AGENDA ITEM
6.6.3

QUALITY & SAFETY COMMITTEE

Bridgend ILG Quality Safety and Experience Report

Date of meeting	19 July 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Claire Ellis, Interim ILG head of quality and safety
Presented by	Ana Llewellyn, ILG Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
ILG Leadership Team	6/5/22	APPROVED

ACRONYMS	
CSG	Clinical Service Group
CTMUHB	Cwm Taf Morgannwg University Health Board

ILG	Integrated Locality Group
JAG	Joint Advisory Group (accreditation for Gastrointestinal Endoscopic Services)
LFER	Learning From Event Report
POWH	Princess of Wales Hospital
COO	Chief Operating Officer
CAMHS	Child and Adolescent Mental Health Service
FACTS	Forensic Assessment and Consultation Treatment Service
WHSSC	Welsh Health Specialised Services Committee

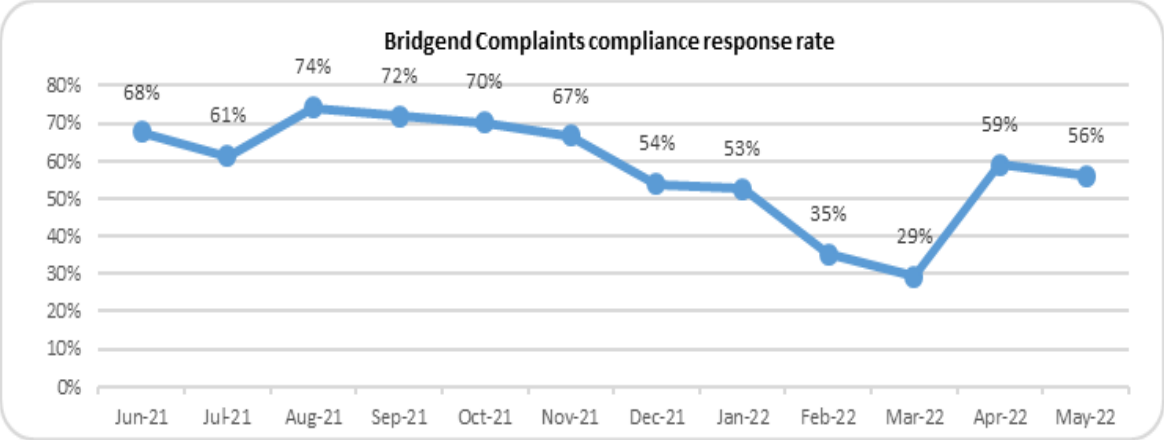
1. SITUATION/BACKGROUND

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

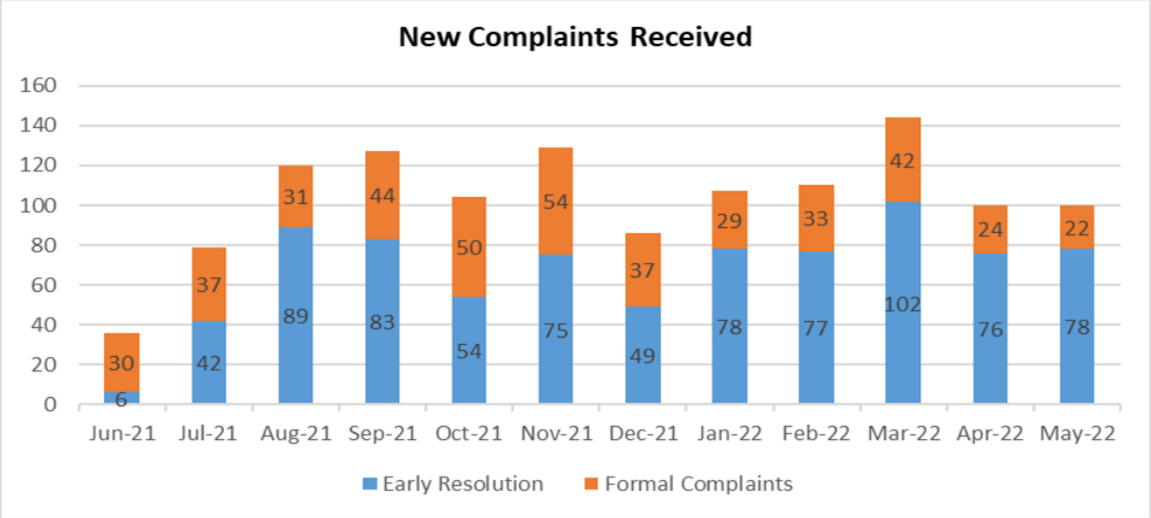
2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

Quality and Safety Dashboard

2.1 The Bridgend ILG Quality and Safety Dashboard can be found in Appendix 1. Our 30 day complaint closure compliance improved towards the end of April 2022, however this has declined slightly during May 2022 due to absences within the ILG Governance team. The ILG have focused on the completion of LFER's in order to provide assurance of learning and in order to receive financial reimbursement for these cases.



Between 01.04.2022 and 31.05.2022 71 formal complaints were closed. Of these complaints 58% (41) were closed within 30 working days. This represents a 26% increase in complaints compliance as compared to the previous 2 months.



2.2 Members will recall that in the previous committee meeting this deterioration was anticipated through April and May due to significant staff depletion in the ILG governance team due to staff sickness and vacancies.

2.3 The vacant Head of Quality and Safety post in Bridgend has been withdrawn and will be used to create an alternative post to sit within the claims team. A Senior Nurse is currently acting into the Interim Head of Governance Post for a 3 month period, leaving the senior Nurse Position unfilled. The vacant band 7 and band 5 vacancies have been filled and the return of two staff

from long term sickness should result in improved compliance from July 2022

2.4 The focus continues on casework required to maintain organisational reputation and secure financial reimbursement i.e. information required by external agencies for assurance and legal defense purposes such as LFERs, coroner statements, Ombudsman, Community Health Council, Healthcare Inspectorate Wales responses, and Delivery Unit notifications. As of 22nd June there are 2 open LFERS in Bridgend which are all on track for submission within the requisite Welsh Risk Pool deadlines. There are no outstanding LFERs for BILG at the point of reporting.

2.5 Considerable work needs to be undertaken to manage the historical and current incidents within ophthalmology. This will have a significant impact on the resources within BILG governance team, which will impact on the Putting Things Right (PTR) deadlines relating to complaint compliance. There are ongoing discussions with the Central Patient Safety Team regarding the appropriate management of these cases going forwards.

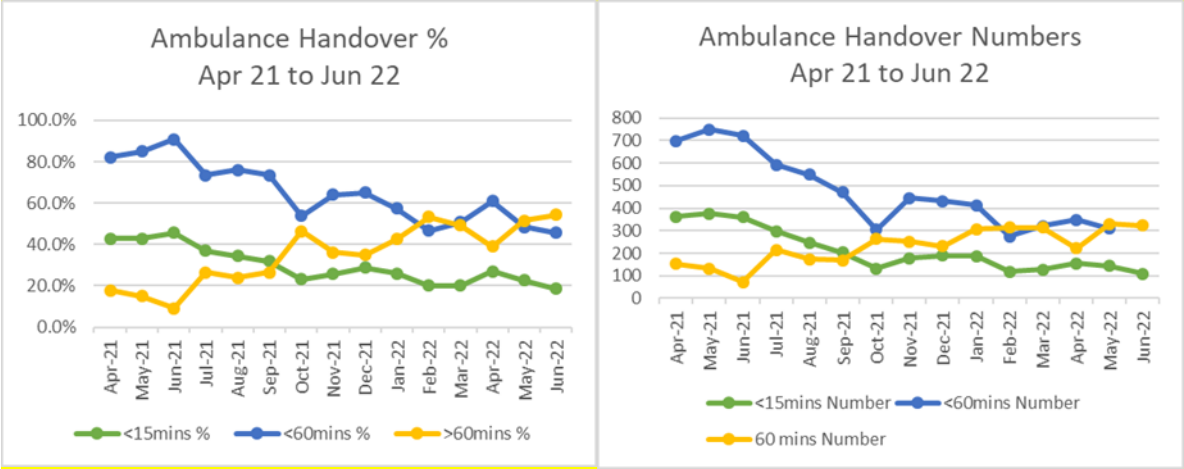
External Quality Assurance

2.6 We have received the Draft Internal Audit Report in relation to Risk Management Processes. The Health Board have been issued with reasonable assurance against the adequacy of the systems and controls in place. The matters which require management attention in BILG relate to the escalation and de-escalation of risks between the Surgery Clinical Service Group and the Organisational Risk Register and management risk reviews which were overdue for a number of risks. In response to the recommendation as part of the action plan, BILG Governance team are now maintaining action logs which evidence key actions and decisions which are made regarding ILG and CSG risks. An action log will also be commenced for use in the monthly risk management meetings chaired by the ILG's Head of Quality and Safety and attended by the ILG Triumvirate. This will provide assurance and evidence of the appropriate scrutiny of risks which are escalated and de-escalated to the Organisational Risk Register.

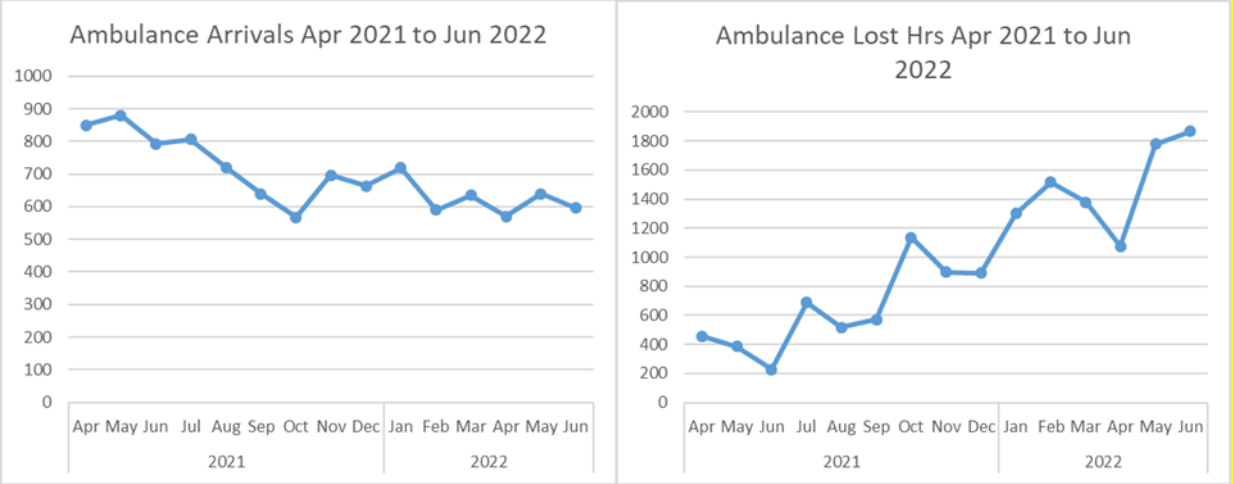
2.7 Lynne Neagle, Deputy Minister for Mental Health and Judith Paget CEO of NHS Wales visited Ty Llidiard on 16th June 2022 and were given a tour of the unit by one of the Young people receiving treatment on the Unit. The feedback was positive and they noted that they were happy with the improvements and future vision for Ty Llidiard.

Internal Quality Assurance

2.8 The Acute Services have continued to manage concerning ambulance offload delay issues through May and June as per the charts below. This is consistent with the profile and pressures for all Health Boards in Wales currently. POWH, in particular had significant delays most notably over the period since the closure of Ysbyty'r Seren at the end of May 2022, resulting in a deterioration of flow options and fewer beds to manage the ongoing challenging situation as anticipated and noted in the previous report. Additional beds have been made available on Llynfi Ward (was ward 21) and additional surge areas have been used and exceeded at times in order to balance the risk in the community, the front door and the entire POW Hospital site .



2.9 The performance against the 15 minute and 1hr ambulance handover indicators has been steadily declining over recent months as a result of crowding within the Emergency Department resulting in around 18.5% of patients being handed over within 15 minutes of arrival and 46% of patients being handed over within 1 hour of arrival.



2.10 The front door pressures are directly associated with poor patient flow through the hospital due to the high numbers of patients awaiting social work allocation, placement or packages of care. As of 4th July there were 108 medically fit patients at POWH which is a concerning deteriorating position. Of these, 30 people were awaiting allocation or assessment by a social worker; 29 patients were awaiting a package of care to start and 22 patients are awaiting placement. Flow is being further constrained by the rise in COVID cases on the POW site as of 7/7/22 there are 60 positive patients on site with 3 wards closed.

2.11 Committee members are also advised that BILG and Executive Leadership Team are extremely concerned about the situation in Bridgend, with an oversaturated hospital template, no community hospital to support appropriate patients and a continuing challenging position in terms of a high number of patients that should not still be in an acute bed. In recognition of this, a Rapid Improvement Cycle of 6 weeks to enable a responsive change with all partners is being developed with a start date of end of July to test out a focussed approach to improve patient safety, flow, experience and create space at the front door to allow ambulance crews to release and respond more quickly to emergencies in the community. Local Authority, WAST and therapy colleagues are key members of this initiative to push the boundaries further and challenge the system blocks to better serve our population. Key metrics are being developed to measure this change period looking at a before and after measurement and also looking at staff surveys to see if the changes are having a positive impact on patient safety and morale.

2.12 The Health Board launched the Datix Cymru Incidents Module on 1st April 2022. The BILG Governance Team are concerned regarding restricted access to data, the inability to amend the incident grading following the review of the initial report and the number of incorrectly allocated incidents. This has

led to a delay in completing the management review, and progress of the incident investigation. These concerns have been escalated to the Once For Wales (OFW) Project Manager for consideration at the OFW All Wales oversight group.

2.13 The Tier 2 Eating Disorder service is a pan CTM service hosted by the Bridgend Mental Health Clinical Service Group (CSG). Due to a number of staff leaving and difficulty recruiting, the service now consists of just a dietician. This risk has been escalated onto the Organisational Risk Register. In order to mitigate the current risk, the service has been closed to new referrals and they will be diverted to the generic Mental Health CMHTS, with the specialist dietician being available to give advice to the teams. A private company has been sourced to provide therapy for those on the waiting list (17 in total). Recruitment has been prioritised and the Job Descriptions for the specialist therapists are being prioritised for job matching. Increased funding is being considered in order to increase the size of the team and provide parity with neighbouring Health Boards, with the aim of improving recruitment and retentions of specialist staff.

2.14 There are a number of Registered Nurse vacancies on ward 14 (up to 50%), which is the only adult Mental Health admission ward in Bridgend. There is a potential impact on quality and safety of patient care as there is an over reliance on bank /agency staff. Recruitment has being prioritised and staff have been redeployed from other ILG's. A multi-disciplinary group has been set up to improve communication, support staff and discuss potential solutions.

2.15 There has been a recent increase in the number of completed suicides in Bridgend County Borough, five of which have had contact with a number of Adult Mental Health Services in Bridgend. These have all been reported as Locally Reportable Incidents (LRI's) and investigations are underway. A thematic review has been commissioned, however initial feedback indicates that no common themes have been identified. The CSG contribute to the Multi Agency Suicide Review Group and attendance at the Safeguarding Board's Immediate Response Group following a completed suicide, in order to identify service users who may be affected, to ensure they are prioritised for assessment and support.

2.16 The prevalence of pressure ulcers are a concern in the Community CSG. There has been an increase in the numbers of patients who require end of life care, patients with complex health and social care needs, along with patients presenting with multiple comorbidities. A CSG Improvement Plan ensures that there is a continued and sustained focus on pressure ulcer prevention and management for patients.

2.17 The total number of falls reported across BILG remains consistent with previous months. The Datix Cymru Falls Investigation Tool does not currently capture avoidable/ unavoidable outcome therefore this information is not available for this reporting period.

2.18 The work to install the security fencing around all areas of the multi-storey car park in POW has been completed on 22nd May 2022.

2.19 CTMUHB provide CAMH services to CTMUHB and Swansea Bay UHB residents. There are issues of access in both services which link both to increased demand and to capacity issues.

Measure	Target	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Part 1 Cwm Taf Morgannwg CAMHS													
The percentage of MH assessments undertaken within (up to and including) 28 days from date of receipt of referral	80%	17.60%	15%	12%	20%	32%	32%	38%	28%	50%	47%	44.70%	26.30%
The percentage of therapeutic interventions started within 28 days days following an assessment by LPMHSS	80%	77%	58%	42.00%	50%	71%	38%	70%	39%	43%	56%	32.50%	28.60%
Part 2													
The percentage of HB residents in receipt of secondary MH services (all ages) who have a valid care and treatment plan	90%	70.10%	74%	72%	78%	81%	70%	59%	59%	69%	85%	58.80%	53.40%
Part 1 Swansea Bay CAMHS													
The percentage of MH assessments undertaken within (up to and including) 28 days from date of receipt of referral	80%	0%	5%	37%	89%	65%	36%	43%	28%	24%	36%	35%	23%
The percentage of therapeutic interventions started within 28 days days following an assessment by LPMHSS	80%	60%	100%	82%	35%	0%	64%	50%	39%	67%	78%	56%	51%
Part 2													
The percentage of HB residents in receipt of secondary MH services (all ages) who have a valid care and treatment plan	90%	81%	81%	65%	84%	82%	84%	84%	89%	88%	100%	100%	97%

2.20 A number of actions have been taken to date including validation of waiting lists, the implementation of additional sessions, a clinical assessment of the evidence base for group therapy sessions, the realignment of assessment to treatment sessions and active recruitment to new posts. A detailed action plan is in place with plans that include but are not limited to the roll out of group interventions where appropriate in each locality, the provision of additional assessment capacity from crisis teams and the provision of pathway support to referrers. Additional capacity has been agreed via a proposal for planned care recovery clinics and this will be implemented in July. Performance improvement trajectories have been developed and shared with the Delivery Unit.

2.21 A young person detained under Section 2 of the Mental Health Act managed to exit Ty Llidiard through the main entrance. At this point it was identified that he must have had a set of keys and access to a fob. Absence without leave (AWOL) procedures were followed and the young person was located by the South Wales Police and he was returned to the unit unharmed. He was searched and the door security fob was found. The keys could not be found and the young person stated he had disposed of them. This young person had absconded on two previous occasions prior to this incident. This incident has been investigated and a risk management plan implemented. Immediate make safes have been actioned in order to provide assurance of safety for all young people on the unit.

Peoples' Experience

2.22 The recent lack of a central resource for logging and responding to patient concerns and complaints has impacted on BILG Governance team. A number of concerns were not passed to us in a timely manner which has impacted on our compliance rates. BILG PALS Service are being utilised to log formal complaints pan Health Board which can impact on their ability to manage some of the site based Early Resolution (ER) concerns and the recording of patient experience.

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

3.1 Continued and increasing levels of overcrowding in ED impacting on care and service delivery alongside poor patient experience.

3.2 Closure of Ysbyty'r Seren has further decreased outflow for POW site with continued high levels of medically fit patients awaiting social work allocation, discharge planning and care packages.

3.3 The increase in Covid-19 infections for in-patients and staff, leading to potential ward closure, increasing staff absences and nosocomial transmission.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	This report covers the Quality and Safety of all MC ILG services and the subsequent impact for all our patients and residents.
	Governance, Leadership and Accountability

Related Health and Care standard(s)	If more than one Healthcare Standard applies please list below: Relevant to all Healthcare Standards
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) Any new or altered services would have their own EIA undertaken.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Creating Health

5. RECOMMENDATION

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