Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under (prior to 81st birthday)

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: invasive ventilation, Glasgow Coma Scale 3 not explained by sedation, no respiratory effort, fixed pupils, no cough or gag reflex. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – below 37 weeks corrected gestational age'. Previously referred to as brain death
Neurological death tested	Neurological death tests performed to confirm and diagnose death
DBD referral criteria	A patient with suspected neurological death
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to Specialist Nurse – Organ Donation	A patient with suspected neurological death referred to a SNOD. A referral is the provision of information to determine organ donation suitability. NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DBD donor	A patient with suspected neurological death
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188) Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Donation decision conversation	Family of eligible DBD asked to make or support patient's organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual donors: DBD	Patients who became actual DBD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Actual donors: DCD	Patients who became actual DCD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested

Referral rate	Percentage of patients for whom neurological death was suspected who were referred to the SNOD
Donation decision conversation rate	Percentage of eligible DBD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations)
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above)

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving invasive ventilation, in whom a clinical decision to withdraw treatment has been made and a controlled death is anticipated within a time frame to allow donation to occur (as determined at time of assessment)
DCD referral criteria	A patient for whom imminent (controlled) death is anticipated following withdrawal of life sustaining treatment (as defined above)
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to SNOD	A patient for whom imminent death is anticipated who was referred to a SNOD. A referral is the provision of information to determine organ donation suitability NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DCD donor	A patient who had treatment withdrawn and imminent death was anticipated within a time frame to allow donation to occur.
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188). Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DCD donor to be assessed	A patient who had treatment withdrawn and imminent (controlled) death was anticipated, with no absolute medical contraindications to solid organ donation.
DCD exclusion criteria	DCD specific criteria determine a patient's suitability to donation when there are no absolute medical contraindications (see absolute contraindications documentation above)
DCD screening process	Process by which an organ may be screened with a local and national transplant centre to determine suitability of organs for transplantation
Medically suitable eligible DCD donor	An eligible DCD donor to be assessed considered to be medically suitable for donation (i.e. no DCD exclusions and not deemed unsuitable by the screening process)
Donation decision conversation	Family of medically suitable eligible DCD donor who were asked to make or support patient's organ donation decision - This includes clarifying an opt out decision.
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual DCD	DCD patients who became actual DCD as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Referral rate	Percentage of patients for whom imminent (controlled) death was anticipated who were referred to the SNOD

Donation decision conversation rate	Percentage of medically suitable eligible DCD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained.
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations).
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above).

Deemed Consent/Authorisation

Deemed consent applies if a person who died in Wales, Jersey or England has not expressed an organ donation decision either to opt in or opt out or nominate/appoint a representative, is aged 18 or over, has lived in the country in which they died for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed consent for a significant period before their death.

Deemed authorisation applies if a person who died in Scotland has not expressed, in writing, an organ donation decision either to opt in or opt out, is aged 16 or over, has lived in Scotland for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed authorisation for a significant period before their death. Note that, in Scotland, a patient who has verbally expressed an opt in decision is included as a deemed authorisation, whereas a patient who has verbally expressed an opt out decision is not included.

Consent/Authorisation groups

Expressed opt in	Patient had expressed an opt in decision. Opt in decisions can be expressed in writing or via the ODR in all nations and verbal opt in decisions are also included in Wales, England and Jersey. Verbally expressed opt in decisions are not included in Scotland
Deemed consent/authorisation	Patient meets deemed criteria specific to each nation as described above. In Scotland, this includes patients who have verbally expressed a decision to opt in
Expressed opt out	Patient had expressed an opt out decision. Opt out decisions can be expressed verbally, in writing or via the ODR in all nations
Other	Patient has expressed no decision or deemed criteria are not met. Paediatric patients are included in this group

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key numbers in potential for organ donation	
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Appendix A.1 gives a fuller explanation of terms used.

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.
Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 PDA data by hospital and unit	
Table 4.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 4.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

5 Emergency department data	
Figure 5.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 5.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

6 Additional data and figures	
Table 6.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. A UK comparison is also provided.
Table 6.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 6.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 6.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.

Actual and Potential Deceased Organ Donation 1 April 2023 - 31 March 2024

NHS Blood and Transplant

Aneurin Bevan University Health Board

Organ Donation and Transplantation 2030: Meeting the Need

In 2023/24, from 13 consented donors the Health Board facilitated 8 actual solid organ donors resulting in 19 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

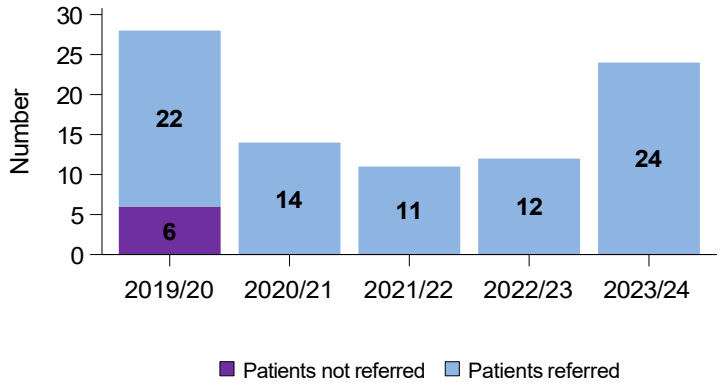
In addition to the 8 proceeding donors there were 5 consented donors that did not proceed.

Best quality of care in organ donation

Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart

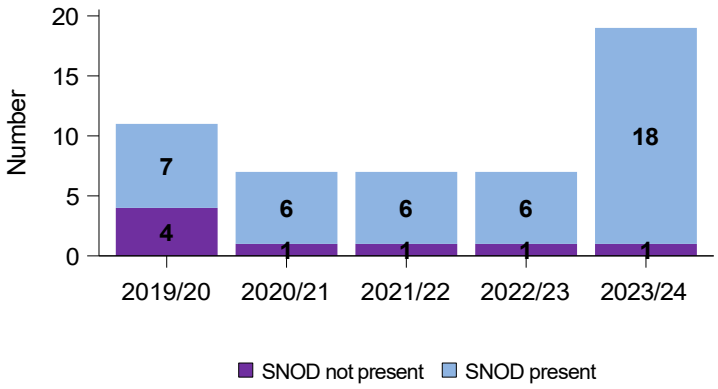


The Health Board referred 24 potential organ donors during 2023/24. There were no occasions where potential organ donors were not referred.

Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



A SNOD was present for 18 organ donation discussions with families during 2023/24. There was 1 occasion where a SNOD was not present.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	Wales*	UK
1 April 2023 - 31 March 2024		
Deceased donors	57	1,510
Transplants from deceased donors	154	3,723
Deaths on the transplant list	15	418
As at 31 March 2024		
Active transplant list	271	7,484
Number of NHS ODR opt-in registrations (% registered)**	1,376,148 (44%)	28,161,705 (42%)
Number of NHS ODR opt-out registrations (% registered)**	189,059 (6%)	2,577,667 (4%)

*Regions are defined using the NHS region definitions
* % registered based on population of 3.11 million, based on ONS 2021 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Health Board are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers comparison with UK data, 1 April 2023 - 31 March 2024

	DBD		DCD		Deceased donors	
	H. Board	UK	H. Board	UK	H. Board	UK
Patients meeting organ donation referral criteria[1]	16	2029	10	5331	24	6911
Referred to Organ Donation Service	16	2017	10	4949	24	6522
Referral rate %		*99%*		*93%*		*94%*
Neurological death tested	13	1534				
Testing rate %		*76%*				
Eligible donors[2]	13	1426	10	3635	23	5061
Family approached	12	1259	7	1849	19	3108
Family approached and SNOD present	11	1215	7	1672	18	2887
% of approaches where SNOD present		*97%*		*90%*		*93%*
Consent ascertained	7	858	6	1023	13	1881
Consent rate %		*68%*		*55%*		*61%*
- Expressed opt in	4	533	4	637	8	1170
- Expressed opt in %		*95%*		*85%*		*89%*
- Deemed Consent	3	246	0	323	3	569
- Deemed Consent %		*58%*		*47%*		*51%*
- Other*	0	78	2	63	2	141
- Other %*		*52%*		*34%*		*42%*
Actual donors (PDA data)	6	788	2	710	8	1499
% of consented donors that became actual donors		*92%*		*69%*		*80%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

For further information, including definitions, see the latest Potential Donor Audit report and up to date metrics via our Power BI reports at:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

Agenda Item: 2.7

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	02 September 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Annual Progress Report against the All-Wales Dementia Care Pathway
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tanya Strange, Head of Nursing Amanda Whent, Lead Nurse for Dementia

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Dementia Action Plan for Wales (2018) sets out the Welsh Government's commitment to promoting the rights, dignity and autonomy of people living with dementia and the people who care for them. An established Regional Dementia Board has developed a Regional Strategy and Action Plan to drive forward improvement actions against the 6 key aims of the National Plan.

In March 2021, Improvement Cymru published the *All-Wales Dementia Care Pathway Standards: High Level Standard Descriptors*. These Standards needed to be reflected in the Regional Dementia Strategy and Action Plan. The Standards will be subject to reporting against a Delivery Framework.

The Regional Dementia Board have taken a proactive approach, through dedicated Workstreams, to implementing the Standards. The Quality and Patient Safety Committee is asked to CONSIDER the Dementia Annual Report for assurance.

Background:

In March 2021, Improvement Cymru published the 'All Wales Dementia Care Pathway Standards'.

These standards have been scoped over the past two years and have been informed by 1800 people, including people living with dementia. The 20 standards indicate what people believe will make a positive difference to dementia care in Wales. The

20 Standards have been 'wrapped' around the person and, with 'kindness and understanding' at its core, consist of 4 broad themes:

- Accessible
- Responsive
- Journey
- Partnerships and Relationships

Each standard applies to all people being assessed, diagnosed and living with dementia and their carers', recognising people with dementia as a vulnerable group, together with individuals with special characteristics such as Learning Disability and Black Asian and Minority Ethnic Groups. The overriding approach for implementation of the standards is one of multi-agency responsibility with the Standards supporting the Dementia Action Plan (DAP) and laying the foundation for what the National DAP will look like over 5 years and beyond.

The Regional Dementia Board is well established. It provides a forum for strategic and clinical leadership, engagement, consultation and joint decision making across the health, social care and third sector agenda for dementia care in the five local authority areas of Blaenau-Gwent, Caerphilly, Monmouthshire, Newport and Torfaen, and the Aneurin Bevan University Health Board. The Dementia Board aligns and reports to the Regional Leadership Group and Regional Partnership Board (RPB).

Through its membership the Dementia Board is also aligned to the work of the regional Carers Board; End of Life Care Board; Mental Health and Learning Disability Partnership Board and the Gwent Adult Strategic Partnership Board. Five Dementia Friendly Community Implementation groups are represented by each local authority. The Board aims to harness the partnership working in the region to meet the priorities identified by people living with dementia and their carers and in the Dementia Action Plan for Wales and the National Dementia Standards.

The Board is supported by a sub structure of Workstreams to take forward specific areas of work. The attached Annual Report highlights key activity undertaken during 2023 and includes priorities for 2024/25.

Asesiad / Assessment

This annual report (2023- 2024) reflects the work that The Patient Experience and Involvement Team of the Aneurin Bevan University Health Board in collaboration with the Regional Partnership Team, the Gwent Regional Dementia Board and Dementia Friendly Communities programme has delivered against the aims, objectives and priorities aligned to both the Dementia Action Plan for Wales (2018-2022) and the All-Wales Dementia Care Pathway of Standards (2022). A readiness programme and the appointment of a Regional Programme Manager has enabled the implementation of the Standards into the Regional Dementia Action Plan and workstream programmes.

The Dementia Annual Report provides an in-depth review of progress taken to implement the Dementia Standards. Key highlights include:

Workstream 1: Community Engagement

- Held 36 community listening engagement events, testing the model in Newport (Maindee and Caerleon)
- Increased attendance at community groups, increasing reach with diverse communities
- Feedback now included in Newport Community Plans
- Exploration of Dementia Hubs in progress ('one stop' shop)
- The Dementia Friendly Communities Gwent Network now has over 200 participants
- Dementia Friends sessions held in local schools to promote intergenerational practice
- Collaborative and strengthened partnership with employment services and other organisations to raise awareness of people who might be working and needing extra support, encouraging organisations to review their employment policies to support people living with dementia, their families, and carers in the workplace.
- Held a Regional Dementia Conference- over 200 attendees.

Workstream 2a: Memory Assessment Service Pathway

- 10 Data Measurement Sets have been agreed nationally and regionally and are being recorded to support impact and benchmarking of services.
- Workstream partners are currently speaking to people living with dementia, families and carers, to encourage them to join the Community of Practice. A scoping exercise is being completed around third sector community support.

Workstream 2B: Carers Education and Support

- The MEC (Mapping, Education and Carers) team have developed a Gwent wide Carers Information Course that now runs in six-week blocks in all five Gwent region boroughs. These are face to face courses. The same course can be held virtually.
- Carers are also offered Positive Approaches to Care training, which is person-centred approaches and interventions in dementia care.
- A resource pack for Carers has been developed and is in use (paper and digital).
- The team are positively working towards increasing the number of carers attending courses. The team are currently developing a Padlet for Carers to access a wide variety of up-to-date information.

Workstream 3: Dementia Connector

- Work is ongoing to scope and collect details of connector roles in Gwent. We aim to develop role descriptors, skills and qualifications required and funding to identify what we already have available and what we may need to develop.
- A commissioning review will take place to consider Service Level Agreements with third sector parties and this will inform future planning.
- Connectors will help and support people, to optimize their wellbeing and access support when needed. Confirmation of funding received.

Workstream 4: Dementia Friendly Hospital Charter

- Established multi-disciplinary In-Patient Group
- Better support for, and inclusion of carers through John's Campaign.
- Wards have proactively engaged in Ward Improvement Plans to help improve patient experience in their areas.
- Increased professional case discussions and the visibility of the Patient Experience and Involvement Team at ward level are having a very positive impact.
- Dedicated internet page for people and staff with numerous resources.
- Improved collaboration with HMP Usk and Prescoed
- Grant funding secured (NHS Charities Together) to drive forward meaningful activities (hospital and community).
- Recruitment of 10 Activity Co-ordinators to date (uniform Job Description agreed)
- Care fit for VIPS across 15 wards
- Enhanced Care Review undertaken
- 184 Dementia Champions in place across ABUHB
- Evaluation of patient safety Bedside Boards undertaken showing real value.
- Falls Awareness Book (Stumble Crumble) created with schools.
- Improved intergenerational activity (ongoing)

Workstream 5a: Learning and Development

- Developed the ABUHB Learning and Development GoodWork Framework Strategy Plan that is linked directly to the Dementia Action Plan for Wales and regional dementia action plan to enable all workforces to engage and achieve the associated aspirations goals and plans.
- Uptake of mandatory dementia awareness is currently 81.7%
- A series of Bitesize learning provided by specialists in areas of practice as well as Staff Induction sessions, meaningful engagement and external learning opportunities have been secured and shared with all Nursing and Residential Care homes within the 5 boroughs. These include bitesize learning on:
  - Mental Capacity Act
  - Assistive Technology
  - Audiology
  - Oral Health care
  - Deprivation of Liberty
  - Hydration & Nutrition
  - Pain Assessment
  - Dementia Awareness (induction)

Workstream 5b: Monitoring

- Working with National Leads on national data set
- Scoping locally information already available.

Priorities for 2024/25

The Regional Dementia Board review progress of all Workstreams at each bi-monthly meeting. The identified priorities for the next year are included throughout the Annual Report and include:

- Identifying people with dementia using a Clinical Workstation- Alert Code 136

- Developing an improved pathway of transition to and from hospital through WAST- Welsh Ambulance Workstream
- Raising awareness and support for Future Care Planning
- Discharge patient flow priorities- reducing ward moves and improving discharge.
- Participating in the research and improvement for Dementia Continence care programme.
- Review ABUHB National Dementia Audit and ABUHB measures, using findings to improve care.
- Embed the Meaningful Engagement Programme and Activity Coordinator Roles
- Review and support the Urgent and Emergency Care pathway
- Establish a People Participation Panel for people living with dementia, their carers and staff.
- Continued community engagement and recruit more Community Listeners.
- Improve dementia care in HMP prisons
- Provision of Dementia Hubs, in the community and in hospital
- Achieve Cultural Competence Accreditation and embed throughout the dementia work programmes.
- Increase intergenerational practice.

Quality, Patient Safety and Risk Assessment

The work of the dementia programme is impacting positively on patients and carers, with more engagement and timely responses to concerns. The introduction of the patient bedside boards is ensuring that staff can identify 'at a glance' that people may have dementia and what their supportive care needs are. A more proactive presence and continued engagement with and training of health and social care staff is important in developing a skilled and informed workforce.

There is however, still so much more to do as identified in the priorities for the coming year. Some of the employed posts supporting the dementia are fixed term and the impact of these posts being discontinued is constantly under review. The Dementia Board will continue to review progress and risks associated with each of the workstreams and will report emerging risks through the Quality and Patient Safety Listening and Learning forum.

Argymhelliad / Recommendation

The Regional Dementia Board have taken a proactive approach, through dedicated Workstreams, to implement the Standards. The Dementia Board will set the work programme for 2025 at the end of year, ensuring priorities are embedded.

The PQSOC is asked to **NOTE** the progress as set out in the Annual Progress Report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care 4.1 Dignified Care 6.2 Peoples Rights
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require mental health and learning disability services Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	National Dementia Standards National Dementia Action Plan Quality Strategy Patient Experience and Involvement Strategy Mental Capacity Act
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Dementia Board

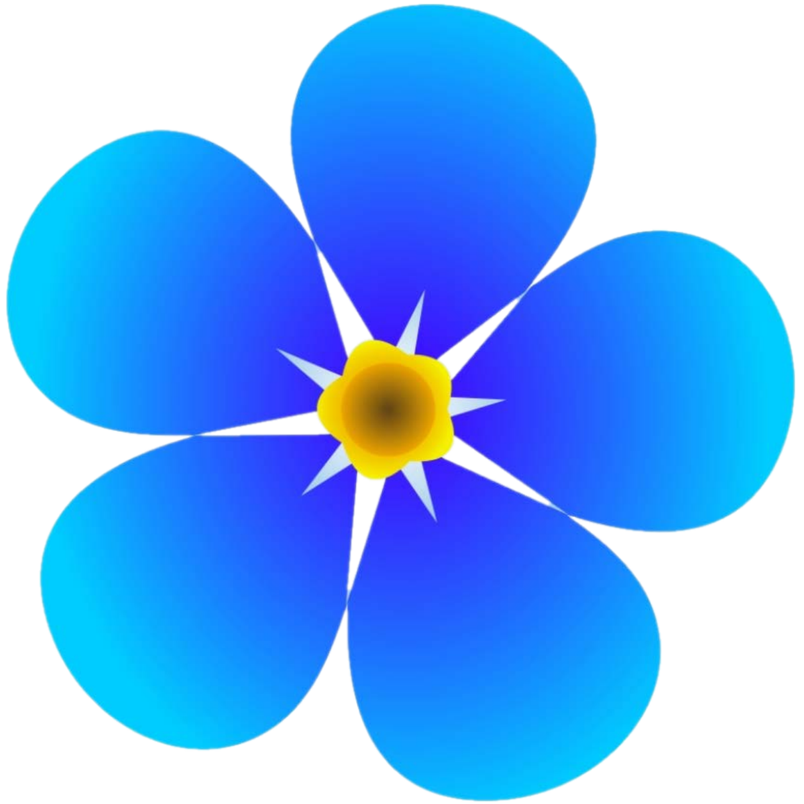
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive

	Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Yes, outlined within the paper
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives

Annual Progress Report against the All-Wales Dementia Care Pathway

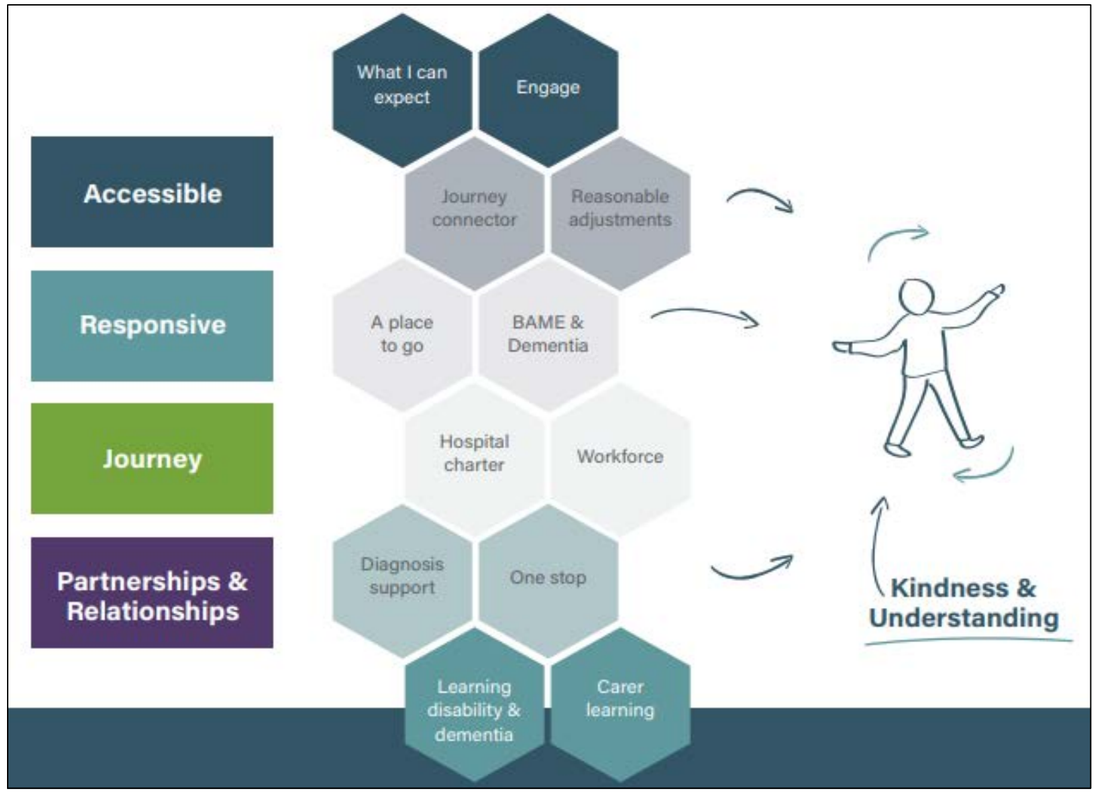
Prepared for the Regional Dementia Board

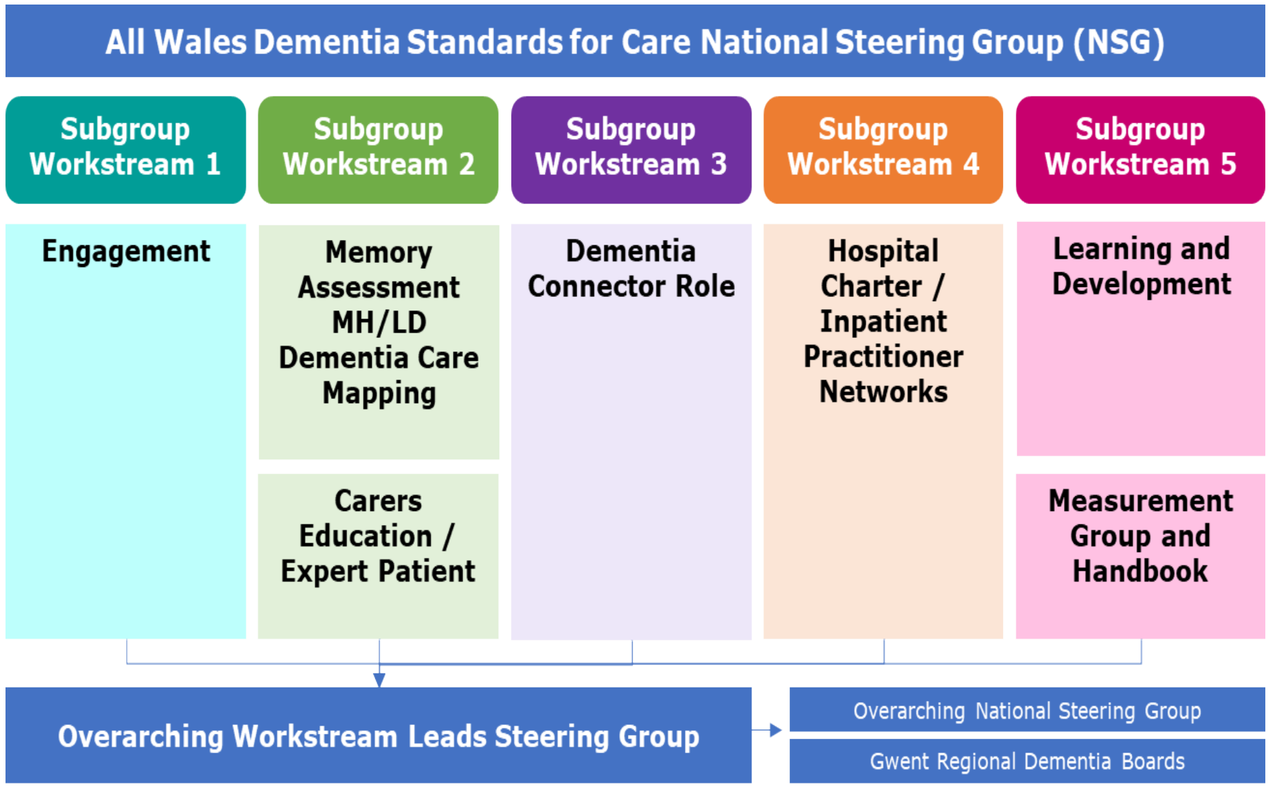
2023 -2024



Introduction

This annual report (2023-2024) reflects the work that the **Patient Experience and Involvement Team** of the Aneurin Bevan University Health Board in collaboration with the **Regional Partnership Team**, the Gwent Regional **Dementia Board** and Dementia Friendly Communities programme has delivered against the aims, objectives and priorities aligned to both the **Dementia Action Plan for Wales** (2018-2022) and the **All-Wales Dementia Care Pathway of Standards** (2022). A readiness programme and the appointment of a Regional Programme Manager has enabled the implementation of the Standards into the Regional Dementia Action Plan and workstream programmes.





Workstream Highlights: April 2023 – March 2024

Workstream 1

Community Engagement

Workstream 1 focusses on **community engagement**. Over the last 12 months 36 engagement events have taken place across the region. This has included attending community groups specifically for people living with dementia and their carers, whilst attending other events involving the wider community. Engagement has focused on seeking feedback from citizens around current services and identifying gaps in care. There has been a priority to share information around the **12 risk factors for dementia** with the aim of increasing knowledge and understanding of promoting a **healthy brain and reducing risk associated with dementia.**

To test the model, the engagement workstream has focused on Newport City as the first region to carry out the 'Listening Campaign'. Feedback informs the Dementia Community Plan for Newport, influenced by the views of people with lived experience. The **Dementia Community Plan** will be replicated in each local authority area in Gwent. This work has identified the need for **hubs** with a dementia specific focus, which would enable people to access support and information in one place.

Dementia Friendly Communities (DFC)

The Dementia Friendly Communities (DFC) Gwent Network **has over 200 participants**. We are currently working across all primary schools in the area, supporting **Dementia Friends** sessions and helping schools set up carers and parents' sessions where required. They connect schools to local hospitals/supported living encouraging **intergenerational activities** to promote emotional wellbeing. We are working with organisations across Gwent to build further awareness and understanding, **tackle stigma** and help support communities with setting up activities/ services to achieve more inclusive dementia friendly environments.

We are working with **employment services** and continue our work with various groups across the localities, sports and social as well as third sector agencies to raise awareness of people who might be working and needing extra support. As part of this work, we encourage organisations to look at their own **employment policies** to help support people living with dementia, their families, and carers in the workplace.

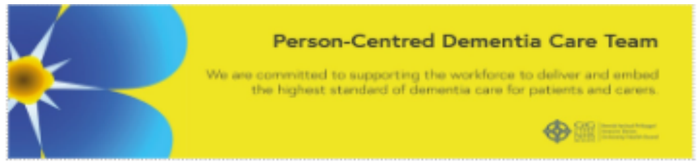
The DFC have created a **logo** to support awareness, understanding and promote collaborative working.

Gwent sy'n Deall Dementia

Dementia Friendly Gwent

Regional Dementia Conference – May 2023

The **Regional Dementia Conference** was an interagency, multi-disciplinary networking opportunity to launch the Dementia Standards of Care and share good practice. The Conference was attended by over **200** delegates from across the region.



Regional Dementia Conference
Influencing, Shaping and Improving Dementia Care

24 May 2023 9am-4.00pm
Christchurch Centre, Malpas Road, Newport. NP205PP

Programme	
9:00am	**Registration and Refreshments**
9.30am	**Introduction to the Day** Jill Evans, OBE, FRCN. Senior Organisational Development Practitioner
9.40am	**All Wales Dementia Standards** Ian Dovaston, Public Health Wales, Improvement Manager.
9.50am	**Workstream 1 Community Involvement and Experience** Tanya Strange, Head of Nursing & Chair of the Dementia Board Joanne Hook, Senior Nurse, Person Centred Care Team.
10.00am	**Workstream Lead 2a & 3 – Memory Assessment Services & Dementia Connector** Alison Marshall – Lead Nurse, Older Adult Mental Health.
10.10am	**Workstream Lead 2b – Person & Carers Programme** Sophie Foote, MEC Team Lead, Older Adult Mental Health
10.20am	**Workstream Lead 4 – Dementia Friendly Hospital Charter** Donna Wigmore - Dementia Specialist Practitioner Amanda Whent, Lead Nurse Dementia.
10.40am	**Workstream Lead 5a – Learning & Development** Amanda Whent, Lead Nurse for Dementia, Person Centred Care Team
10.50am	**Workstream Lead 5b – Measurement** Natasha Harris, Service Manager, Partnerships and Development for Gwent Regional Partnership Board
11.00am	**Q&A Panel**
11.15am	**Refreshments**
11.45am	**Dragons Rugby Wales and Dementia** Karen Burgess, Dragons Rugby, Inclusion Officer.
12.00pm	**Dementia Friendly Communities** Natasha Harris, Service Manager, Partnerships and Development for Gwent Regional Partnership Board
12:15pm	**Young Onset Dementia** Sarah Harries, Head of Clinical Services for Hospice of the Valleys Carolyn Regan – Dementia Support Worker within the CARIAD Dementia Service for Hospice of the Valleys
12:30pm	**Lunch - NETWORKING**
13:30pm	**Hearing Loss and Dementia** Wendy Trump, Clinical Scientist, Head of Adults Services for Audiology
13:45pm	**Dignity & Continence Project for Patients living with Dementia** Professor Katie Featherstone, Professor of Sociology and Medicine and Director of the Geller Institute of Ageing and Memory, University of West London. Victoria Coghlan, Advanced Nurse Practitioner for Bladder and Bowel Service.
14:00pm	**Nutrition, Hydration and Dementia.** Nokhuthula Nyoni-Smith. Lead Dietitian. Aneurin Bevan University Health Board
14:15pm	**Care pathway for oral health care for people living with Dementia** Vicki Jones, Clinical Director of Community Dental Services Consultant
14:30pm	**Q&A Panel**
14:45pm	**Refreshments**
15:15pm	**Assistive Technology and Dementia** Matthew Lloyd, Prevention and Well-being Programme Manager, Regional Partnership Board.
15:30pm	**Positive Approach to Care (PAC) interactive session.** Matt Galloway, Practice Facilitator, Older Adult Mental Health Dawn Morgan, Team Lead, Older Adult Mental Health.
15:45pm	**Closing Remarks Reflection on Pledges and Next Steps** Jill Evans, OBE, FRCN, Senior Organisational Development Practitioner.
15:50pm	**Evaluation / Raffle**
16:00pm	**END- Have a Lovely Evening Thank you for coming**

This document is available in Welsh / Mae'r ddogfen hon ar gael yn Gymraeg

Feedback

Based on feedback relating to signposting and sharing information, we have established a **dedicated dementia email** address where people can contact the **Patient Experience and Involvement Team** if they are unsure of who else to contact. This has been well received.

Workstream 2(a)

Memory Assessment Service Pathway

The aim of **Workstream 2(a)** is to ensure the development and creation of a seamless and **robust pathway** for people diagnosed with Dementia, their carers and others engaged with people living with Dementia.

10 **Data Measurement Sets** have been agreed nationally and regionally and are being recorded to support impact and benchmarking of services.

Workstream partners are currently speaking to people living with dementia, families and carers, to encourage them to join the **Community of Practice,** a forum to help review and deliver good practice in **Gwent.**

Workstream 2(b)

Carers Education and Support

Workstream 2(b) aims to ensure that people living with dementia, carers and families are offered learning, education and skills training. This offer will be 'stage of condition' appropriate and will be provided at significant points of a person's journey.

- The **MEC** (Mapping, Education and Carers) team, funded from the RIF Regional Investment Funds, have developed a Gwent wide **Carers Information Course** that now runs in six-week blocks in all five Gwent region boroughs. These are face to face courses. The same course can be held virtually.
- Carers are also offered **Positive Approaches to Care** training, which is a person-centred approach and intervention in dementia care.
- A **resource pack** for Carers has been developed and is in use. This is in both paper and digital formats.
- The team are positively working towards increasing the number of carers attending courses, by developing a poster to be displayed in all **GP Surgeries**, all Hospital Entrances/Restaurants/Inpatient Units. The team are currently developing a **Padlet** for Carers to access a wide variety of up-to-date information.

Workstream 3

Dementia Connector

Dementia Connector: Model Development

We are continuing to scope and collect details of **connector roles** in Gwent. We aim to develop role descriptors, **skills** and **qualifications required** and funding to identify what we already have available and what we may need to develop.

A **commissioning review** will take place to consider Service Level Agreements with third sector parties and this will inform future planning. This will be a collaborative approach with all stakeholders in Gwent. The Dementia Connector role will help a person **navigate** their care journey, supporting the person living with dementia and their carers/ families and enable timely assistance when required.

Connectors will help and support people, to optimise their wellbeing and access support when needed.

Workstream 4

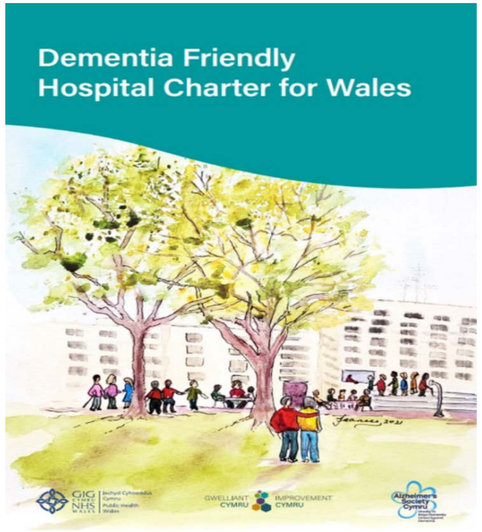
Dementia Friendly Hospital Charter

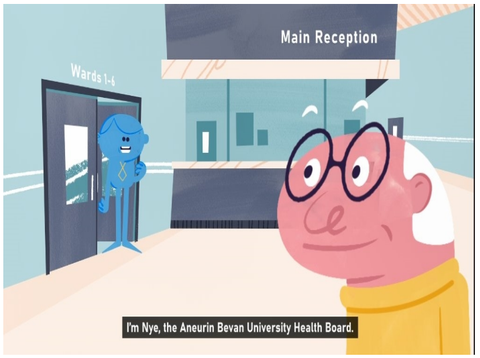
The **Hospital Charter** aims to improve the experience of people living with dementia when they are in hospital. This experience must recognise an individual's personhood, diversity and preferences, shaped by recognising the importance of dignity, respect and kindness.

It provides a **set of principles and indicators** that focus on the needs of people with dementia and their families, carers and supporters and offers an **improvement guide** to assist hospitals in their self-assessment against the dementia friendly principles. Importantly, the Charter **informs people** of what to expect when they receive care and visit a dementia friendly hospital.

Improving In-Patient Person-Centred Dementia Care

Since the launch of the Standards and the Dementia Friendly Hospital Charter in 2022, much has been done across Aneurin Bevan University Health Board to improve people's lived experiences when they are in **hospital**, including better support for, and inclusion of carers. Wards have proactively engaged in Ward Improvement Plans to help improve **patient experience** in their areas. Professional case discussions and the visibility of the Patient Experience and Involvement Team at ward level are having a very positive impact. **Staff feedback** suggests that having the dedicated dementia intranet pages and access to **expert advice** through the dedicated e-mail address has significantly helped. What follows are examples of the initiatives that are having positive impacts on patient care, carer and staff experience. Many of these initiatives have been informed by feedback.

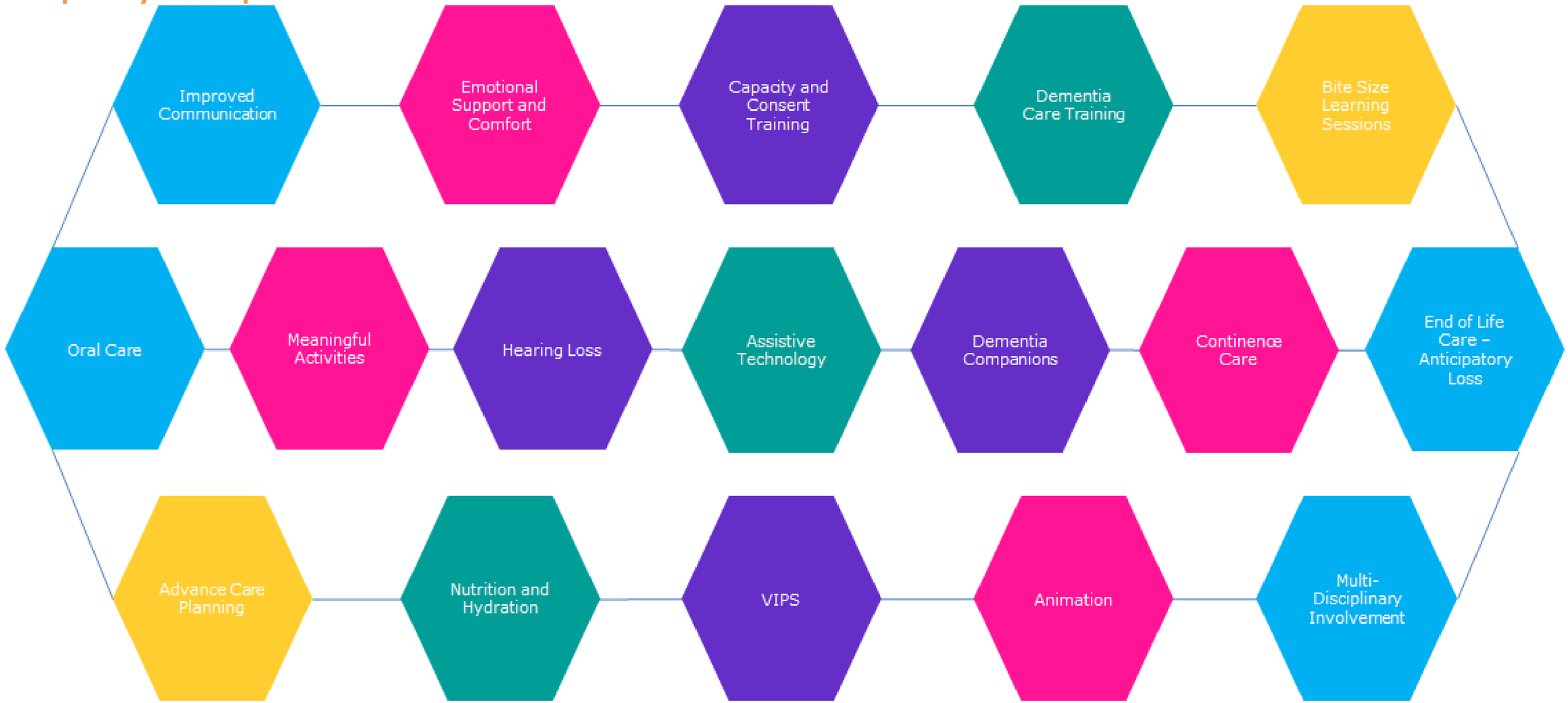




Responding to Patient and Family Feedback

Over the past year we have **listened** to the views of our communities, patients, carers, staff and stakeholders. Our involvement strategies have included either face to face discussions or discussions via webinars and, coupled with a review of written communication, are now better able to identify and drive forward both what we do well and action the improvements needed.

Feedback, specifically from people in hospital, carers and staff has identified these main themes which we use for **learning which we now use for the priority action plan.**



Person Centred Meaningful Activities and Engagement

There is clear **research** evidence to show that engaging people in meaningful activity and engagement has significant benefits both to physical and psychological recovery. A **successful 1st Phase** of this programme has been in place in the General hospitals and evaluated to have a positive impact on patient experience of care.

Through a partnership agreed **Meaningful Activity and Engagement programme**, we aim to build on this 1st phase and embed a multi-disciplinary person-centred dementia approach to care in the community. **NHS Charities Together** have supported this programme by granting the funding to deliver this programme.

We aim to develop and **rollout** a meaningful activity strategy to a range of care homes in Gwent, HMP Usk, the hospital wards within ABUHB, informed by the needs of people living with dementia and their carers across the area, with a suite of meaningful activity resources and learning opportunities. It will be supported by a **practitioner's forum** to support staff, volunteers and carers gain skills, knowledge and confidence to deliver non-pharmacological interventions and embed **person-centred** meaningful activity.

Delivering the Meaningful Engagement Programme

The programme is led by the specialist Dementia Practitioner and overseen by the Lead Nurse for Dementia. A bid was secured through the support of the **NHS Charities Together Grant** which has enabled the recruitment of **2 secondment opportunities** for an 18 months:

- Dementia Practice Educator
- Regional Dementia Meaningful Engagement and Activity Co-Ordinator

The programme will be delivered through a series of actions and measures, managed by a **Meaningful Engagement and Activity Steering Group** which includes:

- Identifying **resources** and approaches which facilitate meaningful engagement.
- Promoting **Biographical tools** such as 'This is Me', 'What matters to me' documents to identify individual interest, hobbies, and routines.
- **Dementia Volunteer Companions** - working with our Ffrind i Mi volunteers, we will link volunteers with care homes. They will be supported with training and supervision sessions.
- **Learning and Development** - through our Dementia Carers Workstream and linking in with a wide range of partners, we will offer awareness training to identify meaningful activities that would support the person they care for.
- Through our **enhanced care framework**, we will work with wards and families on admission and discharge to ensure meaningful activity is considered in care planning.
- **Dementia Champions** will be identified and will proactively strive to educate communities as to the importance of meaningful activity to wellbeing.
- By linking schools with care homes we will support the **Intergenerational** Dementia Friendly Communities programme.

ABUHB Activity Co-ordinators

Meaningful Activities Feedback

This is an outstanding service, providing activities and company for patients whilst having fun.

Cannot thank you enough for your help with my mother. It has been a great help to her demeanor. Thank you.

Through the development Meaningful Engagement with people living with Dementia, the role of the **Activity Co-ordinator** has been development and recruitment for this role is taking place in each Division. There is now a **Task and Finish** Group to develop the role further and provide structure and support for those staff in post.

The role of the Activity Co-oridnator is to provide meaningful engagement, emotional, physical and mental support and **stimulation**.

Meaningful Activities Feedback

Paula is doing an amazing job getting patients involved with the activities.

Patients are interacting with each other, singing and appear calmer.

Patients look forward to spending time in the activity corner. One lady called it her happy place.

Progress so far:

- 10 Activity Co-ordinators currently in post
- Task and Finish Group established with representation from all divisions
- Peer Support group for Activity Coordinators in place
- Support from The Patient Experience and Involvement Team – Regional Meaningful Engagement Dementia Activity Coordinator has worked closely with each Activity Coordinator
- Induction and framework to be developed
- Standardised uniform to be introduced

Care Fit for VIPS

To support implementation of the Dementia Friendly Hospital Charter, we have introduced **VIPS** into our hospitals. VIPS will support clinical teams to deliver person-centred care through:

Valuing and promoting the rights of the person.

Individuals needs- provision of individualised care according to needs.

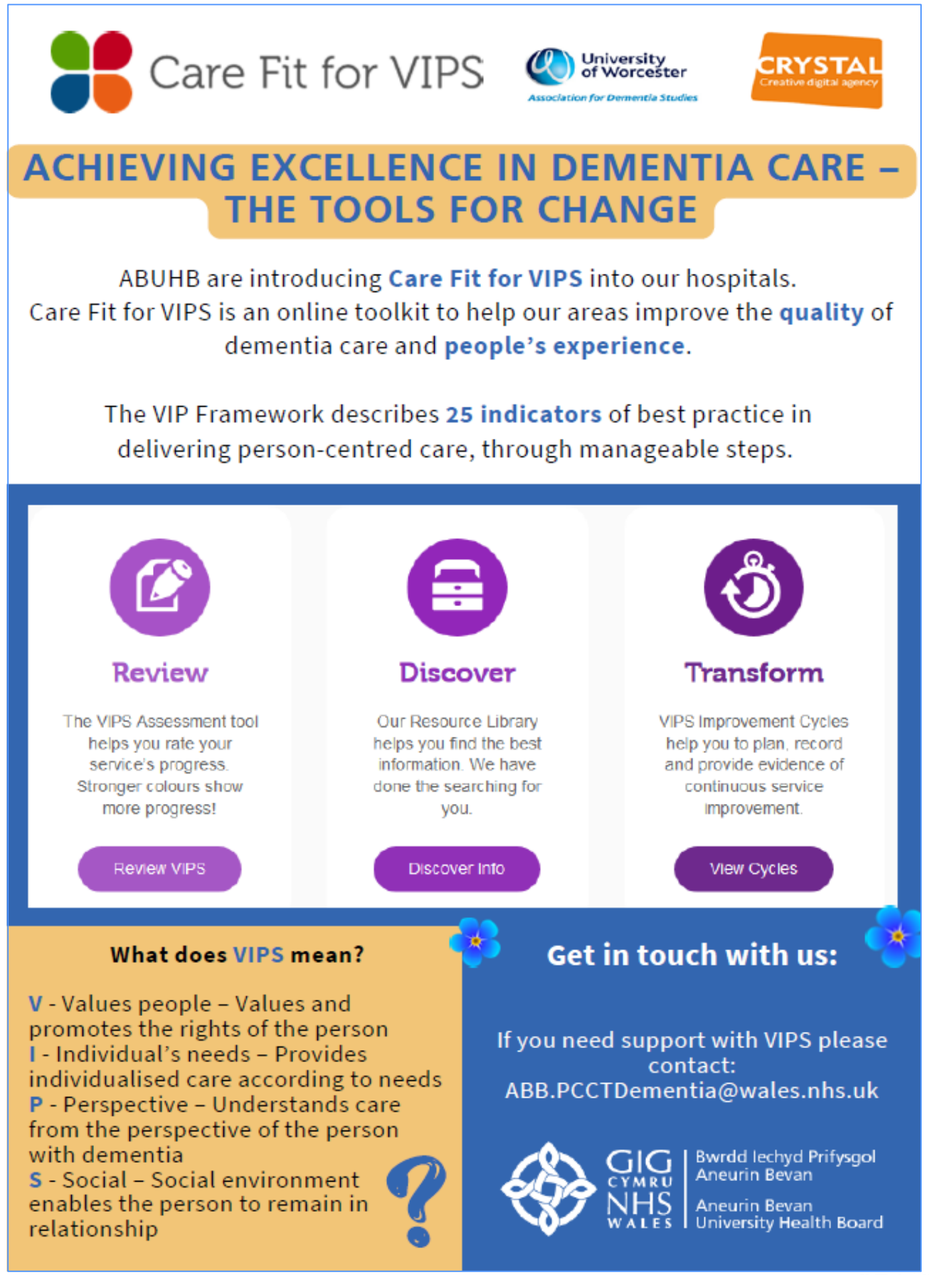
Perspective: staff understanding care from the perspective of the person with dementia.

Social-social environment enables the person to remain in relationship

Phase 1: 15 hospital Wards over 7 sites.

A dedicated tab was made available on the Dementia staff intranet page to support staff to **access resources** required easily.

Experiential opportunities have been made available to the staff on wards implementing VIPS.



Implementing Care Fit for VIPS – 1 year on

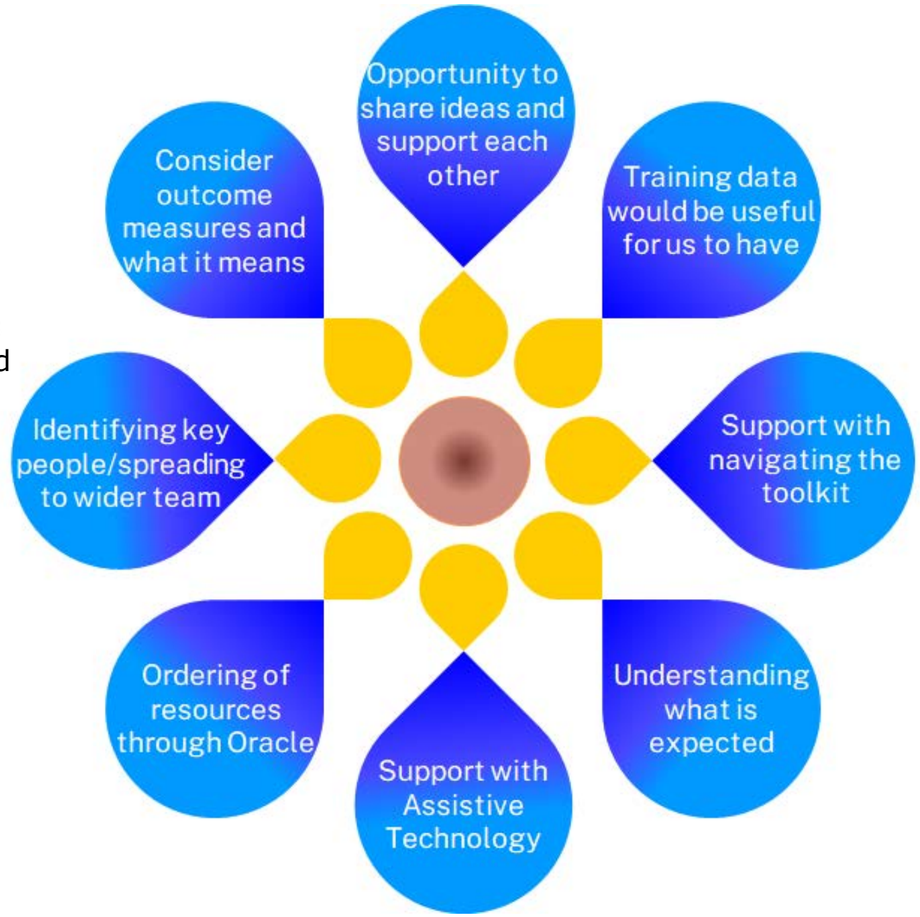
There have been some challenges identified from feedback and these are being worked through:

- Leadership
- Cluttered spaces
- Funding
- Works and Estates costs
- Time / protected time for this work
- Need to formalise so VIPS is priority
- Recruitment
- Toolkit is time consuming
- Department moves /reconfiguration of areas
- Responsibility sitting with key individuals and not spread to wider team.

Series of Workshops

Staff Feedback:
"Thanks for great training session regarding VIPS. It was inspirational".

Monthly Support Group Themes



Next Steps

- Review engagement in the phase 1 areas to decide if we will continue with all 15 areas
- 1 New area commenced in May 24
- 3 areas have booked in for Workshops following individual feedback sessions.

Review Visits	Areas Engaged
Bedside Boards in use	15 Areas (not fully embedded in all)
Dementia Champions in Area	13 Areas
Resources for ME in area	15 Areas (not fully embedded in all)
Display in Area	12 Areas (3 waiting to go back up due to site move)
Supporting John's Campaign	15 Areas
VIPS poster and log in accessible to staff	4 Areas
Feedback Forms for Resources / Experiences	2 Areas
Feedback session to Ward Managers and Senior Nurses	WM – 9 out of 15 SN – 4 out of 7

Evaluation of VIPS / Themes

- All **15 areas** have made improvements in their areas
- **50%** of wards engaged with individual workshop sessions and these areas saw further progress with the wider team.
- Areas that have an activity co-ordinator in post have seen a **higher level of engagement** with all support offered.
- Whilst all areas used the tool kit as a guide, all areas found it **difficult to evidence progress** through the toolkit.
- Main theme from leadership was as this is not formalised; it is often **superseded by higher priorities**.

PDSA Cycles in Progress

Evidence of **good practice** include:

- Nurse Practitioner using '**Meaningful Engagement prescription**' as part of treatment plan in medical notes.
- Picture Menus
- Development of **day room spaces**
- Employment of Activity Co-ordinators
- Training plans
- **'Come dine with me'** nutrition and hydration
- Safe space / quiet corner
- Hairdressing Services e.g., Salon Sunday
- **Environmental audits** and development

Enhanced Care Review

Undertaken November 2023 - March 2024 by the Patient Experience and Involvement Team, led by the Senior Nurse and the Dementia Specialist Practitioner. This audit considered:

- During the **pandemic**, requests for Enhanced Care (EC) increased significantly.
- Although there has been a reduction in requests for enhanced care just before the review, it was felt that more could be done through the **Care Aims Framework** to enhance patient, carer and staff experience, and reduce agency and bank use.
- Executive Team agreed to review of EX across wards with the **highest usage**.
- **Aim** was to improve Quality, Safety and Patient Experience and reduce costs
- Pilot at **YYF** (highest numbers of EC at the time) followed by extended review.
- Review of current EC, documentation, PSAG Boards, Bedside Boards, **EC Framework**.

- EC **Review Tool** Developed
- EC would focus on (summary):
  - ✓ Patients **care journey** since admission
  - ✓ Care package **prior** to admission
  - ✓ Patients' **capacity** (e.g. to consent to EC)
  - ✓ Number of **ward moves**
  - ✓ Patients **presentation/condition**
  - ✓ **Reason** for EC
  - ✓ **Level** of EC being provided
  - ✓ Package of care anticipated on **discharge**
  - ✓ Consideration of **alternatives** to EC
  - ✓ **Staff** feedback

Next Steps:

- Enhanced care and falls- focused MDT review to identify alternative strategies
- Enhanced care and dementia - look to reduce ward moves
- Increasing communication with patients, families and carers- open visiting and active encouragement of families in care through John's Campaign.
- Better engagement with volunteer support
- Embedding meaningful engagement
- Re launch of revised EC framework, risk assessment and flow chart alongside a training programme
- Support for staff re psychological safety and confidence
- Consideration of the resources required to drive forward alternatives to restrictive EC e.g. employment of dedicated Clinical EC lead/s

Dementia Champions

We developed and implemented a **Dementia Champions Campaign** during the month of February 2023 and used this to form actions for 2024:

- Meet the Dementia Champions **in person**
- **Raise awareness** of the role
- Develop and **support** existing Dementia Champions
- Listen to their **feedback**
- **Recruit** new Dementia Champions
- Share the **resources** available to Dementia Champions
- Share the **Reflective Workbook**
- **Identify** those that wish to continue to be a Dementia Champion
- Update the Corporate **Register** of Dementia Champions
- Provide the Dementia Champions with their ABUHB **Daisy Badge** and lanyard

Dementia Champions act as **role models** for other staff members as well as 'connectors' between the wards and the Patient Experience and Involvement Team. They offer **inspiration**, feedback, suggest actions needed to improve the patient and carer experience as well as how the ward environment may be improved.

We encourage Dementia Champions to attend **Dementia Awareness and Meaningful Activity training** to improve their knowledge, skills and inclusive practice and the Bitesize Training sessions have been developed to identify who the ward-based Dementia Champion is.

Two **videos** have been developed to showcase the role of Dementia Champions .

These videos are now part of the **training to recruit** new Dementia Champions and build our network of staff and partnerships both internally and externally.

Person Centred Bedside Patient Boards

Following a successful introduction of the Person-Centred (safety) Bedside Boards, **1400** Boards were purchased and delivered to all the hospital sites within ABUHB.

A mid-way **Impact Evaluation Review**, supported by the Value Based Healthcare Team was undertaken in October 2023 of the 34 wards where boards are erected, Patients, public, visitors, families, carers and staff were asked for their **feedback** on the boards.

The Team developed and shared posters and leaflets with **QR codes** which fed into Microsoft Forms, providing the team with immediate analysis. These were shared through **social media** platforms as well as Pulse web pages. Paper questionnaires were also shared.

The **evaluation** identified that the boards had been very well received by both patients, families and visitors, volunteers, ward staff and the multi disciplinary staff working within the **care settings**.

One of the key staff that benefitted from the boards were **facility staff** who were able to greet the patient by name and, for example, provide the correct drink that the person preferred.

Feedback was used to support further actions such as adding magnetic pen holders and pens; developing briefing communication strategy for carers and staff through the communication teams, using **videos**, briefing newsletters and carers support groups.

> **Gives us information to be able to hold a conversation with them about a topic that they make like.**
>
> **(Volunteer Visitor)**

MY NURSE TODAY IS:		MY PREFERRED NAME IS:	
LANGUAGE		English ☐ Welsh ☐ British Sign Language ☐	Other:
COMMUNICATION		Independent ☐ Hearing aids ☐ Lip reading ☐ Spectacles ☐ Interpreter required ☐	Other:
DIET		Menu: High energy snacks ☐ No oral diet ☐ Food allergies:	Independent ☐ Assistance needed ☐ Full assistance ☐ Dentures ☐
FLUIDS		Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4 ☐ Fluid restriction: _____ ml No oral fluids ☐	Preferred drink: Tea ☐ Sugar ☐ Milk ☐ Coffee ☐ Sweetener ☐ Squash ☐
MOBILITY		Independent ☐ Assistance ☐ Other:	Supervision ☐ Falls Risk ☐
OTHER CLINICAL CONSIDERATIONS: Include relevant PSAG symbols here			
WHAT IS IMPORTANT TO ME			
MESSAGES			

John’s Campaign

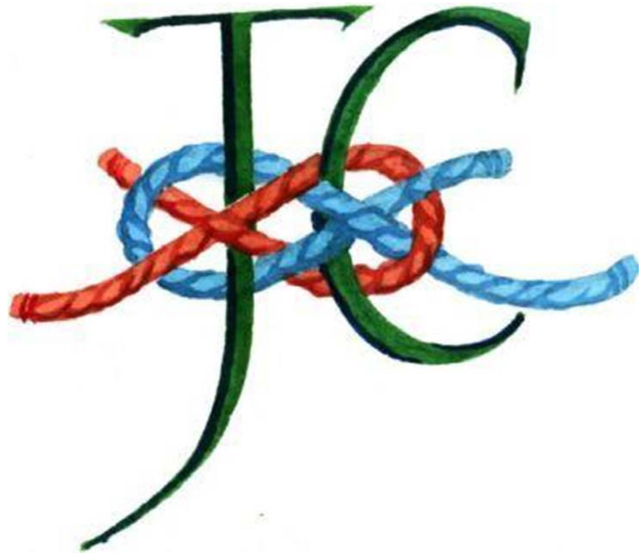
Is the person you are visiting living with dementia?

Are you the main carer?

We embrace John's Campaign, where carers have the right to ask to continue supporting loved ones when they are in hospital.

Please let the ward staff know if you are the main carer and ask about flexible visiting.

John’s Campaign (JC) recognises the importance of **involving carers** who wish to support people living with dementia when they are in hospital. The information for JC is embedded into the staff induction programmes. The "Introduction to ABUHB Dementia Care", alerts staff to the need to recognise the importance of carers and maintain a positive attitude to the involvement of carers, demonstrating sensitivity to their needs and recognising their value to care.



For **Dementia Action Week** (May 2023), we celebrated the re-launch of John’s Campaign on all our wards. Information leaflets and resources were made available on the internal Dementia Intranet pages, included in all the Health Board Induction programmes, **carers education groups** and through our Workstream 1, community engagement meetings.

To increase public awareness of JC, carers leaflets for were promoted and made available through **Carer’s Networks**, ABUHB Carer’s Internet page and our Dementia Internet page, Our dedicated email address was also included and the public asked to contact us if they wished to discuss further: ABB.PCCTDementia@wales.nhs.uk

Intergenerational Practice

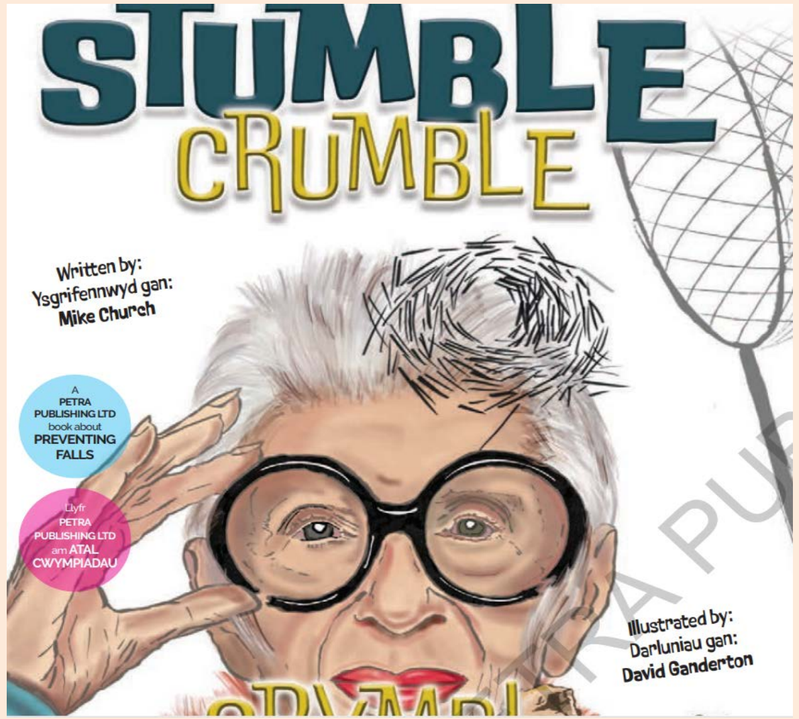
We are proactively developing meaningful intergenerational activities programmes in partnership with schools, colleges, wards and care homes. We know this approach supports:

- Reduction in loneliness/isolation
- Reduction in behaviours that are distressing
- Increased creativity/ mobility
- Increased knowledge about person-centred dementia care
- Reduction in falls
- Positive experience for patient and staff feedback

We have commenced linking the **16 care homes** in the Meaningful Engagement programme to the intergenerational programme with the aim of increasing the relationship between these areas and supporting with learning from schools, hospitals and care homes who already participate in the scheme.

Falls Awareness and Prevention Book:

Following the success of *Billy the Superhero* and *The Elephant in the Room*, we have worked with publishers, storytellers, therapy staff and schools to produce a **falls** awareness book. ***'Stumble Crumble'*** aims to raise awareness of all the risks associated with falls and the importance of falls prevention **across the ages**, highlighting increased risks when people have a cognitive impairment. This book will be launched in August 2024 with schools, Health Board staff and Dementia Friendly Communities.



Specialist Occupational Therapy Activity Programme






Development of a specialist **OT activity-based** programme suited to the complex needs of OAMH in-patient services:

- **Reduce variation** and ensure standardisation **specialist OT offer of activity programmes** across ABUHB OAMH in-patient units
- **Evidence based/best practice** and recognised Occupational Therapy Models of practice.
- Evaluation using standardised **occupational therapy outcome measures**.
- Maximises engagement of a range of individuals with **different needs** in relation to their motivational level and skills in occupations.
- Suited to people/older people with **complex mental health/physical and cognitive needs**.

Results:

The service has been accessed by **152 individuals** on average in a 12-month period (in total in the two Boroughs: Newport and Blaenau Gwent).

The average number of self-management strategies people were using in day-to-day life after intervention were 6-7. Three months post-intervention, this remained as 5-6.

The standardised OT assessment OCAIRS (semi-structured interview) was completed before and after intervention and 3 months post. **Improvement occurred in 8-10 of the 11 domains of the OCAIRS** (no deterioration).

Domains of noticeable improvement were to roles, habits, personal causation, goals and readiness for change. Some continued to improve post treatment.

Feedback forms: On a scale of 0-10, 0 being bad, 10 being excellent: Carer score averaged 8.8 and **Participant score averaged 9.6**.

Older Adult Mental Health to consider extended model of service.

Priorities 2024 – WS4 Dementia Hospital Steering Group

Identifying people with dementia using a **Clinical Workstation - Alert Code 136.**

Developing an **improved pathway of transition** to and from hospital through WAST- Welsh Ambulance Workstream.

Raising awareness and support for **Future Care Planning**.

Discharge patient flow priorities - **reducing ward moves** and **improving discharge**.

Participating in the **research** and improvement for Dementia Continence care programme.

Review ABUHB **National Dementia Audit** and ABUHB measures, using findings to improve care.

Embed the **Meaningful Engagement Programme** and Activity Coordinator Roles.

Review and support the **Urgent and Emergency Care pathway**.

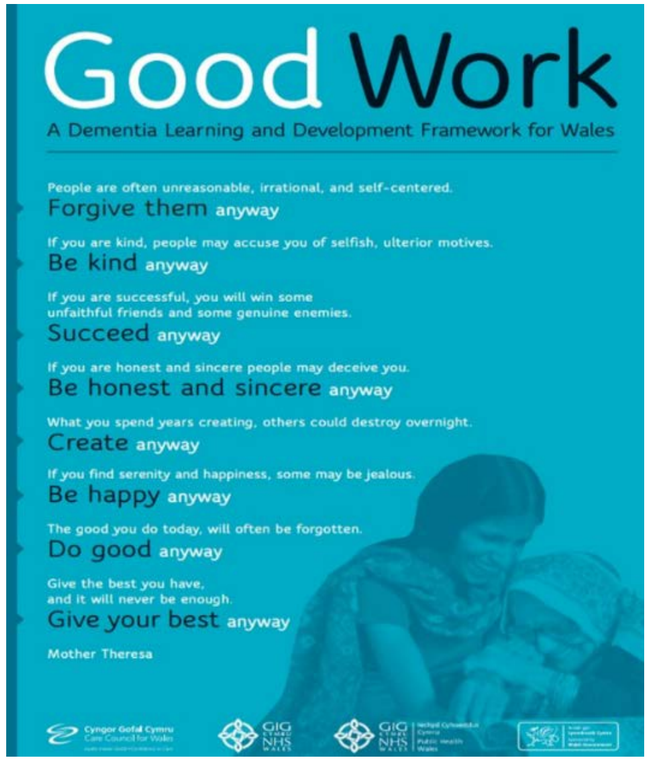
Establish a **People Participation Panel** for people living with dementia, their carers and staff.

Workstream 5(a)

Learning and Development

At the heart of the **GoodWork Learning and Development Framework** is what matters to people living with dementia, and aims to empower patients, carers and health and social care staff to ensure dementia care is person centred.

Local dementia training strategies adopt the values that gets to the heart of what matters to people (**compassionate practice**), ensures staff are technically competent and 'fit for practice' (**competent practice**), are personally engaging and contextualised (**wise practice**), fundamentally resulting in a workforce that are **informed**, **skilled influencers**.



What we achieved during 2023 - 2024:

Over the past year we have we have developed the ABUHB Learning and Development GoodWork Framework Strategy Plan that is linked directly to the **Dementia Action Plan for Wales** and regional dementia action plan to enable all workforces to engage and achieve the associated aspirations goals and plans.

A series of **Bitesize learning** provided by specialists in areas of practice as well as Staff Induction sessions, meaningful engagement and external learning opportunities have been secured and shared with **all Nursing and Residential Care homes within the 5 boroughs**.

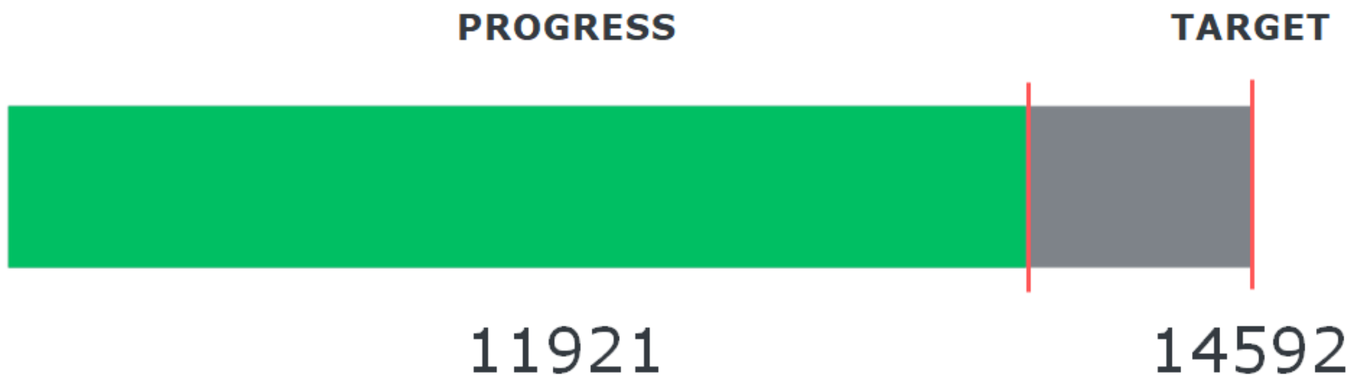
Learning and Development Progress

Dementia Specialist Bitesize Sessions Introduced

Session	Number of Attendees
Mental Capacity Act	14
Assistive Technology	13
Audiology	5
Oral Health Care	41
Deprivation of Liberty	42
Dementia Hospital Charter	31
Hydration & Nutrition	40
Pain Assessment	37
Dementia Awareness (induction)	164
Total	**387**
(95% ABUHB staff 5% other organisations)	

Dementia Awareness and Meaningful Engagement and Activities Education Training is provided 1 day a month.

Dementia Awareness Mandatory Module (online) ESR Compliance for ABUHB



97 participants have attended bitesize training which include staff, volunteers and outside partnerships and care homes.

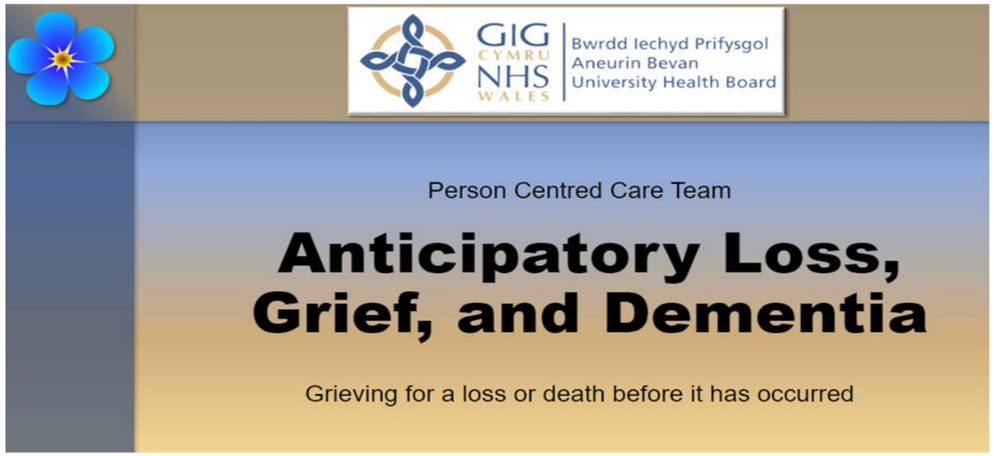
Feedback – verbal feedback has been positive

Extended to care homes, **prisons** and Primary Care networks.

Staff, Carer and Patient Learning

Patient Stories

We have listened to **people's experiences** of dementia care, developed patient and carer stories/films and have used these to improve learning.



What we've heard is that people need to be supported when faced with the reality that dementia can lead to people **experiencing loss** of the person they know as the disease progresses.

We have developed a training programme for staff which focusses on **anticipatory loss and grief in dementia**. The training includes the voice and feeling of people and their carers.

The aim of the module will be to increase the knowledge and understanding of anticipatory loss of a person living with dementia and their carer.

External Training Opportunities

- Organised **Experiencing Dementia** events provided by the award winning Re-Live organisation 200 places were made available via the members of the workstream group to enable multi-partner participation.
- Organised the **Dementia Virtual Bus Training** events open to all partners and delivered training to 90 participants

"The Virtual Dementia Tour – Your Window into Their World"

We have secured a training opportunity for staff and our partners to provide experience and learning, to enable them to better support people living with dementia.

The Virtual Dementia Tour is all about understanding what a person living with dementia experiences daily to gain a greater understanding.

The tour will visit various sites during March, April and May providing 90 training spaces.

What we want to achieve going forward

Dementia Experiential Training

Aneurin Bevan Health Board is in the process of developing an experiential training day for staff working in the Hospitals, Prisons and Care Homes across the region. A task group is being created to create a 1–2-day training to allow staff to engage in an empathetic experience of the challenges people living with dementia face each day.

We would then deliver this training to all of Gwent, workforce and carers. The session would involve slides on the theory behind People with Dementia's experience of pain, hearing loss, loss of vision, etc.

The activity session would be delivered prior to the theory for full impact.

Reaching out into the Communities

Our plans for 2024-2025 is to provide and deliver Dementia Awareness training across Primary Care to:

- GP Practices
- Pharmacy
- Dental Surgeries
- Optometrist

The first session was held on 6 June 2024 and 27 participants have signed up to join the webinar session.

Feedback will be gathered on the training to ensure that we continue to evolve and meet the needs of this new group of partners.

Training within a Care Home Setting

Aneurin Bevan Health Board is in the process of developing an experiential training day for staff working in the Hospitals, Prisons and Care Homes across the region. A task group is being created to create a 1–2-day training to allow staff to engage in an empathetic experience of the challenges people living with dementia face each day.

We would then deliver this training to all of Gwent, workforce and carers. The session would involve slides on the theory behind People with Dementia's experience of pain, hearing loss, loss of vision, etc.

The activity session would be delivered prior to the theory for full impact.

Evaluation of Training

We have developed an evaluation form to capture the participant's feedback so that we can develop and modify the training accordingly to the needs to the audience.

Dementia Friends

We have delivered the Alzheimer's **Dementia Friend's** session at all new staff induction programmes. Informed Level Dementia awareness sessions have been delivered through the Journey of Excellence for new nursing registrants. The International Nursing Programme and the Nursing Apprentice Programme.

Our **Volunteer Training** Programme includes dementia awareness as mandatory. All our volunteers are Dementia Friends. For our Dementia Companions and Dementia Champions, additional training is provided. Digital patient stories have been developed to support listening and learning.

A Mapping and Education and Carers Team **(MECS)** has been developed within the Older Adult Mental Health Division. This team will be scoping developing and delivering a series of learning opportunities throughout 2023. This training is based on the carer education programme.

3D's (Depression, Delirium and Dementia) is being delivered in general hospitals. These sessions need to be reflected and recorded on ESR for future reporting.

Workstream 5(b)

Monitoring

There is much discussion across Wales around what the **National Dataset** for monitoring should contain. A national monitoring proforma to evidence implementation of the Standards has not yet been established.

Locally, we are supporting our workstream leads to identify what **data** we already collect and where there are gaps. We have also connected with performance and measurement leads within quality assurance departments, Local authority, ABUHB and our Dementia Friendly communities, to collaborate on this work.

The Regional Dementia Board have been successful in securing funding for a **Programme Manager**. This post holder started April 2023. This post is pivotal in supporting all workstream leads/teams in driving forward their programme plans. The programme manager reports 6 monthly to the All-Wales Dementia pathways of care groups through Improvement Cymru as well as to the Gwent regional Dementia Board.

A 6 monthly learning and development **update report** is sent to Welsh Government, Public Health Wales for national bench marking and managed by the Workstream 5a workstream

The **National Audit For Dementia** is supported at Executive level and monitors the Improvements of Dementia Care in ABUHB Hospitals and is supported through Workstream 4- Dementia Friendly Hospital Charter.

ABUHB has an annual reporting process of Dementia which is supported from the **Regional Dementia Board** and the workstream 4 group.

Patient, carer and staff experience is monitored through the Patient Experience and Involvement Team and reported on annually.

What we want to achieve going forward

Although much has been achieved we do not underestimate how much more there is to do. Our priority actions for **2024-2025** will include the following, supported by a monitoring and outcomes framework.

People First

We will continue to take all opportunities to engage with people living with dementia, carers, staff and communities. We will focus engagement with those whose voices are seldom heard, linking in with experts in the field to ensure our engagement activities are inclusive and accessible. Making every contact count and Dementia care everyone's business. We will develop a dementia specific People Participation Panel.

Partnerships

We will continue to build our partnerships and agree a shared vision to improving the lived experience for people and develop the health, social care workforce and third sector agencies. Collectively, we shall develop a monitoring and outcomes framework.

Listening and Learning

Feedback from people living with dementia and their carers has been used to support learning. Feedback has been reflected in all of the workstreams, where possible inviting people with dementia and their carers onto the programme of improvement. We will continue to capture feedback to compliment learning provided within ABUHB and across organisations.

The activity session would be delivered prior to the theory for full impact.

What we want to achieve going forward

Intergenerational Practice

Demonstrating the benefits of intergenerational practice, we will rebuild engagement with schools, universities, colleges, ward and care homes to reinvigorate intergenerational practice across our communities and care settings.

Community Listeners

We want to engage with, train and support more members of the public to become Community Listeners. We shall evaluate the listening events at both Maindee and Caerleon with a view to developing the model for all boroughs.

Prison Services

The population of our local prison is an ageing one. HMP Usk and Prescoed has been identified as having a significant number of older prisoners and some of these prisoners have been identified as having, or are likely to develop, dementia and or are living with Dementia. We aim to support these areas with in-person visits, environmental assessment and learning and development improvement plans to improve care for people living with Dementia.

Hospital Hubs

We will work with clinical and operational leads to develop hospital hubs with provision for drop in for people to talk about dementia care. This will be aligned to PALS.

Dementia Community Hub

A Task and Finish group has been developed and a building identified for the pilot of the hub. The pilot is supported by many partners, including the Regional Partnership Board, Heads of Adult Service, Elected Members, Local Authority, ABUHB and Third Sector Leads. A pilot evaluation and impact assessment will help develop a wider Regional model to include hospital sites. the service.

Dementia and Sport

We wish to better understand the impacts of contact sports on a person's risk to developing dementia. The Dragon Rugby sport clubs attended the annual Dementia Conference in May 2023 and delivered a strong presentation on the connections of Dementia and Sport.

Cultural Competence Certification

The Patient Experience and Involvement Team have been working with Diverse Cymru to achieve cultural competence certification. Learning from the assessment and associated training will be used to inform how we approve dementia care in diverse communities.

3rd Sector SLA's

The Patient Experience and Involvement Team have been working with Diverse Cymru to achieve cultural competence certification. Learning from the assessment and associated training will be used to inform how we approve dementia care in diverse communities.

3rd Sector SLA's

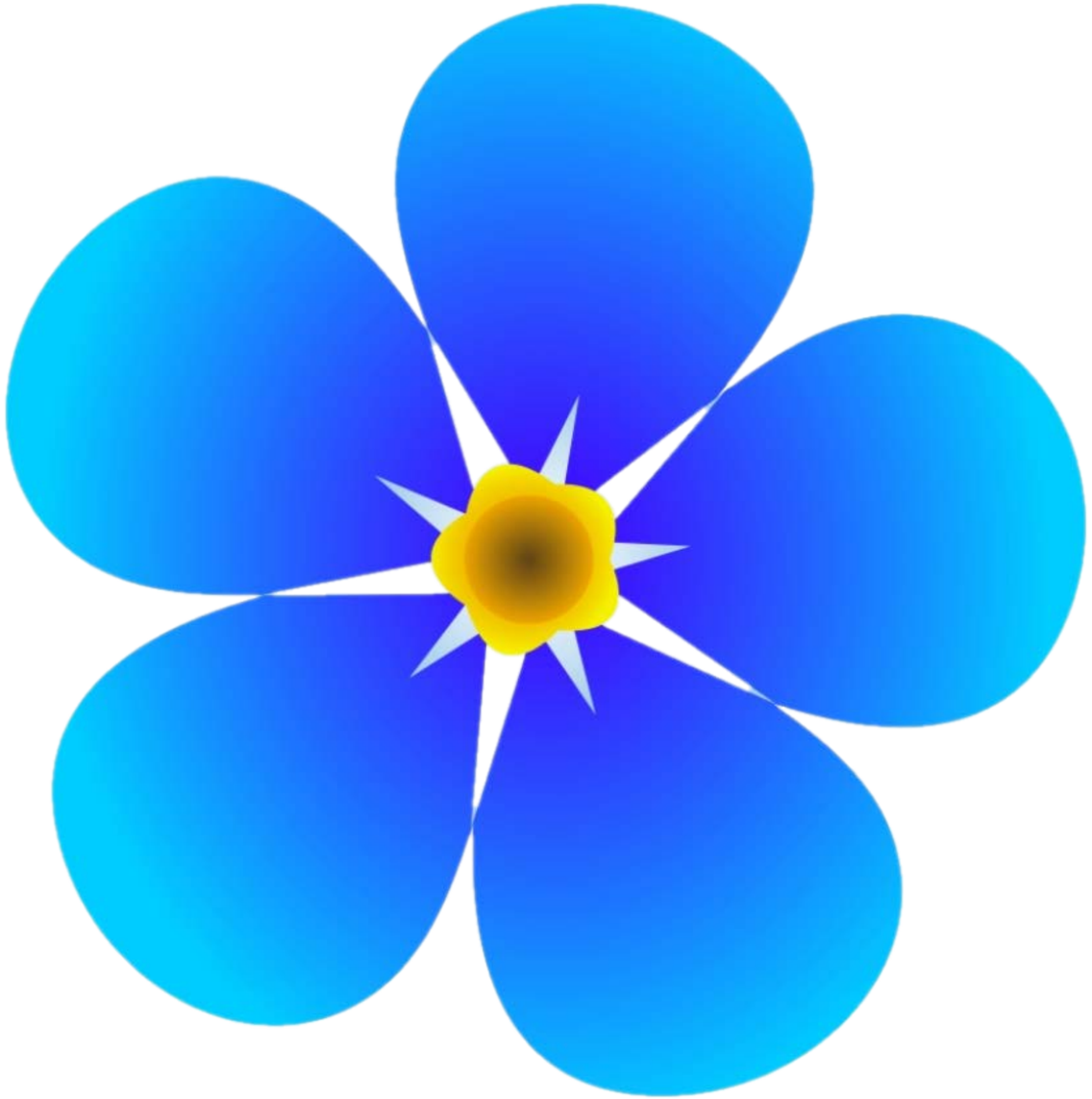
We will work with clinical and operational leads to develop initiatives aimed at minimising ward moves for people with dementia.

Conclusion

The Regional Dementia Partnership Board has established **Workstreams** that support implementation of the of the DAP and the Dementia Standards of Care. This 2023- 2024 Annual Report outlines the developments and actions the Gwent Regional Dementia Board has undertaken during this time as well as the aims and objectives set for the coming years. The programmes of improvements are **person centred** and delivered through a co-production, collaborative model. People's feedback is important in order that we ensure that **what matters** to people is used to help **influence**, **inform and shape** dementia care across the region. Actions taken as a partnership thus far will support the implementation of the Standards during the coming year.

As a Regional Dementia Board, we are committed to focusing on **listening** to our **communities** with an emphasis on diversity and inclusion, using people's feedback to improve the lived experience. This will be embedded throughout our Workstream Programs.

The **Regional Dementia Board** will review progress to date and will set its priorities for 2024-2025 aligning with the identified improvements in care and funding/ commissioning of resources.



Agenda item: 2.8

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	02 September 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality Performance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety Tracey Partridge-Wilson, Deputy Director of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health and Care Quality Standards provide a clear framework to help the planning, delivery and monitoring of healthcare services in Aneurin Bevan University Health Board. The Quality Report is mapped to the six domains of quality and the six quality enablers and structured under the Health Board's Six Pillars of Quality.

The outcomes and indicators reported here are a set of quality indicators that align with the Health Board's priorities and strategic goals. The indicators cover aspects of care, clinical outcomes, patient safety and patient experience.

This is a combined report that includes the measures within quality outcomes framework (QOF) and a narrative on the data. This provides the Board/ Committee with an overview of the Health Board's quality and safety metrics and summary of performance. It is aligned to the Ministerial priorities and key challenges, to comply with the Duty of Quality.

Cefndir / Background

The Quality Report provides current data on quality and patient safety as mapped against the Pillars of quality:

- Patient and staff experience and stories
- Incident reporting – falls, pressure ulcers, medicines management and mortality
- Complaints, concerns and compliments
- Health, safety and security
- Infection Control and Prevention
- Safeguarding

These 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains.

Asesiad / Assessment

Areas of Improvement in Quarter 1

- RAMI - the Health Board has seen improvement in the Risk Adjusted Mortality Indicator with a focus on Learning from Deaths reporting based on the English model.
- The PALS service continues to develop and to focus on early intervention and support for patients and their families when they have concerns, the service will develop to further support the PTR process
- Civica satisfaction rate remains over the 85% benchmark albeit a text solution to increase uptake is being explored.
- There have been no new Never Events since November. The theatres safety programme has been shared with the Committee to demonstrate the success of the improvement methodology and human factors approach.
- Improved uptake of Level 1 and Level 2 Safeguarding training continues and increased safeguarding referrals are demonstrating greater awareness of safeguarding thresholds
- Improved Health and Safety assurance through the Health and Safety Committee
- The operational approach to Quality Assurance is developing with standardised agendas and standardised data sets built upon the Quality Pillars and the STEEEP principles promoting Ward to Board assurance
- Ward Accreditation is currently being rolled out across several Divisions; the first ward to be formally accredited will be approved in August
- A further workshop on the Quality Outcomes Framework has been held with plans for a revised QOF for the September Board.
- The safer care collaborative is moving in-house and there will a quality faculty developed within the Health Board. This includes developing a quality improvement strategy.

Areas to Highlight in Quarter 1

There are several issues, risks and concerns which are discussed in the report and reflect areas requiring improvement in terms of quality outcomes. For Board consideration the areas are summarised below.

- Infection rates continue to rise. An improvement plan is in development and an enhanced monitoring process will be put into place. The report includes the work on antimicrobial prescribing
- Significant improvement has been made but there is continued focus on the quality and safety of care within Mental health and Learning Disability Services
- Quality outcomes and timeliness of care within urgent care. This work continues and relates to several metrics including Ambulance Handover times, 12 and 24 hour waits in ED and improving patient experience.
- Falls remain an area of focus and scrutiny; themes relate to risk assessment and the enhanced care framework. Improvement plans are in place and a SWARM methodology approach in conjunction with a new enhanced care framework is being tested
- Safeguarding Level 3 training remains an area for improvement with a revised training approach planned and to be compliant with the intercollegiate guidance Level 3 training is required for clinical staff.
- Themes from incidents continue to include the deteriorating patient, which has been part of the safer care collaborative, and the impact of extended waits. The recent work on Call 4 Concern has been shared in the report
- The compliance with closure of Putting Things Right concerns within 30 days remains of concern. There has been steady improvement in aged complaints over 12 months. The Health Board has developed a plan to return to the required level of compliance which will be 75% of PTR concerns closed within 30 days.

For the Health and Care Quality Standards that are limited in reporting e.g. Equitable, these will be reviewed to establish what else is being reported that can be inserted into the QOF and what additional measures should be included (i.e. more data is required in relation to safeguarding & domestic violence and children and young people's outcomes)

As part of this work, we will continue to strengthen our governance structures through Board-to-Floor connections that promote cross directorate and multi-professional working. We have initiated work to ensure that the implementation, measurement and monitoring of our strategy is hardwired through our governance and integrated performance reporting.

Listening and Learning

The Health Board recognises that organisational learning plays a vital role in the continuous improvement and development of organisational assurance and therefore improvement plans are in place to focus on:

- Implementation of the Health Board's Listening and Learning Framework which demonstrates our commitment to promote a culture that values, facilitates, and embeds learning and in which the lessons learned are used to improve the quality of patient care, safety and experience.
- This framework demonstrates how learning will be identified, triangulated, disseminated, and implemented into practice, to facilitate and embed a culture of appreciative enquiry and continuous improvement in health care services.
- We continue to strive for a 'Just Culture' of shared learning and a triangulated approach to quality, patient safety and experience.
- A bi-monthly learning and improvement forum has been developed and a highlight report is now available, as well as the minutes and actions from the forum.
- The learning repository is being tested in July 2024, which will allow us to collate, store and utilise this learning, enabling us to share knowledge, shape change, embrace innovation, implement quality improvement and create opportunities to develop excellence in practice.

Key priorities for the next six months include automation and revision to the Quality Outcomes Framework, development of Integrated reporting with Finance, Workforce and Planning, strengthening of Quality Patient Safety structures within Divisions, refreshing the Quality Improvement Plan and strengthening assurance and reporting.

Argymhelliad / Recommendation

The Committee is requested to note the progress of the quality performance report and to take assurance from this report

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

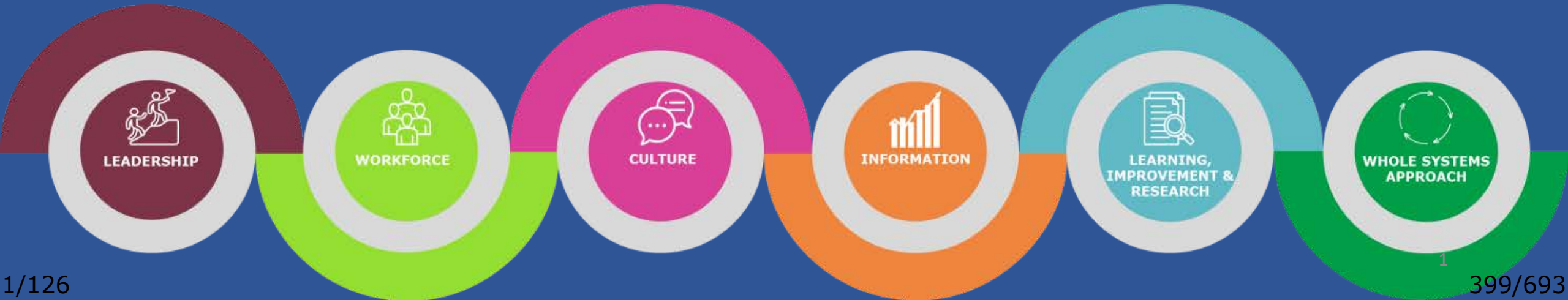
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

Quality Outcomes Framework

Quarter One: 2024/25



Overview

This is a combined report that includes the measures within quality outcomes framework (QOF) and a narrative on the data. This provides the Board/ Committee with an overview of the Health Board's quality and safety metrics and summary of performance. It is aligned to the Ministerial priorities and key challenges, to comply with the Duty of Quality.

This also covers the Health Board's quality priorities including the Quality and Safety Pillars, as included in the Quality Strategy, ensuring that the Patient Experience and Involvement Strategy has been embedded throughout the report.

This reports focuses on learning and improvement throughout quarter one. It also includes:

- Indicators mapped to the existing Quality Outcomes Framework that was developed for 2023/24
- Narrative on indicators
- Additional information is available in the report to provide assurance against these standards
- Areas of escalation
- Good practice
- Learning and Improvement Forum highlights

Background

The current indicators within the Quality Outcomes Framework are being refined for 2024/25. The indicators will be reduced to enable reporting for 4-5 indicators per domain of quality. The QOF has been aligned to the Health and Care Quality Standards:

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

For this year, these will also be mapped to the 'Pillars of quality'.

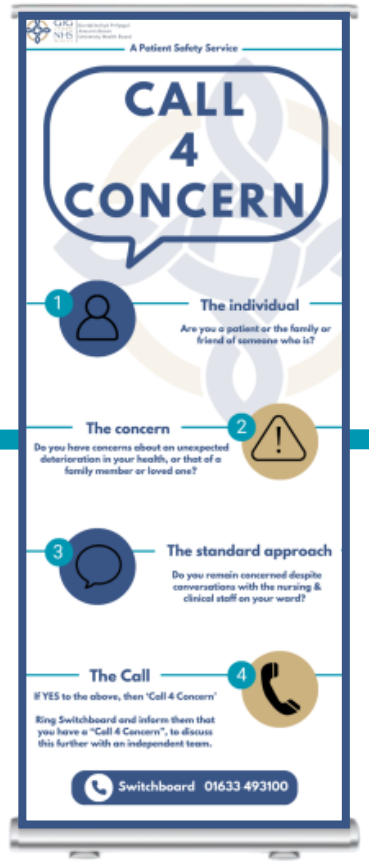
As part of the newly refined QOF, reporting of the indicators will involve working with Digital, Data and Technology Directorate. This will allow automation of reporting and enable reports to be standardised. The use of iconography will provide detail on trends.

For quarter one the existing QOF indicators have been mapped where possible. Some of these indicators that were previously reported quarterly by planning has now changed. Updated data for these indicators has not been possible for quarter one. This will be taken into account in the development of the updated QOF.

Sharing Good Practice

A Patient Safety Service

Now live on wards B0, C4 & Critical Care discharges within GUH.



Martha Mills

Martha Mills was a 13 year old girl who died in 2021 after developing sepsis in hospital. She was admitted following a pancreatic injury after falling off her bike.

During Martha's admission, her family repeatedly raised concerns about her deteriorating condition, however were wrongly reassured that this was all normal for this type of injury and there was no need to be concerned.

In 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier.

Martha's Rule

The 3 proposed components of Martha's Rule are:

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.
2. All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition.
3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

Call 4 Concern

Timeline

March

CCOT launch C4C service for patients discharged from ICU to GUH wards.
Service running 0700 - 1900hrs

April

Collaboration between CCOT and CSST allows 24 hour cover.

NHS England introduces 1st phase of Martha's Rule.

August

'Scale and Spread' of service to wards B0 & C4.

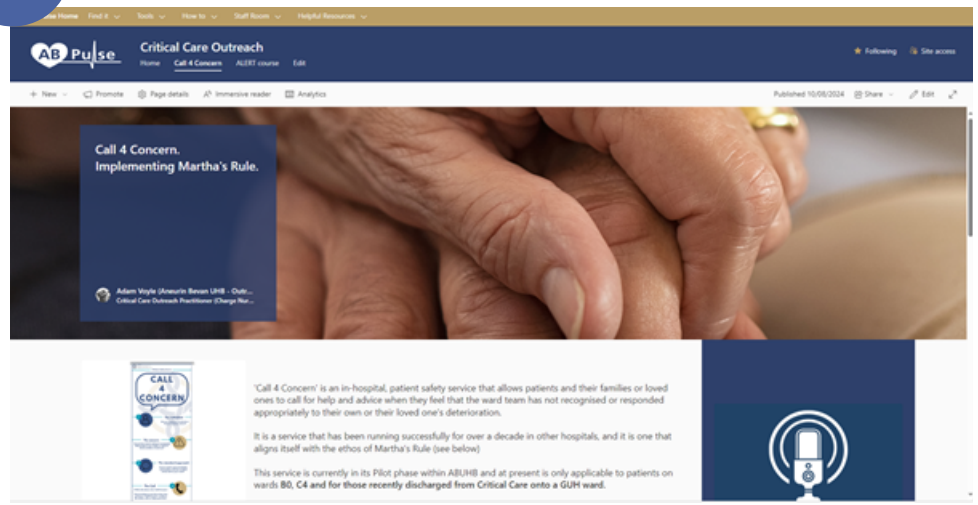
October

'Scale and Spread' of service to further wards
? C0 & A1 (SAU)

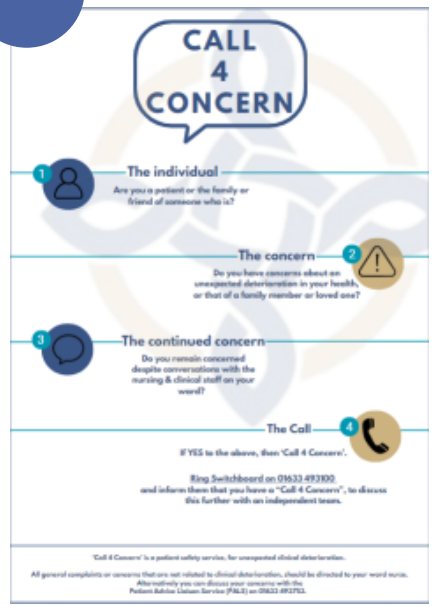
Associated documentation

Patient Advice Leaflet

Intranet Page

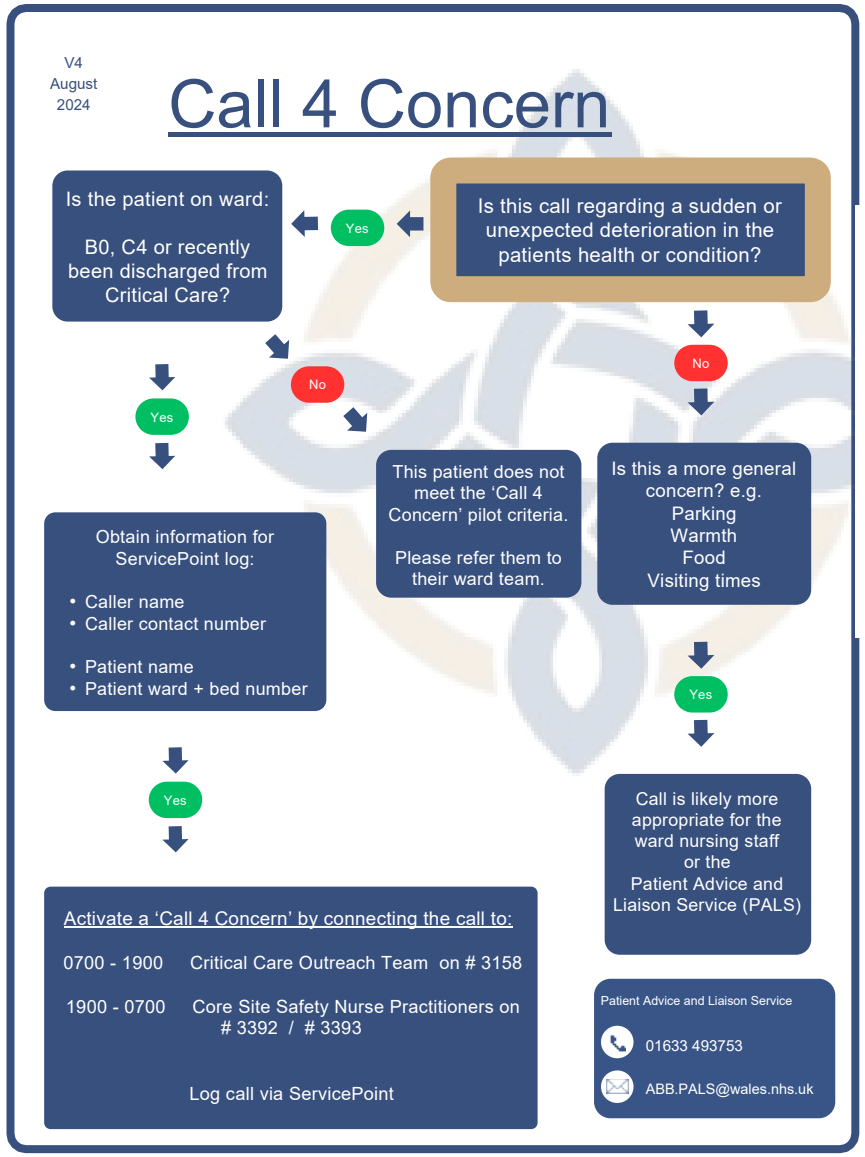


Poster



Banner

Switchboard Flowchart



Ward B0


Welcome to Ward B/0
Ward


Ystafell Dawel
Quiet Room


MENTAL HEALTH
&
LEARNING DISABILITY
A Patient Safety Service
CALL
4
CONCERN
1
The individual
Are you a patient or the family or friend of someone who is?
The concern
2
Do you have concerns about an unexpected deterioration in your health, or that of a family member or loved one?
3
The continued concern
Do you remain concerned despite conversations with the nursing & clinical staff on your ward?
The Call
POST BOX

Ward C4


A Patient Safety Service
CALL 4 CONCERN
The individual
Are you a patient or the family or friend of someone who is?
The concern
Do you have concerns about an unexpected deterioration in your health, or that of a family member or loved one?
The continued concern
Do you remain concerned despite conversations with the nursing & clinical staff on your ward?
The Call
If YES to the above, then 'Call 4 Concern'
Ring Switchboard and inform them that you have a "Call 4 Concern", to discuss this further with an independent team.
Switchboard 01633 493100
Ystafelloedd C4.67 - C4.97
Gofal Anadlol Uchel

Areas of Increased Oversight

Infection Prevention & Control

C difficile

A total of 98 cases of C diff reported from Apr 2024 - Jul 2024. HB rate of 49.07 per 100,000 population. This is 36 more (56% higher) than the equivalent period 23/24.

Staph aureus

A total of 48 cases of Staph aureus bacteraemia reported from Apr 24 - Jun 24. HB rate of 32.55 per 100,000 population. This is 26 more (118% higher) than the equivalent period 23/24.

Gram Negative

A total of 87 cases of E coli reported from Apr 2024 - Jun 2024. HB rate of 59.01 per 100,000 population. This is 5 less (6% lower) than the equivalent period 23/24.

Klebsiella

A total of 32 cases of Klebsiella reported from Apr 2024 to Jun 2024. HB rate of 21.07 per 100,000 population. This is 1 more (3% higher) than the equivalent period 23/24.

Pseudomonas

A total of 11 cases of Pseudomonas reported from Apr 2024 to Jun 2024. HB rate of 7.46. This is 5 more (83% higher) than the equivalent period 23/24.

A strategic improvement group is being developed, chaired by Executive Director of Nursing and Executive Medical Director, for enhanced monitoring of the organisational action plan and organisational themes for learning, recognising the contributing factors are multifactual and multi-disciplinary.

- Complex patients with high-risk antibiotics
- Documentation for antibiotics
- Compliance with fundamental infection prevention measures, i.e. hand hygiene, PPE
- Microbiology tests i.e. MSU, blood culture to support diagnostically and guide antibiotic choice
- Cleaning beds for long stay patients
- Increase education for Facilities staff
- Boarding
- Enable to complete proactive cleans due to capacity
- Medical device management

Mental Health & Learning Disabilities Escalation

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

Urgent Care Escalation

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

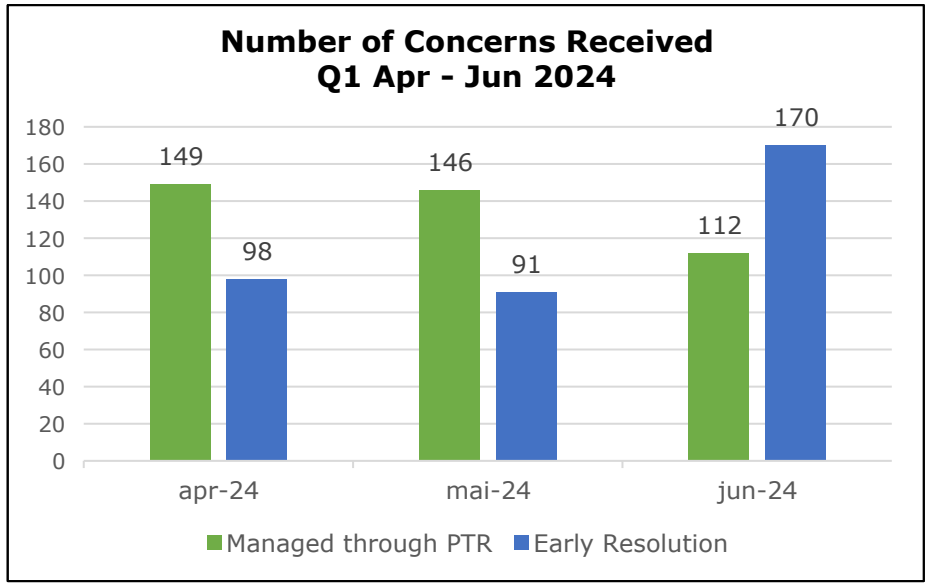
Areas to highlight

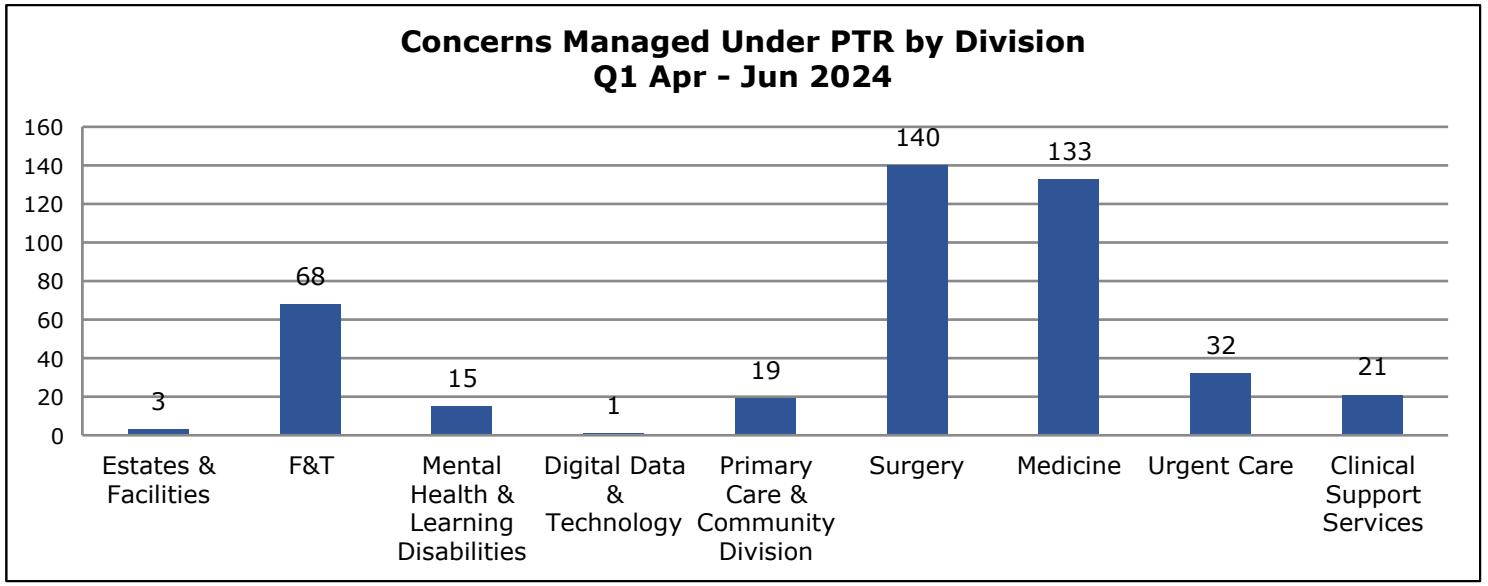
Areas to Highlight – Quarter 1

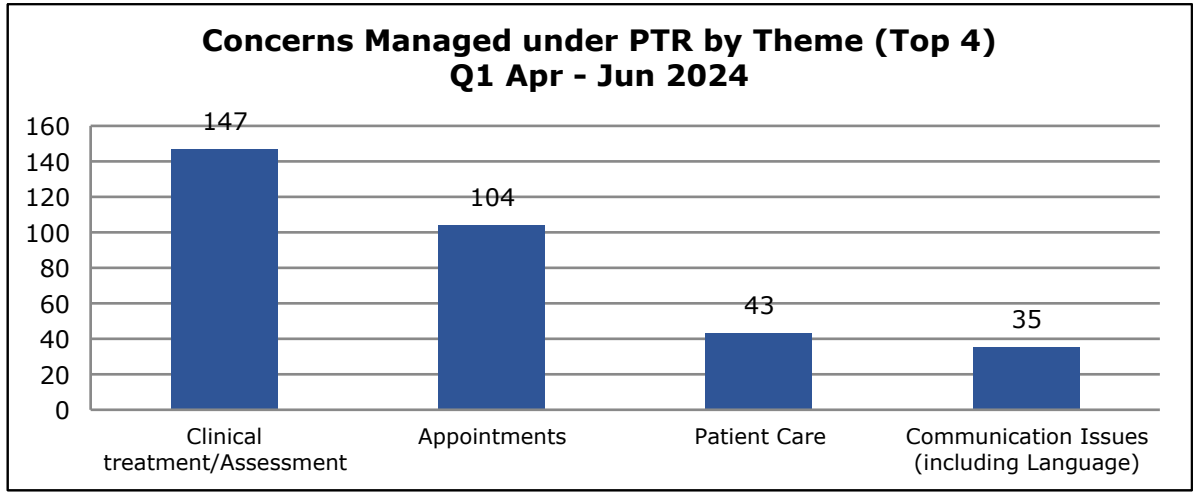
There are several issues, risks and concerns which are discussed in the report and reflect areas requiring improvement in terms of quality outcomes. For Board consideration the areas are summarised below.

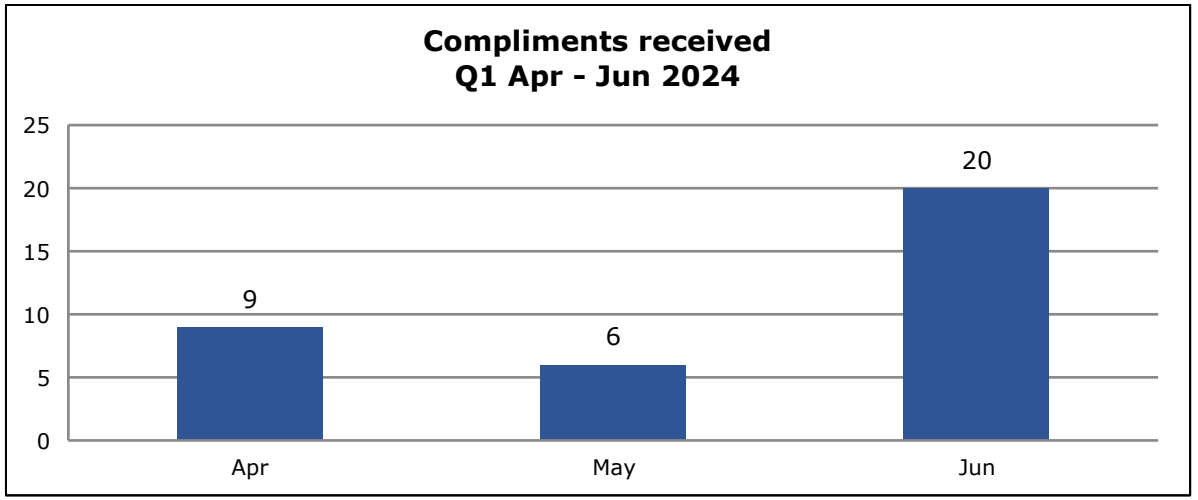
- Infection rates continue to rise. An improvement plan is in development and an enhanced monitoring process will be put into place. The report includes the work on antimicrobial prescribing
- Continued focus on the quality and safety of care within Mental health and Learning Disability Services
- Quality outcomes and timeliness of care within urgent care. This work continues and relates to several metrics including Ambulance Handover times, 12 and 24 hour waits in ED and improving patient experience.
- Falls remain an area of focus and scrutiny; themes relate to risk assessment and the enhanced care framework. Improvement plans are in place and a SWARM methodology approach in conjunction with a new enhanced care framework is being tested
- Safeguarding Level 3 training remains an area for improvement with a revised training approach planned and to be compliant with the intercollegiate guidance Level 3 training is required for clinical staff.
- Themes from incidents continue to include the deteriorating patient, which has been part of the safer care collaborative, and the impact of extended waits. The recent work on Call 4 Concern has been shared in the report
- The compliance with closure of Putting Things Right concerns within 30 days remains of concern. There has been steady improvement in aged complaints over 12 months. The Health Board has developed a plan to return to the required level of compliance which will be 75% of PTR concerns closed within 30 days.

Complaints and Compliments

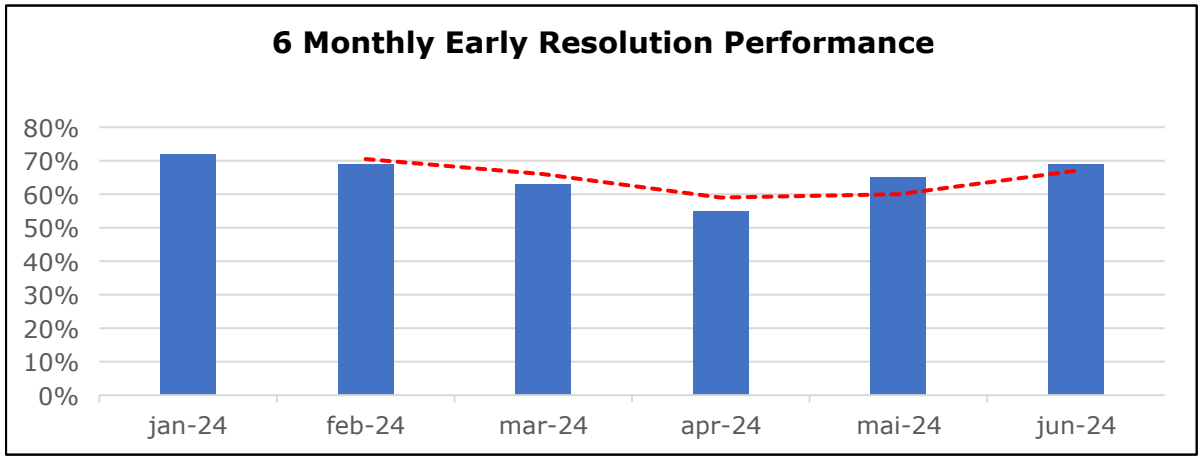


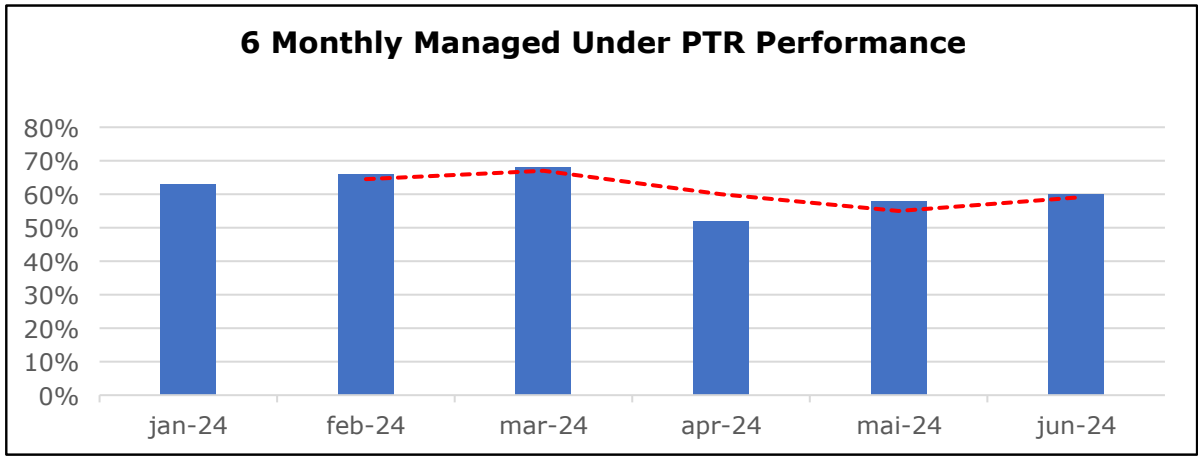






Complaints Performance

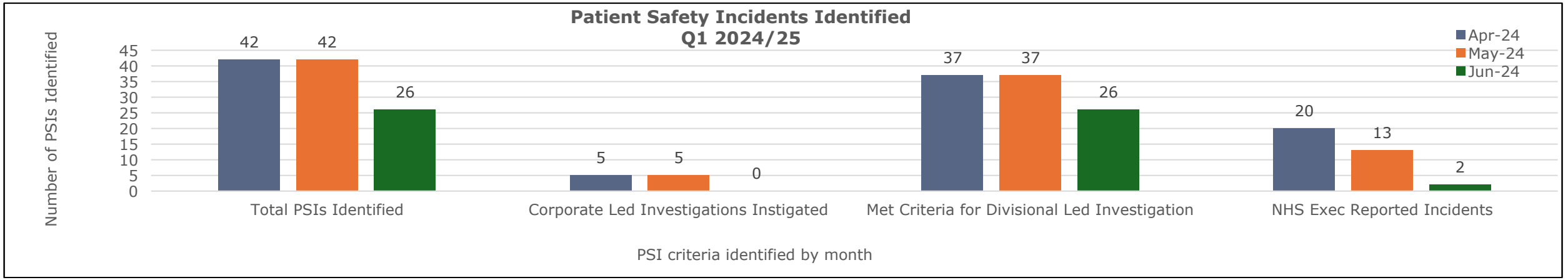


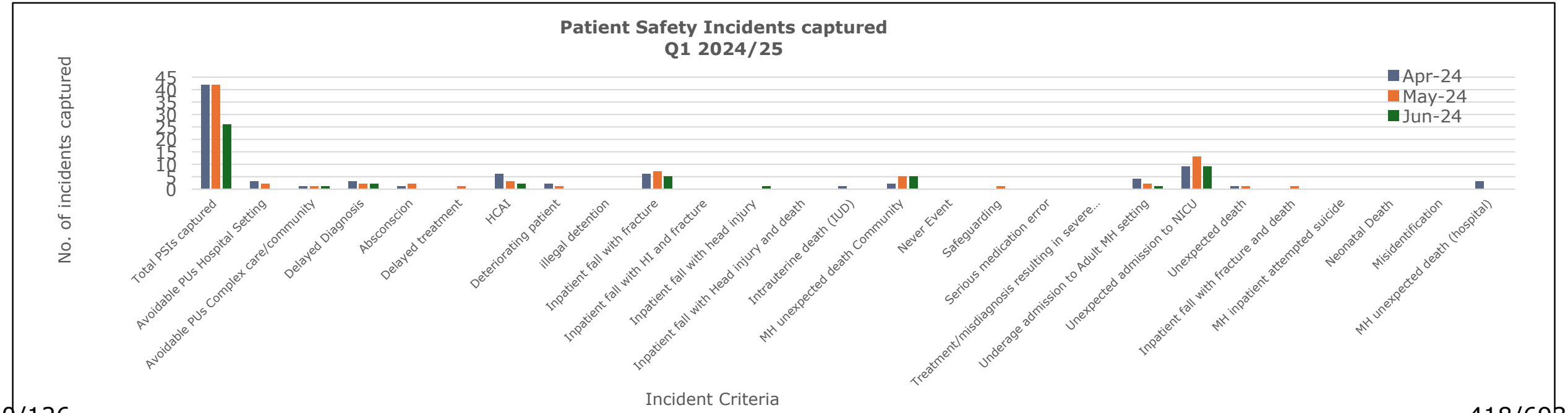


Trajectory for Improvement by Division/ Directorate	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
01 Family & Therapy Services	60%	63%	65%	68%	72%	75%
02 Scheduled Surgical & Critical Care	60%	63%	65%	68%	72%	75%
03 Primary Care & Community	45%	50%	54%	62%	69%	75%
04 Mental Health & Learning Disabilities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

Patient Safety Incidents

A total of **110** Patient Safety Incidents (PSIs) (moderate and above harm) met the criteria for either Corporate or Divisional led Investigation were identified during Quarter 1 2024/25. This is in comparison to **109** in Q1 of 2024/25.

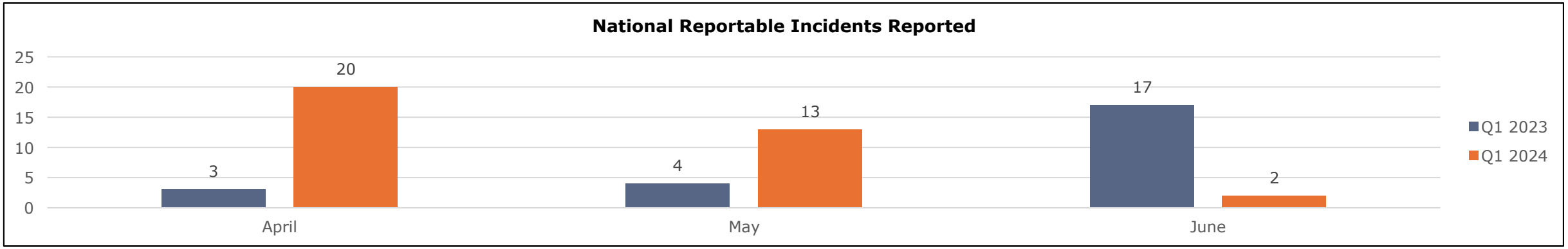




Patient Safety Incidents

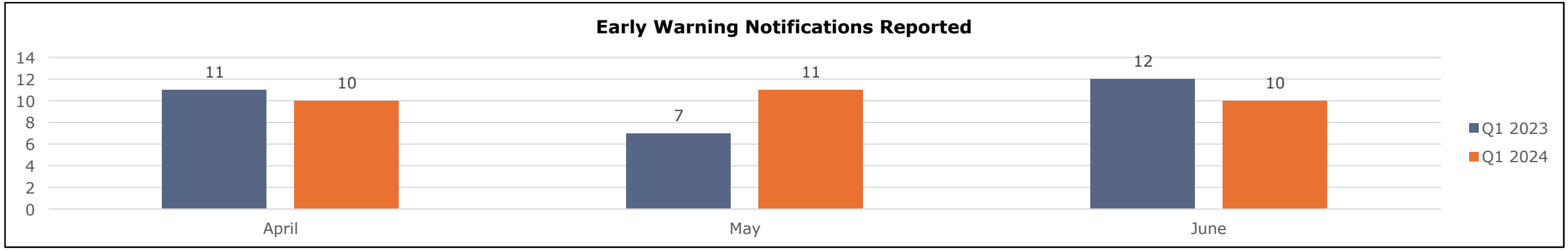
Not all PSIs under investigation were reported as National Reportable Incidents (NRIs). This could be because some NRIs are submitted to the NHS Executive prior to the decision making regarding the proportionality of the investigation (Divisional or Corporate Led). Also, NRI reporting can occur retrospectively after the investigation has been commenced and once further intelligence is received.

In May 2023, the Health Board met with NHS Executive colleagues, to discuss the reporting criteria. As a result, the number of reported NRI's saw a significant increase in June 2023. We have since seen stabilisation of reporting, and continue to monitor.



There were **31** Early Warning Notifications (EWNs) reported to Welsh Government (WG) during Q1 2024/25. Themes included Safeguarding concerns, patient absconsion, misidentification of patients and PRUDICs.

This is in comparison to **30** in Q1 of 2023/24.



Infection Prevention & Control

All Wales comparison – WG Goals

Table 1. Current FY rate per 100,000 population of specimens by HB, Apr - Jun 24

Additional filters for Table 1.
Select month or FY: Current FY
Select organism group: All organisms

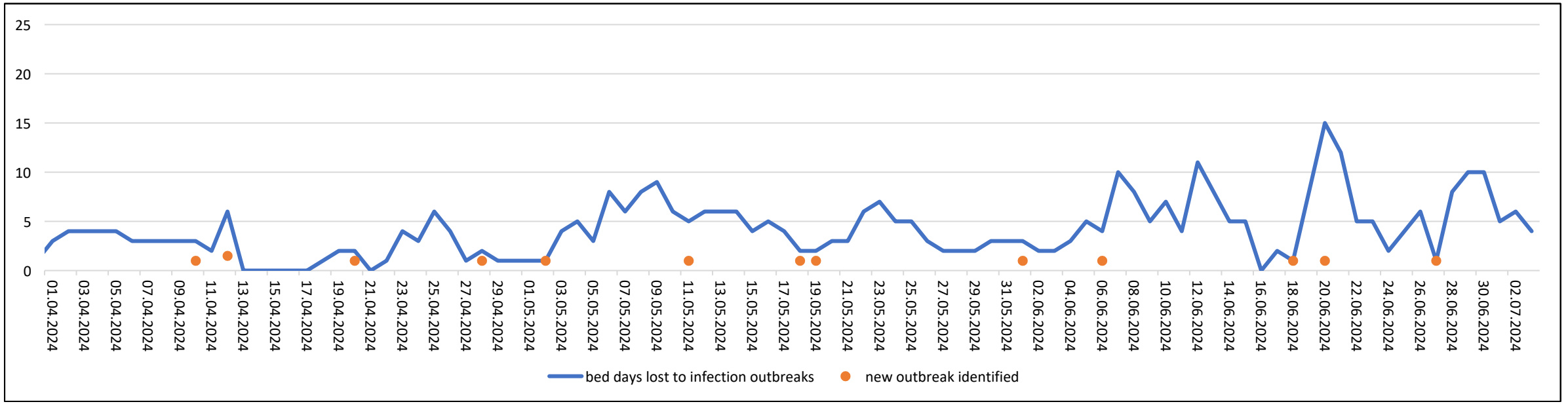
< than same period last FY
= same period last FY
> than same period last FY

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	49.51	1.36	31.2	59.01	21.7	7.46
Betsi Cadwaladr UHB	47.21	1.75	23.31	83.93	12.82	1.17
Cardiff and Vale UHB	45.22	0.79	36.49	53.15	24.59	6.35
Cwm Taf Morgannwg UHB	37.94	0.9	34.33	77.68	24.39	3.61
Hywel Dda UHB	56.24	3.12	29.16	90.62	20.83	9.37
Powys THB	23.97	0	3	0	0	0
Swansea Bay UHB	63.81	1.05	26.15	54.39	35.57	1.05
Velindre NHST						
Wales	48.16	1.41	28.82	67.11	21.77	4.48

Issue	Cause	Remedial Action	Who	When
3 wards closed due to outbreak of Covid infection D5W, 4/4 & Monnow Vale	• Visitor Covid positive • Symptomatic staff – no longer testing	• Cohorted affected patients • Covid safety measures assurance completed by ward managers – good compliance	Infection Prevention Ward Managers	June 2024
Increase in C difficile infection June Total = 24 HAI = 8 CAI = 9 Relapse = 7	• Antimicrobial stewardship • Compliance with fundamental IP measures	• Enhanced cleaning strategy approved & HPV programme commenced		Ongoing
Increase in Staph Aureus Blood stream infections. June Total = 22 HAI = 8 CAI = 14	• 6 skin & soft tissue • 5 bone & joint • 5 respiratory • 2 line associated • 2 urinary • 1 Gastro • 1 unknown	• Promoting ANTT • Reviewing standardisation devices available via Procurement • QI project for admission screening • TVN Wound assessment and management training now available for staff to book via ESR • Viewing skin preparation products	Ward Managers Senior Nurses Tissue Viability	Ongoing
Increase with Gram Negative blood stream infections – fewer cases in June. June Totals E coli = 23 (3 HAI – 20 CAI) Klebsiella – 7 (2 HAI – 5 CAI) Pseudomonas = 3 (3 HAI)	• 18 urinary tract • 9 Hepatobiliary • 2 respiratory • 2 gastro • 1 unknown • 1 skin & soft tissue	• Revisiting the 9 key standards for UTI prevention • Study session arranged for 13th August • Promoting Start Smart then Focus Antibioitic audits • Rapid roll out of the HOUDINI "make the catheter disappear initiative • Review adult antimicrobial guide in line with resistance patterns	Infection Prevention Bladder & Bowel Service Antimicrobial Pharmacists	Ongoing

Infection Prevention & Control

Bed Days Lost



April = 70
May = 135
June = 171

- 6 wards affected by C difficile
- 8 wards closed with Covid outbreaks

Refreshed the Patient Placement SOP & use of the Respiratory Assessment Zone

Antimicrobial Stewardship (AMS)

Ceri Phillips
Consultant Antimicrobial Pharmacist

Antimicrobial Stewardship (AMS)

Learning from 23/24 *C. diff* root cause analyses: 53/229 (23%) patients received suboptimal antibiotics:

- Theme identified around suboptimal use of piperacillin/tazobactam & co-amoxiclav in secondary care
- Two audits undertaken in areas where prescribing had been identified as being suboptimal
- Fewer patients with suboptimal antimicrobials in 24/25 *C. diff* RCAs to date
  - Q1: 14/66 (21%) patients (11 HCAI, 1 CAI), majority of suboptimal prescribing related to piperacillin/tazobactam use in secondary care
  - July 2024: 3/26 (12%) patients (1 HCAI, 2 CAI), of which one was prescribed antibiotics in Spain

36 patients on piperacillin/tazobactam or co-amoxiclav audited in GUH & RGH in Q1

- Around a third of prescribing found to be outside of guidelines/culture results/microbiology advice
- 70% of use on SAU and 40% on MAU 'inappropriate', across a range of conditions. No issues identified on defined medical wards.
- Actions during Q2
  - Feedback to acute medicine & general surgery directorates
  - 5 bespoke education sessions planned to different staff groups.
  - Resistance & guidelines already highlighted in doctors induction
  - Guideline review of two key areas that drive prescribing (respiratory & urosepsis)

40 patients with hospital acquired pneumonia (HAP) or aspiration pneumonia diagnosis audited in YYF Feb – Apr 2024

- 30% prescribing found to be outside of guidelines/culture results/microbiology advice
- Only 35% of patients with a documented HAP diagnosis had a chest x-ray done (further analysis of accuracy of diagnoses underway by registrar)
- 11 patients scored for sepsis, but were not recognised as such
- Actions
  - Audit results to be fed back at YYF teaching session and shared with respiratory directorate once analysis complete
  - Respiratory guideline review as above
  - Sepsis policy being rewritten by Deteriorating Patient Group, to be launched with accompanying education

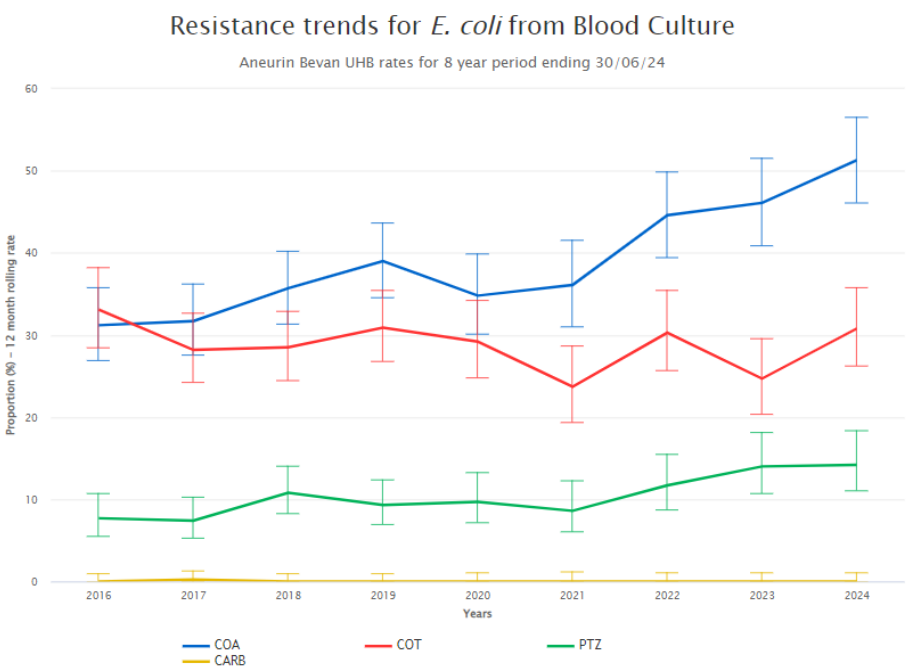
Context: antimicrobial use in ABUHB in 23/24

- Primary care: approx. 75% total use
  - 423,000 antimicrobial prescriptions issued
  - Cost £2.5m
- Secondary care: approx. 25% total use (but complex)
  - Approx. 1 in 3 inpatients on antimicrobials at any time
  - Stock issued equates to 740,000 'days' of antimicrobial therapy
  - Cost £3.6m
- 24/25 Welsh Government targets awaited. Anticipated to change following publication of new 4 nations 5-year National Action Plan for antimicrobial resistance (AMR)

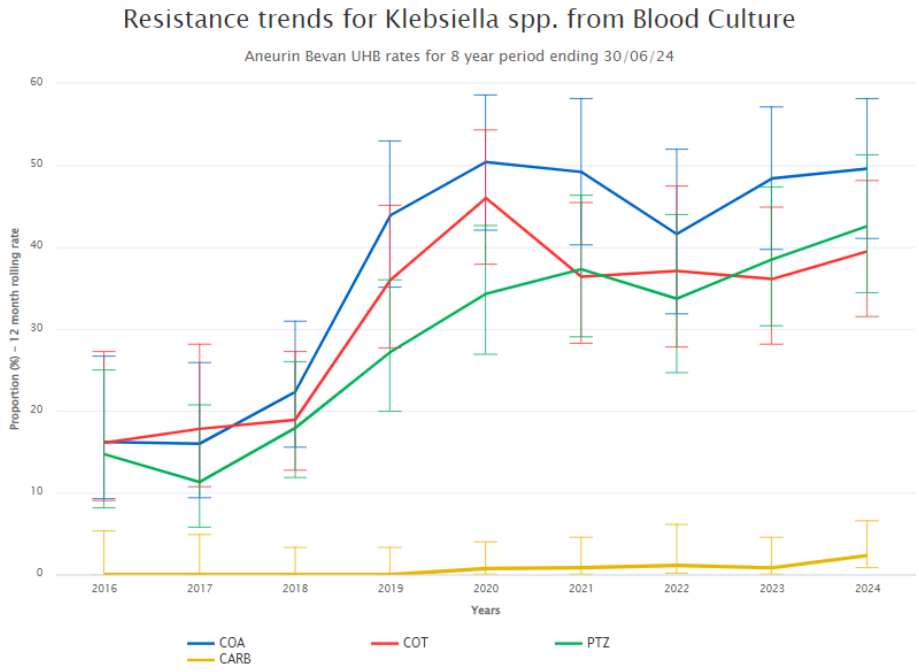
- 4.3 WTE antimicrobial team at full complement from June 2024:
  - 1.0 consultant (HB wide)
  - 1.1 primary care
  - 1.8 secondary care
  - 0.4 admin

Antimicrobial resistance (AMR) in ABUHB

- Antimicrobial use is a key driver of resistance
- The graphs demonstrate increasing resistance to both co-amoxiclav (blue) and piperacillin/ tazobatam (green) in both *E. coli* and *Klebsiella* grown in ABUHB bloodstream infections
- However the increased resistance seen in Klebsiella is *not* thought to be due to local usage patterns, as there is also resistance to other antibiotics that we tend to avoid locally
- Resistance to carbapenems, some of our last line antibiotics, remains low (especially compared to some areas in England)



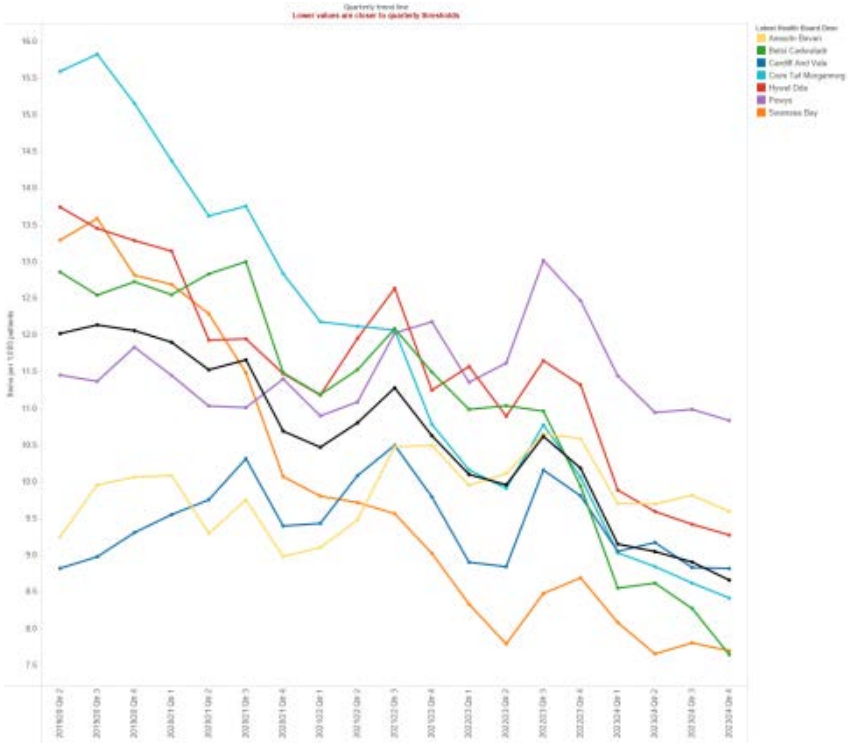
	2016	2017	2018	2019	2020	2021	2022	2023	2024
COA	31.2	31.7	35.7	39.0	34.8	36.1	44.6	46.1	51.3
COT	33.1	28.2	28.5	30.9	29.2	23.7	30.3	24.7	30.8
PTZ	7.7	7.4	10.8	9.3	9.7	8.6	11.7	14.0	14.2
CARB	0.00	0.23	0.00	0.00	0.00	0.00	0.00	0.00	0.00

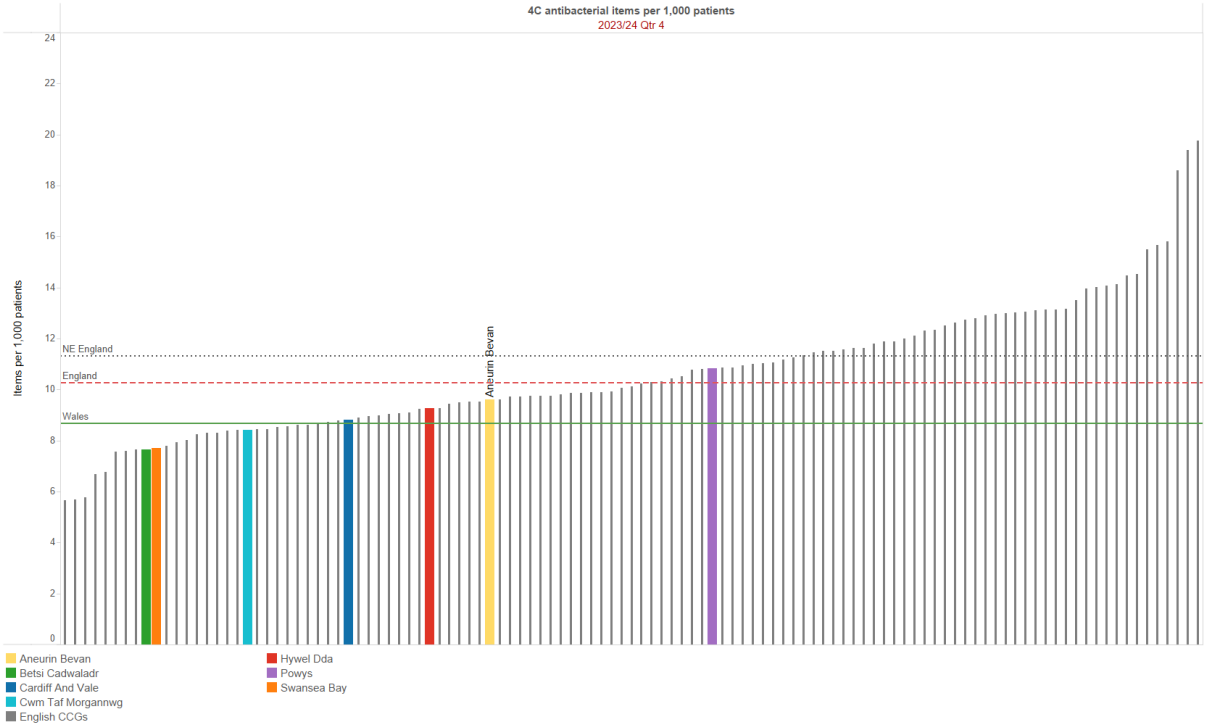


	2016	2017	2018	2019	2020	2021	2022	2023	2024
COA	16.2	16.0	22.3	43.9	50.4	49.2	41.6	48.4	49.6
COT	16.1	17.8	18.9	36.0	46.0	36.4	37.1	36.1	39.5
PTZ	14.7	11.3	17.9	27.2	34.3	37.3	33.7	38.5	42.6
CARB	0.00	0.00	0.00	0.00	0.73	0.85	1.12	0.82	2.33

4C use in primary care

- '4C' antibiotics are high risk of resistance issues as well as *C. difficile* infection
- ABUHB previously lower users of 4C antibiotics, however sustained focus in other HBs has demonstrated use can be lowered further, meaning AB is now an outlier, however remains below the English average
- However some of the lowest 4C users (Swansea, Betsi, Hywel Dda) have the highest *C. diff* rates





Role of the AMS team: primary care

- Business as usual
  - Influence Clinical Effectiveness Prescribing Programme (CEPP) (incentive scheme) to include antimicrobial stewardship
    - 24/25 FY includes 25% weighting for antimicrobial elements, including a focus on '4C' antibiotics
  - Audit & feedback cycles of high volume & high '4C' prescribing practices
    - Cycles completed in 5 practices in 23/24
- Current initiatives
  - Accelerate audit & feedback cycles
  - Learn lessons from a low prescribing practice
  - Collaborate with lymphoedema & podiatry teams on service improvement
  - Out of hours prescribing project to investigate if there is a link between prescribing rate of practice with attendance at OOH
  - Provide support to intermediate care
    - Weekly antimicrobial MDT with CRT since July 2024 to review all patients on antimicrobials
    - Guideline development to facilitate discharge of patients requiring ongoing intravenous antibiotics
    - Introduction of 24 hour infusions to expand the range of intravenous antibiotics available at home

Role of the AMS team: secondary care

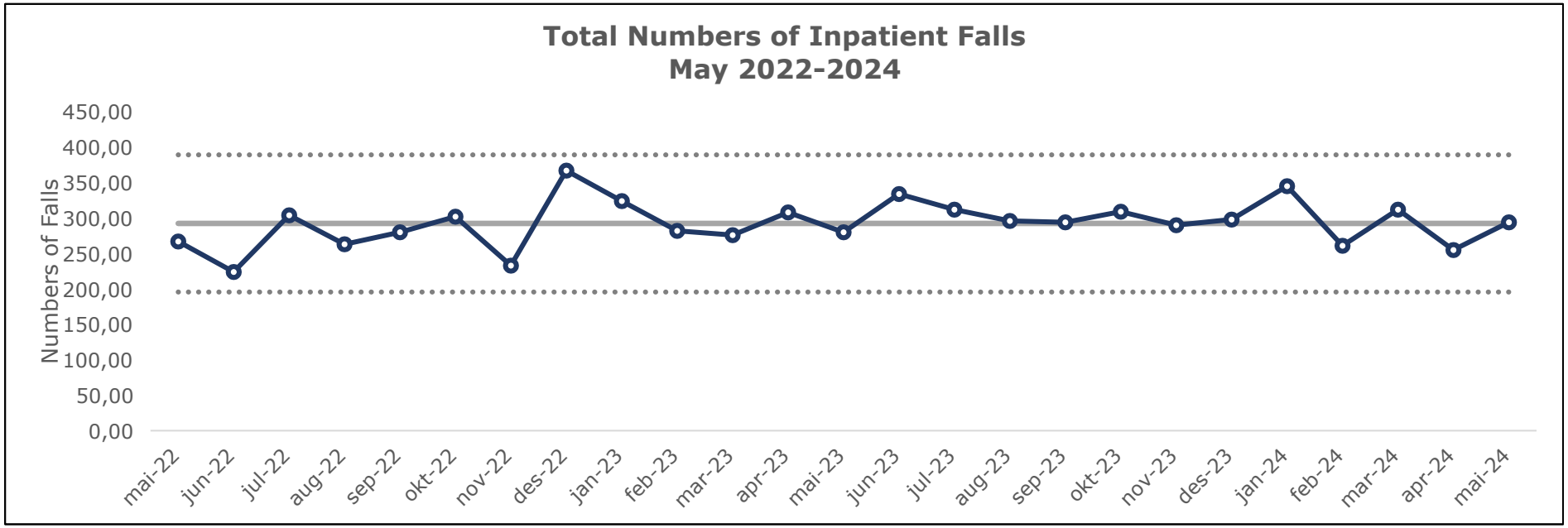
- Business as usual
  - Antibiotic Review Kit (ARK) principles implemented at main sites. Includes automatic stop after 72 hours to force review of the need for antibiotics
  - Weekly ward rounds at 4 main sites to review complex cases, with the exception of medical rounds at GUH due to microbiology staffing levels. >1200 patients reviewed in 23/24
  - Annual point prevalence survey to determine prescribing rates
  - Medicines safety initiatives, e.g. promoting use of oral over intravenous
- Current initiatives
  - Moving antimicrobial prescribing quality audits onto AMAT software to improve uptake by doctors & enable data to be included in dashboards
  - Development of PowerBI antimicrobial usage dashboard to provide directorate, divisional & ward level data (PHW only provides to hospital level)
  - ARK roll out to community hospitals
  - Penicillin 'allergy' de-labelling implementation (documented penicillin allergy associated with 69% ↑ risk in MRSA, 26% ↑ risk of C. difficile infection & 0.6% ↑ risk of death within the following year, compared with patients not reporting an allergy)
  - Enhanced dose optimisation: review of dosing strategies in acute kidney injury
  - Influence electronic prescribing & medicines administration (ePMA) development to include robust AMS functionality

Role of the AMS team: Health Board wide

- Answer clinical queries from all sectors & professions
- Guideline development & maintenance
  - 592 clinical guidelines
- Chair & provide secretariat for AMS governance groups
  - Monthly antimicrobial stewardship group
  - Monthly antimicrobial guideline group
- Education across professions and sectors
  - Reached >1100 individuals in 23/24 FY
  - Annual awareness week every November with promotional activities
- Antimicrobial usage data provision
  - Including *C. diff* root cause analysis
- Policies & procedures
- Research
  - Currently running the UK Antimicrobial Registry trial in secondary care

- Challenges
  - Variation in practice in primary care: localities range from worst to second best in Wales
  - Increasing acuity/complexity of patients: increased need for antimicrobials
  - When workload increases, AMS drops off
  - Pharmacy capacity (traditionally seen as gatekeepers of antibiotics)
    - Staffing pressures → ↓ frequency of ward visits → ↓ scrutiny
    - Pharmacy early years pathway: removal of AMS module to make way for independent prescribing
  - AMS e-learning not mandated in the same way infection prevention is
  - Patient behaviours in the wake of Strep A outbreak
  - Factors beyond direct control
    - e.g. GP practice merger responsible for significant spike in antibiotic use in Torfaen North in winter 23/24
    - *C. difficile* genomics testing indicates numerous linked cases, but with no clear healthcare crossover

Total Number of Inpatient Falls



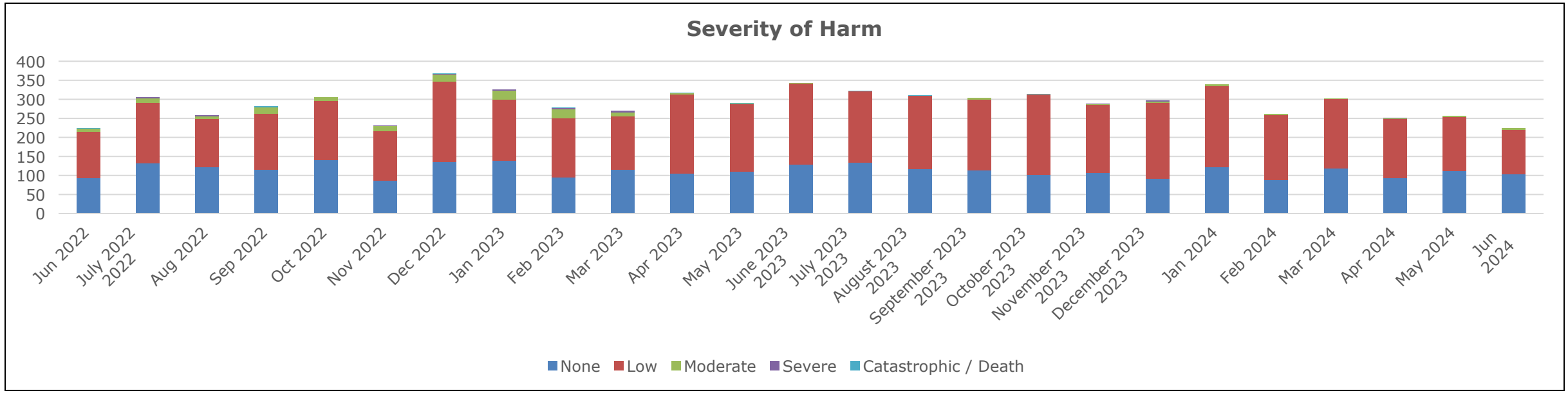
July 2024 - Context

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

The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period May 2022-2024. This period length for this data is selected to ensure the analysis is statistically valuable.

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	• For the given period of analysis, the mean average of fall incidents is 276 which represents a decrease since the last report presented in March 2024 • Following a downwards trend from January 2024 the months of February and April 2024 have seen the lowest recorded values for falls incidents since November 2022.	Although January to May 2024 have seen increased levels of variation as compared to the preceding months some of the values are a positive representation of a decrease in the numbers of reported inpatient falls.

Inpatient Falls Data by Severity of Harm

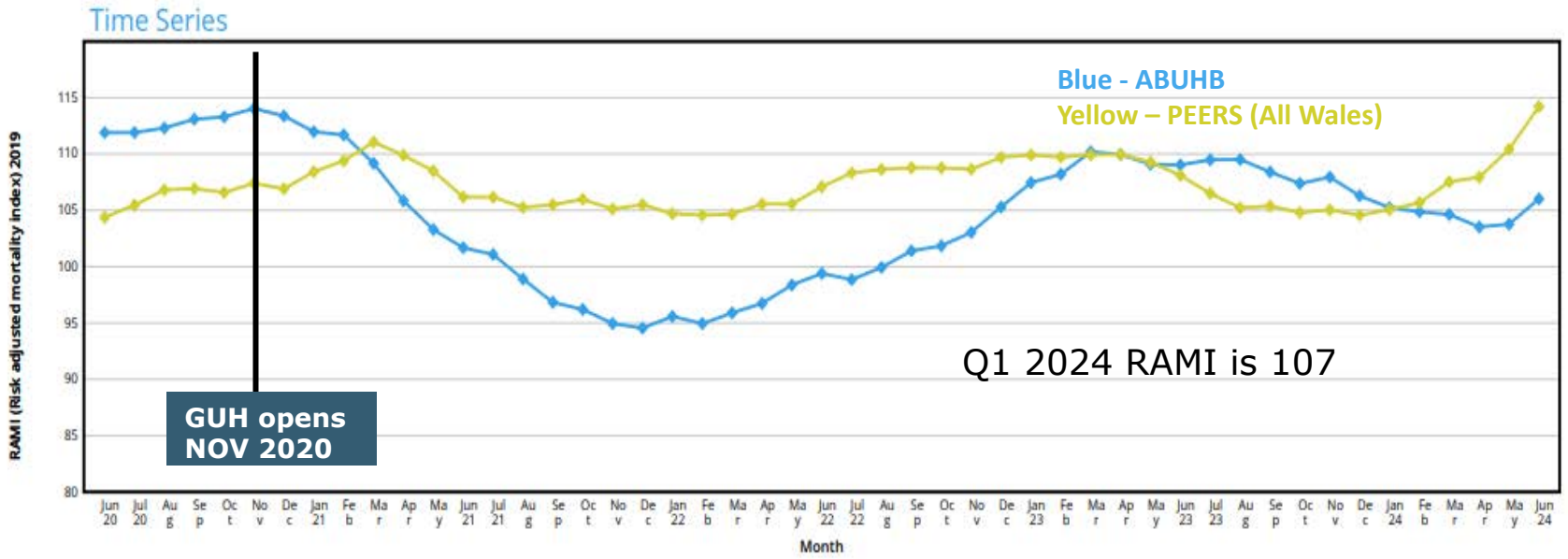


Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	Of the total numbers of falls incidents reported for which the severity of harm is categorised for the given period is 6537. Of this figure the following is identified. • 97% No or low harm. • 2.5% - Moderate harm • 0.4% Severe harm • 0.1% Catastrophic	The severity data is now reflective of the identified level of harm recorded post investigation. As compared to previous reports the % no or low harm is significantly higher than previously represented with a % reduction in the other associated categories of harm.

July 2024 - Context

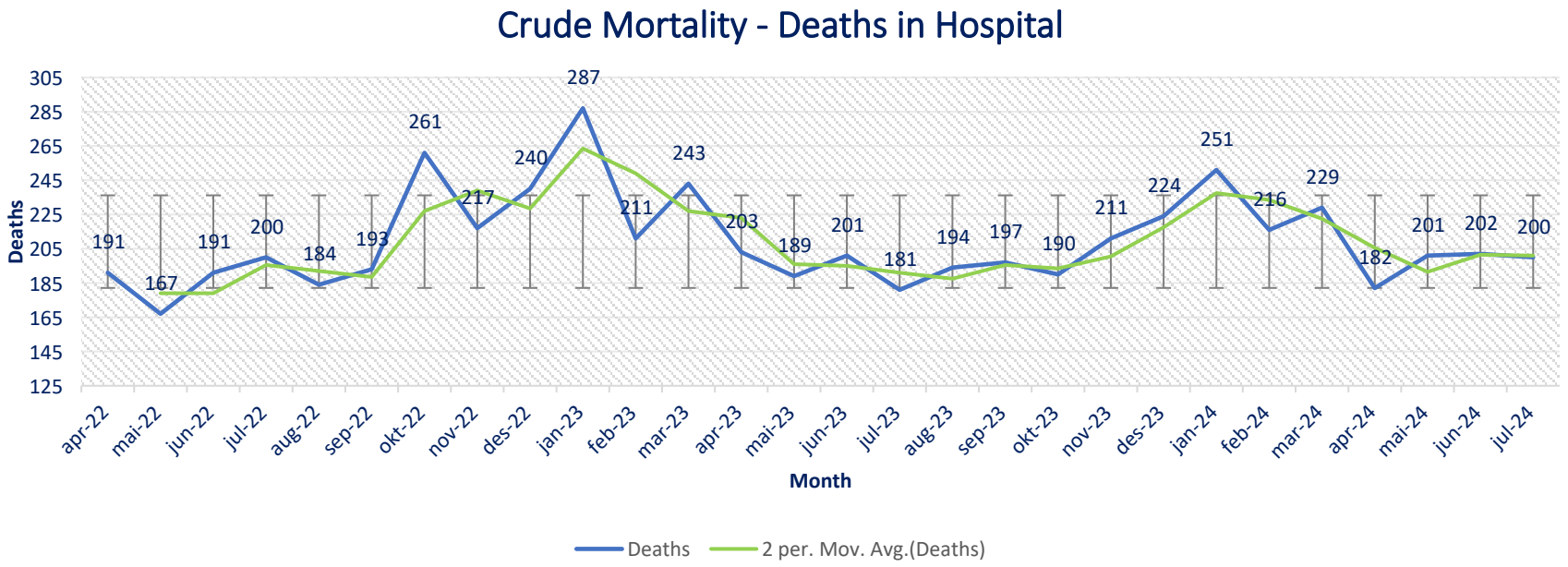
The data represents the collective information for ABUHB and refers to the severity of reported falls incidents for the period June 2022- 2024.

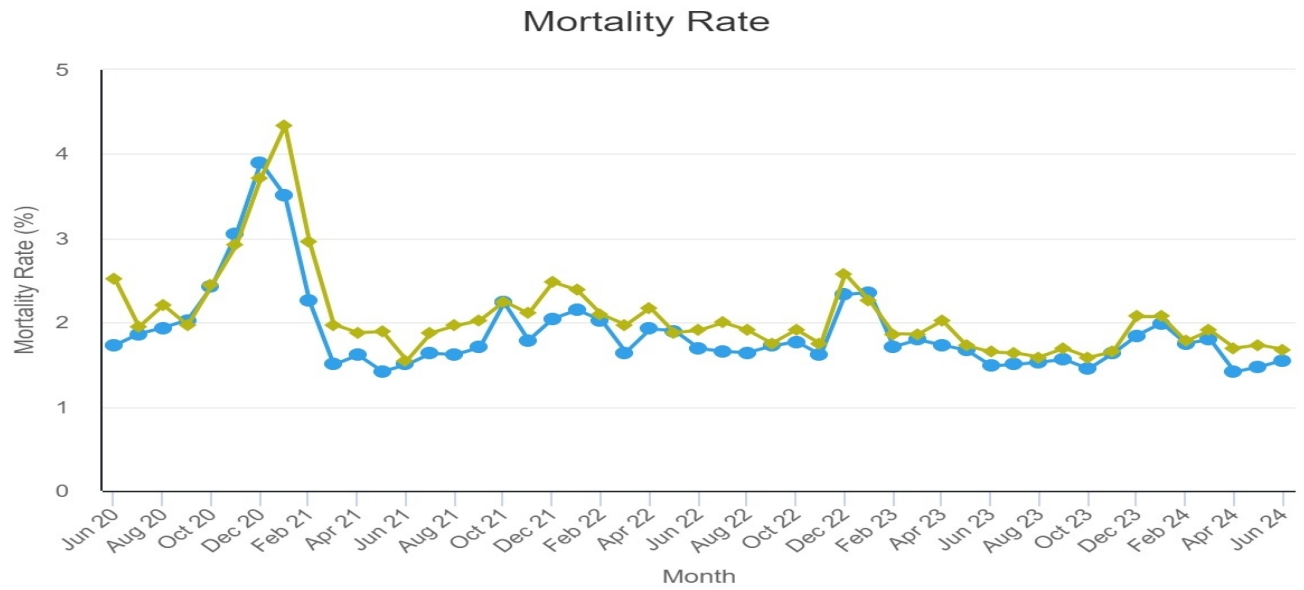
RAMI (Risk Adjusted Mortality Index)



Currently performing 2nd of 6 within All Wales peer group

Crude Mortality in Hospital



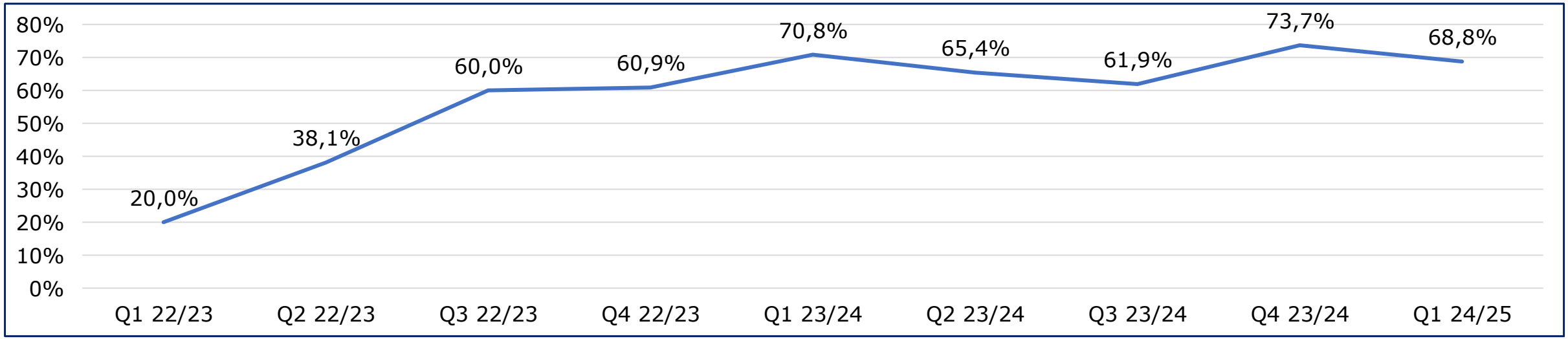


Actual deaths in hospital have plateaued in the past 3 months. However, the mortality rate is slightly increasing. RAMI has been gradually declining since November 2023

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During Q1 (April to June 2024) the Health Board have reported **16 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

68.75% of these cases were reported within the legal timeframes within the legislation.



Health, Safety & Security – Statutory & Mandatory Training

Health and Safety Statutory and Mandatory Training

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

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

Health & Safety	**87%**
Fire Safety	**84%**
Violence & Aggression	**86%**
Manual Handling	**58%**

Health and Safety Training for Senior Leaders

Board Development session held on 24 April 2024 provided a focus on health and safety legislation, including Corporate Manslaughter. The session was delivered by Solicitors from NWSSP Legal & Risk Services.

IOSH Safety for Executives and Directors being planned for Q3 2024/25.

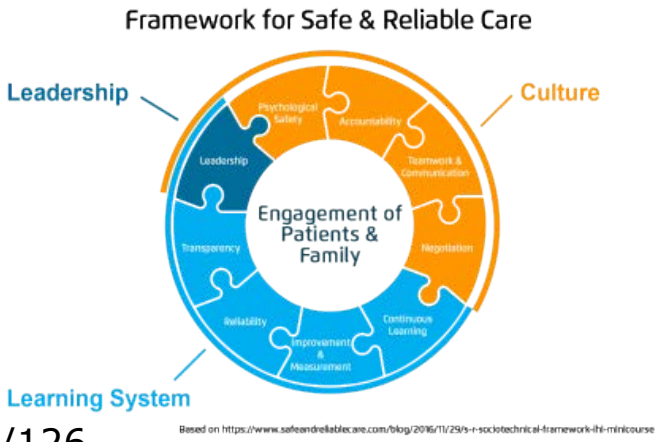
Safe Care Collaborative: Final Update

Organisational Update: Stage-Collaborative Closed in May 2024

- **Learning Session, May 14th**– Face to Face Learning Session held at the ICC focussing on 'Sustaining Successful Improvement'
- **ABUHB Deteriorating Patients Collaborative –** Review to be undertaken around what is next for a local collaborative, reflecting ABUHB strategic direction and the forthcoming National Programme. 'Improvement Cymru', who led SCC, now forms part of the 'Quality, Safety and Improvement' directorate within the NHS Executive are identifying their national priorities.
- **Leadership programme of work** –Executive Safety walkarounds set up for 2024, some cancelled at the start of the year but more completed during April/May.
- **Quality Outcomes Framework**–Maxine Power facilitated session around development of the QOF measures. Aim to reduce these to up to 5 measures per component of STEEEP. Qtr 4 QOF reported.
- **QI Skills Development**– Spread & Scale aim: '*To unleash a million minutes of quality improvement coaching to enable our people to improve their services over the next 4 years'*. Cohort 1 of new QI Coach programme in Autumn focussing on QPS staff, Primary Care and others. 3 programmes 2025 onwards aiming to develop 75 QI Coaches embedded in divisions each year.
- **QI/Nursing Directorate –** ABCi QI Unit moved to QPS/Nursing

Teams Update

- **Storyboards** - Updated for Learning session 6
- **Ward C0 –**Up until the end of April, there hasn't been a Cardiac Arrest for 155 days. Next stage of visual management, screen accessible for full MDT at handover between shifts.
- **Monmouthshire** – Invited to present as spotlight session at final learning session. Reduction in Package of Care hours for medically optimised patients. Reduction in median LOS. Exploring potential to spread Mon integrated model.
- **AMU** – Workforce changes in AMU leadership/ team/coach. Ongoing support for QI within AMU under consideration
- **OT Early Intervention** – Invited to present as spotlight session at final learning session. 6 week Home Based Memory Rehabilitation (HBMR) programme reduced from 770-670 minutes for each patient, allowing for an extra patient to undertake the programme each month. Testing pre-hab memory strategy leaflet for patients on waiting list & planning for spread.
- **Theatres –** Up until the end of May, there hasn't been a Never Event in theatres for over 195 days, equating to 3.9 events avoided. Improvement Advisor in post whose work is aiming to reduce retained material/wrong sided block Never Events in theatres. Work focussing on two areas: Developing Safety Culture via Human Factors training/simulation and QI, plus reliable introduction of NatSSIPS 2. Testing Safety Culture survey as part of Human Factors, updated WHO checklist and 'Pause for the Gauze' being tested and spread across theatres.

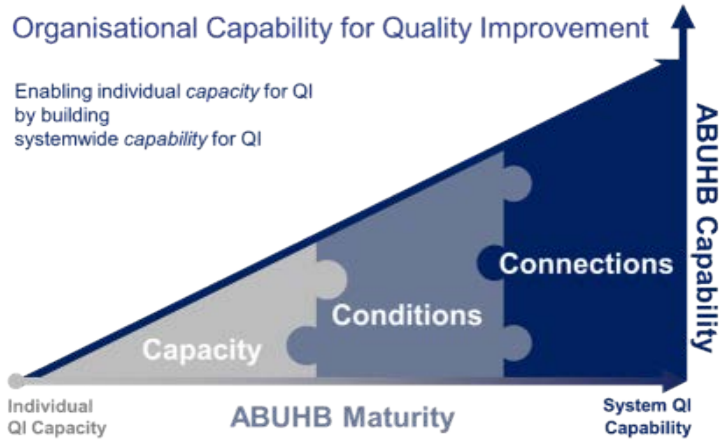


Workstream	ABUHB Team	Score
Acute	Medical Assessment Unit at GUH	2.5
	Ward C0 (ENT surgical ward) at GUH	3.5
	Theatres – Human Factors	2.5
Ambulatory	North Monmouthshire Integrated Team	3.5
Community	OT/MH Early Intervention for Cognitive Impairment Team	3
Leadership	Executives, Leaders for Safety, Faculty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

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

Quality Improvement

*"**Quality improvement** is about giving the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them. It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement."*



Our QI Capability strategy is to build: ♑

Capacity for QI – knowledge, skills, experience

- **QI Coaches integrated into divisions** ♑
- QI Knowledge and Skills Development Framework

Conditions for QI – Enablers for QI

- Clinicians as QI Leaders
- Data systems supporting QI
- Resources to support teams working to improve services
- Patient involvement in QI
- **Human Factors and Safety Culture** ♑

Connections for QI – QI Networks sharing learning

- QI Networks, both internal and external
- Strategic Partners
- **Safe Care Partnership/ Collaborative** ♑
- QI Collaboration

Progress:

ABUHB NHS IMPACT Self Assessment survey - initial results

Spread and Scale Integrated QI Coaches – 90 Day Plan

Aim - "To unleash a million minutes of quality improvement coaching to enable our people to improve their services over the next 4 years"

QI Coach development programme (click for more info)

- **Plan** – Each year x 3 Cohorts x 25 participants = 75 participants each year = 300 QI Coaches in 4 years
- Celebration event for pilot QI Coach Programme in June
- 27 booked on Cohort 1 planned for Autumn 2024 targeted at key staff e.g. QPS, Primary Care, QI Project teams.
- 2025 dates for QI Coach Programme booked
- 16/300 QI Coaches trained in ABUHB
- 4140/1,000,000 minutes of QI Coaching delivered to QI teams between April – May 2024

Human Factors and Safety Culture

- ABCi Improvement Advisor supporting work to reduce Never Events in Theatres – presented to PQSOC
- 195 days since last Never Event in theatres (data to May) equating to 3.9 events avoided
- Testing SCORE safety culture survey
- Updated WHO checklist and 'Pause for the Gauze' being tested and spread across theatres

Safe Care Partnership (SCP)/Collaborative(SCC)

- Safe Care Collaborative ended in May 2024
- Improvement Cymru part of NHS Executive 'Quality, Safety & Improvement Directorate scoping priorities for next stage of SCP work

Safeguarding: Training and Development

Safeguarding Training continues to be provided and monitored, in line with the recommendations of the Intercollegiate Documents for Safeguarding of Children and Adults.

All training for Safeguarding level 1 and 2 is now above the required 85% compliance.

Level 3 Children's and Adults training continues to be a challenge and further work is required across the Health Board to ensure that this is mandated to staff appropriately via ESR and that compliance data can then be analysed.

Training Module	Compliance %
Adult Safeguarding Level 1	87%
Children Safeguarding Level 1	86%
Adult Safeguarding Level 2	90%
Children Safeguarding Level 2	88%

Safeguarding: Activity

Safeguarding activity data must be used with caution when being utilised as a marker of quality improvement. However, the current data available for 2024/25 highlights there has been a substantial number of safeguarding referrals made, or responded to, by the ABUHB Safeguarding Team. This is influenced by a number of potentially negative factors (increased harm) over which we have no control but is also testimony to the effectiveness of the workforce in being aware of neglect and abuse within our population.

	2023/24	2024/25	Increase
Safeguarding Children Strategy Discussion	377	512	36%
Adult Duty to Report	72	102	41%
Child Duty to Report	963	1090	13%

It should be noted that the duty to report figures represent those that were generated by the Health Board and quarter 1 comparisons have been made between 23/24 and 24/25.

Safeguarding: MARAC/Sexual Safety/Serious Violence

Multi-Agency Risk Assessment Conference (MARAC)

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

In QTR 1 2024/25, the Corporate Safeguarding Team attended 32 MARAC, providing information and contributing to safety plans for 394 survivors of Domestic Abuse. An increase in MARAC activity has been noted by the Gwent MARAC Steering Group, with current work on MARAC sustainability being a focus of the Gwent VAWDASV work for the current year.

Sexual Safety

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

In response to this, a Chaperone Policy and Sexual Safety Policy are currently in draft form and awaiting approval from internal processes. The sexual safety policy will in addition provide guidance on risk assessment, recording of sexual safety incidents and timely escalation.

Serious Violence

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

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

In addition, working groups in some localities have been formed to commence multi-agency work in response to the increased activity of the topic.

Violence and Aggression

Type of Violence towards Staff	Q1 – 2023/24	Q2 – 2023/24	Q3 – 2023/24	Q4 – 2023/24	Q1 – 2024/25
Aggressive/threatening behaviour	345	269	314	240	306
Harassment	5	1	8	7	11
Inappropriate use of social media	1	6	0	1	1
Patient clinically challenging behaviour	8	7	6	7	9
Physical assault (physical contact)	187	176	170	176	179
Sexual (inappropriate) behaviour	15	17	10	13	15
Sexual assault	3	4	2	4	4
Verbal assault (gender/sexual orientation)	3	0	0	0	1
Verbal assault (racial abuse)	7	9	14	5	4
Verbal assault (swearing etc.)	10	7	15	5	10
Total	584	496	539	458	540

Violence Prevention and Reduction

Support Systems & Incident Reporting

We have implemented comprehensive support systems for staff who experience violence and aggression through the Violence and Aggression Case Management Team. These systems include clear pathways to support services such as Employee Wellbeing, Connect to Gwent, and other Employee Assistance Programs. In addition, we offer advice and guidance on criminal matters, internal policies and procedures, and broader risk management practices to help ensure a safe working environment.

We strongly encourage employees to report all incidents of violence and aggression through Datix Cymru, and to Gwent Police when appropriate. By doing so, we aim to address issues promptly and effectively, providing the necessary support to our staff while maintaining a safe and secure workplace.

Actions and Improvement

Partnership Working:
We work closely with Gwent Police and other key stakeholders such as Local Authorities, Probation Services, Other NHS Wales Health Boards etc. This multidisciplinary approach ensures a comprehensive support to victims and enables robust intervention strategies.

Education & Training:
Where themes and trends have been identified in relation to incidences of violence and aggression, we have supported local wards and departments with bespoke Violence & Aggression Training, which further supports staff in enhancing their skills in being able to identify early signs of potential violence & aggression, de-escalate situations, apply non-physical intervention techniques and have greater understanding of environmental awareness in relation to the management and prevention of violence and aggression.

Policy Development:
The Management of Violence & Aggression by Members of the Public Policy is currently under review. As part of the review, the policy is being updated to the Violence Prevention and Reduction Policy. The amendments to the policy is reflective of an increasing trend of identified unacceptable behaviour, in addition to workplace violence. As part of the policy amendments, further guidance and protocols have been included in order to assist managers in managing violence and aggression locally.

Violence Prevention and Reduction

All Wales Violence & Aggression Case Management Group:

During the period 2023/24, significant progress was made on an All Wales basis to enhance the management and prevention of violence and aggression within NHS Wales.

A key focus has been on the comprehensive review of the NHS England Violence Prevention and Reduction Standard, with the aim of updating and adopting it as a new Welsh standard.

This collaborative effort has involved stakeholders from across NHS Wales, including health boards, and other key partners such as the Anti Violence Collaborative.

The review process has entailed a detailed assessment of the existing standard, with particular attention to its relevance and applicability within the Welsh healthcare context. This has included evaluating current best practices, identifying potential areas for improvement, and ensuring that the standard aligns with the unique operational, cultural, and regulatory environment of NHS Wales.

The adoption of this updated standard is anticipated to bring several significant benefits to the Health Board, including:

Enhanced Safety for Staff and Patients: By implementing a robust and comprehensive framework for violence prevention and reduction, the updated standard will contribute to a safer working environment for staff and a more secure care environment for patients.

Consistency Across NHS Wales: A standardised approach will ensure that all NHS Wales organisations adhere to the same high standards, reducing variability in practices and enhancing the overall quality of violence prevention and management across NHS Wales.

Improved Reporting and Accountability: The new standard will establish clearer protocols for reporting incidents of violence and aggression, leading to better data collection, analysis, and accountability. This will enable NHS Wales to monitor trends, identify high-risk areas, and allocate resources more effectively.

Increased Staff Support and Training: The standard emphasises the importance of training and supporting staff in recognising, managing, and de-escalating violent situations. This will not only improve staff confidence and competence but also reduce the likelihood of incidents escalating to physical violence.

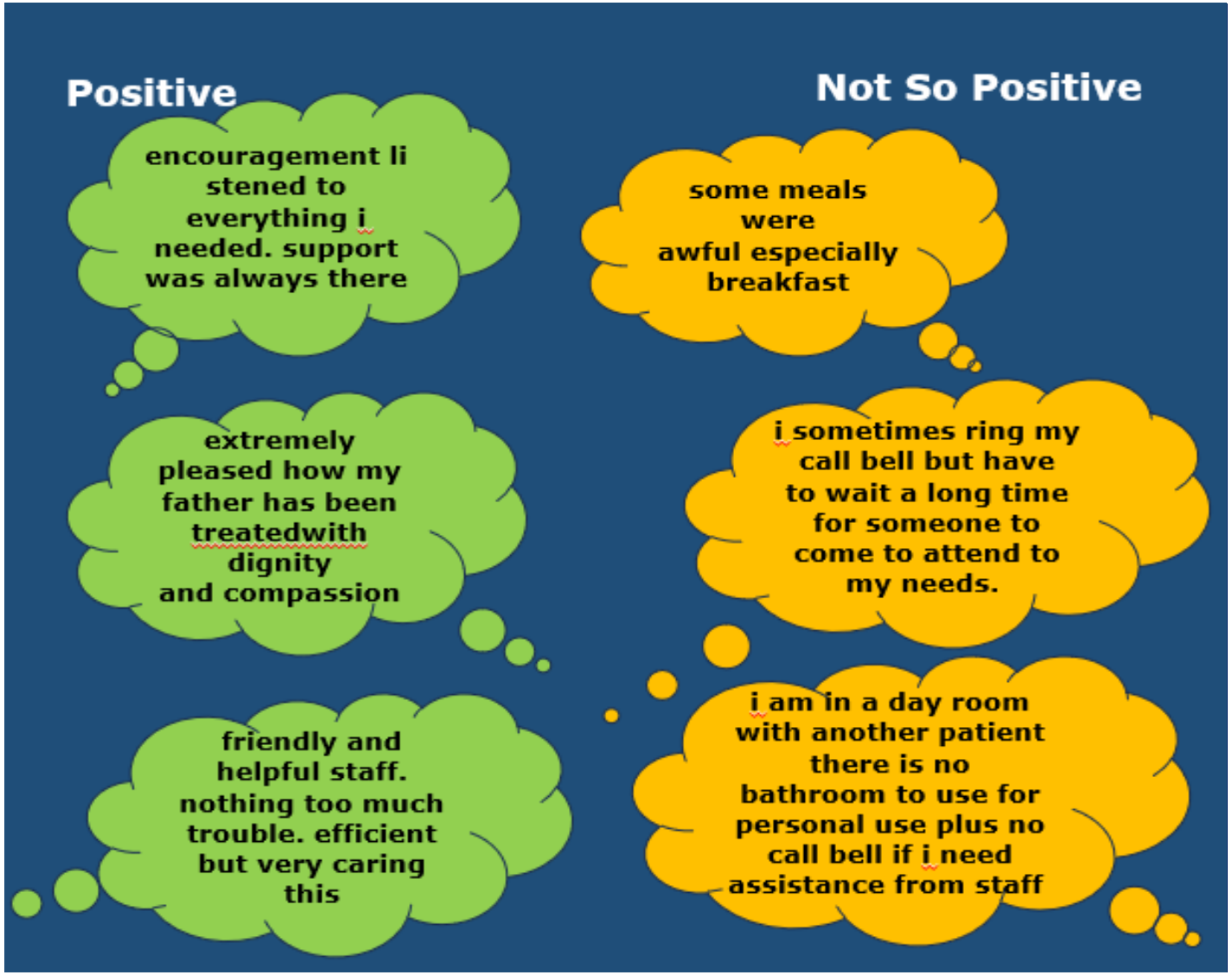
For Information

Priority 1: Person Centred Care

Priority	Outcome Description	Indicator	Reported Position 2023/24		Current Reported Position	Change over the last time period	Latest findings
			Q3	Q4	Q1 2024/25		
Priority 1 - Person Centred	Our patients, their families, and carers receive an experience that not only meets but exceeds their expectations	General experience rating of episode of care	87%	88%	90%	Improved	Overall satisfaction increased to 90% for all surveys (benchmark is 85%). Q1 patient experience feedback captured in Emergency Department (79 responses and 68% satisfaction).
		Number of complaints closed	410	406	385	Decreased	Decrease in number of complaints closed
		Complaints backlog	773	859	816	Improved	Across Q1 2024/25 we saw a 4% decrease in the number of concerns received by the Health Board. Although the Health Board has received on average 20 more concerns per month across the period than have been closed. Despite this, organisationally we have managed to ensure more than 57% of the complaints received are being completed within the 30-working day target, compared with 54% across the same quarter in 2023/24.
	Increased patient, public and staff involvement.	Increase in number of responses in Civica	327	598	1663	Improved	All Surveys - Q4 2023/2024 was 594, due to late additions, Q3 was 282. Significant increase for Q1 2024/2025 of 1663, which is more than the whole of 2023/24. CIVICA is live in 265 areas (end of Q1) across the Health Board.

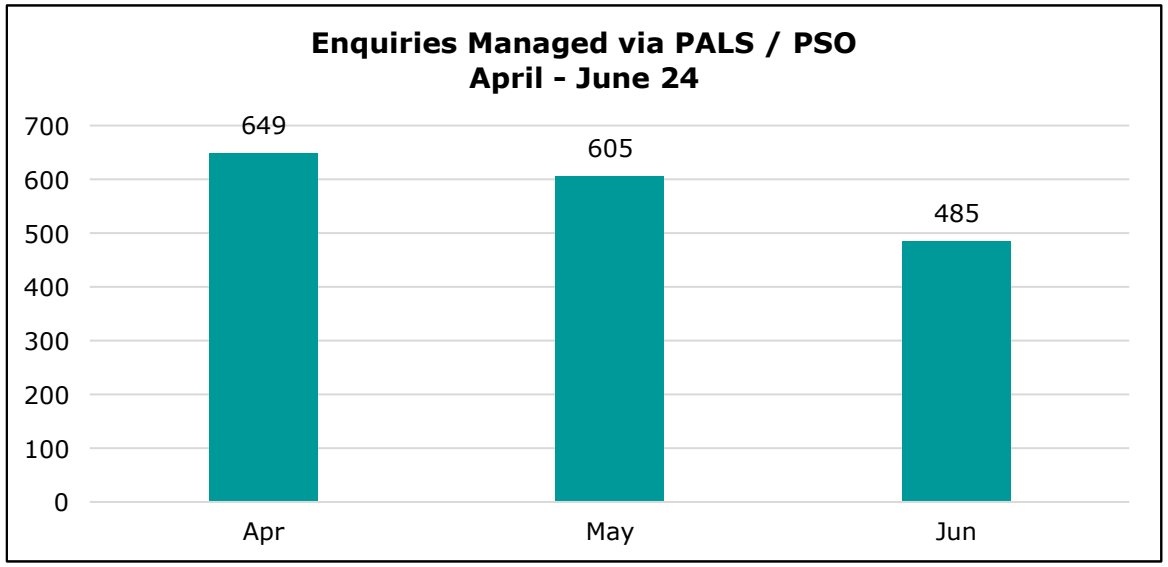
Top 3 Themes from PCC Survey

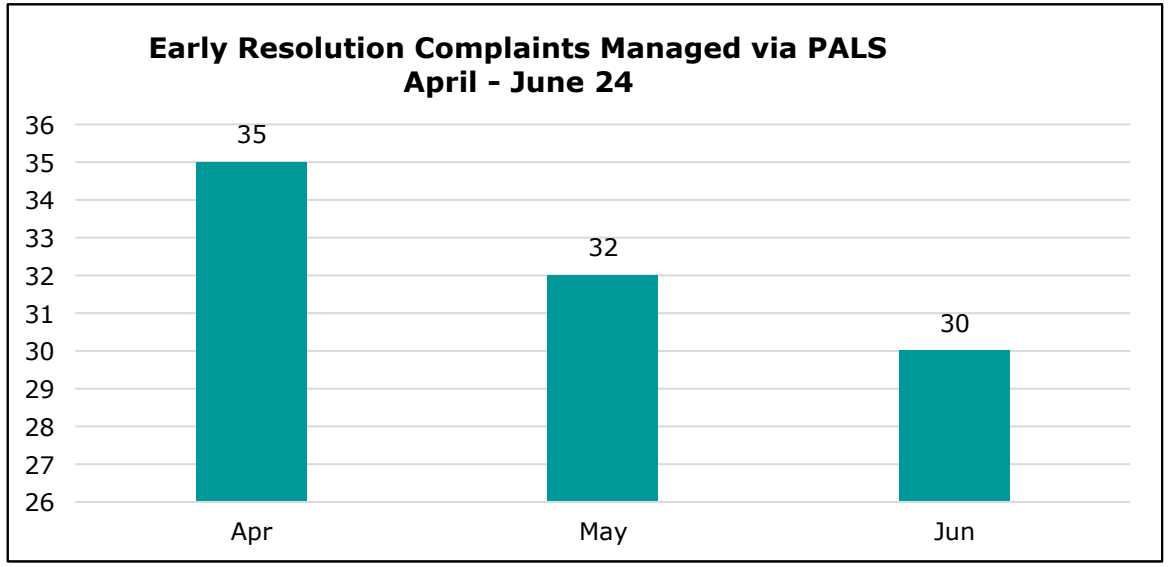
What did we do well? Q9	What could we have done better? Q10
Top 3 themes	Top 3 themes
268 comments around **Emotional & Physical support** •**252** comments around **Compassion** •**208** comments around **Friendliness**	• **60** comments around **Food & Beverages** •**40** comments around **Waiting** •**24** comments around Facilities

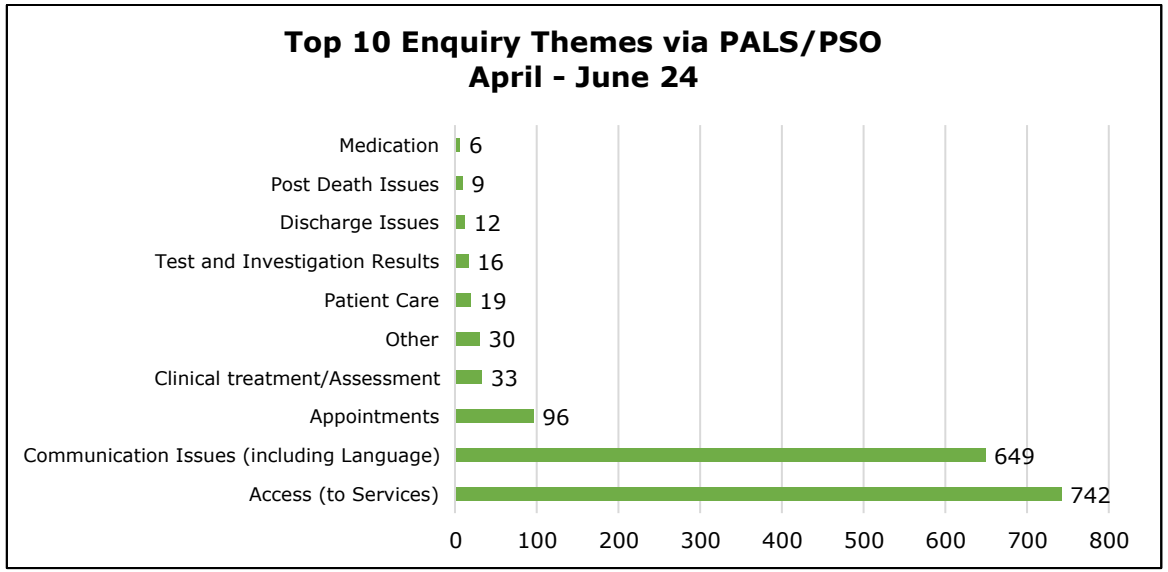


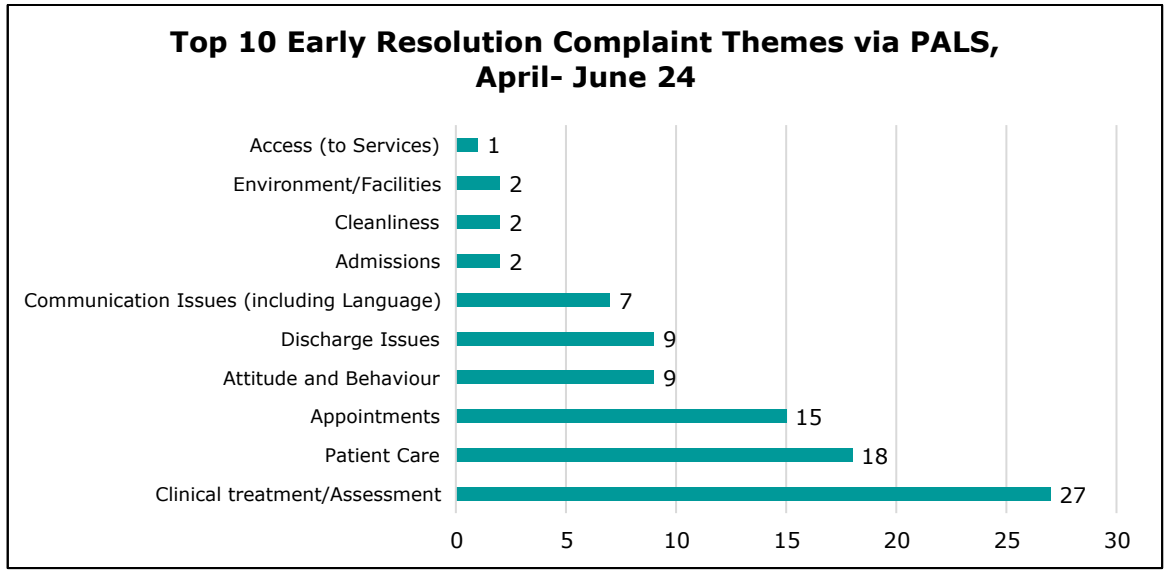
Issue	Action	Learning and Improvement	Who	When
Lack of evidence on listening and learning from patient feedback received from CIVICA	May 2024 – Contact made with QPS Divisional Leads to request sight of their Monthly Reports showing listening and learning from feedback received	Awaiting QPS Team to progress and share listening and learning	Senior Nurse - Patient Experience and Involvement Head of Quality & Patient Safety and Learning& QPS Leads	Ongoing
Low responses from areas that have been 'live' on CIVICA for some time	List of areas with no feedback highlighted to each Division Increase in attendance from CIVICA Team to bespoke and team meetings to support with feedback	Increase in feedback each month with new areas each month collecting feedback	Divisional Leads QPS Leads Senior Nurse - Patient Experience and Involvement / Patient Feedback System Facilitator to monitor	Ongoing
Low responses from ED survey in ED compared to other Health Boards using SMS	PALS Team supporting with survey completion when possible	Noticeable increase with 79 responses in Q1 compared to 19 for Q4	Divisional Lead/QPS Lead Senior Nurse - Patient Experience and Involvement / Patient Feedback System Facilitator to monitor	Ongoing
	Investigation into possibility of SMS Pilot for ED	Awaiting outcome of possible pilot	Deputy Director of Nursing QPS	
Concerns over whether patient feedback is being viewed and accessed by Teams	Recent Audit on active users by location completed and areas with no noted user flagged to Divisions – dates continually shared for training	Ongoing monitoring	Senior Nurse - Patient Experience and Involvement / Patient Feedback System Facilitator	Ongoing
Concerns on whether feedback concerning Facilities are being escalated	2 months bespoke CIVICA monthly reports highlighting all comments relating to non clinical i.e. Facilities. Contact and engagement with Facilities on ongoing actions and CIVICA use	Example of recent issue flagged is a number of patients stating they are cold in a location at SWH	Senior Nurse - Patient Experience and Involvement / Patient Feedback System Facilitator Business Support Manager - Facilities	Ongoing

Patient Advice & Liaison Service

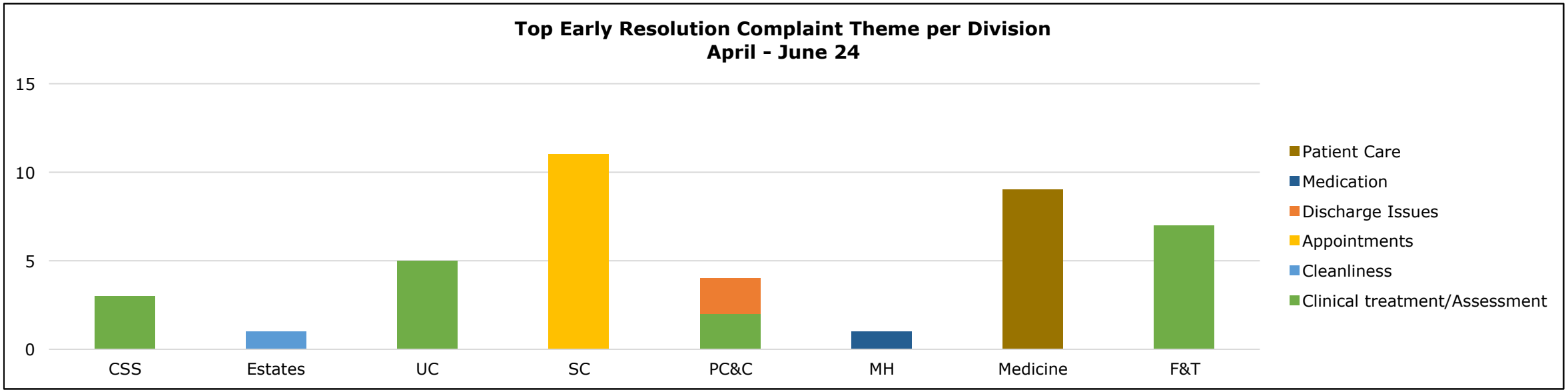


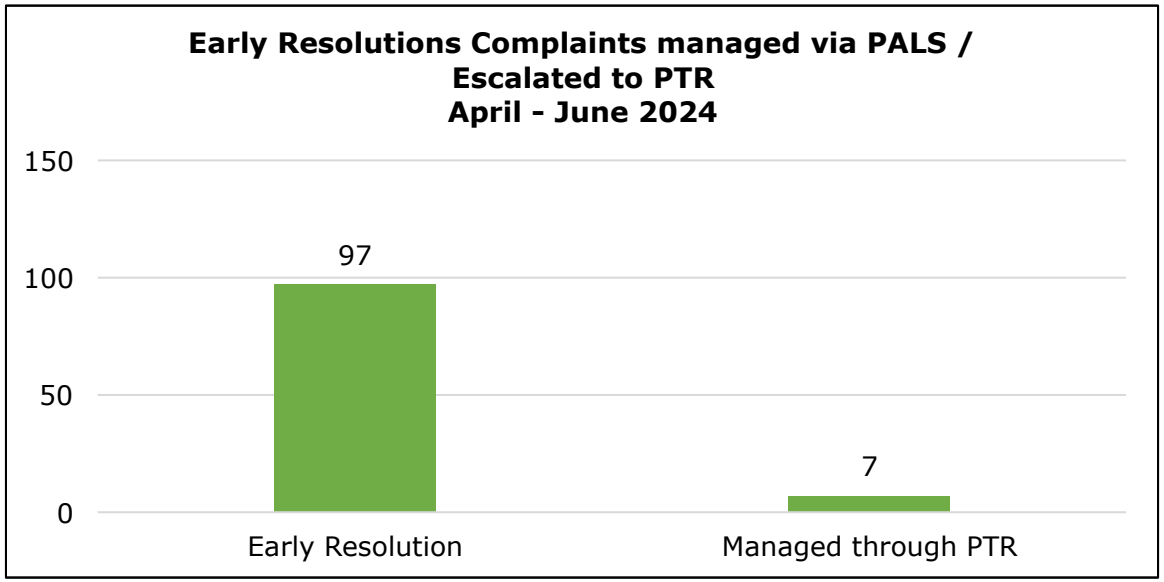


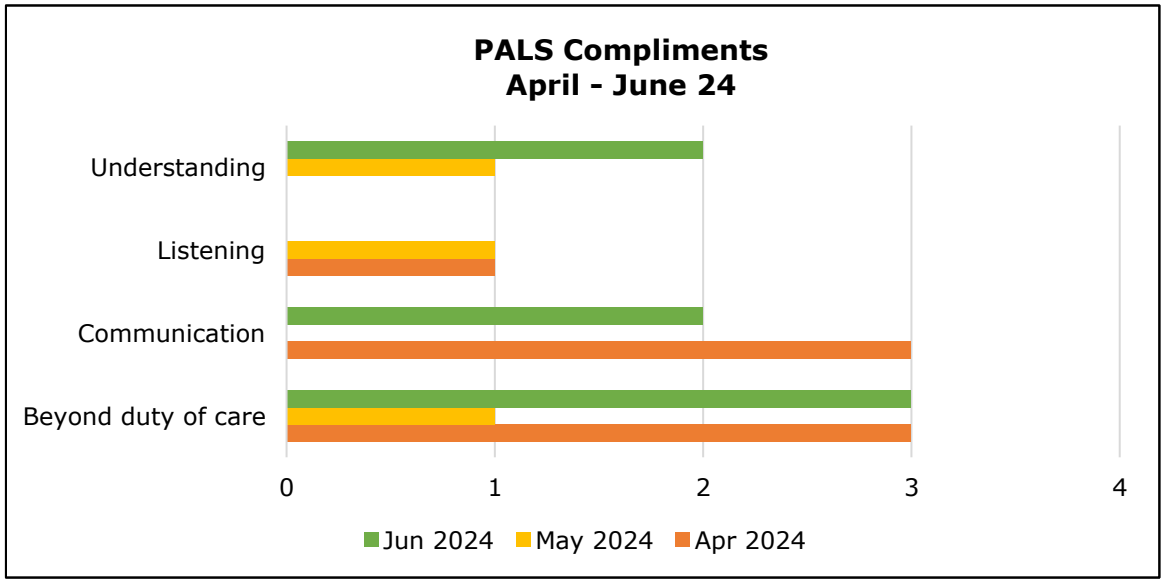




Patient Advice & Liaison Service







Complaints Learning & Improvement

Issue	Action	Learning and Improvement	Who	When
Compliance with WG 30-day timeframe.	Identification and clarification of questions for investigation at the point of contact with the Health Board. Allows for focused and timely investigations.	Weekly assurance and review meetings are taking place with all concerns teams to identify and alleviate bottlenecks preventing conclusion of investigations in an effort to reduce the number of concerns that are not being managed in line with the PTR regulations. The Health Board continues to work closely with external partners such as the Public Services Ombudsman for Wales, Llais, Audit Wales and Health Inspectorate Wales. We will demonstrate an open culture and always seek out opportunities to learn and improve as part of our ongoing commitment to our local population.	Head of QPS and Learning, Senior QPS Manager, Concerns Managers & Deputy Concerns Manager	Ongoing
Complaints Handling & Meaningful Updates	Complaints co-ordinators away session to refresh around PTR Guidelines and complaints management. Process-mapping with key stakeholders of the concerns journey. Ensuring that meaningful updates are being provided to complainants throughout the investigation.	Communication Standards will be developed to reinforce consistency across all concerns teams. We will be clear in setting out resolution proposals, actions, agreements and dates for contact and updates.	Head of QPS and Learning & Senior QPS Manager	September 2024

Listening and Learning

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

- The terms of reference of the learning and improvement forum are being agreed to ensure the Health Board builds on divisional and directorate assurance arrangements by adding a strategic approach to support the Health Board to learn lessons from a range of internal and external sources.

- The learning repository is being tested and will allow us to collate, store and utilise this learning, enabling us to share knowledge, shape change, embrace innovation, implement quality improvement and create opportunities to develop excellence in practice. This has enabled progress in ensuring learning is continually captured within an accessible Learning Repository and builds an Organisational Memory.

- A highlight report from the learning an improvement forum is attached.

Learning and Improvement Update

- The most recent organisational Patient Quality and Safety Learning and Improvement Forum took place on 9 July 2024.

- The forum was well attended with a wide range of professions, both clinical and non-clinical, represented.

- Good news – Aneurin Bevan Continuous Improvement (ABCi) piloted the first test cohort of Quality Improvement (QI) coach programme. Positive feedback was received. The next cohort will be held in Autumn and is fully booked. Three cohorts a year will take place, with an aim to develop 75 QI coaches per year.

- Divisions provided presentations on learning based on the six pillars of quality:
  - Patient and staff feedback and stories
  - Incidents
  - Complaints, concerns and compliments
  - Safeguarding
  - Infection prevention and control
  - Health, Safety and Security

These can be viewed in the minutes from the meeting. The presentations and their learning will be available for all through for future access through the learning repository.

- An update on Learning Repository was demonstrated at the meeting. This demonstrated how all staff employees would be able to use it once live on Pulse. There will be a link on the home page. QPS leads will be able asked to share their learning and will be put into themes.

- There were three presentations presented at the forum that related to: -

  - **Safer Care**: The memory rehab service
  - **Quality Improvement**: What matters most in Neuro Rehab (Bevan submission)
  - **QPS:** SWARM Methodology – learning from falls

These can be found in the minutes.

- Next meeting 15 September 2024

Priority 2: Safe Care

Priority	Outcome Description	Indicator	Reported Position 2023/24		Current Reported Position	Change over the last time period	Latest findings
			Q3	Q4	Q1 2024/25		
Priority 2 – Safe Care	Fewer repetitive incidents in the priority areas and across the Health Board	Reduction in the number of SI's, by harm category	147	151	110	Decreased	A total of 110 Patient Safety Incidents (PSIs) (moderate and above harm) met the criteria for either Corporate or Divisional led Investigation were identified during Quarter 1 2024/25. This is in comparison to **109** in Q1 of 2023/24.
		Reduction in the number of National Reportable Incidents	45	40	35	Decreased	The Health Board reported 20 NRIs in April, 13 in May, with a decrease to 2 in June. In May 2023, the Health Board met with NHS Executive colleagues, to discuss the reporting criteria. As a result, the number of reported NRI's saw a significant increase in June 2023. We have since seen stabilisation of reporting, and continue to monitor.
		Reduction in the number of Never Events	4	0	0	Decreased	0 Never Events reported for Q1 2024.25. Improvement work continues.
		Decrease in the number of reportable IPAC incidents	29/week	See table	See slides	See slides	Q1: 14/66 (21%) patients (11 HCAI, 1 CAI), majority of suboptimal prescribing related to piperacillin/tazobactam use in secondary care
		Increase in the compliance of Health and Safety Statutory and Mandatory Training	86%	87%	87%	Consistent	There has been an increase in all the health and safety areas compared with the previous report. H&S 87%, fire safety 84%, manual handling 58% and V&A 86%.

Priority	Outcome Description	Indicator	Reported Position 2023/24		Current Reported Position	Change over the last time period	Latest findings
			Q3	Q4	Q1 2024/25		
Priority 2 – Safe Care	Improved clinical outcomes	Decrease in the time to complete safety alerts	4 days	4 days	4 days	No Change	The average time to report has stabilised however the data is highly variable with regular peaks above four days.
		Decrease in the number of Falls by 1,000 occupied IP Bed days	7.24	7.35	6.7	Decreased	Q1 has seen a decrease in falls/1000 occupied bed days
		Improved RAMI Score	105	116	107	Decreased	There is a delay in coding data which results in the RAMI being delayed as an accurate indicator. There has been a decrease in RAMI from Q3 – Q4. The Health Board is currently outperforming the Welsh Peer Group Average of 113.46. Positioned as 3rd best RAMI out of Welsh peer group.
		Improved Crude mortality by hospital	4.9	5.15	4.27	Decreased	Deaths per 1000 bed days has remained stable and decreased for Q1
		Decrease in the number of HA pressure ulcers by grade	25%	20%	See table	See table	Reduce HAPU incidences by 25% of baseline within 4 months from the commencement of the faculty. Marked reduction in reported HCAI. Data is being collected from all Divisions (see charts).
		Decrease in the number of HA pressure ulcers	23/week	23 /weeks	See table	See table	Work underway with improvement collaborative which has shown a decrease in reported PU of 2,3,4 grade 1 remain static. Data is being collected from all Divisions (see charts).
		Decrease in the severity of medication incidents	469	448	530	Increased	Moderate & severe Q1 69, Q2 67, Q3 85, Q4 69, Catastrophic Q2-4 is 0 last report in Q1-2.
		Decrease in the number of incidents under - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)	21	19	16	Decreased	Q1 -16 incidents reported to the HSE in accordance with RIDDOR, 68.8% of these cases were reported within the legal timeframes within the legislation.
		Decrease in Preventable Hospital Acquired Thrombosis (HAT) incidents	0	0	0	No change	Quarterly data presented in the narrative. Non preventable HAT incidents – 3 month delay on data and requires case notes review.
		Increase in the number of PREM Audit and actions					Measure to be refined.

Patient Safety Incidents - Learning and Improvement

Issue	Action	Learning and Improvement	Who	When
Outstanding/overdue NRI forms - compliance percentage is decreasing. There is, on occasion a breakdown in communication in the QPS and divisional teams closing the investigation on RL DATIX and informing the corporate team. Hence there may be NHS exec NRI's in the system that can be closed more expediently.	Focused piece of work being undertaken by Assistant Head of Patient Safety to analyse delays.	Meet with QPS leads aligned to divisions weekly to maintain pace. Report to CEO and EDoN monthly outstanding PSI's and escalate blocks.	Corporate PSI Team	Ongoing with review at end of August 2024.
Increased number of NRI's and Divisional investigations open. Reported NRI's peaked at 125 at the beginning of Q1. This figure reduced to 98 by the end of Q1, however there are still significant delays in completion of reports and closures reported.	Closer alignment, communication and direction for all participants involved in a PSI investigation process.	Bespoke rather than generalised training is being provided for Investigating Officers on a 1-2-1 basis to guide them through the investigation process supported by a member of the Corporate Patient Safety Incident team. Bespoke development of Chair, Investigating Officer and staff responsibilities for Patient Safety Incidents has been established. There has been an increase in the number of Executive Chairs to address delays in the initiation of investigation meetings.	Corporate PSI Team / QPS Business partners	Ongoing with review at end of August 2024.
Disparate approaches to investigation level across divisions.	Centralisation of decision making.	All moderate and above harm incidents are presented to the weekly Executive Huddle for an investigation level decision, identification of an appropriate Chair and allocation of Executive Sign off lead.	Clinical Executives	Complete
Some feedback from patients/ families subject to a PSI investigation, is that their contribution/input in to the Terms of Reference and communication throughout the process is below expectations.	Inclusion of families/patients in the PSI process.	A review of the Health Board's Patient Safety Incident Policy in November 2023 to align with the All-Wales Directive and to reflect patient and family feedback on the Safety Incident process. This Policy also more explicitly outlines expectations and procedures. A further update is planned to be approved by the Board in September following a further strengthening of the approach. Inclusion of update of family/patient added to PSI agendas.	Corporate Patient Safety Team	September 2024 Complete

Never Events

- **0 Never Events reported during Quarter 1.**
- **2 Never Events were closed in Quarter 1.**
- **0 Never Events have been reported since November 2023.**

Improvement Work
Key changes to Dermatology Patients accessing services through 'see and treat' route to mandate marking of lesions in marker pen with arrow, and recording number of lesions present and marked. Procedure not conducted if lesion not marked and has been clarified with the patient and the requesting clinician in clinic. *N.B NatSIPPs 2 recommends circling areas to be excised but not recommended in Dermatology due to need to visualise clearance margins.*
Ongoing spot audits to be carried out in 'see and treat' Dermatology clinics to monitor compliance with marking of lesions.
Identification of a dedicated block bay within each hospital site where anaesthetic blocks can be performed safely with adequate resources.
Design of a Local Safety Standard for Invasive Procedures (LocSSIP for Regional Anaesthesia/ Nerve blocks, focusing on the Prep, Stop Block process. Standardised LocSSIP used by all specialities who perform nerve blocks (including Anaesthesia, Orthopaedics, and Interventional Radiology). Education of all staff groups on new LocSSIP once developed.
To provide standardised and formalised training for all Regional Anaesthesia assistants through a mixture of electronic learning and / or lectures. Stop before you block teaching is being included in 'back to basics' teaching programme. E-learning resource created and currently final edit stage.
Provision of a dedicated Regional Anaesthesia assistant on all Health Board sites.

Mortality Learning and Improvement

Issue	Cause	Learning and Improvement	Who	When
Understanding mortality data and how we implement learning from mortality	There is a need to understand what is reported to PQSOC and to Board for mortality. England produce a Learning from Death framework which enables a standardised mortality report.	Mortality report presented at April PQSOC. Will be reported every 6 months. Includes development of Learning from Death Framework. Includes learning from the Medical Examiner service and the mortality review screening panel. Reviewing our end to end mortality process.	Medical Director's QPS team	On-going
Reliability of mortality data	Consistency of mortality reporting and data.	Mortality framework developed for reporting mortality indicators. This describes the approach: Tier 1 – Health Board level, Tier 2 – Divisional level and Tier 3 Directorate level. The QOF currently reports RAMI and crude mortality. There is an All Wales Mortality review group working to standardise reporting of mortality.	QPS Team and Information Manager	Ongoing
Clinical coding	The national target for clinical code is 95% coding completion one month post episode discharge. We are currently coding at 80% because of increasing activity.	Working with coding team to improve coding rate and depth and understand the variation in RAMI compared to the consistent and flat mortality rate over time.	QPS Team, DDT team and Information Manager	Ongoing
Mortality Data and Clinical Outcomes	Developing a governance process around mortality outliers	QPS Team and Information Manager currently drafting a Standard Operating Procedure for Mortality Outliers and investigation.	Information Manager, DDT and QPS Team	On-going
	Develop process for when to undertake a review of case notes	Develop a deep dive SOP to allow scrutiny of notes for review. This will help to interrogate the notes assessing for accuracy of coding and clinicians input for learning from deaths. This will include processes e.g. for MHLD deaths and suicide.		
	Mortality indicators not available to all	Once mortality indicators are agreed, the team will develop as a QLIK app to provide instant access to data.		

Pressure Ulcer Faculty – Introduction and Aims

The Health Board reported increased numbers of unstageable and grade 3&4 Health Acquired Pressure Ulcers (HAPU's). Divisions report data via the HAPU Steering Group and the Quality and Patient Safety Operational Group. The Executive Director of Nursing requested a new focus on reduction and prevention of HAPU's within ABUHB to meet the Welsh Government standard of 0% avoidable Health Acquired Pressure Ulcers.

Aim of the Faculty

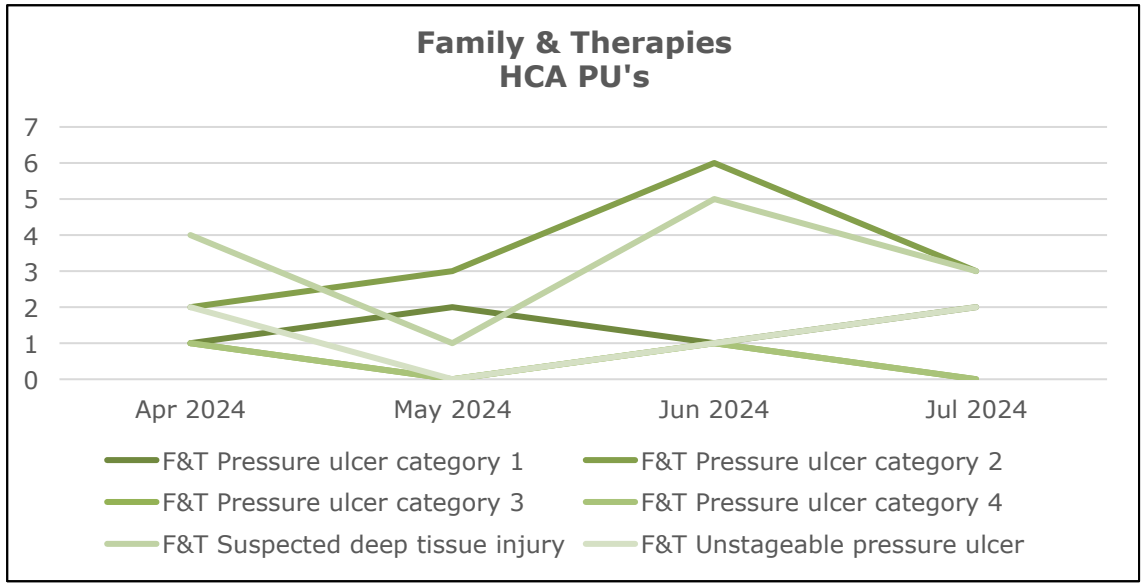
- Reduce HAPU incidences by 25% of baseline within 4 months from the commencement of the faculty.

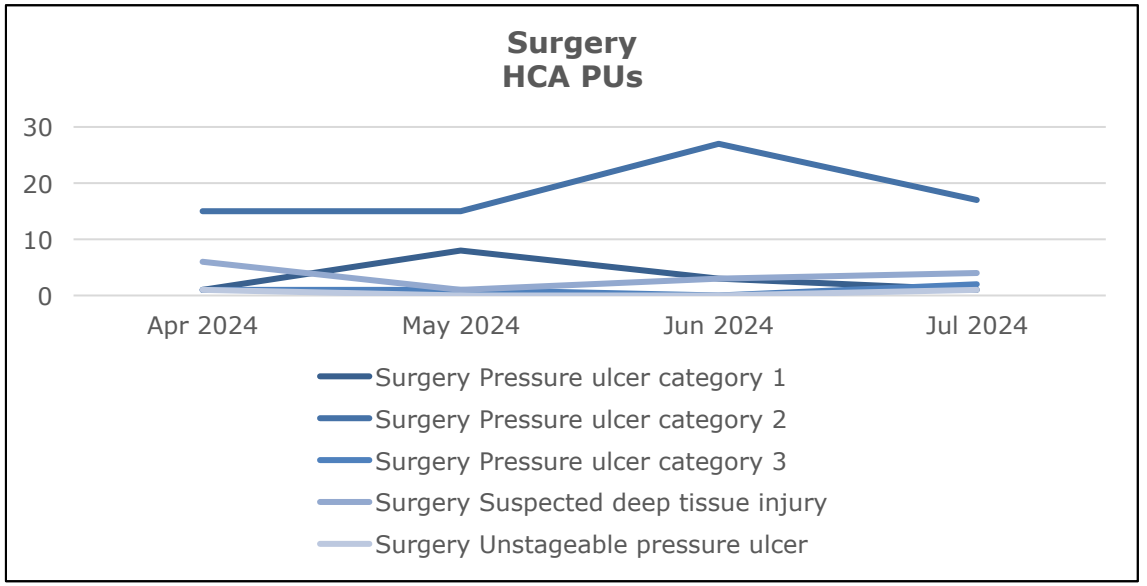
- Eradicate incidence of grade 3 & 4 avoidable HAPUs 4 months from the commencement of the faculty.

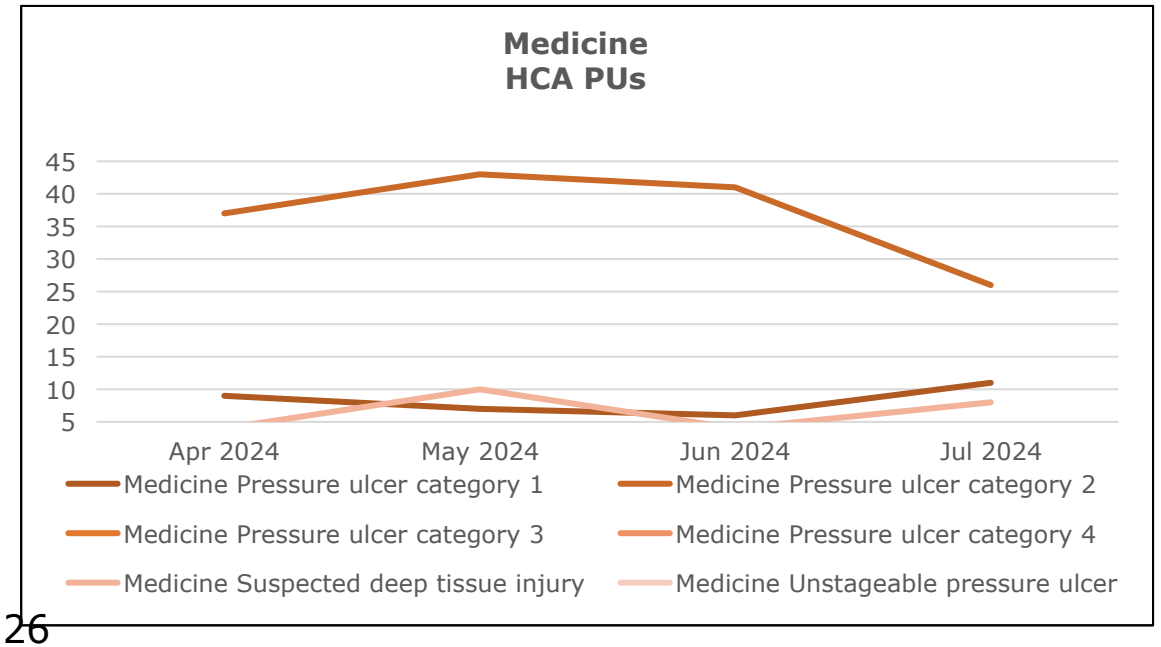
Update

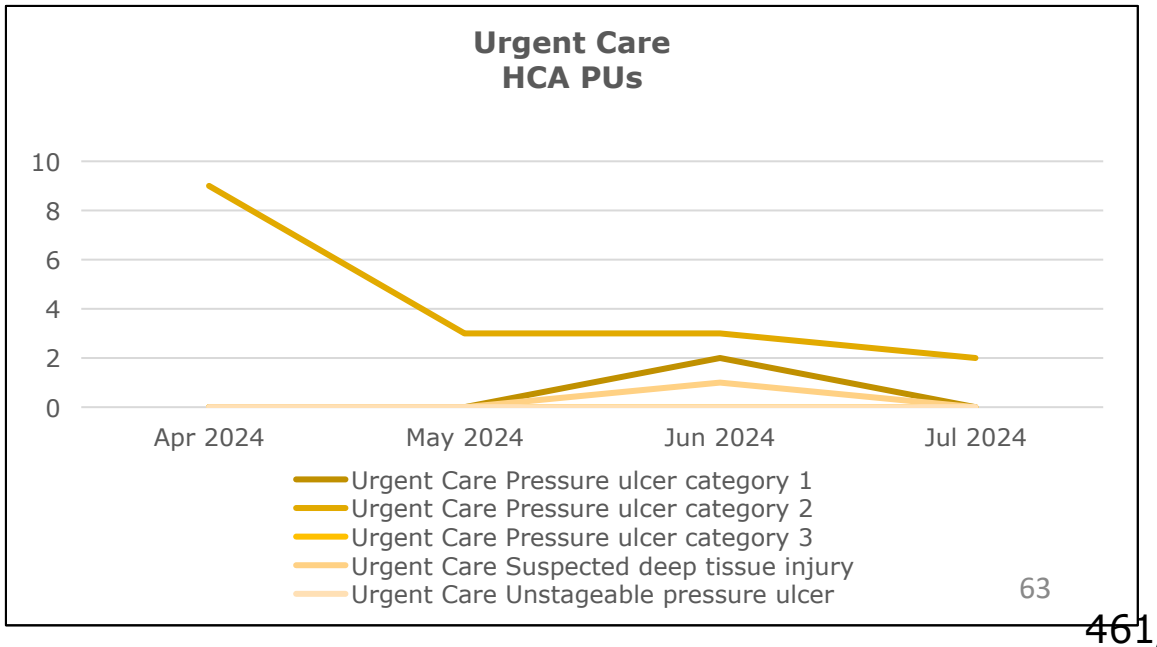
- The faculty continue to meet and now collect data for all Divisions.
- A driver diagram has been produced to look at change concepts.
- These change concepts are being implemented as part of the faculty following improvement methodology, supported by ABCi.

Health Acquired Pressure Ulcer Incidents by Division

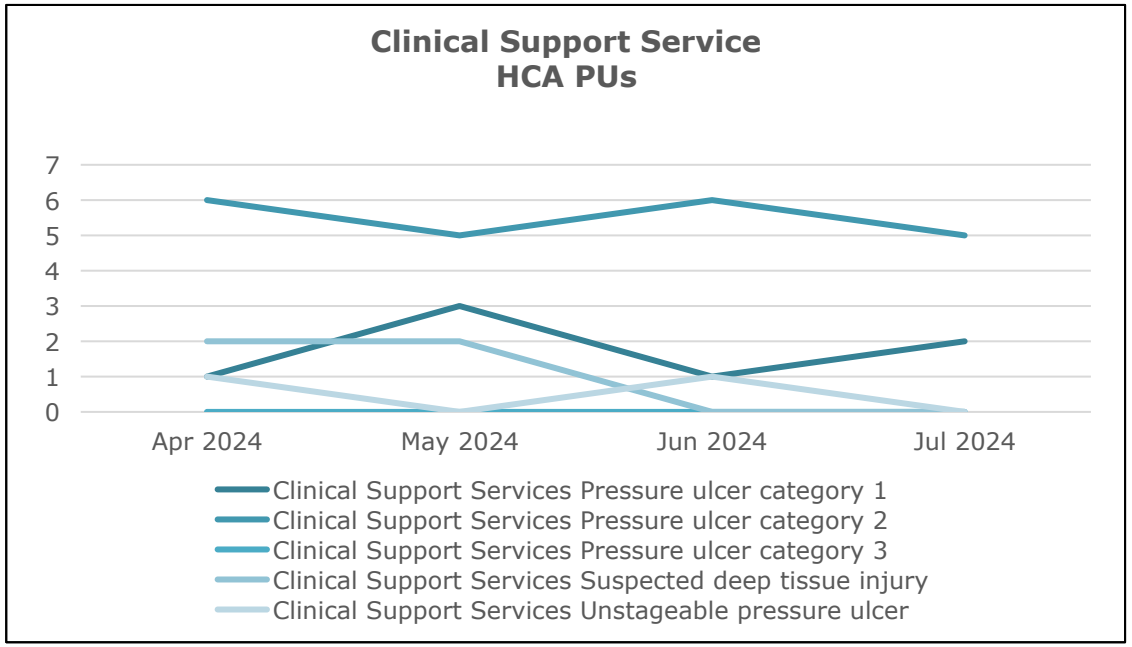


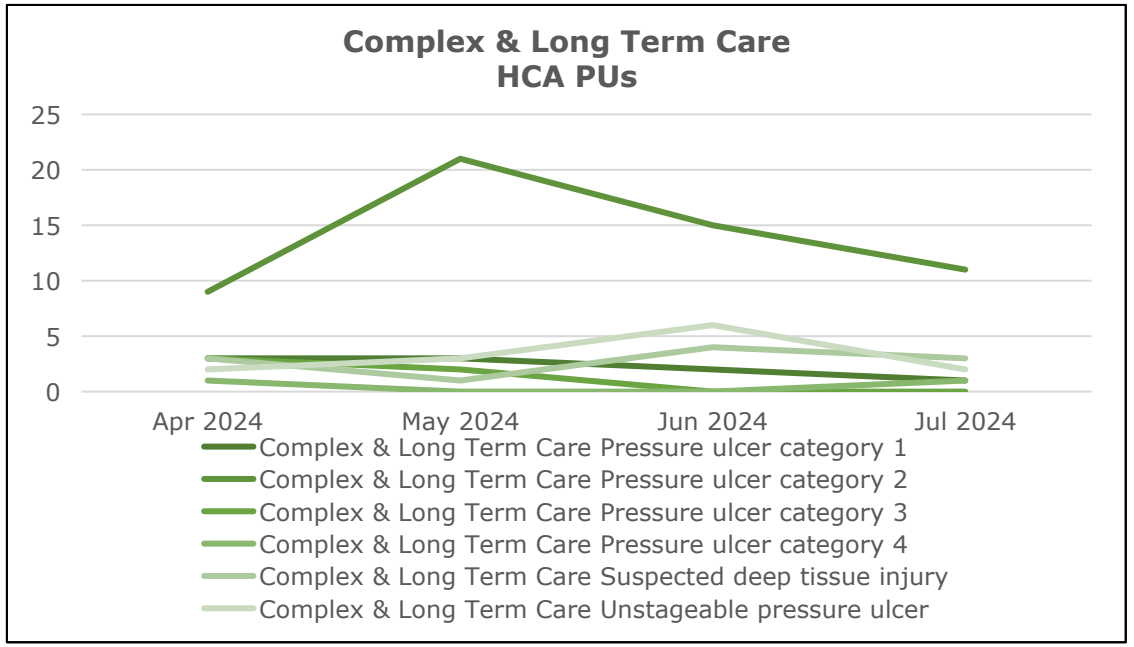


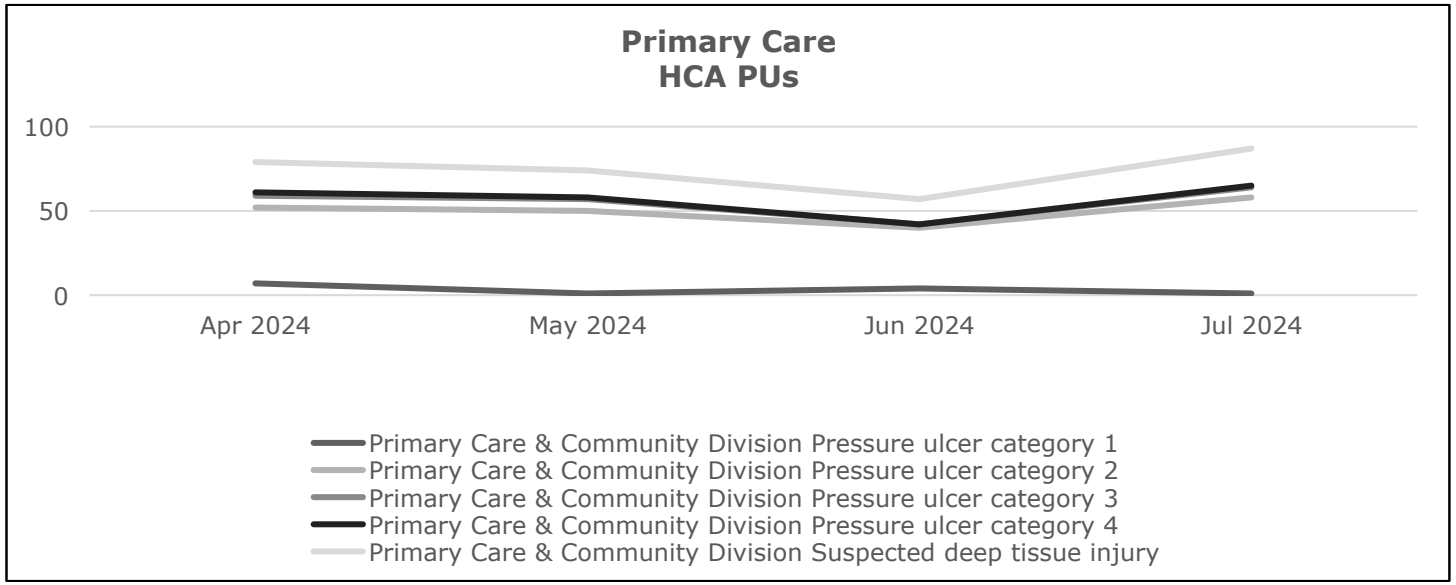




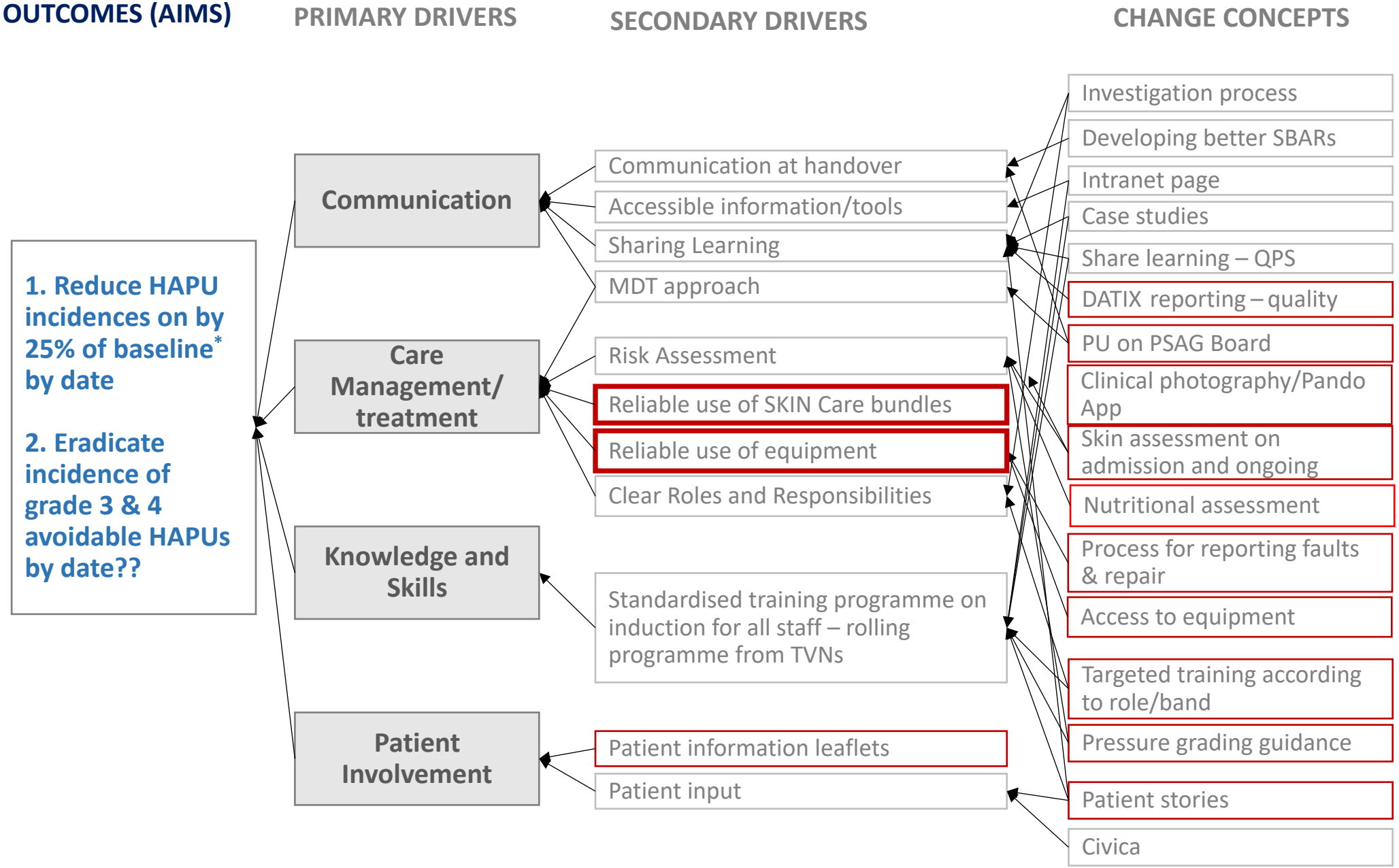
Health Acquired Pressure Ulcer Incidents by Division



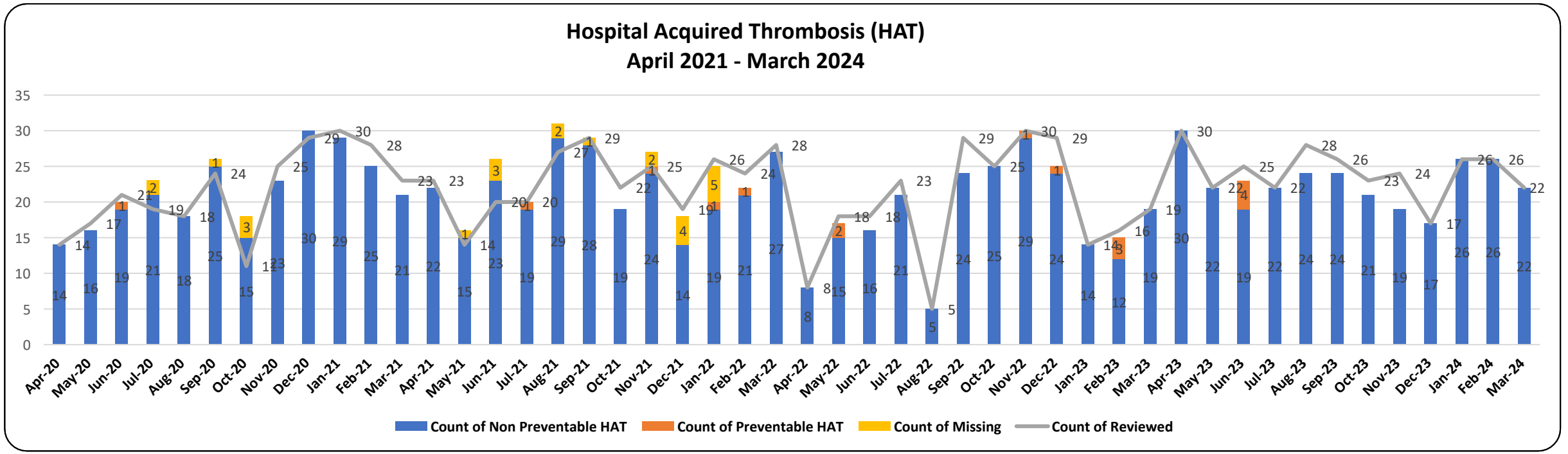


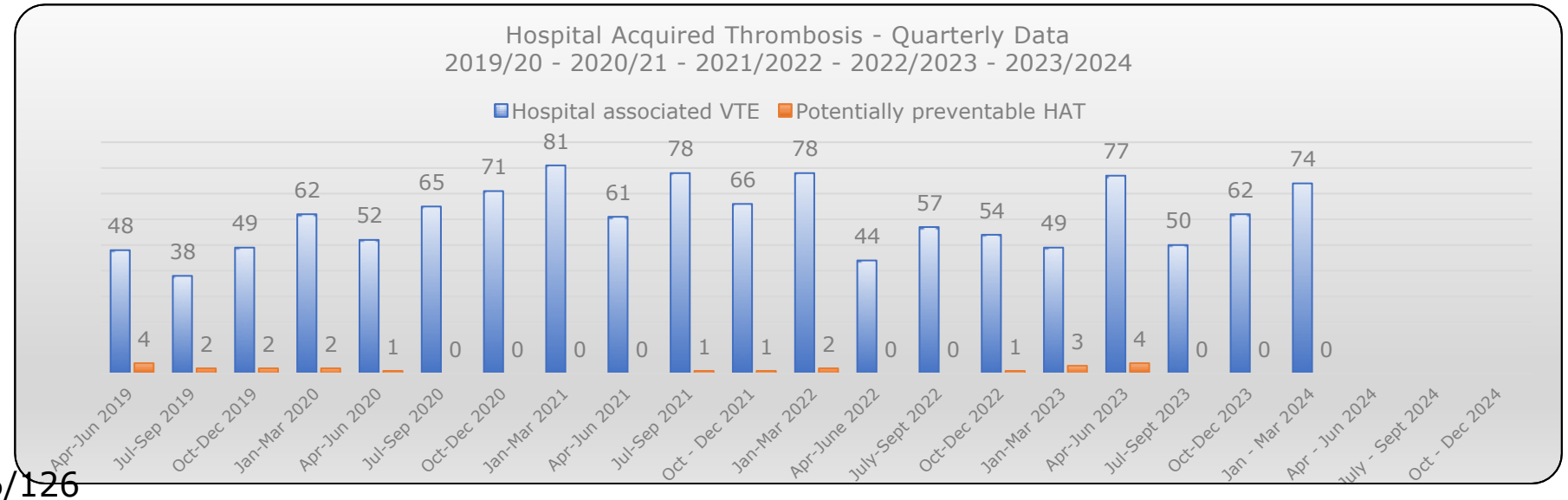


Pressure Ulcer Driver Diagram



Hospital Acquired Thrombosis (HAT)





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

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

Medical Safety Group (MSG)

Reporters View on Levels of Harm				
	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25
None	*194*	*187*	*174*	*210*
Low	*128*	*197*	*205*	*249*
Moderate	*60*	*77*	*57*	*55*
Severe	*7*	*8*	*12*	*14*
Catastrophic	*0*	*0*	*0*	*2*
Total	*389*	*469*	*448*	*530*

- Overarching report discussed at MSG to review Datix incidents of moderate severity and above and to consider learning and actions.
- Divisional exception report is produced for the Medicines Safety Group. This includes numbers of incidents related to medication errors. Reviews common themes and trends.
- Immediate learning within the Division and organisational learning is shared. Linking into the leaning framework and repository.
- Internal safety alerts related to medicines are reviewed and drug safety updates discussed.

Focused Outcomes

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

Medical Safety Group – Improvement & Learning

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

All Wales Patient Safety Solutions: Compliance Status

Alert	Compliance Deadline	Action to achieve compliance	Status
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	Sep-23	Has the deadline has not been met a SBAR has been completed to highlight the challenges, risks and planned work and mitigations with this notice. Work is still on-going.	In-progress

Health, Safety & Security – Learning and Improvement

Issue	Action	Learning and Improvement	Who	When
Manual Handling Training Compliance: the education and training requirements associated with manual handling presents a risk to staff & patient safety	• Implementation of a targeted training programme focusing on high risk areas i.e. patient handling • Review completed on the frequency of update training from 2 to 3 years • Local manual handling trainers to ensure they are competent to support the updates training • Consider additional resource in the Corporate Health and Safety Team to support the demands of delivering foundation training to new starters	• 76 manual handling foundation training courses planned for 2024/25, offering 929 spaces • Frequency of manual handling updates changed to 3 years and updated on ESR increasing Health Board compliance to 67% (at end of July 2024) • Review and cleanse of the local manual handling trainers. Currently 241 active trainers, however, 74 (30.7%) are overdue their update • The level of recruitment within the Health Board, including Bank presents demands that are not sustainable for the Corporate Team to manage with the current resourcing	Executive Director of Therapies & Health Science Head of Health, Safety & Fire Divisional Triumvirates	Ongoing
RIDDOR Reporting: the compliance with reporting to the HSE to comply with RIDDOR for 2023/24 was 67.7%	• Ensure timely incident management and investigation is undertaken to support early identification of RIDDOR reportable incidents • Monitor RIDDOR reporting compliance via the Health and Safety Committee	• 29 incidents were reported outside of the legal timeframe in 2023/24. Whilst this is progress on the 2022/23 performance further improvements are required to ensure timely reporting and investigation	Executive Director of Therapies & Health Science Head of Health, Safety & Fire Divisional Triumvirates	Ongoing
Health and Safety Risk Assessments: the failure to undertake suitable and sufficient risk assessments presents an issue to the Health Board	• Ensure competent risk assessors are available to undertake workplace health and safety risk assessments • Health and safety risks scoring 15+ to be reviewed and updated prior to the Health and Safety Committee planned for September 2024	• A programme of risk assessment training has been implemented • Health and safety risks to be regularly reviewed and updated to ensure the appropriate controls are implemented	Divisional Triumvirates	Ongoing

Priority 3: Timely Care

These measures are not currently available for Q1 2024/25 and will be refined as part of the new updated QOF.

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 3 Timely	Maximising and individuals time and outcomes	Decrease in the time from admission to surgery for emergency admissions	Q3 2023.24	30 hours	Q4 2024	34 hours	No change	Average time to theatre from Arrival/Admission continues generally around 30 hours aside from a period in October/November of 32-42 hours.
		Decrease in the time from surgery to discharge	Q3 2023.24	2.6 hours	Q4 2024	3 hours	No Change	Average time from leaving theatre to discharge has been mostly stable around 3 hours
		Decrease in time spent on a waiting lists	Q3 2023.24	34.16			Improved	Improving trend for our longest wating patients, ahead of plan for those waiting 156 weeks, emerging issues in ENT and Ortho spines with Divisional actions plans
		Decrease in the number of handovers >1 hour, monthly	Q3 2023.24	3353	Q4 2024	3549	Deteriorated	Number increased during the period
		Decrease in the time for patients to be seen by first clinician	Q3 2023.24	4.2 hours	Q4 2024	3.8 hours	Deteriorated	Trend has stabilised since Q2. Was improved in November but returned to normal in December.
		Decrease in the time for bed allocation from request	Q3 2023.24	7.5 hours	Q4 2024	8.4 hours	Deteriorated	Increase from September to November
		Decrease in ED waits >12hrs, weekly	Q3 2023.24	265	Q4 2024	241	No Change	No change
		Increase in discharges before midday;	Q3 2023.24	32%	Q4 2024	32%	No change	Improving indicator value, expected to see further improvement in Q3
		Decrease in the number of patients with a LoS over 21days	Q3 2023.24	563	Q4 2024	549	Improved	>21 days Occupancy is below normal trends
		Number of emergency admissions in hospital over 7 days	Q3 2023.24	354	Q4 2024	354	No Change	Increasing trend since Q1 2023, mainly patients moving from assessment units
		Decrease Overnight bed moves and patient transfers	Q3 2023.24	37.90%	Q4 2024	38.70%	Deteriorated	Increasing trend since Q1 2023, mainly patients moving from assessment units

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 3 - Timely	Maximising cancer outcomes	Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion	Q3 2023.24	60.10%	Q4 2024	62.20%	No change	Stable around 60%
	Improve Mental Health Resilience in Children and Young adults	Decrease in 4 week CAMHS waiting list	Q3 2023.24	86.2%	Q4 2024	100%	Improved	Indicator has improved significantly since last reporting period. National target of 80% remains achieved at 100% compliance.
		Decrease in neurodevelopmental (SCAN) waiting list	Q3 2023.24	29.9%	Q4 2024	34.3%	Improved	Indicator has gradually improved over the last 3 months by 14.7%. However, this remains below the IMTP target.
	Improved mental health resilience in adults	Increase in life satisfaction among working age adults	2021/22	79.50%	Data unavailable	Data unavailable		Reviewing measure
		Increase in percentage of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	Q3 2023.24	68.3%	Q4 2024	67.7%	No change	Measure has been sustained at similar level, with a slight decrease, between reporting periods.
		Increase in life satisfaction among older people	2022/23	85.50%	Data unavailable	Data unavailable	Improved	Increase in indicator over the last 3 financial years and remains above the all Wales average of 84.4%

Priority 4: Effective Care

To ensure reporting in this domain going forward, the QOF will be reviewed to have indicators that are reported in line with effective.

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 4 Effective	Reduced variation in Care	Increased Get It Right First Time (GIRFT) implementation plans by area						Reviewing measure
		Insert ward accreditation measures – to be confirmed						Reviewing measure
	Increased understanding of variation to focus Improvements	Increase in the SMART action plans with accountability in National Clinical Audit						Reviewing measure- see Clinical Audit slides
		Increase in the numbers of wards participating in accreditation (Audits via AMaT)						Reviewing measure- see Clinical Audit slides
		Increase in the actionable audit recommendations by National Clinical Audits						Reviewing measure- see Clinical Audit slides
	Improvement is part of the AB way	Staff Survey – increase in the score for staff being able to raise concerns						Reviewing measure
		Compliance the number of incidents triggering Duty of Candour within 5 days	No Data	No Data	No data	No Data	No Data	Reviewing measure
		QI projects outcomes (Non SCC)	No Data	No Data	No Data	No Data	No Data	Reviewing measure
		Outcomes of the SCP teams	No Data	No Data	No Data	No Data	No Data	Reviewing measure
	Improving Good Health in Pregnancy	Decrease in low birth weight rates	2021	5.10%	2022	6.10%	Deteriorated	Increase in indicator between 2021 and 2022. In line with the All Wales average. Next update due June 2024 (provisional).
		Decrease in stillbirths	2021	3.9	2022	4.5	Deteriorated	Increase in stillbirth rates between 2021 and 2022. 10% decrease in stillbirths observed over the last 5 years.
	Optimising a child's long term potential	Increase uptake in mothers breastfeeding (any breastfeeding)	Q2 2023/24	63.2%	No Data	No Data	Improved	Indicator value has improved by 7.3% between Q4 22/23 and Q2 23/24.
		Increase of eligible children measured and weighed at 8 weeks	Q3 2022/23	39.70%	No Data	No Data	Improved	Improvement in indicator over the last 4 quarters, however this remains significantly below the all Wales average.

For Information
Clinical Effectiveness

Audit Title:	National Oesophago-Gastric Cancer (NOGCA) Audit **State of the Nation Report** Data -1 Apr 2020 – 31 Mar 2022 Published January 2024	Clinical Lead: Miss Tamsin Boyce, Consultant, Surgery
Rationale:	NOGCA is commissioned by Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP).	
Objectives:	It aims to promote quality improvement in patient outcomes, and to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales.	
Presented at Clinical Standards and Effectiveness Group 23rd May 2024		

Upper GI cancer treatment is not delivered in ABUHB. Treatment centralised within Cardiff and Vale UHB (CVUHB). Radiotherapy undertaken at Velindre Cancer Centre (VCC). The Health Board is only responsible for the front end of the patient pathway. Referral to Treatment times (RTT) has increased over the last 10 years due to improved staging and diagnostics as well as an increase in demand.

	ABUHB	National
Patients diagnosed after an emergency admission (lowest rate in Wales SBUHB 20.4% & CVUHB 21.6%)	14.1%	13.1%
% of patients who waited >62 days form urgent referral to 1st treatment	83.3%	
Patients having a treatment plan for curative treatment	32.4%	37.2%
Patients having a treatment plan for non-curative treatment	67.6%	62.8%
Patients with non-curative plans having chemotherapy or radiotherapy	42.8%	34.7%

100% of ABUHB patients completed Radiotherapy

Key Success and Concerns

Report Successes:	
1	Doing well with CT Staging, (96.9%) higher than the national rate.
2	Of the patients with a plan for non-curative treatment, 42.8% are having chemotherapy or radiotherapy, nationally this is 34.7%.
3	With higher diagnosis rate in the Health Board compared to the rest of Wales, the Health Board maintained face to face contacts and MDT's during the pandemic.
4	Lower rates of diagnosis after emergency admissions than other organisations across Wales, although not as good at the UK national rate. ABUHB 14.1% v National 13.1%.
5	Straight To Test endoscopy CT scans done same day if applicable.

Report Concerns:	
1	Lower rates of patients having a plan for curative treatment than the national rate, the Health Board being 32.4% and nationally 37.2%.
2	The Health Board has a lower rate for patients having a plan for non-curative treatment at 67.6% compared to nationally 62.8%
3	Increase in RTT 62-day measure, form 80 days in 201/-2020 to 82.5% in 2020/2022.

Assurance Level

Limited - The project did not achieve the standards or criteria being audited against

Risk Level

Major - Non-compliance with national standards/Significant risk to patients if unresolved

Not on Risk Register within the Health Board as much of the pathway is outside of the Health Boards control - Upper GI cancer treatment delivered in CVUHB and radiotherapy in VCC.

	Report Recommendations:	S.M.A.R.T Actions: Responsible: Due Date: Progress:
1	Cancer Alliances and Wales Cancer Network should review patient pathways in their region to identify opportunities to intervene and reduce high and variable rates of diagnosis following emergency admission and late-stage diagnosis. *Action by*: Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Ongoing work across Wales (National Optimal Pathway) to reduce late-stage diagnosis.
2	Review oesophago-gastric (OG) cancer care pathways against best practice guidance to identify ways to reduce the proportion of patients with OG cancer waiting more than 62 days from urgent referral to first treatment. *Action by*: Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Ongoing work with National Optimal Pathway. Update to Service Level Agreement (SLA) in progress and obtain 2022/2023 data to see accurate performance
3	Explore reasons for non-completion of palliative chemotherapy regimens, including review of patients with OG cancer who died within 90 days of starting treatment, and review patient selection for palliative chemotherapy where appropriate. Action by: Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Specialist OG dietician already present in clinic, there is definitely the workload for further input, there is also OG Dietetic cover in the MDT.

	Report Recommendations:	S.M.A.R.T Actions: Responsible: Due Date: Progress:
4	Given the often profound impact of OG cancer on patients' nutritional status, Cancer Alliances and Wales Cancer Network should review specialist dietetic provision across their region, and ensure OG cancer units are resourced according to national specifications to ensure that all patients have access to appropriate dietetic input. *Action by*: Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Specialist OG dietician already present in clinic, there is definitely the workload for further input, there is also OG Dietetic cover in the MDT.
5	In Cancer Alliances with low rates of active treatment for high-grade dysplasia (HGD), review reasons for non-treatment and determine if more patients with HGD could be eligible for endoscopic therapy Action by: Cancer Alliances	Numbers are so small it is difficult provide a comment. There have been issues, 2 patients delayed pathways for HGD due to uncertainties regarding funding. This is delivered by Cardiff and not specifically covered in the SLA. This caused delays in treatment resulting in more advanced disease at treatment. This has since improved, and processes are less complicated and protracted. Long term funding and workforce remains fragile.

Audit Title:	State of the Nation Report 2024 An audit of care received by patients diagnosed with Lung Cancer in England and Wales during 2022 National Lung Cancer Audit (NLCA)	Clinical Lead: Dr Mat Jones Medical Consultant
Rationale:	Aim of NLCA is to evaluate the patterns of care and outcomes for patients with lung cancer in England and Wales. To support services to improve the quality of care for these patients.	
Objectives:	Management of patients with lung cancer is informed by various national guidelines. The NLCA evaluates current patterns of care against standards. These standards were defined in publications from: The National Institute for Health and Care Excellence (NICE) QS17, Roy Castle Lung Cancer Foundation's national commissioning guidance, the National Optimal Lung Cancer Pathway and the 2022 "Getting it Right First Time" (GIRFT) report. The NLCA has developed a set of indicators to reflect these and encourages healthcare professionals to review the findings of this report and to understand why unwarranted differences in practice exist.	
Presented at Clinical Standards and Effectiveness Group – 23rd May 2024		

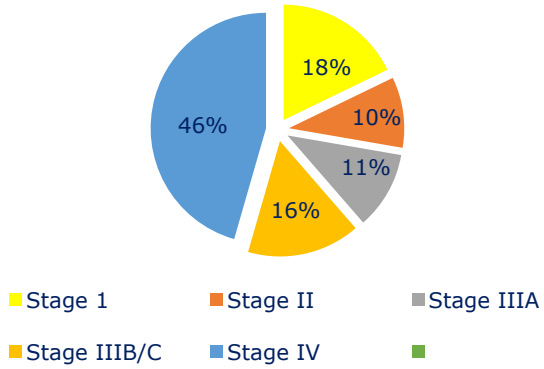
The Health Board has the largest number of patients with 100% data quality on key data items:

- 100% for basis of diagnosis,
- 100% for tumour morphology,
- 100% for disease stage, and
- 100% for performance status.
- 100% of records had data on whether a lung cancer nurse specialist was present at diagnosis.

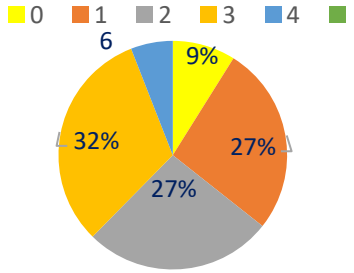
There are two cohorts: a) Small Cell Cancer – 12%, b) Non-Small Cell Lung Cancer (NSCLC) – 88%. There are 5 stages of disease:

- Stage I – 18%
- Stage II – 10%
- Stage III – 27%
- Stage IV – 46%

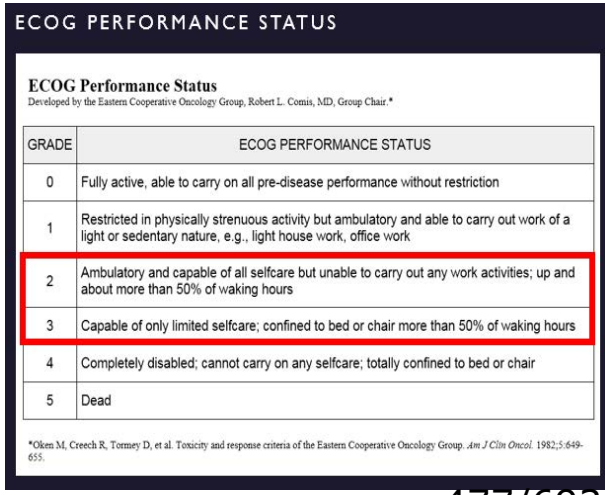
Unfortunately, the highest numbers are in the late stage of lung cancer disease due to late presentation or being asymptomatic at the time of detection.



There are 4 Performance Status (PS) levels, which is based on patients' daily capabilities from independent to bed bound. Low numbers present with a low PS.

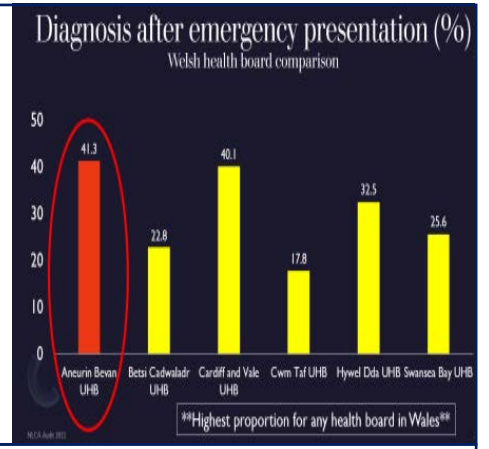


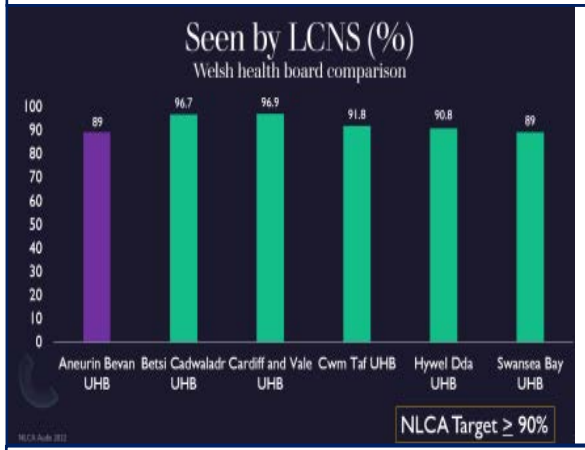
ABUHB Performance status (per cent of known values)



- The Health Board has a lower proportion of PS 0/1 compared to All Wales data, above the average proportion of patient in PS 3 & 4, 38% compared to 35.3%. These are not often suitable for curative treatments and more suited to palliative management as have higher rates of co-morbidities with increased risk of side effects from treatments. This ultimately impacts the HB treatment rates. PS 2 for the Health Board is 27% compared to Wales mean of 23.5%.
- Patients with Stage I/II with PS 0-1 - Confirmed pathological staging NLCA target is >90% within the Health Board was 89.4% (74.5% in 2021) compared to a Wales mean of 89.1%.
- NSCLC patients having surgical resection NLCA target > 17%, the Health Board 15.5% (adjusted for co-morbidities and deprivation), increased from 10.9 & in 2021 and above the Wales mean of 14.3%. In NHS England this is around 18% due in part to increased diagnosis at the early stage through lung cancer screening which is not yet carried out across Wales outside of a pilot Lung Health Check in CTUHB. Ambitions should be to achieve 20%.
- NSCLC patients Stage I/II with PS 0-2 having curative treatment is not always possible due to many factors. These include patient choice, co-morbidities, deterioration during investigation and factors relating to the tumour. The NLCA target >80%, the Health Board rate is 77.9% and improved from 2021 (66.7%) and higher than the Wales mean of 75.8%.
- For SCLC (more aggressive tumours) patients having chemotherapy ,the Health Board treatment rate was 50% in 2021 and in 2022 increased to 61.7% compared to Wales mean of 71.2%. The NCLA target is set at >70%. The Health Board had a high proportion of patients, 47 in total, which was 12% of our whole cohort who presented with small cell cancer. This is a higher-than-average proportion, and these patients are very challenging, often very co-morbid and often present through hospital and emergency settings.
- For NSCLC patients Stage IIIA with PS 0-2 (more advanced disease associated with further spread to Lymph Nodes) the Health Board is pushing boundaries with regards to cancer management. For those achieving curative treatment in this group, the Wales mean is 59.3% with the Health Board achieving 57.1% in 2022 compared to 31.7% in 2021, possibly linked to the pandemic and restriction in treatments during that time.
- NSCLC patients Stage IIIB/IV with PS 0-1 (advanced disease spread to outside the lung) having Systemic anti-cancer treatments (SACT) improved from 2021 rate of 56.6% to 57.8% in 2022 with a Wales mean of 61.8%. This suggests that people are potentially being missed due to challenges such as pathology waiting times and being reliant upon oncology services outside of the Health Board.

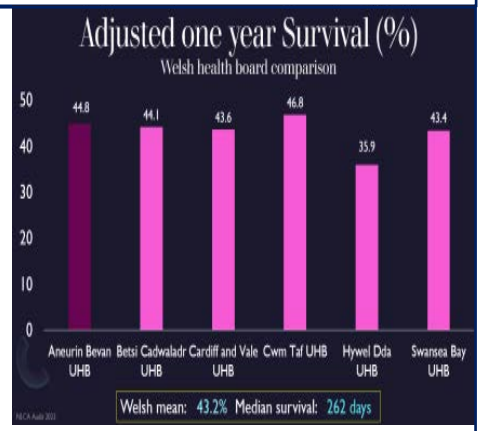
The Health Board has the highest proportion of diagnosis after emergency presentation across Wales with 41.3% presenting in this way, which was interesting compared to the emergency admission rate for NOGCA. However, lung cancer patients generally present with a higher bulk of disease, more co-morbidities, advanced age and poorer PS status when they present in this way. In England, emergency presentations are reduced due to the screening programme. Last year's data was low at 6.3%, but the data was inaccurate and since then the data recording has been managed carefully to ensure the data was robust this year.





The NCLA target for patients being seen by a Lung Cancer Nurse Specialist (LCNS) is 90% and the Health Board is at 89%. This is an improvement on the previous year's data however this is impacted upon by patients presenting as an emergency. This is being addressed to try and bring LCNS into seeing inpatients, to support patients and aid decision making, as the LCNS are pivotal in the management of lung cancer patients and without them the service would not be able to run efficiently. There are plans to develop the LCNS roles going forward.

Looking at how all this impacts patient survival, we know that lung cancer outcomes have been poor in recent years, and with developments in detection and treatments, survival rates have increased. In the Health Board although 1 year survival is still low at 44.8% it is above the Welsh mean at 43.2%, second only to Cwm Taf UHB who do have a screening programme at pilot stage, which may be impacting on survival outcomes. The Welsh median survival in days is 262 which is less than England 327 potentially due to the emergence of screening and reduced deprivation indices as a whole. The chart demonstrates the survival associated with disease stage, highlighting the importance of early detection.



Successes
Introduction of Physician of the week to prioritise lung cancer patients
Improved curative rates for early-stage disease and excellent pathological confirmation rates for early-stage disease and good PS.
More patients with SCLC having chemotherapy
Large increase from 31.7% to 57.1% of NSCLC with stage IIIA and PS 0-2 receiving curative treatment.
Lung Cancer Nurse Specialist input very good with plans to seen inpatients.
Adjusted one year survival rate is second best in Wales at 44.8%.

Concerns
Below target treatment rates for surgical resection in NSCLC, SCLC chemotherapy and NSCLC advanced stage good PS treated with SACT (but all improved from 2021). Concerning numbers presenting as emergency admissions.
Many of the HB patients have high PS and present with advance disease making curative treatment less viable.
Surgical resection rates are under target, although have improved since 202, under the 17% target set by NLCA.
High rate of emergency presentations (41.3%).

Key Messages ABUHB compared to Wales	Wales (n=2211)	ABUHB (n=400)
Curative treatment rates of NSCLC patients with stage I/II and good performance status (0-2)	76.2%	77.9% ↑
Curative treatment rates of NSCLC patients with stage IIIA and good performance status (0-2)	61.2%	57.1% ↓
Surgical resection rate (adjusted) for patients with NSCLC	14.3%	15.5% ↑
Proportion of patients with lung cancer diagnosed after an emergency presentation	29.4%	41.3% ↑
Proportion of patients seen by a Lung Cancer Nurse Specialist	92.4%	89% ↓
Use of systemic anti-cancer therapy for stage IIIB/IIIC–IV NSCLC patients (PS 0–1)	60.1%	57.8% ↓

Conclusions

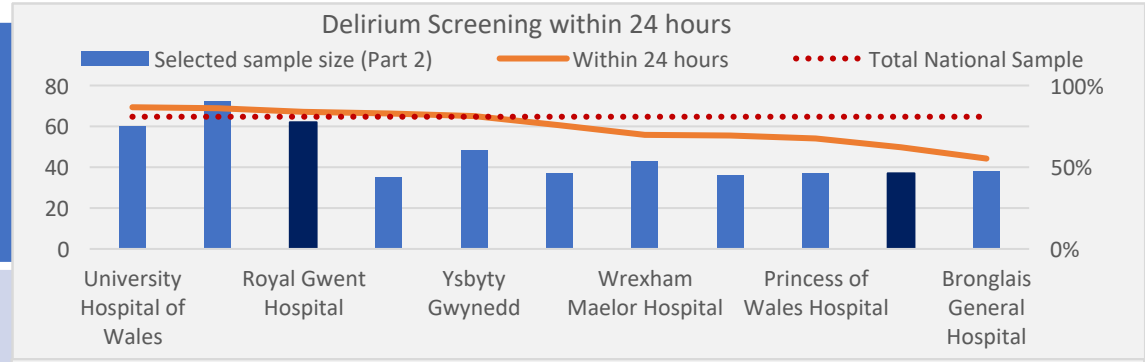
- The ABUHB lung cancer service diagnoses 400 cases of lung cancer per annum [>1 per day]
- The service also deals with abnormal imaging, large numbers of suspected malignancy and metastatic disease
- It is an expanding service with ever changing challenges including a population with severe co-morbidities/ frailty
- Improving indices compared to 2021 data
  - Better curative rates for early-stage disease
  - Excellent confirmation pathological confirmation rates for early stage, good performance status (PS)
- Below target treatment rates for surgical resection in NSCLC, SCLC chemotherapy and NSCLC advanced stage good PS treated with SACT (*but all improved from 2021)*
- Concerning number presenting as emergency admissions – more advanced disease, frailty

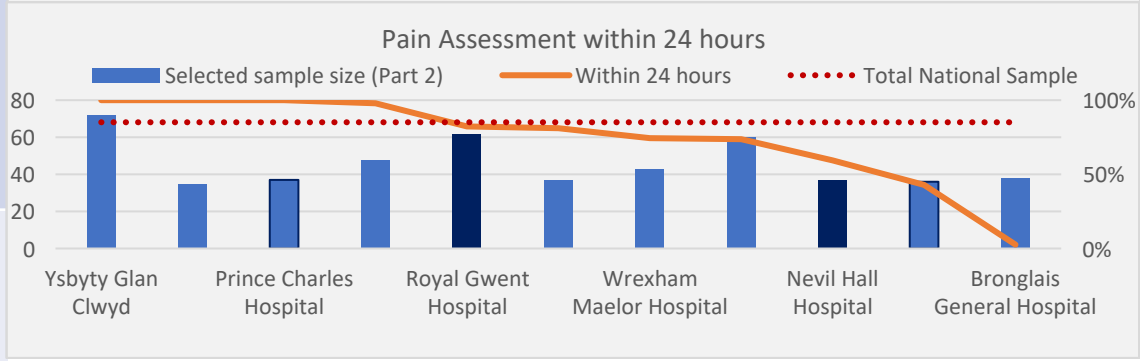
	Report Recommendations:	Progress:
1	Ensure services are implementing targeted lung cancer screening for people aged 55 to 74 who are at high risk of lung cancer.	Lung Health Check Pilots No imminent HB plans
2	Ensure providers have thoracic surgery capacity to meet both current demand for curative surgery and to accommodate the increase in activity caused by the national rollout of the Targeted Lung Health Check programme. Wales: 14% of NSCLC patients diagnosed in 2022 had a lung resection, compared with 16% in 2019	Surgical resection rate below NLCA target No issues with access – but waiting times >4 weeks
3	Ensure NHS hospitals have the necessary resources and capacity (1) to reduce the proportion of patients waiting more than 21 days from diagnosis to first treatment, and (2) for biomarker testing and the timely delivery of results for patients considered for systemic anti-cancer therapy (SACT) Wales: For patients with stage IV NSCLC, the median time from diagnosis to SACT was 52 days (47 days in 2021). For patients with SCLC, the median was 21 days (16 days in 2021).	Ongoing oncology and surgical delays Improved pathological services – PD-L1 in-house from next month, QuicDNA ctDNA project pioneers
4	Ensure at least 70% of patients with NSCLC stage IIIB-IVB and PS 0-1 receive systemic anti-cancer therapy (SACT) in line with NICE guidance. Wales: 60% of patients with NSCLC stage IIIB-IVB and PS 0-1 had SACT, increased from 57% in 2021 - ABUHB: 57.8%	SACT for advanced stage disease below NLCA target Complex patients, frail, multi-morbidity, patient choice
5	Aim to achieve high levels of data completeness in the cancer registration datasets, particularly the Rapid Cancer Registration Dataset and Cancer Outcome and Services Dataset (COSD) in England. Wales: Completeness of data was excellent overall, 98-100%, in key data items (97-100% in 2021)	The only Data Quality measure that the Health Board is not meeting is Morphology (all Patients) 69% Likely transposition error – rates of NSCLC not specified (NOS) remains small

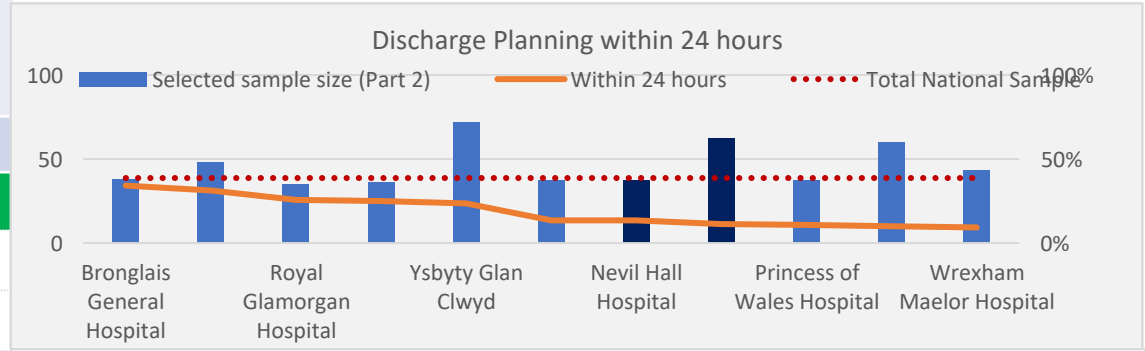
Audit Title:	National Audit of Dementia (NAD) Care in General Hospitals 2022-2023 Round 5 Audit Report **Published August 2023**	**Clinical Lead: Dr Inder Singh** **Site Leads:** **Dr Sheriff (RGH)** **Dr Subhan (YYF)** **Dr Adel (NNH)**
Rationale:	Report presents results of the 5th round of the NAD. Improving dementia care remains a key national priority for health services in England and Wales, highlighted in the Prime Ministers Challenge on Dementia 2022 and the Welsh Government Dementia Action Plan. An extremely high proportion (92%) of eligible hospitals participated in this important audit once again. For the first time the audit was undertaken prospectively, enabling hospitals to take earlier action to improve patient care and experience.	
Objectives:	NAD measures the performance of general hospitals in England and Wales against standards relating to care delivery which are known to impact people with dementia while in hospital. Standards include NICE Quality Standards and guidance, the Dementia Friendly Hospitals Charter, and reports from the Alzheimer's Society, Age Concern and Royal Colleges. Standards are updated for every round of audit.	

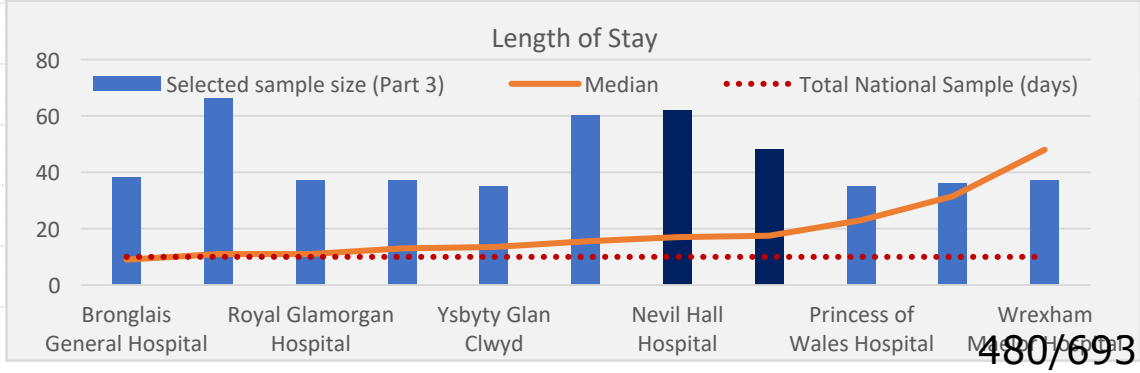
Presented at Clinical Standards and Effectiveness Group – 23rd May 2024.

Key Metrics National Round 5	National	RGH	NHH	YYF
% Delirium screen (inc. noted on admission)	87%	98%	70%	94%
% Pain assessment	92%	100%	69%	82%
% Pain reassessment	92%	100%	59%	22%
% Pain tool – question only	61%	0%	100%	100%
% Initiation of discharge plan in first 24 hours*	45%	11%	14%	19%
Carer rating overall care quality	66%	100%	75%	85%
Carer rating communication	60%	67%	72%	88%









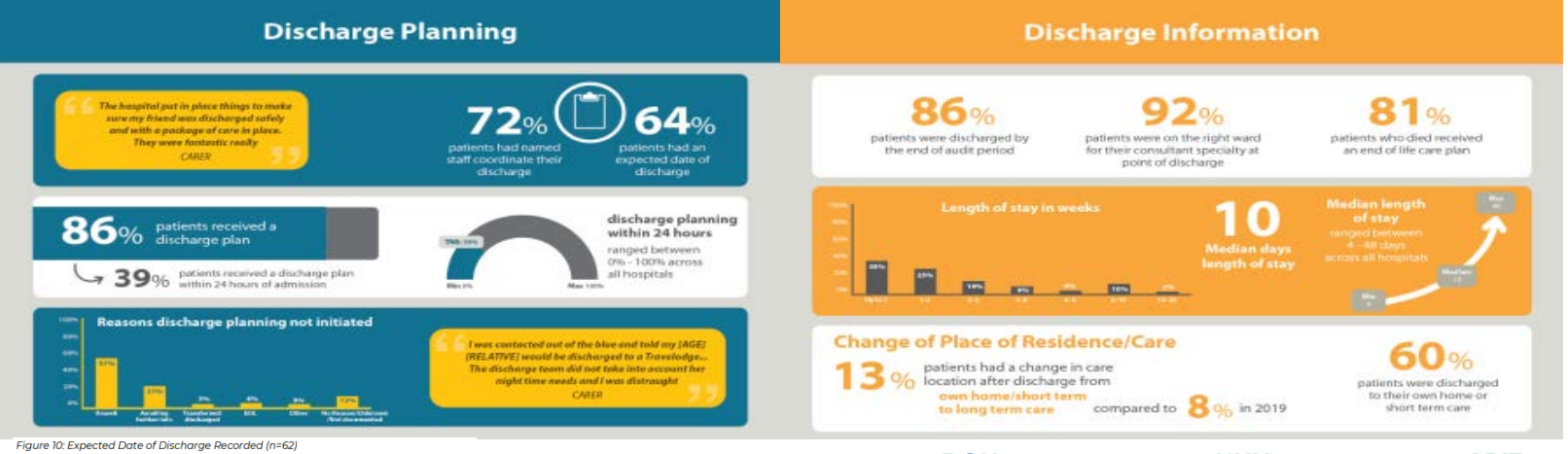
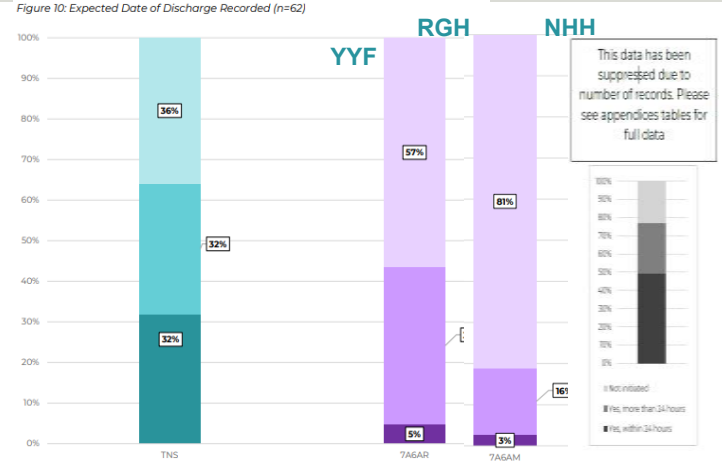
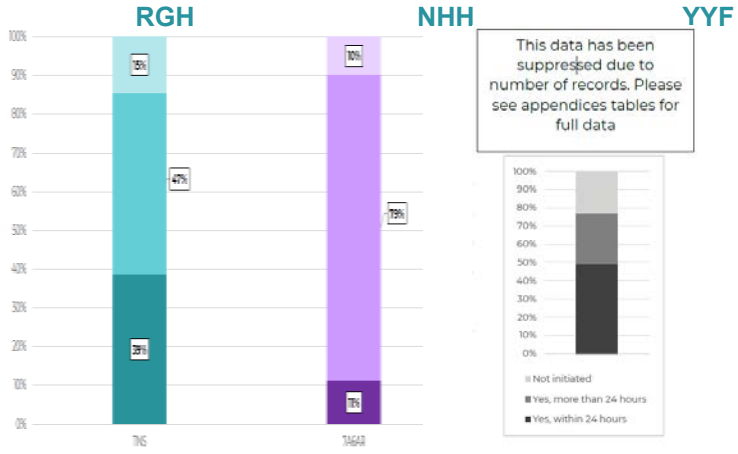


Figure 10: Expected Date of Discharge Recorded (n=62)





Assurance level	
Limited	The project did not achieve the standards or criteria being audited against

Risk level	
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Not in risk register as actions and improvement work remain ongoing

Discharge Information RGH

National R5 Median Length of Stay (days):	7A6AR R5 Median Length of Stay (days):
10	17

National R5 Patients discharged by end of audit period:	7A6AR R5 Patients discharged by end of audit period:
86.4%	88.7%

National R5 Patients were on the right ward:	7A6AR R5 Patients were on the right ward:	National R5 Patients who received an end of life care plan:	7A6AR R5 Patients who received an end of life care plan:
92.5%	88.7%	80.6%	100%

NB. EOL care plan information was only collected for patients who died during admission

Discharge Information NHH

National R5 Median Length of Stay (days):	7A6AM R5 Median Length of Stay (days):
10	13

National R5 Patients discharged by end of audit period:	7A6AM R5 Patients discharged by end of audit period:
86.4%	45.9%

National R5 Patients were on the right ward:	7A6AM R5 Patients were on the right ward:	National R5 Patients who received an end of life care plan:	7A6AM R5 Patients who received an end of life care plan:
92.5%	100%	80.6%	83.3%

NB. EOL care plan information was only collected for patients who died during admission

Discharge Information YYF

National R5 Median Length of Stay (days):	7A6AV R5 Median Length of Stay (days):
10	33

National R5 Patients discharged by end of audit period:	7A6AV R5 Patients discharged by end of audit period:
86.4%	64.3%

National R5 Patients were on the right ward:	7A6AV R5 Patients were on the right ward:	National R5 Patients who received an end of life care plan:	7A6AV R5 Patients who received an end of life care plan:
92.5%	100%	80.6%	66.7%

NB. EOL care plan information was only collected for patients who died during admission

Report Successes:	
1	Pain Assessment and re-assessment in RGH at 100% and YYF pain assessment 82%
2	Delirium Screening noted on admission - RGH 98% and YYF 94% compared to national 87%

Report Concerns:	
1	Expected discharge date (EDD) - RGH - 5% within 24 hours, 39% more than 24 hours, 57% initiated NHH - 3% within 24 hours, 16% more than 24 hours, 81% not Initiated - difficulties with EDD due to patient complexities and delays in social measures YYF - not enough data to analysis
2	Pain Assessment NHH 69% (outlier notification received for NHH data)
3	Lack of use of the Abbey Pain Score tool
4	Discharge planning not carried out within 24 hours for RGH and not completed in NHH - lack of data for YYF
5	Length of Stay median: RGH 17 days, NHH 13 days, YYF 33 days
6	Pain re-assessment for YYF 22%
7	Delirium Screening NHH - 70%

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	•Progress:
Carer feedback	Improve Carer questionnaire completion across the HB	Use the teams currently across the wards (volunteers, PALS etc.) to encourage the carers to complete the questionnaire	Sonya Foley	31/03/2024	
End of Life	End of life care for patients with Dementia	Regular teaching sessions for doctors and nurses across all sites, by palliative care team – Dr Subhan has discussed this option with Palliative Care Consultant. Palliative care team is interested to provide this focused teaching as part of their palliative care teaching	Dr Subhan	31/03/2024	Ongoing

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date/Progress:
1	**Integrated Care Boards/Welsh Government should seek assurance from Trusts/Health Boards regarding their actions and progress with recommendation one.**	Reported to Clinical Standards and Effectiveness Group and Patient Quality and Safety Group	Dr Inder Singh	Ongoing
2	**<u>Comprehensive pain assessment</u>** **The National Report recommends the Medical Director and Chief Nurse should ensure that staff are trained and supported in the use of appropriate tools for comprehensive pain assessment (e.g. e-lfh Pain Management Programme)** **This should include:** • Understanding the need for structured pain assessment. • How pain interacts with symptoms of dementia, and that people with dementia may not articulate pain. • The regular use of an appropriate pain tool for assessing people with dementia on the ward.	Need to introduce and improve structure pain assessment across HB sites (use of the ABBEY if clinically indicated) Link with Education team to review current training	Dr Inder Singh, Sue Pearce (Divisional Nurse), Amanda Whent	Ongoing

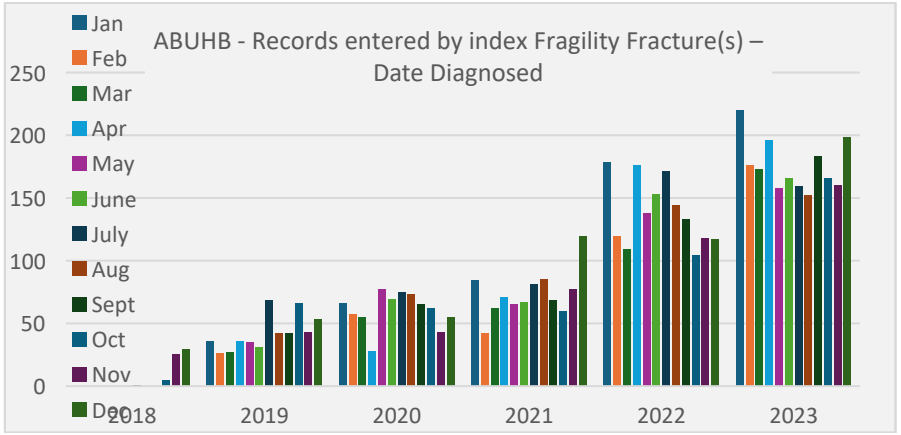
Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
3	The Chief Executive Officer should ensure that the Trust/Health Board has a nominated Board member responsible for dementia in addition to the clinical lead, whose responsibilities will include: • Establishing and implementing hospital systems capable of 1) identifying people with dementia admitted to the hospital and 2) showing the proportion of people with dementia affected by falls, delayed discharges, readmissions, pressure ulcers and incidents of violence/aggression, so that accurate figures may be supplied to NHS England Emergency Dashboard and other national dashboards. • Monitoring the proportion of ward-based staff who have received Tier 2 level training in dementia, and assessing the impact this has on quality of care, as experienced by patients and carers. • Scrutinising feedback from patients and carers and reports of NAD. • Tabling the Trust/Board Annual Dementia Statement for review. • Providing regular reports to the Integrated Care Board/Welsh Government relating to the appropriate governance and monitoring of care of people with dementia. • Developing action plans based on areas identified for improvement in care and patient experience, including ensuring that personal information about their care preferences and needs has been gathered and is available at the bedside; regular review of the environment against "Dementia Friendly" criteria using a standardised tool (e.g. Enhancing the Healing Environment, The King's Fund (kingsfund.org.uk); Patient-Led Assessments of the Care Environment (PLACE) – NHS Digital)	Dementia alert on CWS in practice and currently linking with Improvement Cymru in establishing a benchmark (once achieved CL will be establishing other metrics inc. IP Falls) Dementia training and awareness is ongoing. Good Work Learning and Development Framework level 1. • Informed level 86% on ESR • Skilled level bi-annual reporting to WG • Influencer level presenting on boards, meetings and conferences Feedback review is led by Sue Pearce. Dr Singh and Amanda Whent report to the Board Dementia care plan and environment – Sue Pearce and Amanda Whent	Dr Inder Singh – Clinical Lead Amanda Whent – Dementia Lead Nurse Sue Pearce – Senior Divisional Nurse	6 months	All ongoing

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
Dementia alert	To promote the use of dementia alert (136) in Welsh PAS (Myrddin)	• Promote Ward Clerks entering the Dementia Code (136) into WPAS	Sue Pearce	31/08/2024	Ongoing
Delirium screening and care plan	ABUHB - Quarterly point prevalence audit for the duration of 1 week on assessed for Delirium screening on patient with Dementia	• To provide LoS on the Delirium Audit carried out quarterly • Review the if diagnosis of delirium also have dementia and assess for:- EDD was established, DC planning commenced within 24 hrs, and time (total number of days) away from home.	Dr Singh Dr Singh	31/08/2024 31/08/2024	Ongoing Ongoing
	Improve nursing attendance and engagement with Delirium training – SQID, 4AT	• Continuing with Delirium teaching every 8 weeks (led by Dr Z Subhan) – target audience doctors, staff nurses, HCSW • Involve senior nurses for individual sites to encourage nurse attendance • To deliver focused delirium teaching (SQID) in the ward settings – Dr Subhan to explore this with senior nurses	Kertrina Collins, Natalie Webb, Helen Price Dr Subhan Dr Subhan	31/08/2024 31/08/2024 31/08/2024	Ongoing Ongoing Ongoing
	Measure the outcome of Delirium teaching and training	• Encourage Delirium Champions from each ward in YYF, who will help with the teaching and training for the nurses • A QIP on Delirium Time Bundle has already commenced – to complete the first cycle and present the result to the stakeholders • Delirium training attendance certificate to help with re validation - using AMaT certificate function	Dr Subhan Joanne Stimpson	31/08/2024 Ongoing	Ongoing Ongoing
	Measure the outcome of Delirium teaching and training Improving assessment of delirium in hospital and communication of diagnosis to all teams/carers	• Compliance of recording delirium diagnosis on quarterly basis using IT (WPAS) - link with Kathleen Hyde.	Joanne Stimpson	Ongoing	Ongoing

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
Pain assessment/ Re-assessment	Quarterly one day Audit all patients who scored on pain assessment	• Proportion of patients who had dementia to be assessed for pain using a recommended ABBEY pain scales	Dr Singh	31/10/2024	Ongoing
	Improve pain assessment and re-assessment	• Training and teaching of Abbey Pain score for nurses Dr Subhan has already discussed this with Palliative care Consultant, Dr Patten. Dr Patten has agreed to deliver this training with the help of Palliative care CNS. Dr Patten to discuss with her CNS and update Dr Subhan	Dr Subhan/Dr Patten	31/03/2024	Ongoing
		• To continue with pain assessment using Care Flow question only assessment	Dr Subhan/ Dr Adel	31/03/2024	Ongoing
		• After standard clinical assessment and pain score assessment should be used for patient who cannot communicate pain - has been Further work needed to decide on what pain score screening tool is going to be used across the HB - to ensure continuity.	Dr Singh	31/03/2024	Ongoing
Dementia training	Look at compliance figures on ESR for mandatory All Wales dementia module by site.	• To be looked at in the senior nurse monthly/cross divisional nurse meetings to see if this is beneficial information	Sue Pearce	31/03/2024	Ongoing
Discharge planning/EDD	Improve compliance in completing the Estimated Discharge Date (EDD)	• DISCHARGE PLANNING TO BE COMMENCED IN 80% OF PATIENTS WITHIN 24 HOURS - to prevent de-conditioning in the hospital (goal 5 and goal 6). To encourage all staff to agree EDD in the post take round/MAU board rounds. Discharge coordinators/ward managers to take the initiative in putting an EDD for every patient during board rounds. This should also be discussed in the weekly MDT.	Dr Subhan/Dr Adel/Dr Sheriff	31/03/2024	Ongoing
	Look at HB LoS wide rather than episode	• Compare LoS from episode to HB LoS	Dr Singh	31/04/2024	Ongoing

Audit Title:	Annual report – Improved Fracture Liaison Service (FLS) identification with gaps in monitoring: a call to action for national and regional planners Data - Jan 2022 to 31 Dec 2022 Published - Feb 2024	Clinical Lead: Dr Inder Singh
Rationale:	FLS ensures that patients aged 50 and over who sustain a broken bone after a fall have their bone health and falls risk checked and managed to lower their risk of a subsequent fracture. The FLS is made up of a team of healthcare professionals led by a Clinical Lead who liaise with wider teams to provide bone health care plan. FLSs bring clear benefits to the patient and the system in the long term and have been shown to be clinically and cost-effective.	
Objectives:	Fractures after a fall from standing height or less in adults aged 50 years and over often indicate osteoporosis and increased falls risk. Without urgent management, the risk of serious fractures due to osteoporosis will increase. Fracture liaison services (FLSs) deliver secondary fracture prevention using clear pathways to identify those with potential osteoporotic fractures, deliver systematic assessment, treatment recommendations in line with national guidelines, and monitoring to ensure recommendations are initiated and adhered to. The delivery of this pathway is mapped across key performance indicators (KPI) to support local FLSs to check and improve their local services.	
Presented at Clinical Standards and Effectiveness Group – 23rd May 2024		

The Health Board has improved on all but one KPI from 2022 to 2023 with two of the KPI's moving up into the higher metric grouping:	
KPI 2	Case Identification has increased from 22.6% in 2021 to 42.6% in 2022 with a further increase in 2023 to 54.1%, and from 2022 to 2023 increased from red into amber and is performing better than Wales and National average.
KPI 3	Spine Fractures metric is >20% is green, and in 2021 was 26.1%, in 2022 the increased to 35.4% and a further increase in 2023 to 44.6%
KPI 4	Assessment within 90 days has increased from 21.3% and red in 2021 to 60.3% and amber in 2023 remained amber but increased to 74.2% and although worse than the Wales average is better than the National average
KPI 5	Dexa scan with 90 days was 23.3% in 2021, this decreased in 2022 to 12.4% and a further decrease in 2023 to 9.4%
KPI 6	Falls risk assessment was 34.7% in 20021 however significantly increased to 80.2% in 2022 and a further increase in 2023 to 96.6%, this measure green if over 50%
KPI 7	Bone treatment has a lesser growth although all years are in the green at 57.7% in 2021, 65.7% in 2022 and 67.5% in 2023
KPI 8	Strength and balance by 16 weeks is red for all years at 4.8% in 2021 and 9.1% in 2022 and 10% in 2023 which is increasing and is performance better than the Wales and National average
KPI 9	16 week follow up have significantly improved from 1.4% in 2021 to 19.1% in 2022 and a significant increase to 64.4% in 2023 and performing considerably better than the Wales and National averages
KPI 10	Treatment by 1st Follow up although remains in the red, the performance has increased from 8.3% to 18.1% to 47.3%
KPI 11	1 Year drug adherence for 2022 the Health Board is under performing compared to the Wales and National average at 13.6%. No comparison data for 2023 is available to date



National, Wales and ABUHB data for all KPI's for 2021, 2022 & 2023

green as 80% amber as 50-79% red as <50%		KPI 2. Case identification	KPI 3. Spine Fractures green >20% amber 11-19% red <10%	KPI 4. Assessment within 90 days	KPI 5. DXA within 90 days	KPI 6. Falls risk assessment green >50% red <50%	KPI 7. Bone treatment	KPI 8. Strength & balance by 16 weeks	KPI 9. 16 weeks following up	KPI 10. Treatment by 1st followup	KPI 11. 1 yr drug adherence
National Average 2023	68341	34.7	23	65.5	31.7	61.7	56.9	7.8	28.6	29.2	Not applicable
National Average 2022	80015	40.6	22.5	63.2	29.2	62	56.6	6.8	27.1	28.9	21.9
National Average 2021	74647	37.9	20.3	66.5	31.2	60.8	55.2	5.6	24.5	29	22.3
Wales 2023	3403	20.4	11.1	79.9	17.8	90.9	68.2	6.2	44.6	32.6	Not applicable
Wales 2022	3152	18.9	10.1	77.8	33.5	86.3	62.5	6	21.4	16	24.9
Wales 2021	2030	12.2	6.6	65.2	22.9	61.6	56.7	3.9	13.8	10.3	30.3
ABUHB 2023	2097	54.1	44.6	74.2	9.4	96.6	67.5	10	64.4	47.3	Not applicable
ABUHB 2022	1649	42.6	35.4	60.3	12.4	80.2	65.7	9.1	19.1	18.1	13.6
ABUHB 2021	875	22.6	26.1	21.3	23.3	34.7	57.7	4.8	1.4	8.3	18.4

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Resource and Costs by Staff Band

	WTE required				Annual cost £				
	Nursing	Admin	Radiology	Consultant	Nursing	Admin	Radiology	Consultant	Total
Band 1									£0
Band 2									£0
Band 3		2.5				£77,581			£77,581
Band 4			0.4				£13,518		£13,518
Band 5									£0
Band 6	2.0		0.2		£96,489		£9,649		£106,138
Band 7	2.7				£158,438				£158,438
Band 8a									£0
Band 8b									£0
Band 8c									£0
Band 8d									£0
Band 9									£0
Consultant				0.2				£21,705	£21,705
Total Staff	4.7	2.5	0.6	0.2	£254,927	£77,581	£23,167	£21,705	£377,380
Overheads					£38,239	£11,637	£3,475	£3,256	£56,607
Total	4.7	2.5	0.6	0.2	£293,166	£89,218	£26,642	£24,961	£433,987

Financial benefits

	Year	Hip fracture (inpatient)	Other fracture site (inpatient)	Other fracture site (outpatient)	Clinical vertebral	Total	Average benefit per year
Acute care	2024	£585,330	£34,599	£7,961	£19,780	£647,670	
	2025	£995,061	£52,809	£12,151	£35,604	£1,095,625	
	2026	£1,424,303	£67,377	£15,503	£49,450	£1,556,633	
	2027	£1,697,457	£80,124	£18,436	£57,362	£1,853,379	
	2028	£1,873,056	£87,408	£20,112	£63,296	£2,043,872	
	All years	£6,575,207	£322,317	£74,163	£225,492	£7,197,179	£1,439,436

Estimate of service costs

The Royal Ostoporosis Society has a separate tool to help clinicians, managers and commissioners accurately calculate the costs of your FLS service for the number of patients shown in this FLS Benefits Calculator. The costs shown below are an approximation of the likely range of a what a service would cost for the number of patients expected in your service. **These are approximations only and must not be used in a business case.** For an accurate calculation using local salary, tariff activity, MFF and prescribing data please talk to your Royal Osteoporosis Society contact. All costs are for year 1 only.

	Lower estimate	Upper estimate
Estimate of staffing costs	£378,810	£635,559
Trust overhead charge of 15% applied to staff costs	£56,822	£95,334
Estimate of additional prescribing costs*	£14,744	£152,595
Total costs of FLS	£450,376	£883,488

* Prescribing costs will increase as the number of patients on osteoporosis therapy increases cumulatively each year

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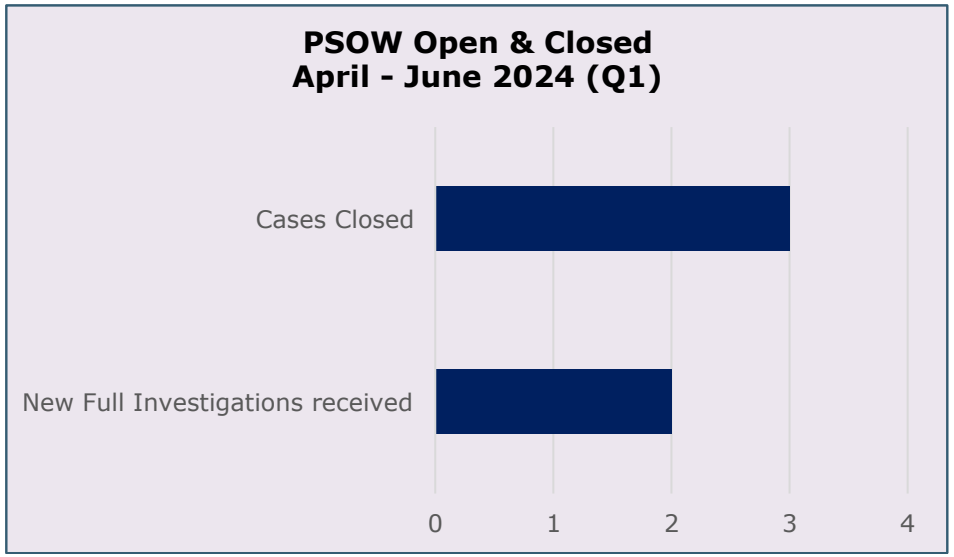
	Report Recommendations:	S.M.A.R.T Actions:	Responsible: Due Date: Progress:
1	More FLSs are now delivering over 80% identification rates for non-spine fractures. FLS that have prioritised improvement in KPI 2 and 3 should contact these services to share best practice for funding and identification pathways.	Based on the annual activity/no. of fragility fractures ABUHB FLS of 4209, The HB needs • 4.7 - WTE nursing staff • 2.5 - admin • 0.6 - radiology staff (dexa scan) • 0.2 consultant. The total annual cost for this is £433,987. The Medical Division has invested 2 WTE CNS and 1 WTE Administrator (147K). Over the period of 5 years the total annual cost for ABUHB FLS including staff cost, overhead charge of 15% and prescribing costs be approx. £450,376 to £883,488. The annual benefits across acute care is equal to £1439,436 and all benefits inclusive of community and social care will be 2.1 Million.	Dr Inder Singh Ongoing
2	To meet the healthcare recovery targets from the pandemic, FLS funding should be prioritised based on expected number of avoided fractures from a comprehensive service. FLSs should describe their capacity gaps and the expected benefit vs effort from re-organising pathways to ensure that at least 80% of higher risk patients are checked within 16 weeks of their fracture. *This may result in lower rates of identification for lower fracture risk patients.*		
3	FLSs should work with their local DXA providers to ensure access to DXA is based on patient need. This may require FRAX before DXA pathways, increasing follow up based on evidence and using FRAX only recommendations to clear backlogs of patients that are unlikely to be cleared in the next four months.		
4	FLS care pathways should acknowledge that specific patient groups need a personalised approach to assessment, decision-making and support. This includes providing patient-facing materials that reflect the languages of their local population.		
5	All senior executive decision-makers should hold a key stakeholder meeting to explore how local needs for fragility fracture patients can be met. Patient representatives and members of the Royal Osteoporosis Society should be invited to the meeting, and it should plan for effective and sustainably resourced FLSs based and designed on the KPIs from the FLS-DB.	FLS is regularly discussed in the Falls and Bone Health Committee but with Patient representation and ROS representation	Peter Carr 8th April 2024 To be discussed

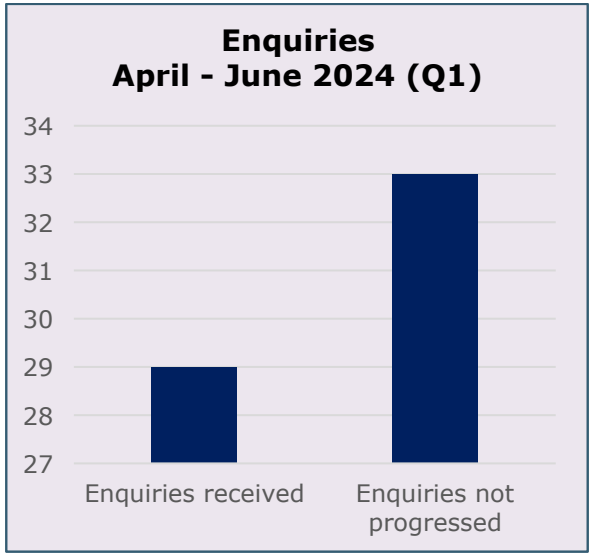
	Clinical Leads Local Recommendations: (if applicable)	Responsible:	Due Date:	Progress:
1	FLS for the ABUHB continues to be a centralised service and this is already achieved, however this needs to be continued.	Dr Singh	Ongoing	Improving
2	Wider partnership with Community Team, Primary Care and third sector.	Dr Singh	Ongoing	Improving

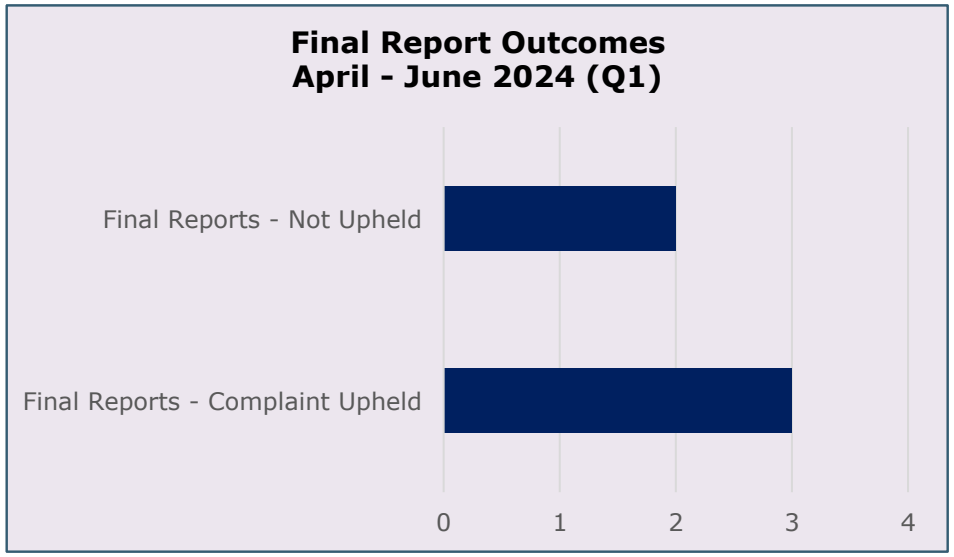
Priority 5: Efficient Care

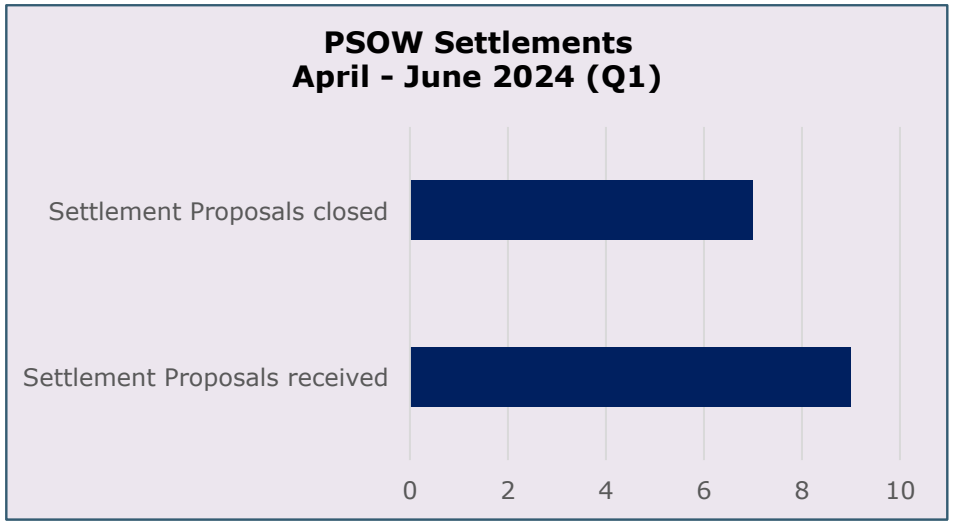
Priority	Outcome Description	Indicator	Reported Position 2023/24		Current Reported Position	Change over the last time period	Latest findings
			Q3	Q4	Q1 2024/25		
Priority 5 Efficient	Patient experiences are visible and acted on	Decrease in the number of open personal injury claims	76	69	71	Increased	No financial Penalties at May 2024 WRP Committee
		Decrease in the number of open clinical negligence claims	657	676	659	Decreased	No financial Penalties at May 2024 WRP Committee
		Decrease in the number of open Coroner inquests	188	205	199	Decreased	Decrease for Q4
		Response time to Public Services Ombudsman for Wales(PSOW)	4 days	3 days	6 days	Improved	Reporting 3-4 days earlier than PSOW target
		Decrease in the number of medically fit for discharge patients	Q2 2023	280	No Data	No data	No longer valid – measure has been discredited
		Decrease in the number of patients cancelled on the day of surgery	Q1 2023 130	Q2 2023 110		Decreased	There has been a decreasing trend in the numbers cancelled in the day of surgery the numbers over the past quarter remain circa 110 per week
		Decrease in the % of hospital as a place of death	3.00%	3.00%		Decreased	There has been a notable decrease in the % of hospital as a place of death in the past quarter outside of normal season trends from 3.2% to 2.75%

Ombudsman (PSOW)

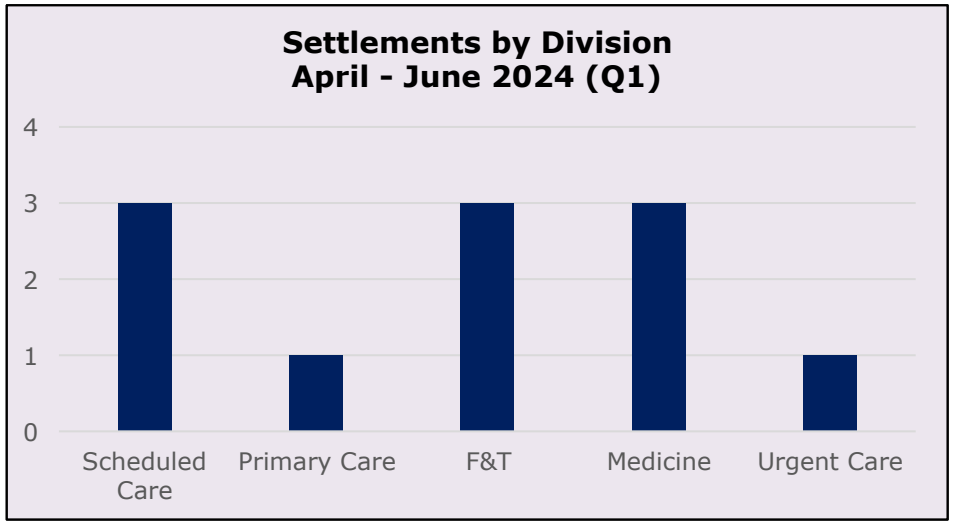








Positively, although the number of enquiries received has been higher, the number progressed by PSOW has been lower. Indicating that the PSOW has been satisfied following receipt of evidence from the Health Board. Overall settlements and final reports upheld has reduced across the period. The Health Board continues to perform above average and the target performance timescales when providing evidence to PSOW.



Priority 6: Equitable Care

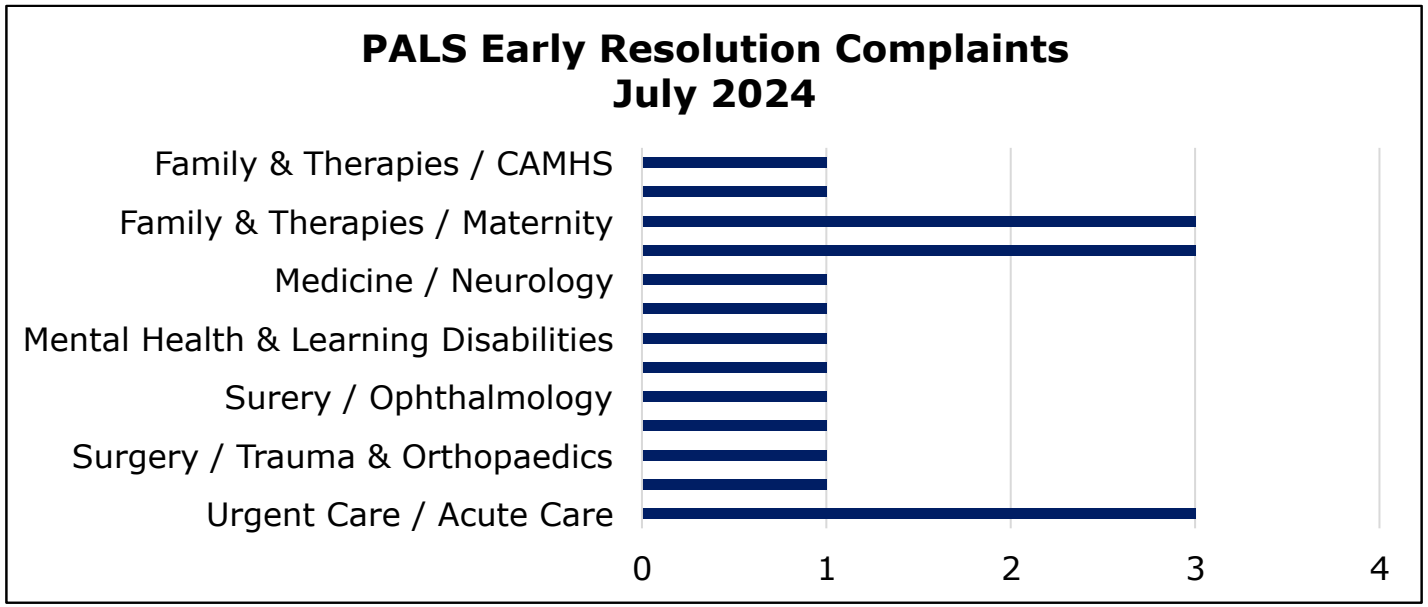
Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 6 Equitable	Improving quality of life and equitable access	Increase in the access to Safeguarding Training	Q3 2023.24	**Level 1** Adult 79% Children 85% **Level 2** Adult 88% Children 86%	Q4 2024	**Level 1** Adult 87% Children 86% **Level 2** Adult 90% Children 88%	Improving	Compliance with training has improved (with tolerance of 85%)
		Narrowing of the life expectancy Gap across our Health Board	Q4 2020	Women 20 years Men 13 years	Q4 2020	Women 20 years Men 13 years	N/A	The current the 13yr (men) and 20yr (women) gap in healthy life expectancy between our wealthiest and poorest communities
		Timely closure of Safeguarding incidents		Measure in development		4 Child Practice Reviews 1 Adult Practice Review 5 Domestic Homicide Reviews		Reviewing measure
		Decrease in the incidents of violence and aggression towards staff	See 2023/24 in table		Q1 2024	540	Increased	Violence and aggression towards staff data presented for 2023/24 and increase for Q1 2024/25.

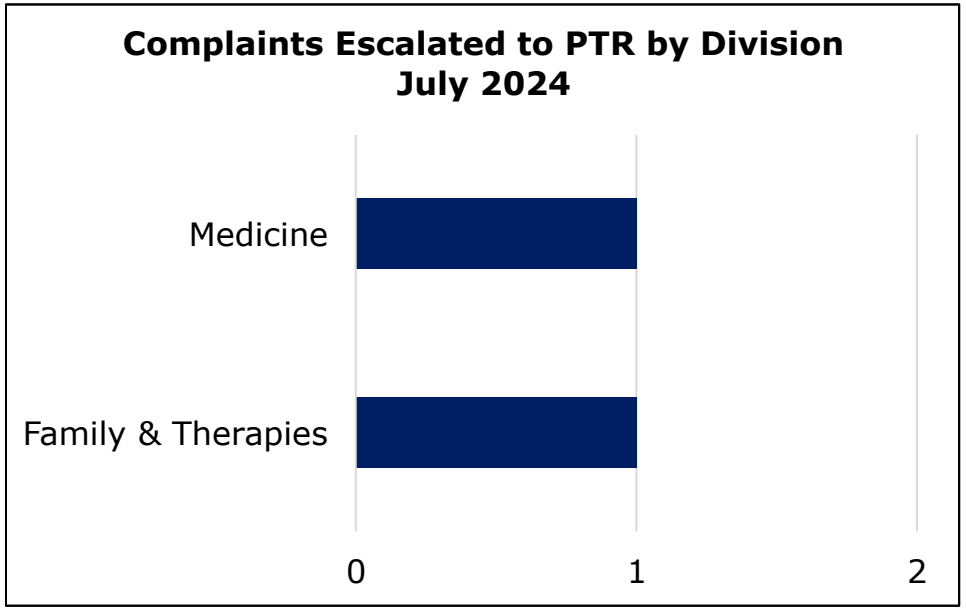
Issue	Action	Learning and Improvement	Who	When
Compliance with Level 3 Adult Safeguarding is currently unreportable, though compliance is known to be low (<10%)	• In the absence of ESR Monitoring targeted training to be delivered with support of Divisional Nurses • Further work with ESR Team to establish how training can be added to requirements	• Targeted training has seen Level 3 Adult Safeguarding Training delivered to significant volumed of senior staff in some division • A solution has been found to the ESR issue and training will be added to individuals requirements from September	ESR Team	September 2024
Compliance with Level 3 Child Safeguarding is currently unreportable, though compliance is felt to be high as sessions well attended	Further work with ESR Team to establish how training can be added to requirements	• A solution has been found to the ESR issue and training will be added to individuals requirements from September	ESR Team	September 2024
Decommissioning of Specialist Domestic Abuse Service in General Practice	• Identify Training offer for General Practice • Clarify referral pathway and sources of support • Develop a Domestic Abuse Champions Network for Primary Care	• No long term sustainability was considered, potentially due to the way the IRIS programme was funded • Interim solutions leave a considerable gap in service provision for those presenting at general practice and reporting Domestic Abuse	Safeguarding Team/Public Health/Primary Care Division	Complete
Significant increase in safeguarding referrals and strategy meetings for vulnerable children and adults	• Consider if there are identifiable causes for increase • Consider resources available to meet increased demand	• Whilst some increase in activity can be attributed to better awareness, there is a multi agency view that there has been an increase in prevalence of incidents which require safeguarding involvement • Non recurring funding utilised to mage challenge whilst long term options reviewed	Head of Safeguarding	September 2024
Staff feeling unsupported or poorly prepared hen asked to give evidence in court proceedings	Working Group established to clarify roles and responsibilities and to develop training on what to expect when giving evidence.	• Changes to operational leadership teams in Divisions/Directorates has brought about a loss of "informal support2 that was provided • Training needs of leadership teams to be reviewed to ensure that knowledge is present to provide support	Deputy Head of Safeguarding	January 2025

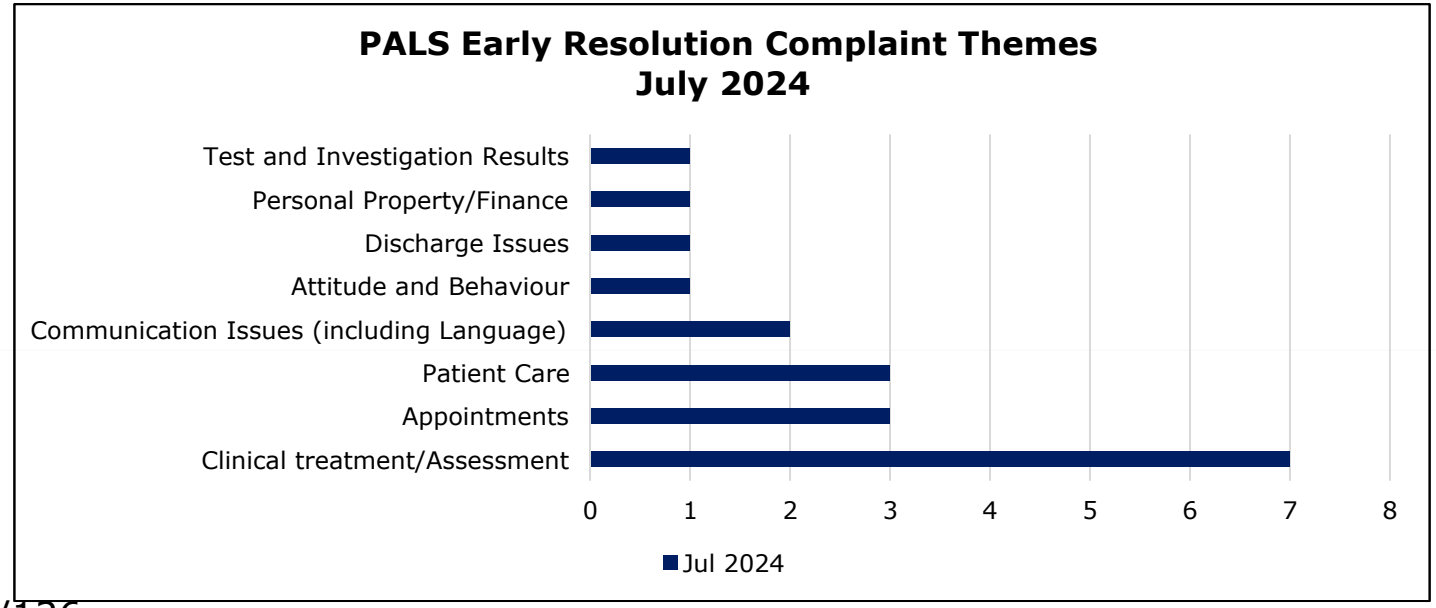
July 2024 Data

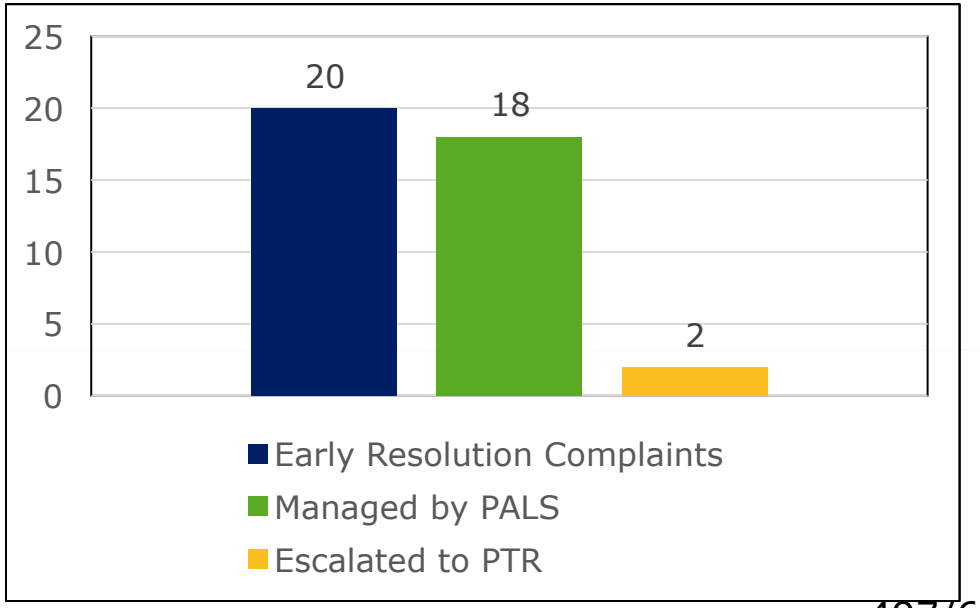
As provided to NHS Executives

Patient Advice & Liaison Service

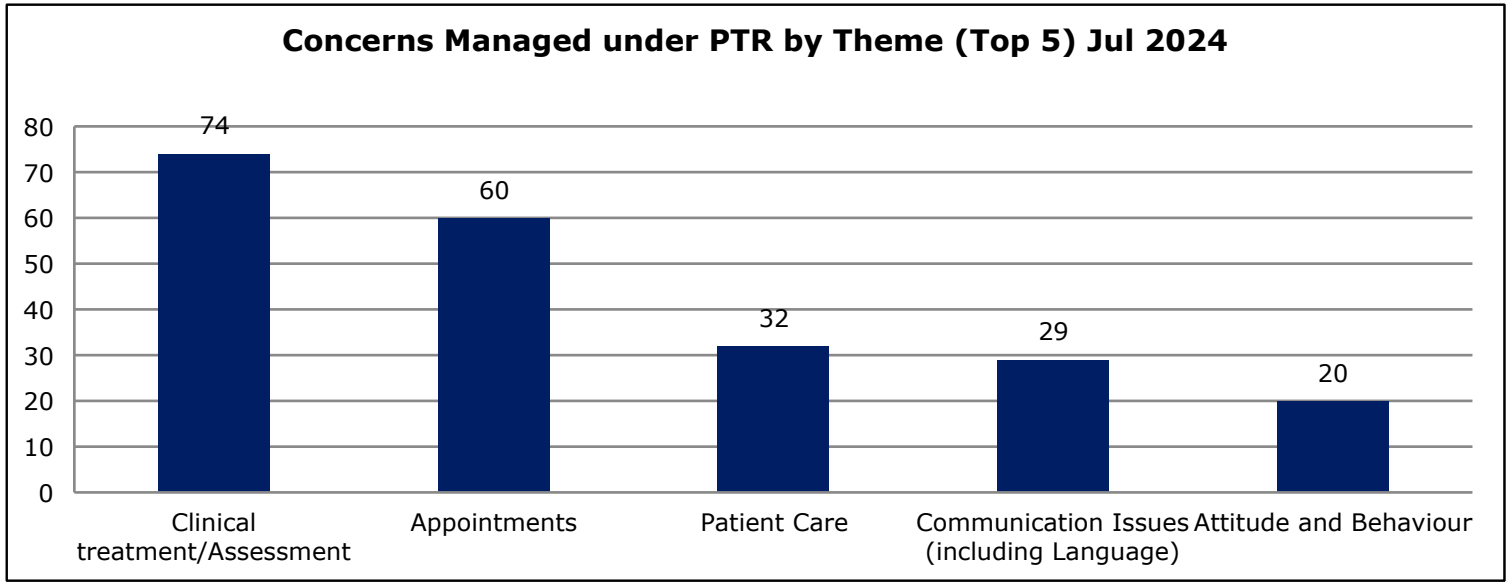




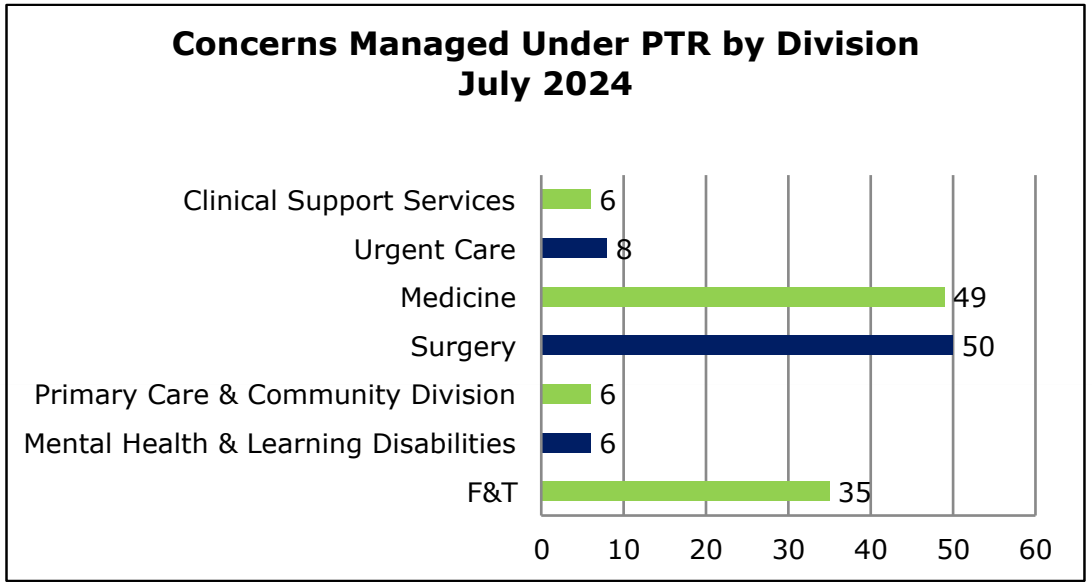




Complaints



Medicine, Surgery & F&T continue to receive the highest number of concerns which require investigation under PTR. These concerns are often complex and cross-divisional in nature. However, senior PTR direction continues to be provided at the outset for such concerns to ensure robust investigation management.



The themes of the concerns remained consistent as per Q1 in relation to:

- Clinical Treatment/ Assessment
- Appointments
- Patient Care
- Communication
- Attitude and Behaviour

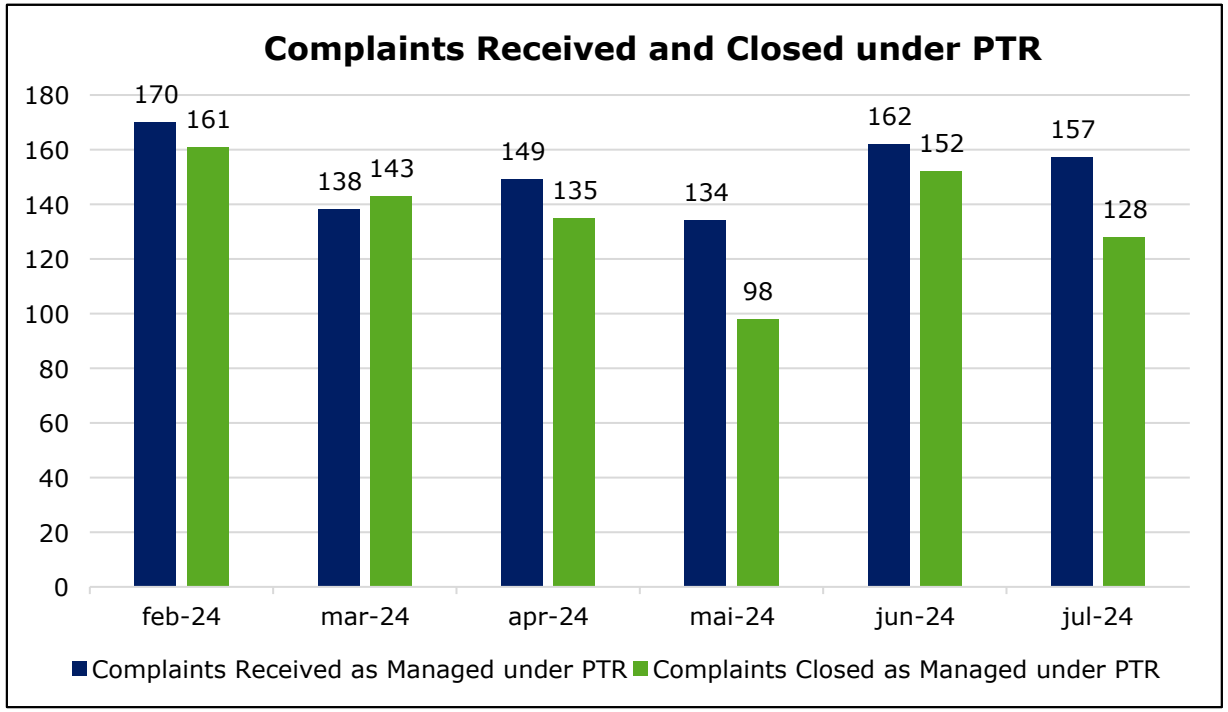
The 'Keeping Well' Project. Will consist of a team contacting patients who are on long waiting lists, the first specialty will be ENT. The conversation will be around their general health, with signposting to various services.

Healthcare staff are being encouraged to undertake 'Sage & Thyme' training which supports with difficult conversations and improving communication with patients, families and carers.

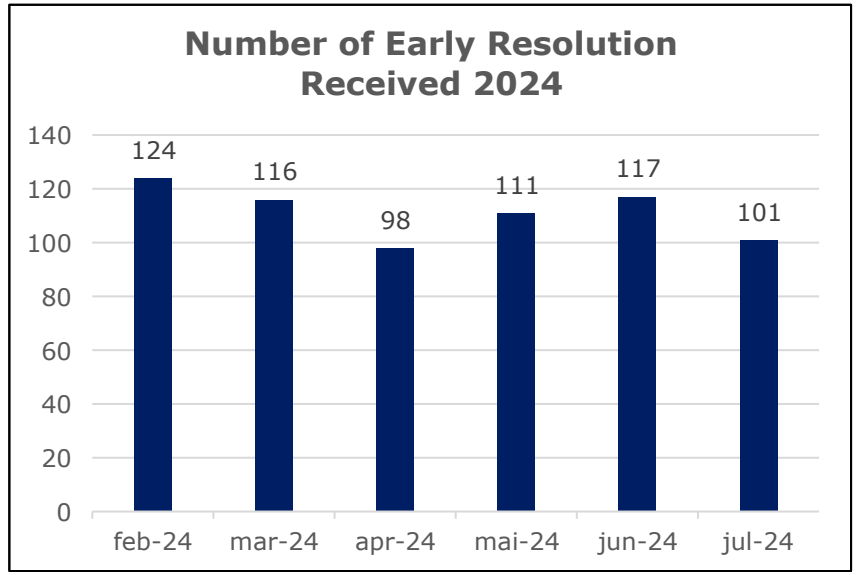
The Health Board aimed to address systemic issues and improve patient safety through the following strategies:

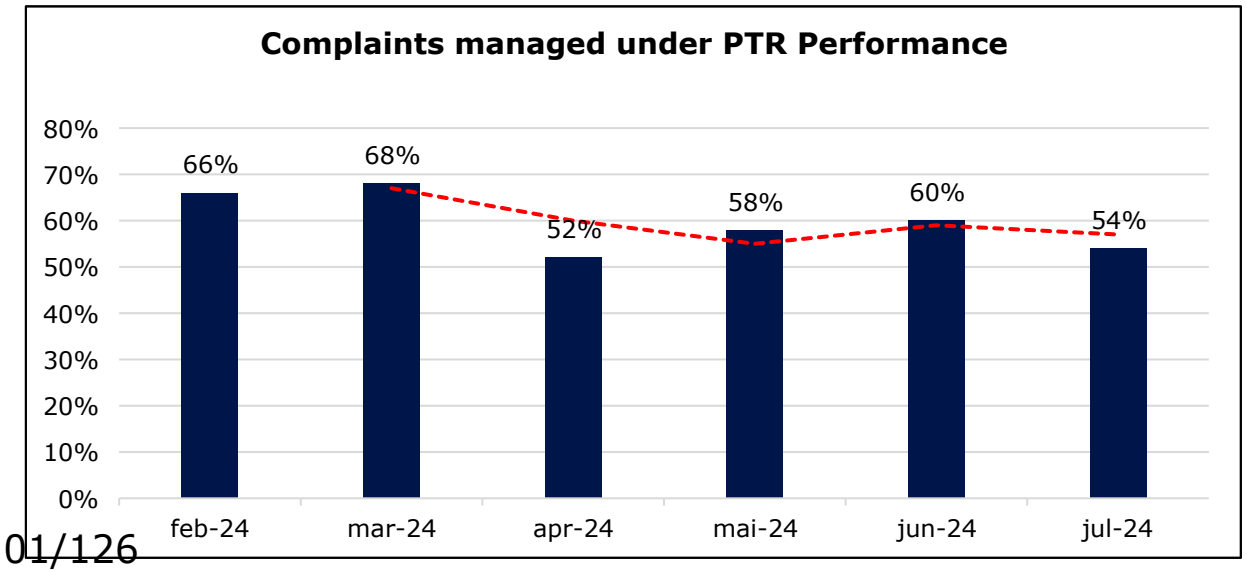
- Thematic Reviews
- Education and Training
- Systemic and Cultural Improvements
- Leadership and Psychological Safety
- Speak Up for Safety Initiative
- Revision of the Deteriorating Patient Policy

Complaints Performance

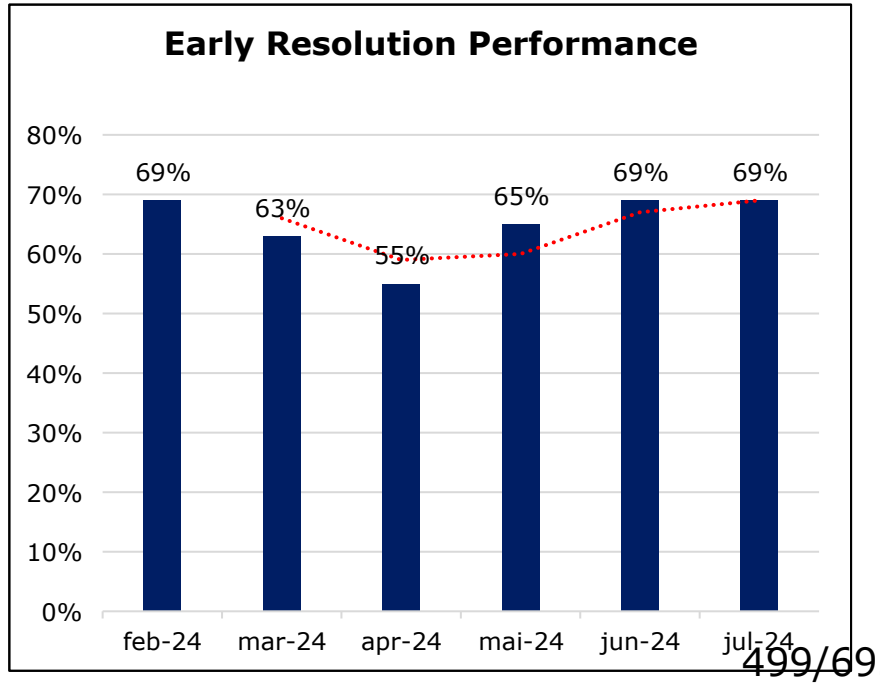


The Health Board has received on average 11% more formal complaints for investigation than those closed per month over the last 6-month period which has resulted in some slippage alongside closure of concerns which have exceeded the 30-day target. The test of change of the acknowledgement team has seen a positive return to improved Early Resolution concerns management.





Compliance fluctuations often result from multiple factors, including delays in closing complaints. When complaints exceed 30 working days for resolution, it indicates inefficiencies that contribute to these fluctuations. Addressing such delays can improve overall compliance and ensure adherence to regulatory requirements.



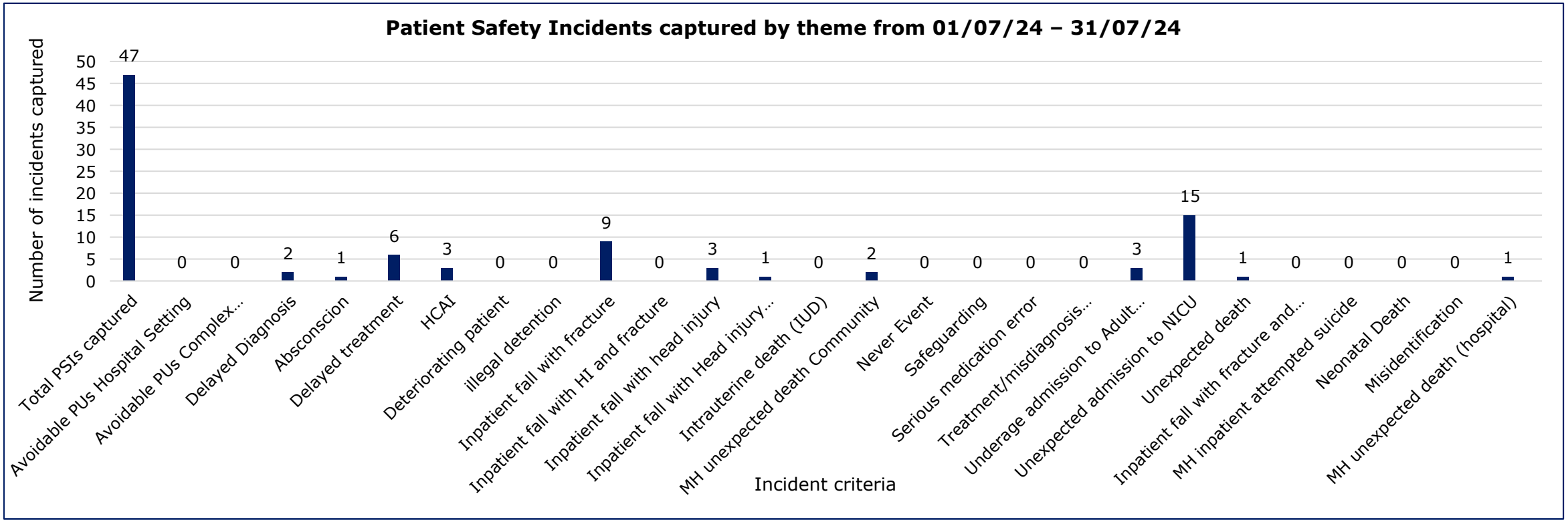
Complaints Improvement and Learning

- Members of the wider PTR teams have been working collaboratively with the central team, sharing knowledge and supporting periods of leave and sickness. Members of the central team have also been spending time in the hubs to gain a more rounded view of the concerns process.

- The central PTR team is collating a 'how to' guide to support the wider PTR teams with more detailed validation on a more regular basis to ensure greater accuracy and robust monitoring/reporting.

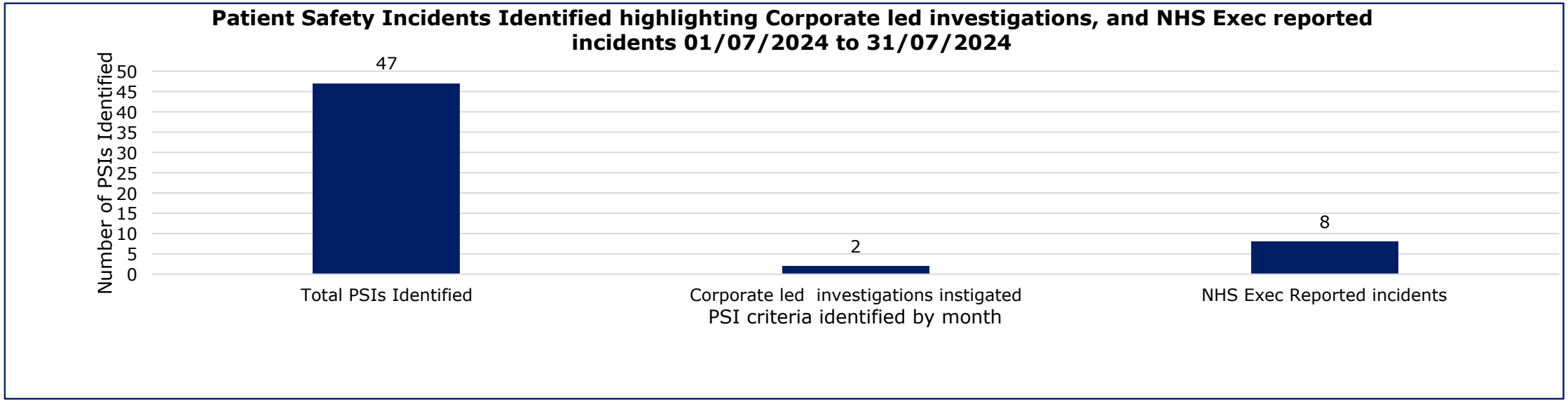
- The central PTR Senior Management Team are planning an away morning in early September with key stakeholders of the PTR process – Complaint Coordinators, administrators, complaints managers, MS/MP and PALS to fully map and define all stages of the PTR process. This will offer an opportunity to consider and fully embed the changes to internal complaint handling processes that have been undertaken internally following centralisation. The aim will be to refresh the key focus and targets for the PTR team as a whole moving forward. Ensuring that thematic coding is being fully utilised to underpin the Health Board's continued drive to be a true "learning organisation".

Patient Safety Incidents



A total of **47** Patient Safety Incidents (PSIs) were initiated as either Corporate or Divisional led Investigations during July 2024. Of these, **39** PSIs met the criteria for a Divisionally led Investigation/concise review/focused review but did not meet the NHS Executive reporting criteria. These incidents are captured and monitored through the Divisional PSI trackers (and would have previously been reported to the Delivery Unit) to allow monitoring of these incidents across the Health Board.

Patient Safety Incidents



The graphic above represents the number of the 47 patient safety incidents that met the NHS exec reporting Criteria, and those initiated as Corporately led. **Six** Divisional led investigations met the NHS executive reporting criteria, and **two** Corporate investigations commenced that were reported to NHS Executive.

HCAIs followed by delayed treatment were the most reported incident types in July although there are no themes i.e. outbreak or same clinical area.

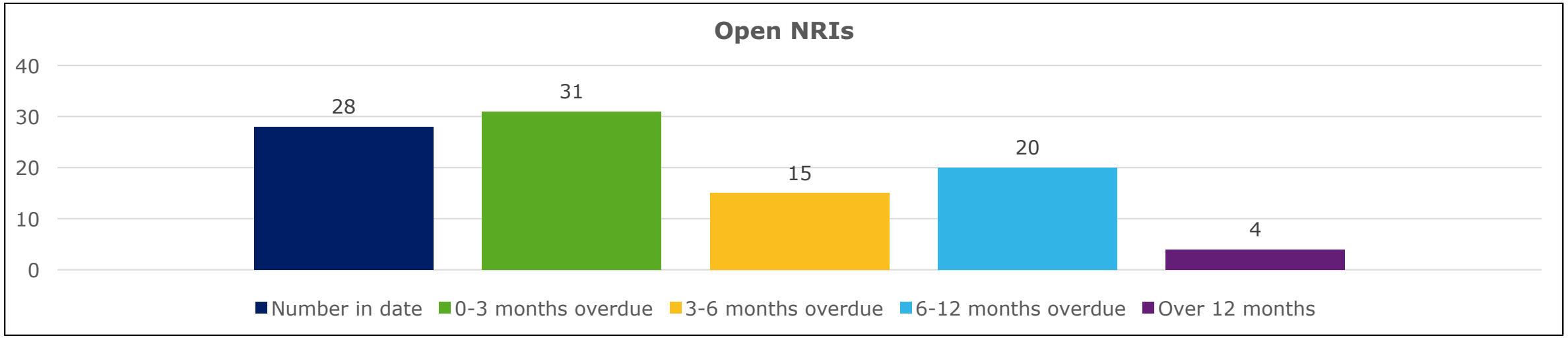
A focused piece of work is being undertaken by the Assistant Head of Patient Safety to scrutinise both open NRI's, in addition to placing a compliance target upon divisionally led, non-reported PSIs in an endeavour hold key stakeholders to account for quality and timeliness of feedback to patients/representatives.

There were **17** Early Warning Notifications (EWNs) reported to Welsh Government (WG) during July 2024. Themes included Safeguarding concerns, patient absconsion, IG breaches, adverse social media coverage and PRUDICs.

During July 2024, 0 Never Events were reported.

Open NRIs

As at the end of July 2024 there remained 98 open and reported NRI's. Of the 98 open NRIs:



Of these, 70 are overdue.

This is in comparison to 125 open reported NRI's in April, 115 in May and 98 in June. Whilst the numbers of reported NRI's open is decreasing, the percentage outside compliance is increasing (47%, 61%, 63%, 71%) respectively.

In respect of the NRIs overdue by more than 12 months, these are very complex cases and have either been in the safeguarding or police arena (3), which have resulted in lengthy delays to Health Board investigation. These cases pertain to administration of heparin in the neonatal unit, Death of MH patient whilst on leave and a sexual assault patient to patient. The remaining one case is currently being prepared for sign off and closure. This incident concerned a lookback at missed to follow-up in the memory service, and it is the harm review assessment attached to this that has taken a protracted period.

Focussed work is taking place within the Corporate Patient Safety Team, working with the Divisional QPS leads and Triumvirates to scrutinise delays and expedite investigation closures and organisational learning. The Patient Safety Incident Team have increased the frequency of divisional meetings from 3-weekly to weekly from the end of July.

NRI Learning and Improvement

- A review of the Health Board's Patient Safety Incident Policy in November 2023 to align with the All-Wales Directive and to reflect patient and family feedback on the Safety Incident process. This Policy also more explicitly outlines expectations and procedures. A further update is planned to be approved by the Board in September following a further strengthening of the approach;
- Bespoke development of Chair, Investigating Officer and staff responsibilities for Patient Safety Incidents has been established;
- Bespoke rather than generalised training is being provided for Investigating Officers on a 1- 2-1 basis to guide them through the investigation process supported by a member of the Corporate Patient Safety Incident team;
- All moderate and above harm incidents are presented to the weekly Executive Huddle for an investigation level decision, identification of an appropriate Chair and allocation of Executive Sign off lead;
- There is now a focused review of open incidents with Divisional Quality and Patient Safety teams and escalation to Triumvirates (then Executives) where delays occur; and
- There has been an increase in the number of Executive Chairs to address delays in the initiation of investigation meetings.
- Strengthened oversight of learning and NRI actions as part of the Divisional Governance arrangements with Executive oversight and the Listening and Learning Framework.

NRI Learning and Improvement

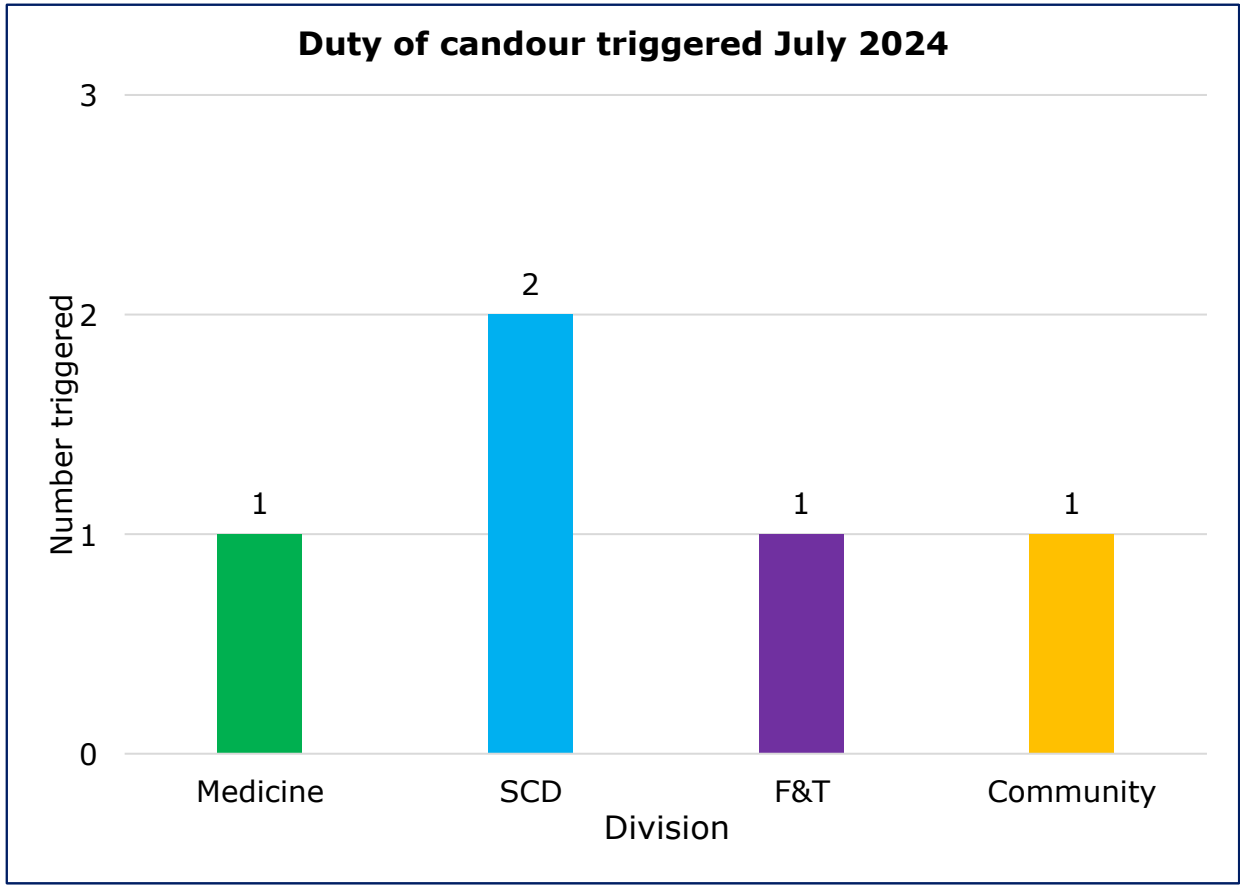
- In respect of learning, the Health Board recognises that organisational learning plays a vital role in the continuous improvement and development of healthcare organisations. Implementation of the Health Board's Listening and Learning Framework, approved in April 2024, demonstrates our commitment to promote a culture which values, facilitates, and embeds learning and in which the lessons learned are used to improve the quality of patient care, safety, quality and experience. This framework demonstrates how learning will be identified, triangulated, disseminated, and implemented into practice, to facilitate and embed a culture of appreciative enquiry, continuous improvement in health care services.

- The Health Board has now established a Learning and Improvement Forum with the purpose of sharing themes and learning across Divisions. We have also established a learning repository, which will allow us to collate, store and utilise this learning, enabling us to share knowledge, shape change, embrace innovation, implement quality improvement and create opportunities to develop excellence in practice.

- The Executive Team and the Board's Patient Quality, Safety and Outcomes Committee will continue to maintain an oversight of quality governance and outcomes, including NRI reporting and timeliness of closures and the evidence of the application of learning across all aspects of patient care particularly monitoring of reoccurrence of themes.

Duty of Candour

In July 2024 there were **2235** incidents affecting patients reported on the Datix Cymru system.
There have been **5** incidents that have triggered Duty of Candour. *This figure is based on the question -* ***Was Healthcare provided a factor?***



Next Steps

- Encourage all staff to complete the Duty of Candour (DoC) training on ESR.
- Quality, Patient and Safety leads to run further sessions on DoC.
- Use incident reports and investigations to identify trends and areas for improvement.
- Implement changes and improvements based on lessons learned.
- Foster a culture of continuous learning and improvement.
- To produce quarterly data for divisional review at the QPS, Learning and Improving meetings.
- Learning and Improvement to be discussed at Patient Quality and Safety Learning and Improvement Forum.

Regulation 28 Coroner Report to Prevent Future Deaths

A Regulation 28 report was issued by the Senior Coroner for the Area of Gwent on 20 May 2024.

The Health Board's response was submitted on 15 July 2024. The Health Board acknowledged that it was experiencing handover delays at all of its sites on 5 September 2023. The Health Board confirmed that the management team have a number of processes in place to improve flow.

1) Pre-Hospital / Flow Centre

Due to the unique nature of the Clinical Futures model that the Health Board manages, a Flow Centre is operated to ensure that all ambulance admissions (excepting life threatening emergencies) and admissions received from General Practitioners are screened to ensure that the patient is referred and streamed to the correct hospital and department. Further actions within this workstream include:

a) Consultant presence in the Flow Centre to aid senior clinical decision making
b) Redirection for specific conditions to eLGH sites rather than the GUH for more appropriate and rapid assessment and treatment
c) Falls response in the community

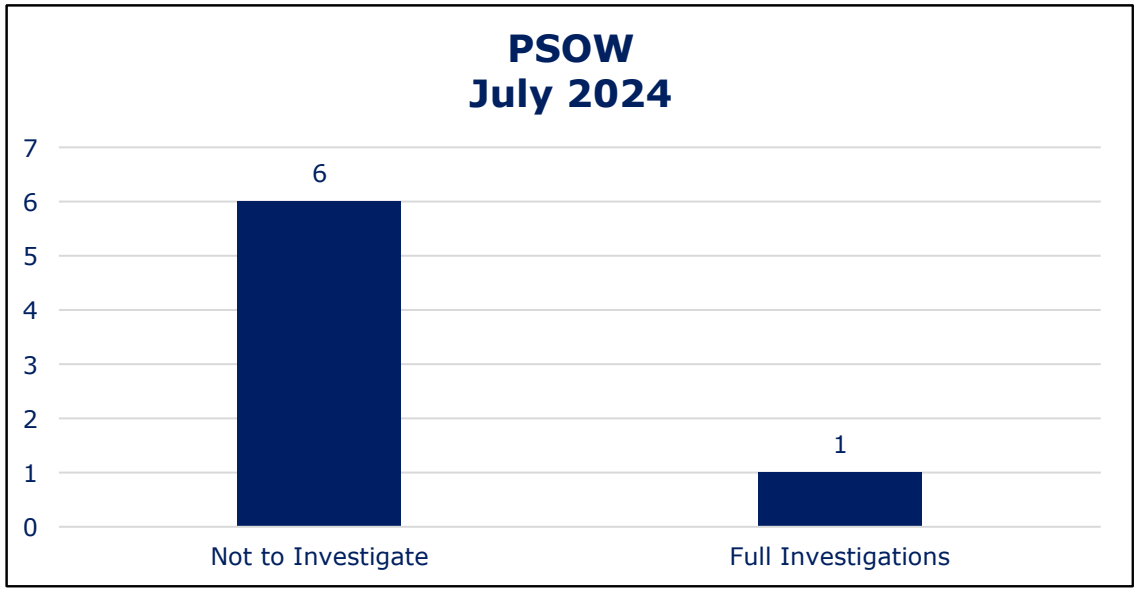
2) Emergency Department/Assessment Area Focus

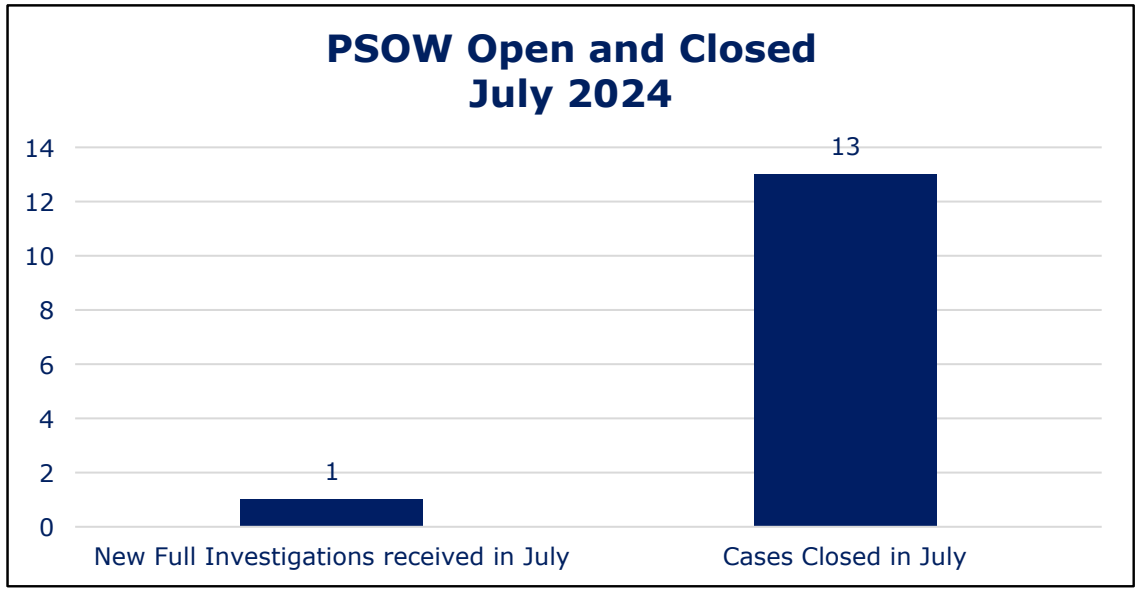
a) Revision of the escalation framework to ensure that the points of escalation during any ambulance handover delays are appropriate
b) Creation of inter-speciality standards
c) Prioritisation and assessment of the balance of risk

3) Discharge Logistics

a) Focussing on how the Health Board can better utilise its discharge lounges to provide an immediate and early pull from wards across all sites to create capacity to support ambulance handover times.
b) Improving how the internal process for the handover.

Ombudsman (PSOW)





July saw the closure of 13 PSOW matters. Positively the Health Board continues to exceed PSOW requirements proving evidence **6 days earlier** than deadlines set.

Of the referrals received PSOW decided not to investigate 6. Only 1 investigation was progressed across July.

The main themes across the reporting period were clinical treatment and record keeping. As a result the requisite divisions have developed an ERASE bulletin in relation to hydration advice to be cascaded across all relevant teams and an audit of paper notes and electronic District Nursing notes will be undertaken by the Deputy Head of QPS.

CIVICA Patient Experience Feedback - July 2024

All Surveys	
707 responses	**91%** satisfaction

Emergency Department Survey	
26 responses	**72%** satisfaction

Person Centred Care (PCC) Survey	
672 responses	**91%** satisfaction

Patient Experience Feedback ED - July 2024
Emergency Department & *Person Centred Care Survey

Adborth Cleifion: Gwrando a Dysgu
Patient Feedback: Listening and Learning

Emergency Department Survey Location/Department	Responses	1 - Did you feel that you were listened to?	2 - Were you able to speak in Welsh to staff if you needed to?	3 - From the time you realised you needed to use this service, was the time you waited:	4 - Did you feel well cared for?	5 - If you asked for assistance, did you get it when you needed it?	6 - Did you feel you understood what was happening in your care?	7 - Were things explained to you in a way that you could understand?	8 - Were you involved as much as you wanted to be in decisions about your care?	9 - Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall exp	Overall
		Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	
Emergency Department	26	72	44	55	81	81	68	74	73	78	72
	Overall	72	44	55	81	81	68	74	73	78	72
	Benchmarks	85	85	85	85	85	85	85	85	85	85

*Person Centred Care Survey Location/Department	Responses	2 - I felt listened to	2 - I was able to make my own decisions about my care	2 - I had care and support from staff who understood my needs and respected my choices	2 - I had the support of my family (or friends) when I needed them	2 - I felt safe	2 - I felt physically comfortable	2 - I was given information and advice that I could understand to help me keep well	2 - I was told who to contact if I need care and support in the future	Overall
		Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	
Emergency Department	15	93	79	93	80	93	93	89	71	87
	Overall	93	79	93	80	93	93	89	71	87
	Benchmarks	85	85	85	85	85	85	85	85	85

Both Surveys

Was there anything particularly good about your experience that you would like to tell us about/ What did we do well?	Was there anything that we could change to improve your experience/What could we have done better?
Top 3 themes **7** comments around **Compassion** **4** comments around **Helpfulness** **4** comments around **Emotional & Physical support**	**Top 3 themes** **6** comments around **Waiting** **1** comment around **Hygiene** **1** comment around **Pain** and **1** comment around **Emotional & Physical support**

*The Person Centred Care Survey is no longer in use in ED (switched Aug 2023) however some paper surveys were completed by patients so included

Patient Experience Feedback Heat Map July 2024 – PCC Survey

Person Centred Care (PCC) Survey – Questions 1-8

Division	Responses	2 - I felt listened to	2 - I was able to make my own decisions about my care	2 - I had care and support from staff who understood my needs and respected my choices	2 - I had the support of my family (or friends) when I needed them	2 - I felt safe	2 - I felt physically comfortable	2 - I was given information and advice that I could understand to help me keep well	2 - I was told who to contact if I need care and support in the future	Overall
		Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	
Complex & Long Term Care	9	94	88	94	83	89	94	94	89	91
Mental Health and Learning Disabilities	20	93	73	93	82	93	88	95	87	88
Medicine	269	86	80	88	89	92	86	85	78	86
Clinical Support Services	37	100	94	99	97	100	97	100	96	98
Family and Therapies	16	94	88	93	84	91	88	94	91	90
Primary Care & Community	129	97	93	97	94	99	96	98	94	96
Surgery	151	99	94	99	97	99	97	99	97	98
Urgent Care	23	89	82	93	86	96	87	91	73	87
	Overall	**92**	**87**	**93**	**92**	**96**	**91**	**93**	**87**	**91**
	Benchmarks	85	85	85	85	85	85	85	85	85

Adborth Cleifion: Gwrando a Dysgu
Patient Feedback: Listening and Learning

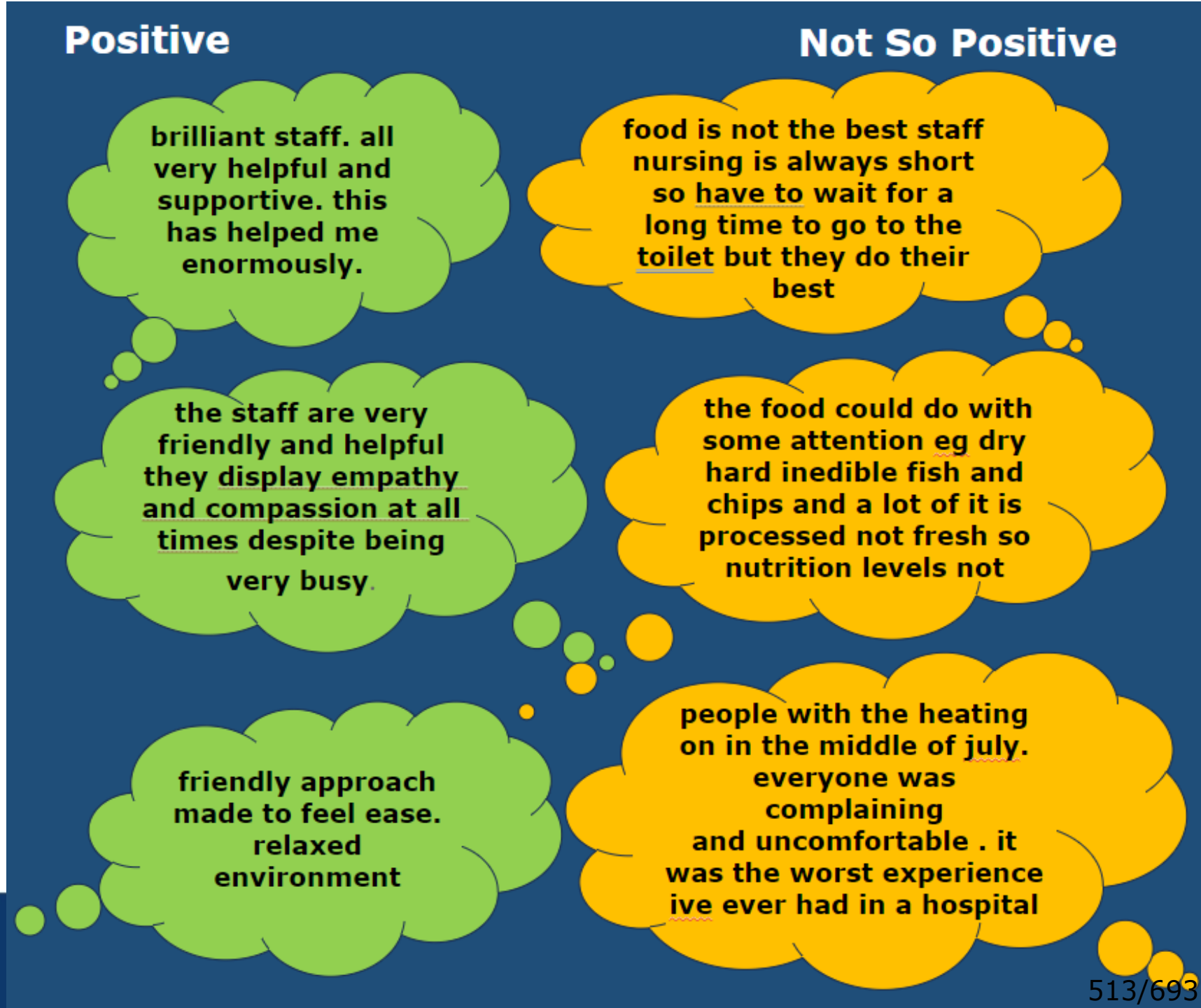
Top 3 Themes from PCC Survey

What did we do well? Q9	What could we have done better? Q10
Top 3 themes • **127** comments around **Emotional & Physical support** • **124** comments around **Compassion** • **112** comments around **Friendliness**	**Top 3 themes** • **26** comments around **Waiting** • **12** comments around **Food & Beverages** • **11** comments around **Comfort**

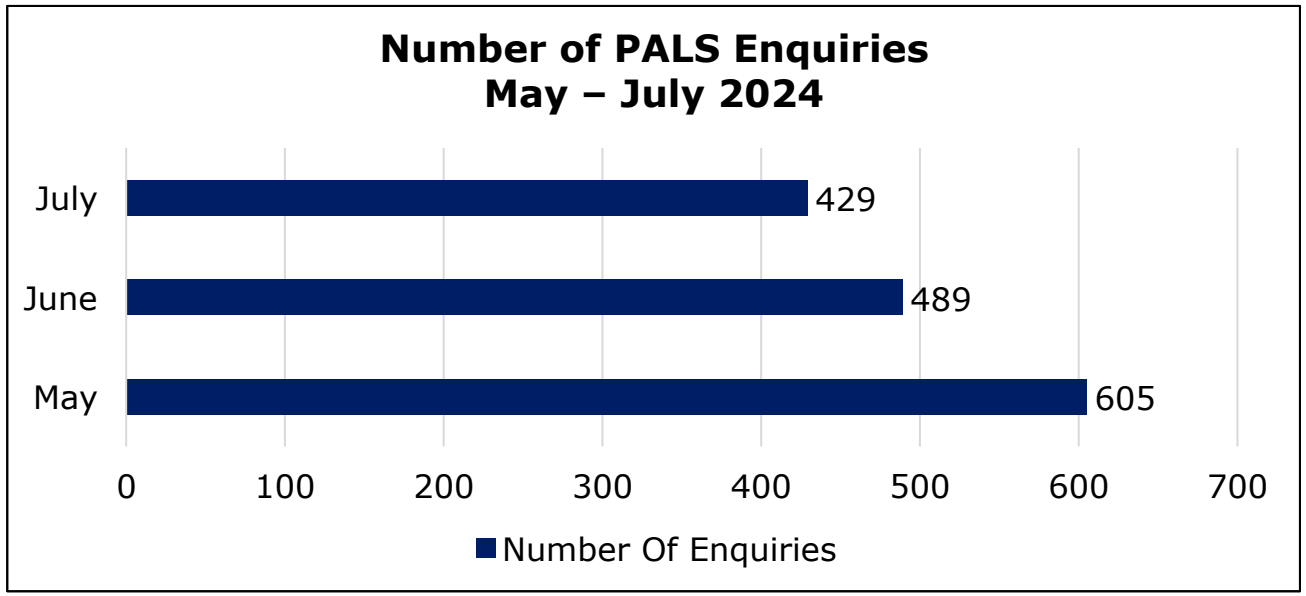
Top 3 Themes from PCC Survey

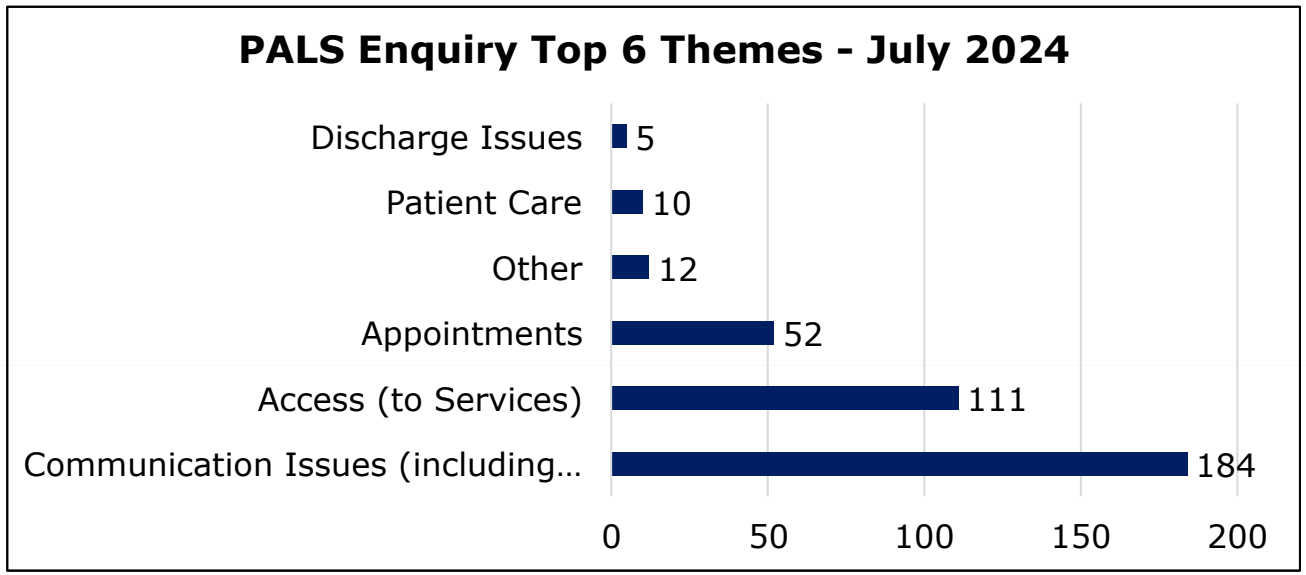
Positive Themes	Negative Themes
Emotional and Physical Support (127) 	**Waiting (26)** 
Compassion (124) 	**Food & Beverages (12)** 
Friendliness (112) 	**Comfort (11)** 

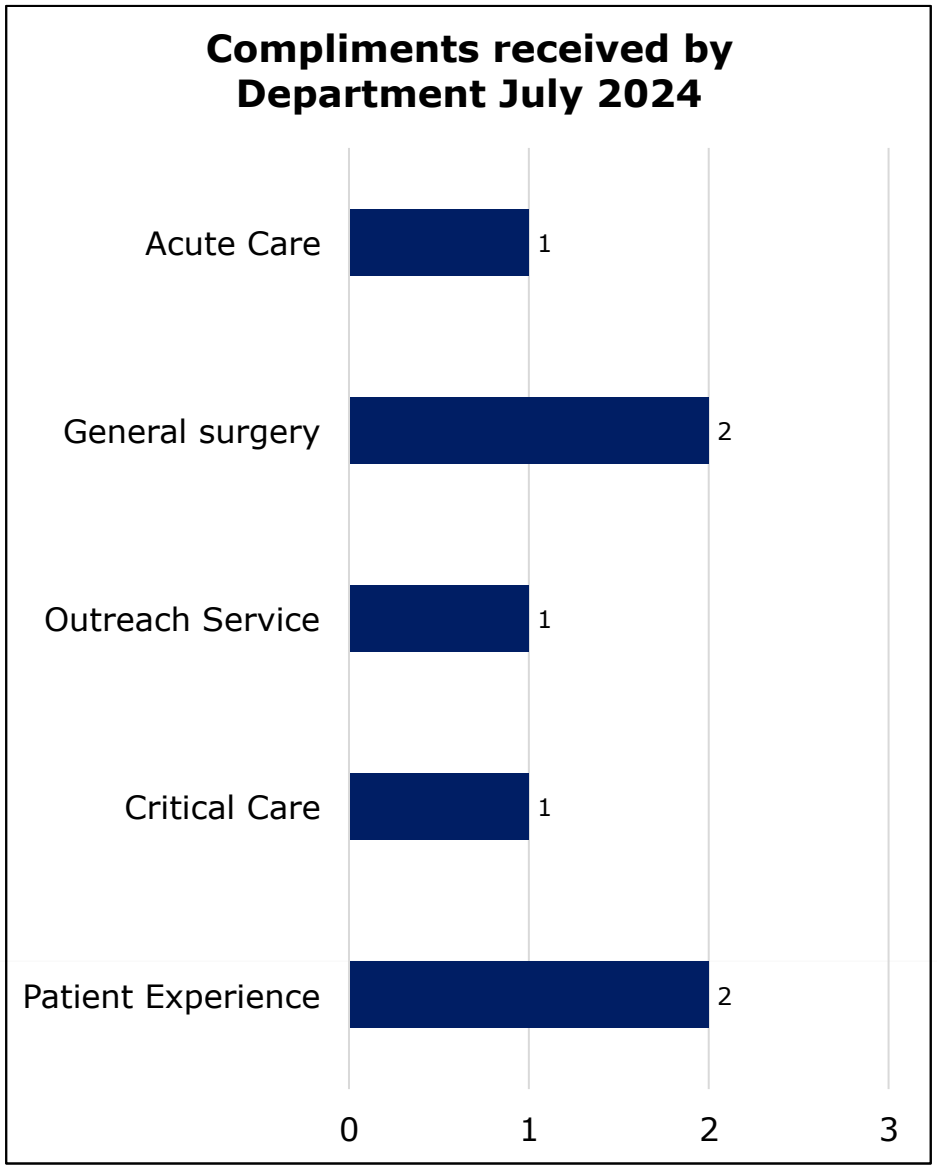
Patient Comments from PCC Survey



Patient Advice & Liaison Service







External Assessments – July 2024

Health Inspectorate Wales - Inspections and National Reviews

Ty Lafant, Llanfrechfa Grange – April 2024
Inspection Report received: 10 July 2024
No. of recommendations identified: 27
No of actions identified: 59
No. of actions outstanding: 12 (in-date)

Health Inspectorate Wales – Immediate Assurance Letters

Month	No. of Immediate Assurance Letters	Ward/Area of concern
July	1	Hafen Deg Ward, County Hospital (CAS-INVES-10704)

Llais Gwent Region Visits

Llais Gwent Region Engagement Report: Hip and Knee Planned Surgery
Inspection Report received: July 2024
Number of recommendations identified: 3
Improvement Plan to be shared with Llais by 06/09/24

Infection Prevention & Control – Healthcare Associated Infections

Rate per 100,000 population

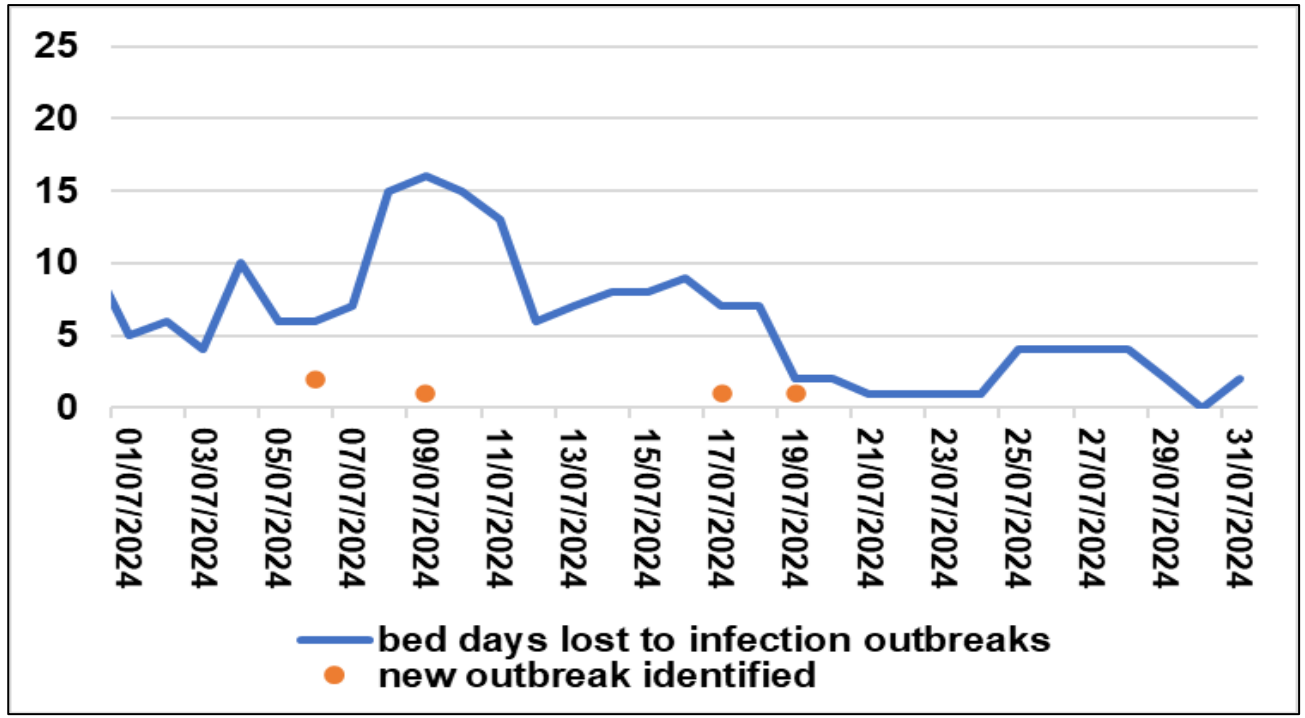
	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	49.58	3.54	31.87	60.71	22.76	7.59
Betsi Cadwaladr UHB	54.34	1.74	23.48	80.42	16.52	1.3
Cardiff and Vale UHB	43.79	1.18	35.51	56.22	25.45	6.51
Cwm Taf Morgannwg UHB	38.41	0.67	29.65	82.87	26.28	4.04
Hywel Dda UHB	59.82	3.11	31.85	95.56	22.53	8.55
Powys THB	29.05	0	2.23	0	0	0
Swansea Bay UHB	58.52	2.34	27.31	52.28	32.77	2.34
Velindre NHST						
Wales	49.58	2.01	28.56	68.31	23.02	4.68

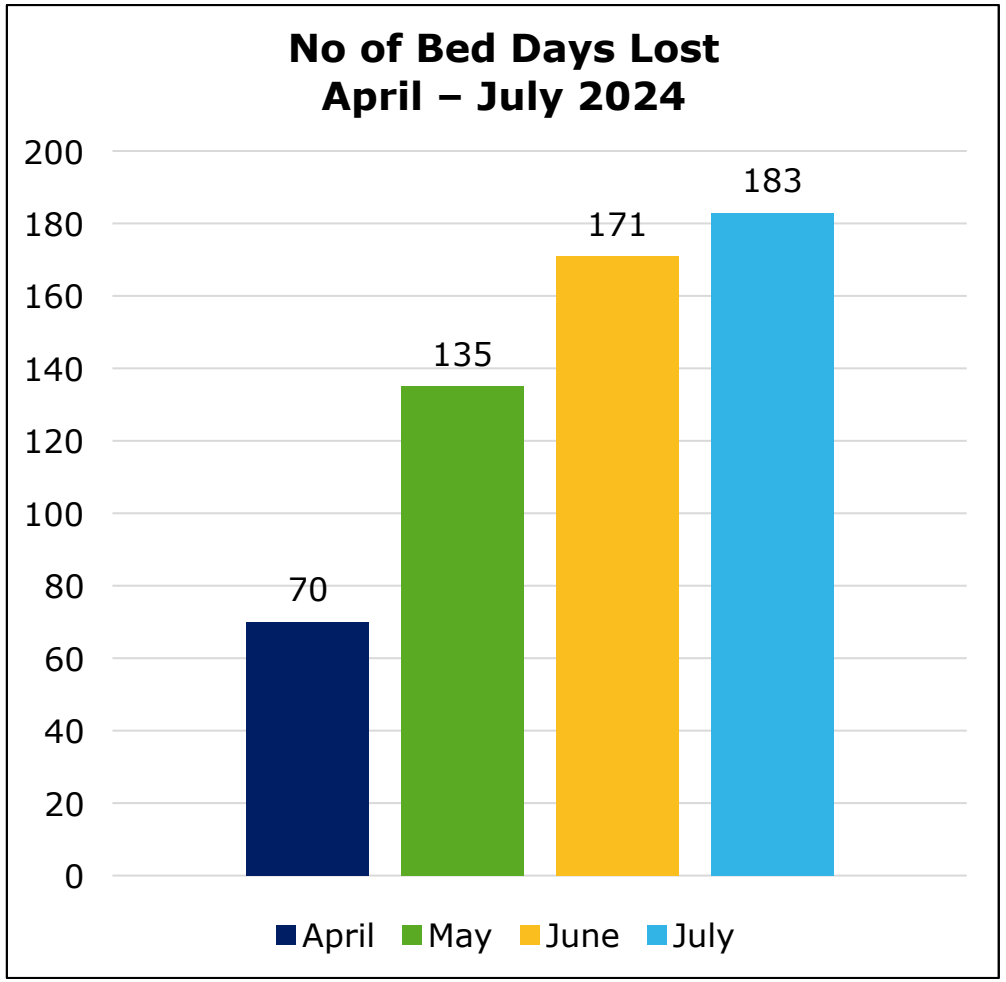
< than same period last FY
= same period last FY
> than same period last FY

Current count of cases for FY 24/25

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	98	7	63	120	45	15
Betsi Cadwaladr UHB	125	4	54	185	38	3
Cardiff and Vale UHB	74	2	60	95	43	11
Cwm Taf Morgannwg UHB	57	1	44	123	39	6
Hywel Dda UHB	77	4	41	123	29	11
Powys THB	13	0	1	0	0	0
Swansea Bay UHB	75	3	35	67	42	3
Velindre NHST	0	0	1	2	5	0
Wales	519	21	299	715	241	49

Bed Days Lost





Changes to the management of sporadic cases of Covid – inline with WG guidance has resulted in beds remaining closed for longer periods, but fewer full ward closures & outbreaks as cases managed within bays.

Infection Prevention & Control – Healthcare Associated Infections

Issue	Cause	Remedial Action	Who	When
1 ward closed due to period of increased incidence of C difficile: Ebbw Ward Not Geno sequencing linked	• Inappropriate sample collection • Complexed patient with numerous courses (9) of antimicrobials	• Period of increased incident meeting • Decant HPV clean • BBE • Requested antimicrobial audit	Division IPT Facilities Pharmacy	
1 ward closed due to norovirus – C6E	• Shared facilities • ? Linked to visitor as no staff reported symptoms	• Enhanced cleaning • Isolation of infected patients	Infection Prevention Ward Managers	Resolved
2 wards closed due to outbreak of Covid infection: C5W (Gwanwyn) & Anwylfan		• Covid-19 principles promoted • Enhanced cleaning of touch points	Infection Prevention Ward Managers	June 2024
Increase in C difficile infection July Total = 25 ▪ HAI = 13 ▪ CAI = 8 ▪ Relapse = 4	• Contaminated commodes & mattresses	• Ongoing promotion of Health Board action plan	Divisions IPT Facilities Pharmacy	Ongoing
Increase in Staph Aureus Blood stream infections. June Total = 20 (4 MRSA of which 2 linked to UHW) ▪ HAI = 9 (1 MRSA) ▪ CAI = 11 (3 MRSA)	• 6 skin & soft tissue damage • 5 respiratory • 3 bone & joint • 2 line • 1 other device • 1 other primary source • 1 urine	• Developed line care group • Ongoing promotion of ANTT • Reached out to company representation to review training and potentially audits relating to practice verses guidelines • Small group identified to review admission screening	Ward Managers Senior Nurses Tissue Viability	Ongoing
Increase with Gram Negative blood stream infections – fewer cases in June. **June Totals:** E coli = 31 (12 HAI, 19 CAI) Klebsiella = 13 (4 HAI, 1, indet, 8 CAI) Pseudomonas = 4 (1 HAI, 3 CAI)	• 21 urine (3 CAUTI) • 8 Gastro • 8 Hepatobiliary • 4 skin & soft tissue • 3 respiratory • 2 other/unknown • 1 bone & joint • 1 line	• Review of UTI 9 standards • Bespoke education arranged for the 13th of August on UTI • Linked with nurse care record re next steps for ongoing care assessment and documentation	Infection Prevention Bladder & Bowel Service Antimicrobial Pharmacists	Ongoing

Infection Prevention & Control - Actions

- Establishing a Strategic Improvement Group – Terms of Reference and Membership
- Assurance provided to Infection Prevention and Antimicrobial Stewardship Committee on organisational action plan
- Over 100 staff across the Health Board and wider community enrolled to join the virtual UTI management study session on 13 August 2024
- Update provided to Divisional Nurses on 24 July 2024

Welsh Government Targets: Antimicrobial prescribing

- Welsh Government antimicrobial targets are still awaited.
- It is assumed that both primary and secondary care will be asked to achieve 70% or more of all antibiotic use in the 'access' category; these are antibiotics that are lower risk of resistance and *C. difficile.*

Access	Watch		Reserve
Amoxicillin	Amikacin	Fusidic acid	Aztreonam
Ampicillin	Azithromycin	Levofloxacin	Cefiderocol
Benzylpenicillin	Cefepime	Lymecycline	Ceftaroline
Cefalexin	Cefotaxime	Minocycline oral	Ceftazidime/avibactam
Co-trimoxazole (sulfamethoxazole/trimethoprim)	Ceftazidime	Moxifloxacin	Ceftolozane/tazobactam
Doxycycline	Ceftriaxone	Neomycin	Colistin
Flucloxacillin	Cefuroxime	Ofloxacin	Dalbavancin
Fosfomycin oral	Chloramphenicol	Oxytetracycline	Daptomycin
Gentamicin	Ciprofloxacin	Piperacillin/tazobactam (Tazocin)	Ertapenem
Metronidazole	Clarithromycin	Teicoplanin	Fosfomycin IV
Nitrofurantoin	Clindamycin	Temocillin	Imipenem/cilastatin
Phenoxymethylpenicillin	Co-amoxiclav (amoxicillin/clavulanic acid)	Tobramycin	Linezolid
Pivmecillinam	Erythromycin	Vancomycin	Meropenem
Tetracycline	Fidaxomicin		Meropenem/vaborbactam
Trimethoprim			Tedizolid
			Tigecycline

- Baseline performance for both primary and secondary care is awaited from Public Health Wales as there have been changes in both groupings and measurement since the previous WG targets.

C. difficile antibiotic root cause analysis themes July 2024

Antibiotic findings	HCAI	CAI	Relapse	Grand Total
No suboptimal antibiotics	10			**10**
No antibiotics received		2	1	**3**
Possible suboptimal use - increased risk of *C.diff*	1	2		**3**
Possible suboptimal use - no increased risk	1			**1**
Root cause analysis pending	1	5	3	**9**
Grand Total	**13**	**9**	**4**	**26**

- 3 suboptimal antibiotics, with no themes for focus:
  - 1 patient received 5 courses of antibiotics in 8 weeks for diverticulitis, including co-amoxiclav and 7 day courses
  - 1 IV antibiotic continued for 2 days when switched to oral in error
  - 1 patient given clindamycin in Spain
- 4/17 patients did not have their acid-suppressing medicine held whilst on antibiotics

Internal Audit - Limited / No Assurance

There were **no** Limited/No Assurance Internal Audits issued or reported to July's Audit Committee.

Business Continuity

Nothing to report.

PSN066: Safer Temporary Identification Criteria for Unknown or Unidentified Patients

- After a delay due to the inability to affix a prefix to the CRN the temporary hospital number has been fixed.
- The process for registration of patient will be released beginning September aligned with the health board improvement programme for WPAS with a phonetic name list.
- Mass casualty records developed and process tested during recent desktop exercise.
- Unable to meet robust merger process due to:
  - Digital Health & Care Wales not addressing a problem with WPAS as we are unable to completely merge records due to an upgrade which broken the technical process (time scales unknown despite escalation).
  - Due to the age of the code which underpins CWS we are unable to merge in-patients until after discharge as the care episode is technically broken (therefore affecting information available to the clinician on viewing the record) – fix with development of CWS2 next year.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	02 September 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Nosocomial COVID-19 Investigation End of Programme
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade – Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Deb Jackson – Divisional Nurse, Family & Therapies

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

For Assurance

The purpose of this report is to provide assurance that the Aneurin Bevan University Health Board Nosocomial Covid-19 Investigation Programme has been completed, meeting the National Programme objectives as set out by NHS Executive.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board successfully concluded its Nosocomial Covid-19 Investigation Programme on 31 March 2024, in alignment with the objectives set forth by the National Nosocomial Programme commissioned by Welsh Government.

This end of programme report aims to provide assurance to the Committee that the objectives of the programme have been realised.

Cefndir / Background

On 25 January 2021, Welsh Government commissioned the NHS Wales Delivery Unit (later known as NHS Executive) to develop a National Framework for investigating nosocomial Covid-19 cases.

March 2021, the Framework for 'Management of patient safety incidents following nosocomial transmission of Covid-19' was published.

January 2022, the Minister for Health & Social Care announced £9 million in funding, over two years, to support the delivery of the investigation programme.

The programme's key objectives included:

- Provide high level assurance that all patient safety incidents of healthcare acquired Covid-19 were investigated in-line with the requirements of 'Putting Things Right'.
- Ensure concerns raised by patients and their families were fully addressed.
- Collect learning from investigations and cross-reference this with patient and staff experience.
- Develop a national learning plan with the NHS Executive Team.

Asesiad / Assessment

The Health Board was allocated £753,155.00 per annum for 2 years to deliver the programme.

The funding allocation was to support: -

- The necessary resource and infrastructure to deliver the programme.
- Establish relevant internal assurance mechanisms.
- Proactively engage with patients and families.
- Establish the necessary infrastructure to provide a dedicated point of contact for supporting families, five days a week.
- Develop a robust governance structure to appraise the Health Board of progress with investigations.
- Establish mechanisms to update NHS Executive Team on progress.
- Engage with colleagues in the NHS Executive Team, who have overall responsibility for national leadership and oversight, in relation to implementation and application of the national framework.
- Work with the NHS Executive Team to develop the national learning plan.

The key elements of the Health Board's programme structure and initiation were: -

Programme Management Team

An internal Programme Management Team within its Quality & Safety and Infection Prevention and Control departments. This team was responsible for conducting investigations into patient safety incidents of nosocomial Covid-19.

Reporting Structure

The programme reported to the Health Board Patient Quality Safety & Outcomes Committee (PQSOC), ensuring appropriate oversight and assurance at the Board level.

Internal Assurance Mechanisms

Internal assurance mechanisms to provide assurance to the PQSOC, the Board, and nationally through the NHS Executive Team's national programme were established.

These mechanisms helped monitor the progress and outcomes of the investigation programme.

Organisational Learning
The Health Board established processes to capture and share organisational learning from the incident investigations. This learning was disseminated both internally and through the NHS Executive national programme to promote best practices and continuous improvement.

Alignment with National Framework
The Health Board programme aligned with the National Framework for the Management of Patient Safety Incidents following Nosocomial Transmission of Covid-19" published in March 2021 and updated in October 2021. This ensured a consistent approach to investigations across NHS Wales organisations.

By establishing this dedicated programme structure and processes, the Health Board demonstrated its commitment to thoroughly investigating nosocomial Covid-19 cases, addressing patient and family concerns, and driving organisational learning to enhance patient safety and quality of care.

The 3 workstreams of the programme which included:
- Establishment
- National learning
- Patient staff and family experience

have all been completed on time and within allocated funding.

Following the successful completion of the Health Board Covid-19 investigation programme, several key outcomes have been achieved: -

Residual Enquiries Management
Measures are in place to manage any residual enquiries through the Putting Things Right (PTR) process, ensuring a consistent and thorough approach to addressing ongoing concerns.

Feedback and Learning
Feedback mechanisms have been established through the Quality, Patient Safety (QPS) divisional forums and the QPS learning group. This ensures that lessons learned from the programme are shared and incorporated into future improvements.

Assurance and Completion
The NHS Executive has been assured of the Health Board's position and completion of the programme, providing confidence in the Health Board's ability to investigate and address nosocomial Covid-19 cases.

National Programme Learning Report
The National Programme Learning Report, which captures the collective learning from the programme, is due to be published by the NHS Executive in the near future. This

report will provide valuable insights and best practices for the wider healthcare community.

These outcomes demonstrate the Health Board's commitment to thoroughly investigating nosocomial Covid-19 cases, addressing patient and family concerns, and driving organisational learning to enhance patient safety and quality of care.

Argymhelliad / Recommendation

The Committee is asked to NOTE the assurance of the Health Board's position from the end of programme report.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	9750 / 2 9515 / 2 8567 / 2 9752 / 6
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply 1.1 Health Promotion, Protection and Improvement 2.1 Managing Risk and Promoting Health and Safety 6.3 Listening and Learning from Feedback
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**

Ar sail tystiolaeth: Evidence Base:	All in line with national Framework lead by The NHS executive
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

National Nosocomial COVID-19 Programme

COVID-19 Investigation Team

End of Programme Learning Report

Background

- On 25 January 2021, the Quality & Safety Team at the NHS Wales Delivery Unit (latterly known as NHS Executive) were commissioned by Welsh Government to develop a National Framework to support a consistent national approach towards investigations following patient safety incidents of nosocomial COVID-19.

- In March 2021, the Framework into the 'Management of patient safety incidents following nosocomial transmission of COVID-19' was published.

- January 2022, the Minister for Health and Social Care announced £9m funding over 2 years to support the delivery of the programme of investigation work into cases of nosocomial Covid-19.

Expected Outcomes of Programme

- To provide high-level assurance that all patient safety incidents of healthcare acquired COVID-19 were investigated in line with the requirements of 'Putting Things Right' , and to ensure concerns raised by patients and their families were fully addressed.

- To collect learning from investigations and cross reference this with patient and staff experience, which would also be captured as part of the programme.

Programme Delivery

Aneurin Bevan University Health Board was allocated £753,155.00 per annum for 2 years to deliver the programme.

The funding allocation was to support: -

- The necessary resource and infrastructure to deliver the programme.
- Establish relevant internal assurance mechanisms.
- Proactively engage with patients and families.
- Establish the necessary infrastructure to provide a dedicated point of contact for supporting families for five days a week.
- Develop a robust governance structure to appraise the Health Board of progress with investigations.
- Establish mechanisms to update NHS Executive Team on progress.
- Engage with colleagues in the NHS Executive Team, who have overall responsibility for national leadership and oversight, in relation to implementation and application of the national framework.
- Work with the NHS Executive Team to develop the national learning plan.

ABUHB Programme Structure

Set up and initiation:

- Establish an internal Programme Management Team within the Quality & Safety/ Infection Prevention and Control Team.

- Establish reporting lines to Patient Quality Safety & Outcomes Committee (PQSOC).

- Establish appropriate internal assurance mechanisms to provide assurance to the PQSOC, the Board and Nationally through the NHS Executive Team national programme.

- Develop mechanisms for capturing and sharing organisational learning from incident investigations through to NHS Executive.

Implementation of Framework within ABUHB

Workstream 1: Establishment

Objective	End of Programme RAG rating
Establish governance structure	
Establish operational delivery group with clear reporting lines	
Quarterly reporting to QPSOG on progress against the requirements of the Framework	
Monthly reporting to NHS Executive on progress	
Input ABUHB Data to repository to hold relevant assurance information, with a robust audit trail.	
Develop COVID-19 Investigation programme risk register	
Support the NHS Executive rolling programme of on-site visits and assurance activities in relation to organisational mechanisms for the implementation.	
Establish a process to integrate nosocomial COVID-19 national incident reporting requirements in keeping with local and national policy, processes for Nationally Reportable Incidents.	
Establish a process to include coordination of dealing with cross-cutting issues (e.g., Legal and Risk advice)	
Seek continued provision of support and advice from the NHS Executive Team	
Establish a process to provide support and advice in relation to local and national communications	

Implementation of Framework within ABUHB

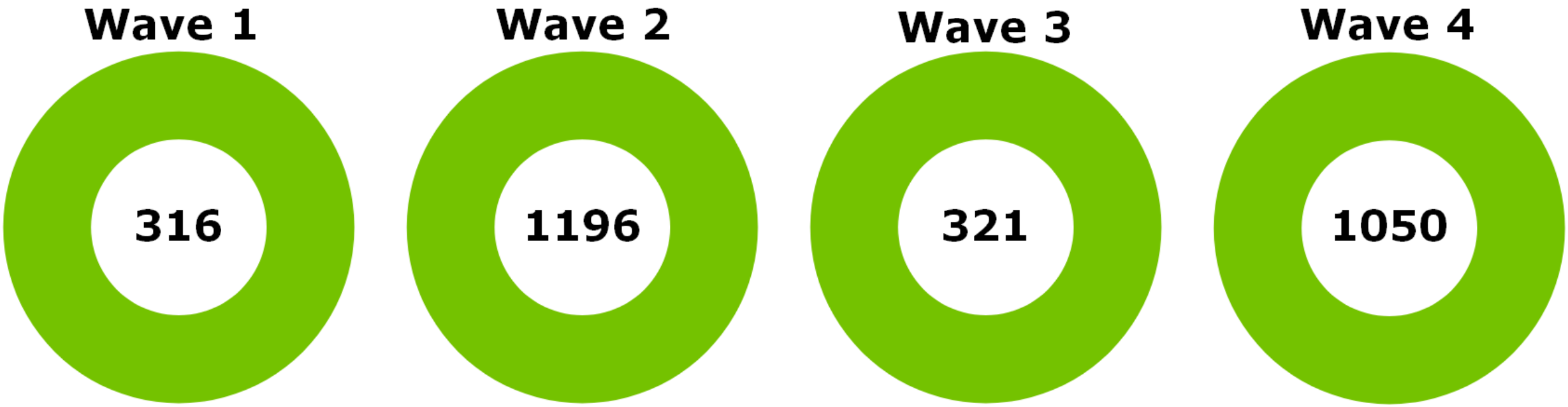
Workstream 2: National Learning

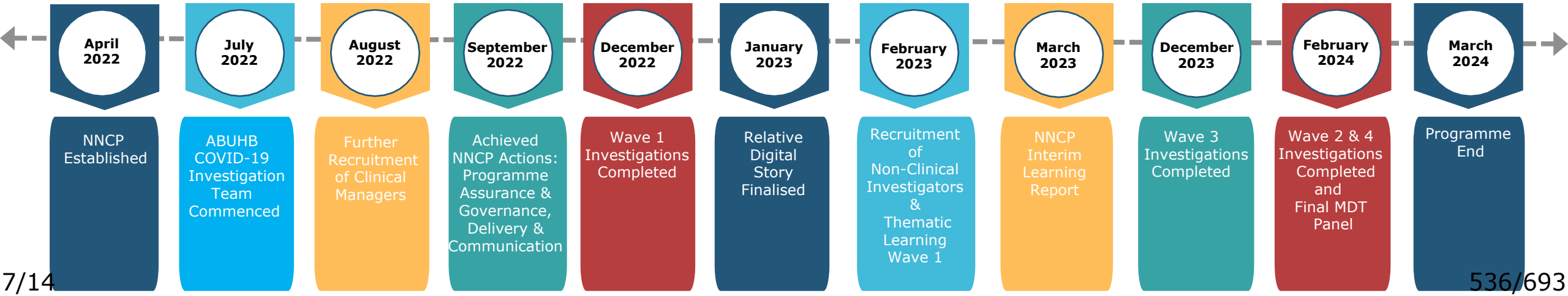
Objective	End of Programme RAG rating
Co-develop with other organisations and NHS Executive a national learning plan	
Engage in a learning and improvement collaboration with key partners	

Workstream 3: Patient Staff and Family Experience

Objective	End of Programme RAG rating
Develop a process to co-ordinate learning to NHS Executive for shared learning across Wales	
Ensure mechanisms for capturing and sharing relevant information from patient, family (or services users) and staff experience, to include the use of Digital Stories.	

Key Milestones





Number of ABUHB Cases Investigated and Categorisation

Categorisation	Number of Cases
Not ABUHB Case	4
False Positive	204
Community Acquired Infection (Positive specimen date ≤2 days after admission)	211
Indeterminate (Positive specimen date 3-7 days after admission)	321
Probable Health Care Acquired Infection (Positive specimen date 8-14 days after admission)	534
Definite Health Care Acquired Infection (Positive specimen date 15 or more days after admission)	1357
Community onset - possible Health Care Acquired Infection (Positive specimen date ≤14 days post discharge, or within 2 days after hospital admission, with discharge from hospital in 14 days before specimen date*)	79
Downgraded at commencement of programme	173
Total	**2883**

*Definition taken from SAGE paper on nosocomial cases of COVID-19 in England

Programme Learning

- A road map of all key changes in Welsh Government and local policy, procedures, guidance and protocols, prior to the programme commencement would have been helpful in accelerating the start of the programme. A significant amount of time at the outset was placed on developing the road map to ensure all key changes were captured to support the investigations and onward scrutiny.
- The use of the clinical surveillance tool, ICNET, was pivotal throughout the programme to support contact tracing, identification and investigation of cases.
- Stakeholder experience improved through an aligned communication strategy:
  - Direct access to the COVID-19 Team through the Single Point Of Contact Line & Email address
  - Internet page containing: Staff, Patient & Family FAQ's, programme team contact details
  - Close liaison with LLais
- Establishing and maintaining multi-professional panel representation throughout the course of the programme provided continuity to assure quality in the application of the framework with additional expertise sought where required e.g. In respect of Mental Health cases.
- The multi-professional approach provided the necessary scrutiny to agree determinants of COVID-19 cases.
- The panel consisted of very senior and experienced registrants who had lived experience of working through the pandemic which brought much needed context to the emerging pandemic and the challenges the Health Board faced throughout.
- NHS Executive oversight, support and visibility provided additional assurance for the Health Board, in regards:
  - Application of the framework
  - Ensuring the multi-professional scrutiny panels were functioning as intended.
  - Ensuring the Health Board was sighted on the programme trajectory, and intervening to provide support if the Health Board was not sustaining the required pace to meet the programme milestones.
  - Provided assurance that the Health Board was consistent in its approach and in-line with other Health Boards across Wales.
  - The All-Wales approach provided touch points, shared learning and peer support for all involved in delivering the programme.
- The Internal Programme Management Team were required to be agile in their approach as they faced many challenges throughout the programme of work. The team structure and skill mix needed to be reviewed and altered throughout to meet the needs of the programme.
- The National Programme demonstrates the benefits of a collaborative All Wales approach.

Organisational Learning

- The pace at which the understanding and transmission of the virus grew resulted in the Testing Strategy and Infection Prevention Control Guidance to be implemented rapidly. Implementing these changes at such a rapid pace was at times extremely challenging operationally, in particular ensuring all front-line staff were fully informed of changes. By way of future learning, a structured and systematic process of audit should be implemented to provide the necessary governance and assurance that all guidance, policies and procedures are implemented at ward level.
- Patient pathways to meet optimal Infection Prevention & Control guidance with some hospital infrastructure coupled with an overwhelming demand was challenging:
  - The data demonstrates the benefits of single occupancy rooms/hospitals for effective Infection Prevention & Control management.
  - The early opening of the Grange university Hospital to manage the pandemic in a single room occupancy hospital significantly improved the ability to ensure patient pathways were optimised and reduced onward hospital transmission of the virus in the acutely unwell.
  - In January 2021 (2 months after GUH opened) ABUHB (with the exception of Powys) demonstrated the lowest rates of hospital onset Covid-19 which was generally sustained throughout 2021/22
- Due to extreme pressure and demand it is acknowledged that record keeping and documentation was, at times, problematic during the pandemic which had an impact on the investigative process. Welsh Nursing Care Records (WNCR) was introduced into ABUHB in November 2022, which allows staff to record, share and access patient information electronically across wards, hospital sites and Health Board areas. WNCR saves times, improving efficiency.
- Maintaining workforce levels in periods of high incidence, due to increased sickness levels and isolation requirements, was challenging. The Health Board took all reasonable steps to ensure appropriate staffing levels, through redeployment and the use of temporary staffing, despite this it remained difficult. In terms of learning, it must be acknowledged that the redeployment of staff requires significant co-ordination and oversight to ensure the wards and those being redeployed are fully aware of roles and responsibilities and have the appropriate training to undertake the redeployment duties asked of them. Co-ordination is required to ensure wards are not overwhelmed by the number of deployed staff and a staggered approach is particularly essential when it is known the merging pandemic is expected to evolve over a protracted period of time.
- ABUHB was the first Health Board to undertake a bereaved relative digital story ‘I kept him safe’. At the request of the relative the story was shared within the Health Board, from Ward to Board, and nationally across Wales. The story demonstrated the impact and devastation of the pandemic on one individual family. It provided valuable learning for the Health Board and allowed the relative to tell her story in memory of her husband.
- Triangulation of data was undertaken from multiple clinical & operational systems with limited integration and access to information was challenging at times. The availability of a central point of access for policy, procedures, processes and decision making documentation would be beneficial for any future programmes of work.

Organisational Learning

Difficulties in regards communication with families and friends was acknowledged throughout the pandemic and again highlighted during the programme. Visiting restrictions compounded problems in regards communication. However, it was necessary to apply restrictions to help reduce transmission of the virus. The Programme identified, that visiting restrictions had adverse effects on patients and family members, and there was limited alternative opportunities for making contact and communicating with loved ones.

In response to this, the Health Board:

- Constantly reviewed and revised visiting arrangements.
- Introduced a Patient Advise and Liaison Service.
- Purchased IPADs to support video calls.
- Has since Introduced: CIVICA, relaunched ‘You said, We Did’ and ‘This is Me’.

Key Milestones

Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)

- The National Nosocomial COVID-19 Programme Interim Learning Report identified the need for improved application and recording of DNACPR as an early improvement theme. Prior to this, in October 2020, the Department for Health and Social Care commissioned the Care Quality Commission (CQC) to conduct a special review of DNACPR decision making. The review was instigated in response to multiple concerns raised during the Covid-19 Pandemic regarding DNACPR decision making without involving people or their family and or carers. The subsequent report, "Protect, Respect, Connect-decisions about living and dying well during Covid-19", published in March 2021 acknowledges extreme demands and increased pressure on health and care staff and services, may hamper decisions and especially communication around decision making.

- The Covid-19 Pandemic and Programme learning has escalated the need to ensure conversations and decision-making process around resuscitation are individualised ensuring "do not attempt cardiopulmonary resuscitation" (DNACPR) decisions are well documented and communicated.
- Following the Covid 19 Pandemic there has been greater awareness and emphasis in Primary & Acute Services to provide more opportunities to discuss the patients wish in relation to cardiac resuscitation. This is evident with a greater number of patients admitted to hospital having already expressed their wishes prior to admission.

- The Health Board is in the process of developing an improvement plan, based on the recent HIW 'Review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decisions for Adults in Wale'. The plan will articulate actions required and timescales to complete in order to improve the service we provide in relation to DNACPR.

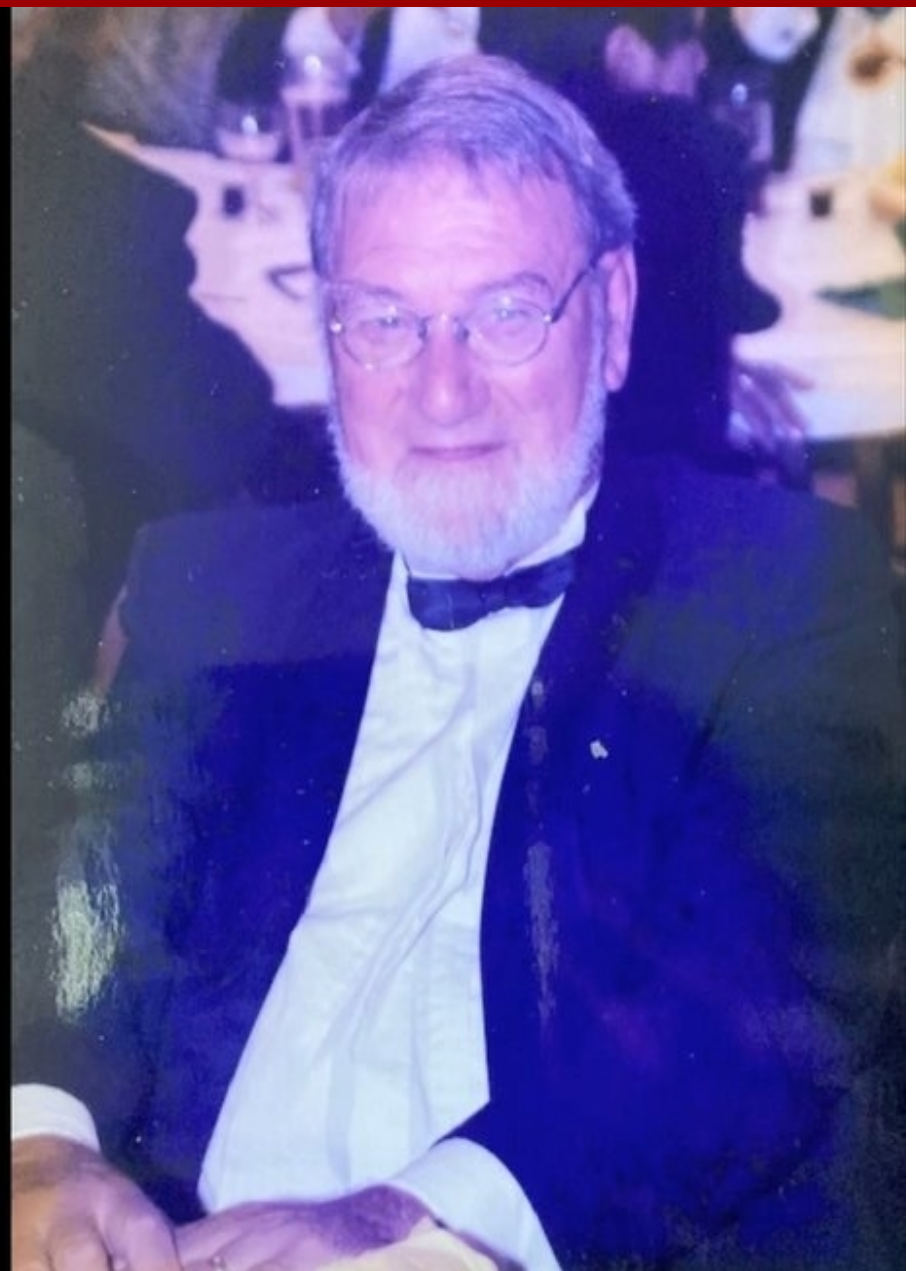
Bereaved Relatives Digital Story

"I kept him safe"

This story has consent to be played anywhere including online

by
Diane Sillman

in memory of
Colwyn Sillman



We wish to thank all those involved in supporting the program and the contribution made to bringing it to a closure.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	02 September 2024
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Patient Quality, Safety and Outcomes Committee – Review of Committee Forward Work Plan 2024/25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Board Business

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Patient, Quality Safety and Outcomes Committee (the Committee) is asked to review the agreed Committee Forward Work Plan appended to this report as Appendix A.

The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2023/24 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

In line with good governance practice, the Committee has a Forward Work Plan that has been developed to ensure statutory requirements for items of Committee

business are scheduled in across the year. The Forward Work Plan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting process.

The Forward Work Programme Plan is designed to assist the Committee in the review of its programme of business. It captures the timing of report submissions, identifies items that have been deferred, and captures new requests for reports. The plan also allows the Committee to monitor and review its business at each meeting.

During the period of July to August the following requests and/or changes to the Forward Work Plan have been included:

Items deferred on the Forward Work Programme:

- Falls and Bone Health Annual Report deferred to November due to ongoing work;
- Health and Safety Compliance Report deferred to November due to ongoing work;
- Commissioning Outcomes Report deferred to November to align with the reporting schedule.
- Primary Care Assurance Report deferred to November to align with Independent Contractor reporting requirements in respect of the Duty of Candour;
- Children and Young Peoples Board Minutes deferred to November meeting to align with the date of the first meeting.

Amendments to the Forward Work Programme:

- Listening and Learning Framework, included within the Quality Performance report;
- Clinical Aduit, included within the Quality Performance report;
- Never Events report, included within the Quality Performance report;
- Clinical Effectiveness and Standards Committee included within the Quality Performance report;
- Report on National Review of Consent to Examination and Treatment Standards in NHS Wales has been removed from the programme as this was a national review conducted in 2023/24 and will not be repeated in 2024/25.

Additions to the Forward Work Programme:

- Listening & Learning Forum Minutes included to be reported as a standard item for reporting;
- Clinical Advisory Group Minutes included to be reported as a standard item for reporting;
- GP Engagement and Child Protection Report included to be reported in November;
- Action Plan on Optimal Antimicrobial Prescribing included to be reported in November;

- Report on the timely closure of Patient Safety Incidents included to be reported in November;

- Protocol for Patients Presenting with Sepsis included to be reported in November.

Following a discussion at the agenda-setting meeting in August 2024, it was agreed that the Committee dates would be reviewed to ensure alignment with the Committee's Terms of Reference and Operating Arrangements, with the meetings now scheduled for: -

- 12th November 2024;
- 20th January 2025;
- 19th March 2025.

Argymhelliad / Recommendation

The Committee is requested to **NOTE** the updated Patient Quality, Safety and Outcomes Committee Forward Work Plan as provided in **Appendix A**.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Annual Programme of Business for 2024-25

Patient, Quality, Safety and Outcomes Committee

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2023/24
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

Area of Focus as per the Committee's Terms of Reference:
The scope of the Patient Quality, Safety and Outcomes Committee encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on: a. The robustness of the Health Board's Clinical Quality Governance arrangements; b. the experience of patients, citizens and carers ensuring continuous learning; c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services; and d. the effectiveness of arrangements in place to support Improvement and Innovation.

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

MATTERS TO BE CONSIDERED	Lead	Frequency of Report	Schedule of Meetings						
			QTR 1		QTR 2	QTR 3		QTR 4	
			30th April	4th June	30th July	2nd Sept	12th Nov	20th Jan	19th March
Preliminary Matters									
Attendance and Apologies	Chair	SI	√	√	√	√	√	√	√
Declarations of Interest	All members	SI	√	√	√	√	√	√	√
Minutes of the Previous Meeting	Chair	SI	√	√	√	√	√	√	√
Action Log and Matters Arising	Chair	SI	√	√	√	√	√	√	√
Committee Governance									
Development of Committee Annual Programme of Business 2025/26	Chair & DoCG	AN					√		
Review of Committee Programme of Business 2024/25	Chair	SI	√	√	√	√	√	√	√
Annual Review of Committee Terms of Reference 2024/25	Chair & DoCG	AN					√		
Annual Review of Committee Effectiveness 2024/25	Chair & DOCG	AN					√		

Outcome of Annual Review of Committee Effectiveness 2024/25	Chair & DOCG	AN						√	
Committee Annual Report 2023/24	Chair & DOCG	AN	√						
Committee Annual Report 2024/25	Chair & DOCG	AN						√	
Committee Risk Report	DOCG	SI	√	√	√	√	√	√	√
NHS Wales Joint Commissioning Quality Committee Report	DOCG	SI	√	√	√	√	√	√	√
Pharmacy Robot Risk Assessment	DOCG	Action			√ (incl. in risk report)				
Quality Governance Framework									
Quality Strategy - Quality Outcome framework	DoN	Quarterly			√		√		
Quality Annual Report 2023/24	DoN	AN				√			
Quality Assurance Framework Annual Review and Evaluation of Progress	Clinical Executives	AN						√	
Primary Care Quality Report	COO	Bi-AN				√**D**	√		
Performance Report on the Pillars of Quality, to include:- • Patient experience and stories • Incident reporting - falls/ pressure ulcers medicines management and mortality • Healthcare Inspectorate Wales Operational Plan	DoN /MD & DOTHS	Quarterly		√	√		√	√	

• Complaint, concerns and compliments • Health Safety and Security • Infection Prevention and Control • Safeguarding • Clinical Negligence Claims and Coroners Inquests Report • Quality & Engagement (Wales) Act, Preparedness and Implementation • Tracking of Improvement Actions Arising from Inspections and Reviews • Cleaning Standards Annual Report • Infection Prevention and Control • MCA & DOLs • Child and Adolescent Mental Health Quality Outcomes Report, including self-harm and suicide • Clinical Audit • Mental health and learning disabilities assurance • Listening and Learning Framework Outcomes • Never Event Incidents • Operational Quality updates on: o Cancer									

○ U&EC ○ Planned Care									
Pillars of Quality Interim Report	DoN	Bi-Annual	√			√			
Healthcare Inspectorate Wales Annual Report	DoN	AN	√						
Stroke Delivery Group Annual Report	DOTHS	AN					√		
Commissioning Assurance Framework, Development, and Implementation	Clinical Executives	AN		√D	√				
Commissioning Outcomes Report	Clinical Executives	Bi-An				√D	√	√	
Putting Things Right Annual Report 2023/24	DoN	AN				√			
Maternity Services: Organisational Improvement and Action Plan	DoN	Bi-An			√			√	
Learning from Death Report	MD	Bi-AN	√				√		
Listening and Learning Framework	DoN	AN	√						
Listening & Learning Forum Minutes	DoN	SI	√	√	√	√	√	√	√
IPC and Cleaning Standards	DoN	AN		√D	√				
Annual Volunteering Report	DoN	AN		√					

Mortuary Incident Action Plan	DoT&HS	AN		**√D**	**√**				
Covid-19 Nosocomial Investigations Report	DoN	AN		**√D**	**√ D**	**√**			
Challenges in securing improvements within the Mental Health & Learning Disabilities	DoN	Action				**√**			
Clinical Advisory Committee Minutes	DoN	SI	**√**	**√**	**√**	**√**	**√**	**√**	**√**
Protocol for patients presenting with Sepsis **PQSOC 3007/07**	DoN	Action					**√**		
Report on time closure of patient safety incidents **PQSOC 3007/07**	DoN	Action					**√**		
Safe Care									
Medical Devices Annual Report	DoT&HS	AN					**√**		
Radiation Protection Group Annual Report	DoT&HS	AN					**√**		
Falls and Bone Health Management Annual Report • Deep Dive on Falls **PQSOC 3007/07**	DoT&HS	AN		**√D**	**√D**	**√D**	**√**		
Health and Safety Compliance Annual Report	DoT&HS	AN			**√D**	**√D**	**√**		

Human Tissue Act Group Annual Report	DoT&HS	AN				√			
Pharmacy and Medicines Management Annual Report	MD	AN			√				
Safeguarding Annual Report	DoN	AN			√				
GP Engagement and Child Protection Report **PQSOC30/07 3.4**	DoN Action	AN				√			
Action Plan on Proper Antimicrobial Prescribing **PQSOC30/07 3.3**	DoN Action	AN				√			
Effective Care									
Research and Development Annual Report	MD	AN				√			
Hospital Transfusion Committee Annual Report	MD	AN			√				
Organ Donation Annual Report	MD	AN				√			
Annual Report on Clinical Audit Activity 2023 – 2024	MD	AN		√					
Overview of Audit Internal & External Recommendation Tracking (relevant to the Committee)	DoCG	Quarterly	√		√		√		
Nutrition and Hydration Committee Update Report	DoT&HS	AN					√		
Review of neurodevelopmental service for U18s	DoN	AN			√				
Patient Centred Care									

Children's Rights & Participation Forum	DoN	Bi-AN			√			√	
Dementia Care Annual Report	DoN	AN				√			
Children and Young Peoples Board Minutes	DoN	SI				√D	√	√	√

Lead Officer	
Key	
CEO	Chief Executive
DoCG	Director of Corporate Governance
DoF&P	Director of Finance & Procurement
DoSP&P	Director of Strategy, Planning & Partnerships
COO	Chief Operating Officer
DPH	Director of Public Health
DoT&HS	Director of Therapies & Health Science
DoW&OD	Director of Workforce & Organisational Development
DoN	Director of Nursing
MD	Medical Director

DOD	Director of Digital
Chair	Chair

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	1/2 yearly
Schedule of Meetings	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Susan Elsmore**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**24 June 2024**

Summary of key matters considered by the Committee and any related decisions made

1. CARDIAC PATIENT SOTRY

Members received an informative patient story about a gentleman who had suffered a sudden cardiac arrest. Members noted the challenges that the patient faced at the outset and how a range of JCC services and the public saved his life. The patient and his family praised the care that they had received throughout this traumatic event. The patient story highlighted the positive impact that the EMRTS service and the cardiac services had made to the patient's quality of life.

2. WELSH KIDNEY NETWORK REPORT

Members received a report outlining the current Quality and Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales and a summary of the highest scoring risks was provided.

3. COMMISSIONING TEAM AND NETWORK UPDATES

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below and updates regarding services in escalation are attached in the tables at the end of the report.

3.1 Cancer & Blood

Members received an update of the quality issues for services relating to the Cancer and Blood Commissioning Team Portfolio.

- **South Wales Plastic Surgery**
  Members noted that this service provided by SBUHB remained at Level 2 of the Escalation process and was the only NWJCC commissioned service where patients were waiting over 104 weeks. The JCC made a choice around not accelerating improvements but within the ICP for 2024/2025 it was agreed to continue with this steady improvements towards the target. However, following approval of the ICP, WG published targets to achieve

104 weeks by March 2025. These were further revised in a letter received from the Deputy General/CEO NHS Wales on 7 May 2024 outlining revised Ministerial targets of no patients waiting over 104 weeks by the end of December 2024. This will require a decision to be made by the NWJCC in July 2024 and the NWJCC is undertaking further work currently with SBUHB to understand the demand, activity and efficiency assumptions in this delivery plan and trajectory, and engaging with Health Boards on the approach to the balance between the financial position and performance.

- **Plastic Surgery Outreach at BCUHB**
  This service was currently within the Welsh Government escalation/ special measures framework for BCUHB as the quality issues concern the operational responsibility of BCUHB for the provision of clinic administration and facilities under a Service Level Agreement between the Health Board and MWL. WG have acknowledged that there was evidence of improvement. Since the last meeting the harms review had been completed and it was presented to BCUHB QPSC Committee in June 2024. The report provides assurance that no evidence of patient harm was found. Despite this being a retrospective review, these issues have been mitigated as the level of service support, administration, quality reporting process, activity and waiting times reporting and ongoing monitoring arrangements have been strengthened. In addition, they have also funded waiting list initiatives to address the backlog and there were fewer patients on the waiting list compared to when the review was started.

3.2 Cardiac

Members received an update of the quality issues for services relating to the Cardiac Commissioning Team Portfolio.

- Although the two service providers in South Wales following a Getting it Right First Time (GIRFT) review have been in escalation for some time, they have been on a de-escalation trajectory for most of that time and both services have engaged well with the escalation process. Swansea Bay Cardiac Surgery Service was de-escalated from Level 2 to 0 of the Escalation Framework in May 2024 and was now out of escalation completely. The Cardiff and Vale Cardiac Surgery Service has been de-escalated to Escalation Level 1 pending receipt of an audit report.
- An update was provided on the exercise into any unreported cases of Mycobacterium Chimera. This bacteria is associated with water heater cooling systems used in cardiac surgery. They undertook an extensive piece of work in terms of a look back and this work has concluded with no new cases having been reported within the last 8 years. This extensive work seems to be working as there had been no recent reported cases.

3.3 Neurosciences

Members received an update of the quality issues for services relating to the neurosciences Team Portfolio.

- NWJCC had reallocated funding to address the Neurosurgery risk and agreed additional money within the ICP for 2024-2025.

- There were two service related risks which were being managed in line with the engagement for service change guidance issued by Welsh Government and the NWJCC were keeping in close contact with Llais.

3.4 Women & Children

Members received an update on the quality issues for services relating to the Women & Children Commissioning Team Portfolio. The risks largely mirror the services in escalation, and it was acknowledged that the volume of risks and escalation issues within the portfolio are concerning and make this a complex and challenging area.

Paediatric Surgery

Members noted the positive progress and good evidence of operational improvement underpinning a reduction in the waiting times and the waiting list in line with the accelerated target over and above the ministerial measures of 52 weeks that the JC agreed last year. The HB was not able to achieve the target by the end of March 2024 due to the industrial action but assurance has been received that the target will be achieved by the end of June 2024. Based on this assurance, the Commissioning Team agreed to de-escalate the service to Level 0 and the service has returned back to normal performance monitoring arrangements. The letter confirming the de-escalation was sent to the provider last week. The JCC ambition for this year was to maintain that 52 week wait.

Wales Fertility Institute

Members noted the positive progress with the Fertility service issues. Due to regulatory issues following an inspection by the HFEA the service was placed in escalation Level 4 with regular reporting through the NWJCC via the Performance Report. A positive inspection report from the HFEA had recently been received and reported through the escalation meeting. There had been good progress in the appointment of a Person responsible (PR) with the intention to appoint more than one person to perform the PR role to ensure sustainability going forward. Following confirmation of the above progress, the Commissioning Team agreed to de-escalate the service to Level 3 and remove the service from the critical escalation Level 4.

Neonatal Care (NICU) and Paediatric Intensive Care (PICU)

Members noted that there was less assurance in relation to Paediatric Intensive Care (PICU) and Neonatal Care and as commissioners it was noted that the same level of progress had not been made within these service areas. A decision was taken to reset the process at executive level and move towards a more outcomes and objectives based escalation. Whilst most of the services have been on a de-escalation trajectory, progress within these two service areas was complicated

due to some underlying themes such as the scarcity of specialist workforce. The NWJCC understood the complexities and this was the reason for the reset approach to try and achieve a better outcome for the population of South Wales.

Members discussed the new approach and questioned how these services would be measured going forward. Members were assured that the NWJCC would be using national benchmarks and metrics and monitoring those together with the Health Board and addressing access to those really highly specialised services to ensure that we are assured on the quality management systems and workforce availability within these two areas.

3.5 Mental Health

Members received an update of the quality issues for services relating to the Mental Health and Vulnerable Groups for the former WHSSC Commissioning Team Portfolio.

Members noted that there had been little change to the commissioning risks since the last report. Funding to address the Neuropsychiatry sustainability risks was approved and was included in the ICP for 2024/2025 with the aim to bring the business case seeking funding release to the Management Group meeting in July 2024.

Members noted the comprehensive summary regarding Gender Development Service (GIDS) for Children and Young People, the Cass review, the new legislation around prescribing puberty supressing hormones and the progress that has been made on Phase one and Phase two of the NHS England transformation programme.

Members were made aware of some issues in relation to a specialist eating disorder provider.

3.6 Intestinal Failure (IF) – Home Parenteral Nutrition

Members received an update on the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio. Members noted that the Independent Provider Framework Agreement with the independent sector for the provision of home care and parenteral nutrition products ended on 30th June 2024. A procurement process was undertaken by the NHS Wales Shared Services Partnership (NWSSP) to renew the Framework agreement. The three open risks were linked to this issue and will be de-escalated following the renewal of this Framework agreement.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

4.1 Services in Escalation Summary

Members noted the content of the report and the Paediatric services in escalation Level 3 were discussed in detail above under the Women and Children's Report.

A copy of each of the services in escalation is attached to the report at **Appendix 1.**

4.2 Quality and Safety Report (Former EASC)

Members received a report providing an update on quality and safety matters for the Emergency Ambulance Services Committee (EASC) commissioned services. Members noted that this report was usually considered under the EASC Management Group before being presented to the EASC Joint Committee.

A range of the measures were presented and discussed. Members provided useful feedback on what information they would find useful for future reports.

4.3 Mental Health and Vulnerable Groups Commissioning Management Team Report

Members received a report providing an update on issues for services relating to the MHVG Commissioning Management Team. Due to the transition of work from the former Quality Assurance Improvement Service into the new NWJCC, the service portfolio reported was focused on the 'National Collaborative Framework for the provision of services for Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals', with a view to presenting a fully integrated MHVG report for the next QPSC meeting.

Members provided useful feedback on what information they would find useful for future reports.

4.4 Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update

A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period February 2024 to May 2024 was presented to the committee.

4.5 Incident and Concerns Report

Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance.

4.6 Policy Group Report

Members received an update on activity and output from the NWJCC Policy Group during the period 1 January 2024 – 31 March 2024 together with an updated overview of all NWJCC policies and service specifications including those published during the current financial year, together with the rationale for their development.

5. ITEMS FOR INFORMATION

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee April 2024;
- Welsh Health Circular: NHS Wales National Clinical Audit and Outcome review plan: Annual Rolling Programme from 2024/2025; and
- QPSC Distribution List.

6. ANY OTHER BUSINESS

Members provided useful feedback on the quality newsletter.

Key risks and issues/matters of concern and any mitigating actions

Key risks are highlighted in the narrative above and summarised below;

- The general concerns with paediatric services in CVUHB.
- Ensuring future reports are aligned to the new duty of quality.
- Ensuring concerns report contain some trends and themes as well as capturing patient experience/stories.

Summary of services in Escalation

- Attached (***Appendix 1***)

Matters requiring Committee level consideration and/or approval

None

Matters referred to other Committees

As above.

Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	2 September 2024

Executive Director Lead: Nicola Johnson and Carole Bell
Commissioning Lead: Vacancy
Commissioning Team: Women and Children

Date of Escalation Meetings: Most recent - 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 19/02/2024

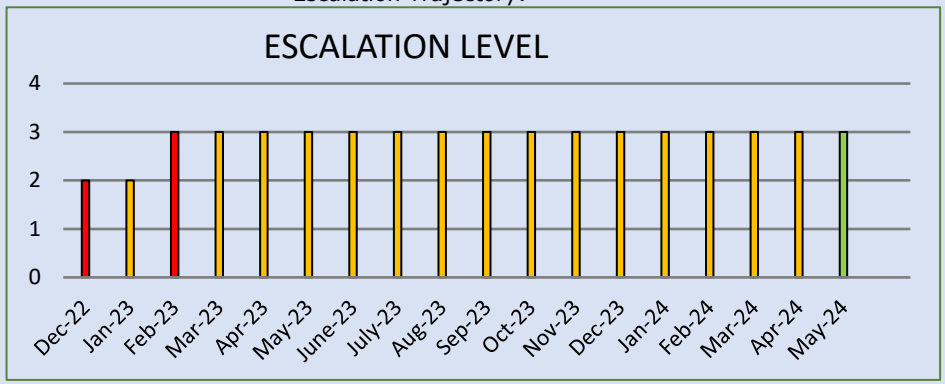
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
May 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
As a result of the service failing to engage fully with WHSSC regarding contract delivery and waiting time profiles, it was agreed that the service should be further escalated from Level 1 to Level 3 of the WHSSC Escalation Framework. A target of 52 weeks was set by the WHSSC Joint Committee.

Background Information:

• The WHSSC Joint Committee committed to a target of 52 weeks and to maintaining this in the ICP 2024/25. There has been operational improvement in the service.

WHSSC assurance and confidence level in developments:

High – Action plan developed and positive progress made in delivering service improvements and securing additional capacity. The target was not met by the end of March due to the effects of industrial action but assurance has been given on achieving it by the end of June 2024. This has been reported to Management Group and JCC with acknowledgement that de-escalation is to be considered at the Commissioning Team meeting in June 2024.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Monthly escalation meetings with CVUHB to review progress against the improvement plan.	Senior Planning Manager	Monthly	
Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Monthly	
Triple escalation meetings established to monitor progress of all three paediatric services in escalation against overarching objectives.	Director of Planning & Performance / Director of Nursing and Quality	16 May 2024	

Issues/Risks:
May 2024 – Escalation status being considered at Commissioning Team meeting in June 2024.

Executive Director Lead: Nicola Johnson
Commissioning Lead:
Commissioning Team: Women and Children

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 19/02/2024

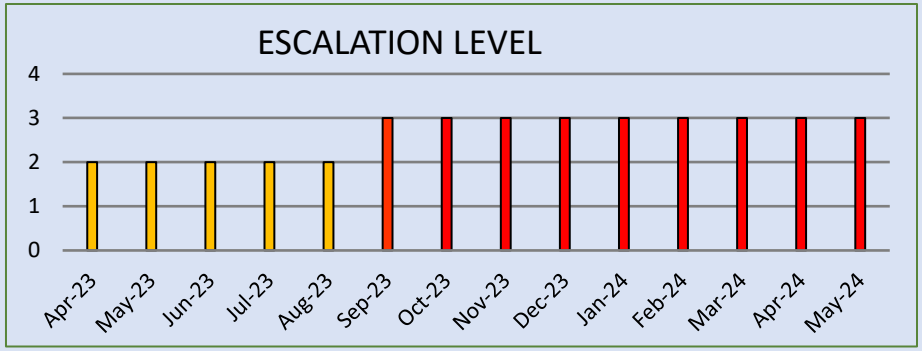
Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
April 2023	**2**
September 2023 – Increased level from 2 to 3	**3**

Rationale for Escalation Status :

Following concerns regarding bed availability due to workforce shortages, refusal rates and pressure sore incidents the service was escalated to level 2. There was limited progress over a 3 month period against the objectives therefore the decision was taken to further escalate to level 3.

Background Information:
There is a risk that a Paediatric intensive care bed, in the Children's Hospital for Wales, will not be available when required due to constraints within the service. There is a consequence that Paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment is not available or the patient being transferred out of Wales. The availability of a bed and staffing constraints have been brought to the attention of WHSSC through various routes including HiW and the daily SITREP.

WHSSC assurance and confidence level in developments:
Low – HB have submitted draft action plan, a final version has been requested. The escalation is predominantly linked to workforce and the lead in time for mitigations is medium term, in particular the recruitment of International Nurses. New streamliners have begun in the HB and although supernumerary at present and will not directly fill PIC vacancies it will support the wider workforce challenges across the Children's Hospital. WHSSC are still awaiting detailed demand and capacity in order to develop a sustainable contracting framework for Paediatric Intensive Care and High Dependency. Escalation status being discussed at executive level within the JCC.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Requested demand and capacity plan from HB to develop sustainable contracting framework for PIC and HD	Senior Planning Manager	30 June 2024	
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Senior Planning Manager	Ongoing	
Triple Escalation meeting to discuss detail and progress against action plan (monthly)	Senior Planning Manager	16/05/24	

Issues/Risks:

Executive Director Lead: Nicola Johnson
Commissioning Lead:
Commissioning Team: Women and Children

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 19/02/2024

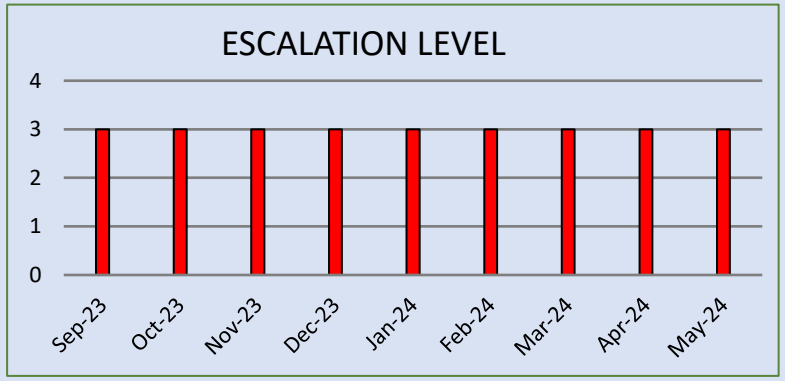
Service in Escalation:
Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	**3**

Rationale for Escalation Status :

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

Background Information:
There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

WHSSC assurance and confidence level in developments:
Low / Medium – First draft of an action plan has been received however further detail has been requested. The mitigations required to support safe staffing levels and improvements against infection rates requires a robust workforce plan which has a medium to long term lead time for completion. Escalation status being discussed at executive level within the JCC.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live	Director of Planning	16/05/24	

Issues/Risks:
March 24 - The service have not submitted an action plan despite being in escalation since Sept 23, they are unable to increase their cot numbers based on the new cot configuration and reported that they cannot safely deliver on the cots that they are currently commissioned, no progress made with exec to exec meeting, possibility that outsourcing from the service may be required, the service remains at escalation level 3 but if there are no improvements increasing the escalation will be considered.
May 24 - Through quarterly assurance meetings with all neonatal units in the South & West of Wales it has been reported that there has been increased pressure across the network for cot availability

Executive Director Lead: Iolo Doull
Commissioning Lead: Dominique Gray-Williams
Commissioning Team: Women and Children

Date of Escalation Meetings: 07/08/23, 19/09/23, 10/10/23, 07/12/23, 15/02/24, 14/03/24, 11/04/24, 08/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 19/02/2024

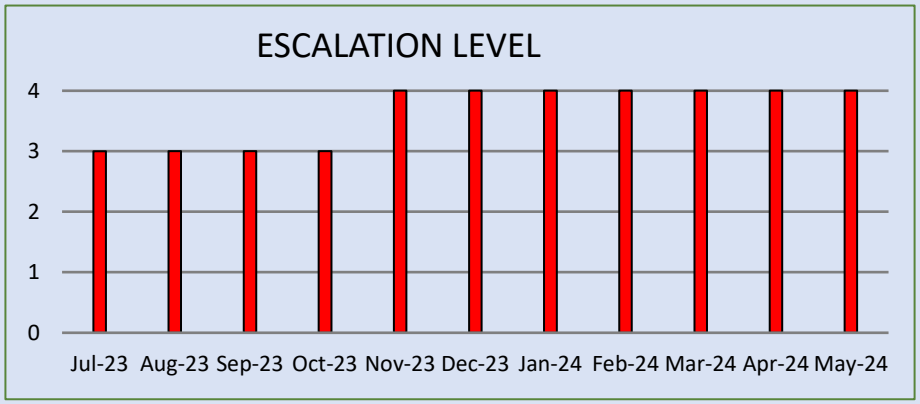
Service in Escalation: Wales Fertility Institute

Current Escalation Level 4

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2023 – WHSSC escalation	**3**
November 2023 – WHSSC escalation	**4**

Rationale for Escalation Status :
Concerns from a number of routes with regards to the service including the WHSSC contract monitoring data submission; adherence to WHSSC policies and HFEA performance outcomes below National average.

Background Information:
A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, WHSSC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service.
There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

WHSSC assurance and confidence level in developments:
Medium – The Health Board have instigated regular Gold Command and operational service improvement meeting with positive progress made in addressing HFEA concerns. The Action plan has been agreed and progress has been made with regards to WHSSC data submissions, however, the service need to ensure time is given both internally and to WHSSC to allow for review and consideration of documentation.

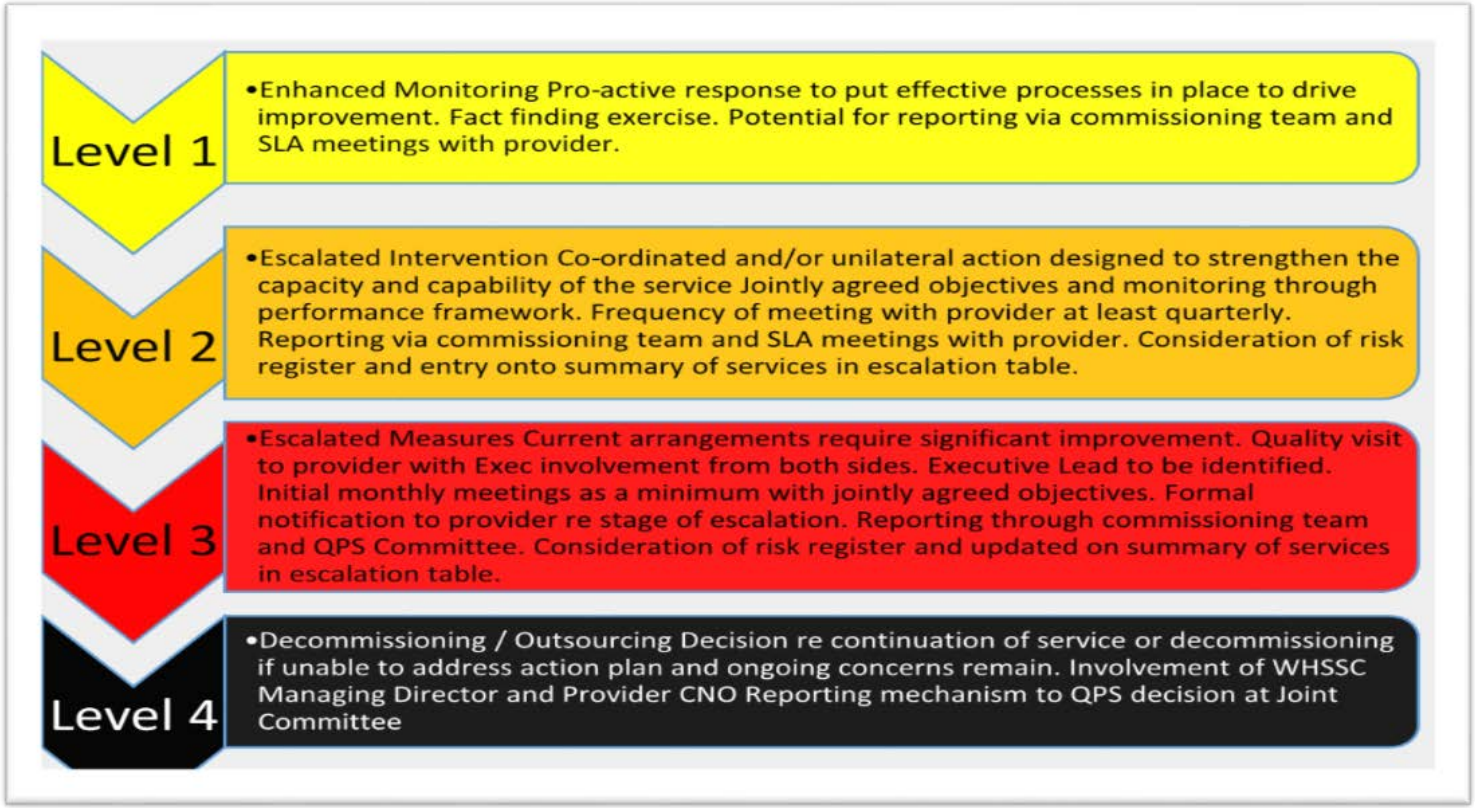
Actions:

Action	Lead	Action Due Date	Completion Date
Monthly escalation meeting to review progress against Action Plan Escalation meeting 19th September 2023 10th October 2023 7th December 2023 15th February 2024 14th March 2024 9th April 2024 8th May 2024	Assistant Specialised Planner	Monthly	13 June 2024

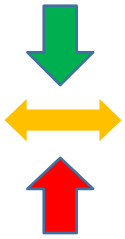
The service submitted an audit of notes to the HFEA at the end of December, they are awaiting feedback from this submission. The service have identified a number of suitable staff members to prepare and take on the role of PR. The intention is for all suitable staff to sit the exam, to ensure sustainability of the service with a PR over Cardiff and a PR over Neath Port Talbot. Cardiff inspection took place in March 2024, following the inspection being considered by the HFEA licensing panel who agreed to changing the licence to a storage only facility. The Neath Port Talbot Inspection took place in May 2024. A review of the HB escalation process has been undertaken and reconfigured to form a WFI sustainability group which feeds into the WFI Assurance, Recovery and Accountability Board. A new clinical service manager took up post at the start of May 2024. The HB have agreed to undertake a comprehensive service review to include, performance, finance, complaints, incidents and risks. It was originally intended for the review to be completed by the end of January 2024 however this has been delayed with the review report due to be shared with the HB Board at the end of May 2024.	SMART Action plan reviewed and agreed	Service Manager	19th September 2023	19th September 2023
	Regular Executive to executive meetings 16th November 2023 21st November 2023 1st December 2023 7th December 2023 21st December 2023	Executive lead SBUHB/ Medical Director WHSSC	16th November	Ongoing
Issues/Risks: There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.				

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the WHSSC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the WHSSC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum: • Chair (WHSSC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • WHSSC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.

Level 4 DECOMISSIONING/OUTSOURCING	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the WHSSC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.



SERVICES IN ESCALATION



Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

PATIENT QUALITY AND SAFETY LEARNING & IMPROVEMENT FORUM

Tuesday 09 July 2024
10:30am – 1:30pm
via MS Teams

Slide-deck of Presentations	PQSLI Foum - Slide-deck - July 202

Attendees:

Craig Roberts (Chair) (CR)	Leeanne Lewis (LL)	Karen Hatch
Claudia Ivins	Kylie Crook (KC)	Bev Lewis
Katie Reardon	Rachel Trask	Rebekah White (RW)
Joanne Hook (JH)	Sally Heal	Gemma Couch (GC)
Gwyneth Radcliff (GR)	Rebecca Wallace	Richard Stubbs
Jacqui Lawrence (JL)	Tom Grace (TG)	Keri Russell
Penny Gordon	Veronique Hughes (VH)	Moira Bevan
Jennifer Winslade	Sarah Roberts	Caroline Rowlands (CRow)
Rhiannon Price (RP)	Tracey Rich (TR)	Deb Jackson
Sarah Cadman (SC)	Jessica Moss (JM)	Simon Hoad
Matt Harris (MH)	Lisa Thomas (LT)	

No.	Agenda Item	Action
1.	**Preliminary Matters**	
1.1	**Welcome and Introductions** CR welcomed everyone to the meeting. The group introduced themselves via Chat Bar.	
1.2	**Apologies for Absence** Tracey Partridge-Wilson Scott Taylor	
1.3	**Good News** ABCi piloted the first test cohort of Quality Improvement (QI) coach programme. Positive feedback. Next cohort is in Autumn and full. 3 cohorts a year will take place. The aim to develop 75 QI coaches per year. VH said the Division had the QPS post agreed, advertised and Sarah Roberts had been appointed.	
1.4	**Terms of Reference (TOR)** LL informed group a draft TOR is in hand and will be shared as soon as Corporate Governance have reviewed and approved.	**LL**
1.5	**Actions from previous meeting** Patient stories – Tom Grace informed the group that the consent video was shared previously there is a meeting due to take place in the week. Funding secured to take forward. Both videos include male and female characters. Patient Participation Panels – LL said, an update had been provided to confirm that Mental Health passports were being used in the Division.	
2.	**Divisional Quality and Patient Safety Learning**	

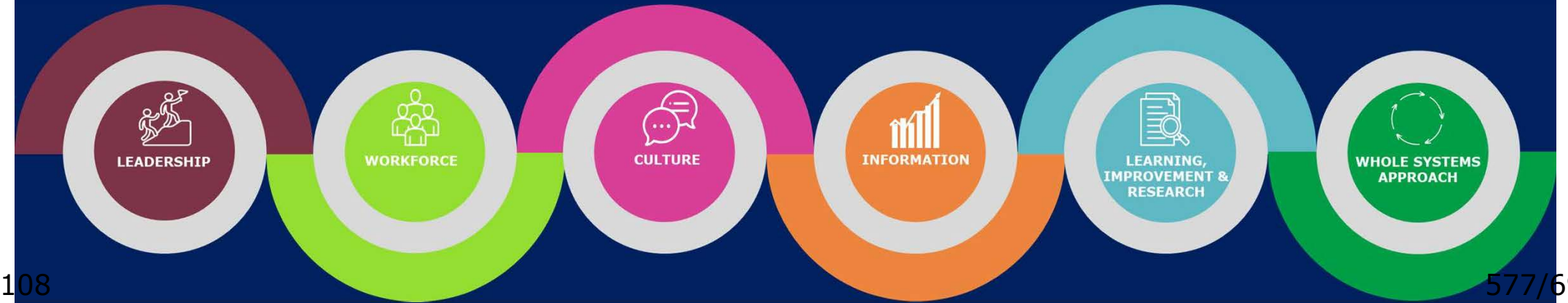
	Examples of learning based on six pillars of quality: – Patient and staff feedback and stories – Incidents (falls, medicines) – Complaints, concerns and compliments – Safeguarding – Infection prevention and control – Health, Safety and Security  Sources of Learning and Ap... Template sent out previously for Divisions to share feedback on the above items. Divisions provided an overview of shared learning via presentations for the above points. These are attached in the slide deck on the first page. These were presented by SC, CRow, KC, GR, TR, RW. VH provided a verbal update in that the Complex Care division are reviewing the quality dashboard. Themes are across Divisions and would be interested in sharing information around falls, duty of candour and Civica. QPS team approach had been welcomed. LL said they were exactly what was required for the repository. Positive discussion followed on how these provided a welcomed update and some shared learning. TR to link in with KC regarding falls and the initiating of colour coding. KC said the aim was to roll it out across all sites.	**TR**
3. Patient Experience		
3.1	**Update: -** • PALS • Civica • Patient Experience: Listening and Learning	

	JH provided an overview of Civica and PALS. The surveys were extremely positive and above target. Early resolutions proved pivotal in the feedback.	
4. Listening and Learning		
4.1	**Listening and Learning Framework – agree implementation plan.** Update on Learning Repository shared by Jacqui Lawrence. It demonstrated how employees would be able to use it once live on Pulse. There will be a link on the home page. (Link to home page - Listening and Learning at ABUHB (sharepoint.com) QPS leads will be able asked to share their learning and will be put into themes. An E form has been created and will be ready for use soon for people to complete and send any relevant information.	
5. Organisational Learning and Sharing Internal		
5.1	**QI – what matters in neuro rehab** CR provided a presentation on Patient Experience (In slide deck) on behalf of the service. This was received positively by the group. Any queries to be sent to Daryl Harris and Linda Tremaine.	
5.2	**Safer Care – Memory Rehab Service** JM, LT & MH provided a presentation. CR acknowledged the work carried out around early intervention within the community and the outcomes achieved.	
5.3	**QPS – SWARM methodology** KC provided a presentation and there was a brief group discussion which welcomed the SWARM methodology. CR said there was good improvement for so many measures.	
Comfort break		
6. Quality and Patient Safety Update		

6.1	Update: - ▪ Quality Patient Safety ▪ Putting Things Right ▪ Patient Safety Incidents ▪ Complaint's feedback RP provided some feedback on complaints, tackling those over 3 months and 9-12 months. There had been a great improvement on those with deadlines. It was noted that with PALS involvement there had been an increase of early resolutions. GC reported that the QPS team have been together a few months and are in the process of team building. QPS workplan has been drafted to align with the QPS strategy. Bespoke training is available to staff and the team are happy to receive any requests. A QPS bulletin will be created and shared going forward.	
6.2	**Health & Safety Incidents Update** Scott Taylor will present at the next meeting.	
7. Final Matters		
7.1	**Draft minutes of the meeting held on 22 May 2024** Matters Arising Nothing reported.	
8. Any Other Business		
	Item 7 on the Agenda was from the previous meeting.	
9. Details of next meeting		
	Wednesday 18th September 2024 10.00am – 1.00pm MS Teams	

Patient Quality, Safety Learning and Improvement Forum

9th July 2024



Agenda Item 2

Divisional Quality & Patient Safety Learning

Examples of learning based on six pillars of quality

Agenda Item 2

Mental Health & Learning Disability (MHLD)

Appendix B: Sources of Learning and Approaches to Sharing and Improvement

	Area of potential learning/new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
1	*Aggregated analysis of patient safety data to determine patterns, themes, and trends*	*Corporate Quality & Safety Teams* *Local leads*	*Face to face safety briefings* *Education programmes (rolling induction)* *Digital platforms*	*Corporate & Directorate/Divisional Board meetings and patient safety reports and dashboards.*
2	*Analysis of individual incidents*			
3	*Analysis of individual complaints* *PSOW - findings upheld*	MHLD Divisional team  	ERASE OAMH QPS meeting Divisional QPS meeting phw.nhs.wales/services-and-teams/harp/urinary-tract-infection-uti-resources-and-tools/uti-downloads/top-tips-for-preventing-dehydration-poster-infection-prevention-society/ Microsoft werPoint Presentat	Ward audits →OAMH QPS MHLD QPS
4	*Analysis of individual claims / redress*			

Agenda Item 2

Primary Care & Community Services (PCCS)

Divisional Assurance

Primary Care & Community Services

July 2024

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

Contents

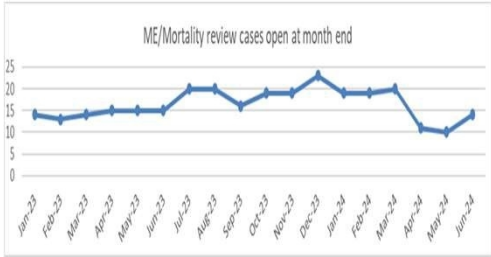
Quality & Patient Safety

Area	Overview
Complaints Management	• Despite continued focus to reduce open & overdue concerns, overdue have increased from 10 in April to 15 in May and 18 in June 2024. • PTR 30 day compliance increased to 100% in June- improvement plan ongoing with close monitoring arrangements in place. This will be adversely impacted with closure of the overdue concerns. • Themes & trends – none identified with new concerns received. • Learning actions – Redesign of CDS consent form to ensure consent is recorded accurately.
Serious Incidents **Safeguarding** **Mortality Reviews**	• No new Executive Led Serious and 6 new Divisional (2 Infection control, 4 avoidable Pressure Ulcers). • Safeguarding open cases reduced to 11– 7 pressure damage which will be reviewed through PU RCA. Mthly reviews continue with Safeguarding & QPS and this month's review is due –relevant managers invited to support progression. • Mortality review open cases increased in line with new cases received. No new learning identified.
Incident Management & Duty of Candour	• Increased focus to reduce unreviewed incidents has led to reduction which is being monitored via ongoing incident meetings. • Duty of Candour – Numbers of incidents triggering has reduced, as processes for review and validation embedded. Rapid review of incidents by managers required. QPS Team review all divisional incidents to establish potential incidents that trigger the Duty.
Top incidents reported - Patient Falls & Pressure Damage	• Pressure Ulcer incidents have stabilised. • Falls/1000 OBD have reduced over past few months following a peak in January (corporate data). • Focus of education relating to L&S BP monitoring and management of falls risk in single room environments, as well as post fall management. • Education has commenced around the clinical photography app, with planning for the roll out across the community sites underway. This will hopefully help with improved PU grading and will support documentation/datix and presentations at PU RCA
Learning & Improvement	• Learning & Quality Improvement Group to address QPS themes / trends to commence in August (in line with availability of members) once ToR and membership agreed. Inaugural meeting will focus on learning from in patient falls and coroners inquest outcomes

Quality & Patient Safety

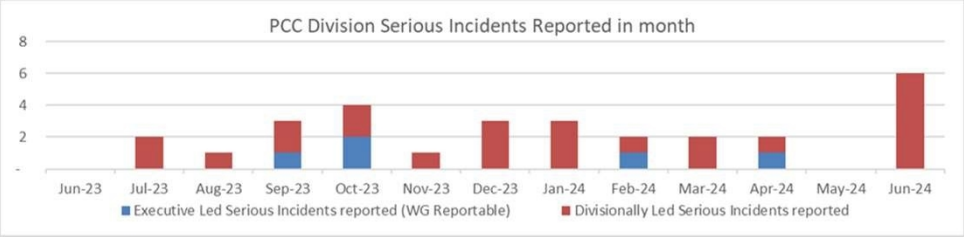
Complaints Management

Mortality



Safeguarding

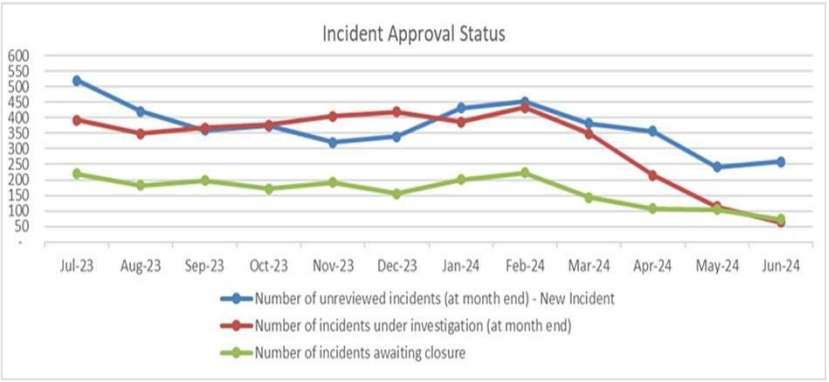
Serious Incidents

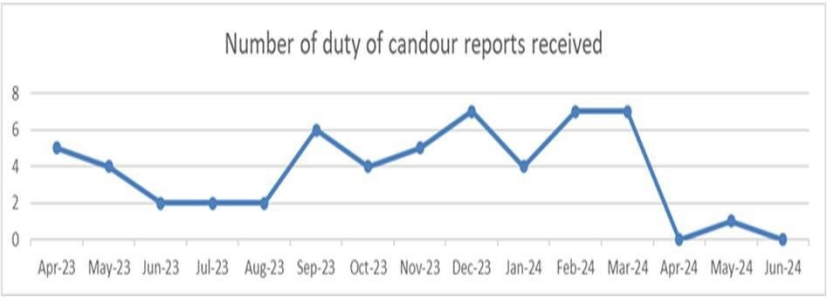


Alerts Compliance

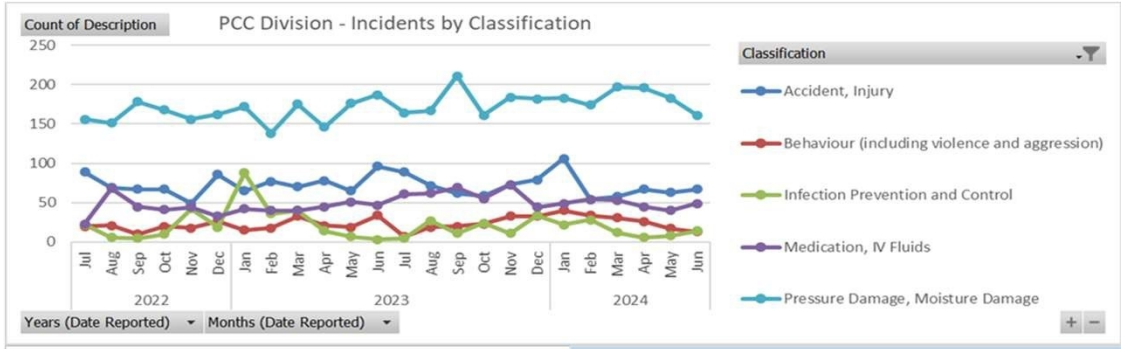
Quality & Patient Safety

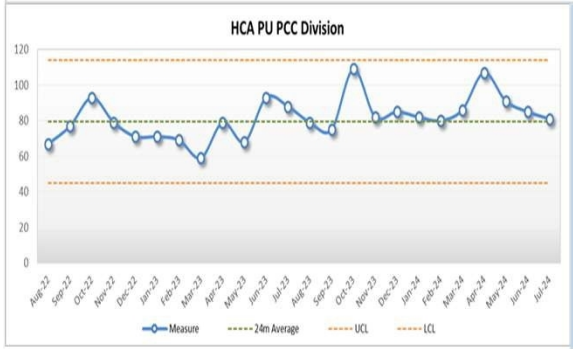
Incidents & Duty of Candour

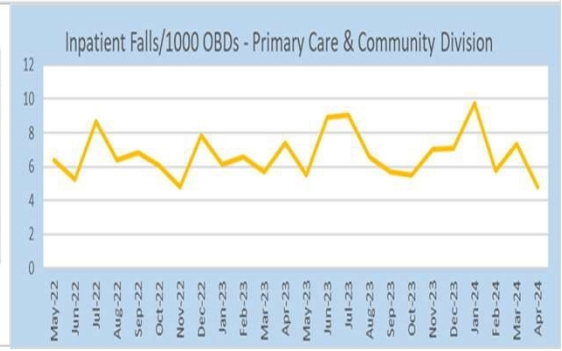




Top Incidents Reported: Falls & Pressure Damage







Agenda Item 2
Family & Therapies

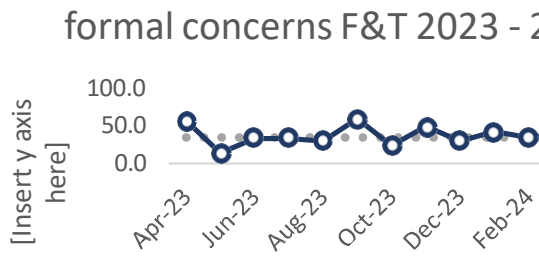
QPS Assurance

F&T July 2024

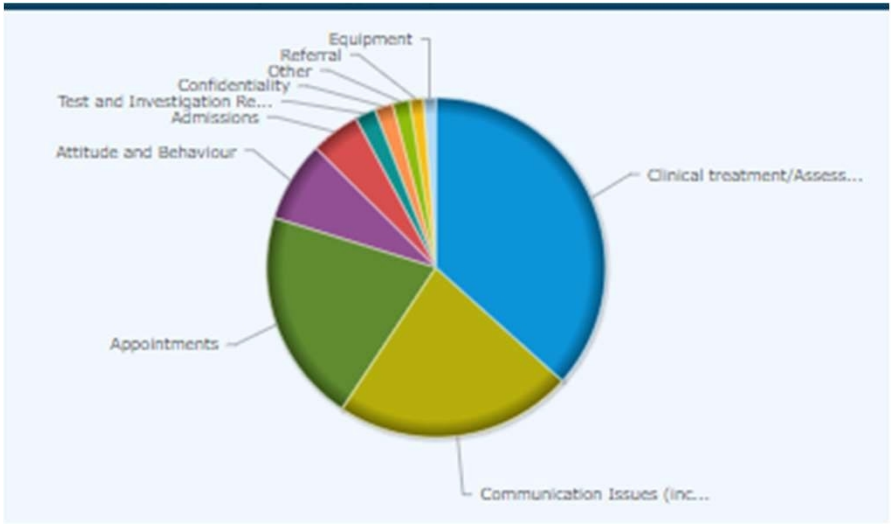
Quality and Patient Safety

Area	Overview
Complaints management	PTR 30 day target has tumbled in June to 9% from 2 months at >60%. Urgent review of divisional processes and reporting mechanisms with PTR to support a return to > 60% for July. Some reduction in open complaints > 6 months
Serious Incidents Safeguarding Mortality Reviews	No new executive SIs. New divisional investigations 1 delayed care gynaecology. Safeguarding training compliance: child and adult areas level 1 and level 2 greater than 90% for the year. 8 months since most recent Never event. QPS monthly theatre audit continues. In conjunction with theatre safety 'Back to Basics' programme.
Incident management and Duty of Candour	All areas improving in incident management and investigations requiring DoC.
Top Incidents Reported	59 maternity weekly review in MDT risk meeting 25 medication errors possible patient harm in 1 on NICU. DoC initial investigation in progress 20 equipment. 1 involving patient / H&S poolside 26 accident to staff 28 pressure damage – details next slide
Learning and Development	Increasing areas using CIVICA with limited results for person centred care, your time in hospital and care closer to home. Governance day session on detection and care of deteriorating patients specifically relating to internal massive haemorrhage. Maternity, gynae, SRH, anaesthetics.

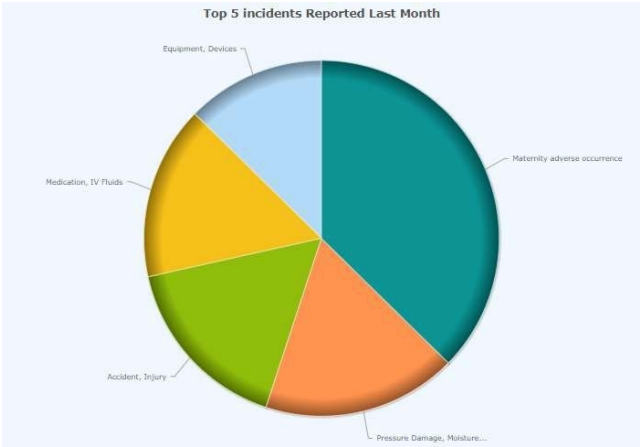
Quality and Patient Safety complaints Serious incidents



F&T has 7 open serious incidents. 1 is in date, 6 are overdue.
ABU16536 – with police
ABU51736 – in collaboration with London and UHW
ABU 29366 – with parents: action plan in progress ABU58918 – abdominal pregnancy
(ABU70154 – measles with PHW and ED. F&T submitted to IO)
ABU56644 – NEVER event with PTR for review
ABU61372 – SRH, legal consideration



Clinical treatment, Communication and appointments main issues

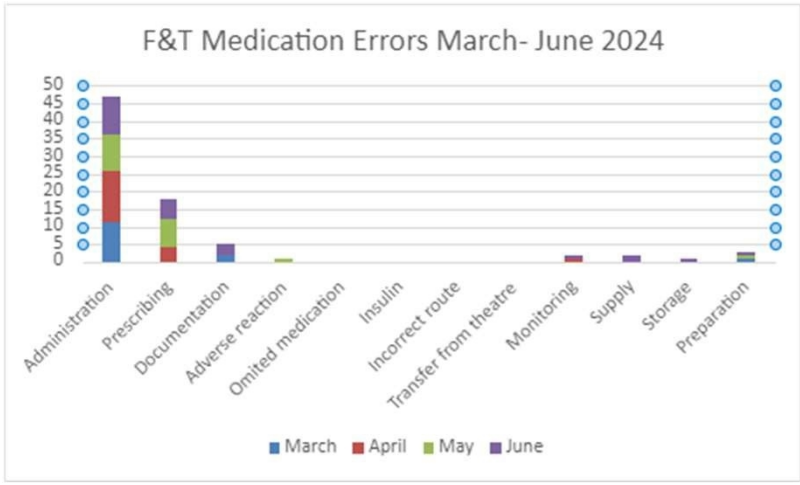


26 accident 25 medication 59 maternity
20 equipment 28 pressure damage

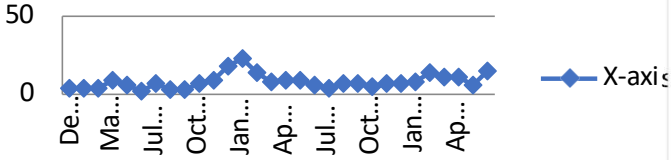
Quality and Patient Safety
DoC Falls
PUs
Medication

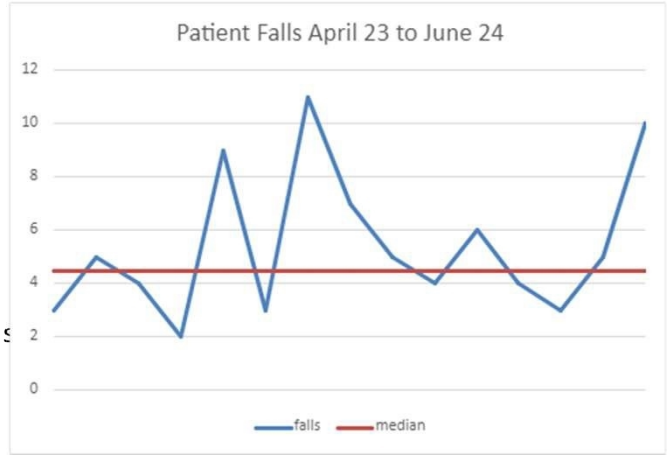
	Equipment related	Grade 1	Grade 2	Grade 4
NICU	Grade 1			
Gynae		1	2	
P&O		4	2	1

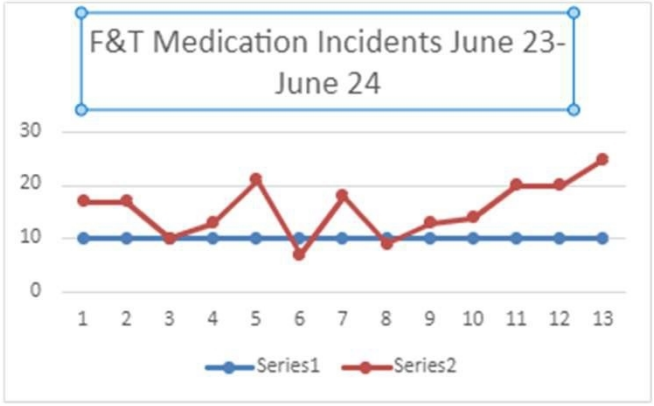
10 Falls – no fractures
NICU 1 dropped baby
Paeds 1 fall in high chair
Paeds 1 fall from window seat
Gynae 1 witnessed 1 unwitnessed
PHN 1 faint following vacc
Therapies 4 during therapy



HAPU by Incident date (Month and year)







Agenda Item 2
Surgery

3

6 Pillars of Quality

1. Patient and staff experience and stories
2. Incident Reporting, Falls, Pressure Ulcers, Medicines Management and Mortality
3. Complaints, concerns and compliments
4. Health, safety and security
5. Infection Control and Prevention
6. Safeguarding

3

Patient and Staff Experience and Stories

Fluid Balance Challenge
QPS team are running a competition on the wards for the best fluid balance audits.
Some areas will be running a hydration awareness event for patients and staff.

OPHTHALMOLOGY: Growing our own

First cohort of band 2/3 HCSW have passed their 1st units for the Fundamentals of Ophthalmology course.
This is a nationally accredited course.

B0 - SBAR project with QPS & Martha's Law (call for concern). First month >85% all elements

C0 - Going to develop a trachy passport. First month >85% all elements accreditation

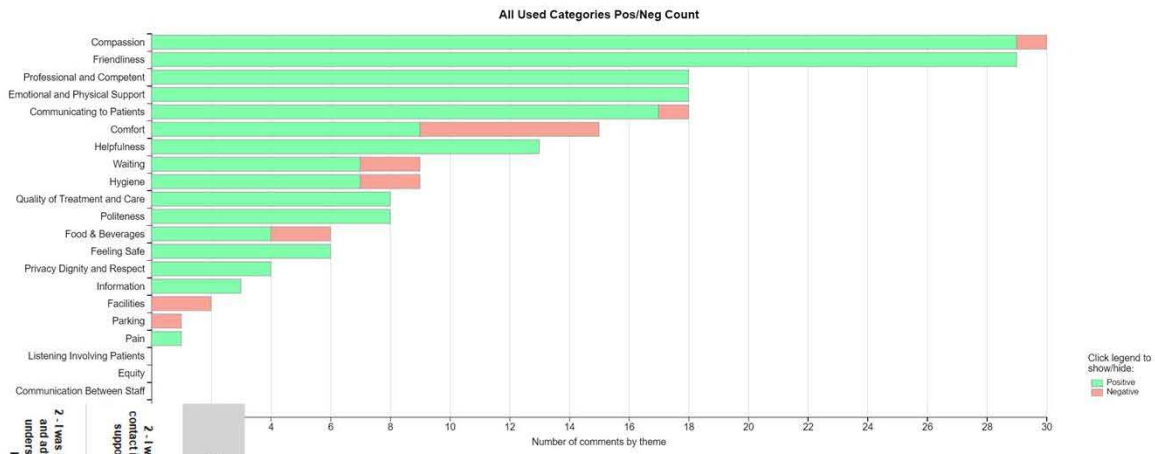
3

Patient and Staff Feedback

CIVICA Feedback June 2024

Adborth Cleifion: Gwrando a Dysgu

Patient Feedback: Listening and Learning



Location/Department	Responses	2 - I felt listened to	2 - I was able to make my own decisions about my care	2 - I had care and support from staff who understood my needs and respected my choices	2 - I had the support of my family (or friends) when I needed them	2 - I felt safe	2 - I felt physically comfortable	2 - I was given information and advice that I could understand to help me keep well	2 - I was told who to contact if I need care and support in the future	Overall
		Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	
Ward 2.3 Rhymney	10	100	100	100	100	100	100	100	100	100
Austin Friars Ophthalmic Diagnostic & Treatment Centre	7	86	92	92	92	100	93	86	93	92
Emergency Eye Clinic - E Block Royal Gwent Hospital	29	95	91	95	100	95	94	94	91	94
Emergency Eye Clinic - Minor Injuries Unit Royal Gwent Hospital	3	100	100	100	100	100	100	100	100	100
Eye Outpatient Clinic - E Block Royal Gwent Hospital	1	100	50	100	100	100	100	100	100	94
Eye Pre-assessment Clinic - E Block Royal Gwent Hospital	1	100	100	100	100	100	100	100	100	100
Eye Theatre - Royal Gwent Hospital	13	100	92	100	100	100	96	100	100	99
Orthopaedic Surgical Unit	48	99	98	100	98	100	98	100	98	99
Ward C7 West	4	100	100	100	100	100	100	100	100	100
Ward D3 East	9	100	100	100	100	100	100	100	94	99
Ward B/0	7	93	86	100	100	100	100	100	92	96
Ward B/4 North Haematology	1	100	100	100	100	100	100	100	100	100
Ward C/0	1	100	-	100	100	100	100	100	100	100
	Overall	97	95	98	99	99	97	98	96	98
	Benchmarks	85	85	85	85	85	85	85	85	85

Patient Feedback:

D3E: The care of the nursing staff ,they couldn't do anything better. On a scale of 1-10.I would give them 10.

C7W: it was great experience for what I was going through.

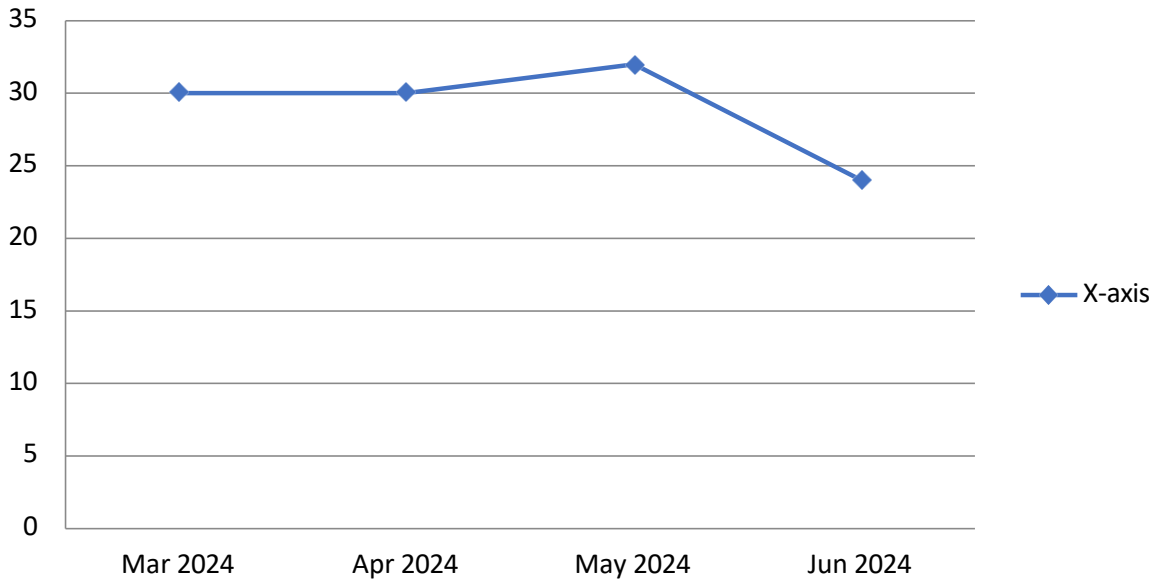
Emergency EYE clinic: really pleased with everything.

Rhymney: everything was done to high standards

3

Incident Reporting – Patient Falls

Falls by Incident date (Month and year)



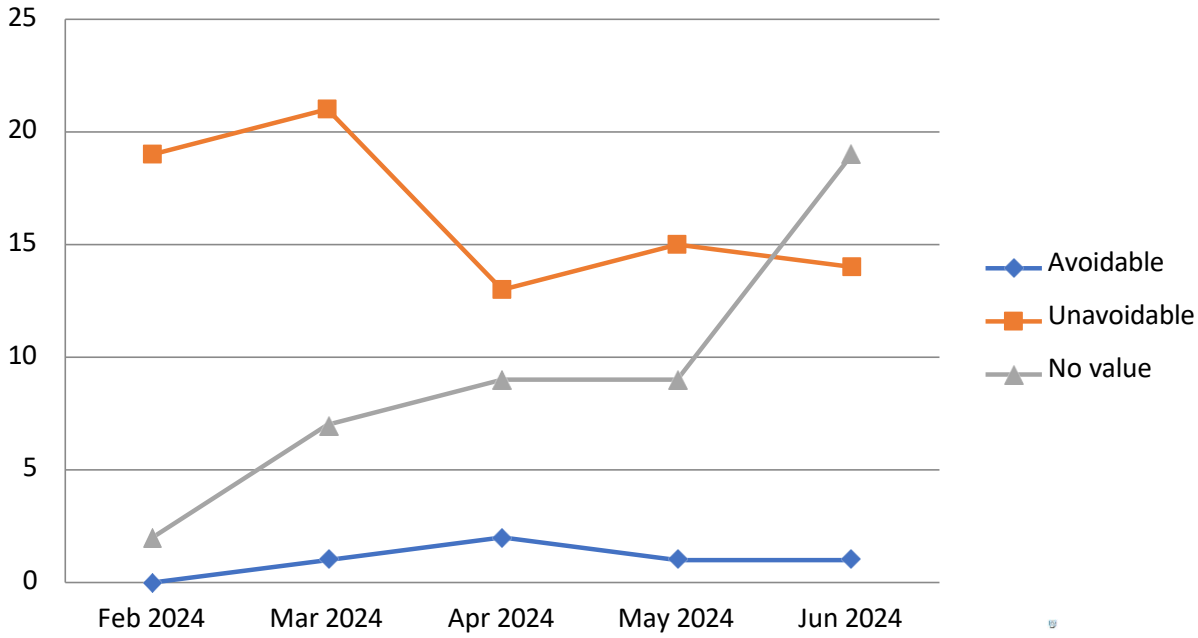
Learning:
patient story on QPS study days
focused reviews on all unwitnessed falls
meaningful activities and deconditioning projects
Sip to Send project: positive patient feedback

No fractures or head injuries sustained.
Injuries were bruises and skin tears.

3

Quality Indicators

HAPU Incidents (Month and year) and Was the pressure ulcer AVOIDABLE?



JUNE: OSU / Theatre project : Preventing Deconditioning.

Patients will be sat in the new pre op room, walked to theatre and wont be in a bed until they are post op.

Immediate physio and getting dressed.

Discharge the same day or morning after their procedure.

The team have a video to explain the project and patient experience.

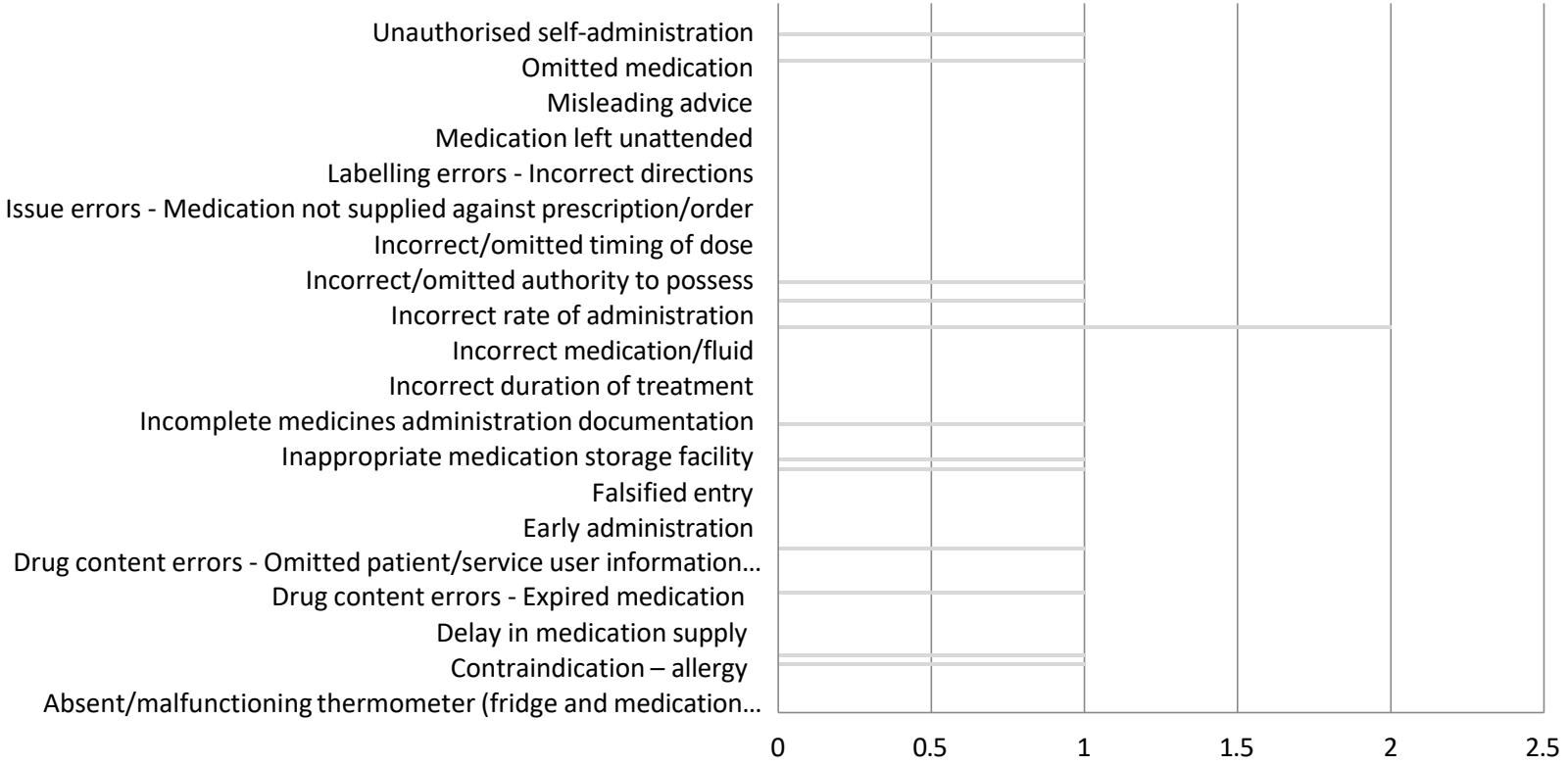
Learning:

- HAPU collaborative
- Move it May will continue through the year, one area a month allocated to do a deconditioning project.
- Education Webinars distributed to all areas

3

Quality Indicators

Surgery - Medications Incidents



Learning:

ERASE for dispensing medication for day release

Safety poster on invasive line use

Family voice in hickman line policy review

Anticoag and diabetic updates on QPS study days

3

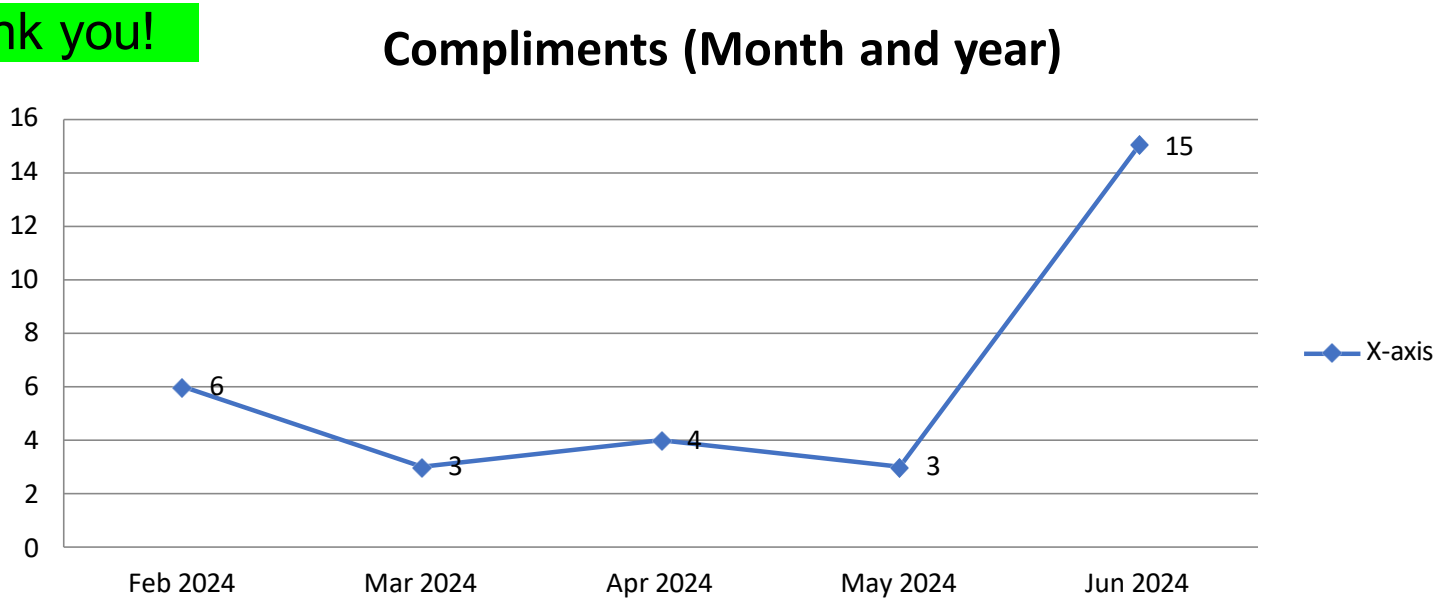
Complaints, Concerns & Compliments

OPEN CONCERNS	Apr 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Total
Trauma and Orthopaedics	1	3	3	2	5	6	3	6	4	3	1	7	12	**56**
General Surgery	0	1	1	1	1	1	2	2	2	4	3	2	7	**27**
Theatres	0	0	0	0	1	0	0	0	0	0	0	0	0	**1**
Ophthalmology	0	0	0	0	0	0	1	2	1	1	0	1	4	**10**
Urology	0	0	0	0	0	0	1	1	0	0	2	2	3	**9**
ENT	0	0	0	0	0	0	0	0	0	1	0	0	3	**4**
Clinical Haematology	0	0	0	0	0	0	0	0	0	0	1	0	0	**1**
Breast	0	0	0	0	0	0	0	0	0	0	1	0	0	**1**
Rheumatology	0	0	0	0	0	0	0	0	0	0	1	0	0	**1**
Trauma and Orthopaedics	0	0	0	0	0	0	0	0	0	0	1	5	0	**6**
Surgery	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**
General surgery	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Ophthalmology	0	0	0	0	0	0	0	0	0	0	0	1	1	**2**
Total	1	4	4	3	7	7	7	11	7	9	10	20	30	**120**

3

Complaints, Concerns & Compliments

Thank you!



3

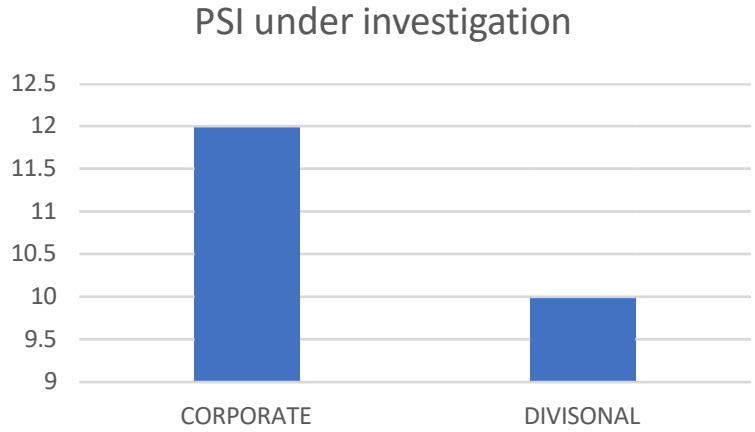
Complaints, Concerns & Compliments

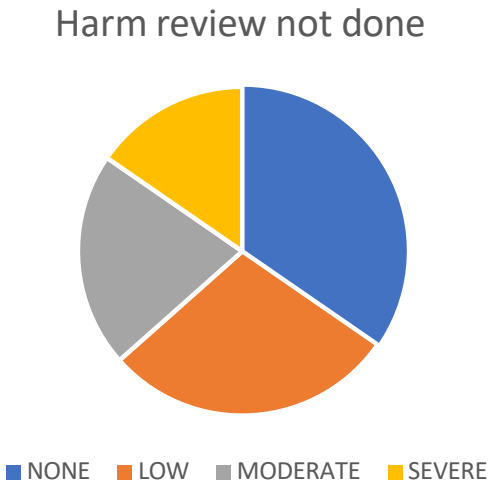
Duty Of Candour

Daily review of all Datix's

Weekly meetings / deep dive with senor nursing team and divisional team to review pending harm reviews and triggered DOC

52 pending harm review:



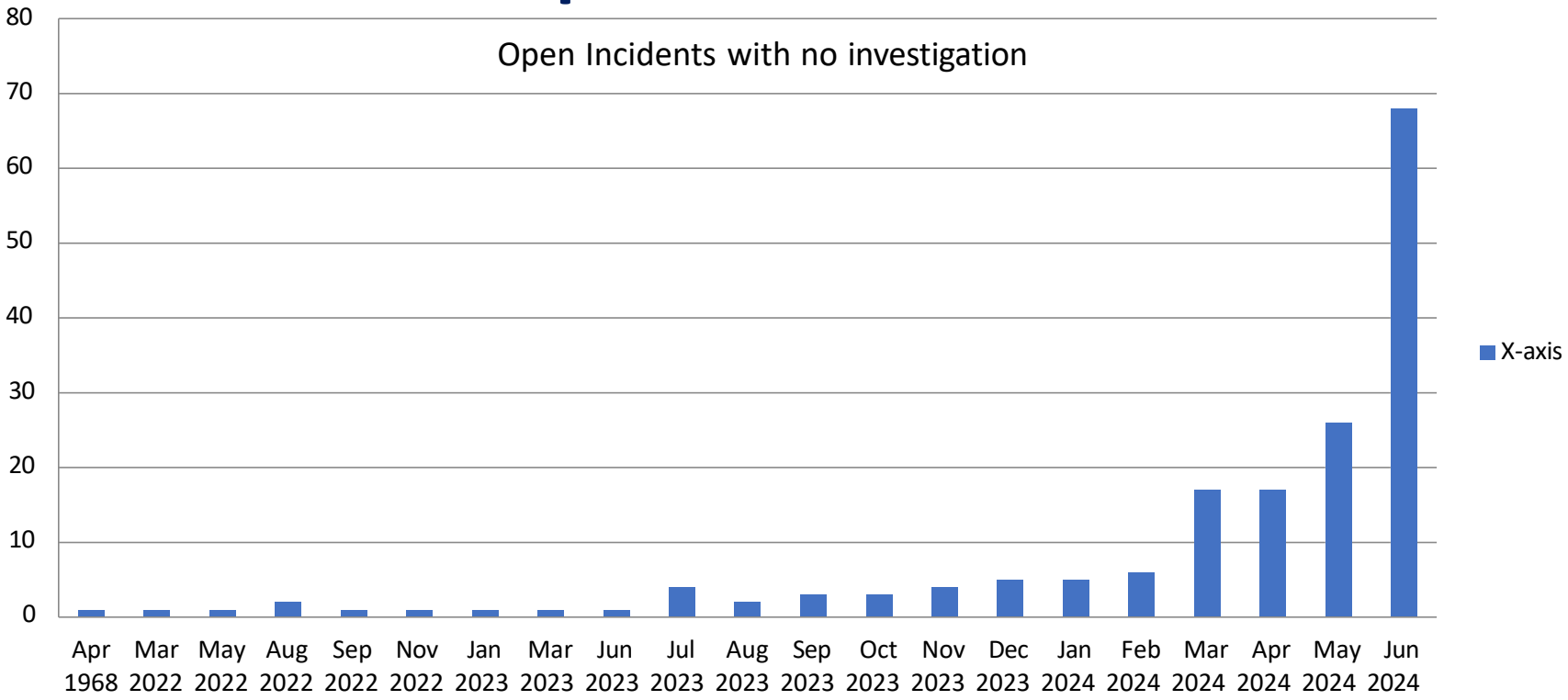


Sharing Learning:

- Sharing Action plans on agenda at both divisional QPS meeting
- Learning shared at weekly ward manager meetings
- Actions assigned on Datix

3

Complaints, Concerns & Compliments



3 Health and Safety Incident Reporting Surgery

During the period was one incident within the Division were reported to the HSE in accordance with RIDDOR.

100%

3 Health and Safety Training Compliance & Risk Assessments Surgery

Health and Safety compliance for the Division as at end of March 2024

H&S	Fire	V&A	MH
82%	78%	81%	39%

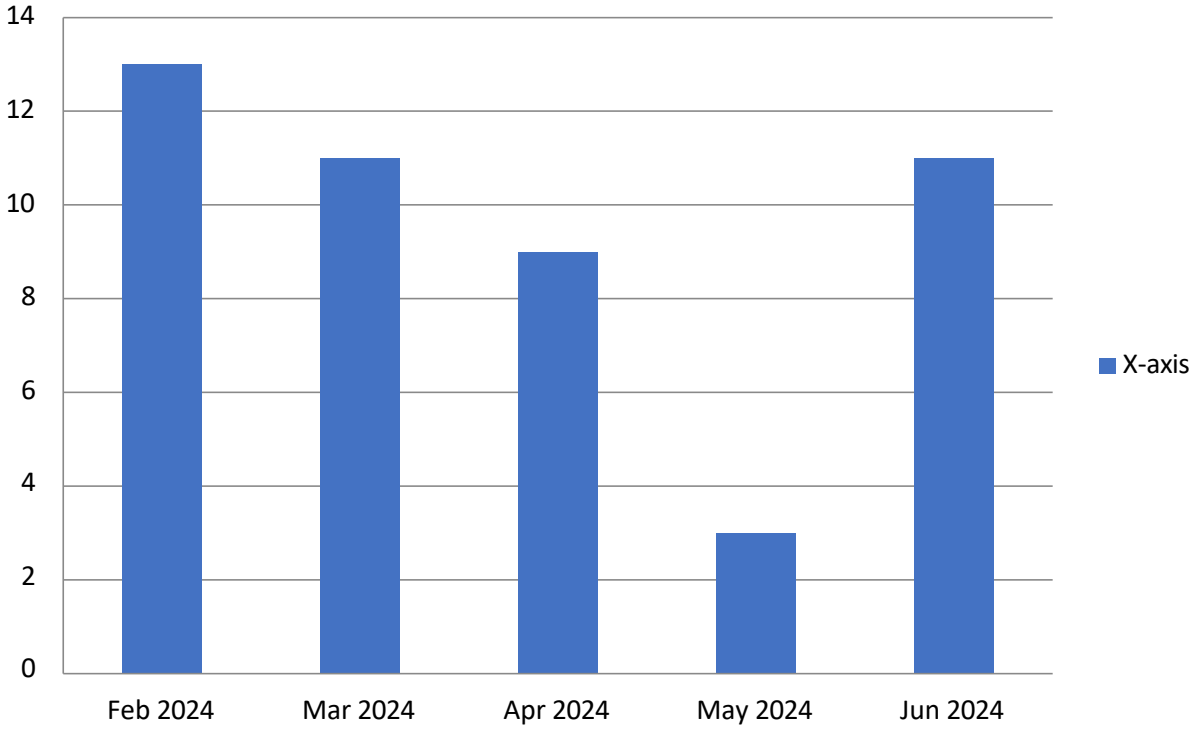
Risk Management
Health and Safety Risks – Total 116
Health and Safety Risks overdue review date 31
Health and Safety Risks – Extreme High Risks (risk rating of 15 or above) 14

Health & Safety Monitoring	Surgery
2023/24 Workplace Inspections Action Status (as recorded on AMAT)	15 Overdue Actions
2023/24 Workplace Inspections Action Themes	Requirement to ensure COSHH Inventories and COSHH Assessments have been documented and communicated to workers Ensure all chemicals are stored appropriately Ensure systems are in place to enable secure doors / doors with access control features are not overridden

3

Infection Prevention & Control

Surgery: Healthcare Associated Infections



Regular ANTT training provided to clinical staff

ANTT cascade trainers in each area.

Review of PPE policy in theatre after a Duty of Candour incident

3

Safeguarding

Competence : Surgery	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	1696	1696	1407	82.96%
NHS|CSTF|Safeguarding Adults - Level 2 - 3 Years|	1228	1228	1016	82.74%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	1696	1696	1395	82.25%
NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|	1228	1228	1002	81.60%

Regular meetings with safeguarding team to review all cases
2 open cases in Surgery under investigation.
Promotion of safeguarding service at ward manager meeting.
Promotion of level 3 training for RNs
Access to safeguarding team on site GUH every Wednesday am.

Quality, Safety & Experience 2024/25 Priorities

- Improve CIVCA feedback collection
- Deconditioning Prevention events through the year
- Ward / Unit accreditation
- Continue Safe Care Collaborative work on preventing patient deterioration
- Education focus on highest reported datix incidents
- Sharing learning from incidents / concerns / PSOW

Agenda Item 2

Clinical Support Services

6 Pillars of Quality

1. Patient and staff experience and stories
2. Incident Reporting, Falls, Pressure Ulcers, Medicines Management and Mortality
3. Complaints, concerns and compliments
4. Health, safety and security
5. Infection Control and Prevention
6. Safeguarding

3

Patient and Staff Experience and Stories

- Wellbeing pilot in Theatres
- Continued Clinical supervision roll out for all new starter
- CIVICA introduced across Critical care
- Regular staff engagement opportunities
- Volunteers and therapy dog visits
- Engagement with PALS service for early concerns escalation
- Student coffee mornings
- Family meetings: feedback to staff at ward manager meetings

3

Patient and Staff Experience and Stories

ITU STEPS 10 Years of service

A local newspaper reported the good work the ITU steps group have been delivering to our local community for the last 10 years.
The ITU follow up group for ex patients and relatives has been offering advice, support and shared experience for our patients and relatives.

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

3

Patient and Staff Feedback

CIVICA Feedback

Adborth Cleifion: Gwrando a Dysgu
Patient Feedback: Listening and Learning

Patient Experience Feedback for Surgery April 2024
Total Surveys Completed = 172

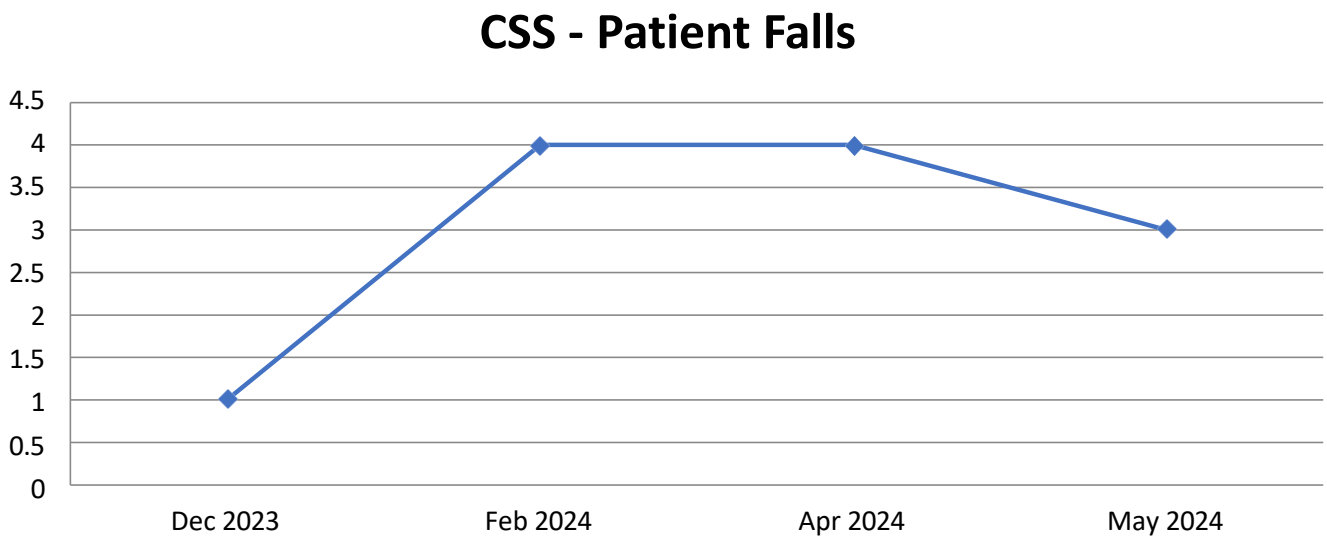
Location/Department	Responses	2 - I felt listened to	2 - I was able to make my own decisions about my care	2 - I had care and support from staff who understood my needs and respected my choices	2 - I had the support of my family (or friends) when I needed them	2 - I felt safe	2 - I felt physically comfortable	2 - I was given information and advice that I could understand to help me keep well	2 - I was told who to contact if I need care and support in the future	Overall
		Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	
Acute Oncology Service	1	100	100	100	100	100	50	100	100	94
Rapid Diagnostic Clinic	12	100	91	100	86	100	100	100	92	96
Surgical High Care	13	100	92	100	100	100	96	100	100	98
Ward C/2	4	100	100	100	100	100	88	100	100	98
	Overall	100	93	100	95	100	95	100	96	97
	Benchmarks	85	85	85	85	85	85	85	85	85

Comments from Patients:
You did everything you could! I don't think there was anything you couldn't have done!!
More funding.Basic items ie pillows. I'm not experienced too comment on medical equipment.
Everything was done well
Care well above their duties

3

Incident Reporting – Patient Falls

1 Fall with wrist fracture.
Focussed review found patient had capacity but did not follow advise given to request assistance when mobilising.

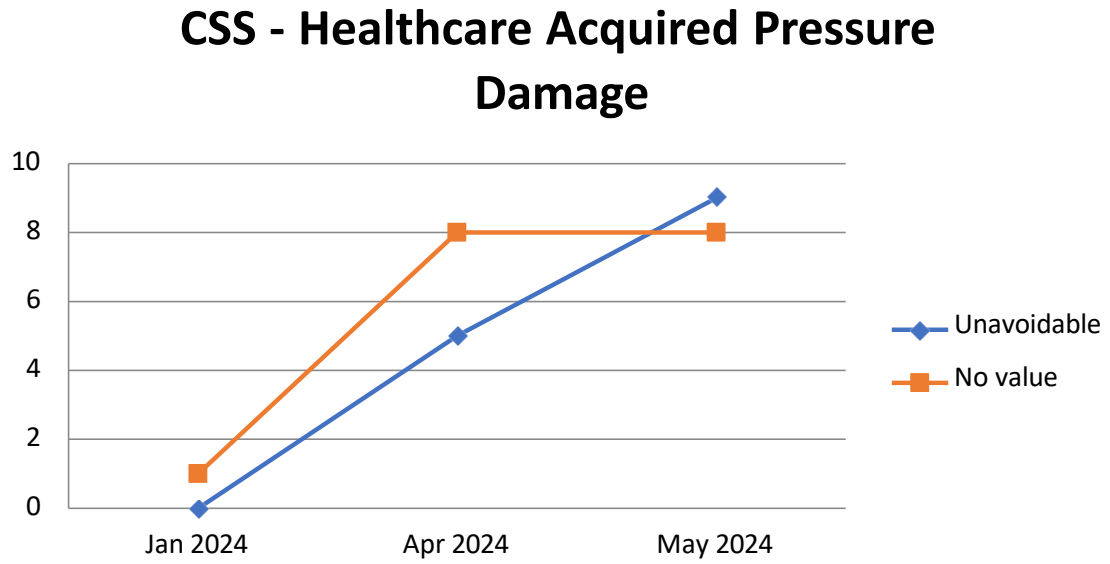


Learning: patient story, focused reviews on all unwitnessed falls, meaningful activities like move it may

3

Quality Indicators

No avoidable Pressure damage reported

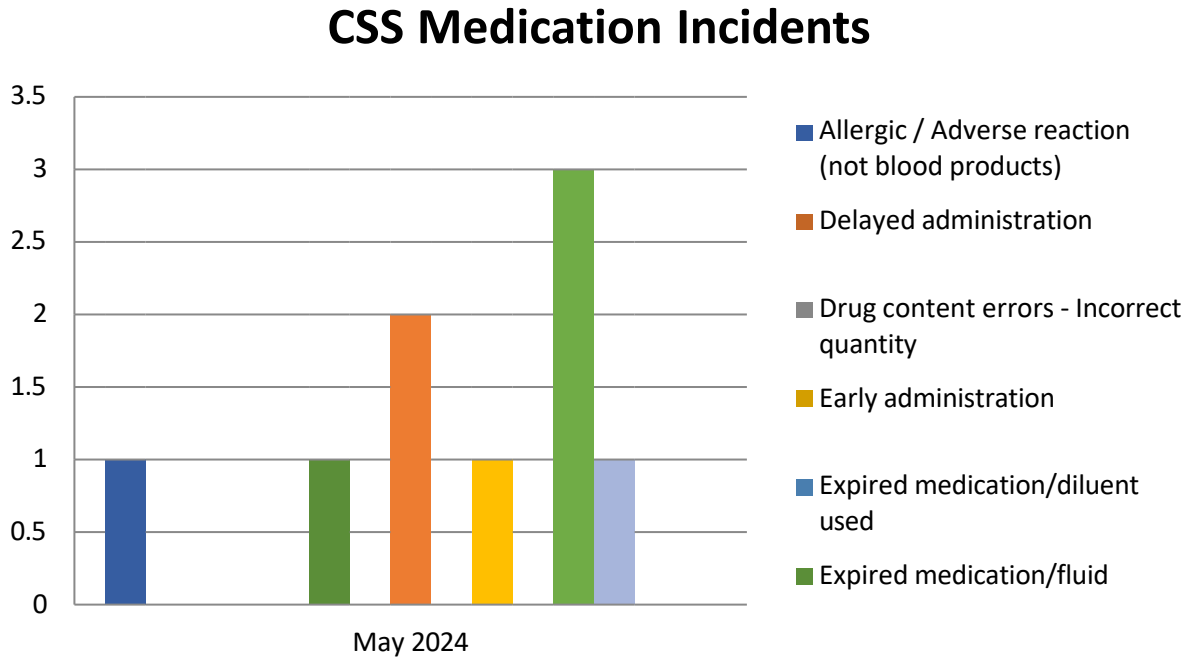


Learning:
HAPU collaborative
Move it May
Education Webinars distributed to all areas

3

Quality Indicators

Themes
Incorrect strength/dose x3
Incorrect medication/fluid x 2

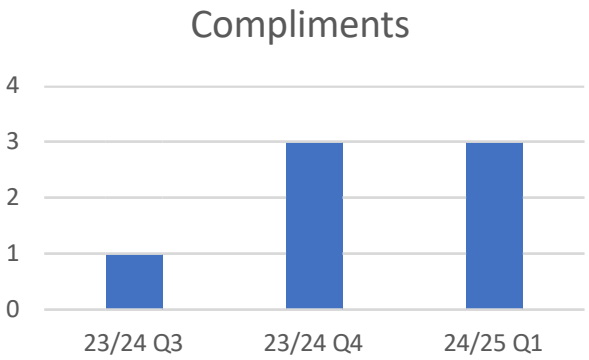


Learning:
ERASE for dispensing medication for day release
Safety poster on invasive line use
Family voice in hickman line policy review

3

Complaints, Concerns & Compliments

Thank you!



Themes	Beyond duty of care	Communication	Environment	Listening	Understanding	Total
Clinical Support Services	4	2	2	0	1	9

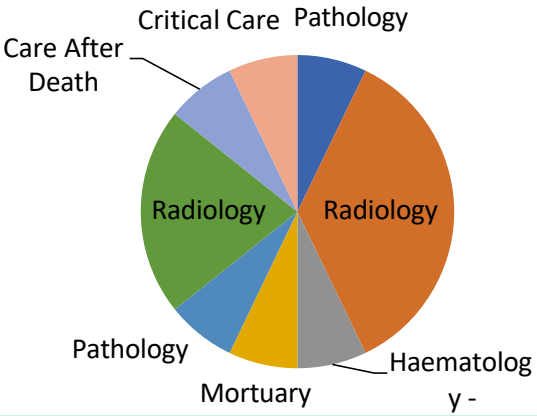
3

Complaints, Concerns & Compliments

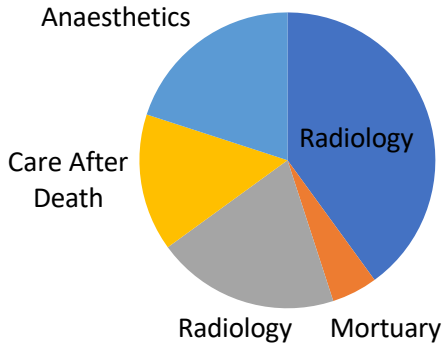
Clinical Support Services Concerns closed in May	Managed through PTR	8
	Early Resolution	7
	Reopened	0
	Total	15

Clinical Support Services Concerns received in May	Managed through PTR	5
	Early Resolution	6
	Reopened	0
	Total	11

Clinical Support Services Complaints Closed May 2024



Clinical Support Services Complaints Received May 2024



3

Complaints, Concerns & Compliments

Duty Of Candour

- Daily review of all Datix's
- Weekly meetings / deep dive with senor nursing team and governance leads to review pending harm reviews and triggered DOC
- **29 Harm Reviews Outstanding**

2 open serious incidents

48856 delayed renal cancer diagnosis: report being drafted.

57640 wrong side block: report finished, awaiting clinical review of breach.

Learning:

- Action plans on agenda at both divisional QPS meeting
- Learning shared at weekly ward manager meetings
- Actions assigned on Datix

3 Health and Safety Incident Reporting CSS

Total of 53 incidents affecting staff reported in 2023/24.

The top 3 types of incidents were:
9 - abuse to staff
9 - Contact with or exposure to hazardous substance
6 - Contact with needles or medical sharps

During the period the five incidents within the Division were reported to the HSE in accordance with RIDDOR. Three out of the five were reported within the legal timeframes

3 Health and Safety Training Compliance & Risk Assessments CSS

Health and Safety compliance for the Division as at end of March 2024

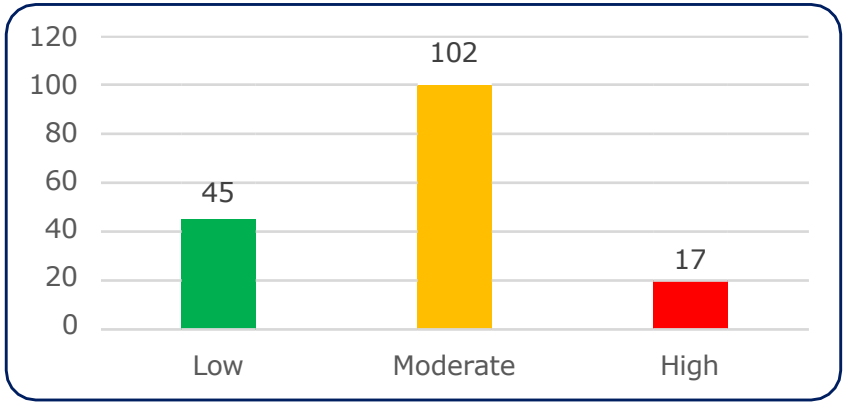
H&S	Fire	V&A	MH
89%	85%	86%	52%

Manual Handling (MH) compliance for high risk staff/areas at end of March 2024 was **45%**

27 Manual Handling Trainers within the Division. 14 are overdue the 2 year update.

The Division currently has 164 active health and safety risks (see below)

61 risks (37.1%) were overdue review at end of March 2024



3

Infection Prevention & Control

IPAC data for May
Cases recorded:

Cdiff: 0
Staph: 0
Gram negative: 0

Regular ANTT training provided to clinical staff

ANTT cascade trainers in each area.

Review of PPE policy in theatre after a Duty of Candour incident

Gloves are off campaign

3

Safeguarding

Competence: CSS	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	1705	1705	1523	89.33%
NHS|CSTF|Safeguarding Adults - Level 2 - 3 Years|	1005	1005	904	89.95%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	1705	1705	1516	88.91%
NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|	1005	1005	897	89.25%

Regular meetings with safeguarding team to review all cases

Radiology: all neuro scans for children are to be reported by staff familiar with our safeguarding reporting process (no scans outsourced to everlight).

3

Quality, Safety & Experience 2024/25 Priorities

- Improve CIVIA feedback Collection
- Patient voice in policy writing
- Health promotion events through the year
- Ward / Unit accreditation
- Ongoing theatre projects to reduce never events
- Continue Safe Care Collaborative work on preventing patient deterioration

Agenda Item 3.1

Patient Experience Update

Adborth Cleifion: Gwrando a Dysgu

Patient Feedback: Listening and Learning

CIVICA & PALS

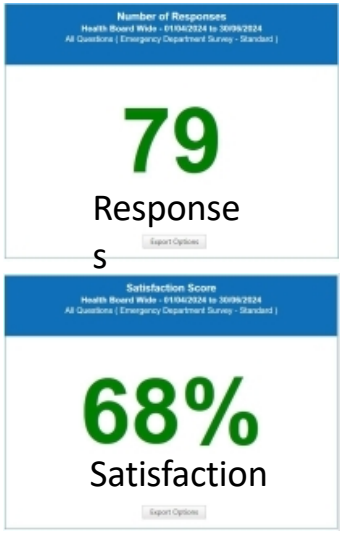
April, May & June 2024 Update

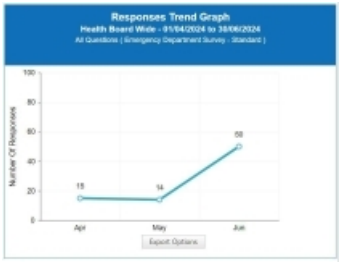
Adborth Cleifion: Gwrando a Dysgu
Patient Feedback: Listening and Learning

Patient Experience Feedback
1st April 2024 – 30th June 2024

All Surveys

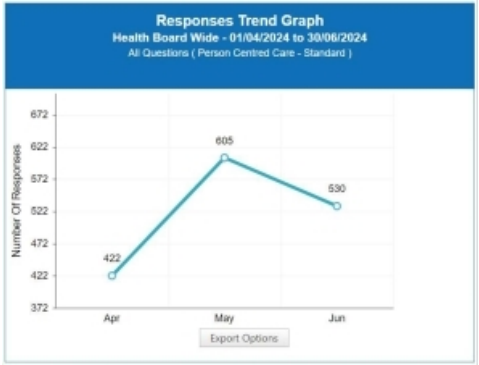
Emergency Department Survey





Response Trend

Person Centred Care (PCC) Survey



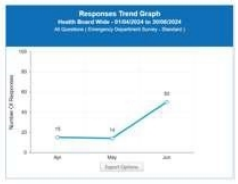
Response Trend

Adborth Cleifion: Gwrando a Dysgu

Patient Feedback: Listening and Learning

Patient Experience Feedback
1st April 2024 – 30th June 2024
Emergency Department Survey

Emergency Department Survey



Response Trend

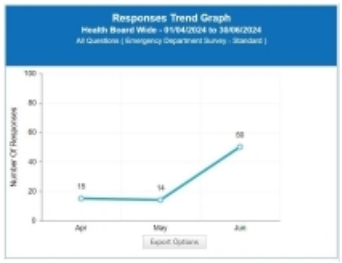
Responses	1 - Did you feel that you were listened to?	2 - Were you able to speak in Welsh to staff if you needed to?	3 - From the time you realised you needed to use this service, was the time you waited:	4 - Did you feel well cared for?	5 - If you asked for assistance, did you get it when you needed it?	6 - Did you feel you understood what was happening in your care?	7 - Were things explained to you in a way that you could understand?	8 - Were you involved as much as you wanted to be in decisions about your care?	9 - Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall exp	Overall
	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	
79	75	44	39	75	72	69	72	72	69	68
Overall	75	44	39	75	72	69	72	72	69	68
Benchmarks	85	85	85	85	85	85	85	85	85	85

Was there anything particularly good about your experience that you would like to tell us about?	Was there anything that we could change to improve your experience?
Top 3 themes **15** comments around **Compassion** **10** comments around **Emotional & Physical support** **9** comments around **Helpfulness**	**Top 3 themes** **24** comments around **Comfort** **21** comments around **Waiting** **4** comments around **Emotional & Physical support**

Adborth Cleifion: Gwrando a Dysgu
Patient Feedback: Listening and Learning

Patient Experience Feedback 1st April 2024 – 30th June 2024 Emergency Department Survey

Emergency Department Survey



Location/Department	Responses	1 - Did you feel that you were listened to?	2 - Were you able to speak in Welsh to staff if you needed to?	3 - From the time you realised you needed to use this service, was the time you waited:	4 - Did you feel well cared for?	5 - If you asked for assistance, did you get it when you needed it?	6 - Did you feel you understood what was happening in your care?	7 - Were things explained to you in a way that you could understand?	8 - Were you involved as much as you wanted to be in decisions about your care?	9 - Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall exp	Overall
		Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	Emergency Department Survey	
Emergency Department	79	75	44	39	75	72	69	72	72	69	68
	Overall	**75**	**44**	**39**	**75**	**72**	**69**	**72**	**72**	**69**	**68**
	Benchmarks	**85**	**85**	**85**	**85**	**85**	**85**	**85**	**85**	**85**	85

Adborth Cleifion: Gwrando a Dysgu
Patient Feedback: Listening and Learning

Patient Experience Feedback
1st April 2024 – 30th June 2024
Emergency Department Survey

Was there anything particularly good about your experience that you would like to tell us about?	Was there anything that we could change to improve your experience?
Top 3 themes **15** comments around **Compassion** **10** comments around **Emotional & Physical support** **9** comments around **Helpfulness**	**Top 3 themes** **24** comments around **Comfort** **21** comments around **Waiting** **4** comments around **Emotional & Physical support**

Adborth Cleifion: Gwrando a Dysgu

Patient Feedback: Listening and Learning

Patient Experience Feedback
1st April 2024 – 30th June 2024

Division	Responses	2 - I felt listened to	2 - I was able to make my own decisions about my care	2 - I had care and support from staff who understood my needs and respected my choices	2 - I had the support of my family (or friends) when I needed them	2 - I felt safe	2 - I felt physically comfortable	2 - I was given information and advice that I could understand to help me keep well	2 - I was told who to contact if I need care and support in the future	Overall
		Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	Person Centred Care	
Family and Therapies	37	96	91	95	96	97	95	95	99	95
Medicine	772	87	77	90	93	93	87	86	75	86
Primary Care & Community	69	88	80	95	91	92	88	89	75	87
Urgent Care	19	89	84	92	94	89	72	89	81	87
Complex & Long Term Care	15	80	79	89	90	100	86	93	87	88
Surgery	480	98	95	99	98	99	97	98	96	97
Clinical Support Services	99	99	92	100	97	100	97	99	96	98
Mental Health and Learning Disabilities	54	94	83	96	86	96	90	91	80	90
	Overall	91	84	94	94	96	91	91	84	91
	Benchmarks	85	85	85	85	85	85	85	85	85

Person Centred Care (PCC) Survey – Questions 1-8

Adborth Cleifion: Gwrando a Dysgu

Patient Feedback: Listening and Learning

Top 3 Themes from PCC Survey

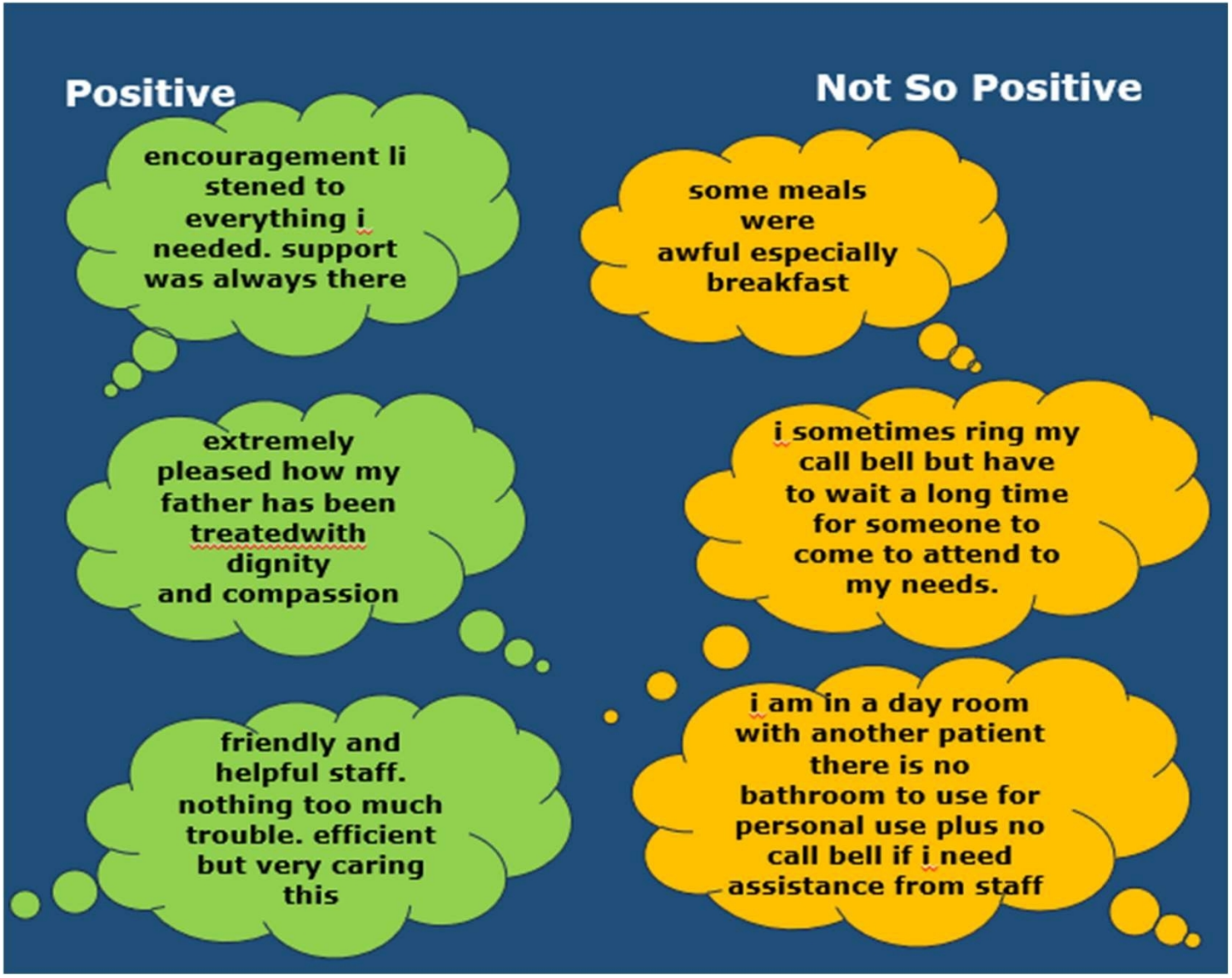
What did we do well? Q9	What could we have done better? Q10
Top 3 themes	**Top 3 themes**
268 comments around **Emotional & Physical support** •**252** comments around **Compassion** •**208** comments around **Friendliness**	• **60** comments around **Food & Beverages** •**40** comments around **Waiting** •**24** comments around **Facilities**

Top 3 Themes from PCC Survey

Positive Themes	Negative Themes
Emotional and Physical Support (268)	**Food & Beverages (60)**
Compassion (252)	**Waiting (40)**
Friendliness (208)	**Facilities (24)**

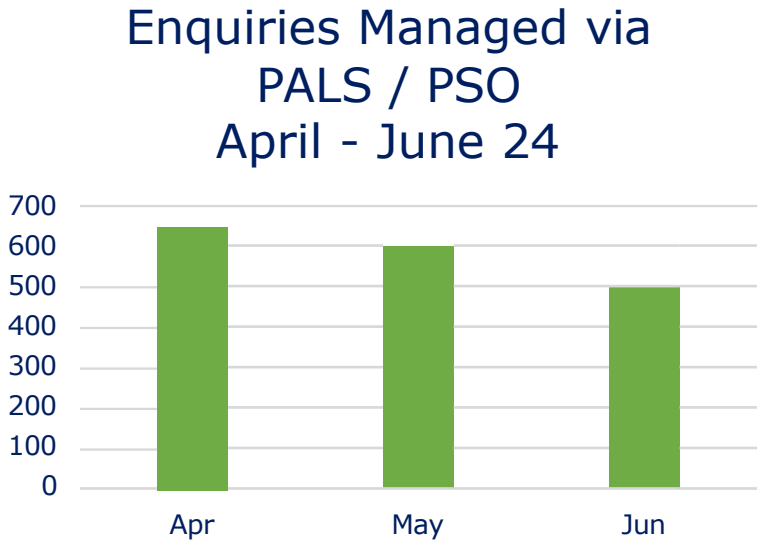
Adborth Cleifion: Gwrando a Dysgu
Patient Feedback: Listening and Learning

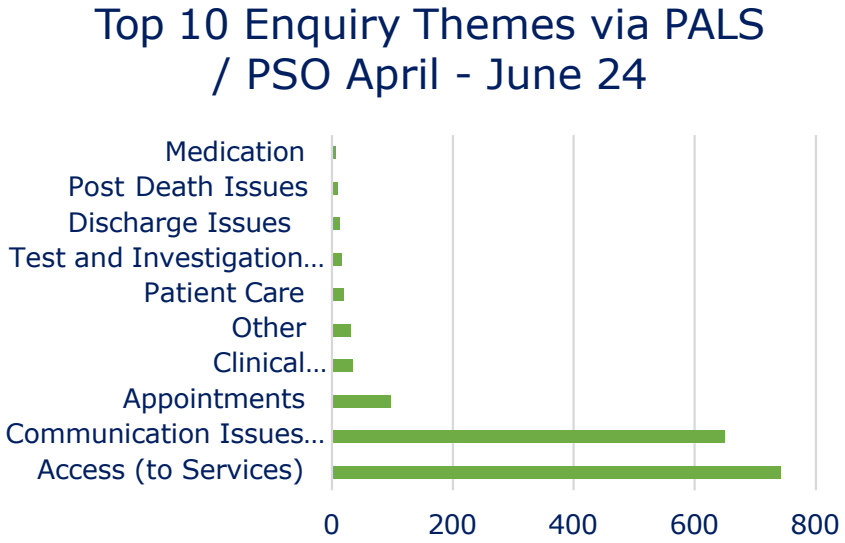
Patient Comments from PCC Survey



Patient Advice & Liaison Service

April, May & June 2024 update

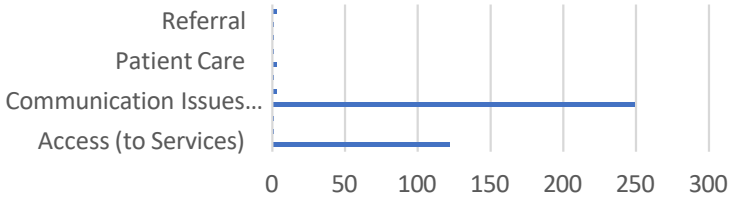




Patient Advice & Liaison Service

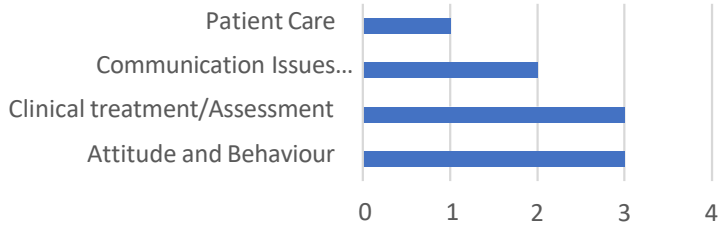
April, May & June 2024 update

Emergency Department PALS Enquiry Themes April-June 2024

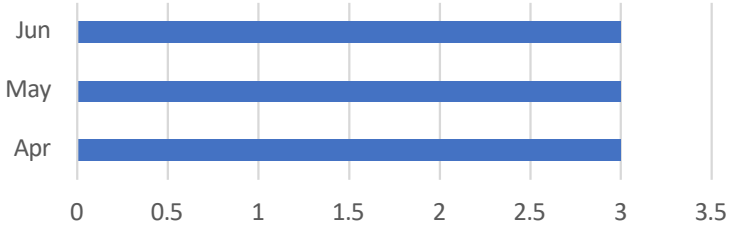


Total PALS Enquiries for Emergency Department April-June 2024 = 386

Emergency Department Early Resolution Concern themes April-June 2024

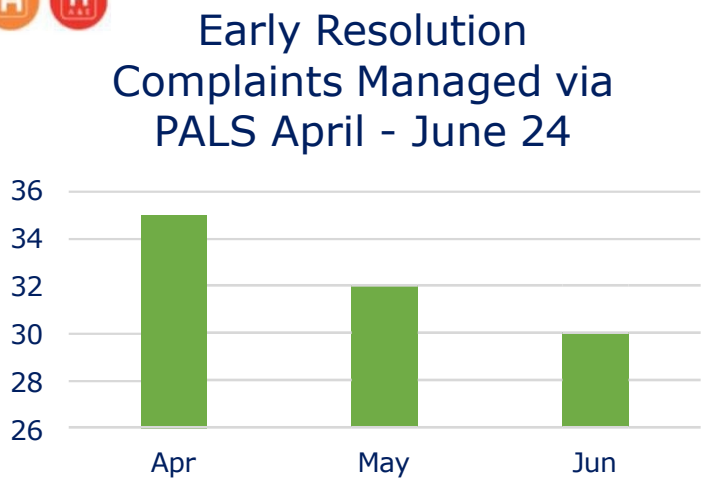


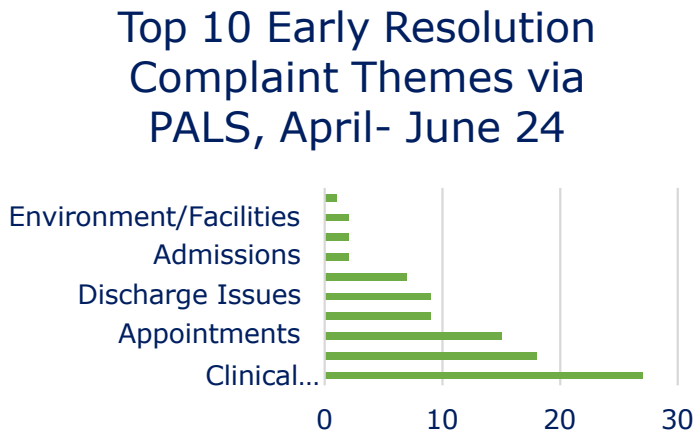
Emergency Department Early Resolution Concerns April-June 2024



Patient Advice & Liaison Service

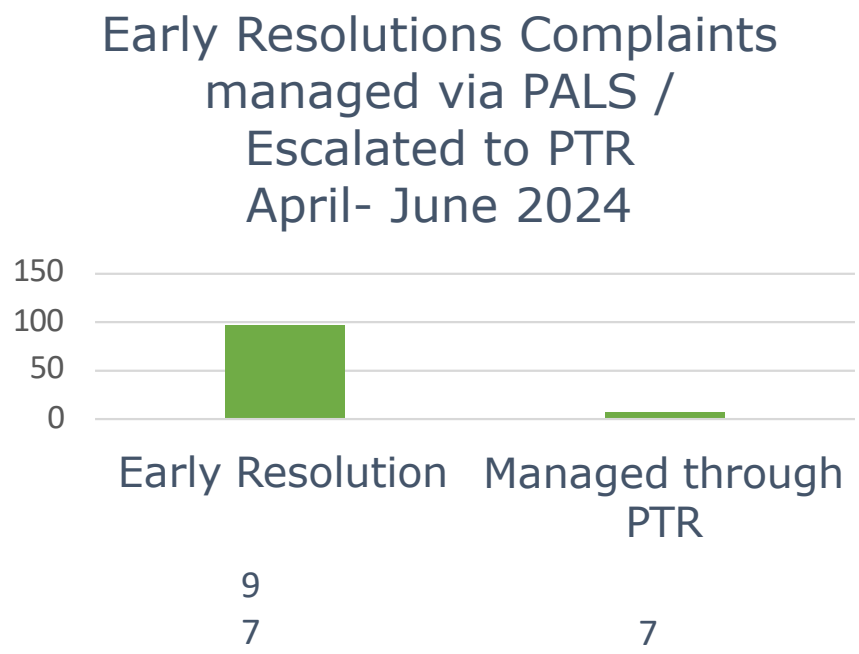
April, May & June 2024 update

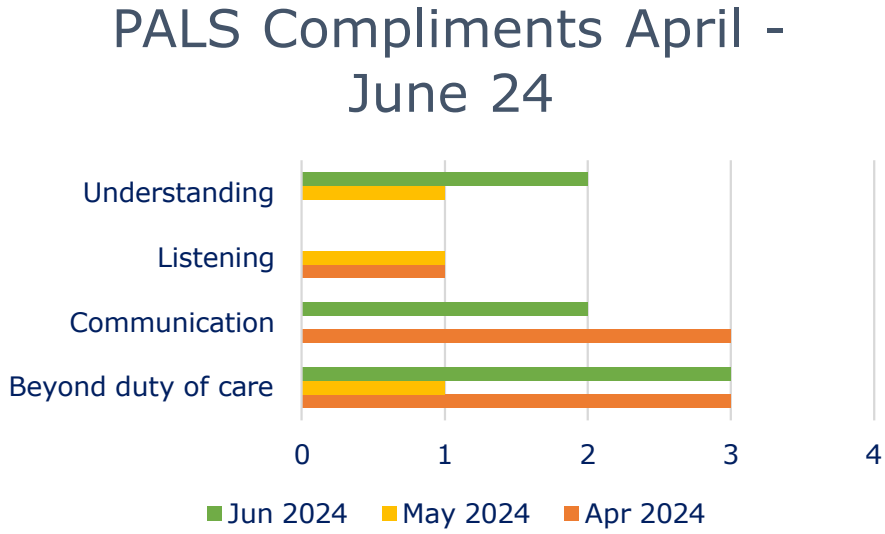




Patient Advice & Liaison Service

April, May & June 2024 update





Adborth Cleifion: Gwrando a Dysgu

Patient Feedback: Listening and Learning

Any Questions?

Agenda Item 5

Organisational Learning & Sharing Internal

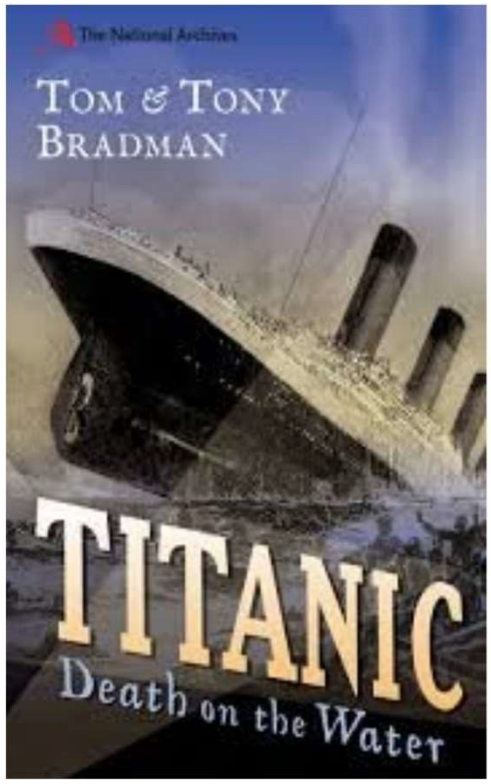
Agenda Item 5.1
QI – what happens in Neuro Rehab

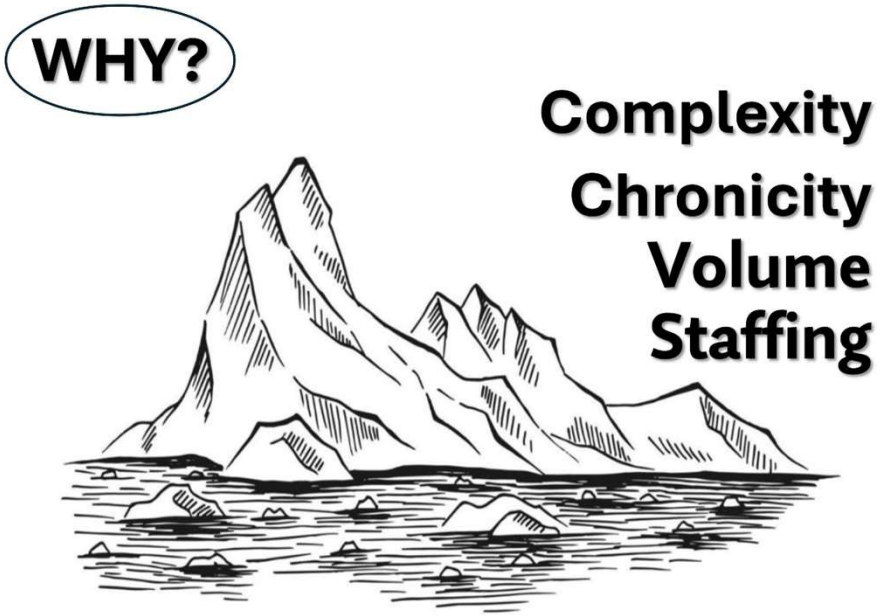
What matters most in Neurorehabilitation: The Neuro-stute Recovery College.

Dr Daryl Harris & Linda Tremain
ABUHB Community Neurological Rehabilitation Service

Allied Health Professional and Healthcare Sciences Conference 2024

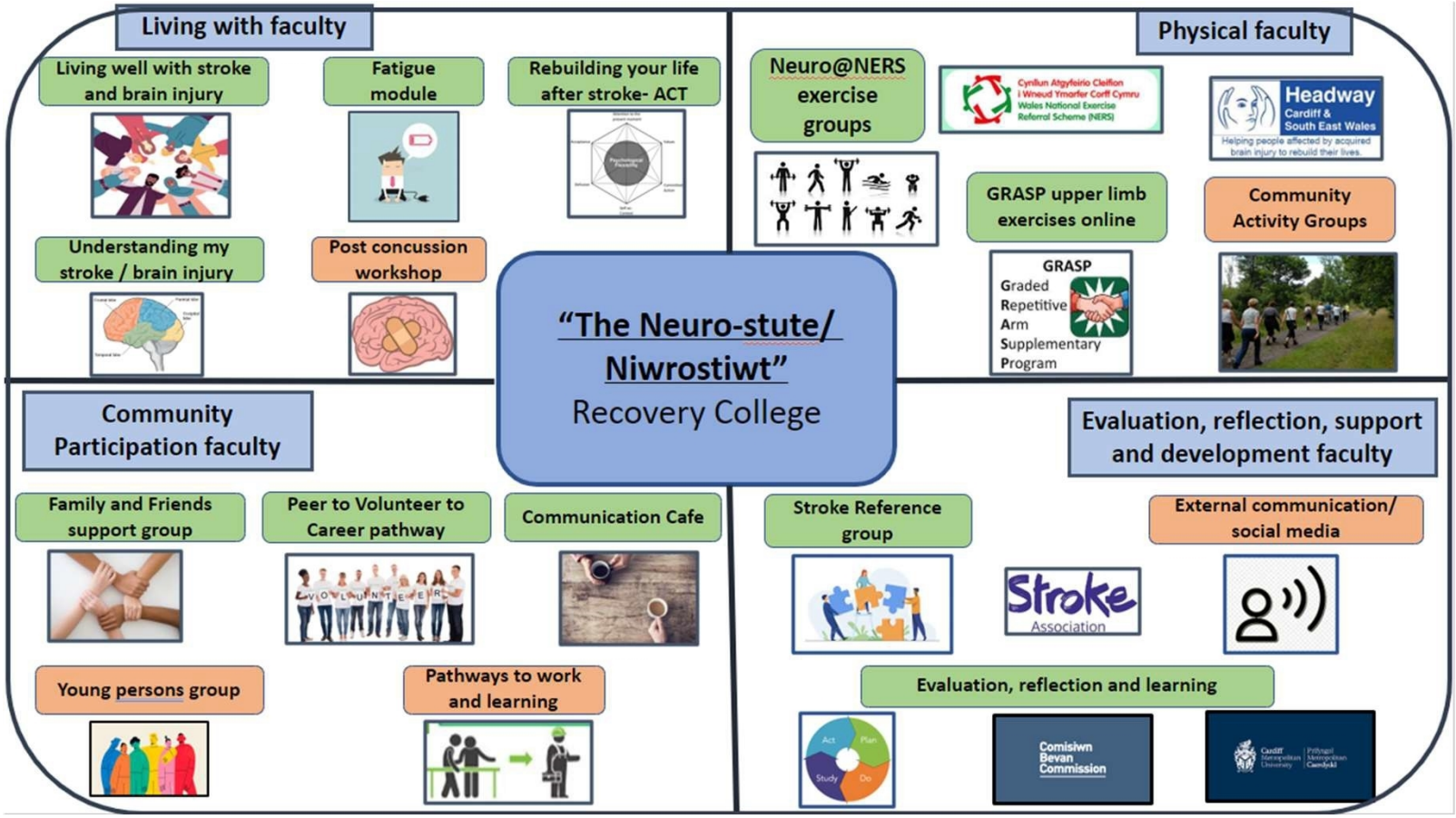
What was the problem we were trying to solve?






HOW?
Traditional Mindset
Needs Mindset
Provision
Principles
COMMUNITY
CONTROL
FOCUS
PERSONAL RECOVERY
PASSIVE

What did we do?



What did we achieve?

SO WHAT?

Project Impact

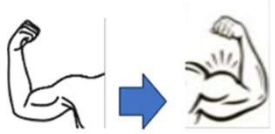
PRUDENT USE OF ALL RESOURCES

More for less

More for less

CAPABLE COMMUNITIES

More capable staff



More capable communities

ADDED VALUE

What matters most to staff and patients?

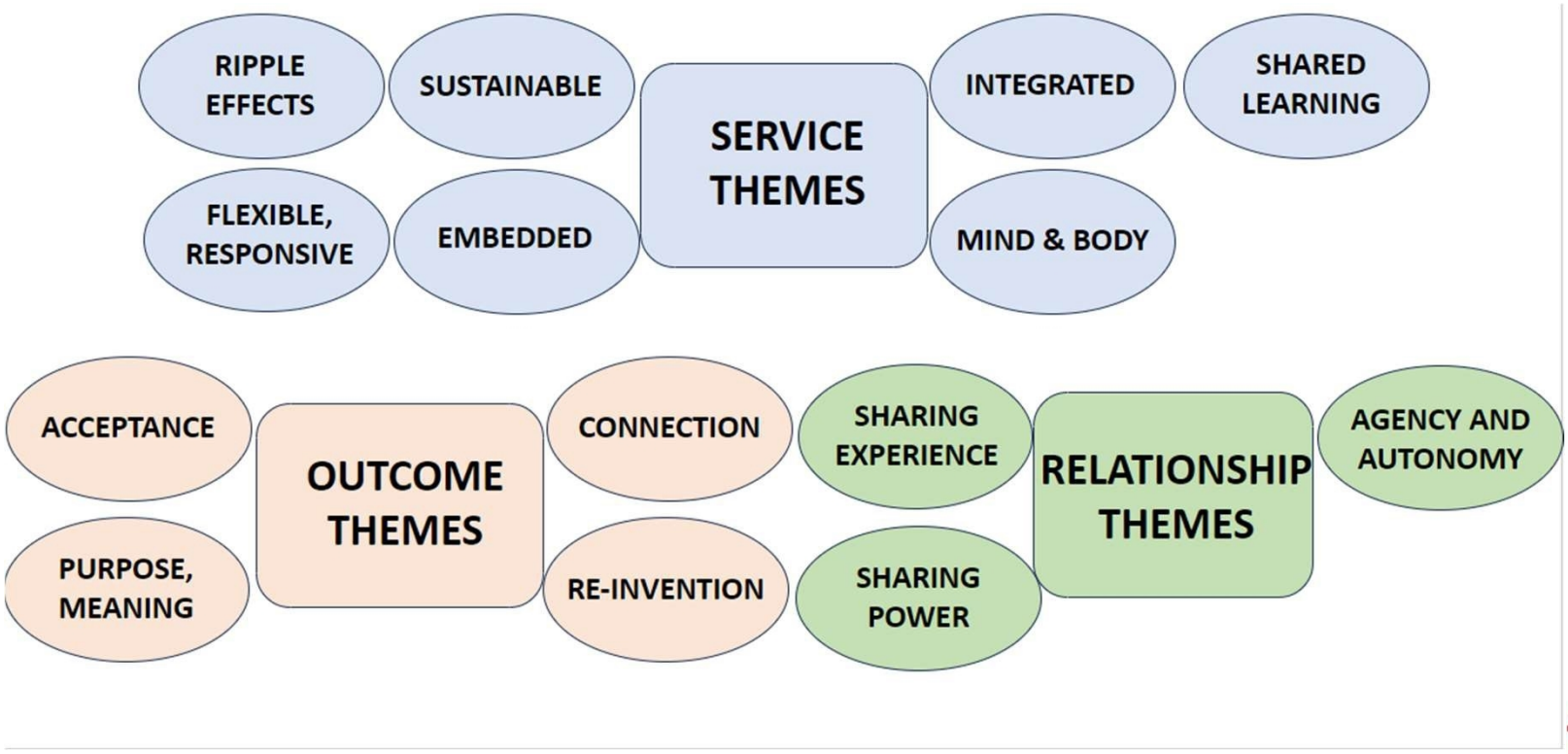
The 'Most Significant Change' (MSC) Technique

A Guide to Its Use

by

Rick Davies and Jess Dart

What matters most?



A metaphor with an ecosystem

The Ecosystem

Community of learning

RIPPLE EFFECTS

SUSTAINABLE

INTEGRATED

FLEXIBLE, RESPONSIVE

EMBEDDED

MIND & BODY

SHARED LEARNING

ACCEPTANCE

CONNECTION

PURPOSE, MEANING

RE-INVENTION

The Harvest

Outcome Variables

Nutrients

Relationship Characteristics

SHARING EXPERIENCE

SHARING POWER

AGENCY AND AUTONOMY

Carole's story

How did this support our employee experience?

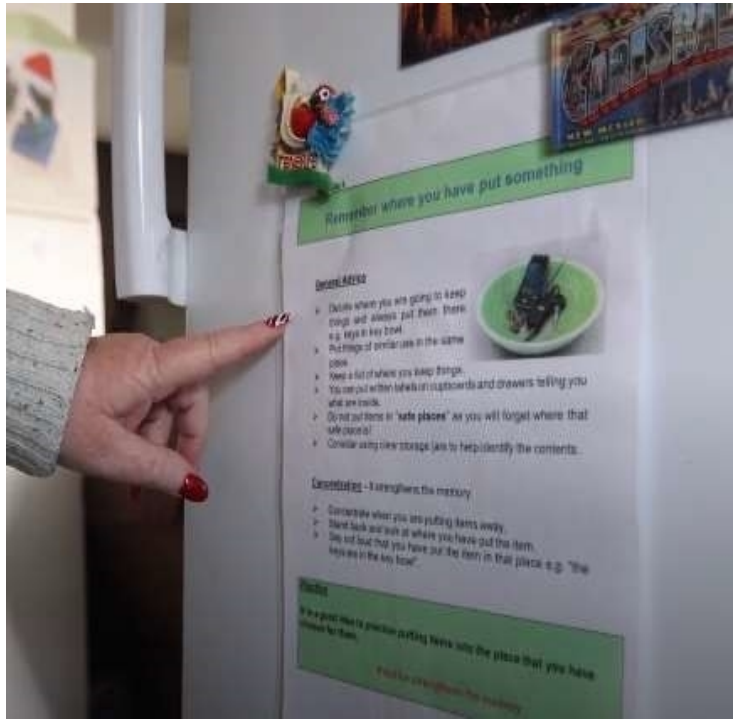
Agenda Item 5.2

Safer Care – Memory Rehab Service

Occupational Therapy: Home Based Memory Rehabilitation

Jessica Moss, Lisa Taylor and Matthew Harris

- **Allied Health Professional and Healthcare Sciences Conference 2024**

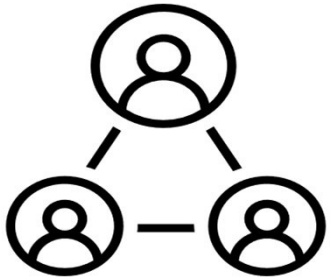


What was the problem we were trying to solve?

- 2020 ABUHB Occupational Therapy service review identified a **significant gap** for people with Dementia **early in their point of contact with memory services**.

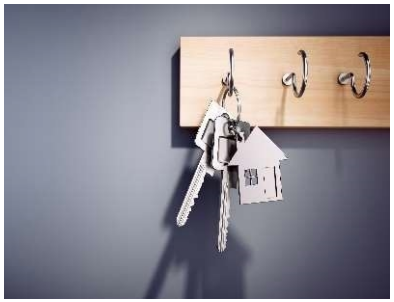
- Interventions should be provided as soon as possible to enable to people to remain as active and involved in their daily life as possible and sustain living in the community.

- Dementia Action Plan for Wales (2018-2022)
- All Wales Pathway and Standards for Wales (2021)
- Memory Service National Accreditation Programme (2018)
- AHP Framework for Wales (2022)



What did we do?:

Pilot service (Newport and Blaenau Gwent) delivering 1:1 programme **Home Based Memory Rehabilitation** (McGrath 2009).



ABUHB Home based Memory Rehabilitation: the story

https://vimeo.com/934744469/c13040469d?share=copy

What did we achieve?: clinical outcomes and PREMS

- Average number of self-management strategies people were using in day-to-day life after intervention were **6-7**.

- OCAIRS outcomes: 8-10 of 12 domains showed improvement.

- Feedback forms: Carer score averaged **8.8** and Partici[illegible]ore averagd **9.6** (scale 0-10)

Quality Improvement : Understanding the problem

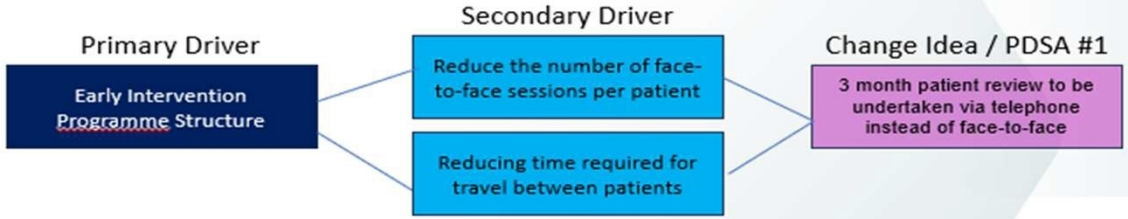
- There is an optimal window of opportunity where HBMR is suitable and makes maximum impact for both the person and carers.
- People are at risk of deteriorating while waiting for the service and waiting times have increased due to demand for this service.

Data evidencing the problem:

- wait time per patient - referral to initial contact.
- Limited caseload capacity and time.
- Growing demand for the service.

What did we do?

Tests of change- PDSA1

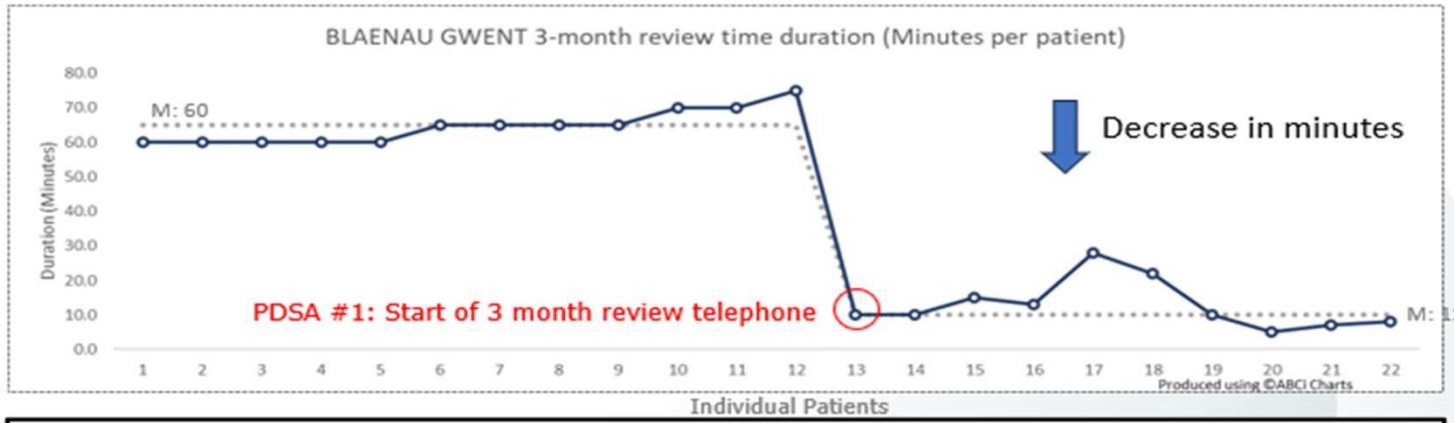


- **Our prediction**: This test of change will reduce the duration* (minutes) when undertaking patient reviews.

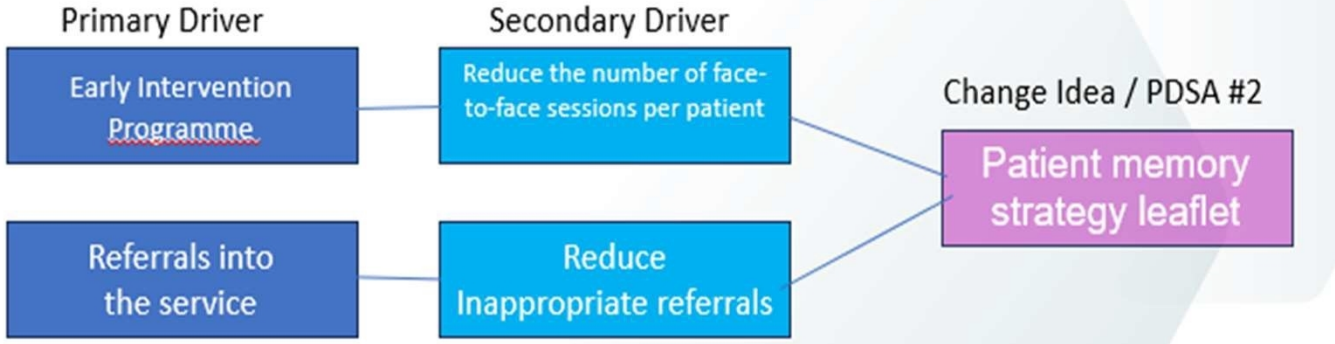
This process measure focuses purely on the duration of the review with the patient. This does not include the reductions in travel time to patient homes.*

**Travel time has been reduced to an average of 50 minutes to 0 Minutes, per patient (when tested).

Process Measure – PDSA 1



What did we do?
Tests of Change - PDSA 2



- Patient memory strategy leaflet. Provide patients information they may be able to apply while waiting to receive the HBMR service.
- **Prediction:** This in turn may reduce the amount of HBMR sessions patients require.

What did we achieve?

Key benefits:

PDSA #1 - We have released time to support more patients in the service (20 - 60 mins per patient). Frees up capacity to support more patients.

- We can see an additional **13** patients per year, EACH!
- Reduction in carbon emissions (travel)
- Reduction in cost of travel
- Patients continue to receive a thorough 3 month review

PDSA #1.5 – Unplanned change, that was required to be made, it has proven to add value to the service

PDSA #2 – We are actively encouraging patients to co-produce the pre-hab information.

- Patients are involved in co-production of this service through QI!
- Potentially further efficiencies can be made to this service

We undertake 3 month reviews with our patients - Unique compared to other services in following the patient journey

Staff experience

-clinician experience delivering this programme (highly rewarding as an OT seeing the impact)

-Clinician experience of QI (feel we have the tools to implement good quality improvement methodology)

-Service lead experience using QI as a team approach to service improvement and development (takes the team with you on the improvement journey- less subjective and hierarchical)

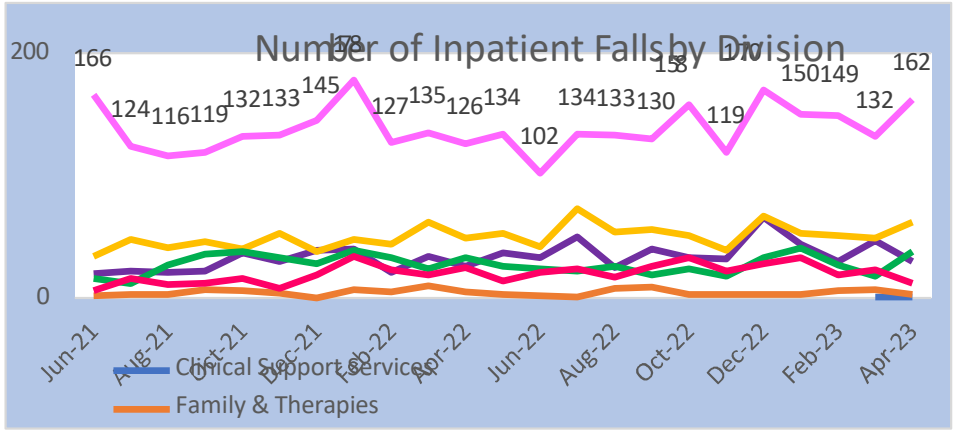
-Staff experience using co-production extremely positive

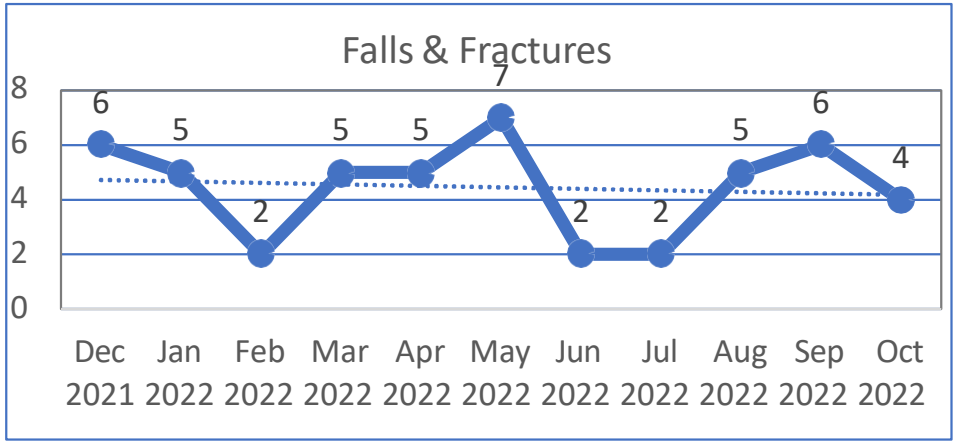
Agenda Item 5.3
QPS – SWARM methodology

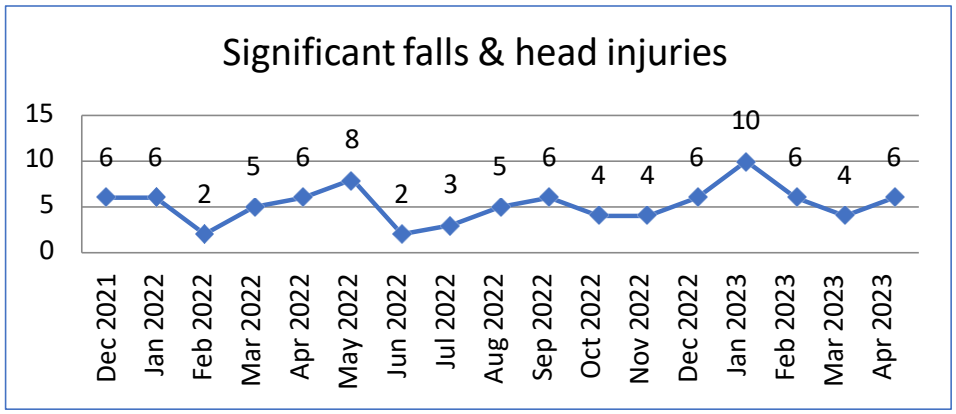
THE IMPLEMENTATION OF THE SWARM HUDDLES FRAMEWORK FOR INPATIENT FALLS

MEDICINE DIVISION

Falls Data & Trend Medicine
DEC 21-APRIL 23







SI Investigations With Falls Theme

CORPORATE		DIVISIONAL	
Current	Closed	Current	Closed
0	5	2	2

THEMES

- POOR COMPLETION OF MFRA: ACTION PLANS NOT COMPLETED WITH PREVENTATIVE INTERVENTIONS/ NOT DATED AND TIMED/NOT COMPLETED TIMELY OR UPDATED WITH CHANGE IN CONDITION
- POOR MDT ENGAGEMENT- OTHER DISCIPLINES UNAWARE OF THEIR ROLE IN FALLS ASSESSMENT- NURSING ROLE
- INAPPROPRIATE FOOTWEAR
- LYING AND STANDING BLOOD PRESSURE NOT COMPLETED
- MEDICATION REVIEWS NOT COMPLETED
- STAFFING AND ACUITY
- ENHANCED CARE
- POST FALLS ASSESSMENT NOT COMPLETED TIMELY OR USING FORM
- NEUROLOGICAL OBSERVATIONS PARTIALLY COMPLETED WITH TIMEFRAMES
- SBARS NOT HIGHLIGHTING RISK OF FALLS, FALLS HISTORY

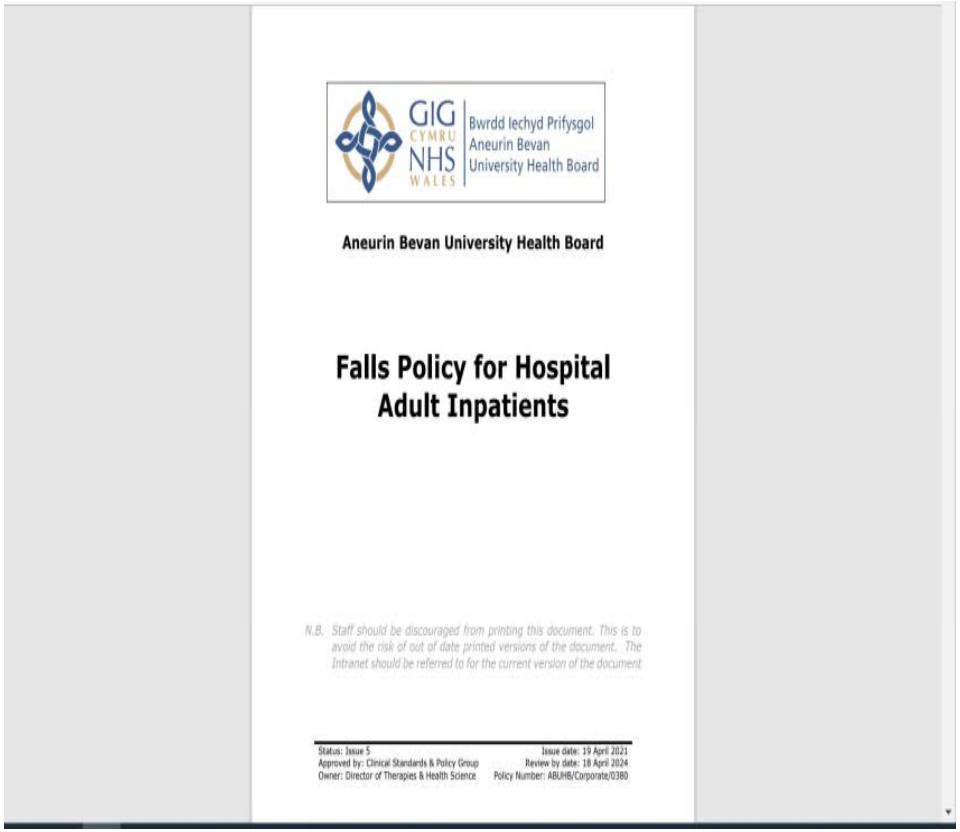
MFRA- FALLS POLICY

5.5) All Clinical Staff:

Are responsible for the following: Complying with and implementing all the requirements of this policy by means of a MDT approach.

6.1 d)

A MDT approach will be adopted in terms of assessing and minimising the risk of falls whilst including Patients, Families and Carers in assessments, planning and making available easy to understand information.

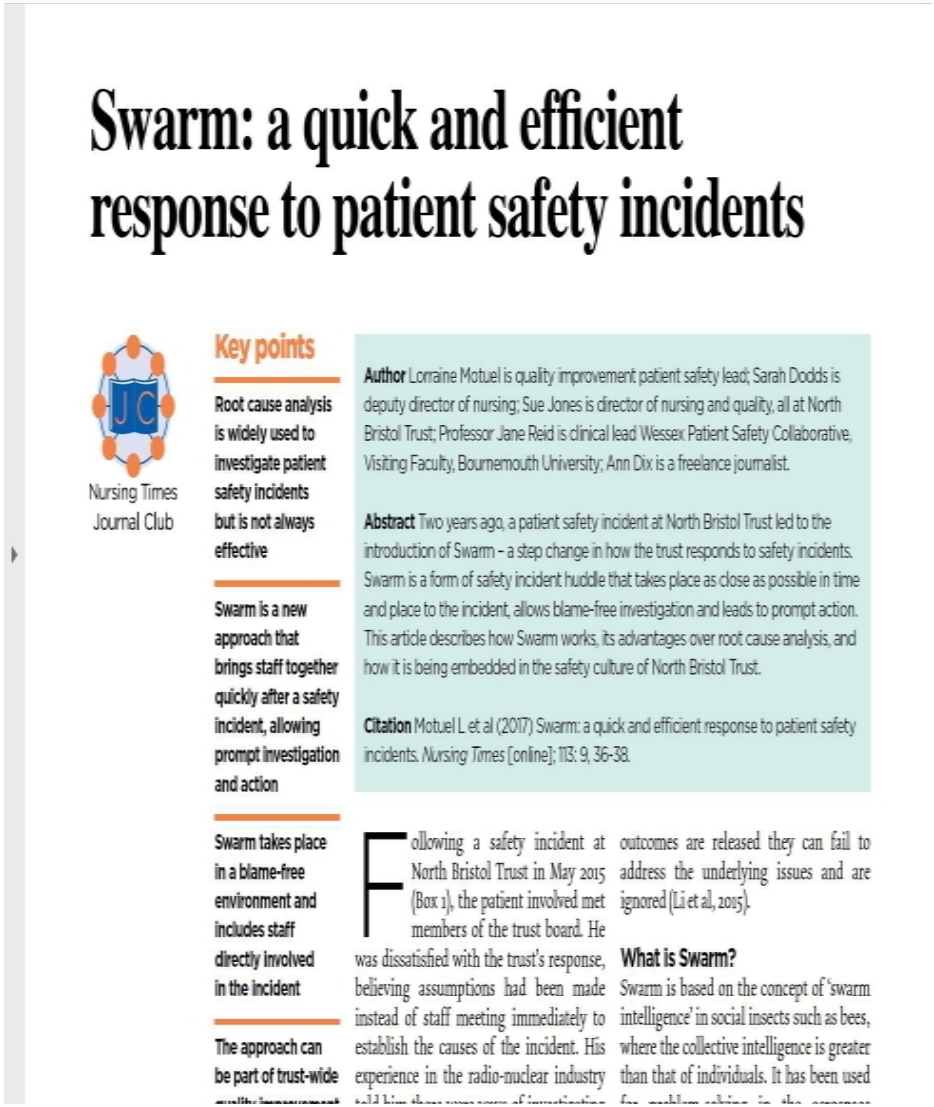


SWARM METHODOLOGY

•- Concept Of Swarm Intelligence In Social Insects
•- Used For Problem Solving In Aerospace And Recently In Hospitals As A
• RCA.

- - Like Bees, Staff 'Swarm' To The Site Of The Incident To Determine Its Causes And How To Prevent It Recurring. The Swarm Is Carried Out In A Blame-free Environment And While The Incident Is Still Fresh In Every One's Mind. This Helps Build A More Accurate Picture Of The Organisational And Human Factors Involved, And Allows Staff To Suggest Improvements That Can Be Made Immediately (LI ET AL, 2015)
- *AN EFFECTIVE SWARM:*

Encourages Candour By Reassuring Participants That They Are In A Blame free Environment
Introduces Participants To Each Other To Create Familiarity And Respect;
Reviews The Facts;
Discusses What Happened, As Well As How And Why It Happened;
Proposes Actions And Assigns Task Leaders With Specific Duties And Deadlines.



Swarm: a quick and efficient response to patient safety incidents

Nursing Times Journal Club

Key points

Root cause analysis is widely used to investigate patient safety incidents but is not always effective

Swarm is a new approach that brings staff together quickly after a safety incident, allowing prompt investigation and action

Swarm takes place in a blame-free environment and includes staff directly involved in the incident

The approach can be part of trust-wide

Author Lorraine Motuel is quality improvement patient safety lead; Sarah Dodds is deputy director of nursing; Sue Jones is director of nursing and quality, all at North Bristol Trust; Professor Jane Reid is clinical lead Wessex Patient Safety Collaborative, Visiting Faculty, Bournemouth University; Ann Dix is a freelance journalist.

Abstract Two years ago, a patient safety incident at North Bristol Trust led to the introduction of Swarm – a step change in how the trust responds to safety incidents. Swarm is a form of safety incident huddle that takes place as close as possible in time and place to the incident, allows blame-free investigation and leads to prompt action. This article describes how Swarm works, its advantages over root cause analysis, and how it is being embedded in the safety culture of North Bristol Trust.

Citation Motuel L et al (2017) Swarm: a quick and efficient response to patient safety incidents. *Nursing Times* [online]; 113: 9, 36-38.

Following a safety incident at North Bristol Trust in May 2015 (Box 1), the patient involved met members of the trust board. He was dissatisfied with the trust's response, believing assumptions had been made instead of staff meeting immediately to establish the causes of the incident. His experience in the radio-nuclear industry

outcomes are released they can fail to address the underlying issues and are ignored (Li et al, 2015).

What is Swarm?

Swarm is based on the concept of 'swarm intelligence' in social insects such as bees, where the collective intelligence is greater than that of individuals. It has been used

SAFER CARE

QUESTIONS ADDRESSED BY SWARM PARTICIPANTS

What happened, to whom, when,

how and why?

Were there gaps in care/treatment?

Could processes be improved?

How can a recurrence be prevented/ the risk of recurrence be reduced?

What immediate action can we take?

How can we ensure shared learning?

How should this inform our duty of candour to the patient and family?

Three examples of how Swarm has made care safer at the NB trust:

- After a patient in an older care ward fell off a chair and fractured their hip, a Swarm established that a seat cushion had been fitted incorrectly.

Staff were unaware that chairs had removable cushions and could be incorrectly assembled, and no one routinely checked their assembly.

The trust issued a safety alert and there have been no further incidents.

- Staff are now aware that they need to align the brakes on each side of shower chairs to avoid them tipping over when patients lean forward.

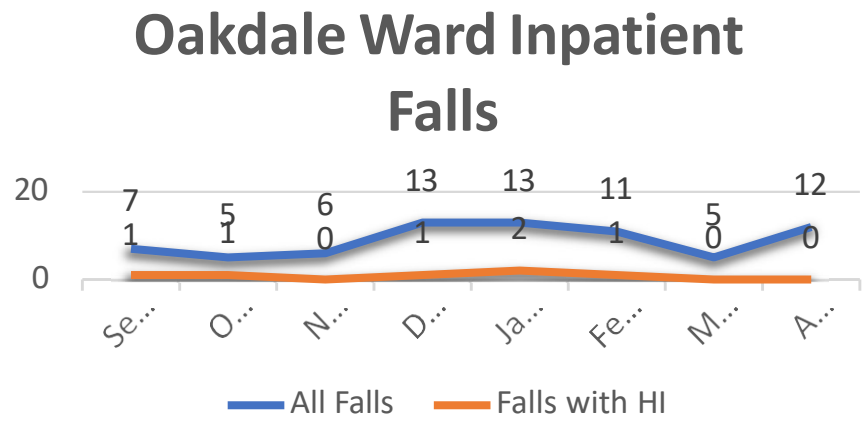
Hooks have been added to hang patients' shower bags on, so they no longer risk falling when bending down to pick them up.

- Swarm has revealed that patients with complex needs who are ready to go home are at greater risk of falls than when they are acutely ill because they are more mobile. Instead of moving them into single rooms before they are discharged, we nurse them in a four-bed bay where we can better observe them.

Implementation plan

- First meeting held with Divisional Leads to obtain engagement Nov 22
- Concept of using swarm approach prior to a fall incident (pre swarm) as well as following incident (post swarm) explored, and agreement obtained.
- Pilot ward-Oakdale YYF for two months.
- Meetings held with ward team and MDT
- Task and finish groups meetings arranged leading up to start date of 3rd April 23

- Development of The Implementation of the SWARM huddles framework for Inpatient Falls (PDSA)
- Pre and post huddle flow charts



DATA COLLECTION

- The aim of the Swarm Project framework is to ensure that falls prevention via risk assessment and effective risk reduction strategies is implemented fully and as a multidisciplinary team, for high-risk individuals, in order to create a safer environment and reduce harm.
- In doing so, to improve the compliance of the MFRA assessment and interventions in its entirety, timely completion, timely implementation of risk reducing strategies and where able to reduce the number of inpatient falls for people who are considered high risk.
- This will be achieved by:
- Introducing Pre and Post incident Swarm huddle meetings that is attended by the key multidisciplinary team members to jointly complete the MFRA and implement risk reducing interventions. Target: more than 95% of patients included in the PDSA.
- Improving the quality of the MFRA assessment ensuring all risks are considered and an individualised action plan is developed and actioned. Target > 95%
- Improving the timeliness of the MFRA assessment completed by setting a two-hour guidance for the Swarm huddles to take place. This will achieve well within the six hours ward admission target set by the Prevention and Management of Adult Inpatient Falls policy (2021). Target 95 % noting that a Swarm huddle MFRA completion will not be achievable currently for patients admitted or who fall out of working hours.
- Ensuring that over 80% of patients are discussed by the multidisciplinary team.

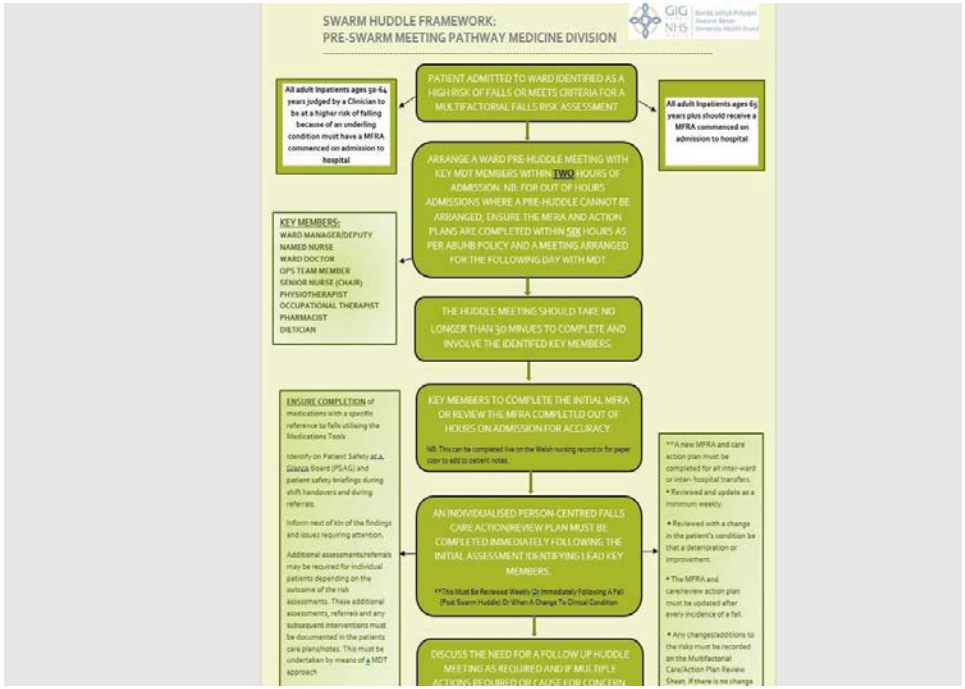
SWARMS QUALITY IMPROVEMENTPROJECT: PDSA FALLS

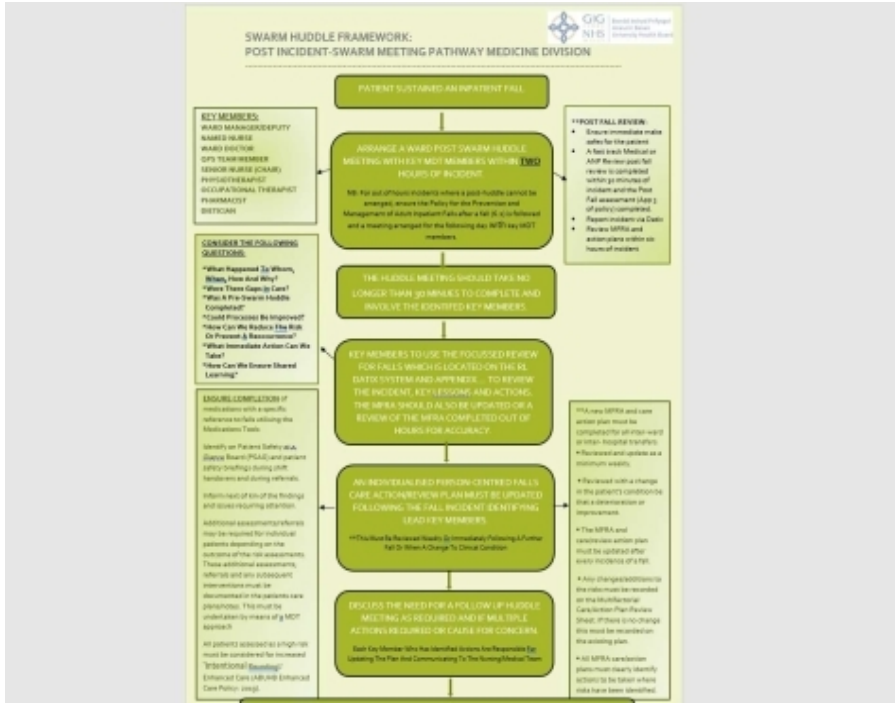
Medicine Division

The Implementation of the SWARM huddles framework for Inpatient Falls

Purpose of Document The purpose of this document is to provide an overview of the Swarm huddles pilot project. This will be implemented for patients considered at a high risk of falls and for use in the prevention of a fall and following an inpatient fall irrespective of the level of harm sustained.	
Authors:	Kylie Crook Lead Nurse Quality & Patient Safety Medicine Division
Contributors:	
Date: 23/01/23	
Version: V1.0	
Summary of Document: The SWARM huddles framework quality improvement project for patient identified of being at high risk of falls and following a falls incident within the Medicine Division.	

Swarm Flowcharts





DATA COLLECTION

QUANTITATIVE MEASURES:

- Prior to the commencement of the pilot Swarms project, baseline data was collected using a newly developed Falls MFRA audit form. Currently there is no specific data collection on the MFRA available to utilise. This was used to measure current compliance and by which to measure the impact of the PDSA and understand if a change for improvement.
- Baseline data from the RL Datix incident reporting system for the pilot ward, on the number of inpatients falls was obtained. This was also used to compare the number of inpatient falls during the project pilot.

QUALITATIVE MEASURES:

- Prior to the commencement of the pilot Swarm project, baseline qualitative data was collected by providing staff members a questionnaire to complete on their knowledge, previous experience of the Swarm framework, the project processes and their perspective on the benefits and barriers to the framework.
- Following implementation of the project, and after each Swarm huddle meeting, the MDT was asked to complete a staff questionnaire.
- This asked specific questions as to the meeting processes, attendance, any interruptions, barriers and if they have found the meeting beneficial in identifying, assessing, and actioning preventative measures of falls risk, for the case under review and if not the reason why.

Do/ACT

- The Swarm pilot project commenced on the 3rd April 2023 on one medical ward in Ysbyty Ystrad Fawr Hospital.
- The project run for two months incorporating the Pre-Swarms huddles in the first month before introducing the post swarm huddles in the second month.
- The swarm huddle meetings incorporated key multidisciplinary team members (Appendix Five) and will be chaired initially by the Senior Nurse for the ward area and/or the Senior Nurse for Quality and Patient Safety for the Medicine Division, following a meeting agenda (Appendix 6).
- A poster developed to advertise the pilot project.
- Baseline data collection, MFRA audit and staff questionnaires were disseminated and completed prior to commencement.
- Familiarisation with swam documents for meetings: meeting agenda, at a glance forms
- A pilot project meeting was completed after the first month with stakeholders to discuss any key concerns.
- The Quality and Patient Safety Team will support the pilot implementation and attend the Swarm huddle meetings as able and be available to support with immediate concerns.

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

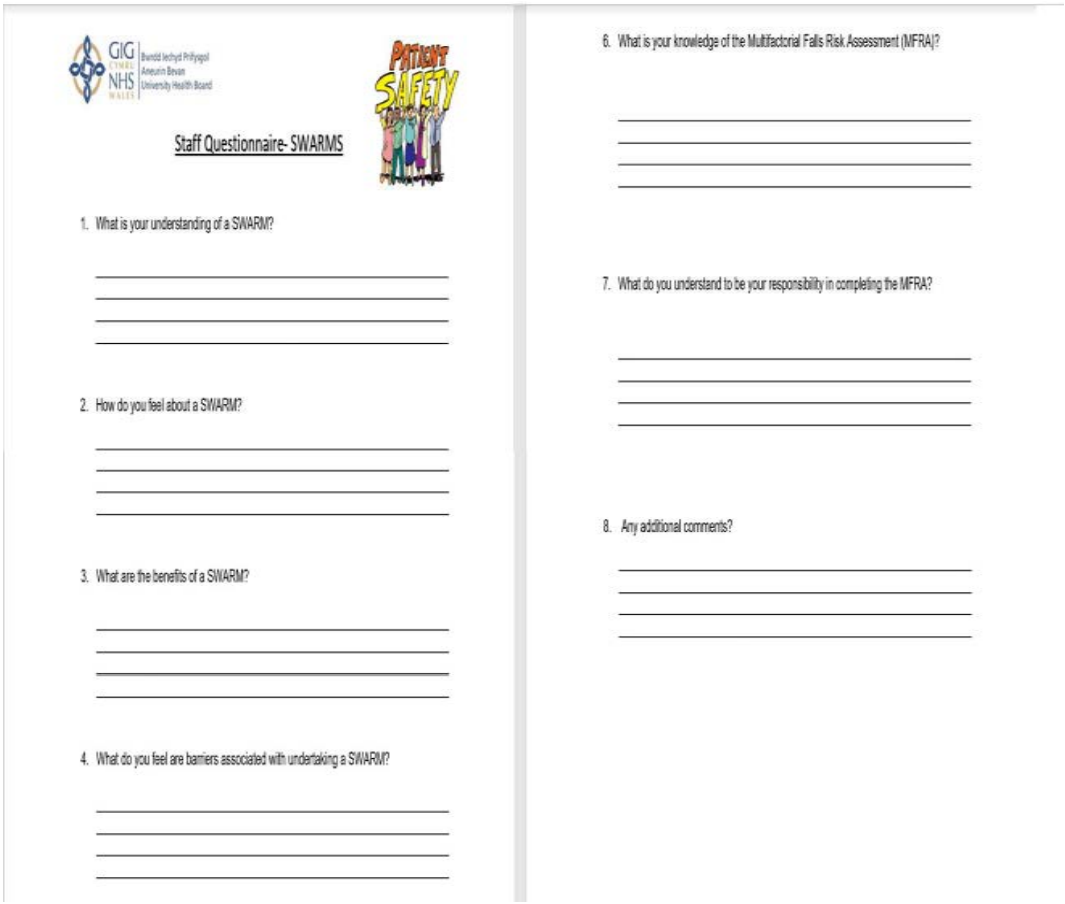
FALLS MULTI- FACTORIAL RISK ASSESSMENT AUDIT

Ward being Audited: _____

Date & Time of Audit: _____

A	General Assessment	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8
	Patient CRN:								
		Yes/NA	No/NA	Yes	No	Yes	No	Yes	No
1	Is there a Falls MFRA in the nursing notes?								
2	Does the Patient meet the criteria for a Falls MFRA to be completed? If no for both then discontinue audit for that patient.								
3	Within the medical clerking record on admission does this detail a falls history and mobility?								
4	If the patient was transferred from another site or ward, is there evidence of a completed MFRA?								
5	If transferred, was there a completed SBAR that reflected if the patient was a high risk of falls?								
6	Was the falls MFRA completed within six hours of admission?								
7	Did nursing complete the falls MFRA?								
8	Has a substantive staff member completed? If no, then state in comments box if a student nurse or agency nurse								
9	Was the MFRA completed in conjunction with the patient? If clinically unable put as N/A								

Staff questionnaires



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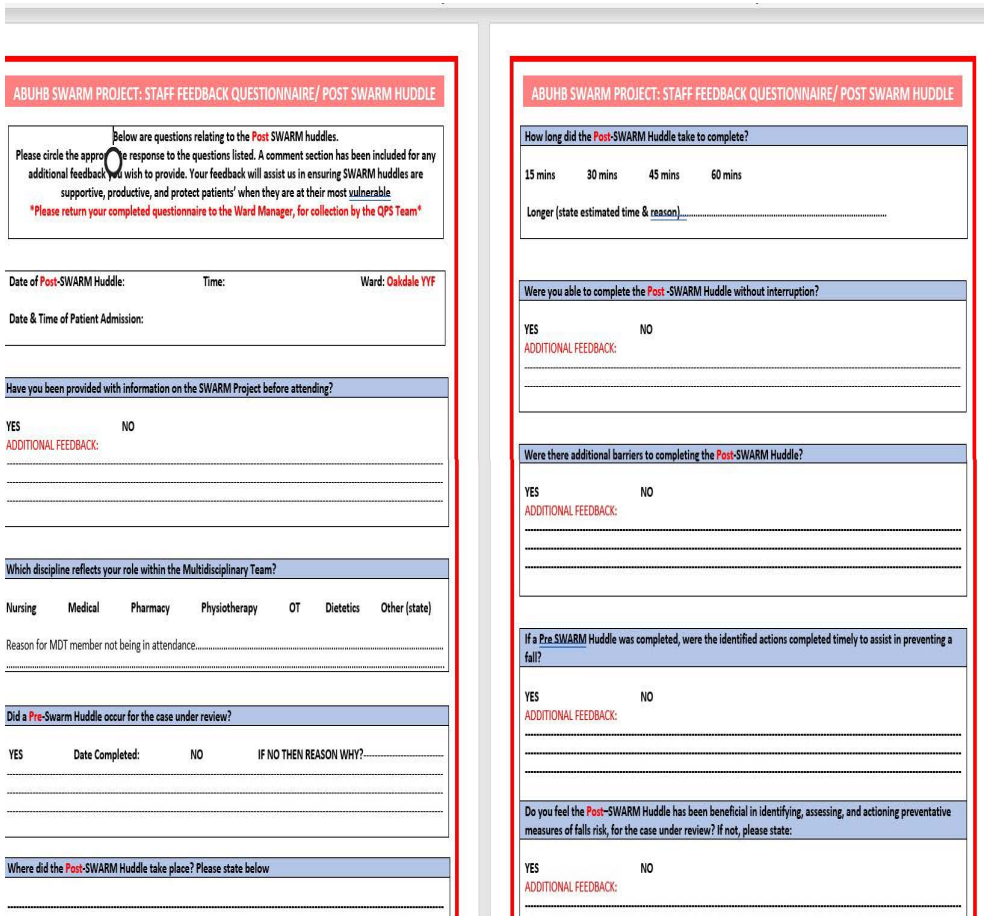
Staff Questionnaire- SWARMS

1. What is your understanding of a SWARM?
2. How do you feel about a SWARM?
3. What are the benefits of a SWARM?
4. What do you feel are barriers associated with undertaking a SWARM?
6. What is your knowledge of the Multifactorial Falls Risk Assessment (MFRA)?
7. What do you understand to be your responsibility in completing the MFRA?
8. Any additional comments?



ABUHB SWARM PROJECT: STAFF FEEDBACK QUESTIONNAIRE/ POST SWARM HUDDLE

Below are questions relating to the Post SWARM huddles.
Please circle the appropriate response to the questions listed. A comment section has been included for any additional feedback you wish to provide. Your feedback will assist us in ensuring SWARM huddles are supportive, productive, and protect patients' when they are at their most vulnerable
Please return your completed questionnaire to the Ward Manager, for collection by the QPS Team

Date of Post-SWARM Huddle: Time: Ward: Oakdale YYF

Date & Time of Patient Admission:

Have you been provided with information on the SWARM Project before attending?

YES NO
ADDITIONAL FEEDBACK:

Which discipline reflects your role within the Multidisciplinary Team?

Nursing Medical Pharmacy Physiotherapy OT Dietetics Other (state)

Reason for MDT member not being in attendance.....

Did a Pre-Swarm Huddle occur for the case under review?

YES Date Completed: NO IF NO THEN REASON WHY?.....

Where did the Post-SWARM Huddle take place? Please state below

ABUHB SWARM PROJECT: STAFF FEEDBACK QUESTIONNAIRE/ POST SWARM HUDDLE

How long did the Post-SWARM Huddle take to complete?

15 mins 30 mins 45 mins 60 mins

Longer (state estimated time & reason).....

Were you able to complete the Post -SWARM Huddle without interruption?

YES NO
ADDITIONAL FEEDBACK:

Were there additional barriers to completing the Post-SWARM Huddle?

YES NO
ADDITIONAL FEEDBACK:

If a Pre SWARM Huddle was completed, were the identified actions completed timely to assist in preventing a fall?

YES NO
ADDITIONAL FEEDBACK:

Do you feel the Post-SWARM Huddle has been beneficial in identifying, assessing, and actioning preventative measures of falls risk, for the case under review? If not, please state:

YES NO
ADDITIONAL FEEDBACK:

SWARM APPROACH PILOT PROJECT

OAKDALE WARD YYF APRIL 2023

IMPORTANT INFORMATION FOR NURSING, MEDICAL & KEY STAKEHOLDERS OF THE MULTIDICIPLINARY TEAM, INVOLVED IN PATIENT CARE DELIVERY

An exciting multidisciplinary quality improvement Swarm pre and post fall pilot project is due to commence on the 3rd april 2023! This will be based on oakdale ward, YYF for an eight -week period.

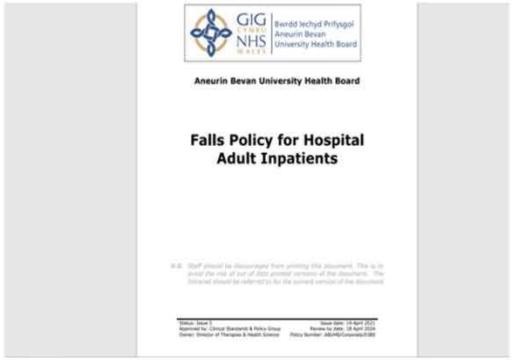
Swarm huddles have been used to identify learning from patient safety incidents and has been designed to start as soon as possible after a patient safety incident occurs (NHS England, 2022). The focus of this pilot will be for patients at high risk of falls and/or who have sustained an inpatient fall.

For this pilot there will be a two-arm approach with the Pre-Swarm huddles being introduced initially from 3rd april to the 3rd May 2023, followed by the introduction of the Post Swarm huddles and completing on the 31st May 2023.

Swarm approach brings all disciplines of staff together, quickly after a patient has been admitted to the ward and who is considered high risk, to immediately assess using the falls multifactorial risk assessment (MFRA) and to implement appropriate preventative measures to try and reduce the risk of a fall occurring. The Post Swarm huddle, is the same approach being completed after an incident of a fall has occurred, to review the factors surrounding the incident, to share learning and implement new or existing preventative actions.

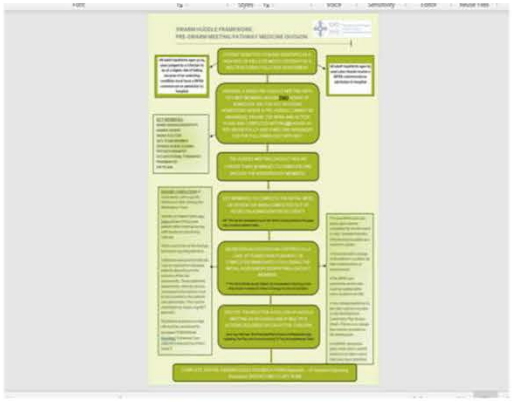
The aim of this pilot is to assess for improvements in the compliance to the MFRA completion and to assist in improved patient's safety and the prevention of injurious falls.

Pilot documentation can be accessed from the Ward Manager on Oak dale ward or the QPS team.

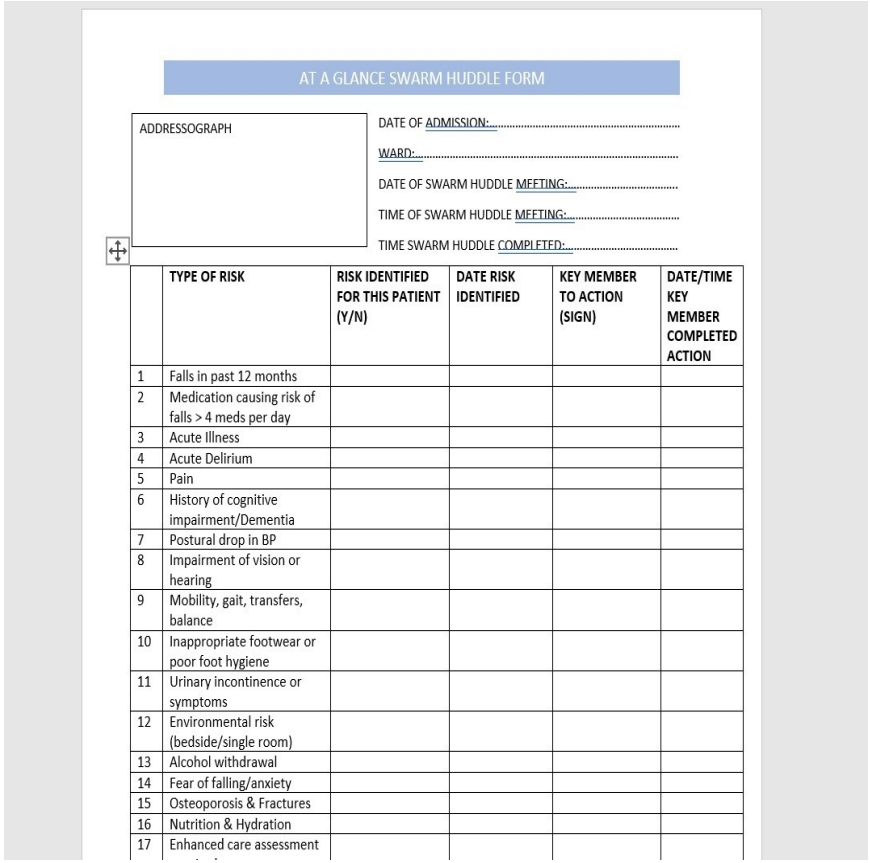


Aneurin Bevan University Health Board

Falls Policy for Hospital Adult Inpatients



Meeting documents



AT A GLANCE SWARM HUDDLE FORM

ADDRESSOGRAPH

DATE OF ADMISSION:.....

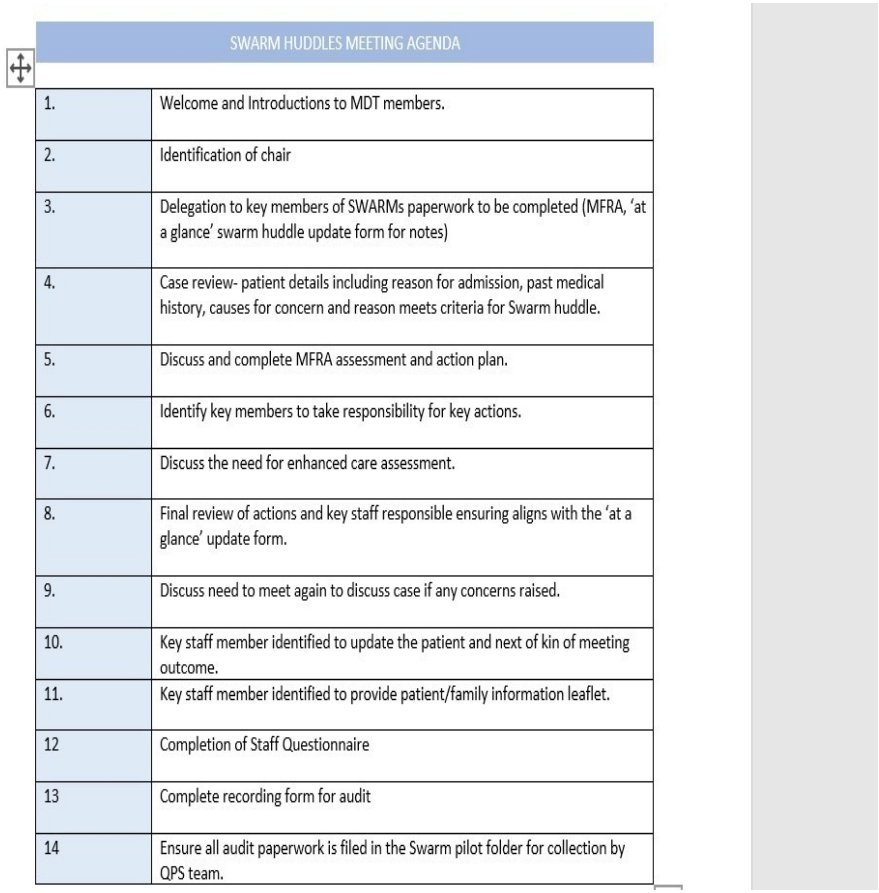
WARD:.....

DATE OF SWARM HUDDLE MEETING:.....

TIME OF SWARM HUDDLE MEETING:.....

TIME SWARM HUDDLE COMPLETED:.....

	TYPE OF RISK	RISK IDENTIFIED FOR THIS PATIENT (Y/N)	DATE RISK IDENTIFIED	KEY MEMBER TO ACTION (SIGN)	DATE/TIME KEY MEMBER COMPLETED ACTION
1	Falls in past 12 months				
2	Medication causing risk of falls > 4 meds per day				
3	Acute Illness				
4	Acute Delirium				
5	Pain				
6	History of cognitive impairment/Dementia				
7	Postural drop in BP				
8	Impairment of vision or hearing				
9	Mobility, gait, transfers, balance				
10	Inappropriate footwear or poor foot hygiene				
11	Urinary incontinence or symptoms				
12	Environmental risk (bedside/single room)				
13	Alcohol withdrawal				
14	Fear of falling/anxiety				
15	Osteoporosis & Fractures				
16	Nutrition & Hydration				
17	Enhanced care assessment				

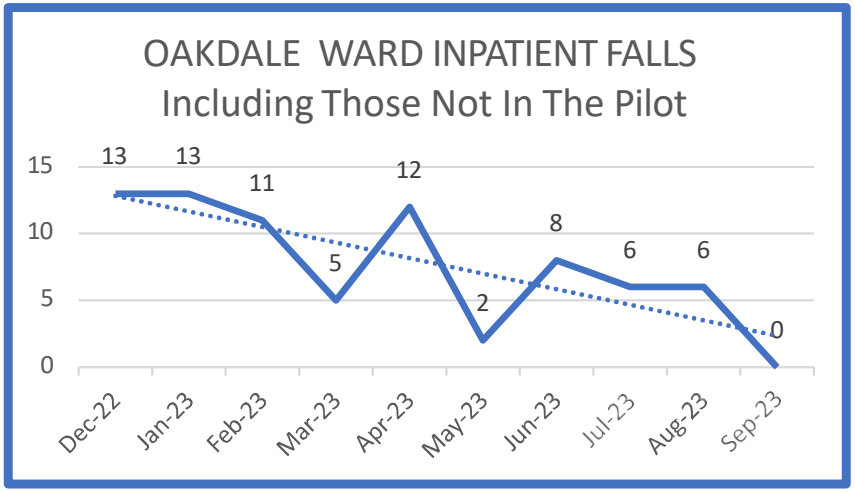


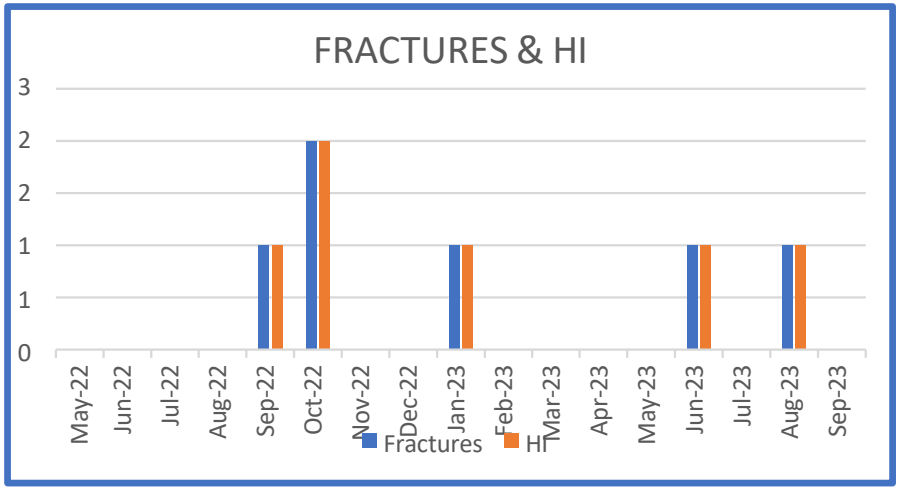
SWARM HUDDLES MEETING AGENDA

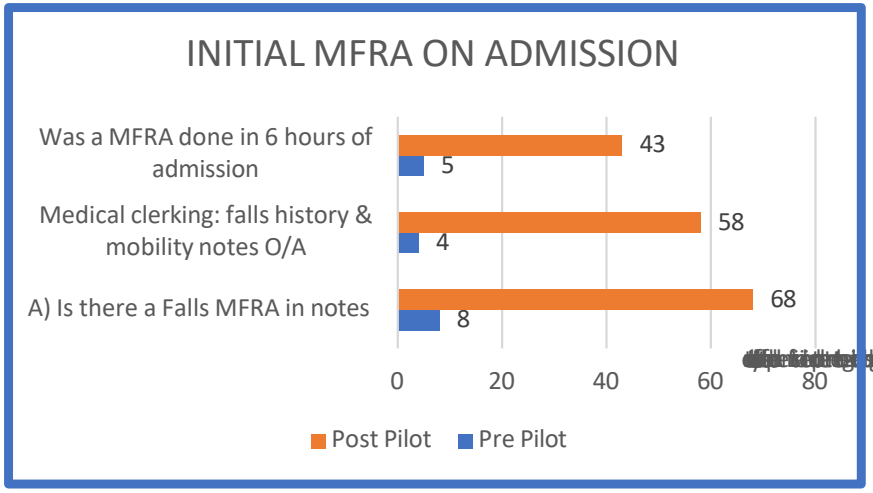
1.	Welcome and Introductions to MDT members.
2.	Identification of chair
3.	Delegation to key members of SWARMs paperwork to be completed (MFRA, 'at a glance' swarm huddle update form for notes)
4.	Case review- patient details including reason for admission, past medical history, causes for concern and reason meets criteria for Swarm huddle.
5.	Discuss and complete MFRA assessment and action plan.
6.	Identify key members to take responsibility for key actions.
7.	Discuss the need for enhanced care assessment.
8.	Final review of actions and key staff responsible ensuring aligns with the 'at a glance' update form.
9.	Discuss need to meet again to discuss case if any concerns raised.
10.	Key staff member identified to update the patient and next of kin of meeting outcome.
11.	Key staff member identified to provide patient/family information leaflet.
12	Completion of Staff Questionnaire
13	Complete recording form for audit
14	Ensure all audit paperwork is filed in the Swarm pilot folder for collection by QPS team.

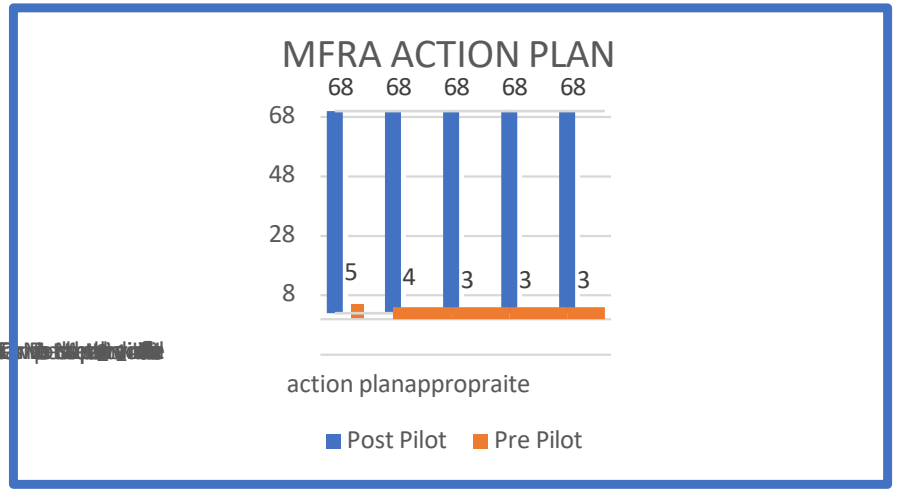
QUANTATATIVE Analysis:

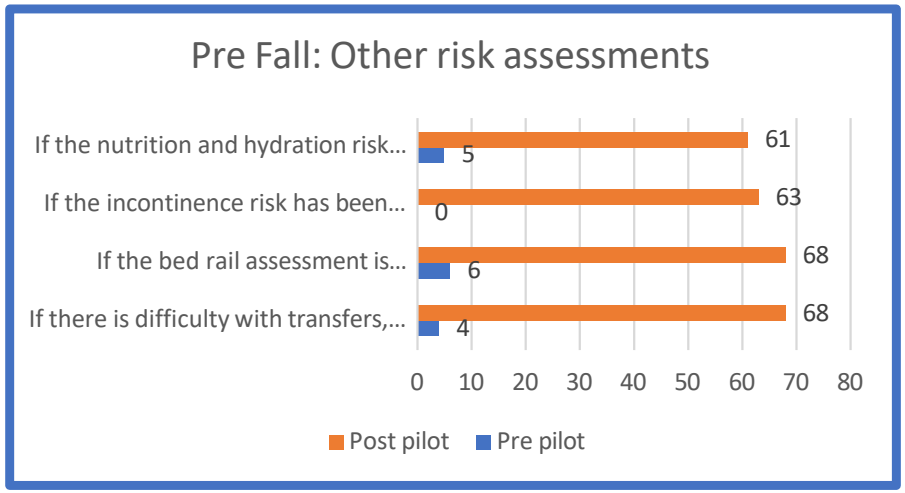
- Pilot period ended 5th June 2023 but ongoing swarms
- 'Time to complete' was the main identified barrier before starting the pilot.
- Pre Audit showed MFRA's not being completed timely or fully with actions.
- 68 patients received a pre-swarm huddle
- 3 falls during this period of pre swarmed patients and who received a post swarm.
- One patient boarded, all patients understanding of actions but non-compliant. All preventative actions/MFRA in place.
- Swarms meetings taking approx. 10 mins to complete and not the anticipated 30 mins.
- Excellent support from physiotherapy & nursing.
- OT and discharge liaison started to join of own accord.
- Generally good attendance by medical team.
- Pharmacy input decreased over period due to staffing. Raised to Divisional pharmacist who is keen to support.
- Swarms being held over weekends/BH's
- One nurse had been non-clinical and was available to support coordination of meetings.
- MFRA's in place and completed prior to meetings with occasional exception with agency staff on duty out of hours.
- At a glance forms in medical notes with key staff to lead was generally completed.
- Although the ward still experiences inpatient falls, to date, the ward has not had a serious incident investigation undertaken or duty of candours raised in relation to falls since Swarms commenced due to no omissions in care identified.

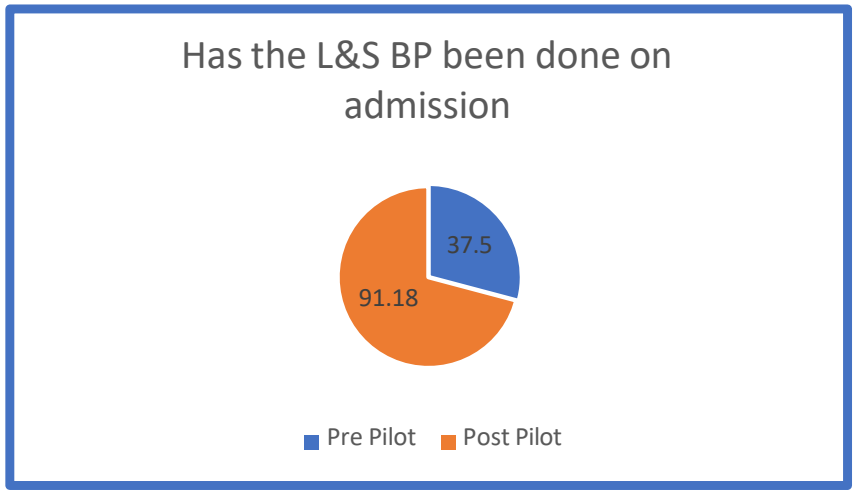

OAKDALE WARD INPATIENT FALLS
Including Those Not In The Pilot
15
10
5
0
13
13
11
5
12
2
8
6
6
0
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23

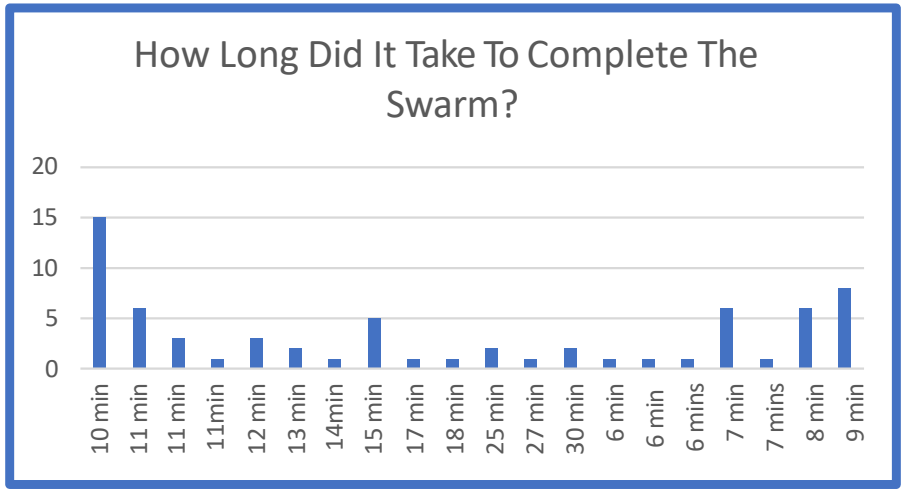

FRACTURES & HI
3
2
2
1
1
0
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Fractures
HI

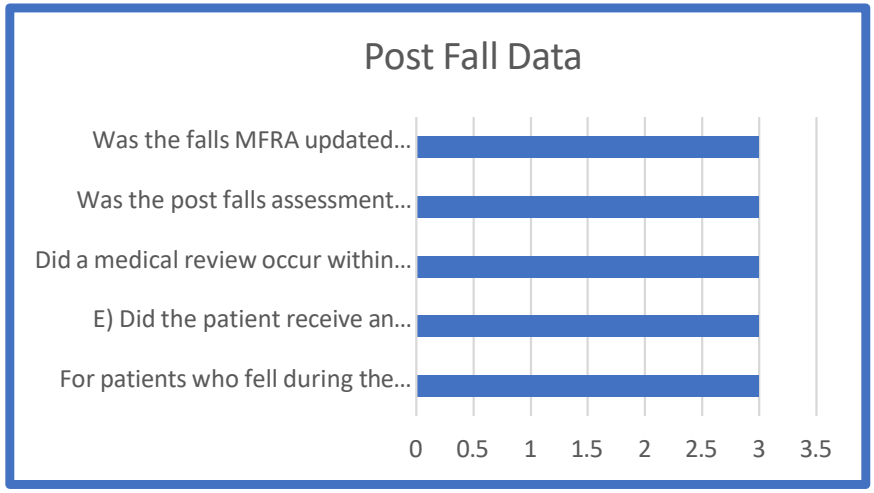

INITIAL MFRA ON ADMISSION
Was a MFRA done in 6 hours of admission
43
5
Medical clerking: falls history & mobility notes O/A
58
4
A) Is there a Falls MFRA in notes
68
8
0
20
40
60
80
Post Pilot
Pre Pilot


MFRA ACTION PLAN
68
68
68
68
68
68
48
28
8
5
4
3
3
3
action planappropraite
Post Pilot
Pre Pilot

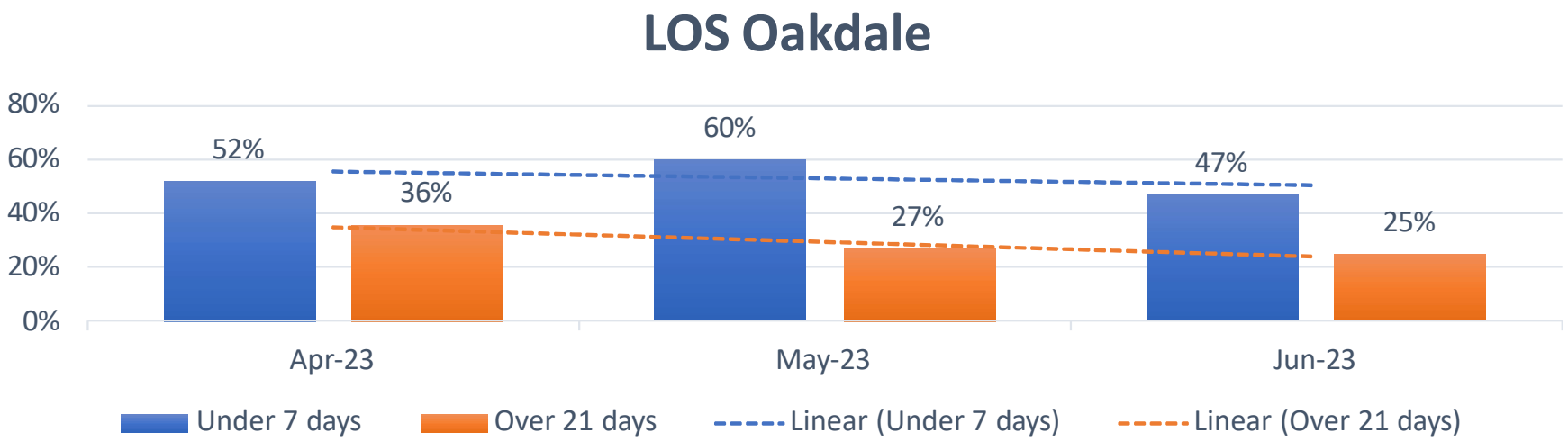

Pre Fall: Other risk assessments
If the nutrition and hydration risk...
If the incontinence risk has been...
If the bed rail assessment is...
If there is difficulty with transfers,...
61
5
63
0
68
6
68
4
0 10 20 30 40 50 60 70 80
Post pilot
Pre pilot


Has the L&S BP been done on admission
37.5
91.18
Pre Pilot
Post Pilot


How Long Did It Take To Complete The Swarm?
20
15
10
5
0
10 min
11 min
11 min
11min
12 min
13 min
14min
15 min
17 min
18 min
25 min
27 min
30 min
6 min
6 min
6 mins
7 min
7 mins
8 min
9 min


Post Fall Data
Was the falls MFRA updated...
Was the post falls assessment...
Did a medical review occur within...
E) Did the patient receive an...
For patients who fell during the...
0 0.5 1 1.5 2 2.5 3 3.5

LOS Oakdale Ward



QUALITATIVE Analysis:

'We feel decision making is now an MDT approach.'

'Awareness of risk assessments has improved, and we are working better as a team..'

- Staff feedback: Very positive and has led to other therapists on other wards enquiring when this process will start on their wards.
- Therapists have sought MFRA training as a result.
- All key members have stated they have seen an improvement in standards of all documentation/risk assessments and MFRA.
- Other therapists keen to be involved in this project.
- Evidence of excellent teamwork as an MDT.
- Each discipline taking a role as chair of the meetings, moving away from nurse led.
- Creativity in team developing a bee sticker to identify patients on PSAG board that have been swarmed.

PSAG BOARD: INDICATING PATIENTS SWARMED

CHALLENGES

- Out of hours admissions delayed swarms being undertaken within two hours (but known challenge prior to start)
- Occasional non-attendances from medical staff due to workload but rectified.
- Non-attendance of pharmacist due to staffing- actions in place
- At a glance forms not being signed off by medical staff when they were the key staff to lead and although action had been completed.
- Ward leadership changes impacted on Swarms approach daily.
- From a spread and scale perspective, not all medical wards have delegated MDT members and who cover multiple wards therefore possible impact on MDT attendance at swarms meetings on some sites.

To DATE:

Appendix A: Learning Repository

(The Learning Repository will have embedded links to the learning sources)

Themes		Source 1	Source 2	Source 3
1	**Falls**			
2	**Pressure Damage**			
3	**Medication Errors**			
4	**Communication**			

Appendix B: Sources of Learning and Approaches to Sharing and Improvement

	Area of potential learning/new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
1	*Aggregated analysis of patient safety data to determine patterns, themes, and trends*	*Corporate Quality & Safety Teams* *Local leads*	*Face to face safety briefings* *Education programmes (rolling induction)* *Digital platforms*	*Corporate & Directorate/Divisional Board meetings and patient safety reports and dashboards.*
2	*Analysis of individual incidents*			
3	*Analysis of individual complaints*			
4	*Analysis of individual claims / redress*			

Appendix B: Sources of Learning and Approaches to Sharing and Improvement

	Area of potential learning/new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
5	*Clinical audit*			
6	*Healthcare Inspectorate Wales inspections (internal & external)*			
7	*Independent reviews and public inquiries (internal & external)*			
8	*Patient, service user, family, and public engagement activities.*			
9	*Patient, service user, family, and public feedback e.g., patient stories*			

Appendix B: Sources of Learning and Approaches to Sharing and Improvement

	Area of potential learning/new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
10	*National networks (See Appendix C)*			
11	*Working collaboratively and learning with colleagues across the health system and wider (e.g. Joint Investigation Framework)*			
12	*Learning from Deaths (mortality reviews)*			
13	*Feedback from the Medical Examiner Service*			
14	*National alerts, thematic reviews e.g. NHS Wales Executive reports.*			

Appendix B: Sources of Learning and Approaches to Sharing and Improvement

	Area of potential learning/new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
15	*Board level engagement activities walkarounds, 15 Steps etc.*			
16	*Staff engagement activities, surveys, exit interviews, safety culture assessments, appraisals etc.*			
17	*Engagement / feedback from Trade Union Partners.*			
18	*Service reconfiguration, projects, and programmes.*			
19	*Educational organisations & surveys e.g., Health Education and Improvement Wales, Universities etc.*			

Appendix B: Sources of Learning and Approaches to Sharing and Improvement

	Area of potential learning/new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
20	*Professional bodies e.g., Health& Care Professional Council, General Medical Council, Nursing and Midwifery Council, Royal Colleges etc.*			
21	*Quality improvement projects / programmes.*			
22	*Planning processes including the development and implementation of the Integrated Medium Term Plan.*			
23	*Internal and external audit reports e.g., internal audit and Audit Wales.*			
24	*WRP National Learning Advisory Panel including publications e.g. Doctrina.*			

Appendix B: Sources of Learning and Approaches to Sharing and Improvement

	Area of potential learning/new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
25	*WRP Learning from Events Hub (in development).*			
26	*Safety II – learning from what went well.*			
27	*National clinical audits including Stroke (SSNAP), falls & fragility fracture audit programme, National Vascular Registry, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE).*			

Appendix C: Key Reports Containing Learning *(Corporate and Local)*

	Report	Key Content	Overseeing Local Group/ Committee/Board	Overseeing Corporate Group/Committee/Board
1	*Learning from Deaths Report* ***Example***	*Outcomes & learning from mortality reviews with patterns, themes, trends, collective intelligence, and RAMI.*	*Medical Directorate Clinical Board*	*Quality Committee* *Health Board / Trust Board*

Appendix D: We Listened and Learned!
(Internal e-document)

What is the main theme?	Where id the learning come from?	Is there a Datix number?	Who is the Lead contact? (email)	*What did you do with the Learning/Did you make any changes/improvements?*	*How will this learning help improve quality & safety*