![GIG Cymru NHS Wales logo — Bwrdd Iechyd Prifysgol Hywel Dda University Health Board]

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	06 October 2020
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality and Safety Assurance Report Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mandy Rayani, Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Sian Passey, Assistant Director of Nursing Assurance, Quality, Safeguarding and Professional Regulation Louise O'Connor, Assistant Director of Patient Experience

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

| ADRODDIAD SCAA |
|---|
| SBAR REPORT |
| **Sefyllfa / 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. |
| **Cefndir / Background**

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

Quality Assurance
The quality assurance information within the report includes a summary of data, intelligence and actions to provide high quality care against the core quality assurance processes that exist within the Health Board and the core quality and safety indicators.

There are a number of core quality assurance processes in use across the organisation; these include Board to Floor Walkabouts, feedback on experiences of care, service specific spot checks, and clinical audit. An overview of quality can be obtained through analysis of quality and safety indicators; these include incidents resulting in harm, serious incidents (SI), and complaints. Near misses will also be reviewed.

Quality Improvement
Previous reports to the QSEAC have included quality improvement (QI) data on the top 3 incidents reported within the Health Board which also feature on directorate risk registers:
• Patient falls (Datix risk reference 45 and 90)
• Pressure damage (Datix risk reference 50, 88, 424 and 594)
• Medication errors (Datix risk reference 84 and 366)

Due to the COVID-19 pandemic, the staff resource for quality improvement has been redirected and therefore limited QI data is available for this report. |

Asesiad / Assessment

Quality and Safety Metrics

1. Key Quality and Safety metrics: Health Board Wide

Table 1 below provides a summary of the Health Board wide key quality and safety metrics for July and August 2020.

Table 1	Engagement in HDdUHB Core Quality Assurance Processes				Key quality and safety metrics				
	Board to Floor	**Feedback on Patient Experience**			**Patient Safety Incidents**				**External Inspections**
		Compliments	**Complaints Managed through PTR***	**Early Resolution**	**PSI* Total**	**% resulting in harm**	**No. resulting in SI***	**% resulting in SI***	
Scheduled Care	0	5	90	16	81	37%	1	1%	0
Unscheduled Care	0	6	102	33	843	33%	4	0.5%	0
Women & Children	0	1	31	6	63	6%	0	0%	Virtual Interview with HIW
Mental Health & Learning Disabilities	0	4	24	9	216	33%	2	1%	0
Community Services	0	0	19	3	867	59%	3	0.5%	0
Primary Care	0	0	46	18	28	25%	0	0%	0
Health Board Total	**0**	**16**	**312**	**85**	**2098**	**43%**	**10**	**0.5%**	**0**

* PTR is Putting Things Right, SI is serious incident and PSI is patient safety incident

Incident Reporting
Table 2: Incident Reporting Trend across the Health Board
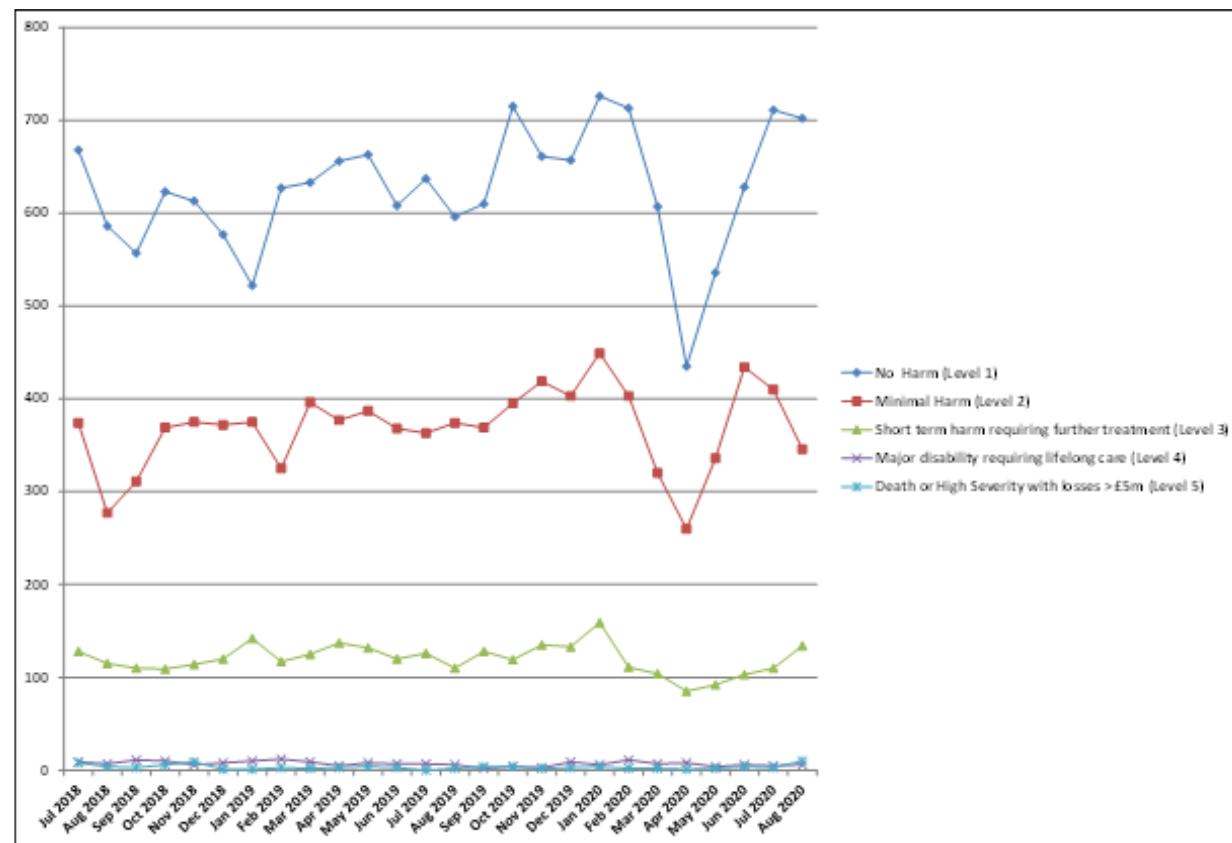
Source of data: Datix

In August **1,289** incidents were reported of which **1,106** were patient safety related. These figures are consistent with previous months.

Within the patient related incidents in July and August 2020, the top 3 patient safety incident themes reported remain consistent with previous reports to QSEAC

1. Pressure damage (including moisture damage) (please see QI work detailed later in the report)
2. Patient accident or fall (please see QI work detailed later in the report)
3. Medication related incident
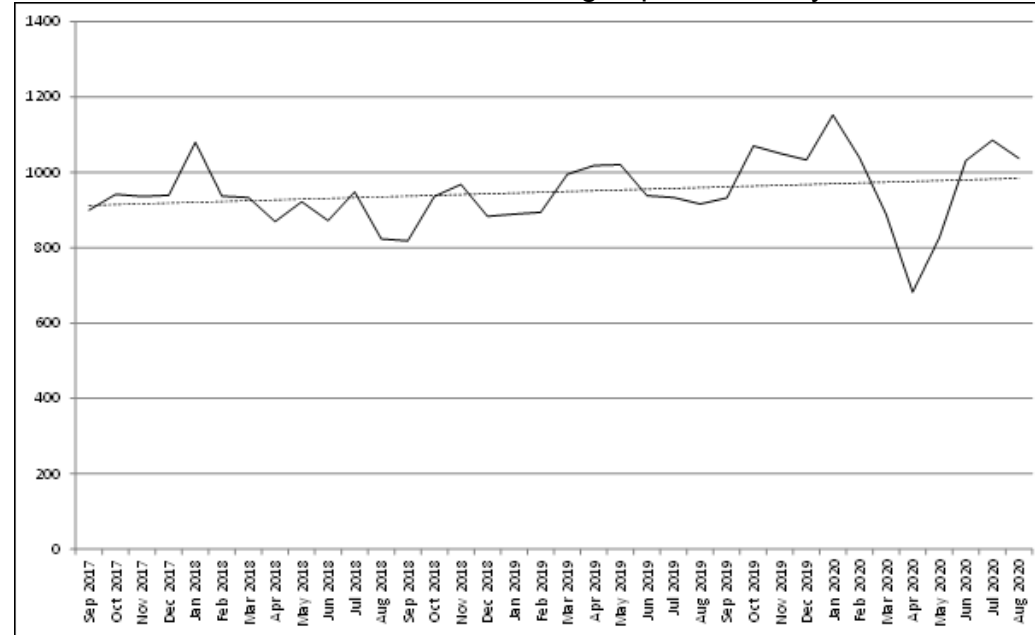
Table 3: Number of pressure damage incidents. The incidents reported in August 2020 are currently being reviewed and scrutinised and therefore the "not recorded" figure for August 2020 may change.
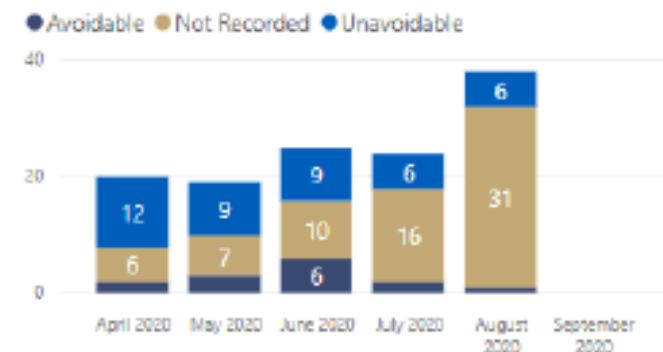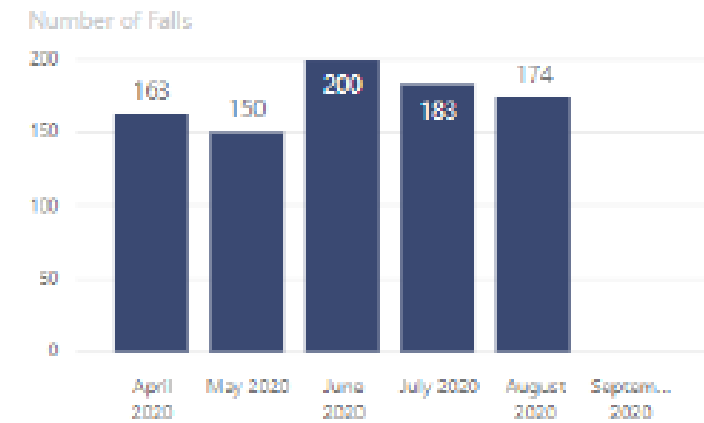

Source of data: IRIS

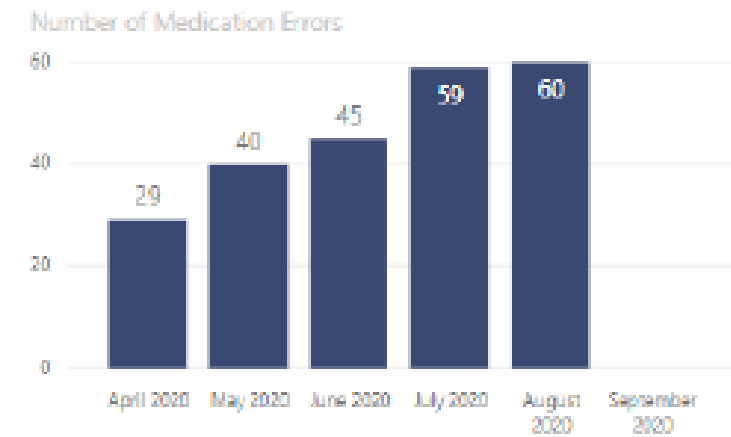**Table 4**: Total number of incidents relating to patient safety

Source of data: Quality Dashboard

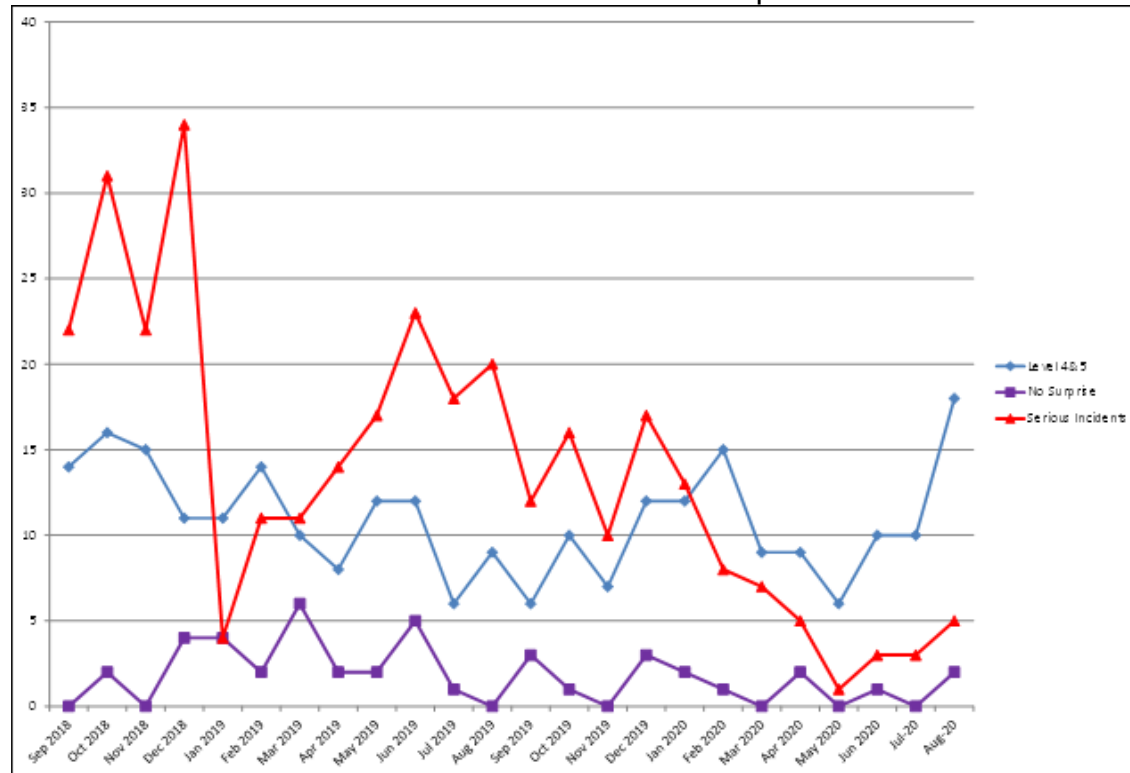**Table 5:** Number of patient falls

Source of data: IRIS

Table 6: Number of medication errors

Source of data: IRIS

Table 7: Level 4 & 5 incidents and serious incidents reported to Welsh Government

Source of data: Datix

Between 1st August and 14th September 2020, **11** serious incidents were reported to Welsh Government (WG); unexpected death (including death of a service user known to Mental Health services) was the highest reported category.

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

*not reportable – temporary change in SI reporting during pandemic
** up to 15th September 2020

Source of data: Datix

Never Events

Since April 2020, the Health Board has reported 5 never events. Closure forms for 3 never events have been submitted to WG. There is close monitoring of the investigation reviews and implementation of associated action plans through Control Groups and Formal Quality Panels. A number of actions have been taken to support Health Board wide learning. On completion of the investigation, the learning is presented at the Health Board Listening and Learning Sub-Committee (LLSC)

Retained foreign object post procedure (Retention of a foreign object in a patient after a surgical / invasive procedure)	2
Wrong site surgery (An invasive procedure performed on the wrong patient or at the wrong site (e.g. wrong knee, eye, limb, tooth). The incident is detected at any time after the start of the procedure.)	3

As reported to the previous QSEAC meeting, the Health Board continues to undertake proportionate and timely investigation on all incidents where there has been harm, with an escalation process to the Executive Director of Nursing, Quality and Patient Experience in place should there be delays in completion of the investigation. On 13th August 2020, the Deputy Chief Medical Officer wrote to all Health Boards and Trusts reinstating the reporting arrangements outlined within the Putting Things Right Guidance.

Table 8&9: Serious incidents reported to Welsh Government Closure Compliance
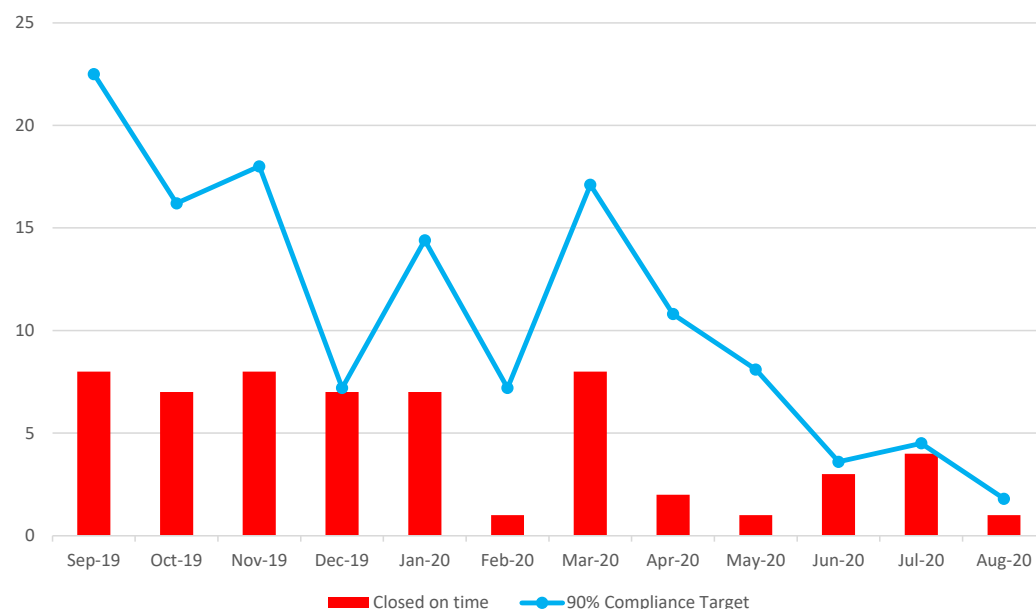
WG ask Health Boards to ensure that there is timely and proportionate investigation of all incidents, and wherever possible, serious incidents are reviewed and closed within 60 working days. There were 2 serious incidents due for closure in August 2020 of which 1 was closed in the agreed timescale (**50%**), and 1 breached the agreed timescale (due to the complexity of the review into this incident).

As at 16th September 2020, there were **27** serious incidents open over 60-days. This is a improvement on the position reported to the previous QSEAC where 30 serious incidents were overdue. The Health Board will continue to monitor and scrutinise internally the quality of these investigations.
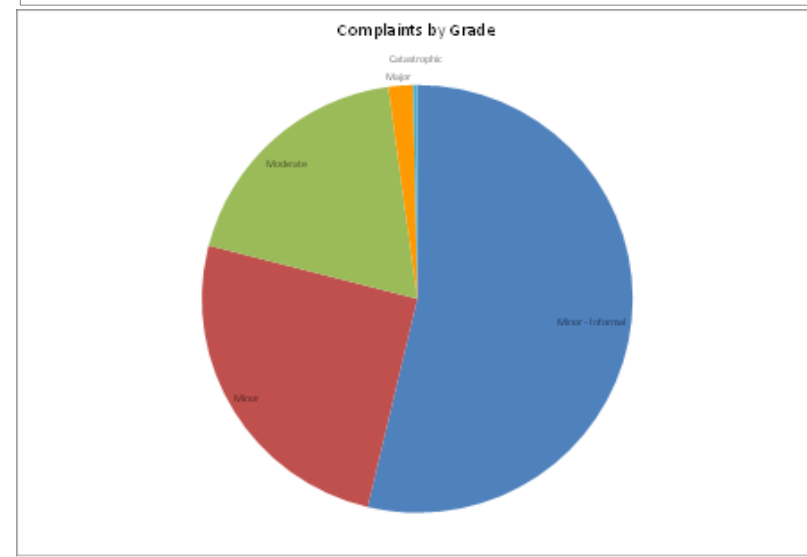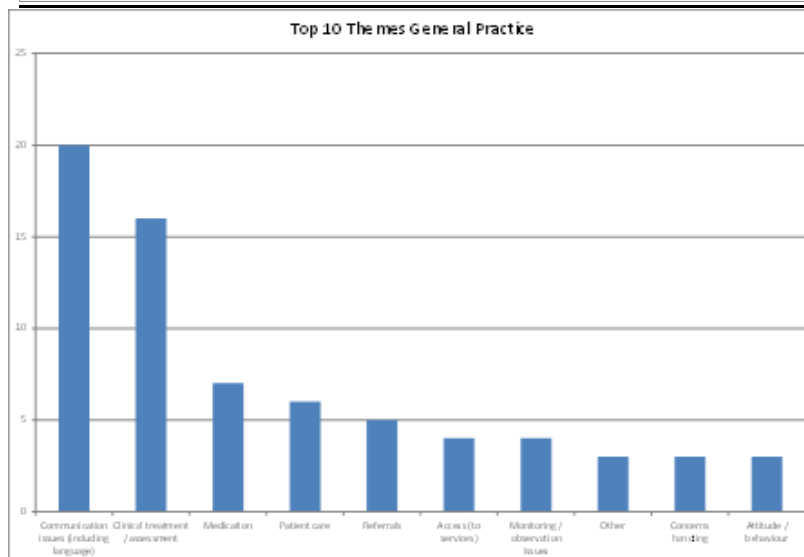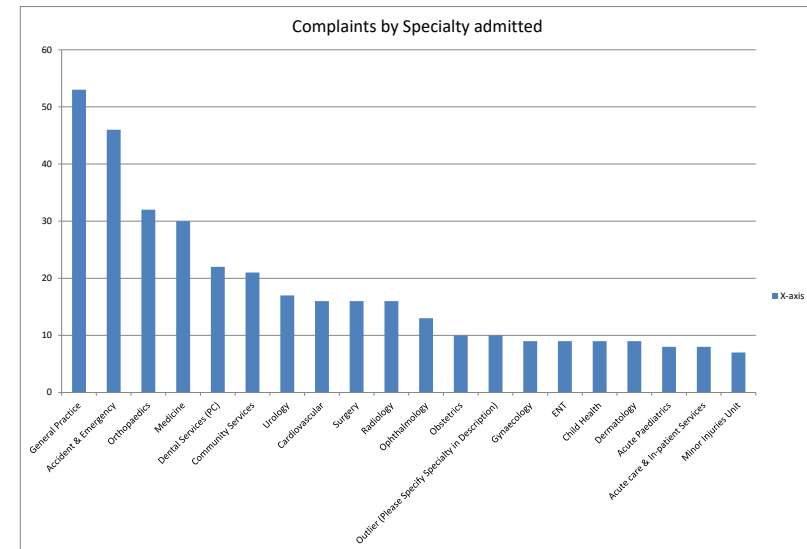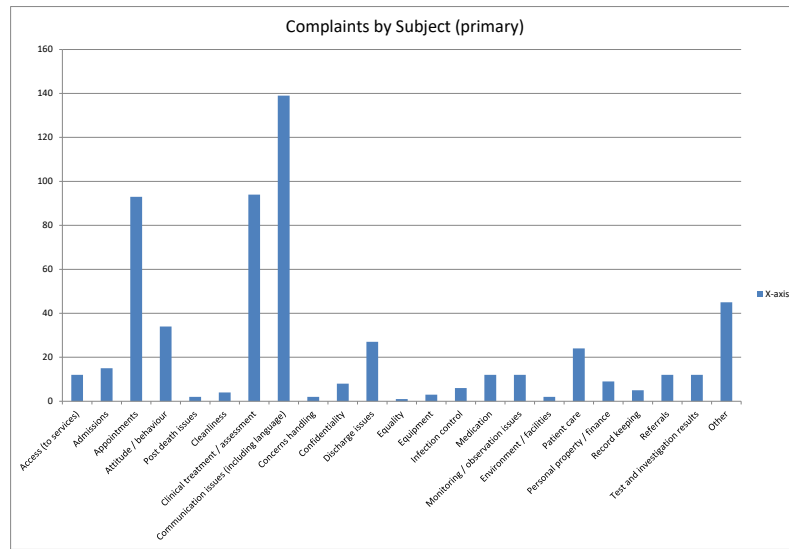
The predicted closure for October 2020 **is ≥25%**, where 3 of the 4 incidents due for closure are complex (2 unexpected deaths within Mental Health Services and 1 child death that is within the Procedural Response for Unexpected Death in Childhood (PRUDiC) process).

Month Closure Due	Total due	Closed (on time)	% closed on time	Closed (outside timescales)	Open at time of report	Not due
Apr-20	12	3	25%	0	9	NA
May-20	8	1	13%	0	7	NA
Jun-20	4	3	75%	0	1	NA
Jul-20	5	4	80%	1	0	NA
Aug-20	2	1	50%	1	0	NA
Sep-20	3	2	NA	NA	1	0

Source of data: Datix

Complaints

The number of contacts (cases, queries, early resolution and cases investigated through the Putting Things Right process) received during July and August 2020 were 573, with the majority of complaints being in relation to communication issues, clinical treatment/assessment and appointments

Complaints by Subject (primary)

Complaints by Specialty admitted

Top 10 Themes General Practice

Complaints by Grade

The highest number of complaints received about General Practice in July and August 2020 were in relation to communication issues and clinical treatment/assessment, with 62% of complaints managed through Putting Things Right (PTR) and 38% of complaints being resolved via early resolution. It is noted that many of the complaints received about Primary Care are linked to a wider complaint where a patient has complained about their care pathway from Primary Care through to Secondary Care, with some elements of the complaint being only a small part of the overall issues raised.

Within Accident & Emergency, the main themes for this period are clinical treatment/assessment and attitude/behaviour. Glangwili General Hospital (GGH) received 48% of the total number of complaints received, with Withybush General Hospital (WGH) 33%, Bronglais General Hospital (BGH) 13% and Prince Phillip Hospital (PPH) 2%.

The common themes identified in relation to major complaints include clinical treatment/assessment, communication and discharge.

The theme of clinical treatment/assessment and discharge will be presented to the LLSC meeting in October 2020, for consideration.

QSEAC will also be aware of the management of inpatient falls work. A corporate wide improvement plan has been developed and will be reviewed by the LLSC on a quarterly basis.

In relation to the ongoing area of communication, there is a wide range of work underway across the Health Board. The main priorities currently include communication around appointments, procedures and patient information, digital correspondence and information, management of patient expectations including preparing for attending hospital during the pandemic; implementation of the improving patient experience charter; and training emphasising the importance of communication from induction through to leadership programmes.

It is proposed that a report on the area of patient communication be presented to a future QSEAC meeting, detailing the work currently being undertaken and planned, in response to the review requested by the QSEAC.

Formal Quality Panels
The clinical Executive Directors have held two formal quality panels since the previous report to QSEAC.

The first panel was held with Primary Care and Mental Health and Learning Disabilities Directorate to discuss a suspected suicide in the community. The panel received an update on the information gathered as part of the 72 hour rapid review, the root cause analysis review currently underway, with a control group established to monitor the progress of the review.

The second panel was held with the WGH Unscheduled Care Directorate and the Scheduled Care Directorate to receive an update on implementation of the orthopaedic improvement and learning action plan. The Operational Quality Safety and Experience Sub-Committee (OQSESC) also received an update with regard to this improvement and learning action plan at the its meeting in September 2020.

WalkRounds™ (Board to Floor Visits)
Due to the COVID-19 pandemic, a decision was made to temporarily halt WalkRounds; therefore no WalkRounds have been undertaken since the previous report to QSEAC.

Internal Quality Surveillance Panel
The inaugural Internal Quality Surveillance Panel was held on 15th September 2020. As previously noted, this panel complements the external and internal review processes and supports a 'no-surprise' approach to pro-actively identifying 'hot-spot' areas across the organisation.

Healthcare Inspectorate Wales (HIW)
Impact of COVID-19 on HIW Inspections
The Health Board received a letter from the Deputy Chief Executive of HIW on 30th March 2020 which advised that due to COVID-19, all inspection work was suspended, with their focus on maintaining only essential statutory and regulatory duties. All NHS inspection reports currently in production or reports with providers requiring responses were also suspended.

In July 2020, HIW advised that they would be piloting a new way of working from August to October 2020, to enable them to deploy their resources in a more agile way, responding to specific risks and issues, whilst taking account of revised operating models during the pandemic. This new approach will be on the use of a three-tiered model of assurance and inspection that reduces the reliance on onsite inspection activity as our primary method of gaining assurance.

- Tier 1 - activity will be conducted entirely offsite and will be used for a number of purposes however, at this stage, primarily where issues cannot be resolved via HIW standard concerns process and where the risk of conducting an onsite inspection remains high.
- Tier 2 - a combination of offsite and limited onsite activity
- Tier 3 - traditional onsite inspection.

HIW informed the Health Board on 11th September 2020 that they are scheduling a Tier 1 review of Ward 10 at Withybush General Hospital on 24th September 2020 via Microsoft Teams.

HIW informed the Health Board on 13th September 2020 that they are scheduling a Tier 1 quality check of Cleddau Ward at South Pembrokeshire Hospital on 28th September 2020 via Microsoft Teams.

Thematic Review: Maternity Services
Virtual interviews were held during August 2020 between HIW and the Health Board Chair, Chief Executive, Medical Director and Director of Nursing, Quality and Patient Experience.

Unannounced Visits – Draft reports received since previous QSEAC report
No draft reports have been received since the previous QSEAC update

HIW Final reports published since previous QSEAC report
HIW has published one report following announced inspections since the previous report to the QSEAC:

Hospital Inspection – Wards 7 & 11, Withybush General Hospital (published 10/08/2020)

HIW undertook an unannounced inspection on 4th and 5th February 2020. The visit resulted in the issue of an immediate improvement plan with issues identified in the report, which include resuscitation trolleys, storage of medications, fire doors and servicing programme for patient beds and clinical equipment. The plan was submitted to HIW who were sufficiently assured with the immediate improvement plan. A robust improvement plan has been established and the full report is available here: https://hiw.org.uk/sites/default/files/2020-08/20200810withybushen.pdf

Hospital Inspection – Paediatric Ambulatory Care Unit and Cilgerran Ward – Glangwili General Hospital (published 07/08/2020)

HIW undertook an unannounced inspection on 4th and 5th March 2020. Five immediate concerns were identified during the course of the inspection, and escalated for resolution during the inspection. These concerns were around broken locks, secure doors not locked, unattended cleaning trolleys and unattended trolleys with sensitive patient data. No concerns were raised during the course of the inspection, which warranted the issuing of an immediate improvement plan. A robust improvement plan has been established and the full report is available here: https://hiw.org.uk/sites/default/files/2020-08/20200807-GlangwiliHospitalen.pdf

Hospital Inspection – Paediatric Ambulatory Care Unit, Withybush General Hospital (published 05/08/2020)

HIW undertook an unannounced inspection on 12th and 13th February 2020. No concerns were raised during the course of the inspection which warranted the issuing of an immediate improvement plan. A robust improvement plan has been established and the full report is available here: https://hiw.org.uk/sites/default/files/2020-08/HIW076%20-%2019259%20-%20Withybush%20Hospital%20-%20Paediatric%20Final%20Published%20Inspection%20Report.pdf

Hywel Dda Community Health Council (CHC)

Hywel Dda CHC have taken a decision to close Hywel Dda CHC offices to members of the general public with immediate effect in light of Welsh Parliament's advice for people to avoid "non-essential contact". The CHC have not published any reports on their website since the last QSEAC update in August 2020.

Welsh Health Specialised Services Committee (WHSSC) Quality and Patient Safety Committee (report of the committee to the WHSSC Joint Committee)

The WHSSC Quality and Patient Safety (QPS) Committee provides assurance to the Joint Committee in relation to the arrangements for safeguarding and improving the quality and safety of specialised healthcare services within the remit of the Joint Committee. Under its terms of reference, the WHSSC QPS Committee hold a minimum of 5 meetings per year. The WHSSC QPS Committee report to the Joint Committee through a Chair's report. The report is published within the Joint Committee papers which are available on the WHSSC website. The report provides a summary of the key matters considered by the WHSSC QPS Committee.

The last formal meeting of the WHSSC QPS Committee was held on 11th August 2020 (see item 3.2 (page 111) of the Joint Committee agenda bundle published on the WHSSC website). Key matters considered include:

- WHSSC QPS Development Day - the initial WHSSC development day was postponed due to the COVID-19 pandemic. The day was rescheduled and held on 15th September 2020. Representatives from all Health Boards across Wales attended the development day, with the Assistant Director of Nursing Assurance, Quality, Safeguarding and Professional Regulation and an Independent Member (Community) representing Hywel Dda University Health Board and in the main, the discussions concentrated on the Assurance Framework that has been developed within WHSSC. The WHSSC Director of Nursing has been asked to attend a future QSEAC meeting.
- Reports from each of the Commissioning teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation.

In July 2020, the Joint Committee received the annual reports of its Sub-Committees (item 2.8 page 160 of the published agenda bundle). The report highlights attendance and the main issues brought to the QPS Committee during the course of the year as well as the reporting arrangements to the Joint Committee.

2. Quality Improvement across the Health Board

Pressure Damage, Falls, and Medication related incidents are consistently the highest-level incidents reported within the Health Board. The three themes also feature on the Risk Register: patient falls - Datix risk reference 45 and 90; pressure damage - Datix risk reference 50, 88, 424 and 594; and medication errors - Datix risk reference 84 and 366)

Inpatient Falls (Health Board)
Target: to reduce the number of in-patient falls where significant harm is sustained
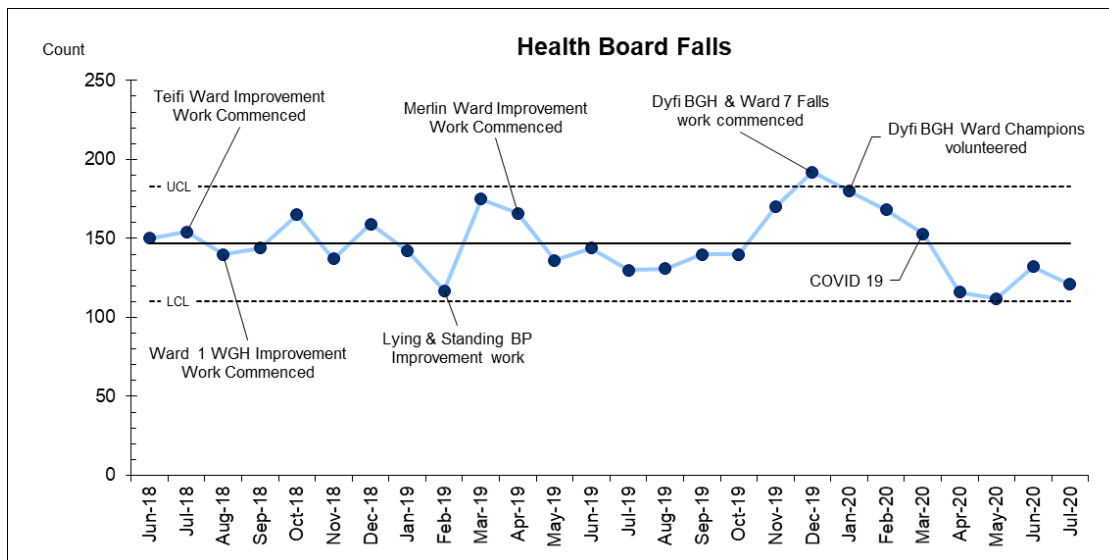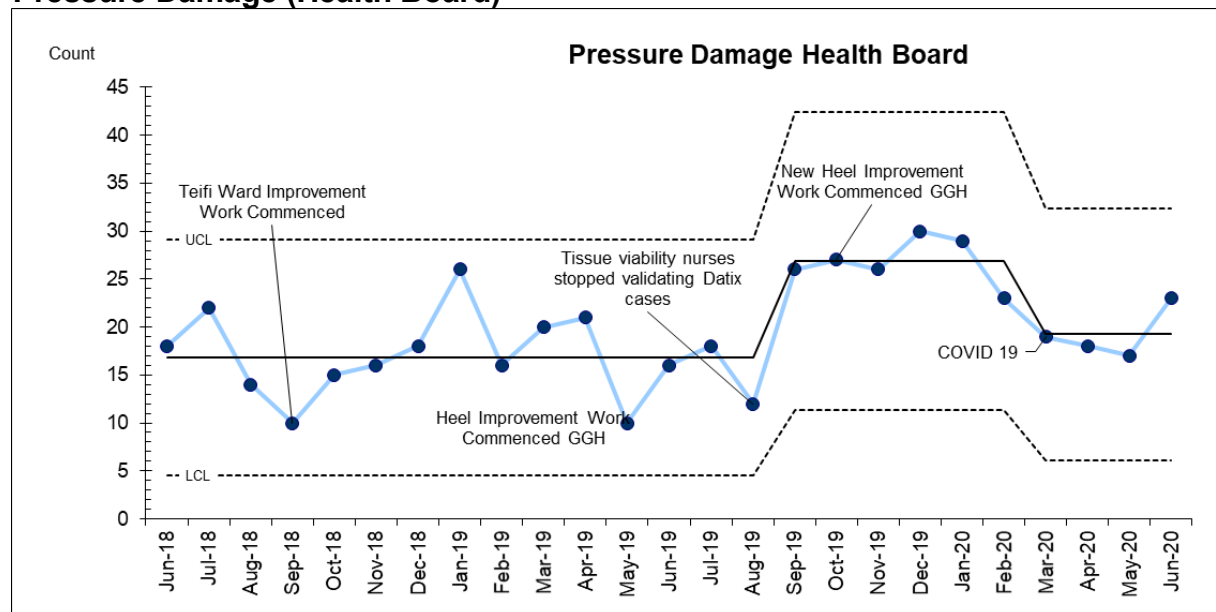

Source of data: Quality Dashboard

The QI Team have been re-deployed to support the COVID-19 pandemic and have not therefore been able to support the key areas previously identified as having a high number of falls. The data since April 2020 shows a decrease throughout the Health Board of inpatient falls, however, there was a significant reduction in in-patient activity during some of this period.

The QI team are transitioning back to business as usual and will therefore start supporting the falls improvement work again. The QI Team have been asked to support the development of a falls strategy for the Health Board as a key priority.

Pressure Damage (Health Board)

Pressure Damage Health Board

Count

Teifi Ward Improvement Work Commenced

New Heel Improvement Work Commenced GGH

Tissue viability nurses stopped validating Datix cases

Heel Improvement Work Commenced GGH

COVID 19

-- UCL

-- LCL

Source of data: Quality Dashboard

The data shows a decrease in the number of pressure damage cases since February 2020 however this may also correspond to the significate reduction in patient activity during the pandemic.

The QI Team work closely with the Tissue Viability Nurses (TVN) and Professional Practice Development Nursing (PPDN) Team to ensure support for pressure damage improvement work.

There has been significant challenge in supporting the pressure damage improvement work during the COVID-19 pandemic. The QI team has been deployed and the TVN service had a reduced service due to workforce challenges. The PPDN team has supported this and improvement work is being reinstated, with work streams identified to take specific priorities forward.

PPH – Ward 3 has been accepted to join cohort 2 of the Enabling Quality Improvement in Practice (EQIiP) programme. This was due to start on 29th April 2020, however was postponed due to the pandemic. When cohort 2 is re-established, the team will be supported to improve the pressure damage position as a key priority. This team is supported by a ward manager, ward staff, Senior Nurse Manager (SNM) PPDN, QI, & TVN.

Pressure damage scrutiny continues on all 4 acute sites and within the community setting. There may be a backlog of cases especially due to less regular meetings during the pandemic period. The PPDN & TVN teams are working closely to support the sites to learn from all cases and respond in a timely manner.

Argymhelliad / Recommendation

The Committee is asked to discuss and take an assurance from the Quality and Safety Assurance Report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	4.1 Scrutinise, assess and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks are identified at service level and monitored through service risk registers and escalated to corporate risk register through governance • Patient falls (Datix risk reference 45 and 90) • Pressure damage (Datix risk reference 50, 88, 424 and 594) • Medication errors (Datix risk reference 84 and 366)
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply

Effaith/Impact:	
Ariannol / Financial: **Ansawdd / Patient Care:** **Gweithlu / Workforce:** **Risg / Risk:** **Cyfreithiol / Legal:** **Enw Da / Reputational:** **Gyfrinachedd / Privacy:** **Cydraddoldeb / Equality:**	Use of key metrics to triangulate and analyse data to support improvement. Development of staff through pooling of skills and integration of knowledge. Integration of reporting methodology improves triangulation of data and therefore reducing likelihood of risks and legal challenge.