Highlight Report to Quality and Safety Committee

Name of Reporting Group	Quality and Safety Group
Date of Last Meeting	April 18th 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

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. The previous report from this group referred to a separate paper on the Sepsis Quality Priority being received by Management Board, this did not occur and the Sepsis paper is to be received by Quality and Safety Group in July 2023.
Suicide Prevention provided a 'deep dive' review for Management Board in May 2023 and have not been included in this report as reported separately.

Learning from Patient Experience

A patient story regarding was presented by Mental Health and Learning Disabilities regarding Speech and Language Therapy and the positive impact on a patient through having person-centred care.

Thematic Presentation: Pressure Damage
Presentation received from R Govier-Williams Tissue Viability Nurse on work underway across the health board to reduce harm from pressure damage. Pressure damage is a quality priority for 2023/4 and this presentation provided an overview of the work underway and priorities for improvement.

Themes presented:

- Areas requiring improvement- Emergency Department and Acute Medical Unit
- Concerns regarding ambulance off-load delays and management of risk of pressure damage at this stage, this is being taken forward nationally
- Development of Patient Reported Outcome Measures and Patient Reported Experience Measures would be beneficial as part of the QI work in pressure damage
- Lack of Tissue Viability Nurse in Morriston

Risk Register

Quality and Safety risk paper from January 2023 shared.
It was noted that Health and Safety Committee has been stood down and the Health and Safety risks will now be managed by the Health and Safety Operational Group.

Patient and Stakeholder Experience Group update

- Events planned for World Patient safety Day in September
- Task and finish group established with DICE and Big Coversation leading, in order to triangulate patient and staff feedback

Areas for escalation

- Human Fertilisation and Embryology Authority review of Wales Fertility Institute being reported through PSC, Gold command in place within service group
- Increase in concerns received from Senedd Members noted by Morriston, these concerns are primarily in relation to waiting times
- MH and LD- positive work around patient feedback tools, to presented in the Patient Safety Congress in September
- Y Llais, Citizen's Voice Body has now been formed and will be invited to a future meeting

Patient Safety and Compliance Group

- Principles for escalation agreed within the group
- Updates received from
  - Additional Learning Needs Steering Group
  - Medical Devices Committee
  - Patient Safety Notice 55- Safe Storage of Medicines

Areas for escalation

- Violence and aggression towards staff in community and acute settings: this will be fed into workforce groups for escalation

Clinical Outcome and Effectiveness Group

Paper was noted with the following key points:

- Two focus presentations were received on the findings of the Health Board Priority Audit Topic – Do Not Attempt Cardio Pulmonary Resuscitation and Discharge Summary Performance in the Ear Nose Throat Department.
- The group were updated on progress with the various tiers of the Audit Hierarchy identified by the Executive Medical Director/Deputy CEO and the Mortality Dashboard.

Safeguarding

- Care Inspectorate Wales Child Protection review has taken place and verbal feedback was received in April, written findings to follow in future reports

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

Mental Health and Learning Disabilities

- No issues for escalation.

- A discussion was held regarding door security and this will be progressed in discussion with the Estates Service.

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
- April 23, Medical Examiner Service managed by Morriston, all deaths across secondary care in Swansea Bay area reporting into SG, this is now being rolled out to community settings
- Duty of Candour process in Morriston currently being tested in Morriston. Initial feedback positive

Neath Port Talbot Singleton

- No issues to escalate.

Primary Care Community Therapies

- CL updated the group around difficult behaviour to staff, working though standardised process to address this issue.
- Duty of candour resource issues, previously escalated
- Managing grade 1 concerns, putting 1 month pilot in place specifically around nursing care, hoping to manage grade 1s as early resolutions

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 9.5.23

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

Key Decisions

- Feedback on Duty of candour process in Morriston to be reported back to QSG
- Process for managing high profile/ high risk Health Inspectorate Wales review to be shared in next meeting

Challenges, Risks and Mitigation

QSG

- HFEA report being managed by 'gold command' within NPTSSG
- Capacity risks within the Safeguarding team
- Risks to delivery of the Duty of Candour identified by service groups

Quality Priorities

- There is a high risk to delivery of the Falls Prevention priority due to the problems with the interface between ward metrics and DATIX, meaning that ward level falls incident data is not readily available. This is an all-Wales issues, which is also affecting other areas of patient safety. Progress has been made with informatics to build a local work around for short term use – this remains in progress.
- End of Life Care (EOLC): there is a risk regarding access to digital intelligence for the priority leads and service groups to routinely access and unclear what is available in systems for recording and sharing of Advance and Future Care Planning (A&FCP).
- Uncertainty on how the HB can use ONS place of deaths information, which may then lead to this being inaccessible in the future.

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

- Falls risk being progressed as part of national discussions regarding Once for Wales
- Meetings have taken place with Digital Projects regarding recording of discussions in relation to EOLC and Digital Intelligence for dashboard development, there is a need to map data and systems relating to EOLC/A&FCP, digital plan to meet internally before meeting with the QP leads again
- Meetings have taken place with Clinical Reference Group to identify solutions for sharing A&FCP documentation across care settings
- Waiting for Digital Intelligence to confirm how we access resident death information in the future.
- Standardisation of Primary Care Palliative Care Register and Meeting - reviewed process being taken to LMC for approval
- Meeting arranged with Workforce and OD regarding sustaining Suicide Prevention training in the longer term

Service Group Actions Required

Quality Priority	Action Required	Leads	Timescale	Impact
End of Life Care	Development of plans to improve training compliance in key areas – identify priority areas for bespoke training and individuals to attend champion training to ensure representatives across all services	Service Group EOLC QP leads	May 2023	Improved knowledge of EOLC, resulting in increased use of key tools, A&FCP, Care Decision Tool and Earlier conversations with the patient – more engaged and changed clinical decision making; improved performance

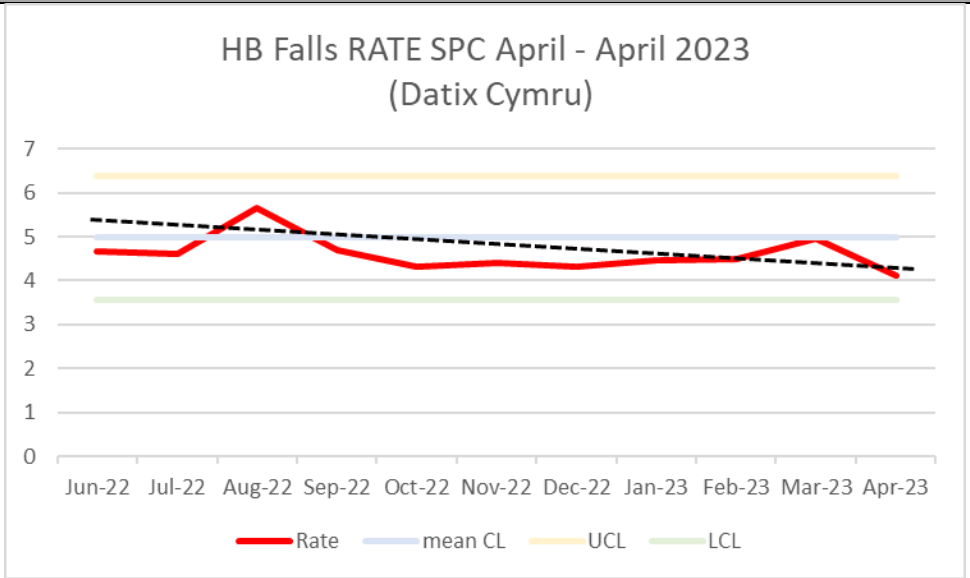
				within the NACEL audit.
End of Life Care	Supporting mapping of current A&FCP and future promotion of A&FCP discussions within available systems	Service Group EOLC QP leads	May 2023	Facilitate sharing of A&FCP to support decision making across all care settings
End of Life Care	Pilot All Wales Treatment Escalation plan within secondary care	MDU, NPTSSG	May 2023	Facilitate consideration of treatment aims (patient priorities and realist treatment options) earlier in the patient's journey – particularly in final deterioration when little reserve to recover
End of Life Care	Standardisation of the Primary Care Palliative Care Register and meetings	PCCT	March 2024	Introduction of best practice to optimise right support at the right time in the right place for people in the last year of life
Suicide Prevention	Develop tier 2 and tier 3	Service group Suicide Prevention QP lead	May 24	Increased awareness of suicide
Sepsis	Identification of Sepsis leads across all clinical areas	Sepsis Steering Group	May 2023	Increased leadership of Sepsis
Sepsis	Monthly audit of Sepsis compliance	Sepsis Steering Group	May 2023	Improved control of Sepsis screening

Financial Implications

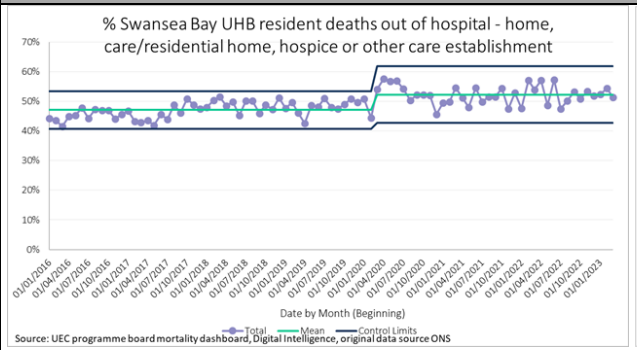
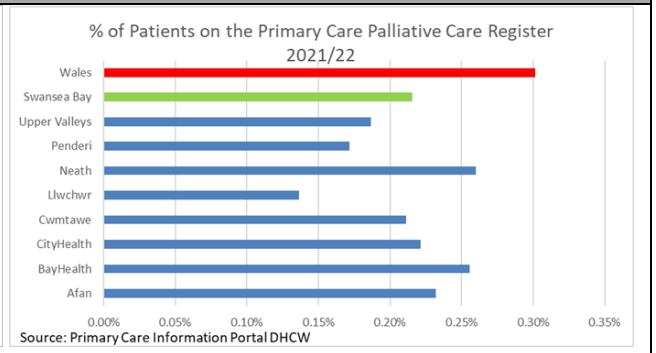
None

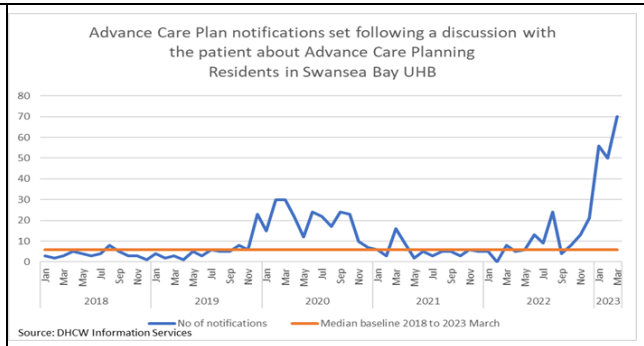
Recommendations
Members are asked to: - Note the update from the QSG - Note the progress being made against the Quality Strategy Implementation Plan - Endorse the decisions made within QSG

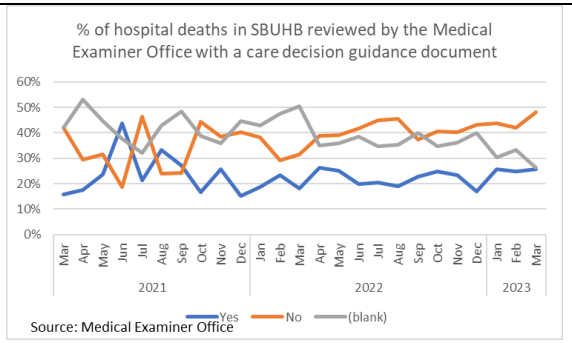
Appendix 1 Quality Priority Updates

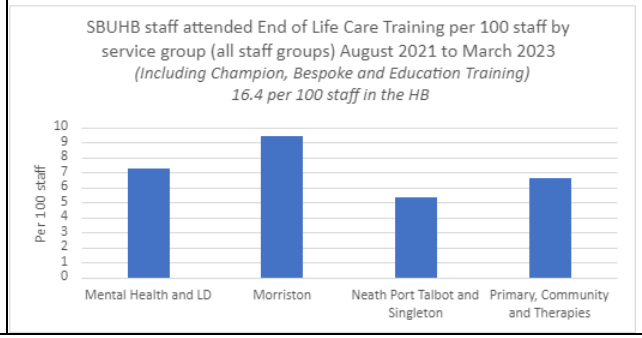
Quality Priority Goals	Methods
Falls Prevention **Reduction in harm from falls** **'Deep dive' update provided to Management Board April 2023**	• Engagement with third sector partner agencies through Regional Falls Prevention Taskforce • Improved Quality Assurance through new audit programme – service 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 – on target to meet goal of 10% reduction in inpatient falls and 10% reduction of falls related SIs
- Community falls prevention to be area of focus for 2023 with engagement with safe care collaborative

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.
- 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	• Establishment of Sepsis steering group • Identification of Sepsis leads in each clinical team • Completion of Sepsis audits across acute sites • Establishment of trajectories for improvement for audit compliance

Measures

- % of patients appropriately screened for Sepsis

Trajectories

	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%	>25%	>40%	>55%	>60%	>70%	>85%	>95%
% of appropriate patients screened in AMU Baseline May 2023 25%	>50%	>70%	>80%	>95%	>95%	>95%	>95%
% of appropriate patients screened in ED Baseline May 2023 53%	>60%	>75%	>85%	>95%	>95%	>95%	>95%
% wards who have access to Sepsis training and resources	>75%	100%	100%	100%	100%	100%	100%

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) 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

Summary of Progress Against Outcomes

December progress position	**Falls Per 1000 Bed Days**	**Number of Falls**
Mental Health and LD	5.6↑ (72% INCREASE compared to March 2023)	23 ↑ (64% INCREASE compared to March 2023)
Morriston	4.1 ↓ (29% DECREASE compared to March 2023)	85↓ (32% DECREASE compared to March 2023- prev month unusually high)
NPTSSG	4.6 ↓ (6 % DECREASE compared to March 2023)	47↓ (10 % DECREASE compared to March 2023)

PCCT	7.7 ↑ (33% INCREASE compared to March 2023)	9 ↑ (29% INCREASE compared to March 2023)
SBUHB*	4.1 ↓ (16% DECREASE compared to March2023)	165↓ (20% DECREASE compared to March 2023)

- **6 x falls related SI incidents in Morriston in April 2023 – deep dive commenced**
- **Continued reduction in overall HB falls rates.**
- **Sustained reduction in falls rates within MH&LD service group.**
- **The overarching Falls Prevention Steering group has revised TOR and membership in order to increase impact and engagement**
- **Regional Falls Prevention Community Taskforce now meeting regularly**
- **QI projects all progressing with data analysis ongoing. Ward focus work stream due to be completed March 2023.**

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	Latest WNCR audit suggests 63% compliance with initial MRFA. Target as set by NICE guidelines is completion within 4 hours – current average time from

						NPTSSG Included in HB update **PCCT** Included in HB update	admission to completion of 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 – focussed on T&O wards **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 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

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.

Communications plan started to be developed – core message to be developed in collaboration with Comms, screen saver was made live in May. Dying matters week – Morriston Good Grief event taking place on Wednesday 11th May a collaboration between End of Life Parasol Service, Care After Death Service and Ty Olwen Trust.

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.

Palliative care register numbers – only available yearly. Work within primary care to standardise this and encourage further recording, waiting for Primary Care Palliative Register to be approved by LMC.
End of life care sessions in the Primary Care development day.

First meeting with Digital to initiate work with to support sharing of DNACPR and other A&FCP documentation across care digital settings, Digital to have some internal discussions regarding progressing with this in the next few weeks.

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	Group Medical Directors	Clinical Directors	Service Group reports	Not available	Currently aim is to have a medical	**Mental Health and Learning Disabilities**	Little attendance at champion training but there

service groups, demonstrated through medical EOLC champions within each service					lead by service group	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	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 Decision guidance	Group Medical Directors	Clinical Directors	Medical Examiner death reviews	22% across the main hospital sites	55%	**Mental Health and Learning Disabilities**	EOLC education and training provides information on the

to support care in the last days of life						**Morriston** **NPTSSG** **PCCT**	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
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** **NPTSSG**	Requested more detail to numbers provided by DCHW Links to scoping work that will take place with Digital to understand

						PCCT	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** 7.2% of staff have attended EOLC training **Morriston** 9.4% of staff have attended EOLC training **NPTSSG** 5.3% of staff have attended EOLC training **PCCT** 6.6% of staff have attended EOLC training and 34 care home staff	Training data processed and provided for service groups individually. Total trained in HB: Champion training – 417 (366 HB staff) Education and bespoke training – 2216 (1888 HB staff) Combined that is 16.4% of HB staff Staff service group needs to be 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		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

A spot audit has been undertaken across adult clinical areas in order to establish the current baseline for Sepsis screening. This showed poor overall compliance with Sepsis screening,

A new Sepsis screening tool has been developed for launch May 2023

A screen saver communication campaign has been running for the past 12 weeks to raise awareness of Sepsis.

Critical Success Factors (CSF)

CSF	Accountable individual Tier 1(Director Level)	Accountable Individual Tier 2 (Head of Service,	Measurement Tool	Baseline	SMART Target	Service Group Updates	HB Progress

		Senior Matron)					
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** TBC **Morriston** Confirmed **NPTSSG** Confirmed for NPT and Singleton **PCCT** Confirmed	
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 for all areas required **Morriston** Confirmation of leads for all areas required **NPTSSG**	

						Lead identified for all areas **PCCT** Leads identified in all areas	
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 May 2023 **Morriston** May 2023 audit result 13% **NPTSSG** May 2023 audit result 0% **PCCT** Not audited May 2023	

Risks to Delivery

Lack of leadership within service groups, this is being mitigated against through group nurse and medical director and designated service group leads