Oral *Chair*

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Attached *Chair*

1.4 PQSOC Minutes 30th July 2024 PB reviewed.pdf (12 pages)

Attached *Chair*

Attached *Director of Corporate Governance*

2.1 Committee Risk Report.pdf (6 pages)
2.1 Appendix A Strategic Risk Register.pdf (1 pages)
2.1 Appendix B Strategic Risk Assessments..pdf (4 pages)

Attached *Director of Nursing*

2.2 Annual Quality Report 2023-24.pdf (5 pages)
2.2 Appendix 1 Quality Annual Report 2023-24.pdf (40 pages)
2.2 Appendix 2 PQSOC Quality Strategy - Implementation Plan Final July 2023.pdf (13 pages)
2.2 Appendix 3 - Reflections on STEEEP Aug 2024.pdf (23 pages)

Attached *Director of Nursing*

2.3 Putting Things Right Annual Report 23-24.pdf (11 pages)
2.3 Appendix 1 Putting Things Right Annual Report 2023-24.pdf (41 pages)

Attached *Director of Therapies & Health Science*

Attached *Medical Director*

- 2.5 Research and Development Annual Report.pdf (4 pages)
- 2.5 Appendix 1 Research and Development Annual Report.pdf (35 pages)

Attached *Medical Director*

- 2.6 Organ Donation Annual Report 2023-24.pdf (6 pages)
- 2.6 Appendix 1 Cover Letter NHSBT Reports Apr 2023 – March 2024.pdf (1 pages)
- 2.6 Appendix 2 Detailed Report NHSBT Reports Apr 2023 – March 2024.pdf (22 pages)
- 2.6 Appendix 3 Summary Report NHSBT Reports Apr 2023 – March 2024.pdf (3 pages)

Attached *Director of Nursing*

- 2.7 Dementia Care Annual Report 2023-24.pdf (7 pages)
- 2.7 Appendix 1 - Dementia Annual Report.pdf (31 pages)

Attached *Director of Nursing*

- 2.8 Quality Performance and Outcomes Interim Cover Report.pdf (6 pages)
- 2.8 Appendix 1 Quality Performance and Outcomes Interim Report Q1 PQSOC Sep 2024.pdf (126 pages)

Attached *Director of Nursing*

Attached *Director of Corporate Governance*

- 3.1 Committee Programme of Business 2024-25 Cover Report.pdf (4 pages)
- 3.1 Appendix 1 PQSOC Forward Work Plan 2024-25.pdf (10 pages)

Attached *Director of Corporate Governance*

- 3.2 NHS Wales Joint Commissioning Committee’s Quality Report.pdf (6 pages)
- 3.2 Appendix 1 - Services in Escalation Summary.pdf (8 pages)

Attached *Director of Nursing*

- 3.3 Minutes 09.07..24 - Patient Quality Safety Learning Improvement Forum. (1).pdf (5 pages)
- 3.3 Appendix 1 PQSLI Forum slide deck July.pdf (108 pages)
- 3.3 Appendix 2 Sources of Learning and Approaches to Sharing and Improvement - DRAFT.pdf (9 pages)

Oral *Chair*

Oral *Chair*

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

MINUTES OF THE PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE MEETING

DATE OF MEETING	Tuesday 30th July 2024, 9:30am
VENUE	Microsoft Teams

PRESENT	Pippa Britton, Independent Member, Committee Chair Helen Sweetland, Vice Chair Paul Deneen, Independent Member Penny Jones, Independent Member
IN ATTENDANCE	Jennifer Winslade, Director of Nursing Rani Dash, Director of Corporate Governance Peter Carr, Director of Therapies & Health Science James Calvert, Medical Director Nicola Prygodzicz, Chief Executive Gemma Couch, Head of Quality, Patient Safety & Learning Kelly Downes, Deputy Director of Nursing Natalie Skyrme, Head of Nursing Ann Marie Matthews, Lead for Clinical Commissioning/IPFR Jonathan Simms, Clinical Director of Pharmacy Sarah Beuschel, Transfusion Practitioner Howard Stanley, Head of Safeguarding Kolade Gamel, Service Group Manager Linda Joseph, LLais Cymru Rhian Gard, Deputy Head of Internal Audit Sara Utley, External Audit Tracey Partridge-Wilson, Deputy Director of Nursing Jayne Beasley, Head of Midwifery & Gynaecology Moira Bevan, Head of Infection Prevention and Control Tanya Strange, Head of Nursing Person Centred Care Ceri Phillips, Consultant Pharmacist Thomas Jaynes, Committee Secretariat Megan Frampton, Committee Secretariat
APOLOGIES	Michelle Jones, Head of Board Business Leeanne Lewis, Assistant Director of Quality & Patient Safety

PQSOC 3007/01	Welcome and Introductions The Chair welcomed everyone to the meeting.
PQSOC 3007/02	Apologies for Absence Apologies for absence were noted.
PQSOC 0406/03	Declarations of Interest

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	There were no declarations of interest raised to record.
PQSOC 3007/04	Minutes of the previous meeting The minutes of the Patient Quality, Safety and Outcomes Committee held on 4th June 2024 were agreed as a true and accurate record subject to the inclusion of the following under minute PQSOC 0406/2.3: Paul Deneen (PD), Independent Member, queried the data presented on the Incident Reporting Module of DATIX Cymru, and in particular the process and criteria for determining "closed" and "rejected" incidents. It was agreed that the guidance for reporting and handling of incidents would be shared with Committee Members by email for information. Action: Director of Nursing/Director of Therapies and Health Science
PQSOC 3007/05	Committee Action Log The Committee received the action log and was content with the progress made in relation to completed actions and against any outstanding actions, as set out within the Action Log.
PQSOC 3007/06	Committee Risk Report Rani Dash (RD), Director of Corporate Governance, provided an overview of the Committee Risk Report, noting that the Committee Risk Register included three high-level risks, three sub-risks, and one corporate risk; all unchanged from the July Board report. RD explained that the corporate risk 'catastrophic failure of the Pharmacy Robot' would be eliminated with the implementation of a new robot scheduled between August and October 2024. Helen Sweetland (HS), Independent Member, asked if the Executive Team had scheduled a session to discuss corporate risks in detail. RD confirmed that a time-out session was planned for September, with a summary of corporate risks to be presented to the Board at the end of September 2024. The Committee: NOTED the delegated strategic risks; NOTED the delegated corporate risk; NOTED the work being undertaken to reduce the risks to within appetite level; and,

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	NOTED the work being undertaken to ensure the Committee is sighted on all risks that have the potential to impact patient quality and safety.
PQSOC 3007/07	Quality Performance Report Jennifer Winslade (JW), Director of Nursing, supported by Peter Carr (PC), Director of Therapies & Health Science, Natalie Skyrme (NS), Head of Nursing – Urgent Care Division, Gareth Marr (GM), Improvement Programme Director for Mental Health and Learning Disabilities, and Tracey Partridge Wilson (TPW), Deputy Director of Nursing, presented the Committee with an overview of the patient quality and safety outcomes performance report for the period. JW outlined key priorities for the next six months, including revising the Quality Outcomes Framework, strengthening divisional quality and safety structures, refreshing the Quality Improvement Plan, and enhancing assurance and reporting arrangements. JW mentioned a planned meeting with the Director of Corporate Governance to restructure the Quality Performance Report for greater assurance.. NS provided an update on patient experience within the Emergency Department (ED) at the Grange University Hospital, noting: - Monthly meetings were being held with CIVICA to look at ways to improve patient feedback capture. The establishment of a people participation panel had been initiated to enhance patient care. Collaboration with Cardiff & Vale University Health Board had been initiated to ensure best practices for caring for dementia patients in ED and Red Cross continued to support patients and staff. The Committee raised a concern about potential abnormalities in recorded waiting times, and requested the data be re-examined. This was due to a statistic within the presentation to the Committee presenting a waiting time for one individual of 225 hours. Action: Jennifer Winslade (JW), Director of Nursing, to review the data presented and provide confirmation to the Committee on its accuracy. GM discussed ongoing improvements in the Mental Health and Learning Disabilities Division, which was under internal Special Measures, and reported progress towards achieving Welsh Government targets.

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TPW updated on the 27 recommendations from Healthcare Inspectorate Wales (HIW), emphasising the use of the AMaT system for tracking actions, with regular progress reports planned.

NS reported improvements in the ED's triage times now down to 17 minutes, and a monthly decrease in the number of patients with chest pains waiting longer than 60 minutes.

Pippa Britton (PB), Committee Chair, inquired about the impact of E-Triage since implementation. NS confirmed this was positive, although the collection of data was still inconsistent.

Penny Jones (PJ), Independent Member, requested information on sepsis protocols. NS provided an overview of current arrangements which included immediate medical assessments and fortnightly sepsis protocol meetings. JW committed to presenting the outcome of a comprehensive sepsis management review to a future meeting.
Action: Jennifer Winslade (JW), Director of Nursing to present information regarding the protocol for patients presenting with Sepsis to the Committee.

JW reported that changes to Patient Safety Incident reporting had led to an increase in reported incidents due to new Welsh Government policy requiring the reporting of stillbirth, birth loss, uterine death, and infection prevention and control issues. JW noted that the Health Board had received feedback from the Welsh Government emphasising the need to improve the timely closure of patient safety incident reports. JW reported that tracked progress over the last three years showed significant improvement, with 8% of reports closed within the target timeframe in 2022, 13% in 2023, and 38% in 2024. JW committed to bringing a detailed report on the timeliness of closures to a future meeting for assurance.
Action: Jennifer Winslade (JW), Director of Nursing, to present a report on the timely closure of Patient Safety Incidents to the Committee.

TPW informed the Committee that in May 2024, Putting Things Right (PTR) established an acknowledgment team dedicated to making immediate contact with patients who had filed complaints. This initiative received positive feedback from the public and reaffirmed the commitment to a patient-centred approach. Despite a 40% increase in complaints compared to the same period last year the Committee observed that early resolution outcomes

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	managed through PTR had improved to 60%. It was noted that the Surgery Division accounted for a significant proportion, primarily concerning appointment issues and waiting times. PC reported a decrease in the total number of falls and severity, with ongoing efforts to minimise harm. Part of the efforts would include collaboration with Divisions to identify any anomalies or areas needing targeted intervention. In addition, a comprehensive review of falls would be included in the annual report scheduled within the Committee's forward workplan. The Committee NOTED the contents of the report.
PQSOC 3007/08	Mortuary Incident Action Plan Peter Carr (PC), Director of Therapies and Health Science, provided an update on the Pathology Directorate's progress regarding the action plans related to the Patient Safety Incident investigations at the Grange University Hospital (GUH). PC reported that the investigations had been completed, chaired by Tracey Partridge-Wilson, and signed off by him as the Executive Lead. He noted that families, the Human Tissue Authority, Gwent Police, the Coroner, and the Welsh Government Quality team had been promptly informed of the incidents in compliance with legislation. The investigation led to the development of an action plan, with most actions already implemented and two remained outstanding. PC noted that the incident investigation and action plan had been communicated to the affected families, with whom he met personally, keeping an open line for further questions. A media response was also provided to maintain public confidence. The root causes were identified as failures in staff adherence to Health Board policies and procedures. While the policies were deemed appropriate, they have since been strengthened and simplified for clarity. PC mentioned that a recent unannounced visit by the Human Tissue Authority to the Mortuary at GUH yielded positive feedback on workplace culture and compliance. Paul Deneen (PD), Independent Member, commended the thorough and transparent investigation. Helen Sweetland (HS), Independent Member, asked whether the revised policies would apply across all Health Board's Mortuaries, to

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	which PC confirmed that they would. Nicola Prygodzicz (NP), Chief Executive, assured the Committee that she had met with the Coroner and Gwent Police, and all stakeholders were satisfied with the action plan. Pippa Britton (PB), Committee Chair, emphasised the importance of ongoing staff training on the revised policies. The Committee NOTED the report.
PQSOC 3007/09	Commissioning Assurance Framework *Ann Marie Matthews (AMM), Lead for Clinical Commissioning / IPFR joined the meeting.* Jennifer Winslade (JW), Director of Nursing, informed the Committee that efforts were underway to create a standardised process for collecting quality information from commissioned services. This approach aimed to ensure consistent and rigorous data collection across the Health Board. Pippa Britton (PB), Committee Chair, supported the move toward a standardised framework, noting that it would provide greater assurance. She inquired about lessons learned from WHSSC's escalation process and the inclusion of an independent member on the working group. Helen Sweetland (HS), Independent Member, asked for examples of commissioned services and the scope of the proposed framework. JW clarified that the Health Board commissioned a wide range of services, with the new approach initially focusing on a smaller scope before expanding to cover all services. She acknowledged the suggestion for an independent member and noted that the working group had not yet been established but would consider the appropriateness of this inclusion at a future point. The Committee NOTED the development and format of the Quality Commissioning Assurance Framework and the associated progress.
PQSOC 3007/10	Maternity Services: Organisational Improvement and Action Plan *Jayne Beasley (JB), Head of Midwifery and Gynaecology, joined the meeting.* JB provided an update on the Maternity Improvement Plan, aimed at improving outcomes for women and babies,

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	supporting staff, and fostering innovation. The plan focused on health promotion, choice, early intervention, and addressing strategic priorities. JB outlined the plan's main themes: governance framework, training, labour and birth, workforce, bereavement care, infection prevention, and pathways of care, each with specific workstreams and measurable actions. JB reported that the plan included 95 actions to be completed over three years, summarising progress in Quarters 1 and 2 and detailing ongoing and upcoming actions for Quarter 3. Pippa Britton (PB), Committee Chair, inquired about measures for supporting Black and Minority Ethnic (BAME) mothers and babies. JB reassured the Committee that a voluntary service is in place to assist non-English speaking women in Gwent and guide them to appropriate services. There are plans to expand this service to reach more diverse communities. JB also noted efforts to pilot debrief sessions in Newport to better engage BAME women, as most current participants are white Welsh/British. Helen Sweetland (HS), Independent Member, questioned the 2026 timeline for appointing a Lead Midwife for Diabetes and requested a glossary of acronyms for broader accessibility. JB clarified that a lead midwife is already in place, though the service is still under development. She also confirmed that future reports would include a glossary of acronyms. Nicola Prygodzicz (NP), Chief Executive, commended the development and implementation of the benefits of the new digital system. The Committee NOTED the ongoing work to implement and embed improvements within maternity services.
PQSOC 3007/11	Review of Committee Programme of Business 2024/25 Rani Dash (RD), Director of Corporate Governance, informed the Committee of amendments and updates to its Forward Work Programme. The Committee NOTED the updated Forward Work Programme as presented.
PQSOC 3007/12	Pharmacy & Medicines Management Annual Report 2022/23 *Jonathan Simms (JS), Clinical Director of Pharmacy, joined the meeting.*

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	James Calvert (JC), Medical Director, highlighted that the annual report provided an overview of the critical role of pharmacy within the Health Board and emphasised the importance of proper prescribing practices. JS reported on performance against key indicators and detailed clear actions taken to address these indicators. He noted significant improvements in the prescribing of Gabapentinoids. Penny Jones (PJ), Independent Member, raised concerns about 30-50% of long-term medications not being taken by patients. JC reassured the Committee that both the Medical and Pharmacy Directorates were aware of this issue. He explained that ongoing efforts were in place to increase patient compliance through enhanced training and integration into clinical practice. The Committee NOTED the contents of the Pharmacy and Medicines Management Annual Report.
PQSOC 3007/13	Hospital Transfusion Committee Annual Report *Sarah Beuschel (SB), Transfusion Practitioner, joined the meeting.* SB presented to the Committee an overview of the successes and challenges within the Hospital Transfusion programme. The update highlighted several achievements, including the successful integration of a Primary Care representative into the HPC (Health Professional Council) and the introduction of a new clinical Standard Operating Procedure (SOP) for the Haematological Management of Major Haemorrhage. Additionally, the programme had begun identifying staff who required essential transfusion practice training and continued to provide training on Blood Track Enquiry. The appointment of a Transfusion Support Officer also marked a significant advancement. SB also noted some challenges; the all-Wales project to implement bedside blood collection had seen limited progress, and the development of the blood component transfusion policy remained outdated due to a small workforce. The Committee was informed of the Quality Improvement (QI) projects in Transfusion, mentioning that the Patient Care Coordinator (PCC) was based in emergency care and that major haemorrhages were transferred to the Lab for further management.

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	The Committee NOTED the contents of the Hospital Transfusion Committee: Annual Assurance Report 2023-24. *Sarah Beuschel left the meeting*
PQSOC 3007/14	Infection Prevention and Control and Cleaning Standards Annual Report 2023/24 *Moira Bevan (MB), Head of Infection, Prevention & Control, Ceri Phillips (CP), Consultant Pharmacist, joined the meeting.* MB presented the Infection Prevention, Decontamination, and Antimicrobial Stewardship Annual Report for 2023/2024, noting key achievements and concerns. The report highlighted improvements in cleaning standards and the successful use of Regional Integration Funds to enhance care across Primary and Secondary Care. Despite being below the national average for reportable organisms, the Health Board experienced increases in certain infections due to factors like antimicrobial resistance and suboptimal prescribing. MB reported a low respiratory infection rate, below the All-Wales average, and noted that the C-section rate had returned to pre-pandemic levels at 3.9%. Ongoing efforts include audits, quality improvement projects, and enhanced cleaning standards. Ceri Phillips (CP), Consultant Pharmacist, discussed the Welsh Government targets for antimicrobial usage. The target to reduce antimicrobial prescribing by 25% in Primary Care was not met, achieving only a 14.8% reduction, partly due to challenges from Strep A outbreaks. However, Secondary Care met the target of using 55% or more of all antibiotics and is currently at 62-63%, with a new target of 72% forthcoming. Pippa Britton (PB), Committee Chair, expressed concerns about the rise in cases of C. difficile. James Calvert (JC), Medical Director, explained that efforts to tackle C. difficile included enhanced antimicrobial prescribing practices and managing high bed occupancy. MB emphasized that tackling C. difficile remained a top priority, with an updated action plan and enhanced governance. CP noted issues with suboptimal prescribing in Secondary Care and efforts to address this cultural challenge.

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	Paul Deneen (PD), Independent Member, requested an updated report and details on the action plan for proper prescribing at the next meeting. Action: Director of Nursing to provide an update to the Committee on optimal prescribing in support of infection prevention and control measures Helen Sweetland (HS), Independent Member, stressed the need for new medical staff to be inducted on proper antibiotic prescribing. This was acknowledged and the Committee was reassured that new staff received a comprehensive induction on Infection Prevention and Control, Pharmacy, and Microbiology. Penny Jones (PJ), Independent Member, inquired about the training for all staff on infection control and antibiotic prescribing. MB confirmed that national training for infection and prevention was available, supplemented by eLearning modules and enhanced training for incidents. The Committee NOTED the key achievements from 2023/2024 and support the priorities for 2024/2025. *Moira Bevan and Ceri Phillips left the meeting.*
PQSOC 3007/15	Safeguarding Annual Report *Howard Stanley (HSt), Head of Safeguarding, joined the meeting.* HSt provided an overview of the Health Board's management of its safeguarding responsibilities for 2023/2024, detailing progress, performance, emerging trends, lessons learned, and the vision for 2024/2025. HSt highlighted a significant increase in activity with an 85% rise in child cases and a 40% rise in adult, which is putting resources under pressure and delaying assurance and improvement work. Despite this, training success improved notably with levels 1 and 2 exceeding 80% compliance, although level 3 training remained low at 15%, falling short of the 50% target. HSt emphasised efforts to make training mandatory and ensure staff are released from duty to undertake it. Pippa Britton (PB), Committee Chair, recognised the challenges and need for improved staff attendance. Penny Jones (PJ), Independent Member, noted the 92% rise in child

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	cases and a 90% increase in reports and questioned the cause. HSt attributed this to societal issues and improved safeguarding mechanisms, with complex cases requiring multiple reports. It was noted that the demand upon and the capacity of the Safeguarding team was being reviewed. Paul Deneen (PD), Independent Member, raised concerns about GPs in Monmouthshire not being updated on child protection issues, stressing the importance of GP involvement. He requested an update on this issue for the next meeting. Action: Director of Nursing to provide assurance on the effective sharing of safeguarding issues with GPs The Committee CONSIDERED the Safeguarding Annual Report 2023/2024 NOTED the eight key priorities of the Safeguarding Annual Work Programme NOTED the challenges associated with an increase in referral activity.
PQSOC 3007/16	Overview of Internal & External Audit Recommendation Tracking Rani Dash (RD), Director of Corporate Governance, presented the report for information. The Committee NOTED the closing position of the 29 audit recommendations; and NOTED the approach being implemented by the Audit Risk and Assurance Committee to ensure a higher level of scrutiny for longstanding recommendations and high-rated recommendations that exceed the threshold for revised deadlines.
PQSOC 3007/17	Children's Rights & Participation Forum Jennifer Winslade (JW), Director of Nursing, noted the forum was supported by Paul Deneen, Independent Member and JW was the Executive Lead. JW noted the forum will report into the Children and Young People's Strategic Board that will be established in September. The Committee NOTED the contents of the report.
PQSOC 3007/18	Review of Neurodevelopmental Service for Under 18s *Kolade Gamel (KG), Service Group Manger, joined the meeting*

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	Jennifer Winslade (JW), Director of Nursing, explained that the report was produced following an all-Wales review in collaboration with the Chief Operating Officer. The Committee NOTED the report for information.
PQSOC 0406/21	Date of the Next Meeting: Monday 02 September, 2024

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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:	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

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

Ar Gyfer Trafodaeth/For Discussion

The purpose of this report is to provide a summary of the current strategic risks that have been delegated to the Patient Quality, Safety, and Outcomes Committee (the Committee) for monitoring, on behalf of the Board.

The report also informs the Committee of any significant operational risks identified by the Executive Committee through the Corporate Risk Register that have the potential to impact patient quality and safety.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation & Cefndir / Background

At the Committee meeting in July, it concluded that the Committee Risk Register contained three high-level risks with three sub-risks, and one corporate risk, for which the Board has delegated responsibility for receiving and scrutinising assurances.

Since July, the risk environment has remained relatively stable, with no changes in the risk score or exposure to the three strategic risks that this Committee monitors. However, changes with the corporate risk overseen by this Committee has resulted in a request to endorse the removal of CRR 004 from the Corporate



Risk Register prior to a formal request to the Executive Committee to remove the risk from the register.

Asesiad / Assessment

Strategic Risk Register (SRR)

Table 1 shows the current status of the three strategic sub-risks delegated to the Committee as at the end of August 2024. The three sub-risks have been reviewed and updated to ensure that the Committee has the most recent information on the internal control system and sources of assurance for each sub-risk.

The Committee Risk Register is included in Appendix A and the individual risk assessments for the three sub-risks are included in Appendix B.

Table 1

Risk Ref:	Risk Description	Sub-Risk	Risk Level	Within Appetite
SRR 005 Chief Operating Officer Theme Service Delivery Appetite Open Score 16 and below	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	Due to inadequate arrangements to support system-wide patient flow.	High 3 x 4 (12)	Y
SRR 008 Director of Nursing Theme Transformation & Partnership Working Appetite Open Score 16 and below	There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.	Moderate 2 x 4 (8)	Y
SRR 010 Director of Therapies & Health Science Theme Compliance & Safety Appetite	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974.	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed, and monitor the Health Board's compliance with the Act's	High 3 x 4 (12)	N

Minimal Score 8 and below		requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.		

It should be noted that, while the risks have been updated to include improved control and assurances, the risk score and level for all three sub-risks have not changed. SRR 005 and SRR 008 remain within the Health Board's risk appetite for the risk domain, therefore the Committee can be assured that these risks are effectively mitigated.

Work will continue with risk owners to manage the risk and ensure that the controls and assurances in place prevent the potential risk from occurring.

SRR 010's risk score and exposure remain outside of the Health Board's agreed-upon risk appetite for the Compliance and Safety risk domain, as shown in Table 1. However, as the Improvement Plan has not been fully implemented, there is potential for the additional planned action to bring the level of risk down to within appetite.

Monitoring of SRR 010 will remain a key focus of the Committee, and the findings of the scheduled Internal Audit of Health and Safety, planned for quarter 4 of the 2024/25 Plan, will provide the Board and Committee with the evidence needed to determine whether the Improvement Plan has delivered the necessary improvements.

Corporate Risk Register (CRR)

The Committee has been delegated responsibility for oversight of any corporate risk (significant operational risks) relevant to the agenda of the PQSOC.

Table 2 shows the one high-level operational risk that has been delegated to the PQSOC for oversight.

Table 2

Risk Ref:	Risk Description	Sub-Risk	Risk Level	Within Appetite
CRR 004 Theme Service Delivery Appetite Open Score 16 and below	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	Due to the current Pharmacy layout/robot at RGH being over 18 years old and not fit for purpose.	Extreme (20)	N



Since the last report to the Committee in July, which stated that work to improve the Royal Gwent Hospital's Pharmacy Dispensary Unit (PDU) would begin in August, the robot has been decommissioned, and renovations to the PDU and installation of the new Robotic Dispensing System have begun. The service has initiated business continuity plans, which will be maintained until the unit's improvements are completed and operational.

The Committee is therefore asked to endorse the removal of the risk from the corporate risk register, acknowledging that decommissioning of the robot means the risk has been eliminated.

All risks are being managed through the project management process; however, the Committee should be aware that there could be delays due to structural engineering remedial work needed to strengthen the floor so that the robot can be safely installed. The Executive Committee will be kept informed of progress and any challenges that may arise during the project's timeline.

Next Steps

Due to recent challenges, the Executive Team did not consider the draft corporate risk portfolio at its Exec Time Out Session scheduled for July. However, the Corporate Risk Register will be included as an item on the Executive Team weekly business meeting in the coming weeks, with a comprehensive report to the Board in November including the status of strategic and corporate risks. Following that, all risks relevant to the PQSOC's remit will be presented in subsequent reports to the Committee.

The closing position as at the end of August 2024, if accepted by the Committee, is that the Committee Risk Register includes three high-level risks and three sub risks.

Argymhelliad / Recommendation

The Committee is requested to:

- NOTE the delegated strategic risks;
- ENDORSE the termination of CRR 004 for formal approval by the Executive Committee;
- NOTE the work being undertaken to ensure the Committee is sighted on all risks that have the potential to impact patient quality and safety.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The Strategic Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. 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:	The Board and respective Committees of the Board have considered risks contained within the Strategic Risk Register

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/	Choose an item. Choose an item. N/A



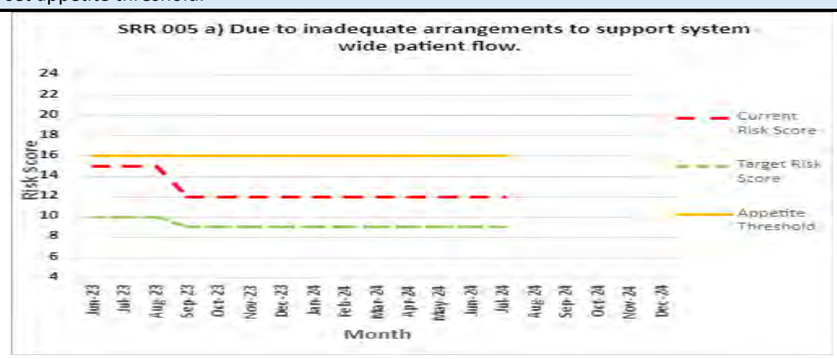
Risk ID	Monitoring Committee	Risk Theme	Risk Owner	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite		Actions to Reduce Risk to Target	Assurance that the Risk is being manged effectively	Target Risk Score				Review of Risk	
							Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Current Risk Score	Risk Level	Current Status Against Appetite	Risk Appetite and Threshold Explained			Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Target Risk Score	Risk Level	Last Reviewed	Next Review
SRR 005	Patient, Quality, Safety and Outcomes Committee	Service Delivery	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a)Due to inadequate arrangements to support system-wide patient flow	•Avoidable deaths or significant harm •Delays in releasing ambulances from hospital sites back into the community •Delayed discharges from acute and non-acute settings resulting in deteriorating patients •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: Focus Processing power Capacity Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. Regional flow processes not always supported with neighbouring HBs (Health Board)	Medium	3	3	9	Moderate	01/07/2024	01/10/2024
SRR 008	Patient, Quality, Safety and Outcomes Committee	Transformation and Partnership Working	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff, the public and partners	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	•Adverse impact on patient experience •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence •Failure to deliver Duty of Quality	2	4	8	Moderate	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX	Medium	2	2	4	Low	01/07/2024	01/10/2024
SRR 010	Patient, Quality, Safety and Outcomes Committee	Compliance and Safety	Executive Director of Therapies and Health Science	The Health Board will fail to protect the Health and Safety of staff, patients and visitors in line with its duties under the Health and Safety at Work Act 1974	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	• Unintended physical harm; • Punitive actions from the Health and Safety Executive (HSE); • Increased levels of staff sickness; • Loss of estate due to unsafe environments; • Financial implications; • Adverse publicity; and, • Reputational damage	3	4	12	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established.	Negative	2	3	6	Moderate	01/08/2024	01/09/2024

RISK THEME	SERVICE DELIVERY					
Strategic Risk: SRR 005	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.**				**Publication Status**	**Public**
Strategic Threat	Due to inadequate arrangements to support system-wide patient flow					
Impact	➢ Avoidable deaths or significant harm ➢ Delays in releasing ambulances from hospital sites back into the community ➢ Delayed discharges from acute and non-acute settings resulting in deteriorating patients; ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence					
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	**3** *(Possible)* **X**	**3** *(Possible)* X		
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Catastrophic)*	**3** *(Minor)*		
Last Reviewed	01 July 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*		
Next Review Due (Quarterly based on current risk score)	01 October 2024					

Risk Appetite Level - Open
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Open SCORE 17 AND BELOW
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
Escalation Policy. Performance and Accountability Framework Major incident Procedures Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. Enhanced monitoring in place for U&EC Range of performance measures/metrics in place Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. Planned care recovery meetings with the NHS execs. Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. WG – IQPD meetings to review areas of focus.	Operational framework – Being revamped through operational framework ahead of next winter. Improve regional acceptance of flow processes with neighbouring Health Boards. Repatriation meetings established and new Wales-wide protocols due to come in regarding repatriation.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. Performance report against measures/metrics **Level 2 Organisational** *(Executed by risk management and compliance functions.)* Divisional Assurance reviews. Performance against measures/metrics reported to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews** 1. Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. External inspections/visits.	**Gaps in Assurance** Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. The impact of the Performance and Accountability framework in improving patient flow **Action to Address Gaps in Assurance** Close monitoring and reporting of the frameworks in practice to support learning and improvements.	**Reasonable Assurance**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING					
Strategic Risk: SRR 008	**There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.**				**Publication Status**	**Public**
Strategic Threat	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.					
Impact	➢ Adverse impact on patient experience ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence ➢ Failure to deliver Duty of Quality					
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**		
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	**2** (Unlikely) x	**2** *(Unlikely)* x		
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**2** *(Minor)*		
Last Reviewed	01 July 2024	**Risk rating**	**= 8** *(Moderate)*	**= 4** *(Low)*		
Next Review Due (Bi-annually based on current risk score)	01 October 2024					

Risk Appetite Level – Open
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure

Risk Appetite Threshold – Open SCORE 17 AND BELOW
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **OUTSIDE** of target but **WITHIN** the appetite threshold. Target level is **WITHIN** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
Corporate Engagement Team Patient Experience and Involvement Strategy- organisational ownership Person Centred Care (PCC) Surveys via CIVICA PCC KPI's (support PCC Quality pillar) 'You said..... we did' public facing information for service areas. PLO service at GUH Introduction of PALS Service (Oct 23) Volunteer Patient Experience Feedback Collaboration to recruit community listeners to support Dementia Awareness Digital patient stories to support listening and learning. Patient Experience and Involvement Strategy DATIX Oversight of Medical Examiner reports to determine patient experience actions Public Engagement- Big Conversation Bereavement held 20th March 2024 People Participation Panel ED in Progress	Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. PCCT staff training to support Civica data entry and retrieval. Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to QPSOG Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. - Discussions with VBHC to pilot SMS in ED through DrDoctor National directives around new national surveys that need to be managed additional to internal roll out programme. Volunteer feedback to be reviewed to identify themes.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. Concerns are fed back to divisional teams when identified. Outcome of the volunteer feedback to drive improvements. Patient Experience and Involvement Team undertaking Culturally Competent Accreditation Immediate feedback and escalation to clinical teams following PALS queries and concerns **Level 2 Organisational** *(Executed by risk management and compliance functions)* Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) Listening and Learning reported through QPSOG/ Outcomes Committee Implemented PALS DATIX Module **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* LLais Reports HIW inspections Advocacy reports	**Gaps in Assurance** No SMS provision to increase the number of PCC surveys. No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped. Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards. **Action to Address Gaps in Assurance** Discussions with VBHC team to consider SMS through DrDoctor with pilot at ED PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Ned to have discussions with facilities around rooms. Patient experience KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation.	**Reasonable Assurance**

RISK THEME	COMPLIANCE & SAFETY					
Risk No: SRR 010	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974**				**Publication Status**	**Public**
Strategic Threat	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.				**Risk Appetite Level - MINIMAL.** Any risk that has a MINIMAL risk appetite level should be managed to a **Score of 8 or below**.	
Impact	➢ Unintended physical harm; ➢ Punitive actions from the Health and Safety Executive (HSE); ➢ Increased levels of staff sickness; ➢ Loss of estate due to unsafe environments; ➢ Financial implications; ➢ Adverse publicity; and, ➢ Reputational damage				**Risk Appetite Threshold -** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls**.**	
Lead Director	Director of Therapies & Health Science	**Risk Exposure**	**Current Level**	**Target Level**	**SUMMARY** The current risk level is **OUTSIDE** of target level and **OUTSIDE** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	3 (*Possible*) **X**	**2** (*Unlikely*) **X**		
Initial Date of Assessment	01 December 2023	**Impact**	***4*** *(Major)*	**3** *(Moderate)*		
Date Reviewed	01 Aug 2024	**Overall Risk Rating**	**= 12** *(High)*	**= 6** *(Moderate)*		
Date of Next Review (Monthly based on current risk score)	01 Sept 2024					



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. Health and Safety Policies and Procedures Dedicated Health and Safety site on ABPULSE Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) Partial Programme of Health and Safety Monitoring (Active & Reactive) Corporate and Directorate Health and Safety Risk Register established.	Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) Consultation and communication with the workforce regarding compliance with the Act New ways of working with Divisions to ensure accountability for health and safety is recognised. Implement key performance indicators to monitor health and safety compliance. Review the governance arrangements for the Health & Safety Committee Health and Safety Policies and Procedures to be reviewed. Onboard further Manual Handling trainers across the organisation to improve compliance. Scope for training non-Health Board staff	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* Health and Safety compliance data extracted from ESR and Datix and reported **Level 2 Organisational** *(Executed by risk management and compliance functions)* Established monitoring of H&S at the Executive Committee Corporate H&S report risk and assurance to the Health and Safety Committee Established monitoring of H&S at the PQSO Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)*	**Gaps in Assurance** Implementation of a health and safety performance report Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act. Compliance on completion of risk assessments and mitigating actions **Action to Address Gaps in Assurance** Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. Review the membership and ToRs of the Health and Safety Committee	**Negative Assurance**

Board Training /development (Completed 24 April 2024) Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. Health and Safety Governance and reporting arrangements (Health and Safety Committee)	Learning from events to be documented and communicated to the organisation.	Performance reviews at All Wales Health and Safety Management Steering Group Internal Audit – H&S processes Review to be included in 2024/25 Plan. South Wales Fire & Rescue Service fire safety audit programme. Health and Safety Executive reviews/inspections.	Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan	

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 Quality Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr James Calvert, Executive Medical Director Jennifer Winslade, Executive Director of Nursing Peter Carr, Executive Director of Therapies & Health Science
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 Board presents the first Annual Quality Report for 2023/24, aligned to the reporting requirements in the Health and Social Care (Quality and Engagement) (Wales) Act (2020), which emphasised quality, transparency, and engagement through the Duty of Quality, Duty of Candour, and Citizen's Voice; Llais.

This report provides a narrative on our quality journey throughout the year and reviews past objectives and sets new priorities for improving patient and staff safety, outcomes, and experiences.

We implemented two strategies aimed at improving services, clinical effectiveness, safety, and experiences, involving patients, families, carers, staff, and the community. Our Quality Strategy prioritises patient safety and staff wellbeing, guiding our plans and decisions. We developed a number of workstreams that impact on patient safety and have driven improvement considering a whole system

approach. There was a commitment and focus on developing our quality management system.

Heading into 2024/25, we carry forward our achievements and focus on continuous quality improvement and would wish to express our thanks to our teams, staff, volunteers, patients, partners, and stakeholders for your invaluable contributions.

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 report is an interim quality report and the full Quarter 1 Quality Outcomes Framework will be reported at the next Board meeting.

Cefndir / Background

In April 2023, the Health Board implemented two strategies aimed at improving services, clinical effectiveness, safety, and experiences, involving patients, families, carers, staff, and the community. Our Quality Strategy prioritises patient safety and staff wellbeing, guiding our plans and decisions. We developed a number of workstreams that impact on patient safety and have driven improvement considering a whole system approach. There was a commitment and focus on developing our quality management system.

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.

Asesiad / Assessment

The Annual Quality Report provides information on our preparation programme to deliver the Duty of Quality and review our reporting and assurance framework. Key workstreams were identified as a priority for the first 12 months and key actions and initiatives can be found in the report to demonstrate the impact on patient safety.

The Health Board adopted a reporting structure which mapped progress 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.

As part of our statutory reporting under the Duty of Quality the report aimed to focus on a report that can be read by members of the public. Our first report reviews past achievements, identifies challenges, and outlines future priorities and monitoring methods. It showcases our efforts to embed quality across the Health Board, using continuous 'Always on' reporting throughout 2023/24.

As part of the Quality Strategy an Implementation Plan was produced for the Health Board to enhance the quality of healthcare throughout 2023. In order to deliver the Health and Care Quality Standards, the plan was mapped with quarterly objectives aligned to the six key quality domains. Highlights of the achievements for 2023/24 can be seen in the Appendix. This plan was built on existing achievements, emphasising continuous improvement and embedding quality, safety, and learning in daily operations.

The report details the work on embedded learning and improvement which has developed over the year. Heading into 2024/25, we carry forward our achievements and focus on continuous quality improvement. The Health Board is refining the workplan for year two and the quality enablers to support the delivery. As ongoing 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.

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 Board is requested to note the progress of work over the past 12 months as reflected in the annual quality 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

LEADERSHIP

WORKFORCE

CULTURE

INFORMATION

LEARNING, IMPROVEMENT & RESEARCH

WHOLE SYSTEMS APPROACH

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Quality Annual Report 2023/24

PERSON CENTRED

SAFE

TIMELY

EFFECTIVE

EFFICIENT

EQUITABLE

Executive Summary

Welcome to the Aneurin Bevan University Health Board's Quality report for 2023/24.

The Health Board presents the 2023/24 Annual Quality Report, reviewing past objectives and setting priorities for improving patient and staff safety, outcomes, and experiences. This report provides a narrative on our quality journey throughout the year.

This year was busy with many challenges, met by the hard work and commitment of our staff, leading to progress in our improvement priorities.

In 2023/24, Aneurin Bevan University Health Board focused on quality and safety, aiming to deliver high-quality healthcare. This focus was bolstered by the Health and Social Care (Quality and Engagement) (Wales) Act (2020), which emphasised quality, transparency, and engagement through the Duty of Quality, Duty of Candour, and the creation of the Citizen's Voice through Llais.

We have implemented two strategies aimed at improving the quality of our clinical services, the clinical effectiveness of care, improving safety and reducing avoidable harm and improving the experience patients, their families and their carers. These strategies have also increased the involvement of patients, families, carers, staff, and the community in planning delivering and assessing the quality of care.

Heading into 2024/25, we carry forward our achievements and focus on continuous quality improvement. Thank you to our team, staff, volunteers, patients, partners, and stakeholders for your invaluable contributions.



Jennifer Winslade
Executive Director of Nursing



Dr James Calvert
Executive Medical Director



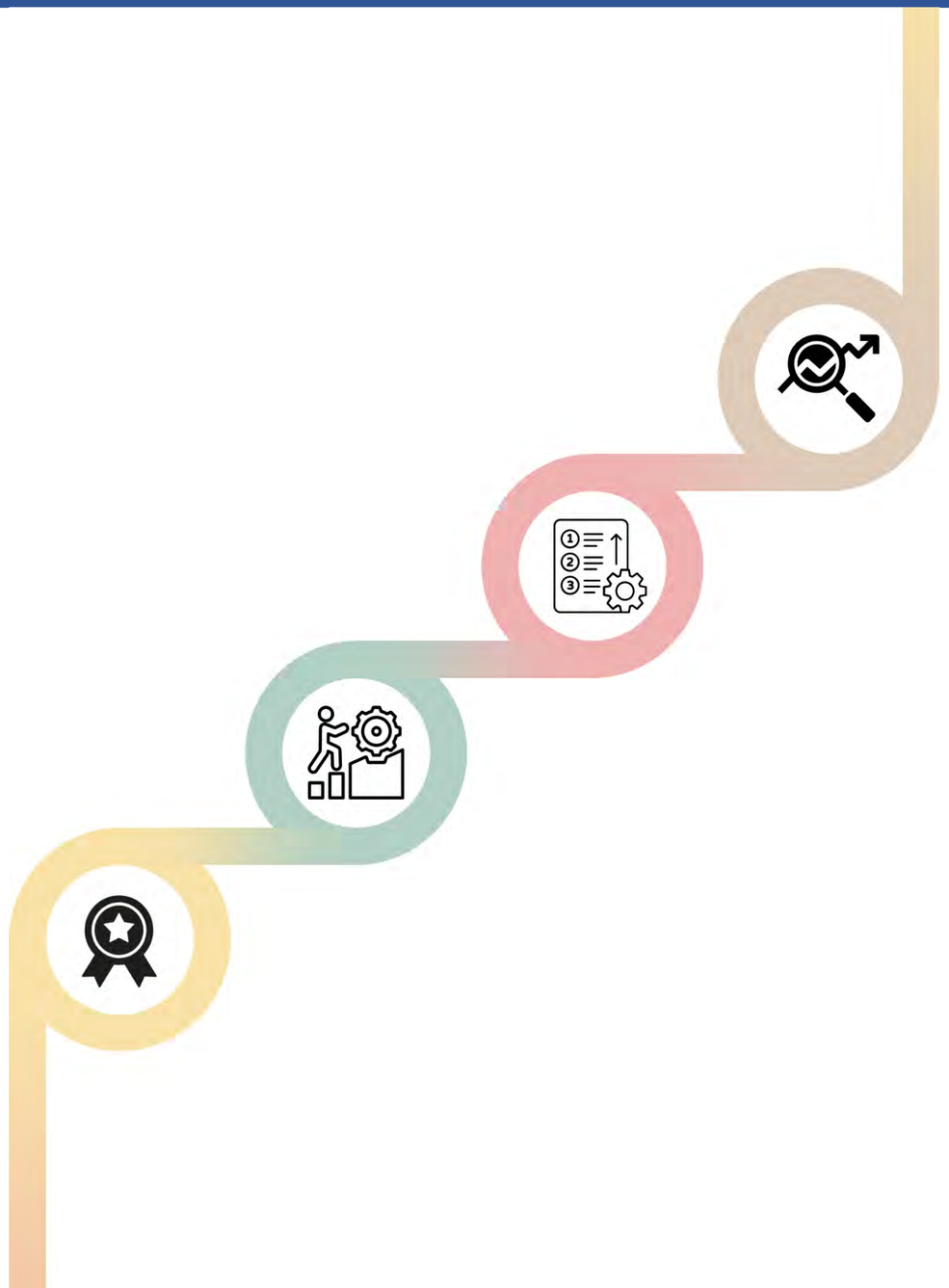
Peter Carr
Executive Director of Therapies
and Health Science

Introduction

NHS bodies must publish an annual quality report detailing steps taken to comply with the duty of quality. Our first report reviews past achievements, identifies challenges, and outlines future priorities and monitoring methods.

Quality standards are guided by the Health and Social Care (Quality and Engagement) (Wales) Act 2020, A Healthier Wales and Core Commissioning Requirements.

This report showcases our efforts to embed quality across the Health Board, using continuous 'Always on' reporting throughout 2023/24. This is reflected in our reporting to the Patient Quality, Safety and Outcomes Committee (PQSOC) and the forward work plan.



Preparation Programme

The Health Board initiated a comprehensive program to prepare for the Health and Engagement Act, including a readiness assessment to identify key leadership roles for quality and candour duties.

Workshops and sessions were conducted with stakeholders to develop a Quality Strategy with input from healthcare partners, patients, and staff, ensuring readiness for April 2023. The strategy was launched through engagement sessions, a Board developmental session, and updates to the intranet, along with public-facing videos and staff information provided by the NHS Executive. Information was also disseminated via memorandums and dedicated webpages with details and training resources.

The Health Board's Quality Strategy is underpinned by "A Healthier Wales," focusing on quality and safety through our 'pillars of quality' program. These pillars help review performance and reporting to the Board and PQSOC, ensuring high standards of care in:

Patient and staff experience
Incident reporting (falls, pressure ulcers, medicines management, mortality)
Complaints, concerns, and compliments
Health, safety, and security
Infection control and prevention
Safeguarding



Reporting and Assurance

The Health Board developed a Quality Outcomes Framework (QOF) as part of its Quality Management System in quarter two 2023/24. This framework tracks outcomes to systematically measure, monitor, and enhance healthcare quality.

The QOF aimed to enable continuous improvement with key goals to:

Identify improvement areas and patient safety risks
Establish benchmarks and quality indicators
Promote evidence-based practices
Enhance patient satisfaction and experience
Ensure compliance with standards and regulations
Enable data-driven decisions and resource allocation
Foster a culture of accountability, transparency, and learning

The QOF has enhanced reporting requirements to the Board and Executive Committee, and providing assurance to PQSOC. Benefits of the QOF have included:

Improved patient outcomes and safety
Enhanced patient experience and satisfaction
Increased adherence to evidence-based practices
Efficient resource utilisation
Regulatory compliance
Improved staff engagement and professional development
Accountability and transparency in care delivery

The Health Board has developed a Governance and Assurance Framework for Quality to support the Quality Management System (QMS) at all levels. This work will continue into 2024/25, reviewing reporting arrangements via Groups and Committees, aiming to implement a new oversight and reporting structure for transparency and performance monitoring. Objectives of the quality governance framework includes:

Define and shape quality governance across the organisation
Support the Board in achieving quality governance
Clarify reporting lines
Increase assurance, public trust, and confidence

A multi-professional Clinical Forum will be developed with Clinical Executives in 2024/25. This will form a Clinical Advisory Committee, which will support Quality and Professional Strategies, provide independent strategic advice and maintain a strategic overview.

Progress on 2023/24 Priorities

Our quality ambitions for the first three years focused on prioritising quality and safety, acknowledging that challenges evolve. Over the past year, our key commitments were:

Learning Organisation: We strive to be a learning organisation where staff deliver high-quality clinical care daily.

System Understanding and Capability Building: We aim to understand our care systems, build capability through an all-teach/all-learn philosophy, encourage innovation, and engage patients, relatives, carers, staff, and communities in improvement efforts while learning from mistakes.

Embedded Quality and Supportive Culture: Quality is embedded throughout the Health Board, fostering a culture of openness and transparency where concerns can be raised.

Collaborating and Partnership: Patients, relatives, carers, staff, and communities will partner with us to achieve our vision.

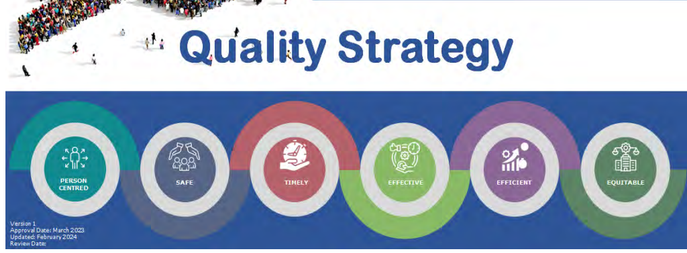
Our strategies have been shaped by the experiences of patients, relatives, carers, staff, and communities, focusing on improvement, planning, and assurance in alignment with the Duty of Quality and Duty of Candour.

Quality Strategy

This provided a:







Blueprint for Patient Safety and Quality: Outlines patient safety and quality for the next three years.

Focus on Quality and Safety: Prioritises quality and safety while addressing emerging challenges.

Improvement Objectives: Sets improvement goals and a supporting framework for the next three years.

Commitment to Continuous Improvement: Embeds a culture valuing quality and continuous improvement.

Patient Experience & Involvement Strategy

This provided a

- Feedback-Driven Culture: Created & based on feedback from staff, patients, families, and carers, focusing on what matters to them.

Passion for Improvement: Acknowledges staff's dedication to improving service experiences.

Learning from Experience: Places learning from experiences at the Health Board's core.



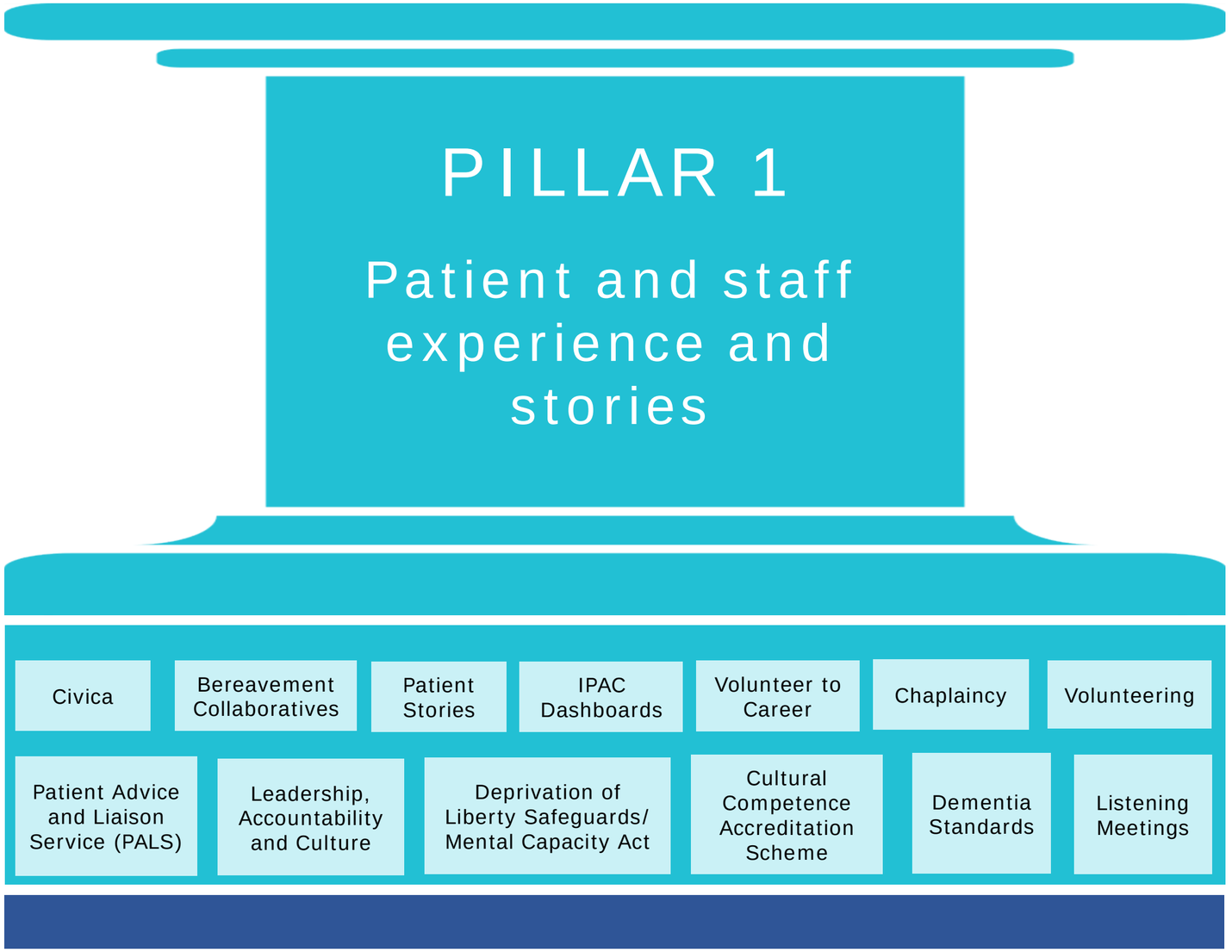




These strategies ensure that quality, safety, and continuous improvement are central to all our activities, fostering a culture of excellence and collaboration.

Progress against 2023/24 Objectives

Delivery of an approved strategy for Quality, Framework and Delivery Plan with a clear understanding of priorities.	Quality Strategy Implementation Plan developed and approved, supporting our reporting structure through a quality outcome framework.
Through the launch of the new system for patient experience and the Health and Well-being survey, put in place mechanisms to learn from the insight gained.	Civica Platform Launch: Enhanced real-time patient experience feedback, enabling ongoing partnerships with patients, families, carers, staff, and communities.
Establish a framework for learning and skills at all levels and the capacity and capability to grow and develop our skills and learning networks.	Listening and Learning Framework: Held meetings to engage and inform this nearly completed framework. Developing Best Practices: Through listening and learning, supporting staff to deliver excellent person-centred care.
Deliver the Safe Care Partnership, Faculty workstreams and the outcomes as set by each team.	Quality Improvement Capability: Expanded through the Safe Care Partnership, building capacity, conditions, and connections for staff to use QI methodology to solve complex problems consistently. Just Culture: Continuously working to correct mistakes, encouraging experience sharing, and restoring confidence.
Agree and implement the measures and reporting structures.	Reporting Structures: Huge progress on developing our reporting structure, reporting via a quality outcomes framework has enabled clear indicators reported aligned to the Health and Care Quality Standards. We have made this a priority to refine reporting for 2024/25.
Review the capability of our data capture systems for resilience and suitability.	Quality Management System: working collaboratively with the Divisions of planning and digital, data and technology has enabled data capture to be developed through existing systems.
Implement new systems to provide insight and support for delivery.	Quality Management System: developing the quality outcomes framework provided quantitative data that can be reported. We have enriched this data with narrative and included patient stories and staff feedback.
• Review our quality and safety structures and teams along with the reporting structures to ensure learning at every level and appropriate assurance and governance.	Reviewed Structures: Aligned resources within Quality and Patient Safety. A review of the reporting and assurance via current governance structures and Groups and Committees will continue through 2024/25.


PILLAR 1
Patient and staff experience and stories
Civica
Bereavement Collaboratives
Patient Stories
IPAC Dashboards
Volunteer to Career
Chaplaincy
Volunteering
Patient Advice and Liaison Service (PALS)
Leadership, Accountability and Culture
Deprivation of Liberty Safeguards/ Mental Capacity Act
Cultural Competence Accreditation Scheme
Dementia Standards
Listening Meetings

Key Achievements

Patient Experience - Launch of the Citizen Feedback System:

Total Responses: 1,343 (Person-Centred Care Survey: 1,137).
Satisfaction Score: 86% for Person-Centred Care Survey.
Surveys: 10 live surveys, including 3 national surveys (Emergency Department, Palliative Care, National Nosocomial Investigation).
Active Areas: 190 areas.
Staff Training: 229 Health Board staff trained.
Promotion: Development of a promotional poster, improved uptake.
Engagement: Enhanced engagement with Teams/Divisions and QPS Teams.
Collaboration: Strong collaboration across Wales on patient experience.

Patient Advice and Liaison Service (PALS):

Launch: November 2023.
Contacts: 3,978 contacts, including enquiries and complaints.
Complaints: 162 complaints received, 155 managed by PALS, 7 escalated to PTR (4.3%).
Compliments: 49 received.
Champion Roles: Developed roles in Equality, Diversity & Inclusion, Dementia, Bereavement, and CIVICA.
Recognition: Nominations are being written in the Patient Experience category at the staff recognition awards for 2024.
Surveys: Planned launch for PALS Patient and Relative Feedback survey will be launched in May 2024.
Engagement: Met with families and clinical teams to avoid escalation to PTR; attended Caerphilly Deaf club following a formal complaint for positive actions.
Outreach: Met with teams, directorates, and divisions to highlight PALS benefits.

Areas for Improvement

Ensuring all 'live' areas are collecting feedback.
Timely access to feedback by some areas.
High volume of feedback from paper surveys, concerns about the method and cost.
Delays with paper surveys might lead to missed or untimely feedback.
Lack of SMS feedback usage possibly affecting response rates.
Slower rollout due to training demands and limited staff (one dedicated member for CIVICA).

Challenges for 2024/25

National progress; the Health Board is the only one in Wales not using CIVICA SMS.
Limited resources, with only one Administrator affecting rollout speed.
Need to demonstrate evidence of feedback collection and learning.
Possible implementation of new Core Questions.
Unable to offer bespoke PREM surveys due to resource constraints.
Costs associated with implementing CIVICA SMS (currently piloting in the Emergency Department).

PALS Challenges for 2024/25:

Achieving absolute early resolution is difficult due to complex enquiries.
Developing a role for a Patient and Family Support Officer for end-of-life and bereavement support.
Lack of dedicated PALS hubs across the Health Board; hubs would offer 'drop-in' opportunities.
Current staffing limits capacity for face-to-face support, prioritising urgent cases.

PILLAR 2

Incident Reporting
Falls
Pressure Ulcers
Medicines Management
Mortality

Leadership, Accountability and Culture	Never Events	Deteriorating Patient	Patient Safety Incident process	QPSE Dashboards
Pressure Ulcers / Medicines Management	Staff Training	Datix (validation)	Falls Panel	Duty of Candour
Learning, Monitoring & Assurance	Just Culture/ Psychological Safety	Mortality	Risk Registers	Human Factors

Falls

Key Achievements

Significant effort in tracking and analysing falls within the Health Board.
Comprehensive data collection system through RLDatix.
Notable reductions in falls incidents observed in February 2024, following a peak in January 2024.
See falls improvement programme for additional information.

Challenges for 2024/25

Managing a high volume of falls incidents, with 44 patients experiencing more than two falls within a short period.
Continued improvement needed in falls prevention strategies, particularly among high-risk patients.

Medicines Management

Key Achievements

Enhanced monitoring and review processes, focusing on antibiotic prescribing and compliance.
Utilization of whole genome sequencing (WGS) for Clostridioides difficile infection identification.
Root cause analyses provided insights into sub-optimal antibiotic use, leading to targeted actions.

Challenges for 2024/25

Addressing sub-optimal prescribing of antibiotics.
Ensuring consistent compliance with hand hygiene and environmental cleanliness.

Pressure Ulcers

Key Achievements

Establishment of the Pressure Ulcer Faculty in 2023.
Implementation of educational initiatives and pilot projects, including a PDSA cycle.
Downward trend in HAPU incidences from January to April 2024.

Challenges for 2024/25

Meeting the Welsh Government standard of 0% avoidable HAPUs.
Sustained efforts needed to maintain focus on prevention and address contributing factors.

Mortality

Key Achievements

Development of a governance process for mortality outliers.
Implementation of the Risk Adjusted Mortality Index (RAMI) tool.
Ongoing efforts to align mortality review processes with quality improvement frameworks.

Challenges for 2024/25

Need for a standardized framework to review and learn from mortality cases.
Ensuring reliability and consistency of mortality data across reporting mechanisms.

Incidents 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.

Falls Improvement Programme

Key Achievements

Data Improvement: Enhanced availability and analysis of falls data across the Health Board have informed key quality improvement initiatives, leading to better monitoring and reduction of falls.

SWARM Methodology Implementation: Rolled out in April 2023 within the Medicine Division, this multi-disciplinary team (MDT) approach is being expanded across the wards.

Digital Integration: Successful rollout of the Welsh Nursing Care Record Multi-Factorial Risk Assessment (MFRA) to wards, with completion anticipated in October 2024. Additionally, a modified MFRA has been developed for use in Emergency Departments.

National Contributions: Contributed to the development of the Falls National Head Injuries pathway and the National Inpatient Falls Network's work on sensor use, setting a national standard.

Ward Accreditation: Falls prevention and management have been incorporated into the ward accreditation initiative, further embedding these practices into daily routines.

Falls Awareness: A highly successful Falls Awareness Week in 2023 saw significant patient and staff engagement across the Health Board.

RIDDOR Compliance: Established a Standard Operating Procedure (SOP) and developed a compliance dashboard within the Datix system to improve reporting and monitoring.

Training: Continued delivery of falls prevention and management training, adapted for the digital format of the Welsh Nursing Care Record.

Challenges for 2024/25

Consistency in Practice: Ensuring consistent application of the SWARM methodology and MFRA across all wards and specialties remains a challenge.

Data Utilisation: While data availability has improved, fully leveraging this data to drive sustained reductions in fall rates and severity of harm requires ongoing effort.

Staff Engagement: Maintaining high levels of staff engagement in falls prevention initiatives, especially in the face of evolving clinical environments and pressures, is a continuing challenge.

Technological Integration: The successful digital integration of falls management tools like MFRA needs continuous support to ensure all staff are proficient and the tools are used effectively.

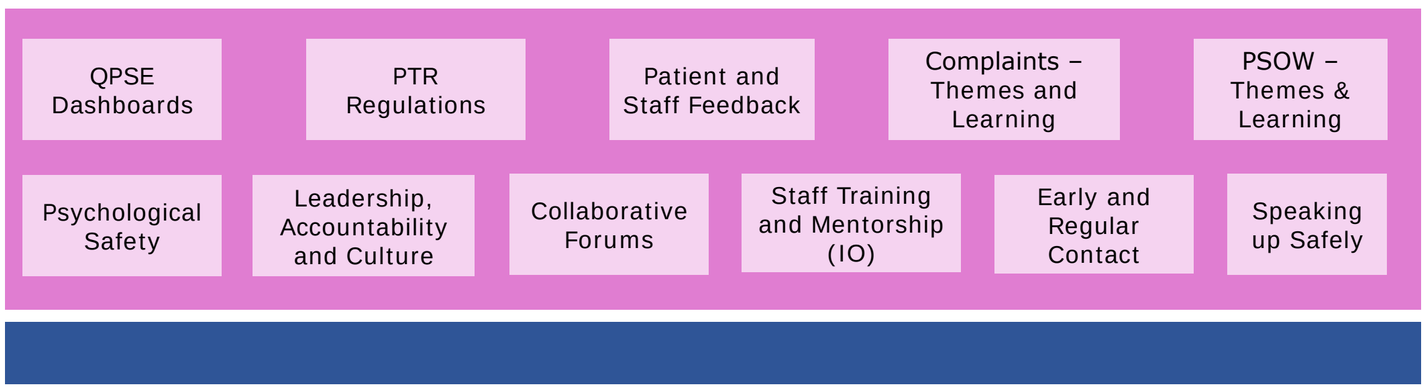
Resource Allocation: Ensuring that adequate resources, including appropriate flat lifting equipment and trained personnel, are available across all units to effectively manage falls.

RIDDOR Reporting: Despite progress, achieving full compliance with RIDDOR reporting protocols across the Health Board requires ongoing monitoring and training efforts.

These achievements and challenges reflect the Health Board's commitment to reducing falls and improving patient safety across its facilities. The next steps focus on building upon these successes through enhanced training, data utilization, and multi-disciplinary collaboration.

PILLAR 3

Complaints, Concerns and Compliments



Key Achievements

PTR Regulations: Active engagement in the review and public consultation.

Early Resolution and Meaningful Engagement: Implementation of PALS.

Planned Initiatives: Introduction of an "Acknowledgement Team" and development of Communication Standards.

Collaboration and Learning: Working closely with various oversight bodies and commitment to an open culture.

Common Complaint Themes

Clinical treatment/ assessment
Appointments
Communication issues.
Concerns about wait times and the impact of Covid on clinical treatment and assessment.

2023/24 Statistics

Formal Complaints: 1,596 received.

Resolved via Early Resolution: 1,555.

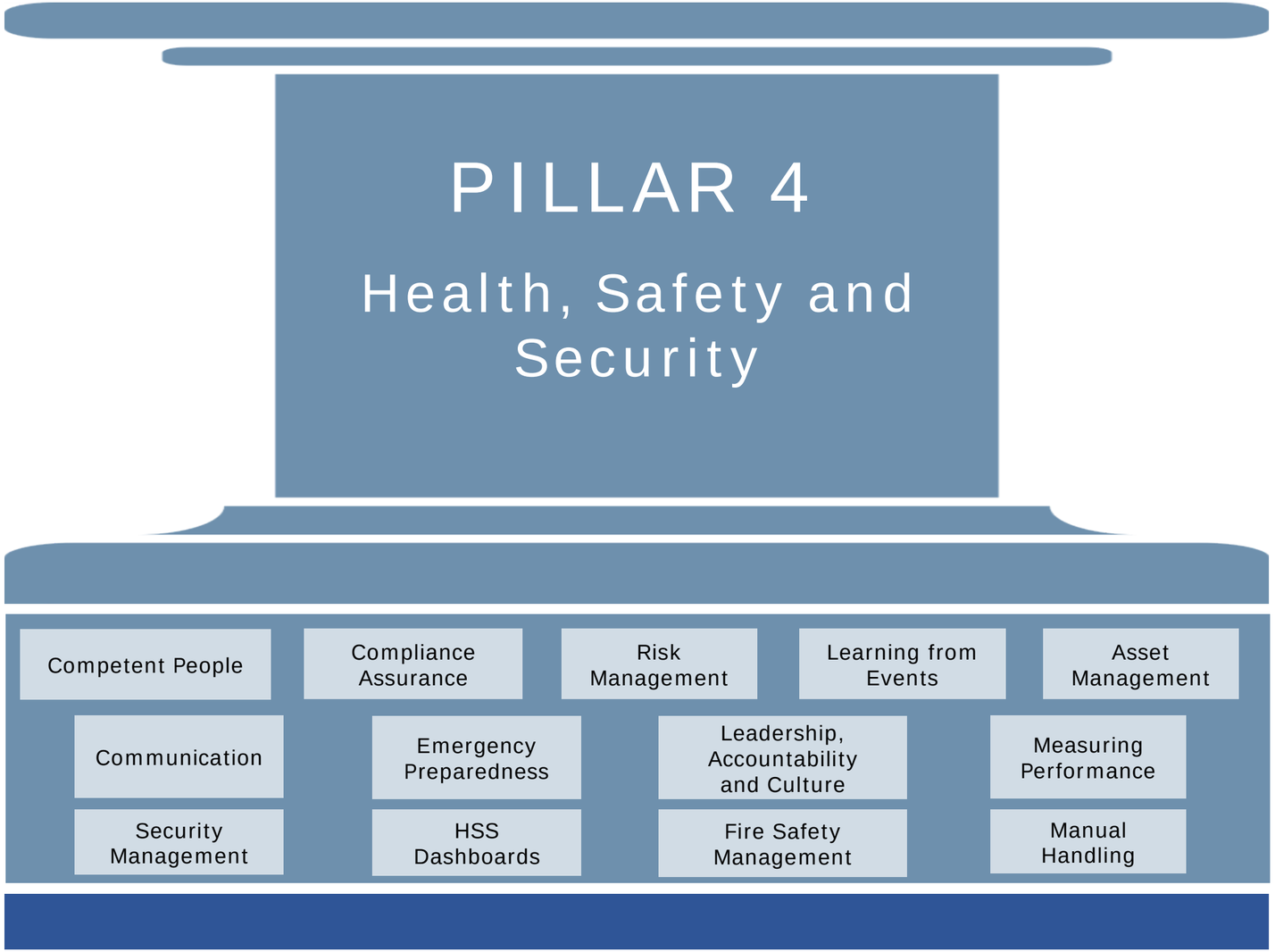
Compliance Target: Striving to meet the Welsh Government's 75% compliance target for 30-working day response times.

Key Focus for 2024/25

Prioritise timely and appropriate management of concerns.

Achieve compliance with the Welsh Government Targets

Collaborate with colleagues, communities, and partners to ensure quality and safety.


PILLAR 4
Health, Safety and Security
Competent People
Compliance Assurance
Risk Management
Learning from Events
Asset Management
Communication
Emergency Preparedness
Leadership, Accountability and Culture
Measuring Performance
Security Management
HSS Dashboards
Fire Safety Management
Manual Handling

Key Achievements

Health, Safety & Fire Improvement Plan: Implemented a 30, 60, 90-day plan, resulting in improved compliance and risk reduction.

Health & Safety Monitoring: Conducted 51 workplace inspections with an average compliance score of 88.2%.

RIDDOR Reporting: Established a RIDDOR Compliance Dashboard and new awareness training sessions.

Training and Development: Conducted various safety training sessions.

Safety Procedures and Protocols: Introduced new or updated procedures.

Fire Risk Assessments: Completed 96% of programmed assessments.

Support for New Developments: Assisted with planning and opening of new facilities.

Fire Alarm System Projects: Replaced outdated systems and planned further upgrades.

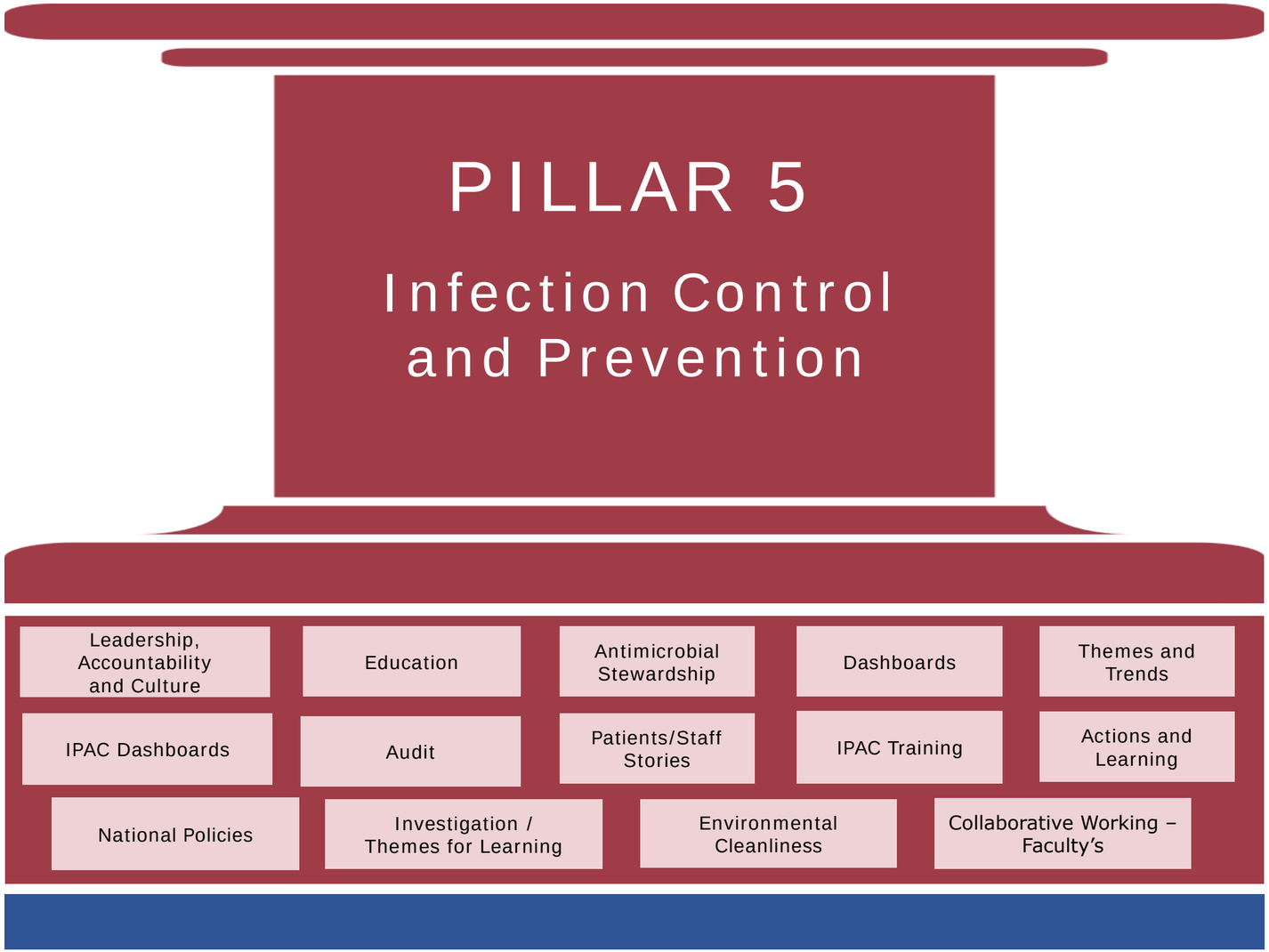
Areas for Improvement

Ensuring timely action completion by local managers following inspections.

Enhanced engagement in Health & Safety to reduce reliance on Corporate Health & Safety.

Challenges for 2024/25

Balancing resources to enhance current safety measures and implement new initiatives.


PILLAR 5
Infection Control and Prevention
Leadership, Accountability and Culture
Education
Antimicrobial Stewardship
Dashboards
Themes and Trends
IPAC Dashboards
Audit
Patients/Staff Stories
IPAC Training
Actions and Learning
National Policies
Investigation / Themes for Learning
Environmental Cleanliness
Collaborative Working – Faculty's

Key Achievements

Welsh Government Reduction Goals: Reduction in infection rates.

C-Section Surgical Site Infections: Reduced to pre-pandemic levels.

Audit & Education: Conducted 1,538 audits and trained 1,294 staff.

Respiratory Infections: Managed Covid-19, Influenza, and RSV rates effectively.

COVID Investigation: Reviewed 2,883 nosocomial infection cases with no cases referred to Legal and Risk.

Key Strategies and Interventions

Focus on Gram-Negative Bloodstream Infections through various initiatives.

Enhanced cleaning strategy and prudent antimicrobial prescribing

Areas for Improvement

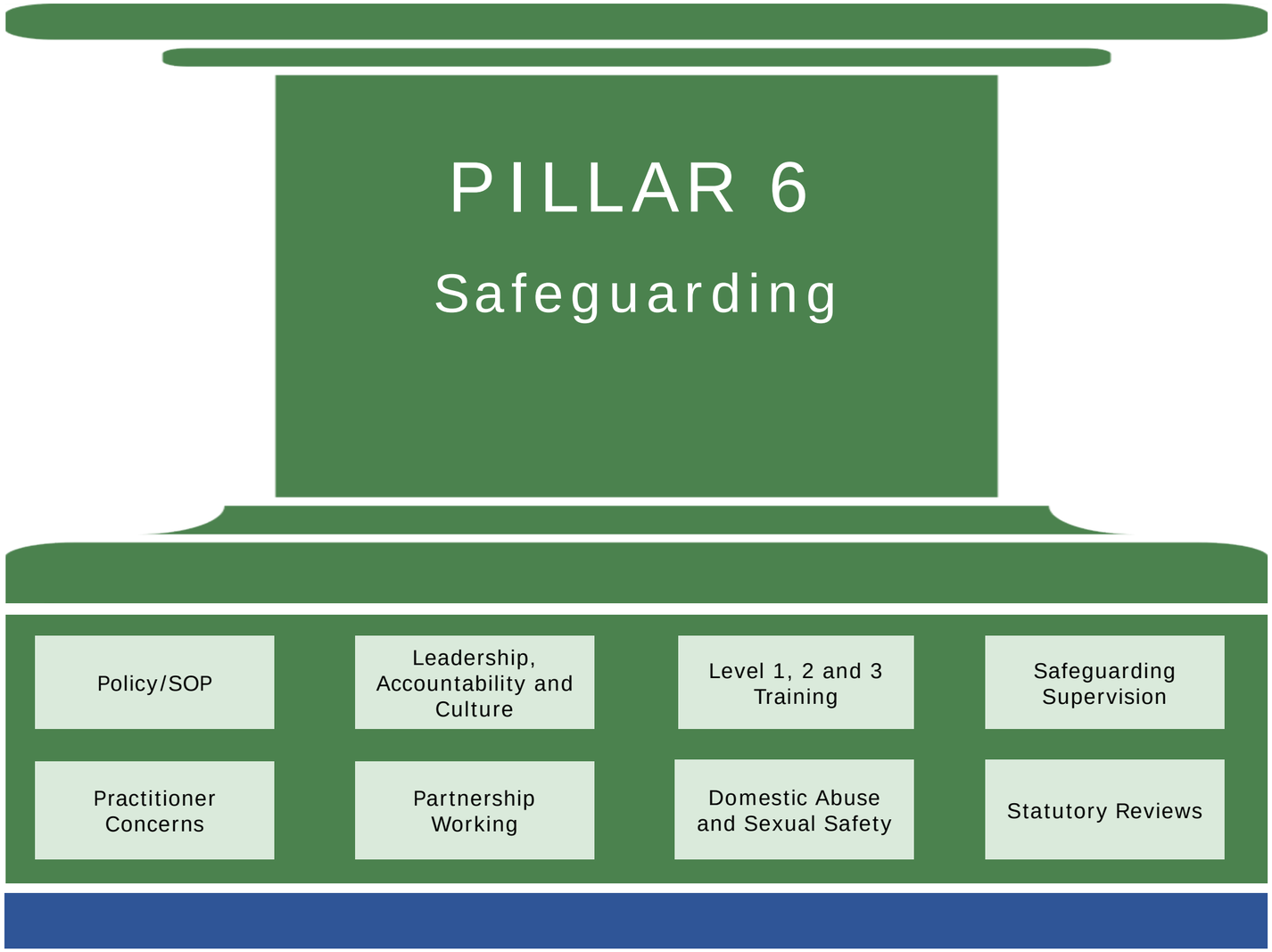
Addressing increase in healthcare-associated infections, particularly Klebsiella bloodstream infections.

Challenges for 2024/25

Developing a robust cleaning program to reduce healthcare-associated infections.

Managing patient flow and infection prevention.

Ensuring ongoing support for infection prevention best practices.


PILLAR 6
Safeguarding
Policy/SOP
Leadership, Accountability and Culture
Level 1, 2 and 3 Training
Safeguarding Supervision
Practitioner Concerns
Partnership Working
Domestic Abuse and Sexual Safety
Statutory Reviews

Key Achievements

Improved Safeguarding Maturity Matrix outcomes.

Delivered Level 3 Safeguarding Training.

Expanded scope for safeguarding supervision.

Achieved reasonable assurance in Safeguarding Audit.

Sustained Independent Domestic Violence Advocate role in urgent care.

Established a productive Safeguarding Committee.

Actively supported MARAC process.

Increased volume of Safeguarding Children and Adult referrals.

Areas for Improvement

Addressing delays in quality assurance and service improvement due to increased operational activity.

Mandating Level 3 Training for specific staff via ESR limitations.

Securing funding for the IRIS program to support domestic abuse survivors.

Challenges for 2024/25

Ensuring primary care staff receive necessary training and resources.

Providing appropriate Safeguarding Adult Supervision.

Developing and launching sexual safety documents.

Revising delivery and monitoring model for Level 3 Safeguarding training.

Launching the DATIX Safeguarding Module for better case management.

Updating internal processes and achieving objectives despite operational demands.

Workstream Priorities

2023/24

Deteriorating Patients

Addressing Deteriorating Patients: 2023/24 Key Actions

Background

Deteriorating patients are a significant issue due to basic care and observation failures and presents a multifaceted problem across the Health Board. Oversight by the Executive Director for Nursing emphasised returning to fundamental nursing, therapy, and medical care practices. A thematic review of serious incidents highlighted issues such as incomplete observations and failures to escalate concerns, underscoring the need for comprehensive reviews.

Objectives

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

Actions and Steps

THEMATIC REVIEWS

- Conducted thematic reviews to identify systemic issues and recurring themes
- Engaged staff in reviews to promote understanding and shared learning across the Health Board.

EDUCATION AND TRAINING

- Developed and implemented regular education programs on managing deteriorating patients.
- Replicated successful initiatives from the Safer Care Collaborative across other departments.

SYSTEMIC AND CULTURAL IMPROVEMENTS

- Fostered a transparent and just culture, encouraging staff to report and discuss incidents without fear of blame.
- Utilised safety culture surveys to gauge climate and identify improvement areas.

LEADERSHIP AND PSYCHOLOGICAL SAFETY

- Embedded psychological safety within the leadership culture.
- Developed leadership competency to empower all staff, especially juniors, to voice concerns.
- Incorporated psychological safety competency development into leadership training.

SPEAK UP FOR SAFETY INITIATIVE

- Launched initiatives such as "Speak Up for Safety" to encourage staff to raise concerns.
- Utilised patient safety walkarounds to proactively identify and address safety concerns.

Safer Care Collaborative

Overview:

A two-year national collaboration aiming to develop systems for safe, reliable, and effective care. It focused on strengthening leadership, supporting quality improvement, working across the system, and reducing patient health deterioration.

Achievements

Surgical Ward C0	Reduced cardiac arrests by 75%.
Monmouthshire Team	Improved patient experience during discharge through personalised care.
Older Adult Mental Health Services	Increased access to home-based memory services.
Acute Medical Unit	Introduced standardised observations every four hours.
Operating Theatres Team	Focused on reducing Never Events and building a safety culture.
Executive Safety Walkarounds	Facilitated direct communication between staff and executives to address concerns and support improvements.

Theatre Never Events

Definition of Never Events

Never Events: Serious, largely preventable patient safety incidents that should not occur if the available preventative measures are implemented.
The national list of never events evolves, but all such events are avoidable adverse incidents.

Background

This programme, led by the theatre's safety team with support from the Executive Medical Director and ABCi, addressed a series of never events that occurred in theatres. Despite prior efforts in quality assurance and system redesign, the lack of an overarching approach led to siloed learning and inefficiencies. This workstream emphasised the need for a more integrated system to enhance learning and improve outcomes.

Challenges included a lack of a universally understood process for preventing never events and contribution of multiple system, personal, and environmental factors to these events. There appeared to be an increased in reporting which indicated a transparent culture but also highlights recurring themes and systemic issues.

A thematic review of never events was undertaken in theatres and included:

Retained Foreign Bodies: Such as retained swabs.
Wrong-Sided Nerve Blocks: Involving teams like Anaesthetics, Radiology, OBS, Gynae, Trauma, and Orthopaedics.

Actions and Insights Over 2023/24

Existing Actions:

Some teams adopted "stop before you block" protocols but faced implementation challenges.
A test on wrong-site nerve blocks highlighted the need for systemic and multifactorial solutions.

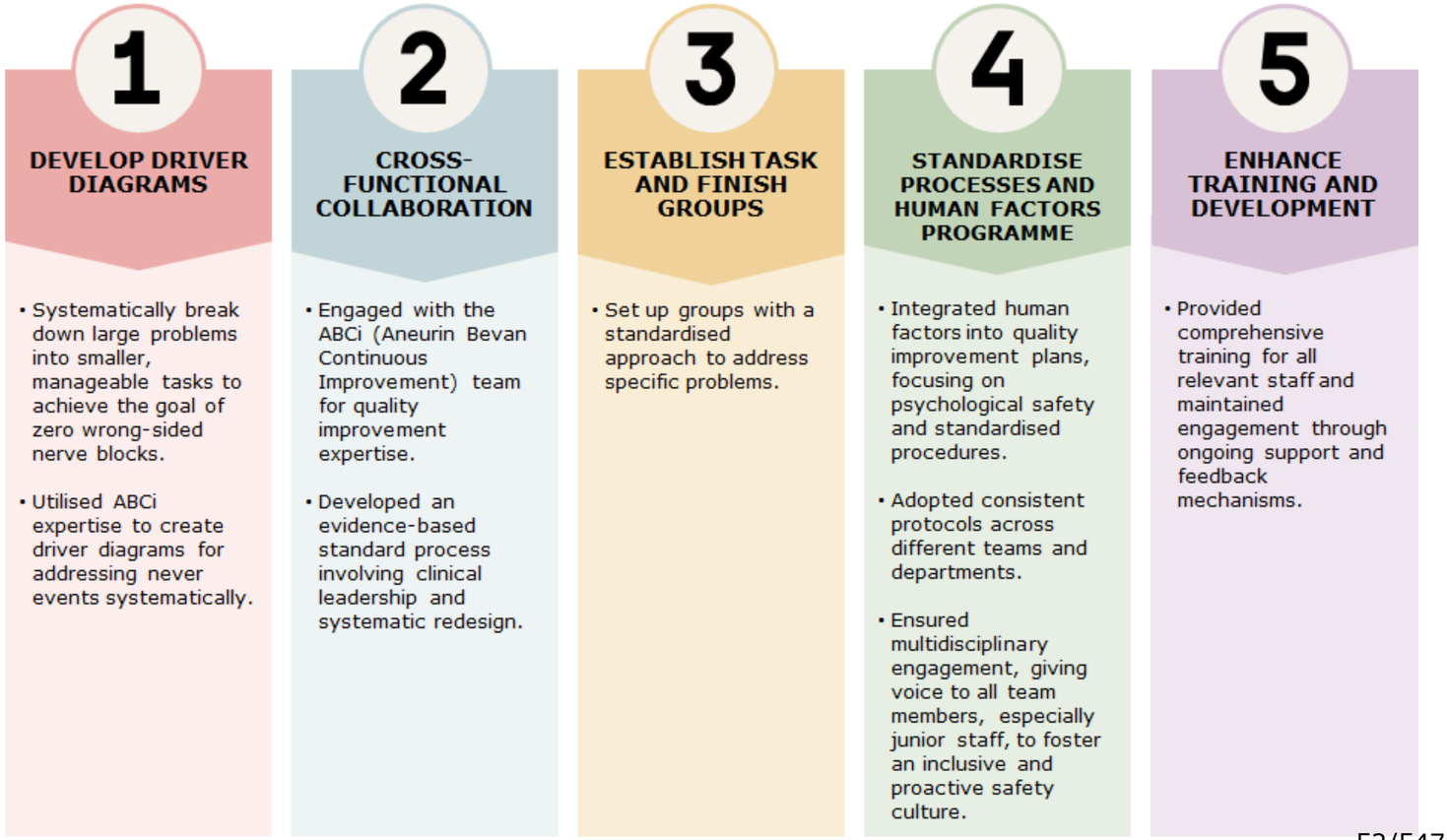
Human Factors Approach:

Simulation-Based Training: Conducted fortnightly simulations in emergency theatres to test systems and generate actionable insights.
Team Training and Psychological Safety: Focused on creating a just and safe culture, improving team dynamics, and fostering situational awareness.

Conclusion

The integration of these actions and strategies has led to a reduction in never events throughout 2023/24. This program has created a more cohesive, transparent, and safety-focused culture within the Health Board, significantly improving patient safety and care quality in theatres.

Key Steps Undertaken in 2023/24



Theatre Quality & Safety Programme

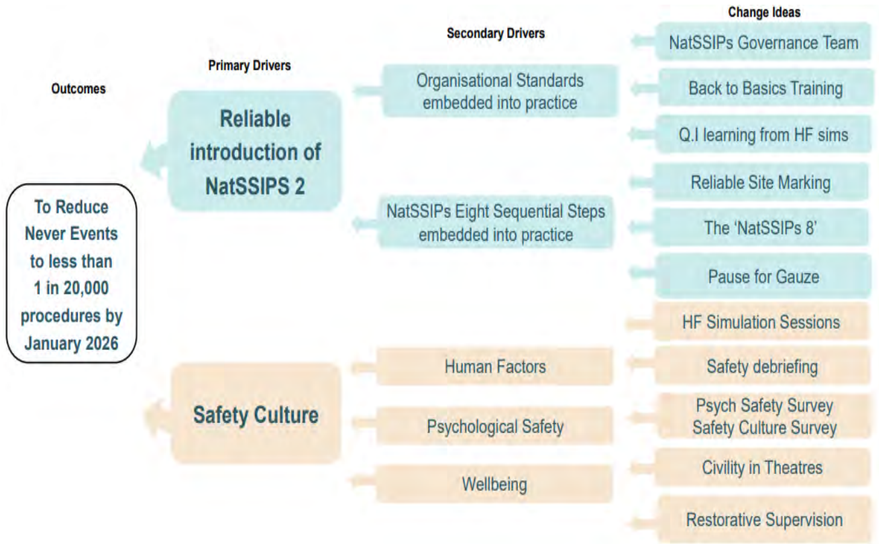
Aim

The aim of the Aneurin Bevan University Health Board Theatre Quality and Safety Programme was to reduce the number of Serious Incidents (SI), National Reportable Incidents, and Never Events across theatre sites. By integrating quality improvement practices into the daily routine of all theatre staff, the programme contributes to a stronger safety culture as a crucial component of the Health Board's Quality Strategy.

Appointment of a Quality Improvement Advisor for Theatres (started January 2024) to support primary safety objectives in theatres, ensuring that lessons from never events and incidents contribute to a stronger safety culture.

Key Actions and Initiatives	
Introduction of National Safety Standards for Invasive Procedures (NatSSIPs) 2	Work began to introduce NatSSIPs 2 across Theatres. Current workstreams focus on updating the World Health Organisation Surgical Safety checklist, using Quality Improvement (QI) principles and co-design with staff to include the 'NatSSIPs 8' sequential steps. The scope of work involves both organisational and sequential steps, with the wider teams exploring ideas for change, including patient engagement and creating a NatSSIPs network for the health board, linking all areas that undertake invasive procedures. Theatre Safety and Compliance workstreams are being reviewed and realigned to the new Theatre Safety Agenda.
Building a Safety Culture Using Human Factors	Regular protected space for the established human factors in theatres programme. Use of simulation as a tool to test the system and identify improvement opportunities through 'listen to learn' debrief sessions. Consideration of system, team, and individual factors at play. Safety culture surveys for staff are used as a listening tool, facilitating debriefing sessions and identifying topics for future workshops to address potential safety concerns and share improvement ideas.
'Quiet for the Count' Project: Started in November 2023.	▪ Purpose: Develop a safety culture and understanding among all theatre team members about the importance of reducing distractions during surgical counts. ▪ Testing and Spread: Initially tested at Grange University Hospital (GUH) and eventually spread across all theatre sites.
Monthly 'Back to Basics' Training Sessions: Started January 2024	▪ Content: Safety education package focusing on different subjects each month to refresh key knowledge and provide updates on essential topics. ▪ Effectiveness: Pre- and post-training surveys demonstrated improvement in understanding and confidence across these areas.
Psychological Surveys: Regular Surveys	▪ Conducted across all theatre sites to capture qualitative data on potential future improvement projects and quantitative measures of psychological safety.

The Theatre Quality and Safety Programme scope of work is visually displayed in a driver diagram to support the reduction of never events in theatres. The diagram breaks down large goals into smaller, actionable tasks, aligning with the systematic approach suggested by the Aneurin Bevan Continuous Improvement (ABCi) team.



Summary

By implementing these comprehensive actions and initiatives, the Theatre Quality and Safety Programme aimed to create an integrated, safety-focused environment in the Health Board's theatres. The programme has emphasised the importance of a strong safety culture, continuous learning, and systematic improvements to reduce never events and enhance patient care quality.

Radiological Serious Incidents

Background

A number of missed diagnostic findings and failures to follow up on radiological exams were identified as critical issues. These incidents dated back to 2019. Undertaking a thematic review of these incidents illustrated failures and found the root causes were identified as both human and system factors, with assumptions playing a significant role in that radiological results were received and acted upon. This work programme was led by the Executive Director of Therapies and Health Science.

Objectives

The Health Board aimed to mitigate these issues by standardising communication protocols, improving IT systems, and addressing human factors to enhance overall patient safety and care quality.

Key Themes and Issues	
Systemic and Human Factors:	▪ Human assumptions are made that no incidental findings exist if none are expected and that someone else is following up on unexpected findings. ▪ Failures in IT systems to capture or record results lead to missed follow-ups. Inconsistent communication methods within the Health Board exacerbate these failures.
Standardising Communication:	▪ Communication of findings has been inconsistent. ▪ The development of the STOP protocol aims to standardise alert communication following significant findings, improving understanding and reducing errors. ▪ The STOP protocol is nearing finalisation and will be shared across the Health Board.
IT System Improvements:	▪ A new Picture Archiving and Communication System (PACS) provider has been selected, with implementation expected next year. This should enhance result communication clarity and accuracy, reducing errors.
Personal and Professional Responsibility:	▪ Emphasis on the responsibility and accountability of requesting clinicians (Referrer: IR(ME)R 2017) to act on results. ▪ Complexities, especially in emergency departments (ED), where imaging may be requested in the name of a consultant who hasn't seen the patient.
Cross-Sector and IT Interface Issues:	▪ Assumptions are driven by the interface between primary and secondary care and differing IT systems. ▪ Errors often occur due to dropdown lists and ambiguous messages in electronic discharge summaries. ▪ Ensuring radiology reports are sent to the correct recipient is critical, requiring correct identification of the referrer, specialty, and location.

Actions Undertaken in 2023/24

01 — Standardising Communication Protocols

- Implementing the STOP protocol to clarify alert communication for significant findings.
- Sharing the standardised communication process across the organisation to reduce errors.

02 — Improving IT Systems

- Transitioning to a new PACS provider to enhance result communication clarity and accuracy.
- Monitoring the correct identification of referrers and specialties to ensure accurate report delivery.

03 — Addressing Human Factors

- Conducting thematic reviews to understand systemic issues.
- Engaging staff in reviews to promote understanding and shared learning.

04 — Enhancing Policies and Promoting Personal Responsibility

- Reiterating the accountability of clinicians to act on results.
- Providing training to ensure clinicians understand their responsibilities and the processes involved.

05 — Cross-Sector Collaboration

- Addressing interface issues between primary and secondary care.
- Ensuring clear and unambiguous communication in electronic discharge summaries.

Conclusion

By implementing these steps, the Health Board aims to reduce errors related to missed diagnostic findings and follow-up failures, thereby improving patient safety and care quality.

Health and Care Quality Standards

As part of the Quality Strategy an Implementation Plan was produced for the Health Board to enhance the quality of healthcare throughout 2023.

In order to deliver the Health and Care Quality Standards, the plan was mapped with quarterly objectives aligned to the six key quality domains. Highlights of the achievements for 2023/24 can be seen in the Appendix.

This plan was built on existing achievements, emphasising continuous improvement and embedding quality, safety, and learning in daily operations.



Duty of Candour

The Duty of Candour, effective from 1 April 2023, mandates all NHS bodies to openly and promptly report, manage, and investigate notifiable adverse patient safety events as stipulated by the Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes compliance with the Concerns, Complaints, and Redress Arrangements (Wales) Regulations 2011.

Healthcare professionals who are subject to a professional Duty of Candour have to be open and honest with service users, colleagues, their employers and relevant organisations.

The statutory duty of candour and the professional Duty of Candour have the same aim: To be open and honest with people who receive care and treatment. The strong links between the statutory and professional duties of candour will empower staff to speak openly about concerns and will encourage learning to improve quality of care.

Operational since April 2023, through the Duty of Candour, the Health Board must be honest in informing patients and their families when things go wrong in providing care or our services fail to meet expectations or the standards that they should. There is an obligation to find out what went wrong; and, to make sure the same mistake does not happen again. A culture of openness, transparency and candour is widely associated with good quality care. It encourages learning and is achieved without apportion of blame. The Duty of Candour applies if the care the Health Board provides has or may have contributed to unexpected or unintended moderate or severe harm, or death. This duty builds on the Putting Things Right process for raising concerns or complaints.

The Health Board has provided information and guidance for all staff. It has shared the national programme of education and publicity to help ensure that colleagues across the Health Board were aware of the new Duty and the steps needed to comply with the Duty. The Duty of Candour integrates into incident reporting via Datix.

This included:

- Education materials are due to be available soon.
  - Staff awareness video
- Staff information leaflet (pdf) explaining what the new Duty means for all staff working in the NHS.
- A dedicated intranet page was also established
- New tools in DATIX that will help is have Candour conversations with patients and their family.
- Standardised templates and letters ensure consistent communication with patients.
- Meetings with Primary Care and community divisions support comprehensive reporting, and staff receive ongoing guidance on applying the Duty of Candour criteria consistently.

Duty of Candour

Achievements for 2023/24:	
Trigger:	Initiated when an adverse event review reveals unexpected or unintended harm (moderate, severe, or death) related to NHS-funded care.
Preparation:	The Health Board aligned incident management systems and processes to meet Duty of Candour requirements.
Training:	Duty of Candour training is available on the Health Board's electronic training platform (ESR), and staff are encouraged to complete it.
Implementation:	Centralised Quality, Patient Safety (QPS) teams and designated Duty of Candour leads ensure consistent training and compliance.
Reporting Tool:	A new Duty of Candour reporting tool supports continuous monitoring and data validation within incident and complaint systems.
Support:	The Patient Safety Incident team assists divisions in implementing the Duty.

Challenges and Improvements:	
Harm Categorisation:	Initial confusion in distinguishing between actual and healthcare-related harm in lower harm incidents led to additional education. Increased understanding is being achieved through education and support across multiple forums.



Learning and Improvement

Organisational Learning for Continuous Healthcare Improvement

In 2023/24, the Health Board placed a significant emphasis on organisational learning to drive continuous improvement in healthcare. By engaging staff and key stakeholders, we began to develop a comprehensive Listening and Learning Framework, demonstrating our commitment to embedding lessons learned to enhance patient care, safety, quality, and experience. This framework is set to be approved in April 2024.

Key Focus Areas for 2023/24:

- Identifying Learning: Actively seeking insights and lessons from various sources, including patient feedback, incident reports, and staff experiences.
- Triangulating Learning: Cross-referencing information from different sources to gain a holistic understanding of issues and ensure accuracy in learning.
- Disseminating Learning: Sharing insights and lessons learned across the organisation to ensure they are accessible to all staff and stakeholders.
- Implementing Learning: Applying the lessons learned to practical strategies and interventions to foster a culture of continuous improvement.
- Just Culture: Promoting a fair and open environment where staff feel safe to report incidents and share insights without fear of blame or retribution.
- Triangulated Approach: Integrating quality, patient safety, and experience data to create a comprehensive understanding and drive informed decision-making.

Initiatives and Developments for 2024/25:

- Bi-Monthly Learning and Improvement Forum: Establishing a regular forum dedicated to learning and improvement, allowing staff to share knowledge, discuss insights, and drive change.
- Learning Repository: Creating a central repository to store and share knowledge, ensuring that valuable lessons and best practices are easily accessible.
- Transformation of the Quality and Patient Safety Operational Group: Evolving this group into a learning and improvement forum to reinforce a culture of continuous improvement.
- Quality Improvement Strategy: Developing a strategy over the next 6-9 months to provide a structured approach to quality improvement across the Health Board.

Commitment to Continuous Improvement:

The Health Board is committed to fostering a culture of continuous improvement, learning from every opportunity to enhance patient care, safety, quality, and experience. By embedding a Just culture and triangulated approach, we aim to create an environment where learning is a fundamental part of our operations, driving excellence in practice and improving outcomes for our patients.

ABCi (Aneurin Bevan Continuous Improvement) / Quality Improvement Timeline of Achievements

In 2023/24, the Health Board made significant strides in quality improvement across various domains, with notable achievements in patient care, training, and operational enhancements. Despite the successes, challenges such as staff limitations, financial constraints, and the effective adoption of new tools remain. Moving forward, the Health Board is committed to addressing these challenges, fostering a culture of continuous improvement, and maintaining high standards of care for all patients.

April 2023	Continued support of All-Wales Safe Care Collaborative & local teams throughout 2023-24 to: o Reduce cardiac arrests on acute wards o Provide home based memory rehabilitation to a greater number of patients diagnosed with cognitive impairment to enable independence o Integrate health and social care services in Monmouthshire to re-able patients both before and after discharge leading to better patient experience
May 2023	New PocEd Measurement virtual training launched helping staff to use and interpret time series data
June 2023	New role: Assistant Medical Director for Quality Improvement Quality Improvement skills framework developed to train staff around QI methods ABCi Time Series Chart tools launched
July 2023	Connecting with Clinical Directors around embedding quality improvement practice via 3 cohorts of CDx training programme
August 2023	ABCi team attended training at Toyota factory, and skills gained were used to reduce delays, particularly in making decision around treatment for colorectal cancers
September 2023	Q Lab funding obtained to support a project which has reduced the time to make decisions around treatment for Head and Neck Cancer patients by around 25 days
October 2023	NHS Wales Awards – 6 projects from ABUHB of 24 across Wales were shortlisted, with two winners across eight categories. Winners were: o Co-production to support neuro-developmental services in Gwent (ABUHB) o Improving our Employee Investigations
November 2023	First ABUHB Deteriorating Patients Collaborative learning session took place focussing on listening to unheard voices including patient stories of bereavement and a junior doctor's experience
December 2023	ABCi team worked with Improvement Cymru to co-deliver Improvement in Practice training for ABUHB staff 24 staff successfully attended 'Sustainability in Quality Improvement' training, leading to several projects being initiated to reduce the carbon footprint
January 2024	Improvement Advisor employed to support Theatre Quality & Safety Programme aiming to reduce Never Events in Operating Theatres through building a culture of safety within theatres and spreading NatSIPPS 2
February 2024	PocEd QI, our bi-monthly QI fundamentals live virtual course, which is open to all staff in the organisation, has now over 230 staff successfully completing the training
March 2024	The ABCi QI Unit continues to support quality improvement across clinical professions. ABCi has moved to sit within the Nursing Directorate which will free up additional support to work with staff across the health board The ABCi team with support from colleagues in nursing, have initiated a Spread and Scale Academy project which aims to, 'Unleash 1 million minutes of Quality Improvement Coaching to enable our staff to improve what matters to them and their patients' The ABCi team have led work in conjunction with Improvement Cymru colleagues to deliver a pilot of the Q Community, 'Quality Coach Programme' to build QI Coaches within clinical areas to support improvement work ABCi continue to support services across different areas such as: o Reducing pressure ulcers o Reducing clostridium difficile infections o Improving enhanced care for inpatients o Improving effectiveness and patient experience around continence for patients living with dementia o Reducing delays around deprivation of liberty assessments

Year in Review: Quality Improvement Milestones and Challenges in 2023/24

April 2023

- Reduction in cardiac arrests on acute wards.
- Increase in home-based memory rehabilitation for patients with cognitive impairment.
- Integration of health and social care services in Monmouthshire, enhancing patient experience.

May 2023

- PocEd Measurement Training- Launched virtual training to assist staff in utilizing and interpreting time series data.

June 2023

- Assistant Medical Director for Quality Improvement appointed.
- Development of a Quality Improvement skills framework.
- Launch of ABCi Time Series Chart tools.

July 2023

- Clinical Directors engaged in embedding quality improvement practices through the CDx training programme.

August 2023

- Participated in Toyota factory training to reduce treatment delays for colorectal cancers.

September 2023

- LoQ Lab Funding: Secured funding to reduce decision-making time for Head and Neck Cancer treatment by 25 days.

October 2023

- NHS Wales Awards: Six ABUHB projects shortlisted, with two winning:
- Co-production in neuro-developmental services.
- Improving employee investigations.

November 2023

- Deteriorating Patients Collaborative: Hosted the first learning session focusing on patient stories and junior doctors' experiences.

December 2023

- Training Initiatives: Co-delivered Improvement in Practice training with Improvement Cymru. Trained 24 staff in 'Sustainability in Quality Improvement,' initiating carbon footprint reduction projects.

January 2024

- Theatre Quality & Safety Programme: Employed Improvement Advisor to reduce Never Events and spread NatSIPPS 2.

February 2024

- PocEd QI Course: Trained over 230 staff virtually.

March 2024

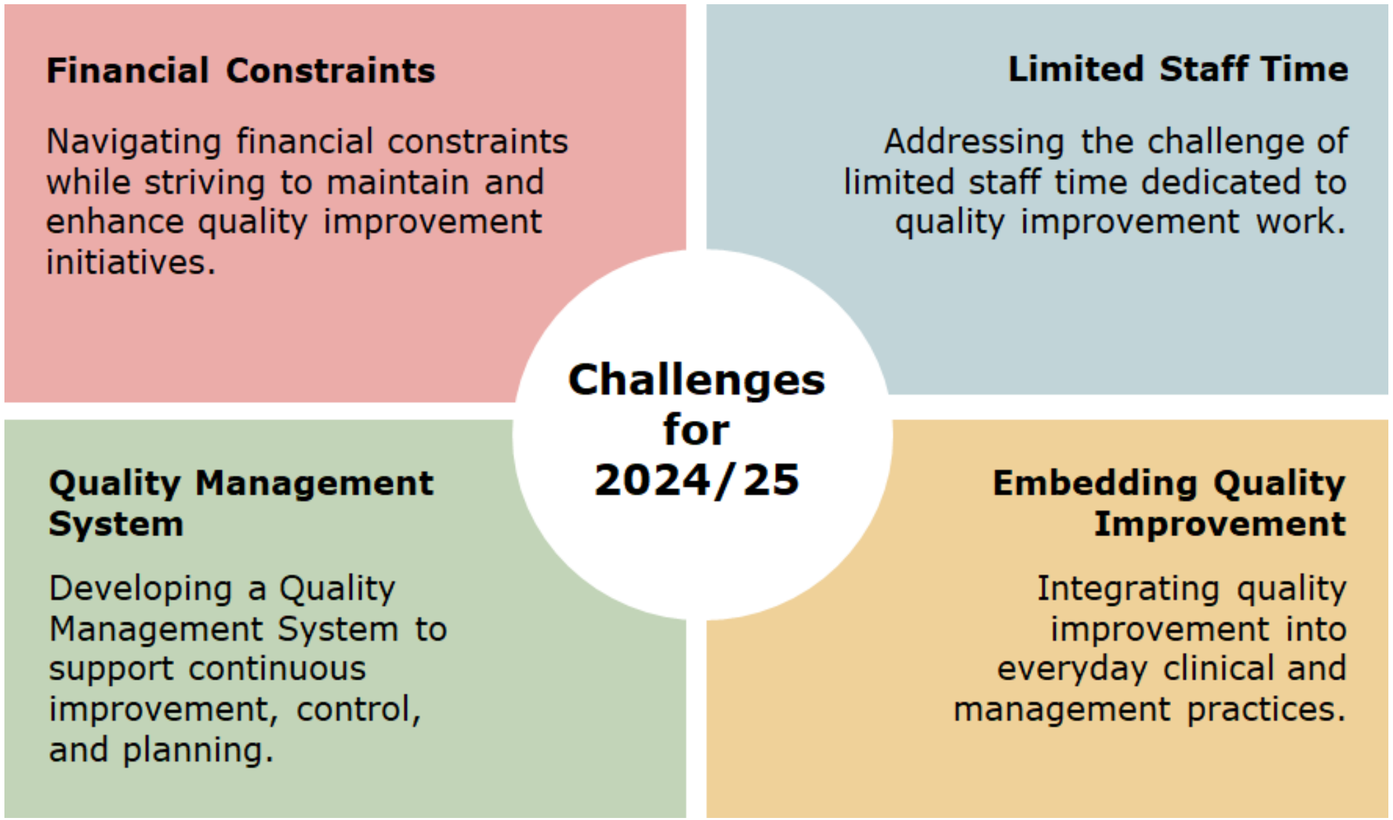
- ABCi moved to the Nursing Directorate, enhancing support for health board staff.
- Initiated Spread and Scale Academy project to provide 1 million minutes of QI Coaching.
- Piloted the Q Community's 'Quality Coach Programme' to build QI Coaches.
- Supported services in reducing pressure ulcers, clostridium difficile infections, improving inpatient enhanced care, and addressing delays in deprivation of liberty assessments.

Quality Improvement

Areas for Improvement:

Team Withdrawals:
Three teams withdrew from the Safe Care Collaborative due to service pressures.

LifeQI Tool Adoption:
The adoption of the LifeQI tool was less effective than anticipated.



Learning from Deaths

The Health Board aimed to complete Mortality Reviews to learn and identify improvement. This has been aligned with the development of a learning from deaths framework (similar to NHS England) that will support an approach of systematic ward to Board reporting and monitoring of mortality, this will be launched in April 2024.

The objective is to ensure systematic ward-to-board mortality reporting and monitoring. Key indicators will include risk adjusted mortality. The Risk Adjusted Mortality Index (RAMI) adjusts for individual patient risk factors and co morbidities and therefore allows comparison between organisations. The accuracy of RAMI is dependent on the completion and accuracy of clinical coding. This has increased to 108 in December 2023 from 103 in 2021. The Health Board has also been reporting crude Mortality as part of the QOF. The mortality rate has remained flat and consistent, necessitating individual mortality reports for deep dives into high mortality specialties.

The role of the Medical Examiner (ME) Service is to provide independent death scrutiny, quality death certification, and reducing the stress of the bereaved. The service began in January 2021 and expanded to all sites in April 2023 (currently excluding maternity, paediatric, and neonatal). Approximately 25% of deaths are referred back to the Health Board for further action or learning. The learning from death framework will allow triangulation of accurate mortality data and Medical Examiner (ME) information for trend identification and condition-specific analysis.

There have been a number of achievements in 2023/24, this includes: Welsh Government mandated ME scrutiny of all deaths (excluding coronial cases) in April 2023, development of a mortality review screening panel to discuss the cases referred by the ME service and assess learning and improvement. The release of biannual newsletters highlighting ME referral themes and learning.

Future Goals for 2024/25 include: -

- Expansion of the ME service to include community deaths, increasing referrals.
- Continued communication of the biannual newsletters for shared learning.
- Sharing positive feedback and compliments from bereaved families with clinical areas.

Implement Robust Audit Processes and Plans

In 2023/24, the Health Board continued its Clinical Audit Strategy, presenting the strategy and new Audit Management and Tracking platform (AMaT) at Divisional meetings. AMaT training was provided, and all National Audits are now managed using this platform. The standardised reporting tool in AMaT facilitates the reporting of successes, concerns, risks, and assurance levels.

A SMART action plan is developed for each audit and monitored by the Quality and Patient Safety Clinical Audit team. Local audits are also being reported on AMaT. The platforms used in the Clinical Standards and Effectiveness Group (CSEG) to discuss each national report and ensure risks identified are acted upon accordingly. This process is enables ensuring full participation in the Programme for NCAORP 2023/2024. Continuous management of NCEPOD studies by the Audit team ensures full participation.

Despite resource issues delaying the Corporate Audit project and staff training, progress has been made. Challenges include obtaining engagement for multi-specialty audits and outdated information requests. For 2024-25, the focus will be on improving audit participation and data accuracy amidst busy clinical environments, while addressing resource constraints.

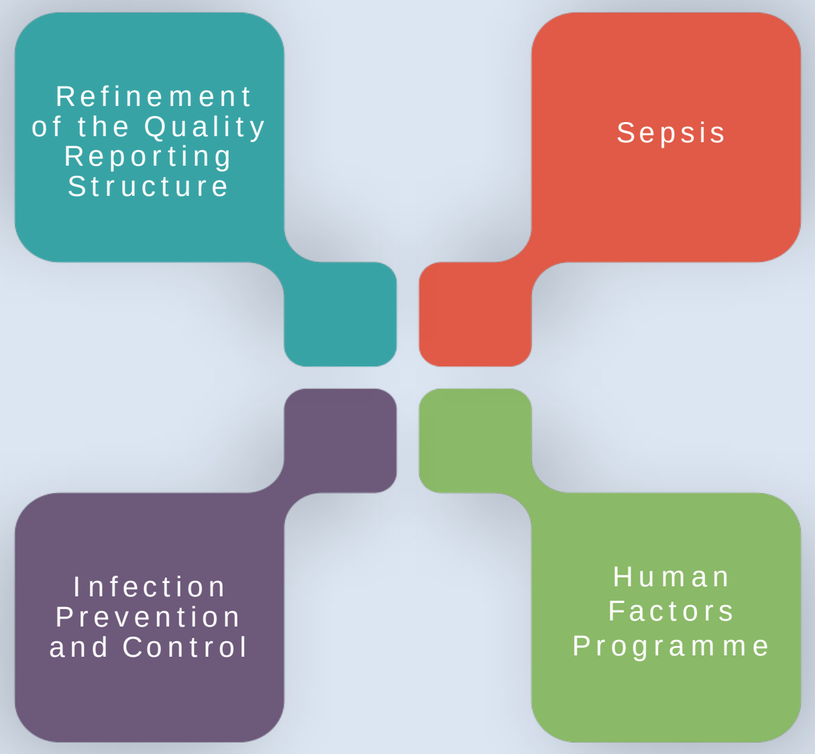
The Health Board Clinical Audit Plan 2023/2024 has been published as well as the Clinical Audit Activity Report 2023/2024 evidencing Health Successes and Concerns within each audit and detailing actions plans moving forward.

Key Workstreams for 2024/25

Commitment to Quality, Safety, and Patient Experience:

The Health Board remains steadfast in its commitment to quality, safety, and patient experience. By enhancing systems of care, promoting continuous learning, fostering innovation, and maintaining a culture of openness and transparency, we aim to create a healthcare environment that consistently delivers high-quality care and positive patient outcomes. Through the strategic initiatives outlined above, we are building a robust foundation for continuous improvement and excellence in healthcare delivery.

Key workstreams for 2024/25 include:



A workstream will be produced for each of these for 2024/25 with SMART action plans. A brief description is provided:

Infection Prevention and Control

With the routine reporting of infection rates, the Infection Prevention and Control pillar of our quality strategy will include a workstream to focus on improving antibiotic prescribing. Work going into 2024/25 already includes:

Enhanced Cleaning Programme:
- Need for a robust cleaning programme to reduce healthcare-associated infections.
- Balancing the safety of patients with bed availability and ward reconfiguration.
- Proposal submitted to Executives for a more focused approach.

Patient Flow and Infection Prevention:
- Daily challenge of protecting patients from infection while managing bed availability.
- Attendance at Patient Flow Meetings to support patient placement.

Reporting and Root Cause Analysis:
- Use of Datix for reporting and analysing healthcare-associated infections.
- Reinstated virtual root cause analysis meetings to identify themes and learning.

Supporting Divisions:
- Ongoing promotion of best practices in infection prevention.
- Financial support from Regional Integration Funds (RIF), with potential risk to service provision if not funded in 2025.

- Antimicrobial prescribing, stewardship and resistance:
  - Work closely with Divisions to reinforce start smart and focus guidelines.

Refinement of the Reporting Structure

Ensure clear, evidence-based reporting across all committee and group levels to assure Health and Care Standards delivery. A workstream will include the following workplan:

Health Board Corporate Clinical Audit Plan: Complete and refine the Clinical Audit Plan to ensure systematic evaluation and improvement of clinical practices.

Annual Health and Care Standards Reports: Develop and regularly update these reports to track compliance with health and care standards, identifying areas for improvement.

Implementation of Standardisation Efforts: Standardise processes and procedures across the Health Board to ensure consistency in care delivery.

Establishment of Corporate Support Roles: Create roles dedicated to providing corporate support and integrating decision frameworks to streamline operations and improve decision-making.

Enhancement of Assurance Mechanisms: Improve mechanisms for assurance to ensure that quality and safety standards are consistently met across all areas of care.

Utilise Existing Resources: Leverage the Health Board's existing resources and support systems to effectively implement key initiatives. This includes using available tools, staff expertise, and technological solutions to drive improvements.

Alignment with Health Board Commitments: Ensure all initiatives and actions are aligned with the Health Board's overarching commitment to quality, safety, and patient experience. This alignment ensures that every effort contributes to the broader goals of enhancing patient care and operational excellence.

Sepsis

The Health Board will focus on implementing the updated National Institute for Health and Care Excellence **(NICE)** sepsis guideline **(NG51)**. The updated guidance aligns with the Academy of Medical Royal Colleges (AoMRC) statement on the initial antimicrobial treatment of sepsis. This will build on improving patient safety by addressing systemic issues related to deteriorating patients. A workstream will be dedicated to sepsis recognition and early assessment from primary care to acute care. A full improvement plan will be developed and ensure the Health Board is delivering the Sepsis 6, focusing on the following:

Initial treatment

Including prescribing/admin of antibiotics

Finding the source of infection

Early monitoring

Escalating care (Call for Concern / Martha's law)

Information and support, - sepsis awareness and safety netting, patient information

Training and education

Audit strategy – develop an implementation plan for the Health Board on audit and assurance for sepsis organisation

We will look to work with the UK Sepsis Trust to embed best practice and to mirror any work undertaken nationally and UK wide to enable early recognition of sepsis and improve sepsis awareness.

Human Factors Programme

Implement Human Factors as a Health Board wide approach. Developed with medical, nursing, admin, and managerial staff, the programme at Grange University Hospital (GUH) promotes patient safety, team performance, and staff wellbeing. It embeds human factors by designing better systems and listening to staff. Stakeholders collaborate in protected spaces to identify solutions and actions.

Initially, the Health Board introduced human factors concepts through half-day workshops for multidisciplinary teams. The programme's core involves "safe listening spaces" and simulations to generate discussions for meaningful change. Originally focused on GUH Emergency theatres, it has expanded to other areas and includes a Human Factors training page on the Health Board's intranet.

With the success of the work on never events, this workstream aims to integrate human factors training and methodologies across the Health Board to improve patient safety and staff well-being. This involves implementing human factors training and establishing "safe listening spaces." The human factors programme currently uses existing training programs and resources to enhance overall patient safety and staff well-being.

Key Enablers for 2024/25

These will be mapped by quarterly goals as part of the year two objectives for the quality strategy. Improvement Plan for 2024/25: Aneurin Bevan University Health Board

1

A Learning Organisation

Foster a culture of continuous learning and improvement throughout the organisation.

- Q1: Embed our quality patient safety and quality improvement teams within our divisions
- Q2: Develop a learning repository for all our staff which will allow us to review how learning will be identified, stored, triangulated, shared, disseminated and implemented
- Q2: Develop a learning bulletin to share learning across the organisation
- Q2: Review mortality data and improve clinical outcomes by implementing a Learning from Death Framework and report
- Q2: Scope our Deteriorating Patients Collaborative
- Q3: Review quality and safety structures and reporting structures ensuring learning at every level.

2

Culture

Establish a supportive and proactive culture focused on quality improvement and patient safety.

- Q1: Engage to identify new quality improvers and support existing Quality Improvers
- Q1: Increase Quality Coaching capacity
- Q1: Develop our methodology to learn from incidents and establish a listening and learning framework, enabling us to deliver an learning forum
- Q3: Establish bespoke Patient Experience Collaboratives and use feedback for learning and improvement
- Q3: Formalise an approach to supporting staff involved in patient safety incidents
- Q4: Support a data informed experience (CIVICA) quality and patient safety agenda organisation wide
- Q4: Introduce an electronic patient feedback system to capture real time patient experience feedback

3

Quality Management System

Integrate quality management systems to ensure continuous improvement and compliance with health standards.

- Q1: Support the ward accreditation programme with quality and patient safety measures
- Q2: Utilise and triangulate patient experience data listening and learning from lived experience to provide qualitative data
- Q3: Improve the quality of incident reporting
- Q4: Identify specific areas within national clinical audits that require improvement

4

Quality Improvement

Use data-driven approaches to inform quality improvement initiatives and enhance patient safety.

- Q2: Produce an annual quality report outlining achievements and areas for strengthening
- Q2: Scope the theatre safety programme
- Q3: Strengthen the link between learning from direct and indirect feedback, investigations, and improvement work.
- Q3: Strengthen and embed 'Human Factors' to examine why incidents occur
- Q3: Utilise Clinical Audit expertise to provide the evidence-base and measurement function which drives quality improvement initiatives
- Q3: Initiate Leaders Skills Development Programme
- Q4: Data informed approach to learning from patient feedback and patient safety incidents

Conclusion

This report highlights the continued commitment of Aneurin Bevan University Health Board in providing high-quality care for everyone. Over the past year, we have made significant progress in enhancing patient safety, improving access to services, and ensuring that our care is compassionate, effective, and centered on the needs of those we serve.

The report presents a balanced picture of the Health Board's commitment to delivering the Health and Social Care (Quality and Engagement) (Wales) Act (2020) over the first 12 months. The Health Board has agreed the priorities clearly set out in the report and developed a robust methodology for improving clinical effectiveness, reducing harm, improving outcomes and embedding and measuring quality. We have collected a large amount of information on the quality of the services we provide aligned to the Health and Care Quality Standards, with a focus on patient safety, clinical effectiveness and patient experience.

We have deliberately focused on learning and connecting that learning into tangible improvements ensuring that we listen to our patients, their families and our communities drawing in a deep understanding of their experience to ensure that this becomes our moral compass for quality. Understanding the themes from the experience of our patients and their service users is critical to the quality management system delivery and therefore quality assurance but the value of individual stories is important to triangulate and understand whether improvements translate to real change. The experience of our staff is also of importance and how we listen to their experiences and understand how we can support them to continuously improve the quality of the care they provide, that safety concerns are responded to swiftly and decisively and that the experience of our patients and their families is improved.

We acknowledge the challenges faced by our healthcare system, including the ongoing pressures on our staff and resources. However, these challenges have only strengthened our resolve to innovate, collaborate, and adapt. Our dedicated teams have worked tirelessly to deliver services that meet the highest standards, and we are proud of the strides made in improving patient outcomes.

It was a year of challenge and change but, amidst this, we are proud that our culture for delivering high quality care and commitment to continuous improvement remains strong. This will be key to our ongoing work in 2024/25. As we look to the future, the Health Board remains focused on further improving the quality of care. We are committed to listening to our patients, supporting our staff, and working together with our partners to build a healthcare system that is resilient, responsive, and ready to meet the needs of our communities. Together, we will continue to work towards a healthier, more equitable future for all.



GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Quality Strategy Implementation Plan

PERSON CENTRED

SAFE

TIMELY

EFFECTIVE

EFFICIENT

EQUITABLE

Introduction

This implementation plan for the new Quality Strategy will be delivered throughout Aneurin Bevan University Health Board throughout 2023.

A key focus in the development of this Strategy is progressing on what we have already accomplished and building on existing structures throughout the organisation. Quality is embedded in our culture, and we are committed to continually improving. Delivering the highest quality healthcare to our local communities and putting Quality, Safety and Learning at the heart of everything we do. We have fantastic teams delivering safe, timely, effective, efficient, and person-centred care. Every day we hear positive stories about how they go above and beyond.

Our commitment to Care Aims Principles (integrated decision making) underpins our ambition to embed a person-centred approach to service provision. The Health Board will adopt, at scale, the 'Care Aims' model across multi-disciplinary teams by truly embedding 'what matters' principles, improving patient experience, voice, value, and choice. This will provide us with improved metrics for patience experience and evidence of feedback influencing service plans, delivery, and improvement.

Our Strategy and this implementation plan was developed in collaboration with a diverse group of people, ranging from healthcare partners to patients and colleagues, and we are grateful for the feedback and insights provided by everyone involved. This collaborative approach is critical to our journey of improvement. We are committed to delivering an open, learning organisation with a 'Just Culture'. We all have the same common goal of improving quality, and by working together, we can enable the organisation to accomplish much more.

This Implementation Plan for the Quality Strategy will be delivered over the next three years, we are in an excellent position to implement it.

We will continue to review the strategy and plan annually as we know this is a ten-year ambition to evolve and sustain its development by our teams. Ultimately, it is about people, and the measure of its success will be determined by the experiences of our patients and staff.

Our Quality Strategy Commitment

- Aneurin Bevan University Health Board will be a learning organisation where staff members work towards delivering high quality clinical care every day.
- We will strive to better understand our systems of care, build capability through an all teach/all learn philosophy, encourage innovation and engage patients, relatives, carers, staff and communities in improvement endeavours, whilst learning from mistakes.
- We will ensure that quality is embedded throughout the organisation creating a culture of openness and transparency where people are supported to raise concerns
- Our patients, relatives, carers, staff and communities will partner with us to achieve this vision.

Six Domains of Quality

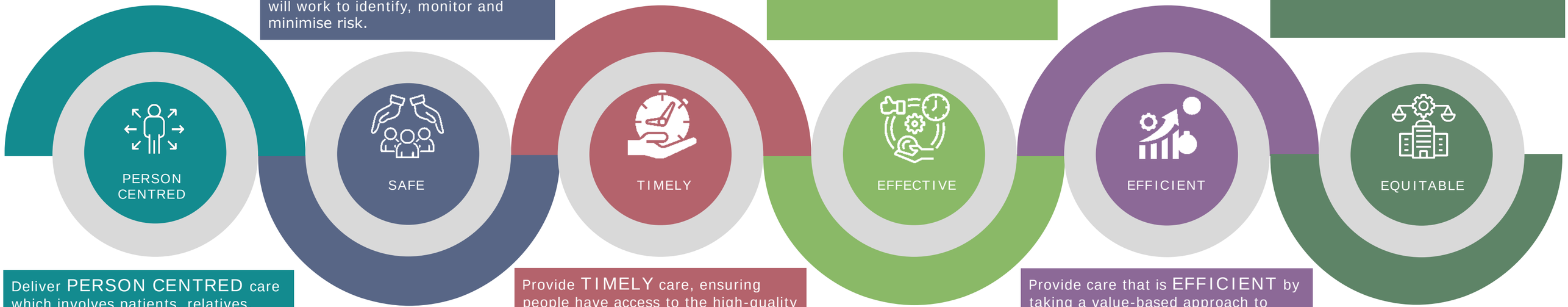
The Quality vision of Aneurin Bevan University Hospital Board (ABUHB) is to be "widely recognised for delivering safe, timely, effective, efficient, equitable and person-centred care." Our first and most important commitment to our patients is to keep them safe. Over the next three years, this Quality Strategy will improve the delivery within these six domains of quality, while continuing to improve patient and staff experience and outcomes.

The experiences of our patients, relatives, carers, staff and communities will continue to be the most important measure of our progress. It is the delivery of this Strategy, together with the supporting strategies of patient experience, risk management, clinical effectiveness and employee wellbeing to deliver high quality care, person centred and effective health and care services for our local population.

Provide SAFE care – we aim to reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information. Care will be delivered by capable and competent staff. Maximising the things that go right and learning from when things that go wrong to prevent reoccurrence. We will work to identify, monitor and minimise risk.

Provide EFFECTIVE care – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to Improve outcomes.

Provide EQUITABLE care, ensuring equal opportunities for individuals to attain their full potential for a healthy life which does not vary in quality and is non-discriminatory. We will embed equality and human rights and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.



Deliver PERSON CENTRED care which involves patients, relatives, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety. We care about the wellbeing of individuals, families, carers and staff, ensuring everyone is treated with compassion, kindness, dignity and respect.

Provide TIMELY care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We will care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.

Provide care that is EFFICIENT by taking a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We will make the most effective use of resources to achieve best value, doing only what is needed, ensuring any interventions represent the best value that will improve outcomes for people.

Deliverables - The goals of the implementation plan include:

1. **Enabling staff to improve quality**

The aim of the delivery plan is to enable staff to improve the services they for our patients and staff. This plan will ensure that we can answer the 'who', 'what', 'when', 'how', and 'why' we have focused on key projects and areas and how this will deliver our strategy. Improve patient and staff experience and embedding improvement into daily practice.

Collectively the measures and actions will help us to move forward towards the integration and sustainability aspirations for the Health Board. Ensuring we are putting quality and safety above all else, driving improvements in health and social care and leading to better outcomes that matter most to the people of Gwent.

2. Implement the Duty of Quality

The duty requires the Health Board to develop leadership and management systems with a view to securing improvement in the quality of services. Through continuous improvement of our services over time, ensuring that quality challenges are improved upon, we will report our learning through our annual quality report.

3. Meet the requirements of the Duty of Candour

This duty will support the Health Board when things go wrong in providing care or our services fail to meet expectations or the standards that they should.
Through this Duty, the Health Board must be honest in informing patients and their families when things do not go right. We will be obligated to find out what went wrong; and, to make sure the same mistake does not happen again.

A culture of openness, transparency and candour is widely associated with good quality care. This must encourage learning and be achieved without apportion of blame.

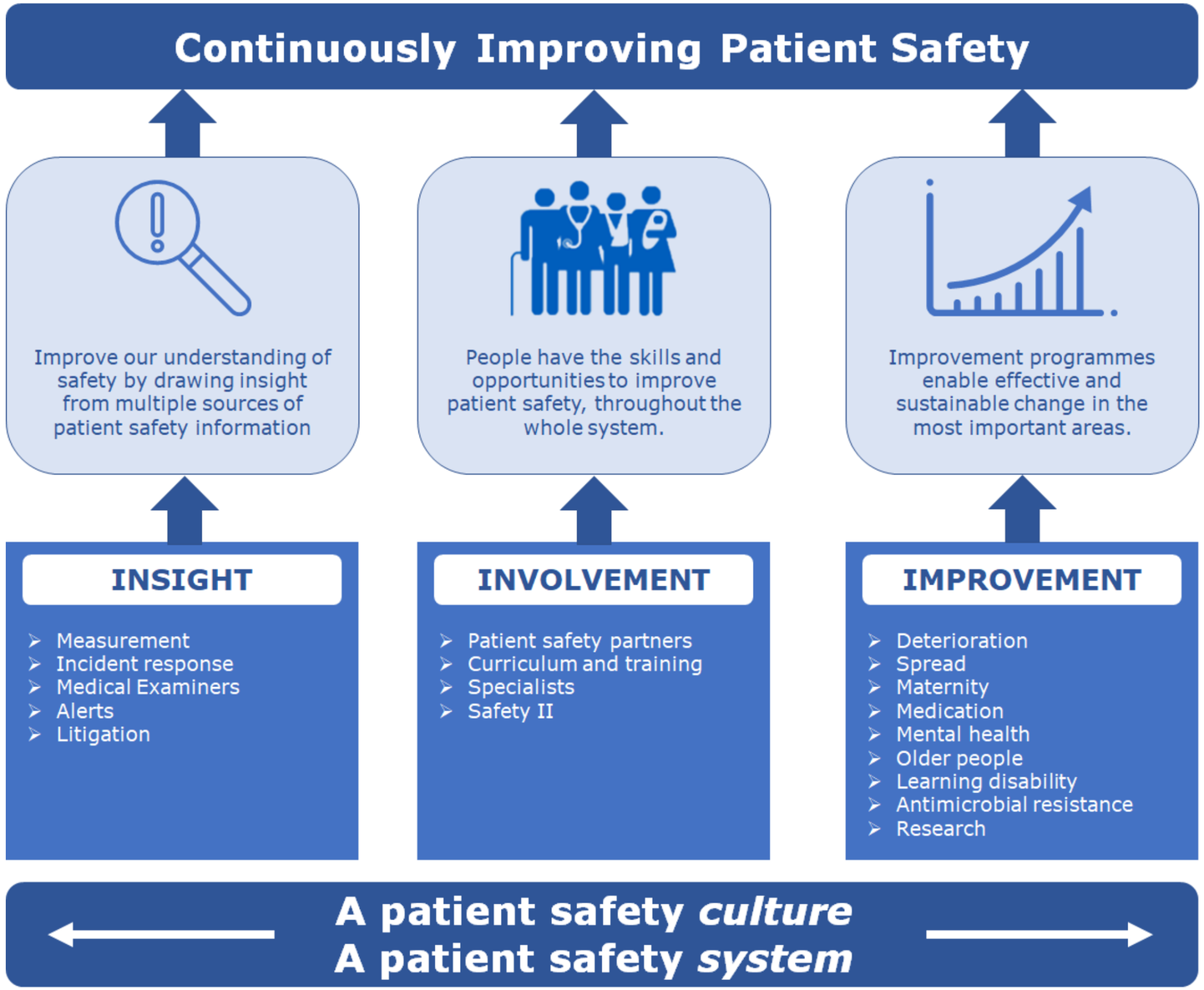
Quality Strategy Performance Monitoring

To successfully implement our Quality Strategy, the implementation plan will form a cohesive approach. This is grounded in a commitment to develop the underpinning foundations of quality through the six domains which can be mapped to our 'pillars of quality' programme.

This means that the way in which we report our quality performance is under development and will be periodically reviewed as a matter of course.

A Quality Outcomes Framework will be used and a report will cover all the performance indicators. This will be available through monthly summary data, more detailed quarterly data and insight, and annual performance review data.

These quality outcome indicators will be the foundations of our Quality Management System and transforming services which will assist in improving quality learning and reducing inequality and risk across the system.



Key objectives for the next year

Delivery of an approved strategy for Quality, Framework and Delivery Plan with a clear understanding of priorities.

Through the launch of the new system for patient experience and the Health and Well-being survey, put in place mechanisms to learn from the insight gained.

Establish a framework for learning and skills at all levels and the capacity and capability to grow and develop our skills and learning networks.

Deliver the Safe Care Partnership, Faculty workstreams and the outcomes as set by each team.

Agree and implement the measures and reporting structures.

Review the capability of our data capture systems for resilience and suitability.

Implement new systems to provide insight and support for delivery.

- Review our quality and safety structures and teams along with the reporting structures to ensure learning at every level and appropriate assurance and governance.

QUALITY PRIORITY 1: Deliver PERSON CENTRED care which involves patients, relatives, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety.

Objective	Actions for each Quarter for 2023				Delivering (so what)	Indicators
	Q1	Q2	Q3	Q4		
Patient and Staff Experience						
Launch a system to capture Patient Experience across the Health Board (CIVICA)	Launch the CIVICA system in Community Hospitals. Divisional awareness campaign commences. Training and user programme commences. Define measures	Generate and review first reports and insight	Define and redesign the questions if required	CIVICA available in all acute and community areas	Opportunities to receive direct patient feedback to inform learning	General experience rating of episode of care Increase in number of responses in Civica
To respond and learn from complaints	Review of resources and processes available to respond to complaints	Recommendations finalised for approval, and implementation complete by the end of the quarter. Reduction in complaints backlog	Reduction in complaints backlog	Backlog of complaints resolved	Timely feedback and response to concerns Opportunities to learn and focus improvement	Compliments - themes identified for improvement Reduction in the complaints backlog Qualitative feedback use of the learning section in Datix Increase in the number of actions plans completed
To listen to feedback from staff	Employee wellbeing survey undertaken by workforce	Results available from survey Capture ideas for improvement generated by staff	Analyse results	Themes for improvement You said, we did approach for ideas	Timely feedback to ideas for staff Enhance staff wellbeing	Triangulate staff experience with data
To ensure that the "Voice of the Child" and the principles of "Making Safeguarding Personal" are integral to safeguarding practices within the Health Board	• Develop key messages to be delivered via Safeguarding Level 3 Training	• Develop key messages to be delivered via Safeguarding Level 3 Training	• Develop mechanisms for feedback from patients on their experience of safeguarding processes	• Undertake case file audit to determine if principles are embedded in process and provide formal feedback to clinical teams	• Care is planned and delivered respecting the views of the individual	• Evidence of person centred care in safeguarding care plans

QUALITY PRIORITY 2: Provide SAFE care – we aim to reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information

Objective	Actions for each Quarter for 2023				**Delivering** (so what)	Measure
	Q1	Q2	Q3	Q4		
Theatre Quality and Safety Programme	Scope, define and design improvement role and objectives with QPS and Division	Advertise and appoint Define work programme to include: – Reducing never events – Building quality improvement capability – Human Factors in Safety programme – Safe Care Collaborative – Acute Workstream	Progress reporting commences		Dedicated time for improvement and accountability from within the Division	Reduction in the number of SI's, by harm category, National Reportable Incidents and Never Events
Implement Human Factors as a HB wide approach	Define programme of work and scope of the simulation programme	Schedule sessions and design of QI programme	Training and wider team engagement Reporting the QI action plan established	Publication of case studies	Training and simulation programme in place with improvement programme of work	Reduction in the number of SI's, by harm category, National Reportable Incidents and Never Events
To implement Datix as the main method of reporting	Awareness campaign to Divisions about the reporting requirements	Review of reports and incidents rolling action plan in place Review of informatics requirements	Implementation of informatics infrastructure as required	Include learning in the Annual Learning festival	The ability to report and highlight incidents to improve patient safety	Reduction in the number of SI's, by harm category, National Reportable Incidents and Never Events
Reporting – redesign the reports and implement an outcome framework	Scope and define the outcomes and measures Align with the Assurance Governance Framework	Approval at Exec and Board First report produced Realign the PQSOC reporting	Refine and design the report Implement the new reporting processes	Review and revise Action Plan as a result of learning from the indicators	Improved oversight governance and assurance to provide learning and insight to be able to make improvements	QOF Updated Board and PQSOC paper format
Review the QPS infrastructure to drive and spread improvement and learning	QPS resource being mapped within Divisions Working with HR to devise the OCP	Draft proposal Undertake OCP for staff with HR	Review structure and interdependencies with Divisions and QPS		An infrastructure designed for improvement	Standardised agenda for Divisions on Patients Safety, QUlaity and risk
To complete a Mortality Review to learn and identify improvement	Through morbidity and mortality reviews and findings from the Medical Examiner Mortality Reviews Mortality framework being developed	Action Plan and reporting in place Validate mortality measures Work collaboratively with All Wales Mortality group and NHS Exec to define measures	Devise a report for Board and Divisions on mortality data Drill into CHKS data for improvements and deteriorating data	Refine mortality report and measures	Identification and learning opportunities used to focus improvements	RAMI Crude mortality rare
Pressure Ulcers Improvement Programme		Revisit and refresh the learning from the collaborative Redesign the information extracted from Datix	Datix learning report established		Improvement in the numbers of HA pressure ulcers and a reduction in harm.	Decrease in the number of HA pressure ulcers by grade Decrease in the number of HA pressure ulcers Decrease in the severity of medicines incidents Decrease in the number of incidents under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
Falls Improvement Programme	Embed the multifactorial risk assessment Falls prevention training Falls review panel in place	From the Fall Review Pannel, Themes identified to inform an improvement action plan Review the Community Falls action plan and revise and update improvement action plan	Hold a learning and design event for Community and Inpatient falls		Reduced risk and prevalence of falls Prevention of risk for those vulnerable to fall	Decrease in the number of falls treated in ED which have had a previous admission – reattendance Improvement in the severity of harm following a fall in hospital Decrease in the number of Falls by 10,000 occupied IP Bed days

QUALITY PRIORITY 3: Provide TIMELY care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place first time

Objective	Actions for each Quarter for 2023				Delivering (so what)	Indicators
	Q1	Q2	Q3	Q4		
Discharge Programme Board programme	• Delivery of Move it May campaign. • Visit to Swansea to view Signal IT system • Short term digital solution – design and analysis	• Away Day RGH Hub • Trusted Assessor workshop • Short term digital solution – development • Prepare operational process for capturing D2RA/Red to Green • Roll out of Nurse Led Discharge	• Short term digital solution – development • Continue to prepare operational process for D2RA/Red to Green • Implement Trusted Assessor model • Full role out of Optimising Patient Flow Framework	• Implement Trusted Assessor model • Short term digital solution – test and run • Continue to develop and review the RGH Discharge Hub	• Optimal hospital care and discharge practice at the point of admission • A Home First approach to reduce re-admission	• Reduce time from surgery to discharge • Reduce Time spent on a waiting list • Reduction of handovers >1 hour • Reduction in time for patients to be seen by first clinician • Reduction in time for bed allocation from request • Decrease in ED waits >12hrs • Increase in discharges before midday; • Decrease in LoS OVER 21 DAYS • Time from Flow Centre call to discharge/ admission from assessment? • Number of emergency admissions in hospital over 7 days • Decrease in the time from request to step up/down to a different site • Decrease Overnight bed moves and patient transfers
Support individuals to stay at home or close to home	• Pilot for extended hours • Start OCP	• Conclude OCP • Publish navigable pathway for ambulatory care offer • Produce strategy and action plan for Community Hospitals	• Service transition to extended hours • Develop the professional hub • Changes to ambulatory care model	• Continuation of existing workstreams • Commence Phase 2	• To support individuals to stay at home or close to home, where this is both safe and appropriate. To support all health care professionals to engage with what is right for individuals, first time.	
Improve Ambulance handovers	• Review Q4 APP pilot and whether permanent roll out beneficial or justifiable • Implement outcome of PRU winter service activity • Complete recruitment process and on-board remaining therapy practitioners, OT and Physio • Identify and recruit Care of the elderly (COTE) locum for duration of the pilot	• System wide engagement on risk stratification and subsequent effect of regular patient flow from ED utilizing eLGH and community sites • Recruitment of locum resilience to enable Frailty assessment • Feasibility assessment of GP resilience to eLGH and GUH front door, possibly utilizing SDEC space	• Procure e-Triage solution and focus on the long lead time aspect (relating to technical integration with Welsh Patient Administration System (WPAS)) • Agree mechanism to be used (i.e. CWS watchlist) and risk management approach for a pilot of a new ED referral process	• Utilize lessons learned from Same Day Emergency Care (SDEC), Integrated Assessment Centre (IAC) and early e-Triage experience to shape new ways of working • Continuous Data and PREM Review	• Maximising and individuals time and outcomes and improving system safety	
Improved Cancer outcomes	• Programme priorities agreed • Programme structure agreed	• Prehabilitation Business Case • Establishment of NHH working groups	• WG approval of NHH Cancer Centre • Patient Group initiated	• Acute Oncology Regional model rolled out • ABUHB Cancer 'Blueprint' agreed	• Maximising cancer outcomes	• Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion • Increase in 5 year cancer survival rates
Timely completion of Duty to Report	• Meet with Local Authorities to understand the prevalence of delayed referrals	• Work with clinical teams to understand the barriers to timely referral	• Review of pathways for referral with Safeguarding committee and Partnership Boards	• Update clinical teams with changes to referral process to strengthen practice	• Referrals will be made via the appropriate route in a timely way, to ensure appropriate and suitable responses	• Reduction in complaints from local authorities in regard of delay in reporting

QUALITY PRIORITY 4: Provide EFFECTIVE care – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to Improve outcome

Objective	Actions for each Quarter for 2023				**Delivering** (So what)	**Indicators**
	Q1	Q2	Q3	Q4		
Increased Get It Right First Time (GIRFT) implementation by area		• Establish a reporting mechanism with Ops to track the progress and implementation			• Clear programme by specialty designed to improve the treatment and care of patients	• Increased Get It Right First Time (GIRFT) implementation actions by area • Number of INNUS's being completed
Implement robust Audit **processes and plans**	• Develop action plan and agreed forward work plan for audit • Implement AMAT as a reporting and analysis tool	• Compliance with the audit plan	• Compliance with the audit plan	• Compliance with the audit plan	• Reduced variation in Care • Increased understanding of variation to focus Improvements	• Increase in the SMART action plans with accountability in National Clinical Audit • Increase in the numbers of wards participating in accreditation (Audits via AMaT) • Increase in the actionable audit recommendations by National Clinical Audits
Implement Duty of Candor reporting	• Awareness campaign to Divisions about the reporting requirements	• Review the DoC reports and effectiveness of the process	• Compliance with DoC audit requirements	• Compliance with DoC audit requirements	• Increased understanding of variation to focus Improvements	• Implement Duty of Candour reporting • Compliance the number of incidents triggering Duty of Candour within 5 days
Ward accreditation	• Test the ward accreditation programme	• Increase in the numbers of wards participating in accreditation	• Reporting against the implementation of the accreditation	• Roll out to clinical areas	• Reduced variation in Care • Increased understanding of variation to focus Improvements	• Audit report available via AMaT to include quality measures and organisational measures
Safe Care Collaborative (also Safe Care)	• Driver diagrams completed for teams • Leadership work plan agreed • Training programme agreed	• Charter complete • Attend action calls and learning session • Monthly reporting • Measurement of progress • Project score	• Leaders for Safety Improvement starting training programme • Safety Coaches starting coaching training		• Reduced variation in Care • Increased understanding of variation to focus Improvements	
Implement a Quality Training Programme to drive and spread improvement	• Define and share the programmes available.	• Safety Coaches starting coaching training	• Implement a Quality Training Programme to drive and spread improvement • Leaders for Safety Improvement starting training programme	• Define and share the programmes available.	• Leadership and skills at all levels and part of what we do to embed our QMS and culture of continuous improvement	• Implement a Quality Training Programme to drive and spread improvement
Medicine Management	• Validate incidents via Datix • Implement medicines safety strategy	• Track progress with medicines safety strategy	• Track progress with medicines safety strategy	• Track progress with medicines safety strategy	• Reporting and action plan via Medicines Safety Group	• Delivery of objectives set medicines safety strategy

QUALITY PRIORITY 5: Provide care that is EFFICIENT by taking a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste

Objective	Actions for each Quarter for 2023				**Delivering** (so what)	**Measure**
	Q1	Q2	Q3	Q4		
Datix infrastructure	• Review resources and infrastructure for Datix management and reporting	• Establish reporting processes • Datix awareness and use training	• Datix awareness and use training	• Datix awareness and use training	• Patient experiences are visible and acted on	• Qualitative feedback use of the learning section in Datix • Increase in the number of actions plans completed
Falls (also an Objective under Safe)	Embed the multifactorial risk assessment Falls prevention training Falls review panel in place	From the Fall Review Pannel, Themes identified to inform an improvement action plan Review the Community Falls action plan and revise and update improvement action plan	Hold a learning and design event for Community and Inpatient falls		Reduced risk and prevalence of falls Prevention of risk for those vulnerable to fall	Decrease in the number of falls treated in ED which have had a previous admission – reattendance Improvement in the severity of harm following a fall in hospital Decrease in the number of Falls by 10,000 occupied IP Bed days
Maximising capacity and resources in outpatients	• As part of the Outpatient Transformation programme, improvement programme targeting DNA's commences 23/24 actions	• Continue Implementation of Did not attend (DNA) action Plan. 5% target. Plan also linked in with Cancer Services DNA improvement plans	• Continue Implementation of Did not attend (DNA) action Plan. 5% target. Plan also linked in with Cancer Services DNA improvement plans	• Review sustained DNA improvements a nd success of the interventions	• Improved utilisation of capacity reducing waste and access to care	• Decrease in the DNA's and CNA'S

QUALITY PRIORITY 6: Provide EQUITABLE care, ensuring equal opportunities for individuals to attain their full potential for a **healthy life which does not vary in quality and is non-discriminatory.**

Objective	Actions for each Quarter for 2023				**Delivering** (so what)	**Measure**
	Q1	Q2	Q3	Q4		
Improve care at the end of life	• Completion of the mortality review	• Learning and theme action plan agreed • Meet compliance of issuing of Medical Certificates within 5 days	• Meet compliance of issuing of Medical Certificates within 5 days	• Meet compliance of issuing of Medical Certificates within 5 days	• Improving quality at the end of life for people and families	• Decrease in the % of hospital as a place of death • Increase in compliance of issuing of Medical Certificates within 5 days
Safeguarding resources and processes	• Review of resources and processes for reporting, staff and patients • Review of training available to different staff groups within the Health Board	• Actions from reviews communicated and action plan development with Operations, Workforce and OD and leadership teams • Develop and mandate safeguarding training in line with All Wales Guidance. • Develop a model of safeguarding supervision for Adult Safeguarding	• Delivery of Safeguarding Training • Role out of Safeguarding Supervision in targeted teams	• Formal evaluation of Safeguarding Training continued delivery • Evaluation of safeguarding supervision • Roll out of additional safeguarding supervision • Continued delivery of Safeguarding Training	• Improving quality of life and equitable access • Timely response to concerns • People and staff able to raise concerns to prevent as well as address • Staff will better understand their role and duty in the safeguarding of children and adults. • Staff will feel supported to support and manage the care of patients who require safeguarding	• Increase in the access to Safeguarding Training • Timely closure of Safeguarding incidents • Appropriate responses irrespective of where the patient presents
Violence and aggression incidents	• Review and analyse V&A incidents • Return to face-to-face Management of Violence & Aggression training	• Review and update the ABUHB Violence & Aggression Policy and develop supporting procedures & protocols, including the internal sanctions procedure	• Launch Violence & Aggression campaign across the Health Board	• Conduct staff survey relating to violence and aggression incidents • Continued delivery of Management of Violence & Aggression Training	• Improving staff experience	• Decrease in the incidents of violence and aggression towards staff

Next Steps

- Establish limitations with reporting of the data and quality limitations.
- Increase validity of the data.
- Develop PQSOC work planner for when reports will be presented to PQSOC.
- Devise timeline will be produced for when reports will need to be submitted to the Committee and details of what reports are expected from each of the Groups.
- Reports that are not part of the quality operating framework will be on a rolling agenda from the Groups to provide narrative of outputs and delivery.

Progress on our 2023/24 priorities

As part of the implementation plan for the Quality Strategy the Health Board set a number of objectives aligned to the Health and Care Quality Standards. These were aligned to each of the domains of quality. There were a number of actions set throughout the first year as SMART objectives achieved by each quarter.

The implementation plan can be found here, and shows our commitments to the Health and Care Quality Standards. This report presents some of the highlights of the operational work programmes that have been delivered throughout 2023.24.

Our PERSON-CENTRED Commitments

To ensure that our patients, their families, and carers receive an experience that not only meets but exceeds their expectations. To improve patient experience in our hospitals and wherever they access healthcare. To increase patient, public and staff involvement.

Launch a system to capture Patient Experience across the Health Board

The Health Board has written and implemented a Patient Experience and Involvement Strategy.
Aneurin Bevan University Health Board launched the CIVICA Citizen Experience platform in February 2023 to capture patient feedback via QR codes.
Feedback is anonymous, allowing analysis down to the ward/team/department level.
A Person-Centered Care Survey was introduced to support quality strategies, providing benchmarks for patient care.
Feedback is reported to the Quality and Patient Safety Operational Group quarterly.
A Patient Advice and Liaison Service (PALS) was introduced in November 2023, with data reported to the same group.

To respond and learn from complaints

In 2023/24, the Health Board made significant strides in managing patient concerns, receiving 1,596 formal complaints and resolving an additional 1,555 through early resolution. Efforts are ongoing to meet the Welsh

Government's target of 75% compliance with 30-day response timeframes, while ensuring the quality of investigations and responses.

Key initiatives included:

Review and Engagement: Active participation in the review of the Putting Things Right (PTR) Regulations, currently under public consultation, to ensure preparedness for any new guidelines.
Patient-Centered Approach: Full implementation of the Patient Advice & Liaison Service (PALS) in November 2023, which focuses on early resolution of concerns through a single point of contact.
Planned Enhancements: Introduction of an "Acknowledgement Team" to ensure timely, meaningful engagement with those raising concerns, and the development of Communication Standards to maintain consistency across concerns teams.
Process Improvement: Weekly assurance meetings to address investigation bottlenecks and improve compliance with PTR regulations.

The Health Board continues to work closely with external partners and remains committed to learning and improvement. Common complaint themes in 2023/24 included clinical treatment, assessment issues, appointment delays, and communication problems, particularly in relation to waiting times—a lingering effect of the COVID-19 pandemic.

Our SAFE Commitments

Provide Safe care - Reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information.

To implement Datix as the main method of reporting

The Incident Reporting module of Datix Cymru was implemented within the Health Board in December 2021. Using Datix as the main method of reporting has highlighted the need for better incident management, the need for increased resources, and improved processes. This will ensure comprehensive closure and follow-up on reported incidents, ultimately aiming to enhance patient and staff safety.

From December 2021 to 31 March 2024, 70,645 incidents were reported, with 95.75% of them closed.

Incidents:

- 76.6% of these incidents were reported as No or Low Harm.
- 2,905 incidents remain open as of March 2024.
- 72% of these open incidents are coded as No or Low Harm.

- 71.3% are classified as patient safety incidents, with the top three types being pressure damage, slip/trip/fall, and medication-related incidents.
- 383 incidents affecting staff remain open.

Datix Team Resources:

- Aneurin Bevan UHB's Datix Team is significantly under-resourced compared to other NHS Wales organizations.
- The Health Board's current team consists of 0.8 WTE compared to the NHS Wales average resource is 3.9 WTE.
- A business case is being developed to increase resources for the Datix Team.

Recommendations ending 2023/24

- Review of 4,144 closed incidents with no conclusion data.
- Rapid review of 1,157 open incidents without a 'Managers Interim Harm Assessment'.
- Develop plans to close the 2,905 open incidents.
- Implement sustainable incident management processes.
- Progress a business case to enhance Datix Team resources through the Pre-Investment Panel (PIP).

Reporting – redesign the reports and implement an outcome framework

The Health and Care Quality Standards guide healthcare planning, delivery, and monitoring. Over the past year, Aneurin Bevan University Health Board developed a Quality Outcomes Framework (QOF), aligned with the quality domains and enablers. This framework establishes indicators for care, outcomes, safety, patient experience, and efficiency, aiming for continuous improvement. Key objectives include identifying improvement areas, standardising practices, enhancing patient satisfaction, and ensuring regulatory compliance.

The QOF has been key to the development of our approach to a 'Quality Management System'. It fosters a culture of learning, accountability, and transparency, setting and monitoring performance targets to maintain high care standards. The framework integrates patient experiences and data to provide comprehensive quality insights, promoting a person-centered approach and collaborative service development. This has been continually refined throughout our first year. The end of year report can be found here.

Review the QPS infrastructure to drive and spread improvement and learning

In 2024, the Health Board achieved significant milestones in enhancing quality, patient safety, and shared learning:

Centralisation of Teams: The Quality Patient Safety (QPS), Putting Things Right (PTR), and Quality Improvement (QI) teams were centralised, leading to improved knowledge retention, consistency, and effective triangulation of complaints and incident processes. This centralisation supports a culture of shared learning and person-centred care.

Team Building and Workplan Alignment: The QPS leads embarked on a Team Building Programme to enhance team performance. A QPS workplan was also developed, aligned with the Health Board's Quality Strategy and Priorities, ensuring focused delivery on key objectives.

Training and Education Initiatives: A comprehensive suite of training specific to complaints and incident investigation is being developed. Collaborations with Welsh Risk Pool colleagues and the Public Services Ombudsman for Wales (PSOW) are underway to create accessible video training and bespoke patient safety incident training.

Patient Engagement and Involvement: Progress continues on the Patient Engagement and Involvement Strategy, with ongoing efforts in patient participation panels and evaluations of the Patient Advice & Liaison Service (PALS) and bereavement services.

Process Improvement: The Patient Safety Incident team is refining incident management processes to ensure timely, high-quality, and person-centred responses. The Health Board is also developing a Quality Management System and refining its Quality Outcomes Framework in collaboration with data and digital teams to support continuous, automated reporting.

Quality and Accountability Frameworks: Collaborative efforts with divisional and central teams are focused on developing a QPS Accountability Framework and a Commissioning Assurance Framework (CAF).

These initiatives reflect the Health Board's commitment to enhancing quality, safety, and patient experience across all services.

Pressure Ulcers Improvement Programme

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.

Pressure Ulcer Faculty 2023 launched, led by Nursing Directorate and Senior Nurses with ABCi support, with a focus on reducing HAPUs to meet Welsh Government's 0% avoidable HAPU standard.

Faculty Aim:

Reduce HAPU incidences by 25% within 4 months.
Eradicate grade 3 & 4 avoidable HAPUs within 4 months.

Progress and Actions 2023/24:

Noted downward trend from January to April 2024.
Develop pre-recorded PowerPoint for teaching.
Use PANDO app for timely wound review and treatment.
Implement PDSA cycles for testing changes across all sites.
Share resources via SharePoint and developed posters across divisions.
Updated driver diagram.
Commenced Pressure Ulcer Pilot in February 2024.
Evaluate collected data at April meeting for signs of improvement.

Falls Improvement Programme

Key Achievements:

Data Improvement: Enhanced availability and analysis of falls data across the Health Board have informed key quality improvement initiatives, leading to better monitoring and reduction of falls.

SWARM Methodology Implementation: Rolled out in April 2023 within the Medicine Division, this multi-disciplinary team (MDT) approach is being expanded across the wards.

Digital Integration: Successful rollout of the Welsh Nursing Care Record Multi-Factorial Risk Assessment (MFRA) to wards, with completion anticipated in October 2024. Additionally, a modified MFRA has been developed for use in Emergency Departments.

National Contributions: Contributed to the development of the Falls National Head Injuries pathway and the National Inpatient Falls Network’s work on sensor use, setting a national standard.

Ward Accreditation: Falls prevention and management have been incorporated into the ward accreditation initiative, further embedding these practices into daily routines.

Falls Awareness: A highly successful Falls Awareness Week in 2023 saw significant patient and staff engagement across the Health Board.

RIDDOR Compliance: Established a Standard Operating Procedure (SOP) and developed a compliance dashboard within the Datix system to improve reporting and monitoring.

Training: Continued delivery of falls prevention and management training, adapted for the digital format of the Welsh Nursing Care Record.

Key Challenges:

Consistency in Practice: Ensuring consistent application of the SWARM methodology and MFRA across all wards and specialties remains a challenge.

Data Utilization: While data availability has improved, fully leveraging this data to drive sustained reductions in fall rates and severity of harm requires ongoing effort.

Staff Engagement: Maintaining high levels of staff engagement in falls prevention initiatives, especially in the face of evolving clinical environments and pressures, is a continuing challenge.

Technological Integration: The successful digital integration of falls management tools like MFRA needs continuous support to ensure all staff are proficient and the tools are used effectively.

Resource Allocation: Ensuring that adequate resources, including appropriate flat lifting equipment and trained personnel, are available across all units to effectively manage falls.

RIDDOR Reporting: Despite progress, achieving full compliance with RIDDOR reporting protocols across the Health Board requires ongoing monitoring and training efforts.

These achievements and challenges reflect the Health Board's commitment to reducing falls and improving patient safety across its facilities. The next steps focus on building upon these successes through enhanced training, data utilization, and multi-disciplinary collaboration.

Our TIMELY Commitments

People have timely access to care when they need it. Reducing waits and sometimes harmful delays for both those who receive and those who give care.

Discharge Programme Board Programme

The Discharge Programme Board has taken significant strides to improve patient discharge processes, focusing on enabling individuals to stay at home or close to home. Key achievements include:

Training and Protocols: Refreshed Optimising Hospital Flow Framework training and a ratified Nurse-Led Discharge protocol are being implemented.

Initiatives: The "Move it May" campaign was successfully delivered, with ongoing work to support hospital flow.

Team Development: The Hospital to Home (H2H) team is fully operational in Monmouthshire and Newport, with the programme now under evaluation.

Facility Upgrades: The RGH Discharge Lounge is complete and operational, and NHH Discharge Lounge is running under a new pull model. Planning for a new GUH Discharge Lounge is underway.

Digital Solutions: The CWS2 (D2RA) digital solution was piloted across three wards, with wider rollout expected post-resolution of technical issues.

Strategic Workshops: Future Flow Design workshops identified key areas for improvement in bed allocation and workforce models.

The upcoming plan for 2024/25 emphasizes:

H2H Program Expansion: Building on the 2023 pilot, this initiative aims to reduce acute care stays by transitioning patients to home care more efficiently, with an average pathway duration of 26 days.

System Reconfiguration: Focus on optimizing care delivery at St. Woolos Hospital and improving timely discharge through Patient Safety Team events and bed plan implementation.

Performance Goals: Reducing Delayed Transfers of Care (DTOCs), improving ambulance handover times, and speeding up ED clinician assessments.

These initiatives are aligned with the goal of enhancing patient flow, reducing hospital stays, and improving overall care quality.

Support individuals to stay at home or close to home

Further work throughout 2023/24 has ensured the Health Board aimed to provide proactive support, enhance community-based care, and ensure individuals can stay well at home or close to home. These include:

Community Resource Teams (CRTs): CRTs work across health and social care to support individuals in their homes. The development and expansion of CRTs will be a key focus, aiming to provide greater service consistency and equity across boroughs. This includes additional support for Acute Front Door services to identify and treat those at risk of avoidable admission, thus ensuring seamless care and avoiding duplication.

Dementia Support: this includes Memory Assessment Services: Strengthening these services with additional consultant capacity, advanced nurse practitioners, audiology, and memory rehabilitation to ensure early recognition and holistic support for individuals with dementia.

Frailty Programme: The report highlights the transformation of services for older adults through the Frailty Programme. This includes proactive recognition of individuals at or near crisis and the development of Acute Frailty Response services to increase Healthy Days at Home

Neighbourhood Care Networks (NCNs): These networks support the coordination of health and care services within specific geographic areas. They focus on delivering a wider range of services closer to home, improving equity of service provision, and supporting sustainable services and workforce.

Improve Ambulance handovers

Progress has been made in reducing ambulance handover delays at the Emergency Department (ED). Previously, around 860 patients per month faced delays over 60 minutes. However, through focused efforts, these delays have significantly decreased from 1,497 cases reported in March 2023.

Key Initiatives:

APP Role Review: The Q4 APP pilot at GUH did not significantly reduce patient conveyance to the ED. The clinician grade in the Flow Centre will continue to be monitored as options are considered for various access points into Health Board services (e.g., Flow Centre, GP OOH, Frailty, SPA).

Frailty Pathway: A trial with a Frailty Consultant in the Flow Centre has been undertaken, and will end in 13 June 2024, and its impact on the frailty pathway is under ongoing evaluation within the Six Goals E&U Programme.

Falls Pathway: A revised falls pathway, implemented on 23 December 2023, has better distributed activity across eLGH sites for patients not meeting GUH falls criteria.

PRU Activity Review: A cost-benefit analysis (CBA) of PRU activities has been conducted and is awaiting review at a future Executive meeting. WAST will continue PRU support as agreed until 30 September 2024.

These improvements highlight the ongoing efforts to optimise patient care and service efficiency within the Health Board.

Improved Cancer outcomes

From 2019/20 to 2023/24, there was a 34% increase in suspected cancer referrals, impacting diagnostic capacity. Despite increased referrals, the cancer conversion rate has not significantly increased, indicating a consistent identification rate despite higher scrutiny. The backlog of patients waiting over 62 days has been consistently high, although there was a slight reduction in percentage terms from 2019/20 to 2023/24. The overall goal is to enhance patient outcomes through more efficient pathways, better patient preparation and support, and targeted training and community engagement initiatives.

Quality Initiatives for 2023/24 included:

Getting Ready for Treatment Initiative: Focuses on preparing patients for treatment through early engagement and resources, improving patient understanding and emotional readiness.

Cancer Cafes: Provide emotional support through peer interaction, showing positive feedback and participation from patients and carers.

Community Cancer Champions: Training for skin cancer awareness targeted at hairdressers, beauticians, and nursery schools, with high engagement from the sector.

Improvement Initiatives: Various initiatives are being undertaken to improve planned care pathways, which likely include cancer treatment pathways. These efforts include deep dives into key specialties and an all-Wales workshop to share best practices

Workshops and Planning: Teams have attended workshops to identify high-impact opportunities for improving planned care, which includes cancer care. This involves assessing current demand, capacity plans, and addressing gaps in both backlog and underlying capacity.

There is a structured timeline to finalise plans and trajectories, including feedback and testing with board members, aimed at enhancing the efficiency and effectiveness of care delivery, potentially improving cancer outcomes.

Timely completion of Duty to Report

An upcoming audit aims to assess the timeliness of duty to report entries within the Wales Safeguarding procedures. Although most reports are submitted within the expected timeframe, concerns have been raised by partners about delays in some cases. The audit will focus on determining how widespread these delays are and understanding the reasons behind them.

The introduction of the national Safeguarding Datix Module will be a key tool in this effort, as it will enable the tracking of the time elapsed between incidents and the submission of reports. This data should help identify specific areas where delays are occurring, allowing for a more focused improvement plan to address the issues and enhance the overall safeguarding process.

Our EFFECTIVE Commitments

To deliver care that is effective, reliable, and based upon the best evidence available. To increase the proportion of patients who receive evidence-based care. To reduce variations in the quality of care. To identify and implement evidence-based best practice guidance. Deliver consistently effective and reliable care.

The following objectives have been added to the main body of the quality report:

Implement robust Audit processes and plans
Safe Care Collaborative
Implement Duty of Candour reporting

The Duty of Candour was implemented on 1 April 2023 under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. This mandate requires all NHS bodies to report, manage, and investigate notifiable adverse patient safety events openly and promptly. It applies when a

patient experiences, or could experience, more than minimal harm during NHS-funded care, with healthcare provision potentially being a factor.

Key Actions and Progress:

Training: All staff have access to Duty of Candour training via the Health Board's electronic platform, with active encouragement to complete it.

Team Centralisation: The Quality, Patient Safety (QPS) teams were centralised in February 2024, with identified Duty of Candour leads working to embed the Act's requirements and ensure consistent training.

Reporting Tool: A Duty of Candour reporting tool is now integrated within the incident and complaint system for continuous monitoring and validation.

Ongoing Challenges and Next Steps:

Harm Categorisation: Initial challenges were faced in distinguishing between actual and healthcare-related harm in lower harm incidents. Ongoing education and support are improving understanding across the Health Board.

Future Focus: In 2024/25, efforts will focus on encouraging staff to complete training, running further sessions, using incident reports to identify improvement areas, and fostering a culture of continuous learning. Quarterly data will be reviewed in QPS meetings, and learning will be discussed at the Patient Quality and Safety Learning and Improvement Forum.

Ward accreditation

The Health Board has launched an accreditation pathway for all wards and teams, utilising the digital system (AMaT) to capture audit data and provide ward-to-board assurance. This system promotes continuous improvement in safety and patient experience through monthly audits. A dashboard allows for easy viewing and sharing of results with the public, staff, and patients.

Key Achievements:

Phased Rollout: Successfully piloted at Ysbyty Aneurin Bevan, with Phase 1 implemented across various wards and Phase 2 and 3 planned.

Structured Improvement: System supports continuous improvement, using audits based on six quality domains and five quality enablers.
Real-Time Data: Utilised AMaT platform for real-time audit results, with accreditation levels (Bronze, Silver, Gold, Platinum) based on 85% compliance.
Independent Validation: Accreditation compliance independently reviewed and validated.

Performance and Metrics:

Evidence-Based: Teams present evidence covering performance indicators, workforce metrics, clinical incidents, complaints, and feedback.
Visibility: Accreditation journey and audit results are displayed on Patient Safety Boards.

Challenges:

Audit Proforma Development: Time-consuming process with monthly updates causing delays.
Staff Support: Need for more support in completing action plans in AMaT.
Scheduling Conflicts: Work pressures impacting meeting schedules.

Goals for 2024/25:

Metrics and Standards: Establish meaningful, evidence-based metrics, balancing quantitative data with patient experiences.
Staff Engagement: Empower staff to lead improvements, overcoming resistance, and managing work constraints.
Sustaining Improvements: Maintain momentum with ongoing support, training, and real-time data monitoring.
Operational Needs: Recruitment of a Business/Data Analyst to enhance digital platform support and data analysis

Implement a Quality Training Programme to drive and spread improvement

ABCi Quality Improvement Skills Development Programme
Objective: Empower staff with the skills, time, and resources necessary for quality improvement.

Key Activities:

PocEd Measurement Course: Trains staff to use data for tracking improvement progress.
Basic QI Training: Over 230 staff trained in quality improvement principles.

Quality Coach Development: 17 QI coaches trained to support local continuous improvement.
Spread and Scale Initiative: Plans to train additional QI coaches over the next four years.
Online Resources: Development of tools like ABCi Charts and Problems to Solutions to support quality improvement efforts.

Challenges and Areas for Improvement:

Team Participation: Three teams withdrew from the Safe Care Collaborative due to service pressures.
LifeQI Implementation: The adoption of the LifeQI system for recording quality improvement has been slower than anticipated.

2024/25 Challenges:

Staff Time: Ongoing challenges with staff availability for quality improvement work.
Embedding Practices: Difficulty in integrating quality improvement into daily clinical and management routines.
Quality Management System: Need to build a system that balances quality improvement with quality control and planning.
Financial Constraints: Budget limitations affecting the scope of quality improvement efforts.

Medicine Management

Key Achievements 2023/24

Exception Reports: This was part of the Medication Safety Group (MSG) Initiatives: Implemented Exception Reports for Divisions to review medication safety incidents, identify trends, and share lessons learned. A collaborative culture was promoted and recognised successful initiatives, with MSG determining further actions like policy changes or education.

Time Critical Medication: A benchmarking exercise was progressed on all ten patient safety recommendations for Parkinson's disease time-critical medication. There was a campaign commitment with continued focus on improving timely administration and education. Training and Awareness was undertaken, included released "Time matters: It's critical" training video and service user posters to emphasize timely medication.

Thematic Reviews: Insulin Safety was a priority and included collaboration with the Diabetic Inpatient Care and Education (DICE) team for a thematic review, issued an Insulin Safety Bulletin, and promoted Insulin Safety Week. As part of anticoagulation safety, the Health Board conducted a thematic review for oral anticoagulant safety. This included updating policies, provided training, and enhanced patient counselling by upskilling pharmacy technicians.

Gabapentinoid Safety: An audit provided insights when conducted an audit on high prescribing practices, leading to ongoing targeted support. Resource development focused on creating a Gabapentinoid Prescribing Resource Pack and offered training sessions in collaboration with the Chronic Pain Group.

Yellow Card (YC) Scheme: There was improved reporting, by forming a cross-sector group, increasing Yellow Card reporting from Secondary Care. Improved reporting accessibility via QR codes and provided targeted training. Collaboration included working with YCC Wales to align national campaigns and celebrate milestones.

Medication Safety Week: A full programme for the week allowed awareness of this week and achieved high engagement during #MedSafetyWeek, focusing on opioid use, yellow card reporting, emergency medication, safe storage, and oxygen safety. An increased visibility of best practices was established as new Medication Safety Boards across wards were used to highlight best practices.

Key achievements for 2023/24:

Our EFFICIENT Commitments

Obtaining the greatest health benefit for our population from the right interventions using the available resources.

Highlights from the following objectives have already been discussed in the report:

- Datix infrastructure
- Falls (also an Objective under Safe)

Our EQUITABLE Commitments

Providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location and socio-economic status.

What we did...

- Safeguarding resources and processes

The Health Board is actively working on improving safeguarding training compliance and is effectively identifying and responding to safeguarding issues within the community. However, there are challenges related to staff availability for training and recording compliance in certain areas. Key points for 2023/24:

1. Training Requirements and Compliance Levels:
   - There is a national requirement for health board staff to undergo safeguarding training suitable for their roles.
   - Current compliance levels for five out of seven training areas are documented. ESR does not yet record compliance for Level 3 Child or Adult Safeguarding, and efforts are underway to address this.
   - There is a slow uptake in Level 3 face-to-face training due to staff availability, and some improvement is needed for Level 1 Safeguarding Adults and Ask and Act training to reach the 85% target.
   - This compliance issue has been escalated to Divisional Leadership Teams via the Safeguarding Committee.

2. Safeguarding Activity Data:
   - The data on safeguarding activities should be interpreted with caution when used as a quality improvement marker.
   - For 2023/24, a substantial number of safeguarding referrals were made or addressed by the ABUHB Safeguarding Team.
   - The volume of referrals is influenced by external factors beyond control, indicating potential increased harm, but also reflects the workforce's effectiveness in recognizing neglect and abuse.

Violence and aggression incidents

This summary highlights the Health Board's commitment to addressing violence and aggression through multi-agency collaboration, data-driven strategies, and proactive policy development and implementation.

Multi-Agency Risk Assessment Conference (MARAC)

Purpose: MARACs are meetings where information is shared on high-risk domestic abuse cases among various local agencies.
Participation: In Q4 2023/24, the Corporate Safeguarding Team attended 33 MARACs.
Impact: Contributed to safety plans for 432 domestic abuse survivors.
Trend: 87% increase in individuals discussed in MARAC.
Future Focus: Sustainability of MARAC, led by Gwent MARAC Steering Group and Gwent VAWDASV work.

Sexual Safety

Context: National report by Women's Rights Network on sexual assaults in hospital settings.

Incidents: 48 incidents reported from 1 August 2023 to 31 January 2024.

- Nature: Mostly inappropriate behaviour by patients towards staff, followed by patient-on-patient incidents, and two allegations against staff.
- Severity: No incidents resulted in physical harm or met the national definition of serious sexual assault.

Current Efforts:

- Developing a Chaperone Policy.
- Refreshing referral pathway to the Sexual Abuse Referral Centre (SARC).
- Creating an overarching sexual safety policy covering risk assessment, incident recording, and escalation.

Serious Violence

Legislation: The Serious Violence Duty 2022 mandates Health Boards to engage in regional strategy development for tackling serious violence.

Data Contribution: ABUHB provides a dataset to the Office of the Police and Crime Commissioner (OPCC) for strategic needs assessment and strategy development.

Funding and Initiatives:

- Funding for 2023/24 allocated to violence reduction in urgent care areas.
- Hiring a Violence Reduction Worker to engage in emergency areas and minor injury units.
- Focus on staff training, data collection improvement, and early intervention for individuals at risk of serious violence or organized crime/exploitation.

QUALITY ENABLERS

As part of the Heath and Care Quality Standards here are some highlights of the work undertaken on the Quality Enablers in 2023/24.

Throughout 2023/24, the Health Board has made collective efforts to enhance leadership capabilities, optimise workforce management, and foster a positive organisational culture that supports staff wellbeing and engagement through the People's Plan.

Leadership

The Health Board has made a commitment to Person-Centred Care: Emphasising that patients and families are equal partners in healthcare planning, development, and monitoring. There has been a Quality and Safety Pledge: Promoting a culture of openness, transparency, and continuous improvement, with staff encouraged to raise concerns and engage in quality improvement initiatives. Other progress in 2023/24 includes:

Leadership Development Programs:

- The Clinical Directors (CDx) and Directorate Managers (DMx) training programs continue to support leadership development, emphasizing collaborative, inclusive, and compassionate leadership skills. Over 300 colleagues have participated in bespoke leadership development programs tailored to their challenges.
- The Leading People Programme, now in its eighth cohort, has shown positive impacts on leadership confidence, self-awareness, and the ability to foster psychologically safe and compassionate cultures.

Raising Concerns and Speaking Up:

- The NHS Wales Speaking Up Safely Framework's self-assessment and action plan have been implemented, with initial engagement and awareness events held. An internal raising concerns email address and an external Employee Assistance Programme are being launched.

Occupational Health and Wellbeing:

- Initiatives like the Wellbeing Centre of Excellence and integrated psychological wellbeing practitioners aim to support staff health. The avoidable employee harm programme has significantly reduced investigations, sick days, and costs, promoting a culture of minimizing harm in HR processes.

Workforce

The Workforce Demographics of the Health Board are vast, employing 13,117 WTE (15,558 individuals), with an increase in clinical services and nursing staff. Efforts focus on reducing turnover and addressing the aging workforce, where 36% are over 50 years old. The Health Board recognises staff contributions and enhancing their experience through feedback and learning opportunities.

Workforce Sustainability and Planning:

- Actions include promoting Band 4 opportunities, creating promotional videos, and increasing training for Healthcare Support Workers (HCSWs) to transition into professional roles like registered nurses.
- The Clinical Futures Workforce Group has been re-established to align people management strategies with Health Board priorities. A workshop with local authorities helped outline key deliverables, which were reviewed by the Gwent Workforce Board.

Workforce Analytics and OptimiSation:

- A workforce establishment controls workstream is linking financial budgets with electronic staff records for better workforce planning and vacancy management. The rollout of systems like SafeCare and new medical e-systems supports this initiative.

Recruitment and Retention:

- Efforts have led to a reduction in turnover from 11.36% to 9.04%, decreased sickness from 6.9% to 6.2%, and successful international recruitment of 74 nurses. The time to hire has been reduced, meeting the national target of 70 days.
- Vacancy reductions include 100WTE HCSWs, 60WTE registered nurses, and 47WTE medical vacancies over 12 months. Variable pay has been reduced by approximately £18 million.

Culture

The Health Board is focused on learning from Experience: emphasising the importance of learning from patient and staff feedback to improve care quality and safety. There is a focus on ensuring a culture of Openness and Transparency, encouraging a culture where issues can be raised and addressed proactively, fostering a safe and supportive work environment. Supporting the work on culture:

Employee Wellbeing:

- The Wellbeing Centre of Excellence provides a supportive environment for staff, increasing capacity for clinical space. Psychological therapy services have seen a 20% increase in demand, with additional support secured to manage this.
- The avoidable employee harm program has been instrumental in reducing the negative impacts of employee investigations, contributing to a healthier culture.

Diversity and Inclusion:

- The Strategic Equality Plan was launched, focusing on equality, diversity, and inclusion over the next four years. There has been an increase in the translation of Welsh language materials and self-reported Welsh language competencies.

Engagement and Experience:

- The Leadership Development Program (LDP) is fully subscribed, indicating strong engagement. The coaching network and various learning masterclasses have been established to enhance leadership skills and team success.

Freedom to speak up

We are committed to fostering an open, learning organization with a 'Just Culture' that promotes safety through support and psychological safety. Our aim is to nurture quality and system safety, valuing people in a collaborative and inclusive workplace where they feel safe to raise concerns and try new approaches.

We encourage staff and patients to 'Speak up for Patient Safety,' raising awareness of escalation processes and early learning mechanisms. Our learning and improvement forum enables sharing of errors, near misses, and incidents.

Over the past year, our human factors development program has supported openness and transparency in patient safety incidents, using simulation sessions and debriefs for all involved staff. We ensure that staff involved in incidents receive support for reflective practice, embedding learning, and preventing recurrence.

Following the NHS Wales Speaking up Safely Framework, the Health Board conducted a self-assessment and developed an action plan for its implementation. An initial engagement event was held in October 2023, and a cross-organizational steering group was established in March 2024. Workforce & OD launched an internal email for raising concerns, transitioning to an external Employee Assistance Program and Speaking Up service by July 2024.

We are rolling out a ward and team accreditation process to ensure teams understand their quality and safety data, fostering ownership of learning and improvements for sustainable change. This cultural shift engages staff in quality improvement and supports them in raising concerns and receiving organizational backing for learning and improvement.

Information

The integration of digital, data, and technology into healthcare is pivotal for enhancing patient safety and quality. By focusing on real-time information, patient access to health data, Artificial Intelligence and health data analytics, the health board aims to improve service delivery and patient outcomes. Addressing challenges like digital inclusion and cybersecurity, and leveraging strategic initiatives, ensures a sustainable digital transformation that benefits both healthcare providers and patients.

Digital technology is integral to daily operations, improving accessibility and connectivity in healthcare. The demand for digital services is increasing, providing numerous opportunities to enhance healthcare processes and patient experiences.

Opportunities for Improvement

Real-Time Information: Electronic ward boards and data dashboards improve patient flow by providing real-time updates on patient and bed status.
Patient Access: Local and national applications empower patients with access to their health data, giving them control over their healthcare decisions.
Artificial Intelligence (AI): AI is being used in radiology, delivering tangible benefits in diagnosis and treatment.
Health Data Analytics: Advanced analytics offer insights into population health, guiding public health initiatives and helping citizens maintain their health at home.

Welsh Nursing Care Record (WNCR) Implementation:

Achievements: Significant progress in rolling out WNCR across most wards. High engagement and substantial digital documentation recorded.

Rolled out to 86% of wards, with all adult in-patient wards expected to be live by September 2024, including Critical Care Areas.
Over 34,000 assessments opened, with significant numbers recorded, such as 44,000 Falls assessments and 821,000 skin bundles.
Monthly user engagement around 3,700, resulting in 1,476,744 risk assessments and 3,724,000 in-patient notes recorded.
Introduction of additional digital documentation, such as Bowel Chart, Skin Inspection & Repositioning Chart, and Mouthcare risk assessment.
Upcoming Version 2.5 will include comprehensive IV catheter and urinary cannula bundles.

Areas for Improvement

Multi-Disciplinary Record Limitation: WNCR is not implemented as a multi-disciplinary record in high turnover areas like medical assessment units, leading to continued use of paper nursing notes. National challenges in standardizing and digitizing nursing documents result in dual record-keeping (digital and paper), impacting nursing efficiency.

Digital Access and Capability: Some nursing staff face challenges with digital systems due to lapsed Nadex accounts, unfamiliarity with laptops, and limited typing skills. Implementation required additional support and training, particularly for hard-to-reach staff, such as night shift workers.

Challenges for 2024/25

Expansion to Paediatric Settings: The move to paediatric settings is complex due to the multi-disciplinary nature of admission and assessment records, delaying full digital integration. Digital Health and Care Wales is pausing development for paediatrics while standardization continues.

New Functionality and Support: Regular updates (2-3 versions annually) will introduce new forms, requiring extensive training and support from nurse educators, specialist nurses, and other stakeholders.

Data Utilization: With the system operational, the focus will shift to leveraging available data for quality improvement initiatives. Development of tools to provide meaningful ward-level data to managers, identifying at-risk patients and compliance with patient assessments.

Learning, Improvement and Research

These have been included in the main body of the report.

- Listening and Learning
- Participation in clinical audit
- Quality improvement

Participation in clinical research

Key Achievements for 2023/24

Implementation of the 2022-2027 Research and Development Strategy

- Research Champions Scheme: Volunteers from staff and the public enrolled.

Leadership Appointment: Associate Medical Director for Research and Development appointed.
Non-Commercial Studies: 112 studies open and recruiting, with 1587 patients enrolled.
Welsh Government Key Indicator: 97% of studies recruiting to Time and Target compared to All Wales' 76%.
Commercial Trials: Increased from 7 (2022/23) to 16 (2023/24), with 52 patients recruited; additional trials in setup and awaiting approval.
Industry Partnerships: Established relationships with industry partners like Sanofi.
Haematology Research: Funded a full-time Band 6 Research Nurse, facilitating growth in commercial research.
Budget Autonomy: Regained control over the budget from HCRW due to high achievement in metrics.
Global Recruitment Achievement: Reached 10% of the global recruitment target for a commercial Haematology clinical trial involving Chronic Myeloid Leukaemia.
Quality Management: Established a Quality Management group and an Inspection Ready sub-group.

Areas for Improvement

Lung Cancer Study Sponsorship: Faced challenges and had to withdraw from the extension stage due to contractual complexities.
Staffing Issues: Vacancies and inexperienced staff affected timely processing of research projects.
Funding Limitations: Covid funding ended, limiting permanent staffing and research capacity.
Communication: Poor communication of service redesigns affected research continuity.
Accommodation Shortages: Lack of R&D accommodation at YYF and GUH sites hindered research delivery and oversight.

Challenges for 2024/25

Research Fellow: Employ to work with Principal Investigators to expand clinical trials.
Capacity Building: Increase research delivery team capacity to set up and oversee a commercial hub.
Promotional Materials: Develop a brochure to showcase clinical trials facilities for building commercial relationships.
Commercial Portfolio: Establish a phased commercial portfolio focusing on areas with existing expertise.
Sponsorship Role: Update documentation and establish a Sponsorship group for study oversight.
Commercial Trial Setup: Improve setup times for commercial trials.

IT Infrastructure: Review and enhance IT systems to support commercial activity and regulatory compliance.
Sustainable Commercial Research: Collaborate with HCRW/WG to develop a sustainable commercial research presence in Wales with UK Government VPAG funding.
Velindre Radiotherapy Unit: Ensure research opportunities for patients at the new unit.
R&D Committee: Re-establish to meet current departmental needs.

Whole Systems Approach

Integrated Care: Fostering collaboration across different care settings to ensure continuity and coordination of care, with a focus on holistic and person-centered approaches. The Health Board plans to coordinate and develop the Integrated Medium-Term Plan (IMTP) for an integrated planning group. Key Activities include:

Integration and Connectivity: Align short-term plans with long-term strategies. Ensure coordination across Divisions, Corporate Functions, and wider partnerships like Regional Partnership Board and Cluster Plans.

Bottom-Up Planning: Develop plans based on demand and capacity, grounded in Executive Team directives.

Alignment with Priorities: Ensure plans meet Ministerial and National Priorities.

Financial Management: Deliver plans within financial limits, articulating risks and consequences.

Community of Practice: Standardize planning approaches, share best practices, and promote consistent methodology.

Championing Planning: Embed planning principles across teams, acting as planning advocates within respective areas.

Issue Resolution: Provide guidance and mediate conflicts to maintain the plan's progress.

Population Health Management: Addressing broader health determinants through programs focused on prevention, early intervention, and comprehensive care models.

Agenda Item: 2.3

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:	PTR Annual Report 2023-2024
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Tracey Partridge-Wilson Deputy Director of Nursing Gemma Couch - Head of QPS, Learning and Improvement

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 Putting Things Right (PTR) Annual Report has been prepared in accordance with the PTR Regulations. The annual report demonstrates our ongoing commitment to the population of the Health Board, which covers Blaenau Gwent, Torfaen, Monmouthshire, Caerphilly, and Newport. This equates to around 600,000 children, young people and adults. It will provide an overview of the 2023/2024 position in terms of how Aneurin Bevan University Health Board (ABUHB) has managed concerns, Redress cases, Claims, Patient Safety Incidents, Duty of Candour and Public Services Ombudsman for Wales (PSOW) cases during this reporting period. It will provide information on progress, performance as well as an overview of emerging themes and trends, including lessons learnt and the subsequent vision for 2024/2025.

Cefndir / Background

The Report focuses on, and describes the successes and challenges related to 'Putting Things Right' during the reporting period. It will encompass, Complaints, Compliments, Redress, Patient Safety Incidents, and PSOW cases and duty of Candour all of which are underpinned by the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

During the reporting period, the Health Board has welcomed and fully embraced the introduction of the Health and Social Care Quality and Engagement) (Wales) Act and NHS Duty of Candour on 1 April 2023.

The provisions of the statutory Duty of Candour, is an organisational duty on all NHS bodies and primary care providers.

Concerns reporting, management and investigation is intertwined with the principles of being open: communicating with patients and their carers must adhere to the Duty of Candour, so in practice these activities should be fully integrated.

This Report was written with input from the Patient Experience and Involvement team, Legal Services, ABCi and QPS teams.

Assessment

The period 2023/24 has brought both opportunities and challenges.

During the reporting period, the Health Board has welcomed and fully embraced the introduction of the Health and Social Care Quality and Engagement) (Wales) Act and NHS Duty of Candour on 1 April 2023. In preparation for this transition the Health Board reviewed its management of incidents, systems and processes to align to the requirements of the Duty of Candour to minimise disruption to service user experience.

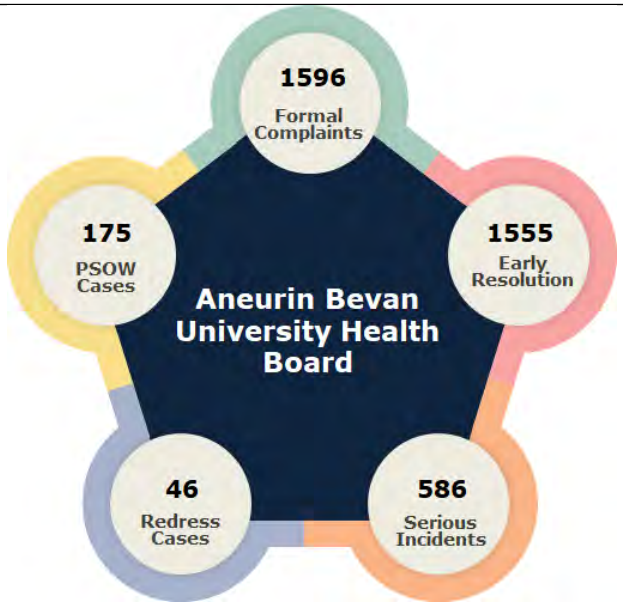
At the heart of the "Putting Things Right" (PTR) and Duty of Candour arrangements is the requirement to be open and honest when dealing with concerns. Most importantly to play a significant role in improving patient safety; endorse a person-centred approach to concerns management and reinforce a culture of organisational learning and quality. This is underpinned by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) 2011.

The Health Board is committed to making it easy for people to raise concerns, feel that they are being listened to, and that their concerns are being taken seriously.

An Organisational Change Process which brought together the Divisional and Nursing Directorate resources for Quality and Patient Safety concluded in February 2024 with the Quality Improvement team from ABCI joining in May 2024. The new model will ensure that Quality Patient Safety (QPS) , PTR and Quality Improvement (QI) services are joined up and are organised to deliver and achieve the vision which is articulated in Health and Social Care (Quality and Engagement) (Wales) Act 2020; ‘A Healthier Wales’ (Welsh Government, 2018) and more recently the ‘NHS Quality & Safety Framework’ ‘NHS Quality & Safety Framework’ Duty of Quality and Duty of Candour.

As a Health Board we aim to echo the NHS core values by putting Quality and Patient Safety first by providing high value evidence-based care for our communities at all times and delivering that in a Person-Centred approach

The Health Board position for the delivery of the PTR regulations in 2023/24 is as follows: -



Patient Experience: Complimentary to the PTR process the Patient Experience and Involvement team have supported clinical teams in meeting with patients or patients' relatives who would like to share their experiences following either incidents and or complaints.

Dedicated members of the Patient Experience and Involvement team meet with the person who has agreed to talk about their experiences to support listening and learning. The person agrees to the format of their 'story' and consents to their story being used either internally, externally or both. The person is not interviewed. Rather, they speak from the heart about an episode of care that has had the most significant impact on them, either positive or negative. The person is shown the film once it has been edited for their approval. The whole process gives them an opportunity to talk about what has happened and put structure to it in the format of a 'patient story', which can then be shared for learning and quality improvement.

The main themes from patient stories to date include:

Poor or inconsistent communication
Restricted visiting during COVID, particularly relatives not being with loved ones ate end of life
The need to better consider reasonable adjustments (neurodiversity and physical disabilities)
Concerns around dementia care
Positive story relating to rapid discharge

Some patients or carers who have shared their experiences are also invited to participate in involvement events such as the Bereavement Collaborative, People Participation Panels and the Dementia In-Patient Working Group. The involvement of patients and carers is increasing through listening and ongoing collaboration.

Formal complaints: During the reporting period, the Health Board has taken receipt of 1596 concerns which have been managed under the Putting Things Right Guidance, meaning that a formal investigation has been undertaken, the findings of which have been collated into a letter of response which is reviewed and signed by the CEO.

Early Resolution: In addition to concerns Managed Under the Putting Things Right guidelines, the Health Board is able to attempt to address concerns within 48 hours and these are considered as Early Resolution. This aims to bring concerns that are appropriate to a swift resolution for people without needing to await a formal investigation and response.

Serious Incidents: During the reporting period 586 incidents were deemed to meet the Serious Incident criteria whereby the incident requires investigation through either the Corporately led Patient Safety Investigation or a Divisionally led Patient Safety Investigation. Both of these processes follow the same structure, but are chaired by an executive chair or by a member of the divisional triumvirate respectively.

Redress Panel: Of the Redress Panels convened by the Health Board, 46 cases were prepared, heard and deliberated upon. Redress panels assess and determine concerns where potential failings and resulting patient harm have occurred. This is a high-level panel with quorate membership.

PSOW Cases: The Public Service's Ombudsman for Wales (PSOW) referred 175 cases to the Health Board for consideration during the reporting period. These encompass matters which are enquiries only, full investigations, anonymous queries and some cases where a full investigation is undertaken by the PSOW service.

Review of Priorities 2022/23

Priority 1: Introduction of the Health and Social Care (Quality & Engagement) (Wale) Act 2020 – (Duty of Candour)

As Duty of candour becomes law on 1 April 2023, the Health Board must:

- Ensure Health Staff have access to and undertake the All-Wales e-learning package.
- Assistant Director of Nursing to chair DoC Divisional leads meeting.
- Identification of key D of C leads within each division.
- Establish D of C dashboard on RLDatix
- Corporate Team oversight to support Divisional colleagues.

All staff now have access to the Duty of Candour training course via the Health Board's electronic training platform (ESR) and are being actively asked to complete this.

Following the centralisation of the QPS teams in February 2024, D of C leads have been identified and are working collaboratively as part of the wider QPS team to embed the core requirements of the Act and deliver consistent and robust training regarding implementation of the Duty of Candour.

A Duty of Candour dashboard has now been developed and is being utilised within the RL Datix system to support continuous monitoring and validation.

PSI team supporting divisional colleagues.

Priority 2: Remodelling of QPS structure across the organisation

Executive Director of Nursing to undertake review of QPS processes in conjunction with Divisional and Corporate colleagues.

The QPS and Complaints Team centralised in February 2024 in order to realise the following benefits; retention of knowledge, skills and experience across the teams, improving consistency, reducing duplication of effort, effective triangulation of complaints and incidents processes across the Health Board and to ensure improved quality, timeliness and person-centred response, and support a culture of shared learning. Since then, we have been working closely with the complaints and operational teams across the Health Board to try and improve our processes.

Priority 3: Learning Framework/Quality Strategy

To embed the new Quality Strategy through the Health Board which focuses on delivering 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
- Develop a robust implementation plan for the quality strategy
- Review and alignment the QPS resources to create a resource structure to deliver the strategy and create a learning framework

The Quality Strategy was implemented throughout Aneurin Bevan University Health Board in April 2023 and has recently been updated. A key focus in the development of this Strategy is progressing on what we have already accomplished and building on existing structures throughout the organisation. Quality is embedded in our culture, and we are committed to continually improving. Delivering the highest quality healthcare to our local communities and putting Quality, Safety and Learning at the heart of everything we do.

Our Strategy was developed in collaboration with a diverse group of people, ranging from healthcare partners to patients and colleagues. This collaborative approach is critical to our journey of improvement.

Priority 4: Improve Complaint Handling
Set up regular SI and Concern 'drop-in clinics' for Divisions to allow opportunity to network and promote collaborative working to improve quality of responses and investigations at source. With closer working divisional/corporate relationships, reduce the backlog of outstanding complaints. Audit of IO's trained across the organisation to evaluate effectiveness of IO training delivered through investigations undertaken. Historic complaint closure. Introduction of PALS to maximise opportunities for early resolution
All actions completed. An audit was undertaken which identified 309 IO's had been trained, however this piece of work also captured that 142 had not undertaken an investigation post-training. This highlighted the requirement for a reset and refresh of IO training and the target audience. Bespoke training will be offered. Historic complaint closure remains a top priority across all complaints' teams. Weekly assurance and review meetings are taking place with complaint hubs to identify and alleviate bottlenecks and issues preventing finalisation. completion of aged complaints. PALS commenced in November 2023.

The 2023/24 year has been challenging for the Corporate Putting Things Right Team with a number of challenges within and external to the team.

Despite the challenges, there has been a number of areas of success:

Redesign and delivery of effective Concern and Investigating Officer training to an evolving and agile workforce.

Improvements in the complaints management process and improvements in the quality of complaints.

Completion of the Covid-19 Investigation requirements.

The roll out and operationalisation of the Patient Advice and Liaison Service Team in November 2023 – this service seeks to intervene early and resolve concerns at the earliest opportunity and supports both in-patients and out-patients.

The establishment of the Patient, Quality, Learning and Improvement Forum with the initial scoping meeting March 2024.

Development of an online complaints form. The new form places emphasis on requesting and capturing the main aspects of the concern and the required details at the outset of patient and family engagement with the Health Board in order to ensure that the complaint response focuses on what matters to the complainant.

The successful centralisation of the QPS resources within the Nursing Directorate

A commitment to ensuring the timely and appropriate management of concerns is a priority, this will continue to be a focus for 2024/25 improve in 2023/24, tackling both existing and new challenges.

Work has continued with the staff, communities and partners to put quality and safety at the heart of everything we do.

The Health Board has identified four key priorities that will frame the PTR Annual Work Programme 2024/2025: -

Priority 1: PTR Regulations and Health Board Concerns Management

1.1. The Putting Things Right Regulations are currently under consultation. The Health Board will ensure we are fully prepared and equipped ahead of any revised guidance being issued, in order to support our staff in the implementation and effective delivery for our communities.

1.2. Early Resolution – Person-centred approach: The Health Board is working to ensure that compliance with the Welsh Government 30-working day target is achieved where possible. Collaborative focus days will be planned to review complex concerns and assist with finalisation and conclusion of high-quality investigations.

Internal streamlining of quality assurance processes. This aims to provide a more consistent approach to the investigating and subsequent responses to concerns.

1.3. Meaningful Engagement: An Acknowledgement Team will be introduced, to understand early on what people raising concerns are seeking and what matters most to them and how we can resolve concerns in a timely and meaningful way so that patients and their families know that they are being listened to and that their concern is being taken seriously.

We will develop Communication Standards to ensure consistency across all our teams. We will be clear in setting out resolution proposals, actions and agreements and dates for contact and updates.

Priority 2: Improving Quality Patient Safety experience, Learning and Improving

2.1 Embed the centralised QPS/PTR/QI teams and revised ways of working.

2.2 A suite of training is being developed which is specific to complaints/ incident investigation. The Health Board also intends to work collaboratively with Welsh Risk Pool colleagues to devise more readily available and accessible video training in the future. The Public Service Ombudsman for Wales (PSOW) will also be supporting bespoke training.

2.3 Patient Safety Incidents (PSI):

- Patient safety incident bespoke 1-2-1 Investigating Officer (IO) training to work with new IO's that have been allocated an investigation.
- Complete a toolkit for IO's, Panel Chairs and staff involved in PSI's in no matter the context.
- Roll-out amended PSI template to align to DoC.
- Revised induction and education and training for PSI chairs.

2.4 The ABCi QI Unit have been working to support the development of Quality Improvement Capability across ABUHB.

In particular, the QI Unit are working with divisional staff to develop Quality Improvement Coaches embedded into clinical teams. To this end, a new Quality Improvement Coach programme has been adapted and tested in ABUHB in conjunction with Improvement Cymru.

The programme will run from Autumn 2024, with 3 cohorts planned each year. Potentially 75 QI Coaches will be trained annually, who can support clinical teams in their improvement priorities.

2.5 Development of the Listening and Learning Framework & Learning Repository: The framework will demonstrate how learning will be identified, stored, triangulated, shared, disseminated and implemented in practice to facilitate and embed a culture of appreciative enquiry and continuous improvement in health care services.

Priority 3: Partnership Engagement & Collaborative working

3.1 To work closely with external partners such as the Public Services Ombudsman for Wales, Llais, Audit Wales, Health Inspectorate Wales through which we will demonstrate an open culture and always seek out opportunities to learn and improve for our ongoing commitment to the population of the Health Board.

3.2 Work with the Medical Examiner's Office to implement the Death Certification Reform.

3.3 Work with the National Bereavement Leads to implement the GRACE bereavement model.

3.4 Continue to meet with and support patients and carers who have raised concerns, either directly or through third parties, such as Llais and the Ombudsman, to improve listening and learning.

3.5 Introduce People Participation Panels for sepsis and dementia.

3.6 Scope existing End of Life Care services and develop an inclusive End of Life Care Pathway in collaboration with people, staff and partners.

3.7 Hold a Big Conversation around Future Care Planning to raise public awareness.

3.8 Divisions to promote the use of the CIVICA system for timely patient feedback.

Argymhelliad / Recommendation

The Committee is asked to: -

NOTE the Putting Things Right Annual Report 2023/2024.
NOTE the four key priorities for the PTR Annual Work Programme.

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):	Governance, Leadership and Accountability 3.1 Safe and Clinically Effective Care 6.3 Listening and Learning from Feedback 3.2 Communicating Effectively
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Not Applicable
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	Choose an item. Choose an item. Choose an item. Choose an item.

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

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	Choose an item.

Service Activity & Performance	Choose an item.
Financial	Choose an item.
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/	Choose an item. Choose an item.

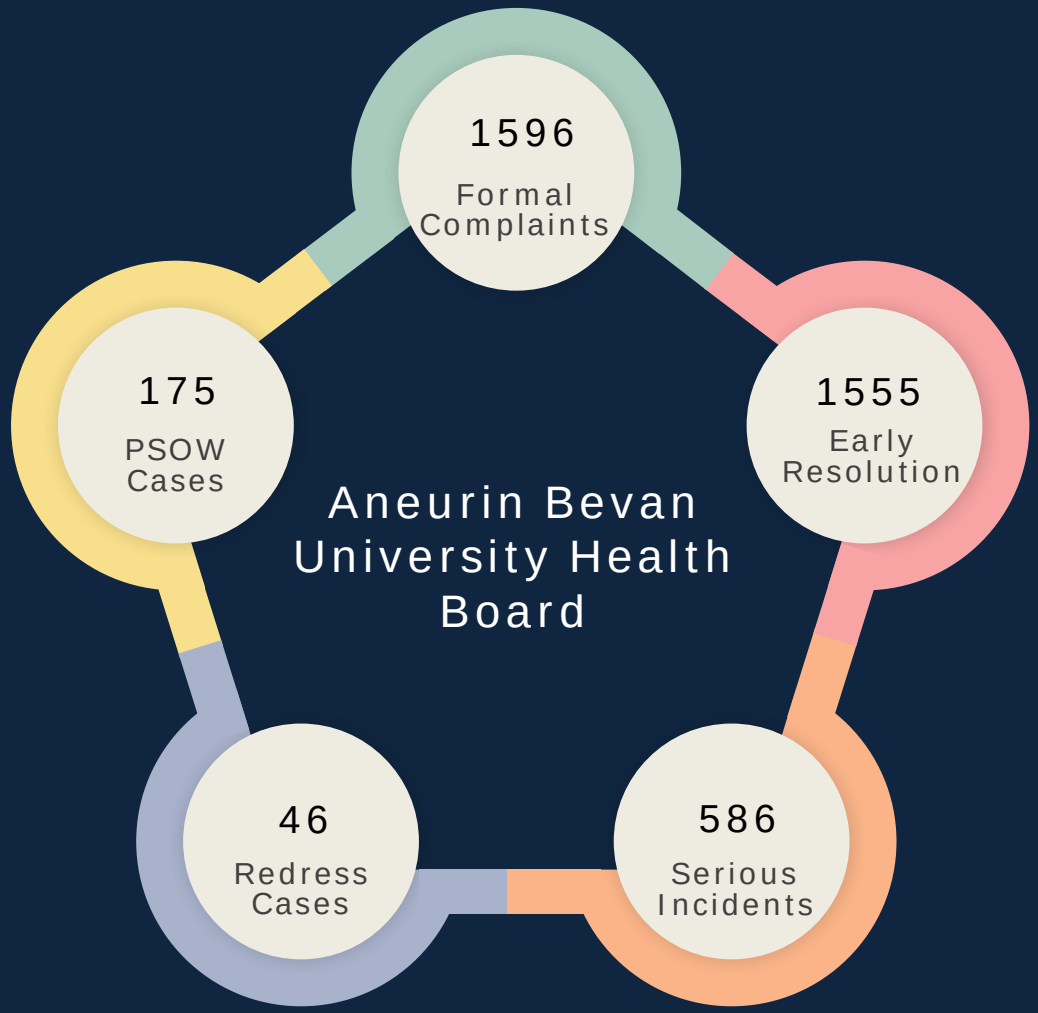
GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Putting Things Right

ANNUAL REPORT

2023-2024



Introduction

Welcome to the Aneurin Bevan University Health Board's (ABUHB) Annual Putting Things Right Report. This report will cover the financial year, April 2023 to March 2024. The annual report demonstrates our ongoing commitment to the population of the Health Board, which covers Blaenau Gwent, Torfaen, Monmouthshire, Caerphilly, and Newport. This equates to around 600,000 children, young people and adults.

At the heart of the "Putting Things Right" (PTR) and Duty of Candour arrangements is the requirement to be open and honest when dealing with concerns. Most importantly to play a significant role in improving patient safety; endorse a person-centred approach to concerns management and reinforce a culture of organisational learning and quality. This is underpinned by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) 2011.

The Health Board is committed to making it easy for people to raise concerns, feel that they are being listened to, and that their concerns are being taken seriously.

During the reporting period, the Health Board has welcomed and fully embraced the introduction of the Health and Social Care Quality and Engagement) (Wales) Act and NHS Duty of Candour on 1 April 2023.

The provisions of the statutory Duty of Candour, is an organisational duty on all NHS bodies and primary care providers.

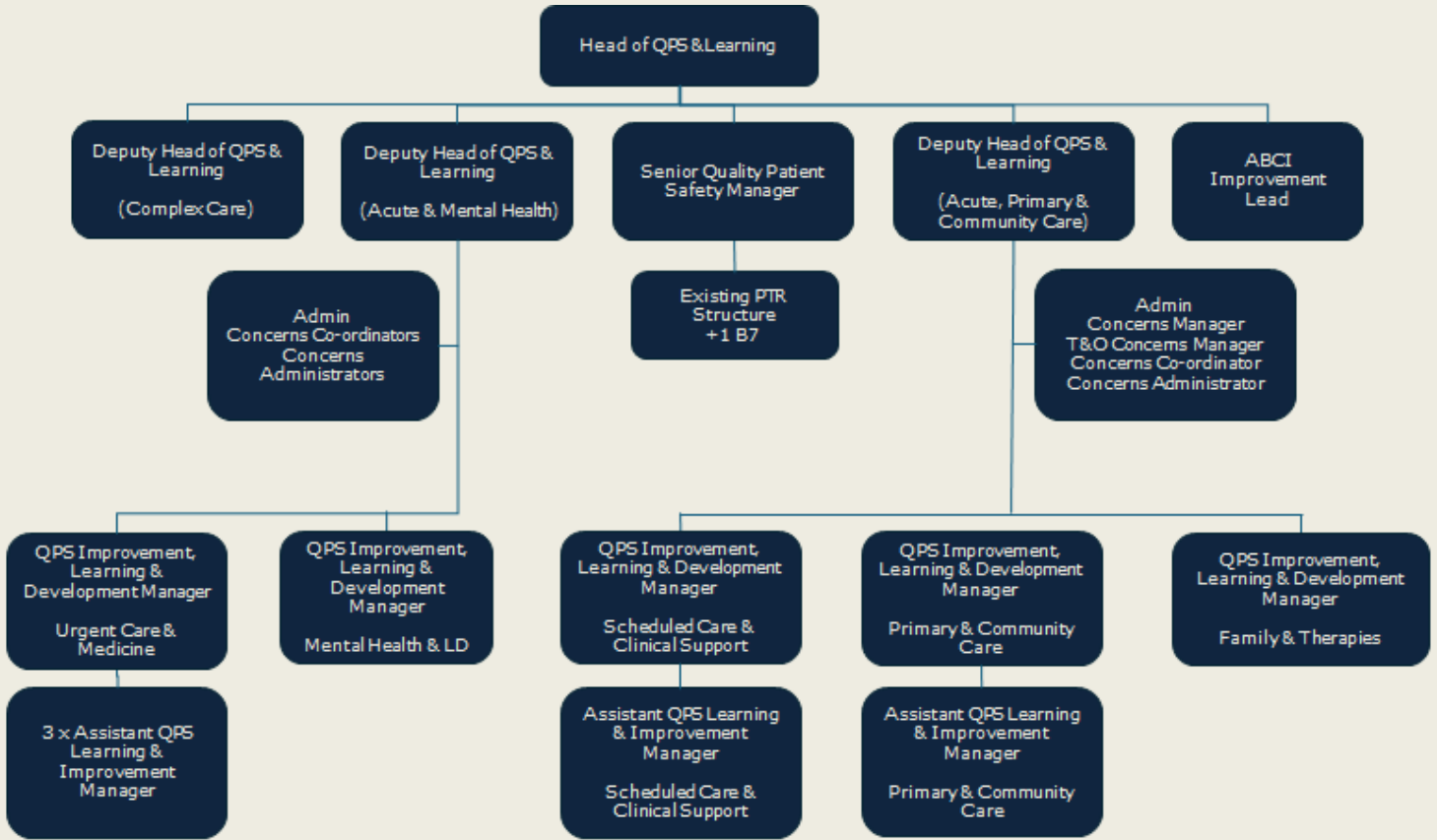
Concerns reporting, management and investigation is intertwined with the principles of being open: communicating with patients and their carers with a requirement that they adhere to the Duty of Candour, so in practice these activities should be fully integrated.

Staffing and Governance

There is a structure underpinning PTR, with executive leadership delegated to the Executive Director of Nursing (EDoN). Since the end of February 2024, the central Divisional Quality Patient Safety (QPS)/PTR teams have been aligned to the Nursing Directorate. Assurance is provided by reporting to the Patient Quality and Safety Learning and Improvement Forum, which in turn reports to the Executive Committee and the Patient Quality and Safety Outcomes Committee.

This committee sets out the Health Board's strategy and objectives to encourage continuous improvement, as well as compliance with national and local policies. It is further tasked with responsibility to develop and implement systems for quality monitoring that are robust, auditable and effective, as well as raising the awareness of the PTR and QPS agenda.

The current Putting Things Right/QPS Team structure is illustrated below:



Review of Priorities 2022/23

1

Introduction of the Health and Social Care **(Quality & Engagement) (Wale) Act 2020 –** (Duty of Candour)

As Duty of candour becomes law on 1 April 2023, the Health Board must:

- Ensure Health Staff have access to and undertake the All-Wales e-learning package.
- Assistant Director of Nursing to chair Duty of Candour Divisional leads meeting.
- Identification of key Duty of Candour leads within each division.
- Establish Duty of Candour reporting on RLDatix
- Corporate Team oversight to support Divisional colleagues.

All staff now have access to the Duty of Candour training course via the Health Board's electronic training platform (ESR) and are being actively asked to complete this.

Following the centralisation of the Quality, Patient Safety (QPS) teams in February 2024, Duty of Candour leads have been identified and are working collaboratively as part of the wider QPS team to embed the core requirements of the Act and deliver consistent and robust training regarding implementation of the Duty of Candour.

A Duty of Candour reporting tool has now been developed and is being utilised within the Health Boards incident and complaint reporting system to support continuous monitoring and validation of data.

The Patient Safety Incident team are offering support to divisional colleagues in implementation of the Duty.

2

Remodelling of QPS structure across the **organisation**

Executive Director of Nursing to undertake review of QPS processes in conjunction with Divisional and Corporate colleagues

The QPS and Complaints Team centralised in February 2024 in order to realise the following benefits; retention of knowledge, skills and experience across the teams, improving consistency, reducing duplication of effort, effective triangulation of complaints and incidents processes across the Health Board and to ensure improved quality, timeliness and person-centred response, and support a culture of shared learning. Since then, we have been working closely with the complaints and operational teams across the Health Board to try and improve our processes.

Review of Priorities 2022/23

Learning Framework/Quality Strategy

3

To embed the new Quality Strategy through the Health Board which focuses on delivering 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
- Develop a robust implementation plan for the quality strategy
- Review and alignment the QPS resources to create a resource structure to deliver the strategy and create a learning framework

The Quality Strategy sets out what the Health Board will do to achieve its vision to continuously improve patient safety by building on two foundations of a patient safety culture and a patient safety system.

The Quality Strategy was implemented throughout Aneurin Bevan University Health Board in April 2023 and has recently been updated. A key focus in the development of this Strategy is progressing on what we have already accomplished and building on existing structures throughout the organisation. Quality is embedded in our culture, and we are committed to continually improving. Delivering the highest quality healthcare to our local communities and putting Quality, Safety and Learning at the heart of everything we do.

Our Strategy was developed in collaboration with a diverse group of people, ranging from healthcare partners to patients and colleagues. This collaborative approach is critical to our journey of improvement.

Improve Complaint Handling

4

- Set up regular SI and Concern 'drop-in clinics' for Divisions to allow opportunity to network and promote collaborative working to improve quality of responses and investigations at source.
- With closer working divisional/corporate relationships, reduce the backlog of outstanding complaints.
- Audit of IO's trained across the organisation to evaluate effectiveness of IO training delivered through investigations undertaken.
- Historic complaint closure.
- Introduction of PALS to maximise opportunities for early resolution

An audit was undertaken which identified 309 members of staff who had undertaken training as Investigating Officer's (IO). However, this piece of work also captured that 142 had not undertaken an investigation post-training. This highlighted the requirement for a reset and refresh of IO training and the target audience of the training package. The Health Board aims to provide accessible video recorded training, supported by bespoke sessions and training materials.

Historic complaint closure remains a top priority across all complaints' teams. Weekly assurance and review meetings are taking place with all concerns teams to identify and alleviate bottlenecks preventing conclusion of investigations.

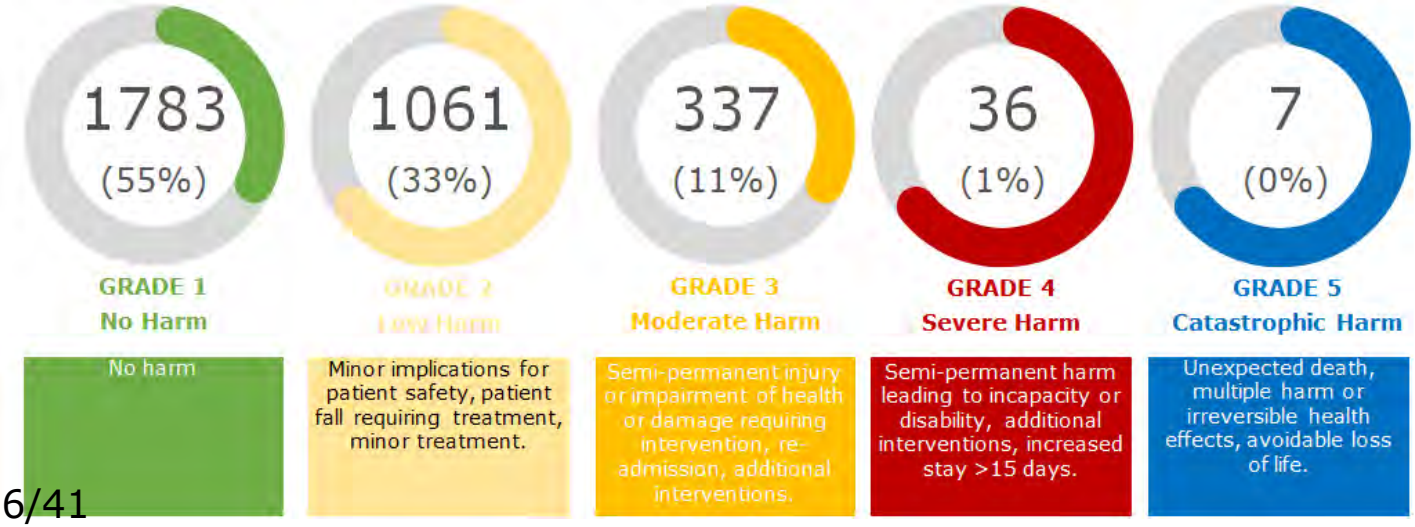
The PALS team fully rolled out in November 2023.

Arrangements for the Management of Concerns

Upon receipt of a concern the central PTR team assume responsibility for review and initial grading supported by the Senior Management Team. Early Resolution is encouraged wherever possible and appropriate to do so. If the matter is more serious or there has been a specific request for a full investigation these matters will be Managed under PTR, with a formal 30-day Investigation. Serious concerns (graded 4 or higher) are shared with the Divisional Triumvirate overseeing the area on first receipt, ensuring they are sighted early. Additionally, the Executive Team are notified of all grade 4/5 complaints via the weekly Safety Briefing.

Concerns are then directed to the relevant division and management team, at which time an Investigating Officer is appointed. It is good practice for the Investigating Officer to contact the Complainant. Under the Putting Things Right Regulations, all formal Concerns have to be acknowledged within 5 working days. We encourage personal contact with each Complainant to ensure that we acknowledge their correspondence in an empathetic and personal manner. For those investigations that require further time, the Concerns Team should contact the Complainant, prior to the 30-day target, to explain the reason for the delay and advise that further time is needed. Within the response, Complainants are offered the opportunity to meet with Health Board Staff. As part of the regulations, there is an obligation on a Welsh NHS body to consider when it is notified of a concern that alleges harm or may have been caused, whether or not there is a qualifying liability. This is included in the response, along with the advice on how concerns can be forwarded to the Ombudsman.

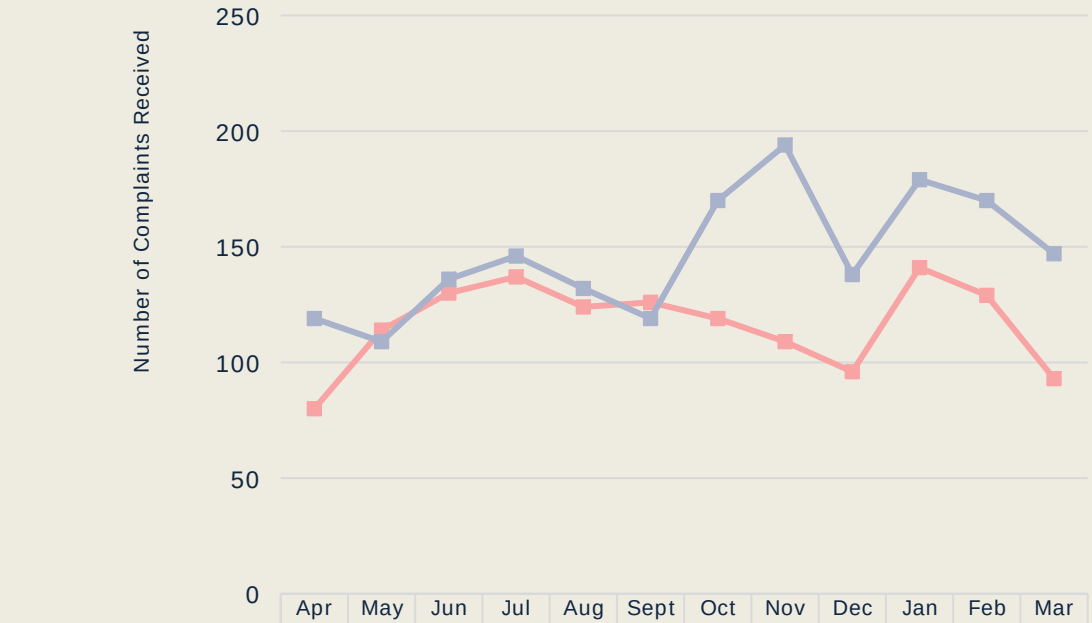
Grading of Complaints Upon Receipt 2023-24



A large proportion of concerns (88%) are graded as low or having caused no harm upon receipt, with moderate representing 11%, and with grades 4 and 5 accounting for 1% of the total received. The grading of complaints is dynamic and should be kept under review throughout the investigation.

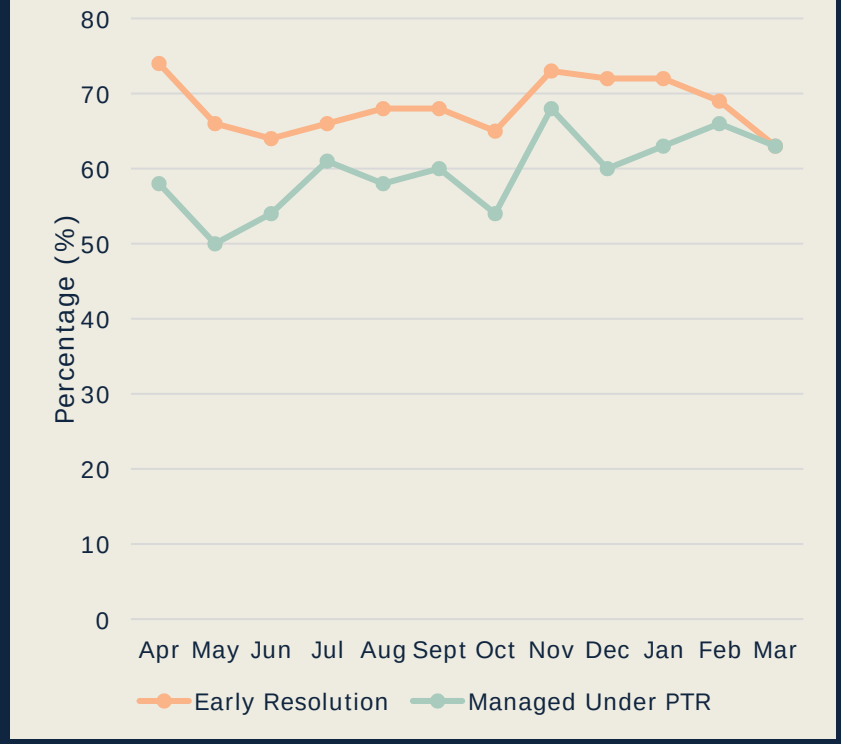
Overall Health Board Compliance

Q3 & Q4 saw an overall steady increase in the number of concerns being Managed Under PTR. Positively, the number of concerns being managed through Early Resolution saw the benefits of the inception of the PALS team in Q3.



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Early Resolution	80	114	130	137	124	126	119	109	96	141	129	93
Managed Under PTR	119	109	136	146	132	119	170	194	138	179	170	147

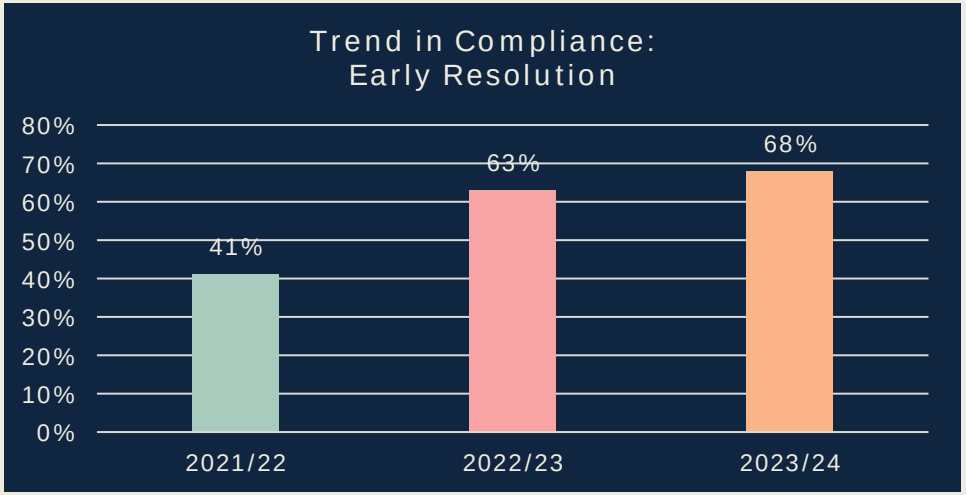
2023- 2024

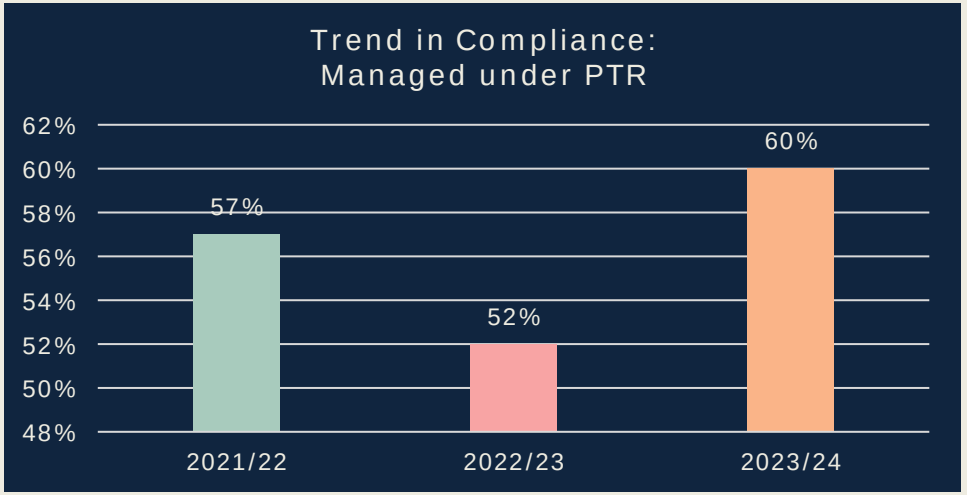


Compliance with the Welsh Government 30-working day target averaged 60% across the reporting period.

Extensive work by the Assistant Director of Nursing whose portfolio includes PTR, and the Head of Quality Patient Safety & Learning and Senior Quality Patient Safety Manager has taken place in collaboration with the Once for Wales data team and the Divisional leadership teams, to prioritise and finalise concerns investigations. Additionally, work has taken place to ensure concerns are accurately recorded on the RLDatix (Datix Cymru) system.

Trends in Compliance





In 2023/24, the Health Board received 1,596 formal complaints and 1,555 early resolution.

Performance has increased for Managed Under PTR concerns from 52% to 60%. Those concerns tend to be more complex in nature, often spanning more than one division and/or organisation. The Health Board aspires to resolve 75% of concerns as Early Resolution, as well as attaining a 75% compliance with Managed through PTR.

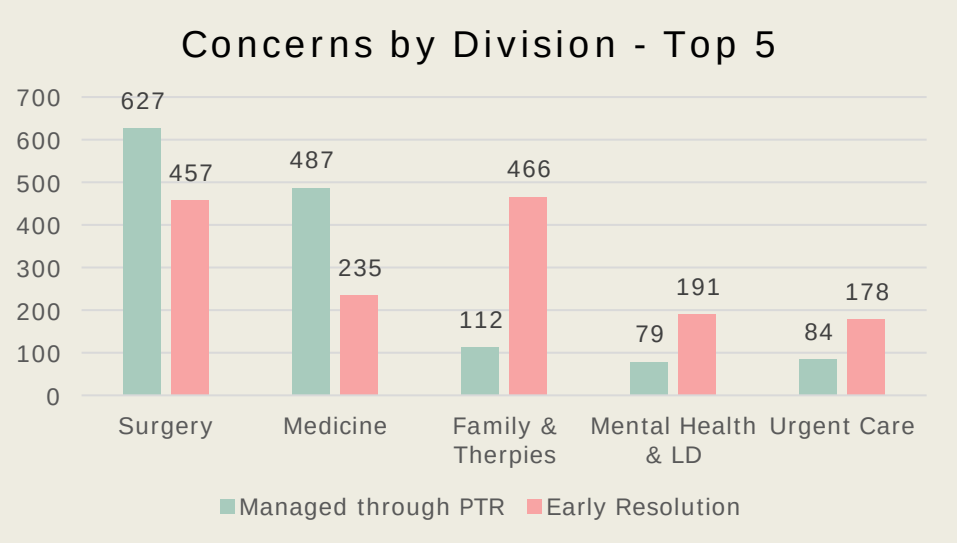
The main themes relate to: Clinical treatment/assessment; Appointments and Communication issues across 2023/24. The effects of the Covid-19 pandemic continue to be evident in relation to concerns raised regarding clinical treatment and assessment; delays in receiving an appointment along with commencement of treatment plans. People continue to express concern about wait times, with waiting list times emerging as a recurring theme across the reporting period.

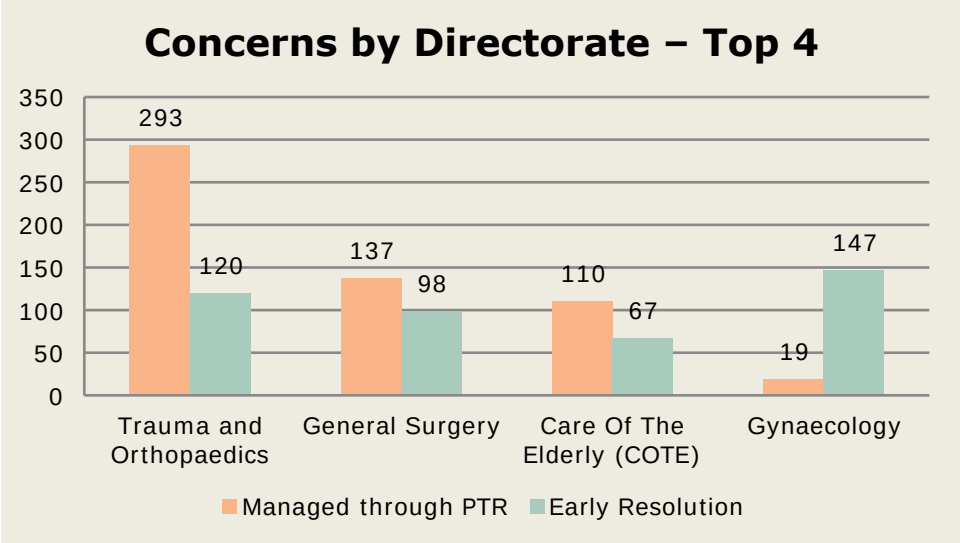
The ongoing work of the Six Goals for Urgent and Emergency Care, Planned Care and Mental Health Improvement Plans seek to improve clinical outcomes and patient experience.

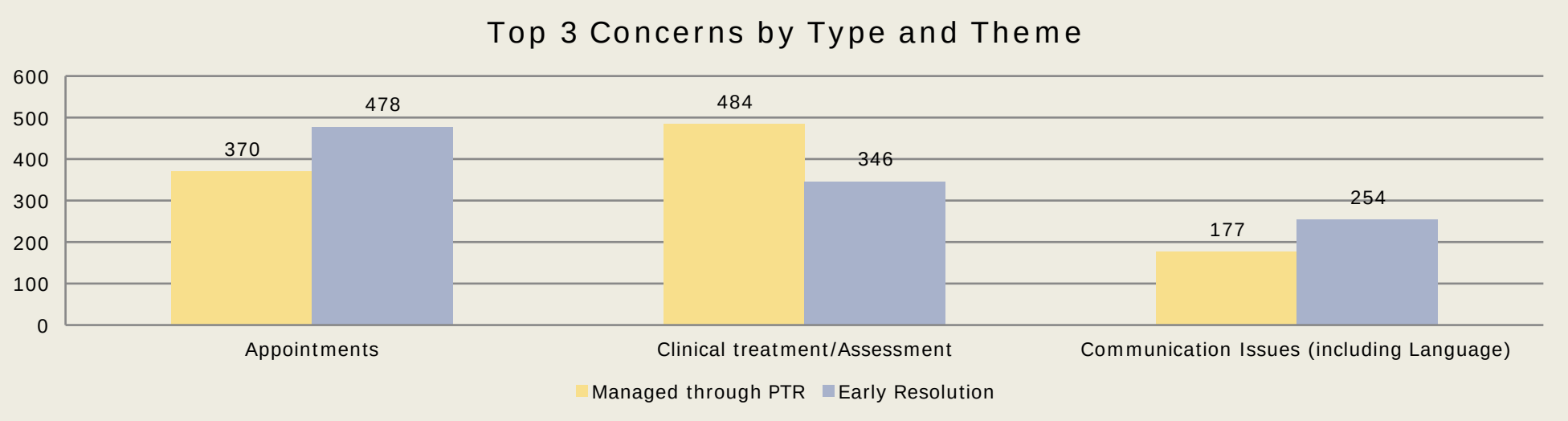
Communication issues continue to be a recurring theme, however positive changes to the management of concerns from the point of receipt and throughout the complaint process are scheduled, beginning with the development of a central acknowledgement team. This will afford people the opportunity to engage with the Health Board early on and ensure a person-centred approach to resolution of their concerns. Meaningful updates throughout the course of investigations to people and families will be the focus of all concerns teams. Both approaches have been recognised by the Public Services Ombudsman for Wales (PSOW), and Llais as positive upcoming changes.

Overall Health Board Compliance

The Health Board reports and monitors concerns received by all services. This allows identification and active engagement with services that are receiving more or less concerns to understand areas of good practice or where targeted improvement and action may be required. This supports the Health Board in its aim to be a proactive learning organisation.







Learning from Concerns

Being open and honest to build trust and ensure transparency with our patients to reinforce our commitment to improving our services and placing quality at the forefront of everything we do.

All complaints and feedback provide us with an opportunity to make changes to improve the services we provide to our population. The following are examples of action that the Health Board has taken following concerns raised by patients and their families in the previous year: the feedback from our Complainants is that they like the use of "You said-We Did" to convey the actions taken.

We have listened to feedback and have implemented the following measures:

The QPS and Complaints Team centralised in February 2024 in order to realise the following benefits; retention of knowledge, skills and experience across the teams, improving consistency, reducing duplication of effort, effective triangulation of complaints and incidents processes across the Health Board and to ensure improved quality, timeliness, a person-centred approach and support a culture of shared learning. Since then, we have been working closely with the complaints and operational teams across the Health Board to try and improve our processes.

Over the last year we have listened to patient feedback and plan on introducing an acknowledgement team to ensure early and meaningful contact with patients and their families to understand early on what matters to them and how we can resolve their concerns as timely and appropriately as possible.

A weekly meeting has been set up with all of the complaints teams to improve communication and to provide direction and support and to understand the challenges in the system which are escalated following the meeting.

We recognise that there should be a clear and consistent approach to ensure effective and meaningful communication throughout the complaints process. Therefore, we have drafted Communication Standards to ensure that communication with patients and relatives is consistent, timely, meaningful and effective. We are continuing to focus on complaints over the 30-day target to address unresolved concerns effectively and improve service quality.

Learning from Concerns

The new Head of Quality Patient Safety and Senior Quality Patient Safety Manager have convened regular meetings with PSOW and Llais to ensure our focus on transparency, collaboration and a commitment to improvement in complaint handling. This also allows for detailed conversations regarding emerging themes and areas for focus that external bodies are identifying through their engagement with local people. This provides the Health Board with a broader understanding of the issues that really matter to our community in relation to healthcare.

PALS

The positive impacts on patient experience is significant and includes:

- Single point of contact
- Early intervention and resolution to patient and family queries
- Helping patients and families to keep in touch
- Supporting patients and families at clinical meetings
- Supporting face to face listening meetings
- Positive assurance for families who are unable to visit/live away
- Facilitated ward moves closer to home
- Attended Deaf Club to listen to concerns and take forward access improvements
- Recommended reasonable adjustments for people with protected characteristics
- Secured volunteer visits for people who are lonely
- Developed a visiting poster based on relative's feedback
- Signposting to support services for example, bereavement support
- Reduced escalation to PTR

Based on PALS feedback, to improve the experiences of people who are at end of life or bereaved, the Health Board are now employing a Patient and Relative Support Officer, providing a dedicated contact at the most distressing time of people's lives.

Patient Experience and Involvement

Complimentary to the PTR process the Patient Experience and Involvement team have supported clinical teams in meeting with patients or patients' relatives who would like to share their experiences following either incidents and or complaints.

Dedicated members of the Patient Experience and Involvement team meet with the person who has agreed to talk about their experiences to support listening and learning. The person agrees to the format of their 'story' and consents to their story being used either internally, externally or both. The person is not interviewed. Rather, they speak from the heart about an episode of care that has had the most significant impact on them, either positive or negative. The person is shown the film once it has been edited for their approval. The whole process gives them an opportunity to talk about what has happened and put structure to it in the format of a 'patient story', which can then be shared for learning and quality improvement.

The main themes from patient stories to date include:

Poor or inconsistent communication
Restricted visiting during COVID, particularly relatives not being with loved ones ate end of life
The need to better consider reasonable adjustments (neurodiversity and physical disabilities)
Concerns around dementia care
Positive story relating to rapid discharge

Some patients or carers who have shared their experiences are also invited to participate in involvement events such as the Bereavement Collaborative, People Participation Panels and the Dementia In-Patient Working Group. The involvement of patients and carers is increasing through listening and ongoing collaboration.

Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service (PALS) was introduced by Aneurin Bevan University Health Board in November 2023.

Consisting of 3 PALS Officers and 3 Patient Support Officers (PSO's), the team operate across the Health Board footprint. PALS officers work 8:00am-8:00pm Monday-Friday (8:00am-5:30pm/11:30am-8:00pm) and 9:00am-2:00pm Saturday, Sunday and Public Holidays and the PSO's work 8:00am-8:00pm 7 days a week. Based in the Grange University Hospital (and travelling across sites) the Team offers confidential advice, support, and information on health-related matters.

Through a single point of contact, they support patients, families, and carers who have queries or wish to raise concerns, with their focus on addressing concerns through early resolution.

Through a bi-lingual public information leaflet, the service was promoted on the Health Board's webpage and through social media.

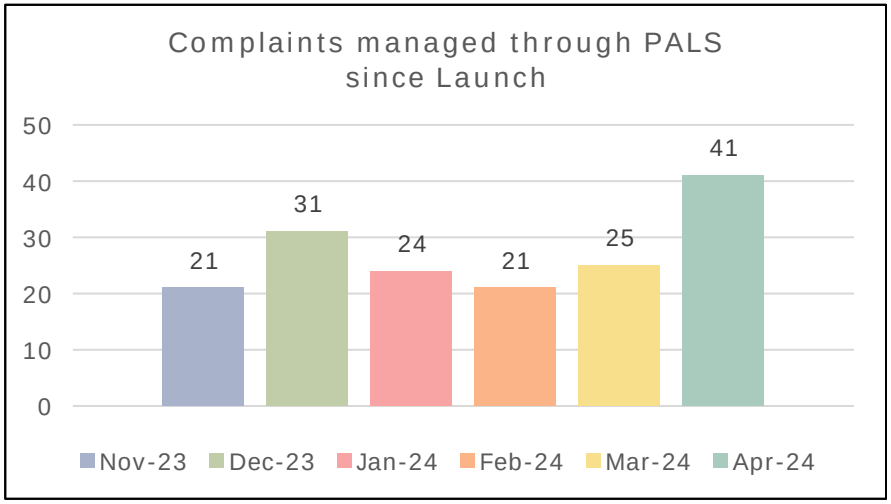
Patients, families, and carers can contact PALS for various reasons, including:

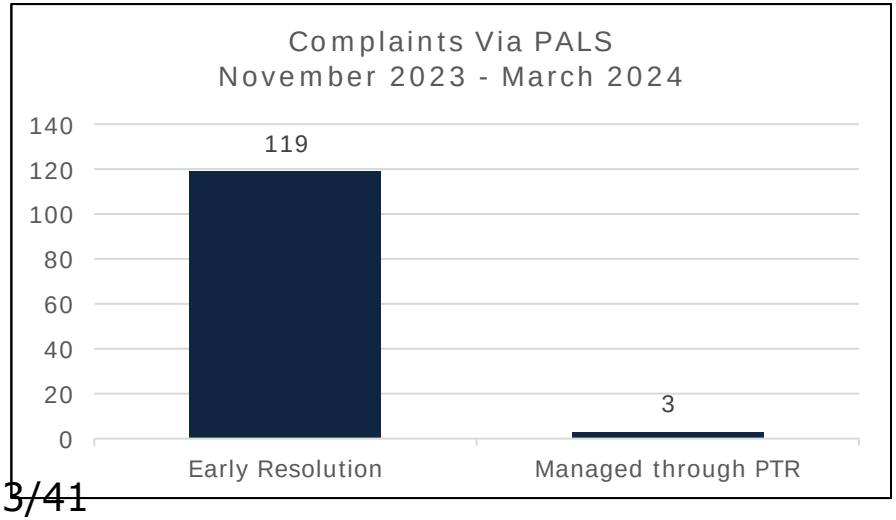
- When they have a problem but don't know who to ask.
- To talk to someone not directly involved in their care.
- To compliment services or individual staff members.
- To provide suggestions for improvements.

The PALS team work closely with clinical staff, supporting communication, concern resolution, and supporting people in face-to-face discussions with clinicians. Clinicians can contact PALS directly to help manage patient concerns and early resolution.

PALS Performance / Impact

- 162 complaints were made over the 6-month period to the PALS Team.
- Of these 155 were managed by the PALS team.
- The total number of complaints escalated to the Putting Things Right (PTR) Team over the past 6 months = 7 (4.3%)





PALS Successes

A PALS officer received a call from a distressed mother who lived in Ireland. Her son, who was in South Wales on a football scholarship, had arrived at the Emergency Department (ED) in immense pain. He had contacted his mother and told her it was too busy and was going to return to his student home. She called us as she had no idea what to do and was scared that he'd leave hospital.

The PALS officer spoke to her and did their best to allay her fears whilst the PSO on duty went to ED and spoke to the young man (who was outside the department ready to leave) and assured him he would be seen as soon as possible. The mother was relieved that her son was going to stay.

The next morning, the PALS officer called her, as they could see that her son had an appendectomy during the night. He was recovering on a ward and his mother said, *"I am so grateful you were on the other end of the phone; it was such a weight lifted off me and I was able to sleep last night when I had originally thought about booking the next flight to Wales."*

The PALS team were contacted by a family who had recently been bereaved by the loss of their wife/mother. Their mother had been in ill health over several years and had been admitted into hospital with a community acquired pneumonia, however, was showing positive signs of recovery following treatment with antibiotics. Sadly, 24 hours following a transfer from the Grange University Hospital to Ysbyty Ystrad Fawr (YYF), she unexpectedly passed away. The family were contacted by the ward but unfortunately did not arrive to see their wife/mother before she passed.

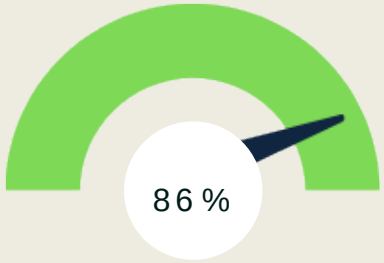
The family did not want to make a complaint but were seeking closure following the death of Mrs W. The events of that night were a blur and even though they remember speaking with a nurse and a doctor, they hadn't retained the information due to the shock.

The PALS team were able to support the family by listening to their experience. Two of the family members lived locally, but one daughter lived in New Zealand. Therefore, the initial contact was made via email so all the family could be part of the communications. The PALS team then facilitated a meeting with the clinical team at YYF, so everyone could sit around the table to have their questions answered. Two of the family members attended in person and the daughter who lived in New Zealand was able to join via Microsoft Teams.

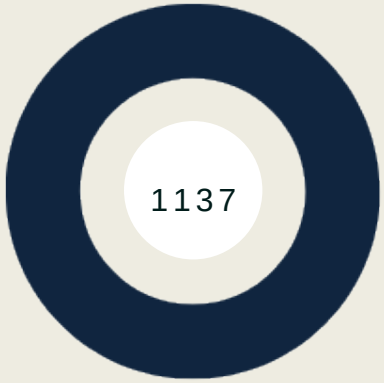
The family found this meeting invaluable as they had a better understanding of the events that happened that night. The PALS team supported the family at the meeting and after, with a follow up call to ensure there were no outstanding queries or questions.

Person Centred Care Survey: 01/04/23 - 31/03/24

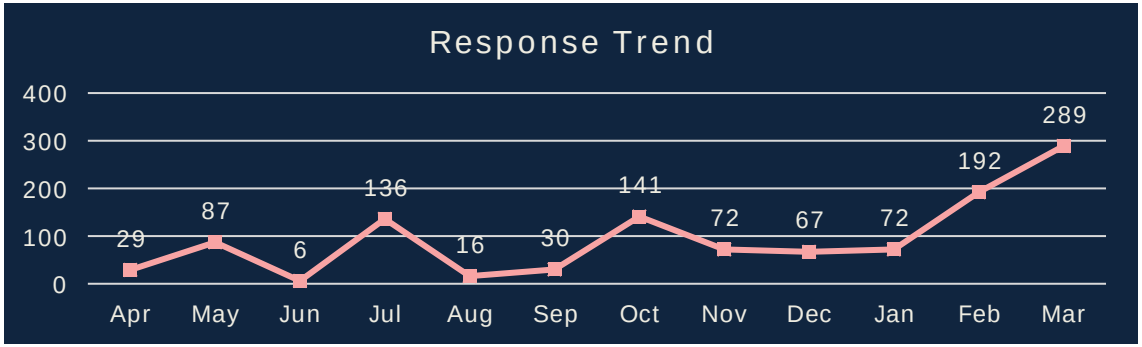
This is a survey we have produced to gain a person centred care baseline (based on the Picker Institute Research of what 'good' person centred care looks like).



Overall Satisfaction Score



Total Number of Responses



Survey Live **Across Health Board**	Total Responses
Health Visiting (survey under review)	1
PEOLC	10
Nosocomial COVID Investigation	0
Emergency Department Survey	123
Person-Centred Care	1137
Care Closer to Home (Parent/Carer Questionnaire)	4
Care Closer to Home (4 – 11 years)	1
Care Closer to Home (11 years and upwards)	3
Your Time in hospital (4 – 11 years)	12
Your Time in Hospital (11 years and upwards)	10
Parent/Carers questionnaire	42

- Of the 190 wards, departments and services that have been set up to use the CIVICA system, 84 have received feedback.
- 1343 responses in total across all surveys.
- Imminently going live on Intranet pages.
- New CIVICA Patient Feedback Branding.
- Working with Divisions to ensure appropriate individuals are identified to receive feedback for their specific area of responsibility, via the CIVICA system.
- Working with Divisions to encourage participation onto the CIVICA system to ensure feedback is captured from all areas.
- Working with Divisional Leads and QPS Teams for Divisional ownership of the feedback and learning.

Top 3 Themes	
What did we do well? Q9	What could we have done better? Q10
189 comments around Compassion – 89 patients used the word **'Caring'** and 60 patients used the word **'Kind'** 150 comments around Friendliness – 107 patients used the word **'Friendly'** 141 comments around Emotional and Physical support– 69 patients used the word **'helpful'**	66 comments around Waiting – 29 patients use word **'waiting'** 37 comments around Comfort – 13 patients use word **'uncomfortable'** 32 comments around Food and Beverage – 4 patients mentioned **'better food'**

Person Centred Care Survey: 01/04/23 - 31/03/24

Division	Responses	I felt listened ti	I was able to make my own decisions about my care	I had care and support from staff who understood my needs and respected by choices	I had the support of my family (or friends) when I needed them	I felt safe	I felt physically comfortable	I was given information and advice that I could understand to help me keep well	I was told who to contact if I need care and support in the future	Overall
		Person Centred Care								
Family & Therapies	19	97	96	94	94	100	95	94	100	96
Primary Care & Community	234	80	75	87	88	95	85	76	61	81
Scheduled Care	243	96	93	96	97	97	92	95	89	94
Workforce & OD	0	-	-	-	-	-	-	-	-	-
Complex & Long Term Care	12	71	80	77	79	83	77	86	91	81
Corporate	0	-	-	-	-	-	-	-	-	-
Medicine	476	89	79	91	94	94	84	85	75	87
Mental Health & Learning Disabilities	128	81	66	85	79	84	78	71	73	77
Multi-Discipline	0	-	-	-	-	-	-	-	-	-
Urgent Care	36	61	72	67	90	75	49	56	53	65
	Overall	87	80	90	91	93	84	83	75	86
	Benchmark	85	85	85	85	85	85	85	85	85

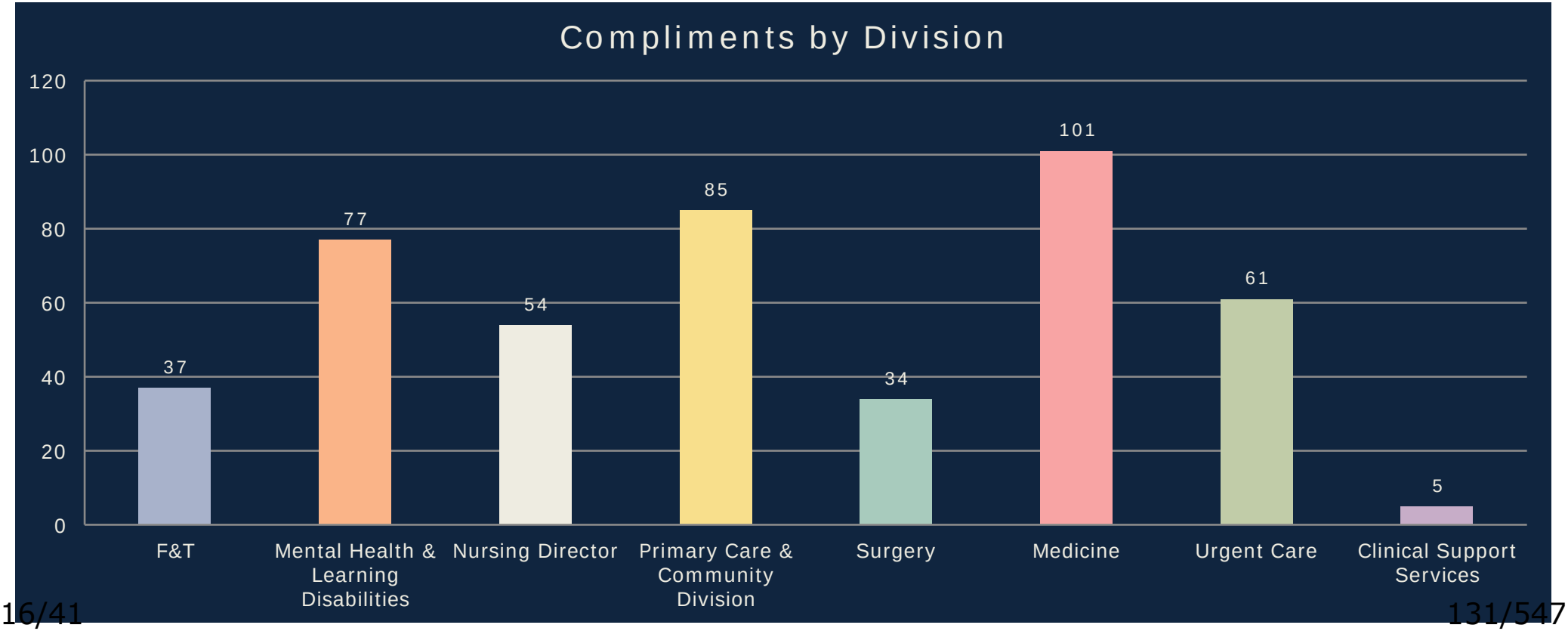


What did we do well? (Q9) Top 3 Themes	What could we have done better? (Q10) Top 3 Themes
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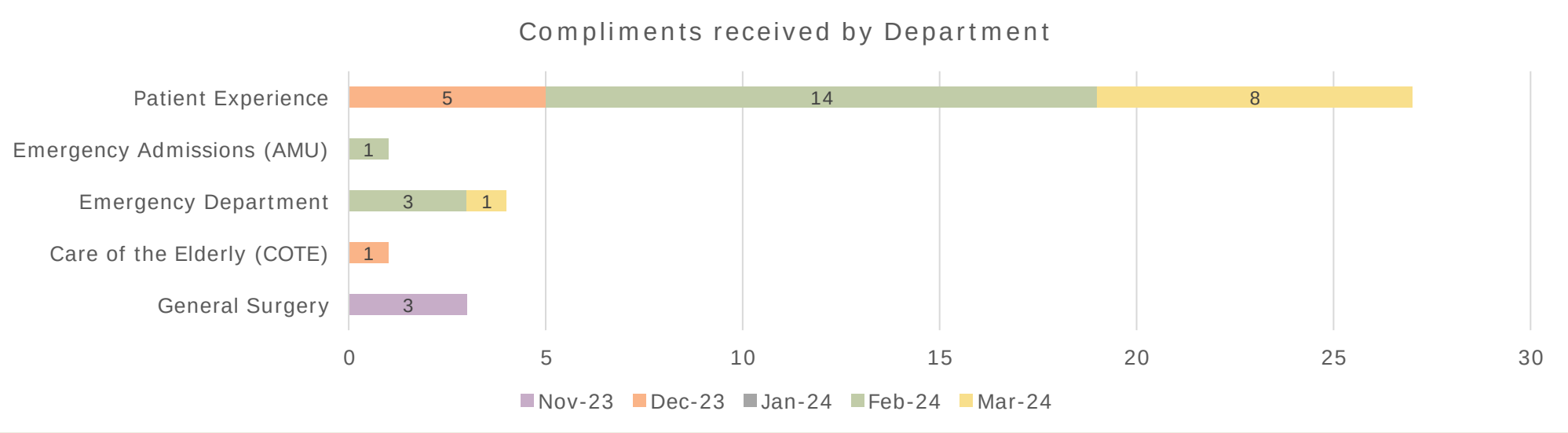
Compliments

The Health Board receives compliments in a variety of ways, including letters, emails, telephone calls, thank you cards, conversations and social media. Compliments are useful for measuring and tracking feedback. They can demonstrate improvements in performance and provide a baseline for measuring patient satisfaction, generating meaningful data can help drive continuous improvement. Compliments acknowledge, reward and promote positive behaviours and practices, also providing staff with social recognition. Positive feedback is pivotal for morale and wellbeing; reinforcing what the Health Board is striving to provide. Complainants often include a compliment within a complaint, areas are encouraged to share these with staff.

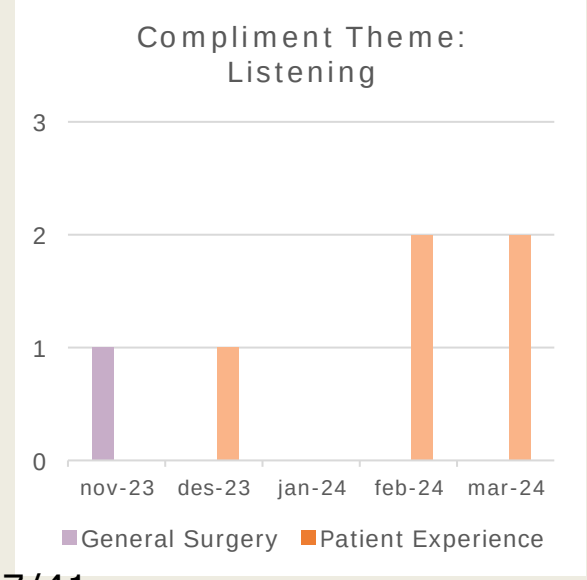
454 compliments were captured on the RL Datix system during 2023/24, which was a 150.83% increase on the compliments recorded in the reporting period 2022/23. Since November 2023 the PALS service have received an additional 36 compliments.

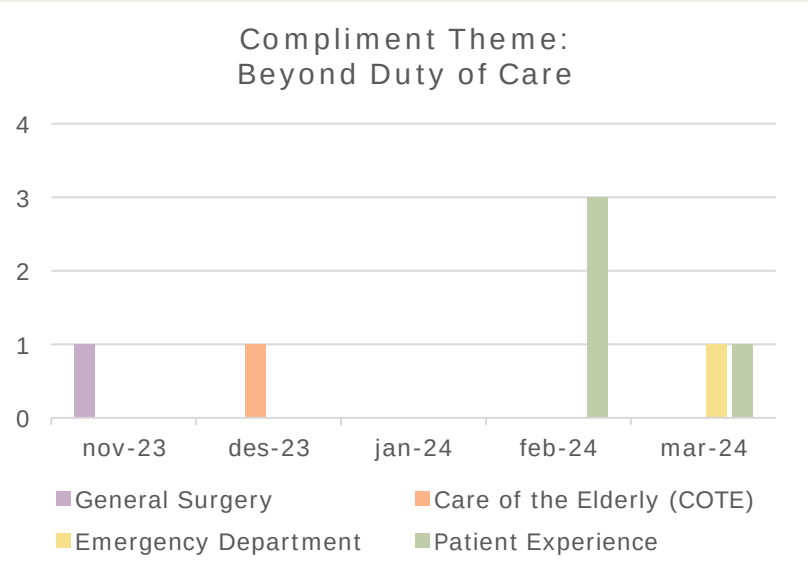


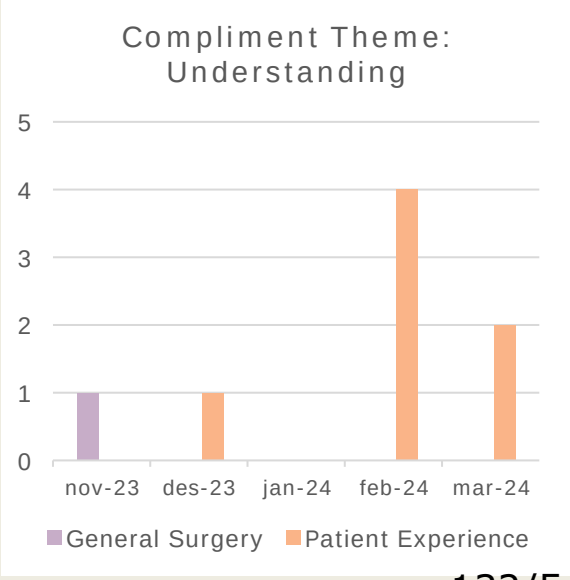
PALS Compliments: November 2023 – March 2024



Themes







Public Services Ombudsman for Wales (PSOW)

During 2023/24, quarterly meetings continued to be held between the PSOW Improvement Officer and Head of Complaints Standards and the Health Board's Concerns Manager, Complaints and PSOW along with the Senior Quality Patient Safety Manager.

Where a concern cannot be resolved to the satisfaction of the complainant, they can refer the matter to the Public Ombudsman for Wales (PSOW), an independent government body offering free, impartial support to those wishing to raise concerns in relation to public bodies and NHS organisations throughout Wales.

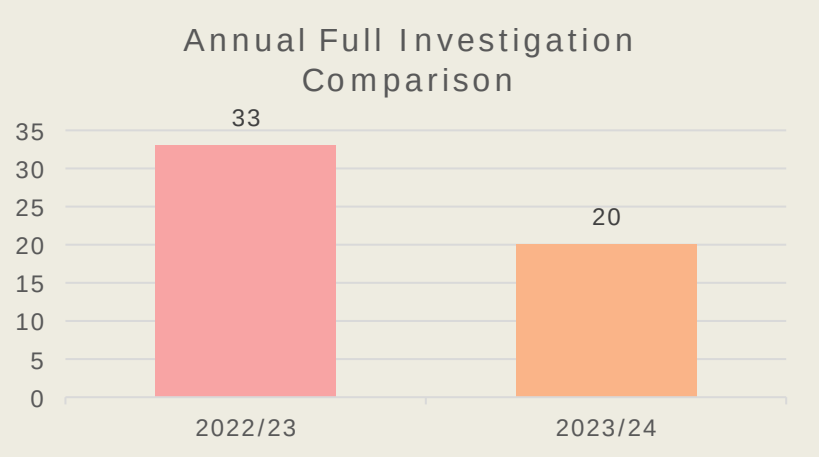
The Ombudsman aims to ensure that public services are delivered properly and fairly and has legal powers to uphold concerns and make recommendations for learning and improvement to prevent similar incidents from happening again. Despite every effort to provide a comprehensive response to complaints there will be occasions when complainants are dissatisfied with the conclusions of the Health Board and they may refer their concerns to the PSOW.

The Health Board recognises that in order to achieve the best outcomes for complainants and their families, open and supportive collaboration with the PSOW is imperative. During 2023/24, quarterly meetings continue to be held with the PSOW Improvement Officer and Head of Complaints Standards. Mutually agreed processes are in place to ensure, wherever possible, deadlines are met.

The Health Board received a Public Interest Report during this reporting period. The Health Board have apologised for any distress caused and we are currently working through a plan to explore how we can meet the Ombudsman's recommendations in relation to the introduction of fampridine in our Health Board area. We are currently working through a plan to see how we can meet the ombudsman's recommendations in relation to the introduction of fampridine (A drug approved for use in NHS Wales and Scotland to treat adults with Multiple Sclerosis (MS) who have a walking disability) in our Health Board area.

The Health Board received 20 complaints requiring full investigation in 2023/24 in comparison to 33 in 2022/23. This represents a reduction of 39%. Often these are accompanied with an early settlement recommendation to apologise for the delay, with assurances the response will be sent as soon as possible. The Health Board is working hard to embed processes to resolve this.

During 2022/2023, 62% of all referrals led to a full investigation compared to 38% in 2023/24. This represents a positive improvement for the Health Board as a full investigation means that the PSOW do not feel we have adequately addressed the complainants' concerns.

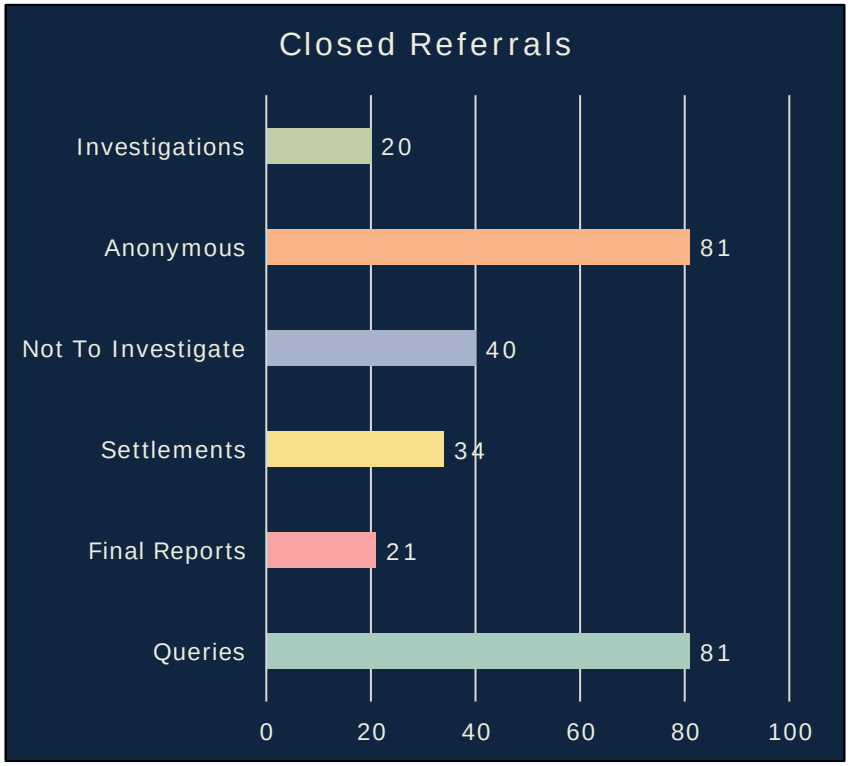


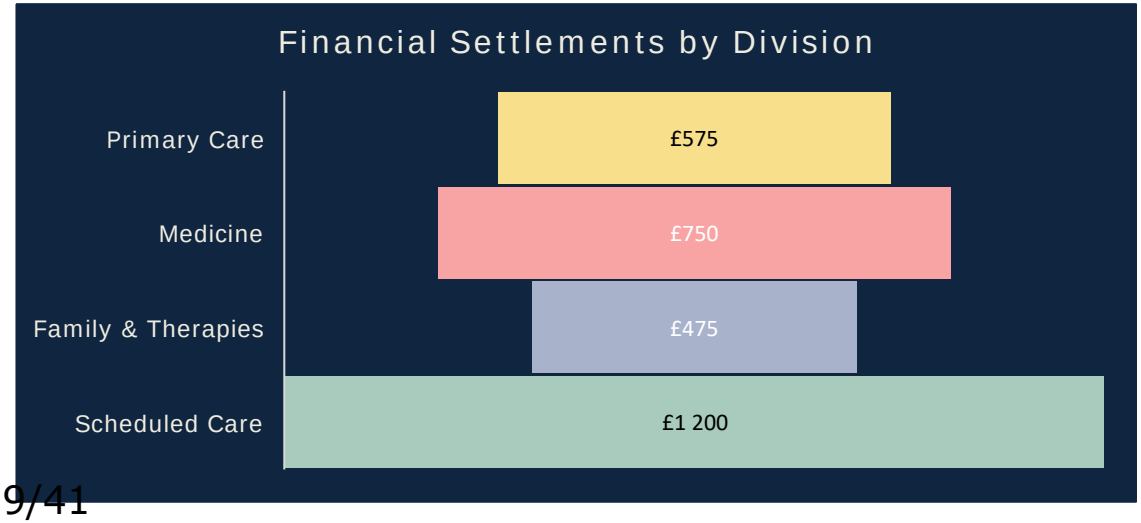
Public Services Ombudsman for Wales (PSOW)

During 2023/24, the PSOW received 175 referrals and 81 queries. Of the 175 referrals, 20 were taken on as full investigations for the Health Board, 34 were settlements and 40 cases were not considered for further investigation. Final reports are included in the overall incoming referrals. The remaining 81 referrals were anonymous, requiring no further action from the Health Board.

When the PSOW Office decides not to investigate a case, it could be for a variety of reasons. A proportion of these cases are deemed 'premature,' which means the Health Board has yet to complete its investigation, while others are deemed out of time or outside the Ombudsman's jurisdiction. Many of these cases can be considered 'premature' because the PSOW believes that no further information can be gleaned and that the Health Board was thorough in their response.

Settlements are also known as 'early resolutions,' in which the Health Board agrees to respond to the complainant or complete a specific action in order to "settle" the case and avoid a full PSOW investigation.





Where the PSOW believes there has been an injustice, they can recommend a financial payment. This can happen at any point, such as part of a settlement or as part of the recommendations following a thorough investigation.

There has been a reduction in financial compensation awarded for the year 2023/24, representing a positive reflection of settlements ordered. In 2022/23 it equated to £4550.00, which was approximately 34% more than 2023/24 which was £3000.00.

Feedback from the Ombudsman including Learning and Actions Implemented

The Health Board now has an electronic referral process in place. This is an electronic form which is submitted via Clinical Workstation database by the Surgeon, stating the date of the operation, details of the procedure and any other relevant information. This is then processed by the scheduling team, following which, patients are added to an electronic scheduling diary which the relevant clinical teams have access to. Any digital communication is saved on the electronic diary.

The Operational Manager for the General Surgery Directorate has commenced a 4-month audit of the new and current process for the scheduling of colorectal cancer patients and this will include the introduction of an excel spreadsheet which collates all referrals for the upcoming 3 months, and which must correlate with the information held on CWS. This is another way to ensure any missing referrals are picked up quickly.

The Stroke Consultant and ward team have recently undergone Carotid Endarterectomy training, as referenced in the NICE guidelines 128; section 1.2.4. It is planned that this will be repeated on an annual basis. Direct contact for advice with the local Vascular surgical team on both the Royal Gwent and Nevill Hall Hospital sites has also been put in place.

The Medicine Senior Nursing Team will be monitoring concerns to review any themes relating to documentation and communication. In relation to audits of use of the" This is Me" documentation, staff will regularly check that the use of the booklets align to patients identified on the patient board as having a cognitive impairment.

Care After Death Team (CAD) webpages have recently been updated to include links and information to the CAD Team, Medical Examiner Service, Coroner, Registrar etc. In addition, a simplified leaflet has been drafted which reflects the updated CAD pages and will be available on wards, reception areas, and general offices. The distribution of the new, simplified leaflet will be Health Board wide by the end of December 2023. These actions will hopefully improve ease of access to important information for those who have been recently bereaved.

The Endoscopy Department no longer use paper referrals. All requests are now actioned via an electronic referral process preventing delays and the risk of paper referrals being mislaid.

Redress

Redress is a range of actions that can be taken to resolve a concern.

- An apology and explanation of what happened;
- and/or an offer of treatment/rehabilitation to help relieve the problem;
- and/or financial compensation. In these cases there has to be consideration of Breach of duty and Causation.

Any health professional has a duty to treat patients properly and this is known as 'the duty of care'. A clinician is expected to offer a diagnosis and treatment which a reasonably competent professional acting in this area would have provided. It therefore has to be proved that the majority of reasonably competent professionals would not have acted in this way. Even if a breach of duty of care is established, causation and damage also need to be established.

If the patient did not sustain injury as a result of the breach of duty, there is no qualifying liability. There must be a causal link between the breach of duty and the damage complained of by the patient.

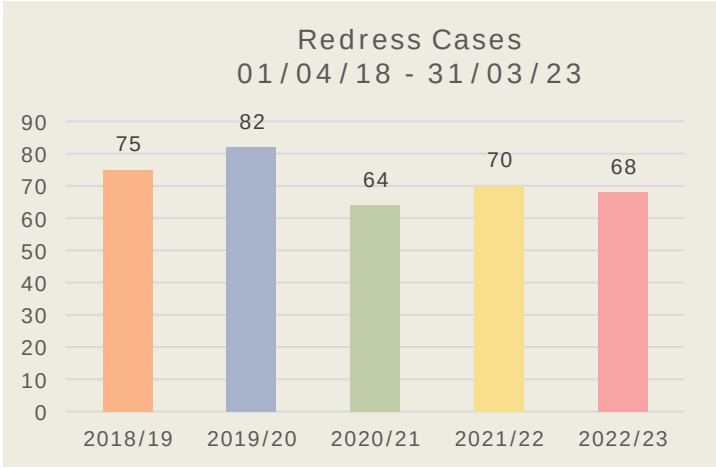
Qualifying liability refers to determining whether a particular act or omission by the Health Board has caused harm or damage to a patient.

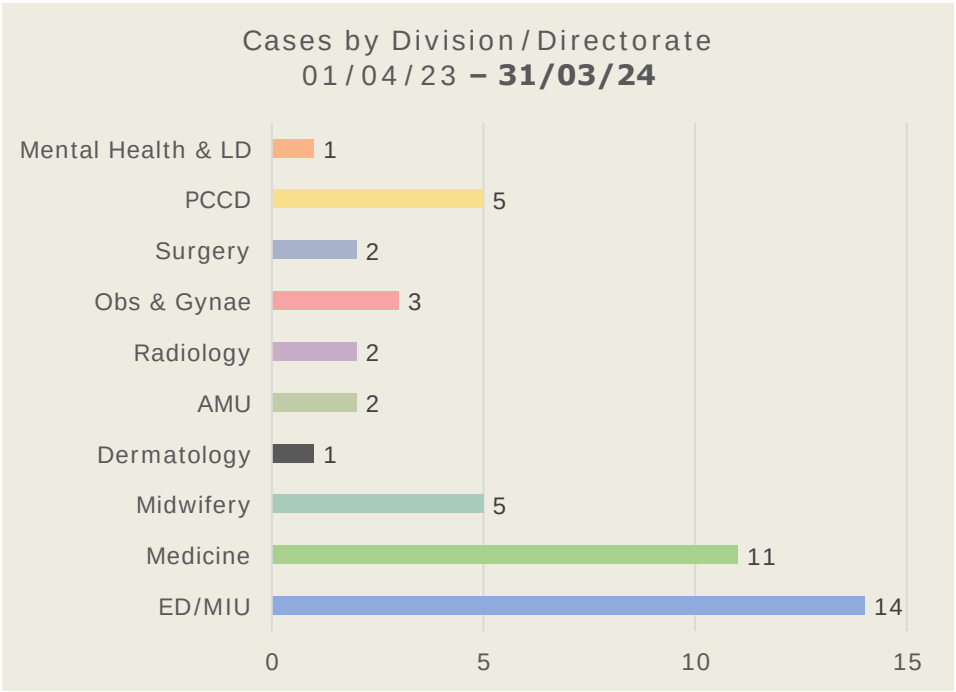
The Health Board's Redress Panel continues to assess and determine concerns where potential failings and resulting patient harm have occurred. This is a high-level panel with quorate membership for Medical, Nursing and Therapies Executives or nominees, together with Chair. In addition to determinations of qualifying liability, there is a strong emphasis on ensuring that learning and actions have taken place to try to prevent future patient harm. Areas of good practice are also highlighted and shared.

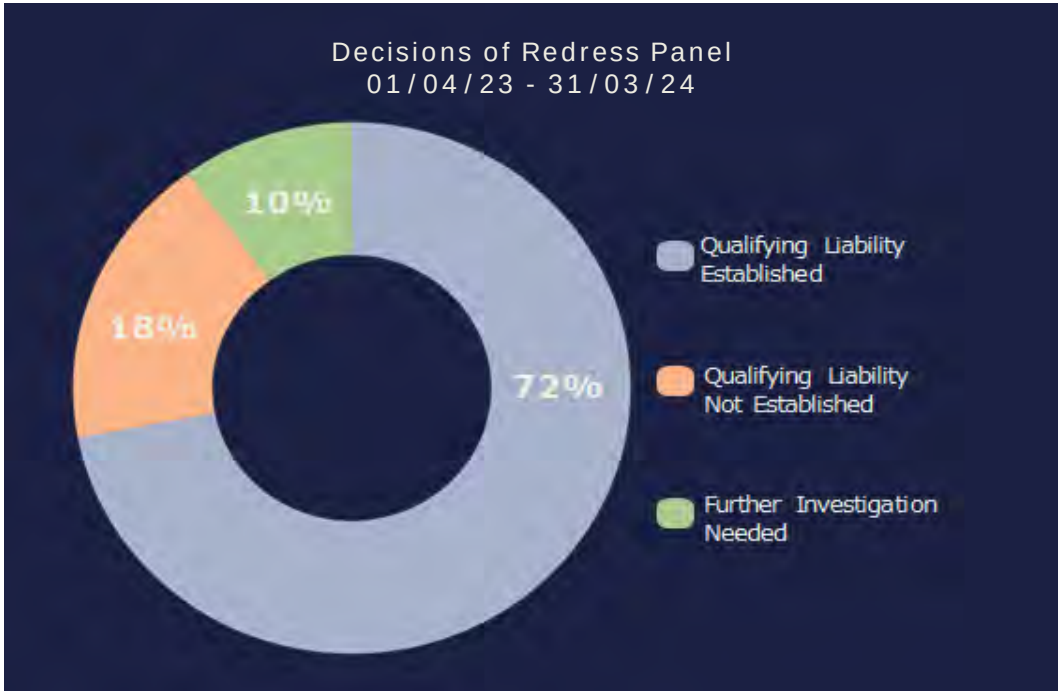
10 Panels have been convened over the course of the year on a monthly basis. This year has also seen the introduction of extra-ordinary panels as a mechanism to bring and determine cases where there has been an urgent need for consideration.

Redress


Extraordinary Panels held
Qualifying Liability established
Further investigations needed
10
1
46
34
6
5
1
Redress Panels held
Cases heard at Panel
Qualifying Liability not established
Exit Redress process: exceeding value


Redress Cases
01/04/18 - 31/03/23
90
80
70
60
50
40
30
20
10
0
75
82
64
70
68
2018/19
2019/20
2020/21
2021/22
2022/23


Cases by Division/Directorate
01/04/23 – 31/03/24
Mental Health & LD 1
PCCD 5
Surgery 2
Obs & Gynae 3
Radiology 2
AMU 2
Dermatology 1
Midwifery 5
Medicine 11
ED/MIU 14
0
5
10
15


Decisions of Redress Panel
01/04/23 - 31/03/24
10%
18%
72%
Qualifying Liability Established
Qualifying Liability Not Established
Further Investigation Needed

Themes of Cases Taken to Redress Panel

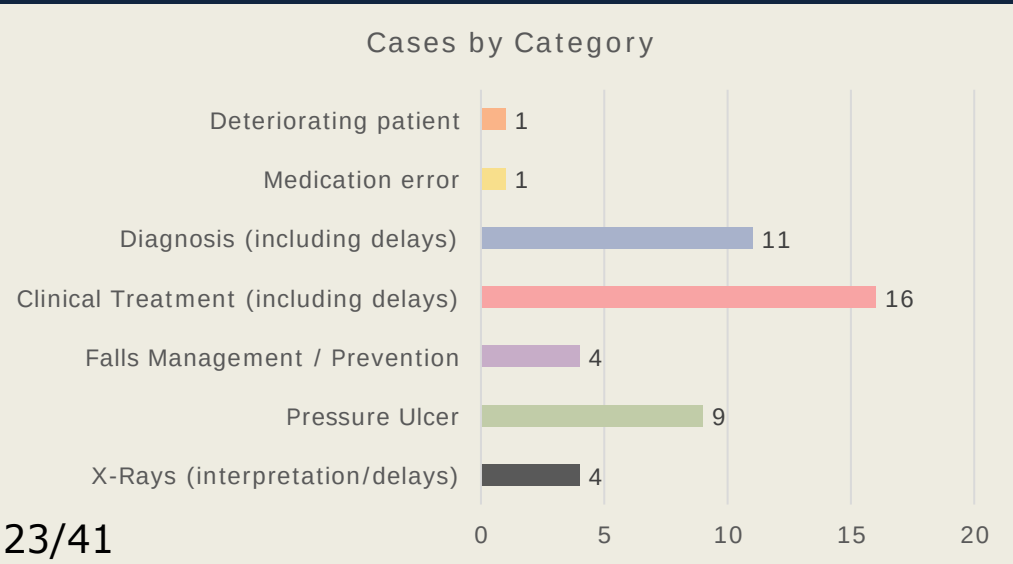
The majority of cases concerned issues of clinical treatment and diagnosis (including delays), although 25% down on the same category of cases in the preceding year. Whilst again the largest class of cases, there continues to be a very mixed picture in the detail of the cases, spread over multiple Divisions/Directorates, sites and timescales, with no evident area of concern or outlier identified.

Only 4 cases involving falls prevention and management feature, these are down in number for the fourth year in a row, and over 50% down on the preceding year.

Pressure ulcer cases were down slightly on the year before, with figures overall below 10 in number

Issues with x-ray interpretation/delays have dropped nearly 75% on the preceding year, a significant drop in this category of case.

In summary, whilst overall case numbers are down, all categories of cases are lower in number than seen the preceding year.



Learning from Redress

DIATHERMY SAFETY IN THEATRE	Diathermy Safety training delivered to theatre practitioners across sites following a patient safety incident. Incident shared with local and wider Theatre Staff and Theatre Users. Standardised method of control adopted to store instrument safely. Theatre Bulletins were developed and shared.
DETERIORATING PATIENT IMPROVEMENT CYMRU INITIATIVE	The Health Board continues to participate in a substantial piece of work around deteriorating patient with Improvement Cymru and the Institute for Healthcare Improvement (IHI). Each Health Board in Wales is part of the Safer Care Collaborative which aims to demonstrate significant improvement and performance across four workstreams, one of which is safe and effective acute care and ensuring structures and processes are robust in response to acute deterioration or concern.
GROWTH SCANS IN PREGNANCY	GAP & GROW training is now incorporated into mandatory study sessions for all midwives. Compliance is monitored via the senior midwives meeting. GAP & GROW 2.0 package was implemented in 2023 and this aligns to the new digital maternity records system 'Badgernet'. The 2.0 package enables online plotting for greater accuracy and provide prompts for referral if baby's growth is slow or static.
DISSEMINATION OF LEARNING	A number of tools have been deployed to help share and maximise the dissemination of learning from Redress cases across the Health Board, including Education and Recommendations after Significant Events (ERASE) bulletins; case presentations to local Clinical Governance days; issuing of ABU Internal Alerts, and Health & Safety Information Sheets.

Claims

ABUHB Legal Services oversee the management of clinical negligence claims, personal injury claims, concerns progressed under the PTR Redress Scheme, and Coroner inquests.

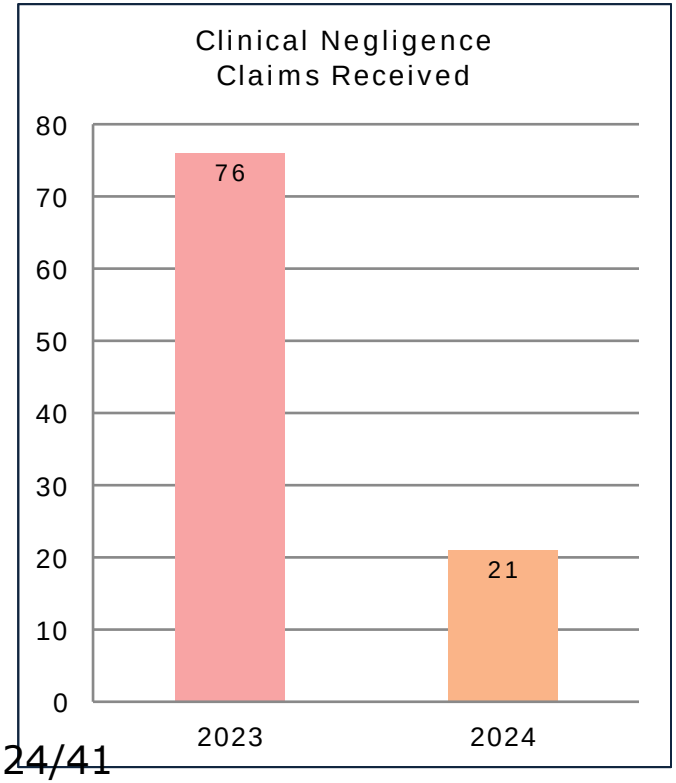
Clinical Negligence and Personal Injury are indemnified activities under the Welsh Risk Pool all-Wales indemnity scheme.

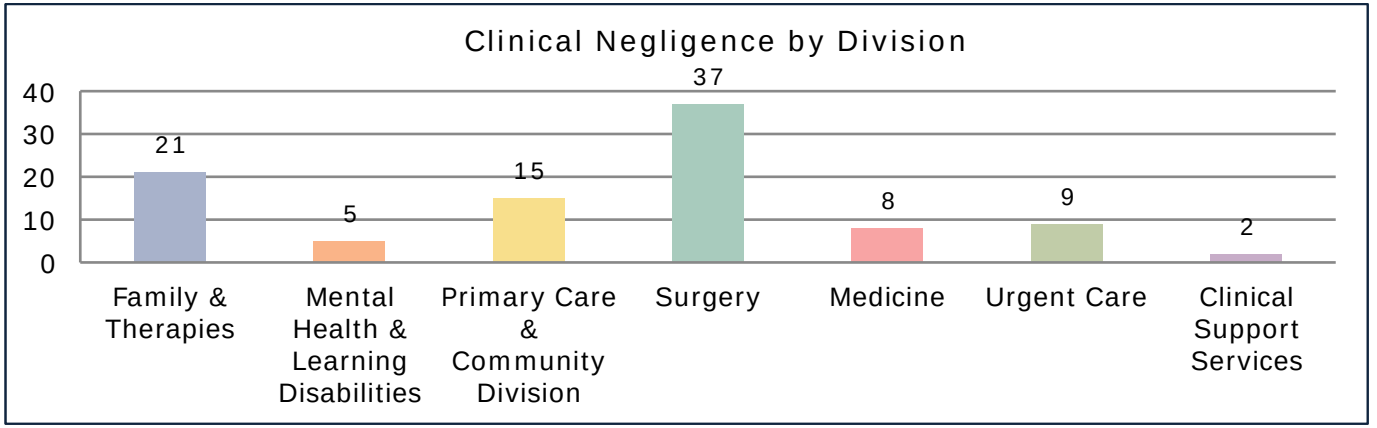
As at 31 March 2024 the Health Board had a combined 436 live claims under management.

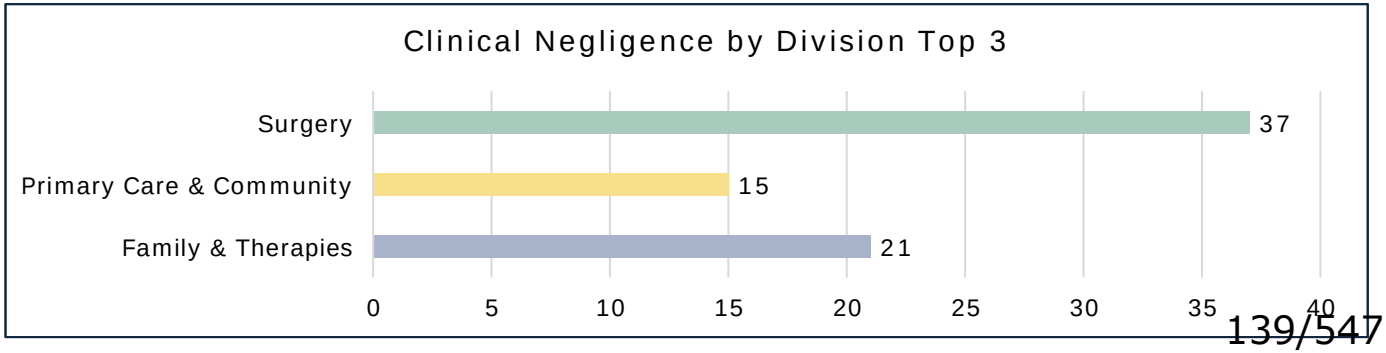
Clinical negligence claims remain very steady at 368 with preceding year at 369.

Personal injury claims continue a year-on-year 15-year downward trend. Total live claims were well under 100 at 68 claims, of which 38 were received in the last 12 months.

Clinical Negligence

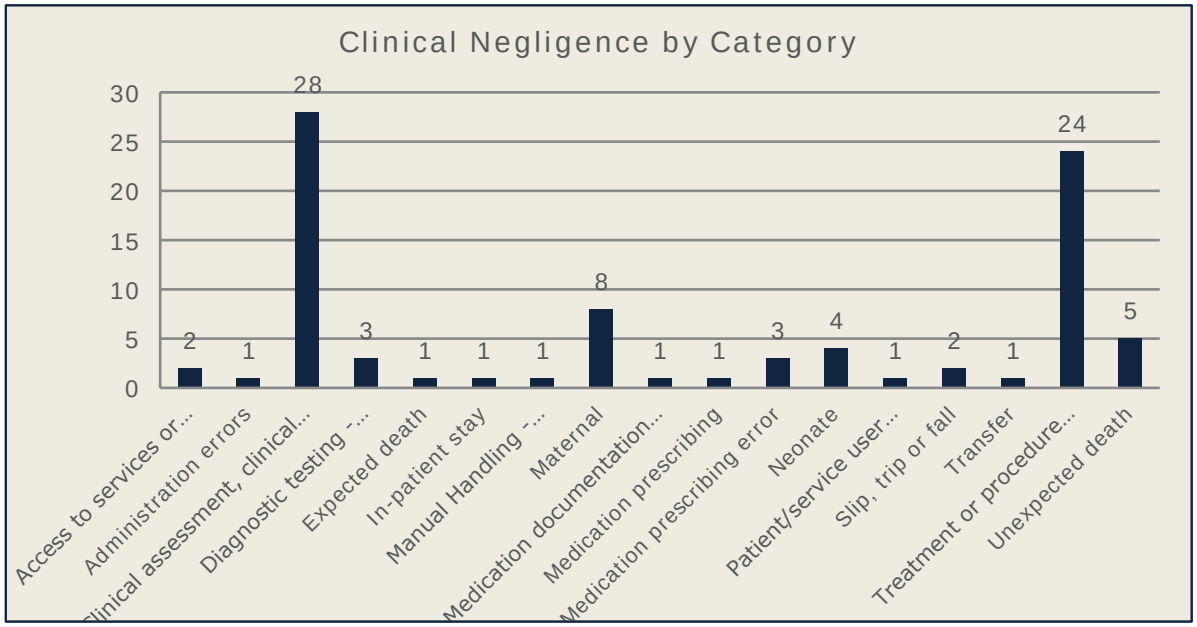


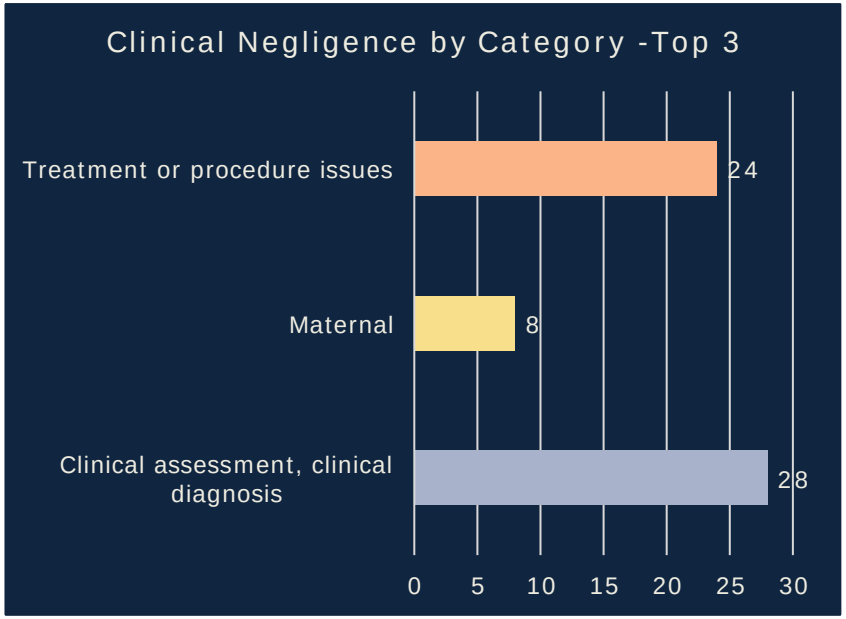




Clinical Negligence

Claims encompass Clinical Negligence and Personal Injury matters. The Health Board aims to provide people with the best level of healthcare and treatment possible and most people do not experience any difficulties. But occasionally things can go wrong and this may result in adverse outcomes for patients. This may then lead to people seeking out independent legal advice in relation to the care they received from the organisation.





Themes Raised in Claims

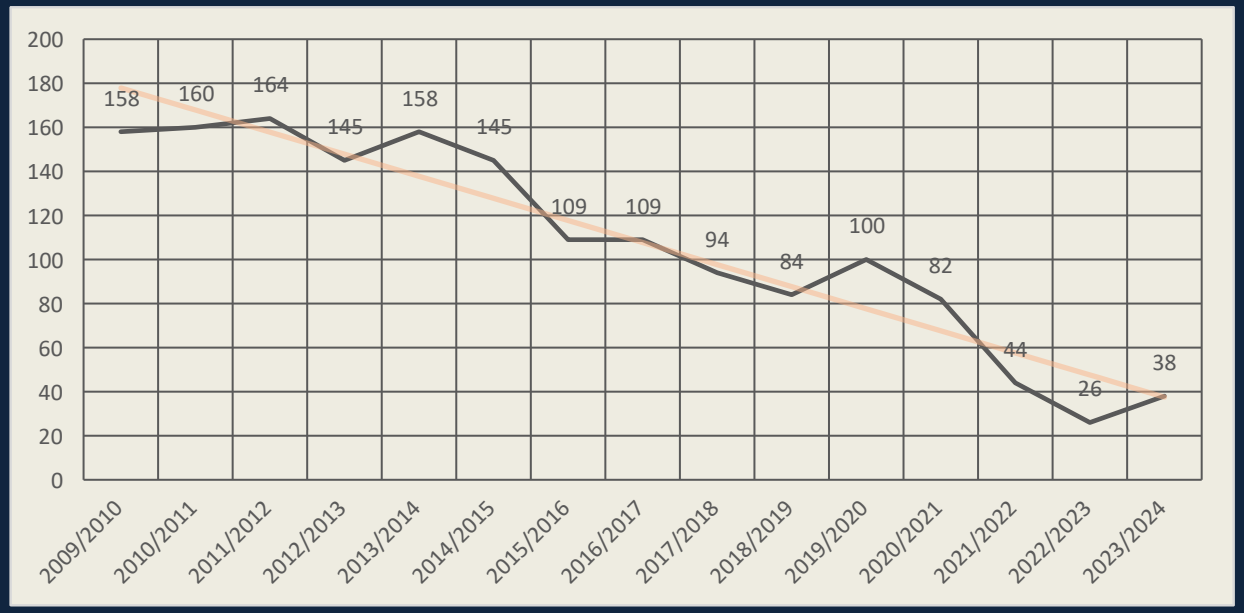
Claims are spread across Divisions and Directorates. Numbers are higher as expected in higher risk areas, including surgery, trauma & orthopaedics, urgent care, midwifery and obstetrics.

Whilst clinical treatment remains the largest class of cases, there continues to be a very mixed picture in the detail of the cases, spread over multiple Divisions/Directorates, sites and timescales, with key themes:

- Delays: Diagnosis / Treatment
- Misdiagnosis
- Deteriorating Patients / Observations
- X-ray: Reporting & Interpretation
- Procedure / Technique / Human Error

Personal Injury

Personal injury claims continue a year-on-year 15-year downward trend. Total live claims were well under 100 at 68 claims, of which 38 were received in the last 12 months. By comparison, 15 years ago the Health Board was running in excess of 160 live claims. Whilst some year-on-year variation, the linear line is a very clear downward trend. This is testament to the commitment and work of multiple teams across the Health Board to mitigate and prevent personal injury incidents on our Health Board sites. The introduction of Safer Sharps has been a significant factor.



Learning from Claims

Clinical negligence and Personal Injury claims require submission of '*Learning from Events Reports' (*LFER) to the Welsh Risk Pool. A Divisional Learning from Events Report (LFER) is produced for each case where failings in care identified, setting out the key 'issues' identified from the investigation and the resulting 'actions' by way of learning, improvement and assurance of all actions taken and to be taken to prevent future harm.

Learning is at the heart of all claims investigated by the Health Board, with local Divisional teams responsible for the development of Learning from Events Reports, the assurance of actions taken, and onward future monitoring, with support from the Divisional senior leadership team and Divisional Director final approval and sign off of LFER's.

LFER's undergo several stages of vigorous scrutiny and assessment by the Welsh Risk Pool, including clinical and peer review via a 'Learning Advisory Panel' (LAP) to provide robust assurance and approval of the Health Board's actions taken, improvements and learning.

Learning from Claims

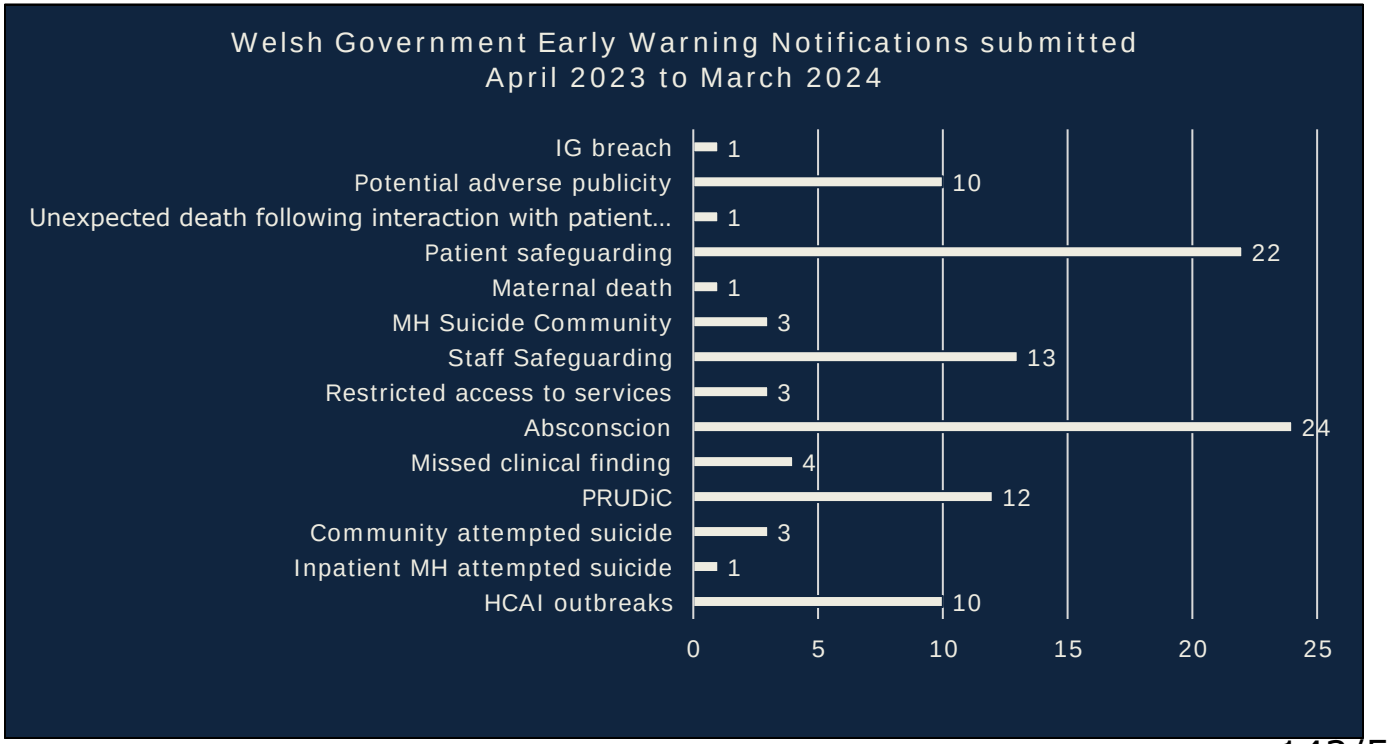
CLINICAL SUPPORT SERVICES: RADIOLOGY	Case involved a never event where a spinal nerve root block injection was administered on the patient's wrong side, patient injected on the right side instead of the correct left side. Root cause identified as human error but steps put in place to reduce risk of re-occurrence include amendment to the Surgical Safety List for Radiological MSK so it now includes a "stop before you block" check and also a "simulation before block" check. In addition "stop before you block" posters displayed in all areas where blocks are administered.
MINOR INJURIES UNIT TRAINING ON FRACTURES	To aid correct diagnosis of fractures MIU guidance for assessment of neck injuries produced and published with focus on improving the selection of patients who require imaging, noting the challenges in clinical assessments of older patients. ENP's received updated neck injury training at ENP teaching session, and communication issued.
HEALTH & SAFETY ALERT TRIPPING HAZARDS	A Health & Safety Department Alert has been issued with regard to identified tripping hazard to remind staff of the safe management of bed and air pump power cord cables to keep staff safe from tripping and electrocution risks.
IMPROVED COMMUNICATION IN THEATRE	A swab was accidentally left behind during insertion of grommets under general anaesthetic. One identified issue was poor communication by staff in theatre with swab counting. Since index event Theatre teams throughout ABUHB have implemented the new revised National Safety Standards for Invasive Procedures (NatSSIPs 2), which were published by the Centre for Perioperative Care in January 2023 and designed to reduce misunderstandings or errors and to improve team cohesion.
IMPROVED ECHOCARDIOGRAM REFERRALS	Significant service improvements following a claim concerning an echocardiogram referral. e-referrals are now live for echocardiogram referrals at the Health Board. All echo physiologists now undergo a formal induction process on joining the Health Board and a 'Red flag' echocardiogram reporting system is in place.

Early Warning Notifications (EWNs)

Welsh Government Early Warning Notifications (EWN) (previously No Surprise Reporting) is a communication function established by Welsh Government. Its purpose is to provide rapid information to Welsh Government on a range of issues, which may or may not relate to patient safety incidents. The EWN process is independent of the incident reporting systems, which are overseen and managed by the NHS Wales Executive. For clarity, where a patient safety incident meets both the requirements of a EWN and a NRI, then both processes will be followed. All Health Boards within Wales are required to alert Welsh Government of any incidents using an Early Warning Notification (EWN) which may trigger media attention, unexpected child deaths (PRUDiC) and incidents of infection outbreaks within a health care setting (i.e. Covid-19, C Difficile).

During this reporting period a total of 108 Early Warning Notifications (EWN's) were submitted to Welsh Government. EWNs are submitted to Welsh Government when it is recognised they need to be alerted to an issue or concern or they require prior warning that an issue might relate to the following:

- Has the potential to affect a number of patients/ staff/ communities etc.
- Has a significant impact on service provision
- May have an adverse impact in the media
- Might cause national or political embarrassment
- Following an Inquest which has resulted in a Regulation 28 or public interest in a Public Services Ombudsman for Wales (PSOW) report
- A positive good news story



Patient Safety Incidents

From 1 April 2023 to 31 March 2024 a total of 24958 (a 9% increase from 2022-23) patient safety incidents were reported via RL DATIX across all ABUHB sites.

Top Three Patient Safety Incident Themes

1

UNEXPECTED ADMISSION TO NEONATAL INTENSIVE CARE UNIT (NICU)

121 cases. This was up from 62 in 2022/23. However, of the 121 PSIs reported via RL DATIX, none of these were categorised as moderate or above harm post-investigation.

2

INPATIENT FALL WITH FRACTURE

Continued focused work continues through education of the Falls Policy for Hospital Adult Inpatients and through learning identified by the Falls and Bone Health Steering Group.

3

MENTAL HEALTH SERVICE USER UNEXPECTED DEATH IN THE COMMUNITY

These cases pertain to service users open to Mental Health Services in the last 12 months are reviewed at the Mental Health and Learning Disabilities Safeguarding panel weekly.

Patient Safety Incidents (PSI) resulting in Moderate harm and above in the reporting period now undergo scrutiny by the Clinical Executives on a weekly basis to determine level of investigation required (divisional or corporate investigation).

50 PSIs (51 in 2022-23) met the Corporate Investigation process criteria in this reporting year.

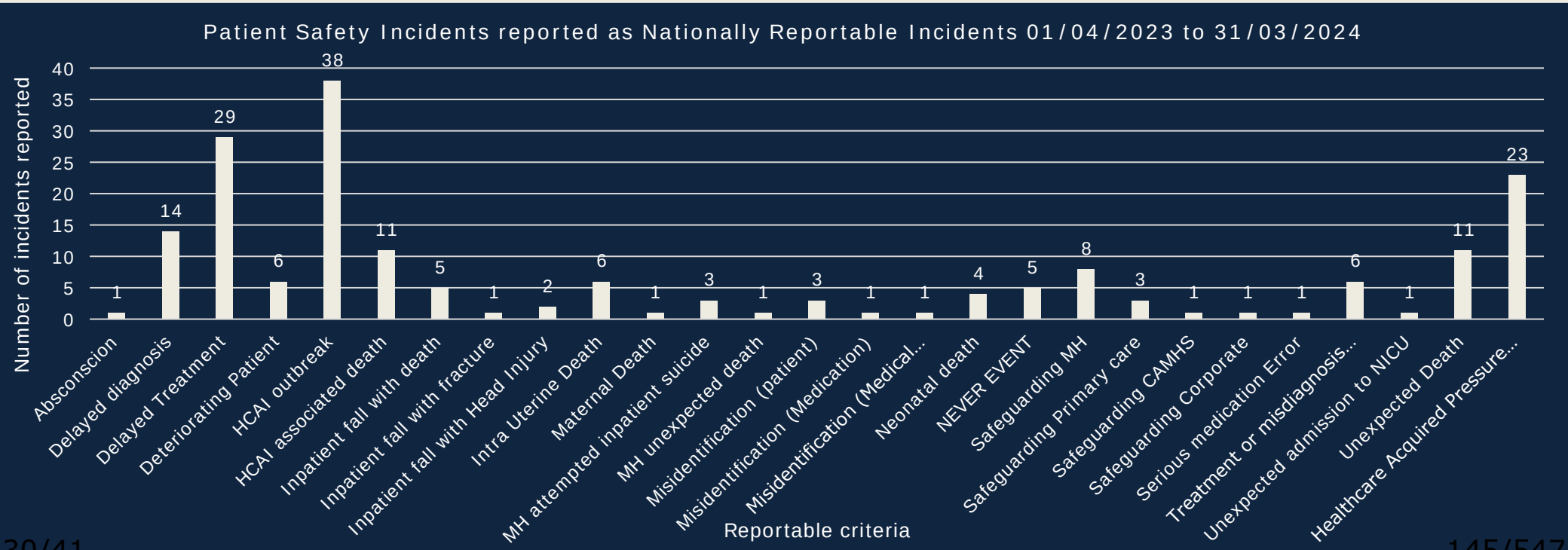
Nationally Reportable Incidents (NRI's)

Patient Safety Incidents that meet the reporting criteria of the National Reporting Framework are reported to the NHS Executive as Nationally Reportable Incidents (NRI's)

From 1 April 2023 to 31 March 2024, 187 incidents were identified as meeting the reporting criteria of the National Reporting Framework. This demonstrates a significant rise in reported incidents in comparison, to the reporting period of 1 April 2022 - 31 March 2023 33 PSIs were reported.

Since November 2023, all Intrauterine Deaths (IUDs) of 22+ weeks gestation meeting the Mothers & Babies: Reducing Risk through Audits & Confidential Enquiries UK (MBRRACE-UK) reporting criteria are now reportable, a change in policy from 22-23. These account for 11 submissions.

In addition, all Health Care Associated Infection (HCAI) outbreaks and HCAI associated deaths (49) are now reported as National Reported Incidents to the NHS Executive, rather than being reported previously as Early Warning Notifications (EWNs) to Welsh Government.



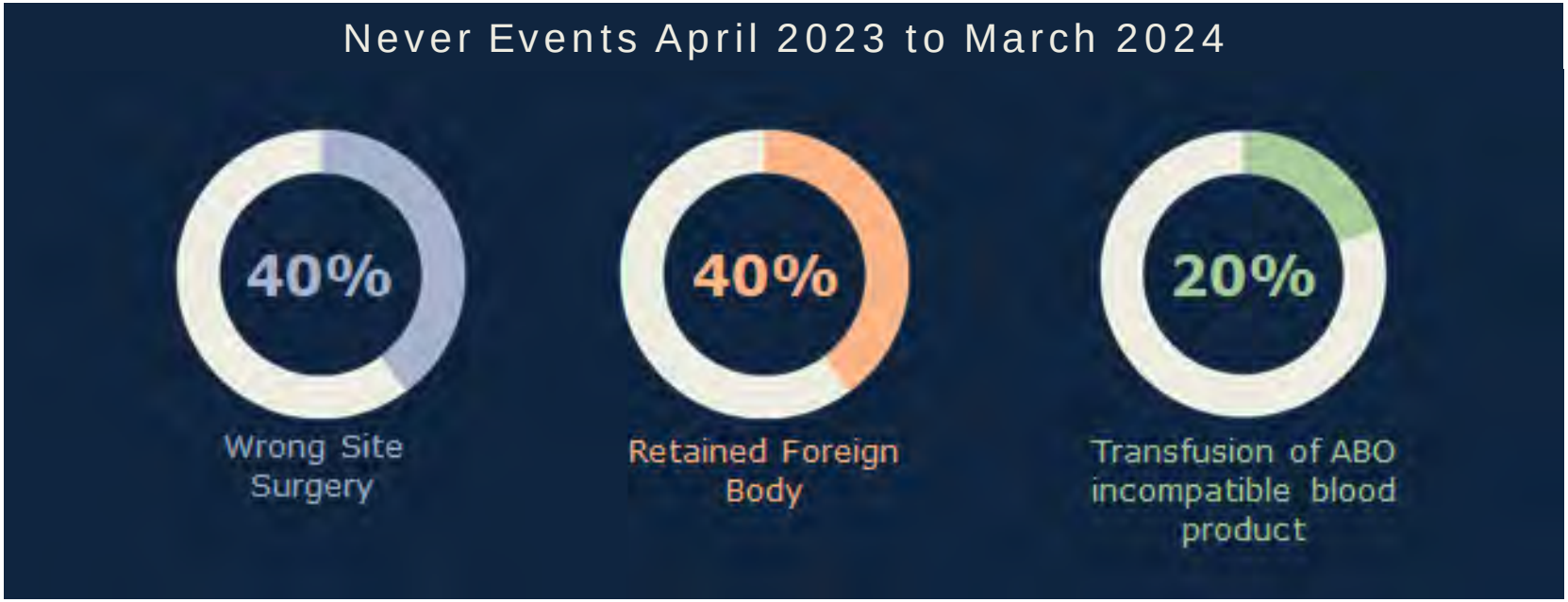
Never Events

Never Events are one of the categories of Patient Safety Incidents that are always nationally reportable, even where no harm has occurred. These are defined as '

"Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers".

Reduction in Never Events

Five Never Events were captured in the reporting period. These included 2 incidents relating to retained foreign bodies in Theatre (retained swabs), 1 relating to wrong site surgery (wrong site dermatological biopsy), 1 wrong site surgery (wrong site anaesthetic block) and 1 incident relating to the transfusion of ABO incompatible blood products. There has been a continued downward trend in Never Events at the Health Board, down from 10 Never Events in 2021-22 and 7 in 2022-23.



Learning & Improvements from Patient Safety Investigations

Ophthalmology

There has been an increase in delayed treatment PSIs in relation to Ophthalmology patients in the reporting period. These PSIs are predominantly glaucoma patients who have been lost to follow-up due to lack of senior reviewers. As such there have been 18 PSIs in this category.

These PSIs are subject to local department harm review by Governance and Clinical Teams

In response to these incidents, a number of improvements have been made to mitigate future harm and improve and optimise capacity:

A diagnostic hub was funded and opened in late January 2024, increasing capacity, offering 8 sessions per week and will continue to review patients.
A Second Glaucoma Consultant post
Exploration of training of community optometrist to support the service.
Redistribution of directorate budget to allow for a part-time optometrist to be employed to see new (and follow-up) glaucoma patients.
Stratification tool has been successfully implemented, allowing for those being virtually reviewed to also be risk-stratified.
Implementation of in- house scanning to ensure high risk patients are booked into consultant led clinics in a timely manner with all patient related information available.

Mental Health & Learning Disabilities

During 2023/24, the Mental Health and Learning Disability Division has developed data in relation to unexpected deaths of patients know to the Division. Data from September 2023 required further exploration, and this has led to the development of a more robust database. The information within the database was analysed and the conclusion has been included in the Health Board Learning from Death report.

Awareness raising sessions have been held in relation to actual risk factors evidenced within the National Confidential Inquiry into Suicide and Self-Harm (NCISH).

The Adult Mental Health Directorate have taken part in a national programme of development of person-centred safety planning. Person centred safety planning in mental health services encourages to work collaboratively with service users, patients and where possible people that matter to them, to develop their knowledge and confidence to try out different strategies to help them feel safer in times of crisis or distress. There is a growing body of evidence supporting the benefit of person-centred safety planning on service user outcomes, in addition to improvements to service user experience. In March 2024, early feedback from patients and staff was positive.

The Mental Health and Learning Disability Division have developed 'Top Tip Tuesday' posters to aid the dissemination of learning from Patient Safety Incidents throughout the Division and to date the topics have been WARRN risk formulation, section 115 meetings, documentation of assessments, physical health monitoring, resuscitation procedures, risk management and rationale for discharge being documented when patients did not attend appointments. The posters are distributed via e-mail but are displayed on staff notice boards, backs of toilet doors etc. The use of these has been evaluated and most of the respondents to the survey found the posters informative.

Radiology

There were 6 PSIs reported as National Reportable Incidents in relation to missed radiological findings.

The Executive Director of Therapies and Health Sciences is leading a focused review to identify actions to minimise future harms including the introduction of a red flagging radiology Standard Operating Procedure through which Radiology will add significant incidental findings to reports, and email the referring clinician to alert them, as an additional safety net.

Theatre Safety

Theatre Safety improvement workstreams are ongoing to ensure that Theatre Safety systems are enhanced. These currently include –

Supporting the ABUHB roll out **of National** Safety Standards for Invasive procedures (NatSSIPS)

- Updated World Health Organisation (WHO) Surgical Safety Checklist to incorporate NatSSIPS (8 Sequential Steps).
- NatSSIPS is covered during staff induction sessions and rolling audit day training.
- Ongoing audit of compliance with WHO Surgical Safety Checklist.
- Current workstream for standardisation for surgical item count boards across all ABUHB Theatre sites.
- Current workstream for standardised Local Safety Standards for Invasive Procedures (LocSSIPs) for regional anaesthetic blocks to be used for these procedures across ABUHB.
- Current workstream to improve and streamline the emergency theatre booking system.
- Team briefings are now captured on the IT system.
- Ongoing 'back to basics' training provided monthly around key theatre safety topics.
- 'Pause for the Gauze' / 'Quiet for Count' project across all theatre sites highlighting the importance of quiet focus time for surgical counts.

Human Factors and Quality Improvement (QI) workstreams

- Regular human factors scenarios including team debriefs and identifying areas for improvement/change.
- Capturing learning from human factors scenarios and sharing summaries and action plans – ensuring learning is shared with the wider teams.
- Audit day training has been re-aligned to allow spread of human factors training to other theatres sites
- Ongoing collection of Safety Culture & Psychological Safety surveys of staff.
- Regular staff surveys asking for ideas for quality improvement and exploring projects.
- Building QI coaching capacity within Theatres.

Patient Safety Team - Successes

The corporate Patient Safety Incident (PSI) Team oversee the investigation and management of Patient Safety Incidents where patient harm is moderate, severe or catastrophic.

The Team have enjoyed a number of successes over the 2023-2024 period: -

- ABUHB Patient Safety Incident Reporting & Management Policy updated and refreshed to map to current best practice, patient and family feedback and the National Reporting policy
- Revised PSI Reporting template incorporating current best practice in Human Factors methodologies
- Revised PSI meeting Agenda, with Actions and Outcomes focus, moving away from meeting minutes
- Patient safety incidents information leaflet updated to align to Duty of Candour.
- 'Time Out' improvement focussed sessions with the team
- Successful reduction of NHS Executive historical closures
- Welcomed new colleagues into the team
- Continued to train new organisational investigating officers.
- Providing 1-2-1 support for Investigating Officers
- Contributing bi-monthly National Patient Safety Forum to share learning and network, including presenting in this forum.
- Presenting at Deteriorating Patient Forum.
- Positive feedback from HM Coroner with regards to report quality.

Duty of Candour

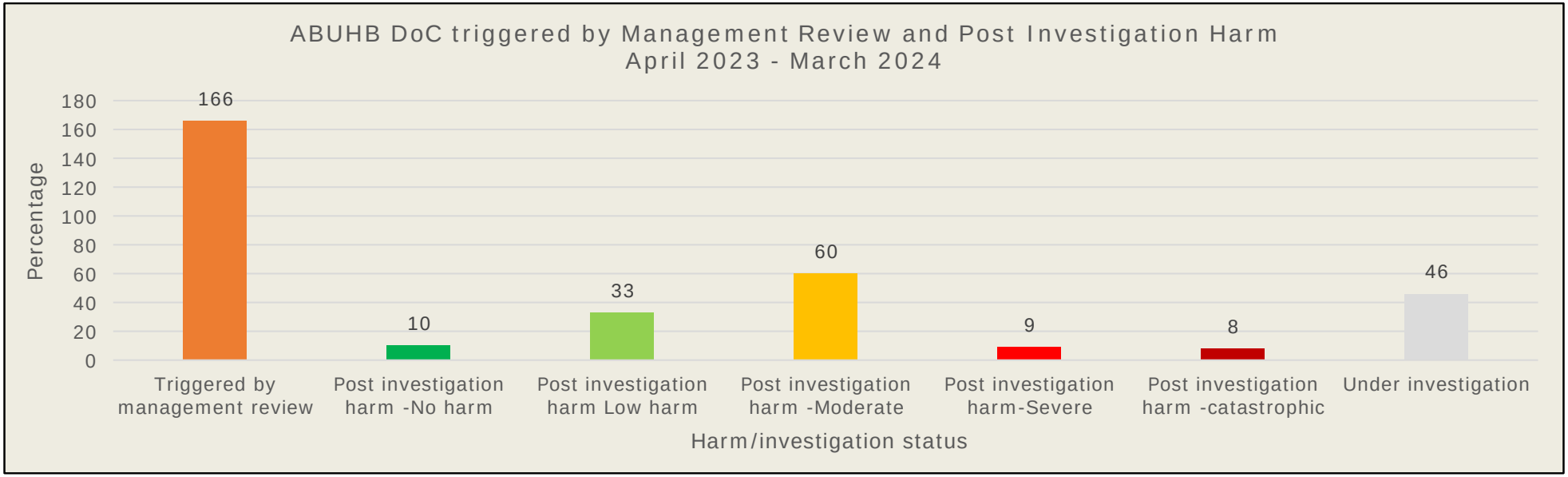
The Duty of Candour came into effect on 1 April 2023 with statutory provisions set through the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

The organisational duty on all NHS bodies requires incident reporting, management and investigation into the circumstances of a notifiable adverse patient safety event to be undertaken in an open and timely manner, including any actions to be taken under the Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011.

The Duty of Candour is triggered when a review of an adverse patient safety event identifies that the service user experienced, or could experience, unexpected or unintended harm that is more than minimal (moderate, severe, death), whilst in receipt of NHS funded care and where the provision of health care was, or could have been a factor in that harm occurring.

In preparation for this transition the Health Board reviewed its management of incidents, systems and processes to align to the requirements of the Duty of Candour to minimise disruption to service user experience.

Following the DoC triggered by management review of incidents, there were 166 incidents in the period, The chart below breaks these incidents down by level of Harm:



Out of these 166 triggering incidents, 44 were then categorised as no/low harm, 60 moderate and 17 severe/catastrophic . Whilst 46 are still under investigation.

Duty of Candour

The harm categorised in the first quarter demonstrated that we required additional education on the harm categories, particularly in distinguishing between actual and healthcare-related harm in lower harm incidents. This is reflected in the feedback from the Divisional Duty of Candour leads who have advised that, when the DoC was first introduced, those submitting and reviewing Datix incidents often found it difficult to distinguish between actual harm and healthcare related harm. The tide is turning and understanding is increasing as this agenda is discussed in multiple forums across the Health Board, thanks to education and support, as well as collaboration with the Divisions and the administrative head within the PSI Corporate team.

Next Steps for 2024/25
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.

Medical Examiner Service within the Health Board and Mortality Review (MR) Screening Panel

Overview:

The Medical Examiner (ME) Service is hosted by NHS Wales Shared Services Partnership and provides an independent scrutiny of deaths in Wales (a similar system is in place in NHS England). This scrutiny is undertaken by a Medical Examiner (ME), who is an experienced doctor with additional training for this role. They are assisted by a Medical Examiner Officer (MEO).

The main role of their service is to; improve the quality of death certification, reduce and avoid unnecessary stress for the bereaved and to strengthen safeguards for the public.

The ME service ensures that an accurate cause of death is recorded. They identify any concerns surrounding the death itself which can then be further investigated by the care provider or coroner if required. They also take the views of the bereaved into consideration. Following this independent review of the death by the ME, the Health Board receives a referral is further action is needed. This provides details of the concern raised and/or highlights any learning for the Health Board with regards to the death.

The scrutiny of deaths by the ME Service began in January 2021 at Aneurin Bevan University Health Board. This process started slowly at each hospital and has gradually spread over two years. All deaths are now reviewed at all sites (excluding maternity, paediatric and neonatal). Approximately 25% of total deaths are referred back to the Health Board for further action by the ME. The Medical Director's team sift and sort the ME referrals and prioritises what needs to be taken to a Mortality Review (MR) Screening Panel.

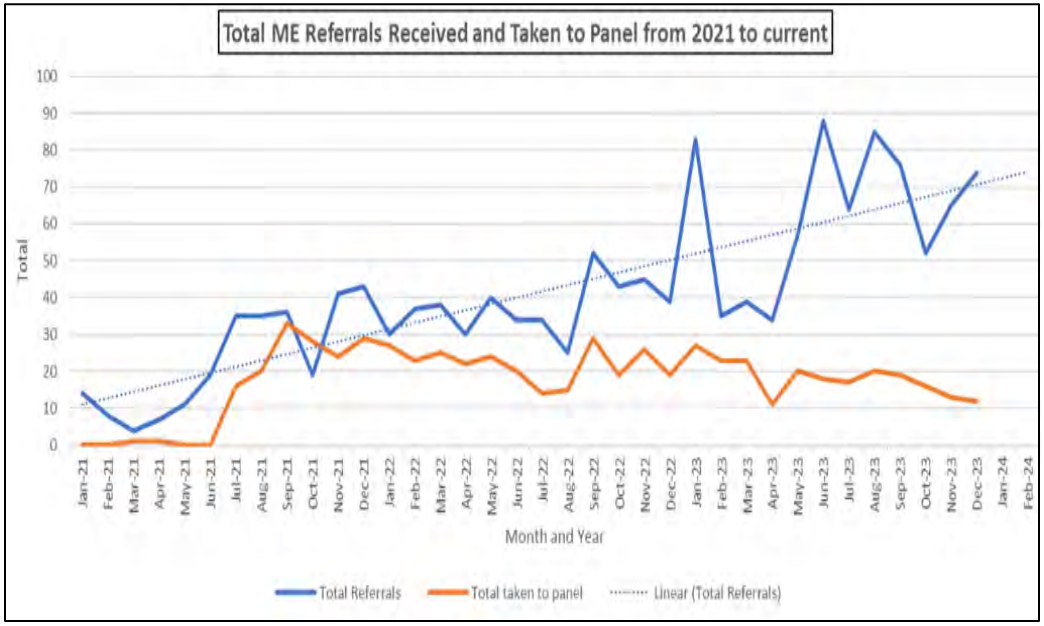
In April 2023, Welsh Government passed legislation for the scrutiny of all deaths (excluding direct coronial cases) by the ME Service. In June 2024 the ME Service expanded their reach to include scrutiny of community deaths throughout Wales. This process is being reviewed ready for implementation by the Health Board. There is no clear timeline at present for provision of ME scrutiny for deaths in the maternity, paediatric and neonatal areas.

Medical Examiner Service within the Health Board and Mortality Review (MR) Screening Panel

Current Work:

Referrals received from the ME that require a review are assigned to a member of the Health Board's Mortality Review (MR) Screening Panel. This is a multidisciplinary group with cross divisional representation that meets weekly. An assigned panel member reviews and presents the case to the group. The panel establishes whether further investigation is required. These actions are then clarified and sent out to the relevant team or clinician for completion.

Throughout 2023/2024 the Health Board's MR Screening Panel has continued to grow and adapt to reflect the expanding nature of the service. The chart below illustrates the increase in the number of referrals received by the Health Board per month since the commencement of the ME Service in 2021. The MR Screening Panel has adapted to reflect the rise in referrals over the past three years.



In April 2023 the Health Board released its first MR Screening Panel Newsletter which focused on themes from the ME referrals and learning. An additional newsletter followed in Spring 2024. Both provided an opportunity for the MR Screening Panel to share information about the ongoing work.

During 2024, the panel membership for level 2 and 3 reviews has increased. Expanding the multi-disciplinary membership of the group allows for more detailed and well-rounded scrutiny of the referred cases.

Medical Examiner Service within the Health Board and Mortality Review (MR) Screening Panel

Future Goals:

Aims for the remainder of 2024 include: -

1. Further expansion of the MR Screening Panel service to adapt and include the deaths in the community, resulting in a further increase in referrals received.

2. Continuing with the biannual newsletter, providing a valuable opportunity for shared learning and themes from ME referrals received.

3. Sharing good news. The ME referral letters often provide positive feedback about the care received for their loved ones, from the bereaved. Going forward we will continue to share these compliments with the clinical areas.

Learning:

Themes are extracted from the ME referral letters that the Health Board receives to inform learning and improvement. Currently one of the most common reasons for ME referrals relate to completion of DNACPR forms. It has been found that forms are not being countersigned in part 6 of the DNACPR form. This theme has been linked into the recent Healthcare Inspectorate Wales report on DNACPR. A memo has been produced to remind staff on the actions needed to be taken to complete DNACPR forms accurately. There is also signposting to the All-Wales DNACPR Policy and information on a training video and highlighting the importance of mental capacity assessment when considering resuscitation status.

There have been a number of concerns related to communication (most frequently relating to the bereaved). We are reviewing how feedback (both good and bad) can be received and captured into the Health Board to share themes and cascade learning. The newsletter that has been produced helps to capture and disseminate the learning and will be produced quarterly.

Conclusion

The 2023/24 year has been challenging for the Corporate Putting Things Right Team with a number of challenges within and external to the team.

Despite the challenges, there has been a number of areas of success:

Redesign and delivery of effective Concern and Investigating Officer training to an evolving and agile workforce.

Improvements in the complaints management process and improvements in the quality of complaints.

Completion of the Covid-19 Investigation requirements.

The roll out and operationalisation of the Patient Advice and Liaison Service Team in November 2023 – this service seeks to intervene early and resolve concerns at the earliest opportunity and supports both in-patients and out-patients.

The establishment of the Patient, Quality, Learning and Improvement Forum with the initial scoping meeting March 2024.

Development of an online complaints form. The new form places emphasis on requesting and capturing the main aspects of the concern and the required details at the outset of patient and family engagement with the Health Board in order to ensure that the complaint response focuses on what matters to the complainant.

The successful centralisation of the QPS resources within the Nursing Directorate

A commitment to ensuring the timely and appropriate management of concerns is a priority, this will continue to be a focus for 2024/25 improve in 2023/24, tackling both existing and new challenges.

Work has continued with the staff, communities and partners to put quality and safety at the heart of everything we do.

Priorities for 2024/25

Priority 1: PTR Regulations and Health Board Concerns Management

1.1 The Putting Things Right Regulations are currently under consultation. The Health Board will ensure we are fully prepared and equipped ahead of any revised guidance being issued, in order to support our staff in the implementation and effective delivery for our communities.

1.2 Early Resolution – Person-centred **approach:** The Health Board is working to ensure that compliance with the Welsh Government 30-working day target is achieved where possible. Collaborative focus days will be planned to review complex concerns and assist with finalisation and conclusion of investigations.

Internal streamlining of quality assurance processes. This aims to provide a more consistent approach to the investigating and subsequent responses to concerns.

1.3 Meaningful Engagement: An Acknowledgement Team will be introduced, to understand early on what people raising concerns are seeking and what matters most to them and how we can resolve concerns in a timely and meaningful way so that they know that they are being listened to and that their concern is being taken seriously.

We will develop Communication Standards to ensure consistency across all our teams. We will be clear in setting out resolution proposals, actions and agreements and dates for contact and updates.

Priority 2: Improving Quality Patient Safety Experience, Learning and Improving

2.1 Embed the centralised QPS/PTR/QI teams.

2.2 A suite of training is being developed which is specific to complaints/incident investigation. The Health Board also intends to work collaboratively with Welsh Risk Pool colleagues and Networks to devise more readily available and accessible video training in the future. The PSOW will also be supporting bespoke training.

2.3 Patient Safety Incidents (PSI):

- Patient safety incident bespoke 1-2-1 IO training to work with new IO's that have been allocated an investigation.
- Complete toolkit for IO's, Panel Chairs, staff involved in PSI's in whatever context.
- Roll-out amended PSI template to align to DoC.
- Induction and education and reset for PSI chairs.

2.4 The ABCi QI Unit have been working to support the development of Quality Improvement Capability across ABUHB.

In particular, the QI Unit are working with divisional staff to develop Quality Improvement Coaches embedded into clinical teams. To this end, a new Quality Improvement Coach programme has been adapted and tested in ABUHB in conjunction with Improvement Cymru.

The programme will run from Autumn 2024, with 3 cohorts planned each year. Potentially 75 QI Coaches will be trained annually, who can support clinical teams in their improvement priorities.

2.5 Development of the Listening and Learning Framework & Learning Repository: The framework will demonstrate how learning will be identified, stored, triangulated, shred disseminated and implemented in practice to facilitate and embed a culture of appreciative enquiry and continually improving health care services.

Priority 3: Partnership Engagement & Collaborative working

3.1 To work closely with external partners such as the Public Services Ombudsman for Wales, Llais, Audit Wales, Health Inspectorate Wales. We will demonstrate an open culture and always seek out opportunities to learn and improve for our ongoing commitment to the population of the Health Board.

3.2 Work with the Medical Examiner's Office to implement the Death Certification Reform.

3.3 Work with the National Bereavement Leads to implement the GRACE bereavement model.

3.4 Continue to meet with and support patients and carers who have raised concerns, either directly or through third parties, such as Llais and the Ombudsman, to improve listening and learning.

3.5 Introduce People Participation Panels for sepsis and dementia.

3.6 Scope existing End of Life Care services and develop an inclusive End of Life Care Pathway in collaboration with people, staff and partners.

3.7 Hold a Big Conversation around Future Care Planning to raise public awareness.

3.8 Divisions to promote the use of the CIVICA system for timely patient feedback.

Agenda Item: 2.5

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:	Research & Development Annual Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr James Calvert, Medical Director
SWYDDOG ADRODD: REPORTING OFFICERS:	Jeannette Wells, R & D Director Sue Bale, R & D Director Dr David Bosanquet, AMD R & D

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 Research and Development Annual Report provides information on the Health Boards key achievements, progress and planned next steps in meeting our research and development strategy – “Research – a core activity” (published December 2022).

Cefndir / Background

Reports from bodies such as the Academy for Medical Science and the Royal College of Physicians show how NHS organisations benefit from undertaking research as part of its core activity. The Health Board recognises this and to ensure that it meets expectations it requires an Annual Report highlighting the achievements and progress to meet the R & D strategy.

The Annual Report provides this information alongside assurances that the R & D department is financially stable and sustainable.

Asesiad / Assessment

The following provides and overview of the achievements during the past year.

- Clinical trial activity has increased from 57 non-commercial studies to 92 non-commercial studies.
- Relationships developed with commercial partners which has seen an increase in the number of commercial trials from 7 (2022/23) to 16 (2023/24) with a further 4 commercial trials in setup and 3 studies awaiting outcomes of the expressions of interest.
- ABUHB has again exceeded the WG/HRW target of 80% of all trials open to recruitment recruiting to time and target with a performance of 95% - increased from 89%. (The Wales average is 78%).
- Health Board was first Health Board in Wales with non-clinical member of staff gaining research officer accreditation. Individual recognised at HCRW Wales conference. Since then a second non-clinician has gained accreditation.
- Joined Wales working group to establish baseline requirements in developing sustainable commercial research presence in Wales, using UK funds to support hub and spoke model of research activity.
- Appointed Lead Nurse in training and education.
- Extended research activity with funded research leads in pharmacy, radiology and pathology.
- Developed research champions programme.
- ICH GCP facilitators trained.
- Research nurse appointed linking NIHR Associate PI schemes. Nurse provides support Health Board staff gain accreditation.
- Enhanced training created for all PI's.
- Positive feedback from students
- Support Advanced Nurse Practitioners to meet requirements set out in the pillars of advanced clinical practice.
- Working in partnership with Cardiff University, University of South Wales and Torfaen Local Authority to share activity, strategies and capability improving the Health Board evidence base.

Argymhelliad / Recommendation

The Committee is asked to receive the report for assurance.

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):	3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Experience Quality and Safety
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:	
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)	
Resource Assessment:	Please confirm you have completed the following:
Workforce	Not Applicable
Service Activity & Performance	Yes, outlined within the paper
Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements

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.



Research and Development Annual Report - 2023



Research and Development Strategy: Research – A Core Activity 2022 – 2027

Foreword

We are pleased to present the Aneurin Bevan University Health Board (ABUHB) annual research and development report which summarises key achievements, progress and planned next steps for the implementation of our research and development strategy: *"Research – a core activity"*.

Reports from bodies such as the Academy for Medical Sciences[1] and the Royal College of Physicians[2] show that NHS organisations which are research active benefit from the 'research effect'. Those benefits include a better care experience, improved outcomes for patients and increased recruitment and retention of staff.

A core theme of our strategy is to ensure that the research infrastructure in ABUHB is financially stable and sustainable. During 2023 Health and Care Research Wales (HCRW), for the first time, set a cost pressure against the Research & Development (R&D) allocation. This resulted in the loss of bank nurses and two nurses were redeployed. Whilst HCRW have a cost pressure for 2024, assurances have been given that this will not affect the NHS. This reinforces the importance of the Health Board generating its own research income to support our patients and clinical services.

Despite external pressure the Health Board has achieved and maintained financial autonomy for its R&D allocation. Welsh Government allow Health Boards financial autonomy where they achieve the all-Wales standard '80% of all trials open to recruitment will recruit to time and target': ABUHB performance has increased from 89% to 95% with the all-Wales average currently at 78%. The annual report summarises key achievements and progress over the last year and planned next steps, including for the coming year and beyond.



Published in December 2022, our Research Strategy aims to achieve a sustainable, streamlined, efficient and innovative research infrastructure built on three strategic objectives

- A sustainable and supported research workforce
- Investment in staff and infrastructure
- A streamlined, efficient and innovative research programme

It sets out our ambition to maximise opportunities for staff to get involved in research and for patients to participate in clinical trials or contribute to research studies that will inform future care. To achieve this, we have engaged widely across the Health Board and social media to establish a number of workstreams aligned to the strategic objectives.

Our vision is to:

- integrate research delivery into operational services
- take research to the patient, regardless of location, wherever possible
- accept referrals from other Health Boards for patients to be included in research offered in ABUHB and vice versa
- build on areas or strength and opportunity
- align strategic plans to Health Board and Welsh Government priorities



To achieve this we will:

- Identify and continually review areas of priority for the Health Board, patients and Welsh Government.
- Work with the Health Board to assess existing referral pathways across organisations and expand to include research.
- Continually review workstream progress, identifying and removing barriers as they arise.
- Continue to identify best practice and share across all workstreams.
- Categorise clinical trials by complexity and risk to determine level of specialist research involvement required to run fully embedded studies.

ABUHB research implementation plan: designed by the workforce for the workforce

A series of engagement workshops were held over the first six months of 2023 to support the development of an implementation plan designed by the ABUHB workforce. As a result, eight workstreams were established.

The workstreams meet monthly and come together quarterly with the research senior management team to discuss progress, risks, barriers and any overlap.



In 2023, HCRW issued WHC/2023/026: NHS Framework for Research and Development – Research Matters – What excellence looks like in NHS Wales. [3]

The framework consists of ten pillars, and in 2023 formed the baseline used by Welsh Government and HCRW for their annual performance review of NHS organisation research and development (R&D) activity.

Workstreams map progress and next steps against the framework to ensure compliance and for ease of reporting.



Why we do Research



1928 the discovery of Penicillin

Sir Alexander Fleming was a Scottish physician and microbiologist. He is best known for discovering penicillin, the world's first antibiotic substance.

His discovery in 1928 of what was later named benzyl penicillin (or penicillin G) from the mould Penicillium Rubens is described as the "single greatest victory ever achieved over disease." For this discovery, he shared the Nobel Prize in Physiology or Medicine in 1945 with Howard Florey and Ernst Boris Chain.



"One sometimes finds, what one is not looking for. When I woke up just after dawn on September 28, 1928, I certainly didn't plan to revolutionise all medicine by discovering the world's first antibiotic or bacteria killer. But I suppose that was exactly what I did."

Alexander Fleming



Strategic objective 1: a sustainable and supported research workforce



Action

Increase the number of commercial trials

Key publications:

- Lord O'Shaughnessy Review of Commercial Trial activity in the UK. [4]
- UK Government Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG) funding: ABPI/NIHR/HCRW opportunity to develop commercial research hubs.

Progress

- Increased the number of commercial trials from 7 (2022/23) to 16 (2023/2024) with a further 4 commercial trials in setup and a further 3 studies awaiting the outcome of expressions of interest.
- A number of relationships have been established with Industry Partners who are keen to work with the Health Board as a preferred partner.
- ABUHB is a member of a group working with HCRW/WG to establish baseline requirements to develop a sustainable commercial research presence in Wales utilising UK Government VPAG funding (anticipated Welsh share: c£20m). The bid will pump prime a commercial hub and spoke model where Health Boards and Trusts in Wales will work together to offer patients the opportunity to take part in commercial clinical trials wherever in Wales the service can be provided. Non-recurrent funding is available from April 2025-March 2029; This will be factored in when bidding for funds to ensure services are sustainable at the end of that period.

Workstream

External Funding

Next steps: 2024

- Work with HCRW to bid for ABPI/NIHR/ VPAG funding to develop a sustainable commercial offering.
- Increase capacity within the research delivery team to set up and oversee the introduction of a commercial hub.
- Work with research active directorates to explore joint research fellow posts part funded by the directorate and part funded by R&D.
- Appoint a clinical research fellow to the clinical trials unit to support sustainable commercial research activity.
- Develop a brochure that will showcase the clinical trials unit. This will be used to build collaborative relationships with commercial companies.

Next steps: 2025

- Establish a commercial portfolio in phases. Phase one will include five clinical areas where there is expertise within the existing department and where commercial companies are already working with R&D and an established PI:

    - Haematology
    - Rheumatology
    - Older adult psychiatry
    - Interventional cardiology
    - Vascular wound healing

- Consolidate relationships with Innovation to support the development of new and innovative ideas through research, utilising HEI and Industry links.
- Manage the risk of the Sponsorship role. Commercial research should always have an external experienced Sponsor.
- Identify and remove barriers to commercial trial set up to ensure rapid study set up becomes a USP that attracts commercial companies to the Health Board as a preferred partner.
- Set up times for commercial trials (from receipt of the local information pack (LIP) to recruitment of 1st patient)
- NB: Metrics are only collected once a patient is recruited and when the recruitment target is less than 2
- 22/23 no data
- 23/24 152 days
- Prepare ABUHB bid for national VPAG funding.

RISKS:

- Commercial spend beyond five years will need to be sustained through commercial capacity building income.
- Inability to support services to continue research activity where a research active service is moved to a site with no research space. e.g. breast services relocation to YYF.

Action

Develop and deliver a training programme for all research active staff and those aspiring to become research active

Established training opportunities:

- ICH GCP (Good Clinical Practice) training.
- Principal Investigator (PI) training.
- Phase 2 trial training.
- Consent to research training.
- Student placement training opportunities.
- National Institute for Health Research (NIHR) Associate PI Scheme.
- NIHR Clinical Research Practitioner registration programme.
- Enhancement of the research team skills to ensure preparedness to accept earlier phase trials (commercial and non-commercial).

Progress

- Lead Nurse specialising in training and education has been appointed.
- In-house ICH GCP facilitators have received training from HCRW. As well as delivering full ICH GCP training the facilitators can deliver study specific ICH GCP training and ICH GCP training tailored to working environments.
- There is now a research nurse linked to the NIHR Associate PI Scheme. The nurse is able to offer all Health Board staff the opportunity to gain this accreditation. This work has already realised benefits by enabling the opening of studies with both medical and nursing associate PIs. The offer is also open to AHPs and non-clinical staff. Currently all AHPs involved in trials have been able to step straight into the PI role.
- In addition to the standard PI training offered, enhanced phase training has now been developed and is available for all PIs. This supports PIs embarking on more intensive complex trials, including PI oversight and documenting evidence of this.

Workstream

Education

- ABUHB were the first Health Board in Wales to support and successfully achieve a non-clinical staff member gaining research officer accreditation. The individual was recognised for their achievement at the HCRW conference. Since then, a second non clinical member of staff has completed accreditation. The Health Board continues to share this good practice by promoting the scheme locally and nationally.
- Student placements have been increased with positive feedback, including a nomination at the student conference. A previous student has secured a job within a research department in Wales.
- Enhanced skills training has been introduced across the research delivery team including emergency scenario training, complex trial toolkit and ward orientation for non-nursing staff.
- Established links with corporate nursing to support Advanced Clinical Practitioners in meeting the research requirements set out in the pillars of advanced clinical practice.

Next steps: 2024

- Develop research documentation training for all levels.
- Complete a training needs analysis at basic, medium and high level for all research active roles.
- Develop general awareness: how to embed research and basic research knowledge training for all Health Board staff.
- Continue to offer placements for student nurses and explore the opportunity to diversify to other specialties.

Next steps: 2025

- Develop phase 2 complex trial training for Health Board PIs.
- Explore the inclusion of 'research awareness' within the Health Board induction package.

RISK:Currently there is no capacity within the induction package to include research, therefore it is important that we continue to offer education on R&D elsewhere.

Action

Workforce Opportunities: Work with university partners to promote opportunities - university collaborations

Building University Partnerships:

- Re-establish the Health Board partnership Board.
- Develop PIs and Chief Investigators (CIs) through partnership working with HEIs and the HCRW faculty.
- Work with universities to develop low intensity low risk research that is relevant to local teams and whereby research can be embedded with light touch specialist research support.
- Review service evaluation oversight and identify most appropriate approval scrutiny route.

Progress

- Cardiff University is the main partner for ABUHB university Health Board status, although within Wales the Health Board also works closely with the University of South Wales, Cardiff Met University, Bangor and Swansea Universities.
- A meeting was held with the Dean of the Cardiff Medical School and his senior staff to explore additional opportunities.
- Made contact with the lead for the Cardiff University Joint Research Office (JRO) to explore the possibility of developing an ABUHB/CU JRO.

Workstream

University Partnerships

HEI and third sector research currently in development

- Cardiff University Business School/ABUHB Staff Well-Being and OD services. An NHS based research centre.
- Supporting Torfaen Local Authority (LA) to become research active. This will include working in partnership with the University of South Wales (USW) and Public Health Wales (PHW) to share strategies, policies, staff, research governance structures, etc; to develop capacity and capability within Torfaen LA to become an evidence-based and research active organisation.

- The Torfaen partnership has been successful in winning an NIHR grant which will enable properly funded activity and present opportunities for further grant applications for more research across the partners. ABUHB staffs' salaries are built into this grant.

Next Steps: 2024

- Benchmark service evaluation review and approval across Wales and develop an SBAR to amend the current process.
- Re-establish the partnership board. The university partnership board is a forum where the local university partners meet with ABUHB Executives and leads for Research and Education to ensure alignment of vision and strategies and plans to deliver these.

Next steps: 2025

- Establish university partnerships outside of Wales.
- Work with HEI partners to look at ways of being able to prioritise areas of research between ABUHB and its university partners where there is a shared interest and capacity.
- Maximise the potential of embedding low risk research university sponsored research into the core service. There is a continuous flow of research studies in development, funding applications, grants applications and awarded grants where research can be delivered between HEI partners (across a wide variety of schools) and ABUHB (across the diverse clinical and non-clinical Directorates).



Strategic objective 2: Investment in staff and infrastructure



Action

Trial feasibility to include assessments of complexity and risk to determine the level of support required from the research team, and capacity required of the clinical team to run the study

Action

Continue to meet HCRW performance metrics that demonstrate best practice and open doors for preferred partnerships.

Governance Infrastructure:

- Establish a new R&D committee.
- Research Quality committee.
- Research Risk Register.
- Audit programme to ensure compliance with GCP.
- Process for local research Sponsorship (under review).
- MHRA inspection preparedness.
- Continually review staffing levels and requirements to ensure progress in delivering the strategy can be maintained.
- Contracts manager appointed.

Workstream

Research delivery and governance infrastructure

Progress:

- Clinical trial activity has increased from 57 non-commercial and 5 commercial studies open and recruiting in 2022 to 92 non-commercial and 10 commercial studies in 2023.
- WG/HCRW all Wales metric '80% of all trials open to recruitment will recruit to time and target': ABUHB performance has increased from 89% to 95% with the all-Wales average currently at 78%.
- Improvement seen in trial set up and opening times, in line with national guidance this is monitored locally to identify and act on any blocks or delays.
- All studies undergo a complexity assessment to determine the level of support required by the research delivery team. Complexity also determines how much of the study can be embedded within standard care.
- At all complexity levels adequate departmental training is provided before the trial opens with ongoing support remaining under review, including the collection of recruitment metrics and problem solving as required.
- The study set-up system has been streamlined across research delivery and research governance teams with the of reducing/removing duplication.
- A trainee contracts manager has been appointed enabling quicker study set-up including implementation of the national contract value supporting the UK approach to standardised costing for commercial contracts and supporting the HCRW One Wales for research delivery programme which further streamlines the set-up process.
- Planning with the Cancer Directorate has led to increasing cancer trial opportunities and embedding research within standard of care. The work has included aligning the research strategy objectives with those set out in the National CReST strategy.[5]
    - Studies include QuicDNA where ABUHB are sponsor and the first site to open. ABUHB and C&V are working closely with Cardiff university to open all sites in Wales. It is anticipated that blood biopsies to determine treatment plans for lung cancer will become standard practice in 2025 reducing the time taken to identify and start targeted treatment.
    - Year one has seen a rise in cancer research recruits by 3% and an increase of cancer trials from 9 to 16, compared to previous year.

- The R&D strategy and action plan is aligned to and takes consideration of the NHS Framework for Research and Development: WHC/2023/026 with regular self-assessment and benchmarking undertaken.
- A neonatal study, 'Neogastric' is the first trial where ABUHB have trialled its embedding model. Extensive departmental training was delivered, including meeting with staff on all shifts and delivering training at the cot-side. The first few recruits were overseen by the research delivery team and these were audited. Early indications are that the model has been a success.

Next steps: 2024

- Develop speciality research leads for each cancer area.
- Work with the of cancer services MDT to ensure research activity is discussed and that information is recorded regarding the number patients who enter cancer clinical trials including Velindre early phase trials.
- Review IT Infrastructure to support commercial activity. More worked is needed to comply with the MHRA expectation that all NHS organisations should be able to provide access to electronic health records, to enable quicker screening and easier access for external monitoring: to do this organisations need to have IT systems that reduce the associated with remote monitoring:
  - Monitors should have read only access
  - Site files should be electronic with enabled electronic archiving
  - Monitor access to files should be fully auditable
- Monitors should only be able to access the files of patients who are participants in the relevant trial

RISK: IT Infrastructure is currently the highest risk on the R&D risk register where the risk of an Information Governance Breach through E-Site files is scoring as high (12). The mitigation's being worked through with IT above will have the ability to reduce the risk to low.

Next steps: 2025

- Continue to monitor the embedding model and commence roll out to other areas under strict audit conditions.

Action

Support research active consultants

Research time: Opportunities

- develop role description to support the allocation of additional responsibility sessions for research within job planning.
- research time awards: i.e., HCRW faculty funding.
- work in conjunction with university partners to promote/establish joint working opportunities.
- ensure research is included in directorate activities. To include directorate meetings, quality committees and MDTs.

Progress:

Associate Medical Director for Research & Development Mr David Bosanquet appointed



Workstream

Workforce Opportunities



Next steps: 2024

- Work with AMD for Job Planning to identify - SPAs and additional responsibility sessions awarded for research and correlate with research activity to validate continuation of paid sessions.
- Support incorporating research additional responsibility sessions into job planning.
- Identify Research Fellows across the organisation and discuss research activity and potential.
- Work with HEIs to progress opportunities for joint appointments.

Next steps: 2025

- Engage with Clinical Directors to ensure they are fully engaged with research activity.
- Engage with Clinical Directors and Directorate Managers to ensure research forms part of their quality agenda, covering research activity, support service engagement and service redesign.

Progress:

- Funded research leads in place in pharmacy, radiology and pathology.
- Funded Histopathologist time to ensure blocks and slides can be accessed in a timely manner for ABUHB patients taking part in clinical trials in ABUHB, Velindre and other sites.
- Regular contact with pharmacy with ongoing discussions to ensure capacity to provide aseptic products required to support the objective to deliver more commercial research as well as many non-commercial studies i.e., rheumatology, neurology
- Research pharmacist now attends all first dosing visits.

Next steps: 2024

- Work with pathology, radiology and pharmacy to identify and address delays in study set-up times.

Next steps: 2025

- Work with pathology, radiology and pharmacy to identify and remove blocks to enable delivery of studies.

RISK: service redesign can result in support services needing additional funding to support research at the new location.

- All Wales R&D directors and HCRW to liaise with Transforming Access to Medicines (TrAMs) coordinators to ensure clinical trials have access to aseptic pharmacy facilities. The aim of TrAMs is to enable access to aseptic pharmacy facilities in three hubs across Wales as part of shared services.

RISK: this is crucial to the success of the national VPAG bid and commercial research aspirations across Wales.

- Work with support services to compliment and streamline the delivery of research trials.
- Reach out to directorate pharmacists to scope ideas to link in with research pharmacists.

Action

Work with estates to enable a research presence across multiple sites

Progress

- Accommodation request made for clinical space in YYF to support surgical and breast cancer clinical trials.

  RISK: bid has so far been unsuccessful (under review)

- A meeting has been arranged with the Medical Director, R&D Director and clinical teams in YYF to explore options.

Next steps: 2024/2025

- Work with estates, planning and the Clinical Futures programme to develop new sites to establish clinical trial activity across multiple sites within the Health Board.
- Consider mobile research unit (possibly using VPAG funding).
- Re-submit accommodation request for clinical space in YYF to support surgical and breast cancer clinical trials (maintain communication channels.)
- Explore opportunities in GUH for clinical research space.
- Continue to work with cancer services, planning and Velindre to ensure clinical trial space and support service availability will be present in the proposed cancer centre at NHH.

Workstream

Support Services Estates

Strategic objective 3: A streamlined, efficient, and innovative research programme



Action

Establish a community of practice

Progress

- Communication mechanisms and engagement have been improved through various channels:
- X (formally Twitter)
- New Internet and Intranet pages
- HCRW and Health Board communications team have established links to ensure Intranet and Internet are aligned and that opportunities are not missed (research time, grant funding, education awards etc).
- R&D have established stronger working relationships with the Health Board communications team following the successful launch and open day in the clinical research centre.
- ABUHB research team are members of the National Communication Alliance, this ensures alignment of ABUHB research communication with HCRW and other Health Boards, subsequently increasing research visibility.
- The R&D Directors and Medical Director and the Health Board Independent Member for research meet on a monthly basis.

Next steps

- Engage with research champions through regular meetings and workshops to understand their priorities for research and also their views on study feasibility.
- Further develop and maintain the Intranet and Internet pages, ensuing opportunities are captured and publicised in advance.
- Develop patient experience poster board for public areas.

Workstream

Community of practice

Communications to improve workforce, patient and public awareness of R&D and to better understand research needs and priorities

Action

Establish a research champions programme

Progress

- Significant progress has been made in developing the research champions programme. The first cohort will meet in 2024. They will:
  - establish a terms of reference
  - discuss their priorities for research and also their views on study feasibility.
  - staff who are research champions will promote and encourage research activity

- Through social media patients and public have shown an interest in being research champions. Role descriptions have been developed and applications are being processed through the volunteer service.
- Research champion logo developed and agreed through consultation with staff and patients and the public. Badges, mugs and lanyards purchased in readiness for the launch.

Next steps: 2024

- **Launch research champion's programme**
- **Establish working groups for research champions**





Aneurin Bevan University Health Board
Research and Development Department

Be a Voice for Research

RESEARCH CHAMPION

Opportunities for patients, carers, and members of the public

Are you:

- over the age of 16
- friendly and reliable?
- interested in research?

Would you like the opportunity to:

- Promote research in the Health Board and the Community?
- Share your views on some of the research studies the Health Board is considering taking on?
- Receive research-related training and education?

ffrind i mi
friend of mine

REGISTER NOW



ABB.Ffrindimi@wales.nhs.uk

Action

Support Principal Investigators

Progress

- PIs are being supported in their roles through development of networking opportunities.
- The PI: randomised coffee trials project launched in 2023 seeks to connect PIs from across the Health Board on a monthly basis regardless of professional background or area of work with the aim of encouraging networking opportunities and peer support.
- Established education sessions.

Next steps: 2024

- Invite external speakers to PI: randomised coffee trials. Record events to share more widely. Increase advertising for events.
- Establish a new open event session on the clinical trials unit where Health Board staff interested in applying for grant awards or research time opportunities can seek advice and guidance. Include university, faculty and HCRW partners as appropriate.

Action

Exploit opportunities to collaborate with internal and external strategy leads

Progress:

Links made with:

- Diversity strategy.
- Communications and engagement strategy – empowering communities to have influence in how we deliver services, tailored to our audiences – utilising staff, community leaders and local trusted voices, listening to staff and patients – identifying correct stakeholders.
- ABUHB nursing strategy
- Clinical futures strategy
- Innovation strategy
- HCRW research framework
- Cancer strategy
- Estates strategy Health Board 10 year strategy

Next steps: 2024

- Continued engagement with cancer board to embed research into all cancer MDTs.
- The Health Board nursing and midwifery strategy aims to embed research and innovation into practice. The workstream will review current and proposed activities to support corporate nursing in realising this aim.

Next steps: 2025

- With executive lead support, work with clinical futures and planning to ensure research activities are inclusive to service redesign.
- With executive lead support, work with estates to establish clinical trials presence in YYF and GUH.

Research Governance

"Today, informed consent is at the heart of medical ethics and regulation to ensure the rights and dignity of research participants is protected"





1920–1951
Henrietta Lacks

Henrietta Lacks was an African-American woman whose cancer cells are the source of the HeLa cell line – the first immortalised human cell line. They reproduce indefinitely under specific laboratory conditions, and continue to be a source of invaluable medical data to the present day.

In 1951, Lacks underwent treatment for cervical cancer at Johns Hopkins Hospital in Baltimore. Cells from a tumour biopsy were cultured and the cell line known as HeLa was created. At the time, no consent was required to use the cells for research. It was only later in 1975 that the Lacks family were made aware of the cell line, and in October 2021, Lacks' estate filed a lawsuit against Thermo Fisher Scientific for profiting from the HeLa cell line without Lacks' consent.

The story of Henrietta Lacks, her family, and the creation of HeLa cells has been a catalyst for policy change. In particular emphasising the importance of informed consent.

Today, informed consent is at the heart of medical ethics and regulation to ensure the rights and dignity of participants of research projects are protected. Seeking informed consent properly respects a person's right to determine what happens to them by giving them the information they need to make a decision.

Forward Plan



The R&D strategy and action plan will remain under review to ensure flexibility to incorporate new guidance, changes to practice locally and nationally, and to continue to forge links to local and national strategies.

2023 examples:

- The Lord O'Shaughnessy Review: Commercial Clinical Trials in the UK, sets out 27 recommendations, including both priority actions and longer-term ambitions for UK commercial clinical trials
- UK government VPAG (voluntary scheme for branded medicines pricing, access and growth) in association with the ABPI (Association of the British Pharmaceutical Industry) will invest £300m over five years to bolster the NHS's capacity to deliver commercial clinical research.
- NHS Framework for Research and Development: WHC/2023/026
- CReST: the cancer research strategy for Wales

The Research Champion initiative has been under development throughout 2023. Volunteers from within the Health Board and members of the public have shown an interest in becoming research champions with members of the public currently being enrolled through the Health Board volunteer scheme. There will be a formal launch in 2024.

The Lead Nurse for Research Education has been in post for a year. Training programmes have been developed and delivered enhancing the knowledge and skills of researchers and aspiring researchers. The lead nurse is a member of the PQSOG and aligns that agenda with the R&D quality group including an audit programme and risk register. Next steps will see the introduction of a new R&D Committee that will receive reports from across all areas of research delivery and governance for information, action or escalation as appropriate.

2024 is set to be an exciting year. The appointment of an Associate Medical Director (AMD) for R&D there will bring a focus to supporting and developing research fellows, PIs and current or aspiring CIs.

The AMD will work alongside the current senior management team to further develop relationships with universities to provide opportunities for staff of all grades to work alongside/shadow university colleagues to better understand enablers to joint working.

In addition, the senior management team will consolidate connections with commercial companies interested in working with ABUHB as a preferred partner; this together with the VPAG funding should ensure ABUHB will be ready to meet the recommendations of the Lord O'Shaughnessy review to increase our commercial footprint. Once the UK Governments implement the recommendations of the review there will undoubtedly be new metrics set for commercial activity and those metrics will be performance managed. The strategy implementation team will continue to work flexibly to ensure the new metrics are implemented with immediate effect.

Recommendations

The Executive team are asked to note the contents of the annual report and submit to the PQSOG for information and submission to the Board.

References:

[1]Enhancing the NHS-academia interface | The Academy of Medical Sciences (acmedsci.ac.uk)
[2] Research for all: Developing, delivering and driving better research | RCP London
[3] Research matters - What excellence looks like in NHS Wales (healthandcareresearchwales.org)
[4] Commercial clinical trials in the UK: the Lord O'Shaughnessy review - final report - GOV.UK (www.gov.uk)
[5] CReSt: the cancer research strategy for Wales - Marie Curie Research Centre - Cardiff University



Agenda Item:2.6

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:	National Organ Donation Report April 2023-March 2024
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr James Calvert, Medical Director
SWYDDOG ADRODD: REPORTING OFFICERS:	Dr Matthew Carwardine – Critical Care Consultant ABUHB & Clinical Lead for Organ Donation Sharon Keightley – Specialist Nurse for Organ Donation

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 latest NHSBT Report regarding Actual and Potential Deceased Organ Donation for ABUHB covers the period 1 April 2023 – 30 March 2024

The covering letter, full report and summary report is attached as Appendix 1.

Cefndir / Background

Health Board organ donation performance reports are produced biannually by NHSBT and include a summary report, a detailed report and a covering letter highlighting key figures and issues.

This latest report will be reviewed at the Health Board Organ Donation Committee (ODC) meeting to be held on 30th August 2024.

The reports are generated using data from the National Potential Donor Audit (PDA) and the UK Transplant Registry.

The PDA reviews all deaths in critical care and emergency department of patient's aged 80 and under to investigate the potential for missed opportunities for donation.

Data from the PDA report also provides information on the quality of care in ABUHB at key stages of organ donation.

This is then reviewed by the ODC to investigate where there is potential opportunities for care improvement.

The ODC has input from a number of stakeholders. Key individuals include the Organ Donation Committee Chair (Shelley Bosson – Independent Member ABUHB), the Clinical Lead for Organ Donation/CLOD (Dr Matthew Carwardine – Critical Care Consultant ABUHB) and the Specialist Nurse for Organ Donation/SNOD (Sharon Keightley - NHSBT).

The ODC Chair, Shelley Bosson, has now retired and stepped down as Chair and the Committee is currently waiting for a new chair to be nominated.

Asesiad / Assessment

Summary of donation activity:

There were 8 solid organ donors over the 12 months from 13 consented donors which resulted in 19 patients receiving a transplant.

80 patients were referred and 24 met criteria for inclusion onto the Potential Donor Audit. This was 100% referral rate.

There were no missed referrals during this period and there continue to be no missed referrals since 2019. This is a key aim to maintain as low as possible as it has the greatest impact in terms of avoiding missed opportunities for organ donation. The rate is a key indicator of Health Board success and performance.

Currently ABUHB is classed as exceptional (gold) for referral rates when compared with UK performance and average (bronze) for SNOD presence and consent rates.

A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families as this has been shown to increase consent rates. This occurred in 18 organ donation discussions but there was 1 occasion where a SNOD was not present. This case has been reviewed by the ABUHB Organ Donation team and consent for organ donation was obtained in and it was believed that there were no specific actions to be learnt from the episode.

A further target is that neurological death tests should be performed wherever possible in appropriate patients. This was not completed for 3 out of 16 potential patients as it was believed to be inappropriate given the personal circumstances of each case. These have also been reviewed by the Health Board organ donation team who agree with the decisions taken.

In addition to solid organ donation, tissue donation is a vital part of donation activity. During the 12-month period 31 corneas were donated by ABUHB patients to the NHSBT Eye Banks.

Other notable activity:

Successful introduction of a protocol for withdrawal of life sustaining treatment in theatres for donation after circulatory death; this has been used successfully for DCD donations.

Successful in obtaining funds from the regional NHSBT funding stream and commissioned Studio Response to produce an Organ Donation Artwork that will be installed at GUH to commemorate our organ donors.

ODC members have participated as faculty in a regional Deceased Organ Donation simulation course on the 15th April 2024 and several ABUHB staff also attended as delegates.

Organ Donation Week in September 2023 saw a number of events take place and the front entrance of GUH was lit up pink to mark the occasion.

A series of Organ Donation storyboards have been installed in the main corridor in GUH and an opening event was held on the 25th August 2023 with some of the donor families and transplant recipients involved in these stories.

In July 2024 the GUH Organ Donation Team was awarded the Runner Up prize in the Team of the Year Award at the Health Board staff recognition awards.

The Organ Donation Team has been well received at several community events in and around ABUHB to promote Organ Donation within the Ethnic Minority Groups, cultures and backgrounds.

Argymhelliad / Recommendation

The Committee is asked to consider the report for assurance.

Appendix 1

NHSBT Reports Apr 2023 – March 2024

Covering Letter



Letter.pdf

Detailed Report



Detailed report.pdf

Summary Report



Summary report.pdf

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 4.1 Dignified Care 5.1 Timely Access Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Experience Quality and Safety
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:	Please confirm you have completed the following:
Workforce	Not Applicable
Service Activity & Performance	Yes, outlined within the paper
Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements

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/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

NHS
Blood and Transplant
www.nhsbt.nhs.uk

Dear Mrs Prygodzicz and Mr Calvert,

The number of donors and transplants in the UK have continued to improve and we are returning to pre-pandemic levels. Please accept our recognition and thanks for the effort of your staff.

This letter explains how your Health Board contributed to the UKs deceased donation programme.

From 13 consented donors, Aneurin Bevan University Health Board facilitated 8 actual solid organ donors resulting in 19 patients receiving a transplant during the time period. Additionally, 31 corneas were received by NHSBT Eye Banks from your Health Board.

The referral of potential organ donors to our Organ Donation Service and the participation of a Specialist Nurse for Organ Donation in the approach to family members to discuss organ donation are key steps in ensuring the success of organ donation.

- Your Health Board referred 80 patients to NHSBT's Organ Donation Services Team; no referrals were missed (100% referral rate) and 24 met the referral criteria for inclusion in the UK Potential Donor Audit.
- A Specialist Nurse participated in 18 organ donation discussions with families of eligible donors. There was 1 occasion when a Specialist Nurse was absent for the donation discussion.
- There was 1 (2%) missed opportunity to follow best practice out of 43 during the time period, compared with 1 (5%) out of 19 in 2022/23.
- In Wales, 44% of the population have registered an NHSBT Organ Donor Register (ODR) opt in decision. This compares to 42% of the population nationally.

Up to date Health Board metrics are always available via our Power BI reports found here:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

- Ensure your Health Board supports your Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities.
- Discuss activity and quality data at the Board with support from your Organ Donation Committee Chair.
- Recognise any successes your Health Board has had in facilitating donation or transplantation, especially during the ongoing NHS pressures.
- An opt-in registration on the NHSBT Organ Donor Register results in the highest rates of consent, please support your Organ Donation Committee in their efforts to promote the NHSBT Organ Donor Register where possible.

Wales introduced deemed consent in December 2015. In Wales, between 1 December 2015 – 31 March 2024, there were 220 occasions when consent was deemed from 346 occasions where deemed consent applied.

In 2023/24, 154 people benefited from a solid organ transplant in Wales. However sadly, 15 people died on the transplant waiting list during this time.

Thank you once again for your vital ongoing support for donation and transplantation.

Yours sincerely,

Anthony Clarkson
Director of Organ and Tissue Donation and Transplantation
NHS Blood and Transplant

Business Disability Forum
Building disability-smart organisations
Positive About Disabled People



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3.6 Solid organ donation

5.1 Referral to Organ Donation Service
5.2 Organ donation discussions

6.1 Supplementary Regional data
6.2 Trust/Board Level Benchmarking

A.1 Definitions
A.2 Data description
A.3 Table and figure description

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report and our Power BI reports with up to date Health Board metrics are available at https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2024 based on data meeting PDA criteria reported at 8 May 2024.

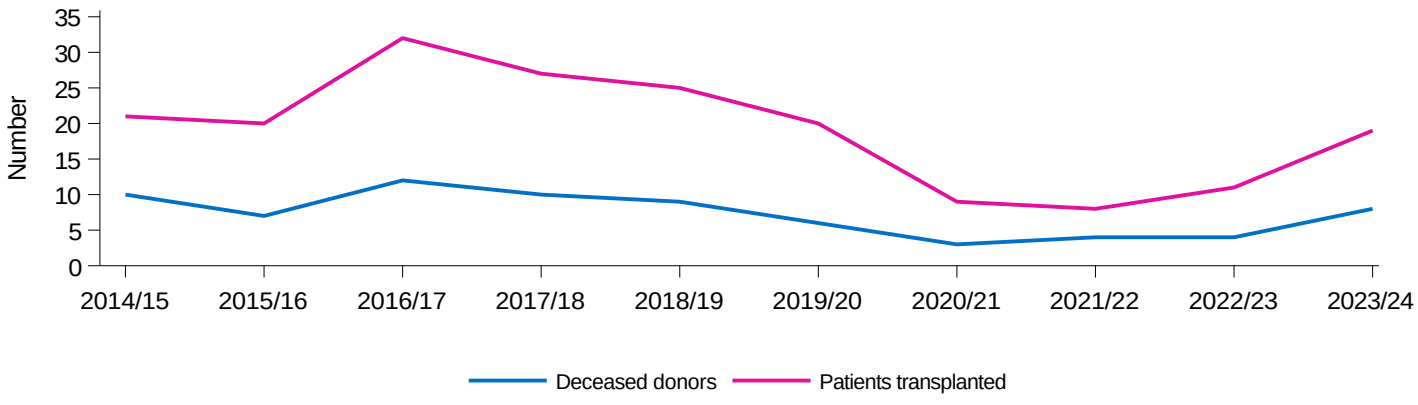
1. Donor Outcomes

Between 1 April 2023 and 31 March 2024, Aneurin Bevan University Health Board had 8 deceased solid organ donors, resulting in 19 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2022/23. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

DBD	6	(4)	15	(11)	3.2	(3.3)	3.6	(3.4)
DCD	2	(0)	4	(0)	2.0	(-)	2.9	(2.8)
DBD and DCD	8	(4)	19	(11)	2.9	(3.3)	3.2	(3.2)

In addition to the 8 proceeding donors there were 5 additional consented donors that did not proceed, one where DBD organ donation was being facilitated and 4 where DCD organ donation was being facilitated.

DBD	8	(8)	0	(1)	5	(2)	1	(1)	2	(0)	0	(0)
DCD	4	(0)	0	(0)	0	(0)	0	(0)	0	(0)	0	(0)
DBD and DCD	12	(8)	0	(1)	5	(2)	1	(1)	2	(0)	0	(0)



2. Key Numbers in Potential for Organ Donation

This section presents key numbers in potential donation activity for Aneurin Bevan University Health Board. This data is presented in Table 2.1 along with UK comparison data. Your Health Board has been categorised as a level 3 Health Board and therefore percentages in this section are only presented on a national level. A comparison between different level Health Boards is available in the Additional Data and Figures section.

It is acknowledged that the PDA does not capture all activity. There may be some patients referred in 2023/24 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA.

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

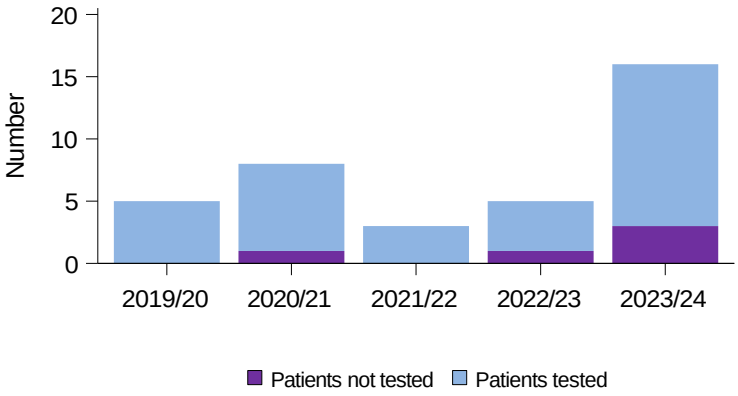
[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* 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

3. Best quality of care in organ donation

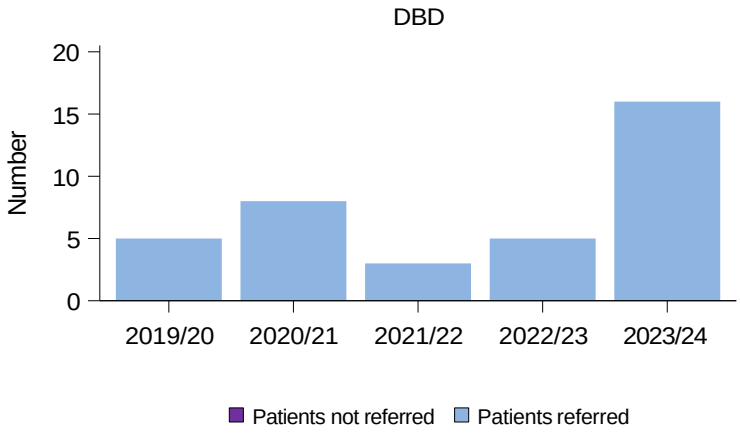
This section provides information on the quality of care in your Health Board at the key stages of organ donation. The ambition is that your Health Board misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

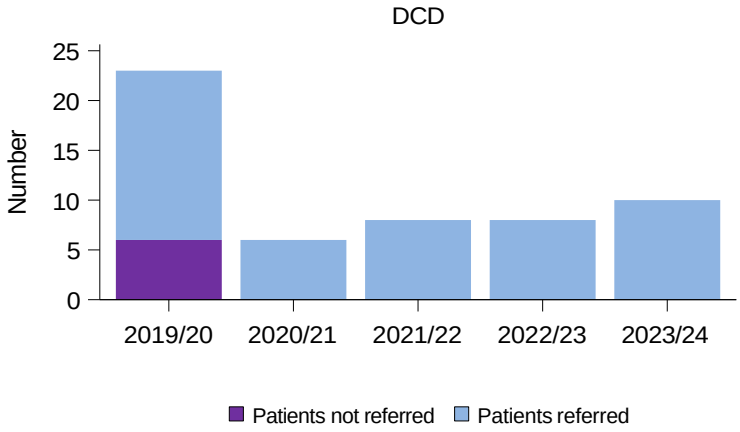


Biochemical/endocrine abnormality	-	32
Clinical reason/Clinician's decision	-	72
Continuing effects of sedatives	-	15
Family declined donation	1	40
Family pressure not to test	1	55
Hypothermia	-	1
Inability to test all reflexes	-	20
Medical contraindication to donation	-	5
Other	-	58
Patient had previously expressed a wish not to donate	-	4
Patient haemodynamically unstable	1	151
Pressure of ICU beds	-	1
SN-OD advised that donor not suitable	-	13
Treatment withdrawn	-	20
Unknown	-	8

If 'other', please contact your local SNOD or CLOD for more information, if required.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.





Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	4
Coroner / Procurator Fiscal reason	-	1	-	-
Family declined donation following decision to remove treatment	-	-	-	9
Family declined donation prior to neurological testing	-	-	-	1
Medical contraindications	-	-	-	42
Not identified as potential donor/organ donation not considered	-	8	-	260
Other	-	1	-	9
Patient had previously expressed a wish not to donate	-	-	-	2

If 'other', please contact your local SNOD or CLOD for more information, if required.

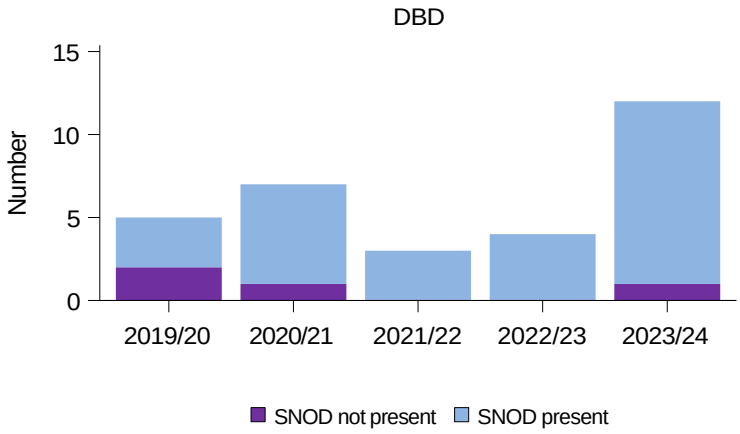
Pressure on ICU beds	-	-	-	5
Reluctance to approach family	-	-	-	2
Thought to be medically unsuitable	-	-	-	42
Uncontrolled death pre referral trigger	-	2	-	6

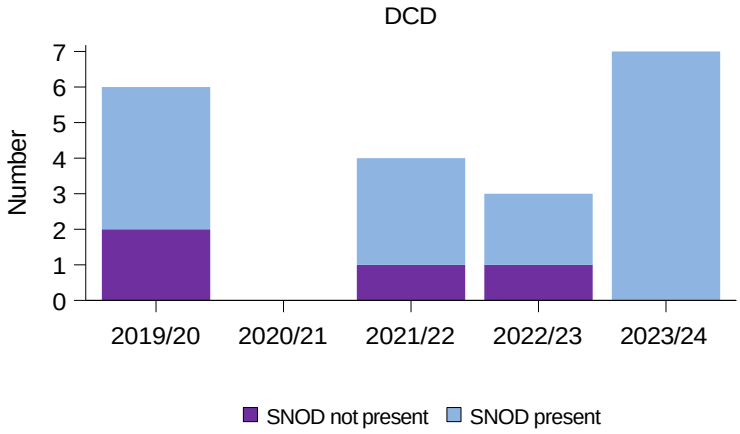
If 'other', please contact your local SNOD or CLOD for more information, if required.

In 2023/24 there were 16 potential donors in your Health Board with an ACI reported, 16 DBD and 16 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

In the UK, in 2023/24, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 23% and 14%, respectively, compared with DBD and DCD consent/authorisation rates of 70% and 60%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known decision of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.



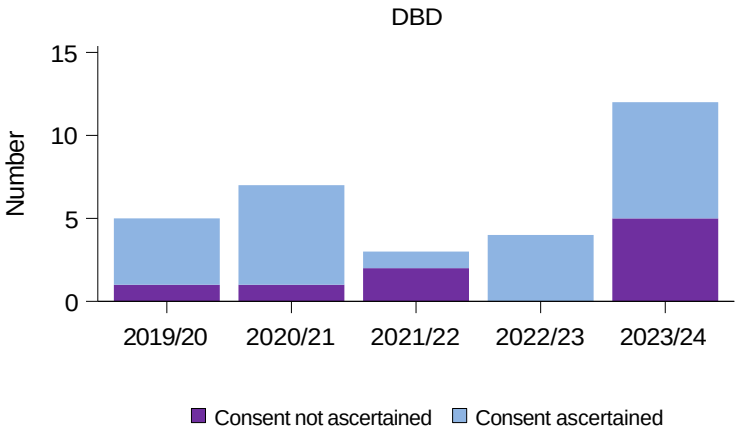


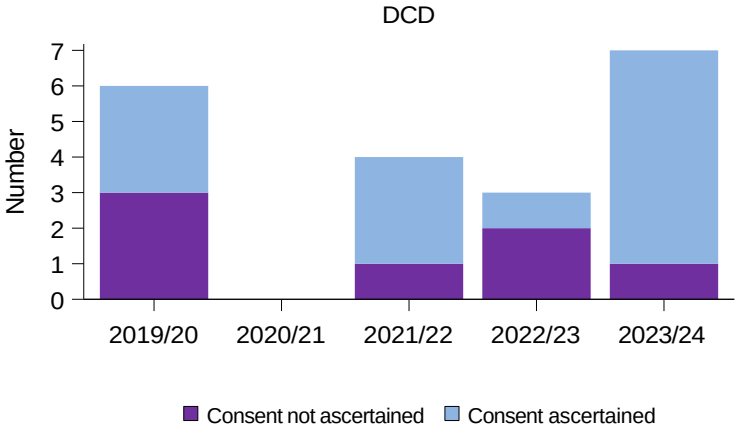
[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 8 May 2024]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 8 May 2024]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 8 May 2024]

In 2023/24 the DBD consent rate in your Health Board was 58%, less than 10 families of eligible DCD donors were approached therefore this consent rate is not presented.





Family believe patient's treatment may have been limited to facilitate organ donation	-	-	-	1
Family concerned other people may disapprove/be offended	-	3	-	4
Family concerned that organs may not be transplantable	-	2	-	8
Family did not believe in donation	-	5	-	9
Family did not want surgery to the body	2	42	-	57
Family divided over the decision	1	12	-	20
Family felt it was against their religious/cultural beliefs	-	49	-	28
Family felt patient had suffered enough	-	24	-	78
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	13	-	17
Family felt the length of time for the donation process was too long	1	30	-	167

If 'other', please contact your local SNOD or CLOD for more information, if required.

Family had difficulty understanding/accepting neurological testing	-	3	-	-
Family wanted to stay with the patient after death	-	5	-	17
Family were not sure whether the patient would have agreed to donation	-	49	-	113
Other	-	24	-	57
Patient had previously expressed a wish not to donate	1	94	-	167
Patient had registered a decision to Opt Out	-	21	-	43
Strong refusal - probing not appropriate	-	25	1	39

If 'other', please contact your local SNOD or CLOD for more information, if required.

Clinical - Absolute contraindication to organ donation	-	3	-	5
Clinical - Considered high risk donor	-	4	-	8
Clinical - DCD clinical exclusion	-	-	1	2
Clinical - No transplantable organ	1	7	1	12
Clinical - Organs deemed medically unsuitable by recipient centres	-	17	-	58
Clinical - Organs deemed medically unsuitable on surgical inspection	-	9	-	6
Clinical - Other	-	3	-	7
Clinical - PTA post WLST	-	-	-	164
Clinical - Patient actively dying	-	4	1	7
Clinical - Patient asystolic	-	3	-	1
Clinical - Patient's general medical condition	-	1	-	6
Clinical - Positive virology	-	2	-	-
Clinical - Predicted PTA therefore not attended	-	-	-	1
Consent / Auth - Coroner/Procurator fiscal refusal	-	10	1	8
Consent / Auth - Family placed conditions on donation	-	-	-	1
Consent / Auth - NOK declined organ donation	-	1	-	-
Consent / Auth - NOK withdraw consent / authorisation	-	6	-	22
Consent / Auth - Other	-	-	-	1
Logistical - Other	-	-	-	1
Logistical - Retrieval team not available	-	-	-	1
Logistical - Unit unable to maintain patient	-	-	-	1

If 'other', please contact your local SNOD or CLOD for more information, if required.

4. PDA data by hospital and unit

Tables 4.1 and 4.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

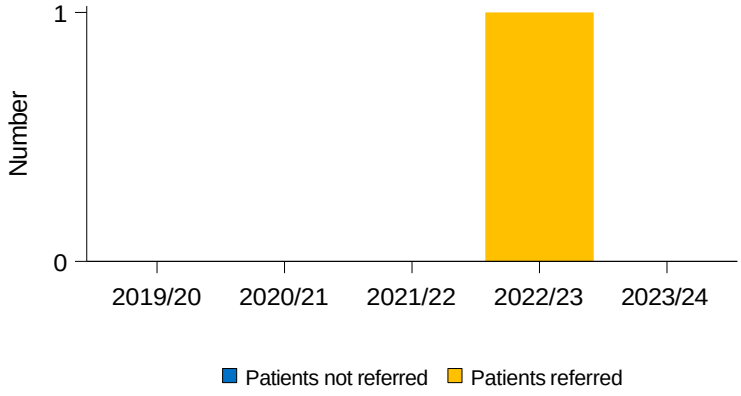
Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Llanfrechfa, The Grange University Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
ICU - general	16	13	81	16	100	13	13	12	11	92	7	58	6

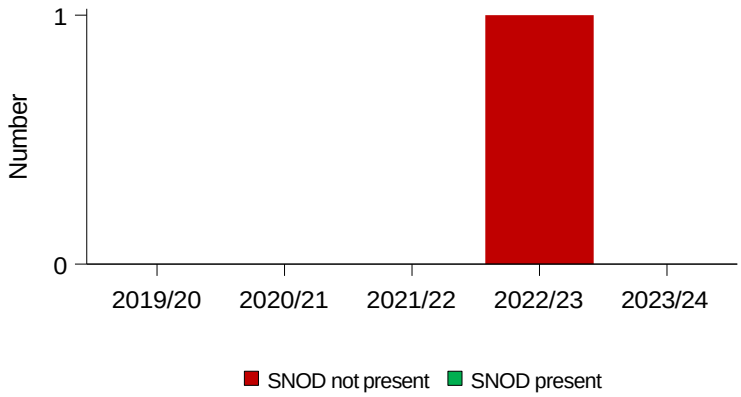
Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Llanfrechfa, The Grange University Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
ICU - general	10	10	100	10	10	7	7	-	6	-	2

Tables 4.1 and 4.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Aneurin Bevan University Health Board in 2023/24 there was 1 such patient. For more information regarding the Emergency Department please see Section 5.

5. Emergency Department data

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a decision in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [4] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.





[4] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 8 May 2024]

6. Additional data and figures

Deceased donors	57	1,510
Transplants from deceased donors	154	3,723
Deaths on the transplant list	15	418
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

Aneurin Bevan University Health Board has been categorised as a level 3 Health Board. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 6.2 shows the criteria used and how many Trusts/Boards belong to each level.

Level 1	12 or more (≥ 12) proceeding donors per year	36
Level 2	6 or more but less than 12 (≥ 6 to <12) proceeding donors per year	51
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	31
Level 4	3 or less (≤ 3) proceeding donors per year	39

Tables 6.3 and 6.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	16	13	81	16	100	13	13	12	11	92	7	58	6
Level 1	1183	881	74	1174	99	858	814	715	682	95	483	68	451
Level 2	539	414	77	538	100	402	388	344	339	99	242	70	220
Level 3	169	138	82	167	99	138	130	119	116	97	81	68	72
Level 4	138	101	73	138	100	98	94	81	78	96	52	64	45

	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Your Trust	10	10	100	10	10	7	7	-	6	-	2
Level 1	2735	2533	93	2669	1932	1066	965	91	590	55	430
Level 2	1532	1426	93	1494	1039	499	454	91	285	57	187
Level 3	583	547	94	559	353	167	154	92	93	56	54
Level 4	481	443	92	464	311	117	99	85	55	47	39

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)

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)

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 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.

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

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

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.

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.

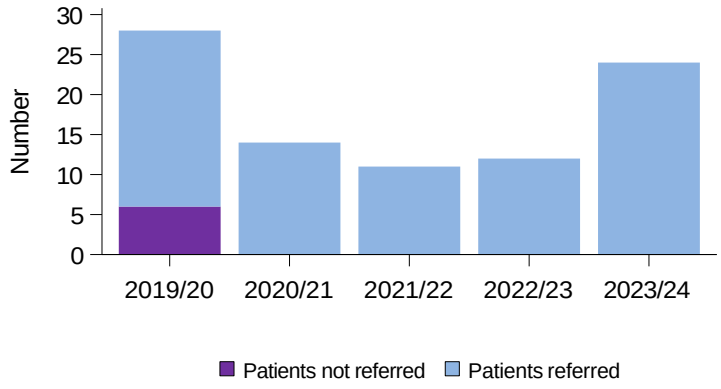
5 Emergency department data	
Figure 5.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time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

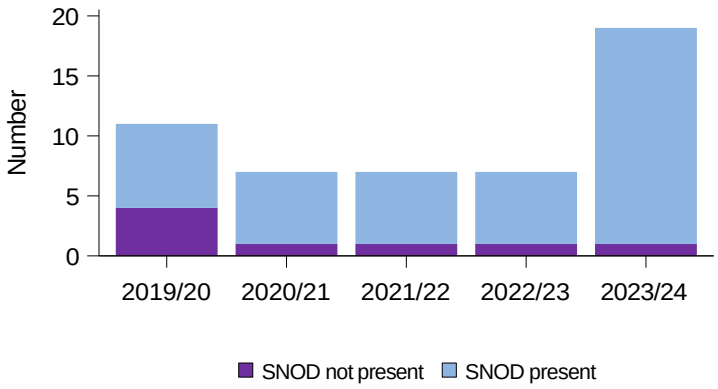
NHS
Blood and Transplant

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.



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



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

- 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.

Deceased donors	57	1,510
Transplants from deceased donors	154	3,723
Deaths on the transplant list	15	418
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 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).

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

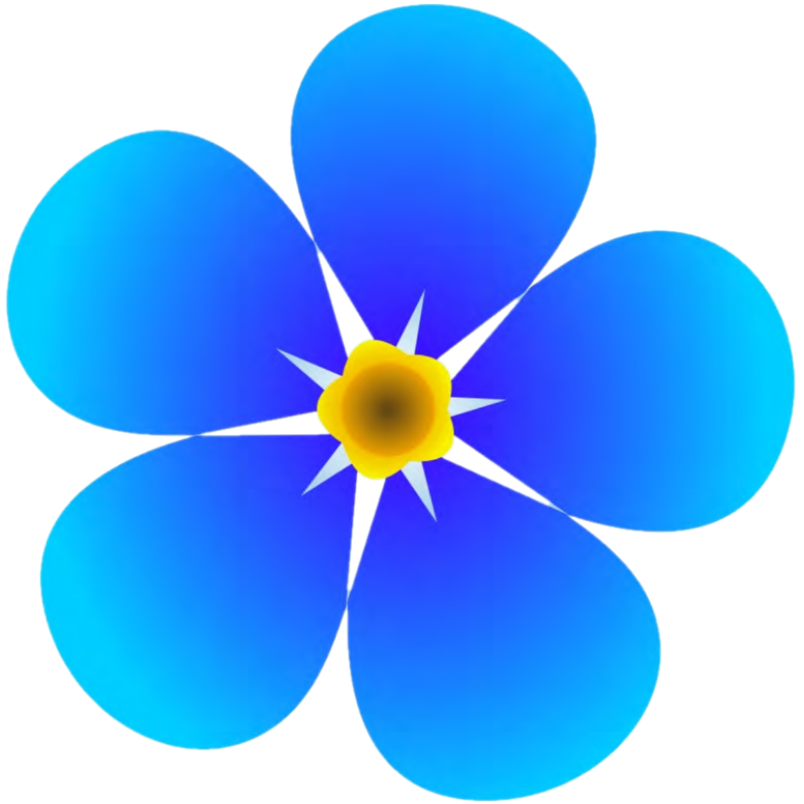
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive

	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

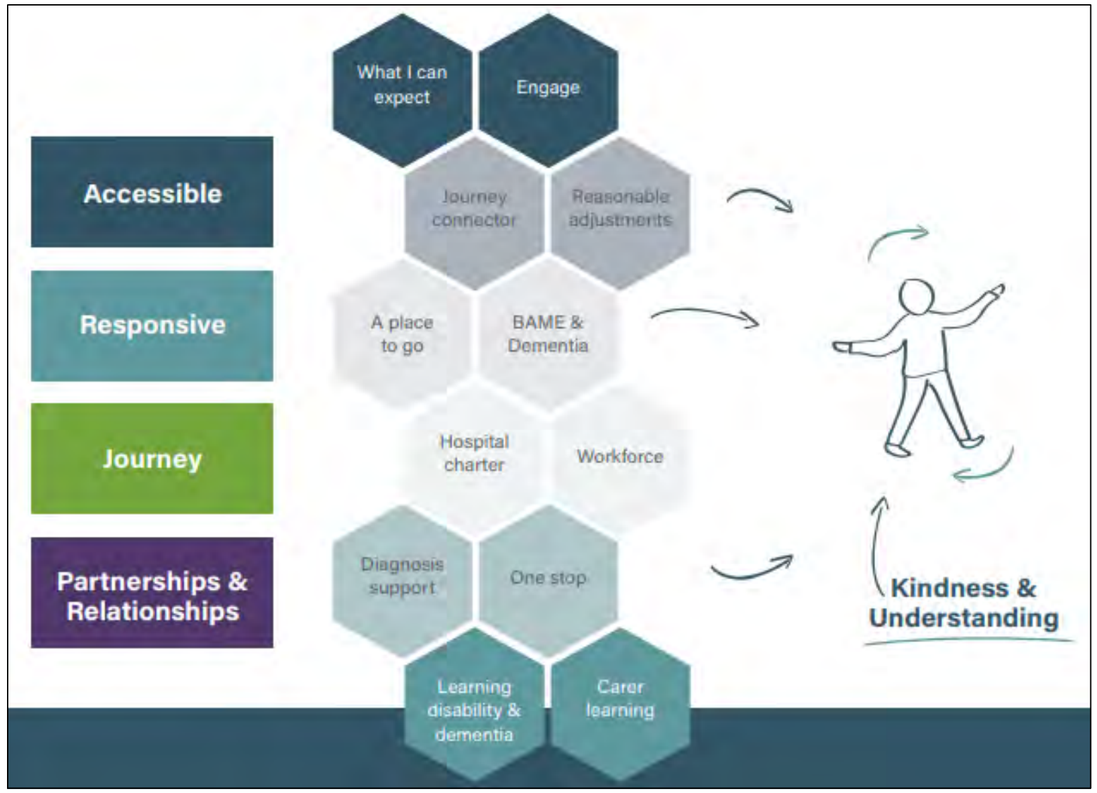
Prepared for the Regional Dementia Board

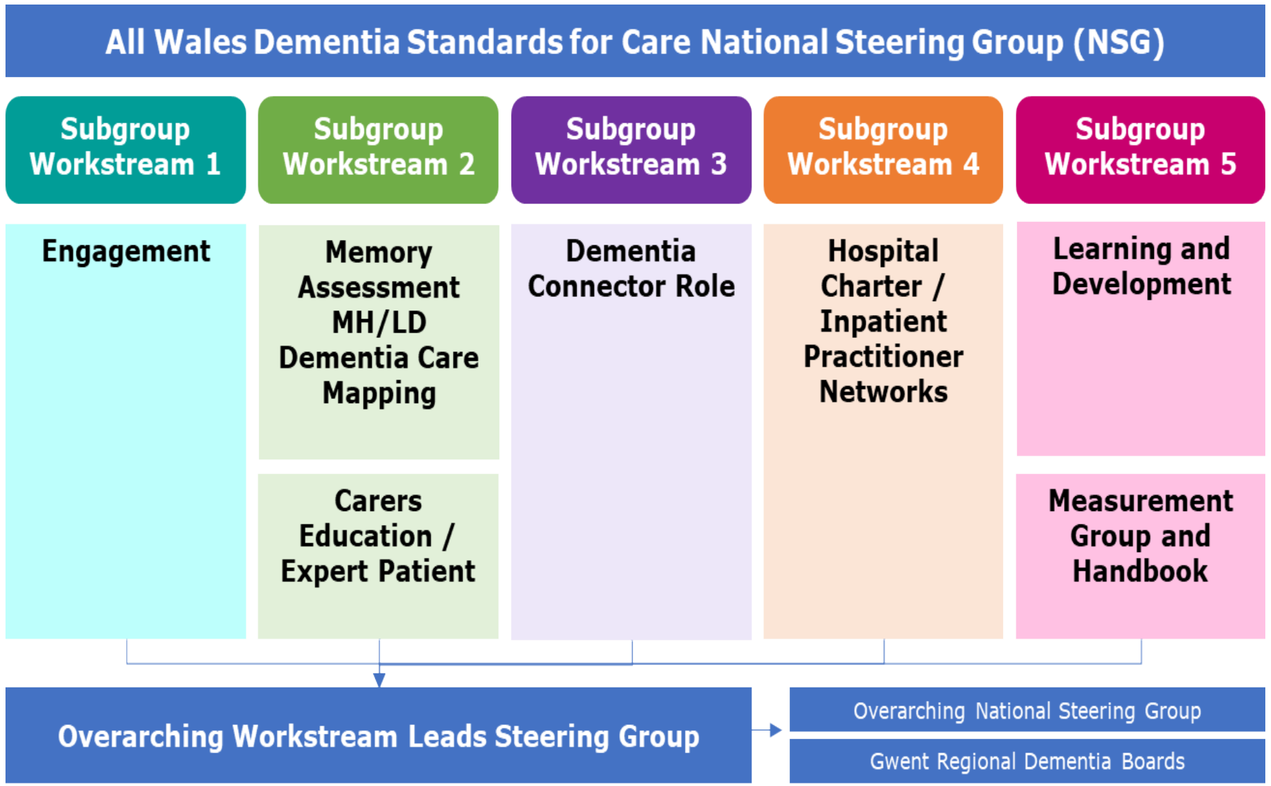
2023 -2024



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

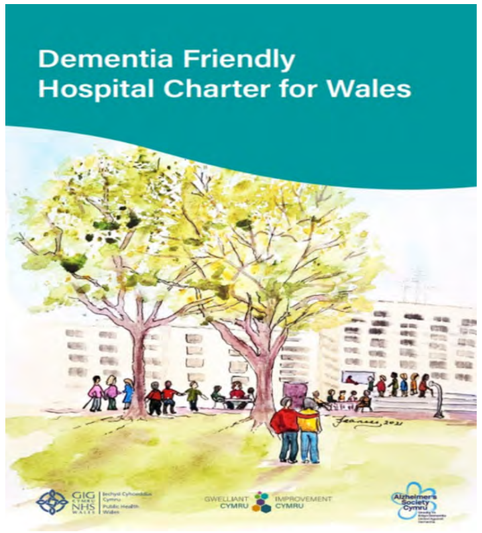
Dementia Friendly Hospital Charter

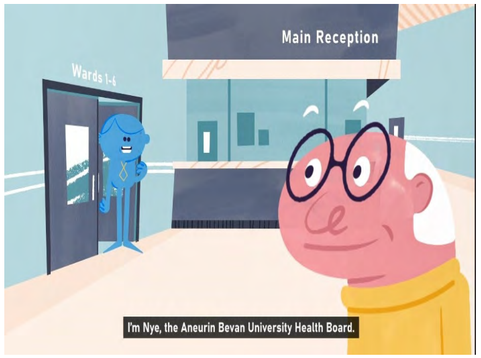
The Hospital Charter aims to improve the experience of people living with dementia when they are in hospital. This experience must recognise an individual's personhood, diversity and preferences, shaped by recognising the importance of dignity, respect and kindness.

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.

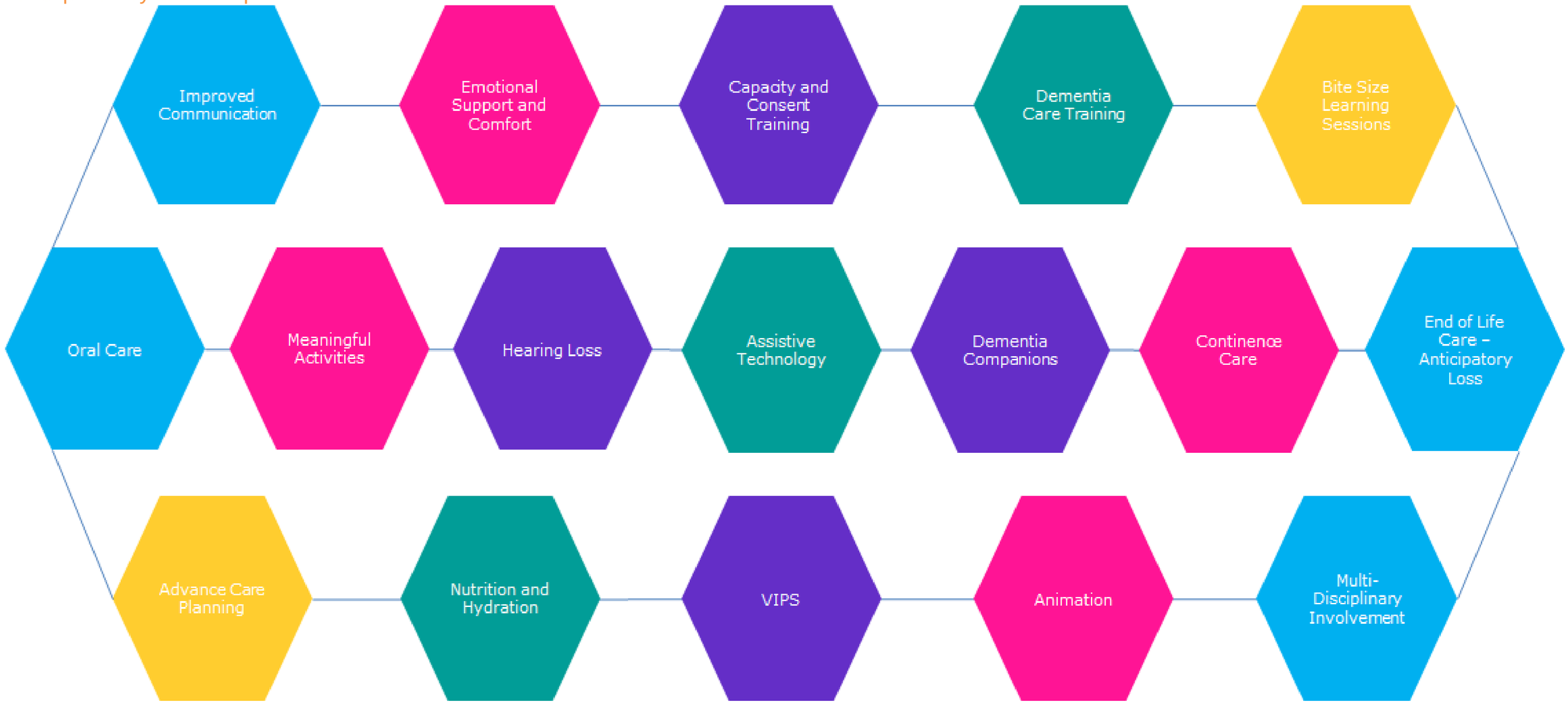




Responding to Patient and Family Feedback

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.



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.



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.

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

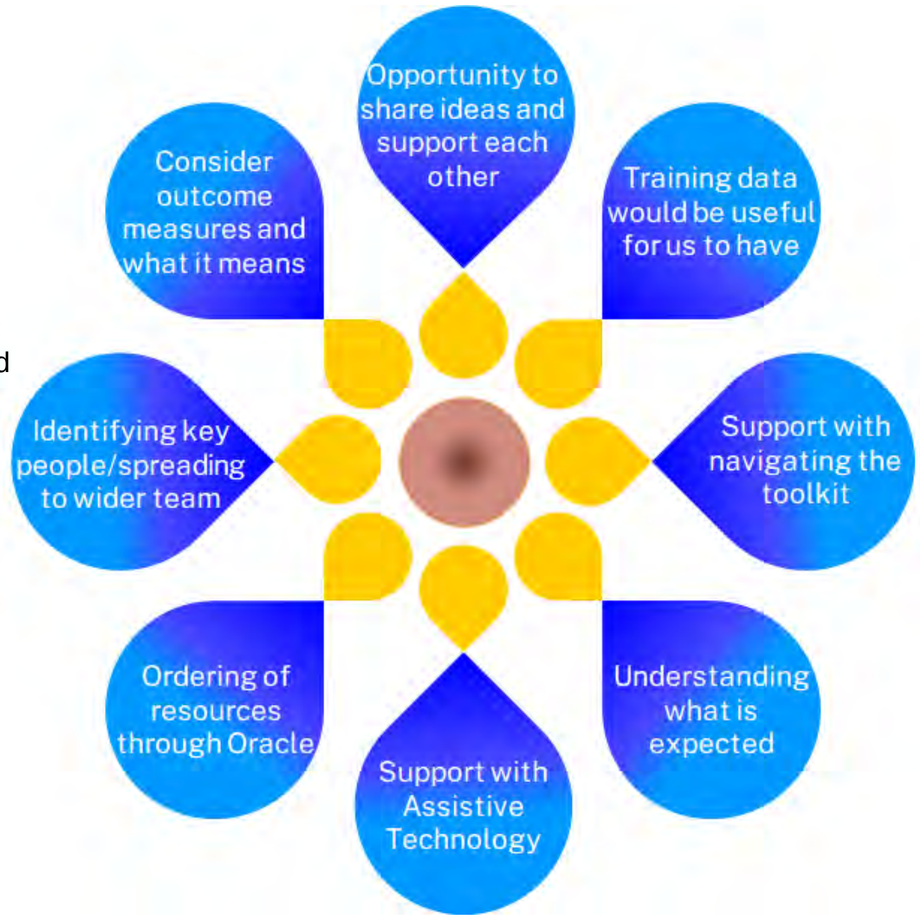
Staff Feedback:
"Thanks for great training session regarding VIPS. It was inspirational".







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.

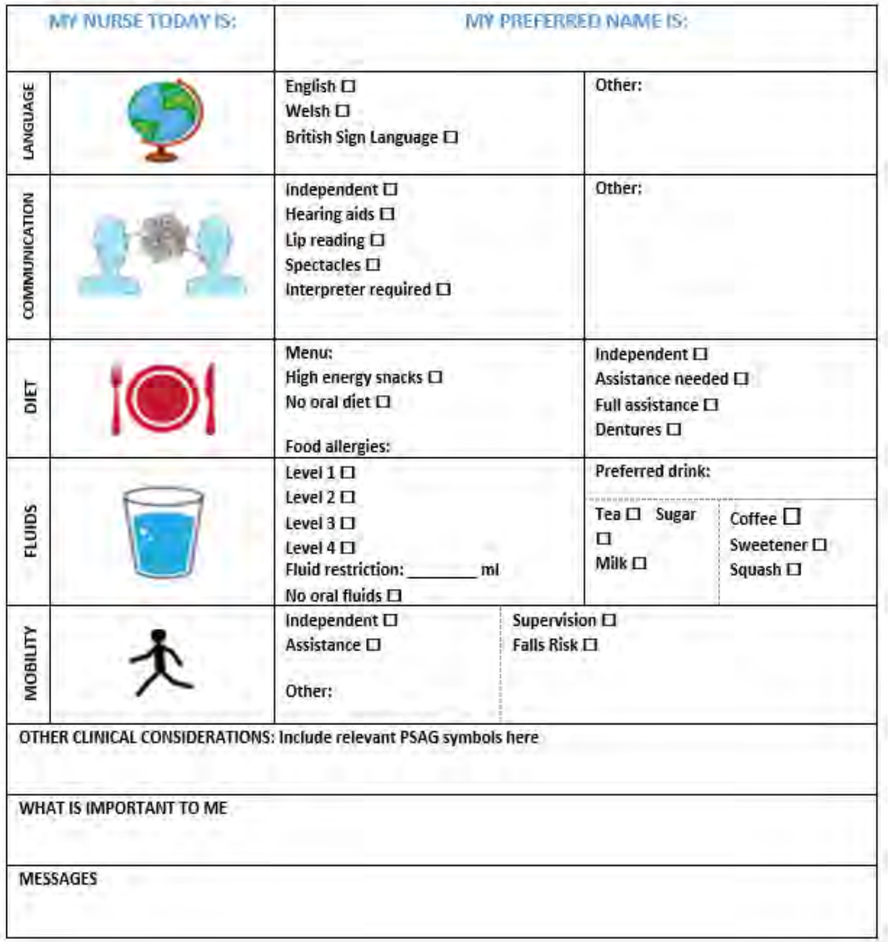
The evaluation identified that the boards had been very well received by both patients, families and visitors, volunteers, ward staff and the multi disciplinary staff working within the care settings.

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



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

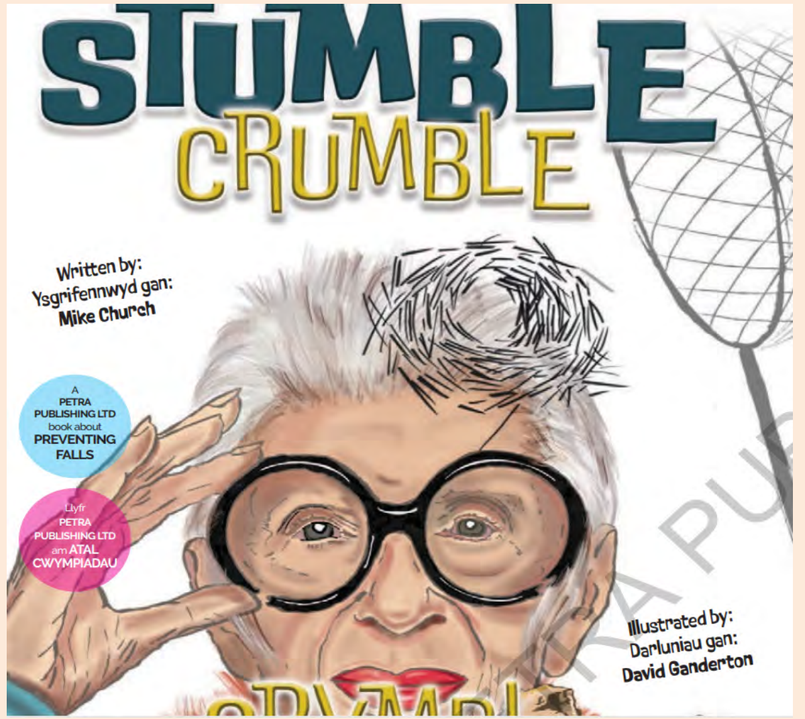
We have commenced linking the 16 care homes in the Meaningful Engagement programme to the intergenerational programme with the aim of increasing the relationship between these areas and supporting with learning from schools, hospitals and care homes who already participate in the scheme.





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.

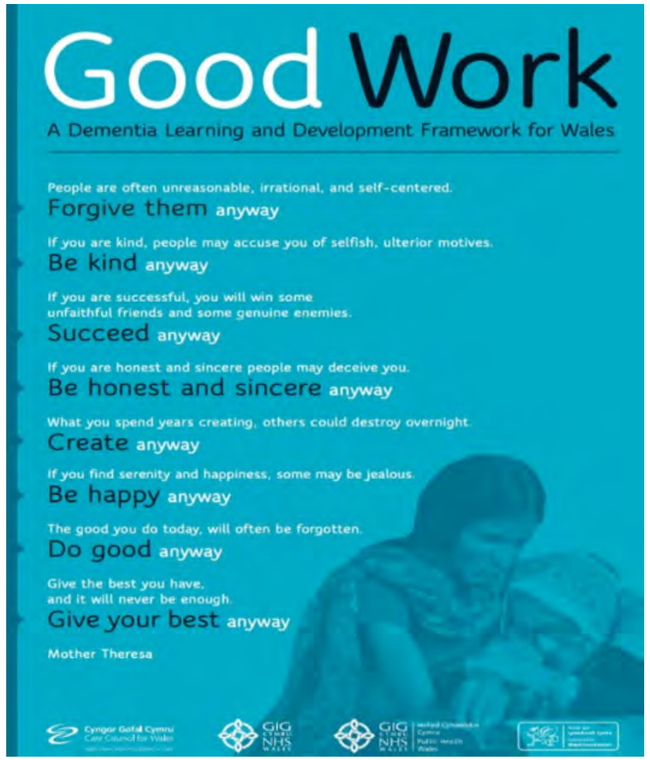
Establish a People Participation Panel for people living with dementia, their carers and staff.

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..

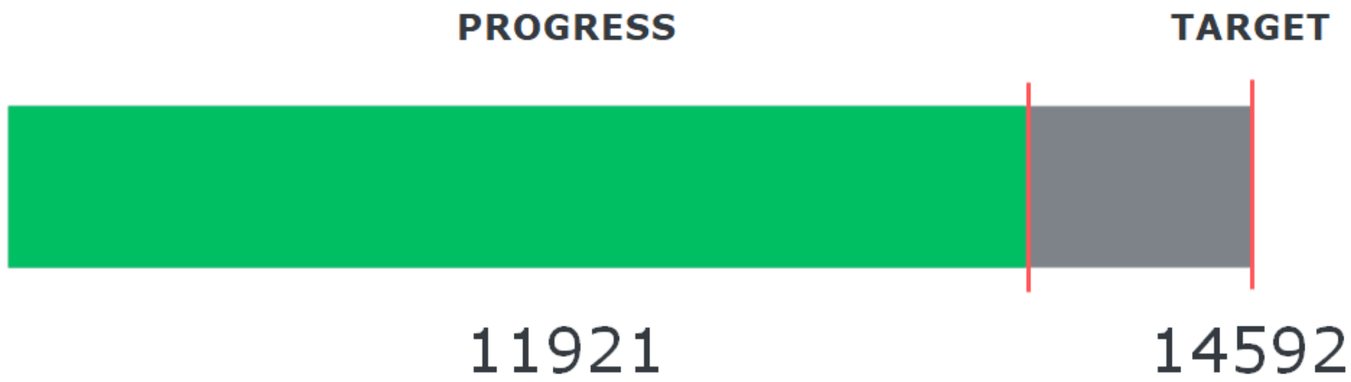
Learning and Development Progress

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.

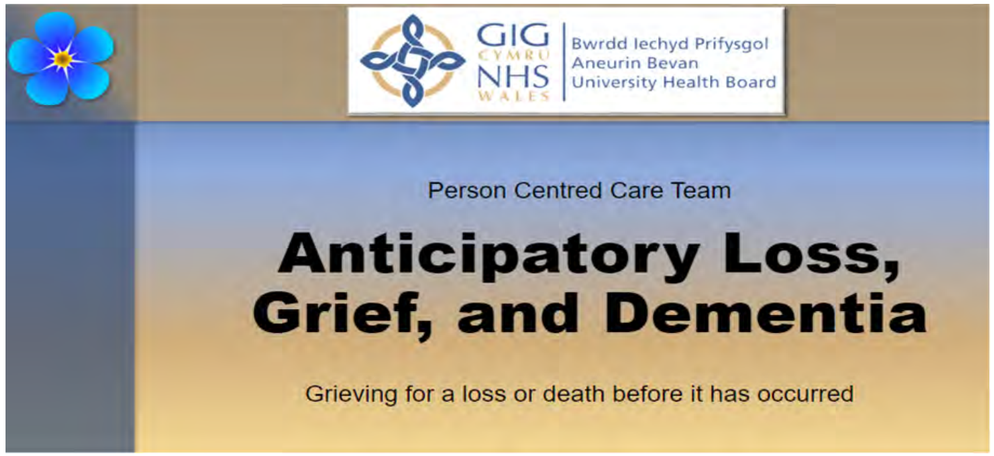
Feedback – verbal feedback has been positive

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

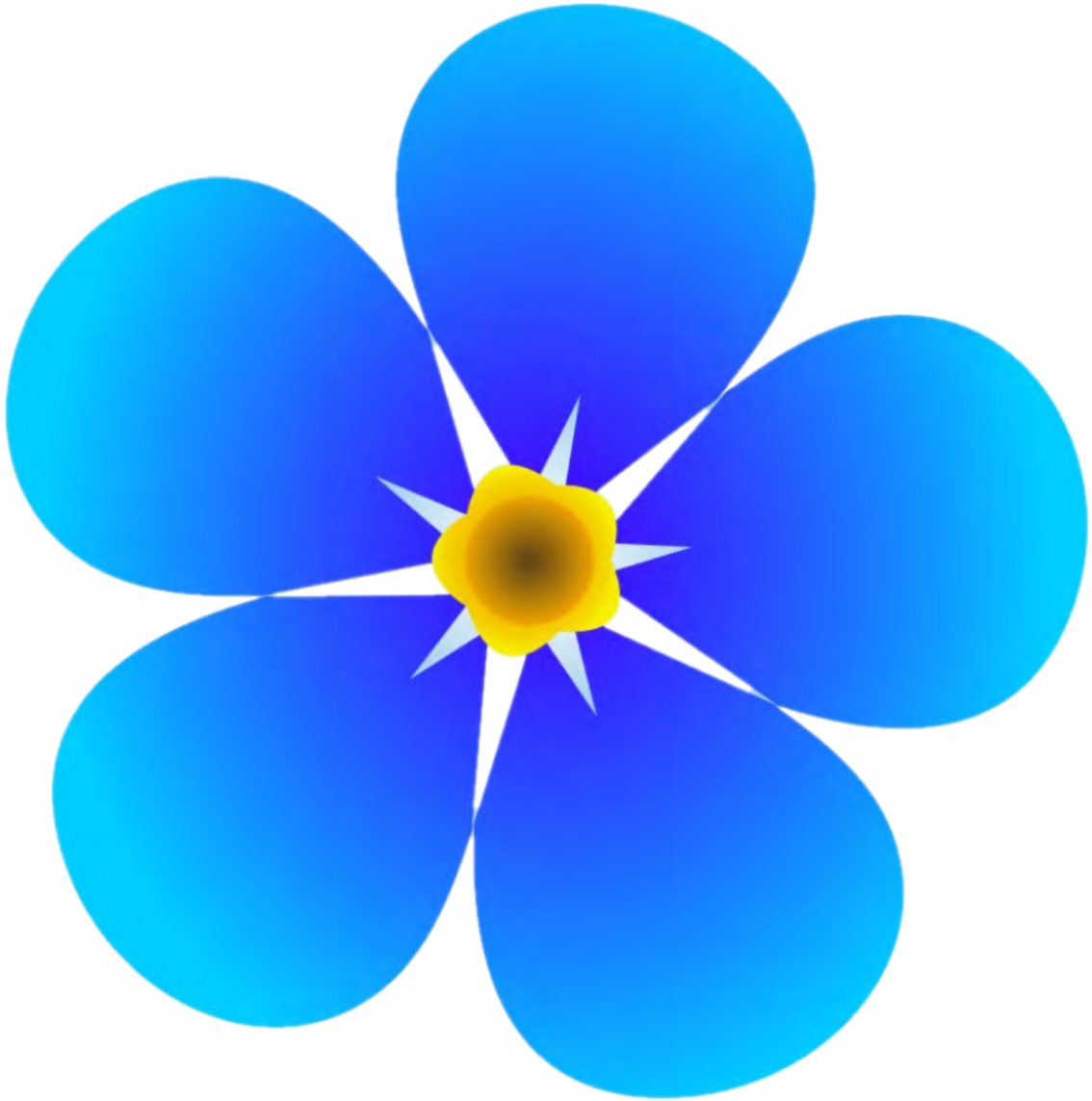
We will work with clinical and operational leads to develop initiatives aimed at minimising ward moves for people with dementia.

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'.

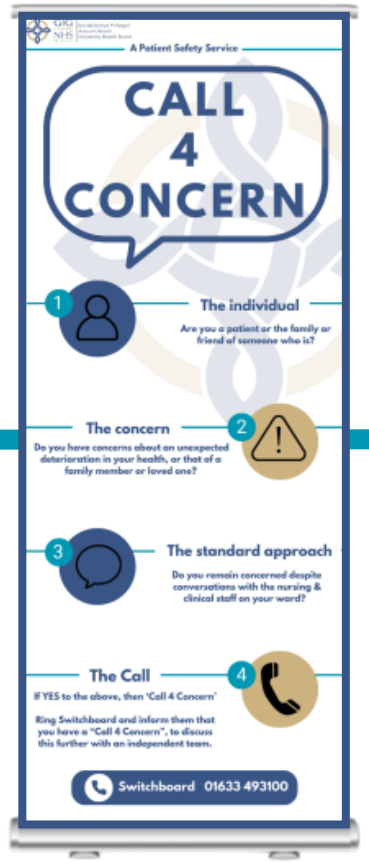
As part of the newly refined QOF, reporting of the indicators will involve working with Digital, Data and Technology Directorate. This will allow automation of reporting and enable reports to be standardised. The use of iconography will provide detail on trends.

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

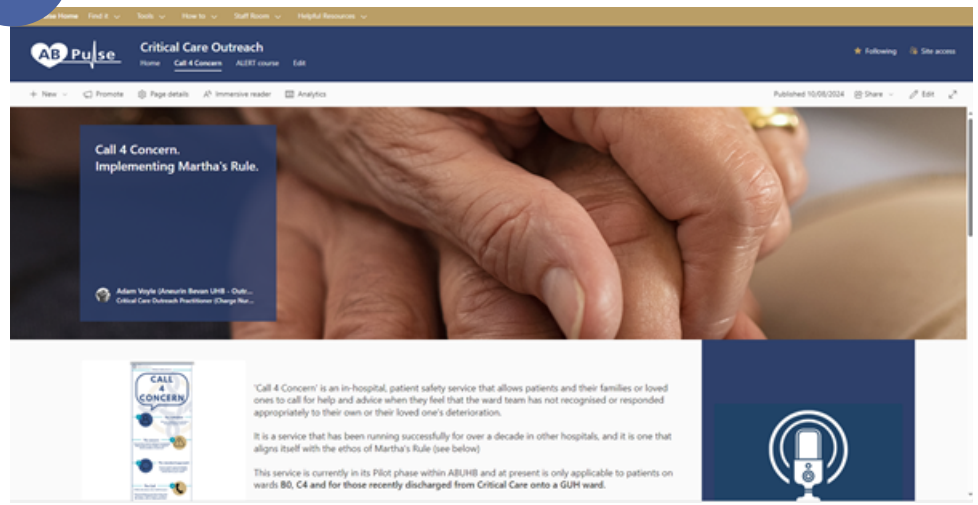
'Scale and Spread' of service to further wards
? C0 & A1 (SAU)

Associated documentation

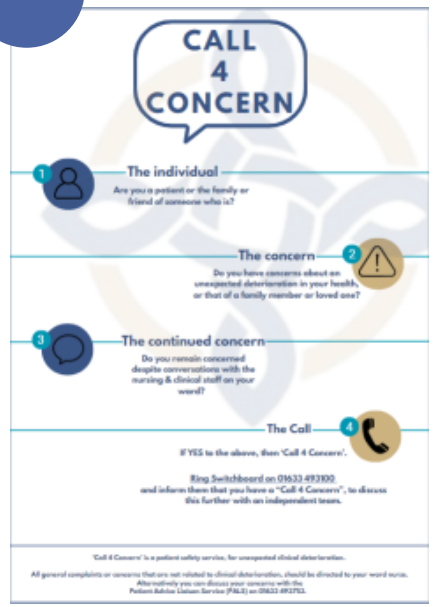
Patient Advice Leaflet



Intranet Page



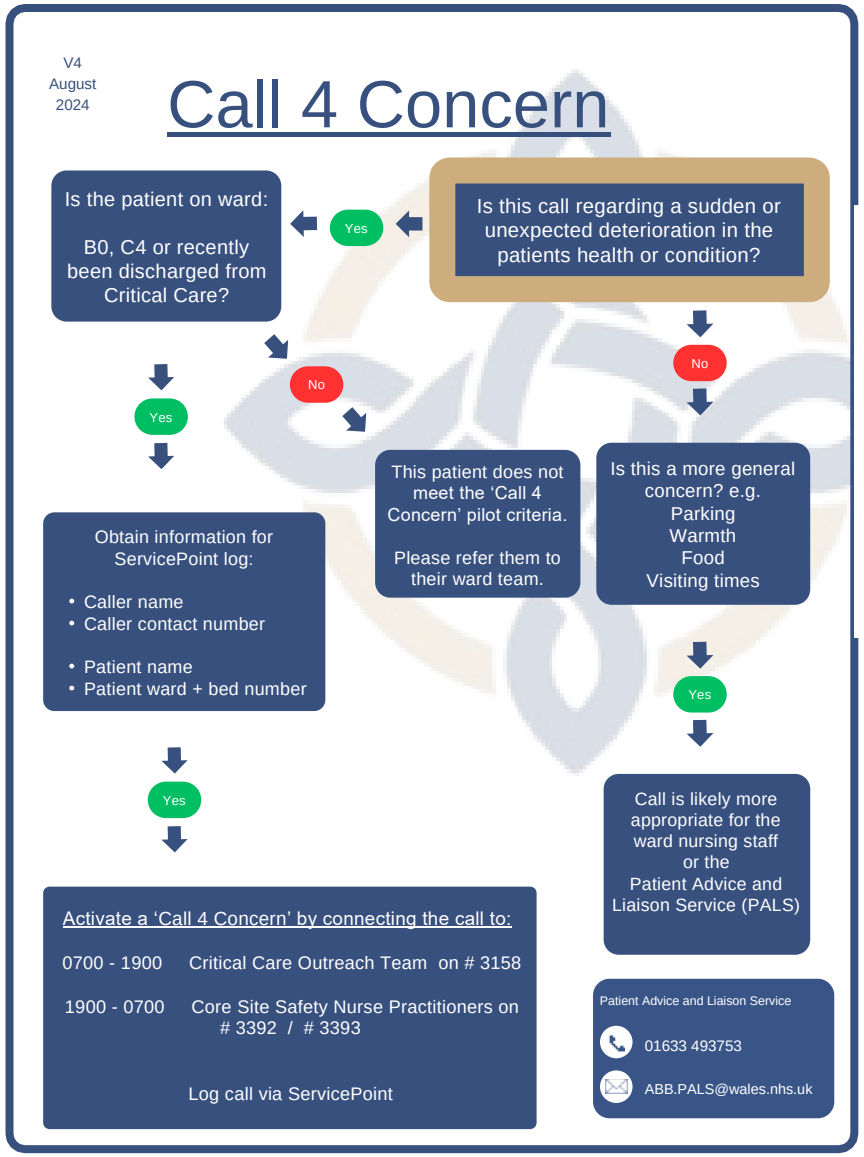
Poster



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.	<u>Progress / Achievements:</u> • 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 <u>Deliverables and Focussed pieces of work</u> • 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

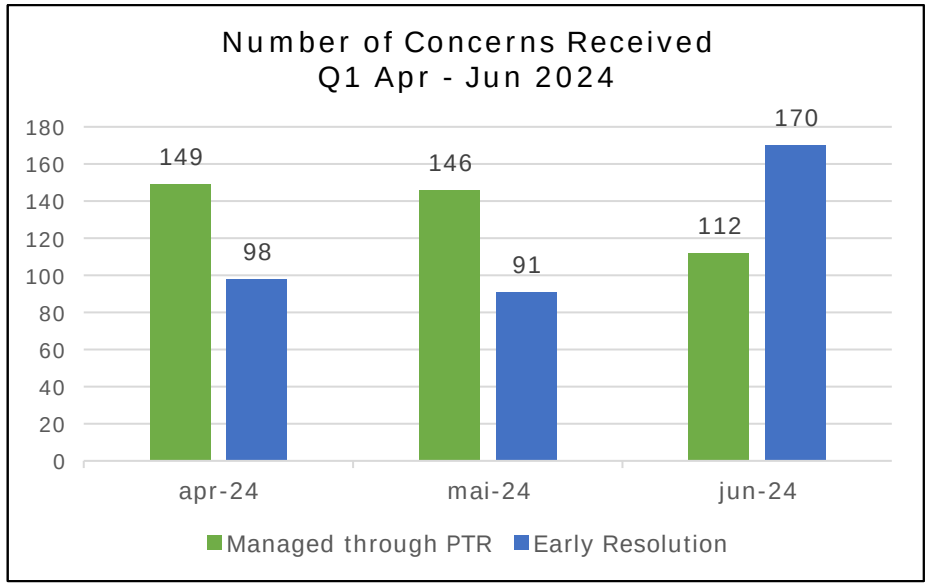
Areas to highlight

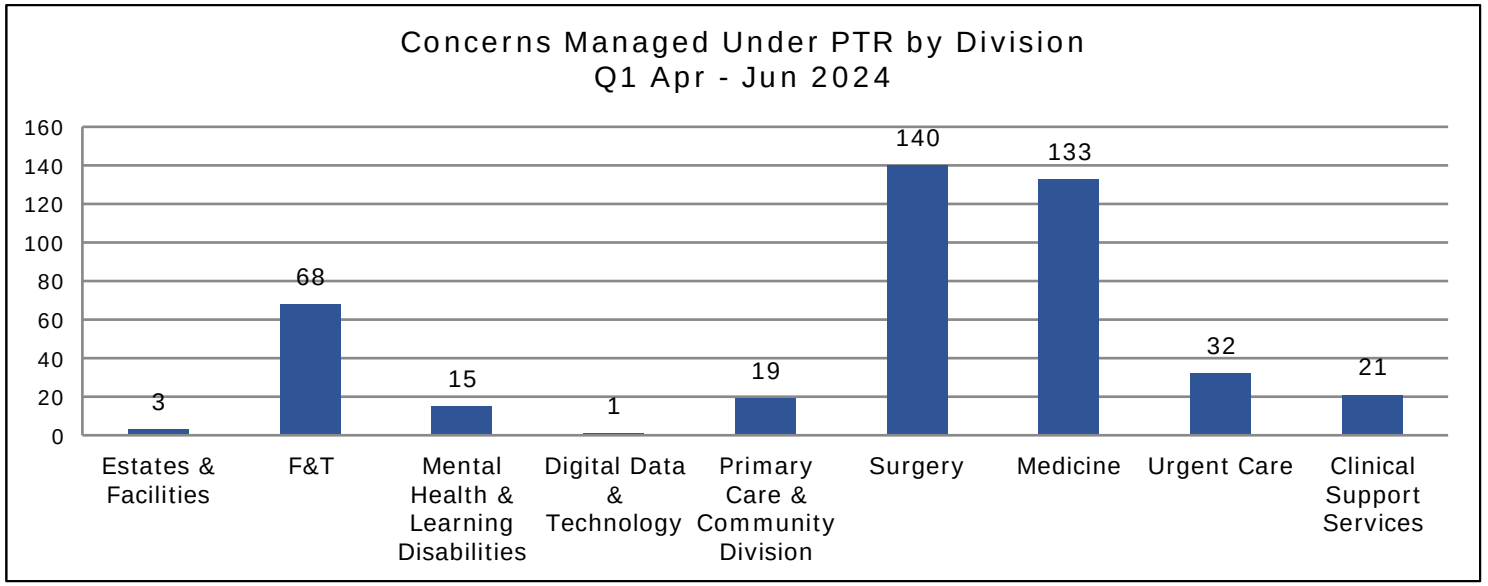
Areas to Highlight – Quarter 1

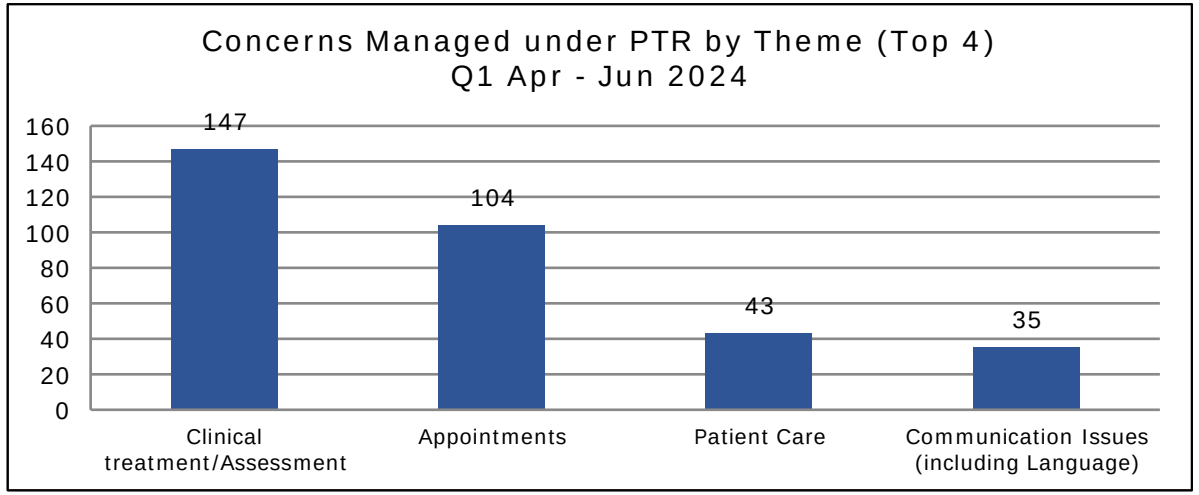
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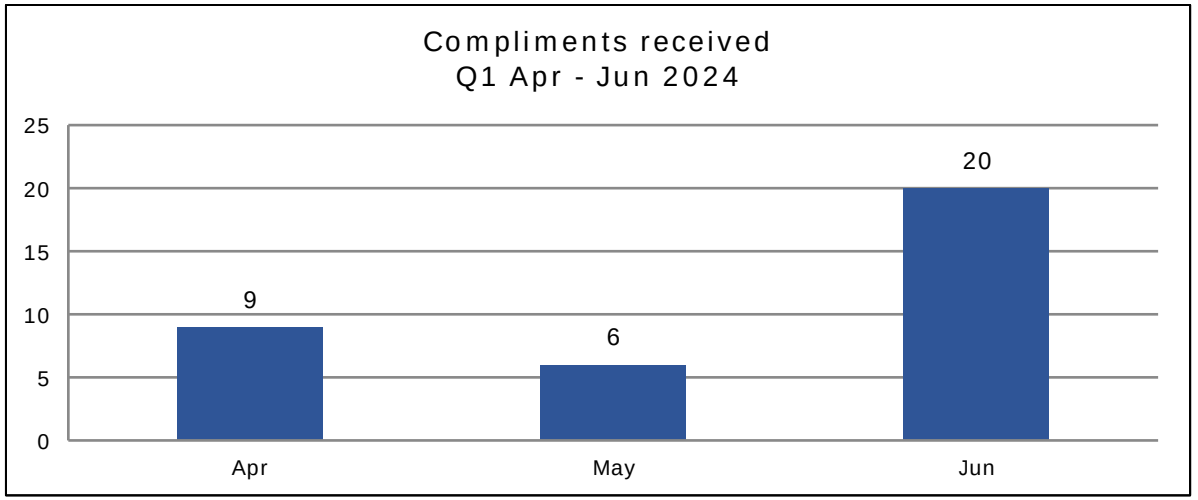
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Complaints and Compliments

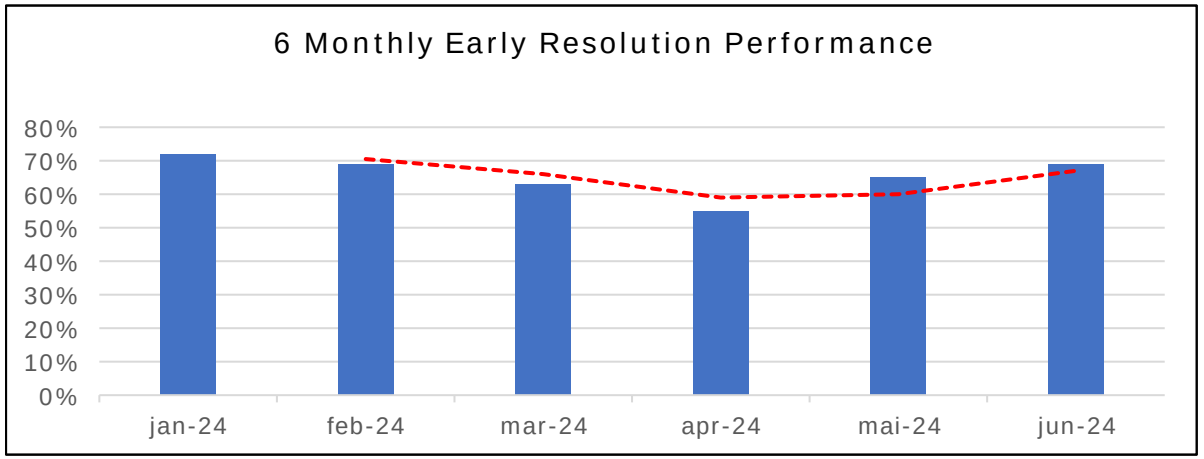


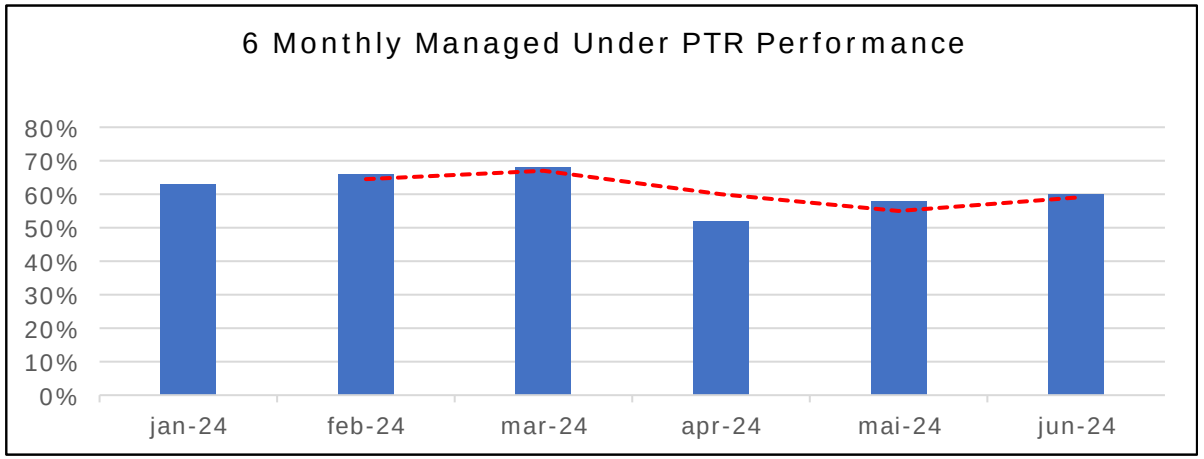






Complaints Performance

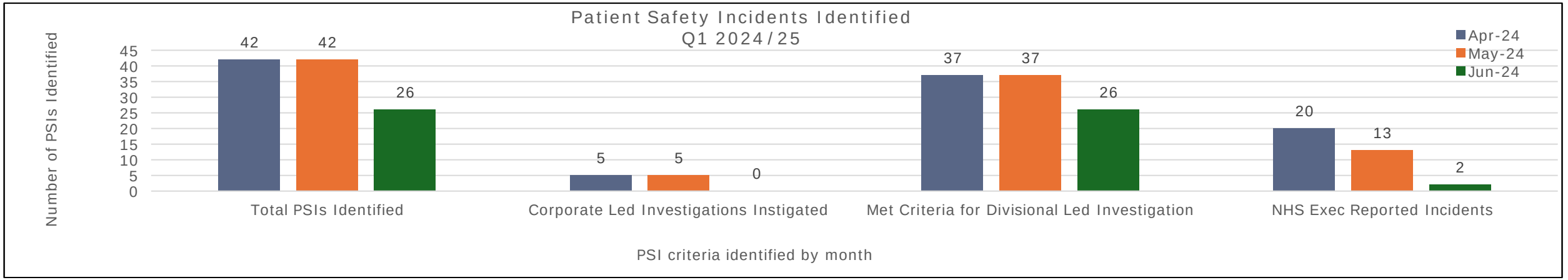


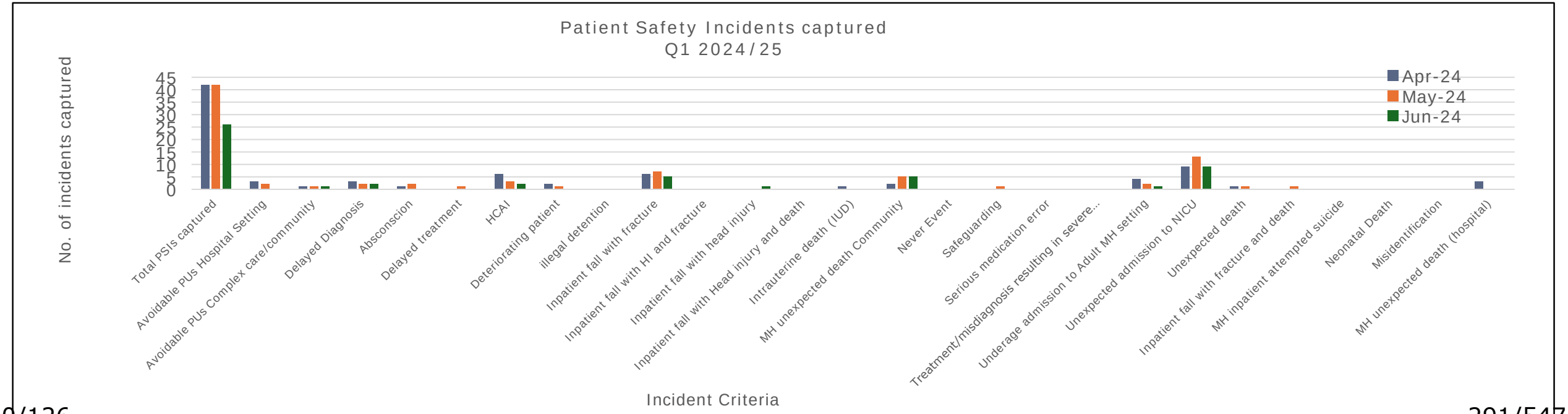


Trajectory for Improvement by Division/ Directorate	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
01 Family & Therapy Services	60%	63%	65%	68%	72%	75%
02 Scheduled Surgical & Critical Care	60%	63%	65%	68%	72%	75%
03 Primary Care & Community	45%	50%	54%	62%	69%	75%
04 Mental Health & Learning Disabilities	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.

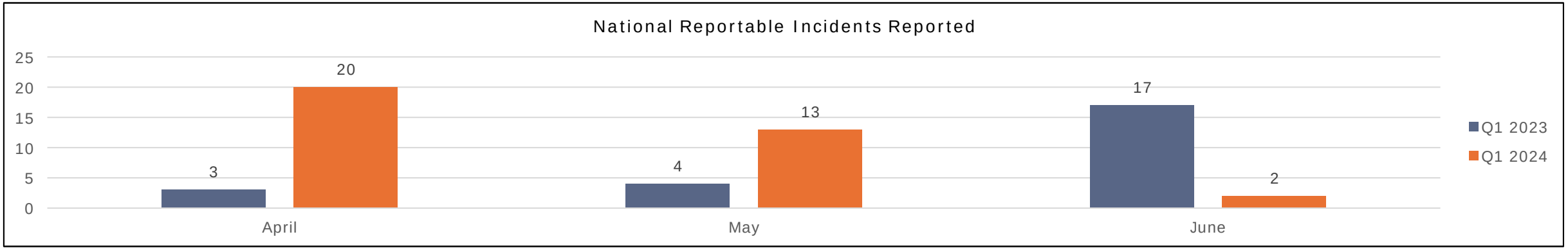




Patient Safety Incidents

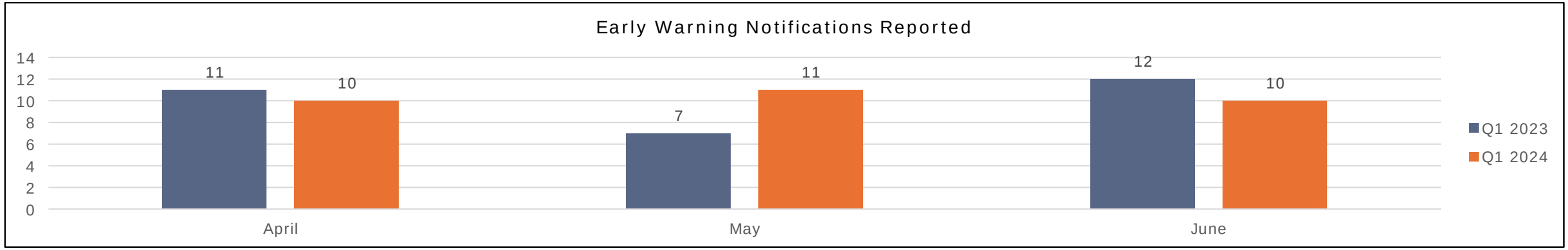
Not all PSIs under investigation were reported as National Reportable Incidents (NRIs). This could be because some NRIs are submitted to the NHS Executive prior to the decision making regarding the proportionality of the investigation (Divisional or Corporate Led). Also, NRI reporting can occur retrospectively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

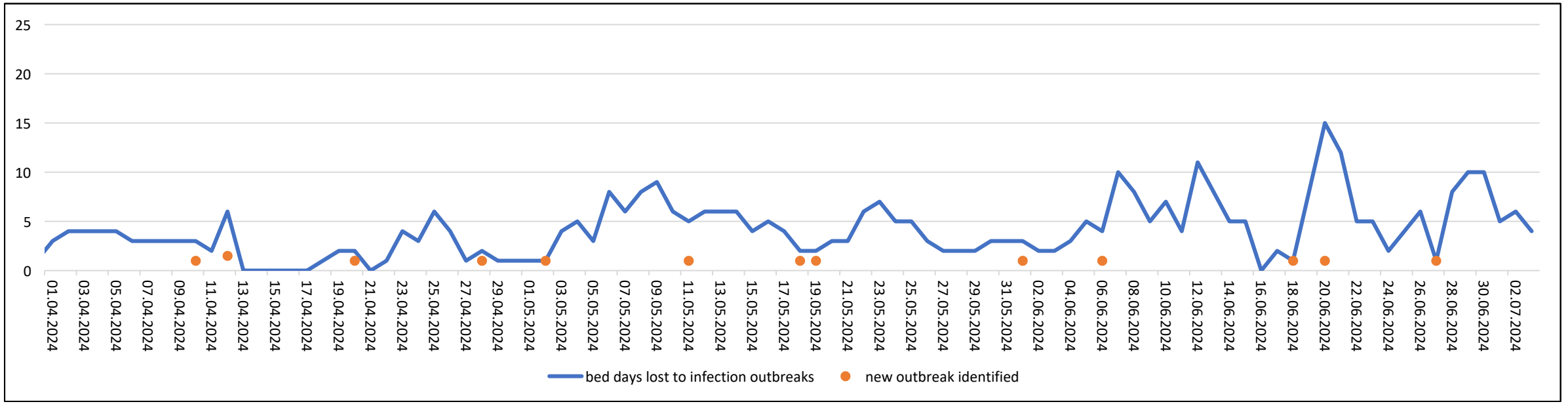
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	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	49.51	1.36	31.2	59.01	21.7	7.46
Betsi Cadwaladr UHB	47.21	1.75	23.31	83.93	12.82	1.17
Cardiff and Vale UHB	45.22	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

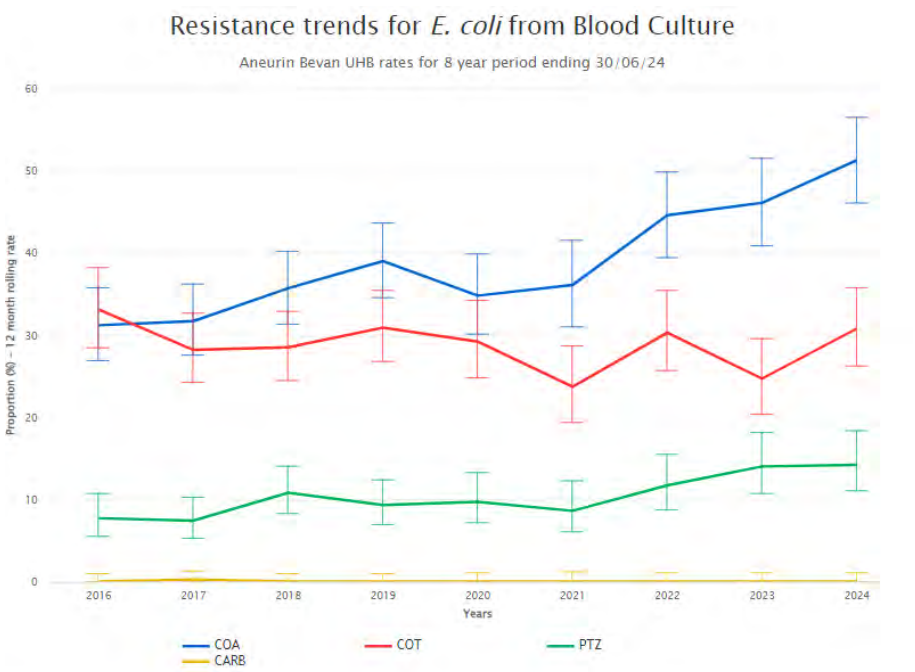
Context: antimicrobial use in ABUHB in 23/24

- 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)

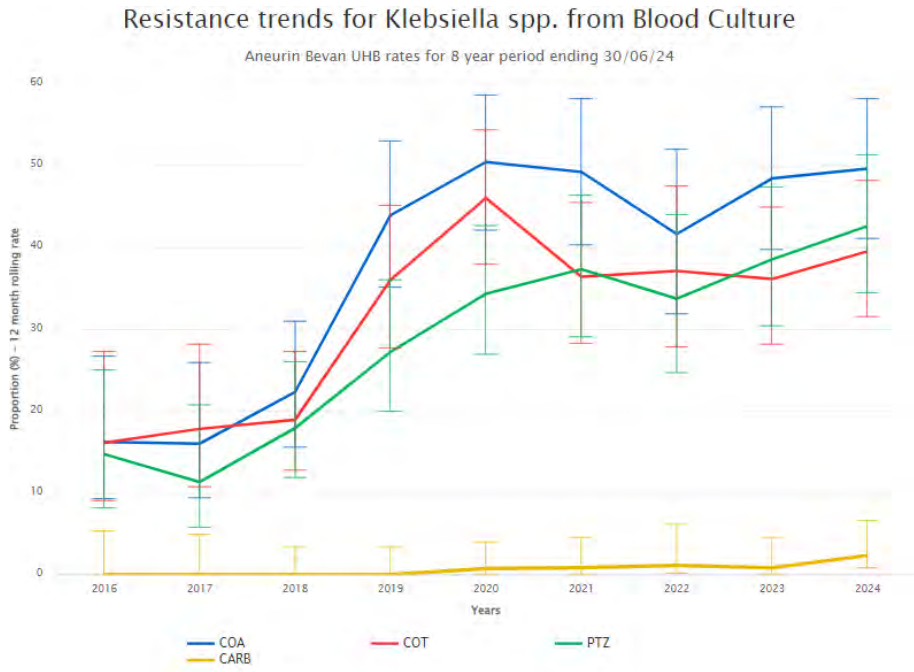
- 4.3 WTE antimicrobial team at full complement from June 2024:
  - 1.0 consultant (HB wide)
  - 1.1 primary care
  - 1.8 secondary care
  - 0.4 admin

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)



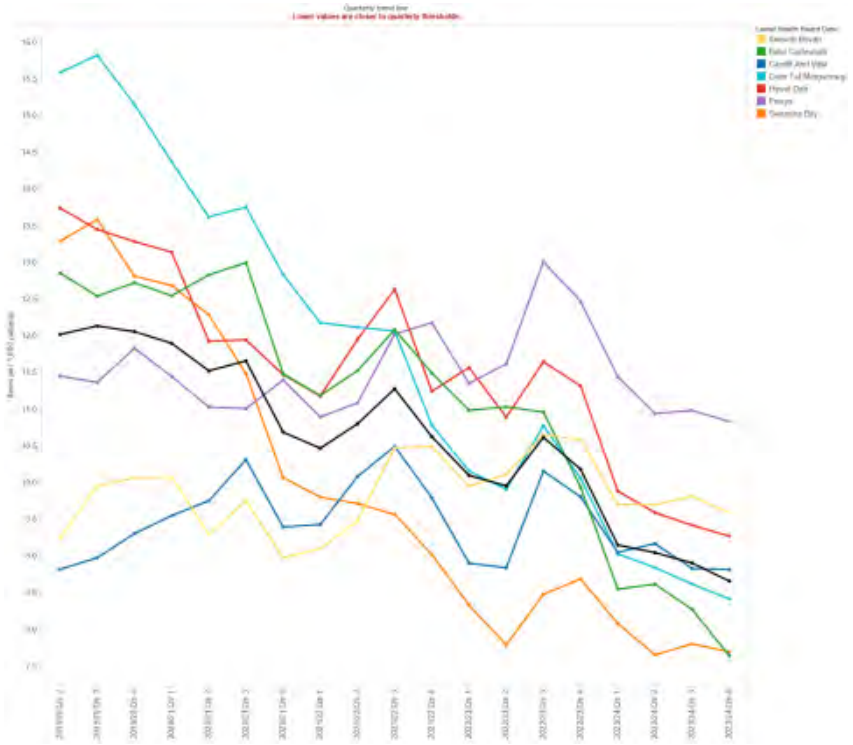
	2016	2017	2018	2019	2020	2021	2022	2023	2024
COA	31.2	31.7	35.7	39.0	34.8	36.1	44.6	46.1	51.3
COT	33.1	28.2	28.5	30.9	29.2	23.7	30.3	24.7	30.8
PTZ	7.7	7.4	10.8	9.3	9.7	8.6	11.7	14.0	14.2
CARB	0.00	0.23	0.00	0.00	0.00	0.00	0.00	0.00	0.00

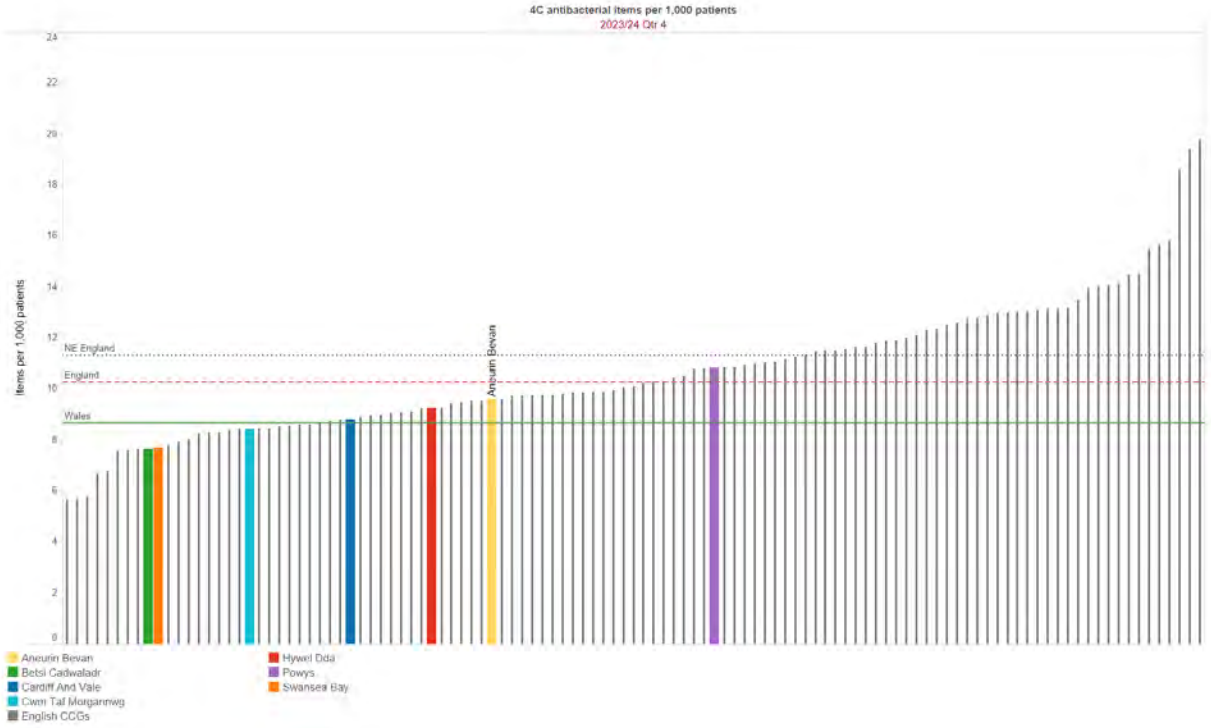


	2016	2017	2018	2019	2020	2021	2022	2023	2024
COA	16.2	16.0	22.3	43.9	50.4	49.2	41.6	48.4	49.6
COT	16.1	17.8	18.9	36.0	46.0	36.4	37.1	36.1	39.5
PTZ	14.7	11.3	17.9	27.2	34.3	37.3	33.7	38.5	42.6
CARB	0.00	0.00	0.00	0.00	0.73	0.85	1.12	0.82	2.33

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

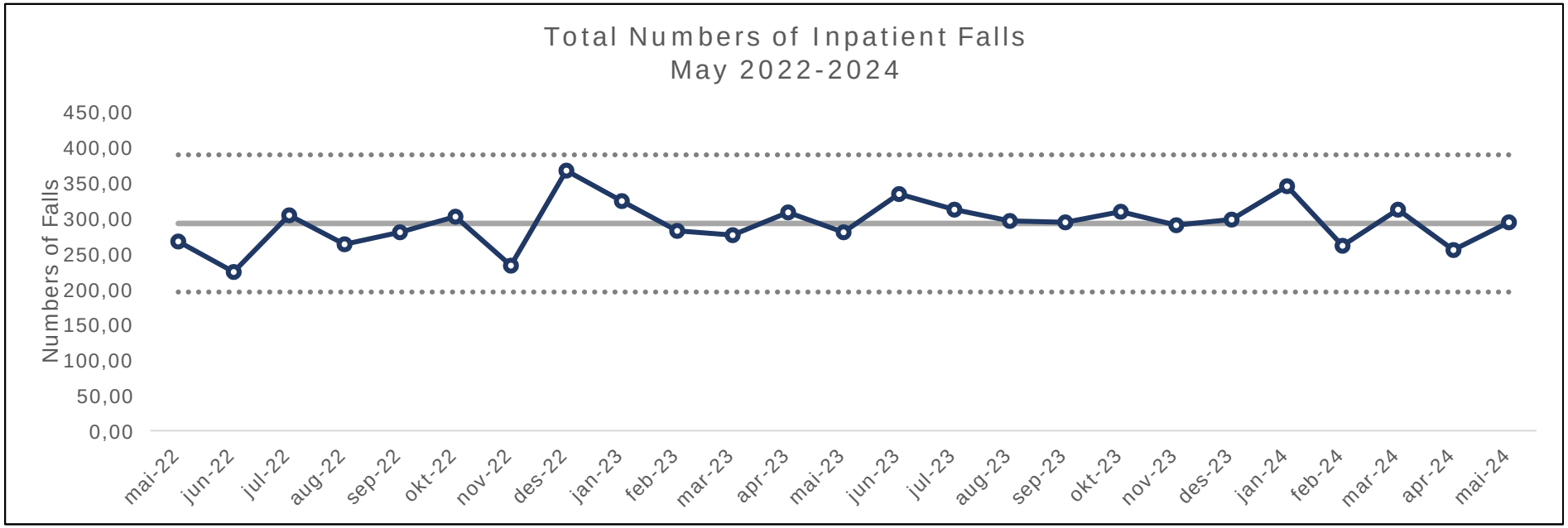
- Business as usual
  - Antibiotic Review Kit (ARK) principles implemented at main sites. Includes automatic stop after 72 hours to force review of the need for antibiotics
  - Weekly ward rounds at 4 main sites to review complex cases, with the exception of medical rounds at GUH due to microbiology 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



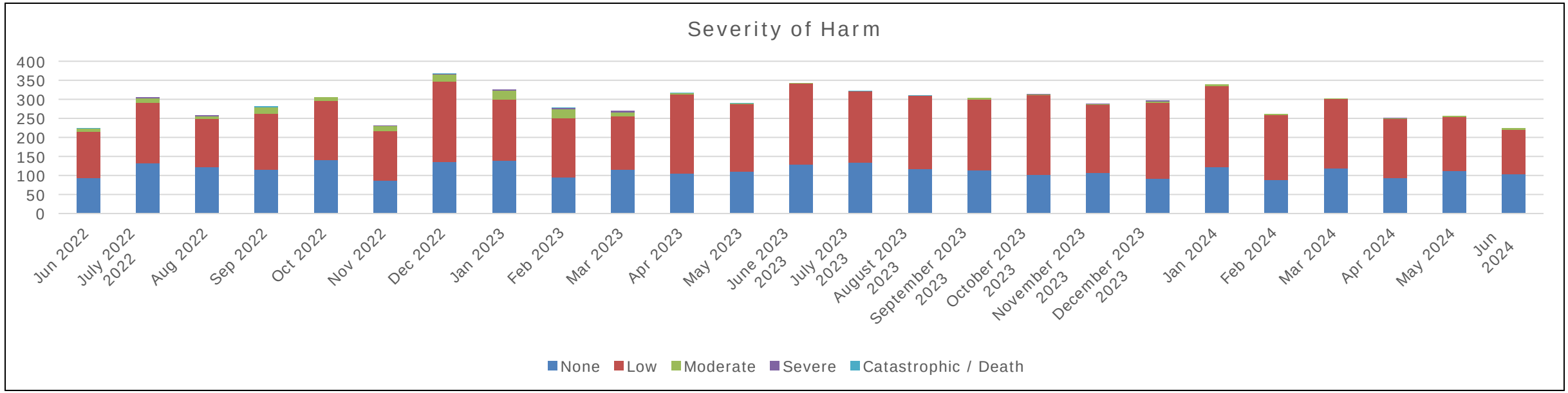
July 2024 - Context

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

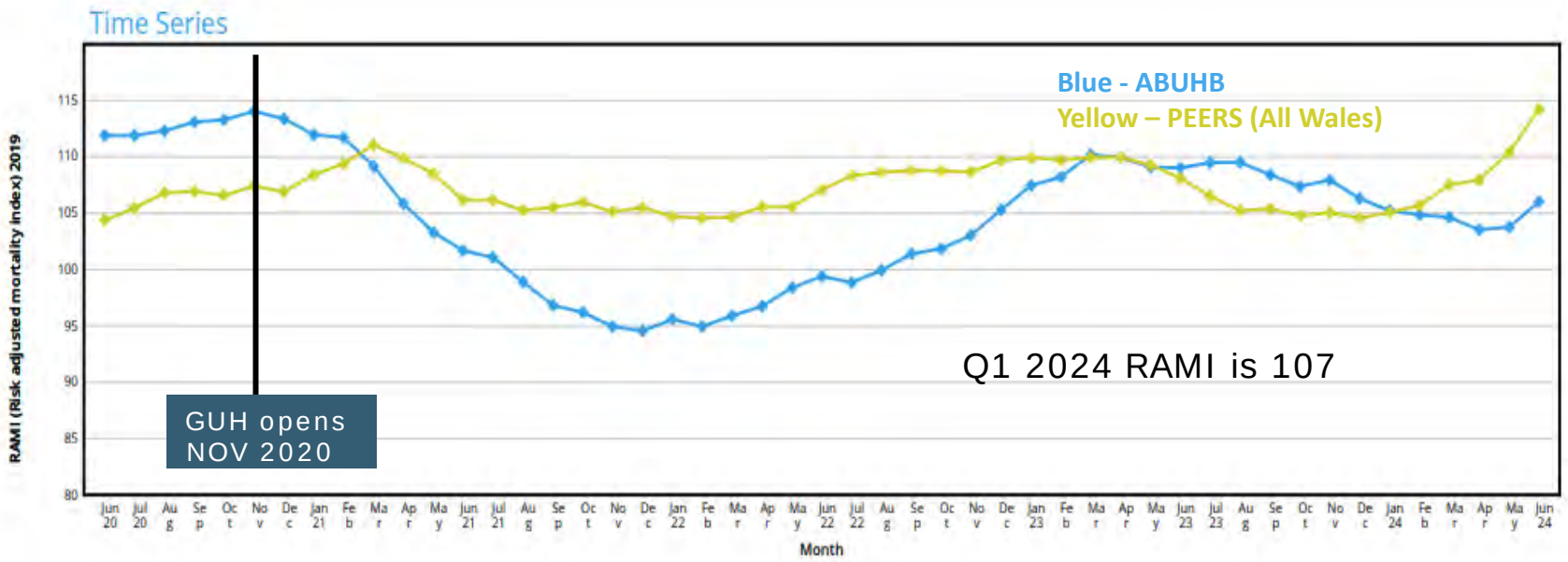


Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	Of the total numbers of falls incidents reported for which the severity of harm is categorised for the given period is 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.

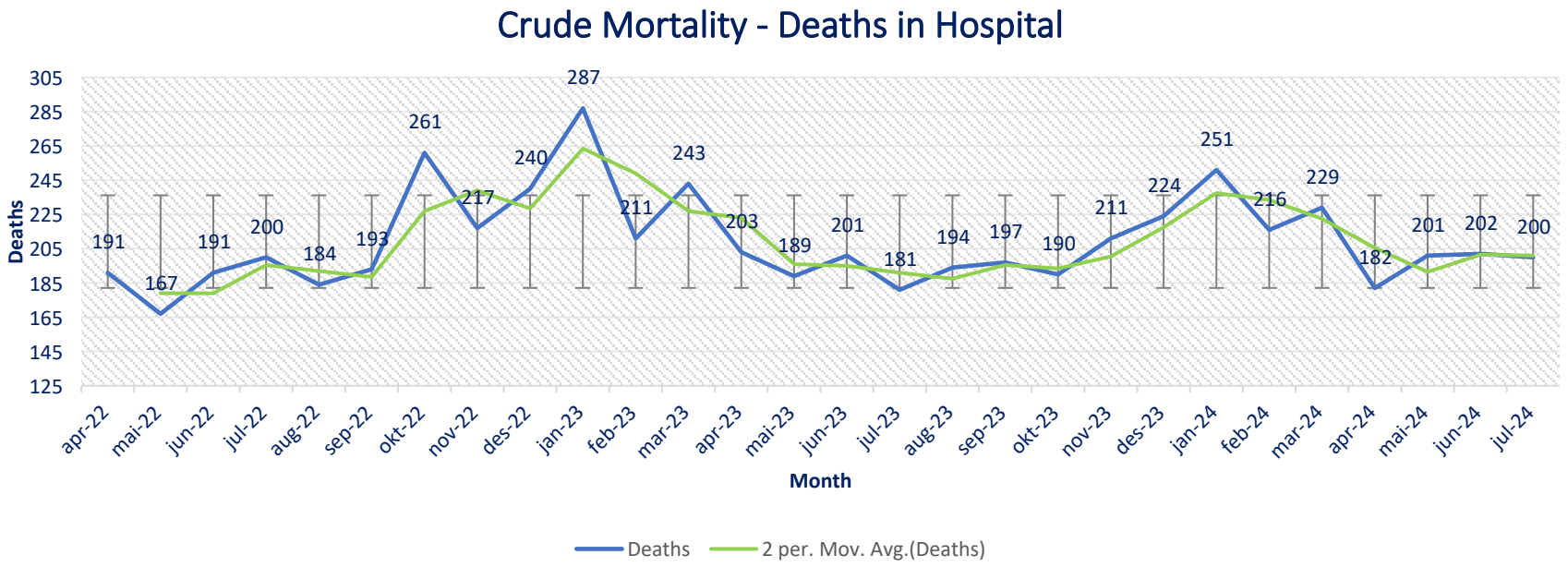
RAMI (Risk Adjusted Mortality Index)

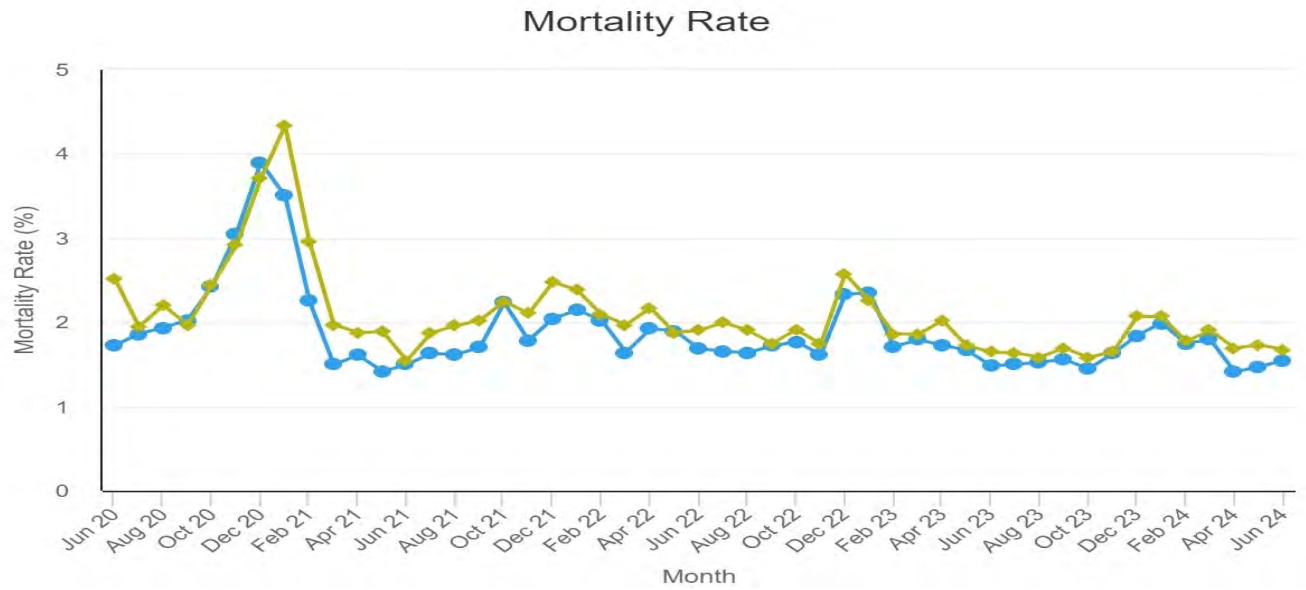




Currently performing 2nd of 6 within All Wales peer group

Crude Mortality in Hospital



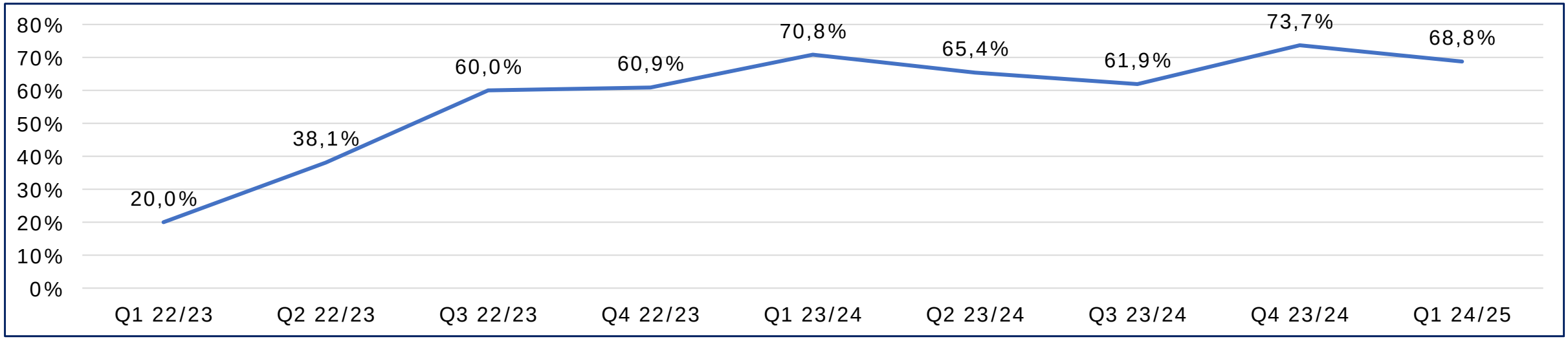


Actual deaths in hospital have plateaued in the past 3 months. However, the mortality rate is slightly increasing. RAMI has been gradually declining since November 2023

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.

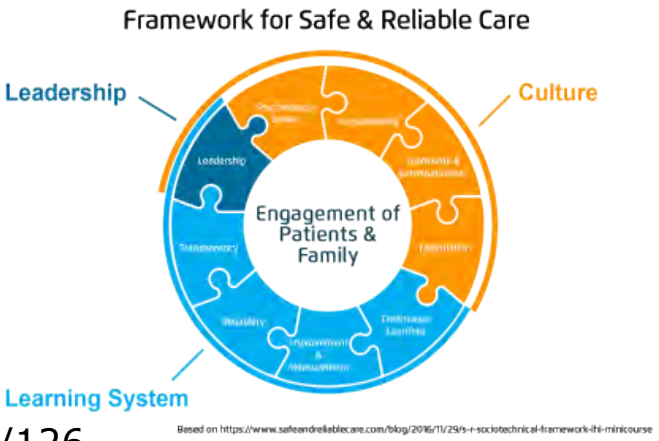
Safe Care Collaborative: Final Update

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.

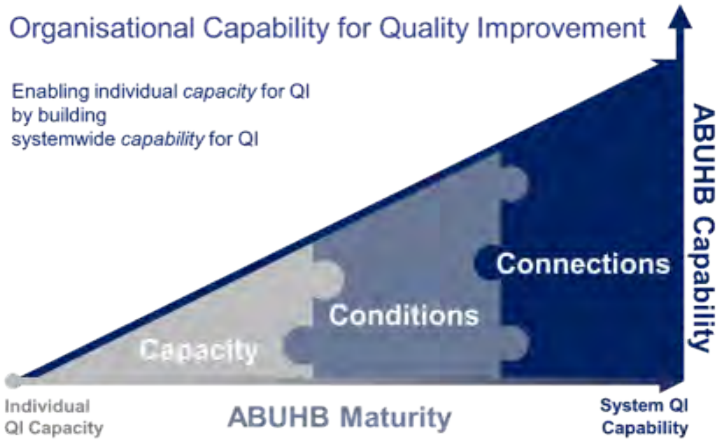


Workstream	ABUHB Team	Score
Acute	Medical Assessment Unit at GUH	2.5
	Ward C0 (ENT surgical ward) at GUH	3.5
	Theatres – Human Factors	2.5
Ambulatory	North Monmouthshire Integrated Team	3.5
Community	OT/MH Early Intervention for Cognitive Impairment Team	3
Leadership	Executives, Leaders for Safety, Faculty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

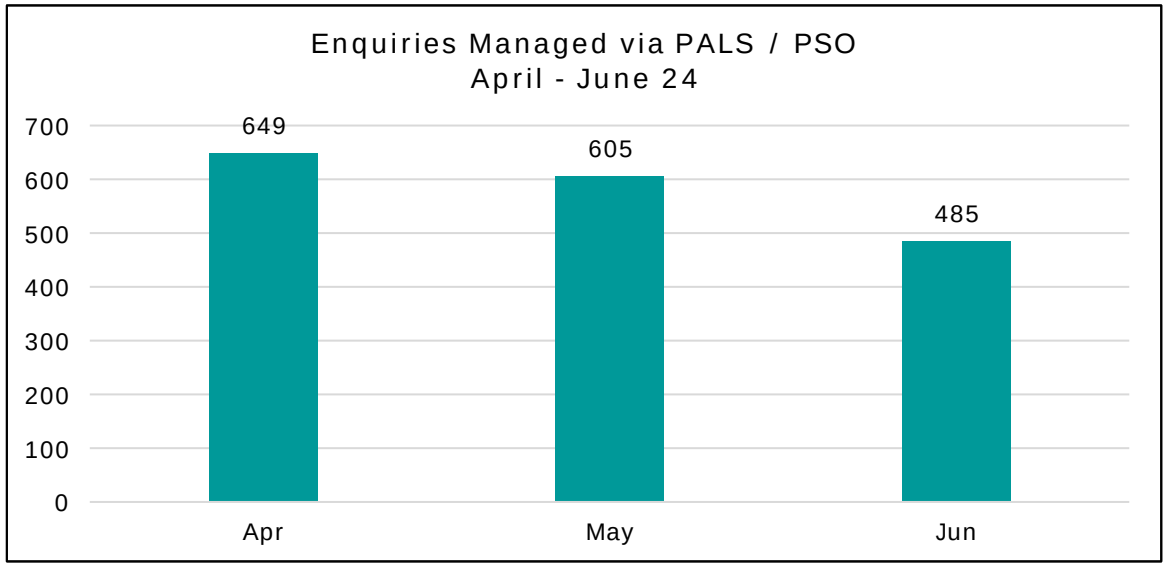
Top 3 Themes from PCC Survey

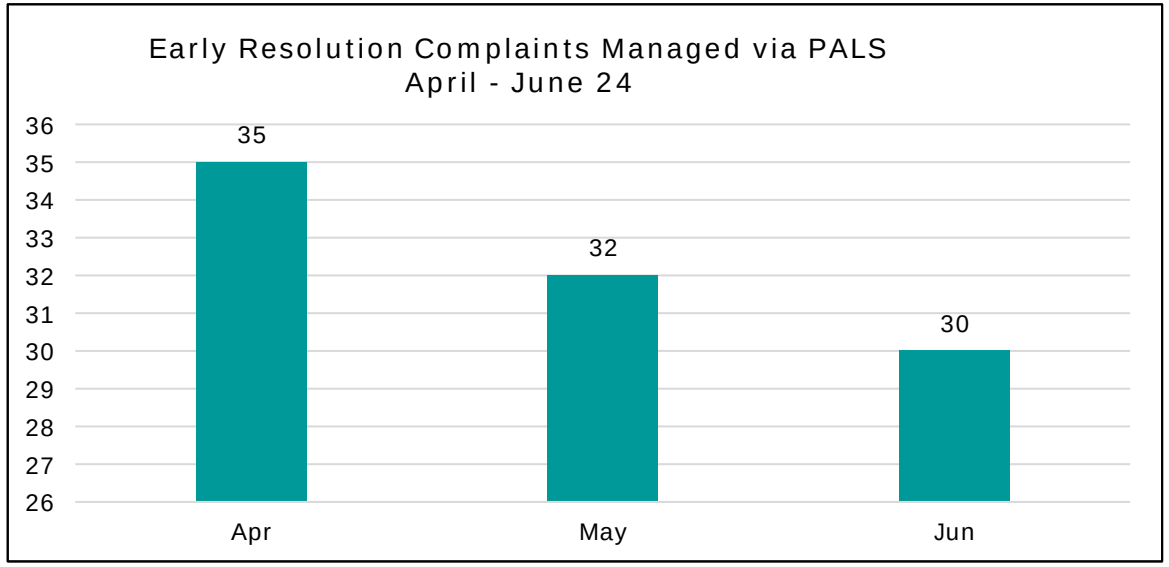
What did we do well? **Q9**	What could we have **done better? Q10**
Top 3 themes	Top 3 themes
268 comments around Emotional & **Physical support**	• 60 comments around Food & Beverages
•252 comments around **Compassion**	•40 comments around Waiting
•208 comments around Friendliness	•24 comments around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

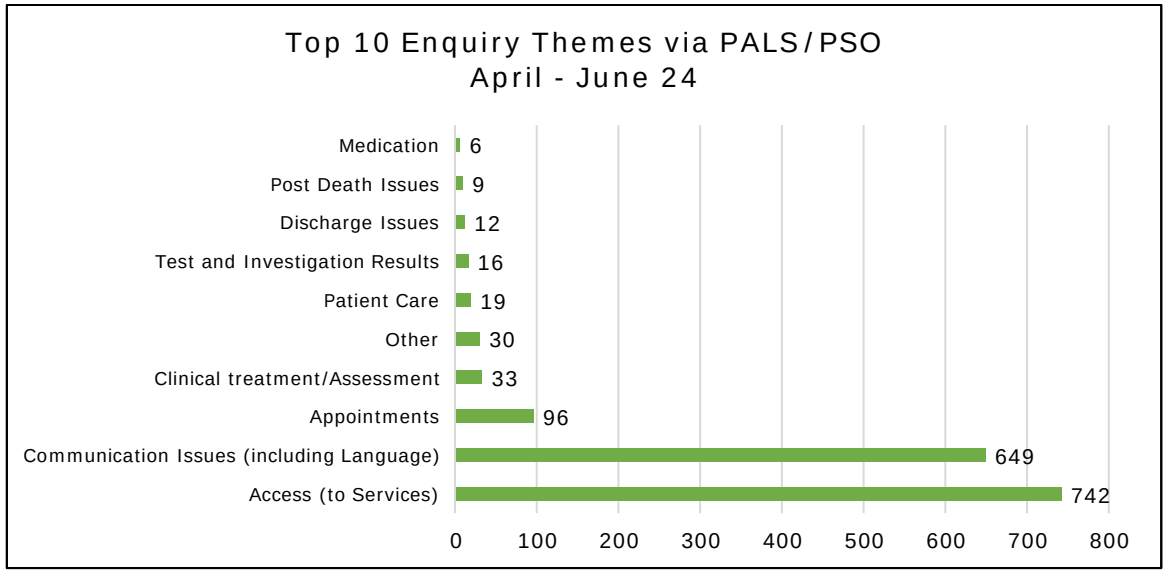


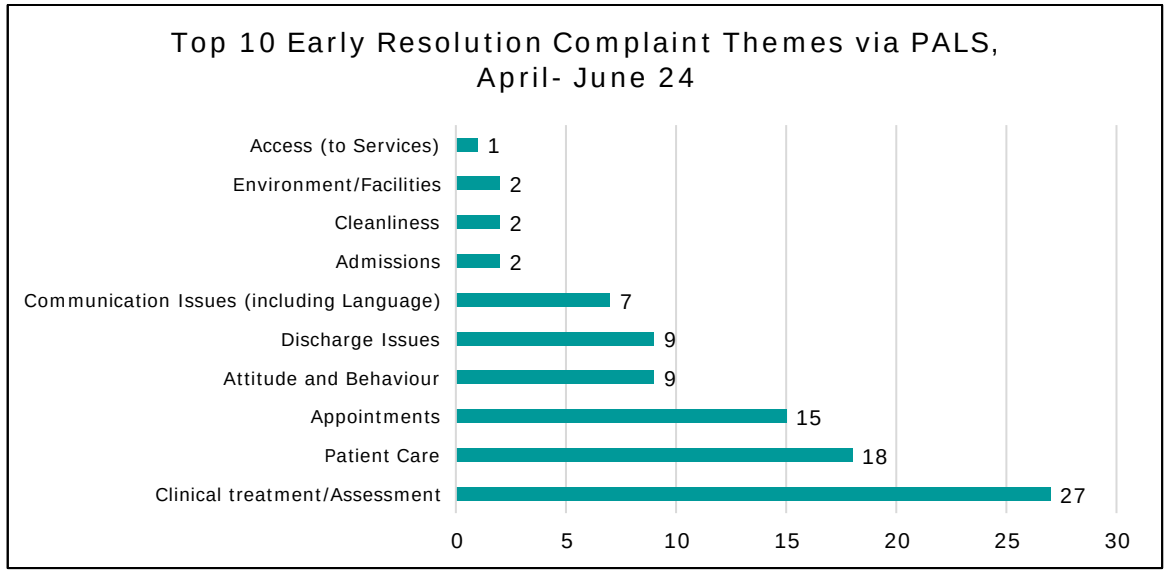
Issue	Action	Learning and Improvement	Who	When
Lack of evidence on listening and learning from patient feedback received from CIVICA	May 2024 – Contact made with QPS Divisional Leads to request sight of their Monthly Reports showing listening and learning from feedback received	Awaiting QPS Team to progress 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

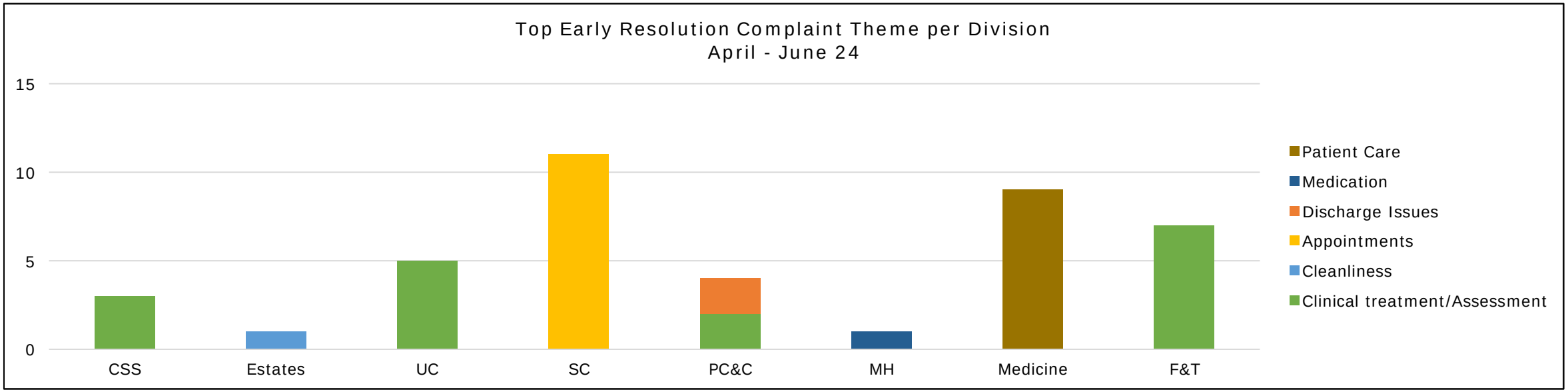


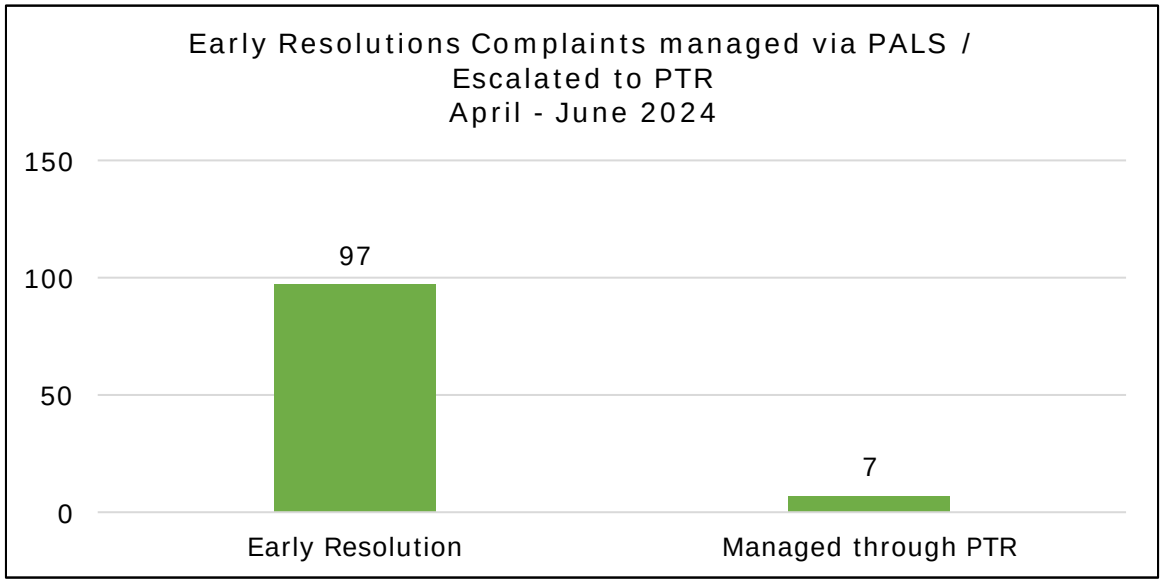


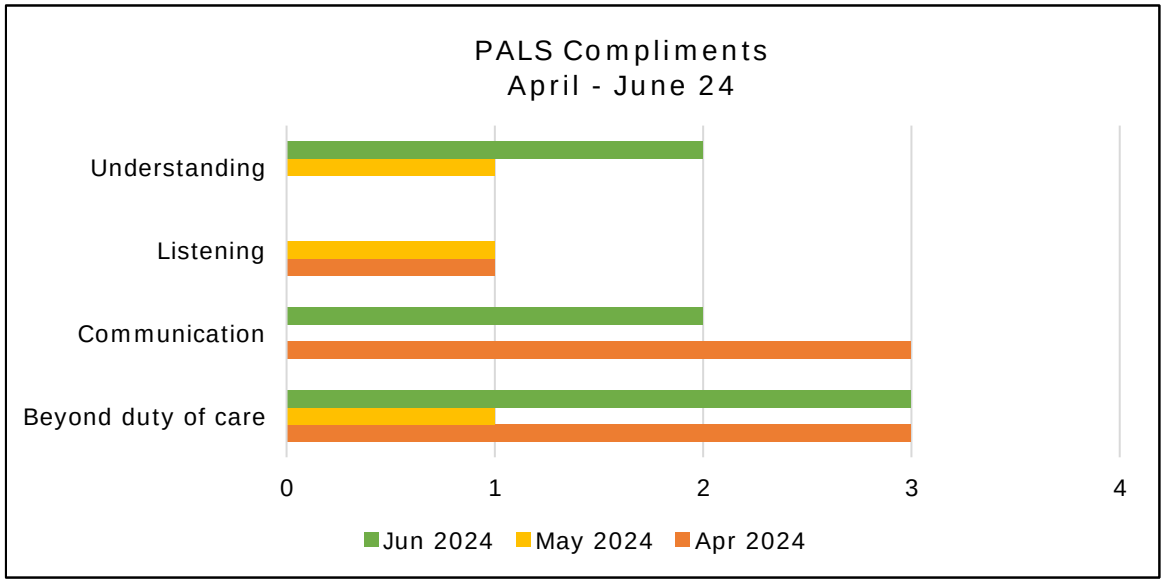




Patient Advice & Liaison Service







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

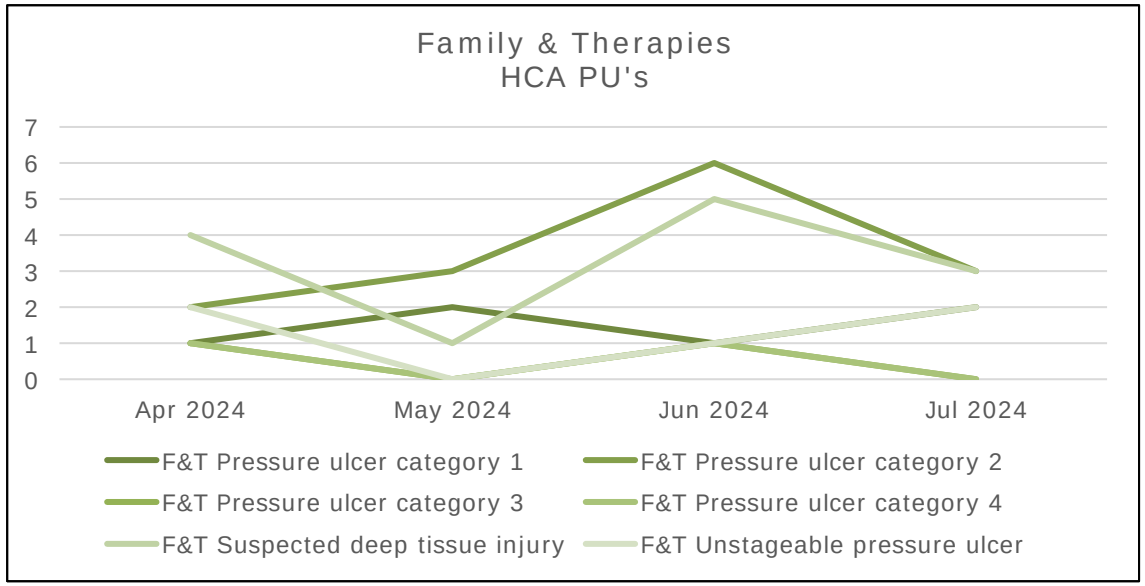
- Reduce HAPU incidences by 25% of baseline within 4 months from the commencement of the faculty.

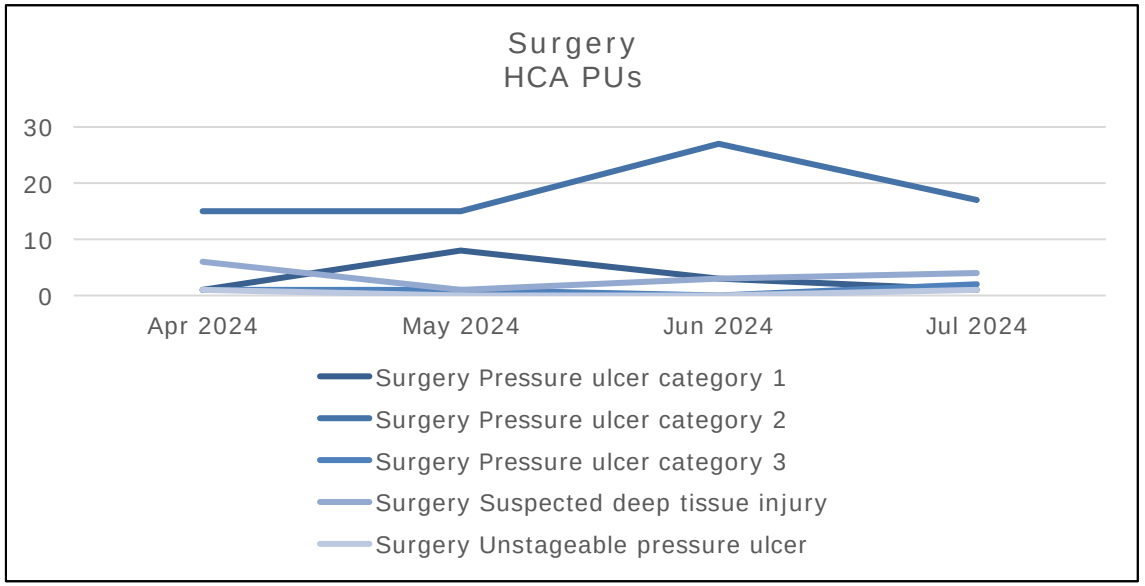
- Eradicate incidence of grade 3 & 4 avoidable HAPUs 4 months from the commencement of the faculty.

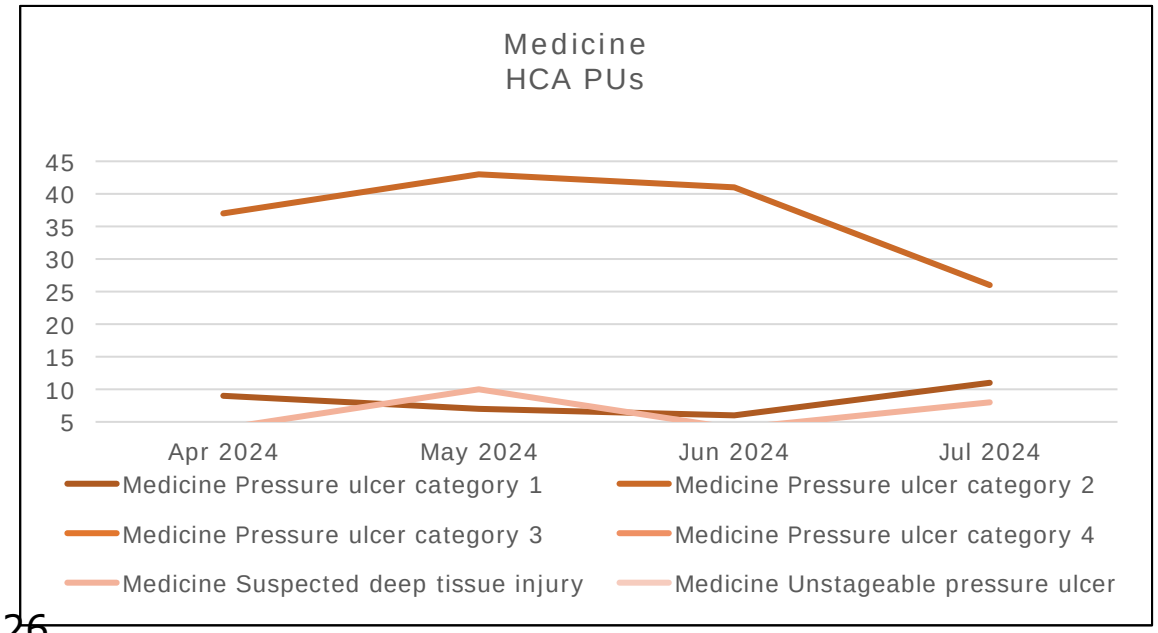
Update

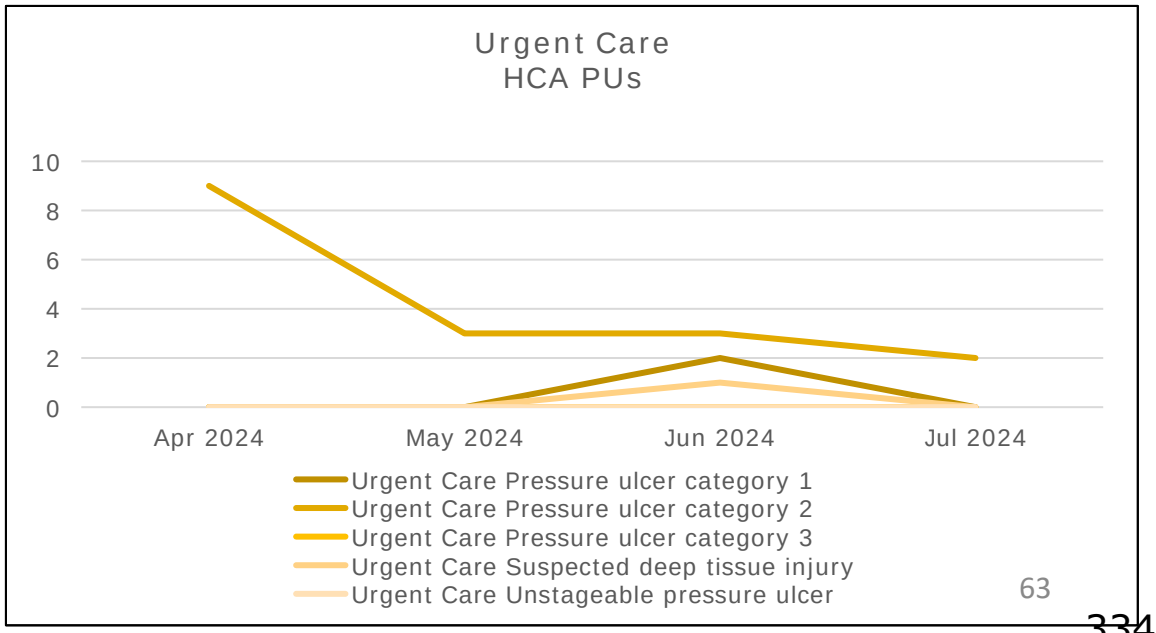
- The faculty continue to meet and now collect data for all Divisions.
- A driver diagram has been produced to look at change concepts.
- These change concepts are being implemented as part of the faculty following improvement methodology, supported by ABCi.

Health Acquired Pressure Ulcer Incidents by Division

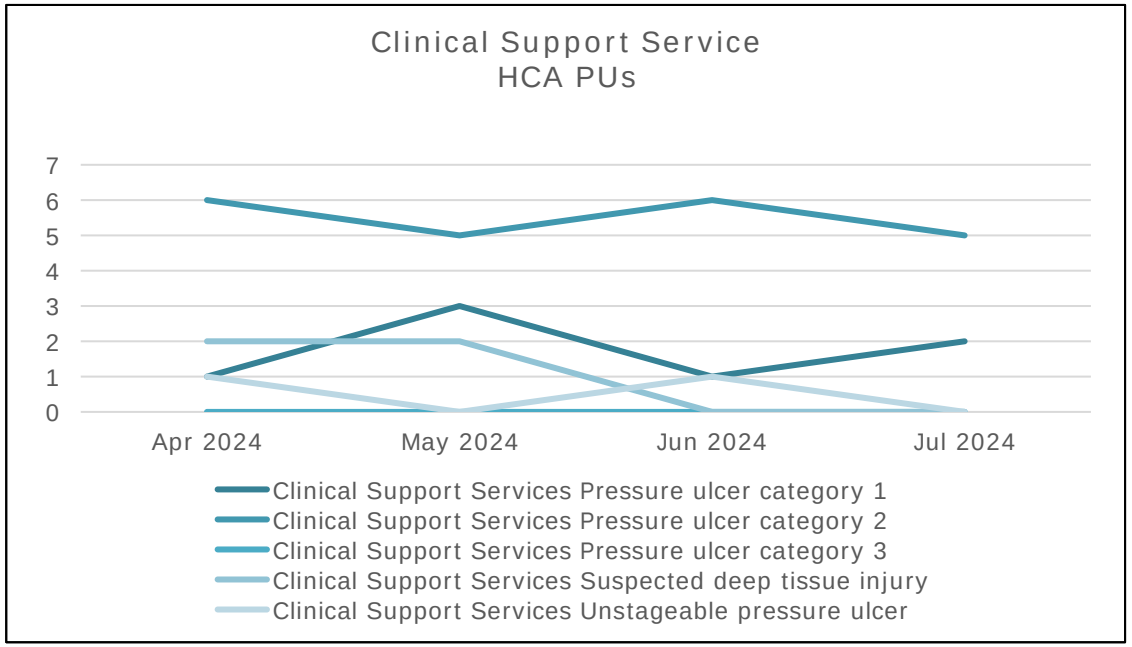


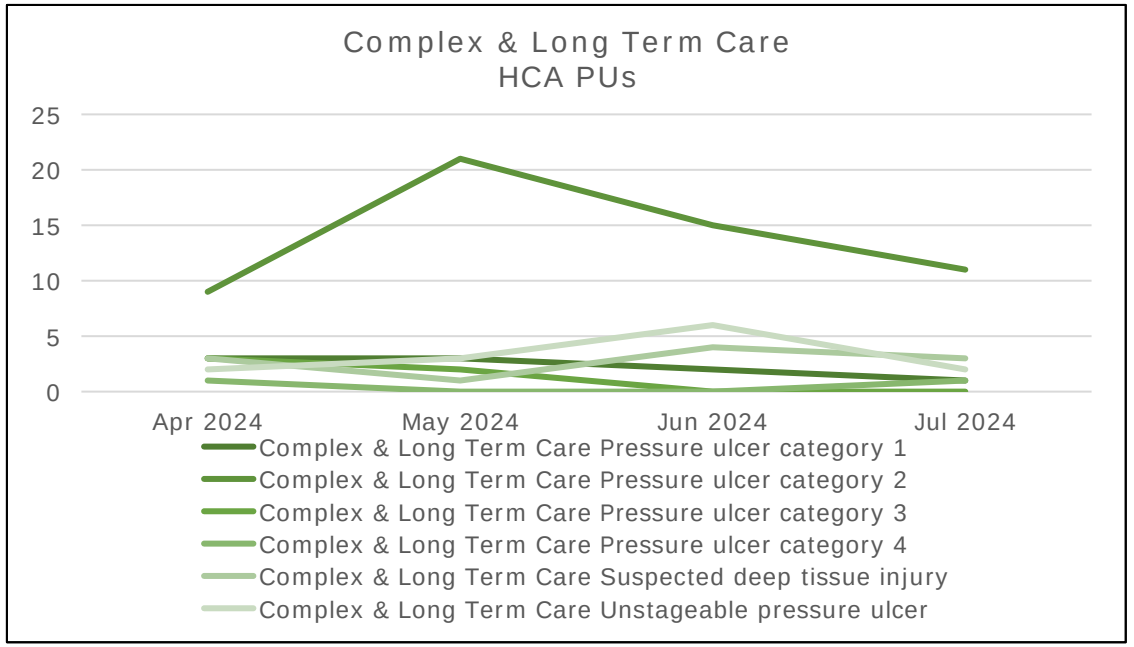


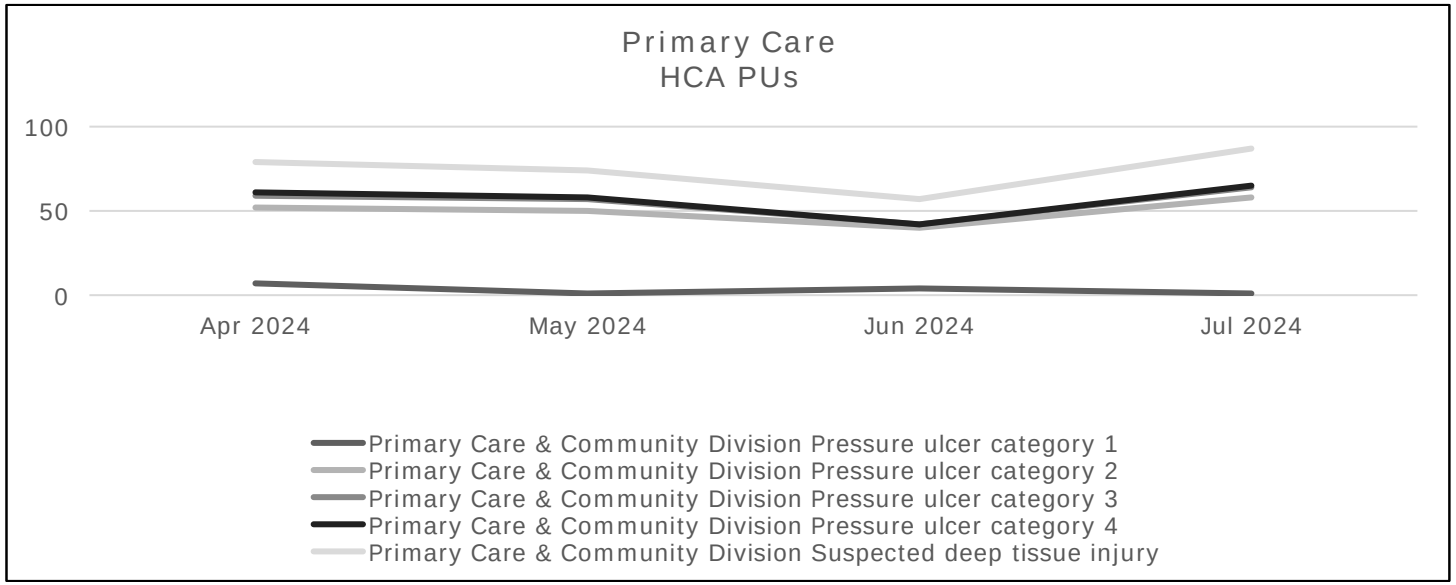




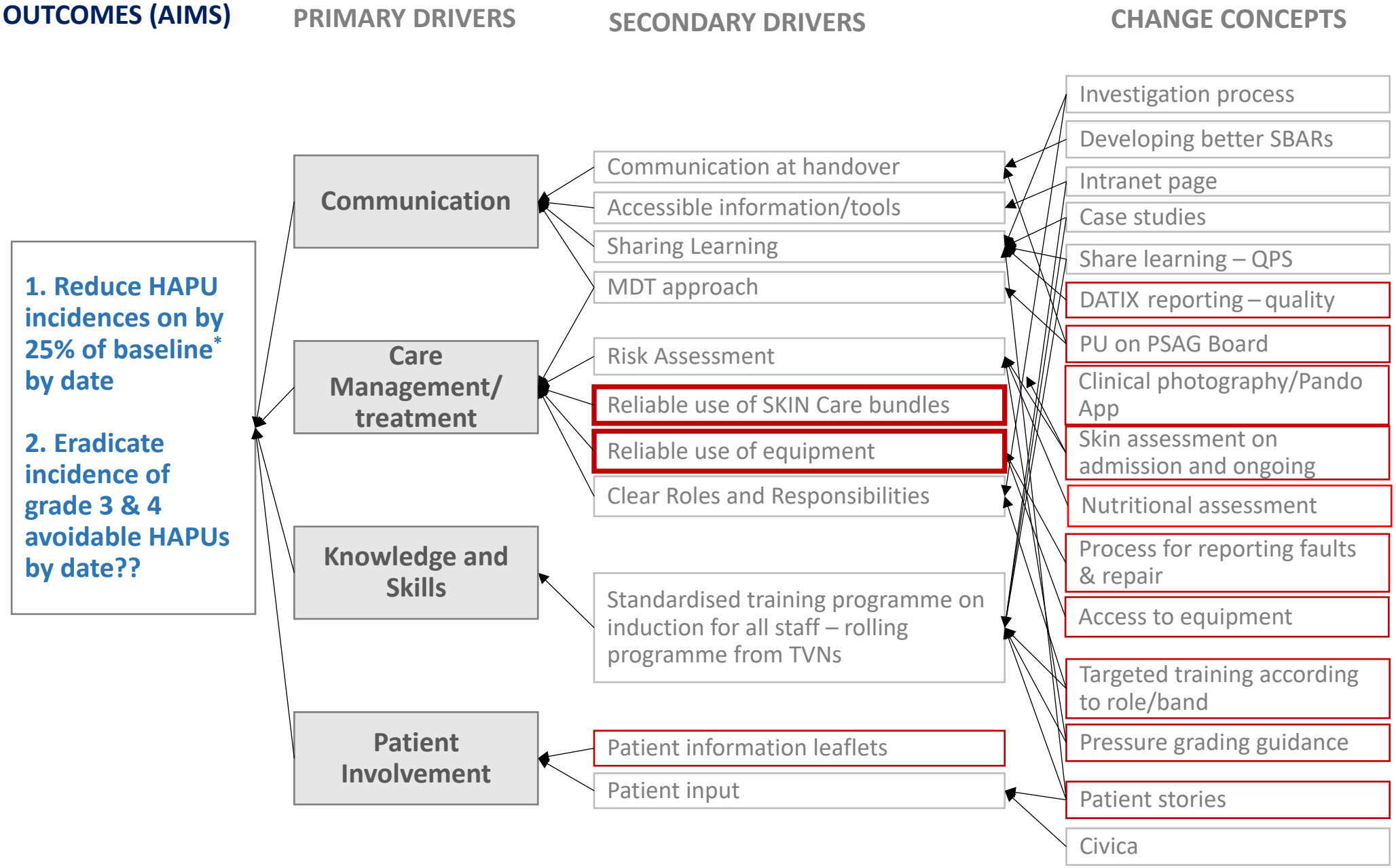
Health Acquired Pressure Ulcer Incidents by Division



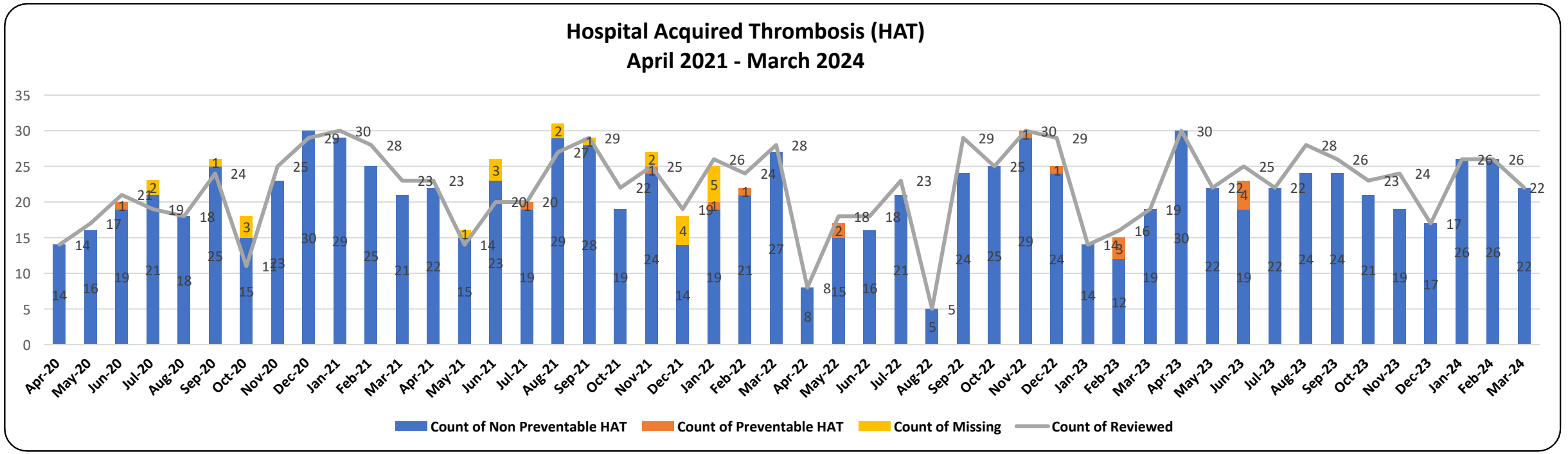


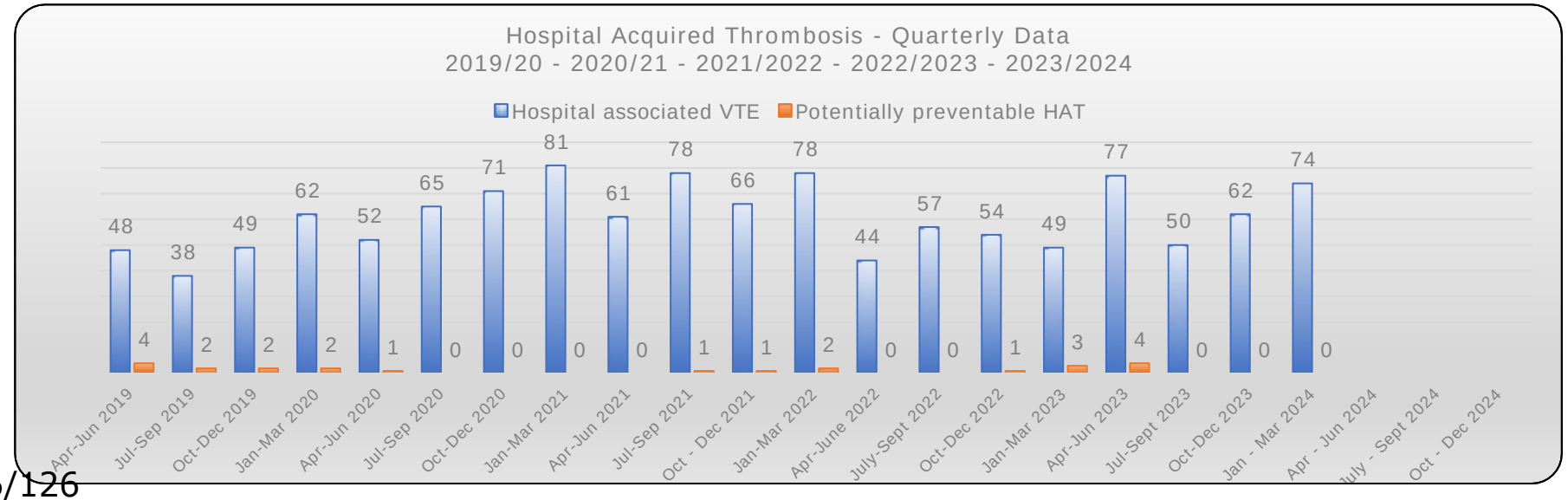


Pressure Ulcer Driver Diagram



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		

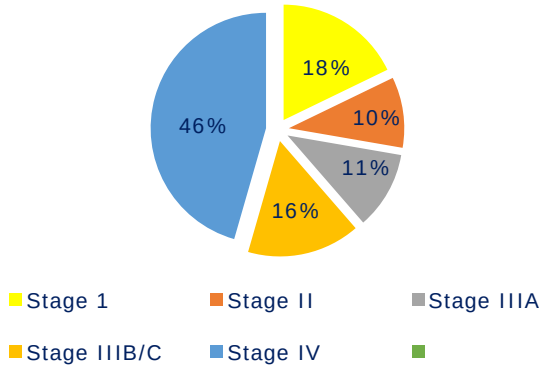
The Health Board has the largest number of patients with 100% data quality on key data items:

- 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.

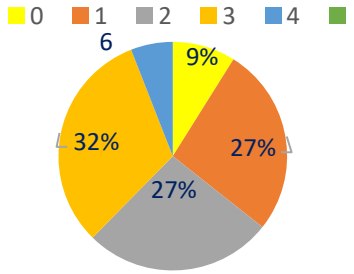
There are two cohorts: a) Small Cell Cancer – 12%, b) Non-Small Cell Lung Cancer (NSCLC) – 88%. There are 5 stages of disease:

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

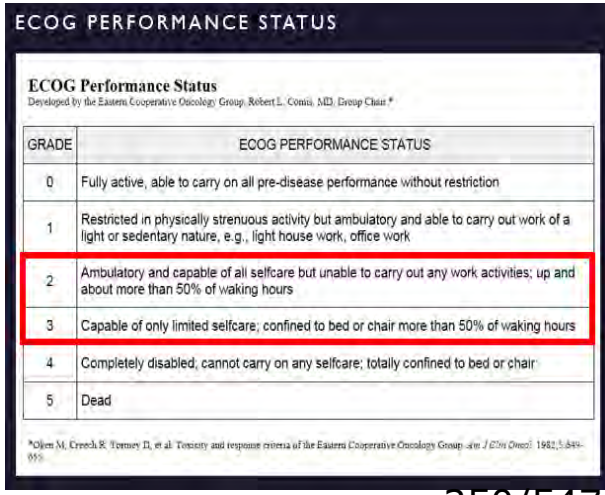
Unfortunately, the highest numbers are in the late stage of lung cancer disease due to late presentation or being asymptomatic at the time of detection.



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)


ECOG PERFORMANCE STATUS

ECOG Performance Status

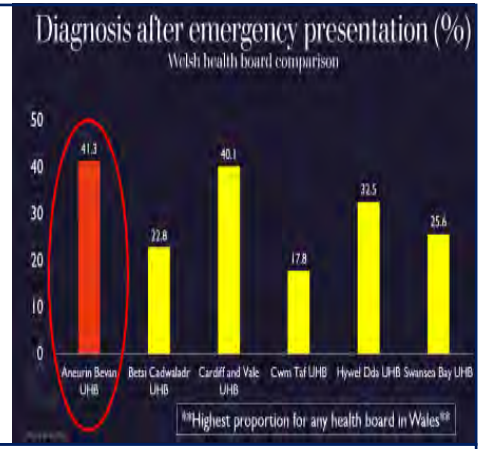
Developed by the Eastern Cooperative Oncology Group, Robert L. Comis, MD, Group Chair *

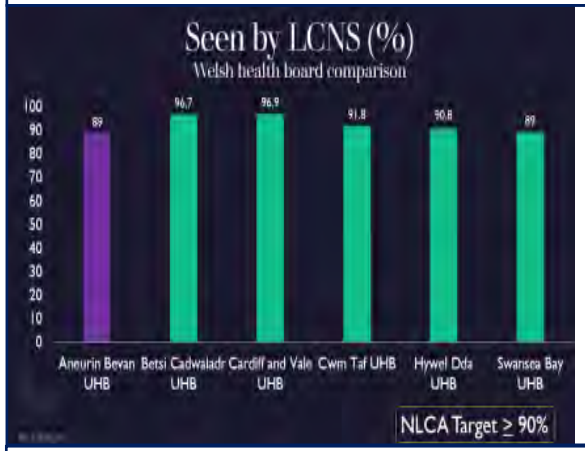
GRADE	ECOG PERFORMANCE STATUS
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours
3	Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any selfcare; totally confined to bed or chair
5	Dead

*Oken M, Creech R, Tormey D, et al: Toxicity and response criteria of the Eastern Cooperative Oncology Group. Am J Clin Oncol 1982;5:649-655

- 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

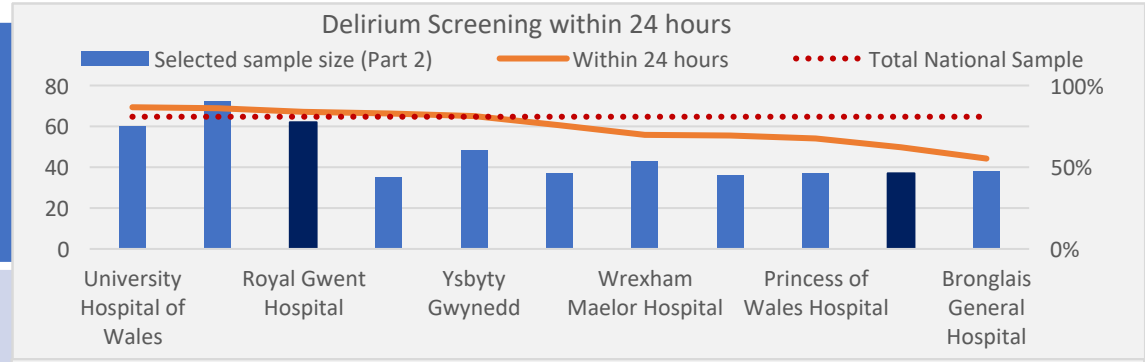
- The ABUHB lung cancer service diagnoses 400 cases of lung cancer per annum [>1 per day]
- The service also deals with abnormal imaging, large numbers of suspected malignancy and metastatic disease
- It is an expanding service with ever changing challenges including a population with severe co-morbidities/ 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

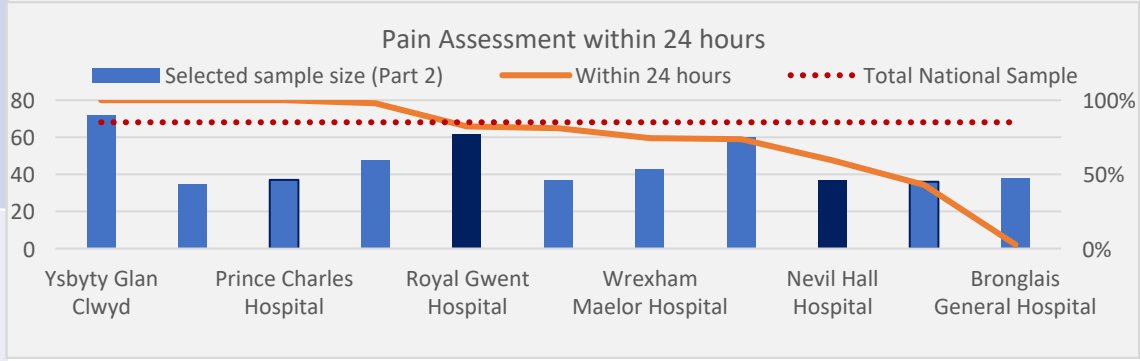
	Report Recommendations:	Progress:
1	Ensure services are implementing targeted lung cancer screening for people aged 55 to 74 who are at high risk of lung cancer.	Lung Health Check Pilots No imminent HB plans
2	Ensure providers have thoracic surgery capacity to meet both current demand for curative surgery 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

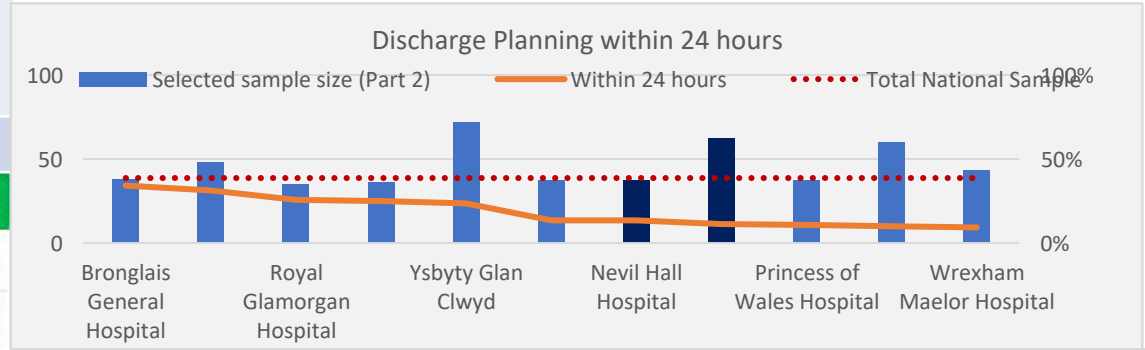
Audit Title:	National Audit of Dementia (NAD) Care in General Hospitals 2022-2023 Round 5 Audit Report Published August 2023	Clinical Lead: Dr Inder Singh Site Leads: Dr Sheriff (RGH) Dr Subhan (YYF) Dr Adel (NNH)
Rationale:	Report presents results of the 5th round of the NAD. Improving dementia care 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.	

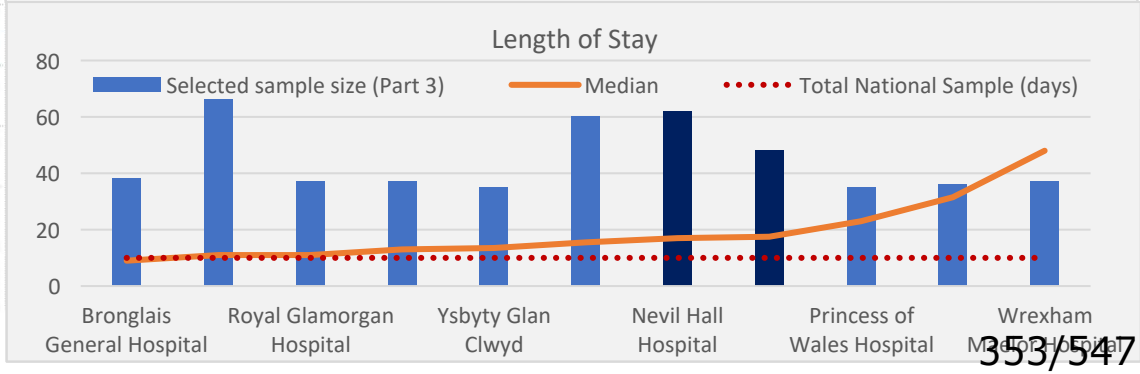
Presented at Clinical Standards and Effectiveness Group – 23rd May 2024.

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%









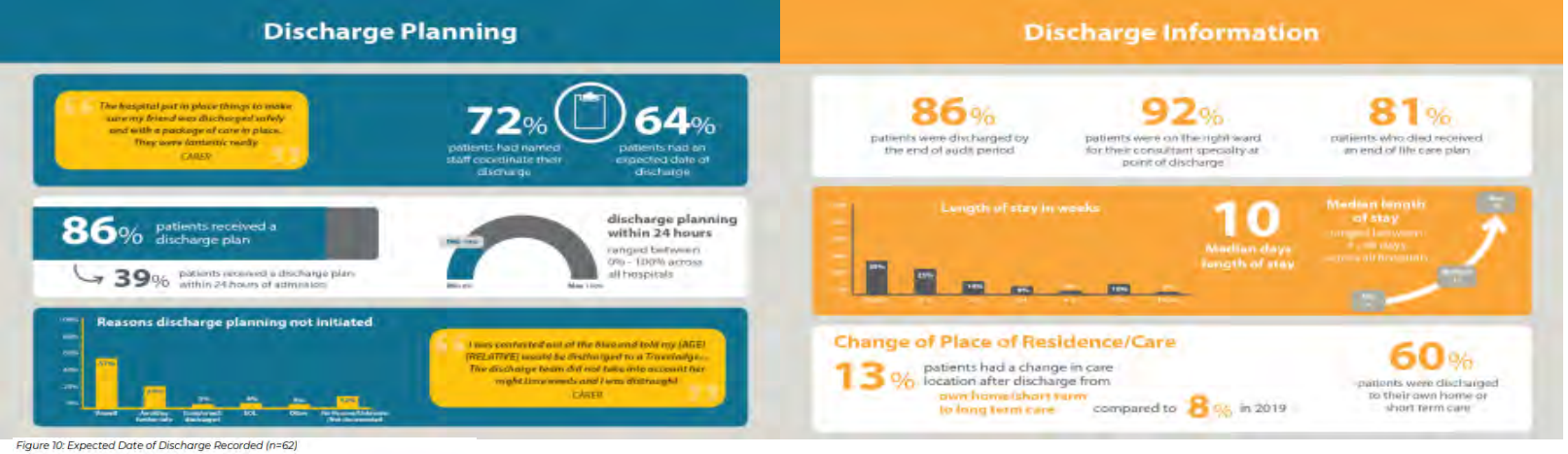
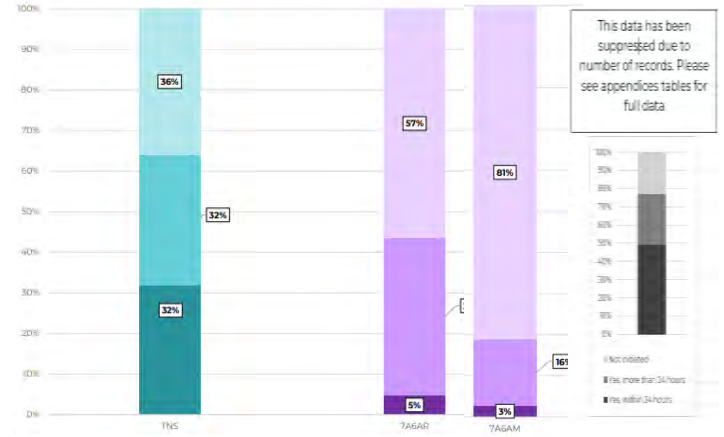
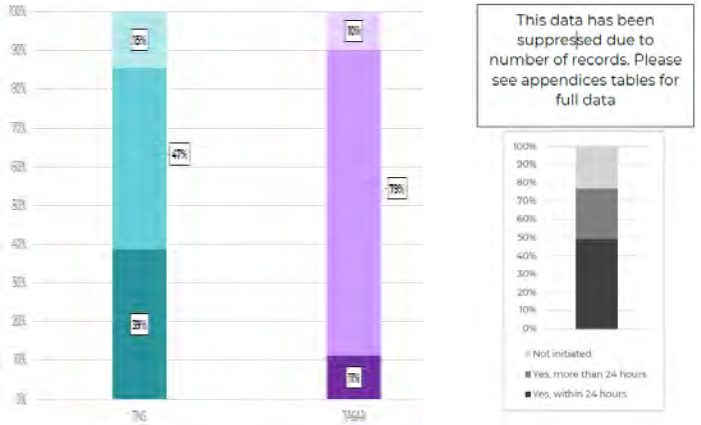


Figure 10: Expected Date of Discharge Recorded (n=62)





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

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

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%

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Discharge Information

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

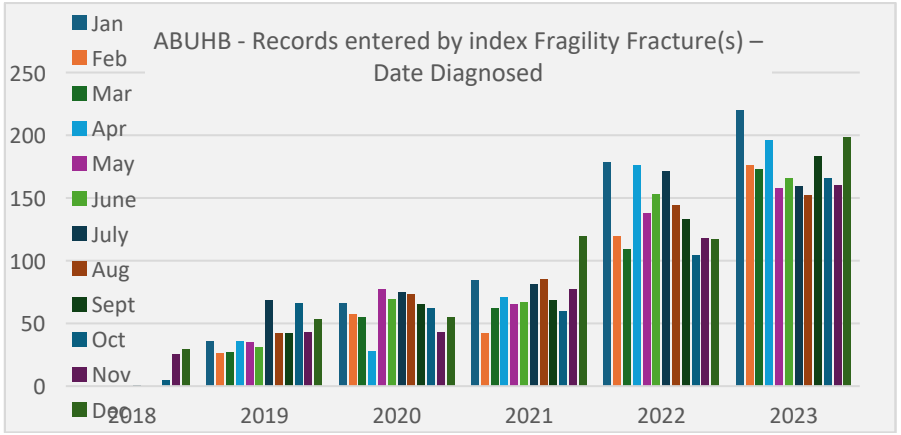
Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
3	The Chief Executive Officer should ensure that the Trust/Health Board has a nominated Board member responsible for dementia in addition to the clinical lead, whose responsibilities will include: • Establishing and implementing 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	Dr Singh	31/08/2024	Ongoing
		• 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	31/08/2024	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	Kertrina Collins, Natalie Webb, Helen Price	31/08/2024	Ongoing
		• Involve senior nurses for individual sites to encourage nurse attendance	Dr Subhan	31/08/2024	Ongoing
		• To deliver focused delirium teaching (SQID) in the ward settings – Dr Subhan to explore this with senior nurses	Dr Subhan	31/08/2024	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	Dr Subhan	31/08/2024	Ongoing
		• 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	Joanne Stimpson	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

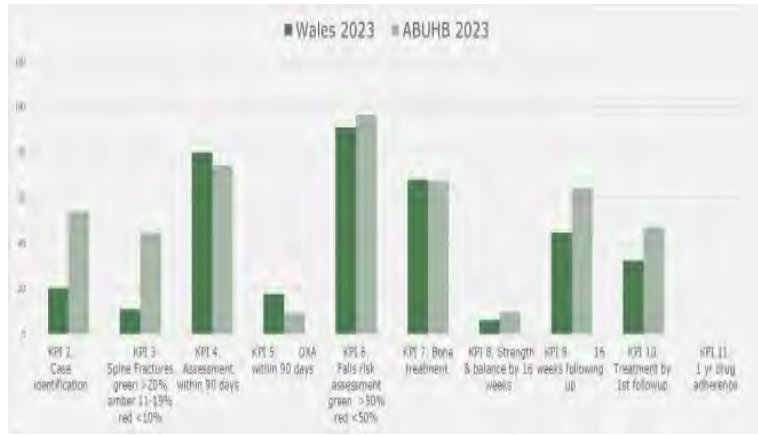
Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
Pain assessment/ Re-assessment	Quarterly one day Audit all patients who scored on pain assessment	• Proportion of patients who had dementia to be assessed for pain using a recommended ABBEY pain 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		£96,480		£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

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

	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.	
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.*		Dr Inder Singh Ongoing
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

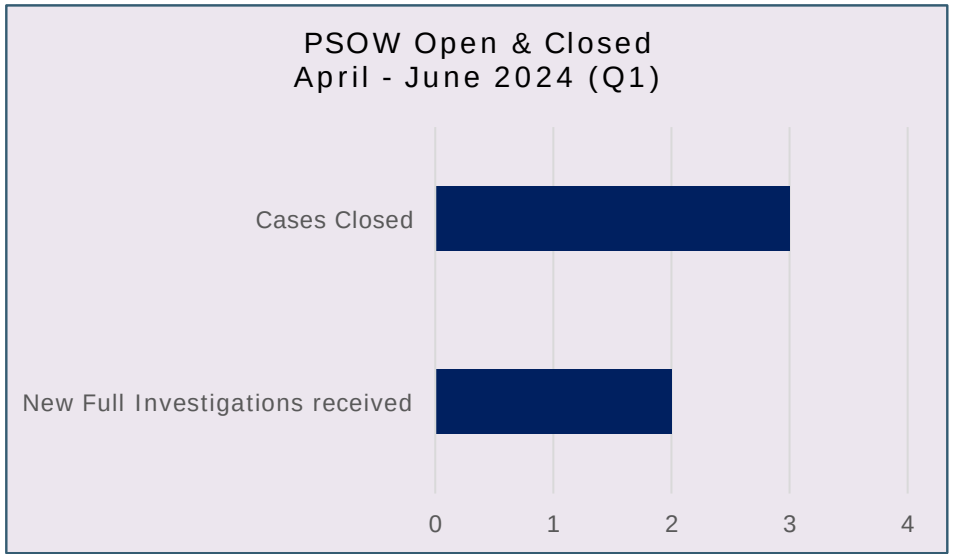
	Clinical Leads Local Recommendations: (if applicable)	Responsible:	Due Date:	Progress:
1	FLS for the ABUHB continues to be a centralised service and this is already achieved, however this needs to be continued.	Dr Singh	Ongoing	Improving
2	Wider partnership with Community Team, Primary Care and third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

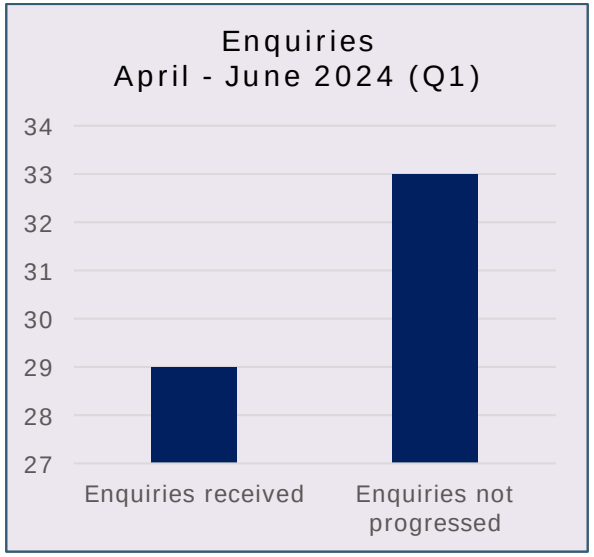
Priority 5: Efficient Care

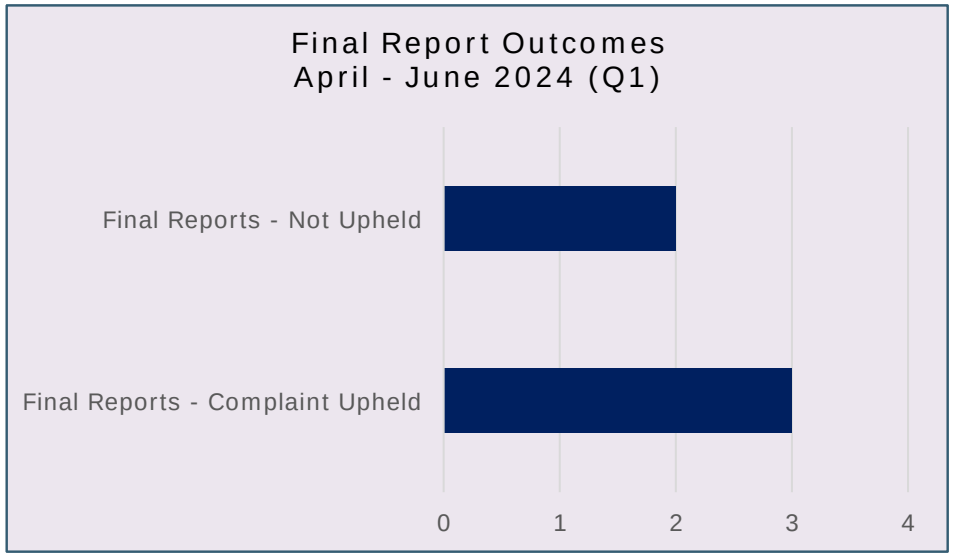


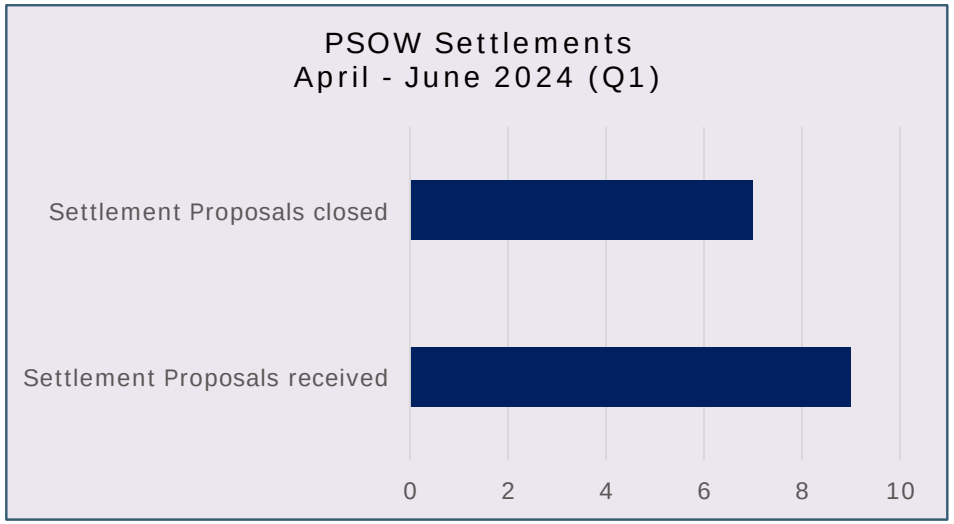
Priority	Outcome Description	Indicator	Reported Position 2023/24		Current Reported Position	Change over the last time period	Latest findings
			Q3	Q4	Q1 2024/25		
Priority 5 **Efficient**	Patient experiences are visible and acted on	Decrease in the number of open personal injury claims	76	69	71	Increased	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)

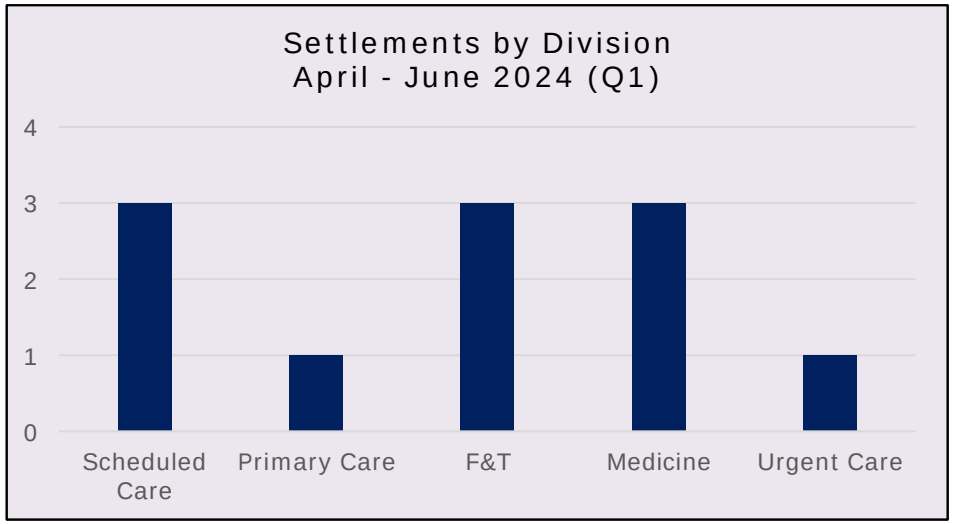








Positively, although the number of enquiries received has been higher, the number progressed by PSOW has been lower. Indicating that the PSOW has been satisfied following receipt of evidence from the Health Board. Overall settlements and final reports upheld has reduced across the period. The Health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



Priority 6: Equitable Care



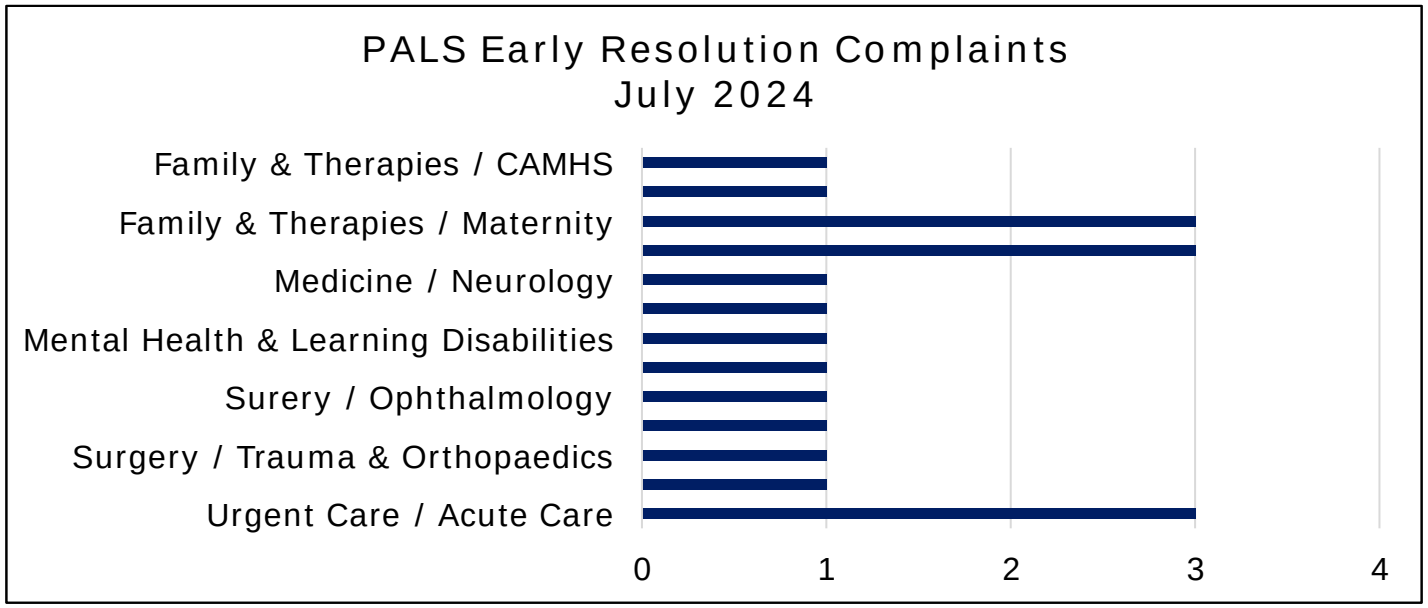
Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 6 Equitable	Improving quality of life and equitable access	Increase in the 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.

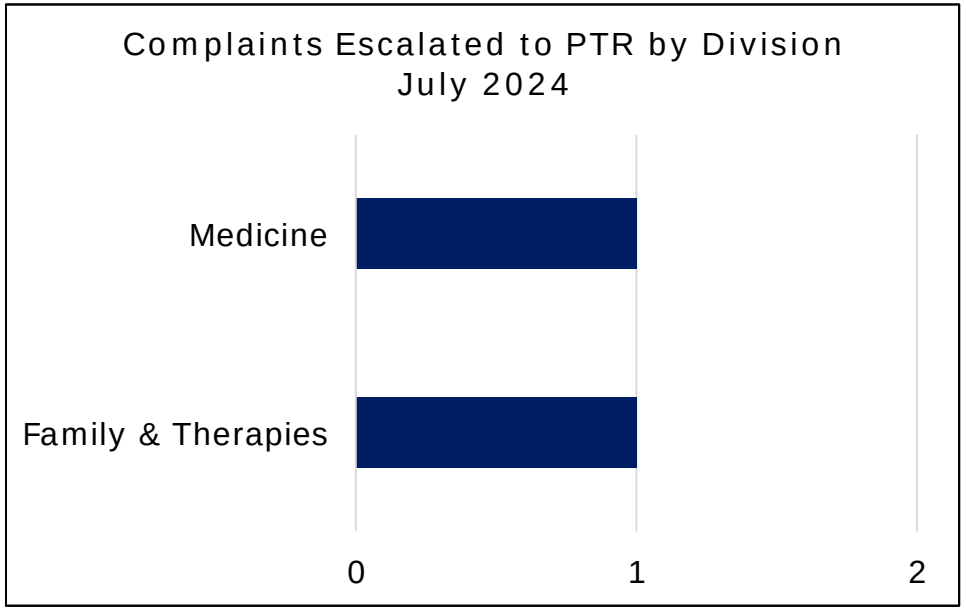
Issue	Action	Learning and Improvement	Who	When
Compliance with Level 3 Adult Safeguarding is currently unreportable, though compliance is known to be low (<10%)	• In the absence of ESR Monitoring targeted training to be delivered with support of Divisional Nurses • Further work with ESR Team to establish 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

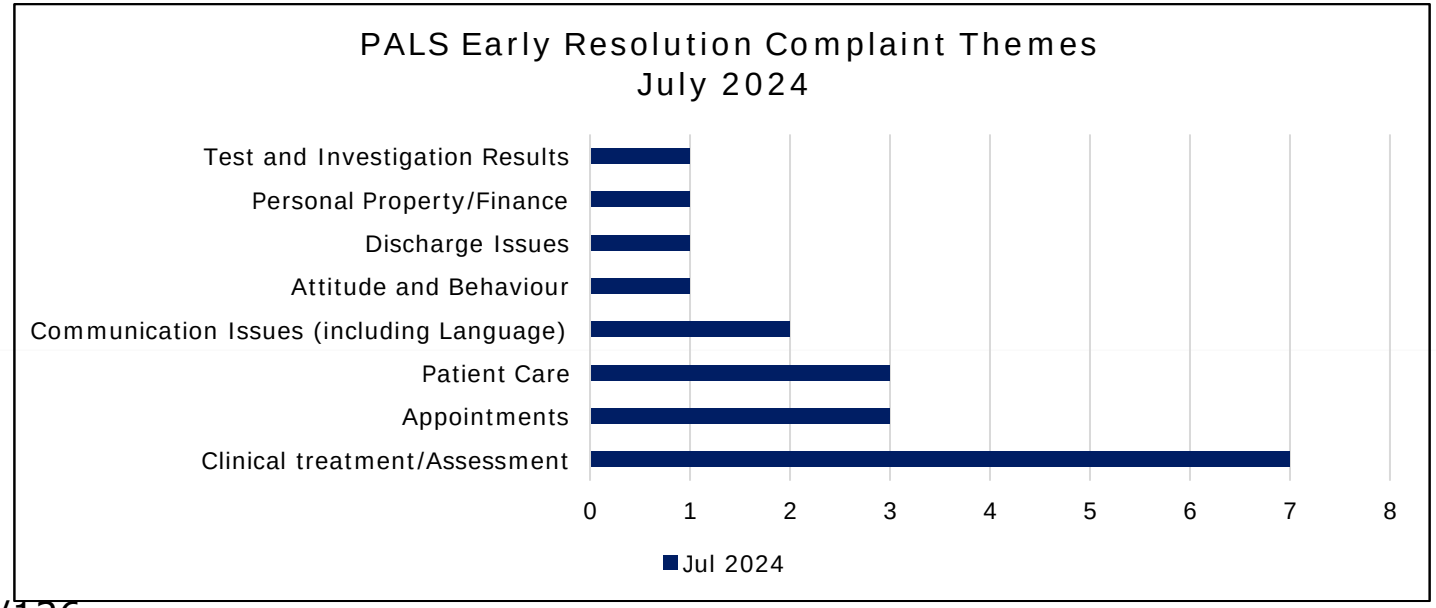
July 2024 Data

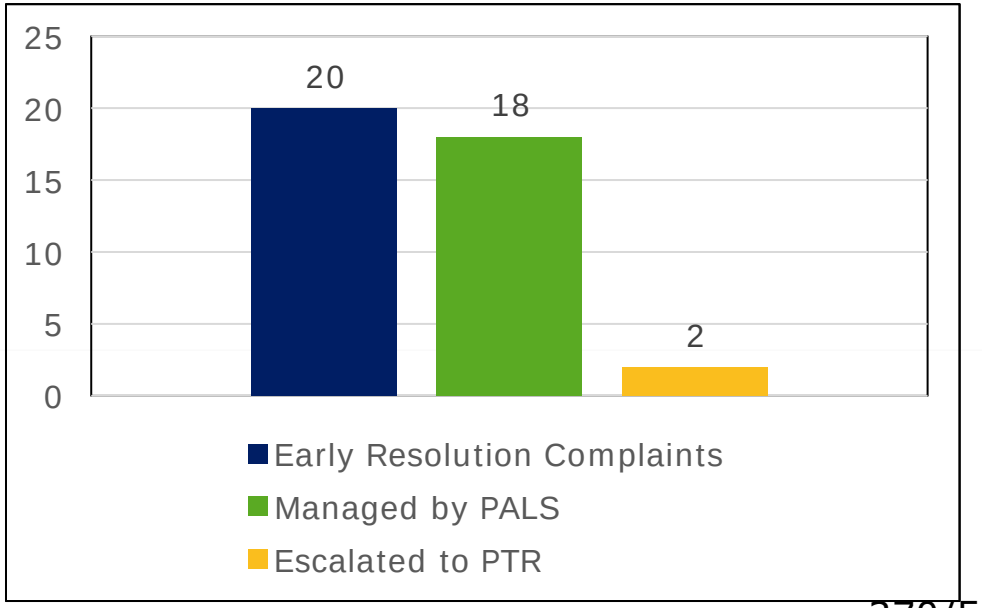
As provided to NHS Executives

Patient Advice & Liaison Service



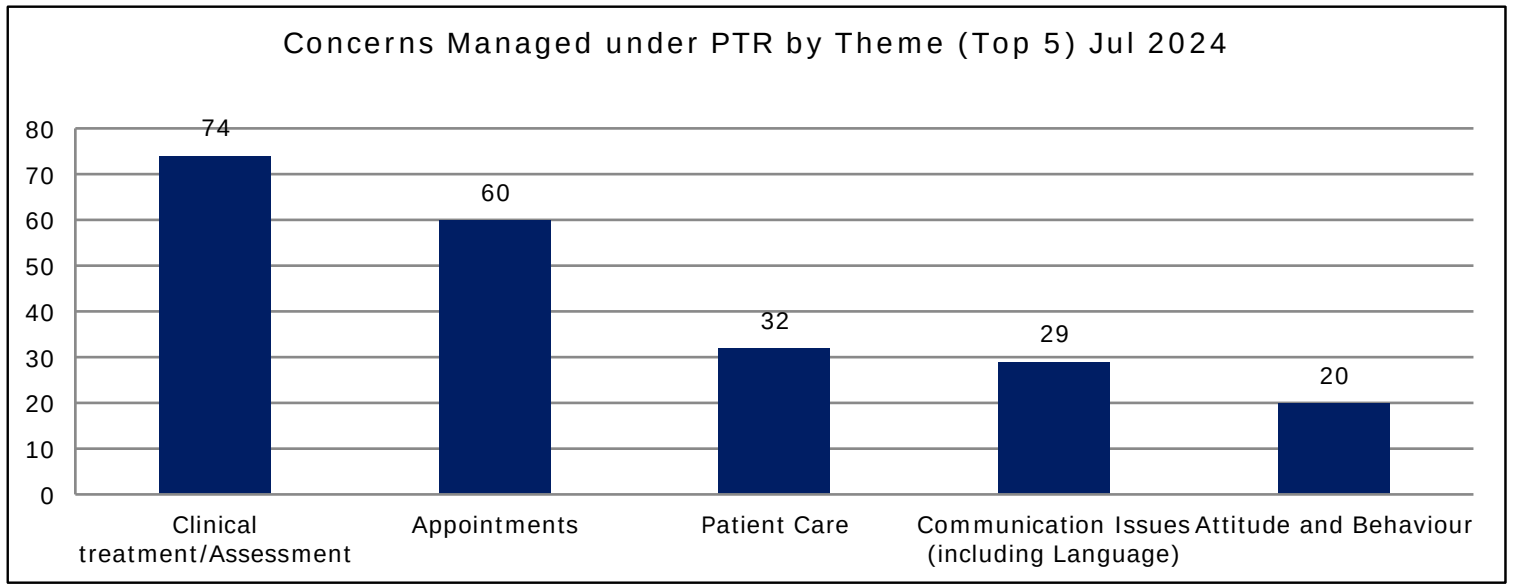




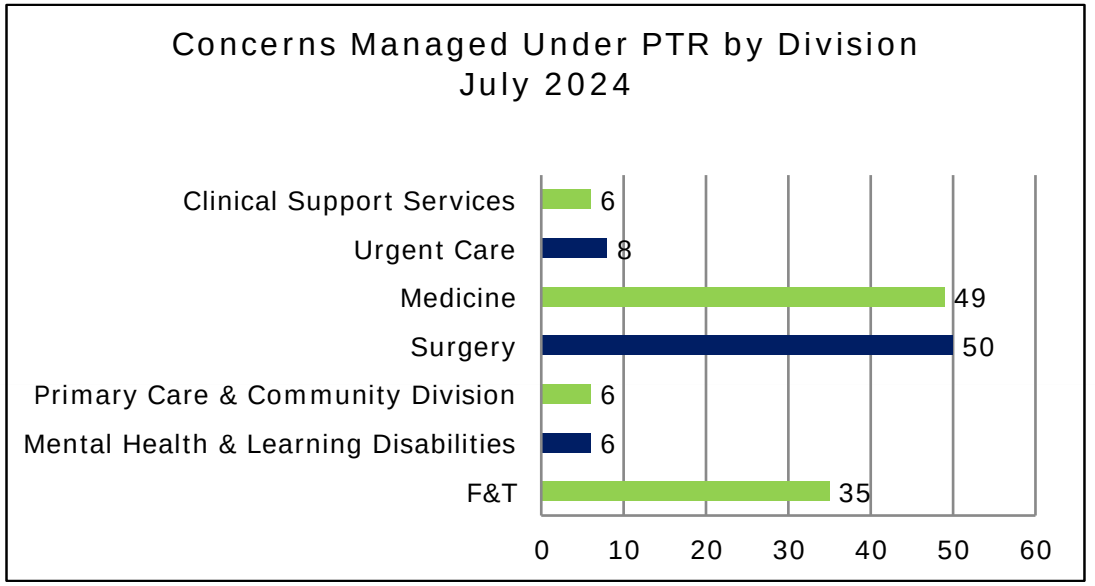


Complaints





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.

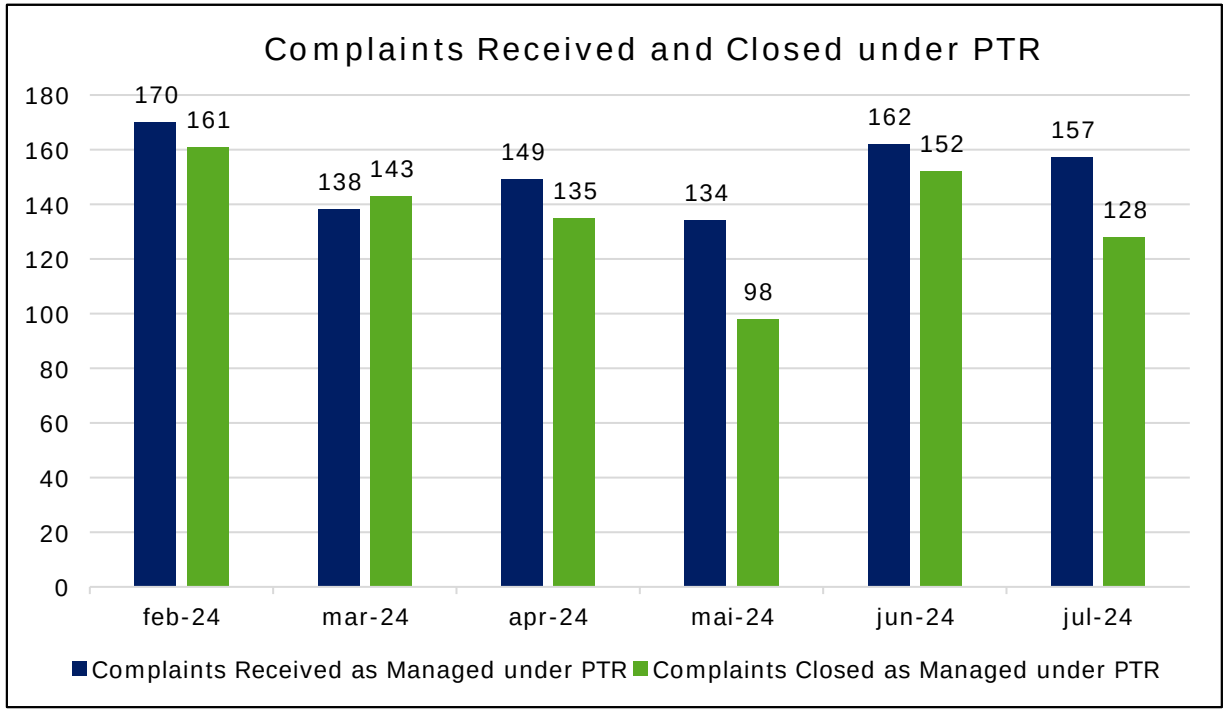
Healthcare staff are being encouraged to undertake 'Sage & Thyme' training which supports with difficult conversations and improving communication with patients, families and carers.

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

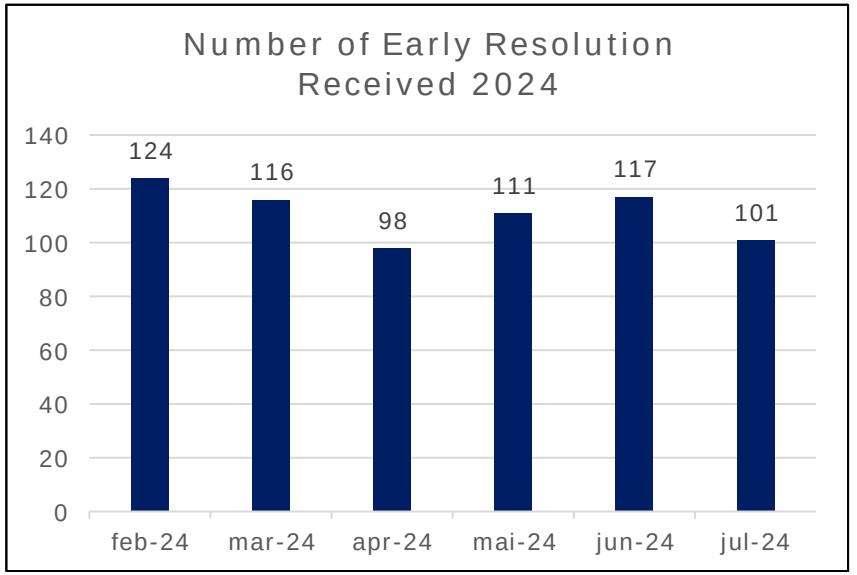
- Thematic Reviews
- Education and Training
- Systemic and Cultural Improvements
- Leadership and Psychological Safety
- Speak Up for Safety Initiative
- Revision of the Deteriorating Patient Policy

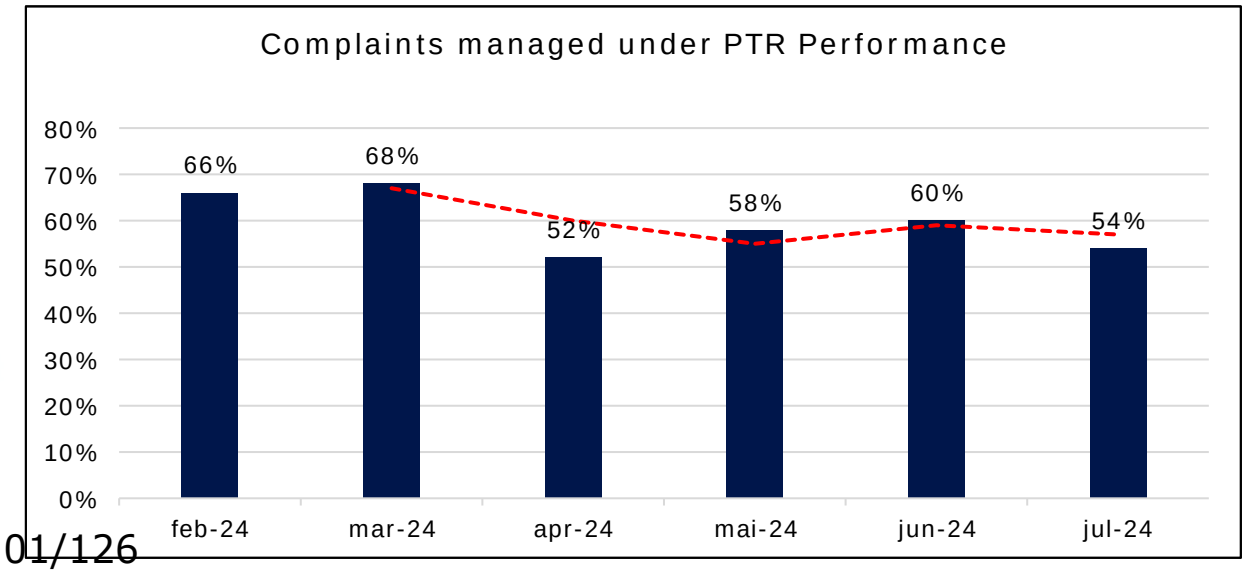
Complaints Performance



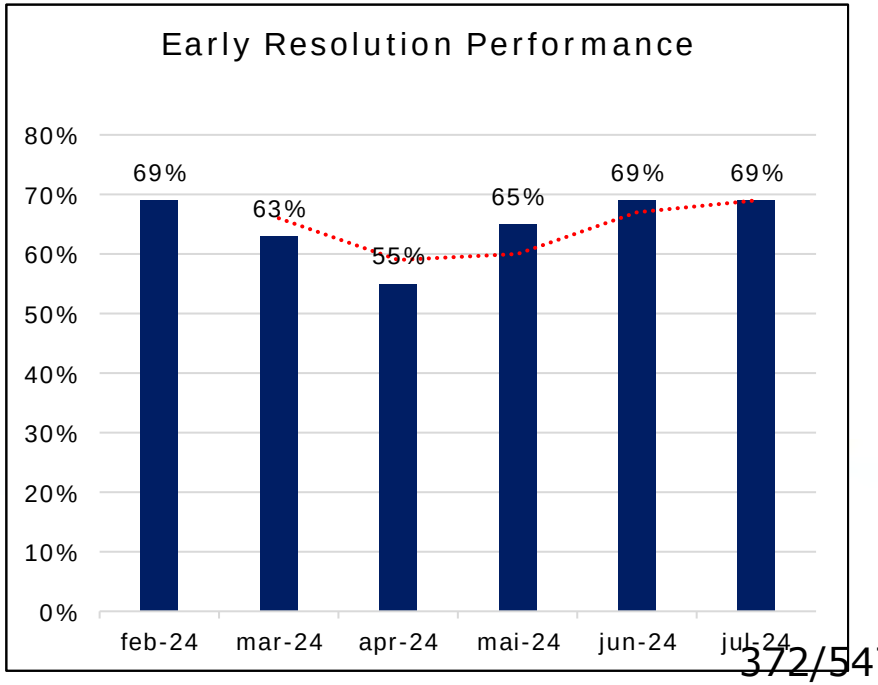


The Health Board has received on average 11% more formal complaints for investigation than those closed per month over the last 6-month period which has resulted in some slippage alongside closure of concerns which have exceeded the 30-day target. The test of change of the acknowledgement team has seen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

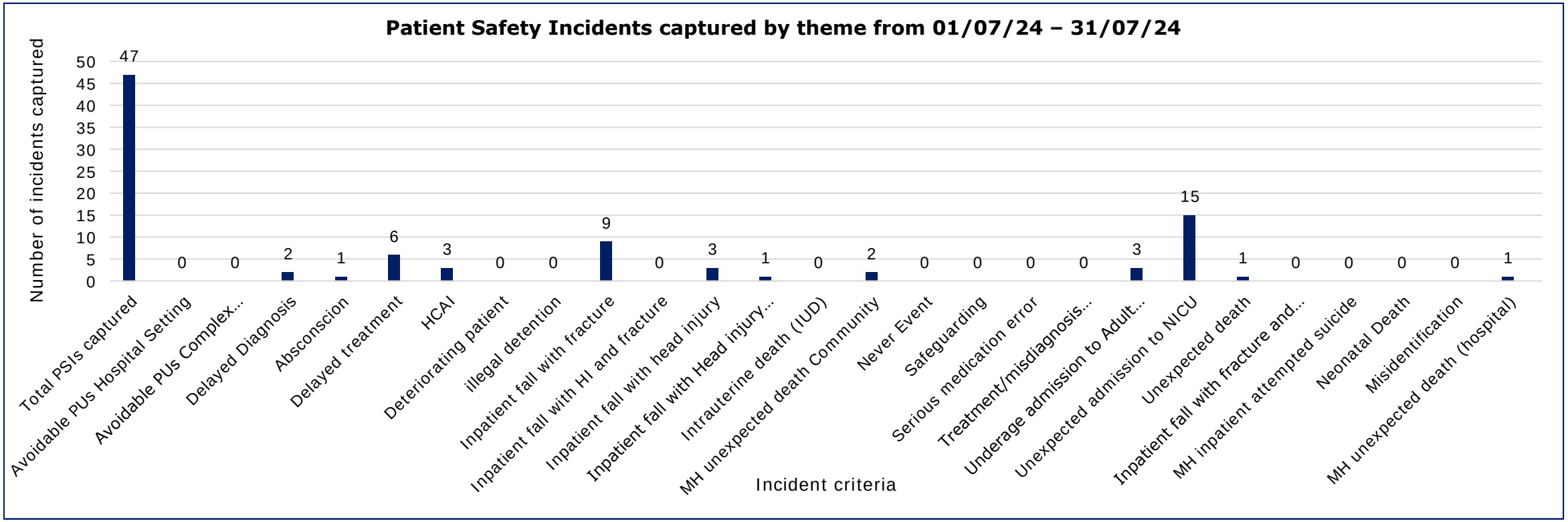
- The central PTR team is collating a 'how to' guide to support the wider PTR teams with more detailed validation on a more regular basis to ensure greater accuracy and robust monitoring/reporting.

- 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

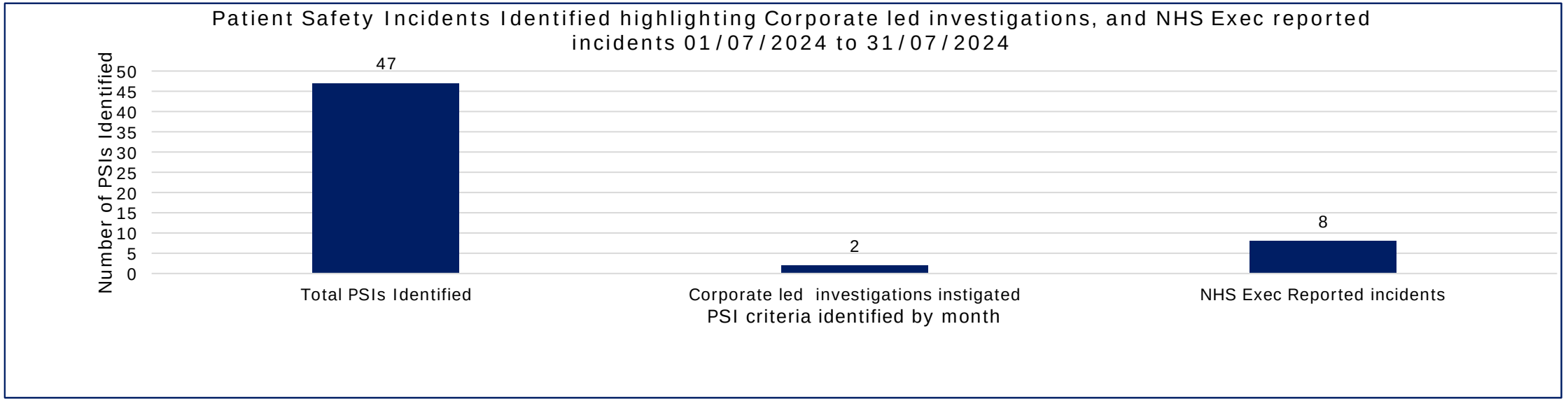




A total of 47 Patient Safety Incidents (PSIs) were initiated as either Corporate or Divisional led Investigations during July 2024. Of these, 39 PSIs met the criteria for a Divisionally led Investigation/concise review/focused review but did not meet the NHS Executive reporting criteria. These incidents 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.

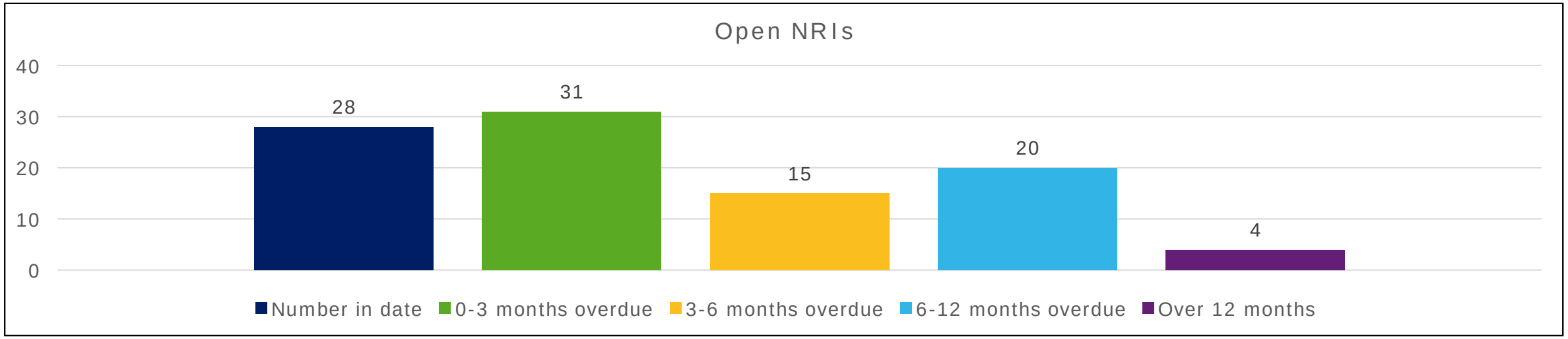
There were 17 Early Warning Notifications (EWNs) reported to Welsh Government (WG) during July 2024. Themes included Safeguarding concerns, patient absconsion, IG breaches, adverse social media coverage and PRUDICs.

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.

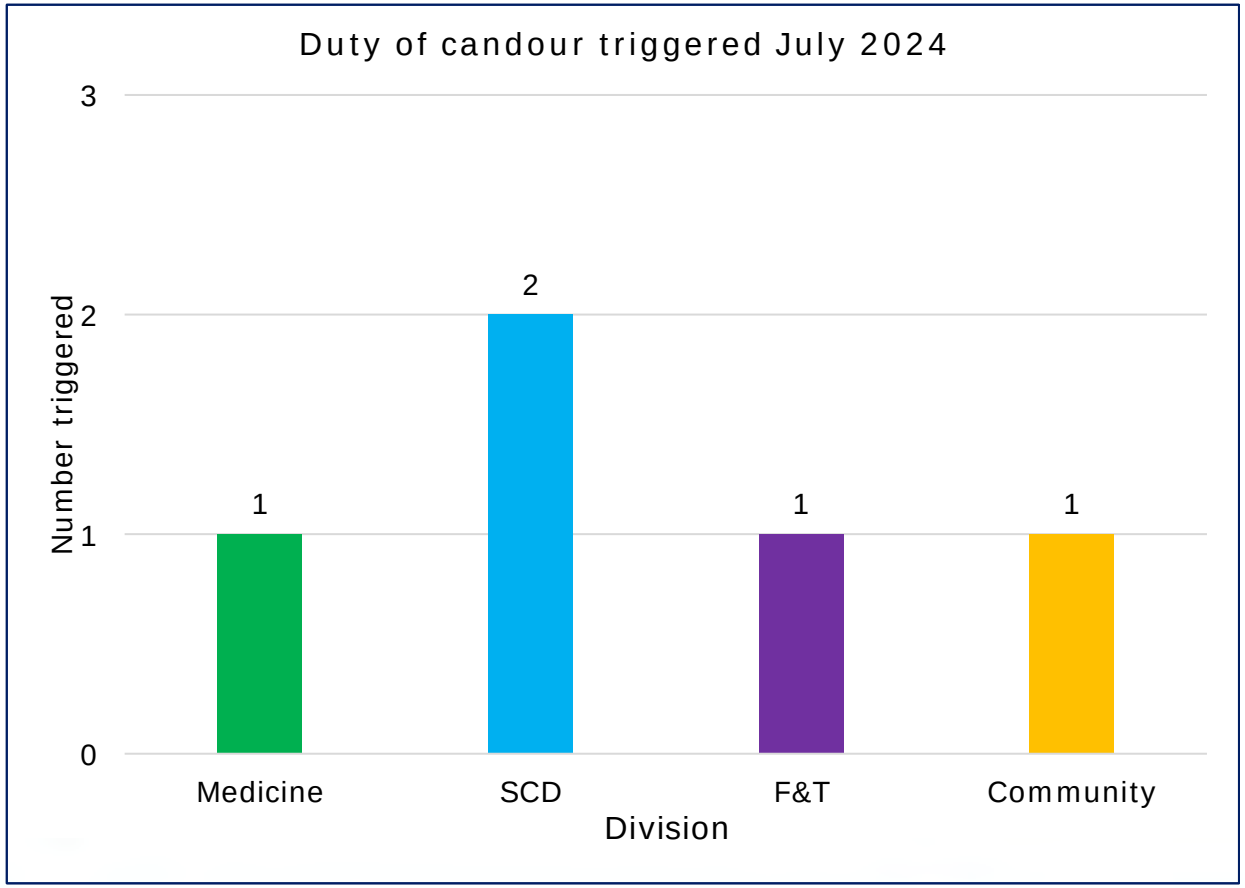
- The Executive Team and the Board's Patient Quality, Safety and Outcomes Committee will continue to maintain an oversight of quality governance and outcomes, including NRI reporting and timeliness of closures and the evidence of the application of learning across all aspects of patient care particularly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

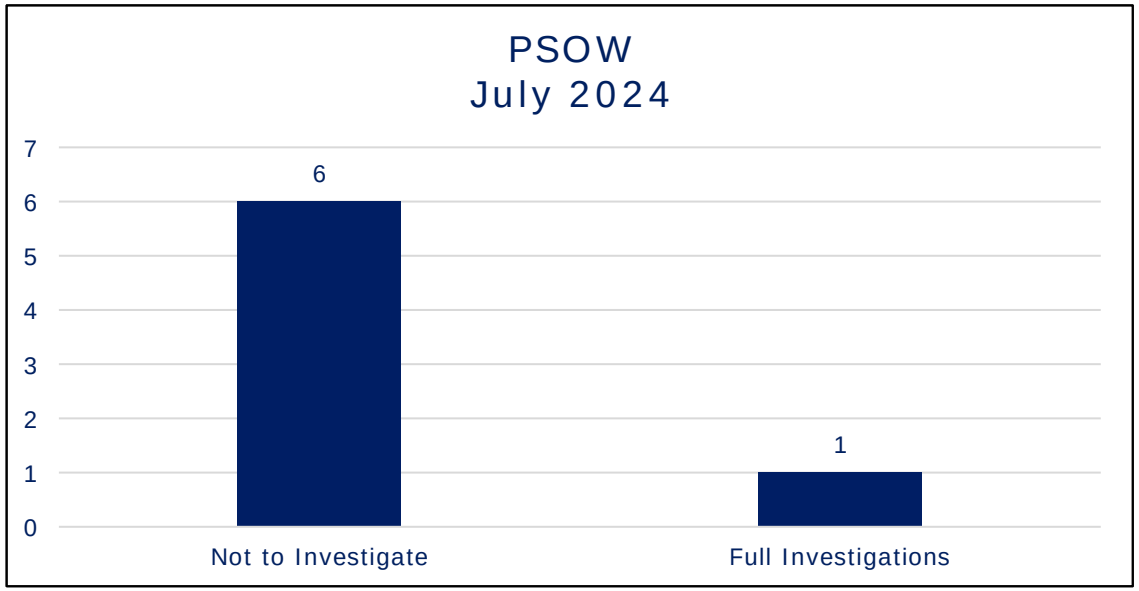
a) Revision of the escalation framework to ensure that the points of escalation during any ambulance handover delays are appropriate
b) Creation of inter-speciality standards
c) Prioritisation and assessment of the balance of risk

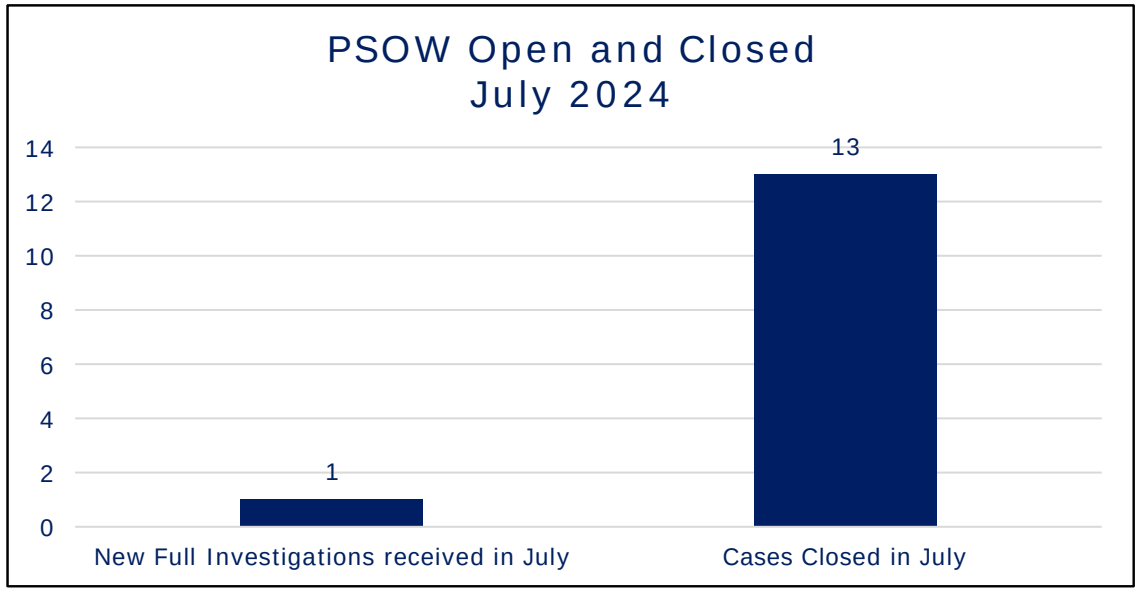
3) Discharge Logistics

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

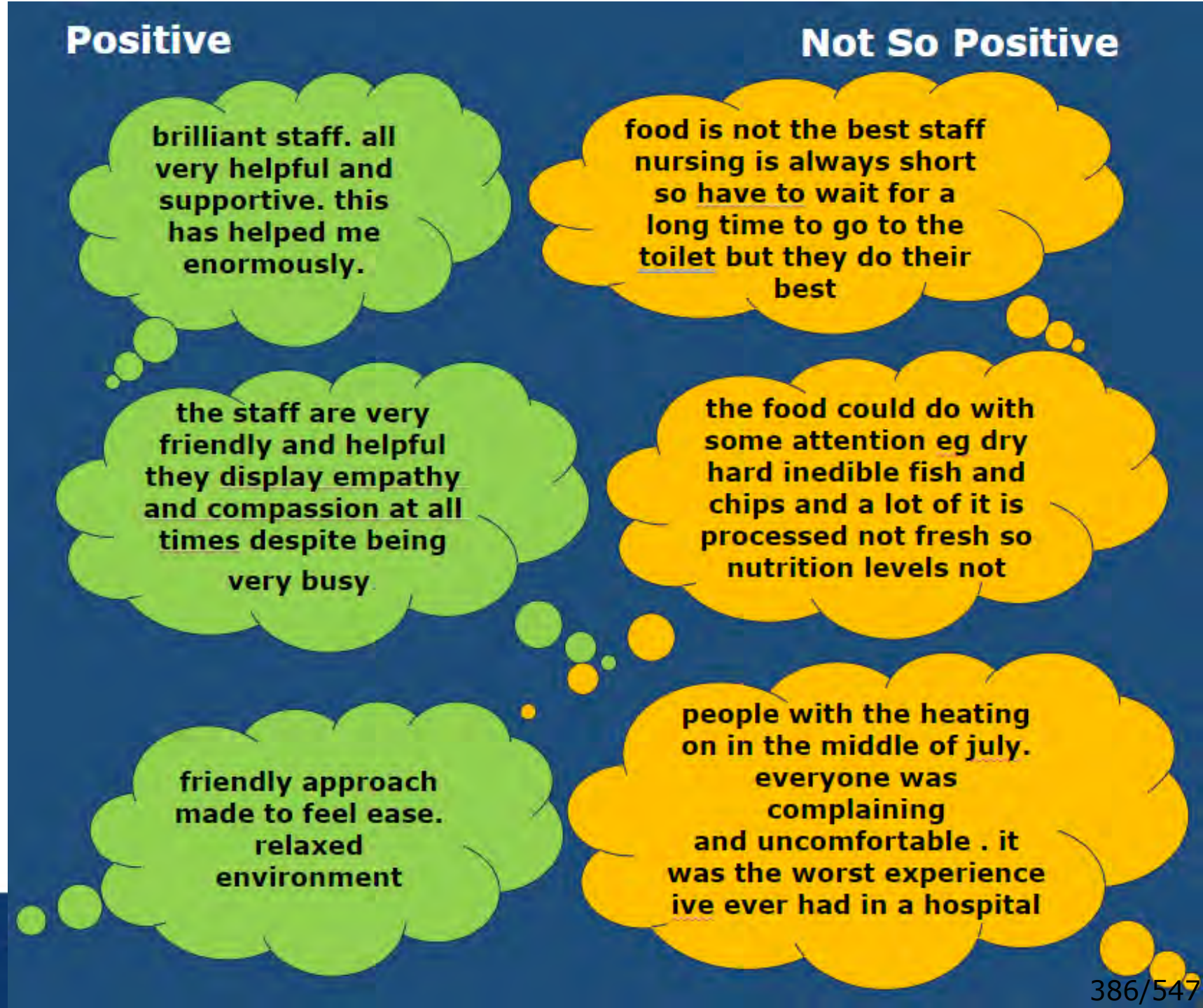
Top 3 Themes from PCC Survey

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

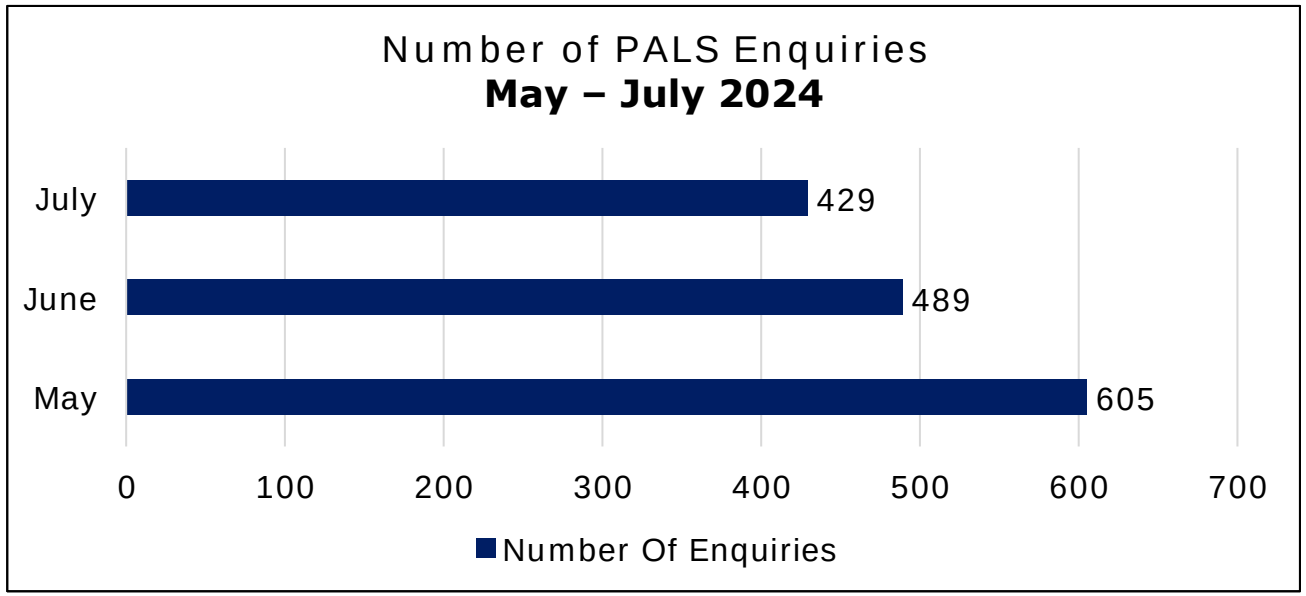
Positive Themes	Negative Themes
Emotional and Physical Support (127)	**Waiting (26)**
Compassion (124)	**Food & Beverages (12)**
Friendliness (112)	**Comfort (11)**

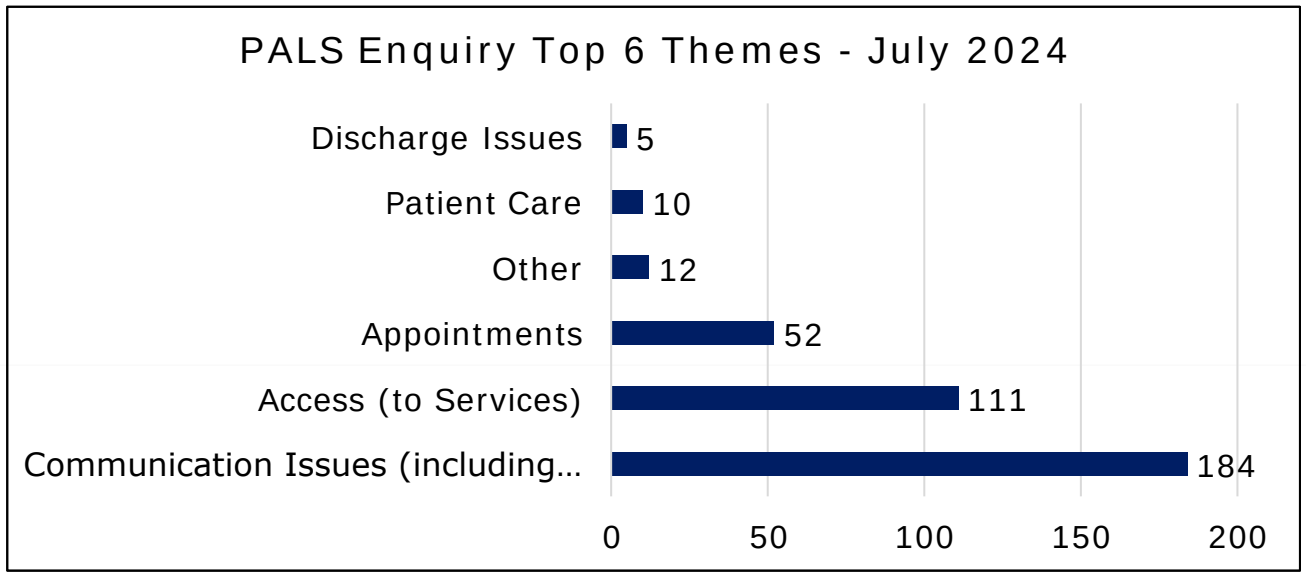
Patient Comments from **PCC Survey**

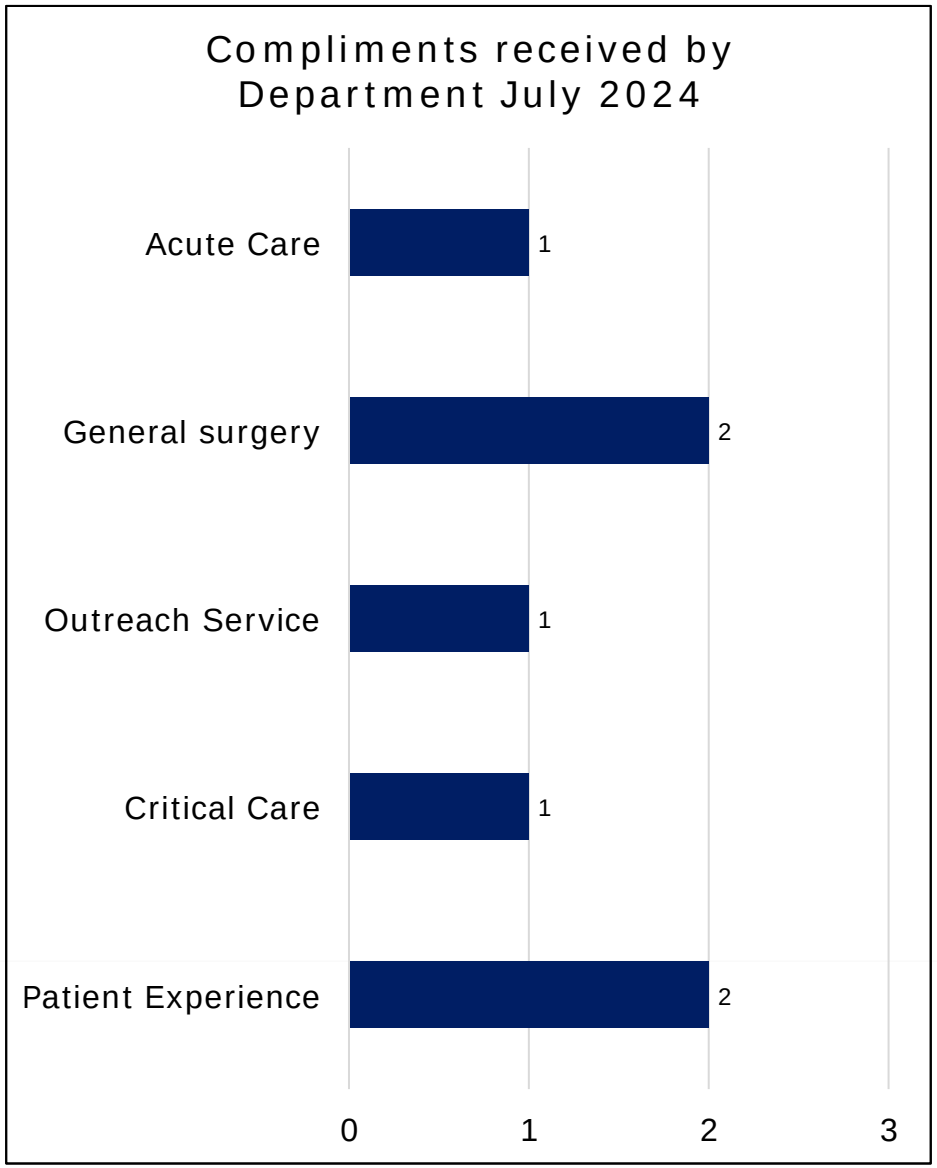


Patient Advice & Liaison Service









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

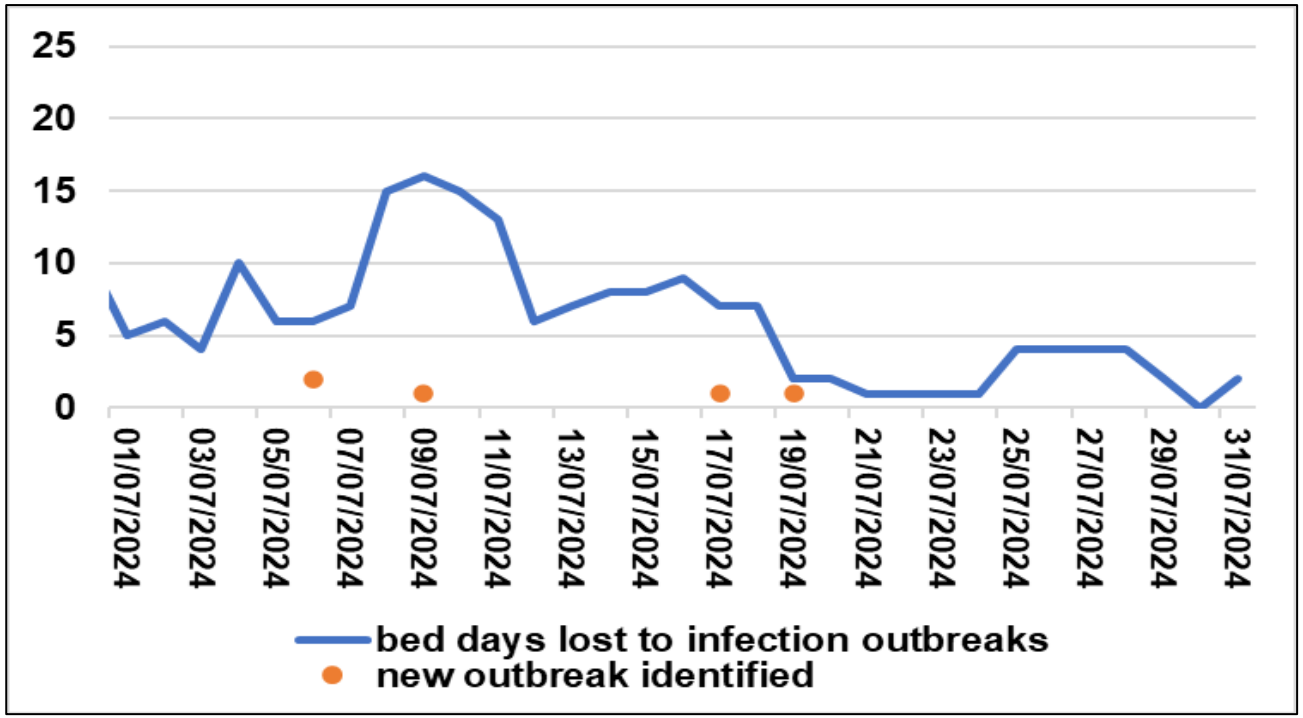
< than same period last FY
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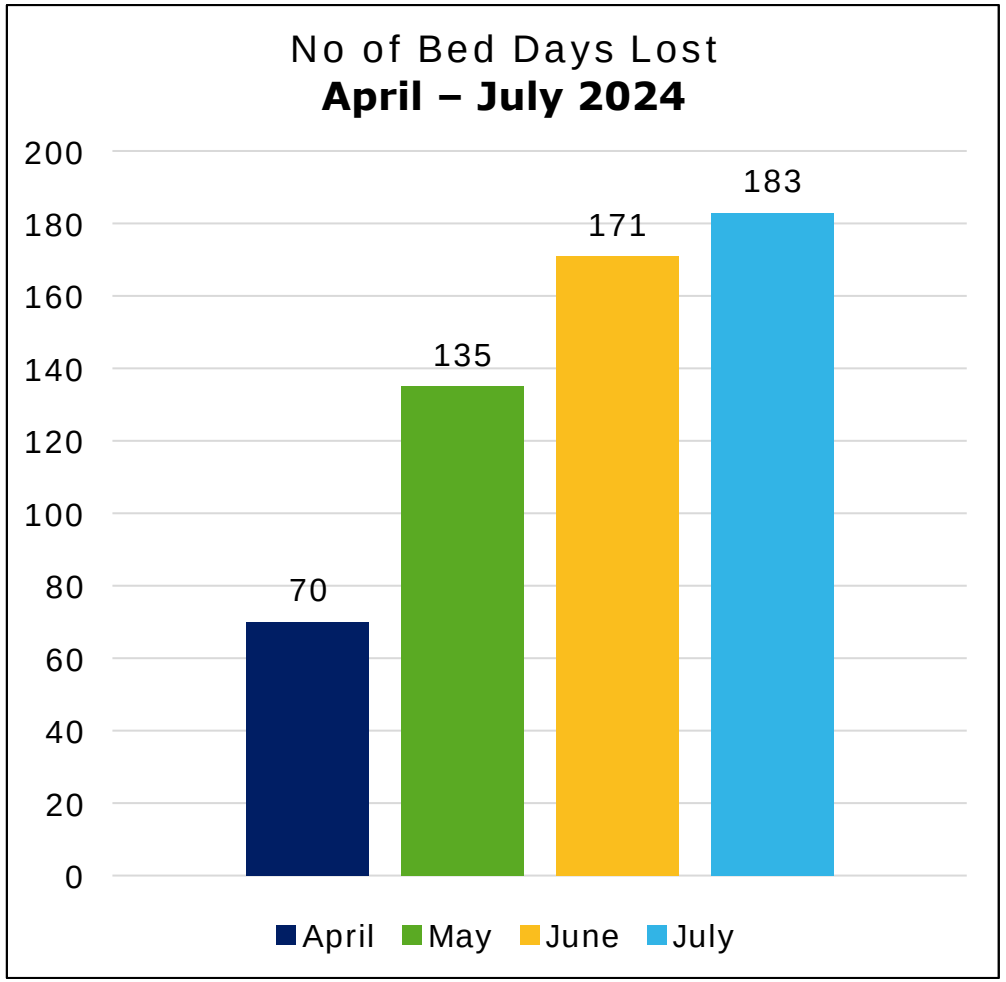
Current count of cases for FY 24/25

	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.

Agenda Item: 3.1

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									

o U&EC o 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

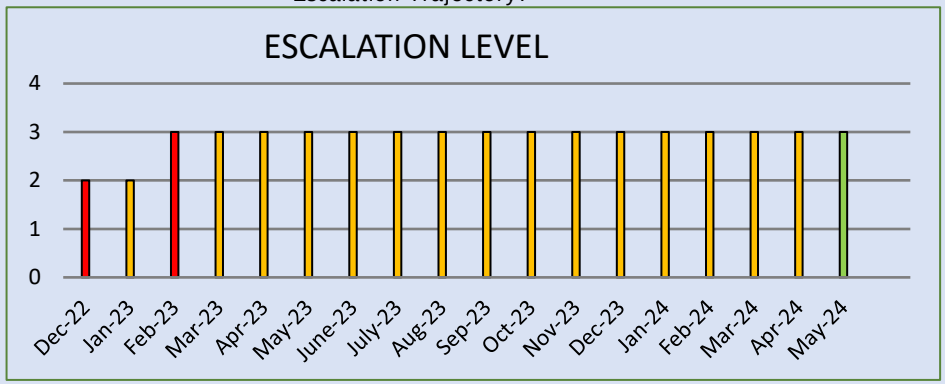
Service in Escalation: Paediatric Surgery

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

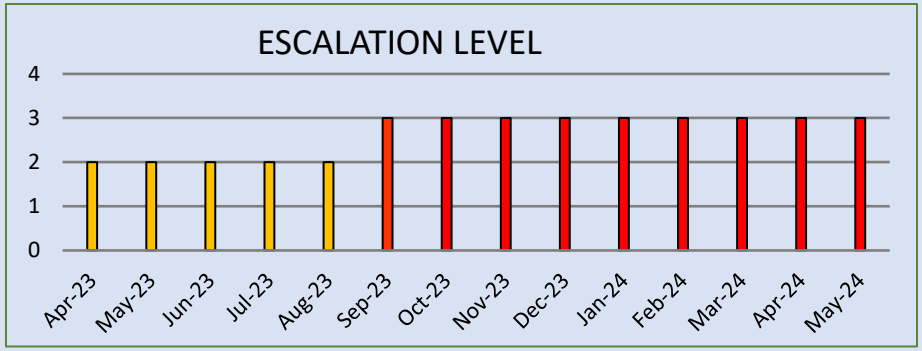
Service in Escalation: Paediatric Intensive Care

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

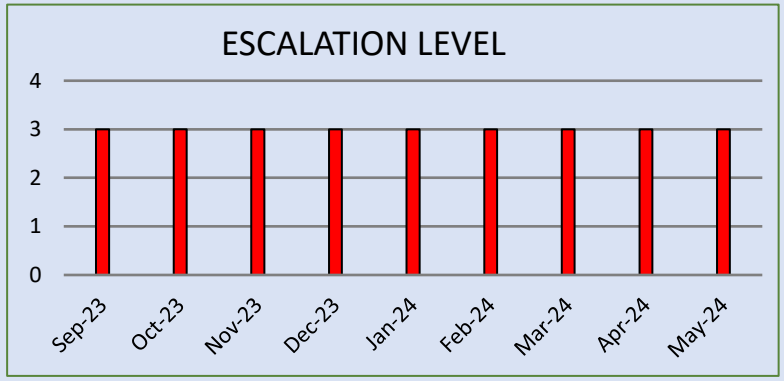
Service in Escalation:
Neonatal Intensive Care Unit

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

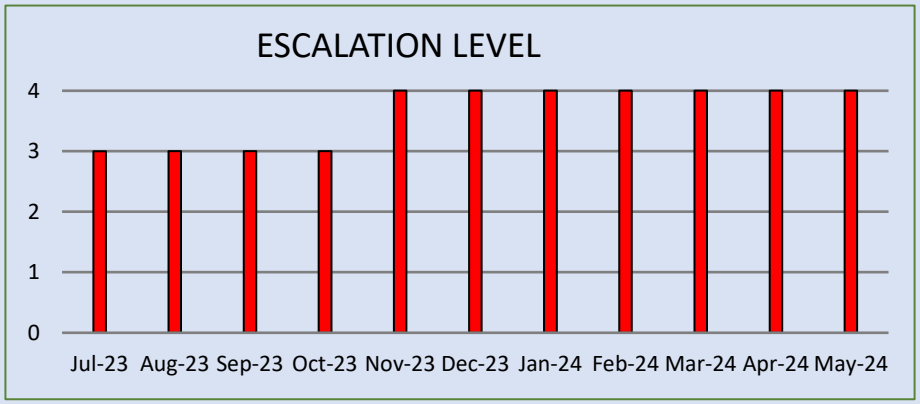
Service in Escalation: Wales Fertility Institute

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:

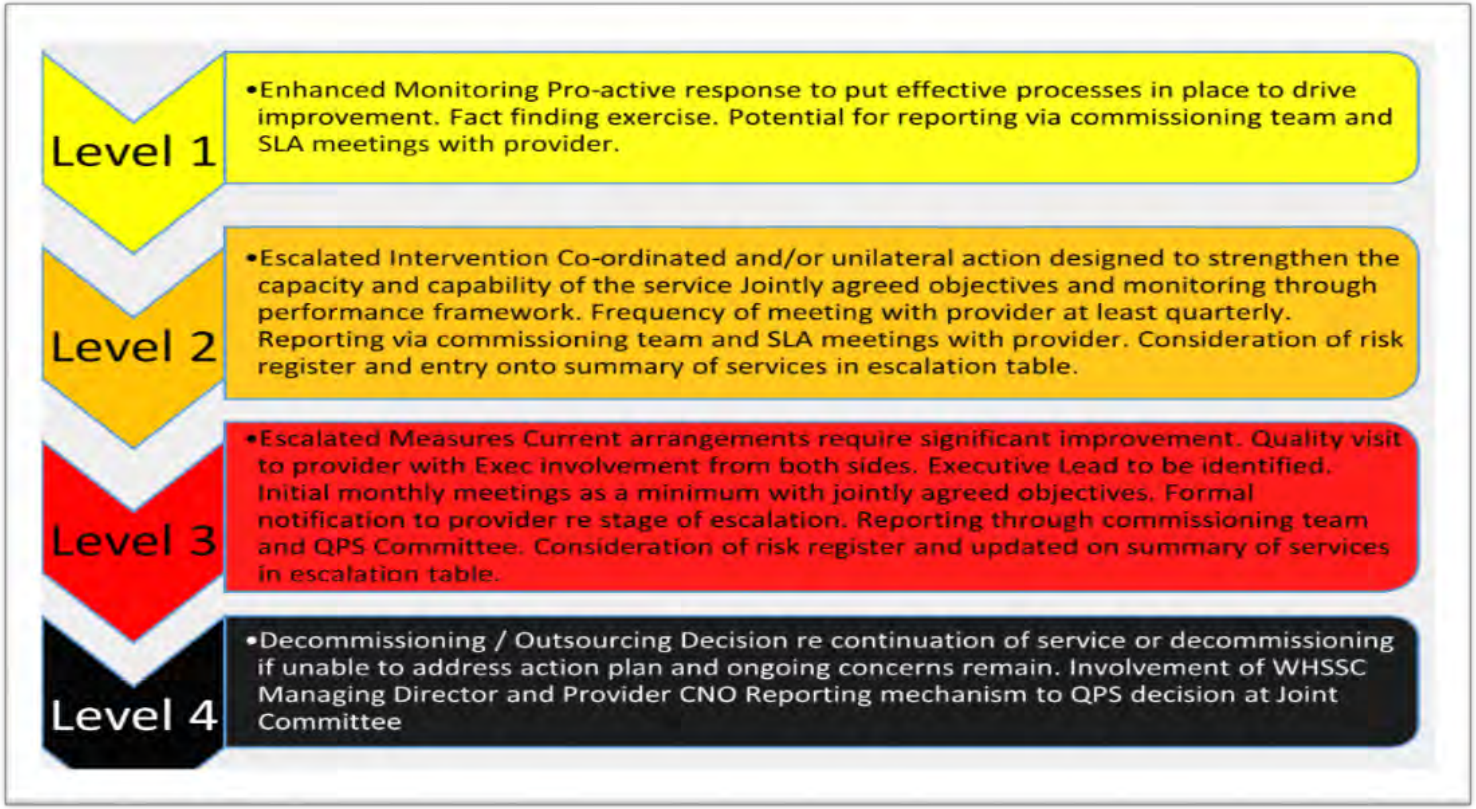
Action	Lead	Action Due Date	Completion Date
Monthly escalation meeting to review progress against Action Plan Escalation meeting 19th September 2023 10th October 2023 7th December 2023 15th February 2024 14th March 2024 9th April 2024 8th May 2024	Assistant Specialised Planner	Monthly	13 June 2024

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

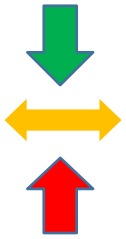
Issues/Risks: There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre 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	

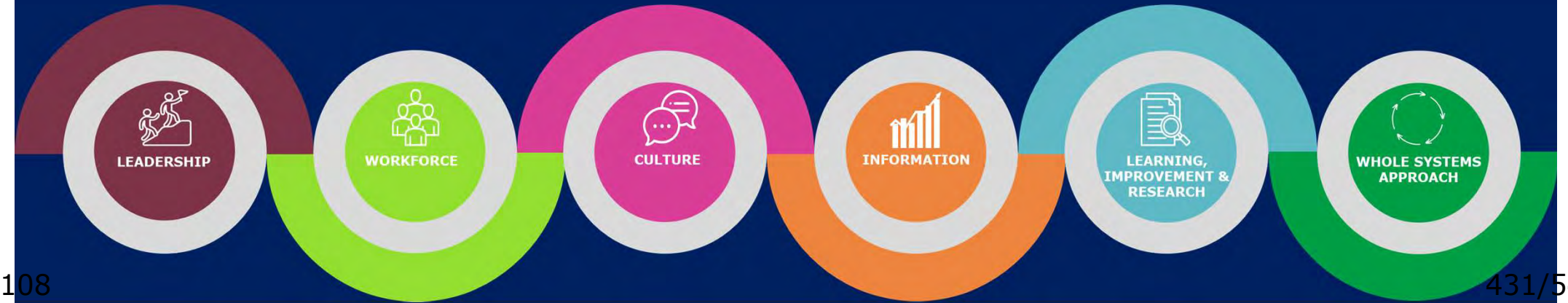
	JH provided an overview of Civica and PALS. The surveys were extremely positive and above target. Early resolutions proved pivotal in the feedback.	
4. Listening and Learning		
4.1	Listening and Learning Framework – agree implementation plan. Update on Learning Repository shared by Jacqui Lawrence. It 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

Contents



Main Report

1. *Achievements*
2. *Emerging Risks & Issues*
3. Quality & Patient Safety
4. Financial Profile
5. *Quality Impact Assessments*

Supporting Information

6. *Workforce Profile*
7. Operational Indicators
8. Divisional Workstream Objectives

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

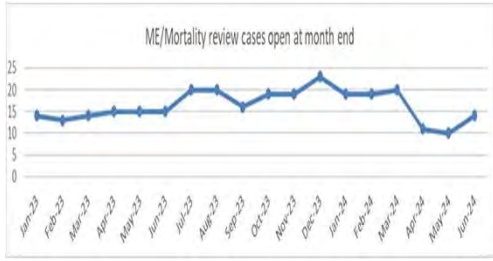


Complaints Management

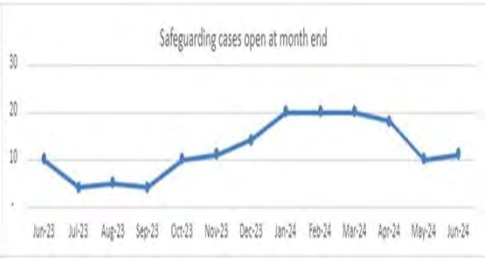




Mortality



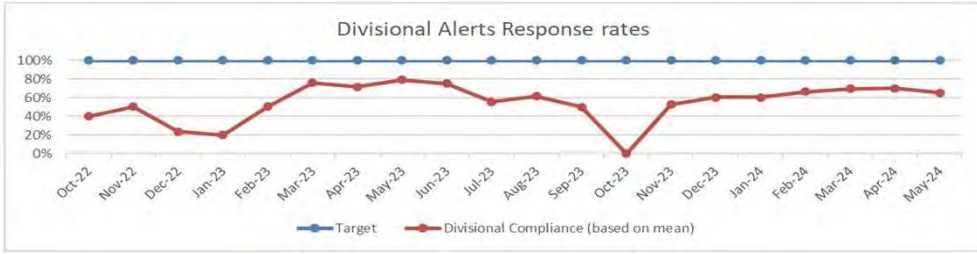
Safeguarding



Serious Incidents



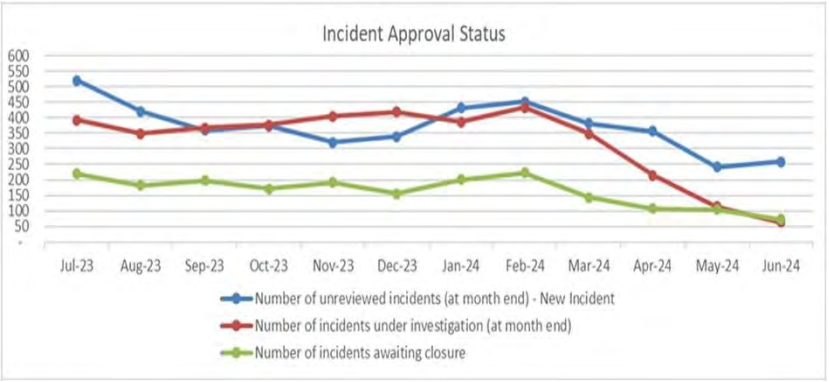
Alerts Compliance

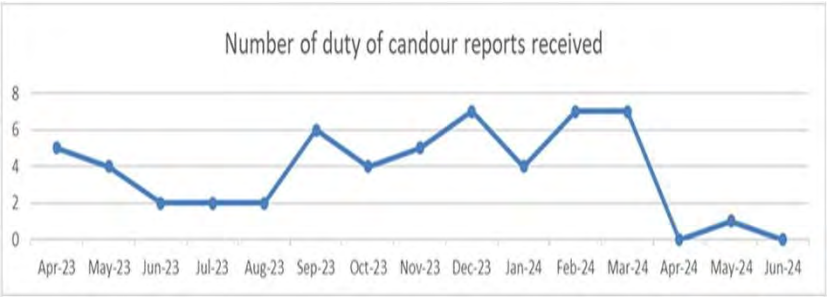


Quality & Patient Safety

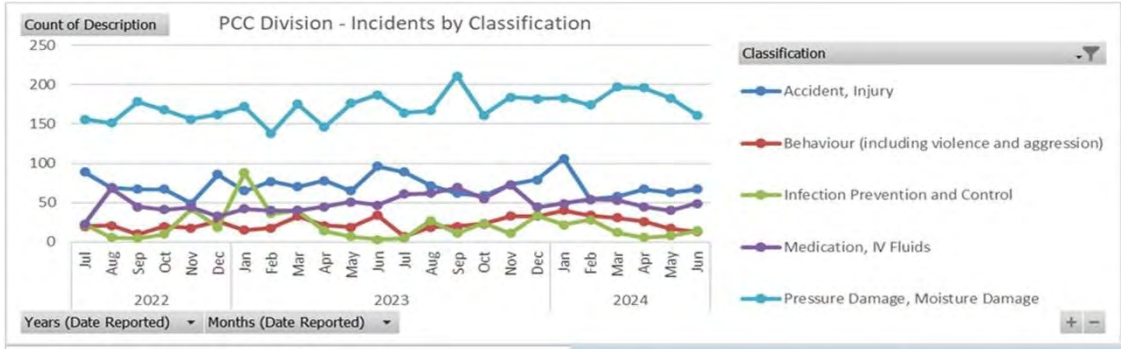


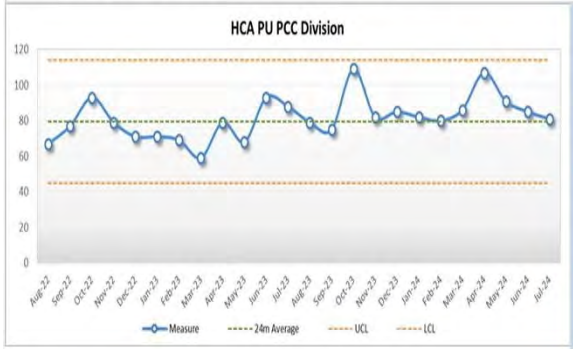
Incidents & Duty of Candour

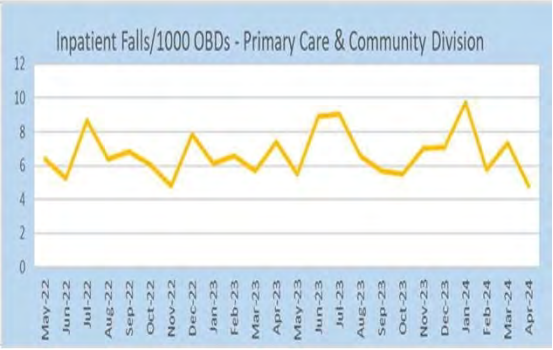




Top Incidents Reported: Falls & Pressure Damage







Agenda Item 2
Family & Therapies

QPS Assurance

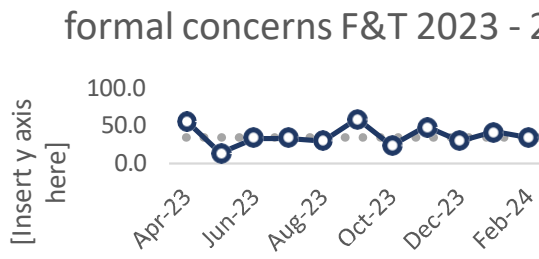
F&T July 2024

Quality and Patient Safety

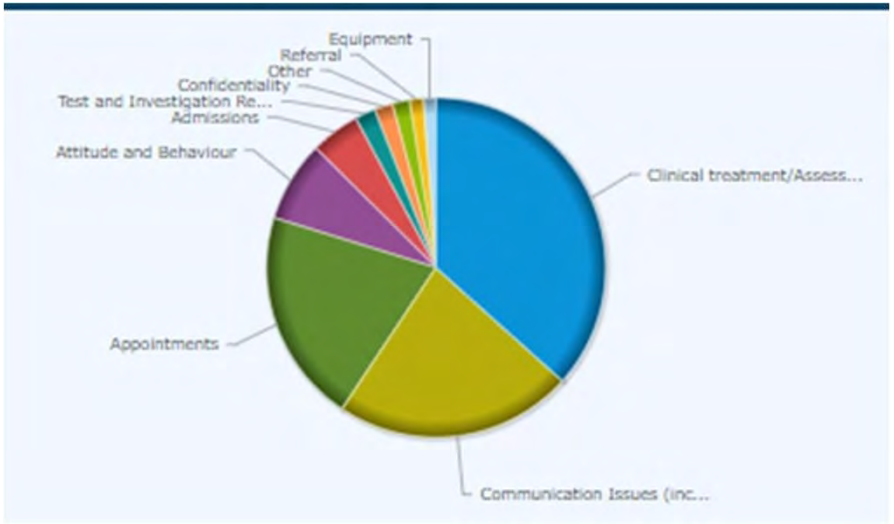


Area	Overview
Complaints management	PTR 30 day target has tumbled in June to 9% from 2 months at >60%. Urgent review of divisional processes and reporting mechanisms with PTR to support a return to > 60% for July. Some reduction in open complaints > 6 months
Serious Incidents Safeguarding Mortality Reviews	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.

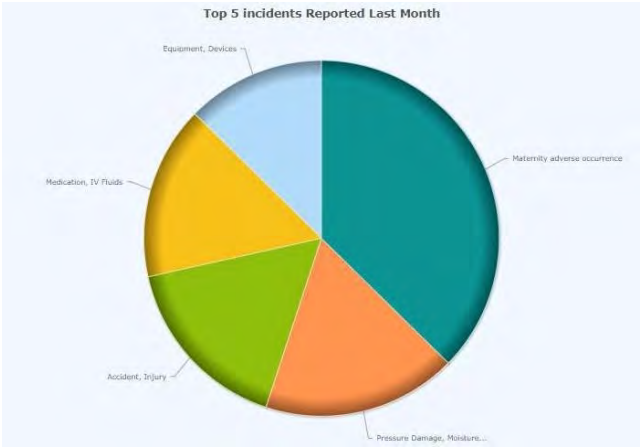
Quality and Patient Safety complaints Serious incidents



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

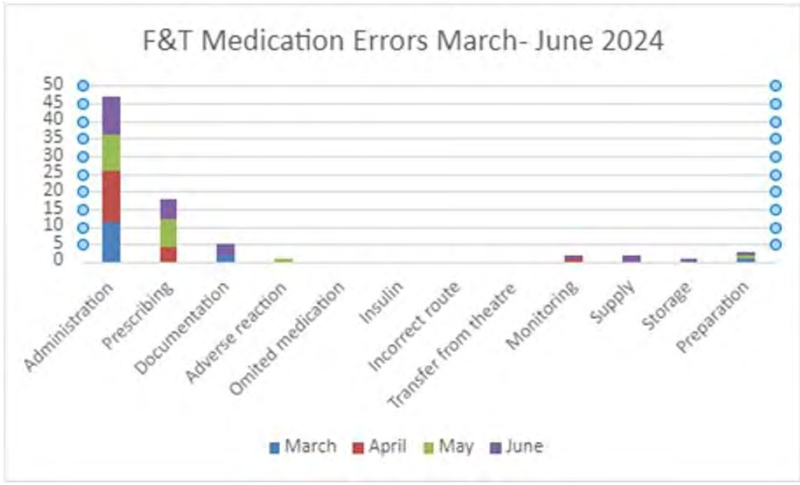


26 accident 25 medication 59 maternity
20 equipment 28 pressure damage

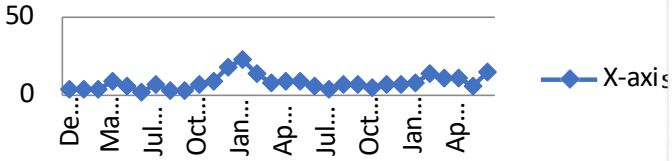
Quality and Patient Safety
DoC Falls
PUs
Medication

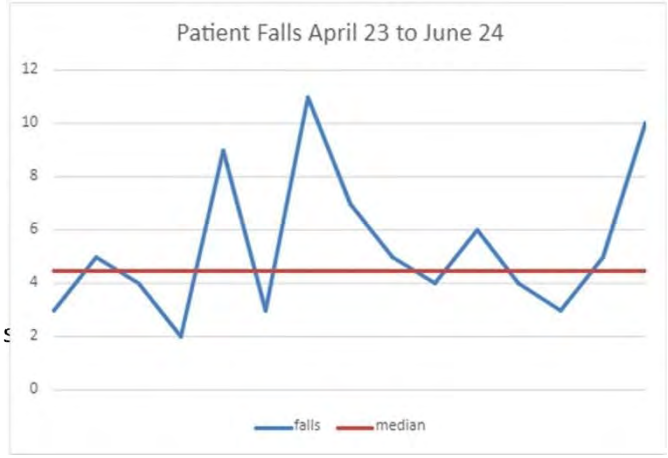
	Equipment related	Grade 1	Grade 2	Grade 4
NICU	Grade 1			
Gynae		1	2	
P&O		4	2	1

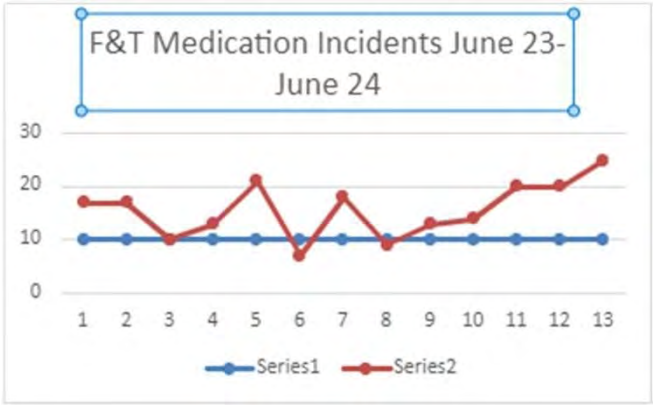
10 Falls – no fractures
NICU 1 dropped baby
Paeds 1 fall in high chair
Paeds 1 fall from window seat
Gynae 1 witnessed 1 unwitnessed
PHN 1 faint following vacc
Therapies 4 during therapy



HAPU by Incident date (Month and year)







Agenda Item 2
Surgery



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

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

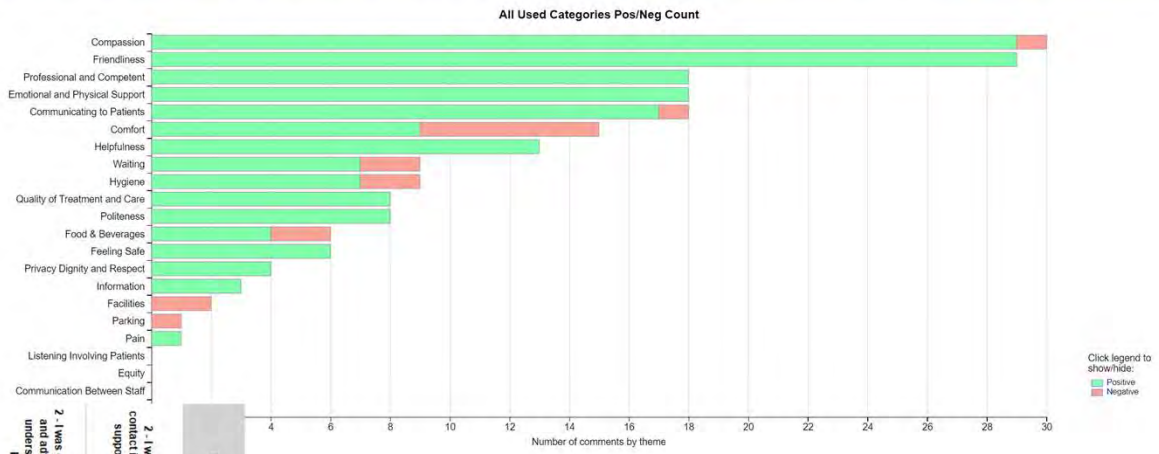
C0 - Going to develop a trachy passport. First month >85% all elements accreditation

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.

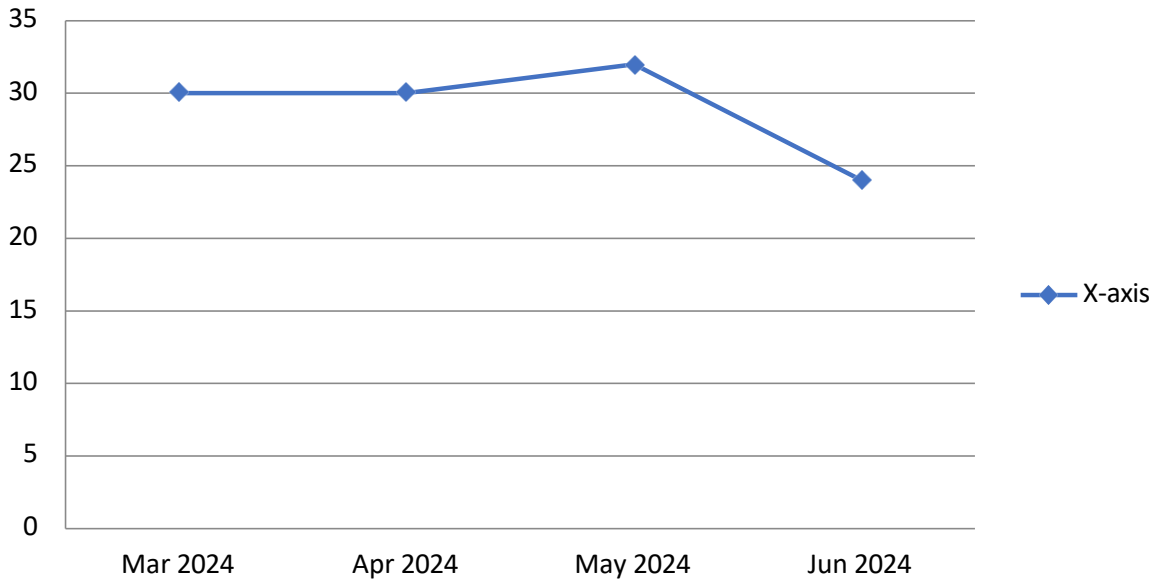
Emergency EYE clinic: really pleased with everything.

Rhymney: everything was done to high standards

Incident Reporting – Patient Falls



Falls by Incident date (Month and year)



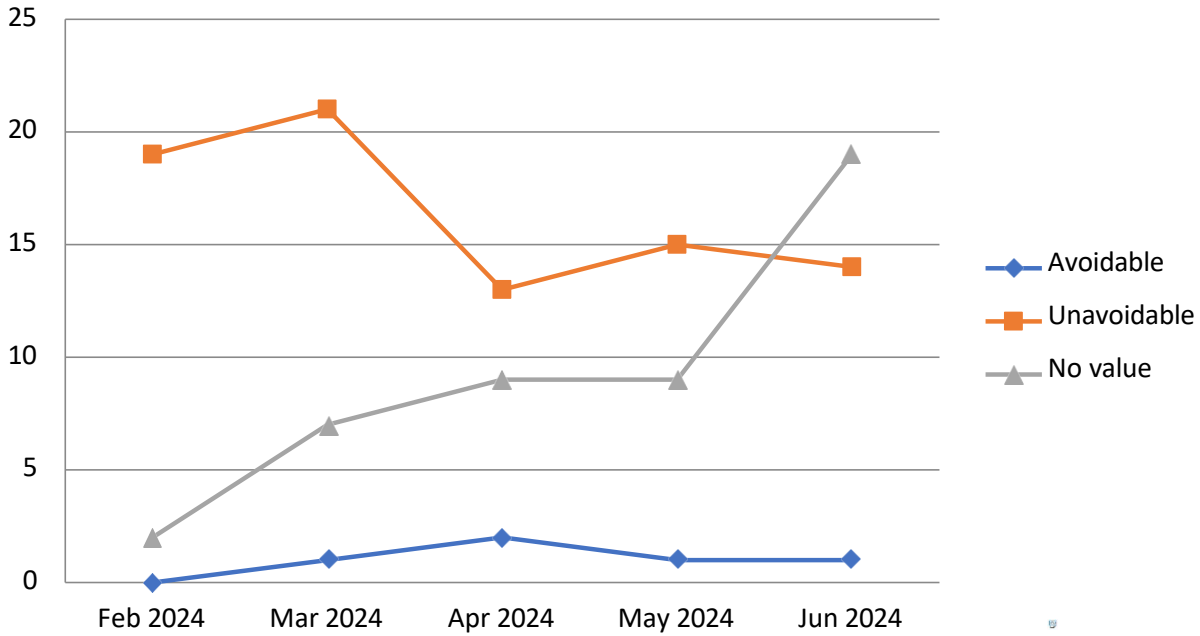
Learning:
patient story on QPS study days
focused reviews on all unwitnessed falls
meaningful activities and deconditioning projects
Sip to Send project: positive patient feedback

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

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.

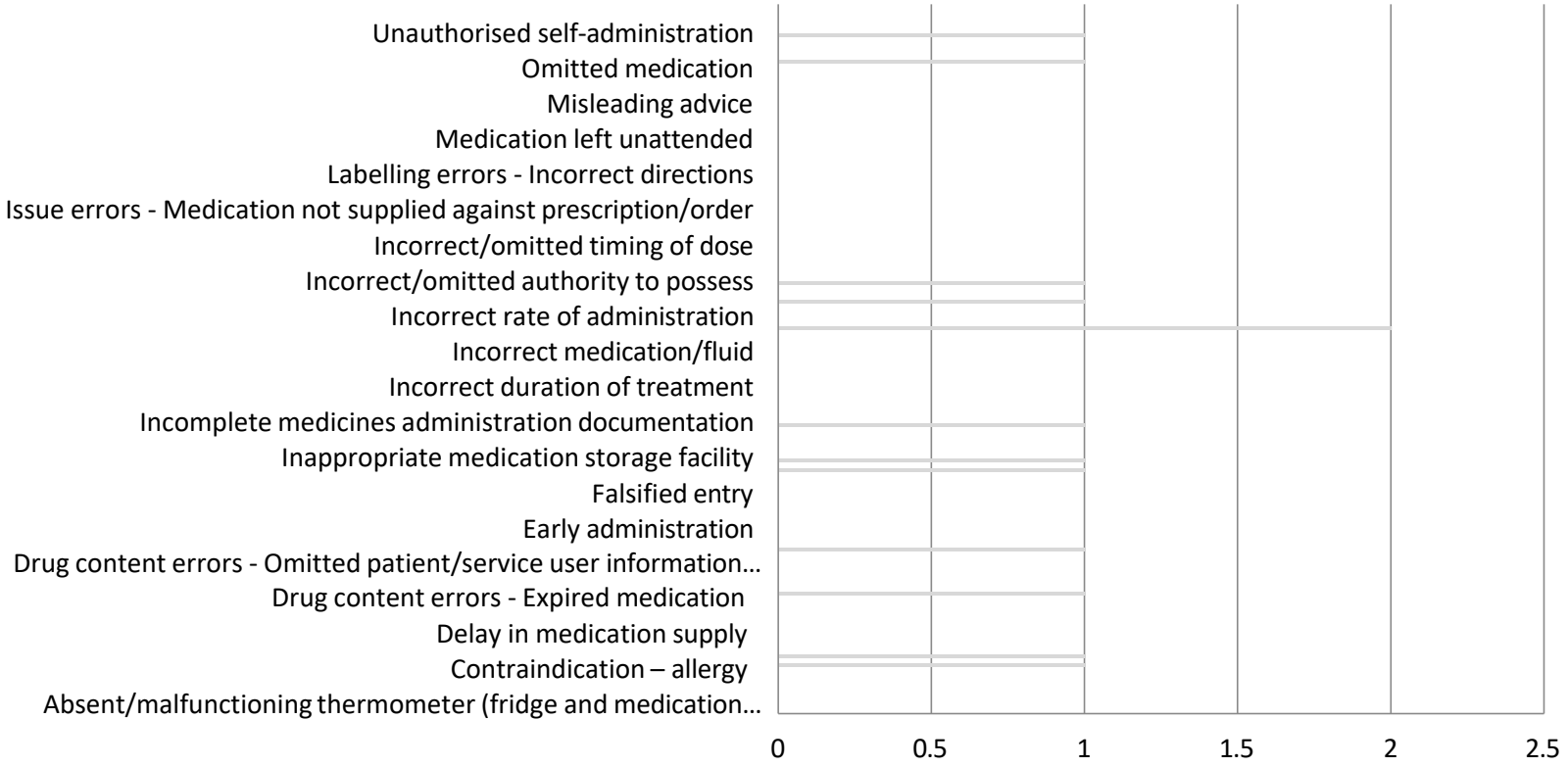
Learning:

- 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

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

Complaints, Concerns & Compliments

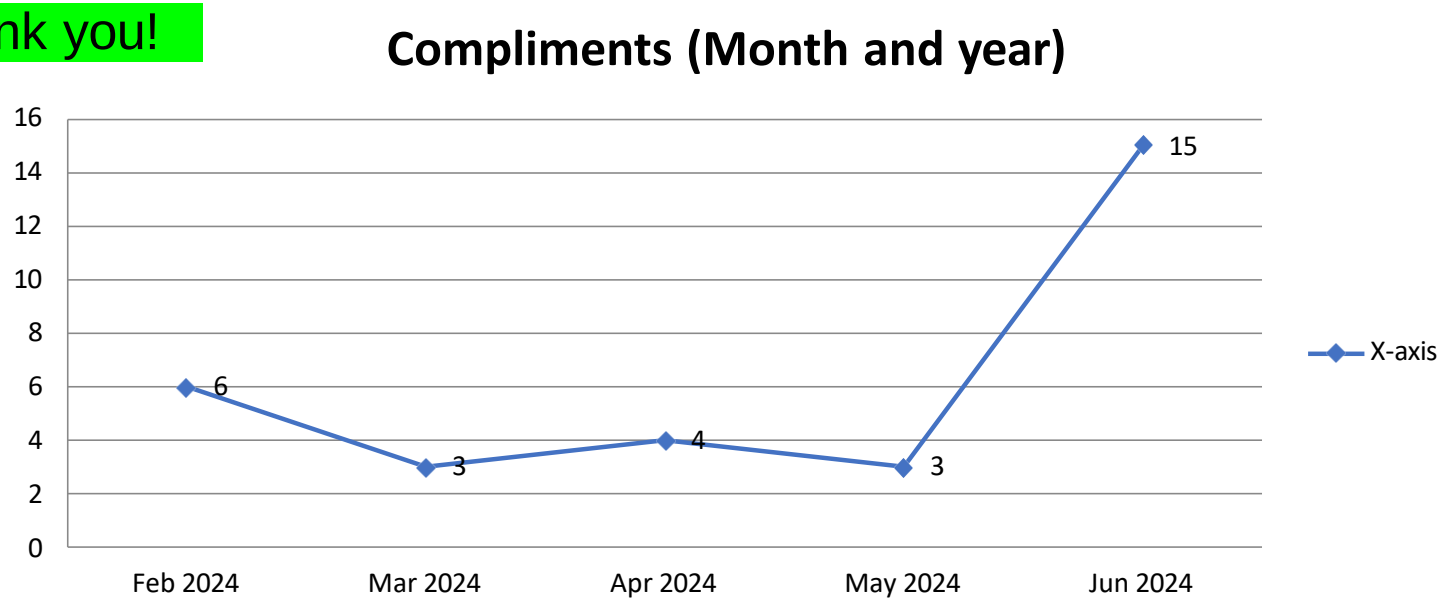


OPEN CONCERNS	Apr 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Total
Trauma and Orthopaedics	1	3	3	2	5	6	3	6	4	3	1	7	12	**56**
General Surgery	0	1	1	1	1	1	2	2	2	4	3	2	7	**27**
Theatres	0	0	0	0	1	0	0	0	0	0	0	0	0	**1**
Ophthalmology	0	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**

Complaints, Concerns & Compliments



Thank you!



Complaints, Concerns & Compliments

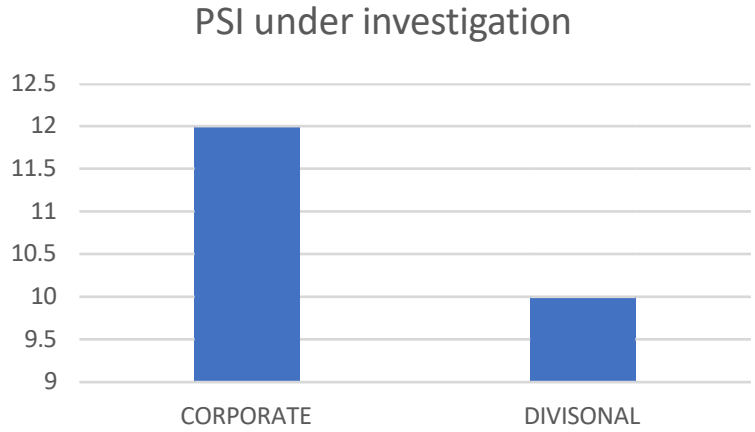


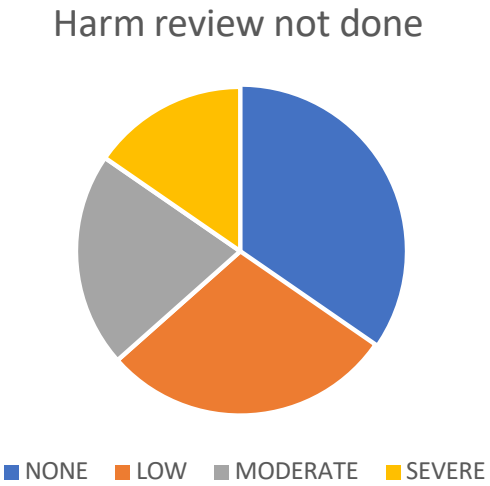
Duty Of Candour

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:



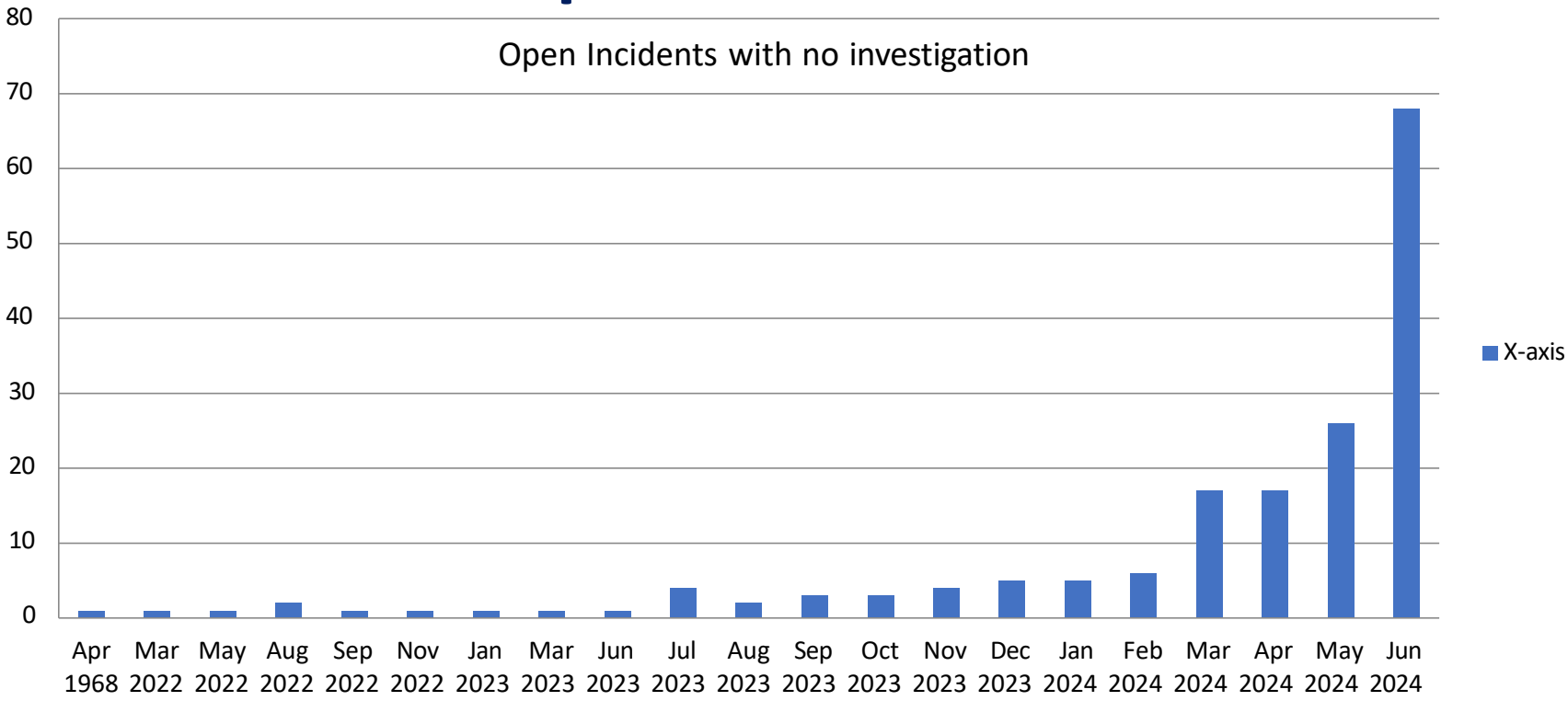


Sharing Learning:

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

Complaints, Concerns & Compliments





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%

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%

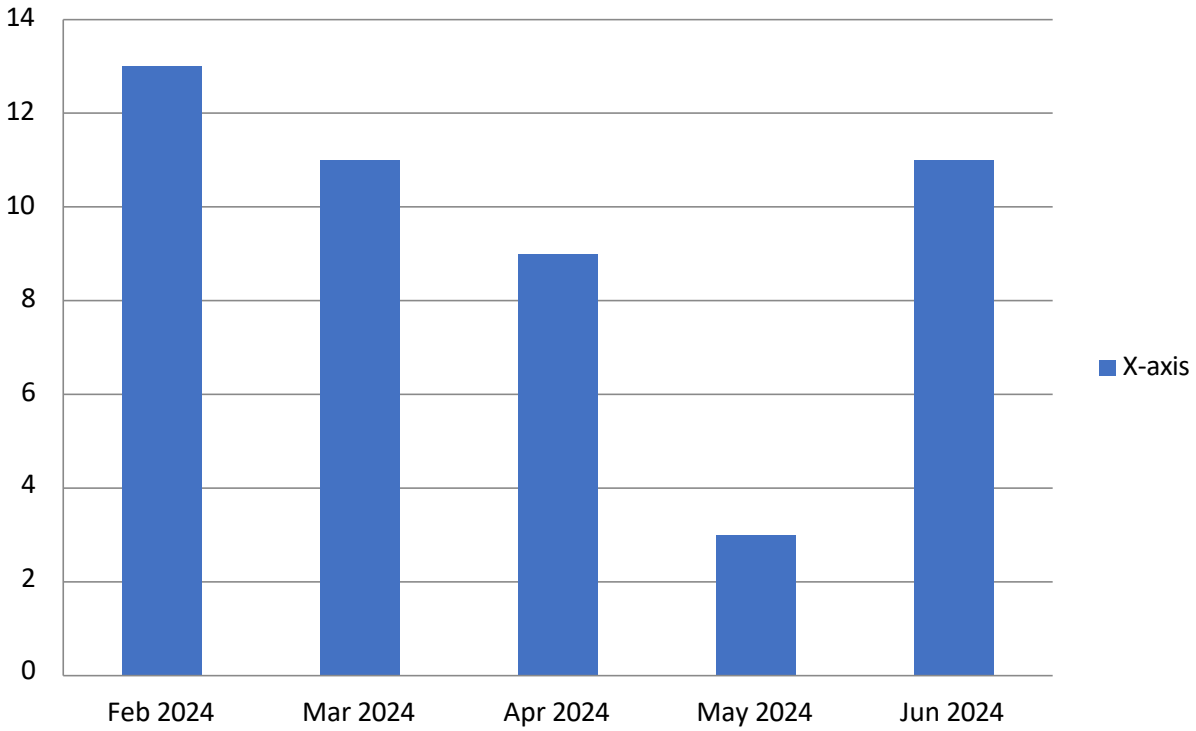
Risk Management
Health and Safety Risks – Total 116
Health and Safety Risks overdue review date 31
Health and Safety Risks – Extreme High Risks (risk rating of 15 or above) 14

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

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

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



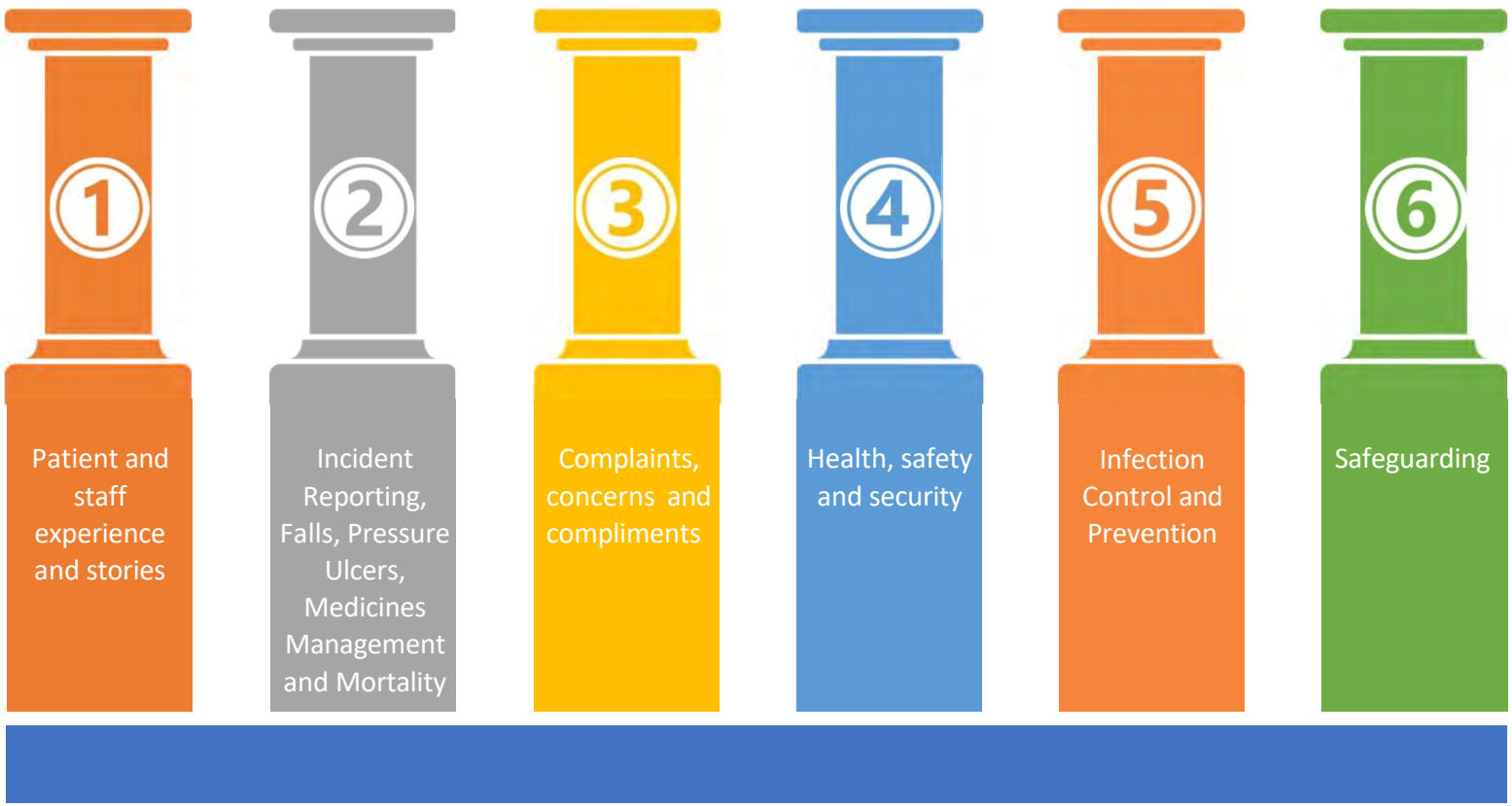
- Improve CIVCA feedback collection
- Deconditioning Prevention events through the year
- Ward / Unit accreditation
- Continue Safe Care Collaborative work on preventing patient deterioration
- Education focus on highest reported datix incidents
- Sharing learning from incidents / concerns / PSOW

Agenda Item 2

Clinical Support Services



6 Pillars of Quality



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

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.



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

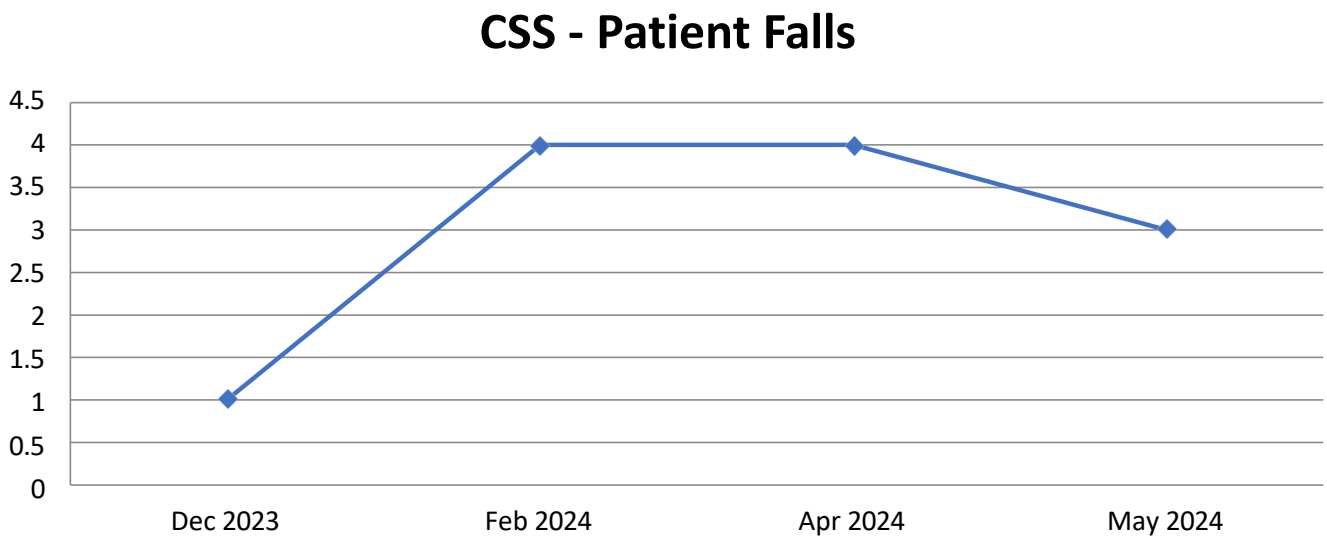
Location/Department	Responses	2 - I felt listened to	2 - I was able to make my own decisions about my care	2 - I had care and support from staff who understood my needs and respected my choices	2 - I had the support of my family (or friends) when I needed them	2 - I felt safe	2 - I felt physically comfortable	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

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.

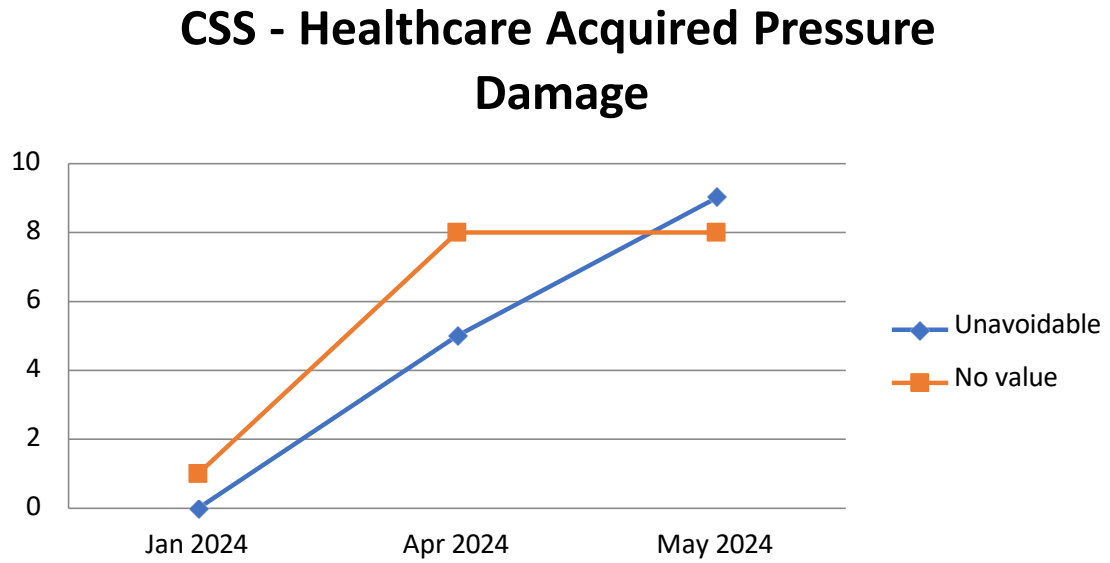


Learning: patient story, focused reviews on all unwitnessed falls, meaningful activities like move it may

Quality Indicators



No avoidable Pressure damage reported

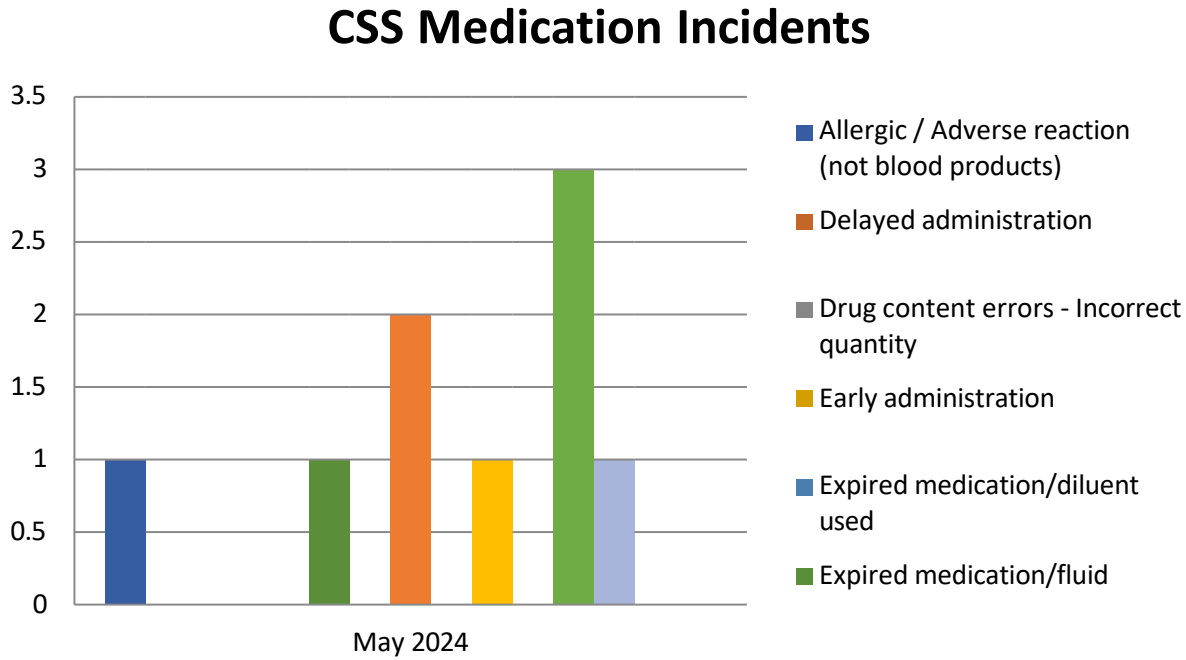


Learning:
HAPU collaborative
Move it May
Education Webinars distributed to all areas

Quality Indicators



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

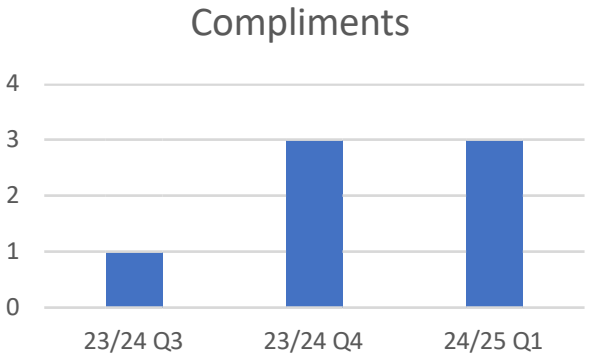


Learning:
ERASE for dispensing medication for day release
Safety poster on invasive line use
Family voice in hickman line policy review

Complaints, Concerns & Compliments



Thank you!



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

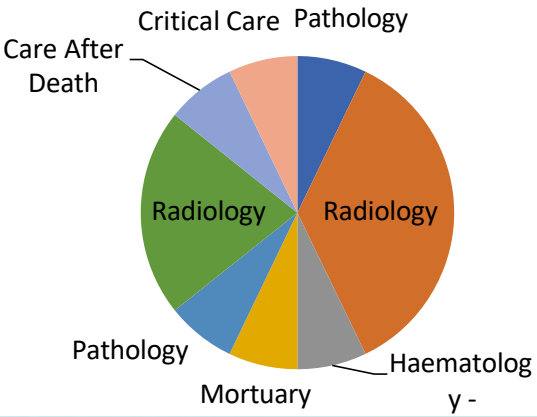
Complaints, Concerns & Compliments



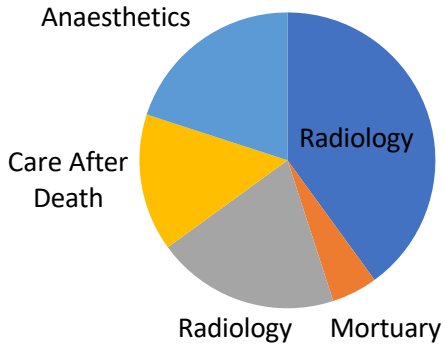
Clinical Support Services Concerns closed in May	Managed through PTR	8
	Early Resolution	7
	Reopened	0
	Total	15

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



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

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



Health and Safety Training Compliance & Risk Assessments CSS



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

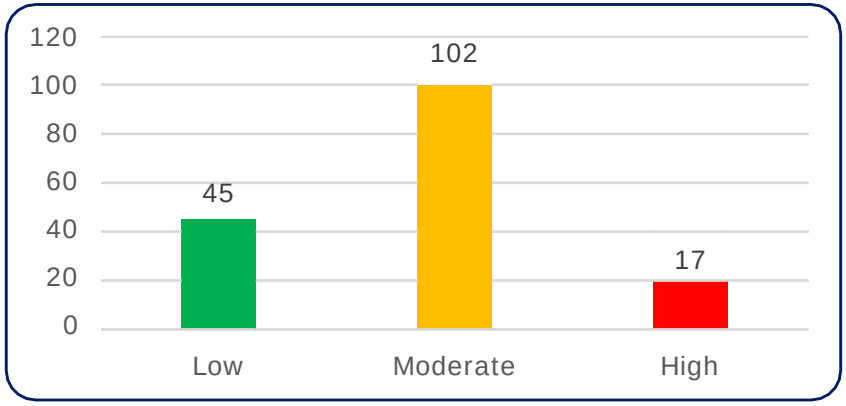
H&S	Fire	V&A	MH
89%	85%	86%	52%

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



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

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).

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

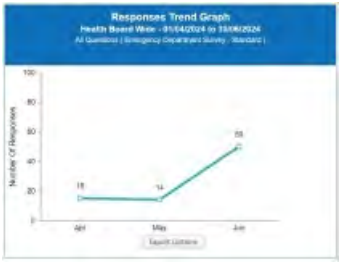
Patient Experience Feedback
1st April 2024 – 30th June 2024

All Surveys



Emergency Department Survey



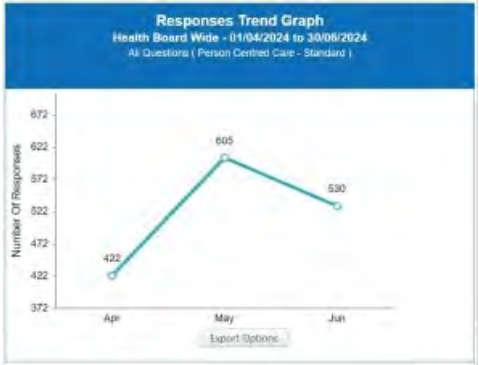


Response Trend

Person Centred Care (PCC) Survey







Response Trend

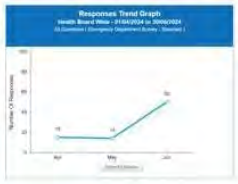
Adborth Cleifion: Gwrando a Dysgu

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

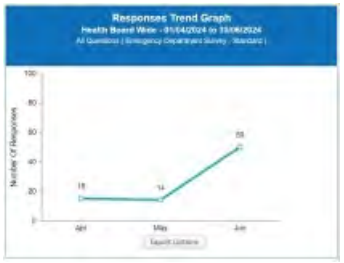
Patient Feedback: Listening and Learning

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?
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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

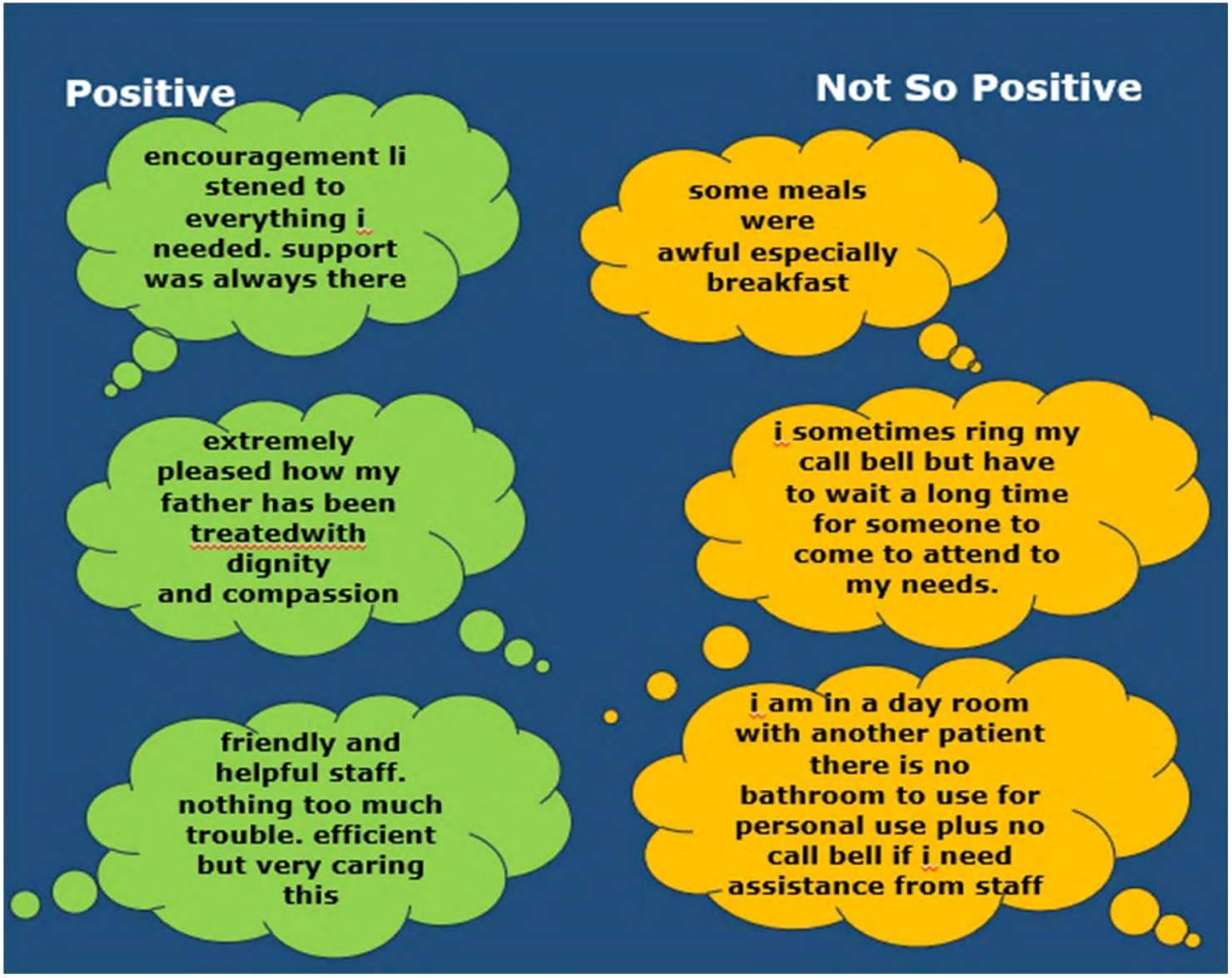
What did we do well? Q9	What could we have done better? Q10
Top 3 themes	Top 3 themes
268 comments around Emotional & Physical support •252 comments around Compassion •208 comments around Friendliness	• 60 comments around Food & Beverages •40 comments around Waiting •24 comments around Facilities

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

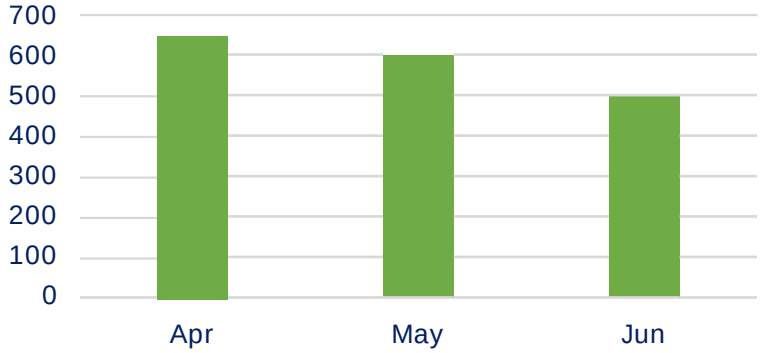




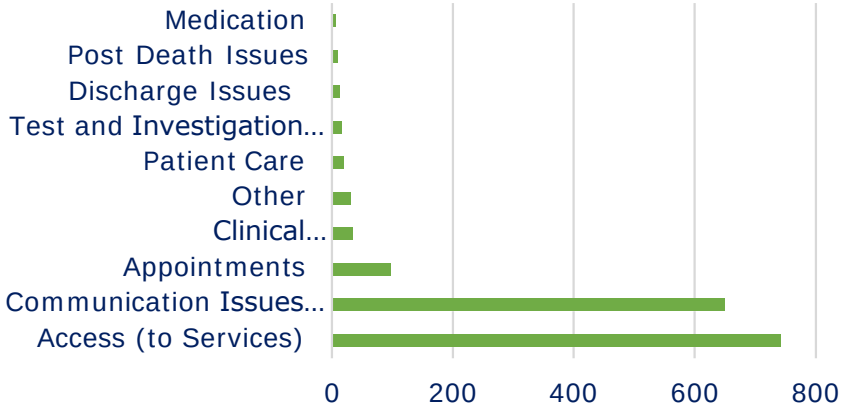
Patient Advice & Liaison Service

April, May & June 2024 update

Enquiries Managed via PALS / PSO April - June 24



Top 10 Enquiry Themes via PALS / PSO April - June 24

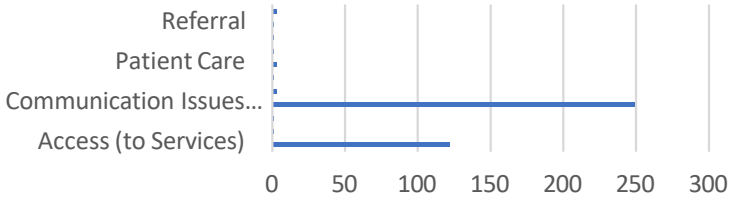




Patient Advice & Liaison Service

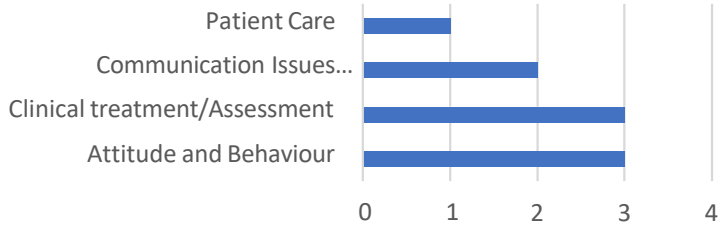
April, May & June 2024 update

Emergency Department PALS Enquiry Themes April-June 2024

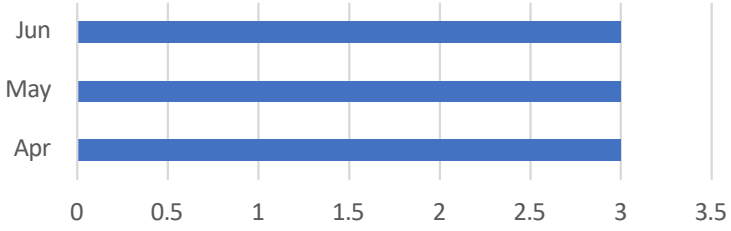


Total PALS Enquiries for Emergency Department April-June 2024 = 386

Emergency Department Early Resolution Concern themes April-June 2024



Emergency Department Early Resolution Concerns April-June 2024

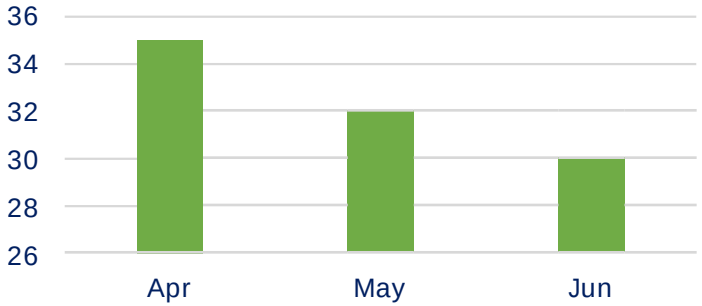




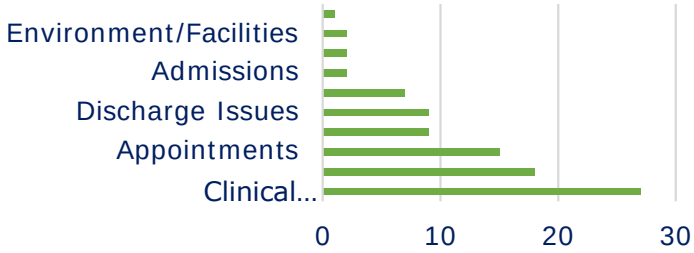
Patient Advice & Liaison Service

April, May & June 2024 update

Early Resolution Complaints Managed via PALS April - June 24



Top 10 Early Resolution Complaint Themes via PALS, April- June 24



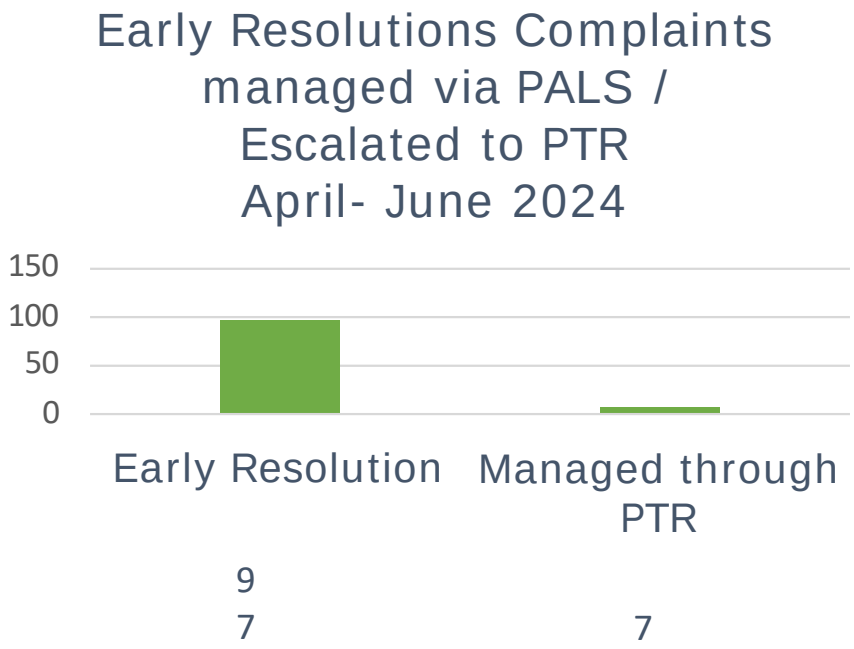
Top Early Resolution Complaint Theme per Division April - June 24

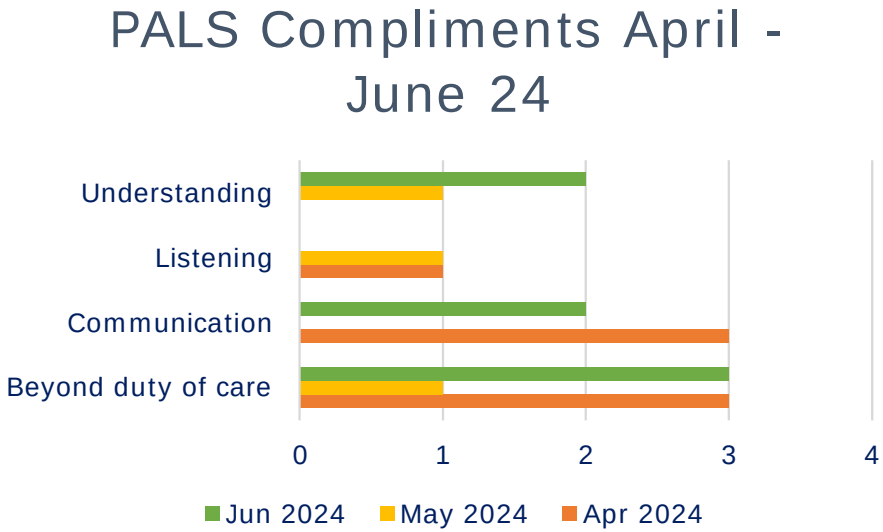




Patient Advice & Liaison Service

April, May & June 2024 update





Adborth Cleifion: Gwrando a Dysgu

Patient Feedback: Listening and Learning



Any Questions?

Agenda Item 5

Organisational Learning & Sharing Internal

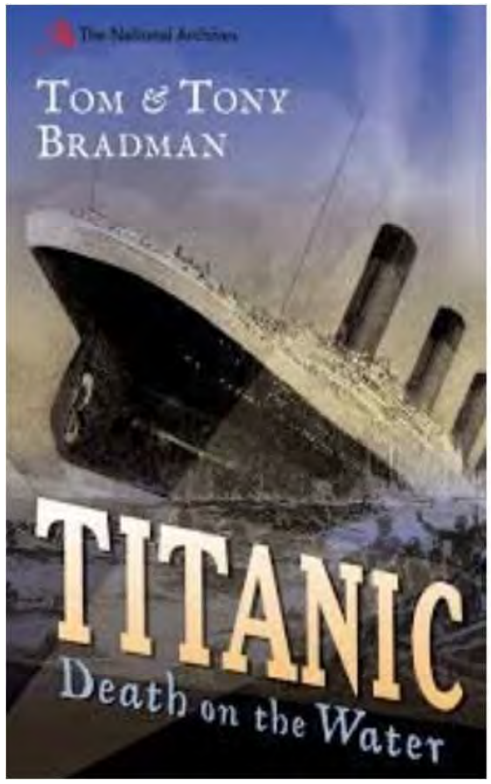
Agenda Item 5.1
QI – what happens in Neuro Rehab

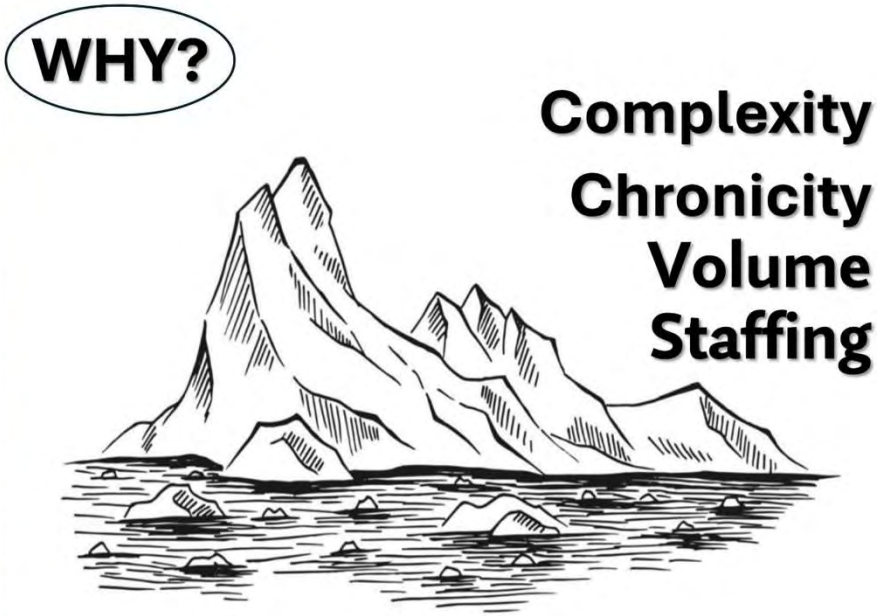
What matters most in Neurorehabilitation: The Neuro-stute Recovery College.

Dr Daryl Harris & Linda Tremain
ABUHB Community Neurological Rehabilitation Service

Allied Health Professional and Healthcare Sciences Conference 2024

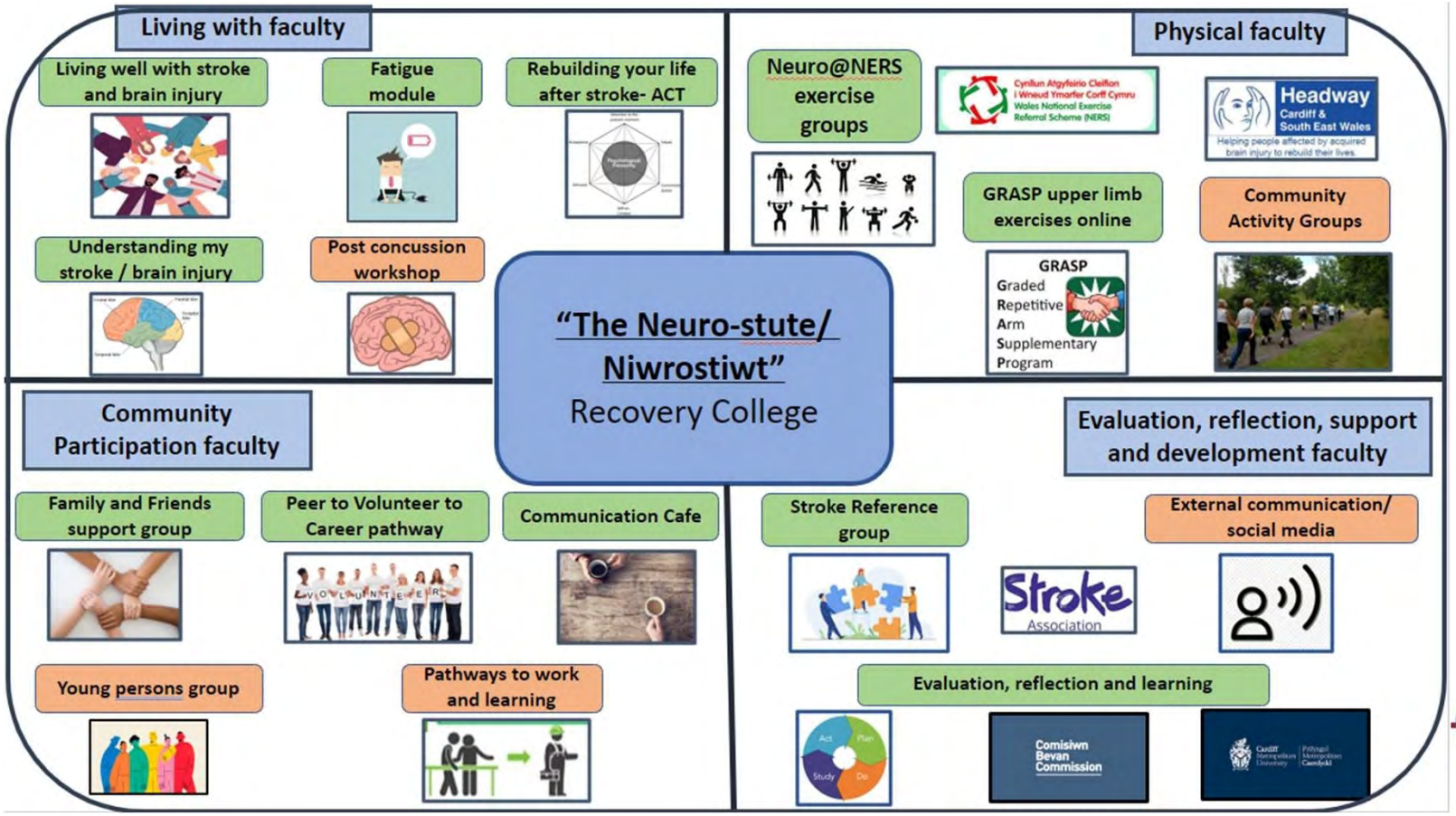
What was the problem we were trying to solve?






HOW?
Traditional Mindset
Needs Based Mindset
Provision
Principles
COMMUNITY DEVELOPMENT
INDIVIDUAL ASSETS / STRENGTHS
CONFRONTATIONAL
PROFESSIONAL EXPERTS
FOCUS ON WHAT'S WRONG
FOCUS ON WHAT'S STRONG
PERSONAL RECOVERY
CLINICAL RECOVERY
PASSIVE PATIENTS
ACTIVE PATIENTS

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

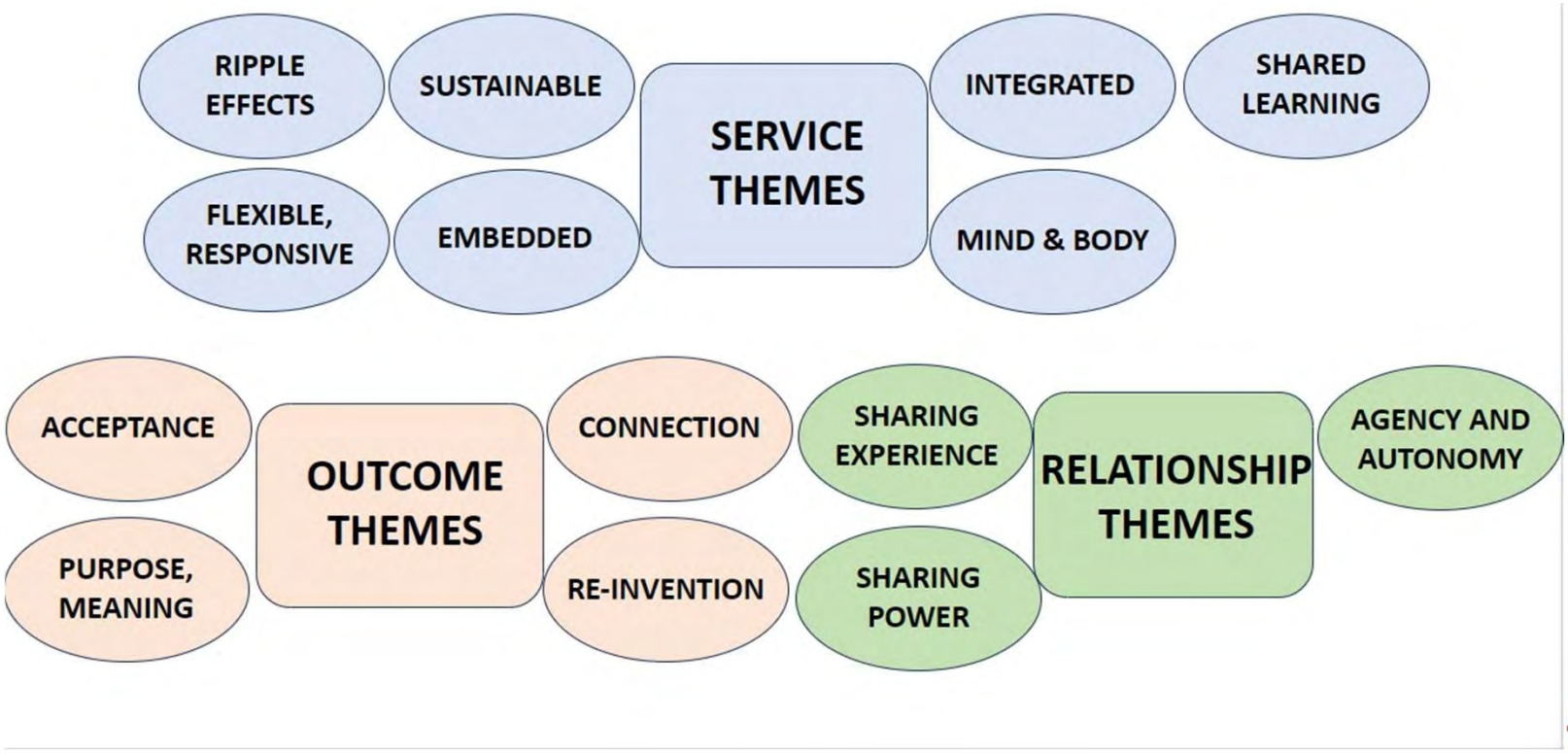
A Guide to Its Use

by

Rick Davies and Jess Dart



What matters most?



A metaphor with an ecosystem

The Ecosystem

Community of learning

RIPPLE EFFECTS

SUSTAINABLE

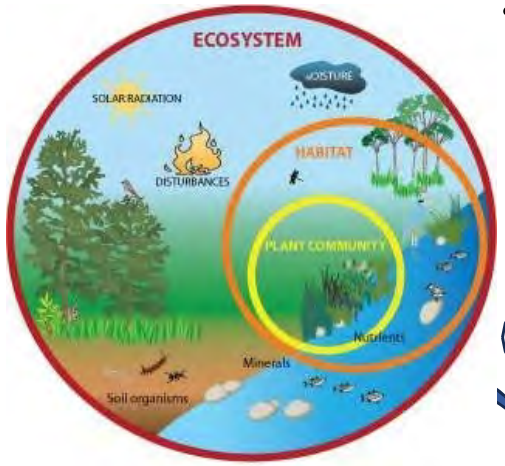
INTEGRATED

FLEXIBLE, RESPONSIVE

EMBEDDED

MIND & BODY

SHARED LEARNING







Nutrients

Relationship Characteristics

SHARING EXPERIENCE

SHARING POWER

AGENCY AND AUTONOMY

ACCEPTANCE

CONNECTION

PURPOSE, MEANING

RE-INVENTION

The Harvest

Outcome Variables

Carole's story

How did this support our employee experience?



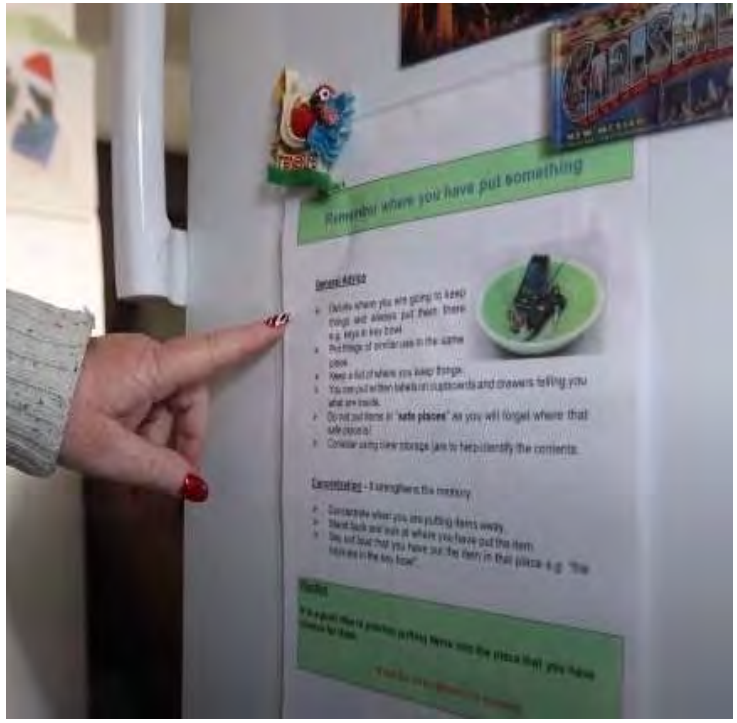
Agenda Item 5.2

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**

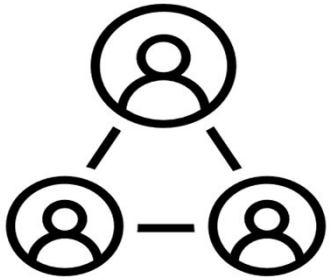


What was the problem we were trying to solve?

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

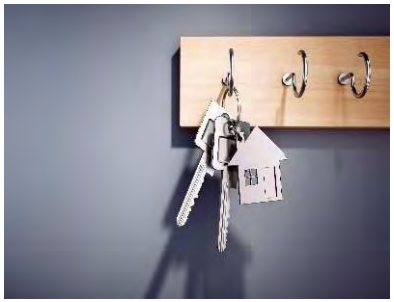
- Interventions should be provided as soon as possible to enable to people to remain as active and involved in their daily life as possible and sustain living in the community.

- 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)

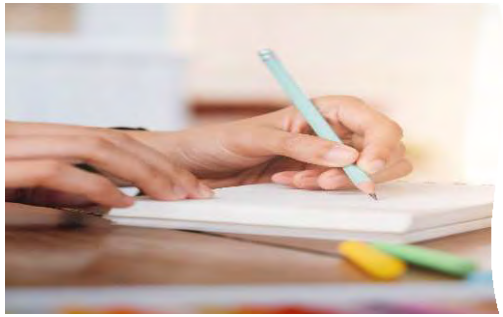


What did we do?:

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.

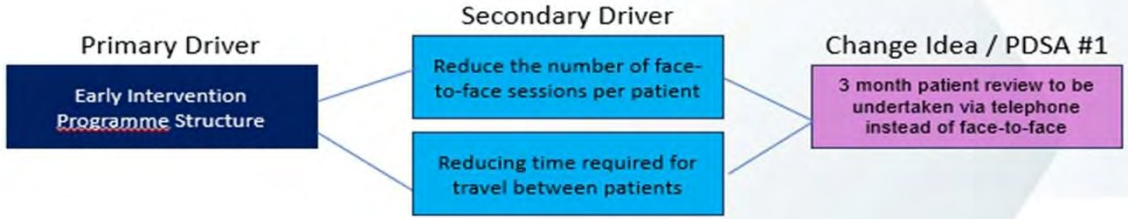
Data evidencing the problem:

- 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.*

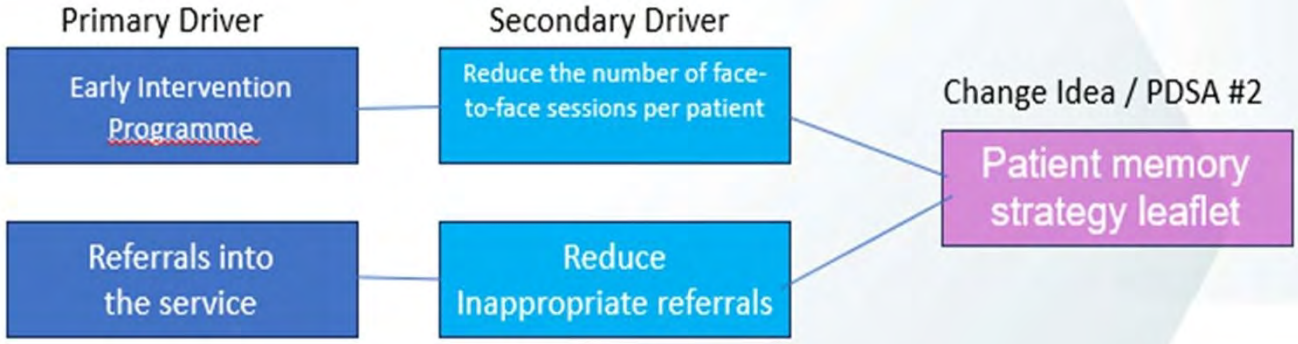
**Travel time has been reduced to an average of 50 minutes to 0 Minutes, per patient (when tested).

Process Measure – PDSA 1





What did we do?
Tests of Change - PDSA 2



- 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

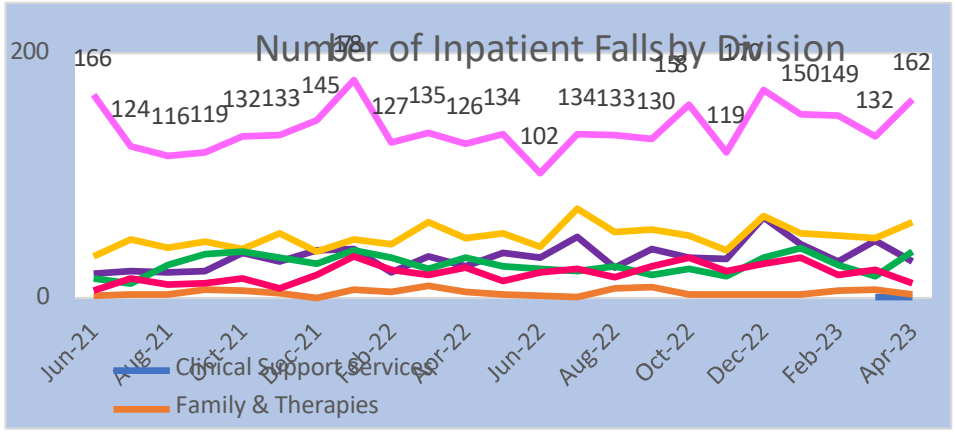
Agenda Item 5.3
QPS – SWARM methodology

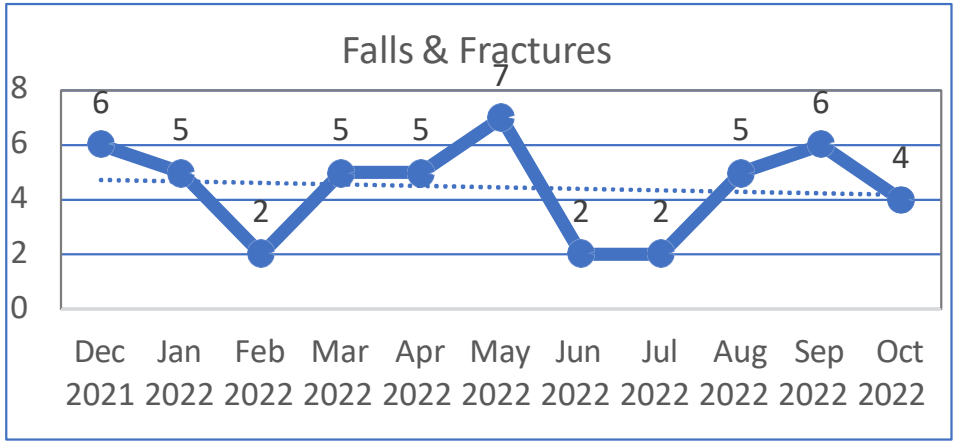
THE IMPLEMENTATION OF THE SWARM HUDDLES FRAMEWORK FOR INPATIENT FALLS

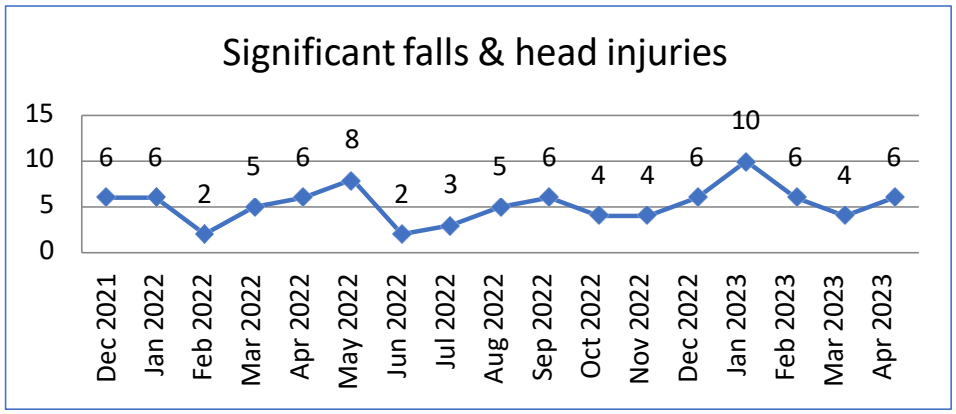


MEDICINE DIVISION

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

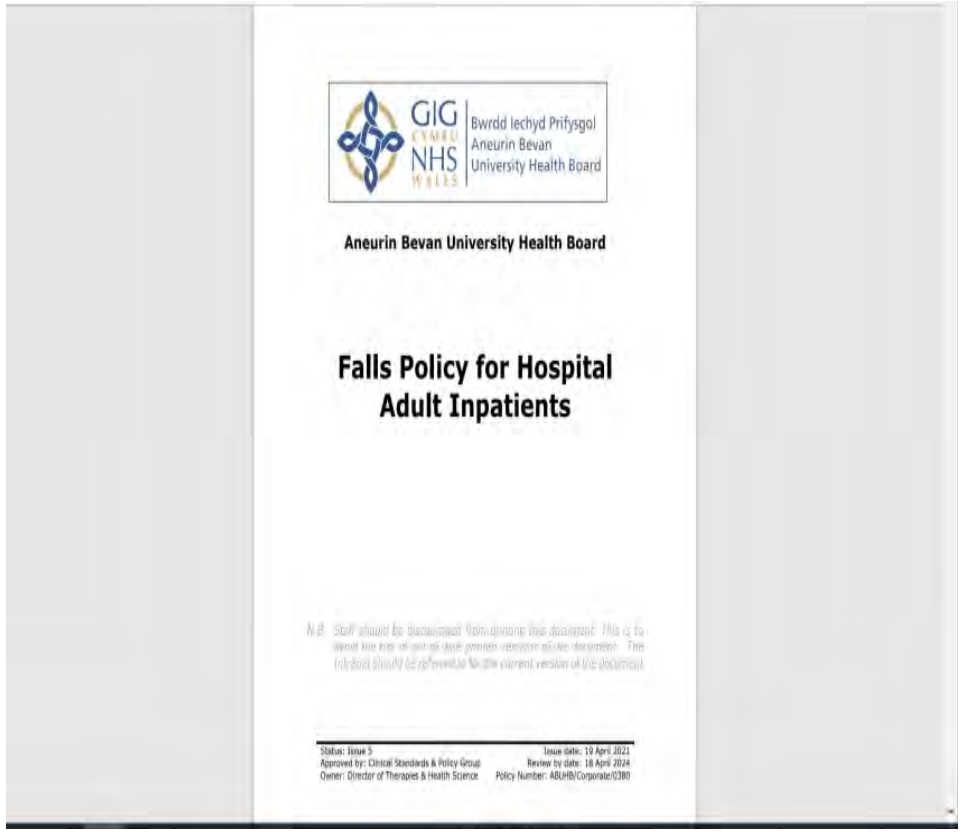
MFRA- FALLS POLICY

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.

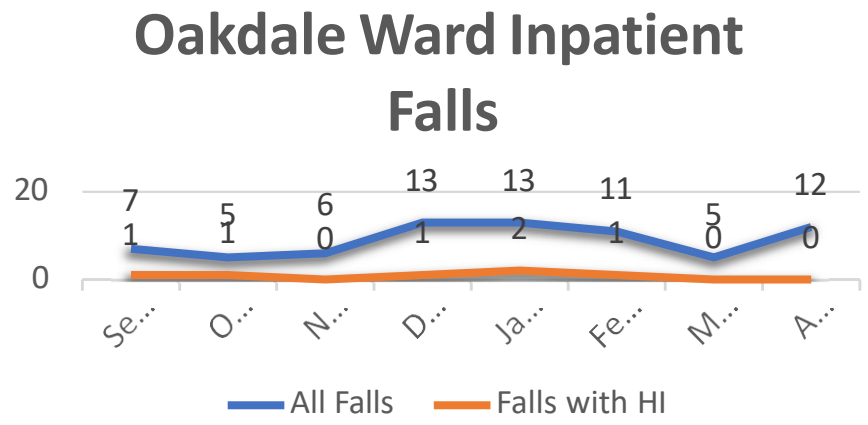
Hooks have been added to hang patients' shower bags on, so they no longer risk falling when bending down to pick them up.

- 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.



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

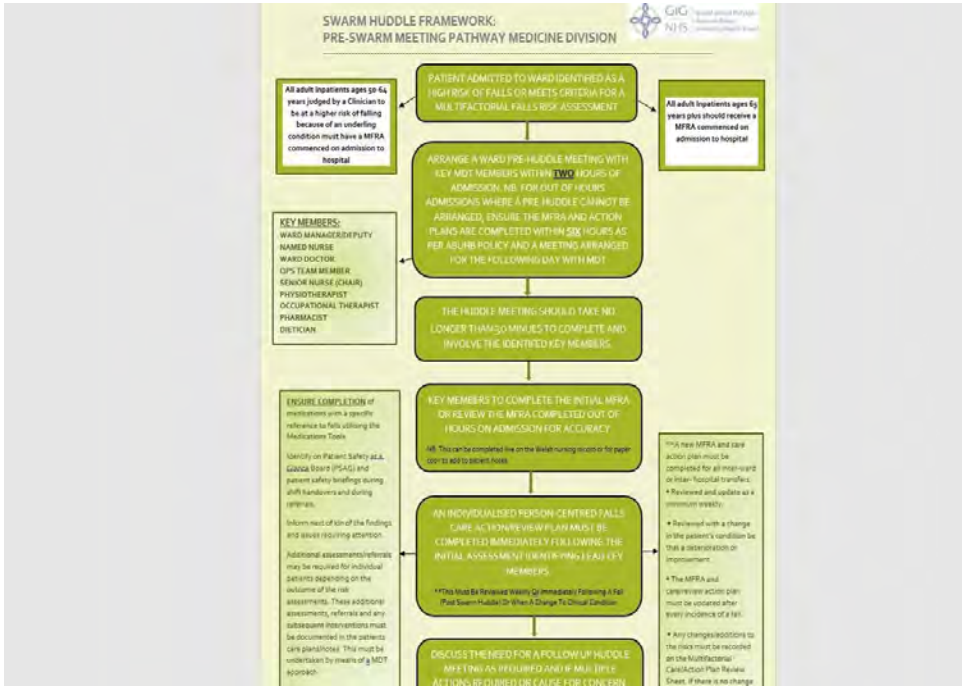
Contributors:

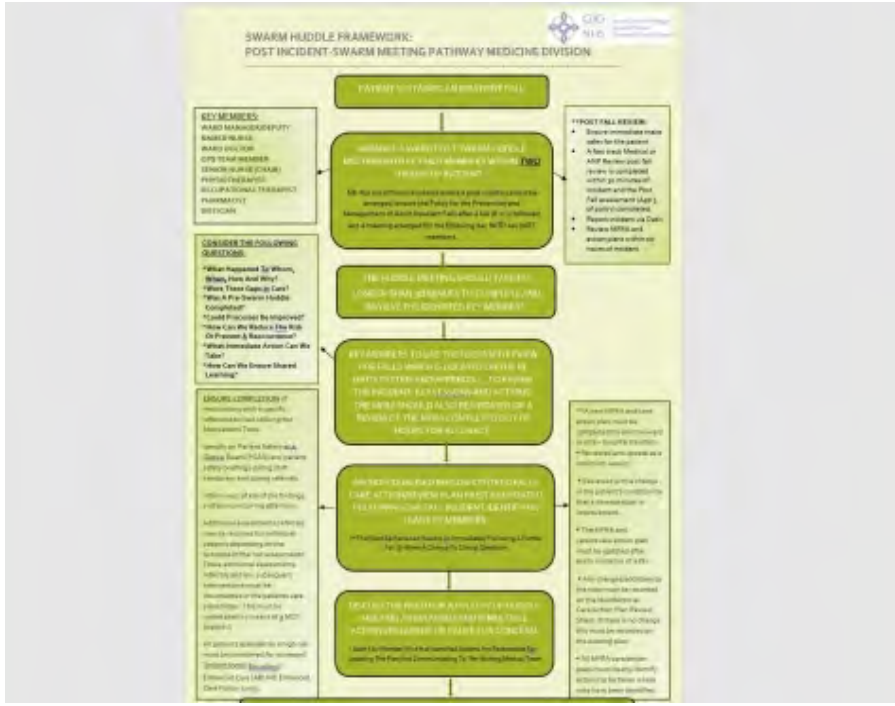
Date: 23/01/23

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



GIG NHS

Staff Questionnaire- SWARMS

1. What is your understanding of a SWARM?

2. How do you feel about a SWARM?

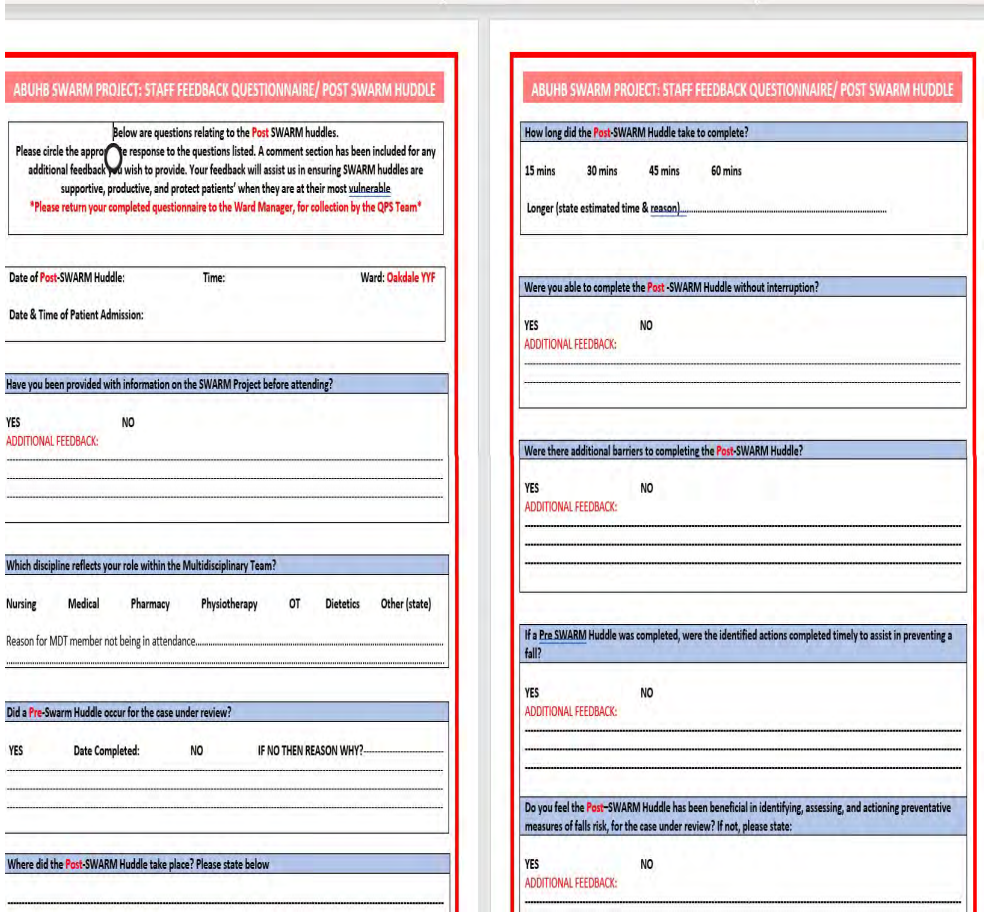
3. What are the benefits of a SWARM?

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.

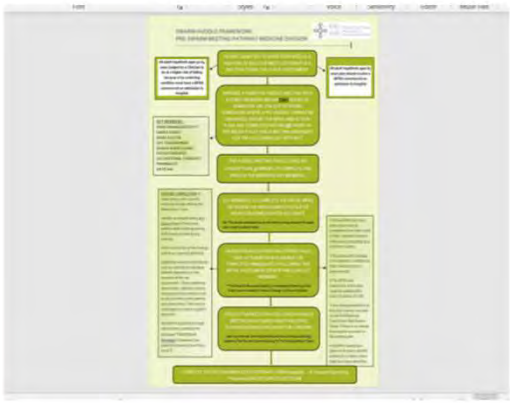
Swarm approach brings all disciplines of staff together, quckly after a patient has been admitted to the ward and who is considered high risk, to immediately assess using the falls multifactorial risk assessment (MFRA) and to implement appropriate preventative measures to try and reduce the risk of a 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.

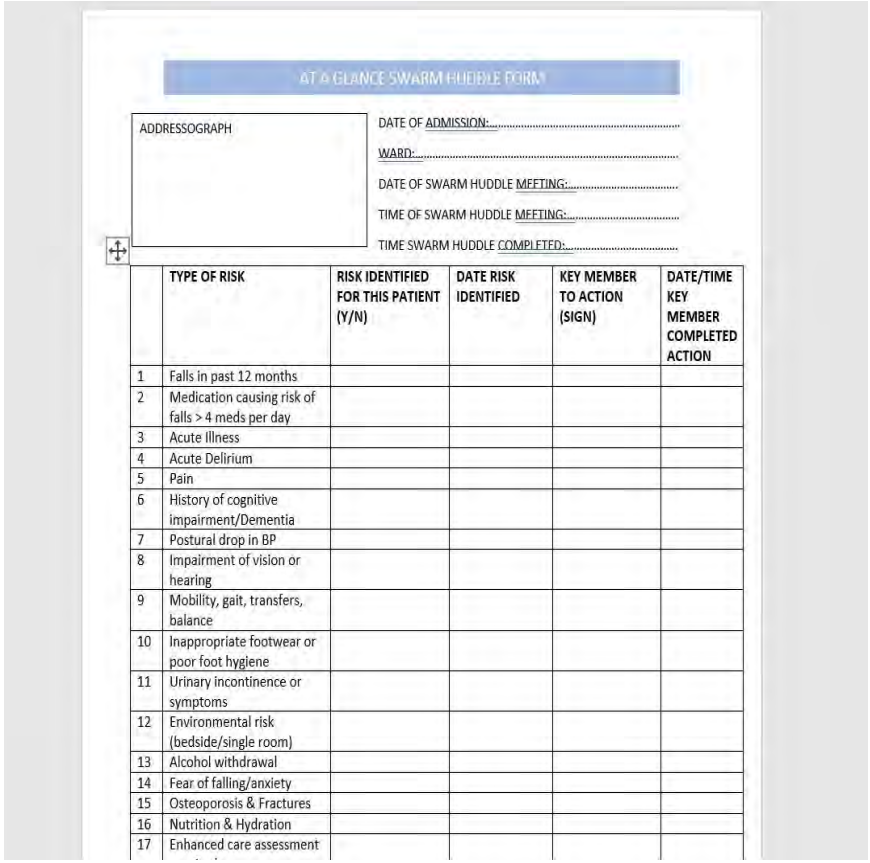
Pilot documentation can be accessed from the Ward Manager on Oak dale ward or the QPS team.


Aneurin Bevan University Health Board

Falls Policy for Hospital Adult Inpatients



Meeting documents



AT A GLANCE SWARM HUDDLE FORM

ADDRESSOGRAPH

DATE OF ADMISSION:.....

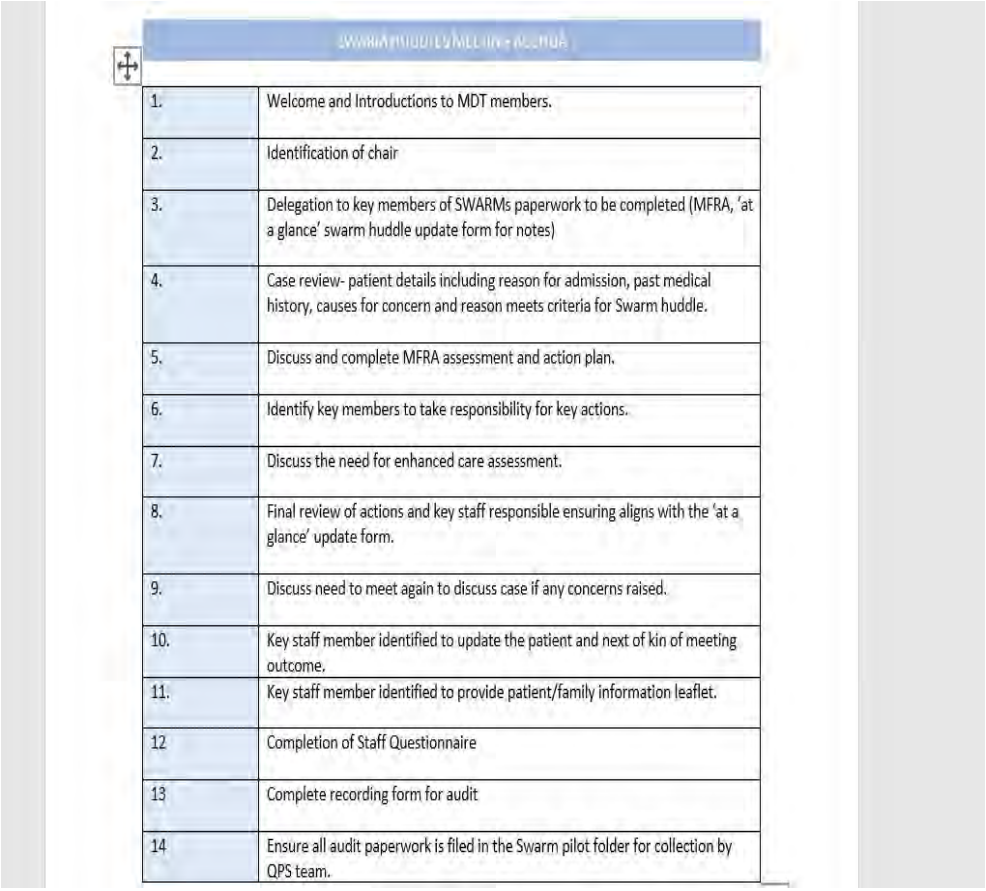
WARD:.....

DATE OF SWARM HUDDLE MEETING:.....

TIME OF SWARM HUDDLE MEETING:.....

TIME SWARM HUDDLE COMPLETED:.....

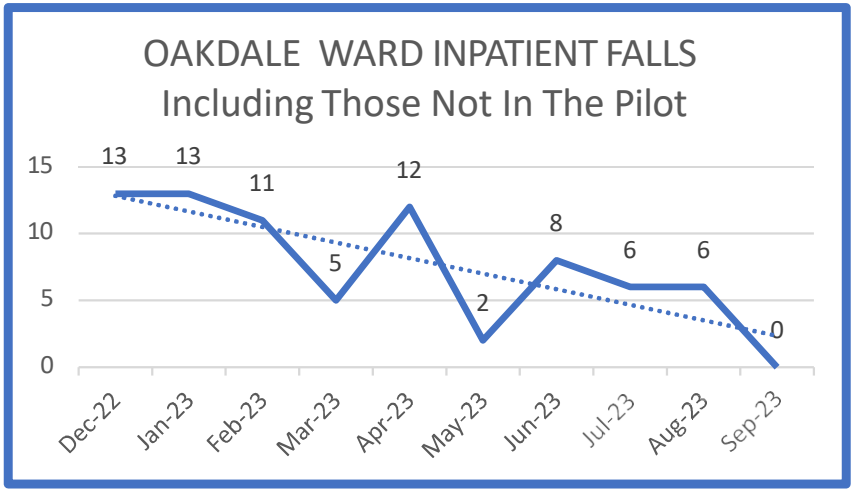
	TYPE OF RISK	RISK IDENTIFIED FOR THIS PATIENT (Y/N)	DATE RISK IDENTIFIED	KEY MEMBER TO ACTION (SIGN)	DATE/TIME KEY MEMBER COMPLETED ACTION
1	Falls in past 12 months				
2	Medication causing risk of falls > 4 meds per day				
3	Acute Illness				
4	Acute Delirium				
5	Pain				
6	History of cognitive impairment/Dementia				
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				

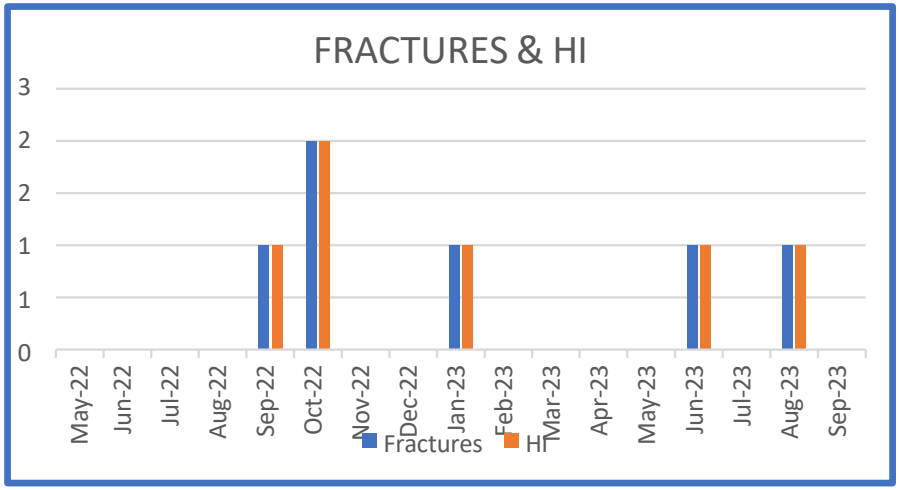


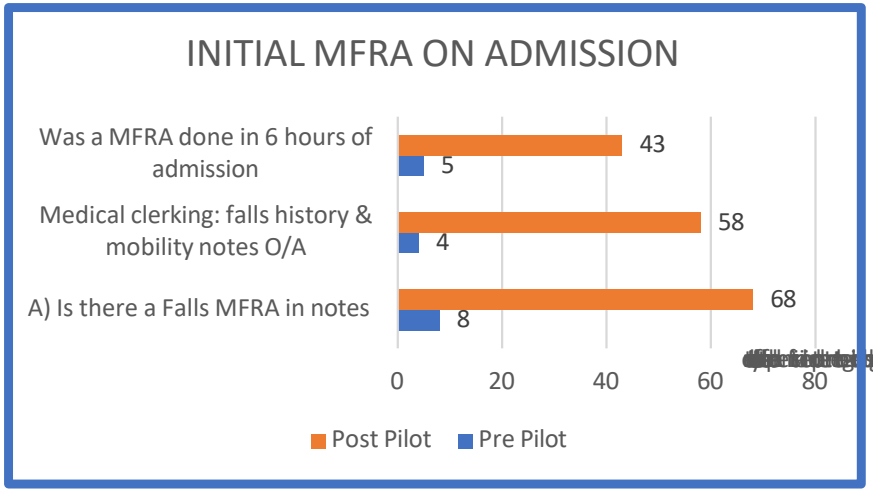
1.	Welcome and Introductions to MDT members.
2.	Identification of chair
3.	Delegation to key members of SWARMs paperwork to be completed (MFRA, 'at a glance' swarm huddle update form for notes)
4.	Case review- patient details including reason for admission, past medical history, causes for concern and 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.

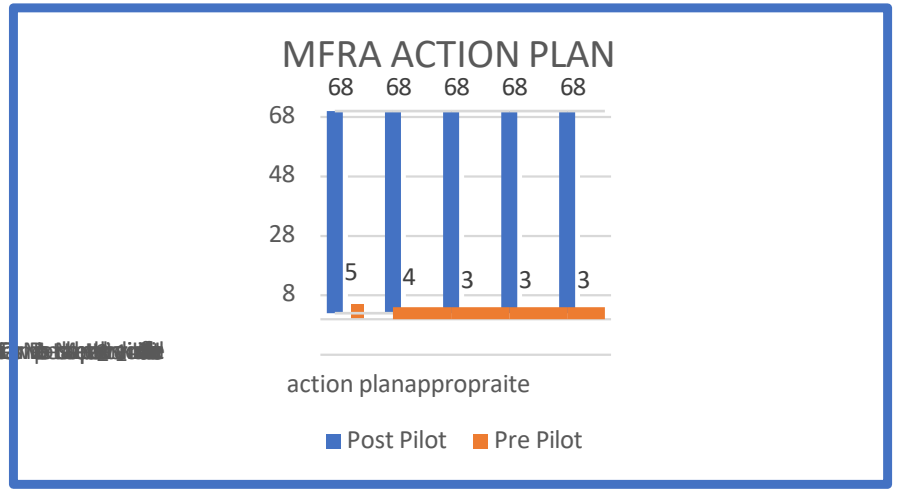
QUANTATATIVE Analysis:

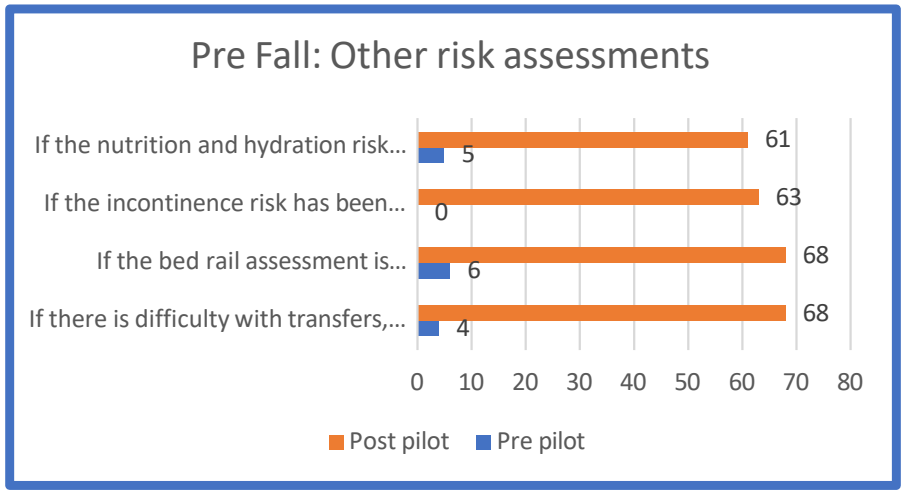
- Pilot period ended 5th June 2023 but ongoing swarms
- 'Time to complete' was the main identified barrier before starting the pilot.
- Pre Audit showed MFRA's not being completed timely or fully with actions.
- 68 patients received a pre-swarm huddle
- 3 falls during this period of pre swarmed patients 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.

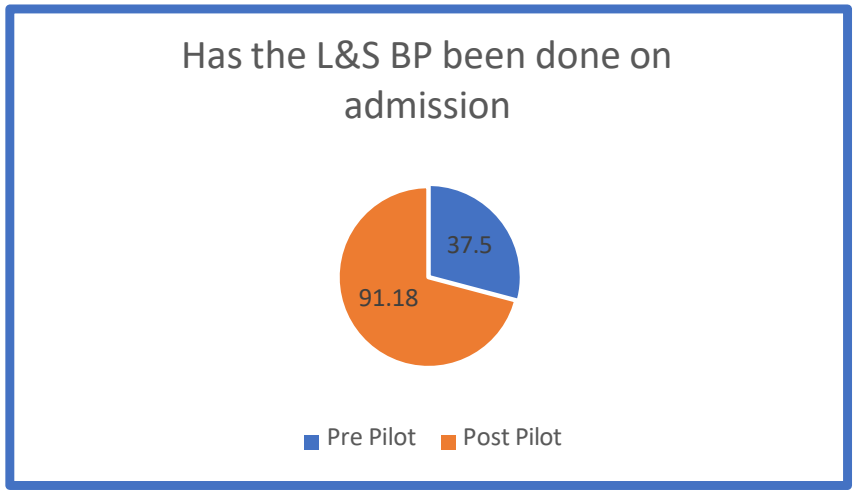

OAKDALE WARD INPATIENT FALLS
Including Those Not In The Pilot
15
10
5
0
13
13
11
5
12
2
8
6
6
0
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23

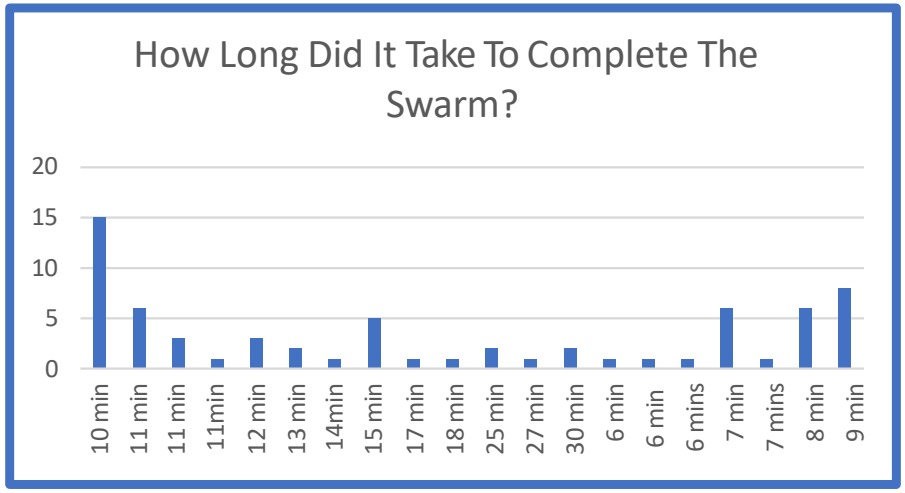

FRACTURES & HI
3
2
2
1
1
0
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Fractures
HI

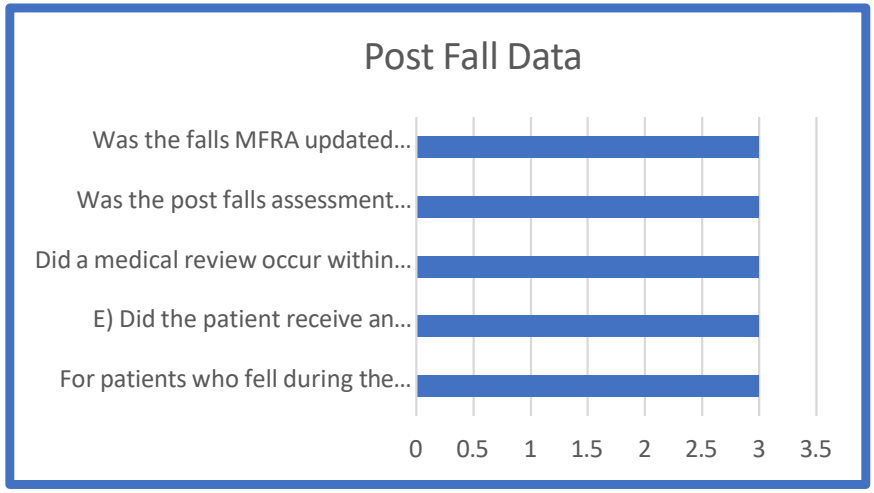

INITIAL MFRA ON ADMISSION
Was a MFRA done in 6 hours of admission
43
5
Medical clerking: falls history & mobility notes O/A
58
4
A) Is there a Falls MFRA in notes
68
8
0
20
40
60
80
Post Pilot
Pre Pilot


MFRA ACTION PLAN
68
68
68
68
68
68
48
28
8
5
4
3
3
3
action planappropraite
Post Pilot
Pre Pilot

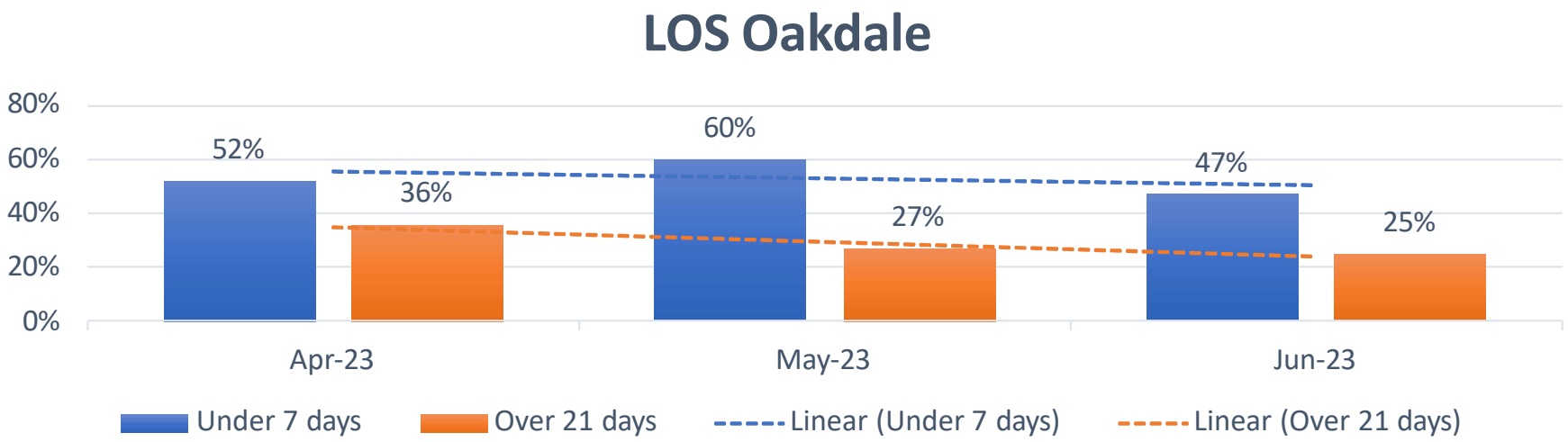

Pre Fall: Other risk assessments
If the nutrition and hydration risk...
If the incontinence risk has been...
If the bed rail assessment is...
If there is difficulty with transfers,...
61
5
63
0
68
6
68
4
0 10 20 30 40 50 60 70 80
Post pilot
Pre pilot


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



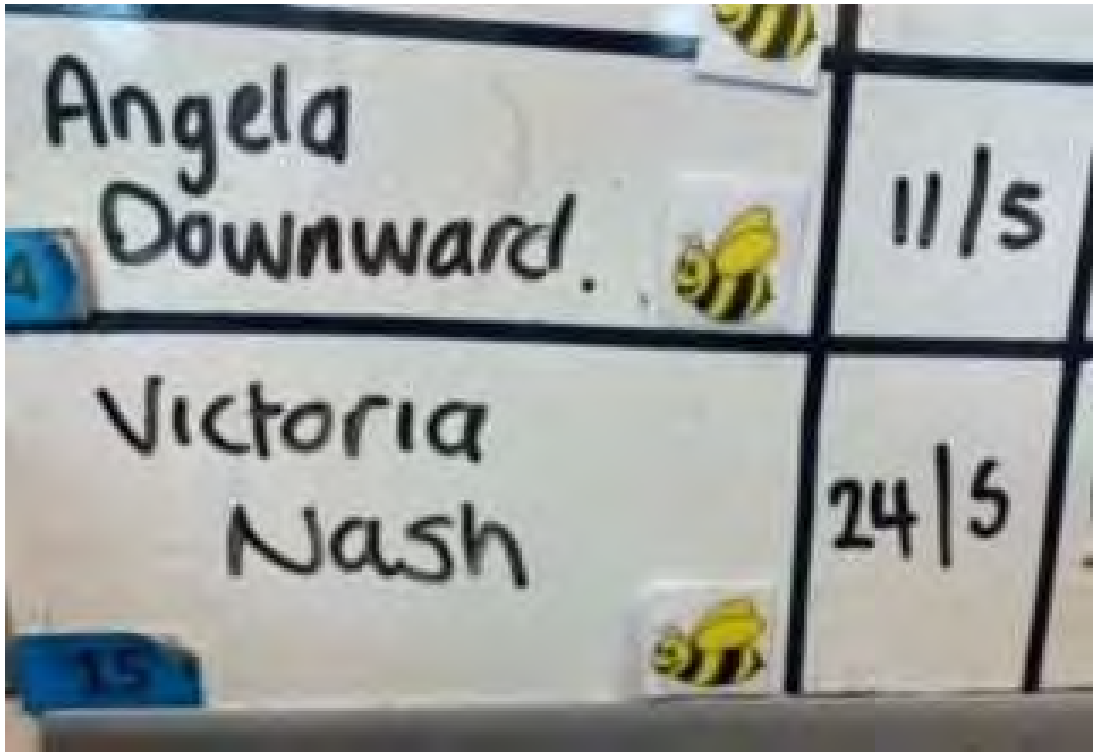
QUALITATIVE Analysis:

'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***