



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Integrated Medium Term Plan 2018/19 – 2020/21

Appendix 2
Quality Assurance and Improvement



Table of Contents

Section	Heading	Page
1	OUR APPROACH TO QUALITY	3
	1.1 Our Aim	3
	1.2 Our Approach to Quality Improvement	4
	1.3 Whole System Approach for Quality Improvement	4
	1.4 Some Key Achievements in 2016/17	5
2	QUALITY ASSURANCE	7
	2.1 Quality Assurance	7
	2.2 Essential Care	8
3	PROFESSIONAL REGULATION	10
	3.1 Professional Regulation for Nurses	10
	3.2 PDR Compliance	10
	3.3 Education and Development	10
	3.4 Nursing and Midwifery Strategy	10
	3.5 Medical Revalidation and Appraisal	11
	3.6 Next Steps	13
	3.7 Quality Assurance	13
	3.8 MARS Development Project	13
	3.9 Constraints Reporting	13
4	PATIENT EXPERIENCE	15
	4.1 Overview	15
	4.2 Listening and Learning from Patient Feedback	16
	4.3 Clear Aims and Measures for Patient Experience	18
	4.3.2 Citizen/Service User/Carer Voice	18
	4.3.3 Executive and Independent Members Walkabouts	18
	4.3.4 Value Based Healthcare and Co-Production	18
	4.3.5 Safeguarding and Public Protection	20
4.3.6 Caring for People with Dementia	21	
5	QUALITY IMPROVEMENT	22
	5.1 Health Care Acquired Infections (HCAI)	22
	5.2 Sepsis/Deteriorating Patient	28
	5.3 Falls	30
	5.4 Pressure Damage	34
	5.5 Hospital Acquired Thrombosis	36
	5.6 Never Events	37
	5.7 National Clinical Audit	38
	5.8 Mortality Review	39

SECTION 1 - OUR APPROACH TO QUALITY

1.1 Our Aim

The Health Board always aims to put the patient first, so that every person that uses our services, whether at home, in their local community, or in a hospital, has a good experience. To do this, the quality and safety of our care and services is a core focus throughout all our plans, from small changes in one service to the driving force for Clinical Futures.

Quality and Patient Safety is at the centre of our work in seeking to achieve excellence, with the patient at the heart of everything we do as we strive to improve the patient's experience and quality of service with every action that we take in primary care, in community services and in our hospitals.

Our purpose therefore is to transform patient experience and nurture a consistently person-centred approach in every member of staff, every day. Evidence suggests that patients who are more actively involved in their health care experience better health outcomes and incurs lower costs, with person-centered care leading to better patient experience. Throughout the Health Board our thinking about quality is guided by the Institute of Medicines dimensions of quality (figure 1) which dovetail with the principles of Prudent Healthcare which emphasise value and co-production and the themes of the Health and Care Standards.

Figure 1.1 - Dimensions of quality in healthcare



This is also reflected in our values, which define what is important to us and how we behave when delivering care. They support a shared understanding about how staff relate to patients, the public and each other. Living our values (figure 2) requires every member of staff to consider five simple questions, which align behaviour and culture, providing an environment in which quality flourishes, with the patient at the centre and an equal partner in their healthcare.

Figure 1.2 - Living Our Values



1.2 Our Approach to Quality Improvement

To provide high quality care, we seek to improve all the time through addressing gaps and/or risks, and in striving for excellence. Our approach to improvement is that all staff have two roles: to do their job and to improve their job, seeing patients as equal partners in their care, and the services we provide through their eyes. We believe that this will ensure that we have the highest quality services for the people we serve.

The Health Board supports a systematic approach to innovation, service improvement and leadership. Actively fostering a culture that enables our staff to be curious, courageous and creative providing opportunity to seek different ways to provide health care and to improve and innovate services. Achieving improvements in the patient experience, outcome and financial efficiency requires rigorous methodology that is rooted in the Science of Improvement. To support this, the Health Board has a Corpora

te Division that focuses its efforts on supporting the quality improvement agenda in the Health Board – the Aneurin Bevan Continuous Improvement Team (ABCi). The team has four key objectives:

- Building the necessary capability for improvement within the Health Board.
- Creating conditions that supports innovative thinking and system re-design.
- Supporting the delivery of strategic objectives through the use of the Institute for Improvement’s Breakthrough Series collaborative methodology
- Building networks both within the organisation, and outside of our Health Board.

More detail on ABCi can be found in section 3.14 – Innovation, Development and Research. This includes our approach to building capacity for improvement, which is based on the **National Programme of Training in Quality Improvement**, “Improving Quality Together”.

Whilst taking the approach that no “one” methodology is right for every improvement, our core improvement method is the Institute for Healthcare Improvement’s (IHI) Model for Improvement, which is well tested and embedded within NHS Wales as the core tool used in the 1000 Lives Plus and the Improving Quality Together programmes (Figure 3).

Using the Plan, Do, Study, Act cycle, it requires clinical teams to be clear about:

- the problem they are addressing;
- the aim of the improvement they want to make;
- the measures they will use;
- the change that will result in an improvement.

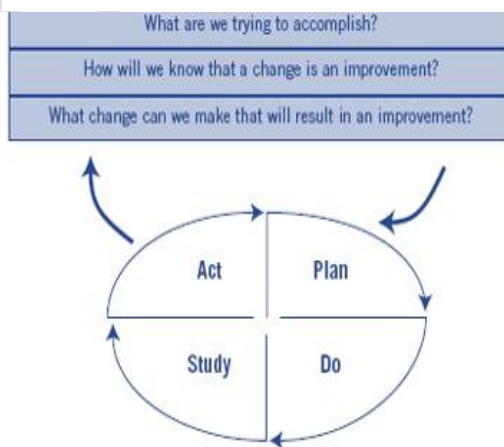
Embedding this methodology at the frontline means the capability to test, measure, implement and sustain improvement increases drastically. To date, over 4,000 staff, at all levels of the organisation, have been trained in improvement techniques.

Corporate Departments within the Medical, Nursing and Therapies and Health Sciences Directorates work on quality issues that impact across the Health Board, but do not relate to any one clinical specialty – such as sepsis, pressure damage and health care associated infections. This work is often supported by ABCi, such as the collaborative on pressure damage.

1.3 Whole System Approach for Quality Improvement




Recognising that the main focus for quality and safety in the health service has been on our hospital services, the Health Board is developing its approach to ensure that its surveillance and review relating to quality covers services from the patient’s home, through community services to hospital care. Where we recognise that improvements are needed, the Health Board looks right across the healthcare system

Figure 1.3 - IHI Model for Improvement



to make sure that changes are made that work together to ensure the best possible outcomes and experience for the greatest number of people. Table 1.2 illustrates the whole system approach we are progressing. We also increasingly work closely with partners in social care and the third sector to deliver improvements in quality. For example, the Dementia Board, which sets our strategy for ensuring that people and their carers can live well with dementia, is the Board for Health, Social Care and the Third Sector. Therefore its working groups cover issues such as increasing the numbers of dementia friendly communities, improving peer group support for people with dementia through to ensuring acute hospital wards have the skills and resources to provide effective and compassionate care for people with dementia, based on the outcomes from the National Audit of Dementia.

Table 1.1 - Quality Improvements across the whole healthcare system

	 Home	 Primary Care/NCN Team	 Hospital
Deteriorating patient/Sepsis: NEWS as a common language	District Nurses record baseline physiological observations, determine what is normal for patient OOH using NEWS	GPS report patient obs/parameters when contacting hospital to admit Nursing Homes trained in NEWS	NEWS used across all acute and community hospitals ABC Sepsis using trigger tool to recognise and respond to Sepsis at front door
Reducing C. Diff	Infection control links with Nursing Homes	Antibiotic prescribing practice information and data for GPs Significant Event review of cases	Antibiotic prescribing practice Cleaning/deep cleaning Handwashing Review of each C Diff case
Reducing Pressure Damage	Reporting of pressure damage for patients on Community Nurse Caseloads	Reporting pressure damage in nursing homes Training of prevention of pressure damage	Training on prevention of pressure damage Revised reporting Improved supply of mattresses
Reducing Falls	Falls Response Service with WAST ensures people are not admitted to hospital unless they need to be following a fall at home, and provides the support they require at home, including Better targeted referral of people who have fallen at home to Community Falls Teams.	Use of I-Stumble tool and training in Nursing Homes to keep people in their home environment and prevent unnecessary admission to hospital. "Deck my zimmer" work so people in Nursing Homes recognise and use their correct walking aid.	Revised Falls Multifactorial Risk Assessment Tool. Review of each inpatient fall that leads to a fracture

1.4 Some Key Achievements in 2017/18

- The success of the Concerns Team in reducing the number of Legacy closures for Serious Incidents that were outstanding from 132 in December 16 to 1 in November 17.
- The success of the staff working to prevent falls at home and in hospital in winning 2 NHS Wales awards.
- The roll out of the sepsis trigger tool to all wards, supported by a Sepsis Awareness Day which was very well attended by the staff from the wards and very well received
- MAU at RGH has increased the number of cases of sepsis recognised and consistently has an 80% or more compliance with the sepsis 6 bundle
- The use of the I-Stumble tool for residents that have fallen in Nursing Homes with associated training has reduced the number of calls to WAST and attendances at Accident and Emergency Departments.
- Implementation of the Enhanced Care Policy which brings standardisation to enhanced care provision in in-patient hospital areas throughout the Aneurin Bevan University Health Board (excluding Mental Health, learning disability and paediatrics areas). The policy outlines the process by which levels of enhanced care are determined, recorded and reviewed, clearly

aligning the need for additional staffing to patient acuity and dependency. This policy is aligned to the Nurse Staffing (Wales) Act (2016), Royal College of Nursing guidance for Safe Staffing for Older People's wards (RCN 2012), the Welsh Levels of Care V1 (2017), the National Patient safety Agency (NPSA), the National Institute for Health and Care Excellence (NICE 2015) and the Nursing and Midwifery Code (2015).

- The "Deck my Zimmer" campaign has harnessed enthusiasm and motivation in Nursing and Residential Homes to ensure that residents can recognise their own walking aid – as well as have fun!

DRAFT

SECTION TWO – QUALITY ASSURANCE

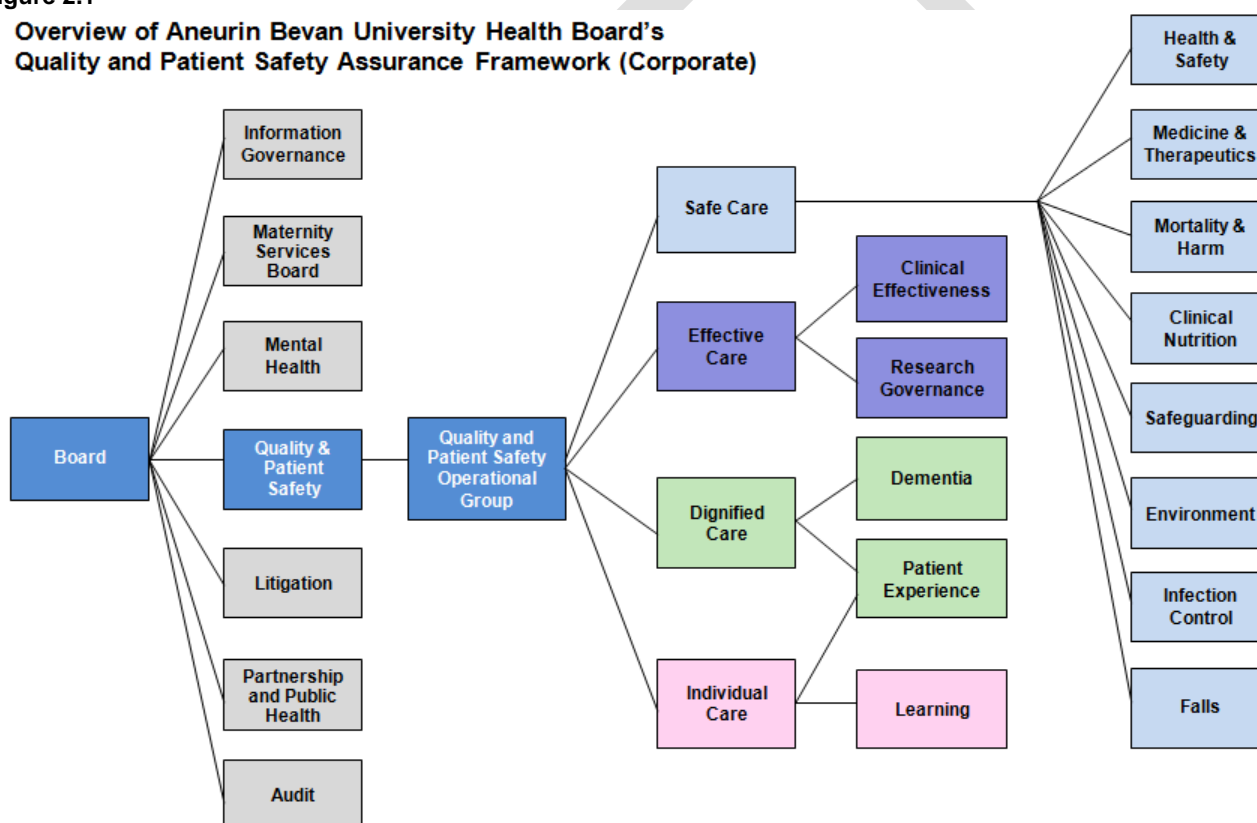
2.1 Quality Assurance

The quality of the care we provide is assured primarily by the Board's Quality and Patient Safety Committee (QPSC), which meets every 2 months and receives reports on issues that fall within its terms of reference. An overview of the framework is shown below (Figure 2.1), demonstrating how the Health Board aligns quality assurance and improvement efforts around the key themes of safe care, effective care, dignified care and individual care. Reporting lines on the work of the various groups and committees feed up to the Quality and Patient Safety Committee through the Operational Group which escalates issues to the Board as appropriate.

The QPSC receives a Quality Improvement Report at every meeting, monitoring high level outcome measures and key process measures for the main areas of improvement described in the section, as well as an overview of themes from Mortality Reviews, Complaints and Incidents. Some of the themes in the Health and Care Standards are led by other Board Committees – such as Staying Healthy by the Public Health and Partnerships Committee, and aspects of Clinically Effective Care through the Information Governance Committee.

Figure 2.1

Overview of Aneurin Bevan University Health Board's Quality and Patient Safety Assurance Framework (Corporate)



The 22 Health and Care Standards are grouped in to 7 themes and provide the framework against which we assess all our services, to identify gaps, risks and areas for improvement. The same 7 quality themes are used in the NHS Outcomes and Delivery Framework and we continue to prioritise areas that reduce avoidable harm to patients, specifically:

- Avoidance, early identification and management of sepsis, healthcare associated infections, hospital acquired thrombosis, falls and pressure damage.
- Compliance with essential care, including dementia, nutrition, hydration, skin care, medicines and continence care.
- Adopting prudent healthcare principles, ensuring that patients are equal partners and fully engaged in our improvement events.

- Embed identification and treatment of dementia across all areas.
- Reducing mortality, sustain this reduction and decrease variation that is not accounted for by the difference in services across our hospital sites.
- Improving the quality improvement skills of our staff.

These health and care standards are embedded at Divisional and Directorate level, with any gaps identified taken forward through improvement plans and risk registers. For each standard, a Corporate Standard Holders is identified who has expertise in that standard and provides a more localised overview of what should be in place to meet the standard. The framework lays out both the corporate systems and processes for the standard and what the Divisions need to have in place to meet the standard. Risks that cannot be managed within the Division are escalated to the Quality and Patient Safety Operational Group, and, where necessary, on to the Quality and Patient Safety Committee.

Independent Members are involved directly through championing specific issues and areas of service, providing challenge and support. They also consider a performance report on quality at every Quality and Patient Safety Committee, which monitors quality outcome measures, many of which are reflected in the quality improvements in this plan. Increasingly the measures reflect quality across the whole patient pathway. The reporting arrangements enable them to monitor against milestones that have been set, to ensure we are moving towards each outcome.

Our assurance processes are supported by many sources of data that we use to learn about how we can do better. This starts with the patient voice by triangulating concerns and patient experience information (for example real time electronic patient surveys or special interest groups) with mortality reviews, national clinical audits, incident reporting (including serious incidents), complaints, Ombudsmen reports, from listening to our staff, stakeholder, partners, patient stories, patient shadowing and patient surveys.

Key safety data is pulled together each week and discussed in an Executive Safety Huddle as an early warning system, in order to identify and address any emerging operational issues. In order to identify gaps and monitor improvement over time on the wards, an electronic dashboard is in the final stages of development. This is, initially, covering pressure damage, in-patient falls, ward complaints and medication incidents, with the data taken from datix. The dashboard will provide data at ward level, but this will also be aggregated to provide Divisional and Health Board overviews.

In response to the Palmer Report (2014) the Health Board is continuing to conduct mortality reviews undertaken by senior, independent clinicians, whilst preparing for the introduction of the Medical Examiner role. The Health Board regularly monitors specific mortality data for Stroke, Myocardial Infarction and Fractured Neck of Femur. Stroke mortality data is monitored alongside National Audit data, and the UHB is looking to develop this approach, and see whether this can also be combined with condition specific mortality reviews. We also have developed processes to ensure that the Health Board can fully participate in all National Clinical Audits (NCA). To support this, we are embedding new processes for the dissemination of the results of NCA reports within the organisation, to ensure areas for improvement are quickly identified and changes agreed and implemented. Our aim is to see year on year improvement in our results in National Clinical Audits.

2.2 Essential Care

We have continually monitored our performance and considered our position in relation to the elements of essential care, building on the recommendations made in “Trusted to Care” and supported by partnership dignity visits and systematic reviews of care.

The following key indicators of quality care are monitored through the quality and patient safety assurance framework and reported to the Quality and Patient Safety Committee:

- Health Care Acquired Pressure Ulcers (National indicator)
- Health Care Acquired Infections (National indicator)
- Incidence of falls and falls associated with harm

The following are underdevelopment and will be reported once the data is robust:

- *Medication errors*
- *Timely nutritional assessment (National indicator)*

Fundamental to this work is the promotion of an improvement culture and safe and effective care in practice in order to reduce harm. This has included the establishment of Pressure Damage Scrutiny Panels to review all instances of significant pressure damage acquired in hospital. This ensures a refocus on understanding the risk factors for pressure damage and the actions that ward staff, the division and the health board needs to take to reduce risk. This is now being taken forward through the Pressure Ulcer Collaborative, in partnership with ABCi. Reporting of pressure damage is now in place for community acquired pressure damage and is being rolled out across care homes. Similarly the establishment of the Falls Scrutiny Panel to review the investigation of every in-patient fall resulting in a fracture ensures a ward to board focus on risk reduction.

The process for capturing real time data on all of these areas is being progressed to ensure a swift response to enable learning and demonstrate improvement against targets.

We are committed to enhancing our engagement with patients and their families to seek their views on the care we provide so that we can listen and learn with the aim of improving patient and family experience. This year we have continued to build on the outcomes of the Evans Report, "Using the Gift of Complaints" on complaints handling in NHS Wales. This concluded that "Putting things right" is the right approach for managing complaints and concerns. The Health Board will continue this work, closely aligned to the patient experience and citizen engagement programme.

We welcome and encourage patients, relatives, carers and the public to communicate their views and experiences with us. In particular, we are encouraging people to raise their concern with us directly at an early stage so that we can work with them to resolve their issues before they escalate into a formal complaint. We have consulted on the Ombudsman Wales Bill in terms of future proofing our work in relation to complaints management and are working in collaboration with the Ombudsman's office and Welsh Risk Pool as part of the National Ombudsman's Network Group.

We are further developing the way we manage concerns (Incidents and complaints) to ensure both the timeliness of the response and the quality of contact, openness and communication with those raising a concern.

The Health Board Executive Director of Nursing is the Executive lead for concerns. We have a Corporate Concerns Team who provide specialist advice and also support the Operational Divisions to manage Incidents and complaints. We have put in place the standards of the putting things right guidance and the standards that are articulated in the Welsh Government White Paper, "Services fit for the future", including an approach whereby we are open with those who complain and we aim to respond with information which is straightforward and easy to understand.

We work with other organisations where concerns cross two or more NHS organisations.

We remain fully committed to using the learning from concerns to improve our service standards and user experience.

2.2.3 External Inspection Process

Throughout the year different health settings across the health board have been subject to external inspection from Health Care Inspectorate Wales and also from the Community Health Council. This provides opportunity to identify good practice and also to progress areas of improvement where this may be necessary in specific wards or areas; directorates and divisions. It is equally important to share findings across the divisions of the health board for the purpose of wider learning. Quarterly briefings of common findings are disseminated to support divisions in this wider organisational learning; to determine any necessary overarching health board actions and to identify any recurrent themes over time.

SECTION THREE – PROFESSIONAL REGULATION

Nursing

3.1 Professional Regulation for Nurses

ABUHB has a clear governance framework relating to the Director of Nursing and wider organisational responsibilities for ensuring all registrants maintain their 'fitness to practice' through robust procedures for the monitoring of registration, appropriate professional, educational standards and in terms of conduct and performance with clear and transparent processes in place to investigate those who fall short of the required standards.

Revalidation is the professional responsibility of the individual registrant; however ABUHB plays a key facilitative role through individualised direct targeted timely information giving and support/ dedicated intranet page / ESR utilisation / provision of folder, templates, forms and other resources /direct pilot partner quarterly update links with the NMC, in supporting registrants to successfully revalidate and renew their registration. The Health Board has over 3,500 Registered Nurses and Midwives, all of whom are required to meet the new NMC revalidation requirements, demonstrating safe and effective practice in line with their Professional Code. In line with the NMC and All Wales Registration and Revalidation Policy individuals who do not meet the requirements will be unable to practice as a registered nurse or midwife.

3.2 PDR compliance

The requirement for registrants to undergo PDR on an annual basis is valued, promoted, discussed and recorded within ABUHB.

3.3 Education and development

The Health Board has a robust preceptorship programme in place known as the **Journey of Excellence** (JoE), supported by practice educators and clinical skills trainers, providing formal support and guidance to registrants. JoE enables successful transition from student to registered nurse or midwife, those returning to practice, overseas staff and those new into post or a new speciality area and those developing through their professional career pathway. This dedicated support provides a structured objectively assessed pathway enabling registrants to confidently and competently deliver safe and effective care to patients, develop professionally and to build expertise working towards advanced practice. It provides a novice to expert approach across clinical practice, education and training, leadership, strategic development, research and audit. The programme also aims to help with recruitment and retention for the organisation and it is supplemented by a structured approach to ongoing mandatory and professional development days for all registered nurses and midwives across the organisation.

3.4 Nursing and midwifery strategy

Our nursing and midwifery strategy '**Living the Code – Delivering the Care**' identifies within the context of national and local imperatives and new legislative changes, the direction and objectives that nursing will need to achieve in the next few years. It outlines the fundamental requirement to working in partnership across all sectors and professionals to deliver workforce, training and education across acute, community and primary care settings.

3.5 Nurse Staffing Levels (Wales) Act 2016

From 6th April 2017 all Health Boards and Trusts in Wales have a duty to comply with sections 25A of the act. There is no statutory guidance relating to Section 25A. In order to comply with this section of the Act the Health Board has reviewed and strengthened a number of systems and processes that can demonstrate that the Board has regard to ensuring that the services it both provides and commissions result in the supply of sufficient numbers of nurses to care for patients sensitively. These include:

- The adoption of approved systems/tools to undertake workforce planning which include
 - Evidence based workforce tools
 - Professional judgement based on the expertise of ward managers and senior nurses to determine the number of nurses required on any ward or care environment based on patient need and acuity

- Use of pre-planned electronic rostering based on agreed establishments and proactive planning drawing upon expected workload and patient throughput.
- Programmes of recruitment of registered nurses on a planned basis throughout the year based on workforce data that identifies vacancy and turnover;
- A programme to review and encourage the retention of registered nurses,
- Working in partnership with a variety of educational institutes to provide adequate education and training of nurses through agreed commissioning of student nurse numbers.
- The development of ward key performance and quality metrics that can be triangulated with staffing levels to demonstrate and evidence the sensitivity of care provided through the workforce numbers.

In preparation for this section of the Act the Health Board can demonstrate that appropriate systems for workforce planning and the education and training of nurses are in place. To strengthen this the strategic nurse education committee has been reviewed and a nursing resource/workforce committee has been established.

From April 2018 sections 25B and 25C of the Act will commence with supporting statutory guidance pertaining to acute adult medical and surgical wards. An action plan has been developed to support implementation which will be monitored by the Executive Team. This includes review of the governance and management arrangements to strengthen the evidencing of decision making and reporting of decisions relating to nurse staffing. Alongside the Capacity Escalation Policies a Staffing Escalation Policy will be in place.

As part preparation for commencement of duties 25B and 25c of the Act effective from April 2018, the Health Board has:

- Assessment completed to confirm the medical and surgical wards included, 12 Wards in Scheduled Care and 15 Wards in Unscheduled Care.
- Each staffing act ward has had a review of the staffing levels in accordance with the Act and statutory guidance
- Paper prepared for Executives and Board to approve the staffing levels in readiness for April. There is a requirement for additional funding which will need to be included in the IMTP, above what is currently being incurred figure TBC £0.260m
- Vacancies for the staffing Act wards currently are 62.25 wte Unscheduled Care and 43.54 wte Scheduled Care. Recruitment activities are ongoing with a further event planned for the 15 March in Bristol. In addition return to practice numbers increased.

Consideration is also being given to the reporting of nurse sensitive care indicators, as identified in the guidance: Patient Falls, Pressure Ulcers and Medication administration errors. This will require the appropriate IT systems to allow ward to board reporting.

The biggest risk relates to RN vacancies with currently approaching 260 wte vacancies across the Health Board. The Health Board is pursuing all options to recruit, including people living locally who have previously been registered either in the UK or abroad and were interested in support to obtain their registration PIN with the NMC.

3.5 Medical Revalidation and appraisal

There are currently 1114 doctors with a prescribed connection to Aneurin Bevan University Health Board, 471 in primary care and 643 in secondary care, 558 of which are in substantive posts. The formal process in place within Aneurin Bevan University Health Board for revalidating our medical workforce is working well. This process supports our doctors in the months prior to their revalidation to enable them to gather the information required in order for a positive recommendation to be made. Alongside this, the Medical Appraisal and Revalidation System (MARS) which acts as an enhanced e-portfolio system to support annual appraisal, has worked well to allow individuals (and the Health Board) to monitor progress throughout the five year revalidation cycle.

<p>Appraisal & Revalidation Highlights:</p> <ul style="list-style-type: none"> ▪ 93% of doctors logged on to MARS. ▪ 94% of secondary care doctors in substantive posts have had an appraisal in the last 18 months. ▪ Appointment of an Appraisal Lead. ▪ SAS doctor engagement particularly encouraging. ▪ Improvements to Appraisal Summary & the development of ongoing QA. ▪ Development of the Appraisers' Network. ▪ Developments in relation to the new MARS system. ▪ Embedded Revalidation Process. ▪ Introduction of formal processes to ensure annual appraisal. ▪ Enhanced Governance Triangulation. ▪ Positive Meeting with Deputy CMO re Revalidation Governance. 	<p>Appraisal & Revalidation Challenges:</p> <ul style="list-style-type: none"> ▪ Ensuring appraisal happens each year, not just prior to revalidation. ▪ Managing appraisal for Clinical Fellows. ▪ Appraiser Support. ▪ Timely recognition of new doctors' revalidation dates. ▪ Clinical Fellow/short term locum revalidation. ▪ Remediation.
--	--

93% of ABUHB doctors are now logged on to MARS and are in the process of undertaking annual appraisal. This figure is unlikely to reach 100% due to the transient nature of some of our medical staff, particularly clinical fellows which make up approximately 8% of our overall total in primary and secondary care. All doctors undertaking appraisal must use the MARS system.

All General Practitioners have to undertake an annual appraisal in order to retain their registration on the Medical Performers' List. The MARS appraisal system and the annual appraisal process is fully embedded into everyday practice.

The following table depicts appraisal rates for the last 12 and 18 months:

Table 3.1

Grade	01/03/2016 – 01/03/2017 (12 months)		01/09/2015 – 01/03/17 (18 months)	
	No of Appraisals	%	No of Appraisals	%
Consultant	369	83%	381	86%
SAS Doctor	89	77%	92	79%
Clinical Fellow/Other	41	48%	43	51%
General Practitioner	420	89%	462	98%

Whilst we aim for all our doctors to have annual appraisal, there will always be a small percentage who do not have an appraisal – for example those on maternity leave. We are particularly happy in the levels of engagement seen from our SAS doctors as there was previously a perception that this group of staff may prove challenging. We have focused on ensuring that we help support our doctors through the appraisal process and we have seen evidence which suggests that this approach has been beneficial, not least the figures shown above. In addition, we have run a number of roadshows aimed at SAS doctors and the feedback we have received from these have been particularly encouraging.

Initial investigations are showing that the quality of the appraisals is also improving significantly as clinicians gain more understanding of the appraisal process. We have already received a large amount of feedback from clinicians advocating the benefits of appraisal, particularly now that it is being carried out in a more structured manner. Although there is still a lot of reticence with regard to the MARS system, it appears that it does support a structured appraisal which is proving to be of benefit to many.

The development of an Appraisers' Network has proved to be successful in supporting and professionalising our Appraisers which in turn is resulting in a higher quality of appraisal. Feedback suggests that these sessions are seen as extremely useful, particularly in identifying and resolving issues. We aim to run these 2 to 3 times per year.

We have also appointed an Appraisal Lead within the Organisation. This individual will work closely with us in order to provide enhanced support to our Appraisers and to assist in the quality assurance of our processes. In addition, this post will be used to ensure that issues and themes from the wider organisation arising through through SIs, mortality reviews etc, will be discussed at appraisal to ensure that lessons are learnt and appropriate reflection is made.

The following table shows the revalidation recommendations made over the past four years:

Table 3.2

	2013/14	2014/15	2015/16	2016 to date
Positive Recommendations	209	346	329	35
Deferral Requests	24	46	42	15
Notification of Non-Engagement	0	0	0	0
TOTAL	231	392	371	50

We are particularly pleased to report that we have had no instances of non-engagement to date. It is our belief that this is due to the positive approach that ABUHB has taken towards revalidation and appraisal.

3.6 Next Steps

We are looking forward to the coming months which will allow us to evaluate our processes and procedures which we have developed over the past 3 years. At an all-Wales level there has been discussion around a series of evaluation visits to Health Boards to look at processes around revalidation to ensure consistency across Wales. We want to make sure that the processes and procedures in place here in ABUHB are considered as an example of good practice across Wales and will use the coming months to firm up on the areas which represent challenges for us.

3.7 Quality Assurance

We are developing a formal process for Quality Assurance within the Health Board which will give our Responsible Officer assurance in relation to the quality and uniformity of appraisals.

3.8 MARS Development Project

The system used to record, monitor and manage appraisal and revalidation is currently being developed and it is anticipated that a radically improved version of the MARS system will be available from mid-2017. We are very pleased that many of the enhancements we have put forward are being accommodated in the new system and we hope that obtaining statistical information which will be extremely useful in monitoring appraisal activity and improving the quality of appraisals will become significantly easier. However, we are also wary of introducing a new system, and will be commencing work with the Revalidation Unit in Cardiff to ensure that we roll the system out in a structured and supported way to all our clinicians, many of whom have only just become familiar with the old system.

3.9 Constraints Reporting

We are keen to improve our ability to report on constraints raised at appraisal. Currently, MARS is unable to give us useful data on this and we are working to develop a process whereby we can record and address many of the constraints raised at appraisal. We are also keen to ensure that the new MARS system is able to provide this information easily.

3.10 Professional Regulation for Therapists and Health Scientists

Therapies and Health Science has 1,200 registered staff working in ABUHB, across 16 staff groups (18 distinct professions) constituting a diverse workforce:

Though operationally managed in different Divisions within the UHB, these are the staff that are ultimately professionally accountable to, and represented on the Board by, the Executive Director for Therapies and Health Science.

Most qualified Therapies and Health Science staff working in ABUHB are registered with the Health & Care Professions Council (HCPC) with the exception of Audiologists, Cardiac physiologists, Neurophysiologists and Nuclear Medicine Technologists who may have a voluntary registration with the Registration Council for Clinical Physiologists (RCCP). Clinical Scientists and Hearing Aid Technicians who work within Audiology are registered with the HCPC.

These bodies provide the necessary governance to ensure protection of patients by requiring that

registered professionals meet the following three requirements:

The current framework of professional regulation is underpinned by codes of conduct and profession specific standards.

The Therapies and Health Science professionals are supported by HCSWs across bands 2, 3 and 4, with skill sets specifically developed to enhance the specialist area that they work within. The UHB has sound governance arrangements for HCSWs by using tools such as the All-Wales Healthcare Support Worker Framework published in 2016; this provides a framework for quality assurance and competence based education. In addition there is the Code of Conduct for Healthcare Support Workers in Wales (2011) and clear systems of delegation and supervision.

Unlike the NMC, the HCPC does not require an annual revalidation to maintain registration although there is a requirement to re-register every 2 years. HCPC registered professionals are required to maintain a portfolio of continued professional development and a random sample is selected at re-registration for audit by the HCPC. All Therapies and Health Science staff within the UHB are required to have an annual PADR which includes a requirement to demonstrate that the individual is meeting the HCPC registration requirements. Within ABUHB, the Executive Director for Therapies and Health Science is responsible for monitoring HCPC registration. To this end, Professional Heads of Service are required to provide evidence to the Assistant Director of Therapies and Health Science every 6 months that all relevant staff are registered. Therapies and Health staff who are not able to meet the requirements that allow them to remain registered with the HCPC, will be unable to practice in ABUHB as a registered therapist or health scientist.

DRAFT

SECTION FOUR – PATIENT EXPERIENCE

4.1 Overview

Understanding the experience of what it feels like to use the services of the Health Board is fundamental to being a learning organisation that is person centred in the design and delivery of services. A good patient experience is at the heart of the quality in healthcare as it encompasses all the dimensions of quality as illustrated in the figure 4.1 below. In order to achieve this, we need to be able to see the experience through the patient's eyes, recognising that every patient is an individual. This means that the patient voice needs to be present and listened to at all levels of the organisation, and that the patient is welcomed as an equal partner in their own care and in the processes of designing and delivering care.

Figure 4.1



The organisation is driven with a person centred focus and this is fundamental to the values and culture. There is a need to continuously improve and embed this approach to care and the delivery and development of services. Working with communities to assess and design services improves those services, whilst seeing individuals as equal partners in treatment decisions and self-care management improves outcomes. The challenge is to develop a new relationship with the public as co-producers in their own care, empowering the public to make informed decisions about the appropriate use of healthcare.

Listening and learning to improve the experience of care is fundamental and the framework for Patient, Family and Carer experience "What Matters to Me" is implemented within a context of integration with the Organisational Development strategy, the Citizen Engagement strategy and the improvement ABCi and value based health care work. This framework and our plan is underpinned by the Health Boards' aims and mission statement of the communities we serve which is:

- Working with you for a healthier community
- Caring for you when you need us
- Aiming for excellence in what we do

The fundamental expectation is that care for every patient should be given in the same way as we would want our family, friends and loved ones to be cared for. The overarching ambition is to demonstrably improve the experience of care for patients and their families and carers. To work collaboratively with

Figure 4.2

Our OD framework helps deliver...

- A culture that enables staff to put patients/carers first.
- Leadership that demonstrates by example that quality of care and patient experience is at the top of their priorities.
- Safe, effective and efficient care, so the patient outcome is good from the patient and professional's point of view.
- A good staff experience, so staff feel positive about their experience of providing care.
- The citizen/service user/carers voice is heard and heeded at all times and all levels of the service

patients, families and carers to bring about real change in their experience and in how we learn and improve the delivery of care and services we provide as a Health Board, understanding what matters to the population we serve.

The key aims of the framework are to:

- Provide accessible ways to actively engage with patients their families and carers encouraging all feedback.
- To act on feedback, demonstrating genuine learning and improvement from listening.
- Identify our key ambitions and an annual programme of work that will be overseen by the Patient Experience Committee to improve patient, family and carer experience throughout the Health Board.
- To better understand from people who use our services “what matters to them” and ensure patients, families and carers are provided with the best possible experience of care whilst using our services.
- Develop the approach to and understanding of person centred care in the planning and delivery of services and care.
- Develop co-production within all service development and improvement work.

The key priorities for 2017/18 include:

- First impressions and enhancing first contact with the Health Board.
- Further development of patient feedback mechanisms and learning from feedback.
- Develop the PREMs Approach to International Consortium for Health Outcomes Measures (ICHOM) Values Based Health Care.
- Focus on the essentials of care and care of older people in hospital.
- Implementation of the Dementia strategy.
- Continue to develop the implementation of All Wales Standards for Accessible Communication and Information for People with Sensory Loss.
- Refresh the Volunteering strategy and further enhance the contribution of volunteers.
- Continue the implementation of the Carers Strategy.

4.2 Listening and learning from patient feedback

Obtaining direct feedback from patients/service users and acting on it is essential. Currently the Health Board has a range of methods for gaining feedback to learn and improve the care for patients and their families. These approaches align to the 4 quadrant framework in the Framework for Assuring Service User Experience.

These include:

- Patient Surveys: such as PREMs, the All Wales core questions, the Health and Care Standards Compliance Tool Patient Experience Survey and bespoke surveys.
- Graffiti Boards and Feedback Boards such as “Top and Pants” ;
- Patient Stories;
- Patient panels;
- Patient groups such as for diabetes, primary care etc;
- Learning from Patient Safety Incidents ;
- Complaints and Claims learning; analysis of themes and sharing stories of cases.
- Compliments, understanding what we are doing well to spread good practice.
- 15 Step Challenge approach, this has been piloted in children’s services
- Observations of Care.



Patient/service User participation (via service improvement approaches):

- Kings Fund and Health Foundation Patient and Family Centred Care Programme. Currently The Stroke Team are participating in a national programme for patients are End of Life. The team are using surveys, shadowing and listening events to understand both staff and patient and family experience.

A “Tool Kit” has been developed to bring the framework to life and ensure that the methods of seeking feedback, listening and learning are more accessible. The tool kit sets out an approach to person centred care and tools to gain feedback, involve and listen to the people who use our services to improve what we do. The use of the tool kit will be aligned to improvement work with ABCi.

In addition to this process patient feedback is also obtained from:

Social media: The Communications Team have set up processes for monitoring, capturing and sharing patient feedback via Facebook and twitter. This provides an opportunity of alerting Wards/departments to all real time feedback enabling ‘on the spot’ resolutions to issues identified. It also assists in capturing compliments, sharing them with teams and individuals in a timely manner.

Monitoring Reviews: Executive walk rounds are well established and link in with the Community Health Council reviews and Dignity Inspections.

Health Boards across Wales are required to support patients/carers to provide feedback in a simple, timely and proactive manner. Within ABUHB in addition to the mechanisms above which are in place in every division we are developing systematic feedback collection on a larger scale using the all wales core questions. The Health Board is now taking this forward as part of an integrated approach with the PROMs and PREMS ICHOM programme and using Dr Doctor as the platform for collection of feedback.

This feedback from patients and their families is collected and used in a number of ways with a focus on listening, learning and most importantly using the feedback to take actions to improve the service. Clinical and Service areas are developing their “You said, we did” Boards.

It is recognised that patient stories are very powerful and can directly influence behaviour and care delivery. Each Formal Board meeting is opened with a patient story. This helps to focus the meeting on the patient who is at the centre of all we do.

Timely analysis of feedback from concerns, complaints, compliments and clinical incidents, is undertaken as recommended by Welsh Government within the Putting Things Right Regulations. Through thorough analysis, assurance can be given on the standard and quality of care as well as alerting Ward to Board about any concerns in a timely way enabling prompt and responsive action to be taken. The analysis, audit and monitoring of the information are essential steps in the good governance. The analysis of the findings is also used to support improvement projects across the Board linking with ABCi and shared via the Learning Committee.

The Quality and Patient safety committee receive bi monthly reports which provides details about complaint performance against the 30 day target, themes and trends and remedial actions taken to prevent further complaints and to improve the patient experience.

Further work now needs to progress on the development of Datix as a reporting and assurance tool and the Executive lead is linking with National leads to look to develop quality dashboards both at a corporate and ward level where data can be used to encourage local ownership and so quickly identify trends to allow a more timely response.



Local engagement events to discuss isolation and loneliness has driven forward a social movement aimed at supporting people to reconnect with their communities.

Ffrind i mi (or Friend of mine) is a new initiative that Aneurin Bevan University Health Board and its partners are developing to try and make sure that anyone who feels lonely or isolated are supported to reconnect with their communities. Working with Community Connectors and existing volunteer befriending services, we aim to both signpost people to existing services and recruit as many volunteers as possible to support those who are lonely and/or isolated. We hope to match the interests of people to volunteers with the same interests e.g. gardening, watching sport, dog walking.

This initiative supports the Well Being of Future Generations Act and has helped inform the Health Boards well-being goals. Ffrind i mi had a ministerial launch in January 2017. More information on this initiative can be found at www.ffrindimi.co.uk

A range of external bodies, including the Community Health Council and Health Inspectorate Wales, also undertake formal, independent reviews of our systems, processes and practice, which also underpin our quality assurance processes and enable a triangulation of data.

4.3 Clear Aims and Measures for Patient Experience

The Patient Experience Steering Group have updated the aims and continue to measure and lead the patient experience agenda in collaboration with other departments, staff and service users/carers. An action plan embracing the All Wales Standards for Accessible Communication and Information for People with Sensory Loss is in place and monitored to deliver change and embed the All Wales Standards for Accessible Communication and Information for People with Sensory loss.

4.3.2 Executive and Independent Members Walk About

Executive and Independent Members of the Health Board place great emphasis on engagement with patients and staff as a mechanism to improve quality and patient safety. A four pronged approach has been adopted and embedded in the organisation, namely

- Patient safety Walk About is a fortnightly programme of an Executive and an Independent Member visiting a service area.
- Executive Directors have a programme of shadowing staff, from porters to surgeons and across all care settings.
- Executive Directors have a programme of visiting service areas that are innovating new models of care.
- Chief Executive has an annual programme of drop-in sessions, covering every hospital site, sessions are open to staff and the public.

4.3.3 Value Based Health Care and Co-production

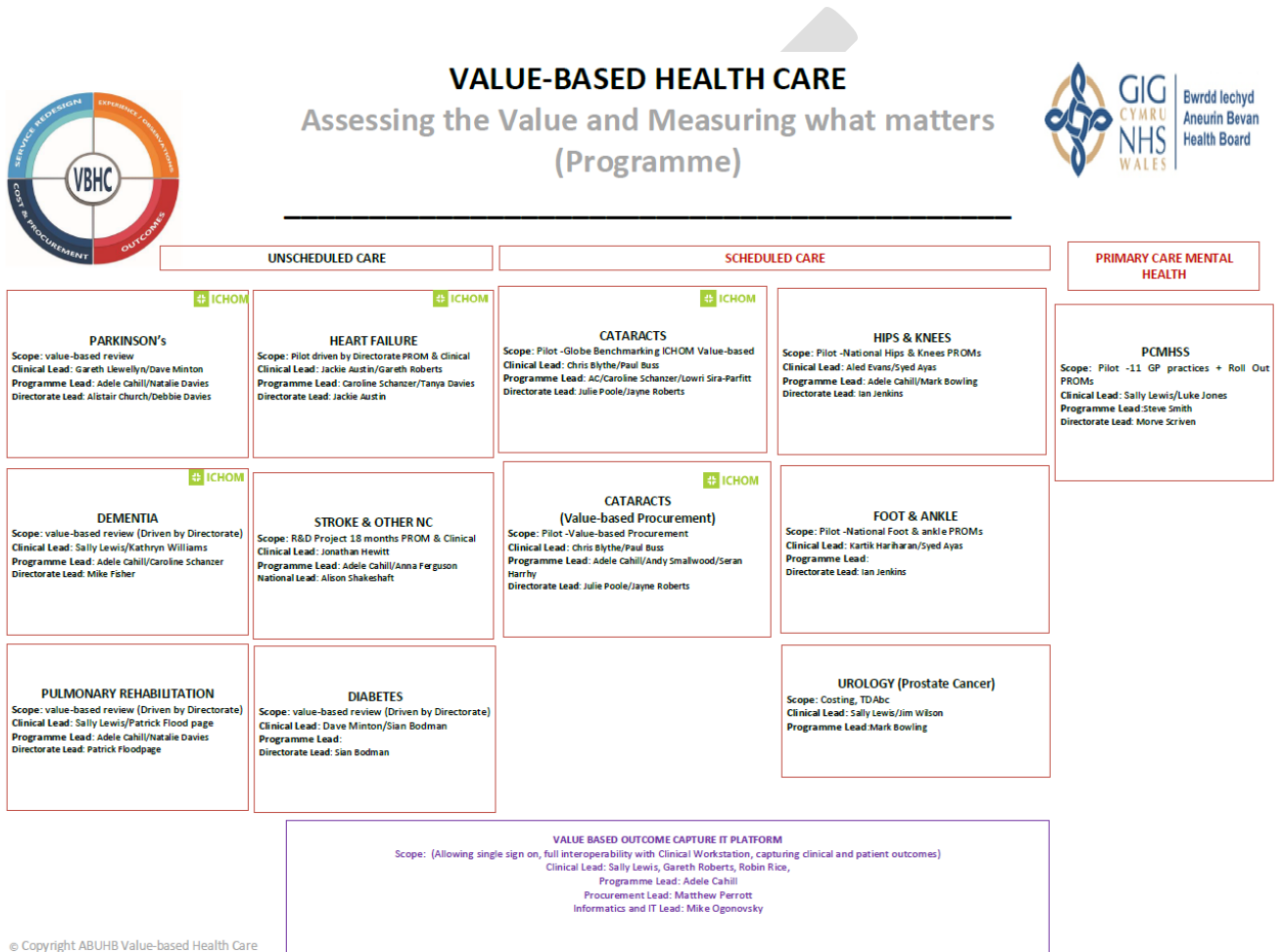
Our current model of health care is based on clinicians deciding what treatment will work best for patients and requiring (sometimes supporting) their compliance with the treatment programme. Whilst this approach has served us well in the past, in the face of the rising tide of long term conditions, it has faltered and stalled. Something else is required to complement clinical expertise and health services. The answer lies in recognising what people and communities want and could do for themselves and reorienting and reshaping health and other services to support them. This new co-productive approach requires major culture change with patient's 'lived experience' being given equal weight alongside the expertise of clinicians. The new approaches will also require a redesign of pathways around people, rather than diseases, and a reshaping of budgets and incentives.

Ensuring the quality and safety of services is enhanced; and preventing poor health and reducing inequalities. Currently the outcome indicators being relied upon to measure progress are limited to specific mortality rates and activity volumes (i.e. emergency hospital and mental health admissions). Value-Based health care and specifically patient reported outcomes have been identified as a means of reflecting the interests of the patient and the challenge to NHS Wales is to establish a consistent evidence based approach to give every patient the opportunity to co-produce and evaluate their own care, both individually and at a service level.

Understanding the quality of life of our population and the effectiveness of the care we provide is essential to make high quality informed internal commissioning decisions. Judgements on equity of service and how to best meet both the needs and demands of the population require a robust evidence based and analysis that will stand up to both clinical and legal challenge in terms of whether or not the care we provide and commission has led to real improvements in outcomes, and that we are allocating resource for maximum impact.

The Health Board is committed to driving Value-Based healthcare as the key vehicle to deliver prudent healthcare, our approach:

- Positions citizens in an equitable relationship with professionals and practitioners in co-producing health care through equal access to shared information.
- Aims to provide a safe, secure, rich digital resource and tool for citizens to access care and be cared for when they need it.
- Enables the professionals and citizens to have the right information at the right time and presented in the right way, to do only what is needed, nor more, no less; and do no harm. It enables the rapid evaluation of new models of care by the clinical teams implementing them according to Value-Based healthcare principles, allowing for prudent investment and disinvestment through the IMTP. This will be essential to the delivery of the clinical futures model and the Specialist Critical Care Centre.
- Provides the opportunity to deploy and support an 'All for Wales' solution for the provision of a cohesive consistent and transparent approach to capturing and sharing information between citizens and health and social care organisations in Wales.



4.3.4 Volunteering

The 1st ABUHB Volunteering Strategy 2014-2017 is currently being refreshed and will be re-launched in 2018.

Key developments in the last three years include:

- The introduction of a streamlined recruitment process whereby volunteers can have their informal interview and checks initiated (included DBS) at a local convenient appointment.
- Raising the profile of volunteering through the publication of dedicated web and intranet pages and annual volunteer recognition events funded by the Charitable Funds committee.
- Innovative full mealtime support, including feeding low risk patients, provided by Age Cymru Gwent Robins at St Woolos and the Royal Gwent Hospitals. This has full governance with specific training and documented, delegated responsibility of the registered nurse. It remains a significant development within the whole of Wales.

- The number of volunteers, including bespoke individual opportunities and larger schemes increases year on year.

The refreshed strategy will focus on:

- Volunteering as Core Business, integral to service development with divisional plans reflecting opportunities to enhance service provision with volunteers.
- Further alignment with the people strategy and maximising the contribution of volunteering across the Health Board.

The 2018 Work Plan, aligned with the Patient Experience Work Plan includes:

- Growing Volunteering in every division across the Health Board
- Ensuring first impressions for people using services of the Health Board are welcoming, accessible and informative, developing a plan for meet and greet services and identifying resources required.
- Expanding Ffrind i Mi (Friend of Mine), building the potential and reach.
- Promoting and recruiting therapy dog volunteering across the Health Board, in partnership with Pets as Therapy and Therapy Dogs Nationwide.
- Holding an annual volunteering recognition event, inviting representatives from volunteer schemes across the Health Board.

4.3.5 Safeguarding and Public Protection

Safeguarding is central to all aspects of Health Board activity and the safety of service users and their families is a priority for us. The safeguarding agenda has increased in breadth and complexity in recent years and is concerned with children and young people; vulnerable adults, particularly the frail elderly; domestic abuse; sexual exploitation, human trafficking and slavery; female genital mutilation and counter terrorism. We recognise the role that the Health Board plays in all of these circumstances. Close partnership working is through the regional Children's Safeguarding Board; Adult Safeguarding Board, the Violence Against Women, Domestic Abuse and Sexual Violence Regional Board (VAWDASV) and Multi- Agency Public Protection Strategic Management Board. This supports service development and through the scrutiny of inter-agency practice, provides assurance and identifies where improvements can be made. Over the coming year we will continue to work with partner agencies to further strengthen safeguarding processes and practice in meeting the requirements for implementation of the Social Services and Well-being (Wales) Act 2014 and the Gender-based Violence, Domestic Abuse and Sexual Violence (Wales) 2015. This is reflected in the review of the Aneurin Bevan University Health Board safeguarding strategy. Implementation is overseen by the Health Board Safeguarding Committee, chaired by an Independent Member, reporting to the Quality and Patient Safety Committee. Priorities include implementing a programme of training that incorporates all aspects of safeguarding at an appropriate level to the right staff; participation in the Welsh Government Gwent pilot of 'Ask and Act' and the launch of a regional VAWDASV strategy to support in recognising and responding to domestic abuse. The health board takes a lead role in the investigation of significant pressure damage wherever this occurs and is working with local authorities to determine the inter-agency process for safeguarding in this regard.

The Health Board has a range of statutory obligations in relation to safeguarding (adults and children). Local governance arrangements for safeguarding have been established and are led by the Executive Director of Nursing & Midwifery. Our safeguarding strategy and training plan **Keeping People Safe (2016- 2019)** takes account of the impact of new legislation relating to Safeguarding and Public Protection including:

- Social Services and Well-Being (Wales) Act 2014;
- Violence Against Women, Domestic Abuse, Sexual Violence (Wales) Act 2015;
- Female Genital Mutilation (FGM) Protection Orders;
- Counter Terrorism and Security Act 2015.

4.3.6 Caring for people with Dementia

The first Dementia Strategy for Wales for Wales will emerge in spring of 2018. The Wales dementia strategy follows broad consultation with people living with dementia, their close families, professional groups, health and social care services, voluntary groups and national organisations in its development, design and purpose. The Dementia Strategy will be of interest to all NHS Wales's employees and public service employees and will set out the expectations regarding minimum and suitable learning associated with skills required to assist people who live with dementia, their families and our communities.

The Health Board led multi-agency Dementia Board will launch an interim Regional Dementia Strategy for consultation in January 2018. This regional strategy involves an overarching aim and individual priority plans for the Aneurin Bevan University Health Board and the 5 Local Authorities. All regional activity will be taken forward through new sub groups of the dementia board via a refreshed dementia board outcomes framework with milestones.

This strategy has been informed by a population needs assessment undertaken by the Alzheimers Society with service users in Gwent and reflects the themes of Together for a Dementia Friendly Wales 2017-2022 (Welsh Government Consultation January 2017). These are:

- Risk reduction and health promotion;
- Recognition and identification;
- Assessment and diagnosis;
- Living as well as possible for as long as possible with dementia.
- The need for increased support in the community.
- More specialist care and support
- Supporting the plan: Research; Education and Training

We are engaged with a number of researchers to take different aspects of dementia research forward. This has included an Ethnography study conducted by Cardiff University in 2 wards within each of 5 UK hospital sites (RGH is the only Welsh centre). The study examines everyday care, medication and feeding practices within acute hospital wards, with a focus on identifying clinical responses to refusal and resistance to food, drink and medicines and includes the experiences of both patients who refuse and their carers. We will be working with the researchers in the development of a structured way of improving the processes of care and patient outcomes.

The Royal Gwent, Nevill Hall and Ysbyty Ystrad Fawr hospitals participated in the National Audit of Dementia and this has supported the Health Board in identifying the key priorities for the coming year including:

- Improving dementia diagnosis rates
- Developing a dementia skilled work force
- Establishing a clear protocol for the clinical assessment of delirium in general hospitals.

SECTION FIVE – QUALITY IMPROVEMENT

Quality Improvement Baseline and Priorities

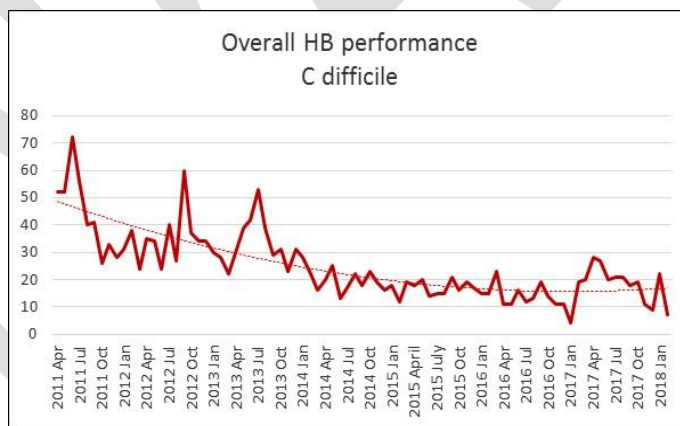
Everything we do as an organisation impacts on the quality of care, safety and the patient experience of that care. Through our assurance processes and learning, we have identified the following priorities as these are the areas which impact across the whole organisation and that we can have maximum impact in reducing harm to our patients. Many of these require integrated working across the whole patient pathway in primary, community and secondary care. Through doing this we will also reduce length of stay and readmissions, and therefore also improve patient flow. Where action plans have been developed and where improvement projections have been identified, these are included within our Patient Safety Improvement Plan, which aims to reduce the number of avoidable deaths and incidents of harm in the organisation. In addition, areas are prioritised on a National basis through the Delivery Framework, and the National Outcomes Framework.

5.1 Health Care Acquired Infections (HCAI) - *Clostridium difficile* (C difficile) and *Staphylococcus aureus* (S aureus)

Aim for C. Difficile, the Health Board is to ensure a rate of no more than 26/100 000 population is delivered in the final 3 months of the reductions period 1 April 2017 – 31 March 2018. Welsh Government has agreed an individual rate for the Health Board for S. Aureus bacteraemias (MRSA and MSSA) which is to ensure a rate of no more than 20/100 000 is delivered in final 3 months of the period, and for E Coli bacteraemia is no more than a rate of 63/100 000 population.

The Welsh Government target for C. difficile was met in March 2017. We achieved a rate of 27.67 per 100,000 population and a 21% reduction compared to the previous year. However, the Health Board saw a sustained increase in cases from February to April 2017. We have seen a welcome downward trend particularly on hospital sites. This, in all probability, is due to sustained deep clean programme, particularly on the Royal Gwent site.

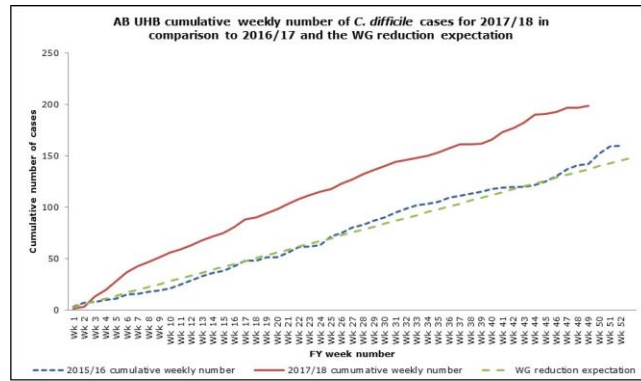
Graph 5.1



Graph 5.1 shows the number of cases of C difficile reducing over the period to March 17. The number of cases per month then increased and slowly reduced to the numbers achieved in early 2017. There was a disappointing increase in cases in January 2018, which included two outbreaks. The number of cases for February has then dropped back down to the number achieved in early 2017.

The Health Board has profiled the improvement required to meet the March 18 target (see Graph 5.2) and this has been built up from Division specific profiles which identifies target numbers of cases weekly, monthly and cumulatively. There is weekly monitoring of performance and feedback to Divisions with the current performance below the profile. This demonstrates that, due to the increase in cases that has been experienced, we will not be able to meet the 2017-18 WG target.

Graph 5.2



The Executive Team were alerted to the March 17 increase and, following an extraordinary meeting of the Champions Steering Group, key messages were disseminated with particular emphasis on ownership. Divisional management teams were asked to reiterate the UHBs commitment to “infection control being everyone’s responsibility”. This is a key message that has been emphasised at all levels of the organisation.

The Health Board has a strong Infection Prevention Performance plan which was reviewed and strengthened following the March 17 increase. As it was identified from surveillance data that more work needed to be undertaken in Primary Care to establish which infections can be considered avoidable and take appropriate action, **a specific Healthcare Associated Infection Primary Care Action Plan has been developed.** This covers c. difficile, Staph aureus (including MRSA) bacteraemia and E. Coli bacteraemia.

The Health Board Infection Prevention Plan ensures that a number of key actions have continued and been strengthened in hospitals. The most important of these going forward are:

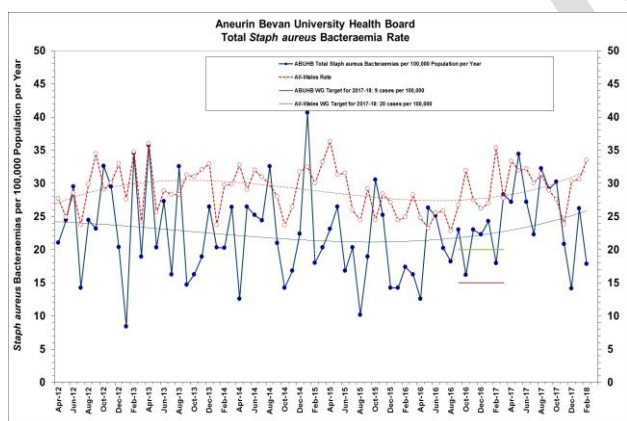
In 2018-19, we will:	When
Appointment of an Executive Lead for the 5 work streams of the 1000Lives National Collaborative for HCAI and Antibiotic Resistance	Qu1 2018/19
Full participation in the 1000Lives National Collaborative for HCAI and Antibiotic Resistance (ongoing)	2018-2021
Appoint to the increased hours for the Antibiotic Pharmacist for Hospital and Community	Qu1 2018-19
The development of a prudent antibiotic prescribing model to ensure antibiotics are prescribed to policy.	2018-2021
Carry out full programme of HPV cleans across NHH and RGH	Qu1 & 2 2018/19
Build on the improved Medical Engagement in HCAI reviews	Qu1 – 4 2018/19
Develop a plan to address the disparity in cleaning hours between acute hospitals	Qu1 & 2 2018/19
A refreshed hand hygiene campaign in conjunction with the Communications Team	2018/19
Ongoing actions that are maintained continuously include:	
<ul style="list-style-type: none"> The dissemination of key messages around hand hygiene, cleanliness and prudent antibiotic prescribing from the Executive Nurse Director, Director of Therapies and Health Sciences and Medical Director. An inspection of mattresses, with appropriate replacement if found to be contaminated. Close communication with Patient Flow Teams to ensure patient movement is appropriate & restricted and symptomatic patients are rapidly isolated. Trend analysis of RCA findings 	

The new **Healthcare Associated Infection Primary Care Action Plan** is now being implemented. Key actions within this plan include:

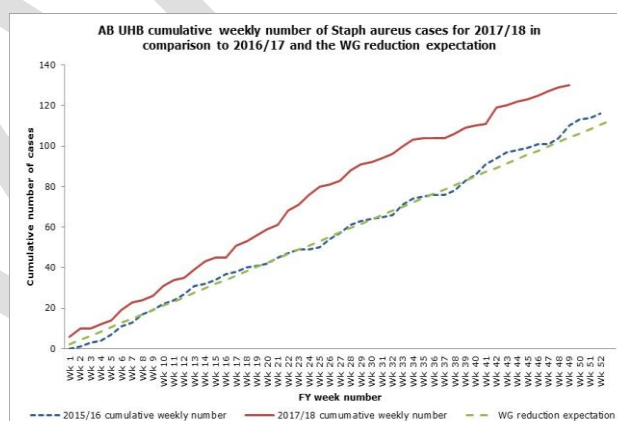
In 2018-19, we will:	When
Establishing current GP antibiotic prescribing audits and cross referencing with C. difficile and antibiotic maps	Qu1 & 2 2018/19
Continue Root Cause Analysis group to analyse GP completed surveillance forms and identify learning. Individual learning fed back and Dissemination of wider learning	2018-2021
Include in the reviews both the source of the infection and whether it was avoidable or unavoidable. Summary report to be presented to the Infection Prevention and Control Committee and Quality and Patient Safety Committee	Qu1 & 2 2018-19
Roll out of ANTT to Primary Care and District Nursing to ensure optimal asepsis when managing wounds/ulcers, monitoring against monthly targets for training in community and primary care	Qu1 2018/19
Establish Care Pathways for ulcers, including diabetic ulcers	Qu1 2018/19
Ongoing actions that are maintained continuously include:	
<ul style="list-style-type: none"> C. diff acquisitions in the community are treated as a significant event, and reported on datix. An analysis of antibiotic prescribing for each case is undertaken by the GP. The Community Pharmacist is undertaking education on management of Urinary Tract Infections (UTIs) in Care Homes, as they have a key population that are at risk of C. diff and often have multiple courses of antibiotics. Highlighting the guidance that has been issued around the requirement for retesting of patients with C. diff if not symptomatic. 	

Aim MRSA/MSSA: Welsh Government has agreed an individual rate for the Health Board for S. Aureus bacteraemias (MRSA and MSSA) which is to ensure a rate of no more than 20/100 000 is delivered in the final 3 months of the period 1 April 2017 – 31 March 2018.

Graph 5.3

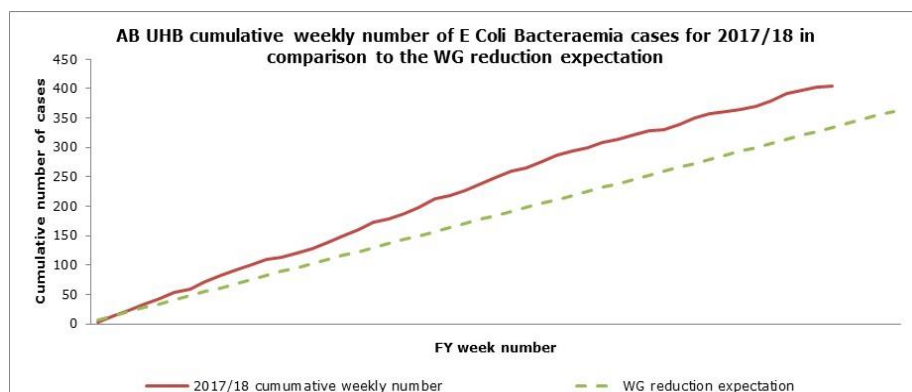
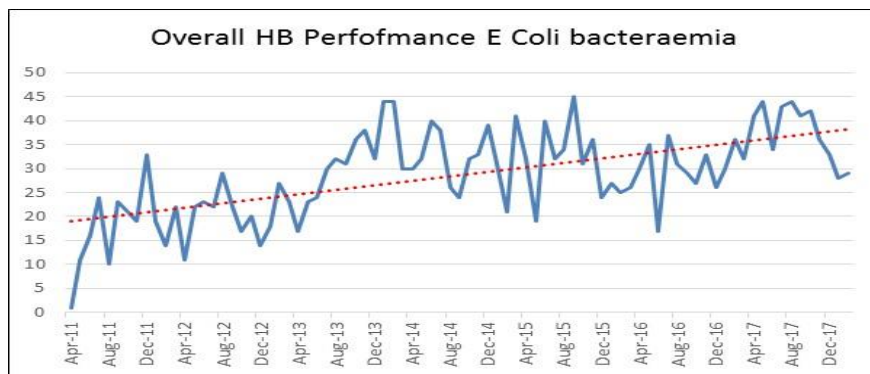


Graph 5.4



The Health Board is currently running above the trajectory due to a rise in Methicillin sensitive S. aureus as opposed to MRSA. Our staff continue to work hard to reach the target set by Welsh Government. The key strategy is a sustained campaign of pre-emptive testing and treating patients to reduce risk, embedding the PVC and Central Line bundle and detailed root cause analysis to establish learning when cases arise.

E-coli bacteraemia is a new reduction expectation for the HB. Welsh Government issued a 2017/18 HB reduction target E Coli – 63 cases per 100,000 population.



E-coli bacteraemia is predominantly a community acquired infection. Infection Prevention are working in collaboration with the Contingence Team to examine E-coli infection linked to catheter care. In addition, the new **Healthcare Associated Infection Primary Care Action Plan** includes a section that specifically addresses the prevention, treatment and management of Urinary Tract Infection. This starts with the establishment of a process for E coli reviews within Community Primary Care and the first meeting has been arranged for May 18. All reviews will conclude the source of the infection and whether it was avoidable or unavoidable. The themes identified in relation to avoidable infections will be captured and fed back to the Infection Prevention and Control Committee so that action can be taken to address them. Plans are also being developed for a campaign to promote hydration across primary care. In addition, urinary catheter incident reviews will be held across primary and secondary care, and themes will be fed back to the Infection Prevention and Control Committee so that action can be taken to address them

The Executive Team were alerted to the recent increase and, following an extraordinary meeting of the Champions Steering Group, key messages have been disseminated with particular emphasis on ownership. Indeed, divisional management teams were asked to reiterate the UHBs commitment to “infection control being everyone’s responsibility”. This is a key message that has been emphasised at all levels of the organisation.

A number of **key actions have continued in hospitals** including:

- The dissemination of key messages around hand hygiene, cleanliness and prudent antibiotic prescribing from the Executive Nurse Director, Director of Therapies and Health Sciences and Medical Director.
- A deep clean of wards affected by outbreaks, utilising hydrogen peroxide vapour.
- An inspection of mattresses, with appropriate replacement if found to be contaminated.
- A proactive programme of deep cleans has been drawn up with plans to utilize D4W as a decant ward.
- Close communication with Patient Flow Teams to ensure patient movement is appropriate & restricted and symptomatic patients are rapidly isolated.

Continuing **actions in primary/community care** include:

- The GP’s appropriate choice of antibiotics is a key component of any C. difficile strategy and Root

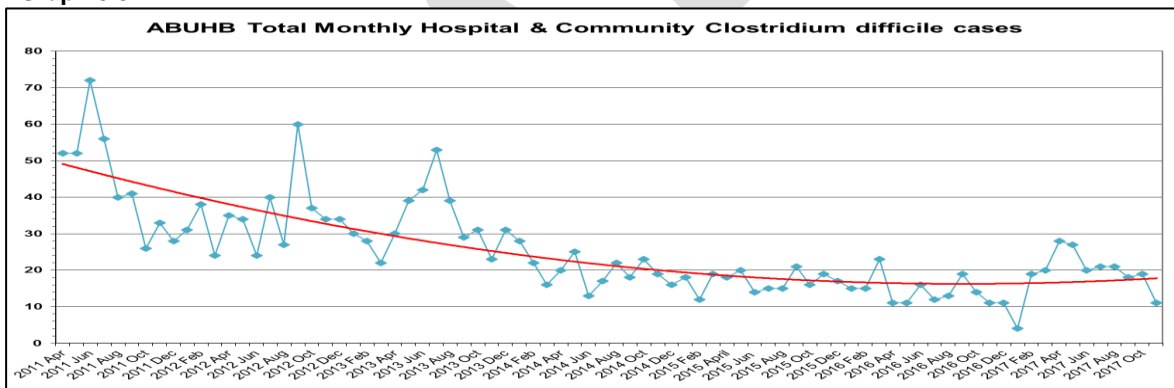
Cause Analysis is undertaken routinely to determine risk factors and potential interventions. A Primary Care Clinical Director is a member of the ABUHB C. difficile Champions Group and drives improvement in the C. difficile rates for both hospital and community acquired infections. Antibiotic maps are discussed and reviewed within NCNs

- C. diff acquisitions in the community are treated as a significant event, and reported on datix. An analysis of antibiotic prescribing for each case is undertaken by the GP.
- The Community Pharmacist is undertaking education on management of Urinary Tract Infections (UTIs) in Care Homes, as they have a key population that are at risk of C. diff and often have multiple courses of antibiotics.
- Guidance has been produced for GPs about other risk factors for C. diff. PPIs can increase the risk of CD associated diarrhoea by approximately 65% and H2 antagonists by approximately 40%.
- Guidance has been issued around the requirement for retesting of patients with C. diff if not symptomatic.

Medium term actions in hospital and primary care include:

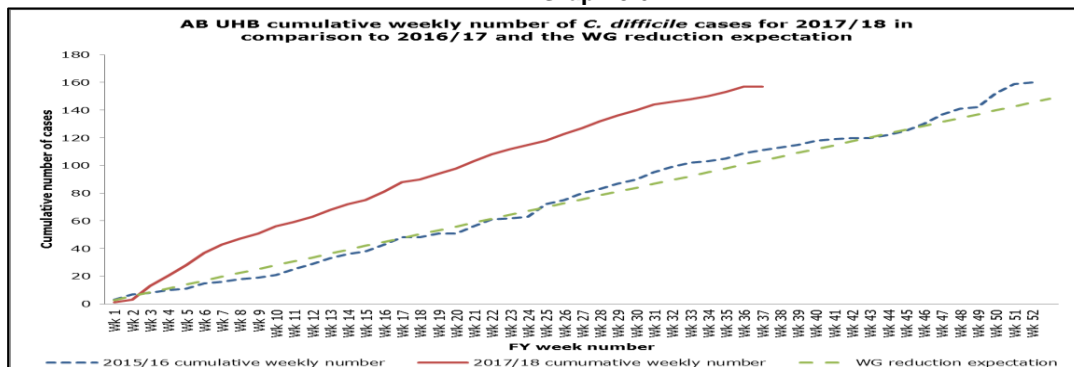
- A refreshed hand hygiene campaign in conjunction with the Communications Team, with support from charitable funds requested
- A review of medical engagement in relation to antibiotic compliance.
- The development of a prudent antibiotic prescribing model to ensure antibiotics are prescribed to policy.
- A review of the number of cleaning hours across all hospital sites to provide an equitable service.
- Dissemination of further guidance to GPs
- Costing of extending deep cleans within RGH and NHH

Graph 5.5



Graph 5.5 shows the number of cases of *C difficile* reducing over the period to March 17. The number of cases per month then increased and has been slow to reduce to the numbers achieved in early 2017. The Health Board has profiled the improvement required to meet the March 18 target (see Graph 5.6) and this has been built up from Division specific profiles which identifies target numbers of cases weekly, monthly and cumulatively. There is weekly monitoring of performance and feedback to Divisions with the current performance below the profile. This demonstrates that, due to the increase in cases that has been experienced, we will not be able to meet the 2017-18 WG target.

Graph 5.6

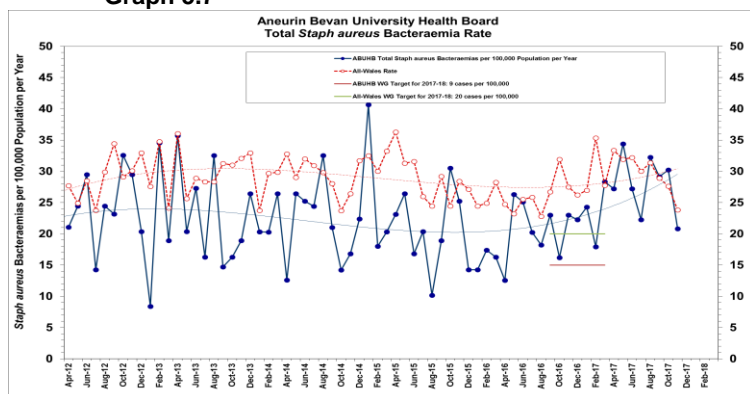


Summary of actions in the Health Board's HAI Action Plan:

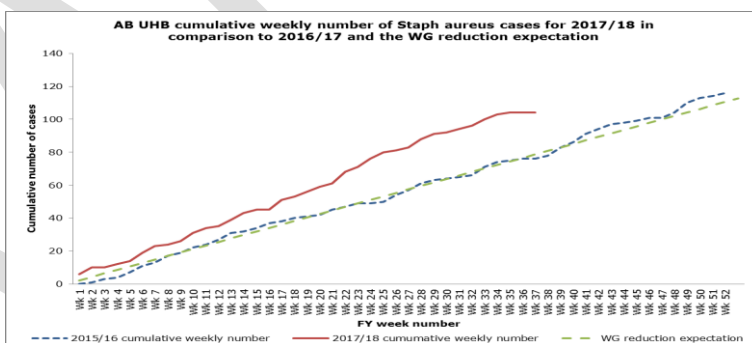
- Extended scope of Champion's Group.
- Divisional targets and accountability.
- Adherence to IC policies and procedures.
- Pro-active clinical engagement.
- Trend analysis of RCA findings.
- Post cause analysis.
- Antimicrobial stewardship.
- HPV charring.
- Focus on community acquired C.difficile.
- Education and training.

Aim MRSA/MSSA: Welsh Government has agreed an individual rate for the Health Board for S. Aureus bacteraemias (MRSA and MSSA) which is to ensure a rate of no more than 15/100 000 is delivered in the final 3 months of the period 1 April 2017 – 31 March 2018.

Graph 5.7



Graph 5.8



Due to historical low rates of S aureus bacteraemia the Health Board has a more stringent target – 15 per 100,000 population. The Health Board is currently running above the trajectory due to a rise in Methicillin sensitive S aureus as opposed to MRSA, our staff continue to work hard to reach the target set by Welsh Government. The key strategy is a sustained campaign of pre-emptive testing and treating patients to reduce risk, embedding the PVC and Central Line bundle and detailed root cause analysis to establish learning when cases arise.

An all Wales collaborative was launched within October and key representation from all the Divisions promoting best practice for the reduction of C diff, bacteraemia, Surgical site infection and leadership. This reinforce the importance of the current care bundles introduced within ABUHB and the key message of the day was to review measurement to enable staff to promote improvement.

2017-18 onwards – The Health Board will continue to put in place plans to enable it to meet the future Welsh targets for reduction in HCAI, once they have been set. The action plan is detailed and dynamic, and reflects an approach to reducing HCAI working together across the whole patient pathway. This will include:

- Hospital Site Infection Prevention Groups.
- Root cause analysis of community acquired HCAI in primary care.
- Environment Strategy.

5.2 Sepsis/Deteriorating Patient

Aim Sepsis/Deteriorating Patient: to eliminate avoidable deaths and harm from sepsis

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

The Collaborative outcome measures are:

- Percentage of patients triggering with sepsis that die within 30 days of recognition;
- Number of patients triggering with sepsis that die within 30 days of recognition.

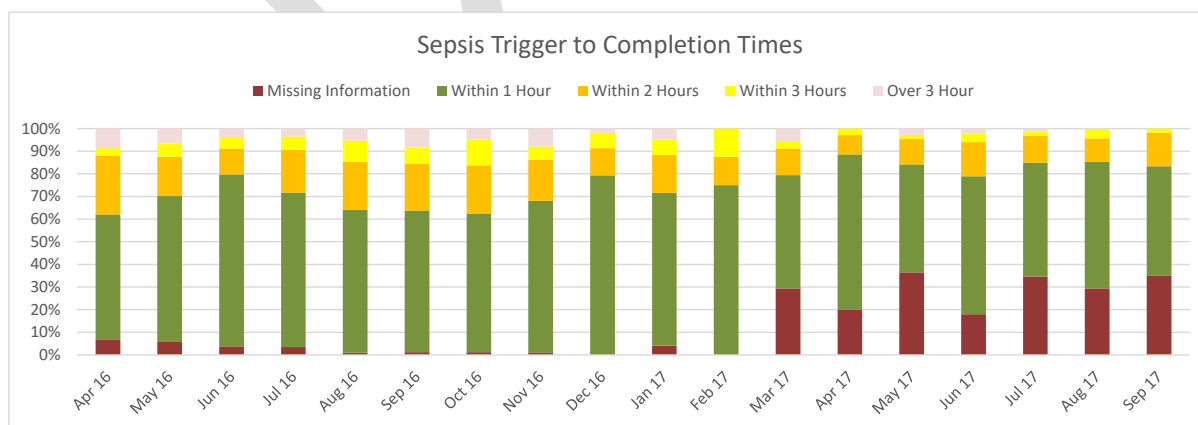
The process measure for the collaborative is:

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

The successes in 2017/18 include:

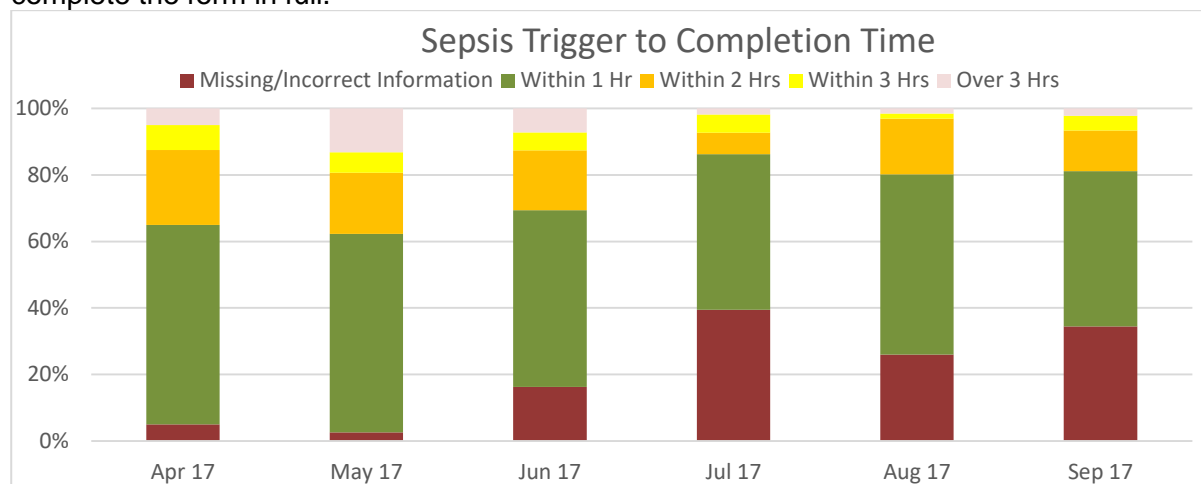
- Working with the vital pack pilot at YYF to ensure that the recording of patient parameters supports the recognition of the deteriorating patient. There have been some issues with the system in terms of its alignment to the Welsh approach to the triggering of sepsis, although these are now being resolved
- Profiling of the presumed source of infections from the ABC sepsis data in the new ABC sepsis database
- Linking with Infection Control in relation to e-coli reduction target, as UTIs are often e-coli related in the elderly
- Pursuing the deteriorating patient agenda on the wards, roll out of the trigger tool and regular meetings acute response and regular audit in acute wards at RGH and NHH
- Improvement in the number of cases of sepsis recognised in MAU at RGH and NHH
- Audit of the deteriorating patient processes at YYF, RGH and NHH, as a baseline before the introduction of vitalpac. However, the results show that the recognition and response to deterioration is still not reliable. The response to this is being taken forward by the Deteriorating Patient Group.

Nevill Hall Hospital: NHH has maintained the number of forms completed through the summer period. Compliance with the bundle has sometimes dropped below 50%, but it is usually missing information on the form that means that their compliance is low. The new database makes this very clear to staff, which will motivate staff to complete the form in full. For those patients not given the sepsis 6 within 1 hour, the bundle is usually completed within 1-2 hrs, which is still good care.



Royal Gwent Hospital: RGH A and E has increased the number of forms completed. The department has shown full participation in the sepsis meetings, with good medical support. When appropriate, the Consultant feeds back non-compliant cases to the junior doctor involved to discuss the care given, particularly when the non-compliance is due to a delay in prescribing antibiotics. The compliance with

the bundle is consistently 50% or more. Many of the non-compliant cases are non-compliant because information is missing. The new database makes this very clear to staff, which will motivate staff to complete the form in full.



Ysbyty Ystrad Fawr: ABC Sepsis covers the whole of YYF, wards and Emergency Department. There is good engagement with the meetings. The System C Pilot started at YYF in September, and the ABC Sepsis Team have worked closely with the IT Staff so that the system can identify and notify clinicians of deteriorating patients. Some inaccuracies have been identified with the current trigger points within the system, and this is being addressed as a priority.

The sepsis screening tool, developed by ABC sepsis with the Emergency Departments, has been rolled out to all the wards in acute hospitals from April 2017. Data taken from the Outreach databases for NHH and RGH showed that the wards were not using the screening tool, which would support them to initiate the treatment for sepsis rapidly on the ward. The Lead Nurse for sepsis, with support from the Divisional Nurses, is now meeting regularly with the wards to review the Outreach database against the forms the sepsis screening tools completed by the wards.

The Lead Nurse for Sepsis organised an extremely successful Sepsis Awareness Day on 22 September, to support the wards in embedding this work. Four people with personal experience of sepsis related their stories at the event, to demonstrate the impact of sepsis on individuals and their family. Teams that have made great improvements in their recognition and response to sepsis also presented at the event, to describe their journey, and the benefits to staff and patients of the timely recognition and response to sepsis.

The ABC Sepsis Steering Group will review the progress in the last year and set priorities for 2018-19 in the near future. These will include:

- Roll out of vital pac to NHH, building on the learning from the implementation in YYF
- To work with primary care and community services to establish NEWS as the common language for deterioration
- To continue to embed the sepsis trigger tool on the wards, as part of the focus on the recognition and response to the deteriorating patient

In 2018-19, we will:	When
To continue to embed roll out of vital pac at YYF <ul style="list-style-type: none"> • Review care flow • launch vital flow 	Qu1 2018/19
Roll out of vital pac to NHH, building on the learning from the implementation in YYF <ul style="list-style-type: none"> • Electronic observations • Care flow • Vital flow 	Qu1 2018/19 Qu2 2018/19 Qu3 2018/19
Prepare for Peer review of Sepsis Recognition and Response in ABUHB Host visits to ABUHB acute hospitals	Qu1 2018-19 Qu 2 & 3

In 2018-19, we will:	When
To work with primary care and community services to establish NEWS as the common language for deterioration and dovetail this with the National work on Out of hospital sepsis: <ul style="list-style-type: none"> • ABUHB meeting on out of hospital sepsis with community nursing teams, out of hours GP service, NCNs and Nursing Homes • develop action plan for ABUHB • Implement Action plan for out of hospital sepsis 	Qu1 2018/19 Qu3 2018/19 2019 - 2021
To continue to embed the sepsis trigger tool on the wards, as part of the focus on the recognition and response to the deteriorating patient and ensure this works alongside the vital pac roll out at YYF and to NHH, in line with timescales above for NHH and YYF. RGH – develop plan for wards once timescale for implementation of electronic system known	Qu4 2018-19
Plan for recognition and response to sepsis systems and processes in Grange Hospital and LGHs	2019 -21
Work with Deteriorating Patient Group sub group on training to agree standardised training for reliable recognition and response to deteriorating patient	Qu1 2018/19
Roll out and embed training	Qu3 2018/19

5.3 Falls

Aim Falls: a target reduction in inpatient falls of 10% by March 2019, with a further reduction of 10% over the next 2 years

Falls, whether they take place in the community or in the hospital, have both human and financial costs. For the individual patient, their relatives and carers, the consequences range from distress and loss of confidence, to injuries that cause pain and suffering, loss of independence and, occasionally, death (NPSA 2007).

Prevention of falls, and effective management of patients following a fall, is recognised as an important patient safety challenge for the UHB. The Executive Team and Board have recognised and responded to this issue, making falls prevention a high priority for the organisation.

Falls Prevention has been included in Integrated Medium Term Plan; it has been identified as a corporate priority and along with other corporate priorities that support delivery of key objectives. Falls Prevention has been included within the Older People's Service Change Plan (SCP); these SCPs primarily relate to cross cutting work-streams, and corporate priorities.

Falls prevention is a key component of the Health and Care Standard 2.3. The standard is about minimising the risk of people falling and promotes the assessment of a range of factors which are known to increase the risk of falling, as well as the importance of developing individual care plans which aim to prevent individuals from falling in order to reduce harm and disability. ABUHB has committed to comply with this Health and Care Standard and it underpins the work undertaken within our hospital sites to avoid preventable inpatient falls.

In April 2016, the Welsh Government issued the Principles, Framework and National Indicators: Adult In-Patient Falls, WHC (2016) 022. This Welsh Health Circular provided clear recommendations to Health Boards in Wales about the actions required to prevent inpatient falls with a framework for delivery. ABUHB has adopted this framework to structure its Falls Action Plan, which is overseen by the Falls Steering Group.

The Falls Steering Group is multidisciplinary and covers both acute and community services. The steering group is chaired by the Executive Director of Therapies and Health Science (who is the corporate lead for falls prevention and management). The steering group meets bimonthly. The steering group involves the Community Health Council as a core member. The steering group reviews and monitors falls data across the Health Board and monitors and reports progress against the Falls Action Plan.

The Falls Steering group has prioritised 3 areas of work to specifically reduce inpatient falls:

1. Inpatient Falls Policy

The Falls Steering Group has overseen an update and revision of the existing Health Board Policy for the Prevention and Management of Adult In-patient Falls. The policy has been updated to:

- Reflect and incorporate NICE Clinical Guidelines 161: Falls in older people: assessing risk and prevention (2013).
- Reflect and incorporate the recent Welsh Government requirements on Health Boards set out in WHC(2016)022: Principles, Framework and National Indicators: Adult In-Patient Falls.
- Provide a revised Falls Multi Factorial Risk Assessment (MFA) Tool.
- Provide a tool to support assessment and care of a patient by medical and nursing staff immediately post fall
- Provide a revised falls flow diagram for patients who are prescribed anticoagulants.
- Update links to other, current ABUHB policies and guidelines.

As part of the process of revising the Falls MFA Tool, it has been piloted on a number of inpatient wards within the Health Board to gain feedback directly from ward based staff on its ease of use and effectiveness.

2. Supporting Implementation of the Policy through Audit and Training

The Health Board understands the importance of good compliance in adopting the revised policy, especially with regard to using the falls multi-factorial risk assessment tool when patients are first admitted to the ward; this is considered a critical step in preventing an inpatient fall. To achieve the required reduction in avoidable inpatient falls it is considered that the policy itself, with the new MFA tool and guidance will not be enough to achieve any significant difference. In response, the Falls Steering Group is working to implement a systematic approach to audit, training, monitoring, advice and support to cover all 103 inpatient wards, including training at ward level for Nurses, Healthcare Support Workers and AHPs.

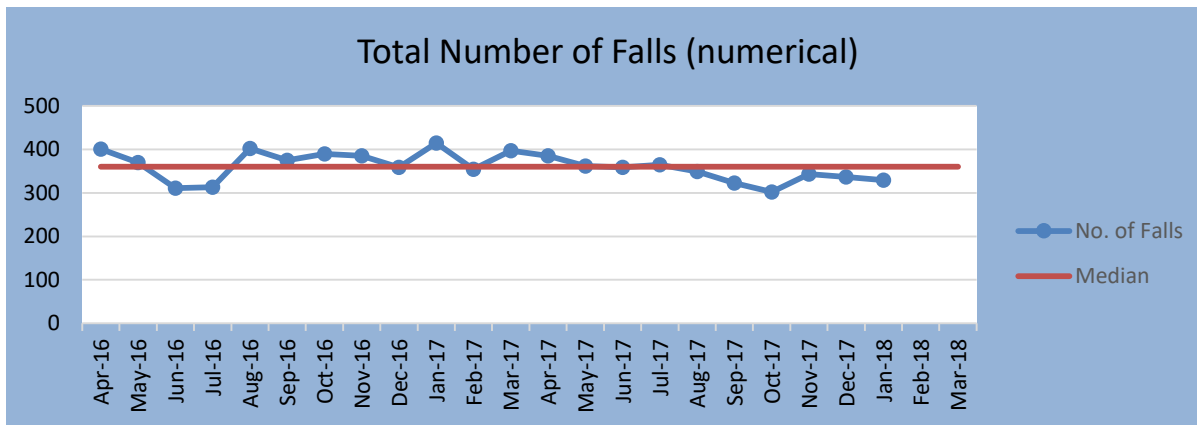
A falls prevention training curriculum has been developed, consistent with the policy and based on best practice from existing initiatives within the UHB and across the UK. Clinical experts from the existing Community Falls Team have been leading and delivering training sessions for ward based staff, targeting those wards that have the highest incidence and risk of falls. This approach has enabled an immediate response to the highest risk areas and provided an opportunity for wards to identify areas of improvement and address changes to practice that will avoid preventable falls.

3. Falls Scrutiny Panel

The Falls Scrutiny Panel was established in 2016; it reviews the investigation of all in-patient falls that result in a fracture, has 3 main aims:

- To review the investigation of each fall to understand whether there was a falls risks assessment and appropriate interventions were put in place to reduce the risk of falls for that individual.
- To provide an overview of in-patient falls with fractures – numbers and locations, as well as systemic issues and learning – and highlight and spread good practice.
- To decide whether the fall was unavoidable or potentially preventable and should be considered for referral to redress.

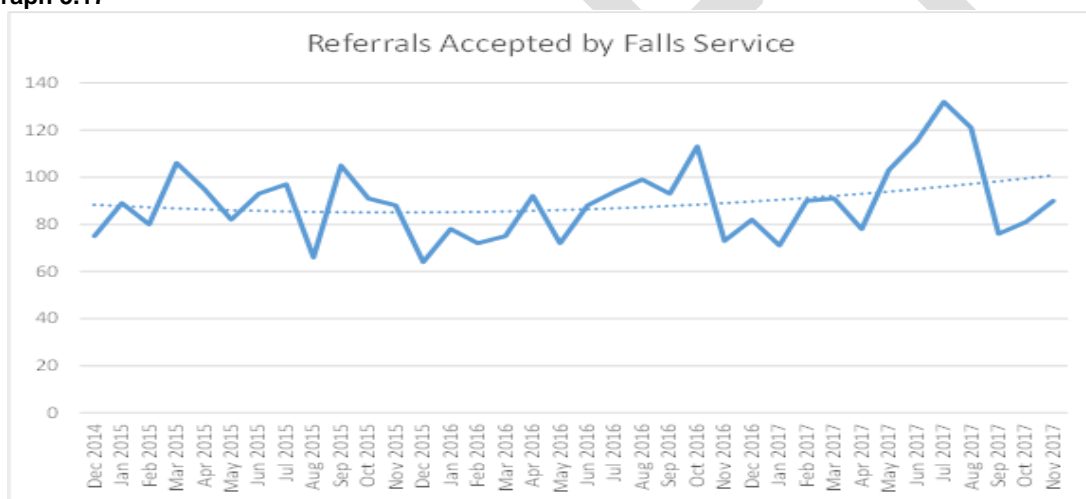
Falls are a complex phenomenon and present a significant safety challenge for the UHB. The UHB's Falls Steering Group has worked to accurately measure the number of falls incidents reported for patients in our community and acute hospitals. Falls metrics have been developed by the All Wales Steering Group for in-patient falls and that align with the care metric in the Trusted to Care Audit tool. The UHB has established routine reporting of these metrics through a dashboard format.



A lot of work has been done by the community services to develop falls pathways, for people who have had a fall in their home, starting with a risk assessment to prevent and minimise the risks of a further fall.

Falls in the Community - The Falls Team in each Borough vary in their staffing and process, although they are all following the same Falls Pathway. The Falls Steering Group has reviewed the current datasets related to referrals to the five locality community based Falls Services (part of the CRTs) to ensure consistency and to remove unnecessary data collection. This will be looked at further when the Falls Steering group undertakes a review of the Community Falls Service in early 2018.

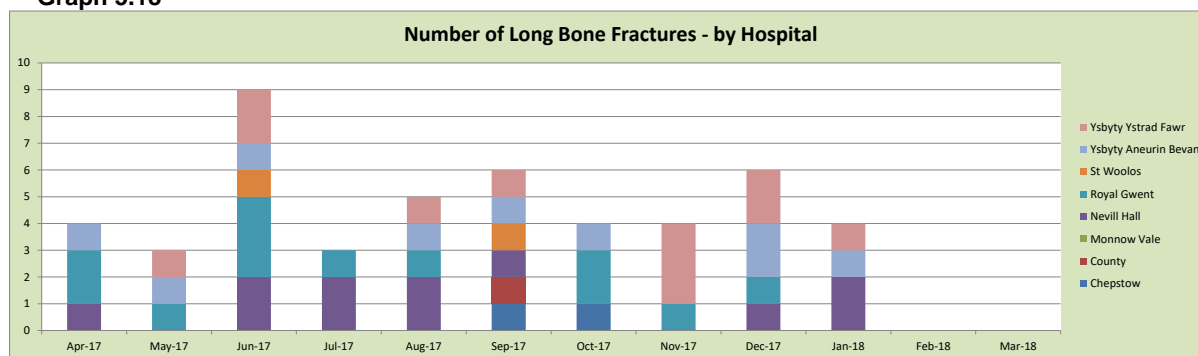
Graph 5.17



In-hospital Falls - The Falls Scrutiny Panel has been established to ensure there is a root cause analysis on all inpatient falls that result in fractured neck of femur. This established baseline data on inpatient falls that result in fractures. The learning has informed changes to practice where appropriate after every individual fall, but also the identification of hot spots and good practice. Changes that are effective in reducing falls and falls with harm are being spread across wards and departments. The data is being monitored to understand the impact of the changes made to ensure that they are effective in reducing falls and harm from falls.

The number of fractured neck of femurs is shown below, by the main acute hospitals:

Graph 5.18



The main learning from the Falls Scrutiny Panel to date has been the need to ensure compliance with the inpatient falls policy, specifically the correct use of the multifactorial falls risk assessment and the falls care plan.

Key actions that have been taken in 2017-18 include:

- The Falls Steering Group has reviewed the Inpatient Falls Prevention Policy and this was re-issued in March 2017. It included a revised Multi-Factorial Risk Assessment, which clearly identifies the falls risk factors for the patient and the actions that can be taken to reduce the risk of falls for that person. A further review in January 2018 has also been completed to incorporate new learning and updates to the Multifactorial Risk Assessment Tool.
- An Inpatient Falls dashboard has been developed and is reported to every Falls Steering Group. The inpatient falls resulting in a fractured neck of femur reported in datix are cross checked with the fractured neck of femur patients reported as having sustained the fracture from an inpatient fall in the National Hip Fracture Database to ensure that the data is accurate. A target reduction in inpatient falls of 10% has been agreed.
- Guidance on the recording of the lying and standing blood pressure for patients has been issued.
- The use of pressure sensors to alert nurses when a patient is on their feet has decreased. But we are continuing to learn about the most appropriate equipment and when it is most effective in preventing falls.
- A business case for the setting up of an inpatient falls prevention team was completed and presented to the Executive Team. However due to the high demand on the small amount of resource available for service development, it was unsuccessful.
- As there will not be a team dedicated to training on falls prevention, a core training on falls prevention and the use of the Multifactorial Risk Assessment Tool has been developed and will be available in
- the New Year for ward based training.
- The Multifactorial Risk Assessment for falls has been reviewed based on the experience of its use on the wards since March and improvements made so that it is clearer and the falls care plan and review of the MFRA are both simpler to record.
- A Medical Assessment Following a Fall Form has been devised and agreed and will be rolled out.
- The basic data collected by the Community Falls Teams in the 5 Boroughs has been standardised so that a core data set is available at the Community Falls Team Workshop which is being held in early 2018.

Target Reduction in Inpatient Falls

A target reduction in inpatient falls of 10% by March 2019, with a further reduction of 10% over the next 2 years

Target	2016-17 baseline	End of 2017-18	End of 2018-19	End of 2019-20	End of 2010-21
10% reduction in falls in 2 years	380/month	361/month	342/month	325/month	308/month

In 2018-19, we will:	When
Put in place a training in preventing in patient falls, using a standard presentation, to support compliance with the Policy for the Prevention and Management of Inpatient Falls	Qu2 2018
Take forward actions following a review of the sourcing and use of standard equipment in relation to falls prevention, such as profiling beds and chairs, in order to reduce in patient falls	Qu2 2018
Develop and implement a Community Falls Service Action Plan	Qu4 2018-19
Implement the form supporting the full medical review of patients immediately after a fall	Qu4 2017-18
Evaluate the pilot of the Care Homes Falls Protocol (I-Stumble) and spread to other Care Homes	Qu 1 and 2 2018-19
Identify key prevention measures to take forward from the National Audit of In-patient Falls (e.g. delirium assessment and lying and standing blood pressure) and develop a plan to pilot and spread their implementation	Qu2 18-19
Develop a plan to improve bone health for older patients at high risk of falls in order to reduce the number of fractures	2019-20

5.4 Pressure Damage

Aim: Zero Tolerance, with interim targets set by the Health Board to achieve 50% reduction in hospital acquired pressure damage and 30% reduction in community settings between April 2017 and September 2018.

Pressure ulcers are costly to the NHS and debilitating and painful for patients. With an aging population, and those with co-morbidities, the risk of developing pressure ulcers increases, presenting a key challenge for health professionals. The occurrence of pressure ulcers is often used as a key indicator as to the quality of care. Pressure Ulcers have a huge negative impact on a person's quality of life and more severe categories can be life-threatening. Prevention strategies are multifaceted and include risk assessment, skin care, continence care, nutrition and hydration, mobility and repositioning and the use of pressure relieving/redistributing equipment.

Although recognised as a key patient safety issue, benchmarking pressure ulcer acquisition with other organizations across the UK is problematic with a majority of Health Boards/Trusts utilising **prevalence** rather than **incidence** data. This is despite the fact that **incidence** data is considered best practice by Tissue Viability experts. The Health Board collects incidence data and is committed to this method of pressure ulcer surveillance. In response the Health Board will identify HBs/Trusts who robustly measure pressure ulcers using incidence data – in order to benchmark pressure ulcer acquisition.

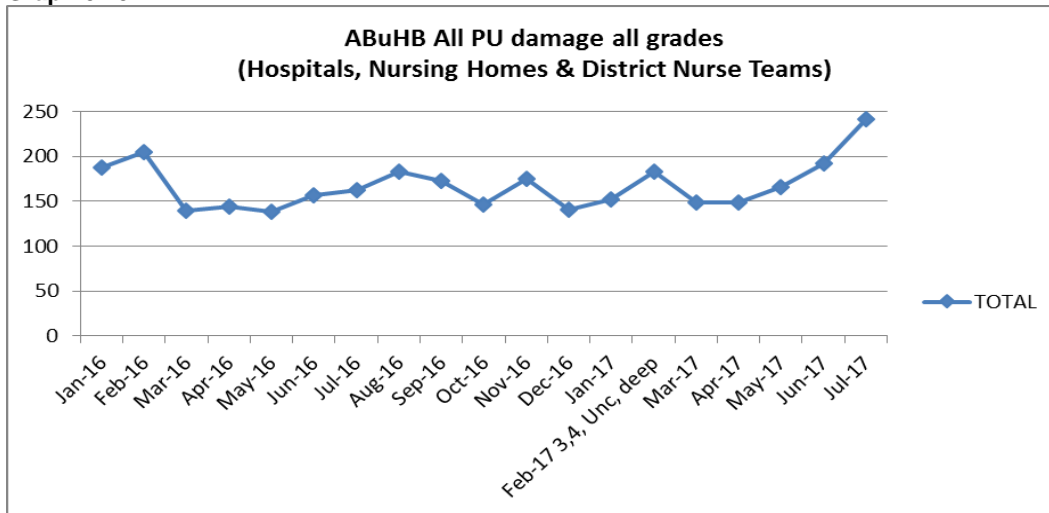
The Health Board has implemented the following:

- A new Policy for the Prevention & Management of Pressure Ulcers, based on NICE Guidance
- Hospital Acquired and Community Acquired Scrutiny Panel for all Grade 3 & 4 Pressure Ulcers, enabling targeted intervention by the Tissue Viability Team and rapid learning to be returned to the ward/service.
- A Tissue Viability Webpage, with a host of resources for staff
- The Tissue Viability Team have been co-located focusing on patient need as opposed to geographical alignment
- Re-design of DATIX, streamlining reporting & categorization
- Health Board wide study days on management & prevention of pressure ulcers
- Improved data on pressure damage in people's own homes through the District Nurses' caseloads.
- A significant piece of work around the prevention and management of pressure ulcers in Nursing Homes has commenced ensuring that serious ulcers are reported appropriately as serious incidents and undergo a review which mirrors the hospital scrutiny panel.
- Commenced a quality improvement project to reduce the numbers of pressure ulcers on one pilot ward.

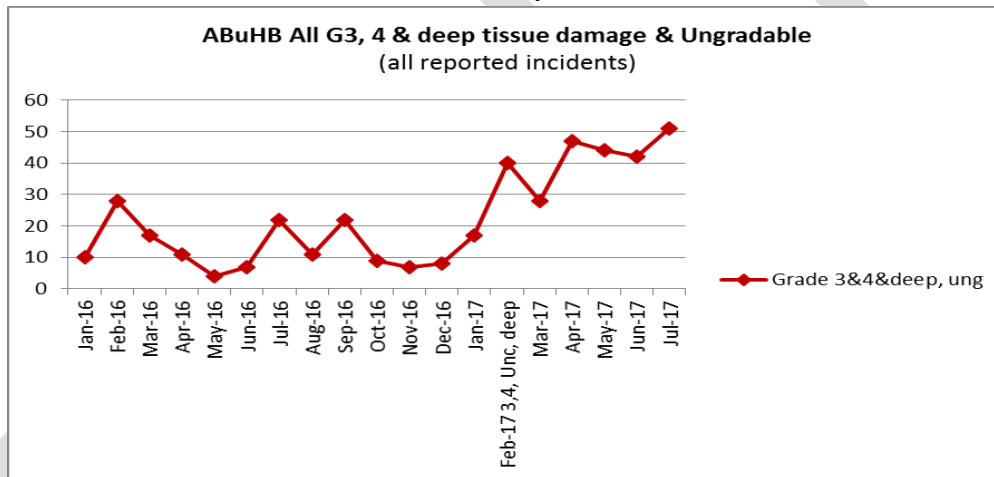
The data collection for pressure damage has been reviewed and streamlined and is now based on Datix collection alone. Following the introduction of this new reporting mechanism, there is confidence that the data is more robust and comprehensive. Whilst the rise in significant pressure damage is of concern, it

is most likely to be due to better reporting. The data is now being cleansed, as some pressure ulcers are reported on each ward, when a patient is transferred between wards.

Graph 5.19



Graph 5.20



A 50% hospital acquired reduction target has been set by the Executive Director of Nursing. This will be met through the following actions:

- A piece of work is underway to ensure the data is cleansed appropriately – removing duplicated reports and adjusting reports where ulcers have been misclassified.
- A pressure ulcer reduction collaborative has been set up with ABCi. The collaborative met for the launch on the 12th September and targets wards on the Royal Gwent site.
- There is an expectation that the collaborative will move to the community and Nevill Hall over the next 6 months.
- A review processes exist for all grade 3 &4 pressure damage in all settings, with learning from the review taken back to the wards.
- Referral to the Tissue Viability Service has been reviewed to ensure that significant pressure damage is reviewed by a member of the team in community, care home and hospital settings.
- In order to support the pressure ulcer agenda further, the Health Board has made a significant investment in pressure relieving mattresses the use of which are being closely monitored to ensure at risk patients receive the most appropriate mattress at the right time.
- An Action plans is in place to drive reduction for hospital acquired pressure damage.

For the Community, a 30% reduction target has been set:

- An action plan to drive the reduction of community acquired pressure damage is under development
- Good progress has been made in the development of review process relating to pressure damage in

Nursing Homes.

- A pressure ulcer reduction project has commenced in Nursing Homes in collaboration with the Chief Nursing Office in Welsh Government.

5.5 Hospital Acquired Thrombosis (HAT)

Our aim for HAT: to reduce HAT by ensuring that all patients have appropriate mechanical and chemical prophylaxis, so that there are no cases of potentially preventable HAT in the UHB. The outcome should be that all cases of HAT have had a full risk assessment and appropriate prophylaxis i.e. they were not preventable, rather than a specific numerical target.

A Hospital Acquired Thrombosis (HAT) is defined as:

“Any venous thromboembolism arising during a hospital admission and up to 90 days post discharge”.

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

The data below shows the number of cases of HAT in ABUHB in 2015 and 2016 to date. The data is derived from combining RADIS data with discharge data.

Table 5.1

April 2016	May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Total
13	14	10	15	1	15	18	12	10	12	15	28	163
Quarter 1 Total		37	Quarter 2 Total		31	Quarter 3 Total		40	Quarter 4 Total		55	
April 2017	May 2017	June 2017	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Total
19	15	18	21	16	16	12						117
Quarter 1 Total		53	Quarter 2 Total		37	Quarter 3 Total		0	Quarter 4 Total		0	

All cases of HAT identified are sent to the Consultant for review. Improvements have been made to the timeliness of the administration of this process and this is improving the number of reviews returned by Consultants. The data shows that most cases of HAT are in trauma and orthopaedics and Care of the Elderly. The number of potentially preventable HATs is very small, but have been in these specialties.

The Thrombosis Group has worked with Elective Orthopaedics to reduce the number of cases of HAT. It will therefore focus on Care of the Elderly in 2018-19.

The introduction of the new All Wales Prescription chart in September 2016 was a key element in ensuring that a thromboprophylaxis risk assessment is completed, and so the right thromboprophylaxis is prescribed. The pharmacists have worked with the ward nurses to ensure that all the wards had only the new prescription chart available from August 17, as the new doctors in training started in August. The Pharmacy audit of the completion of the prescription chart in relation to VTE has been restarted at RGH, and has been brought in at NHH and YYF in September 2017. Once we have a few months of data, we will target the wards with consistently low completion of the prescription chart in relation to VTE in order to ensure that patients are being prescribed the correct thromboprophylaxis.

Our aim for HAT: to reduce HAT by ensuring that all patients have appropriate mechanical and chemical prophylaxis, so that there are no cases of potentially preventable HAT in the UHB. Our trajectory for improvement is shown below:

	2016-17 baseline	End of 2017-2018	End of 2018-19	End of 2019-20	End of 2010-21
Number of patients with potentially preventable HAT	10% of completed RCA	8% of completed RCAs	5% of completed RCAs		
% charts with risk assessment?	Data only for small number of wards	60% across all wards	80% across all wards	90% across all wards	90% across all wards

We will:	When
The Pharmacy audit of the completion of the prescription chart in relation to VTE has been restarted at RGH and has been brought in at NHH and YYF in September 2017. Once we have a few months of data, we will target the wards with consistently low completion of the prescription chart in relation to VTE in order to ensure that patients are being prescribed the correct thromboprophylaxis	Qu1 2018-19
We will continue to work with Consultants to increase the percentage of the RCAs returned in a timely way (2018-19). This has improved in 2017-18 from 30% to 60-70% as we have improved the process to make it much more timely.	2018-2020
We will work with the Trauma and Orthopaedic Consultants and with Care of the Elderly, the two specialties with the highest number of HATs and potentially preventable HATs, to improve the thromboprophylaxis	2018-2020

5.6 Never Events

Never Events are incidents which are serious, but are considered to be unacceptable as we know that they can happen and yet they are preventable. They include issues such as wrong site surgery (for example, operating on the right leg when it should have been the left), and objects like swabs that are not removed during an operation. If a Never event occurs, the Health Board must notify the Welsh Government who request that the Delivery Unit closely monitor the Health Board’s investigation which is a RCA (root cause analysis) investigation to ensure that remedial actions are taken and lessons learnt. In 2017-18, the Health Board will aim to reduce Never Events in invasive procedures through implementation of Safer Patient Notice 034.

Following concern relating to an increase in inpatient suicides over the past 18 months, the Mental Health Division is undertaking an in depth review of suicides across Aneurin Bevan in 2016-17 to look at risk factors /themes and trends and to develop an improvement plan in 2017-18 to reduce the incidence of suicides. This will include a full review of the cases including work on the risk tools used, training for staff members, improvements in environmental risk, such as ligature risks and work within the community to better support patients.

Table 5.3

YEAR	TOTAL SI WITH CORPORATE LED INVESTIGATION (not including suicides plus *)	NEVER EVENTS	SUICIDES	TOTAL REPORTED TO WELSH GOVERNMENT	SIs TO
2013-14	27	3	31	-	
2014-15	21	1	16	85	
2015-16	44	3	27	139	
2016-17	30	2	31	211	
2017-18 (to 1.12.17.)	24	1	Awaiting Confirmation from Coroner	194	

*Also not including inpatient falls that result in a long bone fracture, Pressure Ulcers, HCAI except where they are on part 1a of a death certificate or PRUDIC

The never Event this year has been fully investigated. It was a surgical never event in which the wrong prosthesis was used. An action plan is being implemented which changes the procedures in the operating theatres to ensure that the checking of the prosthesis is more rigorous, that this is linked in to the NatSSIPs in Theatres, and that the learning is disseminated across all the theatres in ABUHB.

5.6.1 Closure of Serious Incidents (SIs)

2016-17 – the Health Board has put in place some additional resources to assist meeting the targets for closure of SIs and improved the % closed within the time frame, and started to address the backlog.

In 2016-17, the Health Board put in place additional resource to assist meeting the targets for closure of serious incidents, improve the % closed within the timeframe and to start to address the backlog of closures (legacy closures). This additional resource has had a great impact on the legacy closures, reducing them from 132 in December 2016 to 1 in December 17, which is a HIW review and we cannot control the process.

Date	Total of closures overdue	Legacy Closures
September 2015	142	114
December 2016	170	132
April 2017	63	28
June 2017	50	13
November 2017	37	1

In 2018-19, we will work to maintain this position, and improve the percentage of serious incidents reported to Welsh Government that are closed within the timeframes.

5.7 National Clinical Audits (NCAs)

Aim: To improve the outcomes from **National Clinical Audits** year on year and to have agreed the key issues for the Health Board from a NCA Report within 1 month of publication, and to have agreed actions to address these issues within 3 months of publication.

The Health Board has developed its processes for full participation in National Clinical Audits on the National Clinical Audit and Outcome Review Programme, and additional investment in staff was agreed to support this process.

These staff are now in post and so the processes for full case ascertainment, review of the results, development of actions to improve the outcomes relating the audits and the monitoring of the implementation of the changes are being implemented. This involves developing the relationships with the Clinical Leads for each NCA, and ensuring that the results of the NCAs are disseminated at all levels in the organisation to support the agreement and implementation of the changes required to bring about the improvement.

We are now up to date with the return of the Part A and B form to Welsh Government. There is an agreed reporting process for the summary of each NCA to the Quality and Patient Operational Group. This Group routinely escalates issues of concern to the Quality and Patient Safety Committee, and so can escalate any concerns relating to the results of a NCA.

In 2018-19, we will embed the new processes for NCA, and work to ensure that we are participating in all NCAs with high case ascertainment

In 2018-19, we will:	When
Ensure participation in all the NCAs in the NCAOR plan. There will be a focus on the 3 audits that ABUHB does not participate in at all, but also continuing monitoring and support to all the NCAs to enable full case ascertainment, so that the results of the audits accurately reflect the service. TARN will be a particular focus as we move towards becoming part of the Trauma Network	Qu1 & 2 2018/19
Address the backlog of reporting to Welsh Government and ensure that reporting of NCAs as they are published is compliant with the required timescale	Qu2 2018/19
Review the reporting arrangements for NCA within ABUHB so there is a clear mechanism for overview of all the results of NCAs and escalation if the results highlight that a service performing poorly when benchmarked against other services in Wales or the UK	Qu1 2018-19
Ensure that the results of each NCA report are summarised and disseminated to the Directorate, Division and the Quality and Patient Safety Operational Group	Qu1 2018/19
Develop a NCA page on the intranet so that audit reports and summaries are easily accessible	Qu2 2018-19
Make links with the Value and Outcomes work stream, so that there is no duplication and the work streams dovetail (ongoing).	2018 -21

5.8 Mortality Reviews

Aim: to complete mortality reviews on 90% of deaths in our hospitals within 1 month of the death

In 2017-18, we have completed the investment in sessions for senior clinicians to undertake the mortality review process and appointed to the last of the 4 sessions and trained the clinician.

The Welsh Government plan is that, when, as a result of the Shipman review, the Medical Examiner role is introduced, the Medical Examiner will undertake the first level of the mortality review, as part of their role, as they agree the cause of death and talk to the relatives of the deceased person. The Health Board will undertake a more in depth review into any deaths that the Medical Examiner highlights. It is currently planned by Welsh Government that the role will be introduced in April 2019. We are working on both improving our bereavement processes and developing the processes to support the smooth implementation of the Medical Examiner role, as the 2 need to work hand in hand to ensure a seamless service which is supportive of bereaved relatives.

One Consultant reviewer has a lead for appraisal and learning, and will work to ensure that learning from appraisals is used within the consultant appraisal process. The Assistant Medical Directors on each site will continue to undertake their lead role, to promote continuity. Our target will be to complete the mortality review for more than 90% of deaths.

The number of reviews completed to date for October 2015-December 2016 is shown below.

Table 5.4

	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	April 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Total
No. Reviewed	135	92	228	148	123	140	159	125	69	139	143	148	120	1769
2 nd Stage Review	11	7	35	7	6	8	10	8	3	7	13	6	5	126
Total Deaths	260	260	371	227	241	247	225	226	191	234	217	245	196	3140
% Reviewed	52%	35%	61%	65%	51%	57%	71%	55%	36%	59%	66%	60%	61%	56%

Learning from Mortality Reviews – The last Mortality Review Group considered how they can maintain an overview of all the mortality data that is available across the Health Board. This includes the mortality data routinely considered by this Committee, the mortality data published on the ABUHB internet site and the mortality data on specific conditions that is included in National Clinical Audit reports. The

Medical Director's Support Team will consider how it can extract mortality data from NCA reports and how it can best be presented to provide this overall picture for the Mortality Review Group.

The discussion at the Quality and Patient Safety Operational Group highlighted that the overview of learning from the Mortality Reviews is appreciated by senior clinicians. It was therefore agreed that the Mortality Review Group will produce this more regularly, after each meeting.

The Group considered some data on the recording of the cause of death in the notes at RGH which had been produced by one of the mortality reviewers. The Group will work with the Task and finish Group on the Medical Examiner to introduce one of the forms that will be required as part of the introduction of the Medical Examiner Role – the Last Entry in the Medical Notes form, which includes the cause of death. The Chair of the Mortality Review Group will also liaise with the End of Life Care Board about the ideal form of an Advanced Care Plan and where these can be stored to ensure that they are accessible to all involved in the care of a patient. Advance Care Plans are not seen in secondary care. If the advance care plan specifies that the person does not want to be admitted to an acute hospital when they are at the end of life, then they would not be seen by secondary care. But the process needs to be clear and understood across the whole health community.

In 2018-19, we will:	When
Continue to drive towards completing a mortality review for 90% of deaths in our hospitals work with the Task and finish Group on the Medical Examiner to introduce one of the forms that will be required as part of the introduction of the Medical Examiner Role – the Last Entry in the Medical Notes form, which includes the cause of death	Qu2 2018/19
the Mortality Review Group will also liaise with the End of Life Care Board about the ideal form of an Advanced Care Plan and where these can be stored to ensure that they are accessible to all involved in the care of a patient. Advance Care Plans are currently not seen in secondary care. If the advance care plan specifies that the person does not want to be admitted to an acute hospital when they are at the end of life, then they would not be seen by secondary care. But the process needs to be clear and understood across the whole health community	Qu3 2018/19

Summary Plans for Quality Improvement - 2017-20

Table 5.5

Desired Outcome/ Impact	Measure	Plan	Time frame
Healthcare Acquired Infections To ensure that a rate of no more than 25/100,000 population (<i>C.diff</i>) and 15/100,000 for <i>S. aureus</i> bacteraemias is delivered by 31 March 2017. Deliver future Welsh targets once set	Rate of <i>C.difficile</i> and <i>S aureus</i> /100,000 population	Hospital site infections prevention plan Root cause analysis of community acquired HCAI in primary care Environment strategy plan	Q4 16/17 Q4 17/18
Sepsis/Deteriorating Patient To eliminate avoidable deaths from sepsis in acute and community settings	Sepsis mortality numbers and rates Auditing use of the tool and the appropriateness of response to the deteriorating patient across all wards.	Spread the use of the trigger tool to all hospital wards (ABC Sepsis) Embed use of NEWS/patient parameters as a common language for recognising and responding the deteriorating patient across the whole health community.	Q4 17/18
Falls To reduce, as far as is reasonably practicable, the	Number of falls resulting in a fractured neck of femur.	Systematic implementation of the Inpatient Multi-factorial Falls Assessment Tool.	Q2 17/18 Q3 17/18

Desired Outcome/ Impact	Measure	Plan	Time frame
incidence of inpatient fall and falls related injuries		Falls scrutiny panel to set targets for reduction of inpatient falls Develop falls prevention action plan for Community.	Q4 17/18
Pressure Damage Zero tolerance to avoidable pressure damage	Compliance and accuracy of pressure damage screening and risk assessment Number of patients with pressure damage (capturing incidence of new pressure damage)	Embedding effective reporting system to monitor pressure damaged in Nursing Homes and Community settings Set targets for further improvement in hospital settings with regular reporting and monitoring	
Hospital Acquired Thrombosis Potential cases of HAT are correctly risk assessed and given thromboprophylaxis to eliminate avoidable HATs	Numbers of HATs by medical ward	Pharmacists and doctors improving risk assessment and administration of appropriate thromboprophylaxis. Implementing new All Wales prescribing chart to document risk assessment undertaken	Q3 17/18
Mortality Reviews To complete mortality reviews on 90% of deaths in hospital within 1 month	% mortality reviews undertaken	4 dedicated sessions for mortality review process Introduction of Medical Examiner	Q2 17/18 Q1 18/19