Highlight Report to Quality and Safety Committee

Name of Reporting Group	Quality and Safety Group
Date of Last Meeting	February 21st 2023
Author	Angharad Higgins, Interim Head of Quality and Safety Eleri D'Arcy Falls Quality Improvement Lead
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 and Safety Group and sub-groups terms of reference Appendix 4: Final Quality Strategy

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 Sepsis quality priority is being reported separately to Management Board and is not included in this paper.

Standardised Terms of Reference
In the report from the January meeting we updated the group on the revised terms of reference for QSG and its sub-groups, these are included as Appendix 3 for noting.

Quality Strategy Update
The Quality Strategy launch event was planned for March 2nd 2023. The event would be a celebration of quality work across the health board on a drop in basis.

The final strategy is included as Appendix 4. The strategy implementation plan is to be presented to QSG in March 2023 and then brought to QSC in April 2023 and monthly thereafter.

EMRTS update
The EMRTs service provided an update on the quality and safety issues affecting their service. Key themes and assurances

- Strategic review of services: the service has been in place since 2015 and has undergone significant growth since this time. The strategic review is being undertaken in conjunction with Wales Air Ambulance and an engagement process is due to commence next month in partnership with the Chief Ambulance Service Commissioner. Further details are available on the EASC website. Next steps will be agreed following this engagement.

- Governance arrangements: a regular programme of governance days is in place within the service, which includes review of air way cases. These days facilitate shared learning across EMRTS.
- Inter-hospital critical care transfer service: update on the performance of the service provided
- Patient liaison service: EMRTS has in place a patient liaison service who support patients and their families after the critical incident. This is a very valuable service which EMRTS hope to build upon
- Risk register: transfer of paediatric patients is a known risk and EMRTS is a member of the transfer task and finish group looking at neonatal and paediatric transfer. EMRTS currently have a training plan being rolled out to maintain their skills in paediatric patient transfer
- Annual report
- Care More Framework

South Wales Trauma Network
Report received

Patient and Stakeholder Experience Group update

- Presentation sharing learning from case reviews undertaken by the nosocomial team. This will become a regular report into the group in order for service groups to take learning back into their teams
- Volunteer Services reported on their work and strategy development
- Arts in Health update provided outlining the positive impact of their work on staff and patients
- NPTSSG shared learning on the importance of good communication with bereaved families
- Morriston shared learning regarding the challenges of discharge planning and the impact on patient experience and outcomes
- PCCT escalated concerns regarding resources to support the delivery of the Duty of Candour
- Action for group to consider how we link in children and young people's feedback into the group's workplan

Patient Safety and Compliance Group

- Medical Devices Group- an issue has arisen relating to a power outage and making sure patients who rely on devices know what to do in these circumstances- a piece of work is being undertaken on this There is work underway with Western Power to ensure that acute sites have continuity of power in the event of a major power outage, however the issue discussed related to community patients who have devices at home
- Morriston- insufficient resources to support Duty of Candour. Learning from patient feedback regarding medication management and managing pain- this is being developed as a quality improvement project.
- PCCT- the contract for the national software system for sexual health services is coming to an end and national work is underway to procure a new system

- MH and LD- Tier 4 service provision and the provision of emergency CAMHS bed on an adult wards was raised as a concern- work is in train to address this. Qualified staff ward cover overnight was also raised- this is being addressed by the service group.

Safeguarding

- Update provided on Quarter 1, 2 and 3.
- Task and finish group established in preparation for the Liberty Protection Standards, this group has met twice.
- The number of Procedure Response to Unexpected Deaths in Childhood (PRUDIC) has increased and co-sleeping has been identified as a theme of concern. There is no criticism relating to health board and all Wales work is planned regarding communication to families on the risk. SBUHB plan work to raise awareness amongst staff.
- Ask and Act training- we are now delivering training in house.
- Training compliance within service groups is being worked through, with challenges from ESR.
- Concerns regarding capacity within the team were raised given the increasing workload of the team and activity having trebled in the past 3 years.

Quality Priorities Programme Board

The February meeting was a review of how service groups are delivering on the quality priorities in their areas and proposed the three additional quality priorities for 2023/24 namely

- Nutrition and hydration
- Pressure damage
- Dementia audit

Goals, methods and outcomes for existing and new priorities were being developed.

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

Mental Health and Learning Disabilities

- An update on the service's internal review against the findings of the Eden Field report was provided. The review did not only look at medium secure services but looked at all services. The review gave assurance that the issues seen in Eden field are not occurring within our services. The recommendations from this report are being taken forward into an action plan which is being overseen by the service group quality and safety group and reported onwards to QSG.

Morriston

- Concerns regarding AMU which were raised through the Guardian Service who undertook an unannounced visit to AMU. The concerns include
- Entry site to AMU, which was essentially designed as a drop off
- Yellow 'fit to sit' area- due to site pressures the number of patients in this and the drop off zone has been far more than expected and the areas is overcrowded
- Flow from AMU- this is part of wider constraints across the HB

- Nutrition and hydration

  An action plan has been developed in response to these concerns and a task force is meeting weekly for eight weeks to progress the plan. A more detailed report will be brought to the Patient and Stakeholder Experience Group.
  Post meeting note: an informal assurance visit has been undertaken and feedback provided to the service group
- A deteriorating position in relation to pressure damage. Further discussion will be held between the service group and Corporate Nursing to progress a Tissue Viability Nurse post within Morriston.

Neath Port Talbot Singleton

- No exceptions to report from adult services
- Paediatrics are working through the refurbishment plans in Morriston and a 15 steps audit had been undertaken by Bay Youth the previous evening, which supported the planned changes
- Maternity- a paper went to Management Board comparing our services against high profile reviews and identifying any actions required in response

Primary Care Community Therapies

- HMP undertaking an unannounced visit in HMP Swansea, this is likely to be accompanied with HIW
- Risks associated with implementation of Duty of Candour being addressed by service group triumvirate

Key Decisions

- Agreement on proposed new quality and safety priorities
- Joint work to be undertaken between Safeguarding and the Deputy Head of Quality and Safety- Maternity and Neonates with regard to raising awareness of co-sleeping
- Patient and Stakeholder Experience Group to engage with Bay Youth to look at joint working

Following the meeting it has been proposed that there will be annual reporting from sub-group chairs into Quality Management Board, replacing the previous intention to provide thematic updates from QSG into Management Board on a monthly basis. Sub-group updates will continue to be reported through the QSG report, complimented by annual 'deep dive' reports.

Challenges, Risks and Mitigation

QSG

- AMU action plan in place within Morriston to reduce quality risks within the service
- 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): discussions being held to identify mitigation to risk regarding digital intelligence and systems for Advance and Future Care Planning (AFCP).
- EOLC: medical lead for in end of life care per service group – discussions being held with the service groups, some have now been identified.

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

Quality Priorities

- Falls risk being progressed as part of national discussions regarding Once for Wales
- Meetings have taken place with Digital Projects regarding recording of discussions relation to EOLC and Digital Intelligence for dashboard development
- Meeting sought with workforce and OD regarding sustaining Suicide Prevention training in the longer term

Service Group Actions Required

Quality Priority	Action Required	Leads	Timescale	Impact
Falls Prevention	- Contribution to Falls Summit outlining Qi work underway within groups to reduce harm from falls	Service group Falls QP lead	28.2.23	Sharing of good practice
End of Life Care	- Development of plans to improve training compliance - – lead identified to complete training matrix	- Service Group EOLC QP leads	30.11.22 (overdue)	Improved knowledge of EOLC, resulting in increased use of key tools, A&FCP, Care Decision Tool and earlier conversations with the patient,

	- Supporting mapping of current AFCP and future promotion of AFCP discussions	Service Group EOLC QP leads		improved performance within the NACEL audit.
Suicide Prevention	- Develop and share plans to increase number of staff trained	Service group Suicide Prevention QP lead	31.12.22 (overdue)	Increased awareness of suicide

Financial Implications

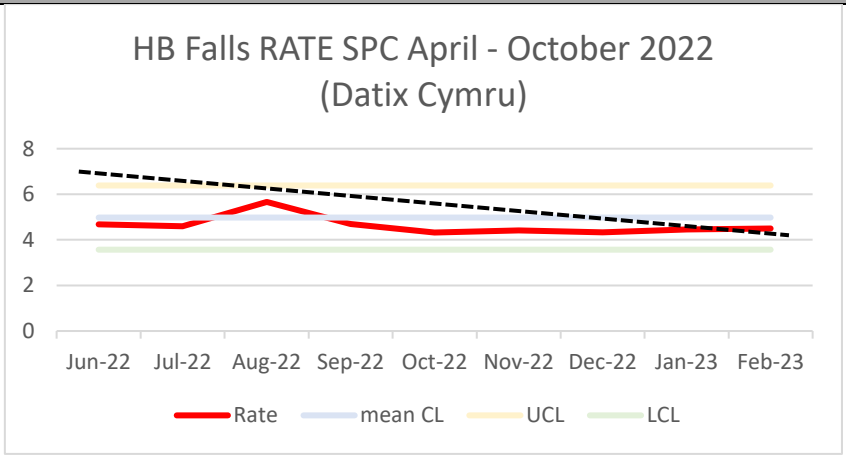
None

Recommendations

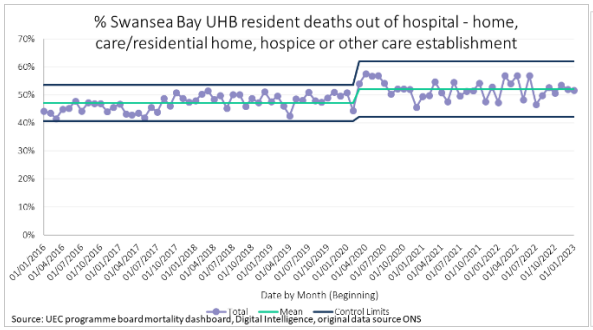
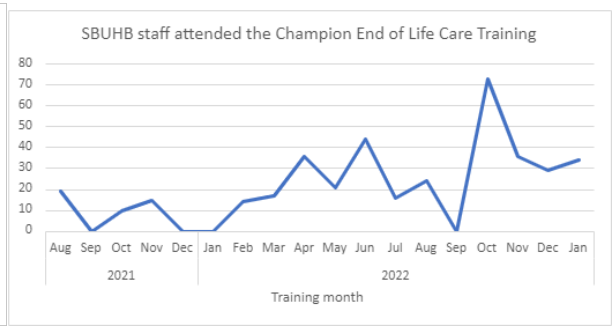
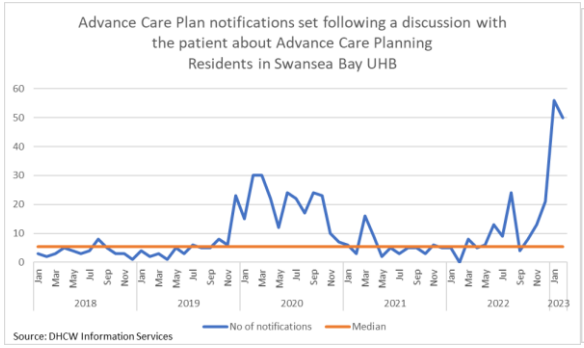
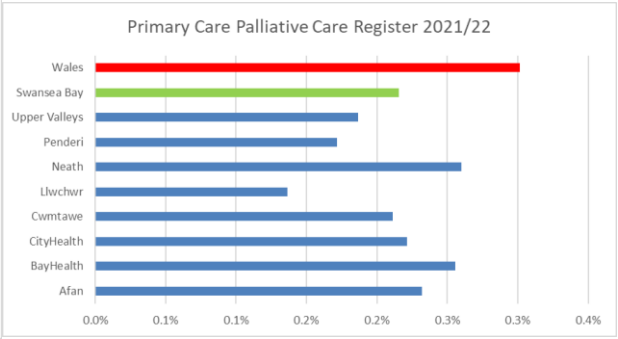
Members are asked to:

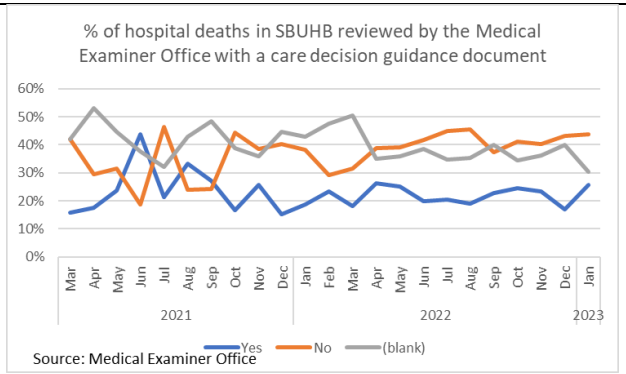
- Note the update from the QSG
- Approve the revised terms of reference for QSG and its sub-groups
- Agree to receiving an annual report from the QSG sub-group chairs
- Receive the report on progress against the Quality Priorities, as outlined in Appendix 1.
- Receive a separate update on the Sepsis quality priority
- Endorse the decisions made within QSG

Appendix 1 Quality Priority Updates

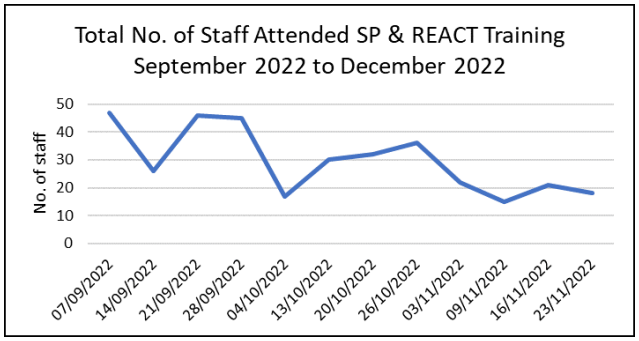
Quality Priority Goals	Methods
Falls Prevention **Reduction in harm from falls**	• Overarching Falls Prevention steering Group Chair handover complete to Helen Annandale, Clinical Director of Therapies • Launch of Regional Falls Prevention Community Taskforce • Improved Quality Assurance through new audit programme • HB Training programme to be agreed
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
- Falls summit planned for 30/3/2023
- Community falls prevention to be area of focus for 2023 with engagement with safe care collaborative

Quality Priority Goals	Methods
End of Life Care **Improved management of End of Life Care in hospital and community settings**	• Review findings of National Audit of Care at End of Life (NACEL): • Build in feedback mechanism from HB Medical Examiner Reviews, • All Patients to be recognised and receive EOLC throughout HB with a focus on early recognition • Ensure training in recognition and management of patients approaching EOLC from 1yr down: Review of Mandatory and Statutory training to ensure EOLC adequately provided
Measures	**Trajectories**
1. 1. % Swansea Bay UHB resident deaths outside of hospital 2. 2. Number of staff trained in end of life care – champion and other bespoke training by service group 3. 3. Advanced future care plan notification in WCP 4. 4. Palliative care register numbers 5. 5. % of deaths reviewed by the Medical examiner with a care decision guidance document	   



- 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

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 195 or below per month, representing a 10% reduction in falls from the 2021/22 injurious falls rates.
2. Achievement of inpatient falls per 1000 bed days below national average of 6.6

Evidence Base

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

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

Summary of Progress Against Outcomes

December progress position	**Falls Per 1000 Bed Days**	**Number of Falls**
Mental Health and LD	8.4↑ (22% INCREASE compared to Jan 2023)	32 ↑ (10% INCREASE compared to Jan 2023)

Morriston	4.6↑ (2% INCREASE compared to Jan 2023)	90↓ (6 % DECREASE compared to Jan 2023)
NPTSSG	4.2 ↑ (5 % INCREASE compared to Jan 2023)	40↓ (17 % DECREASE compared to Jan 2023)
PCCT	4.5 ↓ (50% DECREASE compared to Jan 2023)	5 ↓ (55% DECREASE compared to Jan 2023)
SBUHB*	4.5↑ (2.3% INCREASE compared to Jan 2023)	169 ↓ (8.6% DECREASE compared to Jan 2023)

- **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	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	Latest WNCR audit suggests 63% compliance with initial MRFA.

in-patient settings						**Morriston** Included in HB update **NPTSSG** Included in HB update **PCCT** Included in HB update	Target as set by NICE guidelines is completion within 4 hours – current average time from 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**	**The Falls QI leads are working with service groups to apply QI methodology, current projects include the iSTUMBLE in PCCT (nursing home education to reduce conveyance) and the Bay Watch project in Morriston.**	

						Falls audit shared with Gorseinon for use due to increased falls rate	**Falls summit scheduled 30/3/23** **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	**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**

						PCCT Training compliance now requested as part of falls report for OFPSG		

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. Improve the compliance and recognition of End of Life Care

Evidence Base

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

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

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

Summary of Progress against outcomes

Measures for the priority have been developed and there has been positive engagement from Digital Intelligence with this work.

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. Ongoing discussions with Digital intelligence to develop a digital dashboard going forward.

NACCEL audit 2022 completed with case note review, staff survey and family feedback now awaiting national results

Initiation of work with clinical teams to identify processes for both identification of triggers for advance and future care planning and for sharing detail between clinical teams supporting the patients, across all care setting (primary care/secondary care/WAST/ GPOOH). This includes participation in the Safe Care Collaborative.

Engagement with training around end of life care – induction programmes, end of life care champion programme, bespoke training according to specific needs of the clinical areas – training data accessible to demonstrate areas of engagement. Further work happening to understand needs by Service Group going forward.

Treatment escalation plan discussions started around pilot in Morriston ED and measurement of success

Meetings being arranged with each service group to discuss plans going forward and ensure medical leads for each – Morriston and P,C&T has took place

Communications plan started to be developed – core message to be developed in collaboration with Comms, to be included on the intranet, in Bay Health, screensavers and coinciding with Dying Matters week where possible. Plan to develop targeted videos.

Standardised palliative care register and meetings has been developed by primary care, to be shared in various forums

Safe care collaborative end of life care project will focus on testing the newly developed guidance for the palliative care register and how this will be shared

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 Future aim 50% of services with at least one EOLC champion within Medical Team by 31.10.22, to increase to 100% by 31.12.22	**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.
All areas of SBUHB appropriately	Group Medical Directors	Clinical Directors	NACEL	Not available	Development of audit plan by 30.9.22	**Mental Health and Learning Disabilities**	All service groups are asked to complete the

utilising the All Wales Care Decision guidance to support care in the last days of life,			Clinical audit programme		>70% compliance by 31.10.22 > 85% compliance by 31.12.22	**Morriston** **NPTSSG** **PCCT**	EOLC HB audits and to provide their named leads of the Clinical Lead for EOLC. Waiting for access to data to report. Use medical examiner as a measure for Care decision guidance
Engagement in NACEL audit	Group Medical Directors	Clinical Directors	SRO report	Not available	Named individual from each Service Group to have actively supported NACEL audit 30.9.22	**Mental Health and Learning Disabilities** Findings of Round 3 being reviewed by MH and LD Clinical Audit sub-group. Service group is a member of national NACEL MH group.	Round 4 NACEL audit has been completed with case note review, staff survey and family feedback now awaiting national results.

						Morriston Named leads for NACEL audit identified and supporting **NPTSSG** No lead provided. **PCCT** No lead provided.	
Staff are trained in EOLC	Group Nurse and Medical Directors	Heads of Nursing/ Clinical Directors	Service Group reports	Not available	Minimum of 2 champions per area and tailored bespoke	**Mental Health and Learning Disabilities** 1.2 % of staff have attended EOLC training **Morriston** 4.7% of staff have attended EOLC training **NPTSSG**	Training data processed and provided for service groups individually. Total trained in HB: Champion training – 408 (367 HB staff) Education and bespoke training –

						3.2 % of staff have attended EOLC training **PCCT** 1.9% of staff have attended EOLC training and 24 care home staff	2418 (2117 HB staff) Staff service group needs to be reviewed after ASMR change
Digital communication of A&FCP between care settings							Liaison between primary care/HB/WAST/ GPOOH and EOLC Q&S priority team Understanding of Coding in sharing meaningful EOLC detail within GP record into WCP Meeting with Digital projects to discuss potential.
Risks to Delivery							

1. There is a risk to delivery through limitations of our digital intelligence systems to record discussions relating to EOLC. Initial meetings have took place, further meeting with Digital development to understand scope of A&FCP in current systems and plan for development.

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

Sharing Hope- 149 people engaged in programme in October, 13 different projects underway

Suicide awareness and prevention training- 115 people trained in October

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 outlet for staff at risk of suicide	SRO	Project Manager Sharing Hope lead	Engagement within project Completion of artistic project Funder evaluation report	New project	> 100 participants to engage with project during its duration (2 years) >90% of participants within project to report positive benefit at completion of project		149 staff engaged October Sharing Hope film • As of end of October 2022 – 377 views • Article and film launched for public viewing on 4th October 2022

							• Social platforms Swansea NHS site on Facebook & Twitter • 70 likes – 15 comments, 49 shares on Facebook • 10 likes – 8 shares on Twitter • 2.9 k views via the YOUTUBE link
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:			Total trained up to October 2022- 874

				703 end June 22			
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		Reported having suicidal thoughts in the previous 7 days- 11.9% of referrals.
Staff able to access information on community resources to support wellbeing	SRO	Project Manager	Creation of resource directory	New project	Directory in place and accessible via intranet		Directory in development, in partnership with Hafal (3rd sector organisation)

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.