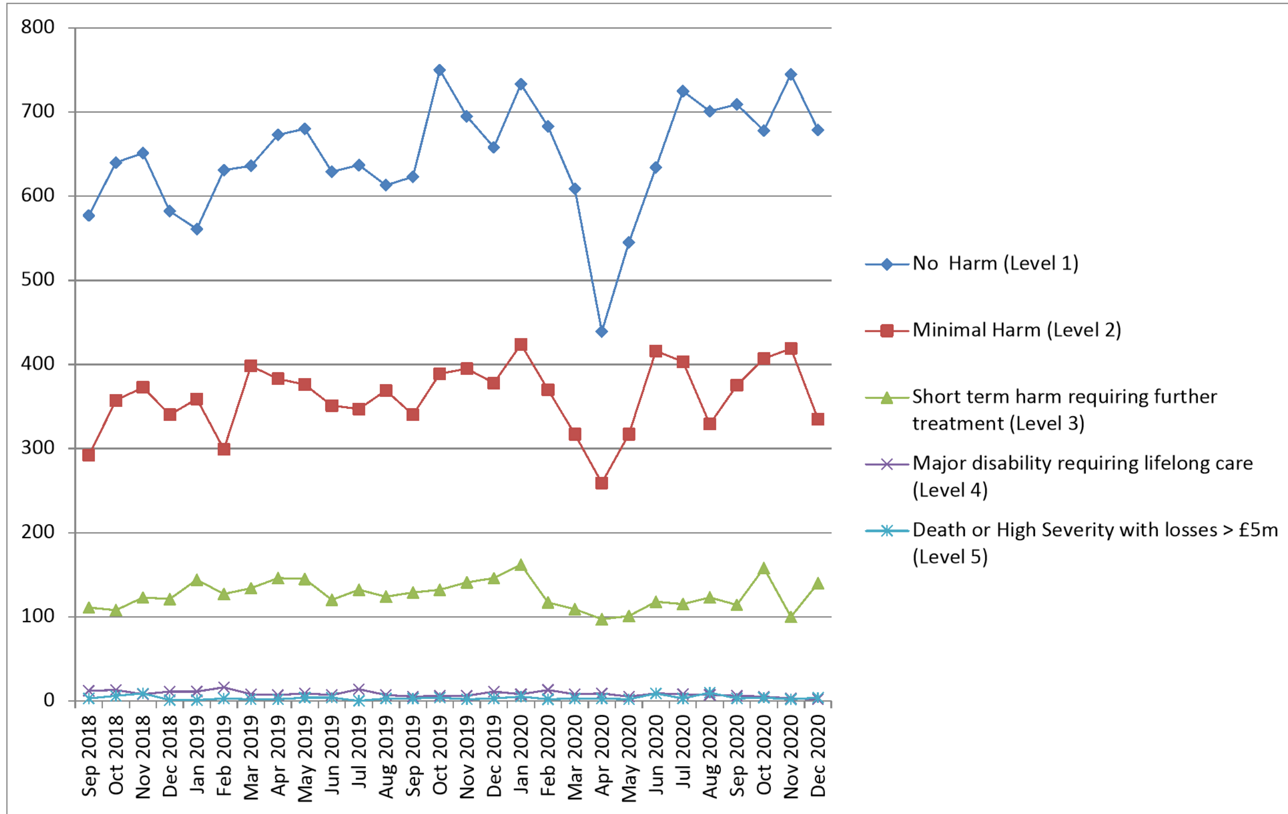
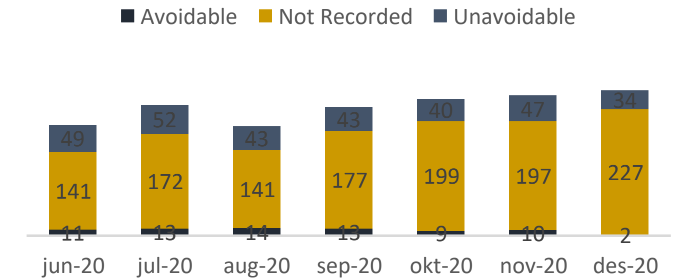
Quality and Safety Assurance Report

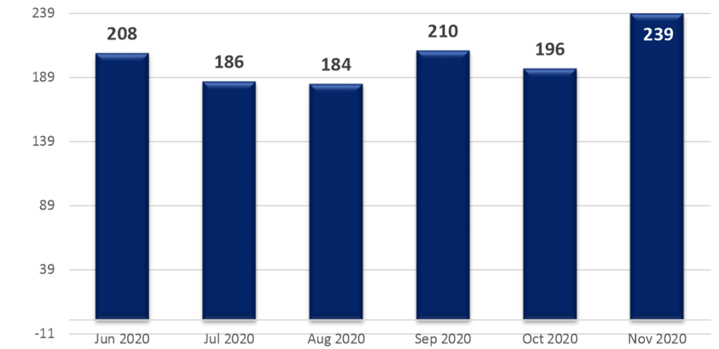
Situation

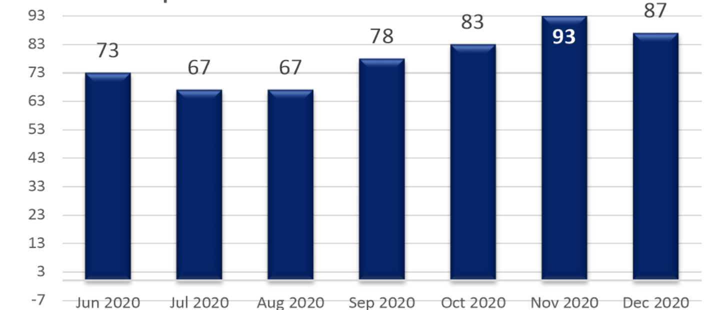
- The purpose of this report is to provide the Quality, Safety and Experience Assurance Committee (QSEAC) with an overview of quality and safety across the Health Board.
- The Health Board uses a number of assurance processes and quality improvement strategies to ensure high quality care is delivered to patients.
- The Quality Improvement (QI) team has been deployed, since February 2020, to assist with the setting up and running of the command centre and to support operational teams with their COVID response. This has enabled the team to develop key relationships with the operational teams, and embed QI skills and methodology in the changes needed with frontline services and in the development of a communication and escalation hub for the Health Board. Some QI work is restarting and a focussed report will be provided to QSEAC scheduled for April 2021.

Incident Reporting



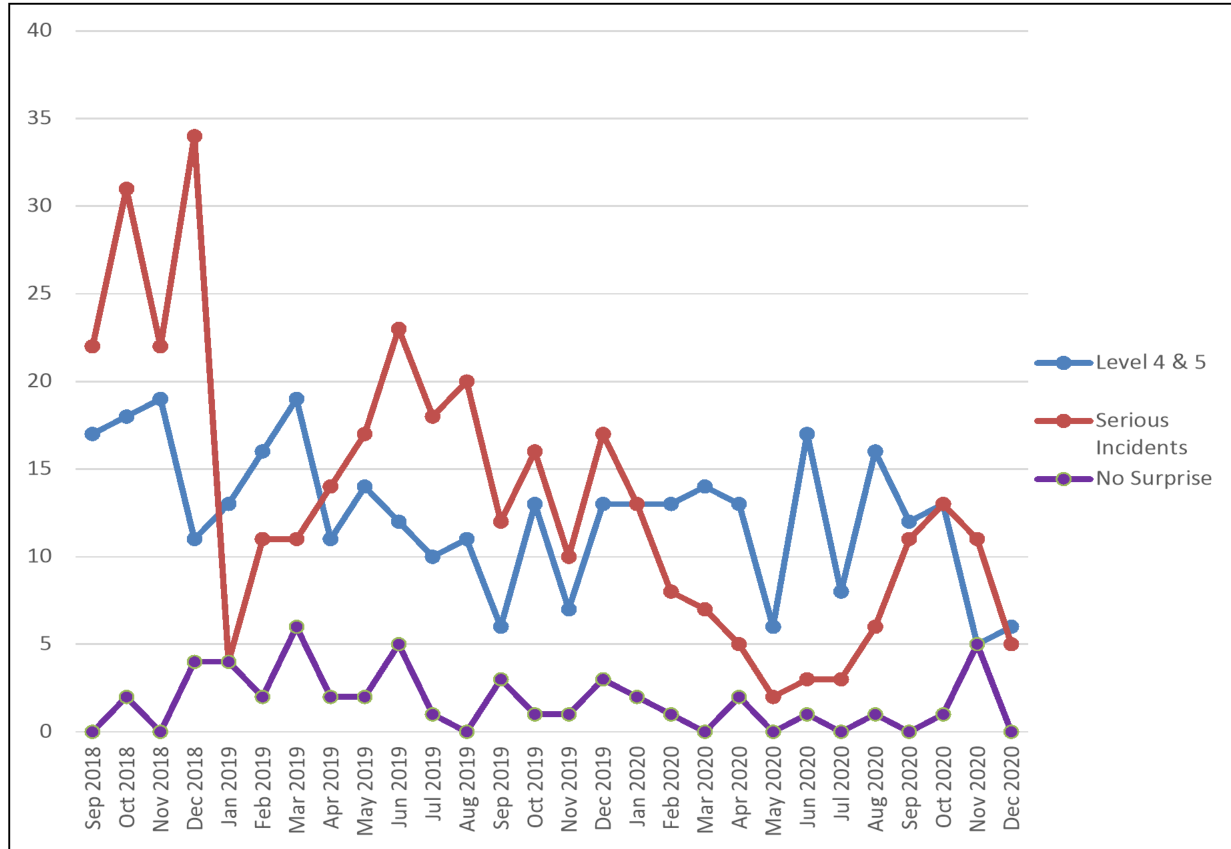






In November and December, 2,804 incidents were reported of which 2,429 were patient safety related. These figures are consistent with previous months

Serious incidents



Between 1st November and 31st December 2020, **16** serious incidents were reported to Welsh Government (WG); Under 18 Admission to an adult Mental Health Inpatient setting was the highest reported category (a formal quality panel has been arranged with the directorate to explore this further).

	Q1	Q2	Q3
Absconded patient*	0	1	2
Pressure Damage*	0	2	2
PRUDiC	1	0	1
Retained foreign object	1	1	0
Patient Fall (serious harm)	1	3	8
Suspected Suicide	1	2	0
Unexpected Death	2	2	6
Neonatal/Perinatal Care	2	0	0
Wrong site surgery / procedure	2	1	0
Under 18 Admission*	0	0	10
Other	0	1	0
Total	10	13	29

*not reportable – temporary change in SI reporting during first wave, requirement to report re-introduced. However, reporting requirements have recently changed in view of second wave pressures

Update 4th January 2021 - NHS organisations only need to report the following serious incidents to the Delivery Unit:

- all never events
- in patient suicides
- maternal deaths
- neonatal deaths
- homicides
- incidents of high impact / likely to happen again including child related deaths (for local decision)

Risks and Mitigation

Patient Safety Incidents

- Scrutiny of all incidents reported are undertaken by the Quality Assurance Information System Team on a daily basis. Reports of themes and trends in reporting are provided to the Head of Quality and Governance, Assistant Director of Nursing, and Associate Medical Director.
- For patient safety incidents where there has been major or catastrophic harm, a rapid scrutiny of the incident is undertaken by the Patient Safety Team with liaison with the Triumvirate and Service Teams.
- The Health Board continues to undertake proportionate and timely investigation of all incidents where there has been harm, with an escalation process to the Director of Nursing, Quality and Patient Experience in place should there be delays in completion of the investigation.
- Improvement and Learning Action Plans are developed and implemented within Directorates in response to the findings of the investigations.
- The learning from serious incidents is shared with the Listening and Learning Sub-Committee.

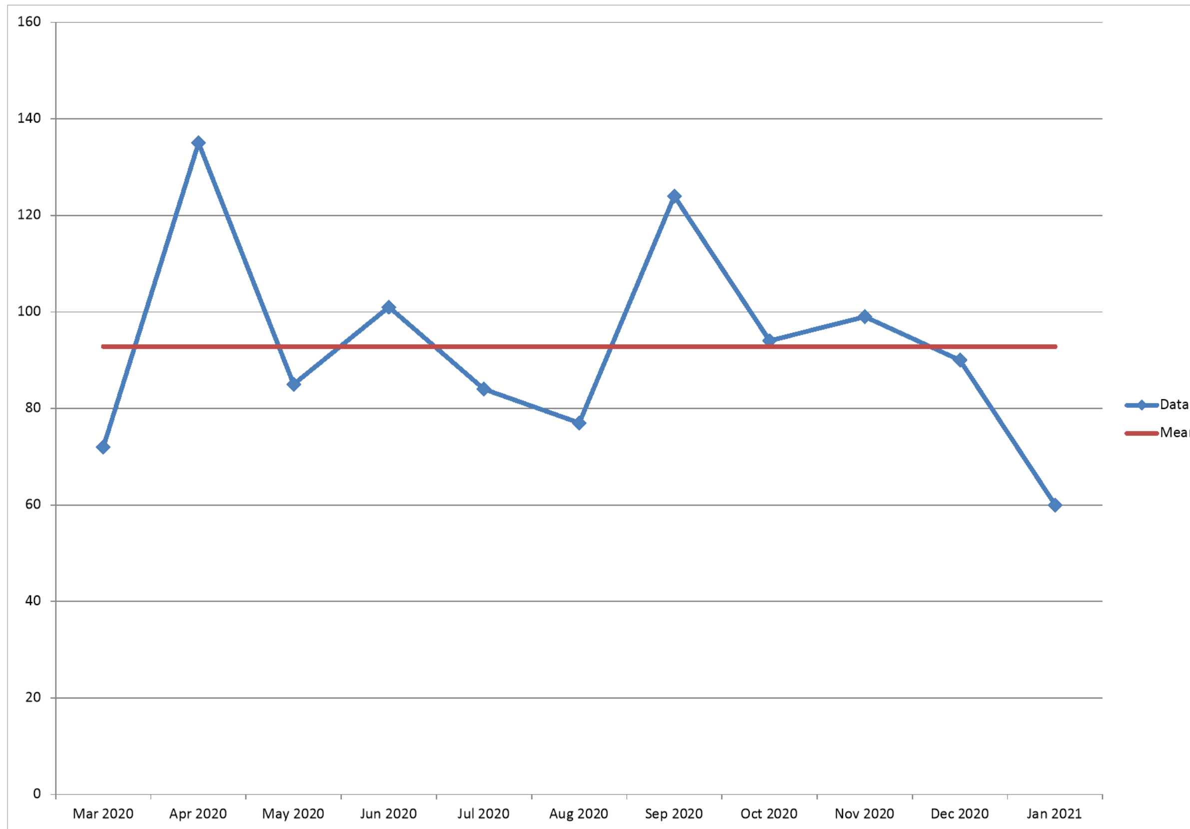
Situation

Focus on COVID-19 related complaints and enquiries

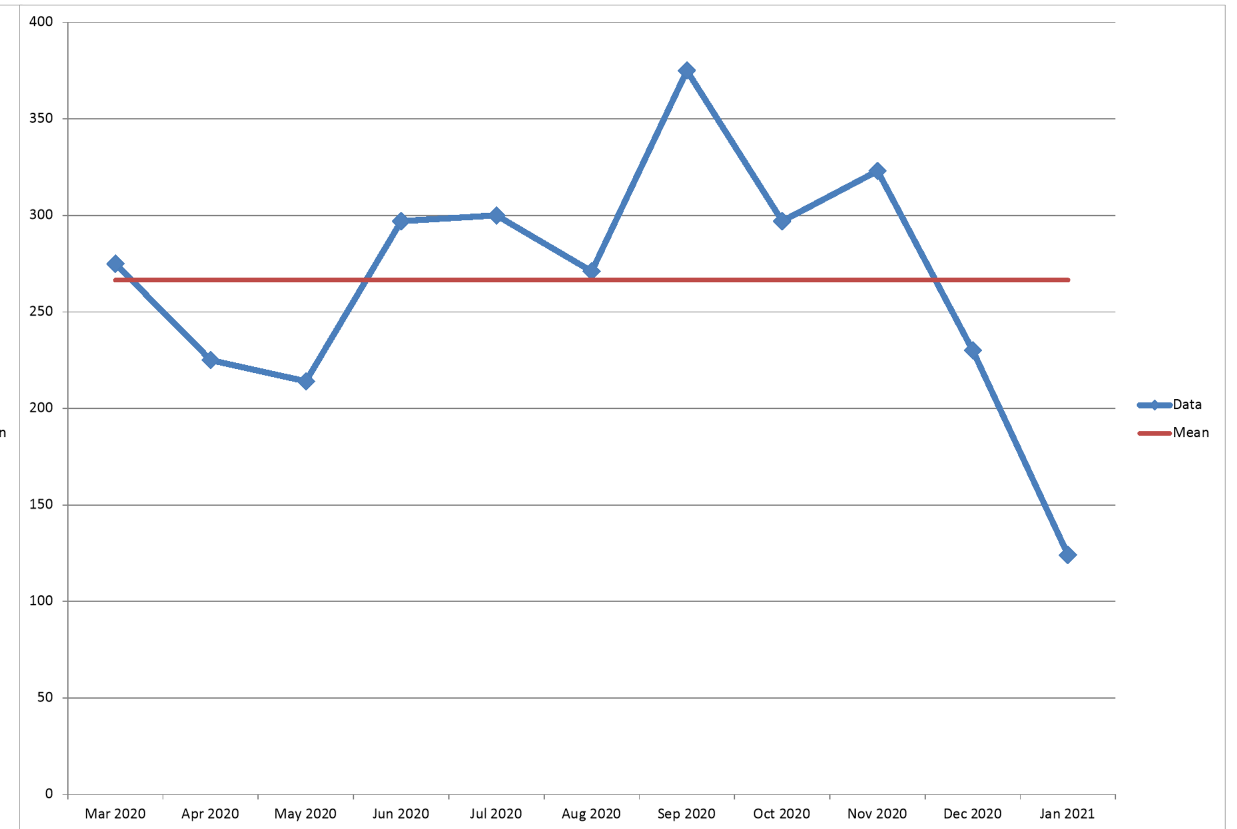
- Since March 2020, the Health Board has received 1023 contacts from members of the public in relation to COVID-19.
- 46% of these were managed as enquiries, 21% were managed as Early Resolution cases and 33% were Managed Through Putting Things Right (MTPTR).
- The majority of contacts are in relation to communication, appointments, clinical treatment/assessment and test/investigation results.
- The top specialties complained about (yearly to date) are Orthopaedics, (50% MTPTR), Primary Care (25% MTPTR), Medicine, Urology and Surgery (collectively 25% MTPTR).
- Of these cases, only 11% required an investigation, with 0.6% (2 cases) graded as Major (Grade 4).

Complaints Trends re COVID-19

Complaints Related to COVID-19 (March '20 to date)

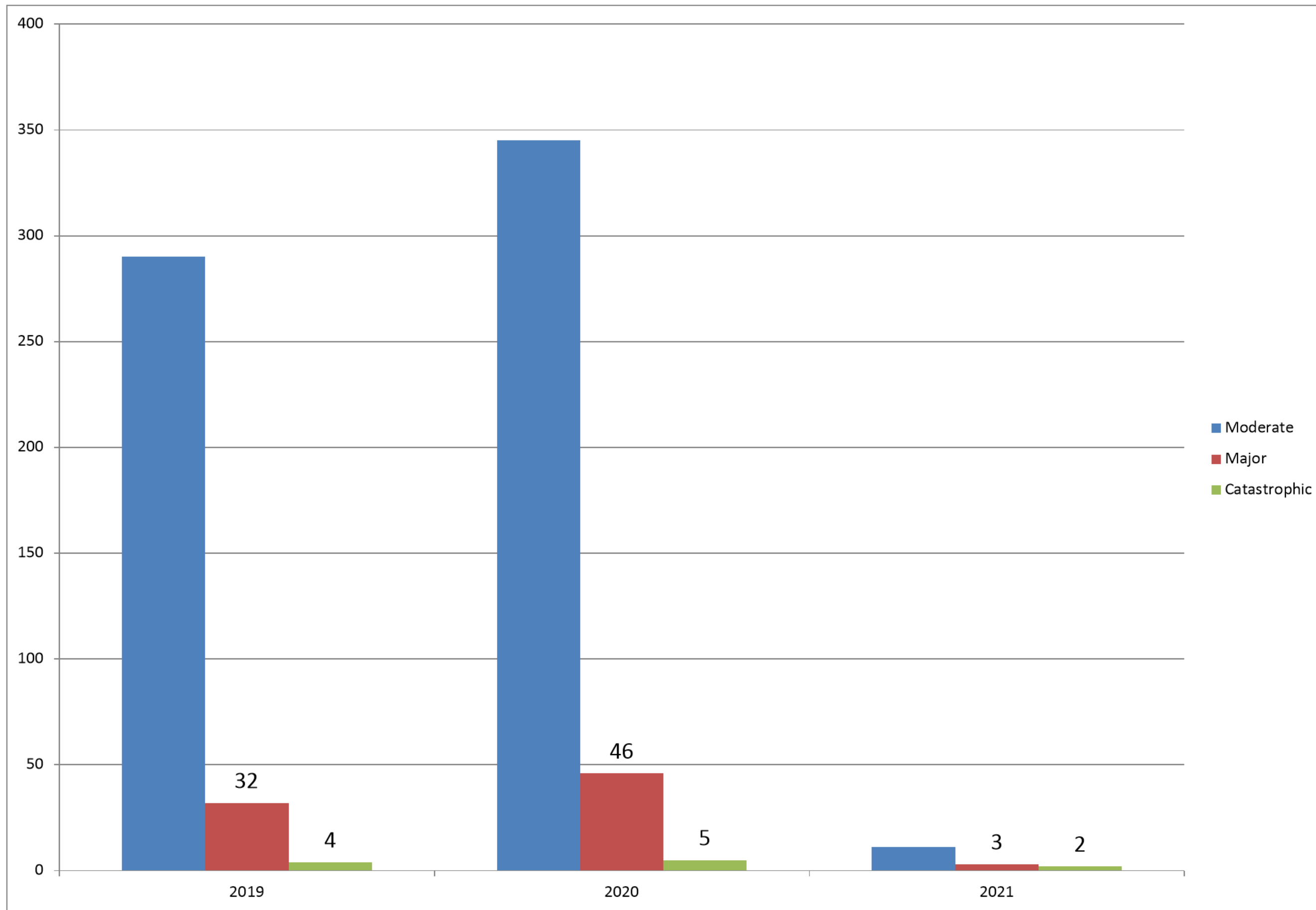


All Complaints Received March '20 to Date



Comparing the number of complaints received in 2019 to those received in 2020, there has been a 10% increase.

Complaints Trends re COVID-19



Although the Health Board received an increased number of grade 4 (major) complaints in 2020, only 2 of these were in relation to COVID-19.

All of the serious complaints (grade 4 (major) and 5 (catastrophic)) received in 2021 are in relation to COVID-19. This situation will need to be closely monitored as, if the grading of the complaints remains the same on closure (i.e. if the investigation upholds the complaints raised), then the Health Board will have received nearly 50% of its average number of grade 5 complaints for a year in the first month.

Risks and Mitigation

Focus on COVID-19 related complaints and enquiries

- All complaints are triaged on receipt.
- Datix has a specific COVID-19 question which requires completion when the complaint file is created to identify any complaints which involve any aspect of COVID-19.
- Close working with Directorates and Legal Services / Quality Assurance and Safety Team to ensure robust and appropriate investigations are undertaken.
- Regular audits and reports are undertaken and presented to Senior Team.

Recommendation

The Quality, Safety and Experience Assurance Committee is asked to:

- Agree to receive a focused quality improvement report at the meeting schedule for April 2021;
- Take an assurance from the Quality and Safety Assurance Report that processes are in place to review and monitor patient experience highlighted through incident reporting, complaints and feedback mechanisms.