GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

HEALTH AND CARE STANDARDS

ANNUAL AUDIT REPORT

2022

Contents

Executive Summary

The findings from the 2022 Annual Health and Care Standards operational audits, patient survey and staff survey are presented in this report. The narrative of this report will focus on the areas of good practice identified by the operational audit, our patients, and our staff, as well as attempting to recognise and explain any areas of concerns that emerge from the findings. When making comparisons to year-on-year results, it must be recognised that there are limitations in making summative comparisons as the number of areas undertaking the audit has increased year on year.

Feedback from patients confirms the high standards of care provided across the Health Board with an overall satisfaction rate of 90% albeit a slight decrease to the 93% achieved last year. They are also complimentary towards the attitude and behaviour of staff and nearly all patients (99%) who participated in this year's audit felt that they had been 'always' or 'usually' treated with dignity and respect during their stay or attendance to hospital.

There are two low scores this year, the first relating to the ability to speak Welsh to staff if needed with an overall patient satisfaction rate of 86% however it's heartening to see an increase on last year's 77%.

The second was related to getting enough sleep and rest, with a score of 88% a slight increase from last year's 86%. Sleep and rest in our hospitals is a continual challenge for us and we need to continue to think creatively on how we can improve this experience for our patients.

Feedback from staff remains low overall and sees a decrease this year to an overall satisfaction rate of 67% in comparison to last year's 78%.

The 3 elements that received the lowest score were:

1. Make you feel a valued member of the organisation and have a sense of belonging (55%) a stark decrease to last year's 78%, some work needs to be undertaken to understand this further

2. Make you feel safe at work (62%) a reduction on last year's 82%

3. Make you feel proud to be a nurse / allied health professional (60%) Whilst this score keeps us in an AMBER position it must be noted that it's a worrying decrease of 22% from last year's 82%. (See Staff and Resources section p.58)

The operational audit findings have confirmed a few key areas for improvement.

Top 3 areas of good practice

1. Implementation of Safe to Start across sites (p. 17)

2. Introduction of a standardised Virtual Visiting service (p.42)

3. Ongoing successful implementation of the Welsh Nursing Care Record (p. 47)

Top 3 areas for improvement

1. **Safe Care** – How can we ensure good patient hydration?

2. **Dignified Care** – How can we improve the environment of care of care for patients and their families. For example, providing privacy for patients and their relatives during visiting?

3. **Individual Care** – How can we improve the assessment and care of patients experiencing delirium and those patients who have a diagnosed learning disability?

The detailed results of the audit are presented in this report

"I would like to extend my gratitude to all the patients, carers and staff involved with the 2022 Health and Care Standards audit process and for providing assurance of where we are delivering excellent standards of care and for identifying where we need to focus our continuous quality improvement during 2023 and beyond."

Greg Dix

Executive Director of Nursing

Background

The Health and Care Standards provides the framework for how services are organised, managed, and delivered on a day-to-day basis. They establish a basis for improving the quality and safety of healthcare services by providing a framework against which standards of care can be measured and highlight focus areas for improvement.

The 22 Health and Care standards have been designed to fit with the seven quality themes which were developed through engagement with the public, patients, clinicians, and stakeholders.

The benefits of the engaging in the annual audit are outline below:

E*nables patients/carers to:*

- Share their views and experiences on what we do well and where we need to improve, which will be used to help improve the services we provide.
- Have a voice in the quality of the care they receive.
- Be central to the design of new services to ensure they meet the requirements of our populations.

Empowers our workforce to:

- Make a difference and ensure ownership of their practice.
- Have a voice in the care that they provide and ensure the focus is on essential elements of care and caring.
- Identify areas of good practice and highlight issues for concern.
- Develop action plans to monitor change.

Enables organisations to:

- Have a mechanism to monitor/measure the quality of nursing care.
- Develop organisational policies and procedures.
- Identify key themes for improvement.
- Adopt a culture of openness and transparency with the quality standards.

Assessment

Compliance Matrix:

The agreed compliance matrix for all elements of the audit

Equal to or greater than 85%
51% to 84%
50% or less

Triangulation of data:

The results from this audit are a part of the wider picture of the services being provided in the organisation. This report will refer to information from other data sources as it helps us to triangulate the information available to us to determine if our organisation is doing the right thing well and providing care which is dignified, safe and effective to meet the needs of individuals.

Source of the data:

Individual question compliance – the source of the data in this report is taken from the Health & Care Monitoring System. The audit includes percentage as well as (Yes/No) type responses for the audit questions. In addition, for the staff and patient surveys a scale of 'Always', 'Usually', 'Sometimes' and 'Never' was introduced.

Interpreting the results

Overall Summary

The HCM audit involves asking patients about their experiences of care and reviewing delivery of care and the assessment of the operational application of the 22 HCSs. This included:

- Examination of patient records to measure compliance against the standards
- Observation of clinical practice
- Environmental assessment

It is important to note that some questions are not included in the operational audit and patient surveys for all areas.

Patient Experience Summary

"I was brought into hospital and was expected to die. Once I recovered my family and I could not be more impressed by the excellent nursing and consultant teams care afforded to me."

(Patient, Ward 5, RGH)

Understanding the experiences of patients, and their relatives/ carers is a key priority for the Health Board, and the HCS audit Patient survey is only **ONE** method by which we can monitor the standard of care provided and better understand the patient experience.

Between 1st April 2022 and 30th June 2022, a total of **646** patient experience surveys were completed across the participating clinical areas. This is compared with the **1,307** surveys completed in 2019. **444** (69%) were completed by the patient/service user, **62** (10%) by a friend/ family/carer and 54 (8%) completed with the support of a Healthcare Professional.

The results of this year's patient survey demonstrate that many patients were satisfied with the standards of care that they received from the Health Board and are complimentary regarding the professional and respectful behaviour of most of the staff. The survey also demonstrates that we do not get it right all the time and this feedback is essential to improve practice. When asked to rate their overall satisfaction with the care provided service users gave the organisation a rating of 90% enabling the Health Board to maintain a RAG rating of green. This is to be commended when considering that the surveys were undertaking during the height of the pandemic

Service User Question	Overall Rag % 2018	Overall Rag % 2019	Overall Rag % 2020/21	Overall Rag % 2022
On a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall experience?	**90%**	**89%**	**93%**	**90%**

Highlights for the Service User Experience

The outcome of this years' patient survey does not vary greatly from the findings of last year's survey. Patients are telling us that they are being treated with dignity and respect. Patients are telling us that staff are kind, helpful and polite. In addition, nearly all patients who responded feel safe.

However, patients are not always able to speak to staff in Welsh if needed. Patients are not having enough sleep and rest. The survey outcome acts as a reminder of what we are doing well most of the time and what we need to improve to make the experience of all service users better.

"Arrived nervous agitated, disoriented completely out of my comfort zone, but from the moment I was met in the car by Bethan who also kindly brought me a wheelchair. My perception began to change and so it went, still a scary time but literally every member of staff was superb, friendly helpful kind and empathetic still not a nice time when you have an operation, but certainty helps 100% by the people on the ward."

"getting sleep was an issue during the night some staff could of shown more consideration by lowering their voices, which of course woke the patients many times through the night and early hours of the morning. however I am very grateful to all the staff"

(Patient, Ward 12, RGH)

"Since my admission I have been treated with nothing more than respect, kindness and dignity off staff and the care received is second to none, should say all staff is A1+. When calling for help with something as rushed and busy as they are they are with you as quickly as possible and always polite and helpful."

(Patient, Ward 6, PCH)

"Everything has been brilliant; I was really nervous after so much scaremongering but honestly I can't fault how the hospital is being run."

(Patient, ACEU, RGH)

Staff Survey Summary

Between 1st October 2020 and 30th April 2021, a total of **249** staff surveys were completed across the participating clinical areas.

Staff Survey Question	Overall Rag % 2018	Overall Rag % 2019	Overall Rag % 2020/21	Overall Rag % 2022
Using a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall satisfaction with your organisation	**69%**	**70%**	**78%**	**67%**

Highlights for the Staff Survey

The outcome of this years' staff survey varies from the findings of last year's survey.

Staff are telling us that they can access up to date information which supports them in doing their job. Whilst ¾ of staff who responded feel that the organisation supports them in having the knowledge and skills to deliver a consistent standard of compassionate care. Furthermore 89% of staff feel that we put local citizens at the heart of everything we do.

It is however concerning to note that just over half of the staff surveyed do not feel a valued member of the organisation and do not have a sense of belonging. In addition, only 40% of our staff report being proud to be a nurse/allied healthcare professional.

In response to this feedback and other sources of information, we promoted and utilised our Values that were launched in October 2020. Values workshops are being delivered by local managers, heightening people's awareness of the importance of our values and its direct impact on patient outcomes. The Leadership Development program launched in March 2022 seeks to elicit behavioural change in our people managers across CTM, with elements of the program focussing on bestowing value on teams and upholding the tenets of compassionate leadership.

Introduction to our Values Sessions form part of nursing and overseas nursing induction events. Staff recognition through our Values based thank you cards / e-cards has been an effective vehicle for managers to thank staff who have upheld our Values.

Furthermore, a Values and Behaviours Health Check assessment tool has been successfully piloted, enabling the leader to identify specific areas of focus based on the shared experiences of their staff. Feeling valued is synonymous with feeling heard and the ability to provide feedback is essential.

Creating a culture of psychological safety is also a key priority as open and honest feedback cannot exist when people do not feel psychologically safe. The values health check reveals where psychological safety is not present enabling targeted support to be sensitively deployed.

In October 2022, our Senior Executive team embarked on a Reverse Mentoring program in partnership with our BAME Network colleagues. This is a strong signal to our staff that our senior leadership are open to learn more about staff experiences and for this to potentially influence their decision-making in the future.

Development of a CTM Nursing and Midwifery Strategy

The priorities of the Chief Nursing Officer have been developed to set the strategic direction for the Nursing and Midwifery professions. The specific areas of work are supported by and/or led by the Office of the Chief Nursing Officer at Welsh Government to aid delivery of **A Healthier Wales (2018*)***

The 5 overarching priorities which have been agreed are:

1. Leading the Professions
2. Workforce
3. Making the Professions Attractive
4. Improving Health and Social Care Outcomes
5. Professional Equity and Healthcare Equality

Work is underway to revise and develop a refreshed Nursing and Midwifery strategy that is underpinned by the above 5 priorities

Summary Operational Audit

The audit results demonstrate that the UHB achieved a level of compliance for the operational questions of > 85% in all 7 Health and Care Standards themes. The following table provides a breakdown of the operational scores and identifies that improvement has been made across 5 of the standards

Operational Audit Overall Theme Summary	**2017 %**	**2018 %**	**2019 %**	**2020/21 %**	**2022 %**
Staying Healthy	**69.0**	**78.1**	**87**	**86.5**	**88**
Safe Care	**92.1**	**94.0**	**93**	**96.3**	**96**
Effective Care	**85.4**	**88.9**	**91**	**93.1**	**91**
Dignified Care	**84.4**	**88.3**	**88**	**90.5**	**100**
Timely Care	**90.0**	**100**	**98**	**100**	**100**
Individual Care	**87.6**	**91.6**	**93**	**94.4**	**89**
Staff and Resources	**88.5**	**94.9**	**98**	**96.1**	**97**

Operational questions: Overall Standard Summary	**2017 RAG %**	**2018 RAG %**	**2019 RAG %**	**2020/21 RAG %**	**2022 RAG %**
Staying Healthy					
1.1 Health Promotion, Protection, and Improvement	68	78	87	87	88
Safe Care					
2.1 Managing Risk and Promoting Health and Safety	97	95	96	98	97
2.2 Preventing Pressure and Tissue Damage	93	98	95	96	98
2.3 Falls Prevention	91	94	96	97	98
2.4 Infection Prevention and Control (IPC) and Decontamination	97	98	98	98	99
2.5 Nutrition and Hydration	88	88	89	93	91

Operational questions: Overall Standard Summary		2017 RAG %	2018 RAG %	2019 RAG %	2020/21 RAG %	2022 RAG %
2.6	Medicines Management	95	98	95	98	99
2.7	Safeguarding Children and Safeguarding Adults at Risk	92	93	90	94	99
2.8	Blood Management	78	94	90	81	100
2.9	Medical Devices, Equipment and Diagnostic Systems	98	97	98	97	100
Effective Care						
3.1	Safe and Clinically Effective Care	80	89	93	93	87
3.2	Communicating Effectively	88	92	94	95	93
3.3	Quality Improvement, Research, and Innovation	89	75	98	92	100
3.4	Information Governance and Communications Technology	100	100	97	97	93
3.5	Record Keeping	85	89	89	93	92
Dignified Care						
4.1	Dignified Care	84	88	88	90	93
4.2	Patient Information	88	90	93	95	94
Timely Care						
5.1	Timely Access (paediatrics only)	90	100	98	100	100
Individual Care						
6.1	Planning Care to Promote Independence	87	91	92	94	86
6.2	Peoples Rights	100	100	99	98	100
6.3	Listening and Learning from Feedback	95	96	100	97	100
Staff and Resources						
7.1	Workforce	88	95	98	96	96

	Question	2017	2018	2019	2020 /21	2022
All excluding neonates, theatres, District Nursing	For this episode of care, is there evidence that the patient's smoking habits been assessed?	76%	81%	87%	89%	97%
All excluding neonates, theatres, District Nursing	For this episode of care, where the patient is identified as a smoker and wishes to stop smoking, is there evidence that they have been provided with information in relation to smoking cessation?	48%	64%	75%	68%	92%
All excluding neonates, theatres, District Nursing	For this episode of care, is there evidence that the patient's weight has been measured?	86%	89%	92%	91%	82%
All excluding neonates, theatres, District Nursing	For this episode of care is there documented evidence that where the patient's weight is unhealthy that they have been provided with information in relation to a healthy diet?	70%	73%	96%	91%	75%
All excluding neonates, theatres, District Nursing	For this episode of care has the patient's alcohol intake been assessed?	79%	81%	87%	92%	89%
All excluding neonates, theatres, District Nursing	Where the patient has an identified problem with their alcohol intake, is there an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	55%	67%	80%	79%	77%
All excluding neonates, theatres, District Nursing	For this episode of care has the patient's illicit substance use been assessed?	40%	59%	75%	72%	100%

	Question	2017	2018	2019	2020 /21	2022
All excluding neonates, theatres, District Nursing	Where the patient has an identified problem with illicit substance use, is there an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	43%	56%	57%	72%	75%
District Nursing	Is the community nursing service able to demonstrate that systems and processes are in place for patients and their carers to access appropriate health improvement opportunities within the community?	100%	100%	100%	100%	100%
District nursing	Is the community nursing service able to demonstrate that systems and processes are in place to achieve individual service user outcomes?	100%	100%	100%	100%	100%

The principle of staying healthy is to ensure that people are well informed to manage their own health and wellbeing.

People's health related behaviours are influenced by a range of factors including social, economic, and physical environment and mental well-being. By making it easier for people to adopt healthy behaviours we will reduce the burden of disease and help narrow the gap in health inequalities arising from long term conditions such as obesity, cancers, heart conditions, stroke, respiratory disease, and dementia.

This means:

- Rapidly reducing smoking prevalence
- Increasing physical activity and promoting healthy weight
- Preventing harm from a range of behaviours including substance use

The questions for this standard focus on promoting these healthy behaviours.

<u>Smoking Reduction</u>

Of the records reviewed a compliance score of 97% was achieved for the assessment of patients smoking habits, compared to 89% in 2020/21.

Notable Good Practice

- The health board's smoking cessation service offers free and friendly support to staff, inpatients and outpatients who wish to stop smoking and would benefit from one-to-one support. We have Over **200 'No Smoking Champions'** now located on all sites and in most wards, departments, and units.

- The Cardiovascular Risk Reduction Health Check Programme that aims to reduce premature mortality from CVD, targeting more socio-economically deprived areas where prevalence of CVD is highest.

Illicit Substances

This year we have seen a significant increase in the assessment of a patient's illicit substance use from 72% to 100% moving us from an AMBER position to GREEN.

Promoting Healthy Weight

Whilst it's disheartening to see that the records demonstrated a 9% decrease in compliance in the measuring of patients' weight (82% from 91% last year), the comments made by staff in the audit suggest that there were several patients who were too unwell to be weighed, in these instances staff should record an answer of N/A.

Notable Good Practice

The catering team in Cwm Taf Morgannwg UHB have been developing several initiatives to help patients, staff, and the wider population to make the healthier choice. Working with the dietitians, they introduced a range of healthier options. The healthier option meal deal runs Monday to Friday and includes two of your recommended five a day of fruit and vegetables.

In addition, the Bar Barista outlets offering coffees and teas that are only served with semi-skimmed or skimmed milk. As well as providing tasty, healthier, meal deal options. The restaurants at Prince Charles and Royal Glamorgan hospitals now offer a fresh, delicious salad bar.

The catering team have also developed a scheme to encourage patients, relatives, service users and staff to eat more fruit. The Fruit Loyalty Card scheme has been launched across Cwm Taf Morgannwg UHB – buy six pieces of fruit and get one free.

	Question	2017	2018	2019	2020 /21	2022
ALL except OPD	Do all patients wear an identification band which states their first and last name, date of birth and NHS number?	94%	98%	99%	99%	100%
ALL	Is the patient's identity checked visually and verbally prior to undertaking a procedure?	96%	99%	99%	100%	100%
ALL except Neonates, OPD, Theatres	For this episode of care, is there documented evidence that the patient has an up-to-date manual handling risk assessment?	88%	89%	96%	97%	99%
ALL Except Neonates, OPD, Theatres	For this episode of care, where the patient has an identified manual handling risk, is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	83%	87%	93%	97%	98%
ALL except Neonates, OPD	If a patient has been assessed as requiring bed rails, is there an up-to-date risk assessment in place?	87%	92%	95%	96%	96%
ALL	Within the clinical area, are all fire restraint doors free from obstruction or closed if not automatic self-closing?	95%	98%	94%	99%	98%

	Question	2017	2018	2019	2020 /21	2022
Paeds only	Is the Child/Young Person in an age-appropriate bed with cot sides/bed rails in situ?	100%	100%	100%	100%	100%
Endoscopy & theatres only	Is there evidence of the team brief and de brief being undertaken?	100%	100%	100%	100%	100%
Endoscopy & theatres only	Is there evidence that the department is compliant with the WHO checklist?	100%	100%	100%	100%	100%

The overall score for this standard remains consistently high across annual audits, demonstrating that the safety and welfare of our patients is taken seriously.

Patient Perspective: Many patients felt that they were made to feel safe whilst in hospital with 99% of the patients responding positively to this question.

Introducing Safe to Start

A new innovative approach to managing patient flow has been launched. The aim of Safe 2 Start is to bring together all ward managers to discuss staffing, capacity, quality, and safety across the hospital site in order to ensure all wards and departments are safe to start the day.

The daily meetings are a way for nurses and departments to express any concerns and to ensure the hospital can deal with the current pressures by ensuring that all wards are staff and working to full capacity and if not, for staff to be mobilised across the hospital to support each other.

The project has successfully been able to support numerous wards that were not safe to start due to staffing constraints and support the extremely busy emergency department to help cut long ambulance delays and bed waits through the identification of ward capacity and planned patient movement.

Embedding the Safe 2 Start concept was key to the delivery of improvement and change for the teams. We have created a structured approach for the teams to describe the demands on their wards, but also to understand the demands other areas are also seeing. In exposing all

ward areas to this, we have now seen a cultural shift where wards are owning and sharing the response to try and minimise and mitigate the risk that patients are experiencing on site.

The safety of our patients is the key priority across the Health Board and this new approach places the patient truly at the centre of all hospital decisions.

'Safe 2 Start' daily meetings are now in place across all community and acute hospitals in CTM UHB.

	Question	2017	2018	2019	2020 /21	2022
ALL except neonates	For this episode of care, is there documented evidence that the patient's skin condition has been assessed and discussed with the patient or advocate?	90%	97%	95%	98%	99%
ALL except neonates	For this episode of care, where the patient has been identified as requiring assistance with looking after their skin, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	98%	98%	95%	94%	98%

Standard 2.2 Preventing Pressure and Tissue Damage

Of the patients reviewed, 99% of the patients had evidence that their skin condition had been assessed and discussed with them or their advocate an increase of 1% compared to last year.

Of the patients who were identified as requiring assistance with looking after their skin, 98% had evidence that they had an up-to-date care plan, which was being implemented, evaluated and had been reviewed within the agreed timescale. An increase from last year's 94%.

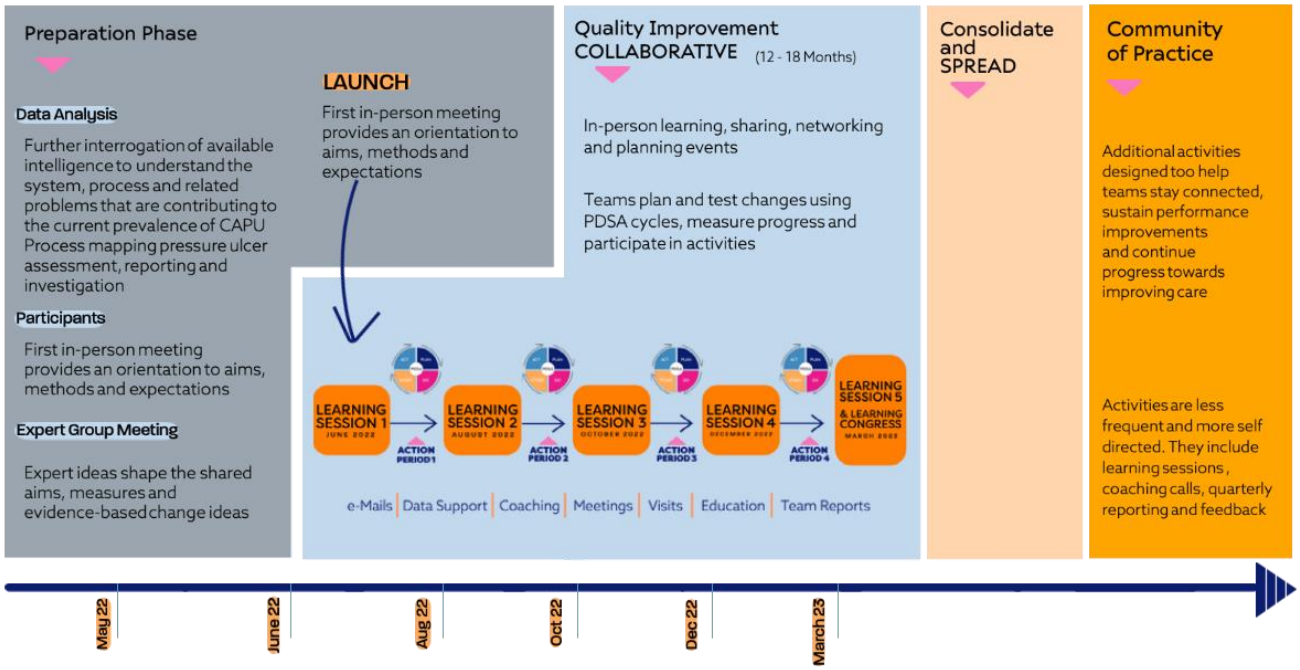
Avoidable Community Acquired Pressure Ulcer Improvement Collaborative Program

For the most part pressure ulcers are avoidable, and their incidence may be related to several system factors such as poor in-hospital flow and over-burden of nurses. When one arises it is painful, debilitating and can have life threatening and devastating impact on patients and their families

The Pressure Ulcer Prevention Collaborative program is a quality improvement initiative designed to support healthcare teams to reduce the incidence of avoidable pressure ulcers in the community.

The primary aim of this initiative is to reduce the number of **avoidable** pressure ulcers across the collaborative areas. A secondary aim is to increase the capacity and capability of frontline clinical teams to improve the care they deliver using quality improvement methods.

This proven methodology enables teams to become part of an active learning community learning from other teams and recognised experts around a chosen topic or focused set of objectives. The collaborative model provides a framework for improvement and sets a momentum and pace for executing sustainable change. The collaborative will run for 12-18 months following the methodology promoted by the IHI (Fig.1).

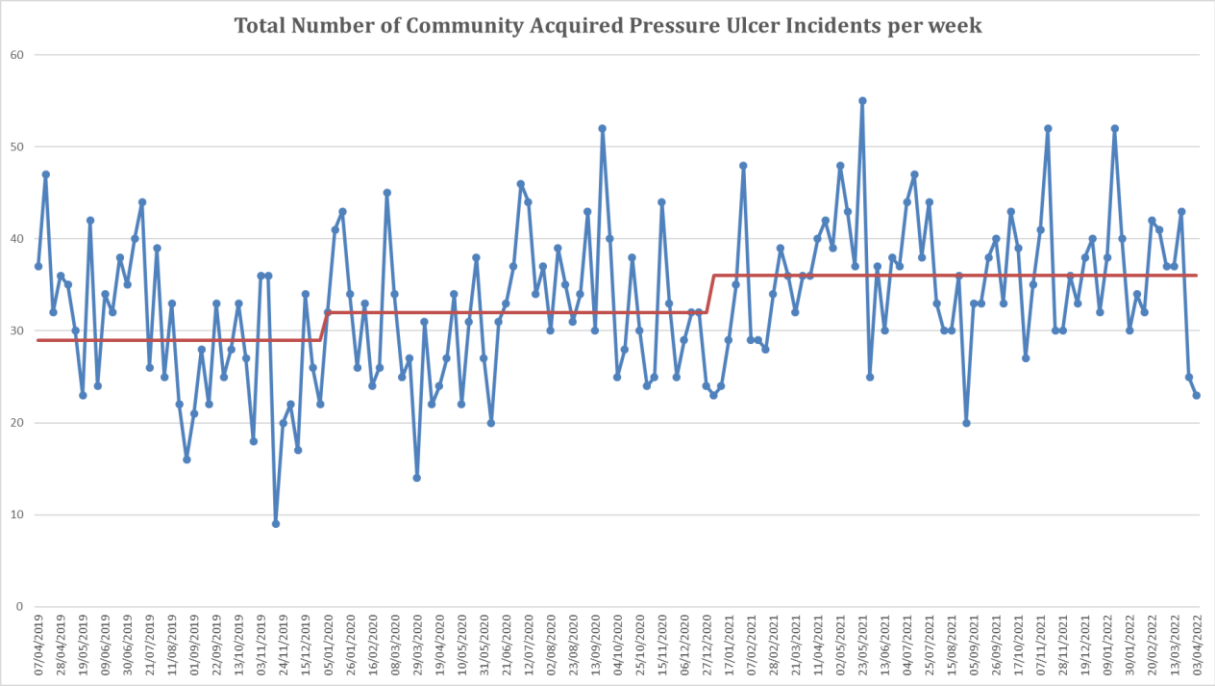


(Fig.1).

Discovery Phase: Understanding the problem

Further interrogation of available intelligence has helped us to start to understand the system, process and related problems that are contributing to the current prevalence of CAPU

The run chart below shows a steady increase in the total community acquired pressure ulcers over the last 3 years



The major themes for action cycles will be identified through a series of learning sessions with periods of action and facilitation between them to promote and produce sustainable change. Teams will be supported to take local ownership for improvement and to build processes of care that are reliable enough to achieve the goal. (*See below*)

Key Milestone dates agreed to date

1. **May 19th** – Inaugural meeting of Expert Faculty
2. **29th June** – Collaborative Launch Event
3. **16th September** - First Learning Session

Pressure Ulcer Investigation Panels

To support a culture of learning and improvement we have introduced a fortnightly programme of investigation panels where we scrutinise all pressure ulcers incidents. The panels consist of a head of nursing, tissue viability nurse and a safety improvement manager.

The senior nurse, ward manager and ward staff attend the panels and present their cases using the patients' nursing records which are reviewed to help identify any areas for improvement and learning.

Where an outcome of avoidable harm has been made which would indicate that there have been missed opportunities, a referral to safeguarding is made. An improvement plan which aims to address all missed opportunities with a view to improve care, patient experience and outcomes along with a proposed percentage reduction of pressure ulcer incidents at clinical level is developed and monitored for progress.

The benefits recently identified through this process include:

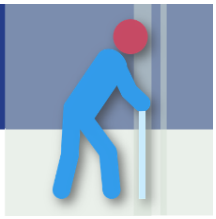
- the importance of using the correct equipment immediately
- escalation of any difficulties in obtaining equipment
- actual repositioning of patients (and not moving the patient back to the original position),
- use of knee brakes,
- use of cushions when a patient sits out

Patient Perspective:

"During your stay, were you given help and advice on how to prevent damage to your skin?"

93% of the patients answered positively to this. This is an increase on last year's 86%

SAFE CARE
Standard 2.3
Falls Prevention



	Question	2017	2018	2019	2020 /21	2022
ALL except neonates & OPD	For this episode of care, is there documented evidence the patient's mobility has been assessed and discussed with the patient or advocate?	96%	97%	96%	99%	99%
ALL except neonates & OPD	For this episode of care, where the patient has been identified as requiring support and/or assistance with mobility, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	91%	91%	96%	97%	98%
ALL except maternity neonates, paediatrics, OPD, theatres	For this episode of care, is there documented evidence the patient's risk of falls has been assessed and discussed?	91%	95%	96%	98%	99%
ALL except maternity neonates, paediatrics, OPD, theatres	For this episode of care, where the patient has been identified as being at risk of falls, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	84%	94%	96%	93%	97%

Patient safety is a priority for us and reducing the incidence of in-patient falls remains a challenge. Whilst we continue to test and develop initiatives to help us tackle this problem. Being in hospital does not mean we can completely prevent falls, but we are committed as a University Health Board to reducing the number of avoidable falls and any injuries that may occur as a result.

Of the patient records reviewed, 99% of the patients had documented evidence that the patient's mobility had been assessed and discussed. Of those patients identified as requiring support and/or assistance with mobility, 98% had evidence of an up-to-date plan of care, which was being implemented and evaluated and had been reviewed within the agreed timescale, a slightly improved position from last year

This year we have seen an increased compliance with our falls risk assessment and care planning. Of the patient records reviewed, 99% of the patients had documented evidence that the patient's risk of falls had been assessed and discussed. Of those patients identified as being at risk of falls, 97% had evidence of an up-to-date plan of care, which was being implemented and evaluated and had been reviewed within the agreed timescale (up 4% on last year's position).

The Quality Improvement team, central patient safety team and the corporate nursing team continue to support the Integrated Locality teams in a targeted approach to reducing inpatient falls. However, it has been recognised there is a need for a CTMUHB wide Falls Prevention and Management Group to be established (please see section 2.3 for further details).

Falls Scrutiny Panels

Hospital sites and community nursing have regular, robust multidisciplinary team falls panels, which include representation from a medic, physiotherapist, occupational therapist, pharmacist and nurse.

All Wales Falls Investigation Tool

The Delivery Unit and Once for Wales Datix team have confirmed plans for an All Wales Falls Investigation Tool to be launched, which will align with a similar tool which in in place for pressure damage investigation. The introduction of a robust investigation tool which will be used across all ILG's will aid consistency and support a clear outcome from panel, with agreed level of harm and whether the fall was avoidable or unavoidable.

CTMUHB wide Falls Prevention and Management Group

This group will support the Quality & Safety Committee's role and function in its responsibility for ensuring the quality and safety of healthcare in relation to the prevention, assessment and management of falls in line with Health Care Standard 2.2.

The terms of reference for this multidisciplinary group have been drafted and an initial meeting took place in June 2022.

The group will:

- Provide a means for the multidisciplinary representation of the Clinical Service Groups, patient safety team (s), corporate nursing team, safeguarding and quality improvement team to work to develop a robust quality improvement programme**,** which will be a vehicle for reducing the incidence of avoidable harm from falls.

- Monitor progress via an annual plan of work, which will include the creation and launch of CTMUHB Falls Strategy, the monitoring of compliance with NICE guidance and any national audits (e.g. fracture neck of femur audits), and the review of the CTMUHB Inpatient falls policy**.**

- Monitor all aspects of the "Putting Things Right policy" and any Safeguarding concerns as applicable to a patient who has sustained a slip, trip or fall within our health care setting; this will allow the patient experience and any financial penalties in terms of redress and claims to feature at the forefront of any improvement work

Whilst there is a need to focus on inpatient falls, it is recognised that there is an urgent need to work with our partner agencies for example Welsh Ambulance Service, Fire service and third sector teams to reduce the number of slips, trips, falls that occur in our community settings which often result in admission to hospital. This will feature heavily in the proposed CTMUHB Falls Strategy and form part of the Falls Prevention and Management Group agenda.

This Falls Prevention and Management Group will assist the Quality and Safety Committee in measuring the success of quality improvement goals by sharing learning and best practice and identifying trends which should be taken into account in improving and escalating risks.

The progress of the "Falls Prevention and Management Group" will be evaluated at their monthly meetings and report on a quarterly basis to the Quality & Safety Committee.

	Question	2017	2018	2019	2020 /21	2022
ALL	Are staff able to give examples of the correct procedure for infection control?	100%	98%	100%	100%	98%
ALL except maternity, peads, LD, OPD,	Are staff able to give examples of the correct procedure for isolating patients?	98%	99%	99%	100%	100%
ALL Except maternity, neonates, OPD,	Are all patients given the opportunity to wash or cleanse their hands with hand wipes prior to eating food?	92%	97%	94%	95%	100%

We achieved a green RAG rating in all three of the infection prevention & control (IPC) and decontamination questions.

The IPC work programme remains a priority for the health board and the IPC committee aims to ensure that the Board receive assurance that safe and effective policies for Infection Prevention and Control are in place. This has been under pressure in the last 2/3 years with the frequently changing guidance for managing the COVID 19 pandemic

Hand Hygiene:

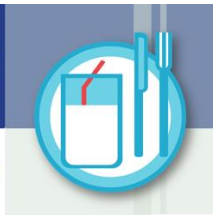
100 % of the areas confirmed that *all patients are given the opportunity to wash or cleanse their hands with hand wipes prior to eating food (up 5%*).

The annual audit does not include a general question on hand hygiene, but compliance is monitored on an ongoing basis using the Care Indicator module of the Health & Care Monitoring System. The expectation is that the audit is undertaken for a minimum period of 20 minutes (or until at least 10 opportunities are observed) across all clinical areas at least once a month and the auditor would observe if all staff disciplines working in patient areas have adequately decontaminated their hands, in accordance with the requirements of the WHO 5 moments.

The target compliance for this indicator is 95%. Several wards consistently achieve 100%, however, the result can be influenced by the time of day the audit is undertaken, the staff on the ward at the time and the number of opportunities for decontamination.

Spot audits by the IP&C team to triangulate the results obtained by the teams themselves demonstrated that there was still work to do to ensure consistency in both the audit process and the hand hygiene required.

The IPC Nurses perform an IPC investigation for other preventable bacteraemia infections, for example urinary catheters. This is shared with the Ward/ District Nursing Team/ Bowel and Bladder team to investigate further and for sharing of lessons learned. This process is currently undertaken on paper, and the aim is to introduce an "IPC huddle" for these also.



	Question	2017	2018	2019	2020 /21	2022
ALL except Maternity, neonates, LD, theatres	Prior to eating, are patients that require help, assisted into a suitable position?	98%	100%	100%	100%	100%
ALL except Maternity, neonates, LD, theatres	Prior to meal service, are bed tables and communal areas cleared and tidied prior to eating?	93%	97%	100%	98%	100%
ALL except Maternity, neonates, LD, theatres	Are patients' meals placed within easy reach?	100%	100%	100%	100%	100%
Inpatient, paeds, MH & LD only	Is there evidence that the systems in place to enable staff to identify patients with special eating and drinking requirements are being implemented and their effectiveness evaluated?	96%	96%	97%	100%	100%
Inpatient, maternity MH, Day Units only	Are water jugs changed 3 times daily?	39%	35%	45%	85%	56%
ALL except Maternity, neonates, MH, theatres	Is fresh drinking water available for patients?	100%	100%	100%	100%	100%
ALL except neonates, MH, OPD, endoscopy, theatres	Are drinking water jugs and glasses within the patient's reach?	97%	100%	97%	99%	100%
Inpatient, ED, Maternity, MH & LD only	During a 24-hour period, are a minimum of 7 beverage rounds are carried out within your clinical area?	48%	56%	48%	70%	59%

	Question	2017	2018	2019	2020 /21	2022
Inpatient, ED, paeds, MH & LD only	Does a Registered Nurse co-ordinate every mealtime?	83%	76%	88%	85%	83%
Inpatient, ED, MH & LD only	Is there evidence that all members of the nursing team are engaged in the mealtime service?	98%	85%	97%	96%	97%
ALL except neonates, OPD, theatres	Is a range of snacks available for patients who have missed a meal or who are hungry between meals?	92%	87%	87%	92%	100%
Inpatient, ED, paeds, MH & LD, endoscopy only	Family/friends can assist at mealtimes?	100%	100%	100%	84%	97%

The Health Board is committed to providing and promoting good nutritional care, as nutrition and hydration are vital aspects of patient care. Early detection and management of nutritional risk across community and secondary care promotes well-being and supports better patient outcomes and improved recovery rates.

The 'All Wales Nutrition and Catering Standards for Food and Fluid for Hospital Inpatients' provides a framework for the nutrition and hydration needs of our patients which includes:

- The provision of nutritious meals that meet all patient's nutritional, therapeutic and cultural needs, and preferences.
- Easy availability of snacks at ward level.
- 'Protecting mealtimes' and promoting mealtimes as a crucial part of the treatment process.
- Supporting all patients to meet their nutritional needs; and
- Early enhanced nutrition for patients who are unable to meet their requirements.

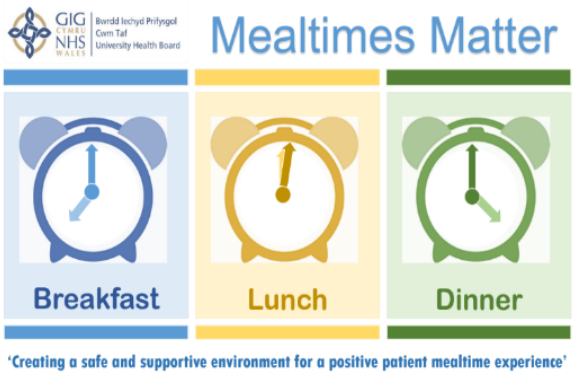
The audit includes several questions around mealtimes and the provision of beverages. We have a consistent low score relating to the changing of water jugs 3 times a day. When looking at the staff comments in the audit they refer to jugs being changed twice a day and then as required.

Conversely, we are scoring 100% for the question relating to the availability of fresh drinking water for patients. In addition, we continue to score low

with the question relating to beverage rounds. Some work needs to be done to understand why this is the case

We need to do some work to understand staff's perception of the three questions to ensure we are getting an accurate reflection of what is happening in clinical practice.

Registered Nurses have a professional accountability for ensuring patients receive appropriate food and assistance to eat where required, monitoring their food & fluid intake in accordance with the All-Wales Catering and Nutrition Standards for Food and Fluid Provision for Hospital Inpatients. Whilst there is an improvement in members of the nursing team engaging in mealtimes there is still some work to be done in improving the co-ordination of mealtimes by a registered nurse.



As a part of identifying priorities for 2020/21 we pledged to redesign our current protected mealtime's policy so that it is more conducive to a supported positive mealtime experience for patients.

A meal does not start with the appearance of food on a table, and it does not end with the last bite. It encompasses various aspects including the preparation of food, the anticipation of a meal, the environment in which it's eaten, the conversation during the meal, eating with dignity, the end of the meal and cleaning up. It is important to realize that an individual's experience around mealtimes extends far beyond the food.

Activities occurring before and after meals, menu choices and how they are offered, how the meal is introduced and the social interactions during mealtimes all need to be actively considered. Each one of these parts affects the individual's overall mealtime experience and consequently their nutritional status. The Patient Mealtime Procedure aims to improve the mealtime experience by:

- Allowing patients to eat meals without unnecessary interruption by limiting non-essential clinical ward-based activities and non-essential patient transfers.

- Ensuring that all patients receive a meal that meets their personal preferences and any specialist dietary requirements, such as modified textured food.

- Supporting clinical staff to prioritise mealtimes.

- Recognising and supporting the social aspects of eating.

- Providing an environment conducive to eating.

- Offering assistance with eating and drinking to those requiring it.

When this procedure is implemented fully it will help in the recovery of our patients empowering nursing and catering staff to provide effective nutritional care. Positive and encouraging behaviour when handling and serving food is essential in '*Creating a safe and supportive environment for a positive patient mealtime experience'*

<u>Using a 'Speaking Mug' to encourage vulnerable patients to drink more</u>

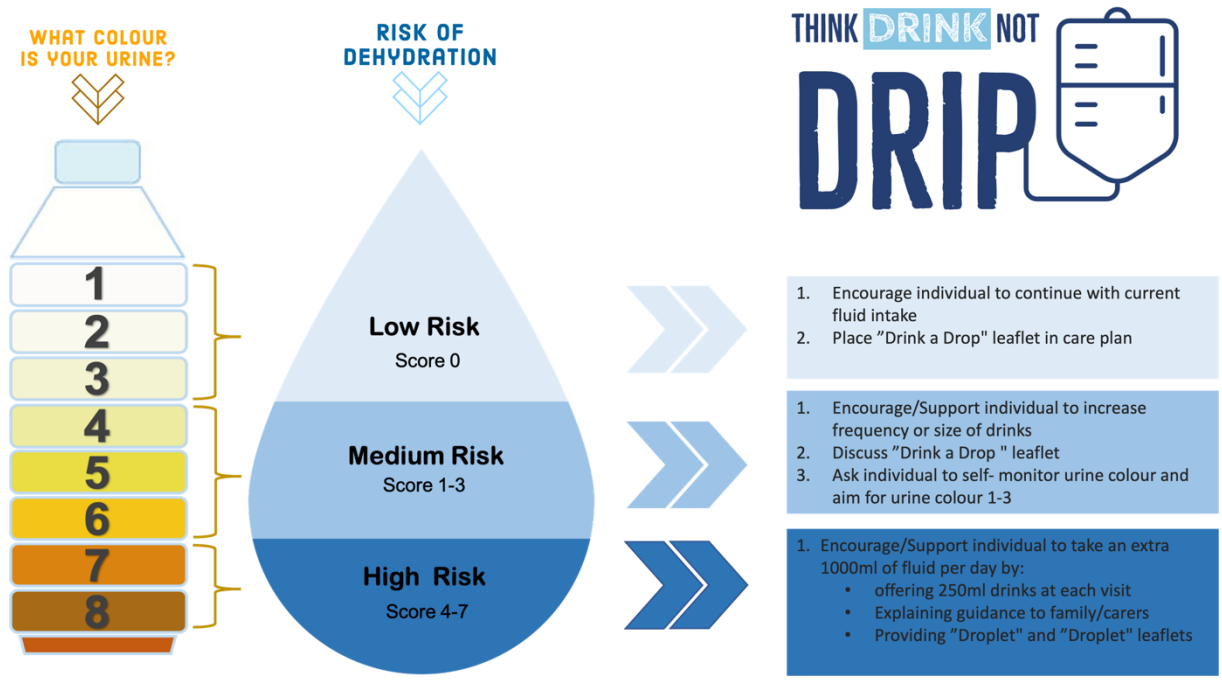
We have tested the use of Droplet® in a bid to see if it helped increase the amount of fluid drunk by our vulnerable patients in hospital. Droplet® is the first hydration aid to tackle dehydration by simultaneously supporting both individuals and carers. Droplet® helps those who need additional support or encouragement to stay hydrated.

We have been testing this across several wards within the Health Board and have seen an average increase of **43%** in the average amount of fluid drunk - that's equivalent to just over 4 8oz glasses of fluid per patient. We need to undertake further tests of change before committing to purchasing further units for the health board

Furthermore Droplet® is one intervention being used in a research study referred to as PARCHED (Prompting And encouRaging Community Hydration through Education). The study aims to test the possibility that education and/or Droplet® can help reduce ill-health in a catheterised community-dwelling population through empowering district nurses to

improve hydration. The study was due to take place over a two-year period but has stalled due to the impact and restrictions imposed by COVID

Building on this work we have been looking at understanding some of the behaviours that might be affecting patient and staffs understanding of the importance of oral hydration. We have developed a poster to raise awareness and need to test this in practice and measure the impact of any behaviour change



Further work is needed to understand the challenges around oral hydration in hospitals

Patient Perspective: The survey scores indicate that most patients are happy with the provision of food and drink and that they are provided with support when required. Overall satisfaction has remained above 97% for all questions.

	Question	2017	2018	2019	2020 /21	2022
ALL except OPD	Are all medication charts completed with the following information: patient demographics and allergies and it is clear whether there is more than one medication chart?	87%	95%	90%	100%	98%
ALL	Is the patient's identity checked visually and verbally prior to giving medication?	96%	99%	99%	99%	100%
ALL	Are all drug cupboards/trolleys locked and secure as per local policy?	93%	100%	100%	98%	98%
All except neonates & OPD	Has the nurse witnessed the patient taking the medication given to them?	100%	99%	97%	97%	100%
All except neonates & OPD	Is there evidence that medication is taken in a timely manner and is not left on lockers/around patient beds?	100%	100%	91%	98%	100%
Neonates & Paeds	Are all medications checked by two qualified nurses?	100%	100%	100%	100%	100%
District Nursing	Is the community nursing service able to demonstrate clearly defined processes including policies and procedures for obtaining and storing medication and for medicines management?	100%	100%	100%	100%	100%

Of the medication charts reviewed, 98% of the charts had the patient demographics and allergies documented on them and it was clear whether there was more than one medication chart completed, however this was a slightly worsened position than last year.

Of those patients observed having medication, 100% of the patients had their identity checked visually and verbally prior to giving medication an improved position from last year

98% of the areas participating in the audit confirmed that all drug cupboards/trolleys locked and secure as per local policy. Where areas were not compliant this was addressed immediately to ensure compliance. Many high-risk areas such as Emergency departments and Theatres are using Mediwell electronic medication dispensary systems. This ensure restricted access and is only accessible with personal identification log in details or fingerprints so no need for keys. Further work is being undertaken with pharmacy to ensure the policy and audit questions relate back to clinical practice in line with local policies.

Additional data can be found in the visual below from the Controlled Drugs Audit. This is conducted monthly as part of the wider point review audits.

Insight detail

Generated on 25th July 2022

Controlled drug medicines and storage audit

Insight detail	Compliance over last 6 periods						Current	Improvement	Overdue actions
Audit	98.1%	97.8%	97.8%	98.2%	99.2%	95.2%	98.3%	▼	4

Low scoring Qs	Compliance over last 6 periods						Current	Improvement	Overdue actions
Q4. Is the nurse in charge clearly identifie? (Eg on duty, on patient at a glance board etc.)	100.0%	100.0%	100.0%	87.5%	100.0%	95.1%	100.0%	▼	
Q6.1. Does the nurse in charge know who has the keys?	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	▼	
Q6.2. Was the person holding the keys a registrant/ ODP?	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	➤	
Q10. Are the controlled drug keys separate from the main bunch of keys?	88.9%	100.0%	100.0%	100.0%	100.0%	88.1%	96.2%	➤	
Q18. The receiving person is NOT the same as the person who ordered the CDs?	88.9%	100.0%	85.7%	100.0%	100.0%	80.0%	95.8%	▼	0
Q20. Is there a record that ward CD stocks checked at least once in 24 hours and daily balances checked by two Registrants?	88.9%	75.0%	87.5%	87.5%	87.5%	69.4%	86.4%	▼	2
Q26. Are transfers of CD's to a new page recorded appropriately?	100.0%	100.0%	100.0%	100.0%	88.9%	96.7%	100.0%	▼	
Q27. • Date…	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	▲	

	Question	2017	2018	2019	2020 /21	2022
ALL	Can staff demonstrate they know the procedure if a safeguarding concern is identified?	93%	95%	97%	98%	99%
ALL	Can staff demonstrate they know the safeguarding lead nurse for their area and how to contact them?	100%	100%	100%	100%	100%

Safeguarding and Public Protection training is vital in protecting our service users, their families, and our communities from harm. Safeguarding Children and Safeguarding Adult training is identified as two of the Mandatory training requirements in the NHS UK Core Skills Training Framework. All staff must have achieved the competency level required to their role in relation to children, young people or adults who are at risk.

The corporate team ensures that appropriate training is available for all staff to ensure that they are confident in safeguarding people. Staff will achieve the competency they require through safeguarding training and dissemination of learning as well as research from Practice Reviews and Multi Agency Practitioner Forums.

There are four key dimensions of Safeguarding Training:

- Adults at Risk
- Child at Risk
- Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)
- DoLS/MCA

The safeguarding team participate in training development and delivery and host several training sessions on Health Board sites to facilitate accessibility for staff. Bespoke training has also been provided by the corporate team to individual staff groups on request where a specific need has been identified.

The Safeguarding Team has undertaken several events and exercises in 2021/22 to embed safeguarding culture and awareness across the health

board including a greater presence on social media and activities during Regional Safeguarding Week. Changes have and will be made to the delivery of safeguarding training for the Health Board for greater accessibility.

Safeguarding training for Adults and Children will be available both virtually and face to face from January 2023. Bespoke level 3 training for adults and children will also be offered to areas of low compliance, where there is an importance to ensure that staff have an appropriate level of knowledge and skills.

The Cwm Taf Multi Agency Safeguarding Hub (MASH) sits within the structure of the Safeguarding Board and acts as the single point of contact for all professionals to report safeguarding concerns across Merthyr Tydfil, Rhondda Cynon Taf and Bridgend. MASH facilitates safeguarding by working together, in one place, sharing information and making collaborative decisions. Through MASH, a more timely and proportionate approach to the identification, assessment and management of safeguarding, child and adult protection enquiries can be achieved.

Cwm Taf Morgannwg currently has two MASHs, one based at Pontypridd Police Station and the other in Bridgend. The success of these Hubs has been developed through a phased co-location of key statutory partners, including the police, health, probation, education, and local authorities. Cwm Taf MASH is the 'front door' for all adult and child safeguarding referrals, including high risk domestic abuse.

The MASH team are available 24 hours day 7 days per week inclusive of the Emergency Duty Team team for out of core hours 9-5pm. Within Health, there are four Public Protection Nurses based in MASH to provide support and guidance to all health colleagues, each allocated to a specific ILG and identified clinical areas for continuity and robust information sharing, they role is pivotal in the facilitate the delivery of the safeguarding agenda across CTM. Our Safeguarding and Public Protection intranet site provides all details for contact numbers for both MASH and the corporate team, relevant email address and information for safeguarding topics. This information is further shared in training and via all communication channels within our governance structures.

The team share learning from adult and child practice reviews and other relevant reviews or investigations. Whilst this is predominantly achieved through the Safeguarding Operational Groups and Quality, Safety and Patient Experience Groups. Further work is required to ensure learning is repeatedly shared effectively throughout the Health Board. Collaborative working with both primary and secondary care will identify further opportunities to provide early help and support with regards to community wellbeing. All Safeguarding policies will be reviewed and updated to reflect the risks and vulnerabilities identified within our communities.

Improved use of SharePoint, social media and comms will improve the ability to repeatedly share learning and key safeguarding messages across the Health Board and communities. Planned audits throughout several services will measure outcomes and evidence if shared learning and changes are effective.

A total of 3,027 safeguarding referrals were submitted by Health and recorded by Cwm Taf Morgannwg MASH for 2021-22. This is inclusive of 2,481 child at risk concerns, 438 adult at risk referrals and 108 related professional concerns relating to staff employed by CTM UHB. This is a reflection on staff awareness in identifying safeguarding concerns and reporting appropriately as guided by the Wales Safeguarding Procedures. The aim of the Safeguarding team is to continue raising awareness and supporting staff to be confident and competent to embed safeguarding within their daily roles and engage within the Safeguarding and Public Protection processes.

Deprivation of Liberty Safeguards and Mental Capacity Act

Deprivation of Liberty Safeguards (DoLS)

Since April 2009 the Mental Capacity Act has been supplemented by the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people who lack the capacity to consent to treatment or care in a hospital or a care home, where the care might involve depriving the person of their liberty. There is a supplementary Code of Practice for the Deprivation of Liberty Safeguards which explains how to identify when a person might be being deprived of their liberty, how deprivations might be avoided and, where necessary and in a person's best interests, how a deprivation of liberty can be authorised.

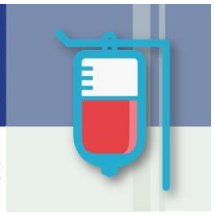
A DoLS authorisation application will need to be made for any patient where:

- You believe the patient lacks capacity to validly consent to being in hospital for care and treatment.
- The patient is under continuous supervision and control.
- The patient is not free to leave; and
- These circumstances apply for a not insignificant period of time.

(For more Information see Page 39)

SAFE CARE Standard 2.8

Blood Management



	Question	2017	2018	2019	2020 /21	2022
Neonates only	All staff involved in direct nursing care should have been trained in Blood Transfusion Administration	78%	100%	100%	95%	100%

Overall results for this question show an improved position in compliance of the staff involved in direct nursing care have been trained in blood transfusion administration of 100% a 5% increase on last year.

SAFE CARE Standard 2.9

Medical Devices, Equipment and Diagnostic System

	Question	2017	2018	2019	2020 /21	2022
ALL except neonates	Are any Manual Handling aids and slings regularly checked for wear and tear?	98%	98%	97%	95%	97%
ALL	Is all equipment used up to date with maintenance and calibration?	99%	96%	99%	99%	97%

The high rating for Standard 2.9 Medical Devices, Equipment and Diagnostics Services shows consistent green RAG rating, this demonstrates that ward staff are proactive in ensuring that equipment is checked and maintained regularly.

	Question	2017	2018	2019	2020 /21	2022
Inpatient areas, emergency departments, mental health and learning disabilities	For this episode of care, where there is doubt about the patients' capacity to make decisions, is there documented evidence that an assessment of capacity has been undertaken?	87%	86%	96%	94%	90%
Inpatient areas, emergency departments, mental health and learning disabilities	Where it has been identified that the patient lacks capacity, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	60%	84%	90%	90%	84%
Inpatient areas, emergency departments, mental health and learning disabilities	For this episode of care, is there documented evidence that where a patient's liberty has been restricted, that a Deprivation of Liberty Safeguard application has been made?	92%	96%	93%	97%	87%
Inpatient areas, emergency departments, mental health and learning disabilities	Where it has been identified that the patient's liberty is being restricted/deprived, is there evidence of an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	80%	97%	84%	90%	76%
Paeds	Are staff able to demonstrate they are aware of the Paediatric Best Practice" guidelines and how to access this document?	100%	90%	100%	100%	100%

Mental Capacity: The Mental Capacity Act (MCA) 2005 has been in force since October 2007 and places the person, who may lack capacity, at the centre of care. In the healthcare context, every adult with mental capacity has the right to decide whether to accept treatment, even if a refusal may risk permanent injury to health or even lead to premature death. If

somebody lacks mental capacity, they should not be deprived of treatment that they need just because they cannot make the decision.

Deprivation of Liberty Safeguards (DoLS): Since April 2009 the Mental Capacity Act has been supplemented by the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people who lack the capacity to consent to treatment or care in a hospital or a care home, where the care might involve depriving the person of their liberty. There is a supplementary Code of Practice for the Deprivation of Liberty Safeguards which explains how to identify when a person might be being deprived of their liberty, how deprivations might be avoided and, where necessary and in a person's best interests, how a deprivation of liberty can be authorised.

A DoLS authorisation application will need to be made for any patient where:

- It is believed that the patient lacks capacity to validly consent to being in hospital for care and treatment.
- The patient is under continuous supervision and control.
- The patient is not free to leave; and
- These circumstances apply for a not insignificant period of time.

The UHB has received investment from Welsh Government to improve the provision of the MCA and DoLS Service in preparation for the Liberty Protection Safeguards (LPS) implementation.

The Liberty Protection Safeguards will provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements.

The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the Deprivation of Liberty Safeguards (DoLS) system. The Liberty Protection Safeguards will deliver improved outcomes for people who are or who need to be deprived of their liberty. The Liberty Protection Safeguards have been designed to put the rights and wishes of those people at the centre of all decision-making on deprivation of liberty.

Due to Covid 19 the implementation of the LPS has been delayed by a year with an unofficial implementation date of Spring 2024.

The figures from the survey correlate with the DoLS Teams Welsh Government Data where the Health Board received the most referrals on record 1220 (+18% on last year, and +7% pre-Covid) which demonstrates that wards are correctly identifying patients that lack capacity to consent to their hospital admission for care and treatment require DoLS authorisations.

The DoLS Team has been heavily involved in training and education groups throughout the Health Board completing work with:

- YCC Improvement Group
- MCA Consent Group
- Ombudsman reports and actions at YCR
- D2RA
- Safeguarding Operational Groups
- LPS All Wales Task and Finish Groups
- Advocacy Support
- Bespoke MCA training with regards to consent, MCA, and legal implications in critical care treatment.
- Bespoke MCA/MHA interface training on the older person mental health wards.

	Question	2017	2018	2019	2020 /21	2022
ALL except OPD	For this episode of care, is there documented evidence that the patient's ability to achieve effective communication has been assessed and discussed with the patient or advocate?	93%	96%	98%	97%	97%
ALL except OPD	Patients have an up-to-date care plan in respect of communication needs?	80%	90%	85%	92%	94%
ALL except theatres	Is a nurse present to support the patient during formal senior contact between healthcare professionals' doctors/consultants/GP Questions and patients?	99%	98%	97%	99%	98%
ALL except neonates, day units, theatres	For this episode of care, is there documented evidence that an assessment of the carer's needs has been considered?	70%	78%	94%	86%	94%

Of the patient records reviewed, 97% had documented evidence that the patient's ability to achieve effective communication had been assessed and discussed with the patient or advocate (unchanged from last year); and of those patients identified as requiring assistance with effective communication, 94% had evidence of an up-to-date plan of care, which had been implemented, evaluated, and reviewed within the agreed timescale (a 2% increase on last year).

It was pleasing to note an increase in the compliance of evidence that a carer's assessment had been undertaken, following the significant decrease of 10% last year.

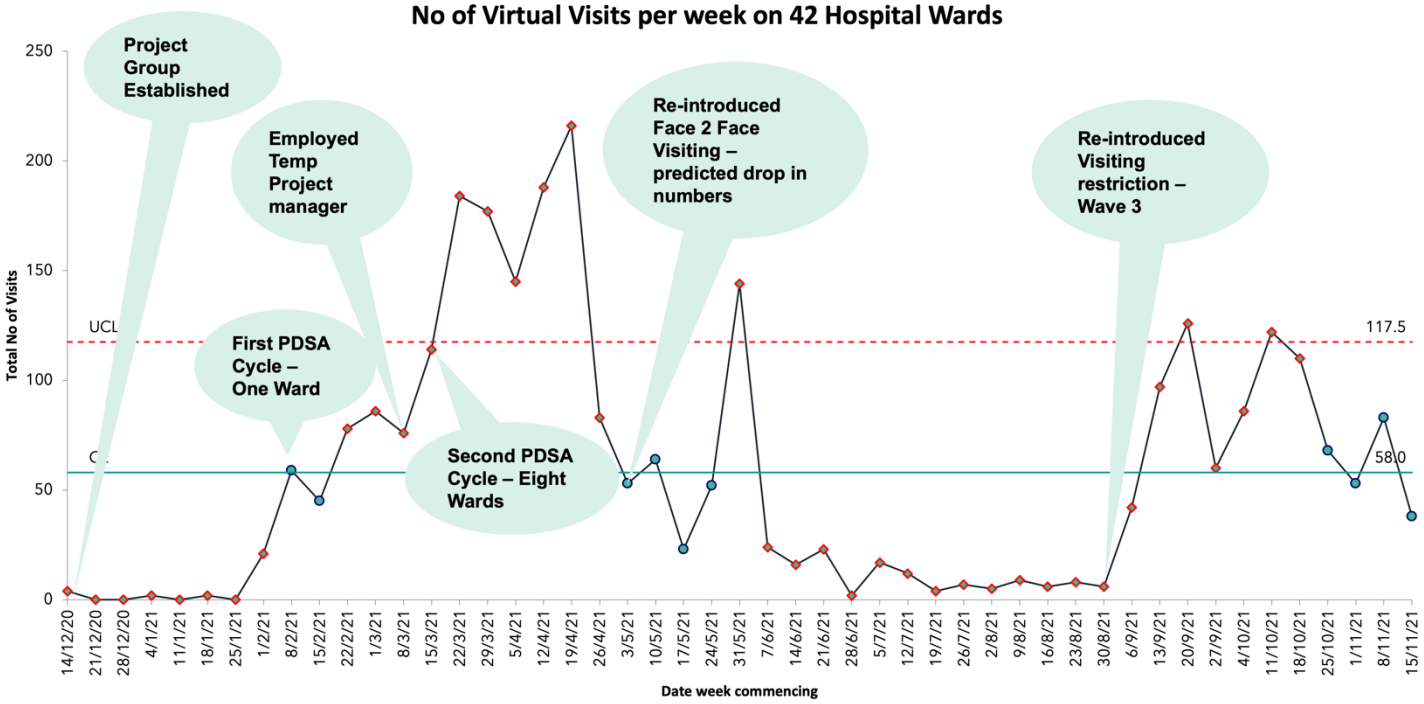
Introducing a Virtual Visiting Service

With its transformative and rapid impact on society, COVID-19 is driving significant changes in our healthcare system. And whilst this has been a catalyst for the need to introduce a virtual visiting service, we must not develop the service for this reason only. Beyond the COVID-19 pandemic and indeed before we know that there are many reasons why relatives/carers may not be able to visit their loved one in hospital. Some examples include simple geography (living away), those who may be housebound and those who are unable to get to the hospital due to transportation issues, to name a few. We know that digital technology has enabled people to stay connected during the crisis and we believe that this can benefit our population beyond the crisis too. With more interactions moving to virtual healthcare models, such as telehealth, we are reimagining how patient care is delivered now and in the future. Our aim was to introduce a Person Centred Virtual Visiting service, to support patient mainlining contact with their relatives while they are in hospital and for whatever reason this cannot be face to face.

What we did

1. Identified key administrators for attend anywhere access
2. Secured and prepared the hardware and software for use
3. Provided Training & technical support for patients & staff
4. Developed Guidelines & resources to support & ensure privacy & security.
5. In partnership with our communications team, developed a communications strategy and resources to support this
6. Undertook an equality impact assessment to ensure we are inclusive of all our citizens needs

The impact of the project can be seen in the run chart below.



We were able to achieve a significant impact for patients and relatives by enabling them to experience / participate in key milestones despite being confined to a hospital bed

Sitting with patient, whilst relatives said their final goodbyes so that they knew patient wasn't alone.

Facilitated Sacrament of the Sick (Last Rites) for end-of-life patients.

Linked in with Crematorium so that patients could be virtually present during a loved one's funeral service.

The ability for us, with the help of relatives, to enable patients to see their pets

We also introduced patients for the first time to new additions to their families. (New babies)

We were able to sit with patients and their family and read letters aloud to them from home

	Question	2017	2018	2019	2020 /21	2022
District Nursing	Is the community nursing service able to demonstrate compliance with systems/ procedures/ policies in place to respond to service user and carer feedback?	100%	55%	100%	89%	100%
District Nursing	Is the community nursing service able to demonstrate a process to evidence achievement of outcomes which will include patient reported outcomes, a regular process to audit care plans and discharge records?	75%	75%	100%	89%	100%
District Nursing	Is the community nursing service able to demonstrate engagement with the Health Boards Quality Improvement strategy, using initiatives and projects to effect real, significant, and sustainable change?	75%	73%	100%	89%	100%
All	Are staff supported and engage in regular audits?	70%	80%	80%	100%	100%

District Nursing: The compliance rating for the question regarding compliance with systems/ procedures/ policies in place to respond to service user and carer feedback has improved this year from 89% to 100%.

EFFECTIVE CARE
Standard 3.4
Information Governance and Communications Technology

	Question	2017	2018	2019	2020 /21	2022
ALL	Can staff demonstrate they know how to ensure that confidential patient information is stored safely and securely?	100%	100%	100%	100%	100%
ALL	Can staff demonstrate they know how to report an incident, accident or near miss via the DATIX reporting system and where applicable conduct an investigation?	100%	100%	100%	100%	100%

All staff when questioned about how to ensure patient information is stored safely and securely were able to demonstrate the appropriate knowledge.

All staff were also able to describe the incident reporting process and mechanism for conduction an investigation, if applicable.

EFFECTIVE CARE
Standard 3.5
Record Keeping

	Question	2017	2018	2019	2020 /21	2022
ALL	For this episode of care, are the patient's demographic details clearly recorded (and where required, has a photograph) on all the patient's documentation?	96%	95%	95%	99%	97%
ALL except Neonates , OPD, Theatres	For this episode of care, is there documented evidence that each plan of care has been assessed and discussed with the patient or advocate?	83%	89%	93%	93%	90%

	Question	2017	2018	2019	2020 /21	2022
ALL except theatres	For this episode of care, are the contact details of the first point of contact recorded in the patient's documentation?	99%	95%	98%	98%	98%
ALL	Is the patient's preferred language clearly indicated in the nursing documents?	80%	82%	85%	88%	94%
ALL except neonates	Does the patient's documentation capture their preferred name and/or title?	83%	87%	85%	89%	86%
Inpatients, ED, paeds, LD, endoscopy, only	For this episode of care, where the patient has an identified swallowing problem, is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	82%	90%	100%	91%	94%
Inpatients, MH, LD, OPD only	For patients who require a food chart, is it signed by a registered nurse for each 24-hour period?	65%	79%	68%	80%	83%
ALL except OPD, theatres	For patients who require a fluid chart, is there evidence that they are kept up to date and evaluated?	94%	92%	99%	98%	75%

Keeping clear and accurate records is a requirement for Healthcare Professionals under their relevant Codes and guidance

The overall RAG rating for Record Keeping is green but the amber ratings achieved for individual questions indicate that improvement is required, in particular around the signing of food and fluid charts by registered nurses.

This is recurring theme from previous audits undertaken, and despite seeing small improvements year on year we need to continue to ensure our registered nursing staff are aware of their responsibility to sign food and fluid charts. In addition, we need to understand any barriers to them achieving this consistently.

Electronic Nurse Documentation

Cwm Taf Morgannwg continues to implement the Welsh Nursing care Record (a digital system to record adult inpatient care) and has successfully implemented this in 3 of our hospitals (Ysbyty Cwm Cynon, Ysbyty Cwm Rhondda, and the Royal Glamorgan Hospital). Prince Charles Hospital will be using the system by mid-September 2022 with the Princess of Wales Hospital planned for Q3/4 2022.

In total 4751 patients have had their care recorded digitally between August 2021-August 2022 with 386,509 digital entries completed. This is the equivalent of 246,458 Pages of A4 paper saved with associated printing cost savings.

A recent audit comparing paper completion to digital completion has demonstrated significant improvement in the completion of key documentation metrics, for example, patients' Spiritual and cultural needs were assessed in 25% of the paper record compared with 92% digitally.
The Implementation of the system has been well received with 69% of staff surveyed agreeing that it has improved the quality of documentation (Survey of 75 staff).

Interviews with 11 ward managers have explored the benefits seen by users with sample comments below.

The evaluation of the implementation and benefits realised will continue until fully implemented across the Health Board. Further releases and content are planned throughout 2022-2024 as part of the national programme to standardise and digitise nursing documentation.

	Question	2017	2018	2019	2020 /21	2022
ALL	If a patient's language of need is Welsh, do staff know how to access a Welsh speaking member of staff?	98%	98%	94%	97%	97%
ALL	For this episode of care, is there documented evidence that the patient's cultural needs have been assessed and discussed with the patient or advocate?	73%	77%	78%	80%	92%
ALL	For this episode of care, is there documented evidence that the patient's spiritual needs have been assessed and discussed with the patient or advocate?	73%	70%	74%	78%	88%
ALL except from theatres	Is there a facility for patients to talk in private to staff (e.g., a quiet room or office)?	97%	100%	97%	95%	95%
ALL except maternity, neonates. OPD, theatres	Is there a quiet room for patients to spend time with their visitors away from their bedside?	55%	61%	60%	69%	50%
Maternity & Neonates only	Are there facilities to preserve a mother's dignity if she wishes to express or feed at the cot-side i.e., patient screens?	100%	100%	100%	100%	
Inpatients, paeds, MH, Endoscopy, Day units	Within the clinical area, are all the bays single sex bays?	83%	85%	94%	73%	72%
Inpatients, paeds, LD, OPD, Endoscopy, Day units	Do all patients have access to single sex toilet and washing facilities?	81%	89%	91%	79%	82%

	Question	2017	2018	2019	2020 /21	2022
All except maternity & neonates	Is there a facility to preserve patient's dignity by communicating to others that care is in progress?	100%	100%	100%	98%	100%
ALL except neonates & theatres	Within the clinical area, are washing and bathing facilities suitable for all Patients?	90%	86%	91%	90%	97%
ALL except neonates & theatres	Within the clinical area, are toilet facilities suitable for all service users?	93%	96%	100%	98%	100%
Inpatients, paeds, MH & LD	Does the clinical area allow patients to bring in personal items to assist with patient orientation/familiarity?	100%	98%	97%	97%	100%
Inpatients, paeds neonates MH, LD only	For this episode of care, is there documented evidence that the patient's normal sleep pattern and needs have been assessed and discussed with the patient or advocate?	79%	86%	80%	84%	95%
Inpatients, paeds, MH, LD only	For this episode of care, where the patient has an identified sleep issue or sleep has been recorded as poor/disrupted is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	64%	83%	67%	86%	93%
Neonates only	Does the clinical area allow for a period of 'quiet time' during the day to ensure that babies have a period of rest/sleep period?	100%	100%	100%	100%	100%
Neonates only	Does the clinical area allow for the noise levels to be controlled at the cot-side especially during periods of rest and sleep?	100%	100%	100%	100%	100%

	Question	2017	2018	2019	2020 /21	2022
Neonates only	Does the clinical area allow for the lighting particularly during periods of rest and sleep to be individually controlled at the cot-side?	100%	100%	100%	100%	100%
Inpatients, ED, neonates, paeds, MH, LD only	Except for areas where care is taking place / close observation is required, are lights within the bed space switched off or dimmed at night?	98%	100%	100%	99%	100%
ALL except OPD	For this episode of care, is there documented evidence that the patient's pain has been discussed and assessed using an appropriate pain assessment tool?	87%	93%	83%	94%	99%
All except OPD	For this episode of care, where the patient has an identified problem with pain is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	78%	85%	74%	87%	100%
Neonates only	For this episode of care, is their documented evidence that the baby's comfort has been discussed and assessed using a developmental care tool?	50%	100%	100%	96%	
Neonates only	For this episode of care, where the baby has an identified disrupted sleep/rest issue i.e., Neonatal Abstinence Syndrome, there is evidence that there is an up-to-date plan of care that incorporates rest and sleep times, which is being implemented and evaluated and has been reviewed within 24 hours?	100%	100%	100%	100%	
ALL except ED, neonates, OPD, theatres	For this episode of care, is there documented evidence that the patient's concerns/anxieties or fears has been assessed and discussed with the patient or advocate?	76%	79%	82%	86%	91%

	Question	2017	2018	2019	2020 /21	2022
ALL except ED, neonates, OPD, theatres	For this episode of care, where the patient has expressed concerns, anxieties, or fears, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	**66%**	**68%**	**78%**	**80%**	**90%**
ALL except OPD, endoscopy, theatres	For this episode of care, is there documented evidence that the patient's hygiene needs have been assessed and discussed with the patient or advocate?	**88%**	**98%**	**99%**	**95%**	**99%**
ALL except OPD, endoscopy, theatres	For this episode of care, where the patient's hygiene needs have been identified is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	**93%**	**90%**	**97%**	**99%**	**96%**
District Nursing	Is there evidence that patient's self-care ability to meet their own hygiene needs have been met	**58%**	**82%**	**93%**	**80%**	**100%**
Inpatients, paeds, MH, LD, day units only	Are patients given the opportunity to go to the toilet before eating?	**96%**	**98%**	**100%**	**98%**	**100%**
Inpatients paeds, MH, LD only	For this episode of care, is there documented evidence that the patient's foot and nail condition has been assessed, and discussed with the patient or advocate?	**60%**	**68%**	**75%**	**86%**	**83%**
Inpatients paeds, MH, LD only	For this episode of care, where the patient has an identified risk or requires assistance with foot or nail care, is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	**51%**	**68%**	**70%**	**86%**	**94%**

	Question	2017	2018	2019	2020 /21	2022
ALL except maternity, OPD, day units	For this episode of care, is there documented evidence that the patient has been assessed using an evidence based oral health tool with respect to their oral health needs?	**93%**	**88%**	**98%**	**93%**	**99%**
ALL except maternity, OPD, day units	For this episode of care, where the patient has an identified risk or requires assistance with oral health, is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	**84%**	**92%**	**85%**	**95%**	**97%**
ALL except neonates	For this episode of care, is there documented evidence that the patient's toilet needs/continence has been assessed and discussed with the patient or advocate?	**90%**	**95%**	**98%**	**95%**	**99%**
ALL except neonates	For this episode of care, where the patient has been identified as requiring assistance with their toilet/continence needs, is there evidence that an appropriate assessment has taken place with an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	**84%**	**92%**	**85%**	**96%**	**99%**

1. Cultural and Spiritual Care:

Spiritual Care is an integral part of healthcare and endorses the need to respect the physical, psychological, and social life values and beliefs of individuals.

Of the records reviewed, 92% of the patients had documented evidence that the patient's cultural needs had been assessed and discussed with the patient or advocate and 88% had documented evidence that the patient's spiritual needs had been assessed and discussed with the patient or advocate, a much-improved position on last year moving us to have a green RAG rating.

2. Environment of care:

Whilst we achieve a GREEN rating for all areas having facilities for patients to talk in private to staff, we achieved an RED rating (50%) for being able to support patients to spend time with their visitors away from the bedside, a noted 19% decrease on last year. Whilst a day room facility is unavailable on many of the wards, we need to consider alternative ways in which we can support private time away from the bedside.

It's very important to note that there has been a slight increase in our compliance scoring related to single sex bays and single sex toilet and washing facilities. Under ordinary circumstances this can be challenging but it is likely that our response to COVID, particularly at its highest peaks has impact on this

3. Rest and Sleep:

Sleep plays a vital role in good health and well-being throughout a person's life. Getting enough quality sleep at the right times can help protect a person's mental health, physical health, quality of life, and safety.

We have seen a significant increase in our assessment and care planning compliance rating moving us to a green RAG score. However, when asking patients about getting enough sleep and rest, we received a score of 88% a slight increase from last year's 86%. Sleep and rest in our hospitals is a continues challenge for us and we need to continue to think creatively on how we can improve this experience for our patients.

4. Ensuring comfort, alleviating pain:

<u>Pain management:</u>

We are pleased to share an improved position in relation to the assessment and management of pain, achieving a GREEN RAG rating with a score of 99%. This can be attributed, in large, to the implementation and increased compliance of the All-Wales pain assessment tool

Patient Perspective: most of our patients continue to feel that they were, as far as possible, always / usually kept free from pain

Patient's concerns/anxieties

We continue to see an improving position with the assessment of patients concerns/anxieties and fears as we also do with the care planning and evaluation of the same. A further increase this year, sees us achieve a GREEN rating.

Patient Perspective: Most of our patients felt that they were always/usually made to feel comfortable.

Personal Hygiene Needs**:**

All areas continue to see a compliance rating of GREEN for the assessment, care planning and evaluation of patient's hygiene needs.

Patient Perspective: 99% of the patients felt that their personal hygiene needs were always/usually met.

Foot Care:

Previous audits have identified concerns around foot care and a significant amount of work has been undertaken to improve both assessment and care planning over the last four years. This year we have seen a 3% decrease in compliance to assessment, moving us back to an AMBER rating. However, it is re-assuring to see an increase in our compliance to care planning and evaluation of patients' foot and nail care. Enabling us to achieve a GREEN RAG rating

Oral Health & Hygiene:

Mouth care is an integral part of nursing practice. Maintaining good mouth care for patients in hospital is imperative in reducing the risk of Health Care Associated Infection and improving patient comfort, nutrition, and experience.

There has again been significant work undertaken in relation to oral health and hygiene, and this year's results show that there is continued compliance for this aspect of care.

Patient Perspective: 93% of the patients responded positively when asked if they were given help with their oral hygiene an unchanged position from last year

Toileting/continence needs:

Promoting continence is a very important nursing role. "Whether or not a patient can be helped to regain continence can have a huge impact on an individual's quality (of life) and wider health and social care" (Learning from Trusted to Care report 2015).

We have continued to see an improvement in compliance with patient records evidencing that the patient's toilet needs/continence had been assessed and discussed with the patient or advocate

And of those patients who had an identified need, 99% had evidence that an appropriate assessment had taken place with an up-to-date plan of care, which had been implemented and evaluated and had been reviewed within the agreed timescale (up 4% on last year).

Patient Perspective: 96% of the patients felt that we always/usually responded quickly and discreetly if they needed help to use the toilet. The comments made by patients give examples of when patients felt that staff did not achieve this, with one patient stating:

"Sometimes I had to wait as staff were busy, but they would always acknowledge my call and tell me they would come as quick as they could" whilst another patient noted that "getting to toilet at night not always timely".

	Question	2017	2018	2019	2020 /21	2022
ALL	Is there evidence to demonstrate that patient identifiable information is treated in a confidential and secure manner?	95%	99%	97%	99%	100%
ALL except neonates, theatres	For this episode of care, is there written evidence in the patient's clinical notes that the patient's consent to the sharing of information with others has been obtained?	76%	76%	88%	88%	85%
Neonates only	Does your unit inform parents that information regarding their baby may be shared with other professionals to ensure appropriate care?	100%	100%	100%	100%	100%
Maternity & neonates only	Is there evidence of information available for women and their families on infant feeding?	100%	100%	100%	100%	100%
Neonates only	Does the clinical area offer translation services and/or professional interpreters to parents?	100%	100%	100%	100%	100%
Neonates only	Does the clinical area have written information available in a language and format appropriate to their local community?	100%	100%	100%	100%	100%
Neonates only	In the clinical area, is there information available regarding unit facilities, local amenities, parking, visiting, local support groups and arrangements for going home?	100%	100%	100%	100%	100%

We have achieved an overall GREEN rating for this standard. However, there is some improvement work to be done in relation to ensuring that there is written evidence in the notes that the patient's consent has been obtained in relation to sharing of information with others.

Examples of good practice include:

- Lockable trolleys are used to store patient records.
- Confidential waste bins are provided on wards.
- Electronic system used where only staff have access.

Patient Perspective: Most patients are satisfied with the information they were given about their care with 96% of the patients responding positively when asked "how often did you feel that you and those that care for you, were given full information about your care in a way that you could understand"

	Question	2017	2018	2019	2020 /21	2022
Paeds only	Is there evidence that the Children and Young People have been correctly triaged on admission?	90%	100%	100%	100%	100%

The above question only applies to paediatric and health visiting areas and relates to the requirement to the recording of core information on the child and young person's admission to hospital. However, there are two questions included in the patient experience survey that relate to this standard.

Most of our patients felt that when they asked for assistance, they got it when they needed it. Patients continue to report that they felt that they were always/usually kept informed of any delays, for example appointment times, tests, treatment, discharge.

INDIVIDUAL CARE
Standard 6.1
Planning Care to Promote Independence

	Question	2017	2018	2019	2020 /21	2022
Inpatients, ED, paeds, MH, Endoscopy, theatre, day units only	For patients with no known diagnosis of dementia, delirium or other cognitive impairment at admission, there is documented evidence that within 72 hours of admission, the following screening question has been asked, Have you/has the patient been more forgetful in the past 12 months to the extent that it has significantly affected your/their daily life?	**76%**	**82%**	**81%**	**86%**	**82%**
Inpatients, ED, MH, day units only	For this episode of care, where the patient has an identified care need in respect of cognitive impairment, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	**75%**	**85%**	**78%**	**90%**	**90%**
ALL except neonates, OPD	For this episode care, is there documented evidence that the patient's level of independence has been assessed and discussed with the patient or advocate?	**93%**	**95%**	**98%**	**97%**	**99%**
ALL except neonates, OPD	For this episode of care, where the patient has been identified as requiring support and/or assistance to maximise independence, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	**90%**	**94%**	**97%**	**91%**	**95%**
ALL except OPD, Theatres	Where appropriate, do all patients have written evidence of a discharge assessment and plan?	**91%**	**93%**	**94%**	**96%**	**77%**

	Question	2017	2018	2019	2020 /21	2022
ALL except OPD, Theatres	Where appropriate, is there written evidence that the patient's family/carer has been involved in discharge planning?	**91%**	**89%**	**89%**	**95%**	**88%**
ALL except maternity, neonates, OPD, Theatres	Does the clinical area have access to mirrors for patients to use?	**95%**	**93%**	**94%**	**98%**	**94%**
Inpatients, ED, paeds, MH, LD only	Does the clinical area have supplies of toiletries for patients who have been admitted without them?	**96%**	**100%**	**100%**	**100%**	**100%**

Patients with dementia/delirium/Cognitive Impairment:

We have achieved an AMBER compliance rating in the compliance with the documentation that the following screening question has been asked for patients with a known diagnosis of dementia and so further improvement work is needed, a worsened position from last year.

We have achieved a GREEN compliance rating with care planning for a patient identified with a care need in respect of cognitive impairment where we have seen an increase in compliance this year

CAM-ICU Assessment for Delirium in Prince Charles Hospital

Background

Delirium is underdiagnosed in ITU and leads to longer admissions, increased complications, and poorer QOL post discharge. If it is not identified, control measures cannot be introduced to mitigate the impact. A multidisciplinary project is underway looking to improve the assessment of delirium on ITU units in Cwm Taf Morgannwg UHB

Challenges

Challenges were initially team awareness and appreciation of the importance of identifying delirium. Additional barriers around agency workforce, and challenges in terms of how it is recorded were mitigated as best possible

Objectives

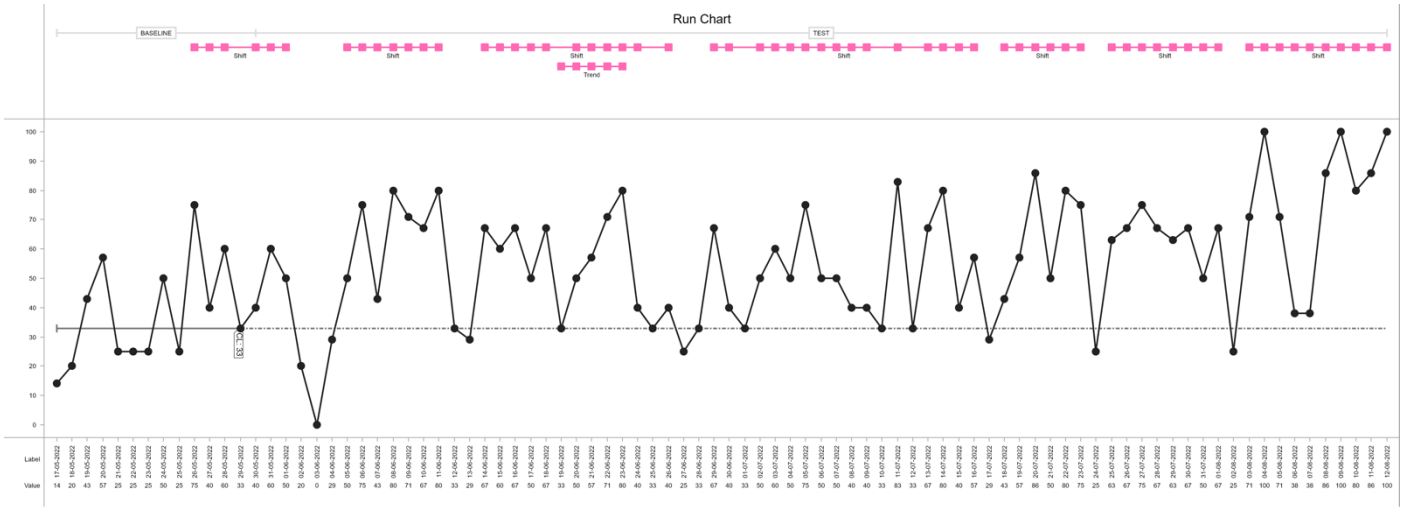
- Increase delirium screening to 75% compliance by the end of the year
- Measure daily compliance and administration errors
- Anticipate improved delirium identification

Solutions

A working party comprised of nursing, psychology, consultants, junior doctors, and member of QI faculty was set up to continuously review the data and plan new cycles of change. This was in liaison with the M&C faculty and advice from the core QI team.

Impacts

The work is ongoing however there has been a significant shift in favor of identification of delirium. Further cycles of change are needed to optimize screening and introduce control measures when delirium identified. The run chart below demonstrates the percentage compliance to delirium screening in ITU



Learning

Further work is ongoing however there is expected to be learning around environmental/human factors that contribute to challenges in delivering care that meets standards outlined in national guidance.

	Question	2017	2018	2019	2020 /21	2022
Inpatients and paeds only	Does the clinical area allow CYP/family/carers to bring in personal items to assist with CYP's orientation/familiarity/anxiety?	**100%**	**100%**	**100%**	**100%**	**100%**
Maternity & neonates only	For this episode of care, is there documented evidence that mothers who require breastfeeding support and/or assistance has been assessed and discussed?	**100%**	**100%**	**100%**	**100%**	**100%**
Maternity & neonates only	For this episode of care, where the mother has been identified as requiring support and/or assistance to establish breastfeeding on the unit, prior to going home, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the last 24 hours?	**100%**	**100%**	**100%**	**89%**	**100%**
Paeds only	Are there age appropriate playrooms for children/young people?	**100%**	**100%**	**100%**	**100%**	**100%**

We continue to achieve a GREEN compliance rating in all the areas highlighted for this standard.

	Question	2017	2018	2019	2020 /21	2022
ALL except theatres	In the clinical area, is there accessible information regarding how patients/relatives/advocates can raise a formal or informal concern?	**95%**	**96%**	**100%**	**96%**	**100%**
Neonates only	Does the clinical area allow parents to regularly feedback their experience of the service?	**100%**	**100%**	**100%**	**100%**	**100%**
Neonates only	Does the clinical area allow parents to be involved in the planning and development of service improvements?	**100%**	**100%**	**100%**	**100%**	**100%**

As with the findings of previous audits, it is pleasing that most wards and departments provide information on how to raise formal or informal concerns. Within CTUHB all patients are given the opportunities to give feedback and where a concern is raised the Patient/Carer should receive a timely response and action where required. Patient/Carer feedback is used to continuously improve services.

A joined-up approach between the patient experience team and the clinical education, quality improvement and audit leads sharing information and working together to make continuous improvements in care.

With **accessible patient experience data** which is shared ward to board and the emphasis on **investigation for learning not blaming,** CTMUHB is making continuous improvements to listen and learn from patient experience.

Cwm Taf Morgannwg University Health Board is committed to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve the quality of patient care, safety, and experience.

A framework of ensuring effective listening, learning, and improving is urgently required and has been a significant criticism of the Health Board in external reviews and audits such as the Health Inspectorate Wales/Audit Wales and NHS Delivery Unit review of quality, governance, and incident management processes. Effective learning and improvement processes has also been a cross cutting theme of concern within the Independent Maternity Services Oversight Panel reviews of our maternity and neonatal services.

This Listening & Learning Framework demonstrates how learning will be identified, triangulated, disseminated, and implemented in practice, to facilitate and embed a culture of appreciative enquiry and continually improving health care services.

The Listening & Learning Framework recognises that the Care Groups and Clinical Service Groups have internal governance and learning structures. This Framework, therefore, seeks to complement and build on these arrangements by adding a strategic approach to support the organisation to learn lessons from a range of internal and external sources, to store and use this learning to share knowledge, shape change and create opportunities to develop excellence in practice.

STAFF & RESOURCES
Standard 7.1
Workforce

	Question	2017	2018	2019	2020 /21	2022
ALL	All clinical staff wear identification badges	84%	92%	96%	93%	93%
ALL	All clinical staff comply with All Wales Dress Code	91%	98%	100%	99%	100%

The All-Wales Dress Code (2010) was developed to encompass the principles of inspiring confidence, preventing infection and for the safety of the workforce.

The principles set out in the code include:

- All staff will be expected to dress in smart (that is, neat and tidy) clean attire in their workplace.
- All staff will present a professional image in the workplace.
- Staff should not socialize outside the workplace or undertake social activities while wearing an identifiable NHS uniform.
- All clinical staff must wear short sleeves or elbow-length sleeves in the workplace to enable effective hand washing techniques.
- All staff must always wear clear identification.
- Staff who wear their own clothing for work should not wear any clothing that is likely to cause a safety hazard.

Staff are to be commended for their efforts to ensure that staff are complying with the All-Wales Dress Code (100%). It is a little concerning to see a decrease in staff's compliance with the wearing of identification badges, down 3%, scoring 93% this could be attributed to the heightened IPC restrictions because of the pandemic

Staff Survey

	Question	2017	2018	2019	2020 /21	2022
ALL	Our organisation aims to make sure you can access up to date information in order to be able to do your job. For example, access to policies, clinical guidelines etc. Do we achieve this?	91%	91%	92%	92%	91%
ALL	Our organisation aims to ensure that as an employee you are treated with dignity and respect. Do we achieve this?	75%	74%	75%	81%	68%
ALL	Our organisation aims to make you feel safe at work. Do we achieve this?	76%	76%	71%	81%	62%
ALL	Our organisation aims to make you feel you have a positive contribution to patient care. Do we achieve this?	79%	77%	79%	85%	68%
ALL	Our organisation aims to provide you with sufficient equipment to do your job. Do we achieve this?	74%	73%	75%	80%	75%
ALL	Our organisation aims to provide you with opportunities to enhance your skills and professional development. Do we achieve this?	72%	72%	70%	78%	74%
ALL	Our organisation aims to provide you with feedback on the outcomes of any incidents/accidents that you report or that are reported within your clinical area? Do we achieve this?	57%	59%	68%	77%	65%
ALL	Our organisation aims to provide you with opportunity to identify and learn from good practice to bring about improvements in care. Do we achieve this?	74%	75%	79%	85%	73%
ALL	Our organisation aims to provide opportunities for you to raise any concerns that you have. Do we achieve this?	75%	75%	73%	83%	74%
ALL	Our organisation aims to provide you with the opportunity to establish a work life balance. Do we achieve this?	63%	66%	70%	81%	67%

	Question	2017	2018	2019	2020 /21	2021/ 22
ALL	Our organisation aims to make you feel a valued member of the organisation and have a sense of belonging. Do we achieve this?	**60%**	**61%**	**64%**	**78%**	**55%**
ALL	Our organisation aims to make you feel proud to be a nurse / allied health professional. Do we achieve this?	**64%**	**64%**	**68%**	**79%**	**60%**
ALL	Our organisation aims to put local citizens at the heart of everything we do'. Do we achieve this?	**77%**	**71%**	**90%**	**63%**	**88%**
ALL	Our organisation aims to ensure that you have the knowledge and skills to deliver a consistent standard in the fundamental aspects of compassionate care. Do we achieve this?	**84%**	**82%**	**86%**	**90%**	**77%**
ALL	Our organisation aims to work together to be the best that we can be. Do we achieve this?	**76%**	**71%**	**74%**	**84%**	**64%**
ALL	Our organisation aims to strive to deliver and develop excellent services. Do we achieve this?	**74%**	**75%**	**72%**	**84%**	**67%**
ALL	Using a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall satisfaction with the care that you provide for your patients and their families?	**83%**	**81%**	**83%**	**86%**	**78%**
ALL	Using a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall satisfaction with your organisation?	**70%**	**69%**	**70%**	**78%**	**64%**

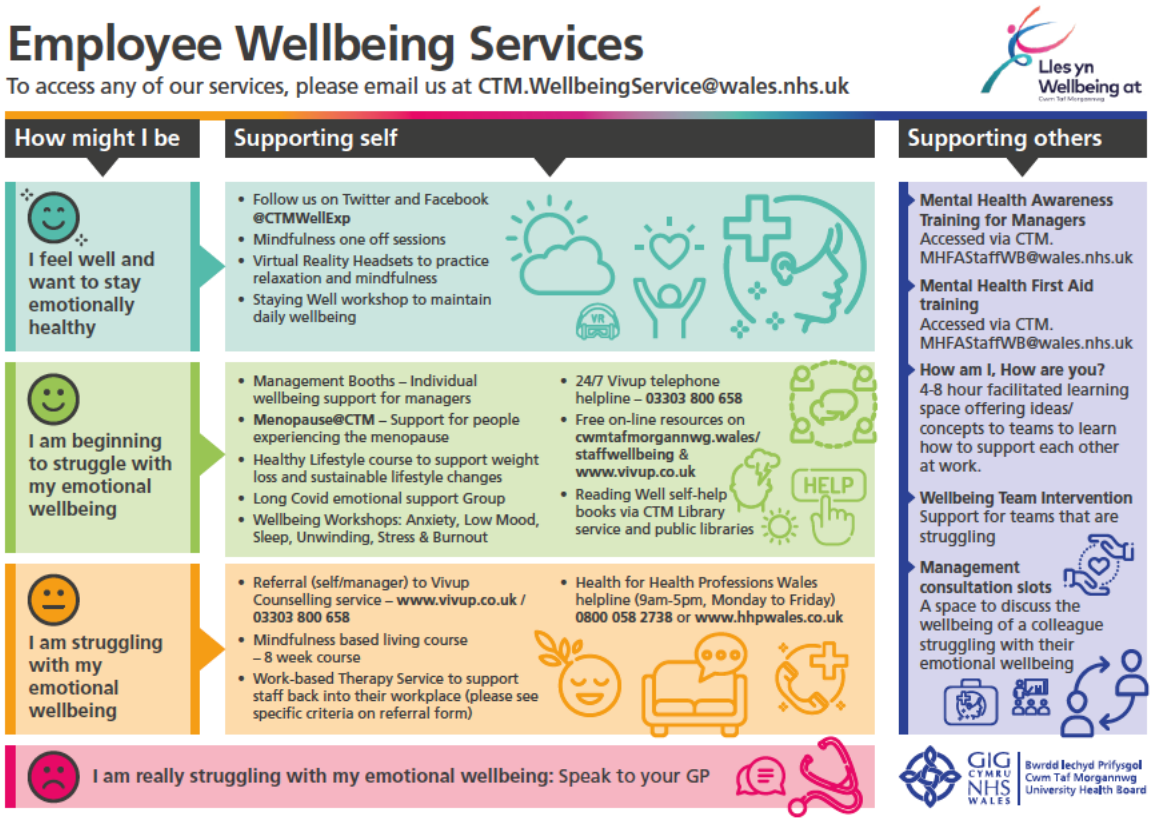
Overall, there is a downward trend in the responses received in this year's Staff Survey. This could be in part attributable to the unprecedented pressures staff have experience over the last two years with the pandemic. However, we must be mindful not to make assumptions and some significant work needs to take place to understand more fully the responses provided by staff

Some of the key themes identified include:

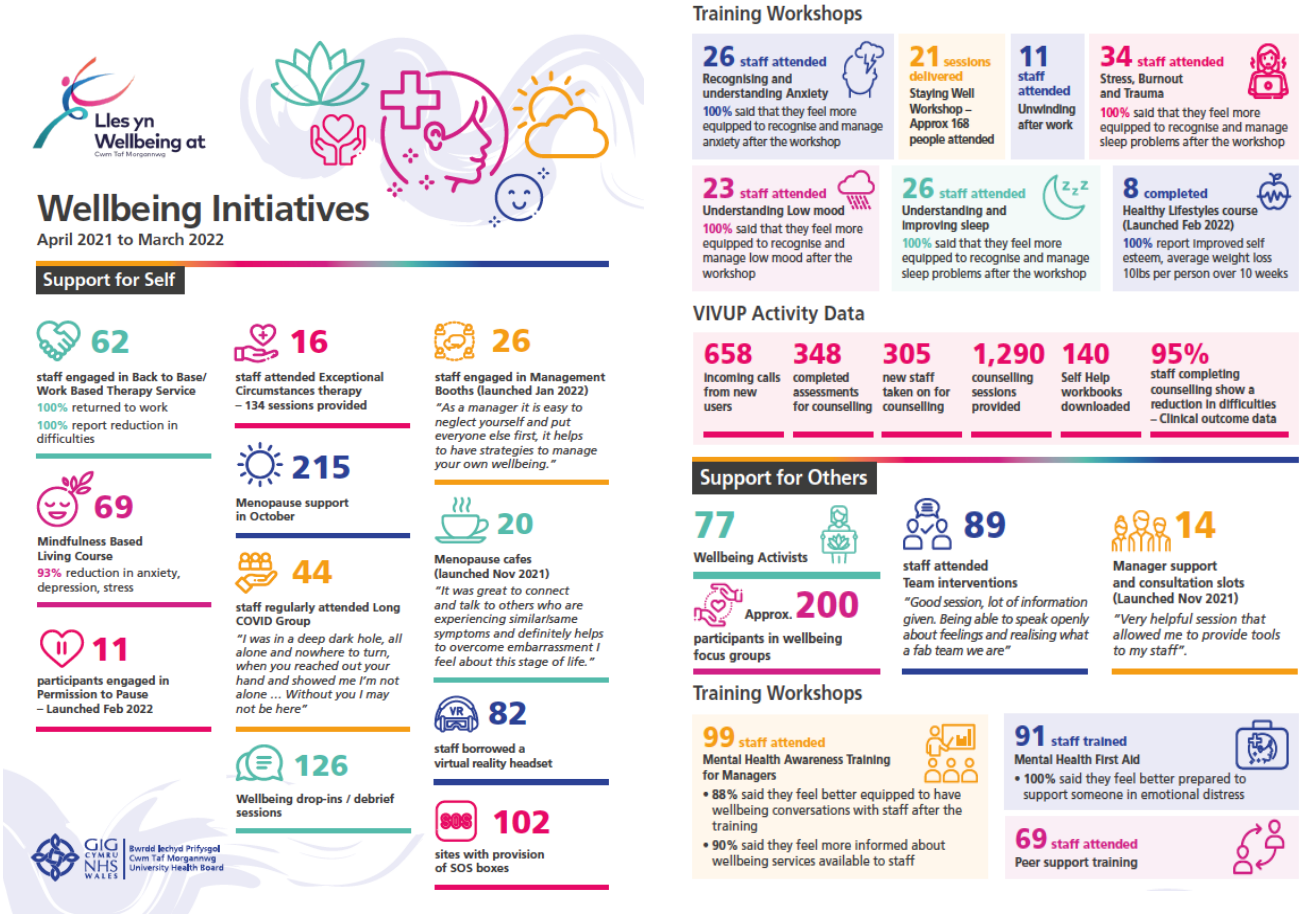
1. Training – often cancelled due to staffing
2. Lack of communication/feedback following an incident
3. Lack of staff
4. Poor skill mix
5. Don't feel valued – perception that organisation focuses on blaming staff when things 'go wrong'

The Wellbeing Service offers a stepped care approach matching the needs of staff to the intensity level of the intervention provided. We continue to contract an Employee Assistance Programme to provide 24/7 telephone support and counselling alongside CBT guided self-help workbooks. We also continue to provide a wide range of Mindfulness based groups and courses.

Over the past 12 months the Wellbeing Service has introduced several new initiatives based on the results of the 2021 Wellbeing Survey (Sleeping Well Course, unwinding after work course), on feedback from our Wellbeing Activists, managers, and other key stakeholders (Manager's Booths, Management consultation slots, how am I, How are you? Course). All the services provided are listed on our Emotional Wellbeing Care Pathway (below)



A summary of our outcome data, activity data and feedback from staff, are listed on our Dashboard (below).



We will be launching the 2022 Wellbeing Survey on 12th September 2022, and we will use those results to review our current service provision.

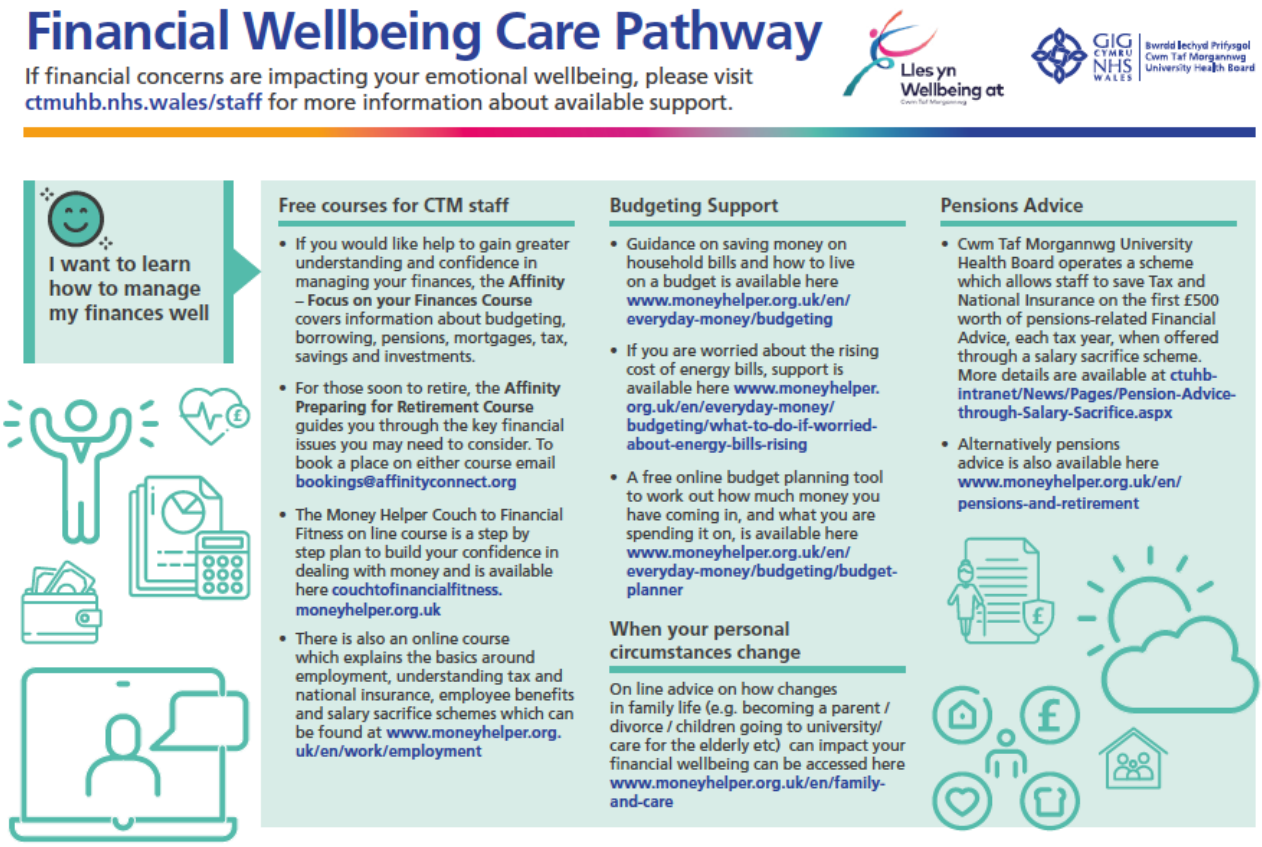
In the past 12 months we have launched a variety of services for staff impacted by the menopause – either directly or because they live or work with someone going through it. These include Menopause café's, Mindfulness for Menopause, Chill Max pillows and the Permission to Pause cause which looks at key lifestyle areas of reducing stress, improving sleep, nutrition, and exercise levels.

At the request of our male staff, we have launched Men's' Wellbeing @CTM in which we have collated wellbeing interventions specifically designed to appeal to our staff who identify as men.

Earlier this year the Wellbeing Service also launched a Healthy Lifestyles 10-week group which provides a psychologically informed course encouraging staff to adopt healthy approaches to nutrition, hydration, exercise, sleep and to understand their relationships with food. The outcome data so far has been very encouraging. Data from the first 4 cohorts demonstrated that 89% of staff who attended reported a loss in

weight, with an average loss of 8.7lbs per person. This is considered a sustainable and healthy loss in weight over a 10-week period. 92% reported an increase in self-esteem, whilst 100% reported an increase in psychological health and quality of life.

In recognition of the current financial pressures that staff may be experiencing and the negative impact that may be having on their emotional wellbeing, we have also put together a financial wellbeing care pathway which sign posts staff to sources of advice, support and financial assistance if required (see below).



Learning from the 2022 Audit

The service specific results of this audit should be reviewed within the operational team's current governance structures to ensure that any areas of good practice and areas for improvement are identified and shared.

Local action plans must be developed for individual wards, departments and services. The ward mangers and senior nurses are expected to progress the improvements identified and feedback through their governance and monitoring arrangements, overseen by the Listening and Learning Forum that reports to Quality and Safety Committee on a quarterly basis.

The health board is asked to accept the Health & Care Standards (2022) audit findings which are presented in this report as an assurance that the care delivered within the health board continues to achieve a high level of satisfaction amongst patients, whilst also identifying areas of improvement.

Simply Do – *using an ideation platform to improve on top 3 areas identified in the 2022 HCs Audit*

The results of the 2022 audit have highlighted 3 key areas for us to improve across the health board these are

1. Patient hydration
2. Providing a dignified environment of care
3. And improving our assessment and care management of patients suffering with delirium and those patients with a diagnosed learning disability

We have launched a challenge on the simply do platform. This challenge has been launched to provide an opportunity for staff to:

- Submit ideas you have that could address one of the 3 key issues raised
- Share those ideas with colleagues via the portal

As part of this collaborative, transparent process, we will:

- Listen to and recognise innovative ideas and approaches
- Share the progress we make together in real-time
- Support you with Improvement training

To find out more about how you can submit an idea go to https://sdi.click/ictmaudit2