| ABM University<br>Health Board | |
|---|---|
| **Date of Meeting: 1st February 2018**<br>**Name of Meeting: Quality & Safety Committee**<br>**Agenda Item:10.1** | |
| ***Subject*** | *Healthcare Quality Division, Feedback Report* |
| **Prepared by** | Charlotte Higgins, Graduate Management Trainee, Corporate Nursing |
| **Approved by** | Cathy Dowling, Interim Deputy Director of Nursing and Patient Experience |
| **Presented by** | Cathy Dowling, Interim Deputy Director of Nursing and Patient Experience |

## 1. BACKGROUND

The purpose of this report is to provide the Committee with the Quality and Delivery Report prepared by the Welsh Government for the period of April – September 2017. The report includes a number of areas of data and intelligence which Welsh Government hold, including an overview of the wider all Wales position on quality and safety issues. Also included, is feedback from the Delivery Unit in relation to the assurance work being undertaken in collaboration with the Health Board in the management of never events.

## QUALITY AND SAFETY ISSUES

### 2.1 Serious Incidents (SI's)

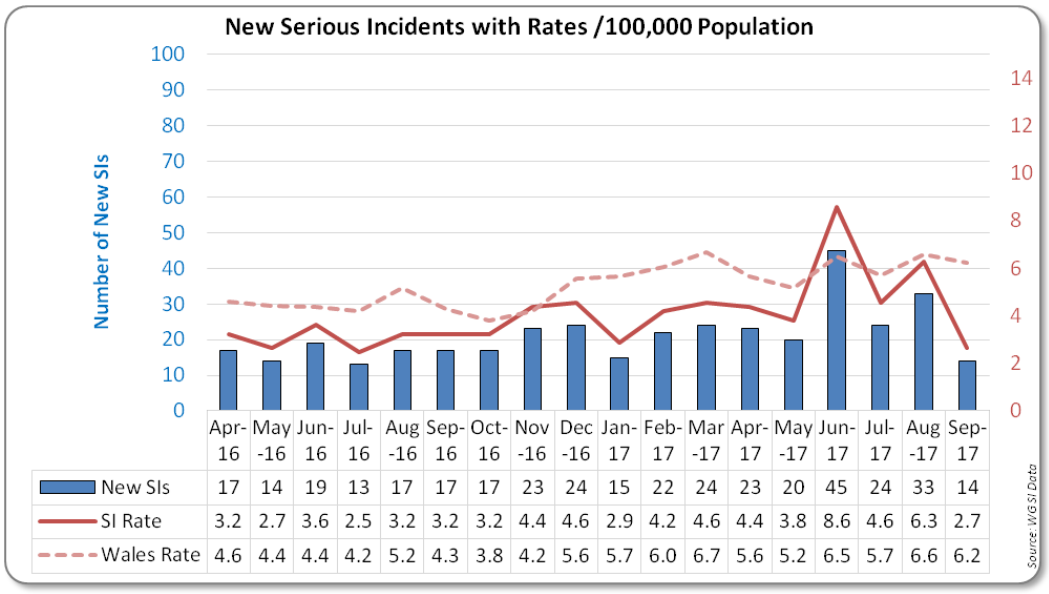
**Rate/timeliness/quality of reporting**

The report commented on the Health Board's rate, timeliness and quality of the reporting of SI's. The graph below states that during the reporting period, the Health Board reported a total of 159 SIs.

With the exception of June, the reporting rate for the Health Board has been below the all Wales rate.

An improvement in the timeliness of our reporting was noted by Welsh Government. The report also commented that the Health Board has dealt with requests for further information in a timely manner.

The Health Board has held a Serious Incident Workshop for Units to encourage SI reporting and promoted the reporting of all fracture neck of femur incidents and serious infection control incidents to be reported. The report highlighted a slight increase in the reporting of patient falls. However, it is considered as low reporting in comparison to the all Wales picture.




| | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| New SIs | 17 | 14 | 19 | 13 | 17 | 17 | 17 | 23 | 24 | 15 | 22 | 24 | 23 | 20 | 45 | 24 | 33 | 14 |
| SI Rate | 3.2 | 2.7 | 3.6 | 2.5 | 3.2 | 3.2 | 3.2 | 4.4 | 4.6 | 2.9 | 4.2 | 4.6 | 4.4 | 3.8 | 8.6 | 4.6 | 6.3 | 2.7 |
| Wales Rate | 4.6 | 4.4 | 4.4 | 4.2 | 5.2 | 4.3 | 3.8 | 4.2 | 5.6 | 5.7 | 6.0 | 6.7 | 5.6 | 5.2 | 6.5 | 5.7 | 6.6 | 6.2 |

## 2.2 Never Events

The Health Board reported one Never Event in this period (INC63532 9685 12SEPTEMBER17 - Wrong implant/prosthesis, which is the subject of an investigation). During this period 6 never events were reported across Wales, most of which are surgical related.

### Delivery Unit Summary

The report includes a summary from the Delivery Unit (DU) of their experience of working with the Health Board on the Never Event reported in this period as follows:

- The Health Board continues to work openly and constructively with the DU.
- Improvements to process are ongoing. The recently introduced Strategic Group is proving beneficial in enabling greater rigour, scrutiny and healthy challenge to the process of managing and learning from Never Events.
- Continued clear leadership and direction from the Executive Director of Nursing has been evident during this period in relation to the Never Event, as well as active involvement by the Medical Director senior managers and clinical staff.

- Terms of Reference were agreed during this period for the Delivery Unit's diagnostic intervention commencing in October. In agreeing these, the Health Board have continued to be open and co-operative during discussions with very good Executive engagement from all four clinical Executive Directors.

**The Delivery Unit identified areas for further improvement as follows:**

- Concerns had been raised in relation to the closure of mental health related serious incidents for which full investigations / reviews had not been completed – The closure forms were returned by Welsh Government. However, the Health Board has made a number of changes to its processes during this period since these forms were

submitted, including improvements to the scrutiny and sign-off process for serious incidents. The expected better outcomes from these changes should be evident during the next reporting period; and

- The need to further develop a more robust organisation-wide framework for learning and ensuring that there is evidence of improvements is an ongoing challenge for ABMU, the HB is working towards improvements.

### 2.4 Patient Safety Solutions (Alerts & Notices)

As of 30/10/2017 improvement in the overall compliance position with alerts and notices has been sustained. The Health Board was the only organisation in Wales to meet the deadline for reporting compliance *with* PSN034 Supporting the introduction of the National Safety Standards for Invasive Procedures.

An update on the present position in terms of compliance against Patient Safety Solutions is provided in Agenda Item 5.2 Patient Experience Report Page 27.

### 2.5 Public Services Ombudsman Reports (PSOW)

During April – September 2017 81 reports (section 21 and 16) have been received across the NHS in Wales of which nine related to ABMU Health Board.

Four of the nine reports were upheld/partly upheld with five not being upheld. One of the four upheld/partly upheld reports was in relation to the complaint handling process. Specifically, in this instance the compliant was upheld in regards to the quality of the investigation. The Health Board has established a Concerns, Redress & Assurance Group and undertakes a deep dive review into concerns responses to support the Unit's learning from their investigations and management to continually improve the quality of investigations and responses.

### 2.6 Regulation 28

The Coroner issued 1 Regulation 28 report to the Health Board during April – September 2017. This report was in relation to the non compliance with local and national guidelines regarding NEWS observations.

Across Wales 10 regulation 28 reports have been issued. They include a variety of subjects; however, the main theme which is included in a number of reports is in regards to patient handover/patient flow. There were also 2 reports where concerns regarding standards of care were raised.

### 2.7 Healthcare Inspectorate Wales (HIW) Inspections/assurance letters

HIW undertook one inspection during this period. The inspection did not result in an immediate assurance letter being issued. The report requested that on occasions where a letter is issued, the Health Board should continue to copy Welsh Government in to responses to HIW.

## 2. NEXT STEPS

The report requested that the Health Board:

- Provide assurance forms for the overdue SI's - **COMPLETED**
- Address the non-compliance with Patient Safety Solutions – **IMPROVED**

- Ensure complaints are dealt with in an appropriate and timely manner - **COMPLETED**

The Health Board since April 2017 has consistently achieved the Welsh Government target of submitting closure forms for 80% of SI's within 60 working days. This will continue to be a priority as well as ensuring the quality of the investigations and timely responses.

The Patient Safety Solutions are being proactively managed and this was recognised by Welsh Government during a Quality and Delivery meeting held in January 2018.

Timeliness of responding to complaints is a priority and the Health Board is achieving the 75% target of responding to complaints within 30 working days. However, the Health Board performance at 78% is below the Health Board's target of 80%.

## 3. RECOMMENDATIONS

The Quality & Safety Committee is asked to Note the report received by Welsh Government titled Appendix 1.

# HEALTHCARE QUALITY DIVISION
# ABERTAWE BRO MORGANNWG UHB FEEDBACK REPORT

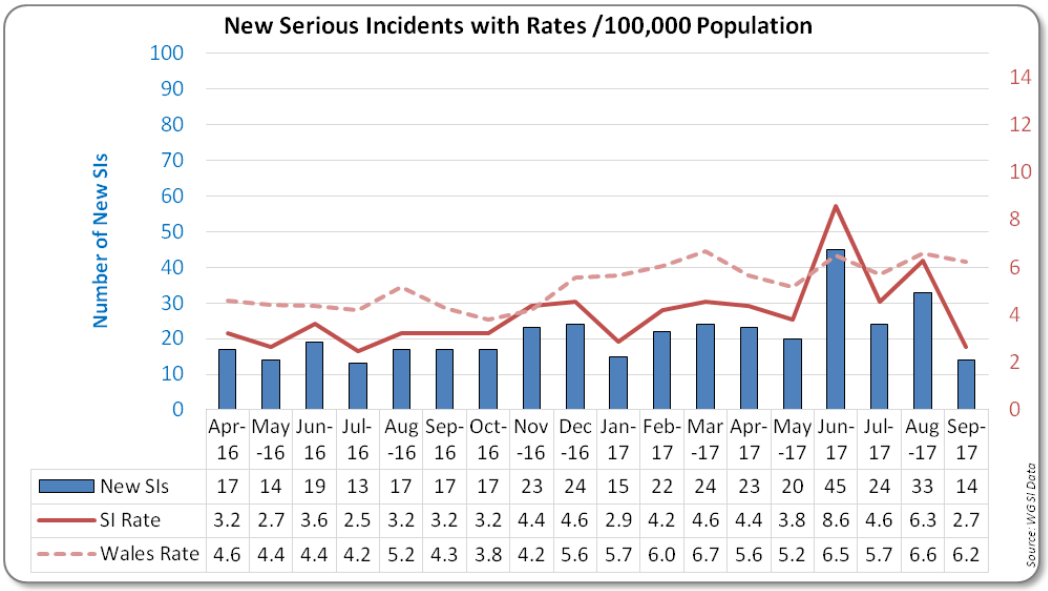
## Introduction

This edition of our feedback report is mainly based on the period April-September 2017. Where the data goes beyond this period, it will be indicated in the relevant section. As with previous reports the aim is to provide an overview of a number of areas of data and intelligence that we hold and provide an opportunity at set points during the year to reconcile the information we hold with that of the organisation to ensure a common understanding and agreed position. It attempts to give you an overview of the wider all Wales position to promote shared learning. Lastly it provides summary feedback from the Delivery Unit in relation to their work with you in seeking assurance of the management of never events.

## Serious Incidents (SIs)

### Rate/timeliness/quality of reporting

- The graph below shows your rate of reporting per 100,000 and how this compares to the Wales rate. During the reporting period your HB/Trust reported a total of 159 SIs. The SI reporting rate for your HB has been below, the all Wales rate other than the spike in reporting in June. It is noted that there has been an improvement in the timeliness of your reporting.
- A small number of reports have resulted in Welsh Government requesting further information. These requests have generally been dealt with in a timely manner.




| | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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| Wales Rate | 4.6 | 4.4 | 4.4 | 4.2 | 5.2 | 4.3 | 3.8 | 4.2 | 5.6 | 5.7 | 6.0 | 6.7 | 5.6 | 5.2 | 6.5 | 5.7 | 6.6 | 6.2 |

### Incident type

- The graphs below provide a summary of the All Wales top 10 categories of SIs and Never Events alongside the top 10 that your organisation reported. This is provided to give you an indication of how your reporting profile may differ against the All Wales picture (please note as this relates to a fixed top 10, not all categories are listed so the totals will not balance with the graph above).

- During this period we note a slight increase in the reporting of patient falls. This however, is still considered as low reporting in comparison to the all Wales picture.

# HEALTHCARE QUALITY DIVISION
# ABERTAWE BRO MORGANNWG UHB FEEDBACK REPORT

## All Wales


## Abertawe Bro Morgannwg UHB

# HEALTHCARE QUALITY DIVISION
# ABERTAWE BRO MORGANNWG UHB FEEDBACK REPORT

**Never Events**

- Your HB reported 1 Never Events in this period.
    - INC63532 9685 12SEPTEMBER17 - Wrong implant/prosthesis
- Across Wales we have had 6 never events reported during this period most of which are surgical related.

**All Wales position:**

| | Apr 17 | May 17 | Jun 17 | Jul 17 | Aug 17 | Sept 17 |
|---|---|---|---|---|---|---|
| Overdose of methotrexate for non-cancer treatment | 0 | 1 | 0 | 0 | 0 | 0 |
| Retained foreign object post-procedure | 0 | 0 | 0 | 0 | 1 | 1 |
| Wrong implant/prosthesis | 1 | 0 | 0 | 0 | 0 | 1 |
| Wrong site surgery | 0 | 0 | 0 | 1 | 0 | 0 |
| **Total** | **1** | **1** | **0** | **1** | **1** | **2** |

Colleagues from the Delivery Unit (DU) have provided a summary below of their experience of working with your organisation on Never Events reported in this period.

**Summary**

- The Health Board continues to work openly and constructively with the DU.
- Improvements to process are ongoing. The recently introduced Strategic Group is proving beneficial in enabling greater rigour, scrutiny and healthy challenge to the process of managing and learning from Never Events.
- Continued clear leadership and direction from the Executive Director of Nursing has been evident during this period in relation to the Never Event, as well as active involvement by the Medical Director senior managers and clinical staff.

- Terms of Reference were agreed during this period for the Delivery Unit's diagnostic intervention commencing in October. In agreeing these, the Health Board have continued to be open and co-operative during discussions with very good Executive engagement from all four clinical Executive Directors.

**Areas for further improvement**

- Concerns had been raised in relation to the closure of mental health related serious incidents for which full investigations / reviews had not been completed – the closure forms were returned by Welsh Government. However, the Health Board has made a number of changes to its processes during this period since these forms were submitted, including improvements to the scrutiny and sign-off process for serious incidents. The expected better outcomes from these changes should be evident during the next period.
- The need to further develop a more robust organisation-wide framework for learning from patient safety incidents and ensuring that there is evidence that

these result in improvements is an ongoing challenge for ABMU, the HB is working towards improvements.

**Open SIs which are overdue for assurance (closure)**

- As of 14 November 2017 your HB had 57 open SIs of which 15 are overdue.. If you are not in a position to close these SIs e.g. due to police investigation please provide us with an update.
- The table below provides an overview of the assurance (closure) forms which WG have received.

| Apr 2017 | May 2017 | June 2017 | July 2017 | Aug 2017 | Sept 2017 |
|---|---|---|---|---|---|
| 10 | 29 | 39 | 20 | 39 | 19 |

Of these a small number of assurance forms which your HB did submit have been returned to you requesting further information, these SIs will remain open until the queries are responded to satisfactory. As of 14 November 2017 these are:

INC-51291 884120APRIL17
INC-56189 910302JUNE17
INC-56129 910805JUNE17
792210NOVEMBER16
INC25594 857207MARCH17
DW-56453 472724MARCH14

## Patient Safety Solutions

Patient Safety Alerts & Notices:

As of 30/10/2017 improvement in the overall compliance position with Alerts and Notices has been sustained. In addition, the Welsh Government's previous six-month report highlighted concern at non-compliance with PSA002 - the prompt recognition and initiation of treatment for sepsis for all patients which was over two years overdue. The Health Board has now reported compliance with this Alert. The Health Board was also the only organisation in Wales to meet the deadline for reporting compliance *with* PSN034 Supporting the introduction of the National Safety Standards for Invasive Procedures.

The HB is not complaint with the following alerts:

1. PSA007 Restricted use of open systems for injectable medication
2. PSN030 The safe storage of medicines: Cupboards

## Public Services Ombudsman Reports (PSOW)

During the period covered by this report 81 reports (section 21 and 16) have been received across the NHS in Wales.

Of these there have been:

- 3 section 16 reports
- 45 upheld Section 21 reports
- 33 not upheld section 21 reports

In the last 6 month feedback report it was highlighted that complaint handling seemed to be a common trend in themes of reports across Wales. Of the 48 upheld section 21 and 16 reports 46% have a complaint handing issue within them showing a continuation of the trend.

The three top themes across Wales are:

- Delay in treatment/referral
- Care planning
- Complaint handling

During the reporting period of April – September 2017 a total of 9 reports were received in relation to your HB. 4 were upheld/partly upheld with 5 not being upheld.

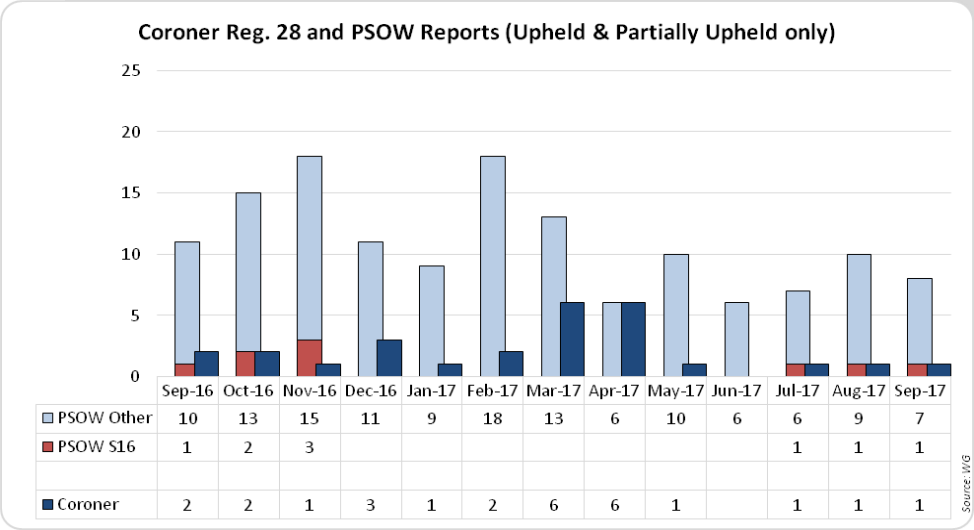
1 of the 4 upheld/partly upheld reports was in relation to the complaint handling process. Specifically, in this instance the compliant was upheld in regards to the quality of the investigation.

## Regulation 28

- We ask the Coroner to share with WG a copy of any health related regulation 28 reports. We review each one and where addressed to a HB or Trust expect to receive a copy of the NHS response.
- The graph below shows your number of reports and how this compares to the Wales picture. The Coroner issued 1 Regulation 28 report to your HB during this period. This report was in relation to the non compliance with local and national guidelines regarding NEWS observations. Across Wales 10 regulation 28 reports have been issued. They include a variety of subjects; however, the main theme which is included in a number of reports is in regards to patient handover/patient flow. There were also 2 reports where concerns regarding standards of care were raised.

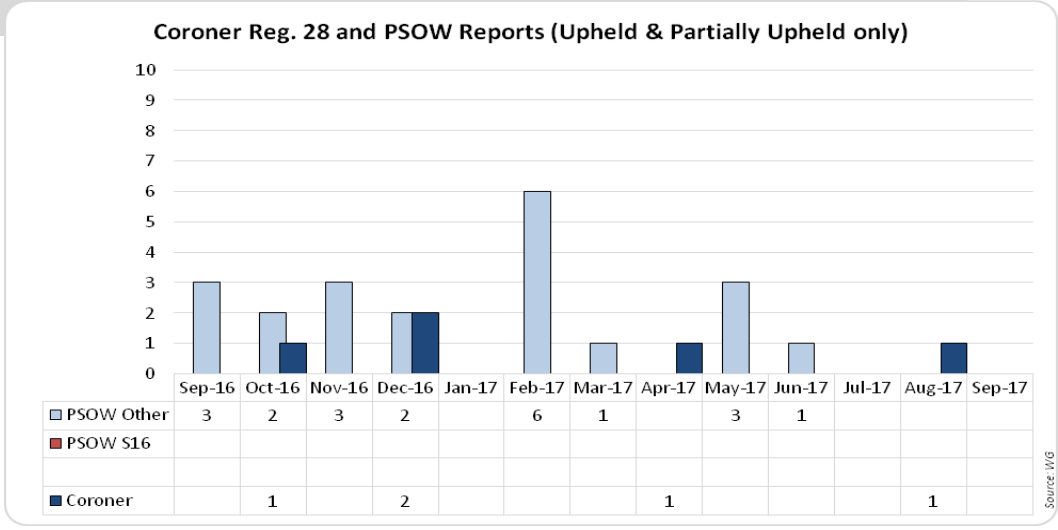
# HEALTHCARE QUALITY DIVISION
# ABERTAWE BRO MORGANNWG UHB FEEDBACK REPORT

## All Wales




| | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PSOW Other | 10 | 13 | 15 | 11 | 9 | 18 | 13 | 6 | 10 | 6 | 6 | 9 | 7 |
| PSOW S16 | 1 | 2 | 3 | | | | | | | | 1 | 1 | 1 |
| | | | | | | | | | | | | | |
| Coroner | 2 | 2 | 1 | 3 | 1 | 2 | 6 | 6 | 1 | | 1 | 1 | 1 |

## Abertawe Bro Morgannwg UHB




| | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PSOW Other | 3 | 2 | 3 | 2 | | 6 | 1 | | 3 | 1 | | | |
| PSOW S16 | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| Coroner | | 1 | | 2 | | | | 1 | | | | 1 | |

## Healthcare Inspectorate Wales (HIW) Inspections/assurance letters

- HIW inform WG of all inspection activity. Where an assurance letter is issued a copy is sent to WG. In responding to HIW, we ask that you share your response with us at the same time. This should include any immediate assurance letter issued to primary care within your HB areas.
- HIW has informed us that during this period they undertook 1 inspection. This inspection did not result in an immediate assurance letter being issued. On occasions where a letter is issued please can you continue to copy us in to your response to HIW.

## Next steps

We hope that you have found this report helpful. We ask that you:

- Address the outstanding queries regarding assurance (closure) forms returned.
- Provide assurance forms for the overdue SIs.
- Address the non-compliance with Patient Safety Solutions.
- Ensure complaints are dealt with in an appropriate and timely manner.

If there is anything we can do provide further support please contact the improvingpatientsafety@wales.gsi.gov.uk mailbox.

## Annex A – SIs open & Overdue as of September 2017

DW-56453 472724MARCH14

528411NOVEMBER14

INC40628 776806OCTOBER16

INC-40136 778410OCTOBER16

780014OCTOBER16

792210NOVEMBER16

INC44192 796922NOVEMBER16

INC-45244 806213DECEMBER16

INC25594 857207MARCH17

INC-51291 884120APRIL17

INC52490 903822MAY17

INC-56189 910302JUNE17

INC-56129 910805JUNE17

INC57708 924727JUNE17

INC58322 926128JUNE17

INC58017 926228JUNE17

INC57872 926628JUNE17

INC57893 927729JUNE17

INC-58395 928403JULY17

inc59607 9335 18JULY17

INC58180 9340 19JULY17

INC57998 9362 21JULY17

INC57850 9410 31JULY17

INC59508 9411 31JULY17

INC58912 9438 02AUGUST17

INC58321 9443 04AUGUST17

INC61034 9444 04AUGUST17

INC60961 9445 04AUGUST17

61085 9452 08AUGUST17

INC60583 9489 14AUGUST17

INC-61545 9502 16AUGUST17

INC-61095 9503 16AUGUST17

INC-61358 9504 16AUGUST17

INC61899 9507 16AUGUST17

INC59236 9508 16AUGUST17

INC61556 9509 16AUGUST17

INC61644 9515 18AUGUST17

INC60448 9516 18AUGUST17

INC-58098 9545 23AUGUST17

INC-60797 9546 23AUGUST17

INC-61024 9547 23AUGUST17

INC-61877 9548 23AUGUST17

inc57347 9557 24AUGUST17

INC59515 9558 24AUGUST17

INC60813 9559 24AUGUST17

INC60853 9563 24AUGUST17

9574 25AUGUST17

INC58297 9581 25AUGUST17

| | |
|---|---|
| INC60302 | 9582 25AUGUST17 |
| INC61878 | 9583 25AUGUST17 |
| INC62199 | 9584 25AUGUST17 |
| INC62172 | 9585 25AUGUST17 |
| INC61335 | 9586 25AUGUST17 |
| | 9590 29AUGUST17 |
| INC61894 | 9596 30AUGUST17 |
| INC61635 | 9606 30AUGUST17 |