GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Hywel Dda University Health Board

Quality, Safety and Experience Committee

Annual Report 2023/24

Introduction

The QSEC Annual Report provides assurances in respect of the work that has been undertaken by the Committee during 2023/24 and outlines the main achievements that have contributed to robust integrated governance across the Health Board (UHB). Six meetings took place during 2023/24:

- 11 April 2023
- 13 June 2023
- 8 August 2023
- 5 October 2023
- 7 December 2023
- 13 February 2024

It is the work of this Committee to shine a light on the things that matter most to our patients, their families and our communities – safe, effective, accessible and patient-centred care. The scale of the pressure in our services that is now the norm, coupled with the longstanding challenges of service configuration and workforce stability within a rural and ageing population, put delivery of these priorities at risk. 2023/4 has been a year both to recognise the hard work and dedication of our teams in maintaining services day-to-day and to acknowledge that questions of sustainability are growing. We know this has consequences for patient experience and we have focussed on being transparent where that is the case. This report gives a flavour of the scrutiny we have applied to matters of concern and reflects the increasing attention we are giving to the impact of actions in place.

We provide scrutiny across all levels of the organisation. At the individual level, we have continued to value first-hand experiences generously shared with us by patients, families and staff through the telling of stories. They bring our work as a Health Board to life, sometimes evoking a sense of pride and other times providing us with a sobering reminder that there is no place for complacency in our commitment to excellence.

At the team and service level, we have considered a standard set of metrics throughout the year (e.g. through the bimonthly Quality Assurance Report). We have taken regular reports on an annual cycle from our sub-committees and other groups (e.g. Operational Quality, Safety and Experience). In addition we have called for 'deep dive' explorations of specific pathways that have been flagged through the triangulation of intelligence (e.g. waiting times for Therapies; Epilepsy in Learning Disabilities review), which draw on both internal and external evidence. The management of the RAAC internal major incident at Withybush Hospital to safeguard access to local, effective care is of particular note, thanks to an exceptional collaborative effort involving our staff, partners and patients.

At the organisation-wide level, we asked our Listening and Learning Sub-Committee to take a close look at communication issues which continue to feature strongly in complaint feedback. We have had a proactive role in championing both the Speaking Up Safely work and the Duty of Candour requirements in recognition of the close links between culture and quality/safety. We received a thorough review of learning

arising from the COVID-19 nosocomial review process and have challenged the organisation to test its shared learning capabilities with it. We have sought to be purposeful in making connections across committee boundaries, forging particular links with the People, OD and Culture Committee.

Finally, work that is mandated nationally has been locally embedded and scrutinised, as is clear from our ongoing work to align our activity with the Health and Care Quality Standards published by Welsh Government and our engagement in national improvement work (e.g. access to support for neurodivergent children and young people). Also within the national context, we ensured that all matters raised by Welsh Government under the 'enhanced monitoring' process were included within the Committee's business cycle.

As we look to the coming year, the Committee will continue to build its focus upon impact and outcomes, enabled by clearer mutual expectations in terms of a 'high support, high challenge' approach to accountability and improvement. We will continue to grapple with the challenges of spreading learning across our broad and diverse organisation, and ensure we give voice to the everyday experiences of our patients and communities in accessing safe and effective care. We are realistic about the extent of the strategic and operational risks posed to quality, safety and experience and will maintain an open and rigorous approach to their management and scrutiny.

Further detail is provided below, and agendas, papers and minutes are available on the Health Board website: Quality, Safety and Experience Committee

❖ **Patient Stories**

During 2023/24 the Committee received the following patient and staff stories.

- **Staff Story (Emergency Department)- April 2023**
  The Committee received a staff story from a Senior Nurse at the Emergency Department in Glangwili Hospital detailing their experience of the Healthcare Inspectorate Wales (HIW) unannounced inspection of the department during December 2022 during a period of extreme pressures. An immediate assurance plan was submitted following receipt of the recommendations and the plan was progressed.

- **Patient Story (Dermatology Services)- June 2023**
  The Committee received a mother's experience of supporting her son through treatment and medication for a skin condition, and the psychological and physical impact of a delay in the referral to the Dermatology team and the approving of medication. A number of service improvement initiatives including cross pathway support, communication methods between services such as the Communication Hub and clinical teams and a revised processes have taken place.

- **Patient Story (Frailty)- October 2023**
  The Committee received a patient experience story from a son relaying his experience of his mother's admission and discharge from hospital following a fall which she experienced during the nighttime, noting his concerns regarding the standards of care provided for his mother and communication from staff prior to discharge. A thorough investigation has taken place in response.

❖ **Corporate Level Risk Register:**

A report was received to the Committee on a bi-monthly basis that informed the Committee of the corporate risks assigned to the committee.

❖ **Planning Objective Update Report and Progress on the Development of a Healthcare Acquired Infection (HCAI) Delivery Plan**

The Committee received bi-monthly updates on the progress of the HCAI Delivery Plan. The Health Board was escalated to enhanced monitoring by Welsh Government in September 2022 due to elevated C-Difficile (C-Diff) infection rates. Updates were provided throughout 2023/24 on the improvement actions underway and Members noted an improved cumulative position in February 2024, with results confirming lower case numbers than last year but not reaching the projected 20% reduction trajectory. *E.coli* rates across the Health Board continue to be a concern. This is being discussed on a wider scale with Public Health Wales to determine a course of action.

Interrogation of data confirms that the burden of infection is primarily community focused. The HCAI delivery plan has effectively reduced hospital acquired infection, now a wider collaborative approach with our colleagues outside of the Health Board is required to decrease these infections.

❖ **Quality Assurance Report**

A quality assurance report was presented to each Committee during 2023/24 which included progress updates on the following areas:

- External Inspections and Reviews Final Reports including Health Inspectorate Wales, Welsh Health Circulars and Ministerial Directives
- Patient Safety Walkabouts by Executive Leads and Independent Members
- Duty of Quality and Candour Reporting
- Enabling Quality Improvement in Practice (EQIiP) outcomes
- IPC / C-Diff Updates
- Nosocomial COVID-19 Review
- Impact of industrial action
- Quality Engagement Act (Wales)

❖ **COVID-19 Nosocomial Transmission Review Closure Report**

The Committee received regular updates on the development of the Covid-19 Nosocomial Transmission Review throughout 2023/24 with over 2000 patient case notes reviewed. The outcome of the review was shared with the Committee in February 2024 and assurance provided that the learning identified will be shared to ensure that improvements are undertaken to strengthen the operational quality governance.

❖ **Operational Quality, Safety and Experience Sub Committee**

The Committee received an update from the Sub Committee at each of its meetings during 2023/24 to enable escalation of key areas of concern and risks. A number of emerging themes were apparent through the update reports provided by Directorate leads during the year, such as relentless pressures on urgent and emergency care services, workforce and accommodation challenges which are being mitigated as far as possible across services. In February 2024, the Committee supported the need to strengthen the operational governance arrangements for the Sub Committee and for clinical executive input going forward.

❖ **The Listening and Learning Sub Committee**

The Committee received an update report from the Listening and Learning Sub Committee at each of its meetings in 2023/24. The meetings provide a Health Board wide forum for shared learning and scrutiny of concerns received by the Health Board via inquests, complaints, incidents and external reports. The Sub Committee also shared good practice and innovation opportunities.

- **Themes and Trends**

In terms of themes that have emanated from incidents and complaints reported to the Listening and Learning Sub Committee in 2023/24, it was apparent that communication was an area of required improvement with thematic concerns relating to attitude and behaviour of staff, communication with patients and communication between services. The Committee received a strategic improvement plan to address concerns raised and noted that developments in this regard will be monitored via the Listening and Learning Sub Committee agenda.

❖ **Deep Dives:** The Committee requested a deep dive report on the following service areas in 2023/24 in light of escalation of risks, fragility of services or temporary service changes:

- **Reinforced Autoclave Aerated Concrete (RAAC)Quality Impact Assessment:** In October 2023, the Committee received an update on the quality impact assessment for managing the clinical risks associated with the Internal Major Incident that was declared at Withybush Hospital due to RAAC. Members were advised that the RAAC Control Group has utilised the Health Board Risk Management Matrix to quantify risk, identify mitigation to inform strategic quality-driven decision-making and identify and assess the effect or

influence of a proposal on the quality and safety of the healthcare system. The Control Group identified actions to reduce risks where quality or safety could be negatively affected. The major incident has been an incredibly challenging process to work through for staff across multiple directorates and services have worked collaboratively and promptly to manage the risks associated with quality, safety and patient experience as best as possible. The Committee noted the immense work undertaken by staff and shared gratitude for their ongoing efforts to mitigate the risks for patients and staff. The Committee also discussed the positive work that had emanated from the urgent response work such as transforming urgent care pathways and patient admission avoidance work.

- **Initial Response to The Neonatal Findings Relating to the Thirwall Inquiry:** The Committee received an update on the Health Board's response to the Neonatal findings from the Thirwall Inquiry, highlighting that the amount of work undertaken in response to the well-publicised 'Lucy Letby' case has improved governance processes and has been co-produced by staff. The Committee were pleased to note the developments and strongly advocated the ongoing culture of openness, honesty and the prompt escalation of concerns.
- **Therapies Services:** In August 2023, the Committee received a Therapies Services waits and performance trajectory report which provided the current waiting times position across Therapies which are failing to meet the 14-week referral to treatment (RTT) Welsh Government targets. A further update was requested to clarify the impact on patient safety. Investigative work was undertaken by the newly appointed Director of Therapies and Health Sciences to further understand the current 14-week therapy RTT performance and the actions required to reduce the detrimental impact across the system and an action plan is scheduled to be presented to the Committee in April 2024.
- **Commissioning CAMHS Tier 4 Update:** In August 2023, the Committee received a report on the length of stay by Health Board young people accessing Tier 4 inpatient beds at Tŷ Llidiard, Princess of Wales Hospital, Bridgend in comparison with other Health Boards across Wales. Concern was raised at QSEC in June 2022 during a Welsh Health Specialised Services Committee (WHSCC) update report that the data presented suggested that Hywel Dda patients stay longer at the facility than patients from other Health Boards in Wales and the Committee enquired whether this was due to pathway challenges. Following this, the Directorate undertook to explore this further. The data shared suggested that the Health Board's admissions data is comparable to other Health Boards with a higher population number. The Committee were also pleased to note the recent development of a Crisis Hwb and Sanctuary Service, which is directed at proving alternatives to admission to hospital and reducing the need for onward referral and admission especially to the Tier 4 unit. The new development is funded by Welsh Government and opened on 3 July 2023.

- **Critical Care Service Arrangements, Prince Philip Hospital:** In August 2023, the Committee received an update position on the temporary changes at the Critical Care service provision at Prince Philip Hospital (PPH) position due to challenges in the anaesthetic rota. The Committee received assurance that the patient pathway and governance arrangements have appropriate mitigating actions and monitoring, and that patient safety is maintained. There had been no reported incidents or complaints relating to individual episodes of care, or reported to the Adult Critical Care Transfer Services colleagues supporting the transfer arrangements, despite the challenges faced in consultant anaesthetic recruitment.
- **Withybush Hospital Emergency Surgery:** In August 2023, the Committee received an update on the arrangements put in place in April 2023 regarding the Surgical on Call Rota at Withybush Hospital (WGH). The General Surgical Clinical team had been unable to sustain a 24/7 consultant on-call cover at due to staffing deficits. The Surgical consultants at Bronglais Hospital (BGH) and Glangwili Hospital (GGH) had agreed to take on the out-of-hours surgical responsibility for WGH patients on a planned rota basis.
- **Epilepsy in Learning Disabilities Review:** In June 2023, the Committee received an update on an external review of epilepsy services for people with learning disabilities that was commissioned due to service fragility. An external review was commissioned, led by Professor Rohit Shankar, Professor of Neuropsychiatry at the University of Plymouth Medical school. The aim of the review was to define the functions and roles for the management of epilepsy in line with NICE guidelines. The report was received with key findings and recommendations and the Committee received the management response and improvement plan in December 2023.
- **Health Visiting**: In June 2023, the Committee received an update on the Health Board's Health Visiting staffing position following workforce challenges which were escalated to the Committee due to chronic recruitment challenges particularly in Ceredigion and Pembrokeshire and the risks associated with the age profile of staff was highlighted. The Committee noted the fragility of the service despite the mitigations in place, including the establishment of weekend clinics.

❖ **The Health Board and Public Health Wales Tuberculosis (TB) Action Plan:** Following receipt of a formal complaint received by Public Health Wales and Hywel Dda University Health Board in relation to the handling of the ongoing outbreak of Tuberculosis (TB), an external review was jointly commissioned to identify lessons learned. The review panel's report was published in January 2023 and the Committee monitored the progress of the operational action plan at its meeting in June and August and in December 2023 noted that actions under the responsibility of the Health Board have now been completed.

❖ **Enabling Quality Improvement in Practice (EQIiP) Update:** In August 2023, the Committee received an overview of the Enabling Quality Improvement in Practice (EQIiP) improvement activities undertaken since 2018. The key highlights include the development of the Single Point of Contact Communication Hub, the Waiting

List Support Service, supporting the Transforming Urgent and Emergency Care programme and the Pelvic Health Improvement Programme. A summary document was shared which provided examples of patient experience, quality and financial benefits realisation of the EQIiP programmes to date. It was agreed that going forward the programmes would align quality improvement objectives 2023/24 with current areas of pressure and challenges that are being reported across the Health Board.

- **NHS Executive All Wales Review of Neurodevelopment and Psychology and Psychological Interventions for Children and Young People:** In December 2023, the Committee received the outcome report of the NHS Executive All Wales review of Neurodevelopment (ND) and Psychology and Psychological Interventions for children and young people. The Committee noted that the two reports provide 9 recommendations that are quite similar in themes. Two multi-disciplinary groups were established and working together to develop an action plan. The groups are being led jointly by Women and Children's Services and Mental Health and Learning Disabilities services and Therapies colleagues also form part of the multi-disciplinary team (MDT) meetings. The action plan progress will be reported at the Committee due to be held in April 2024.

- **Welsh Health Circular: 2023/036 Speaking up Safely Framework:** The Committee received an update on the Speaking up Safely Framework and the robust work undertaken to date, which has been seen as exemplary across Wales. Members noted the robust action plan and the inception of a task and finish group to progress and monitor actions and ongoing updates are shared via the Committee's Quality and Safety Assurance Report.

- **Effective Clinical Practice Advisory Panel:** In October 2023 and February 2024, the Committee received updates from the Effective Clinical Practice Advisory Panel which supports clinicians and healthcare professionals to examine and improve the quality of care, including assessment against local and national clinical effectiveness standards and monitoring and improving the outcomes for patients and service users.

  The Committee raised concern in respect of Interventions Not Normally Undertaken (INNU), whereby the Health Board may be in a position where it may be funding non-evidenced based procedures and not funding evidence-based procedures. A task and finish group has been established to develop a local response to national developments and consider the work already undertaken by the Academy of Royal Colleges.

- **Strategic Safeguarding Working Group:** In June and December 2023, the Committee received the key highlights from the Strategic Safeguarding Working Group meeting which provided an overview of Health Board safeguarding activity. As part of the update, in June 2023, the Committee received the Health Board's response to a report by the Women's Rights Network on concerns raised

regarding patients and staff being sexually assaulted and raped in UK hospitals between January 2019 and October 2022 which offered assurance on the steps being taken to ensure the safety of all staff and patients.

- **Medicines Management Operational Group (MMOG):** In October 2023 and February 2024, the Committee received an update from the MMOG. The purpose of MMOG is to ensure the delivery of safe, effective, evidence-based medicines management across the Health Board and to develop the strategy for medicines management focused on improving clinical outcomes, patient experience and reducing unwarranted clinical variation.

  In October 2023, the protocol for a pilot project on the single checking of injectable medications at Glangwili Hospital (GGH) was approved by the Group and the Committee was asked to note that the current Medicines Policy advocated double-checking for some injectable medicines. Assurance was sought that appropriate governance arrangements are in place to monitor the data and the Committee was advised that the pilot is being led by the Senior Nurse Medicines Management and a process has been agreed for how data and incidents will be flagged and reported to MMOG.

- **Nurse Staffing Levels (Wales) Act:** In August 2023 the Committee received the Nurse Staffing Levels (Wales) Act: Annual Report and noted changes to the nurse staffing levels following the Spring 2023 Nurse Staffing Calculation Cycle. Referring to the summary data within the report, there has been an overall decrease in percentage of wards where nurse-staffing levels have not been met however, an increase in adult inpatient wards.

- **Clinical Audit Reports:** In August and December 2023, the Committee received an update on clinical audit activity and demonstrated the impact these activities have had on quality and safety within the Health Board. Members noted that audit activity has increased considerably over the last year and the intent is to carry out more audits during 2024/25. Requests for audits are due to a number of reasons such as national mandates, professional interests, complaints andareas of identified risk. Re-audits are strongly encouraged and supported by the team.

- **Committee Self Assessment Report and Action Plan:** A refreshed and action-oriented approach to the Committee self-assessment process was developed in 2023 which was intended to be proportionate, achievable and add value to the organisation's governance capability. This included a facilitated workshop and a questionnaire circulated to Members to gather feedback on areas for improvement and reflect on good practice.

  A number of themes emerged when groups were asked to identify priorities for next 12 months including:

  - Outcomes focussed – papers need to be focussed on delivery, impact and outcomes using triangulated data to evidence system is working.
  - Patient voice – need to follow the patient journey through the pathway/system.

- Governance including operational governance – more effective quality governance at operational level.
- Clear purpose of reports.
- Multidisciplinary clinical leadership – Clinical Executive and widening to operational triumvirates.

These, along with similar feedback from other Committee self-assessments will be taken forward as part of the action plan and will feed into the Board Development Programme for 2024/25. In addition, a specific task and finish group has convened to set out a Behaviours Framework, aligned to the Health Board's Values and Behaviours Framework, which will seek to balance high support and high challenge and articulate what behaviours are expected.

- **Written Control Documents:** The following written control documents were presented and approved by the Committee in 2023/24:

  - The Quality, Safety and Experience Committee Terms of Reference (June 2023)
  - The Sub Committee and Operational Groups Terms of Reference
  - Management and Distribution of Safety Alerts and Notices Policy (June 2023)
  - Putting Things Right Policy (October 2023)
  - Being Open/Duty of Candour Guideline (October 2023)
  - Safer User Patient Access Policy (August 2023)
  - Arts in Health Charter (December 2023)