GIG CYMRU NHS WALES
Bwrdd Iechyd Hywel Dda Health Board

Quality and Safety Assurance Report

QSEC Meeting December 2022

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.

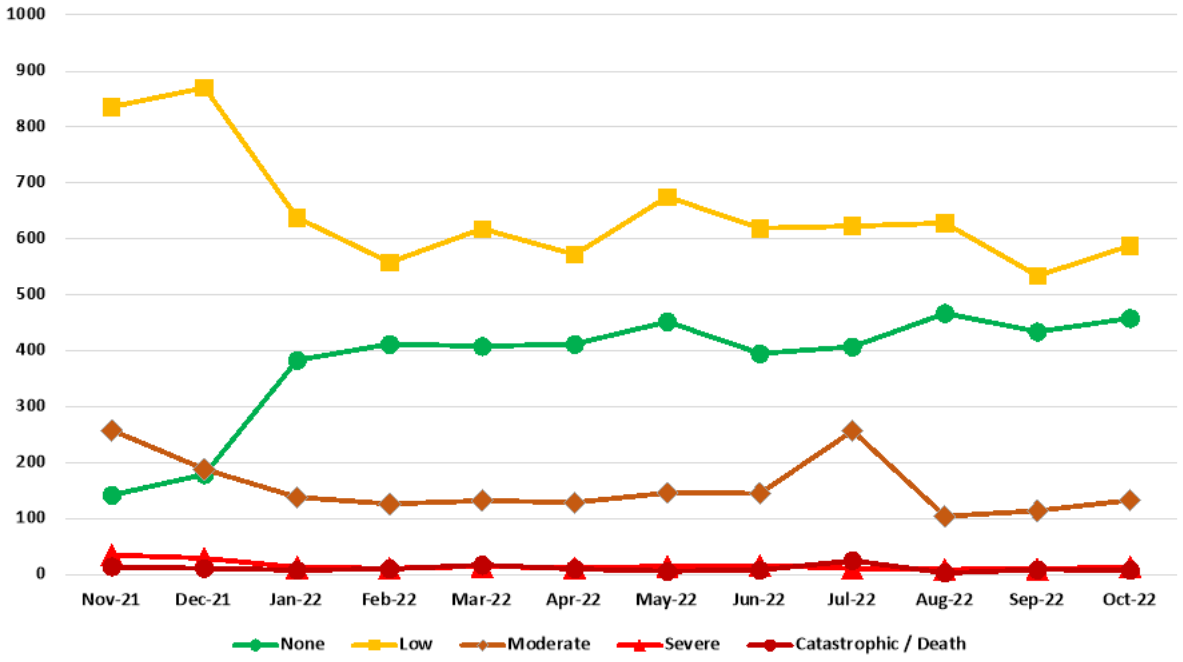
The Health Board uses a number of assurance processes and quality improvement strategies to ensure high quality care is delivered to patients.

This report provides information on concerns including patient safety incidents, externally reported patient safety incidents, nosocomial COVID-19 infections and mortality reviews, and HIW Inspections.

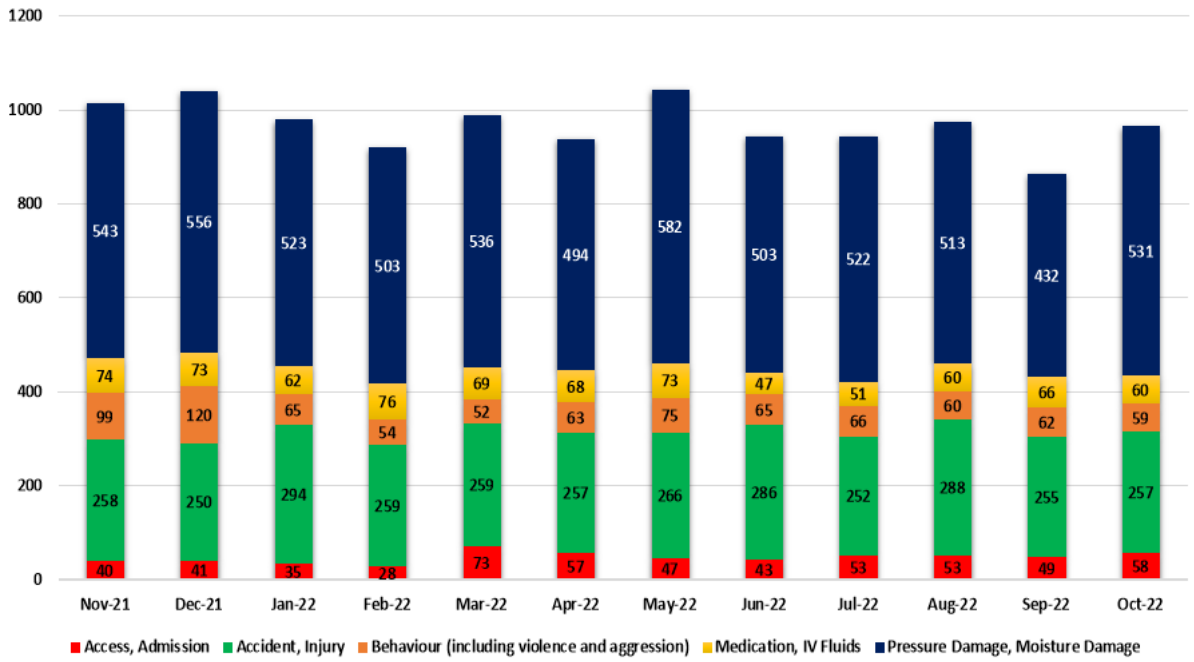
Incident Reporting – 1st November 2021 to 31st October 2022

In September and October 2022, 2,757 incidents were reported of which 2,302 were patient safety related

Incidents by Date Reported (Month and Year) and Severity of Incident



Top 5 Patient Safety Incidents



There were 14,497 Patient Safety Incidents reported on the new system between 1st November 2021 – 31st October 2022

The introduction of DatixCymru in April 2021 has altered the way in which severity of harm is reported. The new system allows the opportunity for the reporter to grade the harm to the person affected (which cannot be changed) and then on closure following investigation the actual harm to the person affected is recorded by the investigator. The run chart above shows the severity of the patient safety incident following investigation.

Of the 14,497, 8,019 have been closed and 3,769 have had the severity amended. 2,184 Incidents were downgraded whilst 1,585 were upgraded.

Weights Recorded On Medication Charts – Puffin Ward Withybush General Hospital (WGH)

Engagement

The Quality improvement Team engaged and began working closely with Puffin Ward at WGH to improve patients weights being transcribed onto patients medication charts within 24 hours of admission to their unit.

This project was identified as there was a reoccurring theme found within the investigations of Hospital Acquired Thrombosis (HAT) that weights were not consistently being recorded and this having an impact on correct doses of medications being prescribed.

Key stakeholders within this project were:

- ✓ Registered Nurses & Healthcare Support workers
- ✓ Medics
- ✓ Pharmacy staff
- ✓ Dietitians
- ✓ Management Team
- ✓ Others identified who may need to be involved- EBME team for any equipment issues

Observations and understanding the problem

Improvement tools were utilised to understand the problem further and on completion of a fishbone diagram themes were identified including:
Staffing, Equipment, Time and Environment.
The stakeholders were able to look at potential change ideas once their baseline data was collected. Regular meetings held with stakeholders to discuss findings.

Plan Do Study Act (PDSA) Cycles

The team used PDSA throughout and a number of tests of changes have been implemented to improve weights being obtained and transcribed onto the medication charts.

Data – Chart 1

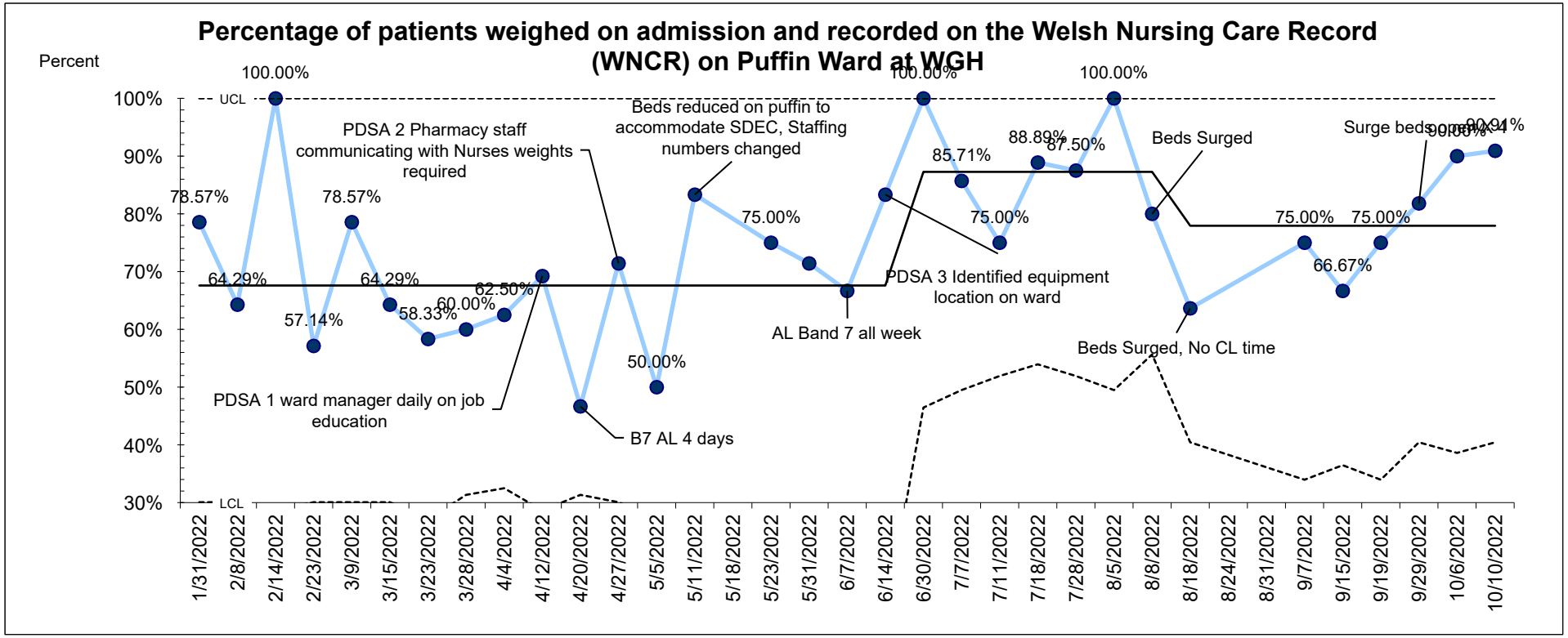


Chart 1 – Baseline data collected until 12.4.22, the first PDSA ward manager daily on job education commenced. Aim of project has been to improve compliance with weights being transcribed across to drug chart however, there has been improvement needed with initial weight being obtained and recorded on WNCR. Step change in data on the 14.06.22. The band 7 has been instrumental in keeping the team engaged throughout the project.

Data continued – Chart 2

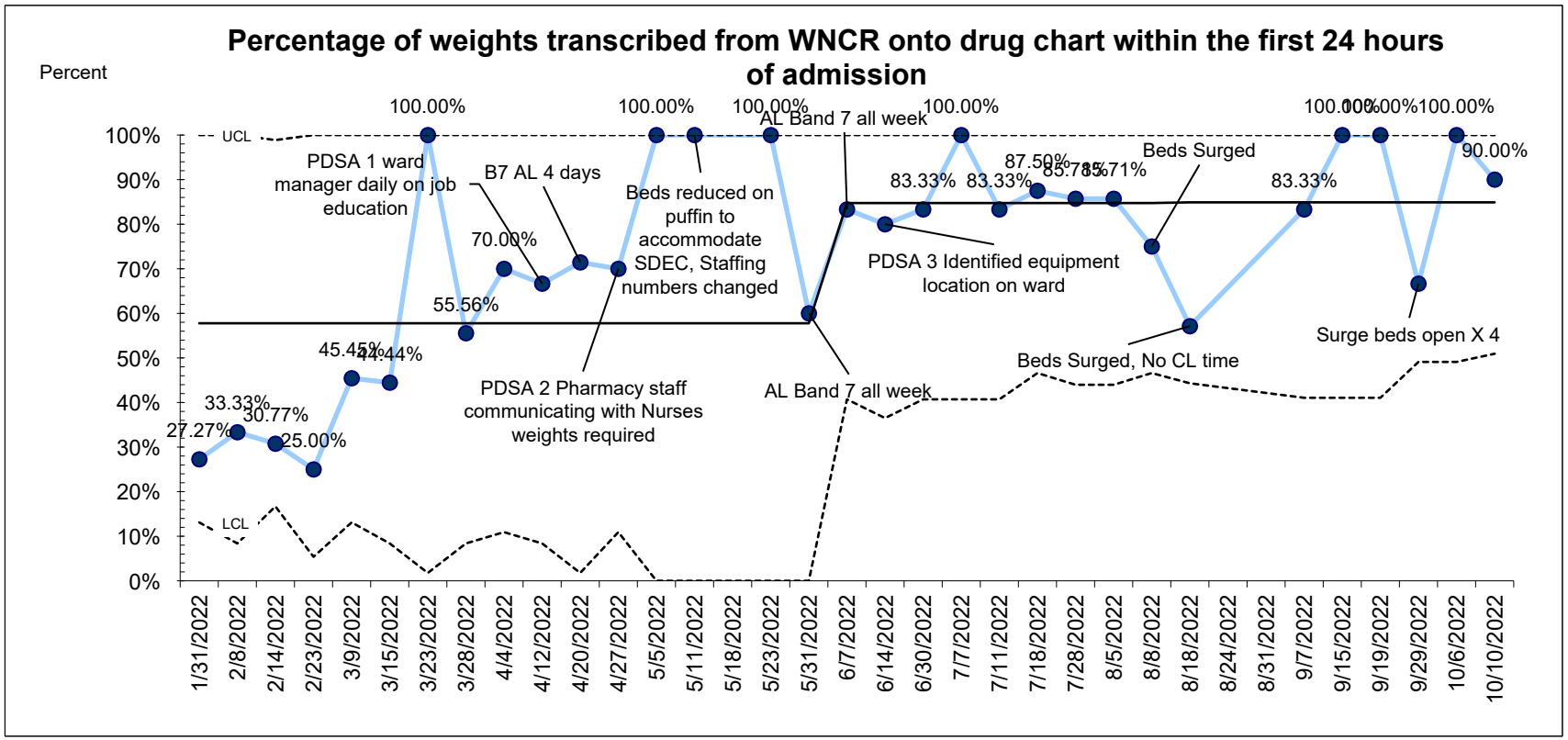


Chart 2- Baseline data collected until the 12.04.22.

Step change in data on the 31.05.22 from 57.78% to 84.75%.

There has been some dips in data when Puffin ward had surge beds open as demonstrated within data.

Next Steps

This project is now being spread to the Acute Clinical Decision Unit (ACDU) at WGH and also the Emergency and Urgent Care Centre at Bronglais General Hospital. We aim to embed the cultural changes throughout the Health Board and continue to spread and scale further.

Nationally Reportable Incidents

Open NRI - Type	21/22 Q4	22/23 Q1	22/23 Q2	22/23 Q3**	Total
Access, Admission	5	0	3	2	10
Assessment, Investigation, Diagnosis	1	2	0	0	3
Behaviour (including violence and aggression)	1	1	1	0	3
Infection Prevention and Control	0	0	0	0	0
Maternity adverse occurrence	0	0	0	1	1
Medication, IV Fluids	1	0	1	0	2
Patient/service user death	6	9	2	3	20
Pressure Damage, Moisture Damage	1	1	0	0	2
Treatment, Procedure	1	1	0	0	2
Accident, Injury	0	2	0	0	2
Monitoring, Observations	1	0	0	0	1
Transfer, Discharge	0	0	2	0	2
Total	17	16	9	6	48

* temporary change to reporting. Revised Serious Incident Framework introduced on 14/06/2021

** data not for full financial quarter

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 Duty of Candour arrangements have been made and agree the lead for further Duty of Candour discussions
- Set the Terms of Reference (ToR) for 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 (this will be between 30 and 60 working days)

Report of themes and trends in reporting provided to Head of Quality and Governance, Assistant Director of Nursing and Associate Medical Director.

A patient safety incident is nationally reported within seven working days from the occurrence, or point of knowledge, if it is assessed or suspected that an action or inaction in the course of a service user's treatment or care, in any healthcare setting, has, or is likely to have caused or contributed to their unexpected or avoidable death, or caused or contributed to severe harm.

The following specific categories of patient safety incidents must be reported:

a) Suspected homicides where the alleged perpetrator has been under the care of mental health services in the past 12 months

b) In-patient suicides

c) Maternal deaths

d) Never Events (2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk))

e) Incidents where the number of patients affected is significant such as those involving screening, IT, public health and population level incidents, possibly as the result of a system failure

f) Unusual, unexpected or surprising incidents where the seriousness of the incident requires it to be nationally reported and the learning would be beneficial

We are also required to report the following in specific circumstances:

- Pressure Ulcers (avoidable - Grade 3 / Grade 4 / Unstageable)
- Unexpected deaths in the community of patients known to Mental Health and Learning Disabilities (MH&LD) Services
- Safeguarding
- Procedural Response to Unexpected Death in Childhood (PRUDiC)
- Abuse / Suspected Abuse
- Healthcare Acquired Infections (HCAIs)

Nosocomial COVID-19 infections

The Quality Assurance and Safety Team continue to progress the review of each patient with nosocomial COVID-19 infection with the all Wales review toolkit being used as the starting point for each review.

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.

The Health Board has commenced the required reporting to the NHS Wales Delivery Unit. Recovering patients with indeterminate nosocomial infection are now included in the review criteria. Previously, QSEC have received the number of in-patients who test positive for COVID-19 within 28 days of their death. This figures in this report include the recovering patients as well as deceased patients.

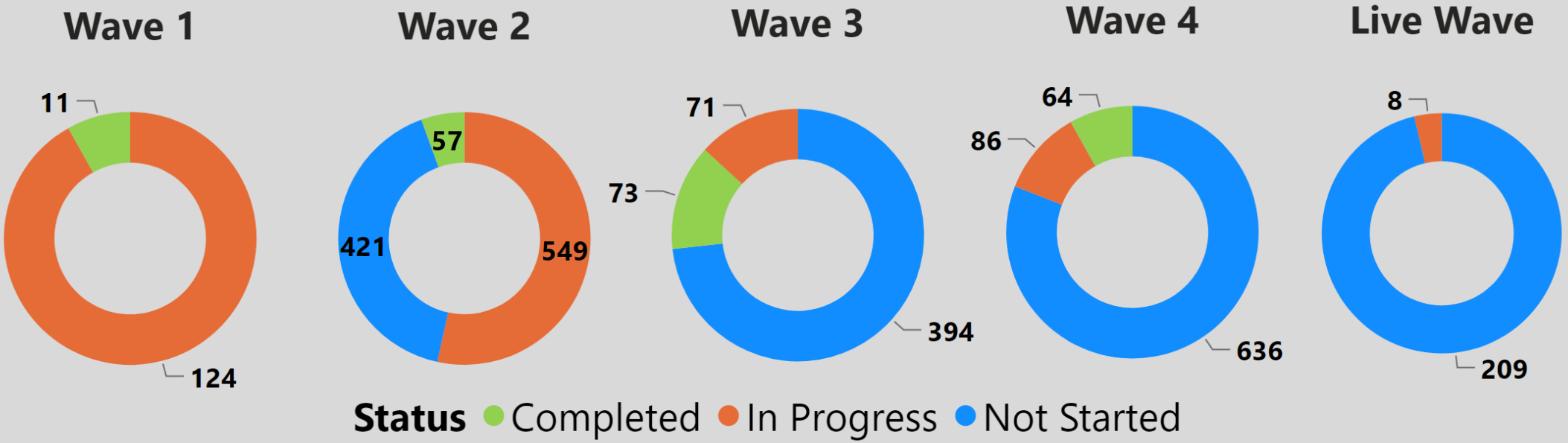
	Wave 1 (27/2/2020 - 26/7/2020)	Wave 2 (27/07/2020 - 16/05/2021)	Wave 3 (17/05/2021 - 19/12/2021)	Wave 4 (20/12/2021 - 30/04/2022) **	Live 01/05/2022 -
Total Incidents	119	1042	356	801	492
Under Investigation	92	281	85	206	50
Not Started	0	584	244	556	430
Referred to Scrutiny Panel	24	125	25	37	11
Completed Investigations	1	50	1	1	0
Downgraded / Recategorised	2	2	1	1	1

Figures as at 01/11//2022

Hospital onset - indeterminate	specimens taken on days 3 to 7 of admission
Hospital onset - probable	specimens taken on days 8 to 14 of admission
Hospital onset - actual	specimens taken >14 days after admission

NNCP Data - Hywel Dda UHB

National Nosocomial COVID-19 Programme



Wave 1	Wave 2	Wave 3	Wave 4	Live Wave	Reset

Total Cases

2810	107
Latest	Change

In Progress

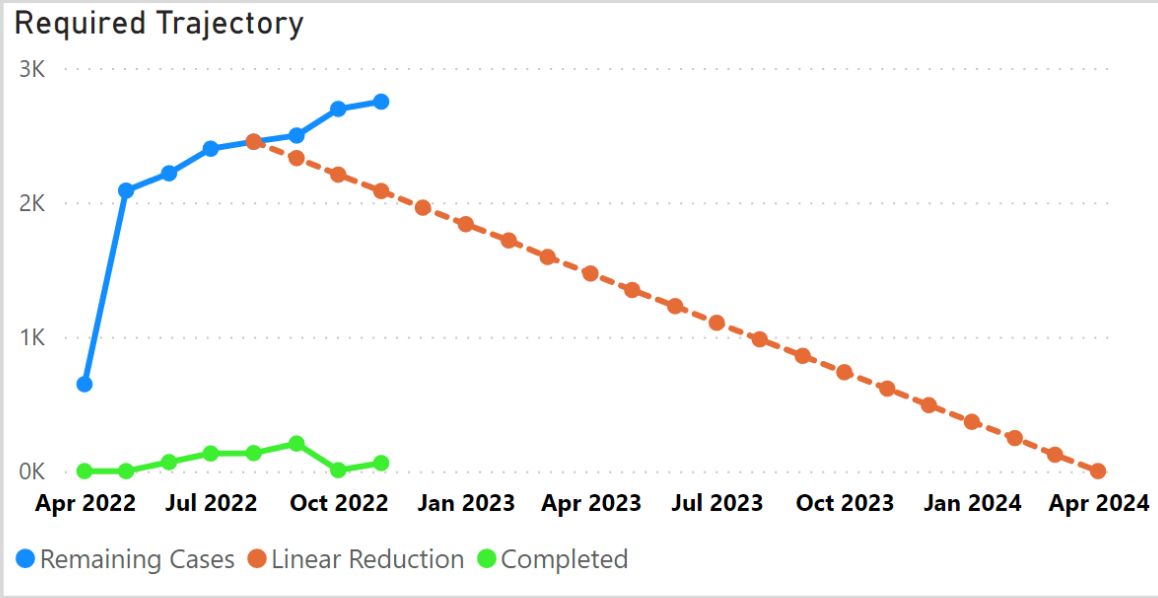
936	-204
Latest	Change

Completed

60	53	2.14%
Latest	Change	%

Not Started

1814	258
Latest	Change



Highlight Report

Key Accomplishments in the previous period:	Upcoming Activities in this period:
CAN COVID-19 Scrutiny Panel continue to meet regularly. CAN Strategic Oversight Group in place. Update provided to the Quality Safety and Experience Committee on 11/10/2022. Start date for the COVID-19 lead investigator agreed. Communication with families of deceased patients underway.	Recruitment continuing to fixed term positions and Patient Safety Officer (COVID-19) bank positions and administration bank position. CAN Scrutiny Panel meeting to be held every other week. CAN Strategic Oversight Group to be held every other month.

Items for escalation to Programme Board:	Top 3 Risks:
Recruitment for COVID-19 review team continues to be a challenge. Quality Assurance and Safety Team continue to progress the reviews whilst the recruitment to the COVID-19 review team continues. Also use of bank staff (nurses (previously senior and experienced nurses and other AHP)) to progress the reviews. Office space for review team is a challenge – health records must remain on site so home working not an option. Rota has been established.	

Risk name	Risk Score	Measure to reduce the risk
Recruitment of COVID-19 review team	**20**	Bank nurses (previously senior nurses) used to progress the reviews. Recruitment continues Establishment of a Patient Safety Officer (COVID) bank position
Availability of office space to undertake the review (unable to take health records off UHB site)	**12**	Limited office space available and therefore rota established to make best use of office space.
Administration support for CAN Scrutiny Panel, CAN Strategic Oversight Group and retrieval of health records etc	**12**	Quality Assurance and Safety Team are undertaking the notes retrieval. Patient Safety and Assurance Manager maintaining decision and action log for Scrutiny Panel. Head of Quality and Governance preparing agenda etc for Scrutiny Panel

HIW Quality Checks/Inspections: summary for 6th September – 30th November 2022

New Quality Checks/Inspections & Reviews

Area of Review	Recommendations	Update
Maternity (GGH) November 2022 (awaiting publication)	TBC	An unannounced inspection took place on 29th and 30th November 2022. There were several areas of positive feedback, no immediate concerns highlighted and the expected recommendations relate to mandatory training and appraisal compliance. **The draft report is awaited**.
IRMER Inspection (GGH) November 2022 (awaiting publication)	TBC	An announced inspection took place on 15th and 16th November 2022. The verbal feedback highlighted no immediate concerns and the expected 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 draft report is awaited**.
Angharad ward, (BGH) Paediatric ward October 2022 (awaiting publication)	8	An unannounced inspection took place on 4th and 5th October 2022. The draft report highlighted no immediate concerns, the recommendations relate to timely CAHMS 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. A factual accuracy response and the improvement plan were submitted 25/11/22. **The final report is awaited**.

HIW Quality Checks/Inspections: continued

An update on previous Quality Checks/Inspections/ Reviews

Area of Review	Recommendations	Update
Bryngofal ward, Prince Philip Hospital (PPH) July 2022 https://www.hiw.org.uk/sites/default/files/2022-10/20221012PrincePhilipHospital-Full-EN.pdf	19	An unannounced inspection took place on 11th 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 **10 recommendations remain outstanding**, 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 27th 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. The final completion date for recommendations is March 2023. At the point of updating this report, **8 recommendations remain open**.
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 – 30th 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 and the final All Wales report is expected to be available towards the end of December 2022.

HIW Quality Checks/Inspections: continued

An update on previous Quality Checks/Inspections/ Reviews

Area of Review	Recommendations	Update
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 7th and 8th 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, there are **2 recommendations open with extended completion dates of December 2022**.
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,** linked to an All Wales piece of work with an extended completion date of March 2023.
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 **3 recommendations open** for sites to take forward. Services are actively chased to complete these actions in a timely manner.
Withybush General Hospital, St Caradog Ward	4	This improvement plan details recommendations in relation to Fire Safety and Health and Safety. There remain **3 recommendations open** at the point of collating this report with extended completion dates. The service and Estates are actively chased to complete these actions in a timely manner.

Health Inspectorate Wales (HIW): Additional Information

Current position

As of the date of this report there are a total of **10 reports** or inspections with **47 recommendations** open. These continue to be tracked by the QAST team to completion.

Services of Concern: New HIW Process

The Health Board received a proposal document from HIW in July 2021, outlining their intention to implement a Service of Concern process, and supporting process guidance. Previously, HIW followed an internal escalation process when an issue of concern came to their attention. The new proposal is to formally use a Service of Concern designation when HIW identifies significant singular service failures, or cumulative or systemic concerns regarding a service or setting.

It is intended that a Service of Concern designation will increase transparency around how HIW discharges its role and ensure that focused and rapid action can be taken by a range of stakeholders, including health boards, to ensure that safe and effective care is being provided. The Health Board provided its responses to the consultation in September 2021, and the process is now in force as of 15th November 2021. Further information can be found via the following link: Service of Concern Process for NHS Bodies in Wales (www.hiw.org.uk)

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 in the process of 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 every Audit and Risk Assurance Committee (ARAC) meeting.
- HIW activity forms part of the quality governance arrangements within Directorates.

Safe Care Collaborative with Improvement Cymru and the Institute for Healthcare Improvement

- The aim of the collaborative is to provide nationally coordinated, locally delivered support for safe reliable and effective care.
- Foundational Site Visits undertaken which identified 4 key themes leading to national shared priorities
- 4 workstreams agreed:
    1. Leadership for patient safety improvement
    2. Safe and effective community care
    3. Safe and effective ambulatory care
    4. Safe and effective acute care

Workstream 1:

Leadership for patient safety improvement

Working together to support the development of the culture and learning system within each health system and across NHS Wales and ensuring that the whole system is working towards common and well aligned goals.

- Focus on executive leaders in organisations
- Executives responsible for patient safety and improvement
- Senior leaders linked to workstream teams
- Leading Patient Safety graduates

Workstream 2:

Safe and effective community care

Keeping people safe care in community settings through prevention of deterioration and appropriate response to acute health care needs is achieved.

- Community focused – care home; community care, with links to primary care
- Focused on deteriorating resident, keeping me safe and where I can be cared for best
- Common elements of team communication; escalation and response as Acute workstream

Workstream 3:

Safe and effective ambulatory care

Keeping people safe in the ambulatory care environment, preventing hospital admissions and treating acute care needs in the most appropriate settings.

- Prototyping and sharing good practice focus
- Hospital at Home; Virtual wards etc. services which provide safe care in the right place at the right time
- Identify teams that are looking to improve their approaches; iterate their practice and learn and share across Wales
- Will be developing a national driver diagram with this workstream from their combined knowledge, expertise and experience

Workstream 4:

Safe and effective acute care

Keeping people safe in hospital, ensuring that structures and processes are robust in response to acute deterioration or concern.

- Focus on deteriorating patient in its widest sense
- Common areas of team working; communication; escalation and response, linked to Community workstream

Recommendation

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
- quality improvement.