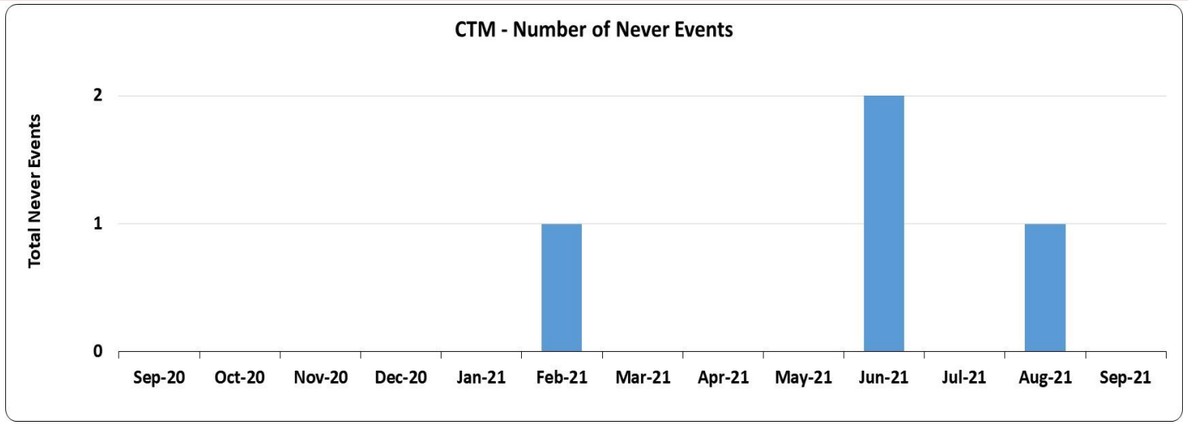
Quality & Patient Safety Dashboard (data to end of September 2021)

Never Events & Serious Incidents

Never Events

Number of Never Events – Quarter 2

1



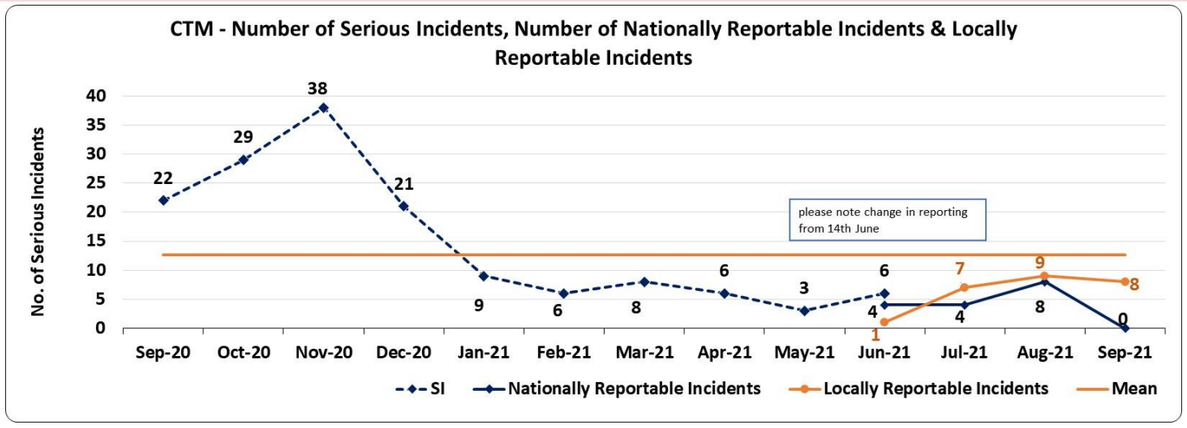
During the last quarter 1 never event was reported in August 2021.

This event related to the incorrect siting of endotracheal tube and the investigation remains ongoing at the time of writing this report.

Nationally Reportable Incidents

Number of Serious Incidents – Quarter 2

12



Type of Nationally Reportable Incidents	Jul-21	Aug-21	Sep-21	Total
Slip, Trip or Fall	1	1	0	2
Unexpected or Trauma related Death	0	2	0	2
Infection	0	2	0	2
Delays	2	0	0	2
Treatment Error	0	2	0	2
Maternal Event	0	1	0	1
Patient Injury	1	0	0	1
Medication	0	0	0	0
Absconding	0	0	0	0
Admission/Transfer/Discharge	0	0	0	0
Incorrect Surgical Porcedure	0	0	0	0
Total	4	8	0	12

Number of Patient Safety Incidents – Quarter 2

6,502

Between the 01.07.21 and 31.09.21 (Quarter 2), a total of 6,502 incidents were reported across the Health Board. This is an increase of 244 compared to the previous quarter. Of these, 86% (5575) were reported as patient safety incidents. Of these, 74 were reported with a severity of severe harm or death, 1.33% of the total number of patient safety incidents reported.

Nationally Reportable Incidents

Previous reports have highlighted the implementation of the NHS Wales National Incident Reporting Policy since 14.06.21. The introduction of the policy changed the terminology from Serious Incident to Nationally Reportable Incident (NRI), as well as the criteria for incident reporting. Incidents that were previously reported at Serious Incidents are now not necessarily reportable as NRI's, however CTMUHB ensure these significant incidents are captured locally for assurance and learning. Any incidents that were SI's under the Putting Things Right legislation are now reported as Locally Reportable Incidents (LRI's) if they do not meet the NRI criterial. This ensures that any harmful incidents occurring throughout the UHB are known, investigated and monitored. During July, August and September 12 nationally reportable incident notifications were submitted to the Delivery Unit.

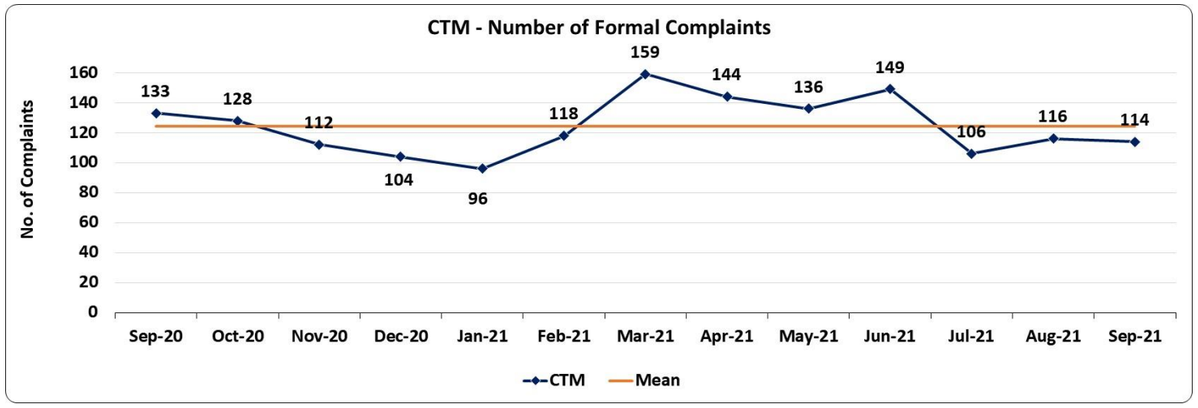
Reviews of Datix continue to ensure that any Covid-19 related harms are captured. Complaints relating to the impact of Covid-19 on those affected by the pause or delay in non-essential services are also being captured.

Complaints & Compliments

Complaints

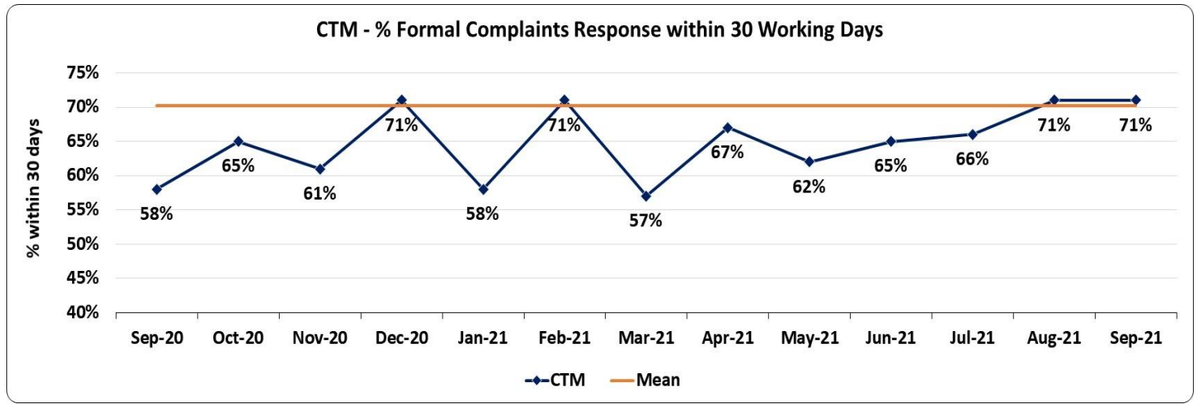
Number of formal complaints managed through PTR – Quarter 2

336



% formal complaints response within 30 working days - September 2021

71%



Complaints

During July, August & September 2021, there were 336 formal complaints received within the Organisation and managed in line with the Putting Things Right regulations. The trend in relation to the number of formal complaints received is reflected in the chart above. For those complaints received in quarter 2, the top 3 themes relate to *clinical treatment/assessment* (134), *communication issues*, including attitudes & behaviours (89) and *appointment issues* (31). The Health Board implemented the new Once for Wales DCIQ Feedback (complaints) functionality within the Organisation from the 05.07.21. A key function of the new system is that more than one subject type can be allocated to a complaint. This will enable more detailed information regarding themes and trends and clearly identify areas for improvement.

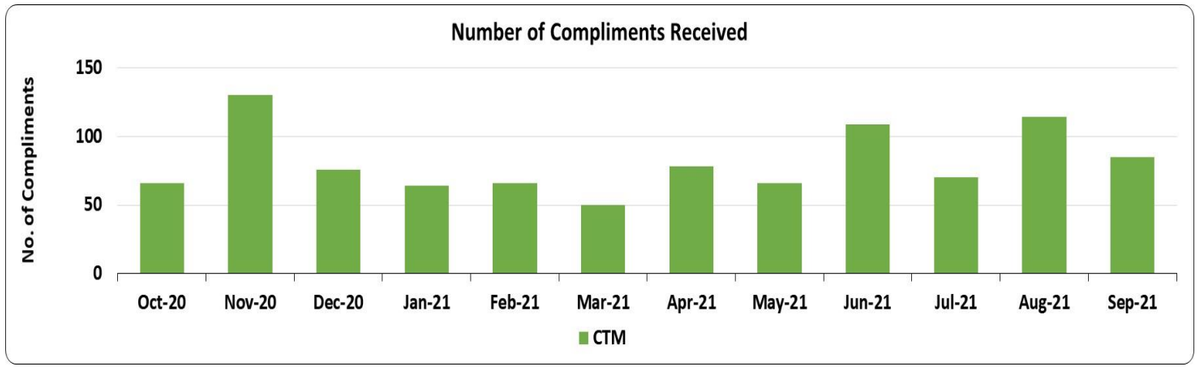
Compliance with the 30 working day target has remained relatively consistent over the last 6 months, which is reflected in the chart top right.

Main Themes from Complaints	
Clinical Treatment/Assessment	134
Communication Issues *(inc. attitudes & behaviours)*	89
Appointment Issues	31

Compliments

Number of compliments – Quarter 2

269



During Quarter 2, there were 269 compliments recorded on the Datix system; a slight increase from the previous quarter (253).

These are now recorded on Datix within a category of *beyond duty of care* and can be broken down into demonstrating favourable **communication, understanding, listening and environment**. It is important that this positive patient/family feedback is used for balance, and greater analysis will provide intelligence for getting things right.

Patient Safety Solutions

Summary:

The Delivery Unit (DU) are currently facilitating a national working group for the review and management of Patient Safety Solutions (PSS). Health boards come together to share their progress and discuss barriers and solutions, which is supporting the ongoing internal work to achieve compliance. The group also offers members an opportunity to raise issue with any specific alerts or notices if required. More recently, the DU are undertaking a review of internal process within health boards in the management of PSS, and will undoubtedly summarise this position in due course. It is understood that the purpose of this is to gain assurance and to streamline a more standardised approach across Wales and within health boards and Trusts.

The internal management, monitoring and reporting process for Patient Safety Alerts (PSAs) and Patient Safety Notices (PSNs) has been reviewed, with a revised process having been approved and implemented. The new process ensures devolved responsibility to the relevant ILG teams with the central Patient Care and Safety Team providing support, co-ordination and oversight leading to reporting. The process is now managed through Datix which will fall in line with future plans due to be delivered through the 'Once for Wales' project. It is anticipated utilising Datix now, will reduce the need of significant process change when this is rolled out. Progress of this new process will be updated at next committee.

Compliance: We have recently achieved and reported compliance in the following 3 areas:

PSA010: High Flow Nasal Oxygen during Transfer	PSN053: Risk of harm to babies and children from coin/button batteries in hearing aids and other hearing devices	PSN046: Resources to support safer bowel care for patients at risk of autonomic dysreflexia
Compliance achieved September 2021	Compliance achieved September 2021	Compliance achieved October 2021

Non-Compliance: The Health Board currently reports non-compliance in 6 PSAs and PSNs:

PSA008: Nasogastric tube misplacement: continuing risk of death and severe harm	PSA012: Deterioration due to rapid offload of pleural effusion fluid from chest drains	PSN051: Depleted batteries in intraosseous injectors	PSN052: Risk of death and severe harm from ingesting superabsorbent polymer gel granules	PSN030 / 055: The safe storage of medicines: cupboards	PSN056: Foreign body aspiration during intubation, advanced airway management or ventilation
Interim arrangements put in place by the Health Board are supported by the Delivery Unit and Welsh Government patient safety team until an alternative product is sourced for Wales. In February 2021, the Health Board received a notification on behalf of the Healthcare Safety Investigation Branch advising that initial investigations are now concluded and this work is moving to the next stage of resolution for an All Wales solution. Through the All Wales Patient Safety Solution group, it has been reported that one Welsh health board has formally written to the Chief Medical Officer for Wales, requesting that this notice be withdrawn and re-issued. Pan Wales, we are currently awaiting a decision.	This notice was issued in April 2021, with a due date of 1st July 2021. This work is centrally led and is linked to the LocSSIP for chest drains. We expect to achieve compliance by 1st November 2021.	This notice was issued in February 2020, with due date of August 2020. We are partially compliant with 1 action outstanding, which relates to training and competency assessment. The Resus Team are leading on this alert and with the recent appointment of a new manager, the training framework and competency assessments will be revised to enable compliance. We expect to achieve compliance by 31st December 2021.	We report compliance in Merthyr & Cynon ILG, and we report compliance in Rhondda Taf Ely ILG. We are currently non-compliant in Bridgend ILG. Work is underway in Bridgend ILG, with support from pharmacy to achieve compliance	Progress with this work has been hindered by 2 factors: The prioritisation of vaccine storage in the Mass Vaccination Centres Access to wards to undertake required audits has been challenged due to Covid-19 and subsequent outbreaks. This notice is being managed by pharmacy and an Action Log has been provided and attached for assurance purposes and to demonstrate planned timescales.	This notice was issued in October 2020, with a compliance due date of 1st July 2021. The notice was disseminated to ILGs and remains non-compliant in all areas. The Medical Director has been asked to be the Executive lead and has nominated leads to progress this work to compliance. We do not currently have an expected date of compliance and will update further at next committee.

In progress and not yet due: The Health Board currently holds 6 PSS that are not yet due:

PSN057: Emergency Steroid Therapy Cards: Supporting Early Recognition & Management of Adrenal Crisis in Adults & Children	PSN058: Urgent assessment / treatment following ingestion of 'super strong' magnets	PSN059: Eliminating the risk of inadvertent connection to medical air via a flow meter	PSN060: Reducing the Risk of Inadvertent Administration of Oral Medication by the Wrong Route	PSN061: Inappropriate anticoagulation of patients with a mechanical heart valve	PSN062: Elimination of bottles of liquefied phenol 80%
This notice was issued Jun 2021, with a compliance due date of 31st Jan 22. Pharmacy have led the initial phase with partial compliance being met. The ILGs will lead on the remaining actions to achieve compliance.	This notice was issued Jul 2021, with a compliance due date of Oct 2021. The ILGs are currently leading on actions to achieve compliance.	This notice was issued Sep 2021, with a compliance due date of 16th Dec 21. The notice has been disseminated - a Task & Finish Group has been set up, led by the central Patient Care & Safety Team to progress to compliance.	This notice was issued Sep 2021, with a compliance due date of 20th Dec 2021. This work is being led by Pharmacy with some actions designated to ILGs.	This notice was issued on 8th Oct 2021, with a compliance due date of 28th Oct 2021. Primary Care services are currently leading on actions to achieve compliance, with oversight by the ILGs and central team.	This notice was issued in Sep 2021, with a compliance due date of 25th Feb 2022. Central team worked with Procurement & Pharmacy identifying areas that stock this item & now this notice will be managed by Pharmacy with support from the ILGs.

Medication Incidents & Mortality Rates

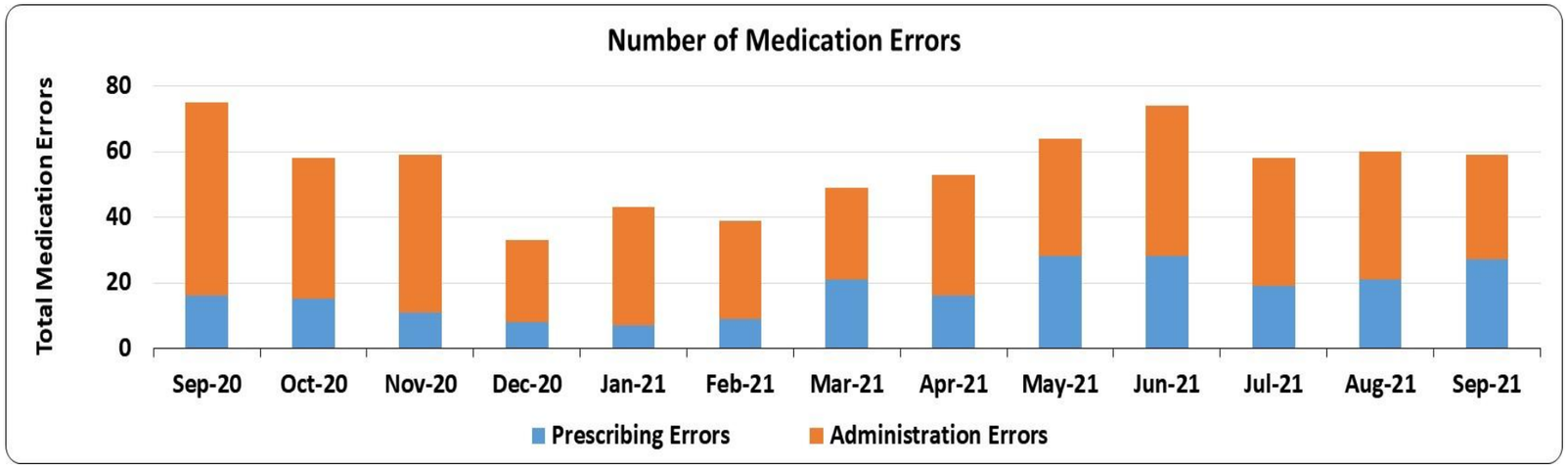
Medication Incidents

Total Medication Incidents – Quarter 2	Total number of Prescribing Errors – Quarter 2	Total Administration Errors – Quarter 2
279	67	110

A total number of medication incidents were reported between the 01.07.21 & 30.09.21, which is consistent with the previous quarter (279).

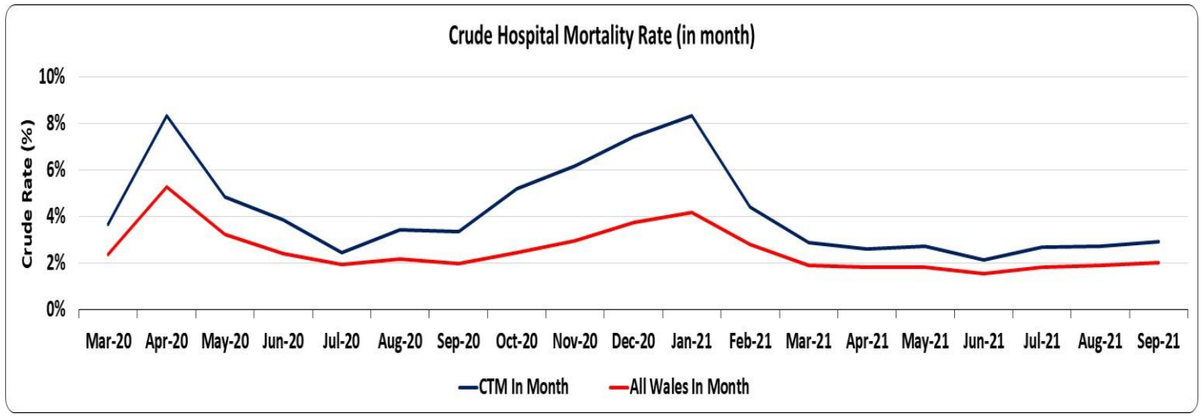
91.7% of the incidents were reported as resulting no (188) or low (6) harm. Of the total number of medication incidents reported 110 related to the administration of medication and 67 to prescribing.

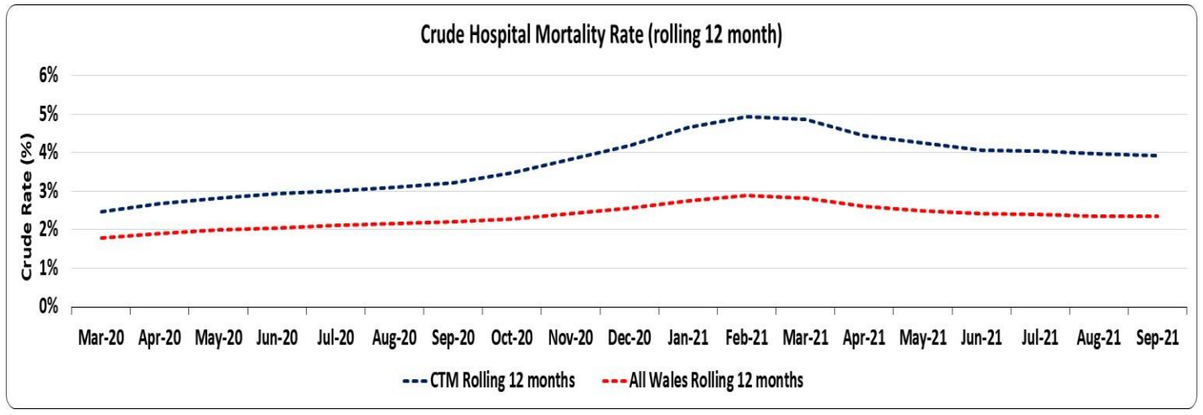
No administration or prescribing medication incidents were reported as resulting in severe harm or death.



Crude Hospital Mortality Rates

In Month Crude Hospital Mortality Rate – September 2021	Rolling 12 Month Crude Hospital Mortality Rate to September 2021
2.94%	3.92%





Overall mortality rates fell following the second COVID wave from 2.89% in March 2021 to the lowest level in June of this year at 2.15%. Rates have increased after this date but not at the levels seen during the second wave with the highest recorded rate being January 2021 (8.34%); a similar rate to that at the start of the pandemic. In month crude hospital, mortality rate for September 2021 is 2.94% with the rolling 12-month rate being 3.92%.

Inpatient Falls & Pressure Damage Incidents

Inpatient Falls

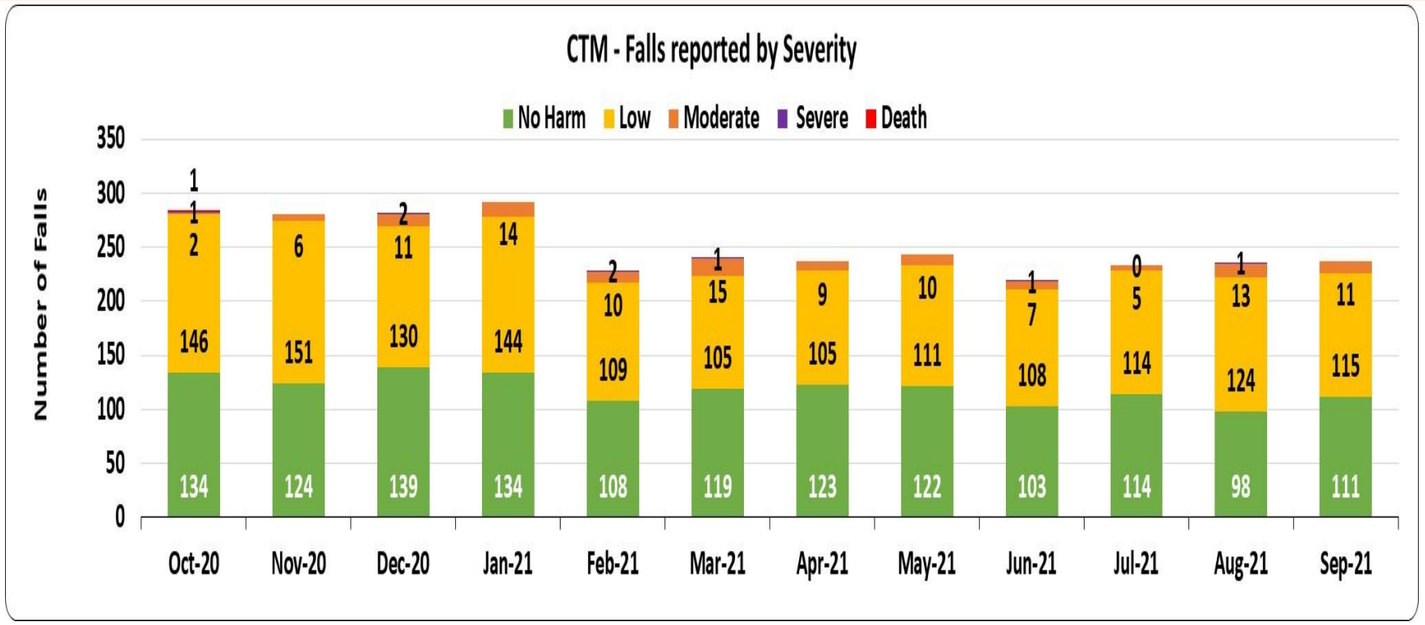
Total number of Inpatient Falls – Quarter 2

706

There was slight increase in the number of falls reported for July, August and September (706) compared to the previous 3 months (699). Although the number incidents reported as resulting in moderate harm has increased this quarter, statistically the volume has not altered significantly over the past 12 months.

No incidents were reported as resulting death. The highest number of inpatient falls occurred at the Seren Unit at Royal Glamorgan Hospital and Acute Medical Unit at Princess of Wales Hospital. The central team *Learning from Events Co-ordinator* has been regularly attending all falls panel and supporting the teams to adopt a standardised and robust process.

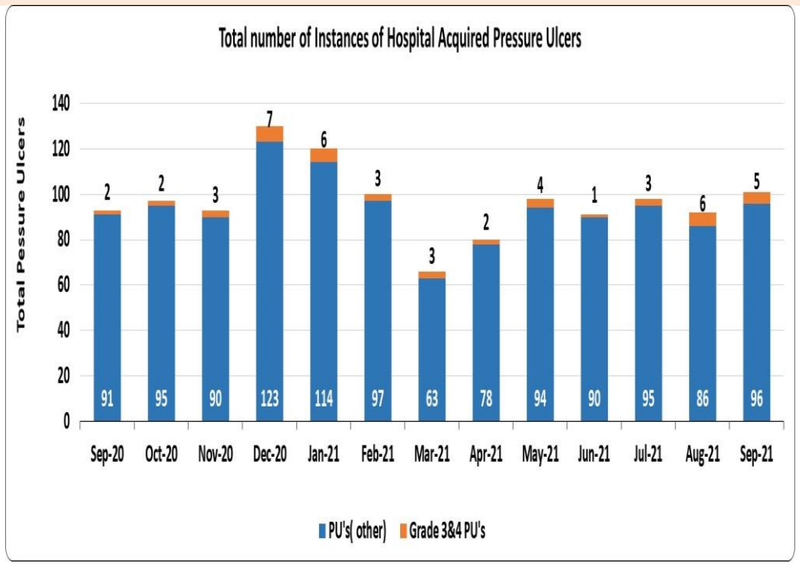
There is some disparity across ILGs still noted, but the work is showing some improvements and is continuing.

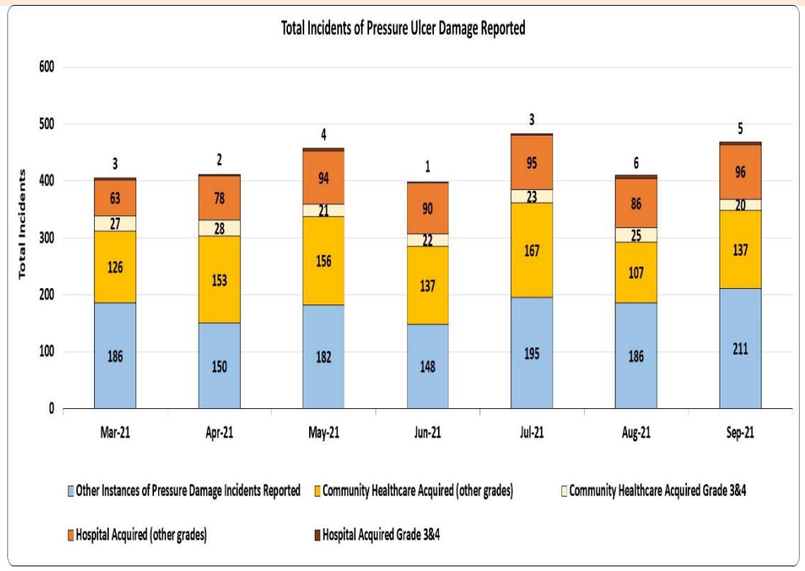


Pressure Damage Incidents

Total number of reported Pressure Damage – Quarter 2

1362





During the reporting period (quarter 2), a total of 1362 pressure damage incidents were reported, an increase of 96 from the previous quarter. The highest number of incidents reported were identified as developed outside of hospital setting with district nursing input (497). Of the total number of pressure damage incidents reported, 29 were identified as hospital acquired, with Emergency care and AMU at Princess of Wales Hospital recorded as the highest. 14 incidents were recorded as Grade 3 and 4.

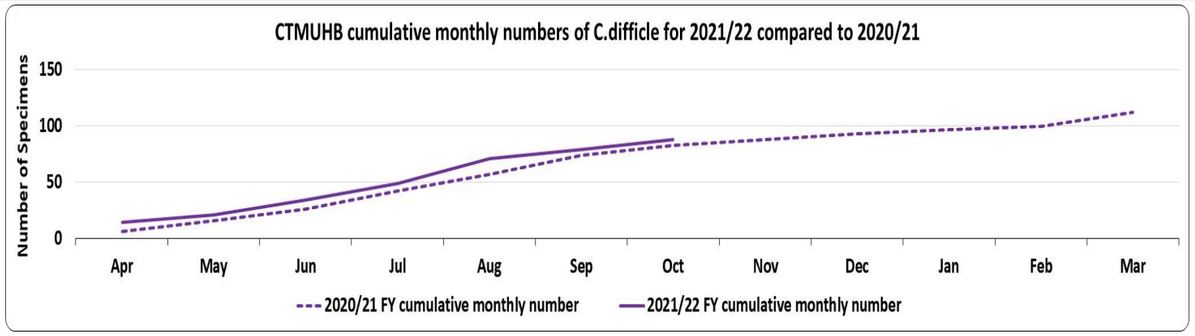
As with falls panels the Learning from events co-ordinator is supporting the PU panels, in addition to a member of the safeguarding team. This is supporting improved recognition of avoidable harm, a consistent approach across all scrutiny panels and improved learning opportunities.

What the data does not provide are outcomes in terms of avoidable and unavoidable healthcare acquired pressure damage. More recent exploration of this, where an All Wales pressure damage investigation was completed, demonstrated that in 1801 cases, 273 were recorded as avoidable, which is 15%. This improved data granulation can support intervention and improvement activities and give enhanced assurance of pressure ulcer prevention within the health board (pressure damage incidents between 01.10.20 - 30.09.21).

Infection Prevention and Control

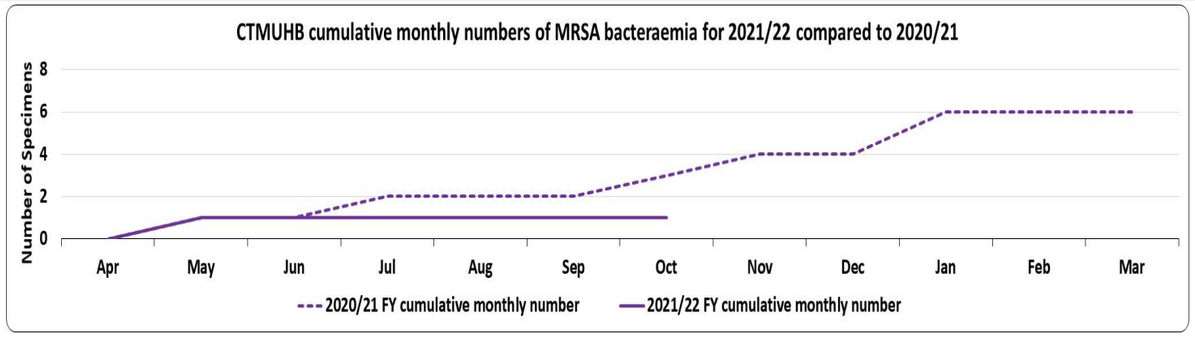
C.difficile

88 C. difficile have been reported by CTM for Apr-Oct 2021. This is approximately 6% more than the equivalent period in 2020/21. The provisional rate per 100,000 population for 2021/22 is 33.46



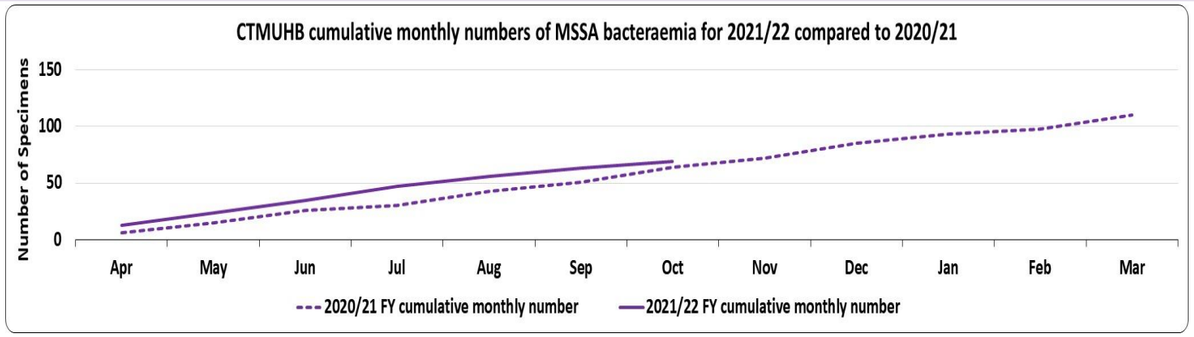
MRSA

1 MRSA bacteraemia have been reported by CTM for Apr-Oct 2021. This is approximately 67% fewer than the equivalent period in 2020/21. The provisional rate per 100,000 population for 2021/22 is 0.38



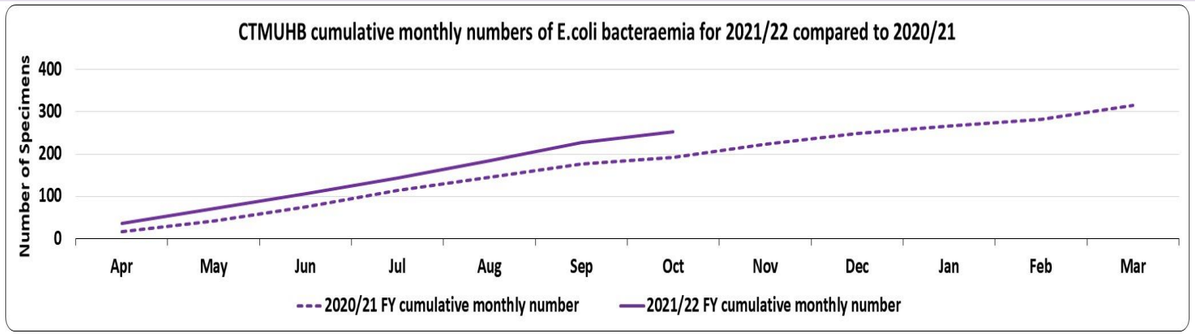
MSSA

69 MSSA bacteraemia have been reported by CTM for Apr-Oct 2021. This is approximately 8% more than the equivalent period 2020/21. The provisional rate per 100,000 population for 2021/22 is 26.23



E.coli

252 E.coli bacteraemia have been reported by CTM for Apr-Oct 2021. This is approximately 31% more than 2020/21. The provisional rate per 100,000 population for 2021/22 is 95.80



The IPC team have supported the Health Boards preparedness and response for the second and third waves of COVID through 2020-21 and managed individual cases/outbreaks of infection throughout CTMUHB. The Team has worked in collaboration with a range of multi-disciplinary colleagues to develop patient pathways and testing strategies, participate in Health Board and ILG meetings, provided IPC advice based on national guidance to inform practice and supported colleagues to undertake risk assessments to minimise the risk of infection to staff, patients and their visitors.

Although the Health Board did not achieve the reduction expectations for reducing healthcare associated infections for 4 of the 5 surveillance organisms for the financial year 2020/21, fewer cases were reported compared to the previous year. An increase in cases has been reported for all surveillance organisms from April – October 2021 but this is mirrored across Wales. Work is ongoing at a national level to determine whether additional use of broad-spectrum antibiotics and sessional use of personal protective equipment has contributed to the rise in cases across Wales.
Despite the increase in S.aureus bacteraemia and gram negative bacteraemia, a significant proportion are community acquired infections and urgent investment is required to appoint a dedicated IPC Team for primary care. Without investment, the IPC team is unable to introduce and support targeted interventions in primary care to make sustainable improvements to reduce community-acquired infections. The Lead IPC Nurse is part of an all Wales task and finish group looking at workforce planning for IPC. The IPC team has developed local reduction expectations for each of the ILGs to facilitate ownership of data and improve clinical engagement. A monthly infographic is shared with the ILG demonstrating their position against the WG reduction expectations. Further engagement is required to strengthen the root cause analysis process in primary and secondary care to learn lessons from incidents and share best practice. Further work is also required to improve antimicrobial stewardship as the antimicrobial pharmacists were redeployed to support the COVID response and have not returned to their substantive roles as yet.

An external review of decontamination in CTM has been jointly undertaken by the Health Board and Shared Services colleagues. The report focusses on the current infrastructure, the processes and systems in place and the role of the decontamination officer. A report with recommendations will be presented to Infection Prevention and Control Committee in November 2021.

Planned improvements to the IPC services –

- Develop a business case for a dedicated IPC resource for primary care
- Develop a business case for a dedicated Decontamination Officer/Operational Lead for Decontamination.
- Support the ILG to introduce targeted interventions in primary and secondary care to influence improvements
- IPC team to deliver a blended approach for IPC training – face to face sessions and access to ELearning
- Provide guidance and support to introduce and implement revised national guidance for IPC across CTM.