Quality Priorities highlight report
November 2024

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

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Please note where a QP has not been able to have an update for the month it is not included in the report.

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Quality Priority – End of Life Care (EOLC)
Goal - Increase proportion of Swansea Bay residents receiving the right care at the right place at the right time in the last year, months, weeks, days of life

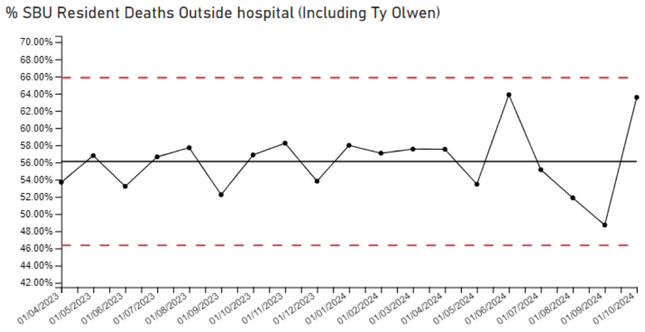
Project Team: Senior Responsible Owner – Sue Morgan (Clinical Lead), Project Manager – Tracy Rowe (part-time) , QI lead – Emma Smith

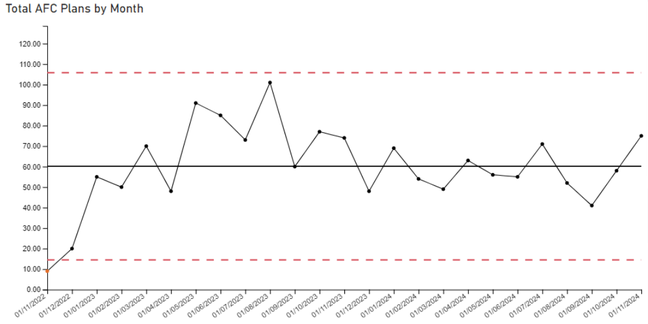
Month – November 2024

Methods
- Increased correct identification of people who may be in the last year of life
- Increase Advance & Future Care Planning (A&FCP) across all care settings
- Increased correct identification of people who may be in the last days of life
- Increase the number of staff given education and training to support high quality EOLC
- Identify and produce systems that support sharing of A&FCP across all care settings

Other critical success factors
- Medical engagement with EOLC throughout service groups, demonstrated through medical EOLC champions within each service
- All Service Groups to participate in completing the Health Board End of Life Care audit.

Key Outcome Measure/s
- Deaths outside of hospital include Ty Olwen, since April 2023 the mean since April 2023 is 56%.
- Start of Jan 2023 A&FCP plan notifications in WCP increased due to Specialist Palliative Care using it.
- By October 2024 approx. 33% HB staff have been trained in EOLC training, (estimated % as may be duplicate staff in both the various training offers) also delivered to external organisations largely university and care homes – LA and private.





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Key achievements
- 30% of HB staff have received training in EOLC - Champion programme, Regular Education sessions, bespoke training requested by Service Groups and care home training.
- NACEL service user feedback 2024 shows significant improvement in experience reported compared with 2022 and compared to rest of England and Wales
- Internal Audit Spring 2023 gave reasonable assurance for End of Life Care.
- A shift in the number of Advance Care Plan notifications set in WCP from median of 6 to 60 per month
- My Life My Wishes adopted by the HB – difficult to count use as is a paper document. Used by District Nursing, Virtual wards, handed out in training and public awareness events (534 given out) and available on COIN & NHS Executive sites to download.
- Public facing page about Palliative and End of Life Care in Swansea Bay on HB internet site
- Engagement in the national Dying Matters Week each year.
- End life care conference restarted with good attendance and positive feedback and multi sector engagement.
- End of Life Care Dashboard development has started – includes some of the measures required, further tweaks to be made

Progress in the last month
- End of Life Care Conference took place, with over 100 attendees – multi-professional, with representatives from hospital and community settings, including care homes, third sector. Positive feedback from attendees, enabled future planning and priorities for the team.
- Treatment escalation plan – feedback received, further review of documents needed to simplify it and a working group to start.
- Primary care record – primary care are reviewing with DHCW what is already pulled from their systems and what can be included in the primary care record WCP to communicate end of life and palliative care of patients.

Actions for the next month	Responsible Owner	Due Date
Review of Treatment Escalation Plan testing	Sue Morgan	November 2024
Plan delivery of HIW DNACPR review action plan	Sue Morgan	January 2025
Review impact of EOLC training on staff and care (to determine method for this)	Philippa Bolton Glenda Morris and Sue Morgan	January 2025
Finalisation of Adult Hospital section of the Dignity of the Deceased Person Policy	Kimberley Hampton-Evans	December 2024

Evidence - End of life care for adults, Updated Sept 2022, https://www.nice.org.uk/guidance/qs13

Quality Priority – Falls
Goal – Reduced falls and harm in hospital and across Primary Care and Community services by 10% in 2023/2024

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

Month – November 2024

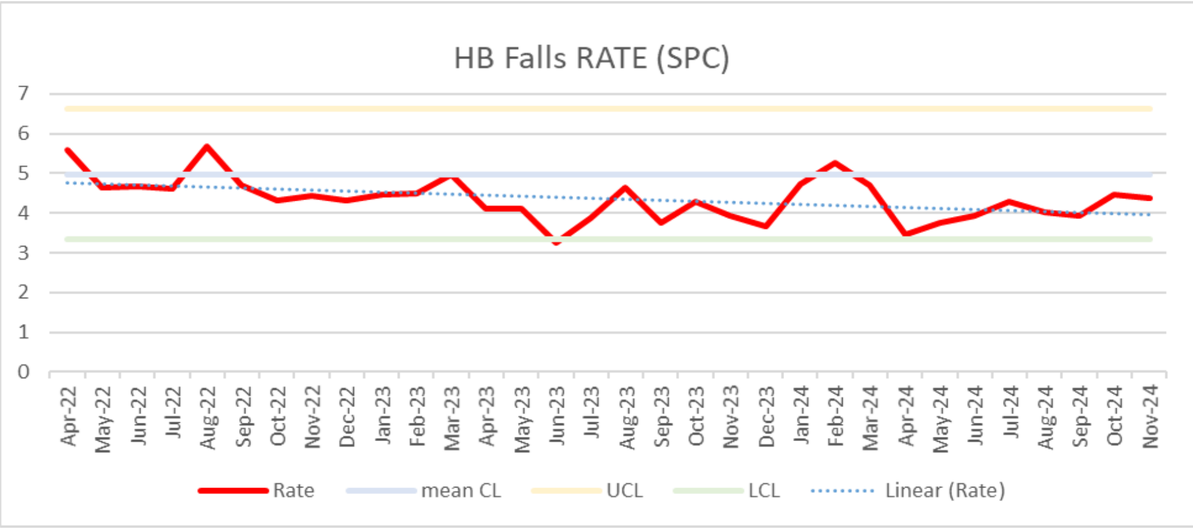
Methods

•Build on Quality improvement programme.
•Embed Falls audit programme.
•Embed reporting structures from service groups Targeted QI input to high falls rate wards
•Develop/Educate clinical workforce
•Engagement with Improvement Cymru and participation in Safe Care Collaboration
•Promote public health campaigns re: healthy lifestyle and physical activity e.g Reconditioning.
•Community Falls services review

Other critical success factors

- *Regional falls prevention taskforce*
- *Overarching Falls Prevention steering group*

Key Outcome Measure/s –



Graph (above) HB falls rate by month.

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Key achievements

- Serious incident reduction since QP start of 80%
- Agreed Governance structure with nominated SRO and Chair
- Improvements noted in National Audit of Inpatient falls 2023
- Safe Care Collaborative (SCC) project completed
- Intergenerational Falls prevention Project – presented at BMJ International Conference 2024
- 2nd annual Active August completed
- New role of Reconditioning Ambassadors created, closing for role 5/9/24 - DoTH Exec sponsorship confirmed
- Relaunch of Regional Falls Prevention Taskforce following evaluation of group
- Further roll out of iStumble project across Dom Care and Care Homes
- Reconditioning Ambassadors launch event inc training

Progress in the last month

- Raising awareness of NAIF audit at SG COEGs
- Deep Dive to Management Board and QSG

Actions for the next month	Responsible Owner	Due Date
Planning of Falls Summit (Primary Care/Clusters)	EDA / AG	Feb 25
Continue work to implement the All Wales Falls Response Framework	EDA/LE	Jan 25
HB to plan how to meet new requirements of National Audit of Inpatient Falls	HA/EDA	Jan 25
Develop Tool to determine avoidability at scrutiny	EDA	Jan 25

Evidence – https://www.nice.org.uk/Guidance/CG161

Quality Priority – Nutrition & Hydration

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

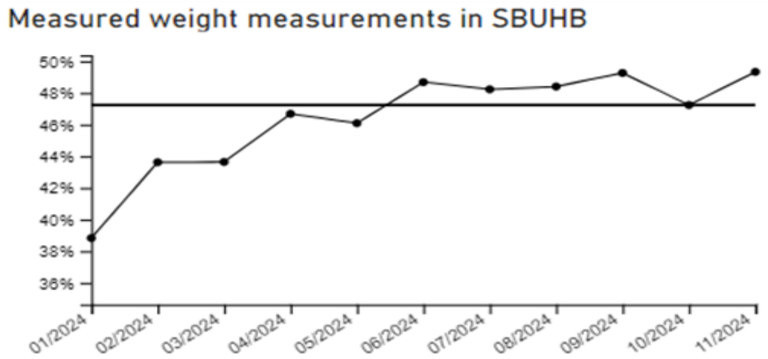
Month – November 2024

Methods

QI areas discussed by N & H committee:

1. Meet minimum standards all Wales catering standards
2. Nutritional screening & processes
3. Compliance with taking weights
4. Safe artificial nutrition non oral
5. Hydration - jugs
6. Nil by mouth days -
7. MH & LD, re-visit SLT & RD provision OPMH

Graphs below show performance data on weights available and accurate weights being measured since the "Don't wait to weigh" campaign – measures against national average of 13.5% - 55% of patients being weighted



Data from January 2024 above shows accurate weight % throughout in patient care. The "Don't wait to weigh" campaign aims to increase SBUHB performance to above the national average of only 13.5% - 55% of patients being weighed . Currently the HB is at 49% with an aim to increase to 60% within 6 months.

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Key achievements

Agreed several QI projects with H & N Committee
First QI project agreed as Weight Monitoring (WM) pilot area Morriston site
Data requested from WNCR system on estimated weights within in patient care at Morriston Hospital
1st phase of QI work to be focussed on above WM, Snack provision & Nil by mouth
QP rep from PCTG service group agreed
It was suggested that standards of catering and patient feedback would develop within the work already being undertaken.
Agreed N & H steering committee would be the forum in which the QI reporting on themes would be set as an ongoing agenda item so that updates and feedback can be established
First QI report presented at N & H committee in November 2023, next report February 2024
Launch of Nutrition & Hydration QP officially launched on Intranet
Nutrition & Hydration Day held with catering departments across 3 main sites
First Learning Symposium held in June – 33 attendees, 10 evaluations requesting more events

Progress in the last month

- Implementation of meal ordering app in Ty Olwen
- Launch of children's A la carte menu 11.11.24
- Launch of revised menu for ED on 18.11.24
- Confirmed actions for HEPMA system and red flags in medication prescribing and food allergens
- Waste exercise completed in ED regarding water bottles
- Learning symposium held November 2024 – 70 attendees
- Deep dive report completed for December management board

Actions for the next month		Responsible Owner	Due Date
QI based days within A & E		JW &stakeholders	Ongoing
Results of scoping survey in SG's		JW & stakeholders	Ongoing
Hydration pilot in Gorseinon Hospital		JW & stakeholders	Dec 24
Launch of poster campaign Snack ordering pilot in Morriston N & H Champions Morriston growing the role		JW &Stakeholders JW & Stakeholders JW & Dieticians	Dec 24 Dec 24 Ongoing

Evidence -

Quality Priority – Pressure Ulcers
Goal – To reduce the amount of patients developing HB acquired avoidable pressure damage by 10% by end of March 2025

Project Team: GND Sharron Price, Subject Expert Rachel Govier-Williams, Eleri D'Arcy (QP Lead)

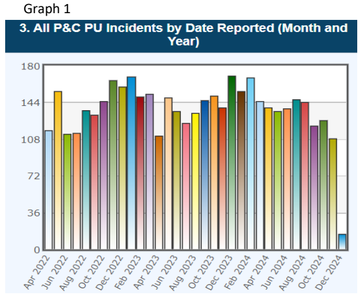
Month – November 2024

Methods
- Build Education and skills
- Build on Documentation & Communication
- Improve Governance & Datix, reporting and investigation
- Address Digital risks
- Provision of equipment MDT approach to prevention & Deconditioning
- Focus on reduction of total incidents and avoidable deep damage
- ***Strategic direction lead by PUPSG QI work planned to target HB hots spots.***
- Accountability of service groups

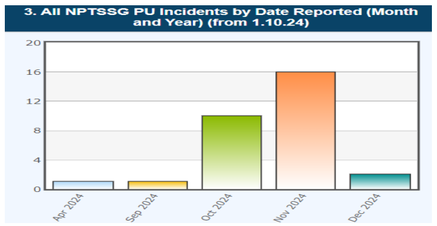
Key Outcome Measure/s Since February 2024, the trajectory has changed. Quarter 1 and 2 of 2024/2025 has seen an **11% reduction** against the same period in 2023/2024. Data suggests the HB is on target to meet its overarching aim of 10% reduction in HB acquired PU's in 2024/2025.
- Governance & closure remain delayed **32% remain open**
- SGs to develop QI plans based on localised data with particular focus on Deep Damage and intervention planning

Data below: *Datix service Group comparison data for HB acquired Pressure Ulcer incidents , sourced from the Dashboards Graphs 1,2 &3 Graph 4 reflects Quarter 2 avoidable harm status for Acute and Primary care. This data is reflective of incidents that have been investigated taken to scrutiny which is 68 % . Graph 4 reflects levels of harm & Deep damage. During this period there was* ***1 National Reportable Incidents*** *in SBUHB. This developed and was deemed* ***avoidable*** *in PCTSG.* ***32 Incidents*** *were deemed Deep damage across the HB but* ***deemed unavoidable*** *following scrutiny.*

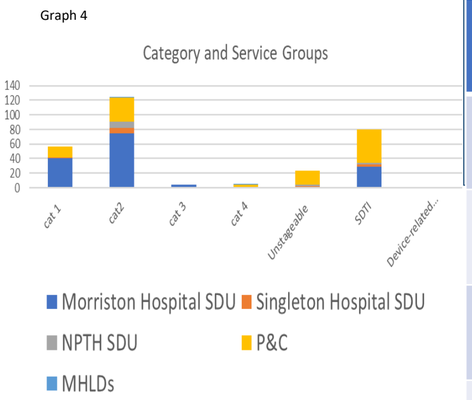
Graph 1



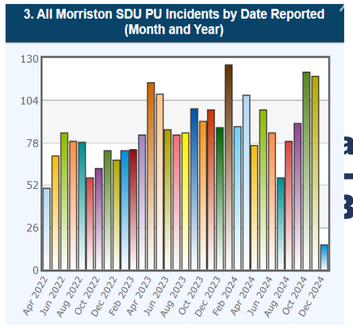
Graph 3



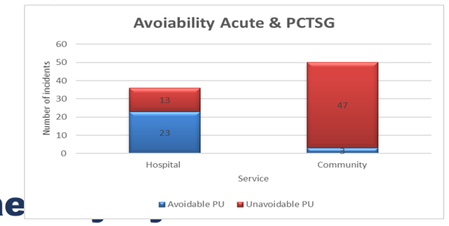
Graph 4



Graph 2



Graph 4



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National/worldwide statistic average of population per 1000 patients that develop a Pressure Ulcer is 0.7 (NICE 2023) there is no statistical average for inpatients per 1000 beds currently available.
The hospital rate of incidents per 1000 bed days was 1.49

Evidence -

Key achievements November

- Pressure Ulcer Champions meeting (Teams)
- STOP pressure ulcer Event week 18th & 22n Nov. Including STOP pressure Towers event,, Stands and education across the HB & Care homes
- HB Champions Register – continued
- QI project continued
- Datix Pressure Ulcer Dashboards developed in pilot
- V7 pressure ulcer care plan for CYP & Adult finalised pending sign off PUPSG
- Educational pressure ulcer page- new live events

Progress in the last month
- ED T&F group working on SOP for Datix reallocation pending Data- agenda PUPSG
- Governance and Incident closures- SG peer reviews planned
- Hot Spots mapping required with QI approach and focused plans – SG to outline in QI plan for PUPSG ongoing.
- Micronates & Neonates PU assessment & Management guidance project - presentation
- HB Strategic Quality Improvement Plan overarching the service groups
- Bespoke Pressure Ulcer Theatre Training continued
- QI project - Rehab & Deconditioning pilot continued
- STOP pressure ulcer Event week 18th & 22n Nov. Including STOP pressure Towers event,, Stands and education across the HB & Care homes
- Acute Hotspot Training
- **NEW** Champions Q&A sessions monthly via Teams planned
- **NEW** Streamliners and Student nurse days

Actions for the next month	Responsible Owner	Due Date
QI projects by SG to be updated	SG reps to report to PUPSG	Nov 2024
STOP pressure ulcer week	Lead TVN / SG	Nov 2024
Datix reallocation Pathway	Clare Baker, Eleri Darcy & Rachel Govier-Williams	Ongoing PUPSG cancelled
ED /unscheduled care REACT risk assessments changed & in place	SG /Rachel. Govier-Williams	Nov 24

Quality Priority Risks - Link to QP Risk Monitoring

QP Area	Date ...	Date Last Updated	Assigned To	Risk Description	Risk Mitigation	Risk Level	Assesse...	Risk Status
End of Life Care	01/08/2024	10/10/2024	Digital	Closed as new risk relating to A&FCP created below. Limitations in digital systems to record discussions relating to EOLC and to share between care settings. This limits the ability to communicate patients wishes and decisions made by care professionals. Without this it could lead to patients not dying in their preferred place of death or treatment initiated that is not appropriate.	Meetings will continue to develop plan. There has been little progression since raising this risk. Therefore it needs to be chased by the EOLC project leads.	Medium	9-15	Closed
End of Life Care	01/08/2024	04/12/2024	Digital	Closed as a joint Digital Dashboard risk created. The existing measures for EOLC that has been identified is not currently available in any Digital Intelligence dashboards. This means data is currently produced in Excel and there is limited sharing which means not everyone is able to see the data available. Some existing information available vis Medical Examiner is not routinely sent to the HB and therefore work is needed to improve this data feed.	Recommendations included in the EOLC internal audit 2023. Progress being made by Digital Intelligence in developing a dashboard with the existing information. There is a now measures available in the Quality and Safety Dashboard which is due to complete by end of October, therefore data not currently available to the wider HB but limited to key members of the project team.	Medium	9-15	Closed
Falls	01/08/2024	10/10/2024	Digital	Awaiting digital dashboard- unable to return falls to BAU and promote learning of incidents as well as active live monitoring without dashboard	Quality & Safety Dashboard is currently in development, the first phase due end of October 2024. Feedback given around ensuring wards/teams level data is available in the filtering. However this is limited to just incidents, phase 2 will widen the access of measures to risk assessments in WNCR.	Medium	9-15	Closed
Falls	01/08/2024	30/10/2024	Service Groups /Health Board	Governance process to investigated falls incidence – slowing learning and sharing of information. no uniformed approach to decisions re avoidability	Learning from incidents/events included on Overarching HB steering Group. mechanism required to share learning back with staff. agree HB avoidability tool	Medium	9-15	In progress
Pressure Damage	01/08/2024	10/10/2024	Digital	Closed as a joint Digital Dashboard risk created. The data is currently made available via Datix and Performance teams. Digital Dashboard needed to make this information more widely accessible.	Quality & Safety Dashboard is currently being developed with phase 1 due end of October 2024. This will include pressure ulcer incidents and categories. Feedback given to ensure wards/teams data is included in filtering.	Medium	9-15	Closed
Pressure Damage	01/08/2024	01/08/2024	Service Groups	Governance - delayed investigations & scrutiny	Reported quarterly	Medium	9-15	In progress
Pressure Damage	01/08/2024	01/08/2024	PUPSG	No medical photography in NPTH, MHLD & Out of Hours	Escalated QS - RR 16	Medium	9-15	Pending
Sepsis	01/08/2024	31/10/2024	Dr Mothukuri	Clinical commitments of SRO and service commitments of QP lead compromise the project progress. No updates Oct 2024	Delegate aspects of required work	High	16-25	In progress
Sepsis	01/08/2024	31/10/2024	Lisa Fabb	Lack of ownership in Morriston service groups, demonstrated in lack of audit, mitigated through group nurse and medical director and designated service group leads. Oct 2024- Morriston QP lead identified awaiting update from them.	Review of reporting structure agreed by SGCD. Support with aspects of audit.	Medium	9-15	In progress
End of Life Care	10/10/2024	10/10/2024		Any advance and future care planning activity (including DNACPR decision making) that has been undertaken in primary and community care is not visible to clinical teams in other areas, eg ED, secondary care, WAST, GPOOH. This means it is not available to support clinical decision making. Thus patients for whom escalation of care to ED or AMU is unlikely to add value, or even cause harm, are subjected to transfer to hospital, adding to patient distress and utilisation of resources that have already been identified to be unlikely to help. In the same way, the patients (and those important to them) are forced to have those difficult conversations repeatedly, which can be distressing and harmful to the patient and those important to them.	HB to work with primary care to extract key end of life care conversations and decision into the GP record section of Welsh Clinical Portal. Robust use to Special Notes between GP practices and GPOOH for identifying patients with treatment escalation limitations.	High	9-15	Pending
End of Life Care	10/10/2024	10/10/2024		When DNACPR decision is made in the hospital setting, the forms are not always given to the patient when they are discharged home, and are rarely forwarded to the GP and GPOOH . This results in either the patient being subjected to a futile or unwanted attempt at CPR, or have to have a repeated conversation about DNACPR with the GP to write a new form. This is frequently ad difficult conversation for the patient. When a DNACPR decision is made in the community, whilst the patient and GP may have a record of this, this decision is rarely shared with secondary care, and inconsistently with GPOOH. When a patient dies in the community without a DNACPR form in the house, the case is referred to the Coroner and this delays the family's ability to organise funerals and impacts on the bereavement complexity. There is currently no IT system in place that provides the "one source of the truth" around DNACPR status of a patient - WNCR may have different recording from GP record, from SIGNAL, from GP OOH, etc. If a DNACPR decision is reversed (in a different care setting) there is currently no way of identifying where the original DNACPR form may have been distributed, to ensure that all clinical teams are made aware of the change in clinical state. This puts a patient at risk of not being offered an attempt at CPR when such an attempt may be successful. There is currently no understanding of the number of people within the Swansea Bay population who have a DNACPR documentation in place.	The HB implements standards for sharing DNACPR documentation - eg All patients are given the relevant copies of the DNACPR form on discharge; Ward Clerks scan and distribute the DNAPCR form copies to GP, GPOOH and ensure a copy is retained in the current clinical record. Explore crossover digital systems used within Swansea Bay to facilitate one source of the truth.	High	9-15	Pending
Nutrition and Hydration	29/11/2024	29/11/2024		Risk reviewed and none to note				
Cross Cutting Issues	29/11/2024	29/11/2024	QP Collaborative Group	Overarching Digital Risks, including: - Digital Dashboard Functionality - concerns around quadrant and card view, number of clicks to the SPC charts and availability of filters. - Dashboard Data inaccuracies relating to the QPs relating to criteria of measures.	Emma Smith is meeting with digital team, has requested feedback to present back by 2/12/24. Feedback by team given, some data quality issues have been resolved. Working group to be suggested to work through feedback.	High		In progress

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