Meeting Date	**26 July 2022**	**Agenda Item**	**6.3**
Report Title	**Quality and Safety Priorities Progress Report**		
Report Authors	Angharad Higgins, Interim Head of Quality and Safety Hazel Powell, Deputy Director of Nursing		
Report Sponsor	Hazel Powell, Deputy Director of Nursing		
Presented by	Angharad Higgins, Interim Head of Quality and Safety		
Freedom of Information	Open		
Purpose of the Report	To share with the Quality and Safety Committee report on the progress of the quality and safety priorities		
Key Issues	**Falls** - Impending change to the SRO for the priority - Inconsistent achievement of reduction of 10% in the number of injurious falls over past 6 months - HB-wide achievement of rates of falls per 100 bed days below national average of 6.6 - There is a recognised need for methods and outcomes for falls prevention within community and Primary Care settings **Sepsis** - Introduction of Sepsis audits and Sepsis trolley audits to establish baseline - Review of Sepsis training **End of Life Care** - Need for clear measurable outcomes to demonstrate impact **Suicide Prevention** - Launch of Sharing Hope project - Review of goals, methods and outcomes set to review scope of priority		
Specific Action Required ***(please choose one only)***	**Information** ☒	**Discussion** ☐	**Assurance** ☒	**Approval** ☐
Recommendations	Members are asked to: **~~1. Note/Receive/Consider/Approve/Recommend/ Endorse~~**			

1. INTRODUCTION

Quality and Safety Committee has previously been advised of the five quality and safety priorities set out in the 2022/23 annual plan and their associated goals, methods and outcomes. The five quality and safety priorities are

- Falls Prevention
- Sepsis
- End of Life Care
- Suicide Prevention
- Infection Prevention and Control.

This paper provides an update on progress against these priorities, identifying

- Goals
- Evidence Base
- Progress against outcomes
- Critical success factors and responsible leads
- Risk to delivery
- Recommendations

Infection Prevention and Control reports directly to Quality and Safety Committee and therefore is not included within this report

2. BACKGROUND

Appendix 1 outlines progress within each of the priorities and actions required, in summary these are as follows:

Quality and Safety Priority	**Falls**
Implications	
1. Quality and Safety Committee are asked to note the change in SRO for the Quality Priority 2. Service Groups are required to put in place reporting systems to measure - Compliance with multi-factorial falls risk assessments in in-patient areas - Services or ward areas with rates of injurious falls above national average for falls per 1000 bed days 3. Service Groups are required to engage with the Programme Manager and QI lead to seek targeted support for areas of high falls 4. PCT Service Group are required to work with the SRO, Programme Manager and QI lead to develop methods and outcome measures 5. Workforce and OD support is required to ensure that training on falls is accessible 6. Communication Team support is required to develop podcast recordings to raise falls awareness 7. Informatics support in developing a digital method of gathering falls data at ward, service and organisational level is required	

Quality and Safety Priority	Sepsis
Implications	
1. The priority's goal requires review to include the management of Sepsis outside of hospital settings 2. Methods will be required from the SRO and PCT Service Group to support the revised goal 3. Service Group are required to ensure that they have identified Sepsis leads in all clinical areas 4. Identified data analysis support is required to identify trends/ deviation. The Project Manager will scope out this need	

Quality and Safety Priority	End of Life Care
Implications	
1. There is no designated project manager for this priority, this will be discussed within the working group and a solution identified 2. Workforce and Organisational Development support is required for the development of a strategic approach to EOLC training 3. Service Groups are required to - Establish their training compliance and develop training plans to achieve 95% compliance with EOLC training, with specific regard to medical staff training - Identify individuals who will support the current NACEL audit - Ensure that Care Decision Guidance is used and build this into their local audit plans, reporting into the EOLC QP group	

Quality Priority	Suicide Prevention
Implications	
1. Note the planned review of the GMOS in order to include wider suicide prevention work, beyond that of prevention of staff suicides 2. Service Groups are required to - Review their compliance with the requirement to undertake ligature risk assessments within clinical areas and to liaise with the Assistant Director of Health and Safety to advise of compliance, by 31.8.22 - Review their training needs with regards to Suicide Prevention, in conjunction with the Project manager, in order to identify the levels of training within their teams	

3. RECOMMENDATION

Quality and Safety Committee are asked to receive this report and note the required actions by Management Board.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
The priorities set out how we will improve the safety and quality of our care in five key areas in order to improve patient experience and outcomes.		
Financial Implications		
None.		
Legal Implications (including equality and diversity assessment)		
None		
Staffing Implications		
None.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
This reflects the requirement of the Act with regard to population health and adopting a system wide long term approach to health improvement.		
Report History	Management Board 13th July 2022 Quality and Safety Committee July 2022	
Appendices	Appendix 1 Quality and Safety Priorities Update Report	

Appendix 1: Quality and Safety Priorities Update

Falls Prevention

Senior Responsible Officer	**Lesley Jenkins,** current SRO for In Patient Falls, meeting on 13.7.22 to agree SRO for Falls Priority, to include community and in patient falls.
Project Manager	**Eleri D'Arcy**
Quality Improvement Leads	**Emma Smith** **Samantha Scott**

Annual Plan Goals

1. Increase patient safety by reducing number of inpatient injurious falls to 195 or below per month, representing a 10% reduction in falls from the 2021/22 injurious falls rates.
2. Achievement of inpatient falls per 1000 bed days below national average of 6.6

Evidence Base

*NICE CG161Falls in older people: assessing risk and prevention National Audit of Inpatient Falls (NAIF) r*ecommendations:

- Multifactorial risk assessment of older people who present for medical attention because of a fall, or report recurrent falls in the past year
- Multifactorial interventions to prevent falls in older people who live in the community
- Multifactorial risk assessment of older peoples' risk of falling during a hospital stay
- Multifactorial interventions to prevent falls in inpatients at risk of falling

Annual Plan Methods

Methods	Accountable Individual	Timescale	Progress
Establish HB Strategic Falls Group with oversight across entire HB, including Primary, Community and Secondary Care.	Deputy Director of Nursing Incumbent SRO for in-patient falls Fall QP SRO	13.7.22	A HB wide group has been established, the term of reference and chairing of this group are being reviewed. The new SRO who will also serve as chair to the group, will be agreed and briefed 13.7.22
Widen scope of current review to include community, WAST and secondary care. *Note: This method and the intended outcomes require review in order to be explicit regarding intended outcomes in each setting. The Falls SRO and*	Programme Manager Falls SRO (once formally agreed)	31.8.22	Methods are in place for in-patient settings, these require refinement in order to identify clear trajectories and accountable individuals at each level. Community and primary care methods and outcomes need to be set out, along

Programme Manager will develop clear methods and outcomes, in partnership with service groups, for ratification by Management Board in August.			with accountable individuals.

Critical Success Factors (CSF)

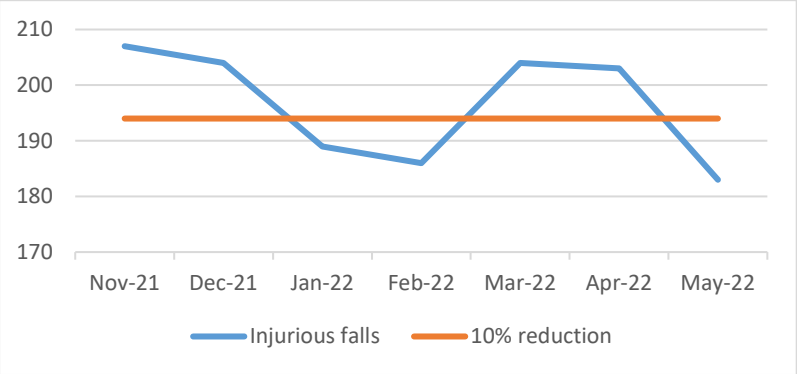
CSF	Accountable individual Tier 1(Director Level)	Accountable Individual Tier 2 (Head of Service, Senior Matron)	Measurement Tool	Baseline	SMART Target
Compliance with multi-factoral risk assessment in in-patient settings	Group Nurse Director	Heads of Nursing	WNCR audit (where used) Ward Metrics	Baselines to be established for each Service Group and provided in August report.	100% by 31.12.22
Establishment of programme of QI support to areas of high incidence in order to undertake tests of change	Programme Manager	Heads of Nursing Falls QI Lead	QI activity reports	Current activity ad hoc and hot co-ordinated	Programme developed and tested in two ward areas by 31.12.22
Increase availability of information and training to staff in order to improve their skills and awareness in falls reduction	SRO Head of Workforce and OD Head of Communication	Project Manager	Training records from targeted training events Number of intranet features Podcast downloads	Ad hoc training provided, no co-ordinated approach	Two targeted training events held by 31.10.22 Two intranet items by 31.12.22 Podcast download

					target to be developed

Progress against outcomes

Rates of Injurious Falls

The rates of injurious falls are not consistently achieving a monthly reduction of 10%. A breakdown of data within service groups is needed in order to identify 'hot spot' areas, where targeted support can be provided.



Falls per 1000 Bed Days

Whilst the Health Board is achieving rates of falls per 1000 bed days, this is not consistently achieved within all ward areas and a greater level of detail is required from service groups in order to identify areas where support can be provided.

Service Group	May-22
Morriston	3.7
NPTH	5.6
Singleton	5.7
PC and T	3.4
MH and LD	4
National Average	6.6

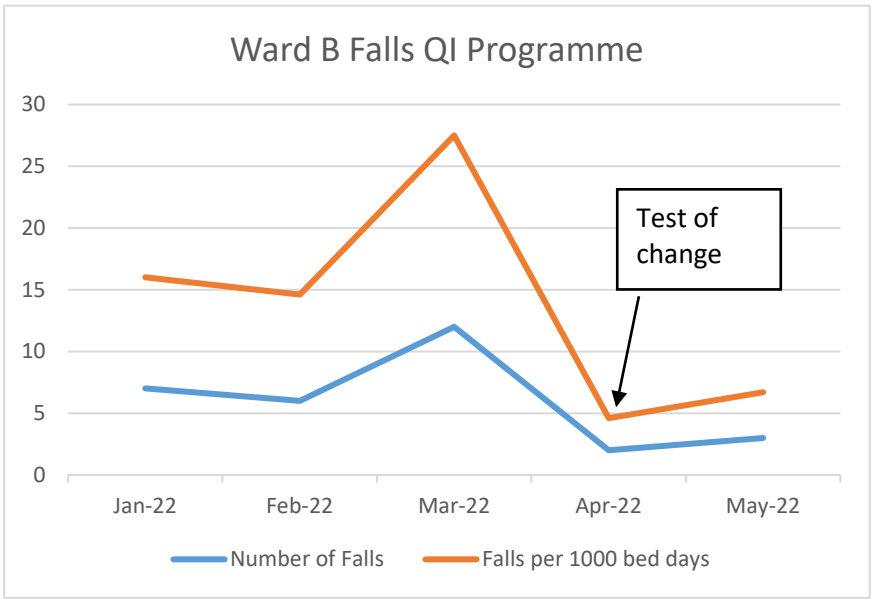
Risks to Delivery

1. Establishment and briefing of the SRO for this priority is pivotal and arrangements are in place for this to be put in place
2. A failure to develop robust methods and outcomes for community falls would risk poor patient outcomes and impact across the whole system
3. A co-ordinated approach to fall prevention skills development is needed in order to reduce the risks associated with a workforce who do not have the skills required to achieve a reduction in falls
4. There is an efficiency risk due to lack of digital information on falls per 100 bed days

Learning and Arrangements for Sharing

'Stumble Stopper' project on Ward B, Morriston.
Ward B, Morriston Hospital introduced a focussed month of falls prevention strategies in April 2022. This included the launch of 'Stumble Stoppers' (an initiative to improve the operationalisation of enhanced supervision of patients) as well as ward based education, focussed safety huddles and a new Falls notice board. The impact on falls rates can be

seen and work is currently ongoing to further evaluate, to plan for spread and scale and to maintain improvements.



Sepsis Prevention

Senior Responsible Officer	Rangaswamy Mothukuri(Sepsis Clinical Lead)
Project Manager	**Lisa Fabb**
Quality Improvement Leads	**Laura Keighan**

Annual Plan Goals

1. Recognition and treatment of all patients with Sepsis within the hospital setting

Note: this goal requires review to include management of risk of Sepsis outside of hospital settings

Evidence Base

Statement on the initial antimicrobial treatment of Sepsis Academy of Medical Royal Colleges (AoMRC), May 2022

Sepsis: Recognition, diagnosis and early management NICE NG51, 2017

Identification of people with suspected Sepsis
Managing suspected Sepsis outside acute hospital settings
Managing acute Sepsis within acute hospital settings
Training and education

Annual Plan Methods

Methods	Accountable Individual	Timescale	Progress
Improve compliance with education of patient-facing MDT staff in the recognition of patients at risk of Sepsis and acute deterioration and Develop a Health Board wide standardised teaching programme.	SRO Project Manager	Review of current training in place and development of new plan 30.R9.22	Review commenced, including attendance at existing training in order to evaluate content.
Ensure Sepsis compliance is captured across the HB to benchmark on a national basis: Aim all patients (100% compliance) are reviewed against SEPSIS criteria *Note: This method requires review to describe 100% of all patients at risk of Sepsis receiving assessment.*	SRO Project Manager	Revised method agreed by 31.8.22	Audit checks commenced to measure compliance

Establish a dedicated SEPSIS TEAM. *Note: This method requires review to describe the establishment of a Deteriorating Patient Team which includes Sepsis.*	Project Manager	Team in place	

Critical Success Factors (CSF)

CSF	Accountable individual Tier 1(Director Level)	Accountable Individual Tier 2 (Head of Service, Senior Matron)	Measurement Tool	Baseline	SMART Target
Identification of Sepsis leads for all clinical areas	Service Group Medical Directors	Clinical Directors	Confirmation of named individuals	No current resource of all named individuals	100% of clinical areas have named Sepsis leads by 31.10.22
Timely assessment for all patients identified at risk of Sepsis. *Note: This description requires review in order to describe the trigger at which a Sepsis assessment would be indicated*	Service Group Medical Directors	Clinical Directors	Sepsis screening audits	Audits completed for Morriston ED, review of Sepsis trolley undertaken on all sites. Baseline to be included in August report	100% compliance with Sepsis audits in clinical areas by 31.12.22
Timely identification and treatment in Emergency Departments	SRO	ED Clinical Leads	Sepsis screening audits	Morriston ED compliance to be included in August report	100% compliance by 31.12.22

Introduction of new Sepsis treatment pathways in line with AoMRC guidelines	SRO Group Medical Directors	Clinical Directors Project Manager	Audit programme	Tool not yet introduced	To be advised in August report

Progress against outcomes

A number of work streams have been initiated to support achievement of the goals, these include

- Sepsis trolley audit across all sites
- Morriston ED audit
- Liaison with all service groups
- 2 QI tests of change using Sepsis stickers.

The audit work is being undertaken in order to establish a baseline for improvement and future reports will include this information and outcomes measures against the goal.

Risks to Delivery

1. The lack of data analysis function risks our ability to measure compliance and to identify deviation from norm

Learning and Arrangements for Sharing

Learning from the two quality improvement tests of change will be report once available.

End of Life Care

Senior Responsible Officer	**Sue Morgan** Clinical Lead
Project Manager	There is currently no designated project manager for EOLC
Quality Improvement Leads	**Emma Smith** **Samantha Scott**

Annual Plan Goals

1. Improve the compliance and recognition of End of Life Care

Evidence Base

NICE Quality Standard 13 End of life care for adults covers care for adults (aged 18 and over) who are approaching their end of life.

The **five priorities for care of the dying person** are:

1. That the possibility (that a person may die within the next few days or hours) is recognised and communicated clearly, decisions made and actions taken are in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

Annual Plan Methods

Methods	Accountable Individual	Timescale	Progress
Review findings of National Audit of Care at End of Life (NACEL): - Build in feedback mechanism from HB mortality Reviews, - All Patients to be recognised and receive EOLC throughout HB *Note: This method requires review in order to differentiate between method,*	Review of NACEL audit : SRO and Group Medical Directors	Submission in line with NACEL timescales	21/22 audit underway

success factor and clear measurable outcome.			
Ensure training in recognition and management of patients approaching EOLC from 1yr down: Review of Mandatory and Statutory training to ensure EOLC adequately provided, >95% staff compliance	SRO Designated QP leads within Service Groups Head of Workforce and OD	31.8.22	Service Groups to review numbers trained in order to establish baseline and set trajectory for achievement of > 95% of appropriate staff *Note: Definition of 'appropriate' to be set within QP Steering Group*

Critical Success Factors (CSF)

CSF	Accountable individual Tier 1(Director Level)	Accountable Individual Tier 2 (Head of Service, Senior Matron)	Measurement Tool	Baseline	SMART Target
Medical engagement with EOLC throughout service groups, demonstrated through medical EOLC champions within each service	Group Medical Directors	Clinical Directors	Service Group reports	Not available	50% of services with at least one EOLC champion within Medical Team by 31.10.22, to increase to 100% by 31.12.22
All areas of SBUHB appropriately utilising the All Wales Care Decision guidance to support care in the last days of life,	Group Medical Directors	Clinical Directors	NACEL Clinical audit programme	To be included in August report	Development of audit plan by 30.9.22 >70% compliance by 31.10.22 > 85% compliance by 31.12.22
Service group engagement	Group Medical Directors	Clinical Directors	SRO report	Not available	Named individual from each Service

in NACEL process					Group to have actively supported NACEL audit 30.9.22

Further CSFs and trajectories for improvement will be included in the August report following joint work with the SRO and QI leads, these will include

- Promotion of Welsh Clinical Portal (WCP) to record conversations around Advance and Future Care Planning. Welsh Government feeds back details of the number of Advance and Future Care Plans in place
- Review of Primary Care Palliative Care Register to support advance and future care planning
- Introduction of My Life My Wishes to support advance and future care planning for patients supported by the Virtual Wards, with the aim to roll this out further across the Health Board
- Development of facility in SIGNAL to record patient needs for support with advance and future care planning (as indicated by estimated prognosis). This is being presented at the SIGNAL user forum in July, and is planned for both secondary care and the Virtual Wards
- Inclusion of triggers for various steps in advance and future care planning and critical illness conversations in Health Board strategies where patients have progressive, life limiting conditions

Progress against outcomes

Work has commenced to develop reporting mechanisms for the priority, it is imperative that this is concluded and that future reports include a clear suite of outcome measures.

Risks to Delivery

1. There is a risk to delivery of quality priority due to the lack of a designated project manager, this will be discussed with the SRO and EOLC QP Group and a proposal developed by 31.8.22
2. There is a risk to delivery of the priority due to lack of agreed outcome measure and trajectories for improvement. This is being addressed through joint work with the QI team and SRO.

Learning and Arrangements for Sharing

None identified within period.

Suicide Prevention

Senior Responsible Officer	**Stephen Jones** Chair Suicide Prevention Group
Project Manager	**Jayne Whitney**
Quality Improvement Leads	**Emma Smith** **Samantha Scott**
Annual Plan Goals	
Suicide Prevention - early recognition of anxiety and depression leading to risk of suicide	
Evidence Base	
Nice quality Statements 189 Statement 1 Multi-agency suicide prevention partnerships have a strategic suicide prevention group and clear governance and accountability structures. Statement 2 Multi-agency suicide prevention partnerships reduce access to methods of suicide based on local information. Statement 3 Multi-agency suicide prevention partnerships have a local media plan that identifies how they will encourage journalists and editors to follow best practice when reporting on suicide and suicidal behaviour. Statement 4 Adults presenting with suicidal thoughts or plans discuss whether they would like their family, carers or friends to be involved in their care and are made aware of the limits of confidentiality. Statement 5 People bereaved or affected by a suspected suicide are given information and offered tailored support	
Annual Plan Methods	

Methods	**Accountable Individual**	**Timescale**	**Progress**
Education of all available staff across the HB in recognising and managing suicide.	Head of Workforce and OD SRO Project Manager	To be included in August report	Progress made in training outlined within later section of this report
Continue to support and work with Swansea Multi Agency Group and other stakeholders across the HB in relation to obtaining a baseline assessment of suicide cases and map against national trends *Note: This method requires review to*	SRO	Engagement completed, engagement is ongoing and MAG are represented within QP Group	

reflect that establishing a baseline is work being undertaken outside of the HB			
Occupational Health and Wellbeing support for staff with anxiety/depression to prevent escalation in risk of suicide	Head of Staff Health and Wellbeing	No timescales set within method, clear trajectories and measures required	Progress outlined in later section of report
Remove ligature risks across all HB premises	Service Group Directors	To be advised by Head of Risk and Assurance	PSN not declared as complete

The delivery of this priority has had a keen emphasis on the prevention of staff suicides through increased staff training and staff access to wellbeing and support services**.** Progress in these areas are listed below, it is now timely that the Quality Priority Steering Group review their Goals, Methods and Outcomes. This review should reflect the requirements of the Talk to Me Too Strategy and aim to achieve a reduction in risk of suicide across all HB areas including within higher risk groups, for example HMP population.

Critical Success Factors (CSF)

CSF	Accountable individual Tier 1(Director Level)	Accountable Individual Tier 2 (Head of Service, Senior Matron)	Measurement Tool	Baseline	SMART Target
Delivery of Sharing Hope project to provide creative outlet for staff at risk of suicide	SRO	Project Manager Sharing Hope lead	Engagement within project Completion of artistic project Funder evaluation report	New project	> 100 participants to engage with project during its duration (2 years) >90% of participants within project to report positive benefit at completion of project

Further work is required to refine the critical success factors in relation to staff training, in order to outline what staff require what level of training. The current internal target of 95% of all staff trained is too broad and does not take into account prioritisation of specific roles.

Progress against outcomes

The Project Manager and QI leads are working to describe the outcome measures and develop a reporting template for the priority, which will be in place for the August report. Current reported progress includes:

Staff Suicide

The Suicide Prevention QI Action Plan June 2022 states there has been zero Staff suicides Since January 2022, Further work is needed to understand the data source and baseline for the last 5 years.

Staff Engagement

The Sharing Hope project has commenced. This project uses a creative approach to supporting staff in talking about their mental wellbeing post-Covid. To date 50 staff have engaged in launch activities as part of the project.

Future reports should include details of referrals from people expressing suicidal thoughts and PROMS from the Wellbeing Service.

Training

Clear measures to outline the number of staff trained to different levels are required, as well as trajectories for improvement, these are being developed by the Project Manager and QI lead.

TRiM Training

There are 70 staff members that have been trained as TRiM Managers, TRiM Practitioners and TRiM Supporters since July 2021.
The aim is to have 50-100 TRiM personnel, with a focus in 'hot spot' areas where staff are more likely to be exposed to trauma. Initially Trim was rolled out in 7 early implementer sights. During Stage Two, Occupational Health and Wellbeing trained TRiM supporters in other areas.

Further work is required to describe the trajectory for achievement of TRiM trained staff in 'hot spot' areas.

REACT Training

REACT is a Health Board wide training which is open to all staff. There are 22 trained REACT facilitators. 832 staff members have had REACT training since November 2021. The cumulative total of those trained in REACT to date is 1768.

Since March 2022 there has been a decrease in the number of staff attending training, due to poor uptake and high numbers of cancellations. The programme is being reviewed with a view to developing an on-line suicide prevention training programme for staff.

Risks to Delivery

1. There is a risk of being unable to measure impact within this priority due to the lack of real time information on suicide rates, this will be considered as part of the review of GMOs.

Learning and Arrangements for Sharing

Positive feedback received from IHI/ Improvement Cymru on the first creative output of the Sharing Hope project, this piece will be shared as part of World Suicide Prevention Day in September.