AGENDA ITEM
6.3

QUALITY & SAFETY COMMITTEE

PATIENT SAFETY QUALITY DASHBOARD

Date of meeting	24th January 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
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Presented by	Lydia Thomas Head of Quality & Safety, Central Patient Safety Team
Approving Executive Sponsor	Executive Director of Nursing Executive Medical Director Director of Public Health
Report purpose	FOR DISCUSSION / REVIEW

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

Joint working with Performance and Planning team		

ACRONYMS	
CA&QI	Clinical Audit & Quality Informatics
ILG	Integrated Locality Group
CAPU	Community Acquired Pressure Ulcer
NEWS	National Early Warning Score
LFER	Learning from Events Reports
DU	Delivery Unit
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
CMO	Chief Medical Officer
HCSW	Health Care Support Worker
YCC	Ysbyty'r Cwm Canon
YCR	Ysbyty's Cwm Rhondda
LOS	Length of stay
WAST	Welsh Ambulance Service NHS Trust

1. SITUATION/BACKGROUND

This presentation of the Quality Dashboard to Committee provides data from October 2022 to November 2022 taken from systems as on 1st December 2022. The Health Board is in the process of transitioning to a new operating model, which requires significant change to data alignment, in addition to introducing changes to the quality governance model and arrangements. As key senior leaders prepare and begin to adapt to new roles and responsibilities, the requirement for assurance from the previous Integrated Locality Groups during this interim period has been streamlined and brought together within this document.

Key areas to note in this reporting period are:

- The average number of complaints over the preceding 12-month period is 94, demonstrating a mean reduction in formal complaints received during October and November (81). Complaints have risen in the past 3 months, however, they remain on a decreasing trend over the 12 month period. Whilst there is an overall increase in early resolutions, data does still not represent a trend and there is no direct correlation with formal complaints. Once the new triage process is fully implemented with the new operating model with centralised complaints, a drive for early resolutions will continue with close monitoring of the impact of this on reduced formal complaints and improved patient satisfaction on timely issue resolution.
- For all complaints received in October and November 2022, the top three themes remain consistent with previous themes and relate to Clinical Treatment and Assessment (231), Communication Issues, including attitudes & behaviour (138) and Appointment issues (108). These reliable indicators must provide a focus for targeted intervention and improvement.
- CTMUHB Complaints response compliance 12-month average is 58% with a target ambition of 75%. Compliance in this reporting period is averaged as 56%. The impact of a changed operating and governance model as well as increased winter pressures may temporarily affect the ability of clinical teams to complete responses in a timely manner. Improving the quality and timeliness of complaint response is a priority for the central team.
- Between October 2022 and November 2022, there is a slight overall increase in reported patient safety incidents; 67 were reported with a severity of severe harm (39) or death (28), an increase of 12 when compared to the previous 2 months. It should be noted that following the introduction of Datix Cymru on

the 01.04.22, services are no longer able to update the harm field completed by the reporter on initial submission. As a result, the severity highlighted on reporting may not necessarily relate to the actual harm determined following investigation. Future reports to Committee will include information to reflect the nuances between these data sources. In addition to the All Wales work being undertaken to include links to the harm matrix in the reporter form, the Health Board is developing concise reporter guidance which includes level of harm information.

- Responsible Managers can link with the Central Business Intelligence Team to change incidents where the level of harm has been entered incorrectly at the initial input. This should facilitate a greater accuracy of reporting, especially in light of Duty of Candour requirements. Notably, an increase in severe incidents has been noted for the Princess of Wales Emergency Department due to an increase in Datix incidents reported in relation to non-patient specific capacity and flow concerns through the department.
- A total number of 505 inpatient falls were reported between October 2022 and November 2022, which represents a decrease of 8 in the number of falls reported in comparison to the previous two months. Of the falls reported, 91% were reported as no or low harm. The remaining incidents were reported as moderate and severe harm. No incidents relating to inpatient falls were reported as resulting in death.
- The highest number of inpatient falls occurred on the Acute Medical Unit (AMU) at Princess of Wales Hospital (24), Emergency Care Centre at Prince Charles Hospital (24), Clinical Decision Unit at Prince Charles Hospital (18), Ward 7 at Ysbyty Cwm Cynon (13) and Ward 10 at Princess of Wales Hospital (13). We have introduced falls per 1000 occupied bed days as an improved measure of benchmarking fall rates, with the next step to set reduction goals for numbers and severity of harm. This also facilitates flexibility in identifying areas of greatest risk and setting reduction targets accordingly. Inpatient falls per 1000 bed days for October was 4.92 and November 4.50 which represents a slight downward trajectory since recording began in August 2022.
- During October 2022 & November 2022, 2 falls were nationally reportable due to being deemed avoidable when presented to scrutiny at falls panel.
- During October 2022 and November 2022, a total of 961 pressure damage incidents were reported. There is no change in numbers of hospital acquired pressure damage incidents when compared to the previous 2 months. Work is in progress with WAST colleagues as an increase in pressure damage incidents is in relation to those patients who are awaiting offload from an ambulance and adequate turning and monitoring is difficult to achieve. This issue has been put forward to be included in the Community Acquired Pressure Ulcer (CAPU) project in the New Year. Pressure damage per 1000 days was 2.84 in October

2022 and 3.12 in November 2022. This represents a largely consistent picture of pressure damage incidents across CTM over time since the first recording in April 2022.

- A total of 223 medication incidents were reported during October 2022 and November 2022. 82% of the incidents were reported as resulting in no (141) or low (42) harm, with the remaining reported as resulting in moderate harm (17) and 2 severe harm. The severe cases relate to a prescribing error in Emergency Care Centre Prince Charles Hospital and a Medication storage, security and disposal in Mental Health Royal Glamorgan Hospital.

- The introduction of a specific Community Pharmacy form has impacted on data quality for medication incidents as a number of fields are not included for completion. Therefore, for incidents reported during October and November 2022, 21 incidents do not include the severity of the incident – this discrepancy is being addressed with the Head Pharmacist. Of the total number of medication incidents reported, the top three types of medication incidents relate to administration errors (75) Medication supply errors (73) and Medication prescribing errors (31).

- There has been a decrease in mortality during the months of September, 2.45% and October 2022, 2.65%. November 2022 data was not available at the time of this report.

- In relation to Patient Safety Solutions (PSS), it is very pleasing to report that further compliance has been achieved in Patient Safety Notice PSN063 since the last report to Committee. This leaves only 1 outstanding patient safety alert, which requires an all Wales solution for compliance. The Health Board now presents very favourably amongst other Welsh Health Boards in terms of PSS.

- Learning from Events reports, (LFER's) continue to be a challenge for the Health Board, with a historic backlog of overdue LFERs. This is included on the corporate risk register as a significant risk due to the potential reputational and financial impact. There remains much work to do in order to clear the backlog, and a shift being realised to ensure current incident management/investigation includes evidence provision on Datix for Learning from Events Reports (LFERs). The new operating model and proposed supporting quality, safety and governance arrangements, places responsibility within the Care Group Governance teams to facilitate the completion of the LFERs.

- **The CTM Listening and Learning Event took place on 23rd September 2022.** This was a significant opportunity to promote and nurture the learning culture supporting continuous improvement and patient safety across the Health Board. Another event is being arranged for 15th March 2023, which will

focus on sharing specific learning from across the health board, which at the time of reporting will encompass a recent high profile child practice review.

- The health board continues to hold quarterly shared listening and learning forums. This forum supports with learning being shared from across the health board along with sharing a patient story. The Learning Repository introduced at the launch of the Listening and Learning Framework, has a 3-month theme focus for those areas, which are the health board's main incident themes/trends. A presentation is set to be presented at the leadership forum in January to promote the listening and learning framework and repository and encourage more learning to be uploaded. SharePoint currently has its limitations, with the plan for an updated version of SharePoint in the near future, the repository is likely to become more intuitive and user friendly.

- A monthly patient safety newsletter is currently disseminated across the health board to highlight the main incident themes and trends for the month along with providing updates in relation to patient safety projects and developments.

  - The new Care Group Operating Model will mean changes will be required to the current CTMUHB Quality and Safety Framework, Putting Things Right (PTR) policies, with necessary changes to aligned systems and Audit processes to provide assurance of patient safety, learning and quality of care across the organisation.

  - Interim Arrangements for Quality Governance and Patient Safety have been in place since November 2022 with Governance teams continuing to work within the ILG framework for Governance until the Organisational Change Policy (OCP) consultation has been finalised.

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

Indicator Description	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept-22	Oct-22	Nov 2022	Trend
Number of formal complaints (managed through PTR)	102	94	95	87	84	87	57	84	82	88	75	**87**	
Number of formal complaints closed (managed under PTR)	107	67	117	100	77	83	81	70	81	69	67	**73**	
Number of Early Resolution complaints	117	174	183	229	180	206	168	175	234	208	181	**187**	
Number of compliments	51	71	59	25	60	182	196	99	24	80	80	**73**	
Number of Ombudsman Received	5	8	7	11	9	9	6	6	5	7	9	**4**	
Number of never events in month	0	1	0	0	0	1	0	0	0	1	0	**0**	
Number of Nationally Reportable Incidents New process from 14.06.21	4	4	7	8	4	5	6	2	9	2	7	**15**	
Number of Locally Reportable Incidents	18	9	17	13	10	5	5	6	7	17	5	**1**	

Data run on 01.12.22

Complaints:

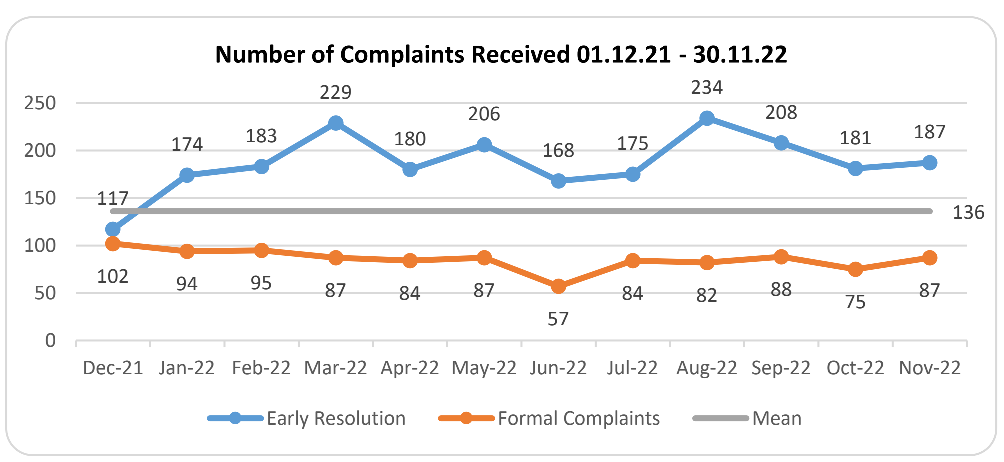
New Complaints Received

During October 2022 and November 2022, there were 162 formal complaints received within the Organisation which were managed in line with the Putting Things Right regulations. The number of formal Complaints managed through PTR has remained relatively consistent over the last 3 months. Within the same period (October and November 2022), the Health Board managed 368 complaints under Early Resolution, representing a decrease of 74 complaints when compared to the previous 2 months (442). The trend in relation to new complaints received is reflected in the chart below.

For all complaints received in October and November 2022, the top 3 themes relate to Clinical Treatment / Assessment (173), Communication Issues, including attitude & behaviour (126) and Appointments (108).

Closed Complaints

Between the 01.10.22 and 30.11.22, the Health Board closed 140 formal complaints (managed through PTR). Compliance with the 30 working day response rate decreased in November 2022 when compared to October, but the trend remains relatively the same with the mean average compliance for 12 months being 58%.



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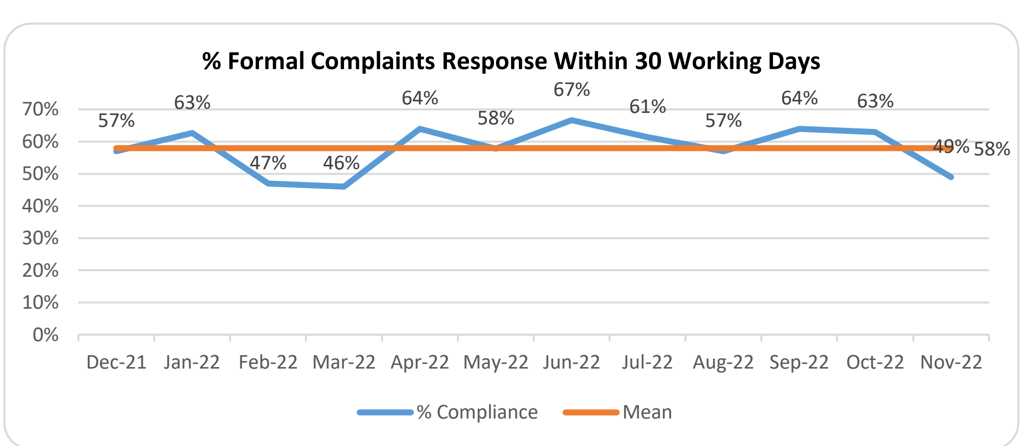

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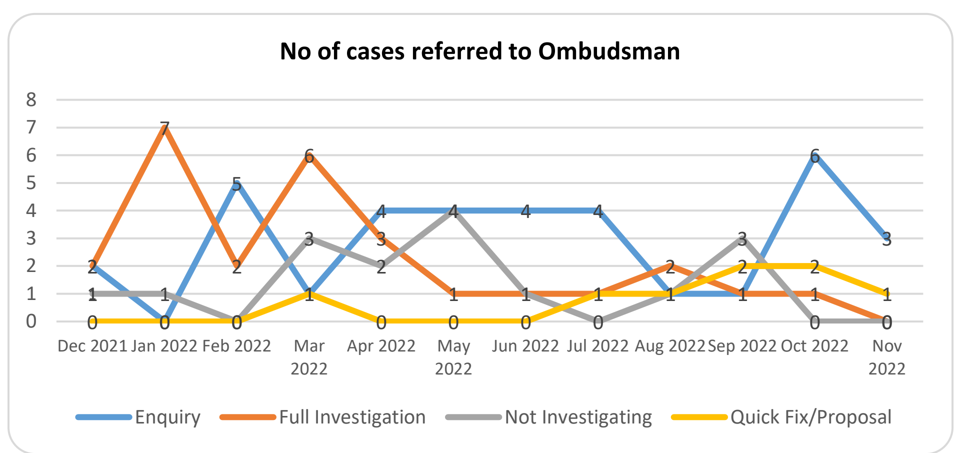
Public Services Ombudsman for Wales
During October 2022 and November 2022, the Health Board received notification of 13 Public Services Ombudsman for Wales (PSOW) referrals. The trend remains relatively the same when compared to the previous 2 months. Of the 13 referrals, 1 case was received as a full investigation, 3 were received as quick fixes/proposals with the remaining 9 managed as enquiries.

Between the 01.10.22 and 30.11.22, the Health board received 6 Final reports from the Public Services Ombudsman for Wales. Of the final reports received, 3 were Upheld (Section 27) and 3 were Not Upheld.



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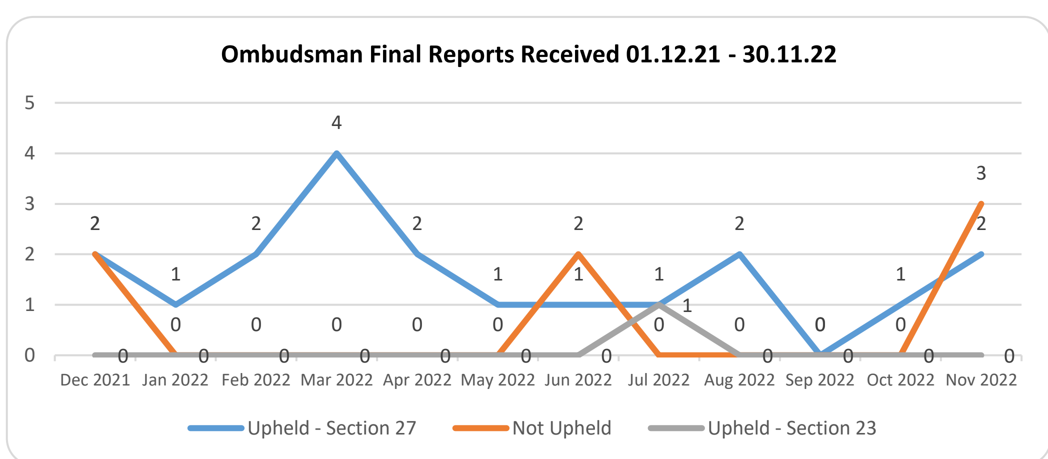

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Compliments
During October 2022 and November 2022, there were 153 compliments recorded on the Datix Cymru system, which represents an increase of 49 when compared to the previous two months (104). The highest number of compliments recorded during October 2022 and November 2022 related to Maternity (49), Emergency Care (28) and Paediatrics (21) all within the Merthyr & Cynon Locality. Compliments are received into the Health Board via a number of mechanisms including social media, Patient experience Surveys as well as thank you cards and emails. This feedback is mainly recorded on the Datix Cymru and Civica user experience systems. Further work is being undertaken within the Health Board to improve the capturing, recording and reporting of the compliments received.

An all Wales Compliments Workstream has been established which will focus on the development of a comprehensive coding structure and system requirements for capturing positive feedback.

Patient Experience:
The latest patient experience data is attached at **Appendix 2**.

Patient Safety Incidents:
Between October 2022 and November 2022, a total of 4,400 incidents were reported across the Health Board. This is an increase of 347 when compared to the previous two months. Of these, 87% (3,807) were reported under the type of patient safety during the two month period. Of the patient safety incidents, 67 were reported with a severity of severe harm (39) or death (28), an increase of 12 when compared to the previous 2 months. This equates to 1.6% of the total number of patient safety incidents reported during the 2 month period. Caveats in relation to severe and death incidents are highlighted in the narrative above.

Nationally Reportable Incidents:
As highlighted in previous reports, following the introduction of the NHS Wales National Incident Reporting Policy on the 14.06.21, the Health Board distinguishes between Nationally Reportable Incidents and Locally Reportable Incidents (those previously classified as serious incidents). The trend for the last 12 months is reflected in the chart below.

During October 2022 and November 2022, 22 nationally reportable incident notifications were submitted to the Delivery Unit (DU) and 6 identified as Locally Reportable Incidents. During November 2022, it was required that historic Appendix B WAST cases would be reported to the DU prior to being investigated; therefore, this represents an increase of 11 nationally reportable incidents when compared to the previous 2 months. It is anticipated a number of these legacy Appendix B incidents will be downgraded following a full review at Multi-Disciplinary Team (MDT) panel.

Type of Nationally Reportable Incidents	Oct-22	Nov-22	Total
Transfer, Discharge	1	5	6
Access, Admission	1	3	4
Assessment, Investigation, Diagnosis	1	2	3
Patient/service user death	0	2	2
Slip, Trip or Fall	0	2	2
Treatment, Procedure	2	0	2

Nationally Reportable Incidents, Locally Reportable Incidents

Month	Nationally Reportable Incidents	Locally Reportable Incidents
Dec-21	4	18
Jan-22	4	9
Feb-22	7	17
Mar-22	8	13
Apr-22	4	10
May-22	5	5
Jun-22	6	5
Jul-22	2	6
Aug-22	9	7
Sep-22	2	17
Oct-22	7	5
Nov-22	15	1

Nationally Reportable Incidents — Locally Reportable Incidents — Mean

Pressure Damage	0	1	1
Maternity adverse occurrence	1	0	1
Safeguarding	1	0	1
Total	**7**	**15**	**22**

Patient Safety Solutions:

Summary

There have been no new patient safety notices or alerts issued since the previous Quality & Safety Committee meeting.

The Delivery Unit (DU) continue to facilitate the national working group for the review and management of Patient Safety Solutions (PSS). During this meeting health boards come together to share their progress and discuss barriers and solutions, which is supporting the ongoing internal work to achieve compliance.

The internal management, monitoring and reporting process for Patient Safety Alerts (PSAs) and Patient Safety Notices (PSNs) is now operating in a structure of devolved responsibility to the relevant ILG teams, with the central Patient Care and Safety Team providing support, co-ordination and oversight, leading to reporting. This will be revised as we progress through the organisational structure changes with the oversight then being provided by the new role of compliance manager.

The Safety Alert Broadcasting System Policy is currently under review and is utilising the DU *All Wales Guidance for the Management of NHS Wales Patient Safety Solutions* published in July 2022 for reference. A national working group for safety alerts has been established in October which aims to support a more standardised approach of managing patient safety alerts/ solutions in health boards. This is going to focus on patient safety alerts and solutions in first instance and then focus on wider alerts such as MHRA's in the second phase of the working group.

Compliance:

In total, there is **1 alert** and **0 notices** in which CTMUHB are non-compliant. Non – compliance status for the alert is an ongoing issue which is currently being reviewed on an All Wales Level.

Since last report:

Compliance achieved: **PSN063**

Non-compliance

PSA008
Nasogastric tube misplacement
An all Wales Training package for NG Tube insertion is being established. The DU have fed back the first national meeting took place in September. 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.

Safety Measure Indicators

Indicator Description	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept-22	Oct-22	Nov 2022	Trend
Number of medication prescribing errors	21	10	13	19	14	15	8	8	21	13	14	**17**	
Number of medication administration errors	41	35	35	41	26	37	32	29	24	26	40	**35**	
Total number of inpatient falls	260	300	254	292	260	258	262	242	240	274	260	**245**	
Number of inpatient falls where harm has occurred (moderate, severe and death)	9	10	13	12	22	25	22	25	25	16	22	**22**	
Total number of instances of hospital acquired pressure ulcers	79	86	105	86	109	100	92	100	119	120	133	**106**	
Number of hospital acquired pressure ulcers grade 3 and 4	0	1	6	2	1	5	4	2	11	5	6	**8**	

Total number of instances of Community acquired pressure ulcers	168	170	147	163	105	104	112	116	96	105	118	**111**	
Number of Community acquired pressure ulcers grade 3 and 4	16	19	16	18	6	5	16	17	8	9	12	**14**	
Number of potential Hospital Acquired Thrombosis (HATs)	6	6	5	13	5	9	7	11	13	10	5	12	
% VTE risk assessments documented on the med. Chart	93	96	98	97	95	92	93	93	97	92	94	95	
Hospital Arrests (2222 calls) Adult	48	42	46	49	44	35	44	45	27	35	39	**N/A**	
% NEWS audit by site (RGH/YCR/PCH/YCC/PoWH/ Ysbyty'r Seren)	89.5	89.8	88.6	87.3	88.9	87.2	87.0	87.7	89.8	90.8	87.0	**90.4**	
C.difficile Rate/1000 admissions	2.87	1.91	2.66	3.54	1.89	1.14	1.55	2.10	2.87	2.83	2.02	**1.21**	
MRSA bacteraemia Rate/1000 admissions	0	0	0.22	0	0	0.19	0.39	0	0	0.20	0	**0**	
MSSA bacteraemia Rate/1000 admissions	2.10	2.12	1.33	2.42	3.15	2.66	1.75	3.05	2.87	2.42	1.61	**2.83**	
E. coli bacteraemia Rate/1000 admissions	5.74	5.09	5.21	4.47	6.10	5.69	6.22	4.77	7.16	8.48	7.87	**6.05**	
% of patients who spend less than 4 hours in A&E from arrival to admission, transfer or discharge (Internal Measure by Arrival Date)	65	66	63	63	62	62	62	62	66	66			
% of patients who spend less than 12 hours in A&E from arrival to admission, transfer or discharge (Internal Measure by Arrival Date)	91	88	87	88	87	88	88	88	88	88			
% turnaround of patients who spend less than 4 hours in A&E (based on discharges) (National Measure EDDS).											61	**63**	
% turnaround of patients who spend less than 12 hours in A&E (based on discharges) (National Measure EDDS).											87	**87**	

AvLOS overall mean (based on discharges only)	5.3	5.6	5.8	5.5	6.0	6.0	5.7	5.5	5.5	5.6	5.6	5.1	
Mortality Rate (CHKS)	3.82%	3.53%	2.76%	2.62%	3.44%	2.65%	2.82%	3.23%	2.81%	2.45%	2.65%	N/A	

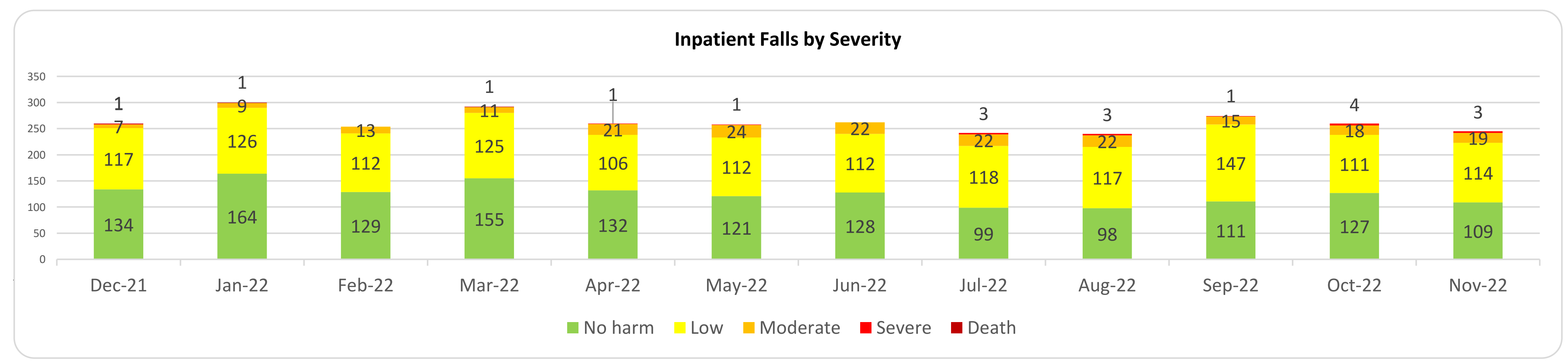
Data run on 01.12.22

Medication Incidents

A total of 223 medication incidents were reported during October 2022 and November 2022. 82% of the incidents were reported as resulting in no (141) or low (42) harm, with the remaining reported as resulting in moderate harm (17) and 2 severe harm. The severe cases relate to a prescribing error in Emergency Care Centre Prince Charles Hospital and a Medication storage, security and disposal in Mental Health Royal Glamorgan Hospital. The introduction of a specific Community Pharmacy form has impacted on data quality for medication incidents as a number of fields are not included for completion. Therefore, for incidents reported during October and November 2022 - 21 incidents do not include the severity of the incident. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (75) Medication supply errors (73) and Medication prescribing (31).

Inpatient Falls

A total number of 505 inpatient falls were reported between October 2022 and November 2022, which represents a decrease of 8 in the number of falls reported in comparison to the previous two months. Of the falls reported, 91% were reported as no (236) or low (225) harm. The remaining incidents were reported as moderate (37) and severe (7) harm. No incidents relating to inpatient falls were reported as resulting in death. During October 2022 and November 2022, the highest number of inpatient falls occurred on AMU at Princess of Wales Hospital (24), Emergency Care Centre at Prince Charles Hospital (24), Clinical Decision Unit at Prince Charles Hospital (18), Ward 7 at Ysbyty Cwm Cynon (13) and Ward 10 at Princess of Wales Hospital (13).



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Pressure Damage Incidents

During October 2022 and November 2022, a total of 961 pressure damage incidents were reported, of which 466 were reported as occurring during the current case load. The remaining pressure damage incidents were reported as being present before admission to this clinical care area/caseload (495). Of the 466, 239 were identified as being hospital acquired and 227 as community acquired. This represents no change in hospital acquired pressure damage incidents when compared to the previous 2 months. The locations with the highest reported hospital acquired pressure damage incidents were the Emergency Department at Princess of Wales Hospital (19), Emergency Care Centre at Prince Charles Hospital (12), and Ward 5 at Prince Charles Hospital (12). There were 14 hospital acquired incidents reported as Grade 3 in October (6) and November (8) 2022. There were no hospital acquired Grade 4 incidents reported during the two month period.

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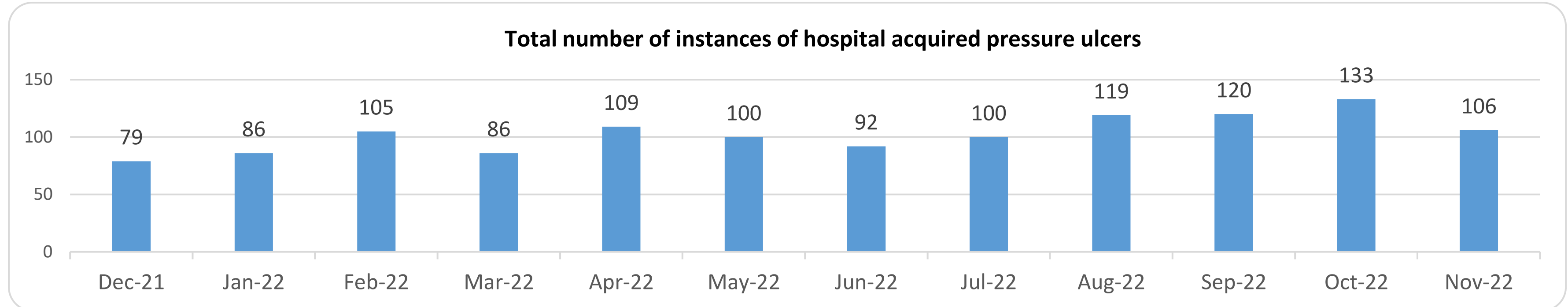
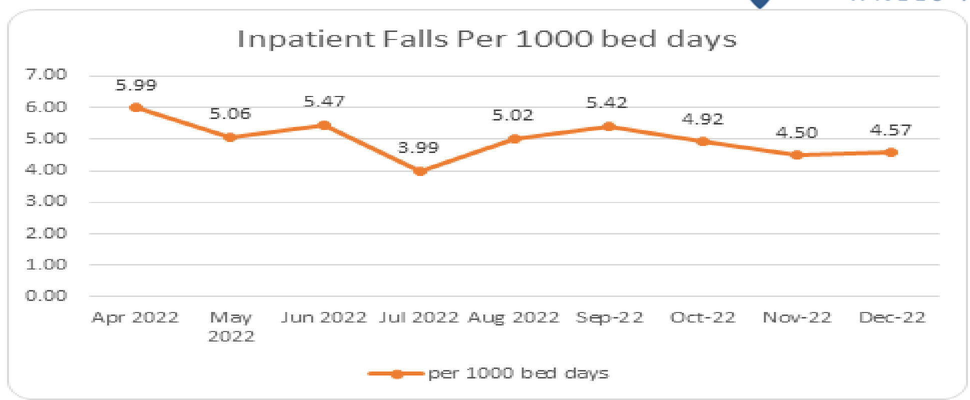
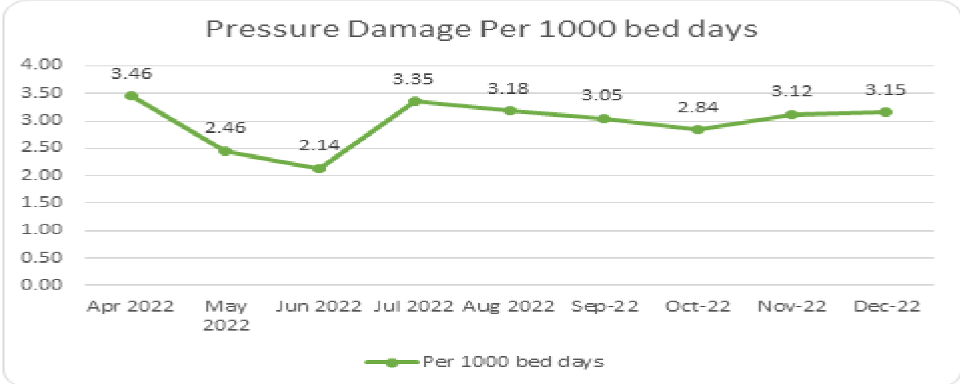


Falls and Pressure Damage per 1000 bed days





Hospital Acquired Thrombosis (HAT) and Venous Thromboembolism (VTE) assessments:
There were 17 potential HATs identified for October 2022 to November 2022 compared to 23 for the previous reporting period from August 2022 to September 2022. It is 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 actual HAT's in relation to potential vs actual.

Hospital Cardiac Arrests and NEWS Training:
For October 2022, the number of calls taken were 39 compared to August 2022, 27 calls and September 2022, 35 calls. November 2022 data was not available at the time of this report. Hospital Cardiac Arrest Calls will remain an important metric, as the ultimate goal 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 this goal.

Recognising Acute Deterioration and Resuscitation (RADAR) group will be expanding metrics to ensure there is a constant review of activities. NEWS training is also being recorded on the new Clinical Audit and NICE compliance monitoring system, so training figures are now available.

Infection Prevention and Control:
A rise in COVID and influenza cases along with other respiratory viruses has put additional pressures on the infection prevention and control team and clinical services. A rise in community prevalence and hospital cases has been reported across our acute and community hospital sites. Clinical pressures and outbreak management is discussed at the weekly IPC Cell meeting. Following a recent review of the testing guidance, all patients presenting with respiratory symptoms continue to be tested for a range of respiratory viruses in addition to COVID.

Mandatory surveillance continues nationally for five key organisms including C. difficile, Staphylococcus aureus bacteraemia and E.coli, Pseudomonas and Klebsiella bacteraemia. Local reduction expectations have been agreed with the Nurse Directors which has improved understanding and ownership of data. More than half of the bacteraemia reported since April 2022 are community acquired infections and a scoping exercise is planned to identify the infection prevention and control nurse resource required to provide a dedicated comprehensive service in primary care. Staff sickness and vacancies within the IPC team has delayed this work.

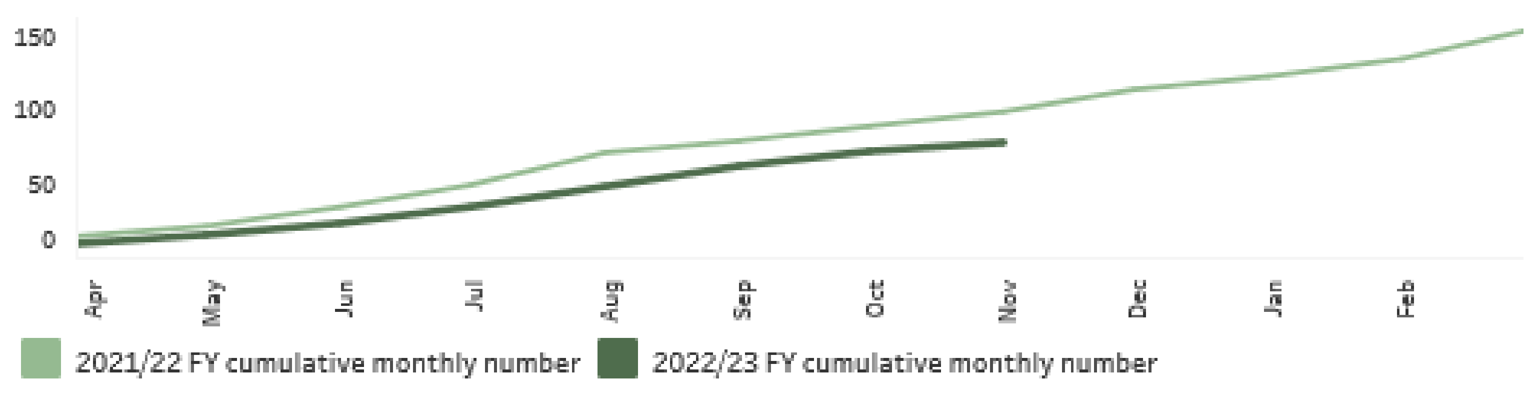
The infection prevention and control team continues to work collaboratively with the care groups to improve the investigation procedure and root cause analysis process for C. difficile infection and preventable bacteraemia. Learning is shared with clinical teams to inform and influence practice. Further engagement and support is required to introduce this in primary care.

Roll out of aseptic non-touch technique (ANTT) has commenced in Bridgend and sessions have been planned to increase the number of ANTT assessors across the Health Board. The infection prevention and control team is working with medical colleagues to improve compliance with infection prevention and control and ANTT training.

Infection prevention and control plan for the next 3 months –

- Review current IPC establishment considering the need for a primary care resource and secure appointments into the IPC Nurse vacancies.
- Support newly appointed IPC Nurses.
- Support improvement work to reduce health care associated infections.
- Continue to support the respiratory/non-respiratory pathways, testing framework and COVID-19 response.
- Deliver an IPC service in line with the new organisational structure.

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of C. difficile for April 2022 to November 2022 against the equivalent period in 2021/22



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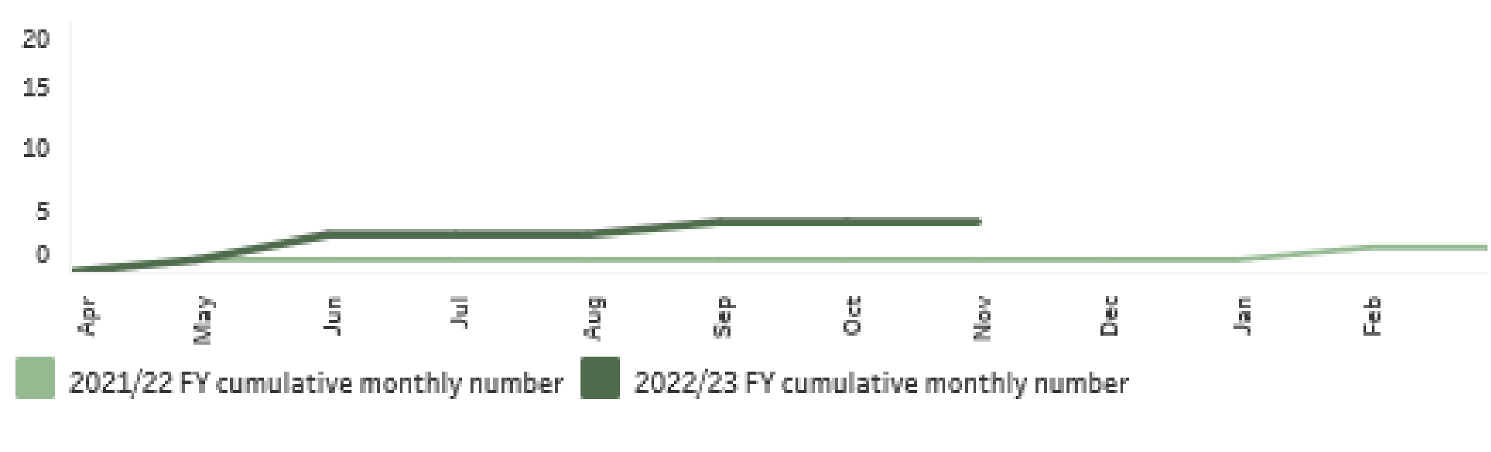
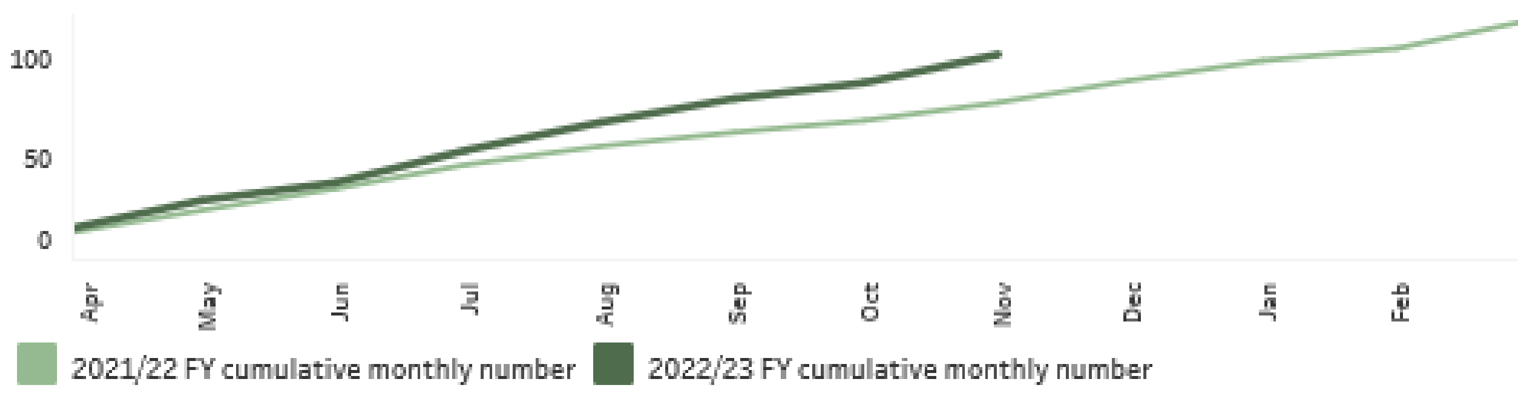
Cwm Taf Morgannwg University Health Board cumulative monthly numbers of MRSA bacteraemia for April 2022 to November 2022 against the equivalent period in 2021/22



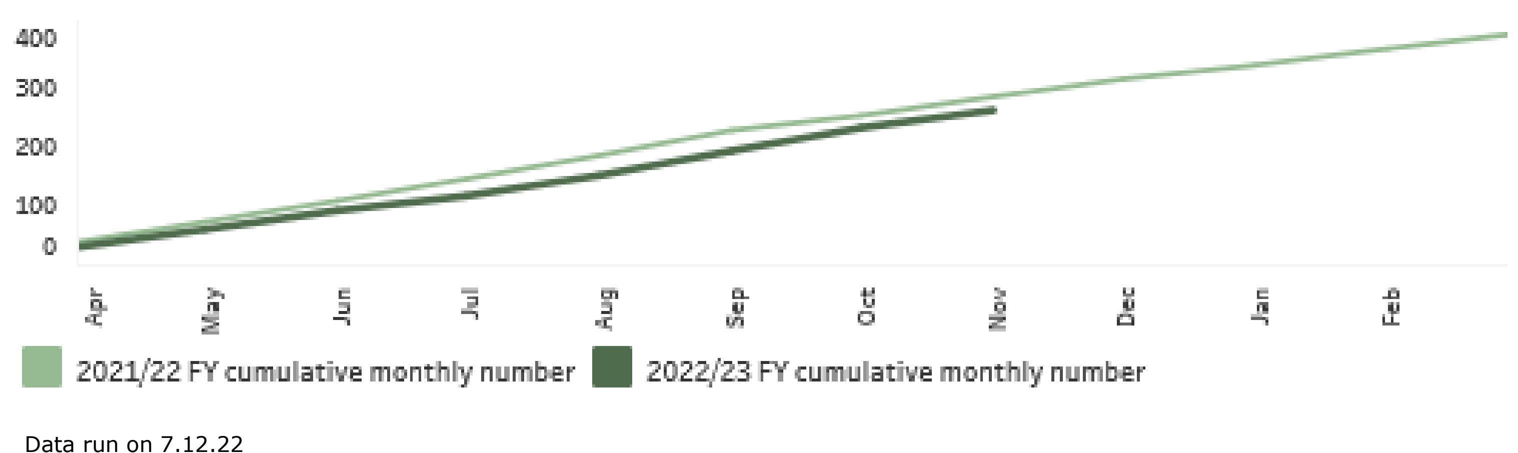
Data run on 7.12.22

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of MSSA bacteraemia for April 2022 to November 2022 against the equivalent period in 2021/22



Data run on 7.12.22

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of E. coli bacteraemia for April 2022 to November 2022 against the equivalent period in 2021/22



Data run on 7.12.22

Emergency Department 4 hour and 12-hour performance:
Compliance with the EDDS National Measure with the 4-hour target has increased to 63% in November 2022 compared to the previous reporting period 61% October 2022, as front door activity remains high. The 12-hour A&E performance remains comparable in October and November 2022 at 87%.

Average Length of Stay:
The ALoS has decreased to 5.1 days in November 2022 compared to 5.6 days in October 2022. A full review of COVID cases will be undertaken as part of the National COVID audit and as part of the COVID mortality review process to identify any common themes, trends and learning.

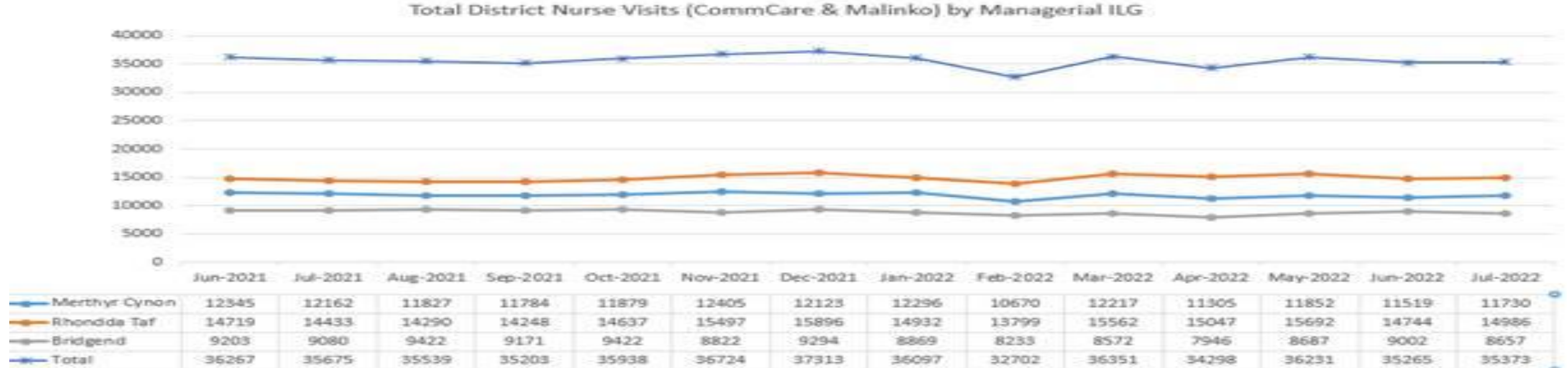
Mortality rate:
There has been a decrease in mortality during the months of September, 2.45% and October 2022, 2.65%. November 2022 data was not available at the time of this report.

Indicator Description	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept-22	Oct-22	Nov 2022	Trend
Community Care Metrics													
District Nurse treatments	37313	36097	32702	36351	34298	36231	35265	35376	36155	35404	36739		
Referral to At Home Services (All Referrals)	102	108	101	141	90	120	122	129	123	128	118	**120**	
Maesteg Hospital (ALOS)	0	0	0	0	0	0	0	0	0	0	0	**0**	
Ysbyty'r Seren (ALOS)	39	42	54	96	55	63	0*	0*	0*	0*	0*	**0***	
*Princess of Wales Hospital, Ward 21 (ALOS) (length of hospital spell where a patient's last episode was on this ward)	-	-	-	-	-	-	46	63	77	102			

Indicator Description	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept-22	Oct-22	Nov 2022	Trend
Community Care Metrics													
*Princess of Wales Hospital, Ward 21 (ALOS) (Patients that were transferred to this ward as opposed to being discharged and admitted there)							16	21	47	23	39	**50**	
Ysbyty Cwm Cynon (ALOS)	61	55	74	54	61	63	49	51	64	64	57	**56**	
Ysbyty Cwm Rhondda (ALOS)	58	82	69	75	67	70	56	67	55	62	80	**69**	
Palliative Medicine, Bridgend (ALOS)	13	25	27	14	19	14	20	9	10	24	19	**23**	
Palliative Medicine, Pontypridd/RGH (ALOS)	9	18	11	8	4	19	12	7	8	8	11	**7**	
Palliative Medicine, YCC (ALOS)	13	9	26	18	16	13	32	16	36	4	25	**28**	

Data run on 01.12.22

District Nurse Treatments and at Home Referrals:



	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022
Merthyr Cynon	12345	12162	11827	11784	11879	12405	12123	12296	10670	12217	11305	11852	11519	11730
Rhondda Taf	14719	14433	14290	14248	14637	15497	15896	14932	13799	15562	15047	15692	14744	14986
Bridgend	9203	9080	9422	9171	9422	8822	9294	8869	8233	8572	7946	8687	9002	8657
Total	36267	35675	35539	35203	35938	36724	37313	36097	32702	36351	34298	36231	35265	35373

The data is currently collected at Health Board (HB) level.

District Nursing

This detail requires to be divided into localities to be able to provide qualitative information on. However, the Rhondda Taf Ely (RTE) District Nurse (DN) calls continue to increase and there are occasions with being unable to support timely hospital discharges.

The DN service as a whole see patients who are NOT housebound but this is due to other services not being available within the HB for the patients and the care falls to the DN teams.

RTE
There has been approximately 500 less visits during September. The ongoing demand continues to challenge the service's capacity. The main issue for the service is non-housebound patients on the caseload.

M&C
The number of palliative care visits continue to rise due to the ageing population we serve, palliative care, increased complexity, chronic health conditions and dementia adding increased pressure to an already overstretched service although the resources

remain the same. Maintaining the quality of care being delivered remains a challenge due to a combination of both an increase in demand and increasing patient acuity. Teams are mitigating against this through collaborative working, both within District Nursing and with supporting services, to share the risk and maintain a high quality service.

Community Hospitals Average Length of Stay (ALoS):

Bridgend

The Band 4 Health Care Support Worker (HCSW) development training is complete with staff completing competencies in practice. WLOC has been implemented in all district nursing teams across the locality; the professional judgment workbook has been completed for Health Education Improvement Wales (HEIW); Civica implemented across all teams plans for out of hours team now in January 2023 and CAPU project for all teams within District Nursing and ward 21. 8,667 patients were visited by a District Nurse during October 2022, November 8821. The service is currently carrying 5 WTE RN vacancy position.

GP

GP referrals continue to account for the majority of the activity, there continues to be some staffing deficits, however, the staff are still managing to provide a timely response to the patients referred to the service.

Ward 21 at Princess of Wales Hospital (POWH)

Representatives from the Ward Team engaged in CTM Community Pressure Ulcer Collaborative work. The ward have implemented *Safe to Start* and daily Multidisciplinary board round. Plan’s in place to pilot the Discharge to Recovery Pathway (DTR). Pressure ulcer audit findings identified a need for training for bank and agency staff. Nurse staffing acuity completed daily on the ward. The service is currently carrying 3 WTE RN vacancies.

Ysbyty Cwm Rhondda (YCR)

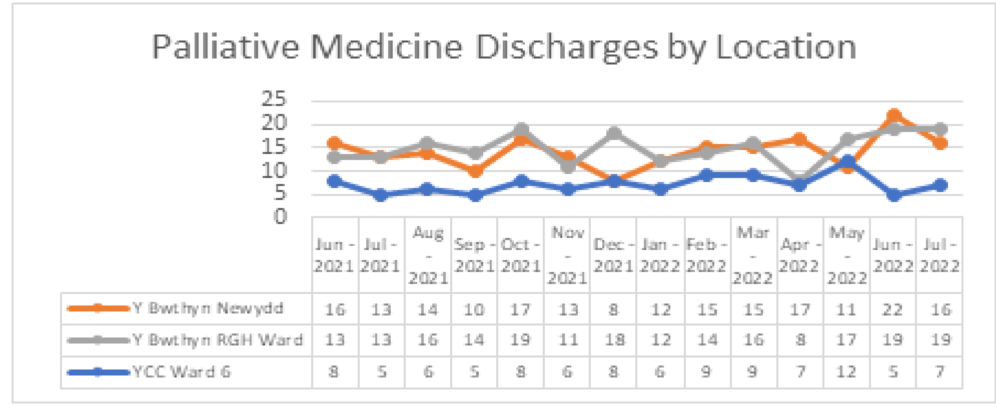
Discharges have decreased by 2 in month, the issue remains with the lack of capacity of required support in the community for discharge. Length of Stay (LOS has increased.

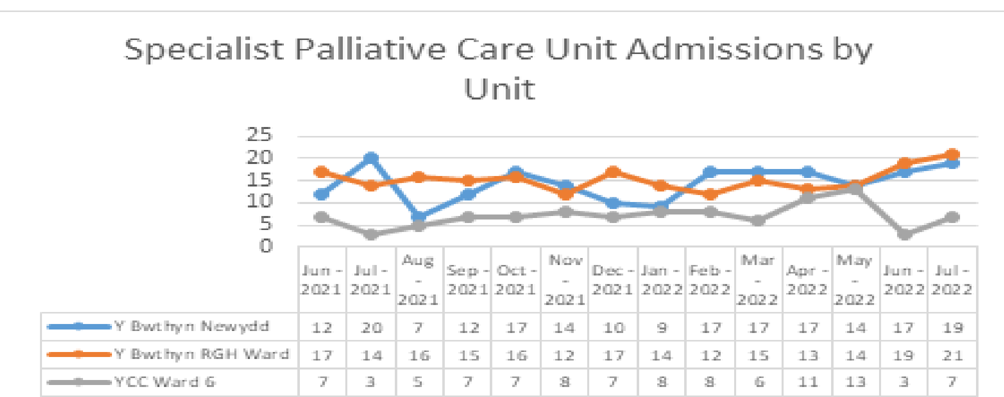
Continues to have a significant number of patients awaiting appropriate discharge destinations. There are currently 39 ‘ready to leave’ patients in YCR, either requiring a POC or care home bed.

Ward 21 at POWH
Representatives from the Ward Team engaged in CTM Community Pressure Ulcer Collaborative work. The ward have implemented Safe to Start and daily Multidisciplinary board round. Plans are in place to pilot the Discharge to Recovery Pathway. Dementia Awareness update training provided for the Ward Team. Pressure ulcer audit findings identified a need for training for bank and agency staff. Nurse Staffing acuity completed daily on the ward. The service is currently carrying 4WTE RN vacancies.

Palliative care inpatient units
The average LOS has increased, however LOS data does not reflect the accuracy against bed occupancy %.

Palliative Care inpatient admission data





Indicator Description	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept-22	Oct-22	Nov 2022	Trend
Mental Health Care Metrics													
Number of 136 assessments in police cells	0	0	0	0	0	0	0	0	0	0	0	**0**	

Indicator Description	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept-22	Oct-22	Nov 2022	Trend
Mental Health Care Metrics													
Restrictive Practices	6	9	1	0	3	0	16	22	12	32	46	**30**	
Number absconding from wards (overall not just detained) ****	21	18	23	25	22	22	21	24	25	18	23	**21**	

Data run on 01.12.22

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

Restrictive Practices
Between October 2022 and November 2022, a total of 76 incidents using Restrictive Practices were reported within Mental Health. This is an increase of 32 incidents when compared to the previous two months. Of these, 68% (52) were reported as not care planned and 32% (24) were reported as care planned. Of the 76 incidents, 92% were reported as no (47) or Low (23) harm. The remaining incidents were reported as moderate (4) occurring on St David's Unit at Royal Glamorgan Hospital (2), Ward 21 at Royal Glamorgan Hospital (1) and Coity Clinic (PICU) at Princess of Wales Hospital (1). 2 severe incidents were reporting as occurring at Coity Clinic (PICU) at the Princess of Wales Hospital.

Absconding Incidents
During October 2022 and November 2022, a total of 44 Absconding incidents were reported. The highest number of incidents reported were for Ward 22 at Royal Glamorgan Hospital (7), and Emergency Care Centre at Prince Charles Hospital (7). 98% of the absconding incidents reported in October 2022 and November 2022 were recorded as No (28) or Low (15) harm, with the remaining incidents reported as moderate harm occurring in Emergency Care Centre Prince Charles Hospital.

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.

- The proposals in relation to a changed operating model presents significant challenges in ensuring the quality, patient safety and people's experience agenda remains well led and managed throughout. Significant leadership changes of key quality, nursing and quality governance roles are imminent and must be mitigated against. Quality governance arrangements during this time is operated within an interim position to ensure that robust oversight is maintained. The OCP in relation to Quality governance and patient safety is currently out for consultation until 19th January 2023.
- The CTMUHB Quality & Safety Framework is currently in draft and presented to Committee in a separate paper today; this will facilitate the direction of travel of national requirements and support the governance teams transitioning into the new care group structures.
- Post pandemic recovery, the impact of Industrial Action and increased demand and pressures of unscheduled care, patient flow and discharge difficulties for patients requiring ongoing support, continues to have considerable and ongoing consequences on the experience of patients and the ability of the HB to provide continuity around its core business. This is an unprecedented, considerably challenging time for health and social care services.
- The health board is working with the Welsh Ambulance Service Trust (WAST) to review how incidences such as patients being unable to receive an ambulance in the community can be reduced, and to mitigate the risk of harm to those waiting extended periods to be off loaded from ambulance in the meantime. The Unscheduled Care Nurse Director and acute sites Heads of Nursing are working through a set of care principles during delays in offloading to Emergency Departments. This will be co-produced with consultants and WAST.

- Ensuring robust implementation of the RLDatix system, which is aligned to the new operating model and progressing the ambition to develop an IT infrastructure to ensure up-to-date high quality data that is readily accessible enable triangulation and is meaningful to facilitate improvement objectives.
- Gaining health board wide assurance across the breadth of UHB services, especially during a period of significant change in its operations is a key requirement.
- Actions to address these issues and risks are in place in the improvement action plans relating to the targeted intervention areas. Beyond this, the Health Board require ambitious pursuit of quality and safety in all it does to provide excellence in service delivery to the population of CTM.

4. IMPACT ASSESSMENT

<table>
<tr><td rowspan="2">Quality/Safety/Patient Experience implications</td><td>Yes (Please see detail below)</td></tr>
<tr><td>This report outlines key areas of quality across the Health Board.</td></tr>
<tr><td rowspan="2">Related Health and Care standard(s)</td><td>Governance, Leadership and Accountability</td></tr>
<tr><td>This report applies to all Health and Care Standards.</td></tr>
<tr><td rowspan="2">Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.</td><td>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.</td></tr>
<tr><td>• 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</td></tr>
<tr><td rowspan="2">Legal implications / impact</td><td>There are no specific legal implications related to the activity outlined in this report.</td></tr>
<tr><td></td></tr>
</table>

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

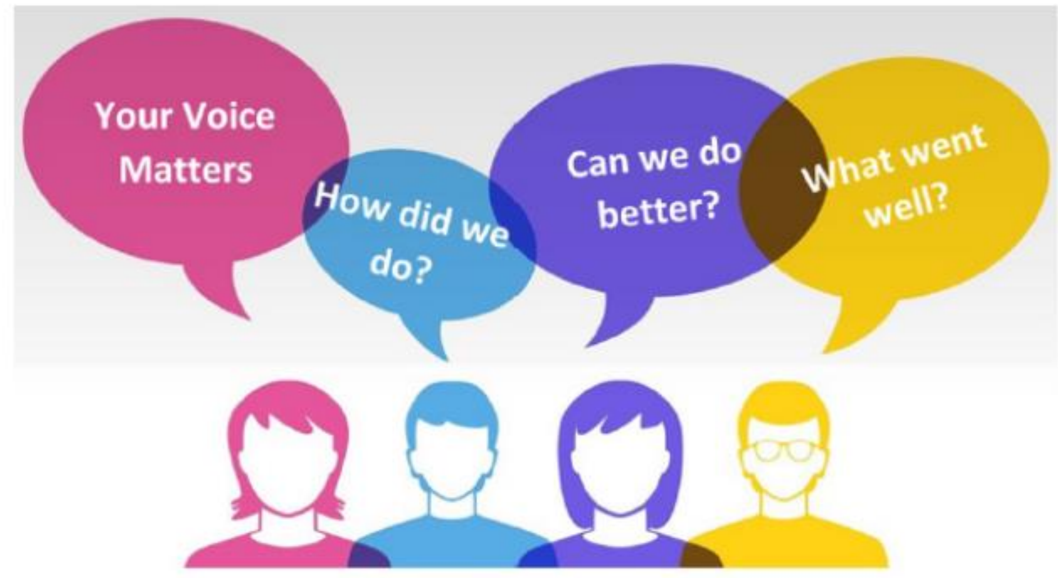
4.3 **NOTE** the risks identified

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

APPENDIX 1:

Delivery Unit Dashboard Reports

APPENDIX 2



Patient Experience

Activity Period October 2022 – November 2022

A patient's voice is critical to enable us as healthcare providers to ensure the services we provide best help patients, families, carers and our communities in times of need. By engaging with our staff and communities, this enables the Health Board to build up an understanding of what is working well but also to drive service change and improvement.

The Health Board continues to engage via a number of different avenues to inform this via systems and services that sit within our acute settings but also those of third party stakeholders as well.

The Civica system continues to be developed and utilised across different specialities to explore how we can support patient feedback and look at the richness of information that this provides us with. There are currently 47 surveys on the system, the number of responses for each are detailed below:

Total Per Month	464	311	371	295	201	1642
Survey Name	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Total**
Maternity- Antenatal - Phase 1	35	31	32	36	29	**163**
Maternity- Antenatal - Phase 2	38	45	51	36	21	**191**
Maternity- Labour birth and postnatal care - Phase 3	69	79	105	109	54	**416**
Maternity- Postnatal community - Phase 4	43	28	27	30	30	**158**
Maternity- A vision for the future | CTM Maternity Services Survey						**0**
Maternity- Prem Questionnaire for Birth partners	0	1	0	2	1	**4**
Maternity- Staff Vision Questionnaire						
Have Your Say	56	4	5	6	2	**73**
Patient Experience	21	20	8	5	7	**61**
Heart Failure-PREM Survey	3	11	18	18	44	**94**
WREM Survey- PROMs/PREMs (Clinical/ Admin Staff)						**0**
WREM Survey- Support staff PREMs						**0**
WREM Survey- Support staff PROMs						**0**
WREM Survey- Platform Experience Outcome Measures	29					**29**
Paediatrics- Your Time in Hospital - Childrens Survey 11 years and upwards	5	2	1	0	0	**8**
Paediatrics- Your Time in Hospital - Children's survey aged 4-11 Years	14	8	3	0	0	**25**
Therapies	1	1	0	0	0	**2**
Pathology						**0**
Frailty Nurse Services	3	6	2	2	6	**19**
Emergency Department - Prince Charles Hospital	119	17	9	0	0	**145**
Integrated Cluster Survey	0	0	0	0	0	**0**
Visiting Survey - Patient	0	0	0	0	0	**0**
Visiting Survey- Staff	0	0	0	0	0	**0**
Wellness Survey	0	0	0	0	0	**0**
Quality of emergency admission patients' experience questionnaire (Infective)	0	0	0	0	0	**0**
Quality of emergency admission patients' experience questionnaire (Trauma)	0	0	0	0	0	**0**

Patient / Service User Experience Survey	0	0	0	0	0	**0**
Parents/Carers Questionnaire	19	11	15	0	0	**45**
YCC Staff Survey	0	0	0	0	0	**0**
Patient Safety Culture Snapshot Survey			20	1		**21**
HUMA Evaluation Phase 1- Oct 2021						**0**
HUMA Evaluation Phase 2- July 2022	9	1				**10**
LymPREM Questionnaire	0	0	0	1	1	**2**
Paediatrics- Evaluation Questionnaire (allergies)	0	0	0	0	0	**0**
RIW Digital Assessments (PREM)	0	41	73	45	2	**161**
Wellness Improvement Service (WISE) Questionnaire	0	5	2	4	2	**13**
Trauma and Orthopaedic (T&O) Patient Experience Questionnaire						**0**
Family Reported Outcome Measures (FROM-16)						**0**
CTM Inpatient Detox Patient Experience Survey						**0**
Staff Survey- Detox						**0**
Easy Read - Your NHS Care						**0**
Health Visitor PREM Survey - 27 Months						**0**
Health Visitor PREM Survey - 6 Months						**0**
Heart Failure Cardiac Rehabilitation						**0**
Homecare Service- Have Your Say						**0**
Patient Experience Survey - Endoscopy					2	**2**
Specialist Nurse – Homeless & Vulnerable Adults						0
Therapies patient experience survey						0

Please see below some of the comments that were left for our staff:

Although I was quite poorly, I had a great experience with the out of hours GP, A&E triage, and GP referral teams who treated me for a kidney infection. All of the staff I interacted with were both friendly and skilled in getting me treated and feeling better. Thank you very much!

From start to finish the service in this ultrasound dept is fantastic. The nurses are great and helpful. Anyone who complains about these services do not

appreciate how great this NHS service are. You all are a credit to the NHS. Have a great Xmas. All serve the world.

I want to thank nurse Miranda for taking time and interest in me to refer me for help because I was so scared I was going to lose the sight in my other eye. Because she was so kind, I saw a lady who has given me lots of support and referring me for help at home. Without her listening to me and understanding how upset I was, I wouldn't know there are people to help me, Thank you Miranda.

Fantastic staff at children ward and the care of DR Chandratreja – Thank you. Trauma coordinator need to be more understanding of patients and remember them when the planned operation is cancelled- this happened last week.

Came for an Xray this am. The radiographer was welsh speaking, it was a help and comfort to me. Would be lovely if all the staff could speak Welsh.

Lack of disabled car spaces at POW. Much worse now since Ambulances taking disabled car spaces. However this has been an ongoing problem before COVID.

This is the second appointment my husband has had at fracture clinic - Both have resulted in waiting over an hour past the appointed time. Staff friendly and helpful. But more staff is needed.

Couldn't fault the nurses or doctors but maybe a better variety of food for the kids.

Carers

As part of the hospital discharge project the Carer's Co-ordinator continues to have a weekly presence at Prince Charles and Royal Glamorgan Hospitals to support staff and carers alike, highlighting the support available within an acute setting and third sector organisations where needed. Due to capacity issues, we have been unable to secure space in Princess of Wales Hospital until December. As part of this process the Health Board has created a new Carers guide to Hospital Discharge which is now in circulation throughout CTM and available online to download. We have also updated our Carers web page (https://ctmuhb.nhs.wales/services/carers-support-services/) on the internet supplying more information to the public and the facility to download this as well.

Carers Co-ordinator has also supported the CAB4Carers advisor and information stands which have been successful in identifying and supporting

unpaid Carers with information across Prince Charles and Royal Glamorgan Hospital, it has also been an opportunity to identify staff Carers. There are plans to expand this across to Princess of Wales Hospital later in the year.

Our Staff carers meetings continue being led by the Carer's co-ordinator and the last staff Carers meeting was received with positive feedback and is gaining more attendees

'thank you for Friday, so enjoyed and found it so informative'

The content of this forum is led by the staff carers themselves to ensure the information provided is relevant to their circumstances and a number of representatives from Health and third party have been invited to present.

As part of the annual engagement plan for the Regional Partnership Board, the Carers coordinator attended the unpaid Carers hackathon engagement events, to help inform the development of the Regional Plan. The hackathons bring together users of services alongside service providers from both the statutory and voluntary sector in Cwm Taf Morgannwg, and key decision makers. This enables all involved to embark on a process of co-creating and co-designing creative conversation starters upon which further crucial operational and strategic conversations can be undertaken to inspire and inform positive service improvement and change.

Chaplaincy Services

Significant Spiritual and pastoral care

Patients	Relatives/Carers	Staff	Religious Rites	Out of hours requests
649	102	265	239	Total 31.50 hrs claimed. 15.5 hrs for the reporting period. 16 hrs were for the Roman Catholic priest from July to mid-October.

Three foetal collective cremation committal services were held. A private service was also held at Llwydcoed crematorium for a mum and dad.

Chaplaincy team continue to deliver classroom training to raise awareness of the department and what this entails, with a focus upon spirituality and how staff can discover their personal spirituality to help their own wellbeing and enable them to know how to look out for spiritual distress within our patients.

Chaplaincy offered support to staff members in two departments due to death in service, a condolence book was provided to each unit. The team also gave and continue to give support to two further departments where traumatic, unexpected death of patients had occurred.

The bereavement workshop was held in the Lighthouse project, with one of our chaplains leading, and was our first community based course. This was very well attended and received by the public. Positive feedback has been given and other agencies/centres have approached us to enquire about this and the 'At a loss café', we hope to be able to offer these widely across the UHB in 2023.

Our chaplaincy volunteers have joined us at Princess of Wales Hospital and are offering a great service/support mechanism to patients on this site. The role of the 'end of life companions' will now be referred to us through the support of the palliative care team in Princess of Wales Hospital rather than the three wards this was initially trialled on, as we did not receive any referrals through this route due to no patients meeting the criteria. As such, this role will now be trialled across the whole of Princess of Wales Hospital from January 2023.

Much preparation and planning has been undertaken for various December Christmas memorial and/or carol services that can now resume after a break due to covid restrictions. Some sites have held Remembrance Day services, one in the Outpatients department at Ysbyty Cwm Rhondda where 50 people attended.

Lead Chaplin has appointed two new chaplains to our vacant band 6 posts that were advertised recently and a further Band 5 vacancy is being progressed through the pre recruitment process within the Health Board. This will enable the team to explore how we can support patients, families, carers and staff alike through new projects in 2023.

Volunteer Service

Meet and Greet Volunteers

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

- The meet and greet volunteers at Dewi Sant Health Park provide a Monday to Friday service and currently signpost those attending the Health Park which now includes wayfinding to the vaccination centre.
- The meet and greet service at Princess of Wales Hospital was reintroduced several months ago, both morning and afternoon shifts are covered Monday – Friday. This service provides wayfinding, signposting, information and distributing hearing aid batteries. In addition the volunteers encourage feedback from service users by handing out or filling in "Have Your Say" cards.
- The meet and greet service at Royal Glamorgan Hospital was reintroduced in September 2022 and provides an invaluable service with signposting, wayfinding and information. The volunteers also support the Macmillan Information Hub by ensuring the leaflets are in an orderly manner and stock up the holders if leaflets are running low. They also liaise with the porter service for those requiring a wheelchair. To date feedback has been very positive and the volunteers are very much appreciated by staff in the area, including switchboard who provide support for the volunteers on a daily basis.
- During November 2022 volunteer information sessions were held in order to recruit additional volunteers to support projects, one of which being the meet and greet service. The team will be introducing the service at Ysbyty Cwm Cynon in the New Year.

Vaccination Programme

Since 2020, our vaccination centre volunteers have supported the work stream across CTM and have been invaluable to the delivery of services. More recently the vaccination sites have moved to clinical venues and our volunteers continue to offer meet and greet support for those attending the centres at Bridgend, Llantrisant, Rhondda / Cynon Valley. In addition meet and greet volunteers are also promoting feedback from those attending the centres via the "Have Your Say" cards in order to collect details on their experience.

The End of Life Companion Volunteer Service – POW & YCC

The end of life companion volunteer project is a joint initiative between the volunteer service, chaplaincy and clinical staff and was launched on 1st August 2022. Monthly supervision sessions took place during November 2022 with Chaplains and volunteers. To date there has been a slow uptake for volunteer support, however, meetings were held between ward managers and Chaplain leading on the project, to review how this service could be promoted to increase referral uptake. Plans are in place to expand the service to other ward areas with the support of the Palliative Care Team and other clinicians to identify patients who would benefit from companionship whilst in hospital. During November several meetings were held between Chaplaincy Volunteers and Chaplains with the focus to reintroduce the service across CTMU HB. It is hoped that the volunteer presence will support the EOL companion project further, by promoting and informing staff of the benefits of patients having companionship during a difficult time and where patients may not have family or friends to visiting.

Wellness Improvement Service (WISE) Volunteers

The Wellness Improvement Service was officially launched on 5th September 2022. During October and November, classroom based sessions have taken place at various venues across CTMU HB's logistical remit. Volunteers have been instrumental in supporting Wellness Coaches with meeting and greeting participants, scribing, encouraging group discussions and helping those participants who may be upset or emotional during the sessions. The volunteers support sessions once a week for the first 6 weeks, then every other week for a further 6 weeks and then monthly up to a maximum of 9 months when the course ends. A meeting with WISE team including wellness coaches is planned for the end of December 2022, to review progress to date, discuss feedback and plan for courses throughout 2023. Furthermore, to explore additional duties and tasks that volunteers can get involved with to support the programme further.

Pets as Therapy Volunteers

The Pets as Therapy service is a positive and welcomed form of alternative therapy, which benefits patients, service users and staff. The volunteer service has been working jointly with Cariad Pet Therapy organisation based in Carmarthen to explore ways in which we could implement their service across CTMU HB. To date this has been an extremely positive working relationship and an agreement developed to identify and document responsibilities from both organisations is in progress, to ensure the recruitment of Cariad Pet Therapy Volunteers is robust, timely and streamlined.

In September 2022, we were pleased to recruit and start one of Cariad Pet Therapy Volunteers who visits Y Bwthyn Newydd at Princess of Wales Hospital and in October 2022 a second Cariad Pet Therapy volunteer started visiting the young people and staff at Ty Llidiard at the same hospital. Plans are in place to induct a further three Pet Therapy Volunteers during December 2022, for the Royal Glamorgan Hospital, one on the Dementia Ward, the second at Y Bwythyn Palliative Care Unit and the third for the mental health ward. Both Cariad Pet Therapy and the Volunteer Service are extremely keen to continue the working relationship and increase the number of volunteers, meetings are planned for the New Year to discuss and arrange information tables at several hospital sites with the hope to recruit volunteers from our local areas.

Breast Feeding Peer Support Volunteers

Breast Feeding Peer Support Volunteers in conjunction with the research team and infant leads continue to support new mothers, with virtual enhanced breast feeding peer support for pregnant ladies from 30 weeks to post-natal care up to 6 months. The BFPS volunteers are also active, offering information and support under the supervision of the infant leads. A further two volunteers are undertaking an induction session in November 2022 to join the Breast Feeding Peer Support initiative. The plan being to reintroduce our Breast Feeding Peer Support Volunteers onto maternity wards across CTMU HB.

Organ Donation Family Support Volunteer

Our organ donation family support volunteer continues to be on call for our 3 DGH sites across CTMU HB. This project was set up in conjunction with the Specialist nurse/Specialist Requester in Organ Donation and the Health Board's Lead Chaplain. In November 2022, our organ donation family support volunteer met with the new Specialist Nurse for Organ Donation and ITU ward manager at Prince Charles Hospital, which included meeting staff and a refresher/orientation session. Both ITU wards and Organ Donation Lead Nurse are keen to utilise the volunteer support whom will be contacted immediately should the opportunity arise. The Organ Donation Family Support Volunteer has also been supporting the End of Life Companion project and providing support for the memorial garden at Ysbyty Cwm Cynon.

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.

In October 2022, Y Bwythyn Newydd at Princess of Wales Hospital were pleased to reintroduce volunteer drivers, to enable service users to access the day unit by transporting them back and forth. The volunteer driver's information hand book was updated in November 2022, with additional information regarding pandemic situations and up to date checks, which is paramount to ensure both volunteers and service users are transported safely.

Patient Feedback Volunteers

Patient, service user public feedback is vital to any organisation as a tool to help improve services and capture positive experiences which can lift staff morale. In November 2022, the Volunteer Service was asked to support an all Wales one off survey concentrating on future visiting. Volunteers who were active in other roles were asked if they were interested in supporting the work stream and over the two week period undertook the survey on various wards across all DGH and Community Hospitals supported by the Volunteer Manager and Volunteer Coordinator. Due to some wards being closed the focus was to carry out the survey in green areas only. To date there are three patient feedback volunteers who will be supporting the work stream at Princess of Wales Hospital and during October / November 2022 undertook a local orientation with ward managers and were introduced to staff on identified wards. The plan is to arrange shifts during December 2022 and Ipads have been set up for volunteers to complete surveys directly via Civica, also encouraging patients and visitors to complete the "Have Your Say" cards.

Moving Forward

Over the past few weeks and months we have been privileged to be able to reintroduce a number of our existing volunteers in a variety of roles. To support further projects a recruitment information session was held the end of November 2022 with a themed approach concentrating on projects that are currently active and in green areas to ensure volunteers are safe. Moving forward we have a number of initiatives that we will be working on alongside supporting projects up and running which include:

- Meet and Greet Volunteers (Dewi Sant Health Park, Royal Glamorgan Hospital and Ysbyty Cwm Cynon
- Cariad Pet Therapy Volunteers (across CTMUHB)
- Wellness Improvement Service Volunteers (various sites across CTMUHB)
- Ward Befriender / Dementia Volunteers (Ysbyty Cwm Rhondda and Ysbyty Cwm Cynon)
- Patient Feedback Volunteers (Various sites across CTMUHB)

Veterans

The new Armed Forces Covenant Duty came into force on 22nd November 2022. This places a legal obligation on Health Bodies to have due regard to the principles of the Armed Forces Covenant when exercising specific functions.

Patient Experience Manager has liaised with a number of third party stakeholders to look at how CTMU HB is able to promote this within the organisation via ESR training and is currently working with colleagues in Learning and Development to explore how we manage this going forward.

Patient Experience Manager also sits on the Armed Forces Steering Group to understand the needs of the armed forces/veterans community, and how we support with information/signposting around the Covenant and Health Board services.

Bereavement

The Health Board's new Clinical Bereavement Lead started on 17th October 2022 and has met with a number of staff/departments to understand the processes the Health Board has in place to ensure we meet the needs of our patients/families in line with the new Bereavement Framework.

The initial focus identified a gap in the service provided to families who suffered a pregnancy loss under 16 weeks and the amount of support being provided. As such, a process has been quickly established to ensure that when babies are going for communal cremation the Health Board is able to inform families and provide them with a choice as to whether they choose to attend or not. This has also provided the opportunity to ensure that signposting is offered should families require further support in their grief journey. A review of the bereavement booklet is also underway to ensure the information is updated and reflects the further support now available to families.

Review of processes is also underway across the Health Board to ensure that the Health Board has policies in place to support all those involved in supporting families in their hour of need. The Health Board's Bereavement Strategy Group allows representatives across all specialities to come together and drive service improvement in this area. The Clinical Bereavement Lead has also set up a Bereavement Champions network to allow information from the Strategy Group to be embedded across acute and community settings but also enables the input of staff who are working with these policies to advise how these translate into working practise.

Clinical Bereavement Lead also sits on the All Wales Bereavement Leads Group to share best practise and knowledge within this field of expertise.

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