AGENDA ITEM
6.4

QUALITY & SAFETY COMMITTEE

PATIENT SAFETY & QUALITY DASHBOARD

Date of meeting	24th May 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence Kellie.l.jenkins-forrester@wales.nhs.uk
Presented by	Nigel Downes, Assistant Director of Quality & Safety
Approving Executive Sponsor	Executive Director of Nursing, Midwifery & People Services Executive Medical Director
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Discussions with key individuals in corporate services and within directorates and localities Joint working with Performance and Planning team	Various dates	Choose an item.

ACRONYMS	
NEWS	National Early Warning Score
HMR	Hospital Mortality Review

1. SITUATION/BACKGROUND

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.03.23 to 30.04.23 taken from systems as on 02.05.23, unless otherwise specified. The Health Board is in the process of transitioning to a new operating model, which requires significant change to data alignment, in addition to changes to the quality governance model and arrangements are being embedded.

This transition provides an opportunity to review and build upon the structure, format and information contained within the Quality & Safety Dashboard. As a result, this revised iteration will continue to be refined over the forthcoming months to improve data accuracy, enable robust monitoring and provide assurance.

Key areas to note in this reporting period are:

- Decrease in the number of complaints received. Implementation of a robust triage process with a focus on early resolution along with the embedding of the PALS at Princess of Wales.
- Compliance with the 30 working day target for responding to complaints decreased to below 50% during March and April 2023. A plan is in place to address the number of complaints open over 30 working days while maintaining the focus on the complaints due.
- Reduction in the number of Public Service Ombudsman for Wales referrals received.
- The number of compliments recorded on the Datix Cymru system has continued to decrease from November 2022. Work is being undertaken to explore options for engaging with staff to ensure robust recording of compliments received.
- The number of patient safety incidents reported has increased during March and April 2023. The inclusion of closed incident information reflects the actual harm following investigation. 0.43% were recorded in March and April 2023 with an outcome of severe or catastrophic / death.
- Patient falls and Pressure Damage Incidents have remained relatively consistent with previous months.
- Number of absconding incidents increased in last 2 months.
- Addition of Medical Examiner Referral information enables a wider and more accurate picture of mortality within the Health Board to be reflected.

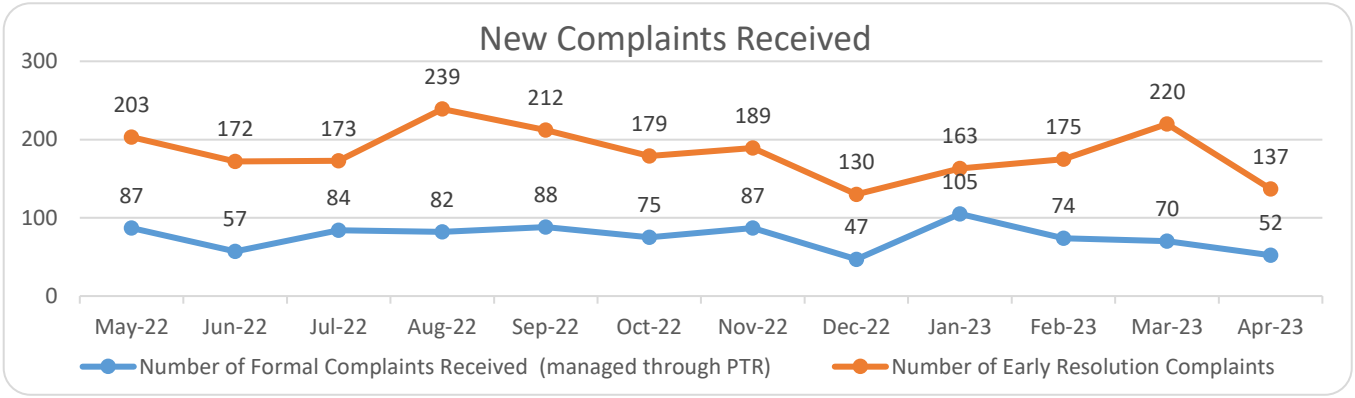
2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Patient / Service User Feedback

Complaints

New Complaints Received

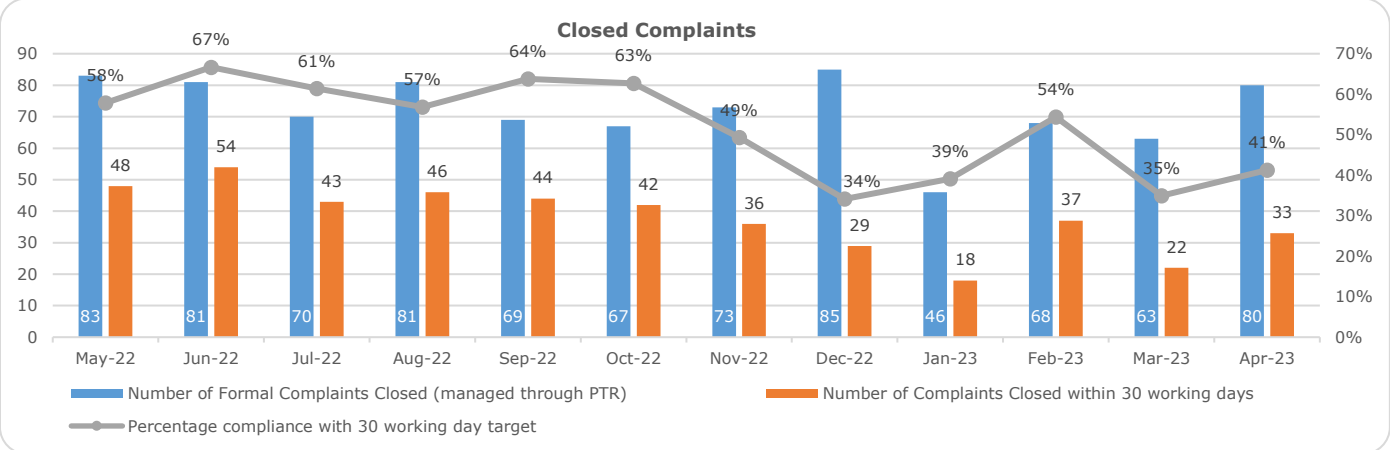
Between the 01.03.23 and 30.04.23 the Health Board received a total of 479 complaints. Of these, 122 were categorised as formal and managed under the Putting Things Right Regulations. The chart below highlights a steady increase in the number of complaints received between December 2022 and March 2023, however this trend has reversed in April 2023 with a significant decrease compared to the previous month.



For all complaints received in March and April 2023, the top 2 types of complaints received remain consistent with previous months, with the addition of medication as top theme. These relate to Clinical Treatment / Assessment (121), Appointments (120) and Medication (50).

Closed Complaints

Within the period of 01.03.23 to 30.04.23.23, the Health Board closed a total of 143 formal complaints (managed under the Putting Things Right Regulations). Compliance with the 30 working day target has decreased and remains below 50% for March and April 2023.



A review of the systems and processes for the management of complaints has been undertaken which has included the standardisation of procedures and templates to ensure a consistent approach is adopted across the Health Board. A robust triage process has been implemented with the aim of an increase in early resolution correlating with a decrease in formal complaints giving a better outcome for our patients and their families which directly impact on and further improve compliance with the 30 working day response rate. In addition a clear process for escalation has been established supported by weekly case review meetings to monitor compliance with Putting Things Right timescales.

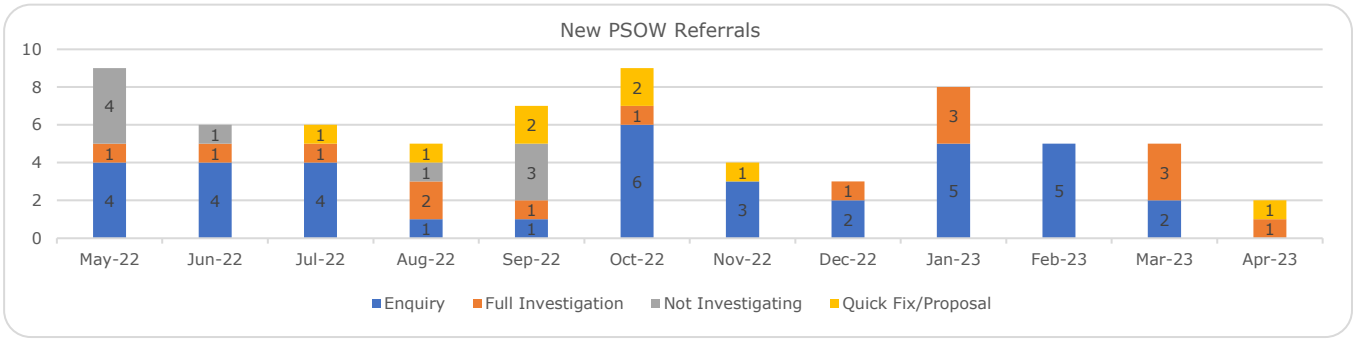
Patient Advisory Liaison Service (PALS)

The role of the PALS officers is now embedded within the Princess of Wales Hospital with two staff in post supporting patients, families and carers proactively in resolving or escalating any queries /issues raised through visibility on the wards, telephone or email at point of contact.

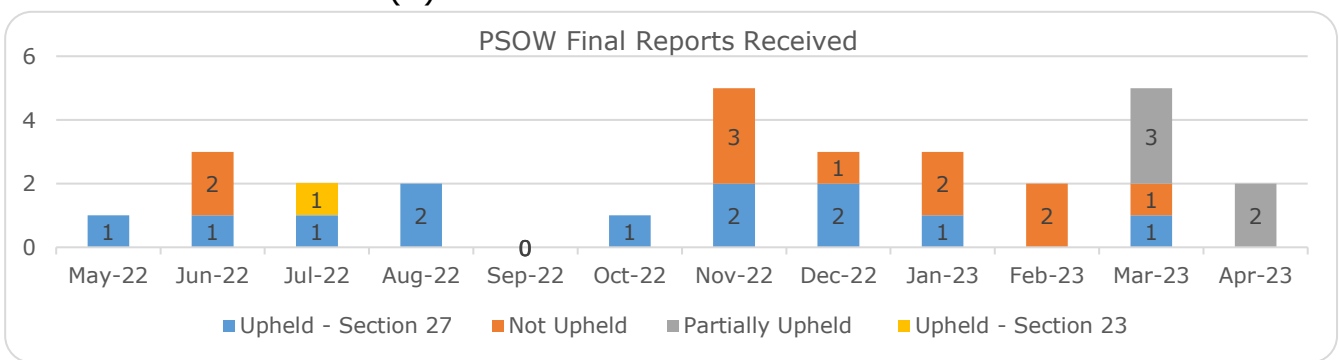
The Health Board is looking to advertise two roles in Prince Charles Hospital next and once recruited will look to extend into Royal Glamorgan Hospital and a part time community based role to ensure there is access to this service across the whole of CTM, promoting engagement with our communities to enable them to drive service improvement.

Public Services Ombudsman for Wales

The Health Board received notification of 7 new referrals to the Public Services for Ombudsman for Wales (PSOW) between 01.03.23 and 30.04.23. This represents a continuation of the overall decrease from November 2022. Of the 7 referrals, 4 were received as full investigations, 2 as enquiries and 1 as a quick fix/early settlement proposal.



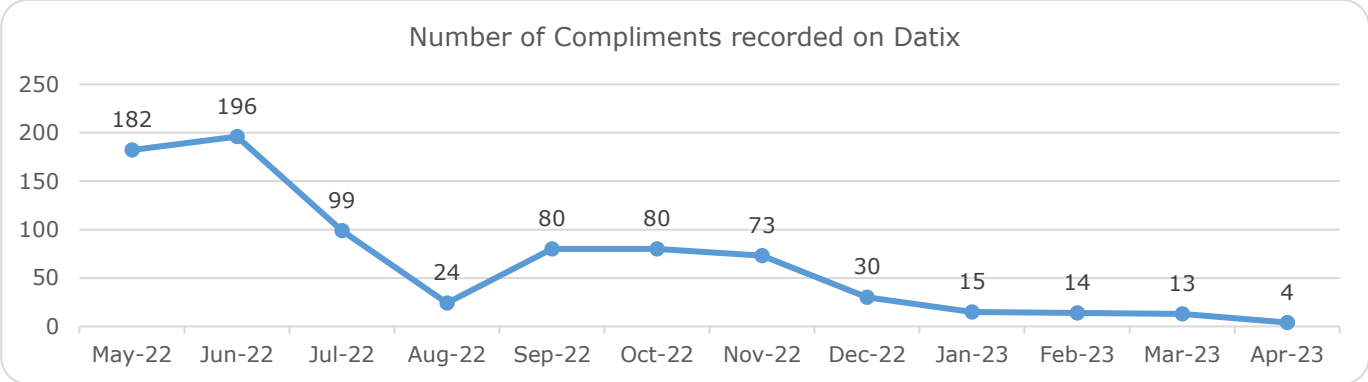
During the same period, the PSOW issued 7 final reports to the Health Board. Of these, 1 was not upheld, 1 was upheld and 5 partially upheld. The upheld reports relate to services provided by Unscheduled Care (4) Primary Care & Community (1) and Families & Children (1).



The Health Board currently has 52 Open PSOW cases, of these 24 are awaiting a response from the PSOW to instigate any further action required. 12 are at final report stage with actions being implemented by the Care Groups.

Compliments

Whilst compliments are received across the Health Board via a number of mechanisms the number of compliments recorded on Datix Cymru has continued to decrease over the 12 month period between 01.06.22 and 30.04.23, this is reflected in the chart below. A total of 17 compliments were recorded during March and April 2023. This is not reflective of the number of compliments received but linked to accurate recording on Datix Cymru.



Work is ongoing to review mechanisms and systems to ensure a robust process is established to capture, record and report information relating to the compliments received.

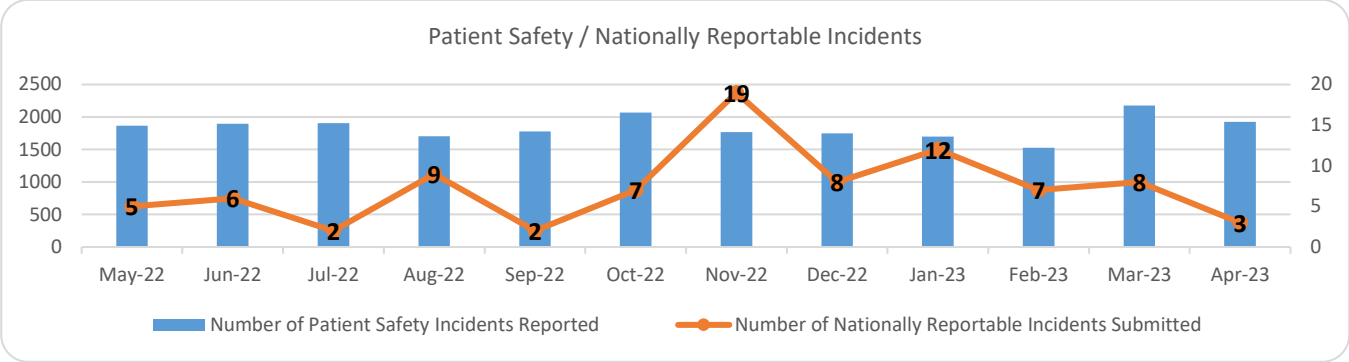
2.2 Patient Safety Incidents

Total Patient Safety Incidents

A total of 4648 incidents were reported between 01.03.23 and 30.04.23, this represents an increase of 911 when compared with the previous 2 months. Following a steady decrease between October 2022 and February 2023, the number of incidents reported where the patient is identified as the person affected has increased in March and April 2023. Of the 4648 incidents reported, 89% (4125) were reported as the patient affected. The top 3 types of incidents reported for March and April 2023, linked to a patient affected are Pressure Damage /Moisture Lesion (1286), Infection, Prevention & Control (744) and Accident, Injury (651)

Nationally Reportable Incidents

Between 01.03.23 and 30.04.23, 11 nationally reportable incidents were submitted to the NHS delivery unit. No never events were identified in this period. The ratio of Nationally Reportable Incidents to the overall number of patient incidents is demonstrated in the chart below.



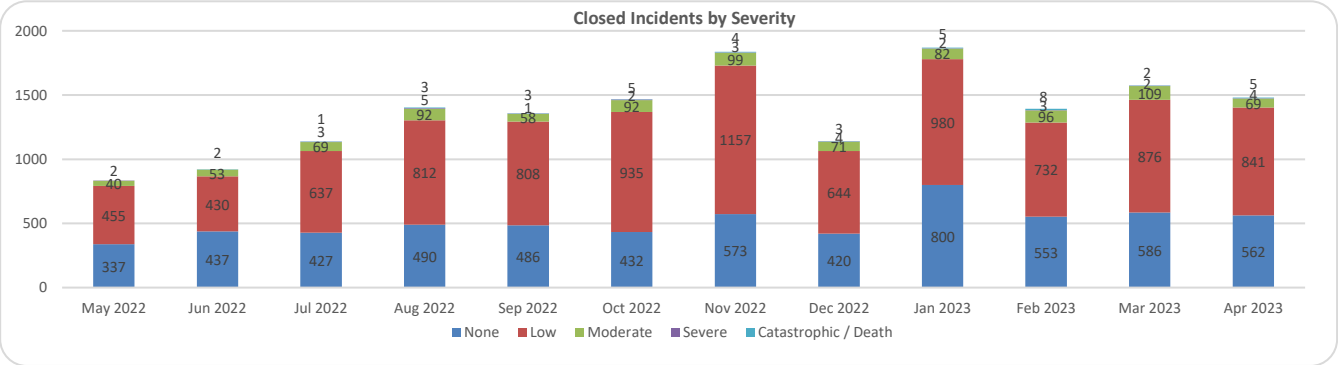
As highlighted in previous reports to Committee it should be noted that Nationally Reportable Incident data is presented based on the date the notification was submitted to the Delivery Unit. This is reflected in the increase in both November and January as a result of the submission of legacy ambulance delays and notification of Ophthalmology incidents following completion of the harm review process that occurred prior to the reporting period.

The type of Nationally Reportable Incident notifications submitted in March & April 2023 is highlighted in the table below:

	Mar 2023	Apr-23	Total
Access, Admission	1	0	14
Accident, Injury	0	0	3
Assessment, Investigation, Diagnosis	1	0	5
Maternity adverse occurrence	1	0	6
Medication, IV Fluids	0	1	2
Patient/service user death	1	0	4
Pressure Damage, Moisture Damage	2	1	11
Safeguarding	0	0	3
Transfer, Discharge	0	0	7
Treatment, Procedure	2	1	9
Total	8	3	64

Closed Patient Safety Incidents

Between the 01.03.23 and 30.04.23 a total of 3120 patient safety incidents were closed. Of these incidents 64 were closed without a severity post investigation being a recorded. In April 2023, changes to the Datix Cymru System were introduced to ensure incidents are not able to be closed without a severity being recorded. In addition an audit programme of closed incidents is being introduced to ensure all required fields are being completed on closure. Of the 3056 where a severity was recorded, 0.43% (13) were closed with severity post investigation of severe harm (7) or catastrophic/ death (7). The 12 month trend is reflected in the table below.

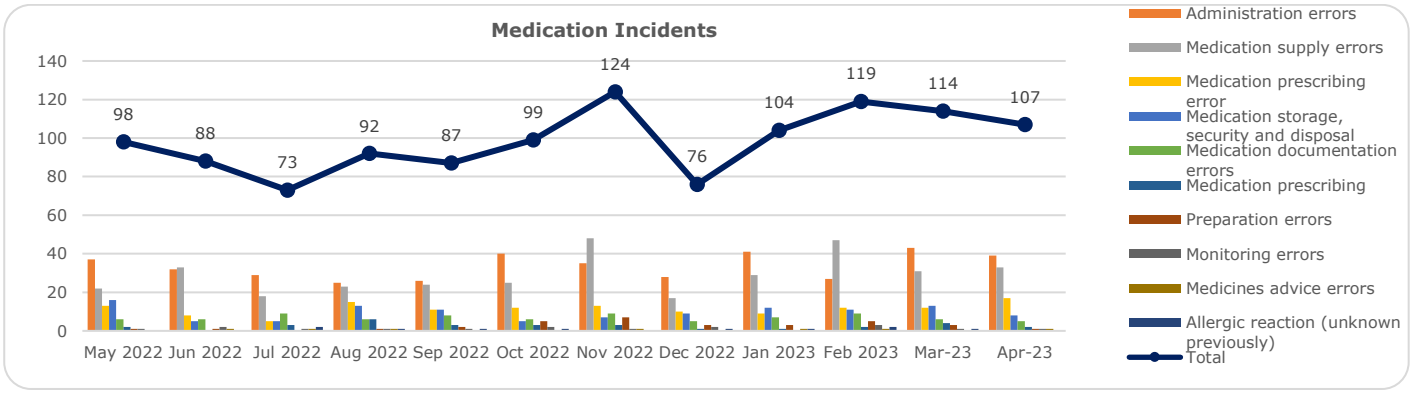


Future reports to Quality & Safety Committee will include information to demonstrate compliance with Duty of Candour Requirements.

2.3 Specific Quality & Safety Metrics

2.3.1 Medication Safety

A total of 221 medication incidents were reported as occurring between 01.03.23 and 30.04.23. This is consistent with the previous 2 month period. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (82) Medication supply errors (64) and Medication prescribing (29).

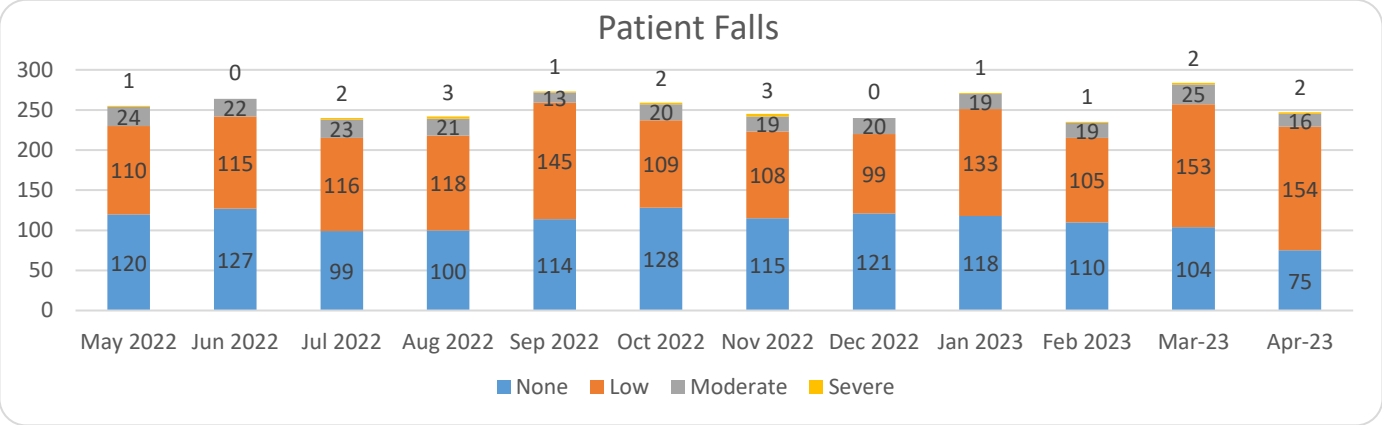


88% of the medication incidents were reported as resulting in no (76) or low (100) harm, with the remaining reported as resulting in moderate harm (22) and severe (3) harm. It should be noted that the introduction of a specific Community Pharmacy form has impacted on the data quality for medication incidents as a number of fields are not included for completion, including the harm field. Therefore, for the 3 months identified above, the harm was not recorded for 20 incidents.

2.3.2 Patient Falls Incidents

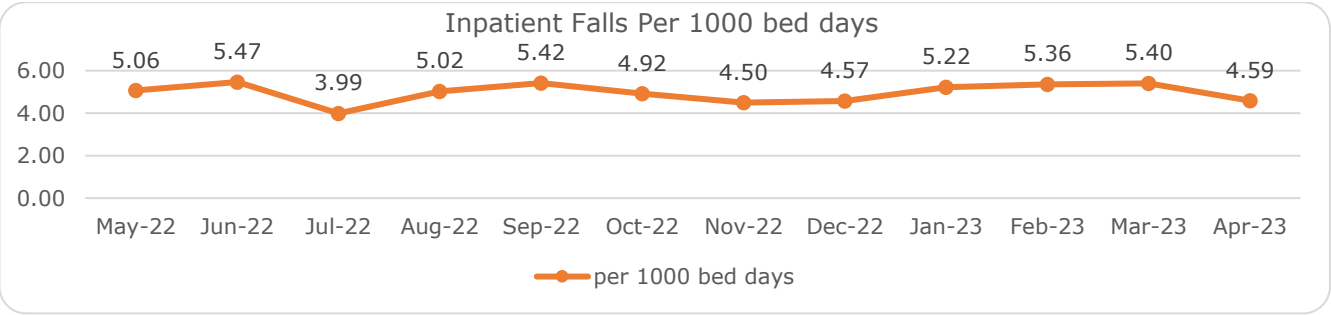
A total number of 531 falls, where the person affected was a patient, were reported during March and April 2023. This represents an increase of 25 in the number of falls reported in comparison to the previous 2 month period. Of the falls incidents within the time period, 92% were reported as no (179) or low (307) harm. The remaining

incidents were reported as moderate (41) and severe (4) harm. No incidents relating to patient falls were reported as resulting in death.



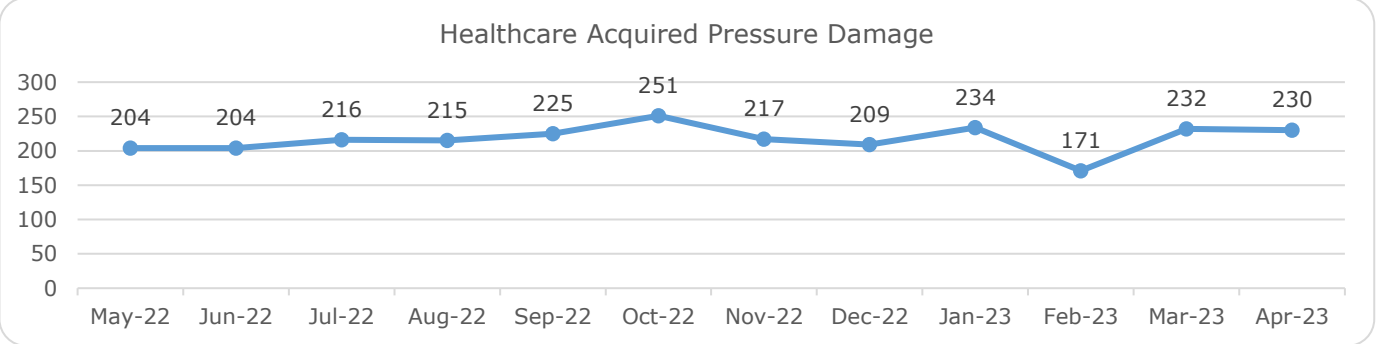
During the time period, the highest number of inpatient falls occurred on Ward 1 at Ysbyty Cwm Cynon (20), Ward B2 at Ysbyty Cwm Rhondda (20), and Ward 15 at Princess of Wales Hospital (18).

Work continues to develop and refine safety metrics for areas such as inpatient falls and pressure damage incidents per 1000 beds.



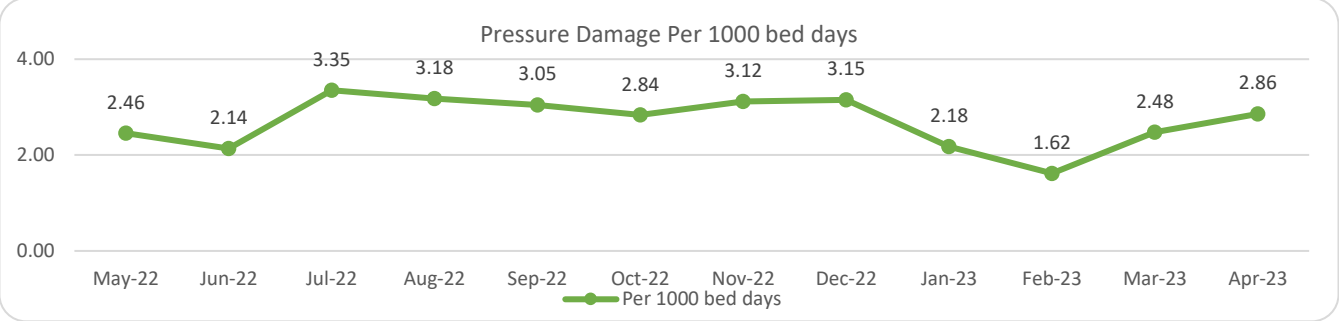
2.3.3 Pressure Damage

Between the 01.03.23 and 30.04.23, a total of 1,001 pressure damage incidents were reported, of which 466 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (535) were reported as being present before admission to this clinical care area/caseload.



Of the 462, 282 were identified as being hospital acquired and 180 as community acquired. This demonstrates a continued decrease of community acquired pressure ulcers identified in the previous 2 months.

The locations with the highest reported hospital acquired pressure damage incidents were reported within the Emergency Department (34), Acute Medical Unit (17), and Ward 8 at Princess of Wales Hospital (7). There were 16 hospital acquired grade 3 pressure damage incidents reported during March (9) and April (7). There were 3 hospital acquired Grade 4 incidents reported during the 2 month period.

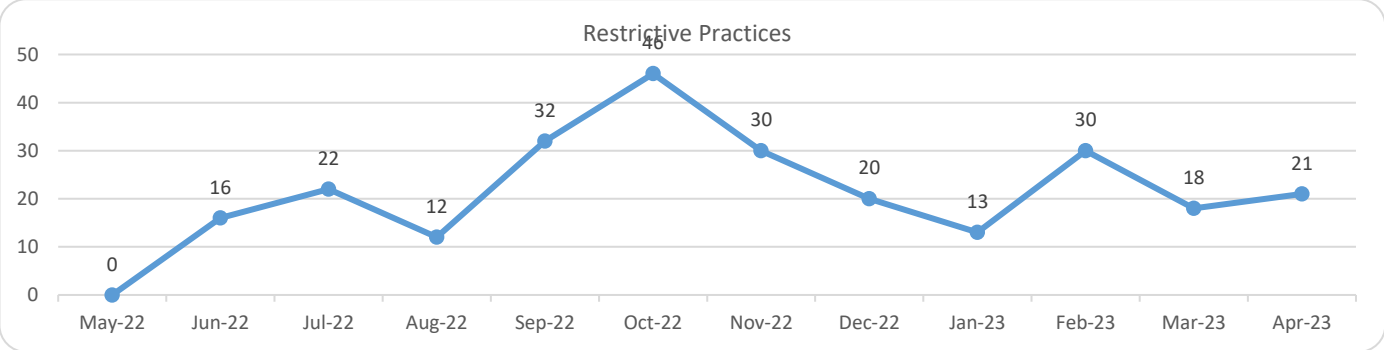


2.3.4 Mental Health Metrics

Number of 136 Assessments in police cells

The number of 136 assessment in police cells remains at 0 (Health Board wide), which demonstrates good compliance with the Crisis Care Concordat, ensuring that those who require mental health assessment are not detained in custody suites.

Restrictive Practices

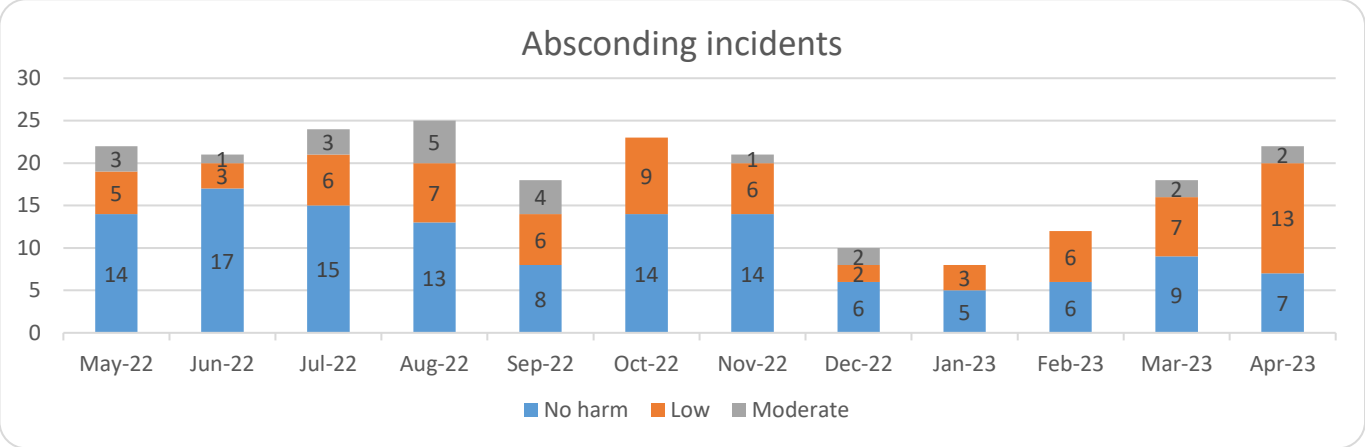


Between 01.03.23 and 30.04.23, a total of 39 incidents relating to using Restrictive Practices were reported within Mental Health. This is a decrease of 11 incidents when compared to the previous two months. Of the 39 incidents, 74% (29) were reported as not care planned, 23% (9) were reported as care planned and 3% (1) as other. Of the 39 incidents, 92% were reported as no (21) or Low (16) harm. The remaining incidents were reported as moderate (2) occurring on the Psychiatric Intensive Care

Unit at the Royal Glamorgan Hospital and severe harm (1) at Coity Clinic (PICU) at the Princess of Wales Hospital.

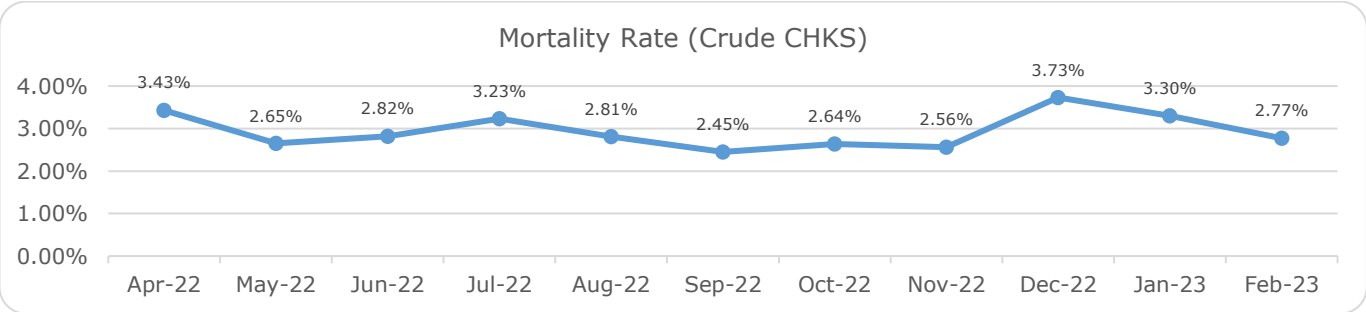
Absconding incidents

During March and April 2023, a total of 44 Absconding incidents were reported, an increase of 24 when compared with the previous 2 month period. 27 were recorded as actual absconding, with the remaining recorded as missing patient / service user (8) attempted (4), failure to return from authorised leave (4) and other (1).



82% of the absconding incidents reported in the time period (01.03.23 to 30.04.23) were recorded as No (16) or Low (20) harm, with the remaining incidents reported as moderate harm occurring in the Emergency Care Department and Ward 9 at Prince Charles Hospital, Emergency Department, Acute Mental Health Admissions Unit and Psychiatric Intensive Care Unit at the Royal Glamorgan Hospital.

2.3.5 Mortality Rate



As highlighted in the chart above, there has been a decrease in the crude mortality rate since December 2022. At the time of preparing the report, the information was not available for March and April 2023. It should be noted that the crude mortality rate is an in-month figure extracted from Welsh Patient Administration System (WPAS) based on the number of patients who have an outcome recorded as deceased. The figure is not adjusted for population, co-morbidities or expected deaths i.e. palliative care.

Work is currently ongoing to develop and implement a data validation process for mortality information and address the disassociation between CHKS and WPAS. A scoping exercise has been undertaken which has established that mortality data is collected in a number of different locations across the Health Board and in differing formats. The work being undertaken will establish a standardised format for the recording of information and ensure data can be collated in a consistent format, with the aim of presenting a more accurate picture of mortality within the Health Board. This will include data captured in Datix Cymru relating to medical examiner referrals and provide the ability to drill down with a greater degree of accuracy.

Medical Examiner Referrals

The table below outlines the number of deaths for 2022-23, the number where an initial review has been undertaken (either by the Medical Examiner or UMR), and the number and percentage outstanding.

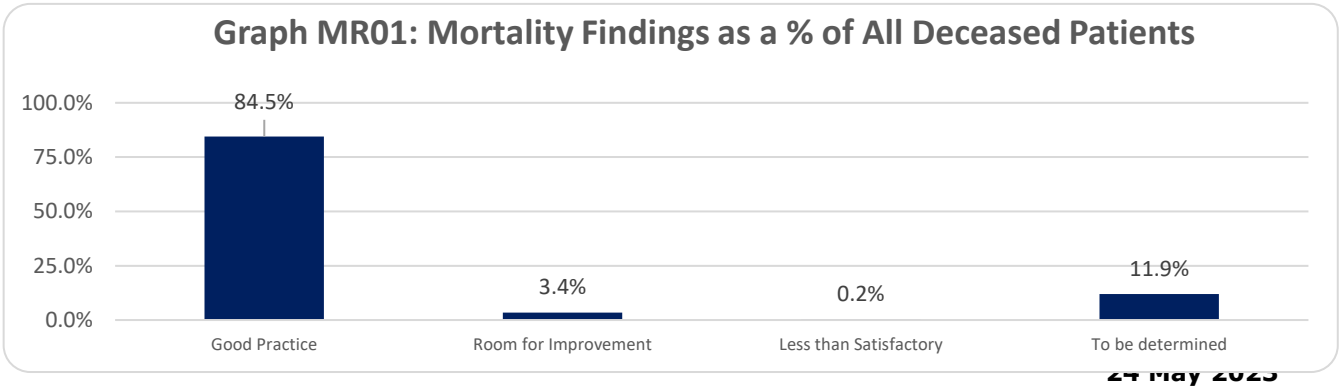
	Total Deaths	Number Reviewed	Number Outstanding
CTMUHB	3250	3183 (98%)	67 (2%)

The table below shows the number of cases referred by ME for 2022-23, cases identified for Hospital Mortality Review, the number where the review has been completed and the number and percentage outstanding.

	Total Deaths	Total Referrals	Number of HMR Required	Number Complete	Number Outstanding	Stage 3 Required
CTMUHB	3250	1401 (43%)	606 (43% of referrals (19% of all deaths)	307 (51%)	299 (49%)	18 (0.6%)

Hospital Mortality Review (HMR) panels, previously known as Stage 2 Mortality Review, have continued across CTMUHB. However, due to a focus on completing the outstanding backlog of Hospital Acquired Covid cases, of which the Mortality Review Team has been responsible for the completion of Wave 1 & 3, this has impacted on the number of 2022-23 deaths that can be reviewed, meaning a backlog of current cases requiring HMR has accrued.

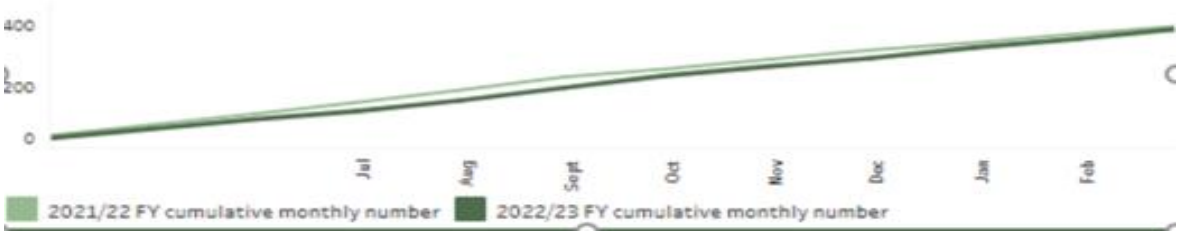
The graph below highlights Mortality Findings for 2022-23.



Further detailed information in relation to medical examiner referrals will be included in future reports.

2.3.6 Infection Prevention & Control (IPC)

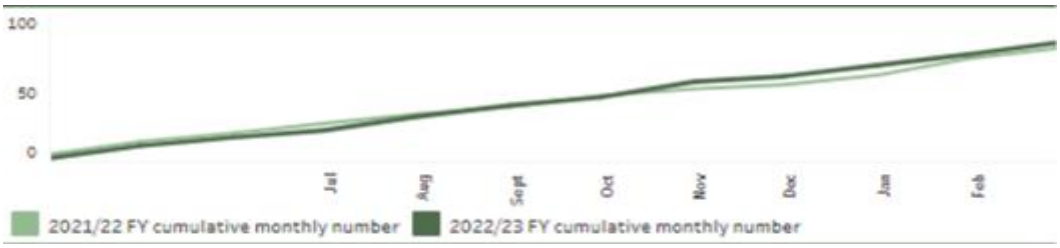
Clostridium Difficile



Whilst CTM marginally missed the reduction expectation for 2022/23 with a rate of 25.34 per 100, 000 population, it currently has the lowest rate in Wales. Key notes to highlight are:

- 26% fewer cases reported in 2022/23 compared to the previous year
- 51% of the cases are healthcare associated infections
- 30% of the total samples were sent from primary care
- The RCA process needs to be strengthened to maximise opportunities for learning and sharing best practice

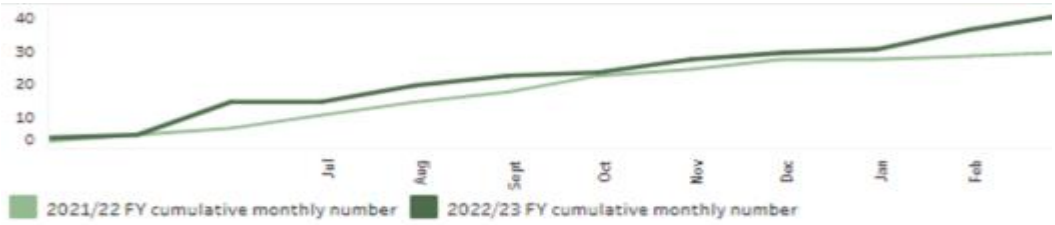
MRSA bacteraemia



CTM reported an increase in MRSA bacteraemia compared to last year and did not meet the reduction expectation for 2022/23. It should be noted that CTM has the lowest rate of MRSA bacteraemia in Wales. Additional points to note include:

- No cases have been reported in the last 6 months
- 75% of the cases reported are community acquired infections.
- No cases associated with a medical device/deemed to be a preventable infection.

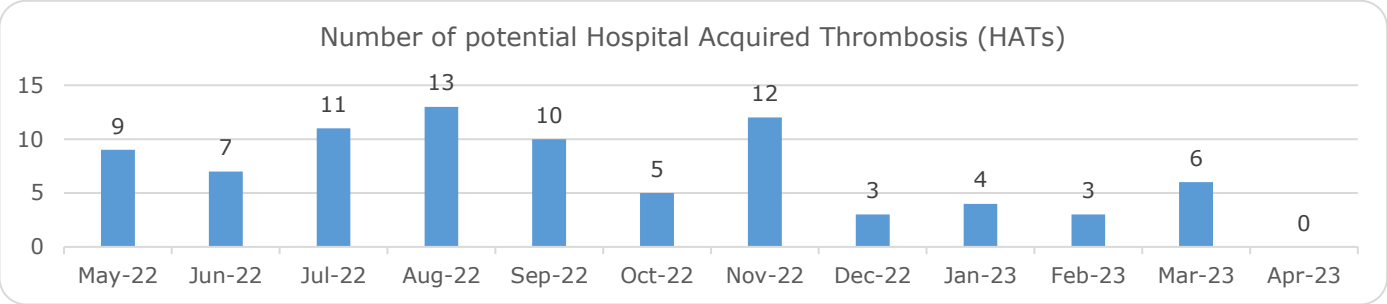
MSSA bacteraemia



CTM did not meet the reduction expectation for 2022/23 and there was a 21% increase in cases reported. 66% of the cases are community acquired infections. 11% of the total cases were deemed to be preventable following investigation by the IPC team and linked to an IV line or post operative surgical site infection._Improvement work is planned for 2023/24 to improve device management and compliance with ANTT practice/IPC Training.

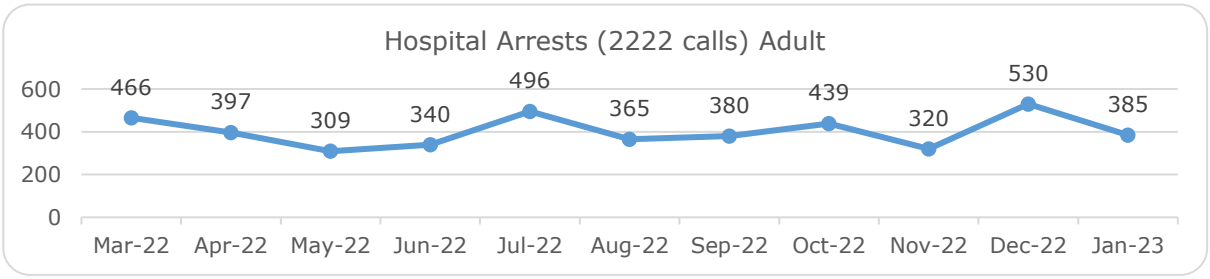
2.3.7 Hospital Acquired Thrombosis (HAT)

There were 9 potential HATs identified for February and March 2023 compared to 7 for the previous 2 month period. Work is required to determine the scope and accuracy of the data on a Health Board wide basis. It is also important to remind Committee that this measure is prior to the investigation of each case to identify if a HAT occurred or not. The ambition is to provide information that shows potential versus actual HATs.



2.3.8 Hospital Cardiac Arrests and NEWS Training

Hospital Cardiac Arrest Calls (222)



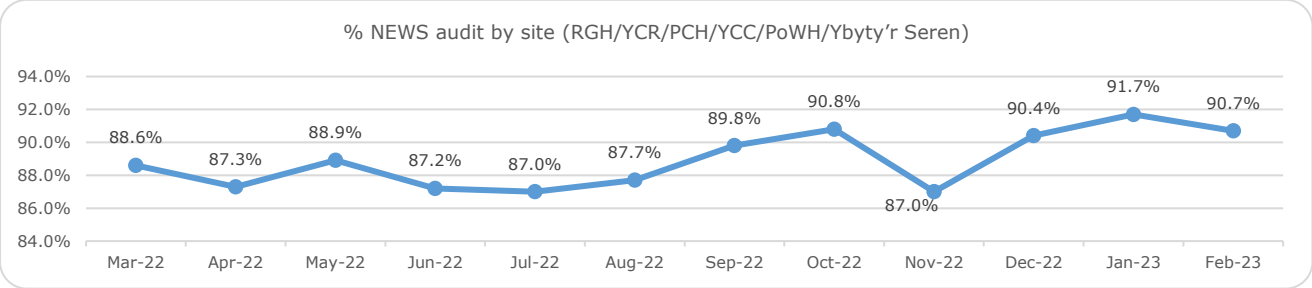
The number of calls taken rose significantly to 530 during December 2022 but decreased to a level consistent with the previous months. Up to date Health Board information was not available at the time of preparing the report. A reliable mechanism for the collation of this information is currently being established.

Hospital Cardiac Arrest Calls will remain an important metric for inclusion in this report, as the objective is for cardiac arrests only to occur in the Emergency Department. Strengthening our pre-arrest reviews and monitoring acute deterioration, as well as improving on our DNACPR processes, NEWS scoring, and training strategy, are integral to success in this area.

NEWS Audit

Following a dip during November 2022, compliance with NEWS has increased to above 90% from December 2022 onwards. Information was not available for March and April at time of preparing the report.

Recognising Acute Deterioration and Resuscitation (RADAR) group will be expanding metrics to ensure there is a constant review of activities in relation to NEWS.



2.3.9 Community Metrics

A number of metrics (summarised in the table below) are measured in relation to Community Services including District Nursing treatments which has steadily increased over the 12 month period. Following a steady increase, average length of stay decreased during April 2023 in Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda, whilst remaining relatively consistent with previous months on other Health Board sites. Further work is required to refine and validate this data.

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb – 23	Mar – 23
District Nurse treatments	34298	36231	35265	35376	36155	35404	36739	36333	34494	35937		
Referral to At Home Services (All Referrals)	90	120	122	129	123	128	119	125	138	125	145	182
Ysbyty'r Seren (ALOS)	55	63	0*	0*	0*	0*	0*	0*	0*	0*	0*	0*
*Princess of Wales Hospital, Ward 21 (ALOS)	-	-	16	22	47	22	39	48	33	21	21	20
Ysbyty Cwm Cynon (ALOS)	61	63	49	51	64	64	57	56	72	80	74	50
Ysbyty Cwm Rhondda (ALOS)	67	70	56	67	55	62	80	68	73	72	79	62
Palliative Medicine, Bridgend (ALOS)	19	14	20	9	10	24	19	23	18	15	18	11
Palliative Medicine, Pontypridd/RGH (ALOS)	4	19	12	7	8	8	11	7	6	10	7	9
Palliative Medicine, YCC (ALOS)	16	13	32	16	36	4	25	28	24	25	18	23

2.4 Patient Safety Solutions

There has been **no** new patient safety alert or notices issued since the last Quality & Safety Committee meeting.

Current Compliance
In total, there is **1 alert** and **0 notices** in which the Health Board are reporting non-compliance.

Non–compliance for alert **PSA008 Nasogastric tube** misplacement status is an ongoing issue which is currently being reviewed on an All Wales Level.
An all Wales Training package for NG Tube insertion is being established. The Delivery Unit have advised that the first national meeting took place in September 2022. The Health Board currently provides face to face training for nurses and F1 & F2 doctors. The assessment following the receipt of training is required to be strengthened. Face to face training was not provided during the pandemic, however confirmation has been received to state this has recently been re-established.

2.5 Patient Experience Initiatives

2.5.1 Carers
Welsh Government issued a directive in 2021, which requires Health Boards to have a process in place to support unpaid carers when the person they care for, are discharged from hospital. A patient information leaflet has been published to ensure that carers have information to help navigate the patient's journey and to offer sign posting to available support through health care/third sector. CTM Carers Steering group is working in collaboration with third sector colleagues, such as Local Council's and the Regional Integrated Fund to explore and develop a further strategic action plan to support the unpaid carer's, using the information from the carer's hackathon (this was held via the Regional Partnership Board with representatives from third sector/health and carers to understand what their needs were) and the population needs assessment.

Funding from Welsh Assembly from 22/23 to support carers short breaks has also been distributed via the Regional Integrated Fund.

2.5.2 Chaplaincy Support
As part of the implementation of the Under 16 baby loss pathway and in partnership with the Clinical Bereavement lead three foetal collective cremation funeral services at Coychurch, Glyntaf and Llwydcoed Crematorium have been held. This initiative is supported by charitable donations from the local Funeral directors, Supermarkets and National Charity "Aching Arms" to ensure the experience is as individual as possible. All were well attended by parents and there has been positive feedback. CTM is the only Health Board in Wales to facilitate such an initiative to support families.

We continue to raise awareness of the role of the Chaplain's department with a focus upon spirituality through delivering teaching sessions to support staff to gain an understanding of their own and others personal spirituality that may impact on their own wellbeing and enable them to recognise spiritual distress in patients and colleagues, signposting them to support as necessary. Specific Training has been

delivered to nurses and doctors in Prince Charles Hospital Neonatal Unit and a group of Doctor's from across the HB.

An extension of this training to support student nurses and midwives training has been delivered to student nurse and midwives as part of their induction programmes. This is to support them to gain the knowledge, skills and competencies relating to spirituality care. This cohort are the first students to come through having had competencies of spiritual care as part of their degree course. Further work to evaluate these competencies and exploring how the department can support the students to embed these skills into daily practice is now taking place.

There are two pilot projects underway at the Princess of Wales hospital. One is to facilitate students to meet and shadow a chaplain and the other to support inpatient wards to write competencies to enable the implementation of spiritual care champions, which is hoped will be rolled out across the Health Board in the future.

2.5.3 Bereavement

Bereavement Clinical Lead continues to be instrumental in changing the pathway and process for pregnancy loss and support families and staff alike.

The PATH02 (pathology 02) form for pregnancy loss has been revised and feedback from families and staff is positive. This change means that the Health Board has a more transparent and patient centred approach to pregnancy loss and families feel more informed of their options of disposal of pregnancy remains. Information booklets have been created and printed and are available for patients and staff.

Training and development of bereavement services continued this month, with training delivered to 45 International educated nurses as well as a band 6 development programme. Feedback was positive and more sessions are planned for the future.

An excellent HTA (Human Tissue Act) inspection was undertaken with a special mention regarding the pregnancy loss changes that bereavement have put in place.

2.5.4 Patient Feedback Volunteers

Patient Feedback volunteers are instrumental in supporting completion of the All Wales Survey/Have Your Say surveys at Princess of Wales and Prince Charles Hospital Sites. The patient feedback volunteers visit weekly and contact the Heads of Nursing and Senior Nurses to agree which areas or wards to target for feedback. Collecting service user feedback is just one role of the volunteering service and forms an essential element, while other projects are undertaken this will remain a core function of the service with an increase in interest from other volunteers to participate.

2.6 Duty of Quality / Quality Impact Assessment (QIA)

Work is underway involving both corporate teams and the change team in establishing a standardised approach to QIAs as well as the implementation of the Duty of Quality's 6 quality dimensions and 5 associated enablers across the organisation's reporting

processes. In seeking to achieve a substantive position for this financial year the corporate nursing and patient safety team led by the Deputy Executive Director of Nursing is preparing to host a summit in quarter 2 of 2023 attending to the implementation across finance, education, operations, quality governance, clinical care, communications and commissioned services.

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

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

- Maintenance of robust quality governance arrangements during the transition to a centralised function has remained paramount. The implementation of OCP in relation to Quality and Governance arrangements is nearly complete, with final vacancies in the recruitment process taking place.
- The transition to the new operating model poses a challenge in relation to the extraction and presentation of data. Work is underway to align the Datix Cymru System to the Care Group Structure and ensure up-to-date information is accessible across the Health Board on a range of metrics.
- Work is required to ensure data from the range of Health Board systems included in this report are consistently captured and appropriately validated.
- Improving and maintaining compliance with the 30 working days complaints response rate.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below) This report outlines key areas of quality across the Health Board.
Related Health and Care standard(s)	Governance, Leadership and Accountability This report applies to all Health and Care Standards.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below. • Report for information for Health Board patient safety & patient experience activity • No service or staff impact in direct response from this report, this is considered through improvement work and other reports • Report not requesting proposal for any changes to services or staff
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below) The requirements to deliver safe, high quality care impact on resources including workforce. The new operating model will support delivery of safe, high quality care.
Link to Strategic Goals	Improving Care

RECOMMENDATION

Members of the Quality & Safety Committee are asked to:

4.1 **NOTE** the content of the report

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

4.3 **NOTE** the risks identified

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

Appendix 1

People's Experience Activity Report (December 2022 – January 2023)

Patient centred care remains the focus of service delivery and improvement across the Health Board and the Patient Experience Team continue to engage with patients, families and carers alike to enable their voices to be heard within this.

This is undertaken through a variety of methods and in terms of receiving first hand qualitative data from patients, the Health Board utilises Civica – patient feedback system. The system continues to be embedded across services with more bespoke surveys being created as further departments come on board. The project team is currently working with the three acute ED departments to create a survey that meets the needs of the service. The SMS texting system requires improved IT infrastructure to enable activation of this service throughout CTM UHB.

Patient feedback received February 2023.

The nurses are very helpful and the food is very good.

My wife has terminal cancer and was brought in to control her pain medication. The ambiance was perfect for my wife. There was a calmness about the place and the staff were very welcoming and attentive. The nurses couldn't do enough for us. It is such a pleasant place. Well done for providing such a facility.

Liaison with family members began in an extremely open and warm hearted way. After months and months have worn on, this now seems to be at a premium and communications are somehow cooler, and the family feel held at arm's length with our very real grief around our relative's condition overlooked. We feel like inconvenient numbers rather than humans, with communication policies being inaccessible and no opportunity for meetings with the family and the key staff after the initial three months.

I want to thank all of the staff at the EPU for their service during such a difficult time. I was offered telephone support after attending A&E with vaginal bleeding. When the bleeding became worse I attended EPU who gave me an ultrasound. There was no heart beat. The staff were incredibly sensitive and understanding at such an awful time for me. I was treated with dignity, respect and was given time. Everything was explained to me in a sensitive way and I am truly grateful.

All staff have very helpful and informative. Would be helpful is there was a shelf in the shower for belongings. Students were brilliant.

Many services manage to have lunch and keep the service running, I do not understand how you need to closed the department for staff to have a lunch break while an eight-month pregnant patient is told to go for a walk. Terrible.

Carers

The Carer's co-ordinator continues to engage with carer's, patients, families and staff alike to raise awareness of the unpaid carer and the need to ensure their voice is heard within the discharge planning process to enable signposting where needed. The weekly information carer stands in the 3 acute hospitals continue to identify and support unpaid carers in a hospital setting. Posters have been displayed throughout the hospital, information booklets provided to emergency departments, discharge liaison services, outpatients departments and the acute wards.

Chaplaincy

Significant Spiritual and pastoral care provided (December 22- end Jan23)

- 663 Patients
- 204 Relatives/carer's
- 364 Staff

The Bereavement and Loss Workshop was presented to CTMUHB 2030 Leaders and the response from community leaders was overwhelmingly positive, which has resulted in subsequent offers for venues to hold more workshops and 'At a loss Cafes' across the Health Board have been provided.

The annual memorial service, in collaboration with County Bereavement services, was held at Llwydcoed Crematorium and live streamed for those who could not and/or felt unable to attend. Carol services resumed at RGH, YGT and YCR and were very well attended, patients and families were pleased these had resumed. Comments below were provided by those attending POW service:

It was a lovely time together singing carols and sharing some of the Christmas readings from the New Testament. At the end one of the hospital volunteers asked to sing a Christmas song "It's the most Wonderful Time of the Year" and one of the patients from Angelton who had previously been a member of a male voice choir joined in with her.

Most people stayed for tea/ coffee and mince pies / biscuits. The hot drinks were especially welcome as it was very cold and as one of the patients with dementia remarked loudly "it's freezing in here!"

It was a joy to catch up with a patient from Caswell who chaplaincy had regular contact with prior to the HB transfer in 2019 and who now has accompanied leave from the ward. He hopes to be able to come to some of the Thursday morning services that are held in the chapel.

Volunteers

Meet and Greet Volunteers

The meet and greet volunteer role provides a wayfinding service for those attending our sites across CTM UHB. The following provides an overview of this service across the organisation.

- The meet and greet service at the Princess of Wales & Royal Glamorgan Hospitals was reintroduced several months ago providing wayfinding, signposting and information. In addition, the volunteers encourage feedback from service users by handing out or supporting the completion of the "Have Your Say" cards.
- In December 2022 recruitment for new volunteers was re-opened and promoted via our local community volunteer centres and the volunteer service intranet and internet sites, which included additional volunteers for YCC, DSHP and RGH.
- Since 2020, our vaccination centre volunteers have supported the work stream across the Health Board and have been invaluable to the delivery of services, during the busiest times with over 120 volunteers supporting with meet and greet, wayfinding and signposting.

Wellness Improvement Service (WISE) Volunteers

The Wellness Improvement Service was officially launched on 5th September 2022. During December and January wellness sessions have continued to take place with volunteers supporting wellness coaches and participants.

Pets as Therapy Volunteers

The Pets as Therapy service is a positive and a welcomed form of alternative therapy, which benefits patients, service users and staff. The volunteer service has been working jointly with the Cariad Pet Therapy Organisation to explore expanding their services more widely across CTMUHB.

To date we currently have the following volunteers and therapy pets at clinical sites which include:

- Palliative Care Unit (RGH) and Dementia wards (RGH)
- Y Palliative Care Unit (POW)

- CAMHS, Ty Llidaird (POW)

Cariad Pet Therapy has been instrumental in supporting CTM UHB with this initiative and have recently won an ITV Wales Wellness award. The Pet Therapy project was presented to the Quality and Safety Committee on the 24th January 2023, which was warmly received and hugely supported, the volunteer service has been invited back to the Quality and Safety Committee at a later date in 2023 to provide a presentation on volunteering from a broader aspect.

Arts, Crafts, Good to Grow and Volunteer Drivers

The Arts and Crafts Group are keen to continue their workshops and plans will be made during 2023 with the aim to make items to donate to our wards and departments, with planned themes. Some of our arts and crafts volunteers also support other projects including WISE, meet & greet and digital support volunteers. To date we have 2 volunteer drivers supporting with transporting participants to Y Bwythyn Newydd to enable them to get involved with the good to grow project which is also supported by volunteers under the guidance of the Occupational Therapist, with a volunteer driver handbook being developed and currently awaiting approval.

Veterans

Work continues to highlight the Armed Forces Covenant and how this affects the service we offer veterans/serving/territorial personnel who have associated medical conditions as a result of their time in service.
The ESR system has been updated to reflect a training package that staff can access to highlight the responsibilities of the NHS organisation.
The exploration of WPAS systems on an all Wales basis is still being undertaken to review how links can be inputted into the system to track patient referrals that can be expedited under the Armed Forces Covenant.

Bereavement

The Clinical Bereavement Lead continues to liaise with staff, third party stakeholders, patients to embed the Once for Wales Care of the Bereaved Framework across the Health Board. This involves a number of facets which are detailed below:

- The Care After Death policy and bereavement checklist has been updated.
- A new Pregnancy Loss under 16 weeks policy has been produced. This policy means that patients who experience pregnancy loss are supported and the procedure they encounter is sensitive and appropriate for their circumstances. A newly created Pregnancy loss

under 16 weeks information booklet produced has also been written to accompany this policy.

- Delivery of bereavement training to bereavement link nurses within clinical areas on pregnancy loss and care after death has commenced.
- Set up regular forums with contracted funeral directors within CTM UHB to share wider vision for bereavement services across the Health Board.

PALS service

The Head of People's Experience and the PALS team in POW are updating processes & procedures to ensure maximising engagement with patients/families/carers and staff. As the service has recently transferred into the People's Experience portfolio this will support the planned expansion of the service across the Health Board enabling visible 'front of house' service supporting people's experience and feedback to support service improvements and shared learning. The Care to Share clinics have been reinstated across the wards in PoW to gain real time patient feedback.