# Service Groups' Highlight Report for Quality and Safety Committee

| | |
|---|---|
| **Meeting Date:** | December 2022 |
| **Service Group:** | Primary, Community and Therapies Service Group (PCTG) |
| **Author:** | Claire Lewis, Quality & Safety Improvement Manager, PCTG |
| **Sponsor:** | Tanya Spriggs, Group Nursing Director, PCTG |
| **Presenter:** | Brian Owens, Group Director, PCTG |

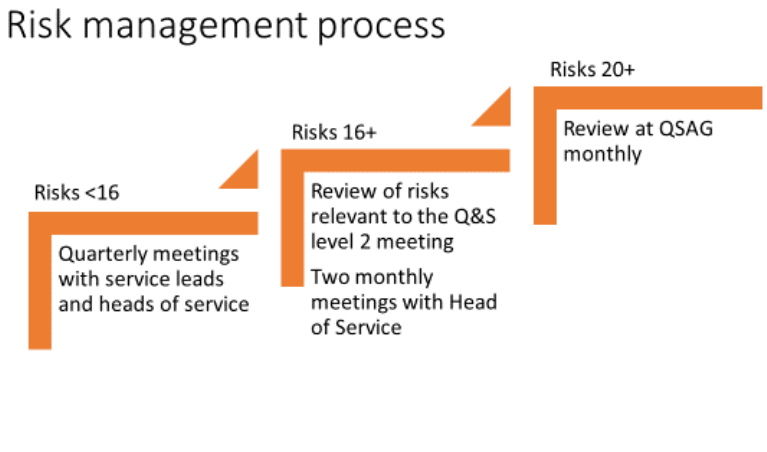
**Summary of Quality and Safety issues since last report to the Committee (Reporting period: September to November 2022 )**

Patient story – Fracture discharge

This paper provides an update to the Quality & Safety (Q&S) Committee on matters of quality and safety overseen by the service group.

**Q&S Reporting Structures** - PCTG continues to review quality and safety structures to align with the revised Corporate and legislative reporting requirements. Structures have been evolving but will now need to be reassessed to comply with reporting and legislative requirements. The new structures will be in place from January 2023.

**Risk management** is strengthened with scrutiny of new risks and risks scored at 16+ at Quality and Safety Meetings. Bi-monthly meetings between Chair of QSAG and Heads of Service have been implemented to ensure regular review of controls, mitigations and scores. Lower level risks are managed at quarterly meetings between Governance and Service Leads. A large number of risks relate to staff vacancies.



New risks with a score of 16+ are required to produce an SBAR report to be presented to Triumverate and relevant second level Quality & Safety meeting for discussion around mitigations, controls and appropriate scoring. New risks will be approved at Quality and Safety Assurance Group.

## Incidents

Nationally reportable incidents

Pressure ulcers
The move to Datix Cymru in April 2022 resulted in a temporary failure locally to pick up pressure ulcer incidents categorised as grade 3 and above. This led to a backlog of cases for investigation when the error was identified in September 2022.

There are currently 16 pressure ulcer incidents that possibly require national reporting dependent on outcome of scrutiny panel. There is ongoing work with the clinical teams to work through the backlog of cases for scrutiny panel in quarter 4, with dedicated roles appointed to undertake investigation and support the process.

Other reportable serious incidents have been reported within performance timescales

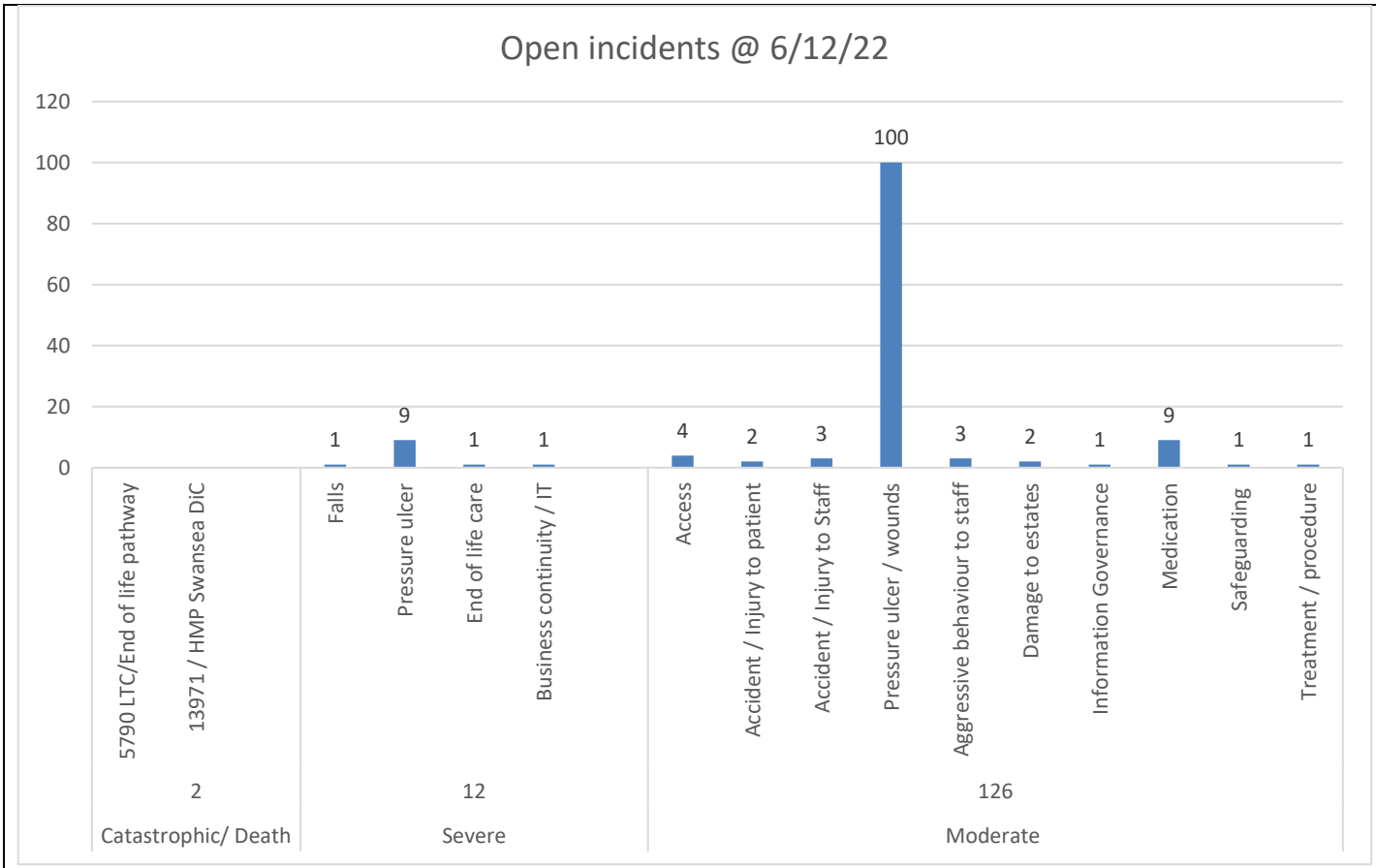
Open incidents

PCT currently have 949 open incidents on Datix Cymru, broken down as follows:

| **Open incidents @ 6/12/22** | |
|---|---|
| **Level of harm** | **Count** |
| Catastrophic/ Death | 2 |
| Severe | 12 |
| Moderate | 126 |
| Low | 404 |
| No harm | 379 |
| Unrecorded | 26 |
| Total | 949 |

There are 2 incidents recorded with a patient outcome of catastrophic/death which are awaiting external agency investigation before closure.

Of the 12 severe harm incidents, 9 relate to pressure ulcers which are awaiting scrutiny panel, and the others did not require national reporting.

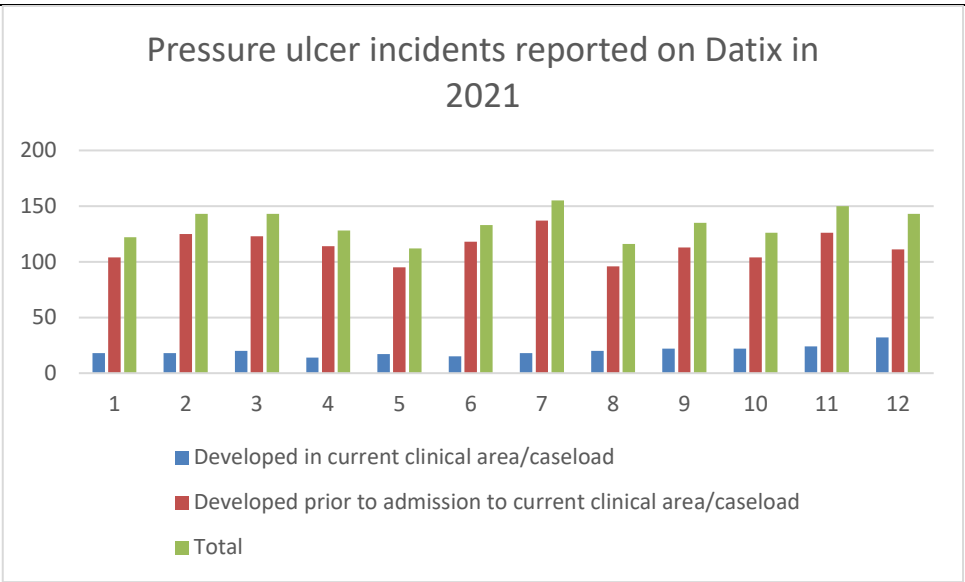



## Incident Performance

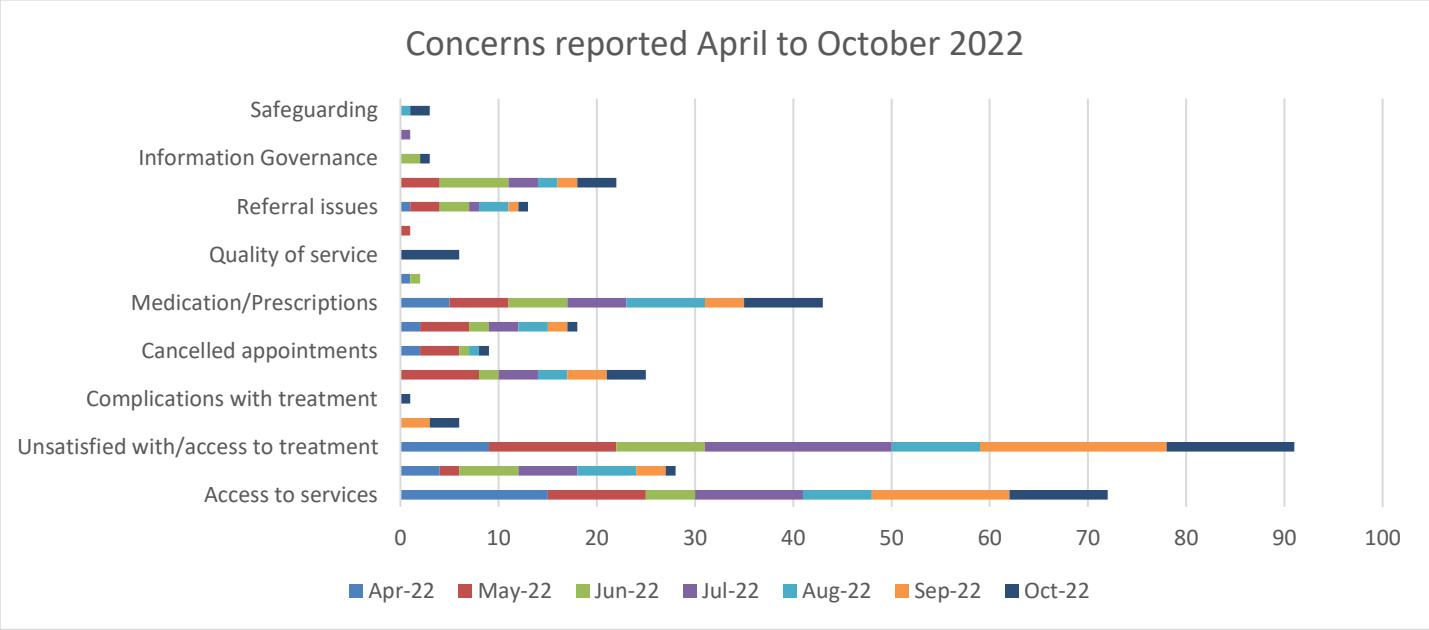
The service group successfully closed down all incidents on Datix Web by end of August 2022.

Open incidents on Datix Cymru are increasing and require a focus to support services to undertake timely investigation and closure. Incident performance will be included in the monthly reporting through the new quality and safety structures from January 2023.

Incidents relating to pressure ulcers are, by far, the highest reportable incidents, with the vast majority of these incidents occurring outside of PCTG clinical caseload (see chart below). This adds to the investigation burden for PCTG and will have an impact when Duty of Candour is implemented, as the severe/moderate occurrences of pressure ulcers will trigger the Duty of Candour. The service group are liaising with Corporate to understand the processes, implications and resource requirements for this.




**Concerns**




<u>Top five themes for Concerns</u>

- Issues with treatment
- Access to services
- Medications and prescriptions
- Delay in appointments
- Staff attitude

<u>Concerns Hot Spots</u>

- A number of concerns and MS enquiries were raised into pharmacy provision and quality of pharmaceutical services within a geographical area. Robust actions are in place regarding pharmaceutical provision in Pontardawe to overcome some of the local challenges.

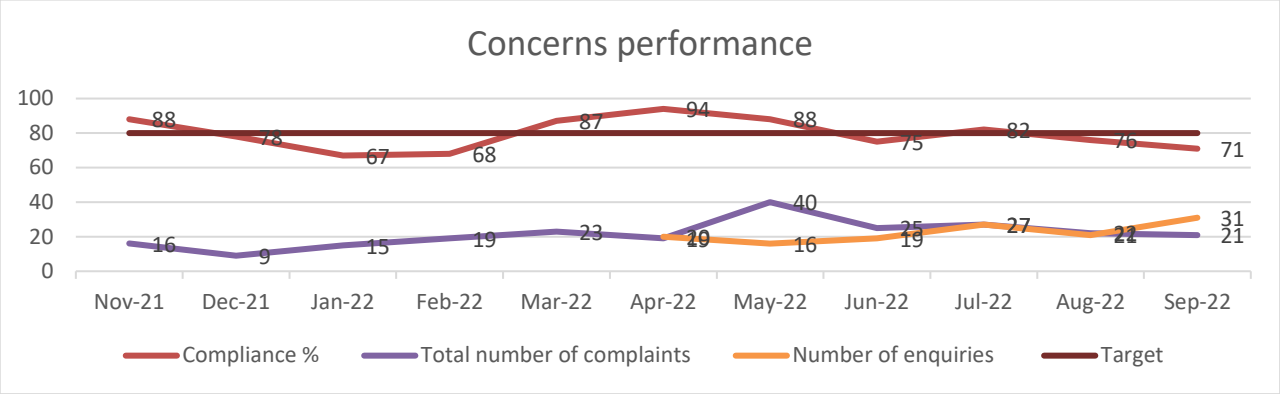
<u>Actions and Learning</u>

- Improved process for communicating with patients when response is delayed by Q3 – action complete
- Deeper dive to understand treatment, medication and access concerns by service by Q4

- Investigation into professional concerns to be completed by end of month
- Sourcing customer care / handling difficult conversations training by Q4

Concerns Performance

PCTG are currently at 71% compliance with performance standard for responding to complainants within 30 working days. This is due to an increase in the numbers of complaints and enquiries being received, and also annual leave over the summer months. Quality and Safety structures within the service group are currently under review.




Of the 141 concerns/enquiries received June to August 2022, only 13 were dealt with as early resolution cases which highlights an opportunity to increase the number of early resolutions though a PALS service . The quality of response is high with only two cases being re-opened and no ombudsman cases reported or upheld during this time period.

**Quality and Engagement Act**

PCTG are currently working through the implications of Duty of Candour implementation in April 2023. There is representation at the national Duty of Candour Working Group and the Duty of Candour Reporting and Learning Task and Finish Group. Presentations have been delivered to the Local Medical Council, and arrangements are in place for further Duty of Candour briefs at Team Brief and through Q&S meetings. Services are being asked to scope the implications for their services.

**Mortality Reviews**

PCTG has responded to the introduction of the mortality review process this year with development of service standard operating procedures and processes, centrally coordinated and monitored by the governance team. A process of learning from feedback has also been developed, with findings shared within PCTG and with relevant contracted/commissioned services. A learning event for mortality reviews in planned for quarter 4.

**Clinical audit**

Audiology completed a trial of NICE guidance within the new Audit Management and Tracking system. Training was delivered in conjunction with the Clinical Audit Team to PCT SG with the invitation extended to Health Scientists within the DoTh group.
A Clinical Audit Task and Finish Group has been formed and will meet in December to develop the next audit plan and develop the process for planning, approval, monitoring and reporting of audits.

**External reviews**

HMP Swansea

The Health Board has responded to the HIW report, Local Review of the Quality Governance Arrangements in place within Swansea Bay University Health Board published on 30th June 2022.

An action plan is in place with timescales and is monitored by the Prison Partnership Board and reports to PCTG Board. Actions are closely related to the Health Care and Wellbeing plan with 27 out of 29 actions completed.

HIW inspections – GDS practices

Eight HIW Inspections & Quality Checks carried out at GDS Practices in 2022. Only one immediate concern raised which has been resolved. Continuation of the implementation of a rolling Practice Support programme undertaken by Dental Practice Advisors (DPA) and dental leads to provide support to practices and assurance for the HB that patients are receiving quality care in a safe environment.

**Ward audits**

An adapted ward assurance audit is being developed for HMP Swansea. An assurance audit to Gorseinon Hospital is planned over the coming weeks.

**Internal Audits**

Internal Audit on safe management of Controlled Drugs was largely positive. Actions in Q3 are to demonstrate activity against key recommendations. Mitigations includes adding Controlled Drug internal pharmacy audits in HMP, GPOOH and Gorseinon to the Health Board dashboard. A template has been devised to track and monitor progress of internal Audit recommendations within agreed timescales. PCTG Plan discussed and agreed with HB Accountable Officer

**Challenges, Risks, Mitigation and Action being taken relating to Quality and Safety issues noted above (what, by when, by who and expected impact)**

| Challenges | Risks | Mitigation | Action |
|---|---|---|---|
| Review and approved Q&S structures to align with Corporate reporting and legislative requirements | Structures and reporting to be in place for internal audit in February 2023 | Working with Corporate Q&S teams to ensure reporting structures are correct. | Develop Quality Management System for PCTG to align with corporate structures Q4. |
| Increasing numbers of open incidents on Datix Cymru | Untimely investigations and actions taken in response to incidents | Governance team to work with services to improve timely investigations.<br><br>Serious incidents are prioritised and monitored weekly | Scope plan for improved trajectory which will require additional resource to achieve reduction Q4<br><br>Review of quality and safety structures and resources across all service groups Q4 |
| Improvement of performance for reporting nationally reportable incidents | Manual monitoring mechanisms<br><br>Clinical resource to undertake timely investigation of pressure ulcers. | Designated clinical roles in place to investigate pressure ulcers.<br><br>Weekly meetings with governance team and clinical team to focus | Working with Corporate Q&S teams to ensure correct process is in place for monitoring / auditing occurrences of pressure ulcers outside clinical caseload Q4 |

| | | | |
|---|---|---|---|
| | Impact of reporting and investigating pressure ulcer incidents that occurred prior to clinical caseload | investigations and update reporting mechanisms | |
| Scope the implications of Duty of Candour for PCTG | Non-compliance with legislation | Awareness and training sessions are being arranged.<br><br>Provide influence through national groups and peers | Individual services to assess practical and resource implications for their services and appoint Duty of Candour Leads for services Q4 |
| Create sustainable services | Inability to recruit to vacancies | Reviewing professional structures and working with professional bodies to create sustainable workforce.<br>Risk assessing patients on waiting lists<br>Supporting contracted services where needed | Service specific actions in place |
| Improving how the service listens and learns and expand user feedback across services | Patient and community involvement in service improvement and development | Developing patient stakeholder champions in services. | QS&I Manager to develop project and complete in line with ACLP support and timescales Q4 |
| Improve routine reporting of Patient Reported Outcome Measures and Patient Reported Experience Measures to provide meaningful information | Missed information that's not routinely incorporated into governance reporting. | Incorporate reports produced into Q&S reporting structures | Improve scrutiny over PROMS and PREMS reports to improve services in line with ACLP project Q4 |
| Working with Corporate Services to improve process for managing safety alerts | Limited assurance provided in a recent internal audit report | SOP and process established within PCTG.<br>Triumvirate Lead to reinforce compliance. | Governance team to share current process with Corporate services. Improve compliance with process in PCTG, in line with Corporate timescales. |

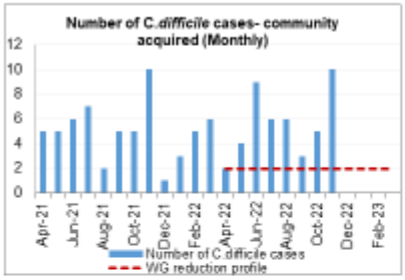
| | | | |
|---|---|---|---|
| Development of primary and community quality indicators | Monitor key areas of quality within service group. | Development of data collation methods to improve reporting and monitoring | QS&I Manager to work with services and senior management team to develop key data metrics to measure quality within service group. To commence Q3 / Q4 |

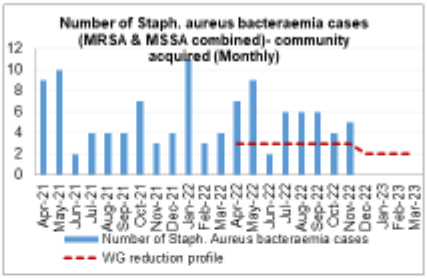
**Progress Against Annual Plan Quality and Safety Priorities 2021/22 (as applicable)**
**Quality Priorities: reduction in healthcare acquired infections; improving end-of-life care; sepsis; suicide prevention; and reducing injurious falls.**

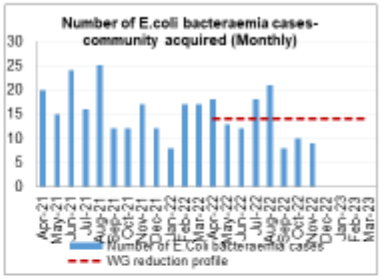
| **Falls prevention** | **Actions and Outcomes** |
|---|---|
| Previous full engagement in multi-agency Falls taskforce | Focus on development of multi-agency single coordinated plan to respond to falls |
| Continued focus on in-patient falls | Reduction in falls in Gorseinon |
| Virtual wards focus on falls assessment in reviews | Improved falls prevention and management driven by CGA |

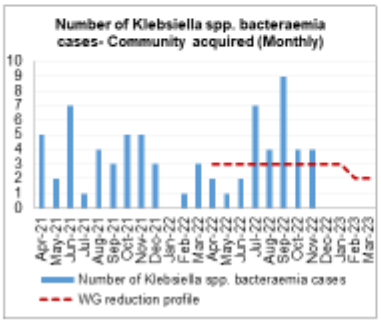
| **Infection prevention and control** | **Actions and Outcomes** |
|---|---|
| PCTG - Priority areas for Community Acquired Infections (CAI) identified as<br>1) E.coli reduction by min. 10%,<br>2) C.difficile reduction by min. 10%,<br>3) Staph aureus reduction by 5 – 10%,<br>4) 4C top 3 outlier practice prescribing reduction by min. 10%,<br>5) Overall antibiotic prescribing top 3 outlier practice reduction by min 10%.<br>Further improvements listed for training compliance, communication, IPC Champion role and Service support visits | Reduction in CAI needed in c.difficile, Klebsiella, Staph aureus and Pseudomonas within quarter 3 to achieve the PCTG target reduction<br>Continuation of site visits: 2 out of 3 priority areas completed – ongoing actions for quarter 3<br>Training matrix devised in quarter 2, for further implementation across all PCTG services<br>C.Difficile scrutiny and reporting structure now finalised, for roll out by the end of quarter 3 |
| Clinical Lead for Antimicrobial Stewardship (AMS) /HCAI – UTI Campaign lead, GMS prescribing ambassador, liaison with LMC and all GMS practices, QAIF UTI QI programme, AMS newsletter, promotion of Microguide app, promotion of c.difficile prescribing guidelines and scrutiny process, GMS template creation for prescribing via ViPC software | Reduction in 4C and overall antibiotic prescribing<br>GMS engagement and buy in regarding prevention and treatment practice<br>Reduction of harm and risk to patients and staff<br>Cost efficiencies associated with reduced prescribing and reduced infection rates |
| Priority tier 1 target area: C.difficile. Continued increase CAI of c.difficile. Targeted campaign around c.difficile prescribing guidelines, sampling, patient education and structured SEA process for monthly scrutiny and reporting | Reduction in inappropriate prescribing via use of the revised c.difficile prescribing guidelines<br>GMS, Care Homes, OOH and wider community service engagement with reduction campaign |

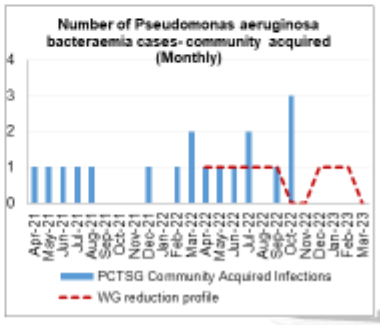
## IPC Charts




| **Sepsis** | **Actions and Outcomes** |
|---|---|
| Established areas of focus for PCT Group with Patient Safety Leads in Resus Team. Health Board wide ACT service to be initial focus. | Agree and create a baseline of how services current position regarding identification and response to Sepsis. Improvement plan to be developed with Services as baselines are completed. |
| NEWS2 Cymru to be considered as potential tool in community settings after baseline completed.<br>Initiate a PCT RADAR Group to feed into the HB RADR Group | Improve identification and have a clear escalation process for non medically led services (this is a known gap in Community services).<br>Opportunity escalate and identify gaps in adopting a consistent approach |

| **Suicide prevention** | **Actions and Outcomes** |
|---|---|
| Steering group to produce template for service group reps to feedback to steering group and for service groups to gain updates on the steering group work | Template to be agreed Dec 2022 |
| PCTSG has an engaged and well established suicide champion, who is responsible for sharing information regularly across the group reporting into to monthly Health and Safety updates. | A template for ligature assessments has been shared and is a standing item on Group health and safety meeting ensuring ongoing awareness and competency in this area. |

| **End of Life** | **Actions and Outcomes** |
|---|---|
| 9 staff (community staff nurses and district nurses) attended the End of Life Champion | The End of Life Champion day is for any health care professionals to attend and have |

| | |
|---|---|
| day from primary and community care. 8 care home staff attended too. We also have done a training session on end of life care in the university for the Fundamentals of Community practice course, some of the 22 that attended were from SBUHB | an overview of End of Life Care, Advance and Future Care planning, Ethics, Recognising dying, and the use of the All Wales Care Decisions for the last days of life. As a result of attending, it is hoped that the health care professional will be able to share their knowledge with colleagues in their work area and will encourage others to attend. |
| Maintain focus on supporting patients to die at home | Increased numbers of deaths outside of hospital since start of C19. From 47% to 52% (source : -End of Life care quality priority measurement dashboard) |
| Fast-Track Parasol Training has commenced with F2F training in Morriston Hospital 6th July 2022. three sessions were providing training to approximately 40 members of staff. Further sessions to be agreed. | To support staff in completing Fast-Track documentation and the process to facilitate a seamless discharge from hospital for end of life care |

## Progress Against Health and Care Standards

Theme 6 (individual care) was the only standard that scored 2 (or below) in previous submission for Health and Care Standards. Evidence of patient feedback and engagement across the service group will demonstrate an increased score. Project to be developed in Q4.

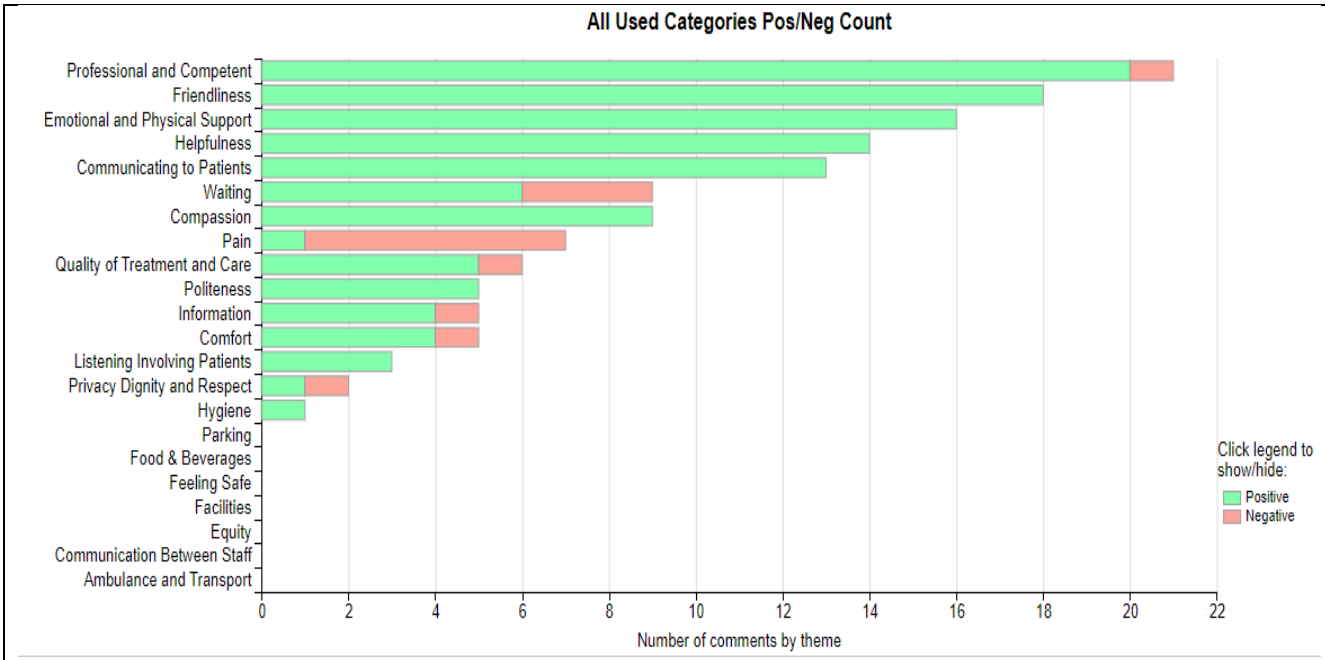
Corporate Services are leading on the submission of this year's Health and Care standards and the Service Group are supporting this work.

## Patient Experience Update

PCTG are currently score 94% for good feedback from patient experience.

Results by Service Group

| Service Group | % Good | % Poor | Total Responses | Very good | Good | Neither good nor poor | Poor | Very poor | Don't Know |
|---|---|---|---|---|---|---|---|---|---|
| Total | 93.9% | 3.1% | 163 | 125 | 28 | 4 | 4 | 1 | 1 |
| Primary Community Therapies Group | 93.9% | 3.1% | 163 | 125 | 28 | 4 | 4 | 1 | 1 |




A deeper dive into individual service feedback is required to develop learning outcomes for the most consistent feedback relating to pain/comfort and waiting times/information. This will be incorporated into new Quality and Safety structures and worked through during Q4.

## Any Other Issues to Bring to the Attention of the Committee

| Key issues/actions | Expected delivery | Risks | Mitigations |
|---|---|---|---|
| GMS Contract Resignation Vacant Practice Panel – 5th December. Resignation complete – 30th April. | Q4 | Securing GMS provision for 2,300 patients | Vacant Practice Panel to consider preferred option for ongoing delivery |
| Significant patient engagement programme for GMS contract changes including, Branch Surgery Closure (x2), premises relocation and Practice Merge Review Panel date – 1st week January 2023 with view to bring recommendations to SBUHB for 26th January Board meeting | Q4 | Managing patient and CHC expectations | Following HB service change process |
| PCT process for reviewing NICE guidance in line with Medical director steer | Q4 | Non- compliance could impact on safe and effective care | Relevant service leads will be allocated to lead based on the guidance Monitor via Q&S Group |

## Recommendations

Members are asked to: Note the contents of this report.
In summary:

- Q&S structures are being reassessed to comply with Corporate reporting and legislative requirements
- Risk management is strengthened with processes in place for continual review
- Open incidents are increasing due to capacity of services and governance. However, possible and actual serious incidents are monitored and reviewed weekly with a trajectory for improvement being developed.
- Renewed focus required to regain compliance with complaints performance by Q4
- Processes are in place to learn from mortality reviews
- The group are implementing processes within Q&S structures to monitor and learn from clinical audit; standard operating procedures to be developed to improve reporting and prioritisation
- PCTG have been proactive in responding to HIW's governance report on HMP Swansea: action plan approved and submitted, actions on target
- PCTG are also responding to HIW audits to dental practices with actions and support in place where required
- Work stream underway to scope requirements for Duty of Candour.
- Action plans in place and progressing for quality priority areas
- Project to be established to improve patient feedback and how the service listens and learns from patients and community.