AGENDA ITEM
6.2

QUALITY & SAFETY COMMITTEE

PATIENT SAFETY QUALITY DASHBOARD

Date of meeting	22nd March 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Louise Mann, Assistant Director Quality & Safety Natalie Morgan-Thomas, Interim Deputy Head for Clinical Audit & Lead Nurse for Clinical Effectiveness
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 ILG's. Joint working with Performance and Planning team	Various dates	SUPPORTED

ACRONYMS	
CA&QI	Clinical Audit & Quality Informatics

1. SITUATION/BACKGROUND

This presentation of the Quality Dashboard to Committee provides data from December 2021 to January 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 60% with a target range of 75%. Reduced complaints compliance has been contributed to by the redeployment of staff for Covid vaccination and anticipated to 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.
- The Never Event incident reported in January 2022 refers to a retained swab within maternity services.
- Although a slight decrease seen in this reporting period, total patient falls continues on an upward trajectory over the 12-month period.
- Two deaths were reported to be as a result of a fall in the Merthyr Cynon ILG, 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. The Assistant Director for Quality and Safety is leading an improvement piece of work around pressure area reduction within the community and a paper will be presented at Committee today.
- There is a significant decrease in medication prescribing errors in January 2022. It is not clear why this has occurred or if will become a trend. Administration errors remain in line with the 12-month average. Medication errors are the

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

- There has been an increase in mortality during the months of November and December 2021. More information is required to establish the true cause of the increase.
- An SBAR has been included in this report in relation to Patient Safety Solutions (PSS). Notices (PSN's) & Alerts (PSA's), illustrating performance in comparison with other Welsh health boards and Trusts. CTMUHB are not *non-compliant* in any PSS where all other Health Boards are compliant.

  Three PSN's & one PSA have achieved compliance in February 2022 and have been submitted to the DU. This will reflect in the DU dashboard after the 15th March 2022.
- 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.
- An increased demand for end of life care remains a trend within District Nursing Teams and primary healthcare services. It is a nationally recognised theme linked with increased numbers of deaths occurring in the community as a result of the impact of the pandemic.
- Average length of stay (LOS) has generally increased this period in part due to a high number of patients awaiting residential, nursing care placements or care packages. Palliative care have seen significant increases in LOS as they support flow in the acute sites through direct admission. Local authorities and domiciliary care providers are experiencing their own challenges in service delivery. Work with the NHS Delivery Unit (DU) on improving discharge arrangements within Ysbyty Cwm Cynon are ongoing and there is a decrease in average LOS seen for January 2022.

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

Data run on 07.02.22

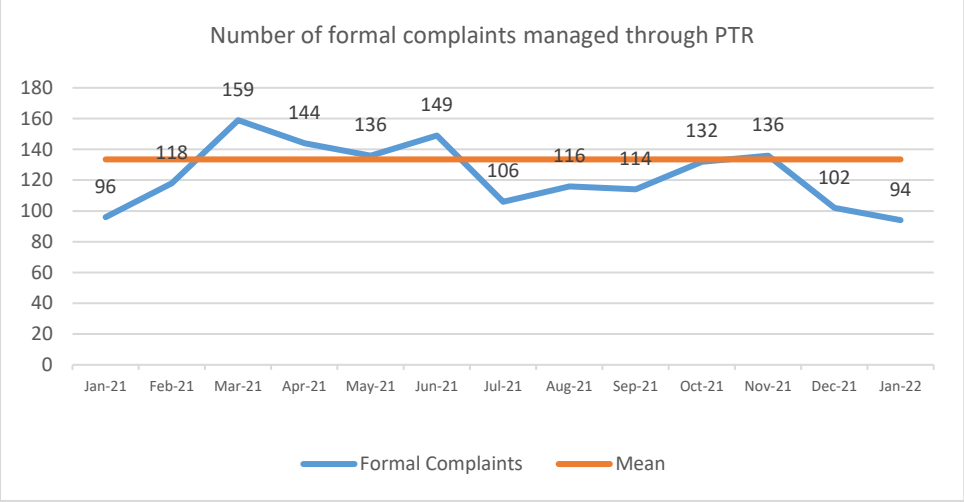
Indicator Description	Feb-21	Mar-21	April-21	May-21	June-21	July-21	Aug-21	Sept-21	Oct-21	Nov-21	Dec-21	Jan 2022	Trend
Health Board Wide Quality Metrics													
Number of formal complaints managed through PTR *	118	159	144	136	149	106	116	114	132	136	102	**94**	
Number of compliments	66	52	81	67	109	70	114	85	55	77	51	**71**	
Number of never events in month	1	0	0	0	2	0	1	0	0	0	0	**1**	
Number of serious incidents (SI) Process until to 14.06.21	6	8	6	3	6								
Number of Nationally Reportable Incidents New process from 14.06.21					4	4	8	0	4	3	4	**3**	

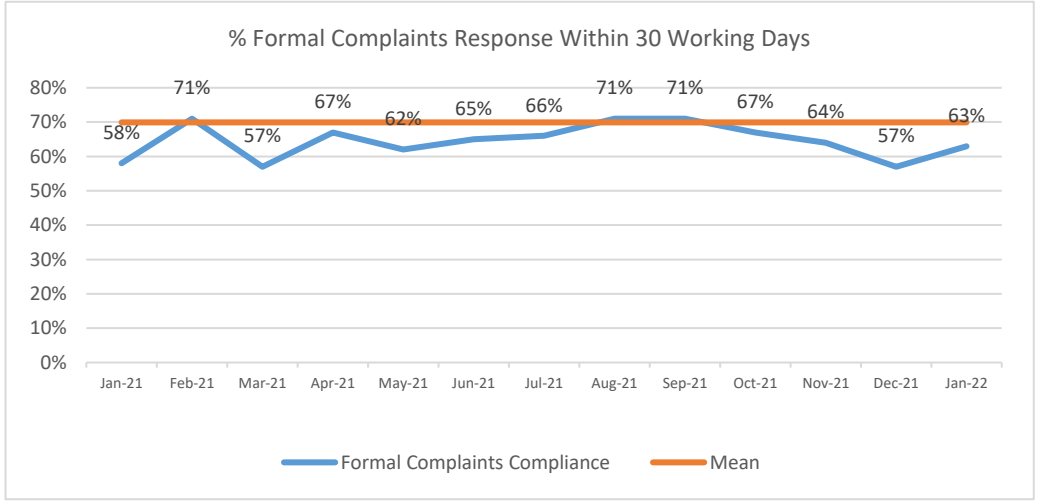
* Calculation of formal complaints received is now run from date first received as of 1st July 2020.

Complaints:

During December 2021 and January 2022, there were 196 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 below. For those complaints received in December 2021 & January 2022, the top 3 themes relate to Clinical Treatment/Assessment (88), Communication Issues, including attitude & behaviour (39) and Appointments (19).

Although compliance with the 30 working day target dropped during the latter part of 2021, it has remained relatively consistent over the last 12 months, which is highlighted in the chart below. It is expected that compliance with the 30 working day requirement will reduce again in February 2022 due to the governance teams supporting the vaccination programme. A new complaints triage process is being piloted which commenced on the 21st February 2022, which over time should see a reduction in formal complaints, which should allow increased capacity to manage formal complaints within timescales. It is also anticipated that accurate, timely response to concerns will enable management through the early resolution category rather than progress as formal complaints.





Compliments

During December 2021 and December 2022, there were 122 compliments recorded on the Datix system, which represents a decrease from the previous two months (132)

Patient Safety Incidents:

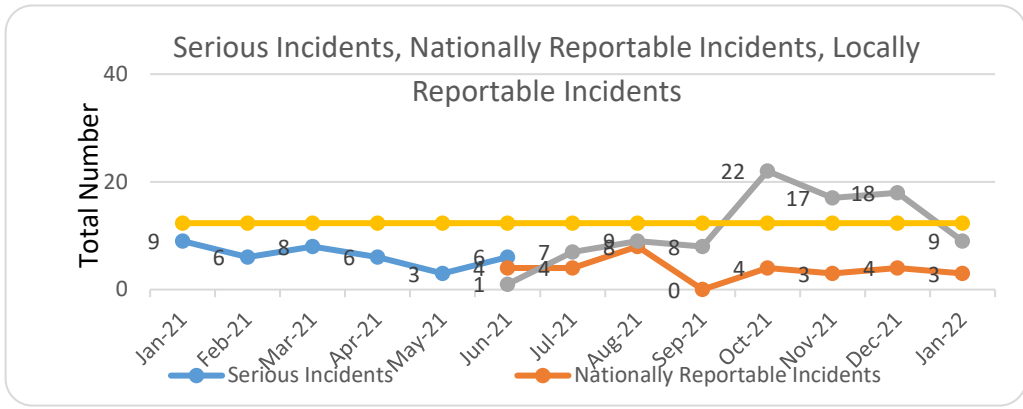
Between the 01.12.21 and 31.01.22, a total of 4233 incidents were reported across the Health Board. This is a decrease of 86 compared to the previous two months. Of these, 87% (3689) were reported as patient safety incidents during the two-month period. Of the patient safety incidents, 60 were reported with a severity of severe harm or death. This equates to 1.6% of the total number of patient safety incidents reported, a decrease from previous months.

Nationally Reportable Incidents:

Previous reports to Committee have highlighted NHS Wales National Incident Reporting Policy which was implemented on the 14.06.21. The introduction of the policy changed the terminology from Serious Incident to Nationally Reportable Incident, as well the criteria for reporting. In addition, the Health Board required that those previously classified as serious incidents but no longer required national reporting, would be captured as Locally Reportable incidents – this ensures that there is continued organisational oversight of robust investigation and learning from our most significant incidents. This change is reflected in the chart below.

During December 2021 and January 2022, 7 nationally reportable incident notifications were submitted to the Delivery Unit. A breakdown of the nationally reportable incidents is provide in the table below:

Type Of Nationally Reportable Incidents	Dec-21	Jan-22	Total
Delays	2	0	**2**
Pressure Damage	0	1	**1**
Treatment Error	1	0	**1**
Admission / Transfer / Discharge	0	1	**1**
Personal injury attributed to clinically related challenging behaviour of patient	1	0	**1**
Unexpected Complications	0	1	**1**
Total	**4**	**3**	**7**



- **Patient Safety Solutions:**

Internally to CTMUHB, PSS are disseminated, monitored and reported by the Patient Care and Safety Team, with overall responsibility appointed to the Head of Quality and Patient Safety. At the last Quality and Safety Committee in January 2022, a challenge was posed as to the performance of CTMUHB in relation to PSS against other Health Boards in Wales. The purpose of the SBAR report below is to outline the current position within CTMUHB and across Wales. It is important to note that PSS is a dynamic process where notices are being issued between internal and external reporting periods, and figures are representative of a point in time:

1. SITUATION

CTMUHB is committed to the continuous improvement of the quality and safety of care provided to all patients. One of many measures to support quality and safety is the issuing of Patient Safety Solutions (PSS). These encompass national patient safety alerts and notices, which are rolled out on an All Wales basis.

2. BACKGROUND

Governed by the Delivery Unit (DU), PSS are issued to all Health Boards across Wales, this includes where applicable Public Health Wales, and the Welsh Ambulance Service NHS Trust. PSS generally provide specific information and guidance relating to the actions that are required to be undertaken to enable the Health Board to reduce the risk and to report compliance. Each PSS has a specified compliance date / deadline.

Performance of Health Boards across Wales is monitored by the DU and reported publically via the DU website. CTMUHB internal monitoring sees PSS reported via a number of channels, which finally escalate to the Quality and Safety Committee on a bi-monthly basis. There are some challenges posed with this reporting structure, which include:

- Reports being submitted up to 4 weeks prior to the Quality and Safety Committee to allow for accuracy checking, dissemination and publication of papers. The performance landscape can change weekly and so it should be considered that the report is a snapshot of a point in time.

3. ASSESSMENT

In total, there are 2 alerts and 5 notices in which CTMUHB are non-compliant. Whilst the supporting evidence should be considered, a snapshot of performance against other Health Boards in Wales is noted as:

Table 1

	ABUHB	BCUHB	C&VUHB	CTMUHB	HBUHB	POWYS	PHW	SBUHB	VELINDRE	WAST
No. of non-compliant alerts	2	0	2	2	3	0	N/A	2	0	3
No. of non-compliant notices	2	3	0	5	4	3	0	7	1	1
Total	4	3	2	7	7	3	0	9	1	4

Considerations:

There are number of considerations that can be made in relation to *table 1.* In relation to Health Board performance:

- There are several alerts and notices that are considered not applicable (N/A) for Powys, due to the absence of a District General Hospital (DGH).
- Similarly, due to the specialised services of both Velindre and WAST, there are several PSS that are N/A.
- All, with the exception of 2 Notices issued since 2014 have been N/A to PHW.

- **PSA008** *Nasogastric tube misplacement: continuing risk of death and severe harm.*
  There are 2 other Health Boards across Wales who report non-compliance with this PSA. The DU are currently accepting of the status of non-compliance as it is recognised that compliance is down to a number of factors including procurement issues. Additionally, the current compliance statements of Health Boards across Wales has changed, but despite this, once a Health Board has reported compliance, even if it falls back out of compliance, this is not recorded or considered by the Delivery Unit. A number of Health Boards report current status as non-compliant (via the All Wales PSS Working Group) and it has been requested via the group that reporting of this notice is removed from the DU website.

- **PSN055** *Safe storage of medicine / cupboards*

There are an additional 4 Health Boards across Wales that report non-compliance in this PSS. There are a number of estate issues that are currently preventing full compliance with this notice and CTMUHB are partially compliant, with safety achieved in priority areas.

- **PSN056** *Foreign body aspiration during intubation advanced airway management or ventilation*
  There are an additional 3 Health Boards across Wales that report non-compliance in this PSS.

- **PSN058** *Urgent assessment / treatment following ingestion of 'super strong' magnets*
  There are an additional 4 Health Boards across Wales that report non-compliance in this PSS.

- **PSN059** *Eliminating the risk of inadvertent connection to medical air via flowmeter*
  There are an additional 3 Health Boards across Wales that report non-compliance in this PSS.

- **PSN060** *Reducing the risk of inadvertent administration of oral medicines by wrong route*
  There are an additional 3 Health Boards across Wales that report non-compliance in this PSS. CTMUHB compliance submitted in February 2022 and will reflect on the DU dashboard on or after the 15th March 2022.

- **PSA014** (Previously issued by the Delivery Unit as PSN061 but later withdrawn) *Inappropriate anticoagulation of patients with a mechanical heart valve*
  CTMUHB compliance submitted in February 2022 and will reflect on the DU dashboard on or after the 15th March 2022.

- **PSN051** *Depleted batteries in intraosseous injectors*
  CTMUHB compliance submitted in February 2022 and will reflect on the DU dashboard on or after the 15th March 2022.

- **PSN061** *Reducing the risk of patient harm – standardised strength of phenobarbital oral liquid*
  CTMUHB compliance submitted in February 2022 and will reflect on the DU dashboard on or after the 15th March 2022.

4. RECOMMENDATION

In late 2021, the central Patient Care and Safety Team embedded a new process for the management of PSS across the Health Board. This devolves responsibility for the facilitation and management of PSS to the ILGs with overall support and oversight from the central team. This new process has taken longer than expected to embed due to the demands of Covid-19, with the 'Booster Vaccination' campaign throughout December 2021, followed by the emergence of the Omicron variant in December 2021, with an impact through January 2022 to the current time.

The central team Head of Quality and Patient Safety, and the Business Manager continue to attend the All Wales PSS Working Group which is led and facilitated by the DU. The group provides excellent resource and support in achieving compliance and is a well led and highly valued group. Health Board attendance should be continued and support should continue to be provided by the central team to the ILGs to facilitate compliance.

Reporting of the progress and matters arising specific to PSS will continue to be reported and escalated to the Quality and Safety Committee.

Indicator Description	Feb-21	Mar-21	Apr-21	May-21	Jun-21	July-21	Aug-21	Sept-21	Oct-21	Nov-21	Dec-21	Jan 2022	Trend
Number of medication prescribing errors	9	21	16	28	28	19	21	27	15	25	21	**10**	
Number of medication administration errors	30	28	37	36	46	39	39	32	31	42	41	**35**	
Total number of inpatient falls	229	240	237	244	219	233	237	240	295	300	259	**301**	

Indicator Description	Feb-21	Mar-21	Apr-21	May-21	Jun-21	July-21	Aug-21	Sept-21	Oct-21	Nov-21	Dec-21	Jan 2022	Trend
Number of inpatient falls where harm has occurred (moderate, severe and death)	9	16	6	10	8	4	13	7	9	16	12	**14**	
Total number of instances of hospital acquired pressure ulcers	100	66	76	87	89	96	87	93	136	104	80	**89**	
Number of hospital acquired pressure ulcers grade 3 and 4	3	3	2	4	1	4	4	5	7	7	0	**1**	
Total number of instances of Community acquired pressure ulcers	131	153	180	178	158	188	125	153	151	163	169	**172**	
Number of Community acquired pressure ulcers grade 3 and 4	20	26	27	21	22	21	22	19	18	20	17	**19**	
Number of potential Hospital Acquired Thrombosis (HATs)	11	8	12	4	3	2	10	12	14	9	6	**6**	
% VTE risk assessments documented on the med. Chart	97%	91%	95%	92%	94%	94%	96%	96%	90%	94%	93%	**96%**	
Hospital Arrests (2222 calls) Adult	34	43	38	39	35	27	42	64	47	35	48	**42**	
% NEWS audit by site (RGH/YCR/PCH/YCC/PoWH/ Ysbyty'r Seren)			82.6%	84.5%	81.1%	87.1%	86.3%	84.5%	84.1%	91.1%	89.5%	**89.8%**	
C.difficile Rate/1000 admissions	0.76	2.29	2.77	1.32	2.28	2.78	4.39	1.42	1.78	1.81	3.14	**1.77**	
MRSA bacteraemia Rate/1000 admissions	0	0	0	0.19	0	0	0	0	0	0	0	**0**	
MSSA bacteraemia Rate/1000 admissions	1.26	2.29	2.57	2.08	1.93	2.22	1.8	1.24	1.07	1.62	2.16	**1.96**	

Indicator Description	Feb-21	Mar-21	Apr-21	May-21	Jun-21	July-21	Aug-21	Sept-21	Oct-21	Nov-21	Dec-21	Jan 2022	Trend
E. coli bacteraemia Rate/1000 admissions	4.28	6.3	7.12	6.61	6.32	6.85	7.98	7.61	4.46	5.78	5.89	**4.71**	
% of patients who spend less than 4 hours in A&E from arrival to admission, transfer or discharge	79	81	75	69	70	68	67	64	61	66	64	**65**	
% of patients who spend less than 12 hours in A&E from arrival to admission, transfer or discharge	90	92	90	87	88	86	85	83	81	83	83	**81**	
AvLOS overall mean (based on discharges only)	7.3	5.6	5.2	5.0	4.6	4.9	5.3	4.6	5.1	5.3	5.3	**5.5**	
Mortality Rate (CHKS)	4.41%	2.88%	2.62%	2.75%	2.14%	2.69%	2.74%	2.93%	3.47%	3.31%	3.84%	**N/A**	

Patient Experience:

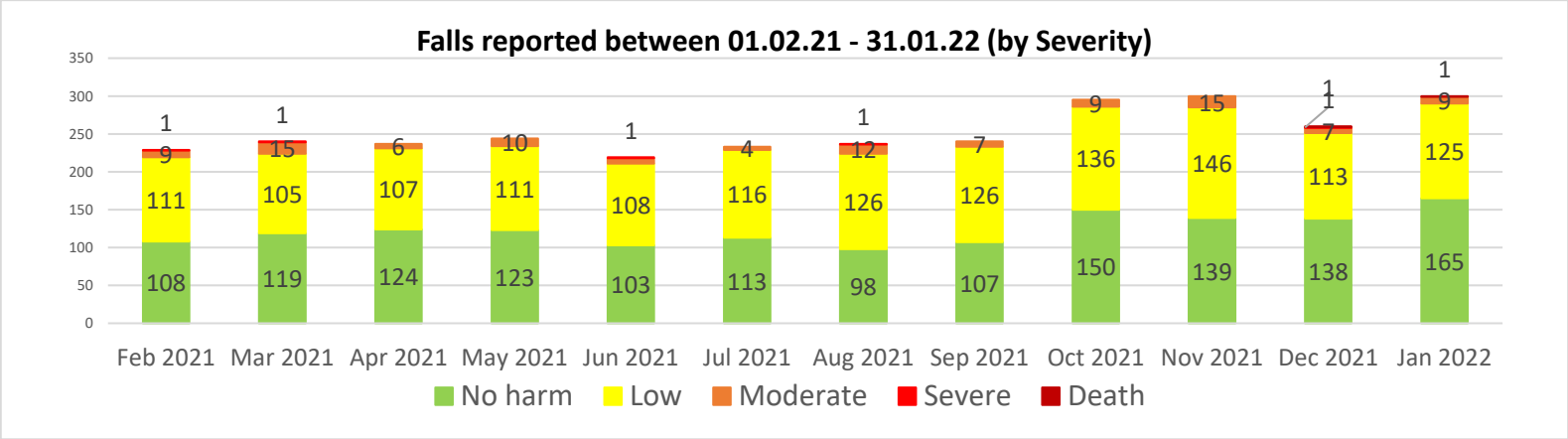
The latest patient experience data is attached at **Appendix 1**. Health Board wide data will be available once the new national 'Once for Wales' system is introduced, this was planned for April 2020, however there is a delay in progressing the project due to Covid-19. A project lead has been recruited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

Medication Incidents

A total number of 153 medication incidents were reported between the 01.12.21 & 31.01.22. 95.4% of the incidents were reported as resulting no (98) or low (48) harm. No medication incidents were reported as resulting in severe harm or death, with 7 reported as moderate harm. Of the total number of medication incidents reported 76 related to the administration of medication and 31 to prescribing.

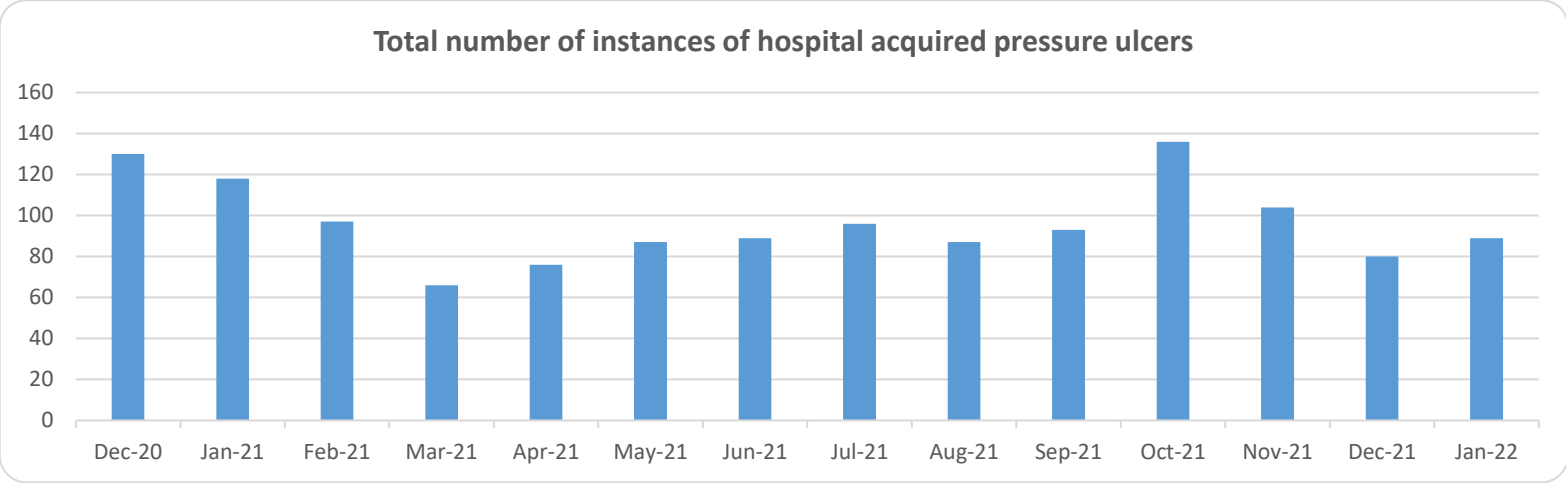
Inpatient Falls

560 falls were reported, which represents a decrease in the number of falls reported in comparison to the previous two months. 3 incidents were reported as resulting in severe harm or death during December 2021 and January 2022. The highest number of inpatient falls (33) occurred in the Seren Unit at Royal Glamorgan Hospital, with 23 occurring in Angelton Ward at Glanrhyd Hospital; both provide care to frail, vulnerable patients within an adult mental health environment.



Pressure Damage Incidents

During December 2021 & January 2022, a total of 972 pressure damage incidents were reported. The highest number of incidents reported were identified as developed outside of hospital setting with district nursing input (341). Of the total number of pressure damage incidents reported, 169 were identified as hospital acquired, with Acute Medical Unit (AMU) at Princess of Wales Hospital recording the highest (13). 1 incident was recorded as Grade 3 in January 2022, there were no hospital acquired Grade 4 incidents reported between December 2021 & January 2022.



Of the 169 hospital acquired pressure damage incidents reported an investigation has been completed for 72 incidents. Of these, 12 have been identified as **avoidable**.

Hospital Acquired Thrombosis (HAT) and Venous Thromboembolism (VTE) assessments:
There were 12 potential HATs identified for December 2021 to January 2022 compared to 23 for the previous reporting period from October to November 2021. As has been highlighted previously numbers of potential HAT's do not translate into actual numbers and this is a subject for spotlight at a future committee.

Hospital Cardiac Arrests and NEWS Training:
For December 2021 to January 2022, the number of calls taken were 90 compared to 82 for October to November 2021. 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 DNACPR processes. NEWS scoring, and therefore training, are integral to this goal.

The Recognising Acute Deterioration and Resuscitation (RADAR) group has met and are in the early stages of forming a cross-organisational programme. The group will be expanding their metrics to keep a constant review of activities; with the introduction of the new NEWS 50 chart from the 1st April 2021 and an associated audit of compliance 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 are now available from April 2021.

Infection Prevention and Control:
COVID has continued to be the focus for the Infection Prevention and Control (IPC) team. The IPC team have continued to support the Health Boards preparedness and response to the second, third and fourth waves of COVID and managed individual cases/outbreaks of infection throughout CTMUHB since 2020. 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.

The Health Board only met 1 out of the 5 infection control reduction expectations for 2020/21. During this year, healthcare acquired inpatient infections accounted for 31% of the alert organisms. The IPC team continue to work collaboratively with the Integrated Locality Groups (ILGs) to reduce healthcare associated infections and monitor progress against the Welsh Government reduction expectations. However, it has been difficult to fully support the improvement work required across the Health Board due to the COVID response and staff shortages within the IPC team. We are currently on trajectory to meet 1 out of the 5 reduction expectations for 2021/22. We have developed local ILG improvement goals in line with the national reduction expectations set by Welsh Government. The ILG position is monitored via local IPC meetings and the Heads of Nursing/Nurse Directors report their figures to the IPC committee meetings on a quarterly basis.

The majority of preventable infections are associated with a urinary catheter. The IPC team are working collaboratively with bowel and bladder service colleagues to investigate every urinary catheter associated bacteraemia. Further engagement is required to strengthen the Root Cause Analysis (RCA) process in primary and secondary care to learn lessons from incidents and share best practice. The IPC team have requested that the ILG take responsibility for initiating and leading the RCA process. Improving IPC practices must be everyone's responsibility and ownership from ward to board is critical to improve patient safety.

Despite an increase in healthcare associated C. difficile infection, a significant proportion of S. aureus and gram-negative bacteraemia are community-acquired infections. Investment is needed to provide an integrated whole system approach for Infection Prevention and Control. More emphasis must be placed on improvements in primary care to advance patient care and safety and influence a reduction in infection rates. The Health Board will not achieve the healthcare associated improvement

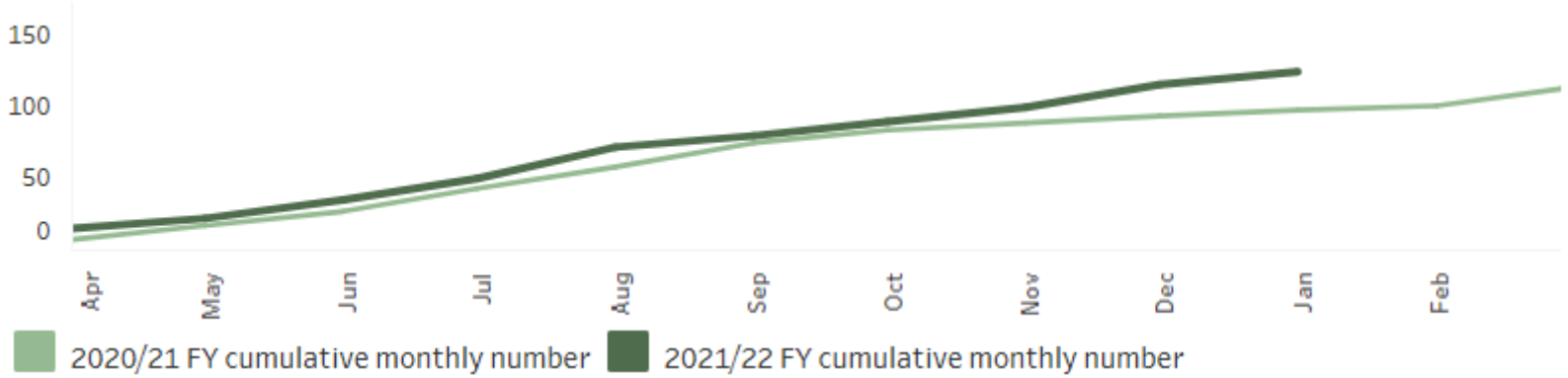
goals without investment in primary care. The Lead IPC Nurse is part of an all Wales task and finish group looking at workforce planning for IPC. Recommendations describing the 'ideal team' will be provided in an attempt to build multidisciplinary teams who are appropriately skilled and resourced to drive the IPC agenda in Wales.

An external review of decontamination in CTM has been jointly undertaken by the Health Board and Shared Services colleagues. A management response is being prepared for discussion at IPC committee. A dedicated resource is critical to lead on the operational agenda for decontamination.

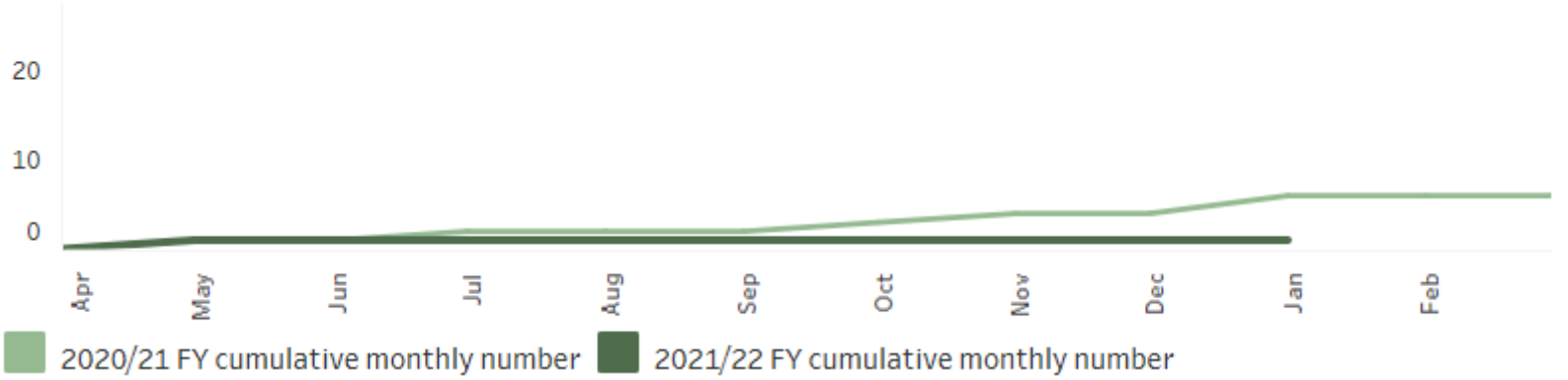
Planned improvements to the IPC services –

- 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.
- Lead IPC Nurse to meet with the ILG Nurse Directors to strengthen the RCA process and request ILG leadership.
- IPC team to deliver a blended approach for IPC training – face-to-face sessions and access to ELearning.
- IPC team to roll out ANTT in Bridgend Locality and arrange refresher sessions for Rhondda Taf Ely and Merthyr Cynon.
- Provide guidance and support to introduce and implement revised patient pathways in line with updated national guidance.

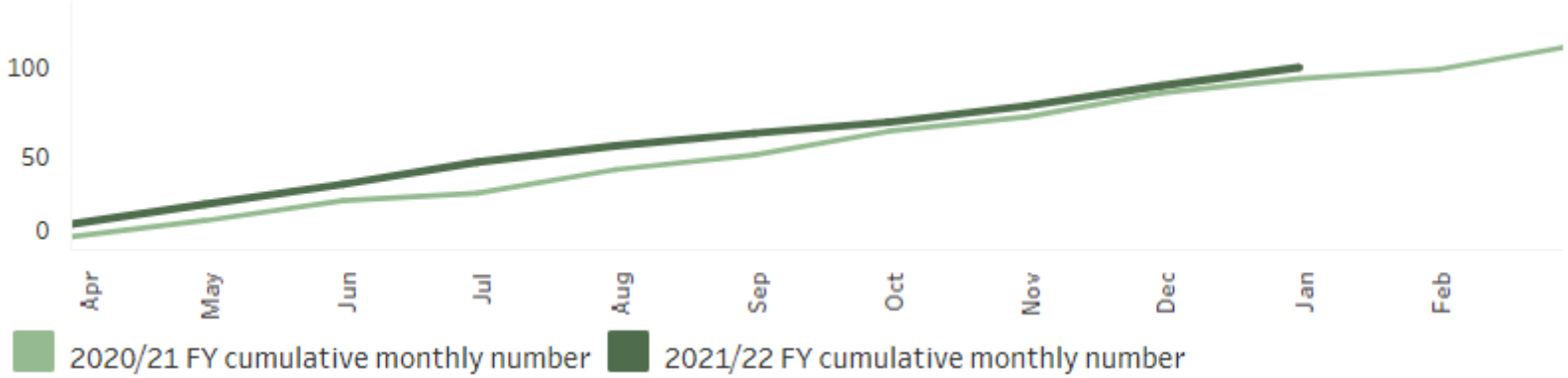
Cwm Taf Morgannwg University Health Board cumulative monthly numbers of C. difficile for April 2021 to January 2022 against the equivalent period in 2020/21



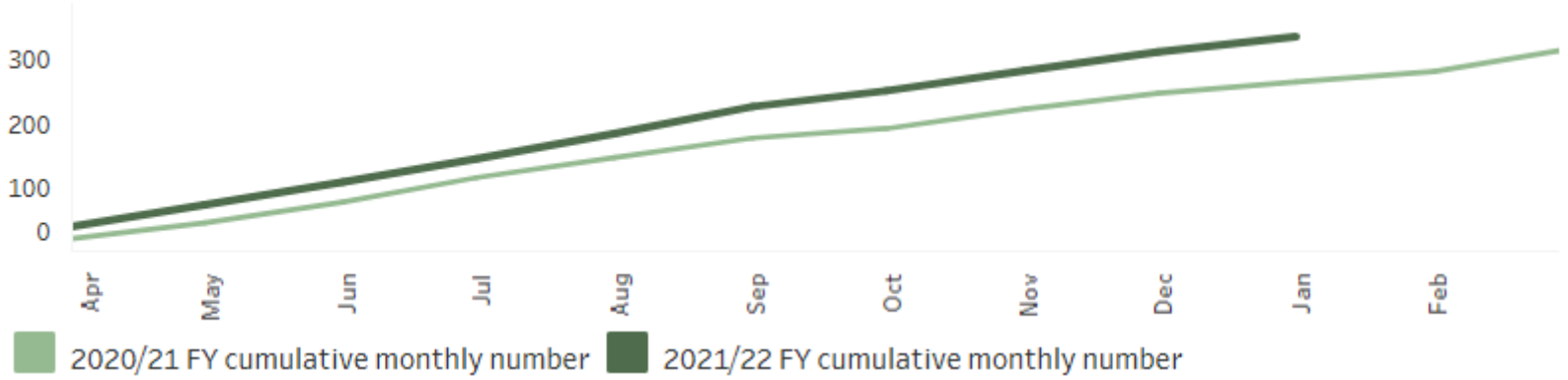
Cwm Taf Morgannwg University Health Board cumulative monthly numbers of MRSA bacteraemia for April 2021 to January 2022 against the equivalent period in 2020/21



Cwm Taf Morgannwg University Health Board cumulative monthly numbers of MSSA bacteraemia for April 2021 to January 2022 against the equivalent period in 2020/21



Cwm Taf Morgannwg University Health Board cumulative monthly numbers of E. coli bacteraemia for April 2021 January 2022 against the equivalent period in 2020/21



Emergency Department 4 hour and 12 hour performance:
Compliance with the 4 hour target has remained at 65% compared to the previous reporting period and activity remains high. The 12 hour A&E performance remains comparable with the previous report period at 82%.

Average Length of Stay:
The ALoS has increased to 5.5 days in January 2022 compared to 5.3 days in December 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.

Mortality rate:
Overall mortality rates continued to fall following the second COVID wave from 2.88% in March 2021 to 2.69% for July 2021 and 2.74% for August 2021. There has been an increase in mortality to 3.31% in November 2021 and 3.84% in December 2021 January 2022 data was not available at the time of this report.

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	Feb-21	Mar-21	Apr-21	May-21	Jun-21	July-21	Aug-21	Sept-21	Oct-21	Nov-21	Dec-21	Jan 2022	Trend
Community Care Metrics													
District Nurse treatments	30783	35354	34258	35911	36262	35675	35522	35174	35938	36724	37313	**36096**	
Referral to At Home Services (All Referrals)	86	142	124	107	116	116	120	98	96	103	101	**107**	
Maesteg Hospital (ALOS)	0	0	0	0	0	0	0	0	0	0	0	**0**	
Ysbyty Seren (ALOS)	0	63	39	26	44	22	27	31	56	45	42	**42**	
Ysbyty Cwm Cynon (ALOS)	62	45	36	40	41	59	48	46	49	55	61	**55**	
Ysbyty Cwm Rhondda (ALOS)	91	56	43	59	54	59	66	54	70	58	58	**82**	
Palliative Medicine, Bridgend (ALOS)	22	22	20	13	16	32	18	18	18	13	13	**25**	
Palliative Medicine, Pontypridd/RGH (ALOS)	8	5	9	9	8	8	8	14	8	7	9	**18**	
Palliative Medicine, YCC (ALOS)	17	19	32	28	14	28	22	41	23	24	13	**9**	

District Nurse Treatments and at Home Referrals:

Merthyr & Cynon (M&C)
The numbers have stabilised in M&C however, this does not demonstrate the complexity of the calls or the impact of Covid. The increase in patient activity /acuity continues to put significant pressure across all 11 teams in M&C ILG. The numbers of referrals for Fast Track end of life care and palliative care in particular continue to be significant following on from the pandemic and the long-term health conditions it continues to affect. In order to manage demand the teams have used their resources efficiently to ensure all patients are seen and have continued to provide safe effective care to a high standard.

Rhondda Taf Ely (RTE)
Patient visits continue to see an increase of approximately 500 patient visits month on month. RTE DN patient visits make up 15000 of the 36096 detailed above.

General Practice
GP referrals continue to account for the majority of the referral activity, although there continues to be staffing deficits colleagues are still managing to provide a timely response to the patients referred to the service.

Community Hospitals Average Length of Stay (ALoS):

Ysbyty Cwm Rhondda
There has been an increase in LOS from 58 days in December 2021 to 82 days in January 2022. There is now bi-weekly meetings with the local authority to discuss and support more timely discharges, which is the main cause of the increase in LOS. There are currently patients awaiting a care home placement and others awaiting a community package of care. A further impact on delays would be patients whom are awaiting Court of Protection.

Ysbyty Cwm Cynon
There has been a decrease in LOS from 61 days in December 2021 to 55 days in January 2022. There is still a high number of patients on site awaiting placement within Care Homes or awaiting packages of domiciliary care in the community. As of 9th February 2022, a total of 23 beds were occupied by patients who were able to be discharged but were awaiting placement/care packages (14 awaiting care home placement and 9 awaiting packages of care). Actions are being carried out to improve patient flow through YCC following recommendations from a recent DU review.

Palliative care inpatient beds
These areas have increased LOS, a contributing factor to this would be the wait for nursing home placements as well as supporting A&E's and site flow with direct admission due to the unavailability of acute beds.

Indicator Description	Feb-21	Mar-21	Apr-21	May-21	Jun-21	July-21	Aug-21	Sept-21	Oct-21	Nov-21	Dec-21	Jan 2022	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	39	27	27	37	16	49	35	35	44	46	35	**20**	
Number absconding from wards (overall not just detained)	10	29	24	16	27	34	23	25	20	25	21	**18**	

Number of 136 Assessments in Police Cells:
Pleasingly this number remains 0 and is showing good compliance with the Crisis care Concordat ensuring that those who require mental health assessment are not detained in custody suites. (All Mental Health Localities included).

Number of Restraints:
Restraints for this month remain at the lower end of the month on month numbers. No discernible trends noted and all incidents reported and reviewed by the mental health teams. (All Mental Health Localities included).

Absconding Incidents
During December 2021 and January 2022, a total of 39 Absconding incidents were reported. The highest number of incidents reported were for Emergency Care Centre Prince Charles Hospital (9), Accident & Emergency Royal Glamorgan Hospital (5) and Enfys Ward, Ty Llidiard (3). The Ty Llidiard reports refer to the same young person and were no harm incidents of attempted absconsion. 1 incident was reported as resulting in moderate harm where an adult patient absconded whilst awaiting a crisis assessment in A&E.

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 has had considerable and ongoing consequences on the ability of the HB to provide continuity around its core business, as well as impacting upon recovery plans.
- Refining and improving data in relation to quality, patient safety and patient experience is ongoing. Adoption of the Once for Wales Incident module is anticipated as going live in April 2022.
- Gaining health board wide assurance of the breadth of UHB services is a priority and improvements to standardise ILG and organisational governance and monitoring is maturing.
- Quality strategy and identification of priorities for the Health Board. Suggest that a '*spotlight on…*' a priority thematic area for the UHB is included in the next Q&S report – a report describing the development of a strategy for prevention and reducing incidence of community acquired pressure damage is presented to Committee today.

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 continue 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	Choose an item.
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 Main Strategic Objective	To Improve Quality, Safety & Patient Experience
Link to Main WBFG Act Objective	Provide high quality care as locally as possible wherever it is safe and sustainable

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 reports

Patient Experience
Activity Period December 2021 – January 2022

Following on from the theme of communication during the last activity period the Patient Experience Team have supported the embedding of the new patient feedback system, Civica. To enable our communities to have a voice, are involved in the building of services we provide across the Health Board and allow us an insight into how we can improve/change what is currently in place.

The system was launched on the staff intranet page at the beginning of January 2022 and led to a number of services engaging with the team to see how they could utilize this forum to gain feedback from patients/carers and families alike. There are a number of surveys currently available on the system (e.g. maternity, paediatrics) and these are being built on as specialities/services come on board.

The system was launched to the public the following week via our internet, social media platforms and third party stakeholders. This feedback is available to staff in real time for them to understand patient experience and action accordingly.

The Health Board continues to receive feedback via a number of other avenues that allow staff/managers a more rounded insight into their services e.g.: concerns, incidents, Community Health Council etc.

Within this the Patient Experience Team also supports a number of departments to build upon the support already in place in different areas:-

Carers

Carers Steering Group continues to be held, last meeting December 2021, with third sector and council representatives to discuss work ongoing across the Health Board to support carers. This is an ongoing forum.

Staff in Mental Health department, Royal Glamorgan Hospital completed Agored training to enable them to identify and support carers. To date we have a further 14 learners registered for this training. There will be an external quality assurance (EQA) on the Agored course shortly (date to be confirmed).

A meeting was held with the All Wales Forum to discuss the Respitality Shared Scotland model. The Health Board has engaged with partners to set up a Task & Finish group to look at producing a small scale respitality model for the benefit of our communities. This is in progress.

Confirmation has been received from Welsh Government that funding will continue for 2022-23, at present the Health Board allocation is unknown. Once allocated the process of funding application for projects in the community will be managed via the Carers Steering Group.

Discussions were held with our communications department to explore updating the Carers pages on the intranet and internet. Exploration of ongoing opportunities that will highlight work being undertaken, resources available and carer engagement to ensure that staff/patients/families have access to information via the Health Board website.

Carers champion distribution list updated to reflect changes during this period.

Monitoring of quarterly reports received from projects run through the Welsh Government Carers grant allocation. This will then be entered into a report in readiness for the Welsh Government end of year report due by 1st May 2022.

Reconciliation of invoices for projects and consequent payments made. Review of outstanding invoices in progress to ensure budgets managed appropriately to comply with year end.

The Health Board has some funding left from this year and we are currently looking at smaller funding projects to support carers in the community.

Appendix 1

Chaplaincy Services

Significant Spiritual and pastoral care

Patients	Relatives/Carers	Staff	Religious Rites	Out of hours requests
286	38	347	165	7 calls amounting to 9:50 hrs

Out of hour's requests

Unfortunately, the number of people we have been able to support has reduced during this period due to the fact we still have a very small team available to be present on sites during core hours. Sickness and Covid have also contributed to this. The team are striving to ensure there is a physical presence across the Health Board. We are also building on our team of bank chaplains, six have come though the recruitment process so far, having these extra chaplains join us as part of our out of hours rota enables us to continue to offer a 24/7 service to the Health Board.

We have continued to work with the ITU family liaison bereavement team, supporting relatives who have lost loved ones in ITU in PCH and RGH, a total of 83 bereavement support calls were made and 5 'This is Me' calls.

We officiated for two Health Board hospital contract funerals, one baby funeral and two of the bimonthly foetal collective cremation services. A Loved and Lost Remembrance service was held at Llwydcoed Crematorium on 4th December 2021. Families who had lost babies within 2021 were invited, and we collaborated with the maternity bereavement midwife to prepare and hold the service. It was well attended with COVID restriction's in place, and live streamed by the Crematorium to accommodate for limitations on numbers that could attend physically.

A number of Christmas services were planned and prepared for different sites, these sadly all had to be cancelled due to rising COVID cases. One of these services was to be delivered as a Thanksgiving/Christmas service for our Health Board volunteers, this was to be held at Glanrhyd Chapel. The Glanrhyd Estates department had worked hard to repair the roof and repainted the whole chapel in time for this, it was a huge disappointment that the service could not go ahead, but we are extremely grateful to the estates team. They have done an excellent job, which allows us to resume our weekly services for patients on site.

Three of our chaplains then worked together to produce a virtual service which went out on the Health Board's social media platforms. We also worked with the communications department to plan and produce a video alongside Paul Mears to mark 2021's National Workplace Day of Remembrance.

One of the team has attended Aneurin Bevan's University Health Board's training for 'End of Life Companions', she will now take the lead in this area to enable the Health Board to offer this service to our patients and their families, alongside our volunteers department.

Volunteer Service

Our previous reports have showcased the innovative ways in which our volunteers have offered their support and continue to be extremely enthusiastic, committed and dedicated to the volunteer service.

Current activity

- Volunteers continue to provide meet & greet support to vaccination centres across the Health Board and recognised that their dedication and commitment has been integral to the success of the programme. In order to keep up with demand and to ensure there is sufficient cover, a steady stream of new recruitment sessions have been undertaken during December 2021. Like many other services during the pandemic we continue to utilise a digital approach where possible and successfully held virtual induction sessions during January 2022, with an additional 14 new volunteers joining us. To date there are around 84 active volunteers supporting the centres and monthly meetings with lead vaccination site managers continue to ensure volunteers are fully supported, kept up to date on plans and to monitor supply and demand

- The volunteer service continues to regularly meet (virtually) with the All Wales Volunteer Managers Network, which provides an opportunity to share current volunteer activity, discuss recent government and health board announcements and guidance. It also provides an opportunity for the Network to share updates and current / future volunteer projects going forward. In addition, it enables the network to share good practice verbally and Teams is utilised as a tool to upload helpful tool kits, documents and plans.

- The volunteer service continues to support active volunteers to become more digitally minded by holding catch up/information sessions. The live

sessions cover a variety of topics from wellbeing, arts, crafts & communication.

- We continue to work in partnership with other services and our Health Board Volunteers continue to support the Dietetics & Nutrition Teams supporting participants to attend online courses. To date our volunteers have digitally supported over 100 participants, enabling them to join and take part with the online sessions.

- Discussions have taken place with the Wellness Improvement Service (WIS) in Primary Care and plans going forward are to involve health board volunteers with a new initiative. The initiative forms part of the NHS post COVID-19 Planned Care Recovery programme and is aligned with various operational objectives defined by the Health Board's Integrated Medium Term Plans. The aim is for volunteers to support wellness coaches at various venues across the Health Board, to also provide support for participants.

- The success of our digital support work and involvement with Digital Communities Wales (DCW) has allowed volunteers to take part in annual reviews requested by Welsh Government. Moving forward discussions will be taking place in February 2022, to devise an action plan for future DCW training and support

- Fortnightly arts and crafts sessions have continued to take place following strict Covid 19 guidance. The sessions are an opportunity to learn new skills and share ideas on how we will be able to support, stimulate and enable patients through various arts and crafts in the future. The focus has been to support the well-being of those volunteers who are patiently awaiting a return to face-to-face contact with our patients and a service was planned in December 2021 at the Chapel in Glanrhyd Hospital, to invite volunteers and staff. However, this unfortunately had to be cancelled as a result of Infection Prevention and Control guidance. In order that all was not lost, one of our Hospital Chaplains recorded a virtual service at the church, which showcased the talented arts and craft volunteers' work, including handcrafted Christmas trees, decorations and a nativity. The service was shared on the Health Board's social media sites and discussions will be taking place throughout March and April 2022 to review where these items could be

placed within hospital settings to further promote our arts and craft volunteers.

- A number of volunteers have continued to take part in supporting the chaplaincy team with creative well-being sessions held virtually and at sites across the Health Board around 'Loss' with the focus being to support staff with mental health wellbeing during the pandemic. Discussions will be ongoing to review potential future dates for these sessions

- Several meetings have taken place (virtually) with the site manager at DSHP and a tour of the new health park has been undertaken. The plan being for health board volunteers to provide front of house meet and greet support during the working week

- Meetings have been held with chaplaincy to discuss the introduction of end of life companions and additional training for existing chaplaincy volunteers. A further virtual meeting took place, which included Heads of Nursing and Senior Nurse Managers, to discuss the potential new initiative and review areas where this could be piloted along with a review of the role description and information relating to the end of life companion volunteer project. The plan moving forward is for further meetings / discussions to take place and a virtual presentation to potential EOL volunteers, in order that they fully understand the role and additional training that would be required and an opportunity to share feedback on the initiative

- Plans for the proposal and timeframe of restarting work experience have still not been confirmed. This has led to the volunteer service receiving a constant stream of enquiries from people looking for work experience and asking us for advice. The plan is to update the volunteer service internet and intranet page in order that the different departments are explained fully and also an opportunity to sign post, further promote and showcase health board volunteers and their involvement with different projects, provide links to good news stories and sign post to appropriate service within the Health Board.

- We continue to engage with our local community volunteer centres (CVC's) and other third sector organisations to explore current activity and opportunities to work in partnership moving forward.

Veterans

The Patient Experience Team is linking in with colleagues in Mental Health to understand the process the Health Board has in place to meet the criteria set down in terms of veterans who have suffered injuries in the line of duty.

Review of the Health Board's internet/intranet pages is due to be reviewed to ensure the information is reflective of the services the Health Board has in place to support veterans.

The Health Board continues to maintain a presence on the Cwm Taf Morgannwg Armed Forces Covenant Panel to ensure that we engage with partners in health and third party stakeholders to provide a voice for our communities.