GIG CYMRU NHS WALES
Bwrdd Iechyd Hywel Dda Health Board

Quality and Safety Assurance Report

QSEAC Meeting June 2021

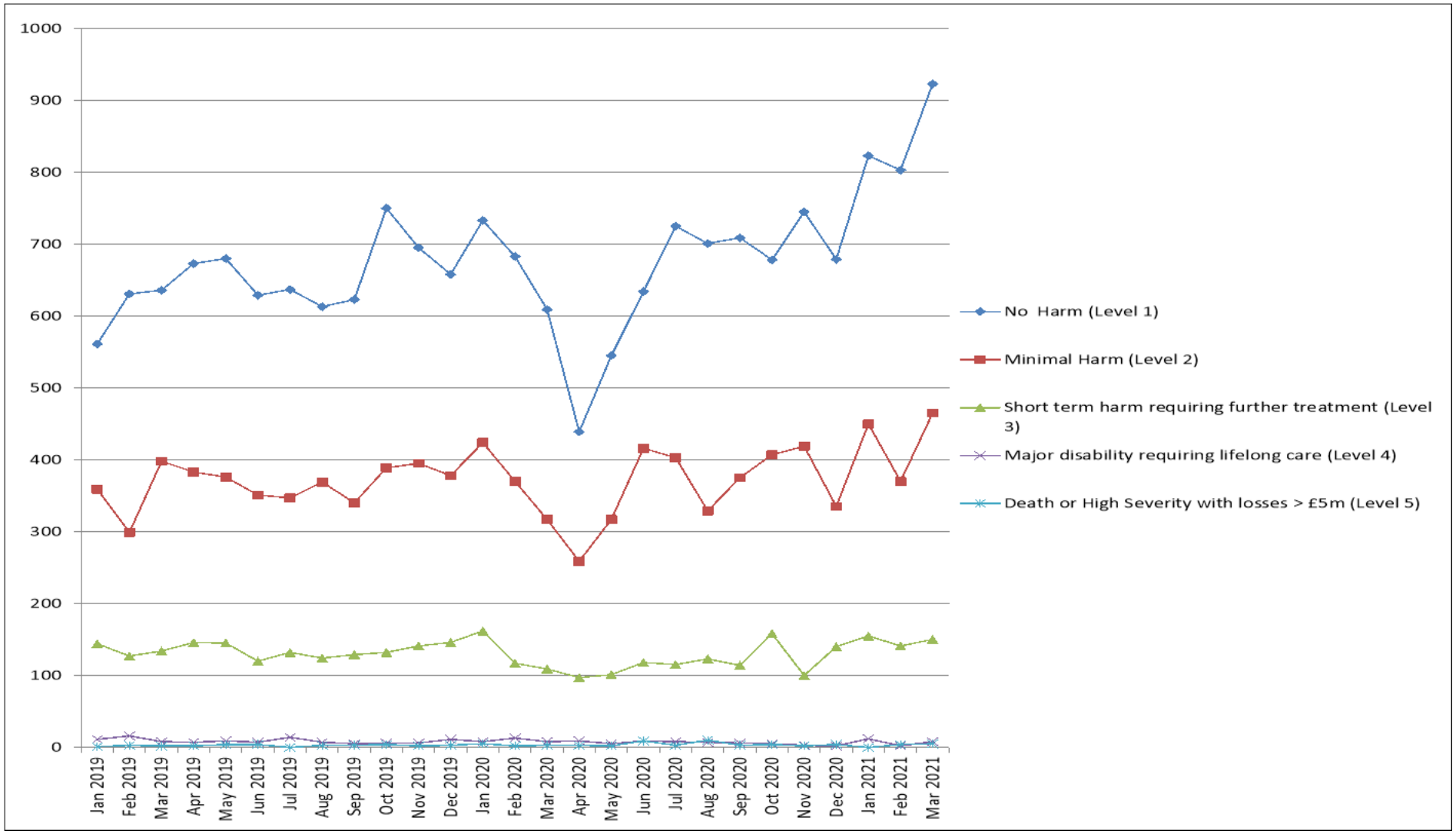
Situation

- 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.
- This report provides information on patient safety incidents, including externally reported patient safety incidents, and inspections by Healthcare Inspectorate Wales (HIW).

Incident Reporting from 1st April 2021

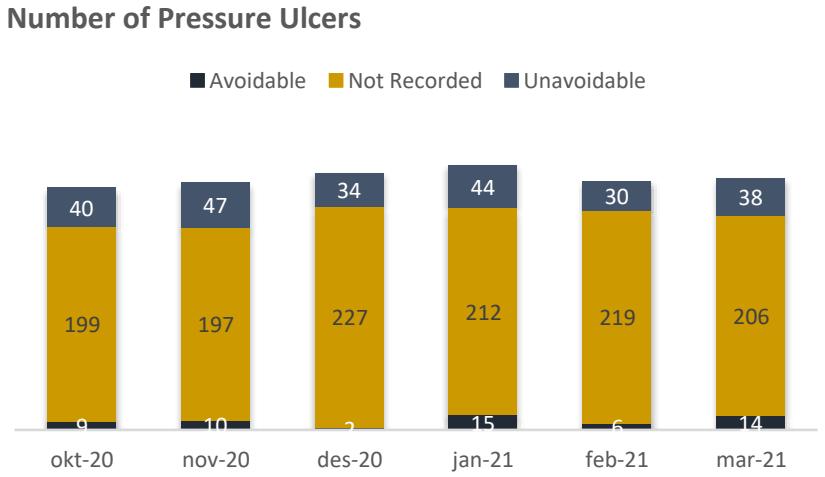
- Early implementers of the new Once for Wales Concerns Management System (phase 1 incidents, feedback (including complaints), redress and claims (including Inquests). Only organisation to "go live" on 1st April 2021.
- Between 1st April and 22nd May 2021, 2,204 incidents were reported; of which 1,910 were patient safety incidents.
- Changes in new system:
  - New all Wales concerns codes
  - Severity of incident captured on reporting and on conclusion of investigation
  - Introduction of form for corporate teams to capture:
    - Case management of violence and aggression incidents
    - External reporting including NHS Wales Delivery Unit, Welsh Government and Health and Safety Executive (HSE).
  - Strengthening of how investigations are captured in the incident module
    - Management review of the incident with 2-3 working days
    - Concise investigation tool (for capturing findings for moderate or major harm incidents (full Root Cause Analysis) RCA tool for serious incidents under development on all Wales basis)
    - Falls investigation tool
    - Pressure damage investigation tool
  - Increased opportunities to identify thematic learning
    - Use of Yorkshire Contributory Factors Framework (see appendix 1) for all incidents – mandatory to complete when closing an incident

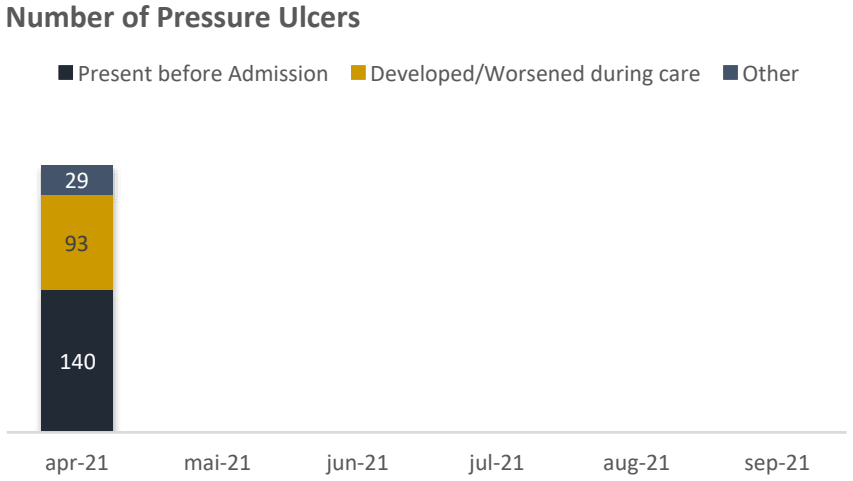
Incident Reporting

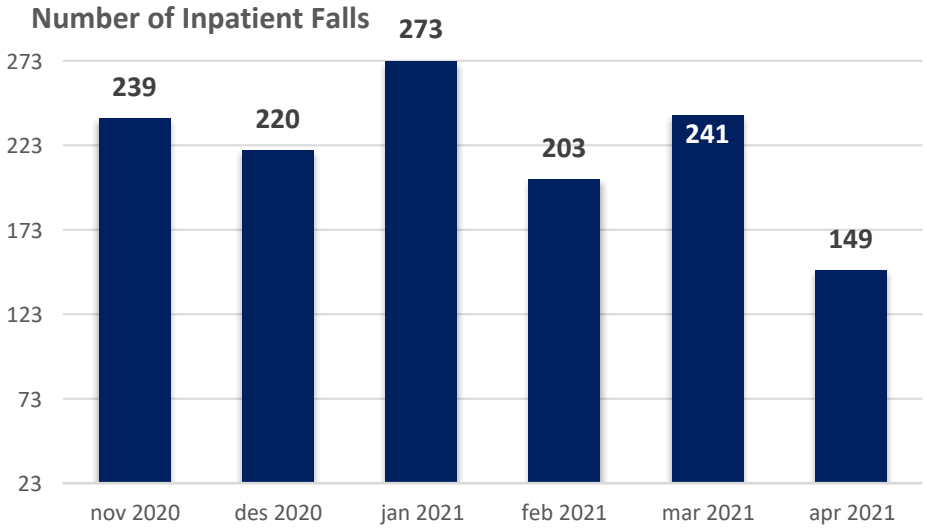


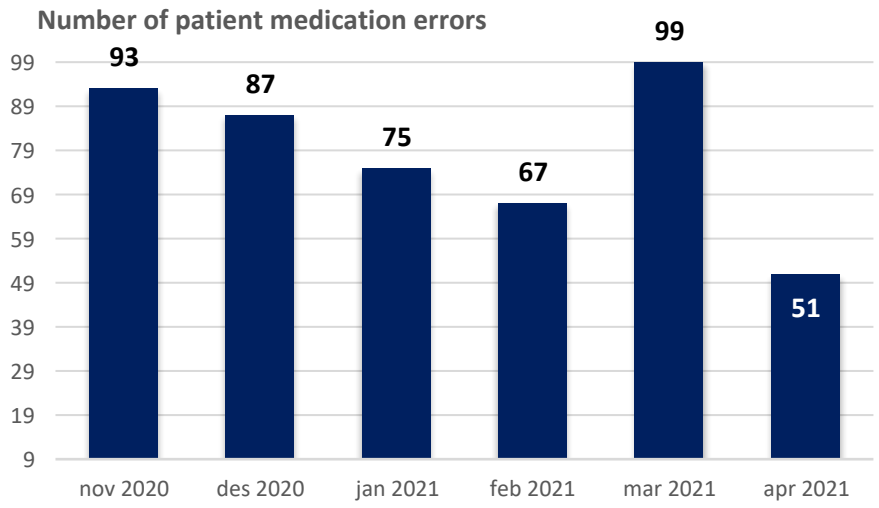
In March and April 2021, 2,781 incidents were reported; of which 2,375 were patient safety related. These figures are consistent with previous months.

Incident Reporting

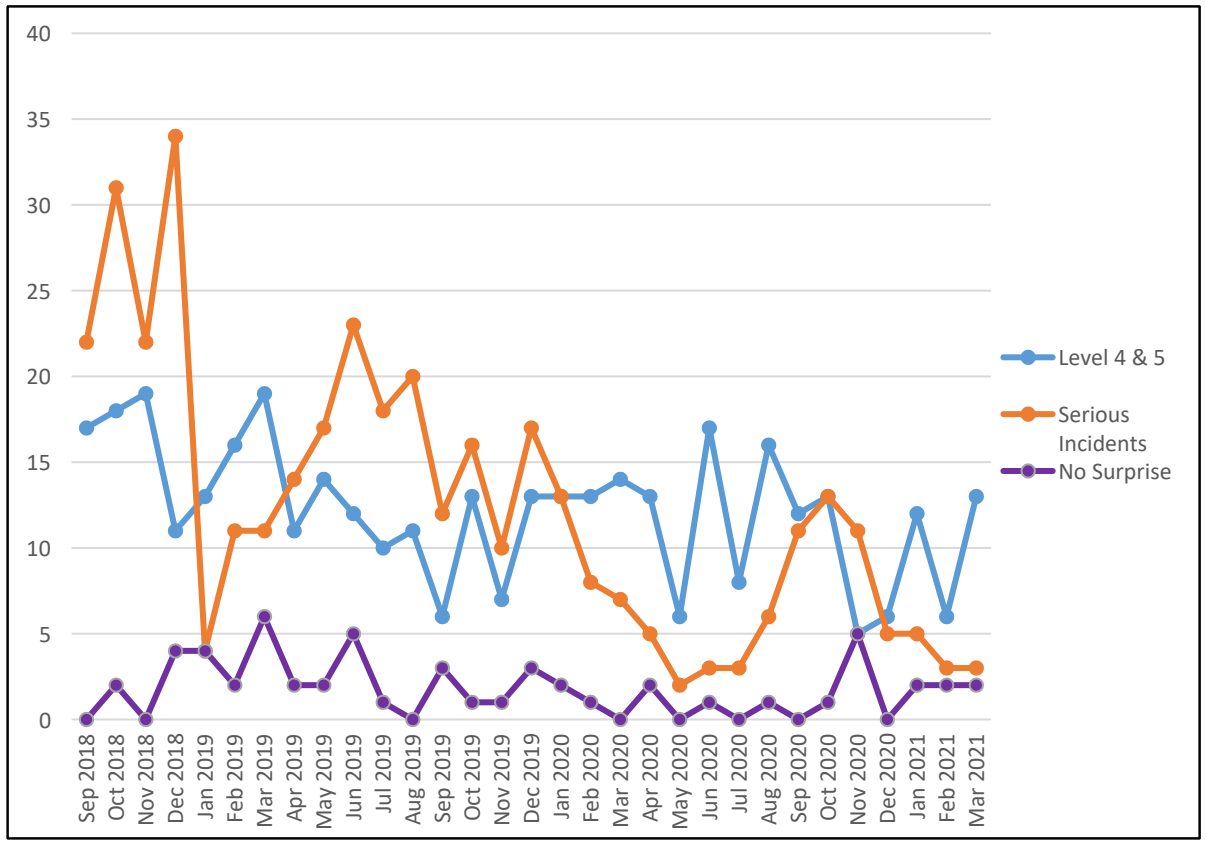








Serious incidents



Between 1st March and 30th April 2021, **3** serious incidents were reported to Welsh Government (WG); All 3 are Unexpected Deaths.

As at 30th April 2021, there were 23 serious incidents open over 60 days. In comparison to February 2021, the position has improved significantly.

	Q1	Q2	Q3	Q4
Absconded patient*	0	1	2	0
Pressure Damage*	0	2	2	1
Retained Foreign Object	1	1	0	0
Patient Fall (serious harm)*	1	3	8	3
Unexpected Death**	4	4	7	5
Neonatal/Perinatal Care	2	0	0	0
Wrong site surgery/procedure	2	1	0	0
Under 18 Admission*	0	0	10	0
Other	0	1	0	2
Total	10	13	29	11

*not reported during reduced reporting periods (see below)
** unexpected death including suspected suicide and unexpected death in childhood (PRUDiC)

During the last financial year, the reporting requirements for serious incident to the Delivery Unit has changed and therefore a comparison quarter by quarter cannot be made as to whether incident numbers have increased or decreased:

- 4th January 2021 to date – reduced reporting due to significant pressures on the NHS
- 13th August 2020 – return to full Serious Incident reporting to the Delivery Unit
- 18th March to 13th August 2020 – reduced reporting due to significant pressures on the NHS

Patient Safety Incidents: National Reporting Requirements

- Letter received 11th May 2021 from the Deputy Chief Medical Officer regarding the phased change to national reporting requirements from **14th June 2021.**
- Term 'serious incident' replaced by 'patient safety incidents' reportable nationally:
  - unexpected or avoidable deaths (wherever they occur) and or severe / permanent harm of one or more patients, staff or members of the public. This will include delays and omissions in care in any setting maternal or neonatal deaths, unexpected deaths of mental health / learning disability patients in the community (either open episodes of care or closed within the last year);
  - all Never Events, as specified within existing all Wales guidance;
  - 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;
  - Occasionally, incidents may present that are unusual, unexpected or surprising, where seriousness of the incident requires it to be nationally reported and the learning would be beneficial (new).
- The primary focus of Phase 2 is to instigate a shift from national reporting of individual incidents to thematic reporting of certain incident types.

Healthcare Inspectorate Wales

- HIW are currently undertaking Quality Checks under a tiered system in order to account for the COVID-19 situation. The Health Board to date has been subject to **ten Tier 1 Quality Checks**, where the check has been done remotely via Microsoft Teams and the submission of documents electronically via Objective Connect.
- A further Tier 1 Quality Check at Steffan Ward, Glangwili General Hospital has been scheduled for the end of May 2021.
- The Health Board has also been subject to **two Tier 3 Quality Checks**, where Inspectors have undertaken on site visits. These reviews related to the Field Hospitals and the Mass Vaccination Centres.
- This report provides progress for the period 25th March – 17th May 2021. Links to each published HIW report can be accessed by clicking on the relevant location listed under “Area of Review” in the tables which follow.

HIW Quality Checks: Summary of Tier 1 Reviews 25 March – 17 May 2021

Area of Review	Recommendations Raised	Update
Prince Philip Hospital – Bryngolau Ward, MHLD	2	The Quality Check was held in October 2020, with recommendations relating to annual risk assessments relating to ligature risks, and staff training compliance confirmed as being actioned by the service. Currently awaiting HIW approval of closure.
Bronglais General Hospital – Enlli Ward, MHLD	0	The Quality Check was scheduled for November 2020, but postponed due to Covid pressures. The interviews were undertaken in February 2021 and no recommendations were raised during the course of the review.
Glangwili General Hospital – Towy Ward	2	The Quality Check was held in November 2020, and progress has been made against recommendations relating to action plans for falls and pressure and tissue damage, and staff training compliance - although neither were fully complete due to Covid-19 outbreaks at the ward. Future actions planned to complete the recommendations have been discussed with HIW, with further evidence being submitted in May 2021 to evidence progress made.
Glangwili General Hospital – Steffan Ward	N/A	The Quality Check was scheduled for December 2020 but was postponed due to Covid-19 pressures. The Quality Check will be held on 25th May 2021, with the Health Board currently collating pre-check evidence and self assessment documentation.
10 Church Close, Begelly - MHLD	1	The Quality Check was scheduled for December 2020 but was postponed due to Covid-19 pressures, with the Quality Check being held in April 2021. One recommendation was raised in relation to the submission of DoLS applications, which is expected to be completed by July 2021. Publication by HIW of the final report is expected soon.
Glangwili General Hospital – Morlais Ward	3	The Quality Check was held in March 2021, with the final report published in May 2021. Three recommendations were raised relating to the completion of a C4C audit, staff training compliance and data regarding restraint incidents, with a view that all recommendations will be completed by March 2022.

HIW Quality Checks: Summary of Tier 3 Reviews 25 March – 17 May 2021

Area of Review	Recommendations Raised	Update
Mass Vaccination Centres	2 Immediate Recommendations 16 Recommendations from main report	HIW inspectors visited the Halliwell Centre and Cardigan Leisure Centre in March 2021, and raised two recommendations within an immediate improvement plan which have all since been actioned and completed. The Health Board have since received a final copy of the report which contained 16 recommendations, of which only one remains outstanding relating to the Standard Operating Procedures for each vaccination centre. The Health Board are awaiting the publication of the final report on the HIW website.

Further Inspections:

Prince Philip Hospital has been subject to a Tier 1 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Compliance Inspections undertaken in February 2021. The Health Board has received the final report, which contained 13 recommendations; two of which have been partially implemented. It is expected that all recommendations will be actioned by April 2022. The Health Board are currently awaiting publication of the report on the HIW website.

HIW published their report on Phase 1 of the National Maternity Services Review in March 2021 and the Health Board has provided its response to the 33 recommendations, which have been raised on a national level. As at May 2021, 26 of the 33 recommendations have been implemented. The report can be found via the following link: 20201118HIWNationalReviewofMaternityServicesEN_0.pdf

Royal Colleges Reports

- The report “National Diabetes Quality Programme (NDQP) – Peer Review”, issued by the Royal College of Paediatrics and Child Health has recently been added to the Health Board’s Audit and Inspection Tracker. This report was initially published during the financial year 2019/20 and contains 15 recommendations, 4 of which have been fully implemented and a further 4 that have been partially implemented. Recommendations cover a range of topics including recruitment, training, and processes for senior management oversight to ensure that services can escalate matters as required.

Risks and Mitigation

- **Patient Safety Incidents**
  - Scrutiny of all incidents reported undertaken by the Quality Assurance Information System Team on a daily basis. Report of themes and trends in reporting provided to Head of Quality and Governance, Assistant Director of Nursing and Associate Medical Director.
  - 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.
- **External Inspections and Peer Review**
  - All correspondence received by third parties in relation to their activity is logged on receipt by the Assurance and Risk team.
  - Process in place for co-ordinating and quality checking responses to HIW requests by the required deadlines.
  - Recommendations from HIW immediate assurance plans and final reports are logged on the central tracker and progress is requested from services by the Assurance and Risk team on a bi-monthly basis.
  - Central tracker reported to every Audit and Risk Assurance Committee (ARAC) meeting.
  - HIW activity will form part of the new quality governance arrangements within Directorates going forward.

Family Liaison Officer Roles

- Further cohort of temporary Family Liaison Officer roles employed until September 2021.
- Roles continue to be well received and appreciated by patients, family members and staff.
- Formal evaluation of the role, including potential future scope, is currently underway in association with Swansea University.
- Review of the 'team around the patient' is being led by the Director of Nursing, Quality and Patient Experience, which will include the family liaison/patient experience function and is anticipated to be operational from 1st April 2022.

Recommendation

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

- patient safety highlighted through incident reporting.
- patient experience highlighted through external inspections and peer reviews.

The Quality, Safety and Experience Assurance Committee is also requested to note the progress made in relation to the sustainability plan for the Family Liaison Officer roles.

Appendix 1

Framework for Patient Safety Incident Investigation: Yorkshire Contributory Factors Framework (YCFF)

The Yorkshire Contributory Factors Framework

Details of Incident	
Name of person completing form	**Date completed**
Brief description of incident	**Date of incident**

Domain 1: Situational Factors

Team factors

Was there any failure of team function?
For example:
- Conflicting team goals
- Lack of respect for colleagues
- Poor delegation
- Absence of feedback

☐ Yes ☐ Maybe ☐ No — Notes

Individual staff factors

Were there any reasons this incident was more likely to occur with the particular staff involved?
For example:
- Fatigue
- Stress
- Rushed
- Distraction
- Inexperience

☐ Yes ☐ Maybe ☐ No — Notes

Task characteristics

Did the task features make the incident more likely?
For example:
- Unfamiliar task
- Difficult task
- Monotonous task

☐ Yes ☐ Maybe ☐ No — Notes

Patient factors

Were there any reasons this incident was more likely to occur to this particular patient?
For example:
- Language barrier
- Uncooperative
- Complex medical history
- Unusual physiology
- Intoxicated

☐ Yes ☐ Maybe ☐ No — Notes

Domain 2: Local Working Conditions

Workload and staffing issues

Was there a mismatch between workload and staff provision around the time of the incident?
For example:
- High unit workload
- Insufficient staff
- Staff sickness

☐ Yes ☐ Maybe ☐ No — Notes

Leadership, Supervision and Roles

Was there any failure of team function?
For example:
- Inappropriate delegation
- Unclear responsibilities
- Remote supervision

☐ Yes ☐ Maybe ☐ No — Notes

Drugs, Equipment and Supplies

Were there difficulties obtaining the correct drugs and/or working equipment and/or supplies?
For example:
- Unavailable drugs
- Equipment not working
- Inadequate maintenance
- No supplies delivery

☐ Yes ☐ Maybe ☐ No — Notes

Domain 3: Organisational Factors

Physical environment

Did the ward environment hinder your work in any way?
For example:
- Poor layout
- Lack of space
- Excessive noise/heat/cold
- Poor visibility (e.g. position of nurses' station)
- Poor lighting
- Poor access to patient

☐ Yes ☐ Maybe ☐ No — Notes

Support from other departments

Were there any problems from other departments?
For example:
- This includes support from IT, HR, porters, estates or clinical services such as radiology, phlebotomy, pharmacy, biochemistry, blood bank, microbiology, physiotherapy, medical or surgical sub-specialities, theatres, GP, ambulances etc

☐ Yes ☐ Maybe ☐ No — Notes

Scheduling and Bed Management

Did any time or bed pressures play a role in the incident?
For example:
- Delay in the provision of care
- Transfer to an appropriate ward
- Difficulties finding a bed
- Lack of out of hours support

☐ Yes ☐ Maybe ☐ No — Notes

Staff training and Education

Were there any issues with staff skill or knowledge?
For example:
- Inadequate training
- No protected time for teaching
- Training not standardised
- No regular/yearly updates

☐ Yes ☐ Maybe ☐ No — Notes

Domain 4: External Factors

Design of Equipment, Supplies and Drugs

Was there any characteristic about the equipment, disposables or drugs that was unhelpful?
For example:
- Confusing equipment design
- Equipment not fit for purpose
- Similar drug names
- Ambiguous labelling and packaging

☐ Yes ☐ Maybe ☐ No — Notes

National policies

Have any national policies influenced this incident?
For example:
- Commissioned resources
- National screening policy
- Interference by government organisations
- National medical/nursing standards
- 4 hour Emergency Department target

☐ Yes ☐ Maybe ☐ No — Notes

Domain 5: Communication and Culture

Safety culture

Did the lack of safety culture in your clinical area contribute to this incident?
For example:
- Patient safety awareness
- Fear of documenting errors
- Attitude to risk management

☐ Yes ☐ Maybe ☐ No — Notes

Verbal and Written communication

Did poor written or verbal communication worsen the situation?
For example:
- Poor communication between staff
- Handover problems
- Lack of communication/notes
- Unable to read notes
- Inappropriate abbreviations used
- Unable to contact correct staff
- Notes availability

☐ Yes ☐ Maybe ☐ No — Notes

Summary

Which are the most important contributory factors for this incident?