Enw'r Pwyllgor: Name of Sub-Committee:	Exception Report from Operational Quality Safety and Experience Sub-Committee
Cadeirydd y Pwyllgor: Chair of Sub-Committee:	Alison Shakeshaft, Director of Therapies and Health Sciences
Cyfnod Adrodd: Reporting Period:	2nd July 2020
Materion Ansawdd, Diogelwch a Phrofiad: Quality, Safety & Experience Matters:	

Resuscitation / Rapid Response to Acute Illness Groups (RRAILS)

A detailed report provided by the Lead officers of the RRAILS Group covered the following topics:

- Confirmation that consistent feedback was received from the Hospitals RRAILS Group with no concerns escalated.
- The Out of Hospitals RRAILS Group Community National Early Warning Score (NEWS) project has been on hold due to the suspension of the Enabling Quality Improvement in Practice (EQIiP) projects during the COVID-19 pandemic. Despite this situation, assurance was given that community based training had been maintained for District Nurses/GP Practices/ and Out of Hours GPs.
- Work steams relating to the sub group for Paediatrics / Mental Health / and Trauma have been ongoing with no concerns highlighted.
- Assurance was received that the Acute Kidney Injury work is being progressed through a pilot to be established in Withybush General Hospital (WGH).
- A briefing was received on the transfer of the All Wales DNRCPR forms into Community and Primary Care. The Policy itself has been revised and now stipulates that following appropriate training, Registered Nurses including District Team Leads can now sign the form.
- Members noted that as part of the revision of the Resuscitation Council Guidelines, COVID-19 Response and Resuscitation Flow Charts have been developed with pathways that have been endorsed by the COVID-19 Gold Command Group. To reduce risk to staff and others in terms of aerosol generation and potential COVID-19 transmission, all patients are to be treated as if they have COVID-19 in relation to resuscitation response. Assurance was provided that in the event of a sudden collapse, all secondary care areas have access to full Personal Protective Equipment (PPE). It was noted that provision of the latter in Mental Health and Learning Disability / and General Practices is progressing, whilst recognising that further assurance is required in relation to Community Hospitals.
- It was reported that due to ongoing delays with the medical review process following inpatient cardiac arrests, a task and finish group has been established to investigate the cause and determine a way forward to reduce delays.
- A position update was provided on the Verification of Death Policy (VOD) in adults which is being updated in relation to Welsh Government (WG) guidance on community and virtual VOD. Confirmation was received that the Health Board will not be including family member involvement in this procedure. Assurance was given that extensive training of over 200 nurses had been conducted across the Community and Field Hospital settings. It is anticipated that the project will be subject to evaluation in July 2020.

- The use of the Sepsis Bundle in the Emergency Departments was reported as consistent, however ward numbers have dropped considerably due to reduced numbers of patients on the wards during COVID-19. Assurance was provided that there will be robust monitoring of Sepsis Bundles in the ward areas to stabilize compliance. Sepsis work in the community will be restarted as part of the EQIiP programme.
- No significant impact was reported on compliance with the admission recognition and response bundles.

The Sub-Committee was assured and accepted the RRAILS Report.

Health Board wide Assurance Report: Cancer treatment during COVID-19

- The Sub-Committee received a comprehensive report outlining a summary analysis on the impact of COVID-19 on cancer referral rates, treatment volumes, and referral to diagnostic rates, and also the current scope of cancer services and treatments during COVID-19, including the Health Board's response to WG on the 'Response to the Framework for Recovery of Cancer Services' benchmarked against the eight key actions.
- Assurance was received on the Health Board's position of a 49% reduction rate on cancer referrals against a 70% reduction across the whole of Wales, and that any suspended treatment pathways were in line with guidance. Patients on these pathways have since been tracked and treatment recommenced.
- It was noted that the biggest COVID-19 impact on the diagnostic pathway was colorectal which was caused by the suspension of Endoscopy Services due to the risk of the aerosol generating procedures and potential COVID-19 transmission.
- Assurances were also received in terms of surgical cancer treatments. A surgical pathway has been maintained for patients that meet the specific criteria through Health Board commissioned services at the Werndale Hospital. Despite the lack of Level 2/3 facilities at this hospital, many patients were able to proceed with their treatment. Those patients who were outside of the criteria have since received their required surgical interventions within the acute hospitals through the recent reintroduction of planned care pathways across the acute sites.
- Through prompt and effective planning, oncology appointments have continued virtually and chemotherapy services maintained across the sites. This also applied to diagnostic investigations, radiological imaging, and phlebotomy services.
- Only one area of concern was highlighted which related to potential delays for patients through capacity issues experienced at the tertiary centres.

The Sub-Committee acknowledged the content of the report and the assurance provided.

Health Board wide Assurance Report – Hospital Acquired Thrombosis

The Sub-Committee received a Health Board position report in relation to Hospital Acquired Thrombosis (HAT) which became a Tier 1 target in 2015/16. WG normally receive reports from the Health Board both monthly and quarterly which include data on the number of positive cases of Venous Thrombo Emboli (VTE) within 90 days of discharge and the number of preventable and unpreventable cases. It was noted that this line of reporting had been suspended during the COVID-19 period, however assurance was received on the following:

- Health Board internal scrutiny and review processes have been maintained via Root Cause Analysis reports reviewed at local clinical team level and by the Thrombosis Group.
- Dissemination of Learning from Events through various fora including Directorate / Site Clinical Governance meetings and directly to individual clinicians.
- In line with the All Wales Thrombo-Prophylaxis Policy, a single risk assessment tool has been developed with the aim of improving compliance, with assessment of patients within a 24 hour period of admission with a planned introduction imminent.
- All avoidable cases are reviewed by the legal team to ensure patients are kept informed and redress offered if necessary.
- Development of a HAT Improvement Plan previously endorsed by QSEAC
- Establishment of a task & finish group to monitor and implement the plan.

Health Board wide Assurance Report: Inpatient Falls

The report on data for inpatient falls during the previous 18 months on each acute hospital site provided a variable illustration on the trends relating to falls and the correlation with quality improvement work initiated in areas deemed as high risk. It was noted that there was a significant downward trend over the 3 month period from the commencement of the initial COVID-19 period. However this was attributed to the reduction of hospital admissions to the non-COVID areas during the pandemic. Members also noted that the quality improvement work has paused due to staff redeployment during COVID-19. Assurance was received that diligence on falls risk assessments is being maintained and post falls protocols followed in the clinical areas.

Health Board wide Assurance Report: Pressure Damage

The report on pressure damage highlighted a slight increase in pressure damage during the previous year particularly in Quarters 3 and 4 which linked to changes made to the reporting and investigating processes as demonstrated by the reclassification of 78 reported incidents not deemed to be actual pressure damage through validation by the Tissue Viability Team. This upward trend was also illustrated in the first quarter report of 2020/21 with a total of 19 incidents in April 2020, 24 in May 2020 and 30 in June 2020. As there is ongoing work to address these, the Sub-Committee received an assurance that these numbers would decrease following the validation process.

The impact of pressure damage related to the use of PPE during the COVID-19 period was described in the main as facial indentation caused by the use of face masks with 9 reported incidents. Members received an assurance by the preventative processes put into place such as use of gel strips to reduce pressure and staff awareness training to mitigate risk. The Sub-Committee acknowledged the additional work being undertaken within acute services to introduce the new All Wales Pressure Damage Assessment Performa and also the ongoing works to critically analyse avoidable and unavoidable pressure damage and also introduce improvements to support evidence based practice.

Heath Board wide Assurance Report: Pharmacy and Medications Management – Medication Incidents

The Sub-Committee received the Pharmacy and Medicines Management Assurance Report on Primary Care, Community and Acute Services which included reference to the challenges in

providing accurate data on medication incidents across the sectors. This largely relies on the DATIX Incident Reporting System which many independent contractors in primary care do not have access to, and pharmacy in the community is only required to report incidents involving controlled drugs, hence the higher number of medication errors reported through the DATIX system across acute services.

Assurance was provided that there are a number of mechanisms in place to support learning from reported incidents and to identify opportunities to avoid harm to patients. All improvement plans following the scrutiny of medication errors are subsequently reviewed by the Medicines Event Review Group (MERG) where areas of concern are identified and shared learning facilitated across the Health Board.

The Sub-Committee noted the common themes on medicines management highlighted in Healthcare Inspectorate Wales (HIW) Reports and the repeat offenders in terms of medication errors, which require a change in culture. This particular theme will be incorporated into a Health Board workshop on medication errors planned for the autumn. Members received an assurance by the systems currently in place and acknowledged the efforts being made to improve processes and to mitigate risk to patients through a zero tolerance approach.

Compliance Status: External Health Regulator Review / Improvement Plan – Healthcare inspectorate Wales: Annual Review

The annual summary of the HIW inspections undertaken within the Health Board during 2019/20 was acknowledged by the Sub-Committee including the themes identified within the recommendations made by HIW for the Health Board.

Assurance was provided that learning is evident particularly in paediatrics and medicines management and that HIW recommendations are discussed as part of the Directorate / Site Clinical Governance Meetings. The Sub-Committee noted that it is anticipated that HIW will restart its inspection programme in the near future following a period of suspension during the COVID-19 pandemic.

Directorate / Site Exception Reports on Risks / Concerns for Escalation

The Sub-Committee reviewed the recurring themes throughout the exception reports from all Acute and Community Services which outlined the substantial change to services including the introduction of surge capacity as part of the emergency planning associated with COVID-19. Also highlighted were the risks associated with the reintroduction of planned care surgical pathways into some acute sites that had not dealt with major surgical cases for a significant number of years. The plans put into place to ensure patient safety and support staff in these circumstances was acknowledged by OQSESC.

The high number of existing nursing vacancies evident across the hospital sites was noted and assurance derived from the efforts made to secure temporary backfill for registered nurse vacancies, with the Sub-Committee commending the development of Healthcare Support Worker (HCSW) Band 4 posts to support the registered nurse workforce.

Risgiau: **Risks (include Reference to Risk Register reference):**
<u>Operational Risk Management – Health Board Overview on Top Rated Risks / Actions for Mitigation</u> The Sub-Committee noted the content of the Operational Risk Management Report and the mitigation plans put in place. Directorate/Site Services Leads and County Representatives were requested to discuss the risks within their respective Directorate/Site Clinical Governance meetings to ensure that the exception reports and quality issues are aligned.
Argymhelliad: **Recommendation:**
QSEAC is requested to note the content of the OQSESC exception report and to seek further clarity on any areas of concern.
Dyddiad y Cyfarfod Pwyllgor Nesaf: **Date of Next Sub- Committee Meeting:**
3rd September, 2020.