Quality Priorities highlight report February 2025

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 – February 2025

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

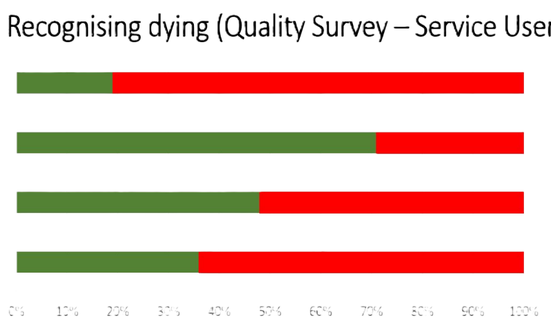
Other critical success factors
- Medical engagement with EOLC throughout service groups, demonstrated through medical EOLC champions within each service
- All Service Groups to participate in completing the Health Board End of Life Care audit.
- Digital resources – informatics and systems

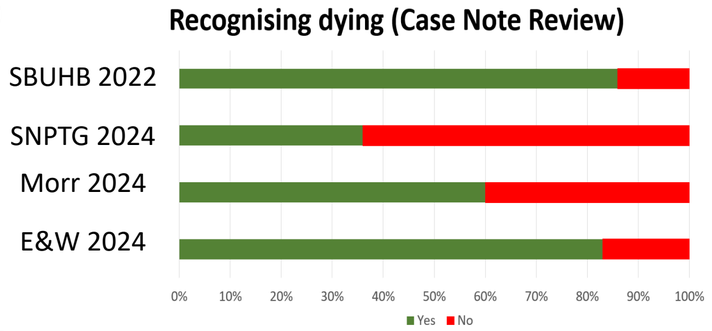
Key Outcome Measure/s
•Deaths outside of hospital 56%
•A&FCP plan notifications in WCP has stabilised at approximately 60 per month
•Approx. 34% HB staff have been trained in EOLC training, (estimated % as may be duplicate staff in both the various training offers) also delivered to external organisations largely university and care homes – LA and private.

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
•Public facing page about Palliative and End of Life Care in Swansea Bay on HB internet site – more content being added
•Engagement in the national Dying Matters Week each year.

Progress in the last month
•Majority of data for deaths in ED analysed. Awaiting further data around patient frailty and co-morbidities to support recommendations
Review of NACEL data for 2024 – excellent feed from service users; contrasting with late recognition of dying phase (outlier across England and Wales) for Singleton, Neath Port Talbot and Gorseinon hospitals combined
Data from WAST paramedics attending care homes being collected
• Data around A&FCP in hospital discharge summaries collected and being analysed

National Audit of Care at the End of Life (NACEL 2024) - Hospital deaths





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Excellent feedback from family and friends – over 200 responders
Significant improvement in experience compared with 2022 audit
Contrasts with case note reviews – documentation of care delivered.
SNPTG outlier for not recognising patient is dying

Actions for the next month	Responsible Owner	Due Date
Complete development of an all Swansea Bay Treatment Escalation Plan document and test it	Sue Morgan	March 2025
Plan delivery of HIW DNACPR review action plan – challenging – resources to support sharing of DNACPR	Sue Morgan	April 2025
Review impact of EOLC training on staff and care (to determine method for this)	Philippa Bolton Glenda Morris and Sue Morgan	April 2025
Finalisation of Adult Hospital section of the Dignity of the Deceased Person Policy	Kimberley Hampton-Evans	April 2025
Review of A&FCP included in discharge summaries for patients discharged to care home	Sue Morgan	April 2025
Survey of paramedics attending calls to Care homes re: availability of robust A&FCP and patient outcomes	Sue Morgan Amy Bartlett	April 2025
Review deaths in ED opportunities for	Hannah Robinson Sue Morgan	April 2025

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 – February 2025

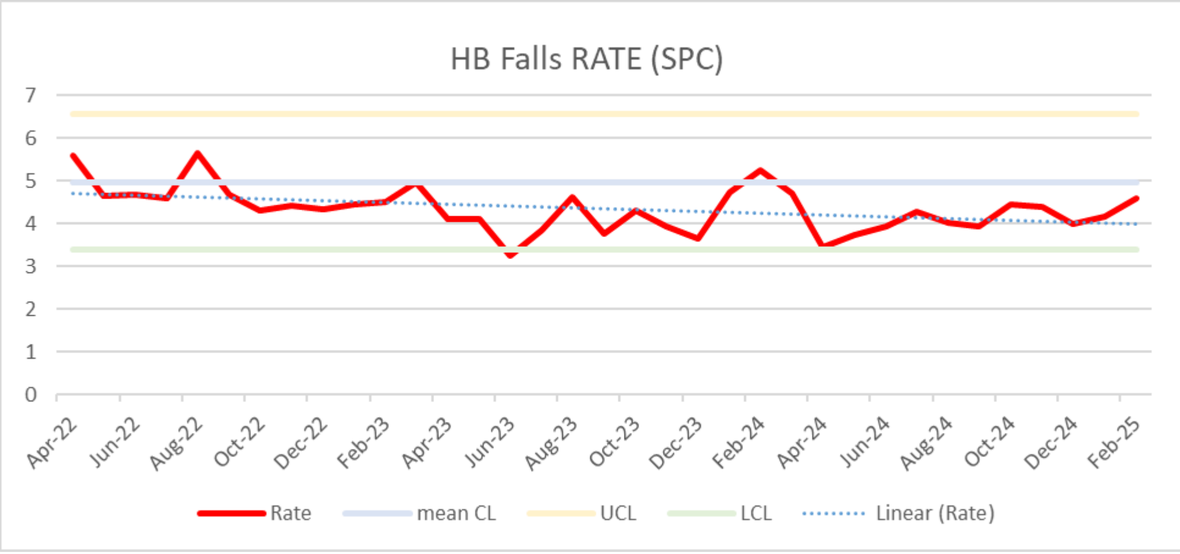
Methods

•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 –



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Graph (above) HB falls rate by month. An upturn in Feb 2025 noted however when compared to Feb 2024 this is a 13% decrease in falls rate.

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 – funding agreed from NHS Exec for additional equipment and training to expand roll out
- Level 1 falls response training underway having provided 30 sessions to care home/dom care and an additional 10 sessions to carers of individuals at risk of falls
- Procurement of lifting equipment for use in care homes and dom care as roll out of iStumble project
- Development of tool to support decision re: avoidability of harm following falls incident

Progress in the last month

- Agreement of Falls working model (to be utilised and populated in PCT Cluster falls prevention summit)
- Falls leaflets distributed to all opthamology services and GP services
- Reconditioning Ambassadors second event – critical time meds impact on deconditioning

Actions for the next month	Responsible Owner	Due Date
Planning of Falls Summit (Primary Care/Clusters)	EDA / AG	March 25
Continue work to implement the All Wales Falls Response Framework – including level 1 roll out with equipment and training	EDA/LE	March 25
Evaluation of falls level 1 training	EDA/SJA	April 25

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

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 – February 2025

Methods

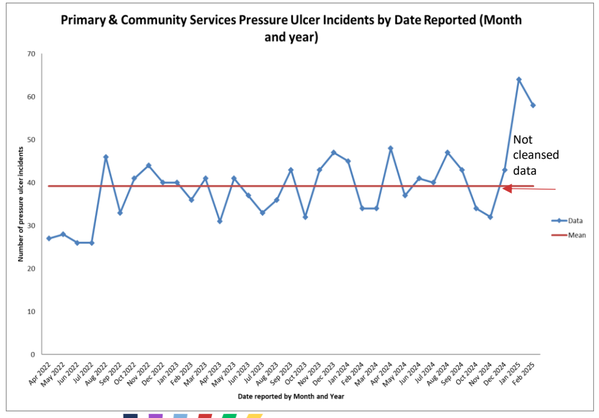
- Build Education and skills
- Build on Documentation & Communication
- Improve Governance & Datix, reporting and investigation
- Address Digital risks
- Provision of equipment MDT approach to prevention & Deconditioning
- Focus on reduction of total incidents and avoidable deep damage
- ***Strategic 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 had changed. Quarter 1 and 2 of 2024/2025 had seen an **11% reduction** against the same period in 2023/2024. Quarter 3 now seeing 5% increase. Virtual Ward and ACT incidents may not be HB acquired. SG and PUPSG lead

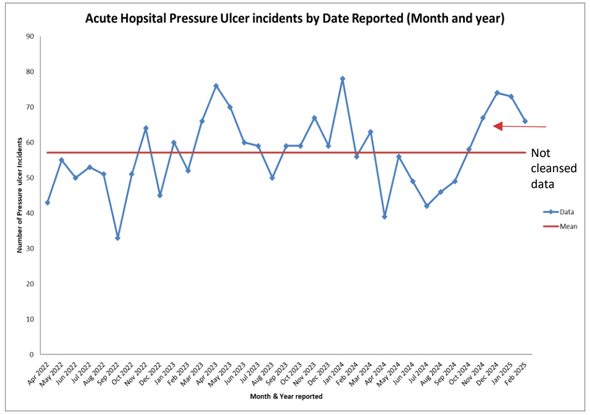
- Governance & closure improved from 46% to 63%
- SGs to develop QI plans based on localised data with particular focus on Deep Damage and intervention planning

Data below: *Datix service Group comparison data for HB acquired Pressure Ulcer incidents , sourced from the Dashboards Graphs 1,2 &3 Reflect PCSG (1) NPSSSG (2) & MSG (3). All data is cleansed in retrospect by Lead TVN. Due to lack of imaging this is less valid in many cases . Dec and January Data not cleansed.*

Graph 1 : PCS Pressure Ulcer incidents validated until Dec 2024 – Jan and Feb not cleansed or investigated.



Graph 2 : Acute Hospital Pressure ulcer incidents, validated until Dec 2024 – Jan and Feb not cleansed or investigated.



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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 Feb

- Pressure Ulcer Champions meeting (Teams)
- PUPSG QI workshop
- QI projects continued
- Executive dashboards, require further changes
- V7 pressure ulcer care plan for CYP & Adult signed off
- Educational pressure ulcer programme continued
- QI business plan for Healthy IO underway
- Deep Dive audits

Progress in the last month

- Governance and Incident closures- SG peer reviews underway
- Datix reallocation SOP agreed by PUPSG
- Scrutiny reviews
- Healthy IO data collection undertaken
- Hot Spots mapping required with QI approach and focused plans – SG to outline in QI plan for PUPSG ongoing.
- HB Strategic Quality Improvement Plan overarching the service groups
- Acute Hotspot Training
- **NEW** Champions Q&A sessions monthly via Teams underway
- **NEW** Streamliners and Student nurse days planned and agreed by university

Actions for the next month	Responsible Owner	Due Date
SG pressure ulcer mapping with staff	SG	May 2025
QI projects by SG to be updated	SG reps to report to PUPSG	March 2025
Deconditioning training Package for band 6 & 7s Preventing Harm	Rachel Govier-Williams & Eleri D'arcy	May 2025

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

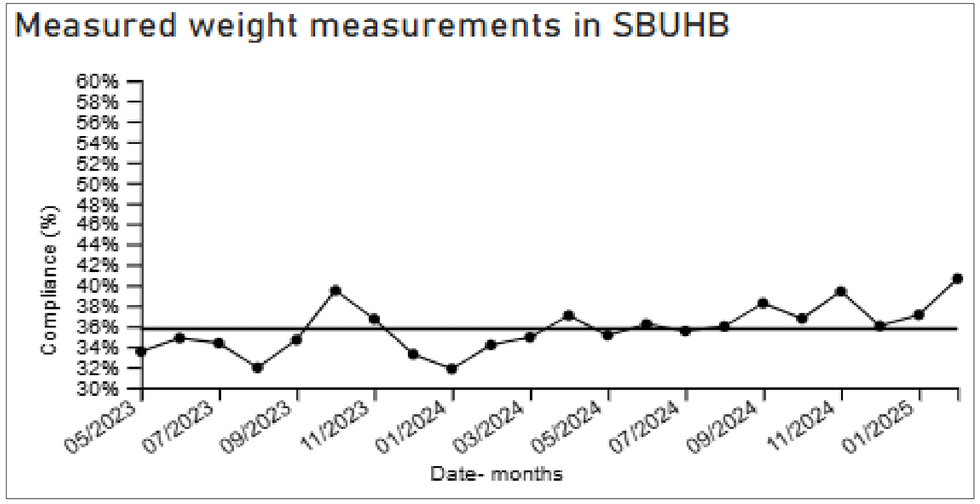
Month – February 2025

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

The Graph below shows the accurate weight compliance % throughout inpatient care. The launch of the Quality Priority "Don't wait to weigh" campaign started in January 2024 with the aim to increase SBUHB performance to above the national average of only 13.5% - 55% of patients being weighed. Currently in February 2025 the HB is at 41% 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

- Pilot study for snack ordering agreed with Morriston Catering to monitor 5 wards on 1st March and 5 Wards on 1s April 2024 – update baseline data collected & trialling a digital ordering system.
- 2nd phase of QP work stream has commenced on Nutritional Risk Assessments – baseline data now collected.
- Don't wait to weigh poster campaign commenced
- Training information on Nutrition & Hydration cascaded through the health board – base line data taken from ESR to monitor compliance
- Emergency Department – QI work has influenced estates in install two new cold water drinking facilities within the department
- Food allergen awareness recording on HEPMA – focus group has completed internal safety notice and instructions and will be ratified on 21st March in the HEPMA digital forum.

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	April 25
Snack ordering pilot in Morriston	JW & stakeholders	March/April 25

Evidence -

Quality Priority Risks - Link to QP Risk Monitoring

Risk Status: In progress × Pending × (Empty) × Incomplete × Clear filters ×

QP Area	Date Reported	Date Last Upd...	Assigned To	Risk Description	Risk Mitigation	Risk Level	Assessed Score	Risk Status
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	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	02/01/2025	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	02/01/2025	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 and could lead to transfer to hospital . 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. Health Inspectorate Wales Report on DNACPR recommendations cannot be met with current processes.	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 H...	28/02/2025	28/02/2025	Service groups/health board	Risk to increasing number of patients weighed in complex care areas - due to the withdrawal via a safety notice of weighted pat slides	Nutritional risk assessments and the need for weights to determine the nutrition needs of the patient in recovery	High	16-25	Incomplete
Cross Cutting Is...	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. - Clinical Digital solutions showing discrepancies between risks reported and clincal presentation. report to follow to QSG	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
Cross Cutting Is...	30/12/2024	30/12/2024	Digital	compliance with digital clinical systems such as Signal is not consistent increasing risks of inaccurate data reporting (particularly when attempting to identify patients who are clinically optimised)	discuss with digital team re solutions?	Medium	5-8	In progress
Sepsis	30/12/2024	30/12/2024		Sepsis data remains difficult to measure robustly. currently monitoring sepsis daeths as a percentage of all sepsis admissions & seperately all sepsis deaths- usually about 30/ & 10/ month. recent sepsis mortality showed astronomical point, this was due to a low number of sepsis admissions. there were less deaths than usual.				
Sepsis	21/02/2025	21/02/2025	Lisa Fabb	Sepsis coding on discharge is not available until about 2 month post discharge. As a result of the lag monthly data on dash board is not reliable		Low	1-4	Incomplete

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