90-day Review Report

Summarising progress against the recommendations of the
Intervention into Systems & Processes for the Management of Serious Incidents at
Abertawe Bro Morgannwg
University Health Board

FINAL

November 2018

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Introduction

Background

In April 2018 the Delivery Unit (DU) issued their report *Intervention into Systems & Processes for the Management of Serious Incidents at Abertawe Bro Morgannwg University Local Health Board* ('the intervention'*)*. As well as recognising areas of good practice, the report made ten recommendations for improvement. This paper reports on the findings of the 90-day review ('the review') of progress against those recommendations.

Methodology

The following approach was used to test the strength and effectiveness of the Health Board's (HB) response:

- Review of the action plan developed by the HB to deliver change following the intervention.
- Desktop review of documents provided by the HB as evidence of action taken, including meeting minutes, training plans, revised policies and procedures, risk registers and investigation reports.
- Semi-structured interviews with selected Executive and Independent members of the Board, Unit Directors, corporate and clinical staff, many of whom had engaged in the original diagnostic intervention.
- Never Events & Serious Incidents. Trend analysis as well as the quality of investigations reports and action plans and whether these resulted in system based sustainable change were used as a measure of improvement.

Executive Summary

The HB has developed a detailed improvement plan to take forward the intervention's recommendations; progress is monitored via their Quality & Safety Committee. The impact of improvements to processes, sharing learning, and improving culture will take time to become embedded, however, there are emerging signs of overall improvement. Areas of risk were also identified during the review, largely issues previously identified which need greater urgency to address.

Progress, most notably:

- *Quality of investigation reports.* Significant improvements have been made to the process of Serious Incident (SI) investigation undertaken by the corporate team.
- *Scrutiny.* The scrutiny applied to investigation findings is more robust. Five investigation reports submitted for DU assurance were assessed – they were thoroughly undertaken, with SMART (specific, measurable, achievable, realistic, time-bound) action plans to improve systems.
- *Sharing Learning***.** Systems and processes to share learning have improved and there is greater sharing of learning across sites. This needs further and ongoing action.
- *Never Event (NE) position.* The HB is now in its eighth month since the last NE report, with none in Morriston Hospital - where concerns initially triggered the DU's intervention identified - for fourteen months.

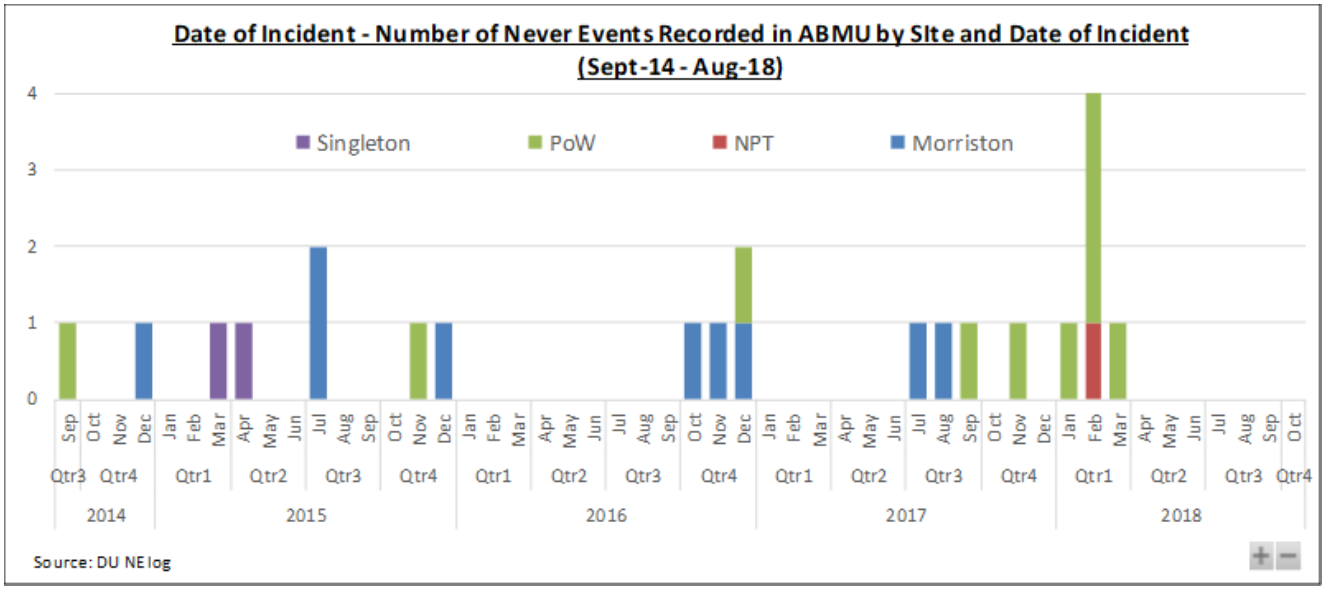
Risks, most notably:

- *Serious Incident (SI) investigations* within the Mental Health & Learning Disabilities (MH&LD) Unit do not undergo robust investigation using recognised methodology.
- *Morriston Theatres for Trauma and Orthopaedics (T&O).* Workforce difficulties are resulting in increasing numbers of patient complaints due to delays in accessing surgery and multiple cancellations.
- *Princess of Wales Hospital.* Issues relating the boundary changes are causing increased pressures, as is the loss of some key staff.

Review findings

Highlights, risks and exceptions from the findings of the review are reported here against the ten recommendations from the intervention report, and within the four aspects of the original Terms of Reference.

The improvement in the number of NE occurrences is shown in the following table:



Comment:

Morriston. After the cluster of T&O/theatres related NEs in 2016/17, the HB undertook improvement work to address a number of risks. The NE position has improved - from five reported in 2016/17 to none in the last fourteen months.

Princess of Wales – reported seven NEs during 2017/18, mostly relating to theatres, but none have been reported in the last seven months.

1. Identification of the quality & safety arrangements across the HB in relation to the management of SIs and how these provide the Board with assurance.

Recommendation 1. To make certain that patient safety is central to the HB's business, the entire Board membership should ensure that learning from Concerns and the understanding of potential risks are used to inform priorities and drive change. This should include:

- review of the Board assurance structures relating to quality & safety matters, strengthening the HB's approach to scrutiny and challenge;
- review of the membership of the Quality & Safety Committee, with a view to enabling a more integrated and holistic approach to quality & safety issues;
- establishing clearer pathways for how learning from SIs is shared, in particular clarifying the roles of the Assurance & Learning Group and Quality & Safety Forum in this regard;
- a strengthened approach to ensuring connectivity between Board members and operational clinical staff;
- standardised reports and templates, including reporting by exception;
- increased triangulation of information and data relating to risk, quality & safety and performance.

Board development. At the time of the intervention the Health Board were in the process of appointing new Board members. Executive posts now filled include the Chief Executive Officer, Director of Nursing & Patient Experience, Medical Director, Board Secretary, Chief

Operating Officer (COO), Director of Workforce & Organisational Development (WF&OD), and Board Secretary. Several new Independent Members have also been appointed.

To support Board development a bespoke and comprehensive programme is being delivered by the King's Fund, focusing on three areas:

- the Board and its function as a whole;
- Executive team development;
- a programme enabling Executive and Unit leaders and their teams to make strong connections and to deliver effectively as a collective.

Assurance structure. The Board assurance structure has been reviewed:

- The role of the two key groups responsible for organisational learning has been revised – the Quality & Safety (Q&S) Forum has become the Q&S Committee's operational group and it also has a clear role to influence the development of the Integrated Medium Term Plan (IMTP) both in terms of general content and priorities.
- A Risk Management Group has been established, responsible for the management of organisational risk, which reports to the Audit Committee.
- New Executive / Unit Director groups have been established to support better cross-Unit working and improve connectivity between the Executive Team and the Unit Directors. The aim is that this reinforces the approach that they are one organisation, and fosters a culture of togetherness, ownership & understanding.

Quality of meetings & information governance. At the Q&S Forum meeting attended by the DU, there were notable improvements in the attendance and quality of the meeting, there was good discussion and valuable contributions were made by the Unit Nurse Directors who ensured a strong patient focus. However, given its important role in the assurance structure, *this meeting needs to further mature and operate with greater rigor to ensure it fulfils its function.* Observed examples requiring a strengthened approach include:

- One of the Unit Nurse Directors at the Forum highlighted significant risks experienced at Morrison Hospital after recently managing an infection outbreak in an overcrowded ward, and urgently requested a HB-wide decision to agree criteria for putting beds in the middle of wards. This important issue was not reported at the subsequent Q&S Committee and it was unclear how it would be taken forward – the minutes did not reflect action needed.
- Not all Units were represented by a Unit Director, which affected the quality of discussion and weakened its ability to discharge its function.
- A number of reports were provided verbally rather than written.

The Q&S Committee was also observed. Changes to the membership and the plans to improve will take time to embed, and the meeting clearly missed the knowledge and experience of a substantively appointed Medical Director. Findings were mixed:

- There was good discussion and guidance from the Executive Director of Nursing relating to reporting arrangements for Safeguarding with agreement to review the report format so that it delivered assurance rather than resulting in more questions.
- The SI and NE report was more detailed and robust and clearly articulated what the learning was and where it had been shared.

- There was, however, limited analysis of papers and discussion of issues or scrutiny.
- The reports remained too long and apart from the dashboard they did not highlight risks or areas requiring discussion or decisions.

Overall, the Committee needs to be more proactive in setting the agenda and holding senior managers to account through rigorous scrutiny and follow-up.

Scrutiny and challenge. There was some evidence of improvement in the level and robustness of scrutiny and challenge relating to SI findings and action plans in the meetings observed. This had previously been found to be weak both at Board level and within many Units – *it is important therefore that this approach continues to be strengthened and is applied consistently across all Units, driven and overseen by the Q&S Committee.*

Performance focus. Good practice was observed at Morriston Unit's Q&S meeting where patient care was clearly central to the agenda. However this was not universal in all HB meetings observed – despite this being the intended aim for all meetings, many lacked structure and focus. Therefore, following intervention findings where there was a dominant focus on activity and performance targets as measures of success rather than on patient outcomes, *further improvements are needed to ensure that this focus on patients is embedded and consistent across all meetings in all Units and within all reports.*

Membership & attendance. The membership of the Q&S Committee has been revised. The Director of Workforce and Organisational Development (WF&OD) and the Chief Operating Officer (COO) are now committed to attending. Board members are better sighted on SIs but *further work needs to be undertaken to ensure that all the information required by the Committee is provided and that the information is at the right level of detail to provide robust assurance.*

Quality of meeting/committee reports. New reporting templates have been introduced and the Executive Director of Nursing is leading on the development of a Ward to Board dashboard to capture core quality ("essential care") indicators. As well as assisting reporting, the tool will enable ward managers to review their data and monitor trends.

Unit reporting to Q&S Committee. The intervention found that the Q&S Committee only considered one report each year from each Unit, which resulted in a lack of Board level oversight of ongoing Unit issues for most of the year. As part of the review, the DU were informed of plans for each Unit to provide monthly reports to the Committee by exception, but this was not yet in place. The Chair of the Committee reported that she had been waiting over six months for this change. Notwithstanding the benefits of the new Exec/Unit meetings described, *the Health Board should ensure that the formal reporting structures from the Units to the Committee are strengthened.*

2. The senior management teams in the six operational Units' collective governance, and the structures and processes that underpin the management and investigation of SIs.

Recommendation 2. The organisation's framework for managing Serious Incidents should be reviewed and strengthened with a view to ensuring consistency of approach and quality across the HB. Particular consideration should be given to ensuring that:

- roles and responsibilities of corporate and Unit staff in investigations are clear;
- criteria for determining which incidents meet WG SI criteria, and ownership of that investigation, are clear;
- the Mental Health & Learning Disability Unit's methodologies and processes for investigating and assuring SIs should be consistent with the HB's SI processes, and should involve other services where appropriate;
- evaluating and rolling out areas of good practice seen across the HB e.g. the Reflective Learning process currently being piloted, and the 'Learning Events' held by the Neath Port Talbot and Primary Care & Community Units;
- reviewing terminology used for grading harm to ensure consistency with PTR

Quality of investigations. The Health Board's corporate team has made significant improvements in the process of investigation, in engaging staff, and in agreeing system-wide changes that minimise the risks of recurrence of NEs. This is evidenced by DU review of five investigation reports submitted for assurance – they were thoroughly undertaken and the action plans were very comprehensive. These were clearly of a higher standard than those submitted by the HB during the previous year when 3 NEs were 'not assured' by the DU. It should be noted however, that not all SI investigations are led by the corporate team, and that *these improvements need to be spread and embedded for all SI investigations.*

Role clarity. The evidence confirmed updated and newly developed documents which robustly describe revised processes which have been approved through the appropriate Board assurance structures. The HB's Standard Operating Procedure for managing SIs has been reviewed; a flowchart describes the approach – it is clear, simple to understand and provides an easy reference guide for staff.

Mental Health Unit & Learning Disabilities Unit SI investigations. The DU observed good scrutiny of SI reports by the Unit Directors at the multidisciplinary Sentinel Incident Group (SIG) whose remit it is to review investigations into confirmed and suspected suicides. The Unit Nurse Director is now a member, which is an improvement and evidently added value. However, prior to being reported to the group, incidents did not undergo the appropriate level of investigation using recognised methodology, rather, they were subjected to clinical (medical) review by junior doctors. Evidence of proactive medical Consultant involvement, although part of the agreed 'process', was lacking during the review and during the SIG meeting where junior doctors presented the findings of their own reviews. The reviews were too focused on the sequences of events and missed opportunities for analysis and learning. There was also no involvement of family or friends in the investigation.

Evidence of the inclusion of related services and/or other agencies in these reviews was also lacking. *The MH&LD Unit has a plan in place to address the issues but until implemented this remains an area of high risk for the Health Board which needs to be addressed with pace.* The Unit has an extensive Quality Improvement programme in place, which is referenced under Section 4.

Princess of Wales Hospital Unit. Two key staff have been lost from this Unit – the Medical Director and the Head of Quality & Safety. Despite some joint working with Cwm Taf University Health Board during this boundary change transition period, it was clear that the impact of the additional work and the absence of these key posts is impacting on clinical governance and placing considerable additional strain on the remaining management staff. Observation of the Unit's Q&S meeting evidenced little progress since the intervention:

- Standard of reports. Reports still contained embedded documents; there was no written report from the Emergency Care department; the Medicines Management report was not circulated in advance of the meeting; metrics were not being used.
- Inappropriate harm categorisation. The Maternity report recorded three incidents as 'negligible' harm (this HB's 'additional' category). However, narrative details indicated that these resulted in actual harm, including bruising from a diathermy pad. No 'Near miss' categories were included.
- Action Plans. There were some good examples of a more robust approach which had been taken through the Falls Group, and NE's reflected better quality Action Plans. However, some documents were presented for scrutiny in isolation, not attached to the investigation report and with no incident overview or summary findings. This made it impossible to scrutinise and test whether it was fit for purpose. Patient's names were also included in the titles of some. Some actions were weak, for example, an action plan following a missed fracture stated that the "surgeon has been reminded" and that there had been "discussion with clinicians" but there was no evidence of systems being reviewed or changed.

Methodology for investigating SIs. Good progress has been made in this area. Formal evaluation of the Reflective Learning pilot is still pending, but there are strong indicators of its success and it therefore being rolled out for use with all SIs. Further detail has been covered within Section 1 of this report.

Definitions of harm. The DU review found that the HB's Datix system has **six** harm grades which is not consistent with the **five** harm grades described in PTR and used by the National Reporting and Learning System (NRLS). The HB's additional category "negligible" adds unnecessary confusion for staff reporting incidents and impacts on the HB's reporting profile. Examples were seen where incidents that had caused harm to patients were wrongly graded as "negligible". *The HB has made no progress in removing this category and now needs to address this as a matter of urgency.*

Recommendation 3. The organisation should review and strengthen its provision of training and support for staff involved in SI investigation, from leading and being involved in the investigation process through to quality assurance and scrutiny of reports and action plans. This should include:

- ensuring sufficient resources are made available to meet the organisation's needs in relation to SI investigations in line with PTR
- undertaking a Training Needs Analysis covering all roles involved in SI investigations, based on a core competency framework. This analysis should be used to develop suitable targeted training and mentoring programmes for staff as part of an organisational learning strategy
- risk assessing the reduction of clinical audit sessions or other protected time for staff training and development

Resources to undertake investigations. A restructuring of the Patient Experience, Risk & Legal Services department has been completed and the corporate SI team have secured a new post which will focus on promoting learning and ensuring consistent approaches to investigations and learning across the HB. Part of the role will focus on training and equipping Unit staff to investigate SIs to a consistently high standard. The corporate team have also introduced a 'buddying system' whereby their expert investigators work alongside less experienced Unit investigation leads while they develop their proficiency.

Reduction in clinical audit sessions. The intervention report highlighted that the HB should undertake a robust assessment of the impact on staff following a reduction in clinical audit sessions. The matter was raised at the Quality Forum at which the DU were present and the interim Medical Director reported he planned to survey Consultants but this was yet to be undertaken. Because this is one of the vehicles for sharing learning within specialties across sites and the effect of the reduction is still being described by clinicians as detrimental, the DU advises that the new Medical Director *should urgently review the situation, alongside other WF&OD and clinical Exec colleagues to ensure that there are sufficient opportunities for protected learning time of this kind to contribute to professional development and organisational safety.*

Recommendation 4. The HB should ensure that staff involved in an SI are sufficiently supported and involved at all stages of the management of the incident. This should include involvement in the investigation through to development of solutions.

Recommendation 5. The HB should strengthen how action plans from SIs are developed, with a view to ensuring that plans:

- are created in a timely manner;
- are developed with appropriate engagement of staff involved in the incident and services which are affected by the incident; and
- focus on delivering long-term solutions rather than short-term fixes.

Recommendation 6. The HB should review and strengthen its approach to quality assurance and monitoring through more robust scrutiny and challenge of SI investigations, reports and action plans to include:

- Unit and Corporate Quality & Safety meetings
- HB-wide groups including HAPUs, in-patient falls
- processes for formal sign off of completed SIs

New Reflective Learning process. The HB's new process of investigation which engages staff in guided Reflective Learning is starting to improve the safety culture where this methodology has been applied. Feedback from staff is universally positive and a digitally recorded Staff Story captures the impact of the approach on one of the Ophthalmic Consultant Surgeons. The account evidenced the positive impact this had on improving patient safety in the department following an NE, through changes to systems as a result of involving staff in more supportive process of investigations, and importantly in developing solutions together. The process was initially introduced for NE investigations - *the emphasis now needs to be on spreading this approach for use with all SIs within a defined timeframe to ensure appropriate pace.*

Informing, involving and supporting staff in investigations following SIs. The roll-out process for the Reflective Learning investigations is in its early days and its progress has been slowed by staffing constraints now being addressed. In the meantime, the HB must take steps to ensure that staff involved in investigations under the 'old' process are more supported, involved and informed. Staff engagement demonstrated little improvement in this area and this *continues to constitute a threat to effective learning and outstanding risks that learning does not result in meaningful change.*

Action Planning. The quality of the Action Plans developed by the HB following NEs has improved. It is vital, however, that this more rigorous approach is applied consistently to all SIs in all Units. The corporate team now use the DU Assurance Checklist to test the robustness of plans; *the HB should consider incorporating this tool into HB processes and ensuring it is used universally to support consistent high standards.*

3. The risk management processes in place to ensure that risks to patient safety are minimised.

Recommendation 7. The HB should ensure more consistent and effective use of risk information and processes to articulate and communicate risks, manage risks and ensure clear and appropriate escalation pathways are in place and adhered to. This should include greater use of the HB's risk register and associated processes.

Work is well underway to develop an accurate organisational risk register, and there are some positive early signs of improvement to the reporting of risk at Unit level. However, there *remains an absence of sufficient information on risk within reports* and there was some misunderstanding that risk register information was now reported to the corporate Risk

Management Group rather than included in Unit reports as an integral element of safe high quality care.

Risk management and escalation. The intervention found that despite having documented risk management and escalation processes in place, in practice these were not always operating effectively. Under section 1 of this report an example was provided where infection risks as a result of ward overcrowding at Morriston were highlighted and a request made for an urgent HB-wide decision on placing additional beds in the centre of wards. There was no documented evidence that this was addressed - robust action to mitigate the risk was not agreed, neither was the issue formally escalated. *It is vital that formal groups are clear of their roles and responsibility in recognising and addressing risks, and that they are meticulous in taking action to manage these within their remit or to escalate as appropriate*.

Recommendation 8. Further work is required to address risks concerning the safety culture within Morriston Unit's theatres and the interface with the Trauma & Orthopaedics department. The work should include OD approaches and cross professional boundaries ensuring a whole system approach involving all staff.

The safety culture in Morriston theatres was found to be of concern during the intervention work. Positive findings during the 90-day review included:

- The Unit Quality & Safety Group was observed to be well-managed, robustly executed and had excellent attendance from a range of senior management and clinical staff.
- The Unit have not reported any NEs since August 2017, when four had been reported during the previous year, with recurrent themes. Staff have confirmed some changes to systems, such as removing screws from operating trays to minimise the risk of errors relating to size selection.
- A new Senior Theatre Matron has been appointed who is experienced and motivated.

However, there remain considerable challenges and staffing issues particularly within T&O, some of which have worsened since the theatre restructure. An internal theatres report highlights that a lack of orthopaedic scrub staff at Morriston is affecting patient experience for both elective and unscheduled care patients. It also sites this as being the main contributor to Referral to Treatment (RTT) underperformance at Morriston; the main issues of concern being:

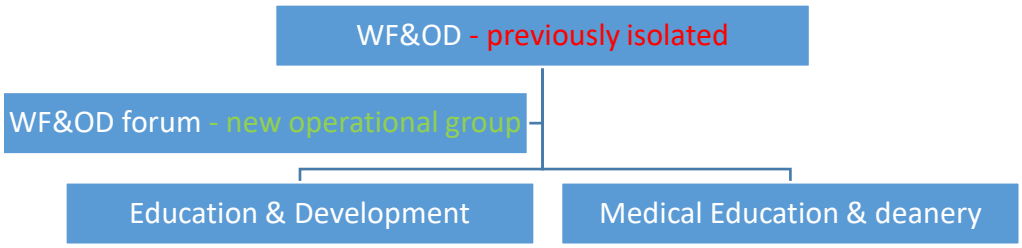
- Considerable staff sickness, retirement, loss of experienced staff to a neighbouring HB, and difficulty in recruiting to the arthroplasty and spinal areas specialities. This has occurred at a time when the patient cohort size has continued to increase for Morriston orthopaedics.
- There are increasing numbers of patient complaints within this specialty – themes relate to delays in accessing surgery and multiple cancellations. The cancellation rate in Quarter 1 for orthopaedics was over 50%, with lack of theatre staff being a major contributory factor.

There is a plan in place, some additional funding has been secured, and a wide range of options are being considered to improve matters, however, *the risks remain significant and the HB will need to continue to address the issues corporately as well as at Unit level.*

4. The systems and processes in place, including monitoring, to ensure that there is learning and improvement from SIs that results in organisational wide sustained improvements in patient safety and quality of care.

Recommendation 9. The HB should develop an organisational learning strategy. The strategy should clearly demonstrate how the learning from Concerns is disseminated across the organisation and how the Board assures itself that actions are implemented to completion and are being sustained.

Strategic approach. The development of a strategy for integrating organisational learning into professional development is a work in progress, being led by the newly appointed Executive Director of WF&OD. Prior to the DU's intervention report, there was no real connection between Q&S and WF&OD but the HB plan to improve this through the newly established WF&OD Forum, of which Medical Education will be a sub-group.



The Executive Director of Nursing – newly appointed and the third Director of Nursing in post since the start of the Q&S Intervention nine months previously – also outlined strategic plans to develop a multidisciplinary *Safety Academy*, working alongside Swansea University, and the development of *Safety Ambassador* roles throughout all departments.

Sharing lessons across Units. Operationally, the HB have introduced new ways of sharing learning, for example:

- Seven-minute safety briefings - a new briefing process developed to support post incident learning. The standard template document is populated for each SI - it allows for clear articulation of the issues, the learning points, and where it is being shared. This provides a good template to ensure consistency for all critical learning events.
- Learning Roadshows being held across different Units. The first took place in the Princess of Wales Hospital in October, where clinicians presented and discussed issues. Six weeks' notice was been given to enable clinical staff from that and other Units to attend.

Recommendation 10. The HB should review and strengthen its approaches to corporate support:

- Business Intelligence information, to enable accurate and intelligent data interpretation and analysis which is consistently presented across all Units.
- Quality Improvement, ensuring that learning from Concerns is a primary driver for organisational QI work.
- Clinical and professional networks which span the Unit boundaries and enable sharing of information and learning across the HB.

Business intelligence support remains a weak area within the sample of Units observed. For example, all Units have posts that carry responsibility for quality and safety or health and safety, but there was little evidence within reports or discussions of systematic interrogation of the data, analysis and interpretation to identify themes and trends i.e. turning date into information, which in turn drive improvement. *The HB would benefit from reviewing these roles within the Units and developing the skills and remit of the post-holders. Through support and direction from the corporate team, consistent expectations and approaches should be fostered, along with encouraging closer working with clinical leads.*

Quality improvement (QI). Within the MH&LD Unit, the DU observed an excellent approach to QI being used to drive improvements in patient outcomes and experience. The work is underpinned by a sound governance framework and has a thorough approach to evaluation of its performance against key indicators. The DU has supported the QI work in two wards in Cefn Coed, developing a workshop model that reviews patient and family feedback (including complaints, incidents, compliments etc.) as well as staff feedback in order to highlight risks and inform areas for improvement. The Unit are considering using this approach on an ongoing basis. The HB may wish to consider using its Organisational Development Team to use this Patient and Staff Experience Workshop model as an approach more widely across the HB, where needed, to drive cultural and behavioural changes in order to improve care.

The intervention originally found that the link between organisational learning and the Quality Improvement (QI) Team are sub-optimal, resulting in a missed opportunity for learning from Concerns to drive QI work throughout the organisation. Strategically, for the HB as a whole, the consideration is still being given to the development of a QI hub, but little real progress had been made.

Next Steps

The DU has been working closely with ABMU Health Board for over two years. Given the current position it is now recommended that:

1. The DU's involvement is scaled back and becomes more consistent with its role within most other HBs.

2. Monitoring of the HB's progress with implementing their Action Plan should be via the Quality & Delivery meetings.
3. The DU should continue to monitor the HB's NE and SI rate, as well as other key quality indicators, via its monthly Internal Board meetings.
4. Concerns – relating to both the action plan and any other quality and safety issues - will be raised with the HB via the Quality & Delivery Meetings with the HB.
5. Escalation of any quality and safety concerns will be made to WG's Quality & Delivery Board, and decisions made there on any further work needed, in line with the current escalation process.
6. Consideration should be given to involving 1000 Lives Improvement in providing relevant targeted organisational support to ABMU with their QI work.

ACKNOWLEDGEMENTS

It should be noted that the commitment of staff towards delivering high quality care for patients was clear.

The Delivery Unit would like to thank those individuals from ABMUHB for their time and co-operation in providing the information and evidence used to prepare this report.

References

Intervention into Systems & Processes for the Management of Serious Incidents at Abertawe Bro Morgannwg University Local Health Board. NHS Delivery Unit. February 2018.