Humber and North Yorkshire
Health and Care Partnership

Quality Update Public Board

November 2022

Quality Update

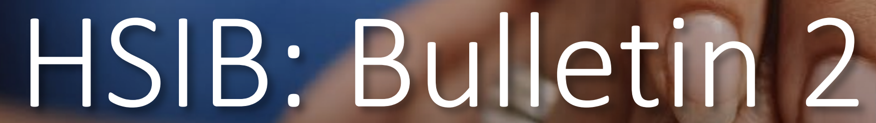
- Areas of Focus:
  - UEC
  - HSIB Investigation – Harm caused by delays in transferring patients to the right place of care.
  - CYP Mental Health Services
  - Maternity
    - East Kent
    - Ockenden 2

UEC

- Monthly Quality Meeting with YAS commencing November – 3 x ICB DoN’s.

- YAS SI data now being received but it is not as comprehensive as I would like to see.

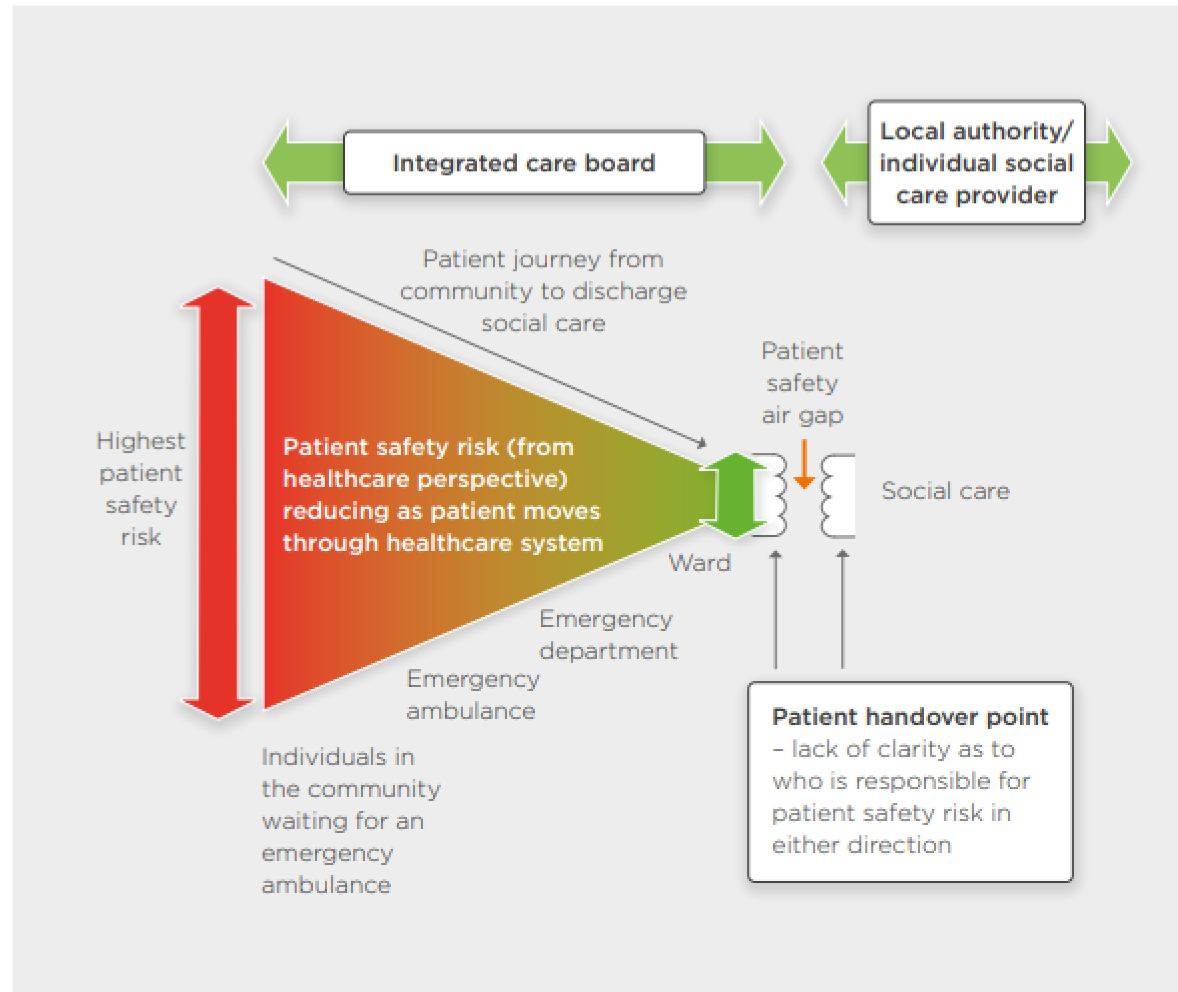
- UEC pressures reflected in CQC findings for both YSFT and HUFT.



HSIB: Bulletin 2

Harm caused by delays in transferring patients to the right place of care.

Figure 1 Simplified diagram of degree of risk to patient safety as a patient moves through the healthcare system to social care



Harm caused by delays in transferring patients to the right place of care

- This national investigation seeks to examine the systems that are in place to manage the flow of patients through and out of hospitals, and considers the interactions between the health and social care systems (the ‘whole system’).

- Safety observation O/2022/197:
    - It may be beneficial for there to be a whole-system patient safety accountability and responsibility framework that spans health and social care.

CYP Mental Health Services

- Calls are growing for a public enquiry into the CYP inpatient MH services and the instances of self harm / suicide.

- TEWV – reports published identifying failures in service provision to 3 young girls who took their own lives.
  - Christie – 22 recommendations
  - Nadia – total of 17 recommendations
  - Emily – 13 recommendations
  - There are commonalities across the recommendations for each case and some are directed at 'systems', LA s – especially in relation to LAC and oversight by commissioners.
  - Will review in more detail and take report to Quality Committee identifying what is relevant for us as an ICB to act upon.

East Kent Report

- What was found
  - A clear pattern.
  - Those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor.
  - The individual and collective behaviours of those providing the services were visible to senior managers and the Trust Board in a series of reports, and lay at the root of the pattern of recurring harm.

East Kent report.

- 4 Key Action Areas:
  - Key Action Area 1: Monitoring safety performance –finding signals among noise
  - Key Action Area 2: Standards of clinical behaviour –technical care is not enough
  - Key Action Area 3: Flawed teamworking –pulling in different directions
  - Key Action Area 4: Organisational behaviour –looking good while doing badly

Ockenden 2

In addition to the immediate and essential actions – progress against these reported last month – this report has;

- 15 categories of Essential actions with multiple requirements within each.
- **BUT**

Overall the findings are summarised as;

- Patterns of repeated poor care.
- Failure in Governance and Leadership