Meeting Date	**18th April 2019**	**Agenda Item**	**5.1**
Report Title	NHS Wales Delivery Unit 90 day review		
Report Author	Cathy Dowling, Assistant Director of Nursing and Patient Experience		
Report Sponsor	Gareth Howells, Director of Nursing and Patient Experience		
Presented by	Cathy Dowling, Lee Joseph and Julie Hopkins (DU)		
Freedom of Information	Open		
Purpose of the Report	In April 2018 the Delivery Unit (DU) issued their repor *Intervention into Systems & Processes for the Managemen of Serious Incidents at ABM University Health Board.* In addition to recognising areas of good practice, the repor made ten recommendations for improvement. The DU published a 90-day review in November 2018 o progress against those recommendations and this pape summarises the outcomes and actions taken by the Health Board.		
Key Issues	The paper discusses the progress made, the DU's remaining area of risk identified in the 90 day report, together with details of the focused work which has commenced to address the risk **Main areas of improvement** • Quality of investigation reports • Scrutiny • Sharing Learning • Never Event (NE) position **Main area of outstanding risk** Serious Incident (SI) investigations within the Mental Health & Learning Disabilities Service (MH/LD).		

	Focused work • MH/LD specific Serious Incident Systems and Process improvement plan • New MH/LD dedicated Serious Incident Investigator • Corporate support to deliver training, mentorship and board assurance regarding the action plan			
Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Recommendations	Members are asked to: • **NOTE**			

NHS DELIVERY UNIT 90 DAY REVIEW

1. INTRODUCTION

The report summarises the Delivery Unit's 90 day review of *Intervention into Systems & Processes for the Management of Serious Incidents at ABM University Health Board* and actions taken by ABM since its publication in November 2018.

The Delivery Unit's 90 day review paper is attached to this report for reference.

2. 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 Health Board* ('the intervention'*)*. As well as recognising areas of good practice, the report made ten recommendations for improvement.

In November 2018, the Delivery Unit reported on the progress against those recommendations in its 90 day review. The methodology for the 90 day review is included in detail within the report.

Progress highlights:

- *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 since the initial report, 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.* All investigation reports relating to the 10 Never Event incidents which occurred in the 2017/2018 financial year, have been assured and closure forms submitted to Welsh Government. Morriston Hospital – where a cluster of NEs in theatres initially triggered the DU's intervention – have had another Never Event in March 2019 (interventional radiology), but there has not been one in theatres for 21 months.

The impact of improvements to processes, sharing learning, and improving culture will take time to become embedded; however, there are positive signs of overall improvement.

Remaining Risks

Areas of risk were also identified during the DU's 90 day review, largely issues previously identified which need greater urgency to address (see report for full details). The DU highlighted the following risk as requiring urgent attention.

- *Serious Incident (SI) investigations* within the Mental Health & Learning Disabilities (MH&LD) Unit do not undergo robust investigation using recognised methodology.

3. GOVERNANCE AND RISK ISSUES

To address the risks in Mental Health/Learning Disabilities, an action plan has been developed. Work to implement the actions is well progressed. Actions and the progress made can be seen in the attached plan;

New Investigation Resource
MH/LD have invested in the creation of a new 'in-house' Serious Incident Investigator who will form part of the MH/LD Quality and Safety Team. The post was successfully recruited in March with the new post holder commencing in April 2019.

Corporate Assistance
The Assistant Head of Concerns Assurance (AHCA) is currently working alongside the MH/LD Quality & Safety Team to implement the action plan. The AHCA is currently mentoring and supporting the investigation of the most serious incidents reported to WG, whilst supporting the team to develop new processes for ensuring the timely management and reporting of patient serious untoward incidents. It is projected that the action plan will be fully implemented by the end of June 2019. Corporate and Welsh Government assurance indicators will be continually monitored throughout this period to identify the point where systems and processes are consistently assured.

New Health Board Serious Incident Investigation Toolkit
Development and dissemination of the new investigation management toolkit will ensure a consistent approach to managing incidents across all units (including MH/LD). The new toolkits have been designed to build upon the success (as outlined in the DU report) of the new collaborative MDT approach to Health Board serious incident investigations. Training to support the fundamentals of undertaking a serious incident investigation is currently in development to support the toolkit. Roll-out of the toolkit and linked training across the Health Board has commenced with MH/LD the first Unit to be supported.

In addition, the DU have facilitated a series of workshops in October and November 2018 for multi-disciplinary mental health staff.

4. FINANCIAL IMPLICATIONS

No financial implications in terms of carrying out the actions discussed in this report.

5. RECOMMENDATION

The committee notes the positive progress made by the Health Board as outlined in the 90-day follow-up report.

The committee notes the focused work plan implemented to address the remaining Health Board risk regarding MH/LD systems and processes for serious incidents.

Governance and Assurance							
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships		
Link to Health and Care Standards ***(please ✓)***	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
Quality, Safety and Patient Experience							
The improvements, as outlined in the 90 day report, and the future completion of the MH/LD work plan, will have a positive bearing on matters of quality and safety. The improvements have and will continue to improve on the quality of investigations where lessons learned from adverse incidents are identified more timely. Changes made to systems and processes will positively engender a positive safety culture.							
Financial Implications							
Improvements should reduce the risk of increasing costs relating to personal injury and/or clinical negligence and redress claims.							
Legal Implications (including equality and diversity assessment)							
The Health Board will be compliant with the Welsh NHS regulations for the management of serious incidents and redress – Putting Things Right (PTR), and Welsh Risk Pool requirements. Processes will be better aligned to the future 'Duty of Candour'							
Staffing Implications							
None identified							
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015 - https://futuregenerations.wales/about-us/future-generations-act/)							
None identified							
Report History	The Delivery Unit has previously attended the Quality and Safety Committee during both its original and 90 day review.						

Appendices	Appendix 1 : NHS Delivery Unit's 90 day review of Intervention into Systems & Processes for the Management of Serious Incidents at ABM University Health Board Appendix 2 : MH/LD Serious Incident Systems and Processes Improvement Plan 2019 Appendix 3 : Swansea Bay Health Board Serious Incident Management Toolkit