A meeting of the Aneurin Bevan University Health Board
Quality and Patient Safety Committee
will be held on Wednesday 12th June 2019, commencing at 1:00pm
in Seminar Room 4, Headquarters,
St Cadoc's Hospital, Caerleon

AGENDA

Preliminary Matters		**Attachment**		**1:00**
1.1	**Welcome and Introductions**	Verbal	**Chair**	**15 mins**
1.2	**Apologies for Absence**	Verbal	**Chair**	
1.3	**Declarations of Interest**	Verbal	**Chair**	
1.4	**Draft Minutes of the Committee held on 4th April 2019**	Attachment	**Chair**	
1.5	**Action Sheet of the Committee held on 4th April 2019**	Attachment	**Chair**	
Presentations				**1:15**
2.1	**Winter Pressures Formal Report 2019**	Presentation	**Kath Smith**	**30 mins**
For Consideration				**1:45**
3.1	**Quality, Safety and Performance Overview**	Attachment	**Dr Paul Buss/ Martine Price**	**15 mins**
3.2	**Risk Assessment Overview**	Attachment	**Chair**	**15 mins**
Break (10 mins)				**2:15**
Items for Quality Assurance				**2:25**
4.1	**QPSOG Assurance Report from Meeting held on 21st May 2019**	Attachment	**Peter Carr**	**10 mins**
4.2	**Quality Dashboard**	Verbal	**Lynne Wilde/ Linda Alexander**	**15 mins**
4.3	**Learning from Cwm Taf Morgannwg University Health Board – Report on Maternity Services**	Attachment	**Deb Jackson**	**20 mins**
4.4	**Tawel Fan – A Lesson for Learning**	Attachment	**Lin Slater**	**10 mins**
4.5	**Putting Things Right Report**	Attachment	**Martine Price**	**10 mins**

4.6	**Annual Quality Statement**	Attachment	**Paul Buss**	**10 mins**
Final Matters/For Information				**3:40**
5.1	Any Other Business • Clinical Coding	Verbal	**Dr Paul Buss**	**5 mins**
5.2	**Items for Board Consideration** To agree items for Board consideration and decision	Verbal	**Chair**	**5 mins**
Date of Next Meeting				
Wednesday 16th October 2019, 09:30am, Conference Rooms 1 & 2, ABUHB Headquarters, St Cadoc's Hospital				**Chair**

Quality and Patient Safety Committee
Wednesday 12 June 2019
Agenda Item: 1.4

Aneurin Bevan University Health Board
Minutes of the Quality and Patient Safety Committee held on Thursday 4 April 2019

Present:

Prof Dianne Watkins	-	Chair, Independent Member (University)
Emrys Elias	-	Vice Chair

In Attendance:

Judith Paget	-	Chief Executive
Liam Taylor	-	Deputy Medical Director
Martine Price	-	Interim Director of Nursing
Kate Hooton	-	Associate Director, Patient Quality and Safety
James Quance	-	Head of Internal Audit (Observer)
Nathan Couch	-	Wales Audit Office
David Thomas	-	Assistant Director, ABCi
Richard Bevan	-	Board Secretary
Sue Bale	-	Research and Development Director
Claire Barry	-	Committee Secretariat

Apologies:

Paul Buss	-	Medical Director
Peter Carr	-	Deputy Director of Therapies and Health Sciences
Phil Robson	-	Special Advisor to the Board
Claire Birchall	-	Director of Operations
Frances Taylor	-	Independent Member
Jemma McHale	-	Community Health Council

QPSC 0404/01 Welcome and Introductions

The Chair welcomed members and officers to the meeting, and in particular welcomed guests and observers who were attending. The Chair noted the committee was not quorate and asked the opinion of attending members whether they wished the committee meeting to go ahead. It was agreed to continue and to note that decisions made would require further ratification at the next QPSC meeting.

QPSC 0404/02 Declarations of Interest

There were no Declarations of Interest made relating to items on the agenda.

QPSC 0404/03 Minutes of the Meeting held on 7 February 2019

The minutes of the meeting held on 7 February 2019 were agreed as a true and accurate record of the meeting.

QPSC 0404/04 Action Sheet – 7 February 2019

The Committee considered the Action Sheet from the meeting held on the 7 February 2019 and noted that all actions had been completed or were progressing.

QPSC 0404/05 Outpatient – Delayed Follow Up and Reported Outcomes

Liam Taylor provided a report to update the Committee on the management of delayed follow-up outpatients in the Health Board.

It was reported that in 2015/16 the Auditor General for Wales examined arrangements for managing outpatient follow-up appointments in all Health Boards across Wales. The report highlighted a number of key points and recommendations:

- Large numbers of patients were on waiting lists for follow-up appointments and were not being assessed effectively.
- Health Boards' arrangements for reviewing outpatient follow-up performance was underdeveloped.
- Welsh Government reporting requirements were not being fully achieved.
- Actions being taken to approve the outpatient service were mostly delivering short term solutions.

The report highlighted the Health Board's long standing commitment to reduce delayed follow-ups and achieve a significant reduction in the delayed follow-up of outpatient appointments as a consequence. Since the reporting of this measure the Health Board had reduced the number of patients overdue their appointment past their target date from 35,333 in April 2015 to 19,603 at the end of January 2019. This was a reduction of 15,730 which represented an improvement of 44.52%.

It was advised that even with the developments and measures that were in place the Health Board had not seen a continuing level of reduction in 2018/19 that had been achieved in previous years, the Health Board would continue to focus on an improved position year on year and expected to see a return to a trajectory of continuing reduction in the 2019/20 financial year.

The Committee discussed the report and agreed that the delayed follow-up outpatient position should be reported on an annual basis to the Quality and Patient Safety

Committee, to discuss areas of potential patient risk and to provide assurance to the Board relating to the ongoing work that was being undertaken within the work stream.
ACTION: Secretariat

The Committee was assured by the report.

QPSC 0404/06 Learning from Cwm Taf Maternity Services Report

Deb Jackson gave a brief overview around the issues highlighted in relation to the governance framework within the maternity services at Cwm Taff University Health Board and outlined any key issues for Aneurin Bevan University Health Board (ABUHB) to take into consideration.

It was highlighted that the Healthcare Inspectorate Wales (HIW) undertook an unannounced inspection and a number of issues were raised at Cwm Taff UHB. As a result of the report from the HIW inspection Cwm Taff Maternity Services the recommendations had been mapped against ABUHB Maternity Services.

The Committee discussed the report, recognising that Aneurin Bevan University Health Board's (ABUHB) Maternity Service had a clear governance framework on the reporting and progress of any quality and safety issues and Serious Incidents. It was noted that no significant areas were identified against the mapping exercise, culture was discussed and Deb Jackson outlined the ways in which staff were involved and informed in all aspects of work and safety. It was reported that the Health Board was the only Health Board to have the Royal College of Obstetricians and Gynaecologists (RCOG) acceptance for consultant cover labour ward.

Martine Price advised that in terms of the future configuration around commissioning and the pathways, a discussion had taken place with the Director of Nursing at Cwm Taf University Health Board and work had commenced around the assurance and quality metrics, and this would be based around the maternity dashboard.

The Committee discussed the commissioning of the maternity dashboard and agreed that an update of the maternity dashboard should be presented at a future committee meeting. **ACTION: Martine Price/Secretariat**

The Committee was assured by the report.

QPSC 0404/07 Quality, Safety and Performance Overview

The Committee reviewed the report, noted the progress that was being made in many areas and highlighted the issues:

Crude Mortality

It was reported that Nevill Hall (NHH) and Royal Gwent (RG) Hospitals had seen an increase in crude mortality going through the winter period, whereas Ysbyty Ystrad Fawr (YYF) had remained relatively consistent.

It was noted by the Committee that Aneurin Bevan University Health Board's (ABUHB) mortality rate had been at the level expected since last winter, and even though it had increased going into 2018-19 winter period, it still remained below the Welsh Average.

Coding

It was highlighted that there were caveats around data, and the report showed that coding completeness was not as timely as the Health Board would like it to be. It was advised that the Health Board was looking to address this.

Sepsis

It was advised that the Collaborative was working in defined clinical areas to improve the recognition and response to sepsis. The focus had been on the front door to the Hospitals, and the key to this is the understanding that sepsis is a time sensitive condition and every extra hour of delay in treating sepsis means a risk in mortality. Therefore, it had to be treated as a medical emergency, like a stroke or myocardial infarction (MI).

C difficile

It was reported that the numbers of cases of C.difficile had reduced from last year, but were likely to be just above the levels required to meet the target in 2018-19.

Hospital Acquired Thrombosis (HATs)

It was highlighted that the Trauma and Orthopaedics Consultants were changing their approach to thromboprophylaxis, in line with regimen advised by NICE guidance. The number of HATs was being monitored to see whether this change in thromboprophylaxis impacts on the number of HATs.

Fractured Neck of Femur
It was highlighted that RGH had overall sustained its reduction in the 30 day mortality rate for patients who suffered a fractured neck of femur, unlike the mortality rate for NHH which showed more variability.

It was noted that RGH was currently performing above the UK average in 4 out of the 6 Key Performance Indicators, and much of the improvement had come from the appointment of an Orthogeriatrician for the service, which had driven improvements in the ward based assessments. It was advised that at NHH an Orthogeriatrician had been in post for a number of years, therefore the improvements to these processes had already been made with focus on other elements of the pathway.

The Committee agreed that they had concerns around the fractured neck of femur pathway and Judith Paget advised that a more detailed report was an agenda item for the next Executive Team meeting for the Senior Executives to look in more detail at concerns around the pathway. The Committee agreed that a further report was to be brought back to the Committee in 6 months' time to monitor any progress that had been made. **ACTION: Secretariat**

The Committee received the report.

QPSC 0404/08 Risk Assessment Overview

- **Risk Register**
  The Committee received the risk register and noted that there were no changes in overall risk scores. The Committee discussed the content of the Risk Register and noted that the risks were consistent with the Committee's work programme.

- **Patient Experience Risk**
  Martine Price gave a brief update on the Patient Experience Risk.

  As discussed at the last meeting the risk had now been updated to reflect the risk relating to patient experience and patient outcomes in all core settings.

  It was advised that ownership for the risk had now been identified as the Acting Director of Nursing and the Medical Director, and the action had now been

updated and key qualities indicators were now in place with monitoring and improvement approaches.

The Committee received the report.

QPSC 0404/09 The Healthcare Inspectorate Wales Report

Lin Slater provided an update on the Healthcare Inspectorate Wales (HIW) Report regarding the events concerning the allegations that were made against a member of staff and the Committee considered any learning for ABUHB.

It was advised that the learning from the internal review was shared by ABMU Health Board with other Welsh Health Boards including Aneurin Bevan University Health Board (ABUHB). It was advised that the action plan was considered at the Safeguarding Committee Meeting held on 23 January 2018, and a briefing was prepared and shared across all divisions and departments of the Health Board.

It was noted that Welsh Government required a more detailed independent review of the ABMU internal review and asked HIW to carry out the independent review. Upon conclusion the review highlighted areas of learning relevant to the NHS in Wales:

- Up-to-date DBS checks for staff (both retrospective and renewal of checks)
- Updated Safeguarding procedures
- Robust mechanism for sharing learning across Wales
- Improved systems of triangulation of information of concerns, incidents and claims
- Robust governance and Board oversight in relation to quality and safety

It was reported that ABUHB had welcomed the opportunity to undertake this benchmarking activity against the recommendations that were made by HIW, and it was recognised that there had been significant activity to support improvement to the processes to ensure public safety and to protect patients form abuse. It was advised that a summary of the actions had been planned, and implementation would be overseen by the Safeguarding Committee.

The Committee received the report.

QPSC 0404/10 ABUHB RRAILS Acute Deterioration Report

Kate Hooton provided a report on the feedback and the action plan from the recommendations that were received from the Peer Review of Acute Deterioration Services.

The Peer Review of Acute Deterioration Services took place across the 3 acute sites on 26 and 27 September 2018 for NHH and RGH, and 4 October 2018 for YYF, and received support from clinical staff and their teams.

It was reported that the initial feedback from the 3 acute sites was received from The Peer Review early in November 2018 and was extremely positive, and the actual draft report with its recommendations was presented to a meeting on 21 December 2018.

It was advised that ABUHB had been looking at the recommendations and putting in links of high level actions against them, and it was noted that work had taken place in those areas and was moving forward. It was highlighted that the action plan had now been received and agreed at both the Quality and Patient Safety Operational Group and Executive Board.

The Committee agreed that an action plan was to be added to the Committee's forward work programme to be reported on an annual basis and was to be brought back to the Committee in 12 months' time. **ACTION: Secretariat**

The Committee received the report.

QPSC 0404/11 QPSOG Assurance Report

The Committee received the assurance report from the Quality and Patient Safety Operational Group (QPSOG) meeting which was held on 19 March 2019.

It was reported that there were no issues raised by the QPSOG that needed to be escalated to the Quality and Patient Safety Committee.

The Committee was assured by the report.

QPSC 0404/12 Independent Member Quarterly Visits Report

Richard Bevan gave an update on the Independent Member's Quarterly Visits.

It was reported that there were two ways in which these visits took place. These were:

- **Patient Safety Executive Walkarounds**
  In 2006 the Health Board introduced Patient Safety Executive Walkarounds, and these visits were undertaken by Executive Team members. The purpose of the visits was to demonstrate the Board's commitment to patient safety in order to enhance the culture of patient safety across the Health Board.

  The Committee was advised of the process and it was acknowledged that escalation mechanisms were in place, via action plans to further support and improve any areas of concern.

The Chair advised that the Independent Members were unaware of the framework that guides the patient safety walkarounds:

- Why was the purpose of the patient safety walkarounds?
- What was the focus of the patient safety walkarounds?

The Committee agreed that a briefing of the patient safety Executive walkarounds would be circulated to the Independent Members. **ACTION: Martine Price/Dr Paul Buss**

- **Independent Members Quarterly Visits**
  In 2018 The Chair of the Board introduced an additional structured programme of visits for Independent Members to visit sites and services in order to enable Independent Members to get more of an understanding of site services particularly in advance of decisions that Board members might be asked to make.

  It was advised that following their visits, each Independent Member was asked to complete a report. This report enabled the Health Board to follow up on any issues in the themed areas of services.

  It was highlighted that further rounds of visits were taking place with regard to Older Adult Services and

Managed GP Practices, and these reports would be submitted to the Committee.

The Committee received the report.

QPSC 0404/13 Quality, Safety, Value, Innovation and Performance

Liam Taylor advised that work was underway with ABCi focussing on future pathways where the above elements can come together to deliver performance via a safety culture.

The first engagement event was due to take place at the end of April 2019. A report on the success of the engagement event would be presented to the Executive Team and then to the Committee at the Committee's October meeting.

QPSC 0404/14 Items for Board Consideration

There were no items for Board Consideration.

QPSC 0404/15 Date of Next Meeting

The next meeting will be held on Wednesday 12 June 2019 at 1.00pm in Conference Room 4, ABUHB Headquarters, St Cadoc's Hospital, Caerleon.

Quality and Patient Safety Committee
Wednesday 12 June 2019
Agenda Item: 1.5

Quality & Patient Safety Committee
Thursday 4 April 2019

Action Sheet

(The Action Sheet also includes actions agreed at previous meetings of the Quality & Patient Safety Committee and are awaiting completion or are timetabled for future consideration for the Committee. These are shaded in the first section. When signed off by the Quality & Patient Safety Committee these actions will be taken off the rolling action sheet.)

Agreed Actions – Thursday 4 April 2019

Minute Reference	Agreed Action	Lead	Progress/ Completed
QPSC 0404/05	**Outpatient – Delayed Follow-Up and Reported Outcomes** It was agreed that the delayed follow-up outpatient position should be reported on an annual basis to the Committee.	**Secretariat**	This agenda item has now been added to the forward work programme, and was to be reported to the Committee on an annually basis.
QPSC 0404/06	**Learning from Cwm Taf Maternity Services Report** It was agreed that an update on the commissioning maternity dashboard should be presented at a future committee meeting.	**Martine Price/ Secretariat**	This item is on the agenda for June's meeting.
QPSC 0404/07	**Quality, Safety and Performance Overview – Fractured Neck of Femur** The Committee agreed that a further report was to be brought back to the Committee in 6 months' time.	**Secretariat**	Fractured Neck of Femur will be on the agenda for October's Committee meeting.

Minute Reference	Agreed Action	Lead	Progress/ Completed
QPSC 0404/10	**ABUHB RRAILS Acute Deterioration Report** The Committee agreed that an action plan was to be added to the Committee's forward work programme to be reported on an annual basis and was to be brought back to the Committee in 12 months' time.	**Secretariat**	This agenda item is on the forward work programme and an update is to be provided to the Committee in 12 months' time.
QPSC 0404/12	**Independent Members Quarterly Visits Reports – Patient Safety Walkarounds** The Committee agreed that a briefing of the patient safety walkarounds would be circulated to the Independent Members.	**Martine Price/Dr Paul Buss**	Patient Safety Walkaround leaflets had been circulated to the Independent Members.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality & Patient Safety Committee Wednesday 12th June 2019 Agenda Item:3.1

3.1

Aneurin Bevan University Health Board

QUALITY AND PATIENT SAFETY REPORT
JUNE 2019

Executive Summary

The Quality and Patient Safety Report for the Quality and Patient Safety Committee provides information on the ABUHB main priorities in this area, as set out in the Integrated Medium Term Plan and the Annual Quality Statement.

This report provides data in the following areas in relation to quality and patient safety:

- High level data on outcomes
- Surveillance and review
- Optimising Care Delivery

The targets used included in the report are either Welsh Government Targets, or targets set within the Health Board, where there is no Welsh Government Target.

Summary of Key Points

The number of deaths and mortality rate have risen going into winter, but show a decrease in February and March, which is the usual seasonal pattern. (section 1.1.).

An overview of participation in NCAs is provided. The results of the National Audit of Care at the End of Life are given in section 2.2. The results of the audit have been discussed at the End of Life Care Board and an action plan is being developed with the Divisions.

The front door departments have struggled to maintain the compliance with the sepsis 6 bundle within one hour of recognition of sepsis during the winter, although the data shows that most people receive the bundle within 2 or 3 hours of recognition, which is still good care. (section 3.1.).

The Health Board did not meet the Welsh Government targets for Healthcare Associated Infections in 2018-19. Actions to address this are focussing on deep cleaning of the wards, prescription of antimicrobials and catheter care. (section 3.2.1.).

The pressure ulcer reduction collaborative has targeted wards on the Royal Gwent Hospital site, although 4 wards from NHH have joined the collaborative. Altogether, the average reduction of Hospital Acquired Pressure Ulcers across the collaborative wards as of May 19 is about 48%. (section 3.4)

There was an increase in the number of in-patient falls in January, but no associated rise in the number of long bone fractures. The falls in February and March have been higher, with an average number of long bone fractures resulting from the falls.

The Quality and Patient Safety Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	

Executive Sponsor: Dr Paul Buss, Medical Director			
Report Author: Kate Hooton, Assistant Director			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Quality and Patient Safety Operational Group]**	**X**
Date of the Report: May 2019			
Supplementary Papers Attached:			

Purpose of the Report

The Quality and Patient Safety Report for the Quality and Patient Safety Committee provides information on the ABUHB main priorities in this area, as set out in the Integrated Medium Term Plan and the Annual Quality Statement.

The Quality and Patient Safety Committee is asked to review the report, note the progress being made in many areas and highlight any issues where further information is required for assurance.

Background and Context

This report provides data in the following areas in relation to quality and patient safety:

- High level data on outcomes
- Surveillance and review
- Optimising Care Delivery

The targets used included in the report are either Welsh Government Targets, or targets set within the Health Board, where there is no Welsh Government Target.

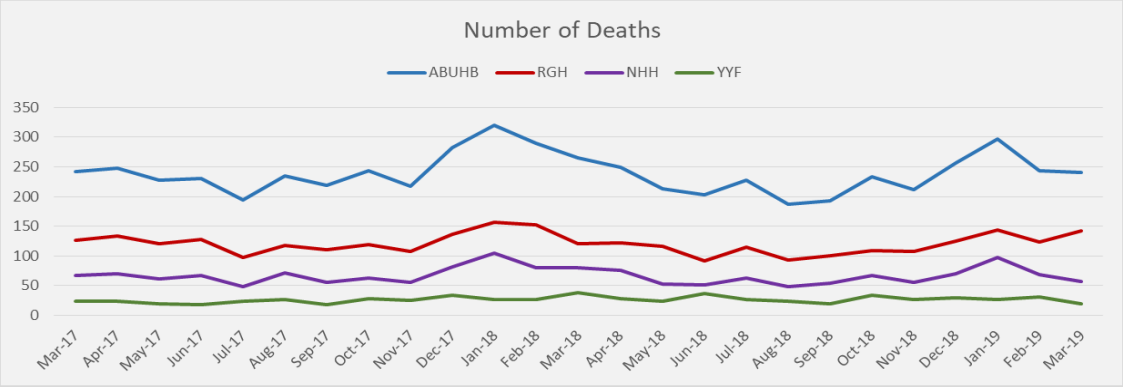
Assessment and Conclusion

The data and narrative in the report demonstrate the position of the health board in terms of performance against a number of quality and patient safety targets, and the actions that are being taken to improve or maintain performance.

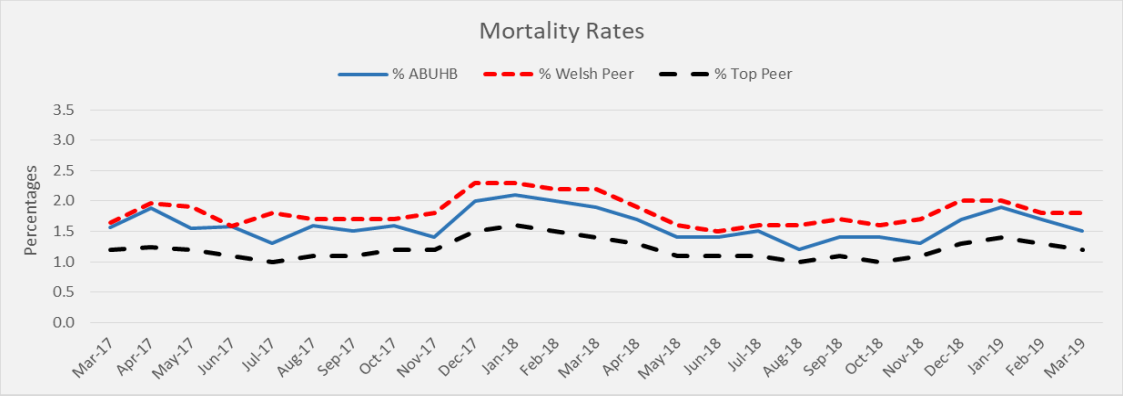
1. High Level Outcomes

1.1 Crude Mortality and Mortality Rate

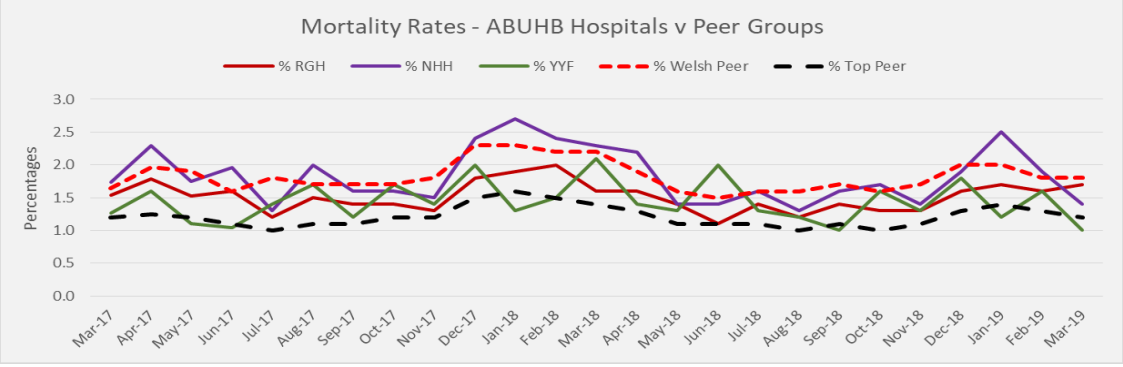
ABUHB and Hospital Crude Mortality March 17 – March 19



ABUHB Mortality Rate against Welsh Peer and Top Peer March 17-March 19



Hospital Mortality Rates with Welsh Peer and Top Peer March 17-March 19



1.2. Narrative on Mortality Data

The line in the run charts which represents ABUHB or an ABUHB hospital, shows more variation than the line for Welsh Peer or Top Peer. This is to be expected as the Peers include much greater numbers of patients and therefore the overall variation is reduced.

The Crude mortality (number of deaths) in ABUHB and NHH and RGH has increased going into the winter period, and decreased in February and March for ABUHB and NHH, with RGH remaining high. Crude mortality at YYF has remained relatively consistent throughout the whole winter period.

The ABUHB mortality rate is generally lower than the Welsh Hospitals. The mortality rate for ABUHB has increased going into the 2018-19 winter period, but remained below the Welsh Average.

The mortality rate for NHH has increased sharply in November and December, and in December-February was above the Welsh Average, decreasing below the Welsh Average in March. Mortality reviews completed for December-March have not shown any concerning trends, and the number of second reviews is consistent with the usual level.

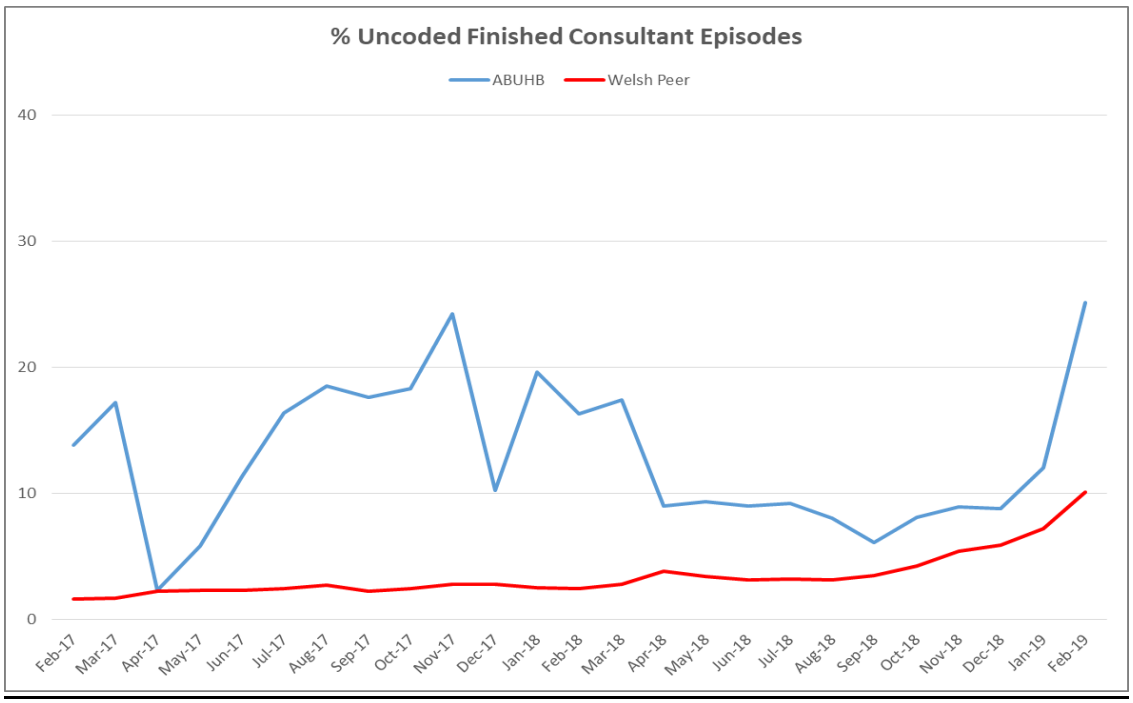
Coding completeness (p5) does not impact on the number of deaths or the mortality rate values. However, it is important for any more detailed analysis of the variation in the numbers or rates, and it impacts on the condition specific mortality rates. The Clinical Coding Department has filled its vacancies and the percentage of uncoded finished consultant episodes is decreasing, but it will be some time before the new staff are working at full effectiveness.

Completeness of Coding

ABUHB Coding Completeness (6 March 2019, CHKS):

Aug 18	92.0%
Sept 18	94.0%
Oct 18	91.9%
Nov 18	91.3.8%
Dec 18	91.5%
Jan 19	90.7%
Feb 19	84.8%

Uncoded Finished Consultant Episodes Feb 17 - Feb 19



2. Surveillance and Review

As a Health Board we are always developing how we use clinical data to identify areas for quality improvement, in line with Professor Palmer's recommendations. The data we are currently using includes:

- National Clinical Audits, with full participation and use of the results to drive improvement year on year.
- Condition specific mortality statistics at an organisational level, such as the MI, Stroke and Fractured Neck of Femur data presented in this report (see section 4.5, 4.6 and 4.7).
- Review of clinical records of patients that die in our hospitals, following national protocols – the mortality review process.

2.1 Mortality Review

Percentage Completion of Mortality Reviews –The Welsh Government plan is that when, in line with the recommendations of the Shipman review, the Medical Examiner role is introduced, the Medical Examiner will undertake the first level of the mortality review. This is part of their role, as they agree the cause of death with the responsible medical team and high light any concerns they have about treatment and

care from their review of the clinical record. They also talk to the relatives of the deceased person to ensure that they agree with the cause of death and were satisfied with the care provided. The Health Board will undertake a more in depth, second level review into any deaths highlighted because of concerns by the Medical Examiner. The new role is being introduced from April 2019 on a non-statutory basis for deaths in acute hospitals. In Wales, the Medical Examiners (ME) and the Medical Examiner Officers (MEO) who support them, will be employed by Shared Services. The Health Board is therefore not implementing the role itself, but will ensure it will work alongside the bereavement service, as it is developed. Shared Services will appoint to the ME and MEO roles, after the ME for Wales has been appointed.

The Welsh Government has set the standard that 100% of the notes of patients that die in our hospitals are reviewed. In ABUHB, we have funding for 4 sessions of senior clinician time to complete mortality reviews, with a focus on learning. However, at the end of 2018, there was a sewage leak into the room at RGH where the mortality reviews are undertaken. The room and notes were temporarily unavailable, which meant that the number of reviews completed at RGH in November and December were very low. The room is now available and the number of reviews completed is increasing. The number of deaths is higher in the winter, and therefore even when same number of reviews are completed, the percentage of reviews completed will drop. Other HBs in Wales achieve a higher percentage of mortality review completion, as most require their junior doctors to complete the review when they do the discharge summary, rather than a review by an impartial, senior clinician.

Health Boards are reporting to the Welsh Government the percentage of deaths reviewed each month and the time taken to complete the review from the death of the patient.

Percentage of Mortality Reviews completed for ABUHB

	April 18	May 18	Jun 18	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	March 19	Total
No. Reviewed	128	143	128	139	129	153	168	122	117	145	117	129	1618
2nd Stage Review	10	12	16	12	12	17	14	19	13	13	3	9	150
Total Deaths	247	212	200	221	182	172	233	208	253	294	244	234	2700
% Reviewed	52%	67%	64%	63%	71%	89%	72%	59%	46%	49%	48%	55%	56%

Learning from Mortality Reviews – The last meeting of the Mortality and Harm Review Group highlighted that there were more deaths from pneumonia, as there often are during the winter period. DNACPR forms are not always completed by the on-call teams, when the patient is clearly appropriate for DNACPR. This learning will be integrated into the action plan from the Health Board audit of the DNACPR form.

The Group again raised the standard of the organisation of the clinical notes, which makes it hard to understand the clinical narrative, particularly at RGH. This could impact on the care given by on-call doctors. The Chair of the Group is raising "notes hygiene" and categorisation with the Divisions.

2.2 National Clinical Audit (NCA)

National Clinical Audits enable healthcare organisations in Wales to measure the quality of their services against consistently improving standards, and to confirm how they compare with the best performing services in the UK. National Clinical Audits also have great potential to provide information to the public about the quality of clinical care provided by NHS Health Boards.

The results of one of these National Clinical Audits are included in this report. The first Report of the National Audit of Care at the End of Life is the NCA included in this report. The results of all the National Clinical Audits are now being reported to the Quality and Patient Safety Operational Group.

The Wales National Clinical Audit and Outcome Review Programme (NCAORP) lists the National Clinical Audits that Health Boards must participate in. There are more than 40 National Clinical Audits (NCAs) on the Programme. ABUHB aims to participate fully in all the NCAs listed below, but there are a further 2 that we do not enter any data for, and 4 that data entry is not in place at all hospitals, or is limited in some way.

The National Clinical Audits that ABUHB participates in on the NCAORP are:

National Joint Registry
National Emergency Laparotomy Programme
Case Mix Programme – Intensive Care
National Diabetes Inpatient Audit

National Diabetes Footcare Audit
National Pregnancy in Diabetes Audit
National Core Diabetes Audit
National Diabetes Transitions Audit
National Diabetes Paediatric Audit
Pulmonary Rehabilitation
All Wales Audiology Audit
Stroke Audit (SSNAP)
Inpatient Falls
National Hip Fracture Database
National Dementia Audit
National Audit of Breast Cancer in Older People
National Audit for Care at the End of Life
Cardiac Rhythm Management
National Audit of Percutaneous Coronary Interventions
Myocardial Ischaemia National Audit project
National Vascular registry Audit
Cardiac Rehabilitation Audit
National Lung Cancer Audit
National Prostate Cancer Audit
National Oesophago-gastric Cancer Audit
National Neonatal Audit Programme Audit
National Maternity and Perinatal Audit
Epilepsy 12 Children and Young People NCA
National Clinical Audit of Psychosis
NCEPOD audits
Mental Health Programme
Maternal Newborn and Infant Clinical Outcome Review programme

ABUHB has no or limited data entry for the following NCAs:

NCA	Case Ascertainment	Narrative	Update
Trauma Audit Research Network	No Participation	Registered for the audit and clinical staff trained for the audit but clinical staff unable to complete data entry within their working day	Appointment of a member of staff to will be required to enter data for this audit. A member of the MDST will be trained in data entry in July.
National Ophthalmology Audit	No Participation	Electronic Records systems for Ophthalmology	The procurement of an electronic medical record system for Wales is to be

(Adult Cataract Surgery)		required as this uploads the audit data automatically.	expedited, based on the Cardiff model. It is predicted to be ready in March 2020.
NACAP – National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: COPD audit and Adult Asthma Audit and Children and Young People Asthma Audit	Full participation at NHH. No participation at RGH and YYF	The COPD NCA has recently moved to continuous data entry and the Asthma NCAs are new. The Respiratory Service has struggled to complete the data entry due to the high volume.	A process has been developed at NHH between the clinical staff and the MDST for COPD data entry. RGH do not consider they have the capacity to adopt this process. Staff pressures at YYF has prevented the process being implemented there. Review of how the MDST can support data entry has identified a way forward, if the Nurse Specialists can identify the patients.
Heart Failure	Full Participation at NHH. Improving participation at RGH and YYF.	Established process at NHH, although reliant on one Nurse Specialist. Good engagement with Specialist Nurses at RGH and YYF, and process with MDST support agreed, but consistency is impacted by annual leave and sickness. Estimated 58% data entry for RGH and YYF for 2018/19 (70% target)	Data entry for 2018-19 closes 11 June. NHH is above 70% and RGH has improved case ascertainment compared to 2017-18, despite issues with the audit system earlier in the year. It is expected therefore that case ascertainment for ABUHB will achieve 70% in 2019-20.
Early Inflammatory Arthritis	Limited participation	Process agreed between the Consultants and MDST	Two vacancies in the Consultant Team have limited participation.
Fracture Liaison Service	Limited Participation	ABUHB has just registered for this NCA. Process to initiate data entry agreed between service and MDST	Data entry has just started and is being monitored

Learning from National Clinical Audit

ICNARC is a continuous data entry national clinical audit of critical care. The results of the audit are routinely reviewed by the Directorate. The recent results of the audit have indicated the pressure

on our Critical Care Units and differences between the two units in ABUHB. As a result of this, the Medical Director has met with the Clinical Director and Divisional Director and received assurance of the learning across the two sites in order to continuously improve approaches to clinical care.

National Audit of Care at the End of Life 2017-18

The National Clinical Audit of Care at the End of Life took place in 2018. It had 3 parts:

- Organisational Audit
- Case Note Review
- Carer Experience Survey

ABUHB submitted the Organisational Questionnaire and a full audit of 80 case notes. However, it should be noted that the audit was completed mostly by members of the specialist palliative care team with some support from Medical Registrars. The patients were all from medical and surgical specialties. The Carer Experience Survey was unsuccessful in ABUHB in 2018, as too few questionnaire were returned to be analysed.

Results

The results of the case note audit show that ABUHB is below the UK National Average in all areas apart from the Governance processes for End of Life Care. The Clinical Director for Palliative Care has categorised the results as follows:

Areas of care approaching national average –

- recognising the dying patient
- having a DNACPR form in the notes
- symptom control.

Areas of below average care –

- communicating with the patient about their deterioration
- communicating with families about deterioration
- documenting discussion of DNACPR with the patient
- documenting discussion of DNACPR with families
- shared decision making
- discussing nutrition and hydration
- individualisation of care plan (Care Decisions Tool for Last days of Life Care)

Area of care well below national average –

- supporting the needs of families- physical, emotional, psychological, spiritual, cultural

The results demonstrate the need for a Bereavement Service to support the needs of families when a loved one dies in hospital. This is being progressed using external funding initially and a business case is being developed for long term funding of the service.

In addition, the following actions have been proposed by the Clinical Director for Palliative Care and considered at End of Life Care Board for inclusion in the ABUHB End of Life Care Action Plan:

- Increasing use of the Care Decisions Tool for Last Days of Life Care
- Improve communication skills for all staff, but particularly medical staff
- Address the needs of all families of dying patients
- Consider ways to improve the environment in which our patients die
- Aim for a shift in culture: so that facilitating a "good death" is prioritised in clinical practice
- Increase engagement from all specialties in End of Life Care

3. Optimising Care Delivery

3.1. Deteriorating Patient/Sepsis – ABC Sepsis

The Aneurin Bevan Collaborative on Sepsis (ABC Sepsis) was launched on 7th January 2015. The Collaborative is working in defined clinical areas, to improve the recognition and response to sepsis and therefore eliminate avoidable deaths and harm from sepsis. Key to this is the understanding that sepsis is a time sensitive condition – every extra hour of delay in treating sepsis means a 7.6% risk of mortality – and therefore it has to be treated as a medical emergency, like a stroke or MI. The focus has been on the front door to the Hospitals, as the report "Just Say Sepsis" identifies that 70% of sepsis cases are in the community.

The Collaborative's outcome measures are:

- the % of patients triggering with sepsis that die within 30 days of recognition, and
- the number of patients triggering with sepsis that die within 30 days of recognition.

The process measure for the collaborative is:

- Sepsis 6 compliance, which means that all 6 elements of the sepsis bundle are completed within 1 hour of recognition.

3.1.1. Review of Results from ABC Sepsis

ABC Sepsis has been collecting data from the sepsis screening tools completed for patients triggering with sepsis in the Emergency Departments and now the wards in acute hospitals. The data is fed back to the wards and departments at the weekly DRIPS (Data, Review, Improvement, Plot the dots, Share) meetings and by e-mail after the meetings. This crucial role has been undertaken by the Medical Director's Support Team.

As the ABC Sepsis process is unreliable on the wards at NHH and RGH, the data for the wards is taken form the Outreach databases for NHH and RGH and from ABC Sepsis database for YYF wards.

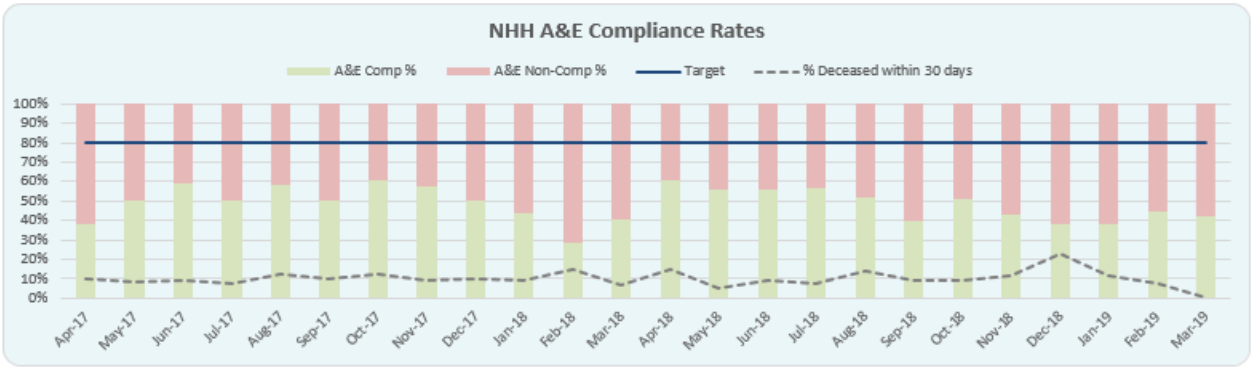
The data for the Emergency Departments is all from the ABC Sepsis database. It should be noted that ABC Sepsis applies the criteria for compliance with the sepsis 6 bundle within 1 hour robustly.

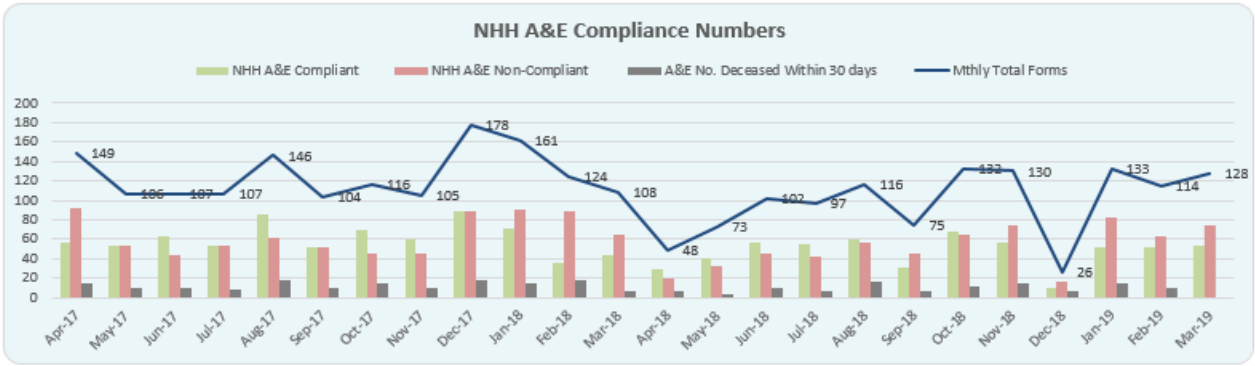
Data entry for NHH is not complete for December 18 due to staff sickness but this is now being addressed. The most recent data is being entered first.

Emergency Departments:

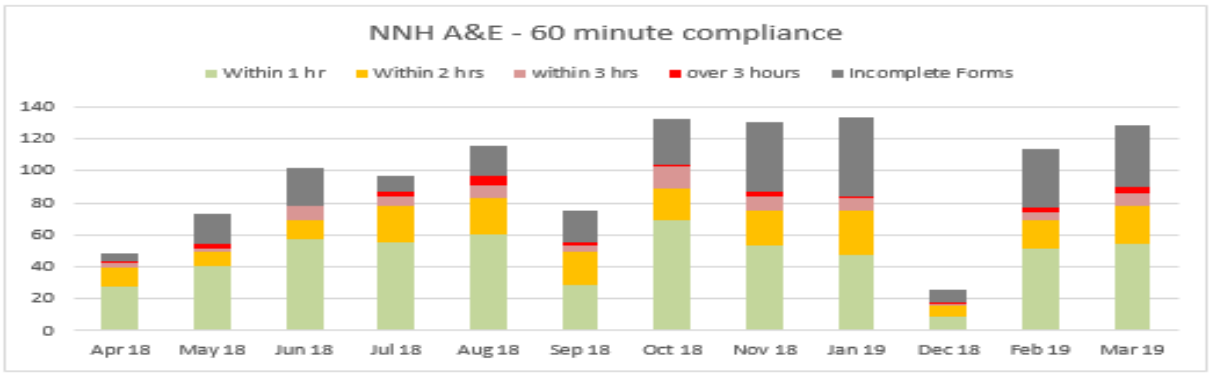
***Nevill Hall Hospital A and E*:** The number of forms at NHH has been maintained over the winter to date, but compliance has decreased. The bar charts below show the number of forms completed in 2 hours and 3 hours, as well as those completed in an hour. This shows that most patients are getting good care. The compliance is being addressed within the department, through discussion with the nurses about completing the form with all the necessary information, and with the doctors about the delays in the prescribing of antibiotics. However, it has been challenging to hold the DRIPS meetings every week in the A and E department during and since the winter period.

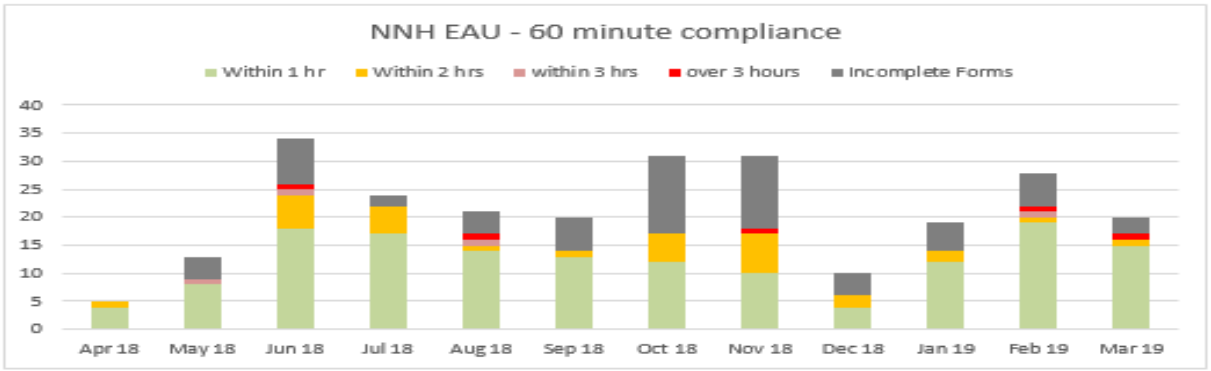
Compliance within 1 hour of recognition of sepsis



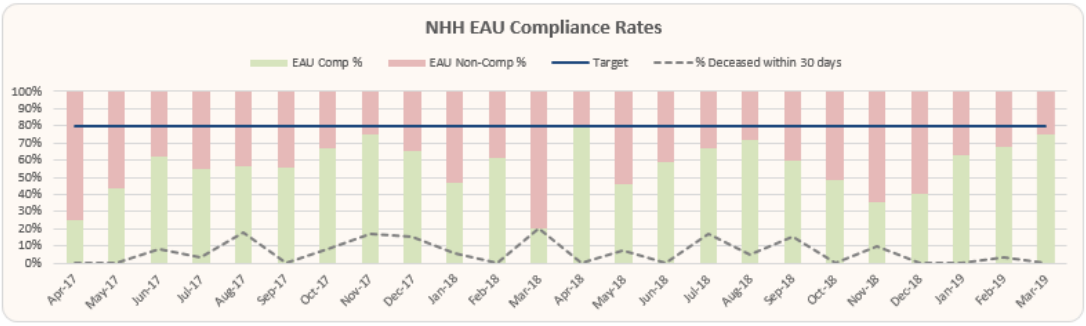


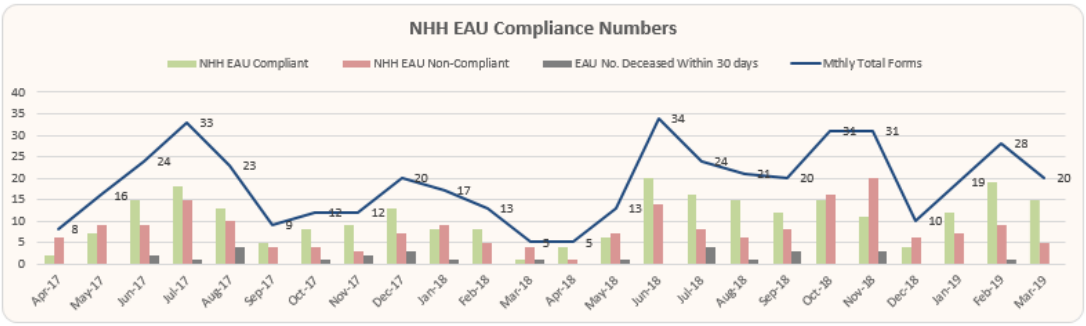
Number of Forms with bundle Completed in 2 and 3 hours



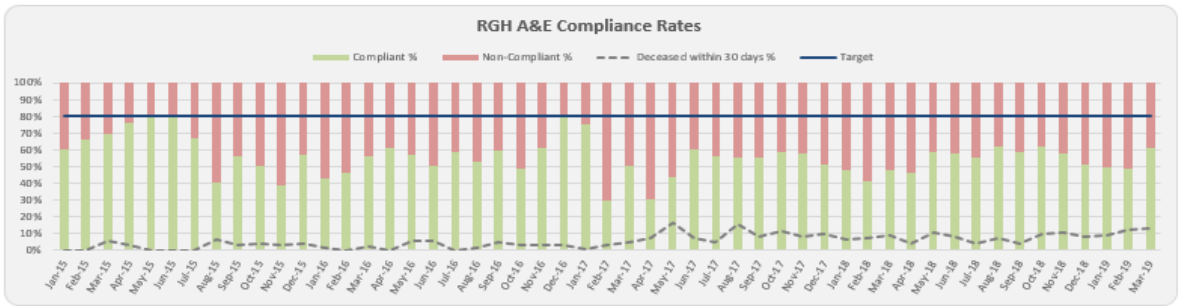


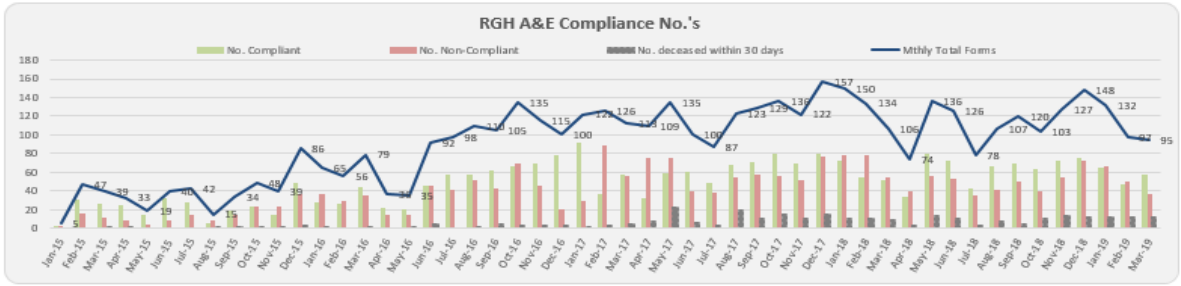
EAU at NHH is now engaged with ABC sepsis. Both the recognition and response to sepsis have improved in the department, and the DRIPS meetings are well attended.





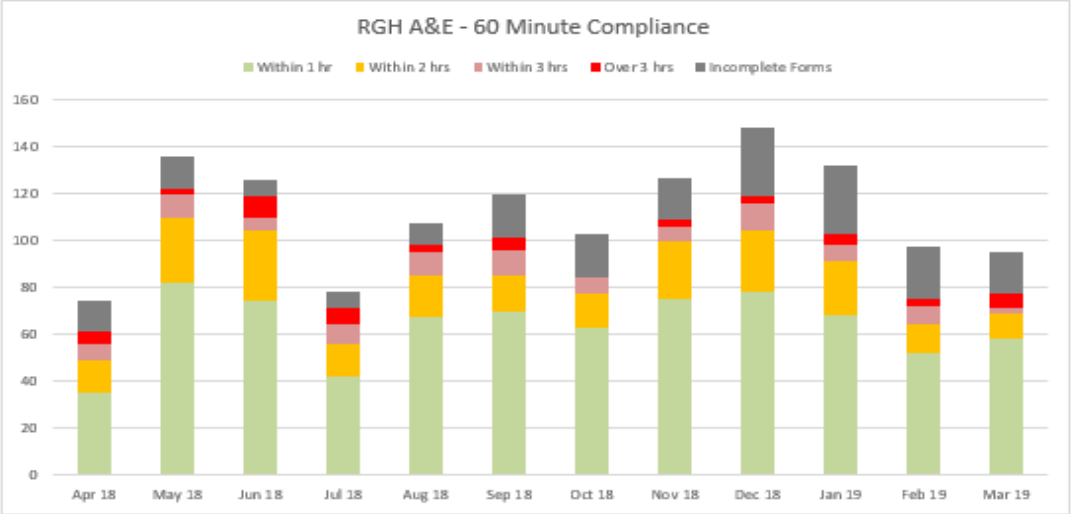
***Royal Gwent Hospital A and E*:** The number of forms from RGH A and E has been high to date over the winter, with good compliance and regular meetings, although it has not always been possible for many front line nurses to attend the meetings. This means learning about the purpose and correct completion of the forms is not being passed on to new staff.



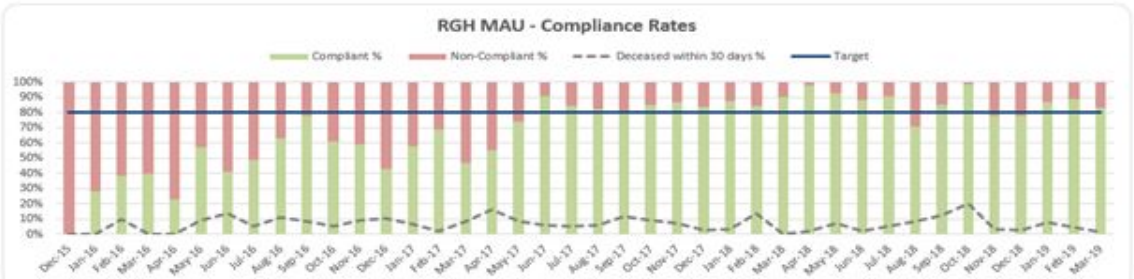


The bar charts below show the number of forms completed in 2 hours and 3 hours, as well as those completed in an hour. This shows that most patients are getting good care.

Number of Forms with bundle Completed in 2 and 3 hours



MAU at RGH is fully engaged with ABC Sepsis. The number of forms completed has improved over the summer period and been maintained into the winter, and the compliance has remained high. ABC Sepsis will capture learning from MAU about how they achieve the high compliance and discuss with the other front door departments how the MAU approach could be used there.



***Ysbyty Ystrad Fawr*:** ABC Sepsis covers the whole of YYF, wards and Emergency Department. The Vital Pac Pilot started at YYF in September 2017, and the ABC Sepsis Team have worked closely with the IT Staff so that the system supports the recognition of deteriorating patients on the wards. There have been issues with the implementation of vital pac, which the Divisions have escalated and responded to. The learning from the implementation was used to inform the roll out of vital pac at NHH.

The compliance at YYF has decreased in the winter period, and the number of forms decreased in February. This is being followed through with the Divisions.

Community:

Work is continuing in a range of areas within the community to implement a change in practice to use NEWS as a common language. In some areas, this has meant providing equipment to enable healthcare professionals to take observations, and doing additional training.

The 1000 Lives Team are now supporting this work, with a Wales Wide learning set in March 2019, and a number of tools to support the roll out.

Wards at NHH and RGH:

On the wards, the number of patients identified as triggering per ward with sepsis has been low – 1 or 2 per week. ABC Sepsis is therefore now focussing its work on the wards on the deteriorating patient generally.

The sepsis screening tool, developed by ABC sepsis with the Emergency Departments, has been rolled out to all the wards in acute hospitals from April 2017. Data taken from the Outreach databases for NHH and RGH showed that the wards were not using the screening tool on all the deteriorating patients seen by Outreach. The Lead Nurse for sepsis, with support from the Divisional Nurses, was meeting regularly with the wards to review the Outreach database against the sepsis screening tools completed by the wards.

3.1.2. ABC Sepsis Steering Group

The ABC Sepsis Steering Group has co-ordinated preparation for the Peer Review of Acute Deterioration in ABUHB. This took place in September and October 2018. All hospitals in Wales will be peer reviewed by the end of 2019. The feedback from the peer review for ABUHB was very positive. The ABC Sepsis Steering Group is now overseeing the implementation of the action plan from the Peer Review.

The Peer Review Team action plan covers five areas: Structure and process to co-ordinate all the elements of acute deterioration, moving towards a Core Site Safety Team 24/7, improved focus on Acute Kidney Injury, Continued learning from vital pac and a more integrated approach to training on acute deterioration across the whole of ABUHB.

3.2 Reducing C Diff and Healthcare Associated Bacteraemia

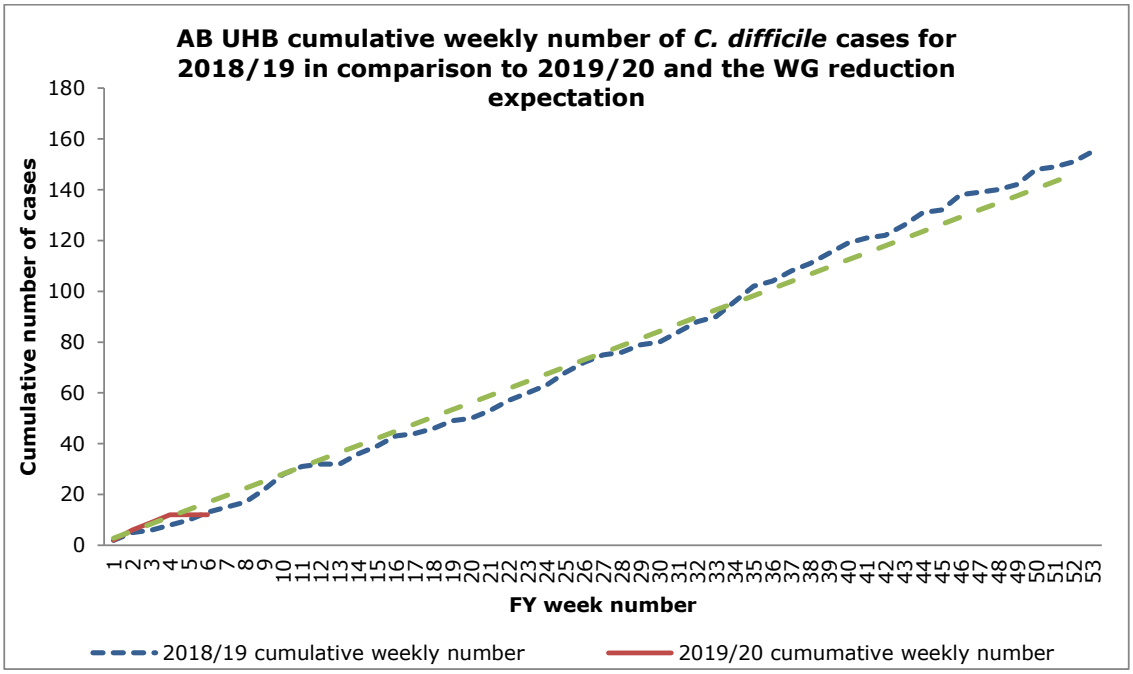
Aim: Welsh Government 2018/19 HB reduction target for C *difficile*, Staph *aureus (MRSA and MSSA)* and E*Coli* bacteraemia are:

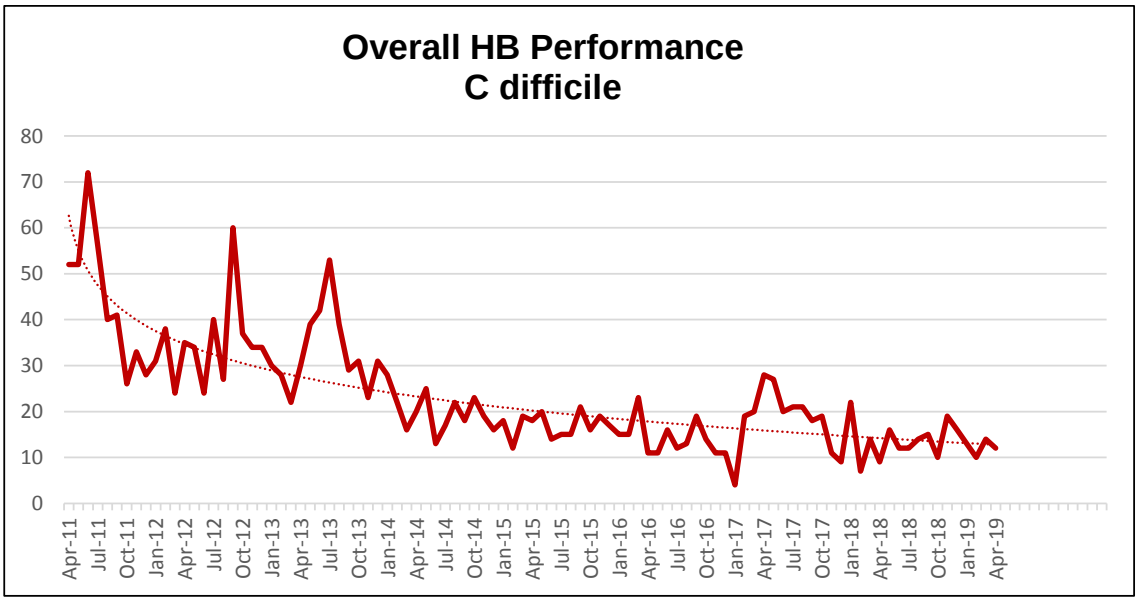
- **C difficile - 25 per 100,000 population**
- **Staph aureus – 19 per 100,000 population**
- **E Coli – 61 per 100,000 population**

Two new targets have been added this year by Welsh Government:

- **Klebsiella – no more than 91 cases**
- **Pseudomonas *aeruginosa* - no more than 28 cases**

3.2.1. Total C diff. Cases





Good progress has been made in relation to C.difficile but the Health Board is just above the number of cases to achieve the required reduction (25.00 per 100K population) with a current rate of 26.77 per 100K population. The Health Boards strategy to reduce cases is heavily reliant on hospital cleans using Hydrogen Peroxide Vapour (HPV).

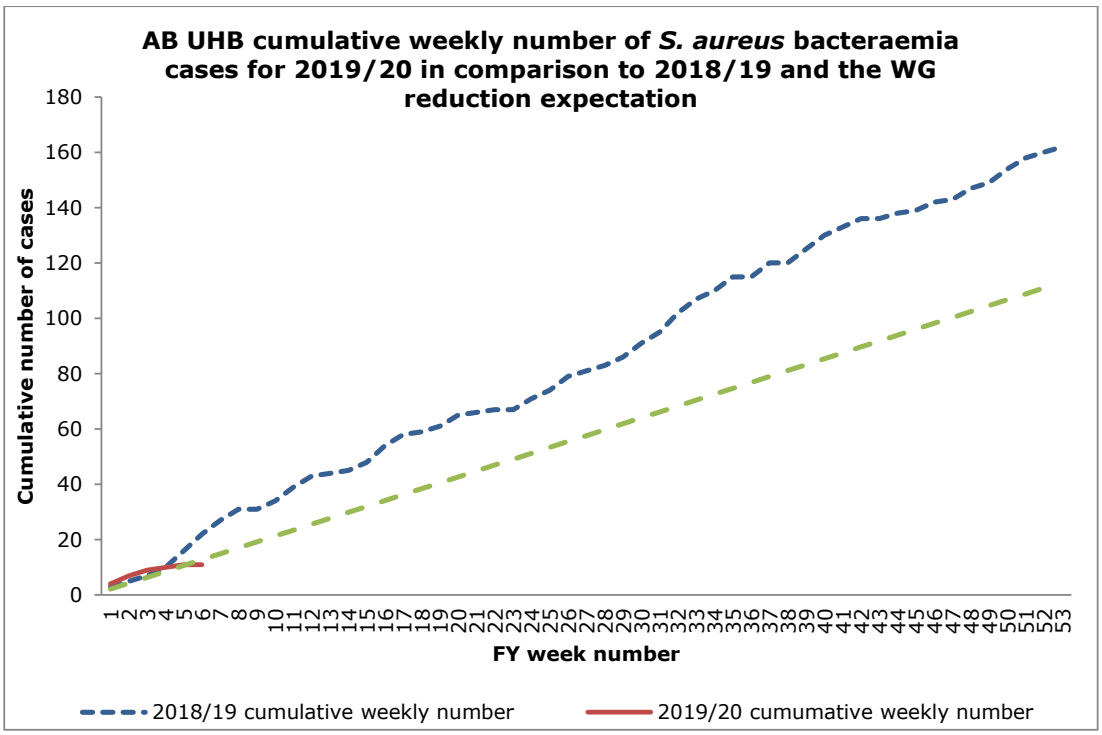
A second important intervention relates to antibiotic guidelines. A change of guidelines utilising co-trimoxazole as the broad spectrum antibiotic of

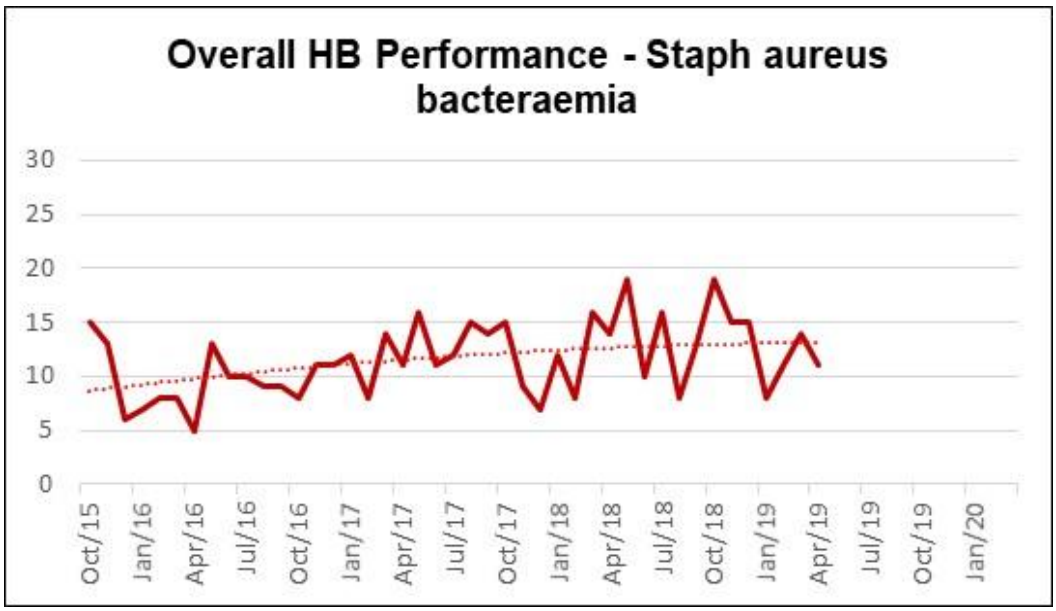
choice was introduced in Cardiff & Vale and Cwm Taff UHBs approximately 2 years ago – which may have contributed to a further reduction in *C. difficile* cases. This change in antibiotic use was discussed at ABUHB Infection Control Committee at the time but the proposal was rejected due to safety concerns around co-trimoxazole use.

Co-trimoxazole use is now being encouraged by one of the Welsh Government Tier 1 antimicrobial prescribing targets, therefore a programme of guideline review is under way by the Antimicrobial Guideline Group. Some moves to co-trimoxazole have already been made in 2017 and 2018 with further changes planned.

Objective	Measure		Latest data	Latest period	5% Reduction	Last Year Position	Trend - last 24 months
Medicines management							
Reduce risk of infection through prescription of appropriate antibiotics	Reduction in the % of the 3 specified antibiotics (Quinolones, Cephalosporin, Co-amoxiclav) as a % of all antibacterial items	Grand Total	5.6%	Feb 2019	5.4%	5.6%	
		Blaenau Gwent East	5.6%		5.8%	6.1%	
		Blaenau Gwent West	5.1%		4.5%	4.7%	
		Caerphilly East	6.1%		5.0%	5.3%	
		Caerphilly North	5.5%		5.5%	5.8%	
		Caerphilly South	6.2%		5.2%	5.5%	
		Monmouthshire North	6.4%		7.1%	7.5%	
		Monmouthshire South	5.6%		6.7%	7.0%	
		Newport East	5.1%		6.2%	6.5%	
		Newport North	5.3%		5.1%	5.3%	
		Newport West	4.9%		4.7%	5.0%	
		Torfaen North	6.1%		4.7%	5.0%	
		Torfaen South	5.0%		4.0%	4.2%	
Prescribing: The latest reported position as at Feb 2019 was reported as 5.6% which is a variance of -.02% compared to the same period the previous year. For NCN benchmarking please see table at foot of this report.							
In the prescribing section above the trends show an improved postion across all NCN's and this measure is also reported to all GP Practices by the prescribing team.							

3.2.2. Total MRSA and MSSA Cases

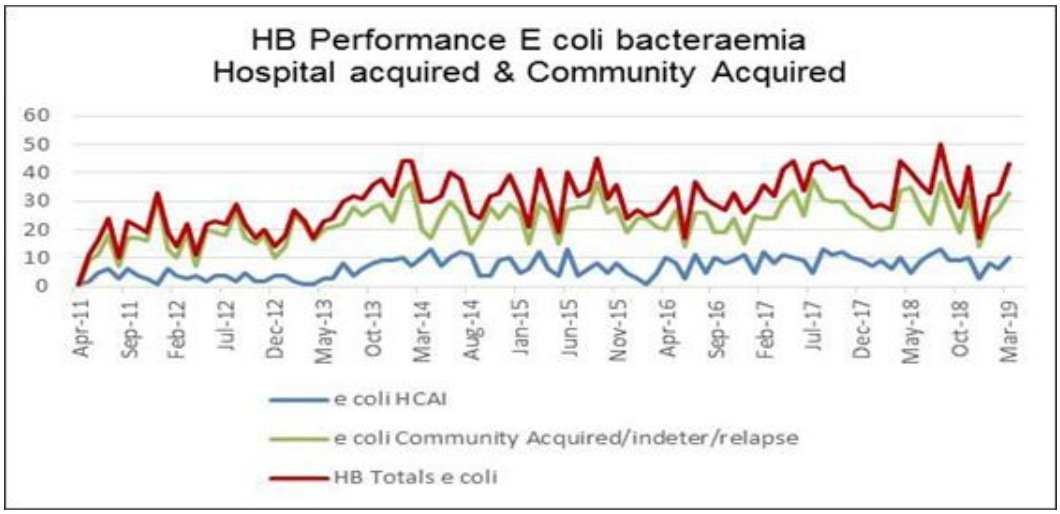


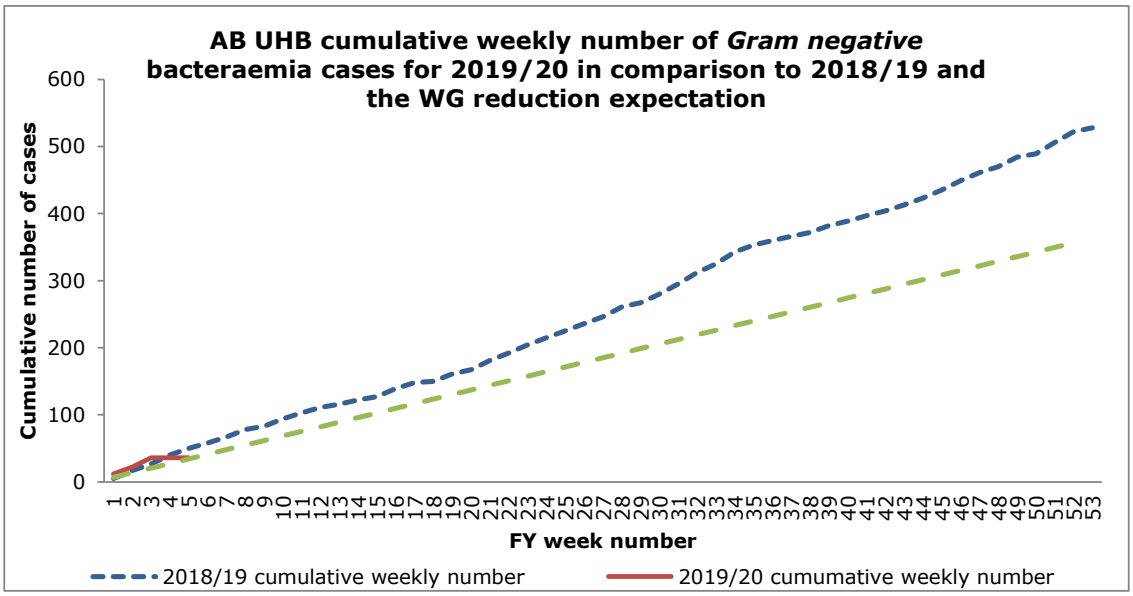


The Health Board has seen a 7% increase in staphylococcus aureus blood stream infections. This is clearly an issue cross Wales as none of the Health Boards will achieve the target this year. It is pleasing to note however that there has been a 30 % decrease in Methicillin-resistant staphylococcus aureus. ***Hospital*** acquired staph aureus blood stream infections are associated with poor IV line and urinary catheter

management. High risk central lines are implicated and in light of this a business case has been approved to appoint two nurses to insert and manage such high risk lines. ***Community*** acquired staph aureus can be associated with poor ulcer management. In light of this a working group including Professor Keith Harding an expert in ulcer management will review best practice and confirm care pathways.

3.2.3. E Coli





EColi bloodstream infection reduction is a relatively new target with a vast majority of cases acquired in the community. EColi bloodstream infections are mostly associated with urinary tract infections although a significant amount are related to the hepatobiliary and respiratory tract.

Public Health Wales have provided comprehensive standards in relation to UTI prevention and management.

Public Health Wales is monitoring Health Boards closely for appropriate urinary tract infection and urinary catheter management in Primary Care as there is a clear evidence base in which to take this agenda forward. Antimicrobial pharmacy will play a key role in the appropriate management of urinary tract infections (UTIs) in Primary Care and the Health Board is supporting this agenda via the appointment of a Consultant Pharmacist and three further antibiotic pharmacists.

Work has commenced introducing draft all-Wales primary care UTI guidance, which was implemented locally in March ahead of national adoption.

A second important piece of work relates to the appropriate use and management of urinary catheters. A working group headed by consultant nurses for continence and infection control is developing and implementing evidence based care pathways and undertaking root cause analysis reviews when issues are identified.

Individual case reviews for EColi in hospital have commenced but not enough reviews have been undertaken to establish any common themes.

It is clear that community acquired infections need focus and scrutiny. As well as benefiting the patient, improving standards in community settings will have a positive effect in prevention secondary care admissions. In light of this a primary care infection prevention nurse has just been appointed to drive this important agenda forward.

3.2.4. Klebsiella – Number of cases

This is a new target and there is an expectation that the Health Board will reduce cases by 10%

Klebsiella species are the most frequently found agents in hospital outbreaks due to multidrug-resistant Gram-negative bacteria. *Klebsiella* species may reside in the bowel, nose, and trachea and on the skin, and are readily transmitted between patients. Contamination of gloves and gowns occurs in 14% of healthcare worker–patient interactions and the organisms survive for more than 2 hrs on hands. In the environment, *Klebsiella* species have been detected from sources such as sinks, room surfaces, door handles, thermometers and liquid soap. Factors for transmission include length of stay, urinary catheter use and high degree of dependency.

Whilst much has been written in peer review journals about this bacteria, the articles relate to hospital outbreaks.

No ABUHB hospital outbreaks have been identified – all cases are sporadic with 4 acquired in the community and one in hospital. The lack of hospital acquired cases is – in all probability- linked to infection control precautions implemented to reduce other pathogens such as C.difficile and MRSA such as hand hygiene campaigns, HPV cleaning etc.

Again, Klebsiella is associated with urinary tract infections, so the work needed in Primary Care to reduce Ecoli blood stream infection should positively impact on Klebsiella acquisition.

3.2.5. Pseudomonas *aeruginosa* – number of cases in

This is a new target with an expectation that the Health Board will reduce the number of cases by 10%. The Health Board is currently running at a 10% reduction.

Again, the work relating to EColi reductions in Primary Care should positively impact the numbers of cases.

3.3 Hospital Acquired Thrombosis

A Hospital Acquired Thrombosis (HAT) is defined as:

> ***"Any venous thromboembolism (VTE) arising during a hospital admission and up to 90 days post discharge".***

There is no target HAT rate, as the rate in a hospital will vary according to the casemix of patients. Even if the patient is correctly risk assessed and given all the correct thromboprophylaxis, they can still develop a HAT. In these cases it is recognised that the HAT was unavoidable. The aim is that all cases of HAT will have been correctly risk assessed and given the correct thromboprophylaxis and therefore were unavoidable.

All cases of HAT that are identified are sent to the patient's Consultant for review. The number of reviews completed by the Consultants has increased greatly over the last year, through improvements to the process, which means the data is now more robust. All cases that are identified as potentially preventable, as the correct thromboprohylaxis was not given, are taken to the Thrombosis Group, to ensure that learning happens at all levels from the individual, to the team, to the organisation. The Group sent out a HAT Newsletter across ABUHB to

disseminate the data on HATs by specialty and to re-inforce the key messages about preventing VTE and correct thromboprohylaxis.

The data for the T and O HATS has been analysed by Consultant and by procedure. This data will be anonymised and sent out to all T and O Consultants. Each Consultant will know which line represents their individual data, so that they can see how they compare to other Consultants. The T and O Consultants are changing their thromboprophylaxis, in line with one of the regimens agreed by NICE. The number of HATs is being monitored to see whether this change in thromboprophylaxis impacts on the number of HATs.

The data below shows the number of cases of HAT in ABUHB in 2017/8 and 2018/19 to date. The data is derived from combining RADIS data with discharge data.

April 2018	**May 2018**	**June 2018**	**July 2018**	**Aug 2018**	**Sept 2018**	**Oct 2018**	**Nov 2018**	**Dec 2018**	**Jan 2019**	**Feb 2019**	**Mar 2019**	**Total**
13	12	14	16	12	9	19	17	25	26	22	20	**205**
Quarter 1 Total		**39**	**Quarter 2 Total**		**37**	**Quarter 3 Total**		**61**	**Quarter 4 Total**		**68**	
April 2017	**May 2017**	**June 2017**	**July 2017**	**Aug 2017**	**Sept 2017**	**Oct 2017**	**Nov 2017**	**Dec 2017**	**Jan 2018**	**Feb 2018**	**Mar 2018**	**Total**
19	14	16	20	13	16	12	16	18	13	14	25	**196**
Quarter 1 Total		**49**	**Quarter 2 Total**		**49**	**Quarter 3 Total**		**46**	**Quarter 4 Total**		**52**	

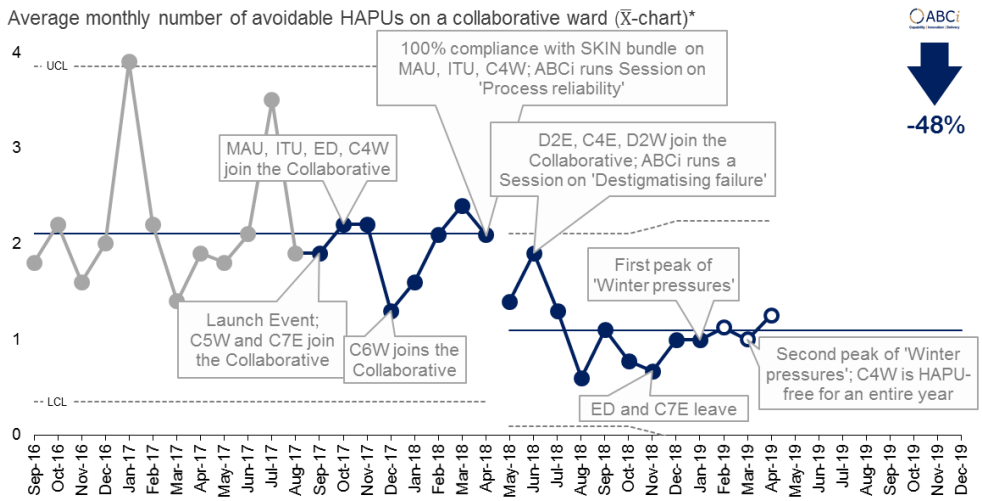
3.4 Pressure Damage

Aim: Aim: Zero Tolerance, with interim targets set by the Health Board to achieve 50% reduction in hospital acquired pressure damage on wards participating in the Improvement Collaborative and 30% reduction in community settings between April 2019 and September 2020

A pressure ulcer reduction collaborative is in place, which targeted wards on the Royal Gwent Hospital site initially. Learning sessions have focussed on PDSA cycles based on evidence based pressure ulcer

reduction guidelines. In addition to attending the pressure damage collaborative, wards participating in the programme have Nominated staff to attend two rolling training programmes on 'Coaching for Improvement' and 'Measurement for Improvement'. By March 2019, the ABCi had trained 26 ward team members as 'Improvement Coaches' and 8 staff as 'Measurement Leads' to help to further improve and sustain achievements. Four wards from NHH joined the programme in November 2018, but to date have not submitted data or completed robust PDSA cycles. Further coaching is required for these new wards.

The different lengths of time participating in the programme mean that some wards have made bigger improvements than others, varying from 80% to 20% reduction in pressure damage. However, ward teams now have well established processes of care and assessment. **Altogether, from the data available in May19, the average reduction of HAPUs across the collaborative wards is about 48%.**



* Average taken over all active wards (MAU, ED, ITU, C4W, C5W, C7E, C6W, D2E, C4E and D2W) and analysed using statistical process control methods. Excluded from the computation are 2 "collaborative" RGH wards who neither report any data nor show evidence of improvement on the individual level. Moreover ED and C7E stopped tracking their compliance with risk/skin assessment and SKIN bundle care in Nov 2018 and are remove from the computation from this point onward.

All grade 3 &4, and unclassified pressure damage is systematically reviewed in all settings, with learning from the review taken back to the wards/Nursing Homes. The responsibility for reviews has transferred to divisions - with oversight by Corporate Nursing.

Data cleansing is in place to ensure that significant Pressure Ulcers are not double counted and classification is accurate. Review of access to the Tissue Viability Service now ensures that significant pressure damage is reviewed by a member of the team in all settings. The numbers of pressure ulcers (all grades) are now reported to Welsh Government on a monthly basis.

An action plan to drive the reduction of community acquired pressure damage is in place to reduce pressure damage by 30%. A pressure ulcer reduction project has commenced in Nursing Homes in collaboration with the Chief Nursing Office in Welsh Government.

Next Steps to Maintain a reduction trajectory.

- Increase the number of wards participating in the collaborative, including further wards from NHH and YYF
- Phased approach to embed the systematic review of pressure damage across the care home sector.
- Development of new Dashboard system to make data available from the ward to the Board along with other health board quality and patient safety metrics.
- The use of technology using hand held scanners to assess a patients risk from pressure damage
- Review of Tissue Viability Education across the Care Home sector
- Continue to identify funding to extend the number of hybrid mattresses across the organisation.

Bwrdd Iechyd Aneurin Bevan Health Board

Quality and Patient Safety Report
Quality and Patient Safety Committee
Agenda Item: 3.1

3.1

3.5 Stroke Care - Stroke 30 day mortality against Top Peer

Acute Stroke Quality Improvement Measures Summary March 2019

72 Hour Pathway Quality Improvement Measures	Aspiration	Aneurin Bevan	Abertawe Bro Morgannwg		Betsi Cadwaladr			Cardiff & Vale	Cwm Taf	Hywel Dda				All Wales
		Royal Gwent	Morriston	Princess of Wales	Bangor	Glan Clwyd	Wrexham Maelor	UHW	Prince Charles	Bronglais	Withybush	Glangwili	Prince Philip	
1. < 4 Hours Care Performance Indicator	95%	46.8%	64.6%	29.0%	36.0%	50.0%	52.4%	42.3%	45.1%	100.0%	78.9%	61.9%	75.0%	51.1%
1a - Direct Admission to Acute Stroke Unit	95%	52.6%	66.0%	26.7%	36.0%	62.5%	51.2%	53.3%	41.7%	100.0%	66.7%	60.0%	70.6%	52.6%
1b - Swallow Screening	95%	62.7%	83.3%	82.8%	93.8%	61.1%	83.3%	49.0%	78.4%	100.0%	94.1%	95.2%	86.7%	75.0%
2. < 12 Hours Care Performance Indicator	95%	96.2%	97.9%	100.0%	100.0%	91.7%	100.0%	96.2%	98.0%	100.0%	100.0%	100.0%	100.0%	97.8%
2a - CT Scan	95%	96.2%	97.9%	100.0%	100.0%	91.7%	100.0%	96.2%	98.0%	100.0%	100.0%	100.0%	100.0%	97.8%
3. < 24 Hours Care Performance Indicator	95%	86.1%	97.9%	58.1%	60.0%	91.7%	78.6%	63.5%	52.9%	100.0%	89.5%	85.7%	90.0%	77.0%
3a - Assessed by Stroke Consultant	95%	96.2%	100.0%	64.5%	64.0%	91.7%	85.7%	73.1%	64.7%	100.0%	100.0%	100.0%	95.0%	84.7%
3b - Assessed by Stroke Nurse	95%	97.5%	100.0%	93.5%	100.0%	100.0%	95.2%	80.8%	88.2%	100.0%	94.7%	95.2%	90.0%	93.8%
3c - Assessed by One of OT, PT, SALT	95%	88.6%	97.9%	93.5%	92.0%	100.0%	97.6%	86.5%	62.7%	100.0%	94.7%	85.7%	95.0%	89.0%
4. < 72 Hours Care Performance Indicators	95%	97.5%	100.0%	93.5%	100.0%	100.0%	92.9%	90.4%	94.1%	100.0%	94.7%	90.5%	95.0%	95.4%
4a - Formal Swallow Assessment	95%	100.0%	100.0%	80.0%	100.0%	100.0%	66.7%	81.5%	87.5%	0.0%	100.0%	86.7%	100.0%	91.2%
4b - OT Assessment	95%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	93.2%	95.8%	100.0%	93.3%	100.0%	100.0%	98.1%
4c - Physiotherapy Assessment	95%	98.6%	100.0%	96.7%	100.0%	100.0%	100.0%	97.7%	95.8%	100.0%	100.0%	100.0%	100.0%	98.7%
4d - SALT Communication Assessment	95%	97.1%	100.0%	100.0%	100.0%	100.0%	78.6%	94.3%	93.8%	100.0%	100.0%	87.5%	90.9%	95.1%

>= Target Within 10% below target More than 10% below taget

Acute Stroke Quality Improvement Measures Summary March 2019

Thrombolysis Quality Improvement Measures	Aspiration	Aneurin Bevan	Abertawe Bro Morgannwg		Betsi Cadwaladr			Cardiff & Vale	Cwm Taf	Hywel Dda				All Wales
		Royal Gwent	Morriston	Princess of Wales	Bangor	Glan Clwyd	Wrexham Maelor	UHW	Prince Charles	Bronglais	Withybush	Glangwili	Prince Philip	
1. Access														
1a - Percentage of All Strokes Thrombolsyed	N/A	17.7%	31.3%	16.1%	20.0%	4.2%	16.7%	11.5%	11.8%	20.0%	31.6%	4.8%	5.0%	16.3%
2b - Percentage of Eligible Patients Thrombolsyed	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	71.4%	100.0%	100.0%	100.0%	100.0%	100.0%	96.5%
2. Time														
1a - Thrombolysed Patients with Door-to-Needle <= 30 mins	50%	7.1%	0.0%	0.0%	0.0%	0.0%	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.9%
2b - Thrombolysed Patients with Door-to-Needle <= 45 mins	90%	21.4%	20.0%	60.0%	0.0%	0.0%	14.3%	16.7%	0.0%	100.0%	33.3%	0.0%	0.0%	20.6%
3c - Thrombolysed Patients with Onset to-Needle <= 90 mins	N/A	0.0%	0.0%	20.0%	0.0%	0.0%	14.3%	0.0%	0.0%	100.0%	50.0%	0.0%	0.0%	8.8%
4d - Thrombolysed Patients with Pre and Post Thrombo NIHSS Score	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

>= Target Within 10% below target More than 10% below taget

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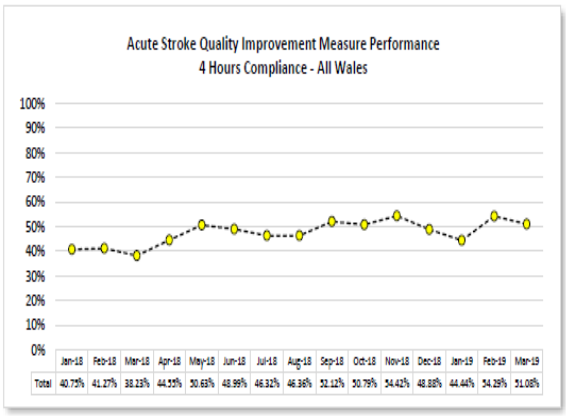
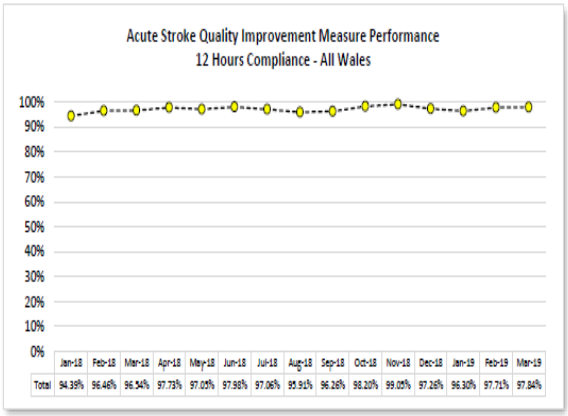
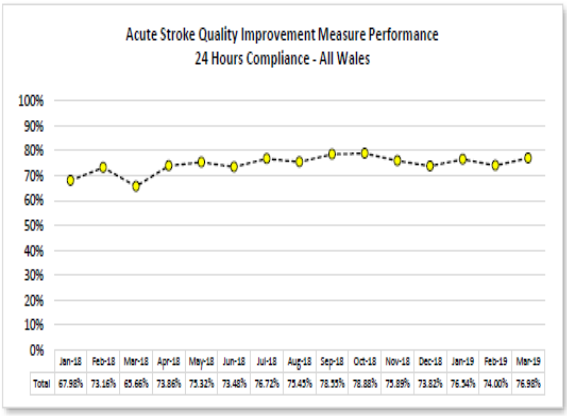
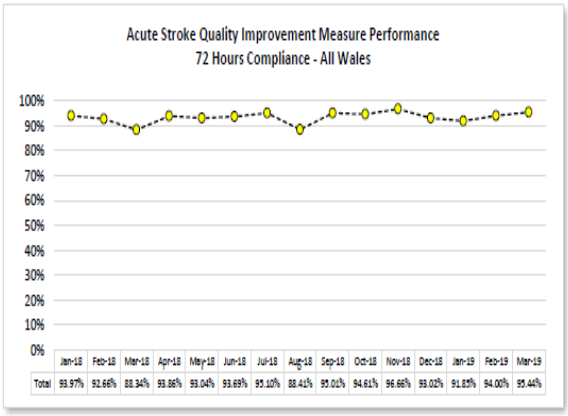
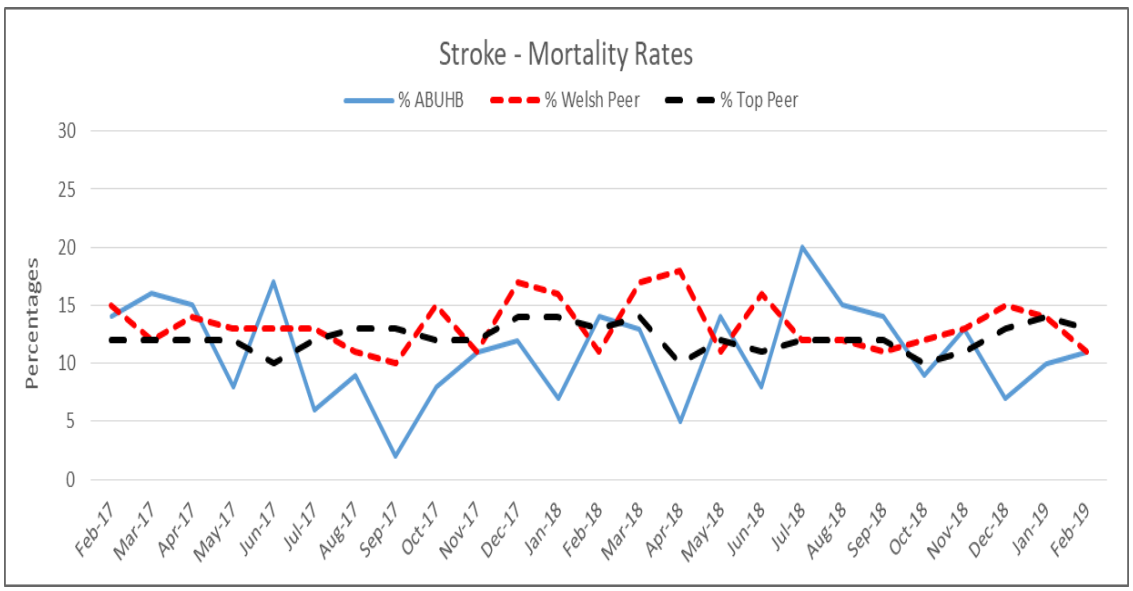
Acute Stroke Quality Improvement Measures Summary March 2019

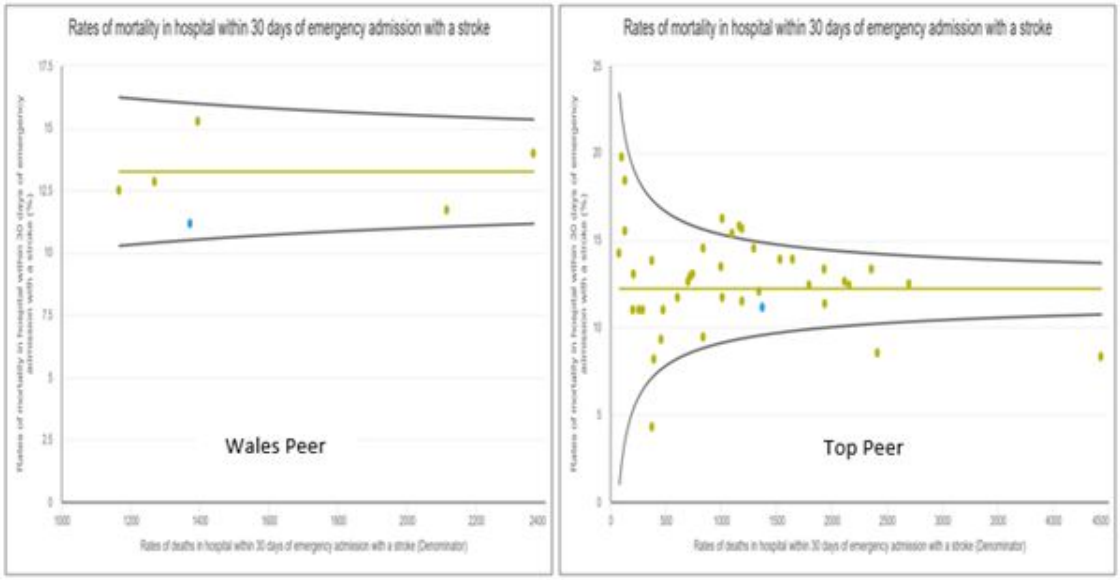




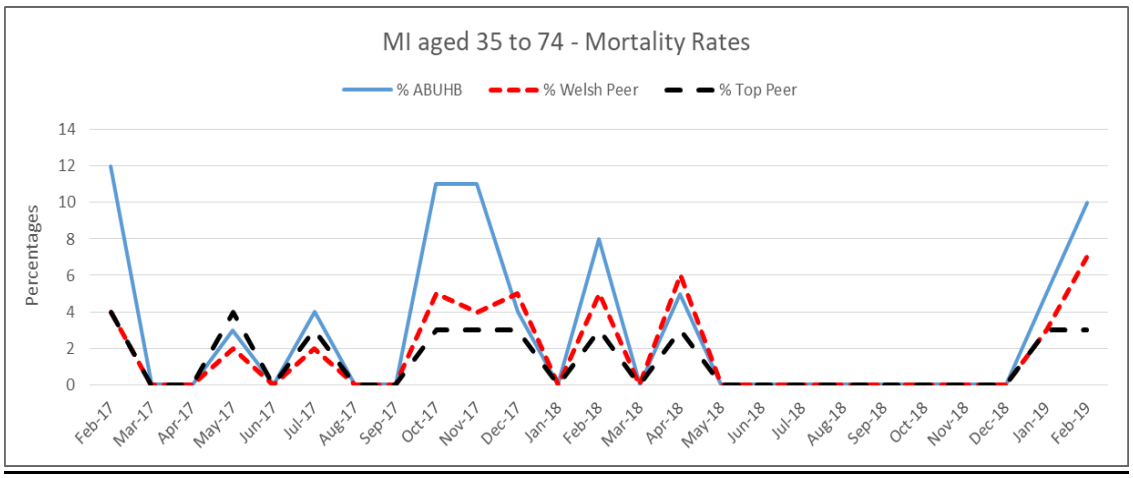


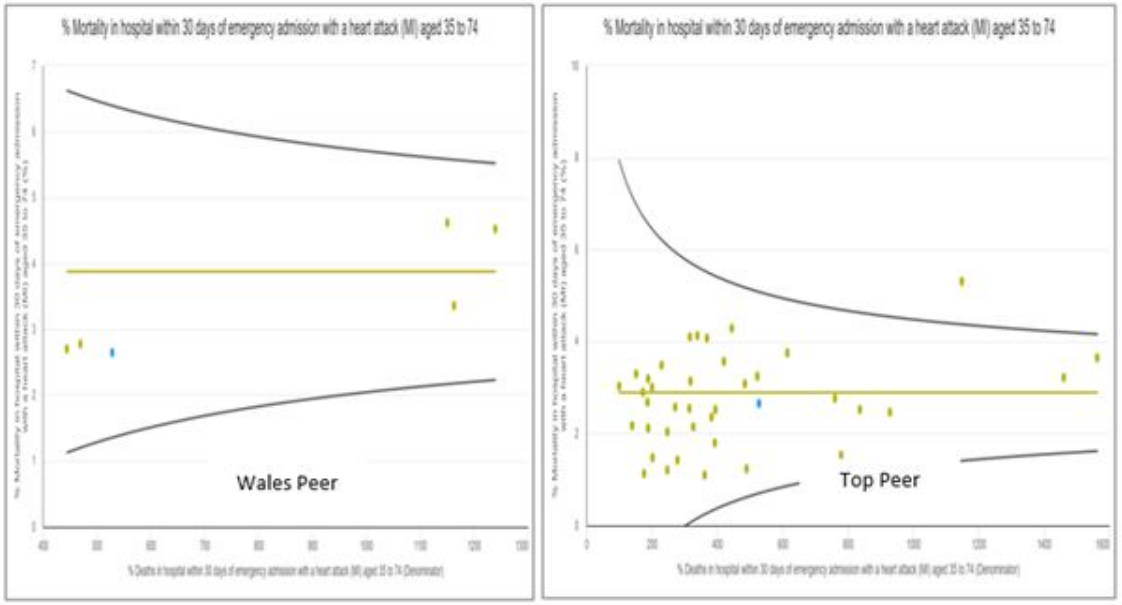






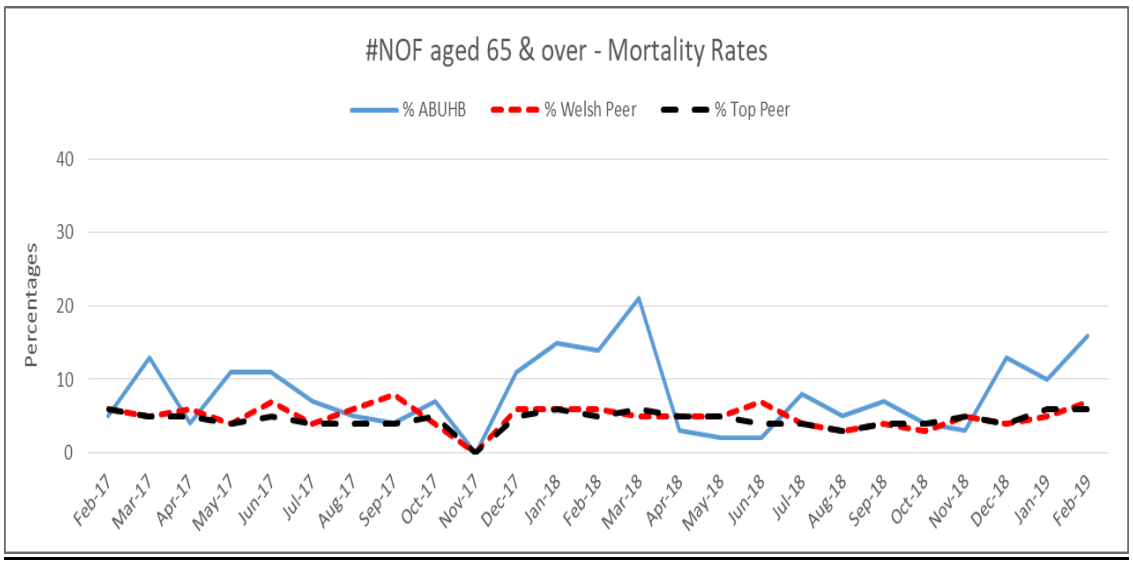
3.6 Myocardial Infarction 30 Day Mortality Ages 35-74 against Top Peer

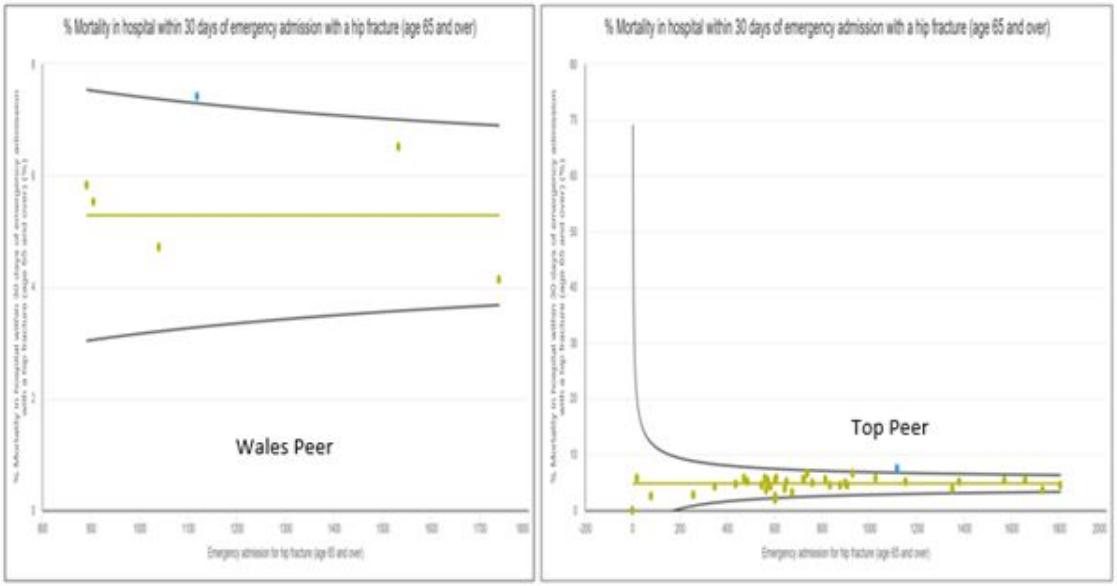




The CHKS data for this measure is under review because of the 6 month period with no deaths.

3.7 Fractured Neck of Femur 30 Day Mortality against Top Peer





The above data is taken from CHKS, and uses the coded data. As deaths are coded as a priority, and our overall coding completeness is lower than it should be, the higher % mortality recently is in part due to a lower denominator (admissions with a fractured neck of femur).

The RGH Adjusted Mortality Rate has been highlighted as an outlier in the 2018 annual report on the 2017 data in the National Hip Fracture Database. The adjustment increases the mortality rate for RGH from 9.2% to 10.8%. A number of changes have been made to the structure of the service and the fractured neck of femur process during late 2017 and early 2018 and more recent data is showed a reduction in the mortality rate at RGH through 2018. However, more recent data has shown an increase in the mortality rate over the winter period. ABUHB will now decide whether to ask for an external review of the fractured neck of femur service.

The detailed results of the NHFD for RGH and NHH in the Annual Report for 2018, based on 2017 data were included in the report to the February 2019 Committee Meeting. Generally, Welsh Services as a whole compare poorly with the UK averages for the NHFD. This has been the case for a number of years, and to address this in ABUHB actions have been taken to improve the care and outcome for patients with a fractured neck of femur at RGH and NHH, these include:

- Appointment of Orthogeriatricians, Specialist Advanced Nurse Practitioners and Flow Co-ordinators at the acute sites.
- Dedicated fractured neck of femur wards, or designated beds at both sites

- Changes to the trauma list process have been put in place to ensure patients with a fractured neck of femur at RGH get to theatre sooner

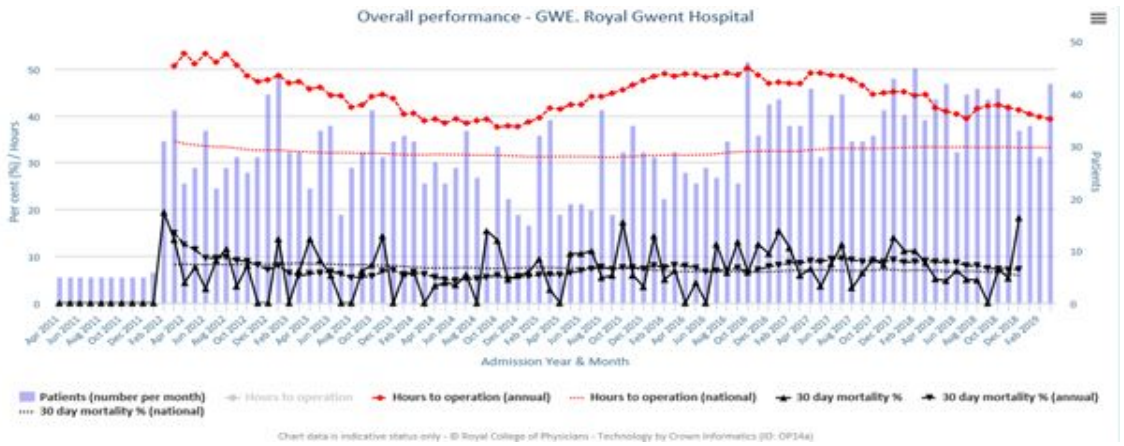
Much of the improvement at the RGH has come from the appointment of an orthogeriatrician for the fractured neck of femur service, which has driven improvements in the ward based assessments. There has been an orthogeriatrician in post at NHH for a number of years, and therefore the improvements to these processes had already been made.

Further actions being taken forward at NHH to improve the care include:

- A robust weekend watch list and out of hours handover for continuity of care
- Advice from the medical team out of hours and at the weekend
- An anaesthetic pathway to improve post-operative care from recovery to the ward
- Careful monitoring of fluid balance and haematological indices by nursing staff and duty orthopaedic medical staff
- Extension of the job plan of the hip fracture service registrars to cover the weekends as this is the period when there has been a lower level of medical cover of these patients

Current data for both RGH and NHH are shown in the following run charts and summary of Key Performance Indicators. This shows that RGH had a sustained reduction in the 30 day mortality rate for patients with a fractured neck of femur until October 2018, but has increased since then. The mortality rate for NHH is more variable. RGH is currently performing above the UK average in 4 out of the 6 KPIs and NHH in 5 out of the 6 KPIs.

RGH National Hip Fracture Database Results



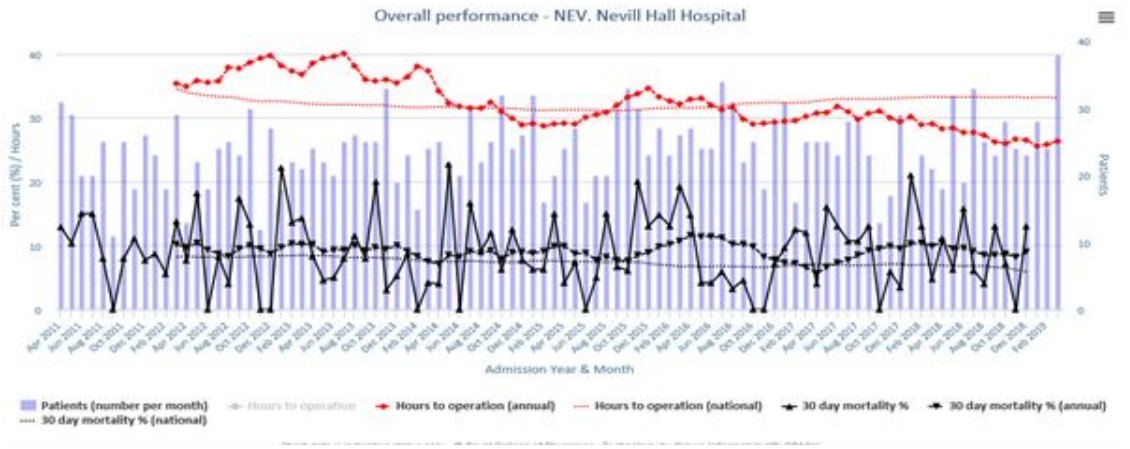
KPI overview: GWE. Royal Gwent Hospital

Annualised values based on 433 cases averaged over 12 months to the end of March 2019.

1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery
96%	52%	77%
NHFD overall: 91%	NHFD overall: 69%	NHFD overall: 75%

4. Prompt mobilisation	5. Not delirious post-op	6. Return to original residence
78%	78%	76%
NHFD overall: 81%	NHFD overall: 70%	NHFD overall: 71%

NHH National Hip Fracture Database Results



KPI overview: NEV. Nevill Hall Hospital

Annualised values based on 306 cases averaged over 12 months to the end of March 2019.

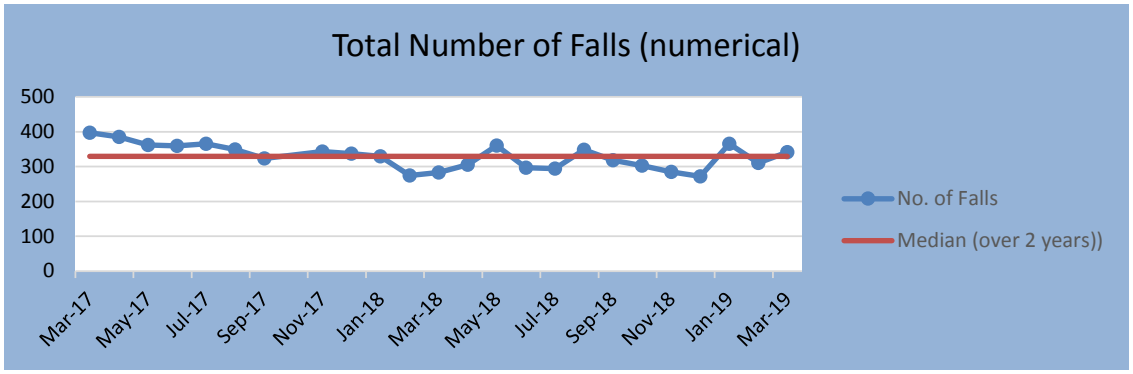
1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery
96%	80%	72%
NHFD overall: 91%	NHFD overall: 69%	NHFD overall: 75%

4. Prompt mobilisation	5. Not delirious post-op	6. Return to original residence
82%	74%	74%
NHFD overall: 81%	NHFD overall: 70%	NHFD overall: 71%

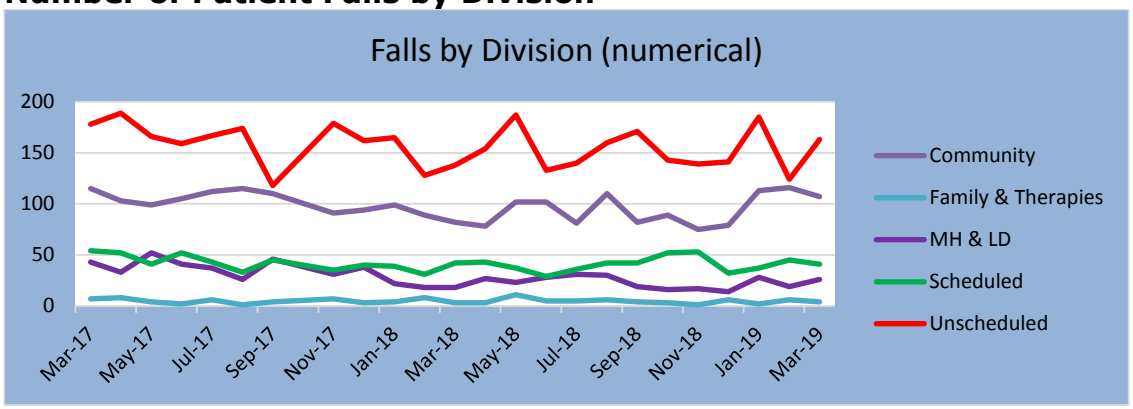
3.8. Preventing Falls

3.8.1. In-patient Falls Data

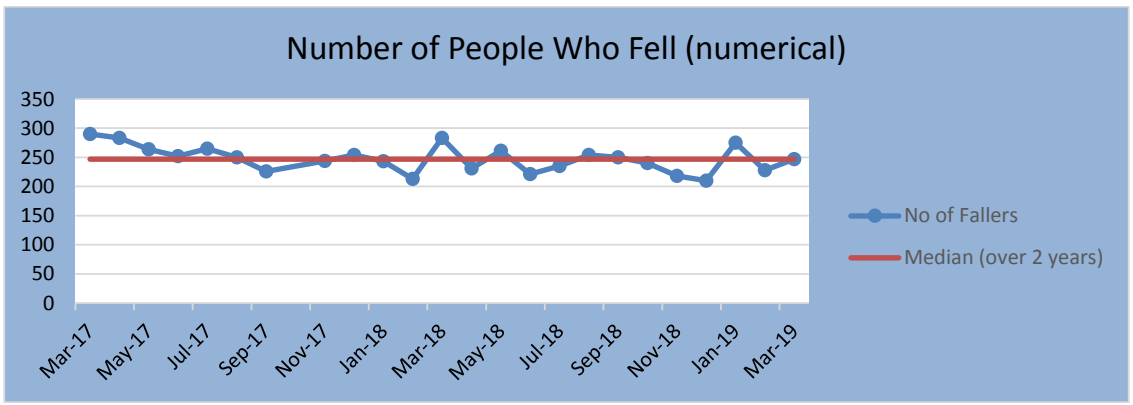
ABUHB Total Number of Falls



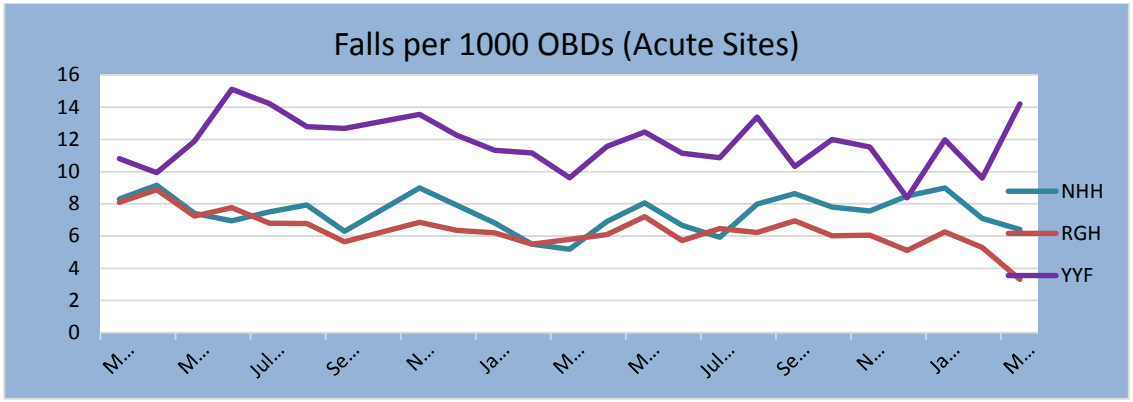
Number of Patient Falls by Division



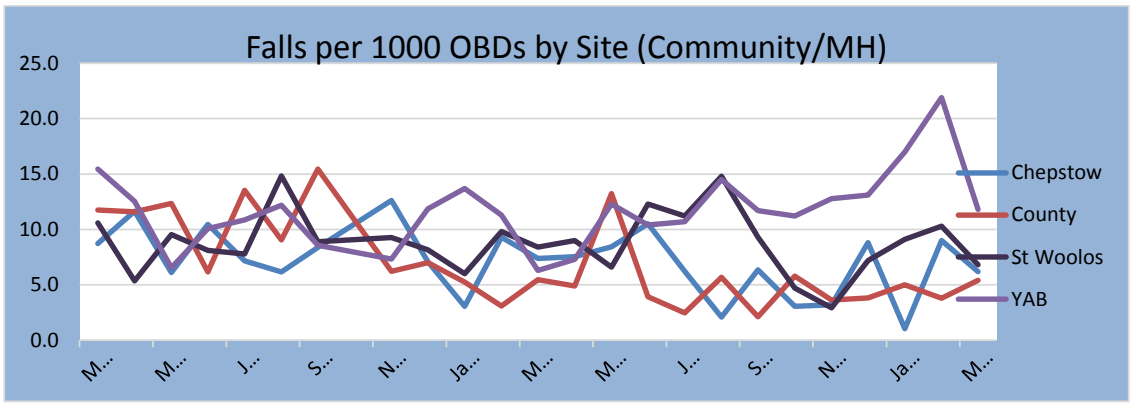
Number of people who fell



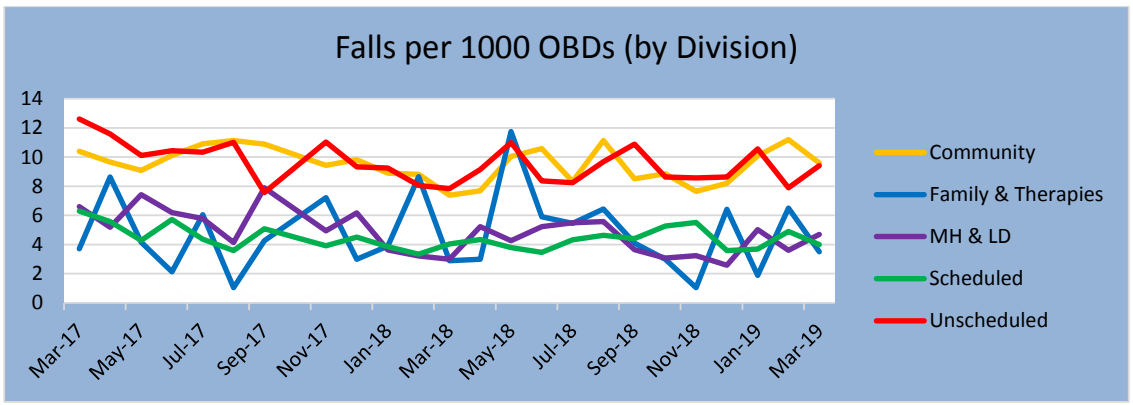
Number of Falls per 1000 Occupied Bed Days by Acute Site



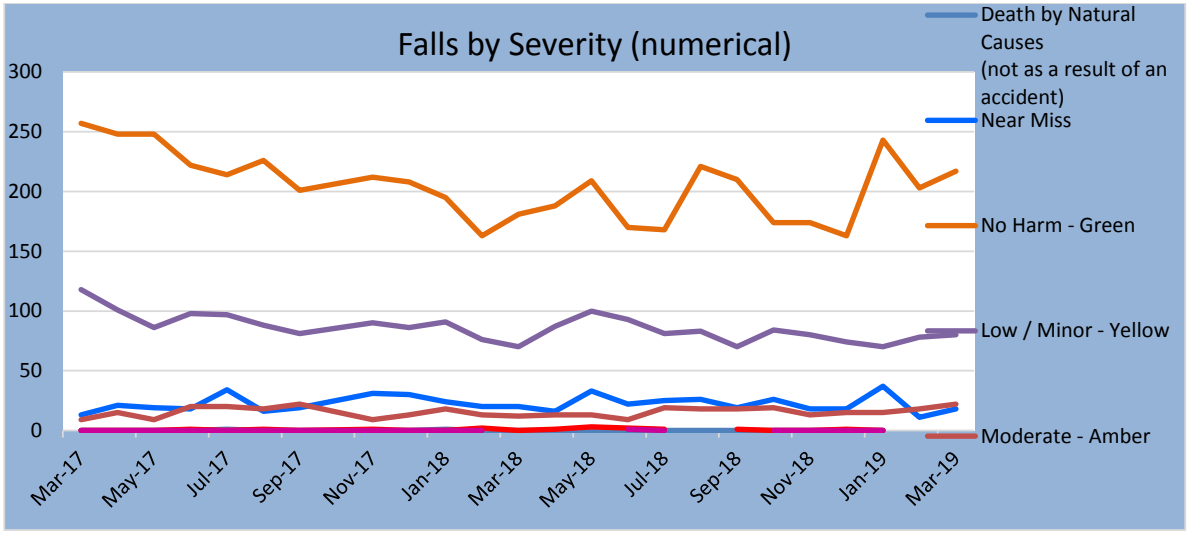
Number of Falls per 1000 Occupied Bed Days by Community/Mental Health Site



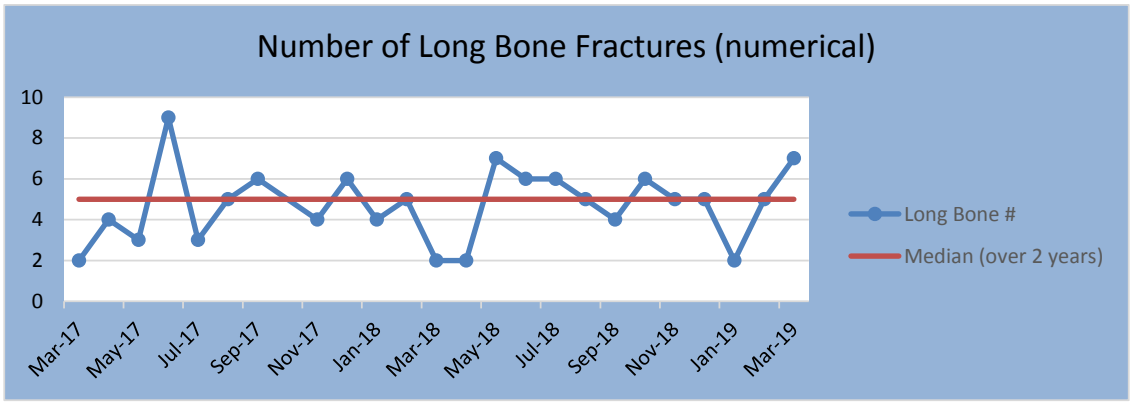
Number of Falls per 1000 Occupied Bed Days by Division



Number of Falls by Severity



Number of Long Bone Fractures



The overall number of falls reported on datix has reduced over the last year. The majority of the reduction is in the low or no harm falls. However, the number of falls increased sharply in January, although the number of long bone fractures reduced in January. In February and March the number of falls has varied, and the number of long bone fractures has been higher.

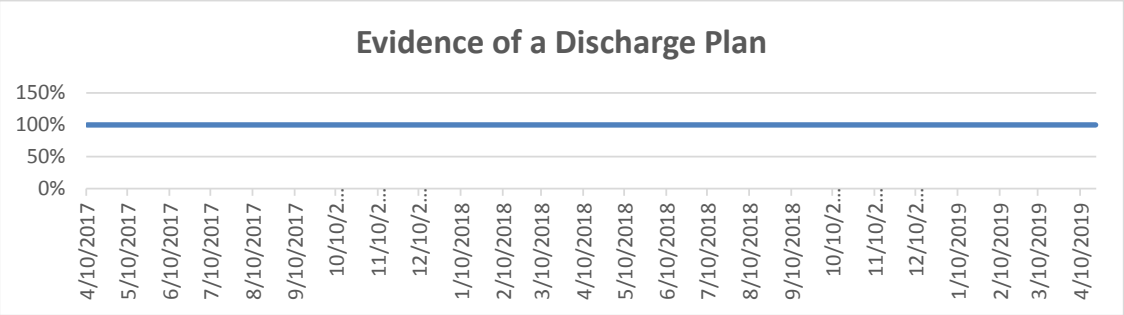
The Falls Steering Group has held a very successful workshop on developing a Falls and bone health strategy for the Health Board and its partners. It is not always possible to prevent falls, and therefore improving the bone health of our population will reduce the risk of fracture, even if a person does fall.

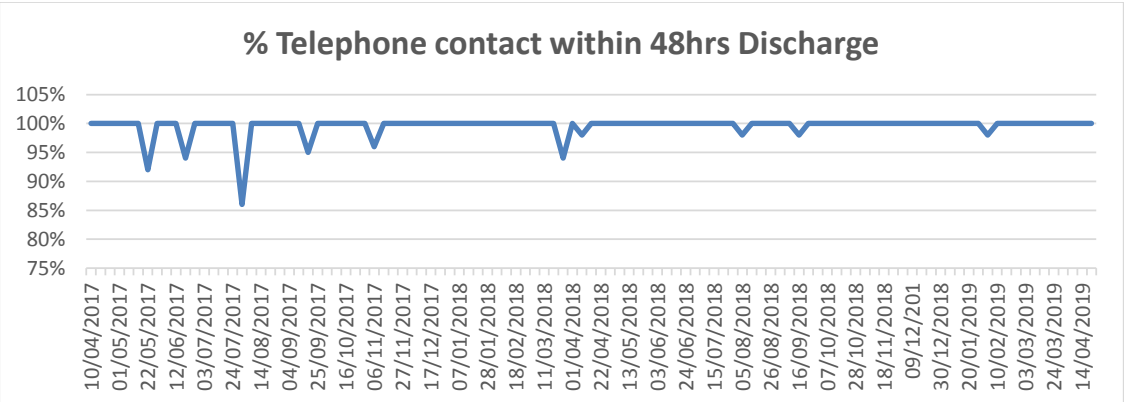
3.9. Mental Health – Compliance with Discharge Plans

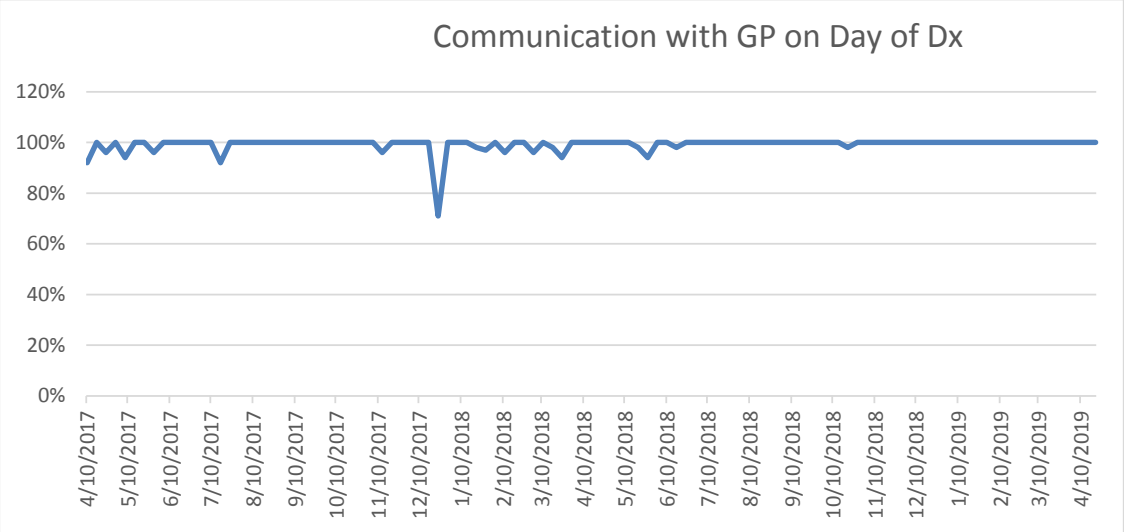
In December 2016 the Coroner issued a Regulation 28 report to the Health Board following the inquest for the death by suicide of a patient on discharge from one of the health board's acute mental health wards. These reports are issued when a Coroner believes that action should be taken to prevent future deaths. The coroner stipulated three points of learning that had to be rectified:

- Decision to discharge made without notification to or consultation with any family member
- No discharge plan or follow up support was put in place
- No contemporaneous notification to her GP of the discharge or the assessment leading to discharge

When a patient is discharged from an acute ward, they are at highest risk of committing suicide in the first 2 weeks after discharge. It is therefore important to ensure that they have a discharge plan, that they are contacted by telephone within 48hrs of discharge, and that the patient's GP is told of the discharge on the same day. The Executive Team huddle monitor compliance on a weekly basis.







The Mental Health Division monitors all three elements very closely, and follows up on each instance where the standard is not met.

3.10. Primary Care – Referrals to Secondary Care

One key patient safety issue for Primary care is to ensure that patients are looked after proactively in the community, so the need for them to contact the Out of Hours service or go to Accident and Emergency is reduced. Some initial primary care data by NCN on A and E attendances, GP referrals to Assessment Units and Emergency Medical Admissions is given below. This will be refined over the coming months.

Objective	Measure		Latest data	Latest period	Target	Tolerance	Trend - last 24 months
Secondary Care Demand							
ABUHB A&E Activity	New A&E Attendances - Patients Aged >65 Years	Grand Total	1521	Apr 2019	1,199	1,261	
		Blaenau Gwent East	138		95	100	
		Blaenau Gwent West	139		127	134	
		Caerphilly East	179		127	134	
		Caerphilly North	79		91	96	
		Caerphilly South	145		118	124	
		Monmouthshire North	140		121	127	
		Monmouthshire South	62		76	80	
		Newport East	106		78	82	
		Newport North	143		105	110	
		Newport West	130		86	91	
		Torfaen North	161		93	98	
		Torfaen South	99		81	85	
A&E Attendances: The latest reported position as at Apr 2019 was reported as 1521 which is a variance of 260 compared to the same period the previous year which equates to an increase of 20.6%. For NCN benchmarking please see table at foot of this report.							
ABUHB Assessment Unit Activity	GP Referrals to Assessment Units	Grand Total	3435	Apr 2019	3,000	3,158	
		Blaenau Gwent East	183		163	172	
		Blaenau Gwent West	247		207	218	
		Caerphilly East	418		333	350	
		Caerphilly North	269		209	220	
		Caerphilly South	301		274	288	
		Monmouthshire North	219		192	202	
		Monmouthshire South	227		218	229	
		Newport East	270		264	278	
		Newport North	317		319	336	
		Newport West	352		295	311	
		Torfaen North	317		288	303	
		Torfaen South	315		238	251	

Objective	Measure		Latest data	Latest period	Target	Tolerance	Trend - last 24 months
ABUHB Emergency Admissions	Emergency Medical Admissions to ABUHB - Patients Aged > 65 years	Grand Total	1833	Apr 2019	1,606	1,690	
		Blaenau Gwent East	126		110	116	
		Blaenau Gwent West	120		115	121	
		Caerphilly East	209		156	164	
		Caerphilly North	84		61	64	
		Caerphilly South	156		122	128	
		Monmouthshire North	184		157	165	
		Monmouthshire South	122		121	127	
		Newport East	125		138	145	
		Newport North	187		165	174	
		Newport West	162		148	156	
		Torfaen North	184		158	166	
		Torfaen South	174		156	164	

Assessment Units: The latest reported position as at Apr 2019 was reported as 3435 which is a variance of 277 compared to the same period the previous year which equates to an increase of 8.8%.

Admissions: The latest reported position as at Apr 2019 was reported as 1833 which is a variance of 143 compared to the same period the previous year which equates to an increase of 8.5%.
For NCN benchmarking please see table at foot of this report.

The Table opposite shows the NCN benchmarking of variance to the reported position for the same period the previous year:

ABUHB Provider Data	A&E (>65Yrs) Attendances	Assessments (>65Yrs)	Admissions (>65Yrs)	Prescribing	OOHs
Grand Total	**21%**	**9%**	**8%**	**0.0%**	**-10.1%**
Blaenau Gwent East	38%	6%	9%	-0.5%	-9.4%
Blaenau Gwent West	4%	13%	-1%	0.4%	-15.8%
Caerphilly East	34%	19%	27%	0.8%	-7.5%
Caerphilly North	-18%	22%	31%	-0.3%	-11.4%
Caerphilly South	17%	5%	22%	0.7%	-11.2%
Monmouthshire North	10%	8%	12%	-1.1%	-12.1%
Monmouthshire South	-23%	-1%	-4%	-1.4%	-13.9%
Newport East	29%	-3%	-14%	-1.4%	-1.9%
Newport North	30%	-6%	7%	0.0%	-13.1%
Newport West	43%	13%	4%	-0.1%	-12.2%
Torfaen North	64%	5%	11%	1.1%	-7.9%
Torfaen South	16%	25%	6%	0.8%	-8.9%

Out of Hours demand

Objective	Measure		Latest data	Latest period	Target	Tolerance	Trend - last 24 months
GP Urgent OOHs Service							
Ensure that patients accessing Primary Care OOH are advised in line with tier 1 targets	% Triaged Within Limit (Reception) (Combined Urgent & Routine Measure)	Grand Total	72.3%	Apr 2019	98%	85%	
		Blaenau Gwent East	72.2%				
		Blaenau Gwent West	69.5%				
		Caerphilly East	76.4%				
		Caerphilly North	73.1%				
		Caerphilly South	71.9%				
		Monmouthshire North	72.1%				
		Monmouthshire South	69.3%				
		Newport East	76.0%				
		Newport North	69.2%				
		Newport West	70.8%				
		Torfaen North	72.6%				
		Torfaen South	71.0%				
OOHs: The latest reported position as at Apr 2019 was reported as 72.3% which is a variance of -10.1% compared to the same period the previous year. For NCN benchmarking please see table at foot of this report.							

Recommendation
The Quality and Patient Safety Committee is asked to review the report, note the progress being made in many areas and highlight any issues where further information is required for assurance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The initial section of the report reviews high level data in order to highlight clinical risks in the system. The quality improvement initiatives in this report are being undertaken to improve patient safety and therefore reduce the risk of harm to our Patients. Improved patient safety also reduced the risk of litigation Issues are part of Divisional risk registers where they are seen as a particular risk for the Division.
Financial Assessment, including Value for Money	Some issues highlighted within the report will require additional resources to support further improvement. These will be subject to individual business cases which will contain the full financial assessment. In many cases, improving the

	quality will reduce harm to patients and/or waste, but this will also be highlighted in the business cases.
Quality, Safety and Patient Experience Assessment	The report is focussed on improving quality and safety and therefore the overall patient experience.
Equality and Diversity Impact Assessment (including child impact assessment)	Advice will be obtained from the Workforce and OD Directorate about how the Impact Assessment is carried out for this report.
Health and Care Standards	Health and Care Standards form the quality framework for healthcare services in Wales. The issues focussed on in the report are therefore all within the Health and Care Standards themes, particularly safe care, effective care and dignified care.
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP and the quality improvements highlighted here are within the Plan.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being Objectives and should also indicate to which Objective(s) this area of activity is linked.*
	Long Term – Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Involvement –Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	The terms are all used routinely in the report, which is presented at every meeting.
Public Interest	The report has been written for the public domain.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee Wednesday 12th June 2019 Agenda Item: 3.2

3.2

Aneurin Bevan University Health Board

STRATEGIC RISK REPORT FOR QUALITY AND SAFETY

Executive Summary			
This paper provides an overview of the profile of the current risks for which the Quality and Patient Safety Committee is responsible for monitoring, at the end of April 2019. The risk profile of the Health Board is continuing to be revised and reworked. Further rationalisation and redevelopment work continues and will further developed prior to the next Committee meeting. This report is provided for assurance purposes for the Quality and Patient Safety Committee.			
The Quality and Patient Safety Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance	✓		
Note the Report for Information Only			
Executive Sponsor: Paul Buss, Medical Director, Peter Carr, Director of Therapies and Health Science, Martine Price, Interim Director of Nursing			
Report Author: Claire Barry, Committee Secretariat			
Report Received consideration and supported by :			
Executive Team	N/A	**Quality and Patient Safety Operational Group**	✓
Date of the Report: 4th June 2019			
Supplementary Papers Attached: Risk Dashboard			

Purpose of the Report
This report is provided for assurance purposes to highlight to the Quality and Patient Safety Committee the risks that are assessed as the key risks to the Health Board's successful achievement of our strategic objectives within the IMTP.
Background and Context
1. Background Risk management is a process to ensure that the Health Board is focusing on and managing risks that might arise in the future. Also, situations where there are continuing levels of inherent risk within current issues within the organisation or in our partnership work.

Active risk management is happening every day throughout all sites and services of the Health Board. Nevertheless, the Health Board's risk management system and reporting also seeks to ensure that the Board is aware, engaged and assured about the ways in which risks are being identified, managed and responded to across the organisation and our areas of responsibility.

The risks referenced within this report have been identified through work by the Board, Committees, Executive Team and items reported through the Health Board's management structures with regard to the implementation of the IMTP, for which the Finance and Performance Committee have oversight.

Table from the updated Risk Management Strategy – January 2017.

Consequence Score	Likelihood Score				
	1 Rare	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
5 - Catastrophic	5	10	15	20	25
4 - Major	4	8	12	16	20
3 - Moderate	3	6	9	12	15
2 - Minor	2	4	6	8	10
1 - Negligible	1	2	3	4	5

2. Corporate Risk Register and Dashboard Report

The dashboard reports are generated from the Health Board's Corporate Risk Register. The reports seek to provide in-overview:

- The key risks for which the Quality and Patient Safety Committee has responsibility;
- The current profile of risks in that strategic objective area and their potential impact;
- Whether risks have worsened, remained unchanged or had been mitigated since the last assessment;
- Historical context of each risk i.e. how long it has been at its level on the Corporate Risk Register;
- The report will also show any risks that have been withdrawn in the last reporting period or whether there are new risks.

The risks for the purposes of the dashboards have been summarised to make them more accessible to the Committee.

There are currently 7 risks on the Quality and Patient Safety Risk Register. These are broken down by the following levels of risk severity.

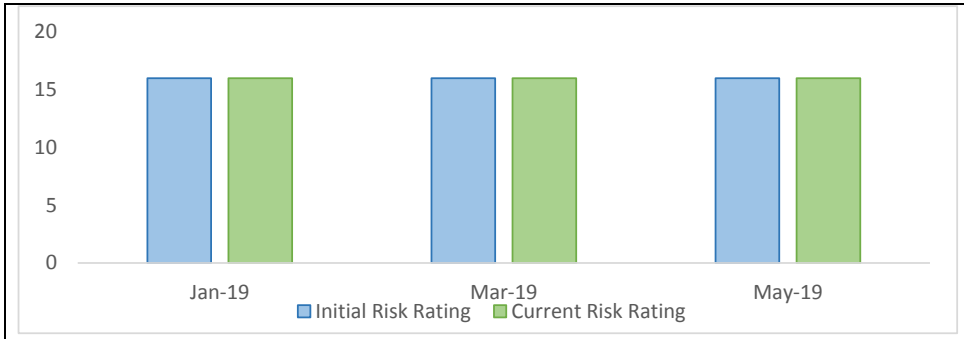
Assessment and Conclusion
This paper provides an overview of risks as at the end of April 2019.

Recommendation
The Quality and Patient Safety Committee is asked to consider this report and note the identified risks as the current quality and patient safety risks for the Health Board as at April 2019.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational risks are a key element of the Health Board's overall assurance framework.
Financial Assessment, including Value for Money	There may be financial consequences of individual risks however there is no direct financial impact associated with this report.
Quality, Safety and Patient Experience Assessment	Impact on quality, safety and patient experience are highlighted within the individual risks contained within this report.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no specific equality issues associated with this report at this stage, but equality impact assessment will be a feature of the work being undertaken as part of the risks outlined in the register.
Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards for Wales.
Link to Integrated Medium Term Plan/Corporate Objectives	The risks against delivery of key priorities in the IMTP, will be outlined as specific risks on the risk register.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to this specific report, however WBFGA considerations are included within the consideration of individual risks
Glossary of New Terms	None
Public Interest	Report to be published

Corporate Risk to a Page Report - as at end of April 2019

CRR15	**Director Lead:** Acting Director of Nursing	**Date Opened:** July 2018
	Assuring Committee: Quality and Patient Safety Committee	**Date Last Reviewed:** April 2019
	Risk: Poor patient experience, deterioration of patient outcomes and quality of care in hospital and community settings due to staff shortages and patients not able to access services on a timely way in both primary and secondary care.	**Target Risk Review Date:** Monthly review undertaken
	Impact: Deteriorating patient experience/outcomes and quality of care.	



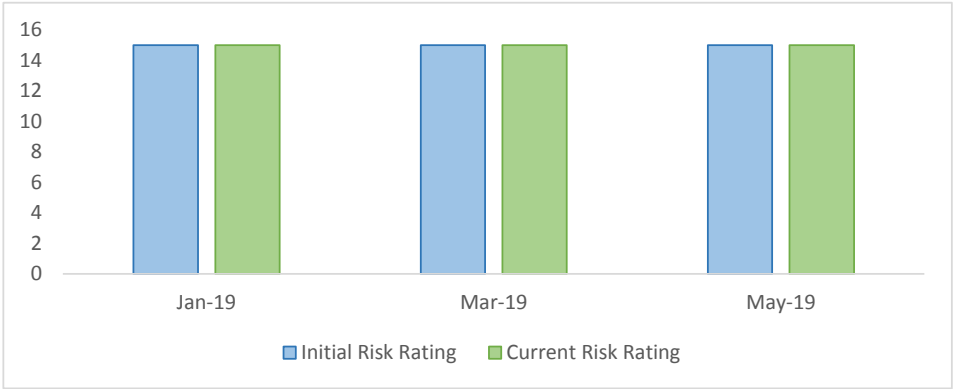
	Consequence	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite Level Low Business Driver – Level	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in March 2019	Risk remained unchanged ⟷		

Controls in place	**Further action to achieve target risk score**
• Monitoring of quality measures via Quality and Patient Safety Committee; • Patient experience is being captured and specific spot checks are being undertaken • Pressure Ulcer Collaborative and ED turnaround launched • Continued monitoring of HIW/CHC/Complaints/incidents to identify any areas of concern and lessons learnt reported to Executive Team • Workforce planning, planned use of temporary staffing and recruitment strategies in place with regular review • Weekly Clinical Executive Huddles take place and are reported to the Executive Team • A Winter Review and learning has been undertaken and will be reported to the Board in May 2019.	• Reduction in Length of Stay to achieve right patient in right place right time. • Recruitment strategy to be further developed • Real time quality reporting with Cliksense will assist assessment and scrutiny.

Sources of Assurances	**Links to**
• HIW Reports • Working the Delivery Unit and Reporting • Community Health Council Reports • Internal Audit and Wales Audit Office Report • Reports from the Learning Committee and Lessons Learnt Reports • Divisional Reports including assessments of Health and Care Standards	**Strategic Priorities in the IMTP** Links to Priority – 3, 4, 5, 6, 7 and 8

Corporate Risk to a Page Report - as at end of April 2019

CRR022	**Director Lead:** Acting Director of Nursing	**Date Opened:** July 2018
	Assuring Committee: Quality and Patient Safety Committee	**Date Last Reviewed:** April 2019
	Risk: Failure to reduce Healthcare Associated Infections	**Target Risk Review Date:** Monthly review undertaken
	Impact: Increase in Healthcare Associated Infections, in hospital and community, placing patients at risk, risk of losing bed capacity because of outbreaks, increasing costs, reducing quality of care, increased risk of mortality associated with HCAI and reputational risk.	



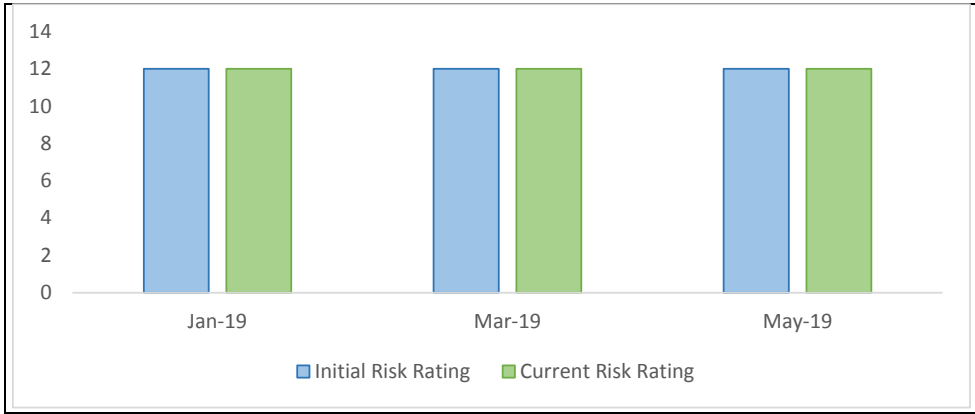
	Consequence	Likelihood	Score
Initial Risk Rating	5	3	15
Current Risk Rating	5	3	15
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in March 2019	Risk remained unchanged ⟷		

Controls in place	**Further action to achieve target risk score**
• There is an annual programme of HPV cleaning for all clinical areas. • An active ward refurbishment programme is in place. • Root cause analysis undertaken for all HCAIs. • Deep Dives carried out for primary and community acquired infection have been undertaken and an action plan is in place. • Further investment in antimicrobial pharmacy agreed and have recently appointed. Investment in new HPV equipment agreed.	• The Antibiotic Strategy under review by Medical Director.

Assurances	**Links to**
• HIW Reports • Working the Delivery Unit and Reporting • Community Health Council Reports • Internal Audit and Wales Audit Office Report • Reports from the Learning Committee and Lessons Learnt Reports • Divisional Reports including assessments of Health and Care Standards	**Strategic Priorities in the IMTP** This risks links to a range of priorities, but particularly priority 8.

Corporate Risk to a Page Report - as at end of April 2019

CRR007	**Director Lead:** Director of Therapies and Health Science	**Date Opened:** March 2017
	Assuring Committee: Quality and Patient Safety Committee	**Date Last Reviewed:** April 2019
	Risk: Compliance rates of statutory and mandatory training of staff	**Target Risk Review Date:** Monthly review undertaken
	Impact: Risk of undermining the quality and safety of services.	



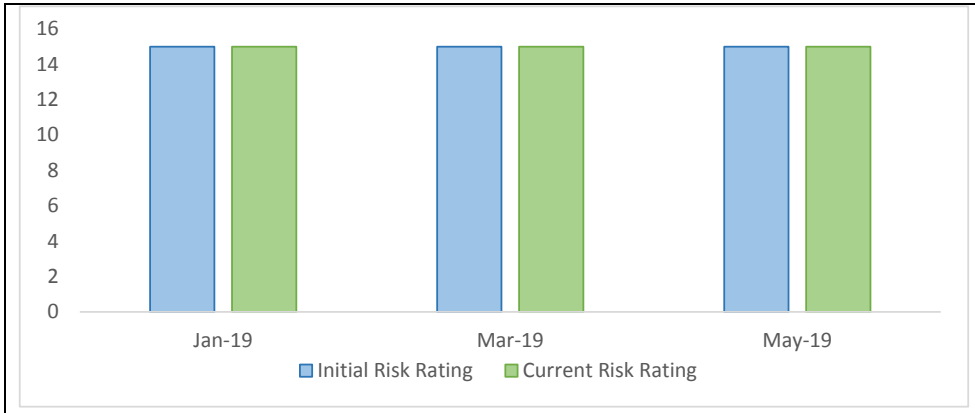
	Consequence	Likelihood	Score
Initial Risk Rating	4	3	12
Current Risk Rating	4	3	12
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in March 2019	Risk remained unchanged ⟺		

Controls in place	**Further action to achieve target risk score**
• Compliance monitored by the Health and Safety Committee. • Access to on-line training has been simplified via ESR and training compliance rates are steadily improving. • Each Division has received latest data and produce improvement plans.	Continued staff awareness raising and communication with regard to requirement for compliance and ensuring requirements are a key feature of Division and Corporate Department compliance and assurance reviews.

Assurances	**Links to**
• Performance Indicator Dashboard • WAO and Internal Audit Reports • Reports from Health and Safety Committee • PADR reports, • Inclusion in Induction Processes.	**Strategic Priorities in the IMTP** This is an enabling risk in support of the delivery of all priorities of the IMTP.

Corporate Risk to a Page Report - as at end of April 2019

CRR023	**Director Lead:** Director of Therapies and Health Science	**Date Opened:** December 2017
	Assuring Committee: Quality and Patient Safety Committee	**Date Last Reviewed:** April 2019
	Risk: Inadequate falls prevention on in-patient wards	**Target Risk Review Date:** Monthly review undertaken
	Impact: Failing to protect patients and risk of increased fractures and harm.	



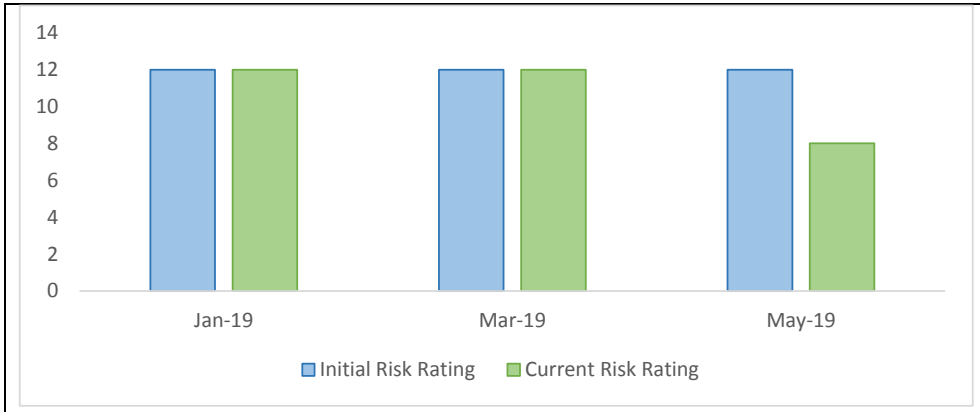
	Consequence	Likelihood	Score
Initial Risk Rating	5	3	15
Current Risk Rating	5	3	15
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in March 2019	Risk remained unchanged ⟷		

Controls in place	**Further action to achieve target risk score**
• 'Prevention and Management of Inpatient Falls' Policy has been updated and disseminated widely across the Health Board. • Training ongoing on wards/sites targeting hot spot areas in the first instance. Monthly Falls Scrutiny Panel review and learning from all inpatient falls resulting in a fracture. Numbers of fractures from inpatient falls is reducing.	• The Falls Steering Group is exploring resources for consistent delivery of falls prevention training for all inpatient areas.

Assurances	**Links to**
• Internal Audit and Wales Audit Office Report • Divisional Reports including assessments of delivery • Reports from Divisional Assurance Meetings • Delivery Framework updates • Executive Board meetings	**Strategic Priorities in the IMTP** Links to Priority number 8.

Corporate Risk to a Page Report - as at end of April 2019

CRR050	**Director Lead:** Director of Primary, Community and Mental Health	**Date Opened:** November 2017
	Assuring Committee: Mental Health Act (Quality and Patient Safety Committee)	**Date Last Reviewed:** April 2019
	Risk: Crisis services in Mental Health will not meet the needs of our population.	**Target Risk Review Date:** Monthly review undertaken
	Impact: Risk to patient safety if services are appropriately not staffed and resourced	



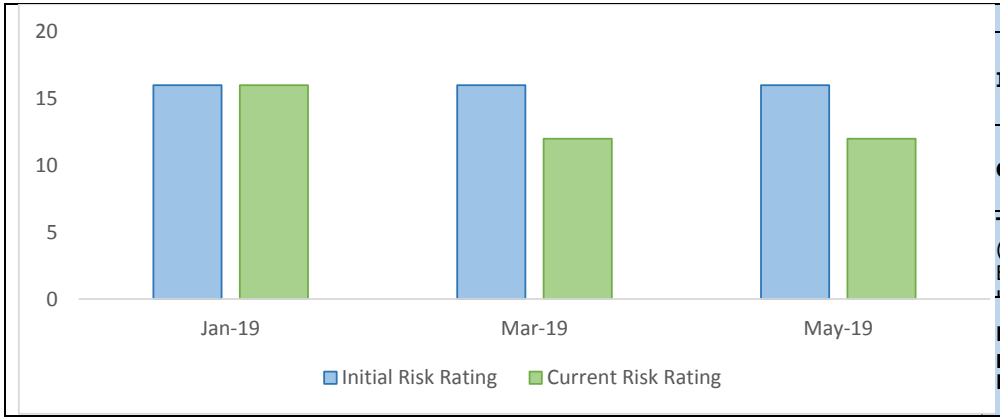
	Consequence	Likelihood	Score
Initial Risk Rating	4	3	12
Current Risk Rating	4	2	8
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in March 2019	Risk has decreased ↓		

Controls in place	**Further action to achieve target risk score**
• Gwent 'Whole Person, Whole System' Acute and Crisis Model being developed to support people with a mental health need who present in crisis. • Remodelling the service to better meet local needs. • Bids for Crisis House and Sanctuary provision prepared. • Inpatient, Crisis Team, Home Treatment Team (HTT), Inpatient and urgent CMHT being reviewed. • Investment secured for expansion of HTT to cover 24/7.	• Work on Single Point of Access to commence during 2019/20.

Assurances	**Links to**
• Internal Audit and Wales Audit Office Report • Divisional Reports including assessments of delivery • Reports from Divisional Assurance Meetings • Delivery Framework updates • Executive Board meetings	**Strategic Priorities in the IMTP** Links specifically to priority 5.

Corporate Risk to a Page Report - as at end of April 2019

CRR040	**Director Lead:** Director of Primary, Community and Mental Health	**Date Opened:** March 2017
	Assuring Committee: Quality and Patient Safety Committee	**Date Last Reviewed:** April 2019
	Risk: Potential fragility of GP Out of Hours Services linked to the overall unscheduled care services of the Health Board Particular risks focus on the availability of GPs to cover the high demand and overnight shifts	**Target Risk Review Date:** Monthly review undertaken
	Impact: Increasing demand on OOHs and other elements of the urgent care system. Risk if Out of Hours cannot be appropriately staffed and the risk that service provision will not meet urgent needs of local people.	



	Consequence	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	3	12
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in March 2019	Risk remained unchanged ⟷		

Controls in place	**Further action to achieve target risk score**
• All aspects of this risk is currently being responded to as part of the Service Redesign Plan and implementation and development of clinical Hub with medical lead nurse and pharmacist in readiness for 111 implementation and expansion for the Winter Plan. • Neighbourhood Care Networks established and plans developed and being implemented. • Extension of all pharmacy schemes in each Borough. • Clinical Reference Group established to develop and advice senior team. • Excellent uptake by VTRs and refresher/taster sessions for new GPs through marketing by OOHs lead GPs. • Ongoing engagement in the development of 111.	• Engagement in the 111 Programme and the readiness checks prior to agreement of 'go live' date. • Fully implement the integrated well-being network, alongside the new workforce model for primary care in five NCN areas to improve sustainability of Primary Care Services.

Assurances	**Links to**
• Internal Audit and Wales Audit Office Report	**Strategic Priorities in the IMTP**

Corporate Risk to a Page Report - as at end of April 2019

• Divisional Reports including assessments of delivery • Reports from Divisional Assurance Meetings • Delivery Framework updates • Executive Board meetings • 111 Programme Implementation Reports	Links to Priority number 3.

Aneurin Bevan University Health Board

Health Board Committee Update Report

Name of Group:	Quality and Patient Safety Operational Group (QPSOG)
Chair of Group:	Peter Carr, Executive Director of Therapies and Health Science
Reporting to:	Quality and Patient Safety Committee
Reporting Period:	21st May 2019

Summary of Key Matters Considered by QPSOG:

Divisional Risk Registers/Concerns

The Divisional Quality and Patient Safety leads presented the Divisional reports on key risks and concerns related to quality and patient safety.

The Facilities Division highlighted risks associated with buildings and infrastructure, including lifts and power supplies.

The Mental Health and Learning Disabilities Division highlighted the continued risk related to ligature points in mental health facilities; risks associated with staff alarms, alarm/call systems; and concerns about some clinic facilities.

Risk associated with recruitment and retention of medical and nurse staffing was highlighted by all operational Divisions (Scheduled Care, Unscheduled Care, Primary Care and Community and Family and Therapy, and Complex Care).

The Unscheduled Care Division noted risks associated with high levels of emergency demand at the acute sites.

The Scheduled Care Division noted risks associated with access and waiting times.

The Primary Care and Community noted the risk of inpatient falls in the community hospitals.

Complex Care noted the risk with the fragility of the nursing home market.

All the risks and concerns are included in the Divisional risk registers with information detailing the action being taken. The QPSOG was assured

that the appropriate action is in place to mitigate the highlighted risks to ensure the quality and safety of services.

Quality, Safety and Performance Report
The draft report was presented and comments invited ahead of its presentation to the QPSC meeting in June 2019.

Putting Things Right (PTR)/ Organisational Learning Report
QPSOG received the bimonthly PTR report (for March / April 2019). The report included information about formal and informal complaints received, Ombudsman cases and serious incidents notified. This report will be presented to the QPSC in June 2019.

National Audit of Care at the End of Life (EoLC)
Dr Edwards presented the outcome of the audit which is now part of the National mandatory audits since 2018, on a three year cycle in three parts. 80 case notes were audited by the Palliative Care team. ABUHB came out well in terms of adhering to corporate policies, guidelines and identified roles. Whilst ABUHB were below the national average across all the measures, the health board was close to the national average in recognising patients are dying and having DNR/CPR forms in the notes. Issues around communication were highlighted, particularly around DNR/CPR discussions and nutrition and hydration and supporting the needs of the family, which links to bereavement support. QPSOG agreed that all specialties need to be involved in carrying out the work to ensure EoLC practices are followed. The audit results have gone to the EoLC Board, which will be monitoring progress on the required action. Palliative Care will support with training in Divisions and Directorates.

Pressure Ulcer Collaborative Update
QPSOG received a presentation by ABCi on the collaborative work, noting progress to date and the plans for transferring the collaborative over to the office of the Nurse Director. With the ABCi support coming to an end, the QPSOG discussed the challenge in sustaining and expanding the improvements in the Divisions already part of the collaborative, and bringing in those that aren't already involved. QPSOG were informed that plans will be developed to ensure appropriate resource and skills are in place within the nursing teams to continue to collaborative work.

Patient Discharge from Hospital to General Practice – Improvement Plan
The HIW Improvement plan was shared with QPSOG. The improvement plan in response to a thematic review by HIW on Discharge.

Review of Impact of Long Waits for Planned Care - Report
QPSOG received a presentation about the Delivery Unit report, noting that even though waiting times have significantly reduced the key messages and underlying issues of patient experience, and how waiting lists are handled, are still relevant. The report highlighted concerns about the length of time patients are going without contact from the health board (45% of cases reviewed had a gap of 6+ months). The Delivery Unit findings are in line with the feedback from the CHC review on how the patient reported the impact on their life waiting for treatment. Specific areas of concern highlighted included coordination when patients are on multiple pathways and deterioration whilst waiting. In response the Health Board will develop an improvement plan, focussed on priority areas, overseen by the Planned Care Board. The Delivery Unit will review the progress in 6 months and QPSOG requested a future update on progress.

Claims & Litigation Annual Report
The draft report was circulated and comments invited ahead of its presentation to a future QPSC meeting.

Matters Requiring QPSC Level Consideration:

- Quality, Safety and Performance Report (scheduled for QPSC meeting in June 2019)
- Putting Things Right (PTR)/ Organisational Learning Report for the period March - April 2019 (scheduled for QPSC meeting in June 2019)
- Claims & Litigation Annual Report (scheduled for a future QPSC meeting.)

Key Risks and Issues/Matters of Concern

There were no key risks or matters of concern to note other than those already noted above.

Date of Next QPSOG Meeting: 18th July 2019

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee Wednesday 12th June 2019 Agenda Item:4.3

4.3

Aneurin Bevan University Health Board

Assurance Framework of Maternity services

Executive Summary

This paper presents to the Quality and Patient Safety committee the assessment undertaken of the ABUHB maternity services following the Welsh Government publication of the Royal College Obstetrics and Gynaecologists(RCOG) /Royal College of Midwives (RCM) report "Review of Maternity Services at the former Cwm Taf University Health Board (now Cwm Taf Morgannwg University Health Board). The assessment framework template was agreed as an all wales approach for Health Boards to provide assurance to Welsh Government.

The assessment was completed by the Clinical Director and Head of Midwifery/Associate Director of Nursing drawing on the multi-disciplinary team and existing evidence relating to the governance and learning structure of maternity services, outcomes of women and sources of independent assurance such as RCOG standards for maternity service, each baby counts, HIW audit and Welsh risk pool assessments. This assessment was then reviewed and tested by the Interim Executive Director of Nursing and Medical Director.

The paper sets out the position against 69 recommendations at the time the assurance framework was submitted to Welsh Government on the 14 May 2019 (Appendix 1) and provides an update as of 6 June 2019.

The Quality and Patient Safety Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	√
Receive the Report for Assurance/Compliance	√
Note the Report for Information Only	

Executive Sponsor: Martine Price Interim Executive Director of Nursing and Paul Buss Executive Medical Director

Report Author: Deb Jackson Associate Director of Nursing/Head of Midwifery

Report Received consideration and supported by : Martine Price

Executive Team		**Committee of the Board [Committee Name]**	**Quality and patient Safety Committee**

Date of the Report: 29th May 2019

Supplementary Papers Attached:
Appendix Assurance Framework

Purpose of the Report

To present to the Quality and Patient Safety Committee the assessment undertaken of the ABUHB maternity services following the Welsh Government publication of the Royal College of Obstetrics and Gynaecologists/Royal College of Midwives report "Review of Maternity Services at the former Cwm Taf University Health Board. The assessment framework template was agreed as an all wales approach for Health Boards to provide assurance to Welsh Government.

The full assurance framework response is attached.

This supporting paper sets out how the assessment was undertaken and the methodology underpinning the RAG status.

Areas in the assessment that have been rated as amber and red are detailed in the report and actions set out.

This assessment document response is set within the context of robust clinical governance arrangements within maternity services that are well embedded and that demonstrate an open and transparent culture. There are clear processes to serious incident investigation, strong family engagement and a learning environment focussed on outcomes to continually learn and improve maternity care.

Background and Context

The maternity services within ABUHB have well established clinical governance arrangements in place that are multi-disciplinary. A learning culture is well developed with a number of forums and ways that learning from concerns, clinical incidents and feedback are shared. Examples include lessons of the month at the empowering lead midwives meeting, presentations at the clinical governance days, individually to members of staff via appraisal and clinical supervision for midwives. At monthly divisional day there is a closing of the loop session. The governance framework includes the quality and patient operational group maternity service board and reporting to the quality and patient safety committee.

There are clear mechanisms in place for women and families to give feedback. Family engagement is well established within maternity. Families are contacted immediatley on receipt of a concern and/ or a clinical incident has occurred. They have a nominated point of contact person who will provide support and updates on the concerns and/or investigation process. This nominated person is also the representative for the family in serious incident investigations. Family are also supported to engage fully with SI investigations if they wish too. All feedback and a written report is provided face to face with the family from the executive lead and the Head of Midwifery. Proactively feedback is sought on an ongoing basis using a number of approaches.

Staff engagement is fundamental and support and development of leadership capability at all levels has been a focus for many years. Midwives have been supported to undertake key leadership and management courses. These range from in house to RCM/RCOG and university modules all incorporating leadership. Midwifery and medical staff also supported to engage with aspiring lead roles to support succession planning and career progression within the maternity service. Staff undertake Service/Quality

improvement programmes such as IQT Bronze, Silver and Gold and this development forms part of appraisals.

In October 2018 the Health Board provided assurance to Professor Jean White, Chief Nursing Officer Welsh Government in relation to incident reporting in Maternity Services in Aneurin Bevan University Health Board. The response provided assurance on the governance framework in place. The governance arrangements for maternity services are well established and fully integrated into the Health Board governance framework.

Following The publication of the RCOG/RCM "Review of maternity services in Cwm Taf University Health Board in January 2019 the Health Board provided further assurance to Dr Andrew Goodall, Director General Health and Social Services NHS Wales Chief Executive, with the attached Assurance Framework.

As part of our governance arrangements, the Health Board's Quality & Patient Safety Committee has received regular reports regarding maternity services. For example:

- 7th February 2018 – paper on the role of the Health Board's Maternity Services Board in providing quality and patient safety assurance of the maternity services including the Maternity Dashboard
- 4th April 2018 – learning from the HIW Report of an inspection of maternity services in Cwm Taf University Health Board

Assessment and Conclusion

The attached assurance framework template sets out an assessment based on evidence of the current position for maternity services in ABUHB against the recommendations contained in the RCOG/RCM report of maternity services in Cwm Taf.

Approach to this assessment

The assessment was completed by the Clinical Director and Head of Midwifery/Associate Director of Nursing drawing on the multi-disciplinary team and existing evidence relating to the governance and learning structure of maternity services, outcomes of women and sources of independent assurance such as RCOG standards for maternity service, each baby counts, HIW audit and Welsh risk pool assessments. This assessment was then reviewed and tested by the Executive Director of Nursing and Medical Director.

Definitions of RAG status:

- **Green** defined as currently fully compliant against the recommendation.
- **Amber** defined as partial compliance with a plan to working towards to achieve.
- **Red** defines as currently not compliant

The following sets out the position against 69 recommendations at the time the assurance framework was submitted to Welsh Government on the 14 May 2019 (Appendix 1).

58 Recommendations Green.
9 Recommendations Amber

2 Recommendations Red

The following provides an update on the position of the amber and red rated recommendations.

Amber Recommendations

Recommendation	Where we are (May 19)	Actions for Improvement	By When
Agree a CTG training programme that includes a competency assessment, which is delivered to all staff involved in the antenatal period an intrapartum	STAN training for multidisciplinary staff biannually RCOG tool kit to support Anatomy and Physiology training and as an All Wales Assessment Tool Risk forum CTG review and learning Half day mandatory CTG training for midwives CTG training in local PROMPT course (all staff required to attend annually) PROMPT requires regular attendance of all disciplines – HB supports at least 4 members of each discipline released to attend.	Consider cancelling Clinical activity on 1 or 2 Fridays a month to ensure all consultants released to attend PROMPT training to be 100% compliant by April 2020. ***Update*** *Discussions taking place at Welsh Government to support the release of the PROMPT medical faculty team.*	September 2019 *5th June 2019*
O&G Consultant Staff must deliver: • A standard induction programme for all new junior medical staff • A standard induction programme for all locum doctors	Formal departmental induction arranged for all junior doctors (ST, FP2, Clinical Fellows, long term Locums) every 6 months and every 4 months for FY2's. Induction booklet sent out in advance Locum induction pack provided on first shift To negate risks associated with new staff long term locums sought over short term whenever possible.	Face to Face induction pack should be provided to locums prior to first shift ***Update*** *Face to face induction in place during daytime hours. For the out of hours system it has been agreed for Locums to present 1 hour earlier than the agreed shift time to have the face to face induction with the labour ward team.*	*June 2019* *Complete*

		Tailor version for short and long term locums.	
Actively discuss the outcomes of SI's with individual consultants who were involved in SI's at their appraisal	The SI reports are shared with the doctors involved and they reflect on it via their appraisal process. However, obstetricians appraisals are not necessarily carried out by other obstetricians and therefore the levels of these discussions may vary. All SI's are reported and learning points are discussed at clinical governance days to allow all members of staff to benefit from the lessons learned.	The Clinical CD in collaboration with Consultant leads will aim to support this inclusion of feedback of SIs to the individual consultant ***Update*** *This has been cascaded by the Clinical Director and agreed by the Divisional Director and implemented*	*Complete* *Complete*
Ensure the Medical Director has effective oversight and management of the consultant body by: • Making sure they are available and responsive to the needs of the service • Urgently reviewing and agreeing job plans to ensure the service needs are met • Clarifying what is to be covered as part of SPA activity (audit, governance, teaching, guidelines, data assurance, train more Consultant Obstetricians as appraisers) • Ensuring the most unwell women are seen initially by a consultant and all women are seen by a consultant within 12 hour (NCEPOD recommendation (National Standard)	60 hour Consultant labour ward cover in RGH 40 hours Consultant Labour Ward cover in NHH allows early and regular review of high risk women 12 hour Consultant cover on LW Mon-Fri in RGH 8 hour cover in NHH in line with RCOG guidance Job Plans reviewed in line with National Guidance and aligned with service need All women are seen within 24 hours by a Consultant All women seen by a Consultant within 12 at RGH All women seen by a Consultant within 24 hours at NHH due to non-resident Consultant Job Plan	In line with ABUHB Clinical Futures plan Hospital All women will be seen by a consultant within 12 hours at the Grange University Hospital The Clinical Director will aim to reduce to 12 hours at NHH prior to the opening of the Grange University Hospital ***Update*** *Continues to be reviewed through job planning*	*September 2019*

Ensure Obstetric Consultant cover is achieved in all clinical areas when required by: • Reviewing the clinical timetables to ensure that 12 hour cover per day on labour ward is achieved • Undertake a series of visits to units where extended consultant labour ward presence has been implemented • Considering working in teams to ensure a senior member of the team is available in clinics and provide cross cover for each other • Considering the creative use of consultant time in regular hours and out of hours to limit the use of locums	12 hour consultant cover on LW Mon-Fri in RGH 8 hour cover in NHH in line with RCOG guidance Job Plans reviewed in line with National Guidance and aligned with service need Training package moving forward to the Grange	Job plans continuing to be reviewed in line with service need. Medical recruitment in progress	September 2019
Develop an effective department wide multi-disciplinary teaching programme • This must be adequately resourced and time allocated for attendance by all staff groups including specialist clinical midwives and SAS doctors • Attendance must be monitored and reviewed at appraisal	PROMPT/Multidisciplinary gynaecology training in place for all staff annually	Available on a monthly basis and staff currently being rostered to attend. Anticipate 100% compliance within the year.	End March 2020
Ensure the Consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period of call. • This must involve the antenatal ward round being performed by the Consultant	Currently the ward rounds are done Mon-Fri by Triage Doctor (ranges between Reg Obs SHO) with advice by LW Consultant. LW acuity in RGH does not allow LW Consultant to perform a face to face antenatal ward round. Ward round on LW is done by a Consultant in the morning and ongoing review of women that are admitted till 8 pm. Antenatal Ward rounds on the weekend are	RGH: No immediate solutions other than continue as above and aim to do ward rounds again 5-8 pm shift and record on register on B5. Future planning – Job plan changes to accommodate Ward rounds for antenatal/gynae wards – ensure new jobs created have Ward rounds incorporated.	Ongoing with Clinical director leading review September 2019

	done by Consultants every 24 hours.	NHH: Consultants have agreed on morning ward rounds by team covering LW and telephone ward rounds at 10pm which get recorded by the Band 7 M/W Weekends: Consultants on both sites to do face to face morning Ward Round and telephone Ward Round at 10pm – to be recorded on register With the opening of the GUH this standard will be met	*Completed* *Completed*
Provide mentorship and support to the Clinical Director • Define the responsibilities of this role • Ensure there are measurable performance indicators • Ensure informed HR advice to consistently manage colleagues' absence and deployment of staff to cover the needs of the service • Consider buddying with a Clinical Director from a neighbouring Health Board	The Clinical Director works in partnership with the Head of Midwifery and Directorate Manager for Gynaecology Services. He is further supported by the Divisional Director The Division has a dedicated HR and Business Support Manager to support all aspects of managing colleagues The Medical Director is available for further support	It has been recognised by the Medical Director that allocated dedicated time for the provision of support to all Assistant MD and CD should be actioned	*Complete*
Continue with efforts to recruit and retain permanent staff	Midwifery compliant to Birth Rate Plus undertaken in 2017/18 Medical Staff recruitment in place. 3 non resident consultants and 2 Speciality Doctors	Consultant vacancies out to advert and specialty doctors advert with medical recruitment	September 2019

Red Recommendations

Recommendation	Where we are (May 19)	Actions for Improvement	By When
Ensure External expert facilitation to allow a full review of working practices to ensure: • An appropriately trained supported system for clinical leadership	All midwifery staff attend 3 mandatory study days annually, educating and updating their role in patient care and safety in line with Health Standard 3.1	Compliance with training below standard of 100% compliance Trajectory in place to support compliance in the coming year.	March 2020 June 2019 completed
Develop a trigger list for situations which require consultant presence on the labour ward which must be: • Agreed by all Consultants in obstetrics, paediatrics and anaesthetics and senior midwives • Audited and reported on the maternity dashboard	This is not currently in place and it is recognised that individual consultants will anticipate being called in different situations	The Clinical Director in collaboration with the obstetric lead and the leads for labour wards is undertaking this work to develop a clear trigger list for consultant presence on labour ward. This will be audited through the risk governance process. The issue in relation to consultant presence for a list of conditions was discussed at the consultant meeting and agreed to engage with the development of trigger from RCOG good practice 8 and 10 Clinical Judgement is used in all cases currently for consultant presence as required. *Work is still continuing All Wales.*	September 2019

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	*Risk Registers for Maternity and Gynae, update to be presented at QPS.*
Financial Assessment, including Value for Money	*Maternity services within ABUHB has a clear financial budget and the Committee is asked to continue to support Birth Rate+ compliance*
Quality, Safety and Patient Experience Assessment	*Included within the framework*
Equality and Diversity Impact Assessment (including child impact assessment)	*Meets all requirements*
Health and Care Standards	*Compliant*
Link to Integrated Medium Term Plan/Corporate Objectives	*All services clear defined within IMTP*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*The wellbeing and future generations act is embedded within the services*
Glossary of New Terms	*RCOG Royal College of Obstetricians and Gynaecologist* *RCM Royal of Midwives*
Public Interest	*Written for the public domain*

Independent Review of Maternity Services at Cwm Taf Health Board – Assurance Framework template

Health Board: Aneurin Bevan University Health Board

Date of Completion: 14th May 2019

Terms of Reference from review	Recommendations	Where we are (May 2019) Examples of assurance evidence	Areas for Targeted Intervention or Improvement	RAG Green – compliance Amber – improvements required Red – Immediate action
1. To review the current provision of care within maternity services in relation to national standards and indicators, as well as national reporting.	7.1 Urgently review the systems in place for: • Data collection • Clinical validation • Checking the accuracy of data used to monitor clinical practice and outcomes • What information is supplied to national audits	Maternity data system in place Multi-disciplinary Data validation undertaken by assistant head of midwifery and labour ward lead, cross referenced to birth registers and personal records. Data is validated by local informatics team and sent to WHISSC prior to maternity service performance board at Welsh Government. This data is then shared with NMPA		
	7.2 Identify nominated individuals (consultant obstetric lead and senior midwife) to ensure that all maternity unit guidelines: • Are up to date and regularly reviewed • Are readily available to all staff, including locum staff and midwifery staff • Have a multi-disciplinary approach • Are adhered to in practice	Consultant Labour Ward leads in place for RGH and NHH. HOM is lead for midwifery Guidelines. Consultant obstetric lead in post and she heads up the Clinical Effectiveness forum in partnership with the Assistant HOM. These meetings are held monthly to review, ratify and disseminate all guidance as it requires updating. MDT involvement in this process. Access to guidelines on Intranet. Assurance on how staff access guidelines on intranet are discussed and recorded at all appraisals and PADR's. For locums the information and guidance is provided in the introduction pack	Further raise awareness to ensure that all staff understand the importance of accessing guidelines electronically rather than printing hard copies which may go out of date.	
	7.3 Mandate and support a full programme of clinically led audit with a nominated consultant lead to measure performance and outcomes against guidelines.	Quality Improvement programmes supported by ABCi team in place and all obstetric staff encouraged to take part in line with contract and training needs. Midwives undertaking leadership courses and those in leadership roles engage with quality improvement programmes and structured service evaluation Audit programme in place and presented at Clinical Governance day. there is a lead Consultant allocated for Audit		
	7.4 Ensure monitoring of clinical practice of all staff is undertaken by the Clinical Director and Head of Midwifery: • To ensure compliance with guidelines • To ensure competency and consistency of performance is included in annual appraisal.	Monitoring of clinical midwifery staff is through PADR, complaints, risk reporting and is supported by Senior management team, consultant midwife and clinical supervisors for midwives. HOM has monthly meetings with Clinical supervisors for midwives who highlight any key issues with Midwifery practice. Action plan agreed by HOM for training and compliance. This is reviewed and signed off by HOM in line with PADR. Monitoring of clinical obstetric staff is through appraisals, job planning, complaints, risk reporting and peer review. Clinical effectiveness forum for updating Guidelines, policy and protocols. Circulates to all consultant, medical staff and Midwives via email updates Clinical governance newsletters		

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		Clinical Supervisors for Midwives have completed a university accredited Competency Framework. their skills are reviewed in line with their PADR and Consultant Lead		
	7.5 Agree a CTG training programme that includes a competency assessment, which is delivered to all staff involved in the care of pregnant women, both in the antenatal period and intrapartum.	STAN training for multidisciplinary staff biannually RCOG tool kit to support Anatomy and Physiology training and as an All Wales assessment tool Risk forum CTG review and learning Half day mandatory CTG training for midwives CTG training in local PROMPT course (all staff required to attend annually) PROMPT requires regular attendance of all disciplines- HB supports at least 4 members of each discipline released to attend	Consider cancelling Clinical activity on 1 or 2 Fridays a month to ensure all consultants released to attend PROMPT training to be 100% compliant by April 2020	
	7.6 O&G consultant staff must deliver: • A standard induction programme for all new junior medical staff • A standard induction programme for all locum doctors	Formal departmental induction arranged for all junior doctors (ST, FP2, Clinical Fellows, long term Locums) every 6 months and every 4 months for FY2's. Induction booklet sent out in advance Locum induction pack provided on first shift To negate risks associated with new staff long term locums sought over short term whenever possible.	Face to Face Induction pack should be provided to locums prior to first shift Tailor version for short and long term locums	
	7.7 Ensure an environment of privacy and dignity of care for women undergoing abortion or miscarriage in line with agreed national standards of care.	Bereavement room in each site support by SANDS association. These rooms are named the Butterfly room. For termination of pregnancy under 20 weeks women are supported in a single room with family present on the gynaecology ward. Tested through leadership walkabouts this is supported by the medical staff Staff are trained to provide sensitive, compassionate one to one support. Privacy and dignity is part of the current curriculum for ST1-2 trainees and is in the RCOG/STratog communication skills package as well as attending training days which it is incorporated in. This skill has to be completed by the end of ST2. See attached curriculum. This process will change in October and is likely to include greater emphasis on communication with Non-technical skills assessments (NOTSS) a greater part of the assessment. The bereavement training is included it in local teaching and role play is an integral part of ST1-2 training regionally.		

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2. Assess the prevalence and effectiveness of a patient safety culture within maternity services including: ○ **The understanding of staff of their roles and responsibilities for delivery of that culture.** ○ **Identifying any concerns that may prevent staff raising patient safety concerns within the Trust.** ○ **Assessing that services are well led and the culture supports learning and improvement following incidents.**	7.8 Ensure external expert facilitation to allow a full review of working practice to ensure: • Patient safety is considered at all stages of service delivery . • A full review of roles and responsibilities within the obstetric team. • The development and implementation of guidelines. • An appropriately trained and supported system for clinical leadership. • A long-term plan and strategy for the service. • There is a programme of cultural development to allow true multi-disciplinary working.	Multi-disciplinary Safety huddles take place 4 hourly on the labour ward. Divisional day where themes from maternity risk register, serious incidents and complaints are shared with staff across the Division by the Quality and patient safety lead. This is called closing the loop and ensures that the quality and patient safety agenda is shared at the appropriate level within a multi-disciplinary team. This is also presented at the operational quality and patient safety meeting which is held monthly. Chaired by the Executive team and has clear TOR. The HOM regularly attends and presents at the quality and patient safety committee which is chaired by an Independent member of the executive board. Key members of the board, including the Chief Executive attend this committee. The Quality and patient safety Closing the loop is also presented at the maternity service Board Chaired by the Executive Director of Nursing. All roles regularly reviewed via job planning in line with clinical workforce demands Clear policies and guidelines are in place in each clinical area and all staff are aware of their location on the intranet to refer to as necessary. Policies and guidelines are reviewed regularly by the clinical leads in each area in monthly Clinical Effective Forum meetings and updated as necessary and are in line with evidence based practice, WAG, RCOG and NICE guidelines. In place are: Clinical Director Obstetric Lead Gynaecology lead Labour ward leads for both obstetric units Oncology lead Obstetric education lead Head of Midwifery Assistant Head of Midwifery Consultant Midwife Senior Midwifery Managers Clinical Supervisors for midwives A full range of war Based clinical lead midwives across all specialities Leadership and service improvement training are supported through PADR and Appraisal. ABUHB produces an IMTP for each service, the annual plan, a three year plan. This all feeds into service modernisation nd the clinical futures plan which includes the new Grange University Hospital. Detailed workforce plans are embedded in all of the above. All new members of staff attend ABUHB corporate induction programme when starting their post. Datix reporting system, health and safety is covered. Newly qualified midwives are supported with a preceptor and junior doctors have an allocated educational supervisor.		

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		All midwifery staff attend 3 mandatory study days annually, educating and updating their role in patient care and safety in line with Health Standard 3.1.	Compliance with Training below standard of 100% compliance Trajectory provided to support compliance in the coming year	
		Maternity staff working in areas that have shift patterns are communicated via email with read receipts and communication brief via posters. These methods has proved successful. For community staff and outpatient clinic staff communication meetings have proved more successful. These meetings have minutes for review. The communication processes in place are to identify any ongoing issues that need to be addressed, all staff are invited to attend or provide feedback via email to the line manager. MDT Clinical Risk meetings are held weekly and staff are encouraged and promoted to attend. All learning actions are cascaded to all staff of the MDT team. HOM and Clinical Director, via the risk minutes. The risk panel consists of a Consultant Obstetrician, Consultant Anaesthetist, Consultant Neonatologist, Senior Midwifery Manager, Governance Midwife and Clinical Supervisor for Midwives. A monthly "lessons of the Month" giving generic learning points is shared with all staff and displayed in all staff areas. MDT Clinical Governance meetings are held monthly with all staff encouraged to attend, learning is shared from all aspects of the clinical areas in a non-punitive manner. This is well attended by all clinicians. ABUHB Clinical Futures updates staff regularly about service vision in a broad aspect whilst SMM meet monthly to discuss long-term service aims that are cascaded to staff via minutes and line managers. Empowering lead midwives meetings are held bi-monthly that all lead midwives attend. Information and actions from Senior Midwifery Management team meetings are disseminated at this meeting and this is also an opportunity for lead midwives to link with senior management and to raise any queries or share good practice. Monthly transfer meetings are held in all midwifery led areas and are chaired by the Consultant Midwife. Also in attendance are the senior midwifery manager, local lead midwife, governance midwife and clinical supervisor for midwives. All midwives are encouraged to attend and their input is valued. Any lessons learnt are incorporated in the monthly lessons for the month and where individual lessons are highlighted the clinical supervisor for midwives will support the midwife to reflect on the case.		
	7.9 Develop a trigger list for situations which require consultant	This is not currently in place and it is recognised that individual	The Clinical Director in collaboration with	

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	presence on the labour ward which much be: • Agreed by all consultants in obstetrics, paediatrics and anaesthetics and senior midwives. • Audited and reported on the maternity dashboard.	consultants will anticipate being called in different situations	the obstetric lead and the leads for labour wards is undertaking this work to develop a clear trigger list for consultant presence on labour ward. This will be audited through the risk governance process The issue in relation to consultant presence for a list of conditions was discussed at the consultant meeting and agreed to engage with the development of trigger from RCOG good practice 8 and 10.	
	7.10 Introduce regular risk management meetings which must be: • Open to all staff • Conducted in an open and transparent way • Held at a time and place to allow for maximum attendance	Clear Datix trigger list in place that is displayed and known to staff in all areas. ALL datix are reviewed in weekly MDT clinical risk meetings which are held across all sites with staff, including trainees invited and encouraged to attend. Meetings are conducted as a learning opportunity in a non-punitive manner and a full MDT presence. This is recorded via the Risk Action plan and recorded in the minutes.		
	7.11 Ensure mandatory attendance at the following meetings for all appropriate staff. Attendance must be recorded and included in staff appraisals. Ensure that meetings are scheduled or elective clinical activity modified to allow attendance at: • Governance meetings • Audit meetings • Perinatal mortality meetings	These meetings are held on a monthly basis and a record of staff attendance is kept and reviewed as appropriate during appraisal and job planning. All meetings are well attended and are quorate		
	7.12 Undertake multidisciplinary debriefing sessions facilitated by senior maternity staff after an unexpected outcome.	Group debriefing following incidents is arranged with the staff wellbeing service as appropriate. Where further support is required this is offered via the wellbeing service to individuals privately		
	7.13 Identify a clinical lead for governance from within the consultant body. This individual must: • Be accountable for good governance • Attend governance meetings to ensure leadership and engagement	Already in place		
L director				
	7.14 Consultant meetings should • Be regular in frequency • Have a starting agenda item on governance • Be joint meetings with anaesthetic and paediatric colleagues	Fortnightly Obs Consultant meetings Pan Gwent meeting monthly-Clinical Governance day inclusive of CD All Consultants (except the ones allocated for labour ward All trainees HOM and assistant HOM Consultant midwife Midwives leads and Midwifery Managers Governance leads Gynaecology manager Senior Nurse and sister for Gynaecology Service improvement manager Administration support. Obstetric anaesthetic meeting monthly Perinatal meeting monthly Across the two acute Sites		

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		Attendance Trainee Education consultant Obstetric lead Consultant Obstetricians Trainee's Neonatologist Midwifery managers Governance midwife Clinical supervisor for midwives Midwives Quarterly maternity service meetings with MDT presence for each site Including the Divisional Director General manager/ assistant GM Clinical director Consultant Obs Lead Consultant Anaesthetist Consultant Labour ward Lead HOM/Assistant HOM Consultant midwife Midwifery managers Consultant neonatologist or patrician Admin support Bi monthly obstetrics and gynaecology directorate meetings including CD HOM/ Assistant HOM Consultant Midwife Directorate manager for Gynaecology Consultant Gynaecology lead Lead Nurse Colposcopy Senior Nurse gynaecology Midwifery Mangers Admin support Monthly maternity service board meetings where appropriate consultant obstetricians are present. This is chaired by Director of Nursing attendance is good with clear TOR and is quorate. ABUHB CHC also a member of the maternity service Board. Meeting last held on the 11th February Minutes and Agenda + TOR		
	7.15 Educate all staff on the accountability and importance of risk management, Datix reporting and review and escalating concerns in a timely manner. Include this at: • Junior doctor induction • Locum staff induction • Midwifery staff induction • Annual mandatory training	All new staff attend corporate induction and are educated about Datix system and general health and safety. Patient safety is covered in more depth regarding governance Medical staff receive an induction pack Governance midwife presents to new doctors about the governance/ Risk/ Datix reporting process and compliance Midwives follow the All Wales preceptorship programme. This has been adapted to include inbuilt Pastoral support as well clinical support in ABUHB. All staff attend ABUHB corporate induction programme Introduction pack for all new starters		
	7.16 Urgent steps must be taken to ensure that consultant obstetricians are immediately available when on call (maximum 30 minutes from call to being present).	All consultants are within 30minutes No issues with delays in traveling		
	7.17 Ensure training is provided for all SAS staff to ensure that they are: • Up to date with clinical competencies.	This is achieved and is monitored via the deanery		

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	• Skilled in covering high-risk antenatal clinics and outpatient sessions.			
	7.18 Agree cohesive methods of consultant working after the merger with input from anaesthetic and paediatric colleagues.	N/A		
3. **Review the RCA investigation process, how Sis are identified, reported and investigated with the maternity services; how recommendations from investigations are acted upon by the maternity services; how processes ensure sharing of learning amongst clinical staff, senior management and stakeholders and whether there is clear evidence that learning is undertaken and embedded as a result of any incident or event.** Work is required to address the culture in relation to governance and supporting all staff with their accountability in relation to incident reporting, escalation of concerns and review of Datix in a timely manner.	7.19 Ensure that a system for the identification, grading and investigation of SI's is embedded in practice through: • Appropriate training to key staff members • Making investigations multidisciplinary and including external assessors.	ABUHB has a trigger list for Si events. Si events are all identified through the weekly MDT risk management meetings and are highlighted to HOM and CD. These are then reviewed and reported to the putting things right team in ABUHB and to WG. An executive lead clinician is allocated and a meeting arranged urgently with multidisciplinary input to review the case. At this meeting terms of reference for the investigation are agreed and an investigating officer/s is identified. Training for investigation reporting is available within ABUHB. A senior midwife is allocated to perform the role of family link and will ensure that the family's concerns are represented in the investigation and that they are updated regularly about the process and progress of the investigation. External review is sought when appropriate. Evidence available if required. All SI investigations are signed off by the executive team. HOM and CD meet with the family to share the findings of the report and to answer any further queries.		
	7.20 Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from Sis.	The measure used to ensure this is the level of reporting form all areas and all staff types which indicates an awareness and willingness to engage in DATIX reporting		
	7.21 Improve incident reporting by: • Delivering training on the use of the Datix system for all staff • Encouraging the use of the Datix system to record clinical incidents • Monitor the usage of the incident reporting system	Governance midwife provides training at induction Training provided when induction to the health board Presentation and training at Clinical governance day bi annually to Provide wider training for midwives and medical staff inclusive of mandatory training		
	7.22 Actively discuss the outcomes of Sis with individual consultants who were involved in Sis at their appraisal.	The SI Report reports are Shared with the doctors involved and they reflect on it via their appraisal process. However obstetricians appraisals are not necessarily carried out by other obstetricians and therefore the levels of these discussions may vary. All SI's are reported and learning points are discussed at clinical governance days to allow all members of staff to benefit from the lessons learned.	The Clinical CD in collaboration with Consultant leads will aim to support this inclusion of feedback of SI's to the individual consultant	
	7.23 Improve learning from incidents by sharing the outcomes from Sis on a regular basis and in appropriate, regular and accessible format.	Shared at CG days and to all staff through lessons of the month and at presentations in mandatory training days		
4. **Review how through the governance framework the Health Board gains assurance of the quality and safety of maternity and neonatal services.**	7.25 Appoint a consultant and midwifery lead for clinical audit/quality improvement with sufficient time and support to fulfil the role to ensure: • That clinical audits are multidisciplinary • That there is a clinically validated system for data collection • That the lead encourages all medical staff to complete an audit/quality improvement project each year to form part of their annual appraisal dataset	Assigned Consultant obstetric lead and Consultant Midwife and Clinical research midwife lead for Audit and Quality Improvement All trainees and many midwives engage with clinical audit Clinical audit is carried out in line with local ABCi templates and structured service evaluation This is reviewed as part of the appraisal process		

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	• Sharing of the outcomes of clinical audits and the performance against national standards.	Clinical Governance days see previous response and improve compliance with sharing to individual Consultant via appraisal process		
	7.26 Agree jointly owned neonatal and maternity services audits of neonatal service data including: • Neonatal outcome data • Perinatal deaths • Transfer of term babies to SCBU • Babies sent for cooling • Each Baby Counts reporting • MBRRACE reporting • Breast feeding rates • Skin to skin care after birth • Neonatal infection • Baby Friendly accreditation • Bliss Baby Charter accreditation	• Neonatal outcome data provided annually through the Unit Annual Report, and the All Wales Neonatal Annual Report. • Perinatal deaths discussed monthly at the multidisciplinary Perinatal Mortality and Morbidity meetings. • Benchmarking done through the Vermont Oxford Network database, the National Neonatal Audit Programme. • Mortality described in the MBRRACE reports. • Mortality Meetings held regularly and deaths discussed in detail. • Mortality presented at the All Wales Mortality Meetings with external peer review. • Neonatal infection discussed fortnightly with microbiologists and weekly at the neonatal Friday meeting. • Baby friendly accredited • 100% compliance data with skin to skin contact		
	7.27 Consider extra resource to the Maternity Governance and Risk team to ensure: • Workload is manageable • That Datix are reviewed, graded and actioned in an appropriate and timely manner	Full time governance midwife, supported by obstetric governance lead and senior midwifery management team. DATIX are signed off and investigated in a timely manner. Any overdue DATIX are reviewed monthly by the divisional quality and patient safety lead		
	7.28 Ensure that the executive level lead role for maternity will work with the maternity department and this role is effective and supported. This individual should: • Have a direct progress reporting responsibility to the Board, in particular while the issues raised in this report are being resolved • Understand and facilitate improvement in the reporting of safety issues and clinical risk • Provide a single point of reference for liaison with external agencies • Ensure all reports from external agencies and regulators are channelled through a single pathway to ensure priorities remain focussed.	We have a maternity service board which meets on a quarterly basis. Terms of reference are in place and meetings are chaired by the Director of Nursing. CHC have a seat on the maternity service board and are present at all meetings. Director of Nursing and Clinical Director reports directly to the Chief Executive Officer. The single point of contact is the Director of Nursing. All reports are channelled through the Chief Executive, Director of Nursing, Medical Director, Divisional Director, Head of Midwifery and Clinical Director		
5. **Review the current midwife and obstetric workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.**	7.29 Closely monitor bank hours undertaken by midwives employed by ABUHB, to ensure: • The total number of hours is not excessive • The Health Board complies with the European Working Time Directive • These do not compromise safety	Midwives who undertake bank hours above the EWTD are required to sign an exemption form and their performance is monitored monthly, alongside sickness absence, incidents and complaints. This is in line with ABUHB Bank Policy. We have never had any links between bank hours and incidents or complaints; however, we are mindful that continued monitored is required. Where sickness management is required at formal level midwives are no longer eligible to do additional or bank hours.		
	7.30 Ensure the Medical Director has effective oversight and management of the consultant body by: • Making sure they are available and responsive to the needs of the service	60 hour Consultant labour ward cover in RGH 40 hours consultant Labour ward Cover in NHH allows early and regular review of high risk women	In line with ABUHB Clinical futures plan Hospital All women will be seen by a consultant within 12 hours at the Grange university Hospital	

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	• Urgently reviewing and agreeing job plans to ensure the service needs are met • Clarifying what is to be covered as part of SPA activity (audit, governance, teaching, guidelines, data assurance, train more consultant obstetricians as appraisers) • Ensuring the most unwell women are seen initially by a consultant and all women are seen by a consultant within 12 hour NCEPOD recommendation (national standard)	12 hour consultant cover on LW Mon- Fri in RGH 8 hour cover in NHH in line with RCOG guidance Job Plans reviewed in line with national guidance and aligned with service need All women are seen within 24 hours by a consultant. All women seen by a consultant within 12 hour at RGH All women seen by a consultant within 24 hours at NHH due to non-resident Consultant job plan	The Clinical director will aim to reduce to 12 hours at NHH prior to the opening of the Grange University Hospital	
	7.31 Ensure a robust plan of births anticipated in each midwifery led unit and consultant led unit is undertaken • Ensure involvement of paediatric staff for all future service design reviews and actions.	ABUHB maternity dashboard is shared across relevant disciplines And regular meetings are held where any concerns in relation to capacity or workforce are raised. Workforce plans are in place in line with the clinical futures Model for the Grange University hospital		
	7.32 Ensure obstetric consultant cover is achieved in all clinical areas when required by: • Reviewing the clinical timetables to ensure that 12 hour cover per day on labour ward is achieved • Undertake a series of visits to units where extended consultant labour ward presence has been implemented • Considering working in teams to ensure a senior member of the team is available in clinics and provide cross cover for each other • Considering the creative use of consultant time in regular hours and out of hours to limit the use of locums	12 hour consultant cover on LW Mon- Fri in RGH 8 hour cover in NHH in line with RCOG guidance Job Plans reviewed in line with national guidance and aligned with service need Training package moving forward to the grange.		
	7.33 Actively share the findings of this RCOG review with the Welsh Deanery and urgently encourage them to revisit the Health Board to: • Reassess the quality of induction, training and supervision in obstetrics • Seek assurance on the suitability of this service for trainees • Appoint a named RCOG College tutor to provide support for the trainees currently on the RGH site with adequate time and resource to fulfil this function	Named RCOG College Tutor for ABUHB Training is being constantly monitored via GMC and Trainee Evaluation Surveys. The HBt has had a named College Tutor with dedicated SPA time for many years Ongoing monitoring of Educational Contract for past 2 and ½ years		
	7.34 Allocate all trainees currently in post a clinical and educational supervisor • The role of clinical supervisor and educational supervisor should be documented and closely monitored by the Director of Medical Education • The competency assessments for trainees must be provided in-house under the supervision of the RDOG College Tutor	All junior doctors (trainee and non trainee) have assigned Educational Supervisors and GP trainees have assigned Clinical Supervisors Clinical Fellows are also allocated an Educational Supervisor The competency assessments for trainees must be provided in-house under the supervision of the RDOG College Tutor – Being done		
	7.35 Undertake a training needs assessment for all staff to identify skills gaps and target additional training	Junior doctors have induction and follow- up reviews with Educational supervisors to address needs and targeted training Extra training needs of Specialist Trainees being identified through their appraisals and appropriate Rota adjustments to achieve this being made		

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		Midwives have annual meetings with clinical supervisors for midwives and CPD needs are discussed and forwarded to education lead. This also forms part of PADR and the NMC revalidation process for midwives.		
	7.36 Clinical supervision and consultant oversight of practical procedures must be in place of all staff including specialist midwives and doctors.	Currently one Consultant covering Obstetrics and Gynaecology emergencies. Oversight of practical procedures being shared between Consultants and SAS and Senior trainees Six Senior Midwifery Clinicians (5 WTE) in NHH are directly supervised by a consultant obstetrician during day to day activities in obstetrics and gynaecology and during on call sessions. Supervision of our midwifery neonatal examiners is in place with consultant neonatologists and they are reviewed annually?		
	7.37 Develop an effective department wide multi-disciplinary teaching programme. • This must be adequately resources and time allocated for attendance by all staff groups including specialist clinical midwives and SAS doctors. • Attendance must be monitored and reviewed at appraisal.	PROMPT/Multidisciplinary gynaecology training in place for all staff annually	Available on a monthly basis and staff currently being rostered to attend. Anticipate 100% compliance within the year	
	7.38 Ensure the consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period of call. • This must involve the antenatal ward round being performed by the consultant.	Currently the ward rounds are done Mon- Friday by Triage Doctor (ranges between Reg-Obs SHO) with advice by LW Consultant. LW acuity in RGH does not allow LW Consultant to perform a face to face antenatal ward round. Ward round on LW is done by a Consultant in the morning and ongoing review of women that are admitted till 8pm Antenatal Ward rounds on the weekend are done by Consultants every 24 hrs -	RGH: No immediate solutions other than continue as above and aim to do ward rounds again 5-8 pm shift and record on register on B5. Future planning - Job plan changes to accommodate Ward rounds for antenatal/ gynae wards - ensure new jobs created have Ward rounds incorporated NHH: Consultants have agreed on morning ward rounds by team covering LW and telephone ward rounds at 10pm which get recorded by the Band 7 M/W Weekends: Cons on both sites to do face to face morning W/R and telephone W/R at 10pm- to be recorded on register With the opening of the GUH this standard will be met	
	7.39 Review the working practice for how consultant cover for gynaecology services will be delivered after the merger. • A risk assessment must be performed to determine the case mix of planned surgery on the Royal Glamorgan site when there is no resident gynaecology cover.	N/A		
	7.40 Review the skills and competencies of the senior clinical	The SMCs all undertook a university based and accredited		

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	midwives covering for tier 1 doctors to ensure: • Their scope of practice is clearly defined in the Job description • The Health Board and the individuals are protected against litigation risk for their extended roles.	period of training relevant to the role they perform. Governance procedures are in place to ensure that these midwives work within the scope of their role within the NMC standards and code. In line with their Job description. A folder of competencies is kept updated in line with their job description. They have dual PADR with Assistant HOM and Consultant Obstetrician		
6. Review the working culture within maternity including inter-professional relationships, staff engagement and communication between health care professionals and their potential impact on improvement activities, patients' safety and outcomes.	7.41 Consider the impact of the planned merger on the current culture of the organisation. The Board needs to carefully consider whether the planned merger of two units, both of which are described as having significant issues with their working culture, is likely to compound the problems rather than correct them.	N/A		
	7.42 In conjunction with Organisational Development undertake work with all grades of staff around communication, mutual respect and professional behaviours. • Staff must be held to account for poor behaviours and understand how this impacts on women's safety and outcomes.	ABUHB attitude and behaviours framework is embedded in annual appraisal document. Clinical supervisors for midwives discuss these at group supervision and with individuals as necessary. Lead midwife for complaints investigates any complaints relating to behaviour and appropriate action is taken by the Senior Midwifery Management team, ranging from bringing the behaviour to the individuals attention, coaching style improvement methodology to disciplinary investigation if a serious misconduct issue or repeat behavioural issues		
7. Identify the areas of leadership and governance that would benefit from further targeted development to secure and sustain future improvement and performance.	7.43 Undertake an in-depth assessment of the service as it moves into the future with its new ways of working and the likelihood of an increased demand for services. • This can determine the structures and competencies of clinical leadership and governance that will support the service.	N/A		
	7.44 Support training in clinical leadership • The Health Board must allow adequate time and support for clinical leadership to function.	There are clear lines of Clinical leadership within ABUHB maternity as already demonstrated. In addition Obstetricians and midwives are encouraged and supported to take part in ABCi programmes at bronze, silver and gold level, the annual RCM leadership and development programme, university modules for leadership and internal coaching from Head of Midwifery and Consultant Midwife. ABUHB will continue to support the service improvement programme through recognition via PADR and Appraisals.		
	7.45 Provide mentorship and support to the Clinical Director • Define the responsibilities of this role • Ensure there are measurable performance indicators • Ensure informed HR advice to consistently manage colleagues' absence and deployment of staff to cover the needs of the service • Consider buddying with a Clinical Director from a neighbouring Health Board.	The clinical Director works on partnership with The Head of Midwifery and Directorate manager for Gynaecology Services. He is further supported by the Divisional Director The Division has a dedicated HR and business support manager to support all aspect of managing colleagues The medical director is available for further support	It has been recognised by the Medical Director that allocated dedicated time for the provision of support to all assistant MD and CD should be actioned	
	7.46 Appoint clinical leads in a structure that supports the service with defined role descriptions and job descriptions and objectives to	In place are: Clinical Director Obstetric Lead Gynaecology lead		

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	include an individual response for each of the following: • Governance and clinical quality to include guideline updating. • Data quality • Medical staff education and training • Multi-disciplinary training • Audit • Risk management • Incident review • Complaints handling	Labour ward leads for both obstetric units Oncology lead Obstetric education lead Audit lead obstetrician Governance obstetric and midwifery lead Head of Midwifery Assistant Head of Midwifery Consultant Midwife Senior Midwifery Managers Midwifery complaints lead Clinical Supervisors for midwives Data quality lead		
8. Assess the level of patient engagement and involvement within the maternity services and determine if patient engagement is evident in all elements of planning and service provision. Assess whether services are patient centred, open and transparent.	7.47 Develop and strengthen the role and capacity or the MSLC to act as a hub for service user views and involvement of women and families to improve maternity care: • Appoint a Lay Chair as a matter of priority and increase lay membership numbers with appropriate support and resources • Support lay members to engage with women using services in the FMU and RGH and at PCH to assess satisfaction and to identify issues relating to choices. • Enhance the MSLC monitoring role in order to assess whether patterns of concerns are found and to ask for regular feedback on action taken.	ABUHB has had an active Maternity Service Liaison Committee for many years. The committee meets formally four times a year and is chaired by a service user. The committee is professionally supported by the consultant midwife and HOM and has representatives from midwifery supervision, lead clinical roles as necessary and community projects. The MSLC chair works with the HOM and Consultant Midwife to ensure service user involvement in planned modernisation of the service (e.g. Planning for Grange University Hospital and implementation of structured service evaluation projects like out-patient induction of labour) The MSLC chair was a member of the stakeholder group for the national survey 'Your Birth - We Care' led by ABUHB consultant midwife. Additionally the chair attends the annual WG performance review alongside the HOM and Clinical Director. The MSLC has conducted service user reviews on breastfeeding and VBAC and has recently been working on a partners information pack. A new chair was recently appointed as the previous chair came to the end of her term of office. The new chair has met with the consultant midwife and plans are underway to give the committee a more user friendly title, to promote further engagement with underrepresented groups, to move meetings from their current hospital based location into community settings, to review the current terms of reference and to establish a more formalised work programme. There are TOR and minutes for these meetings		
	7.48 Utilising the role and strengths of the Community Health Council: • Ensure appropriate resources to act effectively as an independent advocate • Ensure that information is available to families regarding its role and contact details • Explore provision of CHC to act as point of contact and provide direct support for women and families, in addition to acting as a conduit referring to other agencies and support • Involve the CHC in the early implementation of the new maternity facilities at PCH and the FMU at RGH so they can be assured regarding the impact on access and satisfaction with maternity services.	A Member of the Community Health Council is a key member of the Maternity Service Board Supported in the TOR CHC are fully engaged with maternity services and the Clinical futures programme		

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	7.49 Develop the range and scope of engagement with women and families: • Review the effectiveness of patient experience methodology and its impact on service change and improvement as a result of feedback. • As a priority, review and address the monitoring of the outcomes of patient experience as a key part of the governance structure • Feedback the outcomes of all engagement to women and families • Explore methods to hear directly from women and families about their experience including patient stories, diaries, 'mystery shopper' or observation techniques.	ABUHB has an active Maternity Service Liaison Committee as detailed above. ABUHB has a maternity services facebook page with over 3000 followers. This is linked to twitter, Instagram and ABUHB maternity services web site. Service user followers actively share their positive experiences in all areas of the service with the facebook community and any private messages and general enquiries to the team are responded to within 24 hours, often within 1-2 hours depending on the time of day. Photographs and stories from service users are shared frequently, alongside useful information relating to service activity and health at the Maternity service Board through patient stories. Between October 2018 and January 2019 ABUHB maternity services published two books containing a collection of women's positive birth stories from both midwifery led and consultant led areas in the health board. Sixty families were involved in the project and feedback from the families who shared their stories and those who have read the books is overwhelmingly positive. The books are also proving to be an invaluable resource for midwives and students who wish to gain an insight into creating a positive birth experience for women. The project was recognised nationally in the Wales and South West midwifery festival winning the award for midwifery innovation and locally by the ABUHB Chief Executive at the staff recognition awards. The books were launched nationally and the RCM has donated copies of the books to all health boards for sharing with midwives. Complaints from service users are dealt with by the lead midwife for complaints in line with the putting things right process. Complaints are closely monitored for emerging trends and an action plan is created for each complaint and is signed off by the HOM on completion. Women's experiences are shared with individuals as necessary and in training sessions with all maternity service staff at the mandatory training and Clinical governance days. The consultant midwife, consultant obstetricians, senior midwifery managers and Lead Midwife for perinatal mental health all engage in formal conversations with women and their families where a meeting is sought to gain a greater understanding of their birth, either in relation to perceived care issues or due to ongoing negative/traumatic memories of the event. Maternity services work closely with the psychology team to identify women with moderate to severe mental health issues which require psychology involvement.		

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	7.50 Continue to work with and build on the community based engagement approaches being suggested by the MSLC • Explore working with external partners, including the CHC and community based organisations.	N/A		
	7.51 Ensure responses to complaints and concerns is core to the work being undertaken to improve governance and patient safety: • Review and enhance staff training on the value of listening to women and families. • Review the process of investigation of concerns, handling 'on the spot' issues and ensure that all responses and discussions are informed by comprehensive investigations and accurate notes • Priorities the key issues that women and families have highlighted to improve the response • Ensure that promises of sharing notes and providing reports to families are delivered • Clarify the process regarding the triangulation of the range of information sources on patient experience, Sis, complaints and concerns and other data and ensure that there is a rigorous approach to make sense of patterns of safety and quality issues • Review the learning from the Sis in relation to misdiagnosis, failure to seek a second opinion and inappropriate patient discharge.	This is already embedded in ABUHB governance framework (see earlier response)		
	7.52 Learn from the experience of women and families affected by events: • Respond and work with families in the way they require. • Feed the learning into the design of a comprehensive training and support programme that will give women and families confidence in the skills, expertise, communication, safety and quality of maternity care.	All families affected by incidents are contacted and offered the opportunity for a meeting with a senior midwife. The format and duration of contact is service user led. Senior midwives are offered in house training to develop their skills in service user engagement and investigation report writing		
	7.53 Review the communications, support and engagement approach and strategy. • Ensure that the focus is not solely on management of key messages • Demonstrate openness, honesty and transparency, admission of fault and learning from this.	Lessons of the month and outcomes of putting things right. All families are offered the opportunity to meet with the HOM and CD to share the findings of an SI investigation. All are reported to WG		
	7.54 Prioritise an engagement programme with families at its heart. • Women and families affected by events should be part of the improvement, co-design and culture change of the new service.	All families are engaged within the rising concerns process, Si process and within the Maternity service liaison committee. All families have a key link person within the Health board who they can liaise directly with and provides updated reports.		
	7.55 Review the level and effectiveness of the bereavement service • Ensure that appropriate support and counselling is available for all families as required • Consider implementing the National Bereavement Care Pathway that has been developed by SANDS in collaboration with stakeholders including women and their families, RCOG and RCM.	ABUHB has an up to date guideline for all staff on early baby loss, stillbirth and neonatal death. The service works closely with SANDS and local organisations to ensure that the experience of bereaved parents is embedded in processes and that empathy, compassion and kindness are the core values. Each obstetric unit has midwives with enhanced knowledge through experience and training to support staff caring for bereaved families during and following their hospital stay. Each obstetric unit has a sensitively		

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		designed bereavement room with access to a cold cot enabling women and families to spend as much time as they wish with their baby present in their room. Each obstetric unit has a memorial garden in which families can choose ways to remember their baby. These are used in a very positive way and are greatly valued by families at the time of their loss and for months, sometimes years after. Each unit holds an annual commemorative service for families who have experienced baby loss and these are well attended and appreciated by families who want their baby's birth to be remembered long after their loss. Families are signposted to local counselling organisations e.g. the Beresford Centre to support them with appropriately trained counsellors in the months following their loss. Where the loss is unexpected or has initiated an investigation into the event, families are always allocated a family link midwife from the senior team to record their questions, update them about meetings, processes and anticipated deadlines. The HOM and CD visit families to share reports with them personally and to ensure they understand the process.		
	7.56 Provide training for staff in communication skills, in particular on: • Empathy, compassion and kindness	Embedded in the mandatory training sessions		
9. Consider the appropriateness and effectiveness of the improvement actions already implemented by the Health Board	7.57 Continue with efforts to recruit and retain permanent staff.	Midwifery compliant to Birth rate plus undertaken in 2017/18 Medical staff recruitment in place 3 non resident consultants and 2 Specialty Doctors		
	7.58 Seek expert external midwifery and obstetric advice for support in developing the maternity strategy and use the opportunity of change to explore new ways of working.	N/A		
	7.59 Urgently carry out a full risk assessment before committing to the merger on 9 March 2019 to ensure women's safety, including: • Ensuring that length of stay is reduced safely to allow for sufficient capacity in the new merged unit.	N/A		
	7.60 Monitor the effects of the reduced inpatient capacity to avoid any adverse effects on the safety or quality of the service.	N/A		
	7.61 Develop a plan to increase inpatient capacity if that is seen to be required.	N/A		
	7.62 Independent Board members must investigate the lack of action by the Executive Team and Board following receipt of the consultant midwife's report in September 2018. • Independent Board members must challenge the executive over the contents of this report • Independent Board members must ensure they are fully informed on the monitoring of planned improvements.	N/A		
	7.63 Independent Board members must challenge the quality of the data which informs the reports which	N/A		

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	they receive and rely upon for assurance.			
	7.64 Independent Board members should receive training in the implications of the Corporate Manslaughter and Corporate Homicide Act 2007 to better understand their role in ensuring the safety of the services that the Board provides.	N/A		
10. To make recommendations based on the findings of the review to include service improvements and sustainability. Advise on future improvements, future staffing and maintenance of quality, patient safety and assurance mechanisms	7.65 Ensure that criteria for the opening of the new FMU have been agreed by a multidisciplinary maternity guidelines group and that readiness for the merger is assured.	Already in place for ABUHB		
	7.66 Update the risk register and review regularly at Board level.	Risk register is updated monthly reviewed at Divisional MDT. Exec chaired Quality and patient Safety committee quarterly		
	7.67 Develop a strategic vision for the maternity service and use the current opportunity of change to create a modern service that is responsive to the women and their families and the staff who provide care.	N/A		
	7.68 Consider examining other UK maternity services to seek out models for delivery which could better serve their population regarding: • Methods of service delivery • Consultant delivered labour ward care • The role of and function of a resident consultant • Achieving a balance between obstetrics and gynaecology commitments • Reducing the use of SAS doctors for our of hours service delivery and developing their in hours role	N/A		
	7.69 Identify and nurture the local leadership talent	ABUHB actively seeks out midwives who demonstrate leadership qualities from the point of registration to the latter years in their career. Many opportunities are created to shadow midwives in lead roles, take part in service improvement projects and research activity, attend local and national conferences as a delegate, displaying a poster or delivering an oral presentation, or to take up opportunities to develop into a leadership role through interim role opportunities or more formalised development roles. These opportunities range from dipping your toe into a lead role in complaints, governance, midwifery supervision, labour ward coordinator and community team leader to a structured development role into senior roles including senior midwifery manager, consultant midwife and Head of Midwifery. ABUHB has supported the maximum number of midwives possible to undertake the RCM leadership and development programme over the two years since it commenced and ABUHB consultant midwife has been one		

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		of the coaches on this programme. ABUHB has supported midwives to undertake the RCBC First into research scholarship last year and this year. This is a very competitive scholarship and ABUHB maternity services are proud to have a midwife chosen last year and this year, with a further midwife shortlisted for interview.		
	7.70 Ensure that any future service change for the development process of the maternity service as a whole is inclusive for all staff and service users. • Ensure the service is adequately staffed to ensure that all staff groups are able to participate in developing the vision • Consider an externally facilitated and supported process for review • Consider seeking continued support from HIW and the Royal Colleges to undertake a diagnostic review of the service particularly in relation to changes in service provision.	ABUHB meet this in line with the Clinical futures programme		

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee Wednesday 12th June 2019 Agenda Item: 4.4

4.4

Aneurin Bevan University Health Board

Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: A lesson for learning

Executive Summary			
To provide the Quality and Patient Safety Committee with the findings and recommendations for Betsi Cadwaladr University Health Board made in the Independent Report and to consider the implication of these recommendations for the care and services provided by Aneurin Board University Health Board.			
The Quality and Patient Safety Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views	✓		
Receive the Report for Assurance/Compliance	✓		
Note the Report for Information Only			
Executive Sponsor: Martine Price – Interim Executive Director of Nursing			
Report Author: Lin Slater – Deputy Director of Nursing			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board**	**Quality and Patient Safety Committee - June 2019**
Date of the Report: 16 May 2019			
Supplementary Papers Attached:	• Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: A lesson for learning. HASCAS. • Gwent Regional Partnership Board: Dementia Action Plan		

Introduction

An independent investigation by the Health and Social Care Advisory Service (HASCAS) into the care and treatment provided on Tawel Fan Ward in BCUHB: A Lessons for Learning, was published on 3rd May 2018. The report was commissioned by BCUHB in August 2015 to examine specific concerns raised by 23 families about the care and treatment of their relatives between January 2007 and December 2013. As well as investigating the specific concerns raised by the 23 families the investigation team was asked to examine the archives developed during prior investigations and reports including - The Ockendon external investigation (conducted in 2014 and published in May 2015); The North Wales Police Investigation (2014-2015) and the Betsi Cadwaladr mortality review (2015). Consequently an additional 85 patients were added to the investigation. The HASCAS panel examined the care pathways and the care and treatment received by the patients in the investigation cohort in order to identify the lessons for learning.

This paper outlines Aneurin Bevan University Health Board's (ABUHBs) self-assessment against the key findings of the investigation and the actions required to provide assurance to the Board and the Gwent population that the lessons from the Tawel Fan investigation have and will be used to improve the services delivered now and in the future.

The findings and recommendations identified in the Tawel Fan investigation report have been discussed at a number of fora across the Health Board. Actions, interventions and proposed additional work to be undertaken have been discussed at the Board's Cross Divisional Nursing Group meeting on 4th July 2018, the Executive Team meeting on Monday 9th July 2018, a special joint briefing meeting of members of the Health Board's Quality & Patient Safety (QPSC) Committee and Mental Health & Learning Disabilities (MHLD) Committee on 12th July 2018, the Health Board's Safeguarding Committee on 17th July 2018 and the Quality and patient Safety Committee on 25th July 2018. At this latter meeting it was agreed that, for the future, the MH&LD Committee will provide overview and assurance that the lessons learned are being reviewed and appropriate actions implemented. Subsequently an update was provided to the MH&LD Committee in relation to MH&LD services in February 2019 and subsequently this paper was provided to the MH&LD Committee on 11th April 2019, where it was agreed that this should also be provided to the QPSC. The report was also considered at a meeting of the Gwent Wide Adult Safeguarding Board on 4th September 2018 in order to seek assurances with regard to the multiagency arrangements for safeguarding.

ABUHB welcomes the report, the lessons identified and the recommendations made to BCUHB and will use them to guide and evaluate care and services in ABUHB.

Recommendation One:	**Care Pathway and Service Design**
An integrated service review is required to map the needs of the older adult and those with dementia across north Wales. This review needs to involve all stakeholders (from the statutory, independent and voluntary sectors) and those with performance responsibilities. The review should include all care and treatment settings (not just those confined to mental health and older adult services) in order to ensure that all interventions are integrated and that patients, service users and their families do not encounter service barriers that prevent them from receiving access to the care, treatment and support that they need. The review outcomes and options should underpin all current and future health and social care strategies across North Wales and be overseen by the appropriate performance management and inspection bodies.	
Aneurin Bevan University Health Board (ABUHB) Progress and Actions Planned	
The Greater Gwent Health and Social Care and Well-being Partnership Board is a key partnership body; established to lead and guide on the implementation of the Social services and Well0being (Wales) Act 2014 in the greater Gwent area. The provision of coordinated, person centred care, treatment and support is a key long term priority for the Board. Significant work has been undertaken to establish a robust governance framework to direct work and translate it into effective operational delivery at a locality level. The governance model provides shared leadership and ensures that the Area Plan is appropriately aligned with both local authority and Health Board corporate planning and the well-being objectives of the Public Service Board Plans. Five strategic hubs include a Mental Health and Learning Disability Strategic Partnership and the Adult Strategic Partnership, with a regional Dementia Board.	

Aneurin Bevan University Health Board hosts and Chairs the regional Dementia Board. This provides opportunities for the statutory partners, the third sector, service users and carers to work together to improve services across the region of Gwent. A regional Dementia Strategy was launched in May 2018, to support the implementation of the Welsh Governments Strategy for Dementia. A detailed action plan is in development and this includes the requirement for a clear dementia care pathway with consistency in provision of services across the region. As part of this ongoing work, via ICF Dementia Funding, the Gwent Regional Partnership Board commissioned an independent review to map existing Dementia service provision on a regional footprint across all sectors. This work has highlighted best practice examples and provided a whole system view of dementia care services. This was completed in March 2019 and considered at the Dementia Board on 19th March 2019. This is now being used to co-ordinate, plan and develop services across the region.

Recommendation Two:	**Dementia Strategy**

BCUHB is required to develop a detailed and costed action plan to support the implementation of its Dementia Strategy; the plan should be developed in partnership with the Regional Partnership Board response to the Welsh Government's new Dementia Plan. This work should be undertaken in conjunction with Recommendation One. The action plan should incorporate the consequent implications and requirements for all clinical services (not just the Mental Health Directorate) in all care and treatment settings (community, primary and secondary care).The action plan should take into account all of the clinical and practice deficits that have been highlighted by this Investigation and will require independent clinical input and oversight.

Access to therapy and non-medical interventions and treatments should be an integral part of any costed Dementia Strategy plan which takes into account NICE (and all other) best practice guidance in this regard. The capacity and capability of the workforce should be reviewed to ensure that fit for purpose services can be provided. Implementation should be managed and audited in tandem with Recommendation Ten (see below) as the reduction of the use of antipsychotic medication will to a large extent be predicated upon alternative therapeutic interventions being made available. Formal audit and performance management arrangements should be agreed and built into the action plan.

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

As previously noted, the Gwent Regional Dementia Strategy was launched in May 2018. Further development of the Action Plan following the completion of an independent review and mapping of dementia service provision across the region has taken place. Appendix 1.

ABUHB as a key partner in delivering the strategy reporting on progress to the Dementia Board. Work includes the following areas:

ABUHB Hospitals Dementia Group

This group, originally established to focus on improving care of patients with dementia in general hospitals has been expanded to support care and services throughout all areas. The programme of work includes:

- Improvement in delirium intervention in General Hospitals.

- Improvement in the collection of personal patient Information for people with dementia and use to provide care and care conversations across the dementia pathway.
- Ensuring person centred decision making and discharge planning.
- Implementation of workforce training strategy and development of skilled practice
- Ensuring environments in care settings are dementia friendly environments.
- Improvement in individual and organisational understanding of clinical outcomes following admission for hospital care.

Mental Health & Learning Disabilities Division

From a MHLD perspective, the older adult re-design has considered the needs of older adults with mental health needs and their carers and the re-investment in community provision is intended to address the gaps in service provision across Gwent.

The Memory Assessment Team Pathway review is nearly complete with the outcome being one common pathway across all boroughs. This includes mechanisms for measuring the outcomes of interventions provided from this service within the value based health care remit.

Dementia Assessment Wards and Older Adult Functional Wards have completed self-assessment against standards detailed in the QNOAMHS (RPSYCH 2017). This will be repeated annually. A revised Standard Operating Procedure has been implemented.

OAPL (Older Adult Psychiatric Liaison, Formerly RAID) Services are in place with the recent addition of the Flexible Hospital Response Team as part of OAPL to provide a modelling approach to providing personal care, clear communication and engagement and occupation to older adults who demonstrate challenging behaviour due to cognitive issues. This service is currently under review with cross divisional consultation to identify the best use of this resource.

Cross Divisional Pathway Development

A Primary Care and Community Division/MHLD Division workshop identified mechanisms for improved cross divisional working and has established the following workstreams to progress:

- A more integrated approach to In Reach to Care Homes.
- Further embedding Older Adult Mental Health expertise and Memory Assessment Services within primary care / integrated community hubs.
- Meeting the holistic physical and mental health needs of those in community hospitals and older adults mental health wards via enhanced MDT working.
- Enabling the Road to Well-being programme to more accessible for Older People.

Primary Care and Community Division

The training currently being delivered by the Professional Development Teams (PDT) in care homes will promote inclusivity for older adults within the independent sector. Previous work was confined to nursing homes, however since April 2017, residential homes have been afforded equal access to training.

It is recognised that some older people living with dementia in care homes may have limited or fluctuating capacity, therefore the training currently being delivered by the PDT is encouraging the care home workforce to urgently facilitate advance care plans (ACP)

for their residents to promote choice and dignity regarding current and future care needs, especially at end of life.

For those adults living with dementia who no longer have capacity, the team are advocating that the homes convene MDT meetings to prepare a record of best interest decision.

Raising awareness with stakeholders such as Local authorities, Social services, Neighbourhood care networks and District nursing teams will ensure that the older adult living with dementia in the care homes have additional support with regards to Advance Care Planning (ACP).

In addition in meeting the regional plans the MHLD Division's re-design of OAMH services has enabled re-investment in therapy and non-medical interventions.

This has allowed for funding to be released for re-investment in therapy and non-medical interventions. A therapies review is underway with MHLD and Therapies Division mapping current therapy provision against best practice guidelines. The expected outcome will be the development of a new model for provision of therapies.

Development and implementation of Dementia Care Mapping (DCM) Strategy is underway. 27 additional mappers were trained in June 2018. A strategy is being developed to steer the implementation of DCM into care pathways.

Person Centred Care in Dementia Training has been developed and established as mandatory for all staff working in on OAMH Inpatient Dementia Assessment Wards. The target is that 85% of staff will have received this by April 2019. This training is to the informed level of the good work framework.

Dementia, Delirium and Depression training is being provided across Acute and Community Hospitals. This is an ongoing proves and a responsibility of OAPL Services.

The Dementia Co-ordinator role is being reviewed and reinvigorated to further focus on training and development of staff within OAMH, across the wider Health Board and with partner organisations.

Roles within all OAMH Teams are to be mapped against the good work framework. This will make clear the expectation in terms of level of training in dementia across all teams.

Review of clinical environments takes places quarterly for all wards as part of the HEB process. This identifies deficits with fixtures and fittings.

QNOAMHS Self-Assessment has identified deficits in environmental standards which are being addressed. This is through rearrangement of wards where possible and capital funds where necessary. Inability to provide single sex accommodation on one of our wards has been identified but mitigations are in place to manage patient privacy and dignity.

A MH and LD estates strategy is under development to ensure that future decisions are aligned to a vision of fit for purpose OAMH inpatient wards.

Recommendation Three:	Care Homes and Service Integration
The current Care Home work streams need to be incorporated into a single action plan, which in turn should dovetail into the pre-existing BCUHB Mental Health and Dementia Strategies.	

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

In nursing homes across the ABUHB footprint where NHS Continuing Healthcare is commissioned, the development of services is included within the Dementia Strategy.

A common contract has been developed for commissioned NHS care as requirement of SSWB Act (2104) Part 9. This will lead to the development of integrating contract monitoring between statutory organisations overtime.

In addition to the established communication mechanisms with individual and collective care homes, a Care Home Governance Group is in place within the Health Board which brings together service integration from Complex Care, Mental Health and Primary Care. This supports a programme of work that includes:

- The development of in reach service.
- A care home collaborative to reduce pressure damage.
- The development of person centred care alternatives to the prescribing of anti-psychotics in care homes. This involves developing evidenced based research and funding opportunities as alternatives to prescribing anti-psychotic medication. This work stream includes partners from OAMH, Complex Care and Allied health professionals, therapies and supported by research partners Cardiff University. This bid was successful against the Dementia Action plan and will commence in a home in Newport from 1st April 2019 with completion November 2019.
- Work is ongoing in providing support to Care Homes (Nursing), in developing the skills, knowledge and competencies of their carer workforce through schemes of delegation by the Registered Nurses in the homes.

In addition to the above work, in 2011 the Divisional Nurse set up a "Matrons' Forum" where nursing home managers could network and discuss any learning and good practice. Over the years this forum has gone from strength to strength and is used to provide CPD and important updates for Nursing home mangers. The Divisional Nurse/Associate Director of Nursing for Primary Care & Community Division, The Deputy Divisional nurse for Complex Care, and the Senior Nurse for Integration and Professional Development work together to co-produce a forum that is supportive and informative. Within recent months the forum has been re-named as the care Home professional development Forum, Residential Home managers are now invited to sessions that may provide information or updates relevant to their practice.

The Professional development Team are providing training and support to residential home staff as well as Nursing home staff and work with the Complex Care Team to ensure care homes receive the most appropriate support and development to ensure that their staff have the knowledge and skills to care for the older adults in their care.

Recommendation Four:	Safeguarding Training

BCUHB will revise its safeguarding training programme to ensure it is up-to date and fit for purpose. The updated-training programme will incorporate all relevant legislation and national guidance.

BCUHB will engage with all prior safeguarding course attendees to ensure that they are in receipt of the correct and updated guidance. The responsibility for this will be overseen by the relevant BCUHB Executive Director with responsibility placed on all clinical service managers from all of the clinical divisions within the organisation. BCUHB has not been able to ensure staff attend safeguarding training sessions in the numbers required. There are multiple factors involved which will require a detailed and timed action plan with external oversight.

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

The Health Board safeguarding committee provides oversight in respect of safeguarding training. A multi-media programme of training is available to staff and the ABUHB Safeguarding Team continues to support the delivery of face-to-face training through the safeguarding boards. The overall training rate for adult safeguarding, reported in January2019 was 64% and the Health Board therefore recognises that the numbers of staff accessing training requires improvement. The monthly workforce dashboards will be revised to include the disaggregated reporting of compliance with safeguarding training and this is now a standing agenda item for the Safeguarding Committee.

The Intercollegiate Competency Document (ICD) for Safeguarding (Adults & Children) has recently been agreed and the Health Boards Safeguarding Training Strategy will be updated to reflect this new guidance.

Recommendation Five:	Safeguarding Informatics and Documentation

BCUHB has conducted an audit on the compliance of filing safeguarding information in patients' case notes. BCUHB will ensure that the consequent recommendations it set in relation to informatics in its BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018 are implemented – namely:

- The use of the dividers to be re-iterated in safeguarding training, briefings, and other communication activities and a key annual audit activity.
- Process of secure storage of strategy minutes of strategy meetings and outcomes of referrals to be revisited at safeguarding forums with legislative guidance from Information Governance.
- Team and ward managers to continue to include safeguarding documentation in team meetings and safety briefs.

In addition BCUHB will reconsider how clinical teams should record safeguarding information and the quality of the information provided.

This to include specific guidance on:

- The content of protection plans.
- The recording of strategy meetings and all decisions taken (guidance should require a standardised approach across all BCUHB clinical divisions).

- Formal monitoring and review templates should be developed and audited to ensure safeguarding timescales are met and those with key responsibilities in this regard held to account.
- BCUHB will repeat the audit within 12 months of the publication of this report to ensure that all clinical areas are compliant.

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

Within ABUHB DATIX is used to record all safeguarding matters including referrals. This has been updated to ensure that the fields available support recording. The safeguarding team have access to all safeguarding referrals and provide some monitoring of use.

Monthly reports of open safeguarding concerns are provided to each of the Divisions by the safeguarding team to support their management and to trigger timely updates. To support staff in managing historical allegations the Head of Safeguarding meets with Service Leads to review open cases.

MHLD have taken part in an All Wales audit of the Safeguarding Children Standards for Adult Mental Health. Positive findings have been reported at the Safeguarding Committee. Safeguarding referrals are agendered at the bi-weekly Safeguarding Panel within Mental Health and Learning Disabilities Division.

Divisional Designated Lead Managers (DLMs) responsible for investigation safeguarding referrals receive training on management. The corporate safeguarding team will ensure that training is available at least twice a year with sessions planned for May and October 2019.

Safeguarding Committee has recently approved the use of 7 minute briefings to share learning and good practice.

Recommendation Six:	**Safeguarding Policy and Procedure**

The BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018 identified that there were priority actions required in relation to safeguarding policies and procedures. This Investigation recommends that these priority actions are incorporated into the action plan consequent to the publication of this report.

The actions are:

- "To identify those policies, procedures and SOPs that firmly sit within the Safeguarding remit and those that should be the responsibility with internal and external partners;
- Agree a priority list and activity timeframe to review documents within the parameters of Corporate Safeguarding;
- Provide safeguarding expert advice to internal and external partners in order that those documents are reviewed appropriately and in line with local and national policy and legislative safeguarding frameworks;
- Agree a governance structure and reporting framework for all safeguarding policies, procedures and SOPs;
- Update and maintain the Safeguarding Policy webpage;
- Continue to actively participate in the Policy and Procedure sub group of the Regional Safeguarding Boards".

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned
The national safeguarding procedures are currently being revised through a national task group of which the ABUHB Head of Safeguarding is a member. Publication is expected for the end of 2019. Within Gwent consideration is being given to the adoption of a threshold criteria to support a more consistent approach. The Head of Safeguarding for ABUHB is also a member of the Gwent Safeguarding Boards Policy and Protocol sub group. An internal audit of safeguarding practice undertaken by NHS Wales Shared Service Partnership in 2017 provided reasonable assurance in safeguarding policies within ABUHB.

Recommendation Seven:	The Tracking of Adults at Risk across North Wales
BCUHB will work with multi-agency partners, through the North Wales Safeguarding Board, to determine and make recommendations regarding the development of local safeguarding systems to track an individual's safeguarding history as they move through health and social care services across North Wales in order to ensure ongoing continuity of protection for that individual.	
Aneurin Bevan University Health Board (ABUHB) Progress and actions planned	
The Independent Investigation of Tawel Fan and the recommendations made have been considered at a meeting of the Gwent Wide Adult Safeguarding Board. The Corporate Safeguarding Team hold a database of all Duty to Reports made concerning the Health Board. They can report prevalence by Division and ward. The Continuing Health Care Team also hold a database of all safeguarding referrals made in regard to individual nursing care homes. The individual Leads within the Divisions are expected to scrutinise safeguarding data to determine whether there are any patterns in referrals or concerns.	

Recommendation Eight:	Evaluation of Revised BCUHB Safeguarding Structures
BCUHB will evaluate the effectiveness of its new safeguarding structure in the fourth quarter of 2018/2019. This will be overseen by Welsh Government.	
Aneurin Bevan University Health Board (ABUHB) Progress and actions planned	
An internal audit of safeguarding practice undertaken by NHS Wales Shared Service Partnership in 2017 provided assurance in safeguarding structures within ABUHB.	

Recommendation Nine:	Clinical Records
• BCUHB needs to undertake a detailed check of the clinical records in the investigation cohort to evaluate and re-order all commingled casenotes. • BCUHB needs to ensure that none of the commingling involving living patients could have led to any inappropriate acts or omissions on the part of clinical treatment teams during any episode of care (past and present).	

- BCUHB needs to restructure and redesign its hard copy clinical records archiving and retrieval systems. This redesign needs to provide assurance in relation to the tracking of individual casenotes across north Wales together with a set of service level agreements pinpointing the timeframes required for clinical record retrieval and access.

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

The Health Board will be transferring its MH & LD records to WCCIS in 2019-20. As part of the readiness for this the records will be reviewed to ensure their integrity. Any instances of discrepancies in clinical records integrity and tracking are reported as incidents and investigated and records are amended as part of any review.

The Health Board has mandatory IG training for **all staff;** this includes records management and tracking; above that which is required in the Core Skills Training Framework (CSTF).

Recommendation Ten:	**The Prescribing and Monitoring of Antipsychotic Medication**

- The updated BCUHB 2017 antipsychotic prescribing guidance will be kept under review and be subject to a full audit within a 12 month period of the publication of this report.

- BCUHB will continue to work with care homes across north Wales to provide practical clinical advice, guidance and training so that residents with behaviours that challenge can be supported and kept safe with the minimal amount of antipsychotic medication possible. The effectiveness of this should be built into the antipsychotic prescribing guidance audit detailed in the bullet point directly above.

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

Antipsychotic medication prescribing for people with dementia and alternative suitable person centred care, environmental development approaches, knowledge and skills development and governance procedures is an integrated and cross cutting issue. Work is underway to address prescribing governance, roles and protocols against CG42.

Evidence was provided for the Welsh Government All Party review on antipsychotic use and prescribing across ABUHB both verbal and written.

This integrated task and finish activity is supported by best practice, the expertise of OAMH, evidenced based alternative non pharmacological approaches and research partners in Cardiff University. This bid was successful against the Dementia Action plan and will commence with a multi-disciplinary/therapy approach in a home in Newport from 1st April 2019 with completion November 2019. Further examples of activity in this area include:

- A workshop convened for the MHLD and Primary, Community Divisions considered areas of work that overlaps and led to the development of key priorities; anti-psychotic prescribing in care homes is one of those priorities. A task and finish group is convening to work on this.

- A snapshot database of antipsychotic medication reviews for CHC patients in nursing homes is maintained by the Complex Care Team's pharmacist and has led to the creation of an antipsychotic medication data base for residents under the care of

ABUHB by the OAMH directorate, this will be populated over the next year with exploration of smarter ways to import data so it is timelier and a 'living' document.

- The re-design of OAMH services has enable the MHLD division to increase the access to specialist MH care home in-reach provision. A Behavioural Support Team has been introduced aimed at supporting care home staff to develop more holistic, psychologically based care plans which reduce the reliance on pharmacological intervention to manage behaviour that challenges.

- A proposal for enhanced Pharmacy provision working across inpatient and community services has been developed by MH Pharmacy Lead. A key focus of this role will be reviewing of antipsychotic medication. Bids to fund this enhanced Pharmacy provision have been submitted.

- A task and finish group is developing proposal for 'perfect world' wrap around service to care homes. The proposal is that this service will be provided to one/two care homes with measurement of impact including the use of antipsychotic medication.

- The Divisional Nurse for the Primary Care & Community Division and the Lead Nurse for Patient Engagement and Education are leading on a national piece of work to reduce loneliness and isolation. They have put together a team of dedicated ABUHB staff who are known as Ffrind i Mi. Along with many stakeholders and partner organisations and led by the Ffrind i Mi team several initiatives to support isolated and lonely individuals in our communities have been very successful. One such initiative has been intergenerational work between primary schools and care homes. One Residential home has reported that as a result of this work anti-psychotic prescribing within the home has been reduced by 100%. The aim is to share this excellent work and encourage intergenerational work in care homes on a national scale.

Recommendation Eleven:	**Evidence-Based Practice**

BCUHB will conduct a review of all clinical policies to determine the ratification processes that were conducted together with an assessment of the appropriateness of content and currency; this will include all hard copy policy documentation still retained in clinical areas, and all electronic documentation held currently on the BCUHB intranet. As part of this work:

- A risk assessment should be conducted to prioritise the work that needs to be undertaken and to establish whether there are any urgent policy revisions and alerts required to ensure patient safety is maintained.

- Work should be undertaken to review the extant clinical policies across the three BCUHB geographical regions to determine corporate ratification and fitness for purpose.

- All clinical policies should be reviewed with the specific needs of the older adult in mind. Policies should either be re-written to ensure that the evidence-base in relation to the older adult and/or those with dementia is specified in detail, or separate clinical policies and procedures should be developed for this particular patient cohort. This work should be conducted with expert multidisciplinary inputs.

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

The Corporate Team holds a comprehensive database of ABUHB policy documents including Mental Health and clinical policies. There is a flagging system which highlights any policies overdue or any due for review within the next six months. The relevant Division/Directorate is then provided with a list of policy documents which need to be reviewed in the upcoming months. The Corporate Services Manager – Policies and Procedures has close links with the Quality & Patient Safety Manager and Clinical Lead - Mental Health Act Administration regarding the review and ratification of Mental Health Policy Documents. Once documents have been ratified via the correct process (MH&LD QPS or Clinical Standards & Policy Group) these are then securely saved on the ABUHB shared drive and made accessible to all staff via the intranet. Staff throughout the organisation are notified of any new policy documents or updates via the weekly Nye's News and quarterly Policy Digest which are issued and circulated to all staff across the organisation.

MHLD division has a programme of policy review – there is an action plan and policies are ratified via divisional quality and patient safety meeting. This work plan will be assigned to the dementia board divisional action plans for ABUHB. For example, revisions to the EQUiA in line with the Good Work dementia framework are required and scoping of policies which require adjustments related to the protected characteristics of dementia and disability.

The Head of Service/Divisional Nurse for Complex Care is a member of the National Care Home Steering Group and provides notifications and timely sharing of information relating to changes in practice or practice developments.

Recommendation Twelve:	**DoLS**
BCUHB will conduct a formal audit and provide a progress report in relation to the 2017-2018 action plan. This will include a review of any barriers to implementation (such as office accommodation) together with a timed and resourced action plan to ensure full implementation can be taken forward in 2018 – 2019.	
Aneurin Bevan University Health Board (ABUHB) Progress and actions planned	
Recommendation specific to BCUHB. The Health Board has undertaken an audit of patients who have the potential to be subject to Court of Protection and actions taken to support practice. Consideration is currently being given to the impact of the new Liberty Protection Safeguards to support implementation in 2020. A workshop with partner agencies is planned for July and proposals will be provided to the Executive Team in consideration of the way forward.	

Recommendation Thirteen:	Restrictive Practice Guidance
BCUHB will provide assurance that all older adults and those with dementia are in receipt of lawful and safe interventions in relation to restrictive practice management across all care and treatment settings within the BCUHB provision. BCUHB will also ensure that the *Royal College of Psychiatrists' Centre for Quality Improvement (March 2007) National Audit for Violence: Standards for In-patient Mental Health Services* guidance is embedded in all training and policy documentation in relation to 'taking dementia patients to the floor' during restrictive interventions.	
Aneurin Bevan University Health Board (ABUHB) Progress and actions planned	
Within ABUHB, MHLD clinicians are engaged in the national OAMH community of practice and MHLD restrictive practice training lead is engaged in national work to re-design Module 4 of Violence and Aggression Passport for Wales. MHLD training has been re-designed to focus on de-escalation and is entirely consistent with current guidelines. Use of restrictive practice is recorded as an incident on DATIX. A 6-monthly report on the use of restrictive practice is considered at MHLD QPS meeting. Use of restrictive practice is monitored on the divisional quality dashboard. The development of Person Centred Care training and Dementia Care Mapping, as well as the development of the Behavioural Support Team to provide psychological intervention support to care homes and the Flexible Hospital Response Team to model better ways to engage those with cognitive issues on General wards also enhance the ethos of primary prevention.	

Recommendation Fourteen:	Care Advance Directives and Support to Patients and Families
BCUHB has made significant progress in providing support to patients and families when holding end of life conversations and developing advance directives. This is good practice. BCUHB will conduct an audit to establish how many patients and their families have advance directive documentation within their clinical records together with care plans in relation to choice and preference about end of life care.	
Aneurin Bevan University Health Board (ABUHB) Progress and actions planned	
In ABUHB Advanced Care Planning (ACP) is undertaken with patients who have life limiting diseases. This addresses important points such as preferred place of care (PPC) and preferred place of death (PPD) and makes these choices known to the clinical teams delivering care to patients. ACP also incorporates thresholds of care and DNACPR ensuring that no treatment is planned for a dying patient against their wishes. The ACP facilitators within the health board have had 4000 contacts to date with Gwent residents about ACP to raise awareness of the issue and encourage the formulation of ACP's for all citizens across the county. The Primary Care & Community Division Professional Development Team are offering Training on Advance Care Planning to all Nursing and Residential homes within the ABUHB geographical area.	

Currently >70% of residents in general nursing home beds and > 37% of residents in general residential home beds have an active ACP and work is still ongoing.

However ACP is only appropriate for those adults who have capacity to make the decisions and choices regarding their current and future care including end of Life Care. For care home residents who no longer have capacity to articulate those choices and decisions, the PDT are recommending that the care homes organise an MDT meeting (including carers and family/friends) and a record of best interest (RBID) is recorded that will indicate what choices and decisions they think the individual would have made regarding their care if they were able. This should include preferred place of care and preferred place of death, setting ceilings of treatment and resus status. This should then be used to support the clinical decision maker when needed.

All care homes are being encouraged to share any ACPs and RBID with the GP Out of Hours service to ensure continuity of care and adherence to patient preferences.

Recommendation Fifteen:	**End of Life Care Environments**

All older adults and people with dementia have the right to the same access to quality end of life care as any other individual (of any age) with any other condition. If a person is to receive end of life care on an older person's mental health ward (and in particular an acute admission ward) the following should always be undertaken:

- A clinical risk assessment to determine the appropriateness of end of life care being provided in an older people's mental health facility – the risk assessment should take into account the levels of patient acuity and any potential conflicts that could be present;
- An assurance that out of hours medical cover can be provided if the patient's physical condition requires it;
- An assurance that equipment can be resourced with the minimum of delay and that patients are never nursed on mattresses on the floor due to a shortage of hi/low beds;
- An assurance that patients can be supervised appropriately and not left unattended due to other challenges that ward might face;
- An assessment to confirm patients can be nursed in quiet and peaceful environments and that the ward layout can accommodate this;
- An incident form should be completed if a patient receives end of life care due to a lack of appropriate alternative placements and difficulties with transport;
- Consultation with relatives who should be able to request the transfer of their loved one to a different clinical setting if they feel a mental health facility is in any way unsafe or inappropriate;
- The training of all registered nursing staff (including night staff) in end of life and palliative care.

Aneurin Bevan University Health Board (ABUHB) Progress and actions planned

ABUHB's Fast Track End of Life process does not discriminate in relation to adults with physical deterioration and those with mental health deterioration such as dementia who are entering their End of Life. This process enables the preferred environment of care to be commissioned and care provided by staff with the relevant skills and often supported by our local hospices.

Using ACP – The PPC/PPD is identified prior to the point of a patient becoming EoL in most cases – especially if a patient is receiving palliative care. To achieve PPC/PPD if this is home, CHC fastrack is completed to allow discharge home with a package of care (PoC). If home is not suitable, a hospice bed may be offered if available. If neither are achievable or safe and place of death is a hospital, care follows the '*Care Decisions for the Last Days of Life*' guidance in conjunction with 2015 NICE guidance *'Care of the Dying Adult'* to ensure that the wishes of the patient and those important to them are accounted for. This incorporates all of the points raised in relation to delivering clinical care in Recommendation 15.

In addition there is a rolling programme of Sage & Thyme communication training run by the Lead Nurse for Palliative Care which trains staff in communication about difficult issues at the point of EoL.

The OAMH directorate are also working collaboratively with the Alzheimer's society and Cruise in providing pre and post bereavement counselling to those with dementia and their carers.

Conclusion

Aneurin Bevan University Health Board has welcomed the opportunity to undertake this benchmarking activity against the recommendations made to Betsi Cadwaladr Health Board. It is recognised that there has been significant activity to support improvement to care and services for this vulnerable group of patients. There is also acknowledgement that much of the improvement work requires further development to ensure that this is embedded and sustained.

This will continue to be overseen through the appropriate committees responsible for the different areas of work in keeping with governance arrangements.

Supporting Assessment and Additional Information

Risk Assessment (including links to Risk Register)	Reputational risk to the Health Board in failing to address the specific needs of older people in care home settings.
Financial Assessment, including Value for Money	*Not identified in this report.*
Quality, Safety and Patient Experience Assessment	Impacts on the quality of life and care experience of older people living in care homes.
Equality and Diversity Impact Assessment (including child impact assessment)	Addresses potential inequalities of care to older people in care settings.
Health and Care Standards	Contributes to Health and Care Standards concerning: 1.1 Health promotion, protection and improvement 2.1 Managing risk and promoting Health & Safety

	2.2 Falls prevention 2.5 Nutrition and hydration 2.6 Medicines management 3.1 Safe and clinically effective care 4.1 Dignified care 5.1 Timely access to care 6.1 Planning care to promote independence 6.2 Peoples rights; individual care 6.3 Listening, learning and feedback
Link to Integrated Medium Term Plan/Corporate Objectives	Particularly steps 2, 3, 5 and 6 of Dementia road map.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	This work contributes to the 5 ways of working in terms of longer term planning, integration of services, involvement of patients and public, collaboration between partners and the prevention of ill health and promotion of well-being.
Glossary of New Terms	Terms explained.
Public Interest	Paper has been written for the public domain.

Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: a Lessons for Learning Report

Executive Summary

This report was commissioned by
Betsi Cadwaladr University Health Board

May 2018

Report Author:
Dr Androulla Johnstone:
Chief Executive Health and
Social Care Advisory Service Consultancy Limited
and Independent Investigation Chair

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Contents

1 Preface

1.1 The Independent Investigation into the care and treatment provided on Tawel Fan ward was commissioned formally by Betsi Cadwaladr University Health Board (BCUHB/the Health Board) in August 2015 pursuant to the Welsh Government (Version 3 – November 2013) *Putting Things Right: Guidance on Dealing with Concerns about the NHS from 1 April 2013.* The Investigation was commissioned initially to examine specific concerns raised by some 23 families about the care and treatment received by their loved ones between January 2007 and December 2013. At this time the 23 families were held on the BCUHB open concerns register. In order to identify any other patients whose care and treatment might have fallen below an acceptable standard the Investigation was also asked to examine the archives developed during the following prior processes:

1. The Ockenden external investigation (conducted in 2014 and published in May 2015).
2. The North Wales Police investigation (2014-2015).
3. The Betsi Cadwaladr Mortality Review (2015).

1.2 Consequently additional patients were added to the Investigation Cohort which rose to 108 in number. Separate confidential reports have been prepared detailing the findings in relation to each case.

1.3 The Investigation was also commissioned to provide human resource management reports for any person employed by the Health Board identified with either conduct or competency issues in relation to any established untoward events or substandard practice on Tawel Fan ward.

1.4 The care pathways followed, and care and treatment received, by the patients in the Investigation Cohort have been examined closely in order to identify the lessons for learning. It is a matter of public interest to understand exactly what occurred on Tawel Fan ward, how expressed concerns were escalated and managed, and to establish the lessons for learning relevant to both local and national service provision.

1.5 Investigations of this kind should aim to increase public confidence in statutory health service providers and to promote organisational competence. It is the duty of any Independent Investigation Panel to conduct its work in an impartial and objective manner. This Investigation has endeavoured to maintain an independent and evidence-based stance throughout the course of its work with the aim of providing as accurate account of events as the available evidence allows.

2 Acknowledgements

Patients, Families and Friends

2.1 The Investigation Panel would like to extend its sincere thanks to the patients, families and friends who have contributed to this work. For some individuals the process has been a demanding one whereby challenging and difficult experiences have had to be relived.

2.2 The Investigation Panel has heard, and taken into account, a wide variety of views and concerns. There has been no unified set of experiences put forward; family accounts differ greatly. For example: some families stated that in their view Tawel Fan ward was an abusive environment where their loved ones were mistreated, neglected and came to harm. Other families offered the view that the care and treatment their loved ones received was of a very good standard with staff showing kindness and compassion throughout their relative's entire episode of care.

2.3 The Investigation Panel acknowledges the lived experience of every person who has come forward and has endeavoured to provide a fair and balanced view based on an independent analysis of events.

2.4 It should be recognised that each individual who came forward to the Investigation, either in writing or in person, gave a significant amount of their time to the process. We are grateful to them for this.

Witnesses

2.5 Independent Investigations commissioned via NHS frameworks do not have the statutory powers to compel witnesses to take part in proceedings. Whilst individuals who were either employed by the NHS (or who were still active on a professional register) had a requirement to take part in the Investigation, those to whom these conditions did not apply could not be compelled to take part against their wishes. The Investigation would therefore like to thank all of those participating individuals who are currently retired or who no longer work in health related activities for coming forward voluntarily to assist with the inquiry process.

2.6 Those current NHS employees who were called to give evidence were asked to provide information about clinical and managerial practice. We are grateful to all those who gave evidence directly, and to those who have supported them. We would also like to thank the Health Board's senior management team who have granted access to facilities and individuals throughout this process.

Support

2.7 Investigations of this kind can cause a significant degree of distress and trauma to all involved (families, patients and staff witnesses alike). Prior to the commencement of the investigation process there was a requirement to ensure expert and timely support was in place. BCUHB provided access to timely, easily accessible psychological triage and commissioned an independent counselling and trauma therapy service. The Investigation Panel would like to extend its thanks for the level of support that was provided and continues to be provided.

Multi-Agency Partners and External Stakeholders

2.8 The Investigation Panel acknowledges with gratitude the inputs received from Betsi Cadwaladr University Health Board's multi-agency partners together with the Nursing and Midwifery Council and General Medical Council for their assistance and cooperation throughout. We thank them for their patience and the professional courtesies they extended throughout the course of the Investigation.

3 Investigation Terms of Reference

3.1 The original Terms of Reference (ToR) for the Investigation were agreed by BCUHB at the Board meeting held on 8 September 2015. Minor amendments were made in July 2016.

Terms of Reference

"Betsi Cadwaladr University Health Board has commissioned HASCAS Consultancy Limited to provide the lead independent investigator role in relation to the complaints, concerns and disciplinary matters arising from the investigation into the failings of care on Tawel Fan Ward in the Ablett Unit at Ysbyty Glan Clwyd.

Remit

To provide independent and comprehensive investigation management and triangulation of all previous investigation material and evidence which will include:

- *Police investigation statements and written evidence.*
- *External investigation undertaken by Mrs Donna Ockenden and written evidence collated and sent through to the Police and published report.*
- *Complaint files and correspondence.*
- *Internal investigations commenced and suspended when Police investigations commenced.*
- *Mortality review and report.*
- *Any internal audit or external report/review or other information held by the Health Board which is deemed relevant.*
- *Provide family point of contact where additional information to support concerns has and is being provided, meeting with families who have made contact and collate their evidence.*

Purpose

With the evidence available, triangulate all sources of information which will enable the evidence to be collated into a comprehensive public facing document (redacted) and an internal document (un-redacted) and additionally provided into two streams of evidence for the purposes of:

(1) Complaints Management

- *Collated into patient specific evidence so that a comprehensive summary can be made in response to each formal complaint that will stand up to external scrutiny and enable each family to be confident that all information has been used in the response. Where health care issues have been identified or harm caused, the Putting Things Right (PTR) regulations are considered with regard to Regulation 24, 26 and 33 (Harm and Causation).*

(2) Professional Regulation and Employment policies and procedures

- *Collated into staff specific evidence, so that the information which needs to be considered where omissions in professional practice and breaches in clinical standards are evidenced are individualised into summary evidence which can be used as Statements of Case if appropriate for consideration under BCUHB employment policies and where necessary onward referral to the relevant regulatory bodies for example the General Medical Council (GMC) and Nursing & Midwifery Council (NMC). In addition consideration must be given to the notification and or referral to Disclosure and Barring Service (DBS)/Independent Safeguarding Authority (ISA).*

Escalation

If at any time new information is identified the appropriate action must be taken to ensure escalation in line with the relevant policies and procedures.

Timescales

The Investigation will complete the work program which has been set out in 5 stages.
First Stage: August/September 2015
Second Stage: September/October 2015
Third Stage: October/November 2015
Fourth Stage: December/January 2016
Fifth Stage: January/February 2016

Reporting

In keeping with other large and complex NHS investigations a formal governance assurance process has been established for the Tawel Fan HASCAS Investigation.

Team and Resources

The Executive Director of Workforce and Organisational Development will be the Lead Executive Director on behalf of the Board overseeing these arrangements. This role will be supported by a team of senior managers who will provide the required Input and the professional expertise to contribute to the work of HASCAS who will lead the Investigation".

3.2 It should be noted that the Investigation underwent significant time slippage and the dates for the completion of each stage were not met. This was due principally to the Investigation Panel not being able to access key documentation in a timely manner.

4 Summary of General Findings and Key Lessons for Learning

Investigation Context

4.1 There always have been, and probably always will be, occasions when NHS services fail to deliver against the standards that it strives to achieve. The pressures that NHS services face are reported frequently in the media together with the recognition that patient care is sometimes compromised. It is important to recognise that this state of affairs, whilst regrettable, occurs for a number of reasons as part of the ebb and flow of daily service provision within the NHS.

4.2 The Investigation Panel does not seek to be an apologist for the NHS in general, or for BCUHB or Tawel Fan ward in particular, however it would be both unrealistic and unreasonable to visit harsher tests than those deemed to be acceptable for any other NHS service currently delivering patient care under the normal day-to-day pressures that are encountered throughout the United Kingdom. It has therefore been essential for the Investigation Panel to work in a manner proportionate to the circumstances and the available evidence base.

4.3 The Investigation Panel concludes that the care and treatment provided on Tawel Fan ward was of a good overall general standard even though there were key areas identified where clinical practice and process required development and modernisation.

4.4 Nevertheless it was also identified that, on occasions, the experience of some patients and their families was compromised due to a combination of systemic failures exacerbated by significant financial restrictions, poor service design and ineffective governance arrangements. However it should be understood that these issues were not as a result of any failings in relation to Tawel Fan ward *per se* but were encountered by patients and their families across a wide range of services on the care pathway that they travelled.

4.5 These issues encompassed problems from the point of first diagnosis through to (and often past) the point of discharge from Tawel Fan ward and/or the eventual death of a patient. These issues also included the lack of dementia friendly Accident and Emergency Department inputs and the difficulties patients and families encountered on medical wards and with other BCUHB services.

4.6 Tawel Fan was the common denominator in that of the 108 patients in the Investigation Cohort 105 were admitted onto the ward for a period of time. However it is evident that many of the concerns and complaints raised by families did not relate to the ward and that a significant number of families had nothing but praise for the care and treatment their loved ones received on Tawel Fan and for the kind and compassionate care provided by members of the treating team.

4.7 This view was not shared by all of the families in the Investigation Cohort; the Investigation Panel encountered significant dissonance between the accounts provided by family members. It has been a key responsibility of the Investigation Panel to ensure that no single view or family stance took precedence over any other and that all findings and conclusions were made after extensive examination and triangulation of the evidence available. It was also the responsibility of the Investigation Panel to ensure that the focus remained upon lessons for learning rather than calls for punishment and retribution which were entirely disproportionate to the actual findings and conclusions of the multidisciplinary expert Investigation Panel.

4.8 Whilst the Investigation Panel found the care and treatment provided on Tawel Fan ward to be of a good overall general standard, there were nine key factors that served on occasions to compromise the quality of the patient and family experience during the period of time under investigation. These factors are set out below and apply to the experience of the older adult (and their families) across the whole care pathway encountered including Accident and Emergency Departments, medical wards, old age psychiatry and community-based care.

Summary of General Findings

Factors Impacting upon Patient Care

4.9 **Governance.** During the period of time under investigation governance processes (both corporate and clinical) were weak across the whole of the BCUHB provision; this served to disrupt strategy development and implementation. This also served to prevent a robust approach from being taken in relation to patient safety in that evidenced-based practice and organisational learning were under-developed and could not always be relied upon to provide the levels of protection that were required.

4.10 Clinical governance provides the means to ensure patient safety and quality improvement; its effectiveness (or lack of it) has a direct impact on service delivery. In the most basic of terms the care and treatment delivered by BCUHB services was often compromised by:

- poor quality clinical policies and guidelines that did not always provide an appropriate and evidence-based set of standards for practice (particularly in relation to the older adult);
- limited training and education opportunities for staff;
- an ineffective approach to patient safety alerts such as those raised by complaints, incidents and safeguarding referrals;
- inadequate levels of capacity and capability in relation to the workforce in general and medical and nurse staffing in particular;
- ineffective clinical information systems which compromised access to individual patient information in a timely manner.

4.11 **The Care Pathway.** Most of the patients in the Investigation Cohort experienced problems with the care pathway that they encountered. Service interfaces between the disparate BCUHB Clinical Programme Groups (CPGs), such as

those for medicine and psychiatry, often served to create significant barriers which had a negative impact upon patients and the timely access to the care and treatment that they required. As a result patients often experienced:

- delays and restrictions when accessing the most appropriate clinical service (for example: inpatient medical care and hospice beds);
- distress and loss of dignity (caused by prolonged delays in A&E departments and medical assessment units);
- compromised care and treatment that was sometimes provided in clinical environments that were suboptimal;
- hospital acquired infections and injuries (exacerbated by delayed transfers of care);
- compromised levels of health, safety and wellbeing;
- multiple moves driven by service rather than clinical need with a subsequent loss of patient trust and confidence.

4.12 **Financial Pressures and the Consequences for Patient Care.** The financial pressures that BCUHB faced from the point of its inception (and including the period of time under investigation) made a significant contribution to both bed shortages and restrictions to service access (across the system as a whole). The organisation had to fund service developments from a 'zero funding base'. This meant that one service had to close before another could be developed. The interim period often caused pressures within the system (for example: when older adult psychiatric inpatient beds had to be closed during 2012 in order to develop community services) until the new service redesign benefits could work through the system; this had the effect of raising inpatient acuity levels.

4.13 Financial restrictions also placed pressures on staff recruitment practice which meant that clinical services could not recruit to staff vacancies in a timely manner. As inpatient acuity levels rose as a consequence of overlapping service redesign initiatives, the ability to access a workforce with the required capacity and capability reduced. Consequently competing financial pressures served to restrict access to services, increased patient acuity causing 'bottle necks' and delayed transfers of care, and reduced access to a workforce that could provide the levels of skilled care and treatment required.

4.14 **The Clinical Environment.** The clinical environment on Tawel Fan ward was not optimal for the patient cohort receiving their care and treatment there. The ward design did not lend itself to the safe management of the confused elderly person and the ward layout could not be adapted to provide single-sex accommodation.

4.15 In addition, over the years, the fittings and fixtures of the ward had deteriorated and constituted both a risk to health (for example: worn carpets which were trip hazards) and a decline in the quality of the patient experience (for example: the inability of the Ablett Unit boiler to provide a consistent supply of hot water).

4.16 **Care and Treatment.** The levels of care and treatment provided on Tawel Fan ward were of a good overall general standard. From the evidence available it is evident that good nursing care was provided and that the Fundamentals of Care

were maintained well. However on occasions care and treatment did not comply in full with national policy expectation and this meant a consistent and evidence-based approach was not always taken. Of particular note were issues in relation to:

- the management of falls;
- medications management;
- access to therapies (such as occupational therapy, speech and language therapy and psychological services);
- the formal recording of clinical risk assessment.

4.17 Nevertheless a key finding of this Investigation is that the care and treatment on Tawel Fan ward was in general safe and effective as evidenced by the contemporaneous clinical records, internal and external reviews and inspections, patient outcomes, and the evidence provided by a significant number of families who provided information to this Investigation.

4.18 **Safeguarding.** Systems and structures within BCUHB were not always robust enough to support the protection of adults at risk. This was exacerbated by a general lack of consistency on the part of Local Authority partners as to what constituted abuse and how this should be managed. Safeguarding referrals took a long time to process and did not meet the timescales prerequisite in policy guidance. This meant that Tawel Fan ward staff had to manage risks in the interim period without the level of external scrutiny and support required. There was an inability of the system to aggregate safeguarding trends (such as increasing patient acuity and rising levels of patient-on-patient assault) in order to formulate management strategies and workforce responses.

4.19 Despite problems with the system there is no evidence to suggest that Tawel Fan ward was an environment where abusive practice took place either as a result of uncaring staff who acted wilfully in an inappropriate manner, or due to a system that failed to protect. There is no evidence to support findings of abuse from a perspective of cruel or inhumane treatment and neither is there any evidence to support the notion of institutional abuse or neglect.

4.20 **Legislative Frameworks.** The Investigation Panel found that when patients were detained on Tawel Fan ward under the Mental Health Act (1983) processes were managed appropriately and in accordance with the legislation and Code of Practice.

4.21 However it was evident that on occasions patients who had been admitted informally should have been assessed under the Act with a view to formal detention. This is because those patients met the threshold for assessment and it was not always clear under which legal framework they were being kept in hospital and provided with care and treatment. In addition, apparent acquiescence was often taken to indicate that a patient did not need to have an assessment under the Act; however as they did not have the capacity to consent to admission and treatment they were in fact detained but without the legal protections afforded to patients sectioned under the legislation.

4.22 **Carer and Family Support.** During the period under investigation the levels of advice, supportive coordination, counselling and education provided to patients and their families were of an inconsistent standard at the point of first diagnosis. For many patients and their families this served to create confusion throughout the dementia journey that they embarked upon.

4.23 Consequently patients and their families were not always able to plan for the future in an informed manner and on occasions this compromised the levels of trust and confidence they had in NHS services and also compromised their ability to make decisions and be effective co-partners in care and treatment planning.

4.24 **The Clinical Record and Professional Communication.** During the period of time under investigation BCUHB operated (and operates still) a hard-copy clinical records system. Recording templates were inconsistent and were not subject to audit. This meant that the quality of the clinical records varied enormously.

4.25 Of particular concern was the archiving and retrieval system which meant that clinical records could not always be accessed with ease by members of treating teams. This created problems with continuity and, at times, compromised the efficacy of patient care.

Key Lessons for Learning

Patient and Family Support

1 **Counselling.** There is a need for a more comprehensive and specialist range of pre and post diagnostic counselling opportunities for patients and their families. Regardless of how well members of the treating team try to communicate diagnostic information they are to some extent boundaried by their primary clinical roles and functions. It is naïve to expect individual clinicians, no matter how caring and compassionate they are, to be able to provide a consultation in a memory clinic, or a ward-based family meeting context, in *lieu* of formal counselling.

2 **Dementia Coordination and Signposting.** There is a need for the better coordination of patients and their families from the point of first diagnosis; this is in keeping with Welsh Government strategy. Continuity of care and relationship building are essential factors when working with patients and their families over a long period of time, especially as the dementia process is both challenging and progressive.

If BCUHB is to meet the Welsh Government challenge to increase dementia diagnostic rates at increasingly early stages of the condition, an additional resource in relation to support will be required. This will need to be addressed as part of the current BCUHB Mental Health Strategy as increased success in one area will inevitably lead to service pressures in another.

3 **Clarification at the Point of Admission.** When admissions take place during times of crisis it is difficult for families to understand what is happening and what they are being asked to agree to. It is important to clarify events and revisit the decisions made and the subsequent consequences once the admission is complete and the patient has been made safe. It is not good practice for misunderstandings to arise; however on occasions these will be inevitable. To minimise the likelihood of this it is important that families are provided with a clear account of events as soon as is possible and that plans for the immediate future are discussed with them moving forward.

4 **Operational Policy Synchronisation.** In order to provide a streamlined service that can meet expectations it is necessary for there to be a consistent set of criteria in place to guide the care pathway. Operational policies should be developed from an 'integrated' service perspective so that patients and their families can be signposted correctly and reliably.

5 **Living Well with Dementia.** Over recent years a more positive and community-based approach to living with Dementia has grown. Clinical services need to ensure that they are in step with this ethos and assessment and care and treatment planning needs to focus on holistic need with the aim of providing meaningful person-centred care which does not focus on disease processes alone.

6 **Education, Information and Support to Patients and their Families.** People need access to education, information and support throughout their journey with dementia. 'Frontloaded' inputs at the point of diagnosis are not enough, and neither are meetings and consultations with members of treating teams once a person has reached a point of crisis. Consideration needs to be given as to how information can be provided and tailored to each stage of the journey, particularly at key points of transition such as admission to acute inpatient wards or eventual placement in care homes. It should also be understood that family support needs will be ongoing and they should be re-assessed and provided for in a dynamic manner.

7 **Communication Practice across all NHS Services.** Patient and family communication issues were identified in relation to Accident and Emergency, medical and surgical services. There is an obvious need for all NHS services to communicate well; however a key lesson for learning is that all services should (in addition) be dementia aware and appreciate the fact that family members often have to give consent for their loved ones who are no longer able to do this for themselves.

8 **Placing the Patient at the Centre of Decision Making.** The best interests of the patient should always be at the centre of any decisions made. When there are ongoing disputes between families and treating teams these disputes should be recorded and independent advice sought. It is essential that delays to important decisions are avoided (such as admission or discharge) as these can have a negative impact on the safety and welfare of the patient.

9 **Co-production of Care and Treatment Plans.** If adequate education, information and support is provided then people with dementia and their families will be empowered to co-produce care and treatment plans. The co-production of care and treatment plans should be about *"how do you want to live your life"* from the outset of the dementia journey.[1] The process of ascertaining preferred options in relation to treatment (and gaining knowledge about the person) should begin from the first point of contact.

Clinical Governance

10 **Documentation and Clinical Recording.** Where hard copy documentation systems exist clinicians have to work harder when both accessing information and recording it. This can present additional workforce challenges within often highly pressured services.

The hard copy clinical record system as it operated in BCUHB (and operates still) was not always reliable and caused significant problems in relation to both the transmission and transcription of clinical information. It is essential that standardised procedures are established so that records can be traced and accessed in a reliable and timely manner. Standardisation is also essential in relation to clinical documentation so that hard copy records capture all of the essentials of baseline assessment.

11 **Policy Guidance.** Clinical governance systems should provide as a minimum a clear set of policy guidance together with a set of organisational expectations about professional standards. National guidance provides clear best practice guidance for clinicians (regardless of discipline). It is the responsibility of each individual to ensure they are up-to-date and that they work within this guidance. However it is the corporate responsibility to highlight this guidance and to ensure that adherence is monitored and the quality of clinical care and treatment assured.

12 **The Management of Complaints and Concerns.** It is essential that families and their loved ones are informed about how to raise complaints and/or concerns and how these will be managed; where appropriate patients and their families should have access to advocacy services. Clear guidance should also be provided in relation to the management of investigation outcomes. Families should be advised that if they are not happy with investigation outcomes, and if their issues have not been addressed to their satisfaction by the NHS PTR process, then they should contact the Ombudsman. Health services should not endeavour to resolve complaints and concerns beyond the point advised in the All Wales Putting Things Right guidance. This can undermine the process and create a confrontational and intractable situation which is counterproductive and where neither side can move forward.

13 **Professional Standardisation.** Evidence-based clinical guidance and practice adherence is a key tenet of clinical governance. Without systems to ensure access, implementation, monitoring and review the quality of the

1 NHS Wales (2013) *Tools for Improvement 8: 1000 Lives: Co-Producing Services – Co-Creating Health*

patient experience can be compromised and suboptimal practice and/or unsafe practice provided.

14 **Policy Development.** Policy guidance should be tailor made to the needs of the older adult. It is poor practice to subsume them into policies produced for adults of working age whereby the evidence-base in relation to older adults is ignored and care and treatment guidance compromised as a result.

15 **Professional Leadership and Escalation.** When wards are under pressure it is essential that managers and senior clinical practitioners are available to provide advice, leadership and support. During 2013 when Tawel Fan ward was under its most significant period of pressure it was evident that the ward team were able to rely increasingly upon the Modern Matron, the Dementia Nurse Consultant and senior CPG managers. This ensured that (whilst care and treatment and service management issues arose) overarching safety was maintained whenever possible.

Legislative Frameworks

16 **Mental Capacity, Best Interests and Advocacy.** Legislative frameworks must be deployed for patients deemed to have a loss of capacity when making specific treatment decisions. This is of particular importance for those patients who are not detained under the Mental Health Act (1983). The use of independent advocates should be an integral part of any service provided.

17 **Patient-Centred Care.** It is important that care giving is flexible and sensitive enough to ensure dignity, health, wellbeing and safety whilst at the same time allowing the patient sufficient autonomy wherever possible. This applies to all patients, but is particularly relevant for those deemed to no longer have the capacity to make decisions on their own behalf. There should be no ‘one size fits all approach’ and care plans should take into account the needs and preferences of each individual patient which always take preference over those of families and services alike whenever appropriate to do so.

18 **Family Communications, Engagement and Support.** Legal frameworks are complicated to understand and often associated with preconceptions and stigma. It is important to ensure that each family member is acknowledged in accordance with their particular roles (Lasting Power of Attorney, nearest relative and/or next of kin) and their rights are both explained to them and supported. Strategies need to be agreed and put in place so that communication is effective (and bears in mind the needs of large families) without contravening due process in relation to decision making and confidentiality.

19 **The Need for Clarity Regarding Legal Frameworks.** NHS organisations must provide clear guidance to services about the use of the Mental Health Act (1983) and the Mental Capacity Act (2005); the guidance should clarify how they must work together and which takes precedence over the other and in what circumstances. These guidelines should be kept under review and audited where necessary on a patient-by-patient basis.

20 **The Protections that Legal Frameworks Afford to the Patient.** The Mental Health Act (1983) should not be seen as a punitive and restrictive option for the older adult with advanced dementia. Instead it should be seen as the framework under which individuals are protected and their rights upheld.

21 **The Importance of the Independent Mental Capacity Advocate (IMCA).** Under the Mental Capacity Act (2005) all patients have the right to access an IMCA. This is important when complex and difficult decisions have to be made in the patient's best interests as an independent advocate should always be accessed to ensure they are maintained and protected. When there are disputes between family members and the treating team the input from an IMCA is essential to ensure the patient's needs are paramount and that they are addressed in the best manner possible.

22 **The use of Legislative Frameworks.** Even if families are engaged in full, when difficult decisions have to be made in relation to care and treatment risk versus benefit analyses, Do Not Attempt Resuscitation (DNAR), end of life care and any planned changes to a clinical placement an Independent Mental Capacity Advocate should be involved where the patient is deemed not to have the capacity to make decisions on their own behalf.

23 **Accident and Emergency Departments and Medical Wards.** When elderly confused people are admitted to these kinds of NHS facilities the requirements of the MHA (1983) and MCA (2005) cannot be 'suspended'. They apply equally to all care and treatment environments where a patient meets the threshold for assessment and intervention under the Acts. All treatment decisions need to be recorded clearly and any issues in relation to capacity, consent and DoLS should be made explicit and managed in keeping with Acts. The failure to do so could result in illegal detention and the potential for improper care and treatment interventions.

Medication and Treatment

24 **Psychotropic Medications – Documentation and Standardised Evaluation Processes.** Psychotropic medications carry an inherent degree of risk. It is always good practice to adhere to National Institute for Health and Care Excellence (NICE) guidance and to ensure that documentation is completed in a systematic manner. This will ensure a comprehensive record is made of all decisions taken and will assist with a logical and evidence-based evaluation process. Where there are no pre-set organisational standards or clear levels of expectation clinical practice is determined by individual practitioners and might not always be optimal.

25 **Risk Assessment.** Risk assessment is a key cornerstone of clinical practice. As such it should be prioritised and conducted as a core multidisciplinary function. All aspects of clinical risk should be recorded and subsequent care plans documented clearly so that explicit rationales for clinical decision taking are set out and patients are protected.

Efficacy of the Care Pathway

26 **Resourcing.** Patients who are acutely unwell and in crisis require the highest levels of expertise and resource. It is poor practice for financial pressures to remove essential services from wards like Tawel Fan (such as occupational therapy and routine physiotherapy). The quality of the patient experience is reduced, the quality of the care and treatment compromised and the length of stay potentially lengthened. This kind of cost saving is both counter productive and ineffective. Care and treatment approaches should be multidisciplinary in nature. The older adult suffering from dementia often has a range of comorbidities and needs. It is naïve to assume these can be met by a 'traditional' doctor and nurse treating team.

27 **Transitions between Secondary and Primary Care.** The transition point between secondary care and primary care ought to be examined. Arrangements need to be agreed in relation to specialist assessment, monitoring and review once a person has been discharged back to the care of their General Practitioner. This is to ensure that antipsychotic medication is not used as a 'maintenance medication' and that all benefits and risk are kept under regular review.

28 **Access to Medical Assessment.** Psychiatric inpatients should not experience lower levels of medical assessment access than those to be expected in a community setting.

29 **Management of the Elderly Confused Patient in Acute Secondary Care.** Accident and Emergency Departments and Medical Wards must ensure that the care and treatment provided to elderly confused patients is person-centred, dignified and safe. It is not acceptable for them to be left for hours without food and drink, nursed in corridors, or left unsupervised encountering numerous falls that could be prevented with better assessment and management plans.

30 **Strategic Planning and Multiple Moves.** Service provision should be as integrated and person-centred as possible so that patients can experience smooth transitions of care which ensure optimal clinical outcomes and inspire trust and confidence. It is not acceptable for patient care to be compromised by rigid boundaries between services. It has long been recognised that multiple inpatient moves have been associated with raised rates of morbidity and mortality. It is never acceptable for multiple moves to be conducted to meet the needs of the service as opposed to the needs of the patient.

31 **Risk Assessment and Service Modernisation.** Service improvement and modernisation requires financial and service re-modelling. Improvements that require the concurrent running down of one service whilst another is built up carries inherent risks over the period required to enact the change; wards like Tawel Fan can be expected to absorb the pressures. The risks to the system and its ability to manage extant patient services should be understood and compensated for, particularly when specific groups of patients can be readily identified to be placed at additional risk during change management processes.

Safeguarding

32 **Connectivity between Multi-agency Partners.** Safeguarding frameworks require a consistent and unified approach. Despite the challenges posed by geographies (such as county and statutory agency boundaries) systems and processes have to be robust enough to provide person-centred safety measures. The Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (first version 2010 and second version 2013) required small Unitary and Local Authorities to work together to ensure consistency and safety across geographical areas; it also required full cooperation between the NHS and Social Services. It is an essential lesson for learning that safeguarding systems and processes have to be managed across boundaries if they are to achieve their primary goal to safeguard adults at risk.

33 **Prioritisation and Adequate Resourcing.** Safeguarding adults at risk cannot be compromised by an organisation's perceived inability to adequately resource the systems and processes required. All NHS and Local Authority bodies are required to conduct themselves in accordance with policy guidance and any capacity and/or capability shortfalls should be addressed and managed so that their statutory duties can be fulfilled.

5 Overview of Conclusions and Recommendations

Overview of Conclusions

General Conclusions

5.1 The findings and conclusions in relation to BCUHB governance and systems failures have been identified previously by multiple review processes which have already been placed in the public domain. If an organisation operates with inadequate governance arrangements then the likelihood of poor service provision is heightened together with an increased inability to identify and remedy failings and patient safety problems. The findings and conclusions of this particular Investigation concur with those previous findings but also makes a separate and distinct contribution in relation to the following:

- the patient care pathway and service design;
- patient acuity and restrictions to service provision;
- evidence-based practice and the care and treatment of the older adult.

5.2 Any investigation process that undertakes an examination of care and treatment that took place a number of years ago has to differentiate between findings and conclusions that are 'historic' in nature and where practice has moved on and improved, and those where practice remains of a suboptimal nature and where urgent remedial action is required in the here and now.

5.3 The three points listed above have been identified by the Investigation Panel as being the basic underlying factors that made a distinct contribution to suboptimal care and treatment provision in the past and which the available evidence suggests are either still unresolved or in a relatively embryonic stage of service improvement and implementation.

The Patient Care Pathway and Service Design

5.4 One of the most significant findings of this Investigation is in relation to the fragmented care pathway followed by the majority of the patients in the Investigation Cohort; most of the patients in the Investigation Cohort experienced problems with the care pathway that they were placed on. Service interfaces between the disparate BCUHB Clinical Programme Groups (CPGs), such as those for medicine and psychiatry, often served to create significant boundaries which had a negative impact upon patients and the timely access to the care and treatment that they required.

5.5 Older adults are placed at significant risk when care pathways are not managed well. Disruptions to care pathways are known to increase the likelihood of hospital acquired infections and injuries and, on occasions, death. The poor management of the older person's care pathway across north Wales is a key finding of this Investigation. The lack of strategic direction and oversight,

combined with significant financial restrictions, meant that each separate CPG within BCUHB was allowed to develop levels of service provision without any interconnectivity in play. This led to a set of systems that functioned independently of each other and which could not address the day-to-day challenges posed by patients moving between services to the detriment of their health, safety and wellbeing.

5.6 There has been insufficient evidence provided to the Investigation Panel to suggest that in practical terms the experience of a patient would be significantly different today in comparison to that of patients from the Investigation Cohort. This is an area that requires priority and urgent action.

Patient Acuity and Restrictions to Service Provision

5.7 The Investigation Panel established that patient acuity rose on Tawel Fan in the years prior to its closure due to:

- the reduction of care home beds;
- a relatively embryonic community-based Home Treatment Team that could not manage patients in their own homes once they had reached crisis;
- reductions to the numbers of older adult inpatient beds across the Mental Health and Learning Disability CPG.

5.8 This situation was exacerbated by additional pressures placed on mental health services by Emergency Departments, inadequate Out of Hours provision and restricted access to medical and hospice services.

5.9 It is recognised widely in Wales that the number of people with dementia is rising steadily and will continue to rise. Pressures on nursing home beds remain and there is evidence to suggest that community-based services remain under-developed and that older people with dementia still experience compromises in relation to the kinds of service they can be offered in community, primary and secondary care settings.

5.10 The challenges for BCUHB and its multi-agency partners in 2018 is to provide a range of services that do not discriminate against those individuals with dementia and to ensure that a diagnosis of dementia is not one of exclusion or compromise.

Evidence-Based Practice and the Care and Treatment of the Older Adult

5.11 During the period of time under investigation BCUHB did not provide evidence-based clinical policies that pertained to the particular needs of the older adult with dementia and/or mental health problems. The needs of the older adult were subsumed into those for adults of working age which was entirely inappropriate. This lack of evidence-based guidance exacerbated fractures in service provision and led to a high degree of confusion on the part of the treating teams responsible for providing care and treatment.

5.12 Of particular concern was the fact that clinical practice was not subject to audit in the manner prescribed within the United Kingdom for the past twenty years. This meant that clinicians were left largely to 'their own devices' and that there were no structured clinical governance structures in place to ensure patient safety.

5.13 The Investigation Panel heard evidence from many senior clinicians during the course of its work. From the testimonies provided by those witnesses it would appear that the custom and practice around the development and auditing of clinical practice guidance within BCUHB is still in a somewhat embryonic stage. Witnesses described the work as 'being part of a journey', or 'not yet having reached its destination'. This is not acceptable for a modern NHS service and will require urgent and priority actions to take place.

5.14 Part of the challenge that BCUHB needs to face is the underlying culture of resistance to clinical policy uniformity and regulation. The Investigation Panel established that a key barrier to progress being made is predominantly one of custom and practice and that there are views still retained by some senior clinicians within the organisation that the clinical decision-making process should not be overseen by formal governance and management structures. This is exacerbated by a lack of organisational confidence and ethos in relation to formal oversight and performance management as a legacy of the highly devolved and medically-led service model that prevailed for many years within BCUHB.

The Issue of Wilful and Institutional Abuse and Neglect

5.15 The nature and scale of any failures in relation to patient care on Tawel Fan ward cannot be compared to those of the Stafford Public Inquiry or the Trusted to Care Independent Investigation (conducted in Wales), on either a macro (system) or micro (individual patient) level.

5.16 Neither of those robust and universally accepted reports set their findings within the context of institutional abuse or concluded that care and treatment deficits occurred within the context of an abusive system (even though care and treatment fell well below those standards commonly accepted by the general public and statutory services alike). The Investigation Panel concludes that this approach has to be maintained in relation to the circumstances encountered by patients and their families on Tawel Fan ward, especially as the standards of care on the ward have been found to be of a good overall general standard, even though on occasions care and treatment practice across the pathway was compromised.

5.17 The Investigation Panel could not replicate the specific findings of abuse from any of the earlier investigations and reviews that did. This does not mean that the Investigation Panel can categorically state that abuse on an individual patient basis *never* took place on Tawel Fan ward; no investigation of this kind could ever make such a bold statement. However the Investigation Panel can, and does, conclude that the evidence relied upon previously was:

- incomplete; and/or
- misinterpreted; and/or
- taken out of context; and/or
- based on inaccurate (and at times misleading) information; and/or
- misunderstood with thresholds being applied incorrectly.

5.18 The Investigation Panel therefore concludes that there is no evidence to support prior allegations that patients suffered from deliberate abuse or wilful neglect or that the system failed to deliver care and treatment in a manner that could be determined to meet the thresholds for institutional abuse.

5.19 It is essential that this conclusion is made in the clearest and most unambiguous of terms in order to restore public confidence and to ensure natural justice is served.

Safeguarding

5.20 Adult safeguarding frameworks exist purely to provide protection for adults at risk of abuse and neglect; they work at two levels. First: at a multi-agency Local Authorities are the lead agencies and are tasked to bring statutory and other agencies together to co-ordinate the development of effective policies and procedures to protect those at risk. Second: at a single agency level, each organisation must develop its own set of procedures that meet the requirements of the multi-agency framework and legislation, and deliver adult safeguarding services to protect adults at risk of abuse or neglect.

5.21 This Investigation found that the systems and processes in place during the period under investigation were not operating in an optimal manner and the expectations and requirements of the multi-agency policy documentation of the time were not met in full. At a multi-agency level, whilst the six Local Authorities endeavoured to bring agencies together around adult safeguarding for their areas, there is no doubt that the formation of the large Health Board in 2009 disrupted the pre-existing relationships that had developed over the years between local health and social care agencies.

5.22 Each of the Local Authorities developed their own approach to adult safeguarding under the umbrella of the *Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse (2010 and 2013).* Each developed their own safeguarding referral paperwork and it was reported to the Investigation Panel that there were differing referral thresholds in place. Systems and processes did not allow easy tracking of safeguarding information. Referrals were made by name and home address and did not monitor the place of abuse thereby making it difficult for Local Authority safeguarding staff to spot trends from particular clinical areas. In addition, individuals at this time were moving across both agency and geographic boundaries due to closures of care beds. It appears that safeguarding information did not readily follow individuals at risk across geographical boundaries and this built risk into the system.

5.23 These arrangements made it very difficult for clinical staff in the ward areas to navigate the adult safeguarding system easily. There were delays in the process of safeguarding, which often moved outside of the timescales in the policy, and ward staff who were responsible for the protection of the individual whilst they were in their care, often did not receive feedback in terms of what had been decided within the safeguarding meetings rendering ongoing protection and decisions regarding discharge, difficult.

5.24 During the period of time under Investigation there were poor safeguarding record storage and retrieval processes. This resulted in staff being unclear about what protection processes they were supposed to be putting in place and how to best deal with relatives when they were considered to be a risk to the individual in their care. As a result, information to individuals, families and carers was not conveyed clearly which led to confused expectations and understanding of what was happening.

5.25 In relation to BCUHB processes, the Investigation Panel found that adult safeguarding had not been well resourced and each CPG had been allowed to develop its own processes and structures. In addition, Board oversight was not strong and the Executive and Independent Members were not advised clearly of the problems relating to adult safeguarding in either the multi-agency partnership or specific clinical areas. Audit systems during this period of time were rudimentary, so opportunities for BCUHB to triangulate data about safeguarding referrals were lost.

5.26 At the time of writing this report there was evidence to suggest that good foundation work is taking place in relation to the restructuring and resourcing of the internal BCUHB safeguarding frameworks and processes. However a substantial amount of service development is still required in order to ensure safeguarding works to protect adults at risk across north Wales as many of the issues identified by the Investigation Panel are still a problem within current service provision. The Investigation Panel concludes that this constitutes essential and priority work for the organisation and those responsible for its performance management moving forward.

Summary of General Conclusions Specific to Clinical Care and Treatment

5.27 Many of the findings and conclusions made specifically in relation to Tawel Fan are to a large extent redundant as the ward is now closed. However there are key issues that have been identified in relation to clinical practice that need to be highlighted as they are relevant to the care and treatment of the older adult and/or those with dementia regardless of clinical setting.

5.28 Many of the findings of the 2014 *Trusted to Care* report dovetail into those of this Investigation. Basically the needs of the older adult and those with dementia require specialist nursing and medical care and treatment. Older adult services should not be seen as ‘Cinderella’ services but should be recognised as priority services that require clinical staff with expert skills and access to specialist

training. Resources should be ring-fenced to ensure that neither old age nor dementia exclude any individual from accessing appropriate and timely care and treatment.

5.29 During the period under investigation older adult and dementia services were neither planned nor coordinated with the degree of organisational strategic oversight that was required. This not only made an impact upon the quality of the care pathway patients and their families encountered, but also made a direct impact upon the effectiveness of the care and treatment that they received.

5.30 It is of significance that during the period of time under investigation there were no older adult or mental health clinical specialists at Board level or within the senior corporate team. Inspections, strategy and assurance processes were overseen by those with limited expertise and a limited understanding of what evidence-based service provision and care and treatment should look like.

5.31 At the present time significant work has taken place to make services more aware of the needs of the older adult and those with dementia. However the approach taken remains rather *ad hoc* with separate clinical divisions approaching these issues differently. The work currently being undertaken is primarily being led by the mental health division and BCUHB needs to move away from the stance that dementia is primarily the concern of mental health services and embrace a different ethos where the Health Board accepts the care and treatment challenges of old age and of dementia embrace all health and social care provision in all care and treatment settings. However one very positive step has been the decision to appoint a dedicated dementia specialist into the corporate nursing team to ensure that in future a more integrated approach is taken; in this manner resources are beginning to be aligned to support pace and consistency.

5.32 Moving forward BCUHB needs to ensure all aspects of clinical governance come together to ensure the particular needs of the older adult and those with dementia are met. This needs to include workforce capacity and capability, education and training, clinical audit and evidence-based practice guidance, patient safety and safeguarding. Alongside this costed and timed strategic plans need to be developed spanning the entire of breadth of service provision to ensure the needs of the older adult and those with dementia are inbuilt into every service and care and treatment context. The work that needs to be undertaken *must* be built across all executive teams and clinical divisions to ensure full integration and a unified strategic ethos.

Recommendations

Overview

5.33 The setting of recommendations is a primary task for any investigation process. In the case of BCUHB the situation is complex in that the organisation is currently subject to action plans stemming from various other investigation, review and performance management processes; it should also be taken into account that at the time of writing this report the organisation was still subject to

Special Measures. Not all of these issues are related directly to Tawel Fan ward or older peoples' mental health services, but many share a degree of interconnectivity.

5.34 The Investigation Panel has not been privy to all of the outstanding issues or the levels of progress made by BCUHB to-date. To this end the recommendations fall into two distinct categories – the first requiring a concerted degree of oversight (and possible further development) from Welsh Government in relation to ongoing high-level performance issues, and the second requiring practical, operational service change within BCUHB requiring a less intensive level of oversight from external bodies.

5.35 In addition BCUHB will soon be in receipt of the Ockenden Governance Review. This review will provide a significant number of recommendations in relation to governance systems, structures and processes. Consequently this Investigation has limited the setting of its recommendations to strategic and specific clinical practice issues. Following the publication of the Ockenden Governance Review further work will need to be undertaken to provide synergy in relation to action planning and the recommendations from both of the separate investigative and review processes.

5.36 On reviewing the progress made by BCUHB in relation to many of the current recommendations it is working to, it is evident that moving forward *all* future recommendations need to be overseen with the support of a structured action plan that sets:

- clear milestones, aims and objectives;
- clear performance targets and indicators;
- clear methods of audit and evidence collection, progress review and assurance;
- clear costings and resource implications;
- clear indications of where multi-agency inputs are required;
- clear timeframes and completion dates;
- clear methods of accountability and oversight.

5.37 With this in mind the Investigation Panel has reviewed the progress made by BCUHB in relation to the findings and conclusions of this Investigation. The recommendations have been set with the intention of supporting the work that BCUHB has already embarked upon and to also ensure that future strategic planning incorporates inputs from Welsh Government particularly where multi-agency partners also need to make significant contributions to planning, process and service provision.

5.38 The Investigation Panel has identified that during the period of time under investigation, and into the present day, many BCUHB initiatives have either been confounded or rendered ineffective by a lack of integrated, strategic thinking and planning. The recommendations set out below place emphasis on the importance of joined-up thinking and integrated service planning. The expectation is that all recommendations will be completed within 12 months of the publication of this report.

Category One: High-Level Recommendations Requiring External Oversight and Further Development

The Dementia Care Pathway and Service Design

Progress Made

5.39 BCUHB has developed a series of initiatives to improve the quality of the patient and family experience when accessing services for the older adult with dementia. There is a newly developed 'Care Pathway for Patients Developed with Dementia on Medical Wards'. There is also a 'Carer's Passport' initiative which improves the access and practical support available to carers when visiting their loved ones in clinical settings. This is all good practice.

Progress Required

5.40 It is not the intention of the Investigation Panel to detract from the work that is currently taking place within BCUHB. However the newly developed Care Pathway document focuses solely upon very basic patient and carer support and nursing care standards. The care pathway work and service redesign work that is still required is more complex and strategic in nature.

Recommendation One: Care Pathway and Service Design

- An integrated service review is required to map the needs of the older adult and those with dementia across north Wales. This review needs to involve all stakeholders (from the statutory, independent and voluntary sectors) and those with performance responsibilities. The review should include all care and treatment settings (not just those confined to mental health and older adult services) in order to ensure that all interventions are integrated and that patients, service users and their families do not encounter service barriers that prevent them from receiving access to the care, treatment and support that they need.

- The review outcomes and options should underpin all current and future health and social care strategies across north Wales and be overseen by the appropriate performance management and inspection bodies.

Implementation of the National Wales Dementia Strategy

Progress Made

5.41 BCUHB has made significant progress in relation to many key areas detailed within the Wales Dementia Strategy:

1 The Health Board has a designated Consultant Nurse in Dementia care who provides input at a strategic and clinical level into services.

2 There are currently a wide range of opportunities for patients and families to obtain support through memory services and the third sector (such as the Alzheimer's Society). In addition BCUHB dementia training is now open for

families and carers to participate in. This training has been developed alongside families and carers who have provided evaluation. Across the Health Board there are an increasing number of Nurse Specialists with enhanced skill sets to provide ongoing support to patients with dementia and their families/carers.

3 There is a Delirium and Dementia Specialist Nurse available to provide expertise to individuals and services. There has also been a strong focus on the recruitment of Dementia Support Workers who are working across the organisation together with ten Dementia Activity Workers who are further supporting patients when accessing mental health services.

4 The Flynn and Eley Review highlighted the importance of support for those affected by or living with dementia at or around the point of diagnosis. They recommended that BCUHB develop a standard offer of post diagnostic support for people living with dementia and their families as part of a wider network of support.

Significant progress has been made in respect of this recommendation. Memory services have been redeveloped and mapped to local need so that supportive interventions can be offered in each locality in the language of choice supported by dementia support workers and third sector organisations. In the first year of operating over 700 new patients accepted the offer of meeting with a Dementia Support Worker and from that cohort 54 percent have gone on to receive further input.

5 BCUHB has produced a Dementia Handbook in conjunction with the Alzheimer's Society which is given to patients and their families at the point of diagnosis.

Progress Required

5.42 The Investigation Panel acknowledges the steady progress that BCUHB has made in relation to patient and carer support. However a great deal of work still needs to be done. At present the Dementia Strategy is a high-level document that will require further detailed action planning if it is to be implemented in a consistent and sustainable manner. The progress already made (as listed above), together with the progress still needing to be made, should be subsumed into a distinct strategy implementation programme which is supported by a costed and timed action plan.

Recommendation Two: Dementia Strategy

- BCUHB is required to develop a detailed and costed action plan to support the implementation of its Dementia Strategy; the plan should be developed in partnership with the Regional Partnership Board response to the Welsh Government's new Dementia Plan. This work should be undertaken in conjunction with Recommendation One. The action plan should incorporate the consequent implications and requirements for all clinical services (not just the Mental Health Directorate) in all care and treatment settings (community, primary and secondary care).

- The action plan should take into account all of the clinical and practice deficits that have been highlighted by this Investigation and will require independent clinical input and oversight.

- Access to therapy and non-medical interventions and treatments should be an integral part of any costed Dementia Strategy plan which takes into account NICE (and all other) best practice guidance in this regard. The capacity and capability of the workforce should be reviewed to ensure that fit for purpose services can be provided. Implementation should be managed and audited in tandem with Recommendation Ten (see below) as the reduction of the use of antipsychotic medication will to a large extent be predicated upon alternative therapeutic interventions being made available.

- Formal audit and performance management arrangements should be agreed and built into the action plan.

Care Home Provision in North Wales

Progress Made

5.43 BCUHB has been working proactively to support the care home sector. The initiatives that have been put in place include:

1 **Practice Development Team**. This team is responsible for ensuring the delivery of quality, evidence-based and personalised care within the homes. They undertake annual quality monitoring audits utilising an electronic tool that scores the delivery of care associated with Healthcare Standards and the Fundamentals of Care. The team facilitates and delivers training in-house and can arrange for specialist nurse support to provide clinical leadership.

2 **Quality Assurance Framework**. This has been developed to describe and set out quality assurance processes to ensure safe care. This includes holding a monthly clinical management group to proactively discuss each care home with all relevant stakeholders. This helps to gain and collate key intelligence and provides a robust and proactive response in order to support homes as required.

3 **Contracts and Fees**. The Health Board has employed a contracts team. This team works to explicit performance indicators and can work with the Practice Development Team to raise quality and provide practical support directly into any care home experiencing difficulties.

Work is ongoing to ensure the sustainability of the market in conjunction with the need for quality and safe care provision. This work is currently being undertaken with the North Wales Care Home Market Group which incorporates health and Local Authority inputs to sustain access to the market. Membership from this group also works with the National Commissioning Board care home agenda.

4 **Home First**. The Home First Initiative was launched in response to the National Care Home census data undertaken by the National Commissioning Board which identified that BCUHB had a higher percentage of patients in care homes with increased average lengths of stay in comparison to other Health Boards in Wales. This project will reduce the pressure on the care home sector by reducing the demand and thus increasing the bed capacity and availability for those who need such placements.

Progress Required

5.44 The Investigation Panel acknowledges the progress that is being made in this area. Moving forward this progress needs to be audited and any ongoing work programmes need to form part of an integrated process that brings together the BCUHB Mental Health Strategy, the Dementia Strategy and all ongoing service re-design initiatives; particularly those changes and improvements to community support provision.

5.45 A fragile care-home market can impact greatly upon NHS community, primary and secondary care services. Care home provision and quality monitoring needs to be unified into wider strategic action planning as part of an integrated approach to providing timely access to appropriate and good quality services.

Recommendation Three: Care Homes and Service Integration

- The current Care Home work streams need to be incorporated into a single action plan, which in turn should dovetail into the pre-existing BCUHB Mental Health and Dementia Strategies.

Safeguarding

Progress Made

5.46 The BCUHB safeguarding service has been realigned, to incorporate strengthened safeguarding governance, with a focus on prevention and protection. New roles, where team members work across clinical areas in a proactive manner, are being implemented whilst maintaining specialisms. The realigned service incorporates the previously stand-alone services of DoLS, Safeguarding Adults and Children, and Tissue Viability, along with specialised individuals including a Safeguarding Dementia lead.

Progress Required

5.47 At the time of writing this report there were significant areas that still required improvement. However the Investigation Panel acknowledges the fact that BCUHB is aware of the areas that require improvement and is reassured by the levels of increased insight and understanding of its safeguarding responsibilities. BCUHB have identified ongoing issues:

- the current safeguarding training programme is not fit for purpose and requires updating;
- staff are not attending safeguarding training in the numbers required;

- the current database is immature and lacks the ability to triangulate data from IT and reporting databases throughout the organisation;
- the problems with the storage and retrieval of hard copy safeguarding information remains in keeping with the findings of this Investigation;
- there have been difficulties in resourcing the new safeguarding structures in a timely manner;
- governance processes require review in relation to safeguarding policy and process.

Recommendation Four: Safeguarding Training

- BCUHB will revise its safeguarding training programme to ensure it is up-to-date and fit for purpose. The updated-training programme will incorporate all relevant legislation and national guidance.

- BCUHB will engage with all prior safeguarding course attendees to ensure that they are in receipt of the correct and updated guidance. The responsibility for this will be overseen by the relevant BCUHB Executive Director with responsibility placed on all clinical service managers from all of the clinical divisions within the organisation.

- BCUHB has not been able to ensure staff attend safeguarding training sessions in the numbers required. There are multiple factors involved which will require a detailed and timed action plan with external oversight.

Recommendation Five: Safeguarding Informatics and Documentation

- BCUHB has conducted an audit on the compliance of filing safeguarding information in patients' case notes. BCUHB will ensure that the consequent recommendations it set in relation to informatics in its BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018 are implemented – namely:

  - the use of the dividers to be re-iterated in safeguarding training, briefings, and other communication activities and a key annual audit activity;
  - process of secure storage of strategy minutes of strategy meetings and outcomes of referrals to be revisited at safeguarding forums with legislative guidance from Information Governance;
  - team and ward managers to continue to include safeguarding documentation in team meetings and safety briefs.

- In addition BCUHB will reconsider how clinical teams should record safeguarding information and the quality of the information provided. This to include specific guidance on:

  - the content of protection plans;
  - the recording of strategy meetings and all decisions taken (guidance should require a standardised approach across all BCUHB clinical divisions);
  - formal monitoring and review templates should be developed and audited to ensure safeguarding timescales are met and those with key responsibilities in this regard held to account.

- BCUHB will repeat the audit within 12 months of the publication of this report to ensure that all clinical areas are compliant.

Recommendation Six: Safeguarding Policy and Procedure

- The BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018 identified that there were priority actions required in relation to safeguarding policies and procedures. This Investigation recommends that these priority actions are incorporated into the action plan consequent to the publication of this report. The actions are:

  - *"to identify those policies, procedures and SOPs that firmly sit within the Safeguarding remit and those that should be the responsibility with internal and external partners;*
  - *agree a priority list and activity timeframe to review documents within the parameters of Corporate Safeguarding;*
  - *provide safeguarding expert advice to internal and external partners in order that those documents are reviewed appropriately and in line with local and national policy and legislative safeguarding frameworks;*
  - *agree a governance structure and reporting framework for all safeguarding policies, procedures and SOPs;*
  - *update and maintain the Safeguarding Policy webpage;*
  - *continue to actively participate in the Policy and Procedure sub group of the Regional Safeguarding Boards".*

Recommendation Seven: The Tracking of Adults at Risk across North Wales

- BCUHB will work with multi-agency partners, through the North Wales Safeguarding Board, to determine and make recommendations regarding the development of local safeguarding systems to track an individual's safeguarding history as they move through health and social care services across North Wales in order to ensure ongoing continuity of protection for that individual.

Recommendation Eight: Evaluation of Revised BCUHB Safeguarding Structures

- BCUHB will evaluate the effectiveness of its new safeguarding structure in the fourth quarter of 2018/2019. This will be overseen by Welsh Government.

Category Two: Recommendations Concerning Localised Operational Service Change

Informatics and Clinical Records

Progress Made

5.48 The Investigation Panel is aware of the initiatives currently in train to introduce an electronic clinical records system within BCUHB. This work is to be encouraged for the future.

Progress Required

5.49 The issues in relation to the extant hard-copy clinical records and the systems currently in place to store and retrieve them remain a problem that requires priority action in the here and now. The Investigation Panel noted that around 50 percent of the clinical records that it had access to were commingled one patient with another. The Investigation Panel also noted that BCUHB found it difficult to compile complete sets of clinical records; whilst the majority of the patients in the Investigation were deceased, approximately 30 percent of the patients were still living at the beginning of the investigative process. It is of concern that BCUHB could not access complete sets of clinical information for a cohort of living patients and calls into question BCUHB's ability to ensure clinical information is accessible when needed in the interests of continuity of care and patient safety.

Recommendation Nine: Clinical Records

- BCUHB needs to undertake a detailed check of the clinical records in the investigation cohort to evaluate and re-order all commingled casenotes.
- BCUHB needs to ensure that none of the commingling involving living patients could have led to any inappropriate acts or omissions on the part of clinical treatment teams during any episode of care (past and present).
- BCUHB needs to restructure and redesign its hard copy clinical records archiving and retrieval systems. This redesign needs to provide assurance in relation to the tracking of individual casenotes across north Wales together with a set of service level agreements pinpointing the timeframes required for clinical record retrieval and access.

Medications Management and the Use and Monitoring of Antipsychotic Medications

Progress Made

5.50 Internal BCUHB audits concur with the general findings and conclusions of this Investigation in relation to the use of antipsychotic medication in community and primary care settings. BCUHB provided the following information:

"A pilot project was carried out in 2012 where consultants and GPs shared a 3 monthly review of antipsychotic treatment which led to an improvement in the rate of review and reduction in prescribing. However this was not sustainable and it was concluded that this review was better carried out by nursing or pharmacy staff. An aide memoire was developed and the study presented at numerous collaborative events in 2012 and 2013 and to Care Forum Wales.

Prescribing guidance was agreed within the MHLD Division in 2015 and Aide Memoire sent round to GPs as well as several visits to increase awareness.

The baseline audit from GPs across BCUHB was carried out during 2017 in order to establish the extent of prescribing. The results showed about 10% people with dementia prescribed an antipsychotic in Central, 11% in the west and 18% in the East.

The audit recorded whether a medication review had been carried out in the last 6 months. The majority of the people with dementia had a general medication review documented as part of the care home enhanced service or dementia review. Any patients who required further clarification on the need for antipsychotic could be referred to the MH specialist team.

An audit of antipsychotic prescribing in 2015 and again in 2017 in secondary care demonstrated that although prescribing was deemed appropriate in many cases based on target symptoms, there was lack of documented risk assessment and discussion with the carer / patient or ongoing management plans.

As a result the 2015 guideline has been updated and a proforma developed to aid documentation of antipsychotic prescribing and review. Prescribers were asked to pilot this proforma in 2017 and work is ongoing to raise awareness of the importance of including a clear indication and duration for antipsychotic treatment in older people and the need for ongoing monitoring. A training needs analysis and implementation plan will be incorporated into the guidance.

Current Situation

The updated guidance is currently in consultation and reflects the need for greater collaboration and communication across care settings to ensure that patients are reviewed after being discharged to the GP. The review should be undertaken in collaboration with the carer(s). If the GP/practice staff are unable to review or have concerns then the patient should be referred to the community mental health team for advice and support.

A Patient Safety Notice has been drafted to highlight the issue of inappropriate continuation of antipsychotics as the issue extends beyond mental health and into the general hospital where people may be started on antipsychotics for delirium. It is therefore felt that the Patient Safety group should oversee the process of ensuring that people with dementia prescribed an antipsychotic have a documented risk assessment, indication and review date.

Work has been ongoing to raise awareness of this issue and this year a baseline was obtained in primary care which has helped highlight outlying practices who may require support to review their patients. This support has been provided by a limited resource of mental health pharmacists, as well as the mental health community teams.

Ongoing audits in primary and secondary care, and education will be carried out until the process of prescribing review is embedded in practice across primary and secondary care.

Clinicians in both primary and secondary care will be continually reminded to ensure that they follow national and local recommendations to review and reduce antipsychotics medication where appropriate. There may be situations where ongoing use is justified and this must be clearly documented.

Given that antipsychotic medication is used in those who may have lost a care home placement on account of challenging behaviours, there is still considerable work to be done to train carers in managing challenging behaviours without using medication in order to allow the gradual reduction and stop without the fear of re-escalation of behaviours and subsequent failure of placement".

Progress Required

5.51 The Investigation Panel supports in full the very comprehensive work that BCUHB has conducted in relation to the prescribing and monitoring of antipsychotic medication. It is evident that work is ongoing and the following recommendation is set in order to support further the remaining actions that require completion.

Recommendation Ten: The Prescribing and Monitoring of Antipsychotic Medication

- The updated BCUHB 2017 antipsychotic prescribing guidance will be kept under review and be subject to a full audit within a 12 month period of the publication of this report.

- BCUHB will continue to work with care homes across north Wales to provide practical clinical advice, guidance and training so that residents with behaviours that challenge can be supported and kept safe with the minimal amount of antipsychotic medication possible. The effectiveness of this should be built into the antipsychotic prescribing guidance audit detailed in the bullet point directly above.

Evidence-Based Practice and Clinical Guidelines

Progress Made and Still Required

5.52 BCUHB has not been able to provide any progress update in relation to governance processes regarding evidence-based practice and clinical guidelines. It is evident from the information provided to the Investigation Panel that the processes underpinning the development and monitoring of clinical policies and procedures within BCUHB is inconsistent and on occasions clinical staff do not have access to the most up-to-date best practice guidance. The amount of work that needs to be undertaken is significant and will require a detailed risk assessment and focused and timed action plan.

Recommendation Eleven: Evidence-Based Practice

- BCUHB will conduct a review of all clinical policies to determine the ratification processes that were conducted together with an assessment of the appropriateness of content and currency; this will include all hard copy policy documentation still retained in clinical areas, and all electronic documentation held currently on the BCUHB intranet. As part of this work:
  - A risk assessment should be conducted to prioritise the work that needs to be undertaken and to establish whether there are any urgent policy revisions and alerts required to ensure patient safety is maintained.
  - Work should be undertaken to review the extant clinical policies across the three BCUHB geographical regions to determine corporate ratification and fitness for purpose.
  - All clinical policies should be reviewed with the specific needs of the older adult in mind. Policies should either be re-written to ensure that the evidence-base in relation to the older adult and/or those with dementia is specified in detail, or separate clinical policies and procedures should be developed for this particular patient cohort. This work should be conducted with expert multidisciplinary inputs.

Legislative Frameworks: Deprivation of Liberty Safeguards (DoLS)

Progress Made

5.53 The 'BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018' sets out a robust overview of current practice together with the work that BCUHB is still required to achieve.

Progress Required

5.54 The BCUHB Annual Report sets out a work plan which at the time of writing this report was close to completion. The work plan includes:

- *"Review DoLS Policy, Procedures and Guidance in consultation with other partners in Wales i.e.; Health Boards, Local Authorities, Healthcare Inspectorate Wales and Welsh Government to identify priority changes, plans and actions.*
- *Consult with the Professional Advisory Group implementation of a recently devised draft "Gold Standard" DoLS Application Form to improve quality and practice within all clinical areas.*
- *Reporting DoLS and MCA issues and activity across Corporate Safeguarding Areas to raise awareness and implications for practice.*
- *To review the role, responsibilities and functions of the signatories within the Supervisory Body to ensure it is fully compliant to governance expectations and continues to be fit for purpose.*
- *To review the current arrangements for recording DoLS data so it is more streamlined and fit for purpose in monitoring and reporting annually to HIW.*
- *A barrier to full integration of this provision within clinical areas is the lack of office accommodation on acute and community sites".*

Recommendation Twelve: DoLS

- BCUHB will conduct a formal audit and provide a progress report in relation to the 2017-2018 action plan. This will include a review of any barriers to implementation (such as office accommodation) together with a timed and resourced action plan to ensure full implementation can be taken forward in 2018 – 2019.

The Management of Aggression in the Elderly

Progress Made

5.55 The BCUHB 'Assurance Report – Older Peoples' Mental Health Service December 2017' states that:

"In May 2015, the National Institute for Health and Care Excellence published 'NG10', their latest guidelines relating to the management of aggression and violence in health care settings. Until this release, the vast majority of health providers in the UK were implementing reactive strategies to manage incidence of violence and as a consequence there has been a national drive to move away from the reactive paradigm towards a proactive approach which is emphasised in the guidelines".

5.56 Since this time BCUHB has stressed the need for providing the least restrictive procedures possible when managing patients who are exhibiting aggressive behaviours. BCUHB has taken part in a benchmarking exercise with other services in Wales. The Mental Health Division has:

"In response to the changing needs of OPMH [Older Peoples' Mental Health] services, the division has reviewed Restrictive Physical Intervention (RPI) training to ensure that practices taught are commensurate with the needs of our older population. All OPMH clinical personnel undergo a comprehensive five day training package and are assessed for competency prior to certification. Training meets the requirements of the current 'All Wales Passport Scheme' and compliance rates are monitored and reported through governance structures".

Progress Required

5.57 The Investigation Panel acknowledges the progress made by BCUHB in relation to reducing restrictive practices in older peoples' mental health services. The evidence provided suggests that safe and current best practice guidance is being implemented. However there needs to be an assurance that all care and treatment settings within BCUHB (Emergency Departments, medical wards etc.) are working to the same policies and procedures and that all staff involved with restrictive practice incidents are trained to the appropriate standard and that all incidents are recorded and form part of the BCUHB organisational learning cycle.

Recommendation Thirteen: Restrictive Practice Guidance

- BCUHB will provide assurance that all older adults and those with dementia are in receipt of lawful and safe interventions in relation to restrictive practice management across all care and treatment settings within the BCUHB provision. BCUHB will also ensure that the *Royal College of Psychiatrists' Centre for Quality Improvement (March 2007) National Audit for Violence: Standards for In-patient Mental Health Services* guidance is embedded in all training and policy documentation in relation to 'taking dementia patients to the floor' during restrictive interventions.

End of Life Care

Progress Made

5.58 The BCUHB 'Assurance Report – Older Peoples' Mental Health (OPMH) Service December 2017' states that:

- *"Through 2018 Memory Service staff will have the skills and knowledge to hold accurate and sensitive conversations about End of Life preferences.*
- *OPMH link staff supported by specialist hospice nurses and palliative care nurses will assure dignified End of Life care on in-patient wards".*

5.59 The Assurance Report states that *"innovations involving all memory services and OPMH in-patient wards. Memory services are opening the conversation about advance directives with people newly diagnosed with dementia. Such is the sensitivity of this that staff are still undergoing training from specialist hospice nurses".*

Progress Required

5.60 Dementia is a life-limiting condition. Of some concern is the prevailing BCUHB stance that end of life care can be provided appropriately on Older Peoples' Mental Health wards. The rationale provided by BCUHB is that this is to prevent any unnecessary distress caused by a transfer to another care setting.

5.61 The Investigation Panel acknowledges that many families and their loved ones experienced a good standard of end of life care on Tawel Fan ward (and many continue to do so in other similar environments). However not all families report positive experiences. It remains a fact that acute psychiatric admission wards are not optimal places for end of life care to take place due to the conflicting needs of the patient cohort. Of concern would be the retention of patients on acute psychiatric admission wards due to difficulties in finding suitable alternative placements (such as a medical or hospice bed) and/or a lack of timely and suitable transportation. The environment for end of life care has to provide dignified, safe and clinically appropriate care. Regardless of the levels of expert input into care planning from hospice and palliative care staff there will always be circumstances where robust care inputs cannot mitigate against an inappropriate care and treatment setting.

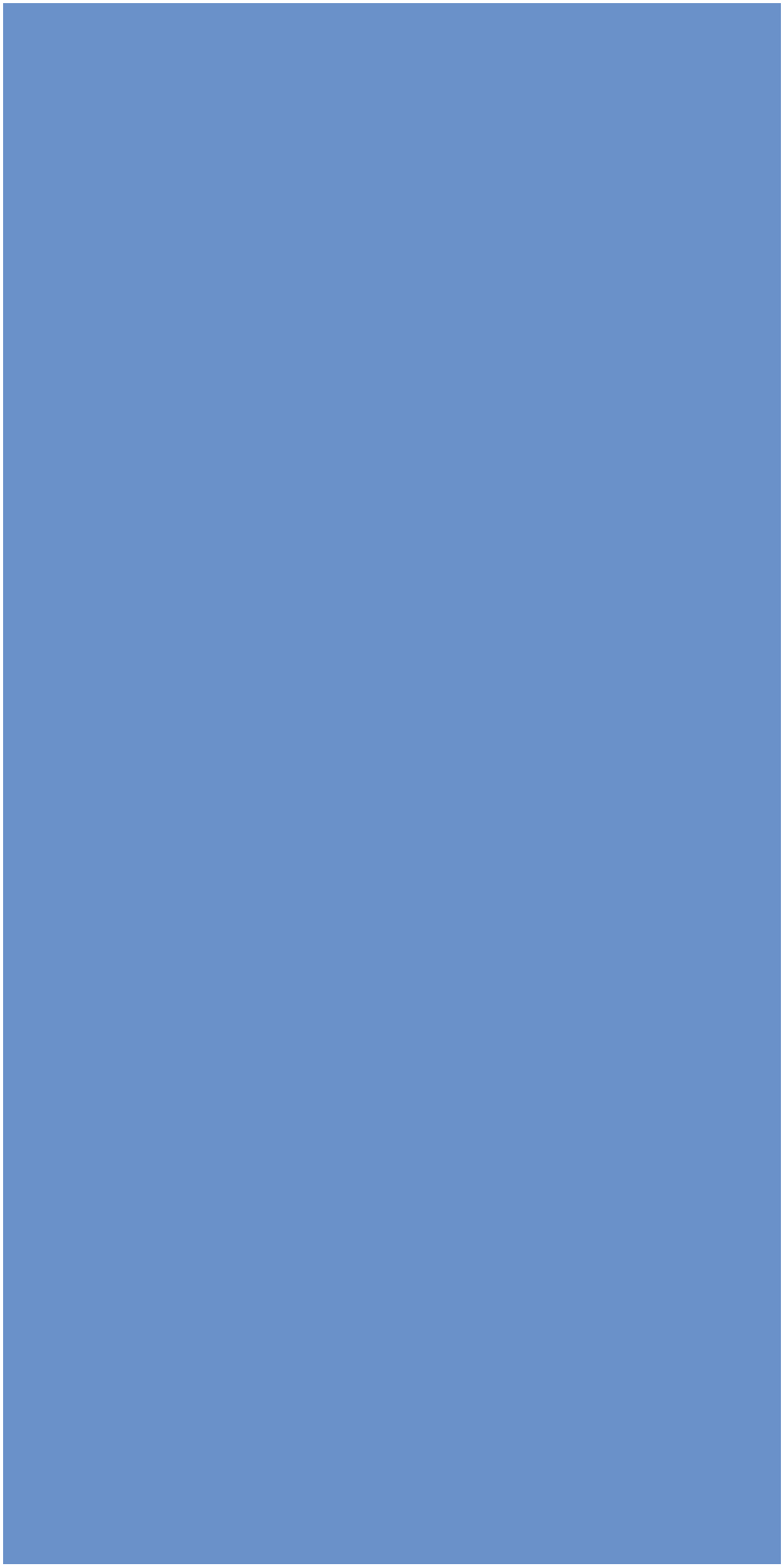
Recommendation Fourteen: Care Advance Directives and Support to Patients and Families

- BCUHB has made significant progress in providing support to patients and families when holding end of life conversations and developing advance directives. This is good practice. BCUHB will conduct an audit to establish how many patients and their families have advance directive documentation within their clinical records together with care plans in relation to choice and preference about end of life care.

Recommendation Fifteen: End of Life Care Environments

- All older adults and people with dementia have the right to the same access to quality end of life care as any other individual (of any age) with any other condition. If a person is to receive end of life care on an older person's mental health ward (and in particular an acute admission ward) the following should always be undertaken:

  - a clinical risk assessment to determine the appropriateness of end of life care being provided in an older people's mental health facility – the risk assessment should take into account the levels of patient acuity and any potential conflicts that could be present;
  - an assurance that out of hours medical cover can be provided if the patient's physical condition requires it;
  - an assurance that equipment can be resourced with the minimum of delay and that patients are never nursed on mattresses on the floor due to a shortage of hi/low beds;
  - an assurance that patients can be supervised appropriately and not left unattended due to other challenges that ward might face;
  - an assessment to confirm patients can be nursed in quiet and peaceful environments and that the ward layout can accommodate this;
  - an incident form should be completed if a patient receives end of life care due to a lack of appropriate alternative placements and difficulties with transport;
  - consultation with relatives who should be able to request the transfer of their loved one to a different clinical setting if they feel a mental health facility is in any way unsafe or inappropriate;
  - the training of all registered nursing staff (including night staff) in end of life and palliative care.



4.4

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Dementia Action Plan Progress report

Dementia Action Plan Progress Report August 2018 - March 2019

Regional Partnership Board

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Action no	Action	Involved bodies
1.1	Ensure that risk reduction messages are included in relevant public health policies and programmes (by September 2018 and annual review).	Welsh Government, Public Health Wales, health boards and third sector.

Actions taken since the baseline report in August

Supporting people living with dementia and their carers was identified as a priority in the regional Population Needs Assessment (PNA) and included in the regional Area Plan required under the Social Services and Wellbeing Act; and local Wellbeing Assessments required under the Wellbeing of Future Generations Act. http://www.gwentrpb.wales/home

Risk reduction messages is a clear priority in the Area Plan and the regional Dementia Board have developed a Dementia Action Plan (DAP) that sets out key actions in relation to risk reduction messages. Delivery is supported by a Good Work sub group under the Dementia Board and a developed set of learning and development principles linked to Good Work strategy. There is a focus on the need to promote public health information as part of every contact with people living with dementia and carers. The Good Work principles will assist staff in disseminating appropriate public health information regarding dementia prevention, and staying well; and Memory Assessment Services and Dementia Support Workers through Alzheimer's Society provide health lifestyle information 'what is good for the heart, is good for the brain'.

Relevant milestones in the next 6 months

To further implement and consolidate key messages as part of Good Work roll out
Continue to promote to all partners the need to include in their policies

RAG rating – *insert RAG rating*

GREEN – ongoing with no concerns		

Additional comments (inc risks to delivery)

Displaying public health information is a crowded landscape, especially in GP waiting rooms with competition to display information – 6 steps would benefit from a national campaign.

Action no	Action	Involved bodies
1.2	Promote action across the six steps to support people to change behaviours and reduce their risk of dementia (by September 2018 and annual review)	Welsh Government, Public Health Wales, health boards (and third sector).

Actions taken since the baseline report in August

The Dementia Board, which includes 3rd sector partners, has been publicising risk reduction messages through its dementia work programme. This involves development of dementia information on linked websites and via newsletters. Events were held during Dementia Awareness Week (DAW) 2018 and will be repeated during DAW 2019. A regional Dementia Roadmap website (developed by the Royal College of General Practitioners in England and adapted for the region) has been commissioned. https://wales.dementiaroadmap.info/ '6 steps' and public health advice appears on the front page alongside a postcode social database.

We have been developing greater links between Dementia Roadmap website and national DEWIS website including key actions

- Distribute '6 Steps to Reduce your Risk of Dementia' to all partners.
- Ensure information is hosted on all partners' websites
- Manage Dementia Roadmap website and monitoring number of hits on website

Relevant milestones in the next 6 months

The 6 steps are included on partner's website and will be reviewed and refreshed as part of Dementia Action Week, and a wider public campaign. The Dementia Board DAP sets out actions for local and regional delivery and we are still progressing the actions below

- Workshops that develop staff skillsets to access, use and promote appropriate information across the dementia pathway as part of Good Work roll out
- Setting out actions for more consistent use of information by staff who work across the dementia pathway or with roles interacting with the public in key settings e.g. libraries, health and local authority settings. Utilising the Public Health approach of 'Make Every Contact Count' for information provision to ensure all staff are confident in disseminated the 6 steps.
- Equipping staff to disseminate dementia public health messages and information is planned via multi agency co-productive education workshops for non-front line staff and staff involved across dementia pathways.
- Further development of the regional Dementia Roadmap website through enhanced workforce contributions across the dementia pathway.
- Materials visible in public areas such as GP surgeries and develop accreditation for Dementia Friendly GP surgeries

RAG rating – *insert RAG rating*

	AMBER – In progress – some concerns	

Additional comments (inc risks to delivery)

See above risk – 6 steps would benefit from a national campaign especially during Dementia Action Week.		
Action no	**Action**	**Involved bodies**
1.3	Ensure that people living with dementia receive advice about the changes that they could be supported to make to increase their general health and wellbeing (by September 2018 and annual review)	Health boards and third sector.
Actions taken since the baseline report in August		
The board promotes co-production with people living with dementia and their carers and service users are involved in Dementia Friendly Community groups. As stated above, through Good Work framework, we will highlight the need to disseminate public health messages. The board oversee a third sector contract with Alzheimer's Society in providing support and information following diagnosis through Dementia Support Worker role. We ensure that carers of people living with dementia are engaged through a monthly dementia group. Carers represented include those currently living with someone with dementia and also bereaved of someone with dementia. These carers are involved in the consultation, planning and development of work programmes and have recently reviewed their terms of reference. A national exercise referral scheme pilot running – slowing the progression of dementia – in Monmouthshire for those with a diagnosis of Dementia and following discussion with GPs. The board will also consider and scope how this might be further developed.		
Relevant milestones in the next 6 months		
As highlighted, delivery of the Good Work framework strategy will prioritise the need for practitioners to provide information to people living with dementia on how they can improve their wellbeing, and also link to aforementioned websites. We will also take forward and develop workshops to ensure all staff are confident in disseminating the 6 steps. The Dementia Board will continue to provide governance and scrutinise the third sector contract with Alzheimer's Society DSW contract and ensure relevant information is provided to people within the first year of diagnosis. Cognitive stimulation therapy for advice around how to aid memory in all boroughs: an ICF bid has been submitted in to move this to SLA with third sector to improve consistent delivery. Further scoping of the national exercise referral scheme pilot running in Monmouthshire for those with a diagnosis of Dementia to consider benefits to Mild cognitive impairment.		
RAG rating – *insert RAG rating*		
	AMBER – In progress – some concerns	
Additional comments (inc risks to delivery)		

Information is provided by a number of partners and there is a need to ensure it is consistent and equitable across the region.

Action no	Action	Involved bodies
2.1	Work with the third sector and people with lived experience to increase the number of people in Wales who are able to recognise dementia through expanding initiatives such as dementia friends and dementia supportive communities / organisations (baseline number: September 2017 and six monthly review thereafter)	Welsh Government, public sector and third sector organisations.

Actions taken since the baseline report in August

Across the Gwent region each of the 5 local authority areas have been awarded Dementia Friendly Community (DFC) accreditation from Alzheimer's Society. A DFC implementation group is active in each area, promoted and chaired by elected members and local AM's. Each DFC group has developed a local action plan to increase Dementia Friends awareness, to provide support to communities, businesses' and organisations to achieve Dementia Friendly accreditation and raise awareness of dementia -Businesses, include key areas such as banks and transport.

From April to March 2019

446 Dementia Friends sessions have been organised and **9676 people** have received the awareness with **31 people completing the train the trainer champion session. This is our highest total in one financial year since developing DFC across the region.**

We are continuing to support a number of businesses and organisations to receive Dementia Friendly Community status and will continue going forward.

Relevant milestones in the next 6 months

On-going
Setting targets for dementia friends and champions for Q1 2019/20

- 1000 Dementia Friends
- 50 sessions
- 10 Train the trainers
- 5 organisations to be awarded DFC accreditation

RAG rating – *insert RAG rating*

GREEN – ongoing with no concerns		

Additional comments (inc risks to delivery)

Continue to implement DFC across the region but will require greater resources to manage and coordinate as we go forward – the coordination is only a small part of a number of roles.

Need to develop an effective on line version of Dementia Friends and there has been some delays working with Alzheimer's Society UK.

Due to equity of ward and recruitment of staff there are challenges to release staff within Acute General hospitals to attend Dementia training and awareness sessions.

Action no	Action	Involved bodies
2.2	Work with local communities and third sector organisations to encourage them to open their services so that people with dementia, their families and carers can participate. (April 2019 and annual review)	Local authorities and health boards

Actions taken since the baseline report in August

People living with dementia and their carers contribute to DFC implementation groups. The Dementia Board also includes a carer's sub group for carers of people living with dementia to prioritise the views of carers. Membership of the regional Dementia Board includes links to people with early onset dementia 'Memories in motion' group.

We are actively developing links with businesses and organisations within communities and increasing the number of DFC kite marks awarded to ensure businesses are more supportive and welcoming to people living with dementia. For example we have been working with local banks, building societies and Tesco in the region and will be aiming to support them to achieve their award in the future. https://www.torfaen.gov.uk/en/News/2019/January/17-Pontypool-Nationwide-Building-Society-awarded-Dementia-Friends-status.aspx

Relevant milestones in the next 6 months

We will continue to set targets for dementia friends and champions and number of organisations awarded DFC kite marks.

Continue to work and support local Dementia Cafes and engage with people living with dementia on what is important and to participate in the design of solutions and services.

Pilot project funded with money from the Health board is exploring a support worker role to enable those with Dementia to attend mainstream services as a form of respite for carer as well as activity for service user within Monmouthshire.

Carers cafes about to commence on Dementia wards in partnership with the Carers Trust and Gavo as part of successful ICF bid.

RAG rating – *insert RAG rating*

GREEN – ongoing with no concerns		

Additional comments (inc risks to delivery)

We have supported a number of partners and businesses to be become dementia aware through our DFC kitemark but recognise we are 'scratching the surface' and will need to continue encouraging businesses.

Although we have good evidence of engaging with carers, there are a large number of carers unknown to services and as a Dementia Board we will actively work to ensure we publicise and highlight the role of carers.

Action no	Action	Involved bodies
2.3	Publicise and actively encourage educational settings to use the 'Creating a Dementia friendly Generation' resources developed by the Alzheimer's Society to build intergenerational understanding and awareness (baseline number: September 2017 and annual review thereafter).	Welsh Government, educational settings and Alzheimer's Society

Actions taken since the baseline report in August

The region has been at the forefront of Intergenerational work and has promoted dementia friendly schools – the first school in Wales to be awarded accreditation was St Joseph's RC in Newport and a number of schools have achieved Dementia Friendly Schools status. https://www.caerphilly.gov.uk/News/News-Bulletin/April-2019/Heolddu-Comprehensive-School-receive-Dementia-Frie

https://m.facebook.com/MonmouthshireCC/posts/2335920999775658

A regional Intergenerational strategy has been developed and launched http://www.southwalesargus.co.uk/news/16321900.lifelong-chorister-performs-first-solo-at-92-years-old/

An ICF Dementia enabled project is working with schools across the region to deliver interactive workshops based around the Elephant who forgot book to increase awareness and understanding of dementia in children, developed and delivered by The Parent Network.

Relevant milestones in the next 6 months

The regional dementia action plan will further develop the key actions, review gaps, set area targets and key performance plans including intergenerational activity.

Educational plans linking intergenerational activity to life histories and dementia will be included in the regional actions plan.

We will actively promote links with Welsh Baccalaureate qualification in schools and develop links with local care homes, hospitals and day care settings for pupils to accrue volunteering hours. We will also link this to the ABUHB's Frind I Mi volunteering initiative set up to reduce loneliness and 'twin' local schools with and care homes.

Set targets and Increase Number of schools receiving DF accreditation and increase number of pupils receiving Dementia Friends awareness through a pilot in Newport. There is need for a dedicated and constant resource to develop the necessary school links.

Expanding opportunities for Health and Social care Students to take placements within the Older Adult Mental health Dementia Care wards. i.e as with current placement on Cedar Parc.

RAG rating – *insert RAG rating*

GREEN – ongoing with no concerns		

Additional comments (inc risks to delivery)

There is considerable interest from schools and care homes and moving forward this area may require a dedicated resource.

Action no	Action	Involved bodies
2.4	Ensure all NHS employed staff who come into contact with the public (inc porters, receptionists and medical/support staff) receive an appropriate level of dementia care training (as specified in – 'Good Work – Dementia Learning and Development Framework) (April 2018 and annual review thereafter)	Health Boards

Actions taken since the baseline report in August

An ICF bid was used to develop Good Work in practice and ABUHB staff were seconded for 3 months to break down how Good Work would be taken forward in a hospital, health and social care settings. The learning will be used to identify pilot sites and to develop 'Good Work' wards and other settings. The Good Work framework is core feature of the regional strategic action plan and the development of a regional education strategy. A number of teams, departments and hospitals have received dementia training as well as dementia friend's awareness including kitchen and maintenance staff. Good work is being used within a regional education model developing dementia service awareness, service preparation, service building.

Learning disability pathway and provider training has been developed. Special interest group member is included in dementia board and sub groups to further support learning and development exchanges across the region.

Relevant milestones in the next 6 months

Actions to implement Good Work are included as part of the regional dementia board strategic action plan. This will include all public facing and non-public facing ABUHB staff, teams and departments and will:

- Involve a series of team led awareness workshops to assist with team preparation methods including team building awareness workshops
- Involve people with dementia in service development and education
- Involve teams in co-productive workshops to initiate education for non-front line staff
- Using dementia roadmap to host material,
- Involving regional IT teams for contribution in role/expertise towards improved IT access in health and social care-shared on DEWIS
- Introduce Dementia Champions on acute hospital wards.

- 200 places for Step inside Dementia across the region.

For ABUHB specifically, consideration of the the development of one database to record levels of training as currently there are various databases used across ABUHB. Build a mechanism to ensure accurate recording of NHS staff teams and services receiving appropriate education through the proposed model of dementia awareness, dementia service preparation and dementia service based on Good Work topics and outcomes.

RAG rating – *insert RAG rating*

	AMBER – In progress – some concerns	

Additional comments (inc risks to delivery)

The development of a single training database for ABUHB will be a considerable effort to take forward.

Action no	**Action**	**Involved bodies**
2.5	Work with local authorities, health boards and Public Health Wales so the needs of people living with dementia are considered as part of the planning process (ongoing).	Welsh Government, Local authorities, Public Health Wales, health boards, Public Service Boards.

Actions taken since the baseline report in August

Links in place with people living with dementia and their carers through Dementia Friendly Community groups, service user groups 'Memories in motion' and Carers groups. Recently as part of the development of the Integrated Care Funding (ICF) spending profile, an independent consultant undertook a gap analysis to develop a regional dementia pathway. A series of workshops were organised in each of the LAs and people living with dementia and carers were integral to each workshop.

A new 'peer to peer' service has been developed across Wales following an engagement workshop in the Gwent region.

MASs link with support groups in each area and are involved in consultation and identifying support. Carers Cafes are about to start in partnership with Carers UK and Gavo on each Dementia ward and should provide links to the Older Adult Carers group and the formation of peer support groups

Relevant milestones in the next 6 months

Continue to support dementia friendly cafes and carer groups. Memories in motion group to be linked fully to Dementia Board.

RAG rating – *insert RAG rating*

	AMBER – In progress – some concerns	

Additional comments (inc risks to delivery)

Groups have been developed but there are large numbers unknown to support services.

Action no	Action	Involved bodies
2.6	Ensure that transport planners/operators consider the needs of people living with dementia in the development of their services, including major contracts such as the 'metro' and the rail franchise, to improve access to passenger transport information, enabling people to plan and undertake journeys on the public transport network (ongoing).	Welsh Government, transport planners/operators.

Actions taken since the baseline report in August
Local work with Newport City transport has been undertaken and Dementia Friends has been delivered to some drivers with 2 members of staff completing the train the trainer course. Work is being undertaken with Newport Licensing department to rollout Dementia Friends to taxi drivers as mandatory awareness raising. Current expansion of the Shared car scheme in Monmouthshire is enabling Carers to visit relatives on units outside of Monmouthshire and to access activities within the borough, this has been funded with money from the Health board.
Relevant milestones in the next 6 months
Complete a gap analysis if services to include transport provision and views of service users.
RAG rating – *insert RAG rating*

GREEN – ongoing with no concerns	**AMBER – In progress –some concerns**	**RED - Not being actioned / will not complete within timescales**

Additional comments (inc risks to delivery)

Action no	Action	Involved bodies
2.7	Develop and undertake training designed to raise awareness amongst transport workers of the barriers that are encountered by those with dementia when using public transport (ongoing)	Welsh Government, transport planners / operators.

Actions taken since the baseline report in August
SEE ABOVE
Relevant milestones in the next 6 months
Max 100 words
RAG rating – *insert RAG rating*

GREEN – ongoing with no concerns	**AMBER – In progress – some concerns**	**RED - Not being actioned / will not complete within timescales**

Additional comments (inc risks to delivery)

Action no	Action	Involved bodies
3.1	Encourage GPs to take up the dementia component of the mental health Directed Enhanced Service (DES) introduced in 2017 (September 2018 and annual review)	Welsh Government and health boards.

Actions taken since the baseline report in August

The Dementia Board includes the dementia lead within the local Neighbourhood Care Networks (NCNs). Dementia Friends awareness has been delivered to some GP surgeries and primary care staff.

Further work is underway in creating expertise and interest in dementia DES by building education workshops and accreditation mechanisms. A dementia vision has been agreed for the 12 NCNs across Gwent and included as part of the Dementia Board's strategic action plan and includes dementia awareness, knowledge and skills. The vision document sets out how each NCN area can access suitable materials and develop awareness and develop greater resources.

Specialist roles are being built in key areas, eg podiatry and optometry and 2 areas are taking up Enhanced Service (DES).

Relevant milestones in the next 6 months

A dementia friendly accreditation for primary care and GP surgeries is being developed and a pilot will start in April 2019.

Increase delivery of dementia friends awareness to GP surgeries as a precursor to further detailed education and training linked to Good Work.

RAG rating – *insert RAG rating*

AMBER – In progress – some concerns

Additional comments (inc risks to delivery)

Support will require support and willingness of busy GP surgeries

Action no	Action	Involved bodies
3.2	Review and update, as needed, the dementia awareness DVD for GPs (September 2018)	Welsh Government.
Actions taken since the baseline report in August		
N/A		
Relevant milestones in the next 6 months		
N/A		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		
The Dementia Board would appreciate an update on progress of above.		

Action no	Action	Involved bodies
3.3	Ensure that primary care practices are able to evidence that they are dementia supportive (baseline April 2018 and six monthly review thereafter)	Welsh Government, primary care practices.
Actions taken since the baseline report in August		
See 3.1		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		
The Dementia Board would appreciate an update on progress of above.		

Action no	Action	Involved bodies
3.4	Work with stakeholders to deliver the most effective ways to increase awareness of dementia to ensure timely diagnosis (ongoing)	Welsh Government.
Actions taken since the baseline report in August		
N/A		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		
The Dementia Board would appreciate an update on progress of above.		

Action no	Action	Involved bodies
3.5	Ensure workforce plans are in line with the principles of 'Good Work' to enable key front line staff to recognise the early signs of dementia (ongoing)	Welsh Government, health boards, Social Care Wales, third sector, public sector.

Actions taken since the baseline report in August

See 2.4. An ICF bid was used to develop Good Work in practice and learning will be used to develop Good Work compliant hospital wards and health/social care teams going forward. ABUHB training sessions aimed at different levels, informed, skilled and influencers linked to Good Work are also being developed.

The Good Work Education and Learning sub group has been established to assist early opportunities for developing dementia skills and learning needs. The membership consists of practitioners from health, social care and the third sector.

Multi agency Step inside dementia training, Dementia Care Matters training for care homes as well as wider dementia training has been delivered through an ICF bid.

Relevant milestones in the next 6 months

Delivery of sub group work programme and to ensure effective dementia training and education through staff induction and aligning to nursing skills and social care workforce best practice. Scope acute ward areas to identify learning and development needs.

Create and facilitate delivery of Dementia training at Skilled, Informed and Influencer Levels to staff in direct patient contact.

Review the data captured during Attain Consultancy analysis to identify gaps and needs in current delivery of services.

RAG rating – *insert RAG rating*

AMBER – In progress – some concerns

Additional comments (inc risks to delivery)

Good Work implementation will involve cultural change and require time and resources to fully embed.
The release of staff to attend training is always a challenge with increasing demands put on front line services.

Action no	Action	Involved bodies
3.6	Ensure access to training for staff who work with people who may have a higher risk of developing dementia (such as those working in learning disabilities, substance misuse, ambulance (April 2019) and prison services(April 2020)	Welsh Government, health boards, Social Care Wales, third sector, public sector.

Actions taken since the baseline report in August

See 2.4 and above.

In relation to Learning Disability services and ABUHB

- All of our staff are expected to attend a Dementia Friends training session
- We deliver Dementia Awareness training to all our clinical staff. This includes a general overview of dementia and specific issues and risks related to PwLD. It also covers the philosophy of care related to supporting someone with dementia.
- We deliver a Train the Trainer session to some of our clinical staff so that they can deliver the Dementia Awareness session to carers and families of PwLD whom they support and facilitate service user specific workshops.
- One of our Community Nurses has recently attended Dementia Care Mapping training and we will need to confirm how this will fit within our Directorates plans.
- We also have the Dementia Good Practice Guidance which has been shared with all staff as an excellent resource guide.

Relevant milestones in the next 6 months

As above and to include actions to increase training to practitioners that support people at a higher risk of developing dementia, particularly at a skilled level to include practical approaches for supporting someone with dementia examples of “the Positive Approach to Care training” by Teepa Snow.
Work will be undertaken to understand the range and content of the dementia training provision procured and accessed across the region to inform a regional training programme aligned with the Good Wood Framework.

RAG rating – *insert RAG rating*

	AMBER – In progress – some concerns	

Additional comments (inc risks to delivery)

Good Work implementation will involve cultural change and require time and resources to fully embed.
The release of staff to attend training is always a challenge with increasing demands put on front line services.

Action no	Action	Involved bodies
3.7	Develop a consistent, clearly understood, diagnosis, care and support pathway, which incorporates standards or care and outcome measures (April 2019)	Welsh Government, health boards, local authorities, Public Health Wales, 1000i lives.

Actions taken since the baseline report in August

The Dementia Board have prioritised the need to develop a common understanding of the dementia pathway across health, social care and the third sector and this is reflected in the regional action plan. The board have a developed its understanding of a dementia referral and care pathway through its sub group structure and will refresh the Dementia Pathway sub group.

As part of the ICF funding profile, the Dementia Board commissioned an independent analysis of dementia care across the region, the output of which is a co-produced blueprint model of a seamless dementia care model. The gaps identified in this work will inform onward commissioning of services from the ICF Dementia Funding Stream.

A major project involving the Value Based Health Care Team, Finance and the Older Adult Mental Health directorate has led to a common pathway development within the Memory assessment service with the introduction of some of the International Consortium On Health Outcome measures. The piece of work is now working to improve completeness of data on a borough level, while also beginning a dialog with GP colleagues about how to improve early referral rates at the beginning of the pathway and how ongoing support post diagnosis may be supported within care closure to home principles for a defined cohort of patients.

The partnership with the Alzheimer's Society Dementia Support Workers is a key part of this pathway discussion and an ICF bid has been submitted to move this service away from 1 year period post diagnosis to coordination of pathway longer term as per Nice guidance.

Relevant milestones in the next 6 months

The regional plan will further develop the outcomes and expand membership for the Dementia Pathway sub group. The group will lead on developing Dementia Pathways, and draw on the expertise across sectors to ensure appropriate support to complete this task, including those able to represent at risk groups.

Raise awareness of pathways across all partners and share with NCN chairs.

RAG rating – *insert RAG rating*

	AMBER – In progress – some concerns	

Additional comments (inc risks to delivery)

A common approach across health, social care and the third sector is required and will involve collaboration across partners and a common understanding

Action no	Action	Involved bodies
3.8	Agree a common approach to Cognitive Impairment (other than dementia) assessment and intervention, with support offered to primary care by specialist memory assessment services where required (April 2019).	Welsh Government, Public Health Wales, 1000i lives.
Actions taken since the baseline report in August		
N/A Outcomes to be developed within the pathway best practice.		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		
The Dementia board would appreciate an update against progress to share with partners There are ongoing discussions with GP colleagues and the Older Adult Mental Health Directorate about how the Memory Assessment Service can support general practice with cognitive impairment. This involves active discussions about developing services for Mild Cognitive Impairment such as the National Exercise Referral Scheme pilot being delivered to those with Dementia in Monmouthshire and how this may be extended to MCI. An ICF bid has also been submitted for access to PET scanning to help differential diagnosis of borderline cases to improve management.		

Action no	Action	Involved bodies
4.1	Continue to implement the recommendations from the memory assessment service national audit and set targets for health boards to increase diagnosis rates by at least 3% a year (September 2018 and annual review).	Welsh Government, Public Health Wales 1000 Lives and Memory Assessment Services (health boards).

Actions taken since the baseline report in August

The Dementia Board includes strategic leads of the Memory Assessment Services, and NCN lead for dementia. The board has established a Dementia Pathway sub group to improve diagnosis rates and implement mechanisms for best practice. Memory assessment clinics are being run in GP surgery and Community Hubs to increase accessibility to services as part of the ABUHB Clinical Futures agenda, bringing care closer to home.

The Gwent Regional Partnership Board commissioned an independent review of Dementia Services. Working alongside the ICF Programme Office, this piece of work helped to identify known services within our area, understand a whole system pathway from the person with dementia and a carer's perspective, and co-developed with our stakeholders what good looks like for Gwent. From this information identification of gaps and needs within the current provision of services can be identified and addressed. Also a need for services to work together differently. Early identification and diagnosis is one of these priorities and a proposed new model and dementia pathway has been proposed which will consider a Dementia Hub in each locality, facilitating a network of services and information to support persons with Dementia and carers.

Relevant milestones in the next 6 months

The regional plan further sets out objectives for service specifications and timescales to support referral, case finding referrals and diagnostic pathways. Dementia Pathway to link to all sub groups and promote consistency and understanding across the region, specifically the Good Work sub group. Work with MAS and GPs to share good practice to improve diagnosis rates.

Value Based Health care have been mapping out the services within the Memory assessment and diagnosis pathway service, with a view of improving efficiency, effectiveness and equity of services. This information will inform the wider Regional Dementia Pathway which will consider the patients and carers journey from early identification through to End of Life in line with DAP.

Further review of the MAS pathways, streamlining the pathway to increase assessment and diagnosis rates by increasing nurse led screening and follow up releases Consultant psychiatrists time for diagnostic clinics.

RAG rating – *insert RAG rating*

AMBER – In progress – some concerns

Additional comments (inc risks to delivery)

A common approach across health, social care and the third sector is required and will involve collaboration across partners and a common understanding. Coding used within GPs and MAS needs to be reviewed as this may affect % diagnosis.

Action no	Action	Involved bodies
4.2	To work with stakeholders to identify and utilise the most robust clinically validated dementia assessment tool(s) for use in the Welsh language and commission research as necessary (September 2018).	Welsh Government and health boards.

Actions taken since the baseline report in August

ICHOM and other outcome measures are being used to establish best practice and enable international benchmarking and implementing ICHOM scales to be part of service specification in memory services.

Public health Wales is developing knowledge and skills workshops and communities of best practice with a regional membership. The regional dementia action plan will set out the expectation of service specification for memory services in relation to rating scales and diagnostic best practice. Specifications and best practice with be described.

Memory assessment services are considering NICE guidance and British Medical guidance to agree a baseline standardised assessment tool for use in pre-screening for Dementia. NICE updated the guidelines for Dementia in June 2018, within this is the recommendations for assessment screening and diagnostic testing to support accurate and timely diagnosis. An ICF bid has been submitted to access PET scanning for borderline cases to improve management.

Relevant milestones in the next 6 months

Improve links to specialist diagnostic services through the development of referral pathways in all settings, the Value Based Health care team are further developing ICHOMS and PLICS in Memory assessment services with a focus on completeness of data over the coming months. This is forming part of the dementia diagnosis pathway across Gwent and the Zarit Carers Burden Scale being one of the Outcome tools added to the ICHOMS suite of measures.

Undertake diagnosis of dementia using a multi-disciplinary approach, involving a range of health professionals, including speech and language therapists and value the participation and views of carers,

Support the use of telehealth and advances in information technology to improve access to timely diagnosis.

The introduction of WCCIS later in the year will enable the MAS to develop the use of automated appointment booking and text to remind services, thus speeding up diagnosis and reducing missed appointments. In the longer term this may be a method of delivering some of the Outcome PROMS to improve better understanding of both Carer and Patient experience.

RAG rating – *insert RAG rating*

	AMBER – In progress – some concerns	

Additional comments (inc risks to delivery)

The use of consistent toolkits across the region will require time to embed

Action no	Action	Involved bodies
4.3	Scope the access to and provision of memory assessment services to those with learning disabilities (June 2018).	Public Health Wales 1000 Lives.
Actions taken since the baseline report in August		
See Point 3.6, 3.7 and 4.2		
Relevant milestones in the next 6 months		
See Point 3.7 and 4.2		
RAG rating – *insert RAG rating*		
	AMBER – In progress – some concerns	
Additional comments (inc risks to delivery)		
The Dementia board would appreciate an update against progress to share with partners.		

Action no	Action	Involved bodies
4.4	Ensure compliance with the Welsh Government's All Wales Standards for Accessible Communication and Information for People with Sensory Loss. (ongoing)	Health boards, local authorities, third sector.

Actions taken since the baseline report in August

Regional Sensory Impairment groups have been established (Eye Care Board and Hearing Care Board) and links to the Dementia board with shared governance under the Gwent Adult Strategic Partnership.

The links between the groups to be further developed through the regional education and development plan and will involve dementia education awareness, preparation and service building model for influencers.

Presentation ratified and shared for Dementia Friendly environments which includes sensory loss. Step inside Dementia Learning program which discusses Sensory deterioration and management strategies.

There are examples of hospital wards and care homes who are adapting environments to be dementia friendly. Dementia Board circulate good practice guidance on dementia friendly environments to all members.

Relevant milestones in the next 6 months

Build on work undertaken with RNIB 'sight loss and the environment' to cover other senses.
To develop an environmental strategy with people living with dementia.
Continue to align information to existing websites to avoid duplication.
Identify and formalise ABUHB Dementia Steering group representative who support sensory services.
Work has been undertaken to access different formats for the Mas Outcome measures and information leaflets, which is an ongoing process. i.e blind version of ACE R III.

RAG rating – *insert RAG rating*

AMBER – In progress – some concerns

Additional comments (inc risks to delivery)

Adapting environments will require time and resources to implement, but progress is being made with the development of new buildings e.g. new critical care centre

Action no	Action	Involved bodies
4.5	Scope a programme of work that will capture, record, share and flag the communication needs of service users with sensory loss (March 2018).	Welsh Government working in collaboration with the NHS Centre for Equality and Human Rights (NHS CEHR), health boards and health professionals and third sector.
Actions taken since the baseline report in August		
See above		
Relevant milestones in the next 6 months		
See above. Work with Eye Care and Hearing Care Boards to undertake engagement and ensure views are incorporated across Good Work and Dementia Pathway sub groups. Link to existing engagement groups.		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
4.6	Review and promote the All-Wales dementia helpline as a key source of information (Review to be undertaken by September 2018).	Welsh Government.
Actions taken since the baseline report in August		
N/A		
Relevant milestones in the next 6 months		
The regional Dementia Board would welcome an update from WG on use of the helpline**.**		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		
The Dementia board would appreciate an update against progress to share with partners		

Action no	Action	Involved bodies
4.7	Review the capacity and role of dementia support workers to ensure all individuals with dementia living in the community have a dedicated support worker working to agreed occupational standards (June 2018).	Welsh Government, Public Health Wales 1000 Lives, statutory / third sector providers

Actions taken since the baseline report in August

The Dementia Board commission a third sector partner to provide a Dementia Support Service for people diagnosed with dementia within the first year of diagnosis. The independent analysis has highlighted the need for ongoing support for an individual with dementia and their carer, a professional that can pull specialist support as needed rather than a person with dementia or their carer experiencing multiple hand-offs.

Feedback from the DSW manager is a standing item at each Dementia Board. The board provide governance and aims to unblock issues as well as monitor performance data through a proposed gap analysis planned within the regional dementia action plan, involving a review of uptake and coverage.

Money has been reinvested in the DSW role by the Older Adult Directorate to expand capacity for the 1 year post diagnosis service in each borough.

Relevant milestones in the next 6 months

Continue to monitor performance of DSW contract and link to the development of the Dementia Pathway sub group and resulting good practice document which includes the service specification of the DSW.
Undertake a gap analysis and review of coverage to include similar roles and dementia coordinators role in memory services.
A bid has been submitted to ICF for the extension of the current 1 year post diagnosis support from the DSW's to as long as necessary as defined by the service user or carer in line with the Dementia Nice guidance June 2018 role of a pathway coordinator.

RAG rating – *insert RAG rating*

AMBER – In progress – some concerns

Additional comments (inc risks to delivery)

Risk to service if funding is cut.

Action no	Action	Involved bodies
4.8	Ensure every diagnosed person with dementia receives a tailored information pack in an accessible format, including, as needed, digital options, and is offered access to a dementia support worker or equivalent (ongoing).	Health boards.
Actions taken since the baseline report in August		
See above. The DSW's are available to all those with a diagnosis of Dementia for a year and during this time the information and resources needed are tailored to the particular needs of the service user and care from a wide range of resources.		
Relevant milestones in the next 6 months		
See above Undertake an audit to ensure information is provided in an accessible format.		
RAG rating – *insert RAG rating*		
	AMBER – In progress – some concerns	
Additional comments (inc risks to delivery)		
Risk to service if funding is cut		

Action no	Action	Involved bodies
4.9	Ensure that carers will be offered an assessment of their own needs and, if eligible, a support plan will be developed with them to identify appropriate support (in line with the Social Services and Well-being (Wales) Act 2014). (Ongoing).	Health boards, local authorities, third sector.

Actions taken since the baseline report in August

Local authorities under the Social Services and Wellbeing Act will provide a carers assessment. A regional Carers Board has been established and partners link with the Dementia Board. The needs of carers are prioritised within the dementia strategic action plan and the board have developed a carers sub group to ensure the views of carers are taken forward.

The Carers Board have established 2 operational boards to deliver the strategic priorities of the Carers Board - Young Carers and Adult Carers. There has also been additional investment in 18/19 (ICF) funding to increase the Local Authority carers support capacity – this has included a focus for several LA's on promotion of carers supports and assessments.

All carers identified are signposted to the relevant local authorities and offered an assessment of their needs. Young carers are supported in several ways and once identified, have access to young carers projects in their areas. We already have a young carers in schools policy in place in every school in Gwent and a young carers in schools programme is ongoing (an accredited award scheme).

Relevant milestones in the next 6 months

Increase public awareness of carers assessment process
Provision of signage for carers and signposting by staff in ABUHB scheduled and unscheduled care wards In progress
Ensure information is shared through Dementia Support Workers when supporting carers within the first year of a dementia diagnosis
Carers Programme Board establishing a programme of work to support GP practices in identifying and supporting carers.
Need to link to Carers Board to ensure collaborative approach and avoid duplication.

RAG rating – *insert RAG rating*

AMBER – In progress – some concerns

Additional comments (inc risks to delivery)

Action no	Action	Involved bodies
5.1	Develop multidisciplinary 'teams around the individual' which provide person-centred and co-ordinated care, support and treatment as needed (April 2019 and six monthly review of implementation thereafter).	Health boards and local authorities.

Actions taken since the baseline report in August

The Heads of Adult Services have submitted a bid to through ICF to develop a Dementia Reablement Service and there will be a focus on working with multi agency partners in team around the person approach. This project directly delivers on the components of the co-produced blueprint model to ensure specialist support is tailored to an individual's needs, and supports collaboration and integration of services.

The Dementia Board have developed a sub group to lead on the development and coordination of a dementia pathway. The development of a pathway will include a focus on early intervention and community working and this approach is part of the wider 'Care Closer to Home' agenda being adopted across health and social care partners in Gwent.

The regional dementia action plan will set out objectives for the dementia pathway and diagnosis sub group to oversee the specifications and membership required to develop pathways that involve wrap around concepts and virtual /flexible pathway teams.

Relevant milestones in the next 6 months

Given WG approval of ICF bid, progress a Dementia Reablement service. Also, partnerships with WAST to increase knowledge exchange of WAST teams as a key partner 'around the person with dementia.

Coordinate service learning workshops aimed at building service awareness, preparation and specialisation across the pathway. Will require a common adopted level of understanding of dementia across health, social care and third sector and will link to Good Work development

RAG rating – *insert RAG rating*

	AMBER – In progress – some concerns	

Additional comments (inc risks to delivery)

Action no	Action	Involved bodies
5.2	Develop an All Wales Dementia Allied Health Practitioner Consultant post who will give advice and support to health boards and local authorities to enable the delivery of person-centred care and drive forward service improvements (April 2018).	Welsh Government, Allied Health Professionals, health boards.
Actions taken since the baseline report in August		
N/A		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		
The Dementia board would appreciate an update against progress to share with partners.		

Action no	Action	Involved bodies
5.3	Ensure that Regional Partnership Boards (as required through the Social Services and Well-being (Wales) Act), prioritise ways to integrate services, care, and support, for people with dementia (Ongoing).	Welsh Government, Regional Partnership Boards.

Actions taken since the baseline report in August

The regional Population Needs Assessment and development of an Area Plan coordinated by the RPB involved engagement with people living with dementia and carers. Integration of services and development of Dementia Friendly Communities is a priority in the Area Plan and governance is provided by the RPB.

The delivery of regional Dementia Action Plan is coordinated by the Dementia Board and progress is reported to the RPB through a Gwent Adult Strategic Partnership

See above further development and specific DFC plans targets and objectives.

Relevant milestones in the next 6 months

A progress report from the Dementia Board will be presented to the RPB as per a cycle of reporting in early 2019. The progress report will also identify key actions required by the RPB to support the integration of services for people living with dementia.

RAG rating – *insert RAG rating*

GREEN – ongoing with no concerns		

Additional comments (inc risks to delivery)

Max 100 words

Action no	Action	Involved bodies
5.4	Work with Social Care, health services and housing providers and involve people with dementia, their families and carers to strengthen collaboration on a strategic approach to housing to enable people to stay in their homes (March 2019).	Welsh Government and Regional Partnership Boards

Actions taken since the baseline report in August

See above. The Dementia Board link with service user review panels such as 'Memories in motion' people with younger onset of dementia. The Dementia Board also includes membership from Housing Association so that views can formally be shared.

A refresh of Part 9 of the SSWB Act sets out the need for Housing to be a statutory partner at RPB and this has been in place for some time in Gwent, which includes a Health Housing and Social Care strategic partnership.

The development of new technologies is a focus across the region and an ICF bid was submitted to undertake further research. We have also engaged with people living with dementia and their carers as part of the regional gap analysis and asked the question 'what would enable you to live in your own home?'

Relevant milestones in the next 6 months

Continue to link with Housing Association and ensure views of people living with dementia are promoted.
Continue to work with Housing Associations to be active partners at Dementia Board.

RAG rating – *insert RAG rating*

GREEN – ongoing with no concerns		

Additional comments (inc risks to delivery)

The strategic approach is in place but we now need to turn the words into action!

Action no	Action	Involved bodies
5.5	Enable housing staff to have access to training to assist them to support people with dementia(Ongoing).	Welsh Government

Actions taken since the baseline report in August

The Dementia Board has proactively linked with Housing Associations and there is good representation on 5 DFC groups and at the Dementia Board.

A number of housing associations have received dementia friends awareness and 5 RSLs have received DFC accreditation
https://www.melinhomes.co.uk/news/melin-recognised-for-dementia-awareness

A joint regional and integrated educational model and plan is being drafted for the regional dementia board partners for consultation in September 2018 and completion by December 2018. The regional model involves service and role awareness building co productive team workshops for frontline and non-frontline services and roles.

Relevant milestones in the next 6 months

Continue to deliver dementia awareness and training to RSLs and link to Good Work strategy.
Require Housing Associations to be active partners at Dementia Board.

RAG rating – *insert RAG rating*

Additional comments (inc risks to delivery)

Max 100 words

Action no	Action	Involved bodies
5.6	Consider the relevant recommendations of the “Expert Group on Housing and Ageing Population” to inform future housing development (September 2018).	Welsh Government, local authorities and registered social landlords.
Actions taken since the baseline report in August		
N/A We will await the recommendatiosns		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
5.7	Review the Housing Aids and Adaptations Programmes to ensure that people are able to access appropriate and timely support (April 2019).	Welsh Government.
Actions taken since the baseline report in August		
N/A		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
5.8	Ensure that relevant recommendations received from the National Independent Safeguarding Board are considered and embedded into policy development across Government and integrated into operational practice (Ongoing).	Welsh Government, health boards and local authorities.

Actions taken since the baseline report in August

Members of regional Safeguarding Board are also members of the Dementia Board and ensure the boards are linked and key messages are shared and collaborative working. Safeguarding linked reviews are routinely commissioned by or presented to the Dementia Board – most recently the Tawel Fan report and learning shared.

The Dementia Board have worked with Gwent Police to develop a missing person's protocol for people living with dementia – the Herbert Protocol. The region was the first area in Wales to introduce the protocol https://www.gwent.police.uk/en/advice/advice/g-m-graffiti-modern-slavery/missing-people/the-herbert-protocol/

Relevant milestones in the next 6 months

Continue to disseminate key Safeguarding linked messages through the Dementia Board and ensure messages are incorporated into organisational learning and management structures.

To continue to link with the regional safeguarding board and ensure national reports are presented to Dementia Board and advocate for people living with dementia are seen as vulnerable group Require Dementia agenda to be raised at future meetings and seen as a condition of vulnerability.

RAG rating – *insert RAG rating*

AMBER – In progress –some concerns

Additional comments (inc risks to delivery)

Action no	Action	Involved bodies
5.9	Ensure health boards provide access to evidence-based pharmacological and psychosocial interventions in line with Matrics Cymru and other relevant guidance (September 2018 and six monthly review thereafter).	Health Boards

Actions taken since the baseline report in August

Membership of regional board includes members in community practice and from the National steering group.

Reducing the use of anti-psychotic medication is a priority included in the Dementia Board's regional action plan. In reach teams are monitoring the use of antipsychotic use and patient reviews with medical teams. A literature review for early intervention and retaining communication in dementia is being undertaken. The Dementia Board have submitted an ICF bid to implement and evaluate alternatives to the use of anti-psychotic medication.

An ICF bid has been submitted to extend the BST staffing to improve response times to referrals. An ICF bid has been submitted to extend the hours that the Flexible hospital Response team work to cover weekends. This team is attached to OPAL and models interventions with personal care to those with dementia or cognitive impairment on General Hospital wards as well as providing failure free activity to reduce conflict or behaviours that challenge and are also monitoring effect on the use of Antipsychotic medication. A third ICF bid has been submitted to scope medication Concordance/ prompting needed to ensure more effective use of medication for those with dementia.

Relevant milestones in the next 6 months

- Developing education plans within the regional learning and development plan for early intervention and retained communication and dementia.
- Build on literature review with a research feasibility study related to early intervention and communication.
- Ensuring continued representation on the 1000lives programs
- Ensure that these programs are linked to memory assessment services
- Building specialist psychosocial interventions –current research proposal
- Building specialists in person centred care
- Linking developments to person centred care as described by Kitwood
- Building programs of appropriate support through dementia care mapping.
- Being inclusive with teams alongside mental health for commissioning and sharing education such as Hand under hand, Teepa Snow

RAG rating – *insert RAG rating*

	AMBER – In progress – some concerns	

Additional comments (inc risks to delivery)

There needs to be a national discussion in relation to medical prompting as this can sit between social services and health – this is a continuing issue raised at Dementia Board and very little can be progressed regionally until a national discussion.

Action no	**Action**	**Involved bodies**
5.10	Respond to the recommendations of the Health, Social Care and Sport Committee's inquiry into the use of anti-psychotic medication (Ongoing).	Welsh Government.
Actions taken since the baseline report in August		
N/A		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		
The Dementia Board have submitted an ICF bid to implement and evaluate alternative use of anti-psychotic medication. We have also developed our Dementia Care Mappers to deliver more Person Centered Training with the aim of alternative intervention to medication.		

Action no	Action	Involved bodies
6.1	Ensure health (including Wales Ambulance Service Trust - WAST) and social services have pathways in place to ensure the responsiveness of community assessment and ongoing management services (Ongoing).	Health boards and Trusts.
Actions taken since the baseline report in August		
The Dementia Board has been working closely with WAST on the development of their Dementia Policy. This was launched in Gwent. A dementia awareness for 'Blue Light' call handlers across WAST, Gwent Police and South Wales Fire Service has been developed. Joint training is being rolled out and further dates planned. Support offered for learning and development with first attender skills, call handler skill sets and referral pathways and case finding pathways. WAST lead included in pathways and diagnosis sub group, examining case finding, first attender skills and referral pathways. WAST Included as a partner in regional learning and development plan and model development.		
Relevant milestones in the next 6 months		
WAST will be invited to sit on the Good Work Learning and Development sub group. Community Assessment requires partners to share a common understanding of dementia and 'what matters' conversation, and for all partners to be working in collaboration.		
RAG rating – *insert RAG rating*		
	AMBER – In progress – some concerns	
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
6.2	Ensure that the new "teams around the individual" enable families and carers to access respite care that is able to meet the needs of the person living with dementia (April 2018).	Welsh Government, health boards, local authorities and third sector.

Actions taken since the baseline report in August

A need for a range of respite opportunities is a priority highlighted by people living with dementia and their carers. Through the regional population Needs Assessment exercise the Dementia Board has considered and mapped regional provision and gaps. Identifying that formal respite is not utilised. A more flexible range of respite is preferred.

The Dementia Board partners have promoted informal respite solutions and a regional gap analysis was submitted as part of Integrated Care Fund (ICF) bid to identify levels of support. A bid was also submitted from the third sector and also included informal and flexible respite provision - a consortium of third sector providers worked in partnership (including Alzheimer's Society, Age Connect and Age UK) providing adhoc respite to those not in receipt of Social care emergency respite or following a statutory assessment. The report is to follow shortly and help understand the need for Respite in Gwent

Relevant milestones in the next 6 months

Await evaluation from ICF respite project and implement good practice. An ICF funded project on dementia and respite has taken place: respite provision to enable carers to maintain their caring role is currently available to the majority via a traditional static arrangement that provides a form of respite at pre-agreed intervals. This type of support is valued, but typically does not offer the carer/cared for flexibility in how respite provision can be used, and when it can be accessed. This pilot initiative works closely with local authority Information, Advice and Assistance services as well as Memory Assessment Clinics to ensure carers are aware of the support available to them. It's a pilot consortium approach to flexible personalised respite solutions to people with dementia and their carers within Gwent over the winter period, preventing escalation of needs and supporting carer wellbeing. The pilot will provide a menu of respite solutions that people can select from when they would like to access respite enabling them to request respite when it is meaningful to them and would offer the most support.

2 respite co-ordinators employed on a full time basis to act as the main point of contact for people with dementia and/or their carers to request a respite service. The co-ordinators will be assigned to geographical areas, though work very closely to support service provision and respite arrangements.

RAG rating – *insert RAG rating*

AMBER – In progress – some concerns

Additional comments (inc risks to delivery)

The informal respite provision is dependent on funding and will be a challenge to deliver without further funding in the short term while more sustainable processes are explored

Action no	Action	Involved bodies
6.3	Monitor the use of funding provided to local authorities for respite provision to identify best practice in supporting the needs of the carer and the person who is cared for and ensure this practice is shared (September 2018 and six monthly review thereafter).	Welsh Government and local authorities
Actions taken since the baseline report in August		
See above. As part of an ICF bid, a consortium of third sector partners have worked together to develop a responsive respite service.		
Relevant milestones in the next 6 months		
Lessons from the respite service will be identified as part of the ICF evaluation		
RAG rating – *insert RAG rating*		
	AMBER – In progress – some concerns	
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
6.4	Further develop use of the new directed enhanced service for residential and nursing care homes (Baseline April 2018 and annual review thereafter).	Health boards and GP practices.
Actions taken since the baseline report in August		
The new care home Directed Enhanced Services is set in the strategic context of promoting physical mental and social wellbeing in all individuals in care homes. Patients living with dementia and providing them with greater support through a more holistic care approach by the wider multi-disciplinary team is taking place. This is currently undertaken by 56 out of 78 of ABUHB GP Practices.		
Relevant milestones in the next 6 months		
We will increase the number of practices and use the appropriate skills of the wider MDT to undertake visits. Require 'buy in' from GPs.		
RAG rating – *insert RAG rating*		
	AMBER – In progress – some concerns	
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
6.5	Monitor the implementation of the recommendations from the Trusted to Care report Ongoing).	Welsh Government.
Actions taken since the baseline report in August		
N/A		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		
Please can we have an update to share with partners		

Action no	Action	Involved bodies
6.6	Ensure that psychiatric liaison services are available to all general hospitals in Wales (Ongoing).	Health boards and Trusts.
Actions taken since the baseline report in August		
The older adult psychiatric liaison service OAPL (older adult psychiatric liaison) service was commissioned in 2015. Currently being expanded to ensure service hours are suitable to service need and with the addition of the Flexible response team. OAPL has Increased capacity through support workers and occupational therapist. The regional dementia plan will further strengthen the learning and development knowledge exchange and advice and support -24hrs.		
Relevant milestones in the next 6 months		
Continue to implement OAPL service.		
RAG rating – *insert RAG rating*		
	AMBER – In progress – some concerns	
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
6.7	Ensure that the recommendations from the Royal College of Psychiatrists National Audit of Dementia in general hospitals are implemented including instructing health boards and trusts adoption the principles of the 'John's Campaign' (September 2018).	Health boards and Trusts.
Actions taken since the baseline report in August		
John's campaign is implemented across the health board as part of the AQF2017-2018. An implementation guide has been developed by ABUHB ambassador which includes a complete set of learning resources. This has been shared across Wales, promoted by Johns Campaign across the UK. Part of AQF 2017-2018 Resource pack in place. General Hospital sub group oversees any implementation learning arising from the RCP NAD		
Relevant milestones in the next 6 months		
Continue to promote John's Campaign and rollout.		
RAG rating – *insert RAG rating*		
	AMBER – In progress –some concerns	
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
6.8	Expand the use of Dementia Care Mapping™ as an established approach to achieving and embedding person-centred care for people with dementia and ensure health boards implement 'Driver Diagram – Mental Health Inpatient Environments for people with dementia (September 2018) (baseline April 2018 and annual review thereafter).	Welsh Government, Public Health Wales 1000 Lives and health boards.

Actions taken since the baseline report in August

Older Adult Mental Health have accessed train the trainer and trained dementia care mappers.

Continued to build on methods of assessing and addressing the quality of person centred care and team learning across the health and social care homes and community.

The Good Work strategy aims to develop knowledge and skills and commission suitable education across the region and across services around the person.

Relevant milestones in the next 6 months

Developing person centred care opportunity is expanded as a key learning need in workshop development within the regional action plan and regional learning plan and workshop templates.

Undertake an audit of training provided across the region and take up of training.

RAG rating – *insert RAG rating*

AMBER – In progress – some concerns

Additional comments (inc risks to delivery)

Action no	Action	Involved bodies
6.9	Ensure older person mental health units have agreed care pathways for accessing regular physical healthcare (September 2018).	Health boards.

Actions taken since the baseline report in August

Physical activity promoted across health board. Cross Divisional work is taking place between Therapies Division and the OAMH Directorate. This work is focusing on improving access to a wide range of therapies on OAMH Inpatient Wards and in the community. The scope includes enhancing the provision of Physiotherapy, SALT, Occupational Therapy, Pharmacy, Podiatry and Dietetics on OAMH Wards.

Cross divisional work between OAMH and the Community and Primary Care Division is taking place examining enhancing physical health care on OAMH wards and mental health care in community hospitals (where all but one of our OAMH wards are situated). This work is in its infancy.

Our Ward on YYF has regular access to the COTE Geriatrician who now attends wards rounds weekly. In addition to this it is now agreed that patients on the OAMH ward on YYF, who are acutely physically unwell, will move directly to an inpatient ward on YYF avoiding the need for being assessed on MAU.

YYF has regular access to the Advanced Nurse Practitioners on site for advice and intervention. OAMH are also part of a Health Board Wide looking at Core Safety. This project is exploring providing access to all OAMH Wards and Community Hospitals to an ANP via Skype 24 hours a day for advice and liaison.

NEWS Policy is implemented on all OAMH Wards and this has been audited in August showing positive compliance.

Relevant milestones in the next 6 months

Ensure as part of '6 steps' public health information that physical exercise encouraged for people living with dementia and their carers. The Dementia Board need to ensure all partners encourage people living with dementia to remain physically active.

RAG rating –

	AMBER – In progress – some concerns	

Additional comments (inc risks to delivery)

Action no	Action	Involved bodies
6.10	Ensure that access to advocacy services and support is available to enable individuals to engage and participate when local authorities are exercising their statutory duties under the Social Services and Wellbeing (Wales) Act 2014 (Ongoing).	Health boards.
Actions taken since the baseline report in August		
Advocacy services are accessed via local authorities, health board and the third sector. Work is underway to ensure that ward staff are able to easily access the available advocacy services through linking to information sources. As part of the wider health and social care agenda under the statutory Regional Partnership Board, the region is moving towards a regional advocacy provision working with the 'Golden thread' programme. Information is included on websites including DEWIS and Dementia Roadmap		
Relevant milestones in the next 6 months		
Further develop web linkage between DEWIS, dementia roadmap and service intranets. Include in Good Work Education and Learning strategy to ensure all practitioners promote advocacy services. Learn lessons from joint commissioning approach with GTAP		
RAG rating – *insert RAG rating*		
	AMBER – In progress – some concerns	
Additional comments (inc risks to delivery)		
Max 100 words		

Action no	Action	Involved bodies
6.12	Identify professionals who would benefit from training in initiating serious illness conversations, and provide such training (March 2019).	National End of Life Care Board.
Actions taken since the baseline report in August		
N/A		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		
Link activity to pathway and diagnosis group to prevent duplicated effort. The Dementia Board will promote the need to Include in dementia awareness, training, preparation and support workshops		

Action no	Action	Involved bodies
6.11	Ensure the 'teams around the individual' discuss the importance of making advance decisions and ensure an agreed palliative care pathway is in place (Ongoing).	Health boards and local authorities.
Actions taken since the baseline report in August		
The region has established a Palliative Care board and a member sits on the Dementia Board to ensure links and collaborative working. Joint education activity is developing for key areas including early Advance Care Planning activity. The dementia coordinators, and DSW roles in memory services and palliative care services; hospice of the valleys; CARIAD; Alzheimer's Society and primary care services are key roles and have service leads in this area of practice. This is included in the Regional dementia board action plan A pathway scoping activity will be developed through the regional dementia plan supported.		
Relevant milestones in the next 6 months		
Continue to promote effective care planning through education and development. Included within an agreed palliative care pathway. Develop dementia specific interdisciplinary teams to coordinate the assessment and management of dementia service provision across all health care settings. Develop clinical referral and care pathways that are flexible including for people with dementia from diverse needs groups and people with younger onset dementia.		
RAG rating – *insert RAG rating*		
	AMBER – In progress – some concerns	
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
6.13	Review the capacity of existing bereavement services and settings in which they are delivered to ensure that the differing needs of families and carers of those with dementia are being met (September 2018).	National End of Life Care Board.
Actions taken since the baseline report in August		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		
See 6.11. The CARIAD service is developed in Blaenau Gwent and also promotes the importance of advanced care planning. The role of memory services dementia coordinators and DSWs was reviewed as part of a gap analysis. An ICF bid was been submitted between Alzheimer's Society and Cruse to improve access to pre bereavement support and to explore peer to peer groups for people who took on previous caring responsibilities.		

Action no	Action	Involved bodies
7.1	Ensure people with dementia, their carers and families are involved in the development of dementia education and training (September 2019).	Health boards and local authorities.

Actions taken since the baseline report in August

The Dementia Board has developed 'Good Work' Education and Learning sub group to take forward consistent workforce development across health, social care and the third sector. Patient stories and 3rd party links are being utilised to develop the personal story in education. The Board has developed the dementia education plan and the regional dementia action plan has set out a model and objectives for co-productive workshops and Good Work group to support team and service awareness.

As part of the ICF development, carers were involved in 5 workshops to develop a dementia pathway including training, education and development needs

Relevant milestones in the next 6 months

We will continue to link with local service user groups such as the 'Memories in Motion' (young people with onset of dementia) to discuss the strategy and ensure coproduction.

Service user groups and carers groups will also be involved in taking forward the Dementia Board agenda with a standing item on the agenda for people living with dementia or their views to be heard.

Constant need to engage with and support people living with dementia to participate and design solutions and services.

RAG rating – *insert RAG rating*

AMBER – In progress – some concerns

Additional comments (inc risks to delivery)

Max 100 words

Action no	Action	Involved bodies
7.2	Improve access to training for carers and families through Good Work rollout (September 2019).	Health boards and local authorities.

Actions taken since the baseline report in August

See above. There is a regional Carers Board and officers from the Dementia Board ensure the voice of people living with dementia is recognised. The Good Work sub group have discussed the need for training for carers. The board has linked to existing boards and partnerships to identify good practice e.g. Learning Development.

There are various carer training in place across the region.

Relevant milestones in the next 6 months

Review current Carer training offered across organisations working with Carers board and ensure we have an equitable access across Gwent.

Develop carer peer to peer support groups as part of wider board agenda and use carer stories

Examine opportunities beyond Alzheimer's Society such as DEEP or Universities.

Revise the carers subgroup for dementia-to be run by people with dementia too.
A detailed review of carers training will require dedicated support of a task and finish group.

The new carers Cafes run in partnership with the Carers Trust and Gavo on the Dementia inpatient wards will provide a valuable resource for providing Good work training opportunities and the development of peer support networks.

RAG rating – *insert RAG rating*

AMBER – In progress – some concerns

Additional comments (inc risks to delivery)

Max 100 words

Action no	Action	Involved bodies
7.3	Ensure that the principles of 'Good Work– Dementia Learning and Development Framework'' are embedded in the new vocational qualifications for social care and health (September 2018).	Social Care Wales.
Actions taken since the baseline report in August		
N/A		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
7.4	Develop learning resources for the health and social care workforce, including the third sector, based on 'Good Work' (September 2018 and annual review).	Social Care Wales.
Actions taken since the baseline report in August		
N/A		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
7.5	Ensure NHS employed staff who come into contact with the public receive an appropriate level of dementia care training (as specified in - 'Good work') (December 2019).	Health boards and Trusts.

Actions taken since the baseline report in August

See 7.1

Dementia Friends awareness regularly delivered across ABUHB and Good Work is in place to develop model and team awareness building workshops to share good practice.

Regional Learning and Development Plan to be completed December 2018.

Dedicated support required to deliver DF awareness across ABUHB and ensure it is included in induction for new staff

Relevant milestones in the next 6 months

The Good Work sub group TORS will be revised by the learning and development strategic group.
The Good Work group will become a workshop development structure for the development of team workshops and non front line dementia awareness, to include information sources and productive learning.

RAG rating – *insert RAG rating*

	AMBER – In progress – some concerns	

Additional comments (inc risks to delivery)

Max 100 words

Action no	Action	Involved bodies
7.6	Ensure training for health and social care staff includes awareness raising about the role of carers and how to involve them appropriately in the care process (Ongoing).	Social Care Wales, Local Authorities and Health boards.
Actions taken since the baseline report in August		
See 7.1 & 7.2 Work to also include importance of role of care. In ABUHB carers training is made available at corporate induction for all members of staff and forms part of staff development reviews. Carer awareness continues to be raised at internal and external events and presentations delivered to strategic and operational groups. Carers champions in GP surgeries are being trained and an e-learning package has been developed nationally.		
Relevant milestones in the next 6 months		
See 7.2 Work to also include importance of role of carer		
RAG rating – *insert RAG rating*		
	AMBER – In progress – some concerns	
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
7.7	Fund an independent evaluation of 'teams around the individual' to inform the continued development of the approach (timing to be confirmed).	Welsh Government
Actions taken since the baseline report in August		
N/A		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
7.8	Work with NHS and social care and research teams to support and promote more dementia related research studies to Wales. Supporting the role of research in delivering good quality care in a flexible and responsive fashion (Ongoing).	Health and Care Research Wales.
Actions taken since the baseline report in August		
N/A The role of the R&D Director and her team in ABUHB is to provide as many patients as possible as many opportunities to be part of research studies, and this includes people with dementia. In Wales, each University Health Board and each Trust receives direct funding from the Welsh Government to support the development of capacity, capability and the delivery of research at a local level. In ABUHB the R&D Director and her team actively supports the development of dementia related projects. The ABUHB R&D Office has enabled dementia research into a broad range of aspects to be funded, supported and delivered. These partners include Cardiff University, the South East Wales Academic Health Science Partnership (SEWAHSP), University of South Wales, Cardiff metropolitan University and Oxford University. Not only research (the R of R&D) but also the D (of R&D), the development of services is actively supported by ABUHB and this includes the Aneurin Bevan Continuous improvement (ABCi) and service improvement through the existing strong partnerships with Universities.		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
7.9	Create more opportunities for people with and affected by dementia across Wales to participate, be involved and engaged in research activity (Ongoing).	Health and Care Research Wales.
Actions taken since the baseline report in August		
Creating opportunities for people with dementia and those affected by it is a key objective for the R&D Office in ABUHB. Projects from March 2018 to date currently being undertaken: • NIHR funded project (£500k, with ABUHB as the lead site) jointly with Cardiff University (Dr Katie Featherstone) exploring the care of people with dementia and their carers, of continence when admitted to acute hospital at NHH. • The genetics of patients with Early onset Dementia with Swansea and Cardiff University through the National Centre for Mental Health research. • NIHR funded project (£30k, with ABUHB as the lead site) jointly with Cardiff University (Dr Katie Featherstone) exploring interventions to improve the experiences of people with dementia when admitted to acute hospital. • NIHR funded project (£2.1m, with ABUHB as a site) including patients with dementia. A randomised, controlled trial of hospital at home with usual care at home. • Additionally, further opportunities and grant applications are being prepared for future research in ABUHB.		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
7.10	Encourage research that uses public health approaches to consider ways of addressing inequalities experienced by people with dementia (Ongoing).	Health and Care Research Wales
Actions taken since the baseline report in August		
N/A		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		

Action no	Action	Involved bodies
7.11	Ensure there are regular opportunities to identify innovative service models and areas of evidence-based practice, to ensure research findings are implemented in services across Wales and to inform research partners of areas where further research could usefully inform practice (Ongoing).	NHS Wales and 'research teams'
Actions taken since the baseline report in August		
The ABUHB Director reports and presents research activity at the ABUHB Dementia Board. Furthermore, opportunities have been made for researchers, including Dr Katie Featherstone from Cardiff University to: • Present the findings of her research to the ABUHB Dementia Board. • To advise the Clinical Futures Team on the relevance of her research on the design of the Grange University Hospital and the services that wrap around it. • To undertake a Service Evaluation project with senior staff in ABUHB, ward staff, facilities staff and HCSWs to explore barriers and enablers to taking up her research findings. There are active, ongoing and mature partnerships between ABUHB and its university partners to develop areas where research could be undertaken, where research applications could be jointly bid for and for Clinical Research Portfolio projects that are open and recruiting across the UK and beyond that ABUHB could be a site for. This is usual behaviour in ABUHB.		
Relevant milestones in the next 6 months		
RAG rating – *insert RAG rating*		
Additional comments (inc risks to delivery)		

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee Wednesday 12th June 2019 Agenda Item:4.6

4.5

Aneurin Bevan University Health Board

Putting Things Right/Organisational Learning Report

Executive Summary	
This report provides the Committee with an update on performance and actions underway to improve quality and performance through implementation of a Putting Things Right/Organisational Learning Service Improvement Programme and Action Plan. The report focuses on formal and informal complaints; Public Service Ombudsman for Wales cases and Serious Incidents for March and April 2019.	
The Quality and Patient Safety Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	√
Note the Report for Information Only	
Executive Sponsor: Martine Price, Interim Executive Director of Nursing	
Report Author: **Martin Lane, Interim Assistant Director of Organisational Learning**	
Report Received consideration and supported by :	
Date of the Report: 12th June 2019	
Supplementary Papers Attached: **Appendix 1** PTR/Organisational Learning Service Improvement Plan	

Purpose of the Report
To provide the Committee with an update on Complaints, Ombudsman and Serious Incident performance in March and April 2019 and outline progress with the PTR Service Improvement Programme to address quality and performance.

Background and Context
The underlying principle of Putting Things Right is that whenever concerns are raised about treatment and care, whether through a complaint, claim or clinical incident, those involved can expect to be dealt with openly and honestly, receive a thorough and appropriate investigation, a prompt acknowledgment and a response about how the matter will be taken forward. The need to ensure that these principles are implemented has been highlighted in the Evans Report 2014.

Assessment and Conclusion
Significant work has been undertaken to improve performance and quality in the handling of concerns with the focus on complaints and complaints referred to the office of the Public Services Ombudsman for Wales. Implementation of this plan has contributed to improved performance on complaints in April 2019 which is now at the highest level since January 2018. Further focussed work is required to ensure that this performance is sustained and also to pro-actively support and enhance the timeliness and effectiveness of investigations into Serious Incidents. Performance for Serious Incidents improved in March, however this was not sustained in April. Initial indications are that performance will again be improved for May 2019 and further work is planned to address sustainability of performance. The Quality and Patient Safety Committee is asked consider this report for assurance and compliance and note the progress made in complaints management and note progress with the action plan for the PTR/Organisational Learning Quality Improvement Programme.

Recommendation
The Committee is asked to consider this report and the assurance it provides on actions being taken to improve quality and performance in management of Concerns.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Concerns raised under these regulations may pose a financial risk. There are also risks to the reputation of the Health Board. If a risk relating to a particular case or trend is found and assessed to be high this will need to be included in the appropriate risk register and escalated as necessary.
Financial Assessment, including Value for Money	The financial implication of the new regulations have to date been positive as more cases are being considered under Redress and thus these cases do not continue to a civil litigation case.
Quality, Safety and Patient Experience Assessment	The report provides a summary of patient concerns raised during the previous two months and actions taken to improve patient experience.
Equality and Diversity Impact Assessment (including child impact assessment)	The Health Board is required to make all reasonable adjustment to allow a patient or relative to raise a concern. An individual assessment is required to ensure that in all cases, all reasonable adjustments have been taken to allow all patients to raise a concern in the most appropriate format.
Health and Care Standards	The regulations relate to the Health and Care Standards 2015 (Individual Care).
Link to IMTP/Corporate Objectives	Concerns are a key theme for Quality Assurance in the 2019-21 IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	***Long Term*** *– actions are being put into place to improve the long term quality and performance of the complaints system and ensure organisational learning from complaints and serious incidents.*

	Integration *– The service for managing complaints and incidents encompasses the whole system of across the Health Board.*
	Involvement *– The PTR team is working in partnership with the Community Health Council and is working with the Public Services Ombudsman for Wales to ensure the involvement of the service user perspective.*
	Collaboration *– The Putting things Right Team is working across corporate, divisional and directorate teams to co-produce its service developments and with Health Board partners throughout Wales to improve its complaints and incident management.*
	Prevention *– Service improvement in the complaints system will help to identify areas for quality improvement in clinical care.*
Glossary of New Terms	***None***
Public Interest	This report has been written for the public domain.

Aneurin Bevan University Health Board

PTR/Organisational Learning Concerns Report
March and April 2019

1. Summary

This report summarises data and information on performance for Putting Things Right (PTR)/Organisational Learning for March and April 2019.

The report includes an update below on actions to improve quality and performance through implementation of the PTR/Organisational Learning Quality Improvement Programme.

2. Update

2.1. PTR Service Improvement Programme

Working in collaboration with the Health Board's Divisions, the Assistant Director of Organisational Learning/PTR is leading a systematic Quality Improvement Programme for PTR. The programme encompasses all areas of the PTR process including concerns, serious incidents and Ombudsman cases with a vision for high-quality management of all elements of the process and improved PTR service that ensures thorough, timely and sensitive engagement and resolution for patients and families where a concern has been raised about the services provided by Aneurin Bevan University Health Board (ABUHB).

2.2. Service Improvement Group and Programme Plan

In January 2019, a number of workstreams were introduced in partnership with the ABUHB divisional complaints teams. The outcome of this work will be options for a revised complaints pathway although several recent changes have taken place to improve performance.

Workshops facilitated by ABCi were held in January, March and April to review the complaints pathway and establish areas for improvement. A PTR/Organisational Learning Quality Improvement Group is established to oversee this programme of work. The group includes senior members of the PTR Team and Divisions with the authority to make decisions on behalf of their department or service. The programme is delivered through a service improvement plan which will describe the future state for the PTR service and how this will be achieved together with a schedule of actions, risks, issues and resources required for delivery of the plan.

Key actions already implemented to improve Quality and Performance in the PTR service include:

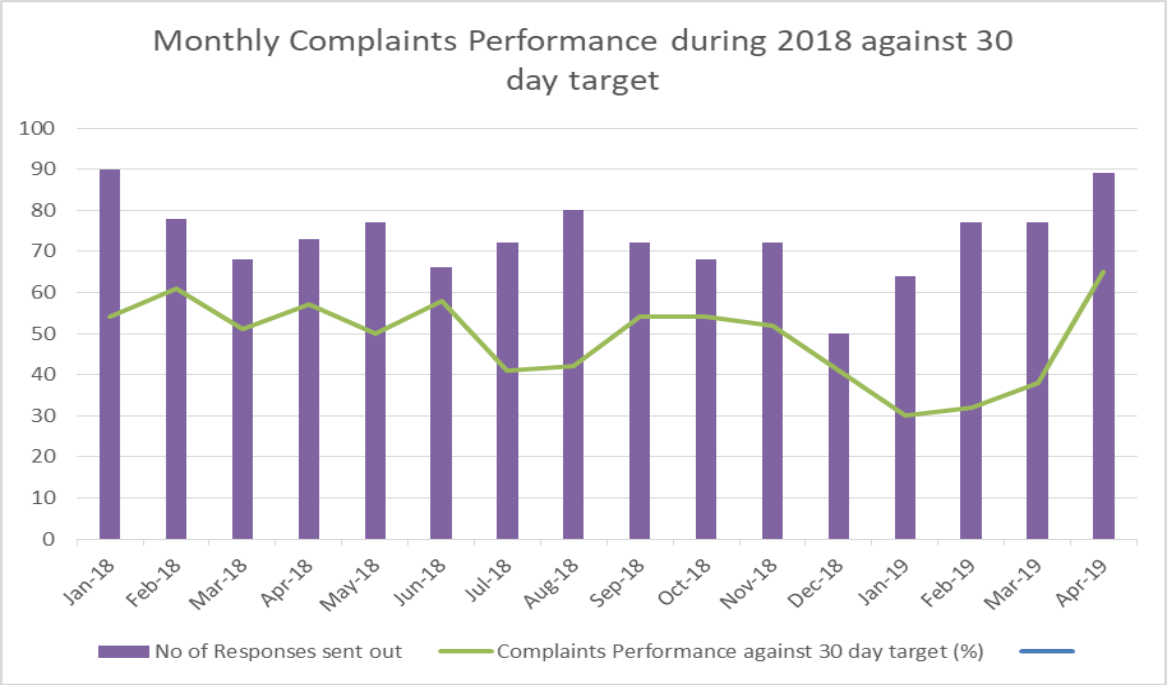
- Introduction of performance improvement trajectories for the Health Board and divisions
- Removal of the additional assurance layer to improve timeliness of responses
- Introduction of a new senior sign-off process at divisional level

- Review of PTR team structure
- Co-location of the complaints and Ombudsman functions of the PTR/Organisational Learning Team to improve team dynamics and administrative cross-cover
- Strengthening of leadership in the PTR team, recruitment into vacant posts and temporary staffing
- Introduction of control process for complaint responses
- Clearer definition of formal and informal complaints.
- PTR team members are working more closely with complaints co-ordinators.
- A complaints tracker has been established to log and track all complaints.
- A thematic review of Ombudsman cases
- Complaints pathway mapping to produce a 'future state' pathway for the service

3. Complaints Performance

This report focuses on formal and informal complaints received in March and April 2019. It includes the number of complaints received, the subject of complaints and the performance against the 30 day target for the Health Board and the individual Divisions.

The Health Board responded to a total of 166 formal complaints during March and April 2019, with the overall performance against the 30 day target in March being **38%** and improving in April 2019 to **65%**.

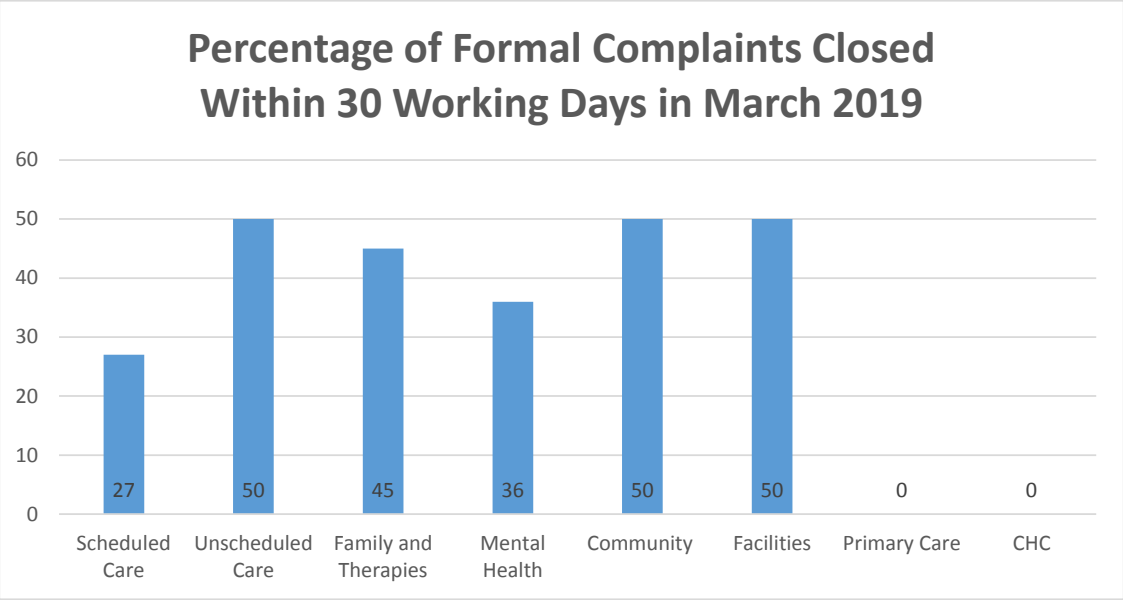


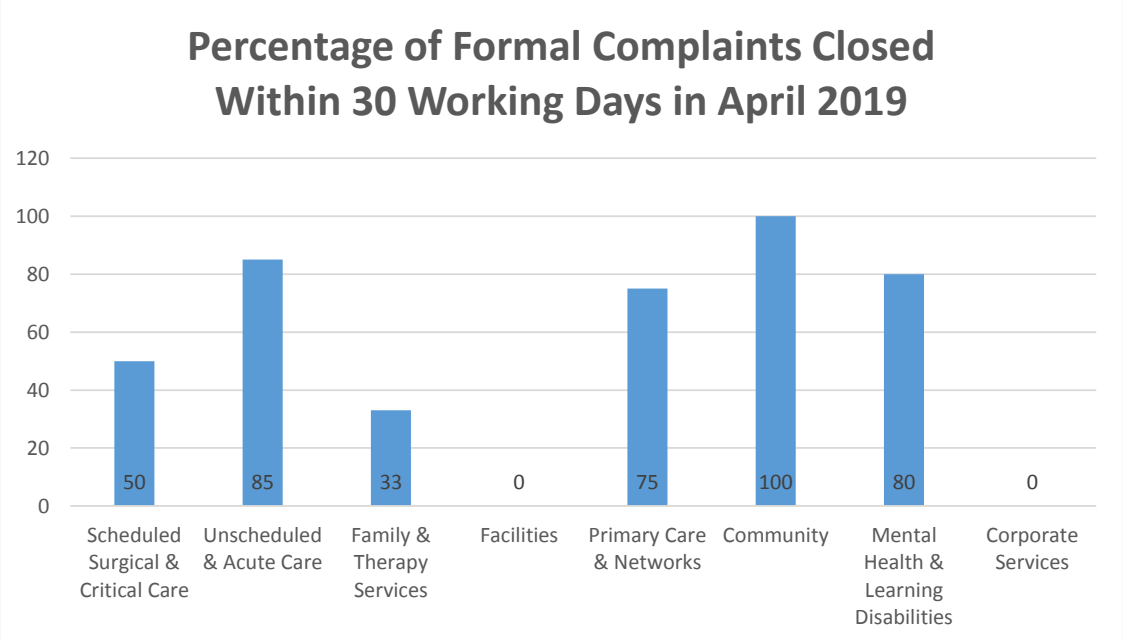
A total of 190 informal complaints were received in March and April 2019. Informal complaints are those that can be addressed 'on the spot' within

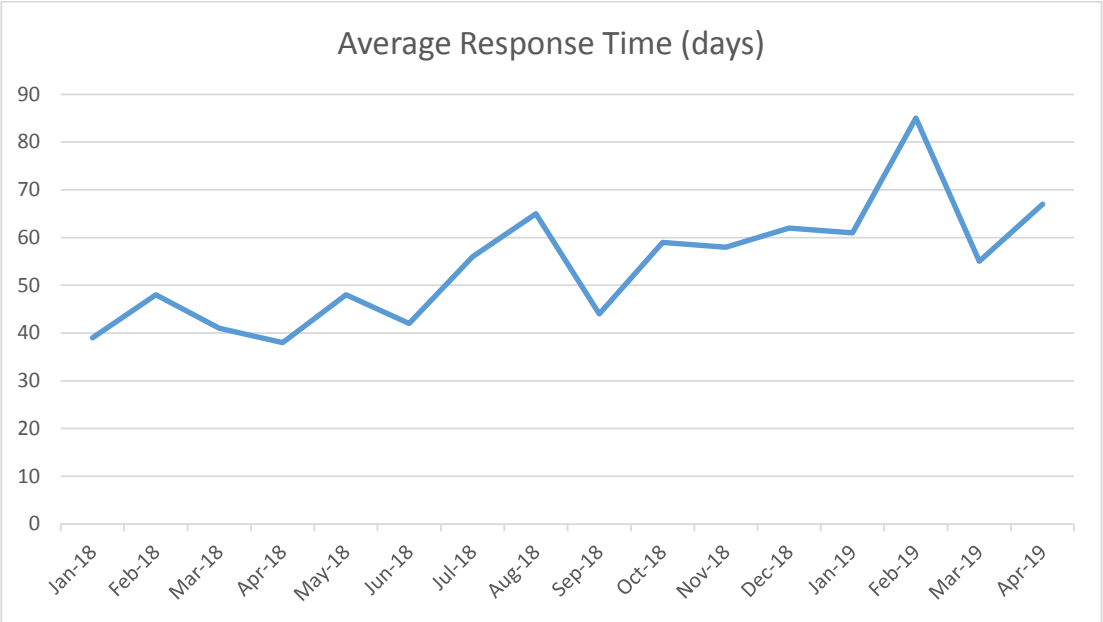
48 hours and which do not require a written response from the Chief Executive.

3.1. Complaints Performance for March and April 2019 by division.

The charts below show the percentage of complaints closed in March and April 2019 which met the Welsh Government Target of 30 working days from receipt of the complaint.



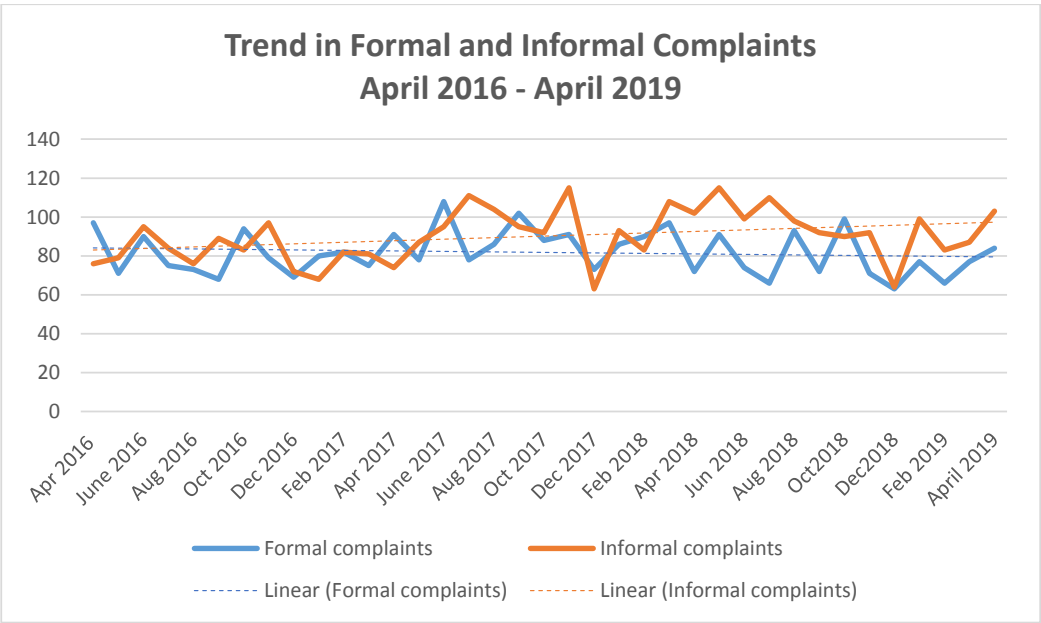




Average time to respond to complaints reduced in March and improved again in April following a high point in February 2019. As complaints performance is measured on the number of complaints sent out within the month that are within the 30 day timescale, it is expected that the changes that took place between January and April 2019 will show a reduction in average response time in subsequent months

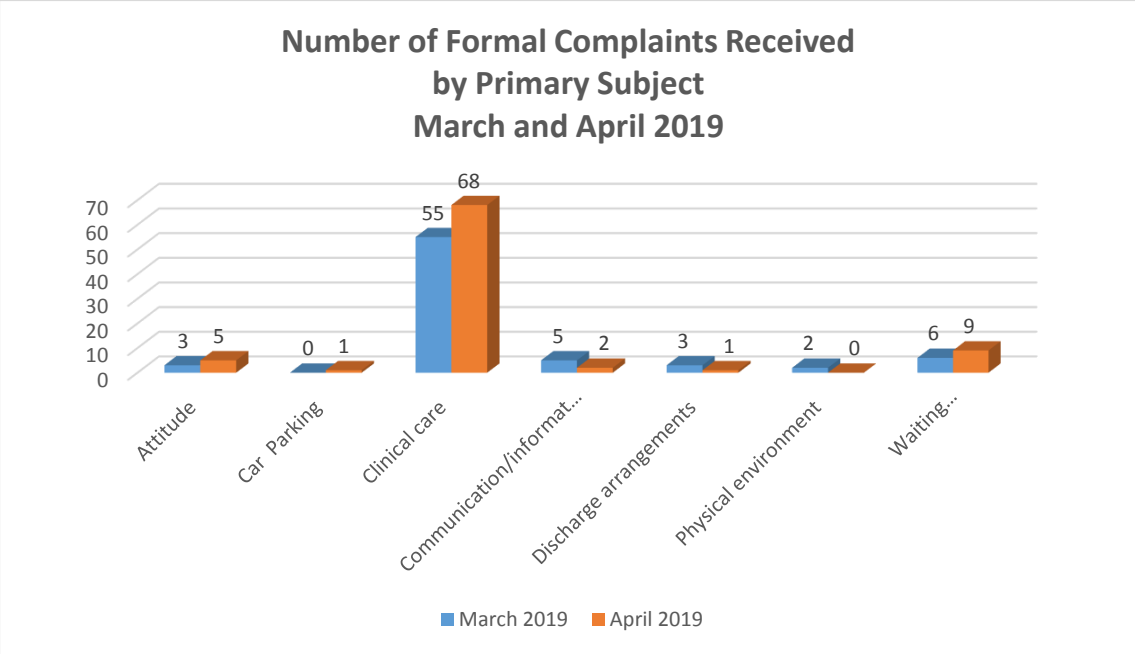
3.2. Trend in the number of Formal and Informal complaints

During March and April 2019, the Health Board received 166 formal complaints and 190 informal complaints. The trend in the number of formal and informal complaints received each month since 1 April 2016 is shown in the chart below.

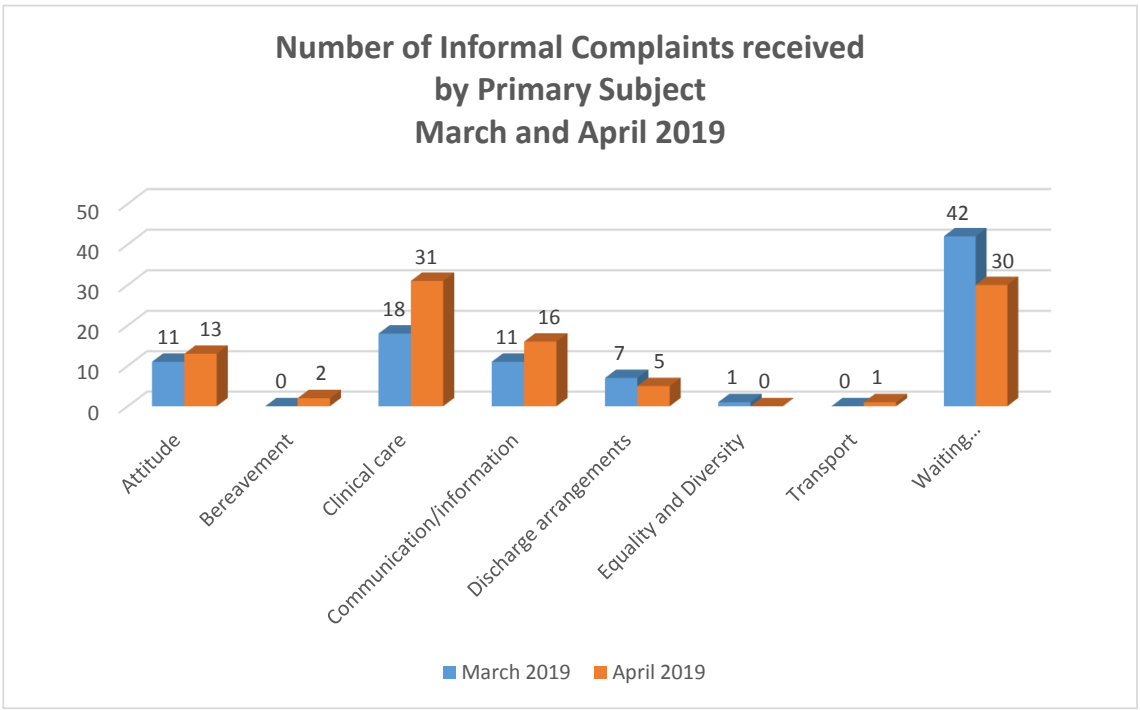


4. Primary Subjects of Formal Complaints

The majority of formal complaints received in March and April 2019 were related to clinical care. Informal complaints also feature clinical care, although the majority received are about waiting times, delays and cancellations.



4.1. Primary Subjects of Informal Complaints



5. Complaints Notified to the Public Services Ombudsman for Wales (PSOW)

During March and April 2019, the Health Board received 111 contacts from the Ombudsman's office, 32 of which related to new complaints. Of these new concerns, 7 were notifications of new investigations and 25 were new queries. The remainder of the contacts were regarding Ombudsman complaints already in the system which included receipt of:

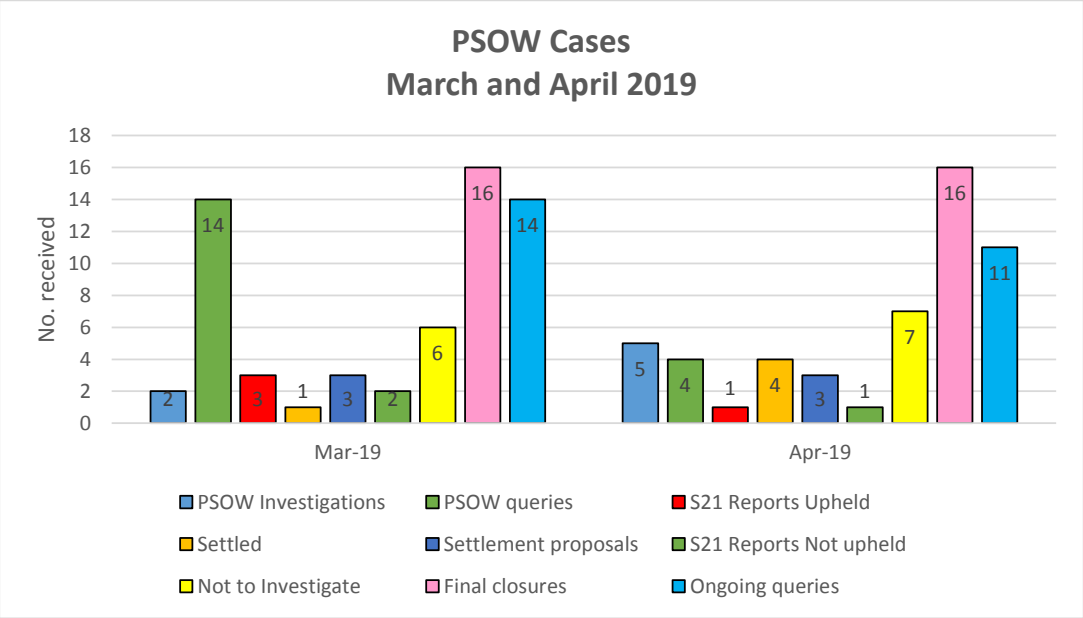
- 10 Draft Section 21 Reports (7 Upheld and 3 Not Upheld)
- 8 Final Section 21 Reports (4 Upheld and 4 Not Upheld)
- 4 settlement proposals.

During this time 7 cases were actually settled, meaning that the Health Board had agreed to the Ombudsman's settlement proposal, mitigating the need to carry out a full formal investigation.

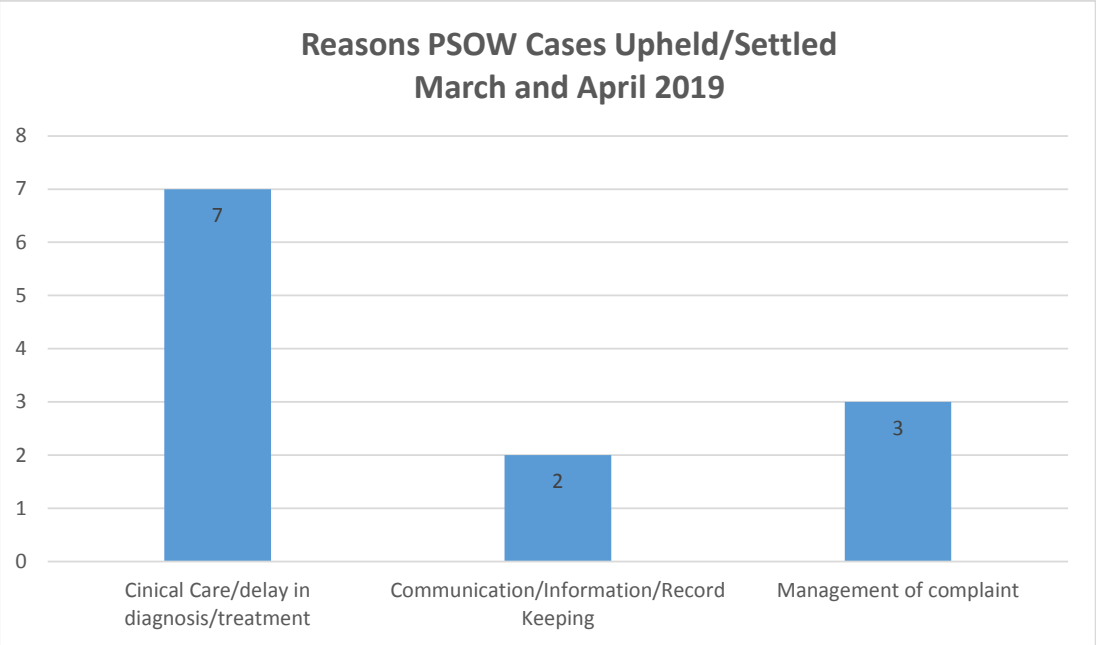
A total of 32 cases were closed by the Ombudsman in this two month period, including:

- 4 cases that were not upheld
- 13 where the Ombudsman had decided not to investigate
- 12 final closures (where evidence was received of the Health Board's compliance with PSOW recommendations)

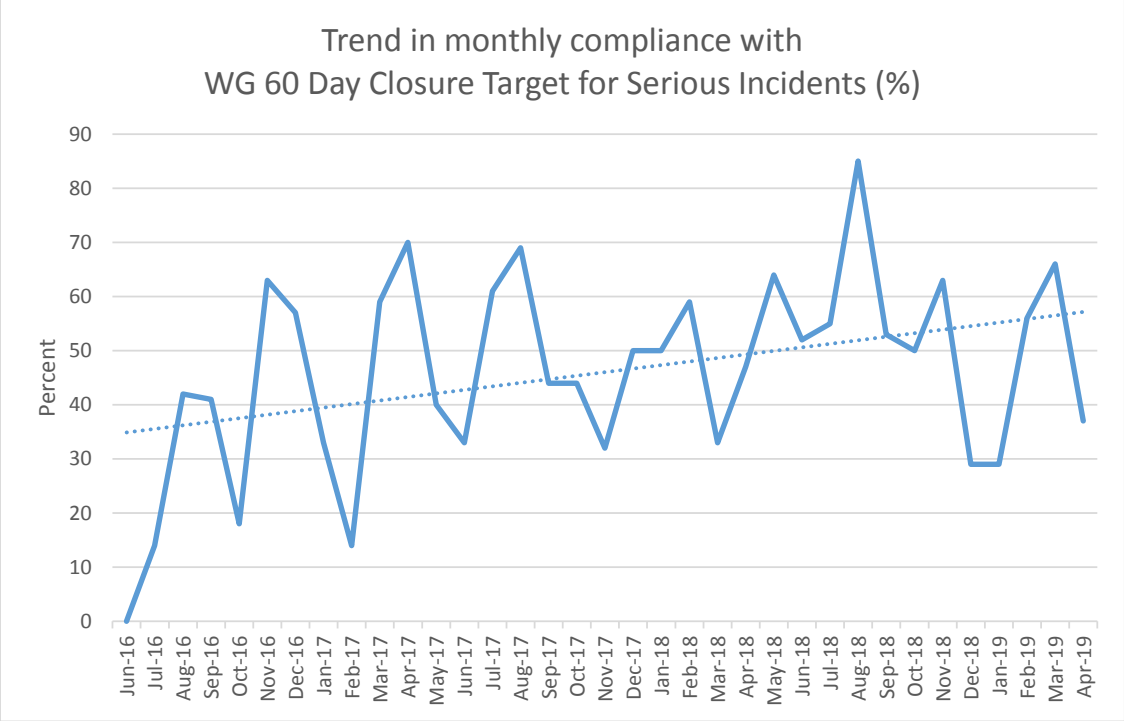
The chart below provides an overview of PSOW activity during March and April 2019.



A review of upheld and settled cases in March and April 2019 identified that clinical care was the highest subject, followed by the management of the complaint and then communication/information/record keeping.



6. Serious Incidents (SIs)



Compliance with serious incident closures is measured as the percentage of closure reports due within the month that are submitted to Welsh Government within 60 days of discovery of the incident.

Total compliance with 60 day closure for Serious Incidents for March 2019 was **66%.** Scheduled Care, Family & Therapies and Community divisions all achieved 100% compliance for SI closures in March 2019.

Compliance in April 2019 reduced to **37%.** Unscheduled Care Division again achieved 100% compliance in April due to proactive management against a performance target of 33%. However three divisions, Scheduled Care, Primary Care & Networks and Mental Health & LD did not meet their performance target for SI closures in April.

Closures of pressure damage incidents are no longer included in performance figures as a new process was recently implemented. Notification and closure of pressure damage incidents now take place concurrently and learning from these incidents subject to internal ABUHB processes.

7. Conclusion and Focus

The significant work and focus continues to towards improved performance and quality in the handling of concerns and to enhance the timelines of investigations into Serious Incidents.

The Improvement Plan oversight and monitoring continues with regular review.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

PTR Service Improvement Action Plan

Aim	Actions	Lead	Timeframe
Management of Concerns			
To support and enhance the performance within PTR and ensure clear lines of responsibility, leadership and appropriate resource.	Review the PTR Team structure/roles and responsibilities and assessment of any resource implications. Implement the structure	Martine Price/Alison Lewis Lin Slater/Martin Lane	**COMPLETE** April 2019
	Provide interim senior leadership to the team until post of Assistant Director of Organisational Learning goes to advert full time.	Martine Price	**COMPLETE**
	Increase capacity within the PTR Team with a Band 6 Concerns Officer.	Alison Lewis	**COMPLETE**
	Replace Band 3 Concerns Administrator.	Alison Lewis	**COMPLETE**
To streamline the current complaints pathway to improve performance against targets and quality of response.	Review operational management of the ABB Complaints inbox.	Martin Lane	**COMPLETE**
	To have clear definitions and categorisation of formal/informal complaints to ensure concerns are responded to in an appropriate manner as per PTR All Wales Guidance.	Martin Lane	March 2019 Awaiting all-Wales 'Once for Wales' guidance. Advice sought from WG. **COMPLETE**
	Process map a sample of complaints across the organisation to identify delays in pathway.	Martin Lane	March 2019 Current process was mapped to provide basis for Future State process map.

Aim	Actions	Lead	Timeframe
			Revised timeline: April 2019 COMPLETE Awaiting draft process map from ABCi
	Following the process mapping develop a flow chart with identified timescales available for all to use to ensure consistent approach and accountability and responsibility at each stage.	Martin Lane	**Revised timeline (As above): April 2019 Dependent on above**
	The PTR team will take responsibility for logging, obtaining consent and sending out the initial acknowledgement letter for all concerns received via headquarters.	Martin Lane	**COMPLETE**
	PTR will develop the use of a complaints tracker that will be updated weekly in partnership with the divisions and monitored and highlight any delays to the complaints co-ordinators.	Martin Lane	March 2019 **Revised timeline (As above): April 2019 COMPLETE**
	Template letters will be reviewed through the Safety and Learning Networks to identify a consistent approach and best practice.	Martin Lane	**Revised timeline (As above): May 2019**
To develop a consistent approach across Divisions to share good practice and improve quality and timeliness of responses	Establish a workstream to clarify key roles and responsibilities.	Martin Lane	March 2019 **PARTIALLY COMPLETE Steering Group established to oversee Quality Improvement Programme**
	Establish Service Improvement Group, with senior divisional representation and support from Director of Operations. GMs to nominate representative.	Martin Lane GMs	**COMPLETE**

Aim	Actions	Lead	Timeframe
	Director Operations to nominate representative	Claire Birchall	
	Review and update the Concerns Policy.	Martin Lane	March 2019 **Revised timeline (As above): April 2019**
Improve data quality in complaints handling	Establish data quality workstream to determine and implement actions to improve data quality.	Martin Lane	March 2019 **PARTIALLY COMPLETE** **Steering Group established to oversee Quality Improvement Programme**
To improve relationships with the Ombudsman and current processes	Undertake a thematic review of Ombudsman Findings over the last 2 years.	Liz Waters	**COMPLETE**
	Share findings with divisions/PTR to Inform improvement work and learning at January Workshop.	Liz Waters	**COMPLETE**
	Re-establish relationship and way of working with Ombudsman.	Lin Slater	**COMPLETE** For continuing review
	Develop Performance metrics and more robust monitoring processes.	Martin Lane	March 2019 **COMPLETE**
Organisational Learning			
To have a training, coaching and mentoring programme that provide staff with the skills to carry out investigations.	Undertake training needs analysis to identify numbers of IO's per Division against number of complaints and serious incidents.	Martin Lane/Alison Lewis	June 2019 Underway - Work progressing with divisions
	Review training materials against needs.	Martin Lane/Alison Lewis	June 2019 Underway

Aim	Actions	Lead	Timeframe
	Agree programme of training dates and prioritise individuals for training.	Martin Lane/Alison Lewis	June 2019
Establish forums for sharing good practice and implementing Organisational Learning	Re-establish the Learning Committee.	Martin Lane/Alison Lewis	March 2019 **Revised Timeline: June 2019**
	Develop forums for shared learning.	Martin Lane/Alison Lewis	March 2019 **Revised Timeline: June 2019**
	Establish a register and learning log.	Martin Lane/Alison Lewis	March 2019 **Revised Timeline: June 2019**
	Re-establish Organisational Learning bulletins.	Martin Lane/Alison Lewis	March 2019 **Revised Timeline: June 2019**
Management of Serious Incidents			
Improve process around management of Serious Incidents and compliance with WG closures	Hold an ABUHB SI workshop to develop closer working relationships with divisions to improve compliance with WG closures.	Alison Lewis	March 2019
	Update the SI policy to clearly articulate closure process and identify roles and responsibilities of PTR Team and introduce an audit process.	Alison Lewis	March 2019
	Develop criteria for identifying what constitutes a serious incident and subsequent management.	Alison Lewis	March 2019
Performance			
Improve compliance with performance measures for concerns and serious incidents	Develop Key Performance Indicators for the PTR process for concerns, Sis and Ombudsman.	Martin Lane/Alison Lewis	**COMPLETE** To complete process mapping as basis for measurement **Revised timeline:**

Aim	Actions	Lead	Timeframe
	Ensure monthly timely reporting of data to inform performance. Develop monthly and quarterly reporting framework	Martin Lane Martin Lane	**June 2019** **COMPLETE** **COMPLETE**
	Each division to identify trajectories for improvement in compliance with concerns and serious incidents Enhance link with Performance review meetings	GMs/Divisional Directors Nick Wood/ Claire Birchall	March 2019 **COMPLETE** **COMPLETE**

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Quality and Patient Safety Committee Wednesday 12th June 2019 Agenda Item: 4.8

4.6

Aneurin Bevan University Health Board

Annual Quality Statement 2018-19

Executive Summary

All NHS Organisations are required to publish an Annual Quality Statement (AQS) as part of the organisation's annual reporting process. The AQS is for our resident population and provides an opportunity to let the public know in an open and honest way about how we are doing in relation to delivering services that address the local need and meet high standards.

The AQS is produced through a process that asks the Divisions for ideas for the content and combines this with required content. All stories are drafted and checked with experts on the subject. The content is audited by Internal Audit to ensure it is consistent with the information reported to the Board and the requirements of WHC 2019 007.

The Quality and Patient Safety Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	

Executive Sponsor: Paul Buss, Medical Director

Report Author: Kate Hooton – Assistant Director, Quality and Patient Safety

Report Received consideration and supported by :

Executive Team		**Committee of the Board [Committee Name]**	**Quality and Patient Safety Committee**

Date of the Report: May 2019

Supplementary Papers Attached: AQS 2018-19

Purpose of the Report

All NHS Organisations are required to publish an Annual Quality Statement (AQS) as part of the organisation's annual reporting process. The AQS is for our resident population and provides an opportunity to let the public know in an open and honest way about how we are doing in relation to delivering services that address the local need and meet high standards.

The AQS for 2019-20 was required to be published on 31 May 2019. The attached AQS has been approved by the Board. The QPSC is therefore asked to receive the report for assurance/compliance. Any comments about content/format will be noted and carried forward into the 2019-20 AQS.

Background and Context
The AQS has been produced to meet the requirements of the WHC/2019/007. The process starts with a request to the Divisions for content, although the author also notes issues over the year and flags them as a possible story for the AQS. All the targets set in "Looking Forward" are also included as detailed stories, as well as being reported in summary in the "smiley face" table. There is an AQS Steering Group which reviews the proposed content, although, this year it only met early in the process, as the later meeting had to be cancelled. All stories are drafted, based on the information provided, and sent to an expert on the area for them to check the content. The Internal Audit Service undertakes an audit of the content every year in order to ensure that is consistent with information reported to the Board over the year, and complies with the WHC/2019/007. With a publication date of May 31st, it has been difficult to provide whole year 2018-19 data within the AQS. The data used within the AQS has been taken from the sources used for the data reported to QPSC and the Board and WG. However, some of the data may be subject to a small amount of change before it is finalised for 2018-19.

Assessment and Conclusion
It is not possible to cover all services within the Health Board in the AQS, but it is important that it does cover primary care and community care as well as acute services and as wide a range of services as possible. It also tries to demonstrate the importance of the integrated working with partners in the delivery of services to the resident population. The AQS 2018-19 has been finalised and approved by the Board. Any comments about content/format will be noted and carried forward into the 2019-20 AQS.

Recommendation
The QPSC is asked to receive the report for assurance/compliance. Any comments about content/format will be noted and carried forward into the 2019-20 AQS.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The Annual Quality Statement has reputational Risks if it is not published, or if the information within it is inappropriate or inaccurate. These are mitigated through review by Committees/Groups of the Health Board and by the Board Secretary, as well as audit by Internal Audit.
Financial Assessment, including Value for Money	The AQS requires resource in the form of staff time to produce it. This comes principally from the Medical Director's budget.
Quality, Safety and Patient Experience Assessment	The AQS reports on Quality of ABUHB services to the public, and is an important part of the Health Boards Annual Reporting process.

Equality and Diversity Impact Assessment (including child impact assessment)	The AQS reports on services only. It aims to cover as many areas of service as possible, but it is not possible to cover everything within the report.
Health and Care Standards	The AQS is written using the Health and Care Standards as a framework and therefore provides some assurance against the health and care standards.
Link to Integrated Medium Term Plan/Corporate Objectives	The AQS reports on many of the Quality improvements within the Quality Appendix of the IMTP to the resident population.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Many of the services/issues covered within the AQS are important for the long term health of the population.
	Integration – The AQS tries to show how service provision is now integrated with and across partner organisations.
	Involvement – The AQS demonstrates the involvement of the public with our services in many areas.
	Collaboration – The AQS demonstrates collaboration across services.
	Prevention – The first section of the AQS is on Staying Healthy, and this year looks at the impact of smoking on the health of our population and on the services to help people to avoid starting smoking, or to quit smoking.
Glossary of New Terms	There is a glossary of new terms within the AQS.
Public Interest	The AQS is for publication.

Aneurin Bevan University Health Board

Annual Quality Statement 2018-2019

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

4.6

Contents

Welcome from Chair and Chief Executive

2018-19 started with great excitement as we built up towards and celebrated the 70th anniversary of the founding of the NHS. Of course this has a particular significance for us in Aneurin Bevan University Health Board (ABUHB) because we are named after the driving force behind the NHS, Aneurin Bevan, as he came from Tredegar, which is within our borders.

So we celebrated with style! There were events over a number of days, but on the 5th July 2018 there were tea parties and garden parties and street parties all over the Health Board! Staff have shared stories and pictures of their memories of working in the NHS – and one of our work colleagues can claim to be one of the first babies born into the NHS! Sandra Brookes, a Healthcare Support Worker on Annwylfan Ward in Ysbyty Ystrad Fawr was born on the 6th July 2018. She was the first girl born in Church village hospital, after it opened on the 5th July 1948.

Whilst we know we can always get better, we think Aneurin Bevan would enjoy looking through this Annual Quality Statement, which is written to tell our citizens about the quality of the healthcare services we provide. We think he would both celebrate with us our achievements and share our frustration and disappointment over the things that have not gone so well. As the 70th Anniversary Year ends, we are proud to work for Aneurin Bevan University Health Board. We will continue to strive to provide a good patient experience for everyone who comes into contact with our services as they are now, and whilst we also start to change our services in preparation for the opening of the Grange University Hospital in the Spring of 2021.

The Grange University Hospital has gone up fast during 2018-19, and in March 2019, we welcomed Vaughan Gething Assembly Member, Minister for Health and Social Services, who marked the topping out of the building by ceremonially pouring some concrete and signing one of the concrete plinths.

During the year the Health Board has continued to have the challenge of recruiting the required number of clinicians to fill current vacancies. This year, the pressure on our services has continued throughout the year, with the long spell of hot weather in the summer 2018 leading to more admissions, in the same way as colder weather in the winter. As always, we thank all our staff for their continued hard work, and the outstanding commitment they show to keeping the patient at the centre of the care they provide. The compliments and thanks on page 30 are a tribute to this.

This AQS demonstrates how we work all the time with our partners in health, social care and the third sector to deliver care for the patients in different ways. We work so closely together that we could not deliver services without them now. Indeed, our plans for the future services will not come to fruition without them

This working together in Wales, something that Aneurin Bevan would be proud of, is designed into the service through its structure, and supported by recent Acts passed by the Welsh Assembly. It is what makes the NHS in Wales special. However it is the privilege of being there for people at their times of greatest need that motivates all of us working in the NHS. This is at the core of our service both now and into the future.

Judith Paget, CEO (Left)
Ann Lloyd, Chair (Right)

Introduction

Aneurin Bevan University Health Board (ABUHB) is responsible for promoting wellness, preventing disease and injury, and providing health care to a population of approximately six hundred and forty thousand people who live in the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen with a budget of approximately £1.1billion.

This Annual Quality Statement describes some of the fantastic achievements in improving the quality of our care and services in 2018-19, as well as some of the challenges.

More information can be found on our website

http://www.aneurinbevanhb.wales.nhs.uk/

Our vision for Aneurin Bevan University Health Board is to

Our Values

Everyone who works within Aneurin Bevan University Health Board share four core values that guide the approach we take to work, how we do things, how we treat each other and how we expect to be treated. We demonstrate our values, each and every day, across our organisation and care system through these behaviours.

We work in a way that is aligned to the vision and values of the organisation and this is visible and explicit in everything that we do and say.

Our senior leadership team consistently role model these behaviours and hold each other to account, and this is reflected across all levels of the organisation.

We recognise the part our individual role plays in the successful delivery of services and work together, across structural boundaries, to make the best use of resources, in order to deliver the highest quality services and care.

We hold each other to account and welcome and accept constructive feedback to help us improve our services

We foster an innovative environment where change is embraced, to enable everyone to effectively navigate whatever challenge lies ahead and provide a high quality experience for everybody who uses our services

We pride our-selves in delivering high quality services (internal and front facing)

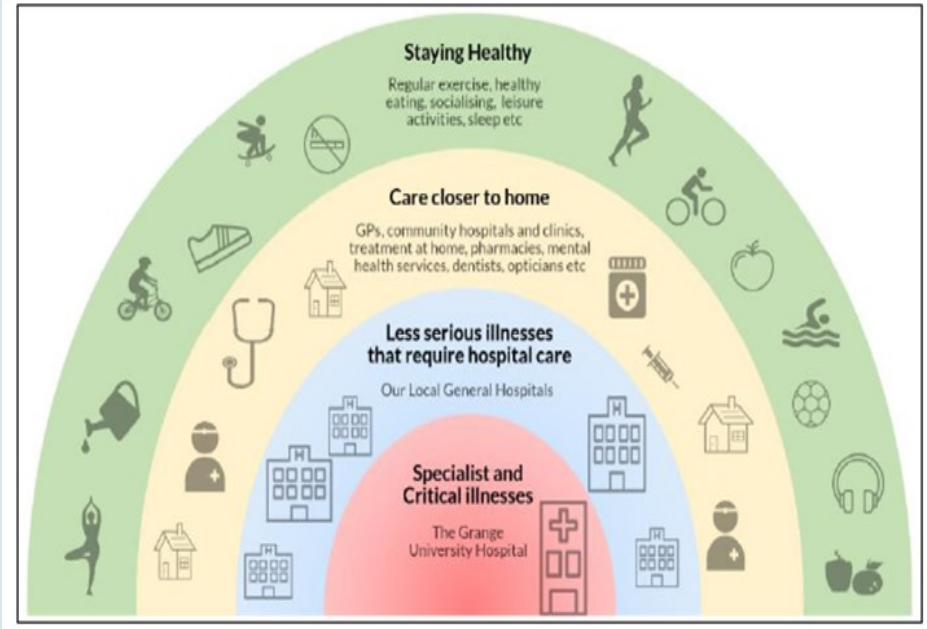
Anyone entering an Aneurin Bevan Health Care setting, feels welcomed and valued at all times.

In order to continue to provide excellence into the future, we have known for some time that the model for our service delivery had to change. With quality and safety at the heart of its design, Clinical Futures is our strategy for delivering health services based on a clinical model that starts by helping people to stay healthy, then aims to support them as close to home as possible with their ongoing health care needs. People with less serious illnesses, and people after the acute phase of their illness will be treated in the local general hospitals. Our sickest people and those requiring specialist care will need to be admitted to the Grange University Hospital. Specialist Primary and community services are at the heart of the model and central to developing a new relationship with patients as partners/co-producers in preserving, maintaining and improving their own health and well-being. Investing in and strengthening primary, community and social care services to create the capacity to support and treat patients in their homes and communities is a core component of the strategy and at the heart of integrated service delivery. There are examples of this integrated working throughout this Annual Quality Statement in line with the Social Services and Well Being (Wales) Act 2014.

The Royal Gwent Hospital, Nevill Hall Hospital and Ysbyty Ystrad Fawr will all continue to provide routine care and treatment as Local General Hospitals, and primary care and community services will provide more care to people closer to their homes

In 2018-19, the Grange University Hospital has rapidly taken shape. Work is progressing on constructing the building in readiness for its scheduled opening in Spring 2021.

We are also making changes in Primary and Community Care to develop care closer to home, with the introduction of Care Navigators who speed up access for patients to the most appropriate Health Care Professional at GP Surgeries.



Introduction

The next 2 years are going to be crucial to the strategy, as we continue to provide high quality, safe care, whilst at the same time, changing them so that they are in the form that they need to be in time for the opening of the Grange University Hospital. Every year we refresh our plan to deliver healthcare services.

Click here to view a video about the Clinical Futures Strategy.

You can access our Integrated Three Year Deliver Plan on our web-site: http:www.aneurinbevanhb.wales.nhs.uk/

Some of our Hospitals are referred to in this report using their initials, as shown below:

RGH: Royal Gwent Hospital, an acute hospital in Newport

NHH: Nevill Hall Hospital, an acute hospital in Abergavenny

YYF: Ysbyty Ystrad Fawr, an acute hospital in Caerphilly

YAB: Ysbyty Aneurin Bevan, a community hospital in Ebbw Vale

We would love to hear your views and you can contact us in a number of ways:

E-mail	abhb.enquiries@wales.nhs.uk
Twitter	www.twitter.com/aneurinbevanhb
Letter	Aneurin Bevan University Health Board Headquarters, St Cadoc's Hospital, Lodge Road, Caerleon, Newport, NP18 3XQ
Facebook	www.facebook.com/AneurinBeavnHealthBoard

Alternatively you can complete the survey using the link below to let us know what you think of this annual quality statement:

https://www.surveymonkey.co.uk/r/LD26KLN

2018-19 Priorities – Summary of Progress

PRIORITY FROM 2017/18 AQS	WHAT HAVE WE DONE IN 2018/19?	HOW HAVE WE DONE?
Staying Healthy We will implement a place based targeting approach focused upon areas where smoking prevalence is greatest in our communities.	A 'place based targeting' approach has been used during 2018-19 in three areas across Gwent, namely Cwmbran, Ebbw Vale and Blackwood. These areas were chosen as half or more of the adult population in these areas smoke. **For more information, see p 7**	
HCAI We will further reduce the rates of infections to the following levels: C difficile rate of 25 per 100, 000 population. Staph aureus rate of 19 per 100,000 population. Gram negative, (E Coli) rate of 61 per 100,000 population.	We have not achieved the target set for us by the Welsh Government 25 C difficile infections per 100,000 population, although we have reduced the rate to 26.37 per 100,000 population, compared to the rate in 2017-18 of 36.81 per 100,000. We have not achieved the target set for us by the Welsh Government and reduced the rate of Staph Aureus infections below 19 per 100,000 population, as the rate for 2018-19 was 26.71. We have not achieved the target set for us by the Welsh Government and reduced the rate of Gram negative (E Coli) infections below 61 per 100,000 population, as the rate for 2018-19 was 72.81. **For more information, see p 14**	
In-patient Falls We will reduce the number of inpatient falls by 10% from April 17 to March 19, and initiate a programme of training on preventing falls, using a standard presentation which supports the use of the Falls Multi Factorial Risk Assessment (MFRA).	During 2016-17, the usual number of falls in a month was 380. With a target of reducing falls by 10%, we therefore wanted to reduce the number of falls by 38 per month to 342 falls per month. We are pleased that in 2018-19, the usual number of falls in a month is 307.5 and we have therefore achieved this target. In early 2018-19, we also put in place a programme of training using a standard presentation, which supported the use of the Falls MFRA, with training undertaken at all our hospitals. **For more information, see p 9**	
Pressure Damage We will spread the Collaborative to wards at NHH and achieve a reduction in the number of days between incidence of pressure damage at both RGH and NHH wards participating in the collaborative.	Altogether, the average reduction of HAPUs across the collaborative wards is about 45%, from the data available at 23.03.2019. The collaborative spread to 4 wards at NHH, but they are yet to provide data or robust implementation of PDSA (Plan Do Study Act) cycles. **For more information, see p 12**	

2018-19 Priorities – Summary of Progress

PRIORITY FROM 2017/18 AQS	WHAT HAVE WE DONE IN 2018/19?	HOW HAVE WE DONE?
Sepsis and Deteriorating Patient We will develop NEWS as common language in community/primary care by establishing pilots in a range of community/primary care services.	Teams from many of the community services are piloting how they can use the usual physiological observations and NEWS score to recognise and respond to deterioration, so NEWS becomes a common language that all services, acute and community, understand. **For more information, see p 15**	
12 hour waits in A and E We will significantly reduce the 12 hour waits in A and E.	In 2018-19, 5463 people waited 12 hours or longer in A & E compared to 5788 in 2017-18. We therefore did reduce the number of people waiting 12 hours in A&E, but the reduction was less than 10% and therefore less significant than we wanted. **For more information, see p 26**	
Dementia We will develop a clear protocol for the assessment of delirium in general hospitals.	The use of the 4AT assessment tool has been taken forward as an improvement project in the Medical Assessment Unit at YYF in order to develop a clear protocol for the assess-ment of delirium. However, the improvement work is still ongoing. It is also being used as part of the assessment on admission to the Care of the Elderly Wards at RGH. **For more information, see p 24**	
Volunteers We will develop a new Welcoming Service at St Woolos with our partner Age Cymru Gwent and expand and extend the Welcoming Service at Nevill Hall Hospital from two mornings a week with our partners Age Cymru Gwent, the RVS, Nevill Hall Leagues of Friends and North Gwent Cardiac Rehabilitation and Aftercare Charity.	A full Monday to Friday Volunteer Welcoming Service has been in place at St Woolos Hospital since July 2018. The Welcoming Service at Nevill Hall Hospital has been expanded and extended from two mornings a week to a full Monday to Friday Volunteer Welcoming Service since Autumn 2018. **For more information, see p 31**	
Staff Wellbeing – develop a Staff Engagement and Wellbeing Strategy to support our staff.	Following engagement with staff, it was agreed that we would develop an 'Employee Experience Framework' instead of 'Staff Engagement and Wellbeing Strategy'. This was launched on 14 February 2019. **For more information, see p 31**	

Many Cancers can be prevented if we adopt healthy behaviours.

We all know that cancer is a major cause of ill health and death, and of health inequalities. Some people get cancer and there is nothing that could have been done to reduce the chance as they are at higher risk because of their genes or their age.

But did you know that 2 in every 5 cases of all types of cancer could have been prevented? For example, for lung cancer, about 7 in every 10 cases are caused by smoking. So if people do not start smoking, or stop smoking, the number of cases of lung cancer will decrease.

Every year in Gwent, about 1400 people get a cancer that was potentially preventable.

The cancers can be prevented if people adopt healthy behaviours, such as:

- Not smoking tobacco
- Being a healthy weight
- Eating a healthy diet
- Being physically active
- Drinking alcohol within national guidelines

In some areas a greater proportion of the population adopt healthy behaviours than in other areas. In general, people living in communities with a higher proportion of healthy behaviours live longer and spend more years in good health than in communities with lower levels of healthy behaviours.

Life expectancy

Across Wales, a smaller proportion of those living in disadvantaged areas adopt healthy behaviours than in the less disadvantaged areas. This pattern is also seen in Gwent, and the proportion of people adopting healthy behaviours is much lower than the average for Wales. This means that a greater proportion of people in those areas will develop the potentially preventable cancers like lung cancer because more people smoke.

In these disadvantaged areas, the number of years that people can expect to live is therefore lower, and the number of years that people can expect to live in good health (Healthy Life Expectancy) is lower still.

	Monmouthshire Less disadvantaged area	Blaenau Gwent More disadvantaged area	Difference
Life expectancy Men	80.5 years	76.0 years	4.5years
Life expectancy Woman	84.1 years	80.2 years	3.9 years
Healthy Life expectancy Men	69.8	59.6	10.2
Healthy Life expectancy Woman	70.7	59.3	11.4

Reducing Smoking

In Gwent, nearly a fifth (19%) of the adults smoke. Despite the encouraging fall in smoking rates overall, differences can be seen across Gwent local authority areas, where in 2017-18, the percentage of people that smoked ranged from 13% in Monmouthshire to 22% in Blaenau Gwent.

To reduce the amount of ill health in the population that is related to smoking, we need to both stop young people from starting to smoke (did you know, two thirds of smokers start before the age of 18?) and increase the number of people who give up smoking.

In ABUHB, we are working with schools to stop young people from starting to smoke:

- The JustB Smoke Free programme goes into secondary schools and works with 12 to 13 year olds, training them to be Ambassadors and talk to their friends about the benefits of being smoke free, and the risks of smoking
- Creating smoke free environments so it becomes the norm not to smoke within the child's community

We are also working to support people to stop smoking by:

- Increasing the number of community pharmacies across Gwent who can provide the whole package of help for people who want to stop smoking
- Promoting the National "Help Me Quit" single website and helpline phone number

"We will implement a place based targeting approach focused upon areas where smoking prevalence is greatest in our communities."

An example of 'place based targeting' during 2018-19 is the approach taken in three areas across Gwent, namely Cwmbran, Ebbw Vale and Blackwood. These areas were chosen as at least half of the adult population in these areas smoke.

The approach was intended to decrease the percentage of adults who smoke through raising awareness of the National Campaign "Help Me Quit" and therefore increasing the number of referrals from these areas to services that help people to stop smoking.

What we did:

A range of resources, including leaflets, posters, place mats, canvas bags and pens, promoting the Help Me Quit service, were collected to form packs.

The packs of resources were distributed to a range of local businesses in each of the 3 areas. For example, all businesses along the high street in Blackwood were offered and accepted resources to display and raise awareness among clients/ customers. The resources encourage people to think about their smoking and to contact "Help Me Quit" if they require further information and support to quit.

Alongside the resource packs for businesses, all the community pharmacies which provide stop smoking services, received prescription bags, promoting the service.

These prescription bags were given to all customers to raise awareness of stop smoking services available in the community.

How did it go?

Businesses, including cafes, shops and takeaways, were offered the "Help Me Quit" poster, cards and leaflets to display to their customers. Due to the enthusiasm shown by the range of businesses, this approach has been rolled out into neighbouring areas (Abertillery, Brynmawr, Blaina and Cwm). 240 local businesses are now displaying the "Help Me Quit" poster, cards and leaflets across these areas.

The project has raised the profile in the areas of the "Help Me Quit" branding and information on local smoking cessation services available.

Monthly feedback reports have identified that some referrals into "Help Me Quit" are from clients who have heard about the service as a result of these resources. Further evaluation of the impact is underway.

<u>In-patient Falls</u> We will reduce the number of inpatient falls by 10% from April 17 to March 19, and initiate a programme of training on preventing falls, using a standard presentation, which supports the use of the Falls MFRA

In ABUHB, we have been working to reduce the number of people for fall and we are working to prevent fractures caused by falls. We have focused initially on people who are falling in our hospitals.

Reducing the number of Inpatient Falls

When people fall, they can hurt themselves physically. However, following a fall, people can also be affected psychologically because of their fear of falling again. Sometimes they stop moving about so much or going out as they are frightened of falling, which then decreases their muscle strength which actually makes them more likely to fall again.

We have therefore been working to reduce the number of falls that occur in our hospitals. Based on the number of falls incidents reported in 2016-17, we set ourselves a target of reducing the number of falls by 10% in 2 years. We have made a lot of changes to the way that nurses assess patients to prevent the individual patient falling. In early 2018-19, we also put in place a programme of training using a standard presentation, which supported the use of the Falls Multi Factorial Risk Assessment.

All falls resulting fractures are reviewed at the Falls Scrutiny Panel and learning for improvement is the purpose of the review.

During 2016-17, the usual number of inpatient falls in a month was 380. With a target of reducing falls by 10%, we therefore wanted to reduce the number of falls by 38 to

342 falls per month. We are pleased that in 2018-19, the usual number of falls in a month is 307.5 and we have therefore achieved this target.

Our wards have really focussed on reducing the number of falls – and the amazing work done by Anwyllfan Ward at YYF to reduce falls is described below (see page 10)

Reducing the number of Fractures following a Fall by improving bone health

Many people as they get older develop "osteoporosis". This is a condition which means that the person's bones are more fragile than other people's. Consequently, they are

more likely to fracture a bone if they fall from a standing height or less – a fragility fracture. There is a simple drug treatment that can strengthen people's bones, if they are identified as at risk of osteoporosis. Treatment should be started as soon as possible after a fracture, and within a maximum of two years

However, there is evidence that only 40% of people with a fragility fracture are identified and treated according to the NICE (National Institute for Health and Care Excellence) recommendations.

In ABUHB, we have started work to increase the number of people over 50 with fragile bones that are identified and receive the correct treatment. Focussing on 5 wards, before we made any changes, we collected data on the percentage of people who had experienced a fragility fracture and were on the correct treatment. We then made a number of changes to our assessment processes to improve the identification of people who should have the treatment, and to the prescription of the treatment.

From May to November 2018, we increased the percentage of people initiated on the treatment from 45% to 81%.

We have therefore applied successfully to take part in an Improvement Collaborative with the Royal College of Physicians in 2019-20, focussing on identifying people with osteoporosis in hospital.

We have also tested a model for identifying and treating people in the Community with Fragility Fractures. We are currently exploring how we can develop this work, particularly for high risk patients with Parkinson's disease, Stroke and Dementia.

Steady on... Stay SAFE

Strength And Balance Falls History Environment

Inpatient Falls Prevention

Reducing Patient Falls on Annwylfan Ward at YYF

Annwylfan is a ward at YYF with 18 beds for older adults. The patients there mainly have advanced dementia and have associated problems which mean they can no longer live safely in the community. On the ward their problems are treated and an assessment is completed to determine what level of care they need in the future.

In 2016, the ward was one of the 10 wards with the highest number of patient falls in ABUHB. Some of the patients who fell unfortunately sustained a fracture. Review of the falls and fractures showed that, as a mental health ward, they assessed the patient's psychological risks well but were not so good at assessing the patient's risks in relation to falls. The new ward manager decided with the nursing team that they would focus on improving falls risk assessment and the management of the risks identified in order to reduce the number of falls and the harm to the patients.

The Senior Nurse for the ward contacted one of the Care of the Elderly Consultants, who provided some training for the ward. This focussed on helping the nurses to think about why a patient might have fallen and what they could do to try and prevent the patients from falling. The Senior Nurse also pulled together the data on the falls that they had reported over the previous year. From the data, it was clear that the majority of falls were occurring within the patient lounge, between midday and 2.00pm, and midnight to 3.00am at night.

The ward began by observing what was happening and what the patients were doing around these peak times for falls.

The issues the team identified that could be

contributing to the fall were:

- Noise levels at meal times leading to agitation
- Light weight furniture that moved as a patient sits down.
- Crowded day areas as there was only one lounge area
- The lay out of the ward making it difficult to observe all areas of the ward
- Drugs rounds taking place at one of the busiest time of the day

The ward was able to make some immediate changes to the environment and the way the ward worked at these times. This included:

- No interruptions to the ward routine at meal times, for patients or staff, so the atmosphere is much calmer and staff can help patients with their meal
- Redesigning the lounge and ordering new, heavier dining room chairs and tables, in colours that contrast with the flooring and walls
- Drugs rounds were reviewed and medicines taken to the patient individually at different times of day
- A programme of activities was set up throughout the day to engage patients
- CCTV was installed to allow patients to wander freely around the ward, whilst still being observed
- Smaller seating areas were created all through the ward, which means the lounge area is less crowded and patients can choose whether they want to be with other people or on their own.

During the next few months there was a steady reduction in the number of falls, however the ward staff thought this could be reduced further. After a patient fell and suffered a fracture in February 2017, the ward team adopted the falls risk assessment for people with physical illnesses. The ward round tool was reviewed to include the identified falls risk factors so this could be shared with the Multi-disciplinary Team and a care plan agreed with the whole team.

"FALLS FRIDAY" was then launched, meaning that a full review of all the patients' falls risk assessments was undertaken every Friday. This enabled the risks identified to be adjusted as the patient got better or deteriorated, and so the actions being taken to reduce the risk could be changed. This information was then presented at the ward round meetings. Falls data on the progress with reducing falls was shared at the monthly team meeting. If a patient did fall, the events leading to the fall were reviewed and learning from this discussed at the first 9am handover after the fall. Additionally the ward team devised detailed induction and resources packs for staff to ensure new staff were fully informed about assessment of falls risks and this added in ongoing learning and development.

In July 2017, a Care of the Elderly Consultant agreed to undertake a weekly medical review of all the patients.

This was extremely beneficial as he would advise on management of Blood Pressure and physical health issues that could impact mobility and increase falls risk.

The ward were able to give the Consultant important information about the patient and their risks relating to falls, as they were really aware of this from the Falls Friday reviews. Patients were experiencing a truly holistic review, looking at their physical and mental health issues.

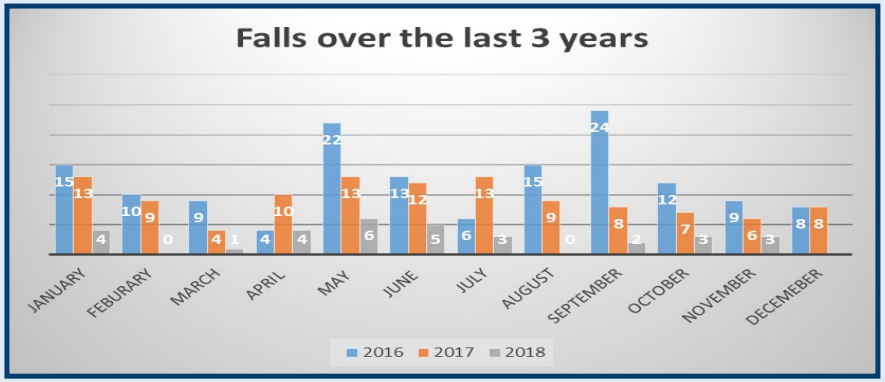
The changes on the ward continued. From 2017, the ward actively encouraged the relatives to engage in meal times and introduced open visiting times.

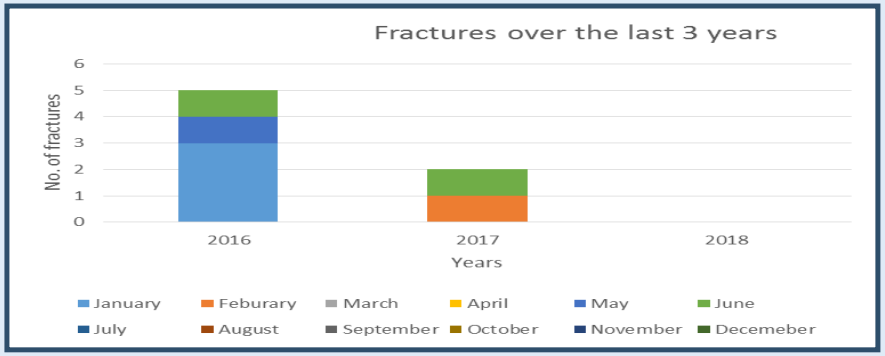
In March 2018 the ward was painted to ensure a colour contrast to help patients with poor eye sight. Seating was put in place around the ward to create small seating areas and allow patients to rest if walking along the ward corridor. A motion sensor alarm check was introduced to ensure alarms were in-place for patients at risk of falls at night.

In September 2018, the nursing station and some walls were removed to maximize the clinical space and reduce noise, increase access to seating areas and allow the ward team to create themed areas to promote discussion and engagement.

Falls have now reduced from 140 in 11 months in 2016 to 31 in the same period in 2018. This is due to the patients now having a full holistic assessment and care plan in relation to falls, and the physical changes to the ward leading to a calmer atmosphere, so patients are less agitated. They also have a number of places to sit so they can find a place that suits them.

The Falls Scrutiny Panel has commended the ward for the standard of its falls risk assessments and care plans. The ward is not stopping here though, and has plans for infra red motion sensors, and new flooring. They are also creating an extended out-door space, which will improve patient wellbeing.





"RELIEVING THE PRESSURE" – REDUCING PRESSURE DAMAGE IN OUR HOSPITALS

<u>Pressure Damage</u> We will spread the Collaborative to wards at NHH and achieve a reduction in the number of days between incidence of pressure damage at both RGH and NHH wards participating in the collaborative

A Pressure ulcer is a damaged area of skin and/or underlying tissue, usually over a bony area, as a result of sitting or lying in the same position for a period of time, putting pressure on that area. They range from patches of red skin to open wounds and can be very painful, taking a long time to heal. They can add days or weeks to a patient's recovery, significantly affect their levels of independence and delay their return home. If they lead to developing sepsis, pressure ulcers can be fatal.

Older, frail people are vulnerable to pressure damage as their skin becomes less supple, particularly if they are unable to change their position themselves. People can develop pressure damage whilst in their own homes, in Care Homes and regrettably, when they come into hospital.

Between 4% and 10% of ABUHB inpatients are at risk of developing pressure damage. In early 2017 the Director of Nursing and the Director of the Health Board's Continuous Improvement Centre (ABCi) agreed to jointly run an 18 month programme to improve ward culture and substantially reduce Health Acquired Pressure Ulcers (HAPUs) across Royal Gwent Hospital, "Relieving the Pressure".

ABCi facilitated a sequence of specially designed, full-day learning programmes, that enabled ward teams to build an understanding of Quality Improvement methods.

During the 'Action Periods' between the learning sessions, the wards had ongoing coaching support from the ABCi team and training from the Tissue Viability Nursing team to update staff on current best practice in relation to preventing and managing pressure damage. In addition to this, some staff from the wards took part in two, four day training programmes, one on 'Coaching for Improvement' and one on 'Measurement for Improvement'. By March 2019, the ABCi had trained 26 ward team members as 'Improvement Coaches' and 8 staff as 'Measurement Leads' to help to further improve and sustain achievements.

Staff participating in the programme:

- have learnt new skills about how to use data to identify what ward internal process to improve (and how to do it) and actually make the changes to improve quality of care.
- have seen how they can learn from other wards and adapt the changes made to suit their ward.
- have had a sense of satisfaction from improving the care for their patients and have had fun!

Patients repeatedly reported how much ward culture has improved compared to a few years ago.

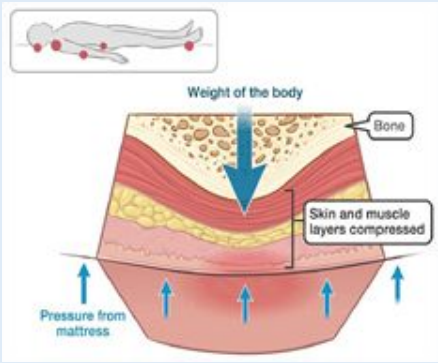
As at March 2019, 12 wards at RGH have been participating on the programme for between 17 and 8 months.

The different lengths of time participating in the programme mean that some wards have made bigger improvements than others, varying from 80% to 20% reduction in pressure damage.

However, most ward teams now have well established processes of care and assessment and were able to go through the busy winter period without an increase in pressure damage—some wards are even free of pressure ulcers for the entire winter.

Altogether, the average reduction of HAPUs across the collaborative wards is about 45% from the data available 23.03.2019. This corresponds to roughly 1 pressure ulcer per month per ward. That makes at least 12 pressure ulcers averted per ward on the programme for a year.

We know that not only have the wards reduced pressure damage, but preventing pressure damage will have reduced the length of stay for patients, and saved money. It has reduced spend on treatment of pressure damage, nurse time and bed use.



We are delighted with the reductions in pressure damage that have been achieved and wanted to bring more wards into the collaborative.

The collaborative therefore spread to 4 wards at NHH, but they are yet to provide data or robust implementation of PDSA (Plan Do Study Act) cycles.

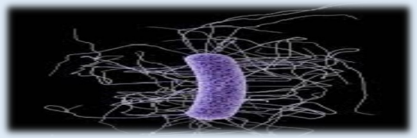
REDUCING (HCAI) Healthcare Associating Infections

HCAI We will further reduce the rates of infections to the following levels:

C difficile rate of 25 per 100,000 population
Staph Aureus rate of 19 per 100,000 population
EColi rate of 61 per 100,000 population

C difficile

C diff. causes very unpleasant and some times severe diarrhoea, and stomach cramps and tenderness. It can be very serious, particularly in older people who are already unwell. Over a number of years, we have been successful in ABUHB in reducing the number of cases of C diff. on our wards, and we planned to reduce this further in 2018-19.



In 2018/19, we have reduced the number of C diff. cases compared to 2017/18, however, we have just missed the Welsh Government target.

Staph aureus

Staph aureus bloodstream infections in patients can cause serious illness and are often related to skin infections, wounds, leg ulcers and urine infections. Sometimes they occur because of poor management of

intravenous drips and urinary catheters
In 2018/19, the Health Board has seen an increase in staph aureus infections to 26.71 and we have therefore not met our Welsh Government target. This has been a problem across Wales. We are pleased however that there has been a decrease in Methicillin-resistant staphylococcus aureus (MRSA)

Hospital acquired staph aureus blood stream infections are associated with Intra Venous (IV) line and urinary catheter management. Our focus in reducing these infections is therefore on aseptic technique with training for all ward staff involved in the management of these devices. Central lines are often used on our sickest patients.

We know that a big proportion of our infections occur in patients with a central line.

We have therefore received approval to appoint two specialist nurses to insert and manage these high risk devices across our acute hospitals.

Community acquired staph aureus can be associated with patients with ulcers. In light of this, a working group including Professor Keith Harding, an expert in ulcer management, will review best practice and confirm care pathways. These will then implemented across the Health Board.

E Coli

E Coli is a bug that causes Urinary Tract Infections (UTIs), particularly in older people. A UTI in an older person can have a very big impact on their health, making them more tired and unsteady on their feet, as well as causing them to become confused.

E Coli bloodstream infection reduction is a relatively new target with a vast majority of cases acquired in the community.

Reducing infection will involve both good management of urinary catheters, as they are often associated with infections, but also the appropriate use of antibiotics in primary care. In light of this a primary care infection prevention nurse has just been appointed to drive this important agenda forward.

The number of E Coli infections has increased in 2018/19 in the Health Board, and we have not met our Welsh Government target.

Reducing HCAI through Appropriate Use of Antibiotics

Inappropriate use of antibiotics over the years has led us to the point where many bacteria have become resistant to the antibiotics we usually use to treat them.

There has therefore been a lot of publicity about only using antibiotics when they are really needed – and about using the right antibiotic for the infection that is being treated.

Which antibiotics we use and when and how we use them is really important for reducing the number of cases of C diff and E Coli. In the Health Board we have therefore been reviewing our Policy on Antibiotic prescribing, and looking at the impact of changes made in other Welsh Health Boards in the antibiotics they use.

In addition, to make sure staff have the information and training they need in this area, both in our hospitals and in the community, we have appointed a Consultant Pharmacist and a further 3 antibiotic pharmacists.

Recognising and Responding to the Deteriorating Patient and Sepsis

Sepsis and Deteriorating Patient

We will develop NEWS as common language in community/primary care by establishing pilots in a range of community/ primary care services

Over the last year, there have been some high profile stories in the news about sepsis. Tragically, people across the UK have died from the condition, sometimes because it was not diagnosed as quickly as it could have been. However, it is still not well known that people who survive sepsis, can have life changing after effects. Sepsis is a difficult condition to diagnose as it has a range of symptoms, and some patients may have all the symptoms and some may have none of them. In ABUHB, we have a programme of work called "the Aneurin Bevan Collaborative for Sepsis" (ABC Sepsis) which has been working with our Emergency Departments and the wards to make sure that we recognise and respond to sepsis in our patients in hospital. This started in 2015 and is still continuing to meet with departments to review each month the care and treatment for patients with sepsis.

The National Steering Group co-ordinating the drive to recognise and respond to acute deterioration and sepsis across the NHS in Wales is reviewing how well Welsh Health Boards and Trusts respond to the challenge of the acutely ill and deteriorating patient and whether our existing approach is working. Where good practice and innovation is identified, it will be shared across Wales to reduce variation and drive up standards of care. The Health Board was reviewed in late September/early October 2018. We are very pleased that the feedback from the review was extremely positive, with recognition that ABUHB has led the way in Wales in recognising and responding to sepsis. We still have work to do and are now developing our action plan in response to the recommendations in the feedback report. This will be published once it has been finalised.

Recognising Sepsis in the Community

We have also been working with Community Teams and Care Homes to support them to recognise and respond to sepsis in patients in the community who may need to go to hospital for treatment. ABC Sepsis has co-ordinated a Group meeting, which brought together all the Teams from the different services in the Community that are piloting work to recognise and respond to sepsis, so they can learn from each other and share ideas.

We now have many Teams working on recognising sepsis, including: District Nursing Teams across the Health Board, Care Homes through training provided by the Health Board, the Out of Hours GP service, Learning Disabilities community team, the continuing healthcare team, and mental health community teams.

By recognising patients with sepsis early on while they are still in the community, we can get them to hospital to receive the treatment they need, and prevent the sepsis getting worse.

The National Steering Group co-ordinating the drive to recognise and respond to acute deterioration and sepsis across the NHS in Wales is now running an initiative to take forward the work on sepsis in the community across Wales. We participated fully in an All Wales Learning Set for the Community Teams which took place in March 2019.

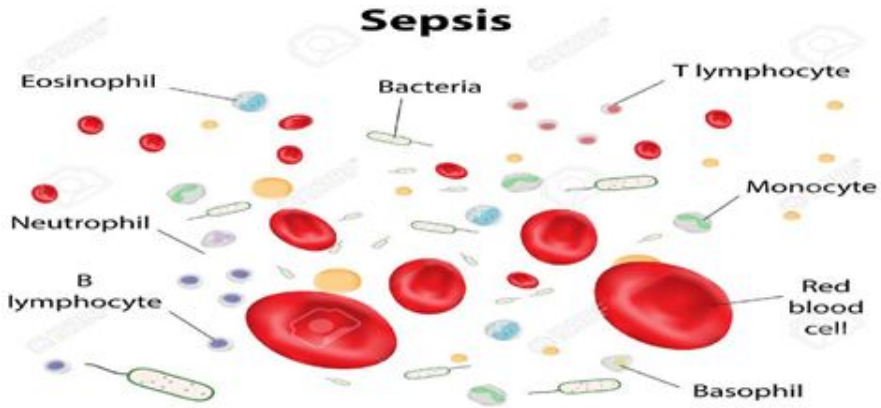
The Life Changing After effects of Sepsis – One Woman's story

To show how important it is to recognise sepsis early, in order to prevent patients dying unnecessarily, or from suffering the life changing after-effects of sepsis, the Health Board heard the story of one mum who experienced sepsis and became extremely poorly but survived. However, she is still recovering from the effect of the sepsis.

"A lovely 47yr old mother of 2 teenage children who was previously fit and well, was admitted to hospital as she had experienced bad diarrhoea and vomiting for some days. She was diagnosed with sepsis and given the appropriate treatment however despite this she continued to deteriorate and was transferred to critical care. Her body became so overwhelmed with sepsis that her heart could not pump effectively and she was transferred to a Specialist Unit at The Royal Brompton Hospital. The lady had a cardiac arrest on arrival to the hospital, but was successfully resuscitated. However, she was so poorly that her husband and sons were told that if she did not start to improve, her only hope would be a heart transplant, and that it was unlikely she would survive.

Thankfully, within a couple of days, she did start to show improvement, and was transferred back to the Royal Gwent Hospital. But she was very weak, had difficulty sleeping as she had vivid, frightening dreams and had no memory of what had happened to her. She was transferred to the ward once she no longer needed a machine to help her breath, but she remained so weak that she could not lift her hand up off the bed and therefore could not feed or wash herself, and she could not retain any information that was given to her. Her voice was so weak that it was difficult to talk to people, and she stared to become withdrawn. She felt helpless, as she did not know who to ask for help and did not know what to expect in the future or how long it would take her to recover.

18 months after she was admitted to hospital initially, she is now at home, but still has difficulty walking as she does not have the use of her right leg, and needs to be looked after by her husband and sons. She feels she has lost her identity as a wife and mother, and has been experiencing depression. She experienced sepsis and survived – but the impact has been life changing for her and her family. That is why we are working so hard to ensure we recognise and respond to sepsis as soon as possible where ever people are – in the hospital or in their own homes. We will also work to improve knowledge and management of patients recovering from the after effects of sepsis.

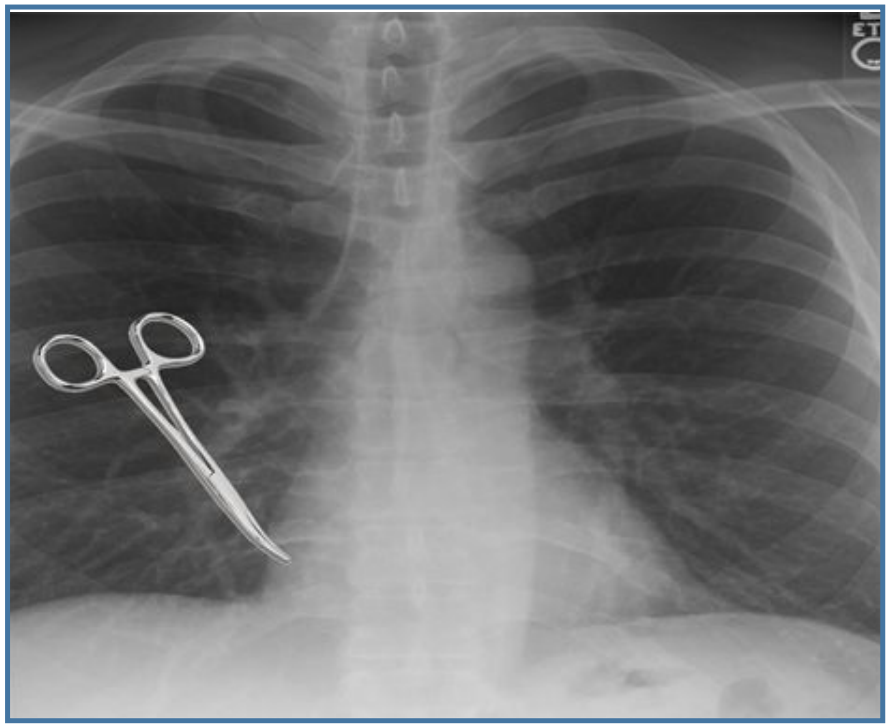


Never Events

Never Events are serious, largely preventable patient safety incidents that should **not** occur if the available preventative measures have been implemented by all healthcare providers.

An example of a Never Event is where a surgical intervention is performed on the wrong site. This would include operating on a patient's right knee when the individuals left knee was the intended site of surgery.

If a Never Event occurs, the Health Board must notify the Welsh Government (WG) who monitor all Health Boards in Wales to ensure that lessons are learnt, and actions put in place to prevent the same thing happening again.



During 2018-19, three Never Events occurred in ABUHB. They were all related to invasive procedures:

- Following the delivery of a healthy baby, the mother required some stiches. A swab (absorbent pad) was not removed at the end of the procedure, but the mother passed the pad without the need for intervention.
- The wrong tooth was removed from a patient, although the tooth removed was not a healthy tooth.
- A different version of lens to the one specified has been used for a number of patients with a cataract however, the lenses were the correct prescription and power.

The three never events therefore did not lead to harm for the patients. However, they should not have happened and are an opportunity for learning about how these events could have occurred. The investigation of the three incidents has led to review of the procedures in place to prevent these events happening, and the strengthening of the measures in place. For instance, in each delivery room in the maternity services, a white board and a pen must be available to record the number of pads, needles and packets of thread used, as they are counted in and out. This means it is visible to every-one involved, not just the midwife assisting the doctor.

We have been putting in place changes to ensure that we meet standards – called the National Safety Standards for Invasive Procedures (NatSSIPs). We will use these incidents to review the changes being introduced as part of the NatSSIPs work and ensure that the learning is included within the NatSSIPs action plans across all areas where similar procedures are undertaken.

A NEW MODEL FOR PRIMARY CARE IN ABUHB

Practices within ABUHB have experienced difficulties recruiting salaried GPs and GP Partners. This is one of the factors that leads to GP practice contract resignations, resulting in some GP Practices now being directly managed by the Health Board, through the Primary Care Operational Support Team (PCOST).

The Health Board currently has four directly managed practices, two of which have the ability due to size and premises- to embrace the "Transformation Model" a new way of delivering primary care using the skills of all the different professionals, to deliver care and treatment for the patient, rather than just relying on the traditional doctor and practice nurse model.

Patients are more able to see the most appropriate healthcare professional to meet their needs, when they need to see them. To do this, the practice has to be big enough both in terms of the number of patients it looks after, and in terms of the building it is based in, to support this new way of working.

Brynmawr Health Centre, with a list size of 10,300 patients, moved into its brand new purpose-built premises in June 2018. Historically, the clinical team comprise the traditional GP and Practice Nurse skill mix.

The practice now employs a much wider clinical multi-disciplinary team including; The following staff in whole time equivalents (WTEs)

- GP Clinical Lead (1 WTE)
- Salaried GPs (2 WTE)

- Clinical Pharmacist (1 WTE)
- Physiotherapist (0.5 WTE)
- Nurse Practitioner (1 WTE)
- Occupational Therapist (1 WTE)
- Mental Health Practitioner (1WTE)
- Physicians Associate (1WTE)

The practice also has Local Authority employed carers and health connectors on site daily, offering appointments to patients. Together, the whole team can meet the needs of its patients with a range of different health needs, there-fore providing a more seamless service to patients and making it a more fulfilling place to work.

Bryntirion Health Centre, has a list size of 9,000 patients and operates from a modern, purpose-built premises. Again, it previously operated with the traditional mix of GPs and Practice Nurses. The Practice came into direct Health Board management on the 1st December 2017, due to GP recruitment difficulties. Bryntirion now boasts a full clinical multi-disciplinary team comprising;

- GP Clinical Lead (1 WTE)
- GP with Management Allowance (0.75 WTE)
- Salaried GP (0.75 WTE)
- GP Retainer (0.25 WTE)
- Clinical Pharmacist (1 WTE)
- Paramedic (WAST Rotation-1 WTE)
- Occupational Therapist (1 WTE)
- Physiotherapist (0.5 WTE)
- Advanced Nurse Practitioner (1 WTE)

A Mental Health Practitioner has recently joined the team. Along with this the practice is hosting an Aneurin Bevan Care Academy Pharmacist (see page 32), who they are supporting and mentoring through their training.

As with Brynmawr, this is a whole practice approach ensuring patients are seen by the most appropriate clinician in a timely manner. The practice can provide patients with more services closer to home, within a familiar setting on a single site. Click here to view a video about Practice Teams

IMPROVING DENTAL SERVICES

Increasing Access to Routine and Urgent Dental Care

We know that some patients have problems accessing NHS dental care, and we have been working with dentists to increase access for a number of years. The Health Board has invested additional funding and therefore increased access to high street dental services in 2018/19. The table below demonstrates the increase in access that has been achieved:

	Feb 15-Jan 17	Feb 17-Jan 19	% increase
Total number of adult patients seen	248,926	256,644	3.1%
Total number of child patients seen	81,606	85,087	4.3%
	quarter ended Dec 17	quarter ended Dec 18	
Fluoride varnish application rate	30.4per 100 FP17s	38.9per 100 FP17s	

Since 2006, patients are no longer "registered" with an NHS dental practices and can receive NHS dental treatment from any dental practice with an "open" list.

This is because there are many people who do not want to go for dental services routinely, but just go when they have a problem. The Health Board therefore commissions an Urgent Dental Access service.

In 2018/19, the Health Board has reviewed the Urgent Dental Access Service. Each appointment is 20 minutes and is accessed via the Dental Helpline. There are practices across Newport, Torfaen, Monmouthshire, Blaenau Gwent and Caerphilly who provide the Urgent Dental Access Service.

Improving Dental Care for Young Children

In order to improve dental health, the Welsh Government has written to all dental teams in Wales with information about preventive dental advice, care and treatment for children aged 0-3 years. In particular, they are encouraging parents to take children to the dentist before the age of 1 year – ideally, as soon as their first teeth come through – and for dental teams to give parents and carers preventive advice to help them keep their children from needing fillings.

Locally, the Primary Care Team and Design to Smile Team have together developed a "young child referral pathway" in order to encourage parents to take their child to the dentist.

Eight practices in Gwent are now part of this pathway, and can take referrals of children from the Health Visitor, the Design to Smile Team or the Flying Start Team. The referrals can be tracked to check whether or not the child has been to the dentist, and can be followed up if necessary.

Transforming Dental care from number of treatments by dentists to prevention by the whole dental team

For many years, NHS dentists have been paid according to the number of dental treatments they carry out. There is no way to pay dentists who spend time talking to their patients about how to prevent problems such as fillings. The NHS in Wales is now working with Dentists to change this and transform the way that dental care is provided.

In 2018/19, the Health Board has recruited a small number of dental practices to take part in the General Dental Service Reform Programme initially collecting data.

The dental teams are asking patients to complete the Assessment of Clinical Oral Risks and Needs (ACORN) toolkit.

This assessment tells individual patients about their own risk of poor dental health and what they can do to improve it.

By putting together all the assessments, the dental practice can understand the oral health needs of the people using their service, and therefore how they need to work to improve the dental health of their population.

This may mean increasing the time between check-ups for people with good oral health, which then gives the dental team more time to spend with people with poor oral health. They can talk to them about the changes they can make to prevent the need for fillings in the future.

It should also allow the practice to take on more patients, particularly children. The aim is to increase the number of fluoride varnish applications in children, which should reduce the number of children needing fillings. Going forward, 20 practices will be taking part

in the programme and changing the way that they work.

WORKING WITH THE WELSH AMBULANCE SERVICE TO RESPOND APPROPRIATELY TO PEOPLE WHO HAVE FALLEN AT HOME

As we have reported previously, ABUHB has worked with the Welsh Ambulance Service (WAST) to provide an effective response to people that have fallen at home. In most cases, the person has not broken a bone, but needs help to get up, and advice about how to reduce the risk of further falls.

Previously, the only response available to WAST was an emergency ambulance with paramedics. Over the last few years, ABUHB and WAST have set up a falls response vehicle, with a paramedic and a clinician from the Falls Team This has been shown to reduce the demand for the emergency ambulances, and to enable more people to remain safely at home, reducing visits to A and E.

Following on from this work, WAST has now developed a falls response framework which focusses on 3 levels of response for a person that has fallen, depending upon the need.

ABUHB has again worked in partnership with WAST and St John Cymru Wales to set up a level one response for a fall where the person needs to be safely lifted from the floor and there are no or only minor injuries from the fall. Together, we are operating two Falls Assistants who can go to the person's home, lift them safely from the floor and carry out an assessment.

The Falls Assistants are supported by the Clinical Support desk, through which a paramedic or nurse provides clinical advice and direction.

The level two response is required when it is unclear whether there is an injury, or the person has a number of long term conditions or complex needs. This is the response that WAST and ABUHB have been developing for a few years with a paramedic and a clinician from the falls team, usually a physiotherapist.

The team can undertake a comprehensive assessment of the person that has fallen in their own home, and put changes in place to reduce the risk of falls for that individual, including onward referrals to community based services.

The level three response is the Emergency Response, and is deployed when there is an obvious injury from the first 999 call, or when the Clinical Support Desk identifies an injury following assessment in the level 1 or 2 response.

The Falls Response Service has been involved with 1961 falls 999 calls from October 2016 to 31 December. 1475 people (75%) have remained at home and only 17% of people required treatment within the emergency department. This has reduced demand on the Emergency Ambulances as well as unnecessary visits to the A and E department due to falls.

Value Based Healthcare

We have some outstanding and innovative work taking place in ABUHB, with a focus on the value of healthcare to our patients. This means providing the care and treatment that lead to the best possible outcomes, outcomes that matter to patients-delivered in the most efficient way, using our finite resources wisely.

At our Value Based Healthcare Conference in March we were thrilled to be joined by Prof. John Moxham from King's Health Partners. Prof Moxham is

keen to strengthen the partnership with the Health Board, and in a statement suggested that 'the expertise and commitment developed within the multi-professional team at Aneurin Bevan is one the distinctive features of our approach, and is critical to successfully implementing value-ABUHB are truly leading the field in the UK'.

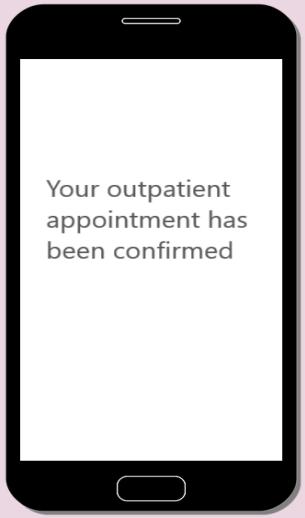
Using technology as a key enabler in delivering a value based approach, the Health Board has invested in a digital platform provided by "DrDoctor" to improve two way communication with patients, and collect outcomes to inform

direct care. This system allows patients to access and communicate with the Health Board via a text or email on their mobile device. Through this system, we are now able to:

- Allow some people to book appointments in outpatients on their personal mobile devices
- Remind people of the date and time of their outpatient appointment
- Give patients information that will help them get to and prepare for their outpatient appointment, so they get more from their time with the clinician
- Obtain information from patients about their current state of health just before they come to or go into an outpatient appointment to support shared decision making between the patient and the doctor
- Collect patient's views about their experience with the service they are using, in order to make improvements
- Collect patient's views about the outcomes of their care and treatment, so we can remodel services to meet the needs of and provide the outcomes that matter to patients

Using Dr Doctor to send texts and e-mails:

- We have sent out over 18000 assessments about the patient's view of the outcome of their care and treatment – some to people before an appointment, some whilst they are waiting in clinic.



- Of the 18000 sent, 78% have been returned electronically, this response rate is above the UK norm.
- 50% of the returned questionnaires have been completed before a patient comes to the appointment, with the remainder being completed in the clinic prior to the appointment

As a result of the feedback on outcomes and patient experience, we have:

- Changed the process for follow up appointments so that patients with long term conditions who feel fine do not need to come to hospital, which frees up time in clinics
- Used the freed up time to make more timely appointments for Patients who need an urgent outpatient appointment.
- Changed the mix of patients in some clinics
- Learnt more about which patients will have a good outcome from surgery, so patients can be given the treatment that is most likely to benefit them

The value based healthcare work is now in all hospitals in ABUHB, and covers 18 different health conditions. It is being used in 140 clinics and therefore 1000s of patients. The work is helping us to change our services as we move towards the opening of the Grange University Hospital, so that patients receive the care that is important to them from the right professional at the right time and in the right place.

Ffrind i Mi/ Friend of Mine is a partnership approach to combatting loneliness and social isolation which can affect people's health and wellbeing. It has created a 'social movement' that aims to reconnect people with their communities. As part of this initiative, telephone befriender volunteers are recruited who ring people regularly who have said they are lonely – just for a chat.

All the volunteers are amazing, but this story about one of our volunteers has really highlighted the benefit to both volunteer and those befriended.

Ffrind i Mi Case Study—Julie's Story

"Julie lives in Torfaen with her husband. She has had a career in customer facing services, including the Women's Royal Voluntary Service and had been the main carer for her disabled son for almost 30 years.

Approximately 7 years ago Julie was diagnosed with a life limiting illness which has initiated numerous hospital appointments and admissions. She is on continuous oxygen and her ability to 'get about' is compromised due to breathlessness. Her diagnosed condition led to complications with her eyes and over the course of her illness she has lost sight in both eyes.

Julie believes that losing her sight was 'the best thing that could have happened' as this made her re-evaluate the needs of her son. Unable to personally care for him any longer due to sight loss and failing health, he is now living in supported accommodation, regaining some of the independence Julie believes he may have lost due to her doing 'everything for him'.

Julie's condition has deteriorated and she is now in the terminal phase of her illness.

At the latter end of last year she was visited by a Community Connector after she had expressed a wish to volunteer. She was referred to Ffrind i Mi with a request that we visit her to see if there was 'anything at all' Julie could do to fulfil her wish to 'give something back' and to give her a sense of purpose.

Following discussion, it was suggested that Julie could be a telephone befriender and speak to people who are lonely and isolated and do not wish to or cannot leave their homes. Ffrind i mi staff delivered volunteer training in her home. She needed to have an occupational health check, as do all volunteers, and the Ffrind i mi staff made it clear to the ABUHB Occupational Health Department that the volunteer role Julie wished to undertake could be done from her own home in her own time regardless of her terminal diagnosis. Finally Julie needed to be DBS checked

"Julie is now a volunteer befriender to 3 older people who live alone. She thoroughly enjoys speaking to these people and feels she has a sense of purpose again. She goes a step further and is encouraging those who are lonely and isolated to volunteer themselves. One of the people she has befriended telephoned the Community Connector and thanked them for referring her to Ffrind i mi. For her, speaking to Julie feels like she has been put in touch 'with a long lost friend'. Julie attends the Hospice day services. She was 'matched' with a lady who was attending the same Day Centre but she had to stop attending due to her illness.

Julie has now been in contact with her links at St David's and trying to see if there is any possibility of her attending again.

Julie speaks from the heart, and the messages she conveys are ones of positivity, purpose and hope in situations where many of us may only see darkness, dread and fear.

Julie has agreed to share her story in the hope that it encourages others to volunteer. This will be Julie's legacy

Winter Experience Survey

Through the winter period, members of the Community Health Council (CHC) have been talking to patients in our A&E department about their experience of care. The feedback has been positive overall. Where any shortfalls were identified, these were addressed immediately. For example when it was highlighted that there was inadequate seating in the Medical Assessment Unit at RGH, additional seating was immediately sought and brought into the department. Also when patients in the Emergency Assessment Unit at Nevill Hall Hospital did not know where to obtain refreshments, clear signage was put in place in the department directing patients/families/carers to where refreshments could be obtained. We would like to thank the Community Health Council for carrying out this survey over the busy winter period, which has helped us to make sure patients are satisfied with our communication with them and their level of comfort.

Identifying Delirium

Delirium: We will develop a clear protocol for the assessment of delirium in general hospitals

Delirium is a term used to describe a condition of ***acute confusion*** which is associated with physical ill health, such as a urine infection. It means that a person who is usually able and clear, becomes confused and unable to focus their attention on a task. If a person with delirium already has dementia, they will be more confused than they usually are. Delirium usually starts suddenly and is temporary. With appropriate treatment of the physical cause, delirium will usually gradually improve over days or weeks, although some patients will not fully recover their previous level of functioning after an episode of delirium. It is really important that we are able to identify delirium, as it occurs in approximately a third of people over 65 years old in hospital.

As the main symptom of delirium is new confusion, it is important that staff are able to tell the difference between delirium and dementia, so that the source of the delirium can be identified and treated. This means staff have to be skilled at finding out about a person's usual health and cognitive abilities, using simple tests to identify delirium and physical examination.

To ensure that staff are clear about the process they should use to identify and treat delirium, we have developed guidance for them. This includes the assessment tool, the 4AT that they can use alongside gathering information to understand whether a patient is normally confused, or whether the confusion is new and recent. However, we need to find out who should use it and when to use it. We also need to be very clear about what should be done if a patient is identified as having delirium and who needs to do it.

The best way to use the 4AT delirium assessment has been taken forward as an improvement project in the Medical Assessment Unit at YYF in order to have a clear protocol for the assessment of delirium. This improvement work is still ongoing. In addition, the 4AT is also used at RGH as part of the assessment on admission to the Care of the Elderly Wards. The results of the improvement projects are being pulled together at the moment, and we should have a clear protocol by the summer of 2019, which will be introduced with a programme of training.

DELIRIUM

A is for Access

The "5 As for access" Scheme is a set of locally agreed standards for GP Practices. The maximum number of A's a surgery can be awarded is 5 and this would mean that the surgery meets all the standards below:

1. Opens at or before 8am with a first appointment at 8.30am or earlier
2. Doors are open during the lunchtime period
3. Last routine doctor appointment is 17.50pm or later
4. Telephone access to a member of staff is available from 8.00am - 18.30pm
5. Patients can book an appointment during one telephone call, without the need for calling back, or on-line.

Not all practices have been able to meet the essential qualifying requirements for the 5 'A' scheme as they have at least one half day closure.

It was agreed that access standards for these surgeries would still be reported but these surgeries would be given 'B' ratings.

There are **78** GP practices across the Health Board area and of these:

- 65 (83%) of these have attained 5A rating
- **1** practice has been rated as 5B.
- **9** are 4A rated
- **3** are 3A rated.

GP Surgeries display a certificate which indicates the rating they have been awarded as part of the "5 As for Access" scheme. The scheme relates to ACCESS ONLY and is NOT an indicator of clinical or any other kind of services provided by surgeries

Home First

We know that some people are admitted to hospital because they need more support at home, and that support can not be set up quickly. Other people wait in hospital for many days after they are fit enough to go home, because they also need a bit of extra support, and that support can not be set up quickly. Getting the support in place is complicated because we work with 5 different Local Authority areas, which all have slightly different health and social care services to support people at home, with different referral and assessment processes and eligibility criteria.

The Local Authorities have therefore worked with the Health Board, and with partners in Voluntary Groups, to set up "Home First". This service will provide a "home first" alternative for patients as a viable alternative to short term admission into hospital, through putting in place support at home, that is short term but set up as quickly as is needed.

The Home First Team has recently started to provide short term support so that medically fit patients can be discharged within 4 hours in some cases, but no longer than 24 hours. The short term support is provided until the usual local authority care package can be put in place.

The Home First Team has a social worker, as well Occupational Therapists and home carers, and they work across all the Local Authorities to assess patients in the same way and provide the same

service.
The Team started working at NHH first in October and then started at RGH in November 2018. Referrals to the team increased in the New Year 2019 and have remained at the higher level, particularly at RGH. "Home First" has made an important contribution to our ability to support people safely at home when a hospital admission might not be the needed.

Winter pressures and 12 hour waits

12 hour waits in A and E We will significantly reduce the 12 hour waits in A and E

It has been a busy winter period for the health board. Since November 2018:

- there have been more attendances at the A and E departments each month than there were in any of the previous 3 years.
- More of the people attending A and E have been aged over 75, and we know that older people have more complex health problems.
- More of the people attending A and E have been looked after in the part of the department for more seriously ill patients (majors).

In order to prepare for the winter period, we made a number of changes. You can read about the "Home First" Service on page 25, which was put in place to make sure that people who were well enough to go home with a bit of extra support did not have to wait in hospital while a package of care was arranged. So some are not admitted to hospital at all, but go home from A and E, which reduces the number of people admitted to hospital. Patients on the wards also get back home as soon as they are well enough to go home, freeing up beds for people who need to be admitted to a ward from A and E.

Learning from previous years, we also put in place a programme of work in the A and E at RGH to reduce any delays to the early assessment of the patient, firstly the "triage", initial assessment of the patient to determine how quickly they must be seen, and secondly the time they are seen by a doctor. This ensures that a patient arriving at the A and E department is assessed promptly and therefore any treatment can be started and decisions about admission to the appropriate ward can be taken in a more timely way. We also set up a series of short gatherings of key people through out the 24hour period, called "Patient Safety huddles".

These short "get togethers" make sure that everyone is aware of the sickest patients in the department, and of any other issues that might impact on the care of the patients in the department and movement of patients on to the wards. We call this our Turnaround Programme.

We have monitored closely the impact of this programme on how quickly patients are given a bed on a ward – and also therefore the number of patients who have to wait more than 12 hours for a bed on a ward. What we have seen is that, even though there has been an increase in the number of patients, with more older and sicker people, there has not been an increase in the time patients wait to be triaged or to see the doctor. Since the focus on safety huddles the time for a patient to be given a bed on a ward has shown a significant decrease in February and March 2019.

For the whole of 2018-19, number of patients waiting more than 12 hours to be given a bed on a ward has decreased compared to 2017-18 to 5463 from 5788. However, this is still too many people waiting in A and E when they should be in a bed on a ward.

IMPROVING THE EXPERIENCE OF PEOPLE WHEN THEIR LOVED ONE DIES IN HOSPITAL

Bereavement, especially in the immediate days following the death of a loved one, results in people having to make important arrangements, such as funerals and registrations of death, at one of the most emotionally challenging times in their life. It is well recognised that when a person is grieving, their emotional resilience is low and their wellbeing suffers as a result.

Families of patients who die whilst receiving care in hospital, face dealing with loss and grief in unfamiliar environments. Within ABUHB, we have not had a dedicated service to support bereaved families, and this has led to variable and inconsistent approaches to bereavement support across our hospitals. This results in families often having to go back to the busy acute wards where their loved one has just died in order to collect personal items and death certificates. The staff on duty on the wards are not able to set aside the time required to provide the invaluable support, information and signposting to services that may be of benefit to the families in the period of grieving after death.

Between January 2017 to July 2018, ABUHB has received 18 complaints which have centred around the arrangements that families have to work through when their loved one dies in hospital. We have therefore obtained initial funding to develop a bereavement service across our acute hospitals, starting in 2018/19.

YYF was identified as the hospital to set up the service in the first instance. Following the appointment of a Bereavement Support Officer, the service started in August 2018. Between August and October 2018, the service supported 65 bereaved families.

The service has had positive feedback from the bereaved families that it has been involved with. In particular, there has been an improvement in the number of days between the death, and the family being able to collect the medical certification of death.

The bereavement service is now being set up at the RGH. It is envisaged that the service will be in place by summer 2019.

Putting Things Right

The Health Board aims to provide the very best care and treatment and we regret when there is cause for any of our patients, or their carers, to raise concerns about the service they have received. Concerns are always taken seriously and viewed as an opportunity to improve the services we provide.

Anyone raising a concern should expect it to be addressed in an open manner and to be assured that they will receive a timely and honest response.

Wherever possible we try to resolve concerns informally which helps us to provide a timely response to the concerns raised. In 2018/2019, approximately 55% of concerns were dealt with informally, although not all complaints dealt with informally and resolved 'on the spot' are captured.

The main issues which led concerns being raised in 2018/2019 were:

- *clinical care*
- *Attitude*
- *waiting times/delays and cancellations, and*
- *communication failures.*

The percentage of complaints responded to in a timely way decreased in 2018/19 and we know that delays in receiving a response to a complaint can cause anxiety and anger for the person who has had cause to complain.

We reviewed the processes used to investigate and respond to complaints. A work programme is being implemented to ensure the process is clear and that everyone involved works collaboratively and is aware of who is responsible for each step.

Through the work programme we will:

- Process map and streamline the complaints pathway
- Develop a consistent approach to improve timeliness and quality of response
- Improve data quality in complaints handling
- Improve compliance with performance measures

ABUHB believes it is important to listen to, and to learn from, any concerns raised in order to prevent similar issues in the future. We will spread learning from complaints and serious incidents by raising

awareness about things that have gone wrong across all Health Board services and working to prevent similar issues happening again.

Learning from concerns can happen in a number of ways and as part of the quality improvement programme for concerns we will:

- Re-establish a learning committee and shared learning forums
- Develop a training, coaching and mentoring programme for staff who carry out investigations
- Continue to support the working groups and educational meetings which already exist in our organisation
- Publish a bulletin, distributed monthly throughout the Health Board, which describes the learning from concerns.

Care Closer to Home Blood Transfusions at County Hospital

Torfaen Community Resource Team (CRT) moved into Cedar Unit at County Hospital in September 2017, providing a clinical area that the Team could use for treatments. They were previously based in an office building and so were more limited in what they could do for their patients

Since moving to the unit, the Rapid Medical/Rapid Nursing element of the team has begun providing numerous new therapies, which patients can attend the unit to receive

Previously patients had to go to RGH or NHH, and so the Team are now able to provide care for Torfaen residents much closer to home.

The team currently provides Intra-Venous (IV) antibiotics, at home or in the unit if a patient is able to attend, IV fluids on the unit, IV Iron transfusions, blood transfusions and Bis Phosphonate transfusions.

The team is very proud of the treatment they can give, which is in line with the health board's "care closer to home" strategy. Here are some examples of how this change has made a real difference to people's lives:

A family member of a very frail 85 year old man, who would rarely visit his GP, commended all the Torfaen Community Resource Team staff, from the emergency home carer to the nurses who looked after his toe nails. The patient's blood transfusions take place in a lovely and peaceful environment, rather than negotiating a very busy hospital where it is difficult to park and find the relevant department.

The patient had been referred to the Team by his GP for increased confusion and a recent fall and was seen in the Cedar Unit Clinic. On his initial visit to Cedar Unit, it was evident that he had been struggling to look after himself and the Rapid Response nurses assisted him with his hygiene in the clinic and cut his toe nails, which were impairing his mobility. At this time, emergency home care was arranged for two calls a day, which he was initially reluctant to receive, but was gently coaxed in to having after a few home visits from the emergency care staff.

Blood results revealed anaemia and the patient was experiencing symptoms, with shortness of breath. He was able to receive a blood transfusion at the Cedar Unit, rather than having to attend a busy District General Hospital. His nephew wrote an email of praise for the

service, stating that the nurses had provided excellent care and the environment was conducive to his uncle's general wellbeing.

Another patient who is 55, with a busy family life, also praised the County Hospital unit which he visits daily for a transfusion as he awaits a liver transplant. Having the treatment at County Hospital fits around his day: taking and collecting children from school.

This patient attends the unit daily for intra-venous antibiotics rather than having to stay in hospital for treatments.

He is a father of three and has stated that having his care so close to home has allowed him to continue with family life as normally as possible. He has praised both the clinic facilities and the CRT staff.

Welsh Health Specialised Services Committee

Specialised services support people with a range of rare and complex conditions. They are not available in every local hospital because they have to be delivered by specialist teams of doctors, nurses and other health professionals who have the necessary skills and experience. Unlike most healthcare, which is planned and arranged locally, specialised services are planned nationally by Welsh Health Specialised Services (WHSSC) on behalf of the seven Health Boards in Wales. WHSSC works closely with our Health Board to ensure that any specialised service commissioned is of a high standard and that there are no concerns identified from a quality perspective. They do this on our behalf through a quality assurance frame work which is monitored by their Quality and Patient Safety Committee and reported back into the Health Board.

So many of our staff go the extra mile for patients. Here are some examples of the "thank you" messages we receive.

My father was admitted to A&E on New Year's Eve following a stroke. The **care, kindness and level of professionalism provided by all staff was exemplary**. My father has now returned home after spending 5 weeks in hospital. He is making a slow recovery and we are hopeful for the future **thanks to the wonderful staff at the Royal Gwent Hospital**.

May I thank the **Physiotherapy department** at **St Woolos hospital** for their **total professionalism**, from the **receptionist to all the staff members** and particular the attention shown to me by student physio who explained in detail my walking problems and physical state. With her help and departments help I feel I'm on the mend. **Great department, great staff "Who Care".**

I just want to take the time to thank the GP Out of Hours, at Ysbyty Ystrad Fawr today. He saw my son, who isn't normally very co-operative in these type of situations or environments and can get very stressed. The doctor **talked and smiled to my son, explained everything to him**, let him hold the instruments and practise on me first. He is the **first doctor ever** to get my son to open his mouth for him to check his throat, he was so comfortable. He needs to be recognised for his **patience and kind nature! What a lovely person!**

I would like to express mine and my family's thanks to **all the staff on Rowan Ward, County Hospital.** The **professionalism and care** that they showed to my father during his last weeks was **exemplary. Nothing was ever too much trouble** and they regularly **went the extra mile** to ensure Dad was as comfortable as possible and were **hugely supportive to the family.**

Just wanted to say **thanks to the lovely lady** I spoke to today in the **Radiology Booking Service** who arranged my next DEXA appointment.

Isn't it lovely when **everything comes together** and you get **such helpful people** on the other end of the line.

Please send our grateful thanks and our best wishes to the **staff** who have looked after our father recently. He spent six nights in intensive care and now **D5 west**, after an infection and renal insufficiency. **The care has been exceptional** and we have been kept informed throughout his stay.

The **nursing care is a credit to the profession** and I am singing your praises to anyone who will listen. As a trained nurse since 1979, I am more than pleased to see the **high level of care** Dad is receiving. The **Urology team** have been **very good and respectful** of Dad's wishes. All the **support services** we've come into contact with have been **helpful, polite and good at their jobs**.

On the 24th October, I underwent a total knee replacement carried out by the **surgical team at Nevil Hall**. I would like to take this opportunity to thank that team, and would also like to give particular thanks to the nursing and care staff on Ward 3/1 together with the physios.

The **ward staff are a credit to the hospital** and showed a **professional caring and compassionate nature** to the patients in their care. I witnessed **acts of personal kindness** to other patients, **over and above** what their job descriptions probably out-lines. Once again a **sincere thanks to all concerned**

I would like to send a message of thanks to all the staff on the Bedwas Ward at Ysbyty Ystrad Fawr, Ystrad Mynach.
Our Mother has been on the ward for several weeks until she was moved earlier today to a different hospital. The care she has had on the Bedwas ward has been **fantastic**, hopefully she won't be too long now at the new hospital before she will be well enough to come home. I am sure the improvements she has made has a lot to do with the care she has been receiving on the ward. She can't have been too easy to deal with when she first arrived, but everyone on the ward **has been great right from day one**.

Staff Wellbeing

Staff Wellbeing
We will develop a Staff Engagement and Wellbeing Strategy to support our staff.

One of the 4 values in the Health Board's Values and Behaviours Framework is "People First". This, of course, means putting our patients first – but for the Health Board, also means looking after our staff too. We therefore wanted to have a "Staff Engagement and Wellbeing Strategy" to support staff in their work for the health board and as they go through a period of signifi-cant change leading to the opening of the Grange University Hospital in 2021.

However, following engagement with staff, it was agreed that we would develop an 'Employee Experience Framework' instead of 'Staff Engagement and Wellbeing Strategy'. This is really important as we know that employee experience shapes patient experience so staff who are happy in their work are able to provide a great patient experience.

The new Employee Experience Framework was launched on Valentine's Day and is presented as an interactive online Toolkit which provides all employees with easy access to a wide range of information and support to help us look after ourselves and others.

We want all our colleagues in ABUHB to have great lives, with their work playing a significant and positive role. This framework marks both the consolidation of what we already do well within ABUHB and the beginning of a new approach that will promote and drive a positive staff experience.

Welcoming People to our Hospitals

We will develop a new Welcoming Service at St Woolos with our partner Age Cymru Gwent and expand and extend the Welcoming Service at Nevill Hall Hospital from two mornings a week with our partners Age Cymru Gwent, the Royal Voluntary Service, Nevill Hall Leagues of Friends and North Gwent Cardiac Rehabilitation and Aftercare Charity.

St Woolos Hospital Welcoming Service

A full Monday to Friday Volunteer Welcoming Service has been in place at St Woolos Hospital since July 2018. Age Cymru Gwent, a valued Health Board partner, recruited new 'Robins' volunteers to meet and greet patients and visitors and complement their well-established ward based

Robins volunteer service. As part of the new Welcoming service:

- Volunteers are easily accessible and identifiable with their distinctive Robins volunteer red tops
- Volunteers work in pairs enabling an added value 'walk with' service for patients and visitors who are anxious or confused
- Volunteers offer 'soft support' to distressed relatives e.g. a cup of tea, a listening ear, support with booking taxis etc.

As a result of the new service, first impressions of St Woolos Hospital have improved significantly

Nevill Hall Hospital Welcoming Service

The Welcoming Service at Nevill Hall Hospital has been expanded and extended from two mornings a week with our partners Age Cymru Gwent, the Royal Voluntary Service, the Nevill Hall League of Friends and North Gwent Cardiac Rehabilitation and Aftercare Charity.

A joint recruitment campaign was held in April 2018 and a full Monday to Friday Volunteer Welcoming Service has been in place since Autumn 2018.

As part of the new Welcoming service:

- Patients, relatives and visitors receive a friendly welcome and offer of help
- A distinctive Welcome Desk and pop up banner draws attention to the service
- Wheelchairs are co-located and volunteers help to ensure availability
- Volunteers who are willing and able have been trained to provide support in pushing patients/relatives in wheelchairs as appropriate.

PRIMARY CARE ACADEMY IN ABUHB

As working in primary care is new to many professionals and requires a different set of skills to working in hospitals, the Health Board has set up and is funding a Primary Care Academy. The Academy co-ordinates Primary Care Training Sites which can deliver training for professionals other than GPs who are new to primary care. The Primary Care Academy has now assessed and approved 18 GP Practices across Gwent: 12 to support training of Nurses new to primary care and 6 to support training of pharmacists new to primary care. One nurse will be supported by PCOST.

- Nursing Scheme: There are 13 placements for trained nurses new to primary care, each 6 months long with a training curriculum and mentorship by a member of the practice clinical team. By completion of the training, the post holders will have all the skills needed to work as a practice nurse.
- Pharmacy Scheme: This is similar to the Nursing Scheme, but is delivered across 2 years and is run in conjunction with Bath University. By the end of the 2 years, the pharmacist will have an Independent Prescriber qualification.

Nurse Staffing Act

Wales is the first country in Europe to write into law (Nurse Staffing Levels (Wales) Act 2016) that Health Boards in Wales have to ensure there are sufficient nurse staffing

levels to meet the needs of patients receiving care. This is being done because the evidence identifies that having the right number of registered nurses and the right skill mix improves patient outcomes and reduces patient mortality. From April 2017, Health Boards have had a duty to make sure that they are providing sufficient nurses to allow the nurses time to care for patients sensitively.

This requirement extends to all care environments NHS Wales provides or commissions a third party to provide nurses. From April 6th 2018, the Health Board has had to comply with new duties:

- Health Boards have to calculate and take reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical wards.
- Health Boards are also required to inform patients of the nurse staffing levels.

Health Boards have to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards

The Health Board has established a Staffing Act Implementation Group with representation from finance, workforce and the divisions to progress implementation of the Act and ensure it is aligned to the ongoing All Wales work.

What have we done to comply with the Nurse Staffing Act?

As a Health Board, we have put in place a work programme to ensure compliance and engagement with the Nurse Staffing Act and its requirements:

- Education about and raising awareness of the Act in all areas of the Health Board
- Recalculation of the nurse staffing levels required on each of the acute wards twice a year, to make sure they are up to date
- Monitoring of the measurements that are particularly sensitive to care provided by a nurse. This includes patient falls, hospital acquired pressure ulcers and medication errors.

How do we tell patients about the Staffing Act?

The Health Board must make arrangements to inform patients of the nurse staffing levels. All acute wards now have the planned nurse staffing rosters clearly displayed at the entrance to wards.

In addition, each ward has a copy of 'frequently asked questions' on staffing levels which patients can access. This was developed with the Community Health Council and is provided in both English and Welsh.

Our Staff

Nurse Recruitment

Along with other Health Boards in Wales and England, we have a higher number of vacancies for registered nurses across the Health Board than usual and have had difficulty in recruiting registered nurses to fill those vacancies. Nurse recruitment therefore continues to be a vital part of the work undertaken by ABUHB.

As this is a problem for the whole of Wales, the Welsh Government have taken actions which are designed to increase the number of nurses being recruited to Health Boards in Wales

- The bursary in Wales for student nurses has continued (unlike England where it has been abolished) and the Welsh Government have increased the number of student nurses taken in to training in Welsh Universities each year. However, ABUHB's partner Universities have not been able to fill The commissioned places for the March 2019 intake of traditional three year full time students.
- Experienced Health Care Support workers can now work part time within the Health Board in their HCSW role and part time as a University student training to be a registered (RN) nurse. The Health Board is hopeful that the number of flexible HCSW students commissioned will increase in line with the reduction in the number of places in traditional full time courses .

Flexible route HCSW training to become RNs	2017/18	2018/19	2019/20
University of South Wales	3	9	8
Open University	Not available	9	5

In ABUHB, we are also doing all we can to recruit nurses, building on changes at a National level or our own local position.

These actions include:

- The Nursing and Midwifery Council have recently held a consultation to review the Return to Practice education standards, for registered nurses who have left the profession. The proposed changes may encourage more nurses to return to the register. We are therefore working with Cardiff University and the University of South Wales to encourage as many nurses as possible who have left the profession to book onto a Return to Practice course, and we will then support them back in to work.
- With the Severn Bridge tolls abolished at the end of 2018 and the comparatively low price of housing in Newport, ABUHB have been holding recruitment events in Bristol to try and encourage nurses to move the short distance from Bristol to ABUHB hospitals to work. There is a plan for 2019 to broaden recruitment activities to include targeted national recruitment activities including advertising in the nursing press, radio adverts and social media communications. We will also attend national and locally arranged events in towns and cities that border our HB area in a bid to maximise recruitment of nurses to ABUHB.
- The recruitment initiative has continued, whereby nurses who trained overseas and are currently living and working in the UK in non-nursing posts are being supported to undertake the examinations required by the Nursing and Midwifery Council in the UK in order that the individuals can then be employed as qualified nurses in Wales. We are very pleased that we will have 28 registered nurses through this initiative by the end of 2019, with another 37 awaiting a start date.

Wales for Africa

The Charter for International Health Partnerships in Wales was developed by the International Health Co-ordination Centre which is part of Public Health Wales. It is based on Wales' history for accomplishment and learning in this area and outlines four foundations of successful international health partnerships. These are:

- Organisational Responsibilities
- Reciprocal Partnership Working
- Good Practice
- Sound Governance

Through our international health engagement, we seek to promote the expertise of health professionals in Wales, sharing common principles with partners and learning new and better ways of working that we can bring back to the NHS in Wales. This strengthens our commitment to action based on sound evidence and respectful collaboration, which promotes health equity within and between countries.

ABUHB is committed to supporting the development of healthcare services in developing countries, with our staff working in Africa and in other countries through out the world. There are huge two way benefits to this with an exchange of ideas and opportunities for development of staff.

In June 2018, Bronagh Scott, the Director of Nursing at that time, visited Namibia with Independent Member of the Board, Prof Dianne Watkins (University), to scope the possibility of providing a leadership development programme for Nurses. This is a project funded by Wales for Africa and is a country wide project with a number of elements. ABUHB is delighted to be involved in the buddying scheme between qualified nurses in Namibia and registered nurses in ABUHB. The nurses will share experiences, ideas and the challenges associated with leading nursing in both countries. ABUHB nurses will benefit by developing greater resilience, empowerment and cultural awareness, and we look forward to hearing from them about their experiences in 2019-20.

LOOKING FORWARD 2019-20

Many of our improvement priorities come from the Health Board's Integrated Medium Term Plan 2019-22. Making improvements in a large and complex service across all areas does not happen in one year. Our priorities are therefore in many cases the same as we have had in previous years, but each year we set clear milestones to take us towards our ultimate goal.

Building Bridges: Intergenerational Strategy

We will have a new initiative on both the hospital wards and in the Care Homes that takes forward our Intergenerational Strategy and will aim to 'twin' all care homes and community wards with schools/uniformed cadet organisations

Coloured Walking Frame Pilot

Following the success of the 'Pimp my zimmer' initiative, we will pilot and evaluate the use of coloured walking frames in 10 Care Homes and designated pilot wards as this will give patients a choice of recognisable colours, with the aim of increasing mobility and socialisation and reducing falls

Volunteering

We will secure funding to extend, expand and improve the welcoming service at the Royal Gwent Hospital in order to:

- Provide a Monday to Friday Meet and Greet service at Levels 0, 1 and 3
- Improve first impressions
- Improve the patient/visitor experience

We will work to meet the HCAI: targets as agreed by WG for:

- C diff, 25 per 100,000 population
- MRSA and MSSA, 19 per 100,000 population
- E coli, 61 per 100,000 population
- Klebsiella, 10% reduction
- Pseudomonas aeruginosa, 10% reduction

Acute Deterioration—AKI

We will agree a consistent approach to responding to Acute Kidney Injury alerts and develop an approach to data collection and measurement across the acute sites (local process data and Nationally collected outcome data)

Acute Deteriorating Sepsis

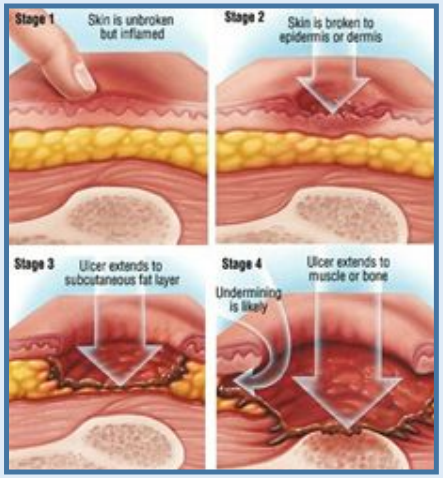
Work with the Start Smart and focus programme to test how the principles can be built into the ABC Sepsis approach in A and E and MAU

Falls

We will develop a plan to improve bone health for older patients at high risk of falls in order to reduce the number of fractures.

Pressure Damage

We will further extend the Pressure Damage Collaborative and continue the reduction in Grade 3 and 4 pressure damage.



Hospital Acquired Thrombosis (HAT)

We will pilot sending HAT data to individual clinicians in Trauma and Orthopaedics (T & O) showing their position relative to the other anonymised T and O Consultants

Endorsements

Statement from Aneurin Bevan Community Health Council

The CHC welcomes the AQS that highlights areas of achievement and also priorities for action.

Mrs Angela Mutlow,
Chief Officer,
Aneurin Bevan CHC

Statement from Audit and Assurance

The Health Board is required by the Welsh Government to obtain assurance on the Annual Quality Statement (AQS), including from Internal Audit. The overall objective of the audit was to ensure that the AQS is consistent with information reported to the Board and other committees and compliant with the Welsh Health Circular: The Annual Quality Statement 2018/19.
As we tested a limited sample of the content of the AQS, we are not providing a high level of assurance against the full content.

Based on the results of our procedures, for the year ended 31 March 2019, we noted that:

- the sample of information tested is consistent with supporting documentation and sources, in all material aspects.
- the AQS is aligned to the Health Board's Integrated Medium Term Plan, with referencing to each of the required themes of the Health and Care Standards.
- the Welsh Health Circular: The Annual Quality Statement 2018/19 is complied with, where applicable.

We would like to thank members of the Stakeholder Reference Group for their help in preparing this Annual Quality Statement. We know we can always improve what we do, and if you have any comments about what would like to read about in the Annual Quality Statement or any other feedback, please email us on abhb.enquiries@wales.nhs.uk

Appendix 1 Glossary of Terms

ABC Sepsis	Aneurin Bevan Collaborative on Sepsis	NatSSIPs	National Safety Standards for Invasive Procedures
ABCi	Aneurin Bevan Continuous Improvement	MFRA	Multifactorial Risk Assessment
ABUHB	Aneurin Bevan University Health board	MRSA	meticillin-resistant Staphylococcus aureus
A and E	Accident and Emergency	NCN	Neighbourhood Care Network
ACORN	Assessment of Clinical Oral Risks and Needs	NEWS	National Early Warning Score
AKI	Acute Kidney Injury	NICE	National Institute for Health and Care Excellence
AQS	Annual Quality Statement	OOHs	Out of Hours
C.Diff	Clostridium difficile	PCOST	Primary Care Operational Support Team
CEO	Chief Executive Officer	PROMS	Patient Reported Outcome Measure
CCTV	Closed Circuit Television	PREMS	Patient Reported Experience Measure
CHC	Community Health Council	RN	Registered Nurse
CRT	Community Resource Team	SCCC	Specialist Critical Care Centre
DATIX	Incident Reporting Tool	T & O	Trauma and Orthopaedic
DVT	Deep Vein Thrombosis	Third Sector	Voluntary Group and Civil Society
E Coli	*Escherichia coli*	UK	United Kingdom
ED	Emergency Department	UTI	Urinary Tract Infection
GP	General Practitioner	WAST	Welsh Ambulance Services NHS Trust
HAT	Hospital Acquired Thrombosis	WHO	World Health Organisation
HAPU	Health Acquired Pressure Ulcer	WHSSC	Welsh Health Specialised Services Committee
HCAI	Healthcare Associated Infections	WG	Welsh Government
HCSW	Health Care Support Worker	WTE	Whole Time Equivalent
IV	Intra Venous		