Quality Priorities highlight report November 2025

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Sponsors: -
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Please note where a QP has not been able to have an update for the month it is not included in the report.

Pressure Ulcers – Action & Intervention
Goal – To reduce the amount of patients developing HB acquired avoidable pressure damage by 20% by end of March 2026

Project Team: Senior Responsible Officer (SRO) - Sharron Price ND , Subject Expert/Author Rachel Govier-Williams, Eleri D'Arcy (QP Lead), Emma Smith (QI support)

Month – November 2025

Key Data Points

Pressure Ulcer Incident Reporting is now on a downward trajectory. By Quarter 3 2025 we have sustained **9 %** reduction in total numbers of Heath board aquired incidents reported and a **15 %** reduction when comparing April 2024 to Nov 2025 to Oct to April 2025. **Graph 1**: Total number of HB acquired incidents across SBU (hospital, community, MH & LD combined). **Graph 2:** Governance and Incident closures.

Primary and community services have seen **27% decrease** compared to the previous 2 quarters, a significant improvement. Normally, PCS shows quarter-to-quarter fluctuations (both increases and decreases). A sustained decrease is atypical and should be examined carefully. The inpatient incident rate is **1.8 per 1,000 bed d**ays, 0.1 % increase to 2024. Morriston has seen a total rate reduction, now down to **(*R* 2.1**)per NPSSG has seen a total rate of (*R 1*.5) The Highest inpatient rates were observed in Morriston **(*R* 2.6)** early 2025, and the lowest NPSSG **(*R* 1.1)**.
Total number of HB acquired incidents across SBU (hospital, community, MH & LD combined**(Graph 1)**. **Graph 2**: Governance and Incident closures.

Harm Profile

Severity: **90 %** of all HBA incidents remain superficial in nature . **10%** are deep in nature. **76%** of deep damage ulcers developed under **PCS** in patients' own homes. **24 %** In our Hospital settings. 13% NPSSG & 14% MSG. 6 NRI HB incidents have been reported in 2025 a more reflective picture of deep damage avoidability scrutiny panel outcomes. **Graph 3: :** The HB levels of damage reported with or without an avoidability status per SG.

The HB have seen a 8% reduction in deep tissue damage

70% all HBA investigated deemed **unavoidable** (15% improvement)- since quarter 1

Over 90% of all community damage incidents investigated were deemed unavoidable.

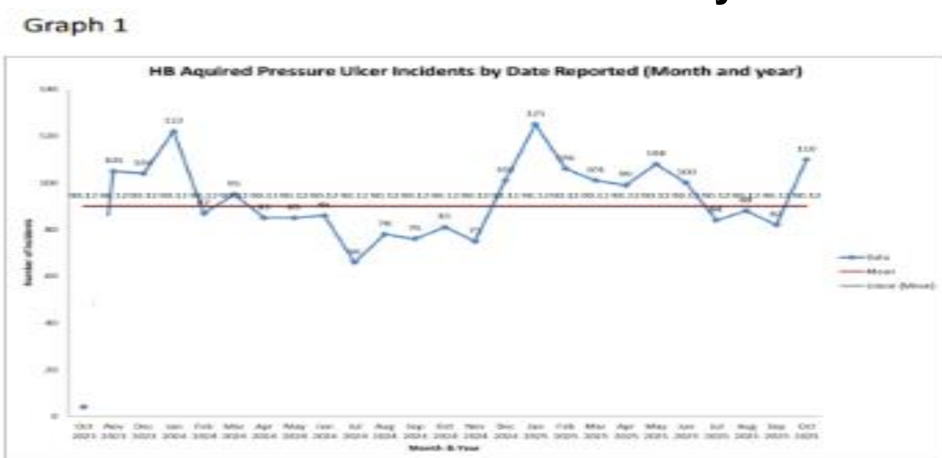
Governance & Learning Of incidents closed in the last quarter: we now see an Improving picture that 65% of all incidents have been investigated and closed. This still requires work and the efficiency of investigating and scrutiny is key to this.

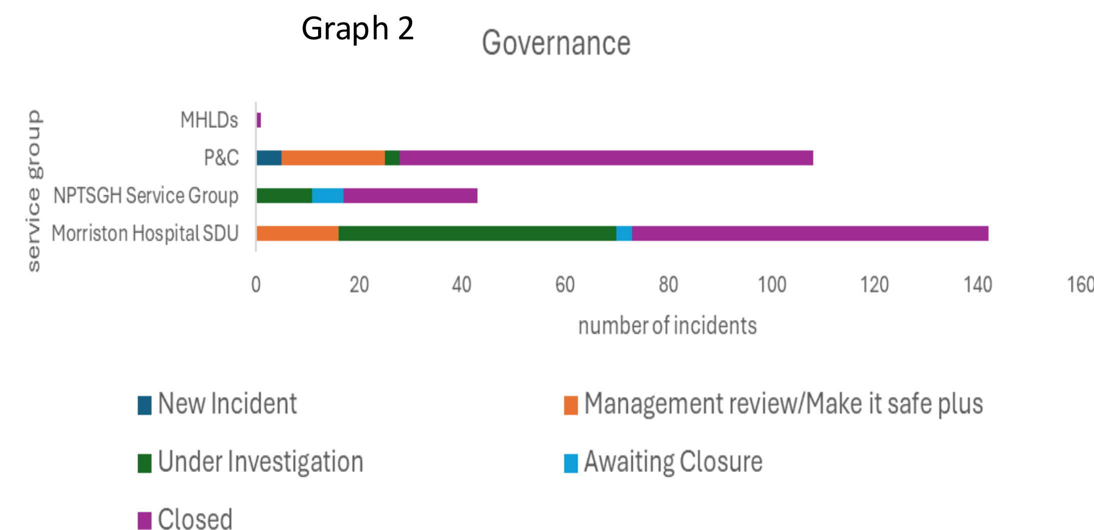
70% deemed unavoidable **30%** deemed avoidable which is a significant improvement however with **35%** not investigated or closed, this an not reflect total status until end of next quarter.

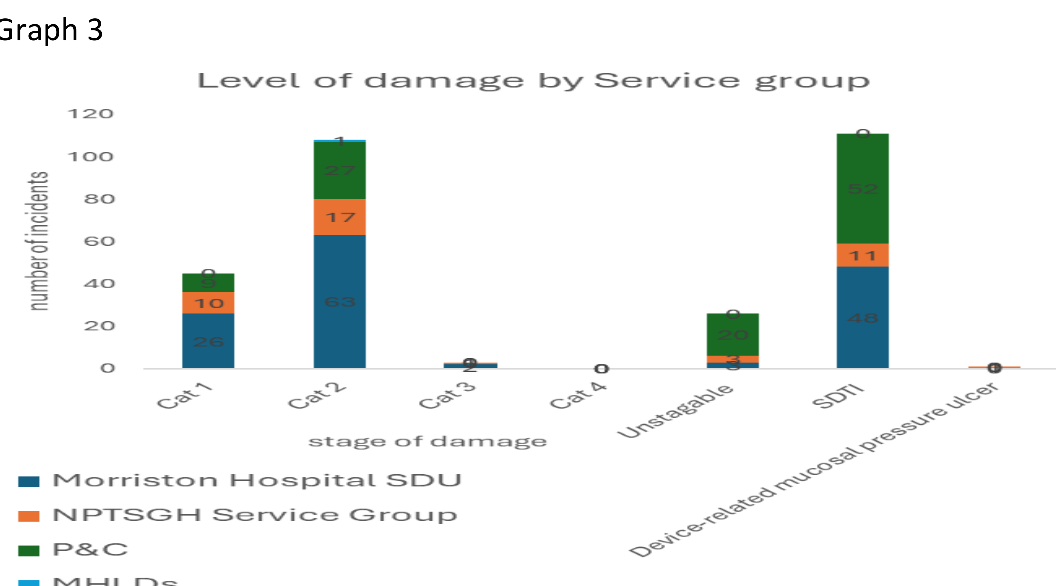
:. Quarter figures will be run again in February 2026.

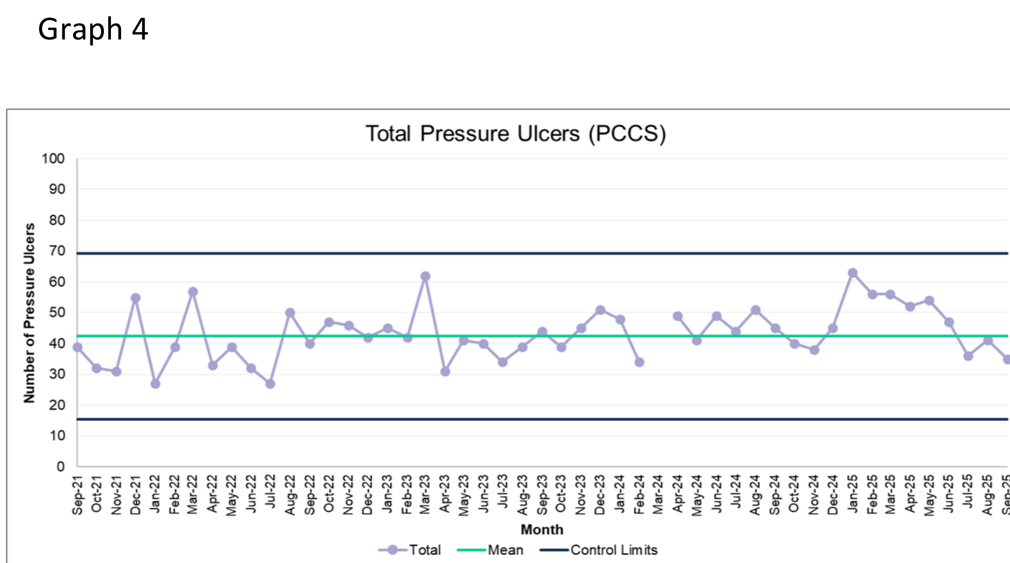
Graph 4: PCS HBA incidnets.

Key Outcome Measure/s









Underlying causes:

Patient factors: Vulnerability, deconditioning (esp. first 72h of admission).

Leadership/Process accountability, admin gaps. Management of teams

Risk assessment & care planning: Incomplete or poorly linked to interventions; staff skill gaps in ulcer recognition, repositioning, and offloading.

Equipment/Resources: Delays in dynamic mattress/bed provision; no targeted support in high-incidence wards.

Education/Training: Limited prevention training, lack of tissue viability expertise, weak engagement in QI.

Documentation/Technology: Delayed/incomplete digital charting; limited use of medical photography.

Governance/Learning: Gaps in guideline implementation and feedback systems

Risks:

- *Limited access to accurate data; executive dashboards don't reflect site-level SG data.*
- *Lack of medical photography for validation (RR 15 / 3701).*
- *Insufficient Tissue Viability Nurse (TVN) resources.*
- *Bed contract delays → risk to patients due to failing equipment.*

Actions to Address Pressure Ulcers (HB):

Governance & Oversight: Pressure Ulcer Strategic Group, scrutiny panels, peer reviews.

Audits & Data: Spot audits, Datix QA audits, data reviews/cleansing. Service provision and Spot audits, Datix QA audits, data reviews/cleansing. Service provision and efficiency.

Education & Training: Multilayered education (face-to-face, Teams, videos), skills days, champions programme, Care home QI education, neonatal & maternity guidelines.

Pathways & Policies: Development of PU pathways, policies, and improvement plans supported by .

Resources & Technology: Centralised Tissue Viability service, digital wound imaging (Improvement Cymru), bed contract finalisation. Shared education, champions and skills programme

Collaboration: Shared responsibility across HB, data sharing. Lessons and good practice, accountability,

Leadership- Strengthen leadership and accountability

What we expect to see (Outcomes by 2026):

- ↓ 20% PU rates in acute sites; ≤1.6/1000 bed days.
- ↓ 20 % avoidable PU in HB.
- ↓ Reduce total number of HBA incidents by 10%
- ↓ Reduce HB acquired Deep damage by 10%
- Improved staff skills, governance, and learning culture.
- Equitable access to tissue viability services & medical photography across sites.
- Better supported care homes.
- Patients consistently receive "right care, right time."

Quality Priority – Nutrition & Hydration

Project Team: Project Team: Senior Responsible Owner – Sarah Collier, Project Manager – Jayne Whitney, QI data lead – Samantha Scott, Project Support, Paul Evans

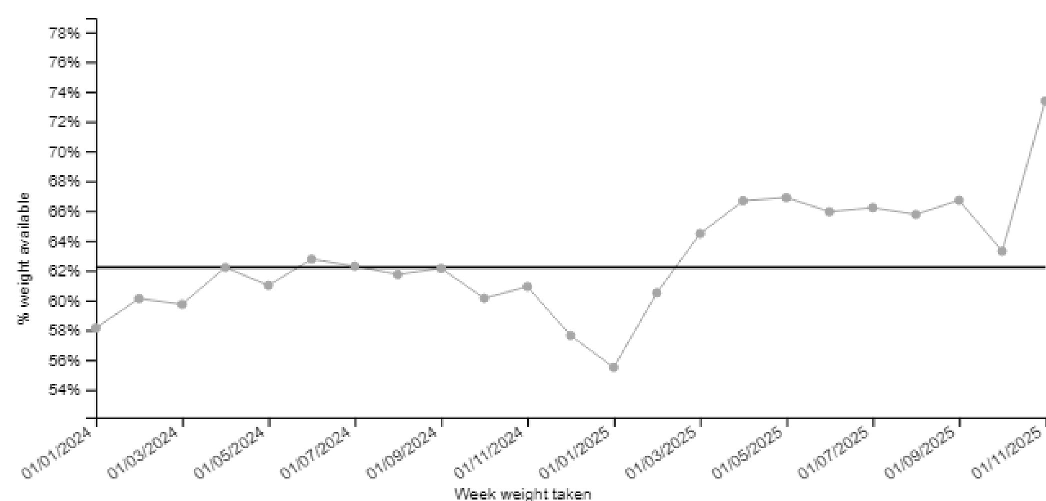
November 2025

Methods

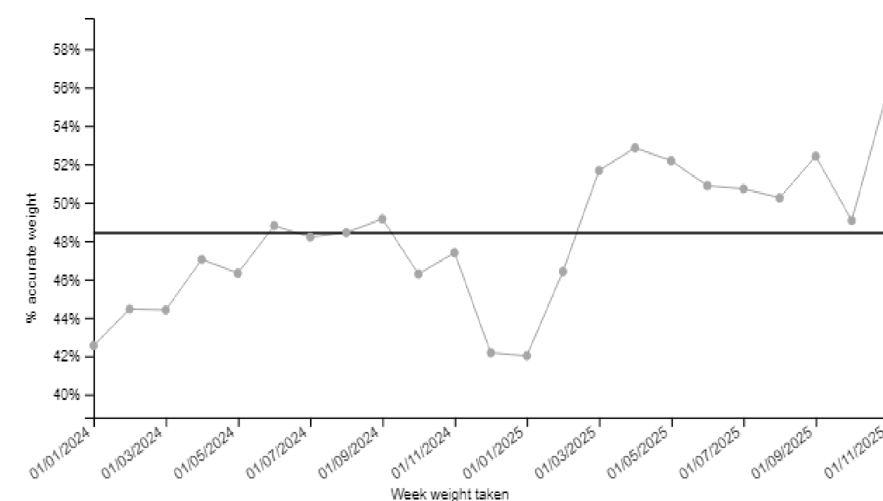
QI areas discussed by N & H committee:
1. Meet minimum standards all Wales catering standards
2. Nutritional screening & processes
3. Compliance with taking weights
4. Safe artificial nutrition non oral
5. Hydration - jugs
6. Nil by mouth days -
7. MH & LD, re-visit SLT & RD provision OPMH

The Graph below shows the accurate weight compliance % throughout inpatient care. The launch of the Quality Priority "Don't wait to weigh" campaign started in January 2024 with the aim to increase SBUHB performance to above the national average of only 13.5% - 55% of patients being weighed. Currently the HB in **November 2025.** The aim to increase to 60% within 6 months. The % accurate weight chart shows from January 2024 there has been a shift in the data showing an improvement. Currently accurate weights is 56% Subsequently, the weight available reported by patients / carer or estimated and measured by staff shows 73%.

% weight available by week weight taken



% accurate weight recorded by week weight taken



Key achievements

Agreed several QI projects with H & N Committee
First QI project agreed as Weight Monitoring (WM) pilot area Morriston site
Data requested from WNCR system on estimated weights within in patient care at Morriston Hospital
1st phase of QI work to be focussed on above WM, Snack provision & Nil by mouth
QP rep from PCTG service group agreed
First QI report presented at N & H committee in November 2023, next report February 2024
Launch of Nutrition & Hydration QP officially launched on Intranet
Nutrition & Hydration Day held with catering departments across 3 main sites
First Learning Symposium held in June – 33 attendees, 10 evaluations requesting more events

Progress in the last month

- Accurate weights taken for the Health Board is 56% - we have achieved 1% over the national average
- It has been agreed to trial snack ordering on the symbiotic digital food ordering app - with in 3 wards across the health board hospital sites.
- Progress has been made in identifying alternative weighing equipment in complex areas of care
- A pilot study on 2 wards using a wasp symbol to identify those with high-risk nutritional needs more visible
- Agreed to roll out Traffic Light Jug System for Hydration - starting with Morriston and 2 areas in Singleton and NPT hospital
- Task & Finish Group for Nutritional Risk Assessments completed scoping exercise in wards in Morriston
  AMAT DATA on monthly audits across the Health Board sites recorded for November shows scores:
- Compliance with access to Nutrition and Hydration 96.2% (median 91%)
- Nutritional Risk Assessments completed on admission in 24 hours 78.3% (median is 82%)
- Nutritional Risk Assessments Rescreening - 90.3% (median is 93%)
- Food & Fluid Charts appropriate completed - 97.6% (median is 96%)
- Weight taken within 24 hours of admissions - 69.6% (median is 70%)
- **Introduction of new audit questions since September 2025**
- Snack availability including general, high calorie, fresh fruit – 98% (Median is 96%)
- Has concerns been raised with Catering Department – 100%
- Has a cooked breakfast been offered for patients scoring above 7 – 93.3% (Median 93%)
- Are Hydration needs being monitored and compliance with hydration rounds – 95.3% (Median 98%)

Actions for the next month	Responsible Owner	Due Date
Snack ordering system	JW &stakeholders	Ongoing
Continue to monitor weight compliance	JW & stakeholders	Ongoing
Nutrition Assessment Campaign	JW & stakeholders	Ongoing
Hydration Traffic Light System agreed to roll out.	JW & stakeholders	Jan/Feb 26
Children's Menu re-launch	JW & Catering Department Morriston	Jan/Feb 26
Change layout of menu	JW & Catering Department Morriston and Bayouth	Jan/Feb 26

Quality Priority – Acute Physical Deterioration
Goal – Improvement in the recognition and management of Physical Deterioration

Project Team: Senior Responsible Owner – Dr. Clare Dieppe, Project Manager – Lisa Fabb, QI lead – Samantha Scott

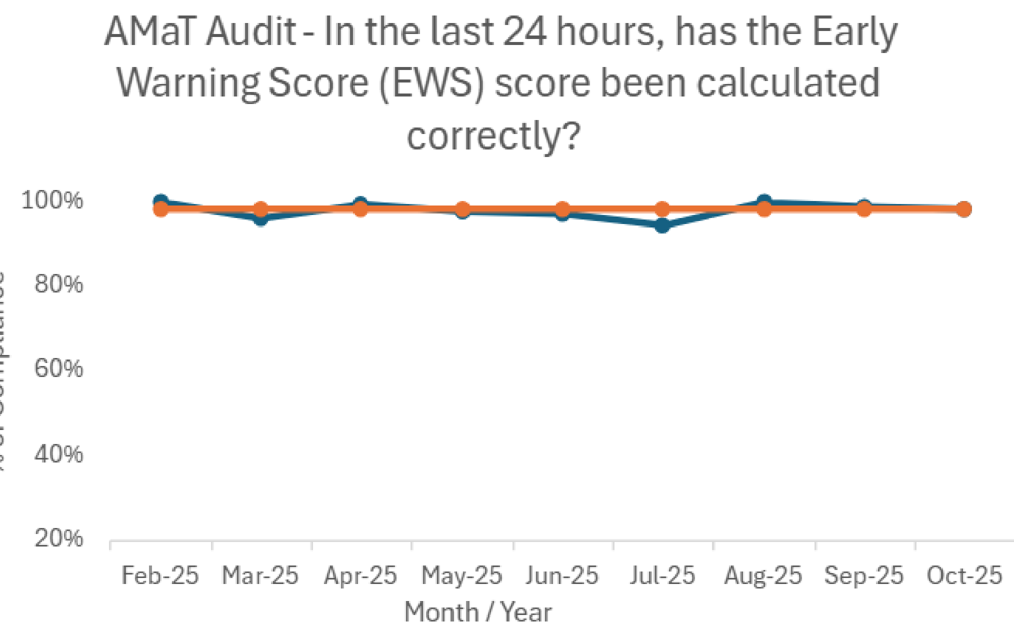
Month – November 2025

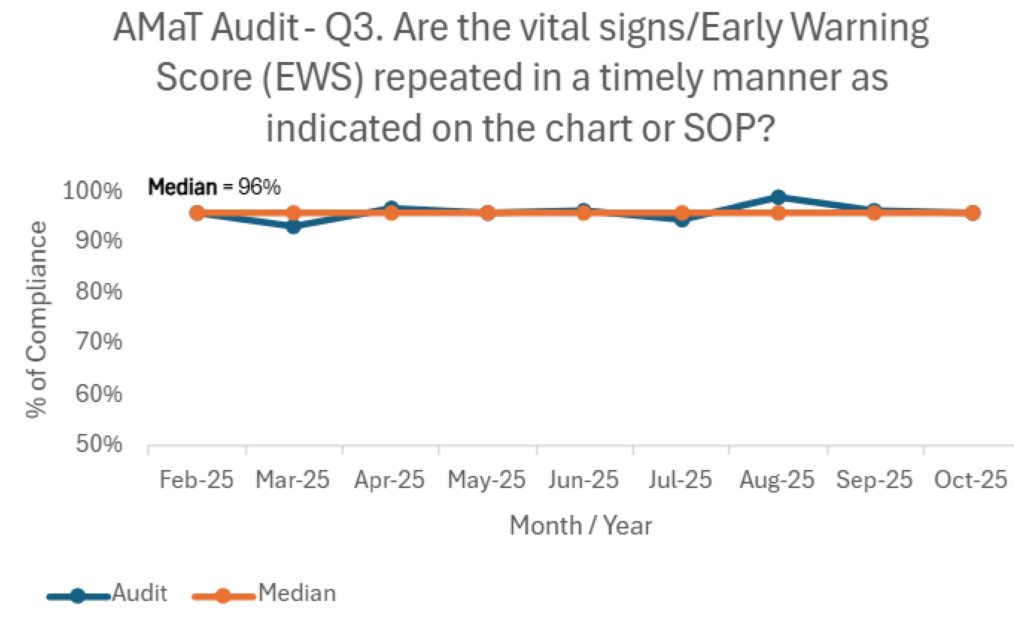
Methods:

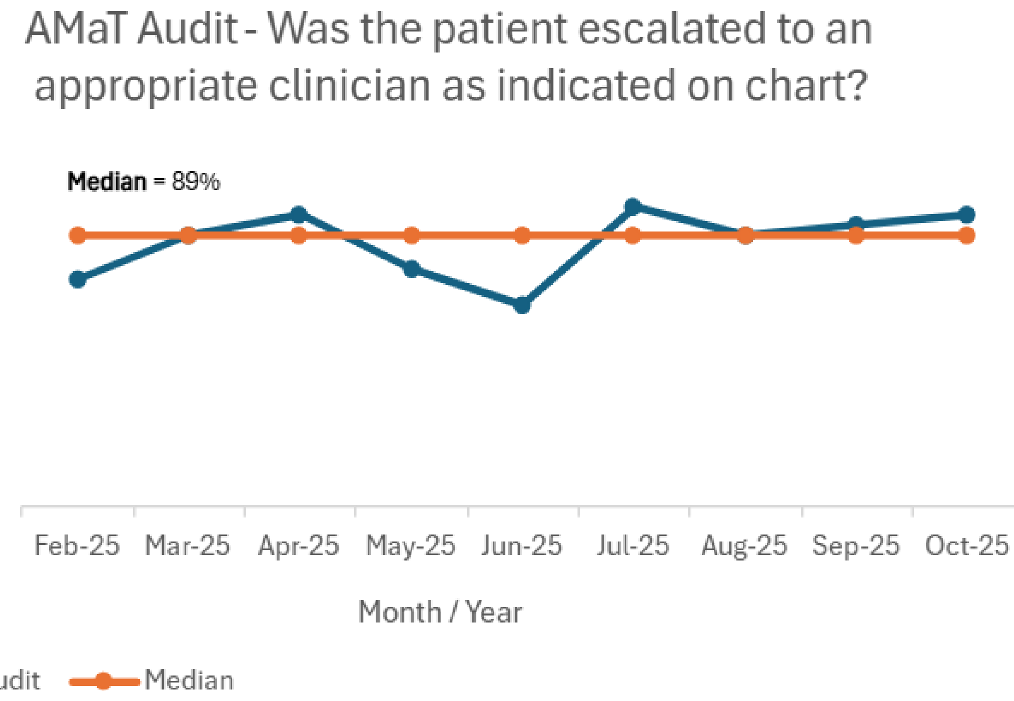
1. Introduction or update of Early Warning Systems (EWS) in all appropriate areas, led by appropriate Service Group, overseen by Acute Deterioration Safety Lead.
2. Core training provided through ESR eLearning, supported by local nurse educators and resuscitation service.
3. Measurement of appropriate use, accuracy and escalation through AMaT monthly ward audit.
4. Engage in national program to share learning.

Other critical success factors:

- Engagement of all service groups
- Robust understanding of EWS escalation data over time.







Key achievements:

- All EWS implemented within required timelines.
- SBUHB first HB in Wales to implement a Patient Reported Wellness Score, putting the patient's voice at centre of care, the only HB in Wales to do this, it has now been recommended APDIN for all of Wales.
- AMaT AD ward audit improved to ensure robust systems to collect AD data over time and develop improvement action plans for all in patient areas including paediatrics and maternity.
- Process has started to review Sepsis processes in the HB including screening and safety netting advice.

Progress in the last month:

- Review of use of Early warning scores
- Engagement with stakeholders including Llais for Call for Concern/ Martha's Law
- NEWS 2 launch rescheduled for 2nd Sept, although this is due to printing and procurement issues it has given is time to strengthen the training and learn from Welsh colleagues who launched in July.

Evidence – NICE Guidance NG51 / New National Guidelines on treating Sepsis by AoMRC

Falls Prevention — September 2025

Project Team: Senior Responsible Officer: Helen Annandale, QP lead – Eleri D'Arcy

What is the Data telling us?: PLEASE NOTE DATA ERROR SEPTEMBER 2025 NO CHART DATA AVAILABLE

In-patient falls rate remains below National average with a down trajectory in last 6 months

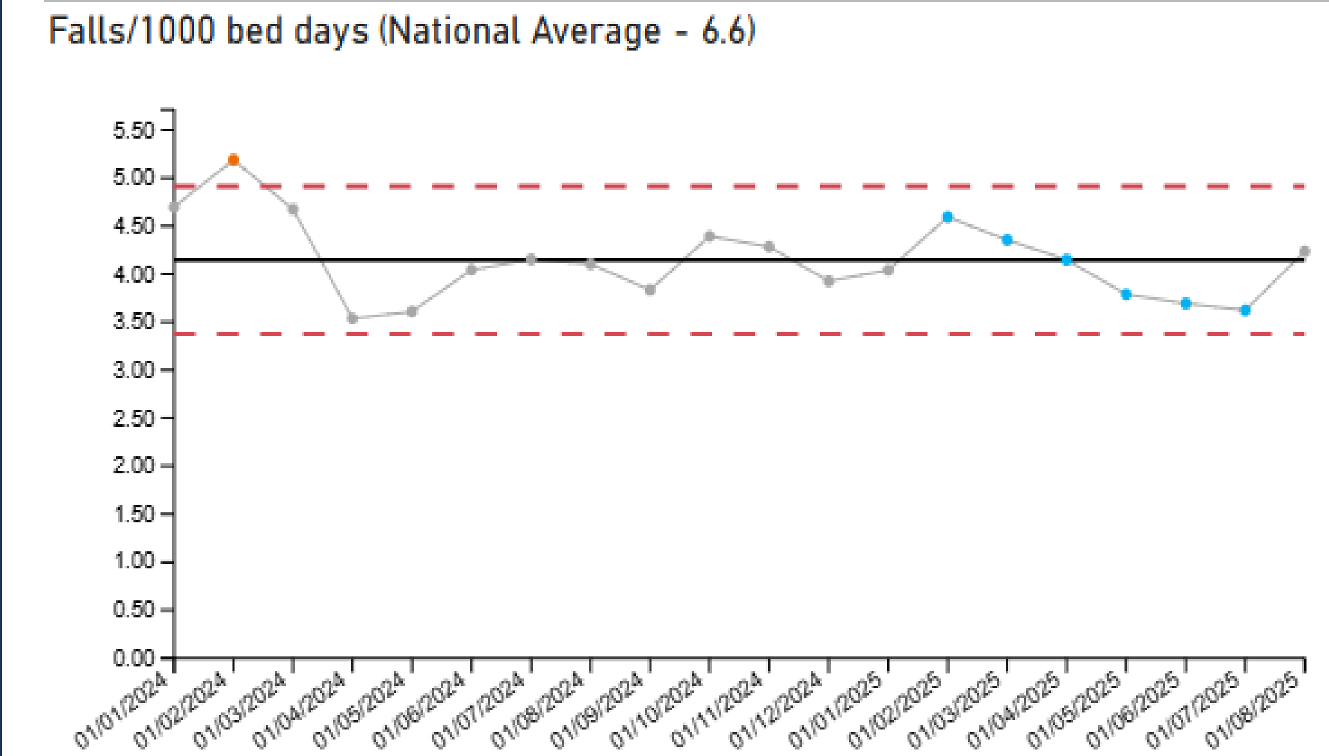
The numbers of incidents causing harm Aug '24-sept '25 is down 7% from the previous year

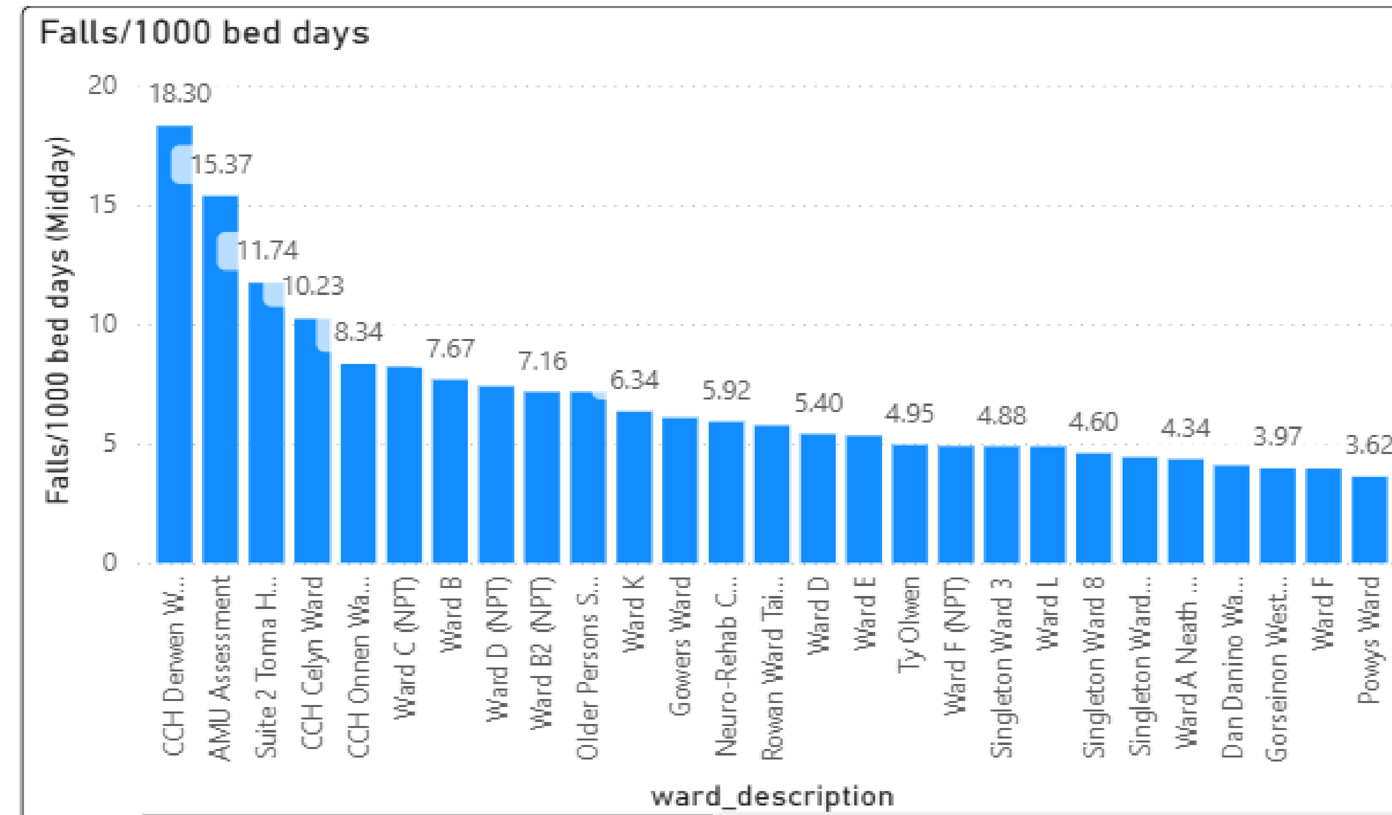
Falls rate by ward over 12 months shows high rates in mental health services, AMU and older persons rehabilitation wards.

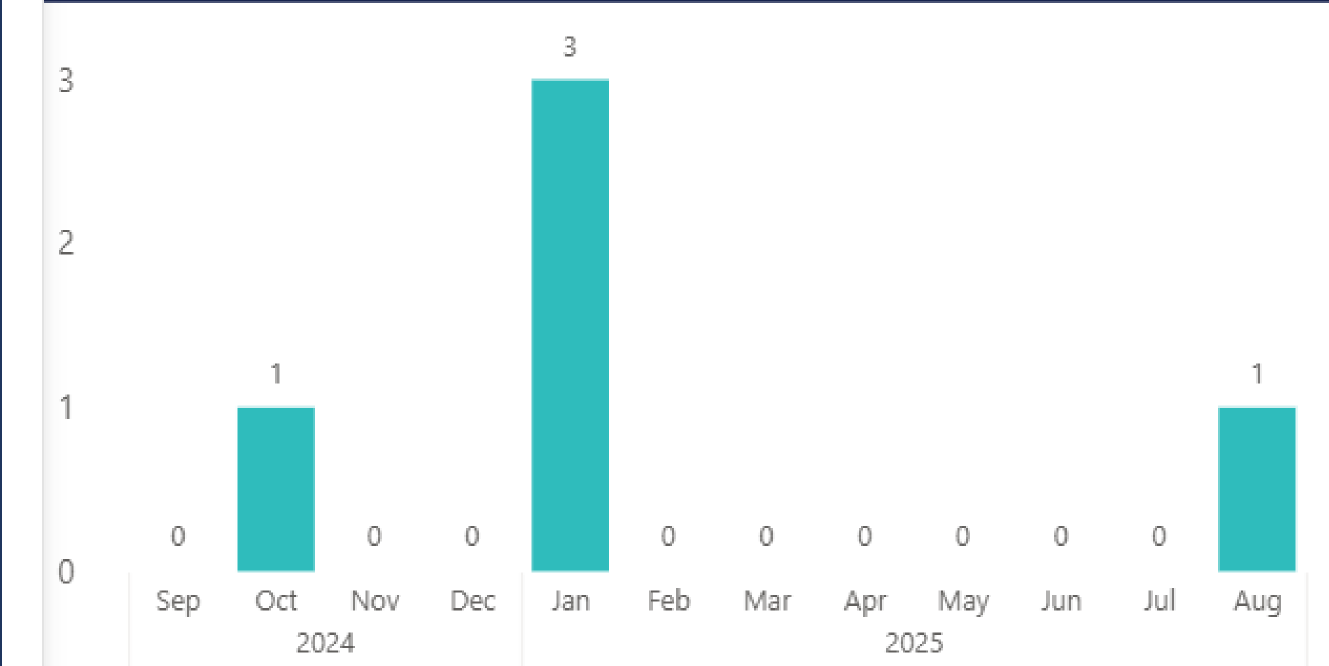
Falls related attendance to ED/MIU averages 2700 per month (approx.. 20% of all ED/MIU attendances) Aug '25 is 17% higher than Aug '24

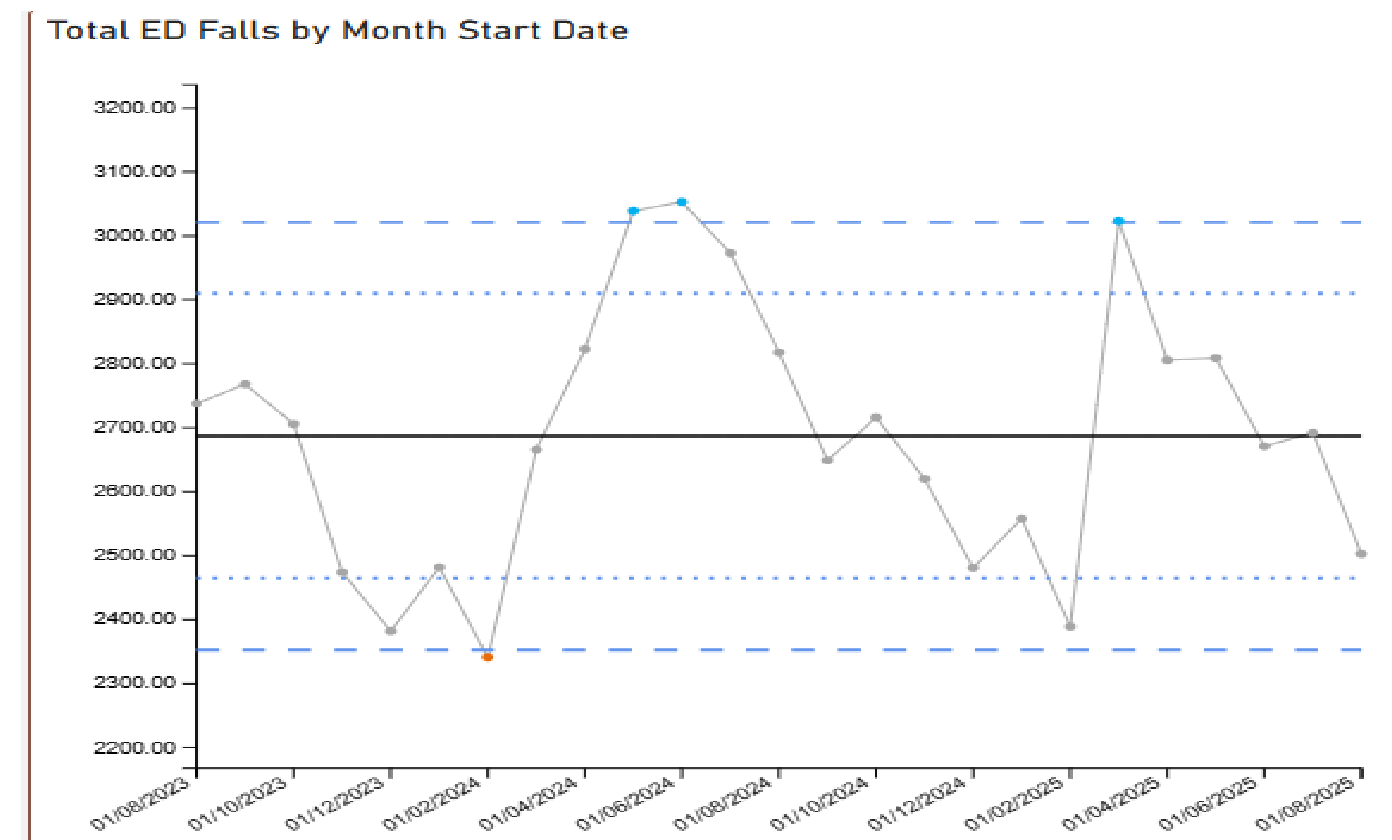
There have been 5 NRI falls related incidents in the last 12 months (Sept'24-Aug'25) compared to 10 in the previous 12 months = 50% decrease

Key Outcome Measure/s –









Underlying causes:

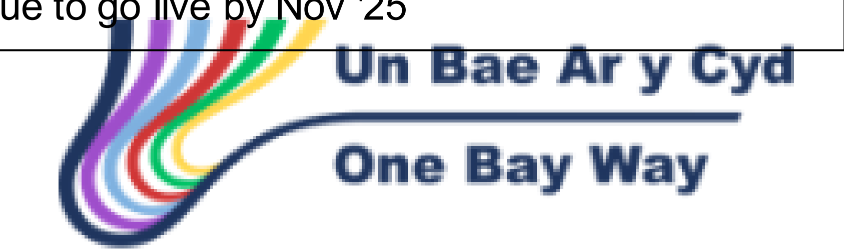
- Ageing population with increasing frailty picture
- Increased demand on WAST and front door services
- Limited alternative WAST response to level 1 and level 2 falls regionally
- Inconsistent approach to falls advice in community/primary care
- Reduced access and provision of falls clinics across region
- Insufficient access to appropriate strength and balance exercise provision
- Some ward areas including AMU do not have an environment which enables safe monitoring of patients at risk of falls
- Risk assessment and care planning inconsistent and inaccurate in some areas of HB

What are we doing about it:

- Regional Falls Prevention taskforce enabling collaboration
- Primary Care action plan agreed
- Development of Level 1 and level 2 falls pathways in collab with therapies, St Johns Ambulance and LA
- Dashboard for care home data now live
- Safe Care partnership work on deconditioning progressing
- Falls page on Waiting Well internet pages
- falls policy update to reflect changes to NICE guidelines and introduction of digital care records
- Improvement in digital audit through AMAT
- Application to fund community strength and balance classes
- Falls due for discussion at Management Board Oct '25
- Recognising progress of level 1 falls response project through shortlisting in 2 National Awards (NHS Wales and HSJ)

What do we expect to see change?

- Reduction in WAST call out from care homes following falls incident (goal – 30% reduction per site by March '26)
- Falls rate not exceeding 5.0 (falls/1000beddays) over proceeding 12 months
- Reduction in conveyance to hospital via WAST for level 2 falls (WG target of 25% reduction)
- New falls policy to be shared 'Oct 25
- Level 2 falls response due to go live by Nov '25



Quality Priority – End of Life Care (EOLC)
Goal - Increase proportion of Swansea Bay residents receiving the right care at the right place at the right time in the last year, months, weeks, days of life

Project Team: Senior Responsible Owner – Sue Morgan (Clinical Lead), Project Manager – Tracy Rowe (part-time) , QI measurement support – Emma Smith

Month – October 2025

Methods

- Increased correct identification of people who may be in the last year of life
- Increase Advance & Future Care Planning (A&FCP) across all care settings
- Increased correct identification of people who may be in the last days of life
- Increase the number of staff given education and training to support high quality EOLC
- Identify and produce systems that support sharing of A&FCP across all care settings

Other critical success factors

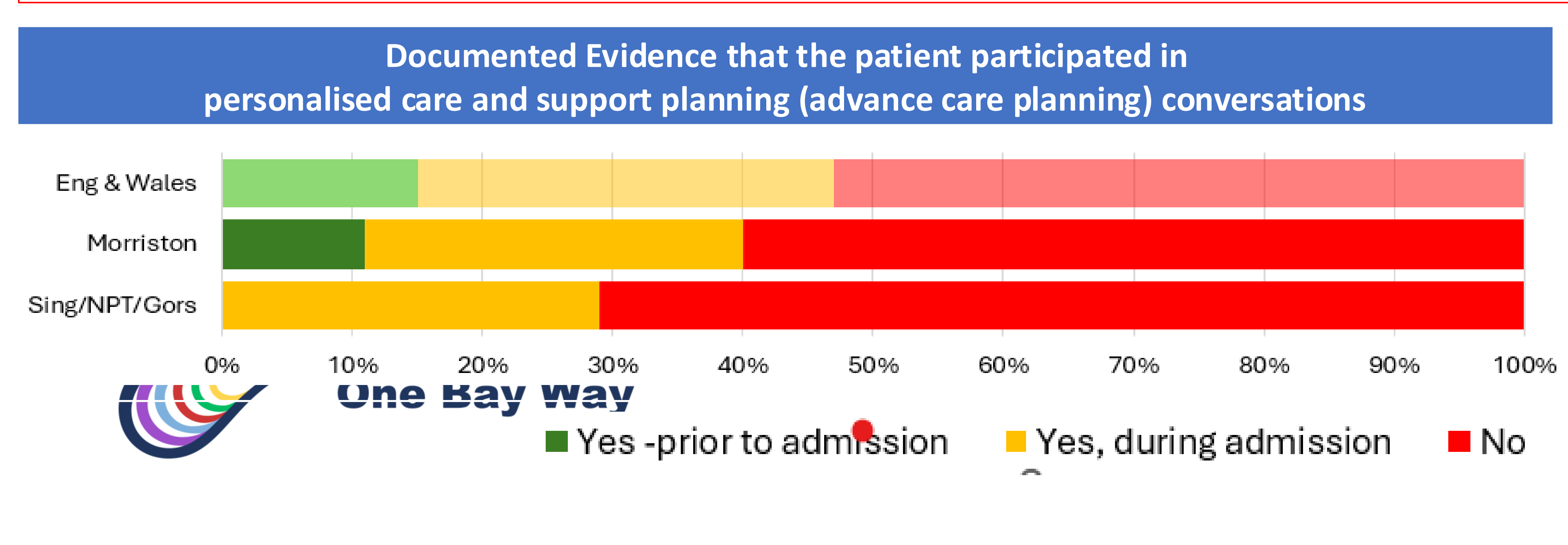
- Medical engagement with EOLC throughout service groups, demonstrated through medical EOLC champions within each service
- All Service Groups to participate in completing the Health Board End of Life Care audit.
- Digital resources – informatics and systems

Key Outcome Measure/s

•Deaths outside of hospital 56%
•A&FCP plan notifications in WCP has stabilised at approximately 60 per month
•Approx. 34% HB staff have been trained in EOLC training, (estimated % as may be duplicate staff in both the various training offers) also delivered to external organisations largely university and care homes – LA and private.

Risks

- **End of Life Care removed from Registered Nurse Induction Programme**
- **Access to data remains a challenge – Awaiting up-date of EOLC dashboard**
- **Resources to support distribution of DNACPR form have not been identified – either digitally or physically**



Key achievements

•30% of HB staff have received training in EOLC - Champion programme, Regular Education sessions, bespoke training requested by Service Groups and care home training.
•*NACEL service user feedback 2024* shows significant improvement in experience reported compared with 2022 and compared to rest of England and Wales
•Public facing page about Palliative and End of Life Care in Swansea Bay on HB internet site – more content being added
•Engagement in the national Dying Matters Week each year.
Data around availability of A&FCP for population in care home better understood

Progress in the last month

- Case note reviews for National Audit of Care at the End of Life (NACEL) Oct 31st - Morriston 101 and Singleton, Neath Port Talbot and Gorseinon 45
- Bereavement Survey component of NACEL – Morriston 96 and Singleton/NPT/Gorseinon 8
- End of Life Care questions/Care Decision guidance to support Five Priorities of the dying patient added to Monthly Ward Audit on AMAT – first month's findings available

Actions for the next month	Responsible Owner	Due Date
DHCW introducing platform for up-loading copy of DNACPR form and Advance and Future Care Planning forms to Welsh Clinical Portal	Digital Team / Sue Morgan	Jan 2026
Work with members of Bay Health Cluster to identify projects for promoting A&FCP	Sue Morgan/Multiple	Dec 2025
Pilot of Would You Be Surprised...? Question on morning Safer Board Round (Neath Port Talbot Hospital) - Needs some modifications	Sue Morgan	Nov 2025
More Case Note reviewers required for NACEL audit Q3 and Q4	Service Group Med Directors	Dec 2025
Sharing and Involving: Public information booklet about DNACPR decision being sent to all clinical areas across the HB with link for feedback on how they are utilised	Sue Morgan	Dec 2025
Preparation for NACEL Patient and Carer Tool – a publicly available tool showcasing NACEL data at hospital level		April 2026

Evidence - End of life care for adults, Updated Sept 2022, https://www.nice.org.uk/guidance/qs13

Quality Priority Risks - Link to QP Risk Monitoring

QP Risk Monitoring ☆

All Items | Add view

Risk Status: In progress ✕ | Pending ✕ | Incomplete ✕ | Clear filters ✕

QP Area	Date Reported	Date Last Updated	Assigned To	Risk Description	Risk Mitigation	Risk Level	Assessed Score	Risk Status	Modified	Modified By
Falls	01/08/2024	30/10/2024	Service Groups /Health Board	Governance process to investigated falls incidence – slowing learning and sharing of information. no uniformed approach to decisions re avoidability	Learning from incidents/events included on Overarching HB steering Group. mechanism required to share learning back with staff. agree HB avoidability tool	Medium	9-15	In progress	December 4, 2024	Eleri D'Arcy (Swansea B
Pressure Damage	01/08/2024	04/07/2025	Service Groups	Governance - delayed investigations & scrutiny	Reported quarterly	Medium	9-15	In progress	July 4	Rachel Govier-Williams
Pressure Damage	01/08/2024	04/07/2025	PUPSG	No medical photography in NPTH, MHLD & Out of Hours	Escalated QS - RR 16	Medium	9-15	Pending	July 4	Rachel Govier-Williams
Acute Physical ...	01/08/2024	18/08/2025	Dr Mothukuri	Clinical commitments of SRO and service commitments of QP lead compromise the project progress. No updates Oct 2024	Delegate aspects of required work	Minimal	1-4	In progress	August 18	Lisa Fabb (Swansea Bay
Acute Physical ...	01/08/2024	18/08/2025	Lisa Fabb	Lack of ownership in Morriston service groups, demonstrated in lack of audit, mitigated through group nurse and medical director and designated service group leads. Oct 2024- Morriston QP lead identified awaiting update from them.	Review of reporting structure agreed by SGCD. Support with aspects of audit. Morriston SG have identified improvement matron who is working on this.	Minimal	1-4	In progress	August 18	Lisa Fabb (Swansea Bay
End of Life Care	10/10/2024	31/07/2025		Any advance and future care planning activity (including DNACPR decision making) that has been undertaken in primary and community care is not visible to clinical teams in other areas, eg ED, secondary care, WAST, GPOOH. This means it is not available to support clinical decision making and could lead to transfer to hospital . Thus patients for whom escalation of care to ED or AMU is unlikely to add value, or even cause harm, are subjected to transfer to hospital, adding to patient distress and utilisation of resources that have already been identified to be unlikely to help. In the same way, the patients (and those important to them) are forced to have those difficult conversations repeatedly, which can be distressing and harmful to the patient and those important to them.	HB to work with primary care to extract key end of life care conversations and decision into the GP record section of Welsh Clinical Portal. Robust use to Special Notes between GP practices and GPOOH for identifying patients with treatment escalation limitations.	High	9-15	Pending	July 31	Sue Morgan (Swansea
End of Life Care	10/10/2024	31/07/2025		When DNACPR decision is made in the hospital setting, the forms are not always given to the patient when they are discharged home, and are rarely forwarded to the GP and GPOOH . This results in either the patient being subjected to a futile or unwanted attempt at CPR, or have to have a repeated conversation about DNACPR with the GP to write a new form. This is frequently ad difficult conversation for the patient. When a DNACPR decision is made in the community, whilst the patient and GP may have a record of this, this decision is rarely shared with secondary care, and inconsistently with GPOOH. When a patient dies in the community without a DNACPR form in the house, the case is referred to the Coroner and this delays the family's ability to organise funerals and impacts on the bereavement complexity. There is currently no IT system in place that provides the "one source of the truth" around DNACPR status of a patient - WNCR may have different recording from GP record, from SIGNAL, from GP OOH, etc. If a DNACPR decision is reversed (in a different care setting) there is currently no way of identifying where the original DNACPR form may have been distributed, to ensure that all clinical teams are made aware of the change in clinical state. This puts a patient at risk of not being offered an attempt at CPR when such an attempt may be successful. There is currently no understanding of the number of people within the Swansea Bay population who have a DNACPR documentation in place. Health Inspectorate Wales Report on DNACPR recommendations cannot be met with current processes.	The HB implements standards for sharing DNACPR documentation - eg All patients are given the relevant copies of the DNACPR form on discharge; Ward Clerks scan and distribute the DNAPCR form copies to GP, GPOOH and ensure a copy is retained in the current clinical record. Explore crossover digital systems used within Swansea Bay to facilitate one source of the truth.	High	9-15	Pending	July 31	Sue Morgan (Swansea
Nutrition and H...	03/05/2025	28/02/2025	Service groups/health board	Risk to increasing number of patients weighed in complex care areas - due to the withdrawal via a safety notice of weighted pat slides	Nutritional risk assessments and the need for weights to determine the nutrition needs of the patient in recovery	High	16-25	Incomplete	August 1	Jayne Whitney (Swanse
Cross Cutting Is...	29/11/2024	29/11/2024	QP Collaborative Group	Overarching Digital Risks, including: - Digital Dashboard Functionality - concerns around quadrant and card view, number of clicks to the SPC charts and availability of filters. - Dashboard Data inaccuracies relating to the QPs relating to criteria of measures. - Clinical Digital solutions showing discrepancies between risks reported and clincal presentation. report to follow to QSG	Emma Smith is meeting with digital team, has requested feedback to present back by 2/12/24. Feedback by team given, some data quality issues have been resolved. Working group to be suggested to work through feedback.	High		In progress	December 30, 2024	Eleri D'Arcy (Swansea B
Cross Cutting Is...	30/12/2024	30/12/2024	Digital	compliance with digital clinical systems such as Signal is not consistent increasing risks of inaccurate data reporting (particularly when attempting to identify patients who are clinically optimised)	discuss with digital team re solutions?	Medium	5-8	In progress	December 30, 2024	Eleri D'Arcy (Swansea B
Acute Physical ...	21/02/2025	21/02/2025	Lisa Fabb	Sepsis coding on discharge is not available until about 2 month post discharge. As a result of the lag monthly data on dash board is not reliable		Low	1-4	Incomplete	April 16	Paul Evans (Swansea Ba
Acute Physical ...	18/08/2025	18/08/2025	lisa fabb	Due to issues with the printing and procurement process of the new NEWS 2 charts, there have been delays rolling out NEWS 2.	Launch has been pushed from July to September. This will ensure a safe buffer to allow for printing and ordering as well as extra time to train staff while there is increased leave during August.	Low	5-8	In progress	August 18	Lisa Fabb (Swansea Bay