PERSON CENTRED

SAFE

TIMELY

EFFECTIVE

EFFICIENT

EQUITABLE

Quality Outcomes Framework

Quarter 4 2023/24

LEADERSHIP

WORKFORCE

CULTURE

INFORMATION

LEARNING, IMPROVEMENT & RESEARCH

WHOLE SYSTEMS APPROACH

Overview

This is a combined report that includes the measures within quality outcomes framework (QOF) and a narrative on the data. This provides the Board/ Committee with an overview of the Health Board's quality and safety metrics and summary of performance. It is aligned to the Ministerial priorities and key challenges, to comply with the Duty of Quality. This also covers the ABUHB quality priorities including the Quality and Safety Pillars, as included in the Quality Strategy and has ensured that the Patient Experience and Involvement Strategy has been embedded throughout the report.

This includes:

- Areas for escalation

- The QOF as aligned to Health and Care Quality Standards

  - Person Centred Care
  - Safe Care
  - Timely Care
  - Effective Care
  - Efficient Care
  - Equitable Care

- Additional information is available in the report to provide assurance against these standards

Priority 1: Person Centred Care

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 1 - Person Centred	Our patients, their families, and carers receive an experience that not only meets but exceeds their expectations	General experience rating of episode of care	Q3 2023.24	87%	Q4 2024	88%	*Improved*	Overall satisfaction score at 88% (benchmark is 85%). Total surveys completed is 594 (previously reported as 570). Paper surveys submitted after month end.
		Number of complaints closed	Q3 2023.24	410	Q4 2024	406	No Change	Slight decrease in number of complaints closed
		Complaints backlog	Q1 2023.24	773	Q4 2024	859	Deteriorated	Across Q3 & Q4 2023/24 the HB have managed to ensure more than half of the complaints received are being completed within the 30-working day target, compared with under 50% across the same quarters in 2022/23. There has been a 16% increase in the number of complaints received by ABUHB in Q4 2023/24. Includes early resolution and managed under PTR
		Compliments – total number of written compliments	Q3 2023.24	114	Q4 2023	132	Improved	Data to be pulled from CIVICA going forward. Themes identified by compliments are: Beyond duty of care, Communication, Understanding.
	Increased patient, public and staff involvement.	Increase in number of responses in Civica	Q3 2023.24	282	Q4 2024	594	Improved	Q4 594 (Q1/2/3 = 749 previously reported as 728. Total 1343 responses. CIVICA is live on all inpatient wards excluding maternity at present. CIVICA is live in 190 areas across the Health Board. Significant increase in Q4 feedback and also training attendance by ward/department teams
	Learning from complaints is implemented	Qualitative feedback use of the learning section in Datix						Measure being refined
		Increase in the number of actions plans completed						Measure being refined

Volunteering – Key Highlights

The Health Board is publishing our Volunteering Annual Report during Volunteer Week 3rd-9th June. The report highlights the benefits of volunteering for those who volunteer, those who are supported and for wider social connections. With over 20 role profiles, people are afforded an opportunity to volunteer in areas of interest and through our Volunteer to Career pathway, an increasing number of volunteers are now gaining skills to enable them to seek meaningful employment.

Some of the key highlights are demonstrated here.

Our volunteers have provided **over 8183** unpaid volunteer hours.	Our Welcomer volunteers at NHHS and YYF have supported over **3651** people since August 2023.	We have **20** spoken languages by **34** volunteers, including **9** Welsh speaking volunteers and **1** BSL volunteer.	WE have **27** Telephone Befrienders supporting **32** patients, mostly on a weekly basis.
We recruited **92** new volunteers in **2023**.	We have launched our **Volunteer to Career** Programme and are the first Health in Wales to do so.	**7** volunteers have gained paid employment through out **Volunteer to Career** programme.	Listening to patients, staff and volunteers, we have created **7 new** volunteers role profiles during 2023.
We have support **5** people to become experts by experience (Mental Health, Gastroenterology and Stroke).	We have provided **49** training sessions for volunteers.	We have provided volunteer and work experience opportunities for **3** people with additional needs.	We held an annual volunteer **celebration event** in June 2023.
We have attended **37** volunteer promotion events across the geographical area.	We now have **130** Hospital Befrienders and End of Life Companions. With our team supporting **321** volunteer inductions during 2023.	We have worked closely with Therapy teams to create **Stroke Peer Support** Volunteers.	We have worked closely with **Cancer Services** and created new volunteer roles including Befrienders, Welcomers and Peer Support.
We have worked closely with the **Alcohol Care Team** and are creating a volunteer led dedicated alcohol support group.	Through our partnership with Cardiff University, over **75 pharmacy students** will have gained patient experience volunteering opportunities.	**52** volunteers have supported the **Ukraine Resettlement** and **Mass Vaccination Centres**.	We have developed **9** personal wellbeing sessions with over **51** volunteers attending.
We have presented our volunteering model at local and **national** events.	**Helpforce Cymru** and **The Bevan Commission** have published a national case study on our Volunteer to Career model.	**Volunteer Long Service:** **26** completed **50 hours** **18** completed **100 hours** **12** completed **200 hours** **7** completed **300 hours** **4** completed **400 hours** **1** completed **500 hours** **1** completed **700 hours** **1** completed **800 hours**	In 2023, the Volunteer Service has won a **Volunteer Award** and have been finalists in **3** other award.

Civica

Top 3 Themes from PCC Survey	
Positive Themes	**Negative Themes**
Compassion (98) supportivethey reassurance empathetic considerate thoughtful compassion reassure kindly supportive angels reassured caring reassuring patience empathy "very patient" kind sympathetic understanding consideration "was patient" compassionate thoughtfulness	**Waiting (27)** "another 5 hours" "for many hours" "after an hour" "for 17 hours" "for 185 hours" "finally" waited waiting ages "after 10 hours" wait cancelled delays eventually "for hours" "for 10 hours" "took too long" "after 245 hours" "took another 5 hours"
Friendliness (75) approachable friendliness warm cheerful friendly pleasant welcoming personable relaxed chatty "open manner"	**Comfort (19)** "not always sleep" "i felt very cold" "ward was cold" "too dark" blaring "no sleep" "kept awake" uncomfortable "the heating" loud "hard to sleep" freezing "room is cold" louder "extra blankets" "room freezing cold"
Emotional and Physical Support (75) "excellent support" helpfulstaff "help and support" "care and support" reassuring helping "put at ease" "great support" helpful reassured assisted supportive supported "put me at ease" helped helpfulpeople "support me" "lots of support" helpfulnice "given excellent support"	**Food & Beverages (17)** "wasnt offered a hot drink" "food this was not" "dont like the food" "any food" "no coffee" "food choice" "better food" "food choices" "or food" "more tea" "food isnt" "any drink" "food not" "choice of food"

Adborth Cleifion: Gwrando a Dysgu

Patient Feedback: Listening and Learning

Bereavement: The Big Conversation

Developing our Bereavement Model is a key priority for the Health Board, the Big Conversation has been the launch of out new approach

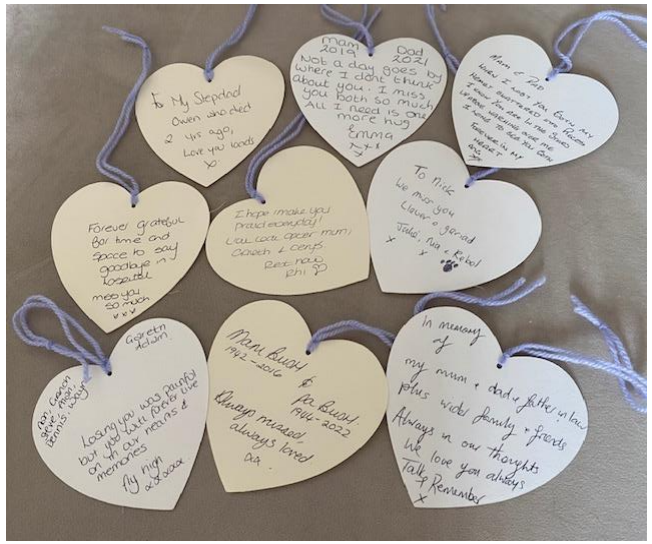
THE BIG CONVERSATION (Bereavement)

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

Morning Programme

9:00am	**Arrival, Registration and Refreshments**
9:25am	**Chair's Welcome** Carol Taplin, Specialist Chaplain, Aneurin Bevan University Health Board
9:30am	**Opening Remarks** Jenny Winslade, Executive Director of Nursing/Executive Lead for End-of-life Care and Bereavement, Aneurin Bevan University Health Board.
9:40am	**Opening Address** Nicola Prygodzicz, Chief Executive Officer, Aneurin Bevan University Health Board
9:50am	**Improving bereavement support in Wales: The new national framework for the delivery of bereavement care and the research which informed it** Dr Emily Harrop, Marie Curie Research Fellow, Cardiff University
10:10am	**Advance and Future Care Planning: Making your wishes known** Dr Clifford Jones, Assistant Medical Director, Aneurin Bevan University Health Board
10:25am	**Living with Loss and Post Traumatic Growth** Rhian Mannings, Chief Executive Officer 2 Wish
10:40am	**The 'Hard to Reach' Myth** Chris Dunn, Chief Executive Officer, Diverse Cymru
10:55am	**Bereavement Support for People Affected by a Death by Suicide** Bethan Bowden, Consultant in Public Health, Aneurin Bevan Gwent Local Public Health Team
11:10am	**Refreshments**
11.30am	**Bereavement Support for People with Sensory Loss** Non Ellis, Equality, Diversity, and Inclusion Specialist, Aneurin Bevan University Health Board
11.45am	**Religion, Spirituality and Pastoral Care** Alan Tyler, Senior Chaplain and Farid Khan, Imam, Aneurin Bevan University Health Board
12:00pm	**The Impact of the New Death Certification Reforms** Dr Jason Shannon, Lead Medical Examiner for Wales
12:15pm	**The Local Vision for Improved Bereavement Services** Tanya Strange, Head of Nursing, Patient Experience and Involvement and Louise Jones, Bereavement Lead Nurse, Aneurin Bevan University Health Board
12:30pm	**Lunch and Networking**

- 20th March 2024
- **170** attendees (public, staff, partners, stakeholders)
- **9** round table discussions
- **51** Messages to loved ones
- Bereavement Collaborative- **50** expressions of interest
- **Evaluation** Report
- **5** borough Big Conversation events in May 2024
- **Peoples feedback** will inform the new Bereavement Model



THE BIG CONVERSATION (Bereavement)

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

Afternoon Programme

Please see Room/Table Numbers in Main Foyer	
1:15pm	**Round Table Conversations - Preparing for loss and bereavement support for:**
• People with **sensory loss and disabilities**	
• People from **Black, Asian and Minority Ethnic** Communities	
• People who have lost a **child or young person**	
• People who have lost someone under **traumatic circumstances** (including suicide)	
• People whose loved ones have died in **hospital/inpatient** setting	
• People who have lost loved ones in the **community**	
• People with identified **religious and spiritual**, and pastoral support at end of life	
• End of life care and bereavement support for people with **cognitive impairment** (including dementia)	
• **Advance and Future Care Planning**: Making your wishes known	
2:15pm	**The Big Conversation - Attendees to return to Main Hall**
2:15pm	**Feedback from all discussion groups to inform the Big Conversation** Chairs: Grant Usmar, CEO Hospice of the Valleys; Carol Taplin, Specialist Chaplain; Tanya Strange, Head of Nursing, Patient Experience and Involvement
3:15pm	**Closing Remarks** John Moss, National Bereavement Framework Programme Manager, NHS Wales Executive
3:30pm	**Event Close**

Bereavement: The Big Conversation Feedback

FEEDBACK: *WHAT DID YOU FIND MOST USEFUL ABOUT TODAY (COMMON THEMES)*

To know I am not alone in my grief	Having honest conversations- ability to **speak freely**	**Power of personal stories (numerous mentions)**
Networking and variation of attendees in conversation groups	**Variety of presentations and round table discussions**	**Learning about the changes of the new Death Reform process**
'Eye opening' informative presentations	**AFCP (numerous mentions)**	**Awareness of what's available**
Really good programme, various contributors	**Hearing about the lived experience of participants (numerous mentions)**	**That change is coming- we need to listen to people's experience**

Learning that there is an obvious **need to talk about bereavement.**

Lack of support can result in **negative grief.**

Sensory loss and bereavement- **opened my mind**.

Round table conversations.

Need to learn so other families don't go through what we did

Knowing **you are not alone**.

Ability to **share experiences.**

Everyone now knows that **change is needed.**

Presentations highlighted the fact that **grief is widespread**

Emotional day but very worthwhile.

Information available.

That **grief can affect all ages.**

" Today, my voice was heard".

FEEDBACK: DO YOU THINK WE NEED TO HAVE MORE CONVERSATIONS ABOUT BEREAVEMENT

100% of feedback received supported the need for more conversations	"Yes. We also need more education across the sector to help bereaved people."
"Absolutely more conversations"	"Yes, specifically around pregnancy/baby loss."
"Yes, and allow people to know what's available"	"Absolutely! Bereavement still feels like a taboo topic despite everyone experiencing it."
"We need more Big Conversations as it raises important issues from all the public including diverse groups"	"Yes. Need a broader range of people's experiences with bereavement services."
"Yes, death is feared and not talked about enough"	"Yes, the more the better."
"Yes- could have a rolling conference focussing on different themes?"	"Absolutely necessary."
"Yes, if points raised are listened to and acted upon and not just a tick box."	"Yes, sharing people's stories to implement change is vital."
"Definitely- more conversations should be encouraged to normalise death and dying"	"Yes, this is just the start."
	"Yes, so people know they are not alone."
	"Need to have these discussions across Wales!"

FEEDBACK: STAYING CONNECTED AND BEREAVEMENT COLLABORATION

We asked: *Would you be interested in helping us **shape** the bereavement model?*

58 people provided written feedback. Of those, **50** people said they wanted to work with us to develop the new bereavement model.

Including the people already engaged, and those who have asked to be involved through social media, this means we will have around **80 people** engaged through our **bereavement collaborative**.

It is likely that **more people** will come forward as we engage in Big Conversations across all 5 boroughs.

COMMENTS AND SUGGESTIONS

*"Maybe, once someone loses a loved one in hospital, let staff take them into another room and **talk to them**, and explain what services are available and maybe tell them you will be in touch with them to arrange a meeting with a bereavement councillor within the Health Board to see how the family are doing"?*

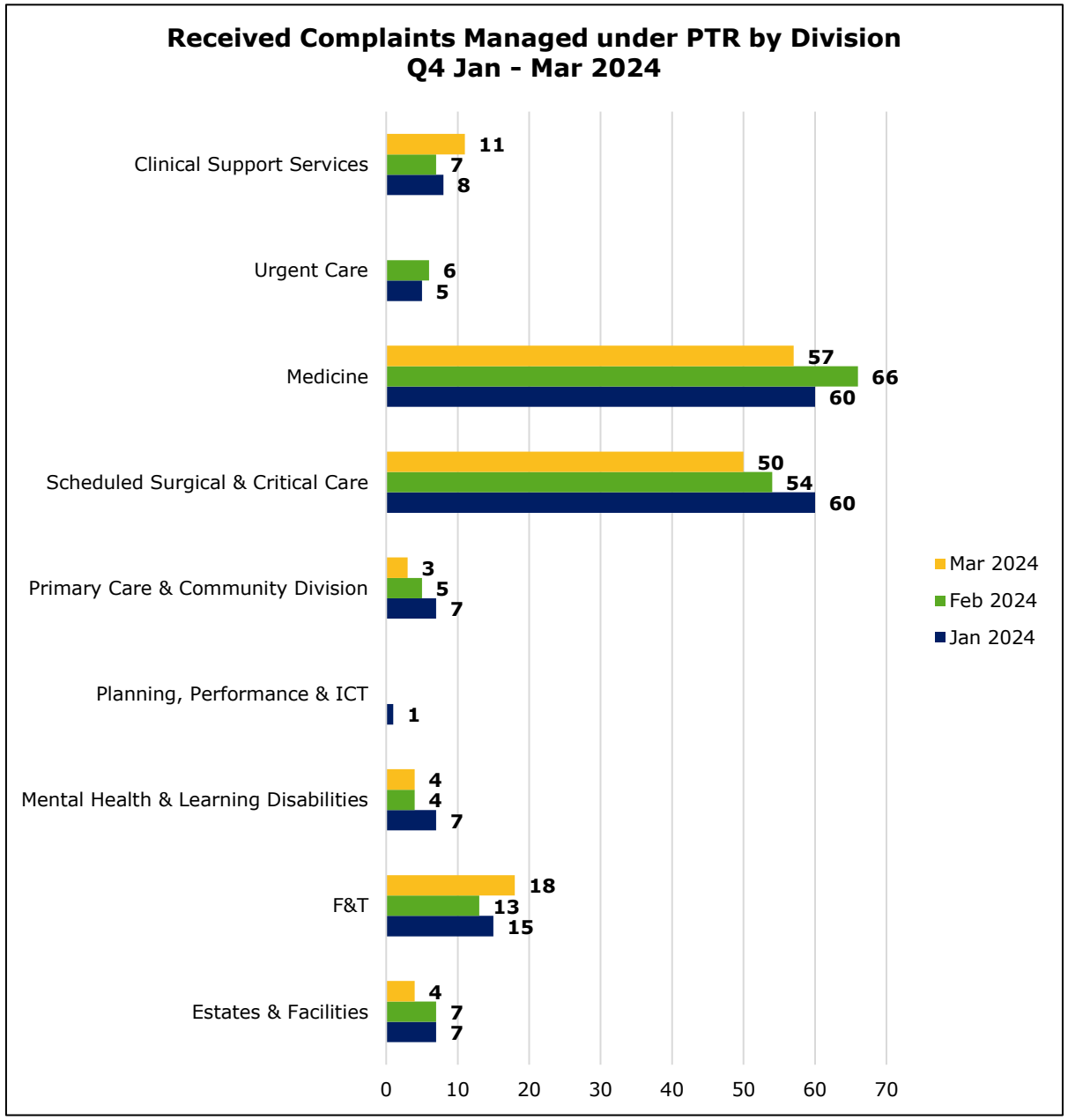
*"**Pregnancy loss under 20 weeks**' gestation needs to be made as important as those pregnancies over 20 weeks. Maternity has protected bed status and 1:1 care. Gynaecology staff deal with baby loss daily, but no protected beds. All baby loss matters, to support our women, we need to be supported to protect them and give the best care possible".*

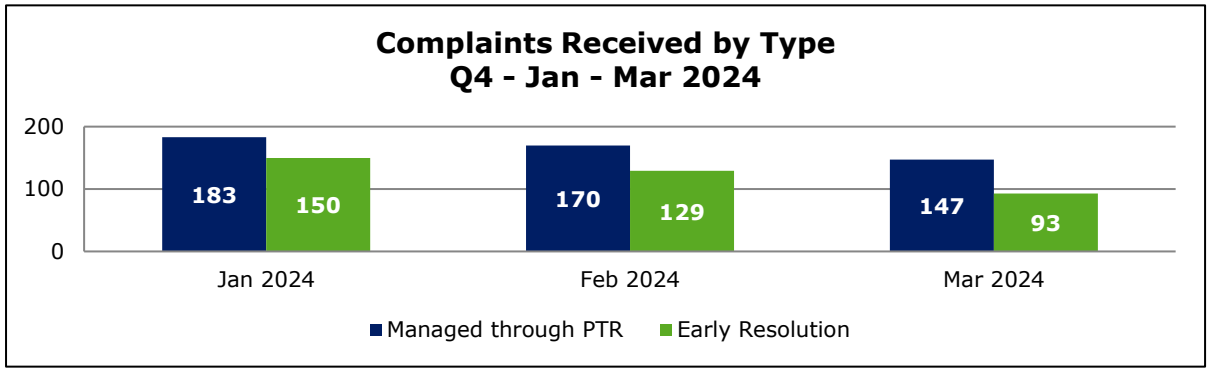
*"We need to be confident we can meet **strict funeral timelines** depending on culture".*

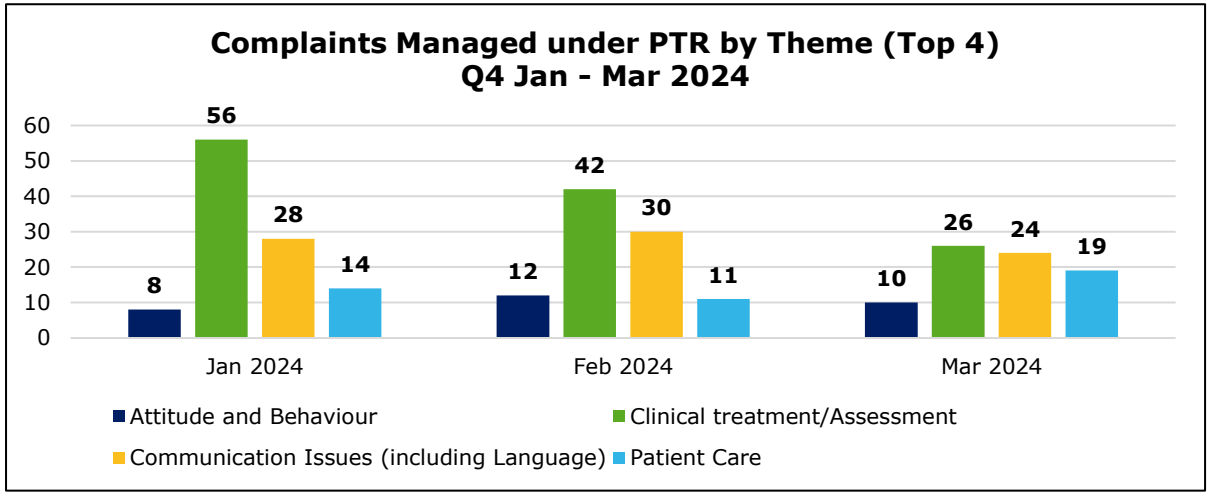
*"Look at allocating **'Bereavement Champions"** like Dementia Champions across the Health Board to raise awareness and improve education".*

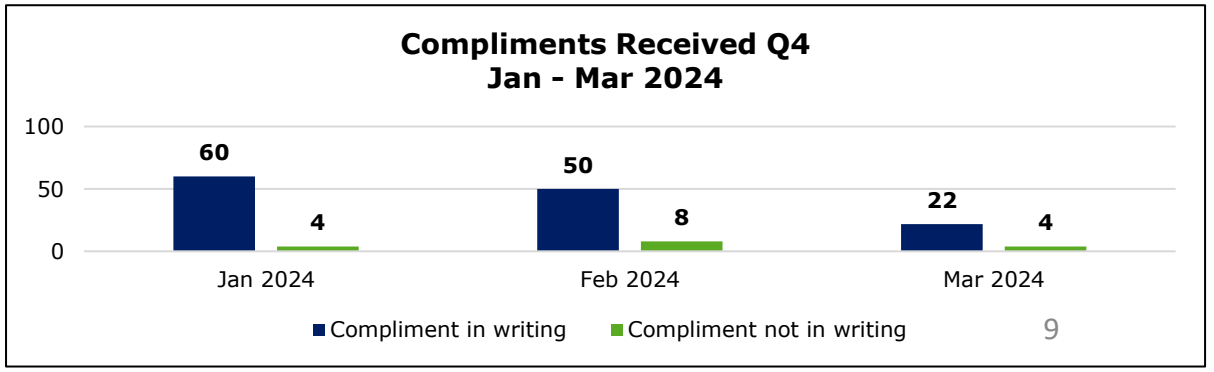
*"Could the model follow a model similar to the **6 principles of trauma** informed practice as this follows a lot of what has been missing".*

Complaints and Compliments

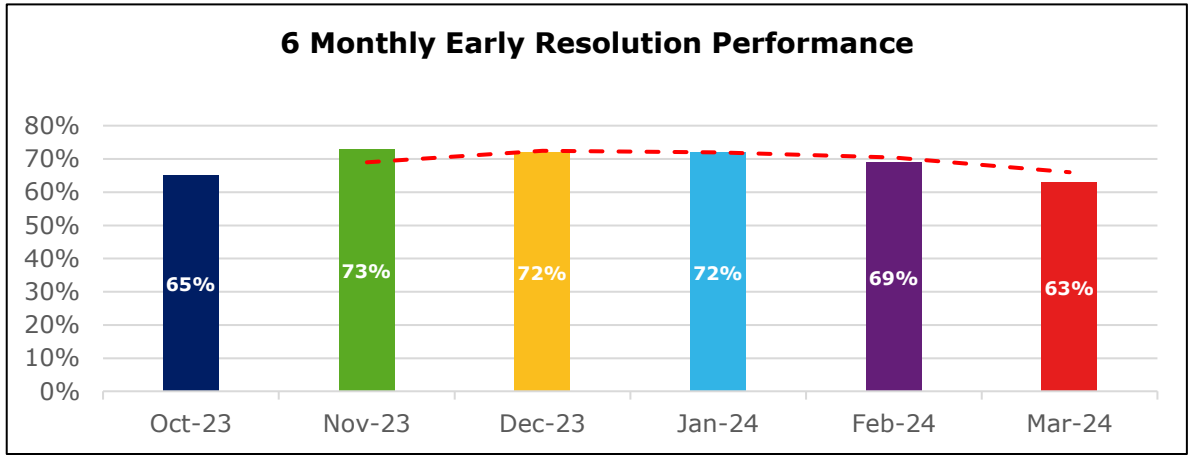


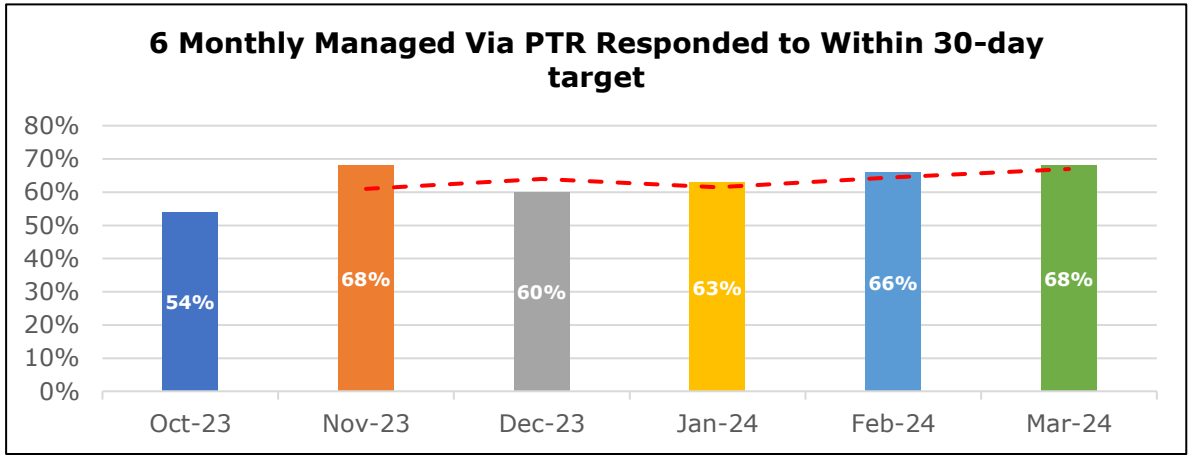






Complaints and Compliments

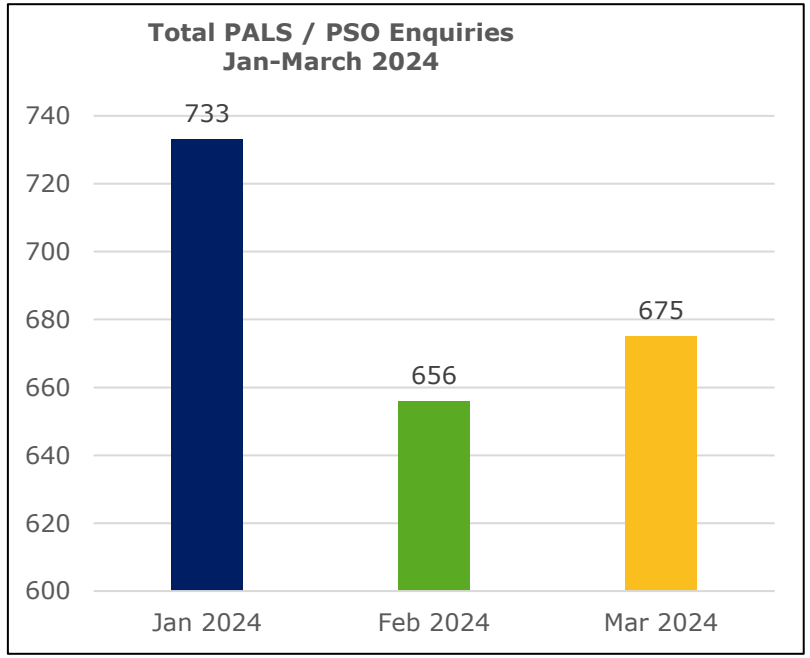


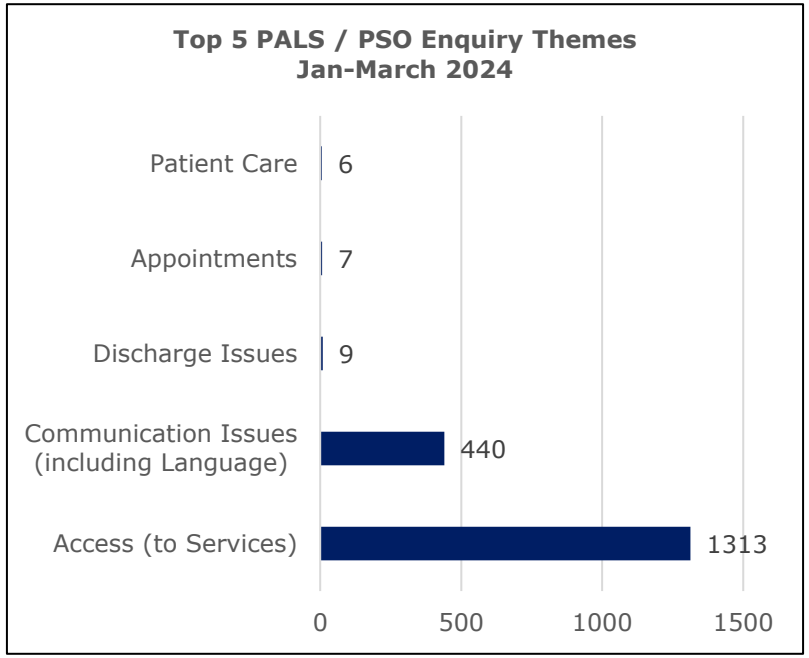


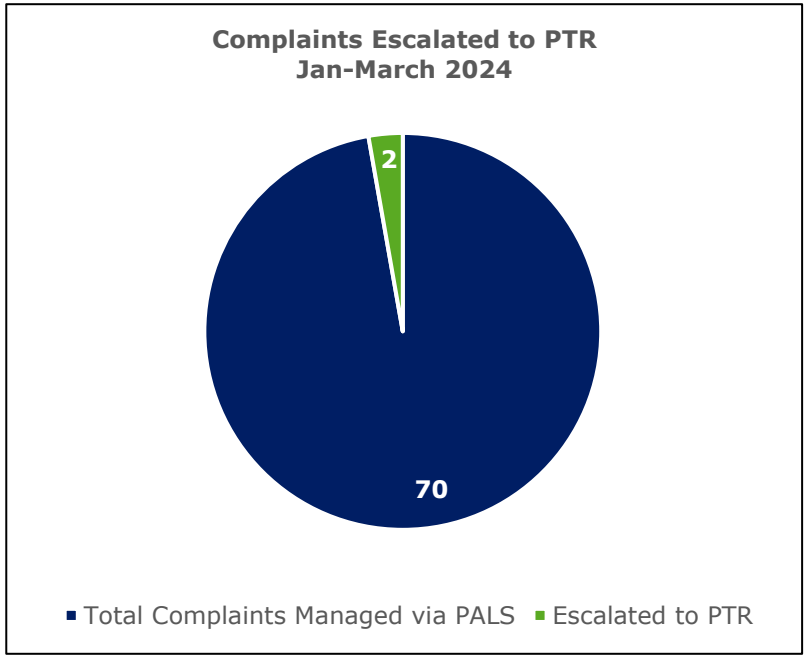
The target of 75% of PTR issues managed within 30 days indicates a positive improvement month on month for the upcoming financial year. In some areas compliance is already exceeding the proposed trajectory.

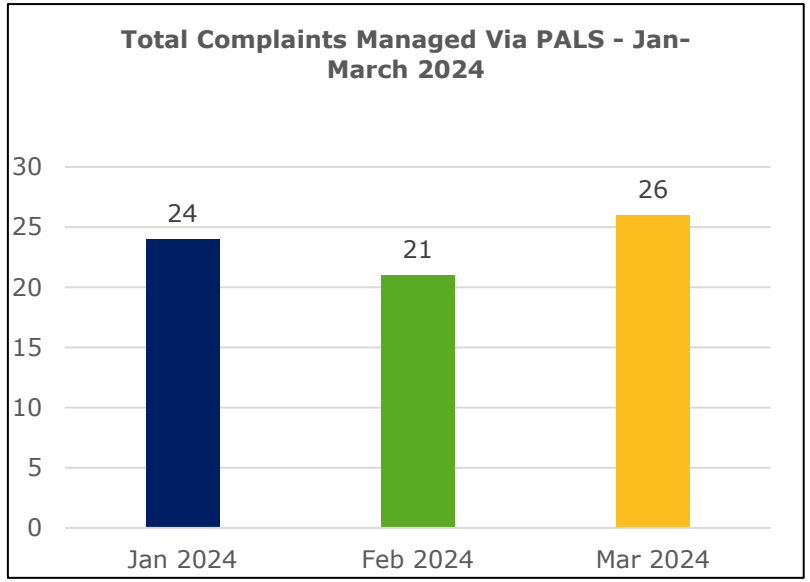
Trajectory for Improvement by Division/ Directorate	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
01 Family & Therapy Services	60%	63%	65%	68%	72%	75%
02 Scheduled Surgical & Critical Care	60%	63%	65%	68%	72%	75%
03 Primary Care & Community	45%	50%	54%	62%	69%	75%
04 Mental Health & Learning Disabilities	45%	50%	54%	62%	69%	75%
05 Urgent Care	55%	60%	65%	68%	71%	75%
06 Medicine	45%	50%	54%	62%	69%	75%
07 Estates & Facilities	90%	90%	90%	75%	75%	75%
08 Complex Care	75%	75%	75%	75%	75%	75%
09 Other	75%	75%	75%	75%	75%	75%
10 Clinical Support Services	60%	63%	65%	68%	75%	75%
Health Board	55%	59%	65%	68%	72%	75%

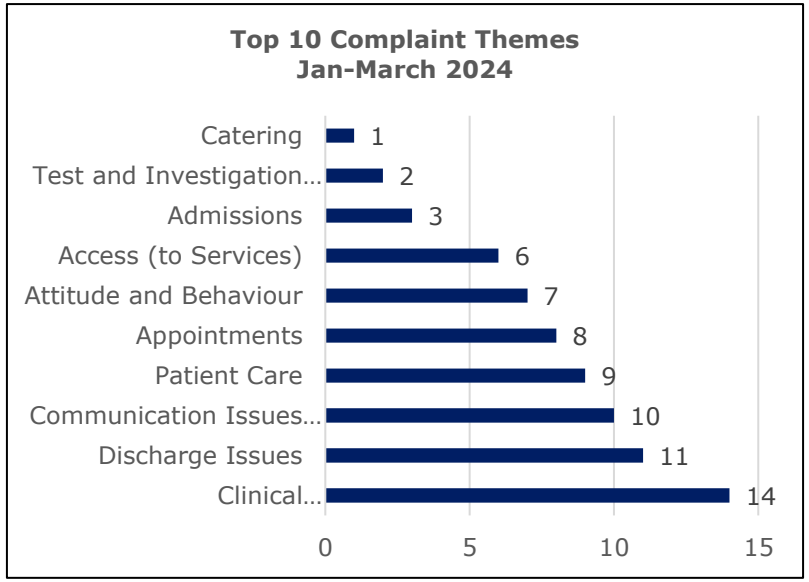
Patient Advice and Liaison Service (PALS)

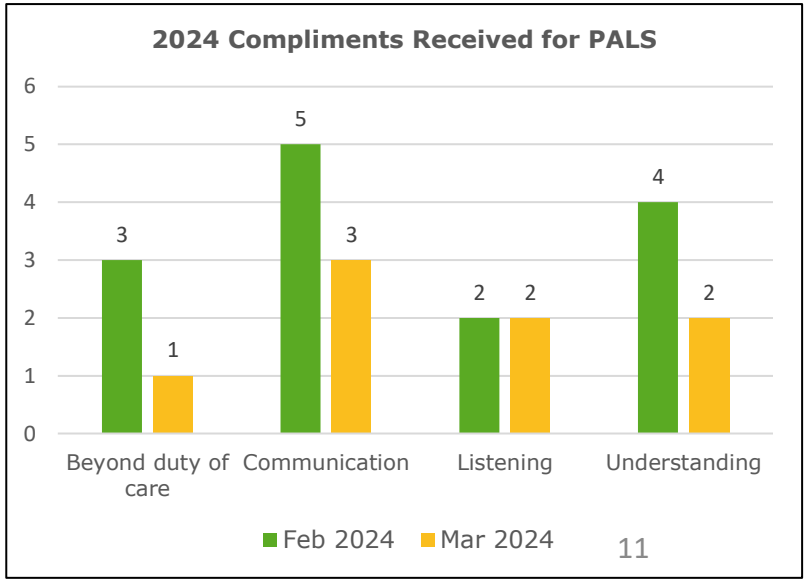












Listening and Learning Framework

- A framework has been developed and approved which demonstrates how learning will be identified, triangulated, disseminated, and implemented into practice, to facilitate and embed a culture of appreciative enquiry, continuous improvement in health care services.

- This framework will compliment and build on divisional and directorate assurance arrangements by adding a strategic approach to support the Health Board to learn lessons from a range of internal and external sources. This will form part of our learning repository, which will allow us to collate, store and utilise this learning, enabling us to share knowledge, shape change, embrace innovation, implement quality improvement and create opportunities to develop excellence in practice.

- The framework provides roles and responsibilities and details our systemic approach to learning, ensuring learning is continually captured within an accessible Learning Repository and builds an Organisational Memory.

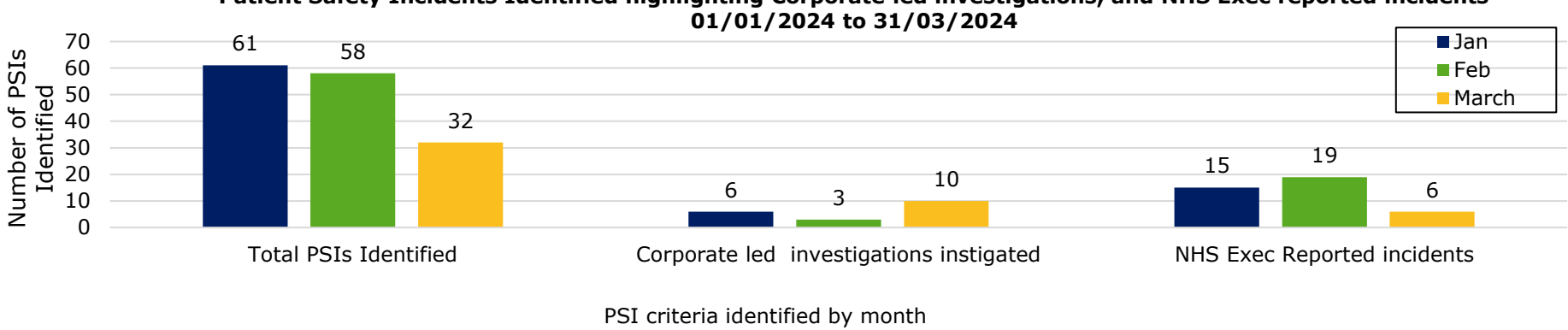
- Next steps will involve presenting at the Learning Forum to produce an implementation plan.

Priority 2: Safe Care

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 2 – Safe Care	Fewer repetitive incidents in the priority areas and across the Health Board	Reduction in the number of SI's, by harm category	Q3 2023.24	68	Q4 2024	75	Increased	As of 31st March 2024, the PSI team were managing 75 live Serious Incident investigations (moderate/ severe), with 30 in meeting stages, and so an upward trend in the overall numbers of Corporate PSI investigations being held, but a decrease in the number still in the meeting stage.
		Reduction in the number of National Reportable Incidents	Q3 2023.24	45	Q4 2024	40	Decreased	The Health Board reported 15 NRIs in January, 19 during February, with a significant decrease to 6 during March 2024.
		Reduction in the number of Never Events	Q3 2023.24	4	Q4 2024	0	Decreased	0 Never Events reported during January, February and March 2024.
		Improvement in the time to respond and close incidents (average time to closure – all incidents)	Q3 2023.24	83 days	Q4 2024	72 days	Decreased	There has been decreasing trend for the time taken to close incidents, and an increase in the number of incidents reported in line with an increased use of the DATIX system.
		Decrease in the number of reportable IPAC incidents	Q3 2023.24	29/week	Q4 2024	See table	Increased	We would anticipate an upward trend in the winter due to the prevalence of respiratory infections, with RGH and NHH having the most outbreaks due to the layout of the ward environments, the table shows specific infection rates
		The number of incidents with no harm themes identified						Refining measure
		Increase in the compliance of Health and Safety Statutory and Mandatory Training	Q3 2023.24	86%	Q4 2024	87%	Improved	There has been an increase in all the health and safety areas compared with the previous report. H&S 87%, fire safety 83%, manual handling 55% and V&A 85%.

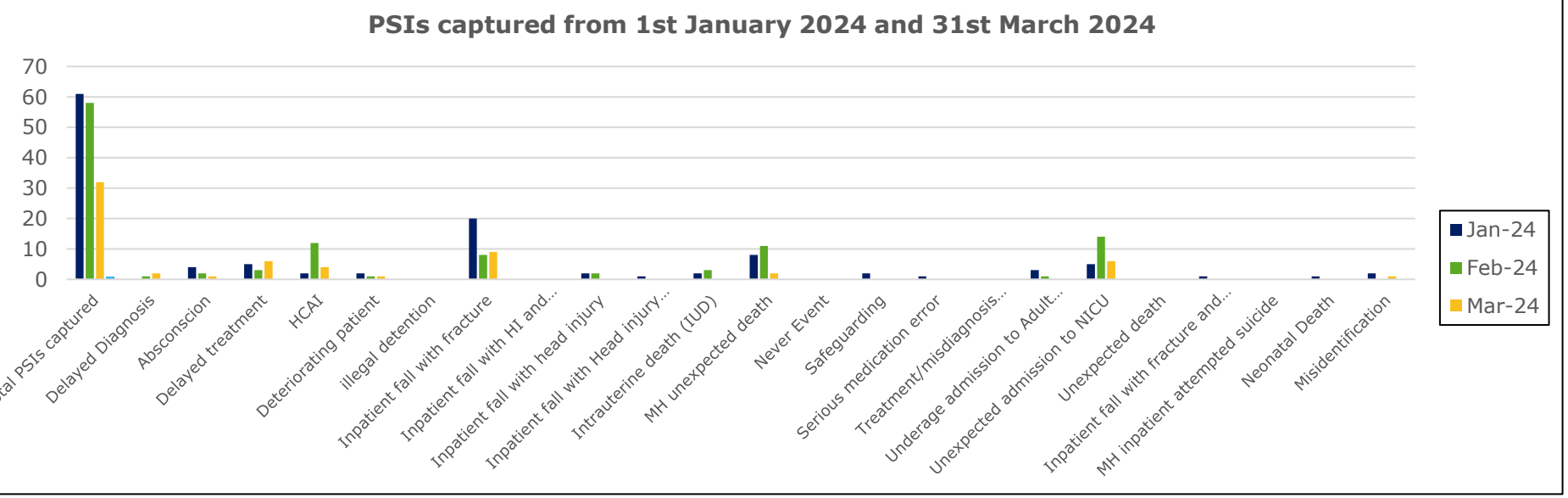
Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 2 – Safe Care	Improved clinical outcomes	Decrease in the time to complete safety alerts	Q3 2023.24	4 days	Q4 2024	4 days	No Change	The average time to report has stabilised however the data is highly variable with regular peaks above four days.
		Severity of harm following a fall in hospital (moderate and above)	Q3 2023.24	44	Q4 2024	49	Increased	Q1 79, Q2 42 Q2 – Q4 number of falls with moderate harm or above remains consistent.
		Decrease in the number of Falls by 1,000 occupied IP Bed days	Q3 2023.24	7.24	Q4 2024	7.35	Increased	Q1 6.95, Q2 7.43 – falls data remains broadly consistent
		Decrease in the number of falls treated in ED which have had a previous admission - reattendance	No Data	No Data			No Data	Measure to be refined
		Improved RAMI Score	Q3 2023.24	114	Q4 2024	110	Decreased	There has been a decrease in RAMI from Q3 – Q4. The Health Board is currently outperforming the Welsh Peer Group Average of 113.46. Positioned as 3rd best RAMI out of Welsh peer group.
		Improved Crude mortality by hospital	Q3 2023.24	4.3	Q4 2024	5.07	Increased	Increase in Deaths per 1000 bed days of 0.77 between Q2 and Q4 of 2023/24. A process is being defined to review deaths, looking at coding and deep dive SOP for reviewing notes.
		Decrease in the number of HA pressure ulcers by grade	Q3 2023.24	25%	Q4 2024	20%	Decreased	Reduce HAPU incidences by 25% of baseline within 4 months from the commencement of the faculty. Reduction of 5% over the quarter
		Decrease in the number of HA pressure ulcers	Q3 2023.24	23/week	Q4 2024	23 /week	Unchanged	Work underway with improvement collaborative which has shown a decrease in reported PU of 2,3,4 grade 1 remain static.
		Decrease in the severity of medication incidents	Q3 2023.24	469	Q4 2024	448	Severe category consistent	Total incidents: Q1 304, Q2 389, Q3 469, Q4 448 Moderate–severe: Q1 28, Q2 67, Q3 85, Q4 69 Catastrophic: 0 reported Q1-Q4
		Decrease in the number of incidents under - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)	Q3 2023.24	21	Q4 2024	19	Decreased	Q3 -21 incidents reported to the HSE in accordance with RIDDOR, 61.9% of these cases were reported within the legal timeframes within the legislation. Q4- 19 incidents reported within 73.6%. This is an increase in compliance with legal timeframe.
		Reviewed Cardiac Arrest calls by 10,000 bed days	No Data	No Data			No Data	Measure to be refined
		Decrease in Preventable Hospital Acquired Thrombosis (HAT) incidents	Q2 2023.24	0	Q3 2023.24	0	Maintained	Non preventable HAT incidents – Q1 72, Q2 70, Q3 – 62. Data is consistent. There is a 3–6-month delay on data and requires case notes review.
		Increase in the number of PREM Audit and actions						Measure to be refined.

Patient Safety Incidents



A total of 210 Patient Safety Incidents were identified during January, February and March 2024. 61, 58 and 32 respectively. MH Unexpected Death, Unexpected Admission to NICU and Inpatient fall with # were the top themes.

There were 30 EWNs reported to WG during this period, 13 in January 12 in February and 5 in March. Themes included varied safeguarding issues, absconsions, misidentification of patients and PRUDiCs.



Themes

Ophthalmology Delays

Ophthalmology report incidents of glaucoma patients lost or delayed to follow up. Each case assessed for harm. Currently one completed PSI, one in progress and a further 7 awaiting review. Currently, 5437 glaucoma patients awaiting a follow-up appointment. Of which 3882 are now past their target date. Diagnostic hub and risk stratification tool are now in place. Further capacity for virtual reviews is being sought. Ongoing discussion with primary care re contract reform due to commence in April and may impact ODTC capacity.

Missed Cancers

The Health Board continues to receive incidents of missed cancer diagnosis via a number of avenues, including patients lost to follow-up appointments, or missed on radiological reporting. There have been three new PSIs in this quarter.

PSI Team

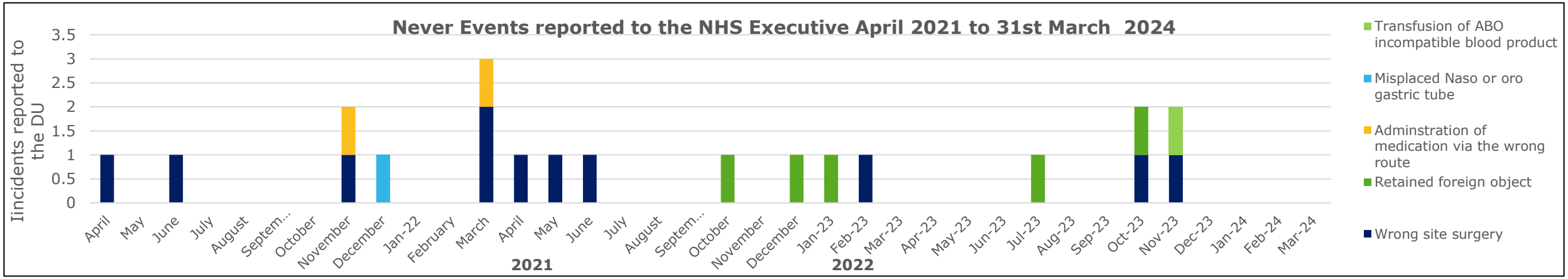
The PSI team have developed a new Patient Safety Incident Report template with guidance notes, drawing on best practice, human factors methodology/ tools and from feedback received from staff, patients, families and HM Coroner. This is currently out for consultation and feedback from key Health Board stakeholders.

Review of Patient Safety Incident Process

Issue	Cause	Remedial Action	Who	When
SI process currently sub-optimal to meet needs of organisation.	Historic process no longer fit for purpose Varying processes across Corporate and Divisions Lack of organisational learning shared	Presentation of all Serious incidents to weekly Executive Huddle for decision regarding level of investigation.	Head of Putting Things Right	Ongoing
		Weekly pre- Executive Huddle meeting to form a decision panel.	Deputy Director of Nursing	Complete
		Ongoing meetings with EDoN and Corporate PSI Team to identify barriers to effectiveness	Director of Nursing/ PSI team	Ongoing
		Divisional engagement and 1-2-1's undertaken. Outcomes to be communicated.	Assistant Director of Nursing	Complete January 2024
		QPSOG is being reconfigured in line with the Learning Framework.	Assistant Director of Nursing/Assistant Director for Quality and Patient Safety	Ongoing

Never Events

- 0 Never Events reported during January, February and March 2024.
- The PSI team are currently engaging with the NHS England Never Events consultation in conjunction with NHS Wales colleagues.



Never Event Workstreams	Improvement Work
2 NE SI's closed in period	Key safety themes identified and prioritised as a key area of improvement focus. Patient Safety Incidents Team supporting ongoing Never Event investigation using a systems approach and methodology (fishbone diagrams) to ensure high quality reviews.
	There will be changes to the All-Wales Transfusion Policy to ensure a standardised approach to the checking procedure across the wards for blood components and products. This will include the process for checking barrier-nursed patients.
	'Back to Basics' programme of training and education for Theatre staff (Scrub, Anaesthetic and Recovery staff) has been commenced. Run on a monthly basis since January 2024, each month focuses on a key topic such as swab counting, standardisation of practice, diathermy practice, and safe handling of medication in theatre for example. This has been incredibly successful and now is being scaled and spread to other areas such as Cardiac Catheter Lab (GUH) and Endoscopy(RGH) where topics can be made bespoke to staff training needs.
	Standardisation of the World Health Organisation (WHO) Safety Checklist is being currently reviewed across Theatres.
	Tackling Safer Culture sessions have been rolled out, the QPS Scheduled Care Team, focusing on 'Pause for the Gauze' locally in advance of the national roll out of NatSIPPs 2. This has been extended across all sites.
	Theatre Safety Bulletins have been developed to improve overall theatre engagement across Theatre Teams. Bulletins contain information on ongoing Theatre Safety Improvement Work and any training updates or information around incidents in theatre. Each Theatre department produces their own Bulletin, and these are shared with other Theatre areas.
	QPS/Theatres have been working alongside the Communications Team to develop an Intranet Page to raise the profile of the Operating Department Practitioner (ODP) role and Theatre Nurse role.

Wider Learning on Incidents

Issue	Cause	Remedial Action	Who	When
There has been an increased awareness and education around systems thinking and Human factors has been highlighted in ongoing Patient Safety Incident investigations to move away from linear Root Cause Analysis (RCA) methodologies and towards a systems-based lens. This will benefit clinical teams, investigating officers and support QPS in patient safety priorities.	Apart from the current provision of 'Introduction to Human Factors', there is currently no formal Human Factors training available in NHS Wales or ABUHB.	The Health Board to scope the potential for formal training provision from external providers as per below; • Creating Patient Safety eLearning | CHFG - Clinical Human Factors Group • Health Services Safety Investigations Body - Education Prospectus (NHS) (turtl.co) • Training Courses | CIEHF (ergonomics.org.uk)	Head of PSI	30 June 2024
PSI documents no longer align with recording actions on RL Datix	Updating of PSI Policy and move over to RL Datix.	Update and circulate for consultation new Report template and Guidance. Amend as per comments. Launch April 2024.	PSI Manager	22 April 2024

Infection Prevention & Control

All Wales comparison – WG Goals

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	38.55	1.52	20.29	59.35	22.66	4.23
Betsi Cadwaladr UHB	41.7	1.16	24.99	79.63	22.67	4.65
Cardiff and Vale UHB	22.35	2.57	28.88	68.24	23.74	3.56
Cwm Taf Morgannwg UHB	28.38	2.03	29.05	85.13	26.57	4.73
Hywel Dda UHB	47.26	2.6	25.97	100.49	28.05	7.53
Powys THB	18.67	0	0.75	1.49	0	0
Swansea Bay UHB	65.2	1.83	34.95	67.02	24.51	5.22
Velindre NHST						
Wales	38.89	1.82	25.61	72.61	23.5	4.63

< than same period last FY
= same period last FY
> than same period last FY

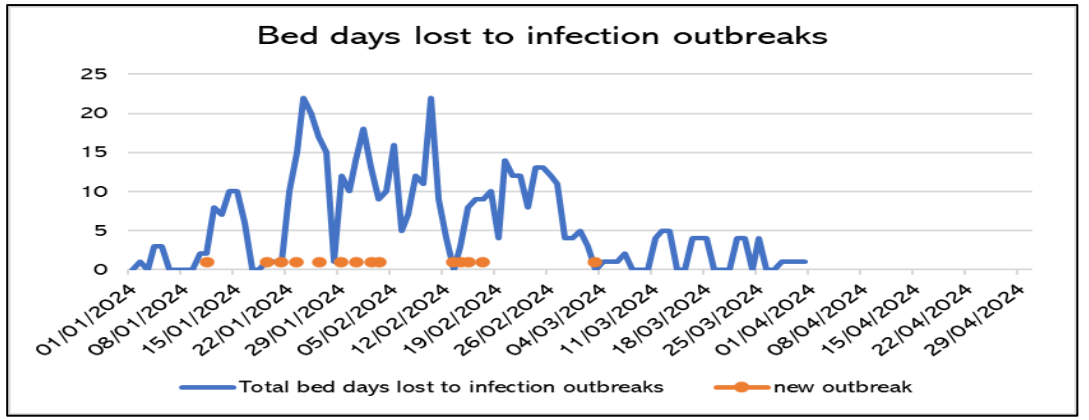
Issue	Cause	Remedial Action	Who	When
3 wards closed at Nevill Hall due to increase of C difficile infection 4/3, 3/1 & 3/4	• Antibiotics prescribed without Microbiology advice • Antibiotics prescribed out of guidance • Failing to withhold PPI while on antibiotics • Isolation • Lapse with mattress checking • Cleaning and ownership of shared equipment • Soiled commode • Gaps with cleaning schedules due to low staffing establishment • Low compliance with hand hygiene	• Antibiotic audits fedback to medical teams • Geno sequencing indicates no onward hospital transmission • Staff reminded to isolate patients when symptoms commence if suspecting infection • Staff reminded to check mattresses at least weekly. Ensure shared equipment is cleaned/wiped down between use. Use "I am Clean" stickers • Decant HPV clean implemented • Visit ward with hand decontamination unit	Antibiotic Pharmacist Ward Manager/ Senior Nurse Infection Prevention	Completed
Increase in gram negatives blood cultures in comparison to previous financial year. One area (community ward) identified 2 cases of Klebsiella associated with urinary catheter antimicrobial sensitives different strain Below all Wales rate for all areas of measurement.	• Majority of cases identified on admission • Increased antimicrobial resistance • Poor documentation compliance with device management • Associated with secondary respiratory	• RCA meeting for all BSI associated with urinary catheter and line infection • Promotion of ANTT • Promotion of procedure packs for blood culture collection and insertion of medical devices • Monitoring of medical device care bundles via AMAT	Antibiotic pharmacist Ward Manager/Senior Nurse Infection Prevention	Ongoing

Infection Prevention & Control

An increase of diarrhoea & vomiting outbreaks coupled with Covid and Influenza circulating resulted in **528** bed days lost due to infections. Three wards at Nevill Hall experienced lost beds due to an increase of C difficile infection. Beds closed to allow deep clean to take place.

Impact of prolonged bed closures managed promptly by: -

- ✓ Risk assessment of patient movement
- ✓ Ensuring patients with same illness cohorted
- ✓ Compliance with fundamental infection prevention measures
- ✓ Correct use of appropriate PPE
- ✓ Public Comms to restrict visiting



Issue	Cause	Remedial Action	Who	When
Suspected Pertussis (whooping cough)	Index case in ED for 12 hours on 22nd – 23rd January 2024	• Contact tracing exercise undertaken to identify patients exposed for at least one hour • Warn & Inform letter sent to 51 parent's and GP	Infection Prevention	Completed 09/02/24
Suspected Pertussis (whooping cough NHH & GUH	Index case presented at GP out of hours on 11th Feb & 12th Feb, transferred to GUH on 12th Feb	• 2 patient contacts – checked for vaccination status • Staff contacts wearing PPE		
Shingles exposure	Patient with confirmed shingles on care of the elderly community ward	• Contact tracing exercise undertaken to identify staff and patient immune status	Infection Prevention	Completed 25/01/24
4 wards closed due to Covid outbreak 11 wards closed due to D&V outbreaks 1 ward closed due to influenza	• Lapse with PPE – staff, visitors & patients • Sub standard cleaning • Staff knowledge of IP measures • Visitors attended with known symptoms • Additional capacity & boarding	• Encouraged correct use of appropriate PPE • Enhance cleaning and recording • Bespoke ward based practical training • Restricted access posters displayed at ward entrance • Comms circulated for visiting	Infection Prevention Ward Manager/ Senior Nurse	At time of outbreak
Patient with healthcare associated invasive group A strep	• Possible staff member working with symptoms of sore throat	• Staff and patient contacts risk assessed for signs of infection- sore throat, skin soft tissue infection or concerns about infection at any site • Staff member visited GP for treatment • 4 patient contacts received prophylaxis antibiotics • Ward and inform letters sent to patient contacts	Infection Prevention Ward Manager Senior Nurse	Completed February 2024
Invasive group A strep identified on admission	• Patient admitted with worsening skin rash for 2 days prior to admission. Considered vasculitic rash secondary to bacteraemia.	• Patient commenced antibiotic treatment • Patient isolated • No patient or staff contacts	Infection Prevention	March 2024
Measles exposure within GP OOH and GUH resulting in three further cases identified measles positive.	• Patient not isolated on presentation to the department	• Contact tracing of patients and staff (71) • Incident Management Team held via Public Health • Under 6 month children offered HNIG • Warn and inform letters sent • Increased comms • Review MMR status • Promote mask fit testing	Incident Management Team	March 2024

Measles Outbreak Update

9 confirmed cases of which 7 onward transmission from exposure in waiting area all unvaccinated
Contact tracing a total of 213 children, MMR history and direct exposure reviewed resulting in:-

- 2 clinics for under 6 months resulting in 15 babies receiving HNIG, everyone received warn and inform letters, and exclusion advice dependant on MMR history advocated, medical alerts placed on children for the incubation and infectious period
- 8 staff members medically excluded

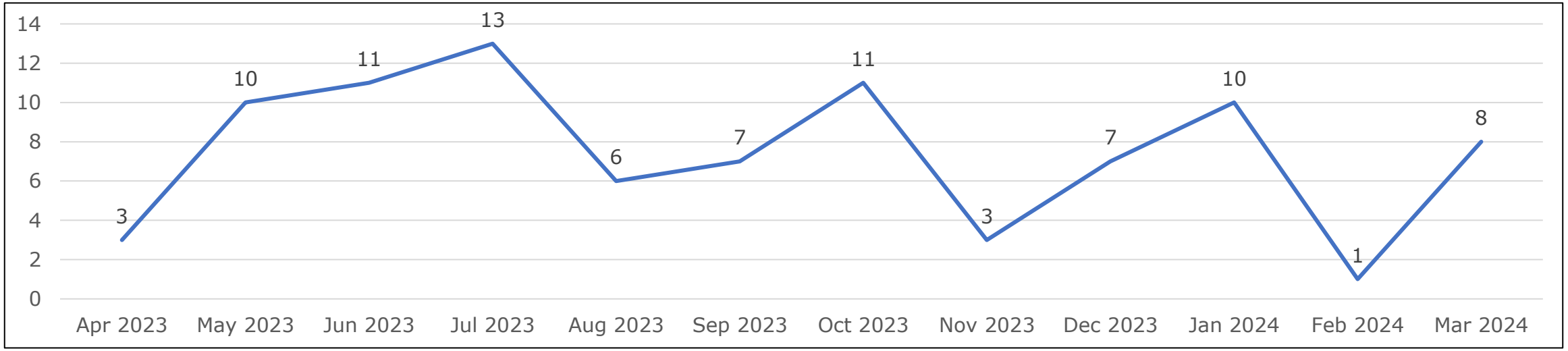
Actions:-

- Revisited patient pathways, screening questions amended, hub relocated outside ED, enhanced cleaning, declutter of environment, air changes checked, promotion of mask fit testing and vaccination
- Primary care reviewed action card to formalise the process developed re the management for:-
  - Identified contacts, staff working in practice, and unvaccinated patients

Health, Safety & Security

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During the period Jan 2024 to the end of March 2024 the Health Board have reported **19 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). This is the lowest reported quarter in 23/24



67.7% of these cases were reported within the legal timeframes within the legislation.

Health, Safety & Security – Statutory & Mandatory Training

At end of March 2024 training compliance for the Health Board was reported as:

Health & Safety	87%
Violence & Aggression	85%
Manual Handling	55%

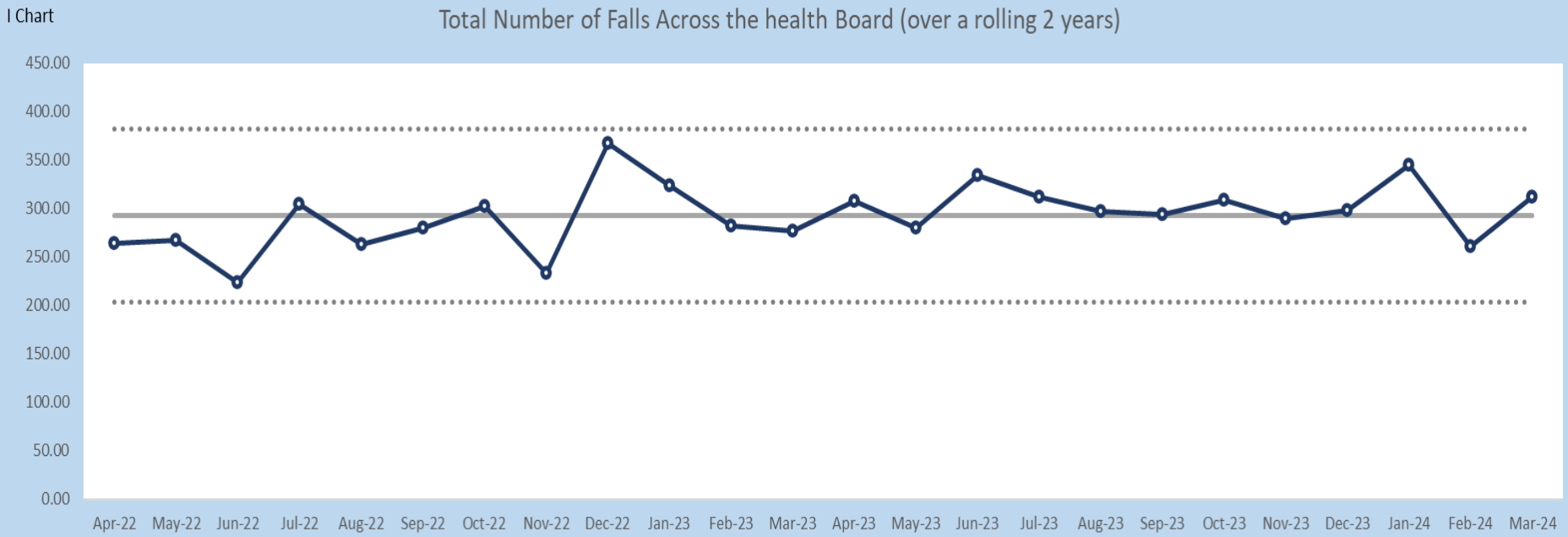
There has been **no change** in the compliance with Violence & Aggression compared with the previous report, however, the compliance with Health & Safety, Fire Safety and Manual Handling have all **increased by 1%**.

Health, Safety & Security – Improvement Plan 2023/24

Seven areas for focus have been identified for improvement in 2023/24. These are:

1) Manual handling training compliance
2) Compliance with the legal timeframes of reporting outlined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013
3) Lack of proactive health and safety monitoring plan
4) The quality and standard of health and safety risk assessments
5) Compliance with the review of fire risk assessments
6) Adequacy of fire alarm systems
7) Compliance with the management of fire barriers (compartmentation)

Total Number of Inpatient Falls



April 2024 - Context

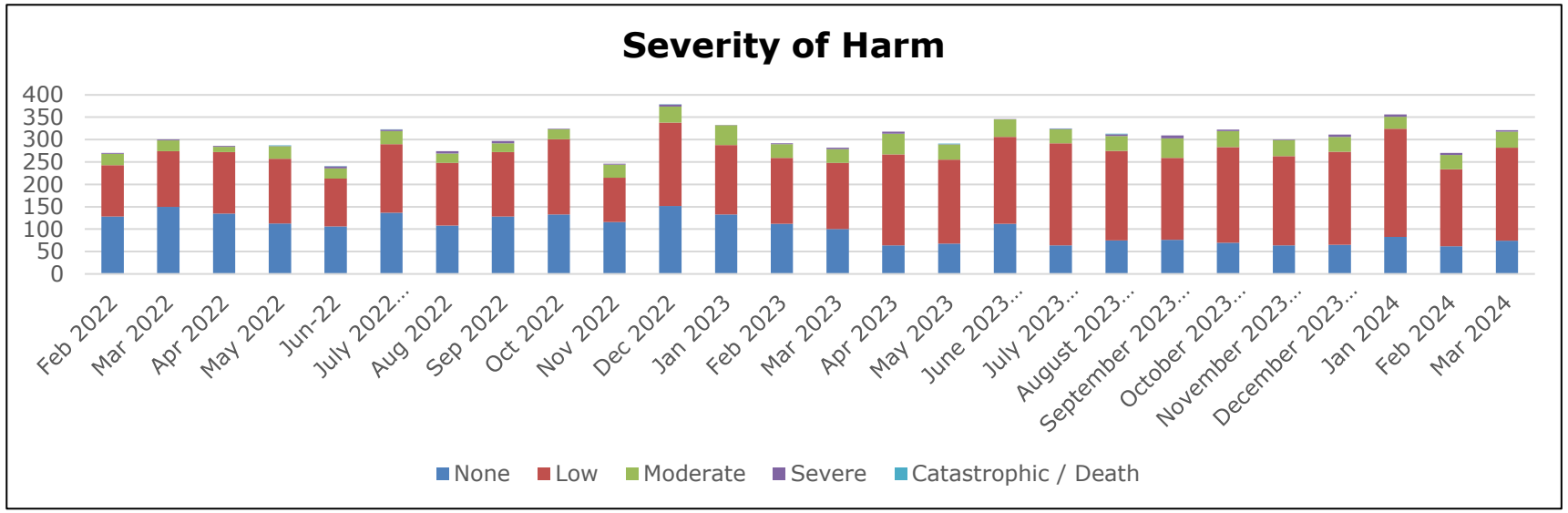
The data used in this chart has been retrieved from RLDatix.

The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period February 2022-24.

With the information available for Q4 2023-24, 44 patients have experienced more than 2 falls with an average of 3.6 per patient. Further work is being undertaken to sub categorise the falls incidents aligned to RLDatix definitions to further enhance the data collection information.

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	• For the given period of analysis, the mean average fall of fall incidents is 290. • Following the period August –December 2023 in which the numbers of falls incidents remained on a steady trajectory along the centreline January 2024, saw a rise to a value more closely aligned to the upper control limit. A subsequent decrease in incidents has been seen in February 2024.	January 2024 saw the second highest value of reported incidents for the period of analysis whilst February 2024 represents the lowest value for reported incidents since November 2022.

Inpatient Falls Data by Severity of Harm



April 2024 - Context

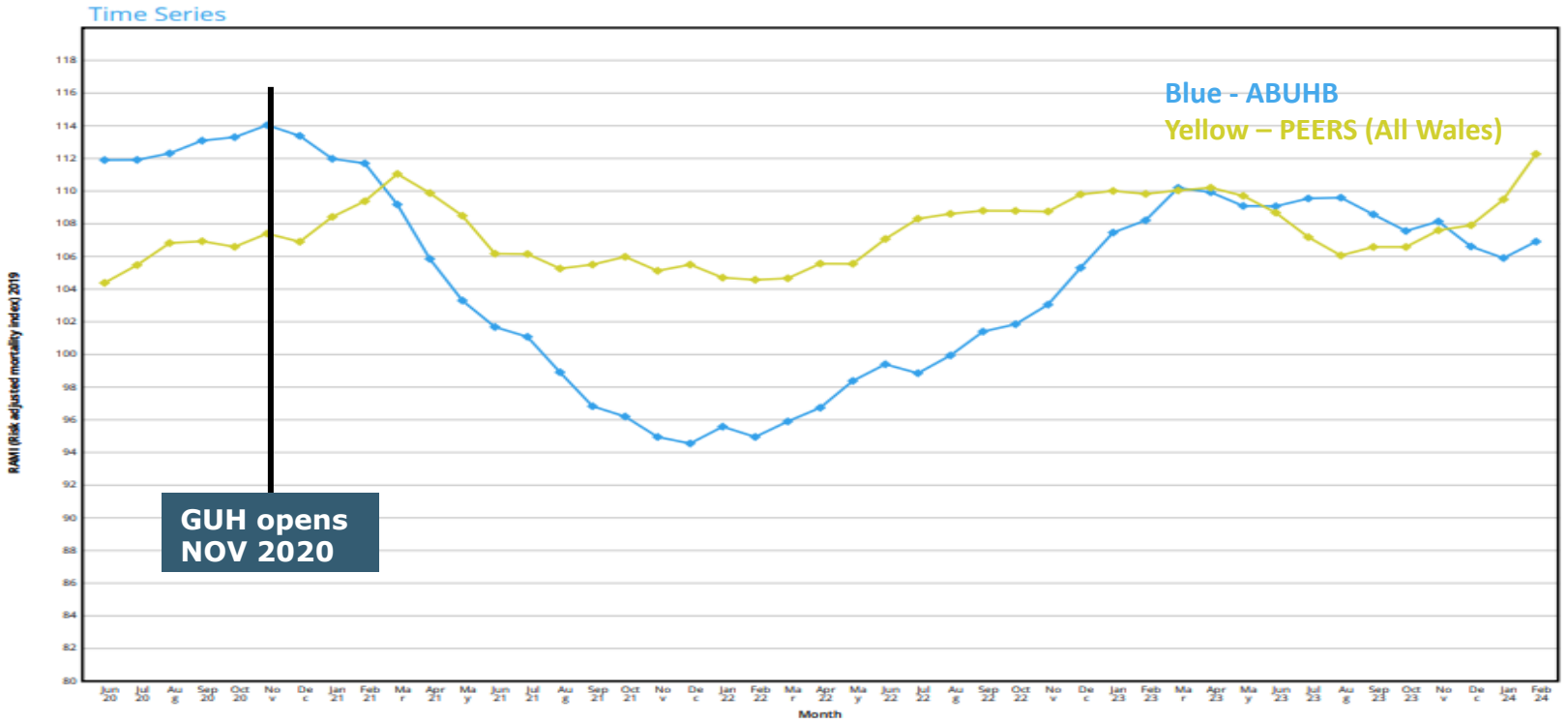
The data represents the collective information for ABUHB and refers to the severity of reported falls incidents for the period February 2022- March 2024.

The severity data is reflective of the identified level of harm recorded at the time of reporting and may be subject to change following investigation.

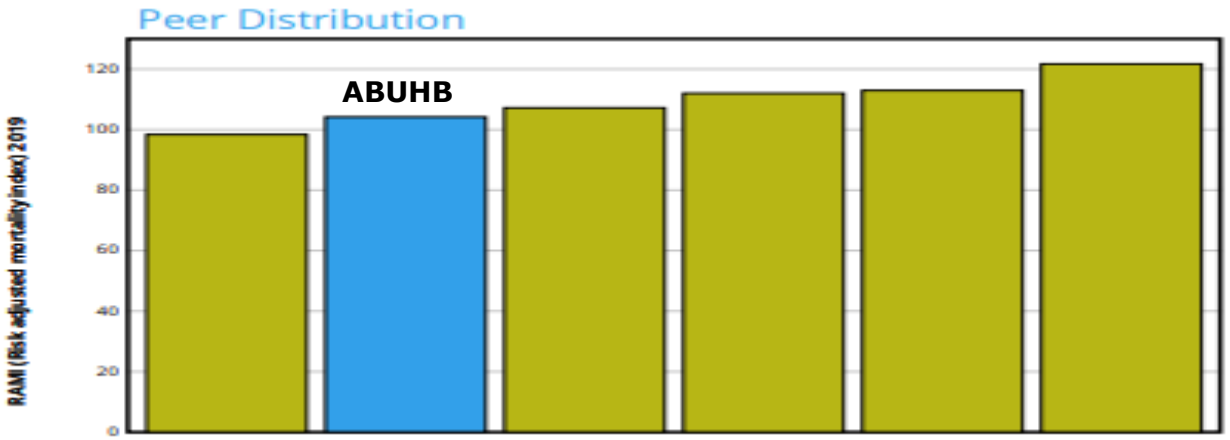
Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	Of the total numbers of falls incidents reported for which the severity of harm is categorised for the given period is 7916. Of this figure the following is identified. • 89% No or low harm • 10% - Moderate harm • 0.9% Severe harm • 0.1% Catastrophic	For 2024 to date no incidents were reported as catastrophic at the time compiling this report with no change post investigation.

RAMI (Risk Adjusted Mortality Index)

RAMI is a mortality index which is a ratio of an observed number of deaths to an expected number of deaths in a particular population. The index is simply the number of observed events divided by the number of expected events.

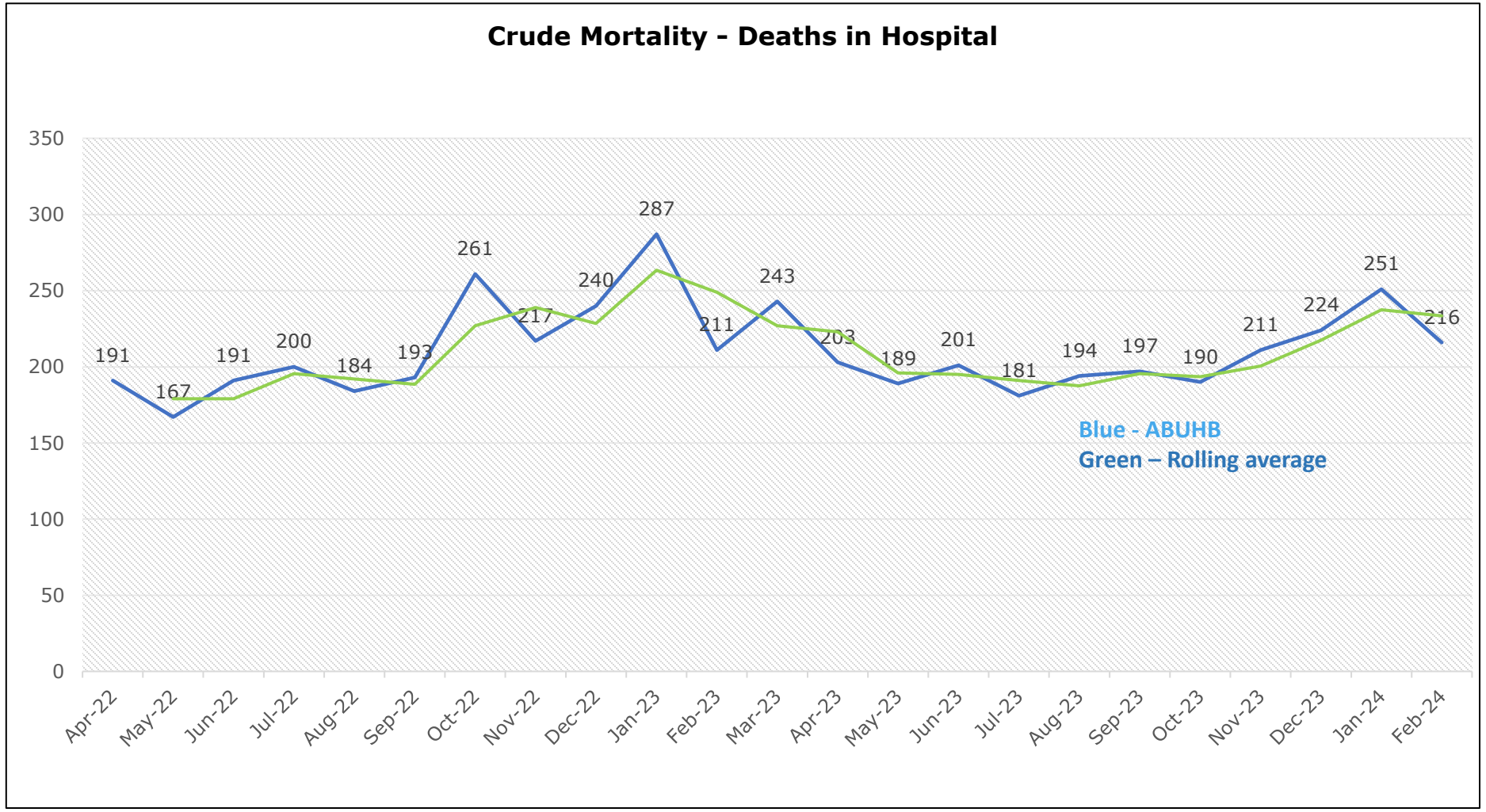


Feb 2024 RAMI is 107



Currently performing 2nd of 6 within All Wales peer group

Crude Mortality in Hospital



Whilst the Health Board RAMI has varied significantly, the crude mortality and mortality rate are flat and consistent.

This emphasises the need for an individual mortality report to undertake deep dives in high mortality specialties.

Mortality Actions

Issue	Cause	Remedial Action	Who	When
Understanding mortality data and how we implement learning from mortality	There is a need to understand what is reported to PQSOC and to Board for mortality. England produce a Learning from Death framework which enables a standardised mortality report.	Mortality report completed. Learning from Death Framework under development and progressing to first draft. This will include learning from the Medical Examiner service and the mortality review screening panel. We are reviewing our end to end mortality process.	Medical Director's QPS team	On-going
Reliability of mortality data	Consistency of mortality reporting and data.	Mortality report available for this PQSOC, proposing a framework for reporting mortality indicators. This describes the approach: Tier 1 – Health Board level, Tier 2 – Divisional level and Tier 3 Directorate level. The QOF currently reports crude mortality. We are part of the All Wales Mortality review group working to standardise reporting of mortality.	QPS Team and Information Manager	Ongoing
Clinical coding	The national target for clinical code is 95% coding completion one month post episode discharge. We are currently coding at 80% because of increasing activity.	Work with coding team to improve coding rate and depth and understand the variation in RAMI compared to the consistent and flat mortality rate over time.	QPS Team, DDT team and Information Manager	Ongoing
Mortality Data and Clinical Outcomes	Developing a governance process around mortality outliers	QPS Team and Information Manager currently drafting a Standard Operating Procedure for Mortality Outliers and investigation.	Information Manager, DDT and QPS Team	On-going
	Develop process for when to undertake a review of case notes	Develop a deep dive SOP to allow scrutiny of notes for review. This will help to interrogate the notes assessing for accuracy of coding and clinicians input for learning from deaths. This will include processes e.g. for MHLD deaths and suicide.		
	Mortality indicators not avaible to all	Once mortality indicators are agreed, the team will develop as a QLIK app to provide instant access to data.		

Pressure Ulcer Faculty – Introduction and Aims

Following the COVID-19 Pandemic, the Health Board reported increased numbers of unstageable and grade 3&4 Health Acquired Pressure Ulcers (HAPU's). Divisions report data via the HAPU Steering Group and the Quality and Patient Safety Operational Group.

The Director of Nursing requested a new focus on reduction and prevention of HAPU's within ABUHB to meet the Welsh Government standard of 0% avoidable Health Acquired Pressure Ulcers. With the success of the previous pressure ulcer prevention and reduction collaborative in July 2018, the Pressure Ulcer Faculty 2023 has been developed, led by the Nursing Directorate and Senior Nurses from Medicine, Unscheduled Care, Urgent Care and Community Care nursing; with support from ABC*i*.

Aim of the Faculty

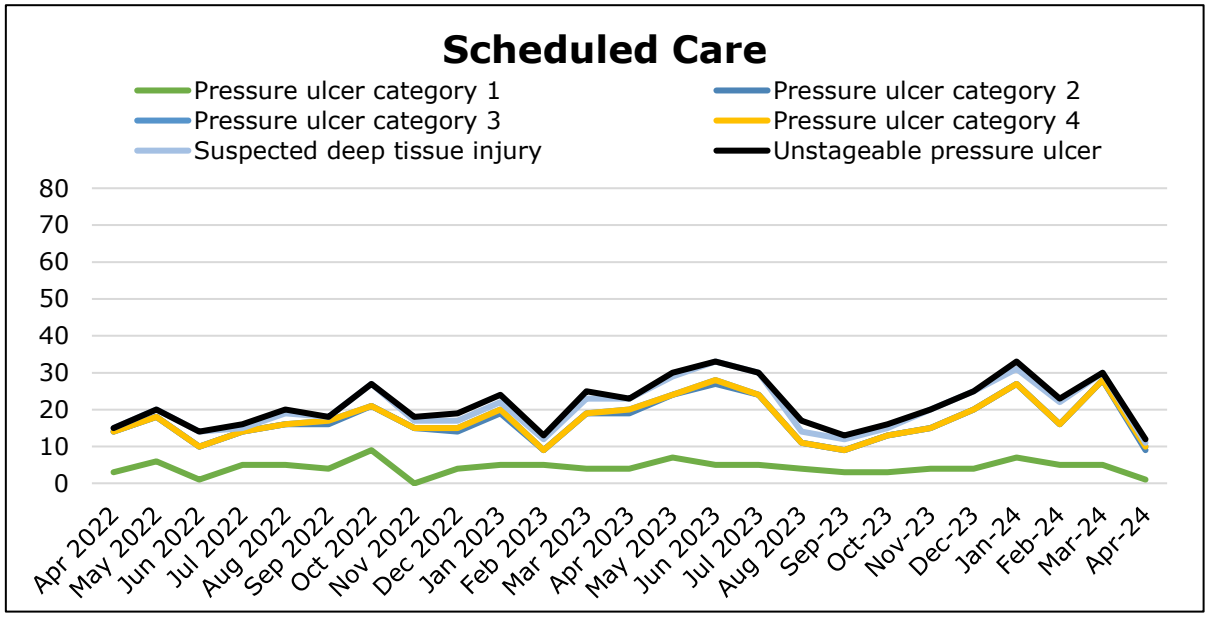
- Reduce HAPU incidences by 25% of baseline within 4 months from the commencement of the faculty.

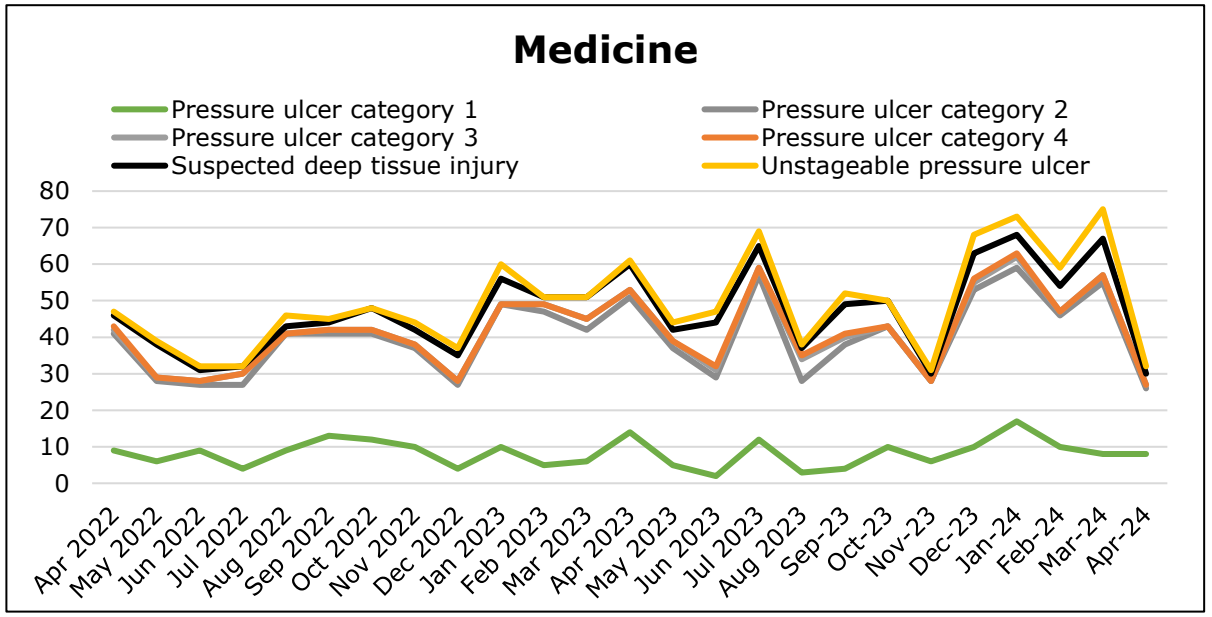
- Eradicate incidence of grade 3 & 4 avoidable HAPUs 4 months from the commencement of the faculty.

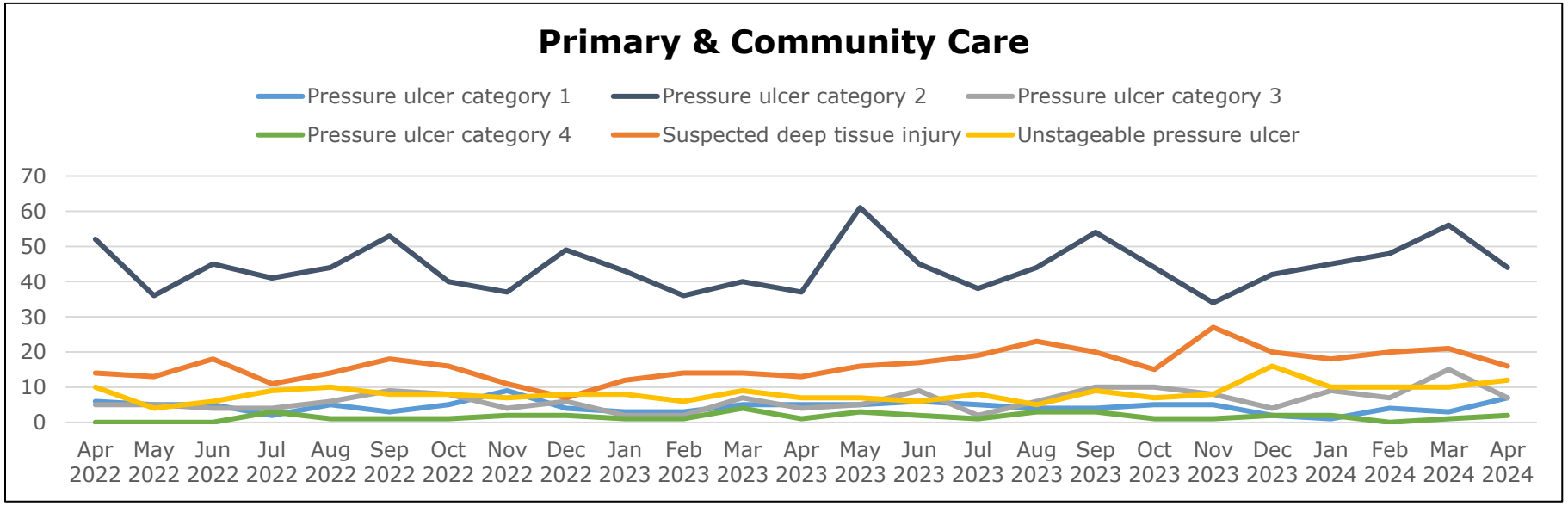
Pressure Ulcer Faculty – Aims and Progress

- Downward trend noted from January to April 2024
- TVNs to develop a pre-recorded PowerPoint teaching package
- PANDO APP to be used to support timely wound review and timely treatment
- PDSA Cycle in progress to support test for change across all sites within ABUHB
- PDSA cycle to be agreed at faculty meeting February 2024
- SharePoint file set up to share all resources
- Sharing of developed Posters across Divisions
- Driver diagram updated
- Pressure Ulcer Pilot commenced February 2024
- Next steps evaluate data collected at April meeting so signs of improvement

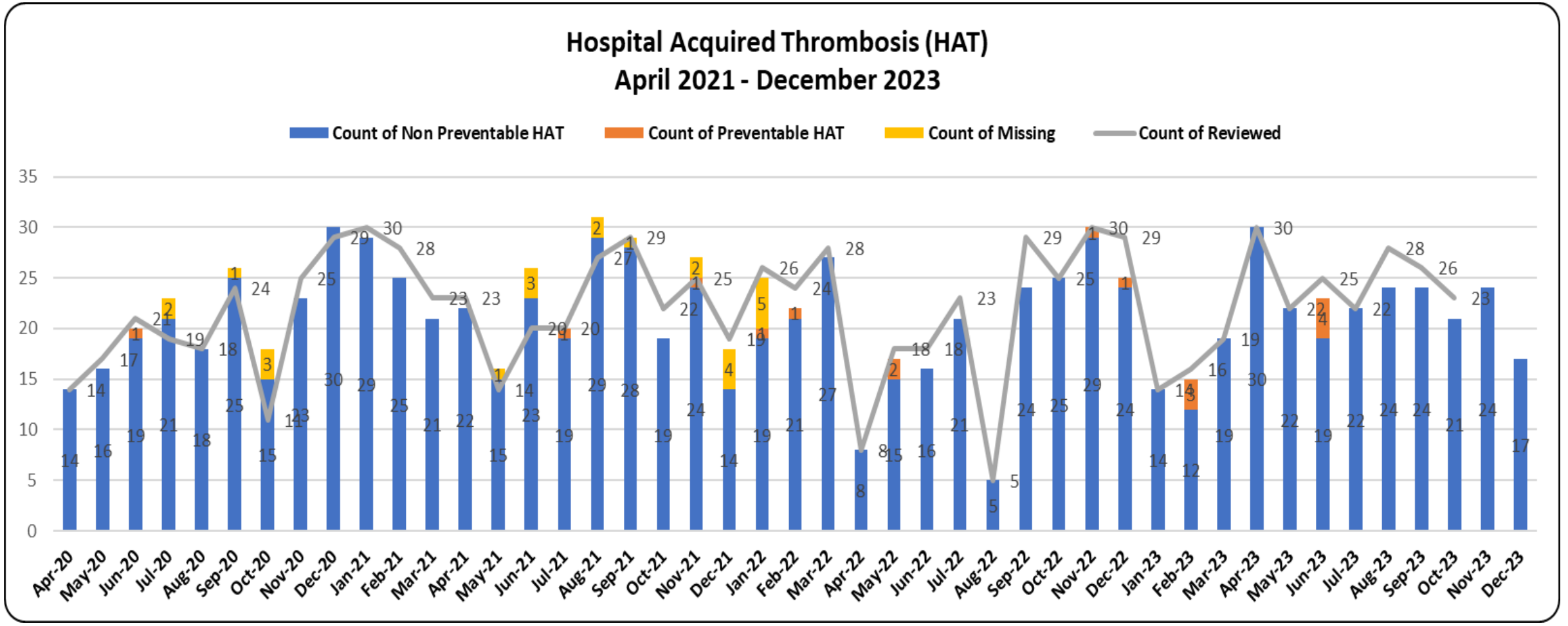
Health Acquired Pressure Ulcer Incidents by Division







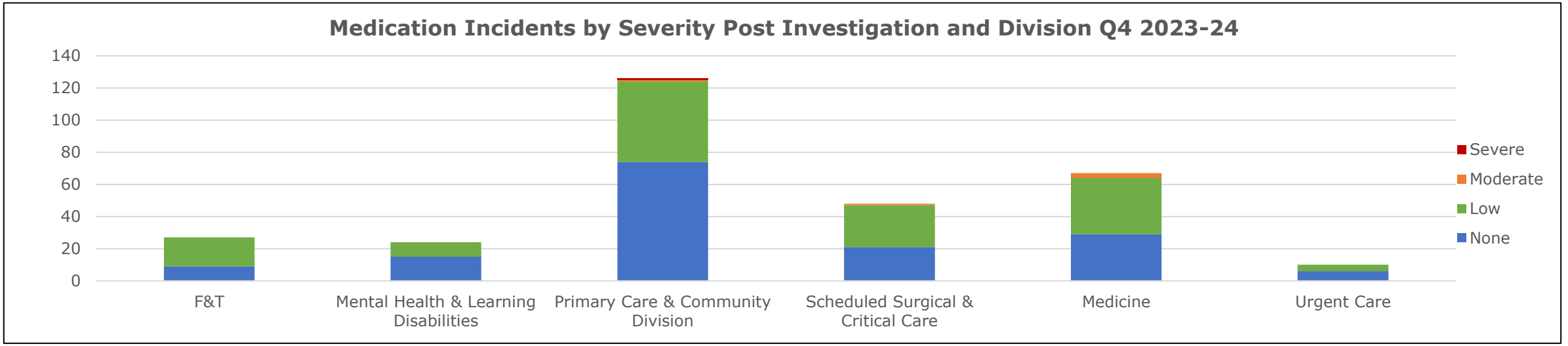
Hospital Acquired Thrombosis (HAT)



All suspected cases of HAT will ensure a review of the case notes has taken place to define if this was prevented. The process and learning for preventable HATs is being reviewed to ensure they are captured as an incident on Datix and the learning is documented.

Meetings are currently taking place with Divisions to share the HAT data by speciality and to ensure there are points of contact within directorates to discuss best practice of thromboprophylaxis and appropriate risk assessment.

Medical Safety Group (MSG)



Reporters View on Levels of Harm				
	Q1	**Q2**	**Q3**	**Q4**
None	188	194	187	174
Low	88	128	197	205
Moderate	21	60	77	57
Severe	7	7	8	12
Catastrophic	0	0	0	0
Total	**304**	**389**	**469**	**448**

- Data for Q4 was scrutinised in terms of type of incidents, themes and areas of concern.
- Total 448 incident reported January to March 2023. Total 306 incidents reviewed and investigated.

Focused Outcomes

- Continue to deliver on the corporate action plan for anticoagulant incident review e.g., pharmacy intervention report, thematic review, SOP update.
- Support DICE with teaching session on insulin/ VRIII in areas requiring support e.g., ED.
- Develop and issue an Internal Alert on Desmopressin following a trend of missed doses of this critical medication.
- Continue to support Mental Health and Neurology to deliver on the Sodium Valproate action plan as per MHRA.

Medical Safety Group – Action Plan

Issue	Cause	Remedial Action	Who	When
Anticoagulation incidents consistent and high-risk potential	Multifactorial as per thematic review	As per corporate action plan	MSG	July 2024
Insulin incidents consistently reported	Multifactorial, but lack of knowledge/ confidence a strong theme.	Continue to support DICE to identify areas requiring Insulin education.	MSG	Ongoing
Desmopressin – multiple incidents of missed doses of this critical medication	Lack of knowledge about drug and risks of omitted doses.	Internal Alert – pending sign off	MSG	April 2024

All Wales Patient Safety Solutions: Compliance Status

Alert	Compliance Deadline	Action to achieve compliance	Status
PSA008 NG Tube misplacement: continuing risk of death & severe harm Compliance deadline: 30/11/2017, updated to 29/09/2023	29-Sep-23	Safe use of NG tubes remains on on-going concern, however ABUHB has now declared compliance with this alert. This will report through the Nutrition and Hydration Group and the QPS Clinical Audit team will be undertaking an audit in sue course.	Compliant
PSA016 Potential risk of underdosing with calcium gluconate in severe hyperkalaemia	15-Dec-23	Work underway. The ABUHB policy for AKI and treatment of hyperkalaemia has been revised, approved by CSPG and added to intranet. ABUHB declared compliance with this in Jan 24.	Compliant
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	29-Sep-23	Project led by Peggy Edwards. Health Board working group and meeting every 8 weeks to progress. Work is still on-going.	In-progress
NatPSA 2023 013 Valproate- Compliance deadline: 31/01/2024	31-Jan-24	Organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients. This is being progressed within neurology and MHLD and a gap analysis and SBAR of outstanding actions needed to comply is being developed. Risks are being escalated within the Division.	In-progress
PSA017 Identified Safety Risks with the Euroking Maternity System. Compliance deadline: 28/06/2024	28-Jun-24	This PSA being led by Peggy Edwards. Important to note the Health Board does not use this system. However, all organisations need to review actions 5 and 6, therefore the focus is on these actions and in progress.	In-progress

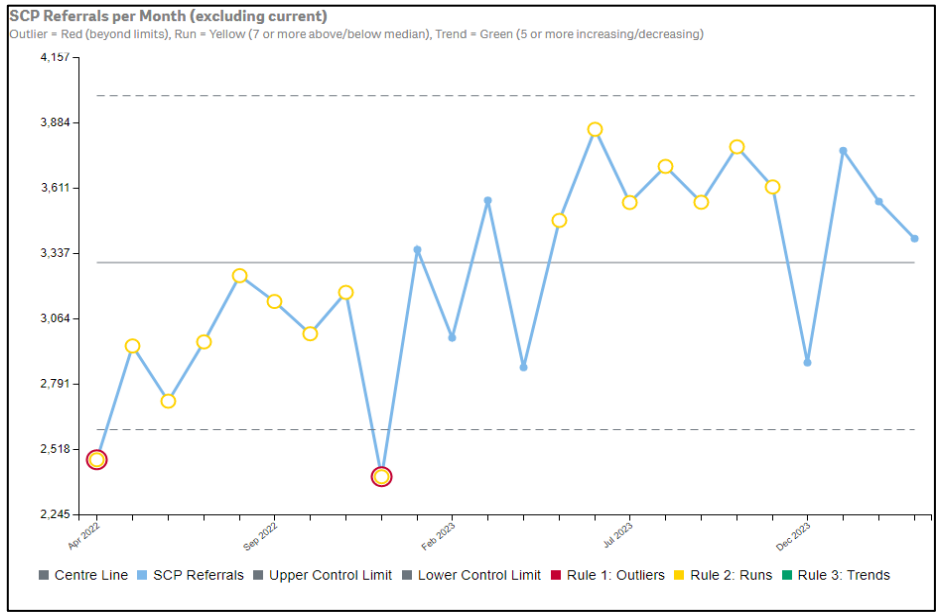
Priority 3: Timely Care

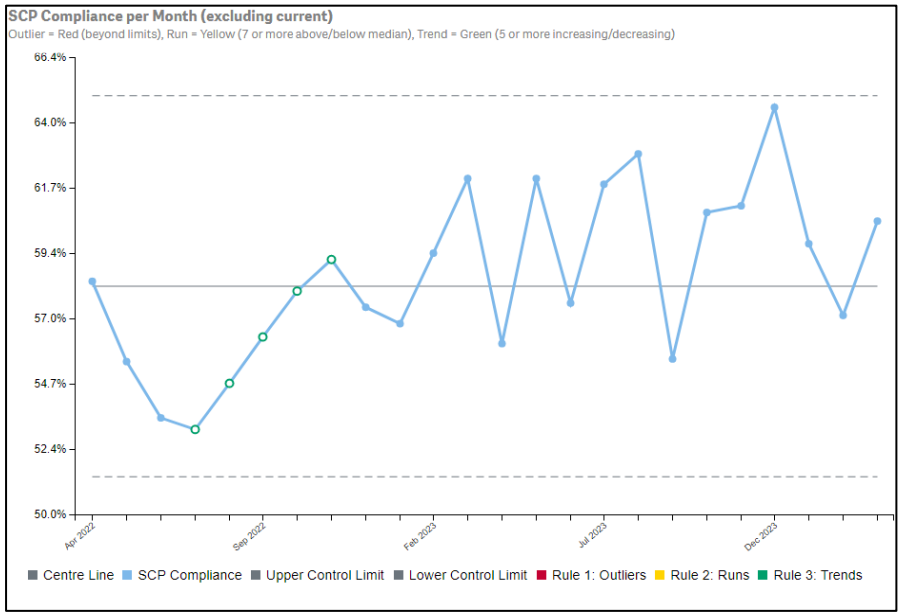
The detailed narrative is included within the Performance Report

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 3 Timely	Maximising and individuals time and outcomes	Decrease in the time from admission to surgery for emergency admissions	Q3 2023.24	30 hours	Q4 2024	34 hours	No change	Average time to theatre from Arrival/Admission continues generally around 30 hours aside from a period in October/November of 32-42 hours.
		Decrease in the time from surgery to discharge	Q3 2023.24	2.6 hours	Q4 2024	3 hours	No Change	Average time from leaving theatre to discharge has been mostly stable around 3 hours
		Decrease in time spent on a waiting lists	Q3 2023.24	34.16	Q4 2024	10	Improved	The Health Board has made good progress towards eliminating waits of over 156 weeks, with 10 patients waiting at the end of March 2024 compared to the March 2023 position of 553.
		Decrease in the number of handovers >1 hour, monthly	Q3 2023.24	3353	Q4 2024	3549	Deteriorated	Number increased during the period
		Decrease in the time for patients to be seen by first clinician	Q3 2023.24	4.2 hours	Q4 2024	3.8 hours	Deteriorated	Trend has stabilised since Q2. Was improved in November but returned to normal in December.
		Decrease in the time for bed allocation from request	Q3 2023.24	7.5 hours	Q4 2024	8.4 hours	Deteriorated	Increase from September to November
		Decrease in ED waits >12hrs, weekly	Q3 2023.24	265	Q4 2024	241	Improved	Improved slightly over the quarter
		Increase in discharges before midday;	Q3 2023.24	32%	Q4 2024	32%	No change	No improvement in indicator value, expected to see further improvement in Q1
		Decrease in the number of patients with a LoS over 21days	Q3 2023.24	563	Q4 2024	549	Improved	>21 days Occupancy is below normal trends
		Time from Flow Centre call to discharge/ admission from assessment?					No Data	Refine measure
		Number of emergency admissions in hospital over 7 days	Q3 2023.24	354	Q4 2024	354	No Change	Preciously increasing trend since Q1 2023, mainly patients moving from assessment units
		Decrease in the time from request to step up/down to a different site					No Data	Refine measure
		Decrease Overnight bed moves and patient transfers	Q3 2023.24	37.90%	Q4 2024	38.70%	Deteriorated	Increasing trend since Q1 2023, mainly patients moving from assessment units
		Reducing time spent in hospital					No Data	Reviewing measure

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 3 - Timely	Maximising cancer outcomes	Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion	Q3 2023.24	60.10%	Q4 2024	62.20%	Improved	Stable around 60%
		Increase in 5 year cancer survival rates	Q2 2023	0.54	Not available	Not available	No data	Reviewing measure
	Improve Mental Health Resilience in Children and Young adults	Decrease in 4 week CAMHS waiting list	Q3 2023.24	86.2%	Q4 2024	100%	Improved	Indicator has improved significantly since last reporting period. National target of 80% remains achieved at 100% compliance.
		Decrease in neurodevelopmental (SCAN) waiting list	Q3 2023.24	29.9%	Q4 2024	34.3%	Improved	Indicator has gradually improved over the last 3 months by 4.1%. However, this remains below the IMTP target.
	Improved mental health resilience in adults	Increase in life satisfaction among working age adults	2022/23	85.5%	2022/23	85.5%	Improved	Increase in indicator over the last 3 financial years and remains above the all Wales average of 84.4%
		Increase in percentage of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	Q3 2023.24	68.3%	Q4 2024	67.7%	Deteriorated slightly	Measure has been sustained at similar level, with a slight decrease, between reporting periods.
		Increase in life satisfaction among older people			2022/23	85.50%	Improved	Increase in indicator over the last 3 financial years and remains above the all Wales average of 84.4%

Maximising Cancer Outcomes - Summary





- Compliance against the 62-day target for definitive cancer treatment has decreased from 62.9% at the end of December 2023, to 56.5% in February 2024, behind the performance ambition set in the IMTP. There has been a significant increase in demand alongside the focus on reducing the over 62 day waits, affecting compliance. Increases in demand relating to the suspected cancer referrals continue to exceed 3,500 referrals per month compared to pre-covid levels of 2,500.
- SCP treatments undertaken increased by 5.5% over 12 months and increases monthly. Improved position in number of patients waiting > 62 days over the last 6 months, 388 waiting over 62 days (September 2023) compared to 346 at the end of March 2024. SCP demand has levelled off but remains high.
- 62 day cancer performance, January 58.8%, February 56.2%, which was as predicted.
- 14 day compliance has deteriorated in both January and February as a result of reduced capacity.
- Cancer backlog - reducing the active patients waiting over 62 and 104 days remains the priority laid out at the March 2023 ministerial cancer summit.

Cancer - Concerns

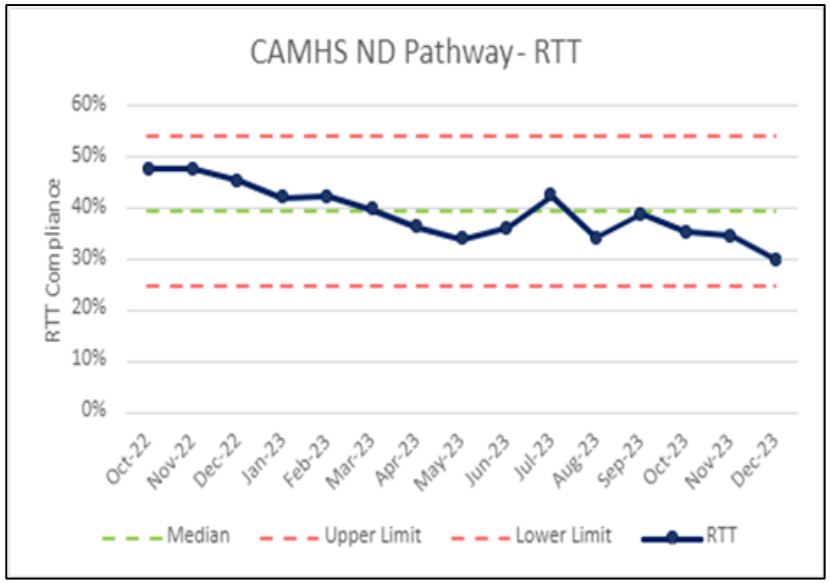
Issue	Cause	Remedial Action	Who	When
Significant delays to FOA for suspected gynae-oncology patients.	Junior doctor industrial action during Q4 2023/24. Consultant backfill/WLI payment rates dispute resulting in loss of capacity	Directorate continues to explore solutions	Division Management staff	Anticipate evidence of improvement during Q1 2024/25
Cancer pathways not meeting 62 day SCP compliance (exception is skin)	Referral demand remains high. Lack of sufficient timely access to diagnostic capacity	Planned Improvement Task and Finish groups have been attended by all disciplines involved in urology, gynae and H&N pathways. Lower GI group will meet for the first time in May 2024. The programme of work makes use of the learning from Toyota training and inclusion of National Optimal Pathway mapping against milestones.	Macmillan National Optimal Pathway Manager Divisional General Managers	Progress will be ongoing. Anticipate incremental improvement by the end of Q2 2024/25
Significant loss of Endoscopy capacity in January, February and March	Junior doctor industrial action during Q4 2023/24. Backfill/WLI payment disputes resulting in loss of activity	Services will mitigate as much loss as possible during IA.	Divisional General Managers & Clinical Directors	End of Q4 2023/24
Loss of breast OPA capacity	Breast Unit opened in YYF in February 2024. Introduction of new one stop model for patients to have all diagnostic tests at one visit. Loss of capacity as the new model embeds.	Service plan to limit capacity loss by providing additional clinics post move as appropriate	Directorate Manager	Q1 2024/25

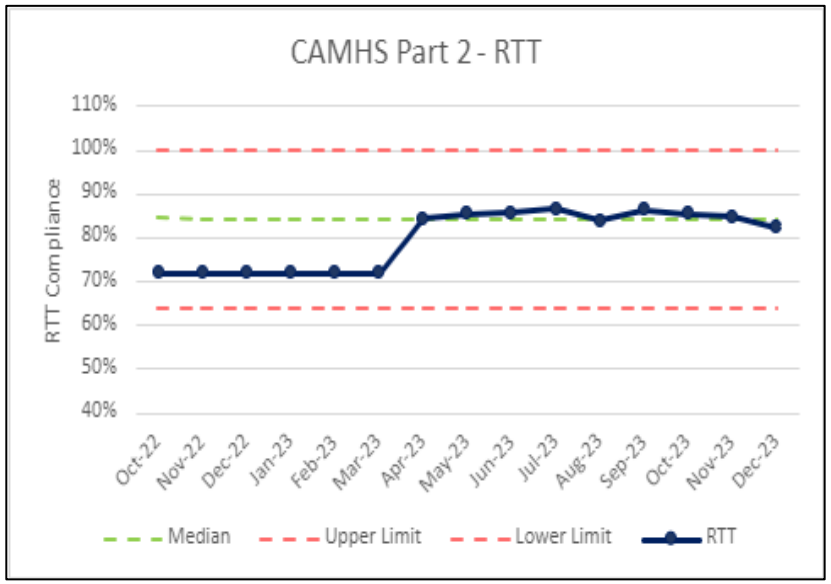
Mental Health in Working Adults

Mental wellbeing and life satisfaction result in better subsequent health outcomes on some physical health indicators, health behaviours and psychosocial indications, including depressive symptoms. Mental wellbeing remains a key priority for the organisation and sustained performance levels have been observed in the 'improved mental health resilience in adults' outcome.

As of February 2024, 68% of Health Board residents over 18 in receipt of secondary mental health services have a valid care and treatment plan. There are concerns on the provision of assessment by mental health service within 28 days from referral which is currently at 17.1% (Feb 24) and interventions less than 28 days from assessment which is currently 7.3% both areas are being addressed in a 90 day action plan monitored by Executive Committee to ensure targeted assurance.

Improving mental health resilience in Children and Young adults





Nurturing future generations is essential for our communities. There is strong evidence that healthy behaviours in childhood impact throughout life; therefore, targeting actions to improve outcomes in these areas has a long-lasting impact on delivery. Young adult mental health is a Ministerial Priority area with CAMHS a focus in the national performance framework.

Progress within the **'Improve Mental health Resilience in Children and Young Adults'** outcome remains mixed. The CAMHS Neuro-developmental (ND) Service remains committed to achieving the 80% target of completing ND assessments within 26 weeks. Quarter 4 of 2023/24 has seen a continued demand of referrals requesting consideration of an ND assessment. There are on average 220 new referrals a month which is a 200% increase on the monthly average for 2019/20 and this challenge has resulted in an RTT compliance for the end of February 2023 of 34.3%. A recovery plan was implemented in April 2023 to be able to support the current waiting lists across the 0-18 years pathway by separating the cohorts of 0-5 years and the 5-18 years.

Priority 4: Effective Care

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 4 Effective	Reduced variation in Care	Increased Get It Right First Time (GIRFT) implementation plans by area						Reviewing measure
		Insert ward accreditation measures – to be confirmed						Ward accreditation is still being rolled out
	Increased understanding of variation to focus Improvements	Increase in the SMART action plans with accountability in National Clinical Audit						Reviewing measure- see Clinical Audit slides
		Increase in the numbers of wards participating in accreditation (Audits via AMaT)						Reviewing measure- see Clinical Audit slides
		Increase in the actionable audit recommendations by National Clinical Audits						Reviewing measure- see Clinical Audit slides
	Improvement is part of the AB way	Staff Survey – increase in the score for staff being able to raise concerns						Reviewing measure
		Compliance the number of incidents triggering Duty of Candour within 5 days	No Data	No Data	No Data	No Data	No Data	Reviewing measure
		QI projects outcomes (Non SCC)	No Data	No Data	No Data	No Data	No Data	Reviewing measure
		Outcomes of the SCP teams	No Data	No Data	No Data	No Data	No Data	Reviewing measure
	Improving Good Health in Pregnancy	Decrease in low birth weight rates	2021	5.10%	2022	6.10%	Decreased	Increase in indicator between 2021 and 2022. In line with the All Wales average. Next update due June 2024 (provisional). 2023 data being validated.
		Decrease in stillbirths	2021	3.9	2022	4.5	Decreased	Increase in stillbirth rates between 2021 and 2022. 10% decrease in stillbirths observed over the last 5 years. 2023 data being validated.
	Optimising a child's long term potential	Increase uptake in mothers breastfeeding (any breastfeeding)	Q3 2023/24	63.2%	Q4 2024	55%	Decreased	Indicator value for 2023 was 57%. Q4 has decreased.
		Increase of eligible children measured and weighed at 8 weeks	Q3 2022/23	39.70%	No Data	No Data	Improved	Improvement in indicator over the last 4 quarters, however this remains significantly below the all Wales average. 2023 data being validated.

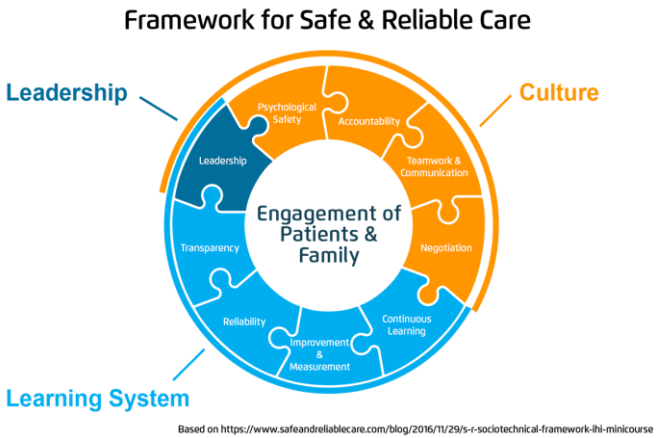
Safe Care Collaborative: January – March 2024

Organisational Update: Stage-Action Period 8

- **Learning Session 5, March 20th**– Face to Face Learning Session held at the ICC with a focus on building Learning Systems. Teams presented storyboards of their work.
- **SCC Close** - Final Celebration event being held on 14th May 2024
- **ABUHB Deteriorating Patients Collaborative –** planning phase
- **ABUHB Deteriorating Patients Collaborative –** Local day in February & April was cancelled due to Industrial Action.
- **Leadership programme of work** – schedule of executive Safety Walkarounds Programme set up until March 2024.
- **Quality Outcomes Framework**– Working to refine QOF in conjunction with Public Health. Quarter 3 report completed reported to the executive team. Information team to develop a Qlik dashboard based on 'Making Data Count' format already used for the ABUHB Performance Dashboard
- **QI Skills Development**– Improvement in Practice training with Improvement Cymru for staff from Primary Care, Mental Health and Collaborative work has been completed. Quality Coach training completed in March with additional 9 coaches
- **OCP – QPS & QI Teams to Nursing Directorate –** QPS staff moved over, focus now on integrating QI Unit
- **Improvement Advisor – Theatres** scoping and initiating work

Team Update:

- **Project Outcomes –** potential to generate Safety Culture outcomes for all teams
- **Storyboards** - Updated for Learning session 5
- **Ward C0 –**Up until the end of March, there hasn't been a Cardiac Arrest for 125 days. Next stage of visual management, screen accessible for full MDT at handover between shifts.
- **Monmouthshire** – Reduction in Package of Care hours for medically optimised patients. Sustained reduction in median LOS. Deep dive identifying ALOS increase due to inability to discharge outlying patients
- **AMU** – Implemented 4 hourly observations. Will be testing visual management of Careflow data. Stickers being used in medical notes to highlight outcome of board round discussions
- **OT Early Intervention** – 30-60 minute saving for each patient during 3 month telephone evaluation rather than face to face adopted as common practice. Testing memory strategy information provision to patients waiting.
- **Theatres –** Improvement Advisor in post, scoping work to reduce Never Events. Testing Safety Culture survey as part of Human Factors. Q Exchange funding bid submitted to Q Community.

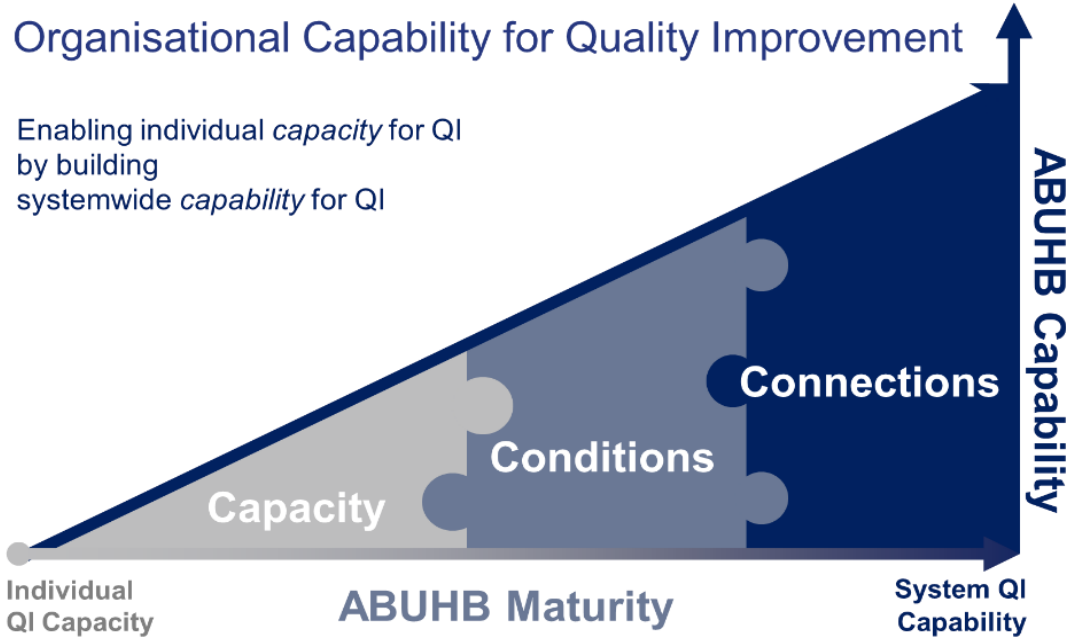


Workstream	ABUHB Team	Score
Acute	Medical Assessment Unit at GUH	2.5
	Ward C0 (ENT surgical ward) at GUH	3.5
	Theatres – Human Factors	1
Ambulatory	North Monmouthshire Integrated Team	3.5
Community	OT/MH Early Intervention for Cognitive Impairment Team	3
Leadership	Executives, Leaders for Safety, Faculty	3.5

Score	IHI - Stage of Project Scoring
0.5	Intent to participate
1.0	Forming team
1.5	Project plan begun
2	Activity but no changes
2.5	Changes tested but no improvement
3	Modest improvement
3.5	Improvement
4	Significant improvement
4.5	Sustainable improvement
5.0	Outstanding sustainable improvement

Quality Improvement - Direction

- "Quality improvement is about giving the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them. It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement."
- Organisational QI Capability is "the organisational ability to intentionally and systematically use improvement approaches, methods and practices, to change processes and products/services to generate improved performance".
- Quality Improvement forms part of the ABUHB Quality Strategy. Our plan is to grow and mature our organisational capability for Quality Improvement (QI), by building capacity, conditions and connections which will enable staff to use QI methodology for solving complex problems, and in so doing provide a consistent approach to testing change ideas, learning and informing our decisions.



Clinical Audit - Reflections

With the introduction of AMaT (Audit Management and Tracking system) in June 2022 there has been a focus on training staff to utilise the system. Currently there are more than 1,300 users across the Health Board. AMaT is used to build the audit proforma, capture data and produce results with an action plan. This license has been extended for a further two years.

There has been improved engagement with Clinical Leads throughout the audit process to discuss results. This has enabled the development, monitoring and completion of improve (SMART) action plans. These are discussed at the Clinical Standards and Effectiveness Group (CSEG). Actions are logged on AMaT and actions are tracked by progress and date.

A standardised Clinical Audit Activity reporting template has been developed in AMaT. This supports review of audit results by CSEG and is used for onward ratification at the Patient Quality and Safety Outcomes Committee (PQSOC). The template ensures risks are discussed and can be escalated to PQSOC, once they have been raised within the Division and placed on the risk register.

Divisional teams have been asked to identify clinical audits as part of their local audit plans. This allows scrutiny and assurance of issues arising from quality and safety risks identified from Datix, complaints and outcomes of care.

Future audit work will include reviewing how the learning from audit is triangulated. This will include working with the Value-Based Health Care team and consider how patient experience is being captured and how this can be linked to audit results.

Clinical Audit – Effective Commitments 2023-2026

Results of clinical audit forms part of our wider Quality Management System in development in the Health Board since Implementation of the Duty of Quality in April 2023. Audit outputs and activity contribute to the "effectiveness" domain of the Duty of Quality.	**To deliver care that is effective, reliable, and based upon the best evidence available. To increase the proportion of patients who receive evidence-based care. To reduce variations in the quality of care. To identify and implement evidence-based best practice guidance. Deliver consistently effective and reliable care.**	
	Aim	**Objective**
	Provide effective care	▪ Deliver consistently effective and reliable care, based on best practice which is delivered as part of a culture that encourages and enables innovation to Improve outcomes. ▪ To ensure that the care delivered to patients is effective and based upon the best evidence available. ▪ Support Divisions to drive improvement priorities from learning.
	Implement the mandatory National Audit Programme	▪ Participate in the relevant national audits to provide assurance of effective care delivery. Use the findings from the relevant national audits to support the continued improvement of quality outcomes by sharing learning and good practice across the organisation. ▪ Produce action plans to monitor the actions needed from audits, ensuring these are measurable and achievable.
	Building audit capability across the organisation through skills development	▪ Developing an organisational training offer covering all staff groups. ▪ Build audit capability across the organisation through the implementation of the web-based Audit Management and Tracking System (AMaT). ▪ Utilise Clinical Audit expertise to provide the evidence-base and measurement function which drives quality improvement initiatives.
	To increase engagement with audit and effectiveness work	▪ To improve the visibility of Clinical Audit Results by implementing the Clinical Audit Strategy, including developing an internal registry ▪ Develop and embed GIRFT processes within the central team, supporting the Divisions to drive improvement priorities from learning.
	Implement NICE Guidance and adoption of Health Technology Wales guidance	▪ Ensure the relevant NICE (National Institute for Health and Care Excellence), and specialist national guidance are regularly assessed and implemented to deliver interventions based upon the best possible evidence. ▪ Utilise best practice evidence and benchmark data to improve outcomes.

Clinical Audit and AMaT – Audit Management and Tracking

AMaT is an innovative system designed to make auditing easier, faster, and more effective. Data can be input and accessed in real time on a smartphone, tablet, laptop or desktop computer, giving healthcare staff increased flexibility and mobility - and more time to spend with patients.

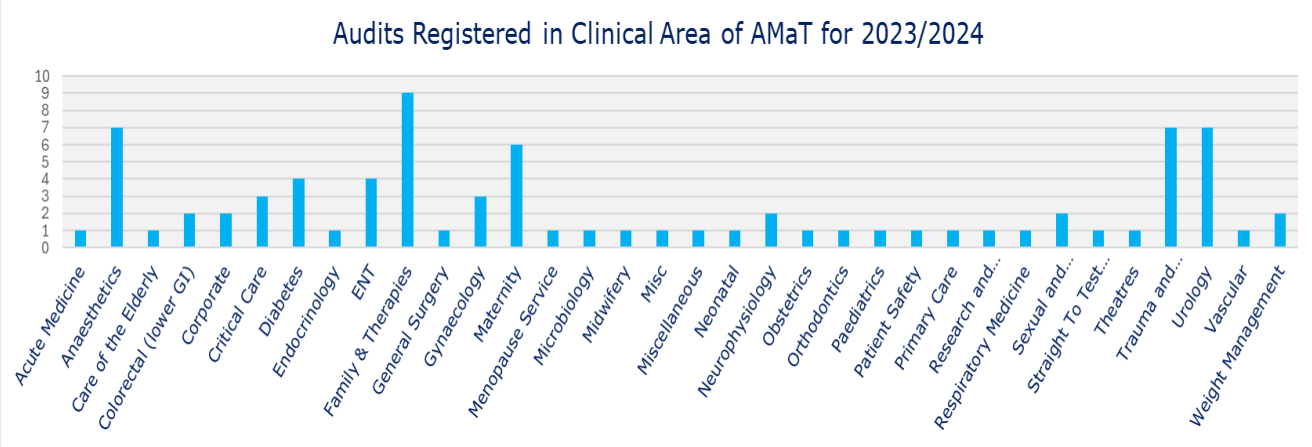
During 2023/2024, 80 projects were added to AMaT.

Project Type	Count
Clinical Audit Project	45
Other	1
Patient Questionnaire (feedback, satisfaction, etc.)	3
Quality Improvement Project	21
Service Evaluation	9
Staff Questionnaire (feedback, satisfaction, etc.)	1
Total	**80**

National Audits do not capture data within AMaT, however the audit process is managed in the system, using various section:

- Audit results and criteria
- Guidance (NICE, HTW, HIW, AWMSG)
- Conclusions and assurance (inc Risk)
- Key success and key concerns
- Recommendations
- Action plans

Projects were recorded under many specialties, and this will grow as the Health Board expands its use of AMaT. Recommendations can be documented, and actions given with timelines.



The Health Board action status within the clinical area shows:

Action Status	Count
Fully Complete	17
New	27
Overdue	3
Partially complete	1
Partially complete (Overdue)	1
Total	**49**

It is difficult to give a forward plan of projects within the Clinical Area as these usually are registered at the time of commencing the audit, even if this a retrospective audit.

Clinical Audit and AMaT – Ward Area Audits

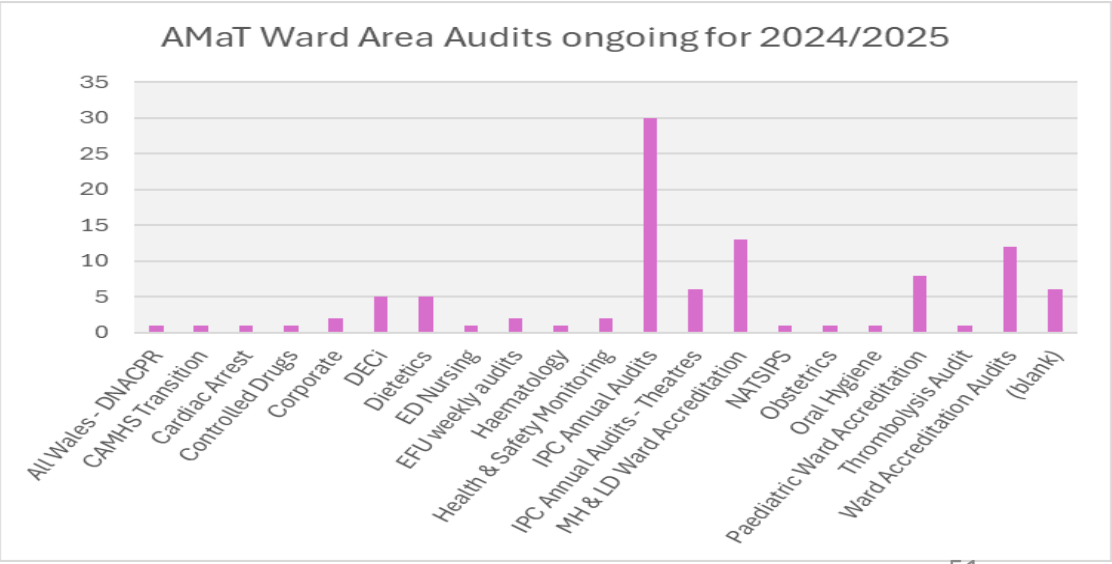
Ward Area is the area in AMaT which will display all audits being undertaken at ward/theatre level. These can be set within projects and the results can be viewed in the dashboard area. Action can be allocated and audited within each audit.

There are a total of 101 audits currently registered and active in Ward Areas. An audit can be linked to one ward, 10 wards or all wards across the sites/Health Board.

These have generated 2,318 actions with 1,335 being fully completed to date.

Of the 101 audits registered a number are still active and included in the plan for 2024/2025. Action status for completed 2023/2024 audits are:

Action Status	Count
Action no longer relevant	24
Fully Complete	1335
New	284
Overdue	608
Partially complete	12
Partially complete (Overdue)	41
Unable to Complete	14
Total	**2318**



National Clinical Audits

Participation in the following NCAs, all results and SMART actions available in Annual Audit Activity Report:

National Lung Cancer Audit Annual Report (NLCA)

National Heart Failure Audit (NHFA)

Management of Heart Attack: analyses from the Myocardial Ischaemia 2023 Summary Report (MINAP)

National Audit of Percutaneous Coronary Intervention (NAPCI)

National Paediatric Diabetes Audit (NPDA)

Fracture Liaison Service Database (FLS-DB) Annual Report

National Pregnancy in Diabetes Audit 2021 and 2022 (NPDA)

National Diabetes Audit 2021-22, Type 1 Diabetes (NDA)

National Diabetes Audit: Care Processes and Treatment Targets 2021-22 (Primary Care)

National Neonatal Audit Programme (NNAP) Summary Report 2022

National Early Inflammatory Arthritis Audit (NEIAA) Year 5 State of the Nation Report 2023

National Vascular Registry State of the Nation Report 2023

National Prostate Cancer Audit (NPCA) State of the Nation report

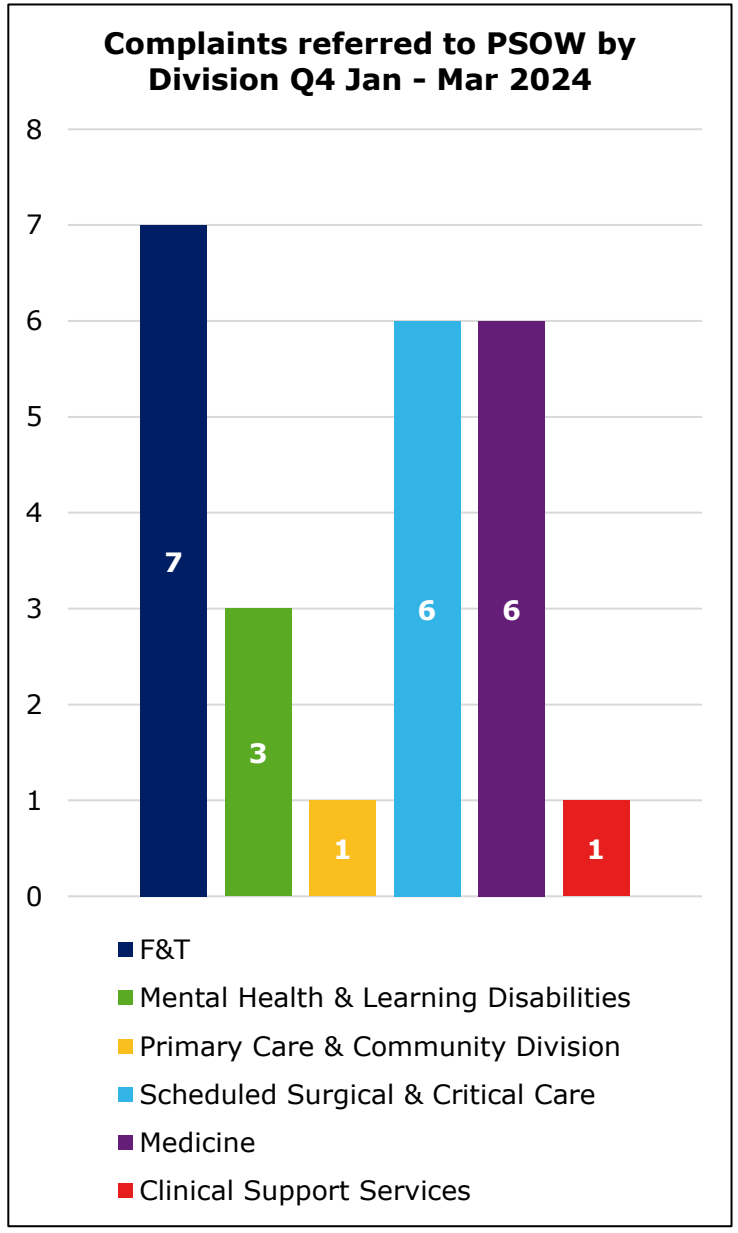
National Bowel Cancer Audit – NBoCA

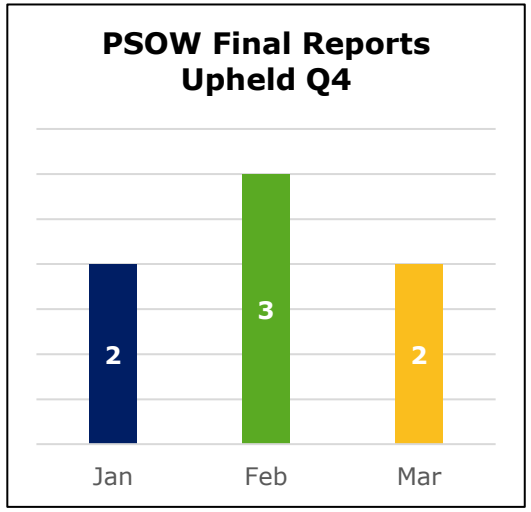
HQIP Planned Activity list for 2023/2024

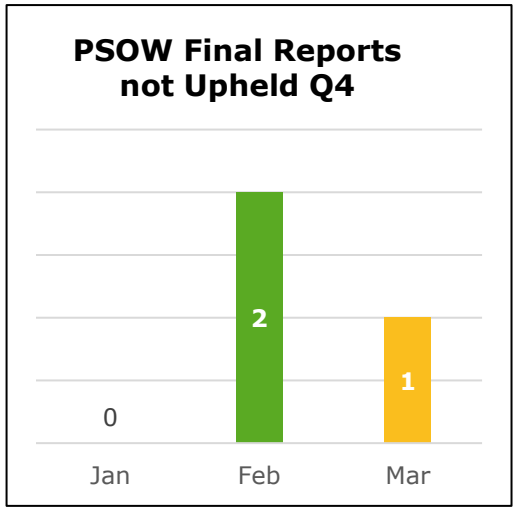
Priority 5: Efficient Care

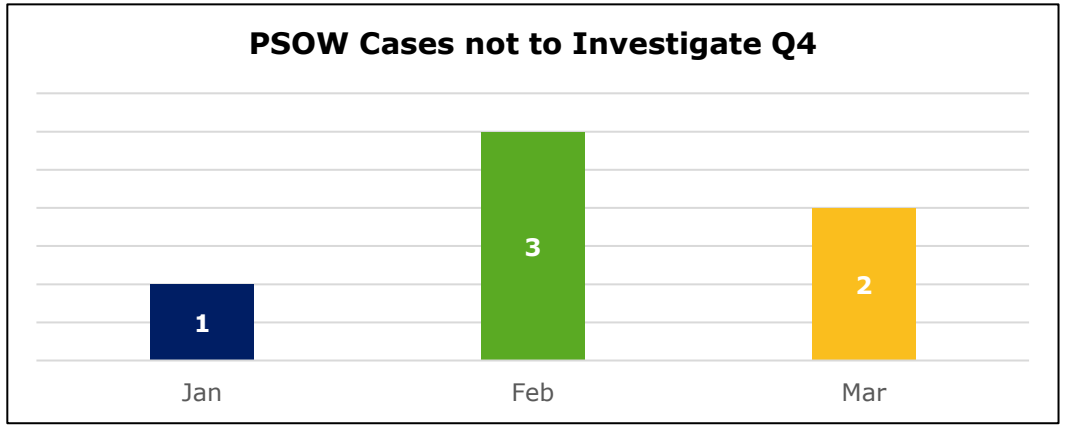
Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 5 Efficient	Patient experiences are visible and acted on	Decrease in the number of open personal injury claims	Q3 2023.24	76	Q4 2024	69	Decreased	No financial Penalties at Jan or March 2024 WRP Committee
		Decrease in the number of open clinical negligence claims	Q3 2023.24	657	Q4 2024	676	Increased	Increased but no financial Penalties at Jan or March 2024 WRP Committee
		Decrease in the number of open Coroner inquests	Q3 2023.24	188	Q4 2024	205	Increased	Increase for Q4
		Decrease in the DNA's and CNA'S	Q3 2023.24	6.6%	Q4 2024	6.8%	Decreased	Overall DNA rate for 2023-2024 was 5.7%, for 2022-2023 was 6.6%. Work in progress with Gastroenterology and Public Health focusing on Hepatology, to understand patterns for DNA's and potential reasons, inclu analysis of secondary care activity following DNA to understand impact. Patient contact has commenced in May to further explore reasons. This is to support service planning and redesign to maximise clinic attendance. This approach will be rolled out in other areas with High DNA rates if pilot successful.
		Response time to Public Services Ombudsman for Wales(PSOW)	Q3 2023.24	4 days	Q4 2024	3 days	Improved	Reporting 3-4 days earlier than PSOW target
		Number of INNUS's being completed	Q2 2022	518	Q3 2022	457	Decreased	There is a national piece of work to review every INNU across Wales, ensuring clinical evidence is up to date, and coding is correct. As a result, the clinical criteria for many of the INNUs will change.
		Decrease in the number of outliers by Specialty	New Measure					New Measure
		Decrease in the number of medically fit for discharge patients	Q2 2023	280	No Data	No Data	No data	No longer valid – measure requires further development
		Decrease in the number of patients cancelled on the day of surgery	Q1 2023	130	Q2 2023	110	Decreased	There has been a decreasing trend in the numbers cancelled in the day of surgery the numbers over the past quarter remain circa 110 per week
		Decrease in the % of hospital as a place of death	Q3 2023	3.00%	Q4 2024	3.00%	No change	Hospital as a place of death has remained static at 3% from Q3 to Q4.
	Improve care at the end of life	Increase in compliance of issuing of Medical Certificates within 5 days	No Data	No Data	No Data	No Data	No Data	Reviewing measure

Ombudsman (PSOW)



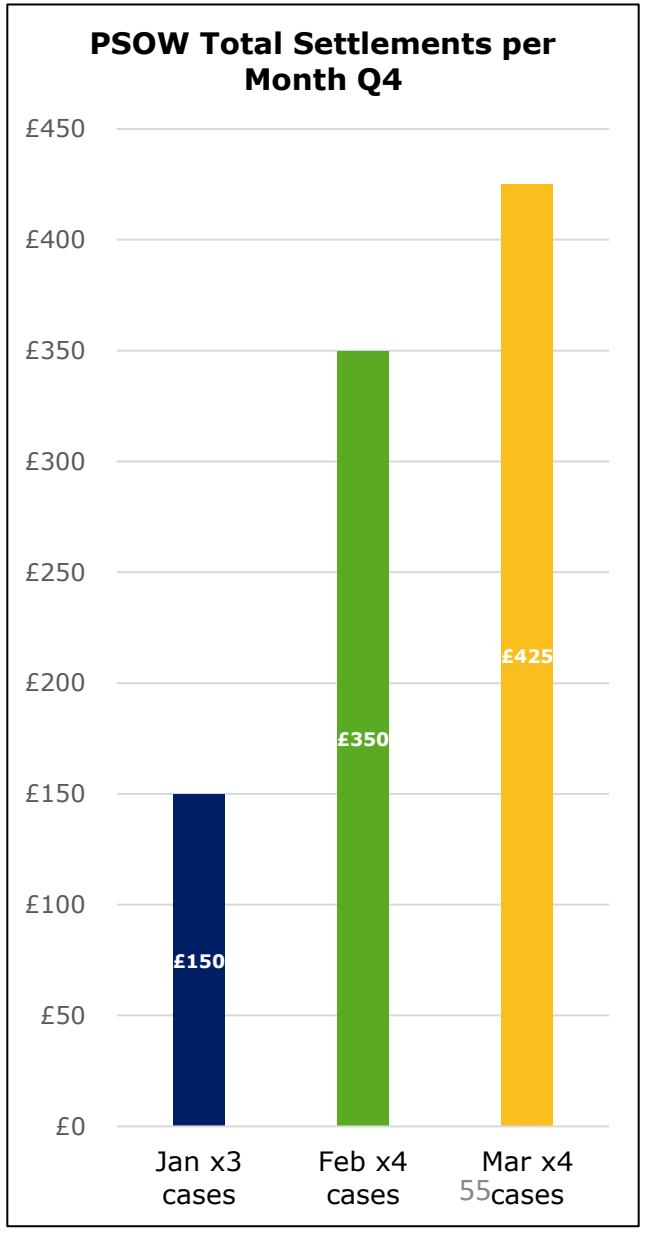






The top 3 subject areas whereby PSOW have been involved relate to:

1. Clinical Treatment/Assessment
2. Communication Issues
3. Complaints Handling



Priority 6: Equitable Care

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 6 Equitable	Improving quality of life and equitable access	Increase in the access to Safeguarding Training	Q3 2023.24	**Level 1** Adult 79% Children 85% **Level 2** Adult 88% Children 86%	Q4 2024	**Level 1** Adult 87% Children 86% **Level 2** Adult 90% Children 88%	Improving	Compliance with training has improved (with tolerance of 85%)
		Narrowing of the life expectancy Gap across our Health Board	Q4 2020	Women 20 years Men 13 years	Q4 2020	Women 20 years Men 13 years	N/A	The current the 13yr (men) and 20yr (women) gap in healthy life expectancy between our wealthiest and poorest communities
		Timely closure of Safeguarding incidents		Measure in development		4 Child Practice Reviews 1 Adult Practice Review 5 Domestic Homicide Reviews		Reviewing measure
		Number of incidents of violence and aggression towards staff (per 1,000 staff)	Q3 2023.24	35.7	Q4 2024	28.3	Improved	Number of incidents for violence and aggression towards staff has continued to decrease, with Q4 being the lowest to date. (Incidents per 1,000 staff) Q1 - 36.6 and Q2-31.7.

Safeguarding: Training and Development

There is a national requirement for staff groups within the Health Board to undertake safeguarding training appropriate for their role. The following shows our current levels of compliance in five of the seven areas. At this current time ESR does not permit recording of compliance at Level 3 for either Child or Adult Safeguarding, with work ongoing to remedy this. However, it is noted that there has been a slow uptake of the Level 3 Training, which is face-to-face, due to staff not being able to be released for training.

Training Module	Compliance %
Adult Safeguarding Level 1	79%
Children Safeguarding Level 1	89%
Adult Safeguarding Level 2	86%
Children Safeguarding Level 2	88%
Ask and Act Training	73%

It is noted some improvement in compliance is required with Level 1 Safeguarding Adults and Ask and Act, to achieve our target of 85%. This has been escalated to Divisional Leadership Teams via the Safeguarding Committee.

Safeguarding: Activity

Safeguarding activity data must be used with caution when being utilised as a marker of quality improvement. However, the current data available for 2023/24 highlights there has been a substantial number of safeguarding referrals made, or responded to, by the ABUHB Safeguarding Team in 2023/24. This is influenced by a number of potentially negative factors (increased harm) over which we have no control, but is also testimony to the effectiveness of the workforce in being aware of neglect and abuse within our population.

	2022/23	2023/24	Increase
Safeguarding Children Strategy Discussion	451 (01/11/22 – 31/03/23)	1932	79%
Adult Duty to Report	263	362	38%
Child Duty to Report	1944	3736	92%

It should be noted that the duty to report figures represent those that were generated by the Health Board.

Safeguarding: MARAC/Sexual Safety/Serious Violence

Multi-Agency Risk Assessment Conference (MARAC)

A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

In QTR 4 2023/24, the Corporate Safeguarding Team attended 33 MARAC, providing information and contributing to safety plans for 432 survivors of Domestic Abuse. It is noted that in this period the number of individuals discussed in MARAC has increased by 87%. This has been noted by the Gwent MARAC Steering Group, with current work on MARAC sustainability being a focus of the Gwent VAWDASV work for the current year.

Sexual Safety

The 2023 the Women's Rights Network published a national report in regard of the volume of sexual assaults that have taken place in hospital settings. A recent report, generated at the request of the National Safeguarding Team, highlights that there have been 48 incidents, in the period 1 August 2023 to 31 January 2024. Analysis of this data has highlighted that most of the incidents related to inappropriate behaviour by patients towards staff, followed by patent on patient and only two incidents where the allegation was made towards a member of staff. In addition, it is noted that none of the incidents resulted in physical harm or fulfilled the national definition of serios sexual assault.

There is work ongoing within the Health Board to develop a Chaperone Policy, refresh the pathway for referral to the Sexual Abuse Referral Centre (SARC) and to develop an overarching sexual safety policy which will provide guidance on risk assessment, recording of sexual safety incidents and timely escalation.

Serious Violence

The Serious Violence Duty 2022 sets an expectation on Health Boards to actively engage with the development of a regional strategy to tackle serious violence. As such, ABUHB has produced a data set which is provided to the OPCC as lead agency and which enables us to actively participate in the strategic needs assessment and production of the strategy.

In addition, funding has been made available for 2023/24 to support work in violence reduction via our urgent care areas. This funding will commission a Violence Reduction Worker to in reach to our emergency areas and minor injury units, with a focus on staff training, improving data collection and early intervention with individuals that may be involved in serious violence and potentially organised crime or exploitation.

Safeguarding: Current Concerns

Issue	Cause	Remedial Action	Who	When
Safeguarding Level 3 Training Non Compliance	Delays in being mandated via ESR	Safeguarding Team working with Divisional leads to establish how this training can be "prioritised" and "delivered" to such a large cohort.	Head of Safeguarding	Q1 2024/25
Decommissioning of Specialist Domestic Abuse Service in General Practice	Funding is not sustainable for 2024/25 to enable the continuation of the IRIS Programme	Public Health, Primary Care, Safeguarding and VAWDASV working collaboratively on a transition programme to ensure that the work previously provided by a commissioned service is supported through exiting services.	Public Health	Q2 2024/25
Non compliance with MAPPA Statutory Duties	There is no dedicated Strategic Lead for MAPPA and no specific resources to support operational responsibilities	Safeguarding and Public Health to work collaboratively to scope whether this duty can be supported from existing resources.	Head of Safeguarding	Q1 2024/25
Statements and Court Reports for Child protection are not being prepared in a timely manner	Absence of a SoP or process for Development/Approval of Statements and Reports	Identification of the Safeguarding Hub as the SPOC and development of a SoP in regard of how requests are managed.	Deputy Head of Safeguarding	Q1 2024/25

Areas of Escalation

C.Difficile

Averaging 22 cases per month since September.

April Total = 25
HAI = 13
Community acquired, relapses and indeterminate cases = 12

During April, 3 wards affected due to period of increased incidence of healthcare associated C difficile: Ebbw Ward, C4E and A3

Lessons learned from outbreak control meetings:-

- Microbiology tests i.e. MSU, blood culture to support diagnostically and guide antibiotic choice
- Contacting Microbiology on weekend for test results and any concerns with treatment to avoid delay
- Appropriate escalation for some antibiotic choices
- Sustaining compliance with cleaning schedules and hand hygiene audits
- Drs to record rationale for all treatment
- Notify nurse in charge if sample being collected
- Discuss AMR linked to renal failure with medical team
- Improve correct use of PPE with Facilities
- Improve hand hygiene compliance with Medics & Therapies

C.diff – update as of March 2024 and actions

228 cases in total for the year ending March 2024 representing a 19% increase in cases

- **159 cases are healthcare associated (HAI) or 'indeterminate' (i.e. HAI / Community acquired infections)**
  - Whole genome sequencing (WGS) identified that 16 (13%) of the definite HAI cases where WGS was available (Total 117) acquired their infection from another patient whilst in hospital
  - Root cause analysis of all CDI cases indicate that compliance with hand hygiene and environmental cleanliness are risk factors.
  - 23% of HAI / Indeterminate cases received sub-optimal antibiotics prior to their C. difficile infection
  - Identified priorities: -
    - Medicine Division Reducing C. difficile Quality Improvement Faculty
    - Organisational Action Plan
    - Ward based CDI training
    - Promotion of proactive HPV programme (challenges in completion of programme 2023-24)
    - Audits to identify areas of sub-optimal antibiotic prescribing

- **69 are community acquired infections (CAI)**
  - Root cause analysis information requested from GP's. Return rate currently around 58%
  - Of the returned RCA's 14% of cases were linked to suboptimal prescribing of antibiotics
  - All suboptimal prescribing is fed back to GP practices via the Antimicrobial Pharmacist Team

Mental Health & Learning Disabilities Escalation

Overall Status Summary	Progress/Achievements What went well this period and upcoming Deliverables	Challenges
• Since July 2023 the MH&LD Division has been subject to internal escalation • A number of quality improvement actions were identified, and these were prioritised into a 30, 60, and 90-day improvement plan. • The Plan has also addressed broader efforts in workforce modelling, leadership, clinical engagement, performance, risk management, and service transformation. • NHS Exec Oversight has been in place • Appointment of an Improvement Director - in post (currently acting Divisional Director) • Appointment of a Divisional Director – who starts in May • Progress on quality, safety, and governance in MHLD has been routinely reported through the Executive Committee, Patient Quality Safety & Oversight Committee the Board, and externally through IQPD. • NHS Exec will continue to monitor delivery of improvements through IQPD and JET meetings • Feedback from the NHS Executive on the improvement plan has been addressed, and there is a commitment to aligning better with the Health Board's Quality Strategy and the new accountability/escalation framework.	**Progress/Achievements:** • Setting The Scene workshop to engage with staff on the setting the vision and ideas for service improvement. • Ongoing support from the QPS team to better align the division with the Health Board Quality Strategy and embed processes. • A strong focus on improved safety governance in line with HB processes from the Nursing Team • Multi-professional clinical leadership opportunities developing • Wider Team support to Implement a process to systematically assess workforce risks and incorporate them into the risk register and the IMTP process. • Models of care: The teams are keen to look at doing things differently and will start having discussions with the directorates. • Increased corporate divisional governance in place – fortnightly • Improved learning from deaths processes **Deliverables and Focussed pieces of work** • Thematic review process • Ward accreditation in line with HB processes • Audit strategy • Daily briefings and escalation processes further embedded at BAU • A review of serious incidents is ongoing, and the Executive Director for Nursing and Chief Operating Officer continue to monitor safeguarding processes, serious incident reporting, and disciplinary processes • Embed Right Care right person and the new rolling out the new model of police and health partnership for mental health crisis response.	• Interim Senior Leadership Team currently in place. • Embeddedness of governance and assurance in relation to the quality and safety of care. • Structures to support strong clinical professional leadership • Additional support and focus on patient safety and safeguarding, staff engagement, cultural and improvement initiatives. • Some of these actions require a longer-term cultural improvement programme to sustain the change. • Ongoing issues with WCCIS (patient information system) and the necessary work arounds for validated information. • Continued focus on 1A/1B performance and the necessary actions to address the waiting list issues, such as validation, triage and rules. • Continue to review staff engagement and communication across the Division.

Urgent Care Escalation

Issue	Cause	Remedial Action	Who	When
Medical Staffing: Medical Staffing to support the Emergency Department (Demand & Capacity modelling showing deficit for demand)	• Increased activity	• Locum processes in place and reviewed weekly with management team and monthly within Directorate • Ongoing recruitment • Demand & Capacity modelling completed	General Manager / Divisional Director / Divisional Management Team	Ongoing
	• Vacancies	• Regular review of medical rotas to match demand within financial envelope are in place with site leads.		
	• Implementation of different models of care	• Explore alternative roles e.g. Physicians Assistants, ANPs etc.		
Nurse Staffing: Vacancies with increased number of patients causing additional staffing pressures and associated governance and costs.	• National shortage of registered nurses • Emergency Department Establishment was increased following the move to the GUH • Challenging place to work due to increased attendances, increased acuity, environmental challenges, inadequate flow	• Recruitments drives for Registered Nurses and HCSWs • Student streamlining • Recruitment of internationally trained nurses • Robust sickness management • Practice Educators working clinically alongside junior staffing • Senior Nurse Point of Contact (POC) • Block-booking of staff secured and robust processes in place to manage roster • Progress alternative roles	Divisional Nurse / Divisional Management Team	Ongoing
System Flow: Congestion within the ED (and Assessment Units). Increased presentations / Long lengths of stay / Ambulance delays	• Increased demand • Poor patient flow • Pathways of Care • Increased Delayed Discharges of Care	• Red Line (24/4) in place from 15 May 2023 to support ambulance offloads and long waits in ED (Now 24/2) • Escalation plan in place to support movement of patients • Comprehensive review of available spaces with Capital Planning colleagues at GUH (Main Wait, Sub-wait and SDEC) • Full Capacity Protocol (FCP) in place • Expansion of ED Main Wait in progress with anticipated completion date of January 2025. • SDEC in GUH open. Predominantly scheduled care utilising but medicine usage increasing along with other pathways such as ED direct referrals and WAST direct access • Acute Release Area (ARA) commissioned from 8 January 2024 which can support 6 patients outside of ED to facilitate timely handover of ambulances. This portacabin is now being decommissioned and removed with work starting 15 April 2024. This supported system flow in Q4 and has now closed.	General Manager / Divisional Director / Divisional Nurse / Divisional Management Team	Ongoing

Next steps

- The QOF framework was developed during Quarter 2 and has been refined as the year has progressed. Throughout the year, more of the outcome measures have been reported and the outcome measures have been updated iteratively.
- This report demonstrates not all measures have been feasible to collect. As part of updating the QOF for the new financial year a workshop has been held to collectively discuss each of the measures, refine the indicator and review how the data is being accessed. For those indicators that are blank, this will be reviewed.
- For the Health and Care Quality Standards that are limited in reporting e.g. Equitable, these will be reviewed to establish what else is being reported that can be inserted into the QOF and what additional measures should be included.
- Working with data, digital and technology the report will become automated and mirror the updated reporting for Board with the use of iconography.