Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Quality and Safety Assurance Report

Quality, Safety and Experience Committee

11 April 2023

Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an overview of quality and safety across the Health Board.

The Health Board uses a number of assurance processes and quality improvement strategies to ensure high quality care is delivered to patients.

This report provides information on:

- Patient safety incidents including externally reported patient safety incidents
- Infection control
- The nosocomial COVID-19 review programme
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- Whole system approach to collaboration and quality improvement

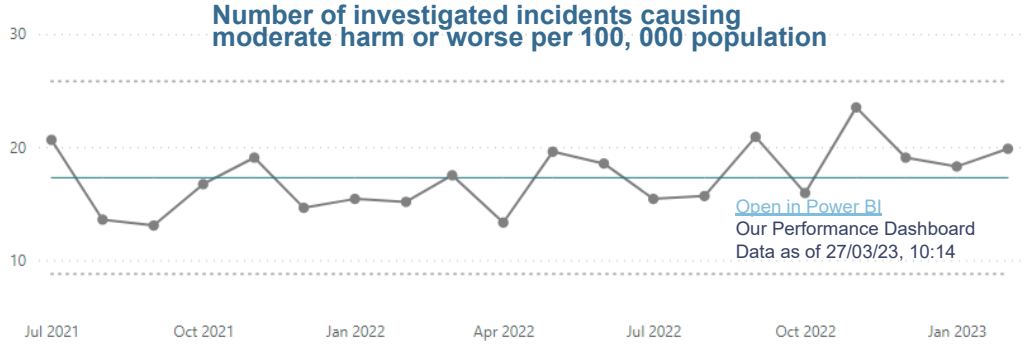
Incident Reporting

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

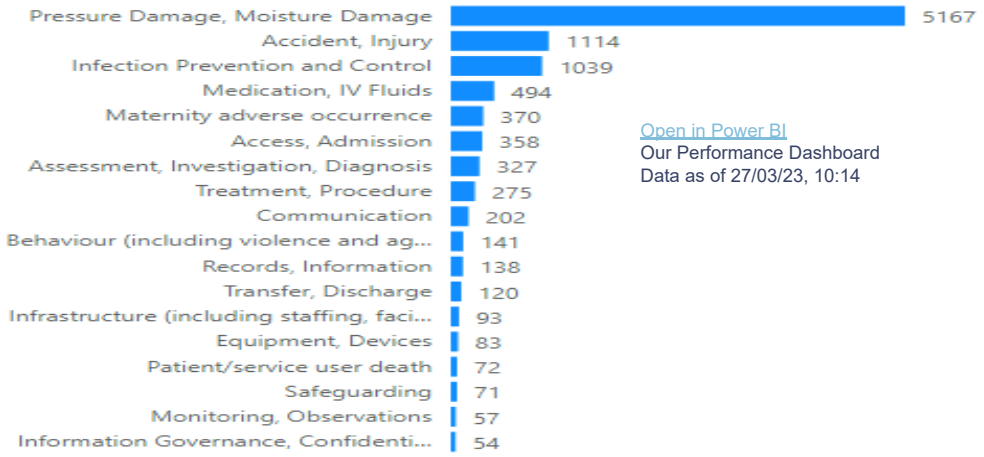
There were 15, 864 Patient Safety Incidents reported on Datix Cymru in Hywel Dda UHB between 1 March 2022 – 28 February 2023.

The spike in reporting seen in January is due to a piece of work to ensure all suspected nosocomial COVID infections are captured on Datix Cymru

Of the 15, 864 patient safety incidents reported, 8,411 have been closed.

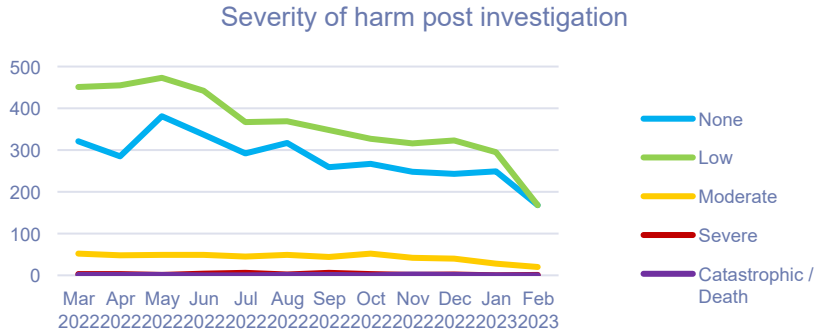


Work is underway to ensure that the severity of incidents post investigation reflects the acts or inactions by the Health Board e.g. an expected death in the community was closed as catastrophic by the service and on review no acts or inactions were identified



Pressure damage, moisture damage – 47% reported are moisture damage incidents; of the pressure damage incidents 88% are deemed unavoidable following investigation

Accident, injury – 27% reported at slips, trips and falls. Timely risk assessment is an area for learning which is being taken forward through the falls reduction work.



In November and December 2022, 3,832 incidents were reported of which 3,386 were patient safety related

Nationally Reportable Incidents

	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4*	Total
Access, Admission	0	0	4	2	2	4	1	13 (6)
Accident, Injury	0	0	0	1	1	1	3	6 (5)
Assessment, Investigation, Diagnosis	0	1	1	3	0	1	0	6 (4)
Behaviour (including violence and aggression)	1	2	1	1	0	1	0	6 (2)
Infection Prevention and Control	1	0	0	0	0	0	2	3 (3)
Maternity adverse occurrence	1	0	0	1	1	1	0	4 (3)
Medication, IV Fluids	0	0	1	0	1	0	0	2 (0)
Monitoring, Observations	0	0	0	1	0	0	1	2 (1)
Patient/service user death	0	2	6	10	1	8	3	30 (22)
Pressure Damage, Moisture Damage	0	0	4	4	1	2	1	12 (0)
Transfer, Discharge	0	1	0	0	2	0	0	3 (2)
Treatment, Procedure	1	0	1	1	2	2	2	9 (7)
Total (total awaiting closure)	4 (1)	6 (1)	18 (4)	24 (14)	11 (7)	20 (16)	13 (12)	96 (55)

Improving management of serious incidents including nationally reportable incidents

Scrutiny of all incidents reported undertaken by the Quality Assurance Information System (QAIS) Team on a daily basis. This ensures that any incidents that may be low harm but that meet the requirement to report nationally are identified e.g. Never Events.

Patient Safety Incidents where the harm is severe or catastrophic and those flagged by the QAIS Team are reviewed by the Patient Safety Team. An Incident Management Group is arranged with the Triumvirate to:

- Review and consider the findings of the initial scrutiny of the incident
- Identify any immediate actions required to mitigate the risk of re-occurrence
- Confirm Being Open discussions and confirm Duty of Candour arrangements including agreement on the Duty of Candour lead
- Set the Terms of Reference (ToR) and scope of the investigation
- Agree the lead Investigator and supporting investigation team
- Identify any risks associated with the incident
- Lay out arrangements for any further investigation team meetings
- Confirm timescales for the investigation

Introduction of routine reports giving reminders of dates that a serious incident is due for closure.

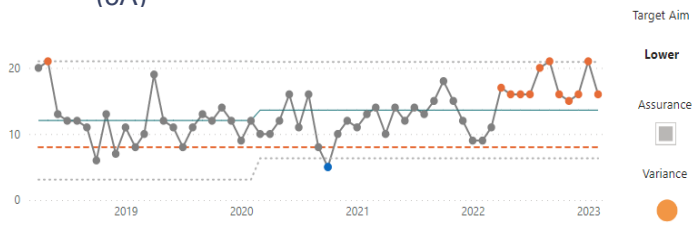
Monitoring of open serious incidents at Directorate Quality and Governance meetings

Infection Control

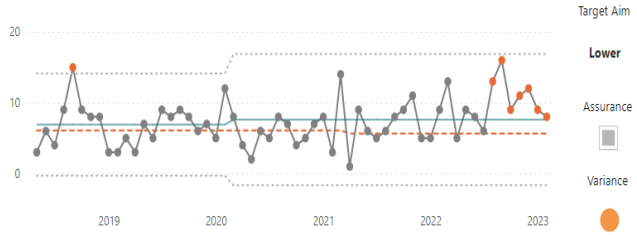
The number of Clostridioides *difficile* infection (CDI) cases continues to be of concern both locally within Hywel Dda and on a wider National basis. February however, showed a slight downturn in cases across Wales.

The Health Board continues the targeted work across areas of concern as highlighted by the HCAI dashboard is ongoing.

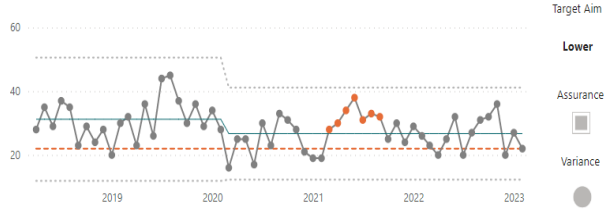
Number of confirmed C.*difficile* cases (5A)



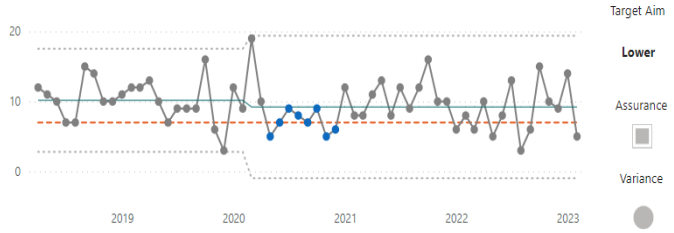
Number of confirmed Klebsiella cases (5A)



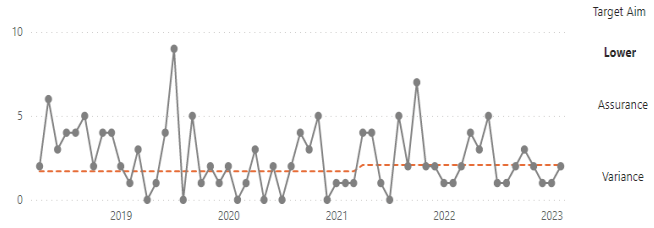
Number of confirmed E.*coli* cases (5A)



Number of confirmed S.*aureus* cases (5A)



Number of confirmed P.*aeruginosa* cases (5A)



Infection Control continued

- The new Health Care Acquired Infection (HCAI) Dashboard highlights at a glance areas of increased infections and allows for a targeted approach to be implemented. Identified areas of increased incidence are currently under close surveillance with measures initiated to mitigate and reduce risk of further cases as detailed in the Health Board's HCAI Implementation Plan.
- Clostridium Difficile Infection (CDI) scrutiny meetings are now embedded on each site for all Hospital Acquired Infection (HAI) CDI's to discuss the findings of the proportionate investigation and determine lessons learnt from each case, allowing identification of common areas of cause such as environmental factors and antibiotic stewardship.
- A trial of a new disinfectant that is known to be effective against CDI spores is being trialled on two areas in Withybush General Hospital (WGH).
- Improved engagement with our medical colleagues is expected to have an impact on antibiotic stewardship with improved compliance and commitment with Start Smart Then Focus (SSTF) audits.
- A new electronic version of the proportionate investigation tool for CDI is being developed to ease use and compliance.
- New site specific trajectories for CDI have been agreed with a reduction expectation rate of 20% based on 1000 hospital admissions; we await Welsh Government infection improvement goals (2023/24) to enable consideration for population based trajectories.
- An internal review of CDI within the Health Board is due to be submitted towards the end of March 2023

Nosocomial COVID Review Programme

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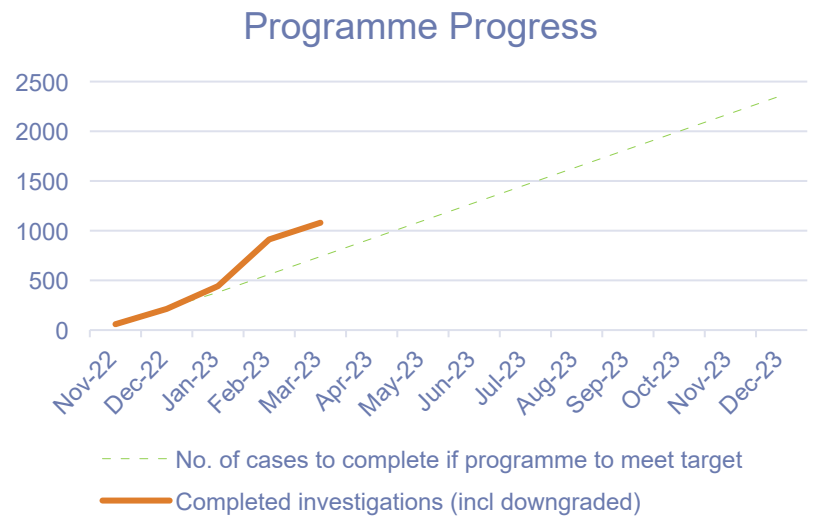
The COVID Programme Review Team and Quality Assurance and Safety Team continue to progress the review of each patient.

Where it is assessed or suspected that an action or inaction, has, or is likely to have caused or contributed to the patient's unexpected or avoidable death, or caused or contributed to severe harm to the patient, a proportionate investigation is also undertaken in line with Putting Things Right.

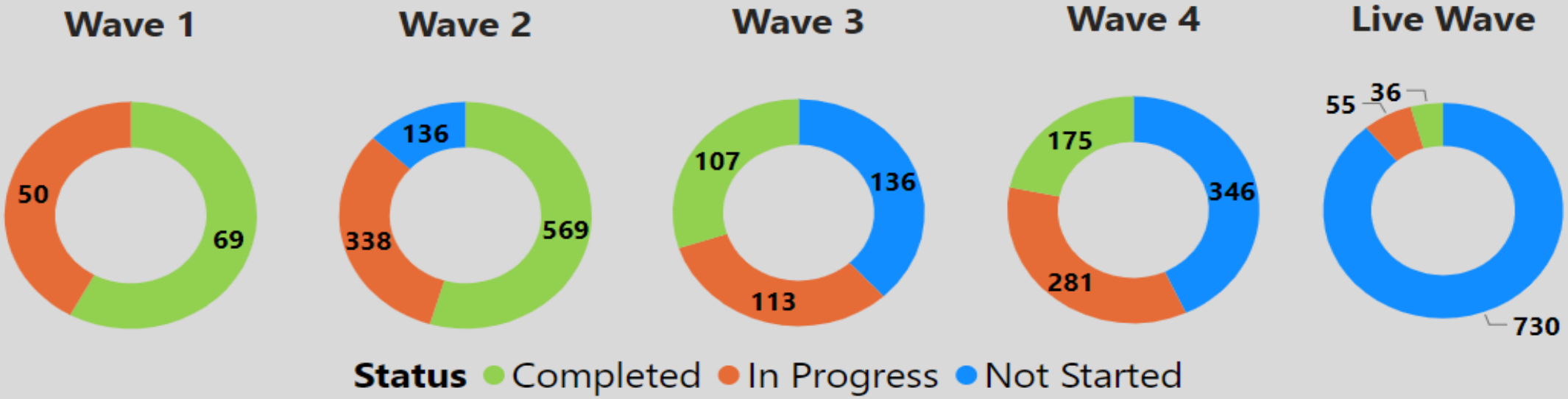
On conclusion of the initial review, the review is screened by Head of Quality and Governance/Patient Safety and Assurance Manager, the COVID Lead Investigator or the COVID Review Clinical Lead and a decision is made as to whether the case should be presented to the CAN Scrutiny Panel

See appendices 1 and 2 for learning previously shared with QSEC.



	Wave 1 (27/2/2020 - 26/7/2020)	Wave 2 (27/07/2020 - 16/05/2021)	Wave 3 (17/05/2021 - 19/12/2021)	Wave 4 (20/12/2021 - 30/04/2022)	**Total (30/03/2023)**	Position As at 18/01/2023	Live 01/05/22 -
Total number of suspected hospital acquired COVID included in the review	119	1043	356	802	**2320**	2320	821
Total not started / under investigation	0	111	99	305	**531**	1087	689
Total review complete (awaiting decision for panel)	33	161	91	204	**473**	568	40
Downgraded	11	47	15	10	**83**	37	10
Total referred to panel (not closed)	9	128	24	75	**236**	295	7
Total completed investigations	66	596	127	208	**997**	333	75

NNCP Data - Hywel Dda UHB



Wave 1 | Wave 2 | Wave 3 | Wave 4 | Live Wave | Reset

Total Cases

2320	0
Latest	Change

In Progress

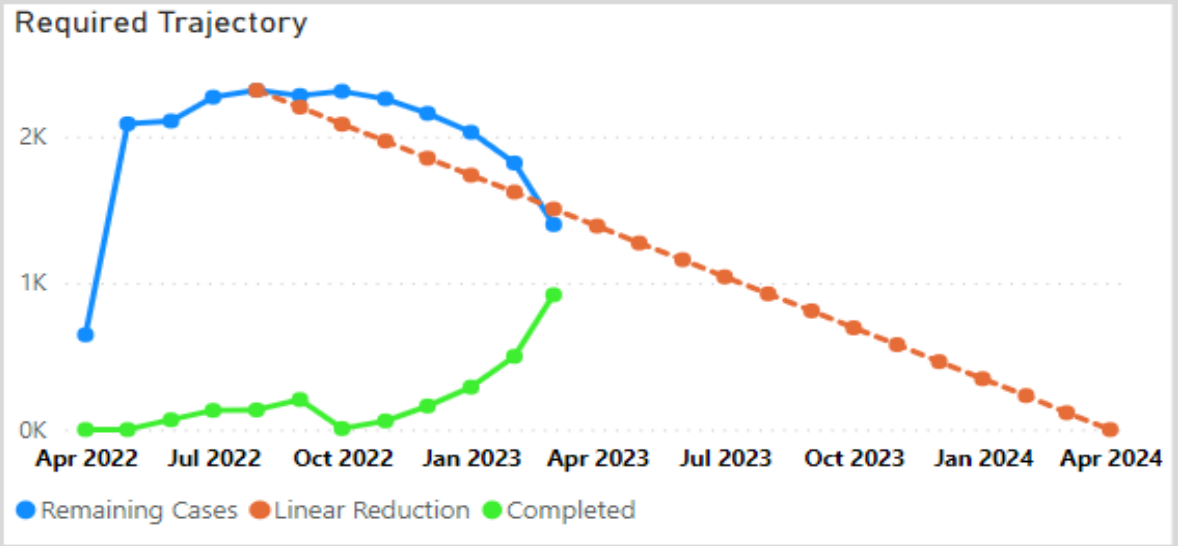
782	-51
Latest	Change

Completed

920	420	39.66%
Latest	Change	%

Not Started

618	-369
Latest	Change



The National Nosocomial COVID Programme published an interim learning report on 29 March 2023. An action plan is currently being developed which will be considered by the Health Board's Corporate Assurance Nosocomial COVID Strategic Oversight Group.

HIW Quality Checks/Inspections: Recent reviews and inspections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Area of Review	Recomm-endations	Update
Mental Health Discharge Review	TBC	On 7 March 2023, HIW published a report following a review undertaken to assess the quality of discharge arrangements in place within Cwm Taf Morgannwg University Health Board for adult patients being discharged from inpatient mental health services to the community. HIW have now announced a review into discharge from all mental health services for services to benchmark against the learning from the Cwm Taf University Health Board report. The deadline for completion is 5 May 2023.
Ionising Radiation (Medical Exposure) Regulations (IRMER) Report GGH	TBC	Following submission of an IRMER notification the service are undertaking a full detailed investigation report which is due for submission on 14 June 2023.
Child Protection Rapid Review	TBC	Following the publication of a Child Practice Review in November 2022 HIW announced a review into current structures and processes in Wales to ensure children are appropriately placed on, and removed from, the Child Protection Register when sufficient evidence indicates it is safe to do so. The Health Board has been requested to share detail of cases. The specific data required is awaited from HIW at the time of writing this report.
Tregaron GP Practice Inspection	TBC	An inspection took place on 16 February 2023. No immediate assurances concerns nor infection control issues were identified. A few points are expected regarding staff induction and location of the practice policies. **The draft report is awaited.**
Do not Attempt Cardiopulmonary Resuscitation (DNACPR) Review	-	HIW announced a formal review of Health Board's management of DNACPR patient processes. Submission of a significant number of historical records took place for this review in February 2023. The Health Board were informed on 8th March 2023 that a piece of work is underway for a national thematic review to be carried out by the Mortality Review (MR) Group at the Welsh Delivery Unit. This review has therefore been postponed for the time being.
Argyle Medical Group Inspection January 2023	2	An announced Quality Check took place on 5 January 2023 at the Argyle Medical Group GP surgery. Feedback on the quality related to environmental risk assessment and protocols dates.
A&E (GGH) Inspection December 2022	27	An unannounced inspection took place between 5 and 7 December 2022. There were several areas of immediate assurance required including securing the gas storage room, promotion of privacy and dignity within the surge areas at times of high capacity, resuscitation trolley checks, regularity of assessments for waiting patients, sepsis screening and the safety and wellbeing of children waiting within the department. Following further assurance the improvement plan for this report was approved and the report published. **There are 15 recommendations open on AMAT**.

HIW Quality Checks/Inspections: An update on those previously reported

Area of Review	Recomm-endations	Update
Maternity (GGH) November 2022	12	An unannounced inspection took place on 29 and 30 November 2022. There were several areas of positive feedback, no immediate concerns highlighted and the recommendations relate to mandatory training and appraisal compliance. The draft report has been received with factual accuracy checks and the improvement plan submitted 23/01/23. **There are 7 recommendations open on Audit Management and Tracking System (AMAT.)**
IRMER Inspection (GGH) November 2022	19	An announced inspection took place on 15 and 16 November 2022. The verbal feedback highlighted no immediate concerns and the recommendations relate to the standard of appointment letters, compliance with IRMER regulations, although acknowledgment that work is well underway to address this aspect, processes require updating and staff training. The report was published 24/01/23. **There are 18 recommendations open on AMAT.**
Angharad ward, (BGH) Paediatric ward October 2022	8	An unannounced inspection took place on 4 and 5 October 2022. The draft report highlighted no immediate concerns, the recommendations relate to timely Child and Adolescent Mental Health Services (CAMHS) assessments, cleaning chemical storage, the requirement of a new clinical medication fridge, the development of menus, the replacement of flooring and reminders to staff regarding allergies and weight recording on drug charts and the countersignature and printing of names on documentation. The report was published on 5th January 2023. **There are 3 recommendations open on AMAT**.
Bryngofal ward, PPH July 2022	19	An unannounced inspection took place on 11 July 2022. The verbal feedback highlighted no immediate concerns and the recommendations relate to maintenance and refreshing environment, reorganisation of clinical room and the use of an office for staff, the provision of a fridge for patient use, consideration of staff uniforms on escort duty, training records, medication records and highlighting attention to the Consultant Psychiatrist and the Psychologist posts currently vacant. At the point of updating this report **9 recommendations open on AMAT** almost all of which relate to Estates matters.
Ward 7 PPH February 2022	19	The inspection took place in November 2021 where 19 recommendations were raised on matters such as workforce, medicines management, governance and leadership, infection prevention and risk and health and safety. **All recommendations are now complete**.
National Review of Mental Health Crisis Prevention	19	This final report into the national review was published in March 2022 involved services benchmarking themselves against the recommendations suggested. The improvement plan was submitted 27 May 2022 which requires some redesign of pathways of care and development of services, communication and engagement with primary care services and development of some staff roles and recruitment into new staffing models. At the point of updating this report **5 recommendations are open on AMAT.**

HIW Quality Checks/Inspections: An update on those previously reported (cont)

Area of Review	Recomm-endations	Update
Ystwyth Medical group Quality Check	0	The quality check took place on 7 February 2022. The review covered environment, infection, prevention and control and governance and staffing. **The report made no recommendations of the service**.
National Review of Stroke Pathways	0	The Health Board's contribution to this review, an onsite inspection, took place at Bronglais Hospital between 28 – 30 March and 16th May 2022 for the clinical areas. HIW also interviewed the corresponding staff at PPH, GGH and WGH for Stroke and Patient Flow. **We await feedback as well as the final All Wales report which was expected to be available late 2022 (not received to date).**
Llandovery Hospital Quality Check	0	The quality check took place on 15 March 2022, following postponement from 2021. The review covered environment, infection, prevention and control, governance and staffing, and some aspects of Covid-19 management. **The report made no recommendations of the service**.
Tregaron Community Hospital	29	An on-site inspection was undertaken on 7 and 8 September 2021, whereby 29 recommendations raised on matters including patient experience, delivery of safe and effective care and quality of management and leadership. At the point of collating this report **all recommendations are complete.**
HIW IR(ME)R July 2021 WGH	40	The improvement plan included access to services, listening to feedback, staff training and some All Wales actions. At the point of collating this report there is **1 recommendation open on AMAT** linked to an All Wales piece of work.
Welsh Ambulance Services NHS Trust Acute improvement plan	31	This Welsh Ambulance Service improvement plan dating from September 2021 includes recommendations that affect or impact and require action for Acute / Emergency services and departments. At the point of updating this report there are **4 recommendations are open on AMAT** for sites to take forward.
Withybush General Hospital, St Caradog Ward	4	This improvement plan details recommendations in relation to Fire Safety and Health and Safety. There remain **2 recommendations open on AMAT** at the point of collating this report with extended completion dates.

HIW Additional Information

Progress of actions agreed following inspections and quality checks

As of 29 March 2023 the current position is a total of 12 reports / inspections with 90 recommendations open. All these recommendations and actions continue to be tracked by the Quality Assurance and Safety Team (QAST) and are now all uploaded to the AMAT system for services to manage and update direct. Support is provided to services for completion and use of AMAT is encouraged. Those recommendations that have exceeded their due date are extended to completion, with discussion with services.

Other correspondence received from HIW

- Healthcare Inspectorate Wales' (HIW) Insight Bulletin
- Request for assurance relating to management of a medication error
- Request for assurance relating to CAMHS support for those between 16 and 18 years of age.
- Notification of a Child Protection Rapid Review
- HIW Review Report: Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Services within Cwm Taf Morgannwg University Health Board
- Postponement of the HIW DNACPR review (whilst the NHS Wales Executive undertake a review)

Other Inspection and Peer Review activity

Welsh Risk Pool

- Correspondence to all LHBs and Trusts received regarding timely learning in all claims and redress cases - potential for the application of penalties where learning is deferred over six months.
- Structured assessment of compliance with Putting Things Right Standards – recently completed and awaiting findings

Risks and Mitigations

- All correspondence received by third parties such as the Welsh Government, the Delivery Unit or Health Inspectorate Wales in relation to their activity is logged on receipt by the Quality Assurance and Safety team (QAST).
- A robust process is in place for co-ordinating and quality checking responses, including gaining executive approval of HIW submissions, by the required deadlines.
- Recommendations arising from HIW, et al, such as immediate assurance plans or final reports are being migrated into the new AMAT software, in the meantime, QAST are pursuing services for updates in advance of any due date.
- The QAST team are supporting services to develop their improvement plans.
- QAST are providing updates for reporting to the Audit and Risk Team for each Audit and Risk Assurance Committee (ARAC) meeting.
- HIW activity forms part of the quality governance arrangements within Directorates.

Whole system approach to collaborative and alignment to priorities

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

What do we know?

- Population of 384,000 across 3 counties
- Very large border with other counties
- Fewer people aged 25-44 & more people aged 55-79 than other areas in Wales
- Highest population growth for those aged >65 in Wales

- Significant increase in number and length of ambulance delays
- Lack of ambulance response in the community
- Number of occupied beds increasing
- Average length of stay increasing

Impact on the whole system and addressing our safety priorities

Our approach to quality

Quality Management System (QMS)

- Improving Together
  - Our Safety Dashboard
- Quality Improvement Strategic Framework 2023 – 2026
- Continuing to build capacity and capability
  - Quality Improvement and Service Transformation Team
  - Enabling Quality Improvement in Practice (EQIiP) Programme
  - Improvement Coach Development

Recommendations from Foundational Site Visit

Summary of Recommendations	Our actions
• Continue to build visibility and engagement with staff groups across sites and lead by example to influence the consistent leadership behaviours	• Timetable for Board Patient Safety WalkRounds for 2023 in place • Independent Member and Executive Engagement Visits
• Optimise the assets that exist in the organisation to influence the culture and build the learning system.	• Improving Together model commenced • Leadership development programmes
• Focus your limited improvement resource on priorities for safety and managing patient care in the right place.	• Two EQIiP Programmes per year • Projects aligned to quality goals, Strategic objective or outcome of Improving Together
• Make data visible by adopting and enhancing the current use of visual management systems/boards.	• Our Safety Dashboard • 'Knowing how we are doing' Boards • Displaying Improvement activity outcomes
• Seek ways to highlight, share and celebrate the variety of work that is happening through multiagency and community care settings	• Improvement Network established • Improvement and lessons from concerns repository under development • Community of practice being considered with Swansea University

Our Transforming Urgent and Emergency Care Programme

Y gofal iawn, yn y lle iawn, y tro cyntaf

Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng

Right care, right place, first time

Six Goals for Urgent and Emergency Care

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Unscheduled Emergency Care (UEC) System and Optimal Flow (Regional)

Dependent on all 'cogs' working and delivering optimal operational performance to deliver their area of responsibility and reduce harm at patient level

3 Cs are high level areas of our UEC Programme Transformation

3Cs improvement embeds best practice outlined in 6 Goals Handbook eg – 24/7 Streaming Hub, Urgent Primary Care (UEC), Same Day Emergency Care (SDEC), and Discharge to Recover and Assess (D2RA)

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Areas of Focus/Projects Aligning to Programmes of Work

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Proactive Care & Risk Stratification (Regional)

- **Goal 1**: Co-ordination planning and support for populations at greater risk of needing UEC.

HDdUHB Long term Goals:
PG 1: Implementation of a digital system for risk stratification and TEC based monitoring and management of vulnerable groups

Areas of focus/ projects:
- Risk Stratification: Includes local and links to strategic /AI Digital Risk Stratification
- Proactive Monitoring (TEC Solutions)
- Co-ordination care, planning and support for high risk groups
- Stay Well Planning
- Prehab & Health Optimisation

Links through to the Regional Tech and Digital Board Proactive Therapy / Planned Care work

Reducing Conveyance & Self-Presentation (Regional)

Goal 2: Signposting people with UEC needs to the right place, first time
Goal 3: Clinically safe alternatives to hospital
Goal 4: Rapid response in a physical or mental health crisis

HDdUHB Long term Goals:
PG 2: Development and implementation of Digitalised Coordination Hub:
PG 3. Defining, scoping and implementation of clinically safe alternatives to hospital.
PG 4. Defining, scoping and implementation of rapid response services in a physical or mental health crisis.

Areas of focus/ projects:
- Urgent Dental Pathways via 111
- SDUC Community Model Scale Up & Roll Out
- MH SPOA, Rapid 24/7 Triage & Assessment
- Alternative Pathways to Admission
- Virtual Ward
- Care Home Immedicare Pilot
- APP Model scale up and roll out
- Palliative Care Pathway Via 111
- Urgent Care Service (within 8hours of contacting)
- 111 Press 2 for Mental Health Scale Up
- Clinical Streaming Hub

Managing Complexity - Community (Local)

Goal 2: Signposting people with UEC needs to the right place, first time
Goal 4: Rapid response in a physical or mental health crisis
Goal 6: Home first approach and reduce the risk of re-admission

HDdUHB Long term Goals:
PG 2: Development and implementation of Digitalised Coordination Hub:
PG 4. Defining, scoping and implementation of rapid response services in a physical or mental health crisis.
PG6. Developing a health and care system for older people (while sitting in PG 6 this spans all goals).

Areas of focus/ projects:
- Home First Hub/SPoA
- Crisis response within 2 hours
- Implement D2RA Pathways within 48 hours
- Management of high impact users
- Reporting of D2RA Pathway Delays (DPoC)
- Right Sizing Community Services

Managing Complexity and Conversion reduction - Acute (Regional)

- **Goal 3**: Clinically safe alternatives to hospital
- **Goal 4**: Rapid response in a physical or mental health crisis
- **Goal 5**: Optimal hospital care and discharge practice from the point of admission

HDdUHB Long term Goals:
PG 3. Defining, scoping and implementation of clinically safe alternatives to hospital.
PG 4. Defining, scoping and implementation of rapid response services in a physical or mental health crisis.
PG5. Implementation of SAFER

Areas of focus/ projects:
- Early identification of complex patients
- Frailty Screening at Front Door
- Implementation of SAFER Principles
- Implementation of Deconditioning Patients
- SDEC Model Scale Up& Roll Out
- Implementation of Clinical Criteria of Discharge
- Improving Standards in Emergency Departments
- Implementation of Digital solutions to support care planning and discharge e.g. Frontier

This includes the BCCC being led within ILP

Y gofal iawn, yn y lle iawn, y tro cyntaf
Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng
Right care, right place, first time
Six Goals for Urgent and Emergency Care

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GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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Links through to the Regional Tech and Digital Board Proactive Therapy / Planned Care work

Reducing Conveyance & Self-Presentation (Regional)

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Goal 4: Rapid response in a physical or mental health crisis

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Goal 2: Signposting people with UEC needs to the right place, first time
Goal 4: Rapid response in a physical or mental health crisis
Goal 6: Home first approach and reduce the risk of re-admission

HDdUHB Long term Goals:
PG 2: Development and implementation of Digitalised Coordination Hub:
PG 4. Defining, scoping and implementation of rapid response services in a physical or mental health crisis.
PG6. Developing a health and care system for older people (while sitting in PG 6 this spans all goals).

Areas of focus/ projects:
- Home First Hub/Single Point of Access (SPOA)
- Crisis response within 2 hours
- Implement D2RA Pathways within 48 hours
- Management of high impact users
- Reporting of D2RA Pathway Delays (DPoC)
- Right Sizing Community Services

Managing Complexity and Conversion reduction - Acute (Regional)

HDdUHB Long term Goals:
PG 3. Defining, scoping and implementation of clinically safe alternatives to hospital.
PG 4. Defining, scoping and implementation of rapid response services in a physical or mental health crisis.
PG5. Implementation of SAFER

Areas of focus/ projects:
- Early identification of complex patients
- Frailty Screening at Front Door
- Implementation of SAFER Principles
- Implementation of Deconditioning Patients
- SDEC Model Scale Up& Roll Out
- Implementation of Clinical Criteria of Discharge
- Improving Standards in Emergency Departments
- Implementation of Digital solutions to support care planning and discharge e.g. Frontier

This includes the BCCC being led within ILP

Key strategic improvement measures for TUEC (Older People)

TUEC Programme Mandate: To implement 24/7 UEC Pathway

Programme Measures ('Ends')

- **Patient / Service User feedback Measures:**
  - *'My care is provided in the most appropriate setting to meet my health and care needs'* i.e What Matters
  - *'How likely are you to recommend our services to your friends or family should they need similar care or treatment'*
- **Patient / Service User Safety Measure:**
  - Closed incidents where harm finally classified reported as moderate or worse
- **TUEC Outcome** Increased number of healthy days at home (overarching Outcome for the Whole Population)
- **TUEC High Level Outcome Indicators**
  - Reducing the number of people over 75 who stay longer than 21 days – measure of impact on discharge effectiveness / efficiency on the 'back door' (Inpatient **Complexity** management)
  - Reduction in **Conveyance** Rates
  - Reduction in **Conversion** Rates
  - Reduction in proportion commissioned care hours / placements following in patient stay (balance measure)

PG1 Performance Metrics ('Means')

- TBC % of population risk stratified as vulnerable and who have stay well plans in place
- Number of patients admitted to the 'virtual ward' TBC
- Number of service users receiving domiciliary care
- Total Number of commissioned domiciliary care hours

PG2 Performance Metrics ('Means')

- No. of direct referrals to SDEC
- Number of GP referrals streamed through CSH and % directed to SDEC or alternatives
- Conveyance Rate (Target 60%)
- Ambulance lost hours (Target 0)

PG3 Performance Metrics ('Means')

- 30% of acute medical take assessed in SDEC. 90% of which go home for >75 year olds, >55 year olds and rest of population
- Number Admissions
- Number of Occupied Beds
- 0-1 day LoS
- 0-3 day LoS
- Re-admission rates (balance)
- Conversion rate (balance)
- Number of patients referred to Home First
- Number and % patients Provided with crisis respone

PG4 Performance Metrics ('Means')

- ED attendances (all)
- ED attendances (WAST)
- 4 hour wait
- >12hr Performance
- % of patients with clinical frailty score recorded (pre morbid and on presentation)
- TBC re EDQDF

PG5 Performance Metrics ('Means')

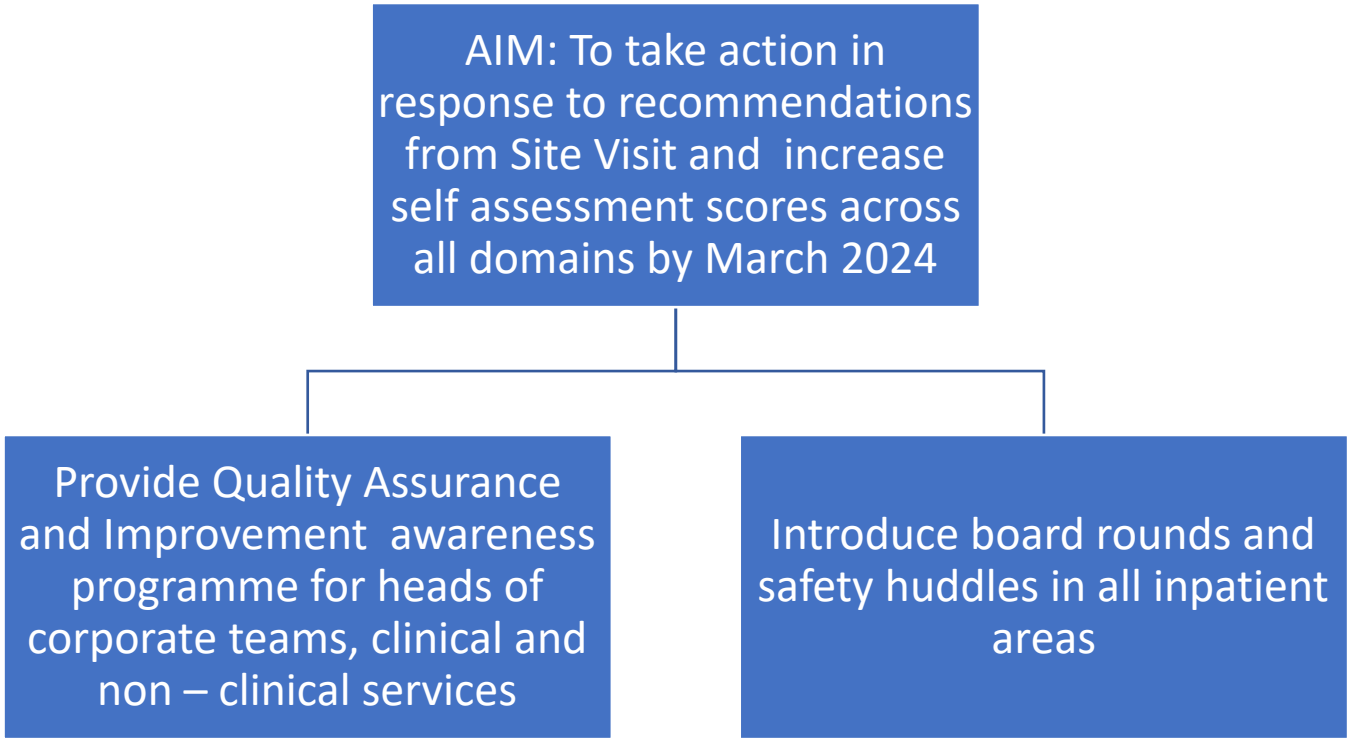
- % of patients have discharge criteria defined by the clinician **and** MDT within 14 hours from 'point of admission'
- 10-14 days LoS
- Number of patients with LoS > 21 days
- Occupied beds rate

PG6 Performance Metrics

- Average length of time to commission domiciliary care
- Average length of time to place into residential and nursing sector
- Number of people reported as clinically optimised
- Number of domiciliary care hours lost (handed back) due to LOS > 7 days
- Number of care hours commissioned following hospital inpatient stay
- Number of residential placements requiring increase to general or EMI nursing following hospital stay

Quality metrics: staff sickness and improved retention levels across all disciplines, reduced incidents, staff feedback

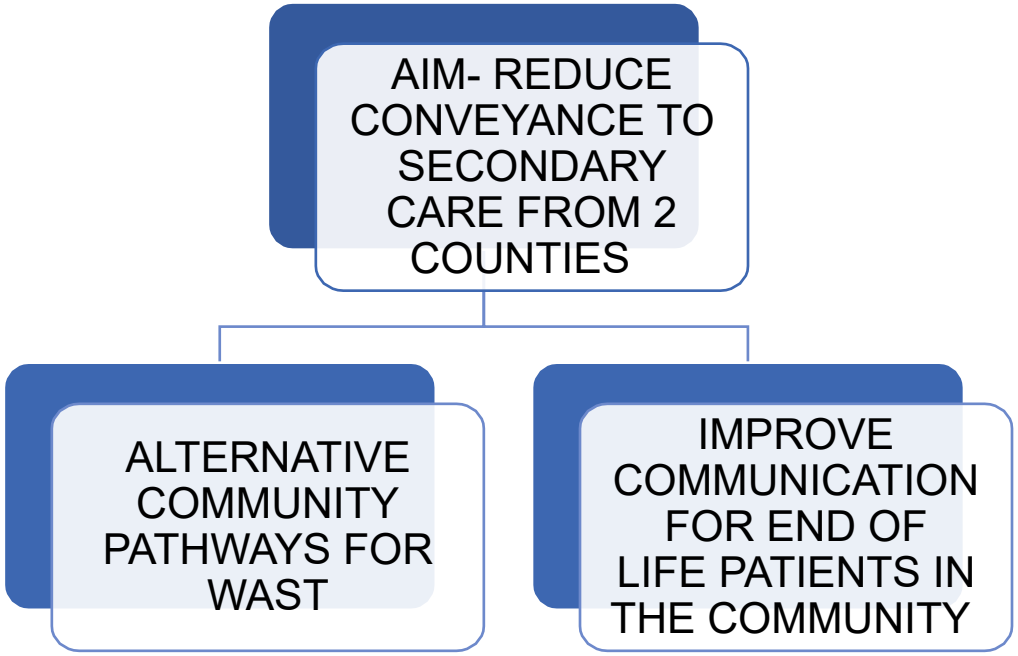
Leadership Workstream 1



Community Workstream 2

Two projects to join our Quality Improvement (QI) Programme (Enabling Equality Improvement in Practice (EQIiP) Cohort 4) from March 2023:

- Palliative Care Communication
- Welsh Ambulance Service Trust (WAST) Community Referrals

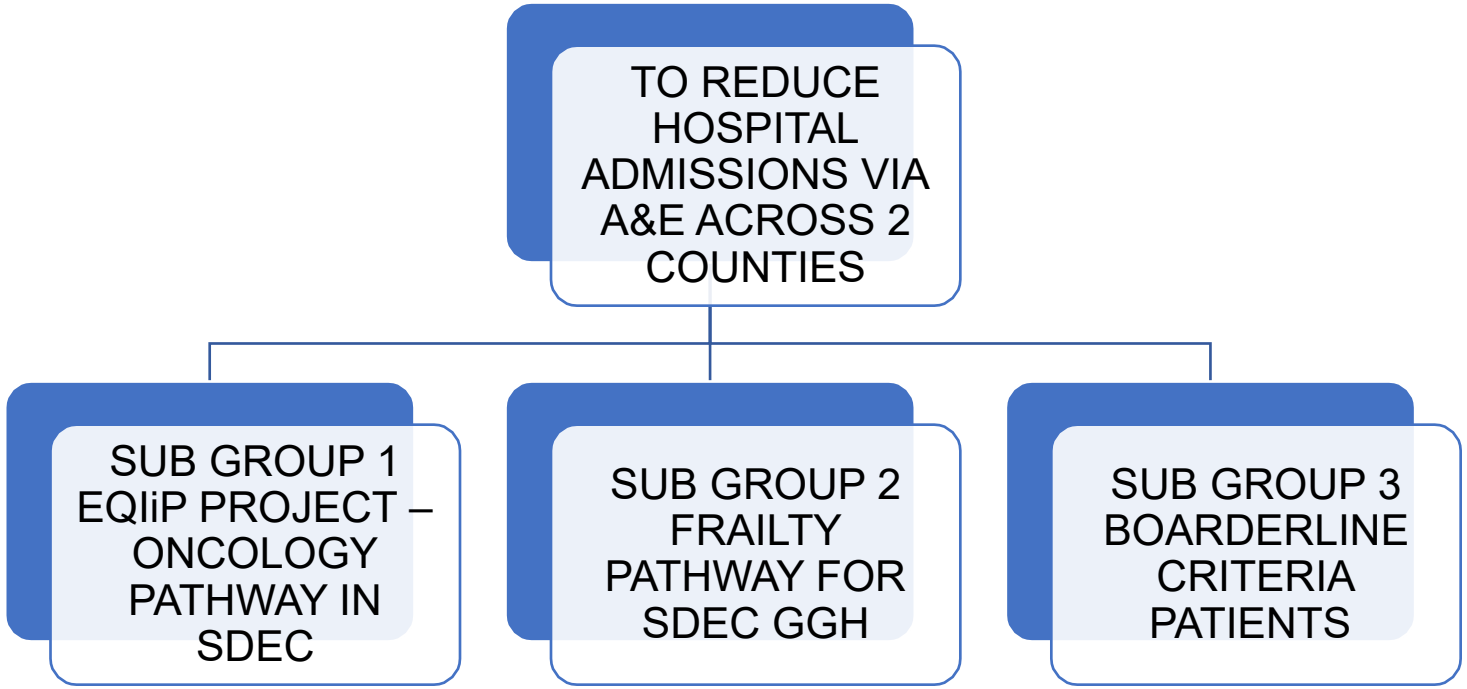


Note - AIM will be SMART when confirmed

Ambulatory Care Workstream 3

Three projects identified. One has joined the QI Programme (EQIiP Cohort 4) from March 2023:

- Oncology Same Day Emergency Care (SDEC)

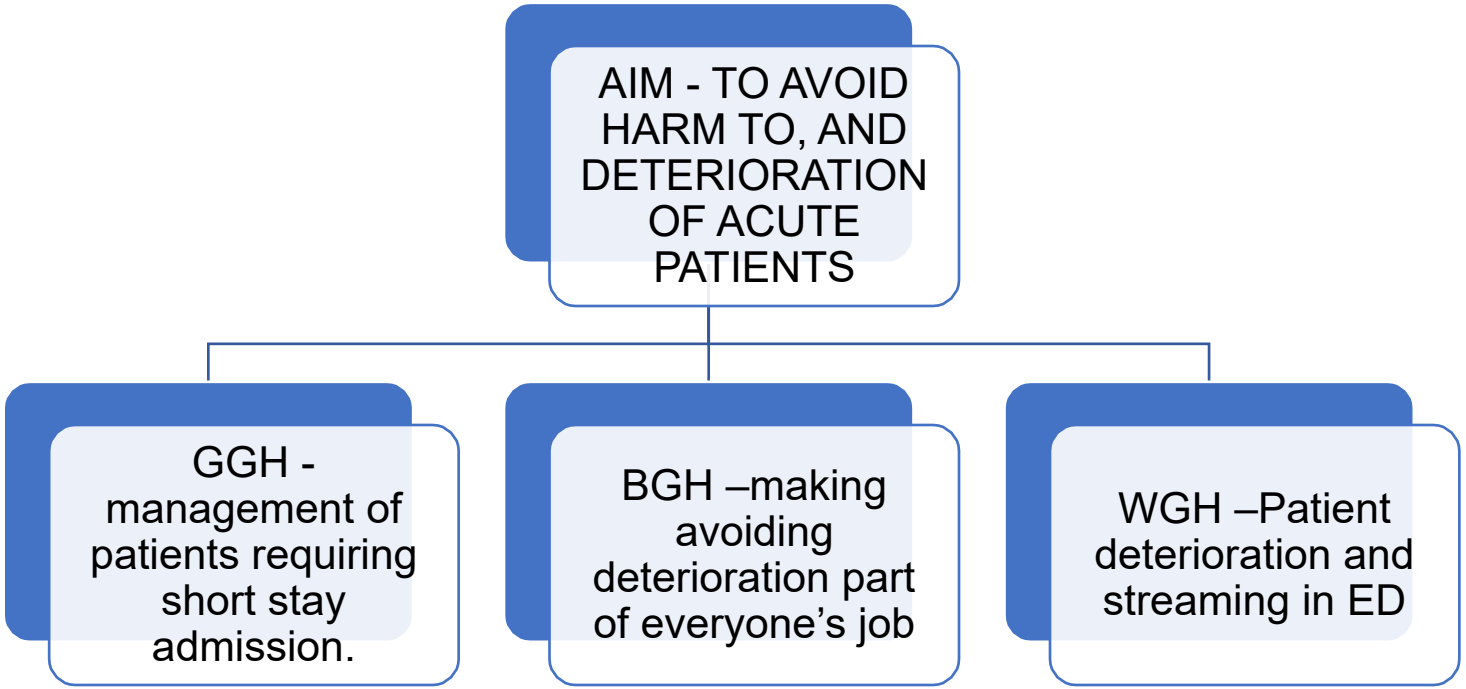


Note - AIM will be SMART when confirmed

Acute Care Workstream 3

Three projects identified. 1 BGH, 1 GGH and 1 WGH
Two projects joined the QI Programme (EQIiP Cohort 4) from March 2023:

- Frailty Discharge Pathway
- Deteriorating Patients



Note - Broad AIM so SMART aims will be project based

Engagement and Leadership

Leadership Workstream

Sponsor: Mandy Rayani, Director of Nursing, Quality and Patient Experience
Leading Patient Safety Team (PST): Sharon Daniel, Assistant Director of Nursing (ADoN); Mandy Davies, ADoN; Will Oliver, Assistant Director of Therapies and Health Science; Cathie Steele, Head of Quality and Governance; Subhamay Ghosh, Associate Medical Director for Quality and Safety; and Subramaniam Nagasayi, Consultant Care of the Elderly.
Coach: Mandy Davies

Community Workstream

Sponsor: Peter Skitt, County Director, Ceredigion
PST Lead: Will Oliver
Coach: Emma Pritchard/Sian Hopkins
Team: Sarah Cameron, Head of Nursing (HoN); Craig Jones, Community Clinical Lead Nurse; RN Katie Lloyd; SNS Marlene Thomas; CN David Rogers; CLN Sian Green; CNS Sharon Jones; DN Stacy Lane; OT Katy Darby; SN David Rees; CLANP Bianca Oakley; CLN Sian Owen; Dr Mohammed Elkhonezy; CL Patricia Clark; and SM Lucy Jane Whelan

Ambulatory Care Workstream

Sponsor: Rhian Matthews, Integrated Care Director
PST Lead: Cathie Steele
Coach: Emma Phillips/ Tessa Phillips/Sharon Jones/Marilize Du Preez
Team:
Health Board Acute Oncology: SNM Bryan Phillips/ Emma Cadman / Dr Daryl Richards
GGH: Lead Dr George Elsom, SM Angela Raynor, ANP Catherine Perkinton, Dawn Tapp
PPH: Dr Louisa Morris, ANP Laura Whitmore,
WGH - Dr Karen Brown

Acute Care Workstream

Sponsor: Keith Jones, Director Secondary Care
PST Lead: Mandy Davies
Coach: Clara Barnes/ Claire Rawlinson/ Andrew Poole/ Sharon Jones
Team:
BGH Leads: Sr Christine Edwards, CNS Veronica Jarman
GGH Leads: Dr Eiry Edmunds, SNM Nerys Lewis, SNM Aysha Davies
PPH Leads: HoN Menir Williams
WGH Leads: Dr Nicola Drake, Dr Karen Brown, HoN Carol Thomas, SNM Jo Dyer

Recommendations

The Quality, Safety and Experience Committee is requested to note the safer care collaborative work and take assurance that processes, including the Listening and Learning Sub Committee, are in place to review and monitor:

- patient safety highlighted through:
  - Incident reporting;
  - Review of nosocomial COVID-19 infection
- patient experience highlighted through HIW inspection and other peer reviews
- quality improvement.

Appendix 1: COVID Learning identified
(reported January 2023)

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Hywel Dda
University Health Board

Good practice

- Timely DNACPR decisions with rationale and discussions documented
- Ceilings of care being agreed and documented
- Regular medical reviews (well documented)
- Use of technology for communication between patient and family
- Documentation of bed location and rationale for moving patients
- Family members visits being facilitated when end of life
- Documentation of PPE usage when patient being visited by relatives

(Note – the above is not consistent across wards and sites)

Areas for Improvement

- Medically fit for discharge patients becoming COVID positive whilst waiting for package of care or nursing home placement
- Increase the use of technology for communication between patient and family when visiting restricted
- Documentation of bed location and rationale for moving patients
- Symptomatic patients – reliance on one diagnosis rather than potential differential of COVID

Appendix 2: COVID Learning identified
(reported to QSEC February 2022)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Areas for improvement

- Timely discussions regarding ceilings of care (sometimes more than 5 days after COVID-19 positive test)
- Documentation that video call / contact with family has happened
- Timely communication from community to hospital e.g. care home closed due to outbreak, ward informed 3 days after care home closed

Good practice

- Ceiling of care discussion with patient and family documented
- DNACPR discussions with patient and family documented
- Initiation of end of life pathway where appropriate
- Regular COVID-19 testing following any symptoms

Observations from outbreak reviews

- We may be unable to categorically answer how patients became nosocomial COVID-19 positive e.g. staff contact / other patient contact / visitor contact

Early wave 3 outbreaks observation

- It would appear that outbreaks are being contained to bays or parts of wards rather than the whole ward being affected

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SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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