GIG CYMRU NHS WALES
Bwrdd Iechyd Hywel Dda Health Board

Quality and Safety Assurance Report

QSEC Meeting June 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.

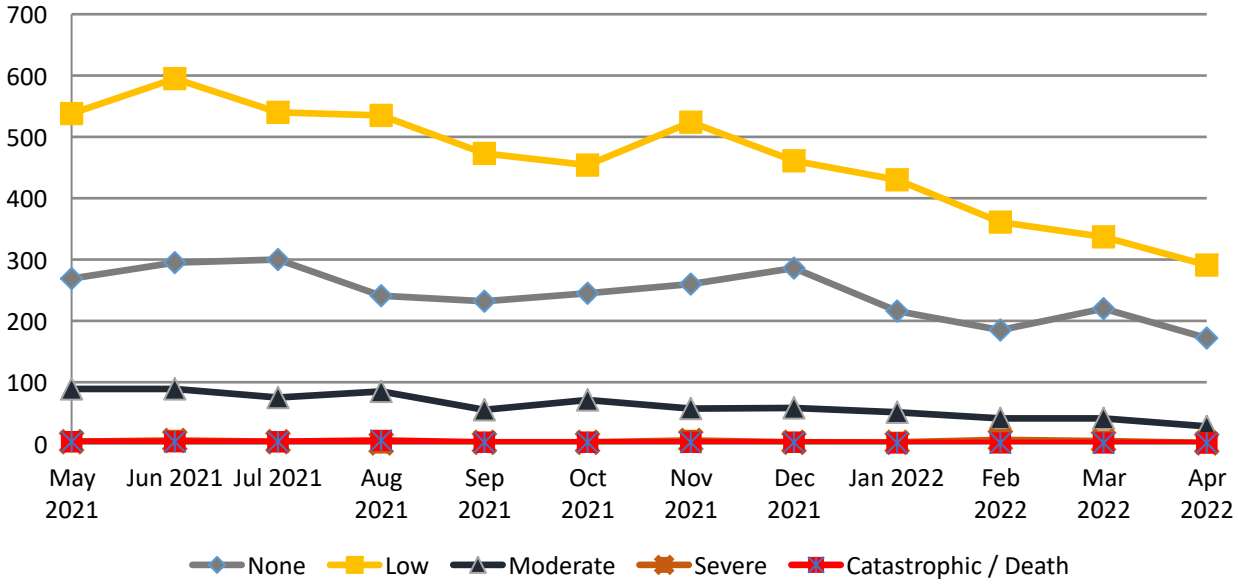
The Health Board uses a number of assurance processes and quality improvement strategies to ensure high quality care is delivered to patients.

This report provides information on patient safety incidents, externally reported patient safety incidents, nosocomial COVID-19 infections, HIW Inspections and Patient Safety Leadership Walkrounds.

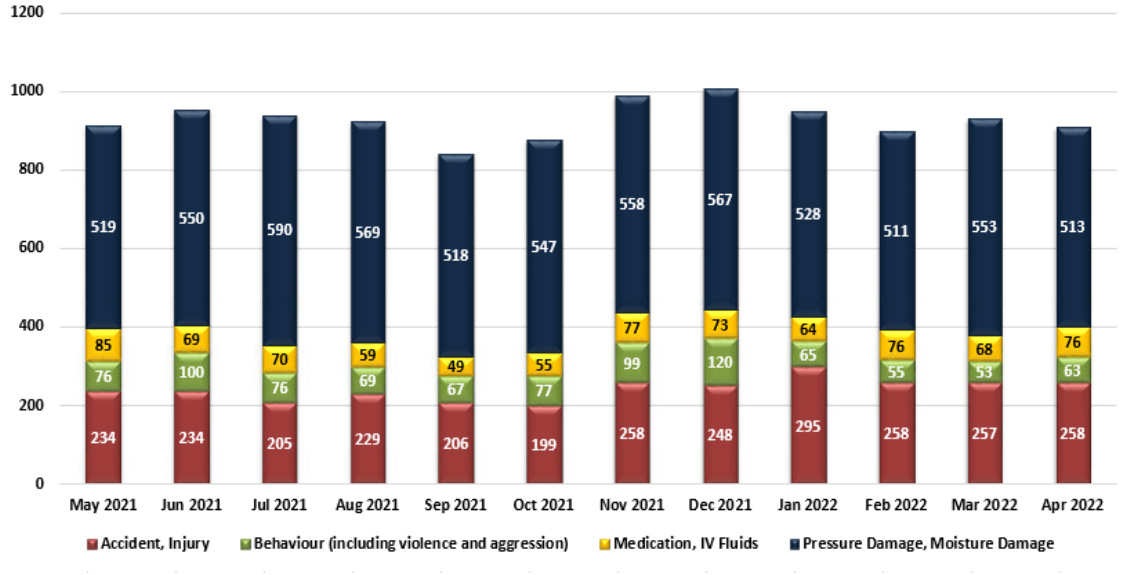
Incident Reporting – 1st May to April 2022

In March and April 2022, 2,791 incidents were reported of which 2,396 were patient safety related

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



Top 4 Patient Safety Incidents



There were 14,277 Patient Safety Incidents reported on the new system between 1st May 2021 and 30th April 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 14,277, 7,978 have been closed and 3,681 have had the severity amended. 1614 Incidents were downgraded whilst 1,939 were upgraded.

Falls Improvement

Focus on inpatient falls: Health Board Falls Strategy

The Quality Improvement Team have been tasked with producing a collaborative falls framework in conjunction with key stakeholders with the following aims:

- to promote falls prevention to reduce the number of avoidable falls in the community and in our hospitals
- to work collaboratively with relevant third sector and social care services
- to ensure an equitable three county approach to community fall intervention
- to develop a seamless transition for patients between hospital and home

The falls strategy group is currently evaluating feedback from the baseline needs assessment which will identify any gaps and areas for focus. The third workshop of the strategy group is due to meet again this month.

Prince Philip Hospital (PPH)

The Quality Improvement and Practice Development Team are conducting a series of away days with the newly qualified nursing staff in PPH with a focus on falls. The first day was held this week with very positive feedback.

Agenda covering topics as follows:

- Lying and standing blood pressure
- Falls documentation
- Post falls care
- Moving and handling – demo of Manga Camel/GERT suit
- Medicines management – good practice, human factors in the work place, interruptions.

Padarn Ward – Glangwili General Hospital (GGH)

The Quality Improvement Team have recently engaged in falls improvement with Padarn ward in GGH. Initial observations have taken place and a number of champions have been identified. Plan Do Study Act Cycles (PDSA) will focus on improvement in completion of the new digital multi factorial risk assessment and implementation of lying and standing blood pressures on patients at risk of falls.

Nationally Reportable Incidents

	21/22 Q1*	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1**	Total
Access, Admission	0	0	0	1	2	3
Assessment, Investigation, Diagnosis	0	0	1	0	2	3
Behaviour (including violence and aggression)	0	1	2	1	0	4
Infection Prevention and Control	0	1	0	0	0	1
Maternity adverse occurrence	1	0	0	0	0	1
Medication, IV Fluids	0	0	0	1	0	1
Patient/service user death	0	0	3	5	9	17
Pressure Damage, Moisture Damage	0	1	2	0	3	6
Transfer, Discharge	0	0	1	0	0	1
Treatment, Procedure	0	1	0	1	0	2
Accident, Injury	0	0	0	0	1	1
Total	1	4	9	9	17	40

* 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.

Between 1st April and 31st May 2022, 17 reportable incidents were reported to the Delivery Unit.

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 MH&LD Services
- Safeguarding
- Procedural Response to Unexpected Death in Childhood (PRUDiC)
- Abuse / Suspected Abuse
- Healthcare Acquired Infections (HCAIs)

Nosocomial COVID 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 inaugural Corporate Assurance Nosocomial COVID-19 Scrutiny Panel has been held and communication with families has commenced.

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 the 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	104	992	301	710	116
Under Investigation	24	507	52	62	0
Not Started	80	485	249	648	116

Figures as at 06/06/2022

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

WalkRounds™

Patient Safety Leadership Walkrounds™ were developed in the USA in the early 2000's through the Institute of Healthcare Improvement (IHI) as a means by which to connect senior leaders with people working on the frontline. The aim was to demonstrate the strong commitment by senior managers to *a culture of patient safety* and as a result the senior leaders become better educated on the concerns of the frontline and can benefit from opening communication channels identifying and thus opportunities for improving safety.

Quality and Safety WalkRounds™ are not an inspection. They are an invaluable way of:

- Demonstrating visible senior leadership in patient safety at a practical level.
- Introduce different conversations and perspectives about patient safety and other "hot" issues among colleagues, executives and managers.
- Identify opportunities for improvement and innovation.
- Encourage reporting of issues, errors and near misses.
- Facilitating Board level engagement direct with frontline teams.
- Combining a top-down and bottom-up approach to safety awareness and management.
- Gaining information and acting on safety problems and issues.

During the pandemic, Walkrounds™ were temporarily stopped. Walkrounds™ have now recommenced and a forward programme agreed with an Independent Member and Executive Director identified.

<u>Snapshot of Issues identified during recent Walkrounds™</u>

- Out of hours dispensing of medication to take home for patients in the Emergency Department
- Patient flow and communication between specialty teams
- Signage for patients and visitors

HIW Quality Checks/Inspections: Summary
15 November 2021 – 6 June 2022

New Quality Checks/Inspections & Reviews

Area of Review	Recommendations	Update
Ward 7 PPH	19	The inspection took place in November 2021 whereby 19 recommendations were raised on matters such as workforce, medicines management, governance and leadership, Infection prevention and risk and health and safety. The recommendations will be tracked via the QAST team and as of the date of collating this report 1 recommendation remains outstanding in relation to staff training with a completion date of September 2022.
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 completion date for recommendations is March 2023.
Ystwyth Surgery 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 now await feedback and the final All Wales report is expected to be available towards the end of 2022.
Llandovery Hospital Quality Check	0	The quality check took place on 15 March, 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.

HIW Quality Checks/Inspections: Summary 16 November 2021 – 6 June 2022

Update on previous Quality Checks/Inspections/ Reviews

Area of Review	Recommendations	Update
Ty Bryn Learning Disability and Specialist Autism Service, Hafan Derwen	18	The Quality Check was held on 1st November 2021, with an immediate assurance plan issued containing 9 recommendations on matters relating to the physical environment and governance. The final report was published in December 2021 and the improvement plan has been in development in conjunction with the Estates team. At the point of collating this report there remain 9 recommendations
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 3 recommendations open the reminder having been completed.
HIW IRMER Oct 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.
WAST 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 writing this report there are 8 recommendations open 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 3 recommendations open at the point of collating this report.
Glangwili General Hospital Morlais Ward Quality Check	8	This onsite Quality Check was undertaken in April 2021. The improvement plan covers staff training, analysis of restraint incidents and patient safety incidents to improve services and evidence of cleaning audits. There are 3 recommendations open with dates for completion of June 2022.
HIW IRMER Remote Inspection April 2021	17	The improvement plan included staff training, Health Board procedures and policies, detailed analysis of patient safety incidents and unintended exposures, audit programme work, listening to feedback and informing patients of waiting times. At the point of collating this report there is 1 recommendation open.

HIW : Additional Information

Current position

As of the date of this report there are a total of 12 reports or inspections with 53 recommendations open. These continue to be tracked by the QAST team to completion.

Services of Concern: New HIW Process

As advised in the December meeting, 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 going forward.
- 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.

Recommendation

The Quality, Safety and Experience Committee is requested to take assurance from the Quality and Safety Assurance Report that processes, including the Listening and Learning Sub Committee, are in place to review and monitor:

- patient safety highlighted through:
  - incident reporting; and
  - review of nosocomial COVID-19 infection
- patient experience highlighted through HIW Inspection