AGENDA ITEM
7.2

CTM BOARD

QUALITY & PATIENT SAFETY REPORT

Date of meeting	27 January 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Louise Mann, Assistant Director Quality & Safety louise.mann@wales.nhs.uk
Presented by	Greg Dix, Executive Director of Nursing, Midwifery and Patient Care
Approving Executive Sponsor	Executive Director of Nursing 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 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 December 2021. At the time of writing, the Health Board is facing a significant challenge in response to the impact of the very transmissible Omicron variant of COVID-19. This has affected workforce capacity in relation to increased patient

activity, employee infections, isolation requirements, in addition to clinical resource deployment to increasing the roll out of booster vaccination for the public. The latest phase of the pandemic has also seen an increased escalation of need at our front door services, combined with winter pressures. It is more important than ever in this unpredictable healthcare landscape that we ensure patient safety first, 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:

- Severe incidents has remained relatively consistent over the 12 last months with the lowest figure reported in November 2021.

  In addition to this, the number of moderate incidents reported as resulting in moderate harm has continued to rise over the last 12 months.

- Across our DGH sites, the number of patient safety falls incidents reported has risen over the last 3 months, although the increase is greatest for the Princess of Wales Hospital. For the last 3 months, the figures are relatively consistent across the 3 DGH sites.

  The number of falls reported as resulting in moderate harm has continued to fluctuate with the highest numbers reported in November 21. Falls reporting is greatest in areas where there are frail, elderly patients with cognitive complexities. The ambition to measure falls in relation to per 1000 bed days is progressing as an improved indicator of quality, prevention and improvement.

- 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 increasing trajectory. The Assistant Director for Quality and Safety is leading an improvement piece of work around pressure area reduction.

- The total number of medication incidents began to increase in May 21 (highest reported, in the 12 month period). Numbers dipped during October 21, but have remained consistently higher than Quarter 1 data for 2021. In line with this, the number of administration incidents has continued to increase, with the highest numbers reported during June and November 2021.

- Mortality rates returned to normative levels for CTM following the second wave of the pandemic from March 2021, with an increase in October 21 (November data not yet available). Further data will reveal the impact of the omicron variant and winter pressures.

- UHB Complaints response compliance reduction seen in December 21 as patient facing activity increased and non-clinical staff redeployed to support vaccination - target range 75%

- As seen in all Health Boards, an increase in cases has been reported for most surveillance organisms from April – December 2021. IPC capacity challenges persist as a result of the pandemic response and a business case for enhanced community focused resources is in progress.

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.

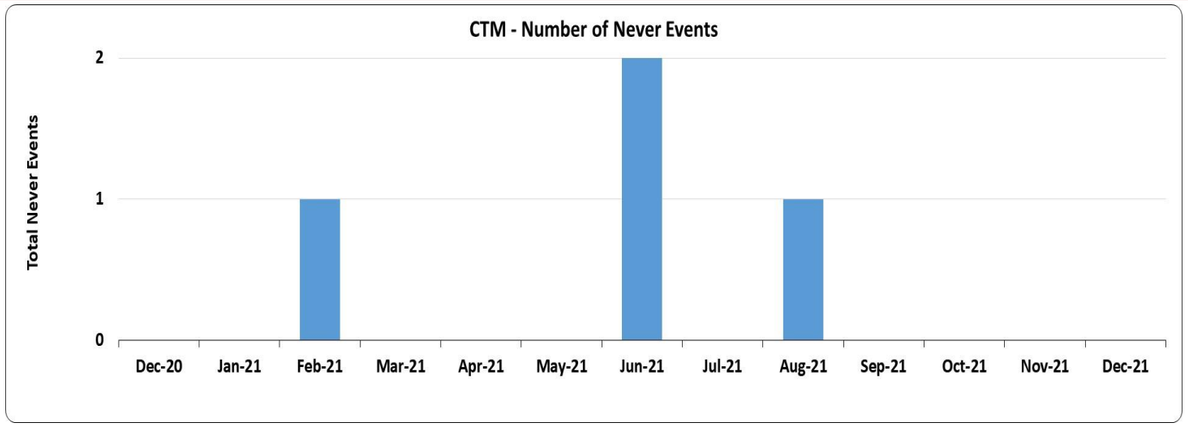
Quality & Patient Safety

Never Events & Serious Incidents

Never Events

Number of Never Events – December 2021

0

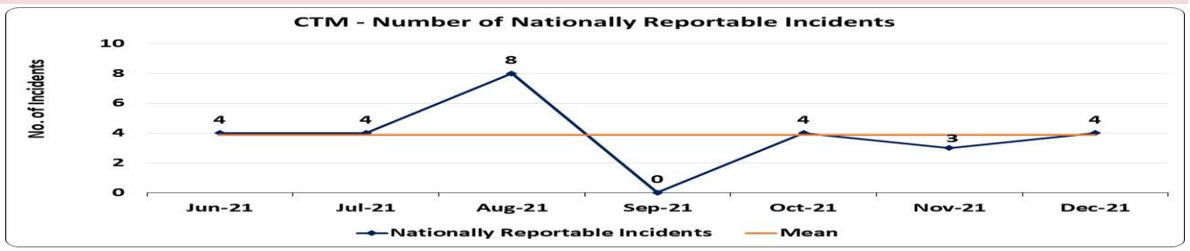


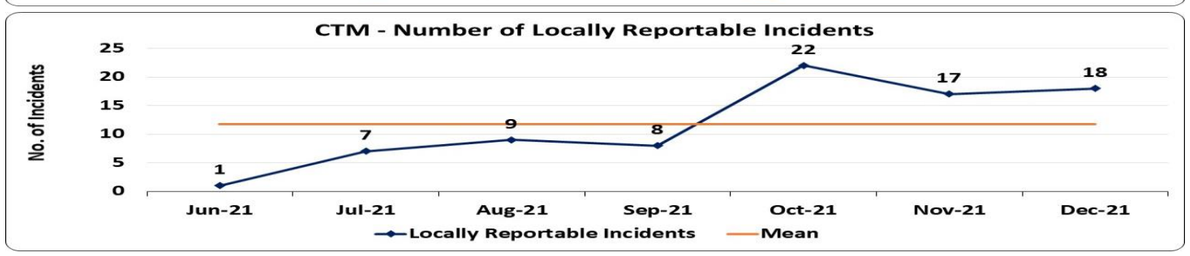
There were no never events reported during the last month (December 2021), with 4 reportable events in the past 12 months.

Nationally Reportable Incidents

Number of Nationally Reportable Incidents – December 2021

4





Number of Patient Safety Incidents – December 2021

1,839

During December 2021 there were 1,839 incidents reported on Datix across the Health Board. Of these 4 were Nationally Reportable Incidents, 1 relating to treatment error, 1 relating to Personal Incident (Personal Injury Attributed) and the remaining 2 related to delays in treatment.

A further 18 were graded as locally reportable incidents. Whilst the time chart suggests a step increase in the numbers occurred in October, this is slightly misleading as the changes in the reporting processes brought in by WG from June 2021 have been adopted at different times by the operational teams, with 17 of the more recently reported incidents related to the period between November 2019 and September 2021. The reporting processes have been reaffirmed with the ILG's and it is anticipated that the data quality issues will quickly be addressed.

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.

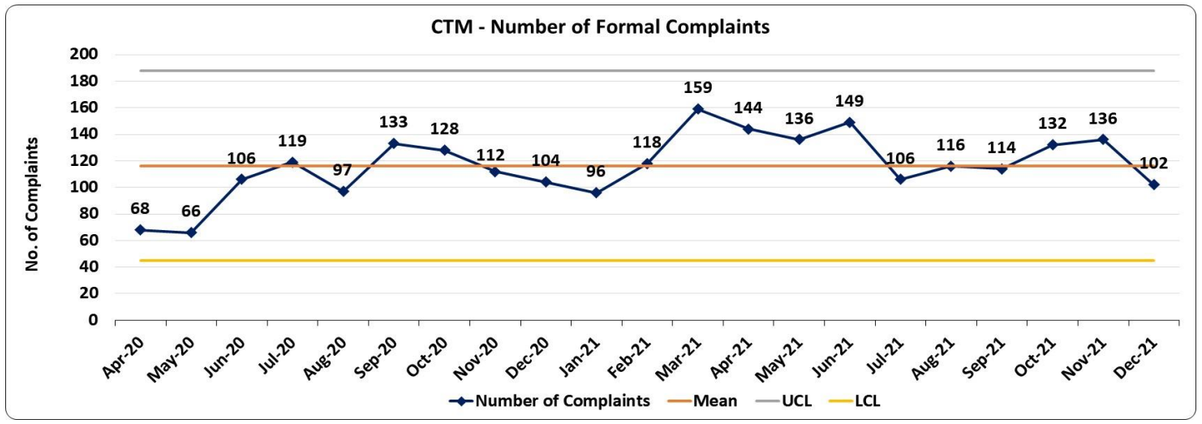
Type of Nationally Reportable Incidents	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Total
Delays		2			2		2	6
Unexpected or Trauma Related Death	2		2			1		5
Slip, Trip or Fall	2	1	1					4
Infection	1		2					3
Pressure Damage					1	2		3
Treatment Error			2				1	3
Medication	2							2
Absconding	1							1
Admission / Transfer / Discharge	1							1
Incorrect Surgical Procedure	1							1
Maternal Event			1					1
Patient injury		1						1
Neo-Natal Event					1			1
Personal Incident - Personal injury							1	1

Complaints & Compliments

Complaints

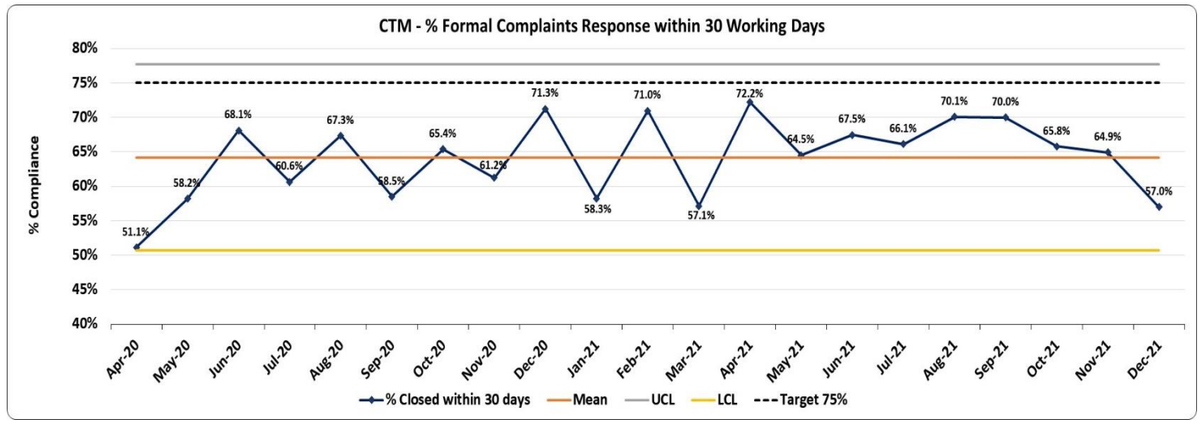
Number of formal complaints managed through PTR – December 2021

102



% formal complaints response within 30 working days – December 2021

57.0%



Complaints

During December 2021, 102 formal complaints were 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 during this period, the top 4 themes relate to clinical treatment/assessment (37), communication issues (17), discharge issues (15) and appointment issues (13).

Compliance with the 30 working day target has fluctuated around a mean of 64% since April this year, as is reflected in the top right chart. Efforts continue to improve to the expected 75% target.

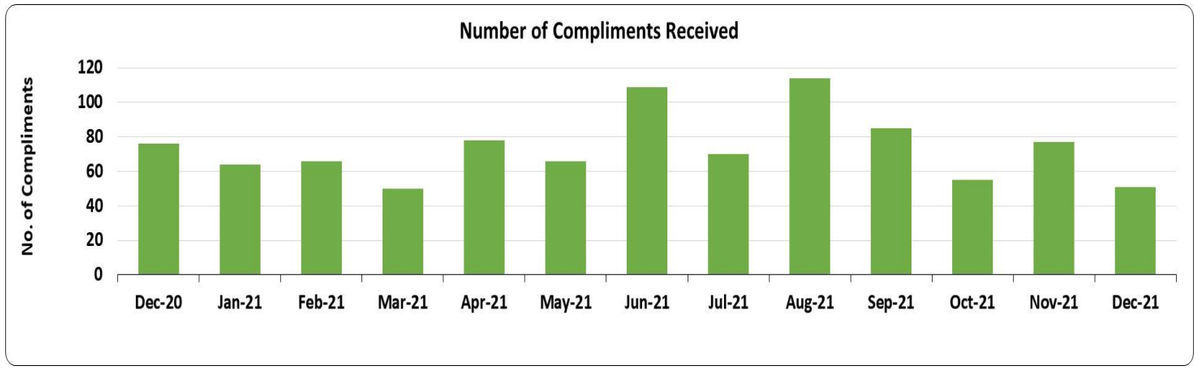
Performance dashboards indicate that the level variation across both areas above is common cause. Services will need to carefully monitor the main themes on the table to the right.

Main Themes from Complaints	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Total
Clincial treatment/Assessment	0	41	48	45	57	64	37	292
Communication Issues (including Language)	43	22	13	16	21	16	17	148
Attitude and Behaviour	0	10	20	8	16	11	5	70
Appointments	0	12	9	10	8	19	13	71

Compliments

Number of compliments – December 2021

51



During December 2021, there were 51 compliments recorded on the Datix system; a third less than the previous period where 77 compliments were received.

Medication Incidents & Mortality Rates

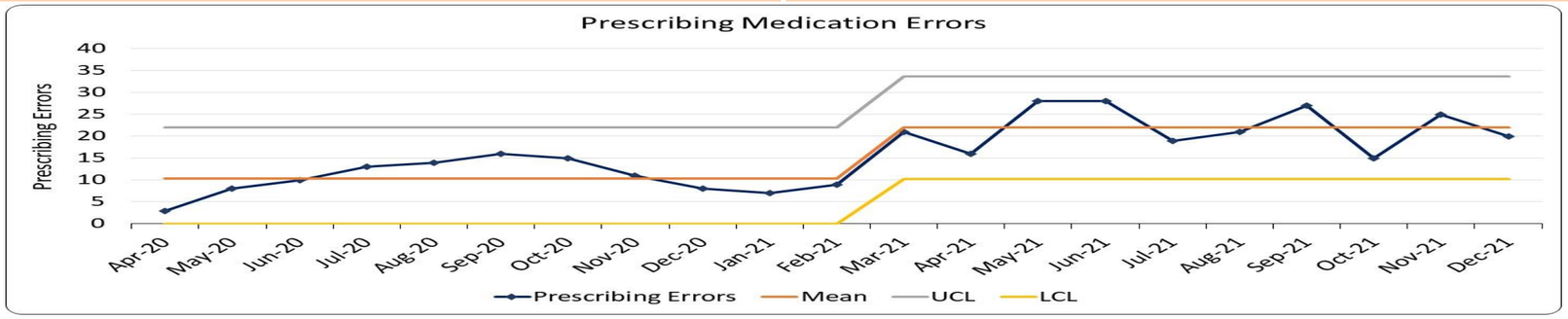
Medication Incidents

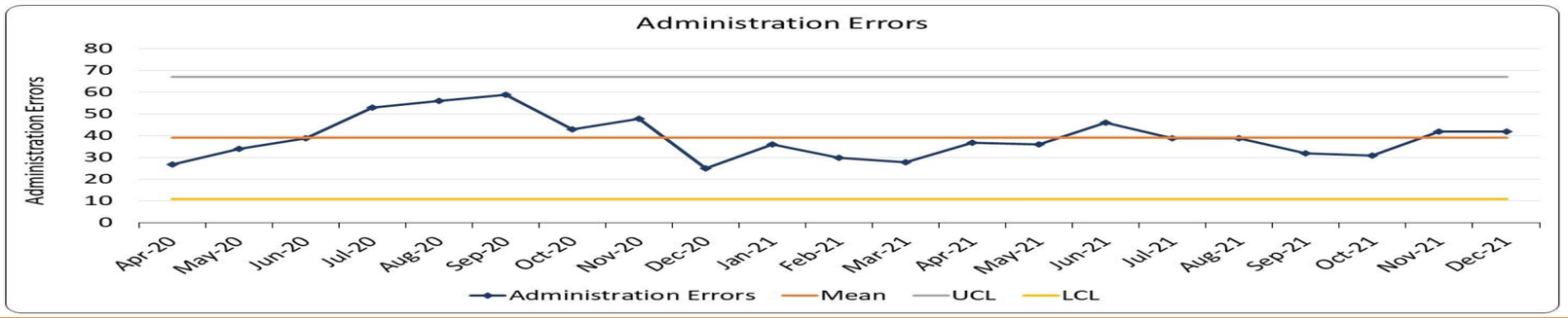
Total Medication Incidents – December 21	Total number of Prescribing Errors	Total Administration Errors
91	20	42

There were 91 medication incidents reported for December. 41 incidents were reported as being related to medication incidents, 21 as prescribing incidents, 8 as medication dispensing, 3 as medication security, 4 as medication monitoring and 14 as other medication error. No administration or prescribing medication incidents were reported as resulting in severe harm or death.

The chart to the right shows a reduction in the number of prescribing errors for December 2021. The reported value is marginally higher than the average for the last 12 months and within the limits of common variation. There has been an increase in the number of administrative errors since October; with 42 errors recorded in both November and December (above the 12-month average of 37).

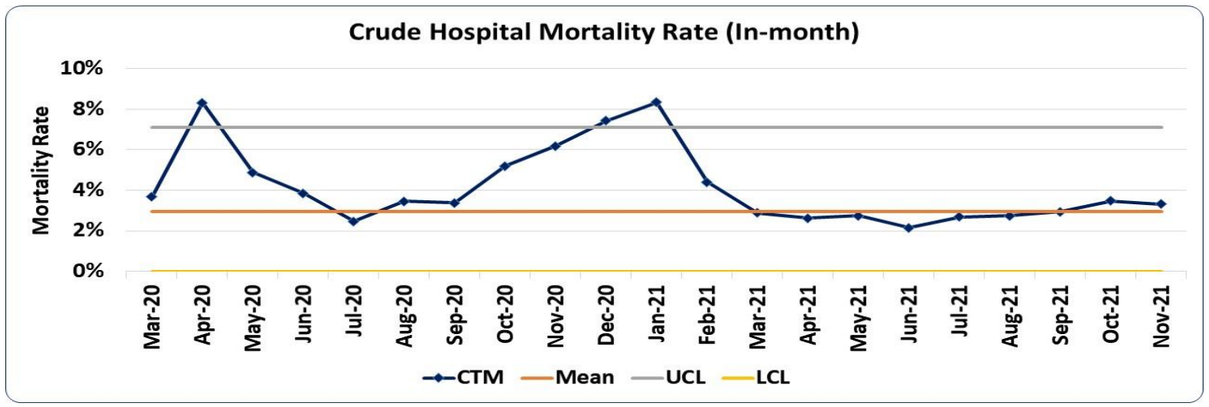
The data indicates that the overall performance in relation to medication and administration errors continues to remain as special cause variation (concern).

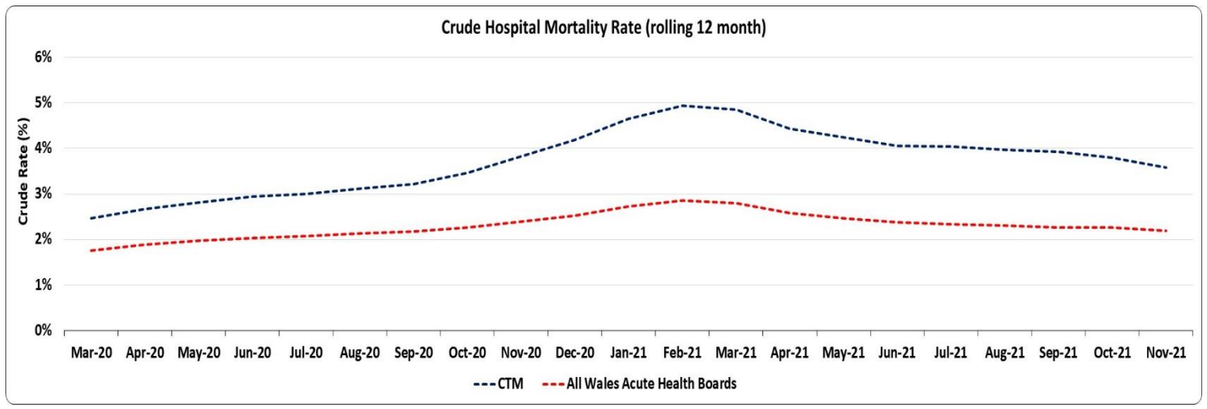




Crude Hospital Mortality Rates

In Month Crude Hospital Mortality Rate – November 2021	Rolling 12 Month Crude Hospital Mortality Rate to November 2021
3.32%	3.58%





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 of this year). Rates have been increasing after this date, but not at the levels seen during the second wave (the highest recorded rate being January 2021 (8.33%). In month crude hospital, mortality rate for November 2021 is 3.32%, a similar level seen in September of last year (3.38%) with the rolling 12-month rate being 3.58%.

Inpatient Falls & Pressure Damage Incidents

Inpatient Falls

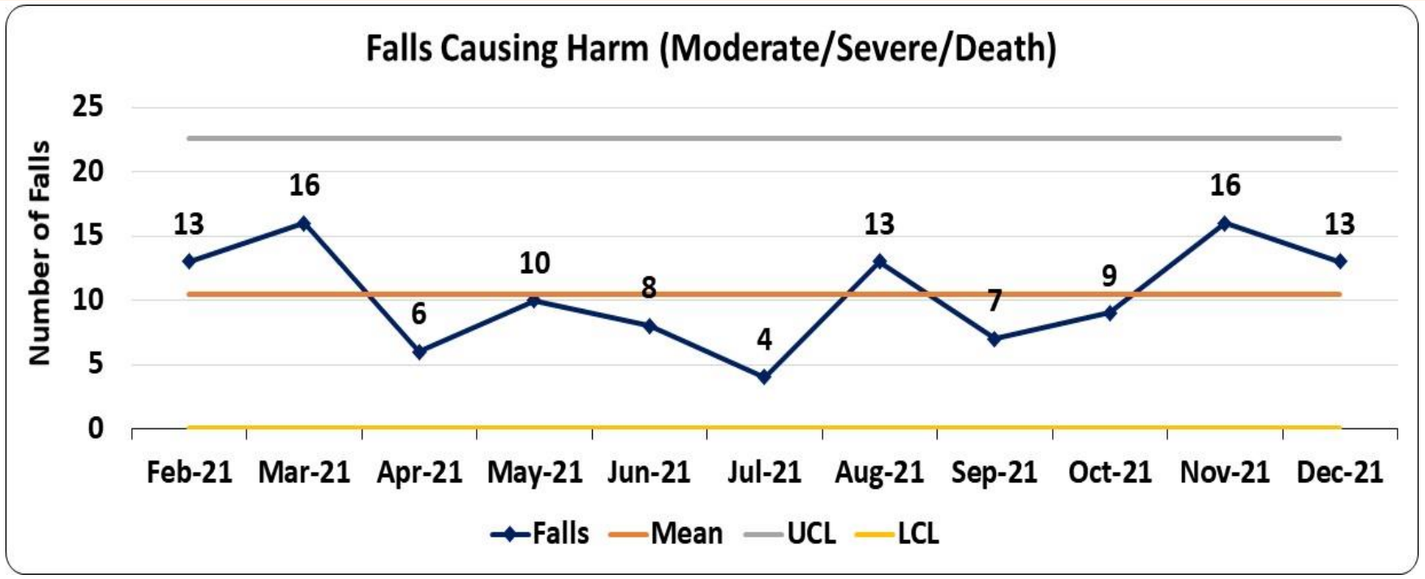
Total number of Inpatient Falls – December 2021

259

There was a decrease in the number of falls reported for December 2021 (259) compared to the previous month (300). This is just above the 12-month average of 252.

The number of incidents reported as resulting in moderate harm this month is 11 with 1 fall recorded as severe and 1 resulting in death. A review is currently underway to identify any opportunities for learning.

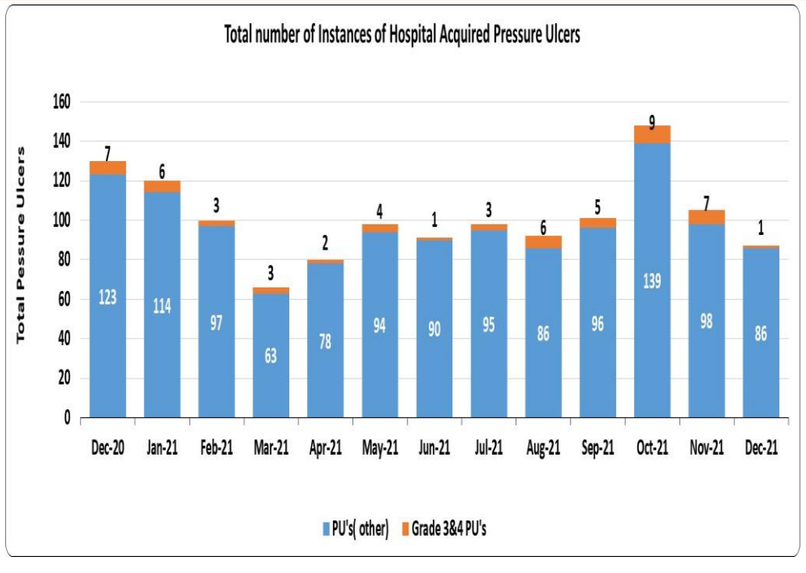
Efforts continue via the Quality and Safety Committee and the Falls Scrutiny Panel to address the high level of hospital falls within the health board. Ongoing initiatives include achieving a greater understanding of the number of repeat falls, falls per bed day, standardising improvement efforts and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

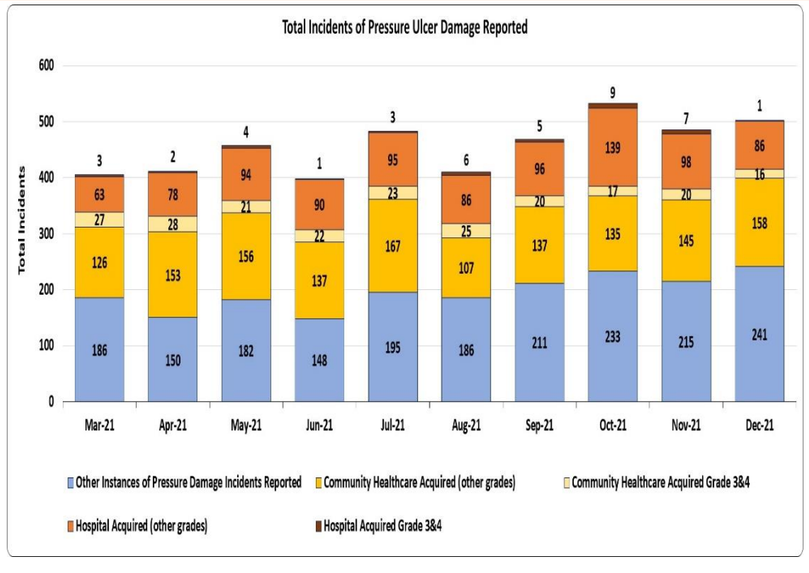


Pressure Damage Incidents

Total number of reported Pressure Damage – December 2021

502





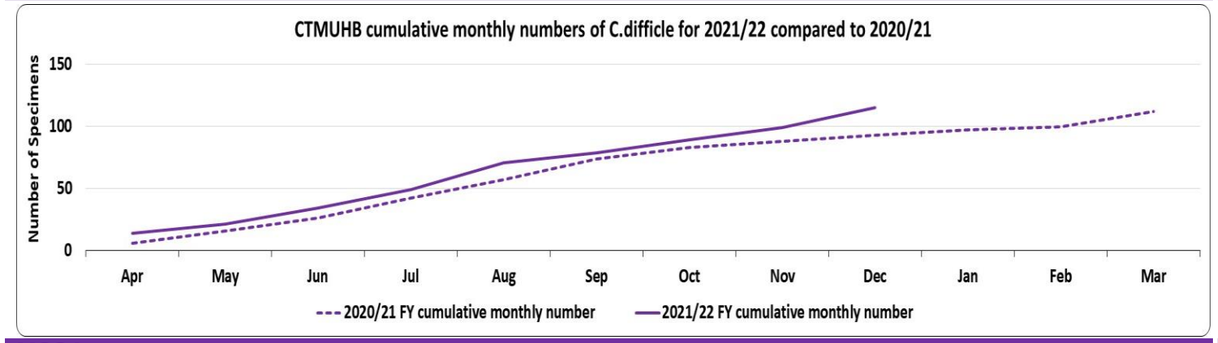
During December 2021, a total of 502 pressure damage incidents were reported, an increase of 3.5% on the previous month (485). The highest number of incidents reported (174) were identified as developed outside of hospital setting (within district nursing settings). Of the total number of pressure damage incidents reported, 87 were identified as hospital acquired, 1 was reported as grade 3. The highest numbers were recorded for AMU at the Princess of Wales and Ward 4 at the Royal Glamorgan Hospital.

In the calendar year 2021, 3030 Healthcare Acquired Pressure Damage Incidents were reported. To date, an investigation has been completed for 1802 (59%) of these, with 257 recording an outcome of avoidable (14%).

Infection Prevention and Control

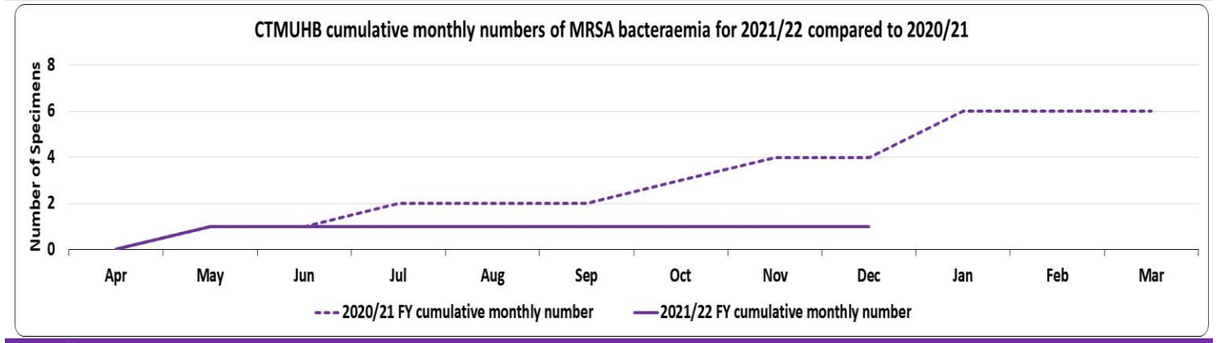
C.difficile

115 incidents of C.difficile were reported by CTM between Apr-Dec 2021. This is approximately 24% more than the equivalent period in 2020/21. The provisional rate per 100,000 population for 2021/22 is 33.93



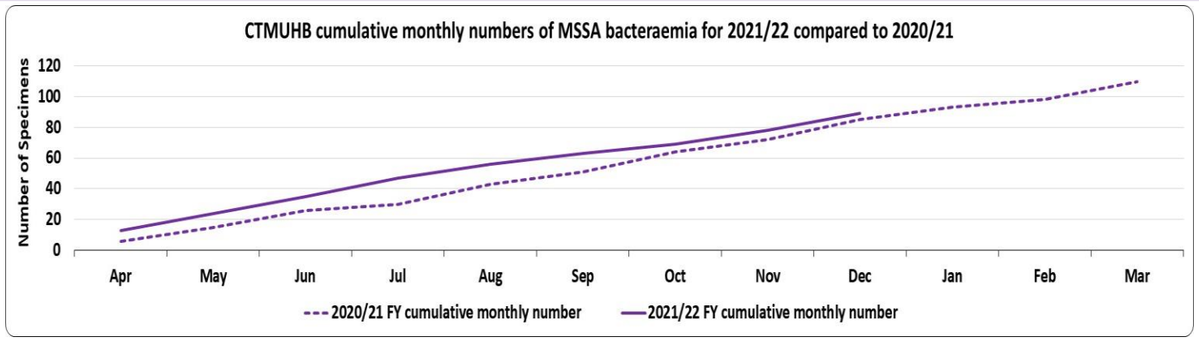
MRSA

1 incident of MRSA bacteraemia was reported by CTM between Apr-Dec 2021 (75% fewer instances than the equivalent period in 2020/21). The provisional rate per 100,000 population for 2021/22 is 0.30



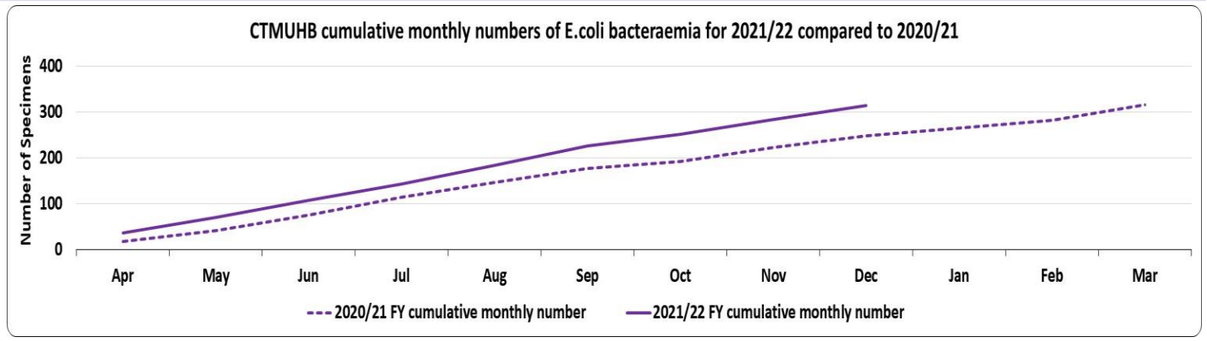
MSSA

89 instances of MSSA bacteraemia were reported by CTM between Apr-Dec 2021 (approximately 5% more than the equivalent period 2020/21). The provisional rate per 100,000 population for 2021/22 is 26.26



E.coli

314 instances of E.coli bacteraemia were reported by CTM between Apr-Dec 2021 (approximately 27% more than 2020/21). The provisional rate per 100,000 population for 2021/22 is 92.65



An increase in cases has been reported for most surveillance organisms from April – December 2021, 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) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. 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