Quality, Safety and Experience Committee

13 October 2020, 09:00 to 12:30

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

Ruth Walker / Stuart Walker

6. Quality, Safety and Experience Themes and Trends 2019-2020

Carol Evans / Angela Hughes

06 - QSE Committee Oct 2020 v5 FINAL.pdf (67 pages)

7. Analysis of Themes and Trends in Deaths of Patients with Mental Illness - learning, action taken and improvement since last year

Ian Wile / Annie Proctor / Mark Warren

07 - Trends 1.pdf (12 pages)

8. Items to bring to the attention of the Board/Committee

Susan Elsmore

9. Review of the Meeting

Susan Elsmore

10. Date and time of next Meeting: 15 December 2020 at 9.00am

Susan Elsmore

Serious Incidents and Never Events Concerns (Complaints and Claims)

Themes and Trends - October 2019 – September 2020

Quality, Safety and Experience Committee

13th October 2020

Definition of a Serious Incident

- A Serious Incident is defined as an incident that occurred during NHS funded healthcare (including in the community) which resulted in one or more of the following:
- Unexpected or avoidable death or severe harm of one or more patients, staff or visitors
- Never Events
- A scenario that prevents or threatens to prevent an organisation's ability to continue to deliver healthcare services
- Allegations or incidents of physical abuse and sexual abuse or assault
- Loss of confidence in the service or adverse media coverage or public concern about the organisation

Definition of a Never Event

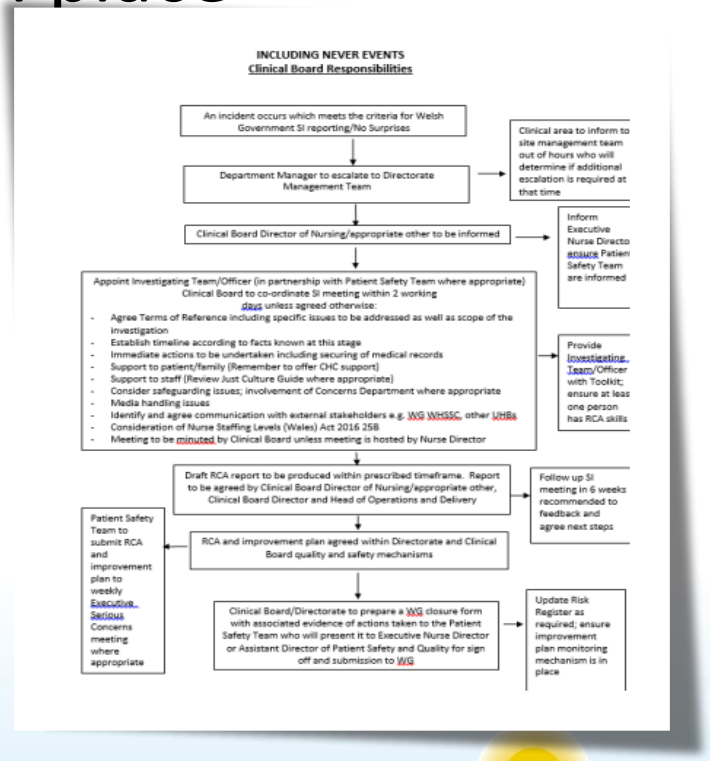
- Welsh Government guidance revised in 2018
- “Never Events are Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers.
- Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never event”.

Serious Incident process

- External requirements
- Changing process from October 2020 – now reporting SIs to the Delivery Unit
- Report SI to WG/DU within 24 hours of the incident via corporate Patient Safety Team
- Timeframe for investigation is 60 working days
- UHB submits a closure form to summarise the findings, recommendations and learning from the incident investigation
- WG/DU review of closure form and confirmation of closure sent to the Patient Safety Team

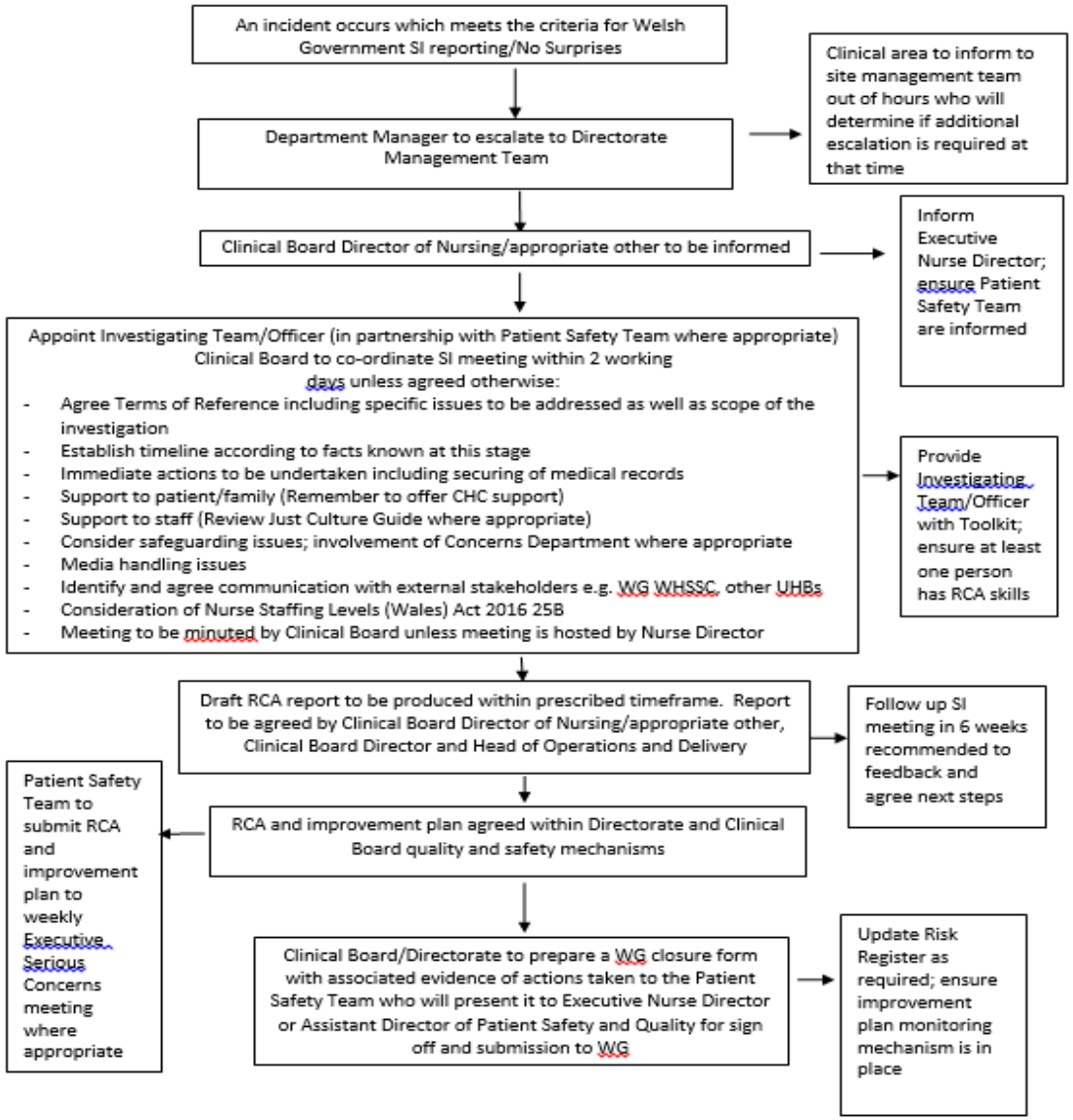
Serious Incident process cont'd

- Internal process
- Incident reporting policy in place
- Flowcharts under review

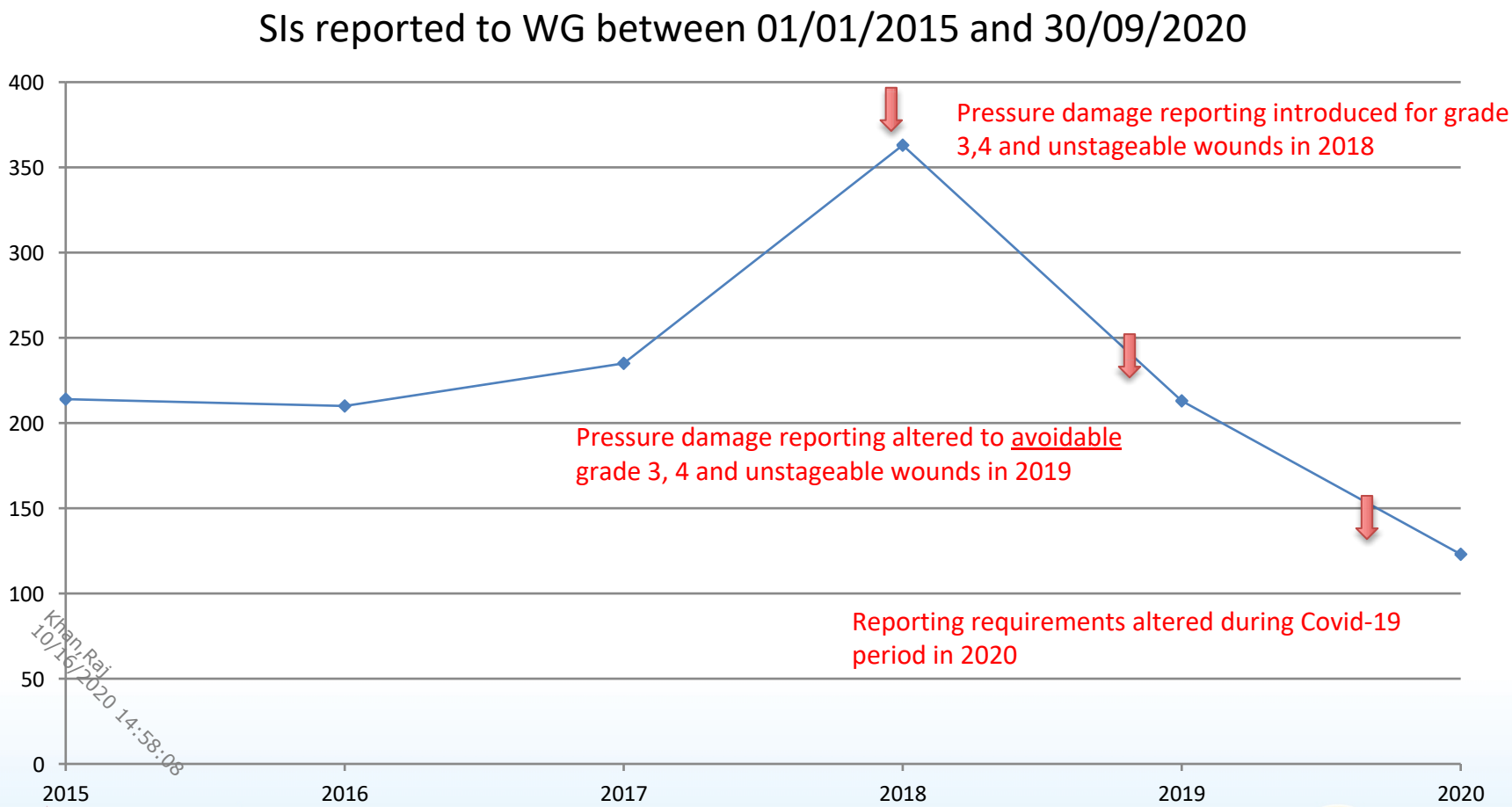


Khan Raj
10/16/2020 14:58:08

PROCESS FOR THE INVESTIGATION AND MANAGEMENT OF SERIOUS INCIDENTS (SI)
INCLUDING NEVER EVENTS
Clinical Board Responsibilities

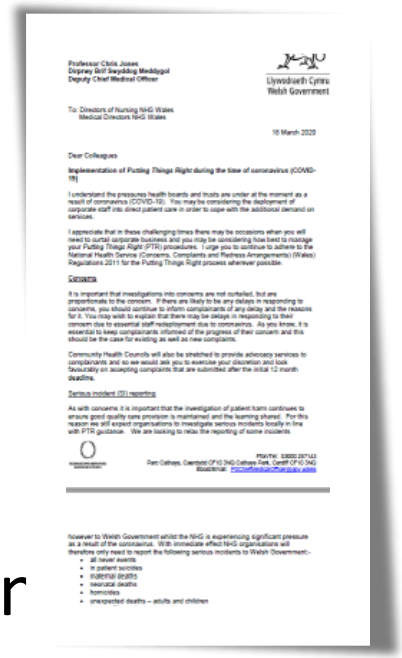


SIs reported to WG between January 2015 and September 2020



WG revised SI reporting March to August 2020

- Never Events
- Inpatient suicides
- Maternal deaths
- Neonatal deaths
- Homicides
- Unexpected deaths – adults and childrer
- Human Tissue Authority incidents
- Incidents of high impact and likely to happen again



Professor Chris Jones
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer

Llywodraeth Cymru
Welsh Government

To: Directors of Nursing NHS Wales
Medical Directors NHS Wales

16 March 2020

Dear Colleagues

Implementation of *Putting Things Right* during the time of coronavirus (COVID-19)

I understand the pressures health boards and trusts are under at the moment as a result of coronavirus (COVID-19). You may be considering the deployment of corporate staff into direct patient care in order to cope with the additional demand on services.

I appreciate that in these challenging times there may be occasions when you will need to curtail corporate business and you may be considering how best to manage your *Putting Things Right* (PTR) procedures. I urge you to continue to adhere to the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 for the Putting Things Right process wherever possible.

Concerns

It is important that investigations into concerns are not curtailed, but are proportionate to the concern. If there are likely to be any delays in responding to concerns, you should continue to inform complainants of any delay and the reasons for it. You may wish to explain that there may be delays in responding to their concern due to essential staff redeployment due to coronavirus. As you know, it is essential to keep complainants informed of the progress of their concern and this should be the case for existing as well as new complaints.

Community Health Councils will also be stretched to provide advocacy services to complainants and so we would ask you to exercise your discretion and look favourably on accepting complaints that are submitted after the initial 12 month deadline.

Serious incident (SI) reporting

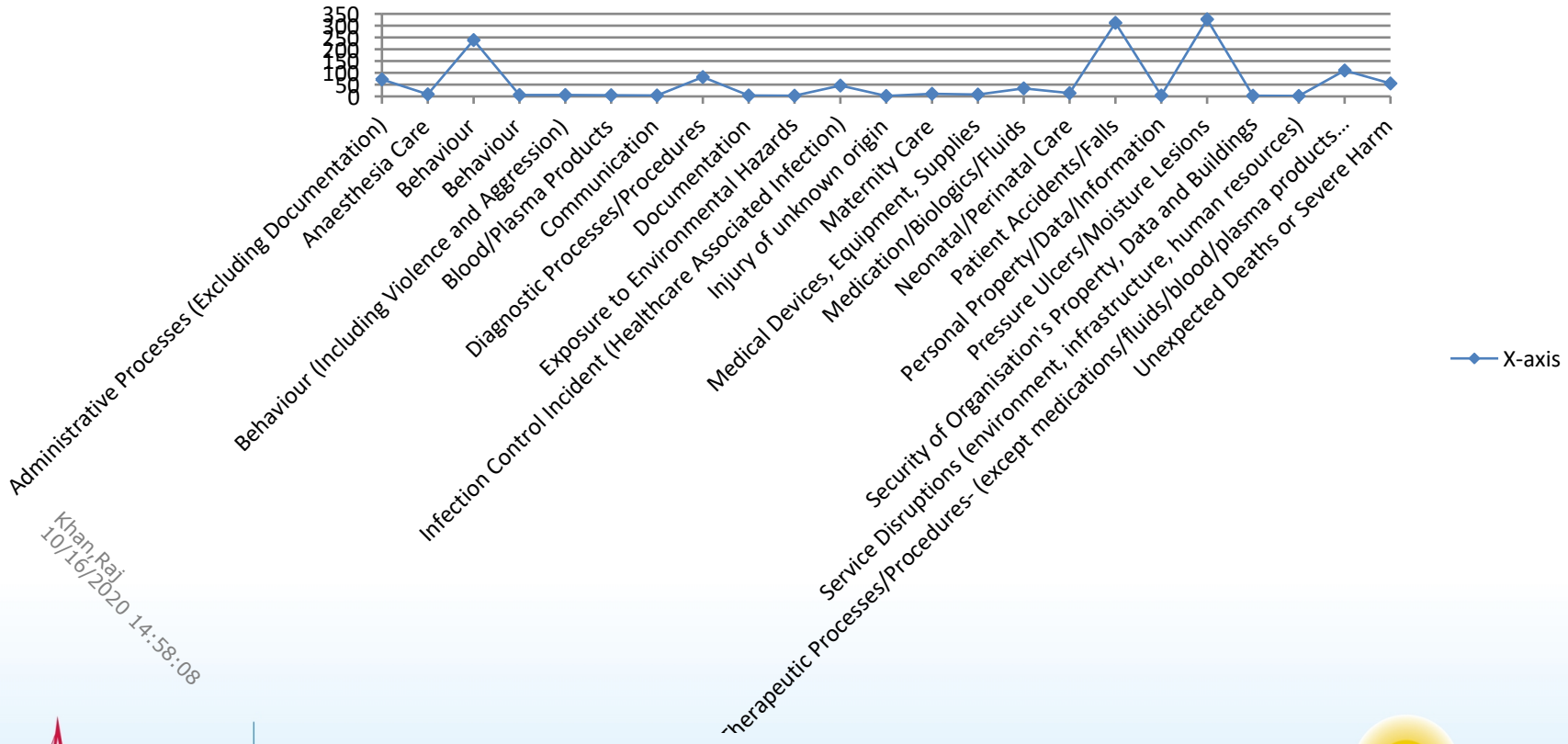
As with concerns it is important that the investigation of patient harm continues to ensure good quality care provision is maintained and the learning shared. For this reason we still expect organisations to investigate serious incidents locally in line with PTR guidance. We are looking to relax the reporting of some incidents.

Ffon/Tel: 03000 257143
Parc Cathays, Caerdydd CF10 3NQ Cathays Park, Cardiff CF10 3NQ
Ebost/Email: PhilipRankin@Wales.gsi.gov.uk

however to Welsh Government whilst the NHS is experiencing significant pressure as a result of the coronavirus. With immediate effect NHS organisations will therefore only need to report the following serious incidents to Welsh Government:-

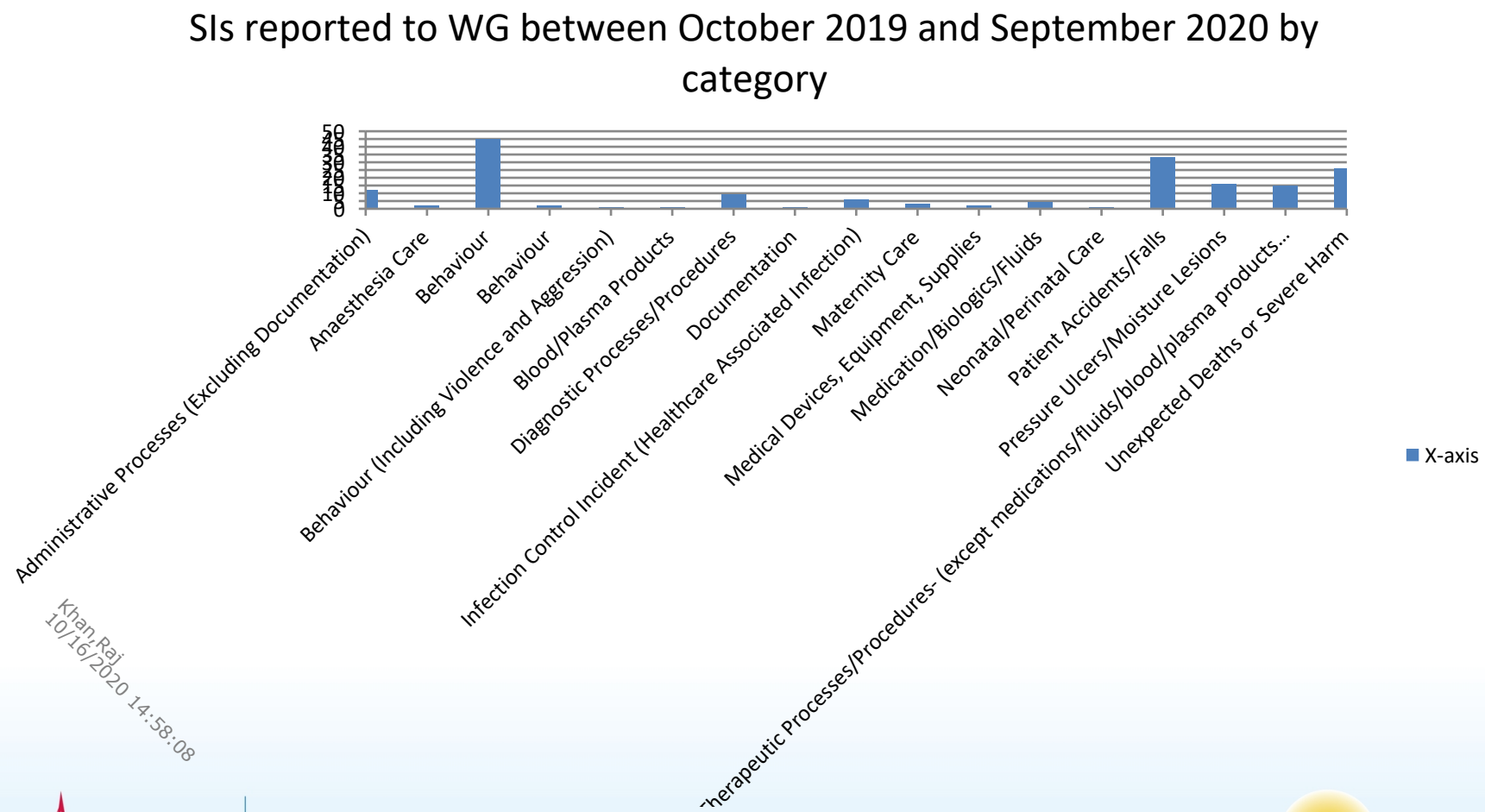
- all never events
- in patient suicides
- maternal deaths
- neonatal deaths
- homicides
- unexpected deaths – adults and children

SIs reported to WG between January 2015 and September 2020 by category



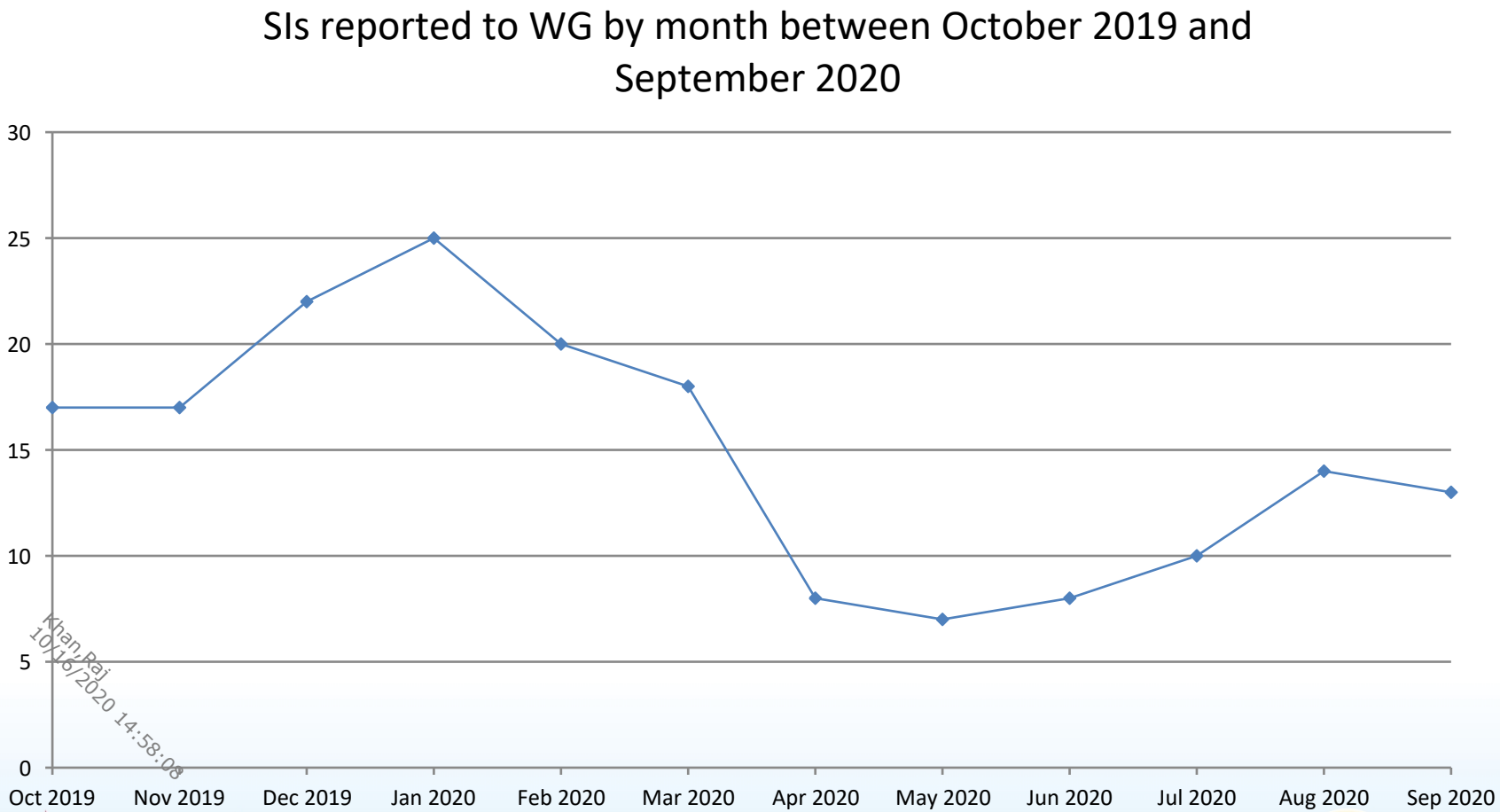
Khan Raj
10/16/2020 14:58:08

SIs reported to WG between October 2019 and September 2020 by category (n=179)

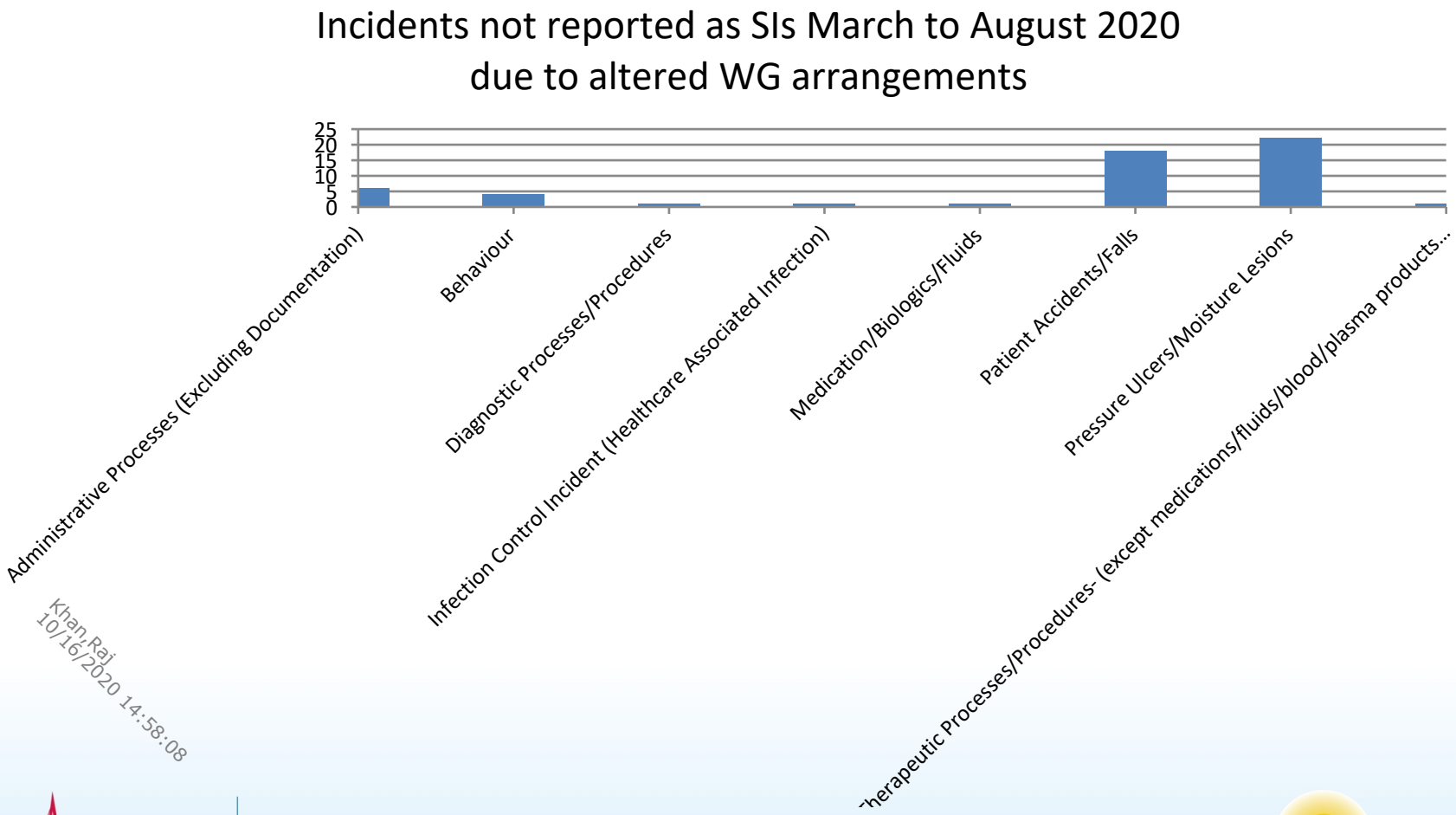


Khan Raj
10/16/2020 14:58:08

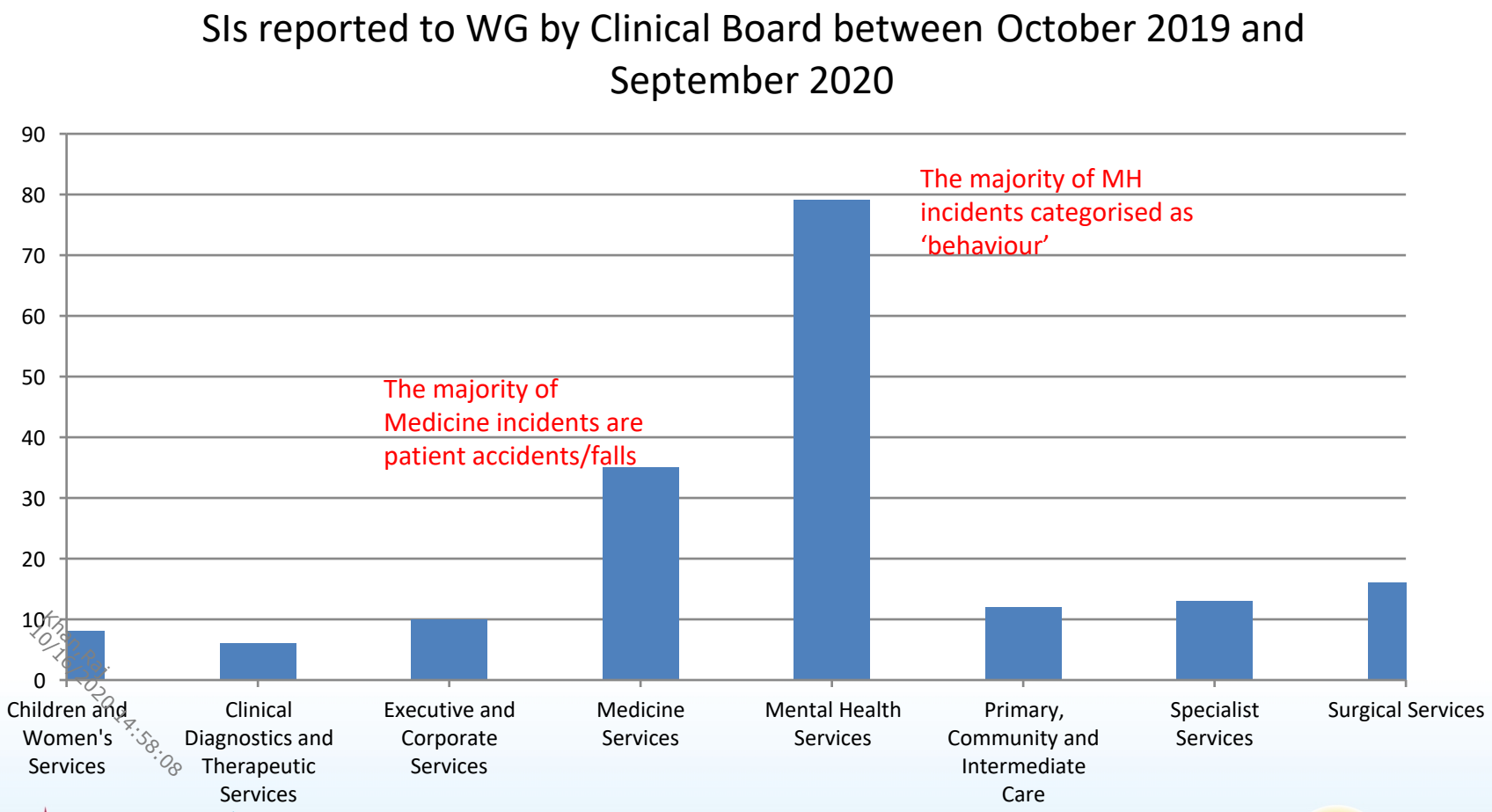
SIs reported to WG by month between October 2019 and September 2020



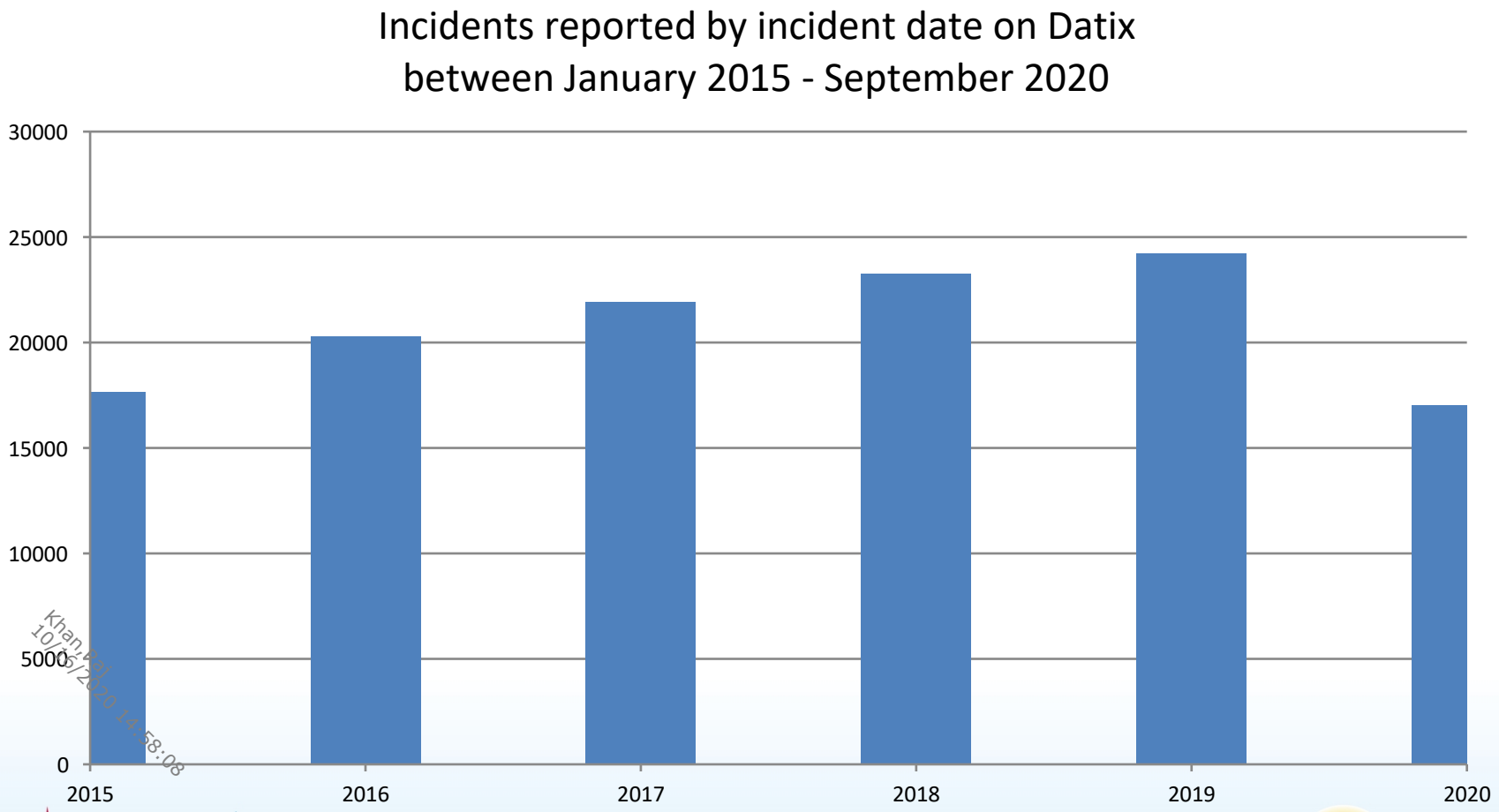
Incidents not reported to WG as SIs due to altered WG arrangements during the early phase of the pandemic (n=54)



SIs reported to WG by Clinical Board between October 2019 and September 2020



General incident reporting data for context

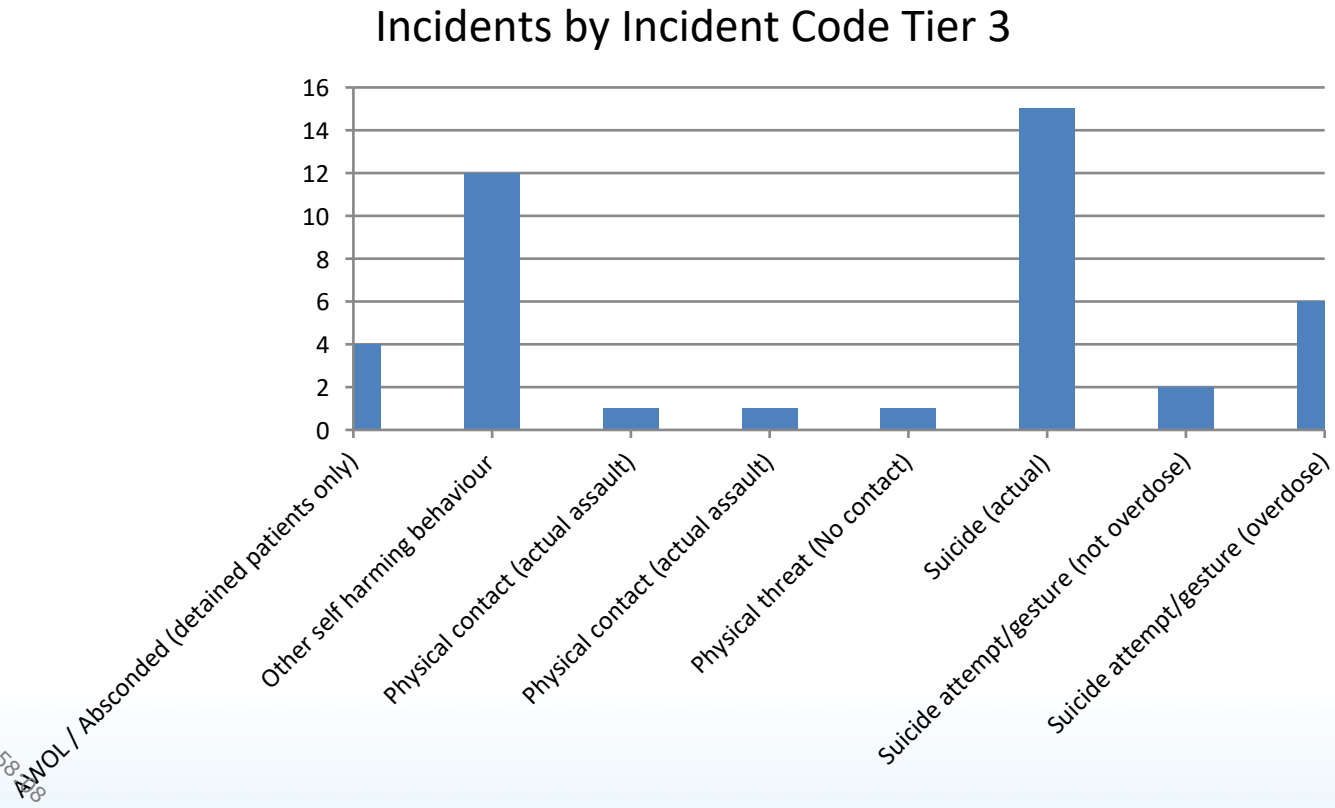


Top 5 SI categories (n=179)

- Behaviour - 45
- Patient accidents / falls - 33
- Unexpected death / harm - 26
- Pressure damage - 16
- Therapeutic processes / procedures - 15

Behaviour incidents (n=45)

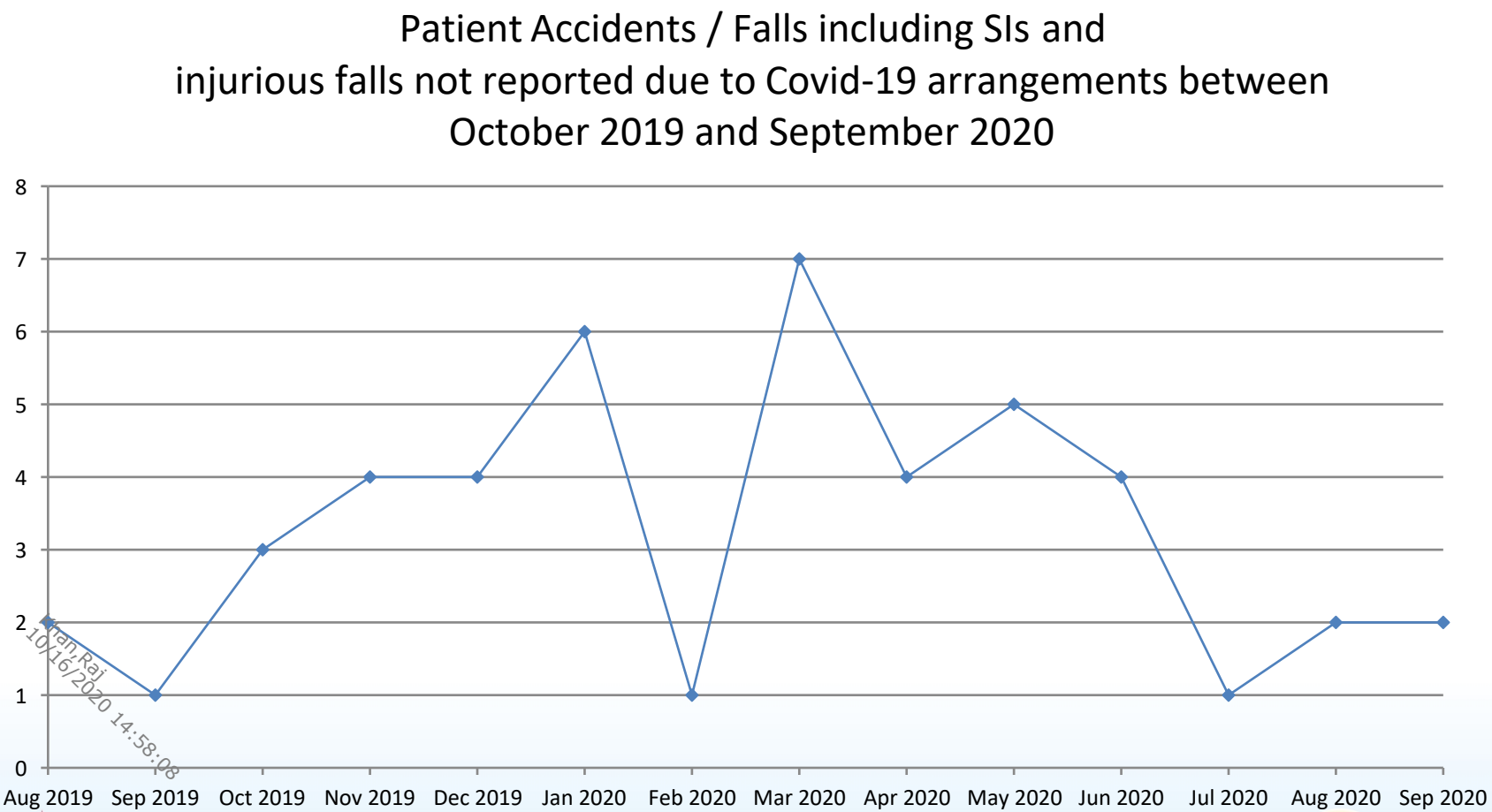
- 42 were reported by Mental Health Clinical Board



Unexpected deaths (n=26)

- 17 were reported by Mental Health Clinical Board; 7 were PRUDiC cases
- Coroner's inquests are generally required in order for us to determine the cause of death and to conclude investigation processes
- A number of incidents involve patients known to Addictions Services
- Physical ill health concerns in conjunction to mental illness is a factor to consider
- Signposting to other services and use of 'opt-in' is often investigated as part of these incidents

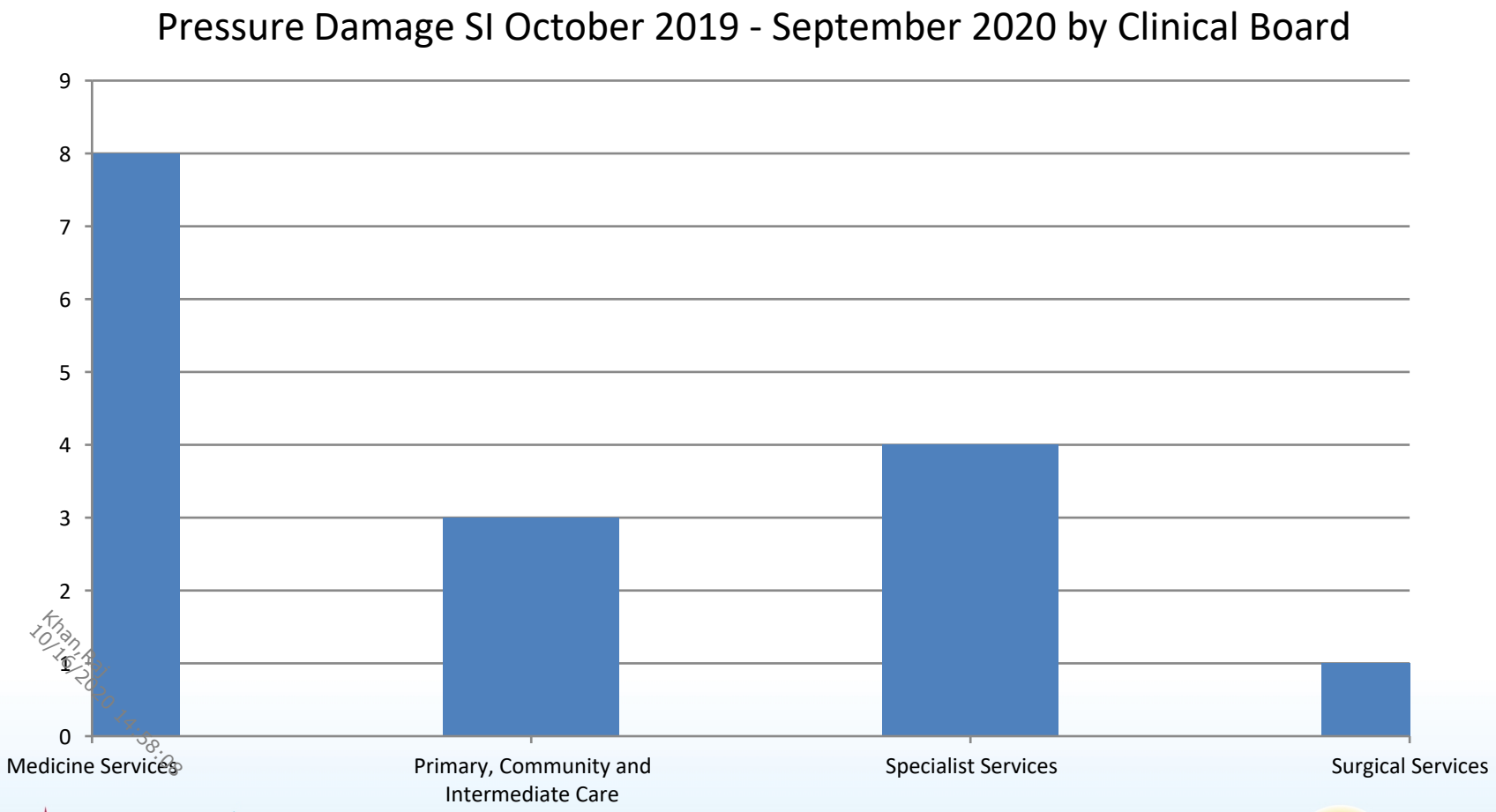
Patient Accidents / Falls (n=46)



Patient Accidents / Falls cont'd

- Incident reviews indicate that falls prevention measures are largely in place
- Post falls procedures require reinforcing
- Falls Delivery Group continues to meet
- Excellent community work underway
- A falls scrutiny panel is to be established
- Re-focus on inpatient falls including education, simulation and audit when recruitment to a Patient Safety & Organisational Learning Manager role concludes

Avoidable Grade 3, 4 and Unstageable Pressure Damage (n=16)



Pressure Damage cont'd

- Pressure Damage Group chaired by Director of Nursing Surgery Clinical Board continues
- Revising processes between Patient Safety and Safeguarding
- Strengthening and spreading the Scrutiny Panel process in PCIC Clinical Board
- Challenge of volume of incidents and timeframe to address the Safeguarding requirements
- The Wound Healing Team are launching their pressure ulcer advisory group in November 2020

Pressure Damage cont'd

- Key learning from review of pressure damage incidents:-
- Pressure damage is most likely to occur in the first week of care – initial assessment and action is crucial
- The majority of pressure damage occurs on sacral, heels and buttock areas – re-positioning is critical
- Patients aged 65 years and over are most at risk of developing pressure damage; patients over 85 years are at extreme risk of developing pressure damage
- Declining to use or improper use of pressure relieving devices can be a factor
- Pressure damage presents a particular challenge for community nursing teams

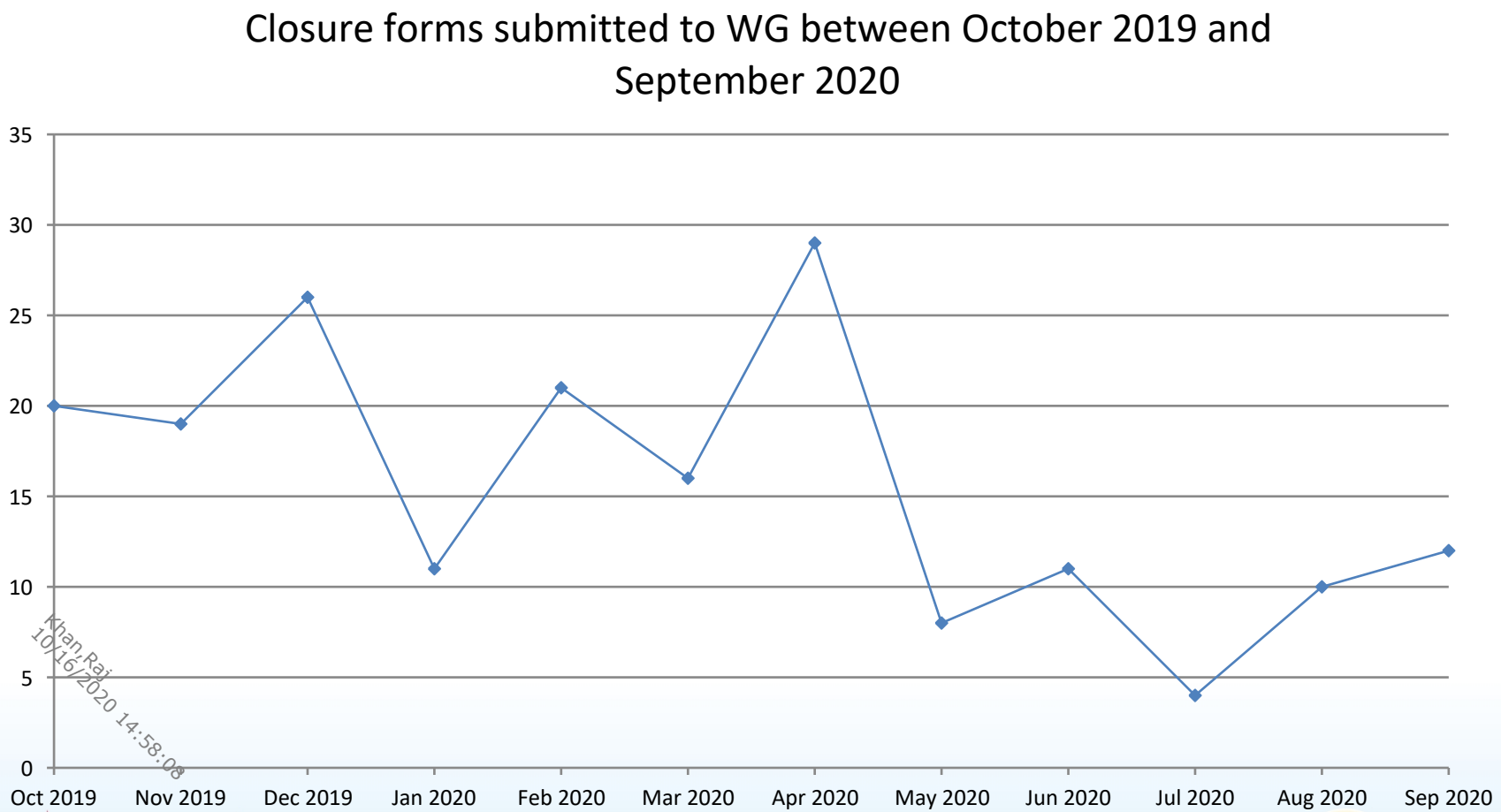
Therapeutic Processes / Procedures (n=15)

- Incidents under this category are varied and most significantly include:-
- A patient who had a perforated bowel during gynaecological surgery for cancer
- A patient with delayed follow up in Dermatology
- A delay in undertaking an ECG on a patient
- Never Events (wrong tooth removal and wrong site block)

Therapeutic Processes / Procedures

- Strengthened monitoring of urgent suspected cancer results in Dermatology
- Processes for patient cancellation of appointments revised
- Cardiothoracic waiting list concerns raised in this category
- A number of investigations in this category remain underway

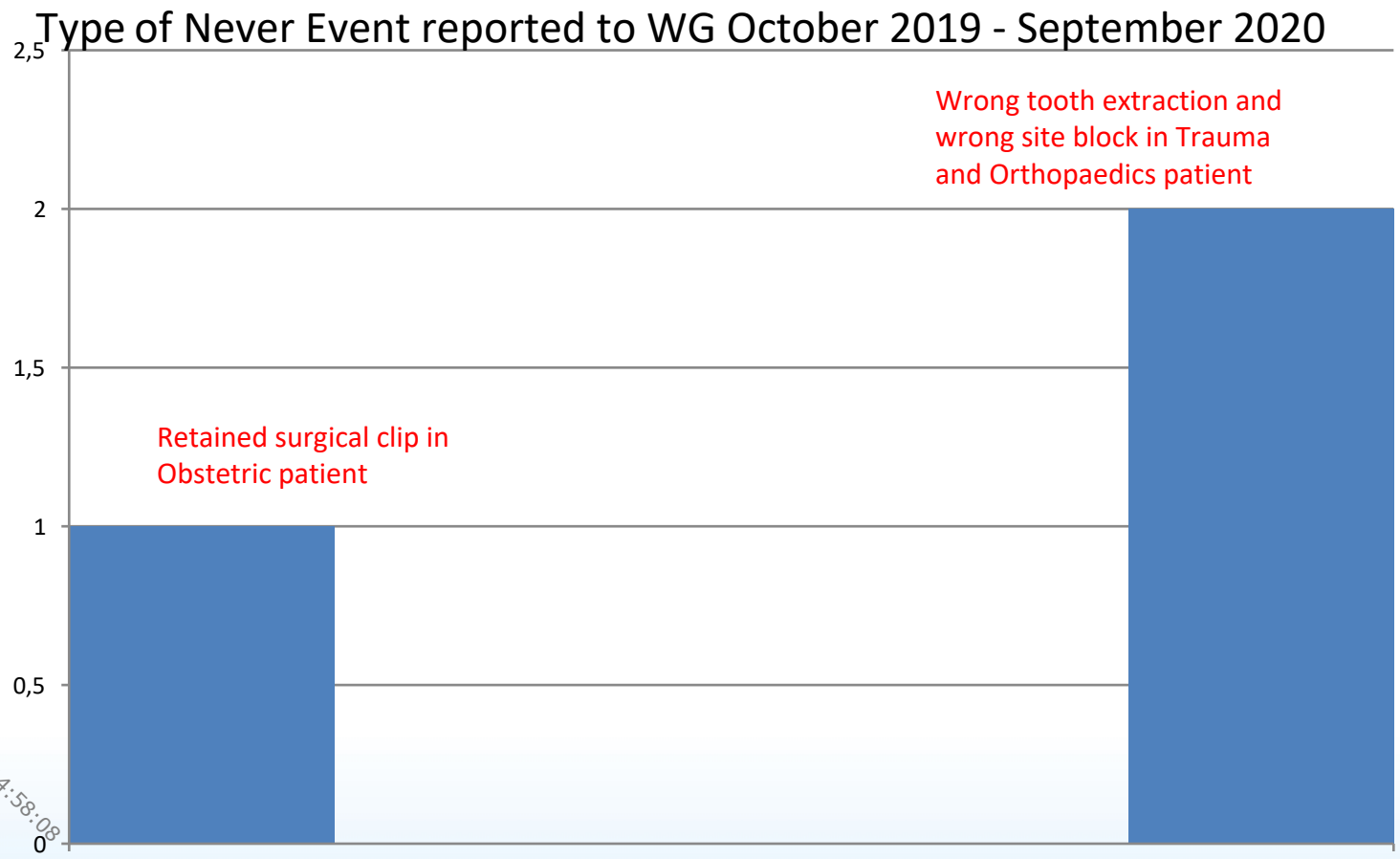
Closure forms submitted to WG between October 2019 and September 2020



Open and overdue SIs

SIs reported to WG October 2019 to September 2020	179
SIs reported to WG that remain open	85
SIs that are overdue for closure	51

Never Events reported to WG October 2019 – September 2020



NHS Wales Never Event data
April 2017 – March 2018

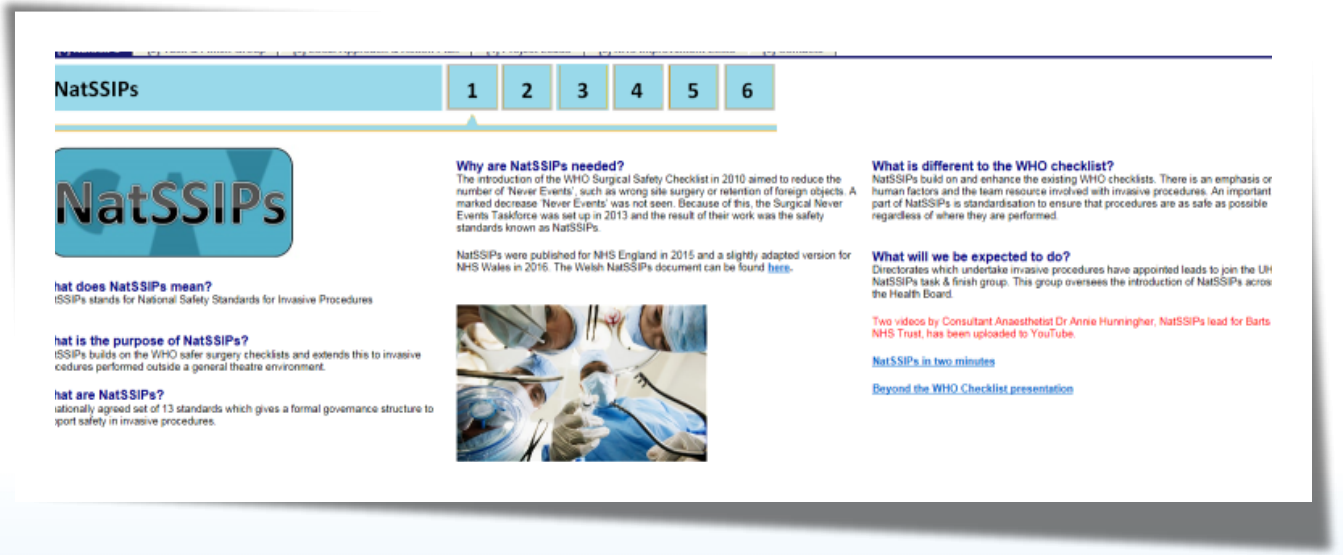
Number of Never Events reported to WG in NHS Wales April 2017 to March 2018	
Abertawe Bro Morgannwg UHB	9
Aneurin Bevan UHB	2
Betsi Cadwaladr	4
Cardiff & Vale	3
Cwm Taf	1
Hywel Dda	2

Never Event learning

- Changes implemented due to Covid-19 procedures must not increase risk of errors
- Implementation of ‘STOP before you block’ to be audited
- Skin closure must not commence until the final swab and instruments count is confirmed to be correct

National Safety Standards for Invasive Procedures (NatSSIPs)

- NatSSIPs group under review
- New surgical consultant appointed to lead the group



Healthcare Associated Infections

- Certain HCAI incidents must be reported as SIs:-
- Any death where *Clostridium difficile* or MRSA is mentioned on the death certificate
- An outbreak of a healthcare associated infection in a hospital that results in the closure of a ward/bay to admissions and causes significant disruption
- Transmission of infectious diseases

HCAI cont'd

HCAI reported by Clinical Board	
Medicine	• MRSA bacteraemia • E2 Covid-19 • E7 Covid-19
Specialist	• Cardiothoracic surgical patient deaths due to Covid-19 • B5 Covid-19
Total	5

The trend has increased due to Covid-19 in this current reporting timeframe

Khan Raj
10/16/2020 14:58:08

HCAI learning

- Use of Visual Infusion Phlebitis score for patients with intravenous cannulae to be monitored
- Clarity of PPE requirements
- Establishment of a PPE Cell to manage the PPE situation
- Reinforcement of physical distancing for staff and patients
- Ability to track bed areas patients were in retrospectively
- Ability to track staff contact with patients

Ionising Radiation (Medical Examination) Regulations incidents

- IR(ME)R incidents are reportable to Healthcare Inspectorate Wales
- 5 incidents were reported in this timeframe (there were 11 in the year prior to this)
- Themes include staff failing to follow patient identification procedures; altered processes due to Covid-19

IR(ME)R cont'd

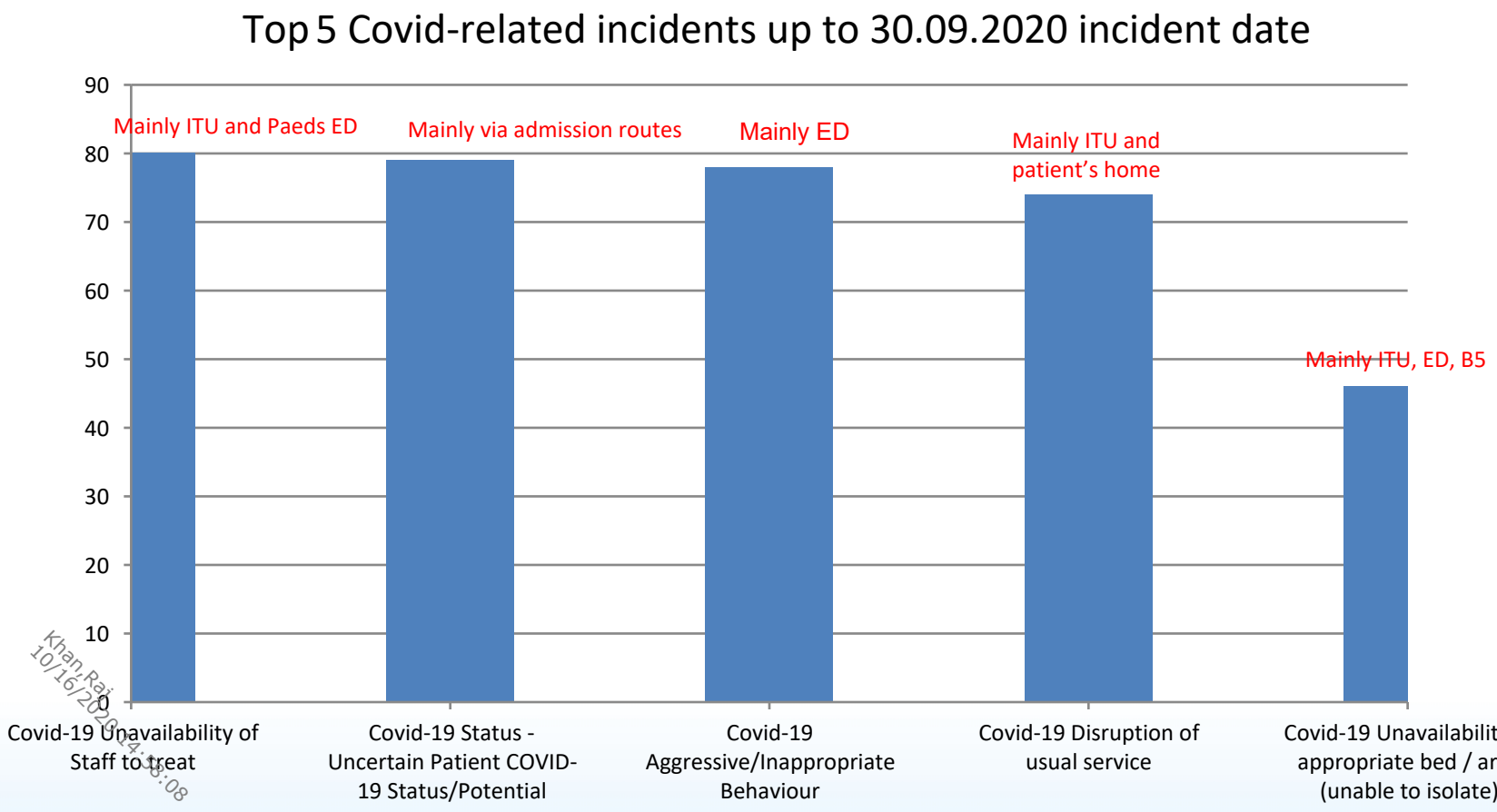
- Electronic solution for requesting, vetting and scheduling of radiological imaging required
- Positive patient identification campaign to be revisited in 2021
- Patient Identification Policy will be updated and ratified shortly

Covid-19 related incidents

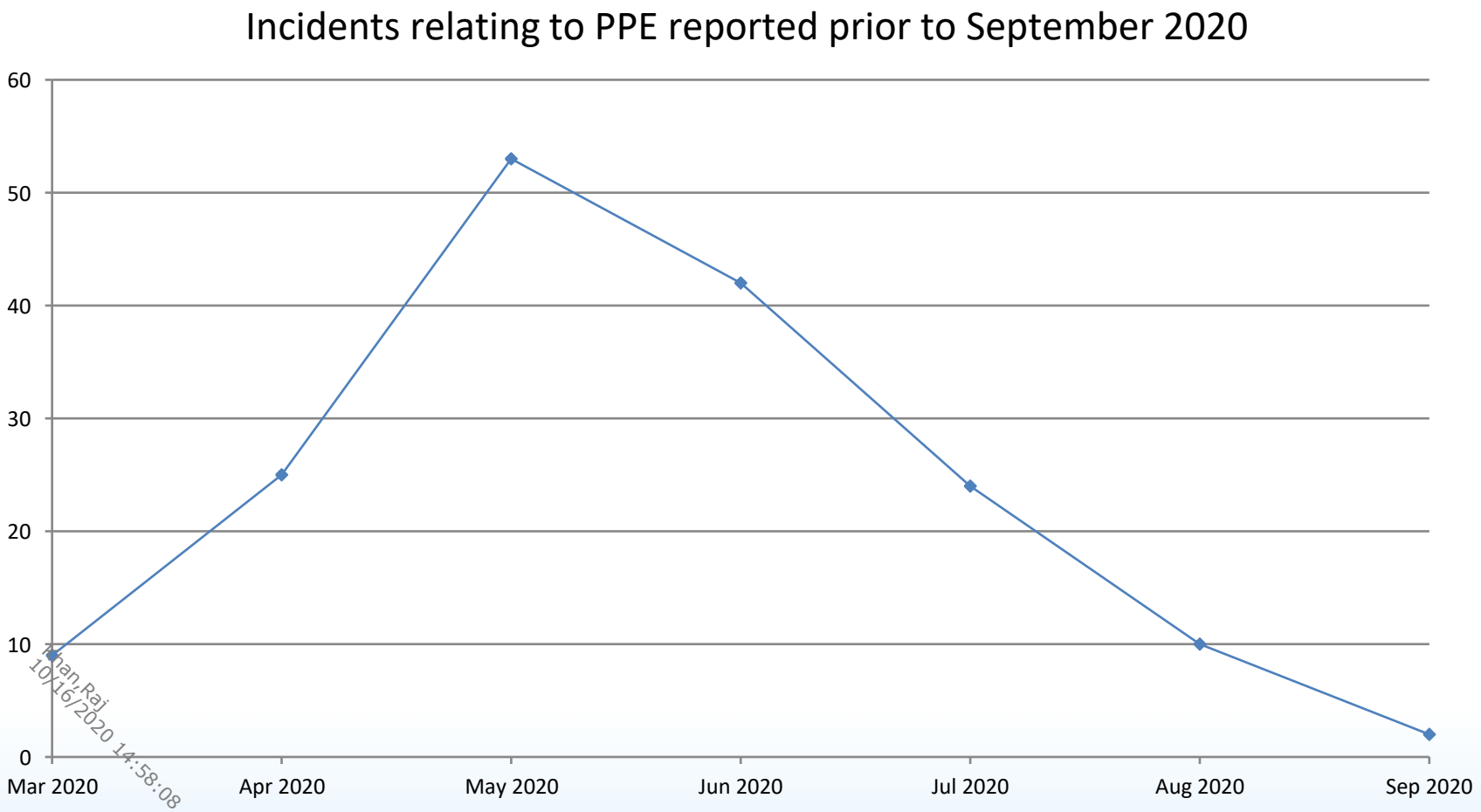
- “Are you reporting an issue related to Coronavirus (Covid-19)?” Yes / No
- New Covid-related categories developed based on what was being reported
- 936 incidents reported with this flag ticked up to the end of September 2020

Khan Raj
10/16/2020 14:58:08

Top 5 Covid-19 related incidents

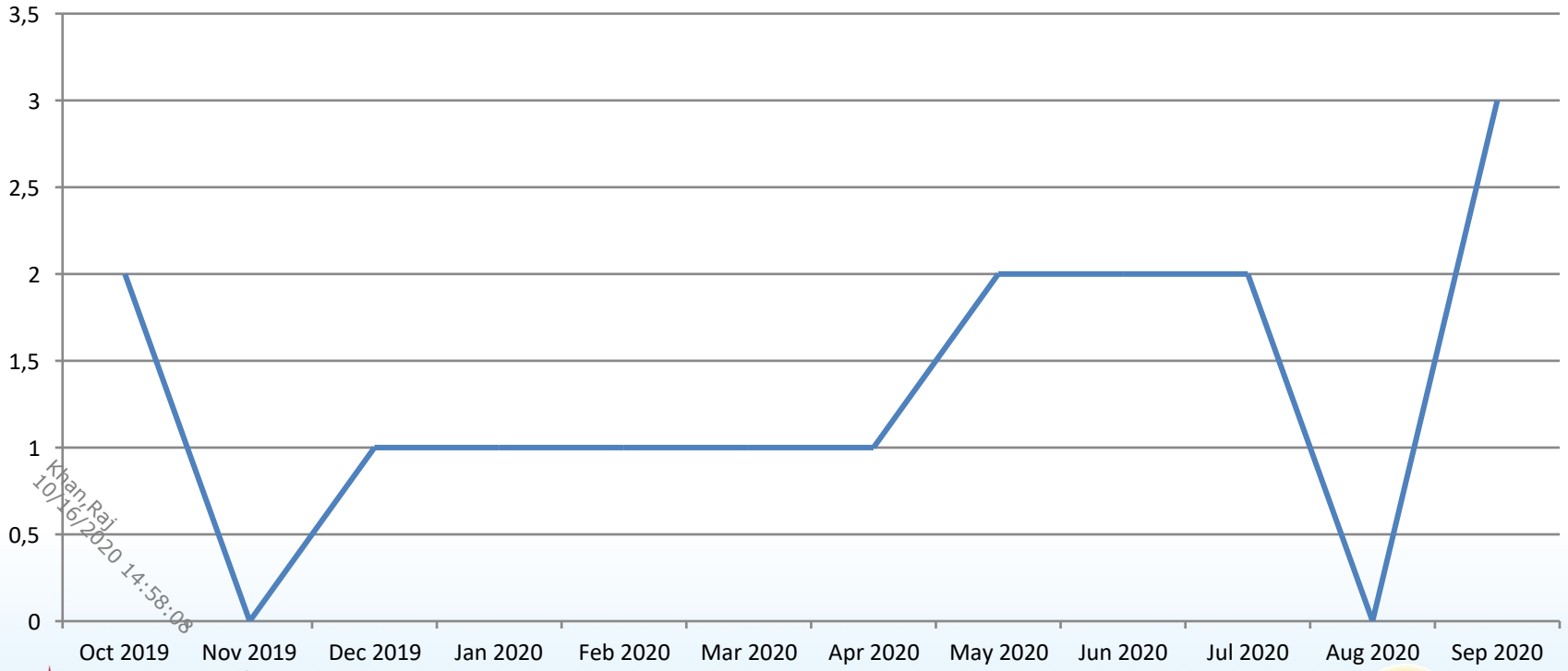


PPE related incidents (n=165)



Admission of a minor to an adult mental health ward

Admission of young people under the age of 18 to Hafan Y Coed between
October 2019 and September 2020 (n=16; source - PARIS)



Admission of a minor to an adult mental health ward cont'd

- Age range of patients is generally 16-17 years
- Length of stay is generally 1 – 16 days
- One patient was admitted twice during this period
- The incidents were generally reported as SIs (some as a cluster and WG reporting not required during altered SI arrangements due to Covid-19)

Admission of a minor to an adult mental health ward cont'd

- CAMHS service repatriated in April 2019
- Initial progress with addressing waiting list slowed in 2020 due to Covid-19
- Vacancies in the service on transfer are being recruited to with some success
- Referrals are increasingly complex; eating disorders are a theme
- New service models are in development

Once For Wales Concerns Management System

- OFWCMS aims to bring consistency to the electronic tools used by NHS Wales health bodies to support their concerns and risk management processes using Datix CloudIQ software.
- Workstreams are underway to support implementation of new software for incidents, complaints, mortality and Redress from April 2021.

OFWCMS cont'd

- Local project board established
- Ambitious and challenging national project plan
- Information governance concerns
- Many opportunities to enhance the software for NHS Wales requirements

- QSE Workshop held in September 2020
- Revised WG SI Framework expected
- Forthcoming Health and Social Care (Quality and Engagement) (Wales) Act – Duty of Candour and Duty of Quality

Themes and Trends from Concerns (Complaints and Claims) 1 October 2019 to 30 September 2020

“Concern” means any complaint; notification of an incident concerning patient safety or a claim for compensation.

- **“qualifying services”** – services provided in Wales/the UK (Part 7) as part of the health service in Wales.

- **“responsible body”** – a Welsh NHS body (LHB/NHS Trust), a primary care provider or an independent provider.

Allegation of harm

- Qualifying Liability: A liability in tort owed in respect of, or consequent upon, personal injury or loss arising out of or in connection with breach of a duty of care owed to any person in connection with the diagnosis of illness, or in the care or treatment of any patient, in consequence of any act or omission by a health care professional; and which arises from “qualifying services”.

Complaints

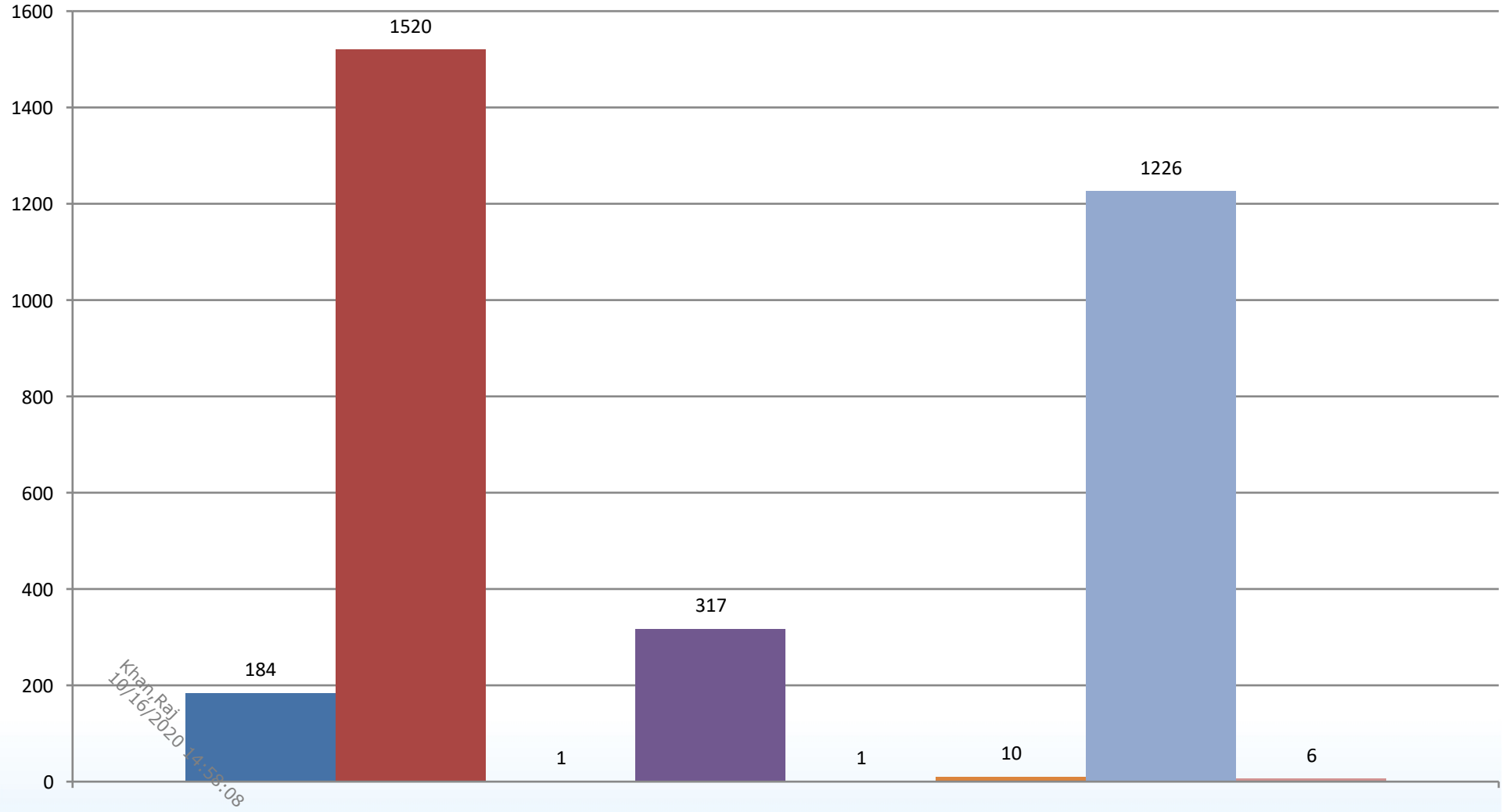
1 October 2019 to 30 September 2020

2977 concerns 19/20

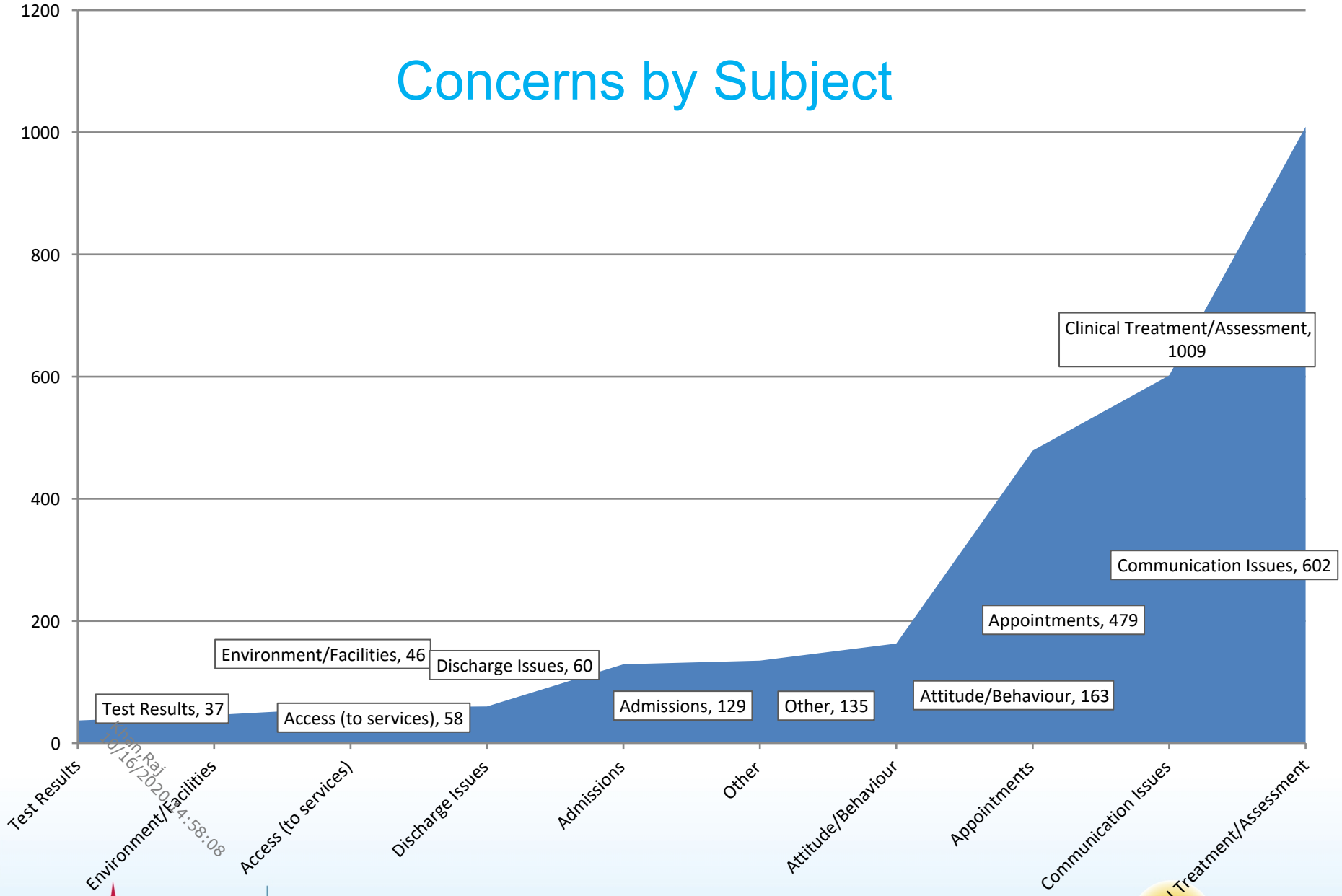
3042 concerns 18/19

- **27% Surgery Clinical Board**
- **21% Medicine Clinical Board**
- 11% Specialist Clinical Board
- 11% Children and Women Clinical Board
- 8% Primary and Intermediate Care Clinical Board
- 8% Mental Health Clinical Board
- 6% Clinical Diagnostics and Therapies Clinical Board
- 5% Capital Estates and facilities
- 3% other organisations

Complaints by Method of complaint



Concerns by Subject



Arjun Raj
10/16/2020 4:58:08

Complaints by Severity (Final)	
(4) Major	2
(3) Moderate - Causing significant but not permanent harm	2
(2) Minor - Low Harm - minor treatment e.g. fell and grazed arm	8
(1) No Harm	2927
(0) Undetermined	38
Totals:	2977

Discussion of Major cases

One was Maternity and one was ophthalmology outsourcing

Moderate

One was a patient fall CD and T and the other was a case in specialist clinical board

38 undetermined

General themes and actions

Ophthalmology Out patients and Insourcing

- Reviewed the commissioning arrangements for out of area boundaries.
- Weekly meetings to agree where referrals should be sent to ensure there are no delays and list urgent patients as necessary.
- Ophthalmology Service Manager and Deputy Health Records Manager meet to agree the information accessible to the Appointment Booking Centre is accurate.
- Changes made to the PMS to allow staff in Health Records to input a target date for new patients.

Documentation

All Wales Electronic Nursing Documentation

PKB and personal health Record will help .

General themes and actions

- Children and Women
- Cwm Taf impact meant we received and investigated concerns which were historical- External expert opinions were requested-no harm identified
- Mental Health
- From families of patients who died by suicide

PCIC

- Out of Hours concerns related to timeliness of call backs, triage etc.
- Cav 24/7 survey of patients
- 654 patients responded

After using the CAV24/7 'Phone first' service, would you be happy to use this service again?

Option	Respondents	
	(n)	(%)
Yes	403	87
No (please say why)	62	13

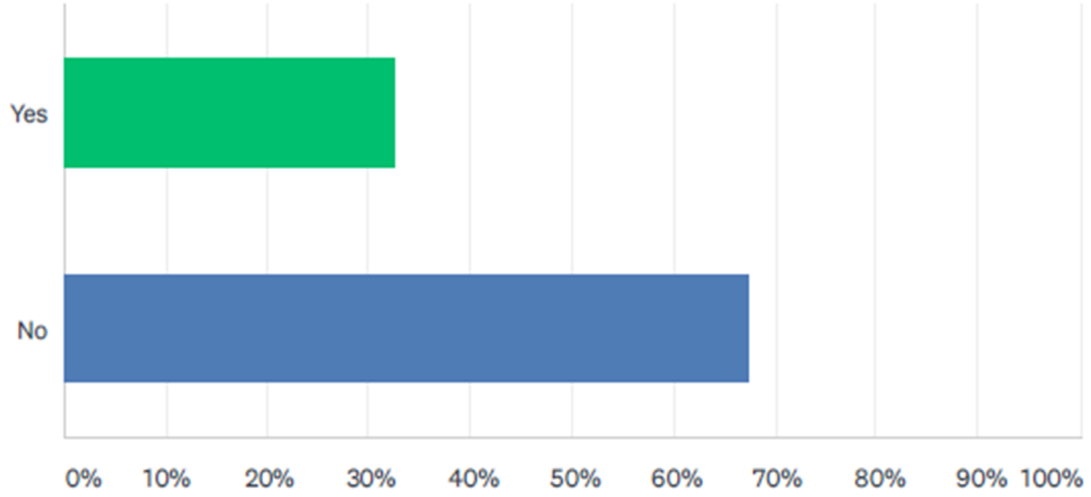
Q33 Why would you be happy to use the service again?

Reason why	Respondents (%)
Process is efficient /Easy to use.	50
Patient didn't wait around in EU	17
The triage before going to EU	20
No other alternative/choice	7
Other*	7

** Many of those that fell under 'Other' responded 'Yes' or did not answer the question correctly.*

Q1 Before attending here today, had you phoned CAV 24/7?

Answered: 55 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	32.73%	18
No	67.27%	37
TOTAL		55

Kiran Rai
10/16/2020 14:58:08

'Our emotions, they say, guide us into facing predicaments and tasks too important to leave to intellect alone'

Daniel Goleman Emotional intelligence

- **NOT** to talk about **perfect responses** or your personal responsibility for 'fixing' things
- **NOT** to give you a tool kit of '**magic words**' **OR** to **always** get it right
- **NOT** to tell you to ignore policy and procedure
- **NOT** to tell you to rely on **policy and procedure** to manage every scenario either

- It **IS** about being **human** and understanding **emotional motivations, reactions and responses**
- It's about **understanding** the whole picture and **how** unconscious thinking affects our perceptions
- It's about starting to **understand** the role **empathy** can play and **how communication is felt**
- It **IS** about seeing a complaint in its entirety and empowering you to reach an **OPTIMUM (not always perfect) OUTCOME**

People not just process

Process -90% of concerns responded to in 30 working days

- In March contacted all people who had an active concern
- 7 day service
- Call all complainants to agree questions for investigation
- Stay in touch
- No surprises
- Bereavement follow up calls

Khan Raj
10/16/2020 14:58:08

Bereavement Calls

Over 450 calls to next of kin when someone is bereaved

Sign post to Cruse to wish upon a star

Loneliness helpline

A reduction in concerns from bereaved families

Cruse Bereavement Care

WISH UPON A STAR

Supporting Sudden Death In Children & Young Adults

Khan Raj
10/16/2020 14:58:08

Covid themed concerns –Restricted or No visiting

Used PPE survey in March then contacted patients following discharge, spoke with relatives and carers

(62.5%) patients reported themselves as being sometimes or often/always lonely in hospital

higher in under 50's age group

What did we do

Virtual visiting using 400 tablets, scheduled phone calls and updates

Delivered via Medical and Nursing students

Visiting-hosted a 7 day visiting helpline in the concerns team

Elective lists

Prehab to Rehab

3, 135 patients on waiting lists cancer and elective were contacted via text message or letter

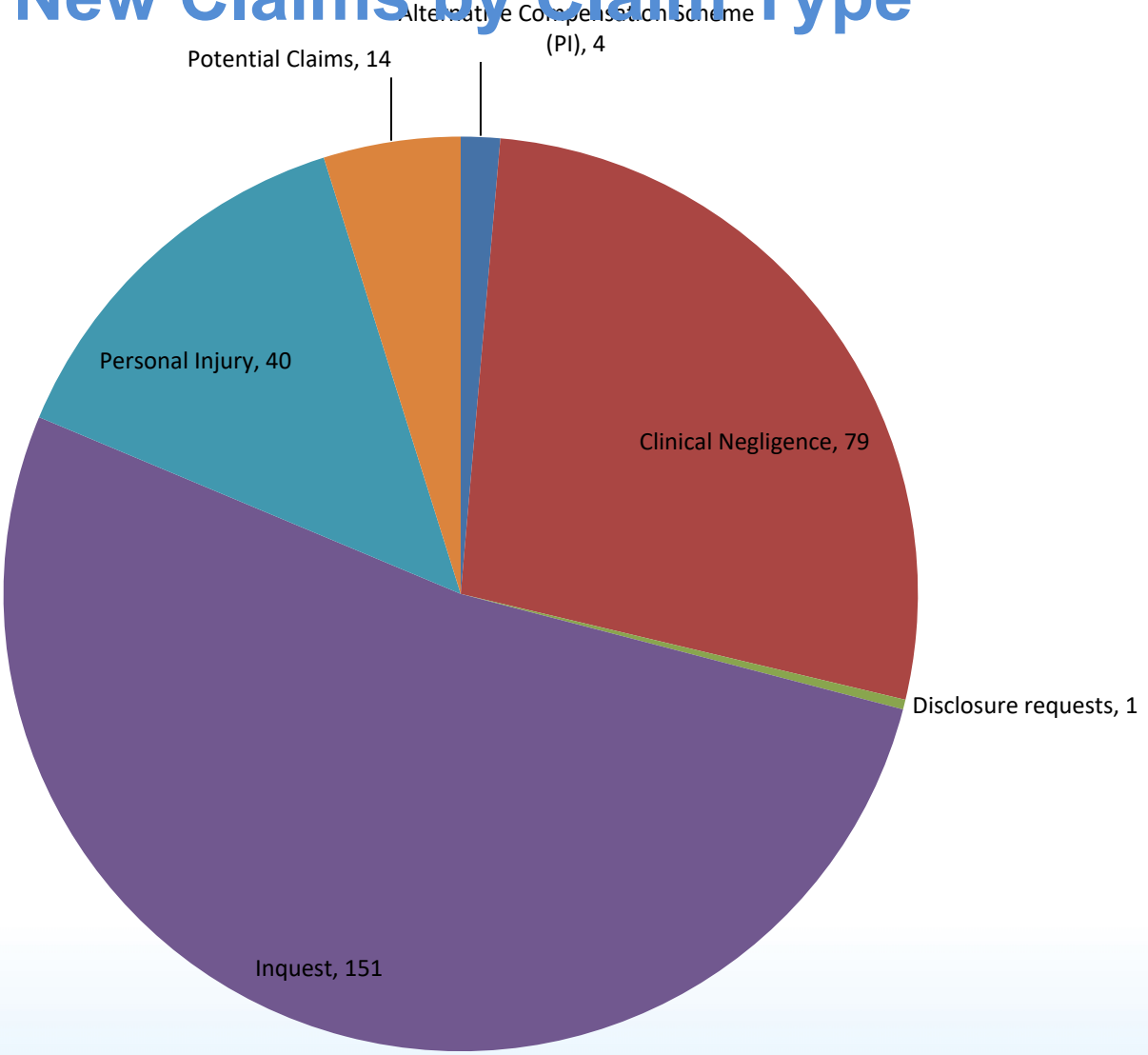
Below is an example of the SMS messages to be used for the ‘Pilot’

“You have been identified from our records as waiting for an operation. We have important health messages to help you keep well and prepare you for your surgery. Please follow the guidance using the link below. Reply POST if you are unable to use the link.” (233 characters = 2 units)

Contact to Patient experience team 7 day helpline

Khan Raj
10/16/2020 14:58:08

New Claims by Claim Type



Khan,Raj
10/16/2020 14:58:08

Claims themes and trends

Top 3 categories identified in **new Clinical Negligence Claims:**

- Failure to diagnose and treat
- Failure to properly monitor treatment
- Sub-standard Surgical Technique -

Personal injury claims

The top three subjects identified were:

- Needle stick/sharps
- Behaviour/Violence - intentional injury
- Trip

From September 2019 we had to complete Learning from Event forms (LFE) for all active claims . For new claims the trigger is 60 days from receipt of claim to evidence immediate learning

The team completed over 300 LFE's –they met with Clinical Board to review clusters and themes

Key Themes
Montgomery consent –for clinical negligence
Surveillance and follow up

Personal injury
Violence and aggression -increased reporting and support
Estates issues –trips etc.

Horizon scanning

Potential concerns/claims

What we can do to prepare

- Clinical negligence claims and concerns
- Personal injury claims
- Inquests
- Contractual/employment
- Public Inquiry

Potential clinical negligence claims/concerns

Hospital acquired COVID infection

- PHW definitions related to 1st positive test – starting point but not definitive
- Between 8-10 days of admission – probable
- Day 15 or later – definite

Treatment of COVID

- End of life decision making

Non-COVID treatment but affected by pandemic

- someone acting up/returning, staff shortages/exhaustion

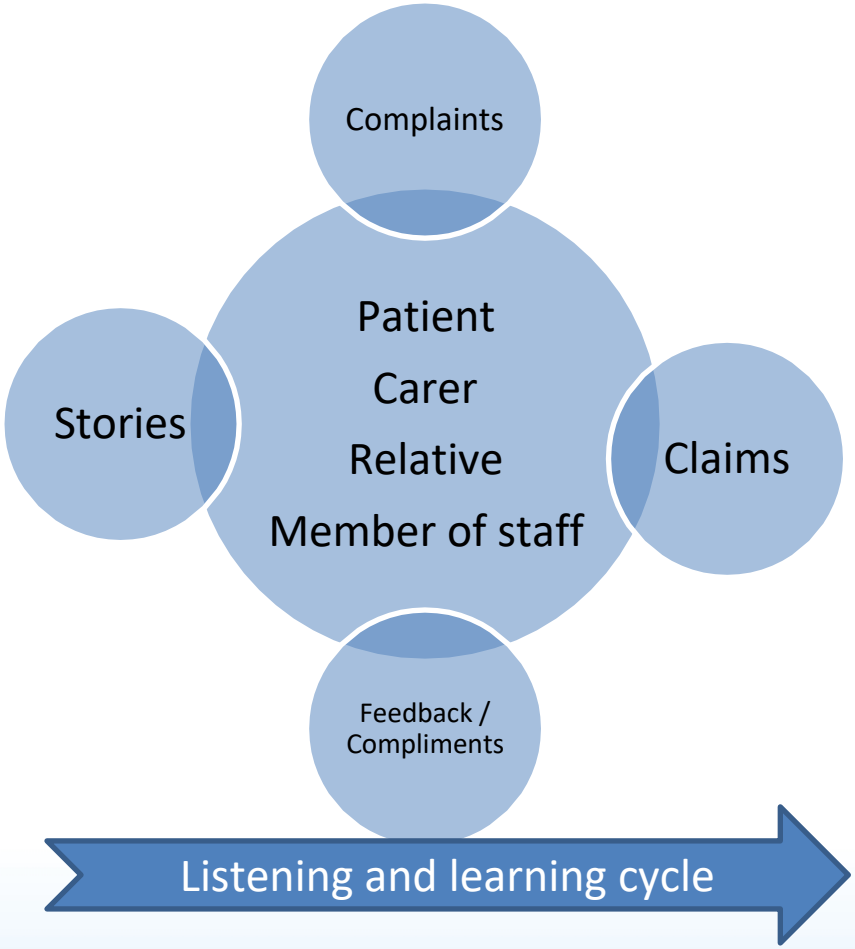
Remote/telephone consultations

Failure to diagnose/treat/follow up

Delays in diagnosis/treatment/follow up

- Decision making around stepping down and stepping up of services
- Consent – where does the individual patient fit in? Montgomery.

Summary



Analysis of Themes and Trends in Deaths of Patients with Mental Illness 2019/2020

#MHNursingFuture

Broad grouping of Causes

- Physical Causes
- Drug and Alcohol related
- Suspected Suicide
- Accidental Death
- Victim of Homicide
- For 2020 Covid-19 Related

#MHNursingFuture

	Physical Causes	Covid-19 related	Drug Alcohol related	Suspected Suicide	Accidental	Victim of Homicide	N/K	Total
2019	24	0	18	24	3	2	0	71
2020	21	19	5	18	0	0	5	68

2020 Figures are for 8 months until the end of August

#MHNursingFuture

Some Themes

- Deaths from Physical Causes continue to reduce life expectancy in those people with Mental Ill Health
- COVID has contributed to a predicted increase in overall deaths in 2020
- Suspected suicide remains a significant cause of Death with a small predicted rise in 2020
- Drug and alcohol related deaths have significantly decreased so far in 2020.

#MHNursingFuture

Suspected/confirmed Suicides

	Deaths from Suspected Suicides	Men	Women
2019	24	19	5
2020 until end of August	18	10	8

- There is a small predicted rise by the end of 2020
- Change in the gender ratio this year: higher proportion of women
- An increase in suspected suicides in Older People consistent with UK wide picture
- Inpatient Suicide accounts for a very small proportion of deaths: 2 out of 42.

#MHNursingFuture

Suspected Suicides

What have we learnt from the analysis?

- Mental Health Services now reach more and more people outside of the traditional patient base
- Too many assessments and not enough treatment
- “Community Mental Health Services have a team for everything but a place for no one”
- Older Adult Services are experiencing a change in patient presentation from dementia to more complex functional challenges

#MHNursingFuture

Themes are systemic

What have we done about these themes?

- Begun to realign the adult community mental health services to a locality model lessening the number assessments and improving the experience of the patient. They are not "bounced" between teams
- Invested in a consultant Nurse for Complex Risk to lead on suicide prevention including training

#MHNursingFuture

Themes are systemic

What have we done about these themes?

- Commenced realignment of adult community mental health services to a locality model lessening the number of assessments and improving the experience of the patient: people are not “bounced” between teams
- Invested in a consultant Nurse for Complex Risk to lead on suicide prevention and training

#MHNursingFuture

Themes are systemic 2

- Realigned Older Adult Community Services towards an enhanced community model to manage complex risk.
- This includes 7 day a week alternatives to admission, single point of entry to services and enhanced training in risk management of this patient group.

#MHNursingFuture

Physical Health

- Major initiatives to encourage positive physical health have not produced any significant changes for people with chronic mental ill health
- We have now appointed 2 Senior Nurses for Physical Health to lead the work on the UHL site for adult and older adult services.
- All staff have had significant learning from the first wave of COVID 19 and are more capable, confident and aware of measures that need to be taken around IP&C and precautions around inter ward transfer

#MHNursingFuture

Drug Alcohol Related Deaths

- A combination of acute and chronic illness associated with long term alcohol and drug use.
- Difficult to understand the figures as low numbers of deaths this year so far compared to the expected increase in alcohol consumption, particularly during lockdown periods, that is likely to become apparent over the next 18 months.
- Vale of Glamorgan did experience a rise in deaths during 2019. Barry in particular felt to be targeted by organised crime in regards to the supply of drugs.

#MHNursingFuture

Models of Community Mental Health Care need to adapt and change to meet the needs of our ever changing population. This is not just adding more and more teams, but building services around the patient and local communities.

#MHNursingFuture