Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
6.4

QUALITY & SAFETY COMMITTEE

PATIENT SAFETY QUALITY DASHBOARD

Date of meeting	18 May 2021
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 Natalie Morgan-Thomas, Interim Deputy Head for CA&QI & Lead Nurse for Clinical Effectiveness natalie.morgan-thomas@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 Director of Public Health
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

EXECUTIVE SUMMARY

This presentation of the Cwm Taf Morgannwg (CTM) Quality Dashboard provides data up to the end of March 2021. This covers a period of changing activity and focus in respect of the significant influence of the second wave of the pandemic during the start of the year; the pace of rolling out of the national vaccination programme, and more recently the lessening impact of an acute pandemic response towards a resetting agenda.

During this turbulent time our Quality Governance and Patient Safety Framework has continued to provide a robust structure for board assurance through a systematic approach to maintaining high quality care and standards. Through ongoing measurement and reporting on safety, effectiveness, staff and user experience, identifying areas for improvement and enabling the sharing of good practice in accordance with statutory obligations, the focus of quality and patient safety has been maintained.

The Health Board has applied the same scrutiny to the measurement of quality indicators and metrics in the same way, and are accountable for providing the same high standard of care delivery and safety measures. The Health Board are in a good position in terms of its progress in relation to its escalation status and external recommendations for quality governance.

This report outlines the current position in relation to the previous agreed quality metrics up to and including March 2021.

Key areas to note are:

- From December 2020 to 19 April 2021, Healthcare Acquired Infections (HCAI's) related to outbreaks were not required to be reported as Serious Incidents (SI's); this data was produced daily and submitted directly to Welsh Government (WG). HCAI severe harm and death are still Serious Incidents – it is the reporting mechanism that has changed, not the requirements of robust investigation and Putting Things Right (PTR).

- The majority of complaints occur within our Accident & Emergency (A&E) and acute medical services, mental health and primary care/localities. Mean compliance with the required 30 day response rate to formal complaints is 57% (to March 2021). The majority of serious incidents occur within obstetrics and gynaecology, head and neck and adult mental health. The mean compliance with the Cwm Taf Morgannwg UHB (CTMUHB) target of completion within 60 days is 21% (to March 2021).
- Advancing learning throughout the organisation is a key focus of the new Listening and Learning forum which commenced in January 2021, which

provides an opportunity to share and spread internal and external intelligence on a pan-organisational basis.

- It is crucial that the voice of those who use our services, their families and Health Board workforce is heard, however logistically difficult. Alternative methods of capturing this during the restrictions of Covid, and until the advent of the Once for Wales model and CIVICA cloud feedback system, are being utilised and reported to provide a rounded perspective on quality and safety issues. Soft intelligence patient experience reporting is valid and captured within **Appendix 1.**
- The Integrated Locality Group (ILG) quality and patient safety reports have become established and timely at reporting their regional business. This overarching report aims to provide added value in ensuring it is providing the committee with cross organisational assurance. This is important, as is the identification and management of themes, trends, learning and improvement. This report will develop to provide the threads required to demonstrate a central position of support, scrutiny, balance, challenge, celebration and pan-organisational assurance to the Committee. **Appendix 2** provides a spotlight challenge to ILG's to provide assurance on an issue of concern within the organisation as a whole. This report features a brief on pressure damage management and improvement within the ILG's, further sharing will take place within the Listening & Learning Forum.

1. SITUATION/BACKGROUND

This presentation of the CTM Quality Dashboard provides data up to the end of March 2021. This covers a period of changing activity and focus in respect of the significant influence of the second wave of the pandemic during the start of the year; the pace of rolling out of the national vaccination programme, and more recently the lessening impact of an acute pandemic response towards a resetting agenda.

During this turbulent time our Quality Governance and Patient Safety Framework has continued to provide a robust structure for board assurance through a systematic approach to maintaining high quality care and standards. Through ongoing measurement and reporting on safety, effectiveness, staff and user experience, identifying areas for improvement and enabling the sharing of good practice in accordance with statutory obligations, the focus of quality and patient safety has been maintained.

There has been significant development work undertaken both centrally and within the ILG's to support this consistent model of quality and patient safety management. Further work to establish robust governance through the clinical service groups is evolving, providing greater dynamic interface and triangulation of assurance through the ILG's to Board. There are some issues with the availability of a satisfactory data infrastructure to support these

developments and colleagues are working hard to make available these new and complex information requirements.

As with previous reports, this report includes a section on capturing available patient experience across the three localities. This is in order to provide cross-reference and triangulation of hard and soft intelligence to gain a strengthened understanding of how services are provided, delivered and where possible, perceived by our public. Whilst services remain affected by the pandemic and restrictions to visiting continue, this report aims to continue to provide an overview of patient experience activities as well as available data on what relatives and carers think of care and services provided by the Health Board.

Again, as with previous reports, this report provides (where available) data for the past 12 months and also includes trends as a Statistical Process Control chart (SPC), albeit this illustration could provide greater clarity of an improving or deteriorating picture with control limits. This will be further illustrated within the ILG reports. The data is taken from the Health Board's Datix system, with further data provided from Myrddin (All Wales system) and other national reporting systems. Additionally, as some data sources are dynamic e.g. Datix and community contact data, metrics are accurate to a specific point in time. These metrics are refreshed every month, therefore data will change from previous reports as new information is included. To ensure clarity the date that data is captured is noted in the report.

The planning and performance team, in collaboration with the quality informatics team continue to work together to develop and improve data integrity and validation. As with the previous report in January 2021, in developing the report on behalf of the Lead Executive Director, the patient care and safety team have worked in partnership with the ILG's. This collaborative relationship is key to establishing an organisation wide systematic approach to maintaining consistently high quality services through target and outcomes setting, ongoing comparative measurement and reporting on safety, effectiveness and experience, identifying areas for improvement and enabling the sharing of good practice and lessons learned.

The Health Board is making good headway in respect of its Targeted Intervention status and Delivery Unit (DU) recommendations for quality governance and incident management. The sustained effort to systematically improve and evidence the Health Boards position against the recommendations, provide meaningful assurance, leadership and delivery of measurable outcomes for those who use our services, and those who work within the Health Board, demonstrates continued commitment to progress the quality agenda.

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

Data run on 09.04.21

Indicator Description	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-2021	Trend
Health Board Wide Quality Metrics													
Number of never events in month	0	0	0	1	0	0	0	0	0	0	1	0	
Number of serious incidents (SI)	7	12	9	13	14	22	29	38	21	9	6	8	
Number of formal complaints managed through PTR *	68	66	106	119	97	133	128	112	104	96	114	126	
Number of compliments	62	26	154	57	49	64	66	130	76	64	64	44	
Number of medication prescribing errors	3	8	10	13	14	16	15	11	8	7	9	21	
Number of medication administration errors	27	34	39	53	56	59	43	48	25	38	33	28	
Mortality Rate (CHKS)	8.33	4.88	3.87	2.48	3.48	3.4	5.24	6.23	7.47	8.3	4.43	NA	

* Calculation of formal complaints received is now run from date first received as of 1st July 2020.

Never Events:
There was 1 never event reported in February 2021. This event related to a CTM patient receiving treatment at an English hospital where a swab was retained. Although the Never Event was not as a result of actions taken by CTMHB clinicians there has been organisational post-surgery involvement and joint investigation.

Serious incidents:
During February to March 2021 a total of 3,478 Patient Safety incidents were reported. Of these, 188 were categorised as a serious incident i.e. resulting in avoidable severe harm or death. This is 0.40% of the total incidents reported. SI reporting has decreased from December 2020 in line with an alternative reporting mechanism for Covid HCAI's and relaxed reporting requirements during the pandemic response. Investigations carried out in respect of serious incidents should be robust and proportionate, irrespective of whether they currently require reporting to the Delivery Unit – these incidents still need to be managed via the SI investigation process; prompt addressing, making safe, contact with families and investigation of patient harm continues to ensure good quality care provision is maintained and the learning shared. Assurance that this is being observed within the ILG's is currently being reviewed by their governance teams. Further review of the SI management process overall is awaited from the DU.

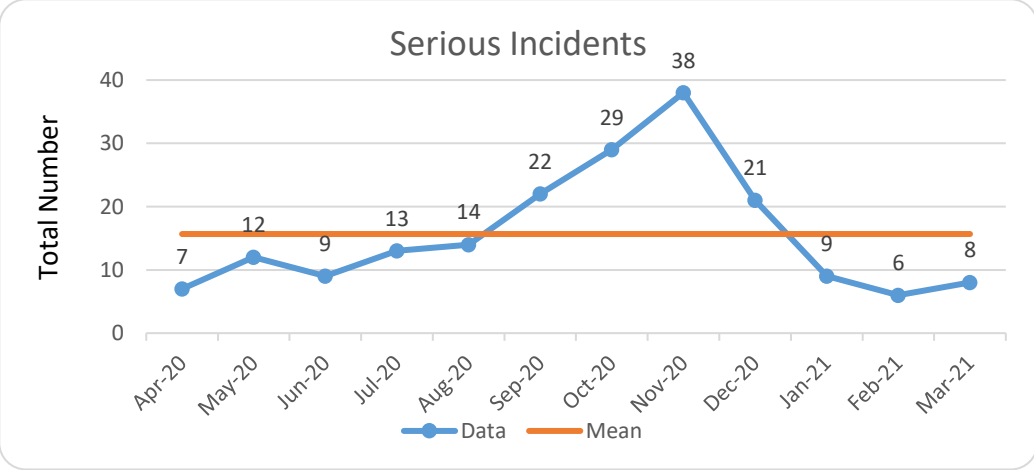
As an organisation we will maintain the now removed 60 day target for SI management and to further improve upon our timescales for investigation and closure wherever possible. Overall UHB mean compliance rate with the 60 day target is 21% representing a very modest increase, however it is recognised that some areas and service groups hold significant backlogs of open SI's. ILG's are working with the central team to develop realistic improvement targets however more focused intervention may be required within services such as maternity and neonates to progress, learn and close serious incident reports.

Serious Incidents Reported to Welsh Government Feb-Mar 2021	Feb 2021	Mar 2021	Total
Unexpected or Trauma Related Death	0	3	3
Admission / Transfer / Discharge	0	3	3
Infection	2	0	2
Neo-Natal Event	1	1	2
Treatment Error	2	0	2
Slip, Trip or Fall	0	1	1
Self Harm	1	0	1
Total	6	8	14

Fig 1. Incident by type: February - March 2021

Unexpected deaths of individuals known to our services as a result of apparent completed suicide remain a feature of SI reporting - 3 cases reported for February and March 2021. A desktop review of suspected suicides in contact with mental health services is in progress and early learning is shared in an additional report to this committee. There is a regional multi-agency approach to understanding, reviewing and preventing suicide within CTM, hosted by the Safeguarding Board.

HCAI-Covid 19 outbreak related deaths continue to be reported daily to the DU since December 2020 and account for the reduction in SI reporting after this date seen below.



As part of ensuring robust, continuous quality governance during the Covid-19 period, quality impact assessments (QIA's) are being undertaken for the key service changes underway to ensure any potential consequences on quality are considered and any necessary mitigating actions are outlined in a consistent way. High risk service changes are escalated to Executives for consideration. It is anticipated for the future that a QIA will be consistently considered as part of all development and proposal

stage of new services, and when planning changes to existing services. This will ensure quality remains the driving component in CTM's provision of its services.

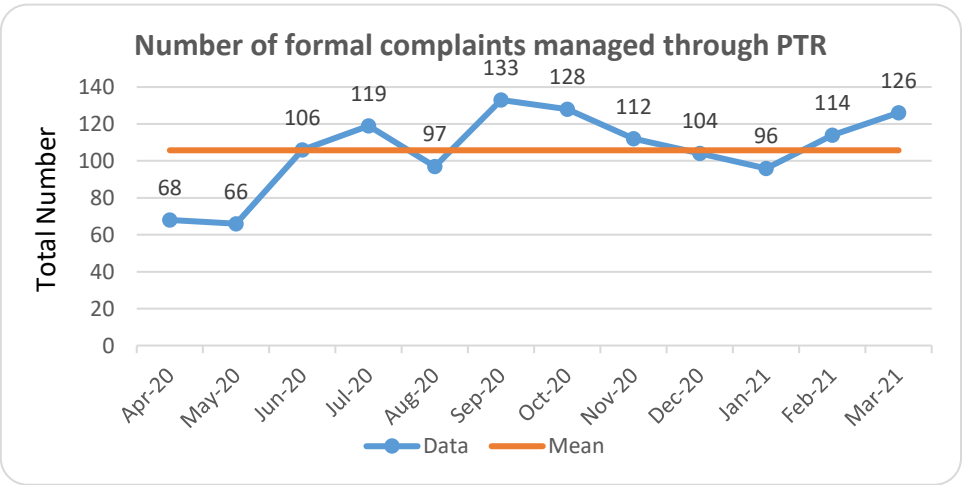
Reviews of Datix continue to ensure that any Covid-19 related harms are captured. Complaints relating to the impact of Covid-19 on those affected by the pause or delay in non-essential services are also being captured; Welsh Government plans to request Health Boards roll out communication to those on our waiting lists will take place before the summer.

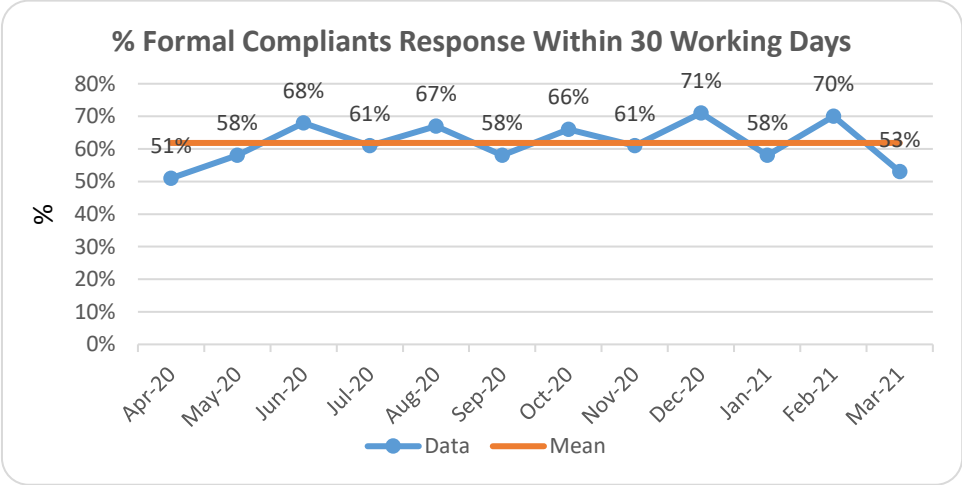
Complaints:

- Complaints are increasing during this reporting period most likely as a result of increased UHB activity following the acute pandemic response in December and January. During February and March 2021, there were 240 complaints managed through Putting Things Right regulations. The main themes from complaints relate to Communication (104), Delays (56), Treatment Error (50), and Admission/discharge/transfer (ADT) concerns (15). The complaints relating to communication are in the main concerned with attitude and behaviour of staff, perceived lack of communication and general communication issues regarding treatment. The delays relate to waiting times, delays in treatment for surgery, follow-ups and investigations in the radiology service. The ADT complaints relate to potential inappropriate or unsafe discharge and poor discharge planning. Treatment Errors relate to reported missed diagnoses, inappropriate treatment, and a perceived lack of duty of care. All complaints are responded to within the corresponding or host ILG, coordinated by the governance team and approved by group/nurse directors. Learning from complaints can be shared with the wider organisation through the Listening and Learning Forum.

- Timely response rates have varied in this reporting period and a direct consequence of clinical teams not having capacity to respond despite relaxed requirements. There are differences in compliance between ILG's reflecting not only resource allocation but also logistical management of the complaints process and differing hosting responsibilities. Work is ongoing to identify the resource/process used within each ILG in order to identify a preferred and therefore consistent model across the UHB. Additional corporate support has been provided to the ILG's to clear any backlog or address any Datix housekeeping issues. The second wave has had an impact on the timeliness of 30 day responses although historical

concerns allocated to the ILG's when they became operational, affect their overall current compliance. As with SI's the corporate team are working with the ILG's on a supported improvement trajectory and a target of 75% of responses made within 30 days is the goal. Complainants have received acknowledgement and explanation where there are any delays in reply. Learning from complaints will be strengthened by the appointment of a centrally based dedicated practitioner and within the locality and organisational governance structure, providing a more streamlined framework for cross pollination of learning and improvement.





Compliments:
During February and March 2021, there were 125 compliments reported to the Patient Advice and Liaison Service (PALS) team, a significant decrease from the previous reporting period (196). The total number of compliments received for the year so far was 823. Visiting has once again been restricted during this period and there is less footfall on sites as a whole. This is a difficult time for anything other than core business for colleagues however, reminders have been sent to colleagues to share any compliments with the PALS team for reporting on Datix. The people's experience module within the new Once for Wales risk management system is anticipated as a method of facilitating standardised meaningful data, allowing for improved triangulation of intelligence on how services are experienced by those who use them. The imminent roll out of CIVICA will enable the UHB to understand real-time patient feedback, highlight positives and drive service improvements through a

continuous feedback loop between health care teams and patients. Valuable insights will be available via dashboards and trend analysis and benchmarking will be easily and intuitively available to wards and departments.

- **Patient Safety Solutions:**

The Health Board currently reports non-compliance in 3 areas.

Summary
The Delivery Unit snapshot review of Serious Incidents in September 2020 identified insufficiencies in our processes for National Safety Standards for Invasive Procedures (NatSSIPs). As a result, internal review within the Patient Care and Safety Unit is underway which will determine the effectiveness of work undertaken to date and implement corrective measures required to ensure a robust process for all invasive procedures. Collaborative working with Health Boards across Wales has commenced with a view to standardise process in CTMUHB and to adopt a proportionate approach to rolling out this work in line with those across Wales.

The internal monitoring and reporting process for Patient Safety Alerts (PSAs) and Patient Safety Notices (PSNs) is currently under review, with a revised process proposal having been approved and implementation imminent. The new process will fall in line with future plans due to be delivered through the 'Once for Wales' project and will therefore reduce the need of significant process change when this is rolled out.

The Health Board currently reports non-compliance in 3 areas:

PSA008

Nasogastric tube misplacement: continuing risk of death and severe harm.
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. There is no further update since the last report.

PSN030 / 055

The safe storage of medicines: cupboards.
We have re-prioritised this work as part of our post COVID resetting processes, while still supporting the significant additional challenges of the vaccine programme. Determining the baseline through audit of all the ward and department areas has commenced, now that we are able to better access areas with the reduction in COVID positive cases. The baseline will be collated and available for benchmarking progress against.

Going forward, the PSN055 audit tool will be broken down into its individual sections and added onto the clinical manager's dashboard, they will then undertake a rolling audit programme. This will provide updated data on compliance which can be reported to ILG Directors, Medicines Management Expenditure Committee (MMEC) and included in HB governance monitoring frameworks.

PSN046

Resources to support safer bowel care for patients at risk of autonomic dysreflexia.
Due to organisation re-structure, accountability for this notice has been devolved to the Heads of Nursing for each ILG. Meeting held on 21 April 2021 established that there is a whole Health Board Action Plan in progress. The key component of the Action Plan is to train all staff on wards across the organisation. An All Wales training package is under development but is not yet complete. As an interim, training is provided by the Clinical Nurse Specialist (CNS) for Bladder and Bowel Care. Training has been prioritised to Advanced Nurse Practitioners (ANPs) to ensure a trained person on each shift. Further updates and timescales will be provided at the next committee.

Whilst CTMUHB report to be an outlier in compliance, the CNS agreed to establish on an All Wales basis how other Health Boards managed and achieved compliance.

PSA010

High Flow Nasal Oxygen during Transfer.

We report as non-compliant in this alert due to a device which cannot be located. There has been an extensive search undertaken to identify the location and this has been narrowed down to one specific area. Meeting held on 22 April 2021, it was agreed by clinical engineering that a further notice would be served to nursing staff in that area to undertake another check for this item. Upon discussion with the DU, we are unable to report compliance until the item is located and addressed. Following advice from the DU, during the meeting on 22 April, assurance was provided that asset lists and equipment check processes are robust and in line with organisational standards, but that devices such as these which move around frequently can be difficult to manage. Updates on further checks will be provided at the next committee meeting.

Patient Experience:

The latest patient experience data is attached at appendix 1. Health Board wide data will be available once the new national 'Once for Wales' system and the CIVICA experience feedback cloud software is introduced, this was planned for April 2020, however there is a delay in progressing the project due to Covid-19. A project lead has been appointed for the UHB.

Medication errors:

The number of medication administration incidents remains comparable at 61 compared to the previous reporting period 63. The number of medication prescribing errors has double at 30 compared to the position for December 2020 and January 2021 (15). The majority of prescribing errors relate to the wrong dose or strength, or wrong advice given. The Medication Safety Steering Group produce a regular newsletter to highlight common errors and to raise awareness of safe medication practice.

Mortality rate:

Overall mortality rates continue to fall following since the second COVID wave from 8.3% in January to 4.43% for February. March data was not available at the time of the report.

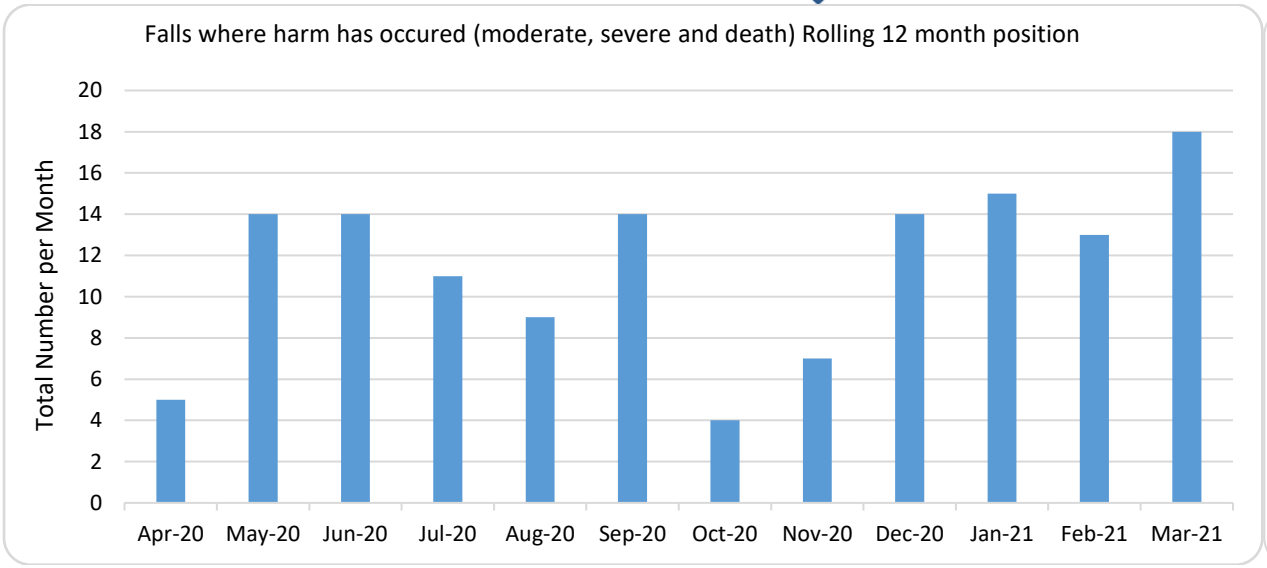
Indicator Description	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-2021	Trend
Total number of inpatient falls **	250	282	254	273	269	306	284	281	282	294	230	**240**	
Number of inpatient falls where harm has occurred (moderate, severe and death) **	5	14	14	11	9	14	4	7	14	15	13	**18**	
Total number of instances of hospital acquired pressure ulcers **	70	81	90	96	99	93	98	94	130	123	102	**72**	
Number of hospital acquired pressure ulcers grade 3 and 4 **	1	1	8	4	2	2	2	3	7	6	3	**3**	
Number of potential Hospital Acquired Thrombosis (HATs)	10	4	4	3	2	13	12	4	11	5	11	**8**	
% VTE risk assessments documented on the med. Chart	100%	100%	100%	97%	100%	94%	99%	94%	91%	96%	97%	**91%**	
Hospital Arrests (2222 calls) (MC & RTE ILGs)	28	30	35	26	32	28	29	48	47	*** 52	34	**43**	
Training % NEWS	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	**NA**	
C.difficile Rate/1000 admissions	16.4	26.45	27.33	42.32	39.67	46.46	23.8	13.66	13.22	10.58	8.78	**31.73**	
MRSA bacteraemia Rate/1000 admissions	0.00	2.64	0.00	2.64	0.00	0.00	2.64	2.73	0.00	5.29	0.00	**0.00**	
MSSA bacteraemia Rate/1000 admissions	16.4	23.8	30.06	10.58	34.38	21.86	34.38	21.16	34.38	21.16	14.64	**31.74**	
E. coli bacteraemia Rate/1000 admissions	43.73	66.12	90.19	103.15	84.63	84.72	34.38	84.72	66.12	47.61	52.71	**87.28**	
% of patients who spend less than 4 hours in A&E from arrival to admission, transfer or discharge	86.7%	90.5%	88.9%	86%	84.3%	80.4%	77.3%	76.3%	73.6%	68.5%	79%	**80.1**	

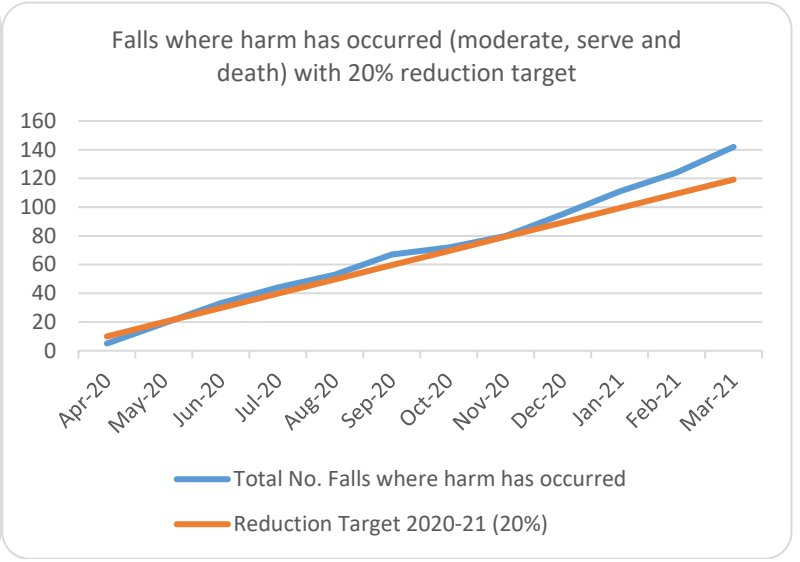
Indicator Description	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-2021	Trend
% of patients who spend less than 12 hours in A&E from arrival to admission, transfer or discharge	99.3%	99.9%	99.3%	99%	97.9%	95.4%	91.4%	89.6%	89.4%	86.3%	92.6%	**95.5**	
AvLOS (based on discharges only)	9.7	7.4	6.5	6.1	6.6	6.4	6.1	6.5	7.4	8.8	8.4	**6.4**	

** The HB and Locality Hospital Acquired Pressure Ulcers and fall data includes all inpatient acute and community hospital sites.
*** From January 2021 the Hospital Arrest figures include the Bridgend ILG position, so are an overall organisation position.

Inpatient Falls:
There was a significant decrease in falls reported for February and March 2021 (470) compared to the previous 2 months (576). The highest number of inpatient falls occurred within medicine and emergency care departments at the Princess of Wales Hospital and Prince Charles Hospital. Although severe harm/death from falls is very low in number there is an increasing incidence of moderate harm from falls reported. There is currently a Datix review by the central patient care and safety team of all falls within the past 24 months ongoing to establish any themes, trends and opportunities for learning/practice development.

Over the past 12 months, a total of 3,245 falls were reported of which, 138 caused harm. An improvement trajectory of 20% reduction in all falls with harm was planned, which was missed by 23 falls. It is anticipated that an ILG Nurse Director will lead on developing a CTM falls management strategy and progress improvement work on behalf of the Executive Director of Nursing.

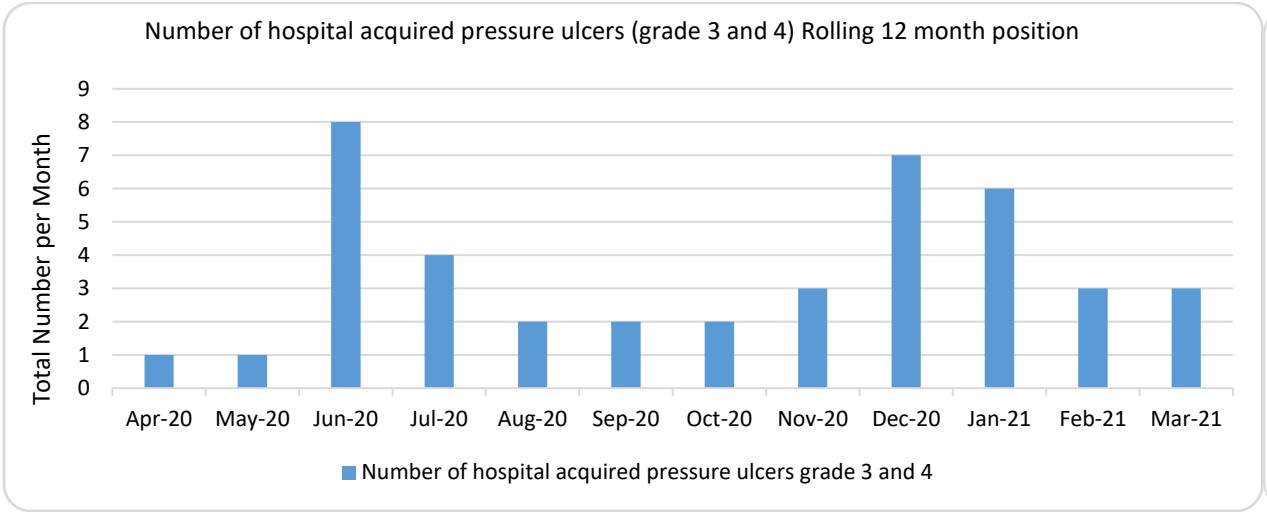


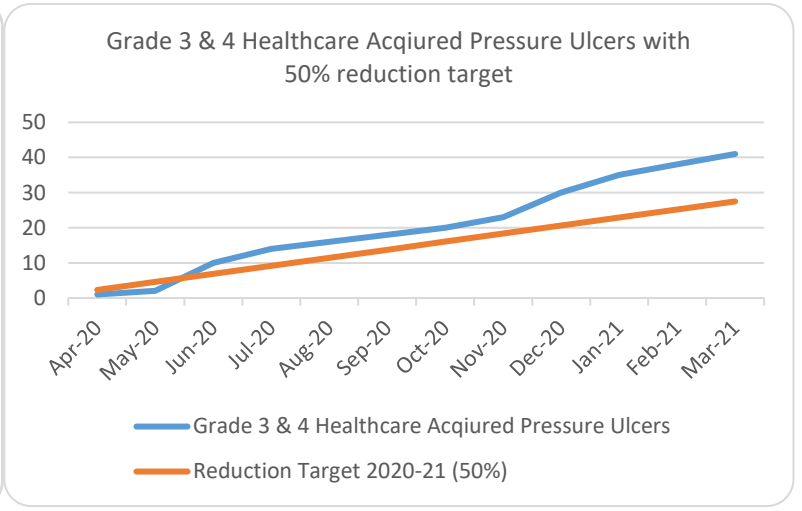


Hospital Acquired Pressure Damage:
The number of reported pressure damage has decreased for February and March 2021 (174) compared to 153 for the previous 2 months. The highest number of pressure damage incidents reported occurred within the patient's home with District Nursing input. There were double the number of pressure damage incidents reported for the Princess of Wales and Prince Charles hospitals compared to the Royal Glamorgan hospital, predominantly within general medicine, care of the elderly and orthopaedics.

Currently, as with falls, only total numbers are reported. Work has completed on reviewing hospital acquired pressure damage to understand the patient 'journey' in respect of deterioration in pressure ulcer grading; early identification of pressure damage; safeguarding reporting; actions taken to prevent pressure damage and if there is sufficient evidence to confirm that prescribed action is effective. The aim of the review is to ensure that current systems such as scrutiny panels are effective in improving pressure care, and that effective learning/sharing is taking place. **A spotlight report on actions to prevent and improve management of pressure damage is at Appendix 2.**

Over the past 12 months, a total of 1,148 hospital acquired pressure ulcers were reported across the Health Board, of which, 42 were Grade 3 and 4s. All avoidable pressure damage must be reported to the Multi-Agency Safeguarding Hub (MASH), the consistency and timing of this requirement within the three ILG's is not uniform. An improvement trajectory of a 50% reduction in Grade 3 and 4s was set for 2020-2021. Progress will be monitored and supported through the delegation of pressure damage prevention and improvement to an ILG Nurse Director. Given the financial and humanitarian cost of pressure ulcers, this potentially avoidable injury is increasingly becoming a key policy and professional target within our organisation.





Hospital Acquired Thrombosis (HAT) and Venous Thromboembolism (VTE) assessments:
There were 19 potential HATs identified for February to March 2021 compared to the 16 for the previous reporting period.

Hospital Cardiac Arrests and NEWS Training:
The data for cardiac arrests now includes all 3 ILGs from January 2021. For February to March 2021 the number of calls has begun to decrease compared to January 2021 due to the decreasing number of critically ill COVID patients. Hospital Cardiac Arrest Calls will remain an important metric as the ultimate goal is cardiac arrests only to occur in the Emergency Department. This is due to strengthening our pre-arrest reviews and monitoring acute deterioration, as well as improving on our Do not Attempt Cardio Pulmonary Resuscitation (DNACPR) processes. Accurate NEWS scoring, and therefore training, are integral to this goal.

Recognising Acute Deterioration and Resuscitation (RADAR) group has met and in the early stages of forming our cross-organisational programme. We will be expanding our metrics to keep a constant review of our activities. With the introduction of the new **NEWS 50** chart from the 1 April 2021 an associated audit of compliance will be undertaken by the Outreach Team on a monthly basis. NEWS training is also being recorded on the new Clinical Audit and NICE compliance monitoring system, so training figures will be available from April 2021.

Infection Prevention and Control (IPC):

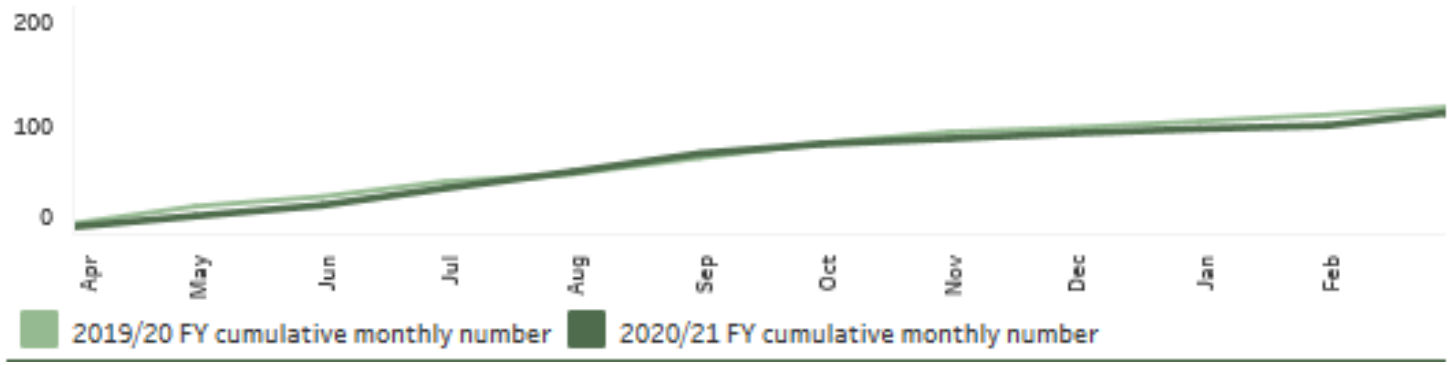
There was a significant increase in the number of C.Difficile infections, MSSA bacteraemia and E.coli bacteraemia reported in March 2021, but only a small proportion of the cases were healthcare associated infections. 12% of the E.coli bacteraemia were associated with a urinary catheter and the Lead IPC Nurse is meeting the Bowel and Bladder team leader next week to raise awareness of this and take improvement work forward.

There are no ongoing COVID outbreaks in any of the CTM sites and the IPC team is resuming core business IPC activities.

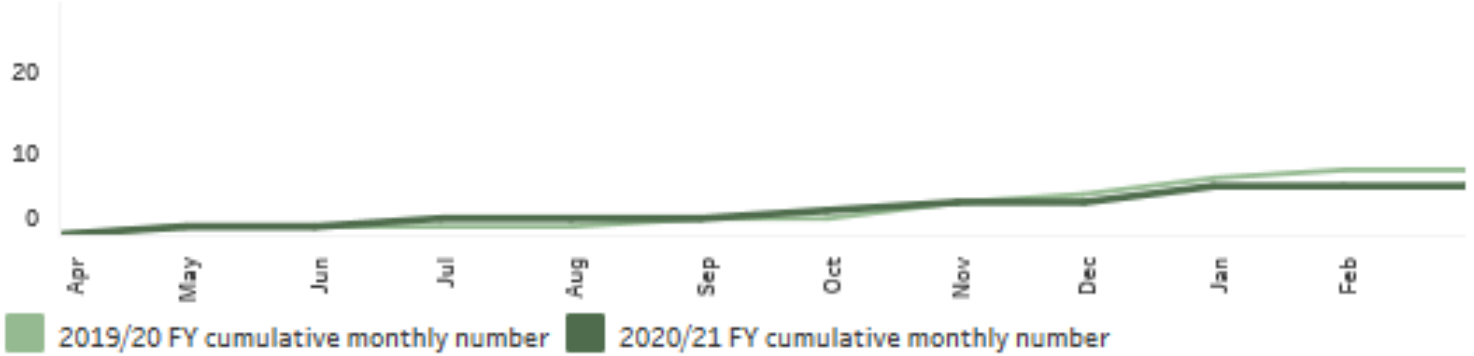
Planned IPC improvements:

- The IPC team will discuss and agree local reduction expectations for reducing healthcare associated infections with the ILG Directors
- Reinstate level 2 IPC training in the classroom setting
- Analyse sources of blood-stream infections to introduce targeted interventions
- Learn from incidents/share learning across the organisation.

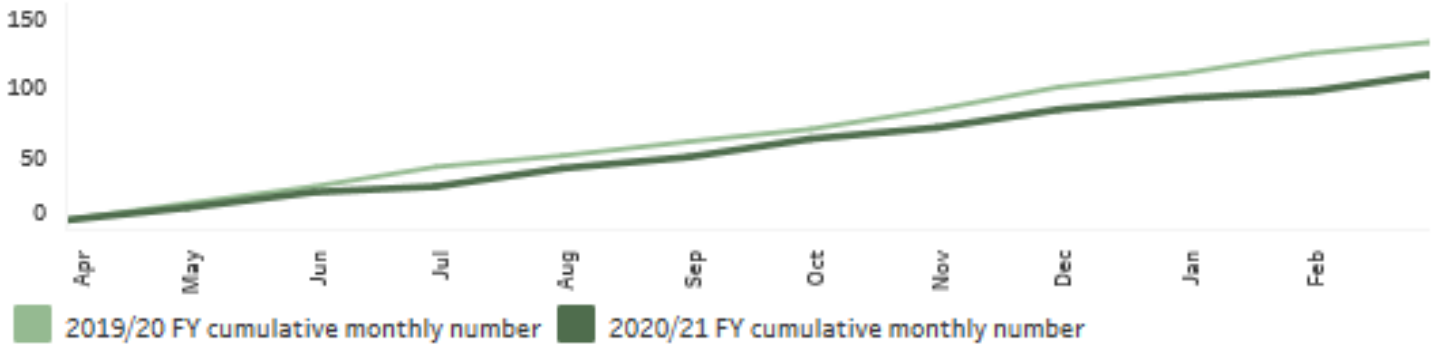
Cwm Taf Morgannwg University Health Board cumulative monthly numbers of C. difficile for April 2020 to March 2021 against the equivalent period in 2019/20



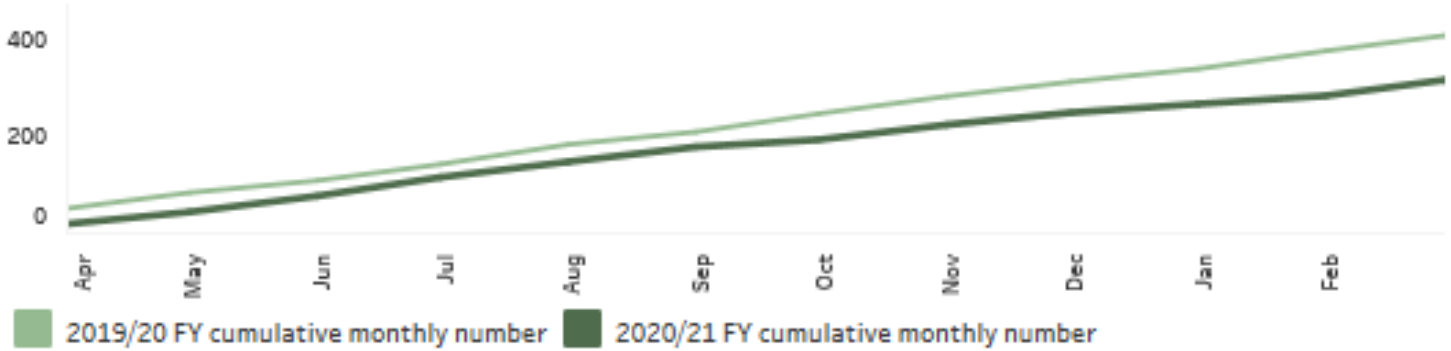
Cwm Taf Morgannwg University Health Board cumulative monthly numbers of MRSA bacteraemia for April 2020 to March 2021 against the equivalent period in 2019/20



Cwm Taf Morgannwg University Health Board cumulative monthly numbers of MSSA bacteraemia for April 2020 to March 2021 against the equivalent period in 2019/20



Cwm Taf Morgannwg University Health Board cumulative monthly numbers of E. coli bacteraemia for April 2020 to March 2021 against the equivalent period in 2019/20



Emergency Department 4 hour and 12 hour performance:
Compliance with the 4 hour target has improved, 80.1% March 2021 compared to 68.5% for January 2021 due to a decrease in general activity. The 12 hour A&E performance has also improved from 86.3% to 95.5%.

Average Length of Stay (ALoS):
The ALoS has decreased from 8.8 days in January 2021 compared to 6.4 in March 2021. A full review of COVID cases will be undertaken as part of the National COVID audit and as part of the COVID mortality review process to identify any common themes and trends.

Primary Care Metrics
Further work is ongoing to develop meaningful community/primary care data. Primary and community care is central to legislative drive for health improvement and population well-being and this requires more sophisticated indicators of quality, safety and person experience. These are being reviewed and re-designed in conjunction with the three locality Groups and Service Group Directors to attempt parity with the assurance measures of secondary care provision. Covid-19 has significantly impacted on how primary care is working at present however progress is being made in the development of specific subgroups in order to maximise the opportunity for learning, action and continuous improvement of all the services. Monthly Quality Assurance meetings are being put in place for the review of Primary Care contractor incidents and complaints. This will enable themes and trends to be identified, along with building capacity for inclusion and shared learning.

Indicator Description	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-2021	Trend
Community Care Metrics													
District Nurse treatments	18832	19699	21290	22908	23706	28447	36940	35138	33488	31616	30770	35281	
Referral to At Home Services (All Referrals)	98	66	92	117	91	125	104	123	100	89	86	141	
Maesteg Hospital (ALOS)	47	53	82	40	44	45	48	74	NA	NA	NA	NA	
Ysbyty Cwm Cynon (ALOS)	39	45	54	54	50	55	36	44	55	84	62	45	

Indicator Description	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-2021	Trend
Community Care Metrics													
Ysbyty Cwm Rhondda (ALOS)	57	46	51	67	61	62	49	52	55	76	91	**56**	
Palliative Medicine, Bridgend (ALOS)	17	13	18	13	10	11	10	10	25	27	22	**22**	
Palliative Medicine, Pontypridd/RGH (ALOS)	17	7	12	10	11	9	30	10	8	19	8	**5**	
Palliative Medicine, YCC (ALOS)	28	19	20	15	17	34	17	28	47	29	17	**19**	

District Nurse Treatments and at Home Referrals:
The activity levels for March 2021 are higher than for previous months in terms of numbers of patients being seen at home. The monthly increase in patient activity has placed significant pressure across all 31 teams. The numbers of referrals for Fast Track end of life care in particular continue to be significant. In order to manage demand the teams have all reduced their patient facing contacts to those that are assessed as most in need/urgent.

GP referrals into the @Home Service continue to account for most of the activity within the team. The service is managing to maintain a timely response despite some staffing deficits.

Community Hospitals Average Length of Stay (ALoS):
Maesteg hospital is currently closed due to ongoing estates works. The average length of stay for Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda Community Hospital has dropped in line with the decrease in overall number of COVID cases. There is a continued shortage of beds in the independent sector for patients needing long-term funded Elderly Mentally Inform (EMI) nursing care and we are therefore "holding" these patients whilst they await transfer.

Indicator Description	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-2021	Trend
Mental Health Care Metrics													
Number of 136 assessments in police cells	0	0	0	0	0	0	0	0	0	0	0	**0**	
Number of restraints	25	32	40	19	32	20	21	19	45	59	30	**21**	
Number absconding from wards (overall not just detained) ****	10	12	28	26	18	16	11	19	7	16	10	**29**	

**** All Wards

Number of 136 Assessments in Police Cells:
Pleasingly this number remains 0 and is showing good compliance with the Crisis Care coordinator ensuring that those who require mental health assessment are not detained in custody suites.

Number of Restraints:
Restraints for this month remain steady. No discernible trends noted and all incidents reported and reviewed by the mental health teams, with upward reporting to the ILG Quality & Patient Safety (Q&PS) meeting.

Number of Detained Patients Absconding:
This number is the highest number reported in the past 12 months. Data has been reviewed within mental health teams to identify trends or patterns and there is no clear underlying issue emerging. Mental health services will continue to monitor to understand further activity in this area over the coming months.

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 pandemic from both the first wave and second wave 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; improved quality indicators have been agreed for use at future Board which facilitates a greater ambition for assurance and measurement of quality.
- An integral quality strategy and identification of priorities for the Health Board will be introduced at the next committee. Suggest that future '*spotlight on…*' report feature consideration of an issue identified by a committee member/s.
- Progress has been sustained against recommendations and 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)	Choose an item.
	This report applies to all Health and Care Standards.

Equality impact assessment completed	Not required
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 Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

Members of the Quality & Safety Committee 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 report