Aneurin Bevan University Health Board

Annual Quality Statement 2016/2017

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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STATEMENT FROM THE CHAIRMAN AND CHIEF EXECUTIVE

Welcome

This is the 5th Annual Quality Statement from the Aneurin Bevan University Health Board. It tells you about the quality of the health services we provide across the area we cover, for people of all ages, and for all types of care and treatment.

Our aim is always to provide high quality services – promoting health and providing high standards of care and treatment with a good patient experience. This has been the driver for our Clinical Futures Strategy –with investment in our primary and community services and local hospitals to provide care as close to home as possible for the services that people use more often. But this strategy also needs high tech, hyper acute care to be centralised in one place. This is the place where we can pull together the right specialist staff with the right equipment to give the right care and treatment for someone in the very acute phase of their illness. The redesign of the stroke pathway is a great example of this and you can read about it on page 21.

We were very pleased that in October 2016, Vaughan Gething AM, Cabinet Secretary for Health, Well-being and Sport approved the building of the Specialist Critical Care Centre (SCCC) in Torfaen. This is the hyper-acute hospital for acutely ill people. The new SCCC will open in 2021 on the site of the current Llanfrechfa Grange Hospital. With this piece of the jigsaw for the Clinical Futures model of services coming in to place, we are now working with our clinicians from all the different specialties and right across the health care services. Together, we are designing the pathways of care so that people are always treated as close to home as possible and are full partners in their care and treatment. As we design the pathways of care, we are also taking account of the two Acts passed by the Welsh Assembly which have big implications for the way we plan and deliver healthcare services.

David Jenkins
Chairman

Judith Paget
Chief Executive

The first is the Well Being of Future Generations (Wales) Act 2015. This Act means that in all that we do, we need to think about how our health services can provide excellent care now that can be maintained into the future, and that does not reduce the wellbeing of our grandchildren. So we have to pay attention to the possible impact of what we do now on the future economic, social, environmental and cultural wellbeing of people in Wales.

The second is the Social Services and Wellbeing (Wales) Act 2014. This provides the framework for improving the wellbeing of people who need care and support or are carers and for transforming Social Care in Wales. It requires the Local Authorities to work more closely with Health Services where this will benefit the wellbeing of the population. We cannot deliver health care services for people without working with our partners in the Local Authorities and the Third Sector, that reach out to people in their own homes as well as helping us to deliver a good patient experience when people are in hospital. You can read about examples of this close working throughout this Annual Quality Statement.

Even though healthcare is becoming increasingly high tech, the treatment has to be given with care and compassion – it has to be delivered by people. Our staff are therefore the heart of all that we do. As recruiting the staff that we need to provide health care – from nurses, to GPs to some specialist medical staff – has become more difficult, so the pressure increases on our current staff. We would like to thank our staff for the professionalism, dedication, care and compassion that they show as they deliver healthcare, 24 hours a day and 7 days per week.

INTRODUCTION

Aneurin Bevan University Health Board (ABUHB) serves an estimated population of over 639,000, representing approximately 20% of the total Welsh population. With a budget of £1.1 billion, it delivers healthcare services to the people in Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys. Quality and improving quality is at the heart of all that we do. This is shown in our values framework which sets out the values and the behaviours that flow from them, that we expect all staff to show. The values are shown here:

We want our patients to have a good experience in our care, which includes being a full partner in their care. This means that care is safe, effective, and timely, focuses on the patient as an individual with dignity and provides good value (outcomes in relation to cost) and equity. Staff must see the service through the patient's eyes, and try to improve it with their every action. This is at the core of the Health and Care Standards – the framework that supports the delivery of high quality services in the NHS in Wales for the public and patients. However, the Health and Care Standards are also clear that the public and patients themselves must take responsibility for helping their healthcare services help them, through working with the services and taking prudent action to protect and promote their own health. The Health and Care Standards provide the overall framework for improving the quality and safety of healthcare services, as it can be used to identify strengths and highlight areas for improvement. We also use National Clinical Audits to understand whether we are meeting service specific standards and how we are doing compared to other healthcare organisations. In addition to this, we use data from mortality reviews, complaints, serious incidents and feedback from patients and the public to learn about which areas we need to improve and how we need to improve them. The Aneurin Bevan Community Health Council also provides us with invaluable feedback through its visits across all our services, which monitor their quality. Aneurin Bevan Continuous Improvement (ABCi) helps staff to improve their service with improvement methodologies, through training and development, and through bringing professionals and organisations together to co-create solutions.

Every year we refresh our plan to deliver healthcare services – both for this year and as we move towards the delivery of our Clinical Futures Strategy. You can access our Integrated Three Year Summary Plan on our website.

We have therefore organised the information in this Annual Quality Statement around the areas of focus of the plan, so that you can see how we are delivering quality services and improving patient experience now and as we also deliver the plan for our future services. However, so you can also see how this work relates to the themes in the Health and Care Standards, we have flagged the main theme each section relates to using the coloured boxes shown here:

Our hospitals are referred to in this report using their acronyms, as shown below:

RGH	**Royal Gwent Hospital in Newport**	**NHH**	**Nevill Hall Hospital in Abergavenny**
YYF	**Ysbyty Ystrad Fawr in Ystrad Mynach**	**YAB**	**Ysbyty Aneurin Bevan in Ebbw Vale**

What do you think about this Annual Quality Statement?

We want to know what you think about this Quality Statement: whether the priorities for next year are the right priorities, how it is easiest for you to give us feedback on your care, whether we have covered the issues that interest you about the services we provide.

We would love to hear your views, and you can contact us in a range of ways:

E-mail	mailto:abhb.enquiries@wales.nhs.uk	**Facebook**	www.facebook.com/AneurinBevanHealthBoard
Twitter	www.twitter.com/aneurinbevanhb	**Letter**	**Aneurin Bevan University Health Board Headquarters, St Cadoc's Hospital Lodge Road, Caerleon, Newport, NP18 3XQ**

2016-17 PRIORITIES – SUMMARY OF PROGRESS

Priority in Looking Forward in 2015-16 AQS	What we have done during 2016-17	How we have done
Patient Reported Outcome Measures/ Patient Reported Experience Measures: We will put in place a team to work on PROMS and PREMs which will complement our work on outcomes and value, through giving the patient experience a stronger focus.	A team is in place to take forward PROMS and PREMS measurement, which has started in Parkinson's disease, dementia and cataract surgery. See More information on p 47	
Healthcare Associated Infections: The UHB is seeking to further reduce the incidence of C difficile infection to deliver a rate of 28 per 100,000 between October 2016 and March 2017.	We achieved the target set for us by the Welsh Government and reduced the rate of C difficile infections below 28 per 100,000 population. We achieved a rate of 27.67 per 100,000 population and a 21% reduction compared to the previous year.See More information on p 42	
Hospital Acquired Thrombosis: We will identify an area with high numbers of HATs and ensure that all patients have risk assessment and appropriate thromboprophylaxis, so that there are no potentially preventable HATs.	Limited progress has been made in improving the risk assessment process as our plan was to use the revised All Wales Prescription chart, but this chart was only routinely available on the wards from April 2017. See More information on p 41	
Reducing In-patient Falls: We will implement a new In-patient Multi-factorial Falls Assessment	The new In-patient Multi-factorial Falls Assessment Tool was introduced in March	

Tool, and a programme of training, with the aim of reducing falls which result in harm, measured by the number of falls which result in a fractured neck of femur.	2017. Wards highlighted as having higher numbers of falls have received training. The number of inpatient falls which result in a fractured neck of femur has reduced in the second half of 2016-17 compared to the first half. See More information on p 25	
Improving the care of people with a fractured neck of femur: We will progress the work of the multidisciplinary group across the whole pathway of care.	Good progress has been made implementing changes identified through the multi-disciplinary pathway group with additional staff appointed and changes to the pathway. See More information on p 34	
Eliminating Avoidable Deaths and Harm from Sepsis: We will roll out ABC Sepsis to the whole of YYF and refocus on the recognition and response to the deteriorating patient across all our acute wards.	The Aneurin Bevan Collaborative on Sepsis has been rolled out to the whole of YYF. There has been a refocussing on the recognition and response to the deteriorating patient across all our acute wards, with an Acute Response Group to co-ordinate the work, and a Deteriorating Patient Audit tool developed and piloted.See More information on p 39	
Flu vaccination for staff: We will vaccinate 50% of our staff against flu.	In 2016-17 we achieved a 52.1%% uptake of the flu vaccine by front line staff. See More information on p 52	

Diabetes Pathway: We will establish co-production of local diabetes service modelling, using local diabetes patient reference groups.	Patient Reference Groups have been involved in co-production of local services for diabetes to improve the "patient interface" with primary care. The group has volunteered to review practice system template letters which are sent to all diabetes patients to ensure that they are "patient friendly". See More information on p 21	
Improving the care of people with a stroke: We will realise the benefits of the stroke service redesign programme through improved performance against SSNAP targets.	Achievement of SSNAP standards have dramatically improved since the implementation of the Stroke Services Redesign Programme. See More information on p 21	
12 hour waits in A and E: We will reduce the number of people waiting 12hours or more for a medical bed	In 2016-17, 6654 people waited 12 hours or longer in A&E compared to 4,725 in 2015-16. Regrettably, we therefore did not reduce the number of people waiting 12 hours in A and E. See More information on p 33	

LOOKING BACK OVER THE PAST YEAR IMPROVING POPULATION HEALTH & WELL-BEING

Inequalities in health

The ABUHB geographical area has a very mixed population. However, when taken as a whole, the population has unhealthy behaviours which lead to a higher risk of developing illnesses. These behaviours include:

- smoking,
- being significantly overweight,
- not eating enough fruit and vegetables,
- drinking more alcohol than the recommended levels and
- not taking regular exercise.

The health outcomes for people in the ABUHB area are therefore worse than in many areas in Wales:

- The ABUHB area has the highest number of people living with type 2 Diabetes across Wales
- Adults in Gwent have generally poorer mental health and well-being than the rest of Wales – and poor mental health is generally associated with unhealthy behaviours.

The data shows that within the ABUHB area, there are more people with these unhealthy behaviours in the areas of greater deprivation – so, for example, the rates of people being significantly overweight are above the Welsh average in Blaenau Gwent, Torfaen and Caerphilly.

This also means that there are poorer outcomes for people living in these areas:

- The age that a person can expect to live to is 9 years lower for men and 7 years lower for women resident in the most deprived areas of the ABUHB area compared to the least deprived.
- There is an 18 year difference in years of a healthy life between people living in the most deprived areas compared to those living in the least deprived areas.

One of the unhealthy behaviours above is drinking more alcohol than the recommended limits. In the ABUHB area there are high levels of alcohol misuse - around 42% of adults reported drinking above recommended limits in the previous week. In relation to patterns of alcohol misuse around 131,118 residents report binge drinking. Alcohol misuse over a long period of time can lead to liver disease. This AQS describes a number of initiatives to help people to drink alcohol within recommended limits. See below for an example.

Brief Interventions – Alcohol

Sadly, over recent years we have seen more people coming in to hospital with illnesses that are caused by drinking more alcohol than is safe for their health. There has been an increase in the number of people who die younger than average with problems with their liver from drinking more alcohol than advised limits and over a long period of time. This is an issue all across the UK, but as described above, in ABUHB areas there are higher levels of alcohol misuse. We have therefore recently developed new nursing posts, to provide support for people who have been assessed as drinking alcohol at harmful levels, to decrease the amount of alcohol they drink or to stop drinking alcohol completely. They work with the people using "Brief Interventions", one-to-one sessions, which are ideally suited to people who drink in ways that are harmful or abusive, but not actually considered 'alcoholic'. Services are available to patients 5 days a week in the Royal Gwent and 2 days a week in Nevill Hall and can put patients in touch with Mental Health Services. Our teams have been collecting data about the number of times people come to A and E or are admitted to hospital because of the amount they drink, and how often they see their GP. There has been a reduction in the number of times those people supported by brief interventions are admitted to hospital and how long they stay in hospital, and they do not visit their GP as often. The people are also reporting that they are drinking less alcohol.

Living Well Living Longer

The Living Well Living Longer Programme in Gwent has been set up to start to change the "Inverse Care Law" – which means that people with the greatest need for health and wellbeing services live in areas with the lowest level of these services. The programme provides health check for people aged 40-60 who are at risk of heart disease, stroke and diabetes and live in the areas with the lowest level of health services. The health checks include a full range of tests, like blood pressure and cholesterol levels. The staff discuss with each person their level of physical activity, their alcohol consumption and their smoking habit. They use the results of the tests to explain the impact of their behaviour on their body. Those that attend are then supported to set personal goals and to get help from the services that can encourage them to have a healthier lifestyle and treat high blood pressure, high blood lipids or diabetes. Here is Shane's story about how the programme has helped him:

'Shane was originally very nervous when he received his invitation to the health check following the sad death of his father 2 years ago due to a heart problems. However, he overcome his fears and felt it was much better to have the health check & knew he would learn a lot about how to be healthy, making small, easy changes he felt he could make. He understood what all the health 'jargon' meant which previously would have been confusing. Shane felt that it was great to be able to have his checks carried out in the community, and that the staff were very knowledgeable, approachable and explained everything really clearly. Shane was really surprised and pleased with his results. Having given up smoking and alcohol, he lost weight and his heart age came out 2 years younger than his actual age which meant he only had a small risk of heart problems in the next 10 years.

He has set himself a new goal to do more physical activity on a regular basis. He was really pleased when, as the 10,000th health check patient, he was presented with a free month's gym membership and a personal trainer session, kindly donated by Torfaen Leisure & a large hamper of fruit and veg donated by Tesco's Pontypool.

In 2016-17, Living Well Living Longer rolled out its health checks to 2 more NCN areas in Gwent, Caerphilly North and Blaenau Gwent. The programme has now been running for a number of years and has won awards for the service it is providing. In total, just over 10,000 citizens have attended for a full health check, with 1475 sessions held in 49 community venues across 4 areas and 25 GP practices.

Flu vaccine for at risk groups

Every year, usually in the winter, people are admitted to our hospitals requiring intensive care due to complications of flu and sadly, a small number of people die. For example, between October 2015 and May 2016, 109 patients were admitted to our care with laboratory confirmed flu. People with particular conditions, like asthma, and older people are more likely to become very poorly if they catch flu.

For some people who spend a lot of time in a few rooms with other people, like in Care Homes or schools, this can increase the risk of flu spreading from person to person.
The flu jab is therefore offered free to a number of vulnerable groups, like people over the age of 65, people with asthma and pregnant women. In addition to this, the Welsh Government is rolling out a programme of flu vaccine for children in schools. Last year, approximately 24,000 primary school aged children were offered the flu vaccine. The vaccine for most children is in the form of a squirt into the nose and is carried out at school within the normal school day. The Welsh Government plans to add at least one year group per year to the programme until all primary school aged children are included routinely.
The Neighbourhood Care Networks are prioritising the flu vaccine and in ABUHB there are 76 accredited community pharmacists who can deliver the vaccine. This means that many people can now visit their local community pharmacy to have the flu jab, rather than having to go to a busy GP practice.
In ABUHB, we still have some way to go to meet the WG target of 75% of people in the vulnerable groups being vaccinated, particularly for those aged under 65, but in March 2017, we had achieved a slightly higher vaccination rate than the rest of Wales.

Asylum Seekers

"An Asylum Seeker is someone who has asked the Government for refugee status and is waiting to hear the outcome of their application." United Nations High Commissioner for Refugees 2012.

Asylum Seekers have come to the UK for many different reasons: many are forced to flee to save their lives or preserve their freedom. But when they get to the UK, many of them have challenges to overcome, because they may not speak English, or be aware of the culture in the U.K. which can be very different to the one they have come from. Some will have physical injuries or have undiagnosed conditions and they do not understand our healthcare system. Some may have experienced very frightening or traumatic situations and maybe experiencing mental health problems as a result.

They therefore need to know how to get the healthcare support that they require. Newport, along with three other cities in Wales, is an area which the Home Office classes as a 'dispersal area' meaning that Asylum Seekers are provided with accomodation in Newport while they are waiting for their application to be processed by the Home Office. On average, there are 25 new arrivals every month, many of whom are single men, but also single women, women with children, and families. ABUHB therefore has an Asylum Seeker Service – a nurse who works with the asylum seekers to assess their health, to provide advice about how to look after their own health and wellbeing while in the UK, to help them register with GPs, refer to relevant agencies and provide advocacy and support to make sure they can get the services they need. The Nurse also liaises with healthcare staff, so that they understand more about asylum seekers and their needs. In this way, the Asylum Seeker Nurse can prevent the asylum seekers having bigger health problems in the future, whether they continue to live in Wales or have to return to the country that they came from.

STRENGTHENING PRIMARY CARE SERVICES

TIMELY CARE

Getting to see your GP

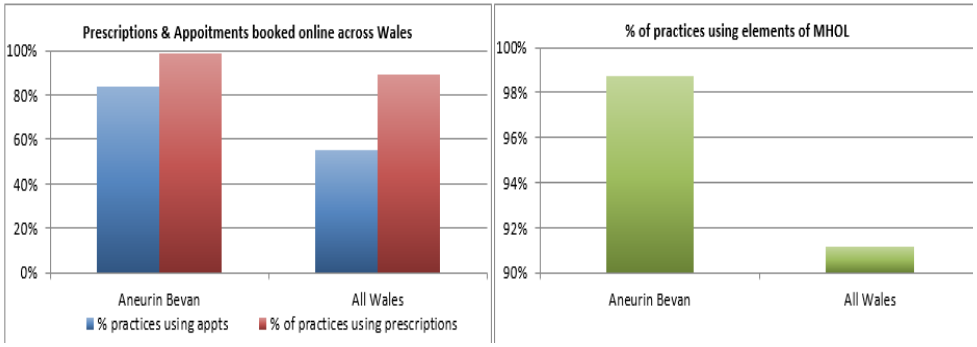
Across the whole of the UK it is getting harder to fill job vacancies for GPs, and many GPs are approaching retirement age. Since April 2013, there has been a net reduction of 8 practices in the ABUHB area, from 88 to 80. In light of this, in ABUHB we have been working hard to make sure that GP practices stay open so people can access GP services as close to home as possible. We have introduced a multi-disciplinary Primary Care Operational Support Team, consisting of GPs, Nurse Practitioners, Practice Nurses, Health Care Support Workers, senior management and administrative support plus a Pharmacist and a Pharmacy Technician. The Team provides a support structure to offer sustainable solutions to already struggling practices. It has provided support to 5 practices, through the sustainability framework, in order to prevent further closures. In addition, the Health Board has supported one practice merger, two branch surgery closures and two practices through the vacant practices process, all of which helped the GP practices to keep going.

How we are doing? In April 2013, we introduced the 5As for Access" scheme, which is a set of access standards for GP practices. To achieve 5As, practices must be able to demonstrate:

1. A - That they open at or before 8am with their first appointment at 8.30am or earlier
2. A - That they open during the lunch time period
3. A - That they offer the last routine appointment at 5.50pm or later
4. A - That they offer telephone access to a member of staff between 8.00am and 6.30pm
5. A - That they allow patients to book an appointment during one telephone call, without the need for calling back, or online.

Since implementation in 2013, compliance with the standard has risen steadily from 55% of practices offering all 5 components to 77.5%.

What are we doing to improve access? Practices in ABUHB continue to increase the use of the online system – My Health Online (MHOL) - that allows patients to make bookings and order repeat prescriptions quickly and easily. ABUHB has the highest percentage of GPs offering both of these options at the same time, compared with the rest of Wales. The bar charts are the latest statistics showing ABUHB's performance for MHOL against the rest of Wales: Although people need to see a health care professional, not everyone needs to see the GP. We have therefore continued to support practices to increase the range of professionals who work in GP practices so that people can see the most appropriate healthcare professional to assist them with their health issue, thus freeing up the GP to see the people that only the GP can help. Some, but not all, GP practices have employed a range of professionals such as pharmacists, physiotherapists, nurses, social workers and dieticians to continue to improve access to their services There is more information about this in the sections on Neighbourhood Care Networks page 18 and the Out of Hours Service on page 19.



In ABUHB GP Practices
11,219 prescriptions ordered online
4,512 appointments booked online
51,718 registered to use online facilities.

Access Quality Improvement Scheme

We are also continuing with the access development programme. 47 practices participated in the scheme between April 2015 and March 2017and were provided with funds to identify and improve patient access within their practices by means of an Access Improvement Plan. Following a review of their improvement plans, all were invited to apply for additional funding for equipment to further improve experiences for patients who need to see a member of the Primary Care Team. In 2016-2017, 6 practices participated in an in-depth 'capacity and demand' pilot exercise to develop improvement plans. Practice Managers from each practice worked with a company to look at the systems and processes they use. The Primary Care team is currently analysing the findings and the recommendations provided by the company and is awaiting their final report. In 2017/2018 the practices will work with organisations that can help them to make the individualised programme of changes to their services that will improve access for patients.

It is proposed that the recurrent funding in 2017/18 will commission the services of an external provider to deliver a bespoke programme of service change improvements to improve access for patients.

Improving Dental Services

Welsh Government allocated an additional £175,000 to Aneurin Bevan University Health Board to assist in improving access to NHS dental services. The Health Board has added £75,000 to the Welsh Government money and put in place contracts for 6 dentists from April 2017.

Referrals to Oral and Maxillofacial Departments for Minor Oral Surgery have been rising over a number of years. Many of these procedures can be safely delivered in the primary care setting. ABUHB now has 2 dental practices that can provide a number of oral surgery services, one in Newport and the other in Blackwood. This reduces demand on hospital dental services and waiting times for patients, so that the hospital dental services can see those patients with more complex treatment needs.

Some people cannot get to a dentist so the Health Board is currently setting up Domiciliary (home) Dental services (DDS) in each of the 4 boroughs, Blaenau Gwent, Caerphilly, Newport and Torfaen. There is already a DDS being provided in the Monmouthshire area. Once the service is in place in the 4 boroughs, patients who are unable to see the dentist will be able to request a referral for a dental 'home' visit.

Optometry

Referrals to the Ophthalmology Department within the hospital has been rising over a number of years. Many patients who require glaucoma follow up appointments can be safely see at the opticians.

From April 2016 the Health Board has put in place contracts with opticians to see patients who need follow up for Glaucoma. Patients are now able to be assessed in a timely manner by a primary care optician. The primary care optician undertakes the patient assessment and produces a report for the hospital Ophthalmologist to review and confirm next steps

Community Pharmacy

Community Pharmacies provide an extensive range of services to patients. Most pharmacies provide the following services:

- Supervised Administration of Medicines
- Needle Exchange Services
- Smoking Cessation Services
- Palliative Care Out of Hours Service
- Medication Administration Service
- Just in Case Scheme

- Emergency Hormonal Contraception
- Flu Vaccination Scheme
- Choose Pharmacy Platform-Common Ailment Service

People are encouraged to contact their local pharmacy to discuss the services available.

GP Practice Based Pharmacists

The Health Board has invested in employing pharmacists that are based in GP Practices. This means that pharmacists can use their knowledge and skills to help and support patients face to face, closer to the patient's home. They are also able to see patients and address medicine related problems that otherwise would need to be dealt with by the GP – freeing up the GP to see patients and deal with problems that need their medical expertise. The practice based pharmacists love their new role, as they are seeing people and talking with them about their health problems, and working with them to make sure that the medicines that they are taking are helping them to be as well as possible. The new community based roles have also allowed some practice based pharmacists to develop their skills and knowledge further by doing additional training so that they can prescribe independently – like a doctor – for patients with certain medical conditions ***e***.g. respiratory conditions.

Neighbourhood Care Networks….What are they and what are they doing to improve local services?

The Health Board needs to work with communities and individuals, combining our services with the strengths and assets that they have in order to prevent ill health, help people to manage their conditions and provide care and treatment as close to home as possible. The Neighbourhood Care Networks (NCNs) are clusters of GP practices that work together with community services, social care, housing services and local voluntary groups to do this. Together, through greater liaison and interaction between the professional Groups, they are working to deliver the aims of the Social Services and Well Being Act. See page 4.

In practical terms, what this means is that the NCNs know what is needed locally to provide comprehensive first-point-of-advice, diagnosis and treatment, together with ongoing care co-ordination and support. They have therefore used the money that has been delegated to them to help sustain and develop primary care to meet the need of the local community. This has included:

- Practice based pharmacists
- Direct access physiotherapy
- Practice based social workers
- Increased access to community based services to reduce demand on GP Practices e.g. Direct Access Physiotherapy, Dietician and complex wound care training.
- Community based dietician
- Non-clinical and clinical training for GP Practice
- Bowel Screening to increase the opportunity for early detection of cancer
- Online Dementia Roadmap (Wales)
- Smoking Cessation services and Smoking Cessation Champions in GP Practices
- Dedicated sessions for National Clinical Audits
- Regular reviews of prescribing budgets, implementing appropriate switches and substitutions where identified.

The NCNs have also been involved in developing an Older Person's Pathway. This pathway uses a tool to identify the older people at greatest risk of becoming unwell and needing significant health or social care support in the near future.

These people are then contacted and visited by a practice based Care Co-ordinator, employed by a Local Charity. Together they draw up a Stay Well Plan, which makes clear how the health and social care staff will work with the person and their community to keep the person safe and well in their own home. By the end of 2016/17, 9 practices were actively using the tool and 722 people had a Stay Well Plan in place. Although this is fewer than was originally hoped, an evaluation has shown that there has already been a reduction in GP appointments, a reduction in required home visits and a reduction in the number of required hospital admissions for those older people participating in the programme.

722 older people on a Stay Well Plan

In the coming year, the NCNs will be prioritising improving the care for people with dementia, the care for those with liver disease, services for people with COPD and mental health and well-being services. There are also initiatives to assist patients with chronic conditions become more digitally aware so patients can take charge of their own health by using the 'My Health Online' to book appointments and make prescription requests online. You can find out more about NCN's in the Board Paper available on the ABUHB internet site.

Urgent Primary Care Out of Hours

The Urgent Primary Care Out of Hours Service (OOHs) has approximately 100,000 contacts a year, with an estimated extra 8000 a year from handling dental calls into the service. This averages around 2000 contacts a week, the majority of which are on a Saturday and Sunday and Bank Holidays.

The UK wide shortage of GPs has sometimes made it hard to fill all the shifts needed to provide the full OOHs Service. Despite this, we have managed to improve response rates to patients in terms of calls returned on time and the percentage emergencies seen within 2 hours compared with last year, although we are still not meeting the National target.

This has been done by looking carefully at what only a GP working in the OOHs service can do and what another clinical professional could do. The range of health care professionals working in the service has then been extended, and the skills of existing staff enhanced. For example, training has been provided to extend the skills of the nursing team, so that they are now able to cover some

home visits, to provide cover in the bases for some visits and verify deaths when patients have sadly died at home. In 2016/17, nurses have been able to verify 502 deaths, staying longer with the relatives at this difficult time, whilst allowing the GPs to focus on other parts of the OOHs service that only a doctor can do. The addition of some Health Care Support Workers to the Overnight Nursing Team has increased the number of people that the nurses can support in their own homes. An Advanced Paramedic is also working in the Out of Hours service, supporting home visiting and the assessment of patients and starting treatments.

It is often children that are brought by their parents to the Out of Hours bases to see the GP. Over the last 6 months of the year, three paediatric nurses have worked alongside GPs in the bases at the weekend as a short term trial to see how they can be most effective, and have both assessed children and initiated treatments. This has shown that there is a role for an Advanced Nurse Practitioner within Paediatrics working across secondary care and the OOHs service.

We have also looked at the calls to the OOHs service about medicines. Changes have been made that have been successful in enabling the pubic to be seen at a local pharmacy when appropriate rather than being seen in a base for an OOHs appointment.

However, even with the wider number of professionals, it has been difficult to recruit sufficient GPs to cover the three bases in the current OOHs service model at Ysbyty Ystrad Fawr, St Woolos & Nevill Hall Hospital. The number of patient attendances across the bases has therefore been reviewed in order to ensure that the available GPs work at the bases where there is greatest need. This highlighted that the Nevill Hall base had the lowest number of patient attendances, particularly Monday to Thursday nights between midnight and 8.00am. It was therefore agreed with the Community Health Council that the Health Board could trial a temporary service change for a 6 week period, when the NHH base was closed at these times. The evaluation of the trial showed that there had been no significant problems or issues raised. But in addition to this, when the NHH base was closed, more professionals were on shift at the times of higher demand, so that overall, the OOHs service was providing the best possible levels of service and patient care with the number of GP shifts available.

Following the trial, it was agreed that a formal public consultation phase should take place. Following this consultation, the Community Health Council and the Health Board agreed in May 2017 to undertake the closure of the NHH base at the times given above as permanent service change.

MANAGEMENT OF MAJOR HEALTH CONDITIONS

The pathway of care for people with Diabetes: We will establish co-production of local diabetes service modelling, using local diabetes patient reference groups.

INDIVIDUAL CARE

The remodelling of the diabetes service into one pathway across GP and hospital services is being done taking into account the views of the Patient Reference Group – groups made up from people with diabetes. Patient Reference Groups have been involved in coproduction of local services for diabetes to improve the "patient interface" with primary care. The Group has volunteered to review practice systems template letters which are sent to all diabetes patients to ensure they are "patient friendly".

Caring for people who experience a Stroke

Improving the care of people with a stroke: We will realise the benefits of the stroke service redesign programme through improved performance against SSNAP targets.

EFFECTIVE CARE

Stroke is a preventable and treatable disease. It is the leading cause of adult disability in Wales, and the third most common cause of death, after cancer and heart disease. It is a devastating condition that changes lives and can have a huge effect on people and their families.

Last year, in January 2016, we redesigned the whole pathway of care for a patient who experiences a stroke, to provide faster and more comprehensive care when the patient most needs it – straight after the stroke happens. Rapid treatment and then full, multi-disciplinary rehabilitation means that a person has the greatest chance of making the best recovery they can from the effects of the stroke. The new service consists of:

- Centralization of care immediately after the stroke in a seven day, multidisciplinary hyper-acute stroke care unit at RGH.
- 'Step down' acute stroke care closer to home delivered at RGH, Nevill Hall Hospital (NHH) and Ysbyty Ystrad Fawr (YYF)
- Inpatient stroke rehabilitation delivered at St. Woolos Hospital (SWH), NHH and YYF
- A Community Neuro-rehabilitation Service to enable early supported discharge (ESD) for stroke survivors, often straight home from the hyper acute unit

One patient called John talked about the new stroke service – both the hospital service and the opportunity to go home as soon as possible, and receive the rehabilitation at home:

In November I had another stroke, but this time it wasn't a mini-stroke. This one affected my balance, and I stopped there for ten days. In that time, around about the 10th day they asked me if I wanted to go home and have the service to my house rather than have it in hospital. Well, I said I'd go home rather than stop in hospital, although the treatment and the care that I received in hospital is second to none, from the Doctor, Sister down to the Tea Lady - I couldn't fault them - the staff were excellent.

The regular audit of the stroke care has shown sustained improvement over the first half of the year following the redesign of the stroke pathway. There has been a deterioration in results in the first two months of 2017. The Stroke Team understand the reasons for the deterioration, and are working to ensure that the results return to the previous high levels.

Keeping people out of hospital – Falls Response Service

One of the frequent reasons for 999 calls to the Ambulance Service is that a person has fallen and is unable to get up, and it is not known whether they are injured. Traditionally, the Welsh Ambulance Services NHS Trust (WAST) will dispatch an emergency vehicle to complete a medical assessment, and help get the person up from the floor. However, if the paramedic is worried about the home environment or the ability of the person to look after themselves without support, the paramedic will need to take them into hospital. This happens particularly when the paramedic is worried that the fall may have injured the person making it harder for them to walk, or when there are concerns about the person's balance.

The Falls Response Service (FRS) was developed, through a partnership between the WAST and ABUHB, to improve the patient experience following a fall by increasing the number of people treated or cared for at the scene of the fall and reducing the number of patients taken to the Emergency Department . A limited FRS was tested in the winter period in 2015-16, and showed promising results which led to a more comprehensive service being set up for the 2016-17 winter period.

The 2016-17, the FRS operated from a specialist vehicle between 08.00hrs and 20.00hrs, seven days per week, from 17th October 2016 to 31st March 2017. The FRS has a two-pronged approach:

1. The first role is to respond to the fall, and to lift the person safely from the floor. The Paramedic and Physiotherapist will perform a full medical and social assessment at the place they have fallen. They will, where appropriate, refer the person to other services that will enable them to remain at home, and prevent further falls. This means the person does not experience the upheaval of leaving their home comforts and being admitted to hospital.
2. The second role is to give advice and support to other Emergency Ambulance staff responding to 999 calls from people have fallen about appropriate care for the person within their own home .

In previous years, in the ABUHB area, WAST have transported to hospital around 67% of people who have fallen at home and contacted 999. During the time the FRS was operating in the ABUHB area, WAST as a whole transported only 57% people who had fallen and called 999 to hospital – a reduction of 10%. Of the people responded to specifically by the FRS, only 22% were taken to hospital, with just 11% taken to the Emergency Department. The remaining 78% of patients were given support that ensured they could be safely cared for within their own home setting, with same day support from other services if it was needed.

As a result of this new collaborative way of working, the number of inappropriate and/or duplicated referrals to the community falls service reduced from 60% to 35%. The reduction in unnecessary referrals means that those patients who need the assistance of the community falls service, receive it without delay, helping to prevent further falls.

Patients and their carers who have benefitted from the Falls Response Service have been very complimentary about their experience. Some of the comments from patients included:

"First class service…"

"They talked with me not to me…"

"Brilliant treatment – couldn't fault it…"

"There was no upheaval, they done it all at home and it was all sorted…"

Working with our partners to prevent falls at home – The South Wales Fire and Rescue Service Home Safety Visit Pilot

The Fire and Rescue Service have been very successful in reducing the number of accidental fires in people's homes, and the number of people injured as a result of them. This has been largely through the increased use of smoke detectors which mean people are warned that a fire has started quickly so it can be more easily put out and people can get out of the house safely.

In order to prevent even more fires in homes, the Fire and Rescue Service have a small team who take this one step further and go to the homes of vulnerable, older people to complete a Home Safety Visit to identify fire safety hazards. They attend 25 000 homes in a year. This might be spotting the overloading of a socket through the unsafe use of extension leads, or advice to a heavy smoker about how to minimise the risk of a fire. But, while they looking for fire safety hazards during a Home Safety Visit, the Fire and Rescue Service are keen to help reduce other risks to the vulnerable person – such as the risk of falls. They have therefore worked with the Falls Team in Newport, and have received training on Falls Prevention. The Falls Team staff have also received training on preventing fires. The Fire and Rescue Service are now looking, not just for fire risks when they complete a Home Safety Visit in an older person's house, but also for falls hazards, such as uneven steps or torn carpets. They can give advice about reducing the risk, or refer the person to other services. The Falls Team are also identifying potential fire hazards, and can alert the Fire and Rescue Service.

Both Teams are enthusiastic about this new partnership, and feel it means they can together reach many more people to prevent both falls and fires!

Reducing In-Patient Falls

Reducing In-patient Falls: We will implement a new multifactorial Falls Assessment Tool, and a programme of training, with the aim of reducing falls which result in harm, measured by the number of falls in our hospitals which result in a fractured neck of femur.

SAFE CARE

Many older people fall at home, and it is a common reason for admission to hospital. In line with most hospitals across the UK, the most frequent incident reported by our staff is that a patient has experienced a fall whilst in hospital. We want to reduce the number of falls experienced by patients in our hospitals. The fall can cause a physical injury, but the fear of falling can stop a person from moving about so much and mean they do not have such an active and fulfilling life. However, no matter how hard we try, we will never eliminate all falls in hospital, as patients need to get up and move about to maintain or improve their ability to do this. In order to prevent as many falls as we can in our hospitals, we assess the risks factors for falls for each individual patient, and make sure we are putting in place the right actions to prevent that person falling. For example, one person may have problems walking and need a zimmer frame to support them, so we need to ensure their zimmer frame is always by their bed. Or if a person's blood pressure decreases when they stand up, a doctor needs to review their medication to see whether they are taking a drug that contributes to this and whether that drug can be changed for another that does not lower blood pressure. Following feedback from our staff that the falls risk assessment form was not easy to use, we have introduced a new multifactorial Falls Assessment Tool which looks at all the different things that might make a person more likely to fall. We have also put in place training on preventing falls when monitoring has shown that a ward has had more falls with injuries, such as a broken bone.

We are monitoring the number of inpatients that have suffered a hip fracture from a fall on a ward. We are pleased that the number of hip fractures from in-patient falls has reduced over 2016-2017. From April-September 2016 there were 35 falls with fractures. From October 2016-March 2017 there were 22 falls with fractures.

Reducing Falls in the Community: We have Falls Services in all 5 Boroughs in the Aneurin Bevan area. The Falls specialist staff in these Teams assess patients referred to them and can either refer them on to the Falls Clinic where they will receive a full medical assessment to see what could be contributing to the falls they are experiencing. Alternatively, the Team can put in place a course of exercises or provide advice on making the environment in the person's home safer.

Dementia Support Workers

DIGNIFIED CARE

When a person is told that they have dementia, they are often frightened and have many questions about what this will mean. In the ABUHB area we have a service that is designed to help people when they receive a diagnosis of dementia. The Integrated Dementia Support Service was developed by Alzheimer's Society and is funded by the Welsh Government to support people that have recently been diagnosed with any form of dementia.

The focus of the Dementia Support Service is on providing support at the point of diagnosis to help the individual and his or her carer with all that comes with that life changing news. Dementia Support Workers (DSW) receive referrals, usually directly from the Memory Teams, where the diagnosis is made. They then contact the individual and arrange to meet them, usually in their own home. Support can be provided for the person with dementia and/or their carer. When they meet, they discuss a range of things. This will usually include:

1. Information about the diagnosis and what it means
2. Information about all available services - third sector and health/social services
3. Support with legal and financial affairs
4. Information about and support with advanced care planning, if appropriate
5. Emotional support

A personalised support plan is agreed for each person and the person can then be supported for up to 12 months after diagnosis. An example of how this works is given below:

"A DSW went to see a gentleman, Mr C, who had recently been diagnosed with vascular dementia. His wife, Mrs C and his son, F, were there too. Mr C did not say a lot at the visit. Mrs C was very upset as her husband was recovering from a chest infection, seemed to have become very frail very quickly and gone downhill generally. Mrs C was now more isolated as she did not drive, and Mr C had stopped driving. She felt she had lost the companionship with her husband as they did not talk as they used to, and Mr C slept a lot of the time.

Mrs C said that Mr C had lost a lot of weight as he was not eating properly. The DSW saw he wore dentures and suggested that this was the reason that he was not eating as they seemed too big, and they should go to the dentist. The DSW also suggested they should have a benefit check with Age Cymru to see if there was anything they were missing out on. Mrs C did not think they would be entitled to anything, but agreed to go.

The DSW gave Mrs C and F some information on vascular dementia. F was keen to support his Dad. The DSW suggested that past memories would be easier to recall for Mr C and so reminiscence might be something he would enjoy. F took some books about Old Abertillary from the cupboard, and Mr C became much more animated once looking through them. He recognised lots of people in the books and Mrs C was pleased with the change in him. The DSW also suggested that listening to music might be something Mr C would enjoy.

On the DSW's second visit, it seemed that things had improved. Mr C had new dentures and was eating better. Age Cymru had been out and Mr and Mrs C were entitled to Attendance Allowance and Council Tax Discount.

Mrs C was very thankful for all the help; she said she felt much better that she now had a support worker to contact."

Supporting older people living in care homes

The Complex Care Team commissions Continuing Care and Funded Nursing Care in nursing care homes. There are robust governance frameworks in place for commissioning, contracting and monitoring the quality of these placements. Registered Nurses and Allied Health Professionals from Aneurin Bevan University Health Board work with the staff in Nursing Homes to support them in caring for their residents. For example, there is a dedicated Nursing Home Pharmacist who visits all the nursing homes in the area. The Pharmacist works with the staff to ensure the residents receive the appropriate medication, the risks with polypharmacy (this is when a person is taking 4 or more medications) are understood, and that antipsychotic drugs are only used when they really need to be. The pharmacist has worked with care home staff to develop policies and procedures that comply with current legislation and NICE guidance for Social Care. For example, the pharmacist is working with Nursing Home staff to develop a Homely Remedies Policy. The idea of this Policy, when it is approved, is that it will allow Nursing Homes to use simple over the counter medications to treat residents for minor ailments without having to call out a GP or the ambulance service. For example, this means that residents have more timely treatment to relieve pain.

There is a team of Community Psychiatric Nurses that reach into Nursing Homes to help them to manage the antipsychotic medication for people with dementia. The team has been increased so that, working with GPs, the medications for all new residents are reviewed 3 months after they have moved in, and they can ensure all residents have a review every 6 months.

They work with the Nursing Home Pharmacist to make sure that the Homes have different strategies for supporting residents with dementia, to ensure that anti-psychotic drugs are used effectively and only where necessary.

In addition to this work on medications, specialist Health Board staff have provided training to Nursing Home staff on promoting continence, infection prevention, falls prevention and preventing and managing pressure ulcers. The continence team have focussed on the promotion of continence, rather than assessment for continence aids. This means they have worked with Nursing Home Staff on toileting regimes, treatment of urinary tract infections, management of constipation and caffeine reduction. The residents are often now able to wear more discrete pads when pads are necessary, increasing their dignity.

The Community Falls Team will advise staff in Care Homes on falls prevention. However, it was identified that when a resident fell in a Care Home, the ambulance was often called to assess the resident and to help to lift the resident safely. Sometimes the resident was then admitted to hospital when they could have remained at the Home. To prevent this, training has been provided in the Care Homes for staff to use the "I STUMBLE" tool. The Tool helps to identify when an ambulance is required because of the need for medical assistance, and when a resident can be safely assisted and lifted from the floor.

In addition to the training provided, a range of specialist teams go in to the Homes to support residents rehabilitating after a prolonged period of ill health. This includes the specialist diabetes service, the specialist complex care Occupational Therapy Team, Community Dental Service, Opticians and the Community Dietetic Service.

SERVICES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS & LEARNING DISABILITIES

Crisis Resolution Home Treatment Team - assisting people to live normally with Mental Health problems

The Crisis Resolution Home Treatment team (CRHT) provide a service for people living with mental health problems who have a crisis, often seeing patient's within one hour of referral. The main focus is on treating and supporting people in their own home, keeping them close their friends and family who they can rely on for support. This prevents admissions to hospital which takes the person away from their home support network. Each person is carefully assessed to decide the level of treatment/support each person requires.

During 2016/2017 the CRHT team assessed 2,936 people, an average of 245 per month. The team admitted 884 patients to hospital and 905 patients were able to be supported at home. 936 people were referred back to the original referrer with advice about further care and support. There is particular challenge recruiting doctors for mental health services at the moment. The Crisis Resolution Home Treatment Team are now providing a service through to midnight. This reduces the demand on the doctors but is also better for the patients, as often they can be seen in their home, rather than having to go to hospital to see the doctor.

Improving services for people with Learning Disabilities

There has been a lot of concern in the last few years that people with Learning Disabilities are disadvantaged in accessing general health services and are not always treated as well as other people. In ABUHB we have a number of initiatives to make sure that people with Learning Disabilities receive the same care as anyone else:

Support Plus: People with learning disabilities have more emotional and mental health needs than the general population, but they use the Primary Care Mental Health Support Services (PCMHSS) less often. Support Plus is a project designed to understand why this is and what needs to be done to increase their use of the service. The project started with conversations with people with learning disabilities to understand why they did not use the PCMHSS, and also discussions with mental health staff. The people with learning disabilities said that they did not know about the PCMHSS and that they needed support to understand and make contact with the service. The mental health staff did not think they had information or support to help them work effectively with people with learning disabilities, particularly talking with the people with learning disabilities so that there was a shared understanding of the problems and the approach to addressing them. Support plus has designed a course for people with learning disabilities on wellbeing, and also a web site that has useful information for both staff and the people with learning disabilities. The courses have been well attended and the web site has had many hits, demonstrating how useful they have been for the service users and staff.

Primary Care Health Liaison: People with learning disabilities also have many physical health problems, but do not go to the GP for screening and support. When they are admitted to hospital, they often are therefore experiencing symptoms that are worse than the general population. Two nurses will now be working with people with Learning Disabilities and the GPs in two NCN areas.

The nurses will make sure that the GPs know about the people with Learning Disabilities on their practice lists, work with the people with Learning Disabilities to encourage them to attend for screening and health checks and help the GPs run special clinics for people with Learning Disabilities.

Mortality Reviews of people with Learning Disabilities: As has been highlighted above, people with Learning Disabilities are more likely to have physical and mental health needs, do not always seek help with their health problems. There are therefore some premature deaths in people with learning disabilities. The average age of death for people with learning disabilities (65 years for men; 63 years for women) is significantly less than for the UK population (78 years for men and 83 years for women). The health care professionals working with people with learning disabilities have therefore started to undertake reviews of the deaths of all people with learning disabilities. The aim of the reviews is to understand more about what could have been done better to ensure that people with learning disabilities get the care they should have, and to improve the services based on this learning. So far, 11 deaths have been reviewed. The reviews have shown aspects of care that could have been done better, but would not have prevented the death, and the learning from these deaths is being taken back into the service.

MATERNAL & CHILD HEALTH SERVICES

Homely surroundings for mums-to-be

Mum's-to-be usually want to have their baby in a homely environment, with the midwife there to help them and check that both the mum and baby are doing well. Therefore we were really pleased to open the Abergavenny Birth Centre on 30 October 2016. Now mums-to-be in the North of the Health Board area, who are fit and well and have not had any problems during their pregnancy, can give birth in a homely environment with access to a birthing pool within Nevill Hall Hospital. The care for the mums and their babies is led by the midwives, as they are able to look after everything if the birth is straight forward. In the 5 months after the centre opened, 192 babies were born in the Abergavenny Birth Centre.

Since the opening of the Abergavenny Birth Centre last year, feedback from those who have used the facilities has been overwhelmingly positive.

In ABUHB, we now have midwifery led birth centres in RGH, YYF and NHH, so mums-to-be can have their baby in a homely environment as close as possible to their home. Home birth is also an option which some mums do choose. In NHH and RGH, there are medically led delivery units for mums and babies who might need a doctor to oversee the birth, in addition to the care from a midwife. Where ever possible, we want mums to have the most natural experience of birth that they can, and therefore choose to have their baby in the midwifery led units. All our ladies are carefully assessed to make sure that it is safe for them to have their baby there. Mums-to-be at NHH and RGH can be moved to the medically led delivery unit if the midwife has any concerns when they are giving birth. As there is not a medically led delivery unit at YYF, the assessment criteria for the midwifery led unit are even tighter, and fewer ladies are assessed as being able to have their baby there.

In Wales, we want to make sure that mums-to-be are supported and well prepared for having their baby, and are happy and confident to have the baby in a midwifery led birthing centre. Our midwives have been talking to mums & dads-to-be to understand how they feel which is part of a survey that is taking place right across Wales. The views of the parents to be are now being analysed and the results will help us to provide the bests service for mums-to-be and their babies in the future.

Maternity Liaison Committee "you said we did"

The people that know best how to improve health care services so that they meet the needs of the people that use them – are the service users! Mums-to-be and new mums have been helping the midwives and doctors to improve the maternity service for 6 years now through the ABUHB Maternity Service Liaison Committee (MSLC). The Committee is thriving and has made sure that the ideas and views of service users are listened to when changes are made to the maternity services. The Committee is led by a service user, and is well attended by women from all areas of the health board, as well as senior midwives.

Service users are told about the Committee during their visits before they have their baby, and it is advertised on the Health Board web page, and the maternity service face book page. The areas that the service users have said need to be improved, and the changes that have been made as a result of what they have said at the Committee are shown in the table below:

Area for improvement	**Changes made based on views of service users**
Information/education for parents-to-be	Development of a rolling programme for parent-to-be education, with the information they want to know, with the same programme now available right across the health board
Visiting times for partners	Longer visiting times for partners, including the option to stay overnight when appropriate
Support for new mums to breast feed their baby	Excellent breastfeeding support to the required Baby Friendly accredited, including the introduction of breast feeding peer support who are recent mums themselves and now are available for new mums while they are still in the hospital
Giving birth naturally when a mum has had a caesarean section	Women wishing to have a natural birth after caesarean section have a clear process to follow with the midwives and doctors that is supportive of their choice and empowers them to succeed
Induction of labour – getting things started	Women can now have the treatment to get the birth process started in the outpatient clinic rather than having to come into hospital and stay on the ward, if the baby is "overdue" and they have not had any problems during their pregnancy
Increasing the use of midwifery led areas for birth by mums-to-be	There are now midwifery led birth centres, with a home from home environment and access to a birthing pool in all 3 main areas of the Health Board
The maternity unit in the Specialist Critical Care Centre	Service Users are involved in the planning of the service and facility in the SCCC

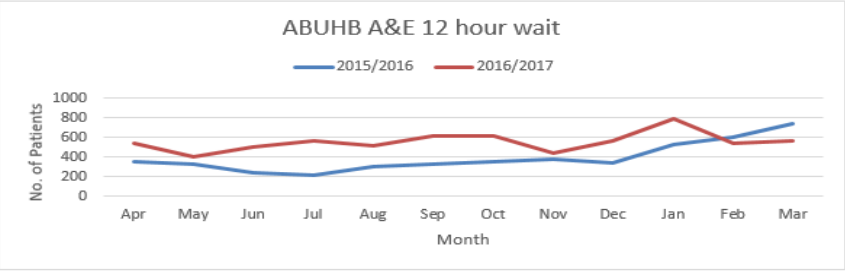
URGENT & EMERGENCY CARE SERVICES

TIMELY CARE

Reducing 12 hour waits

12 hour waits in A&E: We will reduce the number of people waiting 12 hours or more for a medical bed.

If patients have to wait 12 hours or more before they have a bed on a ward, they may not be getting the care they need as quickly as they should. The Health Board therefore makes every effort to reduce the numbers of patients that wait over 12 hours in our A&E departments, with the ultimate aim that no one should wait for 12 hours. We have made changes to help reduce 12 hour waits, such as the new Minor Injuries Unit (MIU). The less seriously ill patients who are less likely to need a bed are now seen in MIU, freeing up the ED clinical staff to treat the major traumas/illnesses (see page 37). Also the new Ambulatory Care Service is designed to assess patients and deal with their problems quickly to enable them to return home, rather than admit them to one of our wards.



Although over the whole winter period in 2016-17, the number of admissions was approximately the same as the number of discharges, and overall patients were not staying as long in hospital as last year, more patients waited for 12 hours or more for a bed than in 2015-16.

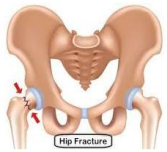
DID YOU KNOW?

- *3 of every 10 people that arrive in A&E have been brought there by ambulance.*
- *75% of patients brought in by ambulance are discharged home again from A&E and do not need any treatment but have had a full assessment*
- *25% of all the people that arrive in A&E are admitted to a bed on a ward*
- *The number of people walking into A&E has not increased much over recent years*
- *The number of people referred to our assessment units by GPs has increased by 12% every year since 2013 – so there were 6,400 more patients referred to our assessment units in 2015-16 compared to 2013-14*
- *NHH admits between 41 and 77 people every day, with 59 being the average. The average number of beds at NHH is 311.*
- *RGH admits between 85 and 153 people every day, with 119 being the average. The average number of beds at RGH is 563*
- *Of the total admissions every day, 55% have been referred for admission by a GP, 45% have come through A&E*

In 2015-16, 4725 patients waited more than 12 hours, and in 2016-17, 6681 patients waited more than 12 hours. This was because there was a 12% increase in emergency GP referrals compared to the previous year, and the people being referred were more ill. However, in February and March 2017, the numbers waiting 12 hours were lower compared to the previous year, and we are working to make sure this decrease continues into 2017-18.

Better Care for people with a Fractured Neck of Femur

Improving the care for people who fracture their Hip:
We will progress the work of the multidisciplinary group across the whole pathway of care.



The General Manager for Scheduled Care is leading a process to completely review the pathway for patients with a fractured neck of femur, from the time they fall to the time they return home. These are often older people who are frail and have a number of long term health conditions. The most important aspect of this work is that is looking at care across the whole pathway, and it will ensure that all the different parts of the pathway work together seamlessly with the patient at the centre. The aim is to reduce the number of people that die within 30 days of the fracture and the average length of stay, as well as to improve the patient experience.

The pathway group has representatives from all the clinical professions involved in the care of a person who has sustained a fractured hip. It has been meeting regularly since June 2016. The group has been identifying changes that will improve the experience for a person based on National Institute for Health and Care Excellence (NICE) guidance, from when they fall and contact the ambulance service, through to the end of their rehabilitation and return home. The group is monitoring the impact of these changes to make sure they are delivering the intended patient care benefits. Good progress has been made in implementing changes and this is shown in the table below:

Changes to reduce the time it takes for the patient to get to the right ward, and to have their operation	An additional Consultant who can operate on these patients and a co-ordinator for emergency patients have been in post since August 16.
	A ward dedicated to Fractured Neck of Femur patients has been put in place at RGH, and a designated area on the trauma ward at NHH was put in place in January 2017, so that the staff have all the skills needed to look after these patients.

Changes to improve the rehabilitation of patients after their operation	Rehabilitation assistants have been appointed and will start in June 2017 to work alongside the nurses, doctors, physiotherapists and occupational therapists on the wards to support patients in achieving their goals.		Volunteers). They will help patients to eat at mealtimes – as part of shared mealtimes and rehabilitation in the day room areas. It is planned for this to commence in summer 2017.
	2 orthogeriatrician consultant posts have been advertised, one for each site. This type of doctor is an expert in looking after older people, and making sure their care and treatment is aligned to their wider health requirements so they achieve the best possible outcome for them.	Changes to ensure the patient can go home as soon as possible	The "Discharge Ticket Home" is being introduced in order start to plan discharge within 48hrs of admission. This plan includes ensuring that patients have a clearer involvement in and understanding of their goals and the part they play in recovering from a fractured neck of femur as quickly as they are able.
	2 Fractured Neck of Femur Nurses have been appointed, (one for each site) to form part of the core team to support the rehabilitation and patient pathway for patients with fractured neck of femur.		Patient Flow co-ordinators are allocated to each ward. They will help to reduce Length of Stay, improve discharges, and support discharges of people back to their normal place of residence.
	A business case has been put forward for volunteers on both sites to support the wards particularly for patients with dementia (Robins		

Changes to help the patient to understand the process so they can make decisions about their care with the clinical staff	A patient involvement/education booklet on the fractured neck of femur care and treatment has been drafted and tested with patients. Comments have been received and this will now be printed.
How will we monitor the impact of the changes?	A range of measurements have been set up and are being monitored by the group, including the time from admission to the operation taking place, and measurement of the patient's view

	of their experience and outcome.

162,714 A&E attendances across ABUHB during 2016/2017 which is 1455 less than the previous year

81.4% of patients treated within 4 hours within our A&E departments

34,503 Ambulance drop off's to:

- Royal Gwent Hospital
- Nevill Hall Hospital
- Ysbyty Ystrad Fawr
- Ysbyty Aneurin Bevan

Treating Minor Injuries

EFFECTIVE CARE

In December 2016 the Royal Gwent Emergency Department (ED) saw the opening of a minor injury unit (MIU). The new MIU includes:

- 6 examination cubicles
- Plaster room / procedures room
- Mental Health interview rooms
- Ear nose and throat / Eye treatment room
- Treatment/examination room

The unit is staffed by Emergency Nurse Practitioners (ENP) who are registered nurses who have received additional training and education in assessing and looking after patients with minor injuries/trauma without the need for a doctor. There are also registered nurses and Healthcare Support Workers to provide the care that the ENP has assessed that patient needs. The ENP's rotate around all our MIU's so they can maintain all their skills.

Minor injuries that can be seen within this new unit, include the following:

- Limb wounds – sprains & fractures
- Eye problems
- Minor head & face injuries (children over 1)
- Minor Ear Nose & Throat problems
- Minor neck, chest & back injuries (from age 20 to 55 years)

If the ENP is unable to manage the injury, the patient is moved over to RGH A&E. For example, if a person has fallen more than 1 metre or down 5 steps they will require assessment by a doctor and are therefore moved to the A&E department.

Having the MIU allows patients to be treated in the most suitable environment for their particular injury/illness. This has improved the experience for the patients with minor conditions as well as those with more severe conditions. Staff within the ED can now focus on patients with more severe illness or injury. People with minor injuries are no longer exposed to other people who are severely ill or have been in serious accidents, which can be very distressing.

One patient who visited RGH MIU in January 2017 stated "I would like to thank the staff there, it was a lot more relaxed than the old A&E and I was dealt with really quickly, the new MIU is a massive improvement"

Health Inspectorate Wales, a regulator of health care in Wales reported "The Health Board has made improvements to the patients experience through recent refurbishment of the MIU, improvements to the signage introducing dementia friendly aspects within the environment and information about the patient's journey through the department was clearly displayed"

Winter Pressures

SAFE CARE

The winter period, from November to March, is a particularly busy time for us in the NHS as the number of emergency admissions to hospitals always increases compared to the summer. There is usually an increase in the number of people coming to hospital with respiratory illnesses, particularly older people. We develop a plan for these "winter pressures" every year. The plan includes doing more to try and keep people from being admitted to hospital (for example, the Older People's Stay Well Plans in Newport, see page 19 and the expanded Falls Response Service, see page 22). The plan also includes improving our processes in hospital, particularly in making sure that nothing delays the discharge arrangements for a patient. To improve this process this winter, we employed additional discharge co-ordinators in both the acute and community hospitals.

This winter, it was particularly busy during January 2017, and we had to open an additional ward on top of the extra beds we had planned for at RGH, to ensure there were enough beds for all the people that needed to be admitted. We also on 2 occasions placed a patient on a ward to be looked after rather than in a corridor in A&E. The main pressure came from the number of people admitted to hospital by a General Practitioner. However, overall from November 2016 to March 2017, we saw a 37% decrease in the number of times that our Emergency Department was on red level of escalation, and we reduced the number of times an ambulance was delayed outside the A and E department because the department was too busy to allow the paramedics to hand the patient over to the A&E Department. We continue to learn every year and include this learning in our plans for the next winter.

TIMELY CARE

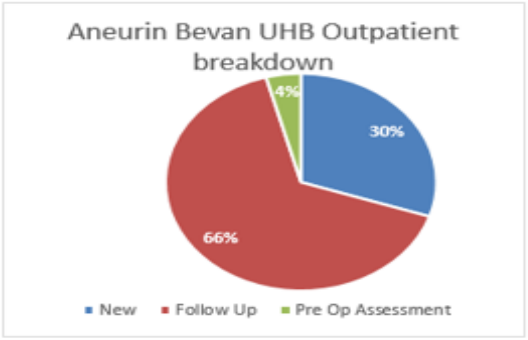
PLANNED CARE SERVICES

Postponement of planned surgery

You tell us that one of the most difficult things we do is to postpone planned surgery close to the date of the operation. You have to make a lot of arrangements to enable you to come into hospital, and if it is postponed, these all have to be repeated when you have a new date for the surgery.

We have therefore planned our operating schedule, based on how many planned operations we have been able to do in that month in previous years. In particular, we have made sure that patients who need to stay in for more than one night because of an operation are planned for the times of year when we usually have more beds available.

To help this, we have also put in place rapid testing for MRSA at both RGH and NHH. We therefore know quickly that a patient does not have MRSA and are able to place them in empty beds normally reserved for planned orthopaedic operations, if necessary. In 2016-17, we have therefore maintained the number of planned operations we do at over 52,000 a year, but have reduced the number of last minute postponements from 3377 in 2015-16 to 3249 in 2016-17.



Our staff saw 1,156,584 patients in the Outpatient department in 2016/2017

DELIVERING SAFE CARE

ABC Sepsis

Eliminating Avoidable deaths and harm form sepsis: We will roll out ABC sepsis to the whole of YYF and refocus the recognition and response to the deteriorating patient across all our acute wards.

People in the UK have a much greater awareness of sepsis now as there have been a number of stories in the media about tragic deaths from sepsis, that might have been prevented had the syndrome been recognised earlier. In ABUHB, the Aneurin Bevan Collaborative on Sepsis (ABC Sepsis) started in January 2015. In May 2016 ABC Sepsis launched the roll out the work to the whole of YYF – the Emergency Department and the wards. This was done to see whether, when a whole hospital works in the same way, it makes it easier to sustain the timely recognition and response to sepsis.

To support this, a special Improving Quality Together (IQT) Silver level course was run for the sepsis champions from all wards and departments. There is good attendance at the weekly ABC Sepsis meetings, and the IQT Silver course has meant that there is a really good understanding of sepsis on the wards – and everyone passed who took part in it! More cases of sepsis have been recognised early and treated within 1 hour of recognition at YYF.

However the relatively low number of cases of sepsis at YYF have made it difficult to show from our data that there has been a measureable reduction in the deaths or harm from sepsis. In 2017, staff will use tablets to record data on the patients electronically at YYF to improve the flow of patients through the hospital. But it will also mean we can collect the basic physiological measurements of patients electronically. The measurements are one of the main ways that we can tell if a patient is deteriorating and may have sepsis. The electronic system will be able to recognise if a patient triggers for sepsis, and alert the doctor and nurse. The ABC Sepsis work at YYF will provide the baseline measurement of the recognition and response to sepsis, so we can monitor whether the electronic capture of the data improves the recognition and the response to deterioration, including sepsis.

In the A&E Departments at RGH and NHH, there has now been a real increase in the number of patients recognised with sepsis, through the hard work of staff there in conjunction with ABC Sepsis. In 2015-16 in the RGH, about 20 forms per week were completed to screen people for sepsis, whilst in 2016-17 this increased to about 30 patients per week. In NHH A&E in 2015-16, about 15 forms were completed per week to screen people for sepsis, whilst in 2016-17 this increased to 20-25. Staff find the sepsis screening tool, that has been developed with them by ABC Sepsis, really helpful in guiding the process of recognising and responding to sepsis. On the wards at RGH and NHH, we have focussed on all deteriorating patients not just those with Sepsis. Following a workshop, we have set up a Steering Group to work on this across all sites, and have developed and tested an audit tool which gives wards a real insight into where they need to improve in recognising and responding to the deteriorating patient. We still promote awareness of sepsis at every opportunity – including taking part in International Sepsis week, when we hold a number of events, including a sepsis awareness raising stand in the main entrance at NHH. The team that manned the stand had a lot of interest in the subject, talked to staff and the public about sepsis, and answered many questions.

Hospital Acquired Thrombosis

Hospital Acquired Thrombosis: We will identify an area with a high number of HATs and ensure that all patients have risk assessments and appropriate thromboprophylaxis, so that there are no potentially preventable HATs in that area.

Some people that come into hospital develop a thrombosis – a blood clot in the leg (a DVT) or in the lung (a pulmonary embolism). We therefore give them treatment with a medication to try and prevent the clots forming – thromboprophylaxis. The best preventative treatment for each person depends upon what they have been admitted for – the main things that can lead to a clot being an operation, particularly a long operation, or being less mobile than a person usually is. However, even if we give people the correct preventative treatment, we cannot prevent all people from developing clots: some people get them anyway.

There are people who should not have the preventative treatment, who may be at risk of bleeding, because the treatment is an anticoagulant that prevents the blood clotting as quickly or effectively as normal. Each person therefore has to have a risk assessment to make sure the risks of the treatment have been considered against the benefits in their individual circumstances. The outcome of the risk assessment and the treatment given are recorded on each person's hospital drug chart. The chart is the same in all hospitals across Wales, and during 2016-17, the chart was changed to make the recording of the thromboprophylaxis risk assessment outcome and treatment clearer. However, the chart was only coming onto our wards in March 2017, as stocks of the previous version of the chart were being used up. There has therefore not been a programme of awareness raising to improve the risk assessment and provision of appropriate thromboprophylaxis started during 2016-17, as it needed to be designed to include the use of the new drug chart. A plan for the awareness raising and improvement has been developed for 2017 and will be rolled out to all specialties.

We monitor how many patients have a HAT each month, and ask our Consultants to review the treatment each patient with a HAT received to make sure it was the correct treatment. During 2016-17, staff changes meant that we were not able to monitor practice in a timely way. However, new staff started their jobs in this area at the end of 2016-17, and getting this process back on track is a key priority to enable us monitor the number of hospital acquired thrombosis and make changes to improve risk assessment and treatment in 2017-18.

In 2016-17, we identified 163 hospital acquired thrombosis, which is about the same number as the 166 identified in 2015-16.

C diff. and Cleaning

The UHB is seeking to further reduce the incidence of C difficile infection to deliver a rate of 28 per 100,000 between October 2016 and March 2017.

C diff. causes very unpleasant and sometimes 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 made a significant reduction in the cases of C diff. on our wards, with a 76% decrease in the number of C. difficile cases in ABUHB compared to 2010-11.

Everyone in ABUHB has been working hard to meet the Welsh Government target for the reduction in the number of cases of C diff. We made good progress through most of the year with a steady reduction in cases. In January 2017 we had a very low number of cases, with just 5 cases in the month. However, in February and March 2017, the number of C diff. infections each week started to increase. The Executive Team and the Infection Prevention Team have been working hard with all the staff in order to reverse this trend.

We were very pleased that despite this increase in cases, we still managed to meet the WG target and reduced the number of C difficile infections from 204 in 2015-16 to 161 in 2016-17, which is a rate of 27.67 per 100,000 population. However, our focus is now to ensure that the increase in cases is reversed and we return to the reductions that we have seen in C diff. in ABUHB. In order to do this, we are continuing to ensure we use the right antibiotics and that everyone washes their hands, but cleaning is also important. This includes cleaning the whole ward regularly every day, cleaning of the bed and bed space when a patient is discharged and special "deep cleans" of a whole ward if there are a number of cases of C diff. on a ward in a short period of time. The other healthcare acquired infection that we have a Welsh Government reduction target for is MRSA/MSSA – both of the staph aureus bacteraemias, Methycillin resistant and sensitive. ABUHB was set a target below the target agreed for every other Health Board in Wales and it was very ambitious. The Health Board achieved a reduction in the number of MRSA cases in 2016-17 to 11 cases, compared to 20 in 2016-17. However, the number of MSSA cases increased compared to the previous year. Taking the 2 together, we did not achieve our Welsh Government reduction target, but ABUHB has the lowest rate of staph aureus bacteraemia in Wales.

Cleaning makes a difference – and our cleaning staff want to help!

One of the main ways of preventing cases of C diff is to make sure that the ward environment is clean. This includes cleaning the bed and the mattress thoroughly after every patient is discharged. This has been the responsibility of the nurses. However, it is a time consuming process to do well, and the skills of the nurses are needed to care for and treat patients. So in YYF, the ward cleaners have tried a different approach. A "domestic discharge team" has been set up and whenever a patient is going home, the ward tells the team and they arrive promptly to complete the whole discharge clean – saving the nurses time, and making sure that the bed can be used again as soon as possible for a new patient. As this was so successful at YYF, it has been started at RGH, with standards for the cleaning being set by the Infection Prevention Team.

In addition to the discharge cleans, the Domestic Team at YYF, which is a hospital with all single rooms, have tested using a new system for allocating the domestic staff to cover all areas effectively, whilst maintaining the cleaning standards required in our hospitals. The ward manager worked with the domestic supervisor, so they knew which patients were going home, which patients had infections and how much care the patient in the room required, from full care to self-care. The domestic supervisor then uses the new system to provide a work schedule for the day for each cleaner.

One of the cleaners said:

"The new ways of working left us feeling motivated and part of the ward team, we feel in control at all times…"

The ward sister is also very positive:

"The standard of cleanliness has improved dramatically. Staff have found the discharge cleans to be invaluable and have contributed to greater patient satisfaction as patients have been able to transfer into vacant rooms in a much timelier manner and nursing staff have found they have more time for direct patient care."

Aseptic Non-Touch Technique

Patients in hospital and community settings who receive injections, have urethral catheters, intravenous lines ('drips') and undergo dressing changes to open wounds are at high risk of infection. As this is a subject where there has been a lot of research and advice has changed over the years, there can be confusion about the best thing to do to reduce the chance of infection. This risk can be substantially reduced if staff adopt a special technique called **aseptic non-touch technique (ANTT)** when these procedures are undertaken. A standardised method of undertaking ANTT has been developed and is used in some parts of the UK but – until recently - not in Wales.
In line with a campaign across the whole of Wales led by the Welsh Government, Aneurin Bevan UHB has been promoting 'Aseptic Non Touch Technique' (ANTT), as a tool used to prevent infections in healthcare settings. In essence, it provides clear guidance about washing hands thoroughly, cleaning equipment really well and making sure that wounds and injection sites for patients are cleaned in the best way. This has been shown to help improve standards of practice and help reduce infection, such as MRSA and MSSA.
ABUHB has over 9000 staff who require training & assessment on ANTT. We have 227 assessors who have already trained 623 members of staff. The assessors have the challenge of assessing 3 staff members per month if we are to ensure all staff are trained and assessed by 1st June 2018 and they are working very hard to achieve this.

Incident & Never Events

Never Events – are serious and largely preventable patient safety incidents that should **NOT** happen if Health Boards have made all the changes that have been identified previously to stop the same incident occurring. Never events are therefore unacceptable incidents. An example of a never events would be surgery on the right knee when it should have been the left knee. If a 'never event' occurs within the Health Board, Welsh Government must be told that it has happened. Welsh Government monitor all Health Boards in Wales and ensure lessons are learnt across Wales and actions put in place to prevent the same thing happening again.

During 2016/2017 ABUHB reported 2 never events. The first incident involved medication being given to patient via the wrong route. This error was identified immediately and corrected and therefore did not result in any harm to the patient. The member of staff concerned received additional training. In addition, the protocol was changed to ensure that two registered professionals checked the medication is being given by the correct route and sign to confirm this. The second never event happened during surgery. One of the needles used to sew up the patient's wound was missing at the end of the operation. An x-ray was taken to find the needle which was later removed under local anaesthetic. However, poor communication also delayed the removal of the needle. Policies have been reviewed in our operating theatres so that the roles and responsibilities of each team member are clear if it is identified that a piece of operating equipment is missing.

One mechanism that the Welsh Government have to make sure that all Health Boards are aware of the lessons from Never Events is to issue Patient Safety Notices. As 65% of all reported Never Events in Wales are related to surgical procedures, a Patient Safety Notice was issued in September 2016 requiring Health Boards to put in place National Safety Standards for Invasive Procedures (NatSSIPs). In ABUHB we are focussing initially on NatSSIPs in our Operating Theatres and Endoscopy Departments, as most of the invasive procedures take place here.

INDIVIDUAL CARE

TREATING PEOPLE AS INDIVIDUALS – LISTENING TO OUR PATIENTS

Ffrind I mi - Friend of mine: 'A prescription for loneliness

Ffrind i mi (or Friend of mine) is an initiative that Aneurin Bevan University Health Board and its partners are developing a programme to try and make sure that anyone who feels lonely or isolated is supported to reconnect with their communities.

Working with Community Connectors and existing volunteer befriending services, through the #CountMeIn campaign, we are aiming to recruit as many volunteers as possible to support those who are lonely and/or isolated. We are also working with many groups, such as police cadets and our volunteers in British Sign Language (BSL). Nursery school children are visiting nursing homes and a bi-lingual scrabble club has been set up. We are arranging for college students to teach older people how to use i-pads to reconnect with family members who live far away. We hope to match the interests of people to volunteers with the same interests e.g. gardening, watching sport, dog walking etc. If you would like to become a volunteer and help us combat loneliness and isolation, or you would like more information on Ffrind I mi, please contact us.
https://www.ffrindimi.co.uk/blaenau-gwent
The story above shows how people can connect across the generations in different ways.

Intergenerational Befriending in Care Homes

After attending the Ffrind i mi/Friend of mine engagement event in May 2016, Arleen Testa, manager of Glan Yr Avon Care Home, Fleur De Lys decided to approach local secondary and nursery schools to ask if they would allow the children to attend the home. The aim was for school and preschool children to visit the older people living in the home and support intergenerational befriending.

During a particular visit, a 3 year old nursery school child approached Arleen and asked *'Why can't Frank talk?*. Arleen explained that Frank couldn't talk with words like she could, but could talk through laughing. The little girl smiled and walked straight back to Frank.

She looked at Frank and started to talk.....
"hahahahahahahaha?" and Frank replied "hahahahahahahaha".

They held this conversation for over 30 minutes. The smiles on both the child's and Frank's faces expressed the sheer joy they both felt at being able to communicate with each other.

She still visits Frank today.

Sensory Loss – Improving access for people with Hearing Loss

Some people are affected by sensory loss, often poor hearing or eyesight, all of their lives. Many people have problems with their hearing and sight as they get older. ABUHB recognises that it needs to offer support to ensure these people are able to understand the healthcare options available to them and to access healthcare as easily as people without sensory loss. To improve the situation for people with hearing loss, the Health Board has offered GP practices the opportunity to purchase 'Hearing Loops' or reimbursement to replace broken/damaged hearing loops. 20 out of 80 practices have taken advantage of this offer, 9 purchasing systems for the first time and 11 receiving replacement equipment. Work is ongoing with practices that do not have this equipment. Induction Loops have also been offered to all Dental Practices through Gwent. British Sign Language Interpreters and Language Line is available to all patients visiting Primary Care Professionals, funded by the Health Board. Through various funding streams many GP practices have purchased 'self-check in' facilities, which mean a person does not need to talk to a receptionist, which is easier for a person with hearing loss. Text messaging about appointments and reminders are being extended across the wider Health Board, which are also helpful for a person with hearing loss.

Patient Recorded Outcome Measures & Patient Recorded Experience Measures (PROMS & PREMS)

Patient Reported Outcome Measures/ Patient Reported Experience Measures: We will put in place a team to work on PROMS and PREMs which will complement our work on outcomes and value, through giving the patient experience a stronger focus.

In health care we try to understand what sort of service it is best to invest in – where to put the money, looking right across the whole health system from contact with GPs to high tech interventions in hospitals, so that we get the biggest impact on health. Sometimes we have done this by looking at how much the service costs compared to other services. Sometimes we have done this by finding out how much the service improves the patient's health – the clinical outcome. In ABUHB, we have been interested for some time in putting these two things together to look at the "value" of a particular healthcare intervention – how much there is an improvement in clinical outcome for the patient relative to the cost of the intervention.

So a drug that makes a small improvement in a person's health, but costs a lot of money is low value. A simple operation may make a large improvement in a person's health but cost a relatively small amount and therefore be high value.

For a number of years in ABUHB we have been working to improve how we cost a service in healthcare. The costing is complex as often different patients need a different combination of interventions, so that it is difficult to do this accurately. But we also need to be able to measure the improvement in health from a particular healthcare intervention – the clinical outcome for the patient. It is important as well that we have the patient's view of the outcome – did we meet their health goals and address "what matters to them"? So a doctor may measure the success of a knee operation in terms of how much a person can bend their leg, but the patient wants to be able to get in and out of the car without pain. This is the Patient Reported Outcome Measure – or PROM. We are also asking about their experience of care or the PREM (Patient Reported Experience Measure) which is how well cared for a person thought they were when they came in to hospital for treatment.

Over the last year we have done a lot to understand how we can measure patient reported outcomes and experience, and have put in place a small team of 4 people to do this. We have been working with an international group who are focussed on measuring both clinical and patient reported outcomes – the International Collaborative on Health Outcome Measurement (ICHOM) – and we have started to measure outcomes in a number of areas. These include Parkinson's disease, dementia and cataract surgery. We will expand this measurement into inflammatory bowel disease, COPD and other areas shortly. We have also been working with the National PROMS programme to support the capture of PROMS in orthopaedics. All this work is supported by the Board and they have agreed to invest in an IT system that will help the team to measure patient outcomes and experience, initially in a few areas, but in more and more areas as we build up our understanding.

An example of the sort of changes that are being made as a result of the work comes from the Parkinson's Disease Clinics. Through asking people about their experience, we found that people with newly diagnosed Parkinson's Disease, coming to the clinic for the first time, found it very difficult to be in clinic with people who have had the disease for a lot longer, as their condition was much more advanced. We are therefore setting up separate clinics for new patients, where all their specific needs for information can also be met.

What you have said.....

I would like to thank the **Out of Hours Service** over the New Year holiday who were working under such considerable pressure due to the extent of the number of calls the service received during this period. The call handler listened to my concerns as I was making a call on behalf of my Auntie, who was quite unwell and lives alone. They assured me that the clinical team would get in touch with my Auntie, which they did. There was a slight delay in getting a house call but this was understandable due to the sheer volume of house calls that were required to be made over the Bank Holiday. **Thank you** for being able to provide this service to a vulnerable lady who was quite unwell and not able to get to the Out of Hours Service due to her illness.

Much appreciated. **January 2017**

I w**ould like to thank** all the team on **D7 East RGH**. I returned home last night following spinal surgery. I had **wonderful care from the team**. The **care and compassion** shown to **all patients was exemplary** and I find myself quite overwhelmed and proud as a fellow nurse to witness this. **All were tremendous** but I would personally like to thank two **health care assistants that were truly amazing,** they put me at ease before my operation and came in to cover a shift until midnight who made such a difference.

Thank you all - December 2016

My father has been in hospital at NHH for some months and has advanced dementia. He is due to go to a care home next week after recovering this time. I wanted to take this opportunity to **commend the staff at Monnow Ward at NHH**. **All of the team** from the **Senior Staff nurses** to the **catering ladies** have been **so kind to my father and supportive to myself and my mother** at this difficult time. Their **knowledge and understanding** of how to handle dementia patients is very in depth. Each member of staff has looked after my father with **care and respected his dignity**. Very often people write to criticise but I really wanted to put pen to paper to **express our thanks to that team** in particular and let you know how **special and professional they are**. They definitely **deserve recognition for their work**. Thank you. **November 2016**

I would like to express my **eternal gratitude and thanks to the staff of Penallta Ward, Ysbyty Ystrad Fawr** where my dear Mother passed away peacefully. She had put up a good fight against her cancer but sadly deteriorated and required care by the palliative team. The **care and compassion** that my mother, myself and my family received is **nothing short of exceptional**. **The dedication that the staff on Penallta Ward have is amazing**. Indeed **all the staff from domestics to doctors were fabulous**. As a healthcare professional myself I have witnessed staff who go above and beyond the call of duty, but **Penallta ward staff hold my highest respect to date**.

Thank you **- November 2016**

Learning from Concerns and Putting Things Right

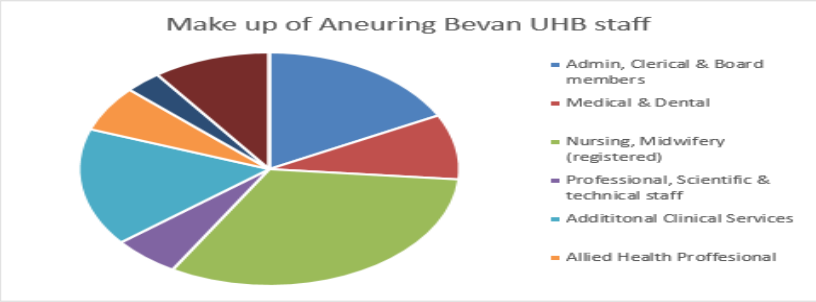
The Health Board aims to always provide the very best care and treatment and it is regretted when there has been cause for any of our patients or their carers to raise concerns about the service they have received. Complaints are always taken seriously and are viewed as an opportunity to improve the services we provide. Anyone raising concerns should expect their concerns to be addressed in a timely manner and be assured that they will receive an open and honest response.

The main issues which led to patients making a complaint in 2016/2017 were waiting times and cancellations, communication failures, and clinical care.

We try and resolve concerns informally and by doing so, we have reduced the number formal concerns during 2016/2017. ABUHB believes it is important to listen and learn from any concerns raised to prevent similar issues arising in the future. We have started 'Carer's Clinics' which encourage patients and/or their carers to discuss and raise queries or concerns to the ward manager immediately. NHH ward 1-2 has taken this approach for a number of years and received very few formal complaints. A bulletin describing all the learning from complaints is distributed all around the Health Board to share good practice and raise awareness of the things that have gone wrong and what should be done to prevent similar issues happening again.

OUR STAFF

STAFF & RESOURCES



Make up of our staff

The Pie Chart above shows how many staff there are in each staff group in ABUHB as at March 2017:

Turning a recruitment issue into an opportunity

The recruitment of experienced pharmacists into Practice Based Pharmacy roles (see page 17) is great for the public and for the pharmacists – but as most of the pharmacists in the new roles came from hospital based pharmacy posts – it left the hospital service with a bit of a challenge! They had many vacancies for experienced staff, but there were mainly only newly qualified pharmacists looking for jobs. So the Pharmacy department in the hospitals used this as an opportunity to modernise the career pathways for pharmacists within the hospital.

This has meant there have been opportunities for development for pharmacy staff, both those without degrees/ formal qualifications and the qualified pharmacists. We have developed new roles such as pharmacy assistants who do some roles in support of the qualified staff.

We also have roles for pharmacists as part of their training e.g. pre-registration pharmacy technicians, who work on the wards with patients, helping patients to understand their medicines. We have also developed roles for the more experienced pharmacists that have undertaken further training and work closely with the clinical directorates. This is especially important with the number of new and complex drugs that are becoming available to treat patients. Come the summer, when the new graduates are available we will have filled most of the vacancies, and have a more flexible team of pharmacy staff, that are loving increasing their skills and working more closely with patients.

Listening to our Staff in ABUHB – The All Wales Staff Survey

If staff are not happy in their work they are less likely to provide a good experience for patients.

Every 3 years, the NHS in Wales organises a staff survey across all Health Boards and Trusts, to find out whether NHS staff in each area feel happy in their work, know what is happening in their organisation and are well supported by their managers. The survey therefore identifies where there is good practice in the management and involvement of staff and where staff management and involvement needs to improve. The survey was last done in 2013, and therefore it is possible to compare the results form 2016 with the 2013 results. In ABUHB, 33% of the surveys sent to staff were returned.

The results of the 2016 staff survey in ABUHB show positive improvements since the 2013 survey, with many scores above the overall NHS Wales scores. For example, there was an improvement in all the questions on communication and 44 out of 45 questions about line management and team working.

However, there are areas where we need to improve. For example, fewer staff (32%) than in 2013 said that they think change is well managed and only 29% of staff saying that they believe that senior managers will act on the results of this survey.

To identify the key things that we need to do in order to make ABUHB a great place to work a series of staff workshops are being held in the divisions to feedback the results and identify the key priorities for improving ABUHB as a place to work.

A staff forum will also be set up to address issues that cut across the organisation. These will then be monitored on a regular basis through the staff forum and via pulse surveys and the next All Wales Staff Survey

Influenza Vaccine – Staff

Flu vaccination for staff: we will vaccinate 50% of our staff against flu.

One group of people that are at a greater risk of catching flu because of the job that they do is our ABUHB healthcare staff. The flu vaccination is the best way of protecting our staff against catching and spreading flu – both to other staff and to patients. The vaccination is therefore good for the staff as it reduces their risk of getting flu, good for the patients as they do not run the risk of catching flu from the staff that are looking after them, and good because the staff are not off sick with flu but are in work to look after patients in the busy winter period. The seasonal flu vaccination is therefore offered every year free to all NHS staff.

In the winter of 15/16, we increased the percentage of staff in ABUHB having the vaccination to 40.64%. In order to further increase this percentage in 2016/17, the publicity about the importance and benefits of the vaccination was improved – with posters all around the Health Board giving clear messages from ABUHB leaders and senior clinicians that are well known to many staff. Flu vaccination sessions were available across all sites, and the flu champions used any opportunity to vaccinate our staff – attending large meetings, conferences and events with a ready supply of the vaccines.

We are delighted that we have achieved our aim this year, with an overall uptake of the vaccination by all ABUHB staff of 50.2%, and by front line staff of 52.1%. This is nearly a 10% improvement upon last year. It was a very busy winter period, and we were helped to cope with the increased demands on the service by the relatively low level of staff sickness absence. We will therefore continue to work to increase the percentage of staff having the vaccination in 2017/18.

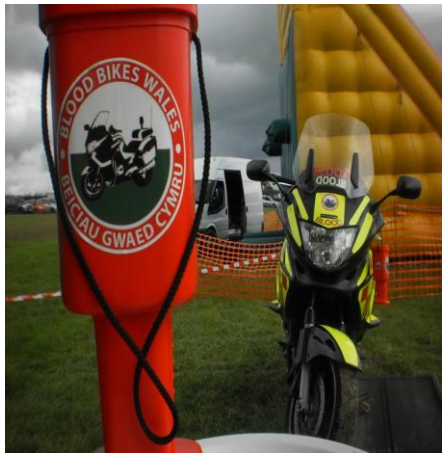
Schwartz Rounds

Schwartz Rounds were recommended by the Francis report (2014) as one of a number of initiatives to help support staff's emotional well-being. In essence, a Schwartz Round offers a regular and protected space for staff to hear and talk about the emotional, psychological and social experiences of work at a time when these opportunities are becoming harder to find. A Schwartz round will last an hour, and is always preceded by a light lunch where staff can begin to relax from their busy and demanding routines.

They are supported by the London based Point of Care Foundation, and are now running in over 100 NHS Organisations, and a growing body of credible evidence supports their value. Within ABUHB Schwartz Rounds have been run for just over 18 months, and are planned and facilitated by a steering group made up of a wide range of NHS employees. We currently hold rounds monthly at the Royal Gwent hospital, Nevill Hall Hospital and Ysbyty Ystrad Fawr, as well as "pop up" rounds at large staff gatherings such as divisional meetings or professional conferences. To date the audience size has ranged from 20 to over 100, and feedback, which is collected after very Schwartz round, is very positive indeed. It seems that Schwartz Rounds are becoming established within ABUHB, and with every round there is increasing interest from staff for more.

Our Volunteers

The Health Board is supported by a diverse range of volunteering schemes and volunteers who are all committed to supporting staff to improve the experience of patients and their families.



One enthusiastic group of people who are keen to make a difference are the volunteers from Blood Bikes Wales. Most of the volunteers are riders who aim to use their skills, time and energy to help the Health Service in Wales.

The NHS uses its own transportation system to move blood and plasma for transfusion as well as other blood products, specimens for testing and documents between hospitals during the day on Mondays to Fridays. Between 7pm and 7am on weekdays, at the weekend and on bank holidays, the regular system used to stop and the NHS used the police, the ambulance service, taxis and couriers to carry out this vital service. This is where Blood Bikes Wales now comes in; its volunteers provide the NHS with out-of-hours transport, saving substantial sums which can be used for frontline patient care. They have provided a reliable and effective service transporting these items between YYF, NHH and RGH. The Blood Bikes service is free of charge and operates between 7pm on Friday evening until midnight on Sunday and this is extended at Bank Holidays to cover the additional days even including Christmas day!

At YYF where there is not a 24/7 laboratory, they have done this for the past two years carrying specimens to RGH for testing. They are providing an efficient and effective service for patients at that hospital and hence contributing to ensuring the quality of their care is maintained at the highest level. Blood Bikes estimate that for each pound the charity receives in donations, the NHS will save at least five pounds.

Blood Bikes Wales is a member of the Nationwide Association of Blood Bikes which shares their quest to provide a reliable, free, high quality service to Health Boards throughout the country. Their local meetings are held in Cwmbran, with details posted on their events page and Facebook. Potential volunteers and supporters are invited to go along to meet the team and find out more.

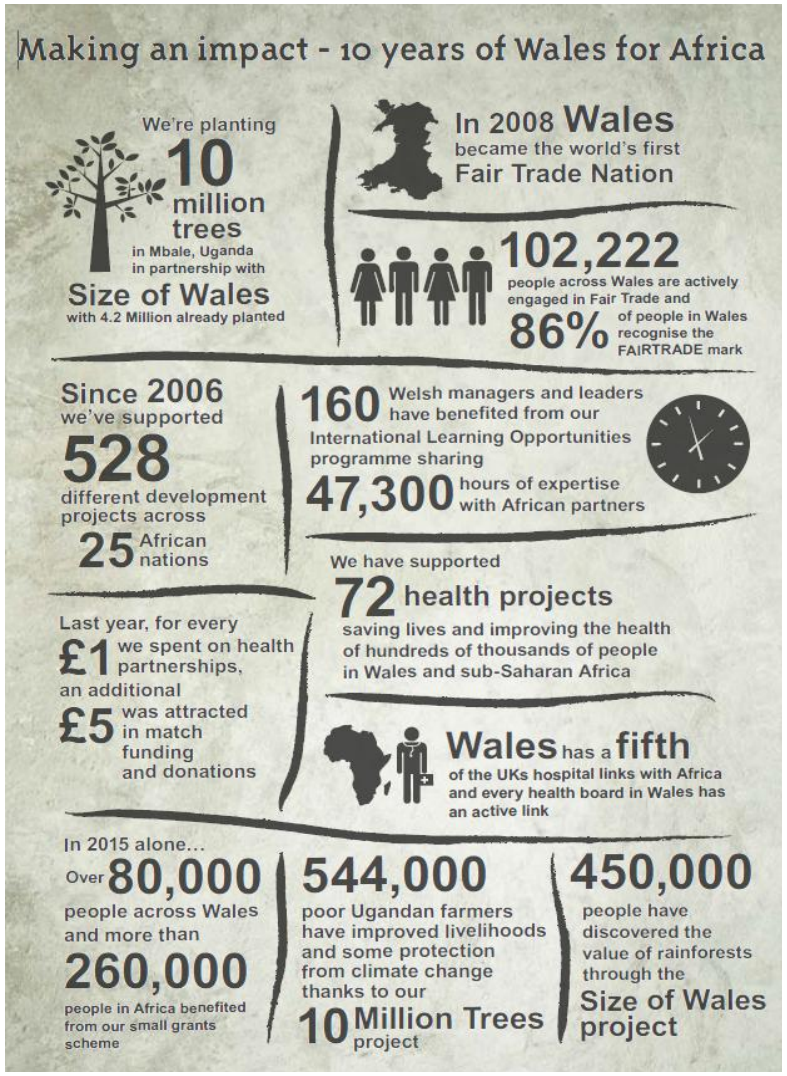
For further information please see the website www.bloodbikeswales.org.uk/ or email enquiries@bloodbikes.wales

If you are interested in finding out more about the wide range of volunteering schemes that support the Health Board please visit the Volunteering pages on our website or contact rhian.lewis2@wales.nhs.uk 01633 623812

Volunteering
Aneurin Bevan

Are you interested in becoming a volunteer?
Please contact:
Lowri.sira-parfitt@wales.nhs.uk
01495 765349

Did you know?....ABUHB has over 1,000 volunteers



Wales for Africa

ABUHB supports the Wales for Africa programme. Our staff have links with countries in Africa through a number of programmes and we are proud to support them do this.

Midwives@Ethiopia is a well-established charity that initially emerged from the Nevill Hall Hospital based SEGHL (Southern Ethiopia Gwent Health Link) in 2012. The charity is made up of six trustees (all midwives), including two ABUHB midwives. The team work in strong partnership with Ethiopian colleagues to deliver robust training courses to midwife tutors, midwives and Health Extension Workers (HEWs) in Southern Ethiopia twice a year.

Opportunities are given to ABUHB staff to travel with the team to Ethiopia to participate in training programmes. Also lecturers and students from all three South Wales Universities and Health Boards have joined the team.

The latest visit in May 2016 was hugely successful with trustees and partners delivering emergency skills training, evaluating knowledge gained from previous training courses, conducting audit and research, visiting rural areas to highlight skills gaps/ need for future training and continuing to strengthen good relationships with partners and the Regional Health Bureaus.

LOOKING FORWARD

Many of our improvement priorities come from the Health Board's Integrated Medium Term Plan 2016/17-2018/19. 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.

Hospital Acquired Thrombosis: We will ensure that the process for monitoring the numbers of HATs is robust, and use the revised drug chart to improve the risk assessment for and prescription of the correct thromboprophylaxis.

Health Care Associated Infections: To further reduce C.difficile infections to a rate of 25 per 100,000 population by March 2018. To reduce E. Coli Bacteraemias to 61 per 100,000 by March 2018

Reducing In-patient Falls: We will ensure arrangements are in place for medical review including reviewing the appropriateness of prescribing medicines which are known to increase the risk of falls, in patients who have fallen or are at risk of falls.

Eliminating Avoidable Deaths and Harm from Sepsis: ABC Sepsis will work with the introduction of vital pac into YYF, to ensure that patients alerted as triggering on NEWS are, where appropriate, screened for sepsis and if necessary, receive the sepsis 6 within 1 hour of triggering for sepsis.

Recognising and Responding to the Deteriorating Patient: To roll out the sepsis screening tool developed by ABC Sepsis to all wards in acute hospitals and, through itsd use, increase the number of patients recognised as triggering for sepsis and responded to with the sepsis 6 bundle in 1 hour

Reducing Pressure Damage: We will see a 50% reduction in hospital acquired pressure damage over the next 18 months and a 30% reduction in level 3 or 4 community acquired pressure damage.

12 hour waits in A&E: To reduce the number of patients over 12 hours in A and E through redesigning D1W

Patient Experience: We will develop a revised Patient Experience Framework for the Health Board and develop the provision of a systematic approach to capturing patient and family feedback with clear outcomes and learning

Dementia: We support the principles and values of John's Campaign, and will work towards carer centred services and visiting, with all our wards at YYF and all the Scheduled and Unscheduled Care Divisions' wards, endorsing the campaign.

Volunteers: We will work with Action on Hearing Loss to introduce new volunteering roles into our community hospitals to better support patients with hearing loss.

ENDORSEMENTS

"Aneurin Bevan Community Health Council welcomes the AQS highlighting areas of achievement and also priorities for action."

Mrs Angela Mutlow, Chief Officer, Aneurin Bevan Community Health Council

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 2016/17.

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 year ended 31 March 2017, 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; and
- the Welsh Health Circular: The Annual Quality Statement 2016/17 is complied with, where applicable.

Audit and Assurance

We would like to thank members of the Stakeholder Reference Group and the Healthcare Professionals' Forum for their help in preparing this Annual Quality Statement. They helped to make sure that the subjects we have covered are those that the public are interested in. However, we know that we can improve this further, and if you have any comments about what you see in the Annual Quality Statement or any other feedback about this report, please e-mail us on abhb.enquiries@wales.nhs.uk

Glossary of Terms

ABC Sepsis	Aneurin Bevan Collaborative on Sepsis	LWLL	Living Well, Living Longer
ABCi	Aneurin Bevan Continuous Improvement	MHOL	My Health on Line
ABUHB	Aneurin Bevan University Health board	MIU	Minor Injuries Unit
A and E	Accident and Emergency	MOS	Minor Oral Surgery
ANTT	Antiseptic Non-Touch Technique	MRSA	Methicillin Resistant Staphylococcus Aureus
AQS	Annual Quality Statement	MSLC	Maternity Services Liaison Committee
C.Diff	Clostridium difficile	MSSA	Methicillin Sensitive Staphylococcus Aureus
CHC	Community Health Council	NatSSIPs	National Safety Standards for Invasive Procedures
CHCT	Continuing Healthcare Team	NCN	Neighbourhood Care Network
COPD	Chronic Obstructive Pulmonary Disease	NICE	National Institute for Health and Care Excellence
CPN	Community Psychiatric Nurse	OOHs	Out of Hours
DSW	Dementia Support Worker	PCMHSS	Primary Care Mental Health Support Services
DVT	Deep Vein Thrombosis	PROMS	Patient Reported Outcome Measure
ED	Emergency Department	PREMS	Patient Reported Experience Measure
GDP	General Dental Practitioners	SCCC	Specialist Critical Care Centre
GP	General Practitioners	SSNAP	Stroke
HAT	Hospital Acquired Thrombosis	Third Sector	Voluntary Group and Civil Society
HCAI	Healthcare Associated Infections		
HDS	Hospital Dental Service	TVN	Tissue Viability Nurse
IQT	Improving Quality Together	WAST	Welsh Ambulance Services NHS Trust
LMC	Local Medical Committee	WG	Welsh Government