Bundle Quality, Safety and Experience Committee 15 October 2019

Agenda attachments

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1	Welcome and Introductions *Susan Elsmore*
2	Apologies for Absence *Susan Elsmore*
3	Declarations of Interest *Susan Elsmore*
4	Chair's Action taken since the last meeting *Susan Elsmore*
5	Hot Topics *Ruth Walker*
6	Serious Incidents and Never Event Paper - Octover 2018/19 *Ruth Walker* 6 - QSE paper on SI Themes and never Events 2019 v3.docx
7	Tracheostomy Stimulation *Ben Hope-Gill*
8	Analysis of Trends and Themes in Deaths of Patients with Mental Illess *Analysis of Trends and Themes in Deaths of Patients with Mental Illness* 8 - QSE report Oct 2019 v2.doc
9	Management of Endoscopy Surveillance Patients 9 - Aug 2019 Management of endo surveillance QSE report.docx
10	Items to bring to the attention of Board / Committee *Susan Elsmore*
11	Date and time of next meeting: *Tuesday, 17 December 2019 at 9.00am* *Coed y Bwl, Ground Floor, Woodland House, Heath*

QUALITY, SAFETY & EXPERIENCE COMMITTEE

15 October 2019 at 9.00am
Medical Education Skills Suite
(Between A2 – B2 Corridor), UHW

AGENDA

1	Welcome & Introductions	Susan Elsmore
2	Apologies for Absence	Susan Elsmore
3	Declarations of Interest	Susan Elsmore
4	Chair's Action taken since the last meeting	Susan Elsmore
5	Hot Topics	Oral Ruth Walker
6	Serious Incidents and Never Event Paper October 2018-2019	Ruth Walker
7	Tracheostomy Stimulation	Ben Hope-Gill
8	Analysis of Trends and Themes in Deaths of Patients with Mental Illness	Ruth Walker
9	Management of Endoscopy Surveillance Patients	Rebecca Aylward / Jeff Turner
10	**Items to bring to the attention of the Board/Committee** Nothing to report	Susan Elsmore
11	**Date and time of next Meeting: 17 December 2019 at 9.00am,** **Coed y Bwl, Ground Floor, Woodland House, Heath**	Susan Elsmore

REPORT TITLE:	**AN ANALYSIS OF TRENDS AND THEMES IN SERIOUS INCIDENTS OCTOBER 2018 – SEPTEMBER 2019**								
MEETING:	Quality, Safety and Experience Committee						**MEETING DATE:**	15th October 2019	
STATUS:	**For Discussion**	**x**	**For Assurance**	**x**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Executive Nurse Director								
REPORT AUTHOR (TITLE):	Head of Patient Safety and Quality, Assistant Director Patient Safety and Quality								

PURPOSE OF REPORT:

Please set out why this report is being provided to the meeting.

SITUATION:

The purpose of this report is to present the Committee with an analysis of the themes and trends in Serious Incidents (SI) reported to Welsh Government between October 2018 and September 2019.

REPORT:

BACKGROUND:
Welsh Government (WG) guidance on Serious Incident (SI) reporting and investigation procedures was updated in November 2013. It forms part of the Putting Things Right guidance which underpins the NHS Concerns, Complaints and Redress Arrangements Wales Regulations 2011.

The guidance stipulates that WG should be notified of an SI through the agreed electronic process within 24 hours of the incident occurring where possible. WG then reviews the incident and allocates a 60 working day timeframe for investigation of the incident.

The UHB has a process in place for the management of SIs and this is now well embedded, with a high level of ownership across Clinical Boards.

At the conclusion of the investigation, organisations are required to submit a closure form which summarises the findings, recommendations and learning from the investigation of the incident. The UHB continues to be praised by WG on the quality of the closure forms submitted as they demonstrate that a thorough investigation has been undertaken, root causes identified and solutions put in place to try and prevent similar incidents in the same set of circumstances.

ASSESSMENT:
The Patient Safety and Quality Department regularly meet with colleagues in the Welsh Government Improving Patient Safety Team. This meeting provides an opportunity to seek

feedback from WG regarding our threshold for reporting incidents and how we compare to other NHS Wales organisations in terms of what we are reporting, quality of information provided to WG and assurance as part of the closure process. In the most recent meeting, no concerns in relation to our reporting were raised with the UHB.

The UHB continues to monitor progress with the WG SI closure report process in a number of ways. At the time of writing this report, the UHB has 97 SIs open with WG. Timely closure of SIs with WG continues to be a priority for the UHB. 45 of the 97 open SIs are overdue a closure form. This continues to be an area in need of ongoing monitoring and improvement within the Clinical Boards. Given the level of complexity of some investigations, conclusion within 60 working days can be problematic. WG currently requires 90% of SIs to meet their 60 working day target.

A detailed review of the themes and trends of SIs is attached as Appendix 1.

In summary, 297 Serious Incidents were reported to WG between 1st October 2018 and 30th September 2019. 5 of these incidents were classified as Never Events.

To compare, 290 Serious Incidents were reported to WG in the previous report to Committee for October 2017 – September 2018. Eight of those incidents were also classified as Never Events. Therefore, there is a slight increase in the number of SIs and a reduction in Never Events reported to WG in this reporting timeframe.

The electronic incident reporting software purchased from Datix and implemented in 2015 is now well embedded in the UHB. Revisions to the system, continued provision of a helpdesk, user support groups and a regularly updated intranet site remain in place to assist staff in their use of the software.

It should be noted that a procurement exercise has recently concluded in NHS Wales whereby RLDatix has been selected to implement a comprehensive risk and compliance management solution known as DatixCloudIQ. This is being taken forwards on a 'Once for Wales' philosophy, intending to standardise the approach to patient safety and sharing of critical trends, insights and recommendations across NHS Wales. This is a complex project and the precise timescales and milestones as part of the project plan are awaited. It is anticipated that the UHB will begin to implement the first module in April 2020.

A revised Incident Reporting Policy and new supporting procedures were agreed at the Quality, Safety and Experience Committee in September 2018.

An important safety net and key benefit of the electronic incident reporting software is that it allows the establishment of various trigger mechanisms to assist earlier central knowledge and immediate escalation of concern to the Patient Safety Team and senior staff within the Clinical Board.

Where appropriate, actions have been implemented to address arising clinical risk in response to individual incidents. Following investigation, it is recognised that continued, focused attention is required on particular areas to address the root causes and ensure shared learning across the UHB, in particular relation to:

- Never Events

- Unstageable, Grade 3 and 4 healthcare acquired pressure ulcers
- Patient accidents/.falls
- Behaviour and Unexpected death or severe harm incidents particularly in the Mental Health setting
- Diagnostic processes/procedures
- Healthcare Acquired Infections
- IR(ME)R breaches due to patient misidentification

The UHB continues to upload patient safety incidents to the National Reporting and Learning System (NRLS). This is generally undertaken on a weekly basis although more significant incidents may take longer to upload whilst clarification of circumstances is sought in order to provide accurate information to the NRLS. Timely management of incidents in line managers queues are reviewed as part of the monthly Executive and Clinical Board performance review procedures. This is an area that continues to require ongoing monitoring to ensure that line managers are responding to incidents in a timely manner which in turn allows the Patient Safety Team to conclude the NRLS upload process.

The Committee should be aware that work is underway in NHS England to develop a new Patient Safety Incident Management System (PSIMS). This is in recognition of the fact that the NRLS is an aging system which requires upgrading. The Head of Patient Safety has been working with colleagues from the Welsh Risk Pool, Delivery Unit and Welsh Government in order to keep abreast of the proposed changes and potential impact on NHS Wales. This will be factored into the Once For Wales project in our upgrade to DatixCloudIQ.

RECOMMENDATION:

The Quality, Safety and Experience Committee is asked to:

- **NOTE** the report and **AGREE** that appropriate assurance has been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.

[Appendix 1]

AN ANALYSIS OF TRENDS AND THEMES IN SERIOUS INCIDENTS OCTOBER 2018 – SEPTEMBER 2019

Introduction

This report presents an analysis of trends and themes related to SIs reported to WG during the period October 2018 – September 2019. Detail of the individual incidents has previously been reported at each Board meeting.

Background

An SI is defined as an incident that occurred in relation to NHS funded services and care resulting in:

- The unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- Permanent harm to one or more patients, staff, visitors or members of the public where the outcome requires life-saving intervention or major medical/surgical intervention or will shorten life expectancy;
- A scenario that threatens or prevents an organisation's ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment;
- A person suffering from abuse;
- Adverse media coverage or public concern for the organisation or the wider NHS;
- Never Events.

All SIs are currently investigated using Root Cause Analysis (RCA) methodology. There is a very well embedded process for the management of SIs which ensures a robust and consistent approach across the UHB regardless of the Clinical Board or nature of the incident. RCA training continues to be delivered to support identified staff in their role as investigating officers. There is an excellent in-house training session delivered by the UHB's Head of Patient Safety and this is very well evaluated. The UHB has been approached by other NHS Wales organisations to support their RCA training requirements.

In recognition of the need to assist staff with identifying suitable recommendations and compiling appropriate action plans post investigation, action planning workshops were implemented in autumn 2017. The workshops have continued in 2019' having been well attended and evaluated. It is timely for multidisciplinary management teams to consider their combined role in action planning and monitoring in order to enhance rigour and governance to the process.

A weekly Executive Serious Concerns meeting continues to be held, led by the Executive Nurse Director, which reviews Serious Incidents and Concerns on a weekly basis as they are reported and seeks to gain early assurance on lessons learned from Clinical Boards by reviewing investigation reports and implementation of action plans. The weekly meetings are also

attended by the Medical Director, Assistant Medical Director for Patient Safety and Quality alongside representatives from Patient Safety and Quality and Concerns Departments. Clinical Boards will periodically attend the meeting to review the position in their area.

This weekly meeting process is considered to be good practice. The UHB has regular requests for senior staff to attend as observers from other NHS Wales organisations.

Number of Serious Incidents reported to WG and overview of Never Events reported in this reporting period

The table below demonstrates the number of SIs and Never Events reported to WG annually from October 2015 and September 2019:

Serious Incidents reported to WG	Number of incidents	Number of Never Events
October 2015 – September 2016	207	5
October 2016 – September 2017	220	5
October 2017 – September 2018	290	8
October 2017 – 27th September 2019	297	5

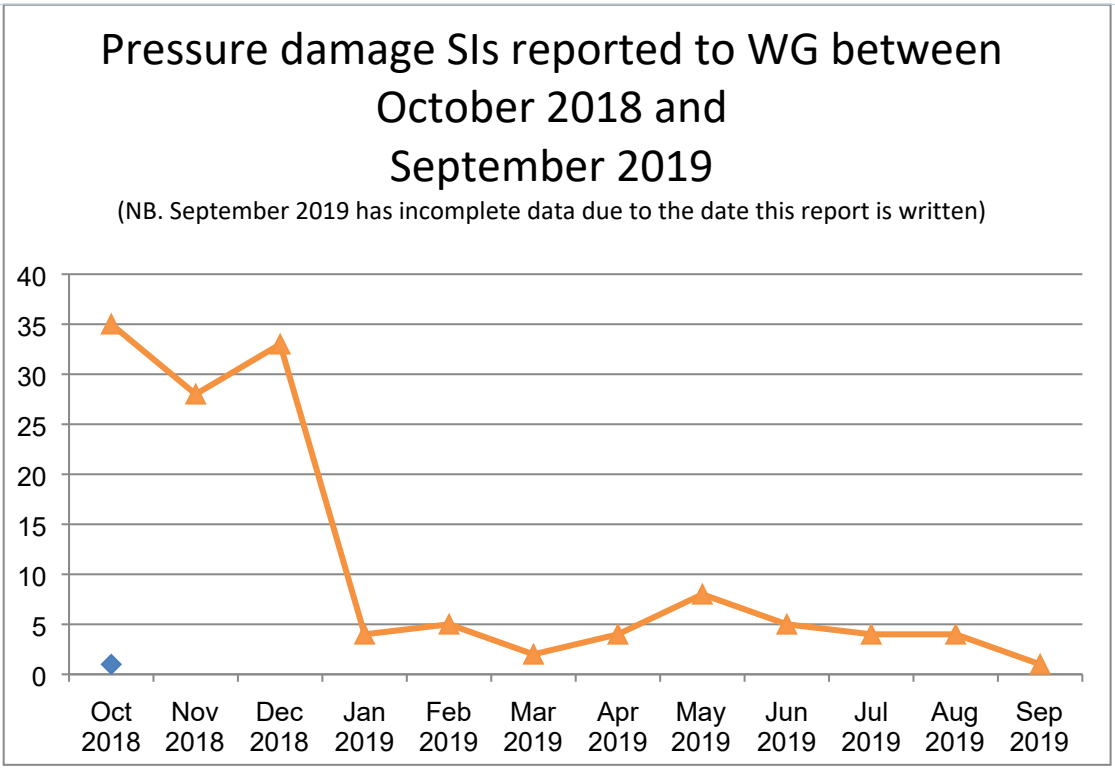
It is evident that the number of SIs reported has slightly increased again this year. In the previous year, the increase was largely in response to continued improved reporting of healthcare acquired pressure ulcers as required by WG at that time. However, Welsh Government changed the pressure damage reporting criteria in January 2019 which has affected our SI reporting rate.

The UHB is currently required to report to WG the patients who have developed pressure damage that is:-

- Grade 3, 4 or unstageable
- which developed whilst the patient was receiving NHS funded care from the UHB and
- which was considered to be avoidable following investigation of the pressure damage.

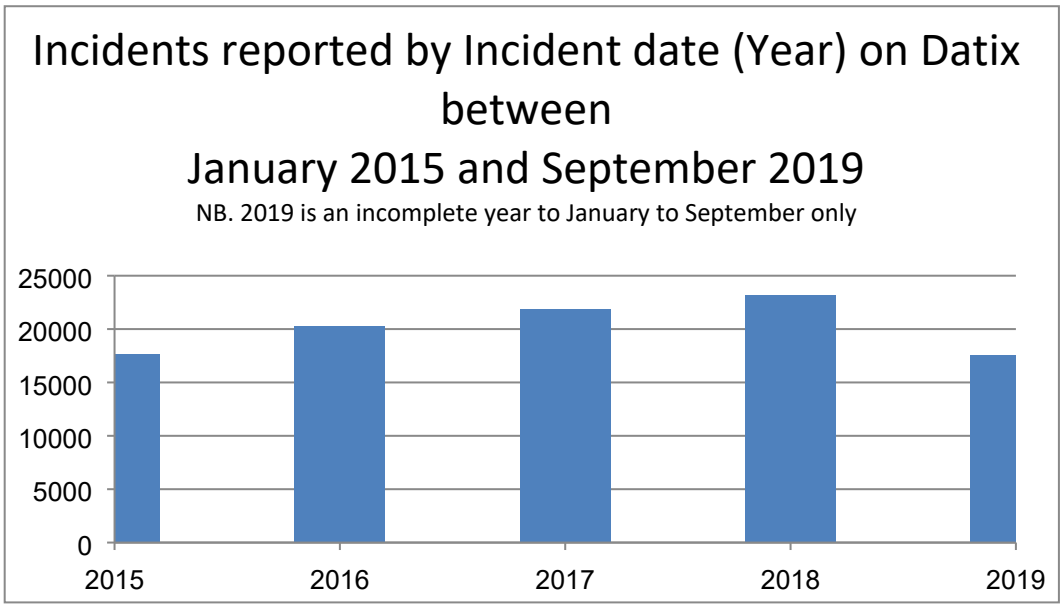
The graph overleaf demonstrates how this altered criteria has affected pressure damage SI reporting.

Health Boards are also required to submit to WG incident data on a monthly basis which demonstrates the number of pressure damage incidents reported that occurred in hospital and non-hospital locations.



It should also be noted that general incident reporting rates are increasing, demonstrating that staff know how to report incidents and that a good reporting culture exists in the UHB. The Patient Safety Team is not complacent however about the need to continuously promote incident reporting, especially with medical staff.

The following graph demonstrates the overall number of incidents reported on Datix since January 2015 (when the current web-based system was implemented) and September 2019 (therefore an incomplete 12 month period).



The number of Never Events has decreased in this reporting period and these incidents will be explored in further detail.

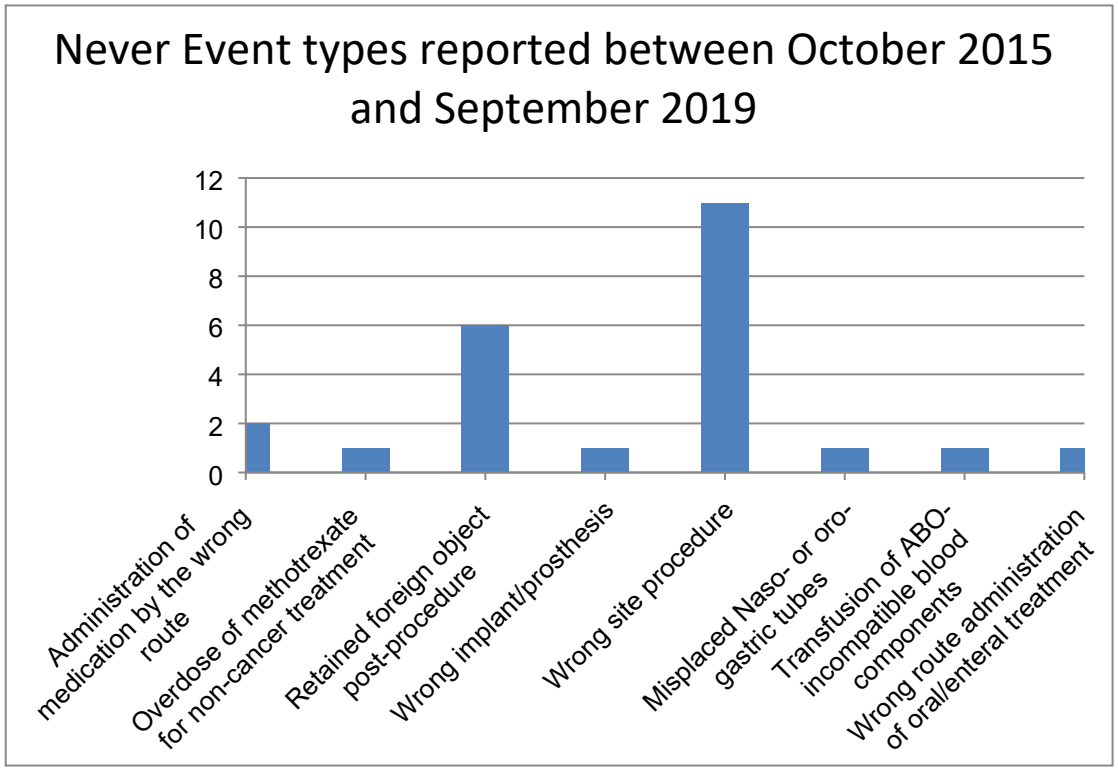
Never Events

There were five Never Events reported between October 2018 – September 2019 which were:

- Medication (Oromorph solution) was incorrectly administered via a sub-cutaneous route
- There was a retained swab incident in a surgical patient
- A patient had a botox injection to the incorrect limb
- A patient had an incorrect tooth extracted
- A patient had a cyst removed and it is currently being investigated to determine whether the clinician intended to undertake the procedure on the selected side of the patient's body on the day (based on the clinical presentation). This has been reported to WG as a Never Event in the interests of openness and transparency whilst confirmation of the circumstances is sought.

The UHB has previously seen trends in retained swabs, wrong site procedures and wrong tooth extractions. Although all of these incidents are very regrettable, none of the patients were significantly harmed as a result.

The following graph illustrates the Never Event types reported between October 2015 and September 2019.



All Never Events are subject to close scrutiny both within the UHB and by WG. WG may ask the Delivery Unit (DU) to work with organisations on SIs and Never Events on an exception basis should problems with assurance of learning occur or in order to maximize opportunities for

system wide learning.

Although each Never Event is unique, there are some common arising themes in the incidents reported by the UHB, including:

- Failure of staff to follow established processes and policies, particularly related to dissemination of policies or education required by staff to ensure policy implementation
- Communication of key information between staff
- Impact of distractions within clinical environments
- Requirement for increased vigilance with the WHO Surgical Safety Checklist
- Value of strong clinical leadership and the impact of a team's culture on safety

In the previous report to the Committee, the significant work undertaken by dental services to address their risk of Never Events was described. It is pleasing to report that there has been a marked reduction in dental Never Events this year with 1 currently reported and under investigation.

From the Never Event types it is evident that the key areas of focus continue to be reducing the risk of incorrect site procedures and avoidance of retained foreign objects post procedure. It is important to highlight that Never Events can occur anywhere within the healthcare setting and they are not restricted to surgical locations. This reinforces that managing the risk of Never Events is an integral component of the National Safety Standards for Invasive Procedures (NatSSIPs).

The UHB's NatSSIPs working group continues to meet. A prioritised work plan is in place to address pan-UHB key risks where there is potential for Never Events to occur based on local experience and / or where the UHB has non-compliance with Patient Safety Solutions issued by WG. Areas prioritised for improvement are:

- Vascular access (a visioning workshop has taken place)
- Naso-gastric tube insertion
- Chest drain insertion

Investigations after adverse events clearly demonstrate where Human Factors have significantly contributed to the incidents. The Patient Safety and Quality Department considers that it is imperative to take forwards a programme focussed on behavioural Human Factors and non-technical skills within the UHB. Other safety-critical industries are much further into the journey of understanding how cognition, decision-making, situation awareness, personality, team-working, leadership, communication skills, stress and fatigue impact on the care and treatment we provide to patients. Advanced clinical skills do not remove our human vulnerability. Improving our understanding of non-technical skills can enhance our clinical skills and improve patient safety. Staff who undertake the Leading Improvements in Patient Safety programme gain an introduction to Human Factors which is positively received. It is appropriate for the UHB to consider options for implementing a specific Human Factors programme as part of the Quality, Safety and Improvement framework.

The Head of Patient Safety has been participating in the TALK© clinical debriefing project which is led by Dr Cristina Diaz-Navarro, Consultant Anaesthetist. This has involved an opportunity to visit Stavanger University Hospital in Norway who are also participating in the research project. Stavanger University Hospital has an excellent reputation for its work on

simulation education. They have embedded education for staff about Human Factors into their multidisciplinary simulation sessions. The Head of Patient Safety is considering how the UHB can best develop a Human Factors programme.

The Patient Safety and Quality Department enjoy a positive working relationship with the Medical Education Department and directorates are encouraged to make use of the simulation suites for education purposes.

Information from WG regarding Never Events across Wales is available up to March 2018. The foll table sets out the type of Never Event and frequency with which it was reported in NHS Wales.

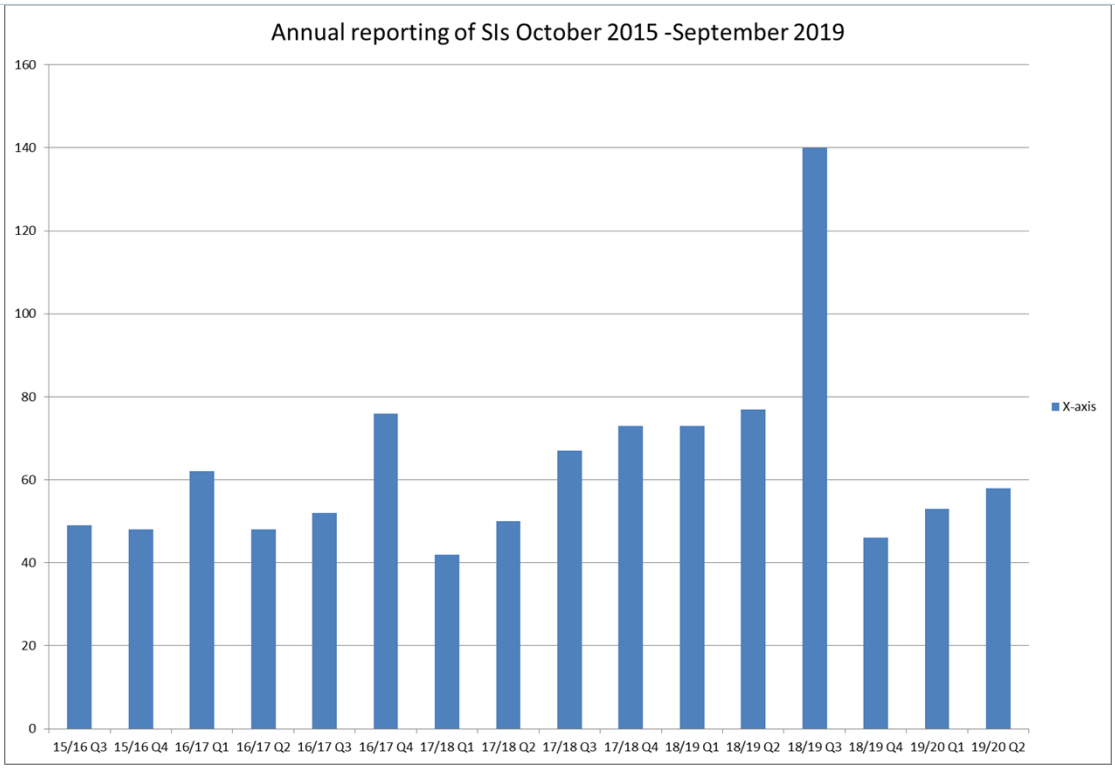
Type of Never Event in NHS Wales April 2017 to March 2018	**Number**
Retained foreign object post-procedure	5
Wrong implant/prosthesis	5
Wrong site surgery	7
Transfusion or transplantation of ABO-incompatible blood components or organs	1
Overdose of methotrexate for non-cancer treatment	1
Wrong route administration of medication	2
Total	**21**

The following table sets out the number of Never Events by organisation in the same reporting timeframe.

Number of Never events reported to WG in NHS Wales April 2017 to March 2018	
Abertawe Bro Morgannwg UHB	9
Aneurin Bevan UHB	2
Betsi Cadwaladr UHB	4
Cardiff & Vale UHB	3
Cwm Taf UHB	1
Hywel Dda UHB	2

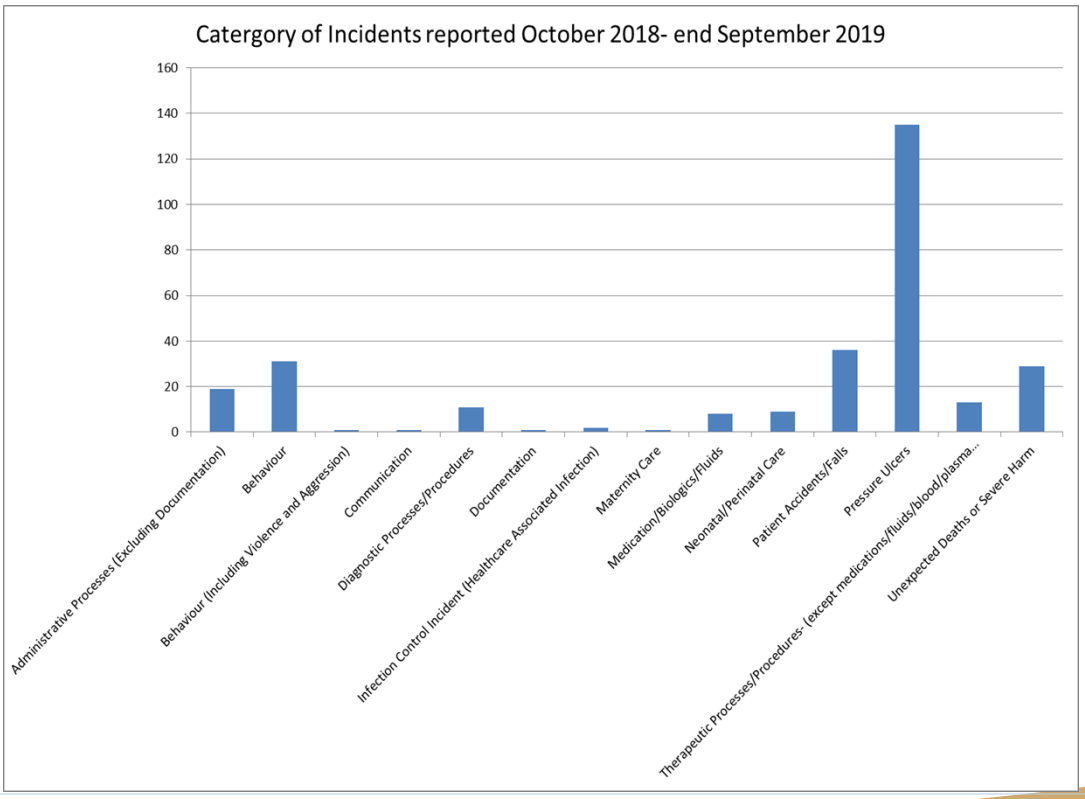
Categories of Serious Incidents reported to WG

The following graph demonstrates trends in SI reporting since October 2015:



The peak in reporting in Q3 of 2018/2019 was due to pressure damage reporting requirements, which have now been revised (as previously described).

The following graph provides a breakdown of the category of SIs reported to Welsh Government between October 2018 – September 2019, by financial year.



The top 5 categories of SI reported to WG by the UHB between October 2018 and September 2019 relate to pressure ulcers, patient falls, unexpected deaths/ behavior and administrative processes. These will be reviewed in turn.

Pressure Damage

As previously described in this report, WG changed its criteria by which Health Boards are required to report pressure damage to them as an SI. The UHB is currently required to report to WG the patients who have developed pressure damage that is:-

- Grade 3, 4 or unstageable
- developed whilst the patient was receiving NHS funded care from the UHB and
- considered to be avoidable following investigation of the pressure damage.

This change in process has had a significant impact on the volume of pressure damage SIs reported to WG. It is a challenge for the UHB to ensure that the Clinical Boards are investigating the pressure damage incidents in a timely manner in order to allow for onward reporting to WG where necessary.

The table below demonstrates the pressure ulcer incidents reported to WG by Clinical Board between October 2016 and September 2019, by financial year.

Pressure damage SIs reported to WG by Clinical Board set out by financial year					
	2016	2017	2018	2019	Total
Children and Women's Services	0	2	1	0	3
Medicine Services	3	45	59	14	121
Mental Health Services	0	2	3	0	5
Primary, Community and Intermediate Care	0	2	52	1	55
Specialist Services	0	12	33	0	45
Surgical Services	5	21	28	11	65
Total	8	84	176	26	294

The Director of Nursing for Surgery Clinical Board leads a pressure damage group and this has continued to meet during 2019. The Patient Safety Team has undertaken a review of all pressure damage SIs reported in 2018 in order to determine key themes and trends. The following issues have been identified through review of pressure damage reports and investigation outcomes:

- The most critical time for Pressure Ulcer development is the first week in care/caseload; 49.7% are present by the 7th day
- 52.24% of Pressure Ulcers were not classified as Serious Incidents when they were first detected and therefore there are likely to be some opportunities to prevent deterioration
- Pressure Ulcers appear on areas of the body that suggest that patients spend most time in prone, semi-recumbent and seated positions; 81.63% of ulcers appear on the sacrum,

buttocks & heel

- 72.45% of patients were assessed to possess 6 or more Contributory Factors for Pressure Ulcer development; patients are very unwell
- Patients aged between 65 and 84 years are at significantly increased risk of developing a Pressure Ulcer when other contributory factors are also present
- Patients aged 85 years or more are at extreme risk of developing a Pressure Ulcer when other contributory factors are also present
- Patient specific factors including patient condition, non-compliance with care provision and unavoidable deterioration in patient condition dominate all other factors in root cause analysis conclusions
- RCA Tools reported that 31.74% of patients either declined care, refused to use items of equipment or misused items of equipment. Patient non-compliance may improve if patient, family and carer communication and education are improved

The intention is to now take forwards an improvement project via the pressure damage group to explore these issues further and to identify the appropriate solutions to improve practice.

The main work being undertaken this year and overseen by the Pressure Ulcer Group includes:

- An update and review the UHB audit tool documentation
- Input into the UHB Total Bed Management contract
- Developing a standardised approach to formulary ordering and management
- Progressing work to meet the Welsh Information Standards for reporting of all stages of pressure damage to WG and the safeguarding process
- Roll out of the 'Guidelines for the Prevention and Treatment of Moisture Associated Skin Damage' (MASD)
- Roll out the All Wales PURPOSE–T risk assessment across the UHB and all wales
- Review of heel off-loading products to improve standardisation across Wales

Pressure ulcer incidents are included in key performance indicators for Clinical Boards to ensure there is appropriate scrutiny in place.

Patient Accidents/Falls

The following table demonstrates the number of SIs related to patient accidents / falls by Clinical Board.

Patient accidents/falls SIs reported to WG by Clinical Board set out by financial year						
	2015	2016	2017	2018	2019	Total
Children and Women's Services	0	4	0	1	0	5
Medicine Services	16	36	28	23	13	116
Mental Health Services	12	13	9	6	1	41
Specialist Services	2	6	2	2	0	12
Surgical Services	5	12	4	12	0	33
Total	35	71	43	44	14	207

The table demonstrates that there has been a significant reduction in the number of injurious falls being reported to WG. Medicine Clinical Board continues to report the highest number of injurious falls but again has shown a marked reduction over the last 9 months. Sadly one on elderly patient died following a reported fall and head injury. Her death was reported to the Coroner and the inquest is awaited.

The prevention and management of falls is a high priority for the organisation and a number of initiatives are underway to continue this trajectory of improvement:

- The well-established Falls Delivery Group in the UHB has a strong presence on the National Taskforce group in Wales, ensuring the UHB is well informed on latest research and evidence and links between policies and frameworks. The Falls Delivery Group has representatives from each Clinical Board within the UHB and also from external organisations such as WAST, Care and Repair and Fire and Rescue.
- The UHB Falls Framework is based on NICE guidelines and evidence-based practice, including sharing of learning from Canterbury District Health Board in New Zealand as part of an allainced approach.
- The Falls pathway has been identified as a priority for the Health Pathways programme of work associated with Canterbury the Cardiff and Vale way.
- The Falls Delivery Group will form the basis for the development of a falls alliance for Cardiff and The Vale of Glamorgan.
- Simulation suite training is to spread and embed
- Implementation of Falls strategy aligned to the work on Pathway transformation and development of an Alliance approach
- A follow up audit of call bells
- Review of the procurement and governance of hover jack equipment and training.
- Standardisation of advice around lying and standing BP recording
- Revision of the ambulatory care pathway
- Development of the Community Falls Prevention Alliance to produce actionable recommendations
- The establishment of an Inpatient Falls Prevention Alliance
- Ongoing development of Nursing e-documentation related to falls risk on wards (All Wales)
- Funding is being pursued for an improved pathway from EU to community services for people aged 75+ at risk of falls

Behaviour and Unexpected Death/Severe Harm

There were 60 SIs reported in this timeframe where the high level category was ‘Behaviour’ or Unexpected Death/Severe Harm.

Such incidents are subject to internal investigation and often to HM Coroner’s inquest processes.

Any deaths that occur in custody will also be subject to investigation by the Prison and Probation Ombudsman. No such death has been reported by Primary, Community and Intermediate Care Clinical Board in this timeframe.

In summary, the incidents in this reporting timeframe can be summarised as follows:

- There were 6 incidents whereby the Procedural Response to Unexpected Deaths in Childhood (PRUDiC) process was initiated. The circumstances of these tragic incidents are all unique but parents co-sleeping with babies is a trend that the UHB has identified and raised with Public Health Wales. The Children and Women Clinical Board have also revisited the advice on co-sleeping that they provide to parents.
- Two incidents have been reported by Specialist Services Clinical Board whereby a patient has died whilst awaiting tertiary cardiac surgery services to which he had been referred. One is a recently reported incident and no further information is currently known.
- There were 4 patients who unexpectedly died whilst under the care of Medicine and Surgery Clinical Boards. Inquest outcomes are awaited.
- The majority of the SIs in these categories were reported by Mental Health Clinical Board with 50 such incidents. They can be summarised as follows:-
- 1 inpatient suicide
- 4 incidents where patients have self harmed but not sustained longstanding physical harm as a result
- 12 of the incidents are likely to be concluded by the Coroner to be death by suicide because of the nature of the patient's death; these were all in community settings
- There were 16 deaths of patients known to substance misuse services where the Coroner concluded that alcohol or substance was a factor in their death
- There are 9 patient deaths where the inquest has not yet been held so conclusions cannot be drawn as the circumstances are not fully clear
- 1 person died where it was subsequently determined that the unexpected death was related to an underlying medical condition
- 3 incidents were reported where the hostile behaviour of patients known to Mental Health services caused harm to others
- 3 incidents where patients known to Mental Health services absconded

The trend is very similar to the previous year.

Mental Health Clinical Board have recently appointed into a Consultant Nurse post. A focus for the post holder will be in relation to deaths by suicide.

A more detailed report setting out processes following unexpected deaths in patients known to Mental Health services is presented as a separate agenda item, to the October 2019 Quality, Safety and Experience Committee by the Mental Health Clinical Board.

The Committee should also be advised that two deaths involved the care of patients with tracheostomies. The first was a child in the community with complex heath needs. The second is an adult in-patient. This is currently under investigation. Cardiff and Vale UHB is currently non-compliant with Patient Safety Notice 049 - Tracheostomies, which was issued in April 2019. This replaced a previous notice, which was issued in May 2018.

Despite extensive work by the clinical teams involved, unresolved issues in the community and paediatric areas of practice are preventing the Health Board from reaching a position of full compliance with PSN049. The UHB has a robust tracheostomy guideline for adult patients and this is well embedded in the organisation. In the expert opinion of the clinical team, the local

UHB guideline exceeds what is required in the cross-Wales 'Tracheostomy Guidelines for NHS Wales'.. The guideline that was reissued in April 2019 included the addition of a chapter on paediatric tracheostomies but did not address any of the factual errors in the adult sections of the guideline.

The adult tracheostomy team provide support to community patients and their carers on an ad hoc basis, but this is not a fully resourced service. . A properly established and resourced service would provide training to those who support patients with tracheostomies, enable a regular multidisciplinary review of patients and assist with troubleshooting in the community to reduce hospital admissions.

The paediatric tracheostomy team have no dedicated time for the development of guidelines, but would like to produce robust guidance as has been developed for adults. The paediatric tracheostomy team provide services for a large part of Wales. The team are keen to develop their service which supports children and their families.

While the number of patients with tracheostomies is relatively small as a percentage of the overall patient population, the potential for life threatening complication is real

A paper in relation to what is required to improve compliance with PSN 049 is being drafted for consideration by the management executive.

Administrative Processes (excluding documentation)

There were 18 incidents reported under the category of Administrative Processes. This is a high level category with sub-categories such as admission, transfer, discharge problems; consent concerns; referrals and handovers.

The incidents reported can be summarised as follows:

- Children and Women Clinical Board – a complication following an invasive procedure with a device subsequently withdrawn from use was reported
- Clinical Diagnostics and Therapeutics Clinical Board – a retrospective SI was reported. This is being managed via the clinical negligence claims route and it relates to a delayed interventional procedure due to clinical judgment. There was a second incident involving the death of a patient following an interventional procedure. There are no identified trends or themes.
- Medicine Clinical Board – an incident was reported regarding the discharge decision on a patient following an early warning score which had been calculated incorrectly
- Mental Health Clinical Board –The main trend relates to the admission of children under the age of 18 to adult mental health wards. 6 such SIs were reported to WG. There is a dedicated bed at Hafan Y Coed for this type of admission and generally children are normally admitted for a short time for assessment and discharged with the relevant support in place. The Executive Director of Nursing has requested that the Children and Women Clinical Board and Mental Health Clinical Board review the operational procedures in place in such circumstances in order to safeguard the well-being of the children.
- Specialist Clinical Board – the UHB has reported the deaths of two patients awaiting cardiac surgery. Both patients had exceeded the accepted referral to treatment time. A number of measures are in place to manage this situation, including:
    - It is the responsibility of the referrer to continue the physical monitoring of these

patients while they are on the cardiac waiting list. This is now widely understood and embedded
    - Patients are provided with an information n booklet and leaflet so that they understand what to do in the event of a deterioration in their symptoms
    - The Aortic Stenosis pathway is being transformed to ensure timely access to surgery for this particularly high risk group of patients
    - Each cardiac surgeon is responsible for prioritising their lists to ensure they operate on the patient who is most at risk.
    - WHSSC and the Clinical Board are considering the use of out-sourcing to improve capacity.
    - New referrals are now being pooled and actively re-directed to Consultants with the shortest waiting lists.
- Surgery Clinical Board – the main trend in Surgery relates to delays in seeing ophthalmology patients. Three patients were delayed in the ophthalmology out-patient setting and all have experienced a deterioration in their eyesight as a result.

Trends to monitor
As previously indicated there are two other categories of SIs to draw attention to:

- Healthcare Associated Infections
- Ionising Radiation (Medical Exposure) Regulation breaches

Healthcare Associated Infections (HCAI)

Certain incidents involving HCAI must be reported to WG as SIs. These include:

- Any death where a healthcare associated infection (including *Clostridium difficile* and methicillin resistant *Staphylococcus aureus)* is mentioned on the death certificate as either the underlying cause of death or contributory factor
- An outbreak* of a healthcare associated infection in a hospital that results in the closure of a ward/bay to admissions and causes signification disruption. closure of a bay which does not cause significant disruption to service should be reported as a No Surprise
- Transmission of infectious diseases

The table below indicates that 2 HCAI SIs were reported to WG in the reporting timeframe representing an ongoing reducing trend.

Infection Control Incident (Healthcare Associated Infection)	Total Oct 2015 – Sept 2016	Total Oct 2016 – Sept 2017	Total Oct 2016 – Sept 2017	Total Oct 2018 – Sept 2019
Children and Women's Services	2	0	0	0
Medicine Services	3	4	0	1
Mental Health Services	0	0	1	0
Specialist Services	3	6	2	1
Surgical Services	4	2	1	0
Total	12	12	4	2

The incidents included presence of *Vancomycin Resistant Enterococcus* in Specialist Services Clinical Board Haematology and Bone Marrow Transplant department. The ward has since been totally refurbished; there have been no further cases since the May 2019. The second incident arose in a Medical Services Clinical Board patient who had *Clostridium difficile* infection recorded on part 2 of their death certificate. All appropriate actions, in line with the IP&C Outbreak Policy were implemented in these cases.

On an All Wales Basis the UHB continues to perform well in relation to IP&C. The position at the end of September 2019 for C&VUHB is:

C - difficle – 49 cases have been reported between April –Sept 2019. This is 21% fewer that the equivalent period in 2018/2019. The UHB is currently on target to meet the reduction expectation target.

Staph aureus – 55 staph aureus bacteraemia have been reported between April –Sept 2019 – this is 29% fewer that the equivalent period in 2018 -2019 although the rate of MRSA is approximately 17% more. Overall the UHB is slightly above the reduction expectation target at this point in time.

The numbers of EColi are approximately 7% more than this period last year with 202 cases being reported from April –Sept 2019. Currently the UHB is not meeting the reduction expectation target.

45 cases of reported Klebsillea are 2% fewer than the equivalent period last year and performance is slightly above the required improvement trajectory. The numbers of pseudomonas are 7% fewer than the equivalent time period and at time of writing the UHB is forecast to meet the reduction expectation target by the end of the financial year.

It is evident from the SIs reported that the UHB must continue to strive to improve performance relating to HCAI. There is a well- established Infection Prevention and Control Group chaired by the Executive Nurse Director which oversees the improvement plan. Key performance indicators for Clinical Boards in relation to this agenda are also monitored monthly with the Executive team. The following improvement actions have been identified as key deliverables for 2019/2020:

- Continue to roll out ANTT to all relevant staff, including medical staff, and ensure allocation of time for staff to attend training, time and IT access to undertake the e-learning module, and purchase of appropriate equipment.
- Continue with the RCA process to ensure a multidisciplinary approach and to make sure lessons are learned from incidents/outbreaks of healthcare associated infection.
- Ensure there is a rolling programme for maintenance or replacement of equipment.
- Work with Capital & Estates to develop a rolling programme for ward/department refurbishment and to ensure the IP&C team is involved at the start of Capital projects related to new builds
- Continue to support the antimicrobial resistance delivery plan
- Work closely with C&V and NHSSS procurement departments to standardise products and equipment in use and to eliminate unnecessary costs to the Health Board
- Work with relevant Clinical Boards to develop further robust winter plans to deal with outbreaks of infections e.g. norovirus, influenza, to avoid disruption to patient flow

- Continue to work with companies and suppliers to ensure support with audit and education and promotional opportunities e.g. WHO Hand Hygiene Awareness week
- Continue to develop the IP&C Link Practitioner programme to ensure that engaged and knowledgeable staff are out in clinical areas to support the IP&C agenda

The UHB has also implemented a joint IP+/Microbiology ward round daily.

Clinical Boards are also focusing on initiatives to reduce bacteraemias including Staph Aureus screening in some areas (orthopaedics, renal and haematology). There is also a sustained focus on the utilization of the PVC and BC insertion packs and bundles.

Ionising Radiation (Medical Exposure) Regulation Breach Incidents

Prior to February 2017 NHS Wales organisations were required to report breaches of the IR(ME)Regulations to WG and Healthcare Inspectorate Wales. This was revised in February 2017 to sole reporting to HIW unless there was a particular need to also report the matter to WG as an SI in its own right. IR(ME)R breach incidents are subject to the same scrutiny internally and via HIW following this change in practice.

There have been 11 incidents reported to HIW in this reporting timeframe which is a significant increase on the previous year where 4 incidents were reported.

The incidents involved:

- wrong addressographs being placed on request forms on 3 occasions;
- the wrong patient transferred to Radiology on 2 occasions;
- equipment failure leading to repeat X-rays on 2 occasions;
- a letter filed in the incorrect patient notes led to an investigation being requested on the incorrect patient;
- the same investigation for a patient was requested by 2 different clinicians;
- an ultrasound was required but a pelvic X-ray was requested;
- an MRI scan was required but a CT scan was requested.

These incidents are all at different stages of investigation.

The main trends and themes include:

- Staff failing to follow positive patient identification processes
- Hazards associated with handwritten request forms
- Hazards associated with repeat examinations and failures in justification processes

The Clinical Diagnostics and therapeutics Clinical Board have also undertaken a review of IRMER incidents from November 2018 – August 2019. Other additional contributory factors were:

- duplicate requests
- booking errors
- vetting errors
- time pressures

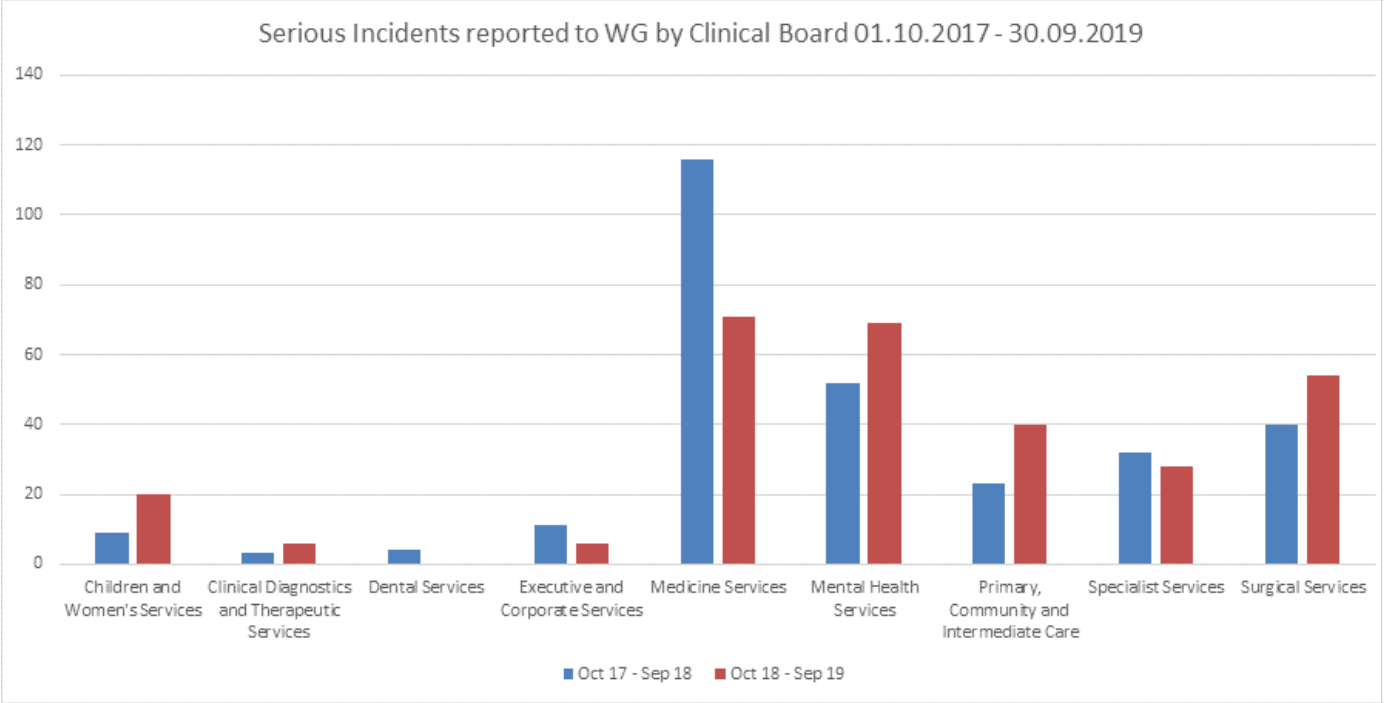
- IT/equipment failure
- communication barriers
- patient factors such as the complexity and the seriousness of their condition
- lapse in concentration
- assumptions at handover of patients
- failure to adequately correlate the clinical information with the patient
- inadequate supervision of junior staff

There is an improvement plan in place that is being monitored by the Clinical Board, however patient mis-identification through the use of the wrong addressograph by the referrer, is a UHB wide issue. Staff were reminded of their responsibilities in relation to positive patient identification and handwritten request forms in the December 2018 Patient Safety and Quality Newsletter. This will continue to be an area of focus for 2019 - 2020. Positive patient identification processes are also checked as part of the internal unannounced inspection process.

The Patient Safety Team concluded the implementation of printing solutions for electronic wristbands for inpatients across the Health Board during 2018. As anticipated however, upgraded wristband solutions do not negate the need for rigorous checking of patient identification prior to interventions.

Representatives from the UHB met with NWIS Executives on 13/9/19 and 20/9/19 to discuss timelines for the delivery of electronic requesting, vetting and scheduling. However, electronic requesting in unlikely to be delivered before 2021 due to the volume of work required. Continued vigilance by referrers and operators is therefore required to minimise the risk of radiation related incidents.

Serious Incidents by Clinical Board



Trends across Clinical Boards are changing; this is largely due to revised pressure damage reporting requirements. Patient falls and pressure damage were a particular feature in Medicine Clinical Board during 2017-2018. but a decrease in both as resulted in a marked reduction in overall numbers reported. Children and Women, Mental Health and PCIC have all seen an increase in the number of SIs reported in the Clinical Board.

Mental Health Clinical Board have seen an increase in unexpected deaths and behaviour incidents which have been described earlier in this report.

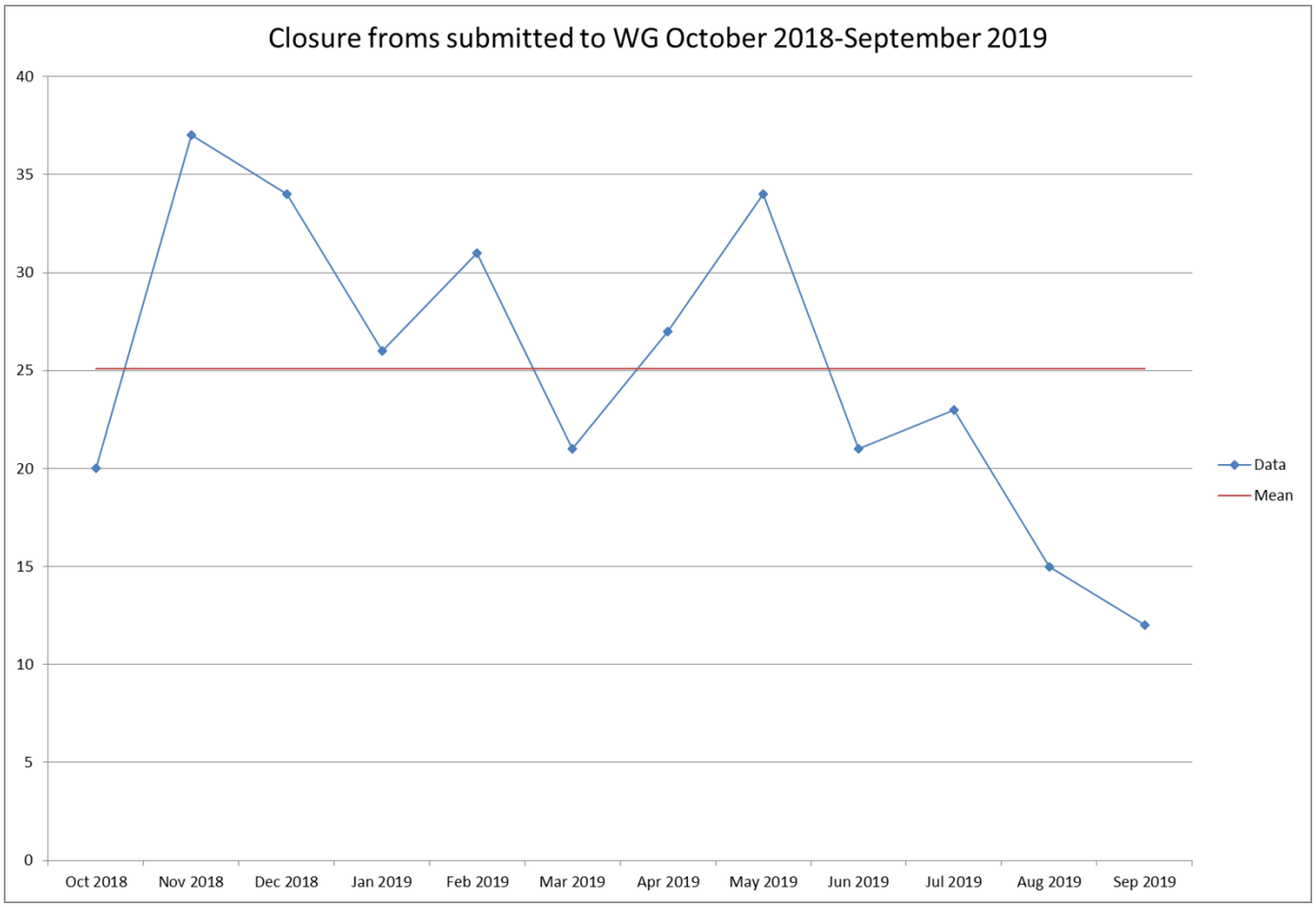
Various categories of incidents were reported in Children and Women Clinical Board and a number of incidents relating to obstetric / neonatal patients are now drawing to a conclusion. PCIC continue to improve the quality of pressure damage reporting – having previously been identified as an outlier in Wales.

Closure of Serious Incidents with Welsh Government

The UHB is required to submit a closure form to Welsh Government on conclusion of a Serious Incident investigation process. This provides assurance on the measures that have been taken to avoid a similar incident in a similar set of circumstances. Closure forms are subject to review within Clinical Boards quality and safety mechanisms, prior to sign off by the Executive Nurse Director or Assistant Director of Patient Safety and Quality.

A trajectory to improve the position of closure form submission to WG was established with the Clinical Boards in April 2016. This has been subject to performance monitoring arrangements and is regularly reviewed to ensure the status of open SIs does not deteriorate. This has been very effective in securing a marked improvement over the last three years and the UHB has continued to make progress over the last 12 months although he number of closures submitted has decreased over the last 4 months and this has a reciprocal effect on the numbers of SIs recorded as open with WG. Closure targets for the Clinical Boards will be re-issued and

processes for the closure of SIs within the Corporate function revised.
At the time of writing this report, the UHB has 97 SIs open with WG. In this reporting timeframe, 294 closure forms were submitted to WG.



SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right		10. Excel at teaching, research, innovation and improvement and	

care, in the right place, first time		provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	x	Long term	x	Integration		Collaboration		Involvement		

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Report Title	**Processes in place for the managment of reported Serious Incidents in Mental Health service users**						
Meeting:	**Quality, Safety and Experience Committee**				**Meeting Date:**	**15/10/19**	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**
Lead Executive:	**Executive Nurse Director**						
Report Author (Title):	**Director of Nursing, Mental Health Clinical Board**						

SITUATION

The Quality, Safety and Experience committee has sought assurance that the Serious Incidents reported by the Mental Health Clinical Board are monitored by the Clinical Board QSE group and that lessons are learned. The Board further asked what could be done in the future to prevent these incidents, what mitigating actions are in place and whether there are any trends.

Statistics on the number of incidents in a mental health setting are included in a seperate Serious Incident and Never Event report to Committee.

BACKGROUND

The 2018 annual report from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) provides findings relating to people who died by suicide or were convicted of homicide in 2006-2016 across all UK countries using national data, those who were in contact with specialist mental health services in the 12 months before the incident and the provision of detailed clinical information via questionnaires by the clinicians involved.

The key findings show that suicide rates show a downward trend, the commonest method of suicide continues to be hanging/strangulation – almost half of all suicides, followed by self-poisoning, usually opiates. The highest risk was in the first 2 weeks post discharge with the highest number of deaths occurring on day 3 post discharge.

ASSESSMENT

<u>In-patient suicide</u>

The NCISH data for Wales shows that in-patient deaths by suicide are similar to the rest of the UK with numbers fluctuating from 3-10 per year. 26% died on the ward, 64% were on leave and 10% AWOL. Hanging/strangulation was the most common method and the majority died in a single bedroom or bathroom. The most common ligature point was doors and the most common ligatures were belts or shoelaces. 13% of in-patient suicides were under a medium or high level of observation.
The serious incident that occurred in mental health in-patient services did not use any of the methods described above.

<u>Community suicides</u>

18% of all patient suicides occur within 3 months of discharge from in-patient care, with the most at risk period being 2 weeks post discharge and the highest number on day 3.

Across Wales, 51% of deaths are due to hanging – this is higher than the national average of 43%. For C&V, 9 of the community deaths were due to hanging. Nationally there was no overall trend in the numbers of suicides in relation to diagnosis.

There does not appear to be a trend in relation to the community deaths, other than the method used. The MHCB currently has a 5 day follow up policy and all but one patient received an appointment within

5 days. Given the NCISH evidence that day 3 is when patients are most at risk, mental health services will consider how to meet this more challenging target.

Drug Related Deaths

The most common substances misused in the 3 months prior to suicide/unexpected death were alcohol (55%), cannabis (27%) and stimulants (18%). Specifically in relation to clients managed by substance misuse services, the most common reason for death is opiate overdose. It is very difficult to establish whether this is intentional or accidental.

ASSURANCE is provided by:

NCISH suggest 10 ways to improve safety:

- **Safer wards** – Hafan y Coed was built to the H&S standards of 2015.Following a serious incident 2 years ago and funding from WG, en-suite doors have been removed and replaced with collapsible saloon style doors.
- **Early follow up post discharge** – new evidence shows follow up should occur on day 3. MH services will consider how to meet this challenge
- **No out of area admissions** – these are rare occurrences with additional capacity opened on PICU to avoid this whenever possible.
- **24-hour crisis teams** – operational
- **Family involvement in 'learning lessons'** – embedded process
- **Guidance on depression** – NICE guidelines followed. Good PMHSS service and long established book prescription scheme
- **Personalised risk management** – WARRN utilised as the risk assessment tool. Recent increase in the number of trainers (10) with fortnightly courses for 15 staff running.
- **Outreach teams** – FEP and FORT for mental health. Re-engagement team for substance misuse. Crisis team/React also provide assertive engagement
- **Low staff turnover** – currently approx. 10% - better than rest of Wales
- **Service for dual diagnosis** – dual diagnosis framework in place with staff trained in each CMHT, liaison psychiatry and links in each inpatient area.

The MHCB is required to balance positive risk taking that will encourage recovery, reablement and personal responsibility against the risks of suicide and self-harm. This approach is one of the cornerstones of high quality, evidence-based mental health care and is widely supported by service users and carers.

The MHCB has a robust process for reviewing serious incidents. The weekly 'sentinel events' meeting is an integrated meeting with the LA in attendance. (The CMHTs are integrated services). The CB has a zero tolerance to failure to appropriately assess the risk of suicide/self harm in the management of any patient. A flowchart outlining the MHCB process for serious incident management is attached as appendix I.

The CB has recently appointed a Consultant Nurse for Complex Clinical Risk (mental health). One of her key priorities is to review the risk assessment policy and develop training to raise standards.

RECOMMENDATION

The QSE Committee is asked to:

- **SUPPORT** the position taken by the Clinical Board.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention	X	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	No

Report Title:	**MANAGEMENT OF ENDOSCOPY SURVEILLANCE PATIENTS**						
Meeting:	Quality, Safety and Experience Committee				**Meeting Date:**	**15/10/19**	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	Chief Operating Officer						
Report Author (Title):	Deputy Chief Operating Officer						

SITUATION

The purpose of this paper is to provide an update on progress in relation to the management of patients on an endoscopy surveillance waiting list overdue their procedure.

The Committee has previously been advised of a trend in SI reporting in endoscopy services. A paper was presented to the April 2018 Committee meeting. At the time of that report 24 SIs related to endoscopy had been reported to WG since May 2015.

BACKGROUND

The Quality, Safety and Patient Experience Committee have received reports at previous meetings regarding the management of patients on an endoscopy surveillance waiting list overdue their procedure. This was against the backdrop of general concerns that patients were waiting too long and governance concerns arising from reported Serious Incidents (SI) in Endoscopy. Proactive management of the surveillance backlog supported by a detailed action plan as a result of these incidents has led to a significant reduction in the number of overdue surveillance procedures, with no new SI's reported.

ASSESSMENT

The volume and risk profile (a clinically agreed risk scoring methodology based on the planned interval date and the amount of time the patient is delayed beyond the planned date) for surveillance patients has improved significantly since the last committee, as follows:

Endoscopy Surveillance			
Risk rating	**Volume Aug 2019**	**Volume Jan 2019**	**Volume Dec 2017**
300% or more	3	6	24
200% - 300%	3	7	32
100% - 200%	3	64	71
75% - 100%	7	70	98
50% to 75%	8	114	205
25% to 50%	22	267	302
0% to 25%	39	368	321
Total > 8 weeks overdue	**101**	**896**	**1053**

There has been an overall reduction of 91% since December 2017 to date, Of the 101 patients

> 8 weeks overdue, 70 patients (69%) have appointment dates. The remaining 30 patients are within the contact process.

This reduction has, in the main, been achieved through additional capacity secured through in-year funding to reduce waiting times. This forms part of the wider Health Board plan to improve patient experience and access to endoscopy services, balancing core and additional capacity across clinical priorities and all categories of patients – urgent, routine and surveillance. Additional capacity will continue to be focused on those patients with the highest clinical need.

As previously reported to mitigate the risk of patients waiting beyond their target date for surveillance procedures, the following practice is now fully embedded:

- Risk stratification process in place so that those with the highest clinical need are prioritised. This will not necessarily be those with the longest wait.
- Clinical and clerical validation process is in place.
- Dedicated administrative staff oversee the surveillance waiting list.
- Patient letters clearly state that if symptoms change during their waiting period, GP advice should be sought.
- Where symptoms have reportedly changed, GP expedite requests are given priority.
- Outpatient clinics are offered to elderly patients to discuss the risk benefits of surveillance.
- Surveillance procedures are now included into core capacity.

No new Serious Incidents have been reported as this backlog has been cleared and since the previous committee report in February 2019.

ASSURANCE is provided by:

- The overall volume of patients overdue their planned surveillance endoscopy has reduced significantly over the last year
- Prospective clerical and clinical validation of the surveillance waiting list is being undertaken with clearance of the backlog
- There are processes in place to mitigate the risk of patients waiting beyond their target date for surveillance endoscopy procedures

RECOMMENDATION

The Committee is asked to:

- **NOTE** the current position and work ongoing in relation to the management of patients overdue their endoscopy surveillance procedure

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	√
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
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5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term		Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								