Aneurin Bevan University Health Board

Annual Quality Statement 2018-2019

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

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Welcome from Chair and Chief Executive

2018-19 started with great excitement as we built up towards and celebrated the 70th anniversary of the founding of the NHS. Of course this has a particular significance for us in Aneurin Bevan University Health Board (ABUHB) because we are named after the driving force behind the NHS, Aneurin Bevan, as he came from Tredegar, which is within our borders.

So we celebrated with style! There were events over a number of days, but on the 5th July 2018 there were tea parties and garden parties and street parties all over the Health Board! Staff have shared stories and pictures of their memories of working in the NHS – and one of our work colleagues can claim to be one of the first babies born into the NHS! Sandra Brookes, a Healthcare Support Worker on Annwylfan Ward in Ysbyty Ystrad Fawr was born on the 6th July 2018. She was the first girl born in Church village hospital, after it opened on the 5th July 1948.

Whilst we know we can always get better, we think Aneurin Bevan would enjoy looking through this Annual Quality Statement, which is written to tell our citizens about the quality of the healthcare services we provide. We think he would both celebrate with us our achievements and share our frustration and disappointment over the things that have not gone so well. As the 70th Anniversary Year ends, we are proud to work for Aneurin Bevan University Health Board. We will continue to strive to provide a good patient experience for everyone who comes into contact with our services as they are now, and whilst we also start to change our services in preparation for the opening of the Grange University Hospital in the Spring of 2021.

The Grange University Hospital has gone up fast during 2018-19, and in March 2019, we welcomed Vaughan Gething Assembly Member, Minister for Health and Social Services, who marked the topping out of the building by ceremonially pouring some concrete and signing one of the concrete plinths.

During the year the Health Board has continued to have the challenge of recruiting the required number of clinicians to fill current vacancies. This year, the pressure on our services has continued throughout the year, with the long spell of hot weather in the summer 2018 leading to more admissions, in the same way as colder weather in the winter. As always, we thank all our staff for their continued hard work, and the outstanding commitment they show to keeping the patient at the centre of the care they provide. The compliments and thanks on page 30 are a tribute to this.

This AQS demonstrates how we work all the time with our partners in health, social care and the third sector to deliver care for the patients in different ways. We work so closely together that we could not deliver services without them now. Indeed, our plans for the future services will not come to fruition without them

This working together in Wales, something that Aneurin Bevan would be proud of, is designed into the service through its structure, and supported by recent Acts passed by the Welsh Assembly. It is what makes the NHS in Wales special. However it is the privilege of being there for people at their times of greatest need that motivates all of us working in the NHS. This is at the core of our service both now and into the future.

Judith Paget, CEO (Left)
Ann Lloyd, Chair (Right)

Aneurin Bevan University Health Board (ABUHB) is responsible for promoting wellness, preventing disease and injury, and providing health care to a population of approximately six hundred and forty thousand people who live in the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen with a budget of approximately £1.1billion.

This Annual Quality Statement describes some of the fantastic achievements in improving the quality of our care and services in 2018-19, as well as some of the challenges.

More information can be found on our website

http://www.aneurinbevanhb.wales.nhs.uk/

Our vision for Aneurin Bevan University Health Board is to

Our Values

Everyone who works within Aneurin Bevan University Health Board share four core values that guide the approach we take to work, how we do things, how we treat each other and how we expect to be treated. We demonstrate our values, each and every day, across our organisation and care system through these behaviours.

We work in a way that is aligned to the vision and values of the organisation and this is visible and explicit in everything that we do and say.

Our senior leadership team consistently role model these behaviours and hold each other to account, and this is reflected across all levels of the organisation.

We recognise the part our individual role plays in the successful delivery of services and work together, across structural boundaries, to make the best use of resources, in order to deliver the highest quality services and care.

We hold each other to account and welcome and accept constructive feedback to help us improve our services

We foster an innovative environment where change is embraced, to enable everyone to effectively navigate whatever challenge lies ahead and provide a high quality experience for everybody who uses our services

We pride our-selves in delivering high quality services (internal and front facing)

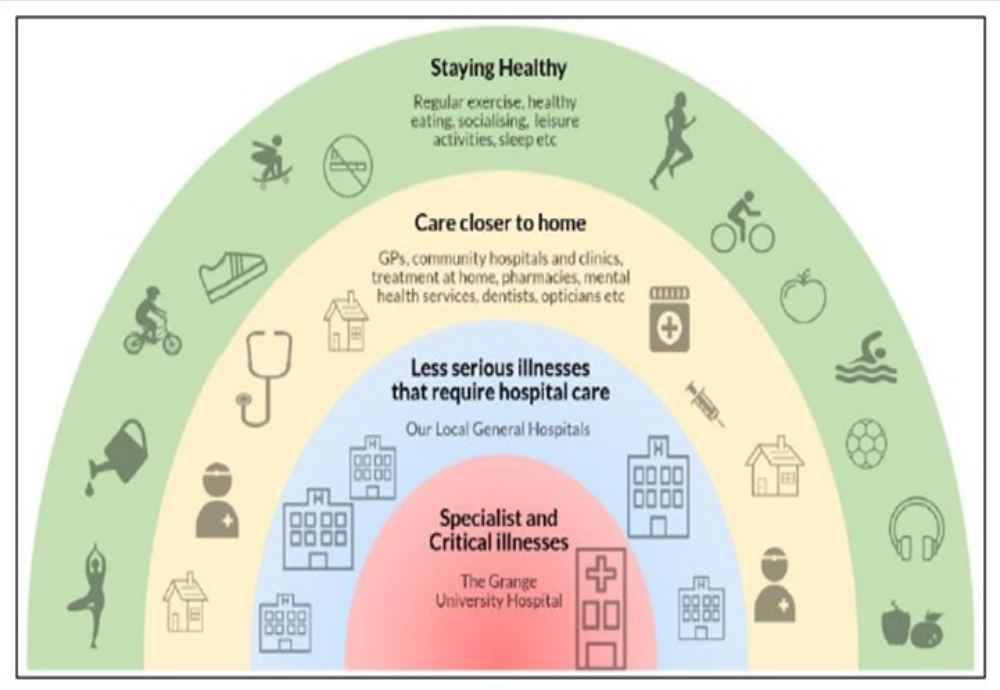
Anyone entering an Aneurin Bevan Health Care setting, feels welcomed and valued at all times.

In order to continue to provide excellence into the future, we have known for some time that the model for our service delivery had to change. With quality and safety at the heart of its design, Clinical Futures is our strategy for delivering health services based on a clinical model that starts by helping people to stay healthy, then aims to support them as close to home as possible with their ongoing health care needs. People with less serious illnesses, and people after the acute phase of their illness will be treated in the local general hospitals. Our sickest people and those requiring specialist care will need to be admitted to the Grange University Hospital. Specialist Primary and community services are at the heart of the model and central to developing a new relationship with patients as partners/co-producers in preserving, maintaining and improving their own health and well-being. Investing in and strengthening primary, community and social care services to create the capacity to support and treat patients in their homes and communities is a core component of the strategy and at the heart of integrated service delivery. There are examples of this integrated working throughout this Annual Quality Statement in line with the Social Services and Well Being (Wales) Act 2014.

The Royal Gwent Hospital, Nevill Hall Hospital and Ysbyty Ystrad Fawr will all continue to provide routine care and treatment as Local General Hospitals, and primary care and community services will provide more care to people closer to their homes

In 2018-19, the Grange University Hospital has rapidly taken shape. Work is progressing on constructing the building in readiness for its scheduled opening in Spring 2021.

We are also making changes in Primary and Community Care to develop care closer to home, with the introduction of Care Navigators who speed up access for patients to the most appropriate Health Care Professional at GP Surgeries.



The next 2 years are going to be crucial to the strategy, as we continue to provide high quality, safe care, whilst at the same time, changing them so that they are in the form that they need to be in time for the opening of the Grange University Hospital. Every year we refresh our plan to deliver healthcare services.

Click here to view a video about the Clinical Futures Strategy.

You can access our Integrated Three Year Deliver Plan on our website: http:www.aneurinbevanhb.wales.nhs.uk/

Some of our Hospitals are referred to in this report using their initials, as shown below:

RGH: Royal Gwent Hospital, an acute hospital in Newport

NHH: Nevill Hall Hospital, an acute hospital in Abergavenny

YYF: Ysbyty Ystrad Fawr, an acute hospital in Caerphilly

YAB: Ysbyty Aneurin Bevan, a community hospital in Ebbw Vale

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

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

Alternatively you can complete the survey using the link below to let us know what you think of this annual quality statement:

https://www.surveymonkey.co.uk/r/LD26KLN

2018-19 Priorities – Summary of Progress

PRIORITY FROM 2017/18 AQS	WHAT HAVE WE DONE IN 2018/19?	HOW HAVE WE DONE?
Staying Healthy We will implement a place based targeting approach focused upon areas where smoking prevalence is greatest in our communities.	A 'place based targeting' approach has been used during 2018-19 in three areas across Gwent, namely Cwmbran, Ebbw Vale and Blackwood. These areas were chosen as half or more of the adult population in these areas smoke. **For more information, see p 7**	
HCAI We will further reduce the rates of infections to the following levels: C difficile rate of 25 per 100, 000 population. Staph aureus rate of 19 per 100,000 population. Gram negative, (E Coli) rate of 61 per 100,000 population.	We have not achieved the target set for us by the Welsh Government 25 C difficile infections per 100,000 population, although we have reduced the rate to 26.37 per 100,000 population, compared to the rate in 2017-18 of 36.81 per 100,000. We have not achieved the target set for us by the Welsh Government and reduced the rate of Staph Aureus infections below 19 per 100,000 population, as the rate for 2018-19 was 26.71. We have not achieved the target set for us by the Welsh Government and reduced the rate of Gram negative (E Coli) infections below 61 per 100,000 population, as the rate for 2018-19 was 72.81. **For more information, see p 14**	
In-patient Falls We will reduce the number of inpatient falls by 10% from April 17 to March 19, and initiate a programme of training on preventing falls, using a standard presentation which supports the use of the Falls Multi Factorial Risk Assessment (MFRA).	During 2016-17, the usual number of falls in a month was 380. With a target of reducing falls by 10%, we therefore wanted to reduce the number of falls by 38 per month to 342 falls per month. We are pleased that in 2018-19, the usual number of falls in a month is 307.5 and we have therefore achieved this target. In early 2018-19, we also put in place a programme of training using a standard presentation, which supported the use of the Falls MFRA, with training undertaken at all our hospitals. **For more information, see p 9**	
Pressure Damage We will spread the Collaborative to wards at NHH and achieve a reduction in the number of days between incidence of pressure damage at both RGH and NHH wards participating in the collaborative.	Altogether, the average reduction of HAPUs across the collaborative wards is about 45%, from the data available at 23.03.2019. The collaborative spread to 4 wards at NHH, but they are yet to provide data or robust implementation of PDSA (Plan Do Study Act) cycles. **For more information, see p 12**	

PRIORITY FROM 2017/18 AQS	WHAT HAVE WE DONE IN 2018/19?	HOW HAVE WE DONE?
Sepsis and Deteriorating Patient We will develop NEWS as common language in community/primary care by establishing pilots in a range of community/primary care services.	Teams from many of the community services are piloting how they can use the usual physiological observations and NEWS score to recognise and respond to deterioration, so NEWS becomes a common language that all services, acute and community, understand. **For more information, see p 15**	
12 hour waits in A and E We will significantly reduce the 12 hour waits in A and E.	In 2018-19, 5463 people waited 12 hours or longer in A & E compared to 5788 in 2017-18. We therefore did reduce the number of people waiting 12 hours in A&E, but the reduction was less than 10% and therefore less significant than we wanted. **For more information, see p 26**	
Dementia We will develop a clear protocol for the assessment of delirium in general hospitals.	The use of the 4AT assessment tool has been taken forward as an improvement project in the Medical Assessment Unit at YYF in order to develop a clear protocol for the assess-ment of delirium. However, the improvement work is still ongoing. It is also being used as part of the assessment on admission to the Care of the Elderly Wards at RGH. **For more information, see p 24**	
Volunteers We will develop a new Welcoming Service at St Woolos with our partner Age Cymru Gwent and expand and extend the Welcoming Service at Nevill Hall Hospital from two mornings a week with our partners Age Cymru Gwent, the RVS, Nevill Hall Leagues of Friends and North Gwent Cardiac Rehabilitation and Aftercare Charity.	A full Monday to Friday Volunteer Welcoming Service has been in place at St Woolos Hospital since July 2018. The Welcoming Service at Nevill Hall Hospital has been expanded and extended from two mornings a week to a full Monday to Friday Volunteer Welcoming Service since Autumn 2018. **For more information, see p 31**	
Staff Wellbeing – develop a Staff Engagement and Wellbeing Strategy to support our staff.	Following engagement with staff, it was agreed that we would develop an 'Employee Experience Framework' instead of 'Staff Engagement and Wellbeing Strategy'. This was launched on 14 February 2019. **For more information, see p 31**	

Many Cancers can be prevented if we adopt healthy behaviours.

We all know that cancer is a major cause of ill health and death, and of health inequalities. Some people get cancer and there is nothing that could have been done to reduce the chance as they are at higher risk because of their genes or their age.

But did you know that 2 in every 5 cases of all types of cancer could have been prevented? For example, for lung cancer, about 7 in every 10 cases are caused by smoking. So if people do not start smoking, or stop smoking, the number of cases of lung cancer will decrease.

Every year in Gwent, about 1400 people get a cancer that was potentially preventable.

The cancers can be prevented if people adopt healthy behaviours, such as:

- Not smoking tobacco
- Being a healthy weight
- Eating a healthy diet
- Being physically active
- Drinking alcohol within national guidelines

In some areas a greater proportion of the population adopt healthy behaviours than in other areas. In general, people living in communities with a higher proportion of healthy behaviours live longer and spend more years in good health than in communities with lower levels of healthy behaviours.

Life expectancy

Across Wales, a smaller proportion of those living in disadvantaged areas adopt healthy behaviours than in the less disadvantaged areas. This pattern is also seen in Gwent, and the proportion of people adopting healthy behaviours is much lower than the average for Wales. This means that a greater proportion of people in those areas will develop the potentially preventable cancers like lung cancer because more people smoke.

In these disadvantaged areas, the number of years that people can expect to live is therefore lower, and the number of years that people can expect to live in good health (Healthy Life Expectancy) is lower still.

	Monmouthshire Less disadvantaged area	Blaenau Gwent More disadvantaged area	Difference
Life expectancy Men	80.5 years	76.0 years	4.5years
Life expectancy Woman	84.1 years	80.2 years	3.9 years
Healthy Life expectancy Men	69.8	59.6	10.2
Healthy Life expectancy Woman	70.7	59.3	11.4

Reducing Smoking

In Gwent, nearly a fifth (19%) of the adults smoke. Despite the encouraging fall in smoking rates overall, differences can be seen across Gwent local authority areas, where in 2017-18, the percentage of people that smoked ranged from 13% in Monmouthshire to 22% in Blaenau Gwent.

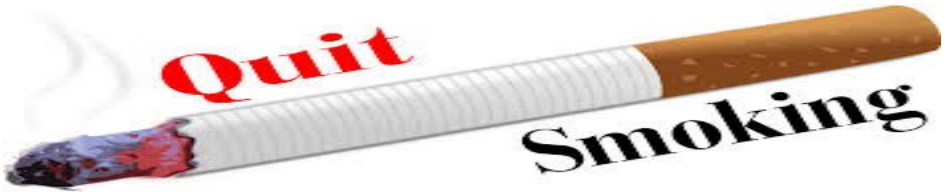
To reduce the amount of ill health in the population that is related to smoking, we need to both stop young people from starting to smoke (did you know, two thirds of smokers start before the age of 18?) and increase the number of people who give up smoking.

In ABUHB, we are working with schools to stop young people from starting to smoke:

- The JustB Smoke Free programme goes into secondary schools and works with 12 to 13 year olds, training them to be Ambassadors and talk to their friends about the benefits of being smoke free, and the risks of smoking
- Creating smoke free environments so it becomes the norm not to smoke within the child's community

We are also working to support people to stop smoking by:

- Increasing the number of community pharmacies across Gwent who can provide the whole package of help for people who want to stop smoking
- Promoting the National "Help Me Quit" single website and helpline phone number



"We will implement a place based targeting approach focused upon areas where smoking prevalence is greatest in our communities."

An example of 'place based targeting' during 2018-19 is the approach taken in three areas across Gwent, namely Cwmbran, Ebbw Vale and Blackwood. These areas were chosen as at least half of the adult population in these areas smoke.

The approach was intended to decrease the percentage of adults who smoke through raising awareness of the National Campaign "Help Me Quit" and therefore increasing the number of referrals from these areas to services that help people to stop smoking.

What we did:

A range of resources, including leaflets, posters, place mats, canvas bags and pens, promoting the Help Me Quit service, were collected to form packs.

The packs of resources were distributed to a range of local businesses in each of the 3 areas. For example, all businesses along the high street in Blackwood were offered and accepted resources to display and raise awareness among clients/ customers. The resources encourage people to think about their smoking and to contact "Help Me Quit" if they require further information and support to quit.

Alongside the resource packs for businesses, all the community pharmacies which provide stop smoking services, received prescription bags, promoting the service.

These prescription bags were given to all customers to raise awareness of stop smoking services available in the community.

How did it go?

Businesses, including cafes, shops and takeaways, were offered the "Help Me Quit" poster, cards and leaflets to display to their customers. Due to the enthusiasm shown by the range of businesses, this approach has been rolled out into neighbouring areas (Abertillery, Brynmawr, Blaina and Cwm). 240 local businesses are now displaying the "Help Me Quit" poster, cards and leaflets across these areas.

The project has raised the profile in the areas of the "Help Me Quit" branding and information on local smoking cessation services available.

Monthly feedback reports have identified that some referrals into "Help Me Quit" are from clients who have heard about the service as a result of these resources. Further evaluation of the impact is underway.

<u>In-patient Falls</u> We will reduce the number of inpatient falls by 10% from April 17 to March 19, and initiate a programme of training on preventing falls, using a standard presentation, which supports the use of the Falls MFRA

In ABUHB, we have been working to reduce the number of people for fall and we are working to prevent fractures caused by falls. We have focused initially on people who are falling in our hospitals.

Reducing the number of Inpatient Falls

When people fall, they can hurt themselves physically. However, following a fall, people can also be affected psychologically because of their fear of falling again. Sometimes they stop moving about so much or going out as they are frightened of falling, which then decreases their muscle strength which actually makes them more likely to fall again.

We have therefore been working to reduce the number of falls that occur in our hospitals. Based on the number of falls incidents reported in 2016-17, we set ourselves a target of reducing the number of falls by 10% in 2 years. We have made a lot of changes to the way that nurses assess patients to prevent the individual patient falling. In early 2018-19, we also put in place a programme of training using a standard presentation, which supported the use of the Falls Multi Factorial Risk Assessment.

All falls resulting fractures are reviewed at the Falls Scrutiny Panel and learning for improvement is the purpose of the review.

During 2016-17, the usual number of inpatient falls in a month was 380. With a target of reducing falls by 10%, we therefore wanted to reduce the number of falls by 38 to

342 falls per month. We are pleased that in 2018-19, the usual number of falls in a month is 307.5 and we have therefore achieved this target.

Our wards have really focussed on reducing the number of falls – and the amazing work done by Anwyllfan Ward at YYF to reduce falls is described below (see page 10)

Reducing the number of Fractures following a Fall by improving bone health

Many people as they get older develop "osteoporosis". This is a condition which means that the person's bones are more fragile than other people's. Consequently, they are

more likely to fracture a bone if they fall from a standing height or less – a fragility fracture. There is a simple drug treatment that can strengthen people's bones, if they are identified as at risk of osteoporosis. Treatment should be started as soon as possible after a fracture, and within a maximum of two years

However, there is evidence that only 40% of people with a fragility fracture are identified and treated according to the NICE (National Institute for Health and Care Excellence) recommendations.

In ABUHB, we have started work to increase the number of people over 50 with fragile bones that are identified and receive the correct treatment. Focussing on 5 wards, before we made any changes, we collected data on the percentage of people who had experienced a fragility fracture and were on the correct treatment. We then made a number of changes to our assessment processes to improve the identification of people who should have the treatment, and to the prescription of the treatment.

From May to November 2018, we increased the percentage of people initiated on the treatment from 45% to 81%.

We have therefore applied successfully to take part in an Improvement Collaborative with the Royal College of Physicians in 2019-20, focussing on identifying people with osteoporosis in hospital.

We have also tested a model for identifying and treating people in the Community with Fragility Fractures. We are currently exploring how we can develop this work, particularly for high risk patients with Parkinson's disease, Stroke and Dementia.

Steady on... Stay SAFE

Strength And Balance Falls History Environment

Inpatient Falls Prevention

Reducing Patient Falls on Annwylfan Ward at YYF

Annwylfan is a ward at YYF with 18 beds for older adults. The patients there mainly have advanced dementia and have associated problems which mean they can no longer live safely in the community. On the ward their problems are treated and an assessment is completed to determine what level of care they need in the future.

In 2016, the ward was one of the 10 wards with the highest number of patient falls in ABUHB. Some of the patients who fell unfortunately sustained a fracture. Review of the falls and fractures showed that, as a mental health ward, they assessed the patient's psychological risks well but were not so good at assessing the patient's risks in relation to falls. The new ward manager decided with the nursing team that they would focus on improving falls risk assessment and the management of the risks identified in order to reduce the number of falls and the harm to the patients.

The Senior Nurse for the ward contacted one of the Care of the Elderly Consultants, who provided some training for the ward. This focussed on helping the nurses to think about why a patient might have fallen and what they could do to try and prevent the patients from falling. The Senior Nurse also pulled together the data on the falls that they had reported over the previous year. From the data, it was clear that the majority of falls were occurring within the patient lounge, between midday and 2.00pm, and midnight to 3.00am at night.

The ward began by observing what was happening and what the patients were doing around these peak times for falls.

The issues the team identified that could be

contributing to the fall were:

- Noise levels at meal times leading to agitation
- Light weight furniture that moved as a patient sits down.
- Crowded day areas as there was only one lounge area
- The lay out of the ward making it difficult to observe all areas of the ward
- Drugs rounds taking place at one of the busiest time of the day

The ward was able to make some immediate changes to the environment and the way the ward worked at these times. This included:

- No interruptions to the ward routine at meal times, for patients or staff, so the atmosphere is much calmer and staff can help patients with their meal
- Redesigning the lounge and ordering new, heavier dining room chairs and tables, in colours that contrast with the flooring and walls
- Drugs rounds were reviewed and medicines taken to the patient individually at different times of day
- A programme of activities was set up throughout the day to engage patients
- CCTV was installed to allow patients to wander freely around the ward, whilst still being observed
- Smaller seating areas were created all through the ward, which means the lounge area is less crowded and patients can choose whether they want to be with other people or on their own.

During the next few months there was a steady reduction in the number of falls, however the ward staff thought this could be reduced further. After a patient fell and suffered a fracture in February 2017, the ward team adopted the falls risk assessment for people with physical illnesses. The ward round tool was reviewed to include the identified falls risk factors so this could be shared with the Multi-disciplinary Team and a care plan agreed with the whole team.

"FALLS FRIDAY" was then launched, meaning that a full review of all the patients' falls risk assessments was undertaken every Friday. This enabled the risks identified to be adjusted as the patient got better or deteriorated, and so the actions being taken to reduce the risk could be changed. This information was then presented at the ward round meetings. Falls data on the progress with reducing falls was shared at the monthly team meeting. If a patient did fall, the events leading to the fall were reviewed and learning from this discussed at the first 9am handover after the fall. Additionally the ward team devised detailed induction and resources packs for staff to ensure new staff were fully informed about assessment of falls risks and this added in ongoing learning and development.

In July 2017, a Care of the Elderly Consultant agreed to undertake a weekly medical review of all the patients.

This was extremely beneficial as he would advise on management of Blood Pressure and physical health issues that could impact mobility and increase falls risk.

The ward were able to give the Consultant important information about the patient and their risks relating to falls, as they were really aware of this from the Falls Friday reviews. Patients were experiencing a truly holistic review, looking at their physical and mental health issues.

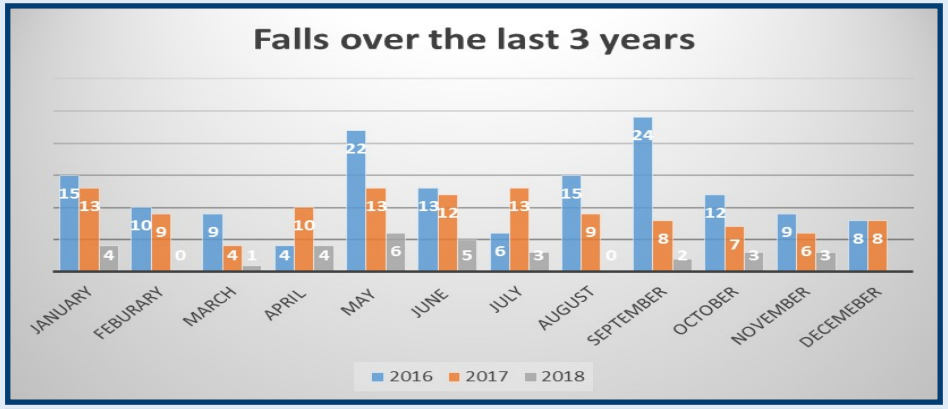
The changes on the ward continued. From 2017, the ward actively encouraged the relatives to engage in meal times and introduced open visiting times.

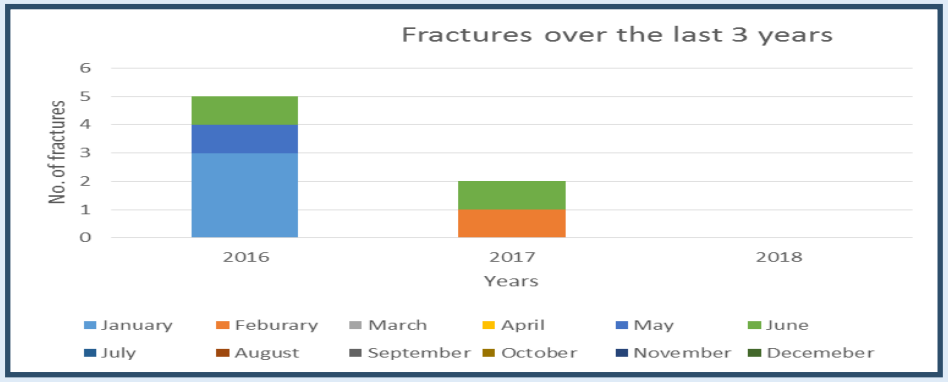
In March 2018 the ward was painted to ensure a colour contrast to help patients with poor eye sight. Seating was put in place around the ward to create small seating areas and allow patients to rest if walking along the ward corridor. A motion sensor alarm check was introduced to ensure alarms were in-place for patients at risk of falls at night.

In September 2018, the nursing station and some walls were removed to maximize the clinical space and reduce noise, increase access to seating areas and allow the ward team to create themed areas to promote discussion and engagement.

Falls have now reduced from 140 in 11 months in 2016 to 31 in the same period in 2018. This is due to the patients now having a full holistic assessment and care plan in relation to falls, and the physical changes to the ward leading to a calmer atmosphere, so patients are less agitated. They also have a number of places to sit so they can find a place that suits them.

The Falls Scrutiny Panel has commended the ward for the standard of its falls risk assessments and care plans. The ward is not stopping here though, and has plans for infra red motion sensors, and new flooring. They are also creating an extended out-door space, which will improve patient wellbeing.





"RELIEVING THE PRESSURE" – REDUCING PRESSURE DAMAGE IN OUR HOSPITALS

Pressure Damage We will spread the Collaborative to wards at NHH and achieve a reduction in the number of days between incidence of pressure damage at both RGH and NHH wards participating in the collaborative

A Pressure ulcer is a damaged area of skin and/or underlying tissue, usually over a bony area, as a result of sitting or lying in the same position for a period of time, putting pressure on that area. They range from patches of red skin to open wounds and can be very painful, taking a long time to heal. They can add days or weeks to a patient's recovery, significantly affect their levels of independence and delay their return home. If they lead to developing sepsis, pressure ulcers can be fatal.

Older, frail people are vulnerable to pressure damage as their skin becomes less supple, particularly if they are unable to change their position themselves. People can develop pressure damage whilst in their own homes, in Care Homes and regrettably, when they come into hospital.

Between 4% and 10% of ABUHB inpatients are at risk of developing pressure damage. In early 2017 the Director of Nursing and the Director of the Health Board's Continuous Improvement Centre (ABCi) agreed to jointly run an 18 month programme to improve ward culture and substantially reduce Health Acquired Pressure Ulcers (HAPUs) across Royal Gwent Hospital, "Relieving the Pressure".

ABCi facilitated a sequence of specially designed, full-day learning programmes, that enabled ward teams to build an understanding of Quality Improvement methods.

During the 'Action Periods' between the learning sessions, the wards had ongoing coaching support from the ABCi team and training from the Tissue Viability Nursing team to update staff on current best practice in relation to preventing and managing pressure damage. In addition to this, some staff from the wards took part in two, four day training programmes, one on 'Coaching for Improvement' and one on 'Measurement for Improvement'. By March 2019, the ABCi had trained 26 ward team members as 'Improvement Coaches' and 8 staff as 'Measurement Leads' to help to further improve and sustain achievements.

Staff participating in the programme:

- have learnt new skills about how to use data to identify what ward internal process to improve (and how to do it) and actually make the changes to improve quality of care.
- have seen how they can learn from other wards and adapt the changes made to suit their ward.
- have had a sense of satisfaction from improving the care for their patients and have had fun!

Patients repeatedly reported how much ward culture has improved compared to a few years ago.

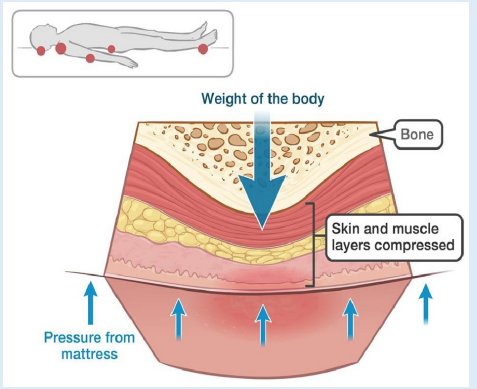
As at March 2019, 12 wards at RGH have been participating on the programme for between 17 and 8 months.

The different lengths of time participating in the programme mean that some wards have made bigger improvements than others, varying from 80% to 20% reduction in pressure damage.

However, most ward teams now have well established processes of care and assessment and were able to go through the busy winter period without an increase in pressure damage—some wards are even free of pressure ulcers for the entire winter.

Altogether, the average reduction of HAPUs across the collaborative wards is about 45% from the data available 23.03.2019. This corresponds to roughly 1 pressure ulcer per month per ward. That makes at least 12 pressure ulcers averted per ward on the programme for a year.

We know that not only have the wards reduced pressure damage, but preventing pressure damage will have reduced the length of stay for patients, and saved money. It has reduced spend on treatment of pressure damage, nurse time and bed use.



We are delighted with the reductions in pressure damage that have been achieved and wanted to bring more wards into the collaborative.

The collaborative therefore spread to 4 wards at NHH, but they are yet to provide data or robust implementation of PDSA (Plan Do Study Act) cycles.

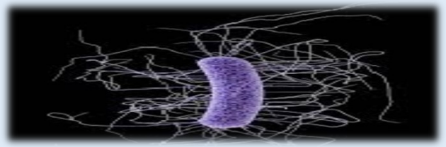
REDUCING (HCAI) Healthcare Associating Infections

HCAI We will further reduce the rates of infections to the following levels:

C difficile rate of 25 per 100,000 population
Staph Aureus rate of 19 per 100,000 population
EColi rate of 61 per 100,000 population

C difficile

C diff. causes very unpleasant and some times severe diarrhoea, and stomach cramps and tenderness. It can be very serious, particularly in older people who are already unwell. Over a number of years, we have been successful in ABUHB in reducing the number of cases of C diff. on our wards, and we planned to reduce this further in 2018-19.



In 2018/19, we have reduced the number of C diff. cases compared to 2017/18, however, we have just missed the Welsh Government target.

Staph aureus

Staph aureus bloodstream infections in patients can cause serious illness and are often related to skin infections, wounds, leg ulcers and urine infections. Sometimes they occur because of poor management of

intravenous drips and urinary catheters
In 2018/19, the Health Board has seen an increase in staph aureus infections to 26.71 and we have therefore not met our Welsh Government target. This has been a problem across Wales. We are pleased however that there has been a decrease in Methicillin-resistant staphylococcus aureus (MRSA)

Hospital acquired staph aureus blood stream infections are associated with Intra Venous (IV) line and urinary catheter management. Our focus in reducing these infections is therefore on aseptic technique with training for all ward staff involved in the management of these devices. Central lines are often used on our sickest patients.

We know that a big proportion of our infections occur in patients with a central line.

We have therefore received approval to appoint two specialist nurses to insert and manage these high risk devices across our acute hospitals.

Community acquired staph aureus can be associated with patients with ulcers. In light of this, a working group including Professor Keith Harding, an expert in ulcer management, will review best practice and confirm care pathways. These will then implemented across the Health Board.

E Coli

E Coli is a bug that causes Urinary Tract Infections (UTIs), particularly in older people. A UTI in an older person can have a very big impact on their health, making them more tired and unsteady on their feet, as well as causing them to become confused.

E Coli bloodstream infection reduction is a relatively new target with a vast majority of cases acquired in the community.

Reducing infection will involve both good management of urinary catheters, as they are often associated with infections, but also the appropriate use of antibiotics in primary care. In light of this a primary care infection prevention nurse has just been appointed to drive this important agenda forward.

The number of E Coli infections has increased in 2018/19 in the Health Board, and we have not met our Welsh Government target.

Reducing HCAI through Appropriate Use of Antibiotics

Inappropriate use of antibiotics over the years has led us to the point where many bacteria have become resistant to the antibiotics we usually use to treat them.

There has therefore been a lot of publicity about only using antibiotics when they are really needed – and about using the right antibiotic for the infection that is being treated.

Which antibiotics we use and when and how we use them is really important for reducing the number of cases of C diff and E Coli. In the Health Board we have therefore been reviewing our Policy on Antibiotic prescribing, and looking at the impact of changes made in other Welsh Health Boards in the antibiotics they use.

In addition, to make sure staff have the information and training they need in this area, both in our hospitals and in the community, we have appointed a Consultant Pharmacist and a further 3 antibiotic pharmacists.

Recognising and Responding to the Deteriorating Patient and Sepsis

<u>Sepsis and Deteriorating Patient</u>
We will develop NEWS as common language in community/primary care by establishing pilots in a range of community/ primary care services

Over the last year, there have been some high profile stories in the news about sepsis. Tragically, people across the UK have died from the condition, sometimes because it was not diagnosed as quickly as it could have been. However, it is still not well known that people who survive sepsis, can have life changing after effects. Sepsis is a difficult condition to diagnose as it has a range of symptoms, and some patients may have all the symptoms and some may have none of them. In ABUHB, we have a programme of work called "the Aneurin Bevan Collaborative for Sepsis" (ABC Sepsis) which has been working with our Emergency Departments and the wards to make sure that we recognise and respond to sepsis in our patients in hospital. This started in 2015 and is still continuing to meet with departments to review each month the care and treatment for patients with sepsis.

The National Steering Group co-ordinating the drive to recognise and respond to acute deterioration and sepsis across the NHS in Wales is reviewing how well Welsh Health Boards and Trusts respond to the challenge of the acutely ill and deteriorating patient and whether our existing approach is working. Where good practice and innovation is identified, it will be shared across Wales to reduce variation and drive up standards of care. The Health Board was reviewed in late September/early October 2018. We are very pleased that the feedback from the review was extremely positive, with recognition that ABUHB has led the way in Wales in recognising and responding to sepsis. We still have work to do and are now developing our action plan in response to the recommendations in the feedback report. This will be published once it has been finalised.

Recognising Sepsis in the Community

We have also been working with Community Teams and Care Homes to support them to recognise and respond to sepsis in patients in the community who may need to go to hospital for treatment. ABC Sepsis has co-ordinated a Group meeting, which brought together all the Teams from the different services in the Community that are piloting work to recognise and respond to sepsis, so they can learn from each other and share ideas.

We now have many Teams working on recognising sepsis, including: District Nursing Teams across the Health Board, Care Homes through training provided by the Health Board, the Out of Hours GP service, Learning Disabilities community team, the continuing healthcare team, and mental health community teams.

By recognising patients with sepsis early on while they are still in the community, we can get them to hospital to receive the treatment they need, and prevent the sepsis getting worse.

The National Steering Group co-ordinating the drive to recognise and respond to acute deterioration and sepsis across the NHS in Wales is now running an initiative to take forward the work on sepsis in the community across Wales. We participated fully in an All Wales Learning Set for the Community Teams which took place in March 2019.

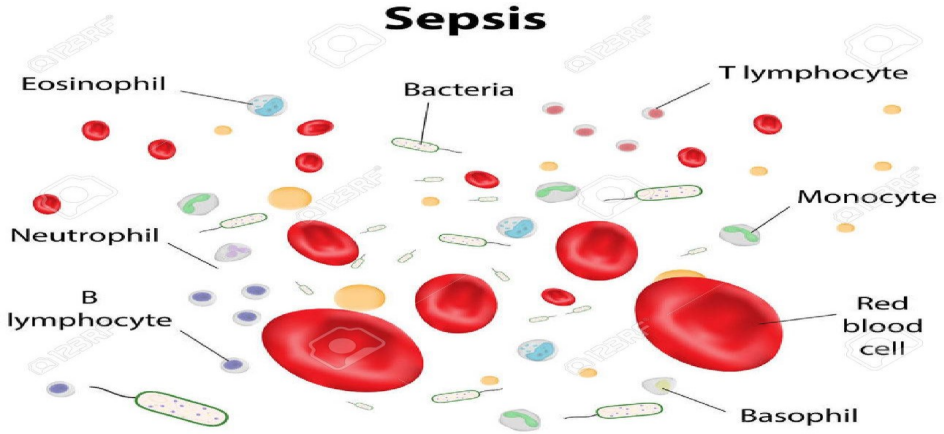
The Life Changing After effects of Sepsis – One Woman's story

To show how important it is to recognise sepsis early, in order to prevent patients dying unnecessarily, or from suffering the life changing after-effects of sepsis, the Health Board heard the story of one mum who experienced sepsis and became extremely poorly but survived. However, she is still recovering from the effect of the sepsis.

"A lovely 47yr old mother of 2 teenage children who was previously fit and well, was admitted to hospital as she had experienced bad diarrhoea and vomiting for some days. She was diagnosed with sepsis and given the appropriate treatment however despite this she continued to deteriorate and was transferred to critical care. Her body became so overwhelmed with sepsis that her heart could not pump effectively and she was transferred to a Specialist Unit at The Royal Brompton Hospital. The lady had a cardiac arrest on arrival to the hospital, but was successfully resuscitated. However, she was so poorly that her husband and sons were told that if she did not start to improve, her only hope would be a heart transplant, and that it was unlikely she would survive.

Thankfully, within a couple of days, she did start to show improvement, and was transferred back to the Royal Gwent Hospital. But she was very weak, had difficulty sleeping as she had vivid, frightening dreams and had no memory of what had happened to her. She was transferred to the ward once she no longer needed a machine to help her breath, but she remained so weak that she could not lift her hand up off the bed and therefore could not feed or wash herself, and she could not retain any information that was given to her. Her voice was so weak that it was difficult to talk to people, and she stared to become withdrawn. She felt helpless, as she did not know who to ask for help and did not know what to expect in the future or how long it would take her to recover.

18 months after she was admitted to hospital initially, she is now at home, but still has difficulty walking as she does not have the use of her right leg, and needs to be looked after by her husband and sons. She feels she has lost her identity as a wife and mother, and has been experiencing depression. She experienced sepsis and survived – but the impact has been life changing for her and her family. That is why we are working so hard to ensure we recognise and respond to sepsis as soon as possible where ever people are – in the hospital or in their own homes. We will also work to improve knowledge and management of patients recovering from the after effects of sepsis.

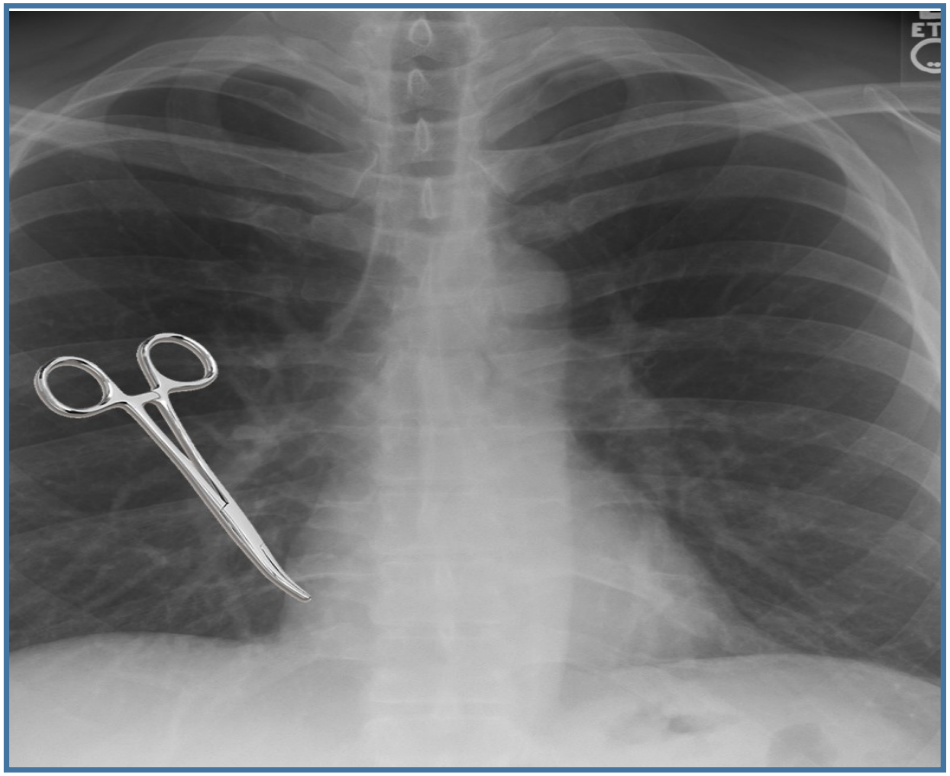


Never Events

Never Events are serious, largely preventable patient safety incidents that should **not** occur if the available preventative measures have been implemented by all healthcare providers.

An example of a Never Event is where a surgical intervention is performed on the wrong site. This would include operating on a patient's right knee when the individuals left knee was the intended site of surgery.

If a Never Event occurs, the Health Board must notify the Welsh Government (WG) who monitor all Health Boards in Wales to ensure that lessons are learnt, and actions put in place to prevent the same thing happening again.



During 2018-19, three Never Events occurred in ABUHB. They were all related to invasive procedures:

- Following the delivery of a healthy baby, the mother required some stiches. A swab (absorbent pad) was not removed at the end of the procedure, but the mother passed the pad without the need for intervention.
- The wrong tooth was removed from a patient, although the tooth removed was not a healthy tooth.
- A different version of lens to the one specified has been used for a number of patients with a cataract however, the lenses were the correct prescription and power.

The three never events therefore did not lead to harm for the patients. However, they should not have happened and are an opportunity for learning about how these events could have occurred. The investigation of the three incidents has led to review of the procedures in place to prevent these events happening, and the strengthening of the measures in place. For instance, in each delivery room in the maternity services, a white board and a pen must be available to record the number of pads, needles and packets of thread used, as they are counted in and out. This means it is visible to every-one involved, not just the midwife assisting the doctor.

We have been putting in place changes to ensure that we meet standards – called the National Safety Standards for Invasive Procedures (NatSSIPs). We will use these incidents to review the changes being introduced as part of the NatSSIPs work and ensure that the learning is included within the NatSSIPs action plans across all areas where similar procedures are undertaken.

A NEW MODEL FOR PRIMARY CARE IN ABUHB

Practices within ABUHB have experienced difficulties recruiting salaried GPs and GP Partners. This is one of the factors that leads to GP practice contract resignations, resulting in some GP Practices now being directly managed by the Health Board, through the Primary Care Operational Support Team (PCOST).

The Health Board currently has four directly managed practices, two of which have the ability due to size and premises- to embrace the "Transformation Model" a new way of delivering primary care using the skills of all the different professionals, to deliver care and treatment for the patient, rather than just relying on the traditional doctor and practice nurse model.

Patients are more able to see the most appropriate healthcare professional to meet their needs, when they need to see them. To do this, the practice has to be big enough both in terms of the number of patients it looks after, and in terms of the building it is based in, to support this new way of working.

Brynmawr Health Centre, with a list size of 10,300 patients, moved into its brand new purpose-built premises in June 2018. Historically, the clinical team comprise the traditional GP and Practice Nurse skill mix.

The practice now employs a much wider clinical multi-disciplinary team including; The following staff in whole time equivalents (WTEs)

- GP Clinical Lead (1 WTE)
- Salaried GPs (2 WTE)

- Clinical Pharmacist (1 WTE)
- Physiotherapist (0.5 WTE)
- Nurse Practitioner (1 WTE)
- Occupational Therapist (1 WTE)
- Mental Health Practitioner (1WTE)
- Physicians Associate (1WTE)

The practice also has Local Authority employed carers and health connectors on site daily, offering appointments to patients. Together, the whole team can meet the needs of its patients with a range of different health needs, therefore providing a more seamless service to patients and making it a more fulfilling place to work.

Bryntirion Health Centre, has a list size of 9,000 patients and operates from a modern, purpose-built premises. Again, it previously operated with the traditional mix of GPs and Practice Nurses. The Practice came into direct Health Board management on the 1st December 2017, due to GP recruitment difficulties. Bryntirion now boasts a full clinical multi-disciplinary team comprising;

- GP Clinical Lead (1 WTE)
- GP with Management Allowance (0.75 WTE)
- Salaried GP (0.75 WTE)
- GP Retainer (0.25 WTE)
- Clinical Pharmacist (1 WTE)
- Paramedic (WAST Rotation-1 WTE)
- Occupational Therapist (1 WTE)
- Physiotherapist (0.5 WTE)
- Advanced Nurse Practitioner (1 WTE)

A Mental Health Practitioner has recently joined the team. Along with this the practice is hosting an Aneurin Bevan Care Academy Pharmacist (see page 32), who they are supporting and mentoring through their training.

As with Brynmawr, this is a whole practice approach ensuring patients are seen by the most appropriate clinician in a timely manner. The practice can provide patients with more services closer to home, within a familiar setting on a single site. Click here to view a video about Practice Teams

IMPROVING DENTAL SERVICES

Increasing Access to Routine and Urgent Dental Care

We know that some patients have problems accessing NHS dental care, and we have been working with dentists to increase access for a number of years. The Health Board has invested additional funding and therefore increased access to high street dental services in 2018/19. The table below demonstrates the increase in access that has been achieved:

	Feb 15-Jan 17	Feb 17-Jan 19	% increase
Total number of adult patients seen	248,926	256,644	3.1%
Total number of child patients seen	81,606	85,087	4.3%
	quarter ended Dec 17	quarter ended Dec 18	
Fluoride varnish application rate	30.4per 100 FP17s	38.9per 100 FP17s	

Since 2006, patients are no longer "registered" with an NHS dental practices and can receive NHS dental treatment from any dental practice with an "open" list.

This is because there are many people who do not want to go for dental services routinely, but just go when they have a problem. The Health Board therefore commissions an Urgent Dental Access service.

In 2018/19, the Health Board has reviewed the Urgent Dental Access Service. Each appointment is 20 minutes and is accessed via the Dental Helpline. There are practices across Newport, Torfaen, Monmouthshire, Blaenau Gwent and Caerphilly who provide the Urgent Dental Access Service.

Improving Dental Care for Young Children

In order to improve dental health, the Welsh Government has written to all dental teams in Wales with information about preventive dental advice, care and treatment for children aged 0-3 years. In particular, they are encouraging parents to take children to the dentist before the age of 1 year – ideally, as soon as their first teeth come through – and for dental teams to give parents and carers preventive advice to help them keep their children from needing fillings.

Locally, the Primary Care Team and Design to Smile Team have together developed a "young child referral pathway" in order to encourage parents to take their child to the dentist.

Eight practices in Gwent are now part of this pathway, and can take referrals of children from the Health Visitor, the Design to Smile Team or the Flying Start Team. The referrals can be tracked to check whether or not the child has been to the dentist, and can be followed up if necessary.

Transforming Dental care from number of treatments by dentists to prevention by the whole dental team

For many years, NHS dentists have been paid according to the number of dental treatments they carry out. There is no way to pay dentists who spend time talking to their patients about how to prevent problems such as fillings. The NHS in Wales is now working with Dentists to change this and transform the way that dental care is provided.

In 2018/19, the Health Board has recruited a small number of dental practices to take part in the General Dental Service Reform Programme initially collecting data.

The dental teams are asking patients to complete the Assessment of Clinical Oral Risks and Needs (ACORN) toolkit.

This assessment tells individual patients about their own risk of poor dental health and what they can do to improve it.

By putting together all the assessments, the dental practice can understand the oral health needs of the people using their service, and therefore how they need to work to improve the dental health of their population.

This may mean increasing the time between check-ups for people with good oral health, which then gives the dental team more time to spend with people with poor oral health. They can talk to them about the changes they can make to prevent the need for fillings in the future.

It should also allow the practice to take on more patients, particularly children. The aim is to increase the number of fluoride varnish applications in children, which should reduce the number of children needing fillings. Going forward, 20 practices will be taking part

in the programme and changing the way that they work.

WORKING WITH THE WELSH AMBULANCE SERVICE TO RESPOND APPROPRIATELY TO PEOPLE WHO HAVE FALLEN AT HOME

As we have reported previously, ABUHB has worked with the Welsh Ambulance Service (WAST) to provide an effective response to people that have fallen at home. In most cases, the person has not broken a bone, but needs help to get up, and advice about how to reduce the risk of further falls.

Previously, the only response available to WAST was an emergency ambulance with paramedics. Over the last few years, ABUHB and WAST have set up a falls response vehicle, with a paramedic and a clinician from the Falls Team This has been shown to reduce the demand for the emergency ambulances, and to enable more people to remain safely at home, reducing visits to A and E.

Following on from this work, WAST has now developed a falls response framework which focusses on 3 levels of response for a person that has fallen, depending upon the need.

GIG CYMRU NHS WALES
Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust

ABUHB has again worked in partnership with WAST and St John Cymru Wales to set up a level one response for a fall where the person needs to be safely lifted from the floor and there are no or only minor injuries from the fall. Together, we are operating two Falls Assistants who can go to the person's home, lift them safely from the floor and carry out an assessment.

The Falls Assistants are supported by the Clinical Support desk, through which a paramedic or nurse provides clinical advice and direction.

The level two response is required when it is unclear whether there is an injury, or the person has a number of long term conditions or complex needs. This is the response that WAST and ABUHB have been developing for a few years with a paramedic and a clinician from the falls team, usually a physiotherapist.

The team can undertake a comprehensive assessment of the person that has fallen in their own home, and put changes in place to reduce the risk of falls for that individual, including onward referrals to community based services.

The level three response is the Emergency Response, and is deployed when there is an obvious injury from the first 999 call, or when the Clinical Support Desk identifies an injury following assessment in the level 1 or 2 response.

The Falls Response Service has been involved with 1961 falls 999 calls from October 2016 to 31 December. 1475 people (75%) have remained at home and only 17% of people required treatment within the emergency department. This has reduced demand on the Emergency Ambulances as well as unnecessary visits to the A and E department due to falls.

Value Based Healthcare

We have some outstanding and innovative work taking place in ABUHB, with a focus on the value of healthcare to our patients. This means providing the care and treatment that lead to the best possible outcomes, outcomes that matter to patients-delivered in the most efficient way, using our finite resources wisely.

At our Value Based Healthcare Conference in March we were thrilled to be joined by Prof. John Moxham from King's Health Partners. Prof Moxham is

keen to strengthen the partnership with the Health Board, and in a statement suggested that 'the expertise and commitment developed within the multi-professional team at Aneurin Bevan is one the distinctive features of our approach, and is critical to successfully implementing value-ABUHB are truly leading the field in the UK'.

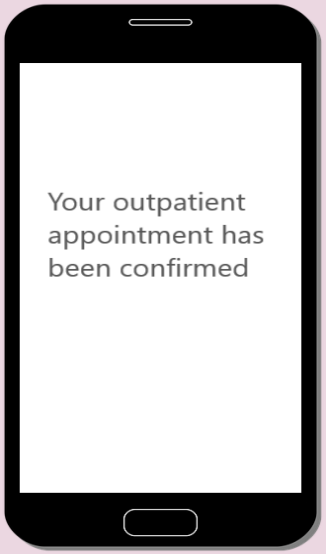
Using technology as a key enabler in delivering a value based approach, the Health Board has invested in a digital platform provided by "DrDoctor" to improve two way communication with patients, and collect outcomes to inform

direct care. This system allows patients to access and communicate with the Health Board via a text or email on their mobile device. Through this system, we are now able to:

- Allow some people to book appointments in outpatients on their personal mobile devices
- Remind people of the date and time of their outpatient appointment
- Give patients information that will help them get to and prepare for their outpatient appointment, so they get more from their time with the clinician
- Obtain information from patients about their current state of health just before they come to or go into an outpatient appointment to support shared decision making between the patient and the doctor
- Collect patient's views about their experience with the service they are using, in order to make improvements
- Collect patient's views about the outcomes of their care and treatment, so we can re-model services to meet the needs of and provide the outcomes that matter to patients

Using Dr Doctor to send texts and e-mails:

- We have sent out over 18000 assessments about the patient's view of the outcome of their care and treatment – some to people before an appointment, some whilst they are waiting in clinic.



- Of the 18000 sent, 78% have been returned electronically, this response rate is above the UK norm.
- 50% of the returned questionnaires have been completed before a patient comes to the appointment, with the remainder being completed in the clinic prior to the appointment

As a result of the feedback on outcomes and patient experience, we have:

- Changed the process for follow up appointments so that patients with long term conditions who feel fine do not need to come to hospital, which frees up time in clinics
- Used the freed up time to make more timely appointments for Patients who need an urgent outpatient appointment.
- Changed the mix of patients in some clinics
- Learnt more about which patients will have a good outcome from surgery, so patients can be given the treatment that is most likely to benefit them

The value based healthcare work is now in all hospitals in ABUHB, and covers 18 different health conditions. It is being used in 140 clinics and therefore 1000s of patients. The work is helping us to change our services as we move towards the opening of the Grange University Hospital, so that patients receive the care that is important to them from the right professional at the right time and in the right place.

Ffrind i Mi/ Friend of Mine is a partnership approach to combatting loneliness and social isolation which can affect people's health and wellbeing. It has created a 'social movement' that aims to reconnect people with their communities. As part of this initiative, telephone befriender volunteers are recruited who ring people regularly who have said they are lonely – just for a chat.

All the volunteers are amazing, but this story about one of our volunteers has really highlighted the benefit to both volunteer and those befriended.

Ffrind i Mi Case Study—Julie's Story

"Julie lives in Torfaen with her husband. She has had a career in customer facing services, including the Women's Royal Voluntary Service and had been the main carer for her disabled son for almost 30 years.

Approximately 7 years ago Julie was diagnosed with a life limiting illness which has initiated numerous hospital appointments and admissions. She is on continuous oxygen and her ability to 'get about' is compromised due to breathlessness. Her diagnosed condition led to complications with her eyes and over the course of her illness she has lost sight in both eyes.

Julie believes that losing her sight was 'the best thing that could have happened' as this made her re-evaluate the needs of her son. Unable to personally care for him any longer due to sight loss and failing health, he is now living in supported accommodation, regaining some of the independence Julie believes he may have lost due to her doing 'everything for him'.

Julie's condition has deteriorated and she is now in the terminal phase of her illness.

At the latter end of last year she was visited by a Community Connector after she had expressed a wish to volunteer. She was referred to Ffrind i Mi with a request that we visit her to see if there was 'anything at all' Julie could do to fulfil her wish to 'give something back' and to give her a sense of purpose.

Following discussion, it was suggested that Julie could be a telephone befriender and speak to people who are lonely and isolated and do not wish to or cannot leave their homes. Ffrind i mi staff delivered volunteer training in her home. She needed to have an occupational health check, as do all volunteers, and the Ffrind i mi staff made it clear to the ABUHB Occupational Health Department that the volunteer role Julie wished to undertake could be done from her own home in her own time regardless of her terminal diagnosis. Finally Julie needed to be DBS checked

"Julie is now a volunteer befriender to 3 older people who live alone. She thoroughly enjoys speaking to these people and feels she has a sense of purpose again. She goes a step further and is encouraging those who are lonely and isolated to volunteer themselves. One of the people she has befriended telephoned the Community Connector and thanked them for referring her to Ffrind i mi. For her, speaking to Julie feels like she has been put in touch 'with a long lost friend'. Julie attends the Hospice day services. She was 'matched' with a lady who was attending the same Day Centre but she had to stop attending due to her illness.

Julie has now been in contact with her links at St David's and trying to see if there is any possibility of her attending again.

Julie speaks from the heart, and the messages she conveys are ones of positivity, purpose and hope in situations where many of us may only see darkness, dread and fear.

Julie has agreed to share her story in the hope that it encourages others to volunteer. This will be Julie's legacy

Winter Experience Survey

Through the winter period, members of the Community Health Council (CHC) have been talking to patients in our A&E department about their experience of care. The feedback has been positive overall. Where any shortfalls were identified, these were addressed immediately. For example when it was highlighted that there was inadequate seating in the Medical Assessment Unit at RGH, additional seating was immediately sought and brought into the department. Also when patients in the Emergency Assessment Unit at Nevill Hall Hospital did not know where to obtain refreshments, clear signage was put in place in the department directing patients/families/carers to where refreshments could be obtained. We would like to thank the Community Health Council for carrying out this survey over the busy winter period, which has helped us to make sure patients are satisfied with our communication with them and their level of comfort.

Identifying Delirium

Delirium: We will develop a clear protocol for the assessment of delirium in general hospitals

Delirium is a term used to describe a condition of ***acute confusion*** which is associated with physical ill health, such as a urine infection. It means that a person who is usually able and clear, becomes confused and unable to focus their attention on a task. If a person with delirium already has dementia, they will be more confused than they usually are. Delirium usually starts suddenly and is temporary. With appropriate treatment of the physical cause, delirium will usually gradually improve over days or weeks, although some patients will not fully recover their previous level of functioning after an episode of delirium. It is really important that we are able to identify delirium, as it occurs in approximately a third of people over 65 years old in hospital.

As the main symptom of delirium is new confusion, it is important that staff are able to tell the difference between delirium and dementia, so that the source of the delirium can be identified and treated. This means staff have to be skilled at finding out about a person's usual health and cognitive abilities, using simple tests to identify delirium and physical examination.

To ensure that staff are clear about the process they should use to identify and treat delirium, we have developed guidance for them. This includes the assessment tool, the 4AT that they can use alongside gathering information to understand whether a patient is normally confused, or whether the confusion is new and recent. However, we need to find out who should use it and when to use it. We also need to be very clear about what should be done if a patient is identified as having delirium and who needs to do it.

The best way to use the 4AT delirium assessment has been taken forward as an improvement project in the Medical Assessment Unit at YYF in order to have a clear protocol for the assessment of delirium. This improvement work is still ongoing. In addition, the 4AT is also used at RGH as part of the assessment on admission to the Care of the Elderly Wards. The results of the improvement projects are being pulled together at the moment, and we should have a clear protocol by the summer of 2019, which will be introduced with a programme of training.

DELIRIUM

A is for Access

The "5 As for access" Scheme is a set of locally agreed standards for GP Practices. The maximum number of A's a surgery can be awarded is 5 and this would mean that the surgery meets all the standards below:

1. Opens at or before 8am with a first appointment at 8.30am or earlier
2. Doors are open during the lunchtime period
3. Last routine doctor appointment is 17.50pm or later
4. Telephone access to a member of staff is available from 8.00am - 18.30pm
5. Patients can book an appointment during one telephone call, without the need for calling back, or on-line.

Not all practices have been able to meet the essential qualifying requirements for the 5 'A' scheme as they have at least one half day closure.

It was agreed that access standards for these surgeries would still be reported but these surgeries would be given 'B' ratings.

There are **78** GP practices across the Health Board area and of these:

- 65 (83%) of these have attained 5A rating
- **1** practice has been rated as 5B.
- **9** are 4A rated
- **3** are 3A rated.

GP Surgeries display a certificate which indicates the rating they have been awarded as part of the "5 As for Access" scheme. The scheme relates to ACCESS ONLY and is NOT an indicator of clinical or any other kind of services provided by surgeries

Home First

We know that some people are admitted to hospital because they need more support at home, and that support can not be set up quickly. Other people wait in hospital for many days after they are fit enough to go home, because they also need a bit of extra support, and that support can not be set up quickly. Getting the support in place is complicated because we work with 5 different Local Authority areas, which all have slightly different health and social care services to support people at home, with different referral and assessment processes and eligibility criteria.

The Local Authorities have therefore worked with the Health Board, and with partners in Voluntary Groups, to set up "Home First". This service will provide a "home first" alternative for patients as a viable alternative to short term admission into hospital, through putting in place support at home, that is short term but set up as quickly as is needed.

The Home First Team has recently started to provide short term support so that medically fit patients can be discharged within 4 hours in some cases, but no longer than 24 hours. The short term support is provided until the usual local authority care package can be put in place.

The Home First Team has a social worker, as well Occupational Therapists and home carers, and they work across all the Local Authorities to assess patients in the same way and provide the same

service.
The Team started working at NHH first in October and then started at RGH in November 2018. Referrals to the team increased in the New Year 2019 and have remained at the higher level, particularly at RGH. "Home First" has made an important contribution to our ability to support people safely at home when a hospital admission might not be the needed.

Winter pressures and 12 hour waits

12 hour waits in A and E We will significantly reduce the 12 hour waits in A and E

It has been a busy winter period for the health board. Since November 2018:

- there have been more attendances at the A and E departments each month than there were in any of the previous 3 years.
- More of the people attending A and E have been aged over 75, and we know that older people have more complex health problems.
- More of the people attending A and E have been looked after in the part of the department for more seriously ill patients (majors).

In order to prepare for the winter period, we made a number of changes. You can read about the "Home First" Service on page 25, which was put in place to make sure that people who were well enough to go home with a bit of extra support did not have to wait in hospital while a package of care was arranged. So some are not admitted to hospital at all, but go home from A and E, which reduces the number of people admitted to hospital. Patients on the wards also get back home as soon as they are well enough to go home, freeing up beds for people who need to be admitted to a ward from A and E.

Learning from previous years, we also put in place a programme of work in the A and E at RGH to reduce any delays to the early assessment of the patient, firstly the "triage", initial assessment of the patient to determine how quickly they must be seen, and secondly the time they are seen by a doctor. This ensures that a patient arriving at the A and E department is assessed promptly and therefore any treatment can be started and decisions about admission to the appropriate ward can be taken in a more timely way. We also set up a series of short gatherings of key people through out the 24hour period, called "Patient Safety huddles".

These short "get togethers" make sure that everyone is aware of the sickest patients in the department, and of any other issues that might impact on the care of the patients in the department and movement of patients on to the wards. We call this our Turnaround Programme.

We have monitored closely the impact of this programme on how quickly patients are given a bed on a ward – and also therefore the number of patients who have to wait more than 12 hours for a bed on a ward. What we have seen is that, even though there has been an increase in the number of patients, with more older and sicker people, there has not been an increase in the time patients wait to be triaged or to see the doctor. Since the focus on safety huddles the time for a patient to be given a bed on a ward has shown a significant decrease in February and March 2019.

For the whole of 2018-19, number of patients waiting more than 12 hours to be given a bed on a ward has decreased compared to 2017-18 to 5463 from 5788. However, this is still too many people waiting in A and E when they should be in a bed on a ward.

IMPROVING THE EXPERIENCE OF PEOPLE WHEN THEIR LOVED ONE DIES IN HOSPITAL

Bereavement, especially in the immediate days following the death of a loved one, results in people having to make important arrangements, such as funerals and registrations of death, at one of the most emotionally challenging times in their life. It is well recognised that when a person is grieving, their emotional resilience is low and their wellbeing suffers as a result.

Families of patients who die whilst receiving care in hospital, face dealing with loss and grief in unfamiliar environments. Within ABUHB, we have not had a dedicated service to support bereaved families, and this has led to variable and inconsistent approaches to bereavement support across our hospitals. This results in families often having to go back to the busy acute wards where their loved one has just died in order to collect personal items and death certificates. The staff on duty on the wards are not able to set aside the time required to provide the invaluable support, information and signposting to services that may be of benefit to the families in the period of grieving after death.

Between January 2017 to July 2018, ABUHB has received 18 complaints which have centred around the arrangements that families have to work through when their loved one dies in hospital. We have therefore obtained initial funding to develop a bereavement service across our acute hospitals, starting in 2018/19.

YYF was identified as the hospital to set up the service in the first instance. Following the appointment of a Bereavement Support Officer, the service started in August 2018. Between August and October 2018, the service supported 65 bereaved families.

The service has had positive feedback from the bereaved families that it has been involved with. In particular, there has been an improvement in the number of days between the death, and the family being able to collect the medical certification of death.

The bereavement service is now being set up at the RGH. It is envisaged that the service will be in place by summer 2019.

Putting Things Right

The Health Board aims to provide the very best care and treatment and we regret when there is cause for any of our patients, or their carers, to raise concerns about the service they have received. Concerns are always taken seriously and viewed as an opportunity to improve the services we provide.

Anyone raising a concern should expect it to be addressed in an open manner and to be assured that they will receive a timely and honest response.

Wherever possible we try to resolve concerns informally which helps us to provide a timely response to the concerns raised. In 2018/2019, approximately 55% of concerns were dealt with informally, although not all complaints dealt with informally and resolved 'on the spot' are captured.

The main issues which led concerns being raised in 2018/2019 were:

- *clinical care*
- *Attitude*
- *waiting times/delays and cancellations, and*
- *communication failures.*

The percentage of complaints responded to in a timely way decreased in 2018/19 and we know that delays in receiving a response to a complaint can cause anxiety and anger for the person who has had cause to complain.

We reviewed the processes used to investigate and respond to complaints. A work programme is being implemented to ensure the process is clear and that everyone involved works collaboratively and is aware of who is responsible for each step.

Through the work programme we will:

- Process map and streamline the complaints pathway
- Develop a consistent approach to improve timeliness and quality of response
- Improve data quality in complaints handling
- Improve compliance with performance measures

ABUHB believes it is important to listen to, and to learn from, any concerns raised in order to prevent similar issues in the future. We will spread learning from complaints and serious incidents by raising awareness about things that have gone wrong across all Health Board services and working to prevent similar issues happening again.

Learning from concerns can happen in a number of ways and as part of the quality improvement programme for concerns we will:

- Re-establish a learning committee and shared learning forums
- Develop a training, coaching and mentoring programme for staff who carry out investigations
- Continue to support the working groups and educational meetings which already exist in our organisation
- Publish a bulletin, distributed monthly throughout the Health Board, which describes the learning from concerns.

Care Closer to Home Blood Transfusions at County Hospital

Torfaen Community Resource Team (CRT) moved into Cedar Unit at County Hospital in September 2017, providing a clinical area that the Team could use for treatments. They were previously based in an office building and so were more limited in what they could do for their patients

Since moving to the unit, the Rapid Medical/Rapid Nursing element of the team has begun providing numerous new therapies, which patients can attend the unit to receive

Previously patients had to go to RGH or NHH, and so the Team are now able to provide care for Torfaen residents much closer to home.

The team currently provides Intra-Venous (IV) antibiotics, at home or in the unit if a patient is able to attend, IV fluids on the unit, IV Iron transfusions, blood transfusions and Bis Phosphonate transfusions.

The team is very proud of the treatment they can give, which is in line with the health board's "care closer to home" strategy. Here are some examples of how this change has made a real difference to people's lives:

A family member of a very frail 85 year old man, who would rarely visit his GP, commended all the Torfaen Community Resource Team staff, from the emergency home carer to the nurses who looked after his toe nails. The patient's blood transfusions take place in a lovely and peaceful environment, rather than negotiating a very busy hospital where it is difficult to park and find the relevant department.

The patient had been referred to the Team by his GP for increased confusion and a recent fall and was seen in the Cedar Unit Clinic. On his initial visit to Cedar Unit, it was evident that he had been struggling to look after himself and the Rapid Response nurses assisted him with his hygiene in the clinic and cut his toe nails, which were impairing his mobility. At this time, emergency home care was arranged for two calls a day, which he was initially reluctant to receive, but was gently coaxed in to having after a few home visits from the emergency care staff.

Blood results revealed anaemia and the patient was experiencing symptoms, with shortness of breath. He was able to receive a blood transfusion at the Cedar Unit, rather than having to attend a busy District General Hospital. His nephew wrote an email of praise for the service, stating that the nurses had provided excellent care and the environment was conducive to his uncle's general wellbeing.

Another patient who is 55, with a busy family life, also praised the County Hospital unit which he visits daily for a transfusion as he awaits a liver transplant. Having the treatment at County Hospital fits around his day: taking and collecting children from school.

This patient attends the unit daily for intra-venous antibiotics rather than having to stay in hospital for treatments.

He is a father of three and has stated that having his care so close to home has allowed him to continue with family life as normally as possible. He has praised both the clinic facilities and the CRT staff.

Welsh Health Specialised Services Committee

Specialised services support people with a range of rare and complex conditions. They are not available in every local hospital because they have to be delivered by specialist teams of doctors, nurses and other health professionals who have the necessary skills and experience. Unlike most healthcare, which is planned and arranged locally, specialised services are planned nationally by Welsh Health Specialised Services (WHSSC) on behalf of the seven Health Boards in Wales. WHSSC works closely with our Health Board to ensure that any specialised service commissioned is of a high standard and that there are no concerns identified from a quality perspective. They do this on our behalf through a quality assurance frame work which is monitored by their Quality and Patient Safety Committee and reported back into the Health Board.

So many of our staff go the extra mile for patients. Here are some examples of the "thank you" messages we receive.

My father was admitted to A&E on New Year's Eve following a stroke. The **care, kindness and level of professionalism provided by all staff was exemplary**. My father has now returned home after spending 5 weeks in hospital. He is making a slow recovery and we are hopeful for the future **thanks to the wonderful staff at the Royal Gwent Hospital**.

May I thank the **Physiotherapy department** at **St Woolos hospital** for their **total professionalism**, from the **receptionist to all the staff members** and particular the attention shown to me by student physio who explained in detail my walking problems and physical state. With her help and departments help I feel I'm on the mend. **Great department, great staff "Who Care".**

I just want to take the time to thank the GP Out of Hours, at Ysbyty Ystrad Fawr today. He saw my son, who isn't normally very co-operative in these type of situations or environments and can get very stressed. The doctor **talked and smiled to my son, explained everything to him**, let him hold the instruments and practise on me first. He is the **first doctor ever** to get my son to open his mouth for him to check his throat, he was so comfortable. He needs to be recognised for his **patience and kind nature! What a lovely person!**

I would like to express mine and my family's thanks to **all the staff on Rowan Ward, County Hospital.** The **professionalism and care** that they showed to my father during his last weeks was **exemplary. Nothing was ever too much trouble** and they regularly **went the extra mile** to ensure Dad was as comfortable as possible and were **hugely supportive to the family.**

Just wanted to say **thanks to the lovely lady** I spoke to today in the **Radiology Booking Service** who arranged my next DEXA appointment.

Isn't it lovely when **everything comes together** and you get **such helpful people** on the other end of the line.

Please send our grateful thanks and our best wishes to the **staff** who have looked after our father recently. He spent six nights in intensive care and now **D5 west**, after an infection and renal insufficiency. **The care has been exceptional** and we have been kept informed throughout his stay.

The **nursing care is a credit to the profession** and I am singing your praises to anyone who will listen. As a trained nurse since 1979, I am more than pleased to see the **high level of care** Dad is receiving. The **Urology team** have been **very good and respectful** of Dad's wishes. All the **support services** we've come into contact with have been **helpful, polite and good at their jobs**.

On the 24th October, I underwent a total knee replacement carried out by the **surgical team at Nevil Hall**. I would like to take this opportunity to thank that team, and would also like to give particular thanks to the nursing and care staff on Ward 3/1 together with the physios.

The **ward staff are a credit to the hospital** and showed a **professional caring and compassionate nature** to the patients in their care. I witnessed **acts of personal kindness** to other patients, **over and above** what their job descriptions probably out-lines. Once again a **sincere thanks to all concerned**

I would like to send a message of thanks to all the staff on the Bedwas Ward at Ysbyty Ystrad Fawr, Ystrad Mynach.
Our Mother has been on the ward for several weeks until she was moved earlier today to a different hospital. The care she has had on the Bedwas ward has been **fantastic**, hopefully she won't be too long now at the new hospital before she will be well enough to come home. I am sure the improvements she has made has a lot to do with the care she has been receiving on the ward. She can't have been too easy to deal with when she first arrived, but everyone on the ward **has been great right from day one**.

Staff Wellbeing

Staff Wellbeing
We will develop a Staff Engagement and Wellbeing Strategy to support our staff.

One of the 4 values in the Health Board's Values and Behaviours Framework is "People First". This, of course, means putting our patients first – but for the Health Board, also means looking after our staff too. We therefore wanted to have a "Staff Engagement and Wellbeing Strategy" to support staff in their work for the health board and as they go through a period of significant change leading to the opening of the Grange University Hospital in 2021.

However, following engagement with staff, it was agreed that we would develop an 'Employee Experience Framework' instead of 'Staff Engagement and Wellbeing Strategy'. This is really important as we know that employee experience shapes patient experience so staff who are happy in their work are able to provide a great patient experience.

The new Employee Experience Framework was launched on Valentine's Day and is presented as an interactive online Toolkit which provides all employees with easy access to a wide range of information and support to help us look after ourselves and others.

We want all our colleagues in ABUHB to have great lives, with their work playing a significant and positive role. This framework marks both the consolidation of what we already do well within ABUHB and the beginning of a new approach that will promote and drive a positive staff experience.

Welcoming People to our Hospitals

We will develop a new Welcoming Service at St Woolos with our partner Age Cymru Gwent and expand and extend the Welcoming Service at Nevill Hall Hospital from two mornings a week with our partners Age Cymru Gwent, the Royal Voluntary Service, Nevill Hall Leagues of Friends and North Gwent Cardiac Rehabilitation and Aftercare Charity.

St Woolos Hospital Welcoming Service

A full Monday to Friday Volunteer Welcoming Service has been in place at St Woolos Hospital since July 2018. Age Cymru Gwent, a valued Health Board partner, recruited new 'Robins' volunteers to meet and greet patients and visitors and complement their well-established ward based

Robins volunteer service. As part of the new Welcoming service:

- Volunteers are easily accessible and identifiable with their distinctive Robins volunteer red tops
- Volunteers work in pairs enabling an added value 'walk with' service for patients and visitors who are anxious or confused
- Volunteers offer 'soft support' to distressed relatives e.g. a cup of tea, a listening ear, support with booking taxis etc.

As a result of the new service, first impressions of St Woolos Hospital have improved significantly

Nevill Hall Hospital Welcoming Service

The Welcoming Service at Nevill Hall Hospital has been expanded and extended from two mornings a week with our partners Age Cymru Gwent, the Royal Voluntary Service, the Nevill Hall League of Friends and North Gwent Cardiac Rehabilitation and Aftercare Charity.

A joint recruitment campaign was held in April 2018 and a full Monday to Friday Volunteer Welcoming Service has been in place since Autumn 2018.

As part of the new Welcoming service:

- Patients, relatives and visitors receive a friendly welcome and offer of help
- A distinctive Welcome Desk and pop up banner draws attention to the service
- Wheelchairs are co-located and volunteers help to ensure availability
- Volunteers who are willing and able have been trained to provide support in pushing patients/relatives in wheelchairs as appropriate.

PRIMARY CARE ACADEMY IN ABUHB

As working in primary care is new to many professionals and requires a different set of skills to working in hospitals, the Health Board has set up and is funding a Primary Care Academy. The Academy co-ordinates Primary Care Training Sites which can deliver training for professionals other than GPs who are new to primary care. The Primary Care Academy has now assessed and approved 18 GP Practices across Gwent: 12 to support training of Nurses new to primary care and 6 to support training of pharmacists new to primary care. One nurse will be supported by PCOST.

- Nursing Scheme: There are 13 placements for trained nurses new to primary care, each 6 months long with a training curriculum and mentorship by a member of the practice clinical team. By completion of the training, the post holders will have all the skills needed to work as a practice nurse.
- Pharmacy Scheme: This is similar to the Nursing Scheme, but is delivered across 2 years and is run in conjunction with Bath University. By the end of the 2 years, the pharmacist will have an Independent Prescriber qualification.

Nurse Staffing Act

Wales is the first country in Europe to write into law (Nurse Staffing Levels (Wales) Act 2016) that Health Boards in Wales have to ensure there are sufficient nurse staffing

levels to meet the needs of patients receiving care. This is being done because the evidence identifies that having the right number of registered nurses and the right skill mix improves patient outcomes and reduces patient mortality. From April 2017, Health Boards have had a duty to make sure that they are providing sufficient nurses to allow the nurses time to care for patients sensitively.

This requirement extends to all care environments NHS Wales provides or commissions a third party to provide nurses. From April 6th 2018, the Health Board has had to comply with new duties:

- Health Boards have to calculate and take reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical wards.
- Health Boards are also required to inform patients of the nurse staffing levels.

Health Boards have to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards

The Health Board has established a Staffing Act Implementation Group with representation from finance, workforce and the divisions to progress implementation of the Act and ensure it is aligned to the ongoing All Wales work.

What have we done to comply with the Nurse Staffing Act?

As a Health Board, we have put in place a work programme to ensure compliance and engagement with the Nurse Staffing Act and its requirements:

- Education about and raising awareness of the Act in all areas of the Health Board
- Recalculation of the nurse staffing levels required on each of the acute wards twice a year, to make sure they are up to date
- Monitoring of the measurements that are particularly sensitive to care provided by a nurse. This includes patient falls, hospital acquired pressure ulcers and medication errors.

How do we tell patients about the Staffing Act?

The Health Board must make arrangements to inform patients of the nurse staffing levels. All acute wards now have the planned nurse staffing rosters clearly displayed at the entrance to wards.

In addition, each ward has a copy of 'frequently asked questions' on staffing levels which patients can access. This was developed with the Community Health Council and is provided in both English and Welsh.

Nurse Recruitment

Along with other Health Boards in Wales and England, we have a higher number of vacancies for registered nurses across the Health Board than usual and have had difficulty in recruiting registered nurses to fill those vacancies. Nurse recruitment therefore continues to be a vital part of the work undertaken by ABUHB.

As this is a problem for the whole of Wales, the Welsh Government have taken actions which are designed to increase the number of nurses being recruited to Health Boards in Wales

- The bursary in Wales for student nurses has continued (unlike England where it has been abolished) and the Welsh Government have increased the number of student nurses taken in to training in Welsh Universities each year. However, ABUHB's partner Universities have not been able to fill The commissioned places for the March 2019 intake of traditional three year full time students.
- Experienced Health Care Support workers can now work part time within the Health Board in their HCSW role and part time as a University student training to be a registered (RN) nurse. The Health Board is hopeful that the number of flexible HCSW students commissioned will increase in line with the reduction in the number of places in traditional full time courses .

Flexible route HCSW training to become RNs	2017/18	2018/19	2019/20
University of South Wales	3	9	8
Open University	Not available	9	5

In ABUHB, we are also doing all we can to recruit nurses, building on changes at a National level or our own local position.

These actions include:

- The Nursing and Midwifery Council have recently held a consultation to review the Return to Practice education standards, for registered nurses who have left the profession. The proposed changes may encourage more nurses to return to the register. We are therefore working with Cardiff University and the University of South Wales to encourage as many nurses as possible who have left the profession to book onto a Return to Practice course, and we will then support them back in to work.
- With the Severn Bridge tolls abolished at the end of 2018 and the comparatively low price of housing in Newport, ABUHB have been holding recruitment events in Bristol to try and encourage nurses to move the short distance from Bristol to ABUHB hospitals to work. There is a plan for 2019 to broaden recruitment activities to include targeted national recruitment activities including advertising in the nursing press, radio adverts and social media communications. We will also attend national and locally arranged events in towns and cities that border our HB area in a bid to maximise recruitment of nurses to ABUHB.
- The recruitment initiative has continued, whereby nurses who trained overseas and are currently living and working in the UK in non-nursing posts are being supported to undertake the examinations required by the Nursing and Midwifery Council in the UK in order that the individuals can then be employed as qualified nurses in Wales. We are very pleased that we will have 28 registered nurses through this initiative by the end of 2019, with another 37 awaiting a start date.

Wales for Africa

The Charter for International Health Partnerships in Wales was developed by the International Health Co-ordination Centre which is part of Public Health Wales. It is based on Wales' history for accomplishment and learning in this area and outlines four foundations of successful international health partnerships. These are:

- Organisational Responsibilities
- Reciprocal Partnership Working
- Good Practice
- Sound Governance

Through our international health engagement, we seek to promote the expertise of health professionals in Wales, sharing common principles with partners and learning new and better ways of working that we can bring back to the NHS in Wales. This strengthens our commitment to action based on sound evidence and respectful collaboration, which promotes health equity within and between countries.

ABUHB is committed to supporting the development of healthcare services in developing countries, with our staff working in Africa and in other countries through out the world. There are huge two way benefits to this with an exchange of ideas and opportunities for development of staff.

In June 2018, Bronagh Scott, the Director of Nursing at that time, visited Namibia with Independent Member of the Board, Prof Dianne Watkins (University), to scope the possibility of providing a leadership development programme for Nurses. This is a project funded by Wales for Africa and is a country wide project with a number of elements. ABUHB is delighted to be involved in the buddying scheme between qualified nurses in Namibia and registered nurses in ABUHB. The nurses will share experiences, ideas and the challenges associated with leading nursing in both countries. ABUHB nurses will benefit by developing greater resilience, empowerment and cultural awareness, and we look forward to hearing from them about their experiences in 2019-20.

LOOKING FORWARD 2019-20

Many of our improvement priorities come from the Health Board's Integrated Medium Term Plan 2019-22. Making improvements in a large and complex service across all areas does not happen in one year. Our priorities are therefore in many cases the same as we have had in previous years, but each year we set clear milestones to take us towards our ultimate goal.

Building Bridges: Intergenerational Strategy

We will have a new initiative on both the hospital wards and in the Care Homes that takes forward our Intergenerational Strategy and will aim to 'twin' all care homes and community wards with schools/uniformed cadet organisations

Coloured Walking Frame Pilot

Following the success of the 'Pimp my zimmer' initiative, we will pilot and evaluate the use of coloured walking frames in 10 Care Homes and designated pilot wards as this will give patients a choice of recognisable colours, with the aim of increasing mobility and socialisation and reducing falls

Volunteering

We will secure funding to extend, expand and improve the welcoming service at the Royal Gwent Hospital in order to:

- Provide a Monday to Friday Meet and Greet service at Levels 0, 1 and 3
- Improve first impressions
- Improve the patient/visitor experience

We will work to meet the HCAI: targets as agreed by WG for:

- C diff, 25 per 100,000 population
- MRSA and MSSA, 19 per 100,000 population
- E coli, 61 per 100,000 population
- Klebsiella, 10% reduction
- Pseudomonas aeruginosa, 10% reduction

Acute Deterioration—AKI

We will agree a consistent approach to responding to Acute Kidney Injury alerts and develop an approach to data collection and measurement across the acute sites (local process data and Nationally collected outcome data)

Acute Deteriorating Sepsis

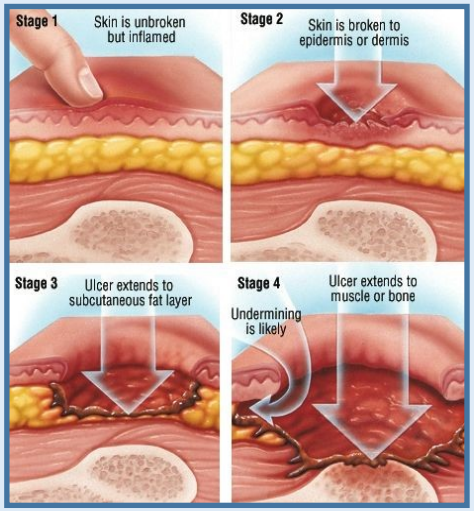
Work with the Start Smart and focus programme to test how the principles can be built into the ABC Sepsis approach in A and E and MAU

Falls

We will develop a plan to improve bone health for older patients at high risk of falls in order to reduce the number of fractures.

Pressure Damage

We will further extend the Pressure Damage Collaborative and continue the reduction in Grade 3 and 4 pressure damage.



Hospital Acquired Thrombosis (HAT)

We will pilot sending HAT data to individual clinicians in Trauma and Orthopaedics (T & O) showing their position relative to the other anonymised T and O Consultants

Looking Forward

Statement from Aneurin Bevan Community Health Council

The CHC welcomes the AQS that highlights areas of achievement and also priorities for action.

Mrs Angela Mutlow,
Chief Officer,
Aneurin Bevan CHC

Statement from Audit and Assurance

The Health Board is required by the Welsh Government to obtain assurance on the Annual Quality Statement (AQS), including from Internal Audit. The overall objective of the audit was to ensure that the AQS is consistent with information reported to the Board and other committees and compliant with the Welsh Health Circular: The Annual Quality Statement 2018/19.
As we tested a limited sample of the content of the AQS, we are not providing a high level of assurance against the full content.

Based on the results of our procedures, for the year ended 31 March 2019, we noted that:

- the sample of information tested is consistent with supporting documentation and sources, in all material aspects.
- the AQS is aligned to the Health Board's Integrated Medium Term Plan, with referencing to each of the required themes of the Health and Care Standards.
- the Welsh Health Circular: The Annual Quality Statement 2018/19 is complied with, where applicable.

We would like to thank members of the Stakeholder Reference Group for their help in preparing this Annual Quality Statement. We know we can always improve what we do, and if you have any comments about what would like to read about in the Annual Quality Statement or any other feedback, please email us on abhb.enquiries@wales.nhs.uk

Appendix 1 Glossary of Terms

ABC Sepsis	Aneurin Bevan Collaborative on Sepsis	NatSSIPs	National Safety Standards for Invasive Procedures
ABCi	Aneurin Bevan Continuous Improvement	MFRA	Multifactorial Risk Assessment
ABUHB	Aneurin Bevan University Health board	MRSA	meticillin-resistant Staphylococcus aureus
A and E	Accident and Emergency	NCN	Neighbourhood Care Network
ACORN	Assessment of Clinical Oral Risks and Needs	NEWS	National Early Warning Score
AKI	Acute Kidney Injury	NICE	National Institute for Health and Care Excellence
AQS	Annual Quality Statement	OOHs	Out of Hours
C.Diff	Clostridium difficile	PCOST	Primary Care Operational Support Team
CEO	Chief Executive Officer	PROMS	Patient Reported Outcome Measure
CCTV	Closed Circuit Television	PREMS	Patient Reported Experience Measure
CHC	Community Health Council	RN	Registered Nurse
CRT	Community Resource Team	SCCC	Specialist Critical Care Centre
DATIX	Incident Reporting Tool	T & O	Trauma and Orthopaedic
DVT	Deep Vein Thrombosis	Third Sector	Voluntary Group and Civil Society
E Coli	*Escherichia coli*	UK	United Kingdom
ED	Emergency Department	UTI	Urinary Tract Infection
GP	General Practitioner	WAST	Welsh Ambulance Services NHS Trust
HAT	Hospital Acquired Thrombosis	WHO	World Health Organisation
HAPU	Health Acquired Pressure Ulcer	WHSSC	Welsh Health Specialised Services Committee
HCAI	Healthcare Associated Infections	WG	Welsh Government
HCSW	Health Care Support Worker	WTE	Whole Time Equivalent
IV	Intra Venous		