GIG CYMRU NHS WALES
Bwrdd Iechyd Hywel Dda Health Board

Quality and Safety Assurance Report

QSEC Meeting April 2022

Situation

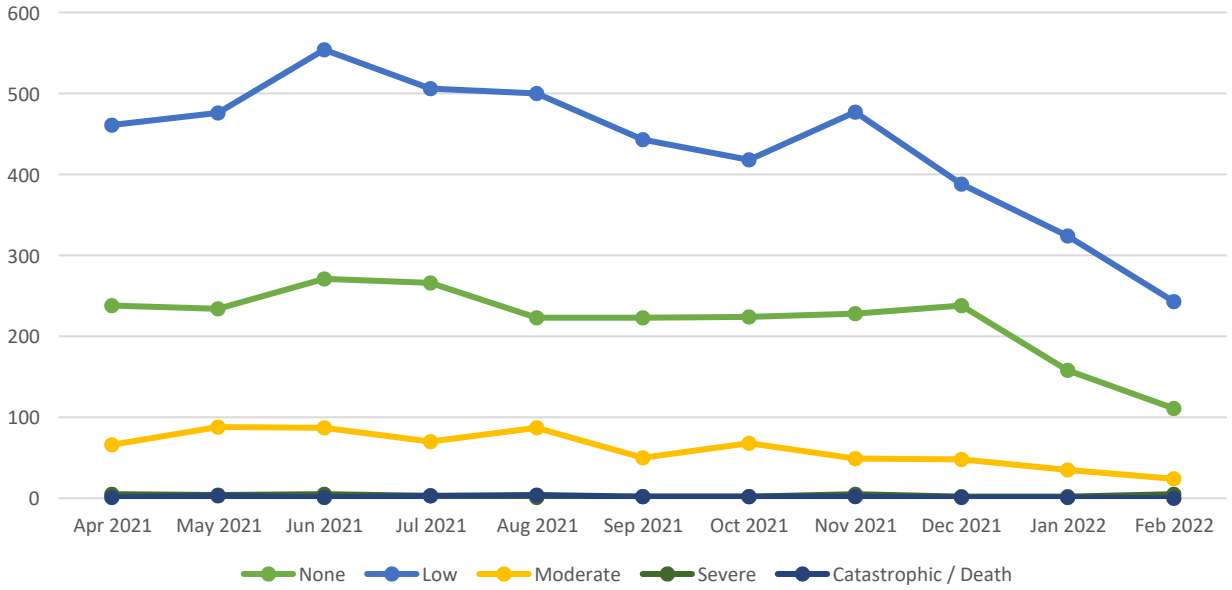
The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an overview of quality and safety across the Health Board.

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, and clinical negligence claims.

Incident Reporting – 1st April to 28th February 2022

In January and February 2022, 2,768 incidents were reported of which 2,353 were patient safety related

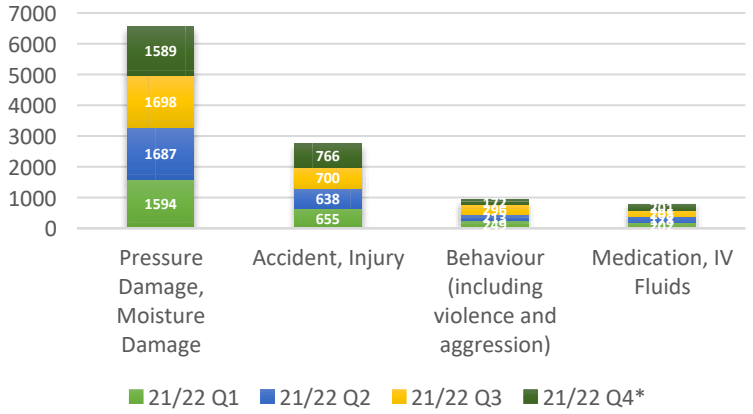


There were 12,972 Patient Safety Incidents reported on the new system between 1st April 2021 and 28th February 2022

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 12,972, 7,426 have been closed and 3,404 have had the severity amended. 967 Incidents were downgraded whilst 2,437 were upgraded.

Top 4 Patient Safety Incidents



Focus on pressure damage

For each pressure damage incident a focussed review is undertaken. In 29 cases, where the focussed review has been completed, the pressure damage (which had developed or worsened during care) was deemed to be avoidable. Of these cases, 9 incidents are grade 3, 4 or unstageable pressure damage.

Pressure damage incident scrutiny panels are held by Heads of Nursing with their teams. The panel consider the findings of the focussed review, consider the wider learning and approve the incident record for closure if appropriate. The Quality Assurance and Safety Team have agreed, in the short term whilst there are operational pressures, to ensure that the discussions at the panel are captured on the Datix incident record.

The Quality Assurance and Safety Team and the Tissue Viability Nursing Team have introduced a corporate scrutiny panel to review and reduce the duplicate pressure damage incident reports and ensure consistency of grading of pressure damage in the incident report forms. This panel is in it's infancy.

Quality improvement work is also underway to consider the appropriate management of incidents where pressure damage is reported as being present on admission. The majority of cases are not known to district nursing services or other Health Board services and it is these incidents where there may be potential learning.

Nationally Reportable Incidents

	21/22 Q1*	21/22 Q2	21/22 Q3	21/22 Q4**	Total
Access, Admission	0	0	0	1	1
Assessment, Investigation, Diagnosis	0	0	1	0	1
Behaviour (including violence and aggression)	0	1	2	1	4
Infection Prevention and Control	0	1	0	0	1
Maternity adverse occurrence	1	0	0	0	1
Medication, IV Fluids	0	0	0	1	1
Patient/service user death	0	0	3	5	8
Pressure Damage, Moisture Damage	0	1	2	0	3
Transfer, Discharge	0	0	1	0	1
Treatment, Procedure	0	1	0	1	2
Total	1	4	9	9	23

* 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 January and 28th March 2022, **9** 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.

The All Wales review toolkit is being used as the basis 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 majority of nosocomial COVID-19 infections within the Health Board are linked to ward outbreaks and therefore, in addition to the individual patient reviews, a thematic review of each outbreak is also being undertaken.

Welsh Government have recently confirmed additional funding for a two-year period to support the Health Board:

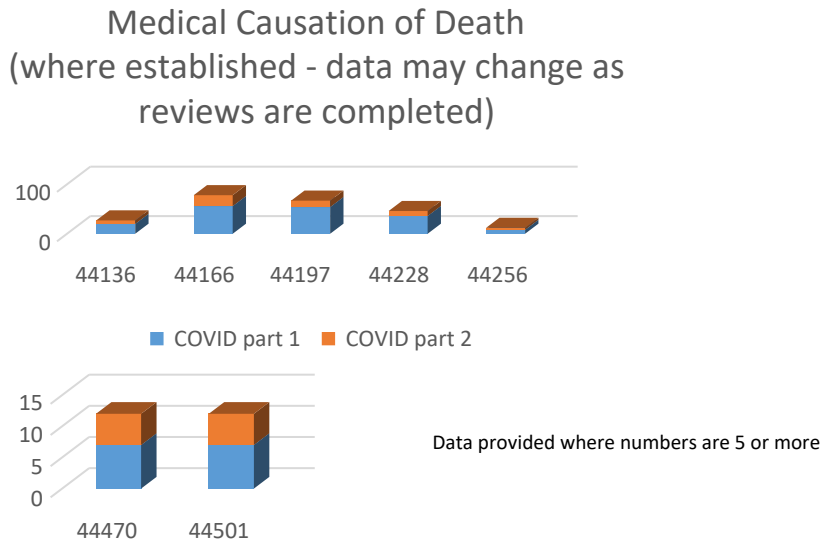
- Put in place the necessary resource and infrastructure to deliver the programme of investigation work in relation to patient safety incidents of nosocomial COVID-19
- Proactively engage with patients and families who have been affected by incidents of nosocomial COVID-19
- Establish a Corporate Assurance Nosocomial COVID-19 Scrutiny Panel

COVID-19 admission pathways

Due to the current COVID-19 infection rate the work to agree the risk assessment model to move away from specific COVID-19 pathways has been delay. Work to agree the model continues.

Number of in-patients who tested positive for COVID within 28 days of their death	01/03/2020 - 31/08/2020	01/09/2020 - 31/04/2021	01/05/2021 - 19/12/2021	20/12/2021 - 31/03/2022
	Wave 1	Wave 2	Wave 3	Wave 4
Hospital onset - indeterminate	<5	44	8	11
Hospital onset - probable	5	68	5	15
Hospital onset - actual	19	156	32	31
% of patient review complete	72%	97%	87%	49%

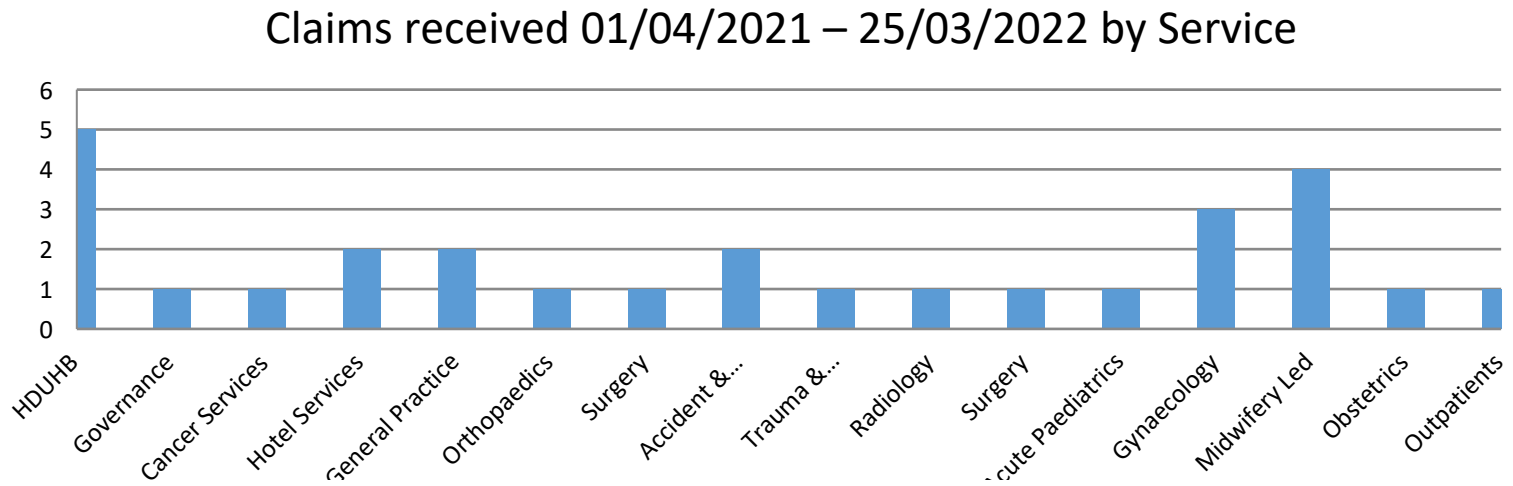
* The period for each wave has been recently confirmed by the Delivery Unit in conjunction with Public Health Wales and therefore this data is presented differently to previous reports

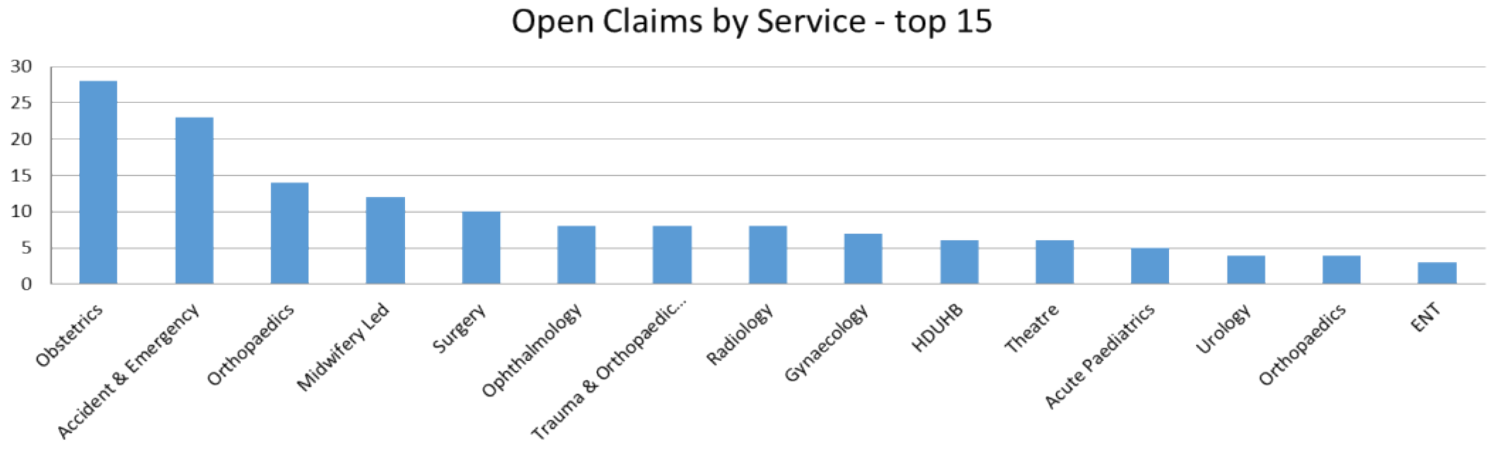


Clinical Negligence Claims

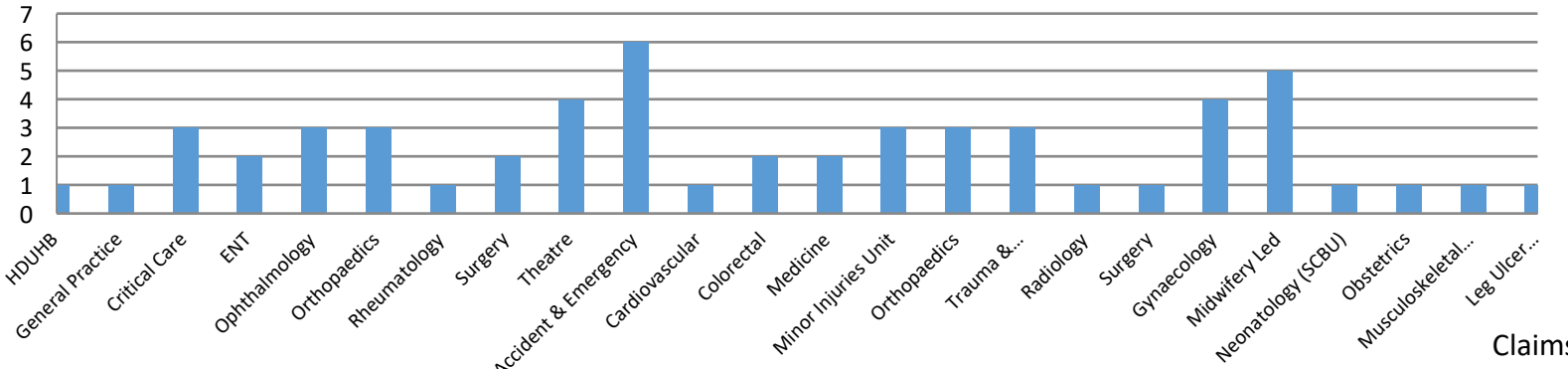
- 211 open clinical negligence claims

  Est. damages (excluding special damages and claimant costs =£11,760.465
- 28 confirmed clinical negligence claims opened since 1st April 2022
- 60 clinical negligence cases closed since 1st April 2022
- Significant theme relates to delay and missed diagnosis/delay in treatment – further analysis of root causes underway
- Specialities receiving higher number of claims are A&E; Obstetrics; Orthopaedics; Gynaecology and Midwifery Care.

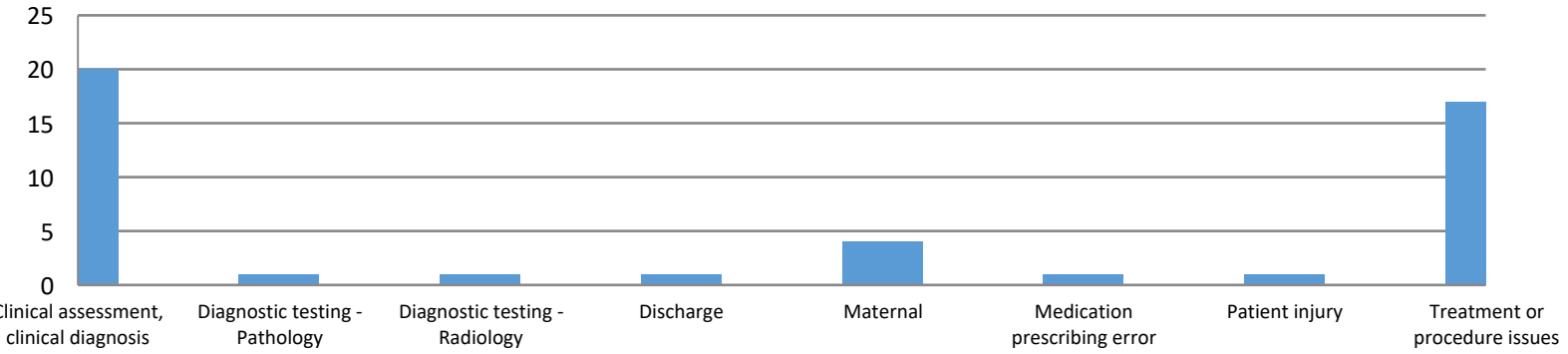




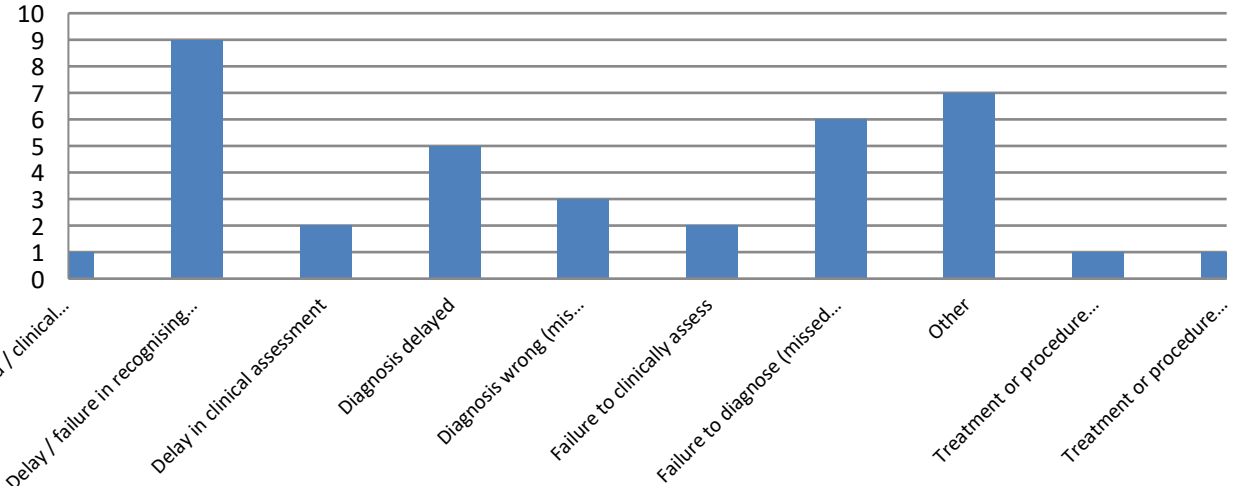
Closed > 01/04/2021 Clinical Negligence Claims by Service



Claims closed by Sub Type



Claims Closed - Assessment, Diagnosis and Treatment - by sub-type



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 clinical negligence claims