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Medicines Management in Acute Hospitals: Update on Progress – **Aneurin Bevan University Health Board**

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This work was delivered by Urvisha Perez.

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Summary report

Introduction

1 Our 2015 report on Medicines Management in Acute Hospitals found that despite low staffing levels and high workload, there were good relationships with ward staff together with effective aspects of corporate arrangements and some medicines management processes. Nevertheless, the Health Board needed to develop its strategic approach and better involve pharmacy staff in key strategic developments and address security and storage in pharmacy and on the wards. We also identified process risks related with medicines reconciliation, allergy status recording, omitted doses and supporting patients to take their medicines properly. There was also a need to strengthen performance reporting and understand more about the reasons for pharmacy team safety interventions.

2 The Auditor General's 2016 national report on Managing Medicines in Primary and Secondary Care also highlighted the many good aspects of medicines management but that medicines management needed a higher profile within health bodies. The report also highlighted the problems with medicines storage, gaps in information about medicines, and the delay in implementing a national electronic prescribing system that was frustrating efforts to improve safety and efficiency.

3 Both reports set out recommendations for improving corporate arrangements for medicines management, its workforce, facilities, processes and monitoring of pharmacy services. In responding to the local recommendations, the Health Board agreed to complete the actions by March 2016. As part of our 2018-19 audit programme, we undertook a high-level assessment of progress made by the Health Board to address our recommendations.

4 In undertaking this work, we:

- asked the Health Board to complete a self-assessment of its progress;
- reviewed documentary evidence to support the self-assessment, as well as board and committee papers; and
- conducted interviews to discuss progress, current issues and future challenges.

5 A summary of our findings is set out in the following section with more detailed information provided in Appendix 1.

Our findings

6 Our overall conclusion is that: **The Health Board has made good progress in addressing our recommendations to improve aspects of medicines management within acute hospitals, but some high-risk recommendations remain outstanding.** We reached this conclusion because:

- The Health Board has taken steps to improve corporate arrangements for medicines management and is playing its part in taking forward the collaborative all-Wales medicines management work programme;
- Good progress has been made in implementing pharmacy workforce recommendations, although the Health Board still has the lowest level of pharmacy staffing per 10,000 population in Wales;
- The Health Board has made some improvements to medicines management facilities, but issues with temperature regulated, secure bulk storage remain and an audit programme for injectable medicines on wards has yet to be implemented;
- The Health Board has made good progress in implementing recommendations related to medicines management processes, but it has yet to develop a register of non-medical prescribers;
- Steps have been taken to improve monitoring and reporting of pharmacy performance indicators, and learning from pharmacist safety intervention rates, but the Board has yet to receive an annual report on medicines management.

7 In undertaking this assessment of progress update, we identified no new risks in relation to medicines management in acute hospitals.

8 In summary, the status of progress against each of the previous recommendations is set out in Exhibit 1. The Health Board should address the outstanding recommendations by the end of March 2020, namely local recommendations R3b, R3d, and R4b and national recommendation R3b.

Exhibit 1: status of 2015 recommendations

Total number of recommendations	Implemented[1]	Ongoing action	No or limited action	Superseded or not within the Health Board's direct control
Local – 20	13	2	3	2
National – 6	4	0	1	1
Total – 26	**17**	**2**	**4**	**3**

[1] Green indicates that the recommendation has been implemented or fully addressed; Amber indicates ongoing action to address the recommendation; Red indicates that limited or no progress has been made; and Blue indicates that the recommendation has been superseded or not within the Health Board's direct control.

Total number of recommendations	Implemented[1]	Ongoing action	No or limited action	Superseded or not within the Health Board's direct control
By theme				
Corporate arrangements – 6	4	1	0	1
Workforce – 5	5	0	0	0
Facilities – 6	4	0	2	0
Processes – 5	2	0	1	2
Monitoring arrangements – 4	2	1	1	0

Source: Wales Audit Office

Appendix 1

Progress to address our 2015 recommendations

Recommendations to be addressed	Status[2]	Summary of progress
Corporate arrangements for medicines management		
Local recommendation R1a. Ensure there is specific executive responsibility for all aspects of medicines management, including quality and safety. **National recommendation** R3a. Health bodies should ensure their Chief Pharmacist is, or reports directly to, an executive director.	Green	1. In our 2015 report we highlighted that executive responsibility for medicines management was mainly focused on the efficiency agenda. As such, we identified scope to extend executive level oversight to all aspects of medicines management. At the time, the interim Chief Operating Officer had executive responsibility for the Medicines Management Programme Board, the focus of which was primarily cost efficiencies. And the Medical Director had executive responsibility for Individual Patient Funding Request (IPFR) panels. 2. Our 2016 national report found that prescribing and medicines management needed a higher profile within health bodies. It found that whilst the Trusted to Care report had raised the profile of certain issues there was a risk that this focus would not be sustained. As such we identified scope for better pharmacy representation at Board committees and for Chief Pharmacists to report directly and regularly to an executive director. 3. Since 2015, the Health Board has split the responsibilities of the Chief Operating Officer. The Health Board now has a Director of Operations and an Executive Director of Primary Care, Community and Mental Health. Responsibilities for medicines management, is split between this executive director and the Clinical Director of Pharmacy (who is also the Health Board's Chief Pharmacist), between them they cover all aspects of medicines management.

[2] Green indicates that the recommendation has been implemented or fully addressed; Amber indicates ongoing action to address the recommendation; Red indicates that limited or no progress has been made; and Blue indicates that the recommendation has been superseded or not within the Health Board's direct control.

Recommendations to be addressed	Status[2]	Summary of progress
		4. The Executive Director of Primary Care, Community and Mental Health chairs the strategic Medicines Management Programme Board, which has representation from all divisions. And the Clinical Director of Pharmacy has overall responsibility for all aspects of medicines management. Whilst the Clinical Director of Pharmacy does not report directly to an executive director[3] he does have lines of professional accountability to the Medical Director, who is an executive director. The Medical Director continues to hold responsibility for Individual Patient Funding Request (IPFR) panels.
R1b. Revisit membership of the Medicines and Therapeutics Committee to ensure general nursing representation.		5. In 2015, we reported that Medicines and Therapeutics Committee had good pharmacist and medical representation from across primary and secondary care. A primary care nurse, who is an independent prescriber also sat on the committee. However, we found there was no general hospital nursing representation. 6. Our follow-up work found that the terms of reference for the Medicines and Therapeutics Committee were updated in August 2019. Its membership now includes the Associate Director of Nursing with responsibilities for Medicine Management.
R1c. Write a medicines management strategy to set out a clear, integrated vision across primary and secondary care that is developed in full partnership between pharmacy, medical and nursing staff.		7. Our 2013 primary care prescribing report found that the Health Board did not have a clear, integrated, strategic approach for prescribing and medicines management across primary and secondary care. This remained the case when we reviewed medicines management in acute hospitals in 2015. 8. Our follow-up work found that the Health Board has taken alternative action to our recommendation. Instead of developing a local medicines management strategy as stated in the original management response, the Health Board plays its part in taking forward the collaborative all-Wales National work programme. The programme was developed following our national report and at the request of the Chief Pharmaceutical Officer. It focuses on the following six key areas:

[3] The Clinical Director of Pharmacy reports directly to the Divisional Director of Primary Care and Community, who in turn reports to the Executive Director of Primary Care, Community and Mental Health.

Recommendations to be addressed	Status[2]	Summary of progress
		• Driving Efficiency • Reducing Medicines related Harm • Improving patient experience / outcomes • Workforce Modernisation • Building Capacity • Improving access to information / benchmarking performance 9. The Health Board stated that reporting on elements of this programme links to the Chief Executive Management Team Strategic National Improvement Programme. The programme is led by health board chief pharmacists, with each taking the lead on various workstreams. They are also responsible for implementing the work locally and disseminating guidance and good practice. The Health Board's Chief Pharmacist leads the 'driving efficiency and savings plan' workstream. The Health Board reported that the Medicines Management Programme Board has received updates on this programme. 10. In December 2018, the Health Board developed its integrated operating model for pharmacy services as part of its transformation programme (Clinical Futures) but it does not cover the totality of medicines management. The model describes principles for all levels of care by a range of pharmacy professionals. The care is based in a variety of settings including; community pharmacy, GP practices, primary and secondary care and supporting outpatient and inpatients.
R1d. Create a standard operating procedure that requires pharmacy to be consulted/involved in the early stages of service change planning, so pharmacy resourcing needs can be assessed and sustainably funded.		11. In 2015, we found that the pharmacy team at the Health Board were not involved in service design/change that involved medicines. In response, the Health Board's 2016-17 service planning guide set out clear instruction for divisions to identify interdependencies and impacts on clinical and non-clinical support services when proposing changes as part of its annual and three-year plans.

Recommendations to be addressed	Status[2]	Summary of progress
		12. Our follow-up work found that the Health Board has strengthened these arrangements by replacing the 2016-17 service planning guide with a formal outline business case proforma. The proforma which is part of a new standard operating procedure, instructs divisions to identify and qualify the impacts of proposed service change including on clinical support services such as pharmacy. The Health Board has introduced a system where the business case is scrutinised at divisional, corporate and executive levels before approval (or disapproval).
R1e. Ensure individual patient funding request panels have two lay members.		13. An all-Wales report from April 2014[4] recommended that panels handling individual patient funding requests (IPFR) should have at least two lay members so they can support each other. In 2015, we reported that the Health Board had no lay members on its IPFR panel. 14. Since we made our recommendation the Health Board has been able to recruit only one lay member, who had been supporting the IPFR panel since November 2016. However, the post has recently become vacant and the Health Board is looking to recruit two lay members.
Medicines management workforce		
R2a. Review the quality and safety implications of current pharmacy staffing levels, and use comparative data provided in this report, to assure itself that pharmacy is providing adequate cover at all acute sites.		15. In 2015, we reported that relative to inpatient activity, the Health Board's pharmacy team had the lowest staffing level in Wales, in addition the skill mix ratio was the joint lowest in Wales. 16. In 2019, we found that the Health Board has taken several steps to address our recommendation. But data from the electronic staff record shows that Aneurin Bevan still has the lowest level of staffing in Wales per 10,000 population across all bands. The Health Board is now prioritising developing its workforce plans in line with its transformation programme (Clinical Futures).

[4] National IPFR Review Group, Review of the individual patient funding request process, April 2014.

Recommendations to be addressed	Status[2]	Summary of progress
National recommendation R4. Chief Pharmacists should seek the support of the NHS Wales Shared Services Partnership's Workforce, Education and Development Services (WEDS) to strengthen current resource mapping approaches to facilitate robust comparisons of pharmacy staffing levels across Wales and to produce a generic service specification. The specification should set out the typical resources required to deliver key pharmacy services, such as clinical pharmacy input and patient education on the wards. The specification should also be flexible enough to recognise that different types of wards will require different levels of resource.		17. The Health Board has sought to address this recommendation through the following actions: • In May 2015, the Pharmacy Directorate submitted a briefing report to the Chief Executive and former Chief Operating Officer that outlined areas of potential investment. The paper outlined: – pharmacy services by hospital and specialism (as at May 2015); – a summary of staffing requirements (including costs) to stabilise and improve the current service; and – a summary of staffing requirements (including costs) to extend the service for some specialisms at the main hospitals, namely Royal Gwent and Nevill Hall. • The briefing paper was used to identify and progress a number of priority areas through the IMTP process. As a result, the following business cases have been approved; antimicrobial stewardship team, clinical pharmacy services to Ysbyty Aneurin Bevan and homecare services. • The Unscheduled Care, Scheduled Care and Family and Therapies divisions have invested in additional pharmacy support at directorate and divisional level. • An ongoing priority for the Health Board is to invest pharmacy time in accident and emergency. The Health Board is currently evaluating pilot projects at the Royal Gwent and Nevill Hall Hospitals in association with Welsh Government. 18. Our follow-up work found that the Chief Pharmacist Group established a Workforce Modernisation Group, which the Health Board's Chief Pharmacist was engaged with. However, this group was stood down when the special health authority, Health, Education, Improvement Wales (HEIW) was established.
R2b. Evaluate whether sufficient pharmacy resource is dedicated to medical staff induction/ongoing training.		19. The Professional Standards for Hospital Pharmacy Services[5] state that the pharmacy team should support induction, and ongoing training and education in the best practice use of medicines for relevant clinical and support staff across the organisation. In 2015, we found

Recommendations to be addressed	Status[2]	Summary of progress
		that across Wales, health boards funded an average of 0.7 WTE pharmacy staff to deliver training to medical staff. Aneurin Bevan had no funded staff for this role. 20. In response to our recommendation the Health Board reported that the pharmacy directorate provided elements of induction and junior doctor training. However, within existing resources, it had been unable to provide input to the junior and senior assistantship training required by Cardiff Medical School. The Health Board indicated that if further dedicated resource were required, a business case would need to be developed between the Head of Medical Education and Pharmacy. 21. Our follow-up work found that the Medical Director, Head of Medical Education and the Clinical Director for the pharmacy directorate held a discussion about whether there was a need to develop a potential business case. No further action was taken because no concerns about the level of support available for training have been raised. We were told, at present medical education has not raised the issue. If pharmacy provide training resource this will need to be funded by medical education.
R2c. Revisit the model of pharmacy services to consider the comparatively high proportion of wards with no visiting service, no wards with a seven-day visiting service, comparatively few named pharmacists and weekday opening hours that are less than average.		22. Our 2015 audit work included a clinical pharmacy review. The review was completed by pharmacy teams on six wards across Nevill Hall, Royal Gwent and Ystrad Fawr hospitals. The review highlighted potential improvements for ward clinical pharmacy services. 23. Our follow-up work found that the Health Board had revisited the model of pharmacy services and had: • Implemented a weekend ward-based approach (as opposed to a dispensary approach) in 2017 that focuses on newly admitted and high-risk patients; • Piloted a weekend pharmacy service in the medical assessment unit at Ysbyty Ystrad Fawr (using funding for winter pressures), which is currently being evaluated; and

[5] For providers of pharmacy services in or to acute hospital, mental health, private, community service, prison, hospice and ambulance settings.

Recommendations to be addressed	Status[2]	Summary of progress
		• Discussed the need for a seven-day service operating between 8am-4pm as part Clinical Futures pharmacy model at the new Grange University Hospital, but the service will be dependent upon funding.
R2d. Review the effectiveness of medicines vending machine services at Ysbyty Ystrad Fawr.		24. In 2015, nursing staff told us there was generally good access to the pharmacy team during normal working hours and out-of-hours. However, at Ysbyty Ystrad Fawr, the unavailability of medications from the vending machine during out-of-hours was an issue. This meant that staff had to fax medication requests to the Royal Gwent Hospital to be sent to Ysbyty Ystrad Fawr Hospital by taxi. 25. Our follow-up work found that in response to a clinical incident with expired medicines, a review of the GP out-of-hours service at St Woolos Hospital was carried out in 2016 as part of the ABCi Silver Project. The review has led to improvements in drug storage processes, which have been applied to the other sites, including Ysbyty Ystrad Fawr.
Medicines management facilities		
R3a. Develop a costed, time bound action plan to significantly improve boundary security at Royal Gwent Hospital.		26. In 2015, we highlighted that the pharmacy at the Royal Gwent Hospital was not secure. The code for the key pad access system was widely known, which left it vulnerable to unauthorised access. At the time, bids for a swipe-card system had been rejected. Also, when our auditors visited the hospital the pharmacy loading bay was unlocked. 27. Our follow-up work found that since 2018 all pharmacy departments have access via their staff ID cards.
R3b. Minimise the current legal and safety risks associated with bulk storage of intravenous (IV) fluids and other bulk items at Royal Gwent Hospital by ensuring items are not publicly accessible and are stored in temperature regulated room.		28. In 2015, we found that the bulk fluid room at the Royal Gwent Hospital was not air-conditioned, or temperature regulated. We highlighted that there might be legal risks to the fluid storage conditions as they were noncompliant with the manufacturers' guidelines on temperature regulations. The manufacturers' guidelines apply to all areas where medicines are stored. The Health Board had identified and escalated the risk. 29. Our follow-up work found that a temperature monitoring system has been installed, but the storage areas are not temperature regulated. The monitoring system allows the Health Board to record and report increased temperatures in storage areas. At the time of our follow-up work, the monitoring system had identified increased temperatures in areas where bulk fluids

Recommendations to be addressed	Status[2]	Summary of progress
	Red	are stored, which the pharmacy team escalated to the Facilities Division in May 2019 to address. 30. The security of bulk storage of IV fluids has not been resolved. There is still no controlled access to bulk storage areas and overflow bulk items are stored in corridors because of a lack of storage capacity. 31. The Health Board indicated that storage capacity will be improved when the new Grange Hospital opens in 2021. Once opened, there will be less need for fluid storage at the Royal Gwent Hospital, meaning there will be space to store fluids in the fluid store and install air conditioning. In the meantime, the issue has been logged on the Pharmacy Division risk register.
R3c. Introduce an out-of-hours alert system to monitor pharmacy fridges at Ysbyty Ystrad Fawr.	Green	32. In 2015, we found the pharmacy fridges at Ysbyty Ystrad Fawr were fitted with alarms that sound when the temperature was out of range but there was no system to alert staff out-of-hours. In 2014, £17,000 of drugs were lost when a pharmacy fridge failed, and pharmacy staff were not alerted. 33. Our follow-up work found that a system to monitor pharmacy fridges at Ysbyty Ystrad Fawr has been installed and alerts are sent to the on-call pharmacist.
R3d. Implement a regular audit programme of the preparation of injectable medicines on the wards.	Red	34. In 2015, Aneurin Bevan was one of three health boards that was unable to confirm how many wards had a risk assessment in place for injectable medicines preparation or how many wards had conducted an audit of aseptic practices related to injectable medicines in the past year. 35. Our follow-up work found that no formal audit programme has been implemented. The Health Board reported that this will be discussed further with the Associate Director of Nursing with responsibilities for Medicine Management. In April 2019, the Health Board's Medicines Safety Group, which reports to the Medicines and Therapeutics Committee, agreed to look at high risk drugs as part of walkabouts. Injectable medicines will be looked at as part of the walkabouts if they are being prepared at the time. The Health Board indicated that the national Chief Pharmacists Quality and Safety Group has discussed the preparation

Recommendations to be addressed	Status[2]	Summary of progress
		of injectable medicines and is considering the merits of developing an All Wales Injectable Policy.
Local recommendation R3e. Develop a costed, time bound action plan to address the ward medicine storage issues from Trusted to Care. **National recommendation** R2b. Each health body should develop a time-bound plan for improving storage and security of medicines on hospital wards, including specific consideration of the benefits of implementing automated vending machines.		36. In 2014, Trusted to Care (the Andrew's report)[6] highlighted serious problems with the administration and recording of medicines at the former Abertawe Bro Morgannwg University Health Board. Following this report, the then Minister for Health and Social Services ordered unannounced spot checks at 20 hospitals across Wales. The spot checks highlighted issues with safe and secure storage of medication on hospital wards across Wales. At Aneurin Bevan, the Royal Gwent, Nevill Hall and Ystrad Fawr hospitals were spot checked. The checks found issues such as unlocked medication cupboards, unattended and unlocked medicines trollies, and treatment rooms left unlocked. 37. In 2019, the Health Board told us that: • **Trusted to Care action plan:** In 2018, the Health Board submitted a self-assessment against the All Wales Medicines Administration, Recording, Review and Storage policy to Welsh Government. Of the 27 standards, the Health Board assessed itself as fully meeting 22 standards and partially meeting five. The partially met standards related to medicines administration training, processes to administer certain medicines and groups of patients, responsibilities for medicines storage and storage of medicines used in clinical emergencies. At the time of our follow-up work, the Health Board had not received any feedback from the Welsh Government. The Health Board reported that the treatment room issues at the Royal Gwent Hospital identified by the Trusted to Care spot checks have now been addressed.

[6] Professor June Andrews, Mark Butler, Trusted to Care: An Independent review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board, May 2014.

Recommendations to be addressed	Status[2]	Summary of progress
		• **Automated medicines vending machines**: The Health Board has submitted the findings from an audit of automated vending machines to the Welsh Government. Of the 86 wards, 41 wards[7] have access to a vending machine. The Health Board indicated that it is committed to this technology and all wards at the new Grange University Hospital will have automated drug storage. When services move to the new hospital, the Health Board will review storage in the local general hospitals and some of the existing vending machines will be released as some inpatient areas move or close.
Medicines management processes		
Local recommendation R4a. Work in partnership with the NHS Informatics Service to set out a clear timescale and funding plan for implementing inpatient electronic prescribing and rolling out access to the Individual Health Record. **National recommendation** R1. The Welsh Government, NHS Wales Informatics Service (NWIS) and all Health bodies should agree a detailed, time-bound plan for implementing electronic prescribing systems in secondary care, along with a clear process for monitoring the delivery of the plan.		38. In 2015, we found that electronic prescribing was not in use on any of the Health Board's acute hospital wards and the Individual Health Record was being piloted for use in medicines reconciliation at four emergency settings at Aneurin Bevan. 39. In 2019, the Health Board told us that: • **Inpatient electronic prescribing:** NWIS has established the Welsh Hospital Electronic Prescribing and Medicines Administration project to develop and implement the national plan for electronic prescribing in secondary care. As this is a national piece of work, the Health Board is not directly involved but there is chief pharmacist representation on the project board and the Health Board is kept updated through the National Chief Pharmacist Group meetings. • A business case for procuring a replacement hospital pharmacy system and an electronic prescribing and medicines administration system is being prepared by NWIS for Welsh Government to consider.

[7] The vending machines are mainly located in the Royal Gwent, Nevill Hall and Ystrad Fawr hospitals. There is also a machine at Ysbyty Aneurin Bevan and County Hospital.

Recommendations to be addressed	Status[2]	Summary of progress
		• The initial phase of the inpatient electronic prescribing involves replacing the existing pharmacy stock control system, which is due to rollout from late 2019. Rollout at the Health Board is expected in early 2020. • **Individual Health Record**: The Welsh GP Record (Individual Health Record) has been implemented and made available to doctors and pharmacists.
R4b. Maintain a register of non-medical prescribers to monitor whether staff are regularly prescribing.		40. In 2015, health boards across Wales struggled to provide us with comprehensive data on the number of secondary care non-medical prescribers, particularly the number of these staff who regularly used their skills. Aneurin Bevan was able to provide information about the proportion of nurses and pharmacists that were regularly prescribing. The Health Board had 107 nurses and seven pharmacists who were independent or supplementary prescribers, of these, 60 nurses and six pharmacists were regularly prescribing. But the Health Board was unable to confirm how many other healthcare professionals were registered non-medical prescribers. 41. In 2019, the Health Board has still to address our recommendation. It reported that a single consolidated register for all non-medical prescribers still needs to be finalised, which will be progressed by September 2019.
R4c. Raise the profile of the medication safety audit results on all wards to promote better medicines management performance and to reduce the frequency of missed doses.		42. In 2015 we reviewed the reasons for missed doses that were recorded on the drugs charts. At the Health Board we found that compared to the Wales average there was a high percentage of occurrences where it was unclear whether a dose had been omitted or not. 43. Our follow-up work found that the Health Board has raised the profile of medication safety audit results on all wards. The reports from the all Wales Medication Safety Dashboard[8] are discussed at the quarterly meetings of the Medication Safety Group, which is chaired by the Clinical Director of Pharmacy. Any nursing specific actions are followed up by the divisional

[8] The all Wales Medication Safety Dashboard is an extract from the NHS Wales Health and Care Monitoring System, wards have access to this system.

Recommendations to be addressed	Status[2]	Summary of progress
		nurses. Missed dose information is also monitored and reported through the all Wales Medication Safety Dashboard. 44. The Health Board also has a programme of health and safety audits for each division, part of which is asking about missed doses. Feedback from the health and safety audits go to the lead quality and safety nurse on each ward, who holds a briefing with ward nurses.
R4d. Learn from the national work on Prudent Prescribing to develop an action plan to increase pharmacy's focus on identifying patients' compliance needs, educating/counselling patients, improving medicines information and supporting patients to take their medicines properly.		45. As part of our 2015 review method, we scored organisations on the actions they were taking to support people to take their medicines properly. The Health Board scored 16 out of a possible 32 points, compared with an average of 17 across Wales. We found that each of the Health Board's hospitals used several methods to support patients, but these were not routinely applied. 46. Our follow-up work found that the Health Board had taken the following actions to address this recommendation: • Ensuring that the all Wales patient information leaflet is available on all wards to provide patients with information about the pharmacy service and encouraging them to ask their pharmacist about any medication issues. • Implementing the MaPPs system (Medicines: a Patient Profile System)[9] in 2017, which was purchased by the All Wales Chief Pharmacists Committee. MaPPs was used to help patients learn about their medication and was accessible across all hospital sites. However, it is no longer in use because it does not meet the requirements of the Welsh Language Standards. • Rolling out from April 2019 'Your Medicines Your Health' is an all Wales campaign to encourage people to clear out all old, unwanted or unused medicines and return them to their local pharmacy where they can be disposed of properly and safely.

[9] Medicines: a Patient Profile System (MaPPs) produces a summary of all a patient's medication in electronic format. This can be printed and stored for uploading to clinical records. Hospital staff can access the service online and quickly produce a report which can be printed or downloaded as a PDF file.

Recommendations to be addressed	Status[2]	Summary of progress
		47. The Health Board did not develop a formal action plan, feeling that supporting patients to take their medicines correctly is a routine part of a ward pharmacists' role, which was enhanced by the MaPPs tool. The focus is now on encouraging patients to ask about their medicines and to take more control (Your Medicine Your Health).
Monitoring pharmacy services		
R5a. Improve the consistency across sites of pharmacy performance reports and work with other health boards to regularly benchmark medicines management performance.		48. In 2015, we found that performance reports considered a good range of medicine-related indicators, but there was scope to strengthen performance reporting through benchmarking and by improving the consistency and format of reports. 49. Our follow-up work found that: • **Pharmacy performance indicators**: In 2019, the pharmacy directorate started working with the divisional Business and Performance Team to review pharmacy performance indicators and how they are reported. • **Benchmarking**: In its management response to our 2015 recommendations, the Health Board told us that further work on benchmarking would be undertaken through the All Wales Chief Pharmacist Group. A workshop to progress this work took place in September 2015, but the Health Board told us that no further action was taken. The chief pharmacist's group has recently discussed the benefits of taking part in NHS benchmarking, which they feel is England centric. The group is working with the NHS Benchmarking Network to develop measures more relevant to NHS Wales. In the meantime, the Chief Pharmacist Group has proposed that Welsh NHS bodies not take part in the pharmacy benchmarking exercise every year and take part next in 2022. The Health Board has recently completed the current benchmarking exercise and the results are expected in November. The benchmarking exercise collects information on several topics including medicines spend, pharmacy structure and governance arrangements, and pharmacy workforce.

Recommendations to be addressed	Status[2]	Summary of progress
R5b. Carry out further analysis of the rate of safety interventions and allergy updates of its pharmacists to identify the root causes and decide whether more resource should be diverted to preventing errors and near misses, rather than correcting them once they have been made.		50. In 2015, we found that pharmacist safety intervention rates at the Health Board were lower than the Wales average. But within the Health Board, Ysbyty Ystrad Fawr had the highest pharmacy safety intervention rate. 51. Our follow-up work found that as in 2015, pharmacist intervention data and medication errors are reported on the Datix system and these are reviewed by the Medicines Safety Group. However, the Health Board has moved beyond this recommendation and the group now produces a range of learning bulletins based on high risk areas, for example anticoagulants, insulin, antibiotics and opiates. The Health Board also appointed a Medication Safety Officer in 2015. The Health Board told us that pharmacy staff will always be required to undertake a 'safety netting' role to correct prescribing errors. In the future the Health Board feels that electronic prescribing and medicines administration systems may help to prevent some of these issues with appropriate decision support built into the system.
National recommendation R3b. Health bodies should have an annual agenda item at the Board (or relevant committee) to discuss an annual report covering pharmacy services, medicines management, primary care prescribing, homecare medicines services and progress in addressing the issues identified in Trusted to Care.		52. Our national medicines management report, published in 2016, highlighted the need to increase the profile of medicines and prescribing within health bodies, particularly since the focus on the national prescribing indicators had decreased since 2014. 53. Our follow-up work found that the Board or its committees have yet to receive an annual report covering all aspect of medicines management and prescribing. The Health Board indicated that it plans to develop an annual report for 2018-19 and at the time of our work it was waiting for the final quarter of primary care prescribing data to become available at the end of July 2019.
National recommendation R5a. Health bodies should ensure they have a targeted plan of action to achieve cost and quality improvements in prescribing in primary care and in secondary care, in line with prudent healthcare principles. The plan of action		54. Our national medicines management report, published in 2016, highlighted that there was scope to improve the quality and cost of secondary care prescribing. 55. Our follow-up work found that the Health Board has an annual programme of work related to medicines management to ensure that 'the medicines prescribed do the greatest good with the minimum effective intervention and the least harm'. The programme of work is overseen by the Health Board's Medicines Management Programme Board. As part of the 2019-20

Recommendations to be addressed	Status[2]	Summary of progress
should be informed by regular analysis of prescribing data to ensure that attention is focused on the areas where the greatest scope exists to secure cost and quality improvements.		programme, the Medicines Management Programme Board has asked divisions to present their medicines management plan every six months. 56. The 2019-20 programme also includes a series of in-depth therapeutic reviews, which cover areas such as chronic pain, mental health, urology and cardiology. The reviews aim to identify areas for improving performance. The therapeutic areas under review will need to provide the Medicines Management Board with information such as: • An overview of current prescribing expenditure in primary and secondary care. • An overview of good practice already implemented and any existing plans that are currently being progressed. • Any cost pressures / new medicines likely to impact within the therapeutic area under review. • The top three prescribing messages that need to be promoted to prescribers. • A summary of proposed actions.

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