



AGENDA ITEM

6.4.3

QUALITY & SAFETY COMMITTEE

BRIDGEND ILG QUALITY SAFETY AND EXPERIENCE REPORT

Date of meeting	22/3/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Cheryl Hucker, Head of Quality and Safety Bridgend ILG
Presented by	Anthony Gibson, Group Director
Approving Executive Sponsor	Executive Nurse Director
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
ILG Leadership Team	28/02/2022	

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



HCAI	Health Care Associated Infections
ILG	Integrated Locality Group
IPC	Infection Prevention & Control
JAG	Joint Advisory Group (accreditation for Gastrointestinal Endoscopic Services)
LFER	Learning From Event Report
MDT	Multi Disciplinary Team
OCT	Outbreak Control Team
PALS	Patient Advocate & Liaison Service
POWH	Princess of Wales Hospital
QSE	Quality, Safety & Experience

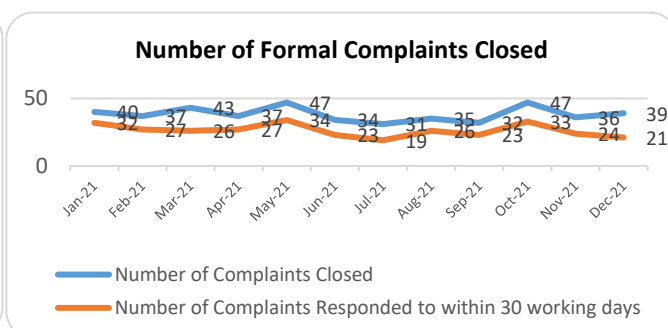
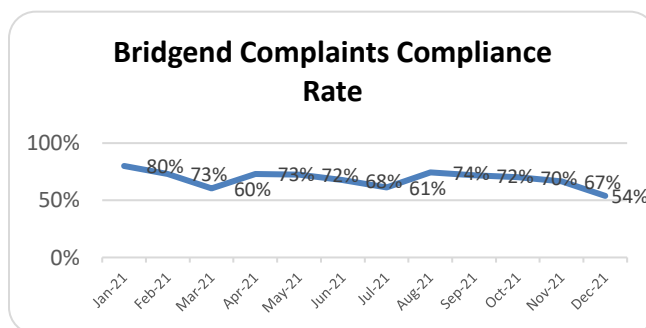
1. SITUATION/BACKGROUND

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

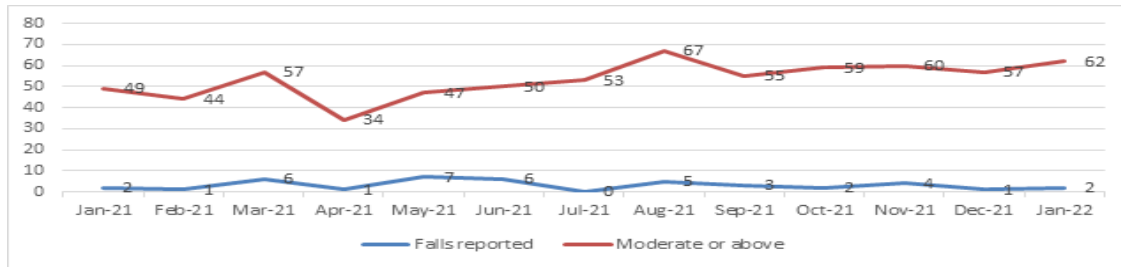
2.1 Sickness, absence and divergence of resource from the Governance and wider operational management teams to support the Omicron Vaccination programme resulted in a deterioration of the ILGs 30 day complaint response compliance to 54%.





- 2.2 Vacancies and secondments to provide interim support to governance team to cover long-term sick and retirement have been progressed and are awaiting Executive led vacancy panel approval. Interim arrangements to maintain cover include utilisation of experienced bank staff to reduce complaint backlog. PALS team supporting with communication pathways to reduce complaint volume/manage concerns via informal route. CSG/ Governance Team assurance meetings are being re-established to improve performance. Increase to compliance expected March / April 2022.
- 2.3 During this challenging period concerns management has focused on casework required to maintain organisational reputation and secure financial reimbursement i.e. information required by external agencies for assurance and legal defence purposes such as LFERs, coroner statements, Ombudsman, Community Health Council, Healthcare Inspectorate Wales responses, and Delivery Unit notifications. Current LFERs assigned to Bridgend ILG have an approximate value of £2.2 million. All 18 LFERs are on track for submission within the requisite Welsh Risk Pool deadlines.
- 2.4 A Regulation 28 Report issued by the Coroner on 28.1.22 identified the requirement for development of a contemporaneous unified patient health record for CAMHS services. This is a national service issue sitting out of the remit of the UHB for its resolution. CTMUHB Exec leading discussions with DHCW leads regarding implementation.
- 2.5 The ILG continues to make progress towards the closure of its 30 open serious incidents/nationally reported incidents of which 15 are Covid related and will progress to closure as part of CTMUHB nosocomial investigation arrangements. 5 of the 15 remaining non Covid cases are scheduled for closure by end of March 2022.
- 2.6 The number of inpatient falls, and falls incurring moderate harm and above remains within normal variation. Weekly integrated MDT falls scrutiny panels have expanded to include serious falls (fracture/bleed) and any falls requiring investigations. Patients who have 3 or more falls are also now presented at scrutiny panel. Serious falls are presented within 7 days so that the outcome of panel determines if a serious incident report is required. The ILG Falls action plan has been updated to reflect the introduction of the post fall medical assessment form, monthly documentation audits, and introduction of post fall debrief for MDT engagement. Identified deficits trigger immediate actions for improvement and monitoring via the CSG / ILG QSE framework. A deep dive report and falls action plan review is provided to ILG QSE Group quarterly.

Monthly Inpatient Falls and Reported Harm of Moderate and Above



2.7 There were 151 healthcare acquired pressure ulcers reported during December and January, of which there were 8 x Grade 3 & 4 pressure ulcers, and 24 x ungradable/ suspected deep tissue injury incidents predominantly arising in the Community CSG. Development of healthcare acquired pressure ulcers reflects the service challenges experienced in terms of staffing, patient acuity and end of life pathway. Additionally Acute CSG report that delayed offloading of ambulances is contributing to the development of pressure ulcers. All patients awaiting offload are managed in line with the UHB skin care bundle. Mitigating actions include Emergency Department/Welsh Ambulance staff working collaboratively to provide pressure care, utilising Repose mattresses, and PALS staff undertaking welfare checks whilst patients on WAST vehicles await off loading.

2.8 All pressure ulcers are reported on detection. Integration of bi weekly MDT Pressure Ulcer Scrutiny panels for Mental Health and Acute is complete, with plans to integrate Community panels by the end of March. Representation from Tissue Viability Service ensures robustness of scrutiny process and determination of outcomes. Panel review has identified that majority of health care acquired pressure ulcers are deemed unavoidable. An ILG Pressure Ulcer Prevention and Reduction action plan for improvement is in situ and monitored via QSE frameworks and a deep dive report and action plan review provided to ILG QSE Group quarterly.

2.9 Key progress and improvement initiatives thus far include:-

Acute CSG report positive evaluation following the introduction of a POWH Registered Nurse Pressure Ulcer Workbook to improve pressure ulcer awareness and improve SKIN bundle compliance. This is now extending to all areas across POWH with workbooks for Health Care Support Workers and Community Staff in development.

In response to the acquisition of community acquired pressure ulcers in end of life/ social care patients, Community CSG has increased carer support, and introduced training and repositioning charts for social care staff and families to complete.

Evaluations of the above initiatives to be presented to next ILG QSE meeting in April 2022 as part of ILGs ongoing monitoring arrangements.

- 2.10 Although there is reduction in COVID 19 cases, POWH site continues to experience demand for COVID 19 capacity. Maintenance of a COVID 19 admission ward continues whilst awaiting guidance from Public Health Wales regarding respiratory pathway, and the first meeting of the Respiratory Pathway group has convened to develop respiratory pathways to replace the current COVID pathways as per national guidance.

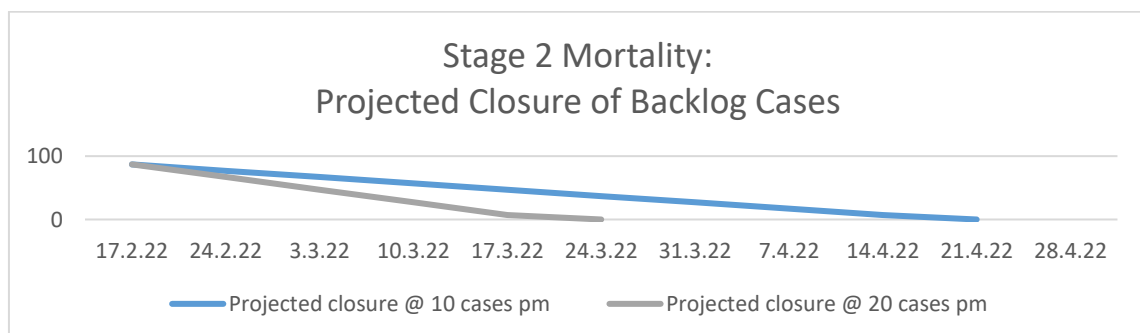
External Quality Assurance

- 2.11 There have been no external quality reports received during the reporting period

Internal Quality Assurance

- 2.12 A new COVID 19 outbreak at POWH triggered increased monitoring and management via the ILGs's weekly MDT IPC and OCT meetings. Controls implemented and re- established.
- 2.13 Strict guidance regarding pre admission and inpatient Covid testing and isolation have been implemented to facilitate progression of elective cancer surgery at Bridgend Clinic, POWH, and the re-establishment of the Green Pathway as part of the ILGs recovery plan which is monitored via the ILGs Planned Care Recovery Board.
- 2.14 Staffing and recruitment continues to be challenging for all service areas increasing reliance on agency and associated patient safety risks. Recruitment and service resetting plans are established for all CSGs and monitored monthly at ILG level and above.
- 2.15 The ILG has noted a rise in C.difficile cases which is reflective of the increase in reported cases across CTMUHB. Organism specific targets for reduction in all HCAI's established, and expectations communicated to ILG service areas and monitored via existing QSE/IPC assurance frameworks as per review of the ILGs IPC action plan.
- 2.16 Reduction in C.difficile and the associated overuse of antibiotics is ILG's focus of attention. Improvement initiatives such as implementation of antibiotic stewardship guidance and introduction of Antibiotic Review Kit are in place and continue to embed. POWH is CTMUHBs pilot implementation site for Pip/Taz restriction trial to reduce the usage of these broad-spectrum antibiotics. The trial commenced early February. Reduction in C Difficile HCAI cases is expected as the pilot embeds. Evaluation of the trials impact to be presented to the ILGs next QSE meeting in April 2022. The ILG wide antimicrobial stewardship group, now chaired by the ILG Group director has been meeting regularly.

- 2.17 Integrated Mental Health and Acute Service root cause analysis meetings are well established with core agendas including comprehensive review of environmental factors, antibiotic stewardship, handwashing, staffing levels and associated training needs. Identified deficits trigger immediate actions for improvement and further review via existing IPC and QSE frameworks. An improvement and monitoring plan is in place to utilise online IPC Level 2 training to increase ILG compliance from its current position of 69%.
- 2.18 A high number of acute C.difficile cases were deemed unavoidable due to community usage of antibiotics and proton pump inhibitors (medications used in the management of gastric ulcers and heartburn). Plans are in place to integrate Community and Acute HCAI Root Cause Analysis meetings within the next month to facilitate shared learning and spread of prescribing and management initiatives.
- 2.19 The increase in hospital acquired C.difficile cases has triggered retrospective review of the last 12 months of C.difficile root cause analysis cases to identify key themes, learning outcomes and recommendations for improvement. Review in progress and findings to be shared at next ILG QSE meeting in April 2022.
- 2.20 Capacity and operational challenges posed by sickness, recruitment and Covid contributed to the suspension of panels and the development of a backlog of 87 non Covid cases requiring Second Stage Mortality Reviews to determine potential harm.
- 2.21 Weekly Second Stage Mortality Review meetings recommenced 17th February 2022 supported by Clinical Audit and Clinical Effectiveness Team and ILG MDT. Implementation of the ILGs plans for adoption of MDT approach and appointment of a Clinical Lead for Mortality Reviews will enable the Stage 2 Mortality Review backlog to be cleared by end of April 2022 and facilitate the timely review of prospective cases.
- 2.22 Stage 2 Mortality Review outcomes are collated by Clinical Audit and Clinical Effectiveness Team. Monthly report to be generated for scrutiny and monitoring via ILG Senior Leadership Team meeting and existing QSE framework.





- 2.23 In response to the Welsh Government deep dive report regarding **Neo Natal service** provision in Merthyr Cynon ILG, Bridgend's **Women and Children CSG** in conjunction with Neo Natal Improvement team have undertaken staff briefings at POWH to ensure implementation of the 31 recommendations transcends both sites. Impact of staffing deficits at POWH have reduced and there is less reliance on bank and agency staff following recruitment and improved sickness rates. Remaining posts and staff establishments are being reviewed and progressed in partnership with the centrally led sustainable workforce group
- 2.24 Neo Natal and Maternity governance groups have formally integrated and a Maternity and Neonatal Assurance Framework is in development, which connects to centrally led workstreams and Maternity/Neo Natal Improvement Teams and improvement action plans. Clinical policies have been reviewed and updated. Admission rates and outcome measures have been incorporated into the revised Neo Natal dashboards and audit programme. Pan Senior Nurse bi-monthly meetings underway with overarching strategic action plan. Scrutiny of performance and full implementation of the Neo Natal improvement plan facilitated through service specific governance arrangements and the wider governance QSE frameworks of the ILG/CTMUHB.
- 2.25 **Acute Service CSG** report an increase in the number of reported incidents involving agency staff. All cases are escalated to the agency provider via central Bank/Agency Coordination team for investigation so that appropriate vetting and barring arrangements can be considered by CTMUHB and the relevant agency/professional body. A CTMUHB process is in place to prevent further shifts being offered to staff it deems unsuitable. All wards have developed "agency information files" to facilitate safe handover and ensure that agency staff are aware of roles, responsibilities, key policies and escalation pathways. Staff recruitment events are being coordinated to reduce reliance on agency staff. Workforce sustainability and modernization action plans are developed and monitored via the ILGs monthly CSG business meetings.
- 2.26 Vacancies and recruitment challenges within **Mental Health CSG** are restricting the ability to provide CTMUHBs Tier 2 Eating Disorder patients with full service. Risks associated with delayed clinical assessment and lack of access to psychological therapy are being mitigated by progressing all new referrals for assessment via generic mental health services and the utilisation of other professional groups to provide psychological support whilst further recruitment / service development initiatives are progressed and monitored via the ILGs monthly CSG business meetings and QSE framework.
- 2.27 **Women and Children CSG** advise that due to redeployment to support Covid immunization programmes there are 2 years of school entry hearing assessments outstanding. School Nurses have completed all screening for



2019/2020. A work programme to address the 2020/2021 backlog commenced January 2022 and sessions are booked in with schools to screen 2021/2022 academic year. School Nurses will continue to support the work programme to the end of the academic year, and are working with the audiology department to source locums to support the catch up program via funding from the care recovery plan. Plans to update and modernise the School Nursing Framework for Wales in development with Welsh Government are in progress. Monitoring and assurance is being provided via the revised MDT integrated governance arrangements that the CSG has introduced.

- 2.28 Progress with the planning for new build **central decontamination** remains a priority for POWH due the dependency on JAG accreditation. Plans are in place to minimise the impact of surgical service disruption whilst essential work is undertaken in response to the Theatre fire enforcement notice.

People’s Experience

- 2.29 Acute Services CSG report that the new Verification of Death Policy is in situ and bereavement boxes are in place in every inpatient area.
- 2.30 Communication has been identified as a theme in concerns, and is associated with the experience of patients and relatives whilst visiting restrictions have been in place, and whilst flow through Emergency Department has been challenged. PALS teams have been supporting wards, Ysbty’r Seren and Emergency Department with virtual visiting, facilitation and welfare checks for patients awaiting off loading in Emergency Department. This has had a positive impact on patient experience and reduced the number of communication related concerns being reported.

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

- 3.1 Members are asked to note point 2.4 and the requirement for Executive support to facilitate discussion and implementation with Welsh Community Care Information System leads.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below: Safe Care Dignified Care Effective Care



	Individual Care
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)
	If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
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	Improving Care

5. RECOMMENDATION

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