| AGENDA ITEM |
|---|
| 6.1 |

# CTM BOARD

# QUALITY & PATIENT SAFETY DASHBOARD

| | |
|---|---|
| **Date of meeting** | 31st March 2022 |
| **FOI Status** | Open/Public |
| **If closed please indicate reason** | Not Applicable - Public Report |
| **Prepared by** | Louise Mann, Assistant Director Quality & Safety<br>louise.mann@wales.nhs.uk |
| **Presented by** | Greg Dix, Executive Director of Nursing, Midwifery and Patient Care |
| **Approving Executive Sponsor** | Executive Director of Nursing<br>Executive Medical Director |
| **Report purpose** | FOR DISCUSSION / REVIEW |

| **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)** | | |
|---|---|---|
| **Committee/Group/Individuals** | **Date** | **Outcome** |
| Discussions with key individuals in corporate services and within directorates and localities<br>Joint working with Performance and Planning team | Various dates | SUPPORTED |

| **ACRONYMS** | |
|---|---|
| CA&QI | Clinical Audit & Quality Informatics |

## 1. SITUATION/BACKGROUND

This presentation of quality and patient safety metrics provides data up to the end of February 2022. The Health Board continues to experience considerable challenges following the impact of the Omicron variant of COVID-19 at the end of 2021 and in

to January 2022. Quality and patient safety remain the central priority, and that we have robust mechanisms in place to maintain visibility of service to Board assurance.

**Key areas to note in this reporting period are**:

- Mean reduction in formal complaints received during the reporting period with January reporting the lowest number of complaints over the past 12 months. However, top themes for formal complaints received remain unchanged in order of definition as follows: 1. Clinical Treatment & Assessment; 2. Communication; 3. Appointment issues.
- CTMUHB Complaints response compliance average was 60% up to January 2022 with a target range of 75%. February data reported the lowest compliance percentage in the last 24 months of 47%. Reduced complaints compliance has been contributed to by the redeployment of staff for Covid vaccination, increased absence and annual leave. It is anticipated that this will continue to affect compliance for quarter 4. Improved systems of complaints triage and early resolution instigated in February 2022 should increase patient satisfaction in timely health board response to concerns and reduce the need for formal process.
- Patient safety incident reporting remains consistent with a reduction in severe harm or death incidents in this period. This may be as a result of improved recognition of categories of harm and corresponding reporting on Datix, further data run will clarify. As a result of changes in national reporting criteria, the health board has developed a local reporting criteria to ensure incidents that were previously termed as 'Serious Incidents' under Putting Things Right (PTR), but no longer nationally reportable, are still reported for oversight, central scrutiny of robust investigation and identification of learning.
- The Never Event incident reported in January 2022 refers to a retained swab within maternity services.
- There were fewer falls reported for February 2022 (252) compared to the previous month (300); on par with the 12-month average of 255 and the number recorded in February 2021.
- Two deaths were reported to be as a result of a fall in the Merthyr Cynon ILG in December 2021 and January 2022, one of which was established to be a collapse, not a fall, and the other is still subject to investigation.
- The number of community acquired pressure damage incidents started to increase in March 2021. With the exception of August 2021 where a significant reduction on numbers were recorded, the numbers have continued on an upward trajectory with a slight reduction seen in February 2022. The Assistant Director for Quality and Safety is leading an improvement piece of work around pressure area reduction within the community.
- There is a decrease in medication prescribing errors in January and February 2022. It is not clear why this has occurred or if it will become a trend. Administration errors are just below the 12-month average. Medication errors

are the subject for a proposed improvement plan supported by the CTM Improvement Team.

- Overall, mortality rates fell following the second COVID wave from 2.88% (in March 2021) to 2.14% (the lowest level in June 2021). Rates have increased after this date, but not at the levels seen during the second wave and a fall in the mortality rate is observed for January 2022 (3.54%). The rolling 12-month mortality rate is 3.07%; a similar level to that observed in July 2020 (3.00%)
- Infection Prevention and Control (IPC) capacity challenges persist as a result of the pandemic and an increase seen in infections are mostly community acquired. More emphasis must be placed on improvements in primary care to influence a reduction in infection rates.

## 2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

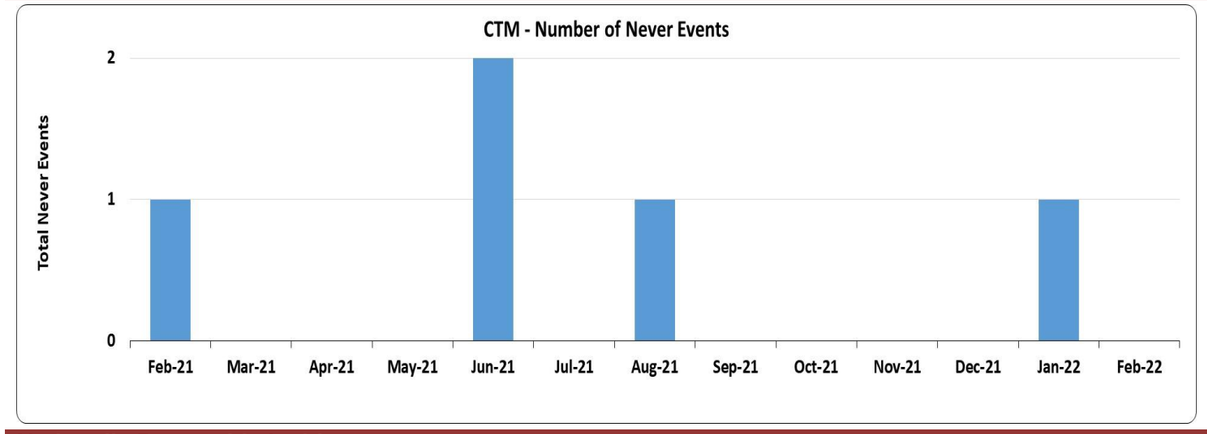
2.1 Concise quality and patient safety metrics are shown below. The measures selected are operational and outputs based; they allow for earlier detection of change in metrics that affect our impact and outcomes, in addition to health board wide consideration of the impact of covid on quality and patient safety.

## 2.2 Never Events & Serious Incidents

### Never Events

Number of Never Events – February 2022

**0**




There were no never events reported for February and in total 4 reportable events have been observed during the past twelve months.

The investigation into the never event that occurred during January 2022 is still under investigation at the time of writing this report.

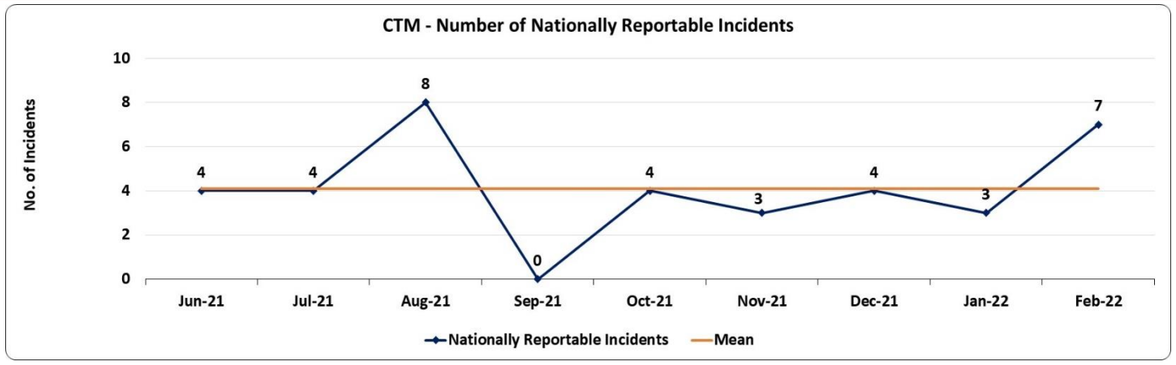
### Nationally Reportable Incidents

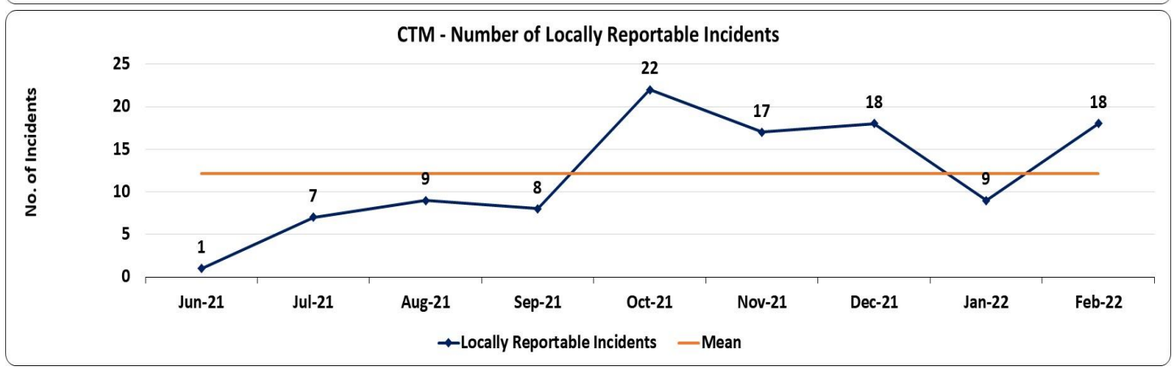
Number of Nationally Reportable Incidents – February 2022

**7**

Number of Patient Safety Incidents – February 2022

**1,676**




During February 2022 there were 1,676 patient safety incidents reported on Datix across the Health Board. Of these, 7 were Nationally Reportable Incidents; 4 relating to delays, 1 relating to a slip, trip or fall, 1 relating to a maternal event and 1 relating to an organisational failure to follow policy/procedure.

A further 17 were graded as locally reportable incidents. Of these, 4 relating to a slip, trip or fall, 5 relating to unexpected or trauma related deaths, 3 relating to radiological investigations, 1 relating to an admission, transfer or discharge, 1 relating to communication, 1 relating to a neo-natal event, 1 relating to failure to follow policy/procedure and 1 relating to self-harm.

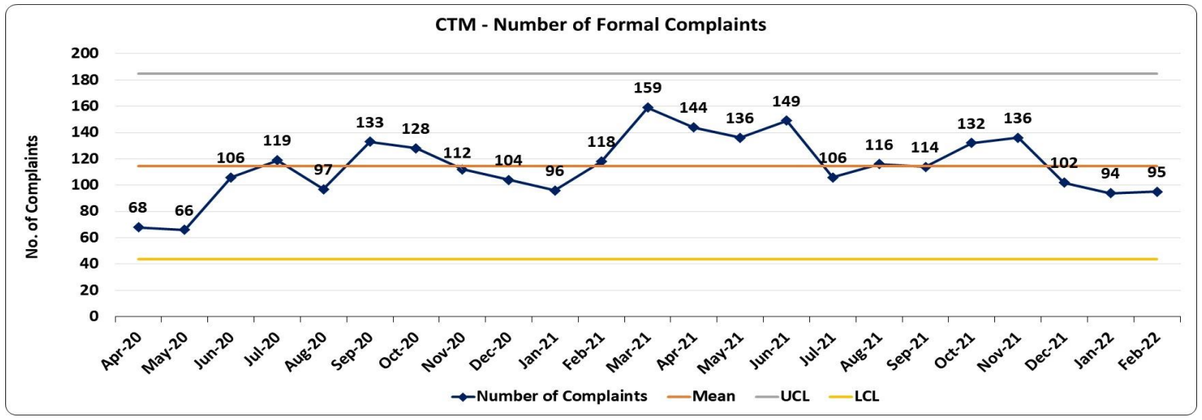
| Type of Nationally Reportable Incidents | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Delays | | 2 | | | 2 | | 2 | | 4 | 10 |
| Unexpected or Trauma Related Death | 2 | | 2 | | | 1 | | | | 5 |
| Slip, Trip or Fall | 2 | 1 | 1 | | | | | | 1 | 5 |
| Pressure Damage | | | | | 1 | 2 | | 1 | | 4 |
| Infection | 1 | | 2 | | | | | | | 3 |
| Treatment Error | | | 2 | | | | 1 | | | 3 |
| Admission / Transfer / Discharge | 1 | | | | | | | 1 | | 2 |
| Medication | 2 | | | | | | | | | 2 |
| Absconding | 1 | | | | | | | | | 1 |
| Incorrect Surgical Procedure | 1 | | | | | | | | | 1 |
| Maternal Event | | | 1 | | | | | | 1 | 2 |
| Patient injury | | 1 | | | | | | | | 1 |
| Neo-Natal Event | | | | | 1 | | | | | 1 |
| Personal Incident - Personal injury attributed to clinically related challenging | | | | | | | 1 | | | 1 |
| Unexpected Complications | | | | | | | | 1 | | 1 |
| Organisational - Failure to follow Policy/Procedure | | | | | | | | | 1 | 1 |
| Grand Total | 10 | 4 | 8 | 0 | 4 | 3 | 4 | 3 | 7 | 43 |

# Complaints & Compliments

## Complaints

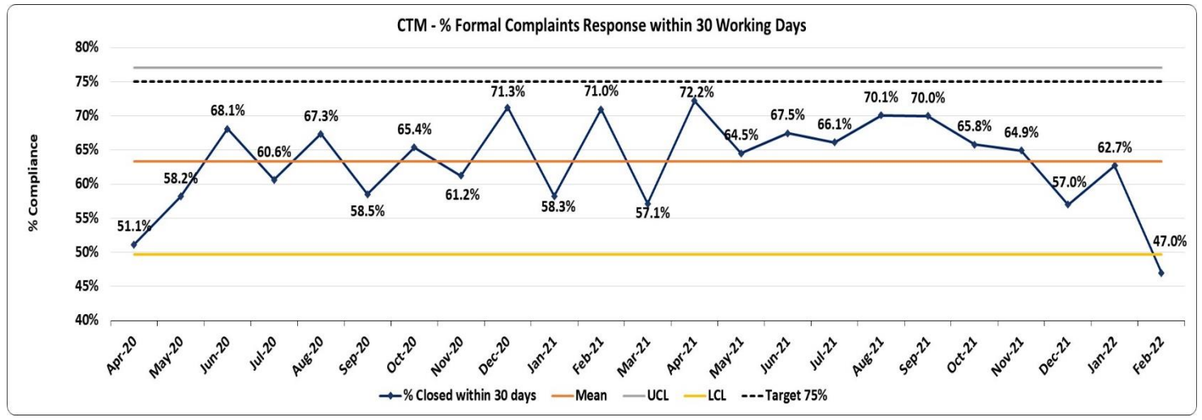
Number of formal complaints managed through PTR – February 2022

**95**




% formal complaints response within 30 working days – February 2022

**47.0%**




### Complaints

During February 2022, 95 formal complaints were received within the Organisation and managed in line with the Putting Things Right regulations. For those complaints received during this period, the top 4 themes relate to clinical treatment/assessment (54), communication issues (15), appointments (7) and discharge issues (6).

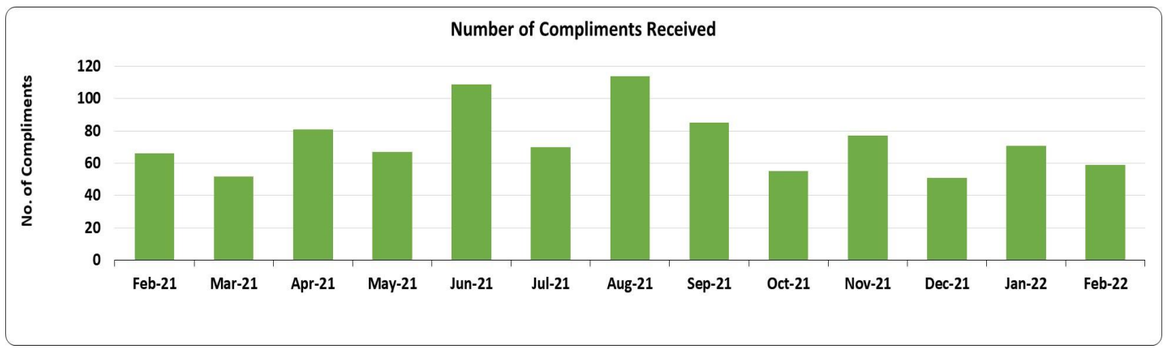
Of concern to the UHB is the recent reduction in the proportion of complaints responded to within 30 days. The service standard in February fell to 47%, as a result of a number of factors including staff redeployment, staff absence and staff leave. Efforts to improve to the expected 75% target continue within ILGs. Measures include better triaging of complaints to establish if opportunities exist for early resolution/better management.

| Main Themes from Complaints | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Clincial treatment/Assessment | 0 | 41 | 48 | 45 | 57 | 64 | 37 | 51 | 54 | 397 |
| Communication Issues (including Language) | 43 | 22 | 13 | 16 | 21 | 16 | 17 | 10 | 15 | 173 |
| Appointments | 0 | 12 | 9 | 10 | 8 | 19 | 13 | 6 | 7 | 84 |
| Discharge Issues | 0 | 4 | 7 | 9 | 5 | 7 | 15 | 8 | 6 | 61 |

## Compliments

Number of compliments – February 2022

**59**




During February 2022, there were 59 compliments recorded on the Datix system; almost 17% less than the previous period. During the past twelve months the average number of compliments received each month has been around 74.

# Medication Incidents & Mortality Rates

## Medication Incidents

| Total Medication Incidents – February 2022 | Total number of Prescribing Errors | Total Administration Errors |
|---|---|---|
| 67 | 13 | 35 |

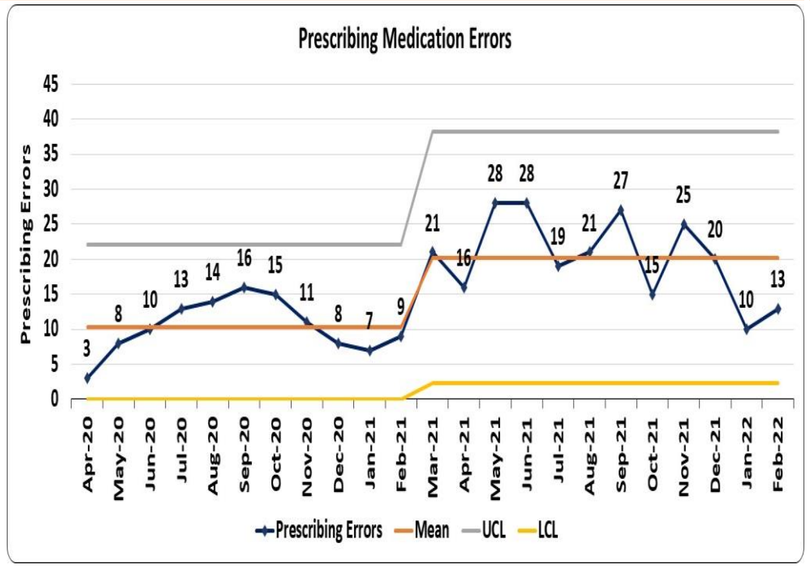
There were 67 medication incidents reported for February 2022 as shown in the table below:

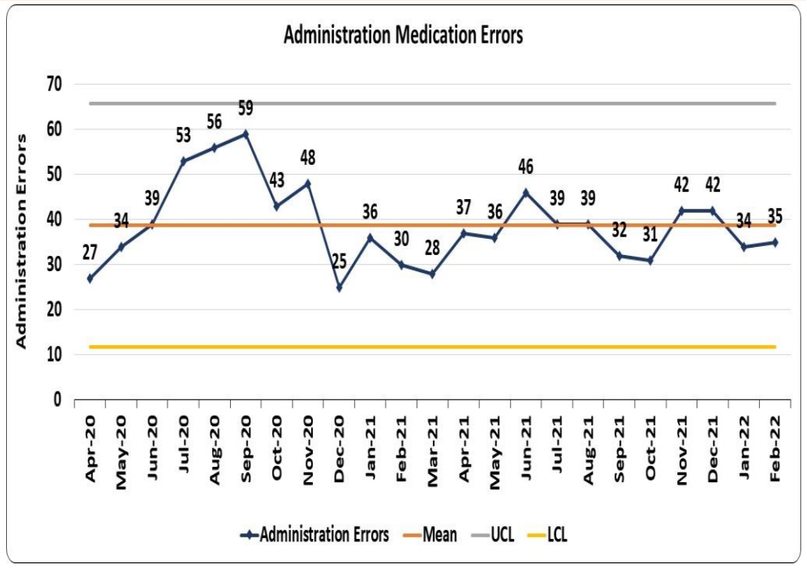
| Medication Incidents February 2022 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Severity | Administration | Dispensing (Pharmacy) | Monitoring | Prescribing | Security | Other | Total |
| No harm | 24 | 5 | 1 | 9 | 2 | 6 | 47 |
| Low | 9 | 0 | 0 | 4 | 1 | 4 | 18 |
| Moderate | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| **Total** | **35** | **5** | **1** | **13** | **3** | **10** | **67** |

Of those incidents reported, none resulted in severe harm or death.

The first chart to the right shows a 30% increase on the previous month in the number of prescribing errors for February 2022 (13). The reported value remains lower than the average recorded for the last 12 months and within the limits of common cause variation. There was also a slight increase (1) in the number of administrative errors this period, with 35 errors recorded (falling just below the 12-month average of 37).

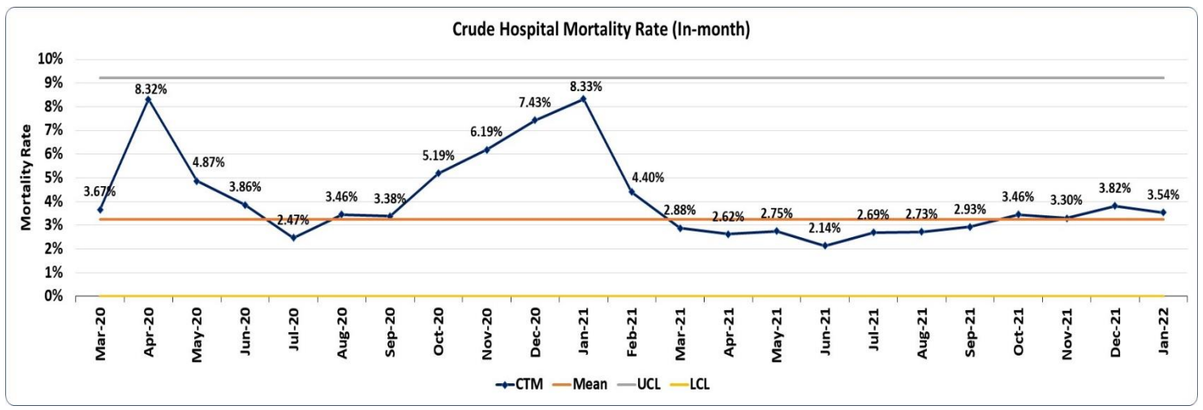
To make the data presented in this section more meaningful, efforts are underway to present medication incident rate per 1000 bed days and to include peer benchmarking.

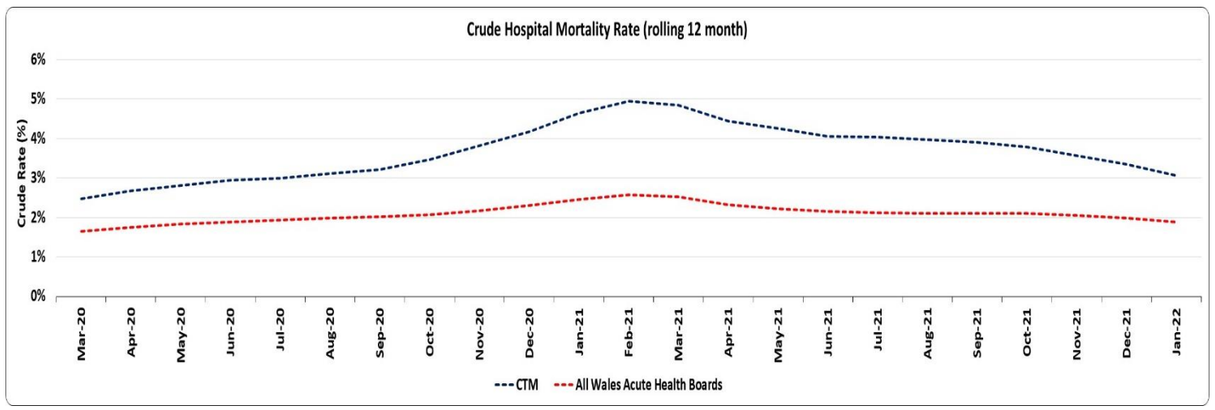



## Crude Hospital Mortality Rates

| In Month Crude Hospital Mortality Rate – January 2022 | Rolling 12 Month Crude Hospital Mortality Rate to January 2022 |
|---|---|
| 3.54% | 3.07% |




Overall, in month mortality rates fell following the second COVID wave from 2.88% (in March 2021) to 2.14% (the lowest level in June 2021). Rates have increased after this date, but not at the levels seen during the second wave and a fall in the mortality rate is observed for January 2022 (3.54%). The rolling 12 month mortality rate is 3.07%; a similar level to that observed in July 2020 (3.00%)

# Inpatient Falls & Pressure Damage Incidents

## Inpatient Falls

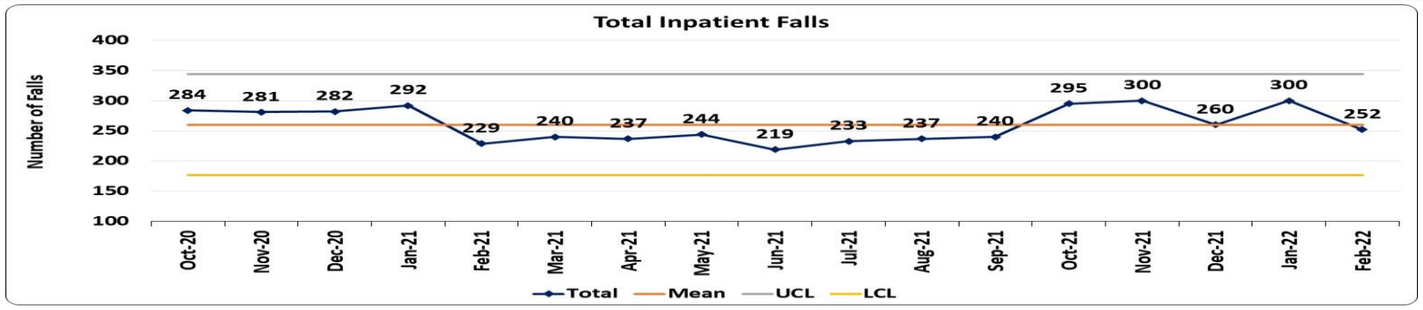
Total number of Inpatient Falls – February 2022

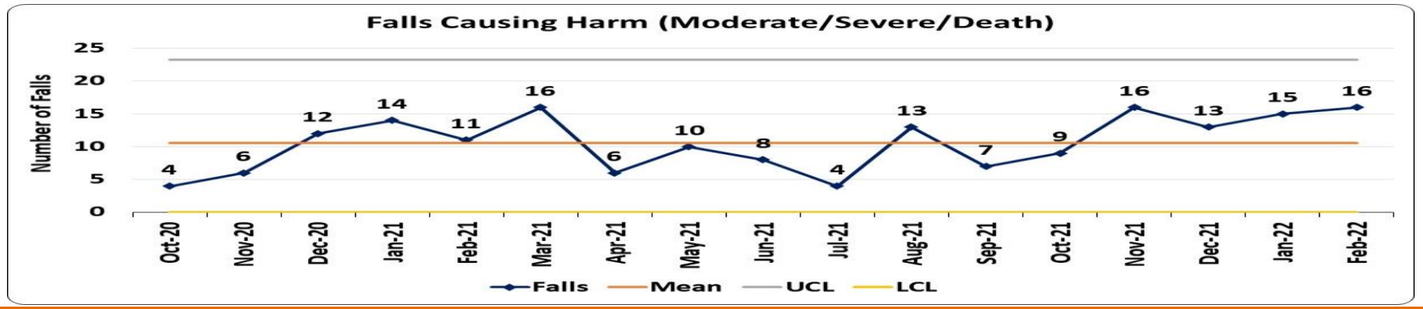
**252**

There were fewer falls reported for February 2022 (252) compared to the previous month (300), at a volume on par with the 12-month average of 255 and the number recorded in February 2021.

The number of inpatient falls resulting in moderate harm this month is 16, with none recorded as resulting in severe harm or death.

Efforts continue via the Quality and Safety Committee and the Falls Scrutiny Panel to address the high level of hospital falls within the health board. Ongoing initiatives include achieving a greater understanding of the number of repeat falls, falls per bed day, standardising improvement efforts and implementing proactive measures for fall avoidance and escalation.

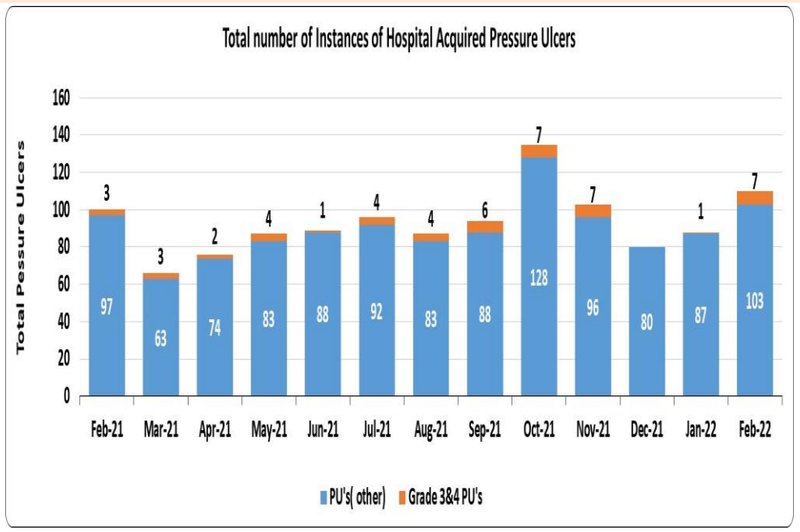


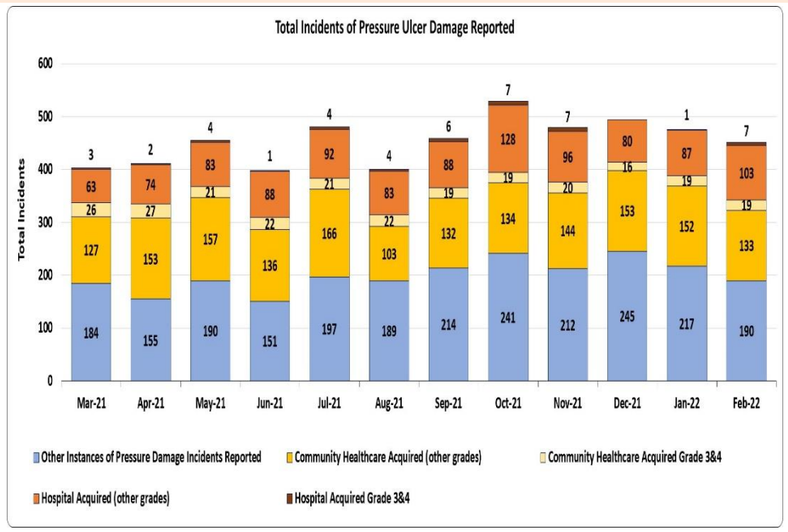




## Pressure Damage Incidents

Total number of reported Pressure Damage – February 2022

**452**




During February 2022, a total of 452 pressure damage incidents were reported, a reduction of 5% on the previous month (476).

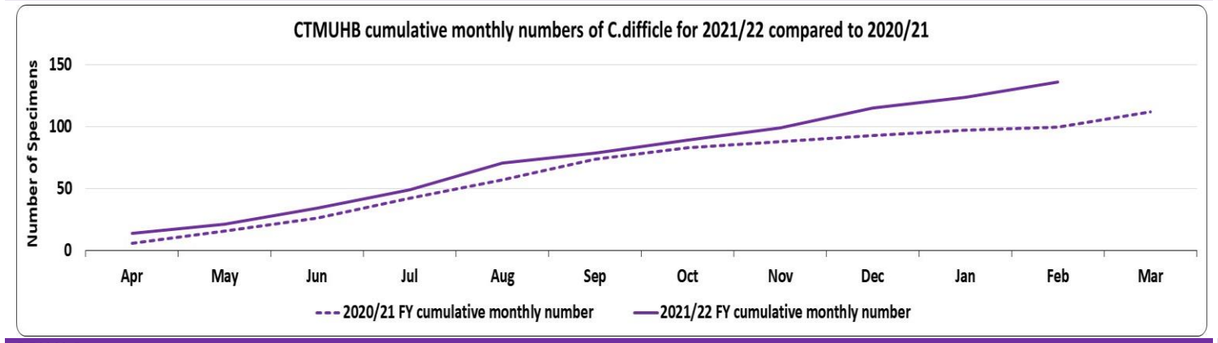
The highest number of incidents reported (152) were identified as developed outside of hospital setting (within district nursing settings). Of the total number of pressure damage incidents reported, 103 were identified as hospital acquired, of which 7 were reported as grade three. The highest numbers were recorded for AMU, Princess of Wales Hospital and Ward 8, Prince Charles Hospital.

Between the 1st February 2021 and 28th February 2022, 3016 Healthcare Acquired Pressure Damage Incidents were reported. Of which, an investigation has been completed for 1928 (63.9%) of these, with 252 recording an outcome of avoidable (13%).

# Infection Prevention and Control

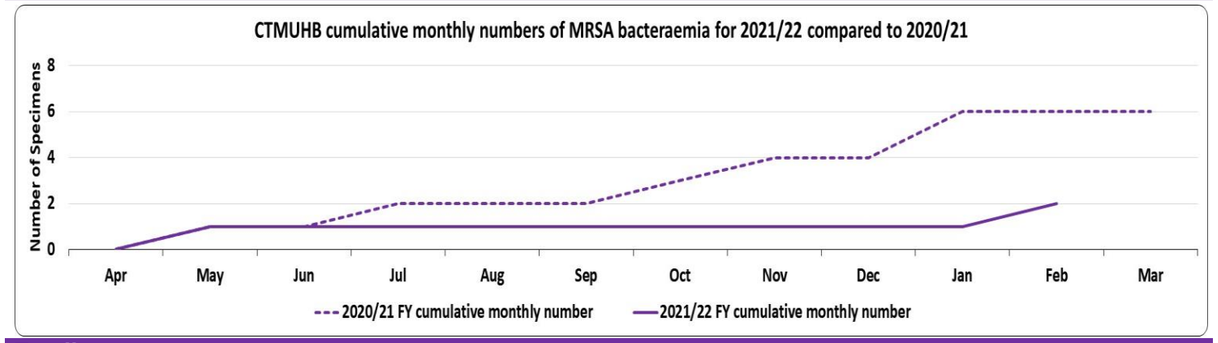
## C.difficle

136 incidents of C.difficle were reported by CTM between Apr-Feb 2022. This is approximately 36% more than the equivalent period in 2020/21. The provisional rate per 100,000 population for 2021/22 is 33.04



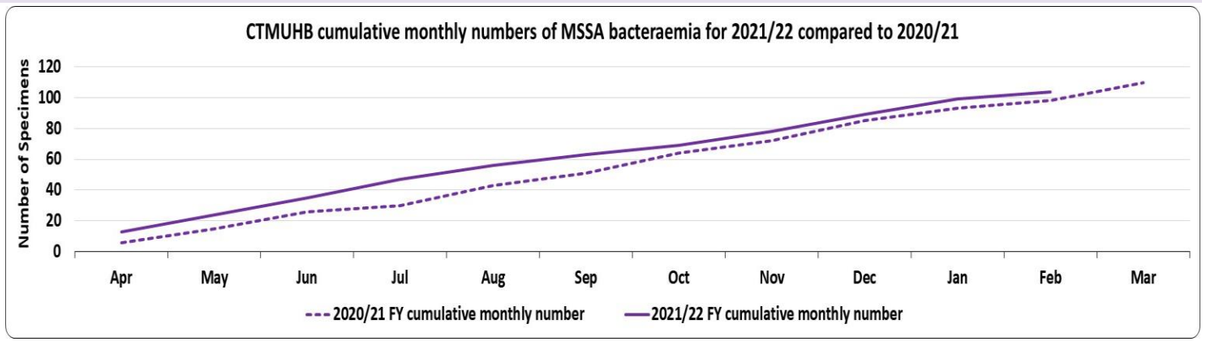

## MRSA

2 MRSA bacteraemia have been reported by CTM between Apr-Feb 2022 (67% fewer instances than the equivalent period in 2020/21). The provisional rate per 100,000 population for 2021/22 is 0.49



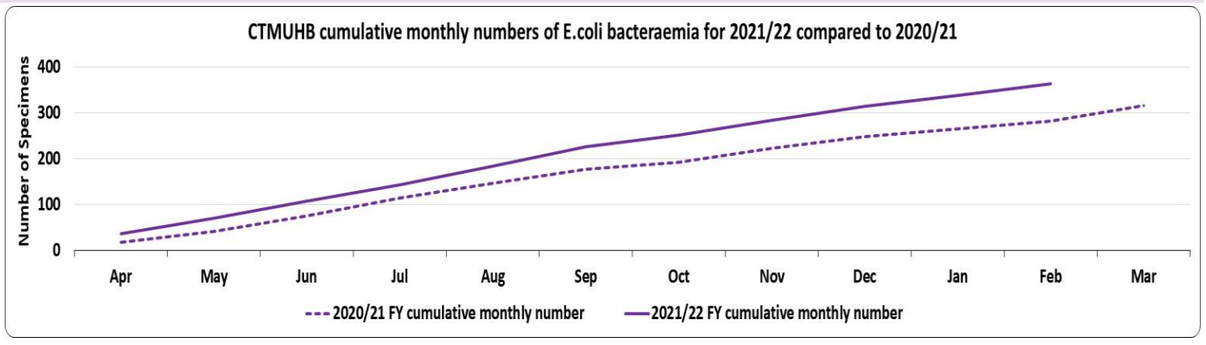

## MSSA

104 instances of MSSA bacteraemia were reported by CTM between Apr-Feb 2022 (approximately 6% more than the equivalent period in 2020/21). The provisional rate per 100,000 population for 2021/22 is 25.27




## E.coli

363 instances of E.coli bacteraemia were reported by CTM between Apr-Feb 2022 (approximately 28% more than equivalent period in 2020/21). The provisional rate per 100,000 population for 2021/22 is 88.19




An increase in cases has been reported for most surveillance organisms from April – February 2022, a situation which is mirrored across Wales. Work is ongoing at a national level to determine whether the additional use of broad-spectrum antibiotics and sessional use of personal protective equipment has contributed to the rise in cases across Wales.

Information on the local reduction expectations for each of the ILGs and the findings of the external review of decontamination in CTM jointly undertaken by the Health Board and NHS Wales Shared Services will be provided in future reports.  Planned improvements to the IPC services have been proposed but remain outstanding.

## 3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

The following issues/risks have been identified in relation to quality reporting within the Health Board.

- As in all public institutions, the impact of the Covid-19 variants has had considerable and ongoing consequences on the ability of the HB to provide continuity around its core business.
- Progressing the ambition to develop an IT infrastructure to ensure up-to-date high quality data that is readily accessible and confident preparation for migrating to the Once for Wales risk management model.
- Gaining health board wide assurance of the breadth of UHB services and consideration of the four harms.

Actions to address these issues and risks are in place in the improvement action plans relating to the targeted intervention areas. Beyond this, the Health Board require ambitious pursuit of quality and safety in all it does to provide excellence in service delivery to the population of CTM.

## 4. IMPACT ASSESSMENT

| | |
|---|---|
| **Quality/Safety/Patient Experience implications** | Yes (Please see detail below) |
| | This report outlines key areas of quality across the Health Board. |
| **Related Health and Care standard(s)** | Governance, Leadership and Accountability |
| | This report applies to all Health and Care Standards. |
| **Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.** | No (Include further detail below)<br><br>If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below.<br><br>If no, please provide reasons why an EIA was not considered to be required in the box below. |
| | |
| **Legal implications / impact** | There are no specific legal implications related to the activity outlined in this report. |
| | |
| **Resource (Capital/Revenue £/Workforce) implications / Impact** | Yes (Include further detail below) |
| | The requirements to deliver safe, high quality care impact on resources including workforce. |

| | |
|---|---|
| | The new operating model will support delivery of safe, high quality care. |
| **Link to Strategic Goals** | Improving Care |

## 5. RECOMMENDATION

Members of the Board are asked to:

5.1 **NOTE** the content of the report

5.2 **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required

5.3 **NOTE** the risks identified

5.4 **SUPPORT** the direction of travel in developing a wider reach of quality reporting and locality based assurance reports