Meeting Date	**23 March 2021**	**Agenda Item**	**3.2**
Report Title	Rationale behind the Five Quality Priorities for the Annual Plan 2021/22		
Report Author	Nigel Downes, Head of Quality and Safety		
Report Sponsor	Christine Williams, Interim Executive Director Nursing & Patient Experience Richard Evans, Executive Medical Director		
Presented by	Nigel Downes, Head of Quality and Safety		
Freedom of Information	Open		
Purpose of the Report	To inform the Quality & Safety Committee on the rational behind the Five Quality Priorities for the Annual Plan 2021/22.		
Key Issues	The Five Quality Priorities: • Suicide Prevention • Falls • Sepsis • Infection Prevention Control – Healthcare Acquired Infections • End of Life Care for Adults		
Specific Action Required ***(please choose one only)***	**Information** ☒	**Discussion** ☐	**Assurance** ☐	**Approval** ☐
Recommendations	Members are asked to: • **NOTE**		

Rationale behind the Five Quality Priorities for the Annual Plan 2021/22

1. INTRODUCTION

This report outlines to the Quality & Safety Committee the rationale for the selection of the Health Board's five quality priorities that will be taken forward within the Annual Plan 2021/2.

2. BACKGROUND

In readiness for deciding on the quality priorities, to be included within the Annual Plan 2021/2, a scoping exercise was undertaken across the Health Board in relation to potential areas to be included. In order to ensure deliverance of this year's quality priorities, it was decided to focus on 5 priority areas/programmes, with other existing programmes continuing to be developed and monitored through normal processes, including Health and Care Standards.

Following this scoping exercise, a Qualities Priorities Workshop was held with stakeholders from across all Service Groups and Corporate teams. The workshop was held via Teams and 27 people were in attendance, including:

- Executive Directors
- Members of the Service Group Triumvirate
- Service Group Quality/Governance managers
- Corporate Teams
- The Chair of the Quality and Safety Committee

Following extensive discussion and debate at the workshop, the quality priorities for 2021/2 were decided as:

- Suicide Prevention
- Falls Prevention
- Sepsis
- Infection Prevention Control – Healthcare Acquired Infections
- End of Life Care for Adults

The Quality Priorities have also been reviewed, discussed and refined at the Senior Leadership Team meetings on 3 March 2021 and 17 March 2021.

These priority programmes will be developed alongside the existing programmes dealing with Fractured Neck of Femur, Local Safety Standards for Invasive Procedures (LocSSIPs), Transcatheter Aortic Valve Implantation (TAVI), reduced medication errors through electronic prescribing and increased adherence to NICE guidelines.

Suicide Prevention

Rationale

Between 2014 and 2018 the overall rate of suicides across Swansea Bay UHB was not substantially different from the Wales average at 12.3 per 100,000 of population. However, as can be seen from Figures 1 to 3, this has been mainly due to Swansea being below the Wales average, as since 2002 the Neath Port Talbot (NPT) area has been above the Wales average, sometimes over 25% higher (Figure 2).

Over the period 2014-2018 (Figure 1), the overall number of suicides was 89 for NPT and 119 for Swansea.

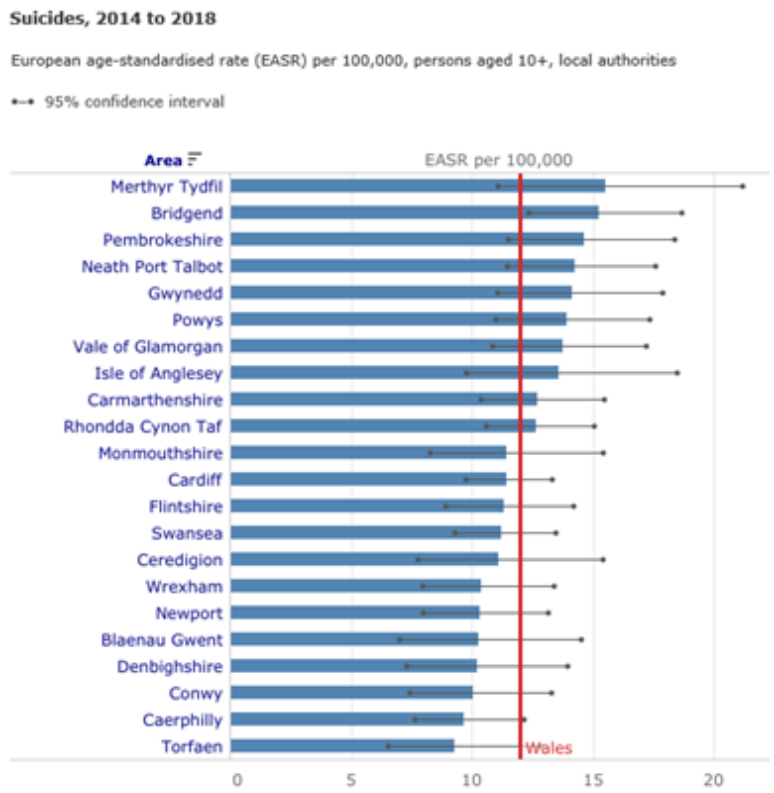


Figure 1

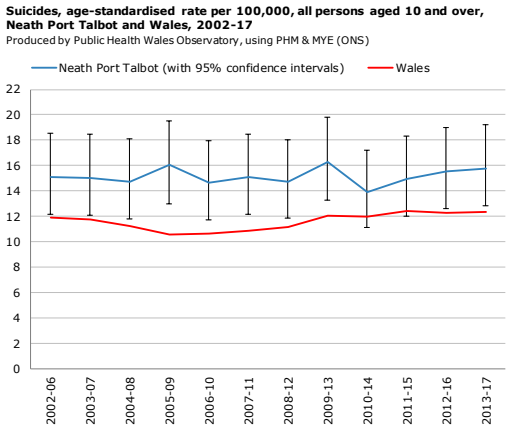


Figure 2

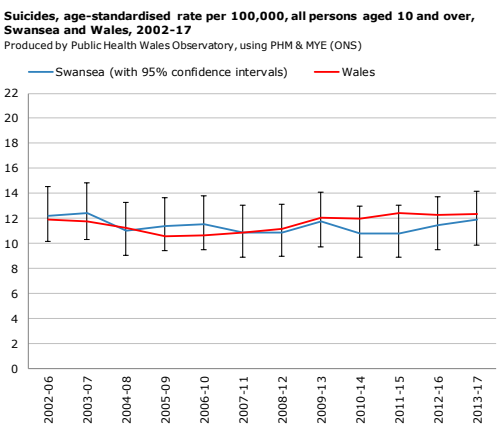


Figure 3

The main contributor to the high European Age-Standardised Rates (EASR) for NPT is the rate of male suicides within NPT. Also of particular concern, from the analysis for 2008-17 at Figure 4 and 5, is the rates for 10-24yrs in NPT being significantly higher than the Wales average.

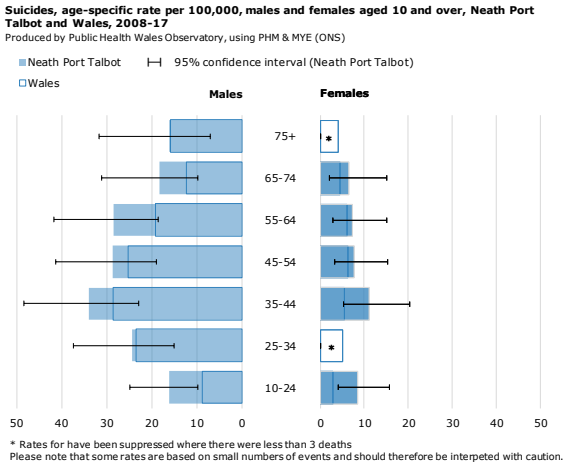


Figure 4

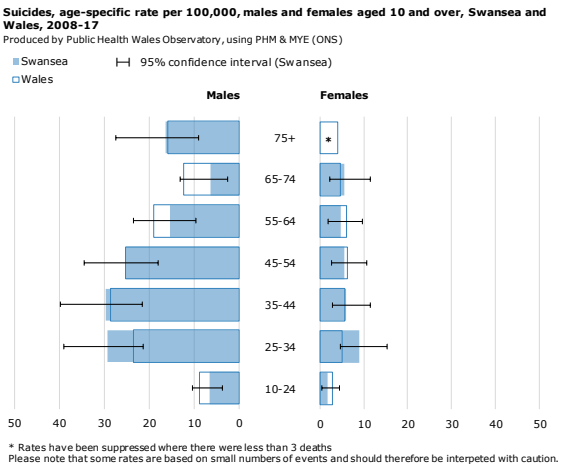


Figure 5

Since April 2020, the Health Board Safeguarding Team have been **invited and contributed** to the Swansea and NPT Local Authorities Rapid Response to Adult Suicide meetings and the Tables below indicate details of data:

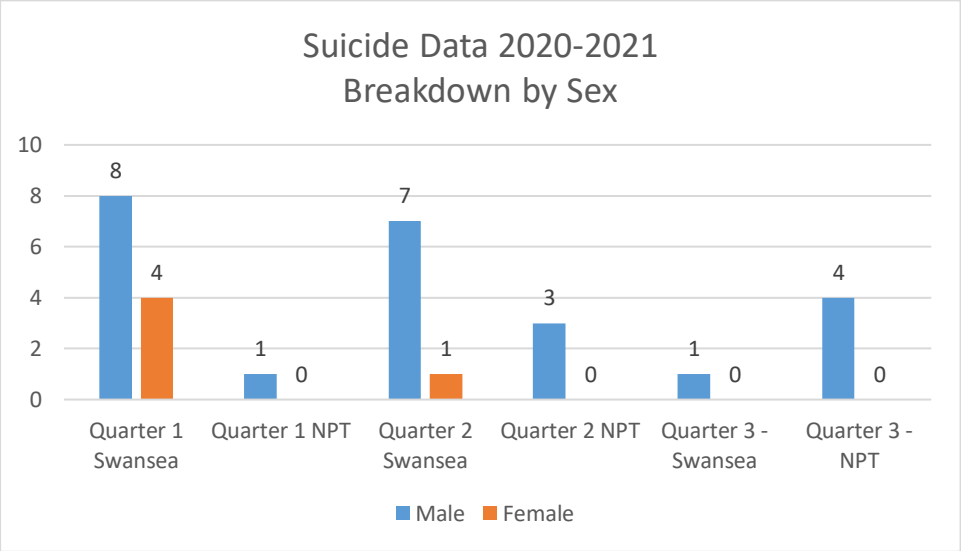


Figure 6

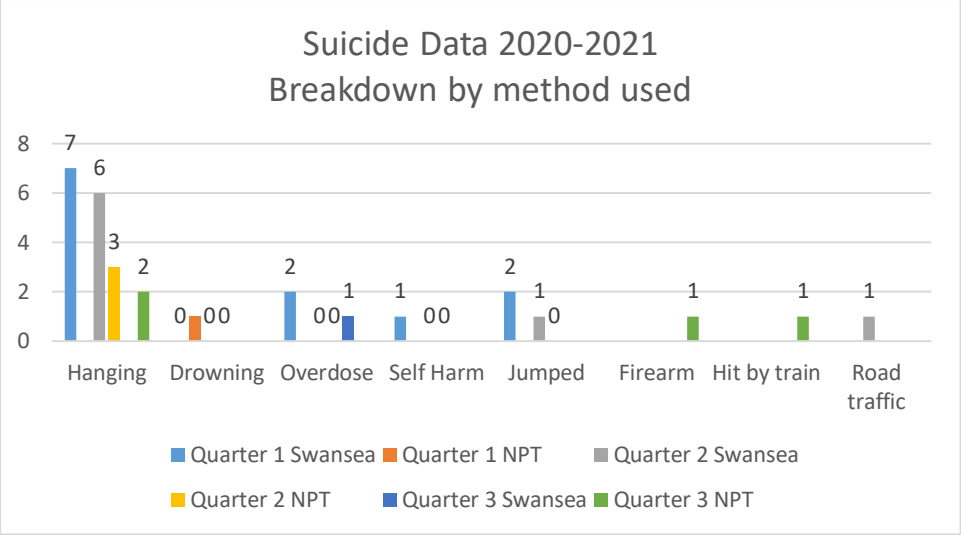


Figure 7

Current Key Programmes of Work:

- A **Multi-Agency Action Group (MAG)** was set up in 2019 following a successful multi-sector and multi-agency workshop that highlighted the commitment to co-ordinated action to prevent suicides & self-harm across Swansea Bay. This group reports into the joint PSB and is chaired by Jennifer Davies, Consultant in Public Health from the Swansea Bay Local Public Health Team. Membership includes Swansea Bay UHB Mental Health Delivery Unit, Primary and Community Service Delivery Unit (including School Nursing), Swansea Council for Voluntary Services (CVS), NPT CVS, Swansea and NPT Social Services, South Wales Police (SWP), local authority representatives including education and safeguarding, probation services, Swansea University and the Ospreys.

- **Production** and **monitoring** of **local action plan** against **Talk to Me 2**.

- **Rapid Response to a Suicide of an Adult**
  The Corporate Safeguarding Team and the Mental Health & Learning Disability Service Group, as appropriate, contribute to the regional Rapid Response to Suicide Meeting process led by Swansea and NPT Local Authorities. The process began as a multi-agency pilot in April and was developed to ensure individuals who potentially are affected by the suicide are supported and safeguarded. The Rapid Response to a Suicide of an Adult pilot process was reviewed and approved by the Regional Safeguarding Board 9th September 2020.

Outcome / Outcome Measurements 2021/2

1. Further improve awareness, knowledge and understanding of suicide and self-harm amongst the public, individuals who frequently come in to contact with people at risk of suicide and self-harm and professionals in Wales.
2. Reduce the risk of suicide in key high-risk groups.
3. Tailor approaches to improve mental health in specific groups.

4. To deliver appropriate responses to personal crises, early intervention and management of suicide and self-harm.
5. Reduce access to the means of suicide (eg reduction of ligature points) within UHB Property.
6. Promote and support learning, information and monitoring systems and research to improve our understanding of suicide and self-harm in Wales and guide action.

Falls Prevention

Rationale

Falls are a major cause of disability and nationally the leading cause of mortality. They are the most common injury sustained by hospitalised patients and a major cause of injury and death among the elderly and debilitated patients. The Health Board has a responsibility for ensuring the quality and safety of healthcare in relation to the prevention, assessment and management of injurious falls in line with Health and Care Standard 2.3: Falls Prevention.

The Standard refers to minimising the risk of people falling. Falls are the most frequently reported adult in-patient clinical incident and falls in the community are a frequent event. An assessment of the range of factors which are known to increase risk of falling is important in developing a plan of care which aims to prevent individuals from falling and reducing harm and disability.

In relation to the standard:

- People should be assessed for risks of falling and every effort is made to prevent falls and reduce avoidable harm and disability.
- Falls prevention strategies are implemented based on national standards and evidence based guidelines.
- People are assessed for risks to their own safety and the safety of others. A plan for managing risk is agreed between the person being cared for and those caring for them.
- Staff receive appropriate information, training and supervision to ensure that people and their carers' are safe.
- People are encouraged to develop or maintain the level of independence they wish, striking a responsible balance between risk and safety.
- People are able to summon help easily at all times, using a telephone, bell or other convenient means. If unable to do so their needs will be checked regularly.

The Number of Inpatient Falls are reported on a monthly basis and the figures for the last year are noted as:

Measure	Locality	National/ Local Target	Internal profile	Trend	SBU											
					Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Inpatient Falls																	
Total number of Inpatient Falls	PCCS	12 month reduction trend			7	9	9	1	4	7	8	7	14	8	9	8	9
	MH&LD				44	31	42	52	55	48	48	71	35	44	31	29	27
	Morriston				110	76	69	60	73	52	69	85	81	77	120	129	92
	NPTH				42	48	56	47	32	55	45	30	41	29	32	30	33
	Singleton				46	43	34	33	45	34	38	34	48	28	47	48	38
	Total				**249**	**207**	**210**	**193**	**209**	**196**	**208**	**227**	**219**	**187**	**247**	**247**	**203**
Inpatient Falls per 1,000 beddays	**HB Total**	Between 3.0 & 5.0			5.68	5.19	5.73	7.76	7.71	6.64	6.44	6.53	6.07	5.23	7.26	6.91	5.56

Figure 8

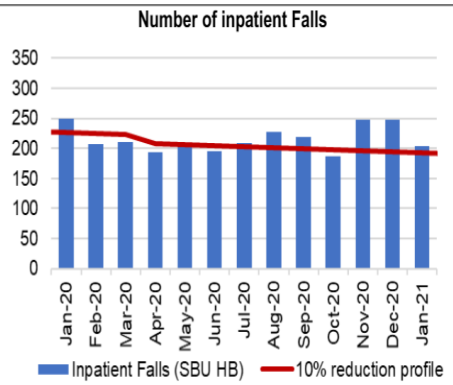
INPATIENT FALLS		
Description	**Current Performance**	**Trend**
Inpatient Falls *The total number of inpatient falls*	• The number of Falls reported via Datix web for Swansea Bay UHB was 203 in January 2021. This is 18% less than January 2020 where 249 falls were recorded. • The Health Board has agreed a targeted action to reduce Falls by 10%.	

Figure 9

Key Programs of Work

- The falls prevention strategies and tools should be based on latest research evidence – such as key recommendations from the Royal College of Physicians National Audit of Inpatient Falls

- Service Groups Local Scrutiny Falls Groups

- Hospital Falls Injury Prevention Strategic Group (HFIPSG)
  - Currently identifying the priorities for the health board agenda in hospital falls assessment, prevention and management in order to develop a Strategic Quality Improvement Plan (SQuIP)
  - To develop a Causal Factors Matrix which is integral to DATIX to support causal factor analysis in the Service Groups
  - To develop a health board falls investigation tool which link to determination of casual factors
  - Support Service Groups to develop quality improvement plans using agreed methodology

- To reduce inappropriate variation in the reporting of serious incidents
- To foster working relationships and collaboration with the Service Delivery Units and maintain the visibility of falls prevention in the organisation
- To develop a health board falls investigation tool which link to determination of casual factors.
- HFIPSG reports to Quality and Safety Governance Group.

Outcome / Outcome Measurements 2021/2

1. The Health Board has agreed a target outcome in a 10% annual reduction of falls with harm.
2. Decrease in Fracture Neck of Femur relating to a reduced number of hospital falls in line with National Database.
3. Decreased inpatient length of stay.
4. Decrease in head injuries as a consequence of fall.
5. Decrease in mortality through falls.

Sepsis

Improving the early recognition and treatment of patients with sepsis.

Rationale

"Sepsis (also known as blood poisoning) is the immune system's overreaction to an infection or injury. Normally, our immune system fights infection – but sometimes, for reasons we don't yet understand, it attacks our body's own organs and tissues. If not treated immediately, sepsis can result in organ failure and death. Yet with early diagnosis, it can be treated with antibiotics." UK Sepsis Trust

Sepsis is recognised as a major cause of mortality and morbidity in the NHS.

It is important to note that some patients with sepsis will die from organ failure despite early recognition and prompt, appropriate treatment. There is a close link between early recognition and general deterioration of patients and the early recognition and treatment of sepsis; including evidence-based trigger for sepsis screening in adults is a raised NEWS score.

SBUHB current position on Sepsis:

- **Audit NICE 50 guideline across NPTH, Singleton and Morriston identified <20% evidence of sepsis screening.**
- Currently not submitting sepsis compliance data to Welsh Government.
- Morriston site: Audit of Sepsis trolleys in clinical areas not checked or used.
- Singleton site: Sepsis tool box which is stored in various locations.

- Neath Port Talbot site: Sepsis tool box is located on resuscitation trollies, which is checked and stocked by nursing staff on ward.

Previous Sepsis Awareness Campaign at Morriston Hospital (2017-2018).

In April 2017, following a successful bid for funding from the Welsh Critical Care Network, Morriston Hospital formed its first dedicated (part-time) sepsis team initially for 12 months till March 2018. Subsequent further funding was gained in September 2017 to continue the work until September 2018.

Sepsis Team, included:

- Lead Consultant (P/T)
- Lead Nurse (P/T)
- Project Support Officer (F/T)

Key Aims of Campaign:

- Training
- Identify Sepsis Champions
- Provide Equipment to wards
- Data Collection during project 2017-2018

Campaign was successful in implementing and rolling out (2017/18):

- Sepsis Champions in ED at Morriston Hospital
- Sepsis Boards within ED at Morriston Hospital
- Sepsis Trolleys provided to seventeen wards
- Sepsis Book and Sepsis Screening Tools

ED Data:

Summary of data for forms receivedin Morriston ED June 2017 – July 2018:

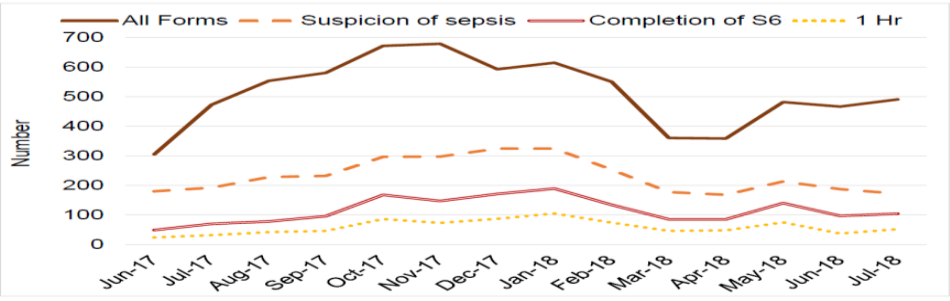


Figure 10

From the total forms completed, 45% were considered to have possible signs of sepsis.

No further data has been collected, since July 2018, by the Health Board in relation to Sepsis.

Current Key Programs of Work

Roll out of National Early Warning Score Cymru (NEWS Cymru) on 1 March 2021.

- The recognition and response to the acutely deteriorating patient relies on a whole systems approach and it is suggested that the revised National Early Warning Score (NEWS2), published by the Royal College of Physicians in December 2017, reliably detects deterioration in adults, triggering review, treatment and escalation of care where appropriate.
- NEWS2 [NEWSCymru in welsh context] is deemed to be an improvement on the original NEWS, in use since 2012, in key areas which include:
    - *better identification of patients likely to have sepsis*
    - *improved scoring for patients with respiratory failure*

NEWS Cymru has been ratified through the RADAR Group and the Nursing & Midwifery Board (February 2021).

Potential Work Programs

- Data collection to review effectiveness of sepsis diagnosis and treatment.
- Implement and roll out of NEWS Cymru.
- Training and education in sepsis for all new staff at induction.
- Face-to-Face based sepsis training and education for existing staff.
- Establishment of a full time hospital sepsis team to carry forward the sepsis related work.
- Each Service Group identify their own clinical and nursing leads for sepsis to feedback to the hospital sepsis team. The long-term aim that each ward/area takes full responsibility of data collection, maintaining training levels amongst staff, monitoring the usage of their sepsis trolleys and stocking them.
- Dedicated support from IT and Quality Improvement team will help bring more direction to the work and wards can do their own QI projects to improve things further.
- Regular meeting with sepsis champions from all wards, on a monthly basis, to discuss common issues and find solutions.
- Review the database to simplify input of relevant data and streamline the process by integrating it with the hospital systems.
- Review of patient notes to establish true positive patients for sepsis as the appropriateness of antibiotics administration is very important.
- Regular sepsis awareness days.
- Review sustainable funding options for the project.

Outcome / Outcome Measurements 2021/2

1. Timely identification and treatment of patients with sepsis in emergency departments.
2. Timely identification and treatment of patients with sepsis in acute inpatient settings.
3. Timely antibiotic review for patients confirmed as having sepsis (measured for patients who remain in hospital 72 hours after antibiotic treatment commenced).
4. Reduction in antibiotic consumption per 1,000 admissions.

5. Reduction in length of stay.

Infection Prevention Control
Healthcare Acquired Infections

Rationale

Health & Care Standard 2.4 *Infection Prevention and Control (IPC) and Decontamination*

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.

Tier 1 Target Infections (Risk Register 739/HBR4, 2286)

- C. difficile
- Staph. aureus bacteraemia (SA BSI)
- E. coli bacteraemia (Ec BSI)
- Klebsiella spp. bacteraemia (Kl BSI)
- Pseudomonas aeruginosa bacteraemia (Ps. aer. BSI)

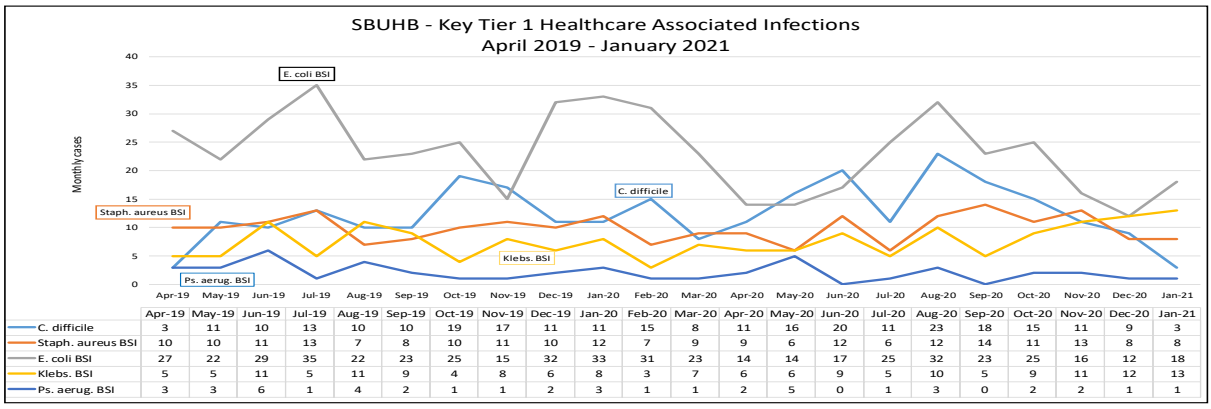
Patient Safety (Risk Register 1750, 2210, 2614):

- safe environment of care
- safe patient care equipment
- safe medical devices

Prevention of Communicable Diseases through immunisation programmes (Risk Register 2273)

Key achievements:

Tier 1 Healthcare associated infections



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
C. difficile	3	11	10	13	10	10	19	17	11	11	15	8	11	16	20	11	23	18	15	11	9	3
Staph. aureus BSI	10	10	11	13	7	8	10	11	10	12	7	9	9	6	12	6	12	14	11	13	8	8
E. coli BSI	27	22	29	35	22	23	25	15	32	33	31	23	14	14	17	25	32	23	25	16	12	18
Klebs. BSI	5	5	11	5	11	9	4	8	6	8	3	7	6	6	9	5	10	5	9	11	12	13
Ps. aerug. BSI	3	3	6	1	4	2	1	1	2	3	1	1	2	5	0	1	3	0	2	2	1	1

Figure 11

- Year-on-year reduction in Staph. aureus bacteraemia, E. coli bacteraemia and Ps. aeruginosa bacteraemia

- Established an Integrated IPC 7-day service.
- Standardisation of nasendoscope decontamination; centralisation of sterilisation community dentistry instruments.
- Established deep cleaning and UVC decontamination across all acute sites.
- 3-month contract for proactive Hydrogen Peroxide Vapour environmental decontamination.

Current Key Programs of Work

- Development of Ward-to-Board dashboard for Tier 1 key healthcare associated infections
- 4D Deep Cleaning & Decontamination Programme
- IPC Training
- Improved IPC support for Primary Care, Community, Mental Health & Learning Disabilities, and potential for Care Homes
- Antimicrobial stewardship activity in primary & secondary care – focussed activity

Potential Work Programs

- Improved informatics infrastructure to align compliance with Hand Hygiene, IPC Audit, IPC Training, environmental and equipment decontamination with healthcare associated infection via Ward-to-Board Dashboard
- Informatics infrastructure for ordering Deep Clean & UVC (or HPV) decontamination, to monitor compliance and enable audit and feedback.
- Provision of decant facilities on each acute site.
- Refurbishment and new build projects to identify opportunity to increase en-suite single room capacity.
- Improved antimicrobial stewardship via clinician–led audit and feedback.
- Development of Immunisation Service Business Case to progress compliance with national targets.

Outcome / Outcome Measurements 2021/2

- HCAI Reduction: Tier 1 target - there were no 2020/21 reduction goals, so assumed 2019/20 goals were extant. Assume the same for 2021/22 until WG confirm otherwise.

	Monthly goal	Annual goal	Current position to 16/02/21	Possible EOY Position	% reduction required to achieve WG Goal	Risk of not achieving % reduction
C. difficile	< 8	< 96	145	165	42%	High
SA BSI	< 6	< 72	105	122	41%	High
Ec BSI	< 21	< 252	204	236	-	Moderate
Klebs. BSI	< 6	< 72	89	104	30%	High
Ps. aer. BSI	< 2	< 21	17	20	-	Moderate

Figure 12

- Informatics infrastructure established and all wards, units and Delivery Groups can access information relating to healthcare associate infection.
- Informatics infrastructure for environmental decontamination – mid-year baseline, benchmark performance and identify improvement via end of year audit.
- Antimicrobial stewardship – reduction in broad-spectrum antibiotic use; improved compliance with 72 hour IV to oral switch, reduction in overall antimicrobial usage.

End of Life Care for Adults

Rationale

Providing high quality care equally to all people regardless of prognosis is essential and there is a particular urgency to the delivery of this care when they are approaching the end of their life. The GMC identifies high quality end of life care, care that upholds a person's dignity and human rights, as a fundamental duty of health care professionals[1]. The principle of 'caring for each another' is built into the values of SBUHB and the identification and attempted relief of distress in all its forms, focussing on the specific needs and wishes of patients and their loved ones is the outworking of this caring principle for those approaching the end of their life. Therefore, passionately striving for high quality end of life care is a core priority of the organisation.

In addition to these ethical principles underpinning the importance of end of life care, its provision results in a series of supplementary benefits. It reduces complex bereavement of those close to the dying person resulting in improvement in public health and well-being within our communities[2]. This is especially important at the current time where the COVID-19 pandemic further exacerbates the risk of difficult bereavement[3]. Gaps in the delivery of good end of life care negatively affects the health of health care staff[4] therefore delivery of high quality end of life care has beneficial effects on staff well-being. It assists in the delivery of cost-effective and prudent healthcare as it works to ensure appropriate use of medical resources such as hospital based care towards the end of life[5]. It reduces the time spent responding to complaints regarding concerns over care at the end of life[6] further ensuring efficient use of health care resources.

- **Swansea Bay UHB scores below average in all but 2 priorities of care from the National Audit of Care at the End of Life (NACEL) Round 2 (2019/20)**

Priority	Swansea Bay score (National average)
Recognising possibility of imminent death	8.5 (9.1)
Communication with the dying person	6.5 (7.8)
Communication with the family	5.9 (6.9)
Needs of family and others	6.3 (6.0)
Individualised plan of Care	4.4 (7.2)
Families and others experience of care	7.7 (7.0)
Workforce	No data submitted

Figure 13

Review of end of life care in patients who died in hospital in 2020 where deaths were unrelated to COVID-19 suggest a more pessimistic picture.

1] Delay in recognising dying

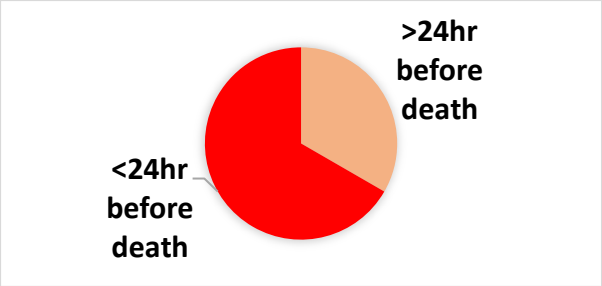


Figure 14

Only one third of the patients were documented to be dying earlier than 24 hours before the time of death.

2] Communicating that the patient is dying with patient and those important to the patient

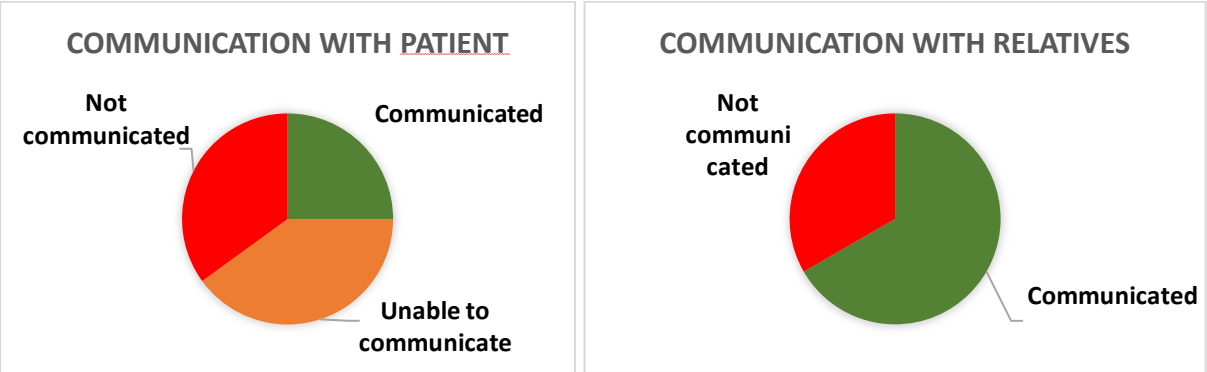


Figure 15

Only 1 in 4 patients was it documented that the discussion had been had with them that they were dying

4/10 were unable to have that conversation because they were drowsy, unresponsive or confused.

2/3rds had documentation that the relatives had been informed that their loved one was in the last days of life.

3] Support and involving patient and those important to the patient

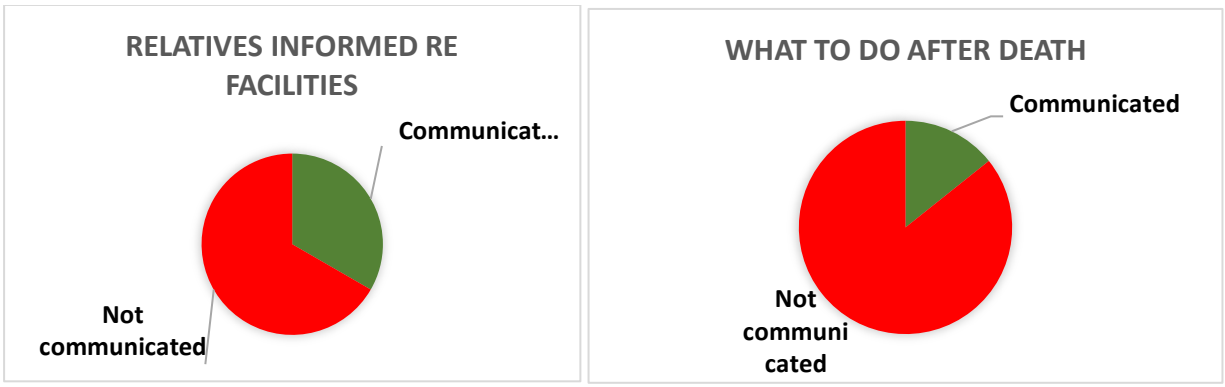


Figure 16

1 in three had documentation that the relatives had been provided with information about facilities,

1 in seven informed about what to do after the death had occurred.

4] Assessment of patient need

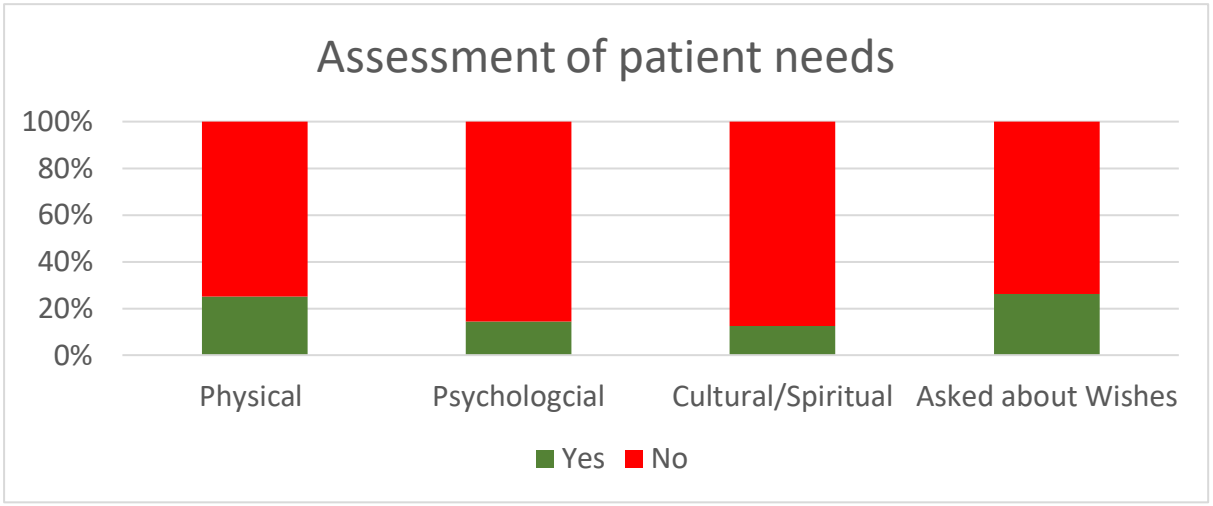


Figure 17

1 in four patients had a documented assessment of physical needs

1 in seven had assessment of psychological needs

1 in eight had assessment of cultural and spiritual needs

1 in 4 had evidence that they had been asked about needs and wishes in the last days of life.

5] Individualised care plan

Figure 18

1 in four had individualised care plan for care in last days of life.

- **Concerns have been raised by staff and families about the delivery of End of Life Care in this Health Board (ombudsman report, DATIX, complaints and patient stories).**

Review of complaints around end of life care (2018)

Highlight that communication underpins a significant proportion.

- Communication between health care professionals and patient/carer
  - Attitude of staff
  - Quality of information exchanged
  - Type of information exchanged
  - Suitability of environment
- Communication between agencies involved in supporting the patient

A survey of staff in Singleton

- A quality improvement project undertaken in Singleton Hospital showed :

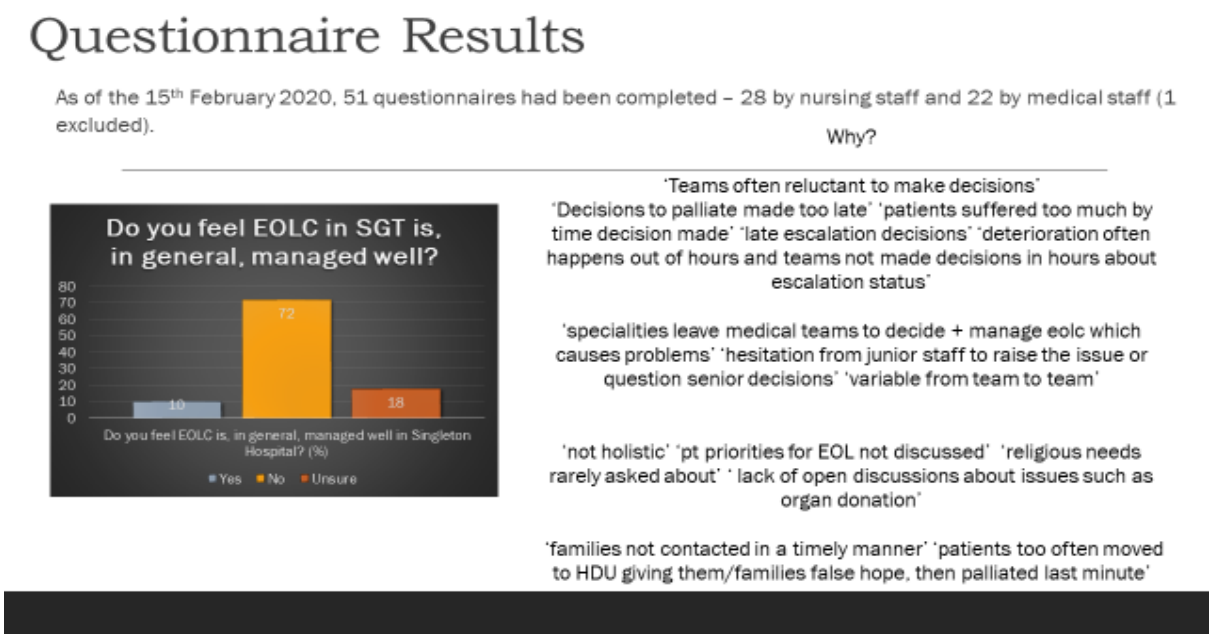


Figure 19

- **The COVID pandemic further shone a light on the deficiencies in End of Life Care delivered by this health Board:**

<u>Impact of Specialist Palliative Care support</u>

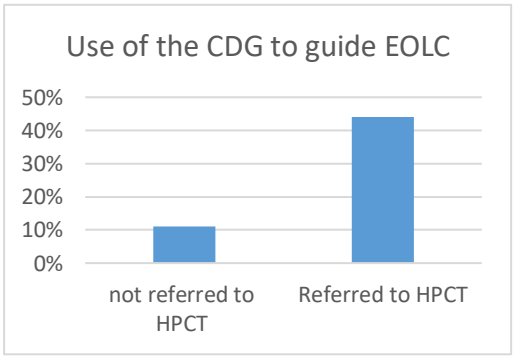
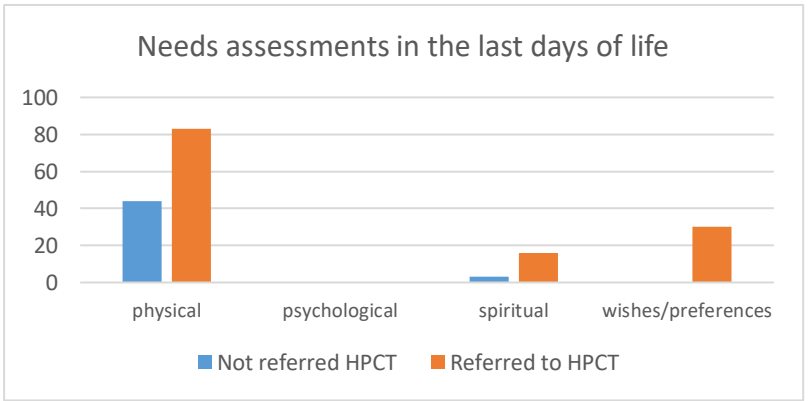


Figure 20



Data relates to patients dying of COVID in the first wave

Figure 21

Key Programmes of work and Outcomes 2021/22:

- Demonstration that high quality end of life care is core value of Swansea Bay University HB.
- Support reflection and learning from incidents, complaints, compliments.
- Full engagement of SBUHB in National Audit process for end of life care.
- All area of SBUHB have up-to-date and accurate understanding of delivery and support of end of life care in their area. Corporate team have full understanding of performance across HB.
- Engagement in All Wales monitoring of standards of care through Care Decision Guidance.
- All member of SBUHB across all care settings have knowledge and skills to support patients in the last days of life, and are confident in recognising dying, communicating with patient and those important to the patient, and in using the Care Decision guidance to support care in the last days of life.

3. NEXT STEPS

The quality priorities are to be reviewed at the Health Board's Senior Leadership Team meeting on 17 March. The quality priorities continue to be developed and refined, and on completion will be ratified by the Board as part of the Health Board's Annual Plan 2021/2.

4. RECOMMENDATIONS

Members of the committee are asked to note and receive this report to inform them of the rationale for the selection of the five quality priorities that will be taken forward within the Annual Plan 2021/2.

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		
This paper provides a summary of the rational for the annual quality priorities 2021/22.		
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)		
None.		
Report History	N/A	
Appendices	N/A	