



**AGENDA ITEM**

7.3.3

**QUALITY & SAFETY COMMITTEE**

**Bridgend ILG Quality Safety and Experience Report**

**Date of meeting**

22nd November 2021

**FOI Status**

Open/Public

**If closed please indicate reason**

Not Applicable - Public Report

**Prepared by**

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Bridgend ILG

**Presented by**

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**Approving Executive Sponsor**

Interim Chief Operating Officer

**Report purpose**

FOR NOTING

**Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)**

**Committee/Group/Individuals**

**Date**

**Outcome**

ILG Leadership Team

4/11/2021

**ACRONYMS**

ABMUHB

Abertawe Bro Morgannwg University Health Board

CTMUHB

Cwm Taf Morgannwg University Health Board



|          |                                                   |
|----------|---------------------------------------------------|
| ILG      | Integrated Locality Group                         |
| CAMHS    | Child and Adolescent Mental Health Services       |
| POWH     | Princess of Wales Hospital                        |
| CSG      | Clinical Service Group                            |
| RTE      | Rhondda Taf Ely                                   |
| ED       | Emergency Department                              |
| DU       | The Delivery Unit                                 |
| COPD     | Chronic Obstructive Pulmonary Disease             |
| PHW      | Public Health Wales                               |
| PTR      | Putting Things Right                              |
| TOMS     | Theatre Operating Management System               |
| WHO      | World Health Organisation                         |
| MDT      | Multi Disciplinary Team                           |
| QSE      | Quality, Safety & Experience                      |
| RN       | Registered Nurse                                  |
| HCSW     | Health Care Support Worker                        |
| CRT      | Community Resource Team                           |
| HCWP     | Healthy Child Wales Programme                     |
| ID       | Patient Identifier                                |
| NatSSIPS | National Safety Standards for Invasive Procedures |
| LocSSIPS | Local Safety Standards for Invasive Procedures    |
| NRI      | Nationally Reportable Incident                    |

## 1. SITUATION/BACKGROUND

- 1.1 The purpose of this report is to provide members with an update on quality and safety issues in Bridgend ILG.

## 2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

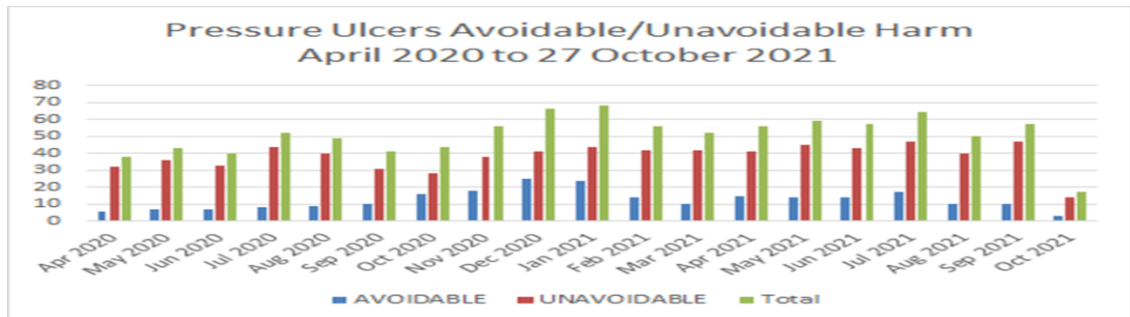
### COVID-19 & Resetting Services

- 2.1 The site continues to see a high demand for COVID 19 positive capacity especially within the Intensive Care Unit. An investigation is underway regarding possible contamination of samples within RGH Pathology, which resulted in reporting errors contributing to inappropriate patient moves at POWH and a new COVID 19 outbreak.
- 2.2 IPC audit and review of COVID patient pathways have been undertaken and an action plan for improvement is in place. Environmental risks within ED are being addressed in collaboration with Estates and are included in the Organisational Risk Register. ILG OCT meetings are held weekly and adherence to PHW 15 Point Action Plan is monitored.
- 2.3 Current demand on acute site is placing pressure on the ability to maintain elective surgical pathway. Recovery management plans are in place and monitored via the ILG's recovery board.

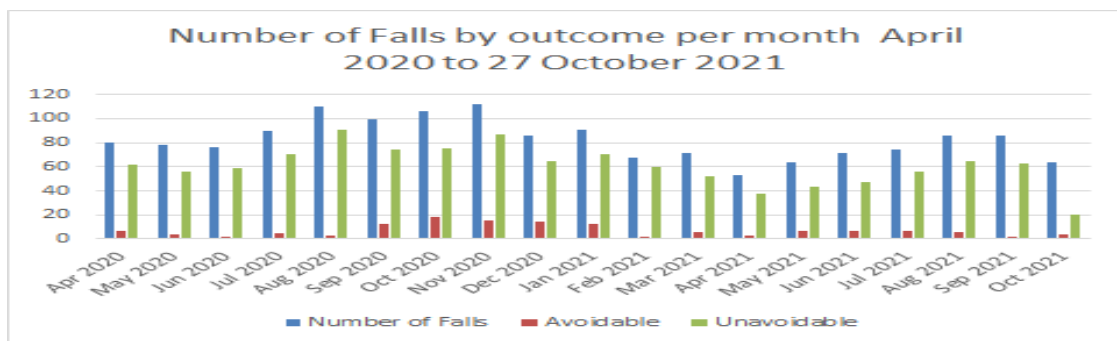
### Quality Assurance

- 2.4 **Cancer Harm Reviews** occur monthly and are undertaken upon completion of the patient pathway. These are reported quarterly to the ILG Quality and Safety meeting. 90 of the 95 breaches identified from March 20 – August 21 have had a harm review, of which 87 were found to be no/low level harm. All logged outcomes and themes are fed back to Clinical Director and pathway improvements actioned. One case of moderate harm has progressed via PTR process for consideration of redress.
- 2.5 **WHO Safety Checklists** are undertaken and checked against the patient ID at all points of transfer between the ward and theatre. NatSSIPS and LocSSIPs are in place to ensure that the correct patient, receives the correct procedure on the correct organ/ site, in the correct way. The checks are undertaken by appropriately registered staff such as RN's and Theatre Technicians and recorded in the mandated fields on the TOMS. The patient is unable to progress through the pathways unless the mandated fields are completed. All interventional / invasive procedures must have a LocSSIP in place. Within BILG legacy NatSSIPS/LocSSIPs from the former ABMUHB are available via the POWH Theatre portal to support the process. These will be reviewed and aligned to CTMUHB as part of the central Patient Safety Unit workstream.

- 2.6 Since the inception of the ILGs, implementation of the WHO checklist has identified 11 incidents of low harm and 1 never event. 9 of the low level harm incidents were associated with potential wrong site surgery i.e. left leg instead of right leg. This suggests that with the exception of the never event, the WHO checklist is being robustly implemented and the potential for serious harm is being averted.
- 2.7 **AMU POWH** has been identified as an **inpatient falls and pressure** ulcer hotspot within CTMUHB. This reflects the current high acuity levels and patient dependency levels on the unit. The area is currently below establishment as there is one team covering two areas. Arrangements to provide interim support via enhanced senior nurse monitoring, and relocation of staff from other teams, are in place whilst mid to long term solutions such as "at risk" recruitment strategies are being explored. ILG Nurse Director led meetings are being set up to review management and scrutiny of vacancy and roster utilisation.
- 2.8 Incident reporting is robust and scrutiny panel reviews are undertaken on all **inpatient falls and hospital acquired pressure damage** reports of moderate harm and greater. Avoidable cases progress via PTR Redress processes and action plans for improvement monitored via governance assurance meetings. To facilitate wider learning across ILG and sharing of improvement plans, an integrated ILG MDT Falls panel has been established, and there is intention to extend this model to unify the ILGs pressure ulcer MDT scrutiny panels. Detailed reports and improvement plans from all panels are presented to the ILG QSE and via CSG performance meetings.
- 2.9 Emergent themes from ILG **pressure ulcer** hotspots in **Community and AMU** are associated with increased demand and reduced capacity in relation to end of life pathways and delayed WAST transfers of care. Level of harm identified is predominantly superficial skin damage. An MDT supported Pressure Ulcer Reduction Project is progressing: notable achievements include completion of Pressure Ulcer Work Book for RNs and HCSW's linked to PADR, and co-production of education tools and information for staff and carers. Audit results indicate improved compliance with SKIN bundle and documentation.
- 2.10 The number of reported **pressure ulcers** across the ILG remains within normal variation, as does unavoidable harm, but some reduction in the volume of avoidable damage since January 2021 has been noted (NB data is not yet complete for October 21).



- 2.11 The pattern of normal variation of incidence and reduction in avoidable harm since January 2021 is mirrored in available data for **inpatient falls**. Key improvements taken forward regarding management and prevention of falls includes the introduction of post fall clinical review documentation and debrief sessions. Additionally the Falls Team/CRT team have been working with Bridgend Falls Prevention Steering Group where the development of a community Falls Prevention Pathway has begun. An iCTM project has been initiated at Angelton Clinic to address the high incidence of falls. Learning from this improvement programme, is being shared across the ILG via the Integrated Falls Panel and regular submission to QSE.



- 2.12 High levels of attendance and walk in majors continue to adversely affect **ED performance compliance**. Compliance with the 4 hour waiting time dropped to 62.5% in September 2021 and 12 hour waits have increased in line with significant discharge blocks whereby LA discharge plans are running at 7-10 weeks. Bridgend ILG are in discussion with BCBC to develop and progress discharge plans. All patients on ambulances are triaged, reviewed by a clinician and placed on appropriate pathway. Pressure ulcer risk assessments are conducted and acted upon, utilisation of pressure prevention aids such as Repose mattresses is being progressed via procurement processes.
- 2.13 Despite ED inability to comply with 5 **WAST red release requests** in September, improvement was noted against August's performance. Work is ongoing to develop a more robust audit trail on department acuity and rationale for red release declines. All WAST Red Release incidents are

investigated and outcomes fed back to the site team and WAST. Findings indicate that appropriate escalation and communication pathways are being adhered to and that the inability to respond to red release requests were unavoidable due to the systemic pressures across areas of the Health and Social Care System and hospital site.

- 2.14 WAST and CTM HQS's meet monthly to review incidents. Actions for further development regarding communications and incident management have been identified. Progression of Head of Patient Flow post and establishment of Flow Improvement Group commencing November 2021. Additionally 2 new pathways 'COPD Exacerbation Pathway' and 'Community Physiotherapy Falls Assessment Protocol' have been developed in collaboration between WAST and COPD Teams as part of a strategy to avert hospital admissions.
- 2.15 Feedback from **RCEM audit** undertaken in July 2021 demonstrated good compliance to standards of patient care. Poor compliance to environmental aspects of the audit appear on the organisational risk register and estates programme of work.
- 2.16 Learning from the PCH HIW inspection resulted in the undertaking of a review of COVID pathways in ED by senior clinical colleagues and IPC. The pathways were found to be resilient but subject to challenge under extreme demand pressures. ED action plans for improvement are aligned to themes arising from **HIW** PCH concerns and a pan CTM HQS/ ED Nurse Leads group has been proposed to ensure standardisation of approach across all ILG EDs.
- 2.17 The **ED Patient Safety Checklist** is aligned to pre-existing POW BRATZ assessment. An audit of 20 cases undertaken in October 2021 demonstrated that the checklist was available in all records. Overall compliance to the standard was 76%. Areas of non-compliance associated with potential data collection issues and amendment of the tool is suggested to rectify this.
- 2.18 In August the percentage of compliance to the inpatient and ED patients at POWH to the **sepsis bundle** had improved to 90%. Compliance was noted to have reduced to 83% in September but has improved further during October to 100%.

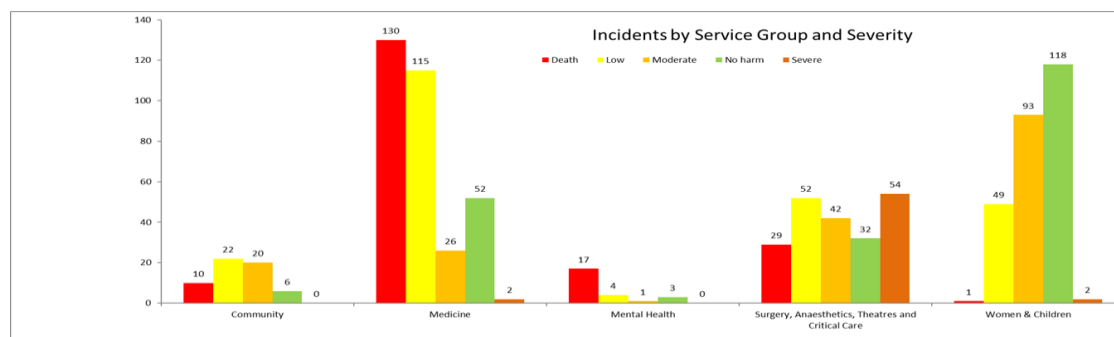
## Quality Assurance – Concerns Management

- 2.19 The ILG's 30 day compliance for **complaint responses** is static at 74%. Ability to improve compliance has been challenged by an approximate 30% increase in the volume and complexity of concerns being formally raised, and staff absence within the Governance and wider CSG teams.
- 2.20 Similarly these issues affect all aspects of concerns performance. Although all 31 of the ILGs **SI/NRI**'s are overdue there has been a marked reduction

in the number of open cases. Closure of cases has been facilitated via pressure ulcer and falls scrutiny panels and review of legacy cases. The closure of 7 obstetric cases are being progressed via the centrally managed DU review process.

Weekly monitoring for concern management continues via CSG governance meetings. Improvement in 30 day complaint compliance and timely NRI investigation will be achievable for January 2022 subject to commencement of 2 key posts i.e. Band 5 support in the Governance Team, and a Band 7 MH/CAMHS Governance, and also completion of DATIX training.

- 2.21 All reported incidents are first line approved and progressed to investigation. A robust process is in place to “close the loop” and ensure that the investigation outcome and learning is fed back to the reporter. There are a total of 1129 open incidents under investigation across ILG services. Emergent themes reflect established workstreams and scrutiny panels such as PU, Falls, Covid, Ophthalmology and Maternity.
- 2.22 The following table provides a break down of incidents and associated harm by CSG. The high number of deaths reported for **Acute Service CSG** reflects the number of COVID deaths under investigation. An ILG Covid review process is in place, which will now align to the centralised review process which is being established.



- 2.23 There was one NRI reported in **Mental Health CSG** during this period relating to the suspected death by suicide on an inpatient in Angleton clinic, this review is being conducted by a team from RTE and is well underway.

## Quality Assurance – Clinical Service Group Issues

- 2.24 **CAMHS CSG** quality, safety and performance issues are reported to this committee separately. For noting a new CSG Manager has been appointed from C&V UHB and the ILG is working to try to secure early commencement of duties. Performance Recovery Plan is to be developed by end of November.



- 2.25 The Ophthalmology Service Improvement Manager has commenced post and the Ophthalmology Harm Review Panels have commenced. A detailed **Ophthalmology** progress report will be provided at the next meeting
- 2.26 **Mental Health CSG** reports that temporary closure of the Calon Lan Detox unit in NPT by SBUHB has affected CDAT's ability to provide inpatient detox. The contingency plan for SBUHB was to use beds on Ward F at NPT, however no detox admissions have taken place since September. The CDAT has seen a rise in alcohol related referrals. Discussions regarding the SLA are progressing with SBUHB.
- 2.27 **Women and CYP CSG:** Scrutiny arrangements for Maternity and Neonatal Improvement continue to be driven and monitored via the Maternity and Neonatal Service Improvement Board which reports to this committee separately. An action plan to address immediate make safes following the neonatal deep dive at PCH has been developed along with a number of key governance appointments to facilitate improvement and monitoring.
- 2.28 The **Health Visiting Service** has completed an audit of the Healthy Child Wales Programme and has evidenced improvements in compliance since 2020. The limitations in performance during 2021 is attributed to redeployments and empty caseloads which have reduced from 12 at the height of the pandemic to 5. There continue to be some data collection issues that are being worked through in an action plan in partnership with primary care and the child health department.
- 2.29 Environmental factors and covid visiting restrictions within the **neonatal unit** have impacted on the ability to implement **parental inclusion in clinical rounds**. Visiting time is unrestricted, and refreshments provided, but in adherence to CTMUHB guidance, only 1 visitor is allowed. This can create tension when receiving children from C&VUHB and SBUHB where there is unrestricted parental visiting. Assurance is provided that alternative opportunities to enable both parents to meet with clinicians face to face or via facetime facilities are utilised. Despite these limitations, feedback from parents at discharge remains positive.

### **Risk Register Profile**

- 2.30 An overview of the ILG's Risk Register was presented to the Management Board, and Board Development Session in October 2021.
- 2.31 The ILG continues to review and refine its risk management processes. Risks are reviewed at CSG performance and assurance meetings. All risks of 15 and over are now reported via the ILG's monthly Performance Review Meeting. Further work is being undertaken to review and validate a number of pending risks prior to escalation to the Organisational Risk Register. 90% of all risks appearing on the ILG risk register are compliant with the organisational formatting requirement. 72% are compliant within their review dates.

## Management of Risk

- 2.32 **Women and CYP CSG:** Members are asked to note emerging children's safeguarding issues, and that CTM Safeguarding Board have commissioned an independent review of 5 child deaths in Bridgend. Bespoke safeguarding training is being supported by central safeguarding team and a deep dive report has been requested to provide assurance regarding immediate make safes. Members will be appraised of the report outcome and arising recommendations at the next meeting.

## People's Experience

- 2.33 At the commencement of Values and Behaviors in Action Week, in addition to the ILG's ongoing staff recognition events, themes identified from the ILG Director's 360 degree appraisal were shared with CSG teams. Results indicated that ILGD's lead by example. Themes regarding visibility, financial constraints, and volume of meetings affecting opportunities to develop service innovation and improvement also identified. Leadership sessions and patient safety visits commencing November in order to progress these conversations further.
- 2.34 To improve quality of care and service accessibility POWH Optometrists have launched the Agored Cymru Level 3 Certificate in Fundamentals of Ophthalmology training package for HCSWs and RN's. This is the UK's first ophthalmology training of its type and is now available to all Welsh HBs.

## External Inspections

- 2.35 Bridgend ILG has not received any formal inspection reports in the reporting period.

## 3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

Members are asked to note the following for consideration:-

- 3.1 Inpatient detox beds for CDAT patients for which there is a SLA with SBUHB. Alcohol referrals to Bridgend CDAT have increased as an impact of Covid. The lack of specific detox beds could lead to an increase in unplanned medical admissions for alcohol related issues.

## 4. IMPACT ASSESSMENT

|                                                       |                                           |
|-------------------------------------------------------|-------------------------------------------|
| <b>Quality/Safety/Patient Experience implications</b> | Yes (Please see detail below)             |
|                                                       |                                           |
|                                                       | Governance, Leadership and Accountability |



|                                                                                                                                                   |                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Related Health and Care standard(s)</b>                                                                                                        | <p>If more than one Healthcare Standard applies please list below:</p> <p>Safe Care<br/>Dignified Care<br/>Effective Care<br/>Individual Care</p>                                                                                                                               |
| <b>Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.</b> | <p>No (Include further detail below)</p> <p>If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below.</p> <p>If no, please provide reasons why an EIA was not considered to be required in the box below.</p> |
| <b>Legal implications / impact</b>                                                                                                                | <p>There are no specific legal implications related to the activity outlined in this report.</p>                                                                                                                                                                                |
| <b>Resource (Capital/Revenue £/Workforce) implications / Impact</b>                                                                               | <p>There is no direct impact on resources as a result of the activity outlined in this report.</p>                                                                                                                                                                              |
| <b>Link to Strategic Goals</b>                                                                                                                    | <p>Improving Care</p>                                                                                                                                                                                                                                                           |

## 5. RECOMMENDATION

5.1 Members are asked to **NOTE** the progress outlined in this report and **DISCUSS** the matters for escalation.