HEALTHCARE QUALITY DIVISION
ABMUHB FEEDBACK REPORT

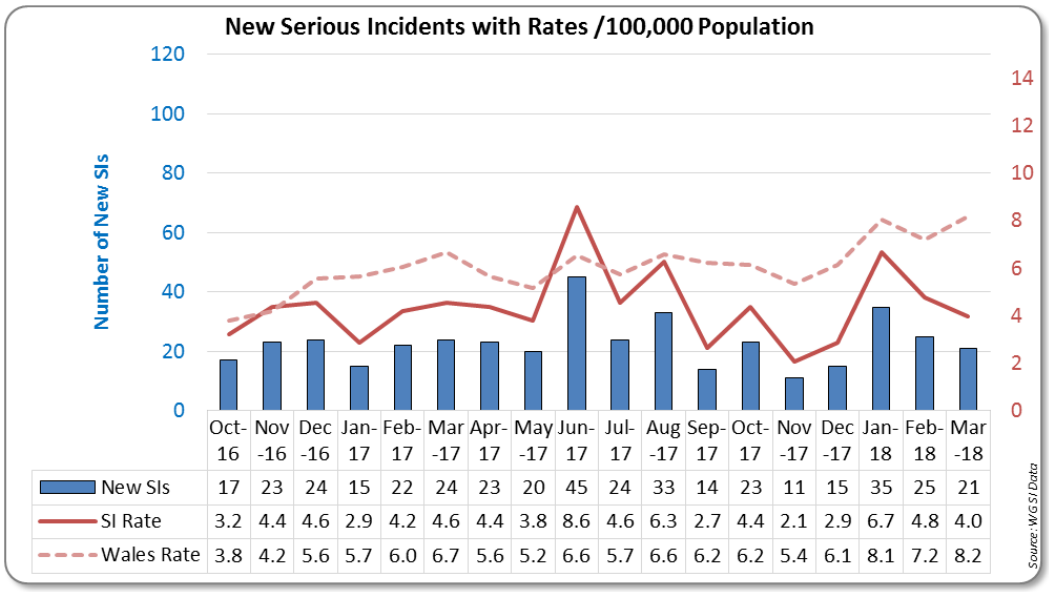
Introduction

You will see that this edition of our feedback report is mainly based on the period October 2017 – March 2018. Where the data goes beyond this period, it will be indicated in the section. The report aims to provide an overview of a number of areas of data and intelligence that the Healthcare Quality team holds and provides 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 reported a total of 106 SIs. The SI reporting rate for your HB is usually below the all Wales rate.
- Serious Incidents are generally reported in a timely manner or an explanation is provided when they are reported late.



	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
New SIs	17	23	24	15	22	24	23	20	45	24	33	14	23	11	15	35	25	21
SI Rate	3.2	4.4	4.6	2.9	4.2	4.6	4.4	3.8	8.6	4.6	6.3	2.7	4.4	2.1	2.9	6.7	4.8	4.0
Wales Rate	3.8	4.2	5.6	5.7	6.0	6.7	5.6	5.2	6.6	5.7	6.6	6.2	6.2	5.4	6.1	8.1	7.2	8.2

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).
- We note that there has been a total of 7 never events reported during this reporting period. **This accounts for nearly 50% of all never events reported**

across Wales. Please see the ‘Never Events’ section below for further comments.

HEALTHCARE QUALITY DIVISION
ABMUHB FEEDBACK REPORT

All Wales

ABMUHB

HEALTHCARE QUALITY DIVISION
ABMUHB FEEDBACK REPORT

Never Events

- Your HB reported 7 Never Events in this period which is of concern.
- Across Wales we have had 15 never events reported during this period.

All Wales position:

	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Wrong route administration of medication	**0**	0	0	0	1	1
Transfusion or transplantation of ABO-incompatible blood components or organs	1	0	0	0	0	0
Retained foreign object post-procedure	1	0	0	0	1	2
Wrong implant/prosthesis	0	1	1	1	1	0
Wrong site surgery	0	1	1	0	0	2
Total	**2**	**2**	**2**	**1**	**3**	**5**

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.

Abertawe Bro Morgannwg

DU Summary

The Health Board continues to work constructively with the DU. Throughout the period of the DU's diagnostic intervention, the Executive Directors and senior team reacted positively to findings where improvement was needed and they have been responsive in making changes to structures and approaches that promote learning. These now need to translate into greater evidence of organisational-wide learning and improved outcomes which show a reduction in the number of Never Events occurring, particularly relating to Trauma & Orthopaedics.

Areas for further improvement

- The HB continues to report a high number of Never Events. Whereas the reporting of incidents is a positive factor, the number of these avoidable events should significantly reduce as the HB makes improvements to safety systems particularly in theatres.
- The HB needs to strengthen its approach to ensuring that learning from incidents is spread across all of its six Units.

Never Events overdue for closure:

- Two NE investigations are still ongoing *968512SEP17 Wrong side humerus screws* (was due by 4.12.17) and *117301DEC17 Wrong site spinal surgery* (was due by 27.2.18).
- Revised action plan/s are still awaited for a further two which were previously *not assured*: *796922NOV16 Wrong prosthesis component, knee* and 806213DEC16 *Wrong side knee replacement*.

Other feedback

- The DU will continue to work with the HB to support implementation of improvements as part of its Quality & Safety intervention

Open SIs which are overdue for assurance (closure)

- As of 18 May 2018 your HB has 33 assurance (closures) forms overdue, these are listed at Annex A. If you are not in a position to close these SIs e.g. due to police investigation etc. please provide us with an update.

- There are a number of assurance forms which your HB did submit which have been returned to you requesting further information, these SIs will remain open until the queries are responded to satisfactory. **As of 30 April 2018** these are:

528411NOVEMBER14

792210NOVEMBER16

INC-51291 884120APRIL17

INC58321 9443 04AUGUST17

inc57347 9557 24AUGUST17

INC62411 & INC62414 9837 04OCTOBER17

INC67424 1151 27NOVEMBER17

INC-67704 1193 04DECEMBER17

HEALTHCARE QUALITY DIVISION
ABMUHB FEEDBACK REPORT

Patient Safety Solutions

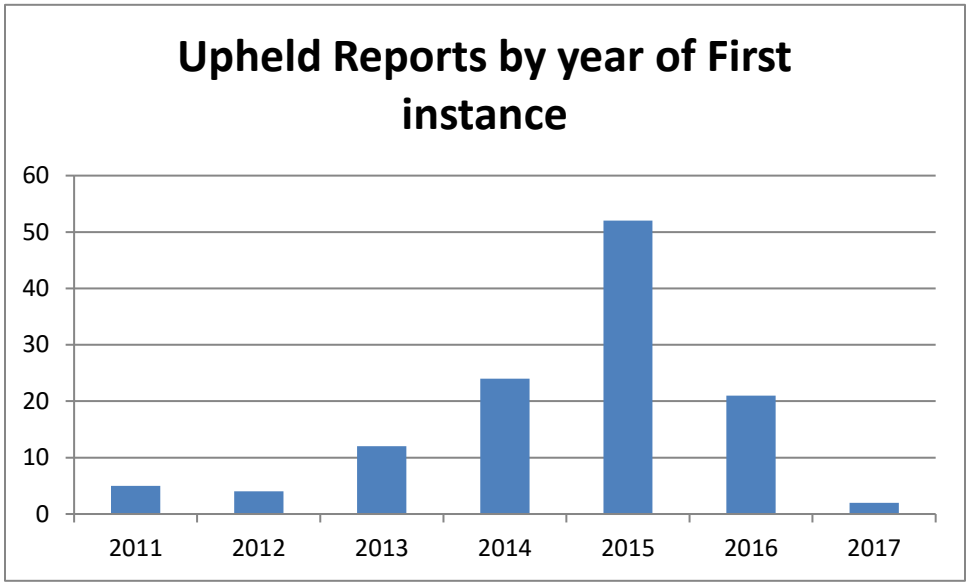
- As of 16 April 2018, you are not compliant with:
    - PSN 030 – The safe storage of medicines: Cupboards
    - PSA 007 – Restricted use of open systems for injectable medication
    - PSA 008 – Nasogastric tube misplacement: continuing risk of death and severe harm
- Your compliance position for Patient Safety Alerts and Notices has consistently been the best in Wales. Of the three which the HB is non-complaint with, two have associated national issues which are being addressed.
- Your HB needs to undertake further work to ensure it complies with the requirements of *PSA007 Restricted use of open systems for injectable medication*, which is 8 months overdue.

Public Services Ombudsman Reports (PSOW)

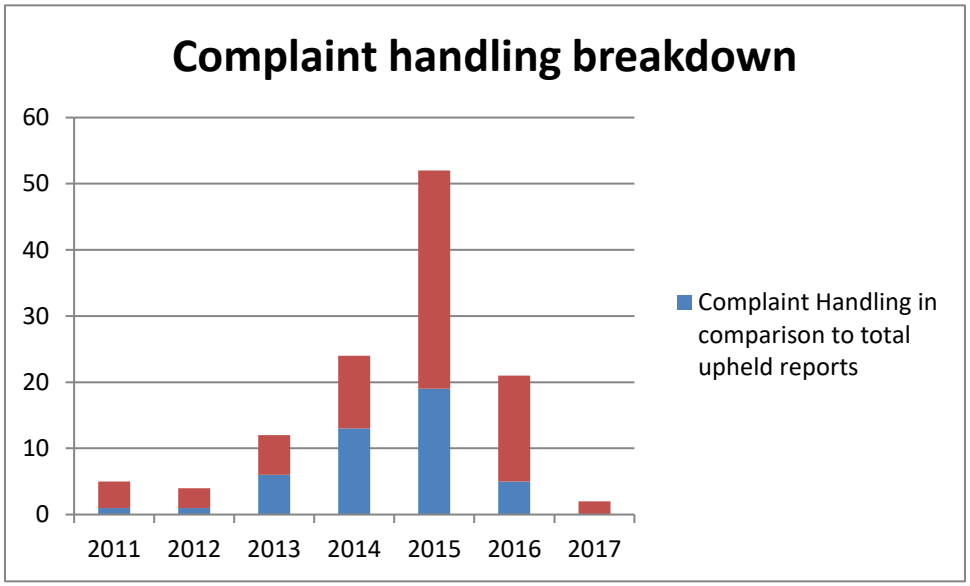
Please note that this is information covers the past 12 months. Future reports will include data for the relative period.

- The PSOW shares copies of all health related reports with WG. We review each case and if necessary will follow this up with the HB/Trust concerned.
- This year we received 192 reports from the PSOW, these were:
    - 4 Section 16 Reports
    - 117 upheld or partially upheld Section 21 reports
    - 71 Section 21 reports that were not upheld
- As concerns take some time to get to the Ombudsman, work has been done to contextualise the data to help identify areas for potential learning. We have looked at what the 'date of first contact' (that is when the concern occurred, and not when the concern was raised) is for each upheld/partially upheld report and have analysed those that date between 2011 and 2017.

- The chart below shows the breakdown of reports by 'year of first contact'.



- The graph below shows the number of reports each year that had a complaint handling aspect.



- As can be seen almost half of the reports in 2014 and over half of reports in 2013 had a complaint handling aspect. Across all years the main theme that comes through is 'delay in responding'.

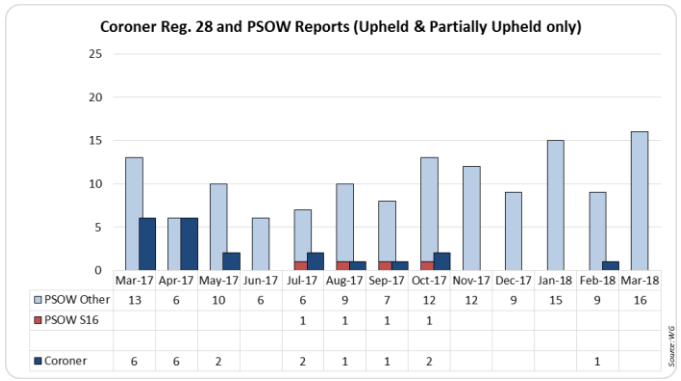
- 25 reports were received in relation to your HB which is a decrease from 2016-17 figures.
- Of there 25 reports, 15 were either upheld or partially upheld.
- The main themes of concerns raised are in regards to implementation of care, delays in treatment and the complaint handling process.

Regulation 28

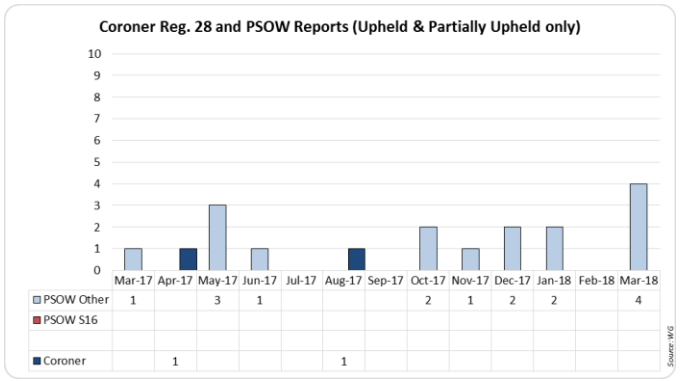
- We ask the Coroner to share with WG a copy of any health related regulation 28 reports. We review each one and where addressed to a HB or Trust expect to receive a copy of the NHS response.
- The graph below shows your number of reports and how this compares to the Wales picture. The Coroner did not issue any Regulation 28 reports to your HB during this period. Across Wales 3 regulation 28 reports have been issued.

HEALTHCARE QUALITY DIVISION
ABMUHB FEEDBACK REPORT

All Wales



ABMUHB



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.
- Between 1 October 2017 and 31 March 2018, HIW undertook 84 NHS inspections (19 at ABMUHB), which resulted in 12 immediate assurance letters being issued.
- In regards to your HB, there were 5 immediate assurance letters issued during this period. These were :
    - Singleton MIU – Hospital Inspection
    - Gwaun Cae Gurwen Dental Practice
    - The Channings – Dental Inspection
    - St Helen's Medical Centre – GP Inspection
    - Princess of Wales (surgical) – Hospital Inspection

Next steps

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

- Continue submitting high quality assurance forms.
- Address the outstanding queries regarding assurance (closure) forms returned.
- Provide assurance forms for the overdue SIs.
- Address the non-compliance [and/or] non-responses with Patient Safety Solutions.
- Ensure that we are copied into any responses to HIW following the issue of an immediate assurance letter

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

HEALTHCARE QUALITY DIVISION
ABMUHB FEEDBACK REPORT

Annex A – SIs overdue as of 18 May 2018

INC44192	**796922NOVEMBER16**
INC-45244	**806213DECEMBER16**
INC57708	**924727JUNE17**
INC58912	**9438 02AUGUST17**
	9574 25AUGUST17
	9590 29AUGUST17
INC61635	**9606 30AUGUST17**
INC63532	**9685 12SEPTEMBER17**
INC-63289	**9713 15SEPTEMBER17**
INC-63169	**9714 15 SEPTEMBER17**
INC-62866	**9725 18SEPTEMBER17**
INC-61879	**9758 21SEPTEMBER17**
INC-63001	**9759 21SEPTEMBER17**
INC64291	**9923 18OCTOBER17**
INC66117	**9958 25OCTOBER17**
INC60186	**9960 25OCTOBER17**
INC65641	**1012 02NOVEMBER17**
INC67461	**1078 14NOVEMBER17**
INC66602	**1095 17NOVEMBER17**
INC-69524	**1173 01DECEMBER17**
	1242 14DECEMBER17
INC-70499	**1250 14DECEMBER17**
INC70305	**1333 21DECEMBER17**

HEALTHCARE QUALITY DIVISION
ABMUHB FEEDBACK REPORT

INC69666 1454 11JANUARY18

INC71221 1455 11JANUARY18

INC72679 148215JANUARY18

INC72204 1499 17JANUARY18

INC72784 1500 17JANUARY18

INC72784 1501 17JANUARY18

INC72142 1506 17JANUARY18

INC73072 151818JANAURY18

INC73119 152019JANUARY18

INC71651 153022JANUARY18