Quality Priorities highlight report
October 2024

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

Authors:-
Angharad Higgins, Clare Baker and Quality Priority Teams

Sponsors: -
Hazel Powell, Acting Director of Nursing and Patient Experience
Lesley Jenkins, Acting Deputy Executive Director of Nursing and Patient Experience

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

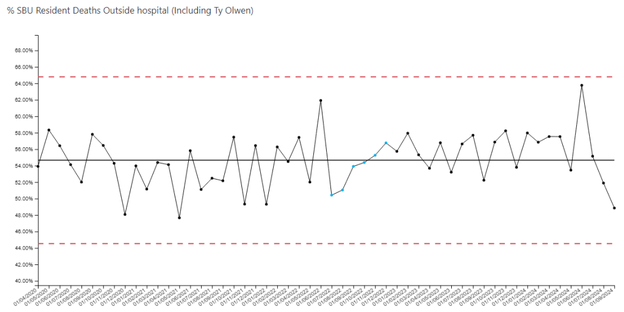
Project Team: Senior Responsible Owner – Sue Morgan (Clinical Lead), Project Manager – Tracy Rowe (part-time) , QI lead – Emma Smith

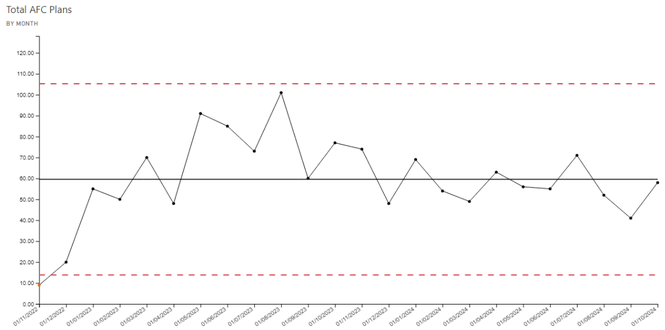
Month – October 2024

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, the baseline mean was 55.7%, the mean since April 2023 is 57.5%.
- Start of Jan 2023 A&FCP plan notifications in WCP increased due to Specialist Palliative Care using it.
- By October 2024 approx. 32% 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.
- Some improvements seen in the National Audit of Care at the End of Life 2022 compared to 2021.
- 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. Co-ordinated by PARASOL team and Care After Death Team, including Health Board venues and the Waterfront Museum, with many third sector organisations.
- End of Life Care Dashboard development has started – includes some of the measures required, further tweaks to be made

Progress in the last month
- MH&LD service group registered for NACEL Mental Health Spotlight audit 2025
- Adult hospital section of the Dignity of the Dying Person Policy has been agreed in principle by the Nursing and Midwifery Board
- End of Life Care Conference venue and agenda finalised for November 20th 2024. Over 100 attendees (with a waiting list) – multi-professional, with representatives from hospital and community settings, including care homes

Actions for the next month	Responsible Owner	Due Date	
Review of Treatment Escalation Plan testing	Sue Morgan	November2024	
Plan delivery of HIW DNACPR review action plan	Sue Morgan	January 2025	
Review impact of EOLC training on staff and care	Philippa Bolton Glenda Morris and Sue Morgan	November2024	
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 – October 2024

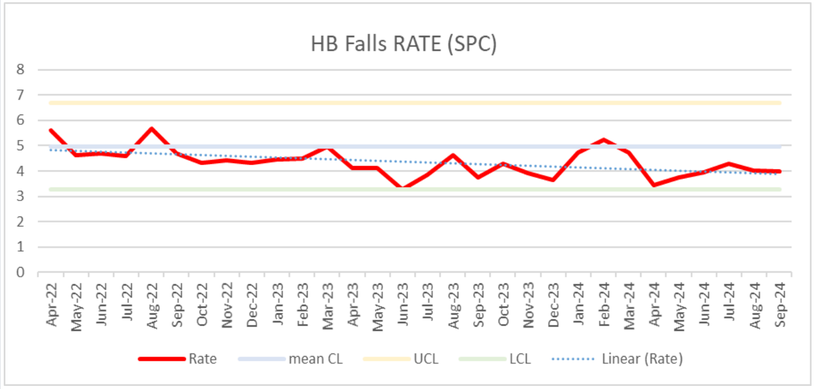
Methods

•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

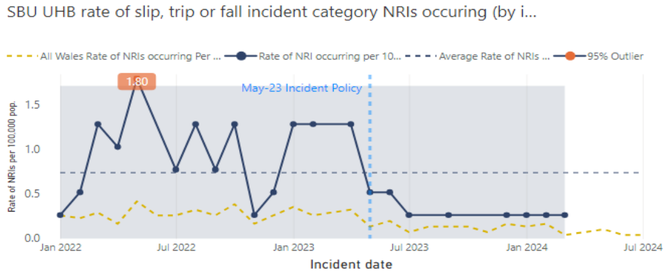
Other critical success factors

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

Key Outcome Measure/s –



Graph (left) HB falls rate by month.
Graph (below) Nationally reported falls incidents against national average



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

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

Progress in the last month

- Falls Documentation audit agreed – plan to trial across all SGs
- Reconditioning Environmental Audit reviewed – service groups to complete shortened version at each site and develop action plans

	Actions for the next month	Responsible Owner	Due Date
	Continue work with PCT re embedding Stay Steady Stay Safe campaign and agreeing standardised assessment for falls	EDA / LT	Dec 24
	Planning for action plan to meet recommendations from NAIF – present to COEG Nov 2024	HA/EDA	Nov 24
	Reconditioning Ambassador launch event	EDA/PE/CM	Nov 24
	Agree mechanism for using Falls documentation audit	EDA with SGs	Nov 24
	Placemat project launch (deconditioning)	EDA/Comms	Nov 24

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

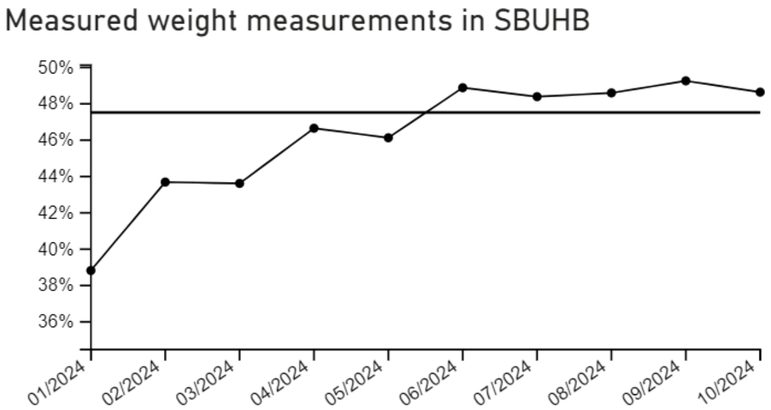
Month – October 2024

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

- Data collected & visits to Childrens wards completed to source baseline data prior to the launch of new menu. BAYouth have signed off menu but wish it to be illustrated differently.
- Snack ordering system progressing and ordering forms audited recognising good practice & Poor practice – will roll out pilot study on 10 wards in Morriston in October.
- QI focus on ED commenced and is currently on going in terms of water bottles
- QI data for Hydration to be piloted in Gorseinon Hospital
- Ongoing discussion regarding allergens on HEPMA
- Learning Symposium to be held on 19th November 2024
- Don't wait to weigh and promotional campaign to commence & poster agreed
- To commence with 2nd phase which is Nutritional screening & processes and Mental Health

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	Oct 24
Organisation of training symposium		JW &Stakeholders	Oct 24

Evidence -

Quality Priority – Pressure Ulcers
Goal – To reduce the amount of patients developing HB acquired avoidable pressure damage by 10% by end of March 2024

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

Month – October 2024

Methods

To be finalised

- Repositioning
- Datix reporting
- Governance Patient information
- Digital
- Platforms
- Education & Skills
- Equipment & Resource
- Documentation

Other critical success factors

Strategic direction lead by PUPSG QI work planned to target HB hots spots.

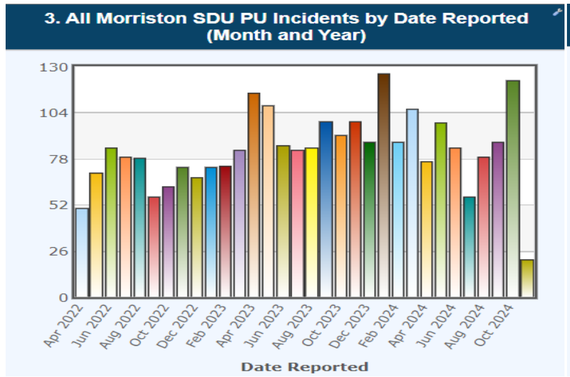
Key Outcome Measure/s **based on quarter 1, Quarter 2 not yet run until Nov 2024**

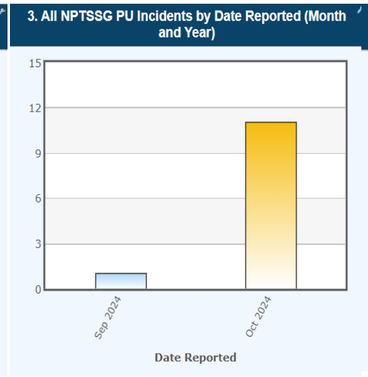
- Reduction in Pressure Ulcer incidents 0.95% reduction in incidents 2023-2024, target 10% reduction. Previous 3 years seen 30% increase year on year.
- **12% Reduction** in HB incidents since Quarter 4, 31% reduction in hospital incidents

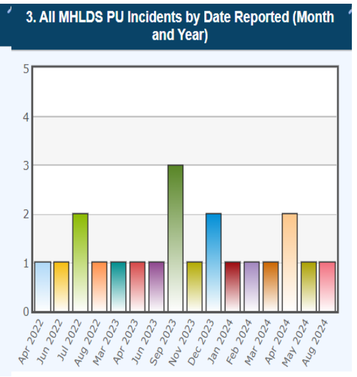
SPC comparison data for HB acquired Pressure Ulcer incidents over the previous 4 years (2020 – June 24)

Graph 1 displays data from 2023 and 2024 along with earlier years. From January 23 and continuing till March 24 there was a *shift* in the data above the median. This increase is reflective of a slight increase in PCS but more notably a significant increase in incidents at Morriston Service Group. NPSSG had also seen and unusual increase for the SG, although the figures are little and don't fully represent well by using percentage increase.

New Dashboard examples NPSSG has now been merged







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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 Oct

- Documentation changed ED REACT agreed
- First Pressure Ulcer Champions meeting (Teams)
- HB Champions Register
- QI project continued
- PUPSG planning Nov
- Datix Pressure Ulcer Dashboards developed in pilot
- V7 pressure ulcer care plan for CYP & Adult finalised pending sign off PUPSG
- Pressure Ulcer Prevention training Programme implemented
- 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 – In Draft
- HB Strategic Quality Improvement Plan overarching the service groups
- Mapping sessions with PCS QI projects ongoing
- Bespoke Pressure Ulcer Theatre Training continued
- Bed Tender Show & Tell and tenderers evaluation complete pending award
- QI project - Rehab & Deconditioning pilot continued
- Review of Unscheduled care risk assessment and documentation to replcate the ED planned changes (REACT)
- PU Training Programme & STOP pressure ulcer events live
- Ward Hot spot training PCS and Care home education project planned –PUPIS involvement
- HOT spot training across the HB
- Fundamentals of tissue viability (Pressure ulcers) training days live across HB for RGN and HCSW

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
ED /unscheduled care REACT risk assessments changed & in place	SG /Rachel. Govier-Williams	Nov 24

Quality Priority – Sepsis
Goal – Improvement in the recognition and management of Sepsis

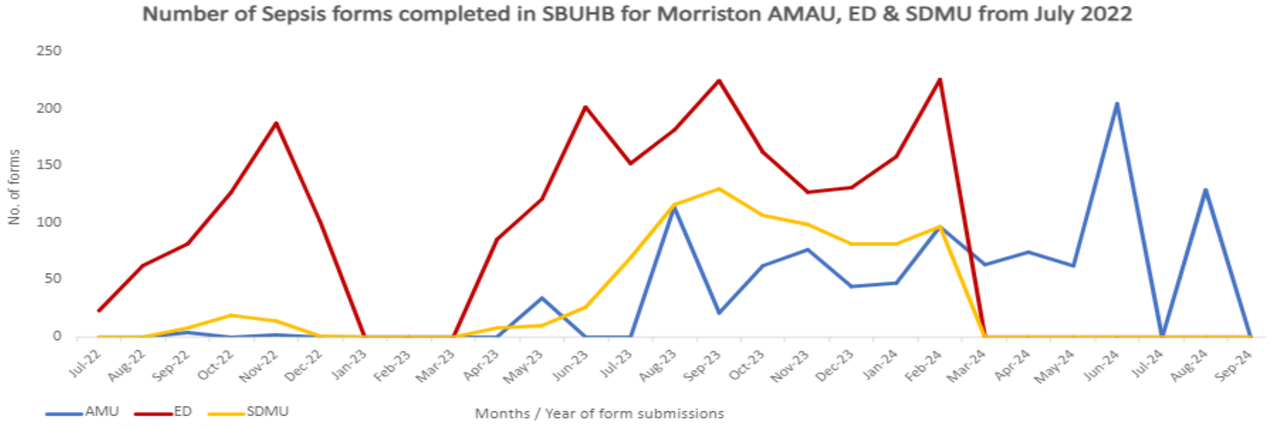
Project Team: Senior Responsible Owner – Dr. Ranga Mothukuri, Project Manager – Lisa Fabb, QI lead – Samantha Scott

Month – October 2024

Methods:
- Sepsis team are working with sepsis leads in clinical teams to develop an action plan to achieve 'business as usual' incorporating governance, training and audit .
- Embed Sepsis and Acute Deterioration audit into monthly Ward audit to ensure robust sustainability.
- Support development and roll out of national sepsis measures.
- Review sepsis training.

Other critical success factors:
- Increase the number of patients appropriately screened for Sepsis
- Reduce harm from sepsis eg inappropriate antibiotic prescribing.
- Priority was given to auditing the admitting units where there has been a significant increase in number of forms completed but percentage of appropriate patients screened remains about the same.
- Plans in place to address this including reaudit, training and raising awareness
- Evidence that Sepsis is business as usual i.e. embed audit in monthly ward audit.

Key Outcome Measure/s
- No. patients screened for Sepsis



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Evidence – NICE Guidance NG51 / New National Guidelines on treating Sepsis by AoMRC

Key achievements:
- Awaiting launch of Sepsis and acute deterioration e learning on ESR on in Oct.
- Compliance with target of antibiotics within 1 hour of recognition of sepsis in various audit has been above 90%.
- Continued to trial robust systems to collect national acute deterioration and sepsis measures and action plan.
- Agreement on easy decision guide to appropriate and efficient training for sepsis.
- Blood culture improvement package, demonstrating some impact.

Progress in the last month:
- National agreement of principles for an all Wales Sepsis screening tool
- 1st dose antibiotics audit completed and action plan in development.
- First Sepsis screening audit results, via AMaT, collected. Currently collaborating with AMaT lead to being reviewed for presentation next month.
- Trial collection of all Wales Sepsis measures to ensure sustainability and reliability.
- Presentation of Sepsis Deep Dive paper for MB.
- Developing easy access DNACPR information for families, patients and clinicians with sepsis.

Actions for the next month	Responsible Owner	Due Date
1st Dose antibiotic action plan complete	Dr R Mothukuri	Oct 24
Roll out Blood Culture Improvement	Lisa Fabb/ Louise Wooster	Sept 24
Signal Sepsis screening report	Lisa Fabb	Sept 24
Continue test of all Wales Sepsis measures	Lisa Fabb	Oct24

Quality Priority Risks - Link to QP Risk Monitoring

QP Area	Date ...	Date Last Updated	Assigned ...	Risk Description	Risk Mitigation	Risk Level	Assesse...	Risk Status
End of Life Care	01/08/2024	10/10/2024	Digital	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	In progress
End of Life Care	01/08/2024	10/10/2024	Digital	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	In progress
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	In progress
Falls	01/08/2024	30/10/2024	Service Groups /Health Board	Governance process to investigated falls incidence – slowing learning and sharing of information.	Learning from incidents/events included on Overarching HB steering Group. mechanism required to share learning back with staff	Low	9-15	In progress
Pressure Damage	01/08/2024	10/10/2024	Digital	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	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	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		The all Wales DNACPR policy states that when a DNACPR decision is made, the form should be shared with the patient, the GP, GPOOH, and other clinical teams that support the patients care. When DNACPR decision is made in the hospital setting, the forms are not always given to the patient when they are discharged home, and The relevant copies of the hospital decision 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 Hydrat	29/10/2024	29/10/2024		Risk reviewed and none to note				

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