Highlight Report to Quality and Safety Committee

Name of Reporting Group	Quality and Safety Group
Date of Last Meeting	May 16th, 2023
Author	Angharad Higgins, Head of Quality and Safety
Sponsor	Gareth Howells, Director of Nursing, Hazel Powell, Deputy Director of Nursing
Presenter	Gareth Howells, Director of Nursing
Appendices	Appendix 1: Summary of progress against Quality Priorities Appendix 2: Quality Priorities Programme Updates Appendix 3: Quality Strategy Implementation Plan Appendix 4: Process for Managing Internal and External Reviews

Summary of the Meeting

This report provides a monthly update position on the work of the Quality and Safety Group and a monthly update on the Health Board Quality Priorities.

Learning from Patient Experience

A patient story regarding was presented by Morriston Service Group on a positive patent experience from the Orthopaedic Team.

Lymphoedema Network Update

Paper presented highlighting the following

- Change in directorate to Director of Therapies
- Discussions underway to develop Clinical Reported Outcome Measures via Microsoft 365
- A consultant has been appointed to undertake psychology work and funding for counsellors is available
- Vacancies within the team are being advertised
- A notes audit is underway and will be formally reported within the Network
- An annual report will be produced and reported to this group.

Medicines Management Quality and Safety Structures

Presentation received on the current Medicines Management governance structures, noting that the greatest challenges are in relation to medicines shortages or recalls.

Agreed that the current reporting arrangements for Controlled Drugs to Patient, Safety and Compliance Group to remain.

Quarterly reports on Medicines Management to be received by QSG.

Service groups have been asked to report on thematic learning in relation to medicines management by July 2023.

Acute Medical Unit Assurance Report

An informal review was undertaken by the Corporate Quality and Safety Team in February 2023. This identified concerns in relation to

- Access and egress
- Patients being accommodated in mixed sex bays for longer than appropriate
- Infection control issues

Morriston Service Group reported that there is an active improvement plan in place and that progress is being made against key metric. The plan will be reported to the next meeting of this group.

National Policy on Patient Safety Incident Reporting

The new policy was shared, highlighting that

- This policy covers patient safety, incident reporting and the management across all Services including independent contractors.
- There is a focus on clarification of requirements of initial assessment following identification of an incident.
- The policy refers to the Yorkshire Contributory factors being built into the investigation tools and it has included the list of NHS Never Events and Just Culture.
- The policy also reflects the Duty of Candour and the requirements under that with clear descriptors of accountability for completion and closure.
- Policy is explicit in terms of Primary care in relation to incident reporting and sharing learning also engaging patients and services users.

Management of Internal/ External Reviews

A process for managing the Health Board response to internal and external reviews was agreed. This is included as Appendix 4.

Internal Audit Review of Governance Arrangements Draft Report Update

Draft report received and reasonable assurance achieved.

Patient and Stakeholder Experience Group update

An update on the May meeting was provided which included:

- Annual review of the group's achievements undertaken
- Good practice from within service groups need to be given increased profile
- No items for escalation, though challenges in the service groups' ability to meet complaints response targets was noted

Patient Safety and Compliance Group

The May meeting did not take place. A request for a standard reporting template was made so that items for escalation can be clearly recorded.

Clinical Outcome and Effectiveness Group

Paper was noted with the following key points:

- Audit showed data point not up to speed, being addressed by National Audit of Inpatient Falls response
- Plan submitted for group to present clinical audit plans completion at a minimum.
- Mortality dashboard currently being developed

Safeguarding

- There has been a 92% increase in referrals to the Safeguarding Team since last year.

Safe Care Collaborative

An update on the Health Board progress on projects within the Safe Care Collaborative was provided. All work-streams are in different stages, with particular progress being made within the Falls and End of Life care work0streams.
Future reports from the Collaborative will be brought through the Quality Priorities Programme Board.

Quality Priorities Programme Board

The Board is currently looking at the goals, methods and outcomes for our existing priorities and the new priorities of nutrition hydration, pressure ulcers and dementia audit.

Issues for Escalation from service groups (which have not been raised within QSG sub-groups)

Mental Health and Learning Disabilities

- No issues for escalation.

Morriston

- Introduction of National Safety Standards for Invasive Procedures (NATSSIP), extended to 8 processes, plan is for small rollout end April 23 for wider consultation. Feedback on progress to come to QSG in June
- Themes for safety summits agreed as – Unscheduled Care Pathways, Local Safety Standards for Invasive Procedure and electronic prescribing.

Neath Port Talbot Singleton

- No issues to escalate.

Primary Care Community Therapies

- No issues to escalate

Quality Strategy Implementation Plan

The first draft plan was shared with the group for comment and the group were advised that progress will be reported to Management Board and Quality and Safety Committee on a monthly basis. This is included as Appendix 1. Additional work-streams to achieve the quality ambitions will be added as delivery of the Strategy progresses.

Summary of Actions' Status at 18.5.23

Actions not yet started	Actions On Track	Actions Off Track	Completed Actions
45	19	0	1

Key Decisions

- Approval of process for managing internal and 4 external quality reviews

Challenges, Risks and Mitigation

QSG

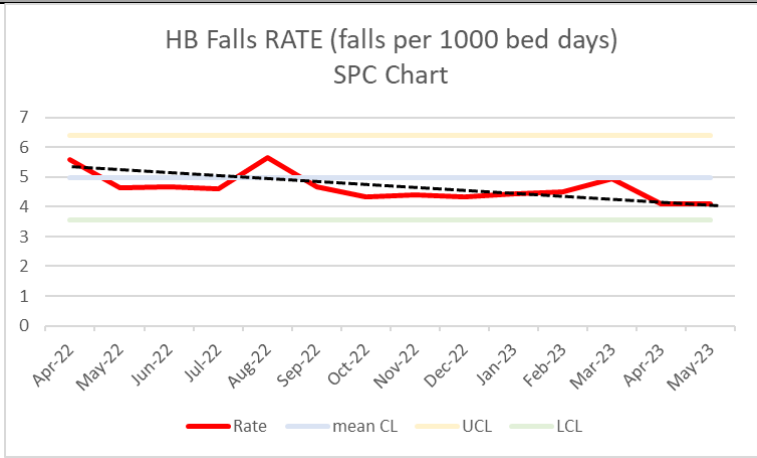
- Capacity risks within the Safeguarding team

Action Being Taken (what, by when, by who and expected impact)

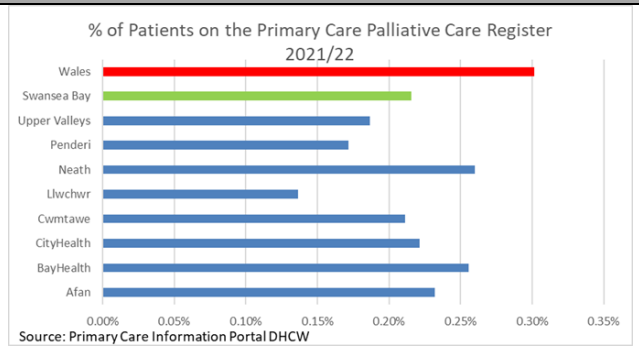
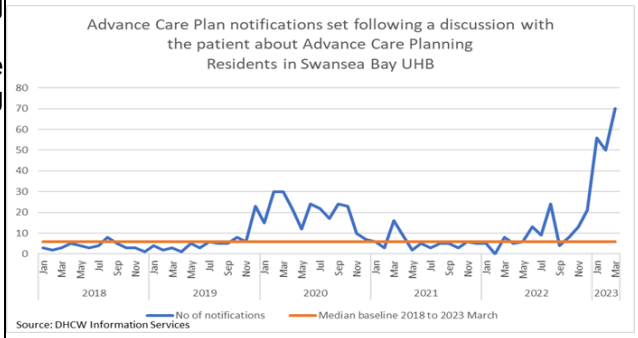
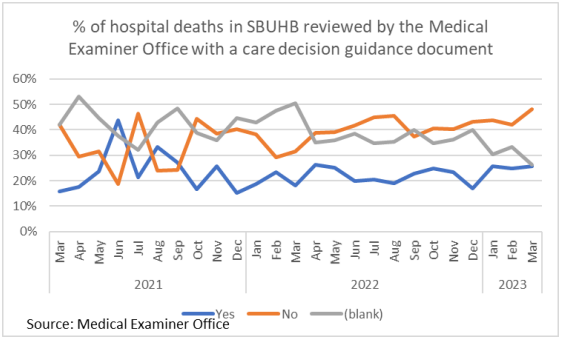
- Increased capacity within Safeguarding fed into IMTP process

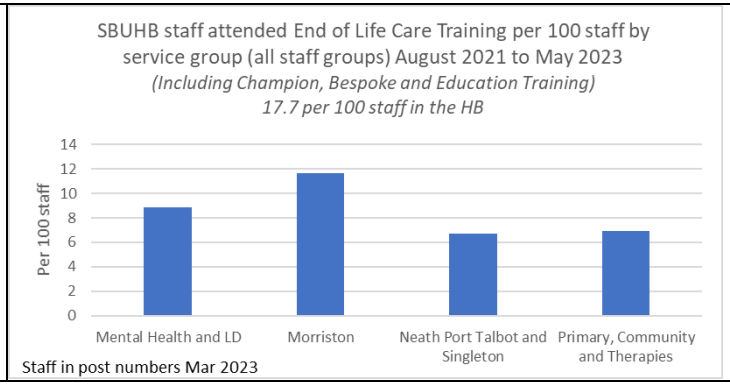
Financial Implications
None
Recommendations
Members are asked to: - Endorse the decisions made within QSG in relation to management of internal and external reviews

Appendix 1 Quality Priority Updates

Quality Priority Goals	Methods
Falls Prevention **Reduction in harm from falls** **'Deep dive' update provided to Management Board April 2023**	• Engagement with third sector partner agencies through Regional Falls Prevention Taskforce • Improved Quality Assurance through new audit programme – service groups trialling • HB Training programme to be agreed • Focus on Reconditioning as pan health board approach – planning phase and to be dovetailed with West Glamorgan's SAFER bundle launch
Measures	**Trajectories**
• Falls per 1000 bed days	

- Continued reduction in overall falls rates
- Community falls prevention to be area of focus for 2023 with engagement with safe care collaborative
- Development of Health Board Falls Strategy in progress

Quality Priority Goals	Methods
End of Life Care **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**	• Increased correct identification of people who may be in the last year of life • Increase Advance & Future Care Planning 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 advance and future care planning across all care settings
Measures	**Trajectories**
1. % Swansea Bay UHB resident deaths outside of hospital – *this measure may change due to ONS license issues nationally* 2. % of patients on the Palliative care register 3. Number of advance & future care plan notifications in WCP 4. Number and % of deaths reviewed by the medical examiner with a care decision guidance document 5. % of deaths within 48hrs of emergency attendance 6. Number of staff given education and training in EOLC 7. Systems enabled to share end of life care/advance & future care planning information across platforms	  



- ONS deaths access issue – uncertainty on how we can use ONS deaths due to license concerns, Digital Intelligence to inform what can be used to understand deaths locally and validate the measure.
- Palliative care register numbers – only available yearly. Work within primary care to standardise this and encourage further recording.
- A&FCP notifications in WCP are increasing – request with DHCW to determine which teams this might be, there has been renewed efforts in Specialist Palliative Care.
- Care decision guidance for last days of life is promoted through the EOLC training and will be available in WNCR next year.
- Measure for in-hospital deaths within xx hrs being developed.
- Continued delivery of EOLC training through various channels - Champion, Bespoke and Education Training. Champion Training under review and information will need to be reviewed by service group (SG) due to ASMR staff changes. Bespoke training delivered on the request of SGs.
- Solution required to digital issues - need a digital dashboard developed to be accessible to all and understand potential of digital systems to support end of life care – EOLC & SPC dashboard being developed, version1 end of May 23.

Quality Priority Goals	Methods
Sepsis: improvement in the recognition and management of Sepsis	• Governance system established at divisional, service group and Health Board level • Audit of acute sites undertaken to provide service groups with baselines • New Sepsis screening form launched • Monthly reports from service groups on improvement work and audit compliance from June 2023

Measures

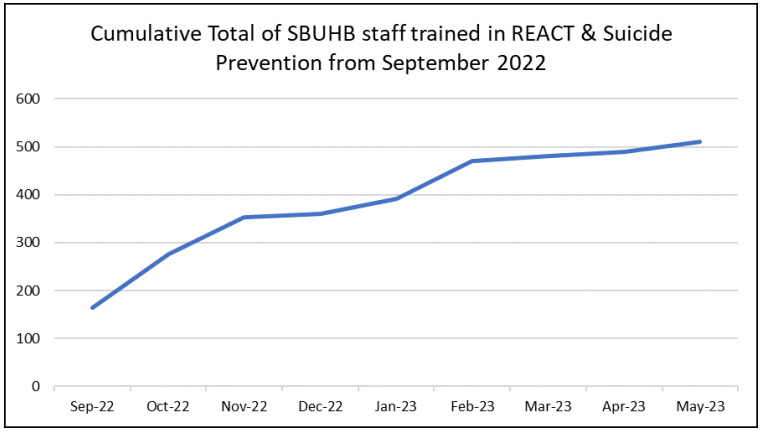
- % of patients appropriately screened for Sepsis

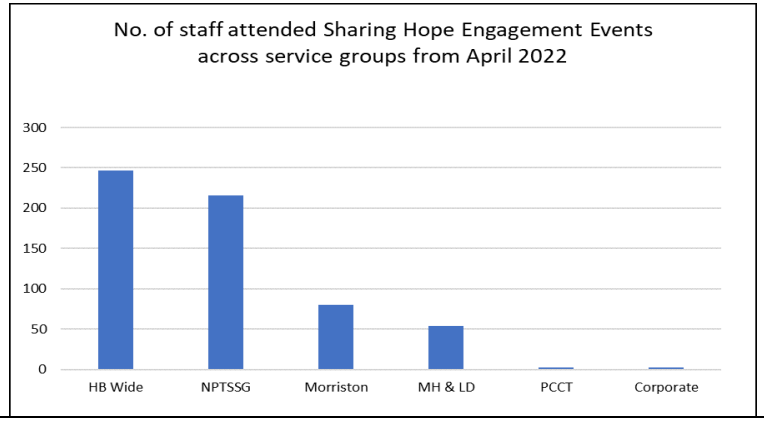
Trajectories

	May 23		June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
% of appropriate patients screened in acute wards in Morriston, NPT, Singleton Baseline May 2023 11% Median May 2023 0%	Trajectory	Not set	>25%	>40%	>55%	>60%	>70%	>85%	>95%
	Actual	11%							
% of appropriate patients screened in AMU Baseline May 2023 25%	Trajectory	Not set	>50%	>70%	>80%	>95%	>95%	>95%	>95%
	Actual	25%							

% of appropriate patients screened in ED Baseline May 2023 53%	Trajectory	Not set	>50%	>75%	>85%	>95%	>95%	>95%	>95%
	Actual	53%							
% wards who have access to Sepsis training and resources	Trajectory	Not set	>75%	100%	100%	100%	100%	100%	100%
	Actual	77%							

- Strengthened management arrangements for Sepsis quality priority including
  - Monthly steering group
  - Monthly meeting with Head of Quality and Safety and Deputy Medical Director
  - Six weekly meetings with service group triumverates
  - Weekly meetings with QI Measurement lead
- Sepsis screening in ED above trajectory
- Health Board wide audits undertaken in Morriston, NPT and Singleton Hospitals in early May
- Sepsis leads confirmed for each service group
- Sepsis champions confirmed across clinical areas
- Sepsis screening tool launched
- Engagement with nursing and medical staff as part of Sepsis screening tool launch

Quality Priority Goals	Methods
Suicide Prevention	• Engagement in Sharing Hope project • Delivery of training in suicide prevention across all teams
Measures	**Trajectories**
• Education of all available staff across the HB in recognising and managing suicide. 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. • Occupational Health and Wellbeing support for staff with anxiety/depression to prevent escalation in risk of suicide. • Remove ligature risks across all HB premises.	



- Successful integration of REACT and Suicide Awareness training.
- Continued success of Sharing HOPE
- Planning for development of HB Suicide Strategy underway
- REACT training to be included in Managers' Pathway

Appendix 2: Quality Priority Work Programme Updates

Falls Prevention

Senior Responsible Officer	**Helen Allendale**
Project Manager	**Eleri D'Arcy**
Quality Improvement Leads	**Sheena Morgan**

Annual Plan Goals

1. Increase patient safety by reducing number of inpatient injurious falls to 161 or below per month, representing a 10% reduction in falls from the 2022/23 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) recommendations:

- 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

Summary of Progress Against Outcomes

December progress position	**Falls Per 1000 Bed Days**	**Number of Falls**
Mental Health and LD	4.7↓ (16% DECREASE compared to April 2023)	20 ↓ (13% DECREASE compared to April 2023)
Morriston	3.8 ↓ (7% DECREASE compared to April 2023)	84↓ (1% DECREASE compared to April 2023)
NPTSSG	5.2↑ (13 % INCREASE compared to April 2023)	55 ↑ (17 % INCREASE compared to April 2023)
PCCT	9.9↑ (25% INCREASE compared to April 2023)	12 ↑ (33% INCREASE compared to April 2023)

SBUHB*	4.1 (No change compared to April 2023)	165 171↑ (3.6% INCREASE compared to April 2023)

- **Continued reduction in overall HB falls rates.**
- **Sustained reduction in falls rates within MH&LD service group.**
- **Increasing rates in Gorseinon hospital – Falls audit planned to review**
- **Community scoping exercise underway with new HB Falls Strategy to follow – expected Aug/Sept 2023**
- **QI projects all progressing with data analysis ongoing.**

Critical Success Factors (CSF)

1. CSF	Accountable individual Tier 1(Director Level)	Accountable Individual Tier 2 (Head of Service, Senior Matron)	Measurement Tool	Baseline	SMART Target	Service Group Updates	HB Progress
Compliance with multi-factoral risk assessment in in-patient settings	Group Nurse Directors	Heads of Nursing	WNCR audit (where used) Ward Metrics	NAIF Audit 2022: 43% compliance with MRFA	100% by 01/06/23	**Mental Health and LD** Audit currently being completed on application of MRFA – awaiting results – not on WNCR **Morriston** Included in HB update **NPTSSG**	Latest WNCR audit suggests 63% compliance with initial MRFA. Target as set by NICE guidelines is completion within 4 hours – current average time from admission to completion of

						Included in HB update **PCCT** Included in HB update	initial MRFA is 41 hours.
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	**Mental Health and LD** QI project of sleep hygiene identified – work in planning stage **Morriston** Baywatch roll out commenced – early analysis in process **NPTSSG** Falls audit shared with service group for wider use **PCCT** Falls audit shared with Gorseinon for use due to increased falls rate	**Safe Care collaboration project – reduce inappropriate WAST Calls Outs and subsequent admission to hospital following fall – focus on domiciliary care provider** **Falls summit completed and scheduled part 2 for wk beg 18/9/23** **See programme of works**

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 intranet items by 31.12.22 Podcast download target to be developed	**Mental Health and LD** ESR training information shared. Training compliance now requested as part of falls report for OFPSG **Morriston** ESR training information shared. Training compliance now requested as part of falls report for OFPSG **NPTSSG** ESR training information shared. Training compliance now requested as part of falls report for OFPSG **PCCT** Training compliance now requested as part of falls report for OFPSG	**ESR data not validated and not reflective of compliance of training available.** **NAIF audit reports ESR Falls prevention Brief intervention training is now Mandatory in 50% of HBs.** **Not mandatory in SBUHB**	

Risks to Delivery
1. Dashboard not yet available – on digital intelligence workstream. SGs unable to act proactively and respond to trends in real time 2. Falls training not made mandatory – uptake poor

End of Life Care

Senior Responsible Officer	**Sue Morgan** Clinical Lead
Project Manager	**Tracy Rowe** (part time)
Quality Improvement Leads	**Emma Smith** **Samantha Scott**

Annual Plan Goals

1. 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

Evidence Base

NICE Quality Standard (QS13) was updated September 2021 and covers care for adults (aged 18 and over) who are approaching their end of life. This includes people who are likely to die within 12 months, people with advanced, progressive, incurable conditions and people with life-threatening acute conditions. It also covers support for their families and carers. It includes care provided by health and social care staff in all settings. It describes high-quality care in priority areas for improvement:

1. Identification - Adults who are likely to be approaching the end of their life are identified using a systematic approach.
2. Advance care planning - Adults approaching the end of their life have opportunities to discuss advance care planning.
3. Co-ordinated care - Adults approaching the end of their life receive care that is coordinated between health and social care practitioners within and across different services and organisations.
4. Out of hours care - Adults approaching the end of their life and their carers have access to support 24 hours a day, 7 days a week.
5. Support for carers - Carers providing end of life care to people at home are supported to access local services that can provide assistance.

Summary of Progress against outcomes

End of life care internal audit gave reasonable assurance in the compliance with end-of-life care (EOLC) quality standards. There are recommendations to ensure NACEL audit recommendations and action plan are aligned, targets for the measures which has been completed for the 2023-24 GMOs and Digital developments for the gaps in data.

Communications – core message shared in May through screen saver and online articles, due in Bay Health magazine in June/July. Dying matters week – Morriston Good Grief event took place on Wednesday 11th May a collaboration between End of Life Parasol Service, Care After Death Service and Ty Olwen Trust which was the largest hosted by the health board "This is the biggest and most successful event for Dying Matters Week we've had so far. Previously, we had a small displays set up from the Care After Death Service and End of Life teams, but this was much more inclusive of all who work together when a person dies. "The overall feeling from this event was that everyone who attended – patients, the general public and our staff – took a lot from it."

Palliative care register project – project team have met and there are plans in June for GP 3 clusters Cwmtawe, Upper valleys and Penderi to start to test out running of the MDT 2 monthly meetings and sharing of patients added to the register to District Nursing to start A&FCP discussions. This project is one of the Safe Care Collaborative projects.

We now have an interim dashboard of information available on a HB and service group level. This work will enable service groups to put in place targeted improvement plans. Engagement with Digital intelligence who are developing a digital dashboard for EOLC & Specialist Palliative Care, first version due end of May 23. We have received a draft of this dashboard but only covers numbers of deaths and doesn't include the other measures key to the priority.

Continued delivery of EOLC training through various channels - Champion, Bespoke and Education Training. Champion Training under review and information will need to be reviewed by service group (SG) due to ASMR staff changes. Bespoke training delivered on the request of SGs.

A&FCP notifications in WCP are increasing – request with DHCW to determine which teams this might be, there has been renewed efforts in Specialist Palliative Care.

Treatment escalation plan pilot started in ED and AMU today, discussions started with Oncology.

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	Service Group updates	HB Progress

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	Currently aim is to have a medical lead by service group	**Mental Health and Learning Disabilities** Medical lead confirmed **Morriston** Medical lead confirmed **NPTSSG** The service group has identified EOLC from Oncology, but representation required from breadth of service group divisions. **PCCT** Medical lead identified	Little attendance at champion training but there are a number who have had bespoke training. Plans to develop a CPD module to encourage medics to attend training
All areas of SBUHB utilising the All Wales Care	Group Medical Directors	Clinical Directors	Medical Examiner death reviews	22% across the main	55%	**Mental Health and Learning Disabilities**	EOLC education and training provides

Decision guidance to support care in the last days of life				hospital sites		**Morriston** **NPTSSG** **PCCT**	information on the care decision guidance QI project to be developed to identify key wards to focus improvements
Completion of the primary care palliative care register	P, C & T Group Medical Director	GP Practices and other care services	Primary Care Information Portal DHCW or local GP data collection if it can be agreed	0.22%	0.40%	**PCCT** Guidance has been developed and awaiting approval from LMC	Safe Care Collaborative is supporting this project Testing to start in 3 clusters Cwmtawe, Upper valleys and Penderi.
Completion of Advance & Future Care Planning	Group Nurse and Medical Directors	Heads of Nursing/ Clinical Directors	Currently A&FCP notifications in WCP	Median 5 per month	100 per month	**Mental Health and Learning Disabilities** **Morriston**	Requested more detail to numbers provided by DCHW

						NPTSSG **PCCT**	Links to scoping work that will take place with Digital to understand where A&FCP can be recorded
Staff given education and training to support high quality EOLC	SRO Group Nurse and Medical Directors	Heads of Nursing/ Clinical Directors	Parasol training database	2533 15.6% of HB staff	3500 by March 2024 21% of HB staff Numbers per area is determined by need of the service group	**Mental Health and Learning Disabilities** 8.8% of staff have attended EOLC training **Morriston** 11.7% of staff have attended EOLC training **NPTSSG** 6.7% of staff have attended EOLC training **PCCT** 6.9% of staff have attended EOLC	Training data processed and provided for service groups individually. Total trained in HB: Champion training – 417 (366 HB staff) Education and bespoke training – 2400 (2060 HB staff) Combined that is 17.7% of HB staff Staff service group needs to be

						training and 34 care home staff	reviewed after ASMR change
Digital communication of A&FCP between care settings	Digital Services			0 system	1 system or improvement in existing systems and how data is recorded	**Digital Services**	Understanding of Coding in sharing meaningful EOLC detail within GP record into WCP Meeting with Digital projects to discuss potential of systems taken place, further discussions required to scope all systems able to share A&FCP information.

Risks to Delivery

1. There is a risk to delivery through limitations of our digital intelligence systems to record discussions relating to EOLC and being able to share between secondary care, primary care, GPOOH, WAST systems. All Wales position on sharing of DNACPR and other A&FCP documentation requires local solution. Initial meetings have took place, further meeting with Digital development to understand scope of A&FCP in current systems and plan for development.
2. ONS deaths access issue – uncertainty on how we can use ONS deaths due to license concerns, Digital Intelligence to work on a change to way that we understand deaths locally but it may mean we are unable to determine place of death outside of an SBUHB hospital site.

Sepsis

Senior Responsible Officer	**Ranga Mothukuri**
Project Manager	**Lisa Fabb**
Quality Improvement Leads	**Samantha Scott**
Annual Plan Goals	
1. Increase the number of patients appropriately screened for Sepsis	
Evidence Base	
• NICE Guidance NG51 • New National Guidelines on treating Sepsis by AoMRC	
Summary of Progress Against Outcomes	
Since the previous report, the oversight and delivery arrangements for this priority have been strengthened. This has been achieved through - Specific support from the Head of Quality and Safety - Introduction of oversight meetings with service groups - QI support to develop measures and reporting tools - Identification of named Sepsis leads at a senior level in each service group In addition, scrutiny and accountability meetings have been put in place with the Sepsis team and service groups in order to address any barriers to delivery. An audit of acute sites was undertaken by the Sepsis and Resus team in May 2023 and service groups are building on this through conducting their own audits in May which will be reported to the Sepsis steering group in June 2023. This data will enable us to identify hot spot areas and put targeted QI support in place to address any issues. In the first instance the following areas have been prioritised: - A and E - AMU - SDMU	

Ongoing support will be provided to complete sepsis audit with sepsis champions and ward managers across adult acute areas and some community sites. The June data is not complete but showing an improvement in number of forms completed but number of appropriate patients screened remains the same.

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A new Sepsis screening tool was launched May 2023 across all adult acute care, mental health, and some community services. Awareness campaign including drop-in sessions for day and night staff on all sites, intranet article, website launch with resources and further training planned.

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	Service Group Updates	HB Progress
Identification of Sepsis lead for Service Groups	Group Nursing and Medical Directors	N/A	Qualitative-confirmation of leads	N/A	Identification of leads	**MH and LD** Confirmed **Morriston** Confirmed **NPTSSG** Confirmed **PCCT** Confirmed	All service groups have identified nursing sepsis leads.

Identification of Sepsis leads for clinical areas	Group Nursing and Medical Directors	**Service Group Sepsis leads**	Qualitative- confirmation of leads		Identification of leads	**MH & LD** Confirmation of leads provided **Morriston** Confirmation of leads provided **NPTSSG** Lead identified for all areas **PCCT** Leads identified in all areas	Morriston, NPTSSG and PCCT have all confirmed local clinical leads. Still awaiting Mental Health and LD. However, some key supporting roles have been identified i.e., sepsis pharmacist.	
Establishment of minimum monthly Sepsis audit programme	Group Nursing and Medical Directors	Service Group Sepsis Leads	Audit reports to Sepsis Steering Group		>95% compliance by 31.12.23	**MH & LD** Not audited June 2023 **Morriston** Awaiting June 23 audit data **NPTSSG**	Audits have been commenced across all acute sites across the HB. The June 23 updates have been delayed due to the industrial action. Updates will be provided by next week	

						Awaiting June 23 audit data **PCCT** Gorsienon Hospital – 100%	commencing 12/06/2023.

Risks to Delivery

Lack of ownership at ward level, this is being mitigated through named senior Sepsis leads in each group.

Senior Responsible Officer	**Stephen Jones** Chair Suicide Prevention Group
Project Manager	**Jayne Whitney**
Quality Improvement Leads	**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	
Summary of Progress against outcomes	
Sharing HOPE - 601 people engaged with the programme since April 22 from the poem and other projects. There have been a number of Sharing HOPE sessions in ITU Morriston Hospital for high-risk trauma these sessions are ongoing throughout the year. The combined total number of people attended the Suicide awareness and prevention and REACT training including newly qualified induction nurses from Sept 2022 = 715 A bespoke REACT & Suicide Prevention training was delivered in March 2023 where 263 NPT Primary care staff attended during there BT4L (Protective time for learning). The Managers Pathway REACT & Suicide Prevention delivered in May 2023 where 7 people attended.	

Critical Success Factors (CSF)from December 2023.

CSF	Accountable individual Tier 1(Director Level)	Accountable Individual Tier 2 (Head of Service, Senior Matron)	Measurement Tool	Baseline	SMART Target	Service Group Updates	Health Board Progress
Delivery of Sharing Hope project to provide creative	SRO	Project Manager Sharing Hope lead	Engagement within project	New project	> 100 participants to engage with		Sharing HOPE 601 staff engaged since April 2022

outlet for staff at risk of suicide			Completion of artistic project Funder evaluation report		project during its duration (2 years) >90% of participants within project to report positive benefit at completion of project		Article and film launched for public viewing Oct 2022. Social platforms Swansea NHS site on Facebook, Twitter and YouTube = 3.7k views as at end of May 2023.
Staff trained in suicide prevention	SRO	Project Manager Service Group Leads	Number of staff trained	REACT: 1739 at end June 22 Basic Suicide Awareness and Prevention: 703 end June 22			New combined REACT & Suicide Prevention Training including newly qualified induction nurses Total trained from Sep 2022 = 715 The Managers Pathway REACT & Suicide Prevention delivered in May 2023 where 7 people attended. A bespoke REACT & Suicide Prevention training was delivered to Primary Care staff during there BT4L (Protective time for learning). Total trained in March 2023 = 263

Staff able to access timely emotional wellbeing support	Head of Wellbeing	Wellbeing Team	Number of staff accessing support who have had suicidal thoughts in past 7 days	11 staff reporting suicidal thoughts in past 7 days (1.1.22-31.5.22)	To be developed		Between Mar 22 to May 23 – 5.64% of cases reported suicidal thoughts in the previous 7 days of initial contact. Between Jan 22 to May 23 – 3% of cases reported thoughts to end life.

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.