Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Quality and Safety Assurance Report

Quality, Safety and Experience Committee

13 June 2023

Situation

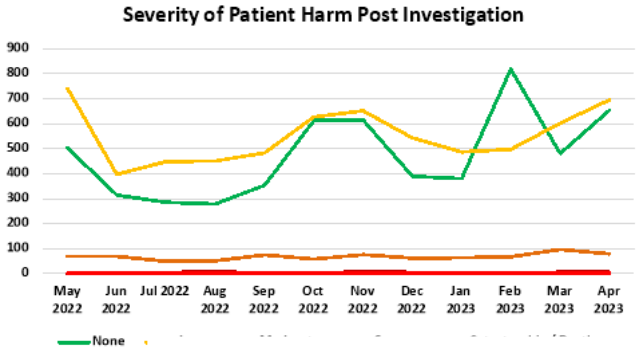
The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an overview of quality and safety across the Health Board.

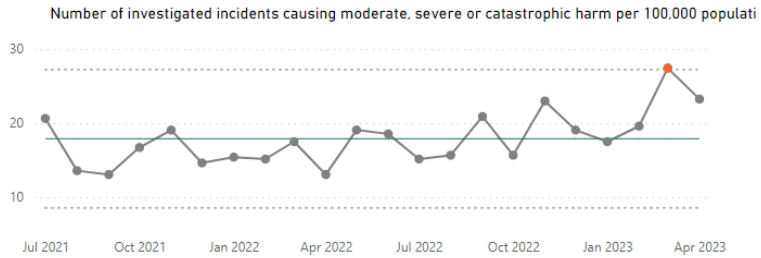
The Health Board uses a number of assurance processes and quality improvement strategies to ensure high quality care is delivered to patients.

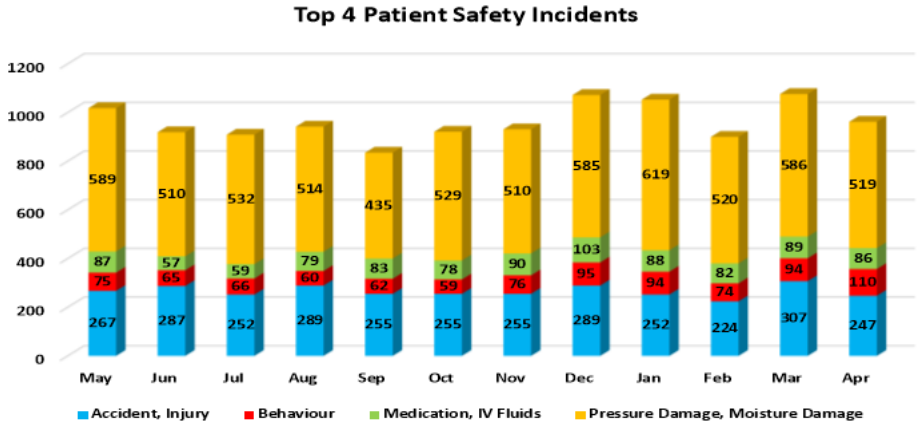
This report provides information on:

- Patient safety incidents including hot spots
- Externally reported patient safety incidents including the recent publication of the *NHS Wales Executive National Policy on Patient Safety Incident Reporting and Management*
- Infection control
- The nosocomial COVID-19 review programme
- Mortality review
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- Independent Member Engagement Visits
- Implementation of the Health and Social Care Quality & Engagement (Wales) Act 2020

Incident Reporting







There were 16,216 Patient Safety Incidents reported on Datix Cymru in Hywel Dda UHB between 1st May 2022 – 30th April 2023.

Of the 16,216 patient safety incidents reported, 8,641 have been closed.

In March and April 2023, 3,182 incidents were reported of which 2,754 were patient safety related

Incident Hot Spots

- Work continues to remind investigators that the grade/severity of an incident should reflect whether the investigation identified any acts or inactions by the Health Board that led to the outcome for the person affected e.g. an expected death in the community was closed as catastrophic by the service and on review no acts or inactions were identified.
- Pressure damage, moisture damage – 44% reported are moisture damage incidents; of the pressure damage incidents, 26% are reported as developing or worsening during clinical care.

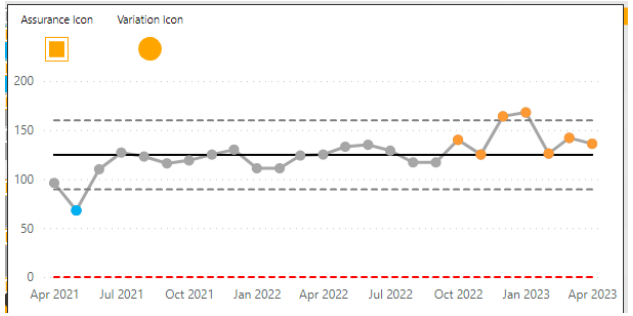
Hot Spots: Our Dashboard

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

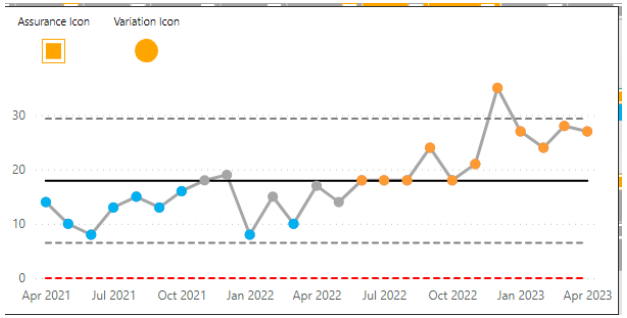
Pressure damage – developing or worsening during our care

- There is a concerning trend in the number of incidents reporting pressure damage developing or worsening during our care.
- Further work is required to explore this trend.

Health Board overview
(as at 01/04/2023)



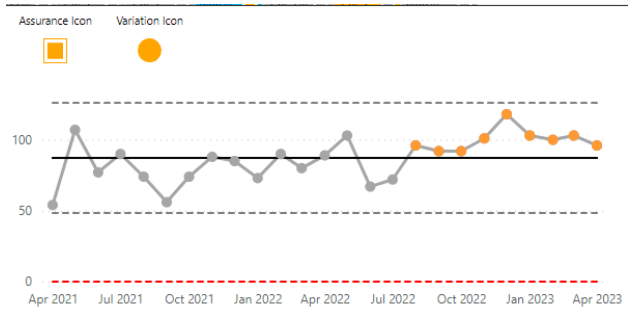
Glangwili Hospital (urgent and emergency care)
(as at 01/04/2023)



Medication Errors

- There is a concerning trend in the number of incidents reporting pressure damage developing or worsening during our care.
- This rise may be related to the launch of community pharmacy reporting
- The Medication Error Review Group has been asked to to explore this trend.

Health Board overview
(as at 01/04/2023)



National Policy on Patient Safety Incident Reporting and Management

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Welsh Government and the NHS Executive has recently published the revised *NHS Wales Executive National Policy on Patient Safety Incident Reporting and Management* (WHC/2023/017)

Under the Policy, the Health Board responsibilities are:

- Accountable for the quality and safety of care and services provided to their respective populations, including care that they contract, agree or arrange for their populations.
- Implementing this policy including endorsement through their Quality & Safety governance framework.
- Ensuring there are appropriate governance and assurance mechanisms in place, facilitating a flow of information across all parts of the organisation.
- Ensuring local systems and processes for incident reporting are in place and embedded.
- Ensuring that there are systems and processes for incident reporting, management and learning for any health care they contract, agree or arrange on behalf of their populations.
- Undertaking analysis of locally reported incidents, including identifying trends and themes from incident data.
- Establishing mechanisms to extract and share learning from incidents, and taking action to reduce the risk of recurrence and improve patient and service user safety, experience and outcomes.
- Ensuring staff are familiar with the requirements of the Policy.

Organisations must ensure they have robust systems and processes in place in relation to local and national incident reporting, including:

- Systems and processes to enact this policy in all areas of the organisation;
- All incidents should be reviewed within an appropriate governance framework to determine required risk management activities as well as any national reporting requirement. Whilst advice and support can be sought from the NHS Wales Executive, it will be expected that organisations are responsible and accountable for their judgements and decisions in line with the policy;
- Integration with other relevant clinical and corporate governance processes e.g. management of complaints and claims, mortality review processes etc.;
- Internal oversight, scrutiny and quality assurance of all incident reporting and investigation processes, including Executive level sign off on national incident notification and investigation outcome forms;
- Clear and demonstrable lines of reporting across all parts of the organisation, including through relevant Committees of the Board;
- Mechanisms for ensuring joint investigations with other responsible bodies and external agencies where applicable and appropriate;
- Mechanisms for recording the outcomes of decisions around national reporting and investigation, including decisions on appropriate investigation methodology. In particular, organisations must ensure they keep robust records around the decisions not to report/investigate incidents as this will be needed for quality assurance purposes;
- Mechanisms for capturing and demonstrating shared learning;
- Mechanisms for ensuring engagement with any affected patient or service user or anyone acting on their behalf, in line with the legal Duty of Candour.

How are we implementing the national policy?

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The measures we are taking, or have in place already, to implement the new policy include:

- Quality Assurance Report for Quality, Safety and Experience Committee,
- Sharing concerns and learning through the Listening and Learning Sub Committee
- Quality and Safety Intelligence Group (the weekly Hot and Happening meeting with the clinical Executives)
- The Clinical Executives Quality Panel
- 'Our performance' and 'our safety dashboard'
- Incident, near missing and hazard reporting procedure
- Incident reporting SharePoint page (which has a link on the home page of SharePoint)
- Concerns management and investigation SharePoint page (this includes incidents and complaints management)
- Nationally reportable patient safety incidents SharePoint page (which has been updated)
- Quality and safety reports to directorate quality and safety meetings including monitoring of action plans following serious incidents and agreed mechanisms for escalation e.g. to Operational Quality Safety and Experience Sub Committee
- Directorate incident scrutiny meetings
- Quality Assurance and Safety Team scrutiny and validation processes (of reports made via Datix Cymru). This includes scrutiny for Duty of Candour and reminders being sent.
- Incident management meetings
- Regular meetings with Welsh Ambulance Services NHS Trust

Nationally Reportable Incidents

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Under the new National Policy we are required to consider whether an incident requires reporting nationally

Principle 1 - 'Must reports'

Incidents related to the following are always nationally reportable

- Never Events, even where no harm has occurred;
- suspected mental health homicides;
- suspected suicide or self-inflicted death
    - in any clinical setting; or
    - during authorised/agreed leave, following recent planned discharge, or following unplanned leave/discharge; and
- maternal, perinatal and infant deaths.

Principle 2 - outcome/harm

A safety incident should be nationally reported if it is assessed or suspected an action or inaction in the course of a patient or service user's treatment or care, in any healthcare setting, has, or could have caused or contributed to their severe harm or death.

Principle 3 - number of patients or service users involved

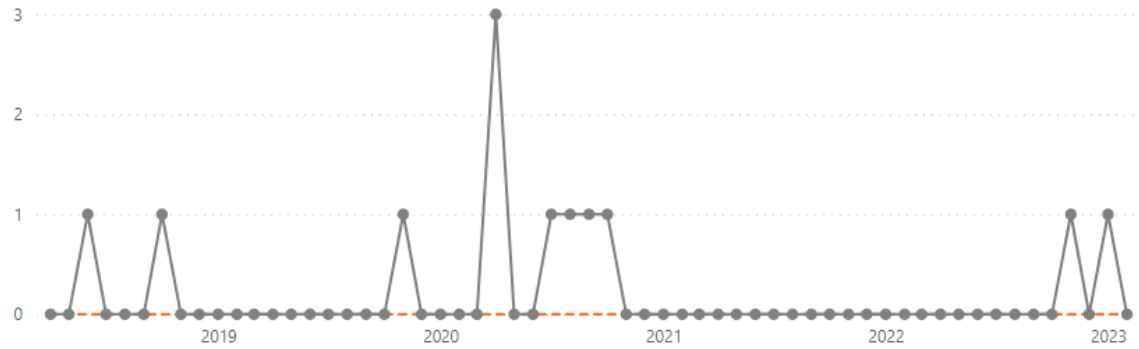
Special consideration must be given to incidents where the numbers of patients or service users affected is significant, even where direct harm has not been, or is difficult to, identify. This includes but is not limited to incidents involving significant:

- screening services;
- IT failures;
- data breaches;
- national system failures; and/or
- service disruptions.

Principle 4 - learning opportunities

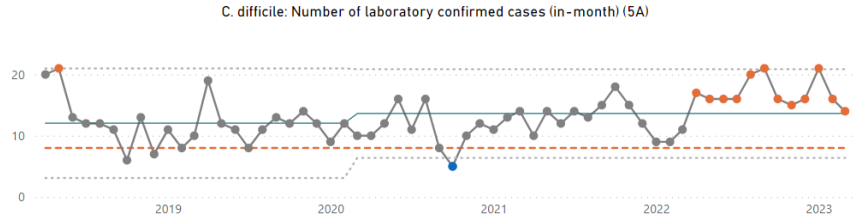
Principle 5 - joint decision making around reporting and investigation

Never Events Reported

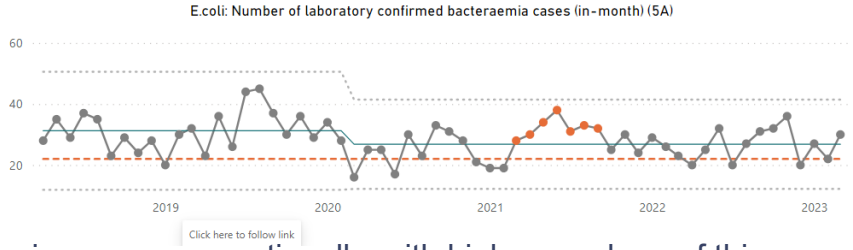


	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	23/24 Q1*	Total
Access, Admission	0	0	4	2	2	4	1	0	13 (5)
Accident, Injury	0	0	0	1	1	1	3	2	8 (8)
Assessment, Investigation, Diagnosis	0	1	1	3	0	1	0	1	7 (5)
Behaviour (including violence and aggression)	1	2	1	1	0	1	0	1	7 (5)
Infection Prevention and Control	1	0	0	0	0	0	13	7	21 (21)
Maternity adverse occurrence	1	0	0	1	1	1	0	0	4 (3)
Medication, IV Fluids	0	0	1	0	1	0	0	0	2 (0)
Monitoring, Observations	0	0	0	1	0	0	1	0	2 (0)
Patient/service user death	0	2	6	10	1	8	4	1	32 (19)
Pressure Damage, Moisture Damage	0	0	4	4	1	2	2	3	16 (3)
Transfer, Discharge	0	1	0	0	2	0	0	0	3 (1)
Treatment, Procedure	1	0	1	1	2	1	1	0	7 (6)
Total (total awaiting closure)	4 (1)	6 (2)	18 (5)	24 (13)	11 (5)	19 (13)	25 (22)	15 (15)	122 (76)

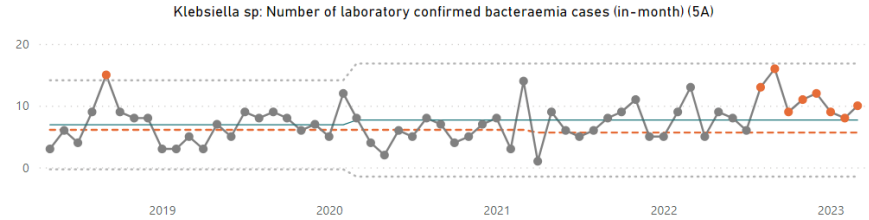
Infection Control



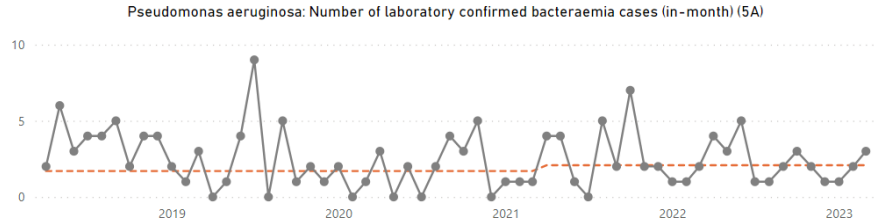
Utilising the Healthcare Associated Infections (HCAI) dashboard and implementing the elements highlighted within the HCAI Improvement Plan, the Infection Prevention Team have targeted areas identified as being of concern with increased cases of ***Clostridium difficile*** **Infection**. This action has begun to show an improvement in both reduced numbers and engagement of medical teams.



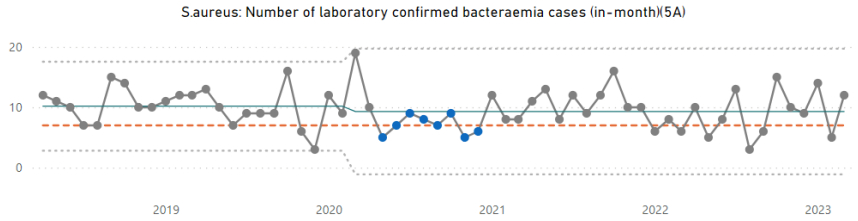
Though our ***E.coli*** numbers remain above target, we have achieved a 7% reduction over the equivalent period last year. There remains an approximate 70% allocation of these cases that are appropriated to non-inpatient cases.



The increase in ***Klebsiella sp***. remains a concern nationally, with higher numbers of this organism seen across the UK and further afield. The patients affected tend to have complex co-morbidities and further investigations show that the main sources identified appear to be either urinary or hepatobiliary.
An increased focus on urinary tract infection (UTI) reduction, education on catheter care and hand hygiene improvement (including patient hand hygiene) is aimed to reduce HAI cases.



The overall numbers of ***Pseudomonas aeruginosa*** bacteraemias remain, with slightly lower numbers (approx. 6% lower) than the same period last year. There remains an equal split with in-patient and non–inpatient cases.



Staph.aureus continues to show reduction improvement and an increased focus on ANTT compliance will assist with sustaining this reduction.

Infection Control continued

- Application of the HCAI Implementation Plan (HCAI Implementation Plan) indicates positive results with some reduction in CDI figures identified across the Health Board as we aim for the accepted trajectories for the year 2023-24 of a reduction rate of 20% for each site, we have seen a reduction in case numbers over the last three consecutive months. Increased engagement from the medical teams and advances made in antimicrobial stewardship are further indicators of improvement, however further commitment is needed from medical teams to conform to mandatory SSTF (Start Smart Then Focus) audits.

- Utilising the HCAI Dashboard enables targeting areas of increased incidence and has proved successful with enhanced interventions applied where necessary with scrutiny meetings held for each CDI case to identify cause or areas of concern or improvement

- An internal review of CDI within the HB has been completed and is currently being reviewed.

- The IP&C Team are developing a Nurse led FMT (Faecal Microbiota Transplant) service through the EQIiP programme to improve the current delivery of this procedure and enable equality of the service for our Community patients. This procedure is available to recurrent or relapses of C*.diff* cases and aims to improve patient's health and experience while reducing C*.diff* infection cases.

- The Infection Prevention Team (IPT) work plan for 2023-24 includes work streams to target both Gram negative (*E.coli/Klebsiella/Pseudomonas*) and *Staph.aureus* bacteraemias. It is understood that the targets set by WG for this year remain unchanged though we await official clarification of this. New use of electronic dashboards and audit tools within the IPT allow for easier capture of data and reporting.

- The recognised community burden of infection including increasing numbers of Gram-negative infections, demands that we have an increased ICN presence to work collaboratively with Local Authority partners, community and primary care teams and incorporate public facing campaigns. Individual and cluster level working with GP's to raise awareness of CDI symptoms continues along with antimicrobial stewardship and latest NICE treatment guidelines.

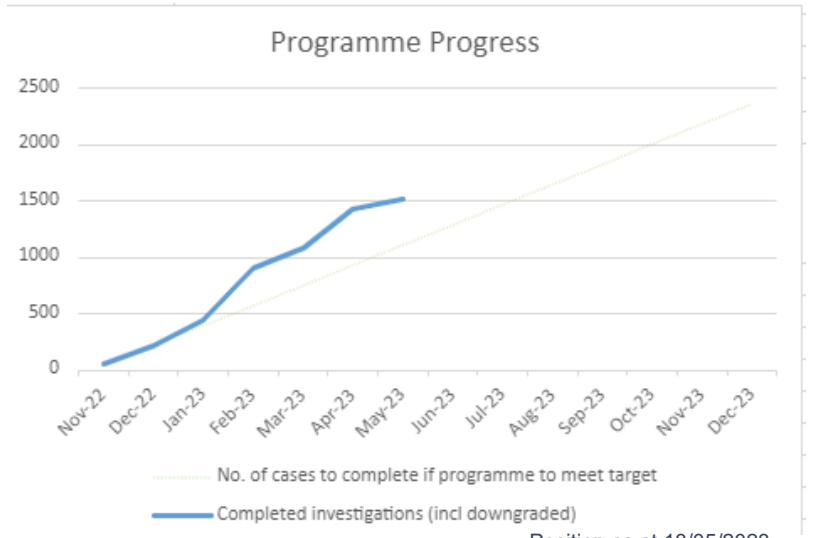
Nosocomial COVID Review Programme

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The COVID Programme Review Team and Quality Assurance and Safety Team have seen a number of important local themes coming through these reviews and they should be considered alongside the national learning coming from all Health Boards during this review process. Hywel Dda themes are listed below:

- The ageing estate and lack of side rooms for vulnerable patients e.g. those undergoing cancer treatment or shielding patients
- The reasons documented in notes for a patient undergoing a swab – this has not always been noted in records, e.g. a contact, the ward suffering a potential outbreak for example
- Communications with family once a result from a swab is known. In some cases the communication with family was very good, but not so in all cases
- The reasons documented in notes as to why a patient was isolated
- Delays in discharge – the review has seen a large number of patient's who were medically fit for discharge (MFFD) but their route to discharge was blocked for a reason such as a) the nursing home destination was closed to admissions due to an outbreak; b) a vulnerable relative at home c) awaiting a package of care and the associated delays getting that in place during the pandemic

Sadly, in a number of cases, some patients who were MFFD remained in hospital, caught COVID and passed away whilst in the hospital ‘s care.



Position as at 18/05/2023

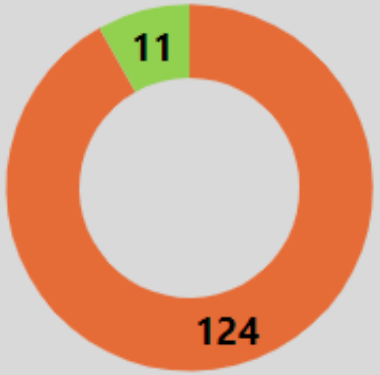
	Wave 1 (27/2/2020 - 26/7/2020)	Wave 2 (27/07/2020 - 16/05/2021)	Wave 3 (17/05/2021 - 19/12/2021)	Wave 4 (20/12/2021 - 30/04/2022)	**Total (18/05/2023)**	Position As at 30/03/2023	Live 01/05/22 -
Total number of suspected hospital acquired COVID included in the review	119	1043	356	802	**2320**	2320	998
Total not started / under investigation	0	69	38	206	**327**	531	661
Total review complete (awaiting decision for panel)	26	142	76	1564	**386**	473	27
Downgraded	14	80	52	49	**195**	83	34
Total referred to panel (not closed)	9	58	7	17	**91**	236	14
Total completed investigations	70	694	183	374	**1321**	997	262

NNCP Data - Hywel Dda UHB

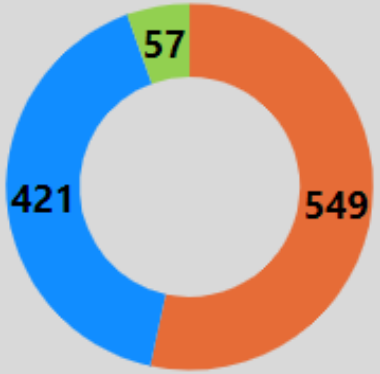
Position reported to the National Nosocomial COVID Programme for end on April 2023

GIG CYMRU NHS WALES
National Nosocomial COVID-19 Programme

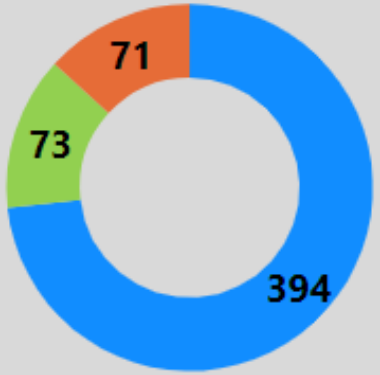
Wave 1



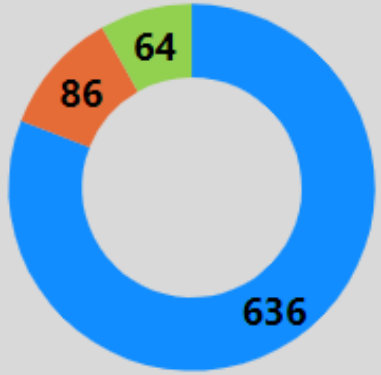
Wave 2



Wave 3



Wave 4



Status Completed In Progress Not Started

Wave 1	Wave 2	Wave 3	Wave 4	Reset

Total Cases

2320	0
Latest	Change

In Progress

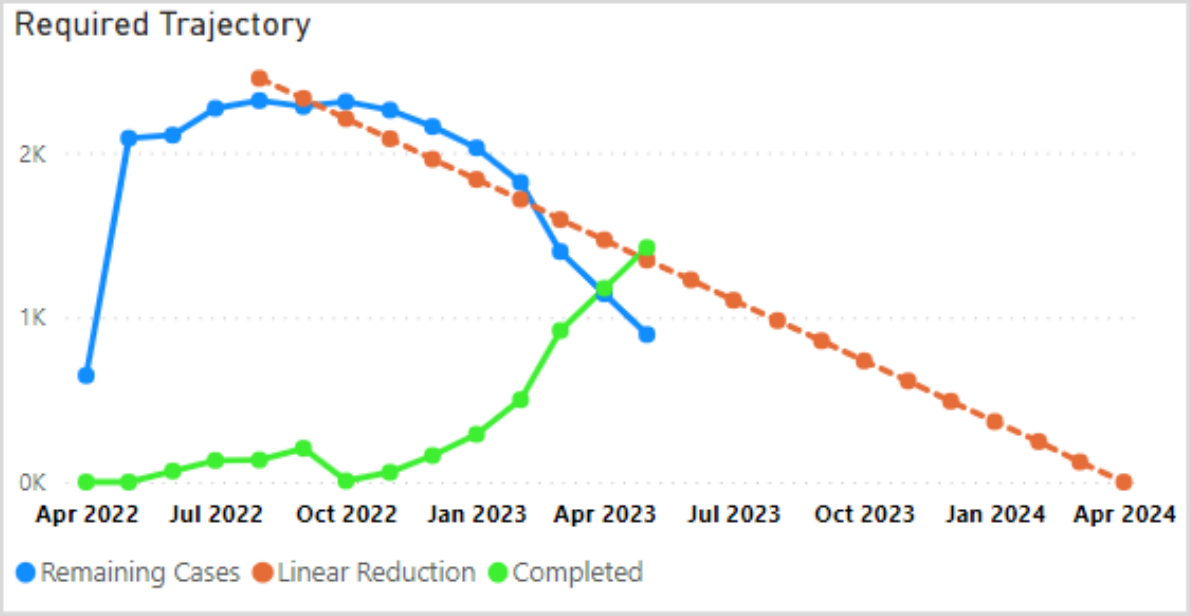
520	-54
Latest	Change

Completed

1424	247	61.38%
Latest	Change	%

Not Started

376	-93
Latest	Change

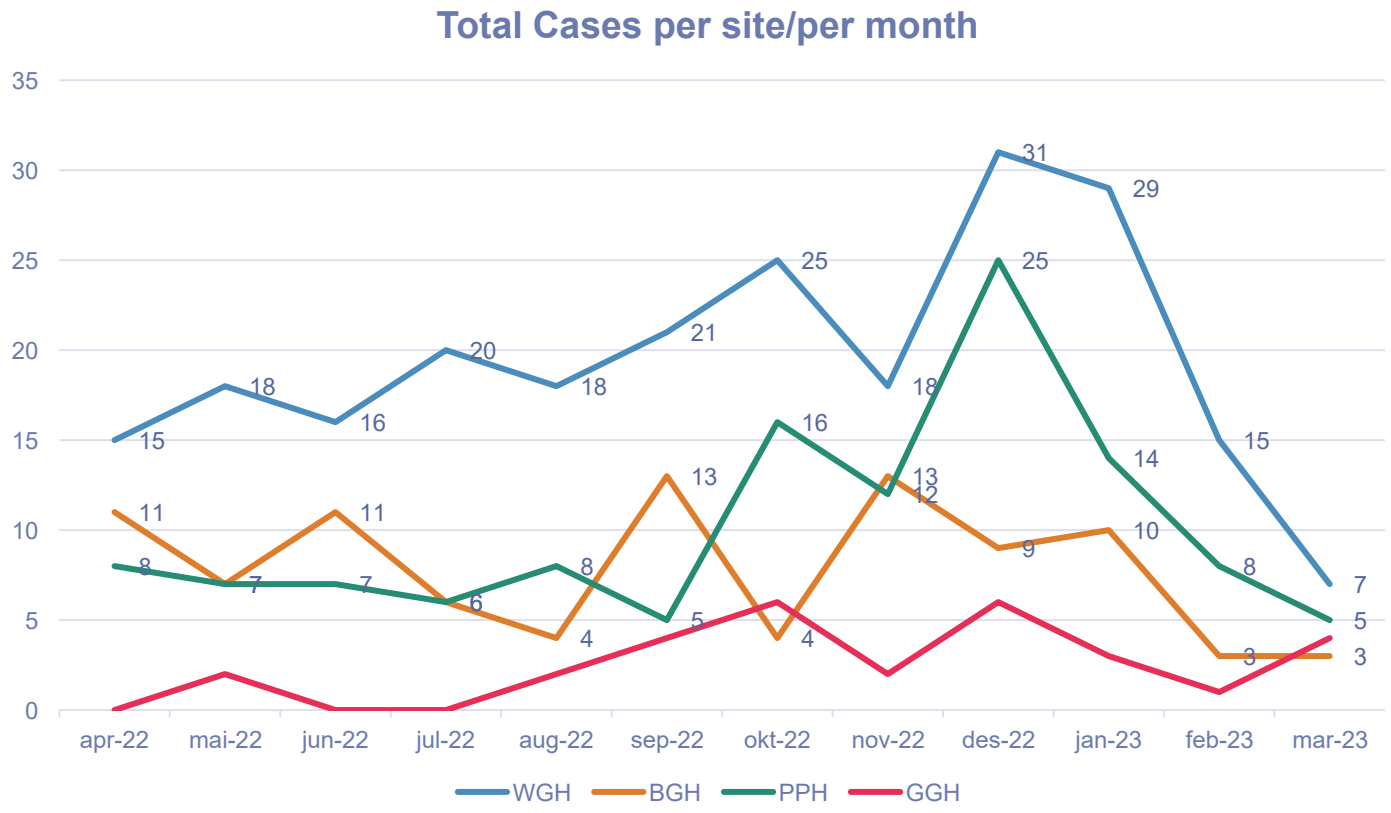


Mortality Reviews

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

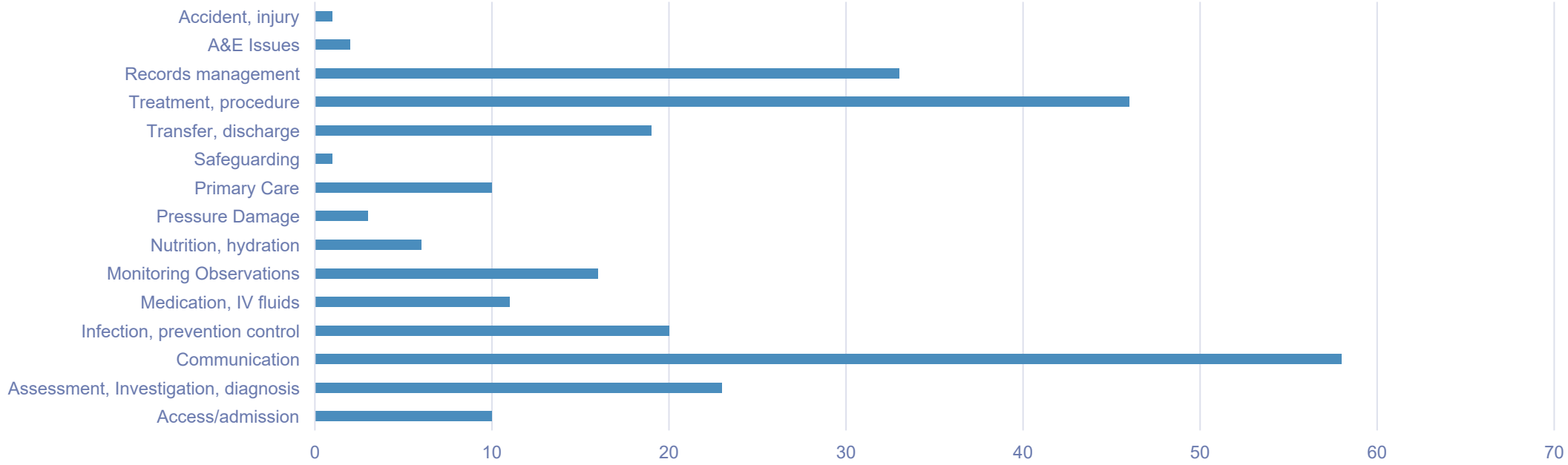
- Mortality Reviewing is well established in line with the All Wales Learning from Mortality Review Framework. A Multidisciplinary Mortality Review Panel meets fortnightly, to review cases that have been referred back to the Health Board following Medical Examiner Service (MES) scrutiny.
- Just under 30% of cases are referred from the MES for consideration. The Panel reviews and determines when a further proportionate investigation is required, in accordance with the national framework.
- Learning from individual cases is also shared directly with the relevant sites, including positive feedback.
- There are processes in place to capture themes emerging from the MES referrals, and any thematic learning being generated from proportionate investigations. Thematic reporting will be fully introduced once all deaths are being scrutinised, including mechanisms to ensure triangulation with other Health Board mortality data.
- MES processes are operational on all acute sites across the Health Board, with 100% of deaths in Withybush, Bronglais and Prince Philip Hospitals, and over 60% of Glangwili General Hospital deaths now being sent to the MES for independent scrutiny (rising to 100% by the end of May 2023).
- Work is ongoing alongside the MES to establish processes to include all community and primary care deaths by the end of August 2023, in line with the statutory introduction of the MES. This includes identifying the resource requirements to ensure future sustainability of mortality reviewing processes.

500 cases received between April 2022 – March 2023 (as recorded on Datix Cymru)



NB – lower figures in GGH reflect the fact that Medical Examiner Service is not fully rolled out

Mortality Reviews – Themes Update



- The theme linked to the main issue per case is being recorded at the point of screening, which highlights the main concerns from a total of 255 cases.
- It is important to note that we are limited by the system to capturing one theme per case.
- When all sites are on board with the process, we will be working towards capturing site specific themes, identifying any timelines and any areas of concern.

Mortality Reviews

- Work continues under the leadership of the Clinical Lead for Mortality to develop wider mortality accountability, through scrutiny of available mortality metrics in key areas and working with Clinical Directors and Clinical Leads to increase ownership and prioritisation of mortality across the Health Board
- Four areas were identified by the Deputy Chief Medical Officer following a routine review of CHKS data, which indicated increases in deaths:
  - in hospital within 30 days of non-elective surgery;
  - in hospitals within 30 days of emergency admission with a heart attack among those aged 35-74;
  - in hospital within 30 days of emergency admission with a hip fracture among those aged over 64;
  - in hospital within 30 days of emergency admission with a stroke.
- The available data in Orthopaedics, Cardiology and Stroke Medicine has been reviewed by Clinical and Service Leads, including wider KPI's and case note reviews where appropriate. Findings have been discussed with the Clinical Lead for Mortality and assurance provided.
- A better understanding of the CHKS data has been developed, through discussions with the Information Team and CHKS. This has highlighted some inaccuracies with coding which make the death in hospital within 30 days of non-elective surgery rate appear higher than it is.
- Assurance has been provided to the DCMO that the Health Board is aware of, and reviewing deaths in the areas highlighted

HIW Quality Checks/Inspections: Recent reviews and inspections

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Area of Review	Recomm-endations	Update
Mental Health Discharge Review	TBC	On 7 March 2023, HIW published a report following a review undertaken to assess the quality of discharge arrangements in place within Cwm Taf Morgannwg University Health Board for adult patients being discharged from inpatient mental health services to the community. HIW have now announced a review into discharge from all mental health services for services to benchmark against the learning from the Cym Taf report. Hywel Dda's response was submitted on time and **we await the final report**.
IRMER Report GGH	TBC	Following submission of an IRMER notification the service have undertaken a full detailed investigation report which is due for submission on 14th June 2023. **The report is currently under executive scrutiny prior to submission whilst collating this report**
Child Protection Rapid Review	TBC	Following the publication of a Child Practice Review in November 2022 HIW announced a review into current structures and processes in Wales to ensure children are appropriately placed on, and removed from, the Child Protection Register when sufficient evidence indicates it is safe to do so. **The Health Board was requested to share detail of cases which took place in accordance with the deadline provided**.
Tregaron GP Practice Inspection	TBC	An inspection took place on 16th February 2023. No immediate assurances concerns nor infection control issues were identified. A few points are expected regarding staff induction and location of the practice policies. **The draft report is awaited.**
DNACPR Review	-	HIW announced a formal review of Health Board's management of DNACPR patient processes. Submission of a significant number of historical records took place for this review in February 2023. The Health Board were informed on 8th March 2023 that a piece of work is underway for a national thematic review to be carried out by the Mortality Review (MR) Group at the Welsh Delivery Unit. **This review has therefore been postponed for the time being.**
Argyle Medical Group Inspection January 2023	2	An announced Quality Check took place on 5th January 2023 at the Argyle Medical Group GP surgery. Feedback on the quality related to environmental risk assessment and protocols dates.
A&E (GGH) Inspection December 2022	27	An unannounced inspection took place between 5th and 7th December 2022. There were several areas of immediate assurance required including securing the gas storage room, promotion of privacy and dignity within the surge areas at times of high capacity, resuscitation trolley checks, regularity of assessments for waiting patients, sepsis screening and the safety and wellbeing of children waiting within the department. Following further assurance the improvement plan for this report was approved and the report published. There are 15 recommendations open on AMAT. Of the 41 actions open, 1 is overdue, 33 have new agreed dates and the remainder are in date.

HIW Quality Checks/Inspections: An update on those previously reported

Area of Review	Recomm-endations	Update
Maternity (GGH) November 2022	12	An unannounced inspection took place on 29th and 30th November 2022. There were several areas of positive feedback, no immediate concerns highlighted and the recommendations relate to mandatory training and appraisal compliance. The final report was published on 16/02/23. **There are currently 5 actions open on AMAT with new future dates.**
IRMER Inspection (GGH) November 2022	19	An announced inspection took place on 15th and 16th November 2022. The verbal feedback highlighted no immediate concerns and the recommendations relate to the standard of appointment letters, compliance with IRMER regulations, although acknowledgment that work is well underway to address this aspect, processes require updating and staff training. The report was published 24/01/23. **There are currently 25 actions open on AMAT, 14 have new future dates and all are in date.**
Angharad ward, (BGH) Paediatric ward October 2022	8	An unannounced inspection took place on 4th and 5th October 2022. The draft report highlighted no immediate concerns, the recommendations relate to timely CAHMS assessments, cleaning chemical storage, the requirement of a new clinical medication fridge, the development of menus, the replacement of flooring and reminders to staff regarding allergies and weight recording on drug charts and the countersignature and printing of names on documentation. The report was published on 5th January 2023. **There are currently 2 actions open on AMAT 1 with a new future date.**
Bryngofal ward, PPH July 2022	19	An unannounced inspection took place on 11th July 2022. The verbal feedback highlighted no immediate concerns and the recommendations relate to maintenance and refreshing environment, reorganisation of clinical room and the use of an office for staff, the provision of a fridge for patient use, consideration of staff uniforms on escort duty, training records, medication records and highlighting attention to the Consultant Psychiatrist and the Psychologist posts currently vacant. At the point of updating this report **there are currently 4 actions open on AMAT with new future dates.**
Ward 7 PPH February 2022	19	The inspection took place in November 2021 where 19 recommendations were raised on matters such as workforce, medicines management, governance and leadership, infection prevention and risk and health and safety. **All recommendations are complete**.
National Review of Mental Health Crisis Prevention	19	This final report into the national review was published in March 2022 involved services benchmarking themselves against the recommendations suggested. The improvement plan was submitted 27th May 2022 which requires some redesign of pathways of care and development of services, communication and engagement with primary care services and development of some staff roles and recruitment into new staffing models. At the point of updating this report **there are at present 4 actions open on AMAT with new future dates.**

HIW Quality Checks/Inspections: An update on those previously reported (cont)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Area of Review	Recomm-endations	Update
Ystwyth Medical group Quality Check	0	The quality check took place on 7 February 2022. The review covered environment, infection, prevention and control and governance and staffing. **The report made no recommendations of the service**.
National Review of Stroke Pathways	0	The Health Board's contribution to this review, an onsite inspection, took place at Bronglais Hospital between 28 – 30th March and 16th May 2022 for the clinical areas. HIW also interviewed the corresponding staff at PPH, GGH and WGH for Stroke and Patient Flow. **We await feedback as well as the final All Wales report which was expected to be available early 2023 (not received to date).**
Llandovery Hospital Quality Check	0	The quality check took place on 15 March 2022, following postponement from 2021. The review covered environment, infection, prevention and control, governance and staffing, and some aspects of Covid-19 management. **The report made no recommendations of the service**.
Tregaron Community Hospital	29	An on-site inspection was undertaken on 7th and 8th September 2021, whereby 29 recommendations raised on matters including patient experience, delivery of safe and effective care and quality of management and leadership. At the point of collating this report **all recommendations are complete.**
HIW IR(ME)R July 2021 WGH	40	The improvement plan included access to services, listening to feedback, staff training and some All Wales actions. At the point of collating this report there is **1 action open on AMAT** linked to an All Wales piece of work.
Welsh Ambulance Services NHS Trust Acute improvement plan	31	This Welsh Ambulance Service improvement plan dating from September 2021 includes recommendations that affect or impact and require action for Acute / Emergency services and departments. At the point of updating this report there are **4 actions are open on AMAT** for each site to take forward, all overdue.
Withybush General Hospital, St Caradog Ward	4	This improvement plan details recommendations in relation to Fire Safety and Health and Safety. There remains **1 action open on AMAT at the point of collating this report with a new completion date.**

HIW Additional Information & Themes and Trends

Progress of actions agreed following inspections and quality checks

As of May 2023 the current position is a total of 10 reports / inspections with 62 recommendations (actions) open. All these recommendations and actions continue to be tracked by the Quality Assurance and Safety Team (QAST) and are all uploaded to the AMAT system for services to manage and update direct. Support is provided to services for completion and the use of AMAT is encouraged. Those recommendations that have exceeded their due date are extended to completion, with discussion with services if appropriate.

Other correspondence received from HIW

- Healthcare Inspectorate Wales' (HIW) Insight Bulletin
- Request for assurance relating to the management of a service user under mental health section

Thematic review of HIW inspection actions

QAST have undertaken a review of all recommendations and actions arising through these inspections which have been themed and this is presented for reflection herewith:

Primary Care inspections

In Primary Care, both GP and Dental services biggest themes seem to be related to staff training records and levels of training compliance, staff management issues, record management, and policy management. It should also be noted that for Portland Street Dental Practice, Old Oak Dental Practice and Ystwyth Primary Care Centre no improvement recommendations were raised during their inspections.

HIW Themes and Trends – Primary care

GP premises

The themes in the recommendations are:

- Staff management issues (10)
- Welsh language standards (6) and
- Staff training records (4).

The pie chart above shows all recommendations raised

Dental practices

The themes in the recommendation are:

- Patient information (4)
- Policy management (3) and
- Health and Safety (2)
- Records management (2)
- Staff Training (2).

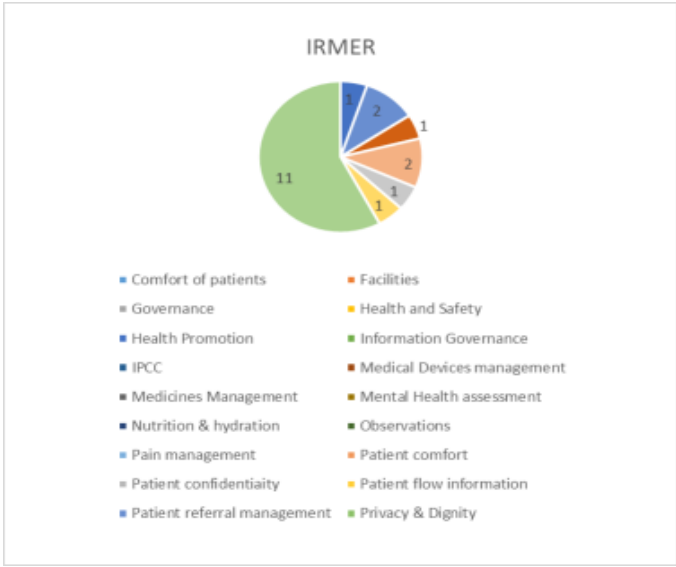
The pie chart above shows all recommendations raised
2 practices received no recommendations.

HIW Themes and Trends – Secondary care

Emergency Department (Glangwili Hospital)
The themes in the recommendations are:

- Medicines Management (3) relating to unlocked cupboard in the Resusitation area, the requirement for securing of the oxygen cylinder storage area and recording oxygen therapy in records;
- Patient Flow information (3) referring to an action to help patients understand their journey and provide updates about their care in the department, improve patient flow, ensure staff are aware of on call arrangements and to provide updates to staff during periods of escalation; and
- Staff Feedback (2) relating to what action has been taken in relation to staff responses and what actions are being taken in relation to less favourable comments in the report.

The pie chart above shows all recommendations raised.



Radiology (IRMER) inspection (Glangwili Hospital)
The themes in the recommendations are:

- Written Documentation (11) (highlighted in green in the pie chart shown below) relating the quality of letters sent to patients
- Employers Written Procedures amendments required (6) and staff being aware of the current examination protocols and written protocols for paediatric patients;
- Patient referral management (2) referring to a review of DAG (Directed Acyclic Graphs) CT referrals and the promotion of a consistent approach for clinical audits; and
- Staff Feedback (2) relating to action to improve the system of providing staff with updates on patient experience feedback and what action has been taken to respond to the less favourable staff comments noted in the report.

The pie chart above shows all recommendations raised

HIW Themes and Trends – Secondary care

Angharad Ward (Bronglais Hospital)
Two recommendations relate to records management and related to information being recorded on relevant clinical documents.

The pie chart above shows all recommendations raised

Maternity Services (Glangwili Hospital)
The themes in the recommendations are:

- Staff Management (3) related to reviewing staff rotas to ensure they are appropriate, an audit of on call consultant attendance and on call consultants attending the evening handover and a display of the rota;
- Information Governance (2) related to an unlocked cupboard and securing patient records; and
- Medicines Management referring to an unlocked medication fridge and an additional recommendation ensuring that medication fridges are locked when not in use.

The pie chart above shows all recommendations raised

Inspection and Peer Review activity

Risks and Mitigations

- All correspondence received by third parties such as the Welsh Government, the Delivery Unit or Health Inspectorate Wales in relation to their activity is logged on receipt by the Quality Assurance and Safety team (QAST).
- A robust process is in place for co-ordinating and quality checking responses, including gaining executive approval of HIW submissions, by the required deadlines.
- Recommendations arising from HIW, et al, such as immediate assurance plans or final reports have been migrated into the AMAT software, as well as QAST pursuing services for updates in advance of any due date and negotiating any new future dates.
- The QAST team are supporting services to develop their improvement plans.
- QAST are providing updates for reporting to the Audit and Risk Team for each Audit and Risk Assurance Committee (ARAC) meeting.
- HIW activity forms part of the quality governance arrangements within Directorates.

The Health and Social Care Quality & Engagement (Wales) Act 2020

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

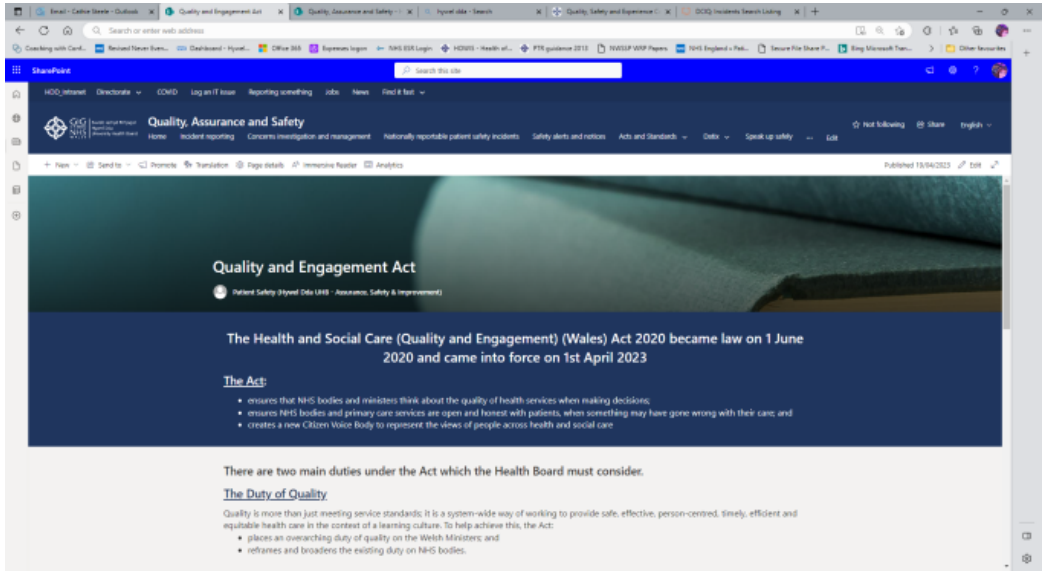
Update on implementation (some highlights)

- Implementation Group continues to meet and make progress on roadmap to implementation
- SharePoint page developed (1756 hits)
- Communication plan refreshed
- Training needs analysis undertaken
- All opportunities to promote the two duties are being used (in excess of 30 presentations to different staff groups given) including concerns proportionate investigation training
- Using the “Our Performance” and “Our Safety” Dashboards and the Integrated Performance and Assurance Report – always on reporting
- Improving together framework

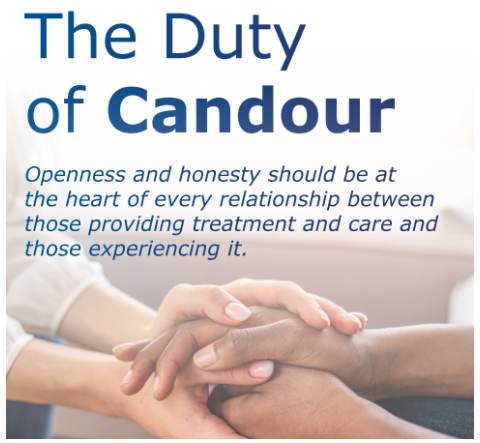
Areas of further work (some highlights)

- Ratification of revised Putting Things Right Policy – seeking support from listening and Learning Sub-Committee as operational ownership group and will then be brought to QSEC for final ratification
- Education on the Duty of Candour triggers – more than awareness sessions
- Support for the identified Duty of Candour leads
- Primary Care capture of DoC and reporting arrangements
- Aligning the “Our Performance” and “Our Safety” Dashboards and the Integrated Performance and Assurance Report with the Health and Care Quality Standards

Staff groups attending DoC and DoQ sessions	Numbers in attendance
Nursing staff	97
Medical staff	123
Therapies staff	27
Primary Care staff	20
Other staff	3
Total of staff briefed (to 26/05/2023)	270



Duty of Candour



The Duty of Candour was enacted on the 1st April 2023 and applies to all NHS care delivered or commissioned and is aimed to create a culture of trust and openness. The Duty is triggered where a service user may have suffered harm categorised as more than minimal harm (moderate or above) and their NHS care was a factor.

During April 2023, there were 340 patient safety incidents where harm was reported as more than minimal.

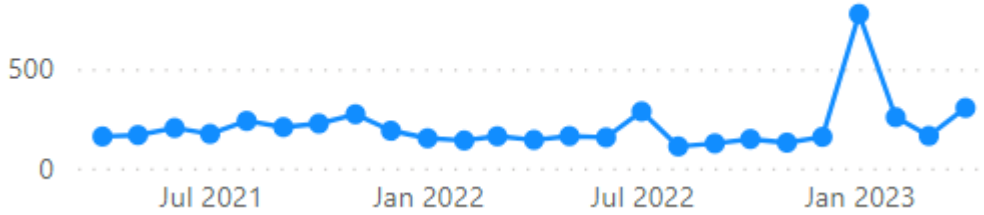
As part of the Management Review, the manager should consider whether the level of harm reported is appropriate and confirm if the incident meets the criteria for Duty of Candour – if it does meet the criteria then the Duty is triggered and contact should be made with the service user or next of kin without delay.

All patient safety incidents reported as moderate, severe or catastrophic and above are reviewed by the Quality Assurance and Safety Team and support and guidance is offered to staff to ensure the duty is carried out accordingly for those cases that meet the threshold. Staff can also consider if the incident took place prior to the duty coming into force during this process or any other factors.

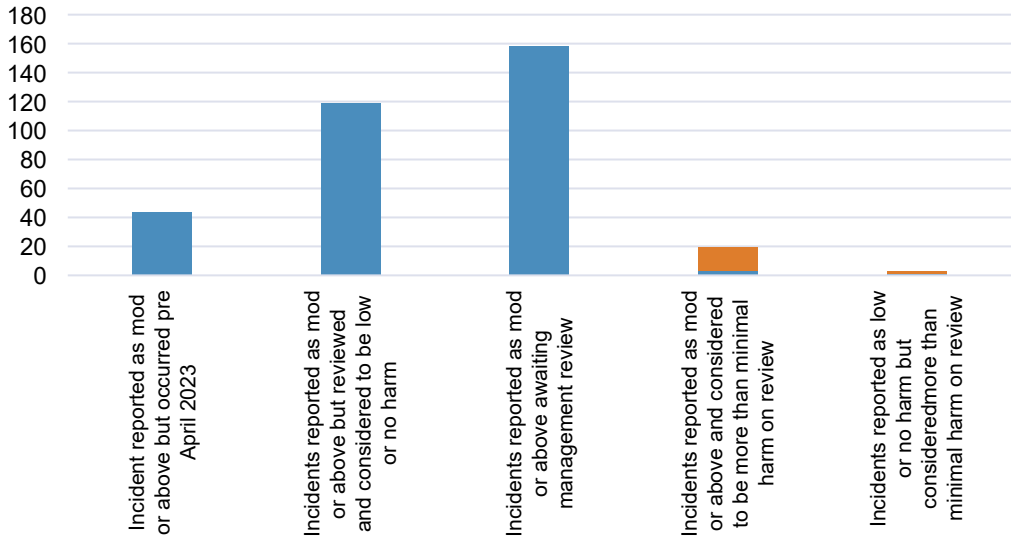
Of the incidents reported in April 2023, 22 incidents have been considered as triggering duty of candour (at the time of preparing this report). Initial contact has been made in 4 cases.

It is clear further work is required to ensure key staff are aware of their duties.

New Incidents by month reported where harm is more than minimal
(340 patient safety incidents reported in April 2023)



Duty of Candour - initial assessment



Orange denotes initial contact being recorded as not being made at time of running data

Recommendations

The Quality, Safety and Experience Committee is requested to note the safer care collaborative work and take assurance that processes, including the Listening and Learning Sub Committee, are in place to review and monitor:

- Patient safety incidents including hot spots
- Externally reported patient safety incidents including the recent publication of the *NHS Wales Executive National Policy on Patient Safety Incident Reporting and Management*
- Infection control
- The nosocomial COVID-19 review programme
- Mortality reviews
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- Independent Member Engagement Visits
- Implement of the Health and Social Care Quality & Engagement (Wales) Act 2020

Appendix 1: COVID Learning identified
(reported January 2023)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Good practice

- Timely DNACPR decisions with rationale and discussions documented
- Ceilings of care being agreed and documented
- Regular medical reviews (well documented)
- Use of technology for communication between patient and family
- Documentation of bed location and rationale for moving patients
- Family members visits being facilitated when end of life
- Documentation of PPE usage when patient being visited by relatives

(Note – the above is not consistent across wards and sites)

Areas for Improvement

- Medically fit for discharge patients becoming COVID positive whilst waiting for package of care or nursing home placement
- Increase the use of technology for communication between patient and family when visiting restricted
- Documentation of bed location and rationale for moving patients
- Symptomatic patients – reliance on one diagnosis rather than potential differential of COVID

Appendix 2: COVID Learning identified
(reported to QSEC February 2022)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Areas for improvement

- Timely discussions regarding ceilings of care (sometimes more than 5 days after COVID-19 positive test)
- Documentation that video call / contact with family has happened
- Timely communication from community to hospital e.g. care home closed due to outbreak, ward informed 3 days after care home closed

Good practice

- Ceiling of care discussion with patient and family documented
- DNACPR discussions with patient and family documented
- Initiation of end of life pathway where appropriate
- Regular COVID-19 testing following any symptoms

Observations from outbreak reviews

- We may be unable to categorically answer how patients became nosocomial COVID-19 positive e.g. staff contact / other patient contact / visitor contact

Early wave 3 outbreaks observation

- It would appear that outbreaks are being contained to bays or parts of wards rather than the whole ward being affected

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

The Duty of **Candour**

Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND