GIG CYMRU NHS WALES
Bwrdd Iechyd Hywel Dda Health Board

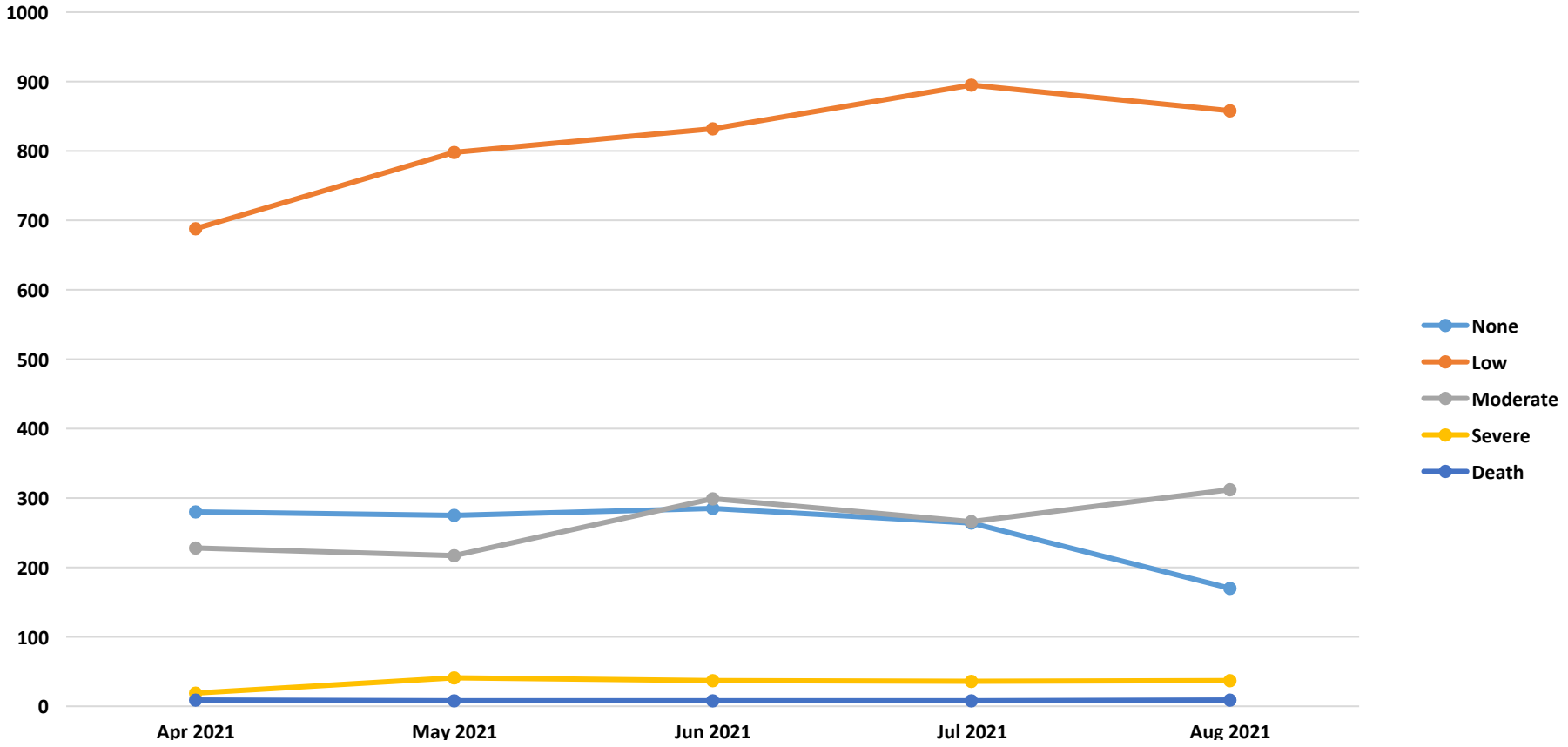
Quality and Safety Assurance Report

QSEC Meeting October 2021

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, including externally reported patient safety incidents, inspections by Healthcare Inspectorate Wales (HIW) and an update on hospital acquired thrombosis improvement work.

Incident Reporting – severity of harm as reported



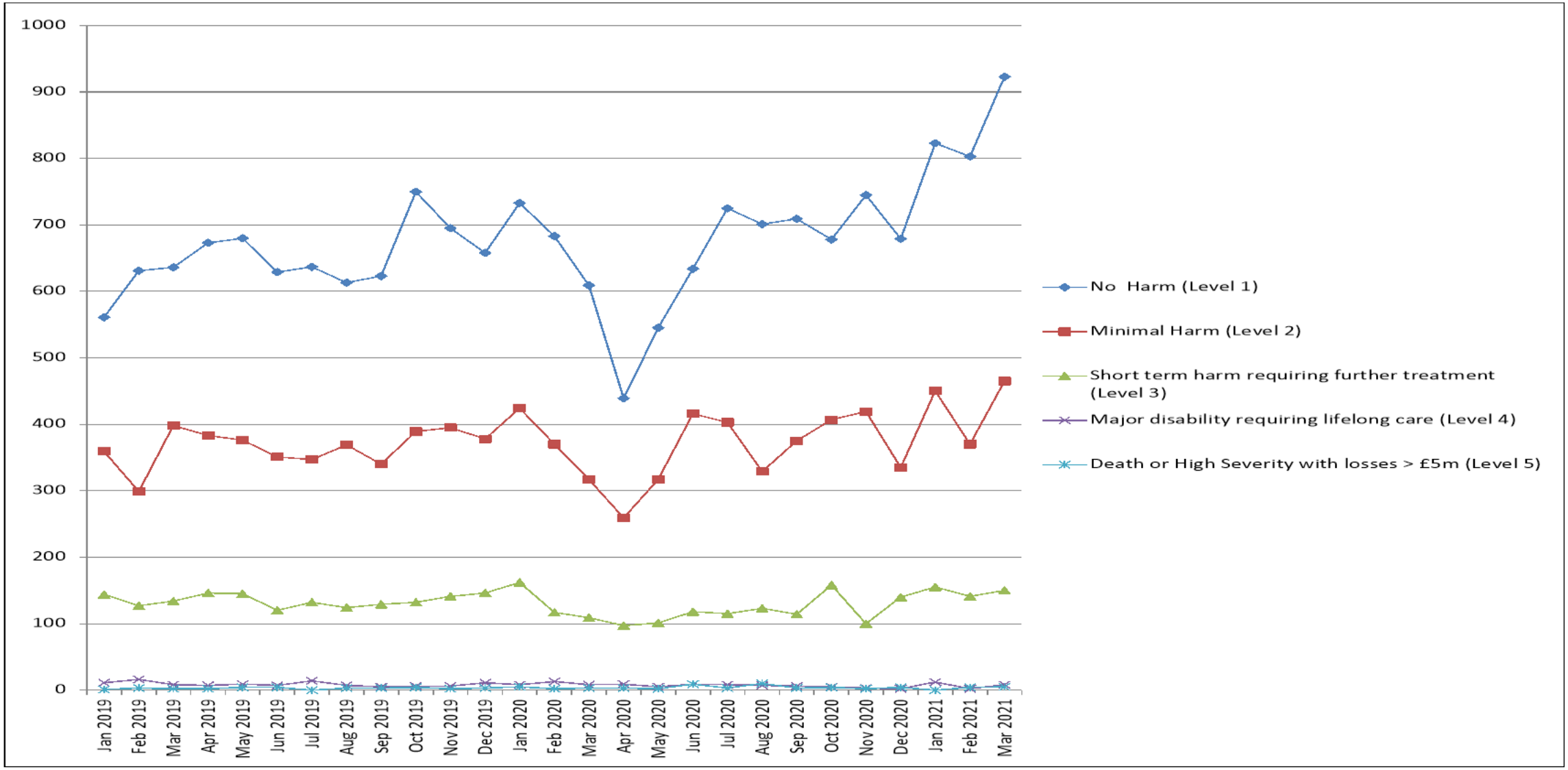
In July and August 2021, 2,855 incidents were reported of which 2,431 were patient safety related. These figures are consistent with previous months.

The work to ensure that quality improvement links with patient safety incidents continues e.g. it has been agreed that management of pressure damage on admission will be a future quality improvement project.

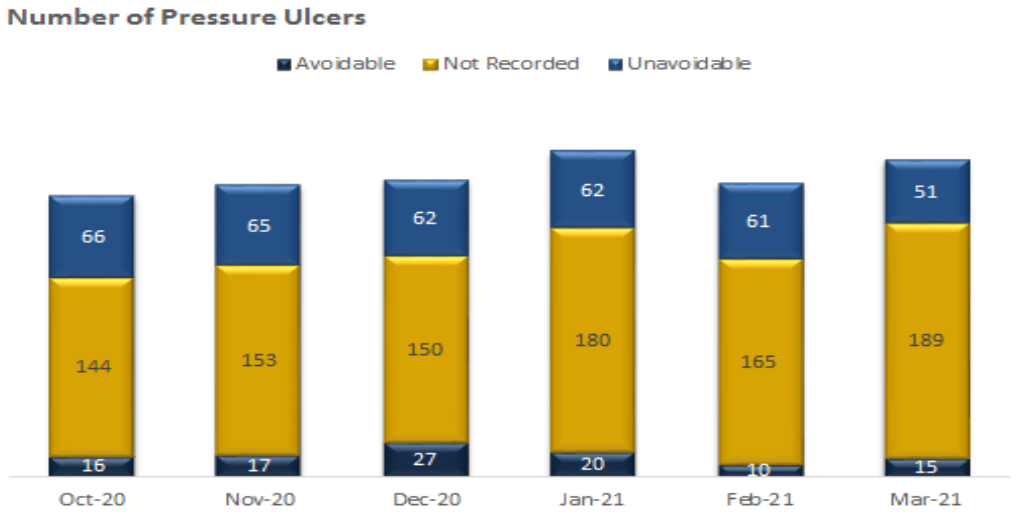
The introduction of DatixCymru in April 2021 has altered the way in which severity of harm is reported. The new system allows the opportunity for the reporter to grade the harm to the person affected (which cannot be changed) and then on closure following investigation the actual harm to the person affected is recorded by the investigator.

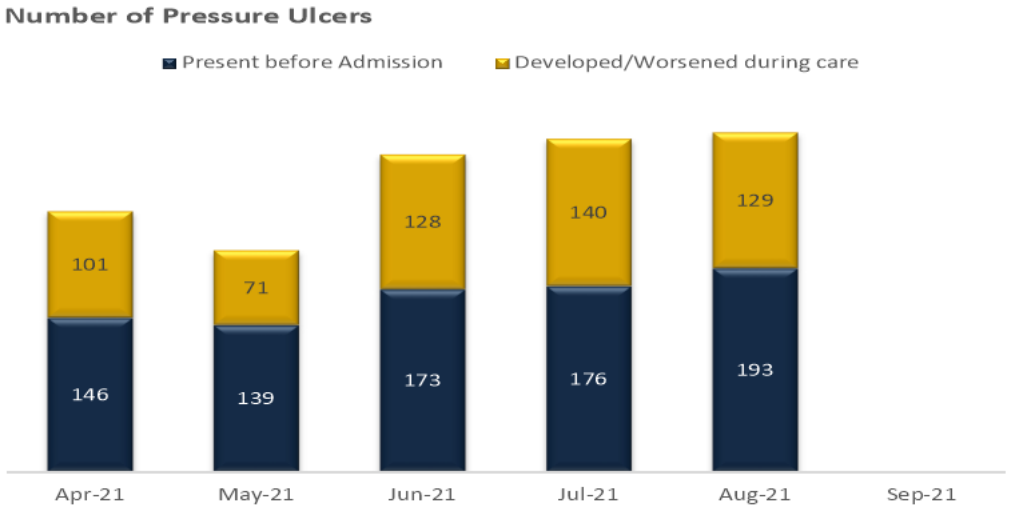
Future reports to QSEC will use the severity of harm on closure of the incident.

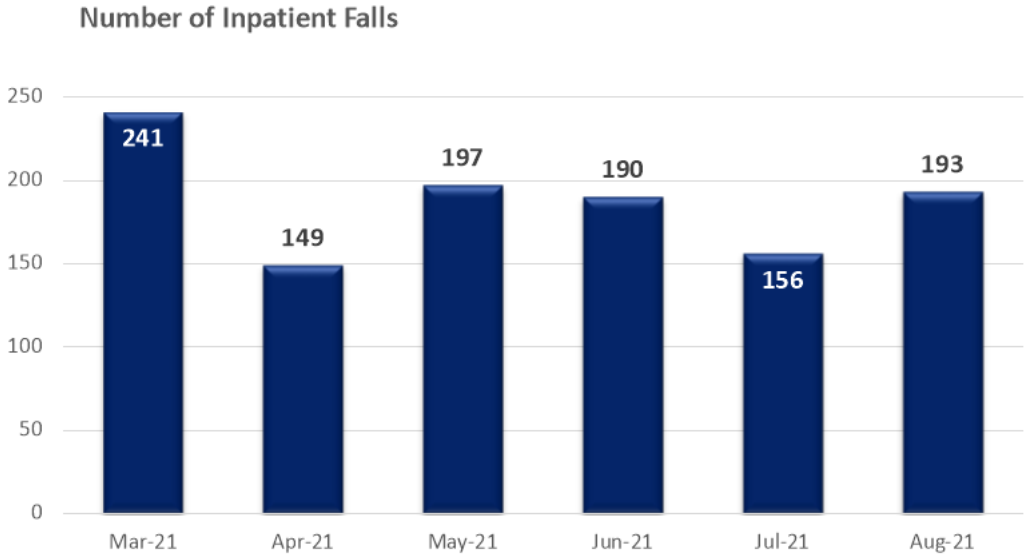
Incident Reporting – severity of harm (01/01/2019 to 31/03/2021)

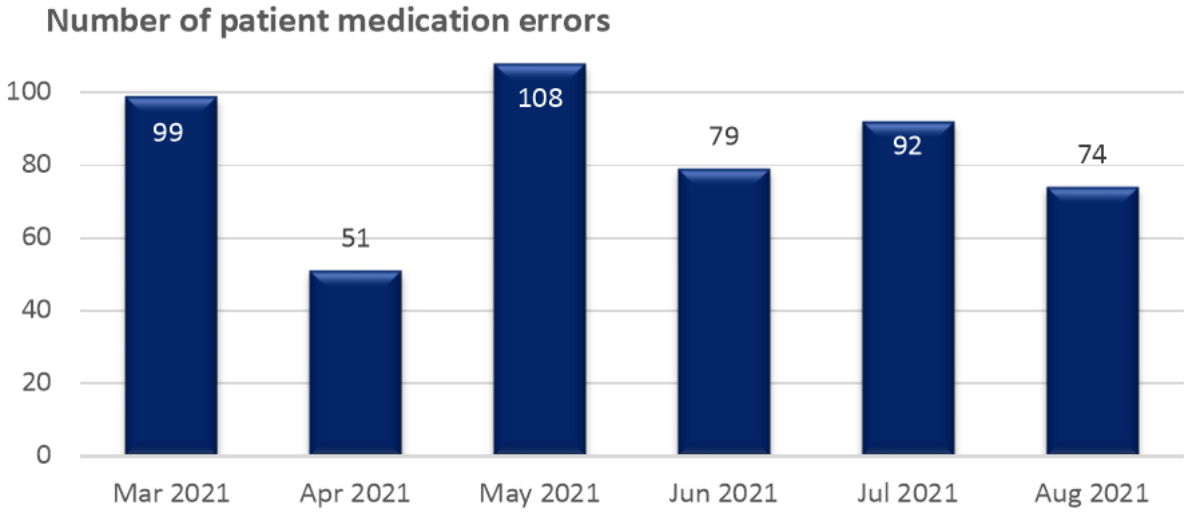


Incident Reporting









Reportable incidents

	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021
Absconded patient*	1	2	0	0	0
Pressure Damage*	2	2	1	0	0
Retained Foreign Object	1	0	0	0	0
Patient Fall (serious harm)	3	8	3	0	1
Unexpected Death **	4	7	5	0	0
Neonatal/Perinatal Care	0	0	0	1	0
Wrong site surgery/procedure	1	0	0	0	0
Under 18 Admission*	0	10	0	0	0
Other	1	0	2	0	2
Total	**13**	**29**	**11**	**1**	**3**

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

Between 1st July and 31st August 2021, **4** reportable incidents were reported to the Delivery Unit; 1 is in relation to Infection Control, 1 is in relation to Self Harm and 2 are Serious Harm.

As at 31st August 2021, there were 18 incident, reported to Delivery Unit or Welsh Government, open over 60 days. In comparison to June 2021, the position has decreased.

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

- 14th June change in reporting requirements – see below
- 4th January 2021 to 13th June – reduced reporting due to significant pressures on the NHS
- 13th August 2020 – return to full Serious Incident reporting to the Delivery Unit
- 18th March 2020 to 13th August 2020 – reduced reporting due to significant pressures on the NHS

Changes from 14th June 2021

Term 'serious incident' replaced by 'patient safety incidents' reportable nationally.

A patient safety incident will be nationally reported within seven working days from the occurrence, or point of knowledge, if it is assessed or suspected 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:

- Suspected homicides where the alleged perpetrator has been under the care of mental health services in the past 12 months
- In-patient suicides
- Maternal deaths
- Never Events
- 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
- Unusual, unexpected or surprising incidents where the seriousness of the incident requires it to be nationally reported and the learning would be beneficial

HAT Improvement plan

Actions complete

- Identify a clinical lead for HAT
- Temporary adoption of the all Wales Thrombo-prophylaxis policy during pandemic period
- Set up an Improvement task & finish group
- Develop an improvement plan
- Secure funding and employ a QIST member who is dedicated to the HAT improvement agenda
- Ensure robust reporting and review processes in place across all acute site for compliance with Welsh Government HAT Tier 1 target
- Review outcomes from HAT case reviews for Tier I target and take appropriate action to share and respond to lesson learnt
- All learning outcomes from HAT reviews are effectively communicated to clinical teams and are acted on

Next steps

- Amend and localise the All Wales TP Policy for HDHUB including an EQIA
- Start date for the HAT QIST practitioner is November 2021 depending on current nurse staffing levels and release. They will support:
    - Develop appropriate training and awareness raising mechanisms for all clinical staff on the prevention of HAT
    - Monitor compliance with the TP risk assessment across the acute sites using QI methodology and data collection
    - Develop robust and consistent approach to Redress process for all preventable HAT cases across all Acute Sites.
    - Full implementation and compliance with all Wales thrombo-prophylaxis policy when approved
    - Highlight issues/good practice/success in local Governance meetings
    - Review newly published NICE Quality Standard 201 – work with the Clinical effectiveness team on a gap analysis and improvement plan to achieve this.

HIW Quality Checks: Summary of Tier 1 Reviews 15 July – 16 September 2021

Area of Review	Recommendat-ions Raised	Update
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 submitted in May 2021 to evidence progress made. The report remains open on the audit and inspection tracker as one recommendation is partially complete.
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.
Tenby Surgery (UHB Managed Practice)	9 Immediate Recommendations 2 Recommendations from main report	The Quality Check was held in June 2021, with 9 recommendations raised on an immediate improvement plan, and a further 2 on the improvement plan. The Health Board have provided responses to all recommendations raised, and submitted a progress update in July on the 9 recommendations raised on the immediate improvement plan. Of the 11 recommendations raised in total, 10 have been implemented and 1 is currently in progress with a view that all recommendations will be complete by September 2021.
Llandovery Hospital	N/A	The Quality Check was scheduled for June 2021 but was postponed by HIW. The Health Board are currently awaiting a revised date for this inspection.
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, and 16 in the Improvement Plan which have all since been actioned and completed. The report has now been closed on the UHB Central Tracker.
St Caradog Ward	2	The Quality Check was held in August 2021, with 2 recommendations raised within the improvement plan relating to addressing issues identified within the fire safety reports and point of ligature risk assessments, and to produce an action plan to address issues raised within the IPC audit. HIW have requested an update on both recommendations within three months of the date of inspection – this will be due in November 2021. The report is awaiting to be published on the HIW website.

HIW Quality Checks: Additional Activity

Further Inspections

Prince Philip Hospital has been subject to a Tier 1 Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Compliance Inspection 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 report can be found via the following link: 20255 - IR(ME)R - Prince Philip Final Report.pdf (hiw.org.uk)

A further Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Compliance Inspection was undertaken at Withybush General Hospital on the 27th and 28th July, within the Nuclear Medicine Department. The Health Board has received the draft report, which is currently with the service to provide management responses to the recommendations raised within.

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 September 2021, 28 of the 33 recommendations have been implemented. It is noted that one recommendation is outside the gift of the Health Board to implement as it is reliant on Welsh Government Directive and an All Wales approach regarding a live PSAG feed. The report can be found via the following link: 20201118HIWNationalReviewofMaternityServicesEN_0.pdf. The Health Board received correspondence from HIW in August confirming that Phase 2 of the National Maternity Services Review will not be progressed. Issues identified in relation to aspects of maternity care which were outside the original scope will be pursued via follow-up work.

HIW Quality Checks: Additional Activity

Further inspections (cont)

As part of their annual reviews programme, HIW have undertaken a local review of the Welsh Ambulance Service Trust (WAST) with focus on the impact of ambulance waits outside Emergency Department on patient safety, privacy, dignity and their overall experience. The Health Board have received a draft of the final report, and is in consultation with WAST in order to provide responses to the 20 recommendations raised by the end of September 2021.

Services of Concern: Proposed HIW Process

The Health Board received a proposal document from HIW on 15th July 2021, outlining their intention to implement a Service of Concern process, and supporting process guidance. Currently, HIW follows an internal escalation process when an issue of concern comes to their attention. The new proposal is to formally use a Service of Concern designation when HIW identifies significant singular service failures, or cumulative or systemic concerns regarding a service or setting.

It is intended that a Service of Concern designation will increase transparency around how HIW discharges its role and ensure that focused and rapid action can be taken by a range of stakeholders, including health boards, to ensure that safe and effective care is being provided. The Health Board has until 30th September 2021 to provide comments or to send any queries in relation to this process, which is intended to be launched in Autumn 2021.

Other Inspectorate Activities

Community Health Council (CHC)

CHC issued a report in August 2021 entitled “Mental Health Care In Our Pandemic”, within which 5 recommendations were raised relating to the review of waiting lists, effective communications, and the need for an easy and quick access to direct mental health support for all ages. Two recommendations have been implemented, with the remaining three due for completion by March 2022.

Human Tissue Authority (HTA)

HTA inspection reports are now captured on the Central Tracker. A routine inspection was undertaken in July 2021 at Glangwili General Hospital, and a Corrective and Preventative Action (CAPA) plan was issued containing 20 actions. All actions are to be completed by December 2021, and updates will be requested from the Pathology Service as part of the bi-monthly service update process.

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.

Recommendation

The Quality, Safety and Experience 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

The Committee is asked to take assurance on the hospital acquired thrombosis improvement work.