

Quality Priorities highlight report September 2025



GIG
CYMRU
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Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board

Authors:-

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Sponsors: -

Angharad Higgins, Head of Quality and Safety

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and Patient Experience**

**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, Subject Expert/Author Rachel Govier-Williams, Eleri D'Arcy (QP Lead), Emma Smith (QI support)

What is the Data telling us: Overview

Incident reporting for pressure ulcers has increased by **8.4%** when comparing 2024 to 2025. This reflects higher numbers both in hospital settings and on community caseloads.
Key Data Points, Graph 1: Total number of HB acquired incidents across SBU (hospital, community, MH & LD combined). **Graph 2:** The HB deep damage reported with or without avoidability status. Deep damage incidents have dropped by **61% from Aug to Sep 2025**

The inpatient incident rate is **1.7 per 1,000 bed days**. The SPC reflects the previous **4.3% reduction** when comparing the same period in 2024/25; however, the overall trajectory remains upward from the **previous rate of 1.38**. The Highest inpatient rates were observed in **Morrison (R 2.6)**, and **NPSSG remains low (R 1.1)**.

Severity: 90% of incidents remain superficial in nature. Of incidents closed in the last quarter: **55%** deemed unavoidable **11%** deemed avoidable **34%** closed without a recorded status, **29%** of incidents remain pending investigation and are not reflected in current figures.

Harm Profile

There has been a **50% reduction in serious harm incidents** compared to 2024/25 to date in both NPSSG and PCS.

No nationally reportable incidents have been recorded in Morrison.

Location of Incidents

Health board-acquired pressure ulcers remain **more prevalent in patients' homes**. The highest report on inpatient sites remains ED/AMAU, with an average of 30 HB acquired per Quarter

Month - September 2025

Underlying causes:

- Patient factors:** Vulnerability, deconditioning (esp. first 72h of admission).
 - Leadership/Process:** Poor accountability, admin gaps.
 - 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.

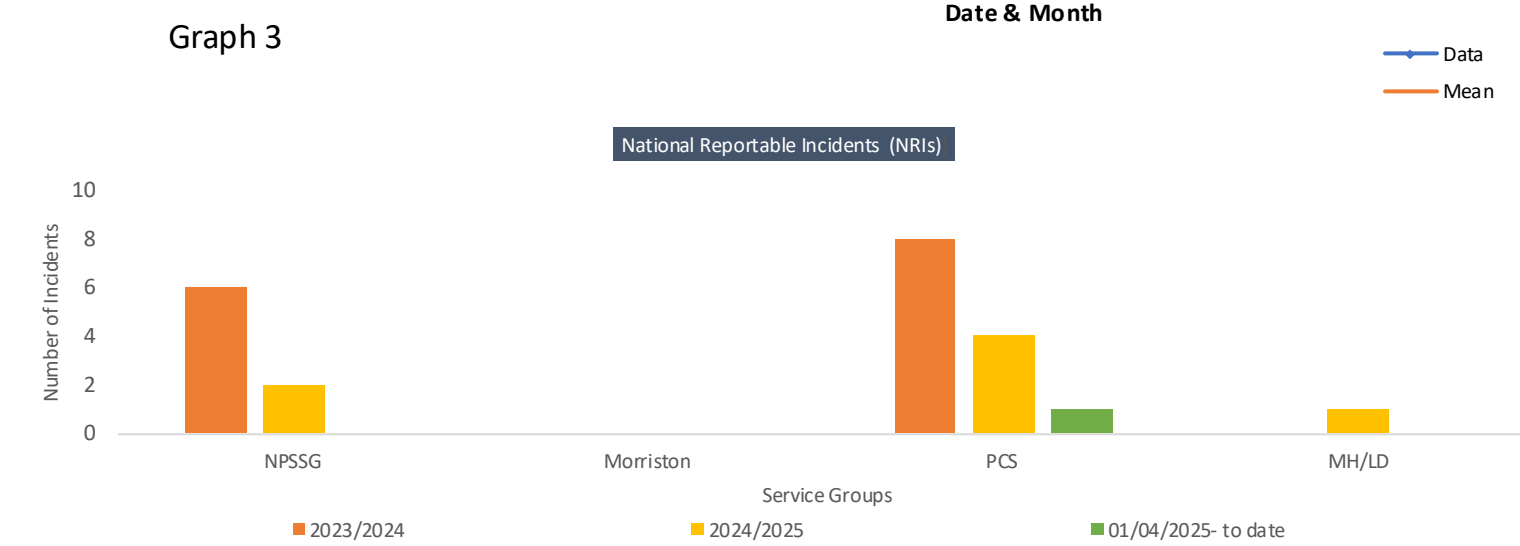
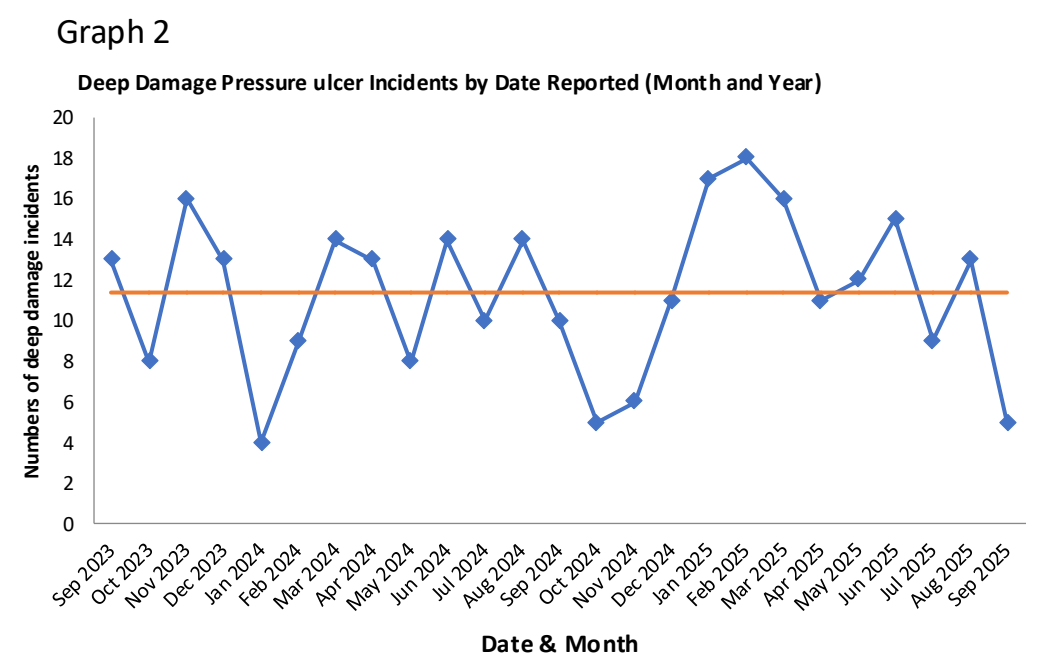
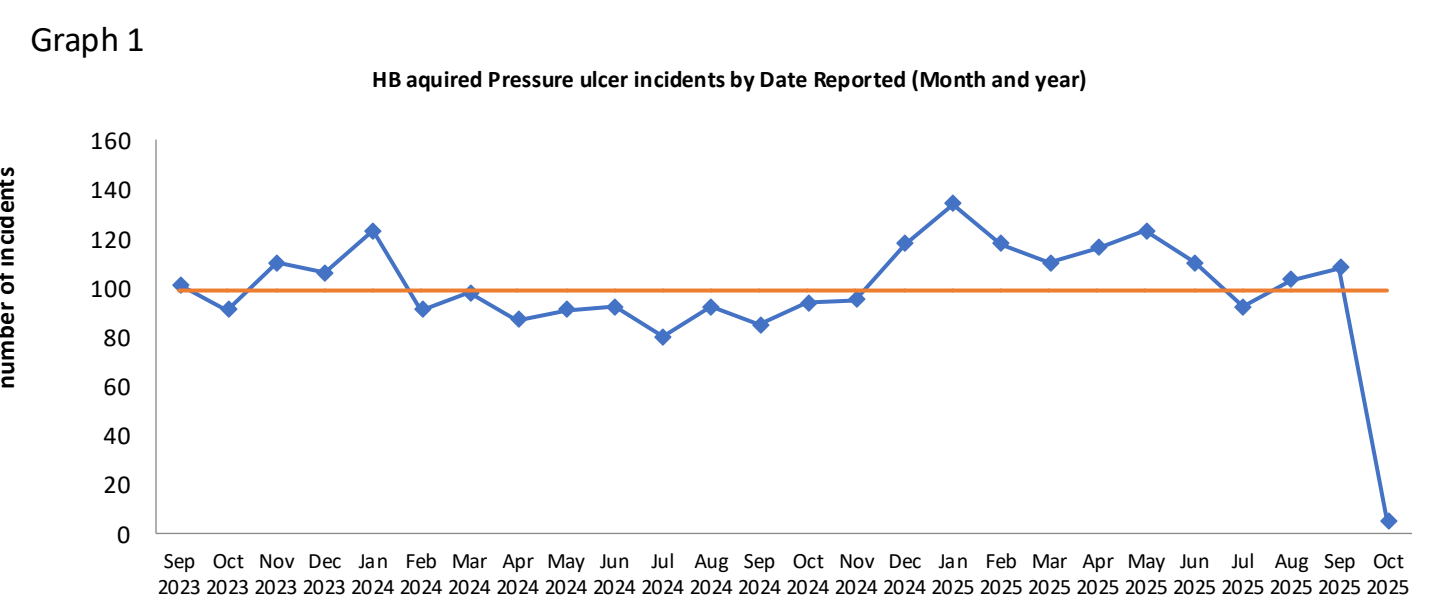
Actions to Address Pressure Ulcers (HB):

- Governance & Oversight:** Pressure Ulcer Strategic Group, scrutiny panels, peer reviews.
- Audits & Data:** Spot audits, Datix QA audits, data reviews/cleansing. Service provision and efficiency reviews
- 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.
- ↓ 10% avoidable PU in HB.
- 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."

Key Outcome Measure/s



Quality Priority – Nutrition & Hydration

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

September 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 **September 2025** shows a median of 48% with an aim to increase to 60% within 6 months. The % accurate weight chart shows from February 2025 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 65%

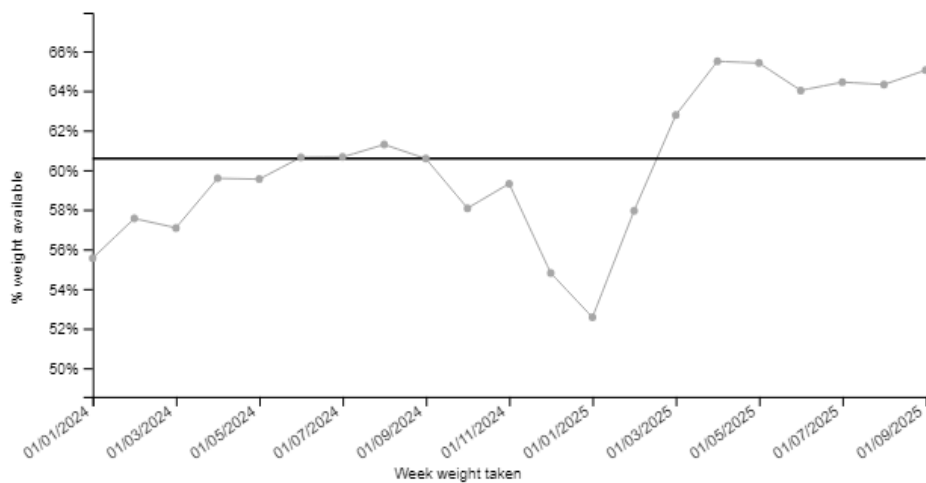
Key achievements

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

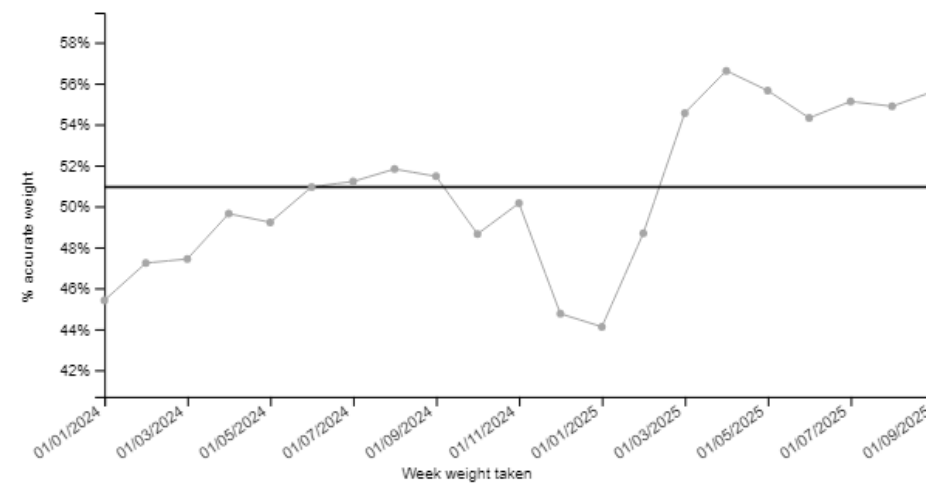
Progress in the last month

- Snack provision digital ordering App being discussed with digital team as part of PDSA cycle.
- Visits completed to all children's wards and report increased satisfaction on snack availability.
- Agreed snack menu would be adapted into admission information for children and parents/family
- Awaiting date to relaunch Children's Menu and taster session
- Awaiting changes visually of the children's menu from Bayouth
- Task & Finish Group for Nutritional Risk Assessments has commenced: completed scoping exercise in wards in Morriston. Areas include Wards C, K, W, H, G and Clydach report is being complete – first analysis of feedback suggests more education and more prompts on WNCR system. Weight equipment still an outstanding issues in complex areas of care. Current Dashboard Data shows across the Health Board a weight available is 68% and an accurate weight at 51%
- NPTSSG are progressing well with the menu choices as visual aids/photos of textured meals in NPT.
- AMAT DATA on monthly audits across the Health Board sites recorded for - September shows scores:
- Compliance with access to Nutrition and Hydration - 100%
- Nutritional Risk Assessments completed on admission in 24 ours - 83%
- Nutritional Risk Assessments - rescreening - 96%
- Food & Fluid Charts appropriate completed - 100%
- Weight taken within 24 hours of admissions - 77%
- Hydration - agreed to roll out traffic light jug system – poster being completed and areas to be agreed across the service groups

% weight available by week weight taken



% accurate weight recorded by week weight taken



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 pilot site to be agreed	JW & stakeholders	October/November 25
Children's Menu re-launch	JW & Catering Departmen Morriston	October/November 25
Change layout of menu	JW & Catering Department Morriston and Bayouth	October/November 25

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 – Sept2025

Methods:

1. Introduction or update of Early Warning Systems (EWS) in all appropriate areas, lead 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:

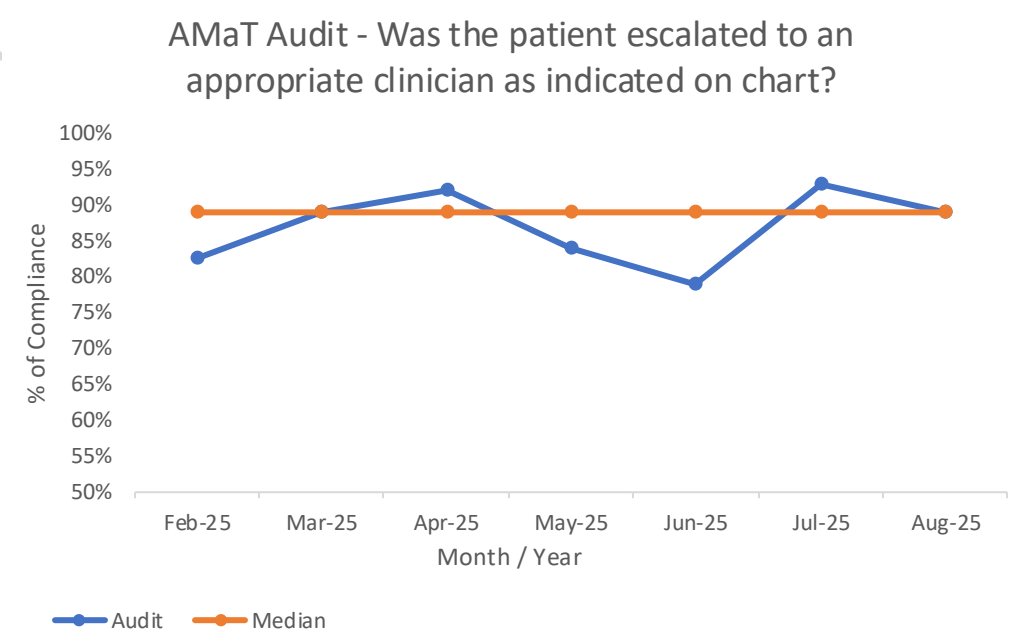
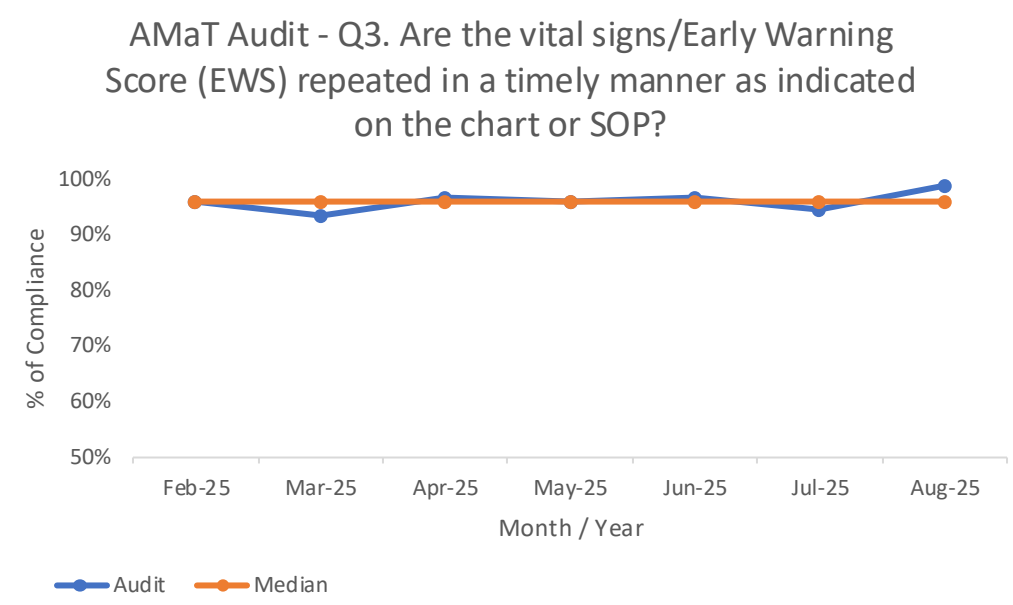
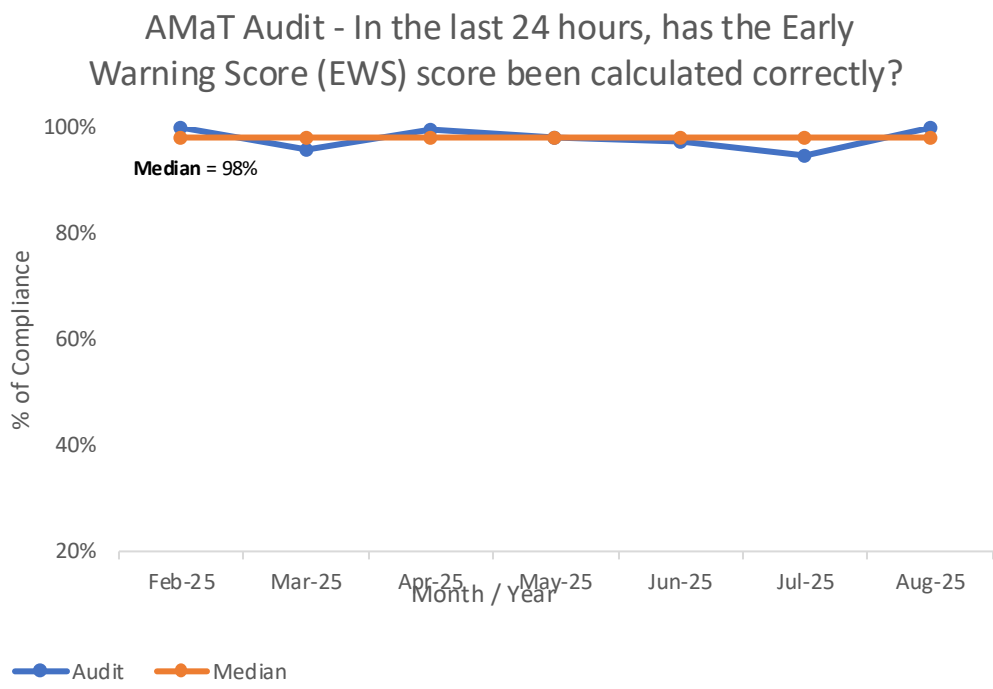
- Engagement of all service groups
- Robust understanding of EWS escalation data over time.

Key achievements:

- All EWS implemented within prescribed timelines.
- 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.
- Incorporated Patient reported wellness score to NEWS 2, putting the patient's voice at centre of care, the only HB in Wales to do this, it has now been recommended By the Acute Deteriorated

Progress in the last month:

- NEWS 2 Launch 2nd Sept 2025
- Planning for WHO World Patient Safety Day- Safe care for every newborn and every child, celebration day 17th September 2025.
- Planning to launch of SBUHB Call for Concern plan on World Patient Safety Day.
- MEWS launched 15th July
- PEWS launched 1 July
- NEWS 2 launch rescheduled for 2nd Sept, although this is due to printing and procurement issues it has given us time to strengthen the training and learn from Welsh colleagues who launched in July.



Quality Priority – Falls

Goal – Reduced falls and harm in hospital and across Primary Care and Community services by 10% in 2025/2026

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

Month – July 2025

Methods

- Falls audit to be integral to ward assurance audits on AMAT
- Embed reporting structures from service groups Targeted QI input to high falls rate wards
- Development of National falls training
- Promote public health campaigns re: healthy lifestyle and physical activity e.g Reconditioning.

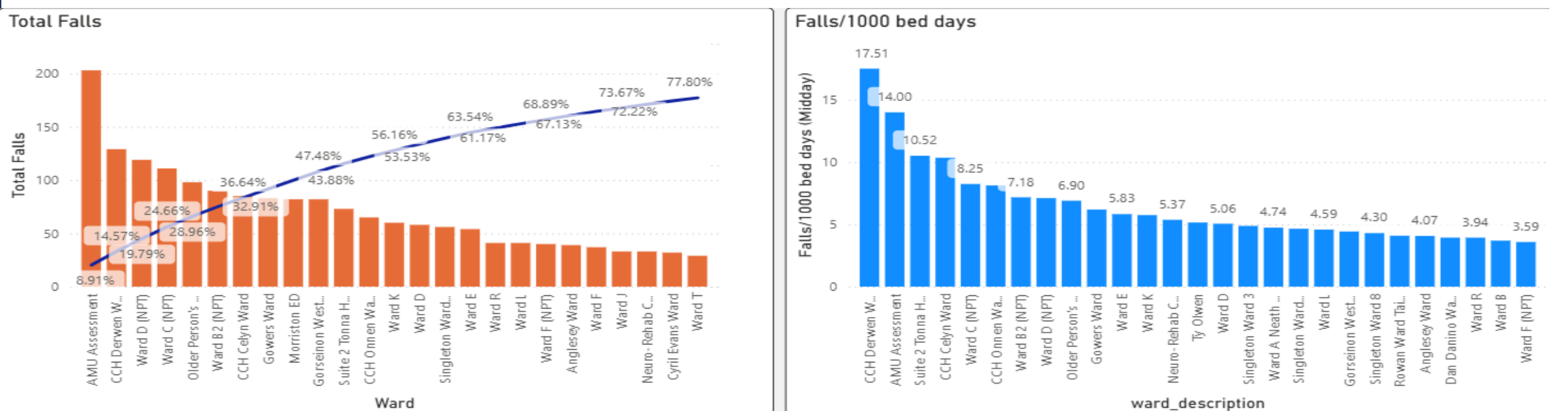
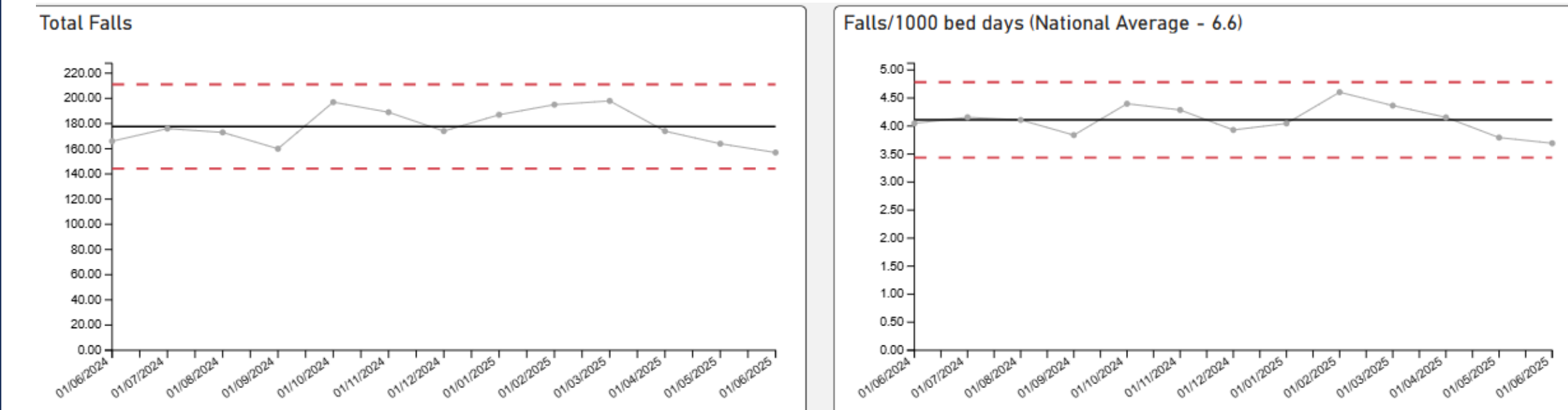
Other critical success factors

- Regional falls prevention taskforce
- Overarching Falls Prevention steering group
- Activity within 6 Goals framework

Key achievements

- Serious incident reduction since QP start of 85% since 2022
- Level 1 falls response in Dom care and care homes LIVE – currently supporting 500+ individuals
- Level 1 falls response training completed: 281 individuals trained in falls prevention, safe retrieval from ground, use of iStumble App
- Procurement of lifting equipment for use in care homes and Dom care as roll out of iStumble project
- Agreement of Falls working model (to be utilised and populated in PCT Cluster falls prevention summit)
- PCT GP cluster Falls summit held – Action Plan generated with key deliverables
- Development of Dom care and Home care iStumble Falls response service Dashboard
- Bespoke Falls training delivered to COPD team
- National deconditioning assessment phase 2 complete – out for regional testing
- Waiting well Falls prevention web page launched

Key Outcome Measure/s –



Progress in the last month

- Development of Stay Strong, Stay Well app – avoiding deconditioning – pt self help tool
- National Pilot of level 1 / 2 St Johns ambulance response underway (started June 2025)
- Shortlisted for NHS Wales Award – Working together – regional falls response model
- Falls made national priority – 6 Goals governance

Actions for the next month	Responsible Owner	Due Date
Upload historic data to care home falls dashboard	EDA	Aug 25
SCP – further deconditioning app development and testing	EDA	Sept 25
Active August – comms campaign plus 2 staff/patient/visitor training sessions	EDA with RAs	Aug 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 – September 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

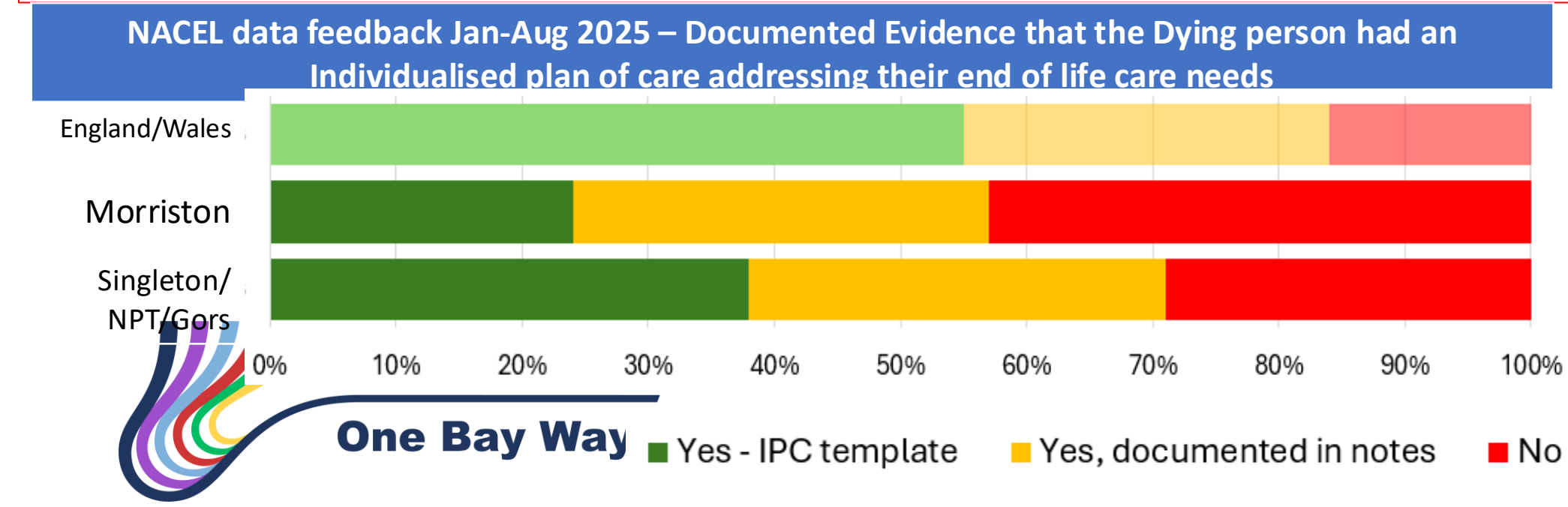
- Medical engagement with EOLC throughout service groups, demonstrated through medical EOLC champions within each service
- All Service Groups to participate in completing the Health Board End of Life Care audit.
- Digital resources – informatics and systems

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

- 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

- Bereavement Survey component of NACEL – approximately 70 responses (Morriston 61-70 and Singleton/NPT/Gorseinon 0-10)
- Submitted HB/organisation information for NACEL audits – Morriston; Singleton/NPT/Gorseinon; Mental Health and Learning Disabilities
- Submission of HB Baseline Assessment of Adult Specialist Palliative Care service and End of Life Care services to NHS Performance and Improvement
- End of Life Care questions/Care Decision guidance to support Five Priorities of the dying patient added to Monthly Ward Audit on AMAT
- Review of Cases – Deaths in ED 2022 and 2024 presented to HB QSAG group

Actions for the next month	Responsible Owner	Due Date
Summary of findings of Staff Survey (replication of NACEL Staff Survey) with District Nursing Team – Awaiting Recommendations	Katie Jones	Sept 2025
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

Quality Priority Risks - Link to [QP Risk Monitoring](#)

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, MIHL & 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 Morrision service groups, demonstrated in lack of audit, mitigated through group nurse and medical director and designated service group leads. Oct 2024- Morrision QP lead identified awaiting update from them.	Review of reporting structure agreed by SGCD. Support with aspects of audit. Morrision 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 (Swansea
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 clinical 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 Bz
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