activity Report, January 2023

- 3.4 a 1 Internal Audit report Jan 2023 FINAL.pdf (8 pages)
- 3.4 a 2 AB 2223-05 Clinical Audit Final Internal Audit Report.pdf (18 pages)
- 3.4 b 1 Clinical Audit Plan Jan 2023 FINAL.pdf (10 pages)
- 3.4 b 2 Clinical Audit Policy_Issue 1.1.pdf (15 pages)
- 3.4 b 3 Clinical Audit Strategy 2022 - 2025.pdf (12 pages)
- 3.4 b 4 QPS Clinical Audit Gantt Chart Template v1.pdf (1 pages)
- 3.4 c 1 Clinical Audit Activity Report - CSEG Draft Jan 2023 FINAL.pdf (6 pages)
- 3.4 c 2 CSEG Nov meeting notes for Jan 2023.pdf (12 pages)

3.5. Annual Report: Organ Donation

Attachment   Medical Director

- 3.5 Organ Donation.pdf (4 pages)

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4. Items for Information

4.1. Highlight Reports:

Attachments   Clinical Executive Directors

a) Quality & Patient Safety Operational Group
b) Children's Rights Participation Forum

- 4.1 a QPSOG Highlight Report 18 01 2023.pdf (5 pages)
- 4.1 b ABUHB Children's Rights & Participation Forum - Highlight Report - December 2022.pdf (4 pages)

4.2. Assurance Reports presented to the Finance and Performance Committee, January 2023

Attachment   Director of Therapies and Health Science and Director of Operations

a) Review of Stroke Services in ABUHB, including the Getting it Right First Time Review
b) Six Goals for Urgent and Emergency Care, including Same Day Emergency Care

- 4.2a Stroke GIRFT Update - F&P Committee Jan 2023 (002).pdf (5 pages)
- 4.2a_App1_RNOH GIRFT ABUHB.pdf (37 pages)
- 4.2a_App2_GIRFT Stroke Action Plan- narrative response.pdf (7 pages)
- 4.2a_App3_ToR National Stroke Programme Board.pdf (9 pages)
- 4.2b Six Goals Urgent and Emergency Care.pdf (7 pages)
- 4.2b_App1_ Six Goals Programme Plan.pdf (11 pages)

4.3. Committee Workplan 2022/23

Attachment   *Director of Corporate Governance*

📄 4.4 a PQSOC Work Programme.pdf (8 pages)
📄 4.4 b PQSO Workplan update_Feb23.pdf (1 pages)

5. Other Matters

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

Verbal   *Chair*

5.2. Any Other Urgent Business

Verbal   *Chair*

5.3. Date of Next Meeting

Tuesday 25th April 2023

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

PATIENT QUALITY, SAFETY & OUTCOMES COMMITTEE AGENDA

Date and Time	Tuesday 7ᵗʰ February 2023, 9.30AM – 12.30PM
Venue	Microsoft Teams

Item	Title	Format	Presenter
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 6ᵗʰ December 2022	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
	'There are no items for inclusion in this section'		
3	**ITEMS FOR DISCUSSION**		
3.1	Patient Quality and Safety Outcomes Measures Report, January 2023	Presentation	Clinical Executive Directors
3.2	Committee Risk Report, January 2023	Attached	Director of Corporate Governance
3.3	Healthcare Inspectorate Wales Inspection Reviews, to include Tracking of Improvement Actions Arising from Inspections and Reviews, including: • Healthcare Inspectorate Wales Reviews • In Search of Accountability, Operation Jasmine • Internal Audit Review: Medicines Management (Reasonable Assurance) – Update on actions	Attached	Director of Nursing / Medical Director
3.4	Clinical Audit a) Internal Audit Review of Clinical Audit (Limited Assurance) and Management Response b) Clinical Audit Plan 2022-24 c) Audit Activity Report, January 2023	Attached	Medical Director
3.5	Annual Reports: a) Organ Donation	Attached	Medical Director

4	ITEMS FOR INFORMATION		
4.1	Highlight Reports: a) Quality & Patient Safety Operational Group b) Children's Rights Participation Forum	Attached	Clinical Executive Directors
4.2	Assurance Reports presented to the Finance & Performance Committee, January 2023: a) Review of Stroke Services in ABUHB, including the Getting it Right First Time Review b) Six Goals for Urgent and Emergency Care, including Same Day Emergency Care	Attached	a) Director of Therapies & Health Sciences b) Director of Operations
4.3	PQSO Committee Workplan 2022/23	Attached	Director of Corporate Governance
5	OTHER MATTERS		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: • Tuesday 25th April 2023		

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
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

Motion to Exclude Members of the Public and the Press

There may be circumstances where it would not be in the public interest to discuss a matter in public. In such cases the Chair shall move the following motion to exclude members of the public and the press from the meeting:

"Representatives of the press and other members of the public shall 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".

Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of the Patient Quality, Safety and Outcomes Committee held on Tuesday 6th December 2022 at 9.30 am via 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
James Calvert	Medical Director
Peter Carr	Director of Therapies and Health Science
Tracey Partridge-Wilson	Assistant Director of Nursing
Rani Dash	Director of Corporate Governance
Bryony Codd	Head of Corporate Governance
Leanne Watkins	Director of Operations
Paul Underwood	General Manager, Urgent Care Division
Steve Bonser	Head of Transformational Change
Jayne Beasley	Interim Head of Midwifery & Gynaecology (item 0612/08)
Deb Jackson	Assistant Director of Nursing, IPAC (item 0612/09)
Lucy Kings	Head of Nursing, Primary Care
Leeanne Lewis	Assistant Director for 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
Linda Joseph	Deputy Chief Officer, CHC
Krisztina Kozlovszky	Internal Audit Manager, NWSSP
Emma Guscott	Committee Secretariat

Apologies:
None noted.

	Preliminary Matters
PQSOC 0612/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC 0612/02	**Apologies for Absence** There were no apologies for absence to record.
PQSOC 0612/03	**Declarations of Interest** There were no Declarations of Interest to record.

1

		Committee Governance
PQSOC 0612/04		**Draft Minutes of the Meeting Held on the 16th August 2022** The minutes of the Patient Quality, Safety and Outcomes Committee meeting held on the 16th of August 2022 were noted as a true and accurate record.
PQSOC 0612/05		**Committee Action Log** The Committee discussed the actions and members were assured that all actions had clear timelines. Members thanked the teams involved for the completion of previous actions.
PQSOC 0612/05		**Review of Committee Programme of Business** Jennifer Winslade (JW), Director of Nursing, informed the Committee that the Health Board was reviewing how it reported patient quality and safety. Rani Dash (RD), Director of Corporate Governance, informed members that the Committee Workplan had been agreed for 2022/23, noting possible changes to its structure once the review had taken place. On completion of the review, JW requested a review of the Committee programme of business. **Action: Director of Corporate Governance/Director of Nursing** RD informed members of a point raised by Shelley Bosson (SB) Independent Member and Chair of the Organ Donation Group. SB noted the delay in the schedule of the Organ Donation Annual Report on the Committee Workplan. The Organ Donation Annual Report was published in July 2022, but not scheduled until February 2023. Timing to be noted on future workplans. **Action: Director of Corporate Governance/Secretariat** Peter Carr (PC), Director of Therapies and Health Sciences, requested alignment of Committee Workplans to avoid duplication. RD informed members that when there was an interest across Committees on a particular subject, presentation to the whole Board would be acceptable. James Calvert (JC), Medical Director, requested an update to the diagram of Committees and sub-Committees, noting that the information did not reflect the current status. **Action: Director of Corporate Governance/Lead Executives**
		Items for Approval/Ratification/Decision
PQSOC 0612/06		**Quality & Safety Outcomes Report, December 2022** Lead Clinical Executives presented the update to the Committee. Noting that the presentation was a new format, replacing the original report, members were welcomed to share feedback. The following key points were noted: • Health Inspectorate Wales (HIW) were moving from the current Health Care Standards to the new standards based around the 'Six Domains of Quality'. Future Health Board reporting and the updated Quality Strategy Structure would align to this. The development of the refreshed Quality Strategy Structure was discussed. The finalised Health Board Quality

2

Strategy, incorporating governance and linking into risk management and patient safety, would be presented to Board members in March 2023.

- Safe Care Collaborative was discussed, a collaboration between Improvement Cymru and the Institute for Health Care Improvement. Several Health Board teams had attended learning workshops and would be working collaboratively to provide nationally coordinated safe and reliable local care.
- Never Events, Complaints and Serious Incidents (SI) were discussed. A key point to note was the historic number of wrong site surgeries. There had been a significant reduction, however, improvement work was underway with theatres and divisions. Thematic reviews would be taking place, to share learning across divisions. Further collaborative work, focusing on a patient centred approach, was taking place within concerns management.
- Fall management and data was discussed. The Health Board Falls Policy had been revised, including additional training and support to educate staff about the changes. A detailed report on falls would be coming back to the Committee in February 2023, noting that this was monitored weekly by the Executive Team.
- Clinical Audit was discussed, noting that the Clinical Audit Strategy was updated and published in October 2022. A detailed update on Clinical Audit would be presented to Board members in February 2023.
- The Six Goals of Urgent and Emergency Care were discussed. The Health Board were progressing against the action plan submitted to Welsh Government in June 2022. The Same Day Emergency Care (SDEC) units had been opened in the Grange University Hospital (GUH) and Ysbyty Ystrad Fawr (YYF).
- Urgent Care Performance was discussed. The Health Board was working alongside Welsh Ambulance Service Trust (WAST) to improve handover wait times over four hours and improve patient experience; and an escalation plan had been implemented. A whole system position was required to improve handover and wait times in emergency departments, noting the several hundred patients medically fit for discharge but awaiting packages of care in the community.
- In relation to planned care recovery, the 52-week forecast had worsened for December 2022. Members were informed that there would be a focus on improving Paediatric wait times through December 2022. A refreshed agenda was being implemented around support and communication for patients waiting for treatment.
- The Health Board continued to work on improving its Cancer backlog. Performance had been on a three-month improvement trajectory. Monthly Cancer Board meetings oversee improvements, including the aim for patients to have first contact on the Cancer pathway within 14 days.

Paul Deneen (PD), Independent Member, requested information on the following:
- Noting other parts of the UK have a Patient Charter, was the Health Board considering incorporating this alongside the refreshed Quality Strategy. Jennifer Winslade (JW), Director of Nursing, informed members that early consultation of the Quality Strategy would look at options to incorporate a Patient Charter, developed alongside patients and staff.
- Proposed information technology support systems to improve quality and patient safety data and the integration of systems with primary care. JW

3

	informed members that the Aneurin Bevan Continuous Improvement team were in the process of developing an improved patient quality dashboard. James Calvert (JC), Medical Director, discussed current systems used and informed members that there were national plans for integration of systems. In addition, work was being undertaken to improve step up and step downs in secondary care, and improve communication between primary and secondary care, with a particular focus on quality improvement of discharge summaries for GPs.
	Helen Sweetland (HS), Independent Member, requested assurance on how management teams ensure that junior doctors are learning from quality and safety incidents, noting the required improvements to discharge summaries. JC assured members that work was being undertaken within the refreshed quality strategy to improve communications with junior doctors and all staff, enabling measurable, evidence based shared learning.
	The Committee thanked the team for the comprehensive update, noting the improved layout of the presentation. Members were encouraged to share feedback on the new format of the presentation with JW outside of the meeting.
PQSOC 0612/07	**Contractual Arrangements with Welsh Ambulance Service Trust (WAST) inter-site transfers** Leanne Watkins (LW), Director of Operations, supported by Steve Bonser (SB), Head of Transformational Change, provided the Committee with an overview of the Health Board's contractual arrangements for WAST inter-site transfers. Members were informed that informal concerns had been raised on the effectiveness of the inter-site transfer model and the monitoring of contractual requirements. The following points were highlighted: • No WAST related Serious Incidents (SI) had been recorded in the financial year to date. • Governance was in place to monitor and review inter-site transfers. This was overseen by a multidisciplinary team. • Regular monthly meetings take place with Health Board representatives and WAST colleagues. • A recent request from the Health Board to WAST to change their rotas for capacity to meet demand had seen a small 1.5% improvement in performance. James Calvert (JC), Medical Director, reminded members of concerns raised that WAST had been borrowing the Health Board Transfer Practitioner (TP) vehicle and requested an update. SB informed members that the original Service Level Agreement (SLA) had expired, however, it had stated that any Health Board vehicles could be utilised to respond any red 999 call. There had since been an agreement between the Health Board and WAST, if the TP vehicle had been booked for a patient transfer, it could not be used. A revised SLA was in progress, to include the potential ringfencing of the TP vehicle.

4

	Members thanked SB and LW for the comprehensive update, noting that any previous concerns had been addressed within the report. The Committee **RECEIVED** the report for **ASSURANCE** and **COMPLIANCE**.
PQSOC 0612/08	**Maternity Services Improvement Plan and Update** Jennifer Winslade (JW), Director of Nursing, supported by Jayne Beasley (JB) Interim Head of Midwifery and Gynaecology, provided an overview of the Health Board's improvement plan based upon the findings of The Ockenden Review. The Committee was reminded that the report had been presented to Board members and that the Health Board's independent review of the maternity led units had commenced. The recommendations, service actions and timescales were discussed, as outlined in the report. Paul Deneen (PD), Independent Member, requested assurance that weekend consultant cover was appropriate and whether or not this was benchmarked against other Health Boards across Wales. JB informed members that the Health Board consultant cover was benchmarked across Wales. JW assured members that patients requiring more complex care and planned caesarean sections were scheduled between Monday and Friday. Consultants were on site between the hours of 9am and 5pm on weekends, and available on-call out of hours. To further support patient care, there were Senior Registrar and Senior House Officers (SHOs), alongside experienced senior midwives on site at all times. The Committee: • **NOTED** the comprehensive work undertaken to evidence the RAG rating against the national reporting tool. • **NOTED** the progress made within the Division against the RAG rating within the local improvement plan. • **RECEIVED** the report for **ASSURANCE** and **COMPLIANCE**.
PQSOC 0612/09	**Nosocomial Covid-19 Review: Investigating and learning from Cases of Hospital Acquired Covid-19** Deb Jackson (DJ), Assistant Director of Nursing IPAC, provided an overview to the Committee on the investigative process and learning from hospital acquired Covid-19. Presentation slides to be shared with members outside of the meeting. **Action: Assistant Director of Nursing IPAC/secretariat** Members were informed that the investigation process was completed in order of Covid-19 waves. Wave 1, covering dates from the 27th of February 2020 to the 26th July 2020, was nearing the end of completion. The Health Board was aligned to the National Nosocomial Covid-19 Programme (NCCP) national roadmap. Members were assured that the Health Board was reviewing relevant governance frameworks associated with complex cases. The Committee thanked Deb Jackson for the presentation.

5

PQSOC 0612/10	**Quality & Engagement (Wales) Act: Preparedness for Implementation** Jennifer Winslade (JW), Director of Nursing, informed members that a presentation from Welsh Government (WG) on the Quality & Engagement Act, alongside a full discussion, would be taking place at the Board meeting on 7th December 2022. JW informed members that the Health Board would have an extended timeframe, from the 1st of April 2023, to implement the Duty of Quality, as outlined in the act. The Duty of Candour requires implementation from day one, and the Health Board was working on a plan for implementation for the final quarter of 2022/23.
PQSOC 0612/11	**Healthcare Inspectorate Wales (HIW):** **Grange University Hospital (GUH) ED Review** Tracey Partridge-Wilson (TP-W), Assistant Director of Nursing, provided an overview of the findings of the HIW unannounced visit to the emergency department (ED) at GUH that took place in August 2022. The report outlined HIW identified improvements and Health Board actions, including timescales. Noting that the published review had been discussed by Board members, members were assured that out of the 75 actions, only 7 were outstanding. Helen Sweetland (HS), Independent Member, flagged the positive feedback outlined in the review from both staff and patients in ED. Members were reassured that staff felt supported by their line managers and encouraged to raise concerns, and noting the positive comments received from patients regarding care and dignity. James Calvert (JC), Medical Director, informed members of Health Board plans to encourage an environment of psychological safety, where staff feel safe to voice concerns. Conversations were underway between JC and the Director of Workforce and OD for the potential to incorporate 'Freedom to Speak Out Guardians', a model used in NHS organisations across England. The Committee **RECEIVED** the update. **Immediate Assurance- GP Practice** TP-W informed members that HIW had inspected Lawn Medical Practice in Rhymney, Tredegar. Safeguarding was flagged as an immediate action, noting that the Health Board had commenced additional Safeguarding training for GPs. The Health Board had received immediate actions and were awaiting a full report on the findings. The full report outlining HIW findings at the Lawn Medical Practice, including finalised actions, to come back to a future Committee meeting. **Action: Assistant Director of Nursing** The Committee **RECEIVED** the update. **Improvement Plans relating to Mental Health Units at Ysbyty Ystrad Fawr (YYF)**

6

TP-W provided an overview of the HIW review of the Mental Health Units at YYF. Immediate actions had been addressed, and the Health Board was awaiting the full report.

The Committee **RECEIVED** the update.

HMP Prison Services, ABUHB Self-Assessment
Lucy Kings (LK), Head of Nursing in Primary Care, provided the Committee with an overview of the Health Board's self-assessment of governance arrangements within HMP Usk and Prescoed. The self-assessment was 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.

Members were informed of results for an inspection undertaken at HMP Usk and Prescoed in 2021, during which 95% of the prisoners reported good or excellent care.

Members were requested to review and accept the action plan by way of assurance regarding current Governance arrangements for Her Majesty's Prison Usk and Prescoed. The Committee **APPROVED** the report.

Update and Tracking of Improvement Actions Arising from previous Inspections and Reviews
TP-W provided the Committee with an overview of the report, noting the progress of the delivery against recommendations and outstanding actions from HIW inspections conducted across the Health Board.

Pippa Britton (PB), Independent Member and Committee Chair, thanked TPW for the clear tracking of actions, providing members with reassurance of tracked actions and clear timelines.

Paul Deneen (PD), Independent Member, requested assurance that the Health Board could be made aware of finalised reports and headlines prior to them being made public. Jennifer Winslade, Director of Nursing, has made a request to the HIW relations manager that the Health Board receive dialog prior to publication, in order to respond appropriately.

The Committee **NOTED** the report.

HIW Annual Report 2021/22
TP-W briefly discussed the report. Members were informed that the HIW relationship manager had attended meetings with Executives and Board members, during which the report was discussed in detail. Members requested that the HIW Annual Report be noted for information at a future meeting, if not for formal discussion. **Action: Director of Nursing/Secretariat**

The Committee **NOTED** for the report for information.

7

PQSOC 0612/12	**Clinical Standards and Effectiveness Group Report**
	James Calvert (JC), Medical Director, supported by Leeanne Lewis (LL) Assistant Director for Quality & Patient Safety provided the Committee with an overview of the National Clinical Audit (NCA) programme audit results as presented to the Clinical Standards and Effectiveness Group (CSEG) in September 2022.
	Members were informed of Health Board plans for the implementation of the Clinical Audit Strategy. Staff training had commenced for the newly purchased AMAT system. The AMAT system aims to provide assurance that each of the National Clinical Audits had been undertaken, with action plans developed and owned by the Directorate, Quality and Patient Safety teams and the CSEG.
	JC welcomed feedback from members of areas of interest, to inform deep dives, providing assurance in future reports.
	Members welcomed the inclusion of CSEG meeting minutes as an appendix for future updates and recommended that discussions take place to align the report with the new format used for the Quality & Safety Outcomes Report. LL to discuss with Jennifer Winslade (JW) the option of future CSEG reports to be presented in the new presentation format.
	JC flagged Diabetes Care as an area of concern. Members were informed that the service had been disrupted by COVID-19 and staffing issues. The newly appointed Diabetes Clinical Director planned to assess staffing models, ensuring the best care was provided to patients. Peter Carr (PC), Director of Therapies and Health Sciences, reminded members of the previous Executive approved business case for Diabetic Insulin Pumps, in response to audit concerns. Funding was discussed and members were informed that the business case was a priority for the Health Board. Discussions had taken place with finance colleagues around allocation of funds, when available.
	Paul Deneen (PD), Independent Member, noted the National Paediatric Diabetes Audit (NPDA) results 2020/21 and the shortfall in psychological support for children, and highlighted the work required to address this. PC informed members that there were national challenges around the recruitment of registered Psychologists and that the Health Board was working alongside Health Education in Wales (HEIW) to commission additional posts, including additional Psychology Assistants.
	The Committee **RECEIVED** the report for **ASSURANCE** and **COMPLIANCE**.
PQSOC 0612/13	**Learning from Death Report**
	James Calvert (JC), Medical Director, supported by Leeanne Lewis (LL), Assistant Director of Quality and Patient Safety, provided a high-level overview of the report. Members were informed that the Health Board had created a system of monitoring deaths based on the Professor Palmer report in 2014 and subsequent Welsh Government recommendations.

8

	Members were reminded of the statutory requirement for all deaths in Wales to have an independent review by the Medical Examiner (ME) by summer 2022. The Health Board had implemented a phased approach, and as of December 2022, all inpatient deaths in the Royal Gwent, Ysbyty Ystrad Fawr and Grange University Hospitals were subject to scrutiny by the ME. The Health Board's Mortality Review Panel integrated itself with intelligence received from the ME independent reviews, alongside the analysis of data taken from the Risk Adjusted Mortality Index (RAMI) to learn from deaths. Members were informed that the Health Board plans to triangulate learning from deaths, combining relevant findings from clinical audits and ME data, to inform deep dives with clinicians going forward. Paul Deneen (PD), Independent Member asked about adequate available resource. LL informed members that Primary Care had flagged within their Integrated Medium-Term Plan (IMTP) that an increase in reviews would be a challenge with current available resource. LL would be contacting the ME to utilise predicted data to inform required resource. Future reporting was discussed. JC informed members that the ME identified clusters and themes, and this would be utilised to focus reports for future updates to the Committee. Members welcomed this approach. The Committee **RECEIVED** the report for **ASSURANCE** and **COMPLIANCE.**
PQSOC 0612/14	**Health & Safety Compliance Report** Peter Carr (PC), Director of Therapies and Health Sciences and delegated Executive Lead for Health and Safety (H&S), supported by Scott Taylor (ST), Head of Health and Safety presented an update to the Committee on the Health Board's current position and governance arrangements. Health and Safety teams were currently reviewing policies and assurance arrangements. Members were informed that a Health & Safety Committee had been established to oversee the management and monitoring of compliance against statutory health and safety requirements. The Health and Safety Committee is accountable, through the Quality and Patient Safety Operational Group, to this Committee. The following key points were discussed; - • High level H&S recommendations relating to workplace inspections and quality risk assessments taken from internal audits undertaken in 2019/20 were monitored through the Audit, Risk and Assurance Committee. • The H&S teams intend to use the newly purchased AMAT system to monitor and track compliance against actions. • Statutory and mandatory training continued to be a challenge. Work was being undertaken, alongside workforce colleagues, including the review of current training strategies. • H&S staff incidents were discussed. A downward trajectory had been reported in RIDDOR reported incidents, however violence and aggression towards staff remained a concern, with 988 incidents of aggressive and threatening behaviour towards staff reported since January 2022. The

9

	Health Board had recently developed guidance on the management of violence and aggression for staff and would be reviewing security management going forward. Members raised concerns over the compliance with manual handling training. There was currently a 50-60% uptake across the whole Health Board. Members were assured that the data was broken down based upon risk and that the H&S teams and delegated Executive leads were working on improving compliance. Paul Deneen (PD), Independent Member, requested further information on violence and aggression against staff, including numbers, comparison against other Health Boards and staff support. A detailed update on comparative data between Health Boards on violence and aggression against staff to come back to a future meeting. **Action: Head of Health and Safety/secretariat** In addition, a further discussion was requested around violence and aggression, including the impact of negative social media comments to the health and safety of staff members. **Action: Head of Health and Safety/secretariat** PC assured members that all Health Boards in Wales adhere to a response to violence and aggression, both online and physical, as part of the Welsh Health Circular, working cooperatively with police forces across Wales. The Committee thanked ST for the comprehensive update and thanked ST and the Health and Safety team for all their hard work, particularly during the height of the pandemic and throughout.
	Items for Information

PQSOC 0612/15	**Highlight Reports:**
	    a) Quality and Patient Safety Operational Group
	    b) Children's Rights and Participation Forum
	    c) WHSSC QPS Committee Report
	
	The Committee **NOTED** the highlight reports for **INFORMATION**.

PQSOC 0612/16	**Internal Audit Reports presented to the Audit, Risk and Assurance Committee on the 6th October 2022:** **a) Children's Community Nursing Service- Children & Young People's Continuing Care (Reasonable Assurance)** The Committee **NOTED** the report for **INFORMATION**.
PQSOC 0612/17	**Putting Things Right Annual Report 2021/22** The Committee **APPROVED** the report.
	Other Matters
PQSOC 0612/18	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** None noted.

10

PQSOC 0612/19	**Date of Next Meeting**
	The date of the next meeting was noted as: - Tuesday 7th February 2022 09:30 -12:30 via Microsoft Teams.

11

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
7th June 2022	**PQSO 0706/08**	**Covid-19 Concerns and Claims: The National Framework & Investigative Process** Regular updates on the investigation process and progress would be monitored through the Committee.	**Director of Nursing**	February 2023	Substantive item included within the PQSO Committee work programme 2022/23.
7th June 2022	**PQSOC 0706/12.2**	**Patient Quality and Safety Outcomes Report:** 'Getting it Right First Time' (GIRFT) Stroke Review would be presented to the Committee following its publication, including the Health Boards management response.	**Director of Therapies and Health Science**	February 2023	The Health Board's Finance and Performance Committee considered the findings and associated action plan at its meeting on 11th January 2023. A copy has been included within the PQSO Committee papers for information (February 2023).
7th June 2022	**PQSOC 0706/13**	**Operation Jasmine and the Coroner's Inquests – further reflection and learning:** A further update on implementation of the improvement plan to be presented to the Committee in February 2023.	**Director of Nursing**	February 2023	Included on the PQSO Committee's agenda for 7th February 2023 (agenda item 3.3).

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
16th August 2022	**PQSOC 1608/06**	**Urgent and Emergency Care:** Weekly data on SDEC to be shared with members outside of the meeting.	**Director of Operations/ Senior Programme manager**	October 2022	SDEC performance included within the Six Goals for Urgent and Emergency Care (including SDEC) report presented to the Finance & Performance Committee at its meeting on 11th January 2023. A copy has been included within the PQSO Committee papers for information (February 2023). Weekly/monthly data will be monitored operationally by management and escalations to Board as appropriate.
16th August 2022	**PQSOC 1608/06.1**	**Urgent and Emergency Care :** Members requested a full report on the opening of SDEC and the impact on patient care to come back to the Committee.	**Director of Operations**	February 2023	The Health Board's Finance and Performance Committee considered an update on the Six Goals for Urgent and Emergency Care (including SDEC) at its meeting on 11th January 2023. A copy has been included within the PQSO Committee papers for information (February 2023).

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
16th August 2022	**PQSOC 1608/08**	**Clinical Audit Strategy 2022-2025:** A review of the Clinical Audit Strategy four key priority areas and the implementation of the AMaT system to come back to the Committee.	**Medical Director**	February 2023	Clinical Audit Plan; Clinical Audit Activity Report; and internal audit review of clinical audit, included on the PQSO Committee's agenda for 7th February 2023 (agenda item 3.3).
16th August 2022	**PQSOC 1608/09**	**Clinical Audit Activity Report (Local and National), Quarter 1, 2022-23:** Information on the audits outlined in the report without actions against them come back as an update to the Committee.	**Medical Director**	February 2023	Clinical Audit Plan; Clinical Audit Activity Report; and internal audit review of clinical audit, included on the PQSO Committee's agenda for 7th February 2023 (agenda item 3.3).
16th August 2022	**PQSOC 1608/16**	**Committee Risk Report, July 2022** An update on the plan highlighting the benefits associated with the Risk Management Strategy to be circulated to members of the Committee, aligning with the update to Audit, Risk and Assurance in October 2022.	**Head of Corporate Services, Risk and Assurance**	February 2023	Plan circulated to Committee members, for information.
16th August 2022	**PQSOC 1608/16.1**	**Committee Risk Report, July 2022** CAHMS risk profile (CRR028): An update on the funding position from Welsh Government to be included in the Committee Risk Report at the next meeting.	**Head of Corporate Services, Risk and Assurance**	February 2023	Outlined within Committee Risk Report, included on the PQSO Committee's agenda for 7th February 2023 (agenda item 3.2).

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
6th December 2022	PQSOC 0612/09	**Nosocomial Covid-19 Review: Investigating and learning from Cases of Hospital Acquired Covid-19:** Presentation slides to be shared with members outside of the meeting.	**Assistant Director of Nursing IPAC/secretariat**	December 2022	Slides shared with Committee members.
6th December 2022	PQSOC 0612/11	**Healthcare Inspectorate Wales (HIW): Immediate Assurance- GP Practice:** A full report outlining HIW findings at the Lawn Medical Practice, including finalised actions, to come back to a future Committee meeting.	**Director of Nursing**	February 2023	Outlined within HIW Reviews Report, included on the PQSO Committee's agenda for 7th February 2023 (agenda item 3.3).
16th August 2022	PQSOC 1608/10	**Psychosis Audit:** A target date for the action *Development of a strategy to address inequalities in access to the service* to be shared, as outlined in the report.	**Medical Director**	December 2022	The actions will be presented to the Clinical Standards and Effectiveness Group in November 2022 with a target date of December 2022 for finalisation.
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.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
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	Nutrition and Hydration Standards and Strategy and Update deferred to April 2023. To be included within the PQSO Committee work programme for April 2023.

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.
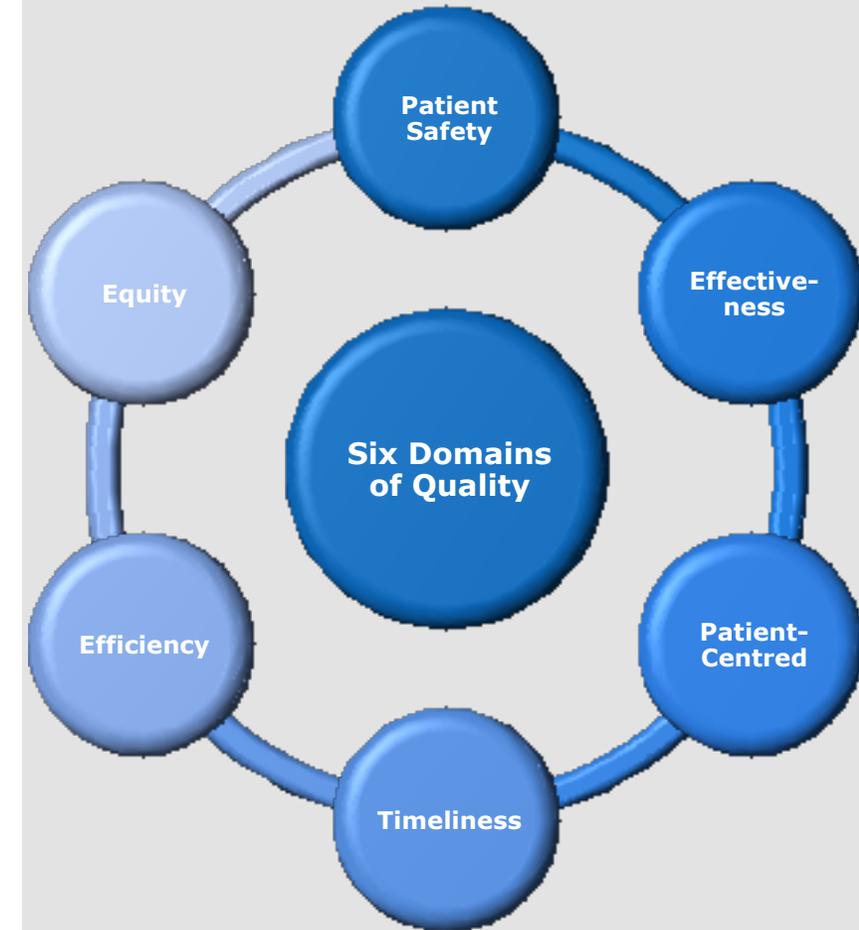
Overview

The Patient, Quality and Safety performance report provides committee with an overview of the Health Boards 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 **not closed** and to be reported on/during the **next** 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)	4	2	2	1 out of the 2 closed	0 (of those closed)
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents)	1	0	1	1	1
Medication errors never events	0	0	0	0	0
Any complaints about nursing care	9	4	5	0 (requires validation)	0 (requires validation)
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.	Divisional Nurses Nurse Staffing Programme Lead	February 2023
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.	Divisional Nurses Nurse Staffing Programme Lead	February 2023
Requirement to report nurse staffing levels aligned to complaints is ambiguous.	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 at the time 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 earlies opportunity and whilst the patient is still within our care to improve accurate and timely validation.	Divisional Nurses Nurse Staffing Programme Lead	February 2023

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 Structure

Why

Our Vision for Quality

Quality aims

What

Quality priorities

Quality Domains

How

Quality Improvement

Quality Assurance & Governance

Data and reporting
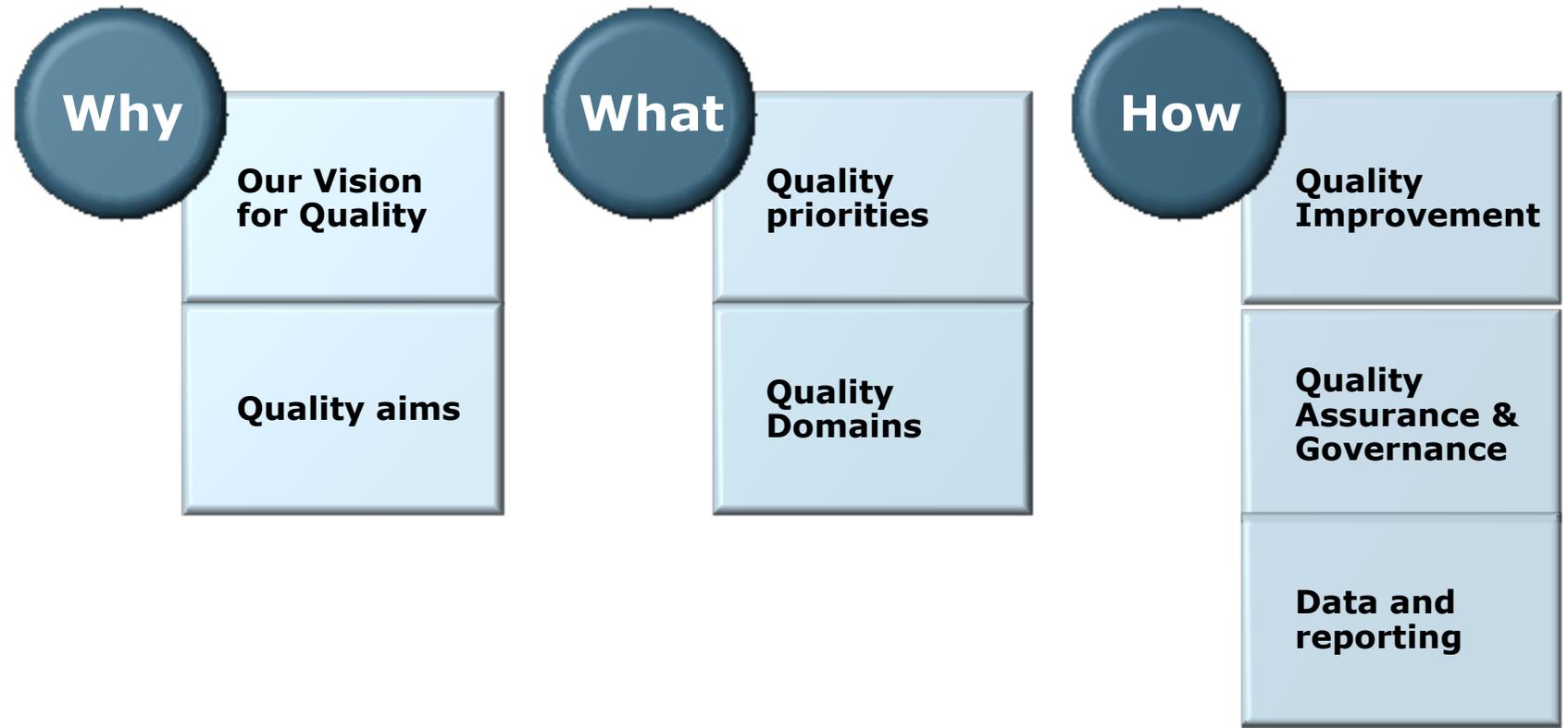
- First meeting held in December with Clinical Exec leads and Divisional Leads

- Delivery Unit meeting in February

- Quality strategy underway

- Board session in March on quality

- Safer care collaborative

Safe Care Collaborative - update

Framework for Safe & Reliable Care

Based on https://www.safeandreliablecare.com/blog/2016/11/29/s-r-sociotechnical-framework-ihi-minicourse
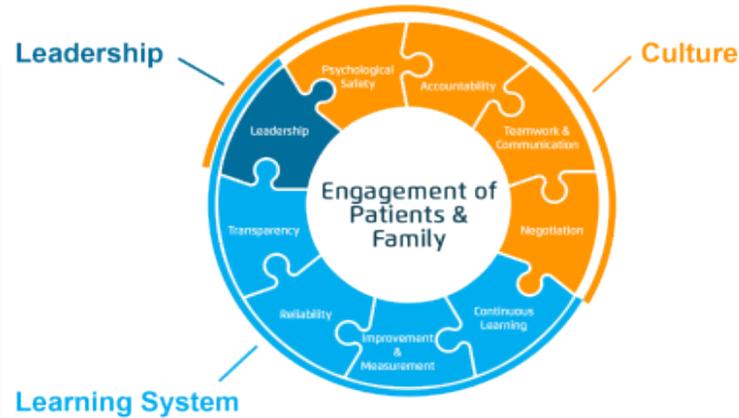
Programme of work

- Regular observation, escalation and response
- Improve use of Careflow data at ward and at aggregate level
- Communication between teams during step up/step down
- Focus Discharge processes
- Keeping patients at home/hospital admission avoidance
- Collaboration across the system between primary, secondary, community, mental health and social services
- Better use of data to evaluate and improve services

Update

- All Teams have identified what they are trying to accomplish within the timeframe
- Data lead now in place and designing with the coaches and the teams the measures and outcomes
- CareFlow data and use initially mapped
- Driver Diagrams reviewed and updated
- First phase outcomes identified.
- Teams have managed to maintain momentum despite operational pressures

Collaborative Workstream	ABUHB Team
Acute	Medical Assessment Unit at GUH
	Ward C0 (ENT surgical ward)
Ambulatory	Gastro-intestinal Ambulatory Care Unit (GACU)
	Monmouthshire Integrated Team
Community	Clinical Assessment & Treatment in Care Homes (CATCH)
	Mental Health OT Team

Develop ABUHB Quality Strategy incorporating Risk and Governance

— A Quality Governance Day with Exec Leads and QPS, and QI (ABCi) has taken place.

— Risk and Governance reviewing the assurance framework for Committees and Operational Group.

— Quality Based Management System being developed access to data in real time, sitting in one place, providing a helicopter view within each Directorate / Division.

— Develop a standardised annual quality plan for each Directorate using pillars of quality, to inform a quality improvement plan and adoption of risk registers.

— 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 agendas and templates 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

Management of Risk and Patient Safety

— Review of current Health Board endorsed Risk Management Strategy to ensure alignment with latest, evidence based best practice and revised, Board approved Risk Appetite Statement.

— Benefits realisation plan linked to the objectives of the strategy, progress monitored by the Audit, Risk and Assurance Committee.

— Establishment of a Risk Management Community of Practice to:
  ➢ "Use the Community of Practice as a space to raise queries, concerns, or areas of good practice to share learning amongst colleagues." Risk Management Community of Practice ToR2022

— Contribution to the development and anticipated National RL DATIX Risk Management module, ensuring that the electronic risk management system is user friendly, captures appropriate data and allows for clear tracking, escalation and consistent reporting. The Health Board is hoping to 'go live' with the new system in 2023.

Next steps

- WG Quality & Engagement Act
  - Duty of Candour
  - Duty of Quality

- Review current structures for what works well

- Map goals and timeframes – SMART objectives

- Person centred approach - directly involve our patients and staff

- Reinstate safety walk arounds

- PTR and QPS teams working together to develop a plan for learning and sharing of incidents

- Divisional learning / reporting through Governance structures

- Embrace a Just Culture – psychological safety

- Quality strategy being produced

National Reportable Incidents

Reportable incidents submitted to the Delivery Unit 14/06/2021 to 31/12/2022

Bar chart — *Number of National Reported Incidents* (x-axis) by *Reporting criteria* (y-axis):

- Treatment or misdiagnosi... — 5
- Serious device Error — 2
- Safeguarding — 1
- Inpatient fall with fracture — 2
- Unexpected Death — 2
- Unexpected admission to... — 2
- Serious medication Error — 2
- Never Events — 14
- Maternal Death — 1
- Homicide (MHS service... — 1
- HCAI C Diff — 1
- Deteriorating patient — 3
- Delayed Treatment — 3
- Delayed diagnosis — 6

From the 14/06/2021, the reporting framework was changed whereby only incidents categorised as severe harm were required to be reported.

When considering reporting an incident, the following should be applied:

"A patient safety incident will be nationally reported within 7 working days from the occurrence or point of knowledge, if it is **assessed** or **suspected** an **action** or **inaction** in the course of a service user's treatment or care, in any healthcare setting, **has** or **is likely to have caused or contributed** to their **unexpected or unavoidable death** or **caused or contributed to severe harm"**.

Data captured is from 14/06/2021 when phase 1 of the new reporting framework was introduced to 31/12/2022.

A total of 45 incidents were considered to meet reporting criteria and were submitted during this period.

Learning and Improvement

- Standardisation of needles used in the administering of local anaesthetic to the cervix
- ERASE (Education & Recommendations After Significant Events) posters
- SWARM – MDT review immediately after injurious falls
- Falls focused review via DATIX after all falls
- QPS process training days
- QPS bulletins
- Deteriorating patient action plan - TEP education, access to CareFlow
- Radiology SBAR re missed diagnoses
- Review of stop before you block procedures
- All SCD patients assessed for enhanced care o/a
- Review of surgical pathway including guidance flowchart for patients not allocated to a team

Never Events

Never Events reported to the DU

Chart legend:
- Misplaced Naso or oro gastric tube
- Adminstration of medication via the wrong route
- Retained foreign object
- Wrong site surgery

X-axis: April, June, August, October, December (2021), February, April, June, August, October, December (2022)
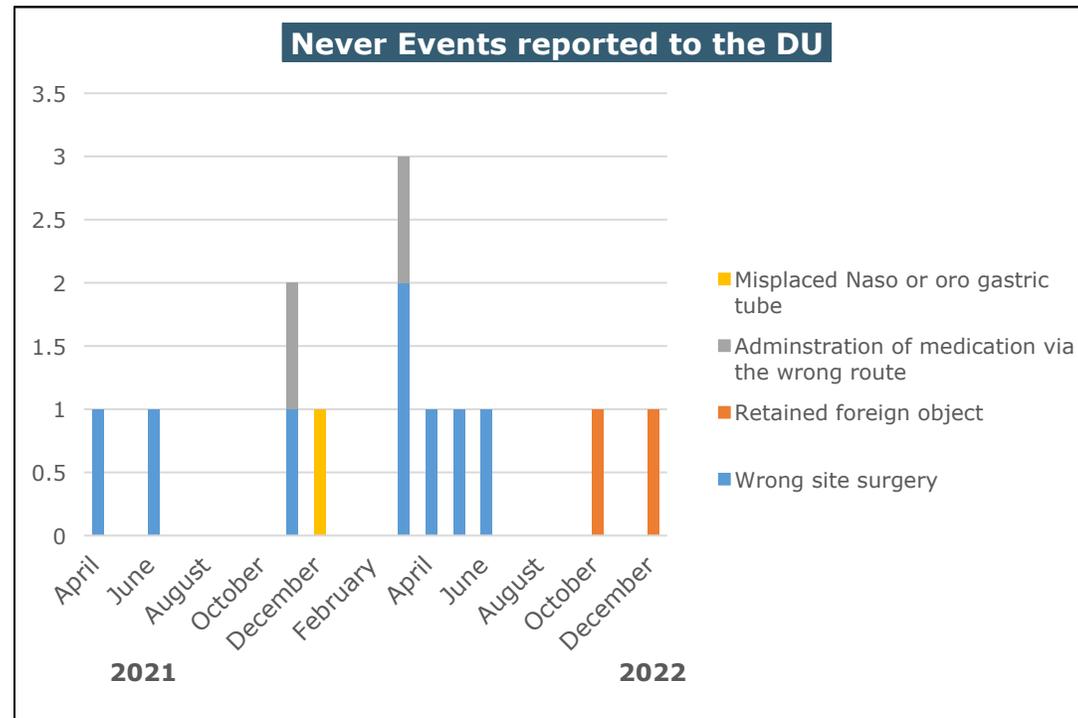
- Never Events comprise 25% of ABUHB's NRIs
- Therefore, ¼ of all NRIs reported by ABUHB since April 2021 are NEs N.B. the reporting criteria for NRIs changed in June 2021 meaning far fewer incidents are NRIs. As all NEs are mandatory NRIs this accounts for NEs being such a high % of NRIs
- 1 x new NE this reporting period-retained swab
- NRIs - 11 out of the 13 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.

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	TBA
	Learning from Never Events not embedded within the organisational culture.	Explore a repository of completed and appropriately redacted investigations and action plans – Intranet page		

Complaints and SIs

Early Resolution Performance

Nov-22: 71.85%
Dec-22: 69.86%

Performance

Nov-22: 70.00%
Dec-22: 59.18%

Enquiries Recorded by Patient Liaison Officers

Dec-22: 1053
Jan-22 (until 23/01): 617

Complaints Data November to December 2022

	Nov-22	Dec-22
Open complaints	468	471
Formal complaints received	156	89
Early Resolution	119	58

Serious Incidents captured November to December 2022

	Nov-22	Dec-22
Total SI's identified	23	31
Falls with Fracture	6	7
Falls with Head injury and Death	1	1
Red 1 investigations instigated	6	5
Never Events	0	1
Reported incidents	3	10

Complaints and SIs

Issue	Cause	Remedial Action	Who	When
Reduced compliance in closure of formal concerns within 30 working days.	Staffing pressures due to PTR sickness and Divisional operational pressures had results in reduced prioritisation of Complaints and SI process.	• Meet with Divisional Triumvirates, QPS leads and Complaints Coordinators to revisit process and expectations.	Assistant Director of Nursing /PTR Senior Team	Ongoing
Protracted SI investigations and delays in sharing reports with families and HM Coroner adding psychological distress and resulting in adjournments, additional complaints.	• Lack of key stakeholders at meetings • Increased complexity of incidents • Cross-divisional incidents • Quality of reports • Lack of action plans • Divisional operational demands • Inequalities in QPS resource across different divisions • Size of PTR SI team and overreliance on SI team	• Re-mapped SI process • Monthly meeting with SI team, DON and ADON • Planned move to F2F IO training • Planned monthly catch up with Safeguarding team	Assistant Director of Nursing /PTR Senior Team	Ongoing
Historic DU closures- now down to 4 but oldest goes back to April 2019.	Lack of progress on investigations Difficulty in getting engagement meaningful information that would enable PTR to pull together closure summary	• 3 weekly meeting with Divisional QPS leads to discuss outstanding closures N.B. QPS leads can also be unable to influence progress within their Division. • Escalation to Execs • Updates provided to DU	Assistant Medical Director Assistant Director of Nursing Divisional QPS leads	Ongoing

Listening and Learning from Feedback

Concerns

- Relative feedback identifies teams do not recognise needs and **what matters** to people.

- Staff unable to recognise **'at a glance'** when patients in hospital are living with dementia and may have additional needs.

- Risk that people living with dementia do not receive **person-centred** dementia care.

Learning Actions

➤ Revision and production of new **patient bedside boards** across wards.

Listening and Learning from Feedback

Feedback	Learning Action
Relative/CHC feedback about visiting. Inconsistent messages from staff around visiting e.g. some carers can visit anytime, others by appointment only.	➤ Re-launch of John's Campaign for the public 01/03/2023 ➤ Information around John's Campaign for staff and carers developed. ➤ Public awareness animation reinforcing ABUHB commitment to support carer visiting through the Dementia Friendly Hospital Charter.
Patient, carer and CHC feedback. Lack of communication. Unable to get through on telephones.	➤ Establishment of Patient Liaison Officers at GUH ➤ Improved access via telephone for relatives Enquires recorded by PLO's in December in December **1,053**. ➤ CEO has commissioned a patient experience strategy and a review of patient experience resourcing
Patient experience at RGH. CHC feedback. Distress of relative re communication, information, visiting restrictions, oral care.	➤ Patient story (wife) used at listening event with staff. ➤ Visiting with a purpose reinforced. ➤ Inpatient hospital dementia action plan revised to reflect feedback and actions needed. ➤ Development of new patient bedside boards ➤ Relaunch of Johns Campaign. ➤ Staff training re: oral care. Oral Health staff awareness film produced.
Patients at risk/dying alone. Respite for carers during end of life.	➤ Recruitment of End of Life Companion Volunteers (50). ➤ Will support people at end of life who have no relatives and will also provide respite visits for people whose carers need a break.
Feedback from people and CHC around impact of service disruption on psychological wellbeing (particularly cancer services). Patient story about their cancer journey during COVID and psychological needs not being met.	➤ Patient story played at Board. ➤ £300,000+ secured from NHS Charities together to develop psychological recovery service.

Listening and Learning from Feedback

Feedback	Learning Action
Patients and relatives unable to provide real time feedback.	➢ CIVICA Citizen Feedback system to be launched February 2023
Patient concern regarding reasonable adjustments at GUH.	➢ Meeting with staff and patient. ➢ Patient story filmed and used at learning event.
Patient concern re dignity, respect and perceived 'ageism'.	➢ Digital patient story produced and shared internally and at National HealthCare Support Worker Conference. Will be used at HCSW induction.
Feedback from the Deaf community and CHC around immediate access to BSL interpreters (impacted during COVID).	➢ Introduction of Sign Live, 24 hour video relay service with immediate access to online BSL interpreter. Funding secured to test proof of concept over next 18 months. ➢ Members of the Deaf community have produced supportive BSL films to inform people of the new service and where it is in operation.
Feedback from patients, relatives, staff and CHC. Boredom and social isolation of patients in hospital (particularly in single rooms).	➢ Suite of meaningful activities purchased and ward baskets with range of activities provided across ABUHB. ➢ Staff training (including volunteers) re benefits of meaningful activities developed and delivered (rolling programme). ➢ Development of Dementia Companion volunteer role to engage people in meaningful activity (diversion). ➢ Bid submitted to NHS Charities Together which would support the development of a meaningful activity strategy for staff and informal carers.
Patient, service users and families were unable to understand the process followed after a patient safety incident.	➢ Following patient safety incidents, an information guide for patients, service users, and families was developed and finalised with the help of feedback and knowledge gained from patients, families, and CHC. It has been written in both Welsh and English, in addition to being adapted as a BSL video available on the Intranet and internet pages.

Listening and Learning from Feedback

Civica Citizens Feedback System	Patient and Public Webinars	'Experts by Experience'	Patient Bedside Boards	Dementia Champions	End of Life Companions
Patient Stories/Learning Events	Student Placements	Wales Listens Campaign	Staff Educational Films	Growing our Volunteer Workforce/National Presentations	Psychological Recovery in Cancer Services

Issue	Cause	Remedial Action	Who	When
Limited patient experience data	No current electronic feedback system to gather patient experience.	Organisational hierarchy agreed. Friends and Family Test survey will be live via CIVICA at County Hospital in January 2023 and across the Health Board in February 2023.	Patient Centred Care Team	Ongoing
Volunteer recruitment unable to proceed at pace	Vacancies in Patient Centred Care Team. Short term funded posts means that staff leave to find permanent posts.	Agreement to recruit WTE band 4 volunteer co-ordinator. Successful applicant will commence end of February 2023.

Priority focus on volunteers already going through the recruitment process.

To readvertise for volunteers from March 2023. | Patient Centred Care Team | Ongoing |
| Limited Patient/Staff Stories | Staff vacancies in Patient Centred Care Team. Only one member of staff in team able to produce narrated story (not visual). No current systematic plan to gather and store stories. Ongoing funding required for commissioned films. | Development of Patient/Staff story protocol in progress.

Additional Digital Story Training secured

Story repository system in development. Series of patient stories in progress to report to Board | Patient Centred Care Team | Ongoing |

Health, Safety & Security

Abuse to staff data 2022 (*extracted from Datix Cymru*)
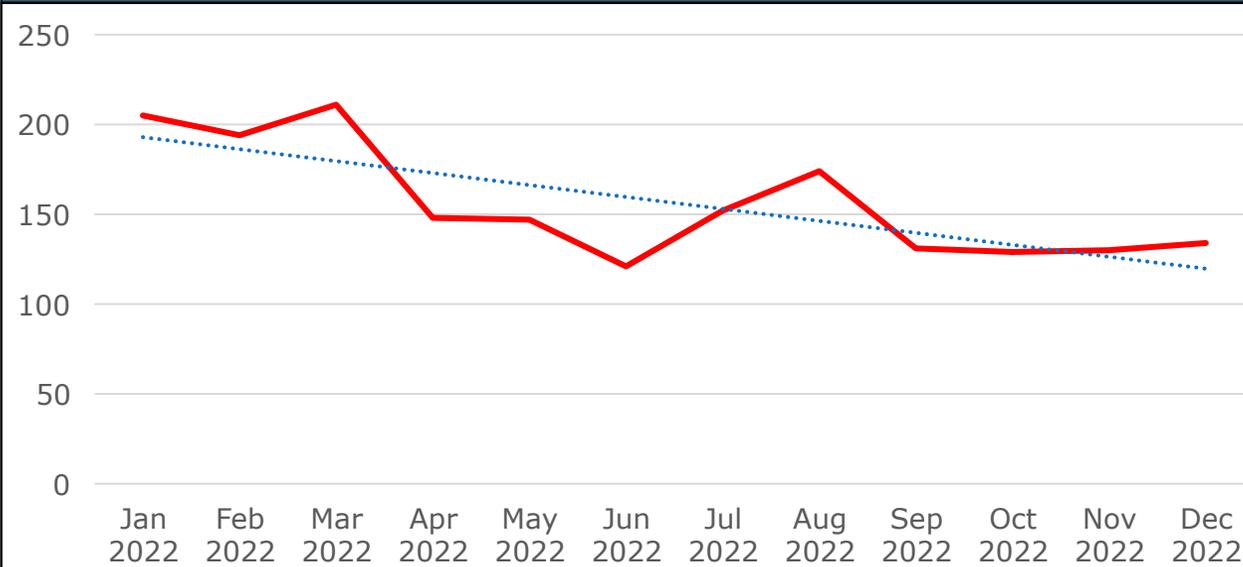
Abuse to staff continues to be the highest health and safety reported incident towards our workforce, however, the trendline highlights a downward trajectory during 2022.

Plan to benchmark this data across NHS Wales.

Issue	Cause	Remedial Action	Who	When
Compliance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 44% of incidents reported during 2022 were reported within the legal timeframe	Failure to obtain intelligence to support the decision to report incidents to the HSE	Conduct an audit to identify the gaps in compliance	Head of Health, Safety & Fire	April 2023
		Awareness to be raised 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		

Infection Prevention

ABUHB – Reduction Expectation Goals

	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	150	33.28	8	1.78	91	20.19	99	21.97	243	53.92	88	19.53	14	3.11	345	76.55
Betsi Cadwaladr UHB	214	40.38	13	2.45	127	23.97	139	26.23	384	72.46	117	22.08	27	5.10	528	99.64
Cardiff and Vale UHB	116	30.52	9	2.37	101	26.57	108	28.41	235	61.83	98	25.78	20	5.26	353	92.87
Cwm Taf Morgannwg UHB	86	25.37	4	1.18	114	33.64	118	34.82	288	84.98	61	18.00	29	8.56	378	111.53
Hywel Dda UHB	153	52.11	8	2.72	74	25.20	82	27.93	256	87.19	90	30.65	23	7.83	369	125.67
Powys THB	9	8.98	0	0.00	0	0.00	0	0.00	1	1.00	1	1.00	1	1.00	3	2.99
Swansea Bay UHB	146	49.57	10	3.40	106	35.99	116	39.38	205	69.60	77	26.14	34	11.54	316	107.28
Velindre NHST	2		0	0.00	1		1		7		0		0		7	
Wales	876	36.68	52	2.18	614	25.71	663	27.76	1,619	67.80	532	22.28	148	6.20	2,299	96.27

Current Position

E Coli	243 cases of E coli reported from Apr 2022 to Dec 2022. This is -8% fewer than the equivalent period 2021/22. Provisional rate is 53.92 per 100,000 population.
C diff	150 cases of C diff reported from Apr 2022 - Dec 2022. This is -7% fewer as than the equivalent period 2021/22. Provisional rate is 33.28 per 100,000 population above WG trajectory.
Klebisella	88 cases of Klebisella reported from Apr 2022 to Dec 2022. This is 16% more than the equivalent period 2021/22. Provisional rate is 19.53 per 100,000 population.
Staph aureus	97 cases of Staph aureus bacteraemia reported from Apr 2022 - Dec 2022. This is 3% more than the equivalent period 2022/22. Provisional rate is 21.97 per 100,000 population. WG target 20 per 100,000 population.
Pseudomonas	14 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

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	• Action plan developed • Roll out of Antimicrobial risk kit (ARK) • Aseptic Non Touch Technique (ANTT) roll out • Focus on care bundles & device management • Implement HOUDINI project (removal of catheter) • Introduction of Purewick device (female external catheter) • Deep Dives re: Klebsiella and Cdiff	Divisional Management Team Antimicrobial pharmacist Infection Prevention Team	Monthly review via Reducing Nosocomial Transmission Group
Respiratory virus Covid/Influenza The number of hospital outbreaks has ranged from 1 to 14 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	• Stop asymptomatic testing for exposed patients • Removed testing of asymptomatic • staff • Ongoing promotion of prudent Infection prevention measures • Continual review of patient pathways • Step down guidance updated • Promote vaccine programme "its not to late"	Divisional Management Team Infection Prevention Team	Monthly review via Reducing Nosocomial Transmission Group

Patient Story

- Insert Patient Story Video

Covid-19 Investigations

	Wave 1 (27/02/2020 – 26/07/2020)	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	313	837	439	990	1132
Investigation Not Started	29	820	422	793	933
Under Investigation	26	14	17	24	73
Downgraded/ Recatergorised	17	0	0	173	126
Referred to Scrutiny Panel	0	0	0	0	0
Completed Investigations	241	3	0	0	0
Check +/-	0	0	0	0	0
Deaths	148	226	49	173	120

Learning Themes so far from Wave 1:
- Communication
- COVID-19 Testing
- Incomplete documentation
- DNACPR
- Patient dignity

Issue	Cause	Remedial Action	Who	When
Investigation Resource Live wave & Post April 2023 Duty of Candour	Out of scope of the NNCP framework	Awaiting direction from DU re reporting Live Way on completion COVID investigation timeframe of March 2024	COVID 19 Investigation team (CIT)	Ongoing
Data preparation	Conflicting & missing information in DATIX re: Outbreaks.	• Access to Timeline granted • Review of the systems to align	CIT	Ongoing
	Discrepancy in the cross verification between whiteboard data and LIMS data for live wave.			

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	83%	83%
2	81%	78%

- Due to vacancies over the past year there has been no provision of Level 3 training, leaving a gap in compliance.

- The Safeguarding Team is now fully established and a Level 3 Training will recommence in April 2023 with a recovery plan to achieve compliance.

Safeguarding

Learning from Safeguarding Reviews

ABUHB, as a partner of the Safeguarding Board, participate in statutory multi agency reviews.

The most recent review highlighted some learning in relation to:

- Sleep environment assessments

- Discharge from maternity of complex and/or out of area patients

The Safeguarding Committee have set up two task and finish groups to look at any risk and to make any required changes to policy/practice.

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 in busy Emergency Department & Children's assessment Unit.	Paper forms were not being sent to Local Authorities as there were too many processes to follow before sending. Handwriting was also causing issues when they were being received.	• An online form was devised. Agreement to trial was sought from the Gwent Safeguarding Board and 5 Local Authorities. • The trial has seen 60% increase in reporting. • Positive feedback received from Local Authorities. • Looking to rollout, in stages, across the Health Board.	Corporate Safeguarding Team	Trial commenced September 2022 – ongoing
Poor compliance with Level 3 Safeguarding Training	• Gaps in safeguarding team • Poor uptake of existing offer • Absence of clear mandate • Changes in national expectation	• All vacancies filled within the Corporate Safeguarding Team. • Venues have been booked and a booking calendar is being finalised to allow staff who require level 3 safeguarding training to book up until the end of the year. • Work has commenced to refresh the child and adult level 3 training packages. • Level 1 and 2 compliance sits at 80% for the previous quarter.	Corporate Safeguarding Team	Training will commence in April 2023
Inability to track safeguarding enquires made through our early intervention and prevention Hubs.	No system in place to record enquires and track progress of calls	A Single Point of Access system has been developed, to allow calls to be logged, record advice given and track ongoing management. The system allows for easy audit and data analysis. Data can then be tracked to look at training needs, patterns of concern and overall governance.	Corporate Safeguarding team	January 2023

Falls Data
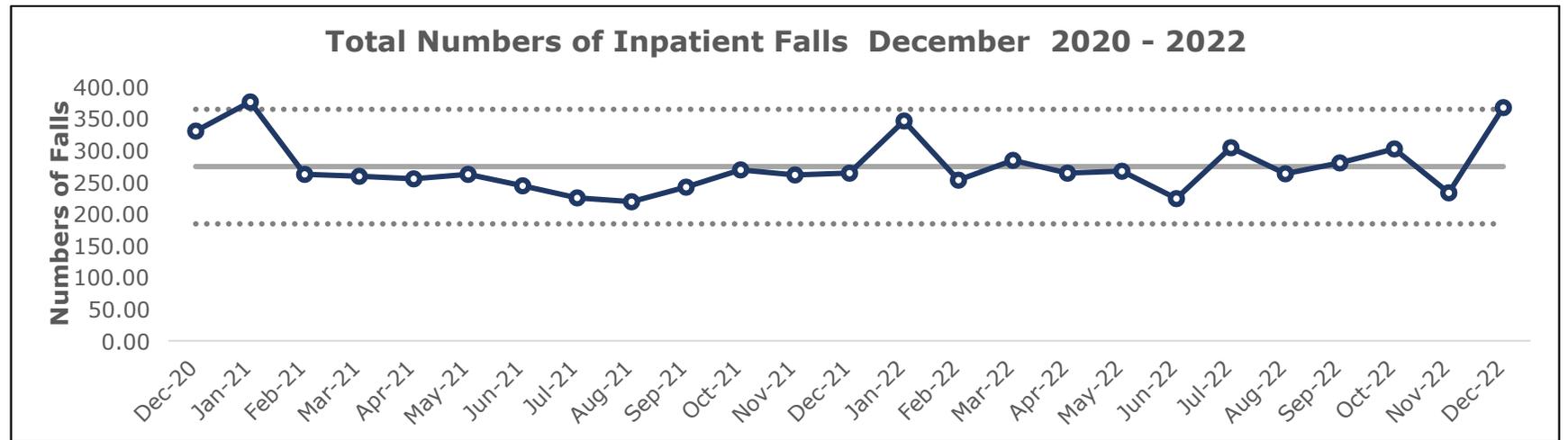
Total Numbers of Inpatient Falls December 2020 - 2022

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 December 2020-2022.

Divisional Context comparing November and December 2022 reported falls incidents for their given patient cohort.

Medicine =   30% increase
MH & LD = 52% Increase
PC & C = 42% Increase
SC = 46% Increase
F & T = No Change
Urgent Care = 22% Increase

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 was 274 between December 2020-22. • July and October 2022 saw a rise in the numbers of reported falls to the highest levels since January at 304 and 302 respectively.. This has been followed by a significant upward trajectory in December 2022 to 367 which is aligned to the upper control limit	December has seen the highest numbers of reported falls incidents since January 2022

Falls Data
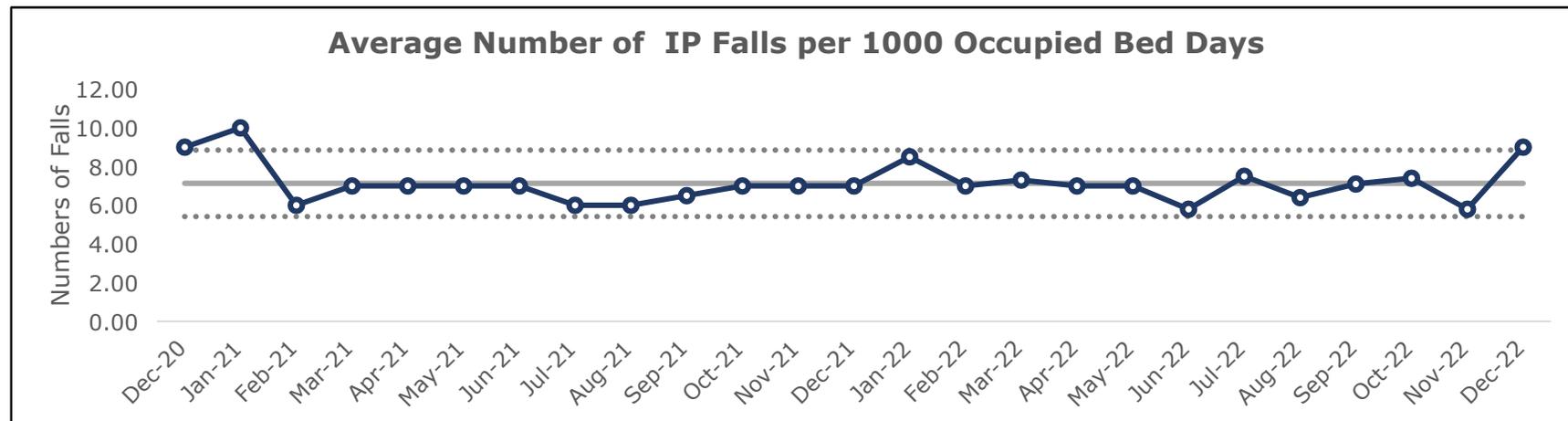
Average Number of IP Falls per 1000 Occupied Bed Days

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 reported for the period October 2020-2022.

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 December 2020-22 was 7 which is marginally above the National average of 6.6.
	
	• Aligned to the National average for the given period the following is demonstrated:
	
	  30% above National Average
	  26% below National Average
	  44% Aligned to the value of 6.6
	
	• November 2022 saw a downward trajectory to the lowest value of 5.8 since June 2022. A subsequent rise has been seen in December 2022 to a value of 9.
		Again 2022 saw a greater degree of variation as compared to 2021 across the corresponding 12-month period.
		
		December 2022 has seen the value rise to 9 which is marginally above the upper control limit for variation.

Falls Data
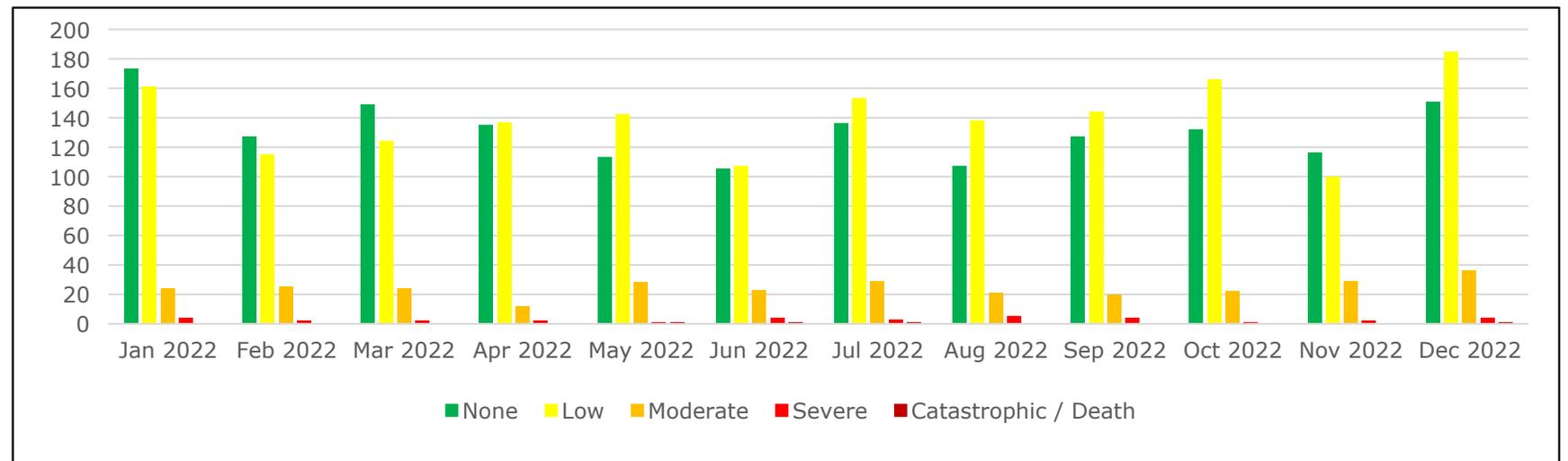
Context

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 January to December 2022.

The data is reflective of the identified level of harm recorded as of January 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 information provided details the distribution of the levels of severity associated as reported for falls incidents for the 12-month period of 2022. 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	

SDEC at a Glance 8/8/22 – 13/1/23

SDEC Daily Patient Volume
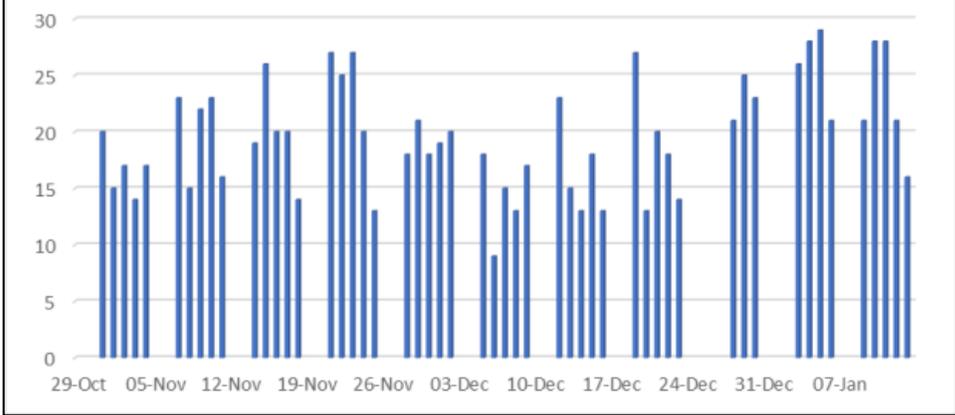
Time Spent in SDEC
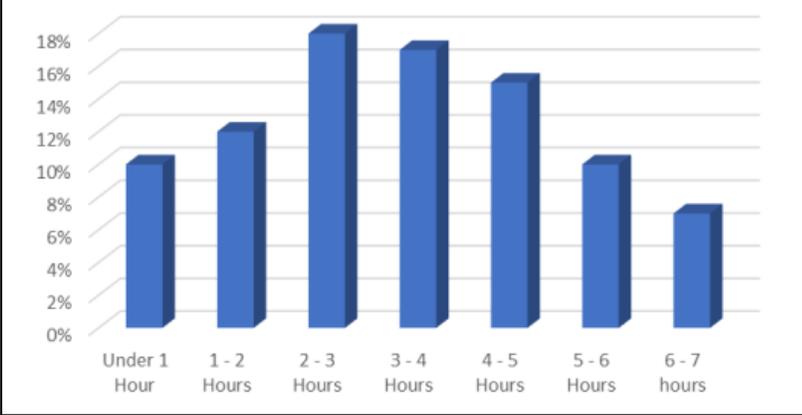
SDEC by Speciality
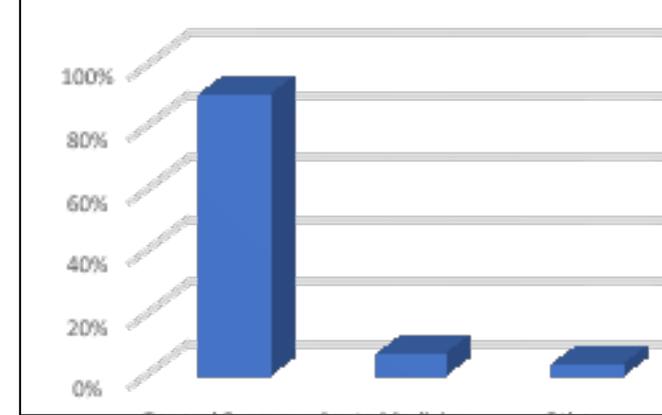
2126 Patients seen

Average 19 Patients per day

200 Next day Returners

Median Time 4 hours

1682 Patients Discharged Same Day (79%)

390 Admissions

Progress Summary

- Surgical model well developed:
  - Primarily GP referred via Flow Centre
  - Some Direct from ED Triage streaming
  - Amber CEPOD opened at RGH (pilot)

- Introduced Trauma pathway in Dec 22

- Plans to utilize for Acute Oncology patients in Feb '23

- Ad-hoc utilization for Maxfax, Gynae and Gastro

- Continue to explore speciality in-reach

- Overall aim remains to embed an Acute Medicine Model but requires completion of capacity planning exercise

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

Dyfodol Clinigol Clinical Futures

Urgent Care Performance

Count of Time from Arrival to Departure from A&E >12 hrs : [7A6G9] GUH [Cwmbran]
Data Updated: 2023-01-16 06:00:46
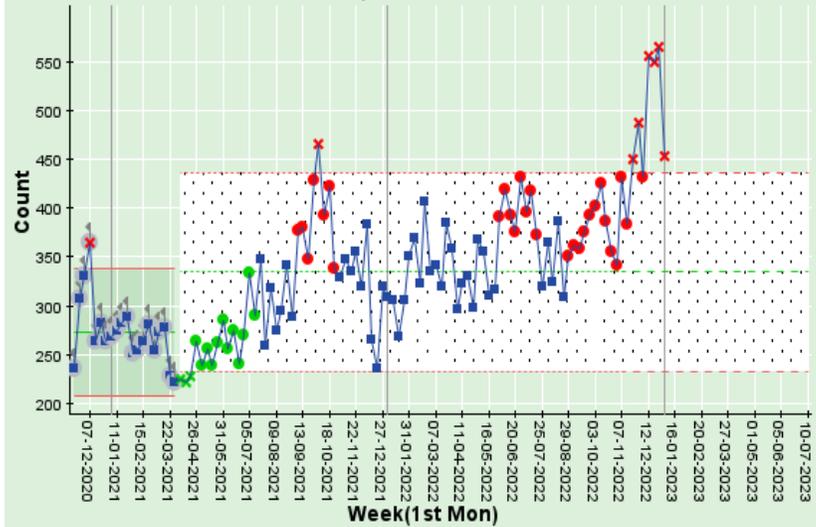
Count of Time from Arrival to Departure from A&E >24 hrs : [7A6G9] GUH [Cwmbran]
Data Updated: 2023-01-16 06:00:46
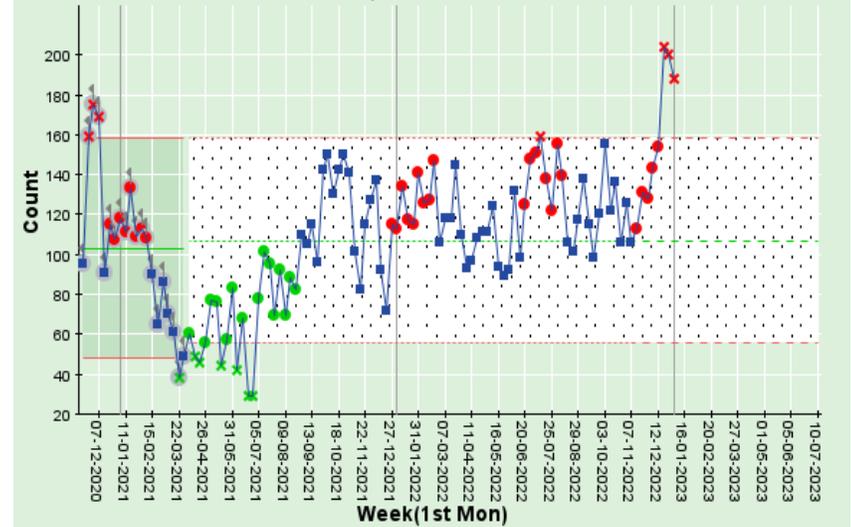
Count of Time from Arrival to Departure from A&E > 48 Hours : [7A6G9] GUH [Cwmbran]
Data Updated: 2023-01-16 06:00:46
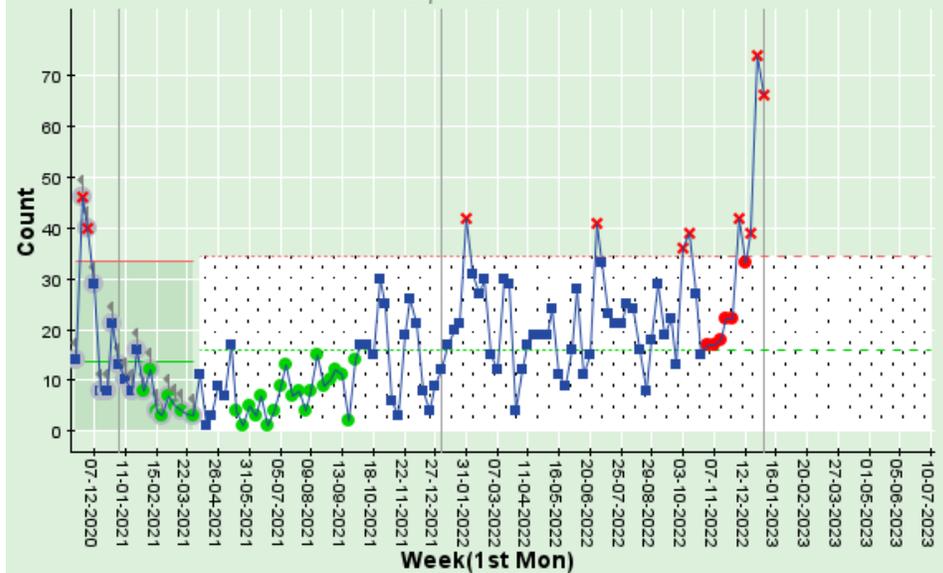
Urgent and Emergency Care

Time from Arrival to Departure from A&E : [7A6G9] GUH [Cwmbran] * ED Specialty Referred To : (Last 6 months)
Data Updated: 2023-01-19 06:00:41

A&E attendances : [7A6G9] GUH [Cwmbran] * Uro + Max + Ort + TRA + UHW + ENT + Sur + Fra + Gyn + Str + Psy + Mor + Ana + Phy + Pae + Oph + Cri + Obs + Med + A&E : (Last 6 months)
Data Updated: 2023-01-19 06:00:41
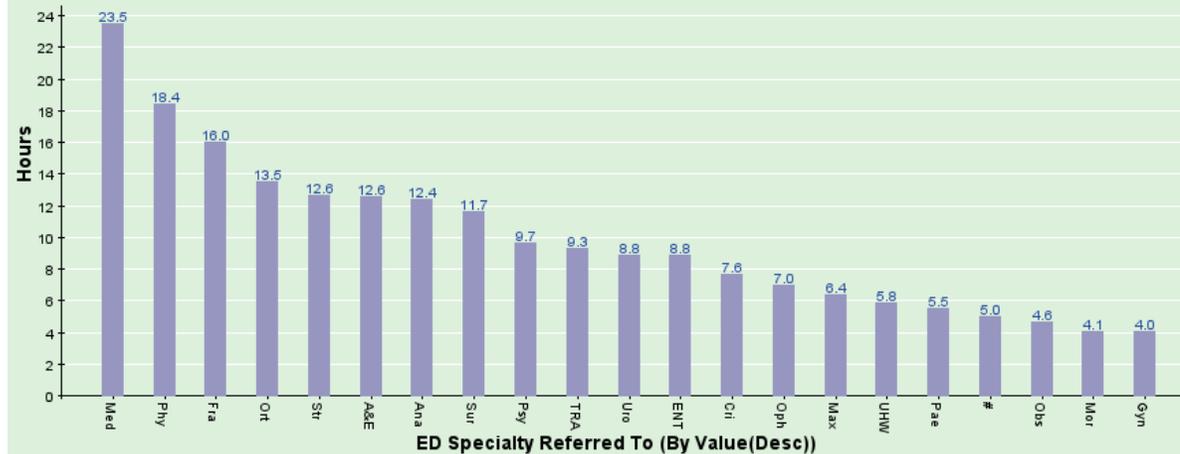
56% of attendances have no specialty recorded, assumed to be patients assessed out. Of the patients attending ED who are referred to a specialty, the demand in the last 6 months is highest for Medical (33%) and Paeds (28%).
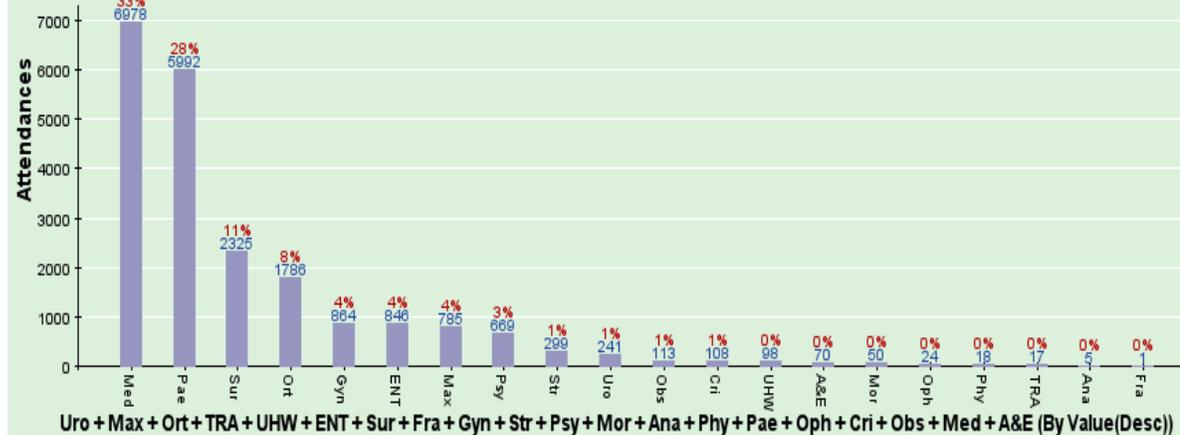
Average time for Medical Specialties from arrival to departure in ED is almost 24 hours, this was above 30 hours in the last 2 weeks of 2022.

Urgent and Emergency Care

Count of Time from Arrival to Departure from A&E > 48 Hours : [7A6G9] GUH [Cwmbran] * ED Specialty Referred To : (Last 6 months)
Data Updated: 2023-01-19 06:00:41

Count of Time from Arrival to Departure from A&E > 48 Hours : [7A6G9] GUH [Cwmbran] * Med : (Weekly - 2 years, prediction)
Data Updated: 2023-01-19 06:00:41
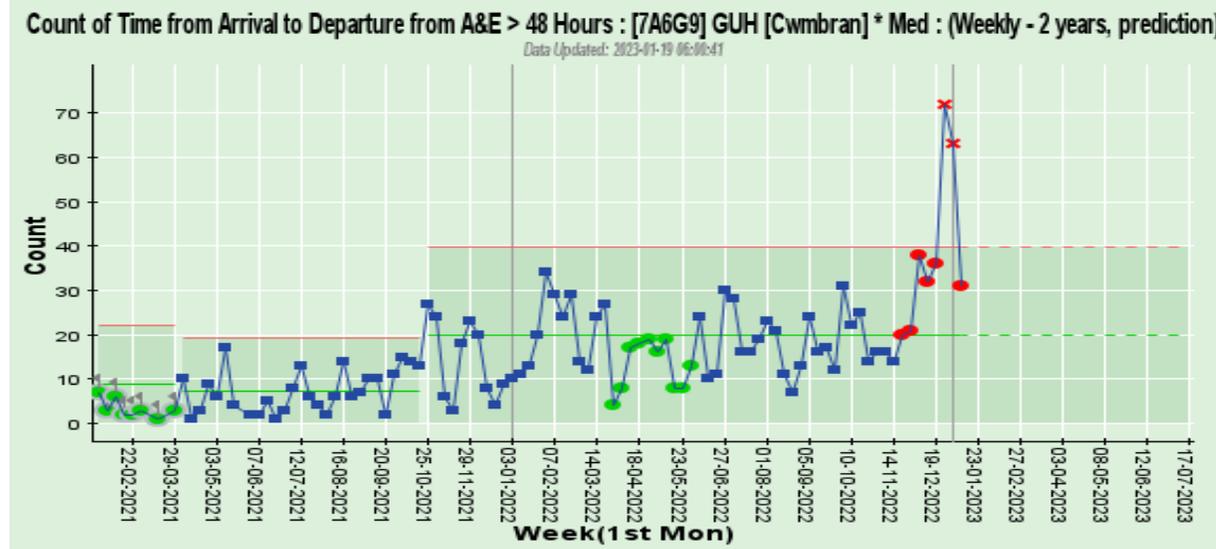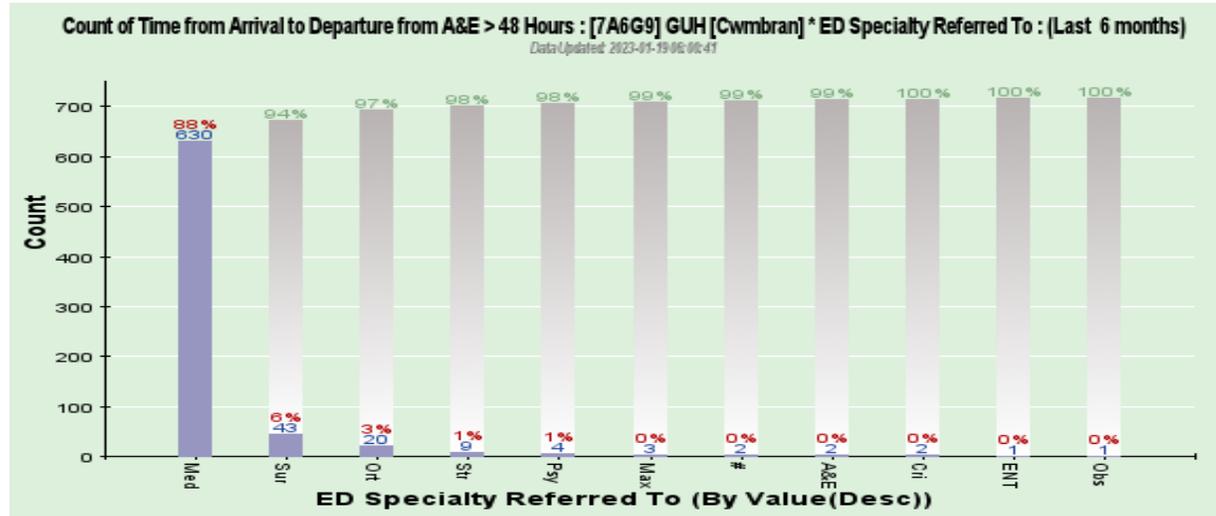
88% of the 48+ hour waits in ED are for medical specialties. The tie to departure for medical specialties over 48 hours are normally occurring at around 20 per week but were particularly high through December 2022, peaking at 72 the week of 26th.

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 / DMT	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: Increasing vacancies and absence with increased number of patients causing additional staffing pressures with 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 secured and robust processes in place to manage roster	Divisional Nurse / DMT	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 through Capital Bid Application with Welsh Government • A1 capacity to support Respiratory Pathway • SDEC commissioned but only for General Surgery and adhoc Specialty involvement at present due to deficits in the Acute Medicine workforce deficits	General Manager / Divisional Director / Divisional Nurse / DMT	Ongoing

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

Number of pateints waiting over 52 weeks for new outpatient appointment

Number of patients waiting more than 104 weeks for referral to treatment
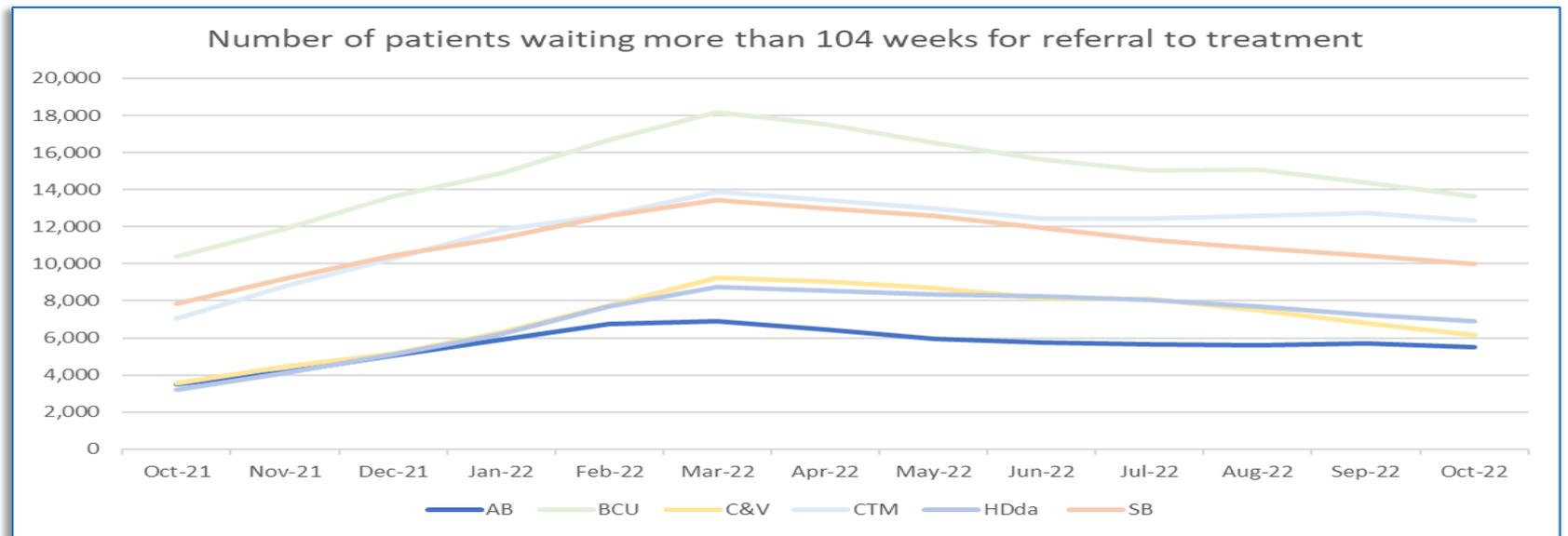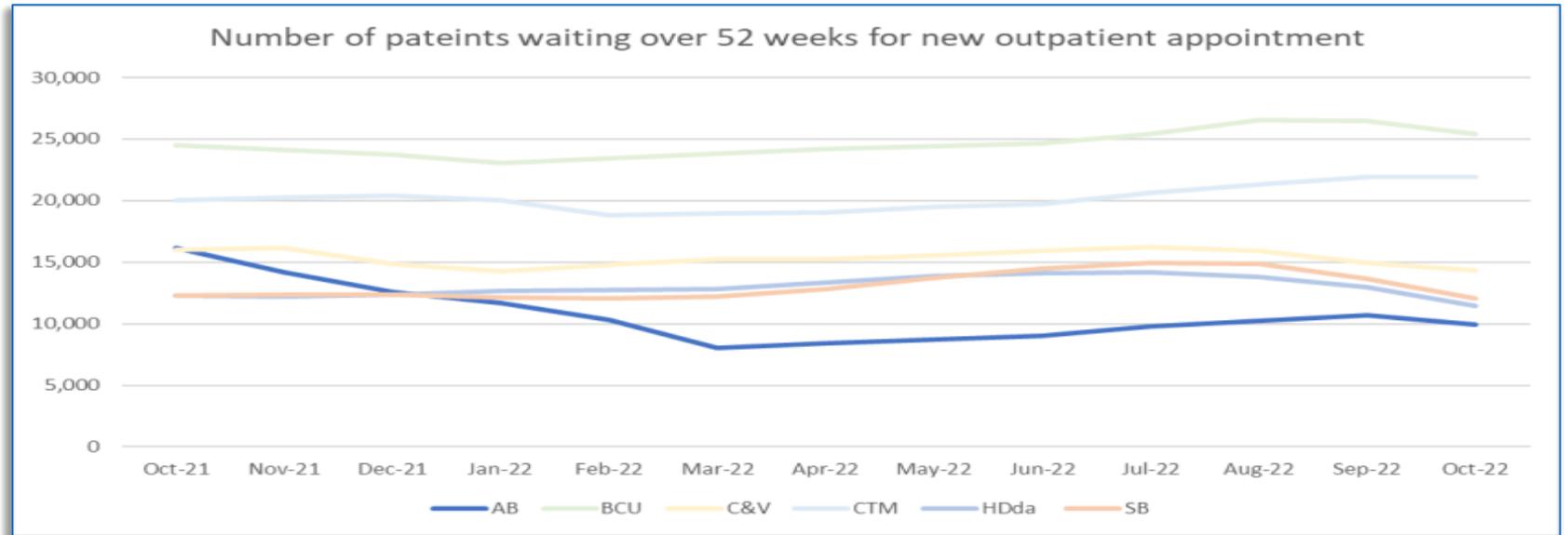
Overview of Health Board Performance Cohort Treat in Turn

Stage 1 (Outpatients) Waiting List

Booked Patients on Waiting List
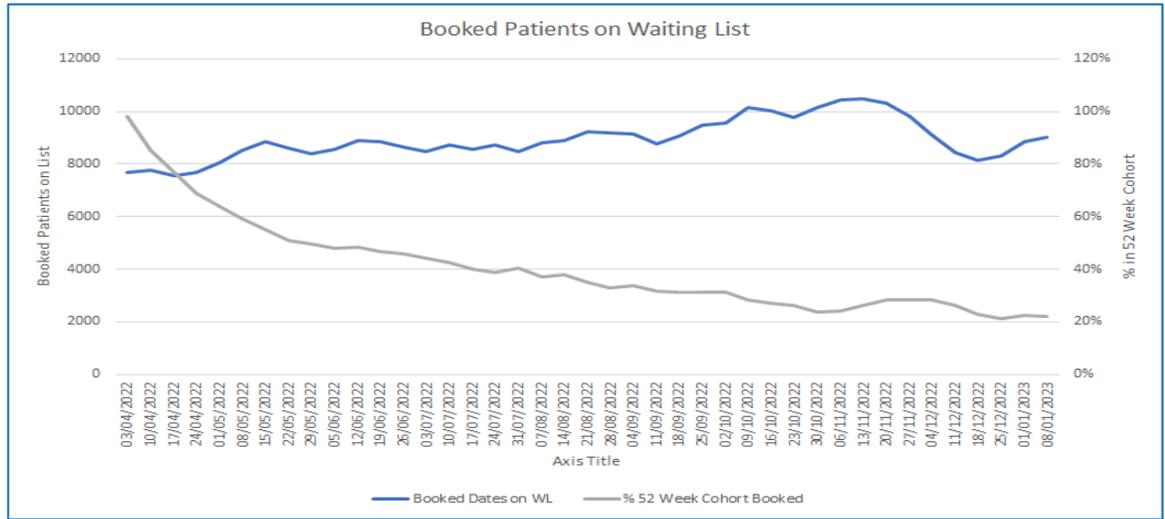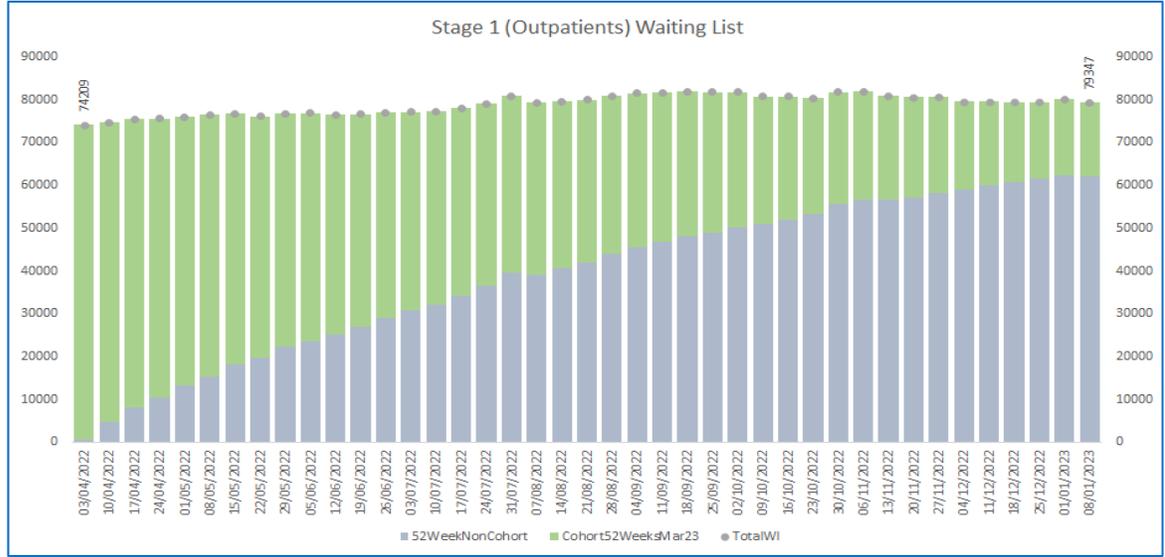
Outpatient waiting list and 52 week cohort

- The number of patients on the outpatient waiting list has increased by just under 5k since the start of the financial year.
- Of the patients currently on an outpatient waiting list, **22%** are within the December 52 week cohort.
- The number of patients booked on the list has been increasing since September which has resulted in an improvement in our overall 52 week position and patients being booked from the cohort.

Overall Activity Summary Update

Outpatients
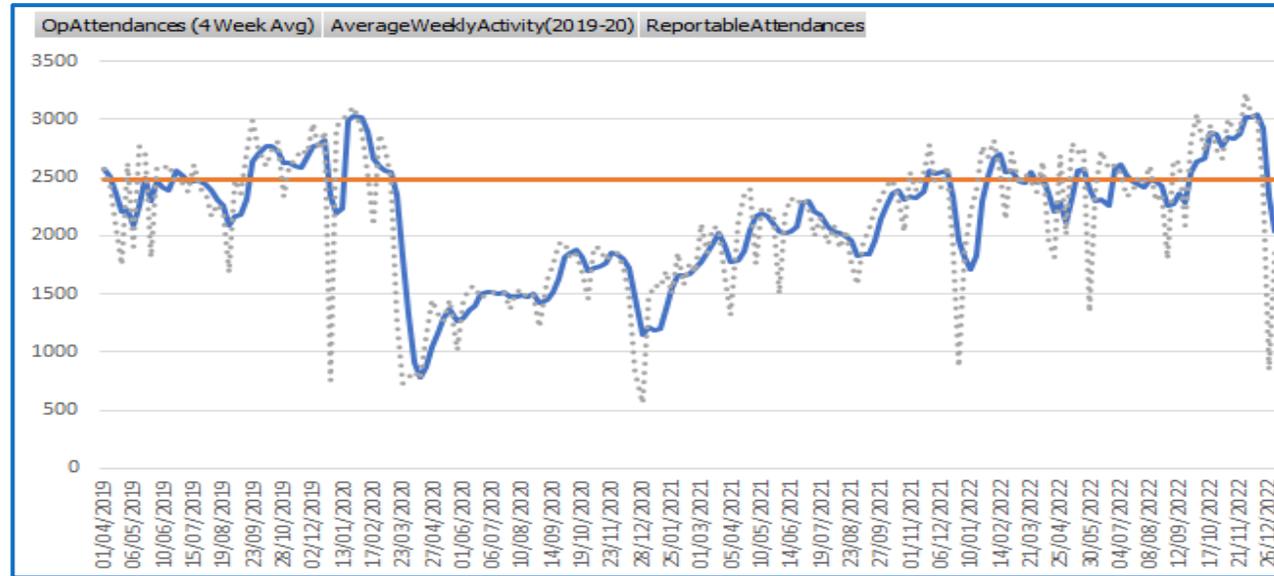
Elective Admissions
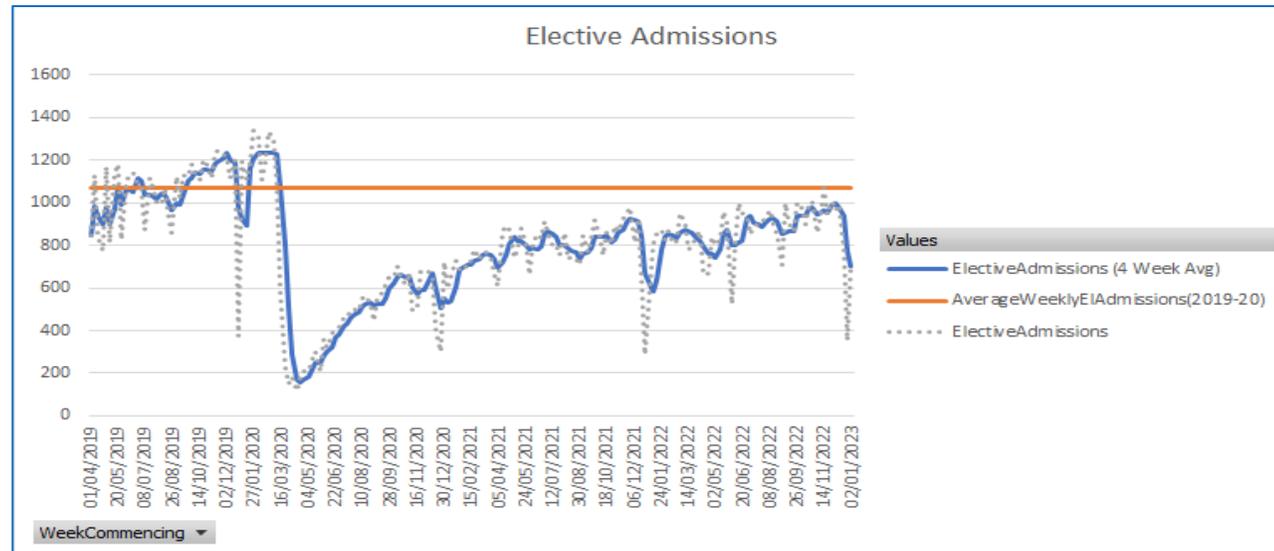
Planned Care Recovery – >156 Week Wait Current Position

Total Waitlist > 156 Weeks Wait

Weekly Inpatient/Day Case Activity – T&O
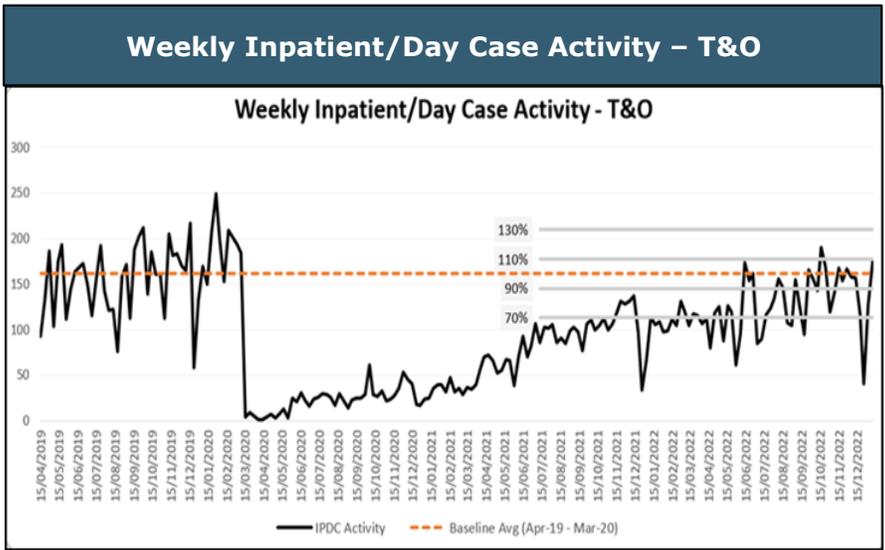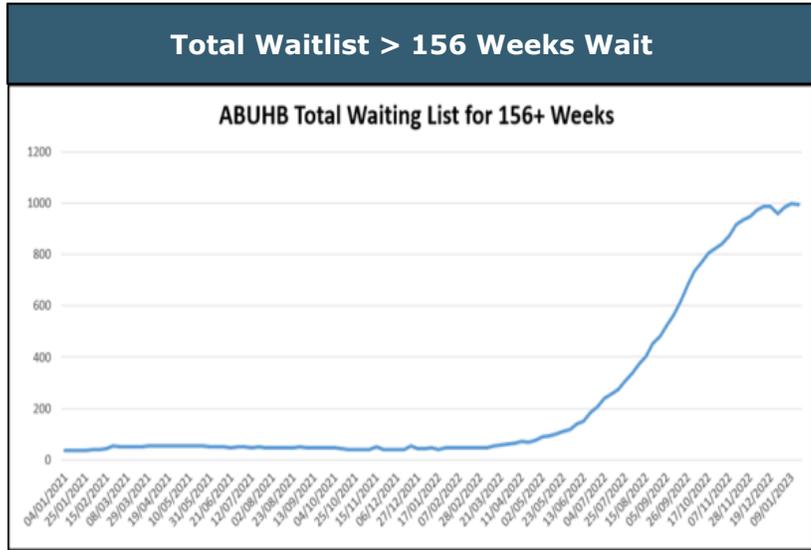
- Position has remained fairly static throughout December and remained under 1000.

- The Stage 4 position has reduced slightly in month from 795 to 772, and 18 Orthopaedic patients remain at Stage 1 – there has been progress noted in addressing waits at this stage.

- UHB has the potential to eliminate 156 week waits by March 2023, however subspecialty case mix is cited as a barrier to achieving this.

Planned Care; Performance and Look Forward

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV*	DEC	JAN	FEB	MAR
Number of patients waiting over 52 weeks for a new outpatient appointment - forecast	9,700	9,579	9,380	9,200	9,000	9,000	9,100	9,810	9,902	9,540	9,709	10,007
Actual	6,514	6,029	5,813	5,778	5,730	5,857	5,773	5,886	4,873			

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV*	DEC	JAN	FEB	MAR
Number of patient wating more than 104 weeks for treatment - forecast	6,514	6,029	5,813	4,485	3,962	3,618	3,251	4,466	4,412	4,165	4,095	*4,201*
Actual	8,925	9,147	9,381	10,076	10,373	10,831	10,883	11,033	9,786			

— Outpatient programme in place with plans in all specialties
— Roll out of SOS and PIFU Programmes
— All patients being contacted and validated
— Maintaining profile but risks in specific specialties
— Progress in clearing longest waits for treatments
— Remodelled theatre utilisation and implementing programme to create additional sessions
— Ambulatory Models to protect capacity
— Regional Programme in Place – taking forward Ophthalmology, Orthopaedics and Diagnostics

Cancer – 62 day Performance

SCP Pathway Monthly Performance
Aneurin Bevan UHB

SCP FOA Compliance per Month (including current)
Outlier = Red (beyond limits), Run = Yellow (7 or more above/below median), Trend = Green (5 or more increasing/decreasing)
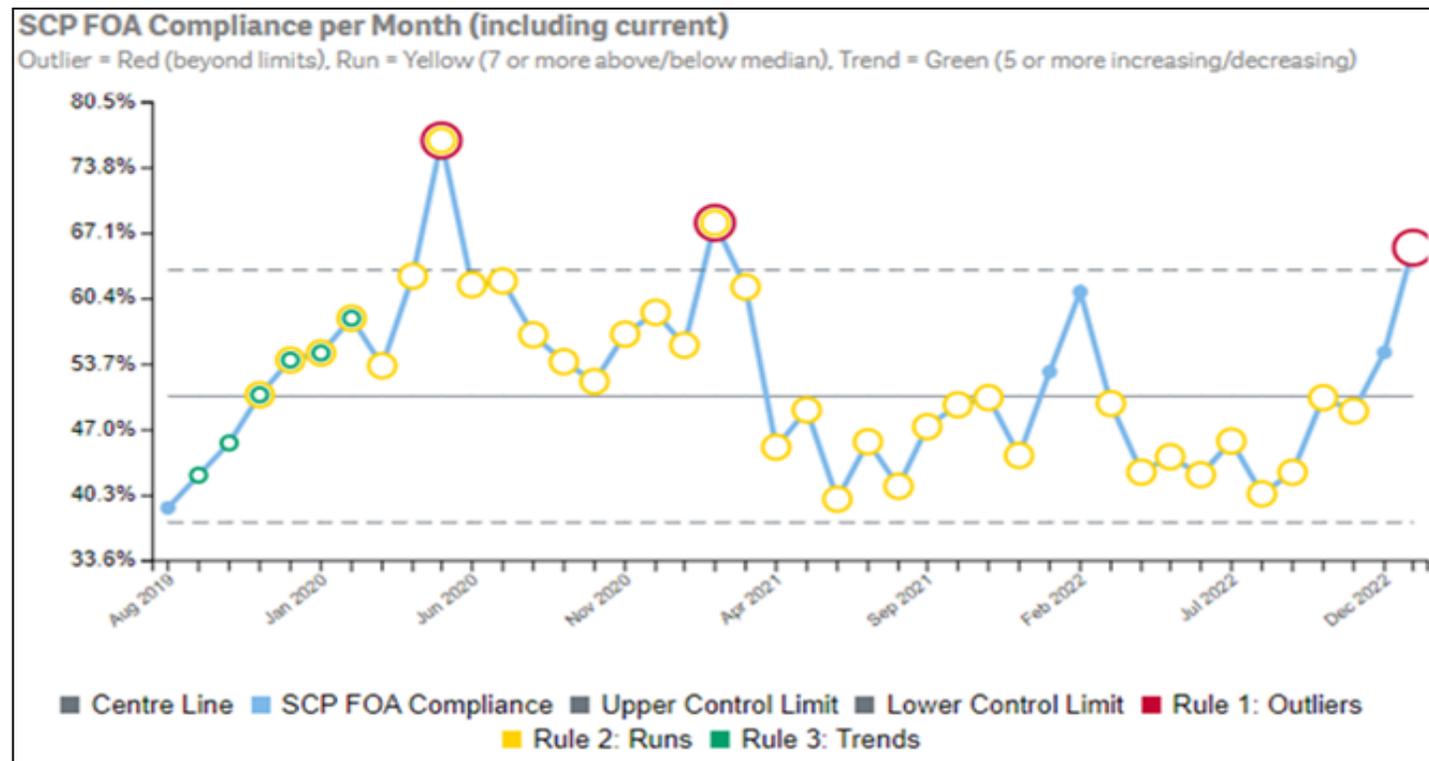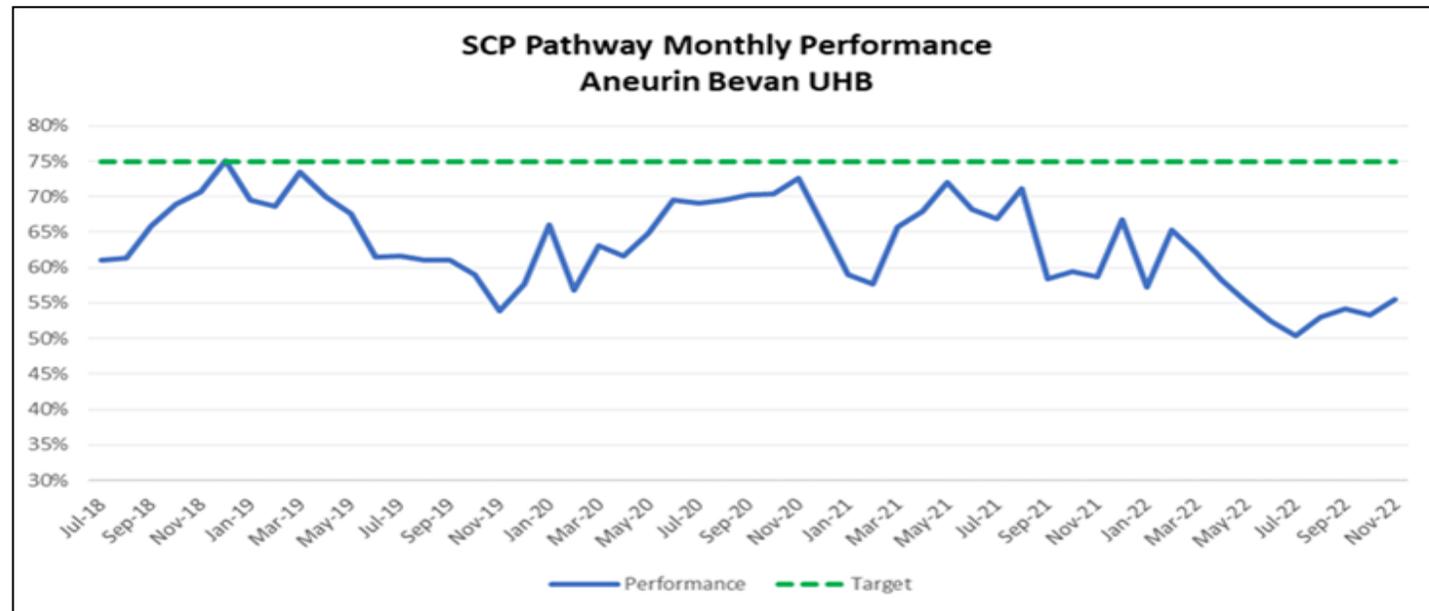
This is the graph representing the % of patients being seen within 2 weeks of suspicion.

Cancer – Backlog Recovery

Total Active Waits Greater than 62 Days
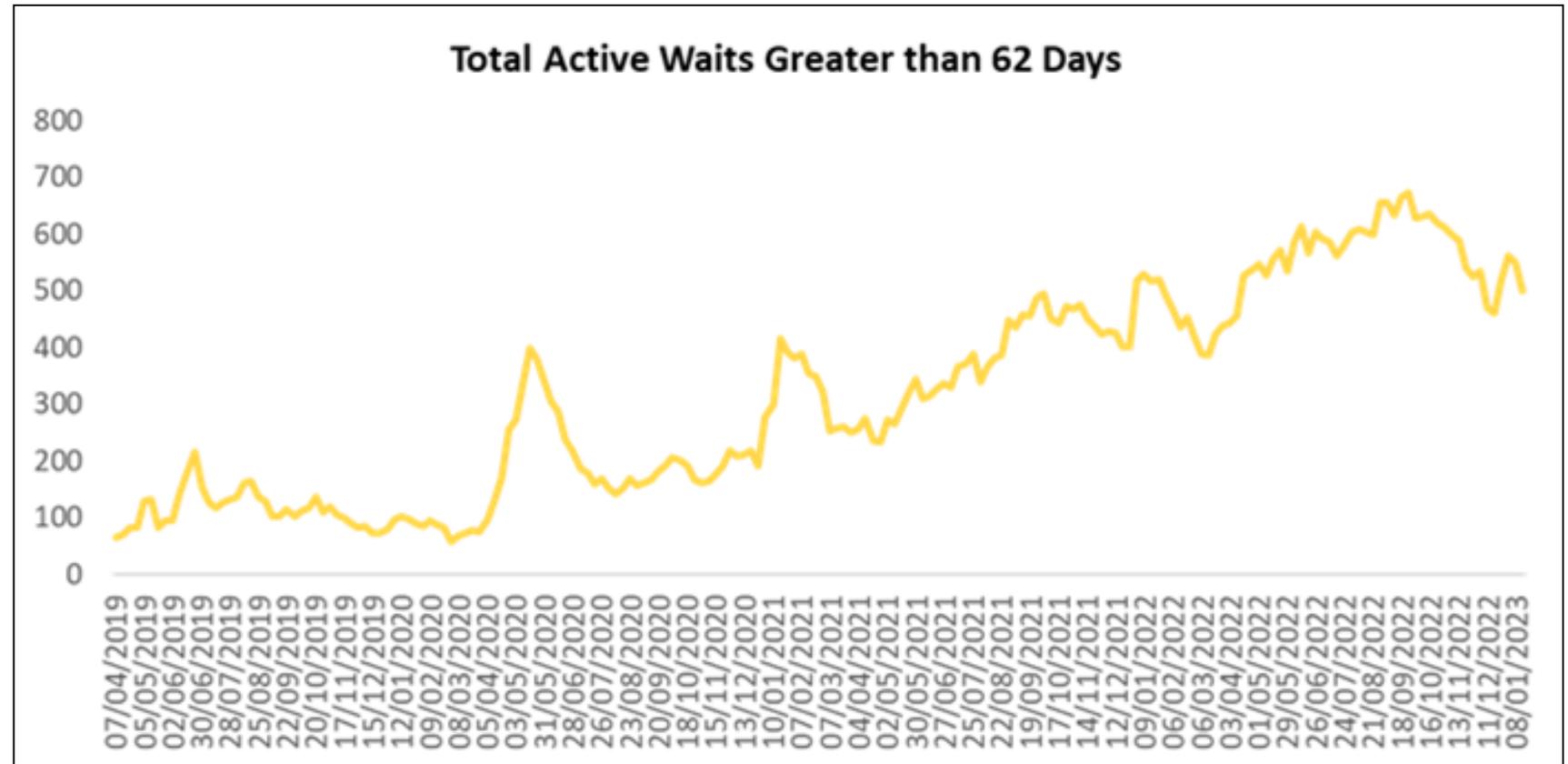
The 262 day cancer backlog is still ahead of projections provided to Welsh Government however has seen an increase post Christmas. Further reduction of the backlog remains as the highest priority for services.

Recovery Challenges

Issue	Cause	Remedial Action	Who	When
Breast outpatient waiting times	Core capacity not meeting demand. Additional WLI to maintain and reduce waiting times not realised due to outpatient staffing	Tuesday, Thursday and Saturday additional clinics to be established creating capacity surplus. Outpatient staffing being explored from within Gynae to support clinics. Full D&C and backlog reduction profile being completed to forecast recovery	Sian Redwood, Glenys Mansfield	27/01/2023
Colorectal surgery waits >6 weeks	Capacity shortfall	Change of surgical job plans every 16 weeks will allow 2 more inpatient lists	Dawn Baker-Lari	28/02/2023
Pathology waiting times	Capacity shortfall	Outsourcing of routine work continuing. Early signs of benefit to USC pathology reporting times	Arvind kumar	28/02/2023
Cancer backlog increasing again	Lost activity over festive period and rapid rise in demand in early Jan. Rise being seen across majority of tumour sites	Executive led cancer assurance meetings established from early February to scrutinise backlog data and associated performance measures	All services	28/02/2023
Delayed time to first appointment	Pay dispute reduced capacity for additional work, combined with period of exceptionally high demand	Demand and capacity work has now created sufficient slots to meet current demand and planned for future demand growth	Louise Harvey	Completed – Waiting times back within acceptable ranges
Dermatology – Pathology waiting times and outpatient delays	Pathology turnaround times delayed due to rapid increases in demand affecting both cut up and reporting. Derm OPA times increased due to abnormally extended period of high referrals	Outpatient waiting times resolved and now avg 10 days. Pathology outsourcing underway with improving waiting times anticipated in January	Arvind Kumar Dawn-Baker Lari	Jan/Feb

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	07 February 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Strategic Risk Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Danielle O'Leary, Head of Corporate Services, Risk and Assurance

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

This report seeks to provide a summary of the current key risks which encompass the Corporate Risk Register and form the strategic risks delegated to the Patient, Quality, Safety and Outcomes (PQSO) Committee for oversight.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides an overview of all **13** strategic risks described within the Corporate Risk Register, which receive oversight from the PQSO Committee.

Response to the COVID-19 pandemic, through front line service delivery, restart and recovery plans, Primary and Secondary Care demand increase and associated risks continue to have the greatest impact on service delivery. This sustained response alongside increased demand for services, challenges in timely discharge and significant workforce constraints continues to represent the most significant risks to the Health Board's delivery and the achievement of the objectives outlined within the IMTP.

The Committee is requested to note that the remainder of Quarter 4 will be dedicated to the review of risk management arrangements, assurance requirements and the development of an integrated Risk and Assurance system. This approach, when embedded, will enable to the Board to seek appropriate assurance and have focussed oversight on risk, internal control processes and assurance arrangements.

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.

Internal controls are identified, and action plans developed 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. Whilst active risk management is performed daily at an operational level, the Health Board's risk management strategy and process ensures that the Board is informed, engaged, and assured about the approach that Health Board uses to identify and respond to perceived risks.

The approach adopted by the Health Board to strengthen the alignment between Board and Committee business and the Board Assurance Framework continues to embed and provide a foundation for Board and Committee business to be risk based and focussed on assurance needs. This approach will also help to ensure the correct business is directed to the most appropriate committee.

Asesiad / Assessment

Current Organisational Risk Profile:
There are currently **30** Organisational Risk Profiles, of which **13** are delegated to the PQSO Committee for oversight. The following table provides a breakdown of the risks and level of severity:

High	**11**
Moderate	**2**
Low	**0**

A high-level breakdown dashboard of all strategic risks which are routinely reported to the Committee, including current score, target score, risk appetite level, risk treatment and trend since last reporting period is included at *Appendix 1*.

The risk assessment documentation and updates for each risk is attached to this report at *Appendix 2*. The Committee is requested to note that the Health Board will be actively working to review risk targets to ensure realistic and as far as possible; set within the context of the Board's appetite for risk and the current internal and external environmental factors which inform the backdrop of service delivery. There are currently two (2) risks that routinely report to the PQSO Committee that are being managed within an agreed risk appetite level, these are:
- **CRR013** Failure to prevent and control hospital and community acquired infections to include COVID-19

- **CRR023** Potential risk to population health in relation to avoidable harm due to priority being given to management of the COVID pandemic.

Update on risk CRR028 - Continued inappropriate admissions of Children and Young People to adult mental health in-patient beds

At the December 2022 PQSO Committee meeting, members requested an update on risk **CRR028** specifically, in relation to progress of discussions with Welsh Government and associated funding for the proposal to re-purpose existing Health Board estate. The Health Board is pleased to report that confirmation of capital funding for the proposal was sent on 20th January 2023. Further development of the implementation and project plan is now underway. Once a project plan with clear milestones for delivery and completion has been developed, a recommendation will be made to the Committee to de-escalate this risk and for it to be managed locally, by the service as part of usual project risk management arrangements.

Argymhelliad / Recommendation

The Committee is requested to:
- **RECEIVE** the overview of the Strategic risks which routinely report to the PQSO Committee.
- **NOTE** the update in respect of risk CRR028 as requested by the Committee in December 2022.
- **NOTE** the risks that are currently being managed within an agreed risk appetite level.
- **NOTE** the updates received for each of the Committee risks.

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	Choose an item. Choose an item. Choose an item. Choose an item.

Strategic Equality Objectives 2020-24	

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.	**(Feb 2023 ARAC)**	**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.	**(Feb 2023 ARAC)**	**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. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Feb 2023 ARAC)**	**PQSO**	**Director of Operations**

the COVID pandemic.	*(red)*	*(red)*	would include the use of technologies and innovations.	*(green)*				
CRR010 Inpatients may fall and cause injury to themselves.	15	10	**Zero or low** in the interests of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Feb 2023 ARAC)** ⬌	**PQSO**	**Director of Therapies and Health Science**
CRR027 'Effectiveness of COVID vaccination and booster programme compromised resulting from the emergence of a Variant of Concern	25	20	**Moderate** risk appetite level will need to be applied to this risk profile, given the unpredictability of the potential of variants of concern 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.	**No**	**Treat** the potential impact of the risk with mitigations. **Tolerate** the unpredictable element of the VoC and other mutations.	**(Feb 2023 ARAC)** ⬌	**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.	**(Feb 2023 ARAC)** ⬌	**PQSO**	**Director of Primary, Community and Mental Health Services**
CRR003 Mental Health services will fail to meet the anticipated	12	8	**Low** risk appetite level in the interests of patient safety. **Moderate** risk appetite levels will need to be taken to explore further	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Feb 2023 ARAC)** ⬌	**PQSO**	**Director of Primary, Community and**

increased demand of the Health Board population, for Mental Health support, in light of the COVID 19 pandemic.			innovations and appropriately reconfigure services and implement new arrangements.		**Tolerate** the impacts of some mitigations and acknowledge that some may not work.			**Mental Health Services**
CRR037 Clinically unsafe and inappropriate inter-site patient transfers and into communities	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.	**(Feb 2023 ARAC)**	**PQSO**	**Director of Operations**
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.	**(Feb 2023 ARAC)**	**PQSO**	**Director of Nursing/Director of Operations**
CRR039 Delays in discharging medically fit patients partly due to delays in accessing packages of care from Partners - *covered in part by CRR019 on	20	10	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when exploring new and innovative ways of working alongside key Partners and acknowledge that some controls and mitigations are outside of the Health Board control.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**(Feb 2023 ARAC)**	**PQSO**	**Director of Operations and Director of Primary, Community and Mental Health Services.**

Risk								
CRR (unmet demand and ambulance delays)*								
Safeguarding CRR030 – (New risk/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.	**(Feb 2023 ARAC)**	**PQSO**	**Director of Nursing**
CRR040 Putting Things Right (PTR) - Continued and sustained non-compliance with The NHS (Concerns, Complaints and Redress Arrangements)	20	8	Low (averse to risk) Risk Appetite Level 2	No	**Treat** the potential impacts of the risk by using internal controls.	**(Feb 2023 ARAC)**	**PQSO**	**Director of Nursing**

(Wales) Regulations 2011								
CRR044 Non-compliance with a key component of the new vision (2022-2027) for children's services is the Programme for Government commitment to remove private profit from the care of looked after children - Unregulated placements are used for children and young people who present with significant risk and need bespoke care packages when spaces are not available in registered accommodations.	20	10	**Low (averse to risk) Risk Appetite Level 2**	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**(Feb 2023 ARAC)**	**PQSO**	**Director of Operations**

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision	
• **Providing high quality care and support for older adults** • **Less serious illness that require hospital care**		*CRR010 –* *Threat Cause: Patients will fall whilst they are in our services* *Threat Event: Patients will be harmed or injured.* **TREAT**	
High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence	**Risk Appetite**	Risk appetite in this area is zero or low in the interests of patient safety.
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**	

Patient, Quality, Safety and Outcomes Committee	• Comprehensive corporate inpatient falls prevention action plan agreed. Policy for the management of and reduction of Inpatient Falls is in place. • Multidisciplinary training and support to drive improvement • Reports on inpatient falls provided to Executive Team	**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.*

	and Quality, Patient Safety and Outcomes Committee. • Improvement metrics agreed and overall numbers of inpatient falls is within trajectory for improvement. • An ongoing data analysis allows for the identification of shifts and trends associated with falls and activity outside of normal variation. • ABUHB engagement in the 'All Wales Inpatient Falls Network' in support of the development of a more consistent, standardised approach to falls management across Wales. ABHUH are also actively engaged in the' 4 Nations Falls Collective'. • The 'Falls and Bone Health Committee' looks to align its work to the National Audits and associated recommendations.						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	3	5	2	5

• Promoting (through training) the multidisciplinary requirements of the policy including completion of required risk assessments & care plans. ABUHB are actively engaged in the development of a generic level 1-2 falls training platform which will be promoted as a national production on completion and delivered via ESR. • To also include the promotion of the newly developed falls specific medication review tool and falls associated Head Injuries pathway. Further awareness sessions are being delivered. • Learning from serious incidents with audit of agreed actions and expected outcomes. • Evaluation of the falls components of the 'Once for Wales 'incident reporting system to ensure the opportunity to maximise the value of the data sets included. Further work is being undertaken to evaluate and confirm the accuracy of the systems outputs to inform the falls data sets. • Engagement in the planning process for the implementation of the electronic version of the MFRA as part of the WNCR. • Promoting the implementation of the 'Focus Review' held within the Incident reporting system.	Ongoing	20	15	10

Trend			Executive Owner: Director of Therapies and Health Science
		⬇	
Mapping Against 4 Harms of COVID			**Update**

January 2023

The 'Falls Policy for Hospital Adult Inpatients' was formally launched in July 2021 supported by an extensive awareness raising campaign. Staff training has been aligned to the requirements of the revised Policy. Work continues across ABUHB sites to further promote the MDT approach and requirements. The Falls and Bone Health Committee monitor the progress and impact of this work. The policy will be subject to minor changes following the complete rollout of the WNCR MFRA across all hospital sites in ABUHB.

A collaborative review of the governance structures in support of the management of falls has been undertaken by the Falls and Bone Health Steering group. This group will be retitled the 'Falls and Bone Health Committee' with the establishment of two new subgroups to undertake work associated with inpatient falls and those in the community setting outside of the hospital environment. The Falls and Bone Health Committee will report directly to the Patient Quality, Safety and Outcomes Committee. The revised governance structure will come into effect from February 2022. The first meetings of the subgroups took place in March 2022 with a focus on defining the 'Terms of Reference' and determining the agreed membership. Both groups are developing programmes of work to further inform the corporate action plan.

Whilst the 'Hospital Group' will focus on the inpatient setting the ''Community Group will look at the prevention and transition aspects of the persons pathway. Both groups will be cohesive in coordinating the elements of their programmes activities where commonality exists between both. Representatives from both groups would contribute to the work through a task and finish setting.

A group is being established to review the learning processes and actions adopted for those inpatient falls associated serious incidents and injury, including the mechanisms for the

	monitoring/auditing of associated action plans. The group has identified that further work is required to ensure that learning is being implemented, monitored and audited in a consistent and coordinated way across the Health Board. The development of an incident reporting framework is being considered but would look to take account of those beyond that of falls incidents. From a falls perspective this would be coordinated via the 'Hospital Group' and feed to the Falls and Bone Health Committee for oversight. A meeting to discuss the opportunities to develop a framework is scheduled for the 19th July 2022 and will take account of the ability to adopt a standardised approach.
	Work continues in light of ongoing system pressures and falls in the Emergency Department, with an Audit/ Pathway working group established to consider opportunities to improve safety in this specific environment. An evaluation of DATIX data is being undertaken to look at the themes that contribute to the numbers of incidents which will be used to inform next steps and subsequent improvement initiatives in this environment.
	A representative for ABUHB is working with other HBs in Wales to develop a level 1-2 falls training platform which will be delivered via ESR and available to all staff. This is intended to support a guided introduction to falls prevention and management through an interactive learning approach. This will help to inform the development of an ABUHB falls training framework which will take account of the requirements of the hospital and community setting. A scoping exercise has also been undertaken to look at other available falls training resources held within ESR and to which staff groups the content is applicable. This is being used to inform the development of training matrix for review which will take account of all Wales platform which is in its final stages of evaluation. Work is also being undertaken to ensure falls management is included as a component of the JOE programmes in both primary and secondary care.
	The Health Board continues to participate in the 'All-Wales Inpatient Falls Network, including engagement in the 4 Nations Falls Collaborative; this provides opportunity for shared learning and benchmarking. National audit outcomes will be presented to the respective Falls and Bone Health Groups and Committee to ensure any recommendations are considered within the context of the programmes of work.
	The key priorities identified at a 4 Nations level are as follows:
	Deconditioning, Develop the principles of National Guidelines

	- Training and development, build a training programme resource, linked to evidence-based practice (linking evidence of impact). - Falls Data, agree a framework for collecting comparable data (including common language/definitions, across sectors including sharing potential) - Dissemination guidelines, agree the principles of sharing good practice with respect to Community, Primary Care, Social Care, Emergency Services, Inpatient and Care Home settings Inpatient falls management has been subject to an internal audit for which reasonable assurance has been given. The outcome was subject to several recommendation for which a management response has been provided. The activities which for the response will be coordinated via the 'Hospital Group' with progress updates provided to the Falls and Bone Health Committee. Work has commenced on the development of standardised questions in support of fulfilling the requirements of the Health and Care Standard 2.3 Falls Prevention. This will underpin falls related specific audits which will look at information gathering from a qualitative and quantitative perspective and will look to include observational audits. There is ongoing engagement in the establishment of the implementation plan for the introduction of the electronic version of the MFRA as part of the WNCR. Training will be as a systems approach and will need to be supplemented by the ongoing provision to fulfil the clinical requirements for the completion of the MFRA. A phased approach has been adopted with implementation initially in all wards in GUH. It is anticipated further implementation is planned for April 2023. In the interim both an electronic and paper version of the MFRA will be in use across the Health Board. To support the change, the training has been adapted to ensure staff are aware of the content and completion requirements of the electronic document. Training will also continue for those who are using the paper copy of the MFRA. Work is being undertaken to implement the 'Focus Review' held within the incident reporting system to support the investigation processes for falls with fractures in the first instance. An SOP is currently in development to support implementation.

An audit is being undertaken to evaluate the availability of appropriate lifting equipment associated with the requirements to move patients post fall. The outcomes are to be presented to the Hospital Falls and Bone Health Group and Committee early in 2023.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision	
• **Provide high quality care and support for older adults** • **Care closer to home** • **Less serious illness which require hospital care**		***CRR038 Risk of*** delays in discharging medically fit patients ***Due to*** partly due to delays in accessing packages of care from Partners - covered in part by CRR019 (unmet demand and ambulance delays) on CRR TREAT TOLERATE	
		Impact Deteriorating position in relation to social care crisis significantly impacts on Health Board's ability to do its business and manage increased demand. Full understanding of partner risk profiles is required to develop new ways of whole system working.	
High Level Themes	• **Partnership** • **Patient experience and outcomes** • **Quality** • **Financial** • **Reputational** • **Public Confidence**	**Risk Appetite**	**Moderate (cautious risk taking) Risk Appetite Level 3**
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**	

Patient Quality, Safety and Outcomes Committee	• Multiple internal SOPs to support the timely discharge of medically fit patients • Existing relationships and professional arrangements with social care • Legislation requirements e.g. S117 etc.	**Inherent** *Risk level before any controls/mitigations implemented, in its initial state.*		**Current** *Risk level after initial controls/mitigations have been implemented.*		**Target** *Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	4	5	2	5
• RPB review of step closer to home pathway. • Explore options to increase community beds/virtual bed capacity in conjunction with Partners. • Development of Health and Social Care Winter Plan	Autumn 2022	**20**		**20**		**10**	

Trend		**Executive Owner: Director of Operations and Director of Primary, Community and Mental Health Services**
Mapping Against 4 Harms of COVID		**Update**
		January 2023: The Health Board is developing, in conjunction with key partners, a Winter Plan based on the reasonable worst case scenario data that has been shared from Welsh Government. The plan will include actions being taken forward by acute Divisions to optimise patient discharge into communities and increase flow through the system. The Board is due to receive the draft plan for endorsement on 19th October 2022.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision		
Getting it right for children and young adults **Supporting adults in Gwent to live healthy and age well** **Provide high quality care and support for older adults** **Staying healthy** **Care closer to home** **Less serious illness which require hospital care**		*CRR003 (March 2017)* *Risk of:* Mental Health services will fail to meet the anticipated increased demand of the Health Board population *Due to:* Continued and sustained Health Board response to the COVID Pandemic **TREAT**		
		Impact: Levels of population well-being could decline creating enhanced and sustained reliance on mental health services for children and adults. Unmet demand in communities potentially leading to increase in demand for Secondary Care Mental Health Services.		
High Level Themes	- Partnership - Research, Innovation Improvement Value - Quality and Patient Safety - Patient Outcomes and Experience	**Risk Appetite**	**Moderate (cautious risk taking)** **Risk Appetite** **Level 3**	
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**		
Patient Quality, Safety and Outcomes Committee	1. Key transformation programme in place to address: a) A whole system model to meet mental health need with a key focus on developing/strengthening open access foundation tier and mental health support within Primary Care; to enable prevention and early intervention. b) Redesigning crisis services and acute care. c) Redesigning services for people with complex needs. 2. A programme is in place monitoring bed availability and flow through the system, overseen by the Deputy Divisional Nurse.	**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.*

	• 3. Systems and processes are in place to monitor demand. • 4. Engagement with local academia to continue to monitor the impact of COVID on the wellbeing of the general population. • 5. Securing additional resources both within year, and recurrent.		

Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	Due Date	Likelihood	Consequence	Likelihood	Consequence	Likelihood	Consequence
		4	4	3	4	2	4
• Development of new models to meet the mental health needs of the population across all Tiers e.g. Foundation Tier, Primary Care Mental Health, Secondary Care Specialist Mental Health Services	May 2022	**16**		**12**		**8**	

Trend			Executive Owner: Director of Primary, Community and Mental Health Services
		⟷	

Mapping Against 4 Harms of COVID	Update

Harm from COVID itself

Harm from overwhelmed NHS and social care system

Harm from reduction in non-COVID activity

Harm from wider societal actions/lockdown

January 2023
No funding for sustainably funding PWP service currently identified although existing service will continue to be funded through NCNs. However, bids were produced for additional funding from WG to fund a range of service improvements including reducing waiting times across IAS, PCMHSS and psychology. WG supported all bids with exception of neurodevelopmental bids. Subsequent follow up meeting held with WG representatives and funding also agreed to support ADHD service development, although IAS bid not supported by WG as new funding expected to be released next year.

Risks associated with MAS clinic follow up waiting list in Caerphilly currently being investigated due to concerns about patients being lost to follow up during Covid period. Review of patient notes completed in Caerphilly and remedial action plan has been developed. Initial checks in other boroughs suggest issue contained within one borough, however now confirmed that some issues also identified in Blaenau Gwent MAS and audit to commence in borough shortly. SBAR being finalised and will be considered by Executive Team on 11 August 2022.

Work ongoing to review SISU OBC financial costs. SBAR under development for consideration at 18th August Executive Team meeting. OBC now delayed two months and finalised case to be considered at November 2022 Public Board in light of further work required on financial case and benefits.

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

• WG letter confirming initial funding response to funding bids and HB response
• SBAR attached regarding introduction of ADHD service supported by Exec Team, Health Board, CHC and LMC.

	FUNDING AWARD LETTER Aneurin Bev...	ST Letter - 08.07.2022.docx	Exec Team SBAR template ADHD ...

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision			
• **Getting it right for children and young adults** • **Supporting adults in Gwent to live healthy and age well** • **Provide high quality care and support for older adults** • **Staying healthy** • **Care closer to home** • **Less serious illness which require hospital care**		*CRR023 – (May 2020)* *Risk of: Unknown or unmet non-COVID harm across population health* *Due to: Priority being given to management of the COVID pandemic* **TREAT**			
High Level Themes	• Population health • Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Finance	**Risk Appetite**	**Low (averse to risk) Risk Appetite Level 2**		
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**			
Patient, Quality, Safety and Outcomes Committee	• Departmental repurposing and redesign to accommodate non-COVID activity has occurred. New ways of working adopted e.g. virtual reviews. Nosocomial Group operating, providing advice and support. • Adapt and sustain progress being monitored through Exec Team meetings via Director of Operations. • Plan in place for for green recovery (treatments) RGH – all specialities excluding orthopaedics • Orthopaedic operating at OSU and NHH (P2) • Outpatient Steering Group • Robust escalation reporting and escalation arrangements within primary and community services division.	**Inherent** *Risk level before any controls/mitigations implemented, in its initial state.*		**Current** *Risk level after initial controls/mitigations have been implemented.*	**Target** *Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*		**Due Date**	Likelihood	Consequence	Likelihood	Consequence	Likelihood	Consequence

Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	Likelihood	Consequence	Likelihood	Consequence	Likelihood	Consequence
		4	5	4	5	4	5
Early recovery plan agreed focusing on Cancer, 52 weeks, Follow Up waits, Diagnostic and Therapies waiting times, and Eyes Care. Formal recovery plan for 2022/23 being developed as part of the Annual Plan. Focus on new ways of working will be fundamental to the approach. Risk stratification and validation of lists is ongoing and focus is on Urgent and Cancer work.	Ongoing	**20**		**20**		**20**	

Weekly tracking of recovery plus tracking of new ways of working in place, the priorities outlined above mirror those in F&T with similar work progressing operationally around risk stratification, validation, daily scrutiny of cancer pathways, WLI OPD sessions for clinically urgent patients, maximising PAC and theatres and on a transformational level, redesigning of services.	Ongoing			

Trend		**Executive Owner: Director of Operations and Director of Primary Care, Community and Mental Health**

Mapping Against 4 Harms of COVID	**Update**

January 2023
Prioritisation for use of capacity is as follows:

- Cancer, suspected cancer, and urgent, for new outpatients (R1 for ophthalmology) for all surgical and non-surgical specialities including therapies
- Suspected cancer, urgent and routine for diagnostics (due to the number of cancer cases that arise from routine tests)
- New urgent and routine outpatients over 52 weeks
- Patients waiting for a new outpatient appointment over 104 weeks
- 100% delayed Follow-up outpatients
- Adhering to the surgical prioritisation during the coronavirus pandemic (Version 2 – June 2020 – P1a, 1b, 2, 3 and 4), as well as the separate guidance in terms of obstetrics and gynaecology (RCOG) and ophthalmology (RCOphth):

Trajectories in terms of ministerial target delivery being completed.

Patient access and activation team formed.

Outpatients
- Validation and patient contact plan in situ for 22/23 to ensure waiting lists are clean and accurate; that patients who do not require their appointment are removed from the waiting list, and improving communication to patients.
- SoS and PIFU implementation plan developed for 22/23. Particular focus required for specialities with long waiting lists. Social distancing requirements stopped in opd and templates increased accordingly.
- New outpatient one stop treatment unit at RGH – monies obtained from WG for recurring staffing/consumable requirements. Task and finish group in situ to undertake implementation of Unit – Quarter 3 phased opening. Waiting times for patients will be reduced for the procedures undertaken within the unit.
- Use of E:Advice automated system to go live in Quarter 3.
- Outpatient speciality transformational plans complete and trackers in place to monitor delivery and impact on activity and financial impacts.
- DNA implementation plan developed to improve clinic utilisation, decrease waiting times and potential patient harm.

	➤ Hospital cancellation plan developed with the aim of increasing clinic utilisation, improving booking processes for patients, decreasing wasted slots, and decreasing waiting times. ➤ Specification completed for automated booking system to improve clinic utilisation and increase backfills. **Treatments** ➤ Increase in overall elective sessions to 91% with additional sessions allocated to Urology at RGH going live in 2 weeks. Further GS sessions to go live in Oct and Dec in YYF. ➤ Current theatre vacancies 22 wte but reducing to 9 wte with staff starting. 13 wte students starting in Sept / Oct to enable further sessions to open early 2023 and ongoing successful Recruitment Wheel ➤ Regular retention drop-in sessions take place across Theatres to ensure opportunities to retain staff. Current turnover for Theatres is at 3%, reduced from 7% last year. ➤ Successfully increased and recruited to establishment of Band 6 ODPs at GUH in order to mitigate turnover and open opportunities for internal Band 5s to progress. ➤ Sickness absence training has taken place with all Theatre Managers, supported by Workforce colleagues, has been robustly managed over the past 12 months. Sickness dropped from 9.3% to 6.3% ➤ Fixed Term Agency Workers ended at GUH and has supported improvement in skill mix ➤ Systems in place to facilitate a more flexible workforce to enable moving staff across sites ➤ Human Factors / Wellbeing initiatives to improve staff experiences ➤ Exploring Band 4 Assistant Theatre Scrub Practitioners to provide sustainable workforce ➤ Reconfiguration of Theatre Model – programme underway following Lightfoot modelling, expected to be implemented end of 2022 ➤ Project in place to increase and consolidate day case activity to improve utilisation and increase DC rates ➤ Implement SDEC / CEPOD RGH – 10 sessions subject to approval of funding ➤ Local Ophthalmology Solution NHH – 7 sessions subject to approval of funding ➤ Extended Day Surgery Ward Opening Times RGH / NHH (facilitates evening / later discharges) ➤ Good recent investment in operating tables, anaesthetic machines, stacking systems

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22	Risk Description, Appetite and Decision		
• **Provide high quality care and support for older adults** • **Staying healthy** • **Care closer to home** • **Less serious illness which require hospital care**	***CRRO037 Risk of:*** Inadequate nurse staffing levels and reliance on temporary staffing. ***Due to*** Additional capacity, patient acuity and significant staffing requirements for enhanced levels of care **TREAT** **TOLERATE**		
	Impact Negative impact on staff morale, patient experience and outcomes. Non-compliance with legislative and statutory requirements, creating exposure to reputational damage.		

High Level Themes	• **Staff well-being** • **Patient experience and outcomes** • **Reputational** • **Public Confidence** • **Quality**	**Risk Appetite**	**Low (averse to risk)** **Risk Appetite** **Level 2**

Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**		
Patient Quality, Safety and Outcomes Committee	• Health Board Recruitment drives • Safer staffing legislation • Pay incentives for Health Board bank staff • Proactive engagement with agencies	**Inherent** *Risk level before any controls/mitigations implemented, in its initial state.*	**Current** *Risk level after initial controls/mitigations have been implemented.*	**Target** *Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*

Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	3	5	1	5

• On-going local and international recruitment of registered nurses. • 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. • Recalculation of roster establishments on both acute and community hospitals. • Implementation of local bank incentives. • 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 • Introduction of transitional care wards with appropriate skill mix to reduce RN requirement.		**20**	**15**

Trend			Executive Owner: Director of Nursing and Director of Operations
		⟷	

Mapping Against 4 Harms of COVID	Update
Harm from COVID itself Harm from overwhelmed NHS and social care system Harm from reduction in non-COVID activity Harm from wider societal actions/lockdown	**January 2023** Inadequate nurse staffing levels and reliance on temporary staffing has an impact on patient quality and safety. The risk relates to both registered and unregistered nurse staffing.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22	Risk Description, Appetite and Decision

• Less serious illness that require hospital care • Providing high quality care and support for older adults	**CRR013 – (Jul-18)** **Risk of:** Widespread hospital and community harm, with potential increase in demand and acuity of hospital or community acquired infections. **Due to:** Failure to effectively manage community and hospital transmission of Health Care Acquired Infections (HCAIs) to include COVID 19. **TREAT**
	Impact Potential impact on staffing, resources and infrastructure of an already pressured acute hospital system. Further potential impact on Primary and Secondary care services if need in communities are not managed.

High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence	Risk Appetite	**Low (averse to risk)** **Risk Appetite** **Level 2**

Committee Assurance	Internal Controls – Policies/Procedures	Risk Score					
Patient, Quality, Safety and Outcomes Committee	• Robust internal policies • Multiple SOPs	**Inherent** *Risk level before any controls/mitigations implemented, in its initial state.*		**Current** *Risk level after initial controls/mitigations have been implemented.*		**Target** *Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	Due Date	Likelihood	Consequence	Likelihood	Consequence	Likelihood	Consequence
		3	5	2	5	2	5
Reducing nosocomial transmission group (RNTG) which is clinically led, reports to Executive Team weekly. COVID hospital transmission implementation plan is in place, recently updated to include the Hierarchy of Controls and with frequent auditing and monitoring.	Ongoing	**15**		**10**		**10**	

Organisational thermometer updated to reflect community prevalence				
Ongoing monitoring of the Clostridium Difficile rapid implementation plan via RNTG				

Trend				Executive Owner: Director of Nursing
	⟷			

Mapping Against 4 Harms of COVID	Update
Harm from COVID itself Harm from overwhelmed NHS and social care system Harm from reduction in non-COVID activity Harm from wider societal actions/lockdown	**January 2023** **COVID-19** There has been a reduction in community prevalence of COVID across Wales (latest ONS figures (02/09) indicate 1 in 65 people in Wales have COVID). There has been a corresponding continuing reduction in the impact on ABUHB hospitals, however, there are still 3 ongoing ward outbreaks at the Royal Gwent Hospital. There are no other outbreaks at any of the other ABUHB hospitals. Outbreak Control meetings are held for each identified outbreak with a focus on identifying learning and action points to prevent further transmission, they are also reported to Welsh Government. As routine in-patient testing stopped in May 2022, outbreaks were identified due to there being one or more symptomatic case. All patients then exposed to a positive case are then tested in-line with agreed HB policy. Overall figures indicate that a total of 81 COVID +ve patients in August were identified as either definite healthcare acquired infection (HAI), probable HAI or indeterminate cases. 11 of these cases sadly died within 28 days of their COVID +ve result (5 Definite HAI and 5 Probable HAI's). Mortality reviews are conducted for all of these cases. The HB has a comprehensive Testing Policy which is currently being updated to reflect very recent updates to the Welsh Government (WG) testing Framework. An update to the WG Staff Risk Assessment has also very recently been published and will be reviewed accordingly to ensure that staff can return to work safely when they have been identified as a close contact of a COVID +ve case. All HB standard operating procedures and policies relating to COVID-19 are discussed and ratified at the Reducing Nosocomial Transmission Group (RNTG). The number of care homes in active outbreak or with identified cases has also reduced (7 currently in 'outbreak'). The Infection Prevention Team working collaboratively with the Public Health Team continue to support homes as required. ***C. difficile***

	C. difficile within ABUHB continues to exceed the Welsh Government reduction expectations, which reflects an increasing trajectory across Wales. There were 25 cases of *C. difficile* in the HB in August. 10 of these cases were healthcare associated, 8 community acquired, 2 indeterminate cases and 4 relapses). All cases are subject to an RCA review. An outbreak has been identified on C4E at RGH, with 3 cases in 1 month – an outbreak meeting has been held and learning identified around timeliness of isolation and general infection prevention measures acknowledging the challenges around reliance on a temporary healthcare team. The ward is to undergo a full HPV clean and a follow-up meeting will be held to ensure actions have been addressed and all learning identified. **Increased Incidence of Surgical Site Infection (Trauma & orthopaedics)** Period of increased incidence of surgical site infections across GUH & RGH (identified July 2022): 8 cases Investigation, led by the Division, is ongoing, action plan developed 2 patients have sadly died – Mortality Reviews in progress

| Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision	
Priority 1 – Every child has the best start in life **Priority 2- Getting it right for children and young adults** **Priority 3 – Adult in Gwent live healthy and age well** **Priority 4 – Older adults are supported to live well and independently** **Priority 5 – Dying well as part of life**		*CRR030 – (New risk/re-framed Sept 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. **Due to:** These would not have been identified in the height of the pandemic due to staff redeployment, reduction in face to face contacts and reduced NHS provision. There are increasing rates of safeguarding disclosures from patients (adults and children) and professional concerns/ allegations. **TREAT**	
		Impact: Increasing disclosures impact on the amount of time and activity required from all directorates to manage; challenging conversations with patients and staff, completing DTR's, conducting investigations, liaising with the MDT and safeguarding meetings.	
High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Staff Well Being • Financial • Public Health - COVID	**Risk Appetite**	Risk Appetite is low in this area due to potential impact on quality, experience and patient outcomes however, tolerances could be flexible as the Health Board develops innovative ways to mitigate this risk.
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**	

Patient Quality, Safety and Outcomes Committee	- Safeguarding Training offered at all levels throughout ABUHB. - Supervision and case review available - Robust monitoring of safeguarding activity through the Safeguarding Committee via quarterly reporting - Monthly practitioner concerns data shared with Divisions to review and manage - Safeguarding Work Plan for 2021/22 in progress and owned by the divisions - Safeguarding Strategy in place - Redeployment of workforce to mass vaccination clinics has ceased - DoLs consortium overseeing activity e.g. Waiting lists, compliance monitored via the QPSOG and PQSO Committee. - Local escalation framework for DoLS.	**Inherent** *Risk level before any controls/mitigations implemented, in its initial state.*		**Current** *Risk level after initial controls/mitigations have been implemented.*		**Target** *Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		5	5	3	4	2	5
- Agreement of clinical sessions for Best Interests Assessors to support mass vaccination clinics, mitigated by commissioning agency BIAs. - Regional consortium will continue to monitor the DoLS action plan and escalate as required. - Safeguarding positon continues to be monitored at Safeguarding Committee with escalation to Executive Team as required and reporting to PQSOC. - Weekly Executive Huddle includes Safeguarding to report themes and concerns - Safeguarding training will be reviewed to incorporate Hidden Harms and the impact of COVID-19 on children and adults at risk, to improve HB team member understanding of changing demands of patients/service users. - Review of data collection for safeguarding in the HB to take place, to streamline processes for reporting safeguarding and understanding demand and resource. - Safeguarding Hub within the Corporate Safeguarding Team developed to offer advice and support to the HB Mon- Fri 9-5pm. This is to be continued as a permanent feature and demand and resource to be continuously reviewed.	31st Jan 2022 Monthly Quarterly Weekly 31/06/2022 31/06/2022 Quarterly	**25**		**12**		**10**	

Trend		**Executive Owner: Director of Nursing**

Mapping Against 4 Harms of COVID	Update

January 2023
1. Training compliance:

- **Level 1 Safeguarding Adult Training** - Overall compliance 80% (↑ 69% Q2)
- **Level 1 Safeguarding Children Training** - Overall compliance 79% (↑ 77% Q2)
- **Level 2 Safeguarding Adults Training-** Overall compliance 57% (↑40% Q2)
- **Level 2 Safeguarding Children Training** - Overall compliance 49% (↑ 23% Q2)
- **VAWDASV Group 1 Training** - Overall compliance 69% (↔ 69% Q2)

Safeguarding Training is an ongoing agenda item at the Safeguarding Committee with plans to address low compliance rates across the directorates.

Safeguarding training will be reviewed to incorporate Hidden Harms and the impact of COVID-19 on children and adults at risk.

2. Safeguarding Operational Group has ceased due to unforeseen leadership absence in the Corporate Safeguarding Team. This is planned to be recommenced in Q1 2022/23. The SOG Work Plan has been maintained in this period and is up to date for Q4 2021/22 with progress on actions been maintained.

3. Members of the Safeguarding Committee have identified priorities for QTR 4 2021-2022
    Namely:
    - Training, particularly Level 2.
    - Aligning Safeguarding Level 3 training
    - Awareness of when Duty to Report Required
    - Using case examples and scenarios to raise awareness
    - Continuing Health Care funded placements and links to Safeguarding

These will be incorporated into the new Work Plan to meet the needs of the directorate

4. Ongoing collaboration with the Regional Safeguarding Board regarding pertinent issues relating to the pandemic. These include;
    - suicide for children and young people
    - fabricated and induced illness
    - child sexual exploitation

	5. Deputy Head of Safeguarding co-chairing (and previous author) of the SMM redesign. This will piloted in 2022/23 at ABUHB as an improved quality assurance tool for safeguarding. Work with the Regional Safeguarding Board for them to pilot the redesigned SMM as a multi-agency quality assurance tool. Due to staffing shortages across NHS Wales, there has been an increased reliance on agency staffing in clinical areas. There has been an increase in professional concerns/ allegations relating to agency staff members. These have tended to be complex to resolve. The Corporate Safeguarding Team have created a Section 5 SOP which is in the process of sign off, and needs a thorough launch and communication within the Health Board, with DBS processes included to improve the understanding and smooth process for such safeguarding concerns.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision	
Priority 2- Getting it right for children and young adults **Priority 3 – Adult in Gwent live healthy and age well** **Priority 4 – Older adults are supported to live well and independently**		*CRR027 (June - 2021)* *Risk of:* new COVID variants emerging *Due to:* significant and sustained spread of disease culminating in the effectiveness of COVID-19 vaccination and booster programme being compromised **TREAT**　　　　　**TOLERATE**	
		Impact Potential impact on ability to staff services appropriately, also leading to widespread disease and harm in communities, eventually impacting on Health Board services, Primary, Secondary and Tertiary).	
High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Staff Well Being	**Risk Appetite**	**Moderate (cautious risk taking)** **Risk Appetite** **Level 3**
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**	
Patient Quality, Safety and Outcomes Committee	• Continuation of data, surveillance, and monitoring activities to inform any deterioration from 'Covid Stable' to 'Covid Urgent' (as per WG national policy), as could be triggered by emergence of a new variant, and initiate standing up of IMT arrangements as necessary e.g.: ▪ Local IMTs controlling clusters and outbreaks and keeping cases as low as possible (standing up / frequency of	**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.*	

	local IMT arrangements are determined by local need – *however, data and surveillance information outlining the epidemiological situation continues to be shared on a routine basis and escalated as necessary).* ▪ Gwent IMT – *a handover and governance certificate has been produced to transfer Gwent IMT's key responsibilities (including ongoing surveillance, analysis and impacts of Covid-19) to the Gwent, Test, Trace Protect Leadership Group and the Gwent Local Resilience Forum Human Infectious Diseases Group* • Keeping abreast of guidance from WG. • Continuing public messaging on adherence to restrictions. • Vaccination Programme Board monitoring roll-out of programme weekly. Transitioning of the Gwent Test, Trace, Protect Service – with a focus on vulnerable settings including Health and Social Care - into a Health Board and Single Host LA model (Caerphilly County Borough Council) during Q1 2022/23 until at least 31st March 2023. The Health Board component of the Service will be led by a Consultant in Public Health and consist of: ▪ Regional Cell Delivery Team (programme and project management expertise, business support and administration) ▪ Public Health and Protection Team (specialist public health expertise, clinical expertise, and contact tracing teams)			

	▪ Data & Surveillance Team (epidemiology and data analysis expertise)						

Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	Likelihood	Consequence	Likelihood	Consequence	Likelihood	Consequence
		5	5	4	5	4	5
When standing, Gwent IMT leads on multi agency response to manage community response. Sit reps (SBAR) to WG are submitted on a routine basis when required *(stood down as of February 2022)* or on an exceptional basis. Gwent IMT involves representatives from 5 x Local Authority Directors of Public Protection, ABUHB Director of Public Health, & Public Health Wales Health Protection. Gwent IMT & Gwent, TTPS delivery and management of National VAMC guidance, regional testing plans etc. Gwent IMT has handed over to GTTPS Leadership and Gwent LRF HIDG as described above under controls. The Wales Outbreak Control Plan and the Gwent Covid-19 Prevention and Response Plan describe the operational 'response model' moving forward and the IMT will be reinstated if necessary in accordance with those arrangements. It is noted that there is a commission from Welsh Government to Public Health Wales to review the Wales Outbreak Control Plan and that the Gwent LRF Human Infectious Diseases Group is to review the Gwent Covid-19 Prevention and Response Plan The Gwent Test Trace Protect Service Leadership Group is the key partnership body established to lead and guide the TTP service established in the face of the Covid-19 pandemic and will continue in this role as the service transitions to an Integrated Health Protection Service. Transitioning of GTTPS to facilitate ongoing Covid-19 response where required, inclusive of Data & Surveillance capabilities to inform the need for any escalation of the Health Board response.	Monitored weekly at present	**25**		**20**		**20**	

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

Harm from COVID itself

Harm from overwhelmed NHS and social care system

Harm from reduction in non-COVID activity

Harm from wider societal actions/lockdown

The Omicron variant spread rapidly around the world in December 2021 with control measures having little effect on slowing spread down due to it being much more transmissible than previous variants. The easily transmissible sub-variant of Omicron, called BA.2, now appears to be causing most cases. Recent easing of restrictions and waning immunity from the vaccines could be factors behind the rise too.

Experience to date shows that the Omicron variant has resulted in a much lower rates of serious illness than previous waves, due to high levels of vaccine induced population immunity (realised risk) and the variant itself causing less serious illness (inherent risk). However, there has been an increase in hospitalisations in recent week particularly in older age groups. It is hoped that future variants of COVID-19 will also have a lower inherent risk of serious illness and that vaccines will be equally effective (realised risk), but that is by no means certain. The risk of a future variant being both highly transmissible and having a higher inherent risk of serious illness than Omicron remains a very real risk.

On 4th March 2022 Welsh Government published their transition plan 'Together for a Safer Future: long-term COVID-19 transition from pandemic to endemic' which recognises that vaccination and treatments are our best future defence. Together for a Safer Future sets out two future planning scenarios – Covid Stable and Covid Urgent. Covid Urgent is premised on a new variant that has a high level of vaccine escape or other advantages that puts large numbers of people at risk of severe illness (similar to the Alpha wave in Dec 2020). If this scenario were to arise in the future it would require all of us to work together to reintroduce protective measures.

The ABUHB COVID-19 mass vaccination programme has given over 374,337 booster vaccinations. The programme continues to provide first, second and third doses of the COVID-19 vaccination in line with JCVI guidance and WG policy for all relevant age groups. Last month Welsh Government announced the Spring booster programme for over 75s, care home residents and immunosuppressed. The Spring booster has recently commenced through the MVC model for over 75s and immunosuppressed with mobile vaccination crews vaccinating care home residents (starting on 21/03/22). Welsh Government have also confirmed that Wales will be providing a universal vaccination offer to 5-11 year olds which started on the 10/02/2022 and is also being delivered through the MVCs.

| Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision	
• **Provide high quality care and support for older adults** • **Care closer to home** • **Staying Healthy** • **Dying well**		***CRR039 Risk of** delayed cancer treatments delivered to patients* ***Due to** deteriorated position in cancer performance specifically in relation to 62 day waits.* TREAT	
		Impact Reduced levels of patient quality, outcomes and experience, public confidence, and potential reputational damage to the Board.	
High Level Themes	• Quality and Patient Safety • Patient Outcomes and Experience • Public Confidence • Reputational • Financial	**Risk Appetite**	**Low (averse to risk)** **Risk Appetite** **Level 2**
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**	

Patient Quality, Safety and Outcomes Committee	• Cancer Services Board to monitor and review delivery plans associated with cancer targets (KPIs) • Regular reporting on cancer KPIs to Welsh Government. • Cancer Directorate performance meetings. • Use of business intelligence tools (Lightfoot SFN,	**Inherent** *Risk level before any controls/mitigations implemented, in its initial state.*	**Current** *Risk level after initial controls/mitigations have been implemented.*	**Target** *Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*

	Qliksense, Performance warehouse data).							
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*		**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
			5	5	4	5	2	5
- Cancer Assurance meeting recommencing from February 2023 focussing 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 (Feb/March) 14 days first seen measure remains as priority to ensure rapid access to diagnostics. - Optimal Cancer Pathway manager to begin in post 13.02 with early focus on H&N and Urology			**25**		**20**		**10**	
Trend			**Executive Owner: Director of Operations and Medical Director**					
Mapping Against 4 Harms of COVID			**Update**					
			January 2023 Backlog reduction has been hindered by Christmas period and has subsequently increased. This has also resulted in a drop in performance for December by around 4%. Cancer assurance meetings are due to recommence in February and will be focussed on the key measures of backlog reduction, 14 day and 62-day compliance. 14-day compliance continues to improve and is at 66% for January against a 75% initial target.					

Harm from COVID itself

Harm from overwhelmed NHS and social care system

Harm from reduction in non-COVID activity

Harm from wider societal actions/lockdown

	Pathology turnaround times remain a major challenge to delivering care within 62 days. Continuation of outsourcing is therefore fundamental to further reducing waiting times.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22	Risk Description, Appetite and Decision
• **Provide high quality care and support for older adults** • **Care closer to home** • **Less serious illness which require hospital care**	***CRR037 Risk of*** clinically unsafe and inappropriate inter-site patient transfers and into communities ***Due to*** lack of availability of safe and appropriate transfer vehicles, staff and skill mix to facilitate the transfers. **TREAT**

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

High Level Themes	• Quality and Patient Safety • Patient Outcomes and Experience • Public Confidence • Reputational • Financial	Risk Appetite	**Low (averse to risk)** **Risk Appetite** **Level 2**

Committee Assurance	Internal Controls – Policies/Procedures	Risk Score					
Patient Quality, Safety and Outcomes Committee	• Existing Health Board contractual arrangements with WAST •	**Inherent** *Risk level before any controls/mitigations implemented, in its initial state.*		**Current** *Risk level after initial controls/mitigations have been implemented.*		**Target** *Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk*	Due Date	Likelihood	Consequence	Likelihood	Consequence	Likelihood	Consequence
		4	5	3	5	1	5

score or maintain it.				
WAST provide 11x vehicles of an appropriate skill mix to undertake Inter-Site Transfers as part of the Clinical Futures Model. This includes the following: • 1x Transfer Practitioner Ambulance (24/7) • 1 x Paramedic 999/EMS Ambulance (12/7 day shift) • 9 x UCS Ambulances (3 x 24/7 & 9 x 12/7) Six-month collaborative review of the Inter-Site model by EASC in conjunction with WAST undertaken as part of SLA. Recommendations being worked through with triumvirate of Health Board staff (Associate Director of Operations, Head of Transformational Change & Consultant Anaesthetist). Revision of renewal of formal SLA and service specification ongoing. Governance of standards & SLA via the following: • Monthly reports provided by WAST as per commissioning agreement/SLA • Tier 2 Ambulance Service Monitoring Group Meeting • Monthly report to Director of Operations highlighting performance • QPSOG receive monthly report at each meeting		20	15	5

Additional workstreams via Six Goals Urgent & Emergency Care Programme (workstream 4 & 5). These are managed corporately as part of an all Wales Programme. 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)			

| Trend		⬌	**Executive Owner: Director of Operations**
Mapping Against 4 Harms of COVID			**Update**
Harm from COVID itself Harm from overwhelmed NHS and social care system Harm from reduction in non-COVID activity Harm from wider societal actions/lockdown			**January 2023** Handover Improvement Plan actions & timelines added. 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.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22	Risk Description, Appetite and Decision
- Getting it right for children and young adults - Supporting adults in Gwent to live healthy and age well - Provide high quality care and support for older adults - Staying healthy - Care closer to home - Less serious illness that require hospital care - Dying well	**CRR019 – (Jan 2022) Re-framed** ***Risk of:*** Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand. ***Due to:*** Significant delayed transfers of care, domiciliary and care home constraints. **TREAT** **TOLERATE**

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

High Level Themes	• Patient Outcomes and Experience • Population Health • Quality and Safety • Reputational • Public confidence • Financial	Risk Appetite	**Low (averse to risk)** **Risk Appetite** **Level 2**
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**	
Patient, Quality, Safety and Outcomes Committee	• Health Board Emergency Pressures Escalation Policy (revised Nov 2021) • Health Board surge plans. • Health Board SLA with WAST • System Leadership and Response – whole system planning – meets x2 weekly. • Cross-site meetings to discuss system and flow pressures meets x4 daily. • Emergency Care Improvement Board – meets monthly • Urgent Care Transformation Board	**Inherent** *Risk level before any controls/mitigations implemented, in its initial state.* / **Current** *Risk level after initial controls/mitigations have been implemented.* / **Target** *Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	

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

Trend since last reporting period		Executive Owner: Director of Operations

Mapping Against 4 Harms of COVID	Update
	January 2023 The Health Board continues to work alongside the Delivery Unit to maximise discharges, this includes engagement with Senior Nurses, discharge co-ordinators and relatives/family members. Continued population engagement on accessing most appropriate services, at the right place, at the right time and teams at the GUH are continuing to have sensitive conversations with family members regarding discharges. A number of Health Board initiatives are underway and regular reviews are undertaken to understand benefits and extract learning. SDEC care currently being delivered in Respiratory and Gastroenterology with the potential to increase patients being treated there if pts can be streamed from Flow Centre. Build has commenced for dedicated SDEC in GUH site that will incorporate surgery and acute medicine in Summer of 2022. The Clinical Operating Model for SDEC at GUH is being refined, workforce recruitment and on-boarding plans developed. Orders for the equipping of the facility have been progressed to capitalise on the funding that has been allocated by WG; to be committed this Financial Year. Outcome of System Re-set weekend – significant system benefits were seen over the weekend and this was down to a number of factors. The outcome of the weekend currently in the process of being typed up and to be shared with the Exec team about what we should prioritise for WF supply and embed in our system over winter and beyond. In particular initiatives that work included (but is not exhaustive): 7 day cover for pharmacy and therapies - Input of home first on the weekend - Growing team of Physicians Associates to support discharge - Focus on discharge not step down GUH Frailty model Escalation plan agreed at Executive Team December 2021. Continues to embed and implement – table top exercise planned for Spring 2022. Holly Ward – step closer to home facility enabled w/c 24th Jan 2022. It is important to note that this risk profile should be reviewed and considered in conjunction with **CRR002 (Workforce)** and cross reference to **CRR013 (IPAC)** Resource/staffing capacity has been significantly impacted particularly at ED and MAU due to infection outbreaks and ward closures.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22	Risk Description, Appetite and Decision

Priority 1 – Every child has the best start in life Priority 2- Getting it right for children and young adults		CRR028 – (June-2021) *Risk of: -* Continued inappropriate admissions of children aged under 18 to acute adult mental health wards. Particularly where admissions are of under 16-year-olds, are for longer than 72 hours and/or are not compulsory detentions under the Mental Health Act. *Due to:* Inability to access appropriate acute/crisis beds for this age group in the region	
		TREAT	

High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Staff Well Being	**Risk Appetite**	**Moderate (cautious risk taking) Risk Appetite Level 3**

Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**		
Patient Quality, Safety and Outcomes Committee	• Policy in place for the use of adult MH beds for up to 72 hours. • Designated bed in Extra Care Area • C&YP aged under 16 are nursed 1:1 and are prevented from mixing with other patients on the ward. • If YP is detained under the Mental Health Act, the safeguards inherent with this legislation apply.	**Inherent** *Risk level before any controls/mitigations implemented, in its initial state.*	**Current** *Risk level after initial controls/mitigations have been implemented.*	**Target** *Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*

Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	4	5	2	5
CAMHS is working with partners to develop Crisis support for C&YP which will include crisis beds.	Ongoing	**20**		**20**		**10**	

Trend	⬄	**Executive Owner: Director of Operations**
Mapping Against 4 Harms of COVID		**Update**

| Harm from COVID itself | Harm from overwhelmed NHS and social care system |
| Harm from reduction in non-COVID activity | Harm from wider societal actions/lockdown |

It should be acknowledged that this risk is part of a broader National risk in relation to children who present to acute services in crisis. The Health Board continues to work with Welsh Government on a National level to develop plans to mitigate this risk.

Although it is acknowledged that this is an issue for the Health Board as it has already been realised, it remains a continuing risk not only to the Health Board but across Wales and as a result CAMHS has over the last few years created and extended their liaison response and crisis outreach response which is evidenced to have reduced self-harm and suicide and diverted children, young people from hospital with a reduction in bed use in spite of the increase in crisis presentation. CAMHS is also looking at further enhancements building on weekend cover, particularly boosting the out of hours cover and ongoing work with key stakeholders:

- At a meeting with Gwent Local Authority Heads of Children's Service on Monday 06 September 2021, we agreed to develop a guide document in relation to the support of Children's Crisis Admission (these are children classed as a delayed discharge from hospital on social grounds).
- As part of the agreement, CAMHS and the 5 Gwent Local Authority Heads of Children's Service agreed to a shared responsibility for keeping the child/young person safe in hospital (previously this had been the sole responsibility of ABUHB/CAMHS).
- CAMHS and the 5 Gwent Local Authority Heads of Children's Service also agreed to explore a medium to long term plan of providing psychosocial support to children and young people in the community as an alternative to hospital admission.
- CAMHS received an investment of £500k non-recurring in 2021 towards management of crisis admissions that will be utilised in partnership with ABUHB colleagues and Gwent Local Authority Heads of Children's Service, to meet crisis bed requirements.
- The convening of a pathway group between ED and CAMH's to ensure there is an agreed protocol and escalation should these patients present

Further developments are underway currently working with Works Estates to establish a CAMHS Crisis Rapid Assessment Centre and Intervention at the St Woolos site. The site will aim to provide:

• A safe space for young people struggling with emotional distress to be able to access skilled support on an ad hoc basis, as opposed to attending ED
• The Centre will aim to reduce hospital admissions and emergency presentations by providing practical, therapeutic interventions.
• Young people who have been assessed by CAMHS emergency liaison team and who are awaiting discharge can attend the centre to wait safely and securely for transport.

- We have advised Welsh Government that, we're planning on establishing a CAMHS Crisis Hub / Discharge lounge (described as a Sanctuary Provision for children and young people Crisis to align with WG policy strategy).

	• The proposal (first of its kind in Wales to mitigate the indicated risk) was received favourably by WG and will be forwarded to Government Co-operation Unit for their consideration/approval.
	• As part of efforts to secure funding for our CAMHS Crisis Hub, we have also registered a proposal with the Gwent RPB (that has a regional allocation of £11.2m annually over the next 3 years to support Gwent Housing with Integrated Care programme). We're looking for £950k to establish a Crisis Hub on the St Cadocs site and have put forward a bid for the current 2022/23 Capital funding stream.
	• We have been working with Welsh Government (WG) colleagues and Housing with Care Fund (HCF) programme through the Gwent Regional Partnership Board for the creation of a discharge lounge/safe space to assess then reduce the need for CYP to remain in the Emergency Department for a prolonged period.
	• We are now in receipt of Capital funding confirmation, with a total project cost of £1,925,000 (£950,000 WG direct funding and £975,000 through the HCF programme £950k + £975k = £1,925,000).
	• The timeline for delivery of the scheme as discussed with Works and Estates colleagues is Quarter 4 of 2023/24.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22	Risk Description, Appetite and Decision

Enabling priority			CRR040		
			Risk of: Lack of public confidence, reputational and financial damage/impact. **Due to:** Continued and sustained non-compliance with The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 **TREAT**		
High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Staff Well Being	**Risk Appetite**		**Moderate (cautious risk taking) Risk Appetite Level 3**	
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**			
Patient Quality, Safety and Outcomes Committee	• 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	**Inherent** *Risk level before any controls/mitigations implemented, in its initial state.*	**Current** *Risk level after initial controls/mitigations have been implemented.*	**Target** *Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	

Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*		**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
			4	4	3	4	3	3
• Revision and ratification of current policies • Validation and Completion of SOPS - Overview of PTR Formal Complaints Standard operating Procedure and Formal concerns process and concerns Divisional approval process • Work with divisions to ensure optimal utilisation of RL datix system to monitor risk and capture compliance data		April 2023 April 2023 Ongoing February 2023 Ongoing Ongoing	**16**		**12**		**9**	

• Recruitment and training to all PTR team positions in order to ensure that the Corporate function is effectively supporting the organisation. • PTR senior team and ADN to work with Divisional Triumvirate, QPS leads and Complaints Coordinators to revisit process and expectations. • to consistency across processes Continuing PSOW delivered training • IO training face to face recommenced • EDON checking standard of complaint responses • Meet with all Divisional nurses about expectations	February 2023 Ongoing			

Trend		NEW RISK	Executive Owner: Director of Nursing
Mapping Against 4 Harms of COVID			Update
			January 2023

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22	Risk Description, Appetite and Decision

Priority 1 – Every child has the best start in life Priority 2- Getting it right for children and young adults			CRR044 *Risk of: -* Non-compliance with a key component of the new vision (2022-2027) for children's services is the Programme for Government commitment to remove private profit from the care of looked after children *Due to:* Unregulated placements are used for children and young people who present with significant risk and need bespoke care packages when spaces are not available in registered accommodations. **TREAT**			

High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Staff Well Being • Partnerships	Risk Appetite		**Low** **Risk Appetite** **Level 1**		

Committee Assurance	Internal Controls – Policies/Procedures	Risk Score					
Patient Quality, Safety and Outcomes Committee	• Governance and contract monitoring arrangements well established •	**Inherent** *Risk level before any controls/mitigations implemented, in its initial state.*		**Current** *Risk level after initial controls/mitigations have been implemented.*		**Target** *Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	

Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	Due Date	Likelihood	Consequence	Likelihood	Consequence	Likelihood	Consequence
		5	5	4	5	2	5
To be determined following review by Executive Team		**25**		**20**		**10**	

Trend		NEW RISK	Executive Owner: Director of Operations				
Mapping Against 4 Harms of COVID			Update				

January 2023
NEW RISK

**Patient Quality, Safety
and Outcomes Committee**

**Health Inspectorate Wales
Inspections – Quarterly Update**

February 2023

Overview

To provide the Patient Quality, Safety & Outcomes Committee with progress on : -

- Inspections undertaken since October 2022
- Improvement plans with outstanding actions
- Maindiff Court CMHT Report (embargoed)
- Llanyravon Surgery Report

ABUHB Inspections undertaken since October 2022

Maindiff Court Community Mental Health Team

15-16 November 2022

Immediate assurances: None

Embargoed Report
Publication Date: 16 February 2023

Existing Improvement Plans with Outstanding Actions

Division	In-Date	Out-of-Date	Total
Mental Health & LD			
Maindiff Court CMHT	9	0	**9**
Twyn Glas	0	1	**1**
Ty Cyfannol & Annwylfan Wards	3	14	**17**
National Review of Mental Health Crisis Prevention in the Community	0	3	**3**
Urgent Care			
Emergency Department – GUH (1-3/11/21)	0	5	**5**
Emergency Department - GUH (1-3/08/22)	2	5	**7**
Family & Therapies			
Review of Healthcare Services for Young People	0	1	**1**

Mental Health & LD Division

Hospital/ Ward/ Area	Date of Inspection	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	No. of immediate actions identified by ABUHB	No. of actions outstanding	No of recommendations identified in Improvement Plan	No. of actions identified by ABUHB	Total No. of actions outstanding
Maindiff Court CMHT	15-16/11/22	N/A	N/A	N/A	N/A	13	22	**9**

Outstanding Actions		
The health board / local authority should reflect on duty desk arrangements and workload and take action where appropriate.	Directorate to review duty desk arrangements across all teams.	March 2023
	Discuss with professional leads within the team.	February 2023
The health board / local authority must continue to engage proactively with general practice where issues are identified and the health board is encouraged to support the service with this as needed.	Identify a lead practitioner to attend NCN meeting regularly.	February 2023
The health board / local authority must provide HIW with an update on the progress and planned implementation of the ADHD / ASD pathway.	Neurodivergence pathway is a priority for the Division (Health Board). It is anticipated that further funding will be available from WG in the new financial year to better resource the existing diagnostic and treatment clinics.	April 2023
The health board / local authority must consider how one-to-one psychology waiting times can be reduced to ensure that service users receive the most appropriate level of intervention.	Team lead and Principal Psychologist to meet and review waiting list quarterly.	March 2023
The health board / local authority must ensure that their lone working arrangements are robust and are sustained.	Health and Safety team are reviewing lone working arrangements at Maindiff Court.	January 2023
	Directorate has authorised works and estates planning for CCTV and better lighting within the vicinity of Rholben Villa (Team Base).	March 2023
The health board / local authority should provide an update to HIW on the progress and outcome of the capital / infrastructure bids.	Confirmed costs from the ICT department have now been received and sent to the Health Board's Capital Team to request urgent funding to complete this.	Funding will be released over next 2 years
The health board and local authority must further explore and embed joint working arrangements.	Monthly leads meeting between health and social service leads re-established.	February 2023

Mental Health & LD Division

Hospital/ Ward/ Area	Date of Inspection	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	No. of immediate actions identified by ABUHB	No. of actions outstanding	No of recommendations identified in Improvement Plan	No. of actions identified by ABUHB	Total No. of actions outstanding
Twyn Glas	20/04/21	N/A	N/A	N/A	N/A	2	2	1

Outstanding Actions			
The health board should ensure all items on the environmental audit are given suitable timescales and actioned appropriately.	The LD Directorate will review the environmental audit and ensure that all items on the audit are given suitable timescales and actioned appropriately.	End June 2021	Arjo confirmed baths will be delivered and installed February 2023.

Mental Health & LD Division

Hospital/ Ward/ Area	Date of Inspection	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	No. of immediate actions identified by ABUHB	No. of actions outstanding	No of recommendations identified in Improvement Plan	No. of actions identified by ABUHB	Total No. of actions outstanding
Ty Cyfannol & Annwylfan Wards	5-7/09/22	✓	3	7	3	44	78	**17**
Outstanding Actions								
The garden area of Ty Cyfannol should be cleaned, and individuals encouraged to maintain the area.		Raised with Facilities Division. Meeting convened for w/c 14.11.2022 to clarify outdoor cleaning schedules for all MH & LD wards.			December 2022		Meeting to be rescheduled for January	
The health board needs to provide a wider range of therapeutic and physical activities for patients on Ty Cyfannol, including activities outside of weekday working hours and opportunities to exercise. This issue was also a previous recommendation during our previous inspection of the ward in 2017.		The lead for OT is arranging 'Music and Hospitals' to attend the ward regularly.			November 2022		Attended 2 wards prior to Xmas. Funding not available for regular sessions. Head OT continuing to pursue this	
		Continue to bid for OT Technicians to work out of hours and weekends on the Ward to support activities outside of core hours.			Ongoing		Ongoing	
The health board needs to consider gender segregation on the wards by ensuring that proper safeguards are put in place, and that care plans and risk assessments are completed accordingly.		Standards for mixed occupancy wards to be discussed and agreed at Divisional QPS meeting.			November 2022		Taken forward to next QPS meeting in January 2023	
The health board should ensure that relevant policies are reviewed and kept up to date prior to their expiration date. This includes the Equality and Diversity Policy which expired in November 2021.		Policy is currently being updated.			March 2023		Ongoing	
The health board should implement a process for gathering and obtaining feedback from patients, carers and families on Annwylfan.		Schedule and plan for obtaining feedback to be discussed at the next Directorate QPS meeting.			December 2022		December meeting was cancelled. On agenda for March 2023	
The health board must review the policy for the Assessment and Management of Environmental Ligature Risks within the Mental Health and Learning Disabilities Division. The review date expired on 31 January 2020.		This policy is complete and awaiting ratification by the MH/LD Division's QPS meeting before being ratified by the Health Board.			December 2022		Awaiting procedure for use, maintenance & storage of ligature cutters. To be agreed at QPS meeting of January 2023.	

Mental Health & LD Division

The health board must remove or repair the Ty Cyfannol garden shelter which presents as a ligature risk, and include it in the ligature audit process.	Costings have been requested from the Health Board's Minor Works Department to replace the shelter – monies have been released via Capital funding to purchase. Awaiting costings.	March 2023	Ongoing Awaiting costings & works order
We recommend a more secure and appropriate container is arranged for the ligature cutters inside the patient property cupboard on Ty Cyfannol.	Siting of ligature cutters to be included in Assessment and Management of Environmental Ligature Risks within the Mental Health and Learning Disabilities Division.	December 2022	See above – aiming to be complete by Jan 2023
The health board must ensure that all patient call bells can be reached by patients from their beds on Annwylfan.	Bed positioning in relation to bells to be reviewed in each bedroom.	December 2022	Awaiting update
The health board should ensure that relevant policies are reviewed and kept up to date prior to their expiration date, including the Use of Restrictive Physical Intervention Policy which expired on 26 September 2019.	This policy will be reviewed by the end of December 2022.	December 2022	Revised draft policy to be presented to H&S Committee in February 2023
	An interim guidance pertinent to Mental Health has been developed to be considered as an appendix for the Health Board's policy. To be considered at MH/LD Division's policy group of 17.11.2022 & QPSE meeting of 24.11.2022.	November 2022	Timescales have shifted – to be discussed at next policy group Ongoing
The health board must draft a structured policy regarding use of the ECA on both wards. We further recommend improvement in the documentation and daily records entries for patients who spend time in the ECAs so that a clear picture of their time spent on the ECA can be established.	Seclusion & Segregation policy currently being drafted.	December 2022	Still being developed
	ECA guidelines to be included as appendices, to include required documentation to record ECA stays.	December 2022	Ongoing
The health board should improve the structure of the Annwylfan ward round summary to ensure that details of every person present are captured for every ward round.	Summary sheet to be developed by newly formed Annwylfan ward Development Group.	December 2022	Ongoing Delayed due to sickness
Photographs of detained patients undertaking Section 17 Leave should be kept on record.	This is not currently Health Board policy. This will be discussed at the MH/LD Division's QPS meeting for decision.	November 2022	Moved to January QPS Meeting
The health board should take steps to improve the completion of patient care notes on Ty Cyfannol.	Division to consider standards for clinical recording and training that might be required at Divisional QPS meeting.	November 2022	Moved to January QPS Meeting

Mental Health & LD Division

Hospital/ Ward/ Area	Date of Inspection	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	No. of immediate actions identified by ABUHB	No. of actions outstanding	No of recommendations identified in Improvement Plan	No. of actions identified by ABUHB	Total No. of actions outstanding
National Review of Mental Health Crisis Prevention in the Community	Report received 09/03/22	N/A	N/A	N/A	N/A	19	26	**3**

Outstanding Actions			
Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.	Mental Health & Learning Disability (MH & LD) Division will ensure that anyone who has been assessed by or is open to the in-patient unit, Community Mental Health Team (CMHT), Crisis Resolution Home Treatment Team (CRHTT) or Crisis Liaison Team (CLT) will be given deterioration advice and have a crisis plan. This may be part of a Community Treatment Plan or a 'crisis card' or similar if not open to services.	October 2022	Ongoing – linked to re-introduction of safety plans to be discussed on 27.1.23 with AMH Directorate.
Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	MH & LD Division will work with Primary Care & Community (PC&C) Division to develop a process to ensure that people access assessment and monitoring pertinent to their needs. Inpatient wards will also review audit findings of physical health screenings upon admission.	September 2022	Ongoing - Need to identify the correct forum for these discussions to progress, but also link with the review of the MH & LD physical health policy.
Health boards and GP services must ensure that there are clear and robust follow up processes in place to ensure timely and appropriate follow up for people who have received crisis intervention, and are not subsequently admitted in to hospital.	People who access the MH service in crisis will be clear about what follow up is planned for them (if any) by whom, and how to seek further support if required. The Gwent Mental Health Delivery Group meeting will progress this agenda.	September 2022	Ongoing - the Division is involved with some national work with the DU about safety planning for people who have been involved in crisis services. Pilot to commence on 20.2.23 for 3 months.

Urgent Care Division

Hospital/ Ward/ Area	Date of Inspection	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	No. of immediate actions identified by ABUHB	No. of actions outstanding	No of recommendations identified in Improvement Plan	No. of actions identified by ABUHB	Total No. of actions outstanding
Emergency Department, GUH	1-3/11/21	✓	12	23	0	58	87	**5**
Outstanding Actions								
Introduce an electronic waiting time board	The ED is working towards an automated display of live waiting times for triage and wait to be seen by a clinician in keeping with accepted good practice as recommended by the Royal College of Emergency Medicine.		November 2022		Being progressed with recent allocation of WG funding - completion March 2023.			
Ensure a system wide solution to poor flow and overcrowding at the ED waiting rooms.	There is continued work across the Health Board to improve the flow of patients through the ED and assessment units, via the Urgent Care Transformation Programme.		October 2022		Ongoing			
Further arrangements are put in place to ensure that all patients are made to feel that they can access the right healthcare at the right time.	Right Place Right Time is part of the ongoing transformation work led by Director of Operations and Director of Primary Care & Community, through 6 Goals workstream.		October 2022		Ongoing education and information for the public to access the right service first time.			
The Health Board is to inform HIW of the actions it has taken to address the recommendation made in the HIW Review relating to improving patient flow.	The Health Board will provide HIW with an update on flow improvements.		November 2022		The Health Board continues to implement a number of initiatives to improve flow across the wider system during unprecedented pressures across the whole Healthcare system.			
Clinical supervision is completed annually.	The Health Board is currently reviewing a new model for Clinical Supervision.		October 2022		Ongoing piece of work across Health Board.			

Urgent Care Division

Hospital/ Ward/ Area	Date of Inspection	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	No. of immediate actions identified by ABUHB	No. of actions outstanding	No of recommendations identified in Improvement Plan	No. of actions identified by ABUHB	Total No. of actions outstanding
Emergency Department, GUH	1-3/08/22	✓	3	26	0	20	75	**7**
Outstanding Actions								

The health board must ensure that waiting times are displayed in a prominent position within the waiting area	The ED is working towards a safe system to provide live waiting times for triage and wait to be seen by a clinician in keeping with accepted good practice as recommended by the Royal College of Emergency Medicine.	November 2022	Being progressed with recent allocation of WG funding – Completion March 2023
The health board must ensure that the microphone in the reception desk is working correctly at all times.	The department is currently scoping alternative solutions to the current microphone system to improve communication between patients and staff.	December 2022	Being progressed with recent allocation of WG funding – Completion March 2023
The health board is to provide details to HIW with the continuing actions taking place to manage the overcrowding in the waiting room and the RAU that are not conducive to providing safe and dignified care.	3 to 5 moves per hour will be provided by the Operations Team to both ED and the Assessment Units (AMU and SAU). These decisions will be monitored and recorded at every site meeting.	~~December 2022~~ January 2023	Ongoing
	If the above plans do not materialise the ED NIC will advise the Clinical Site Manager so that a revised plan can be established and implemented.	December 2022	Ongoing
The health board must ensure that there is an area available to facilitate red release calls at all times.	3 to 5 moves per hour will be provided by the Operations Team to both ED and the Assessment Units (AMU and SAU). These decisions will be monitored and recorded at every site meeting.	~~November 2022~~ January 2023	Ongoing
The health board must ensure that the information on how they have learned and improved on feedback received is prominently displayed within the department on a 'You said, We did' board or similar.	You said, we did system to be introduced wider across the ED.	December 2022	Utilised for the commissioning of the Screening & Testing Unit and being progressed wider across the unit
The health board must ensure that action is taken to improve compliance with staff appraisals.	Improvement plan in place for annual appraisals.	December 2022	Ongoing

Family & Therapies Division

Hospital/ Ward/ Area	Date of Inspection	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	No. of immediate actions identified by ABUHB	No. of actions outstanding	No of recommendations identified in Improvement Plan	No. of actions identified by ABUHB	Total No. of actions outstanding
Review of Healthcare Services for Young People	Report issued 11/09/20					37	69	**1**
Outstanding Actions								
Health boards and service providers must ensure environments protect the safety and wellbeing of young people. There must be robust systems in place to monitor risks within the environment and ensure maintenance work is conducted in a timely way.	A quiet/breakout room for young people to be furnished with input from younger people.	June 2022				**Update January 2023** Early February, the Senior Nurse and team to pull the plan together and one of the COT/ELT staff are liaising directly with the ward, once Divisional Nurse has cleared it, following a meeting. We are also refurbishing a ward in St Cadoc's (Bettws Ward) specifically for those young people who present at GUH in crisis but are not admitted. This action has taken longer than expected as there has been a focus on Windmill Farm a Provision for C&YP to stay to overt admission to an acute ward. **Update September 2022** Unit was used for another function during Covid-19; however funding has been secured and approved. Plans extended to December 2022.		

Independent Contractors

- **Llanyravon Surgery – 4 October 2022**
Immediate assurances: 11
Overarching Improvement Plan Recommendations: 28

- **Nant Dowlais Health Centre – 5 October 2022**
Immediate assurances: 2
Overarching Improvement Plan Recommendations: not yet received

- **Lawn Medical Practice – 8 November 2022**
Immediate assurances: 24
Overarching Improvement Plan Recommendations: not yet received

Division	In-Date	Out-of-Date	Total
Lawn Medical Practice	Awaiting update from Practice Manager		
Llanyravon Surgery	Awaiting update from Practice Manager		
Nant Dowlais	Awaiting update from Practice Manager		

Independent Contractors

Issue	Cause	Remedial Action	Who	When
GMS are independent contractors, therefore, the Primary & Community Care Division (PCC) does not formally endorse the HIW response.	Independent contractors (GMS,GDS, CPS and GOS) complete the response independently of the Health Board. The Primary & Community Care Division does not approve the HIW report prior to its submission.	• Primary & Community Care provide support where required. • PCC to review HIW management flow chart for independent contractors. • PCC to consider the actions identified and where appropriate the division would provide support and advice or seek assurance where there is a contractual clinical/professional concern.	Primary Care & Community Division	March 2023
		• Meeting to be arranged with clinical executives to discuss the HIW management of Independent Contractors.	Assistant Director of Nursing	March 2023

Questions

OPERATION JASMINE / CORONER INQUESTS

Actions for Improvement

ACTION	RESPONSIBLE	STATUS	START	END	NOTES	UPDATE – JANUARY 2023
Action #1:						
"Lets not forget" – a schedule of awareness raising sessions	Linda Alexander Linda Jones	started	12/2021	12/2022	• Programme over the next 12 months. • Featured in CNT newsletter December 2021. • Awareness sessions via a 'Digital Story' will be completed by end of May 2022, plan in place to ensure awareness sessions, utilising the Digital Story, are embedded within all nursing programmes to include the N&M Academy.	Digital story completed. This has been the focus of a half day workshop detailing Operation Jasmine / Flynn report for 2 cohorts of the new nursing and midwifery leadership academy. The digital story is due to be reviewed and shared with partner Universities for awareness raising in undergraduate nurse training. **Complete**

ACTION	RESPONSIBLE	STATUS	START	END	NOTES	UPDATE – JANUARY 2023
Action #2:						
A standardised Quality Assurance Framework for commissioned work	Michelle Forkings Veronique Hughes Helen Morgan Nadine Morgan	started		06/2022	• Draft Framework will be completed by mid-June 2022.	Meeting arranged with key individuals to take this work forward. F&T, MH/LD & Complex Care working on governance and assurance plan.

ACTION	RESPONSIBLE	STATUS	START	END	NOTES	UPDATE – JANUARY 2023

Update – January 2023

Action #3:						
A review of the Margaret Flynn Action Plan to assess progress	Tracey Partridge-Wilson Howard Stanley	started		06/2022	• Draft assessment plan developed.	ABUHB Flynn Review - DRAFT ... **Complete** Complex Care provide assurance reports in relation to pressure ulcers and governance. Corporate safeguarding processes and training contain specific reference to Pressure ulcers as neglect.

ACTION	RESPONSIBLE	STATUS	START	END	NOTES	UPDATE – JANUARY 2023
Action #4:						
A review for the process of professional reflection	Linda Jones Lyn Middleton	Complete		01/2022	• Reflection template launched at Senior Leadership meeting in December 2021. • Featured in Corporate Nursing Newsletter. • REFLECT is promoted as the tool of choice for the N&M leadership Academy. • Clear evidence noted of being utilised in clinical practise. • Tool also shared cross–professionally.	**Complete**

ACTION	RESPONSIBLE	STATUS	START	END	NOTES	UPDATE – JANUARY 2023
Action #5:						

Update – January 2023

ACTION	RESPONSIBLE	STATUS	START	END	NOTES	UPDATE – JANUARY 2023
A strengthening of the patient and family voice with meaningful patient experience gathering	Tanya Strange	started		09/2022	• Numerous CHC buddying programmes in place since September 2020. • Dementia webinar being held for people living with, or caring for, people with dementia in May. Objective is to secure an 'Expert by Experience' reference group. • 4 ABUHB members of staff have undertaken Community Engagement training which will enable community engagement across the boroughs and for dedicated groups such as carers. • Civica business case finalised with monies secured to procure the system.	CIVICA going Live in February 2023. Expert by Experience group established. Will need to be expanded over the coming year. 2 community listening events taking place in March/April 2023 in line with the National Dementia Action Plan. Aim is to encourage members of the public to become community dementia champions.

ACTION	RESPONSIBLE	STATUS	START	END	NOTES	UPDATE – JANUARY 2023
Action #6:						
Education programmes – sessions on accountability, record keeping standards, raising concerns, reflective practice.	Linda Alexander Linda Jones	started	12/2021	12/2022	Programme over the next 12 months: • Current educational opportunities reviewed, and assurance sought in regards inclusion of sessions on accountability, record keeping, raising concerns and reflective practice. • NMC videos now utilised within JOE and preceptorship programmes which includes – short, snappy reinforcements. • Sessions incorporated into the OSN's well-being, educational and support cafés. • Reflective practice covered within the template.	Programme ongoing **Complete**

Update – January 2023

ACTION	RESPONSIBLE	STATUS	START	END	NOTES	UPDATE – JANUARY 2023
Action #7:						
Review of DECI/HACI processes across all areas	Linda Alexander Linda Jones	started		12/2021	• HACi reviewed by EDoN –to be rolled out across all areas. • Task and Finish group established to progress roll out across Health Board. • Necessary amendments being made to audit. • IT capabilities being explored to improve compliance and tracking of metrics. • SOP under development • Workshop held to establish a framework for audit.	A governance structure for audit has been identified from the workshop. Refinement of the HACi tool is ongoing. With the advent of new ideas / workstreams potentially will supersede the HACi this includes - all Wales workstreams developing core care audits and ward accreditation schemes

ACTION	RESPONSIBLE	STATUS	START	END	NOTES	UPDATE – JANUARY 2023
Action #8:						
Consider safety tools (10 steps for safety) to heighten awareness and positioning of QPS	Tracey Partridge-Wilson/ Leeanne Lewis	started		02/2022	• Quality management system - Meeting with clinical execs 24th May 2022.	Meeting with Clinical Execs held in Dec 2022. Quality Strategy underway. Defining Pillars of Quality. Duty of Quality- Quality Management System. Duty of Candour will focus on severity of harm. Performance report to incorporate PU data. Focused review on Datix module to include learning. Complex care provide performance reports.

Update – January 2023

						☐Weekly report re providers ☐Monthly locality dashboards ☐Monthly pressure ulcer report ☐Escalating Concerns ☐Safeguarding

ACTION	RESPONSIBLE	STATUS	START	END	NOTES	UPDATE – JANUARY 2023
Action #9:						
Consider an approach of inter-Divisional reviews	Deb Jackson Penny Gordon	Not started		12/2021	[Potential to feed into #8 and #1] • There is good work already ongoing in relation to mortality reviews and patient transfers, which promotes inter-divisional reviews, need to learn from this. • Need to progress a meeting with the QPS leads; Karen Hatch, Alex Scott and Tracey Partridge-Wilson to discuss the concept more widely and identify areas where this approach could be used.	The mortality review process was seen as an example of good practice and in ensuring multi professional/ multi divisional representation. Some cases from mortality have been shared at DMT/QPS etc

Update – January 2023

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	07 February 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Medicines Management Internal Audit Report Update on Actions
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Calvert – Executive Medical Director
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

A Medicines Management review was undertaken as part of the Internal Audit plan for 2021/22. This review was specifically focused on controlled drugs with the following audit objectives:

- Governance for the management of controlled drugs.
- Adherence to the Health Board's controlled drugs policy.

This report provides an update on the agreed management actions. The committee is asked to note the findings of the internal audit review together with the progress made.

Cefndir / Background

The Health Board has a policy for the Management of Controlled Drugs which establishes the standards of practice for all Health Board staff on the procedures relating to the safe and secure handling of controlled drugs.

Internal Audit undertook testing across a range of wards and departments in Grange University Hospital, Royal Gwent Hospital, Nevill Hall Hospital, Ysbyty Ystrad Fawr and Ysbyty Aneurin Bevan. In addition, the review examined the requirement for Pharmacy to undertake six monthly audits of controlled drug balances.

The Final Audit Report and the management response is attached in appendix 1.

Asesiad / Assessment

The original scope of the review was to determine any risks to the Health Board with respect to; policies regarding controlled drugs, controls in place to identify/prevent controlled drugs missing/theft and to review the oversight of incidents relating to controlled drugs.

Overall, the review received a classification of 'reasonable' assurance for both the governance of controlled drugs and the application of the controlled drugs policy.

It is important to note that compliance was demonstrated for reconciliation of stock balances of controlled drugs across all the 23 areas tested with no discrepancies identified.

In terms of governance for the management of controlled drugs, this focused on the work of the Gwent Controlled Drugs Local Intelligence Network. Recommendations were provided regarding the need to update the terms of reference of the group, which have since been actioned.

The second audit objective focused on adherence to the Health Board's controlled drugs policy.

Areas identified during the review requiring further management action include:

- ward stock checks not being undertaken on a weekly basis in all areas (74% compliance for ward testing and 100% compliance for theatre testing).
- Pharmacy not achieving compliance with the six monthly stock checks (79% compliance for ward testing and 0% for theatre testing).
- Policy for the Management of Controlled Drugs requiring updating.

A summary of the management action plan is provided in table 1.   There are two outstanding actions, both of which are still within the timescales agreed for management action.   Details of these recommendations and plans for the completion of the remaining actions are provided.

Asesiad / Assessment

Table 1.

Recommendation	Management Response	Due	Priority
R1 Management should review the terms of reference (ToR) for the Gwent Controlled Drugs Local Intelligence Network, including its quoracy requirements. Meetings that are not quorate should either be deferred or recognised at the start of the meeting ensuring those in the meeting understand the implications of this. The requirement to complete minutes and action logs after each meeting should also be added to the ToR.	The terms of reference of the Gwent CDLIN were reviewed and updated as requested at the next possible CDLIN on 1stAugust 2022. 1. The TOR was updated to remove need for Police representation at each meeting. 2.To recognise any non-compliance with quoracy requirements at the start of any meeting. The implications of this to be noted in the minutes. 3.To add the requirement to complete minutes and action logs after each meeting will be added to the TOR (minutes and actions have been in place for every meeting since JC took over as CD-Lin in Jan 2021).	Complete	Low

R2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy. Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version. The use of red pen on the wards is to make stock checks more visible. The practicality of this will be reviewed. Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock. The policy will also include a description of the audit framework that will provide assurance the policy is being followed.	31/3/23	Medium	
Update The policy is currently being reviewed and will be completed by the end of March in line with the agreed management response.				
R2.2 Once the Policy for the Management of Controlled Drugs is updated, the Health Board should undertake periodic reviews to ensure wards are adhering to the updated Policy and confirm the areas of non-compliance identified as part	The standard operating procedure for pharmacy 6 month stock check on the wards is being updated by a Principal Pharmacy Technician. This will include updating the way reconciliation checks confirmation are documented to ensure compliance. The policy can include the need for periodic audits to review use of the policy and confirm areas of non compliance have been rectified.	31/3/23	Medium	

of this review have been rectified.			

Update

As per recommendation R4, a review has been completed to ensure consistency of the Pharmacy process for undertaking stock checks of controlled drugs across all hospital sites. The updated policy will include reference to this standard operating procedure together with the requirement for compliance testing against the revised policy.

R3. Management should continue as planned to add the Omnicell user guides to Sharepoint and direct staff to this learning material. The guides should be useful to the front end user and also to Ward Managers regarding the reporting capabilities within an Omnicell machine.	There are user guides for both end and superusers provided by Omnicell. The Principal Pharmacy technician at RGH has developed basic user guides for the wards which detail the common functions with picture guides. These are available on the wards, but staff cannot always find them. The plan is to add them to SharePoint and signpost staff to them. Short training videos are also to be developed which will be uploaded to YouTube. QR codes will be placed on the side or front of the cabinet and linked to the videos which will show staff how to maximise the Omnicells functionalities.	Complete	Medium

Update

User guides have been developed and are now available on the AB Pulse SharePoint page Omnicell (sharepoint.com). Unfortunately, Omnicell have not provided any training videos. Whilst this proposal was an additional management action it cannot be progressed at this stage. Should such videos become available at a later date then this will be reconsidered.

R4 The Pharmacy Team should comply with the relevant Health Board policies and SOPs for controlled drugs, in particular the removal of expired	A full review will be conducted into the Pharmacy processes relating to 6-monthly CD stock reconciliations to determine the extent of the issue and to provide assurance of compliance. The Pharmacy Team will input into the Management of Controlled Drugs Policy, with the potential to visit the mechanism of how expired drugs are	Complete	Medium

controlled drugs and the completion of six-monthly stock reconciliations (which should all be completed in a consistent manner). Where compliance with the policy cannot be achieved, for example due to resourcing, an agreed temporary deviation from the

Policy should be agreed and approved at an appropriate Group | reported to Pharmacy, to ensure a more robust system with auditable records is available in the future | | |

Update
A review has been completed to ensure consistency in the Pharmacy checking process across all hospital sites. A QR code has been developed which is available for wards to use to notify Pharmacy of expired stock.

Argymhelliad / Recommendation

The Patient Quality, Safety and Outcomes Committee is asked to note the findings of the Medicines Management Internal Audit report, which provides 'reasonable' assurance for the management, administration and storage of controlled drugs within the Health Board.

The committee is asked to note the actions that have been taken to address the recommendations. All actions will be completed once the policy for the Management of Controlled Drugs has been reviewed. This is due to be concluded by the end of March 2023.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.6 Medicines Management 3.5 Record Keeping 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. Choose an item. Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. 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:	Not applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	To be tabled at Executive Team for information following PQSOC.

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.

Medicines Management

Final Internal Audit Report

June 2022

Aneurin Bevan University Health Board

Contents

Review reference:	AB-2122-14
Report status:	Final
Fieldwork commencement:	20th April 2022
Fieldwork completion:	18th May 2022
Draft report issued:	20th May 2022
Debrief meeting:	5th May 2022
Management response received:	31st May 2022
Final report issued:	6th June 2022
Auditors:	Simon Cookson, Acting Head of Internal Audit
	Stephen Chaney, Deputy Head of Internal Audit
	Laura Howells, Principal Auditor
	Rhian Gard, Principal Auditor
Executive sign-off:	James Calvert, Medical Director
Distribution:	Rhiannon Jones, Director of Nursing
	Jonathan Simms, Clinical Director of Pharmacy
	Jane Thomas, Senior Primary Care Pharmacist
Committee:	Audit, Risk and Assurance Committee

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

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Finance & Risk Committee.

Audit reports are prepared by the staff of NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

The review sought to provide Aneurin Bevan University Health Board ('the Health Board') with assurance that there are adequate arrangements in place for the management, administration and storage of controlled drugs.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- ward stock takes not being completed weekly in line with policy;

- the Pharmacy Team not achieving 100% compliance with six monthly stock checks in line with policy; and

- Policy for the Management of Controlled Drugs requiring updating.

Other recommendation points are included within the detail of the report. Overall, we reconciled 109 drugs across 23 areas at five different Health Board sites, with no stock count exceptions noted. Although there are areas for improvement, we found staff undertake their responsibility for the management of controlled drugs professionally.

Report Classification

		Trend
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	Incorporated into the Divisional Audit - Unscheduled Care Wards (2016/17)
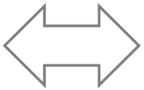
Assurance summary[1]

Assurance objectives	Assurance
1 Governance	Reasonable
2 Controlled drugs policy	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
2	Policy for the Management of Controlled Drugs update	2	Design	Medium
2	Weekly controlled drug stock takes	2	Operation	Medium

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

| 3 | Omnicell guidance | 2 | Design | Medium |
| 4 | Pharmacy stock reconciliations and expired drugs | 2 | Operation | Medium |

1. Introduction

1.1 The Medicines Management review was completed in line with the 2021/22 Internal Audit Plan. The Medicines Act 1968 was published to provide a framework for the management of drugs. In addition to this legislation, some medicines are also governed by the Misuse of Drugs Act 1971 and associated regulations such as the Misuse of Drugs Regulations 2001. Medicines that are listed in Schedules 1-5 of the Misuse of Drugs Regulations 2001 (and subsequent amendments) are known as 'controlled drugs'.

1.2 Aneurin Bevan University Health Board (the 'Health Board') has a Policy for the Management of Controlled Drugs (the 'Policy'). It establishes the standards of practice to be adopted by all Health Board staff on the procedures relating to the safe and secure handling and storage of controlled drugs.

1.3 The Chief Executive has overall responsibility for the management of medicines in the Health Board. This responsibility has been delegated to the Health Board's Medical Director.

1.4 The key risks considered in this review are:

- lack of policies and procedures that outline the arrangements and responsibilities for controlled drugs;
- ineffective controls leading to missing drugs / theft; and
- lack of oversight of incidents / issues relating to controlled drugs within the Health Board.

1.5 As part of the audit, we reviewed a range of speciality wards at multiple hospitals across the Health Board. The hospitals and corresponding wards visited include:

- Royal Gwent Hospital – Wards C7 West, C6 East, D2 West, D5 West, C4 East;
- Grange University Hospital – Wards A0, B0, CCU, ACU (B2), C3, C4, and Theatres 6, 7, 8, Recovery;
- Nevill Hall Hospital – Wards 4/3, 4/4/, 3/3, Minors;
- Ysbyty Ystrad Fawr – Wards 2/2 Bargoed, Birth Centre; and
- Ysbyty Aneurin Bevan – Wards Tyleri, Carn Y Cefn.

2. Detailed Audit Findings

Audit objective 1: Governance for the management of controlled drugs

2.1 The Gwent Controlled Drugs Local Intelligence Network (the 'Group') is responsible for sharing intelligence regarding the use and potential abuse of controlled drugs (CDs) that are purchased or ordered, prescribed, dispensed, handled and administered within the Health Board's geographical region.

2.2 We reviewed the terms of reference (ToR) of the Group. We found that it stated meetings will be held quarterly at the discretion of the Chairperson, but no less

than three times per year. However, due to the Covid-19 pandemic and a change in Medical Director, there had been a gap between January 2020 and September 2021. During this time, the Medicines Safety Officer and the Senior Primary Care Pharmacist still received Datix alerts.

2.3   Meetings have now recommenced and are quarterly.

2.4   Roles and responsibilities of the Group were noted in the ToR as well as setting out information regarding the Chair, how the membership was comprised, and what the quoracy requirements are. We reviewed meeting minutes against the requirements of the ToR.

2.5   Meetings were quorate at the January 2020 and 2022 meetings, but not at the September 2021 meeting. The ToR states a representative from the Police must be in attendance, but no representative was present at this meeting. However, an update to the meeting had been provided by the Police which was delivered by the Senior Primary Care Pharmacist. We have raised this as **matter arising 1**.

2.6   We identified from minutes that the Group maintains actions logs and this is noted as good practice. We would recommend that the requirements for both minutes and action logs be included within the ToR, when next reviewed. We have raised this within **matter arising 1.**

2.7   We analysed the aims and objectives of the Group and compared them to the agenda items in meetings to consider how they were delivering their objectives. There were examples of subjects discussed that indicated coverage of the key objectives stated in the ToR. Additionally, we noted the review and discussion of individual incidents and themes at the January 2022 Group meeting we attended. From observing this meeting and reviewing the minutes and summary tabs of Datix spreadsheets, we confirmed that the Health Board identifies themes, trends and patterns of incidents.

Conclusion:

2.8   Although there has been some non-compliance with the ToR, individual incidents and themes are discussed at the Group meetings in sufficient degree, therefore, we have provided **reasonable assurance** over this objective.

Audit objective 2: Adherence to the Health Board's controlled drugs policy

Policy

2.9   There is a Policy for the Management of Controlled Drugs (the 'Policy') in place which is available to staff via the intranet. This is in date and is not due for review until November 2023. The Policy sets out the standards of practice to be adopted by all Health Board staff on the procedures relating to the safe and secure handling and storage of controlled drugs.

2.10   Although the policy is in date, due to changes in practices since the pandemic and the opening of the new Grange University Hospital the Policy will be reviewed this financial year (2022/23). We identified some non-compliances with the Policy. At the next review date of the Policy, the Health Board should review the Policy to see if all of the content remains relevant. We have raised this as **matter arising 2**.

2.11   The results of our compliance testing with the Policy are noted below (total of 19 wards). The four Theatre areas have been dealt with in a separate table. Red grading is less than 50% compliant, amber is 51-75% compliant and green is 76-100% compliant.

2.12

Policy Reference (Wards Testing)	Sample % compliant
13.1 – controlled drugs keys held on their own	0%
12.1 – red ink used for stock reconciliation	32%
16.0 – only one register should be used at a time	89%
6.4 – appropriate stock levels are maintained	N/A – no standard stock levels kept
10.1 – the order book must be kept in a locked place	63%
14.0 – where possible patient-controlled drugs should be stored on a separate shelf	0%
14.0 – [patient] details should be recorded in the back of the controlled drugs register	68%
12.1 – Balance checks of all stock must be carried out at least once every week	74% - but all completed within one month
13.2 – Registers must be bound (not loose leaf) with sequentially numbered pages	100%
13.1 – Keys for the controlled drugs cupboard must be held on the person of the designated person in charge	100%
12.1 – Reconciliation of register balances…carried out…a minimum of every six months by pharmacy staff	79% **- matter arising 4**

2.13   Where the non-compliances are rated red above, we understand that this may be due to the practicalities of the work environment, for example a lack of space or keeping the controlled drugs key with other keys for ease of use. Overall, these non-compliances pose minimal risk, such as not marking when a stock count was completed in red ink. Therefore, we have not raised a specific finding regarding this.

2.14   We also reviewed compliance with the Policy within the Theatres service area, based at the GUH. Three theatres were selected, along with Theatre Recovery. The compliance rate for Theatres is noted below:

2.15

Policy Reference (Theatre Testing)	Sample % compliant
13.1 – controlled drugs keys held on their own	100%
12.1 – red ink used for stock reconciliation	100%
16.0 – only one register should be used at a time	100%
6.4 – appropriate stock levels are maintained	N/A – no standard stock levels kept
10.1 – the order book must be kept in a locked place	75% - not in Theatre Recovery
14.0 – where possible patient-controlled drugs should be stored on a sperate shelf	N/A
14.0 – [patient] details should be recorded in the back of the controlled drugs register	N/A
12.1 – Balance checks of all stock must be carried out at least once every week	100% - they are carried out twice daily
13.2 – Registers must be bound (not loose leaf) with sequentially numbered pages	100%
13.1 – Keys for the controlled drugs cupboard must be held on the person of the designated person in charge	100%
12.1 – Reconciliation of register balances…carried out…a minimum of every six months by pharmacy staff	0% - matter arising 4

Controlled drugs stock testing

2.16   12.1 within the Policy states that checks of all stock must be carried out at least once every week by two authorised staff and then that check documented and signed by both staff. Across all sites tested there was a compliance rate of 78% for weekly stock checks.

2.17   Across the 23 areas visited we reconciled 109 drugs throughout these areas to the Controlled Drugs Register. Our sample compliance findings are below:

2.18

Stock reconciliation testing	Sample % compliant
Controlled drugs register fully complete	100%

List of controlled drugs at front of register	100%
Two authorised staff complete register	100%
Running balance maintained for each controlled drug	100%
Entries reconcile	100%

2.19   We identified no issues when completing our sample reconciliation testing across the five sites.

Omnicell

2.20   The areas tested used either a controlled drugs cabinet (i.e., a locked cabinet that is manually opened) to store drugs or an automated medication cabinet, called an Omnicell that also contains other non-controlled drugs.

2.21   Where an Omnicell is used, authorised staff can access the controlled drugs via fingerprint technology rather than keys. Two fingerprints are required for the removal of controlled drugs (the user and a witness). The name of the controlled drug is typed into the Omnicell keypad and then the required drawer where the drug is held flashes green and unlocks. Inside the draw are compartments each holding separate drugs, the required compartment flashes green once the draw is opened.

2.22   We noted issues with some staff using the Omnicell machines on their wards. We observed some non-substantive staff, who had access to the Omnicell machine, who were unaware how to adequately use the automated system. We witnessed staff ignore the clear green flashing lights identifying where the required drug was being stored, with some staff trying to pull open locked draws and opening up multiple compartments within drawers before locating the requested drug.

2.23   We identified an Omnicell machine on one ward registering 15 discrepancies. We queried this with the Ward Manager who suggested that an update to the machine had been causing issues and a lack of time meant the discrepancies had not been investigated. An Omnicell stock discrepancy with a controlled drug (Morphine Sulphate ampoules) had been noted by the Ward Manager on the day of our testing (but prior to us arriving at site).

2.24   18 ampoules had been listed in the Omnicell machine, but only nine were available. After checking the Controlled Drugs Book (the required legal document for control drug records), it was confirmed that the figure of nine was correct and the Omnicell machine was adjusted down. No further investigation had taken place.

2.25   When on site we counted the number of ampoules available and confirmed the Controlled Drugs Book and Omnicell machine were then consistent. If used correctly, the Omnicell machine quickly directs a user to the medication inventory and potential drug diversion issues that need attention i.e. creating a clear audit trail and nullifying the need for hard-copy controlled drugs books to be used.

2.26 We requested the Ward Manager to print out a report of all the Morphine Sulphate drug movements from the Omnicell, as we wanted to investigate the discrepancy previously found. However, the Ward Manager was unable to do this. We requested a member of Pharmacy to assist with this process, but they were also unable to print off the required report (Ward C6 East, Royal Gwent Hospital).

2.27 There is a knowledge gap within the Health Board over how to maximise the full potential of an Omnicell machine within the wards. This, however, has already been recognised. We were informed that the Principal Pharmacy Technician - Systems Manager has developed a basic Omnicell user guide. We understand this will be added to Sharepoint this year so staff can access when first using an Omnicell machine to understand its full functionalities. We have raised this as **matter arising 3.**

2.28 It should be noted that when completing the sample stock checks of controlled drugs within the Omnicell machines throughout the Health Board sites, no discrepancies were identified.

Pharmacy

2.29 12.1 in the Policy states that the Pharmacy Team should undertake their own six-monthly audits of wards/departments to check that the controlled drug balances are correct. If any discrepancies are found, these should be reported to the Ward Sister and the Pharmacist responsible for the area should investigate.

2.30 From the clinical areas visited, we identified four wards where there was no evidence that the Pharmacy Team had undertaken a stock reconciliation at the minimum of six-month intervals. We noted that the process for completing the six-month stock checks was inconsistent across the sites visited. This has been raised as **matter arising 4**.

2.31 Additionally, we noted a number of wards holding expired controlled drugs. Each expired drug identified during testing was adequately labelled to warn staff from using them.

2.32 There is a risk that expired controlled drugs stored within the controlled drugs cabinet may be accidentally used for patient treatment causing unintentional patient harm. This has also been included within **matter arising 4.**

Conclusion:

2.33 Although there are areas for improvement around compliance with the Policy, as there were no instances of stock imbalances during our sample testing, we have provided **reasonable assurance** over this objective.

Appendix A: Management Action Plan

Matter arising 1: Quoracy (Operation)	Impact
We reviewed the terms of reference (ToR) of the Gwent Controlled Drugs Local Intelligence Network (the 'Group') to identify the requirements of the Chair, how the membership was comprised, and what the quoracy requirements are. We then reviewed meetings against the requirements of the TOR. Meetings were quorate at the January 2020 and 2022 meetings, but not at the September 2021 meeting. The ToR states that a representative from the Police must be in attendance, but no representative was present at this meeting. Therefore, the meeting went ahead without being quorate. Minutes are maintained after each Group meeting. We identified from minutes that the Group maintains actions logs and this is noted as good practice.	Potential risk of: • There is a risk that if the Group meets when the meeting is not quorate, binding decisions cannot be made. This may lead to delays in responses to controlled drug incidents.

Recommendations	Priority
1.1 Management should review the terms of reference (ToR) for the Gwent Controlled Drugs Local Intelligence Network, including its quoracy requirements. Meetings that are not quorate should either be deferred or recognised at the start of the meeting ensuring those in the meeting understand the implications of this. The requirement to complete minutes and action logs after each meeting should also be added to the ToR.	Low

Management response		Target Date	Responsible Officer

1.1	The terms of reference of the Gwent CDLIN will be reviewed and updated as requested at the next CDLIN on 1st August 2022.
	   1. The TOR will be updated to remove need for Police representation at each member.
	   2. To recognise any non-compliance with quoracy requirements at the start of any meeting. The implications of this to be noted in the minutes.
	   3. To add the requirement to complete minutes and action logs after each meeting will be added to the TOR.
		August 2022	Senior Primary Care Pharmacist

Matter arising 2: Policy update (Design)	Impact
There is a Policy for the Management of Controlled Drugs in place. This is in date and is not due for review until November 2023. The Health Board confirmed that although the Policy is in date, due to changes in practices since the pandemic and the opening of the new Grange University Hospital, the policy will be reviewed this financial year. Through our testing we identified examples of non-compliance with the Policy. At the next review date of the Policy, the Health Board should consider whether all sections of the Policy remain relevant. Stock takes of controlled drugs should be completed by ward staff on wards at least once a week. There were four wards in our testing where this did not happen, although these wards had completed stock checks within the previous month.	Potential risk of: • Policy becoming impractical and not taking into consideration the environment in which staff operate e.g. lack of storage space. • Increased risk of drugs being able to be misappropriated / misused if regular stock takes are not completed.

Recommendations	Priority
2.1 Management should review the Policy for the Management of Controlled Drugs and update where required.	Medium
2.2 Once the Policy for the Management of Controlled Drugs is updated, the Health Board should undertake periodic reviews to ensure wards are adhering to the updated Policy and confirm the areas of non-compliance identified as part of this review have been rectified.	Medium

Management response	Target Date	Responsible Officer
2.1 The CD Policy is due for review during 2022/23. As in previous reviews a working group with representatives from Pharmacy and nursing will be set up to update the policy. A number of sections and standard operating procedures will be updated to make the policy more relevant and practical. This will support compliance with the policy.	March 2023	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services

Controlled drug keys being held on their own may have been best practice. However, this may not be convenient on the wards. This could be removed in the updated version.

The use of red pen on the wards is to make stock checks more visible. The practicality of this will be reviewed.

Keeping patients own CDs on a separate shelf may not always be possible. However, they should be clearly differentiated from ward stock.

The policy will also include a description of the audit framework that will provide assurance the policy is being followed.

2.2	The stand operating procedure for pharmacy 6 month stock check on the wards is being updated by a Principal Pharmacy Technician. This will include updating the way reconciliation checks confirmation are documented to ensure compliance.	March 2023	Head of Pharmacy - Operational Services/Principal Technician, Pharmacy Technical Services
	The policy can include the need for periodic audits to review use of the policy and confirm areas of non compliance have been rectified.		

Matter arising 3: Omnicell (Design)	Impact
We noted issues with staff utilising Omnicell machines on their wards. We observed some non-substantive staff who had access to the Omnicell machine and who were unaware how to adequately use the automated system. Furthermore, we witnessed staff ignoring the green flashing lights, identifying where the required drug was being stored. We also found some staff trying to pull open locked draws and opening up multiple compartments within drawers before finding the requested drug. There is a lack of knowledge throughout the Health Board over how staff can maximise the use of an Omnicell machine's capabilities. This, however, has already been recognised. The Principal Pharmacy Technician - Systems Manager has developed a basic Omnicell user guide. This will be added to Sharepoint this year so staff can access when first using an Omnicell machine to understand its full functionalities	Potential risk of: • Drugs not being appropriately accounted for due to lack of knowledge in using an Omnicell machine. • Drugs being misappropriated / misused and not investigated due to an inability to use Omnicell.

Recommendations	Priority
3.1 Management should continue as planned to add the Omnicell user guides to Sharepoint and direct staff to this learning material. The guides should be useful to the front end user and also to Ward Managers regarding the reporting capabilities within an Omnicell machine.	Medium

Management response	Target Date	Responsible Officer
3.1 There are user guides for both end and superusers provided by Omnicell. The Principal Pharmacy technician at RGH has developed basic user guides for the wards which detail the common functions with picture guides. These are available on the wards, but staff cannot always find them. The plan is to add them to SharePoint and signpost staff to them. Short training videos are also to be developed which will be uploaded to YouTube. QR codes will be placed on the side or front of the cabinet and linked to the videos which will show staff how to maximise the Omnicells functionalities.	August 2022	Head of Pharmacy - Operational Services / Principal Pharmacy Technician – Systems Manager

Matter arising 4: Pharmacy stock reconciliations and expired drugs (Operation)	Impact
From the clinical areas visited, we identified a number of wards where the Pharmacy department had not undertaken a stock reconciliation at the minimum of six-month intervals. Additionally, we noted a number of wards holding expired controlled drugs. Each expired drug identified during testing was adequately labelled to warn staff from using them.	Potential risk of: • without six monthly stock reconciliations by Pharmacy, the Team will not be compliant with the Policy and areas where controlled drugs may be being misappropriated / misused, go unidentified.

Recommendations	Priority
4.1 The Pharmacy Team should comply with the relevant Health Board policies and SOPs for controlled drugs, in particular the removal of expired controlled drugs and the completion of six-monthly stock reconciliations (which should all be completed in a consistent manner). Where compliance with the policy cannot be achieved, for example due to resourcing, an agreed temporary deviation from the Policy should be agreed and approved at an appropriate Group.	Medium

Management response	Target Date	Responsible Officer
4.1 A full review will be conducted into the Pharmacy processes relating to 6-monthly CD stock reconciliations to determine the extent of the issue and to provide assurance of compliance. The Pharmacy Team will input into the Management of Controlled Drugs Policy, with the potential to visit the mechanism of how expired drugs are reported to Pharmacy, to ensure a more robust system with auditable records is available in the future.	September 2022	Head of Pharmacy - Operational Services

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	07 February 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Internal Audit Report
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

In November 2022 Internal Audit undertook a review of the process for delivering clinical audits within the Health Board. The report outcome was "limited assurance" for the areas assessed.

Significant areas requiring attention included:
- A Clinical Audit Strategy should be fully implemented.
- Lack of a local clinical audit plan, therefore unable to plan audits in areas with greatest risk.
- Audits that should be completed may go unidentified, leading to additional clinical risk.
- Limited tracking/ monitoring of actions arising from clinical audits.

This report provides details of the ongoing work underway within Clinical Audit to address and rectify these issues.

Cefndir / Background

A review of Clinical Audit processes was completed as suggested by the 2022/23 internal audit action plan. The review sought to identify areas for improvement in the processes that are in place to manage local and national clinical audit. The risks identified as part of the review were:

- Governance structure / arrangements in place.
- Lack of a clinical risk register or identification of relevant risks.
- Failure to have an effective reporting pathway for clinical audit results.
- Failure to act upon the results of clinical audits.
- Failure to participate in the NHS Wales National Clinical Audit and Outcome Review.
- Clinical audits not being used to provide assurance to the Board over the management of associated risk.
- Internal audit recommendations are not implemented.

See Appendix One for summary of audit objectives and assurance.

Assurance on the completion of the internal audit actions is being monitored by PQSOC.

Asesiad / Assessment

Implementation of Clinical Audit Strategy
Limited assurance was given to the Health Board due to the lack of a clear Clinical Audit Strategy. This has been addressed by the launch of a new strategy in October 2022. An implementation plan, including actions to implement the four priorities for clinical audit is underway. Over the next six months the audit team will improve internal performance and adherence to the strategy by engaging with service leads. See Appendix Two for dates of Divisional meetings (February and March 2023).

As part of the implementation of the Clinical Audit Strategy, directorate clinical leads are being asked to identify clinical priorities where audit work will support the improvement of patient care using a risk based-approach. This includes audits that are required following clinical incidents, complaints or risks. Active engagement with the Divisional Triumvirates and Clinical Leads over the coming months will inform the development of a clinical audit plan.

Tracking and monitoring of actions of audit
Given the absence of a local clinical audit plan, the internal audit report provided limited assurance for this objective. The Health Board's audit team have started to develop a local clinical audit plan. This will be formalised in April 2023. Following completion of the program of Divisional meetings, clinical teams will be informed of the expectation to register audits with our clinical audit team. The new web-based system 'Audit Management and Tracking' (AMaT) will be used to register and record local audits, as advised in the report. This will include a nominated audit lead, reason for audit (e.g. complaint, response etc), methodology (how will data be collected and analysed), audit standard, timeline, and an action plan (including where results will be presented). All audits will be registered on AMaT to ensure comprehensive records are maintained and timelines for completion of audits and resultant actions adhered to (The lack of documentation, audit tracking and monitoring of actions highlighted within the report are being addressed via the introduction of AMaT).

Key benefits of AMaT include simple management of audits, easy management of reaudits, visibility of noncompliance and areas of focus for future improvement projects.

Training to use AMaT started in July 2022. AMaT will be used to track and monitor actions raised in local and national clinical audits. An action plan will be produced with measurable improvements within a specified timeframe. Data can be presented using dashboards and easy-to-read graphical presentations. This will facilitate presentation of results at Clinical Standards and Effectiveness Group (CSEG).

Weaknesses were seen in the tracking of actions raised from audit. Little evidence was provided to demonstrate that audits affect the Health Board's future planning. To rectify this, work is underway to develop a standardised annual plan for each Directorate to report on quality-based data. This report will include results from clinical audit. It will be used to develop a quality improvement plan and adoption of risk registers. This will take place over the next six months through engagement with the Divisions, working alongside risk.

Clinical Leads are now being 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. This will be reflected in future clinical audit activity reports that are presented to PQSOC.

Clinical Audit Plan
Internal Audit advised a review and renewal of the Clinical Audit Strategy; to include roles and responsibilities for clinical audit leads and monitoring groups. This is reflected in the Health Board's Clinical Audit Policy, which is currently being updated. This document describes the use and conduct of clinical audit and sets out the principles, roles, responsibilities in auditing clinical practice. This will be updated over the next four months.

Further advice by Internal Audit was to create a local clinical audit plan, this is being developed by the audit team who are planning for the next twenty-four months. This will provide a prioritised summary of planned clinical audit activity and outcomes, that is regularly updated and scrutinised in accordance with the above clinical audit policy and strategy. A standardised clinical audit report template is being developed electronically in AMaT, providing consistency in reporting clinical audit. This will allow completion of audit actions to be visible to the corporate and divisional teams. Going forward, clinical audits can be used to provide assurance to the Board over the management of associated risk.

Reasonable assurance was provided for completion of National Clinical audits and results being noted in an effective system. Where applicable, the Health Board participates in the Annual Programme, detailed in the NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP). These are currently being added to AMaT. Dates for the annual publication of the NCAORP has started to be shared with Divisions. The NCAORP dates will form part of the Health Board's clinical audit plan. We will be utilising the scheduling function in AMaT to develop the clinical audit plan, aligning audit activity and reports, so it is all held centrally. The functionality of the system will be assessed over the next six months to establish the effectiveness of our audit plan.

Part of the clinical audit plan will include a date for timely presentation to CSEG. The Group will review and monitor the audit findings and progress, conclusions

and actions. The escalation process for actions raised within audits will be via PQSOC, which provides assurance to ARA. Our ambition is to ensure clear lines of communication which ensures full Board engagement in the consideration of audit results and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place.

Governance and risk
A further risk raised in the audit report was the lack of an effective reporting pathway for clinical audit results. In the future, the clinical audit plan will be monitored by CSEG, to ensure lessons are disseminated across the Health Board and that the plan is being delivered effectively. Actions and findings from national and local clinical audits will be monitored by CSEG and will be utilised to inform future planning within the Health Board.

Identification of relevant clinical risks from audits will be incorporated onto the Divisional risk register. Implementing a clinical risk register for audit will follow the internal audit recommendations and be initiated following the first CSEG meeting in January 2023. Results of all clinical audits undertaken needs to be triangulated and inform future planning. The development of an annual audit report by the clinical audit team will allow the learning from clinical audit to be fed-back to clinical areas.

Where the Health Board has been identified as an outlier on a national audit, we have produced a standard operating procedure to ensure a standardised approach is undertaken to reviewing, investigating and responding to outlier notifications arising from national clinical audits. This will be undertaken by the clinical audit lead and be signed off by CSEG and a summary will be provided to the Executive team. This allows an escalation process for actions raised within audits, as advised by Internal Audit. This commenced in January 2023.

A Quality Governance Day with Clinical Executive Leads took place in December 2022 to kick start development of a Quality Strategy, to coincide with the implementation of the Duty of Quality in April 2023. A further aim is to review the assurance framework for Committees and Operational Groups. Working alongside Risk and Governance will ensure the appropriate governance structures and arrangements are in place for Clinical Audit. The development of a Risk Management Strategy and Board Assurance Framework will address how risks from Clinical Audit are escalated. This will provide assurance from each applicable divisions / directorate. This will be finalised in the next six months.

The recommendations in this report will be shared with the Assistant Directors for Quality and Patient Safety in Nursing and Therapies and Health Science, thus ensuring the audit guidance extends into all aspects of governance for Aneurin Bevan University Health Board. This will ensure all areas have identified clinical audits that allow scrutiny and assurance associated with quality and safety risks identified from Datix, complaints and outcomes of care. This will enable the development of the audit plan.   This will be completed within the next six months.

Resource
It was highlighted that the Health Board needs to consider whether it has given enough resource to those responsible for clinical audit to carry out the Strategy. The internal auditor addressed the lack of resource within the Health Board to lead and support the clinical audit plan and implementation of AMaT. As part of AMaT implementation a consideration will be given to resources within the Clinical Audit

Team. Currently the resource is a 0.8WTE Clinical Audit Lead who delivers both the National Clinical Audit and Local Audit Plans. This post has also taken on implementation and training of AMaT. This is an ambitious workload for full implementation of the Strategy. A scoping exercise to look at resources for audit departments within Wales will take place. We have started reaching out to other Health Boards in Wales to understand resources within audit departments to ensure both national and local clinical audits are effectively monitored.

The clinical audit team are carrying out a data acquisition project to assess resources within directorates to contribute to clinical audit. The clinical audit team are carrying out a data acquisition project to assess resources within directorates to contribute to clinical audit. This will allow the clinical audit team to produce an overarching investment plan, considering the resource for audit and utilising AMaT. This will need to include future resource and an ongoing funding stream for AMaT.

There has been a follow up meeting with the internal investigator to discuss the internal audit report's findings at length. This will ensure there is an action plan in place to rectify these issues over the coming year.

Argymhelliad / Recommendation

Note the assurance provided by the clinical audit team in developing a clinical audit plan for the next twelve to twenty-four months.

All limited assurances are being worked through as part of the clinical audit plan to ensure recommendations within the Internal Audit Plan have been 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):	3.3 Quality Improvement, Research and Innovation 2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse
	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.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	AB 2223-05 Clinical Audit Internal Audit Report. January 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:	Clinical Standards and Effective Group (26.01.23)

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

Appendix One

Summary of audit objectives and assurance provided by Internal Audit.

Objective	Conclusion	Assurance
There is an approved clinical audit strategy and clinical risk register in place.	The Health Board needs to formalise the Clinical Audit Strategy and consider whether it has given enough resources to those responsible for clinical audit to carry out the Strategy.	Limited assurance.
An appropriate local clinical audit plan is developed, approved, with progress, conclusions and actions monitored by an appropriate forum / committee.	Given the absence of a local clinical audit plan, we have provided limited assurance for this objective	Limited assurance.
Where applicable, the Health Board takes part in the Annual Programme, detailed in the NHS Wales National Clinical Audit and Outcome Review Plan.	National Clinical audits are being completed and results noted in an effective system.	Reasonable assurance
Results of all clinical audits undertaken are triangulated and inform future planning.	There is evidence of oversight of the national clinical audit plan. However, there are still weaknesses in the tracking of actions raised and little evidence that the audits affect the Health Board's future planning.	Limited assurance.

Appendix Two

Clinical Audit Strategy and Plan for Divisions

Division	Meeting Date	Time	Venue
F&T	Monday 6th February	9:30am	Microsoft Teams
Medicine	Wednesday 8th February	12:15pm TBC	Microsoft Teams
SCH	Thursday 9th February	10:30am	Microsoft Teams
Mental Health	Thursday 2nd March	9:30am	Microsoft Teams
PC & Community	Chaser email sent 17.01.23		
Urgent Care	Tuesday 21st March	10:30	Microsoft Teams

Clinical Audit

Final Internal Audit Report

November 2022

Aneurin Bevan University Health Board

Contents

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

Acknowledgement

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

Disclaimer notice - please note

Executive Summary

Purpose

The audit was undertaken to review the process for delivering clinical audits, including how they are used by the Health Board to support assurance.

Overview

We have issued limited assurance on this area. The significant matters which require management attention include:

- A Clinical Audit Strategy should be fully implemented, with the draft that is available requiring significant review.

- There is no local clinical audit plan. Therefore, the Health Board cannot effectively plan to complete audits in areas with the greatest risk. Audits that should be completed may go unidentified, leading to additional clinical risks.

- There is limited tracking / monitoring of actions raised and the delivery of clinical audits.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Classification

Trend

Limited | More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Assurance objectives	Assurance
1 Clinical Audit Strategy	Limited
2 Local clinical audit plan	Limited
3 National clinical audit plan	Reasonable
4 Future planning	Limited
5 Follow-up of previous recommendations	Limited

Key matters arising

	Assurance Objectives	Control Design or Operation	Recommendation Priority
1 Clinical Audit Strategy	1, 2	Design	High
2 Local clinical audit plan	2, 4	Design	High
3 National clinical audit results	3, 4	Design	Medium

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

1. Introduction

1.1   A review of Clinical Audit was completed in line with the 2022/23 internal audit plan. The review sought to provide Aneurin Bevan University Health Board (the 'Health Board') with assurance that there are effective processes in place to manage local and national clinical audit plans.

1.2   The risks considered as part of this review were:
- Inappropriate governance structure / arrangements in place.
- Lack of a clinical risk register or identification of relevant risks.
- Failure to have an effective reporting pathway for clinical audit results.
- Failure to act upon the results of clinical audits.
- Failure to participate in the NHS Wales National Clinical Audit and Outcome Review.
- Clinical audits do not provide sufficient assurance to the Board over the management of associated risk.
- Internal audit recommendations are not implemented.

2. Detailed Audit Findings

2.1   The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	3	3	1	7
Operating Effectiveness	-	-	-	-
Total	3	3	1	7

2.2   Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Audit objective 1: There is an approved clinical audit strategy and clinical risk register in place.

2.3   The Health Board has a draft Clinical Audit Strategy (the 'Strategy') setting out its vision for clinical audit for 2022-2025. The Health Board has four priorities regarding clinical audit, these are:

- There is scrutiny of National Clinical Audit performance with robust development, monitoring, and progression of improvement plans.
- Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk.
- Trainees are supported to participate in meaningful clinical audits that support clinical governance.

- Groups and committees across the Health Board will commission clinical audit to support effective assurance where no other evidence is available.

2.4   The Strategy includes actions to implement the four priorities, however, many of these actions remain outstanding. There is also no clear plan to implement these actions. **Matter arising 1.**

2.5   It was noted, within a report sent to the Patient Quality, Safety and Outcomes Committee (PQSOC), that issues identified within clinical audits are included on the divisional risk register and a number of areas are also included within the covid and corporate risk registers.

2.6   However, there is no evidence that any checks are completed to ensure all remedial actions are included within these registers. There is currently no process in place to ensure the actions are assigned to an appropriate person and the Health Board does not complete spot checks to confirm actions are being completed in a timely manner. The Health Board places reliance on each division correctly identifying all necessary issues, adding them to their divisional risk registers and then monitoring them effectively.

2.7   Additionally, there is no evidence that the Health Board has considered whether it has the resource at an operational level to ensure clinical audit is carried out to a high standard and any resulting actions are implemented. This is also included within **matter arising 1.**

Conclusion:

2.8   The Health Board needs to formalise the Clinical Audit Strategy and consider whether it has given enough resources to those responsible for clinical audit to carry out the Strategy. Therefore, we have given this objective **limited assurance.**

Audit objective 2: An appropriate local clinical audit plan is developed, approved, with progress, conclusions and actions monitored by an appropriate forum / committee.

2.9   There is no local clinical audit plan in place. Until recently, there has been little governance over what local clinical audits have been completed. We were unable to be provided with a list of local clinical audits completed for the past year as this list did not exist. **Matter arising 2.**

2.10   However, going forward, the Quality and Patient Safety Lead for National Clinical Audit informed us local clinical audits have been requested to be added to the AMaT[2] application. This is the programme used to monitor and detail all information for any national clinical audits. This is in its infancy and there are currently only a very limited number of local clinical audits noted within the system. **Matter arising 2.**

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[2] Clinical audit software title

2.11 As there is no local clinical audit plan, a reconciliation between what is on the plan and what is logged on AMaT cannot be completed.

2.12 Given the lack of plan and ability to review any local clinical audits, we were unable to completed testing for this objective.

Conclusion:

2.13 Given the absence of a local clinical audit plan, we have provided **limited assurance** for this objective.

Audit objective 3: Where applicable, the Health Board takes part in the Annual Programme, detailed in the NHS Wales National Clinical Audit and Outcome Review Plan.

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

2.15 The Quality and Patient Safety Lead for National Clinical Audit confirmed that the Health Board participates in all audits where applicable (excluding any related to functions the Health Board does not carry out).

2.16 National clinical audits and their results are added to the AMaT system (which is also used across Wales). A review of the system confirmed that national clinical audits from the national plan are being recorded and used to effectively maintain clinical audit information.

2.17 However, during interviewing we found that there is no deadline by which each audit has to be completed. This sometimes leads to difficulty in obtaining participation from some divisions, particularly where staffing resources may be an issue. We could not therefore confirm whether each audit was completed in a timely manner as this information is not tracked. **Matter arising 3**.

2.18 The AMaT system is straightforward to use, and there is an AMaT user guide available, but this is not held on the intranet. **Matter arising 4**.

Conclusion:

2.19 National Clinical audits are being completed and results noted in an effective system. Therefore, we have provided **reasonable assurance** for this objective.

Audit objective 4: Results of all clinical audits undertaken are triangulated and inform future planning.

2.20 Following the publication of each national clinical audit, the Clinical Lead, in conjunction with the Divisional Director, reviews the reports and develops an action plan to address any requisite improvements. Both results and action plans

are presented to the Health Board's Clinical Standards and Effectiveness Group (CSEG) which reports to Quality and Patients Safety Operational Group - a subgroup of the PQSOG.

2.21   Minutes from both groups confirmed actions are discussed at the CSEG meetings along with a summary of each audit undertaken presented by the designated clinical lead for that area. An update report is presented to PQSOC, most recently going in August 2022, which discussed in detail each of the audits.

2.22   Local clinical audits are not discussed at any forum. There is no evidence that the actions from these audits are monitored and there is no clear escalation process if actions identified as part of the audit require further investigation. **Matters arising 1 and 2.**

2.23   We were not presented with evidence that national clinical audits inform the Health Board's future planning or that actions raised are monitored and tracked. We were informed that there are plans to put all actions raised through national clinical audits onto AMaT so they can be tracked. This has not yet been completed. Clinical audit is only mentioned briefly in the Health Board's Integrated Medium-Term Plan (IMTP). **Matter arising 3**.

Conclusion:

2.24   There is evidence of oversight of the national clinical audit plan. However, there are still weaknesses in the tracking of actions raised and little evidence that the audits affect the Health Board's future planning. Therefore, we have provided **limited assurance** for this objective.

Audit objective 5: A review on the progress / completion of previous audit recommendations raised.

2.25   As part of this audit, we undertook a review of the progress / completion of previous audit recommendations raised within the 2018/19 Clinical Audit internal audit report. Three recommendations were raised within this report. During the 2019/20 financial year a follow up of the recommendations within the 2018/19 report was undertaken. The remaining outstanding actions from each of the three recommendations are noted below, and an updated position has been added.

2.26   **Recommendation 1 – Quality & Patient Safety Assurance Framework**

Actions relating to this audit noted in the 2019/20 report:

- Completion of the development of the QPS Strategy & Assurance Framework; and
- Assessment of the level of clinical audit required by the Health Board.

This recommendation has been **fully superseded** by recommendations one and two below.

2.27   **Recommendation 2 - Clinical Audit Framework**

Outstanding actions noted with in 2019/20 report:

- The update of the Clinical Audit Strategy & Policy remains contingent on the completion of outstanding actions identified in this report and has an implementation target date of June 2020.

This recommendation has been **fully superseded** by recommendation one below.

2.28 **Recommendation 3 – Divisional Clinical Audit**

Outstanding actions noted with in 2019/20 report:

- Completion of the development of the divisional QPS assurance frameworks; and
- Monitoring against the divisional QPS assurance frameworks at the CESG meetings.

This recommendation has been **fully superseded** by recommendations three and four below.

2.29 The Covid-19 pandemic has delayed the Health Board's improvement of Clinical Audit and its implementation of actions raised during the 2019/20 internal audit. Actions still remain outstanding and to continue to improve the clinical audit process these should be implemented as soon as possible.

Conclusion:

2.30 Little progress on the implementation of previous recommendations has been noted, therefore we have given this objective **limited assurance**. However, these recommendations have been superseded by the current matters arising within appendix A and recorded as such.

Appendix A: Management Action Plan

Matter arising 1: Clinical Audit Strategy (Design)	Impact
The Health Board has a draft Clinical Audit Strategy (the 'Strategy') setting out its vision for clinical audit for 2022-2025. The Health Board has four priorities regarding clinical audit. The Strategy includes actions to implement the four priorities, however, many of these actions remain outstanding. There is also no clear plan to implement these actions and parts of the strategy are yet to be completed.	Potential risk of: • Lack of assurance that statutory requirements have been considered and the necessary processes are in place. • Ad-hoc approach to clinical audit leading to reduced patient welfare.

Recommendations	Priority
1.1 Review and renew the Clinical Audit Strategy, which should include: • how the Health Board plans to track and monitor actions raised in national clinical audits; • the process for designing a plan for local clinical audits and what needs to be taken into consideration when creating a local clinical audit plan; • resourcing requirements to ensure both national and local clinical audits are effectively monitored; • role and responsibilities for clinical audit, including the monitoring groups; • how assurance is provided from each applicable divisions / directorates; and • the escalation process for actions raised within audits.	High

Management response		Target Date	Responsible Officer
1.1	The internal audit focused on two main parts of the clinical audit, firstly at how the health board participate in national clinical audits and then secondly its participation in local clinical audits. It has been highlighted that sample testing around the local clinical audits would have been undertaken but not possible at this time as the control framework around this area was not robust. However, it has been noted in the report that this is improving.	NA	NA - Information

The Clinical Audit Strategy was updated and published in Oct 2022. It provides the Strategic Direction for Clinical audit for the Health Board and sets out the commitment to quality and effectiveness through the application of clinical audit to support delivery of: High quality, patient safety, patient experience and clinical effectiveness.	Completed Oct 2022	Assistant Director QPS (Leeanne Lewis) / Quality and Patient Safety Lead for National Clinical Audit / Dr Leo Pinto
The strategy includes the requirement for Divisions and Corporate leads to develop Clinical Audits plans aligned to quality and safety risk with a key set of benchmarks to support this. The Divisional Triumvirates will be sighted on all relevant documents relating to Clinical Audit, as well as the Clinical Lead.	March 2023	Assistant Director QPS (Leeanne Lewis) / CSEG / Divisional Triumvirate
The newly purchased web-based Audit Management and Tracking (AMaT) system will allow audit to be more efficient. Standardised reports can be produced via AMaT, documenting success – areas where good practice has been identified, challenges – areas where practice requires improvement and an action plan with specific timeframes and nominated lead.	May 2023	Assistant Director QPS (Leeanne Lewis) / CSEG / Divisional Triumvirate
Using AMaT Clinical Directors will be empowered to undertake audits more effectively and enable presentation of data as a dashboard system and easy-to-read graphical presentations. This will improve engagement with the clinical directors, QPS audit team and Clinical Standards and Effectiveness Group (CSEG).	May 2023	Assistant Director QPS (Leeanne Lewis) / QPS Clinical Audit team/ Clinical Directors / CSEG
The QPS team will work in collaboration with Clinical Audit leads to utilise AMaT to its full capabilities. This will allow tracking of results and an action plan to be produced with measurable improvements within a specified timeframe.	May 2023	Assistant Director QPS (Leeanne Lewis) / QPS Clinical Audit team/ Clinical Directors / CSEG
ABUHB will facilitate the wider use of data from audit and national registries to be used as supporting information for medical revalidation and peer review. We will aim to create a report on audits in which individual ABUHB employed substantive doctors have participated and these being presented in doctors' annual appraisal. This would include a zero-return statement e.g. this doctor has not undertaken an audit this year.	March 2023	Assistant Director QPS (Leeanne Lewis) / Executive Medical Director / Assistant Medical Directors
Where ABUHB has been identified as an outlier on a national audit we will implement a SOP, which will ensure a standardised approach is undertaken in reviewing, investigating and responding to outlier notification in relation to national clinical audits.	March 2023	Assistant Director QPS (Leeanne Lewis) / CSEG / Executive Medical Director and Divisional Triumvirate

This will be undertaken by the audit clinical lead and be signed off by CSEG and a summary will be provided for the Exec team.

Description	Date	Responsible
The Terms of Reference for CSEG have been updated. CSEG oversees the governance relating to clinical audit and reports biannually to PQSOC the outcomes and improvements plans relating to national audit.	Completed	Assistant Director QPS (Leeanne Lewis) / Quality and Patient Safety Lead for National Clinical Audit / Dr Leo Pinto
A Quality Governance Day with Exec Leads, QPS, Risk and Governance and QI (ABCi) will take place with an aim to review the assurance framework for Committees and Operational Groups. This will review governance arrangements for reporting findings of clinical audit and consider the assurance of how audit is reported and the structure within ABUHB.	March 2023	Executives: Dr James Calvert/ Jenny Winslade/ Peter Carr / Assistant Directors
The recommendations in this report will be shared with the Assistant Directors for Quality and Patient Safety in Nursing and Therapies & Health Science, thus ensuring the audit guidance extends into all aspects of governance for ABUHB. There is work underway to develop a standardised annual plan for each Directorate to report on Quality based data, including clinical audit and will be used to inform a quality improvement plan and adoption of risk registers.	June 2023	Assistant Directors QPS – Leeanne Lewis/ Tracey Partridge-Wilson / Karen Hatch
The Clinical Audit team will be reviewing our implementation plan for clinical audit. The plan will include sign off for audit plans within AMaT to review risks and escalation. The plan will need to include an ongoing funding stream for AMaT. As part of the feedback, the internal auditor highlighted the lack of resource at ABUHB to lead and support the clinical audit plan and implementation of AMaT. As part of the implementation plan a consideration will be given to resources within the Clinical Audit Team. Currently the resource is a 0.8WTE Clinical Audit Lead who delivers both the National Clinical Audit and Local Audit Plans. This post has also taken on implementation and training of AMaT. This is an ambitious workload for full implementation of the Strategy.	June 2023	Assistant Director QPS (Leeanne Lewis) / Quality and Patient Safety Lead for National Clinical Audit / Dr Leo Pinto

Matter arising 2: Local clinical audit plan (Design)	Impact
There is no local clinical audit plan in place. Until recently, there has been little governance over what local clinical audits have been completed. We were unable to be provided with a list of local clinical audits completed for the past year as this list did not exist. Furthermore, there is no approach or oversight for identifying clinical risks and how these may be incorporated into a local clinical audit plan.	Potential risk of: • Audits not being completed, and necessary remedial actions not being undertaken, increasing risk to patient harm. • Lessons learnt from audits are not being distributed increasing risk to patient harm. • Clinical risks are not identified.

Recommendations		Priority
2.1	The Health Board should create a local clinical audit plan using a risk-based approach.	High
2.2	The clinical audit plan should be monitored at an appropriate forum, to ensure lessons are learnt across the Health Board and that the plan is being delivered effectively.	High
2.3	The local clinical audits should be recorded onto AMaT, as is currently being done with national clinical audits.	Medium

Management response		Target Date	Responsible Officer
2.1	As part of the Clinical Audit Strategy an implementation plan will be developed to ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registries included in the annual Plan. The strategy includes the requirement for Divisions and Corporate leads to develop Clinical Audits plans aligned to quality and safety risk with a key set of benchmarks to support this.	March 2023	Assistant Director QPS (Leeanne Lewis) / CSEG / Divisional Triumvirate/ Executive Leads

The plan will ensure ABUHB has clear lines of communication which ensures full Board engagement in the consideration of audit results and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place.

2.2	The Divisional Triumvirates will be sighted on all relevant documents relating to Clinical Audit, as well as the Clinical Lead. Audit should be mandatory and non-performance will be challenged. AMaT will facilitate clinical audit and provide an oversight of the data. This will improve accountability for clinical audits, developing a clear action plan and allow tracking of actions, providing assurance to the Committee and Executive Board. Going forward there will be standardised approach to reporting audit findings. These will be reported under: • Areas where good practice has been identified • Areas of where practice requires improvement • Actions to be taken - using SMART objectives We will ensure learning from audit and review is shared across the organisation and communicated to staff and patients.	January 2023	Assistant Director QPS (Leeanne Lewis) / Quality and Patient Safety Lead for National Clinical Audit / Dr Leo Pinto / CSEG / Divisional Triumvirate
2.3	It is acknowledged that the current process in ABUHB for local audit has lacked structure and formal documentation. AMaT will be utilised for local audit and will enable the development of a formally recognised process for reviewing the organisations performance when reports are published. The AMaT report will include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.	March 2023	Assistant Director QPS (Leeanne Lewis) / Quality and Patient Safety Lead for National Clinical Audit / Dr Leo Pinto
	The Clinical audit lead, CSEG and the Assistant Medical Directors will scope how to mandate the use of AMAT. We will agree on a formal process for registering a local audit (which sets out audit lead, reason for audit (e.g. complaint response etc etc), methodology (e.g. how will data be collected and analysed), standard being audited against, timeline, when report due and action to be taken from audit (including where result will be presented). This will be approved in advance – with prioritisation e.g. National audit takes precedence and local audit not addressing a risk issue as lowest priority. **All** audits will be registered.	June 2023	Assistant Director QPS (Leeanne Lewis) / Clinical audit lead / CSEG / Assistant Medical Directors

Matter arising 3: National clinical audits (Design)	Impact
The Quality and Patient Safety Lead for National Clinical Audit could not identify a deadline by which each national clinical audit had to be completed. This sometimes leads to difficulty obtaining participation from some divisions, particularly where staffing resources may be an issue. We could not therefore confirm whether each audit was completed in a timely manner as this information is not tracked. We were unable to confirm that national clinical audits inform the Health Board's future planning or that actions raised are monitored and tracked. Clinical audit is only mentioned fleetingly in the Health Board's Integrated Medium-Term Plan (IMTP).	Potential risk of: • Audits may be completed some time after they were included within the national clinical audit programme. • Data used may be significantly out of date and therefore may not be useful. • Planning does not take into account actions identified from clinical audits.

Recommendations	Priority
3.1 The Clinical Standards Effectiveness Group should monitor when an audit is added to the national clinical audit programme and how long it is scheduled to complete. Those responsible for completing audits that are facing significant delays should be asked to provide reasoning for this, and additional support should be provided where required.	Medium
3.2 Actions and findings from national and local clinical audits should be monitored at an appropriate forum and should be utilised to inform future planning within the Health Board.	Medium

Management response		Target Date	Responsible Officer
3.1	As each National Clinical Audit (NCA) is published it will be added to the web-based audit tracking system AMaT and assigned to a Clinical Lead. The Clinical Lead will act as a champion and point of contact for every National Clinical Audit and Outcome Review which the Health Board is participating in. Full participation is expected in ALL NCAs. The NCA programme for 2022/23 will be shared with Clinical audit leads to allow planning for attendance at CSEG.	March 2023	Assistant Director QPS (Leeanne Lewis) / Quality and Patient Safety Lead for National Clinical Audit / Dr Leo Pinto

AMaT is seen as the solution to effectively recording audit results, tracking progress and challenges and developing an action plan within a specific timeframe.

With the introduction of AMaT, there will be positive engagement for participation in audit. Audit should be mandatory and non-performance must be challenged. ABUHB is in the process of training staff to use AMaT, currently 90 users are registered. All National Clinical Audits are to be registered. The Clinical Audit Strategy states that all NCA's will be registered on AMaT with relevant documentation uploaded and allocated an audit lead. The Clinical Lead is the audit mentor for the specialty of the NCA. There are currently 35 audits registered in the Clinical Audit area on AMaT.

March 2023

Assistant Director QPS (Leeanne Lewis) / CSEG / Divisional Triumvirate / Clinical Leads

3.2   The use of AMaT will allow reports to be easily produced for Clinical Directors and Clinical Audit Leads.   Key benefits include simple management of audits, easy management of reaudits, visibility of noncompliance and areas of focus for future improvement projects. AMaT will facilitate clinical audit and provide an oversight of the data. This will improve accountability for clinical audits, developing a clear action plan and allow tracking of actions, providing assurance to the Committee and Executive Board.

March 2023

Assistant Director QPS (Leeanne Lewis) / CSEG / Divisional Triumvirate / Clinical Leads

Going forward there will be standardised approach to reporting audit findings. These will be reported under:
- Areas where good practice has been identified
- Areas of where practice requires improvement
- Actions to be taken - using SMART objectives

The Clinical Standards and Effectiveness Group (CSEG) oversees the governance relating to clinical audit and reports biannually to PQSOC the outcomes and improvements plans relating to national audit.

Assistant Director QPS (Leeanne Lewis) / Quality and Patient Safety Lead for National Clinical Audit / Dr Leo Pinto

Matter arising 4: AMaT user guide (Design)	Impact
The AMaT system is used to add the information from national clinical audits and going forward also local clinical audits. Those who are responsible for adding the local clinical audit information to the system may be unfamiliar or unsure how to best utilise the programme. There is an AMaT guidebook available, but this is not held on the Intranet.	Potential risk of: • The AMaT system not being used to its full potential

Recommendations	Priority
4.1 Add the AMaT guidebook to the Intranet.	Low

Management response	Target Date	Responsible Officer
4.1 This will be actioned, the AMaT guidebook will be added to the Clinical Audit intranet page for ABUHB.	December 2022	Quality and Patient Safety Lead for National Clinical Audit

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Heol Billingsley
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CF15 7QZ

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

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING
DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	07 February 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Clinical Audit Plan 2022/24
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

Aneurin Bevan University Health Board is committed to delivering safe and effective care to the population of Gwent. Clinical audit is an essential tool in ensuring that services continually evolve and develop and are responsive to quality and safety risks. 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 guideline defined standards of care. It also improves the quality of care and patient outcomes.

The Health Board has four priorities:
- That there is scrutiny of national clinical audit performance at directorate and divisional level (overseen by the Clinical Standards and Effectiveness Committee) with robust development, monitoring, and completion of improvement plans.
- Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risks identified from datix, complaints and outcomes of care.
- Trainees are supported to participate in high quality clinical audits that support clinical governance.

- Groups and committees across the Health Board commission clinical audit to support effective assurance where no other evidence is available.

Cefndir / Background

Clinical audit is one tool in a wider Quality Improvement Strategy aimed at providing assurance with respect to delivery of best practice care. Aneurin Bevan University Health Board complied with Welsh Government requirements by participating in all mandatory National Clinical Audits (NCAs). The Health Board's clinical audit team are updating the following organisational documents, as suggested by the Healthcare Quality Improvement Partnership (HQIP). They must be linked and read together to ensure the effective management of clinical audit:

- The 'Clinical Audit Policy' describes the use and conduct of clinical audit: the document sets out the principles, roles, responsibilities and practices a healthcare provider will follow in auditing clinical practice and improving the quality of services to meet the needs of patients.

- The 'Clinical Audit Strategy 2022-25' sets out the principles of how an audit is identified as required, planned and linked with the Quality Management System under development in Aneurin Bevan University Health Board. It describes how the Health Board will implement the strategy and increase the impact of audit on improvement in clinical services. The strategy was launched in October 2022 and implementation is underway.

- A clinical audit plan/ programme is being developed for the next two years. This will provide a prioritised summary of planned clinical audit activity and outcomes. This will be regularly updated and scrutinised in accordance with the above clinical audit policy and strategy.

- A clinical audit report template has been developed in a web-based Audit Management and Tracking system (AMaT). This will provide consistency in the reporting of clinical audit and will allow completion of audit actions to be visible to the corporate and divisional team.

In its review of clinical audit, HQIP suggested that clinical audit should be integral to Board assurance of quality and improvement. To be able to provide this assurance a clinical audit programme should provide confirmation that clinical practice compares favourably with evidence of guideline defined practice and where this is not the case, that changes are made to improve the delivery of care.

Our clinical audit programme will reflect national and local drivers for quality improvement. It will aim to balance key drivers with directorate/division/service/ clinician priorities. The programme will assess if the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registries included in the annual plan.

Development of 2023/24 Programme

In developing the Aneurin Bevan University Health Board audit programme the Clinical audit team considered the following:

- Ensure directorates participate in all national clinical audits, national confidential enquiries and service reviews relevant to its service provision.
- Ensure all clinical audit activity within directorates is registered on AMaT.
- Mandatory participation in audits on the National Clinical Audit and Patient Outcomes Programme (NCAPOP).
- Participate in national audits, not on NCAPOP, but are included in the list for reporting as part of the Health Board's Quality Plan (e.g. Falls, pressure ulcers).
- Clinical audits identified or required for Board Assurance Framework.
- NICE guidance and HTW adoption. Audit is not mandatory but implementation and audit of NICE guidance can be subject to external review.
- Projects requiring re-audit after changes in practice.
- Work with clinicians, service managers, divisional governance and quality managers and clinical audit staff to ensure that the clinical audit programme for their directorate meets all clinical, statutory, regulatory, commissioning and other Health Board requirements.
- Ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development).
- Ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registers included in the annual Plan.
- Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should include consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.

As part of the implementation of the Clinical Audit Strategy; directorate and clinical leads will identify projects that relate to clinical priorities where audit work will support the improvement of patient care. This includes audits from clinical incidents, complaints or risks. Engagement meetings with Divisions to facilitate implementation of the Clinical Audit Strategy and develop a clinical audit plan are scheduled for the next two months. The programme will commence from April 2023.

The National Clinical Audit and Outcome Review Plan (NCAORP) is published by the Welsh Government (WG) annually. This plan is one of the foundation 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 plan also details the full list of national audit projects that all healthcare organisations must fully participate in, where those services are provided.

Full participation is mandatory in all NCAs and are registered on AMaT. The identified Clinical Lead, in conjunction with the Divisional Triumvirate will review the audit reports and develop an action plan to address any requisite

improvements. The NCA programme and Clinical Outcome Review Programmes (CORP) will be shared with Directorates for 2023/24 and clinical audit leads to allow planning for attendance at Clinical Standards and Effectiveness Group (CSEG).

The introduction of AMaT will make auditing easier, faster, and more effective. Key benefits include simple management of audits, easy management of reaudits, visibility of noncompliance and areas of focus for future improvement projects. This will allow tracking of results and an action plan to be produced with measurable improvements within a specified timeframe. Using AMaT, Clinical Directors will be empowered to undertake audits more effectively and enable presentation of data using a dashboard and easy-to-read graphical presentations. The clinical audit team are training staff to use AMaT, currently there are over 90 users trained.

Creation and delivery of actions plans arising from audit are an opportunity to improve safety and patient experience. Use of AMaT will ensure there is a system for prioritisation of clinical audit and enable monitoring and tracking of actions. AMaT will facilitate effective clinical audit and provide an oversight of audit data. For future meetings, Clinical Leads are 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 production of audit action plans by directorates for approval at CSEG. This will improve accountability for clinical audits, visibility of action plans and allow tracking of actions, providing assurance to the Committee and Executive Board. Future reports will include consideration of improvements (planned and delivered) and an escalation process to ensure the Executive Board is made aware when issues around participation, improvement and risk identification against recommendation are identified.

CSEG will develop a process to enable shared learning from audits across the organisation and communicated to staff and patients. Results from clinical audits will be triangulated with other quality measures to inform future Quality Improvement plans.

AMaT is seen as the solution to local improvement and the implementation and monitoring of NICE guidance and of HTW adoption. We have aspirations that using the AMaT platform will be a reliable and comprehensive system for monitoring local compliance with evidence-based guidance prioritising NICE and HTW guidance in the first instance. This new system will allow improved clarity, oversight and assurance of compliance and mitigation.

The Health Board's clinical audit programme will provide a list of all the clinical audit projects planned or undertaken. The clinical audit programme will be updated every month to ensure the rolling nine-month NCAORP plan is reflected in the programme. See Appendix One for current 2023 NCAs and CORP. The scheduling function on AMaT will be utilised to develop this plan and will align with CSEG meetings and include dates for Operational Groups and Outcome Committees. This will be evaluated after six months. See example of Excel Gantt Chart until an AMaT audit schedule is developed.

The Health Board's clinical audit intranet page will host a link to the HQIP site. The regular publication of a National Clinical Audit and Outcome Review e-bulletin highlighting developments and findings from recent reports will be made available to clinicians via CSEG. The aim of the clinical audit team is to raise the profile of clinical audit with boards, patient groups, clinicians and all staff working within the health board. AMaT is enabling closer partnerships working with health boards/trusts clinical audit teams to improve knowledge and understanding of national and local audit/review activities.

For the year 2022/23, the clinical audit team will produce an annual audit report. Our ambition is to ensure full Board engagement in the consideration of audit results and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place.

The Terms of Reference for CSEG have been updated. CSEG oversees the governance relating to Clinical Audit and reports biannually to Patient, Quality and Safety Outcomes Committee, the outcomes and improvements plans relating to National Audit. This is part of the assurances processes required by Welsh Government to be taken internally by all Welsh Health Boards.

Identification of relevant risks from audits will be incorporated onto the Divisional risk register going forward. There is work underway to review the assurance framework for Committees and Operational Groups. The development of a Risk Management Strategy and Board Assurance Framework will ensure the appropriate governance structures and arrangements are in place for clinical audit and address how risks are escalated.

Argymhelliad / Recommendation

Note the assurance provided by the clinical audit team to develop a clinical audit programme for the next 12-24 months.

Work is underway to implement the clinical audit strategy, update the Health Board policy on clinical audit, produce a clinical audit programme and produce an annual Health Board audit report. AMaT is being implemented. Engagement with Divisions on clinical audit is planned.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item. Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve 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:	Clinical Audit Strategy Clinical Audit Policy
Rhestr Termau: Glossary of Terms:	
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)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working	Choose an item. Choose an item.

https://futuregenerations.wales/about-us/future-generations-act/	

APPENDIX ONE
NATIONAL CLINICAL AUDIT AND PATIENT OUTCOMES PROGRAMME (NCAPOP)
9 MONTH PUBLICATION SCHEDULE

Please see the nine-month publication schedule for the National Clinical Audit and Patient Outcomes Programme (NCAPOP) – covering the National Clinical Audit (NCA) programme and also the Clinical Outcome Review Programmes (CORP). This will form part of the Clinical Audit Plan which will be updated every three months to ensure the programme updates are constantly planned for a rolling nine-month programme.

HQIP ref.	Audit/CORP title	Name of publication	NCA or CORP	Delivery organisation	Publication date
304	NACAP – National Asthma and COPD Audit Programme	National Asthma and COPD Audit Programme – Airways Report	NCA	Royal College of Physicians	Thu 12/01/2023
352	FFFAP – Falls & Fragility Fracture Audit	Fracture Liaison Service Database (FLDSB) Annual Summary Report	NCA	Royal College of Physicians	Thu 12/01/2023
370	NPCA – National Prostate Cancer Audit	National Prostate Cancer Audit Annual Report	NCA	Royal College of Surgeons	Thu 12/01/2023
372	SSNAP-Sentinel Stroke	SSNAP – Sentinel Stroke Data Report	NCA	Kings College London	Thu 12/01/2023
378	GI-NOGCA – Gastro-Intestinal Cancer Audit Prog. – National Oesophago-Gastric Cancer Audit	National Oesophago-Gastric Cancer Audit Annual Report	NCA	Royal College of Surgeons	Thu 12/01/2023
379	GI-NBoCA – Gastro-Intestinal Cancer Audit Prog. – National Bowel Cancer Audit	National Bowel Cancer Audit Annual Report	NCA	Royal College of Surgeons	Thu 12/01/2023

246	NDA – National Diabetes Audit	National Diabetes Audit Core: Complications and Mortality Report	NCA	NHS Digital	Thu 12/01/2023
384	NDA – National Diabetes Audit	National Diabetes Audit (Data only)	NCA	NHS Digital	Thu 12/01/2023
392	NELA – National Emergency Laparotomy Audit	NELA Annual Report	NCA	Royal College of Anaesthetists	Thu 09/02/2023
246	NDA- National Diabetes Audit	National Diabetes Audit Core: Complications and Mortality Report	NCA	NHS Digital	Thu 09/02/2023
377	NLCA – National Lung Cancer Audit	National Lung Cancer Annual Report	NCA	Royal College of Surgeons	Thu 09/03/2023
353	FFFAP – Falls & Fragility Fracture Audit	Falls & Fragility Fracture Audit Annual Report (Wales only)	NCA	Royal College of Physicians	Thu 09/03/2023
371	PICANet – Paediatric Intensive Care Audit	Paediatric Intensive Care Audit Annual Report	NCA	University of Leeds	Thu 09/03/2023
376	CVD Prevent- Cardiovascular Disease Prevention Audit	Cardiovascular Disease Prevention Audit Annual Report	NCA	NHS Benchmarking Network	Thu 09/03/2023
395	NCISH – Mental Health CORP	Mental Health CORP Annual Report	CORP	University of Manchester	Thu 09/03/2023
397	NPDA – National Paediatric Diabetes Audit	National Paedatric Diabetes Audit Core Report	NCA	Royal College of Paediatrics and Child Health	Thu 09/03/2023
376	CVD PREVENT – Cardiovascular Disease Prevention Audit	Cardiovascular Disease Prevention Audit Annual Report	NCA	NHS Benchmarking Network	Thu 13/04/2023

387	NDA – National Diabetes Audit	National Diabetes Audit (Data only)	NCA	NHS Digital	Thu 13/04/2023
373	SSNAP – Sentinel Stroke	SSNAP – Sentinel Stroke(Data only)	NCA	Kings College London	Thu 13/04/2023
373	NDA – National Diabetes Audit	NDA Core Annual Report – Care Processes and Treatment Targets	NCA	NHS Digital	Thu 08/06/2023
386	NDA – National Diabetes Audit	NDA Diabetes Prevention Programme (DPP) Annual Report	NCA	NHS Digital	Thu 08/06/2023
262	NPDA – National Paediatric Diabetes Audit	National Paediatric Diabetes Audit Admissions report	NCA	Royal College of Paediatrics and Child Health	Thu 13/07/2023
380	NACEL – National Care at the End of Life Audit	National Care at the End of Life Audit Annual Report	NCA	Kings College London	Thu 13/07/2023
388	NDA – National Diabetes Audit	National Diabetes Audit Type 1 State of the Nation report (Y1) 2021-2022	NCA	NHS Digital	Thu 13/07/2023
389	NDA – National Diabetes Audit	National Diabetes Audit Young Type 2 State of the Nation report (Y1)	NCA	NHS Digital	Thu 13/07/2023

https://www.hqip.org.uk/ncapop-9-month-publication-schedule/

Aneurin Bevan University Health Board

Clinical Audit Policy

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Status: Issue 1.1 (review date extended to April 2024)   Issue date: 11 April 2019
Approved by: Clinical Standards & Policy Group   Review by date: 11 April 2024
Owner: Assistant Director for Quality & Patient Safety

1/15   199/342

Table of Contents

Status: Issue 1.1 (review date extended to April 2024)   Issue date: 11 April 2019
Approved by: Clinical Standards and Policy Group   Review by date: 11 April 2024

2/15   200/342

Aneurin Bevan University Health Board
Title: Clinical Audit Policy
Owner: Assistant Director for Quality and Patient Safety

ABUHB/Clinical/0901

1.   Introduction and Definitions

Clinical audit is at the forefront of Welsh Government's drive to improve patient care in Wales. The results of clinical audit provide an invaluable insight into the quality of care being provided by a service and over time can be used to monitor how well improvements are being taken forward. National Clinical Audit also benchmarks our clinical services against similar services in other Health Boards and Trusts in England and Wales.

NHS organisations in Wales are expected to participate in clinical audit as part of the requirements of Standard 3.3 of the *Health and Care Standards 2015*. The standard requires healthcare organisations to have a cycle of continuous quality improvement that includes clinical audit.

In this Policy and in the Clinical Audit Strategy, the definition of clinical audit adopted by ABUHB is that used by the Healthcare Quality Improvement Partnership (HQIP):

"Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes."
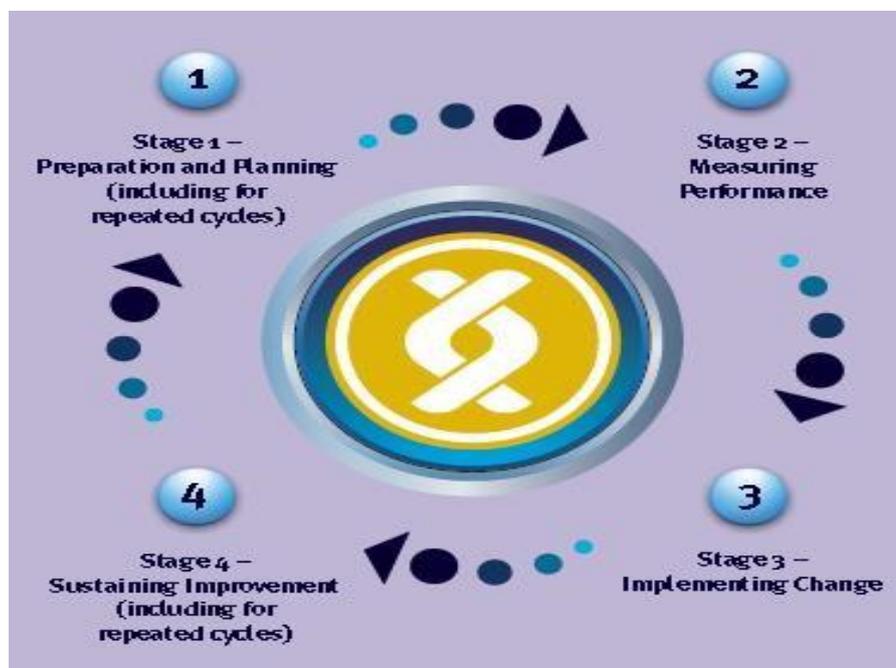
There are four stages in the clinical audit cycle:

Status: Issue 1.1 (review date extended to April 2023)   Issue date: 11 April 2019
Approved by: Clinical Standards & Policy Group   Review by date: 11 April 2023

3/15   201/342

Aneurin Bevan University Health Board   ABUHB/Clinical/0901
Title: Clinical Audit Policy
Owner: Assistant Director for Quality and Patient Safety

- **Stage 1 – Preparation and Planning:** to agree required standards and clinical audit methodology
- **Stage 2 – Measuring Performance:** data collection in order to evaluate performance against required standards
- **Stage 3 – Implementing Change:** using action planning where shortfalls are identified
- **Stage 4 – Sustaining Improvement:** through monitoring and service development, with repeated clinical audit cycles as required

2. Policy Statement

Aneurin Bevan University Health Board (the Health Board) is committed to using Clinical Audit, including National Clinical Audit, as a key quality improvement methodology, in conjunction with other quality improvement methodologies like 1000 Lives/IHI Model for Improvement. As part of this process, Clinical Audit provides assurance about compliance with accepted clinical standards within the services provided by the Health Board. It is expected that this Policy, working with the Clinical Audit Strategy, aligns with the Health Board's wider governance and assurance mechanisms, and its value and outcomes work, that will inform and enhance the process of improving clinical services.

3. Purpose

The purpose of this policy is to set out the rationale for clinical audit and provide a framework for such activity, including standards, guidance and procedures. It also outlines the support available from the Medical Director's Support Team for National Clinical Audits on the National Clinical Audit and Outcome Review (NCAOR) Programme, for Health Board wide clinical audits and for the development and design of other clinical audit projects taking place within the Divisions and Directorates.

This policy aims to support a culture of best practice in the management and delivery of clinical audit, and to clarify the roles and responsibilities of all staff involved.

4. Scope

This Policy applies to anyone engaged in the clinical audit process within Aneurin Bevan University Health Board, in primary, community and

Status: Issue 1.1 (review date extended to April 2024)   Issue date: 11 April 2019
Approved by: Clinical Standards and Policy Group   Review by date: 11 April 2024

4/15   202/342

hospital care. This includes all staff, clinical or non-clinical, and students and trainees.

Within the Health Board, there are three broad areas of clinical audit:

- National Clinical Audits that are part of the Welsh National Clinical Audit and Outcome Review Programme, and it is mandatory for the Health Board to participate in these audits.
- A small programme of Health Board wide clinical audits, that are determined annually to review the standard of service in relation to issues highlighted through complaints and serious incidents, mortality reviews, external reports and patient experience surveys.
- Programmes of local audits within Directorates that are determined by clinical staff within the services or the Division, and often carried out by doctors in training as part of their training.

5.   Roles and Responsibilities

The table below sets out the key leadership roles and responsibilities for clinical audit activity and the role of key committees and groups in relation to clinical audit:

Lead	Responsibilities
Chief Executive	The Chief Executive is the Accountable Officer of the Health Board and as such has overall accountability and responsibility for ensuring it meets its statutory and legal requirements in relation to clinical audit.
Medical Director	The Medical Director is the Executive Lead for clinical audit and is responsible for ensuring that the Health Board Clinical Audit Strategy and annual programme of clinical audit are aligned to the Board's strategic interests and concerns and support assurance to the Board on the clinical services.

Status: Issue 1.1 (review date extended to April 2024)   Issue date: 11 April 2019
Approved by: Clinical Standards and Policy Group   Review by date: 11 April 2024

5/15   203/342

Assistant Director of Quality & Patient Safety	The Assistant Director is responsible for leading the development of Health Board Policy and Strategy in relation to the practice of clinical audit. In addition, the Assistant Director is also responsible for the co-ordination and monitoring of participation in the NCAs on the NCAOR Programme and in ensuring a programme of clinical audits is agreed and carried out annually.
Divisional Directors	Divisional Directors are responsible for ensuring that the services within the Division are participating in and implementing changes based on the results of the NCAs on the NCAOR

Lead	Responsibilities
	programme. They are also responsible for maintaining the overview of local clinical audits within the Directorates, to ensure they comply with this Policy.
Clinical Directors	Clinical Directors are responsible for ensuring a programme of local clinical audits is planned and carried out. They are also responsible for having the structure and processes in place so that the audits are reported and presented locally, and that changes are made based on the results of the audits, and that the full audit cycle is completed to ensure that the changes have made an improvement to the services. This responsibility may be delegated to a Directorate Lead for Clinical Audit. Clinical Directors are responsible for appointing a clinical lead for the NCAs on the NCAOR Programme for services in their Directorate, and supporting them in participation in the full audit process.
Clinical Leads for National Clinical Audits	The NCA Clinical Leads are responsible for having systems and processes in place to facilitate full participation in their NCA, and for ensuring the results of the audit are considered locally and changes are made to improve the service against the standards within the NCA.

Quality & Patient Safety Lead for National Clinical Audit	The QPS Lead for NCA is responsible for day-today operational matters in relation to delivery of the National Clinical Audit and Outcome Review Programme and putting in place effective systems and processes with other members of the Medical Director's Support Team to support this, and the overall dissemination and reporting of the results of NCAs within the Health Board.
Medical Director's Support Team	The members of the Team support the Clinical Leads in respect of providing relevant reports and assurance documentation on their NCAs in a timely manner.
Quality and Patient Safety Operational Group	The QPS Operational Group is responsible for reviewing the results of all the NCAs on the NCAOR Programme and escalating any concerns to the QPSC. It also will review the
Lead	**Responsibilities**
	audit reports for all of the health board wide audits and agree the action plans.
Quality & Patient Safety Committee	To monitor that the outcomes in clinical audits for the services in the Health Board are improving.
Divisional Quality and Safety Groups	To review participation in and results from NCAs for services in the Division and support the Clinical Leads and Directorates in taking forward the agreed changes where they are outside the control of the Directorate.

6.   Processes and Procedures

6.1. Process for National Clinical Audits: Participation, review of reports, dissemination of results, escalation and improvement actions

The Welsh Government National Clinical Audit and Outcome Review Committee publish the National Clinical Audit and Outcome Review Annual Plan (The Plan) which lists the NCAs that all Health Boards and Trusts are expected to participate in. The Plan also confirms that the the findings

Status: Issue 1.1 (review date extended to April 2024)   Issue date: 11 April 2019
Approved by: Clinical Standards and Policy Group   Review by date: 11 April 2024

7/15   205/342

from audits and reviews must be used to measure and drive forward improvements in the quality and safety of healthcare services in Wales.

In ABUHB a Clinical Lead for each NCA on the NCAOR Programme will be appointed by the Clinical Director for the service. All NCAs will be supported by one of the members of the Medical Director's Support Team.

The Plan requires 100% participation, in terms of case ascertainment and submission of complete data, where applicable, with audits listed as part of the Annual Programme, and completion of the full audit cycle, including the implementation of changes to improve the results.

The Clinical Lead for each NCA will ensure that there are systems and processes in place for participation in the audit, review of the results within the Directorate, identification of the priority areas for improvement and agreement of the changes that can be made to make improvements to the outcomes for the service.

The Quality and Patient Safety Lead for NCA will maintain an overview of all the NCAs on the NCAOR Programme in an excel spread sheet, and work with all the members of the Medical Director's Support Team to ensure that the spread sheet is up dated. The MDST will work with the Clinical Leads to achieve the full audit process for each NCA. In particular, they will draft Headline Data slides that summarise the key results for each NCA. The slides will be used to disseminate the results of the NCA across the Health Board and at key Groups and Committees. This will mean there is an overview of the results of all the NCAs at all levels in the Health Board. The MDST will also co-ordinate the reporting to the WG of the 2 part Assurance Proforma: Part A (key findings) and Part B (action plan).

The Quality and Patient Safety Operational Group will receive a report at each meeting of all the Headline Data Slides for the NCAs published since the last meeting. Any concerns will be escalated to the QPSC. An NCA Annual Report will be published each year, showing the development of the overall processes for NCA and summarising for each NCA the key findings for ABUHB, improvements in outcomes as a result of the changes that have been made, the actions that are being implemented to address the key findings and the progress with those actions.

The steps in this process and the responsibilities for the main actions are summarised in the table below:

Status: Issue 1.1 (review date extended to April 2024)   Issue date: 11 April 2019
Approved by: Clinical Standards and Policy Group   Review by date: 11 April 2024

8/15   206/342

Step in NCA process	National Audit Clinical Lead Responsibilities	Medical Director's Support Team Responsibilities
Registration for NCA	Clinical Director appoints Clinical Lead, Clinical Lead registers to participate in National Clinical Audit on NCAORP, sign off by Caldicott Guardian where necessary	Allocate member of Team to liaise with and support Clinical Leads for each NCA
Identification of all cases that meet audit criteria		Support for identification of cases/access to records
Data entry	Identify who will complete data capture and data entry for 100% cases and 100% audit fields, with ability to track case ascertainment	Limited data entry as clinical knowledge often required

Step in NCA process	National Audit Clinical Lead Responsibilities	Medical Director's Support Team Responsibilities

Status: Issue 1.1 (review date extended to April 2024)   Issue date: 11 April 2019
Approved by: Clinical Standards and Policy Group   Review by date: 11 April 2024

9/15   207/342

Aneurin Bevan University Health Board
Title: Clinical Audit Policy
Owner: Assistant Director for Quality and Patient Safety

ABUHB/Clinical/0901

Analyse results and disseminate	On publication of National Clinical Audit Report – analyse report and local results. Amend and agree Part A and Headline data slides.	Draft Headline Data Slides and draft part A Summary of key findings for ABUHB). Reporting of headline data slides to QPS Operational Group. Dissemination of Headline data slides. Submit Part A to WG
Agree priorities for improvement	Identification of local Priorities for Improvement from the report and agreement of changes to be made with Directorate. Complete Part B and return to MDST	Send Part B (summary of actions) to Clinical Lead. Submit completed Part B to WG.
Set up and monitor change programme	Initiation of Improvement Programme to put in place and monitor impact of changes (Directorate level/Divisional level/Board level)	Support for Improvement Process in Clinical Specialty/Directorate as required.
Step in NCA process	**National Audit Clinical Lead Responsibilities**	**Medical Director's Support Team Responsibilities**
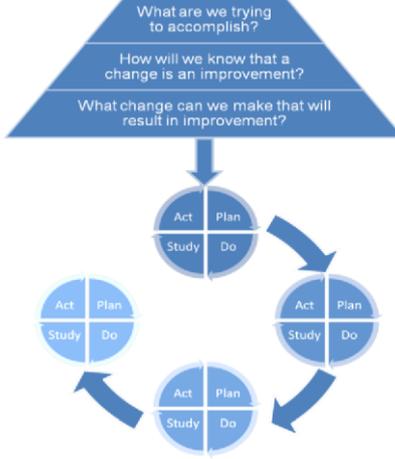
	Reaudit	Annual Report on NCA

6.2. Process for agreeing and carrying out the annual Health Board wide clinical audit programme

Each year, the Health Board will agree and carry out a number of clinical audits on issues that have been highlighted through the Health Board's surveillance mechanisms. These include: complaints, serious incidents, claims, mortality reviews, external inspections.

The Medical Director's Support Team will collate the issues that have arisen, and suggest a programme of about 6 clinical audits to the Quality and Patient Safety Operational Group for discussion and agreement. The Group will discuss and amend the list, drawing on the knowledge of all the members of the Group across the Divisions and Corporate Departments. Some issues will have a one off audit, others may be a routine annual audit (record keeping).

Once agreed by the QPSOG, the MDST will develop a plan for each audit. This will be agreed with the relevant corporate lead for the issue. The MDST will co-ordinate the completion of the audit and a report on the results of the audit. An action plan will be developed with the Corporate Lead and the report and action plan will be taken to the QPSOG.

6.3. Divisional/Directorate Clinical Audit Programmes

The Clinical Director is responsible for ensuring that the directorate agrees an annual clinical audit plans, which address local clinical issues in the Directorate. The Directorates are also responsible for having the structure and processes in place so that the audits are reported and presented locally, and that changes are agreed and implemented, based on the results of the audits, and that the full audit cycle is completed to ensure that the changes have made an improvement to the services.

Clinical Audits undertaken by doctors in training will usually be part of the Directorate Audit programme and should be agreed with the doctor in Trainings Consultant and/or the Audit Lead for the Directorate. These audits do not need to be registered with the Medical Director's Support Tea. If the doctor in training requires a certificate to demonstrate that they have completed the audit satisfactorily, this should be provided by their consultant or the Audit Lead for the Directorate.

Status: Issue 1.1 (review date extended to April 2024)   Issue date: 11 April 2019
Approved by: Clinical Standards and Policy Group   Review by date: 11 April 2024

11/15   209/342

Aneurin Bevan University Health Board   ABUHB/Clinical/0901
Title: Clinical Audit Policy
Owner: Assistant Director for Quality and Patient Safety

7.   Conduct of Clinical Audit

7.1 Distinguishing Between Clinical Audit, Data Collection and Research

Clinical audit and research have complementary roles to play in ensuring clinical effectiveness. However, there is sometimes some confusion as to the distinction between the two activities.

Most commonly the difference is described in terms of research determining the right thing to do and that the role of audit is to determine whether the right thing is actually done *(Smith, R, 1992, Audit and research – BMJ 305: 905-906).* The purpose of research has also been described as 'to add to a general body of scientific knowledge which has universal application', and the purpose of clinical audit as 'to enable practitioners to monitor and improve practice in specific situations' *(Closs SJ, Cheater FM, 1996, Audit or research – what is the difference? Journal of Clinical Nursing 5: 249-256).*

If a project is deemed as research then it should be progressed in accordance with the Research and Development Policy.
Collection of baseline data will not normally be classified as 'clinical audit'. However, such exercises will be regarded as part of the clinical audit process if the aim is not just to define standards but to follow on with a full clinical audit cycle including re-audit.

7.2 Good Practice

The Health Board encourages all staff to develop and design clinical audits that are multidisciplinary and that are undertaken across the whole ABUHB service, rather in one site. Partnership working with other local and regional organisations is also encouraged where improvements to the patient journey may be identified through shared clinical audit activity.

Patients and carers view the quality of care differently to healthcare professionals and provide a unique perspective based on their personal experience. Involvement in the focus of clinical audits and in the development and design of clinical audits is therefore encouraged.

7.3 Use of standards (or criteria) in clinical audit

Audit standards are formal statements about how patients or service users should be managed or services delivered. They define the aspects of care to be measured in order to find out whether what is being carried out is correct. Standards may already exist locally or nationally in the form of guidelines or protocols. National standards are available for certain treatments and conditions in the form of NICE or Royal College /

Status: Issue 1.1 (review date extended to April 2024)   Issue date: 11 April 2019
Approved by: Clinical Standards and Policy Group   Review by date: 11 April 2024

12/15   210/342

Aneurin Bevan University Health Board   ABUHB/Clinical/0901
Title: Clinical Audit Policy
Owner: Assistant Director for Quality and Patient Safety

professional body guidelines and are also incorporated into large-scale service delivery documents such as the National Service Frameworks.

If there are no recognised standards available from these sources, audit specific standards need to be developed working with the Clinical Audit Lead. The standards should relate to the audit objectives and should always be based on the best available, most up-to-date evidence of what constitutes best practice. A literature search will need to be undertaken to identify relevant evidence from which to develop the standards.

7.4 Reporting and Dissemination

Once an audit is completed an audit report must be written detailing what was done, the findings, any recommendations and action plans. A successful audit in one area may be transferable to other parts of the organisation, and so it is recommended that the Directorate should maintain a database of their audits so that they can be used by other areas as a basis for an audit there.

Once a round of data collection has been completed and the data has been analysed, the results should be presented at specialty governance/audit meetings where the findings should be discussed, action plans agreed and a commitment to re-audit made in a designated timeframe.

7.5 Action plans for improvement

One mechanism for the Health Board to improve its services and clinical care is by developing and implementing action plans in response to the clinical audit results. Action plans should be specific, measurable, achievable, realistic and timely (SMART). They must have clear implementation timescales with identified leads for each action. Action plans should also have been approved by the relevant head of service or lead manager.

Not all clinical audits will require an action plan e.g. where an audit shows that standards are being met or guidance followed. For such audits there should be an explicit statement saying 'no further action required' in the audit summary report and a reason given for no re-audit.

The relevant divisional governance/audit groups will monitor the implementation of actions, ensuring that any identified changes are incorporated into relevant business plans as appropriate.

Status: Issue 1.1 (review date extended to April 2024)   Issue date: 11 April 2019
Approved by: Clinical Standards and Policy Group   Review by date: 11 April 2024

13/15   211/342

7.6 Re-Audit

It is important to ensure that the audit cycle is completed. The Directorate should ensure that re-audits are planned as part of their audit plans, allowing enough time for changes to be implemented.

8.   Information Governance

Collection, storage and retention of data and Confidentiality and Ethics

All clinical audits must adhere to NHS Information Governance policies and standards. Audits should pay special attention to the Data Protection Act (1998) and the Caldicott Principles (1997). This means that data should be:

- adequate, relevant and not excessive
- accurate
- processed for limited purposes
- held securely
- not kept for longer than is necessary.

9. Training

Clinical Professionals receive training on the audit methodology as part of their professional education. Where this is not the case, guidance on completing a clinical audit is available on the ABUHB intranet site. Support and advice for individuals undertaking an audit can be provided by the members of the MDST.

10. Health and Care Standards

This policy supports the implementation of standard 3.3. which requires healthcare organisations to have a cycle of continuous quality improvement that includes clinical audit.

11. Review

This policy will be reviewed in 3 years or earlier if there is a significant change in guidance or the Welsh Government approach to Clinical Audit.

Status: Issue 1.1 (review date extended to April 2024)   Issue date: 11 April 2019
Approved by: Clinical Standards and Policy Group   Review by date: 11 April 2024

14/15   212/342

Clinical audit: 10 simple rules for NHS boards

1. Use clinical audit as a tool in strategic management as part of the broader quality improvement programme; obtain assurance that the strategy for clinical audit is aligned to broader interests and targets that the board needs to address
2. Consider the full range of quality improvement tools and choose clinical audit if its methodology is best suited to assess the issue at hand and develop an improvement plan
3. A clinical audit strategy must include a combination of national and local priorities with sufficient resources to complete the cycle for each element of the programme
4. Agree on the timescale and resources required for each clinical audit activity upfront but have a process in place to deal with variations and additional requirements
5. Operate a rolling clinical audit programme that covers the different stages of individual projects on a continuous basis focused on outcome improvements for each area
6. Ensure the professionalism of clinical audit by agreeing what constitutes unacceptable variation in clinical audit results compared to evidence based standards, outcomes at similar organisations, or with standards developed within the organisation where national guidelines are not available
7. Ensure with others that clinical audit crosses care boundaries and encompasses the whole patient pathway
8. Develop a clear strategy to ensure patient and stakeholder engagement at the different stages of the clinical audit cycle, make clinical audit reports patient-friendly and publicly available, and disseminate summaries of results to stakeholders and patients in a variety of ways
9. Share clinical audit results with other providers, commissioners, regional clinical networks and local patient networks. Publish outcome statistics and evaluations
10. Provide sufficient education and training in clinical audit beyond the clinical audit team, and use junior doctor clinical audit and quality improvement projects as a valuable resource

Appendices:

1. national-clinical-audit-and-outcome-review-plan-2018-19 2. www.hqip.org.uk

Status: Issue 1.1 (review date extended to April 2024)   Issue date: 11 April 2019
Approved by: Clinical Standards and Policy Group   Review by date: 11 April 2024

15/15   213/342

Aneurin Bevan University Health Board

Clinical Audit Strategy 2022-2025

Contents:

Aneurin Bevan University Health Board
Title: Clinical Audit Strategy 2022 - 2025
Owner: Patient Safety & Quality Department

ABHB/Clinical/1092

1. Introduction/Overview

Looking forward to our future - Our Strategic Direction: 2022-25 sets out the vision for clinical audit for the Health Board. The vision is to be recognised as the best healthcare provider in our class, consistently performing within the top 10% nationally. The mission is to safeguard the health and well-being of the population we serve and to abide by our Health Board values.

The values we aim to show are:

Clinical audit is one tool in the wider quality improvement strategy aimed at providing assurance of delivery best practice. This strategy sets out the principles of when clinical audit should be used and will clarify how the development of the clinical audit plan can be achieved, placing patients first. The application of the strategic direction to clinical audit is described in this strategy, contributing to the range of quality improvement activities and governance arrangements of the Health Board.

What is Clinical Audit?
The National Institute for Health and Clinical Excellence (NICE) describe clinical audit as:

> "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery" (NICE 2002)

2. Statement

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

When conducted in accordance with best practice standards, clinical audit:

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

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

3. Aims/Purpose

- This strategy sets out the Health Boards commitment to quality and effectiveness through the application of clinical audit to support delivery of: High quality, patient safety, patient experience and clinical effectiveness.
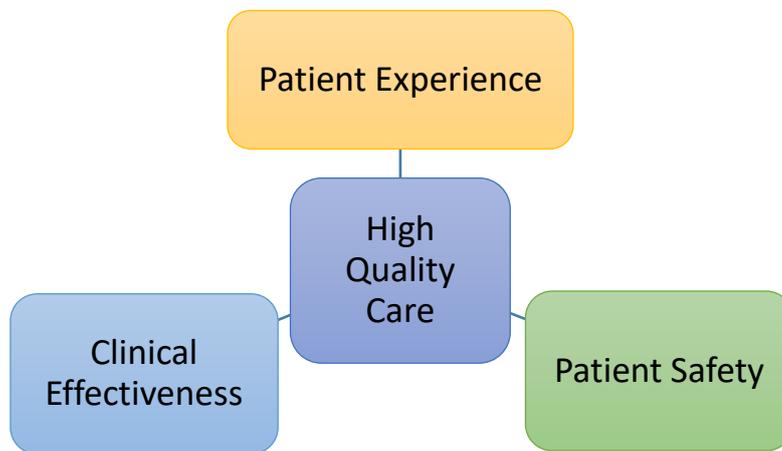
- Cost-effective clinical services to ensure that care is both sustainable and effective
- National Audit engagement at a local level.
- The Trust Quality Account as part of the Trust Annual Report.
- Compliance to regulatory requirements from NHS Improvement and the Care Quality Commission.
- Reports on the compliance with clinical standards that can be used for assurance.

Status: Issue 1   Issue date: 06 October 2022
Approved by: Clinical Standards & Policy Group   Review by date: 05 October 2025
Page **4** of **12**

- Quality improvement as part of the national and local Commissioning for Quality and Innovation (CQUIN) targets and local Clinical Commissioning Group initiatives.
- Quality improvement projects and local audits that are aligned to the Trusts priorities for improving care.
- Demonstrable NICE compliance and best practice evidence implementation.

4. Objectives

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

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

5. Scope

Our strategy is relevant to:

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

6. Roles and Responsibilities

Responsibility for the implementation of this strategy is with the Divisional Triumvirate, Clinical Leads and Clinical Directors and presented to the Clinical Standards Effectives Group.

Status: Issue 1   Issue date: 06 October 2022
Approved by: Clinical Standards & Policy Group   Review by date: 05 October 2025
Page **5** of **12**

5/12   218/342

7. Main Body

Priority 1
There is scrutiny of national clinical audit performance with robust development and monitoring of improvement plans

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

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

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

Priority 2
Divisions will identify clinical audits that allow scrutiny and assurance associated with quality and safety risk

Quality is the endeavour of continuously, reliably, and sustainably meeting customer, patient, or service user needs. This definition places quality at the centre of the health service and as the organisational strategy, not merely a component of the strategy. The Duty of Quality

applies to all health service functions in Wales and applies to both clinical and non-clinical functions and the people that deliver those functions.

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

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

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

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

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

Priority 3
Trainees are supported to participate in meaningful clinical audits that support clinical governance

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

Aneurin Bevan University Health Board
Title: Clinical Audit Strategy 2022 - 2025
Owner: Patient Safety & Quality Department

ABHB/Clinical/1092

that were necessary action plans are developed to support the requisite improvements.

Trainees should be supported to undertake meaningful clinical audits that support quality and safety priorities and participate in the resulting quality improvement.

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

Priority 4
Groups and Committees across the Health Board will commission clinical audit to support effective assurance as required.

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

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

The groups ultimately report to the Patient Quality Safety and Outcomes Committee, a sub-committee of the Board.

Status: Issue 1
Approved by: Clinical Standards & Policy Group
Page **8** of **12**

Issue date: 06 October 2022
Review by date: 05 October 2025

8/12

221/342

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

➢ Quality Planning – the Health Board priorities and plans for the delivery of high quality and safe services

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

➢ Quality Control – The processes in place to ensure that the care being delivered
  o Every group that forms part of the quality assurance framework will review the evidence available to support its function in overseeing the quality-of-care provision
  o Consideration will be given to implementing clinical audit where no existing evidence is available
  o Clinical audit should be considered to provide evidence of improvements here required.
  o Clinical audit will be implemented to meet mandated national requirements e.g., DNACPR audits

8. Resources

Welsh Health Boards and Trusts are required to ensure sufficient resources are available to undertake participation in all audits, reviews, and national registries. Undertaking Clinical audit is mandatory and should be incorporated into existing job plans.

9. Training

Training on how to use AMaT will be conducted by the Corporate QPS team. This will involve training sessions that will be delivered virtually by AMaT and organised by the QPS team. The following training plan will be implemented throughout ABUHB.

Status: Issue 1   Issue date: 06 October 2022
Approved by: Clinical Standards & Policy Group   Review by date: 05 October 2025
Page **9** of **12**

9/12   222/342

Recommendation	Action	Responsible group / Individual	Completion Date
Priority 1	All Clinical Directors, Directorate and Divisional Management Teams, Senior Nurses, Clinical Governance and Quality and Safety Leads will register with AMaT	Divisional Triumvirates	July 2022
	All national audit reports and local data will be disseminated to the Divisions using AMaT	Quality and Patient Safety Team	July 2022
	National audit action plans developed to address requisite improvements will be saved, monitored on AMaT	Divisional Triumvirates	August 2022
	All audits and Improvement plans will be presented at the Clinical Standards and Effectiveness Group	Divisional Triumvirate and Clinical audit lead	September 2022
Priority 2	Divisions will register two local clinical audits on AMaT that address a current Divisional quality and safety priority	Divisional Triumvirates	July 2022
	Implement the two registered audits and record the results on AMaT and present the outcomes of these	Divisional Triumvirates	August 2022

Status: Issue 1   Issue date: 06 October 2022
Approved by: Clinical Standards & Policy Group   Review by date: 05 October 2025
Page **10** of **12**

10/12   223/342

	audits at a Divisional Quality and Patient Safety meeting		
	Present overview of local audit activity in Clinical Standards and Effectiveness Groups	Divisional Triumvirates	September 2022
Priority 3	Provide each cohort of Medical Trainees with registration and training information for AMaT	Medical Education	August 2022
	All clinical supervisors to register with AMaT	Divisional Triumvirates	July 2022
	All clinical audits undertaken by medical trainees to be registered on AMaT and results to be uploaded to AMaT	Directorate Management Teams	From August 2022
	All clinical audits completed by medical trainees to be presented at a clinical audit meeting or quality and patient safety meetings	Directorate Management teams	From August 2022
	All medical Trainees to be issued with a certificate to evidence their involvement in the clinical audit	Directorate Management teams	August 2022
Priority 4	All groups and committees that form part of the ABUHB Quality Assurance Framework should review the evidence available to them to identify gaps in assurance and consider commissioning clinical audits to address these gaps.	Chairs of ABUHB groups and Committees	October 2022

Status: Issue 1   Issue date: 06 October 2022
Approved by: Clinical Standards & Policy Group   Review by date: 05 October 2025
Page **11** of **12**

11/12   224/342

Aneurin Bevan University Health Board
Title: Clinical Audit Strategy 2022 - 2025
Owner: Patient Safety & Quality Department

ABHB/Clinical/1092

10. Implementation

Clinical Directorates should ensure that all relevant staff are aware of the Policy, especially those who are involved with Clinical Audit.

There will be standardised approach to reporting audit findings. These will be reported under the headings
- Areas where good practice has been identified
- Areas of where practice requires improvement

- Actions to be taken - using SMART objectives

11. Equality
The policy does not require an Equality Assessment Impact Assessment (EqIA).

Adherence to this policy will identify opportunities to replicate or improve equitable health-care delivery across Aneurin Bevan University Health Board.

12. Audit

This policy will be subject to the formal auditing process to ensure it is fit for purpose, has been implemented effectively and to assess compliance.

13. Review

This policy will be reviewed every three years, or sooner should the author or legal requirements deem it to be relevant or required.

Status: Issue 1
Approved by: Clinical Standards & Policy Group
Page **12** of **12**

Issue date: 06 October 2022
Review by date: 05 October 2025

12/12

225/342

National Clinical Audit Plan 2023

Task	Week Ending	06-Jan-2023	13-Jan-2023	20-Jan-2023	27-Jan-2023	03-Feb-2023	10-Feb-2023	17-Feb-2023	24-Feb-2023	03-Mar-2023	10-Mar-2023	17-Mar-2023	24-Mar-2023	31-Mar-2023	07-Apr-2023	14-Apr-2023	21-Apr-2023	28-Apr-2023	05-May-2023	12-May-2023	19-May-2023	26-May-2023	02-Jun-2023	09-Jun-2023	16-Jun-2023	23-Jun-2023	30-Jun-2023	07-Jul-2023	14-Jul-2023	21-Jul-2023	28-Jul-2023	04-Aug-2023	11-Aug-2023	18-Aug-2023	25-Aug-2023	01-Sep-2023	08-Sep-2023	15-Sep-2023	22-Sep-2023	29-Sep-2023	06-Oct-2023	13-Oct-2023	20-Oct-2023	27-Oct-2023	03-Nov-2023	10-Nov-2023	17-Nov-2023	24-Nov-2023	01-Dec-2023	08-Dec-2023	15-Dec-2023	22-Dec-2023	29-Dec-2023
Clinical Standards Effectiveness Group					X								X										X						X										X									X					
PQSOC							X										X								X					X											X									X		
National Asthma and COPD Audit Programme- Airways Report			X																																																		
Fracture Liaison Service Database (FLDSB) Annual Summary Report			X																																																		
National Prostate Cancer Audit Annual Report			X																																																		
National Oesophago-Gastric Cancer Audit Annual Report			X																																																		
National Bowel Cancer Audit Annual Report			X																																																		
National Diabetes Audit Core: Complications and Mortality Report							X																																														
National Emergency Laparotomy Audit Annual report							X																																														
National Lung Cancer Annual Report																X																																					
Falls & Fragility Fracture Audit Annual Report (Wales only)											X																																										
Paediatric Intensive Care Audit Annual Report											X																																										
Mental Health CORP Annual Report											X																																										
National Paedatric Diabetes Audit Core Report											X																																										
Cardiovascular Disease Prevention Audit Annual Report											X																																										
NDA Core Annual Report - Care Processes and Treatment Targets																										X																											
National Diabetes Audit Diabetes Prevention Programme (DPP) Annual Report																										X																											
National Care at the End of Life Audit Annual Report																												X																									
National Diabetes Audit Type 1 State of the Nation report (Y1) 2021-2022																												X																									
National Diabetes Audit Young Type 2 State of the Nation report (Y1)																												X																									
National Paediatric Diabetes Audit Admissions report																												X																									

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	07 February 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:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety Joanne Stimpson – Clinical Audit Lead

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 local data against the report recommendations, ensuring alignment to services, detailing Health Board results using SMART goals.

Cefndir / Background

Clinical Standards Effectiveness Group (CSEG) is held bi-monthly, the last meeting was held November 2022. The reports published for inclusion in the meeting were:
- National Audit for Percutaneous Coronary Intervention (NAPCI) 2022 Summary Report
- National Maternity & Perinatal Audit – Clinical report 2022
- National Clinical Audit of Psychosis - National report for Wales - Early Intervention in Psychosis Audit
- Myocardial Infarction National Audit Project (MINAP) 2020-2021

The January 2023 CSEG meeting will include presentations from:
- National Hip Fracture Database (NHFD) annual report
- National Early Inflammatory Arthritis Audit (NEIAA)
- National Vascular Audit (NVA)
- National Diabetes Audit (Care Processes and Treatment Targets)
- New Procedure Policy request: Orbital atherectomy
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reviews, encompassing: testicular torsion study, transition from child to adult health services, Crohn's disease, epilepsy hospital attendance, community acquired pneumonia hospital attendance.

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 production of audit action plans by directorates for approval at CSEG.

Asesiad / Assessment

Additional information can be found in the attached CSEG meeting notes

National Audit for Percutaneous Coronary Intervention (NAPCI) 2022 Summary Report

Report Recommendations
During COVID-19 there was a 70% fall in elective PCI activity during the first wave, with less of a fall for patients being treated for NSTEMI (35%). The smallest reduction in activity was for primary PCI to treat STEMI (14%). Day case PCI for elective procedures: we continue to identify wide variation in practice determined by local logistic issues and not patient characteristics. Use of drug eluting stents instead of bare metal stents: almost all Hospitals perform well, with a high proportion of drug eluting stent use across all clinical syndromes.

Key points:
PCI activity has increased in Aneurin Bevan University Health Board after Cardiology Services were centralised at GUH. Elective PCI cases are gradually increasing in Aneurin Bevan University Health Board following the peaks of the Covid pandemic. Left main PCI cases have good outcomes when compared with national and worldwide benchmarks. The proportion of Intravascular Ultrasound (IVUS) use in left main PCI cases is at 89% which follows the British Cardiovascular Intervention Society (BCIS) Guidelines.

The majority of day case PCI patients are discharged the same day. Drug eluting stents are universally used in all stenting cases. Data capture remains incomplete leading to inaccurate representation of Aneurin Bevan University Health Board PCI practice. Compliance has improved with the appointment of Cardiology PACS Manager and regular submission of data to NICOR. Aneurin Bevan University Health Board PCI services comply with national guidelines in delivering a safe and effective PCI service. Data report is 2020/2021 and Aneurin Bevan University Health Board outcomes have improved since this data capture.

Actions:
- Internal audits required to review operator compliance.
- Work in progress to have Primary PCI delivered to Aneurin Bevan University Health Board patients in GUH.
- In the process of recruiting scrub nurses' staff, radiographers, Cardiac Physiologists and ANP's.
- Plan to appoint consultant.

National Maternity & Perinatal Audit – Clinical report 2022 based on data from 2018/2019

Report Recommendations:
There was improved availability and quality of information regarding interventions. There is a need to offer episiotomy following instrumental birth. Reviewing cases for post-natal admissions. Epidural/spinal GA / analgesia should be separated for data collection. A request to review meaningful data such as skin to skin.

Key points:
Using Apgar <7/ Post-Partum Haemorrhage rates and readmission rates comparable with other Health Board's. There is a higher rate of spontaneous vaginal births and lower rate of caesarean and instrumental birth. Obstetric anal sphincter injury rates compare favourably (use of OASI trial) now on Part 2 of the trial. There is a lack of data for birth without intervention and higher rates of birth weight <10th centile.

Actions:
- BRAN - Benefits, Risks, Alternatives, do Nothing used in Aneurin Bevan University Health Board and expanding antenatal education working with early years framework to put in place.
- Moving to digitalised of maternity health records to improve data capture (delayed) to 2023.

Outcomes:
- Maternity services using the acronym in antenatal care and for communication, working to embed this work in the early year's framework for antenatal education.
- Go live date is aimed for 2nd May 2023.

National Clinical Audit of Psychosis - National report for Wales - Early Intervention in Psychosis Audit

Report Recommendations:

- Screen and intervene – better access.
- Think family – better links with families.
- Equitable access – reaching out to communities possibly experiencing FEP.
- Outcome focused – ARMS – At Risk Mental State, working to prevent people slipping into psychosis, Aneurin Bevan University Health Board does not have the capacity currently to work with people with ARMS.

Key Points:

- Aneurin Bevan University Health Board had higher compliance in 6 out of 8 Total National Standards (TNS) than comparators.
- For 3 standards Aneurin Bevan University Health Board was the highest in Wales
- Aneurin Bevan University Health Board services were higher than comparable English standards in 5 out of the 8 standards despite England having had established EIP longer than Wales.
- In Aneurin Bevan University Health Board every patient is seen within 2 weeks.
- Training Cognitive Behavioural Therapy for Psychosis (CBTp) therapists is quite specialised and currently only one clinician in Wales meets the criteria, however Aneurin Bevan University Health Board is training ALL EIP staff to deliver CBTp.
- The pandemic accounted for a lower than desired Family Intervention outcome at 57% as these are preferred face to face.
- Prescribing of Clozapine – for people who have tried 2 other anti-psychotic drugs with limited success, approx. 20% not offered in Aneurin Bevan University Health Board.
- Employment and education programmes were affected by the pandemic, Aneurin Bevan University Health Board has a full time Occupational Therapist (OT) developing vocational opportunities.
- Physical health screening – previously scored poorly but have hugely improved at 85%, physical health interventions is reactive to the screening at 48%.

Actions/Outcomes:

There is a national steering group which monitors activity and service development of FEP teams across Wales. Aneurin Bevan University Health Board is a part of this group and standards continue to be monitored via this group.

Myocardial Infarction National Audit Project (MINAP) 2020-2021

This reports data period was during the pandemic and the Health Board was without a MINAP Coordinator for some time. Appointment of a new Coordinator has seen an increase in case ascertainment (CA). Previous CA has been 85-100% however due to the issues above, for this period, only 46-58% was achieved. NICOR also had issues with Aneurin Bevan University Health Board data and this should be re-aligned in the next report. This report covers the period of transition from RGH to GUH.

- RGH has 100% compliance for patients seen by a Cardiologist, and patients admitted to a Cardiac Unit/Ward, RGH is the best performing Site across Wales at 92.11%.
- RGH % of NSTEMI patients undergoing angiogram during admission is 89.19% which is below the average for Wales and patient receiving the angiogram with 72 hrs of admission rate for RGH is 57.58%, most hospitals in Wales are not recording enough cases.

- Almost 100% of Aneurin Bevan University Health Board patients are discharged on all secondary prevention medication. Post cardiac event referred to Cardiac Rehab, the pandemic has given an opportunity to reflect on how the service is delivered. There are offers of virtual or face to face service, which has improved the compliance which is 92% take up from 76%.

Key Points:
There was a significant fall in activity reflected in the data as a result of:
- Significant disruption due to COVID-19 in 2020/21 and staff absence.
- Possible confusion NICOR as mid-year switch in hospitals – under ix (J Kerr, NICOR).
- What limited data there is for RGH prior to centralisation on GUH site is reassuring.
- New appointment – of Registered Nurse.
- Directorate planning strategies to improve performance for NST-ACS and BC for repatriation of PPCI (element of) to address delays in transfer patients who present to GUH.

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.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 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
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:	NSTEMI – Non-ST Elevation Myocardial Infarction STEMI – ST Elevation Myocardial Infarction NICOR – National Institution for Cardiovascular Outcomes Research OASI – Obstetric Anal Sphincter Injury FEP – First Episode of Psychosis EIP – Early Intervention Psychosis PPCI – Primary Percutaneous Coronary Intervention
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.

Aneurin Bevan University Health Board

Clinical Standards Effectiveness Group

Minutes of the Meeting of the Clinical Standards Effectiveness Group held on Thursday, 24th November 2022 at 14:00-16:00, via Microsoft Teams

In attendance:
Dr Leo Pinto - Asst Medical Director for Clinical Effectiveness (Chair)
Leeanne Lewis – Asst. Dir. Of Quality & Patient Safety (Vice Chair)
Anita Goff - Lead Nurse H&C Standards, Quality & Patient Safety
Tom Grace - MCA Lead / Head - Deprivation of Liberty Safeguarding
Sarah Cadman - Head of Quality & Improvement, MH&LD
Stephen Edwards – Consultant Anaesthetist, & Deputy Med. Director
Carly Cole – Operations Manager, Scheduled Care

Guests:
Mandyam Roopashree (Observer)
Alla Rybak (Observer)
Shawmendra Bundhoo – Consultant Cardiologist
Jayne Beasley – Interim Head of Midwifery & Gynaecology
Nigel Brown – Consultant Cardiologist

Apologies:
Dr Clifford Jones - Primary Care Clinical Director Division
Caroline Rowlands - Deputy Head of Nursing, QPS and Nurse Education
Patrick Chance - Consultant in Old Age Liaison Psychiatry & Clinical Director
Jonathan Sims - Clinical Director of Pharmacy
Seema Sindhakar – Consultant Anaesthetist
Glenys Mansfield – General Manager, Scheduled Care
Paul Mizen – Clinical Lead, Urgent Care
Emily Knight - Clinical Effectiveness and Formulary Pharmacist
Joanne Stimpson - Quality & Patient Safety Lead for NCA

CSEG 2411/01 Welcome and Introductions
The Chair welcomed everyone to the meeting and emphasised the importance of the Clinical Audit in improving patient care.

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 23rd June 2022

The draft minutes of the meeting held on 15th September 2022 were considered by the group and agreed as an accurate record and outstanding actions discussed. It was highlighted that there was an error in the date of the September meeting, which was held 15th September and not 24th September as documented in the draft notes.

CSEG 2411/02 – National Audit for Percutaneous Coronary Intervention (NAPCI) 2022 Summary Report
Dr Bundhoo presented the PCI activity within ABUHB, which is captured in a into a software dataset by the consultant carrying out the procedure with assistance from any registrars available. James Stevens ensures the quality of the data entered and submitted to NICOR. Dr Bundhoo highlighted the Key Messages from the report:
- The effect on activity from COVID-19 – this was also affected by the move from RGH to GUH, also causing discrepancies were NHH patients going to Cardiff and RGH patients receiving NSTEMI in RGH
- Use of Intracoronary Imaging (ICI) during PCI
- Variation of Day Case activity
- Usage of drug eluting stents opposed to bare metal stents

Key Message 1 - Dr Bundhoo stated that ABUHB does not provide a 24/7 Primary PCI service and all patients are referred to University Hospital of Wales (UHW) and self-presenting patients to GUH can be offered a Primary PCI between the hours of 08:30 & 17:00 Mon-Fri and 09:00 & 13:00 on Saturdays. The number of patients admitted to ABUHB has increased since the setup of Cardiology services in GUH. Presented were the figures of ratio of IP v OP over recent years which showed 2019/20 just under 400 and roughly 50/50, with 2020/21 over 400 however with roughly 85% OP activity and an increase of over 700 patients in 2021/22 with approx. 80% OP activity.

PCI for inpatients and outpatients
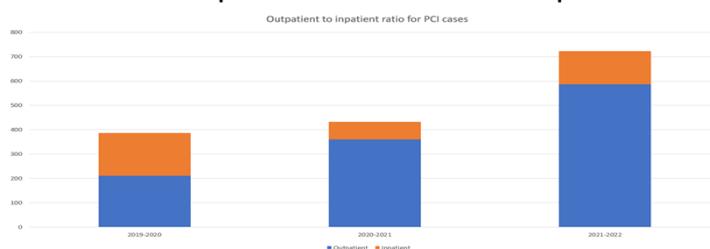
Current guidelines state -

'All patients admitted with a suspected ACS who are suitable to undergo coronary angiography should be considered for angiography +/- Percutaneous Coronary Intervention within 72 hours if there are no justifiable delays'

However, many patients will have 'justifiable' delays in their pathway due to other medical issues. ACS patients undergoing Coronary Angiography without justifiable delays treated within 72 hrs, previously in RGH were at approx. 84% compared to the National Average (NA) of 61% and during the pandemic and after the transition to GUH due to less IP admissions therefore bed availability improved there was an increased to just over 91% and more recently Sep 20 – Nov 21 reduced back to approx. 85% although double the number of cases.

ACS patients undergoing coronary angiography without any justifiable delays

Percentage of patients undergoing index angiography without justifiable delays
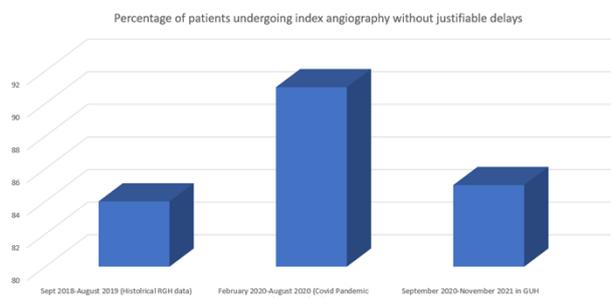
Mean days from admission to Cath Lab referral, from Cath Lab referral to Angio/PCI approx. 2 days, reducing during the pandemic and mean days from Angio/PCI to discharge fell during the pandemic due to reduced admissions, however, has increase from 3.3 to 4.4 due to more complex cases with multiple stage procedures before discharge.

Key Message 2 - The use of ICI during PCI of the unprotected LMS was affected by the drive for not performing open heart surgery however complex the case, and UHW Surgical Dept. had a large outbreak of C-19 followed by the entire service moving to University Hospital of Llandough (UHL) causing delays for patients requiring revascularisation and increasing the numbers Left Main Angioplasty to be carried out and it is recommended that patients should undergo an intracoronary imaging with the intravascular ultrasound or there's another modality called optical coherence tomography to ensure that the stent is well apposed, however complexities with the dataset (protected/unprotected left main) requirements show ABUHB is unfairly underperforming and dissecting our data shows that we were 89% (26/29 cases) using Intravascular Ultrasound (IVUS) performing about the NICOR and British Cardiac Intervention Society target of 75%. A peer review journal published in August showed ABUHB with very good outcomes compared to the national and the worldwide benchmarks in terms of the outcome and Dr Bundhoo was one of the paper authors.

Key message 3 – variation of day case elective activity is compromised due the data capture and further analysis proves ABUHB is performing at 89%. When patients are not discharged same day often this is due to a change in processes where the patient used to come back in time for a stent however now these are admitted for stent next day.

Key Message 4 – Drug eluting stents have been used in ABUHB since 2015

LL asked if the service could support the addition activity and is there expectations of this rising further. Dr Bundhoo stated that the 2 Cath labs can support the number of cases however, staff losses has impacted the department so there is a need to recruit into those posts and figures have dropped to 85% which remains above the national average and the waiting time as remained approx. 2 days compared to other areas at 11 days. There are also plans to appoint another Consultant Interventional Cardiologist in the next 12 months and increasing the times of the Saturday lists by 2 hours.

SE asked if the NICOR data showed longer term outcomes, SB stated that there is feedback for NICOR, no flags due to no risk of outlier status.

Key points:
- PCI activity has increased in ABUHB after Cardiology Services were centralised at GUH
- Elective PCI cases are gradually increasing in ABUHB following the peaks of the Covid pandemic
- Left main PCI cases have good outcomes when compared with national and worldwide benchmarks
- The proportion of IVUS use in left main PCI cases is at 89% which follows the BCIS Guidelines
- Majority of day case PCI patients are discharged the same day
- Drug eluting stents are universally used in all stenting cases
- Data capture remains incomplete leading to inaccurate representation of ABUHB PCI practice.
- Compliance has improved with the appointment of Cardiology PACS Manager and regular submission of data to NICOR
- ABUHB PCI services comply with national guidelines in delivering a safe and effective PCI service
- Data report is 2020/2021 and ABUHB outcomes have improved since this data capture

Actions:

- Internal audits required to review operator compliance
- Work in progress to have Primary PCI delivered to ABUHB patients in GUH
- In the process of recruiting scrub nurses' staff, radiographers, Cardiac Physiologists and ANP's
- Plan to appoint consultant

CSEG 2411/03 – National Maternity & Perinatal Audit – Clinical report 2022

Jayne Beasley presented the above audit report, the 4th report based on data from 2018/2019 which reports on 97% eligible births in Wales (88% - England). Key findings for Wales were that there is lower rate of births for ladies over the age of 40 however Wales had a higher rate of BMI>30. Wales has better rates of ladies with pre-existing hypertension diabetes and a lower rate of babies born between 27/40 & 41+6/40. Wales rates for Small for Gestational Age (SGA) is higher than England and Wales have more babies born to mothers who smoke with a lesser rate of smoking cessation.

Wales has a higher rate of unassisted vaginal births, however Emergency and Elective Caesarean Section (EL/CS, EM/CS) births are on par with England, however Wales have a lesser rate of Vaginal Births after CS (VBAC) and a higher rate of those are successful VBAC. Wales rate of assisted births is less than England as is Induction of Labour rates (IOL) & Episiotomy Assisted Birth and Unassisted, and 0.1% less 3- & 4-degree tears in Wales compared to England.

Postnatal readmission rates are higher in Wales and have significantly less breast milk at birth rates and the Apgar >7 at 5 minutes (babies requiring assistance) is higher in Wales.

The presentation showed ABUHB is comparable to other Welsh HB's in all these indicators apart from 'Birth without intervention definition 2' which only provides data for HDUHB and is suspected to be a data capture issue across other HB's. The same data was presented showing NHH and RGH and has since become one unit.

ABUHB Clinical Summary report:
- Majority of women birthed between 37-41+6/40
- 12.3% Instrumental birth, 27.6% Caesarean section (old data and CS rates currently around 33% comparable to other HB's
- 24.6% vaginal birth had episiotomy
- 33.5% women had Induction of Labour
- 61% who opted for VBAC were successful
- OASI rates 3.1%
- Post-natal readmission higher following Caesarean birth
- 50% SGA babies born after due date
- Data completeness issues :- anaesthesia/augmentation/BMI/ethnicity/comorbidities

LP asked in the CS rate has now improved as a single site. JB stated that the rate has increased but this is the case across Wales. HM asked about how ABUHB compare with other HB's regarding breast feeding rates. JB voiced concerns around the accuracy of the data which shows ABUHB approx. 60% with Powys being the best performing HB in Wales.

LL asked when the next more updated report is due to compares across Wales and could our services have improved as expected and do we have assurance of

the data. JB stated that the reports are always out of date and would like and All Wales digital platform which is some time away.

Recommendations:

- Improved Availability & quality of information regarding interventions
- Offer episiotomy for instrumental birth
- Review case of PN readmission
- Data Reviews for completeness, user feedback to support
- Epidural/spinal GA / analgesia should be separate for data collection
- National maternity data set with pre-existing conditions
- Review meaningful data such as skin to skin

Key points:

- Apgar <7/ Post-Partum Haemorrhage rates and readmission rates comparable with other HB's
- Higher rates of spontaneous vaginal births
- Lower IOL rates - difference in local data approx. 25% NMPA possibly removed elective cases
- Lower rate of caesarean and instrumental birth
- Obstetric Anal Sphincter Injury rates compare favourably (use of OASI trial) now on Part 2 of the trial
- Lack of data for birth without intervention
- Higher rates of Birth weight <10th centile

Actions:

- BRAN - Benefits, Risks, Alternatives, do Nothing used in ABUHB and expanding antenatal education working with early years framework to put in place
- Moving to digitalised of maternity health records to improve data capture (delayed) to 2023

CSEG 2411/04 – National Clinical Audit of Psychosis - National report for Wales - Early Intervention in Psychosis Audit
Sarah Cadman presented to the group NCAP EIP Annual report 2021/2022.
- Aims to improve the quality of care that NHS MH Trusts in England and HBs in Wales provide to people with psychosis
- 5-year programme until July 2022
- Spotlight on Early Intervention in Psychosis (EIP) teams in Wales – specialised services that aim to provide prompt assessment and evidence-based treatment to people with First Episode Psychosis (FEP)
- Standards based on EIP Access & Waiting Time Standard guidance which details NICE recommended management and treatment

The findings of this audit report need to be interpreted in context of the COVID-19 pandemic which has severely impacted the functioning of the health sector over the last two years.

SC stated that ABUHB are leading the way in this service across Wales. 100 case notes for under the age of 65 and receiving FEP and open to Children and young people, were looked at by NCAP.
This audit focused on the employment status of the patients selected. In Wales, 85% had their employment status documented and 8% were in paid employment. 63% were unemployed and seeking work leaving 7% did not want to work or seek education/training to support obtaining employment. Of the people employed and seeking work, 43% were offered employment support and 2% were specifically offered individual placement and support (IPS).
SC showed the trends over the last 4 years of the 8 standards which mostly showed a gradual increase. ABUHB had higher compliance in 6 out of 8 on the standards compared to Total National Standards (TNS) and 5 out of 8 were higher than the English TNS and highest in Wales in 3 standards. England has had established EIP services far longer than Wales.

The standards are (NICE QS 80 & QS 102)
ABUHB results are: **ABUHB = ORG03**
1. Timely Access – seen within 2 weeks of referral – 21% compliance achieved (ABUHB believe this should be 100% as everyone is seen within 2 weeks of referral)
2. Cognitive behavioural therapy for Psychosis (CBTp) - at least one session of a course delivered by a person with the relevant skills, experience and competencies – ABUHB 60% - the NICE Stds are very specific about the required skills and currently only one clinician in Wales meets this. ABUHB are training all EIP staff to deliver CBTp-informed interventions

People with FEP should take up cognitive behavioural therapy for psychosis (CBTp) (NICE QS80, NICE QS102). To meet this standard people had to receive at least one session of a course of CBTp delivered by a person with the relevant skills, experience and competencies.
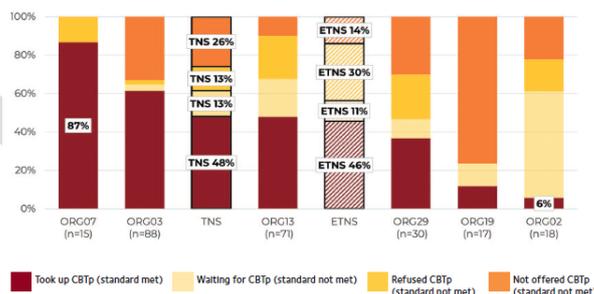
3. Family Intervention (FI) – 57% compliance achieved. This was impacted by the pandemic as FI is usually a face-to-face intervention.

People with FEP and their families should take up FI (NICE QS80, NICE QS102). To meet this standard people had to have received at least one FI session **delivered by a person with the relevant skills, experience, and competences.**
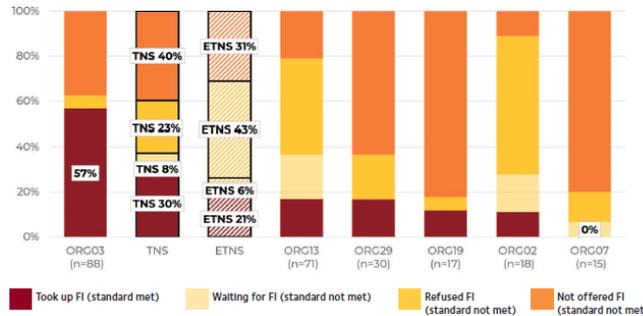

4. Prescribing of Clozapine – for people who have tried 2 other anti-psychotic drugs with limited success. Clozapine is a drug that requires in-patient admission to commence and requires significant monitoring (blood tests) thus isn't acceptable to all people

People with FEP who have not responded adequately to or tolerated treatment with at least two antipsychotic drugs should be offered clozapine (NICE QS80). This analysis was conducted on people who were identified as having had treatment with at least two antipsychotic drugs and not having responded adequately to or tolerated them (n=26).
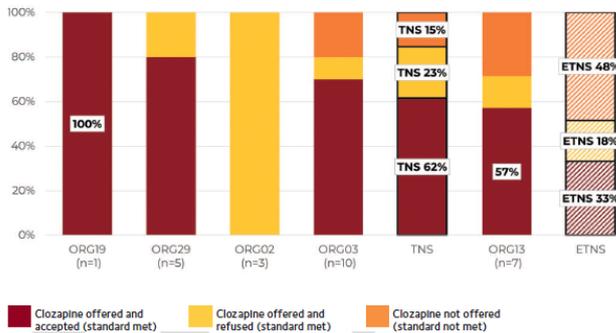
5. Supported employment and education programmes – 36% (affected by the pandemic) There is now a full time OT in post who is developing vocational opportunities within the team

People with FEP should take up supported employment and education programmes (NICE QS80, NICE QS102). This analysis was carried out on responses from people who were identified from their casenotes as not being in work, education, or training at the time of their initial assessment (n=140).
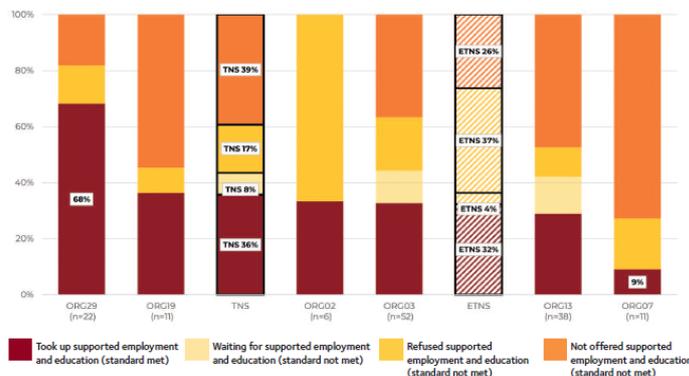
6. Physical health screening – previously scored poorly but have hugely improved at 85%

People should receive a physical health review annually which includes smoking status; alcohol intake; substance misuse; BMI; blood pressure; glucose and cholesterol (NICE QS80, NICE QS102). To meet this standard people must have been screened on all seven measures, this includes people who were offered but refused screening[4].
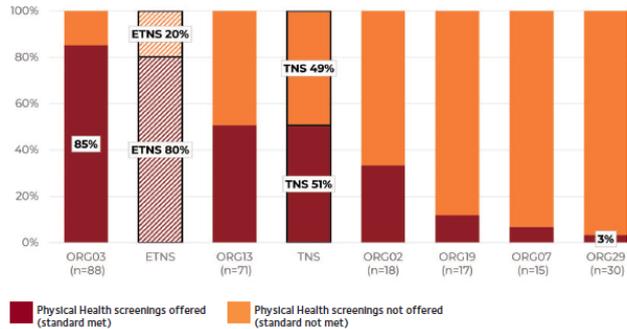

7. Physical health interventions – reacting to health screening, 48%

People must have been offered all relevant interventions where screening indicated a risk level requiring intervention, within the last 12 months (Lester UK Adaption Tool, Shiers et al., 2014; NICE CG115 and NICE CG120).
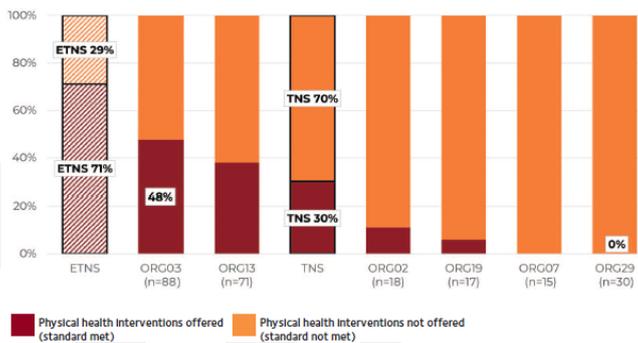
8. Carer-focused education and support programmes – 35% - again, this was affected by the pandemic

Carers should take up carer-focused education and support programmes (CESP) (NICE QS80, NICE QS102). This analysis was carried out on all people in the sample who had an identified carer (n=202).
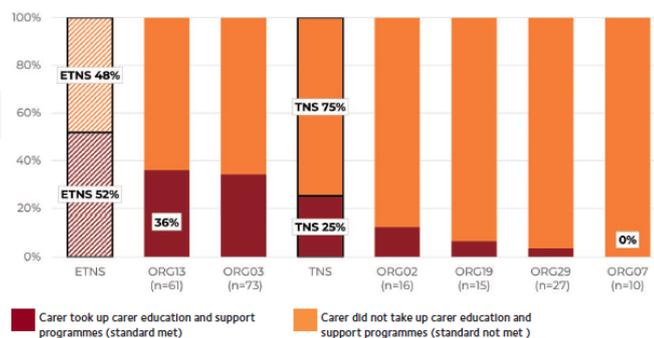
Also used are outcome measures, our team use 'Dialog' of about 15 questions and positive and negative symptoms experience. ABUHB scoring better than the NA.

NCAP makes 4 recommendations:
1. Screen and intervene – better access
2. Think family – better links with families
3. Equitable access – reaching out to communities possibly experiencing FEP
4. Outcome focused – ARMS – At Risk Mental State, working to prevent people slipping into psychosis, ABUHB does not have the capacity currently to work with people with ARMS

Actions:
 There is a national steering group which monitors activity and service development of FEP teams across Wales. ABUHB is a part of this group and standards continue to be monitored via this group too

CSEG 2411/05 – Myocardial Infarction National Audit Project (MINAP) 2020-2021
Dr Nigel Brown presented the MINAP report and stated there is a caveat to the report as the data was during the pandemic. It must also be noted that there was no MINAP Coordinator in post and this reflects in the case ascertainment. Previously rates for ABUHB were 100% stringent data and 85% non-stringent data and this report shows 58.2% and 46.7%. Recently realised MINAP haven't recorded some of the data and this is trying to be realigned but will take some time.
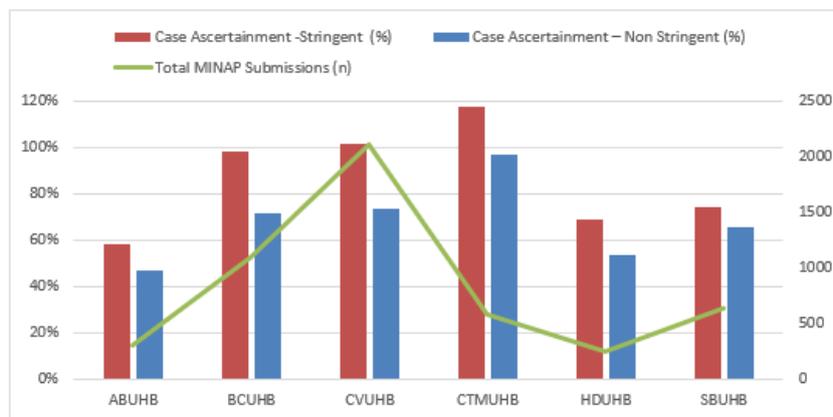

The data is RGH as pre-transition to GUH. % of all NSTEMI patients seen by a Cardiologist was 100% and all NSTEMI admitted to a Cardiac Ward/Unit just above 90%.

Chart: % of all NSTEMI patients seen by cardiologist / % of all NSTEMI patients admitted to cardiac unit/ward
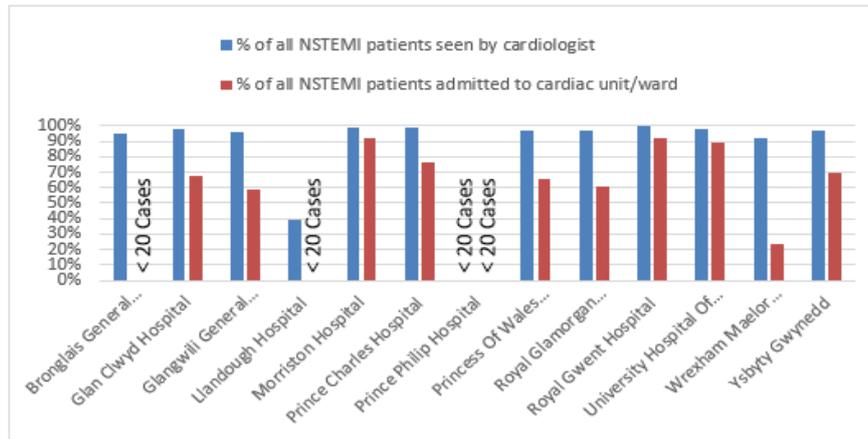
Almost 90% of patients underwent an angiogram and just short of 60% within 72 hrs. NA is 66% and legitimate delays such as other medical issues, must be considered.

Chart: Proportion of NSTEMI patients undergoing angiogram during admission (%) / Proportion of Patients with angiography within 72hrs of admission (%)
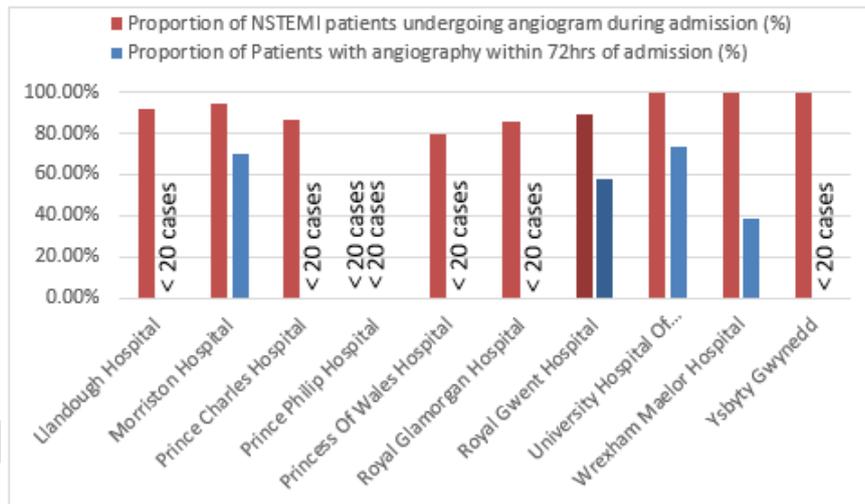
Almost 100% of ABUHB patient are discharged all secondary prevention medication. Post cardiac event referred to Cardiac Rehab, the pandemic has given an opportunity to reflect on how the service is delivered. There are offers of virtual or F2F service, which has improved the compliance which is 92% take up from 76%.

Chart: Proportion of all eligible patients referred (%) / Proportion of all eligible patients referred (%)
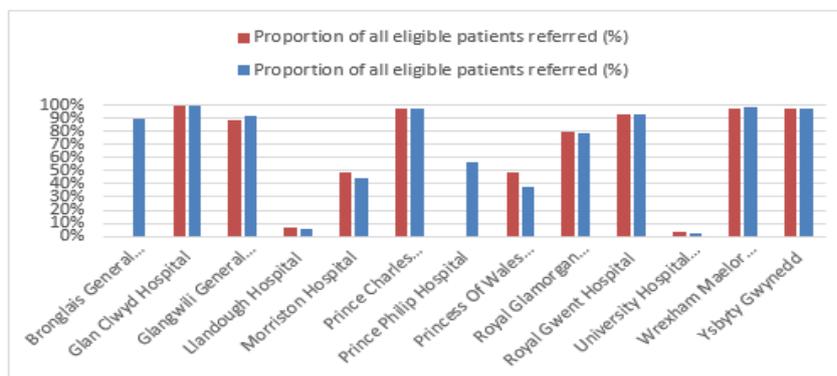
Key Points:
  • Significant fall in activity reflected in the data as a result of:

- Significant disruption due to COVID-19 in 2020/21 and staff absence
- Possible confusion NICOR as mid-year switch in hospitals – under ix (J Kerr, NICOR)
  - What limited data there is for RGH prior to centralisation on GUH site is reassuring
  - New appointment – Louise Croxford, RN (cardiac) – up to date – not an audit that can be done away from the service
  - Directorate planning strategies to improve performance for NST-ACS and BC for repatriation of PPCI (element of) to address delays in transfer patients who present to GUH

LP identified that there is an overlap with PCI and MINAP and is there potential for collaboration. Dr Brown stated that unfortunately not. Dr Brown stated that there is a clinical trial underway that allows for populating MINAP and a secondary database. Angiography is done early in the admission, where MINAP are further down the pathway.

Actions:
No Actions were discussed.

Next meeting Thursday 26th January 2023 @ 14:00 – 16:00

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 February 2023
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health Board Organ Donation report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr James Calvert, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Dr Stephen Edwards, Deputy Medical Director

Pwrpas yr Adroddiad
Purpose of the Report

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

NHS Blood and Transplant (NHSBT) provide the Health Board with a bi-annual report for assurance that potential deceased solid organ donors are identified and appropriate opportunities for organ donation are not missed.

The Aneurin Bevan University Health Board Organ Donation Committee (ODC) has been re-established post-COVID to provide local detailed governance and oversight and has received the latest report on 8th December 2022.

Cefndir / Background

The ODC has been re-established under the chairmanship of Shelley Bosson (Independent Member) to ensure that the Health Board has effective systems and processes to maximise the appropriate opportunities for solid organ donation from patients who have deceased following either Brain Stem Death (BSD) or Donation after Circulatory Death (DCD). There is additionally a programme of corneal harvest from deceased donors.

The Health Board has a Clinical Lead for Organ Donation (CLOD) and an embedded Specialist Nurse for Organ Donation (SNOD) to lead on both the local operational

elements and the promotion and awareness of organ donation amongst professional peers.

NHSBT provides a network of regional and national oversight, and it also provides an on-call system of SNODs who support and attend whenever a potential organ donor is identified. They also provide benchmarking performance data.

Asesiad / Assessment

During the 6 months of the report, there was 1 solid organ donation which resulted in 3 patients receiving a transplant. 1 further donor was consented but did not proceed to donation. This was due to a prolonged time to asystole (cardiac arrest) once withdrawal of life sustaining treatment took place, which made the patient ineligible to donate.

There were no missed referrals for consideration for organ donation in the latest report - a position that has been sustained since 2019. This is a key performance indicator because it has the greatest impact in terms of avoiding missed opportunities for organ donation.

The NHSBT standard is that a SNOD should be present during every organ donation discussion with families, as this has been shown to be effective in increasing consent rates. This occurred in 2 organ donation discussions but there was a third occasion where a SNOD was not present. This case has been reviewed by the Health Board team who felt there were no specific actions to be learnt from this - of note the consent for organ donation was obtained in this particular case without the SNOD accompanying the doctor for the initial approach to the family.

The Health Board performance is therefore currently rated as exceptional (gold) for referral rates and consent rates when compared with UK performance and average (bronze) for SNOD presence at organ donation initial discussion.

Another reported measure is for neurological brain stem death tests to be performed wherever possible in appropriate patients. This was not done for 2 out of 3 potential patients as the clinical team determined that it was not clinically appropriate at the time. These specific cases have been reviewed locally by the Health Board team and discussed with the regional NHSBT team who agree there was a clear explanation to support that decision-making in the context of these particular cases. The ODC agreed to ongoing monitoring of this metric and there is active discussion with NHSBT on the utility of the metric.

It is recognised that the regionalisation of services is changing the numbers of patients being cared for in the Health Board at the time when they may become a candidate for organ donation, and there are discussions with NHSBT to ensure that sufficient resources are sustained across the acute hospital network to respond.

Since the Health Board became an alliance site for tissue donation there has been a significant increase in tissue donation referrals due to a well-established process within Critical Care. Conversion rates to donation remain low (which is

reflective of national benchmarking) and over the 6 month period 2 corneas were donated by Health Board deceased patients to the NHSBT Eye Banks.

Discussions are ongoing to enable timely referral documentation, and to ensure that there are sufficient staff to undertake the tissue harvesting before any further rollout of that programme.

As part of the national process to recognise each occasion when an act of organ donation takes place, the Health Board receives a small sum through NHSBT, which the ODC oversees. It is considering how to best to use this to commemorate organ donors from our community.

The ODC has refreshed its terms of reference, and as part of its work programme is reviewing relevant operational policies.

Argymhelliad / Recommendation

The Committee is asked to note the latest organ donation performance report, which has been reviewed at the Organ Donation Committee, and to note the work programme.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 5. Timely Care Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Dying Well as part of life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Improve patient experience by ensuring services are sensitive to the needs of all and prioritise

	areas where evidence shows take up of services is lower or outcomes are worse
	Choose an item.
	Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	No applicable
Rhestr Termau: Glossary of Terms:	Not applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Organ Donation Committee

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	07 February 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality and Patient Safety Operational Group (QPSOG) Highlight Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr, Executive Director of Therapies and Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	

Pwrpas yr Adroddiad   **Purpose of the Report**
Er Gwybodaeth/For Information

ADRODDIAD SCAA   **SBAR REPORT**
Sefyllfa / Situation   Routine highlight report from the Quality and Patient Safety Operational Group (QPSOG)
Cefndir / Background   From the QPSOG meeting held 18th January 2023
Asesiad / Assessment   **Divisional Risk Registers/Concerns**   The Divisional Quality and Patient Safety Leads were given the opportunity to escalate Divisional risks and concerns related to quality and patient safety.   All Divisions noted the continued risk associated with staff shortages, increased staff sickness absence and the increasing reliance on temporary staff (nursing and medical). Also, whilst nursing vacancies are improving in some areas, higher patient acuity is requiring further staffing. The Executive Directors present reinforced the Executive level support for making staff substantive if action can be taken to reduce spend on locums/agency staff. On a positive note, local recruitment events are taking place and apprenticeships are being offered.

Increased pressure and demand in the urgent care pathway was highlighted, impacting on flow and delays, including pre-hospital and in-hospital delays.

The condition of the Health Board estate was highlighted as an ongoing issue and service risk by a number of Divisions.

All the Divisional risks and concerns raised are included in the Divisional risk registers with information detailing the mitigation action being taken. The QPSOG was assured that the appropriate action is in place at Divisional level to address and mitigate the current risks to ensure the quality and safety of services. No risks were escalated for additional assistance from the QPSOG.

Quality, Patient Safety and Experience Report
A verbal report was presented and comments invited ahead of the formal report being prepared for presentation to the PQSOC meeting in February 2023.

Corporate Health and Safety
The group received an update on key developments related to all functions of corporate health and safety:

The Health Board is maintaining compliance with statutory health and safety requirements.

An HSE inspection of the Pathology contamination level 3 facility at RGH has taken place and recommendations have been received. A task and finish group has been established to take these recommendations forward.

A fall at NHH outpatients resulting in a wrist fracture has been reported to HSE under RIDDOR as per the guidelines. The fall was due to the patient falling over a promotional banner and as a result an alert about positioning and safety of promotional banners has been issued.

An inspection of respiratory protective equipment has taken place and this will be rolled out across all inpatient areas and the results fed into the Health and Safety Committee and the local health and safety forums.

HIW funding has been secured to support the manual handling agenda for this financial year (22/23) and the aim is to increase training provision in the short term.

The fire alarm system at RGH requires repair/replacement. Improvement schemes are being implemented and bids seeking capital investment have been submitted.

The #Bekind campaign to prevent violence and aggression to staff is being run across the Health Board and a review of security arrangements across the sites is underway. A survey is also being sent to staff to gauge feeling.

COVID Investigation
The group received an update on the COVID investigation

External Reviews and Inspections

The group received an update on the unannounced HIW visit to YYF - Anwylfan & Ty Cafanol Wards. 44 recommendations were received and most had been completed. 14 were still ongoing but had been progressed. From a Health Board wide perspective there were several policies which were out of date, including Restricted Interventions, Equality and Diversity and, Environment Ligature Risk. A Seclusion Policy also needs to be developed. We have also been asked to consider our approach to gender segregation and develop principles for mixed sex wards.

Also reported to the group was an announced visit by HIW and CIW to the North Monmouthshire Community Health Team at Maindiff Court. 12 recommendations were received, including the standard of the estate and an action plan will be submitted. Further information about this visit will be shared with the QPSOG in due course.

The actions from the visits will be shared at PQSOC.

Liberty Protection Safeguards

The group received an update on the replacement of the Deprivation of Liberty Safeguards (DoLS). The is still no formal date for implementation and Welsh Government are still reviewing the consultation. The possible implementation date is 2024.

Datix Update
It was reported that the Health Board is still operating two systems (old and new) and there is a need to close down open records from the old system. A target date to close down the old system by 31st March 2023 was agreed. The Health & Safety team has offered support to the Divisions to transition over any outstanding Datix records.

Safe Care Collaborative
The group received an update on the Safe Care Collaborative which is taking place with Improvement Cymru and the Institute for Health Care Improvement. The collaborative will run from March 2022 until March 2024. The collaborative will address the leadership, culture and learning systems in the organisation.

Electronic SBAR/SOP for Internal Patient Transfers
The group received an update on work to develop an electronic SBAR tool to support safer transfer of patients between wards and hospital sites. The group were asked to share views on the tool to support its development and implementation.

Date of the Next QPSOG meeting: 15th March 2023

Argymhelliad / Recommendation

Matters Requiring PQSOC Level Consideration:

- Quality, Patient Safety and Experience Report (scheduled for PQSOC meeting in February 2022)
- Reports and actions plans from HIW visits

The Committee is asked to note the report for information.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	NA
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 3. Effective Care 4. Dignified Care 6. Individual care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Entire IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Divisional QPS assurance data
Rhestr Termau: Glossary of Terms:	CIW – Care Inspectorate Wales COVID - coronavirus disease DATIX - a risk management information system to collect and manage data on adverse events (as well as data on complaints, claims and risk) with the purpose of collecting such data to support learning and improvement DoLS - Deprivation of Liberty Safeguards HIW – Health Inspectorate Wales HSE – Health & Safety Executive QPS – Quality and Patient Safety

	RGH – Royal Gwent Hospital RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations SBAR – Situation, Background, Assessment and Recommendations SOP – Standard Operating Procedure / Protocol YYF – Ysbyty Ystrad Fawr
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	NA

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.

![GIG Cymru NHS Wales / Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board logo]

Highlight Report

Group Name:	**ABUHB Children's Rights & Participation Forum**
Group Aim:	The Forum is led by the Family & Therapy Division on behalf of Aneurin Bevan University Health Board on the area of children's rights and participation. This is the key children's rights and participation forum for Aneurin Bevan University Health Board. The group will inform and drive a children's rights approach, placing the UNCRC at the core of planning and service delivery, influencing the integration of children's rights into every aspect of decision-making, policy and practice.

Date Completed:	07/12/22	**Date of Last Meeting:**	06/12/22

Completed By:	Dr Kavitha Pasunuru (Chair) Sian Thomas Consultant Nurse Child Health Rebecca Stanton, Head of Transformation Programme
Distribution List:	Patient Quality, Safety & Outcomes Committee
Summary:	The usual forum meeting was adapted to a workshop session on this occasion for us to think collaboratively about our priorities moving forward. The meeting took place in person to encourage these conversations and bring the energy and passion of members together. The agenda included: - • Scene setting and the focus of the workshop • Previous action plan and Kite mark

	- Involving young people in the interview process project – update
	- Workshop: setting the new forum priorities

Scene Setting / Action Plan / Kite Mark

Sian Thomas presented the PowerPoint presentation (attached) to document the forum's journey so far, and reflect on learning that we can take forward for our upcoming kite mark application.

Children's Rights & Participat...

Involving Young People in the Recruitment Process

This has been a successful project that has the potential to expand to other areas. Sharing the good practice and process has given other departments the encouragement to think about how they might embed this within their own recruitment processes. This agenda item will be an ongoing item to discuss progress and developments.

Workshop: Setting New Forum Priorities

The group were provided with our previous action plan, and given key questions to reflect on and answer that included;

What are the strengths in our current approach?

Main strengths identified were the number of attendees at the meeting, and people having a passion within this area. Also, the fact that we have a regular meeting to keep up the momentum of this important area of work.

Opportunities to do things differently? How?

Plenty of opportunities identified for the coming year, but examples included; teams sharing regular good practice either through reports into the forum or via a Teams channel so we can capture the activity no matter how big or small. The Teams channel will also encourage practice in between meetings and motivate people to try out ideas. In addition, we discussed looking at the opportunity of a Social Media presence to

promote the work we are undertaking, but most importantly, to engage further with people about how we might do things differently and promote Children's Rights in a way that suits them.

What do you see as our key focus areas moving forward? How do we know when we've achieved them?

Again, plenty of discussion around ideas, but some themes included; increasing the amount of feeding back we do with each other in the forum, devising a communications strategy to explore opportunities through social media, fresh engagement with our Regional Youth Forum, and exploring awareness training around Children's rights that can be shared wider within departments.

How do you envisage your area contributing to these priorities? What support would you need from the forum?

The regular meetings are currently a support, but we discussed having a blended approach moving forward; people appreciated the opportunity to come together face to face and have a workshop style interaction. The Children's Commissioner office are also keen to visit and hear about our plans for the upcoming year.

Another action identified is that we are going to explore options for creation of a charter and sub-groups of the forum that could build on our current activity.

Comment from Chair / Items for Escalation

Develop a Task and Finish Group for the upcoming mapping exercise.

Actions / Next Steps

- Actions as highlighted above through the workshop session.

- Communication and Social Media Strategy with James Hodgson, to be discussed at the next meeting.

- Guidelines re: Involving Young People in recruitment approved by the Clinical Standards & Policy Committee.

- New dates setup for the New Year with additional Task and Finish Groups to address themes identified within the workshop.

- Presentation in Feb (next meeting) from CEO of NYAS around their parent advocacy project.

- Priorities to be transferred to an action plan for the New Year.

Aneurin Bevan University Health Board

Review of Stroke Services

Executive Summary	
This paper provides an update of progress in respect of the ongoing review of stroke services within the Health Board and the proposed service response, informed by a report and recommendations from the national 'Getting it Right First Time' team. An overview is also provided in respect of plans to establish national and regional stroke networks across Wales.	
The Board is asked to:	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	
Executive Sponsor: Peter Carr, Director of Therapies & Health Sciences	
Report Author: David Hanks, Head of Service Planning	
Report Received consideration and supported by:	

Executive Team		Committee of the Board: Finance & Performance Committee	

Date of the Report: January 2023
Supplementary Papers Attached: Appendix 1 – Health Board Stroke Report Appendix 2 – GIRFT Action Plan Appendix 3 – ToR National Stroke Programme Board

Purpose of the Report
To note contents and endorse the proposed actions.

Background and Context
Stroke services are provided in a number of sites across the Health Board, with acute / hyper-acute beds focussed on the Grange University Hospital (GUH) and rehabilitation services provided at Royal Gwent Hospital, Nevill Hall Hospital and Ysbyty Ystrad Fawr. There is a strong and acknowledged evidence base supporting a range of time-sensitive interventions in response to an acute stroke, thereby providing optimal treatment and recovery potential. These include the administration of medications and the delivery of thrombolysis for appropriate cases within a specified time window. Performance

1

management against these interventions was originally developed as 'intelligent targets' 15 years ago, and these have now evolved into the Sentinel Stroke National Audit Programme (SSNAP) which provides a national database into which a wide range of performance data can be entered and monitored.

The Health Board has an established Stroke Delivery Group, chaired by the Executive Director of Therapies & Health Science, which provides a strategic overview and direction for stroke services, monitoring performance and agreeing development actions / interventions as considered appropriate.

The Group has long acknowledged the evidence base for timely treatment and recognises the commitment and dedication shown by the multi-disciplinary team and supporting workforce to provide the highest possible standards of care. However, concerns have grown in recent months that the severe and ongoing pressures within the urgent care system have constituted a significant barrier to the delivery of optimal stroke care, with significant adverse impact on service performance as represented in the SSNAP data for the Health Board. The Group has therefore made clear its intention to address and improve the situation, based on best practice, organisational consensus and a robust action plan.

As part of this intention, the Group - in liaison with other Executive colleagues – agreed in 2022 to commission a review of the service by the national 'Getting It Right First Time' (GIRFT) team. The team have an established track record and reputation following visits to over 100 stroke services across the UK, and the key benefits of the review were considered to be: -

- A comprehensive and objective external review of current service / position
- An assessment of performance against established national benchmark criteria
- An ability to provide innovative solutions and learning
- A series of short- and medium-term recommendations for service improvement

The GIRFT team duly visited the Health Board in May 2022, visiting the sites at GUH, RGH, NHH and YYF. Time was spent with the service teams on each site, with initial verbal feedback / impressions provided on the day and to be followed by a formal report and recommendations.

Assessment and Conclusion
Outline of recommendations
The final report from the GIRFT team was received in September 2022 and is attached as Appendix 1. The report includes a total of 20 short- and medium-term recommendations, from which the key priorities are seen to be as follows: - • Provide supernumerary specialist stroke nurse presence at GUH on a 24/7 basis to ensure ownership and direction of the stroke patient pathway • Enhance pre-hospital notification arrangements to ensure elimination of avoidable delays at the front door • Increase thrombolysis rates to be consistently within agreed national norms • Raise organisational priority for patients gaining access to the acute stroke unit within four hours

2

- Widen range of workforce options / competence to ensure 24/7 ability to perform swallow assessments
- Review rehabilitation / early supported discharge pathway, with emphasis on seven-day access to therapies, (this being considered likely to involve utilising fewer rehabilitation sites in the Health Board)
- Ensure robust arrangements for patient review six months post-discharge
- Support development of clinical leadership for the service

Response and action plan

A number of actions have been or are being undertaken in response to the report as follows: -

- A task & finish group – chaired by the Executive Director of Therapies & Health Science – has been established and is meeting regularly to focus on the response
- The task & finish group has reviewed the recommendations and has developed a short / medium term action plan, with a core theme of enhancing the ability of the service to deliver an optimal patient pathway. A summary narrative and proposed action plan (which continues to be updated to reflect the latest position) is attached as Appendix 2
- Monthly implementation support meetings are ongoing with the GIRFT team clinical leads
- It is intended to take a summary paper with proposals for the development of the service to the Executive Team, with a view to these being incorporated into the Health Board's IMTP and supporting business cases to be brought for consideration as appropriate
- Longer term actions will be overseen by the Stroke Delivery Group over the coming months

Establishment of the National Stroke Programme Board and plans to create National and Regional Stroke Networks

The NHS Wales Health Collaborative Executive Group (NHSWHC CEG) is the responsible governance group for the current Stroke Implementation Group (SIG).

In June 2022 the CEG endorsed the establishment of a National Stroke Programme Board (NSPB), supported by a core programme team within the NHS Wales Health Collaborative. The newly established National Stroke Programme Board (NSPB) met for the first time in October 2022; it will provide oversight of the national stroke programme and will work in partnership with the regional stroke programmes to improve the stroke pathway and develop a programme of work to scope out and develop comprehensive regional stroke centres (CRSCs). A draft Terms of Reference is attached as Appendix 3.

The CEG also endorsed the recommendation that:
1. the planning assumption that four CRSCs and regional Operational Delivery Networks (ODNs) are required and that regional work within the programme should be structured accordingly
2. the National Stroke Programme Board produces a clear and unambiguous case for change demonstrating current outcomes and the expectations for improvement by delivery of the national standards and the new service models that will follow.

The purpose of the National Stroke Programme Board is listed in the Terms of Reference and which, amongst other things, includes developing a full programme business case.

3

The initial meeting in October suggested this was about supporting the establishment of four comprehensive regional stroke centres. At this meeting it was requested (by Peter Carr) that the maturity of stroke services in each region must be assessed to determine future investment and to ensure parity of central resource allocation across Wales, whatever the maturity of each region. In addition, at the meeting it was made clear (by Peter Carr) that investment in the comprehensive regional stroke centres in isolation of the sub-acute stroke rehabilitation pathway would be failure.

Whilst further work is required to determine the scope of the four CRSCs and ODNs across Wales, it has been accepted from the offset that ABUHB will form its own regional ODN with its CRSC already established at the Grange University Hospital, mainly because this regional model/configuration was already consulted on and agreed through previous South Wales regional planning work and because the ABUHB number of strokes for its population meets the accepted threshold for CRSCs.

In establishing a regional ODN for the ABUHB population, the first step will be to appoint a ODN Programme Manager, with funds made available by the National Programme and the post reporting to the Medicine Division. ABUHB will now be required to review its internal governance arrangements for stroke delivery to reflect the establishment of its ODN, and it is proposed that an ABUHB Stroke Operational Delivery Network Board be established, replacing the existing Stroke Delivery Group.

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It is acknowledged that there are significant challenges involved in achieving the above aims, including the availability of investment funds, maintaining the discipline of stroke priorities within a severely pressurised urgent care system and motivating a dedicated but exhausted workforce. However, it is considered that the GIRFT recommendations have delivered important additional strategic momentum to the need to address the current service issues. This, together with the public support for the aims received from both the Delivery Unit and Health Inspectorate Wales now provide a key opportunity to make sustainable improvements to the Health Board's stroke services, to the benefit of many patients over the coming months and years.

Recommendation
The Finance and Performance Committee is asked to: -

1. Note the current position and the progress made to date
2. Note the GIRFT report/recommendations and the proposed response of the Stroke Delivery Group
3. Confirm support for the proposed response and actions, which will include bringing proposals/business cases to the Executive Team for targeted investment where appropriate.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The GIRFT work stream has been largely based on a risk assessment of the adverse impact of wider system pressures on the stroke pathway and the recommendations in this paper are intended to address and mitigate these risks

4

Financial Assessment, including Value for Money	Stroke pathway interventions are fully-evidenced based and it is acknowledged that compliance with these provides an optimal value-based healthcare outcome in terms of system efficiency, length of stay, recovery and clinical outcomes
Quality, Safety and Patient Experience Assessment	The GIRFT initiative places a high priority on enhancing quality standards and the patient experience, and is fully supported by stakeholders / partners such as the Stroke Association and Health Improvement Wales
Equality and Diversity Impact Assessment (including child impact assessment)	It is intended that the improvements in the service generated by implementation of the action plan will give real quality benefits to all stroke patients, regardless of background and protected characteristics
Health and Care Standards	The GIRFT initiative aligns closely with a number of the Health and Care Standards
Link to Integrated Medium Term Plan/Corporate Objectives	The consequent action plan for stroke services will form a key priority within the 2023/24 IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Implementation of the action plan will support the intentions of the Act in the following ways:-
	Long Term – addressing the long term needs of the population and organisation by providing enhanced and more effective services to meet future stroke demand.
	Integration – providing an improved and integrated service configuration in response to the current concerns of service consistency, sustainability and access.
	Involvement & Collaboration – the action plan has been developed in collaboration with all key stakeholders across the service and has been endorsed by the multi-disciplinary task & finish group which includes the Delivery Unit and the Stroke Association
	Prevention – implementation of the action plan across the whole patient pathway will support the prevention of future challenges of key service access and delivery and hence improve population health.
Glossary of New Terms	New terms are explained within the body of the document
Public Interest	The GIRFT report is being made widely available to all stakeholders and other health boards as part of public interest sharing of best practice and lessons learned

5

GETTING IT RIGHT FIRST TIME
Stroke Medicine Review Report
Aneurin Bevan University Health Board
September 2022

This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT), in collaboration with the Wales Planned Care Board team. It aims to identify improvements in stroke services at ABUHB to help them ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.

Written by:

Dr David Hargroves Consultant Stroke Physician, East Kent Hospitals University Foundation Trust (EKHUFT), Clinical lead for Stroke, EKHUFT & South East (Wessex, BOB, Kent, Surrey and Sussex) for NHSE/I, National Speciality Adviser for the National Stroke Programme for NHSE, National Clinical Lead for Stroke (GIRFT) for NHSE/I and;

Dr Deb Lowe, Consultant Stroke Physician & Geriatrician Wirral University Teaching Hospital, National Clinical Director for Stroke Medicine – NHSE&I, Senior Clinical Advisor for Stroke Medicine – NHSI GIRFT Programme

Table of Contents

1. Introduction

Getting It Right First Time (GIRFT) is a national programme designed to improve patient care, by reducing unwarranted variations in clinical practice. GIRFT helps identify clinical outliers and best practice amongst providers, highlights changes that will improve patient care and outcomes and delivers efficiencies (such as the reduction of unnecessary procedures) and cost savings.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience.

The ambition of the programme in Aneurin Bevan UHB is to identify examples of innovative, high quality and efficient service delivery as well as identifying areas of unwarranted variation in clinical practice and/or divergence from the best evidence-based care. RNOH/GIRFT worked closely with the National Clinical Lead for Stroke in Wales, Dr Shakeel Ahmad, to ensure that this project is aligned with the Wales Stroke Strategy.

2. Background

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT) was approached by the Aneurin Bevan University Health Board (ABUHB), to conduct a review of their Stroke services using the GIRFT methodology, with the aim to support the Health Board with effective delivery, structure and performance of their stroke services.

This Programme of work is split into three phrases:

1) RNOH/GIRFT delivered a summit meeting on Thursday 27th January 2022 to provide colleagues from ABUHB with an overview of the GIRFT Programme and the GIRFT stroke workstream in England and to explain the principles and approach of the stroke programme planned for ABUHB.

2) The RNOH/GIRFT team visited all four stroke units in ABUHB on 11th May 2022; Nevill Hall Hospital (NHH), Ysbyty Ystrad Fawr (YYF), Royal Gwent Hospital (RGH) and The Grange University Hospital (GUH). A deep dive review and feedback meeting was conducted at GUH with key stroke staff attending either in person or joining virtually from the other three sites that had been visited earlier in the day.

3) Once this report has been delivered and the recommended actions made clear, the GIRFT Stroke Clinical Leads will hold a series of virtual monthly implementation support meetings. The purpose of these meetings will be to support and challenge the ABUHB clinical, operational and analytical teams to implement the recommendations from this report and to leave a legacy of sustainable quality improvement.

This document captures the key findings and recommendations arising from the visit to ABUHB by Dr David Hargroves and Deb Lowe on the 11th, May 2022. We are extremely grateful to all those who attended our visit and gave such open and honest feedback.

This report is a companion document to the Health Board Provider Level SSNAP Datapack. Many of the process markers of performance used in the GIRFT stroke analysis come from The Sentinel Stroke National Audit Programme (SSNAP). This is a major national healthcare quality improvement programme based formerly at the Royal College of Physicians (RCP) in

London, now housed within the School of Population Health and Environmental Studies at King's College London. SSNAP measures the quality and organisation of stroke care in the NHS and is a single source of stroke data in England, Wales, and Northern Ireland. It measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards, including the 2016 National Clinical Guideline for Stroke.

3. Aneurin Bevan University Health Board

The Aneurin Bevan University Health Board (ABUHB), which was established on the 1st October 2009, covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys and services a population of 600,000 and has approximately 850 stroke admissions per year. It employs over 14,000 staff, two thirds of whom are involved in direct patient care. There are more than 250 consultants in a total of over 1000 hospital and general practice doctors, 6,000 nurses, midwives, allied professionals and community workers.

ABUHB has a new specialist and critical care centre, the Grange University Hospital (GUH), which opened in November 2020, has 560 beds and features a 24-hour Acute Assessment Unit, Emergency Department and Helicopter Pad. It provides a 24/7 Emergency Service for patients that need specialist and critical care. Upon opening, GUH became the only Hyper Acute Stroke Unit in ABUHB, taking over this role from the Royal Gwent Hospital (RGH), based in Newport. RGH is one of three enhanced Local General Hospitals operating in ABUHB, the others being Nevill Hall Hospital (NHH), in Abergavenny, and Ysbyty Ystrad Fawr (YYF) in Ystrad Mynach. Each of the Local General Hospitals provides therapy and rehab services for stroke patients. Most patients are admitted via the Flow Centre to GUH for their acute phase of care. Any self-presenters at the ELGhs or patients who have had a stroke whilst on an ELGH site are assessed and depending on clinical presentation are almost always "dripped and shipped" to GUH.

There are also Community Hospitals and facilities which were not included in this review but may care for some patients once they have completed their stroke pathway and awaiting discharge as a step-down facility. These are:

1) St Woolos Hospital (Newport) 'Ruperra' ward and formally dedicated to Stroke Rehabilitation. However, when GUH opened this ward moved to the ELGH and is now a community ward.
2) County Hospital (Pontypool) this hospital receives patients who normally reside in Torfaen, from both the Royal Gwent and Neville Hall Hospitals for rehabilitation after stroke,
3) , provide some community based inpatient stroke rehabilitation services.
4) Monnow Vale, (Monmouth) provides community based inpatient rehabilitation, not specifically for stroke patients
5) Ysbyty Aneurin Bevan (Ebbw Vale) provides community based inpatient rehabilitation, not specifically for stroke patients
6) County Hospital (Pontypool) community based inpatient rehabilitation, not specifically for stroke patients

3.1. ABUHB and Its People

The strength of a National Health Service is in its people. The power of an organisation is so often in the loyalty, dedication, shared purpose and clear vison of its staff to deliver the best care they can and to always put the patient at the centre of everything they do. We were impressed by the culture and leadership at all the hospitals, which became evident within a few minutes of meeting the multi-disciplinary teams.

We also witnessed frustration and fatigue; to be expected at the end of a two-year pandemic, but this ran deeper and relates to a longer duration than the pandemic as it was clear that many felt unable to influence change within their organisation, yet still were willing and able to speak up and express their desire to drive the necessary changes forward.

We were told that the workforce challenges throughout NHS Wales are significant across medical, nursing and therapy teams, but are particularly marked in some of the ABUHB hospitals. BASP-Stroke-Medicine-Workforce-Requirements-Report and the https://www.hee.nhs.uk/our-work/hee-star are useful bench marking tools which the ABUHB stroke team may wish to use to address these workforce challenges.

There is good evidence for working within networks and we were very pleased to hear that the Welsh Stroke Strategy looks to support the development of stroke networks across Wales, to share knowledge, information, facilitate inter-organisational collaboration and learning and manage change. This will require excellent leadership, and we were impressed to see so many natural leaders across the professions whose skills need to be harnessed to support delivery of high-quality care.

4. Service Overview

The following Service Overview was provided by ABUHB prior to the meeting and discussed during the deep dive session. Additional information was gathered in the pre-visit virtual meeting and in the meetings with staff on the day.

SERVICE OVERVIEW – Aneurin Bevan University Health Board				
1	**Population served**	Total Number: 600,000 in ABUHB		
2	**Hospital beds in total in individual hospitals**	Where based and Total Number: 1217 RGH 218 NHH 212 YYF 227 GUH 560		
3	**Stroke beds**	Number of beds Stroke Rehab RGH 24 Stroke Rehab NHH 22 Stroke Rehab YYF 15 Hyper Acute Stroke GUH 12+ 3 general medicine	Base and No. of Hasu=1 HASU GUH HASU 12 beds specifically for HASU the ward is 15 bedded with the additional 3 beds used for GM patients		
4	**Stroke Consultants**	Number per site RGH- 1 Consultant NHH – 1 consultant YYF – 1 consultant GUH – 4 consultants	Number On-Cal 8 Stroke-only	Further detail: i.e. 5/7 or 7/7 service 1:8	

		Total DCC's:45,	Consultants on-call:	
5	**Stroke Nurses**	WTE Number 4	Hours of Cover 7am -5pm	Plans in discussion for 12 hour cover when vacancies filled and staff trained.
6	**Stroke Ward Staffing**	Registered Nurses: 3 day 3 night Health Care support: 3 day 3 night Nursing Bands: Band 6 x2 Band 5 Band 3 Band 2	Therapists: SLT 0.7WTE dedicated SLT for HASU 1WTE SLTA FOR HASU (No other sites have stroke specific staff. Only able to provide 4 day dysphagia cover. Occupational Therapists: GUH 0.8WTE BAND 7, 0.6 BAND 6 RGH= 1 WTE BAND 7, 1WTE BAND 6, 1WTE B5, 1WTE BAND4 1 WTE B3 NHH: 0.8 WTE BAND 6, 1WTE BAND 5, 0.8 WTE BAND 4 YYF: 1WTE BAND 6, 1WTE BAND5 1WTE BAND 3 AND 0.8 WTE BAND 8A FLOATING Physiotherapist: GUH 2 WTE YYF 2.5 WTE RGH 3.6WTE NHH 3.3 WTE	Extra Detail: 1 ward manager, supernumerary to numbers by day (M-F)
7	**Psychology**	1 WTE Psychologist for Stroke 1 WTE Assistant		Based in Community Neuro rehab service but in reach to wards and

		psychologist for Stroke 1 WTE Consultant psychologist for Stroke and Neurological conditions		provide life after stroke psychology service through 1:1 interventions and group based psychoeducational modules
8	**ESD and community stroke rehab Service**	5 days Cover 0800-1700	Speech Therapy 1.2 WTE OT 3.2 WTE Physio 2.8 WTE Dietitian 0.4 WTE Therapy Assistant Practitioner: 5.6 WTE Life after Stroke Wellbeing practitioners: 1.8 WTE	Extra detail: 1 physio is also Team Lead so has 0.3 WTE dedicated to managerial role. All patients can access the service based Niwrostiwt Neuro Recovery College which delivers education on common stroke issues and opportunities for personal recovery.
9	**6/52 and 6/12 Review Process**	6 weeks follow up consultants 6/12 is completed by CNS		
10	**Stroke imaging**	Access to CTA: hours / per day 24 hours a day Access to CTP: hours / per day 0 Hours a day Access to AI: Y/N Not available But funding been approved the Welsh Government recently		
11.	**Relationship with IAT Centre & Hours of Service:**	**Access to MRI first line for acute stroke and TIA patients?: There are no dedicated slots for stroke and TIA but this is available daily.** **Current waiting for TIA imaging. MRI two weeks, CT one week, Carotid doppler one week.** **Inpatient CT 10 min to 1 hour, MRI 2 to 24 hours (same day 60%, next day 40 %), MRI Scans requested after 3 pm mostly done next day.** Modality used for carotid imaging? Carotid Doppler Please describe: Bristol South meads 8am to 6 Pm 7 days a week		

Most of this report focuses on the performance and data we have for ABUHB's hyper-acute stroke service, as the GIRFT methodology relies heavily on the use of data to drive improvement. This, however, is only one part of the complex pathway of stroke care within this hospital group. It was important to the visiting team to understand the flow, the facilities, and the people within the three surrounding stroke units to enable a rounded discussion at the deep dive meeting held at GUH and to support the development of strategic and quality improvement recommendations.

4.1. Nevill Hall Hospital

The NHH Rehab Team

Nevill Hall Hospital (NHH) in Abergavenny has 213 inpatient beds and a wide range of services including a 24/7 nurse led minor injuries unit and a medical assessment unit.

The stroke ward at NHH had 28 beds when we visited, 24 beds were funded and 21 of these were stroke beds; the remaining were general care of the elderly beds. The team informed us that on average, 20% of the beds were occupied by acute stroke admissions; these patients don't get entered in to SSNAP as this hospital is not classed as a routinely admitting stroke unit. The model in ABUHB is that all patients should come through the Flow Centre for admission at the GUH not ELGHs. There is access to thrombolysis 24/7 and a 'drip and ship' model is employed with some but not all patients moving to The Grange for their hyper-acute stroke care. The length of stay was reported to be 42 days. As the ward is mixed, this figure also included patients classed as "General Medicine and Care of the Elderly".

There are two medical consultants that support the unit, one substantive and one locum consultant that is going through the Certificate of Eligibility for Specialist Registration (CESR) route. The medical lead at this ward is very clearly a highly valued member of the team and there was a positive inclusive culture felt on the ward. The ward has two foundation doctors and one CMT doctor during the week. There had been two experienced Clinical Nurse Specialists supporting the ward on a pro-rata basis that had moved to the Grange when the HASU was centralised in 2021. These posts have not been backfilled on the ELGH sites. We were pleased to hear that ABUHB had recruited two new Nurse Consultants in other areas so there could be scope to develop similar roles in Stroke

There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. There was a very high level of neuro-rehabilitation expertise within the group of senior therapists that we were able to meet. Of note there was only 0.6 WTE dysphagia trained Speech and Language Therapy provision. At the time of the review, it was reported that there was no psychology support but in theory there is usually 4 hours

per week of support for inpatients. The role of rehabilitation assistants was recognised and their ability to support 7 day working with the correct supervision was supported.

Access to Early Supported Discharge (ESD) and Community Rehabilitation Teams (CRT) was variable. There was usually at least a 1 week wait to access 'ESD' and there was no enablement/domiciliary care included within the commissioned service. The ESD responds to received referrals within 1 day of discharge Monday – Friday. Contact is via telephone triage – if same day assessment is indicated, it is available (staffing challenges may sometimes affect this). If same day assessment is not indicated, we target the right profession to complete the assessment – this approach is based on the Malcolmess Care Aims intended outcomes framework and aims to get the right person out to assess at the right time. This allows stroke survivors to settle at home and explore their new functional status so that when we assess they are able to identify hopes and goals in a more meaningful way than they can on the first day home from hospital when they are often very tired and just needing time. The pathway was commissioned for 3 months, but this could be extended based on patient need. If a patient was discharged to a nursing home, there appeared to be less access to specialist stroke rehabilitation. The ESD team works with people for up to 3 months (average 8 weeks). If ongoing support is required, this is arranged through outpatient physio/SLT services. The clinical psychology team support over a longer time frame up to and over one year.

Social work support is locality based and can be variable with significant delays for packages of care. It is not unusual to wait 4 weeks for a larger package of care and even longer delays for nursing home placements.

There had previously been a commissioned Stroke Association Family and Carer support worker service across ABUHB, but this service had been decommissioned. Following the end of the commissioned stroke association service, Life-After Stroke support is provided through 2 Life after Stroke wellbeing practitioners who are embedded in the Community Neuro Rehab Service. The recently appointed2 practitioners will support anyone who has had a stroke in the past year and provides face to face, telephone and virtual support as appropriate. The service sends a letter and leaflet contact for people to request support. The service will also in reach to the stroke units if in reach support is requested by the ward staff.

The estates at Nevill Hall were sub-optimal for delivery of effective rehabilitation. There was inadequate therapy space and no quiet space for speech and cognitive assessments. Toilet facilities were mixed sex, and you could not enable patients requiring a hoist for transfer to use the bathrooms. Some of the environmental constraints within this ward could be addressed by returning the ward to 24 funded beds and utilising the released space to address the above concerns.

The YYF Rehab Team

Ysbyty Ystrad Fawr (YYF) in Hengoed has 164 inpatient beds and has a Minor Injuries Unit, medical assessment unit included within its services. It has 30 rehabilitation beds, 15 of which are usually occupied by stroke patients. It was reported that the length of stay is approximately 42 days on this ward. At times the stroke ward may be occupied with more General Medical or Care of the Elderly patients so the length of stay will be affected by this. It was also reported that it was unusual for acute stroke patients to present to this hospital and only a handful of patients had been transferred to The Grange by 'drip and ship'. This is because all patients are managed through the flow centre and directed to the GUH. Stroke patients are referred from the HASU at GUH into this unit for rehabilitation. This makes flow management and discharge planning difficult, as the ward works with multiple locality social work teams and different commissioned community CRT services and one ESD team. There seemed to be a lack of a commissioned pathway for complex neurological rehabilitation.

There is a single-handed consultant who is job planned to deliver 6 PAs to support the service and there has been a Stroke Consultant vacancy at this site for almost 5 years. There are additional ward rounds by a Care of the Elderly Consultant but when the Stroke Consultant is away, there is usually only one ward round per week. Junior doctor support can be variable but on average there are 5 junior doctors including F2's, GPVTS and two registrars. There was an excellent culture of training and education within the unit and supported places to attend the Welsh Stroke Conference each year. There was good support from ward-based pharmacists for safe prescribing.

There was excellent nursing leadership, as with all the hospitals we visited, but there are significant nursing recruitment challenges at YYF with a 50% nursing vacancy rate despite attempts at international recruitment. Band 4 nurses had recently been appointed using band 5 funding.

There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. Once again there was limited dysphagia trained Speech and Language Therapy provision with only 1.2 WTE SLT for the entire hospital; of this, only 0.6 WTE is dysphagia trained SLT. The remaining 0.6 WTE is for communication only. At the time of the review, it was reported that there was no psychology support but in theory there is usually support for inpatients from an in-reach on referral model. There is a very limited spasticity service offered at this hospital with ad hoc support available. The senior physiotherapist was also being trained to administer Botox therapy which is to be commended.

There is good social work support and a discharge coordinator role but still major delays in accessing packages of care and nursing home places.

Follow up post discharge is delivered at 6 weeks by the Stroke Consultant, but there is no routine 6 month follow up.

The ward was made up entirely of single rooms. Whilst this has some advantages for privacy and infection control, there is evidence that stroke patients in the rehabilitation phase get a lot of benefit from the socialisation of communal bay accommodation and therapy spaces. The toilet facilities could not accommodate patients that needed to be hoisted. The rehabilitation therapy space was not based on the rehabilitation ward and was not exclusively reserved for the rehabilitation ward.

4.3. Royal Gwent Hospital

The RGH Rehab Team

Royal Gwent Hospital in Newport has approximately 370 inpatient beds and again a 24/7 Minor Injuries Unit and Medical Assessment Unit amongst its services. There are 24 stroke rehabilitation beds, and these are usually exclusively occupied by stroke patients with the occasional complex neurological rehabilitation patient. The average length of stay is

approximately 44 days. There are some self-presenting stroke patients making up around 10-15% of all admissions; these patients are rarely moved to The Grange.

The Medical Consultant cover is currently being provided by a Consultant from The Grange who carries out a twice weekly ward round. The ward is also supported with daily specialty doctor cover; this is clearly not a sustainable model and new consultant appointments were being explored to support the medical workforce. There are 4 junior doctors that support this ward, one foundation doctor and three middle grade speciality doctors.

There were significant challenges across nursing recruitment with 5 RN vacancies and 4 CSW vacancies at the time of our visit. It was clear to see that there was strong nursing leadership as this unit has previously been a nurse led rehabilitation unit, but frustration was expressed with the ongoing recruitment difficulties. There was a good working relationship between the therapy and nursing teams with key interventions to support nursing workload.

There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. Once again there was limited dysphagia trained Speech and Language Therapy provision with only 1 WTE band 6 SLT for the entire hospital. There was a reported delay of 3-4 weeks for PEG insertion. There is psychology support from an in-reach on referral model.

There were similar challenges to NHH and YYF with access to ESD and CRT, with a perception of a delay in availability onto ESD. NHH ESD responds to received referrals via a telephone call the day after discharge from hospital. Assessment is undertaken on the same day when required. Delays in packages of care, which sit within Social Services / Community Resource Team (CRT) is still a concern and may delay access. Only patients that were fit for transfer could be discharged for home therapy, with only one patient able to do so. Neuro-rehabilitation out-patient services were only available for Physiotherapy.

There are significant delays to access packages of care and nursing home placements. Stroke patients are moved to other ward areas to support flow due to discharge delays if they are no longer receiving active rehabilitation. It was reported that on average 15% of patients were medically optimised for discharge.

There were two large therapy areas on the ward but no quiet room for speech and cognitive assessments. There was one bathroom accessible for hoist transfer patients. Group rehabilitation was offered, and Occupational Therapists had changed working patterns recently to support morning Personal Activities of Daily Living (PADL) assessment and to support the nursing staff.

4.4. The Grange University Hospital

The GUH Rehab Team

As described earlier, this new hospital has 560 beds and provides all Specialist and Critical Care services for Gwent. It is also a major Trauma Centre for the region as well as being ABUHB's Acute Stroke Centre. It has 15 stroke beds, 12 of which are funded Hyper-Acute Stroke Unit beds, with an average length of stay of 6 days. It is difficult to meet the 4 hour target for admission as beds are not ring-fenced and frustration was expressed about the inability to manage their own beds.

There are 7 side rooms, two bays with 4 monitored beds in each and one therapy room on the ward (which at times of high demand in the hospital overnight was being used as a General Medical patient bed, although this has now been removed from the site escalation plans)

There are 4 stroke consultants that support the acute stroke pathway. There are 6 Neurologists that are employed by this Health Board and are based at the Royal Gwent Hospital, but only one works within the stroke team. A total of 8 consultants support the on-call rota from the four ABUHB hospitals. There is remote PACS radiology access to support remote review of brain scans

There were reported to be excellent nursing levels and no issues with recruitment. There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. There was 0.8 WTE SLT in post but 1.4WTE funded Speech and Language Therapy. There was no dietician support for the stroke unit with psychology support being offered as an in-reach service to the ELGH rehab site.

The acute care pathway was reviewed during our discussions with the team, and we had the opportunity to 'walk' the stroke pathway from A&E to radiology and up to the ward. Pre-alerts do occur directly to the stroke nurses but there is often limited information, which does not

enable pre-registration. Stroke Specialist Nurses are available Monday to Friday, 8am to 5pm and outside these times the Medical Registrar supports acute stroke assessments in A&E. An A&E sister commented during the visit, that she couldn't understand why the stroke review team would visit the resuscitation /high intensity A&E area as "stroke patients should never be assessed here". This was concerning, as acute stroke patients are some of the most acutely unstable patients in the emergency department. We accept that this may have been the opinion of an individual, but parity of esteem for stroke patients and support for the stroke team in A&E is essential to a successful stroke pathway.

Following initial review, suspected stroke patients go directly to CT +/- CT Angiogram. This pathway is less streamlined out of hours. Artificial Intelligence decision support software is not used, nor is Commuted Topography Perfusion (CTP), to support recanalization referrals and decisions. Thrombolysis is given in A&E. MRI is available 0730 to 2000 7 days a week for investigating minor strokes and stroke mimics and CT provision is available 24/7.

Thrombectomy services are delivered at Bristol South Mead Neuroscience Centre, 8am to 6pm, 7-days a week. There are good relationships between the referring hospital and the Neuroscience centre, although Thrombectomy rates remain well below a potential target of 8-10% of all stroke patients.

There are no specific TIA and Minor Stroke out-patient clinics delivered at GUH as the model for GUH does not include an outpatient footprint. These are all provided by the three other hospitals. Patients wait between 5 and 6 days to be seen and there is no provision for 'one stop assessment'. There is no access to first line MRI imaging, as per NICE guidelines, and patients often wait up to a week for brain and carotid imaging. Vascular surgery centralised in SE Wales on 18th July 2022 and is performed at the Regional Vascular Unit at the University Hospital of Wales in Cardiff. Intracerebral Haemorrhage Patients requiring Neurosurgical Intervention are also managed here.

5. SSNAP Data Performance Metrics: Findings and Recommendations

The recommendations that we have made in the report have been based upon the data accessible to us at the time of the visit to ABUHB and within the SSNAP published annual portfolio reports. It is also based on information from Trust Executives, Clinical Leads and Operations Managers on the pre-visit meeting and at the site visits. These are not exhaustive but are key areas that if focused on will reduce unwarranted variation and improve delivery of services along the stroke pathway.

During the deep dive visit on 11th May 2022, RNOH/GIRFT presented performance data for SSNAP registered routinely admitting stroke services in Wales, benchmarked against all stroke units in Wales and against the English national average. GUH is represented as the single routinely admitting stroke service in ABUHB; however, it is recognised that there are patients directly admitted to ELGHs and may not transfer to GUH (and therefore not included in SSNAP data). This included data from the most recent published SSNAP data available for the period October 2021-December 2021. Although this represents only a short period in time, having reviewed annual data in preparation for this visit, the Clinical Leads are confident that this quarterly data is representative of the performance out with this timeframe, and that recommendations are all relevant for future quality improvement.

5.1 Stroke Activity and Performance

Figure1

| Routinely Admitting Team	Admissions (Oct 21 - Dec 21)	SSNAP level	SSNAP score	Case ascertainment band	Audit compliance band	Combined Total Key Indicator level
Grange University Hospital	186	D	48.4	A	B	D
Glan Clwyd District General Hospital	95	D	59	A	A	D
Maelor Hospital	92	D	42.5	C	A	D
Ysbyty Gwynedd	88	D	44	A	A	D
University Hospital of Wales	178	C	64	A	A	C
Prince Charles Hospital	135	C	65	A	A	C
Princess Of Wales Hospital	70	D	45.6	B	A	D
Bronglais Hospital	28	B	71.7	A	A	B
Prince Philip Hospital	40	B	72	A	A	B
West Wales General	44	C	63.2	B	B	B
Withybush General Hospital	45	A	81.7	A	B	A
Morriston Hospital	153	D	59	A	A	D

5.2 SSNAP Patient-Centred Data (routinely admitting teams)

Figure2

Routinely admitting teams	Patient Centred Data										
	Scan	SU	Throm	Spec Asst	OT	PT	SALT	MDT	Std Disch	Disch Proc	PC KI
Grange University Hospital	A	E	D	D	B	B	D	E	D	C	D
Glan Clwyd District General Hospital	B	E	D	D	C	C	B	C	A	C	C
Maelor Hospital	B	E	B	D	D	D	D	B	C	D	D
Ysbyty Gwynedd	C	E	E	D	E	D	D	C	A	D	D
University Hospital of Wales	B	E	E	E	B	A	C	B	B	A	C
Prince Charles Hospital	A	E	C	E	A	B	C	D	B	B	C
Princess Of Wales Hospital	B	E	C	E	C	D	E	E	A	C	D
Bronglais Hospital	A	C	B	B	C	B	C	C	A	E	B
Prince Philip Hospital	A	D	E	A	C	B	B	B	A	C	B
West Wales General	A	E	C	B	C	B	C	B	A	C	B
Withybush General Hospital	A	B	B	A	B	A	C	B	B	A	A
Morriston Hospital	C	E	D	B	C	B	C	D	B	C	D

5.3 Admission to record start
Figure3
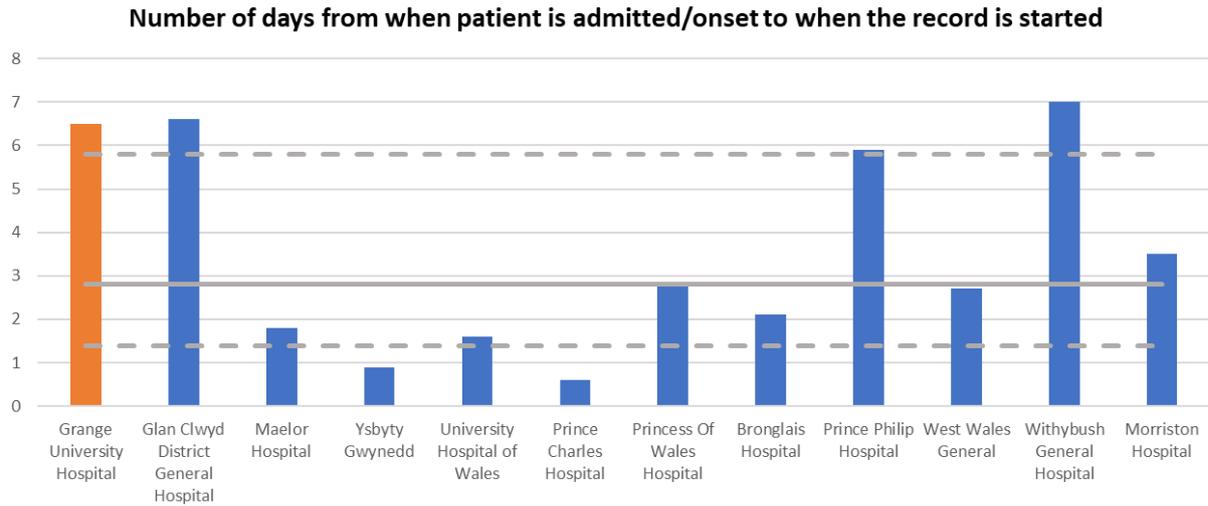
Number of days from when patient is admitted/onset to when the record is started

Grey lines show the median and interquartile range of sites in England

Team-centred results at team level for Audit Compliance measure C5.1

Source: SSNAP Oct 2021-Dec 2021

Number of days from when patient is admitted/onset to when the record is started – 6.5 days

5.4 Delay (days) between clock start and date of starting electronic SSNAP record
Figure 4
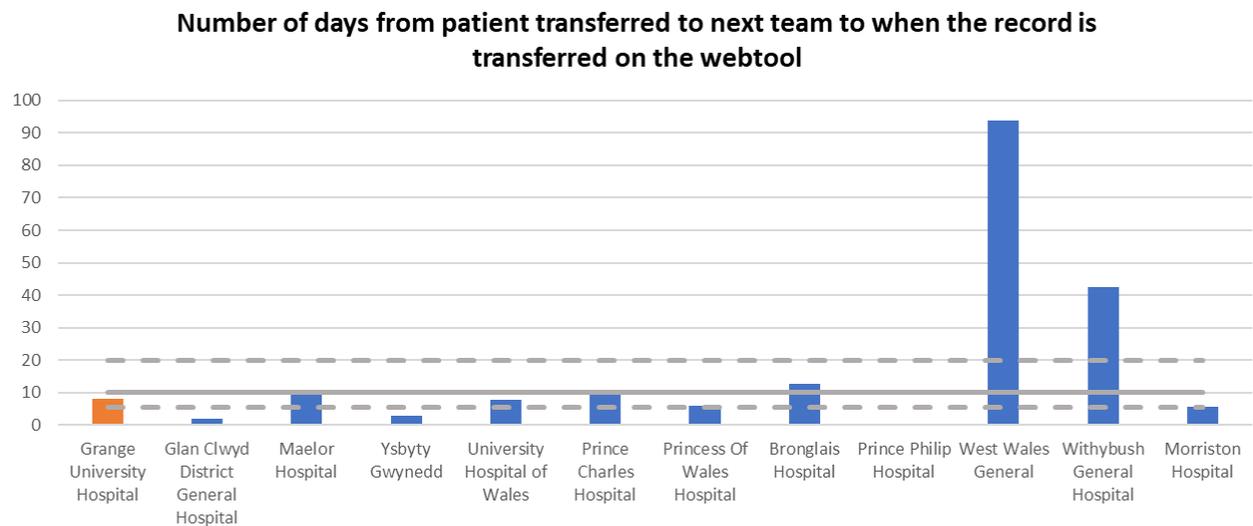
Number of days from patient transferred to next team to when the record is transferred on the webtool

Grey lines show the median and interquartile range of sites in England

Team-centred results at team level for Audit Compliance measure C4.4

Source: SSNAP Oct 2021-Dec 2021

Number of days from patient transferred to next team to when the record is transferred on the webtool – 7.9 days

Analysis from the most recent SSNAP process markers (fig 1 and 2) at the time of this review demonstrated:

- A good level of case ascertainment band
- Excellent data submission for time to first scan
- There is significant opportunity for improvement in the timely access to the stroke beds at GUH with specialist assessments (particularly SLT) and access to mechanical thrombectomy
- Improvement is required in audit compliance, with significant delays of 6.5 days from admission to records starting respectively (fig 3)
- MDT working and discharge processes are lacking in the SSNAP record

SSNAP collects data on the whole care pathway from initial arrival at hospital, through all inpatient settings, across ESD and community rehabilitation and up to a six-month follow-up appointment. Use of SSNAP is an imperative to drive quality improvement. Recognising that the overall aim of SSNAP (fig 4) is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients is vitally important. SSNAP operates through manual provider level data entry. Acknowledging that SSNAP is only as good as the data submitted is paramount; all efforts should be made to ensure data is entered as accurately possible

Recommendation 1: Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.

5.5 Patents discharged with ESD or CRT
Figure 5

Patients discharged with ESD or CRT
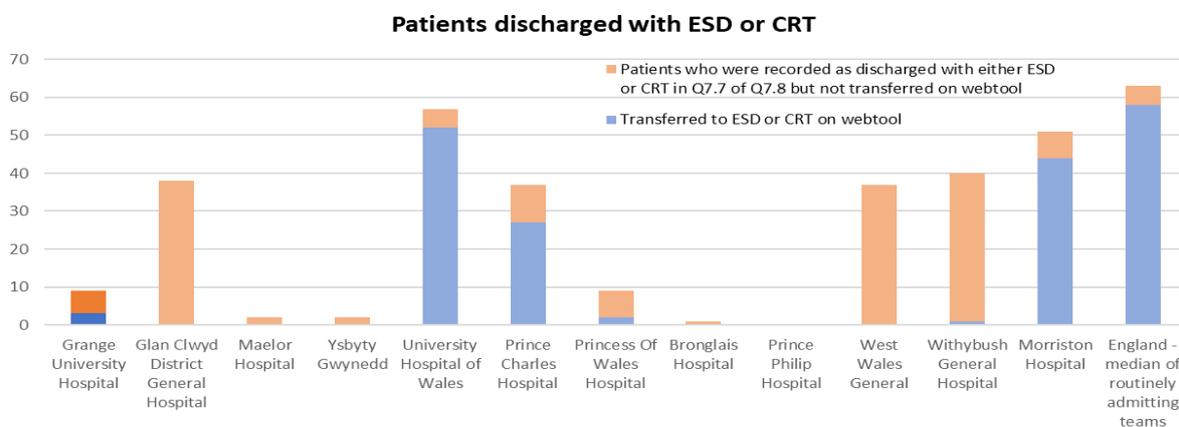
Team-centred results at team level for Audit Compliance measure C4.6
Source: SSNAP Oct 2021-Dec 2021

Total number of patients discharged with ESD or CRT: 9x patients
- *Transferred to ESD or CRT on webtool – 3x patients*
- *Patients who were recorded as discharged with either ESD or CRT in Q7.7 of Q7.8 but not transferred on webtool – 6x patients*

Local intelligence suggests the number of patients supported with ESD during this timeframe was 31 referrals accepted from GUH during Q3 of 2021 (total number of referrals received from all sites including Cardiff and England was 85).

There was wide variation in the access to ESD as recorded on SSNAP. At GUH, the rate of patients discharged with ESD or CRT is significantly lower than the England median. Continued rehab may be delivered at ELGH sites.

Recommendation 2: Commission an ESD pathway process flow map. It is only after full mapping of a needs-based ESD pathway or Integrated Community Stroke Service Model (ICSSM stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)**) that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB.**

6. Hyper-Acute Stroke Pathway SSNAP Performance Metrics
6.1 Percentage of patients scanned within 1 hour of clock start
Figure 6
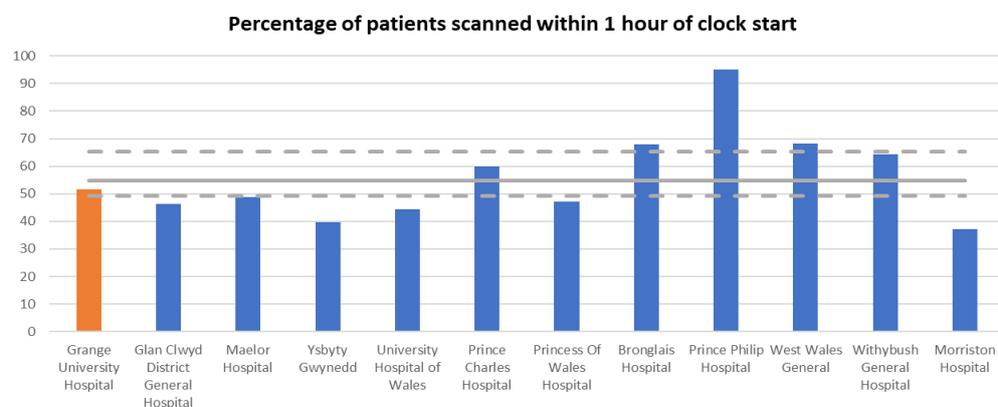
Percentage of patients scanned within 1 hour of clock start

Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 1.1A

Source: SSNAP Oct 2021-Dec 2021

***Percentage of patients scanned within 1 hour of clock start – 51.6%***

GUH's percentage of patients scanned within 1 hour of clock start was slightly lower than the national average.

Pre-hospital identification of suspected stroke patients could reduce delays to scanning and delivery of emergency treatment and stroke unit admission.

Recommendation 3: Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity. Refer to NOSIP, page 17 National-stroke-service-model-integrated-stroke-delivery-networks**.**

6.2 Clock start to stroke time
Figure 7
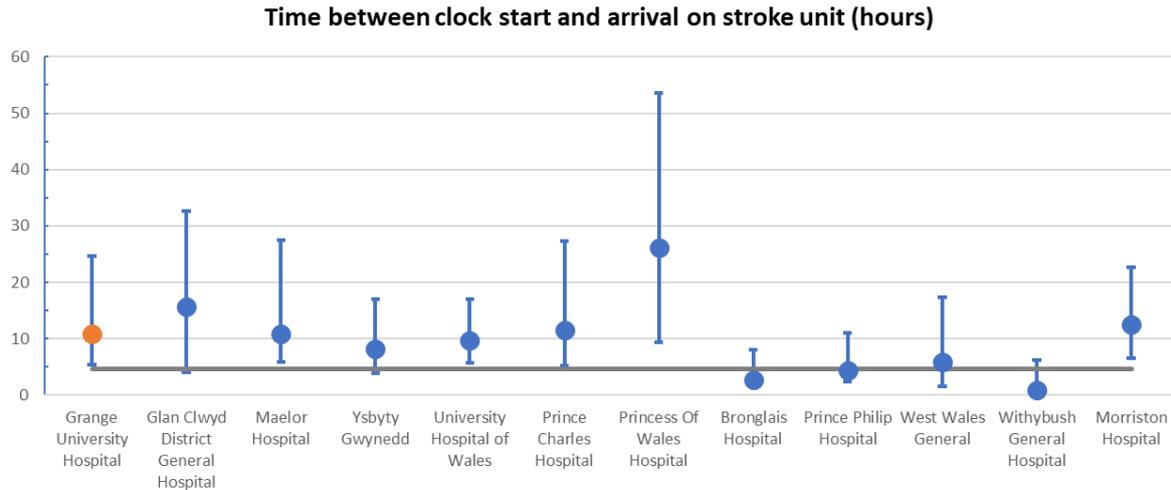
Time between clock start and arrival on stroke unit (hours)

Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient centred results at team level for Key Indicator 2.2A

Source: SSNAP Oct 2021-Dec 2021

Time between clock start and arrival on stroke unit (hours) – 10.85

Timely admission to a Stroke Unit is considered a vital aspect of hyper acute care. GUH rates are on a par with the Welsh average, but are however, below the England average rates. There is inadequate bed capacity at GUH to enable all stroke patients to have an admission within 4 hours of presentation to hospital and enable equitable access to evidence-based stroke unit care for all.

Recommendation 4: ABUHB to develop a strategy to improve direct access to the stoke unit within 4 hours of presentation.

6.3 Stay on stroke unit
Figure 8
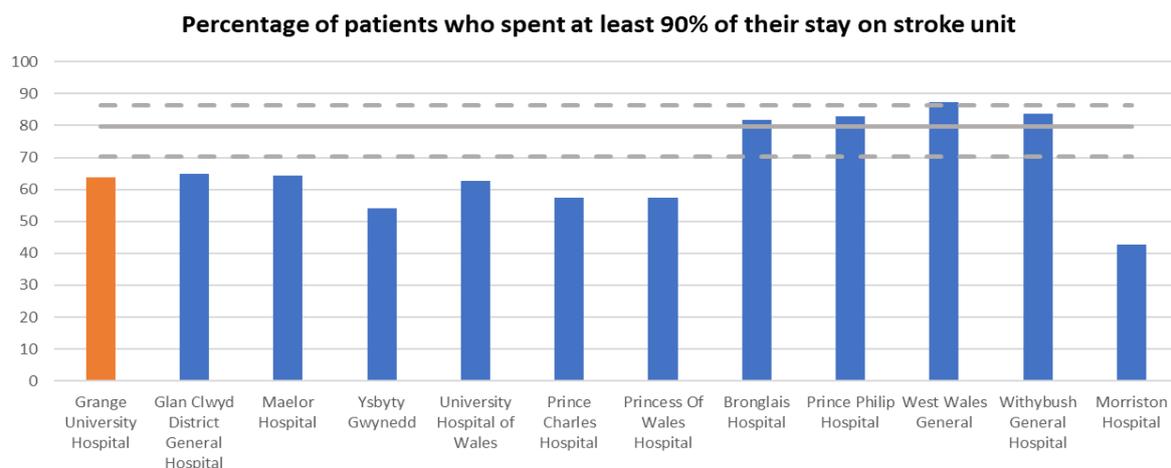
Percentage of patients who spent at least 90% of their stay on stroke unit

Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 2.3A

Source: SSNAP Oct 2021-Dec 2021

Percentage of patients who spent at least 90% of their stay on stroke unit – 63.9%

The GUH rates for accommodating patients for 90% of their in-patient stay on a stroke unit is lower than the England median. Patients that spend greater than 90% of their time on a stroke unit have fewer severe complications compared to those spending less than 90% of their inpatient stay on stroke units. The RGH reported moving stroke patients to other wards when they were medically optimised, to release beds. This will also have a positive impact on the 90% stay target.

Recommendation 5: Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for imaging (see fig 7 and 8) should help to release bed capacity and increase access.

6.4 Thrombolysis rate (all stroke)
Figure 9
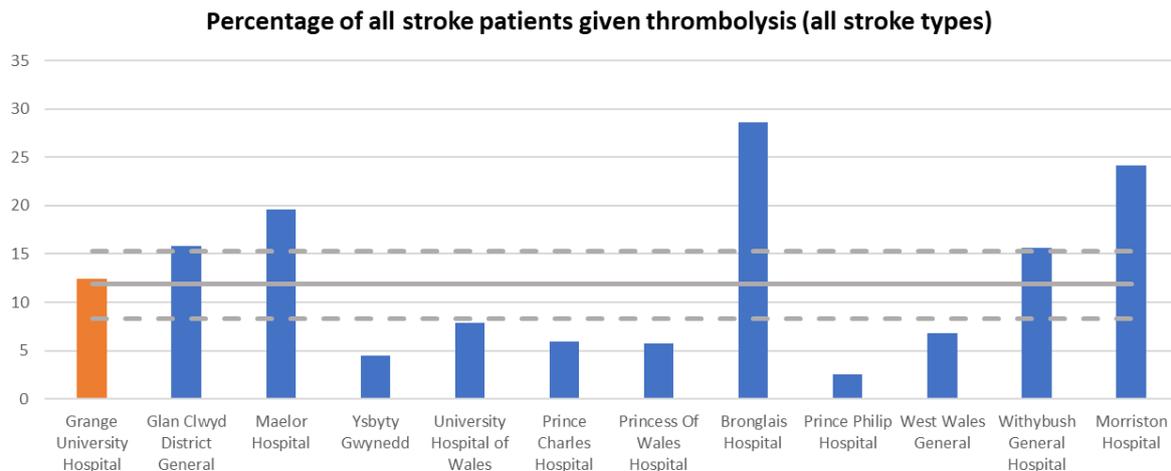
Percentage of all stroke patients given thrombolysis (all stroke types)

Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 3.1A

Source: SSNAP Oct 2021-Dec 2021

Thrombolysis rate – 12.4%

The thrombolysis rates are slightly above the England national average of 12%.

Recommendation 6: Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.

6.5 Clock start to thrombolysis

Figure10
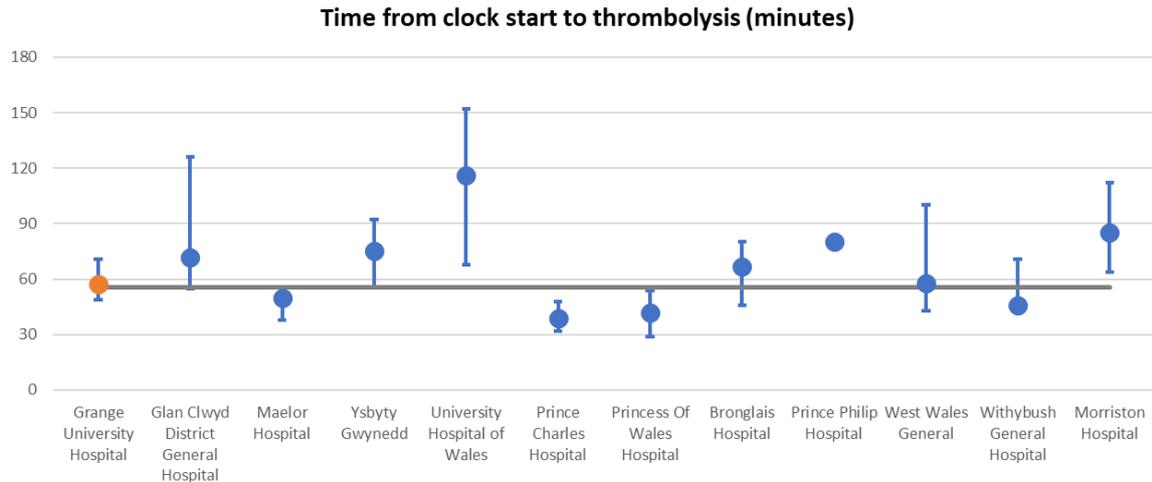
Time from clock start to thrombolysis (minutes)

Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 3.5A

Source: SSNAP Oct 2021-Dec 2021

Time from clock start to thrombolysis (minutes) – 57mins

The GUH is providing timely access to thrombolysis from admission. Rates are in line with the median of sites in England. Aiming for a target closer to 30 minutes is gold standard and is being achieved in many highly performing stroke units in England, aided mostly by pre-registration of patients, immediate review by the stroke team and going straight to CT scanning.

6.6 Median time between clock start and being assessed by stroke nurse

Figure 11
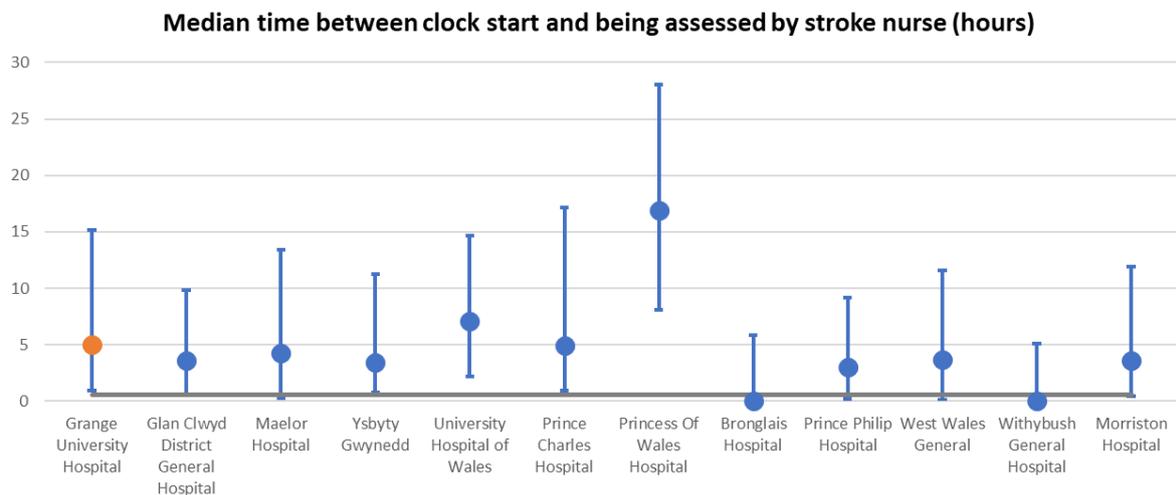
Median time between clock start and being assessed by stroke nurse (hours)

Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 4.4A

Source: SSNAP Oct 2021-Dec 2021

Median time between clock start and being assessed by stroke nurse – 4.95hr

GUH's median time between clock start and being assessed by a stroke nurse is 4.95 hours. There is variation due to GUH's inability to deliver a Stroke Specialist Nurse Assessment out-of-hours (outside of Monday-Friday 8am to-5pm).

Recommendation 7: Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.

6.7 Specialist consultant assessment - % assessed by stroke consultant within 14hrs

Figure 12
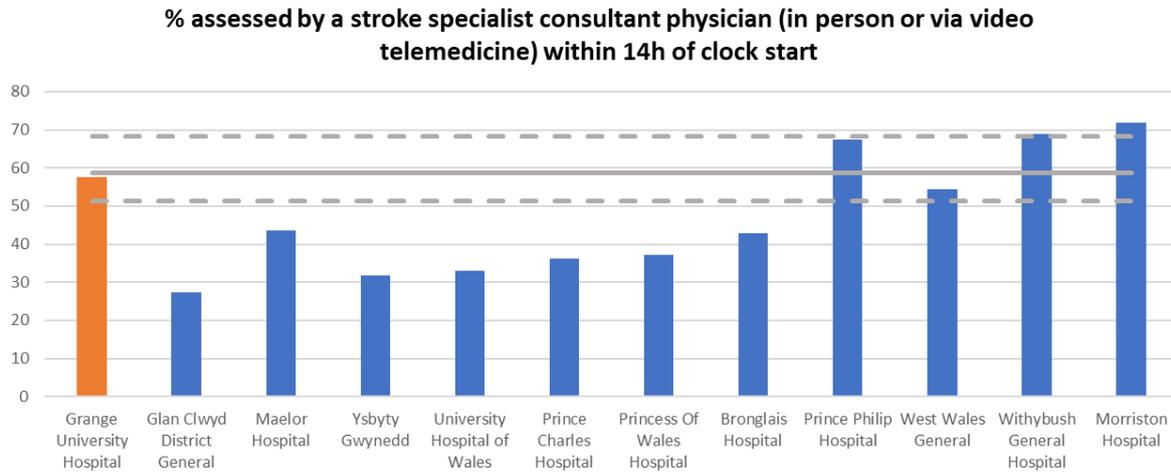
% assessed by a stroke specialist consultant physician (in person or via video telemedicine) within 14h of clock start

Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Item Reference G9.19

Source: SSNAP Oct 2021-Dec 2021

% assessed by a stroke specialist consultant physician (in person or via video telemedicine) within 14h of clock start – 57.5%

Good practice identified: The percentage of patients assessed by a stroke specialist consultant physician within 14hrs of clock start is in line with the English national average.

6.8 Specialist consultant assessment – Time between clock start and being assessed

Figure 13
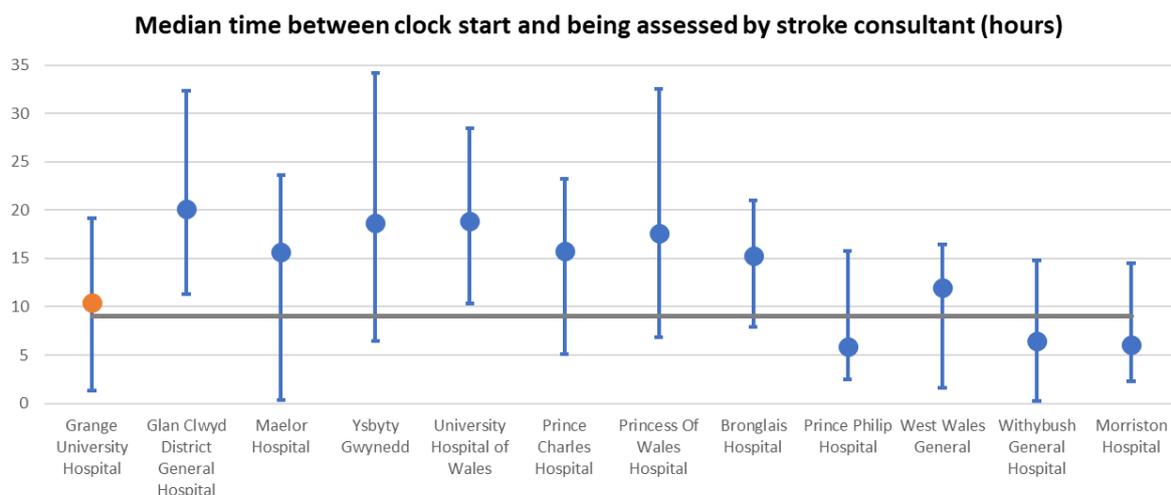
Median time between clock start and being assessed by stroke consultant (hours)

Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 4.2A

Source: SSNAP Oct 2021-Dec 2021

Median time between clock start and being assessed by stroke consultant (hours) – 10.37hrs

GUH are in line with the national average for the median time taken for first consultant review.

6.9 Swallow screen within 4 hours
Figure14
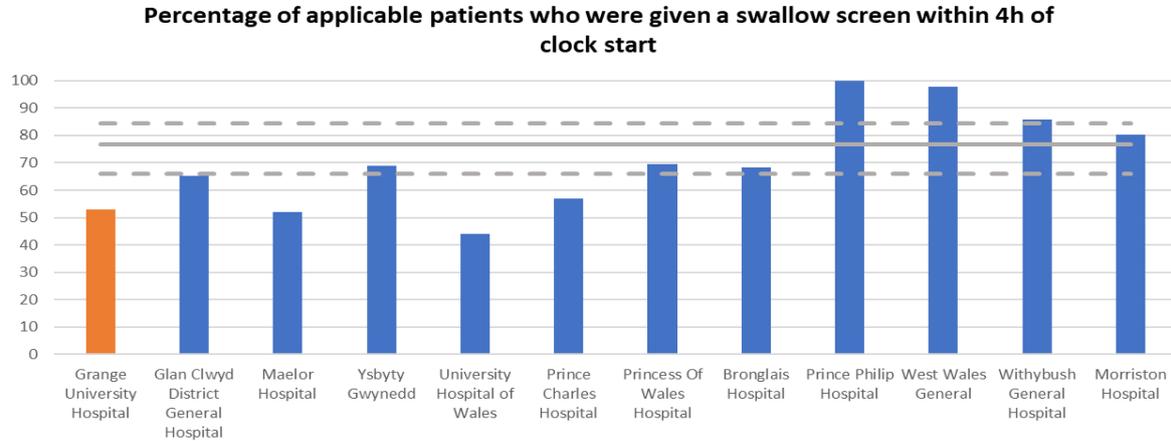
Percentage of applicable patients who were given a swallow screen within 4h of clock start

Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 4.5A

Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients who were given a swallow screen within 4hrs of clock start – 52.8%

Only 52.8% of patients accessed a swallow screen within 4 hours, this is significantly lower than the national average.

Recommendation 8: Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.

6.10   Swallow Screen within 72hrs of clock start
Figure15
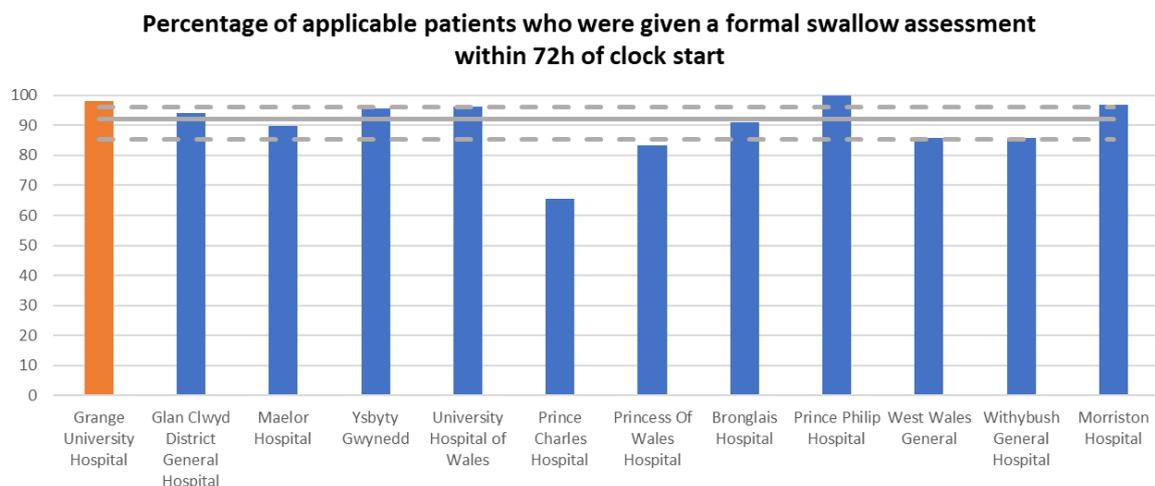
Percentage of applicable patients who were given a formal swallow assessment within 72h of clock start

Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 4.6A

Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients who were given a formal swallow assessment within 72h of clock start - 98.2%

Good practice identified: 98.2% of GUH's patients accessed a formal swallow assessment by a Speech and Language Therapist within 72 hours of clock start. This is in the top quartile when compared with NHS Trusts in England.

6.11   Antibiotics for newly acquired pneumonia
Figure16
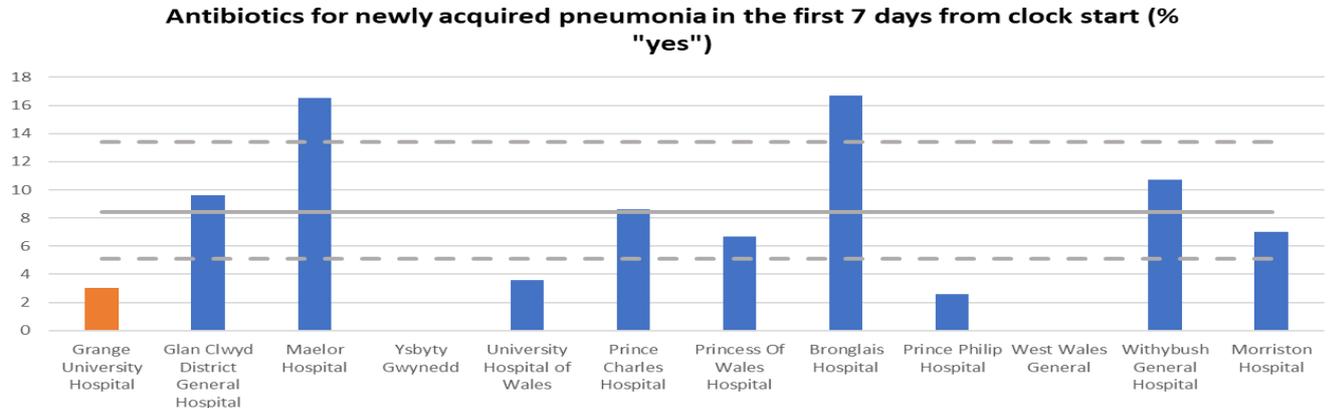
Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Post72h Indicator J26.3

Source: SSNAP Oct 2021-Dec 2021

Antibiotics for newly acquired pneumonia in the first 7 days from clock start – 3 cases

Good practice identified: The data shows a low use of antibiotics for presumed pneumonia within the first 7 days of admission. This may be due to good processes being in place regarding swallow screening.

6. MDT Working

There is good evidence of early supported discharge and the delivery of therapy in people's homes.

There are, however, significant social care delays. Findings from the Stroke Association survey show that 50% of patients feel abandoned following discharge.

There is significant room for improvement in discharge processes and services i.e. social, packages of care and availability of care homes. Offering a stepdown for these patients to encourage flow across GUH and the rehab sites should be a priority. A goal should be to maximise support for patients who are most impaired and dependant following discharge.

ABUHB took part in the Welsh Leadership academy that ran last year and found the outcomes very valuable. They put a cohort of staff groups (e.g. doctors, 3rd sector, managers etc) through the programme and found that this is invaluable when it comes to team working and improving leadership and effectiveness of a service. Several staff also enrolled on the first Wales Stroke and Neuro Leadership Programme which ran into the pandemic

Recommendation 9: ABUHB to put more cohorts of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.

The community discharge pathway demonstrated a time based model, the current commissioned pathway is for 3 months. The Stroke Association carers support pathway has not been fully embeded in all units, with significant gaps in two thirds of the units. Currently,

patients in a residential or nursing home in this region do not have access to rehabilitation, other than ESD to people who meet the ESD criteria. People with more significant impairment requiring additional staffing to undertake effective rehab do not fit the criteria. The ESD rehab programme is time limited but there is a Neuro recovery college model which provides a range of educational modules covering fatigue management, living well with stroke, GRASP upper limb rehab, rebuilding your life after stroke, community exercise. These modules are open for people to attend and provide support for much longer than 3 months for ESD. The Life After Stroke wellbeing practitioners also support on a longer term basis as do the clinical psychology team. We also informed that there is also a pathway to which works in partnership with the DWP to support people back into employment and or voluntary roles.

The psychology team routinely provide life after stroke support. The Acquired Brain Injury (ABI) team have also stepped in to provide longer term rehab on a number of occasions. Both the ABI and psychology resources are small and we have worked hard to prioritise people who are most in need of ongoing support. The basis of our prioritisation is risk to wellbeing and ability of people who are already proximal to manage this risk.

The Niwrostiwt Recovery College was developed by the ABI and psychology teams to support us in our commitment to doing the most good for the most people, whilst minimising harm and maximising autonomy. Whilst led by the ABI team the Niworstiwt is a collaboration between CNRS ABI & Stroke teams, people with lived experience of stroke and brain injury, Headway and the Stroke Association. The latter organisations contribute to the Stiwt's steering group.


Recommendation 10: Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support: stroke-integrated-community-service-february-2022.pdf (england.nhs.uk).

Recommendation 11: Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.

Recommendation: 12: Embed the National Stroke Service Model in ABUHB
https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf

7.1 Applicability and minutes of OT
Figure 17

Applicability and minutes per day of occupational therapy
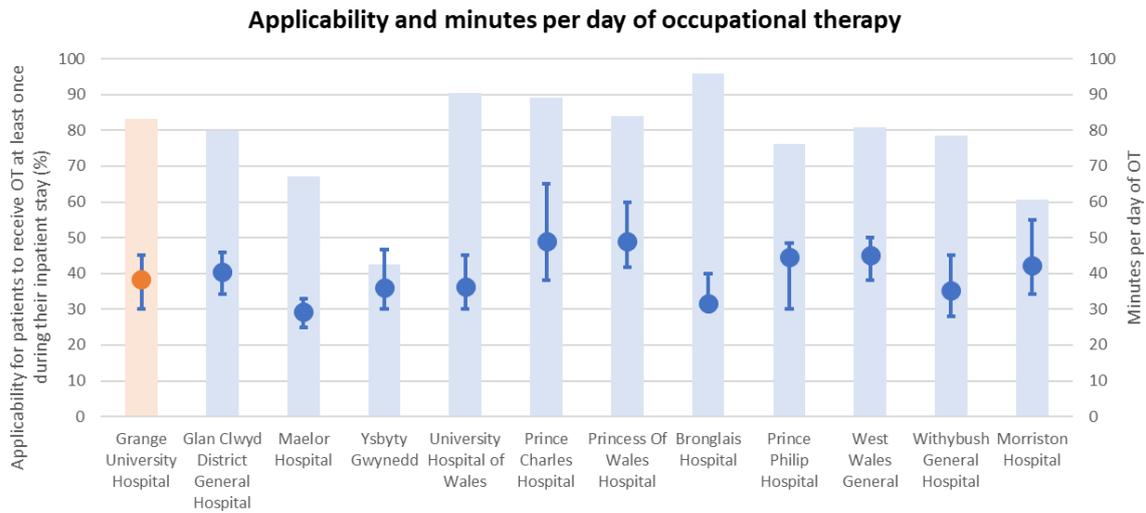
Bars show the % of patients applicable to receive physiotherapy at least once during their inpatient stay (England median is 87%). Dots show the median minutes receiverd per day (and interquartile range)

Patient -centred results at team level for Key Indicators 5.1A and 5.2A

Source: SSNAP Oct 2021-Dec 2021

Applicability and minutes per day of OT – 38.38%, in line with Wales's average

7.2 Clock start to OT assessment time
Figure 18
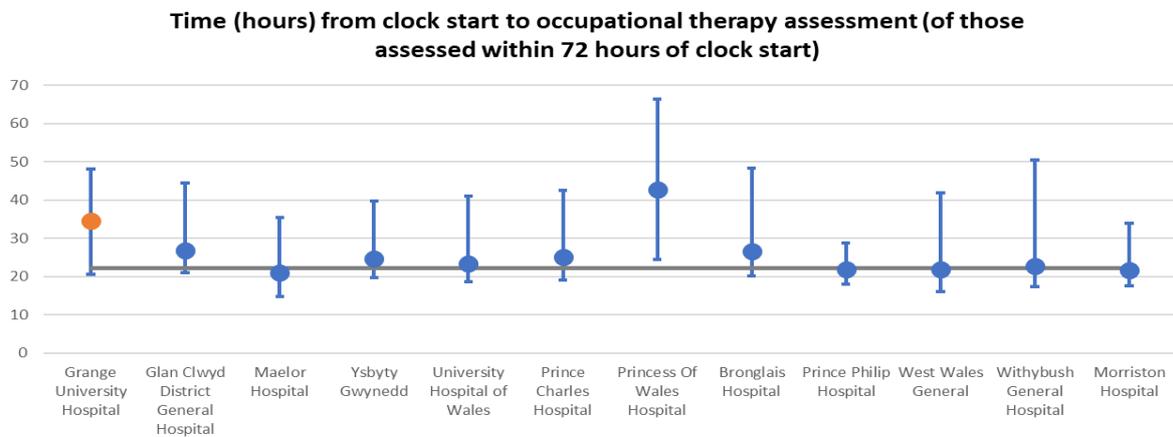
Time (hours) from clock start to occupational therapy assessment (of those assessed within 72 hours of clock start)

Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 8.2A

Source: SSNAP Oct 2021-Dec 2021

Time from clock start to occupational therapy assessment – 34.35 hours

7.3 Applicability and minutes of physiotherapy
Figure 19


Applicability and minutes per day of physiotherapy
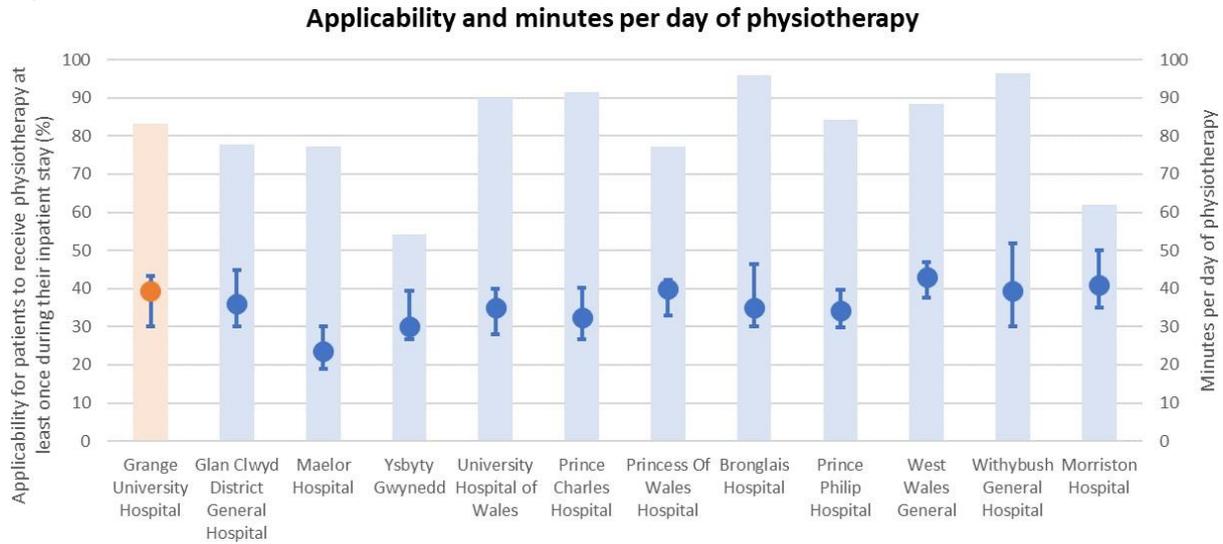
Applicability and minutes per day of physiotherapy – 39.2% in line with Wales's average

7.4 Clock start to physiotherapy assessment time
Figure20
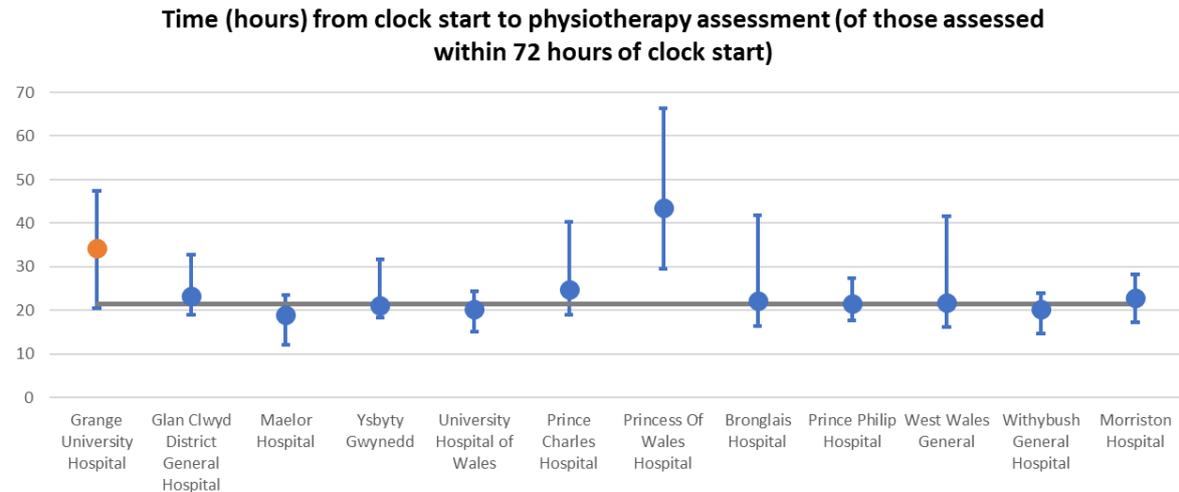
Time (hours) from clock start to physiotherapy assessment (of those assessed within 72 hours of clock start)

Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 8.4A

Source: SSNAP Oct 2021-Dec 2021

Time (hours) from clock start to physiotherapy assessment (of those assessed within 72 hours of clock start) – 34.17%

Recommendation 13: Ensure 7 day access to physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients

7.5 Applicability and minutes of SALT
Figure21

Applicability and minutes per day of speech and language therapy
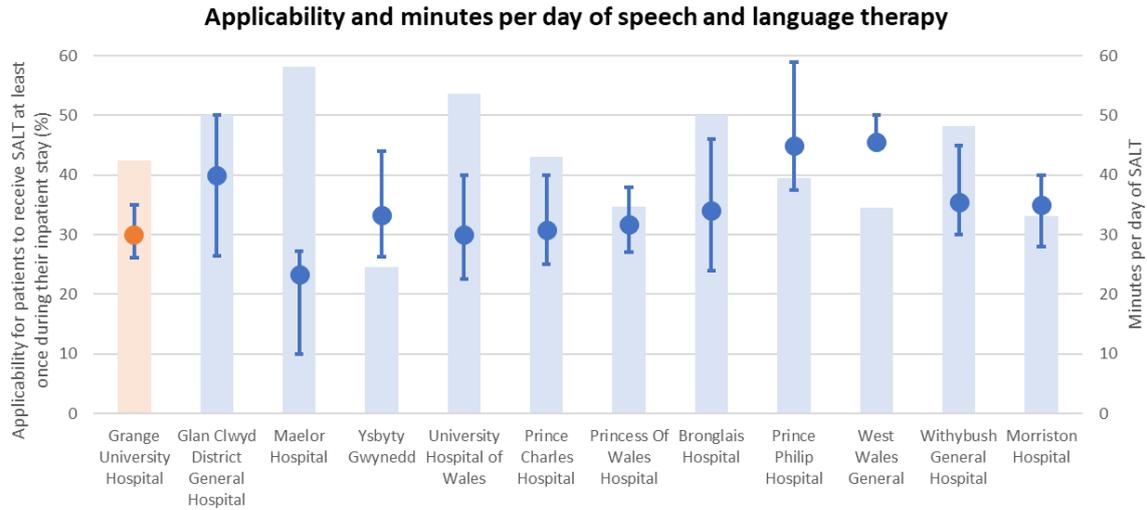
Bars show the % of patients applicable to receive speech and language therapy at least once during their inpatient stay (England median is 54.4%). Dots show the median minutes receiverd per day (and interquartile range)

Patient -centred results at team level for Key Indicators 7.1A and 7.2A

Source: SSNAP Oct 2021-Dec 2021

Number of minutes per day on which SALT is actually received – 30%, below Wales's average.

7.6 Clock start to SALT assessment time
Figure22
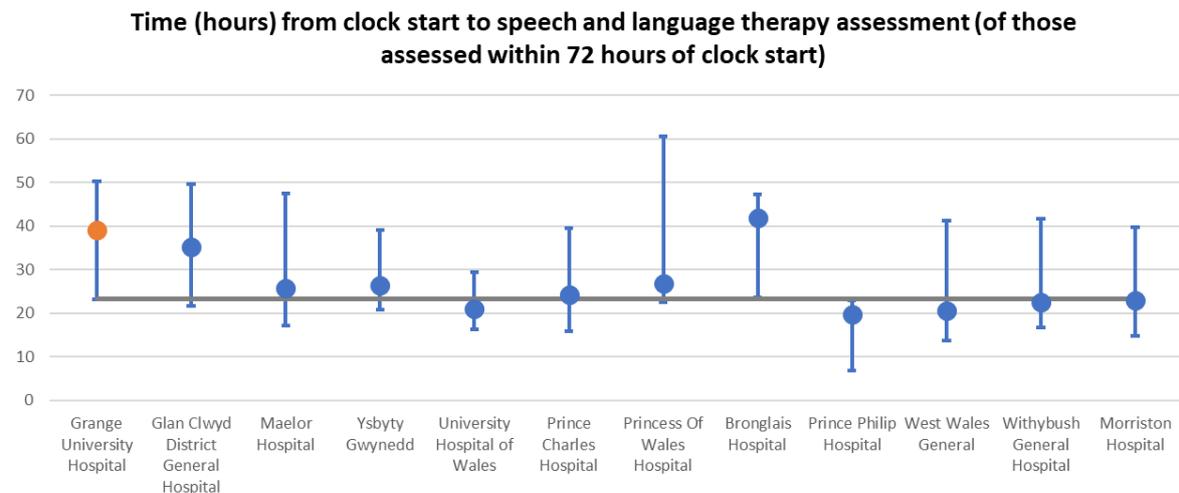
Time (hours) from clock start to speech and language therapy assessment (of those assessed within 72 hours of clock start)

Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 8.6A

Source: SSNAP Oct 2021-Dec 2021

Time (hours) from clock start to speech and language therapy (SLT) assessment (of those assessed within 72 hours of clock start) – 39.05hrs

There is variation in the timely access to speech and language therapy services (see fig 21 and 22), as well as to physiotherapy and occupational therapy. The HASU currently provides a 5-day service for speech and language therapy. There are significant challenges in this pathway. The SSNAP standard is that sites should have at least two of the therapies shown available seven days a week. In most units, this is physiotherapy and occupational therapy.

Recommendation 14: The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT, embracing a capability framework of competency [Stroke Educational Framework https://stroke-education.org.uk/.

Currently not meeting the SSNAP 5 day standards for intensity of therapy, so it is clear that a review of rehabilitation staffing is required to meet 5 days before expansion to days can be considered. Expanded use of rehabilitation assistants and group therapy sessions to be considered. It may be worth exploring a virtual liaison tele-swallow service given the extreme staffing pressure within speech and language therapy.

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7.7 Applicability and minutes per day of psychology
Figure23

Applicability and minutes per day of psychology
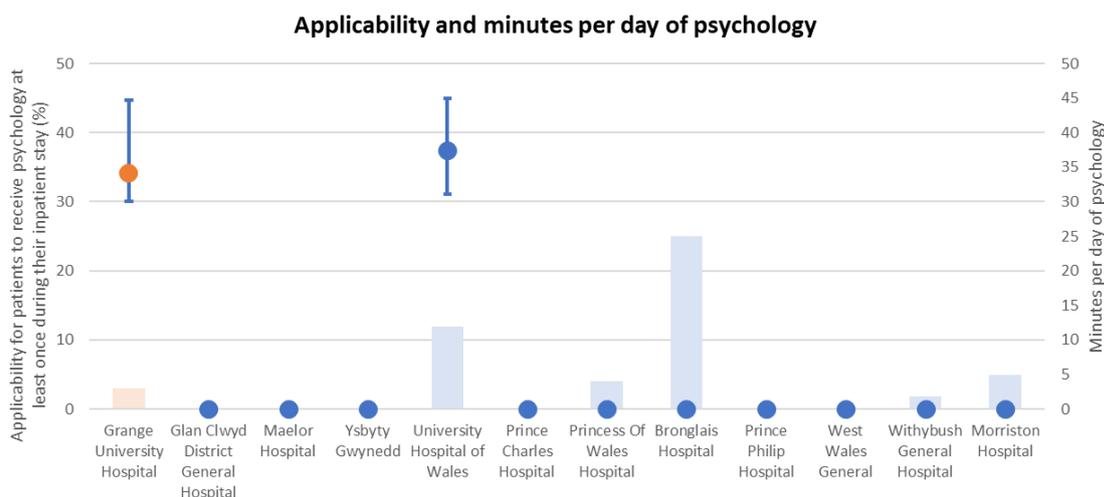
Bars show the % of patients applicable to receive psychology at least once during their inpatient stay (England median is 3.2%). Dots show the median minutes receiverd per day (and interquartile range)

Patient-centred results at team level for Item Reference J7.3-J7.7

Source: SSNAP Oct 2021-Dec 2021

% of the patient's days at in hospital (out of period patient requires psychology across all teams) on which it is received by the patient – 34.2%

Assess to neuropsychology is variable across the region. A high proportion of patients (1 in 3) may require psychological support post-event. The current psychology model is 1 session of in reach per week for each ELGH based stroke unit. However, at the time of the GIRFT visit the psychology resource was significantly depleted by absences. We are told this has improved now, although there have not been any applicants to cover fixed term appointments, through secondments or agency staff. The psychology service provides support across the whole pathway and takes referrals from medics, primary care and healthcare professionals.

The ABUHB CNRS psychology team work across the width and along the full length of the stroke pathway. In practical terms this involves responding to requests for assistance from the HASU, the three sub-acute rehabilitation wards, the three Early Supported Discharge Teams, the ABUHB Living Well-After Stroke Service, and colleagues working in community services supporting stroke survivors. The CNRS psychology team have also been instrumental in the establishment of the Neurological Conditions Recovery College.

Recommendation 15: Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a commissioned neuropsychology service that supports a matched/stepped psychological model of care approach.

7.7 Continence plans

Figure 24
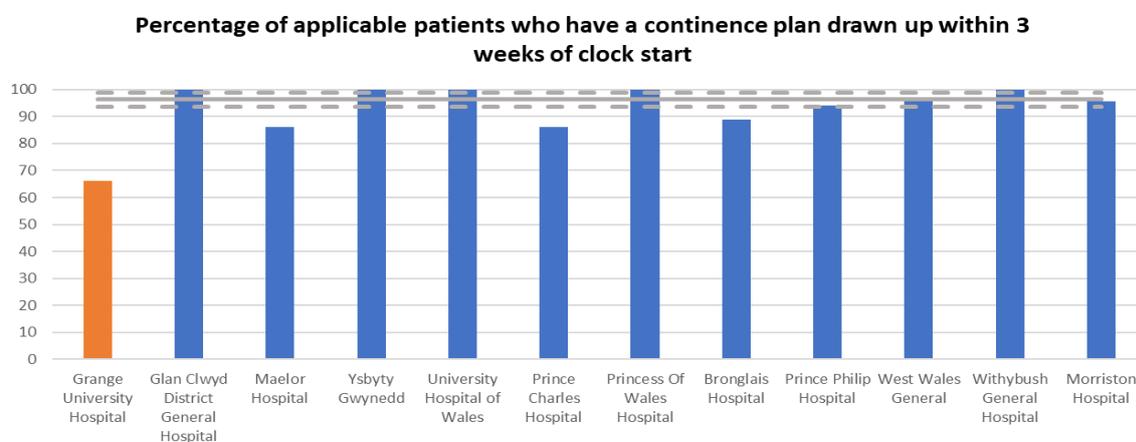
Percentage of applicable patients who have a continence plan drawn up within 3 weeks of clock start

Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 9.2A

Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients who have a continence plan drawn up within 3 weeks of clock start – 66.1%

The data showing the percentage of patients who have continence planning within 3 weeks of admission is low in comparison to the national average. This is likely to be an issue with documentation in medical notes and hence data reporting.

Recommendation 16: ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.

7.8 Nutrition screening and seen by dietician at discharge
Figure25
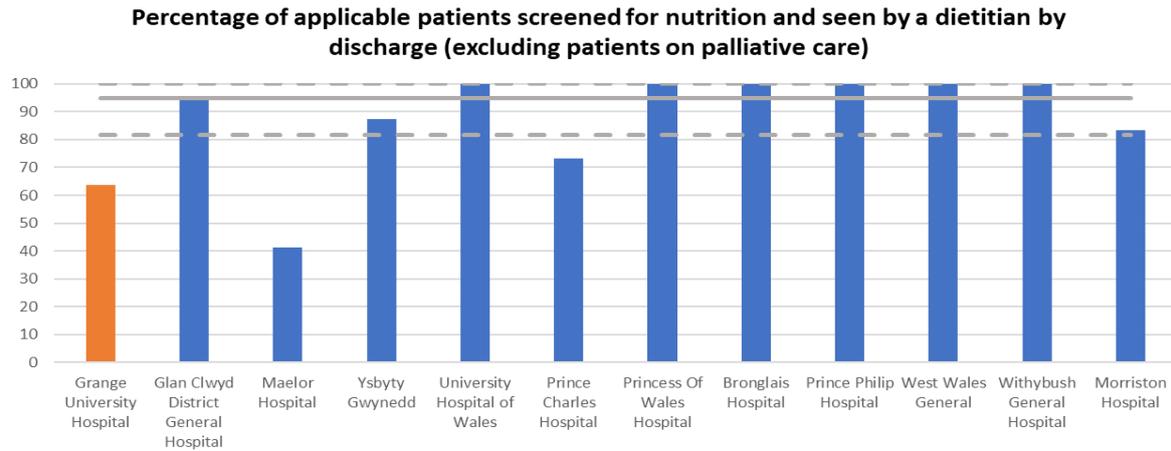
Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge (excluding patients on palliative care)

Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key indicator 9.1A

Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge (excluding patients on palliative care) – 63.6%, below Wales average

The data showing the percentage of patients who have been screened for nutrition and been seen by a dietitian by discharge is low in comparison to both the English and Welsh national averages. This is likely to be due to an issue with documentation and hence data reporting. We were informed that all patients assessed by ESD teams have a nutritional screen completed.

Recommendation 17: Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.

7.9 Mood and cognition screening by discharge
Figure26
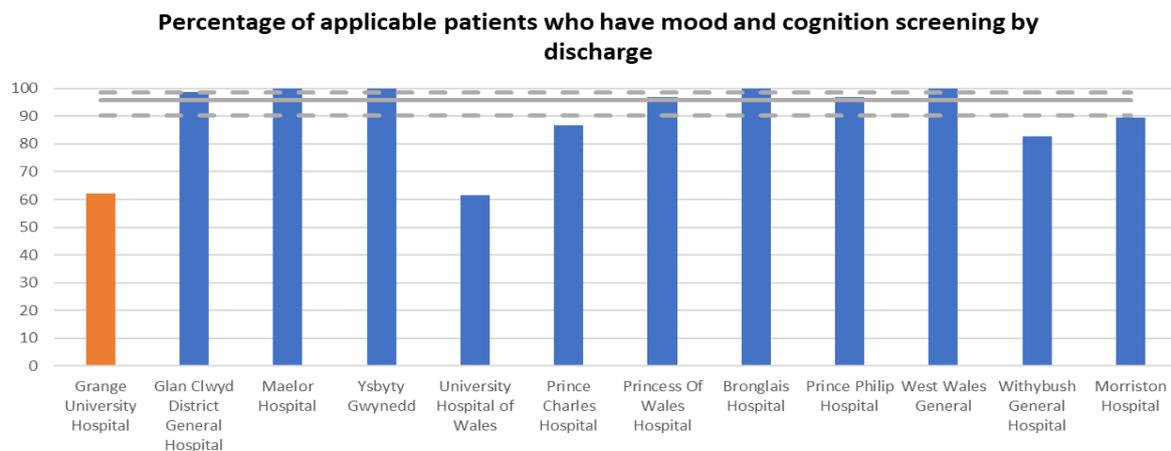
Percentage of applicable patients who have mood and cognition screening by discharge

Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 9.3A

Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients who have mood and cognition screening by discharge – 62.1% which is below the Wales average.

It was evident there is focus on mood and cognition assessment. The data showing the percentage of patients who have mood and cognition screening by discharge is low in comparison to the national average. This is likely to be an issue with documentation and hence data reporting.

Recommendation 18: Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.

7.10 Nursing therapy and rehab goals
Figure27
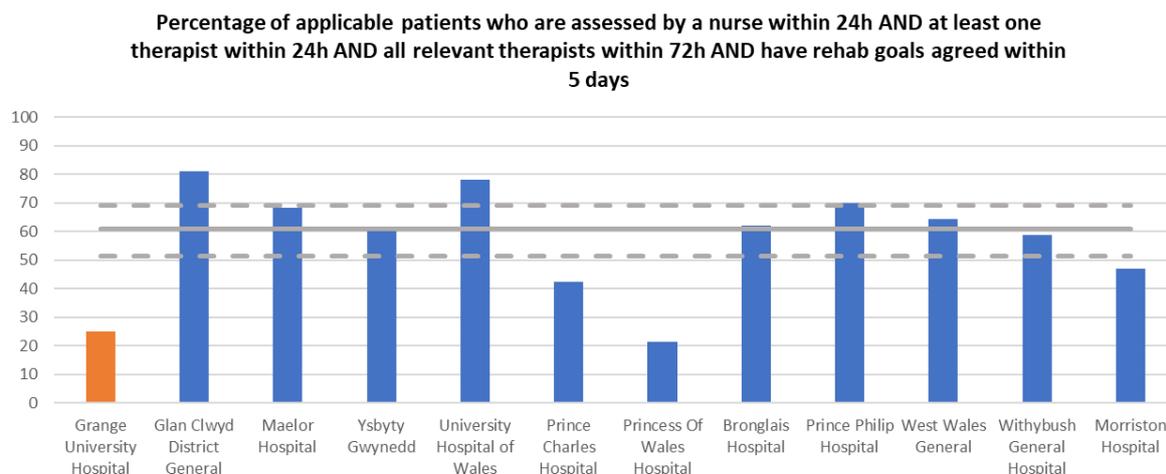
Percentage of applicable patients who are assessed by a nurse within 24h AND at least one therapist within 24h AND all relevant therapists within 72h AND have rehab goals agreed within 5 days

Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 8.8A

Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients who are assessed by a nurse within 24h AND at least one therapist within 24h AND all relevant therapists within 72h AND have rehab goals agreed within 5 days – 25%

This performance measure (see fig 27) may be related to poor documentation, which makes it difficult for a data clerk to record that this target has been met. Although goals are often set, this may not be clearly documented following MDT discussions.

Recommendation 19: Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5 day rota.

7.11 Joint health and social care plan by discharge
Figure28
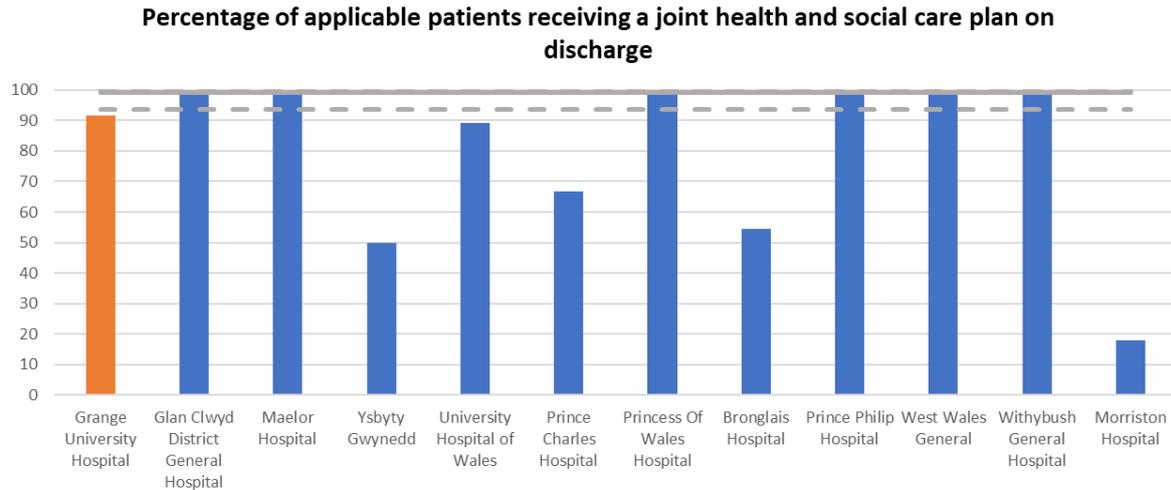
Percentage of applicable patients receiving a joint health and social care plan on discharge

Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 10.1A

Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients receiving a joint health and social care plan on discharge – 91.7%

Joint health and social care planning by discharge is delivered and documented in over 90% of patients, this is below the English national average.

7.12   Discharged with a named contact
Figure29
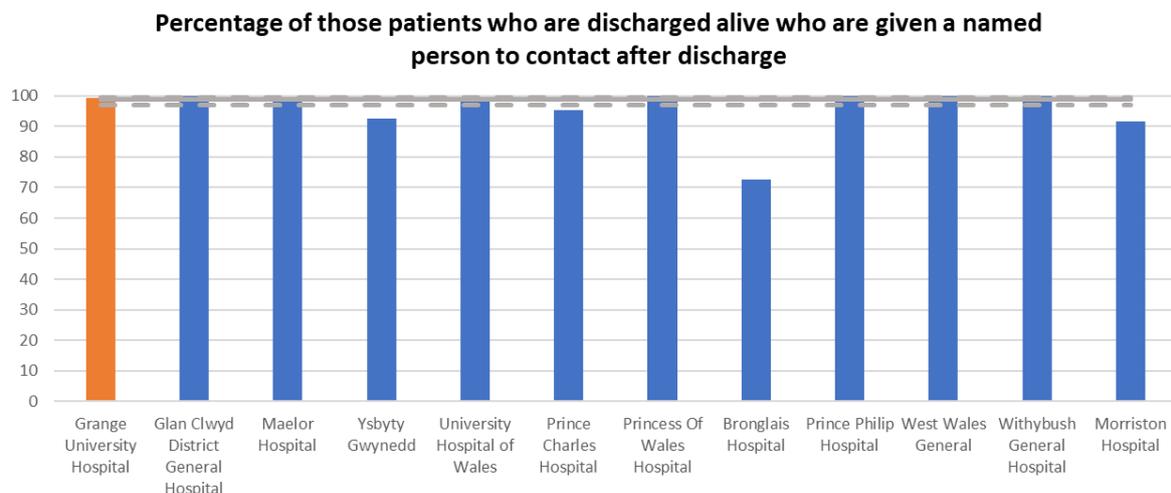
Percentage of those patients who are discharged alive who are given a named person to contact after discharge

Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 10.4A

Source: SSNAP Oct 2021-Dec 2021

Percentage of those patients who are discharged alive who are given a named person to contact after discharge – 99.3%

7.13 Patients applicable for a 6-month assessment
Figure 30

Proportion of patients alive who are considered applicable to be assessed at 6 months
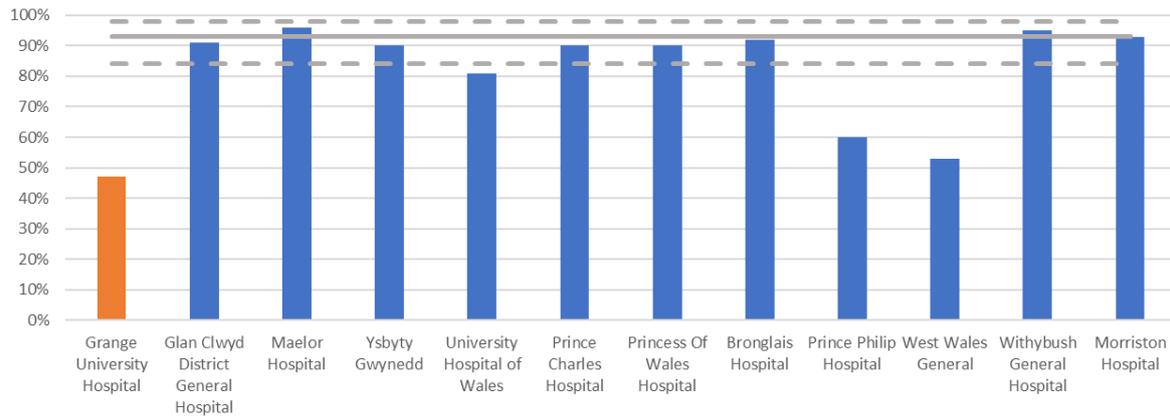
Grey lines show the median and interquartile range of sites in England

Team-centred results at team level for Item Reference B12.3

Source: SSNAP Oct 2021-Dec 2021

Proportion of patients alive who are considered applicable to be assessed at 6 months – 47%, below Wales's average.

7.14 Applicable patients receiving 6-month assessments
Figure31

Proportion of applicable patients receiving 6 month assessments
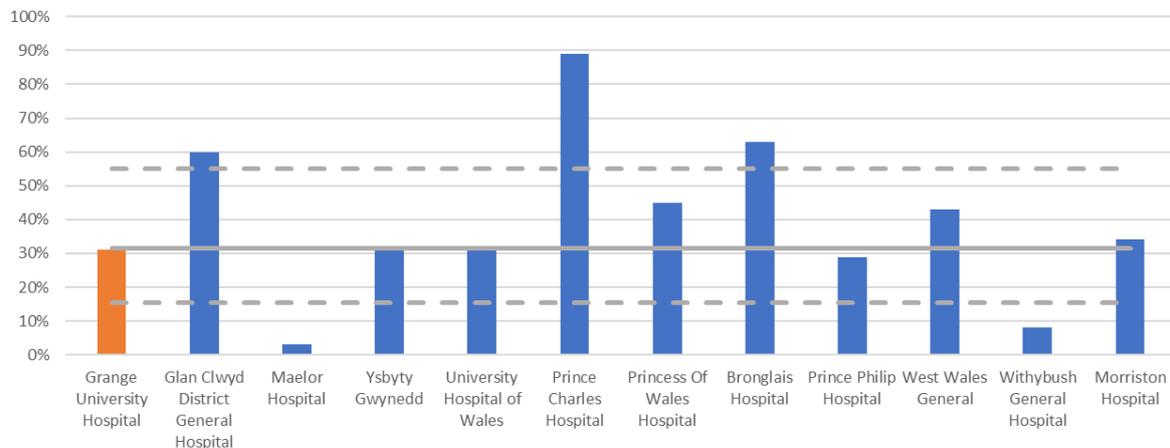
Grey lines show the median and interquartile range of sites in England

Team-centred results at team level for Item Reference B13.3

Source: SSNAP Oct 2021-Dec 2021

Proportion of applicable patients receiving 6-month assessments – 60%

There is unwarranted variation in the proportion of patients who receive a 6-month assessment.

Delivering an adequate review post discharge is essential to ensure that patients have completed all the necessary investigations to identify the aetiology of stroke, have had access to appropriate post discharge rehabilitation, are taking appropriate secondary prevention and are having their risk factors for recurrent stroke adequately managed. This

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does not need to be delivered by a secondary care stroke physician and is often more effectively delivered by community stroke nurses who deliver a more holistic approach

Recommendation 20: Standardise post discharge reviews using the GM-SAT six-month post stroke review tool.

8 Secondary prevention

8.1 If in atrial fibrillation, discharged on anticoagulants
Figure32
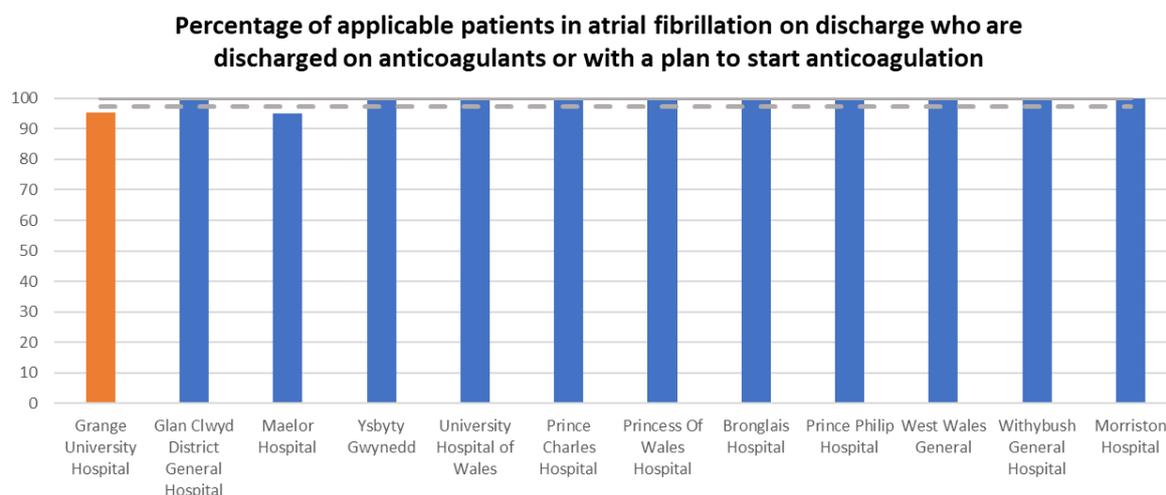
Percentage of applicable patients in atrial fibrillation on discharge who are discharged on anticoagulants or with a plan to start anticoagulation

Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 10.3A

Source: SSNAP Oct 2021-Dec 2021

Percentage of applicable patients in atrial fibrillation on discharge who are discharged on anticoagulants or with a plan to start anticoagulation – 95.2%

9 Summary of Recommendations
The table below summarises the recommendations made in the body of this report and is intended to serve as a useful tool for action planning.

Table of Recommendations

#	Recommendation
1	Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.
2	Commission an ESD pathway process flow map. It is only after full mapping of a needs-based ESD pathway or Integrated Community Stroke Service Model (ICSSM stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)) that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB.
3	Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity. Refer to NOSIP, page 17 https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf.
4	ABUHB to develop a strategy to improve direct access to the stoke unit within 4 hours of presentation.
5	Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for

	imaging should help to release bed capacity and increase access.
6	Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.
7	Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.
8	Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.
9	ABUHB to put more cohorts of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.
10	Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support: stroke-integrated-community-service-february-2022.pdf (england.nhs.uk).
11	Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.
12	Embed the National Stroke Service Model in ABUHB https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf
13	Ensure 7 day access to neuro-physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients.
14	The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT, embracing a capability framework of competency [Stroke Educational Framework https://stroke-education.org.uk/.
15	Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a commissioned neuropsychology service that supports a matched/stepped psychological model of care approach.
16	ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.
17	Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.
18	Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.
19	Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5 day rota.
20	Standardise post discharge reviews using the GM-SAT six-month post stroke review tool:https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/07/gm-sat-proforma.pdf

GIRFT Stroke Action Plan (narrative response)

No.	Recommendation	Health Board Response	Proposed Action Owner(s)
	ACUTE SERVICE		
1	**Real time data recording with regular audit meetings to review SSNAP data accuracy**	Recommendation supported in principle, although recognise the practical challenges involved for clinical staff. Establishing the SSNAP co-ordinator as a permanent post in the service is an important first step. Proposed actions • Urgent plan for replacement of SSNAP data co-ordinator • Prepare business case for permanent funding for the SSNAP co-ordinator post • Establish robustness and accuracy of SSNAP data as a standing audit meeting topic • Seek advice from GIRFT team regarding successful examples of real time data entry • Include as part of formal proposal paper to go to Executive Team • (Note – recognise that higher banded role may be very useful for overseeing and expediting patients through the system)	**Rhys Monk** Tanya Richards Yaqoob Bhat
2	**Commission an ESD pathway process flow map – expected that this will lead to reduction in number of rehabilitation units**	Accepted as an important pre-requisite for longer term review of rehabilitation service provision Proposed actions • Prepare initial mapping based on previous work undertaken within therapies / seek additional modelling support • Seek recent examples (via GIRFT) from other services to ensure comprehensive coverage • Initiate discussion with therapies management team regarding wider impact of this and other related recommendations in the context of recent therapies strategy work streams	**Adele Griffiths** David Hanks Collette Kiernan Medicine Division
3	**Consistent process for pre-notification of acute stroke presentations to the stroke team, optimising and thereby optimising access to imaging**	This is recognised as a critical first step to consistent timely assessment and delivery of thrombolysis therapy for all appropriate patients. An efficient and effective pathway will involve the ability of public / community to recognise and act on acute stroke symptoms, clear lines of communication with WAST, robust ownership of stroke pathway within GUH, understanding of pathway within ED and responsive radiology capacity. This is inevitably also linked to the recommendation for 24/7 presence of a supernumerary stroke specialist nurse	Sue Pearce Febe Palmer Tanya Richards Samantha Hurn (WAST) Mike Jenkins (WAST)

Stroke GIRFT action plan 06.12.22

		Proposed actions • Review current pathway in consultation with WAST / ED colleagues and identify current areas / causes of delay • Assess potential for further community publicity programme for FAST etc • Work closely with Delivery Unit review of stroke radiology pathway • Build in to plan / business case for 24/7 specialist nurse presence and role	
4	**Develop strategy to ensure prompt transfer of patients to acute stroke unit i.e. within four hours**	It is recognised that delays in transfer to the stroke unit are strongly related to severe pressures within the wider urgent care system and the subsequent utilisation of all available acute beds when managing clinical risk at the front door. Progress with this recommendation is also again linked to the recommendation for 24/7 presence of a supernumerary stroke specialist nurse, but it is important to identify and address any readily avoidable areas of delay as soon as possible Proposed actions • Urgent review of existing operational policies with aim of identifying early actions that reduce blockages and delays • Discuss options with Operations team to assess realistic and sustainable protocol for element of bed protection, given severe wider operational pressures. • Aim to establish 'stroke champions' within the emergency department • Develop proposal that sets out the conclusions from the above and incorporates the beneficial impact of other related recommendations / work streams • Include as part of formal proposal paper to go to Executive Team	Peter Carr Carl Rees Yaqoob Bhat Rhys Monk David Hanks
5	**Ensure access to the stroke unit for stroke patients for 90% of their stay**	It is considered that progress on recommendations 2 and 4 will be highly influential in delivering this recommendation as a positive consequence. Emphasis should therefore be placed on the former to avoid complication and duplication of service effort. Proposed actions • Ensure clear data on current patient stays and ward locations • Pursue actions in respect of recommendations 2 and 4 • Measure improvements in compliance as / when progress with the above is delivered • Ensure benefits of element of ringfencing	**Tanya Richards** **Rhys Monk** **Carl Rees**
6	**Optimise thrombolysis pathway to ensure rates of 15-20% of acute stroke presentations have opportunity for thrombolysis**	Pleasingly, the service is currently delivering thrombolysis rates within this target range, but it is recognised that further improvement is desirable to ensure consistent delivery. It is considered that progress on recommendations 3 and 7 (together with the forthcoming Delivery Unit review of stroke radiology pathways) will be highly influential in delivering this	**Yaqoob Bhat** **Rhys Monk** Tanya Richards

Stroke GIRFT action plan 06.12.22

		recommendation as a positive consequence. Emphasis should therefore be placed on the former to avoid complication and duplication of service effort. Proposed actions • Pursue actions in respect of recommendations 3 and 7 • Work closely with DU review of stroke radiology pathway to assess any further sources of delay • Continue Clinical Director-led weekly audit of thrombolysis activity and metrics to measure improvements in compliance as / when progress with the above is delivered	
7	**The service should aim for 24/7 supernumerary specialist nurse cover to be the key point of contact and 'own' the priority of driving patients through the stroke pathway**	The emphasis placed on this by the GIRFT team as a key priority action is noted. Whilst there is a clear cost implication, it is intended that this should be one of the first actions to progress as an important step in strengthening the Health Board commitment to an optimal stroke pathway. Proposed actions • Develop practical plan / business case for increasing specialist nurse establishment to deliver 24/7 coverage • Include as part of formal proposal paper to go to Executive Team • Progress business case through usual Health Board scrutiny procedures	**Sue Pearce** **Rachel Pritchard** Febe Palmer Tracey Morgan Peter Carr
8	**Ensure 24/7 availability of ED or stroke staff competent and able to provide swallow screening within two hours**	Some progress has been made in respect of training additional staff groups for this competence, but the need to continue and embed arrangements is acknowledged. Once again this is linked to the recommendation for 24/7 presence of a supernumerary stroke specialist nurse, which could provide consistent additional expertise. Initial screening as a triage for more detailed swallow assessment – important to maintain key professional role of SLT Proposed actions • Meet with ED team to review current arrangements to establish baseline position and realistic gap to address for consistent delivery • Progress rollout of training for additional staff groups e.g. ED / ward nursing staff (noting link with ED 'stroke champions')	Sue Pearce Chris Morgan Claire Parks Roxy Williams Febe Palmer Tanya Richards Jenna Adams Alison Williams

Stroke GIRFT action plan 06.12.22

9	**Put cohort of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.**	This is considered to be an important area for development and will be fully supported through the Medicine Division and the Executive-led Stroke Delivery Board Proposed actions • Seek further guidance from GIRFT team and Stroke Network • Discuss requirements at Stroke Delivery Board • Develop Divisional / Directorate plan as part of wider training & development strategy – to include within job plans • Confirm nominations	**Chris Heath** Collette Kiernan Directorate / Divisional team
10	**Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support:** stroke-integrated-community-service-february-2022.pdf (england.nhs.uk).	This relates to a wide-ranging recommended model of stroke care in the community, much of which is contained within the other specific recommendations within the GIRFT report. It is considered that a more general review of the model and analysis of the remaining compliance gaps in the Aneurin Bevan service forms part of the longer-term agenda of the Stroke Delivery Group once the specific actions linked to other recommendations have been progressed / implemented. It is recognised that this model will influence the operation of the ESD pathway	Peter Carr
11	**Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.**	The importance of ensuring good levels of support for carers is noted and the service would wish to work closely with the Stroke Association to identify priority areas for further work. Proposed actions • Prepare baseline assessment of current provision against the SACS pathway • Consider and prepare a gap analysis / development plan, based on observed best practice and gaps identified	David Hanks Rachel Pritchard Katie Chappelle Adele Griffiths
12	**Embed the National Stroke Service Model in ABUHB** https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf	This relates to a wide-ranging recommended model of stroke care delivery, much of which is contained within the other specific recommendations within the GIRFT report. It is considered that a more general review of the model and analysis of the remaining compliance gaps in the Aneurin Bevan service forms part of the longer-term agenda of the Stroke Delivery Group once the specific actions linked to other recommendations have been progressed / implemented.	Peter Carr Yaqoob Bhat

Stroke GIRFT action plan 06.12.22

13	Ensure 7 day access to neuro-physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients.	It is considered that this and a number of the other recommendations are closely linked to wider reviews of therapy resourcing and distribution, and to the desirability of changes to the configuration of stroke rehabilitation services generally referenced in recommendation 2. It is therefore intended that this and the other relevant recommendations are considered as part of the discussions with the senior therapies management team, informed by the conclusions of the ESD pathway mapping and analysis from the specific therapies mentioned. Proposed actions • Prepare initial ESD mapping based on previous work undertaken within therapies • Prepare baseline assessment of existing physiotherapy provision and options for delivering the seven-day / 45 minute standards • Initiate discussion with therapies management team regarding wider impact of this and other related recommendations in the context of recent therapies strategy work streams	**Collette Kiernan** Sarah Carrington Suzanne

14	The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working	As above, it is considered that this and a number of the other recommendations are closely linked to wider reviews of therapy resourcing and distribution, and to the desirability of changes to the configuration of stroke rehabilitation services generally referenced in recommendation 2. It is therefore intended that this and the other relevant recommendations are considered as part of the discussions with the senior therapies management team, informed by the conclusions of the ESD pathway mapping and analysis from the specific therapies mentioned. Proposed actions • Prepare initial ESD mapping based on previous work undertaken within therapies • Prepare baseline assessment of existing therapy provision and options for delivering seven-day working • Initiate discussion with therapies management team regarding wider impact of this and other related recommendations in the context of recent therapies strategy work streams	**Collette Kiernan** Adele Griffiths

Stroke GIRFT action plan 06.12.22

15	**Deliver adequate psychological and emotional support for stroke survivors and their families.**	This is acknowledged as an important element of support for stroke patients and their families, and an area that should be prioritised. Whilst definitions of 'adequate' may be difficult, we would wish to learn from existing examples of best practice and to develop the service locally as a high bench-marked level of provision. Recognised that emphasis needs to be placed on the rehabilitation element of the pathway to avoid a medical focus. Proposed actions • Prepare baseline assessment of current provision and benchmark against peers, informed by current good practice guidelines, research evidence of benefits etc • Consider and prepare a gap analysis / development plan / business case for the service, based on bench-marked practice and gaps identified • Include as part of formal proposal paper to go to Executive Team	**Daryl Harris** Helen Hak
16	**Ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.**	This is acknowledged as an important part of patient well-being and recovery, and that it is important that the work being undertaken is fully documented and reported as required. Proposed actions • Ward teams to review current practices, informed by current good practice and agree standard procedures to ensure consistent delivery and documentation of care • Consider and prepare action plans if required to address any gaps in service • Include as part of formal proposal paper to go to Executive Team if/as needed	**Sue Pearce** **Rachel Pritchard** Febe Palmer Suzanne Bryant
17	**Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.**	The importance of good nutrition as a core element of physical recovery and rehabilitation is acknowledged and supported. Note potential lessons from recent pilot in T&O service Proposed actions • Review current pathway, informed by current good practice and agree standard procedures to ensure consistent delivery and documentation of care • Consider and prepare action plans if required to address any gaps in service • Include as part of formal proposal paper to go to Executive Team if/as needed • Consider input from nutritional support worker pilots	Catherine Jones / **Louise Evans** Febe Palmer
18	**Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held**	This aligns closely with the work to develop psychological and emotional support for the service, and these points will be picked up as part of that workstream.	**Daryl Harris** Helen Hak

Stroke GIRFT action plan 06.12.22

	to provide assurance.		
19	**Ensure 24 / 72 hour care bundles are delivered consistently. Improve documentation of MDT goal setting in case notes.**		**Sue Pearce** **Rachel Pritchard** Helen Hak
20	**Standardise post discharge reviews using the GM-SAT six-month post stroke review tool.**	Post-discharge reviews are recognised as an important element of continuing stroke care and of ensuring maximum long-term rehabilitation and recovery. It is considered that the recommended establishment of a 24/7 specialist stroke nurse presence would support progress with maintaining robust review arrangements. Proposed actions • Prepare assessment of current baseline provision and of the practicality and cost of standardisation under the GM-SAT tool • Prepare business case as appropriate for proposed implementation	**Yaqoob Bhat** **Sue Pearce**

Stroke GIRFT action plan 06.12.22

National Stroke Programme Board
Terms of Reference

Author: Lynda Kenway, Stroke Implementation Group Manager

Reviewed by:

Approved by:

| **Date:** 30/07/2022 | **Version:** v0c |

Purpose and Summary of Document:

This paper sets out the terms of reference for the Stroke Implementation Group's National Stroke Programme Board.

1   Introduction

Stroke is the fourth leading cause of death in Wales, and it can have a significant long-term impact on survivors. There are currently almost 70,000 stroke survivors living in Wales, and an estimated 7,400 people experience a stroke each year. Stroke can change lives in an instant, but with the right support, people can make a good recovery.

The NHS Wales Health Collaborative Executive Group (NHSWHC CEG) is the responsible governance group for the Stroke Implementation Group (SIG) and the National Stroke Programme Board (NSPB). The NHS WHC CEG reports to the NHS Wales Collaborative Leadership Forum. The National Stroke Programme Board (NSPB) provides oversight of the national stroke programme and works in partnership with the regional stroke programmes to improve the stroke pathway and develop a programme of work to scope out and develop comprehensive regional stroke centres (CRSCs). This paper sets out the terms of reference for the National Stroke Programme Board.

2   Background

The Stroke Implementation Group was established in 2013 to provide national leadership and support for the delivery of effective person-centred, value-based, stroke care in Wales.

The Stroke Implementation Group identifies priority areas for collaboration to improve the provision of stroke services at a regional or national level and facilitates decision making which is in the best interests of the regional or national population, as appropriate, based on the best evidence available. The Collaborative Executive Group is the responsible governance group for the Stroke Implementation Group team and National Stroke Programme Board and approves the SIG work programme.

This programme has been established on the request of the NHSWHC CEG following several reports and papers setting out the various challenges for stroke services in Wales. In June 2022 the CEG endorsed the establishment of a National Stroke Programme Board (NSPB), supported by a core programme team within the NHS Wales Health Collaborative. The team will oversee a consistent approach to the establishment of regional stroke networks which deliver a sustainable stroke service model for Wales that meets national stroke standards and improves outcomes for patients.

The CEG also endorsed the recommendation that:

1) the planning assumption that four regional CRSCs and ODNs are required and that regional work within the programme should be structured accordingly
2) the National Stroke Programme Board produces a clear and unambiguous case for change demonstrating current outcomes and the expectations for improvement by delivery of the national standards and the new service models that will follow.

The Collaborative Programme Team comprises of representatives from the Stroke Implementation Group:

- Senior Chief Executive Lead for Stroke – (CEO Swansea Bay University Health Board)
- National Clinical Lead for Stroke
- National Nurse Lead for Stroke
- National AHP Lead for Stroke
- SIG Manager/National Programme Manager
- SIG Senior Project Support Officer

Activities of the Programme Team are supported by NHSWHC leads from:

- Senior Management Team
- Planning
- Communications & engagement
- Finance & resources

3 Purpose and roles

The purpose of the National Stroke Programme Board is to provide:

- executive guidance to the National Stroke Programme

- detailed oversight of the work to develop comprehensive regional stroke centres and operational delivery networks. Ensuring that regions are supported to develop standardised programme plans

- develop a clear process to evaluate and scrutinise regional plans ensuring that there is an independent panel in place to provide assurance

- determine the national case for change

- agree national standards, guidance, service specifications and pathways

- support the public and professional engagement and consultation process

- Develop a full programme business case

In fulfilling the above purpose, the NSPB will act on behalf of the Collaborative Executive Group, working within the parameters set by that group, and will be informed by the Stroke Implementation Group work programme.

Specific roles of the NSPB are to:

- support the delivery of the agreed work programme through prioritisation and the identification and resolution of issues affecting progress which need the input and agreement of senior stakeholders

- receive and review reports from the agreed subgroups and regional programmes on delivery against the agreed priorities and timelines, and hold the regions CEOs to account for this delivery

- Seek assurance that regional boards are on track to deliver against the agreed priorities, and escalate any identified risks/issues concerned

- consider and resolve dependencies between activities within the programme and dependencies related to other local, regional, and national work

- ensure the identification and management of risks associated with the programme

- formulate and agree key recommendations to the Collaborative Executive Group, and, in some cases for eventual approval by Boards, in terms of:
  - programmes, projects, and activities to be continued or added to the work programme, through annual and in year review
  - decisions and actions stemming from work undertaken by the Programme Team, where this has impacts across organisational boundaries
  - the closure of existing programmes, projects and activities, on completion or for other reasons
  - the allocation of resources to support the delivery of the programme
  - reports, business cases and other representations to be made to Welsh Government and external stakeholders in support of the delivery of the programme

- ensure that the work of the Programme Team is communicated appropriately to all relevant stakeholders in NHS Wales and to relevant external stakeholders

- consider direct requests from Welsh Government for the Programme Team to take on new work or expand existing programmes of work, ensuring those agreed are consistent with the remit of the programme and can be met either through existing resources or are supported by additional resources from Welsh Government

4 Guiding principles

In conducting its business, the National Stroke Programme Board will:

- work in a spirit of collaboration, with trust and respect in support of the needs of the current the population of Wales and future generations
- support the principles of prudent healthcare
- be guided by the best available evidence

5 Authority and reporting

The National Stroke Programme Board will act as an executive subgroup of, and be accountable to, the Collaborative Executive Group. The SRO will report to each meeting of the Collaborative Executive Group on the activities of the NSPB.

Decisions made by the NSPB that would have a material impact on services delivered by health boards, trusts, or special health authorities, on the content of the work programme will be advisory to the Collaborative Executive Group and will be referred to that Forum for agreement. Where necessary, such recommendations may need to be agreed by individual boards or regions.

The NSPB has no specific delegated authority from statutory health bodies, although Chief Executives may make commitments via the Collaborative Executive Group within the normal limits of their delegated authority.
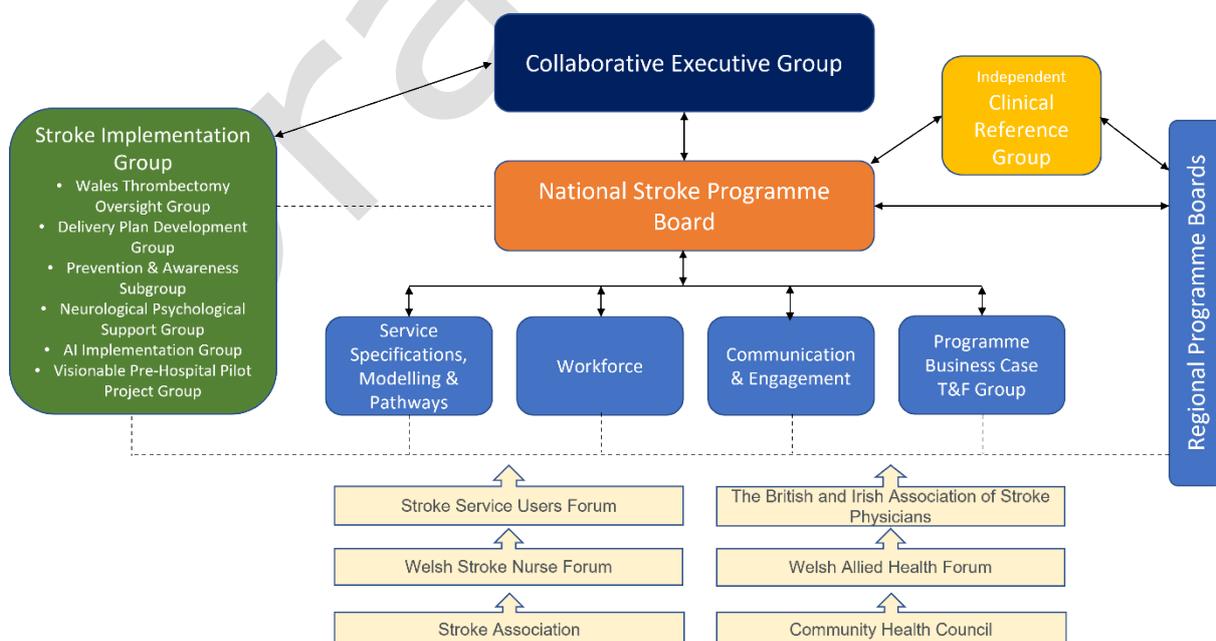
6 Membership

The membership of the board will be consistent of representatives from:

- health board Director of Finance

- health board Director of Planning

- health board Director of Nursing

- health board Directors of Therapies and Health Science

- health board Medical Director

- health board Director of Workforce and Organisational Development

- NHS Wales Delivery Unit

- Welsh Government

- Emergency Ambulance Service Committee

- Welsh Health Specialist Service Committee

- Health Education & Improvement Wales

- Digital Health Care Wales

- Welsh Ambulance Service Trust

- Community Health Council

- Stroke Association representative

- communications & engagement leads

- regional stroke programme managers

The programme should also seek to engage with external clinical advisors who will provide advice to the Board as well as supporting development of the programme

The Programme Board should be underpinned and supported by professionals from the pathway, together with wider enabling and ancillary services including:

- Allied Health Profession leads – physiotherapy, Occupational therapy, dietetics, speech and language therapy, psychology
- Community Rehabilitation Teams

- Health board stroke clinical leads

- Improvement Cymru

- Primary Care

- Radiology services

- Research

- Social care teams

- Value Based Health Care

In addition, the following will be invited to attend meetings of the NSPB:
- Collaborative Senior Management Team members and other senior managers where relevant to the topics under discussion
- Strategic Clinical Advisor, Welsh Government
- A minute taker provided by the Collaborative Team

Other individuals may be invited to attend specific meetings of the NSPB, at the discretion of the Chair, where this will facilitate the work of the group.

7 Chair

The National Stroke Programme Board will be chaired by the SRO for the lifetime of the Programme.

8 Arrangements for meetings

8.1 Frequency of meetings

The Programme Board will meet quarterly, except in cases where the Chair agrees that there is sufficient business to justify convening additional meetings.

Meetings of the Programme Board will be scheduled for 12 months ahead, and any cancellations or changes will be notified at least seven days in advance.

8.2   Circulation of papers

Agendas, supporting papers and minutes of the previous meeting will be circulated to members of the Programme Board at least five days before each meeting.

8.3   Quorum

The quorum for meetings of the Programme Board shall be 50% of the group's full members.

8.4   Attendance

Except in exceptional circumstances, all members of the Programme Board should endeavour to attend all meetings of the group. If unable to attend a specific meeting, members may nominate a deputy, at executive director level, to represent them.

8.5   Decision making

Bearing in mind that key decisions are advisory to the Collaborative Executive Group, the Programme Board will seek to reach decisions by consensus. If that is not possible, decisions will be referred to the Collaborative Executive Group, making the Group aware of the nature of the disagreement and the split of views.

8.6   Withdrawal of individuals in attendance

At the discretion of the Chair, any, or all individuals in attendance at a meeting of the Programme Board (i.e., non-members) may be asked to withdraw from parts of the meeting, to facilitate full and frank discussion.

9   Conduct of urgent business

Where urgent business is required to be conducted between meetings, the Chair will arrange for members views to be sought by email and the outcome will be reported to the next meeting of the Programme Board.

10   Support

The Programme Board will be supported administratively by the Programme Team. In liaison with the Chair, the Programme Team will be responsible for:

- setting the schedule of meetings
- booking meetings

- sending invitations to attend meetings on behalf of the Chair
- preparing and circulating agendas, papers and minutes
- maintaining and following up on a list of agreed actions
- preparing reports for the Collaborative Executive Group
- facilitating the conduct of urgent business by email

11   Review

These terms of reference will be reviewed by the Programme Board at least annually and any changes will be ratified by the Collaborative Executive Group.

	Aneurin Bevan University Health Board **Six Goals for Urgent and Emergency Care**

Executive Summary

This paper outlines the Health Board's most recent performance status in relation to Urgent and Emergency Care and the proposed plans for making system improvements via the "Six Goals for Urgent and Emergency Care" Programme.

The Performance Data highlights some areas that have deteriorated and some with signs of improvement. However, it must be noted that this is snapshot from November 2022 and the current situation is expected to show an even more challenging picture for December.

However, through the Six Goals and other IMTP programmes there is considerable ambition and determination to deliver improvements for the population of Gwent and our staff. The Programme reflects this with numerous projects on-going and at various stages of life cycle.

The Board is asked to:	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	
Executive Sponsor: Leanne Watkins, Director of Operations	
Report Author: Simon Roberts, Senior Programme Manager, Clinical Futures	
Date of the Report: 3rd January 2023	
Supplementary Papers Attached: Appendix 1 – Six Goals Programme Plan	

Purpose of the Report

To provide the Committee with an overview of the Aneurin Bevan Initial 'Six Goals' Programme and associated performance and financial status.

1

Detailed Update

Performance

The last full performance report submitted on behalf of the Health Board was for the period November 2022. The below table represents the reported performance for Urgent care for that period.

Measure	Report Period	National Target	Current Performance	Previous Period Performance	In Month Trend
Category A ambulance response times within 8 minutes.	Nov-22	65%	55.2%	56.4%	↓
Number of ambulance handovers over one hour	Nov-22	0	841	882	↑
% patients waiting < 4 hrs in A&E figures inc. YAB & YYF	Nov-22	95%	72.3%	73.9%	↓
Number patients waiting > 12 hrs in ABUHB A&E departments	Nov-22	0	1662	1689	↑

Table 1.1 Nationally reported Urgent Care measures for November 2022

The data reflects what is a generally deteriorating position that is being felt both within Gwent but also nationally as we move further into winter. However, there are some areas that demonstrate improvement.

Category A ambulance response times within 8 minutes has deteriorated to 55.2% although the number of ambulance handovers within ABUHB exceeding 1 hour has improved to 841 occurrences. The proportion of patients waiting more than 4 hours within A&E (all sites) has deteriorated to 72.3% however the number of patients spending more than 12 hours in A&E has improved to 1662.

It is anticipated that December performance will be challenged even further due to a number of factors widely reported on nationally. These include factors such as higher levels of respiratory infections (flu, Covid-19, Strep A) in circulation combined with areas of staff shortages and strike action all affecting demand and subsequent ability to manage that demand.

In response to these pressures, the Six Goals for Urgent and Emergency Care Programme is already established with Six workstreams led by a mix of clinical and managerial leaders represented from both primary and secondary care.

The programme governance structure is as per below and recognizes key links to other IMTP programmes as well as the importance of reporting to the Regional Partnership Board and engagement with the CHC.

Six Goals Programme Governance
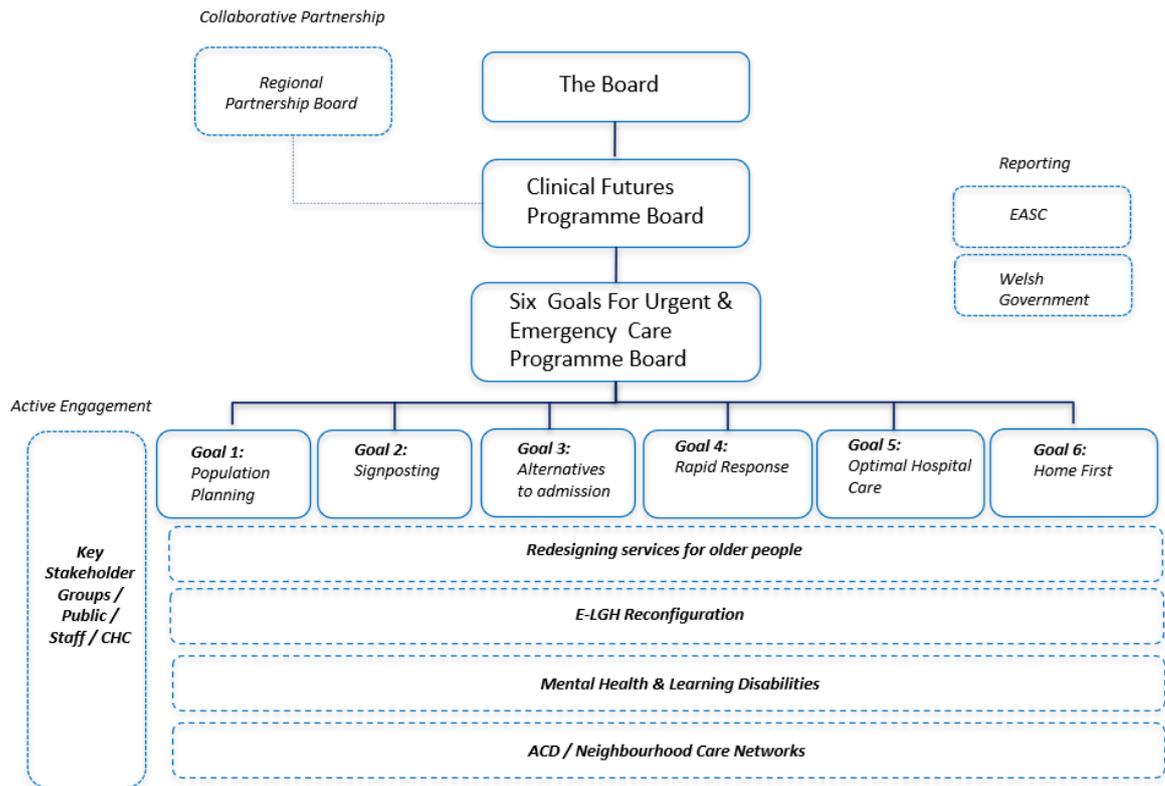
A national six Goals Programme Board exists to give strategic oversight and assurance for the delivery of Programme objectives. The Board is supported by a Programme integration group which consists of senior responsible officers (SROs) tasked with developing national action plans for each of the Six Goals intended to enable Health Boards and partners to deliver the policy vision.

Welsh Government has indicated that two key priorities of programme are implementation of Urgent primary care Centers (UPC) and Same Day Emergency Care (SDEC) supported by £2.96M of revenue funding until 2025/26. The Programme plan addresses each of these areas.

Assessment and Conclusion

Progress Summary by Goal as of December 22

The Health Board has seen broadly positive momentum through each of the goals in the context of significant operational pressure. The connections between programmes are starting to mature, it is clear that projects in Goal 1 and 6 will primarily be driven through the 'Redesigning Services for Older People '(RSfOP) Programme.

3

Engagement with Welsh Government continues to build momentum with Welsh Government and national goal lead representation at programme board.

Goal 1: A ' High intensity User Service Model' exists within ABUHB where referrals are made to a Lead Nurse who is able to make the right community or social referral required to support the patient in safe discharge. However, the model requires strengthening to sustain and grow which is supported by the national Goal 1 lead. A Business case is in development and funding source required for this – closely linking with National Goal 1 lead to develop.

In addition, Proactive Falls and Frailty service scoping and design will form part of Goal 1 but is driven by the RSfOP Programme.

Goal 2: Urgent primary Care centres are already established with a number of referral streams including 111 and re-directions from Minor Injury Units or A&E. UPC has seen significant demand recently notably linked to Strep A concerns. Recently the National UPC programme led a peer review of our service, and the findings will be analysed, and action plan developed in early 2023. In Addition, a UPC model review is planned in February 23.

Goal 3: Same Day Emergency Care (SDEC) at the Grange opened in August 22, largely receiving General Surgery Patients however there are plans to maximize the capacity offered by SDEC by integrating Acute Medicine into the model. SDEC at Ysbyty Ystrad Fawr (YYF) opened in October 22, seeing 'ambulatory' medical patients referred from the AMU.

Further services based on the same day ambulatory care model have been implemented in the organisation. Respiratory Ambulatory Care (RACU) funding has been extended to March 23 with the centre established in the Royal Gwent Hospital. A Gastroenterology

4

Ambulatory Care (GACU) model provides consistent service and includes admission avoidance. Further detail on the SDEC service models and other existing services that work to the same principles are included below for information:

SDEC GUH at a Glance 8/8/22– 9/12/22
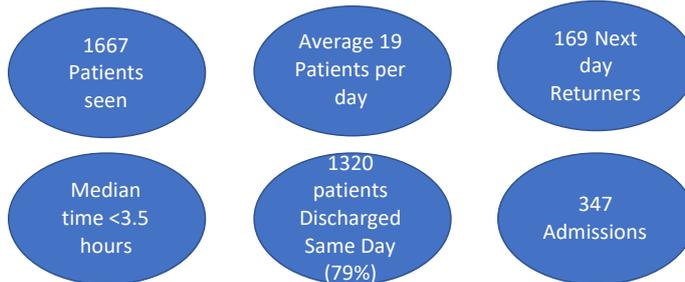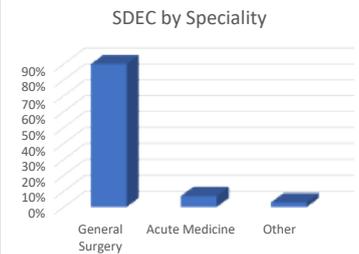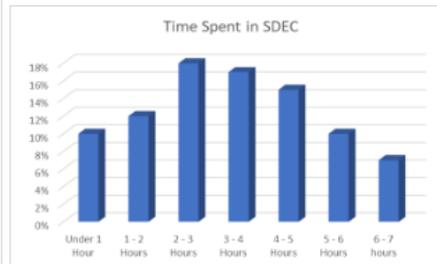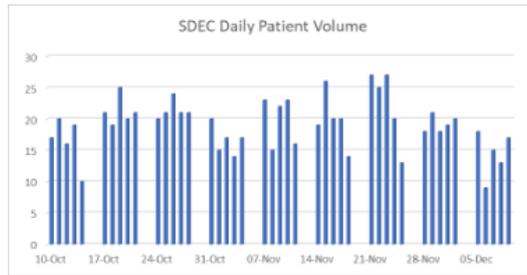
1667 Patients seen	Average 19 Patients per day	169 Next day Returners
Median time <3.5 hours	1320 patients Discharged Same Day (79%)	347 Admissions

Progress Summary
- Surgical model well developed :
  - Primarily GP referred via Flow Centre
  - Some Direct from ED Triage streaming
- Working with Trauma to introduce a pathway in Dec 22
- Plans to utilize for Acute Oncology patients in Feb 23
- Ad-hoc utilization for Maxfax, Gynae and Gastro
- Continue to explore speciality in-reach
- Overall aim remains to embed an Acute Medicine Model but requires system wide capacity & workforce planning

Enhanced Local General Hospital Medical Assessment Units
- Approx 50 referrals (WAST and GP) streamed per day to eLGH (3 sites) via Flow centre
- Patients who meet criteria who do not require The Grange for assessment
- Approx 8 referrals per day from Minor Injury Units
- 80% + Assess out rates from eLGH MAUs

SDEC at The Grange
- Primarily General Surgery from GP via Flow Centre, some from ED
- Introducing a wider range of specialty same day access
- Plan to fully adopt for Acute Medicine linked to workforce change across system
- Mean range 17 to 29 Patients per day, plan to double via acute medicine roll out

SDEC at Ysbyty Ystrad Fawr
- Referrals from Medical Assessment Unit
- Primarily COTE patients
- 7 – 10 patients per day

Respiratory Ambulatory Care Unit (RACU) St Woolas
- GP Referrals from Flow Centre
- 7 - 8 patients per day
- *5 day 900-1300 – next day referrals until 4pm*

Gastroenterology Ambulatory Care Unit (GACU) Royal Gwent
- GP Referrals from Flow Centre and some from ED
- Mostly planed appointments but some acute / admission avoidance
- 2-4 acute referrals per day
- *5 day 900-1600*

5

In Addition, to support the principles of Goal 3 'admission avoidance' an Advanced Paramedic Practitioner (APP) is working in the flow centre from December 22 to support direction to the right place first time and also support joined up working between ABUHB and WAST. A Frailty Assessment Service Pilot planned in Jan 23.

Goal 4: ABUHB has received funding via the Six Goals national 'Innovation Fund' to support implementation of an electronic Triage solution for ED and MIUs. The eTriage project board has been established, aiming to implement in Q2 2023 which will improve clinical visibility of the often very busy waiting areas and improve patient experience.

Ambulance handover improvement is a key focus of Goal 4 and there is a plan to pilot a push model of flow in Q4 22. This would encourage timely referrals of limited patients to specialities at given times of the day ensuring that clinical risk is more equitable across a hospital site.

Goal 5: A re-energized Discharge planning framework will be launched in January 2023 in collaboration with the Delivery Unit. So far, training has been completed at eLGH sites with Focused engagement led at 3 wards on at each site to engage staff and generate ideas for improvement linked to Multi-Disciplinary Team Board rounds, daily huddles, red/green days and criteria led discharge.

Goal 6: A business case has been approved to provide additional First Front Door Therapies staff dedicated to ED to support a 'home first' approach. The first team member started in Late December with on-going recruitment to additional therapies posts. Homeward bound Nurse led wards have been developed at 2x eLGH sites for Medically Fit For Discharge patients with the aim that this provides more suitable care for those not requiring regular medical intervention and encouraged reablement.

In Summary, it is generally accepted that there is no one single solution to alleviate some of the challenges faced currently, however through a mix of tactical and strategic initiatives incremental improvement can be made to improve patient care and staff wellbeing in what is an increasingly challenging environment.

Recommendation
The Committee is asked to note the contents of this report.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	This report has no financial consequence although the financial benefits are being assessed to ensure value for money.
Quality, Safety and Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.

6

Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact, but the assessments will form part of the objective setting and mitigation processes.
Health and Care Standards	This report contributes to the good governance elements of the H & CS.
Link to Integrated Medium Term Plan/Corporate Objectives	The objectives will be referenced to the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Six Goals is part of both short- and long-term strategy
	Integration – It is anticipated that Six Goals will have a positive impact upon the well-being of staff and population
	Involvement – Involvement of various internal and external groups is continuous
	Collaboration – Collaboration with various internal and external groups is continuous
	Prevention – Team members have the authority to raise concerns and flag problems
Glossary of New Terms	New terms are explained within the body of the document.
Public Interest	Report not to be published.

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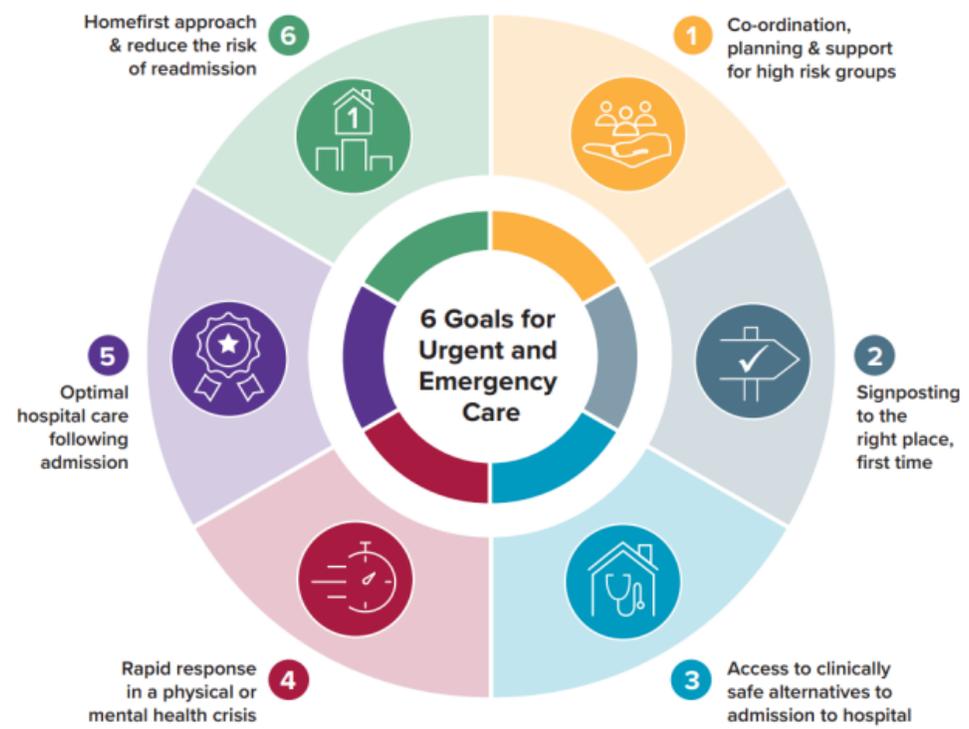
Six Goals Programme Plan
December 2022

Six Goals Work Programme

Six Goals For Urgent & Emergency Care Programme

Goal 1:
Population Planning

High Intensity Service Users

Proactive Falls

High Risk Adult Cohort

Goal 2:
Signposting

Urgent Primary Care Centres

NCN Signposting

111 & Option 2

Goal 3:
Alternatives to admission

SDEC / Hot clinics

Flow Centre Development

One directory

Scheduled MAU slots

Goal 4:
Rapid Response

Physician response unit

eTriage

Mental Health services

ED referral Improvement

WAST Improvement

Goal 5:
Optimal Hospital Care

Discharge Pathways

SAFER Principles

Education & Training

PSAG Boards

Goal 6:
Home First

ED Therapy services

MFFD Cohort

Trusted Assessor Model

Rapid Response and Community resilience

Six Goals Plan
A high level overview of activity and deliverables planned to 2024

Workstream	2022			2023			2024	Key Upcoming Dates
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	

Goal 1 *Population Planning & Intervention*
- RSfOP 2: Community Falls response/Prevention
- RSfOP 1: Proactive Frailty (HRAC)
- HISU: Business Case Development (Expansion & Integration)

Key Upcoming Dates:
- **Oct 22** - Falls Response Mapping
- **26th Oct 22** - HISU Business case to PIP
- **19th Sept 22** - RSfOP 1 Project team recruitment to commence

Goal 2 *Signposting*
- UPC GUH Audit
- Signposting Table top
- 111 Option 2 Development
- GP+
- ACD : ACD Development
- MSK 1 : Therapies MIU/UPC

Key Upcoming Dates:
- **Oct 22** - Signposting Tabletop Analysis
- **Nov 22** - MH Single point of access via 111 go-live

Goal 3 *Safe Alternatives to Admission*
- SDEC GUH (Phases 1-4)
- SDEC: RACU (Respiratory - to Mar 23)
- RSfOP 2: Hot Clinics/Ambulatory Care
- SDEC CEPOD Pilot
- SDEC YYF Pilot to Mar 23
- Scheduled AMU Slots
- CF7 Pathways (eLGH)
- Flow Centre APP Pilot
- One SPA review (FC & SPA)

Key Upcoming Dates:
- **17th Oct 22** - SDEC CEPOD Pilot at RGH
- **Oct 22** - YYF SDEC planned commencement
- **Nov 22** - Flow Centre APP Pilot
- **Nov 22** CF7 pathway Proposals to LMC

Goal 4 *Rapid Response*
- Review of MH pathways and referral
- PRU Business Case
- WAST Improvement plan
- eTriage Implementation

Key Upcoming Dates:
- **26th Oct 22** - PRU Business case to PIP
- **Oct 22** - Commence etriage T&F group
- **Oct 22** - MH Pathway volume/outcome review to Execs

Goal 5 *Optimal Hospital Care*
- GUH Patient Pathways (1, 2 , 3)
- Education and Training
- Discharge Planning Reviews
- PSAG Improvement with Digital enablers
- Roles/Responsibilities Task & Finish
- eLGH: eLGH Reconfiguration

Key Upcoming Dates:
- **Sept 22** - Discharge Planning training at 3 sites
- **Oct 22** - eLGH Flow Centre 'table top' analysis
- **Oct 22** - GUH clear status pathways flowdown to staff

Goal 6 *Home First*
- MFFD Cohort
- RSOP 1: Extension of Core Rapid Medical (HCSW 8-8)
- Front Door Therapies GUH & Criteria led discharge pilot
- RSOP 1: Urgent Responsive Care at Home (Overnight HCSW)
- Begin joint trusted assesor model discussions
- RSfOP: Direct Access Pathways

Key Upcoming Dates:
- **13th Oct 22** - MFFD Proposal to Execs
- **Nov 22** - Rapid Response negamenet events
- **Nov 22** - Advertise posts for Overnight HCSW
- **Dec 22** - 1st Therapies posts recruited to

Denotes Governance outside of Six Goals Programme

Denotes funding through RIF

Goal 1: Population, Planning, Prevention

	Work Area	Actions	Lead/Sub Lead	Timeframe	Progress
1.1	**High Intensity Users**	• Develop business for enhanced integrated model including community outreach, joining up response to frequent attenders to ED, OOHs, WAST and facilitating care plans • Integrated processes with Health Inclusion Service to support vulnerable service users (drug users, sex workers, homeless, refugees) • Further integration with other agencies via community panel meetings including Welsh refugee support, housing, The Wallich etc) • Consider hub approach to bring together support services, located near to RGH, to support redirection	Will Beer/Victoria Goodwin	Q3 2022/2023 Q3 2022/2023 Q4 2022/203 TBC/longer term plan	- Business Case is developed and will be submitted via PIP process however **funding source not yet identified** - Linking with National Goal 1 lead for possible funding and model design
1.2	**Proactive Frailty (High Risk Adults Cohort)** Project agreed to form part of the Redesigning Services for Older People Programme **Phase 2**	Building upon the work of the High-Risk Adults Cohort Project, implement a process to ensure multi-agency and proactive management of those who are at risk of frailty or of whose risk is increasing. • Scope pilot in one area • Plan and design systematic implementation including identifying resource requirements	Will Beer/Mel Laidler	Scoping -2022/2023 (programme resource dependant) Implementation-2023/204	- Successful Winter Bid to Regional Integrated Fund to bring forward planning and scoping phase to Q3/Q4 2022/2023 (project manager, medical sessions, project support) -Project Manager post on trac
1.3	**Proactive and preventative response to falls in the community** Project agreed to form part of the Redesigning Services for Older People Programme **Phase 2**	Work in partnership to develop a proactive and preventative falls programme in the community • Map the current falls provision across the CRTs • Support Monmouthshire NCN as 'test bed' Borough for Household Cavalry approach • Scope a preventative and proactive community falls programme/action plan	Will Beer/Karen Hatch	Scoping - 2022/2023 Implementation-2023/2024	-Monmouthshire proposal in development and seeking funding via Integrated Partnership Board- **Dec 2022** -Initial review of CRT Falls mapping to be discussed at the community falls group on 3rd Nov - **Nov 2022** - Gap analysis and rolling prevention campaign development

Goal 2: Signposting

Goal Leadership:
- Dr Alice Groves
- Dr Alun Walters
- Rebecca Pearce

	Work Area	Actions:	Lead (s)	Timeframe	Progress
2.1	Public Communications and Engagement	- Linking to Nye Bevan Champions forum (Third Sector) - Linking to large local employers - Start local and national messaging campaign via Six Goals Comms plan	Dr Alice Groves/Rebecca Pearce / James Hodgeson	- Through Winter	
2.2	Urgent Primary Care Centres (UPCC)C 24/7 Development	- In-hours Primary Care escalation - Re-directions review of outcomes - Scoping re-directions from GUH - GP+ (Access to diagnostics etc) - Ensuring pathway consistency	Dr Alice Groves/Rebecca Pearce	- On-going - Q2/Q3 2022 - TBC	Adastra outages has severely hampered progression during August /September
2.3	Think 111	- Develop working group to review TOR and risk associated with criteria - Development of MH services via option 2	Dr Alice Groves/Rebecca Pearce	- Q2 2022 - Q3 2022	Mental Health Single point of Access to begin from November via 111 option 2
2.4	WAST Remote Support	- Initial process Commenced May 22 - Professional support out of hours	Dr Alice Groves/Rebecca Pearce	- Implemented - On-going	
2.5	NCN Signposting	- Develop signposting in the community strategy i.e IAA Team (Information, advice and assistance), booklets, practice care navigation	Dr Alice Groves/Rebecca Pearce	- On-going	Mapping session held November, need to engage primary care signposting through

Goal 3: Safe Alternative to Admission

	Work Area	Actions:	Lead (s)	Timeframe	Progress
3.1	Flow Centre Advanced Paramedic Practioner (APP)	Pilot ahead of winter, an APP at the Flow centre to improve patient flow and reduce conveyance This is to test and strengthen the workforce model, senior decision-making function and provide additional advanced clinical assessment skills. Options to access existing WAST/HB pathways	Dr Paul Mizen / Paul Underwood	Q3 22/23	Progressing with WAST, scope/cost model operating 9am-9pm, 7/7 aligned to the demand. 66% of WAST referrals via Flow Centre are between 9am and 9pm, with 33% occurring overnight 9pm - 9am. Training and SOP agreed. APP is in the FC effective 12th Dec
3.2	Clincal Frailty 7 Pathway	The development of an clinical frailty score pathway to improve the flow of older patients through our system via the Flow Centre. Essentially ensuring that the patient is seen at the right time, in the right place by the right person. The pathway will aim to stream patients who meet the clinical criteria to an eLGH site for initial assessment, improving flow and optimising patient outcome	Dr Paul Mizen / Paul Underwood	Q4 22/23	A series of appropriate questions has been agreed following discussion with the frailty team and is based on the clinical frailty score. Proposal taken to Medical Leadership Group and LMC. Plan to commence in Dec 22
3.3	Same Day Emergency Care (SDEC)	Implement SDEC at the GUH in a phased approach for General Surgery with Flow centre referrals followed by ED streaming and wider specialities engagement. Develop the wider staffing model for Acute Medicine. Pilot of SDEC at YYF commenced 31st Oct 22 through to March 23 (RIF funded) Ensure continued service of the Respiratory Ambulatory Care unit (RACU) . RACU currently sees 40- 50 patients per week directed from GPs via the Flow Centre GAMACU 20 – 40 keeping well (3500 per year). 5-10 acute reviews . Helpline calls, referrals from FC, some direct	Dr Paul Mizen / Paul Underwood	Q4 22/23	SDEC GUH opened on 8th August 22. Plan to grow Acute Med and interim options including T&O. volume is 80 – 120 per week. YYF SDEC opened on 31st October, seeing 25 – 35 patients per week RACU funding extended, constant volume GACU 25% acute 2 to 4 ascitic drains / IBD flare ups that would have been GUH admitted and MAU assessment time

Goal 3: Safe Alternative to Admission…continued

	Work Area	Actions:	Lead (s)	Timeframe	Progress
3.4	Scheduling of Urgent Care – MAU Royal Gwent Hospital	Five scheduled urgent care slots per day have been introduced in the Acute Medical Unit (AMU) at the Royal Gwent Hospital (RGH) for GP referred patients via the Flow Centre. Primarily aiming to avoid overnight admissions of lower acuity patients	Dr Paul Mizen / Paul Underwood	On Hold	Currently paused. Low patient volume, requires further communications work via NCNS.
3.5	Service Access Points, Directory & Virtual Advice	Reviewing all entry points into the system across secondary/primary/community care. Establish a baseline of the current service provision including, how the service is accessed, operating hours, volume of activity etc This includes review of existing services across Single Point of access (SPA) and the Flow Centre and consideration of changes resulting from Redesigning Services for Older people Programme	Dr Paul Mizen / Paul Underwood	Q4 23/24	Engagement required across primary, secondary, community and local authorities to develop an options appraisal Joint mapping workshop scheduled in January 23
3.6	Elderly Frailty service at the Grange (Pilot)	Development of an Elderly Frailty assessment pathway at the Grange supported with specialist staff	Tracy Morgan / Diane Murray	Q4 23/24	Pilot scheduled to begin at GUH in January 23

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

Dyfodol Clinigol
Clinical Futures

Goal 4: Rapid Response Actions

Goal Leadership:
- Dr Alastair Richards
- Steve Bonser

|	Work Area	Actions:	Sub Lead (s)	Timeframe	Progress
4.1	ED Referral Improvement	Improvement of the referral to speciality process from ED. Currently a manual process with variation in process time for referral T&F group established to begin in Q4 to define proposed improved process	Dr Paul Mizen / Simon Roberts	Q4 22/23	Paper drafted. Meeting held with Juniors and specialists. Pilot scoping
4.2	PRU Business Case development	Work with partnership with WAST to understand the shared strategy in relation to PRU Develop a business case to ensure PRU Service continuation	Steve Bonser/ Carl Ashford	Q3 22/23	Business case developed, Further discussion required on the clinical model
4.3	E-Triage System	Work to seek funding to adopt and embed E-Triage technology within the GUH Emergency Department E-triage technology offers the opportunity to improve reception and nursing available time and the ability to promote redirection based on algorithm set by us	Simon Roberts/ Roxanna Williams	Q4 22/23	Funding for a 1 year pilot has been agreed. First Project Board held 26th Oct Contract ready for signatures, carrying 3 key risks
4.4	HB/WAST Improvement plan integration	As part of the 6 Goals Programme, Goal 4 workstream should be developed in partnership with WAST to ensure both improvement plans are reflected and agreed upon	Steve Bonser	Q3 22/23	WAST nomination received to participate in Goal 4 to support joined up approach
4.5	Mental Health Pathways Demand and Outcomes	Ensure all pathway information is available and accessible. Complete analysis on pathway demand and outcomes . Develop the MH single point of contact service to commence in November (also accessible via 111)	Michelle Forking	Q3 22/23	Demand analysis on-going due to complete in Q3. MH Single point of access to commenced in November

Goal 5: Optimal Hospital Care Actions

	Work Area	Actions:	Lead (s)	Timeframe	Progress
5.1	Discharge Policy & Pathways	Update of HB discharge policy to ensure policy reflects current environment and best practices in discharge planning. This aims to provide clear definitions and guidelines in the following areas – 1) Roles & Responsibilities, 2) Escalation methods 3) Red/Green day process 4) Standard pathway terminology to be used across the HB Awaiting launch of DU discharge framework	Sue Pearce / Sandra Mason	Q2 2023	Discharge policy T&F group to be established, meetings to start next week GUH pathway clarity is already in motion, 3 clear pathways for internal navigation (Remain at GUH/Step-down /Fit for discharge) . Communications to follow in Sept. Handbook also developed. Red/Green day refresher training on-going, needs to be reflected in the policy.
5.2	Embed Safer principles	There is variable use of the SAFER principles across the Health Board and there is a need to relaunch and embed the principles of SAFER, including the importance of daily senior review, setting the EDD/MFDD at early stage and to plan discharge from admission To embed the MDT approach to Board Rounds to ensure that all care is coordinated by the whole team, with the aim to reduce 'waits' for each input to happen. Refreshing the use of red/green day processes	Sue Pearce / Sandra Mason	Q3 2023	Work is being undertaken on the eLGH sites to re-focus on optimising discharge planning. A ward has been identified at each site to start with and will roll out to all wards, using a phased and supportive approach was considered the best approach. The SAFER principles are key to the optimising patient discharge programme. Focus to date has been on the setting of meaningful estimated discharge dates, daily board rounds and timely discharges as early in the day as possible. As part of the national work the SAFER principles have been reviewed and amended these will be launched with the framework in the next few weeks. In the interim
5.3	Education and Training	Education & Training package to be developed to increase discharge planning awareness and knowledge. This includes accountability, impact on flow and the wider organisation. This will cover both mandatory training and refresher training.	Sue Pearce / Annie Lewis	Q1 2023	Reviewing mandatory corporate training package, proposal of addition D2RA modules. Training days planned in Sept, Oct, Nov and Dec within Medicine. Sessions covered several aspects to include roles and responsibilities. This will be a rolling programme over the next 6 months across the eLGH sites. It is envisaged that this will improve knowledge and skills around discharge planning, leading to reduced length of stay and optimise the patient journey.

Goal 5: Optimal Hospital Care Actions …continued

	Work Area	Actions:	Lead (s)	Timeframe	Progress
5.4	Patient Status at a Glance Boards (PSAG)	The PSAG Boards to be standardised, across the GUH and ELGHs to Plan for every patient	Sue Pearce / Sandra Mason	Q2 2023	PSAG Boards redesigned within Medicine at RGH. Further feedback required from tests of change as above. An audit tool has been developed and audits will commence throughout November to review the information recorded on patient status boards. All wards hold regular board rounds and in most areas this is daily. The introduction of afternoon huddles is also being rolled out across sites. The huddles support a review of the actions agreed at the morning board round and identifies any issues with proceeding with these, it also facilitates an update on any changes that require escalation.
		Review digital enhancements either STREAM or existing careflow technology			Further exploration required regarding digital options
5.5	Performance monitoring	Development of Discharge dashboard to enable visibility for daily/ weekly snapshot of medically fit delays by reason, site and LOS. Also trend analysis for delay types.	Sandra Mason / Owain Sweeting	Published September 2022	Completed - ongoing review of measures to ensure report is fit for purpose

Goal 6 : Home First Actions

	Work Area	Actions:	Lead (s)	Timeframe	Progress
6.1	Front Door Therapies & Criteria Led Discharge	Business case development to provide ED GUH therapy provision (on a 5-day service initially) to increase the number of patients returned home direct from ED Once established, evaluate and pursue business case for 7-day coverage Once staff in place, test 'criteria led discharge ' at the front door	Collette Kiernan / Emma Ralph	Q3 22/23	Senior Physio in place, recruitment to follow in December for OT, Asistants therapy practitioners in Dec/Jan
6.2	'Homeward Bound' Nurse led capacity for MFFD patients	Alternative bedded capacity (taking learning from the Step Closer to Home pathway to develop a centralised model of support) Wards at 3x sites identified, SOP developed, Staffing and GP provision for medical input arranged.	Tracy Morgan / Sue Pearce	Q3 22/23	Going live at RGH 11th Dec, YYF on 18th Dec and NHH in January pending GP provision
6.3	Trusted Assessor Model	Work with partners to develop an agreeable trusted assessor model drawing on past experience and models used in other regions	Mel Laidler / Collette Kiernan	TBC	Proposal for GASP around definitions presented
6.3	Urgent Response Care (Older People)	Proposal for a small-scale approach to develop two teams of HCSW working initially in the out of hours period 8 pm to 8am, seven days per week. Each team would consist of two Health Care Support Workers who are trained to undertake observations and provide personal care and support to people to enable them to stay safely in their own home	Mel Laidler / Redesigning Services for Older People Programme	TBC	Funding Application approved through RIF
6.5	Extending CRT Model	extend the operational hours for CRT rapid up to 8pm Monday to Friday, by Jan/Feb 23. It is proposed that by recruiting additional support now, it would be possible to make the existing CRT medical team more robust across all areas and develop a weekend response in the same timescale.	Mel Laidler / Redesigning Services for Older People Programme	TBC	Funding Application approved through RIF

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							✓
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						defer	

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 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						✓	
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 Public Health							✓
Research and Development Annual Report	Annually	Director of Public Health							✓
Medical Devices Annual Report	Annually	Director of Therapies & HS					✓		
Point of Care Testing Annual Report	Annually	Director of Therapies & HS					✓		
Quality and Safety Outcomes Report	Standing Item	Clinical Executives	✓	✓	✓	✓	✓	✓	✓
Committee Risk Report, including BAF	Standing Item	Director of Corporate Gov	✓	✓	✓	✓	✓	✓	✓
WHSSC QPS Committee Report	Standing Item	Director of Nursing	✓	✓	✓	✓	✓	✓	✓
Quality Domain: Dignified Care & Individual Care									

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	25th April
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					✓		
Patient Experience Report	Quarterly	Director of Nursing		✓			✓		✓
Dementia Care Annual Report	Annually	Director of Nursing							✓
Clinical Negligence Claims and Coroners Inquests Report	Bi-Annually	Director of Nursing				✓			✓
Patient Safety Incidents and Learning	Standing Item[2]	Director of Therapies & HS	✓	✓	✓	✓	✓	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			✓		✓		✓

[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							✓
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	

Items Requested by Committee Members / Internal & External Stakeholders									
			5TH April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	April 2023
An Evaluation of the Psychological Wellbeing Practitioner Role (request from Committee Chair)	tbc	Director of Primary Care, Community & MH							
Contractual arrangements with WAST- inter-site transfers (Action taken from meeting in August 2022)	Ad-hoc	Director of Operations					✓		
Community Health Council Children's Audit (requested via Head of Corporate Services, Risk & Assurance)	tbc	Director of Operations/Direct or of Primary, Community & MH/NWSSP							

Discharge Planning Audit (requested via Head of Corporate Services, Risk & Assurance)	tbc								
Access to Primary Care Audit (requested via Head of Corporate Services, Risk & Assurance)	tbc								
The Monitoring of Commissioned Services- Transferred action from MHAMC (MHAMC 0609/06.1)								✓	
Public Health plans to improve late presentation of Cancer (PQSOC 1608/11)- for information		Consultant in Public Health						✓	
Report on Violence & Aggression (to include the impact of social media and all-Wales comparative data) PQSOC Action- 0612/14	tbc	Director of Therapies & Health Sciences							
IN-COMMITTEE (Action 0612/IC5) A Report on the findings of the Serious Incident Review of Caerphilly MAS, aligning to the National MAS review.	tbc	Director of Primary Care, Community & MH							

Report title as scheduled within Workplan – Not included on agenda	Lead	Update
Quality Assurance Framework Annual Review and Evaluation of Progress	Clinical Executive Directors	Review ongoing (Quality Strategy). Board development session scheduled for February 2023
Cleaning Standards Annual Report	Director of Operations	Deferred due to capacity issues within the Facilities Division
Pharmacy and Medicines Management Annual Report	Medical Director	Request to defer to April 2023
Nutrition and Hydration Standards and Strategy	Director of Therapies and Health Sciences	Request to defer to April 2023
Infection Prevention and Control Report	Director of Nursing	Included within Patient Quality and Safety Outcomes Measures Report, January 2023
Putting Things Right Reporting (complaints, compliments, and redress)	Director of Nursing	Included within Patient Quality and Safety Outcomes Measures Report, January 2023
Patient Safety Incidents and Learning	Director of Nursing	Included within Patient Quality and Safety Outcomes Measures Report, January 2023
Quality & Engagement (Wales) Act, Preparedness and Implementation	Director of Nursing	Reported to Committee in December 2022
Blood Management Annual Report	Medical Director	Request to defer. TBC
Falls Management Report	Director of Therapies and Health Sciences	Request to defer to April 2023