Public Quality, Safety & Experience Committee

Fri 28 April 2023, 14:00 - 15:30

MS Teams

Agenda

14:00 - 14:10 10 min

1. Standing Items

1.1. Welcome & Introductions

Ceri Phillips

1.2. Apologies for Absence

Ceri Phillips

1.3. Declarations of Interest

Ceri Phillips

1.4. Minutes of the QSE Committee Meeting held on 11.04.23

Ceri Phillips

1.4 Public QSE Minutes 11.04.23.pdf (10 pages)

1.5. Action Log – Following the meeting held on 11.04.23

Ceri Phillips

1.5 Action Log.pdf (2 pages)

1.6. Chair's Action taken since last meeting

Ceri Phillips

14:10 - 14:45 35 min

2. Items for Review & Assurance

2.1. Quality Indicators Report

15 minutes *Jason Roberts*

2.1 QI Report -02.05.23 final.pdf (31 pages)

2.2. Ward Accreditation & Improvement

10 minutes *Jason Roberts*

2.3. Board Assurance Report – Patient Safety

5 minutes *James Quance*

2.4. CHC Reports

5 minutes *Abigail Harris*

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Transport to Health Services

- 2.4 CHC Letter to SR Re Access to Transport Survey Report.pdf (2 pages)
- 2.4a FINAL Transport to Health Services report.pdf (62 pages)

14:45 - 14:50
5 min

3. Items for Approval / Ratification

Jason Roberts

Policies for ratification including:

- Mental Health Clinical Risk / Risk Mitigation Management Policy (UHB 119)

14:50 - 14:50
0 min

4. Items for Noting & Information

4.1. Minutes from Clinical Board QSE Sub Committees:

Jason Roberts

4.1.1. Mental Health Clinical Board - 16.02.2023

- 4.1.1 MHCB QS Minutes 16.02.23.pdf (8 pages)

4.2. Radiation Protection Group Chairs Report

Fiona Jenkins

- 4.2 Radiation Protection Group Chairs Report.pdf (3 pages)

14:50 - 14:50
0 min

5. Items to bring to the attention of the Board / Committee

Ceri Phillips

14:50 - 14:50
0 min

6. Agenda for the Quality, Safety & Experience Private Meeting:

i) Private Minutes

ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)

iii) Pressure Damage – Children's Hospital Update (Confidential Discussion)

14:50 - 14:50
0 min

7. Any Other Business

14:50 - 14:50
0 min

8. Review of the Meeting

14:50 - 14:50
0 min

9. Date & Time of Next Meeting:

Tuesday 6th June 2023

Time – 2pm

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via MS Teams

14:50 - 14:50
0 min

10. Declaration

Ceri Phillips

“To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]”

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Unconfirmed Minutes of the Quality, Safety & Experience Committee

Held on 11.04.2023

Via MS Teams

Chair:		
Ceri Phillips	CP	Committee Chair
Present:		
Akmal Hanuk	AH	Independent Member – Community
Keith Harding	IM	Independent Member – University
Mike Jones	MJ	Independent Member – Trade Union
Rhian Thomas	RT	Independent Member – Capital & Estates
In Attendance		
Paul Bostock	PB	Chief Operating Officer
Sandeep Hemmadi	SH	Interim Clinical Board Director for Children & Women
Angela Hughes	AH	Assistant Director of Patient Experience
Charles Janczewski	CJ	University Health Board Chair
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Andy Jones	AJ	Director of Nursing and Midwifery, Children & Women's Clinical Board
Fiona Kinghorn	FK	Executive Director of Public Health
Anna Mogie	AM	Deputy Director of Nursing - PCIC
Aled Roberts	AR	Assistant Medical Director, Clinical Effectiveness & Safety
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
James Quance	JQ	Interim Director of Corporate Governance
Catherine Wood	CW	Director of Operations - Children & Women
Clare Wade	CW	Director of Nursing for Surgical Clinical Board
Observing		
Stephen Allen	SA	Regional Director - Llais
Rebecca Aylward	RA	Deputy Executive Nurse Director
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Marcia Donovan	MD	Head of Corporate Governance
Meriel Jenney	MJ	Executive Medical Director
Richard Skone	RS	Deputy Medical Director

QSE 23/04/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh and noted that it was the first meeting being performed under the new monthly format.	**Action**
QSE 23/04/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 23/04/003	**Declarations of Interest** The Independent Member – University (IMU) advised the Committee that he was the Clinical Expert in relation to the Jasmine Report which was being discussed later on in the agenda. The CC noted that the IMU would not be required to leave the meeting and that he could respond to any discussion points raised.	
QSE 23/04/004	**Minutes of the Committee meeting held on 7 March 2023** The minutes of the Committee meeting held on 7 March 2023 were received. **The Committee resolved that:**	

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	a) The minutes of the meeting held on 7 March 2023 were approved as a true and accurate record of the meeting.	
QSE 23/04/005	**Action Log following the Meeting held on 7 March 2023** The Action Log following the Meeting held on 7 March 2023 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 7 March 2023 was noted.	
QSE 23/04/006	**Chair's Actions** No Chairs Actions were raised.	
QSE 23/04/007	**Children & Women's Clinical Board Assurance Report** The Children & Women's Clinical Board Assurance Report was received. The Interim Clinical Board Director for Children & Women (ICBDCW) advised the Board that significant and innovative work was being delivered by the Children & Women's Clinical Board (the Clinical Board). He added that Children had been disproportionately impacted by the Covid 19 pandemic, and the Clinical Board had seen significant growth in demand for the service since 2019, with that demand continuing to outstrip capacity. It was noted that the Health Inspectorate Wales (HIW) had undertaken 2 unannounced visits of Maternity services but that they had been impressed with the Clinical Board for the work undertaken following the initial inspection in November 2022. The Director of Operations for Children & Women (DOCW) presented the Committee with the work undertaken to support Women, Children and Families over the past 12 months and noted that the scope of the Clinical Board's services was large. The Clinical Board team was very cognisant that whilst the Maternity services were high profile, the breadth of services provided by the Clinical Board to young people and their families in the community did not always get the same attention as the more well known services. She added that one of the lesser known, but high impact, services was one that had been reported to the Committee in March 2023 in relation to Looked After Children (LAC). It was noted that the Committee had received information at the March meeting regarding the demand and capacity perspective of LAC as well as the actions being taken, and that the latest report received for the current meeting was the LAC service from a patient's perspective. A patient story would be shared to highlight that. The Director of Nursing and Midwifery, Children & Women's Clinical Board (DNCW) read out the reflections of a Grandmother of a Looked After Child, aged 15 who had been in foster care since the age of 3. The story highlighted the struggles the child had been through and noted that arrangements were made for an independent review officer, a social worker, and a LAC nurse to intervene and contact the child. The Grandmother noted that the LAC nurse had been brilliant with the Grandchild and that the struggles in their life started to improve and that they were now happy, smiling and working towards their GCSEs in 2023. She concluded that the LAC nurse had made a positive impact on the 15-year-old which had created a real turning point and had made a great difference in their life. The DNCW noted that the story indicated the value of the LAC service and noted the importance of the work undertaken by that team as well as all of the additional and unseen work that the LAC nurses provided.	

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The Committee was advised of another service which the Clinical Board wanted to highlight - the continence service.

The DNCW noted that over the past 12 months, the team had been able to halve the number of young people waiting for continence input due to a combination of a number of actions. Notably the service was moving to a much more nurse led service, using Band 4 assistants, using additional training and referral criteria and other interventions.

He added that the work was continuing and was a really good example of a service that only a year or so ago had been struggling under significant restraints.

The DOCW noted that the examples provided were very strong examples of where the service had impacted on, not just the physical health of children and young people, but the holistic care of that child, enabling them to go to school, giving them a quality of life and confidence that would hopefully go with them as they moved into adulthood.

She added that a key part of that was working together with all of the Clinical Board's partners, such as Local Authority (LA) and Third Sector colleagues.

It was noted that partnership working linked into some of the great work undertaken in Child and Adolescent Mental Health Services (CAMHS) which had recently been relaunched and showcased the different facets of the emotional health and wellbeing that the Clinical Board had to offer.

The DOCW advised the Committee that in relation to the eating disorders in Children's services, the team had extended the scope and reach of the team. Assessments for the team were completed in pairs as per the Maudsley model which was recognised as the gold standard model of care for that group of children in the UK.

She added that the eating disorder service had also set up a Multi-Family Group Therapy which was very well received and provided a holistic model of care that allowed children and families to access support.

The DNCW advised the Board that following the Ockenden report publication in 2022, the service had undertaken a gap analysis of the Maternity service against the recommendations of the report.

He added that the Maternity service and Clinical Board were very grateful for the support received by the Board in supporting the resources required and the investment of £2.7m.

The CC conveyed the thanks of the Committee and asked for that to be fed back to the relevant teams.

The Independent Member – Community (IMC) asked if there were any specific programmes of work or assurance that could be given in terms of developing more nurses, like the one identified in the Patient Story.

The DOCW responded that work was being undertaken to recruit "community connectors" who would provide wrap around support for young people and their families and noted that in terms of LAC nurses, the Clinical Board was actively recruiting more into the team.

The Independent Member – Capital & Estates (IMCE) noted that she had been encouraged to see the co-working between the Children and Women's Clinical Board and the Mental Health Clinical Board and in particular the 16-25-year olds transition period.

She asked how that was progressing.

The DOCW responded that it had progressed very well. The Health Board had received funding from Welsh Government which would usually be split between Adult Mental Health services and CAMHS. The Clinical Board had looked at services with a completely different lens across the 2 clinical boards and asked "what was the right thing to do for that young person" and it was decided that the Clinical Board would move away from historic boundaries of how the service could be delivered and pool resources to create a seamless waiting list entry for that child which would follow them right through the pathway.

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The Executive Director of Therapies and Health Sciences (EDTHS) invited the DNCW to draw attention to non-hospital services, such as the work undertaken by the Designated Education Clinical Lead Officer (DECLO).

	The DNCW responded that the DECLO was a very busy role and that they had undertaken a lot of great work. He added that the only issue the Clinical Board could raise was that the role was shared between 2 Health Boards and so work would need to be undertaken to revisit the amount of resource each Health Board would receive from the DECLO. The Chair of the University Health Board (UHB Chair) thanked the team on behalf of the Board and noted that the Board had been pleased to see the way in which the Clinical Board had responded to the recommendations made by the HIW in relation to Maternity services which had helped the Health Board to avoid any escalation process with HIW. He added that in relation to the report received, it did not note what was being done for long waiters and asked what was being done with regards to those patients. The DOCW responded that it was being looked at with 2 lenses: • Support whilst they waited for the service • How the wait could be addressed She added that over the past few months, the Clinical Board had looked at the waiting lists and re-evaluated how the services could run those lists. It was noted that the biggest challenge for the Clinical Board was the volume of the waiting list and the struggle to recruit and retain staff. The UHB Chair thanked the DOCW for the response and asked that the QSE Committee revisit the issues identified in 6 months' time to provide more assurance. **The QSE Committee resolved that:** a) The progress made by the Clinical Board to date was noted. b) The content of the report and the assurance given by the C&W Clinical Board was noted.	**JR**
QSE 23/04/008	**Quality Indicators including: Peri-Natal Mortality** The Quality Indicators including: Peri-Natal Mortality were received. The DNCW advised the Committee that the Health Board had established a system for the critical review of still births. He added that when a stillbirth occurred a monthly MDT review discussion took place very quickly after the incidents. It was noted that the information provided to the Committee showed the count of still births tracked per 1000 and that there had been a downward trajectory in stillbirths between 2016 and 2018. The DNCW advised the Committee that since 2020 the trajectory had increased from 16 stillbirths to 30 in 2022. He added that there was isolation in the data from the Covid-19 pandemic and noted a national increase since the lifting of lockdowns which was mirrored in the data presented by the Health Board. It was noted that the stillbirths were robustly reviewed. All incidents had the MDT rapid review undertaken and all incidents reports had gone on to have a full MDT review. It was noted that the Health Board had benchmarked stillbirth rates against other organisations of a similar size to the Health Board and noted that the average rate was 3.3 per 1000. The DNCW added that the provisional Office for National Statistics (ONS) data suggested there would be a national rise but noted that the statistics were yet to be confirmed and released. The Committee were presented with the Perinatal Mortality Review Tool which identified the areas that the review undertook which included:	

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- Patients perspective of care
- Social circumstances
- Antenatal care
- Screening for gestational diabetes and fetal anomalies
- Growth screening
- Management of fetal movements
- Development of significant obstetric complications
- Intrapartum care
- Fetal Monitoring

It was noted that the Health Board utilised the tool for the robust and standarisation review of all deaths of babies up until 28 days post birth to provide answers to the bereaved families and to support local and national learning.

The DNCW advised the Committee that the review panel comprised of an obstetrician consultant, DNA theologist, senior midwives, the bereavement team, risk managers and, importantly, lay members (to ensure compliance with the Ockenden recommendations in terms of that lay member representation).

He added that in terms of outcomes, the grades identified were:

- A – The review group concluded that there were no issues in care identified up to the point that the baby was confirmed as having died

- B – The review group identified care Issues that they considered would have made no difference to the outcome of the baby

- C – The review group identified care issues that they considered may have made a difference to the outcome of the baby

- D – The review group identified care issues which they considered were likely to have made a difference to the outcome of the baby

The majority of the Health Board's cases in 2021/22 were category A or B which would have not changed the outcome.

It was noted that the Health Board had 3 category C, 2 of which were delays in Women attending the outpatient assessment unit with reduced fetal movement, and the other a failure to prescribe aspirin at the 16-week check.

It was noted that the Health Board had also two category D cases. Both were complex patients in complex social care circumstances and substance misuse and that there was a human error in mis-plotting the first growth scan of one of those patients.

The DNCW added that had it been plotted correctly, it would have shown a small for gestational age baby, but that the outcome would have unlikely been any different.

He added that since the category D incident, the Clinical Board had introduced electronic growth plotting into the system which reduced any risk of human error and was shown to be much safer.

He concluded that learning was shared through risk and governance meetings and quality, safety and experience meetings both at Directorate level and at Clinical Board level and that communication briefings had been developed to share the learning and were distributed across a number of different mediums.

The Executive Director of Public Health (EDPH) advised the Committee that conversations were being held separately on the planned equality, equity, safety, experience framework and the stillbirth data on ethnicity did not appear to have been analysed by socio economic status.

She asked if there was something that the Health Board could be doing in that arena.

The DNCW responded that it was recognised that those from ethnic minority backgrounds were at greater risk of stillbirth and it was also known that there was a communication barrier. It was important to strive to ensure that those groups received effective communication and were made aware of the risk factors that they had as well as the need for them to access services early.

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	He added that work was being undertaken with regards to those individuals who were seeking asylum and who were coming into the area geographically, to see how the system could provide information to them in a timely manner because of their risk profiles. The EDPH noted that it could be an area that could be explored for the framework. The CC asked how concerned the Committee should be given that the trajectory was continuing upward. The DNCW responded that there was a danger in looking at just 2 months of data because no stillbirths had been observed in March 2023 and noted that a sufficient time frame would be required to look at data because the current percentages were small. **The QSE Committee resolved that:** a) The Quality Indicators including: Peri-Natal Mortality were noted.	
QSE 23/04/009	**Pressure Damage Collaborative Work Plan** The Pressure Damage Collaborative Work Plan was received. The Director of Nursing for Surgical Clinical Board (DNS) advised the Committee that the report had been delayed since January 2023. She added that the report provided the Committee with information about what the Pressure Damage Collaborative (the Collaborative) was and its aims. It was noted that when the Committee had received the Pressure Damage Collaborative Work Plan in Summer 2022, one of the goals of the Collaborative was to reduce the incidence of healthcare acquired pressure damage within the Health Board by 25% by July 2022. The DNS advised the Committee that the most recent data available to the Collaborative showed that the current figure for February 2023 for "Health Acquired Pressure Damage" was 2.55 cases of pressure damage per 1000 bed days which indicated that the initial goal of a 25% reduction had been exceeded as it was now 27%. The Independent Member – University (IMU) noted that it was pleasing to see the data, but asked if there was a risk of complacency because the Collaborative had driven down incidents but it had been quoted in a number of places that all pressure ulcers were potentially preventable. He added if the ambition to drive down further than 25% had been lost. The DNS responded that the Collaborative would never get complacent and noted the data being captured was for all pressure damage across the Health Board. She added that the data could be considered for that as well and that it was important to recognise that the team should be looking at all pressure damage. It was noted that one of the complexities was that as the Health Board increased its regional service and was bringing more patients into the system, a much higher incidence of pressure damage was being reported and there was a risk for reporting multiple times if the referring Health Boards were also reporting those incidents. The DNS added that she would gladly take on the advice of the IMU as to how to report on the data in a different way. The Deputy Director of Nursing – PCIC (DDNP) added that in terms of the Community element of pressure damage a lot more could be done with patients, such as providing them with the right equipment. She added that all pressure damage was scrutinised and was supported by the District Nurses in exactly the same way as other areas. The same root cause analysis was undertaken, although the findings of such analyses did, on times, highlight themes that were outside of the Health Board's control.	

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	The UHB Chair asked whether length of stay in acute settings was factored in for any allowance to the exceptional circumstances and also if there was an ability to learn from others who may have made more progress with pressure damage. The DNS responded that patients who were waiting for periods of time before they could get into the Health Board with regards to ambulance waits was something that could be linked to incident reporting data once the data and business intelligence was completed. She added that the team would then be able to track patients who had waited for longer and that the next six months would give the Collaborative rich data that could be interrogated. It was noted that a pressure damage update report would be received by the Committee again in 6 months' time. The END noted that he could provide further assurance that the Collaborative would not get complacent and that they would continue to drive pressure damage down in the Health Board. He added that in relation to benchmarking, there was nowhere in Wales that had been perceived to have done better than the Health Board, but that data would be looked at for similar sized organisations in NHS England and reported back to the Collaborative. **The QSE Committee resolved that:** a) The contents of this report and the actions being taken forward to address areas for improvement were noted.	**JR**
QSE 23/04/010	**Quality of Care Assurance in Commissioned Services in response to the Operation Jasmine & the Flynn Report** The Quality of Care Assurance in Commissioned Services in response to the Operation Jasmine & the Flynn Report was received. The DDNP advised the Board that Operation Jasmine was a major and wide-ranging investigation into the deaths of 63 individuals living in residential and nursing care homes in South East Wales and had been carried out by Gwent Police between 2005 and 2013. She added that a review of Operation Jasmine and the events associated with it was announced by the First Minister of Wales and that the review was led by Dr Margaret Flynn and involved consultation and workshops with key stakeholders across Wales, including involvement from the Health Board. It was noted that that since the recommendations from Operation Jasmine and the Flynn Report, much had changed in how Local Authorities, Health Boards and the regulators operated and dealt with monitoring and identifying care concerns with residential and domiciliary care providers. Social care legislation had also been introduced to address the issues. The DDNP advised the Committee of the partnership assurance mechanisms which had been put in place. Those included Key Performance Indicators (KPIs) which were monitored weekly and could provide an early indication of risks to patient safety in care homes and included: • Pressure Ulcers – Stage 3 and above pressure damage was reportable to Care Inspectorate Wales (CIW) by care homes under the revised RISCA guidance on notifications • Regulation 60 notifications of incidents (CIW) • Safeguarding referrals • Contract monitoring visits • Formal Advocacy services • CIW Inspection reports – non-compliance notices She added that the Health Board had commissioned, wholly or jointly with Local Authorities, from a range of independent sector care providers which included: • The Funded Nursing Care Contribution (FNC) to all individuals who were placed in nursing homes in the Cardiff and Vale geographical area • Entirely funded nursing and residential/supported housing placements for individuals assessed as eligible for Continuing NHS Health Care (CHC)	

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	• Cardiff and Vale residents placed with residential providers under CHC outside of the Cardiff and Vale geographical area • Domiciliary Care Packages for individuals assessed as eligible for CHC or joint funding arrangements. It was noted that the majority of individuals placed and funded in the above areas were done so under the auspices of Primary, Community and Intermediate Care Clinical Board. The Committee was advised that there had been a joint contract and service specification for residential nursing care across the Health Board and both Local Authorities since 2005. However, this was out of date and did not reflect legislative changes and responsibilities. The DDNP added that partner agencies undertook a significant piece of work during 2019/20 to review and update that and a joint Regional Common Contract for residential care was agreed and implemented across all agencies in 2021. She added that the terms of the contract were clear and detailed with a focus on individuals' and services outcomes, and assessment and monitoring against fundamental health and social care standards, and that such requirements had been built into the new contracts from the Flynn report. The END advised the Committee that the reports had been received by the UHB Chair via Welsh Government (WG) and the Health Board had responded on the UHB Chair's behalf to WG and that WG had the assurance from the Health Board's response. The IMU asked if the Health Board knew, as a result of post the COVID situation, what percentage of delayed transfers of care was due to patients with pressure damage. The DDNP responded that she was sure that the information was available if it was contributing to someone's delayed discharge, but noted that pressure damage was not usually a 'contributory factor' because both District Nurses in the community and in Nursing homes had the ability to manage all but the very most complex of discharges the Health Board undertook. **The QSE Committee resolved that:** a) The recommendations of the Flynn Report and the current UHB and partnership arrangements in place to support quality assurance of care for commissioned placements in residential care homes in Cardiff and Vale were noted.	
QSE 23/04/011	**Board Assurance Report – Patient Safety** The Board Assurance Report – Patient Safety was received. The Interim Director of Corporate Governance (IDCG) advised the Committee that he would take the paper as read and noted that it was the version that had been received by the Board the week prior to the Committee meeting. He added that the Committee received to consider those risks that were allocated to the Committee and provide ongoing assurance to the Board. The UHB Chair highlighted that the Committee was being asked to look at 7 areas of risk on the report and noted that seven areas of risk seemed to be disproportionate to the time the Committee had available to consider them in any depth. He asked if the Chair would prefer to rotate those risks so that the Committee would look at a couple of the risks at each Committee meeting and then move on next time to another couple of risks considering the Committee was now meeting monthly. The Chair agreed with that approach. **The QSE Committee resolved that:** a) The risks in relation to Patient Safety, Quality and Experience were reviewed and the Committee would provide further assurance to the Board when the Board Assurance Framework was reviewed in its entirety, were noted.	

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QSE 23/04/012	**National Collaborative Commissioning Unit Quality Assurance and Improvement Service Annual Position Statement 2021-2022** The National Collaborative Commissioning Unit Quality Assurance and Improvement Service Annual Position Statement 2021-2022 was received. The Assistant Director of Patient Experience (ADPE) advised the Committee that the report came to the Committee for assurance from the National Collaborative Commissioning Unit. She added that the report provided the Committee with an overview of the three National Collaborative Frameworks which were overseen by the National Collaborative Commissioning Unit and included: • National Collaborative Framework Adult Mental Health and Adult Learning Disability Hospital Services ('Adult Hospital Framework') • National Collaborative Framework for Child Adolescent Mental Health Service (CAMHS) Low Secure & Acute Non-NHS Wales Hospital Services ('CAMHS Hospital Framework'). • National Collaborative Framework for Adults (18+ years) in Mental Health and Learning Disabilities care homes & care homes with nursing for NHS and Local Authorities in Wales ('Care Home Framework') It was noted that the report was received nationally and so there was very little Cardiff and Vale data to reflect upon, but the ADPE advised the Committee that the Health Board specific data from the report was as follows: • Medium secure hospitals • Low secure hospitals • Controlled egress hospitals • Uncontrolled egress hospitals The CC noted that it would have been good to see the outcomes in the report and asked for those to be discussed when future iterations of the report came to the Committee. **The QSE Committee resolved that:** a) The activity for the three National Collaborative Frameworks throughout 2021/22 was noted.	
QSE 23/04/013	**Minutes from Clinical Board QSE Sub Committees:** The Minutes from Clinical Board QSE Sub Committees were received. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	
QSE 23/04/014	**Committee Self-Effectiveness Survey** The Committee Self-Effectiveness Survey was received. The IDCG advised the Committee that 8 survey responses had been received in regards to the Committee and that the one area to highlight was regarding questions 8 and 9 which related to Committee meeting packages and the organisation and time afforded to Committee business. He added that work was being undertaken to improve those areas highlighted, including the move to a monthly meeting. **The Committee resolved that:** a) The results of the Annual Board Effectiveness Survey 2022-2023 relating to the Quality, Safety and Experience Committee were noted.	
QSE 23/04/015	**Items to bring to the attention of the Board / Committee:** No items were raised.	

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QSE 23/04/016	**Agenda for Private QSE Meeting** *i) Private Minutes -* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)* *iii) Relocation of Pentyrch Surgery*	
QSE 23/04/017	**Any Other Business** No other business was raised.	
	Date & Time of Next Meeting: Tuesday, 6th June 2023 at 2pm via MS Teams.	

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Action Log

Quality, Safety & Experience Committee

Update for meeting 11 April 2023
(Following the meeting held on* 07 March 2023*)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 23/01/013	**Pressure Damage**	Committee to be provided with a copy of the Pressure Damage Collaboration's annual paper.	**11.04.2023**	Jason Roberts	**COMPLETED Updated on 11 April 2023**
QSE 23/01/010	**HIW Activity Overview**	Once published, the Committee would receive a copy of the report relating to the Mental Health Services at Hafan y Coed visit.	**11.04.2023**	Jason Roberts	**COMPLETED Updated on 11 April 2023**
Actions in Progress					
QSE 23/03/010	**HIW Activity**	Once published, the Committee would receive copies of the reports relating to (i) Maternity Services and (ii) IRMER Inspection	**09.05.2023**	Jason Roberts	**Update on 9 May 2023**
QSE 23/03/007	**Specialist Clinical Board Assurance Report – re** South Wales Trauma Network	To update the Committee with regards to the WHSSC funding for South Wales Trauma Network review and associated actions	**29.08.2023**	Jason Roberts/Sarah Lloyd	**Update in August 2023**
QSE 23/03/008	**Looked After Children – Assessment Backlogs**	An update report to be brought back to the Committee in 3-4 months.	**29.08.2023**	Jason Roberts/Catherine Wood	**Update in August 2023**

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MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
QSE 23/04/007	**Children & Women's Clinical Board Assurance Report**	revisit the waiting list issue identified in 6 months' time to provide more assurance.	**10.10.2023**	Jason Roberts	**Update in October 2023**
QSE 23/04/009	**Pressure Damage**	An update report to be brought back to the Committee in 6 months' time.	**10.10.2023**	Jason Roberts	**Update in October 2023**
Actions referred to Board / Committees					
Actions referred FROM Board / Committees					
UHB 22/09/011	**Integrated Performance Report**	Pressure damage – the management approach to mitigating pressure damage issues to be explored further at the Quality, Safety and Experience Committee	**09.05.2023**	Jason Roberts	**Update on 09 May 2023** Due to be considered at the QSE Committee meeting on 9 May 2023

Report Title:	Quality Indicators – Progress Report				Agenda Item no.	*2.1*
Meeting:	Quality, Safety & Experience Committee		Public	✓	Meeting Date:	09/05/23
			Private			
Status *(please tick one only):*	Assurance	✓	Approval		Information	
Lead Executive:	Executive Nurse Director					
Report Author (Title):	Assistant Director of Patient Experience					

Main Report
Background and current situation:

In June 2020, the QSE Committee agreed a range of quality indicators that would be routinely monitored at each meeting. This paper provides an overview of current performance against those quality indicators that are available.

A quality Indicator should be specific, measurable, and aligned with the goals of the program or intervention being evaluated.

This paper will also discuss how the proposed indicators will be implemented and evaluated, including any data collection methods or tools that will be used. Additionally, the paper will address potential limitations or challenges associated with using the proposed indicators and how these may be addressed. It should be noted and will be acknowledged that for many of our indicators there is a lack of national benchmarking data.

The paper aims to provide a comprehensive assessment of quality in a particular field and to identify areas for improvement. Quality Indicators can be to guide decision-making and improve outcomes for individuals, organizations, or communities.

There continues to be significant operational pressures across the Organization, made more challenging with the ongoing staffing pressures, patient acuity and levels of activity. The QSE framework is embedded and the committees/groups established in 2022 will support the acceleration of the implementation of the framework, with particular emphasis in 2023 on the learning and service improvement from all of the available sources.

The report is being presented in line with the Duty of Quality Act.

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- The six **domains of quality** and five **quality enablers**.
- Quality-driven **decision-making**.
- Demonstrate improved quality with **evidence**.
- **Quality Standards** 2023 will replace the Health and Care standards

It is noted that following consultation, workforce will be added as an enabler

Key messages

- We must put the quality and safety of our health services above everything else
- The duty of quality influences many health-related policies and frameworks
- In turn, these also affect how we approach delivering quality in healthcare services
- Strengthening our quality management system helps us make sure our decision-making focuses on improving the quality of health services

The Learning Committee will be where the thematic reviews will be considered, to ensure that sustainable and measure improvements are put in place, utilizing tested quality improvement methodology. Each of the Clinical Board Directors of Nursing will have a key area to concentrate upon through multi professional engagement, such as reduction in injurious falls, reduction in avoidable pressure ulcers, psychological safety etc.

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 is a piece of legislation introduced in Wales to improve the quality of health and social care services and increase public engagement in the planning and delivery of these services.

The Act aims to achieve this by: creating a duty of quality and improvement for health and social care services: The Act requires health and social care organizations to provide high-quality services that meet the needs of individuals, promote their well-being, and consider the views of patients, service users, and their families.

Promoting a culture of continuous improvement: The Act establishes a duty for health and social care organizations to continually improve the quality of their services. This includes identifying areas for improvement, acting to address these areas, and monitoring and evaluating the impact of these improvements.

Encouraging public engagement: The Act requires health and social care organizations to involve patients, service users, and their families in the planning, delivery, and evaluation of services. This includes gathering feedback, consulting with the public, and involving service users and their families in decision-making processes.

Strengthening the role of the healthcare inspectorate: The Act establishes Healthcare Inspectorate Wales (HIW) as the independent regulator of health and social care services in Wales. HIW is responsible for monitoring and assessing the quality of services, making recommendations for improvement, and taking enforcement action where necessary.

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Overall, the Health and Social Care (Quality and Engagement) (Wales) Act 2020 aims to improve the quality and safety of health and social care services in Wales by placing a greater emphasis on continuous improvement and public engagement. By involving patients, service users, and their

families in the planning and delivery of services, the Act seeks to ensure that services are designed around the needs of individuals and promote their well-being.

Duty of Quality

The Duty of Quality, as part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, came into force in April 2023. It is a lever for improving and protecting the health, care and wellbeing of the current and future population of Wales. It aims to ensure a stronger citizen voice and to improve the accountability of services to deliver a better experience and quality of care. Doing so contributes to a healthy and more prosperous country.

The Act is intended to have positive benefits for everyone in Wales, supporting a culture and the conditions needed to drive improvements in health care. The Duty of Quality requires the Welsh Ministers, with regards to their health-related functions and NHS bodies, to think and act differently by applying the concept of "quality" across all functions. They will need to consider quality within the context of the health service and health needs of their populations. The Duty of Quality requires quality driven decision making and planning to ultimately deliver better outcomes for all people who require health services. It requires involving people in decisions that affect them, balancing short-term needs with planning for the longer-term, with action to prevent problems occurring or getting worse. The prevailing intention is to build on the positive culture of quality at the heart of the Welsh health system, enacting a broader system-wide duty of quality, which strengthens decision making, action, improvement and ultimately, improved outcomes for the population. The Duty of Quality guidance document is currently undergoing public consultation. The guidance sets out a definition of quality alongside six domains of quality and five quality enablers. It is proposed that these become our Quality Standards 2023 which will replace the Health and Care Standards (April 2015). NHS bodies will be required to take these new standards into account, for the purpose of discharging the duty of quality.

Duty of Candour

The Duty of Candour is a legal requirement. It requires healthcare organizations and care providers to be open and honest with patients and their families when something goes wrong with their care or treatment.

Specifically, the Duty of Candour requires healthcare providers to:

Inform patients and their families as soon as possible when an adverse event has occurred.
Offer an apology and provide appropriate support to patients and their families.

Conduct a review of the adverse event and share the findings with the patient and their family.
Provide information on how the patient can make a complaint or raise concerns.

The Duty of Candour is intended to promote a culture of transparency, openness, and learning within healthcare organizations. By being open and honest about adverse events, healthcare providers can improve patient safety, learn from mistakes, and prevent similar incidents from happening in the future.

In Wales, the Duty of Candour applies to all healthcare providers, including hospitals, care homes, and community health services. Failure to comply with the Duty of Candour can result in regulatory action, including fines and sanctions.

The duty applies to NHS bodies in Wales and requires them to be open and transparent with people when they come to harm whilst using services. The duty will be triggered when there is an incident

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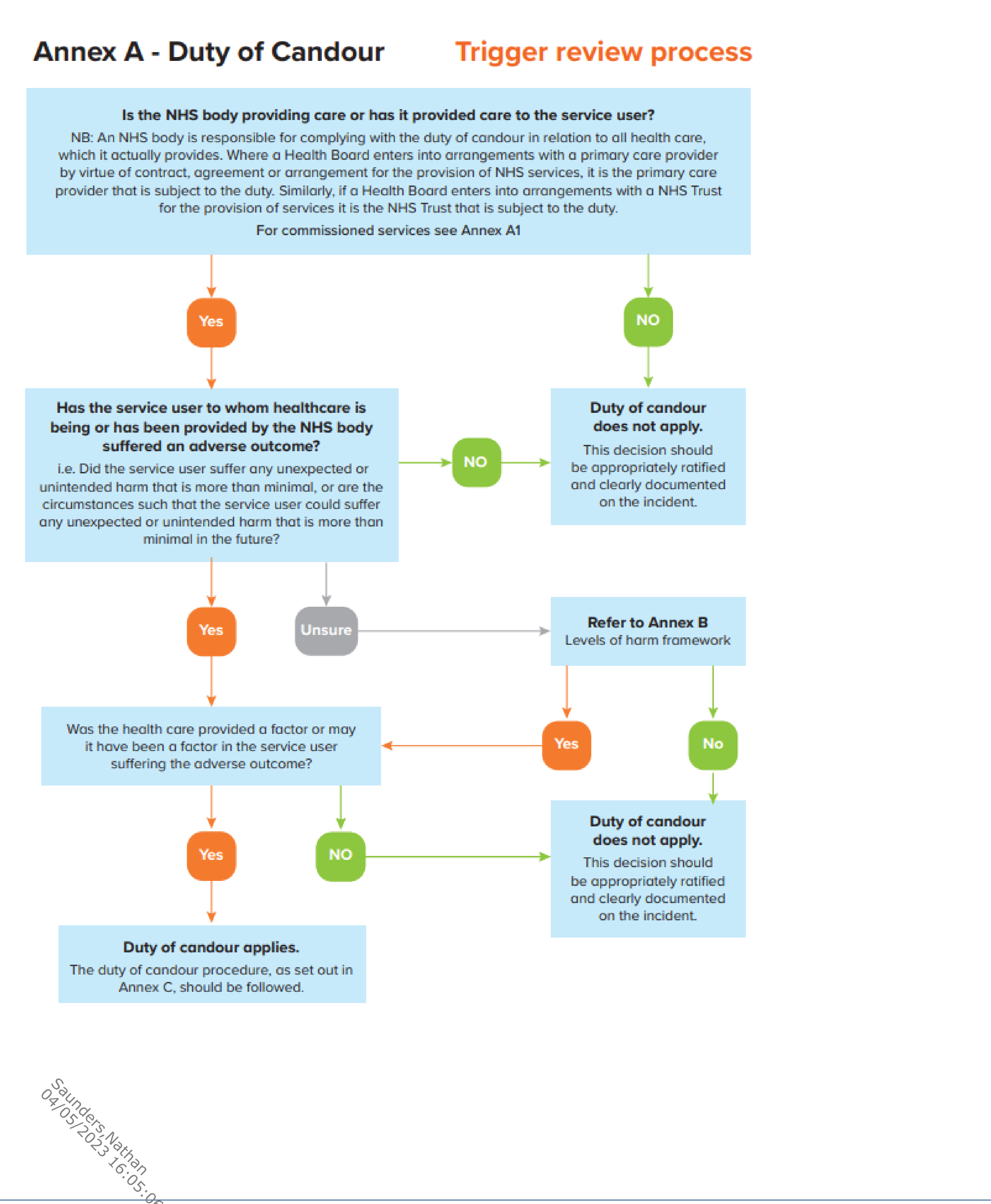
that causes harm that is more than minimal, the harm is unexpected or unintended and health care was or could have been a factor in causing the harm. When this type of incident occurs, the duty requires NHS organisations in Wales to notify the person involved offering a sincere apology for the harm and detailing what investigations will be done to learn from the incident. It also requires NHS bodies to produce an annual report on Duty of Candour incidents, summarising the number, type and learning from those incidents.



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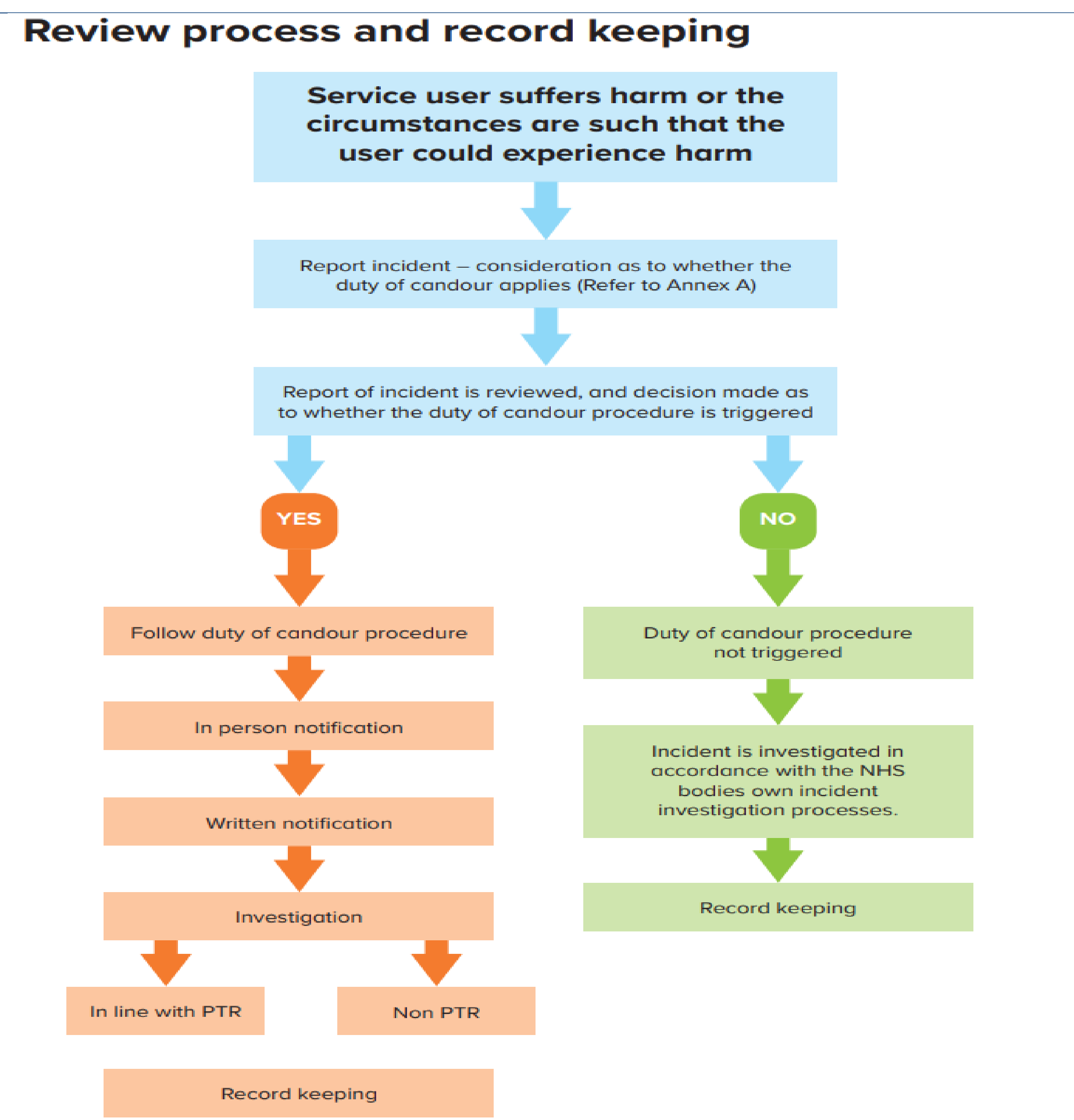

In practice this means - the trigger process for Duty of Candour essentially forms another gateway into existing investigation and PTR processes. It does not require additional investigation work. Organisations will have existing processes in place whereby incidents are reviewed and it is at this point, that a decision is made as to whether the Duty of Candour procedure is triggered.

Once confirmed that duty has been triggered, this will be the Duty of Candour procedure start date, also known as the day the 'NHS body first becomes aware'. The organisation will then have 30 working days to undertake their investigation as per PTR timescales.

There must be a gateway to redress if appropriate.

Initial feedback from cases

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On review approximately 37% of Incidents are being regraded from the initial grading and in line with the grading framework. There is discussion with the reporter to agree the rationale

When does the Duty of Candour apply?

IMPORTANT- this section sets out the conditions that must be satisfied in order for the Duty of Candour to apply. These must be worked through when applying the harm framework.

The duty is triggered in relation to an NHS body if it appears to the body that both of the following conditions are met:

(1) The first condition is that a person (the "service user") to whom health care is being or has been provided by the body has suffered an adverse outcome.

(2) The second condition is that the provision of the health care was or may have been a factor in the service user suffering that outcome.

We have identified incidences where the harm has occurred when the person is not in receipt of health care such as a fall at home, road traffic accident etc. Pressure area development at home etc

The duty may be triggered by an action taken by a NHS body during the provision of health care or by a failure to take action.

The duty is not triggered where harm is related to the natural course of the service user's illness or underlying condition.

Review of incidents, better understanding for staff and the public regarding health care acquired harm as opposed to disease progression etc. will ensure we have more comprehensively validated data which reflects our level and severity of health care acquired harm. It is imperative that with any incident regardless of the harm the informal or formal duty of Candour prevails and patients, families and staff are fully aware of how an incident is investigated and the outcome.

Level of harm	Incidents that would not trigger the duty of candour procedure
None	**Any patient safety incident that had the potential to cause harm but impact resulted in no harm having arisen.** e.g: Appointment delayed, but no consequences in terms of health. e.g: Patient fall – where no harm was suffered or additional interventions required. eg: Near miss – where the potential for harm was noticed and action taken to avoid occurrence of harm.
Low harm/minimal harm	**Any patient safety incident that resulted in a minor increase in treatment and which caused minimal harm to one or more persons receiving NHS-funded care.** Minor increase in treatment could include: e.g: First aid, additional therapy, medication or rehabiliation e.g: Patient fall - requiring one off observations and/or minor treatment. e.g: Increase in length of stay by 1 - 3 days.

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Unexpected or unintended moderate harm	**Examples of unexpected or unintended levels of moderate harm and types of incidents that would trigger the duty of candour procedure include:** **Moderate harm –** (a) **moderate increase in treatment** and (b) Significant but not permanent harm. **Moderate increase in treatment could include:** • An unplanned admission/re-admission, • An unplanned return to surgery, • Increase in length of stay by 4 -15 days, • Cancelling/postponement of treatment, • Transfer to another treatment/care area, such as secondary care or intensive care as a result of the incident. Examples of the type of incidents that would trigger the duty of candour procedure include: **Description of incident** – unplanned admission. Patient was seen by a member of the community MH team; who fails to recognise, or act on evidence of poor medication compliance/failure to adhere to treatment sessions/expression of suicidal thoughts. **Level of harm as a result** - the patient self-harms, causing moderate harm requiring admission to hospital. **Description of incident** - Operation cancelled. **Level of harm as a result** – Leading to deterioration and a longer stay in hospital > 4 days and recovery delayed. **Description of incident** - Patient receives opioids despite this being documented as an allergy. **Level of harm as a result** – Leading to the patient suffering a significant reaction and required emergency treatment.

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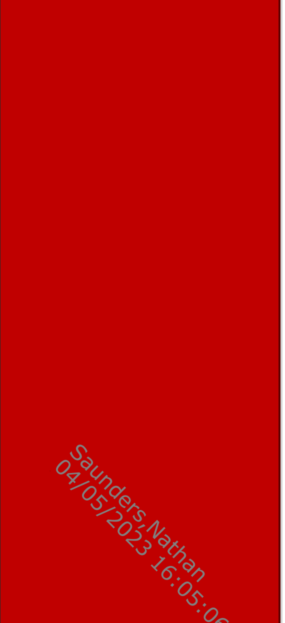
Unexpected or unintended severe harm	**Examples of unexpected or unintended levels of severe harm and types of incidents that <u>would</u> trigger the duty of candour procedure include:** **Severe harm would include:** • Avoidable, permanent harm or impairment of health or damage leading to incapacity, disability or the loss of recovery potential. • Avoidable permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage. • Increased length of stay by >15 days **Examples of the type of incidents that would trigger the duty of candour procedure include:** **Description of incident** - loss of recovery potential. Delays in thrombolysis or AHP treatment. **Level of harm as a result -** resulting in loss of recovery of walking or speech, which is permanent. **Description of incident** - Patient suffers an adverse reaction to medication that they are documented to be allergic to. **Level of harm as a result –** Leading to the patient suffering brain damage or other permanent organ damage.

Unexpected or unintended death	**Examples of unexpected or unintended death and types of incidents that <u>would</u> trigger the duty of candour procedure include:** **Examples of the type of incidents that would trigger the duty of candour procedure include:** **Description of incident** - Wrong blood transfused. **Level of harm as a result -** Leading to multi-organ failure and a fatal cardiac arrest. **Description of incident** - Patient suffers an adverse reaction to medication that they are documented to be allergic to. **Level of harm as a result** - Leading to severe anaphylaxis and subsequent death. **Description of incident -** Patient presents with chest pains and is asked to wait in clinic/practice/emergency department. **Level of harm as a result -** Patient suffers a fatal myocardial infarction in the waiting area, which they then die from.



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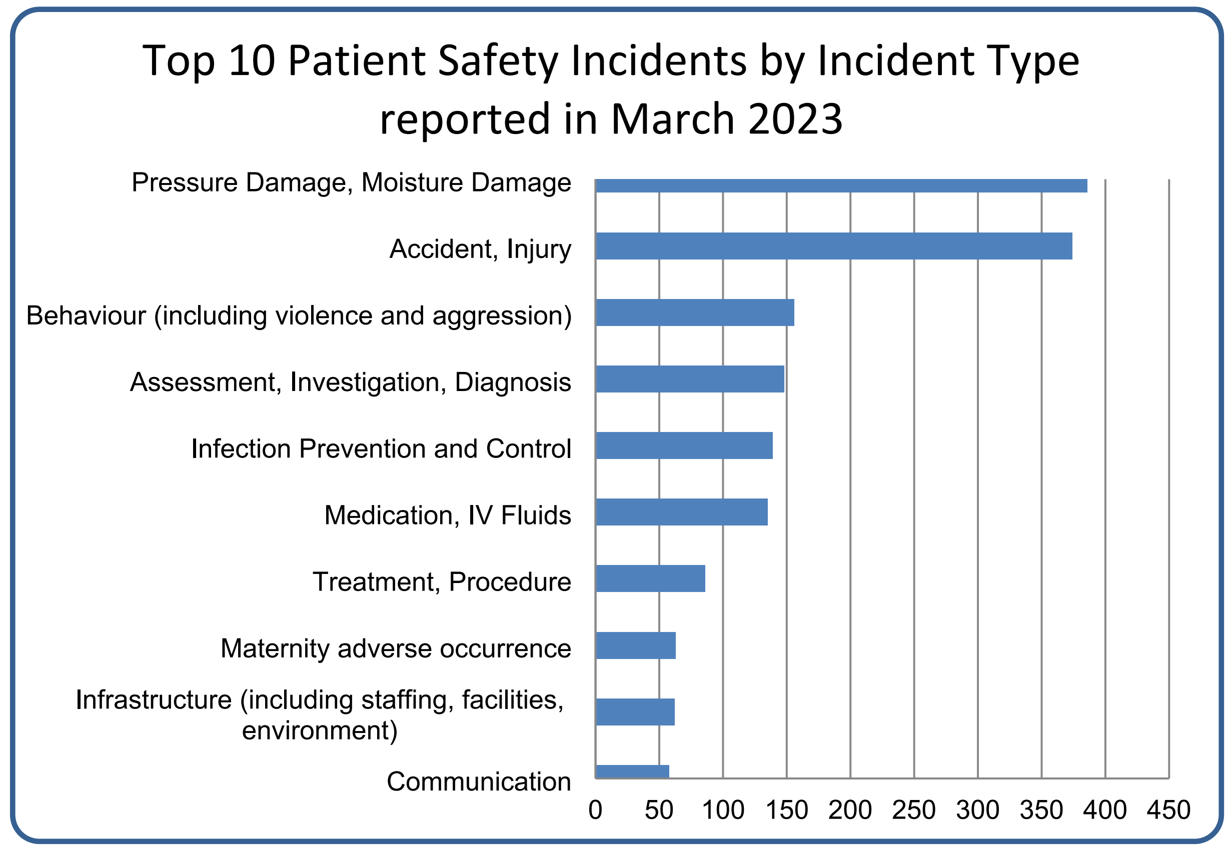
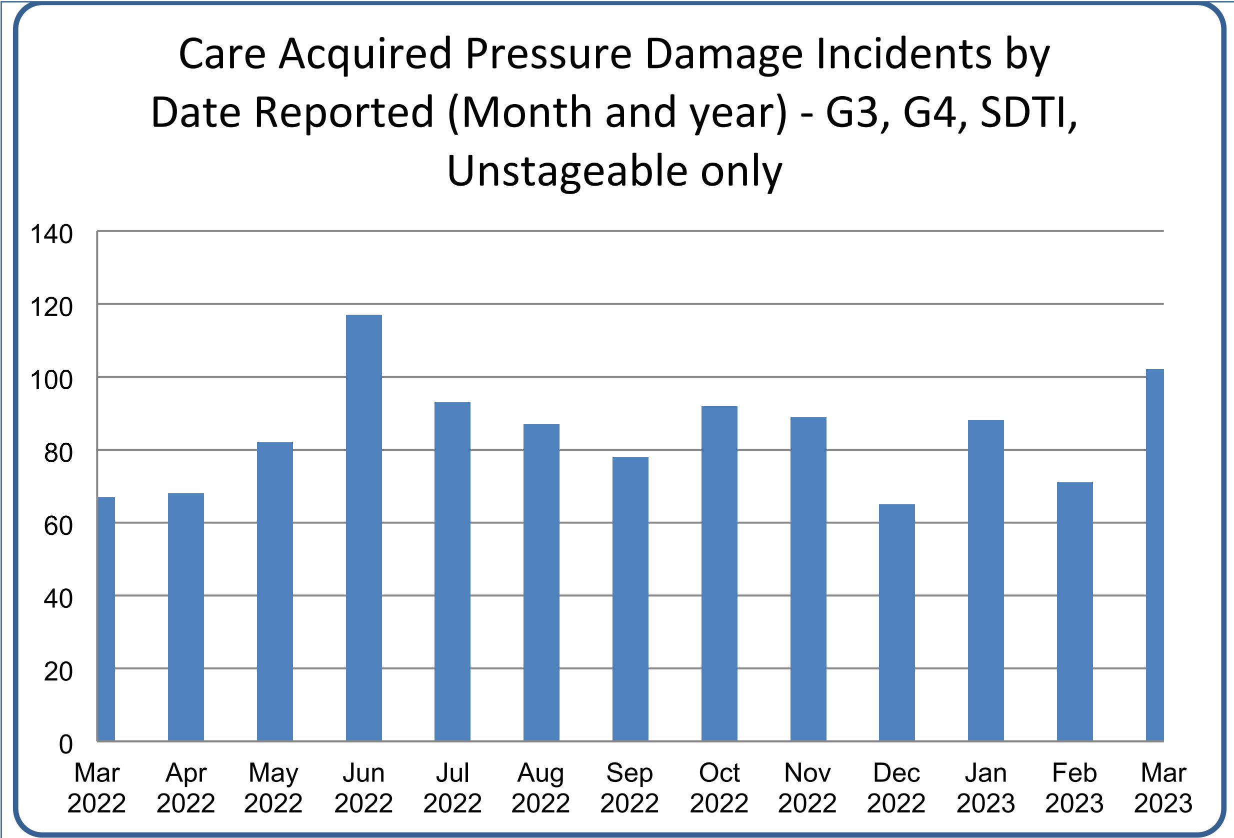
Incident reporting

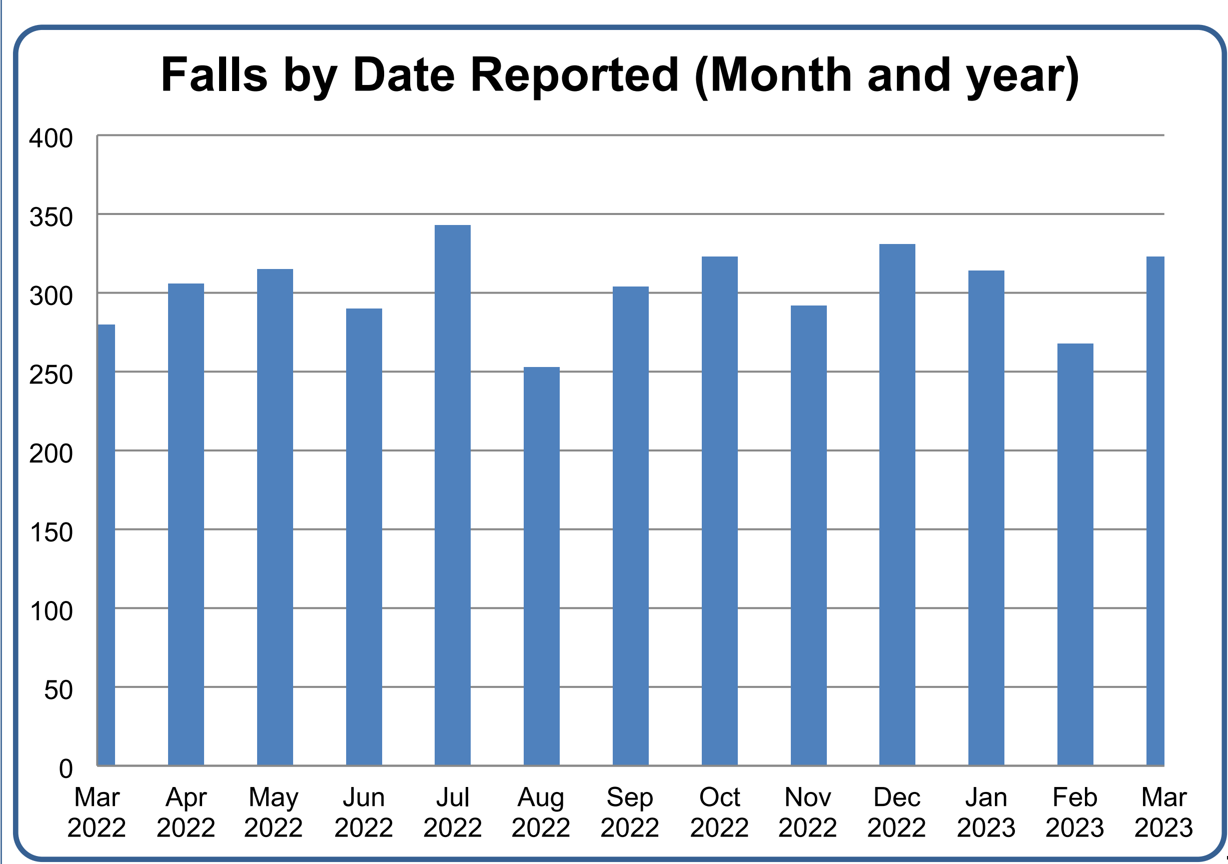
The chart below illustrates patient safety incidents reported during March 2023 by incident type. A total of 1853 incidents were reported during this period affecting patients/service users, an increase of 363 from the previous month. This is increased from this time last year where we reported 1275 patient safety incidents for March 2022. This was the month that we went live with the new Datix OfWCMS which may explain the slight reduction. However, at the time, during monitoring of activity, we did not see a reduction in incident reporting. As is usual, pressure damage and accident/injury (falls), are the most commonly reported incidents. The new addition of IPC incidents into the top 10 reflects the retrospective entering of previous Covid cases onto Datix during their review and investigation process and does not represent new incidents.



The chart below shows the trend for pressure damage reporting over the last year, this focusses on pressure damage that has occurred or worsened whilst in receipt of NHS care and those that are graded as 3, 4, suspected deep tissue injury or unstageable only. We reported more pressure damage in March of this year compared to March 2022, again this may have been slightly impacted by the change to the new Datix reporting system. This data is based on date reported not incident date which can be different.

There has been awareness raising of pressure damage reporting in areas not usually associated with high levels of pressure damage. A focus was given in March to pressure damage being reported within Acute Child Health where it was identified that device related damage is a challenge for the Paediatric Critical Care Unit. WHSSC are providing ongoing support with this and a visit is being arranged for key individuals to Great Ormond Street to see how they manage device related pressure areas. Pressure damage scrutiny panels are rolling out across the Health Board following the success reported in Primary Care and Adult Critical Care. The purpose of these panels is to provide oversight on the reviews and ensure appropriate learning is gained.





Falls

Looking in more detail at falls, found on floor, fall from bed/trolley and fall on level surface are the most commonly reported fall categories.

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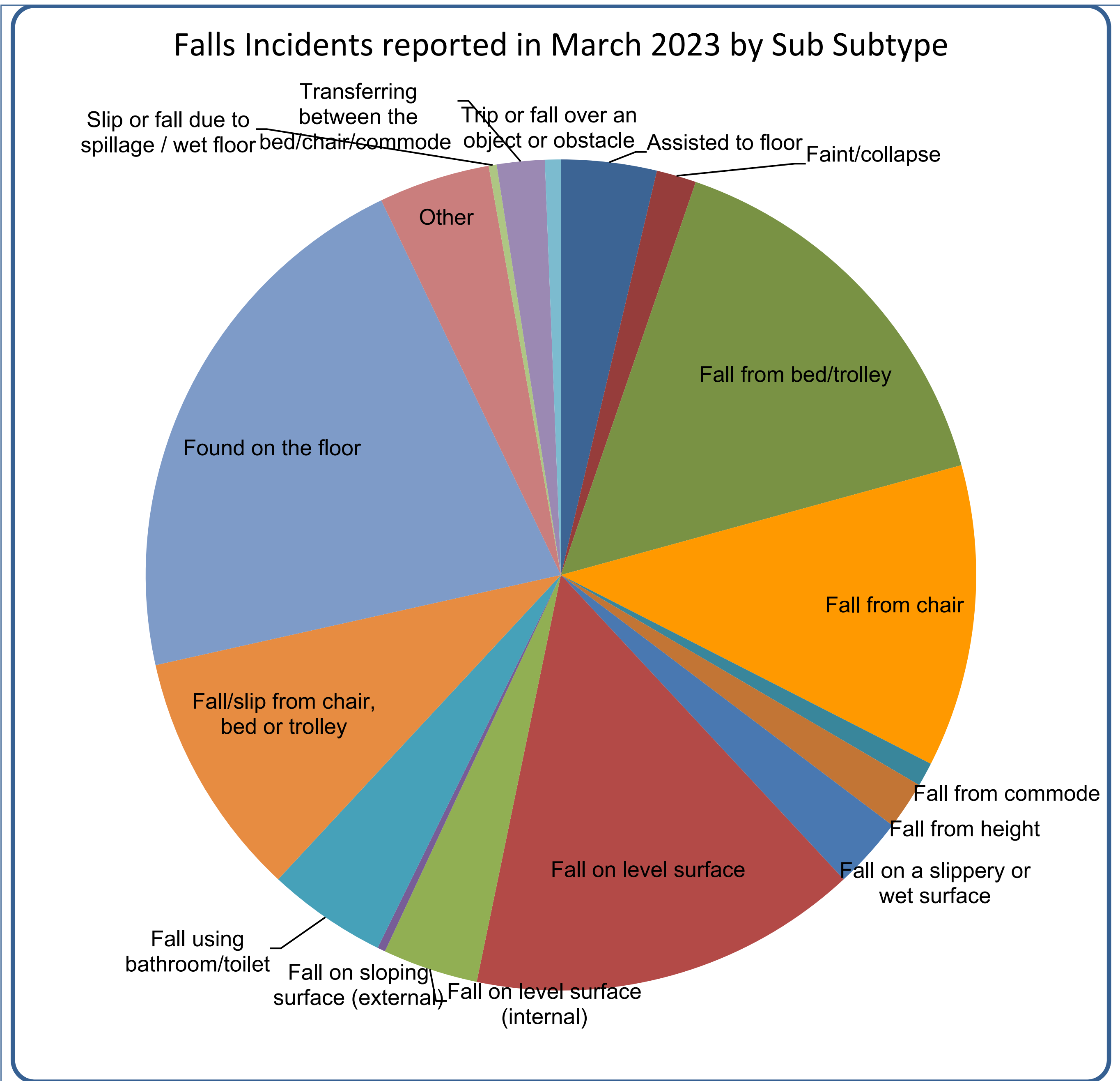

Nationally Reportable Incidents (NRIs)

The table illustrates performance of Nationally Reportable Incidents until 28th February 2023. It is an improving position and reflects the focus and hard work of the Clinical Boards and Patient Safety Team. However, the number of open and overdue NRIs increased in February.

	Open	Overdue
September 2022	53	34
October 2022	48	29
November 2022	51	26
December 2022	43	19
January 2023	46	20
February 2023	57	26
March 2023	65	27

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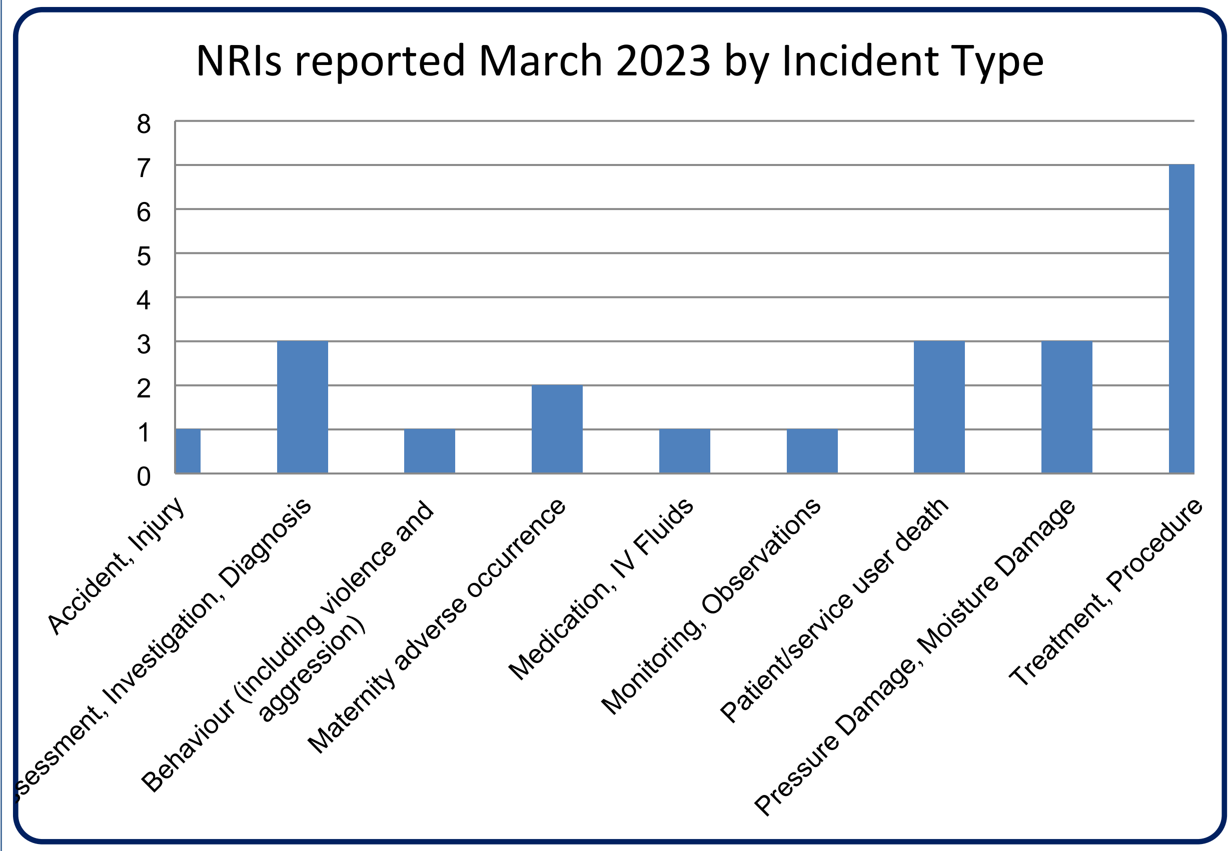
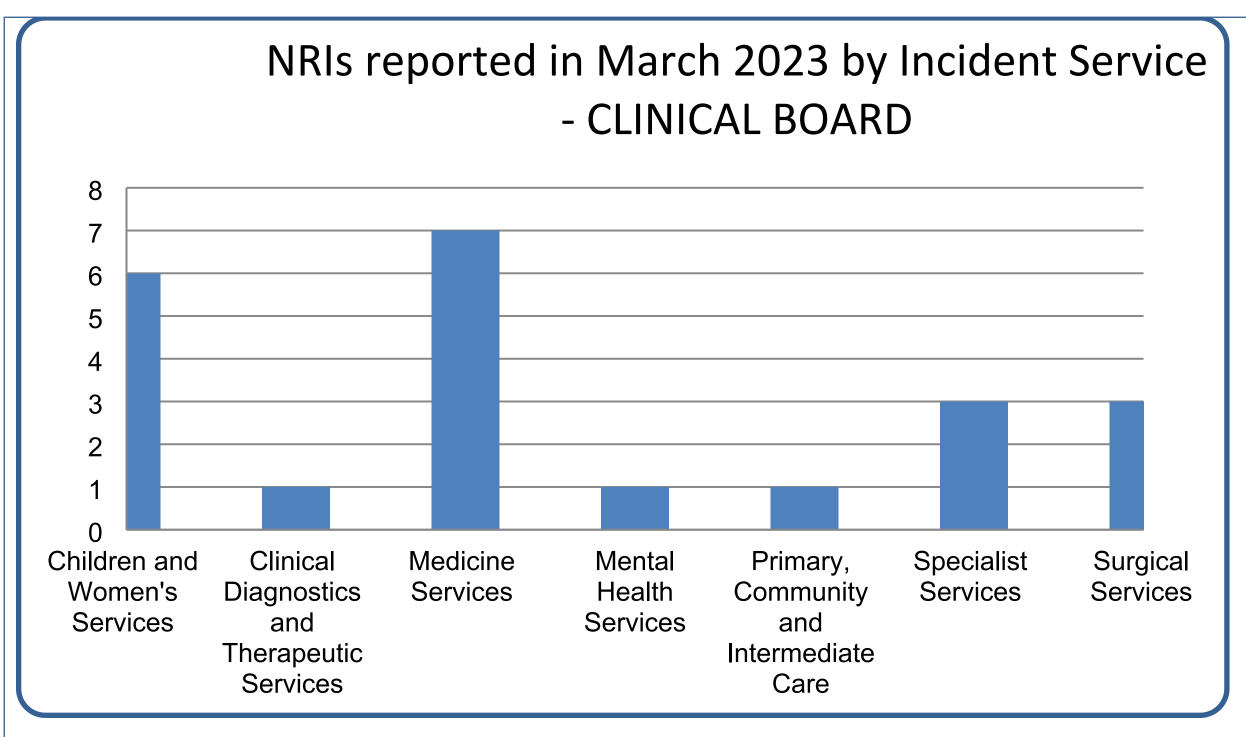
Clinical Board	Open NRIs as of 01.04.23	Overdue NRIs as of 01.04.23
Children and Women	13 ↑	5 ↔
CD&T	4 ↔	0 ↔
Executive	3 ↔	2 ↔
Medicine	10 ↑	4 ↔
Mental Health	11 ↓	6 ↑
Surgery	7 ↑	3 ↔
PCIC	3 ↔	1 ↓
Specialist	12 ↑	6 ↑
Total	**65** ↑	**27** ↑

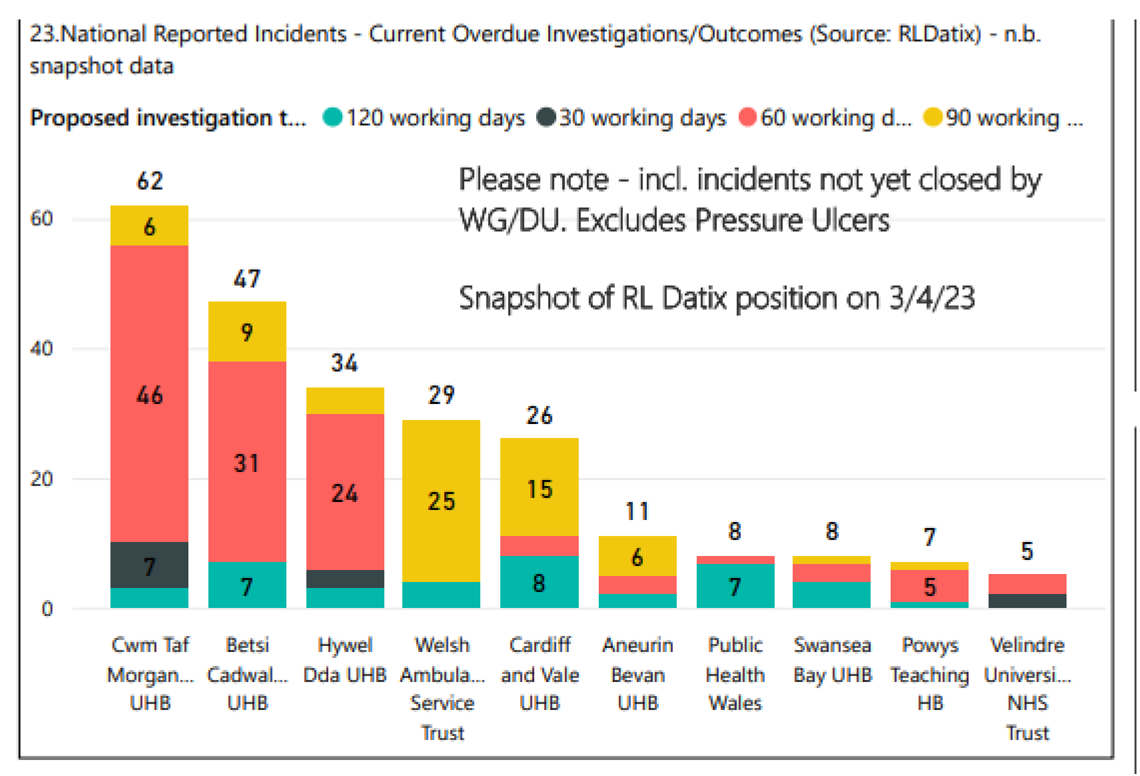
The above shows that most Clinical Boards have seen an increase in open NRIs over the last month, this follows a similar trend to the previous month.



The above shows the breakdown of the type of incident reported as an NRI in March 2023.

The chart below shows that Medicine reported the highest number of NRIs followed by Children and Women. Medicine NRIs were a combination of pressure damage, a fall, a medication error and treatment/procedure incidents. Children and Women NRIs were adverse maternity incidents, treatment/procedure and assessment and monitoring issues.





All Wales position

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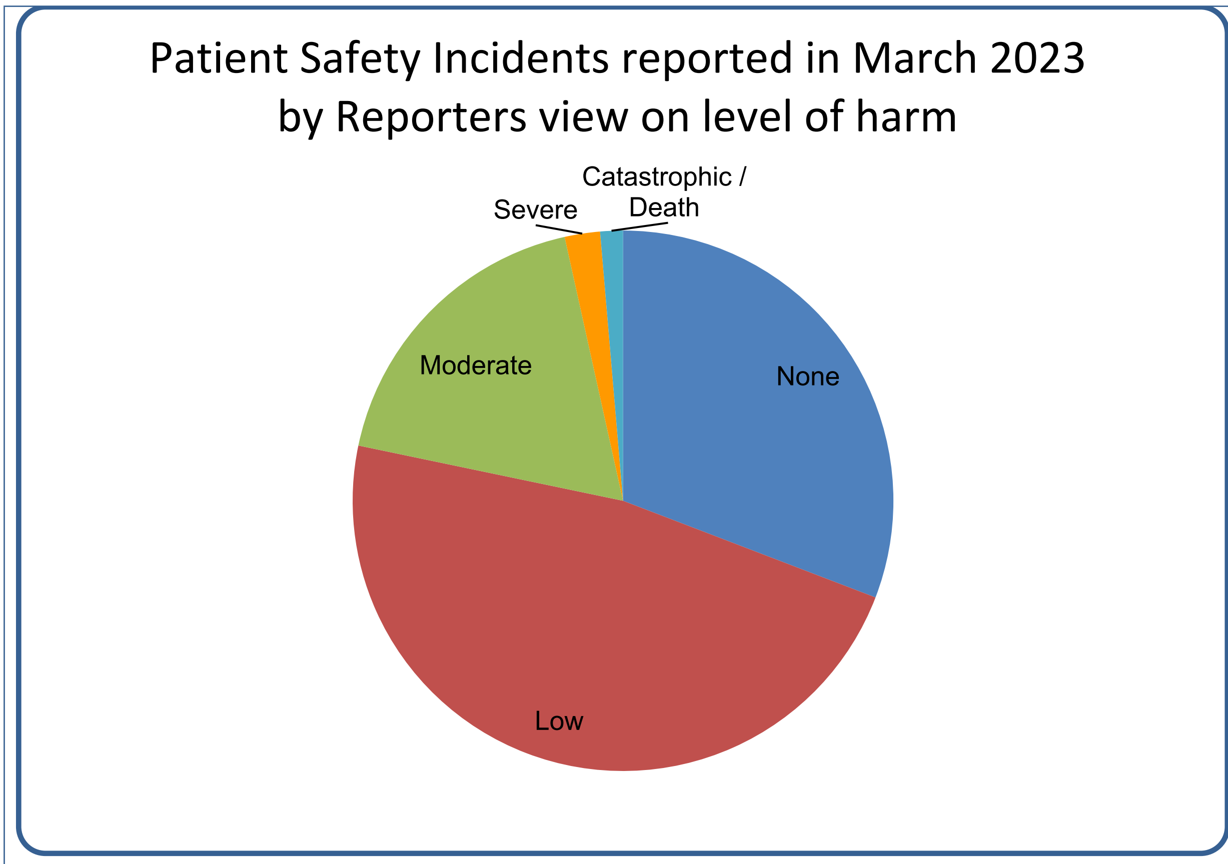

Mortality

The November 2022 Quality Safety and experience committee agreed a three-tier model for reporting and monitoring mortality data across the Health Board.

Tier 1 Health Board wide mortality measures which will be reported including All-Cause Mortality and Crude inpatient mortality.
Tier 2 - Clinical Board level mortality indicators which includes some condition specific mortality indicators.
Tier 3 – Specialty level mortality indicators to include condition and intervention specific mortality data.

Tier 1 mortality data will be included as part of the quality indicators report on a regular basis and Tier 2 indicators will be reported to board a six-monthly.

Tier 1 Mortality
Measuring the actual number of deaths over time (crude mortality) supports the monitoring of trends in mortality rates. The Crude inpatient Mortality chart demonstrates the numbers of inpatient deaths that occur in the Health Board on a weekly basis and compares this measure with the average for the previous 5 years for the same week. The blue line demonstrates a mortality rate that is comparable to the 5-year average for the same reporting week with the exception of March 2020 and December 2020 to February 2021, the first and second waves of Covid-19 where inpatient deaths rose above the 5-year average.

Crude all-cause mortality demonstrates the weekly number of deaths registered in Cardiff and the Vale of Glamorgan regardless of where they occurred. COVID – 19 deaths the pink line illustrates the number of deaths where COVID-19 features anywhere on the death certificate. There is a correlation between increases above the five-year average and deaths where the patient had Covid on their death certificate during the first two waves of the pandemic (Spring 2020 and Winter 2020/21).

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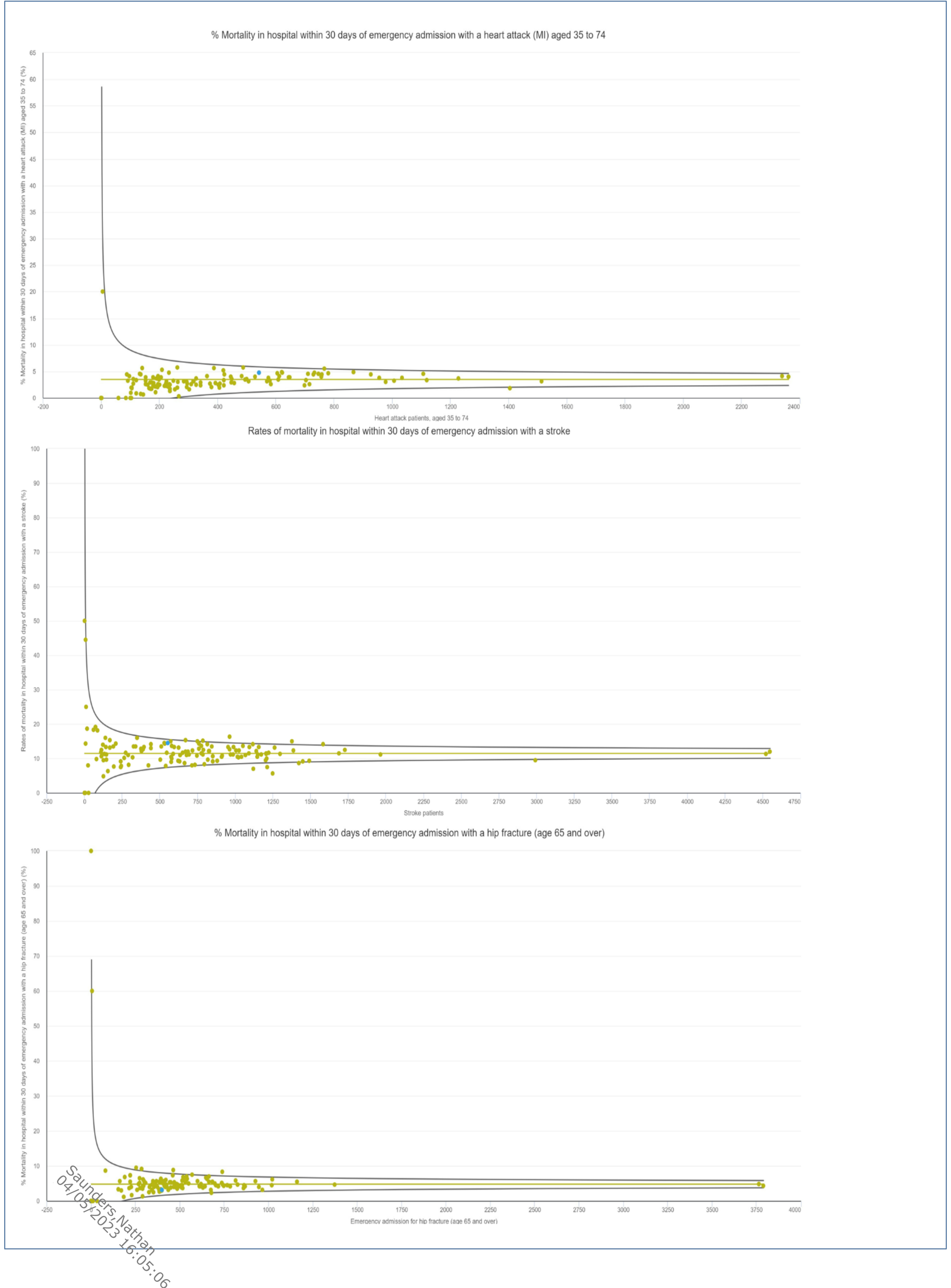

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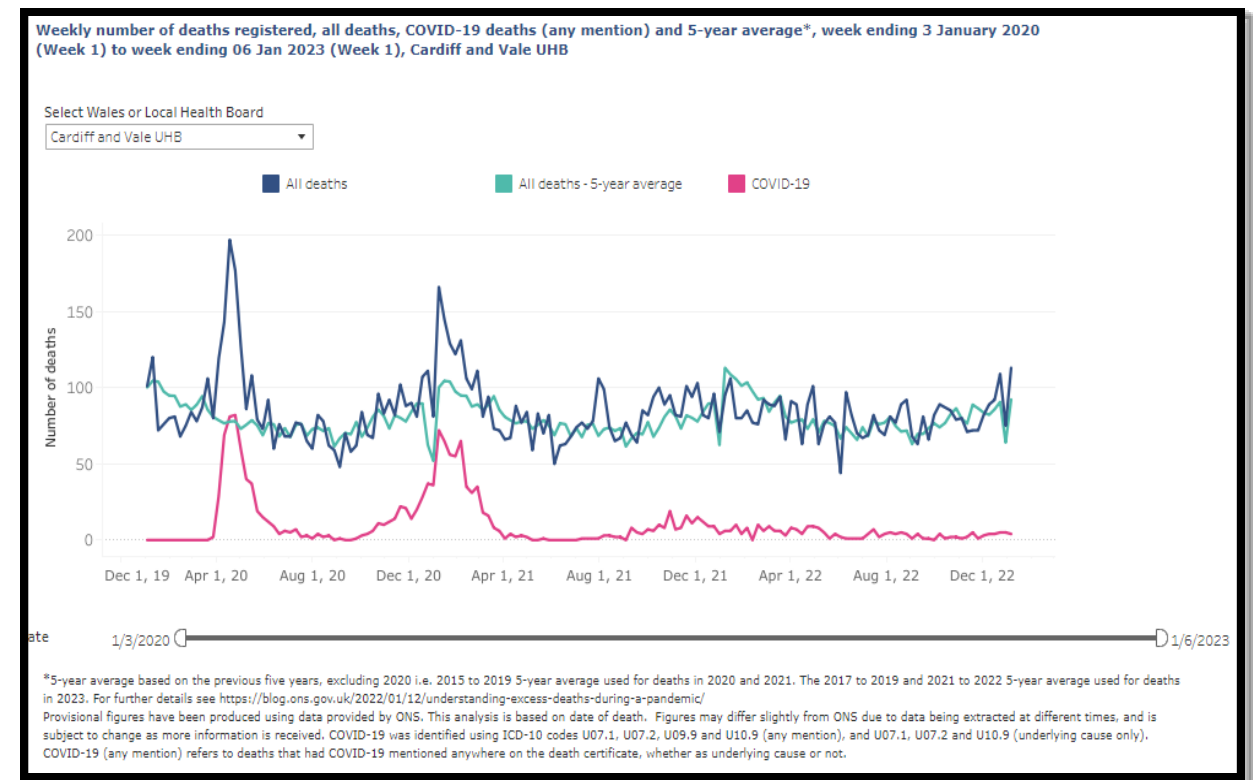
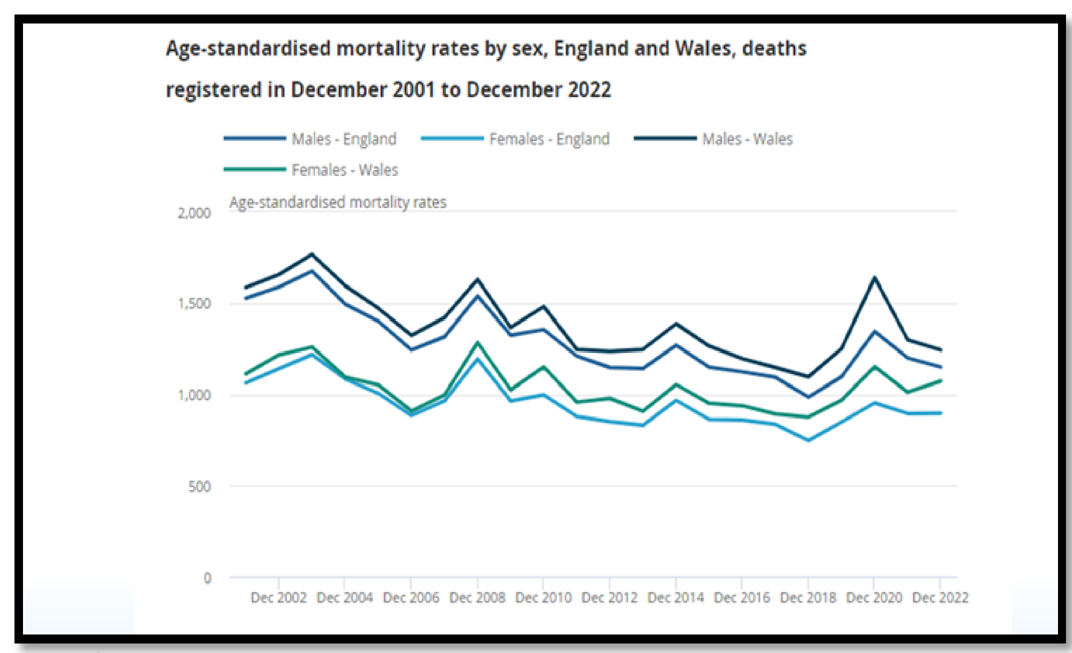
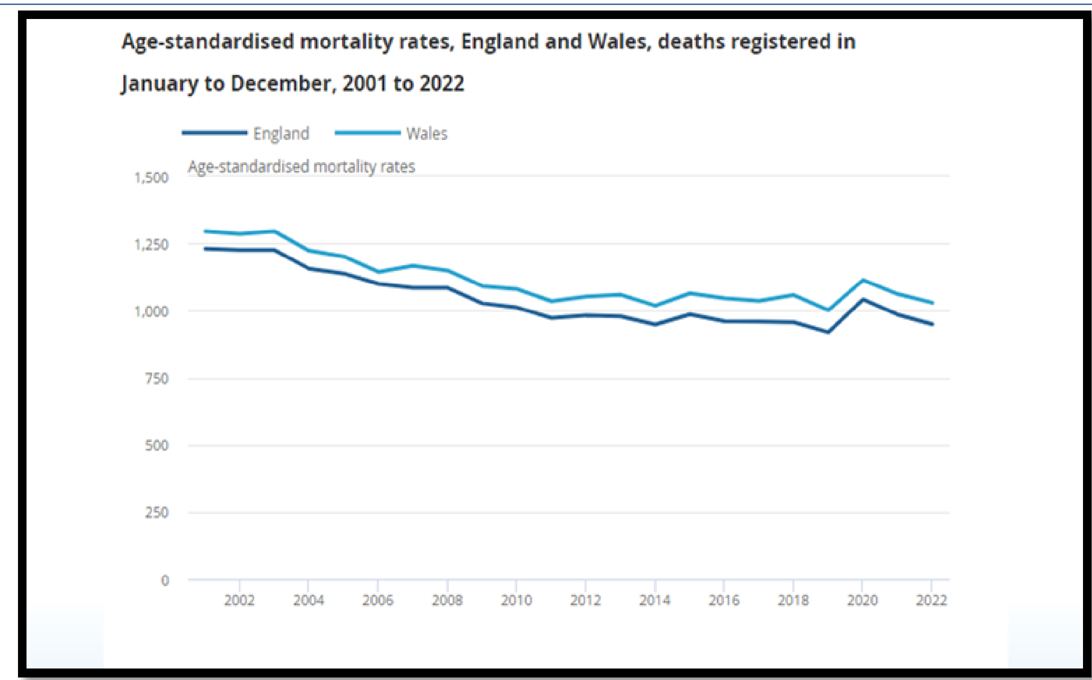


Source: Public Health Wales Covid Dashboard, ONS Mortality (CovidDashboard_ONSmortality | Tableau Public - https://public.tableau.com/app/profile/public.health.wales.health.protection/viz/CovidDashboard_ONSmortality/ONSdeaths)

Age standardised mortality by sex is shown to be lower in December 2022 (figure 3) when compared to the same period in 2021, although this reduction is not statistically significant in Wales. The age-standardised mortality rates in 2022 were significantly lower than most other years since 2001 in Wales and England (figure 4), although it remains above the rate observed in 2019.

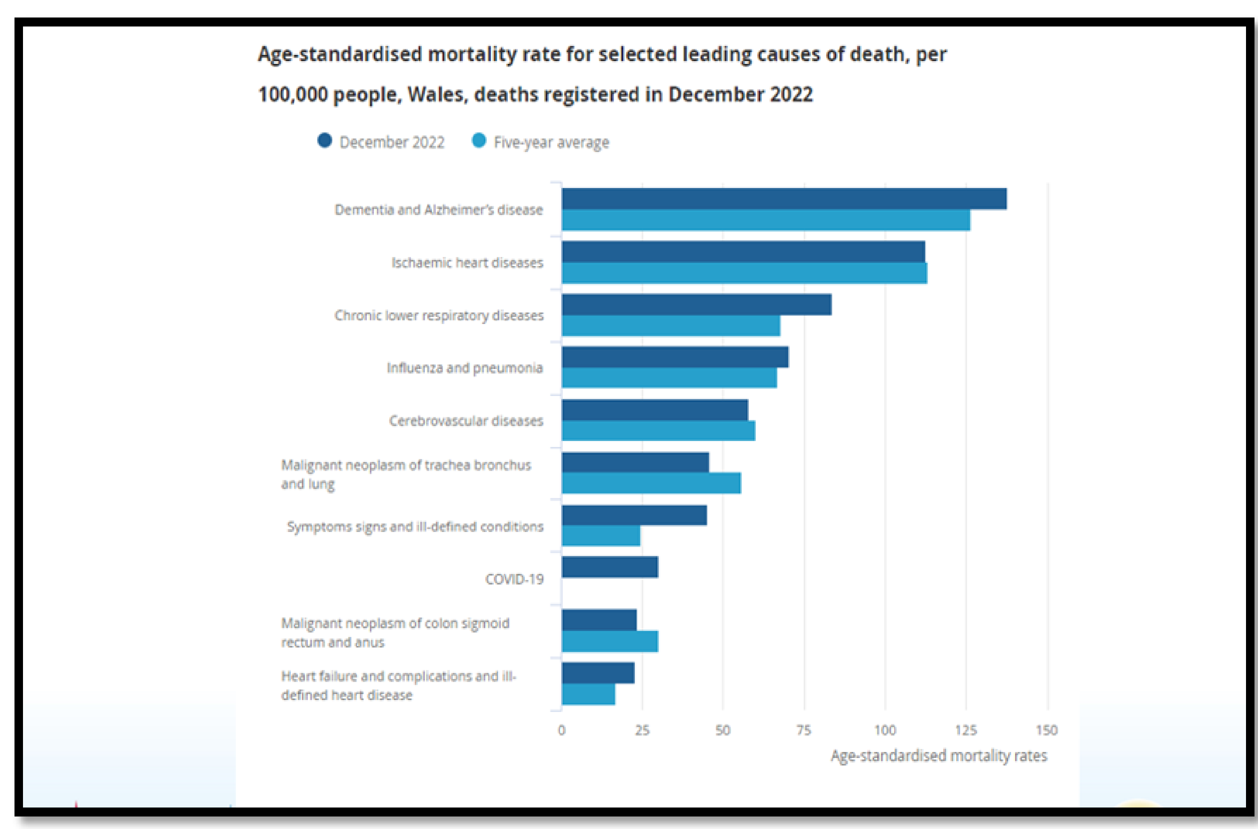


Source: Monthly mortality analysis, England and Wales - Office for National Statistics (ons.gov.uk) (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/monthlymortalityanalysisenglandandwales/december2022)



Source: [Monthly mortality analysis, England and Wales - Office for National Statistics (ons.gov.uk) - https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/monthlymortalityanalysisenglandandwales/december2022](https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/monthlymortalityanalysisenglandandwales/december2022)

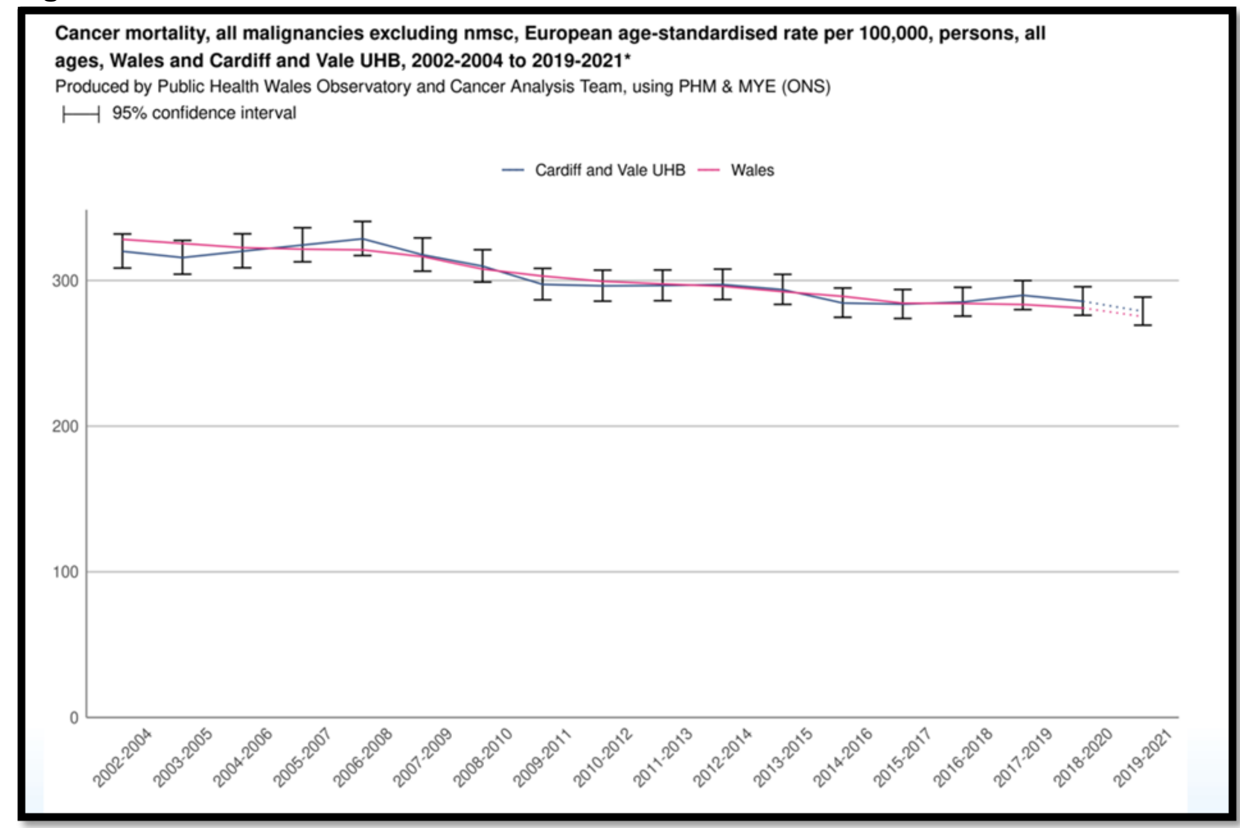
Figure 5 illustrates that Alzheimer's and dementia remains the leading cause of death in Wales in December 2022, with a rate higher than the five-year average.



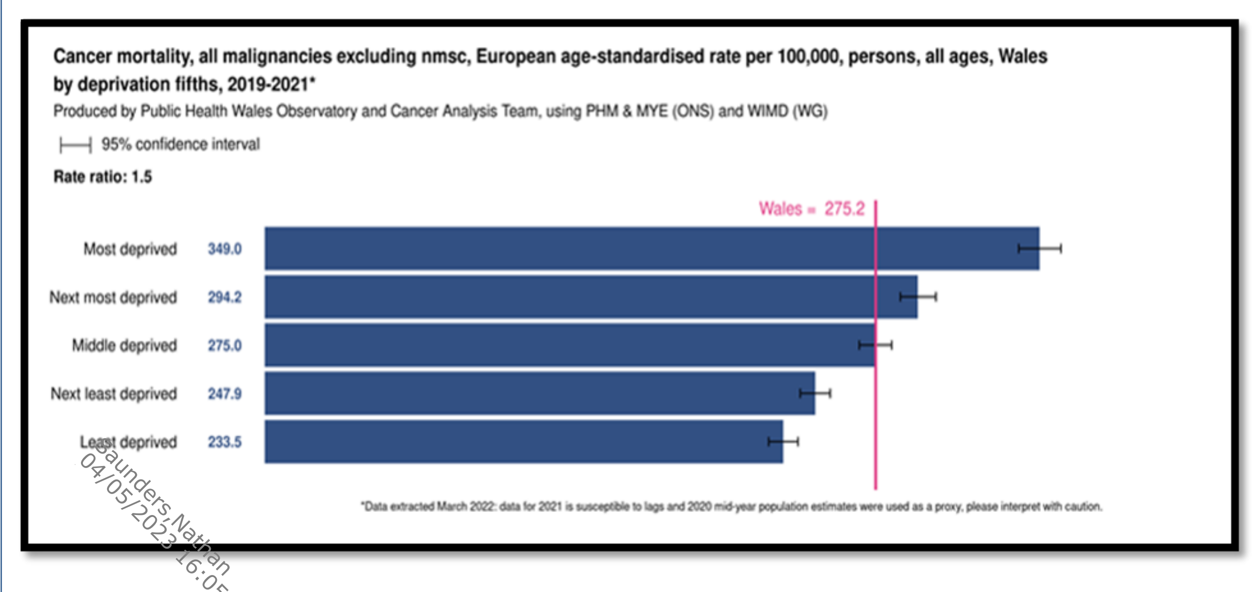
Source: [Monthly mortality analysis, England and Wales - Office for National Statistics (ons.gov.uk) - https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/monthlymortalityanalysisenglandandwales/december2022](https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/monthlymortalityanalysisenglandandwales/december2022)

Figure 6 illustrates cancer mortality rates per 100,000 population (excluding non- melanoma malignant neoplasm) and demonstrated a reducing trend in population rates in Wales and in Cardiff and Vale UHB area.

Figure 6



The age standardised cancer mortality, reported as mortality per 100,000 population, demonstrates significant variation in relation to deprivation. Mortality rates in those living in the most deprived fifths in Wales are around 50% higher than those living in the least deprived areas. The pandemic has impacted on this for some diagnoses, particularly marked in colorectal cancer mortality, where inequalities in cancer mortality increased rapidly from a 30% relative difference between the most and least deprived areas of Wales in 2019 to 80% by 2021.



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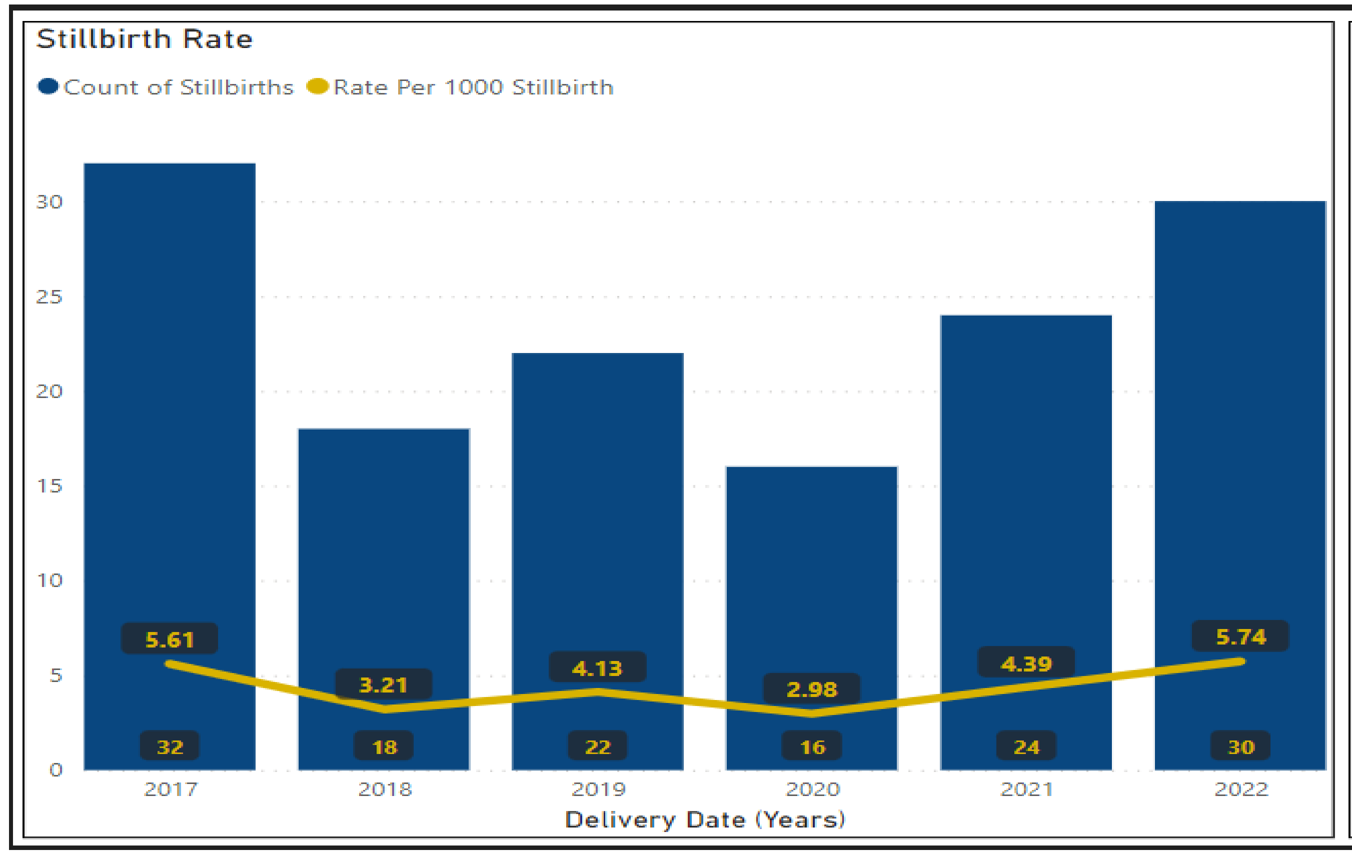
Maternity Outcome

Still birth rates in the UK fell to 3.9 per 1000 births in 2019 and 2020 with increased rates associated with ethnicity in several populations, in particular, Bangladeshi, Pakistani, Black African and Black Caribbean. Provisional figures from the office of National Statistics suggest that still birth rates increased in 2021 to 4.2 per 1000 births with a particular increase noted in the second half of 2021, national rates for 2022 are not yet reported. Still Birth Rates in Cardiff and Vale UHB increased from 2.98 in 2020 to 4.39 in 2021 and to 5.74 in 2022. The presence of a Fetal Medicine Unit, means that the Health Board provide specialist diagnosis and treatment of complications which might arise in unborn babies.

All still births and perinatal deaths are reported through the Perinatal Mortality Review Tool (PMRT) and are reviewed at the Health Board Perinatal Mortality Review Meeting, where all aspects of maternity and neonatal care from booking to birth and beyond are discussed.



The national still birth rate in 2021 was 4.2 stillbirths per 1000 births (provisional ONS data) and C&V rate was 4.39.

The aim is by 2030 to be at 2.5 still births per 1000 births or less *in line with the aim embedded in Saving Babies Lives – the care bundle for reducing perinatal mortality*

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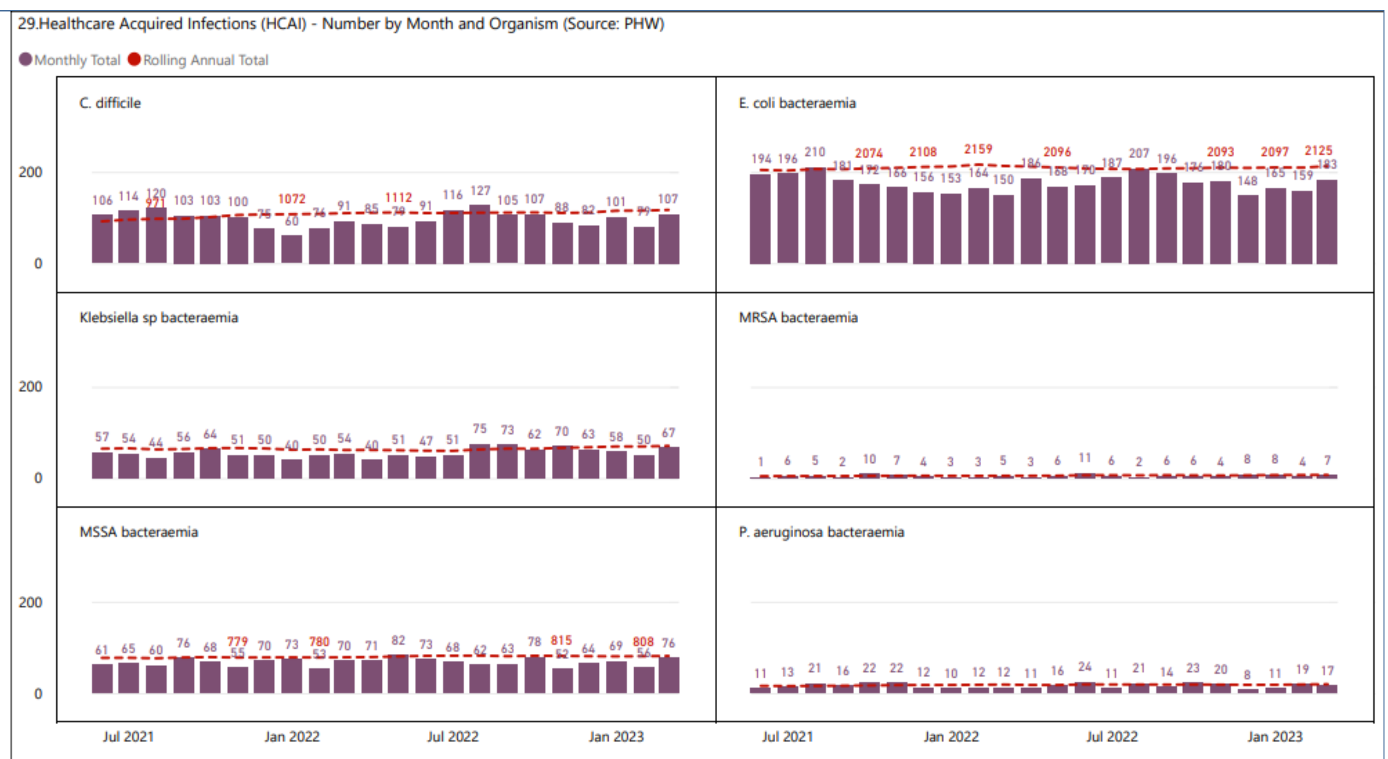
Infection, Prevention and Control

All Wales information



Timely

Our health care system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.

There has been a sustained improvement in:

Ambulance Patient Handover Improvement Trajectories

Cardiff and Vale

Based on the latest figures the Cardiff and Vale waits over 1 hour represent 9% of the All Wales figures

However, we continue to monitor the patient wait in the EU Department and the experience, the concerns and feedback suggests, that whilst staff continue to try and deliver high quality care, the flow throughout the Health Board remains challenging.

The Health Board is currently developing the – RELEASING TIME 2 CARE (RT2C).

RT2C is a framework combining 6 elements of change, each covering a multitude of tools, techniques and resources.

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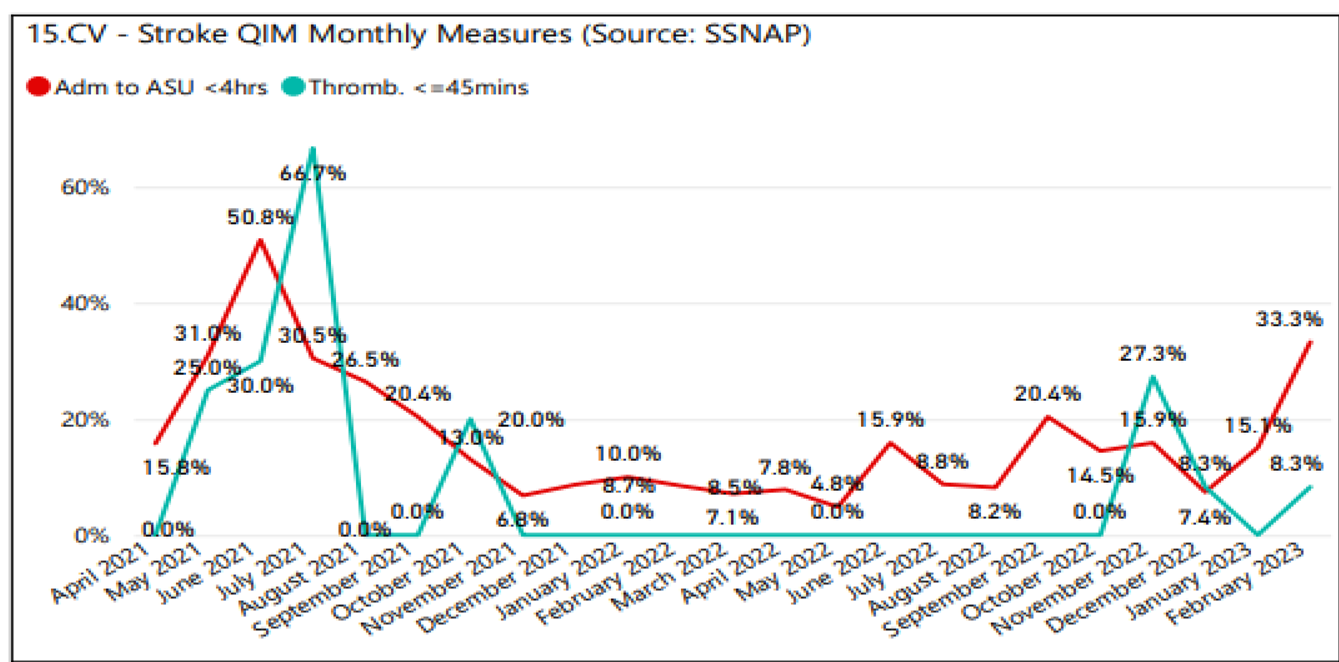
Following the pandemic, the long waits for treatment etc. have worsened. The Concerns data reflects the public concern regarding waiting times.

Effective

Our health care system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal outcomes possible for them and that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.

The stroke pathway is one that is time critical with key decisions that improve both mortality and outcome in relation to Quality of Life.



Across Wales, the percentage of people admitted to an Acute Stroke Unit in less than 4 hours is 22.8 %

There has been significant public awareness raising of the symptoms of stroke and the time critical nature.

There is ongoing work to improve the service:

- Increased out of hours CNS support for "Code Stroke".
- Dedicate specialist middle grade to support Emergency Unit for Stroke.
- Focused training for acute medics on stroke assessment, thrombolysis and thrombectomy.
- Ringfencing additional stroke beds and deploying pull model "Think thrombolysis, Think Thrombectomy".
- Thrombectomy next steps – work to strengthen neuroradiologist workforce.

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Efficient

Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments targeted at those likely to gain the most benefit, ensuring any interventions represent the best value that will improve outcomes for people.

The more clinical staff feel that their time is being taken up in non-clinical activity, the more likely they are to say that they would not want their relatives treated in the department.

The tools of Value Based Healthcare should be used to inform the design of all healthcare pathways and develop the outcome measures.

Through the Tendable Audits we are able to monitor the time that Nursing staff spend undertaking non-nursing tasks

Equitable

Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality because of personal characteristics such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation; the organisation that provides care; or location where care is delivered. We embed equality and human rights in our health care system and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

This is an area of focus in the Health Board. Equitable care in Wales refers to the principle of providing healthcare services that are fair, just, and meet the needs of all individuals and communities, regardless of their background or circumstances.

In Wales, the Welsh Government has a commitment to achieving health equity, which means ensuring that everyone has the same opportunities to achieve good health, regardless of their socioeconomic status, ethnicity, or other factors. This includes addressing health inequalities, which are differences in health outcomes between different groups of people.

To achieve equitable care in Wales, the Welsh Government has implemented various policies and initiatives, such as the Welsh Health Equity Status Report and the NHS Wales Health Equity Action Plan. These initiatives aim to identify and address health inequalities and improve access to healthcare services for all individuals, particularly those from disadvantaged backgrounds.

Additionally, the Welsh Government has also established the NHS Wales Centre for Equality and Human Rights, which provides advice, guidance, and support to health and social care organizations in Wales to ensure that they promote equality and human rights in their services.

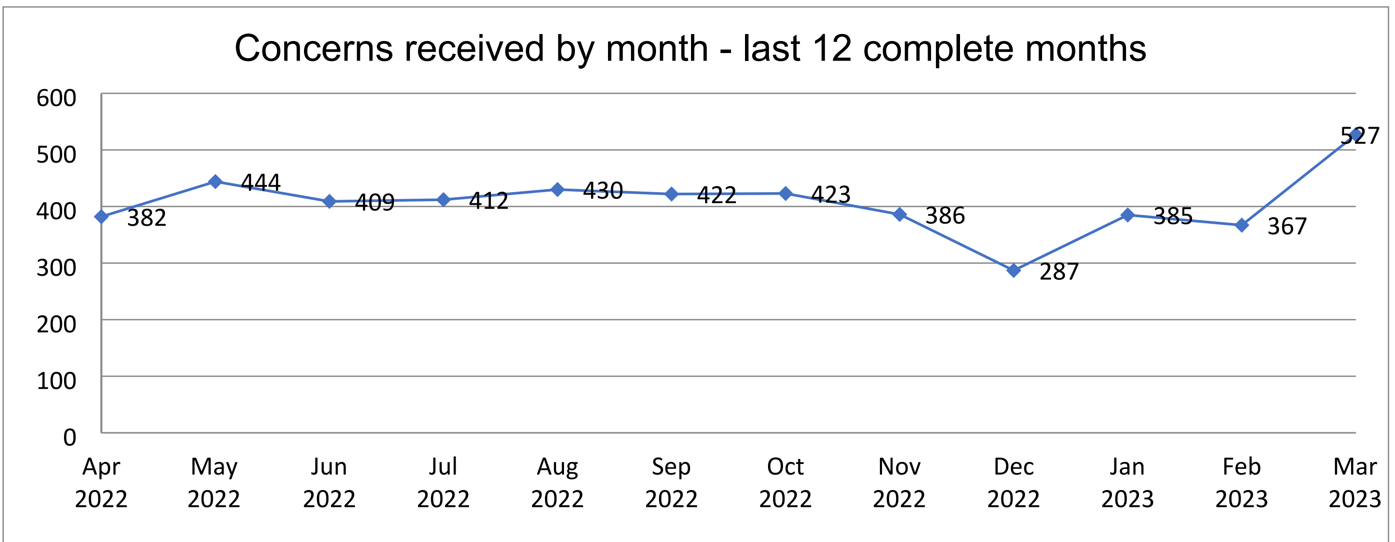
Saunders, Nathan
04/05/2023 16:05:06

Overall, equitable care in Wales is about ensuring that healthcare services are accessible and responsive to the needs of all individuals and communities, regardless of their background or circumstances.

Health Inequalities - the links between where people live, their socioeconomic status, their life expectancy and how many years they can expect to live healthily, are well-documented. Welsh Government and the NHS have been working to address health inequalities over many years. The fact that people from the most deprived areas of Wales are more likely to live shorter lives, with fewer years spent in good health, than those in the least deprived, is socially unjust and is something that must be addressed. Alongside deprivation, other factors such as ethnicity, gender, geography or intersecting risk factors have led to sustained health inequalities in society. Some health inequalities are avoidable, unfair and highlight systematic differences in health between different groups of people. We are engaging with the work of the new NHS Health Inequalities Group to strengthen the coordination of work to tackle health inequalities and to amplify its impact.

Person-centred

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.



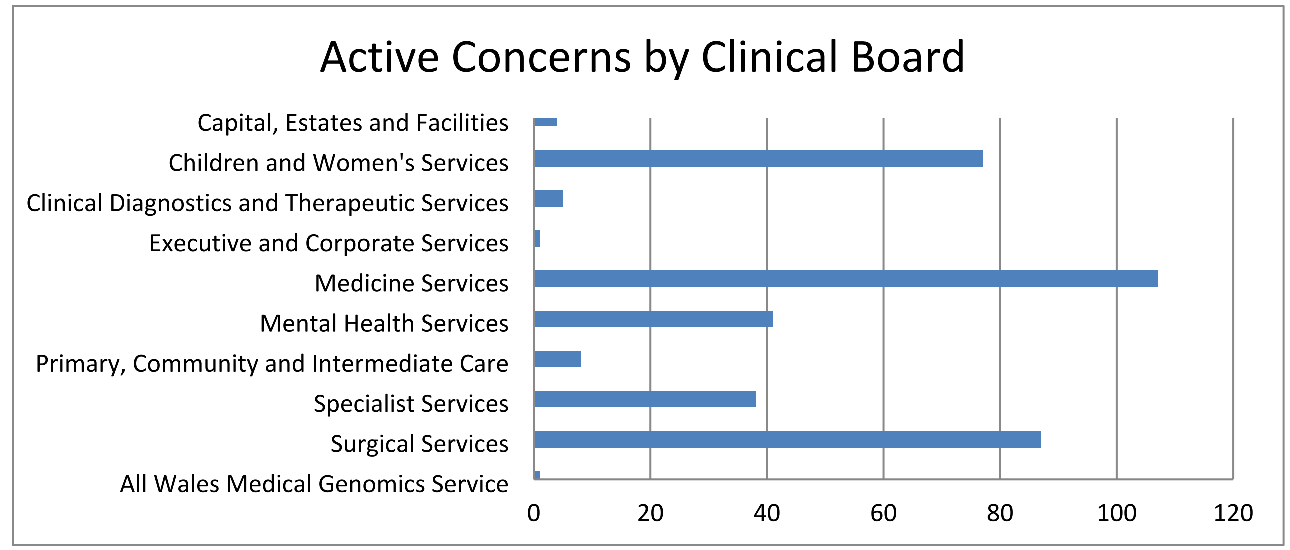
1. **Over 83 % of concerns are where possible processed via Early Resolution**
2. October 30 day performance 85%
3. November 30 day performance 77 %
4. December 30 day performance 78 %
5. January 30 day performance 77%
6. February 30 day performance 81%
7. March 30 day performance 85%

Saunders,Nathan 24/07/2023 16:05:06

CONCERNS

As a Health Board we are committed to listening to people who use our services, resolving their concerns where possible in a proportionate and empathetic manner. We aim to provide an effective and timely process for responding to concerns, which enables the Health Board to improve services based on lessons learnt, with the aim of achieving high quality, compassionate and effective care for all service users, whether in provided or commissioned services.

We currently have 322 active concerns. As anticipated, we noted a reduction in concerns during December which is in line with previous years due to the Christmas period, however, we had a significant increase in January also in line with previous years. Surgery and Medicine Clinical Boards consistently receive the highest number of concerns, the high volumes of concerns received in Medicine and Surgery Clinical Board is in line with the number of patient contacts and complex care both Clinical Board's provide. The number of necessary cancellations and delays due to Covid or Industrial action and the significant increase and demand on services like EU.



The graph below demonstrates the 10 main themes noted in Concerns.

Communication and Clinical treatment have historically been noted as the primary subject in concerns, however, concerns regarding cancellations of appointments have increased and now follows closely behind Communication, followed by Clinical Concerns regarding environment, facilities. Attitudes and behaviours are continuing to be recorded as a theme and increasingly statistically significant in number.

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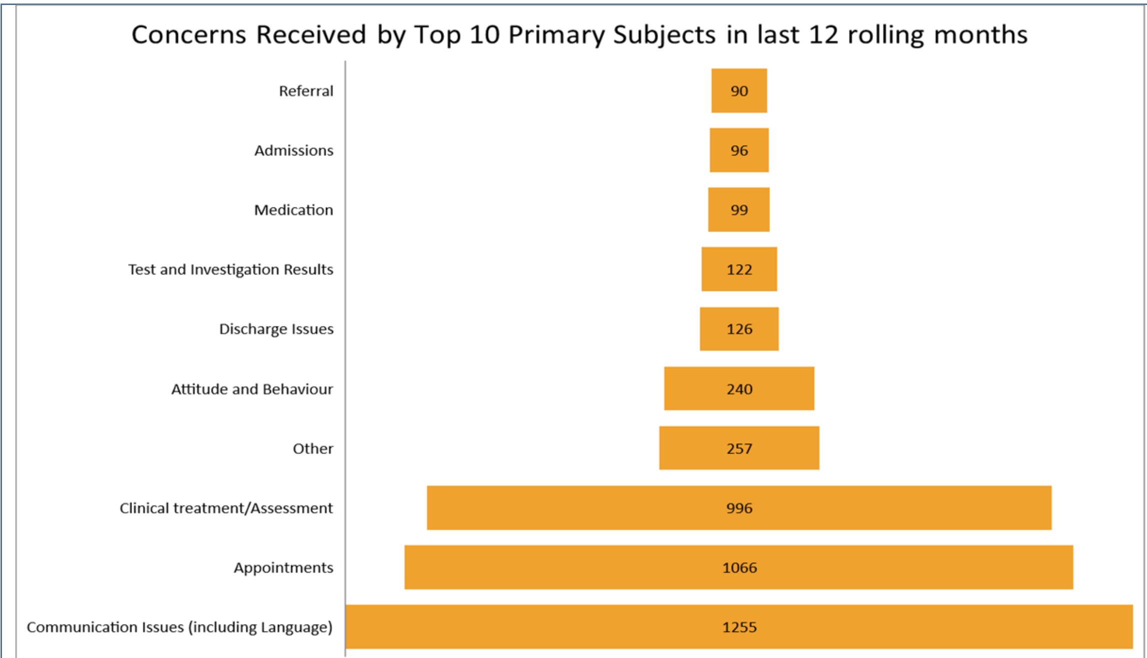
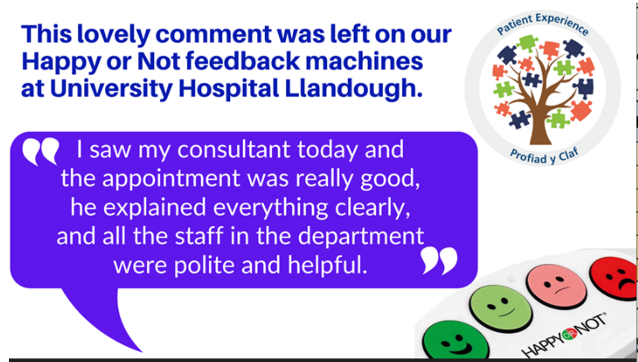


We have received 87 compliments in this time frame

Every Friday on Social Media we publish some feedback from our Kiosks which receive positive comments on twitter.



The Welsh Risk Pool, at the request of Welsh Government, have undertaken a validation exercise of the 2022-23 Q2 quarterly complaints data prepared for submission by each health body.

The validation exercise was intended to provide support to each health body in relation to the assurance of local processes for the application of the requirements of the Putting Thing Right regulations, published definitions and guidance and the maintenance of accurate and consistent information within the Datix Cymru system.

The validation exercise consisted of verifying source data provided by the health body and comparing this to the prepared proforma, addressing variances or queries through liaison with staff within the organisation.

The validation report is presented using the standard approach to audit assurance ratings and contains recommendations to enhance local processes.

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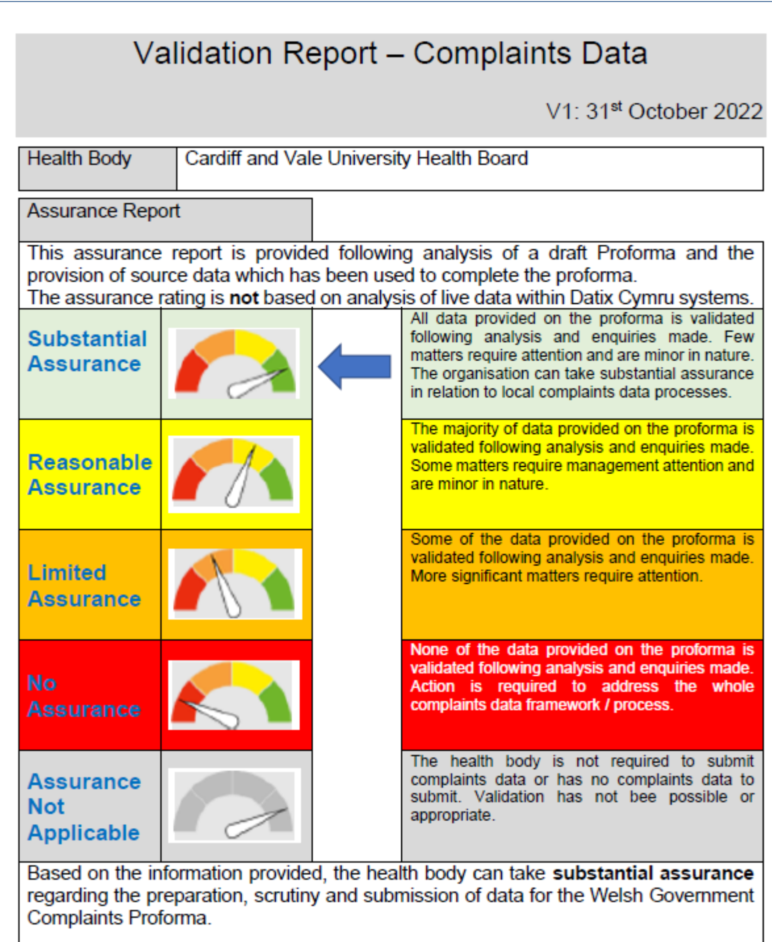

Validation Report – Complaints Data

V1: 31st October 2022

Health Body	Cardiff and Vale University Health Board

Assurance Report

This assurance report is provided following analysis of a draft Proforma and the provision of source data which has been used to complete the proforma.
The assurance rating is **not** based on analysis of live data within Datix Cymru systems.

Substantial Assurance		All data provided on the proforma is validated following analysis and enquiries made. Few matters require attention and are minor in nature. The organisation can take substantial assurance in relation to local complaints data processes.
Reasonable Assurance		The majority of data provided on the proforma is validated following analysis and enquiries made. Some matters require management attention and are minor in nature.
Limited Assurance		Some of the data provided on the proforma is validated following analysis and enquiries made. More significant matters require attention.
No Assurance		None of the data provided on the proforma is validated following analysis and enquiries made. Action is required to address the whole complaints data framework / process.
Assurance Not Applicable		The health body is not required to submit complaints data or has no complaints data to submit. Validation has not bee possible or appropriate.

Based on the information provided, the health body can take **substantial assurance** regarding the preparation, scrutiny and submission of data for the Welsh Government Complaints Proforma.

Assurance Rating	SUBSTANTIAL ASSURANCE

Proforma suitable for submission to Welsh Government?	YES – Submitted to WG by Welsh Risk Pool

Patient Experience Feedback <u>**HappyOrNot feedback**</u> (All locations)

In relation to the 'HappyOrNot' feedback, those reported as being satisfied are respondents who when asked: ***How would you rate the care you have received?***

A breakdown of the feedback for February and March is:

Summary values	February	March
Surveys completed	**1268**	**1338**
Response: Very happy button (Excellent/Very	61%	62%
Response: Happy button (Good/Positive)	10%	13%
Response: Unhappy button (Fair/Negative)	7%	7%
Response: Very unhappy button (Poor/Very	22%	18%
Respondents satisfied	**71%**	**74%**

Saunders,Nathan
02/05/2023 16:03:06

Below Gives the March feedback, broken down by which day of the week the feedback was received: it is pleasing to note that despite the increase in concerns received the satisfaction score has improved by 3%

Civica 'Once for Wales' platform

Our system went live on Friday 28th October and we are currently surveying up to 600 patients daily via SMS. At the time of reporting we have contacted some 45.287 people for feedback via text messaging - we are seeing a return rate of 19%. It is our understanding this is higher than many organisations but will be a focus for improvement with more targeted experience data collection over the next year with an aim for a minimum return of 25%. We are pleased to note a month on month improvement in our return rates.

The table and figures below give some of the summary information received during February and March.

Summary values	February	March
Surveys completed	1768	1915
Respondents satisfied	**89%**	**89%**

For the above, the 'Respondents satisfied' figure is based on those who answered the rating scale question: *Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?* and gave a score of 7 or more.

Table below. Gives a detailed breakdown of March's rating question feedback.

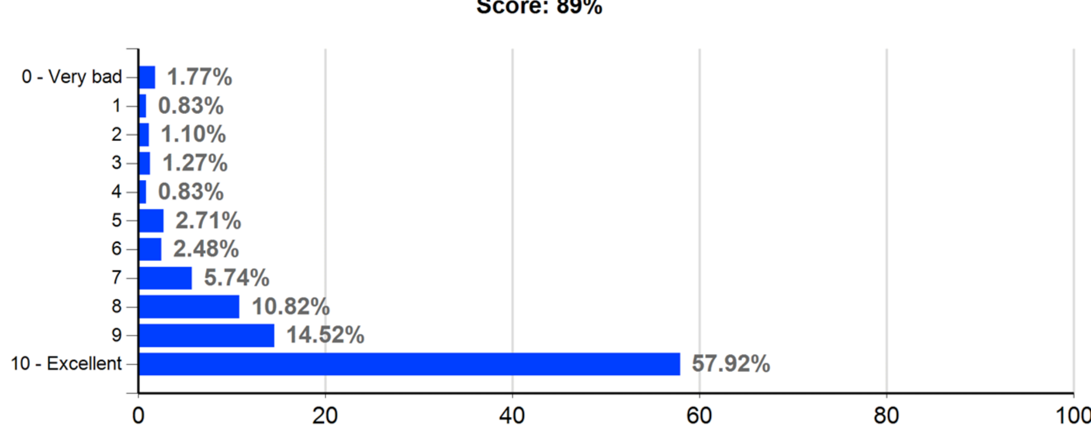
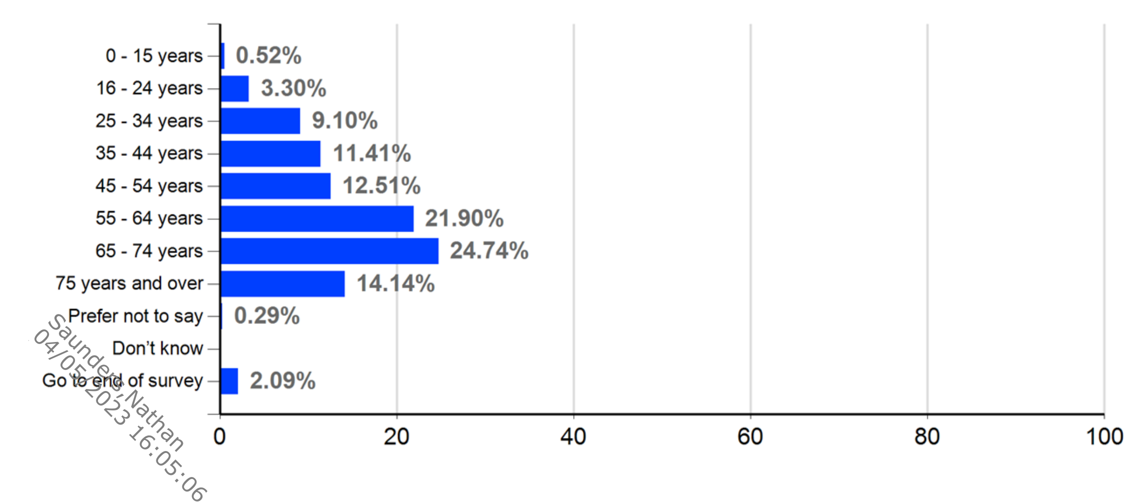


Table below. Gives March's feedback, broken down by age group of respondents.



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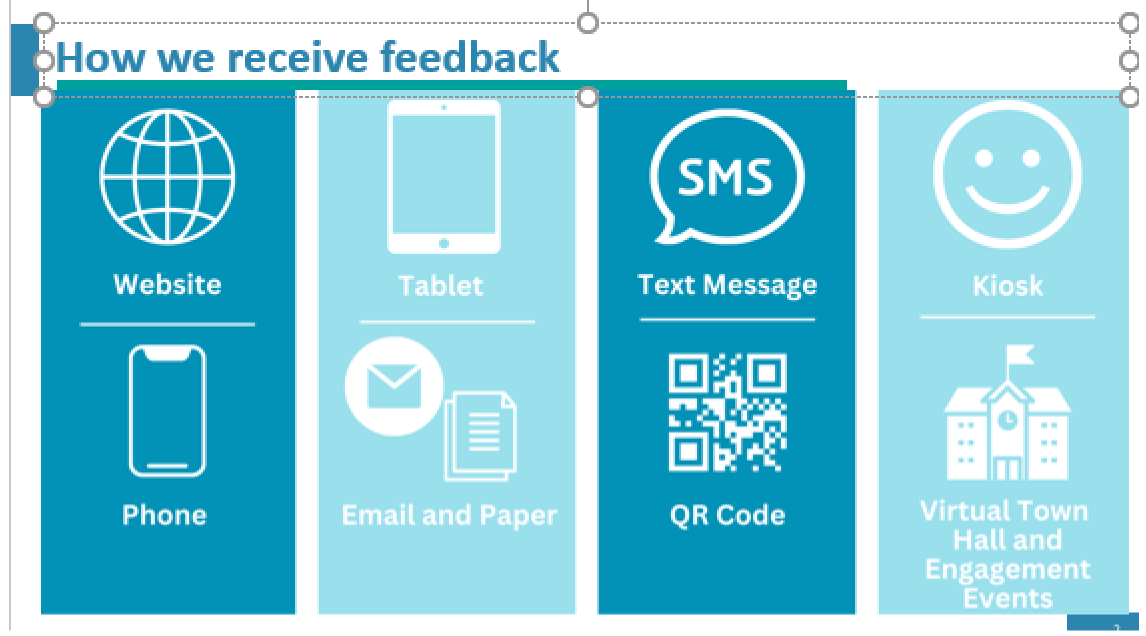
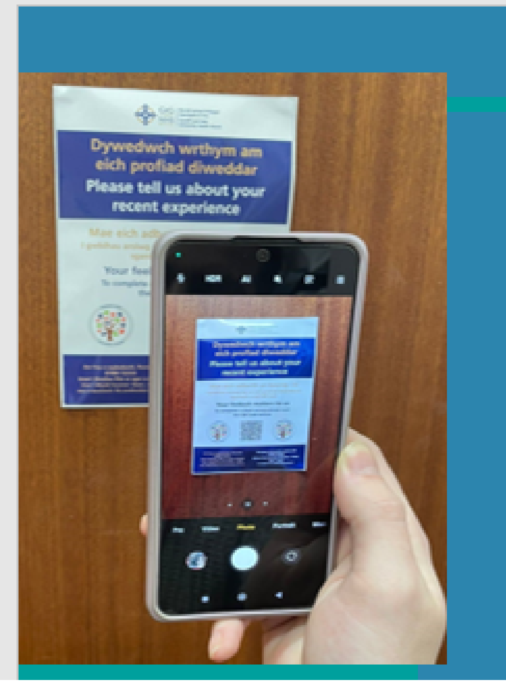


The reports available via the Civica platform are quite detailed and include:



Tell Us in 2

- The Patient Experience Team have recently launched a new way for patients to leave feedback on their services while in hospital.
- Posters, stickers and signs are placed around hospital sites and at bed sides displaying a QR code, inviting patients to share their recent experiences of using the Health Board's services.
- Once scanned, the QR code gives the individual to access the "Tell Us In 2" survey - a short questionnaire, which takes around two minutes and can be completed in English or Welsh. All responses are anonymous.
- When individuals complete the questionnaire, it is asked that they give an open and honest opinion of their experiences so the Health Board can share compliments, best practice or suggestions, to learn from experiences and help shape services for the future.
- For those requiring special assistance in completing the questionnaire, a dedicated telephone helpline is available from 10am-1pm, Monday – Friday.

Accessibility

- Informative, clear and user friendly survey pages – logical layout, sharp colours and contrast
- Mobile friendly survey pages which adapt to screen size
- BSL for those who are hearing impaired
- Themes for children and young people
- Surveys in languages - English, Welsh and more
- Digital story integration

Saunders,Nathan
04/05/2023 16:05:06

Key Messages

Quality is defined as continuously, reliably and sustainably meeting the needs of the population that we serve

The QSE enablers will promote a culture of measuring both quality and experience of the people who use our services and the staff who deliver the serviced.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Work continues to develop the dashboard for presentation at the Quality, Safety and Experience Committee. This report provides the current position and progress in relation to these indicators identified for review by the QSE Committee.

Recommendation:

The Committee are requested to: Note the content so the report and the developing process to monitor Quality Indicators

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

Objective	Tick	Objective	Tick
1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term		Integration		Collaboration	✓	Involvement	✓

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes

Quality indicators should help to identify areas of concern.

Safety: Yes

Delays in investigations presents a delay in identified learning and mitigation being put in place at the earliest opportunity the Quality Indicators should help when viewed collectively to pre-alert to areas of concern.

Saunders,Nathan 04/05/2023 13:05:06

Financial: Yes
Failure to identify learning from themes will lead to increased harm and litigation.
Workforce: No
Legal: Yes
We need to adhere to the relevant legislation.
Reputational: Yes
There is media interest in QSE.
Socio Economic: Yes/No
Consideration of socio-economic disadvantage needs to be further explored through interrogation of the quality indicators to the level of low super output areas of social deprivation in comparison to areas of affluence.
Equality and Health: Yes
Many quality indicators when reviewed in detail demonstrate equality and health inequalities.
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
04/05/2023 16:05:06

Cyngor Iechyd Cymuned De Morgannwg
Canolfan Fusnes Pro Copy (Cefn)
Parc Tŷ Glas
Llanishen, Caerdydd
CF14 5DU

South Glamorgan Community Health Council
Pro Copy Business Centre (Rear)
Parc Tŷ Glas
Llanishen, Cardiff
CF14 5DU

08 December 2022

Ms. Suzanne Rankin
Chief Executive
Cardiff & Vale University Health Board
Executive Headquarters
Woodland House
Maes Y Coes Road
Cardiff

Dear Suzanne

Re: CHC Report on Transport To Health Services in Cardiff & the Vale of Glamorgan

Please find attached the CHC's report, "*Transport To Health Services*". the following are just a small sample of the findings of this activity:

- The primary mode of transport used by patients when attending health care appointments is a car.
- Parking, including disabled parking was highlighted as an issue for those patients using a car.
- Public transport provision is reported to be highly inadequate in terms of availability and reliability. Cost is also a barrier to some patients.
- The distance required to travel to health appointments is a barrier to some patients.
- Transport issues prohibit some people from visiting friends and family in Hospital.

Saunders,Nathan
04/05/2023 16:05:06

Cadeirydd / Chair: Mr Malcolm Latham, BA, MSc, MCMI, FIBMS **Ffôn/Tel:** 029 20750112
Prif Swyddog / Chief Officer: Mr Stephen Allen, O.St.J MSc: MIHM **Ebost/Email:**SouthGlam.chiefofficer@waleschc.org.uk
www.southglamorganchc.wales www.facebook.com/southglam.chc
www.demorganwwgcic.cymru www.twitter.com/southglamchc

We would ask that the Health Board now consider the findings, as laid out within this report, and respond to the potential learning we have identified on page 60 and the points below.

1. Conerning to note that unavialblity of Disabled parking was specifically mentioned by respondents. Is the Health Board confident that it has ample disabled parking and is the Health Board confident on the signage directing people to the Disabled Parking facilities?

2. Through discussions with Local Authorities as part of the Regional Partnership Board would the Health Board raise on behalf of respondents the issues surrounding Public Transport and seek a response to the issues raised in this report.

3. Through discussions with the Third Sector would the Health Board work with partners to address the issues raised relating to community transport and the criteria used for people to access, and report back on this issue.

4. A number of respondents indicated they missed or had to been late to an appointment across Primary and Secondary care services. Could the Health Board respond to these issues as indicated by respondents the increased administration required in rescheduling appointments had a financial impact on the way the Health Board delivers its services.

5. Consideration of the report be given when planning or altering services and that the ability to facilitate visitors as appropriate be factored into all future planning processes.

We look forward to receiving your response in due course.

Yours sincerely

Stephen Allen
Chief Officer

Saunders,Nathan
05/05/2023 16:05:06

Cadeirydd / Chair: Mr Malcolm Latham, BA, MSc, MCMI, FIBMS **Ffôn/Tel:** 029 20750112
Prif Swyddog / Chief Officer: Mr Stephen Allen, O.St.J MSc: MIHM **Ebost/Email:**SouthGlam.chiefofficer@waleschc.org.uk
www.southglamorganchc.wales www.facebook.com/southglam.chc
www.demorganwwgcic.cymru www.twitter.com/southglamchc

South Glamorgan Community Health Council

Transport To Health Services

September 2022

Saunders,Nathan
04/05/2023 16:05:06

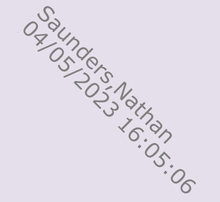
www.southglamorganchc.wales

Accessible formats

This report is also available in Welsh.

If you would like this publication in an alternative format and/or language, please contact us.

You can download it from our website or ask for a copy by contacting our office.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04/05/2023 16:05:06

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About the Community Health Councils (CHCs)

CHCs are the independent watchdog of the National Health Service (NHS) within Wales. CHCs encourage and support people to have a voice in the design and delivery of NHS services.

CHCs work with the NHS, inspection and regulatory bodies. CHCs provide an important link between those who plan and deliver NHS services, those who inspect and regulate it and those who use it.

CHCs hear from the public in many different ways. Before the coronavirus pandemic, CHCs regularly visited NHS services to hear from people while they were receiving care and treatment. CHCs also heard from people at local community events, and through community representatives and groups.

Since the coronavirus pandemic, CHCs have focused on engaging with people in different ways.

This includes surveys, apps, videoconferencing and social media to hear from people directly about their views and experiences of NHS services as well as through community groups.

Saunders,Nathan
04/05/2021 16:05:48

There are 7 CHCs in Wales. Each one represents the "patient and public" voice in a different part of Wales.

Executive Summary

The CHC recognises the difficulties some patients face with regards to transport to health services.

The Older Persons Commissioner for Wales published a survey in 2019 on the subject of transport to health services. If you would like to read the Older Persons Commissioners for Wales Report, you can do so via this link:
https://olderpeople.wales/library/Accessing_Health_Services_in_Wales_-_Transport_Issues_and_Barriers.pdf

The Older Persons Commissioner for Wales kindly granted the CHC permission to reproduce this survey in order to gain feedback and insight from a local perspective regarding to access to health services in Cardiff and the Vale of Glamorgan, on their experiences with transport, as this is often raised as an issue.

The CHC received a number of surveys which asked respondents to provide feedback on transport to Primary services and Secondary / Tertiary services. In addition we received a number of comments through social media and direct contact with the CHC.

The survey questions were focused surrounding these areas;

Primary health: Those health services which provide the first point of care within or close to your community, including general practice, pharmacy, dentistry, and opticians.

Secondary / tertiary health: Those health services which provide care in hospitals (including community hospitals) and treat particular types of illness, such as cancer.

Saunders,Nathan
04/05/2023 16:05:06

Overall, there were mixed responses from the public around transport to health services with some experiencing no difficulties at all, while others have missed or been late to health service appointments due to transport issues.

When asked about transport to health services, respondents provided feedback on the following areas:

Types of Transport Used

The majority of respondents informed us that they use their own car, or someone else's car to travel to both Primary and Secondary / Tertiary health services.

Frequency of Travel to Health Services

The majority of respondents visit Primary services every 2-3 months and visit Secondary / Tertiary services less than once a year.

Travel Time to Health Services

The majority of respondents spend on average 15 minutes or less travelling to Primary services and 20 – 30 minutes travelling to Secondary / Tertiary services.

Assistance When Travelling

The majority of respondents reported not requiring any assistance when travelling to Primary or Secondary / Tertiary health services, but for those who do the majority of respondents would receive help from a family member.

Saunders,Nathan
04/05/2023 16:05:06

Transport Difficulties

The majority of respondents reported experiencing no difficulties when travelling to Primary services, but for those who do, they listed it being too far to walk, and not having access to a car as the main issues.

A high percentage of respondents reported difficulties when travelling to Secondary / Tertiary health services, the main reasons given for this shows it is too far too walk, and there is inadequate parking available at the location they are travelling to.

The Impact of Transport

The majority of respondents reported that transport issues rarely or never prevents them from accessing Primary health services, and therefore has not caused them to be late to or miss a Primary service appointment.

Respondents also reported that transport issues rarely or never prevents them from accessing Secondary / Tertiary health services, although a high percentage report that they have missed or been late to a Secondary / Tertiary health service appointment due to transport issues. With approximately 1/3 of respondents reporting that transport issues have affected their ability to visit someone in Hospital.

Transport Information

The majority of respondents informed us that they would contact the transport provider or the health service in order to access transport information, and the majority of respondents would do this online.

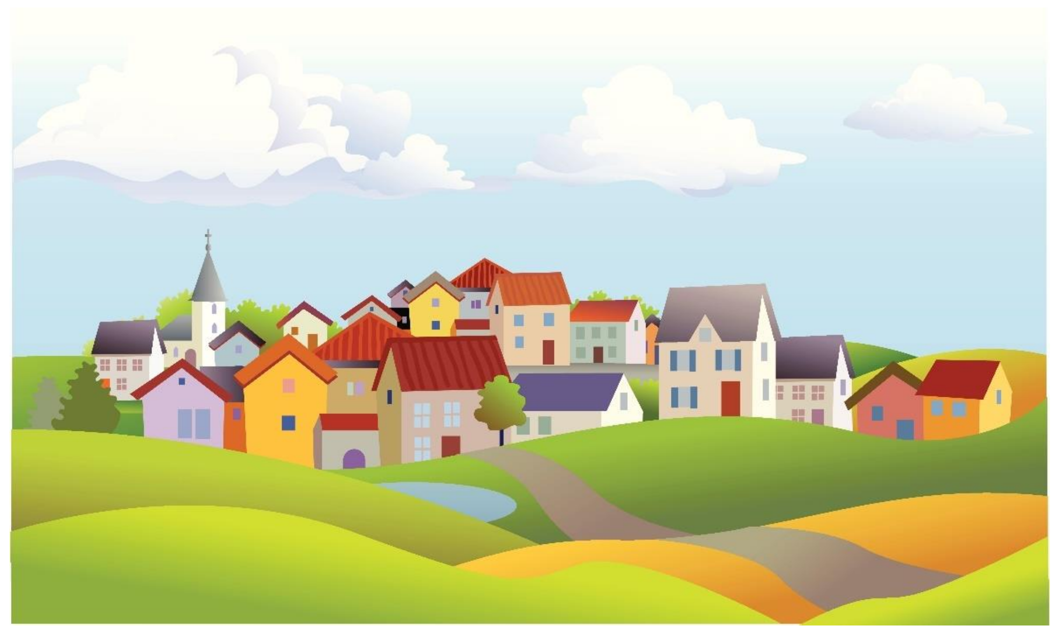
Saunders Nathan 04/05/2016 16:10:06

Introduction & Background

The South Glamorgan Community Health Council strives to hear from patients and the public across all demographics, communities, and groups within Cardiff and the Vale of Glamorgan.

As well as requesting general feedback from the public on matters concerning their healthcare, the CHC also run specific, targeted campaigns for information and feedback from patients with specific health conditions or disabilities, or on specific services within the NHS. In order to ensure we hear from all groups of society with regards to their healthcare provision.

Many people across Wales face challenges when travelling to health services such as their GP or Hospital appointments.



Saunders,Nathan
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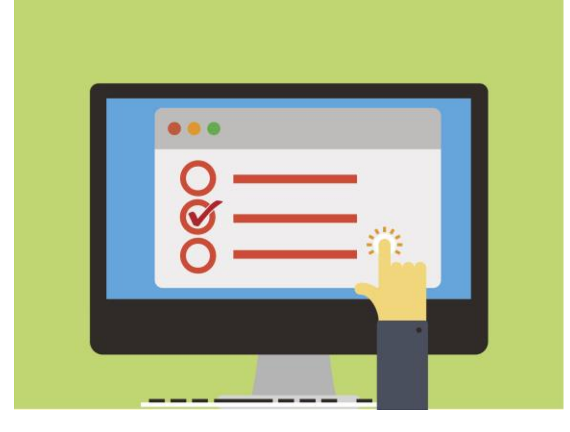
In this instance, the CHC wanted to hear directly from patients about their experiences of travelling to health services in Cardiff and Vale of Glamorgan, in order to identify the types of transport people use, and how transport to health services could be improved.

The CHC recognises the importance of gaining insight into what travelling to Health Services is like for patients in Cardiff & Vale of Glamorgan, with the intention of making recommendations to Cardiff & Vale University Health Board on how to improve the experience from a patient point of view, if appropriate to do so.

What we did



The South Glamorgan CHC published a survey to gain feedback from patients around their experiences of travelling to health services in Cardiff and the Vale of Glamorgan.

The survey was originally devised and published by the Older People's Commissioner for Wales, and the CHC would like to extend thanks to the commissioner for their permission to use this survey. If you would like to read the Older Persons Commissioners for Wales Report, you can do so via this link: https://olderpeople.wales/library/Accessing_Health_Services_in_Wales_-_Transport_Issues_and_Barriers.pdf

The survey was listed on our website and publicised through our Facebook and Twitter social media channels. Details of the survey were also included within our regular stakeholder briefings.

Saunders,Nathan
04/05/2021 16:05:06

The South Glamorgan CHC also distributed paper copies of the survey at the Festival of Transport in Barry Island on 12th June 2022, the Minority Communities Ethnic Health Fair in Cardiff City Hall on 29th June 2022 and the St Athan Village Party in St Athan on 2nd July 2022.

The survey was available for completion in both English and Welsh.

The survey refers to different types of health services:

Primary health: Those health services which provide the first point of care within or close to your community, including general practice, pharmacy, dentistry, and opticians.

Secondary / tertiary health: Those health services which provide care in hospitals (including community hospitals) and treat particular types of illness, such as cancer.

The survey was available online for completion from 23rd May 2022 to 15th August 2022 and asked respondents to provide information around the following:

- How patients travel to Primary and Secondary / Tertiary health services
- How often patients travel to Primary and Secondary / Tertiary health services
- How long it takes patients to travel to Primary and Secondary / Tertiary health services
- If patients require assistance to travel to Primary and Secondary / Tertiary health services and who assists them.
- How easy or difficult it is for patients to travel to Primary and Secondary / Tertiary health services.
- The impact of transport on patients' ability to access Primary and Secondary / Tertiary health services.
- How patients access information about travel options to any health service.

Saunders,Nathan
04/05/2023 16:15:06

Who we are hearing from

The CHC survey was open to patients who had any experience of travelling to health services in Cardiff and the Vale of Glamorgan.

The CHC received a number of online and paper surveys, although not all respondents answered all questions. In addition we received comments vi social media and direct calls into the CHC Office.

100% of respondents chose to complete the English language version of our survey.	45% of respondents use their own car to travel to Primary health services	82% of respondents do not usually need someone to help them travel to Primary health services
33% of respondents have had their ability to visit someone in Hospital affected due to transport issues.	49% of respondents use their own car to travel to Secondary / Tertiary health services	74% of respondents do not usually need someone to help them travel to Secondary / Tertiary health services

Saunders,Nathan
04/05/2023 16:05:06

What we heard

The findings of the survey have been split into two sections; Transport to Primary Health Services, and Transport to Secondary/Tertiary Health Services.

Transport to Primary Health Services

Primary health: Those health services which provide the first point of care within or close to your community, including general practice, pharmacy, dentistry, and opticians.

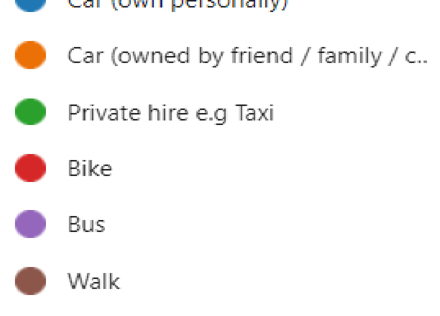
24% respondents walk to their Primary health services	16% respondents visit Primary health services monthly	20% respondents say that travelling to Primary health services is difficult
67% respondents rely on a family member, partner or spouse to help them travel to Primary health services	23% respondents report that transport sometimes or often prevents them accessing Primary health services.	32% respondents have been late to, or missed a Primary health service appointment due to transport issues

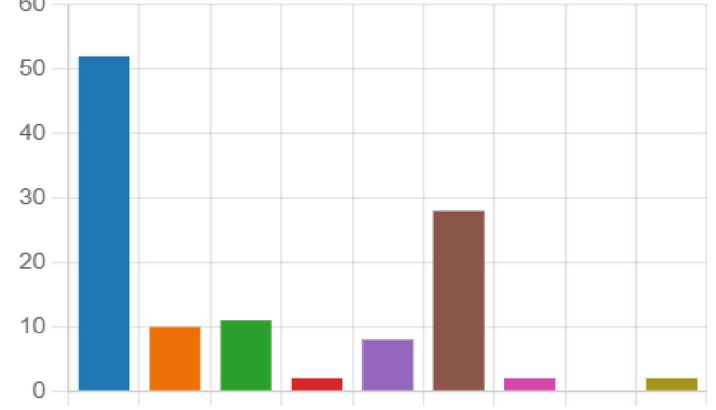
Saunders,Nathan
04/05/2023 16:05:06

Type of Transport Used

In order to get an idea of how patients currently travel, the CHC first asked respondents to provide information on the type of transport they normally use to travel to Primary health services. The results show that the majority of respondents either travel by car or they walk.

1. What mode of transport do you usually use to travel to primary health services (e.g. the GP)?





For those respondents who answered 'other' only one provided any further detail:

'No public transport availability'

Saunders,Nathan
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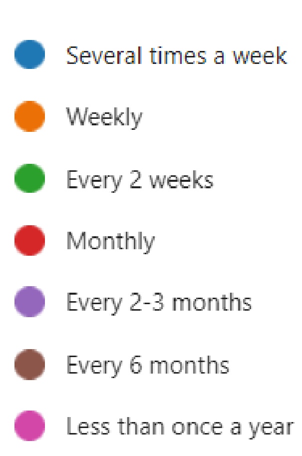
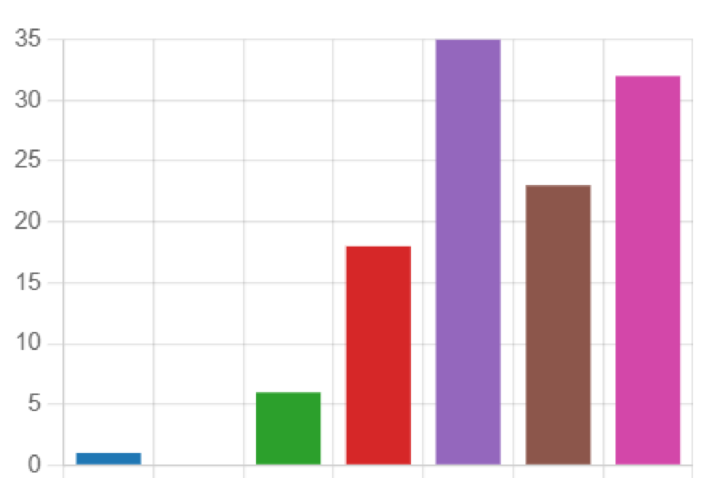
Frequency of Travel to Health Services

The CHC then asked respondents about the frequency with which they visit Primary health services.

2. How often do you visit primary health services?





Although responses varied, the results did show that the majority of respondents attend Primary Health Services either every 2-3 months (30%), or less than once a year (28%).

Travel time to Health Services

The CHC questioned respondents on how long on average they spent travelling to Primary health services.

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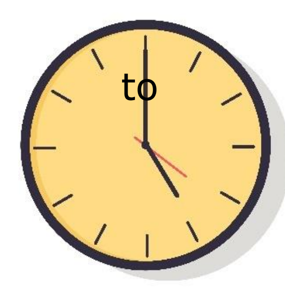

57% respondents spend 15 minutes or less travelling to Primary health services.

30% respondents spend 20 – 30 minutes on average travelling to Primary health services.

9% respondents spend 40 – 60 minutes travelling to Primary health services.

2% respondents spend over 60 minutes travelling to Primary health services.

Assistance when travelling

The CHC then asked respondents whether they usually needed someone to help them travel to Primary health services.

As indicated in the results below, 82% respondents stated they did not need help from anyone to travel to Primary health services.

For those respondents, who answered 'yes' to needing assistance, CHC also asked respondents to provide information on who would usually help them travel to Primary health services. The majority of respondents stated they would normally receive help from a family member, partner or spouse.

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4. Do you usually need someone to help you travel to primary health services?

For those who selected 'other', they gave the following additional responses:

'Driver'

'Taxi Driver'

'Driving Miss Daisy

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Transport Difficulties

The CHC wanted to understand any difficulties with transport that patients may be encountering, when travelling to Primary health services.

We asked respondents to rate how easy it is for them to travel to their Primary health services.

72% respondents informed the CHC it was usually or sometimes easy to travel to their Primary health service.

20% respondents reported it was usually or sometimes difficult to travel to Primary health services.

8% respondents confirmed it was neither easy nor difficult to travel to their Primary health service.

For those respondents who found travelling to their Primary health service difficult, we asked them to provide more detail on these difficulties.

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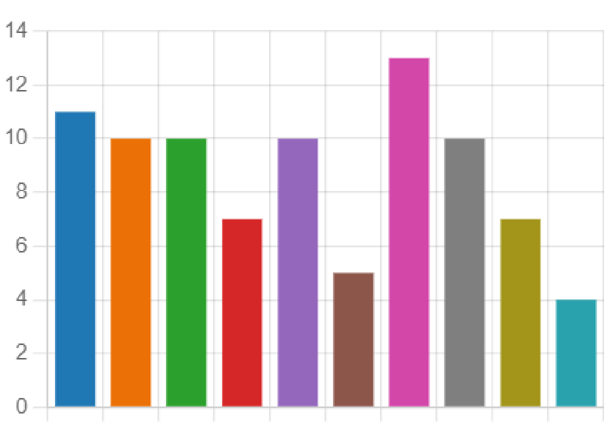
Respondents were permitted to select all answer options that applied to their circumstances for this question. As shown in the graph below, the most common difficulties we were told

- didn’t have access to their own car, or a friend, family member or carers car.
- public transport was not available.
- community transport was either unavailable or not convenient.
- it was too far for them to walk.
- difficult to access or arrange transport for their appointments.

7. If you answered ‘Sometimes difficult’ or ‘Usually difficult’ to question 6, what are the reasons for this? Please select ALL options that apply

- I don’t have access to my own car
- I don’t have access to someone ...
- Public transport isn’t available
- There are accessibility barriers t...
- Community transport is not avai...
- It costs too much
- It’s too far for me to walk
- It’s difficult to access / arrange t...
- Parking is limited / unavailable a...
- Other



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Other responses selected in feedback include:

'Takes two people to offer my husband sufficient support due to his mobility difficulties'

'Public transport isn't available; I am able to walk at the moment but due to aging this won't always be the case'

'I don't have access to my own car; I don't have access to someone else's car (friend, family or carer); It's too far for me to walk; I use community transport because public transport is multiple buses each way and I need to leave extra time because of poor reliability of buses, taken off service, running late it can take over 1- 1/2 hrs to go one way for a hospital appointment'

'Public transport isn't available; Dinas Powys GP is walkable (3-4 km) but part of the ash-path is substandard in width with brambles protruding from the hedge, despite being the direct and only route from St Cyres to DP-The Murch. The Vale Council consulted and were again told it was bad 18 months ago, but did nothing. There should be on obligation on the GP/Health Centre in their 'active travel' plan to assess and press the Council over such obstacles to walking and cycling access routes'

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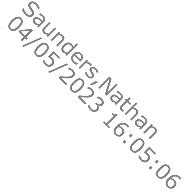
The CHC wanted to further understand the transport circumstances of those patients who answered that they found travelling to Primary health services 'usually easy' or 'sometimes easy' and so asked them to provide more information on why they had answered in that manner.

Respondents were permitted to select all answer options that applied to their circumstances for this question. The most selected answers included

- respondents having access to their own car, or the car of a friend, family member or carer.
- respondents confirming it is close enough for them to walk.
- respondents stating that parking is available at or near to their Primary health service.


Saunders,Nathan
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8. If you answered ‘Sometimes easy’ or ‘Usually easy’ to question 6, what are the reasons for this? Please select ALL options that apply

There are no accessibility barrier...

Community transport is availabl...

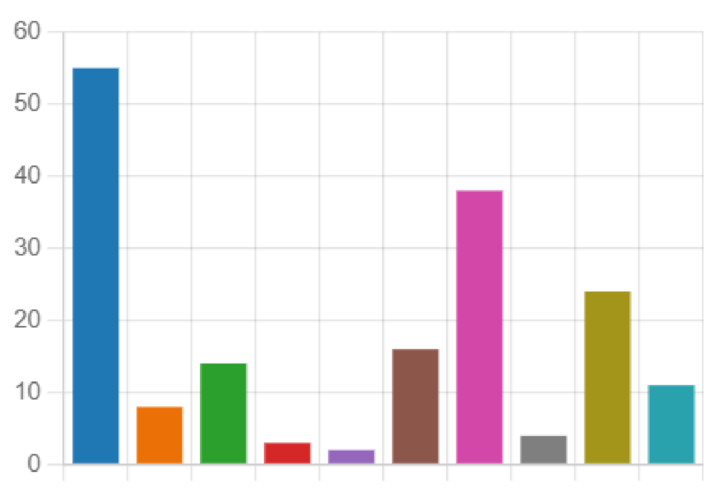
I can afford it

It’s close enough for me to walk

It’s easy to access / arrange tran...

Parking is available at or near to...

Other



For those who selected ‘other’ only one respondent provided the following additional information:

‘No public transport availability’

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The Impact of Transport on healthcare

The CHC asked respondents to provide information on the impact that transport has on their ability to access Primary health services.

The results showed that the vast majority of respondents confirmed that transport rarely or never prevents them from accessing Primary health services.

9. What impact does transport have on your ability to access primary health services?

- Often prevents me accessing pri...
- Sometimes prevents me accessi...
- Rarely prevents me accessing pr...
- Never prevents me accessing pr...

For those respondents who answered 'often prevents' or 'sometimes prevents' them from accessing Primary health services, we asked them to provide further explanation on their response.

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The most common reasons we were advised of included.

- respondents stated they didn't have access to their own, or someone else's car.
- respondents stated that community transport is not available or convenient.
- respondents stated it's too far for them to walk.
- respondents confirmed it is difficult to access or arrange transport for their appointments.

For those who selected 'other' only one respondent provided the following additional information:

'Family availability to take me – they work'

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10. If you answered 'Often prevents' or 'Sometimes prevents' to question 9, what are the reasons for this? Please select ALL options that apply

Public transport isn't available

There are accessibility barriers t...

Community transport is not avai...

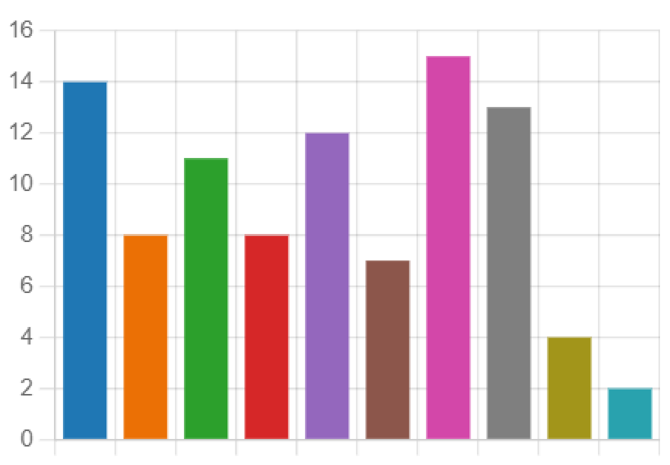
It costs too much

It's too far for me to walk

It's difficult to access / arrange t...

Parking is limited / unavailable a...

Other



Late or Missed Appointment

The CHC asked respondents to inform us as to whether they had ever been late to or missed an appointment at a Primary health service, as a result of issues with transport. We often hear about parking as a key issue … It is pleasing to note that 68% respondents responded that they had not been late to or missed an appointment due to transport issues, whilst 32% respondents confirmed they had been late to or missed an appointment due to transport issues.

The CHC then asked those respondents who answered 'yes' to provide the reasons for this. The most common reasons were,

- respondents stating they don't have access to their own, or someone else's car.

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- respondents stating that public transport was late or cancelled.
- respondents stated that they couldn’t find parking.
- respondents chose to answer ‘other’ to this question.

For those who answered ‘other’, they gave the following reasons:

‘Taxi very late’

‘9am appointment travelling from Newport side of Cardiff to Llandough OPD during peak traffic unacceptable appointment times should be based on areas the patients have to travel from & OPD should be moving with times as in outside of 9-5 hrs flexibility

‘Taxi unavailable’

‘heavy traffic’

‘Both times I was pregnant (including past my due date), I was too uncomfortable to walk (waddled) or drive my car. Thus I cycled everywhere. Without this form of transport, probably couldn't have faced a second pregnancy. Problem is that bike parking at UHW didn't look very secure. Plus people smoked nearby. This put me off attending appointments’

‘Tyre blew’

‘bad/slow traffic’

‘Ambulance cancelled on the day’

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‘traffic congestion’

Transport to Secondary / Tertiary Health Services

Secondary / tertiary health: Those health services which provide care in hospitals (including community hospitals) and treat particular types of illness, such as cancer.

49% respondents use their own car to travel to Secondary / Tertiary health services	3% respondents visit Secondary / Tertiary health services several times a week	70% respondents rely on a family member, partner or spouse to help them travel to Secondary / Tertiary health services
43% respondents state that travelling to Secondary / Tertiary health services is difficult	31% respondents state that transport sometimes or often prevents them accessing Secondary / Tertiary health services	41% respondents have been late to or missed a Secondary / Tertiary health services appointment due to transport issues

The CHC then repeated each question asked in respect of transport to Primary health services, for transport to Secondary / Tertiary health services.

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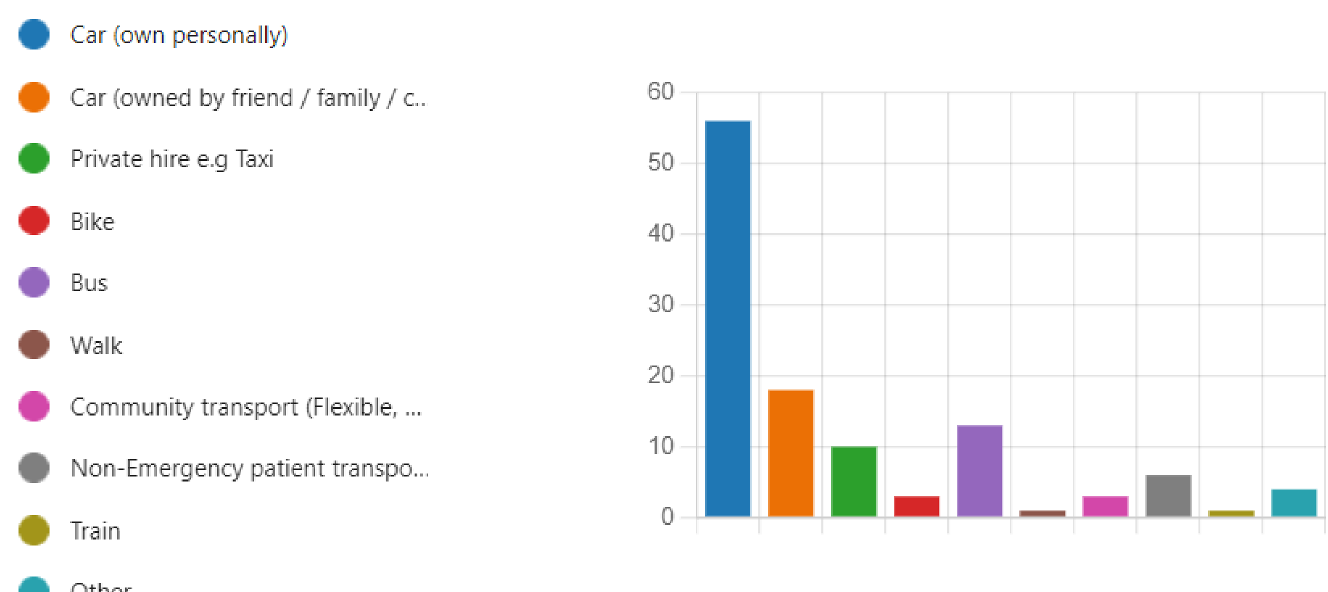
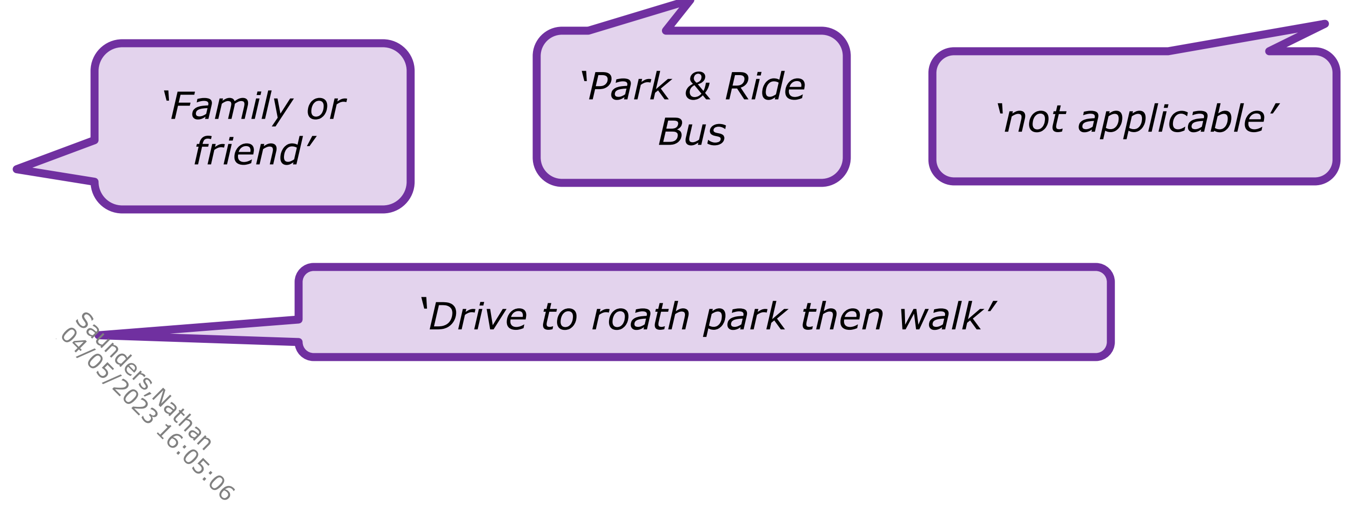
Types of Transport Used

The CHC requested information from respondents on the mode of transport they usually use to travel to Secondary / Tertiary health services. The majority of respondents said they usually travel by car.



For those respondents who answered 'other' they provided the following additional comments:



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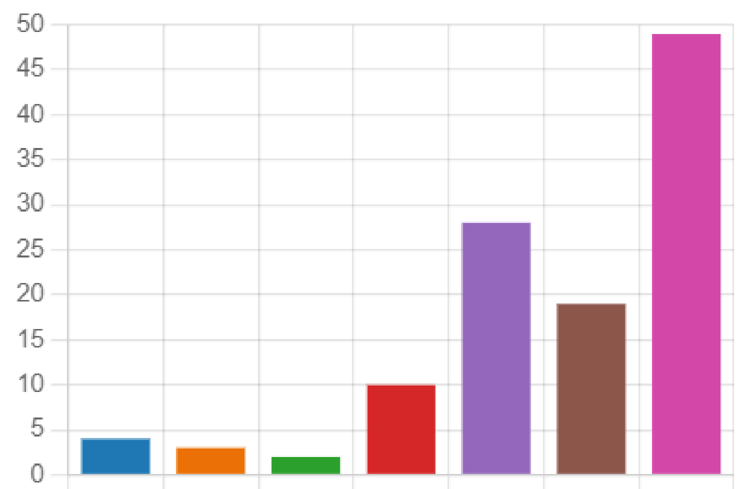
Frequency of Travel to Health Services

We then requested information on the frequency with which respondents travel to Secondary / Tertiary health services. Whilst the majority of respondents said they attend these services less than once a year, it was also good to see that we are able to get feedback from respondents who attend regularly as this is helpful to get an insight at how patients travel to these services on a regular basis.

14. How often do you visit secondary / tertiary health services?

- Several times a week
- Weekly
- Every 2 weeks
- Monthly
- Every 2-3 months
- Every 6 months
- Less than once a year



Travel Time to Health Services

Our survey then asked respondents to provide information on the average length of time it takes them to travel to Secondary / Tertiary health services.

7% respondents spend 15 minutes or less on average travelling to Secondary / Tertiary health services.

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44% respondents spend 20 – 30 minutes on average travelling to Secondary / Tertiary health services.

33% respondents spend 30 – 60 minutes on average travelling to Secondary / Tertiary health services.

7% respondents spend 60 – 90 minutes on average travelling to Secondary / Tertiary health services.

3% respondents spend 2 - 4 hours on average travelling to Secondary / Tertiary health services.

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Assistance when travelling

The CHC asked respondents to confirm whether they usually needed someone to help them travel to Secondary / Tertiary health services or not.

26% respondents confirmed they do usually require help from someone when travelling to Secondary / Tertiary health services.

74% respondents confirmed they do not usually require help from someone when travelling to Secondary / Tertiary health services.

16. Do you usually need someone to help you travel to secondary / tertiary health services?

We then asked respondents who they usually receive help from when travelling to Secondary / Tertiary health services. The majority of respondents who answered this question said they would receive help from a family member, partner or spouse.

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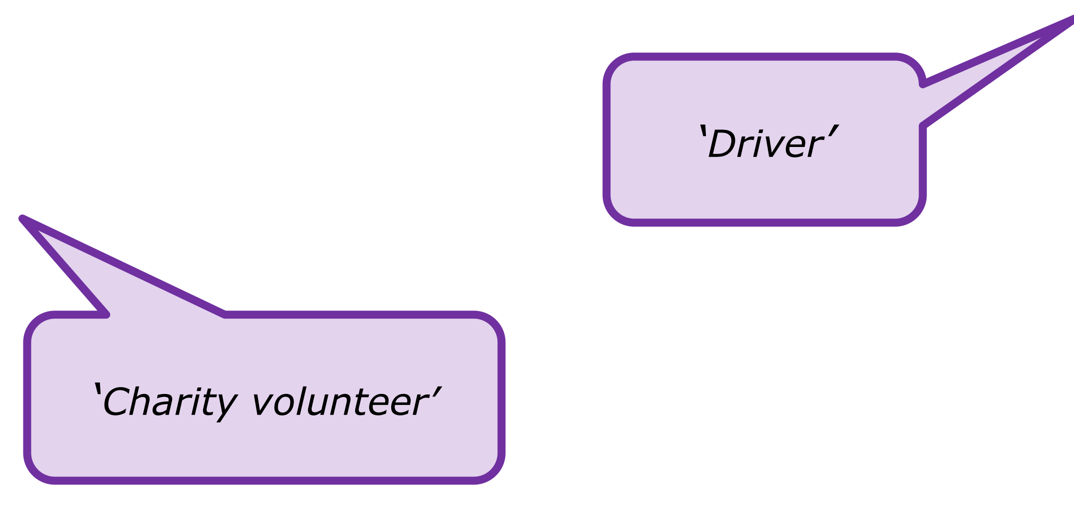
17. If you answered 'Yes' to question 17, who usually helps you travel to secondary / tertiary health services?

Those who answered 'other' they provided the following additional information:



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Transport Difficulties

The CHC wanted to understand any difficulties with transport that patients may be encountering, when travelling to Secondary / Tertiary health services.

We asked respondents to rate how easy it is for them to travel to Secondary / Tertiary health services.

45% respondents told us it was usually or sometimes easy to travel to their Secondary / Tertiary health service.

43% respondents told us it was usually or sometimes difficult to travel to their Secondary / Tertiary health service.

12% respondents told us it was neither easy nor difficult to travel to their Secondary / Tertiary health service.

In order to further understand the reasons behind the respondents' difficulties, we asked them to provide additional information on why they had answered 'usually difficult' or 'sometimes difficult'.

Respondents were permitted to select all answer options that applied to their circumstances for this question. The most common answers were

- respondents didn't have access to their own car, or a friend, family member or carers car.
- public transport was not available.
- it was too far for them to walk.
- parking is limited or unavailable near to the health service.

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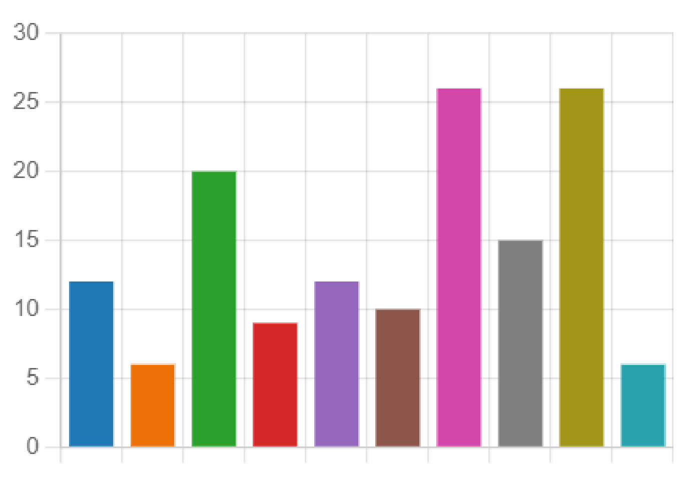
19. If you answered 'Sometimes difficult' or 'Usually difficult' to question 19, what are the reasons for this? Please select ALL options that apply



Those who responded 'other' provided the following additional comments:

'Long journey along a busy route'

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'Have to allow a lot of time due to traffic congestion and time to find a parking space'

'Family availability to take me'

'"I don't have access to my own car; I don't have access to someone else's car (friend, family or carer); Community transport is not available / convenient; It's too far for me to walk; Public Transport does not run often enough'

The CHC also wanted to better understand the circumstances of those who answered 'Usually easy' or 'Sometimes easy' and so requested respondents provide additional comments around the reasons for their answer.

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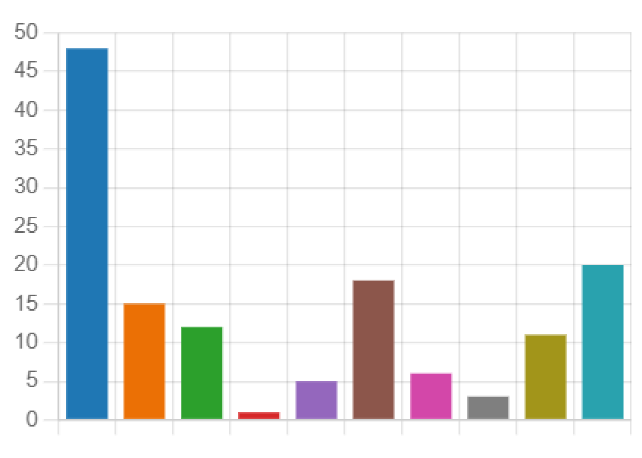
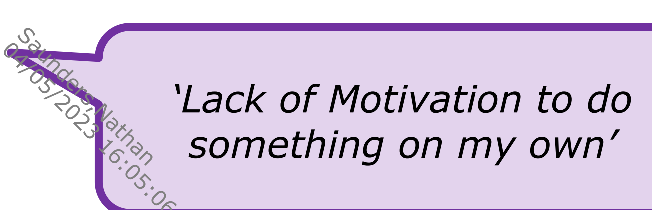
Respondents were permitted to select all answer options that applied to their circumstances for this question. The most common responses were,

- having access to their own car, or the car of a friend, family member or carer.
- respondents state they can afford it.
- respondents selected the answer 'other'.

20. If you answered 'Sometimes easy' or 'Usually easy' to question 20, what are the reasons for this? Please select ALL options that apply



Of those respondents who answered 'other' only two chose to provide additional comments on this:



'Cycle there quickly'

The Impact of Transport on healthcare

The CHC asked respondents to provide information on the impact that transport has on their ability to access Secondary / Tertiary health services.

10% respondents reported that it often prevents them accessing Secondary / Tertiary health services.

22% respondents reported that it sometimes prevents them from accessing Secondary / Tertiary health services.

28% respondents reported that it rarely prevents them from accessing Secondary / Tertiary health services.

41% respondents reported that it never prevents them from accessing Secondary / Tertiary health services.

We then asked those respondents who had reported that transport 'often' or 'sometimes' affects their ability to access Secondary / Tertiary health services to provide the reasons for this.

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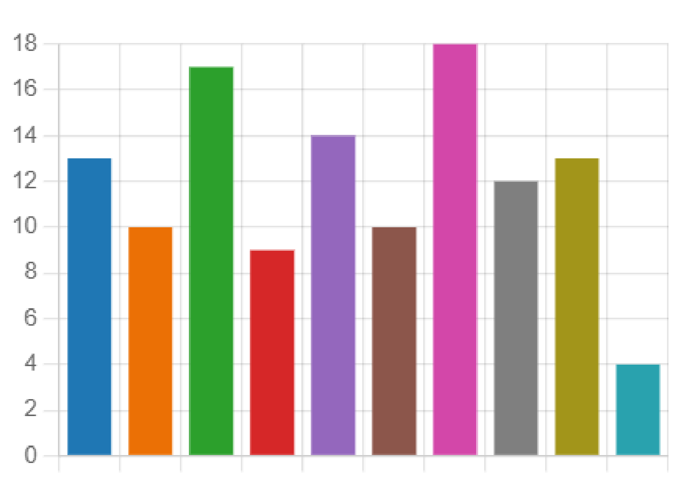
Respondents were permitted to select all answer options that applied to their circumstances for this question. Whilst the number of responses received for each

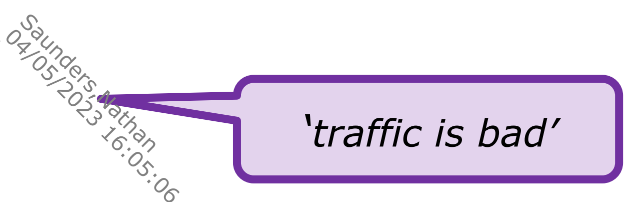
statement were similar, the most commons answers were,

- respondents didn't have access to their own, or someone else's car.
- public transport isn't available.
- community transport is not available or convenient.
- it's too far for them to walk.
- parking is limited or unavailable at or near to the health service.

22. If you answered 'Often prevents' or 'Sometimes prevents' to question 21, what are the reasons for this? Please select ALL options that apply



For those who answered 'other' they provide the following additional information:



'Crowded roads'

'Availability of community transport can be an issue sometimes and buses can be up to 1-1/2hours each way'

'Public transport is very limited and does not go near the 1 hospital, the other hospital is completely off public transport from where I live'

Late or Missed Appointment

The CHC asked respondents to tell us if they had ever been late to or missed an appointment at a Secondary / Tertiary health service due to transport issues.

41% respondents confirmed they had been late to or missed an appointment at a Secondary / Tertiary health service due to transport issues.

59% respondents confirmed they had not been late to or missed an appointment at a Secondary / Tertiary health service due to transport issues.

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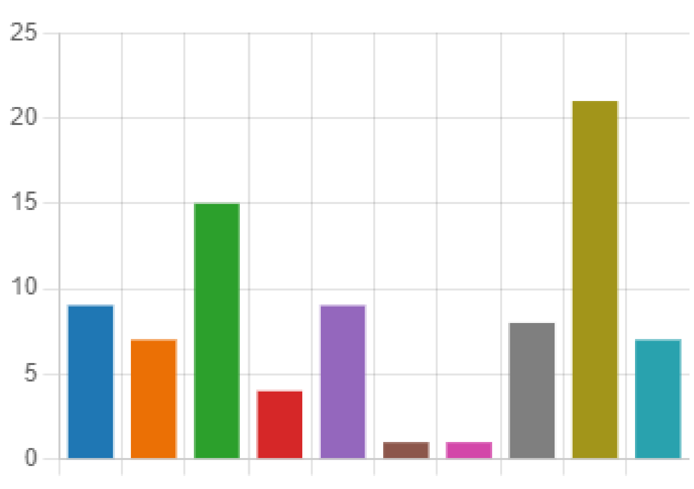
For those respondents who answered ‘yes’ to being late to or missing a Secondary / Tertiary health service appointment due to transport issues, we asked them to provide additional information on the reasons for this.

Respondents were permitted to select all answer options that applied to their circumstances for this question. The most common answers were,

- they don’t have access to their own, or someone else’s car.
- public transport was late or cancelled.
- they couldn’t find parking.

24. If you answered ‘Yes’ to question 23, what were the reasons for this? Please select ALL options that apply

I didn't have access to my own c...
I didn't have access to someone...
Public transport was late or can...
There were accessibility barriers ...
Community transport was not a...
I couldn't afford it
It took me longer to walk than e...
I couldn't arrange transport for ...
I couldn't find parking
Other



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Respondents who answered 'other' to the above question, provided the following additional comments:

'Taxi often late'

'Unexpected traffic or accident'

'Delays in being picked up by non emergency ambulance transport'

'9am appointment travelling from Newport side of Cardiff during peak traffic hour'

'Childcare'

'No public transport'

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Hospital Visiting

The CHC also wanted to identify whether respondents had ever had transport issues affect their ability to visit someone in hospital.

> *'Bicycle parking not always secure and free of smokers'*

33% respondents confirmed that transport issues have affected their ability to visit someone in Hospital.

67% respondents confirmed that transport issues have not ever affected their ability to visit someone in Hospital

The CHC then asked those respondents who had answered 'yes' to the above questions, to provide the reasons for their answer.

Respondents were permitted to select all answer options that applied to their circumstances for this question. The most common responses are noted below.

- respondents stated they don't have access to their own, or someone else's car.

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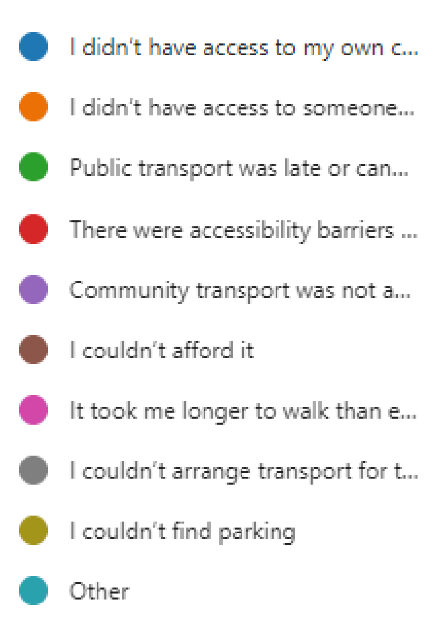
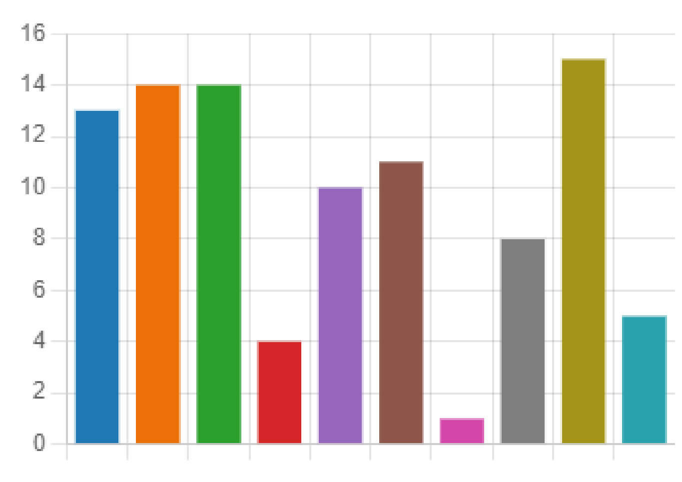
- respondents stated that public transport was late or cancelled.

- respondents stated that they couldn't find parking.

26. If you answered 'Yes' to question 26, what were the reasons for this? Please select ALL options that apply





We then asked those respondents who answered 'other' to provide further information on this. Only one respondent chose to provide additional comments:

'Not in a fit state to drive'

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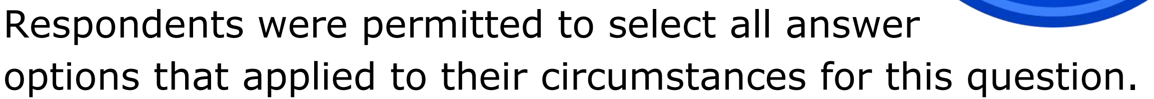
Transport to Health Services Information

The final section of the CHC survey asked respondents to provide feedback on who they would contact, and how they access information about travel options to any health service.



Respondents were permitted to select all answer options that applied to their circumstances for this question.

29% respondents stated they would contact a transport provider for information about travel options to a health service.

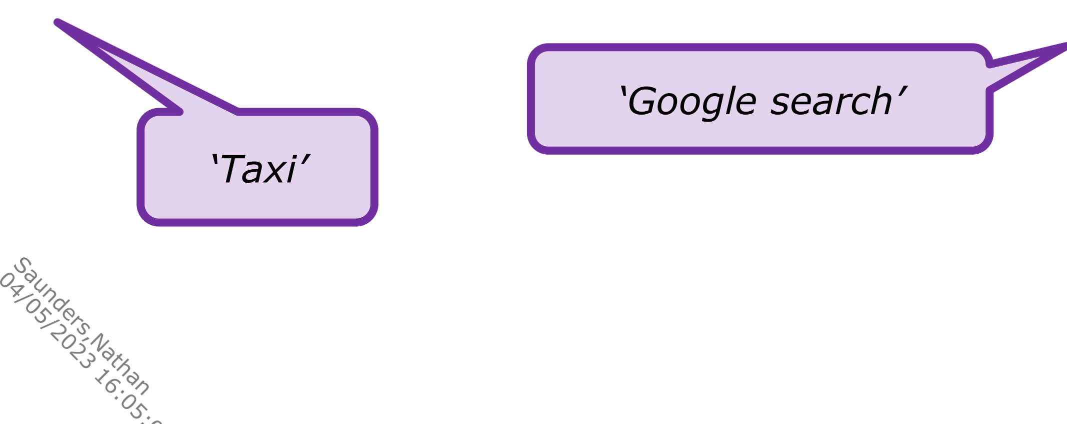
21% respondents indicated they would contact the health service.

6% respondents confirmed they would contact a local / community group for information.

34% respondents would contact Family / Friend.

10% respondents chose to answer ‘other’.

The respondents who answered ‘other’ were then asked to provide further comments on this.



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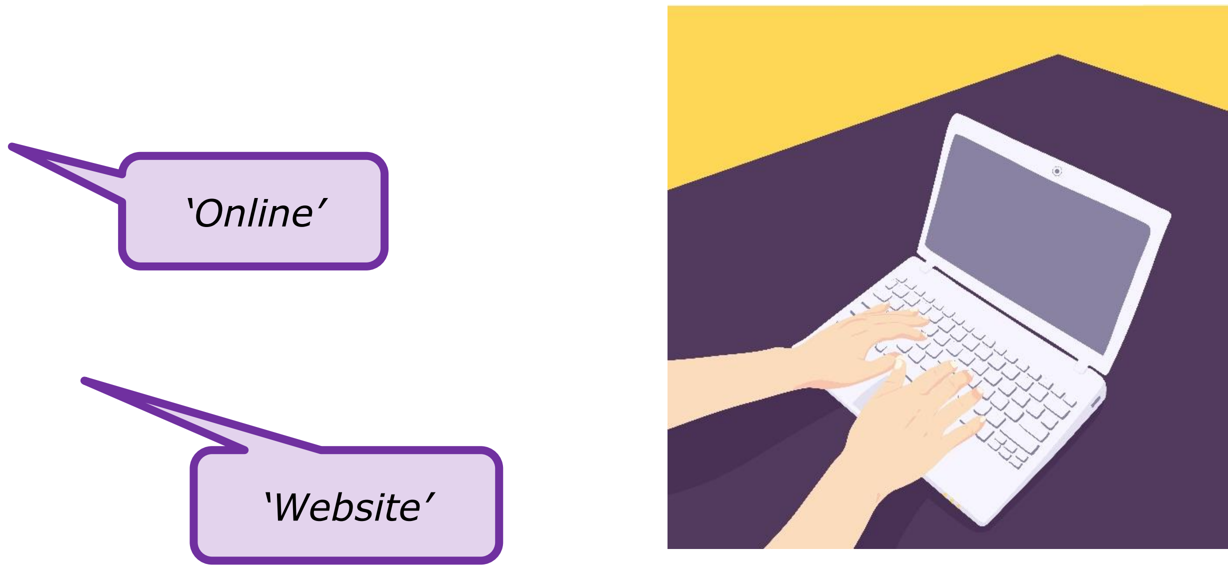

The survey asked respondents how they would normally access information about travel options to any health service, and the vast majority of respondents told us they access this information online. Nevertheless, appointment letters and the telephone were still considered as a popular method to access information also.

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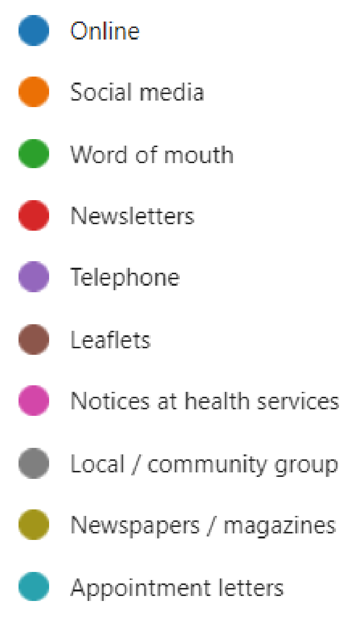
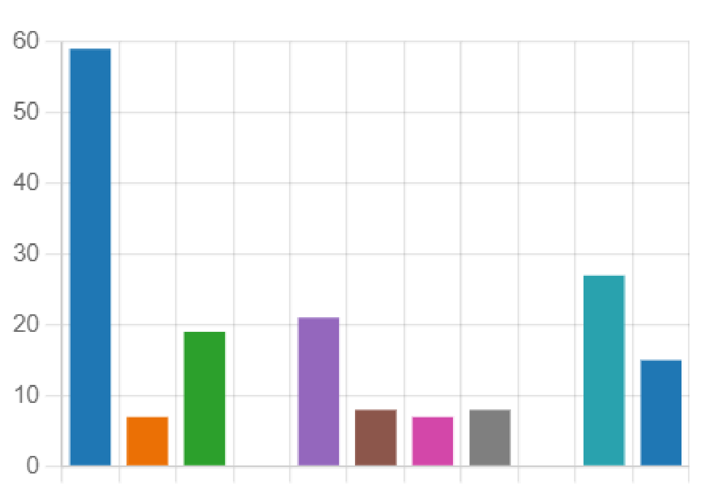
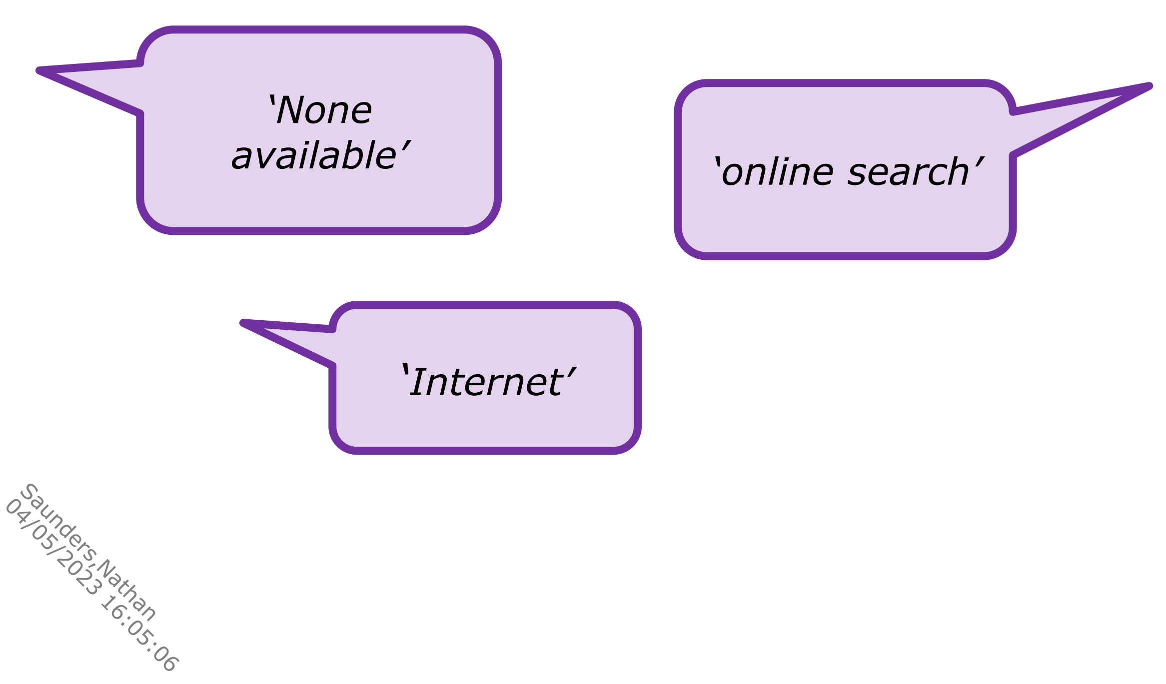
28. How do you access information about travel options to any health service? Please select ALL options that apply to you





The respondents who answered 'other' provided the following additional comments:



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The final question asked in this survey, asked respondents to provide any further comments they wished to submit on the subject of Transport to Health services.

The overwhelming majority of respondents cited either the lack of, or unreliability of public transport and availability of parking as the two main issues surrounding transport to health services. Given that the previous answers highlighted car parking and transport as some of the most common difficulties people faced, it is clear this is a big issue.

'Would use bus if the service was more reliable.

'Bus services from where I live are really poor

'Although Newport Council runs nine journeys a day to the heath hospital will not pick up in our area although it has to pass'

'Currently, I am fairly mobile in terms of walking so getting to GP is fine, less so to the major hospitals in Cardiff as public transport there does go very close to where I live. However, I worry as to when I am less mobile in the coming years.'

'CCC provides very poor public transport and infrastructure links across the majority of Cardiff. Recent speed restriction law changes will make this situation (travel chaos and times) worse.'

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'I am fortunate enough to be able to afford a taxi if I need to go to hospital for myself or to visit someone. However, for those who are reliant on public transport (as I am) there needs to be an improvement in transport to health services. There are some park and rides in Cardiff but not for all areas and the bus service is good in some areas and really not good in others. Getting across Cardiff from suburb to suburb is very difficult and getting more so. Buses are not as reliable as in the past and traffic is much worse.'

'Main issue is distance and the lack of public transport to the facility I have had to use.'

'Bus service is appalling in my area.'

'Reliability is the key factor when using public transport ie bus. Local bus provider is very unreliable.'

'I don't drive neither does my husband therefore every appointment at Hospital requires a taxi to ensure I can get to appointments. If the bus service was reliable I would be able to use a bus sometimes but after treatment and feeling unwell this is not always a viable option.'

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‘I have in the past tried to use public transport to get to University Hospital of Wales, Heath. It resulted in having to plan to catch two buses which was fine as I knew there would be a delay with the connection and I had set out with plenty of time for the delays but on the return journey as it was late afternoon the bus was extremely busy and uncomfortable as it travels along Western Avenue and picks up at the college.”

‘Avoid parking at Heath. What's happening with bus to Llandough from toys r us?’

‘Parking needs to be more accessible for everyone’

‘Several different providers of for example buses to UHW or CRI from Thornhill Cardiff. Stagecoach, Adventure, Cardiff bus. Caerphilly buses run down past Crematorium but who runs them. Hard to quiz all sites to find who goes to UHW and has stops reachable from my home as I have limited mobility. Driving can be a challenge with knee swelling up. Traffic can be very heavy. Caught out by Uni open days. Knee swelled as driving for longer than anticipated. The 86 route keeps changing. Didn’t go to Crematorium, now it does. I couldn’t walk to Heol Hir where the stop was as nearly a mile. Buses for all routes cancelled frequently. Parking at CRI difficult. Have disability badge for UHW and plenty of parking in multi storey. Llandough hard to access by bus. Drove. Hard to park near unit. Need a unified transport hub to see ALL bus routes available, and trains, and disabled parking.’

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'I live in a rural area with limited and unreliable travel public transport and appointments with health care is limited and these cause or would cause significant issue and ability for me to access healthcare if I didn't have my own transportation sufficient funds or friends to help me access the healthcare I need I also have a phone and ability finds and means to access online to search for information however without this I couldn't access healthcare if I didn't have parking again this would prevent me accessing healthcare.'

'Whilst transport to health providers is not an issue to me, I appreciate the difficulties for those without their own transport and remember meeting a family in the waiting room who had had a very long and complicated bus trip to get to their appointment. I really felt for them.'

'When receiving antenatal care, I was regularly late for appointments and presented with elevated blood pressure due to the stress of parking. I regularly worried about where I would be able to park when I went into labour.'

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'The biggest problem getting to the hospital is access to parking, it can take ages to find space, so there is the worry that you will be late for the appointment. Also it means that I am in an agitated rushed state of mind for the appointment. Now a family member drops me at the hospital and picks me up after, but if I wanted the family member to come in with me, the issues with parking would then be the same.'

'More patient parking needs to be provided at hospitals. Disabled people may not be able to use public transport and because of parking issues our family normally has to rely on someone else to take them to a hospital appointment as parking cannot be relied upon. So many people I know tell me the situation with parking makes hospital appointments difficult and stressful.'

'Our nearest hospital Llandough is only ten minutes away. However most appointments as well as A and E are located at UHW which is a long drive away and on a busy route so will have to allow a hour travelling time each way. UHL however has very limited parking for patients and visitors . especially with the increase in services at the hospital.'

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Along with the comments on parking received, disabled parking issues were specifically mentioned.

'I can drive myself but have problems walking from car parks to hospital. Close Hospital parking spaces are limited, so I drive hubby to his appointments and he drives me - if no spaces available, only one goes in for appointments while the other drives several miles away to park until whoever has the appointment comes out and rings for their lift home. Neither of us can manage to use public transport due to health difficulties. Parking at UHW has been reduced - they took away disabled parking spaces to build a new unit, then closed the disabled spaces near 5e entrance for maintenance without warning visitors - leaving about a dozen disabled spaces in the nearest car park. The previous disabled spaces in their permanently closed car park have not been reopened!'

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The Park & Ride system was also specifically mentioned in the feedback we received.

'Last time I had an appointment at UHW Casualty, it was 6pm September 2021. Was assured would be out by 10pm. So glad I ignored the call handler. Was tempted to use Park and Ride Llanedeyrn. If I had would have been unable to access car as got out of UHW 4am on a Saturday morning. Thus park and ride stopped and no City Circle. Puts me off going to UHW as no public transport out of hours.'

'There is considerable pressure on parking at the hospital, so they have a park and ride system which generally works well, except that one waits a long time sometimes for the community bus.'

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Other respondents left feedback on their experiences with Ambulance, Hospital and community transport.

'Ambulance for what turned out to be broken clavicle and 12 stitches would have taken 12 hours so got lift'

'I never appear to receive information about transport. I only used it once (arranged by hospital) but had a very long journey back because of other patients being transported.'

'Although I have no issues with transport, I work with older people and 99% of them have issues with transport. They are unable to access their community for support, they have to cancel appointments at hospitals and GP's. I work with volunteers who provide specific transport for people to attend appointments. We have some success but unfortunately there are not enough volunteers for the people needing support. Transport is the main reason for carers not being able to access the community to get support.'

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A few respondents took the opportunity to comment on the distance they were required to travel when accessing GP services.

'Doctors need to go back to usual working practices. Travel to the St Athan clinic is difficult unless you have a car. They need to get back to all clinics and services in all locations.'

'Why do I have to travel by car to Church Village when I can walk the 200 yards to my local practice in Creigiau? I thought that emission controls were important, not to mention the cost of fuel. This practice really needs to rethink its working methods. Same with the pharmacy, often takes 2 or 3 visits as prescription drugs are not in stock.'

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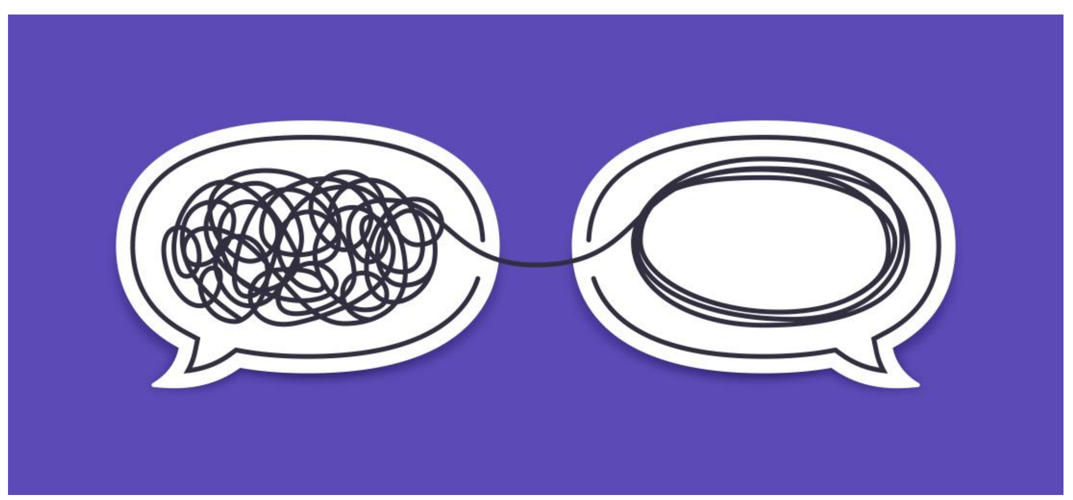

Learning from what we heard

From the survey results gathered by the CHC, it is clear that the primary mode of transport patients utilise when attending Primary and Secondary / Tertiary care appointments is a car, either their own, or someone else's. Although this allows them to reach their destination, parking then becomes an issue, particularly when visiting Secondary / Tertiary health services.

It was concerning to note that unavailability of disabled parking was specifically mentioned within the survey responses, as service providers should ensure there is adequate provision of suitable, accessible car parking spaces for those disabled patients who travel to health services via car.

Survey respondents have informed the CHC that public transport is either too costly, unreliable or completely unavailable depending on their destination. A number of survey respondents stated that they would use public transport if it was more reliable, or more widely available. This is of particular importance when considering patients who do not have access to their own, or someone else's vehicle. The CHC considers the availability of public transport to be an important issue that

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service providers must consider when planning the delivery of current and future health services.

It is also important to remember that using public transport may be entirely inappropriate for some patients who may be very unwell, or who experience accessibility barriers when attempting to utilise public transport.

It was also concerning to note that cost was reported to be a barrier to a number of respondents when attempting to access all types of healthcare. This could disproportionately disadvantage those patients on a lower or fixed income, or patients who are currently without employment. This is also a cause for concern for those patients who regularly attend these services.

It was also reported to the CHC that Community Transport provision is poor, with a very low number of respondents using this mode of transport to attend Primary and Secondary / Tertiary health services. A number of respondents stated that Community Transport was completely unavailable to them, which again will disproportionally disadvantage those without access to a car, or for those who cannot use public transport. It is also important to note that there are strict criteria for patients to meet when using Community Transport, social issues such as lack of available finances would not qualify someone to be able to access Community Transport. The CHC would like to see more Community Transport available to a wider cohort of patients.

It was concerning that, a high percentage of patients confirmed they have missed or been late to, a Primary health service appointment (32%), or a Secondary / Tertiary service appointment (41%) as a direct result of issues with transport. There are numerous consequences when patients are late to or miss appointments across the NHS. If a patient misses an appointment entirely, diagnosis or treatment will be delayed with potentially life-threatening consequences. Increased

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administration time is required to re-book missed appointments. The need for multiple appointments then creates longer waiting times for everyone in terms of accessing services or receiving treatment. Delays may be caused to other patients with booked appointments if patients arrive late and overrun their allocated appointment slot, along with financial consequences for the health service provider.

For numerous respondents, the distances required to travel to health services is a barrier to accessing health services or contributes to them being late for or completely missing health service appointments. The survey results showed that respondents were happy to walk to healthcare services if they were closer to home, but for some this was a difficulty for them. This must also be noted and considered by the Health Board when planning the provision of future services. Cardiff & Vale University Health Board have produced a strategy document called 'Shaping Our Future Clinical Services' in which they indicate their intention to provide health services closer to patients' homes where appropriate.

The document can be accessed via the link below:

https://shapingourfuturewellbeing.com/wp-content/uploads/2021/02/shaping_our_clinical_services_brochure_v3.pdf

It is also concerning from those who commented that transport issues affect 33% of respondents' ability to visit someone in Hospital. This is of particular concern for those patients who may be required to stay in Hospital for a prolonged period of time, as this may contribute to feelings of isolation and loneliness which do not lend themselves to a patients' speedy recovery. It is also of concern if the patient in question is in any way considered to be vulnerable or is unable to advocate for themselves. The inability of friends and family members to visit and advocate on behalf of the patients is concerning.

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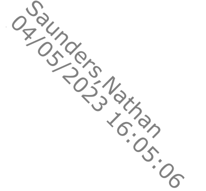
Finally, survey respondents informed us that the most popular two options for who they would contact in order to find out about transport services would be the transport provider (29%) and the health service (21%), with the majority of respondents informing us they would access transport information either online or via their appointment letter. The CHC believes that the UHB should ensure that all transport information is included on their website and is kept up to date, it may also be useful to patients to provide links to the various transport providers on the Health Board website. The CHC would also like to see transport information included in all appointment letters.

The CHC has taken learning from this exercise with regards to survey development. Whilst we are grateful to have been given permission from the Older Persons Commissioner for Wales to use their survey, the CHC will devise and publish surveys which include more 'open text' response boxes; allowing respondents to write in their own words and provide more detail in response to questions. Although gathering statistical data allows the CHC to compare the response figures across each question, the main focus for the CHC is the individual feedback gathered from patients regarding their experiences, in their own words.

Thanks

We thank everyone who took the time to share their views and experiences with us about their health and care services and to share their ideas.

We hope the feedback people have taken time to share influences healthcare services to recognise and value what they do well – and take action where they need to as quickly as they can to make things better.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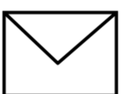
Feedback

We’d love to hear what you think about this publication, and any suggestions about how we could have improved it, so we can use this to make our future work better.

This report is available in Welsh and English.

Contact details



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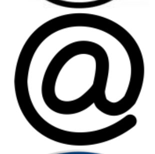

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If you write to us in Welsh, we will answer in Welsh. This will not lead to a delay in responding to your correspondence.

We welcome telephone calls in Welsh.

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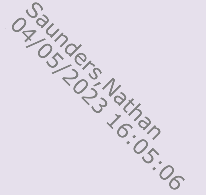
South Glamorgan Community Health Council



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MENTAL HEALTH CLINICAL BOARD
Quality, Safety & Experience Committee

Thursday 16th February 2023 at 9:30am
MS Teams Meeting
Minutes

Attendees:		
Tara Robinson (Chair)	Deputy Director of Nursing, MHCB	TR
Alexander Bridgeman	Recovery, Operations	AB
Alison Lewis	Patient Quality and Safety Department	AL
Andrea Sullivan	Senior Nurse for Patient Safety, Quality and Experience	AS
David Seward	Mental Health Act Manager	DS
Heather Hancock	Directorate Manager, Adult MH	HH
Jayne Bell	Consultant Nurse, MHCB	JB
Joanne Wilson	Directorate Manager, MHSOP	JW
Katja Empson	EU Consultant	KE
Lisa Walters	Lead Nurse, Adult MH	LW
Neil Jones	Clinical Director, MHCB	NJ
Rob Kidd	Clinical Lead, P&PT	RK
Sue Tapper	Admin Manager, MHSOP	ST
Suzie Cheesman	Patient Quality and Safety Department	SC
Teresa Delaney	Directorate Manager, P&PT	TD
Tracey Skyrme	Head of Inquests, Patient Experience	TS
Apologies:		
Andrew Vidgen	Deputy Clinical Director, Adult MH	AV
Jenny Pinkerton	Occupational Therapy Clinical Lead MHSOP	JP
Mark Doherty	Director of Nursing, MHCB	MD
Marianne Seabright	Lead Nurse, MHSOP	MS
Nicola Evans	Head of People and Culture	NE
Norman Young	Consultant Nurse, MHCB	NY
Rachel Rushforth	Senior Nurse for Quality, Safety and Education	RR
Rebecca Marsh	Deputy Head of People's Services	RM
Victoria Gimson	Pharmacy Lead	VG

Part 1:	**PRELIMINARIES**
1.1	**Welcome and Introductions** TR welcomed all and introductions were made.

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1.2	**Apologies** Apologies were given as noted above.
1.3	**Minutes** The minutes for the meeting on 20/10/2022 have previously been approved by MD. Minutes MHCB QSE 20th October 2022 (1)
1.4	**Action Log** The action log was discussed and updated. MHCB QSE Action Log.xlsx
Presentation **KE and AB presented the 'Six Goals Framework'. This is a national programme across Wales to support organisations to transform emergency and unscheduled care. There are some areas in which Mental Health Provision is a key part.** Six Goals Programme - How we move forwa	
Part 2:	**GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY**
2.1	**UHB QS&E Committee** Not discussed.
2.2	**Regulatory Compliance** Not discussed.
2.3	**Risk Register** The risk register was discussed and reviewed.
2.4	**Escalation Reports and Escalation of Key QSE Issues from Directorate QSE Groups** **Adult Mental Health – Dated 12/01/2023** LW discussed the recent Adult QSE Meeting. There have been issues with people breaking into Pendine's garden. Ongoing discussions about frosting windows looking into courtyard in HYC. Recruitment and retention are ongoing issues. Estates issues include leaks and damp in walls, a toilet leak above MHA office and ongoing issues in Headroom. Focus has been on pushing consistent fire safety checks, and identifying MHA Champions in the ward. Work has been done with the retention of staff to try to accommodate them on their preferred wards. Changes to Elm ward were discussed, the ward will be moving back to low-secure in the future. HH noted that she has requested an updated quote for Britplas fences, and this item is linked to the larger piece of work around open-door discussions and Metrasens machines.

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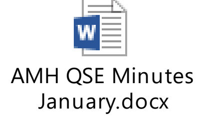
AMH QSE Minutes January.docx

MHSOP
JW discussed the latest QSE minutes. MHSOP have set up a care and treatment plan subgroup to look at pathways. There are major staffing gaps across the wards and community teams. Using agency staff, moving staff around and planning promotional events to attract staff.

Will be introducing MHSOP and neuropsychiatry areas to the 'Keeping You Well' website. Occupational are increasing activities off the wards. The MHSOP 2a Business Case is due to be heard at the end of March. There are several different schemes being developed by Physical Health in MHSOP. There are ongoing issues with the lifts used for deliveries.

MHSOP are trialling a new primary nurse model, where each primary nurse is linked with an associate nurse. The reporting of observation levels is being reviewed. REACT have very low staffing levels, looking at long-term solutions. An audit is being completed regarding pathways e-referrals on AMAT. Open dialogue training is being held at the end of March.

MHSOP Q S Minutes 5.12.22.doc

Psychology and Psychological Therapies
RK discussed the latest psychology QSE meeting. A guest speaker from the Public Health department attended, who discussed the demographics of the CAV footprint and services in relation to this. A discussion was held around recent Stonewall Cymru training. In the February meeting, RK had official Welsh Government slides with information about duty of quality and candour. There is a move to 'Domains of Quality'. Professor Neil Roberts joined the February meeting and discussed the Trauma Informed Wales Framework. Discussed the 'Trace Tool' which is being trialled within P&PT.

TR and NJ requested to invite Professor Neil Roberts to the next QSE meeting, and to add the Trauma Informed Framework as an agenda item. CQ mentioned that the framework needed to be co-produced, and questioned if the implementation of this framework would sit across the organisation or within the Clinical Board. NJ happy to discuss in the next QSE meeting and then take this to Executive level.

P&PT QS Minutes and Action log 07.12.2

Pharmacy
Unable to attend – update attached.

MH Medicines Management Group M

MH ACT
Two Welsh Minister referrals have been completed as rights had not been read in the first 14 days. DS received an email from the Senior Medical Officer from the Welsh Government,

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	as this wasn't the first incidence. DS hopes that the Mental Health Act champions will help with this. The MHA office have lost some staff so are very busy at the moment. **MHIPC** Not available for discussion. **SUI Steering Group** Main topic of discussion was the Reducing Restrictive Practices Framework. Health boards have been asked to evidence how they are measuring their work against the new framework. RK discussed the connection with the trauma informed framework. JB mentioned that there is a lot of work to be done around understanding the framework prior to the response, the Clinical Board are expected to present progress at the next SUI meeting in approximately 2.5 months. Jayne Bell - Notes on SUI SG.docx
2.5	**Controlled Document Oversight Group** TR discussed the new Teams Channel and the terms of reference. Any comments to be sent to NH. CAV_MH Policies and Procedures Teams Channel TOR CDOG.docx 2.5b Meeting Notes CDOG 27-01-23.docx
Part 3:	**HEALTH PROMOTION PROTECTION AND IMPROVEMENT**
3.1	LW discussed the Reflective Practice that has been facilitated externally for Cedar and Alder wards. The developing themes include; personality disorders, mentorships and preceptorships, debriefs, lack of understanding around the role/function of Cedar Ward (LW linked to operational policy), staffing levels on nights and ILS training. The senior team will be meeting to discuss this. TR noted that the trauma informed approach was discussed with the practitioner. Attendance is going well, difficulty to release staff for meetings, keen. RK discussed facilitating Schwartz Round – AS will be evaluating the engagement and value of the reflective practice sessions to staff. There was discussion around who will be trained to be Schwartz facilitators. CQ discussed the need to a multi-professional and service approach to this across the clinical board.
Part 4:	**SAFE CARE**
4.1a	**Patient Safety Incidents** A number of improvement plans have now been uploaded onto AMAT. There is hope this will help the CB to monitor their process against the improvement plans. Themes developed from the improvement plans have helped to develop an overarching improvement plan for the mental health clinical board. JW requested that improvement plans are available for all to view. TR and AS requested supporting input to ensure the plans are robust and meaningful. AS discussed that the improvement plan is broken down into 7 recommendations, with a number of actions for each recommendation. These actions need to be allocated to an individual. This is helpful to keep track of actions, and is a good source of evidence for

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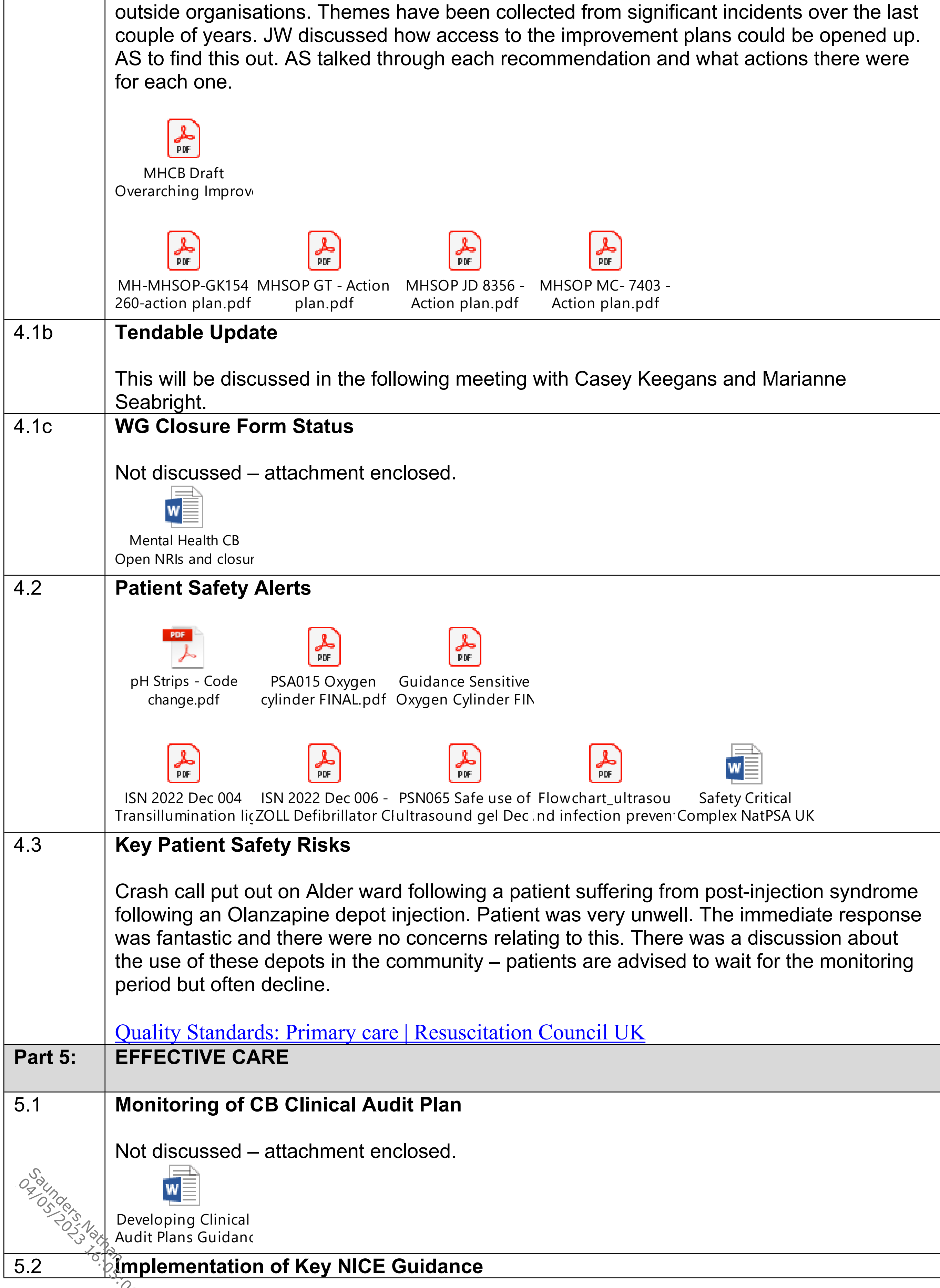

	outside organisations. Themes have been collected from significant incidents over the last couple of years. JW discussed how access to the improvement plans could be opened up. AS to find this out. AS talked through each recommendation and what actions there were for each one. MHCB Draft Overarching Improv MH-MHSOP-GK154 260-action plan.pdf · MHSOP GT - Action plan.pdf · MHSOP JD 8356 - Action plan.pdf · MHSOP MC- 7403 - Action plan.pdf
4.1b	**Tendable Update** This will be discussed in the following meeting with Casey Keegans and Marianne Seabright.
4.1c	**WG Closure Form Status** Not discussed – attachment enclosed. Mental Health CB Open NRIs and closur
4.2	**Patient Safety Alerts** pH Strips - Code change.pdf · PSA015 Oxygen cylinder FINAL.pdf · Guidance Sensitive Oxygen Cylinder FIN ISN 2022 Dec 004 Transillumination li · ISN 2022 Dec 006 - ZOLL Defibrillator C · PSN065 Safe use of ultrasound gel Dec · Flowchart_ultrasou nd infection preven · Safety Critical Complex NatPSA UK
4.3	**Key Patient Safety Risks** Crash call put out on Alder ward following a patient suffering from post-injection syndrome following an Olanzapine depot injection. Patient was very unwell. The immediate response was fantastic and there were no concerns relating to this. There was a discussion about the use of these depots in the community – patients are advised to wait for the monitoring period but often decline. [Quality Standards: Primary care | Resuscitation Council UK]
Part 5:	**EFFECTIVE CARE**
5.1	**Monitoring of CB Clinical Audit Plan** Not discussed – attachment enclosed. Developing Clinical Audit Plans Guidanc
5.2	**Implementation of Key NICE Guidance**

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	NJ discussed the new guidance that Esketamine is not to be used in treatment resistant depression. Doesn't believe anyone is using this currently. NJ also discussed the attached standards around the transition from CAHMS to Adult mental health care. Overview | Esketamine nasal spray for treatment-resistant depression | Guidance | NICE Overview | Delirium: prevention, diagnosis and management in hospital and long-term care | Guidance | NICE – ps03_22 Delivering better outcomes for
5.3	**QNWA Standards** NJ discussed ongoing work on 1:1's in the inpatient space. A small pilot study has led NJ to continue with concerns relating to medical 1:1's. Most inpatients will be seen once per week by their consultant, NJ is working towards an additional 1:1 outside of ward rounds. This was discussed with MD concerning 1:1 work with other staffing groups like nursing. NJ also discussed care plans, most patients do not have this in place in terms of a holistic document which includes multidisciplinary input and is shared with the patient and updated on a weekly basis. Moving forward, NJ would like to be clear about expectations of 1:1's and care plans and agree how the Clinical Board will monitor and audit against the QNWA standards. There are also NICE quality and safety standards which has quite stringent criteria and NJ would like the Clinical Board to state their position in relation to these. There was a discussion about ensuring additional 1:1 time adds value, and how this would be monitored. NJ is aiming for clarity around the standards, to enable them to be monitored. This is to be included in care plans to ensure patients know what they can expect. The standards will be across Adult and MHSOP. TD mentioned that this could be an opportunity to formalise and focus work that is being done informally. Potential of producing a template e.g. categorising patients as red/amber/green. TR will invite TD to QNWA discussion. The standards could be monitored on Tendable or AMAT. TR mentioned that the Clinical Board are working towards SIRAN accreditation and have been allocated funds for this. NJ discussed the upcoming Royal College of Psychiatry invited review. This will be taking place in March, they will be visiting and interviewing staff. Notes relating to incidents will be being uploaded to them. A review document will be received in approximately 4 months, and there will be a visit 6 months after this to follow up on the recommendations. QNWA Standards.xlsx
5.4	**POMH Update** Unable to attend.
5.5	**Research and Development** Not discussed – attachment enclosed.

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	Developing Clinical Audit Plans Guidance1 MHCB_Newsletter_DECEMBER_2022(1) (
Part 6:	**DIGNIFIED CARE**
6.1	**HIW/CHC, DECI (dignity and essential care inspections) reports and improvement plans** LW gave an overview of the recent HIW visit to Pine Ward. Immediate and outstanding actions were discussed. No concerns regarding staff practice, good verbal feedback was received. JW discussed the recent HIW visit to Ash Ward. There was one immediate assurance relating to staff being trained in SIMA. Staff who were out of compliance have now been booked in. The floor of Ash treatment room is an outstanding action, JW will chase this up. Draft HIW reponse Ash Ward Jan 2023 (
6.2	**Equality, Diversity and Access** TR noted that the recording of ethnicity on Paris is low in some areas, Rehab are doing well in filling this out. JW requested that Ethnicity be made a mandatory field, and TD requested an update of the ethnicities available due to limited options and duplication. RK spoke about other personal characteristics which are a big part of an individual. Mentioned the importance of improving ability to have conversations around this as part of quality improvements around person centred care. Queried whether Stonewall training would be useful for additional staff. RK will discuss with directorates. 6.2 Inpatient Ethnicity.docx
Part 7:	**TIMELY CARE**
7.1	**Initiatives to improve access to services** Not discussed.
Part 8:	**INDIVIDUAL CARE**
8.1	**Compliments, Complaints, Trends** RK congratulated Dave Hitt and Rhiain Lewis for achieving Agored accreditation for one of their training modules. Compliment 29.12.22.pdf
Part 9:	**STAFF AND RESOURCES**
9.1	**Staffing levels, Streamline nurses, Staffing Establishments, Temporary Staffing** Agency HCSW will be ending on the 1st April 2023, TR requested that the Directorate Leads discuss and plan for filling the gaps created by this.

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	Recruitment Update_.pptx Agency HCSW.pdf
9.2	**Staff Surveys** Not discussed.
9.3	**Self-Harm and Suicide Prevention Conference** TR directed attendees to the information in the pack. Booking Link Conference Speakers 2023.jpg
Sub – group reports	
Part 10:	**ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE:**
10.1	**PPE Audit** Not discussed.
Part 11:	**AOB**
	Nothing discussed.
Part 12:	**DATE & TIME OF NEXT MH CLINICAL BOARD QSE MEETING:** **Thursday 20th April 2023 at 09:30am** **DATE & TIME OF NEXT MH CLINICAL BOARD LESSONS LEARNED MEETING:** **Thursday 23rd February 2023 at 9.30am**

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Report Title:	Chair's Report Radiation Protection Group			Agenda Item no.	4.2	
Meeting:	UHB QSE Committee	Public	X	Meeting Date:	09.02.2023	
		Private				
Status (please tick one only):	Assurance		Approval		Information	x
Lead Executive:	Fiona Jenkins, Executive Director of Therapies and Healthcare Sciences					
Report Author (Title):	Lesley Harris, Head of Radiography UHL					

Main Report
Background and current situation:

This report is a summary of relevant information from the UHB Radiation Protection Group since the last meeting held on 24th January 2023 (April meeting postponed to 23/05/23).

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Within the first quarter, the employed Radiation Protection Service (RPS Cardiff) has undertaken a review of compliance against the Ionising Radiation Regulations 17 within the UHB. The areas included within the review were: UHW, UDH, CHW, Lakeside Wing, the Spinal unit.
The were 2 actions for the UHB
Action: Consider implementing a HB-wide policy on training of non-radiation workers in radiation areas.
Action**:** The radon risk assessment should be reviewed. Where radon concentrations are found to be well below 300 Bqm-3 (annual average), re-measurement of radon levels every ten years is appropriate. *- H&S unit contacted and action raised with them- required by end of 23/24.*

On 25/04/23 the HSE visited the UHB, the intent of the visit was to inspect work in relation to the Health Board's consents to administer radioactive substances to people, add radioactive materials to products and the discharge radioactive material. The areas visited were Radiopharmacy and Nuclear Medicine Department at UHW

A formal report is not issued by the HSE unless there is a breach of the regulations. Verbal feedback was provided throughout the day and during the closing meeting. To date there has been no formal report received, this is not expected.

The feedback was very positive overall with the inspectors stating that there is clearly a good safety culture with strong routes for escalation of concerns or incidents. It was evident that staff were well trained and knowledgeable. It was commented that the Radiation Risk Assessments and Local Rules were of a high standard and in depth, some minor suggestions for improvement were made. Discussion with trade union representatives confirmed and reassured the inspectors that staff felt their voices were heard and there were appropriate escalation methods in place and these were well known.

Enquires were made regarding the number of employees within the Health Board, including how many of those worked within Radiation areas and how many required personal dosimetry monitoring including the number of classified workers and the justification for classification. The various types of radiation activities within the Health Board were explained and on which sites they occurred.

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An enquiry was made against the Governance structure within the Health Board in relation to Radiation Safety. It was explained that within Radiology there is a local Radiation Protection Supervisor (RPS) group which meets quarterly, this group reports to the UHB Radiation RPG, who report to the DoTH and minutes are shared with the Clinical Board QSE group. Assurance was

provided that there were appropriate means of escalation in place if required outside of the scheduled meetings. The inspectors were happy there are appropriate Governance structures in place, however they suggested ground level staff attendance at the RPG may be beneficial.

Review of staff training records and personal dosimetry was conducted. Staff training records were very good, with a particular interest when staff last completed radiation protection training. Personal dosimetry results were reviewed for Nuclear Medicine staff, a couple of staff members had non-returns or lost badges within the last year. Although assurance was given that the importance of this was raised with staff at the time, the inspectors were concerned and raised that staff were in breach of their legal requirements and HSE could intervene if compliance deteriorates further.

The required medical examinations had been completed for the classified workers within Nuclear Medicine.
There was a wholly positive review of the injection room, scan room and control room, with HSE inspectors complimentary about the layout of the scan room (including location of emergency stops) and the protocol listing on the console.

Contingency plans were discussed at length and it was confirmed that these are practiced with staff annually at their VBAs.

Adequate spills kits were available, there was evidence that spills procedures were practiced with individuals.
Contamination monitoring already in place, however the probe used for hand and feet monitoring is not deemed to be adequate due to the small probe surface. This should be replaced to ensure accurate monitoring. The Clinical Board Director of Operations provided assurance that funding would be sought to ensure adequate equipment was in place.

Actions:

- Review attendance requirements of the Radiation Protection Group meeting and whether ground level staff should attend.

Recommendation:

The QSE Committee are requested to:

- **BE ASSURED** that the UHB has a functioning committee for radiation protection, which oversees regulatory requirements and our compliance for the UHB.
- **NOTE** that there is a need to implement a Health Board-wide policy on training of non-radiation workers in radiation areas, which will be progressed.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x

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5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term	x	Integration		Collaboration	x	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Detailed within the report
Safety: Yes/
An enquiry was made against the Governance structure within the Health Board in relation to Radiation Safety – Outlined within the report
Financial: Yes
The Clinical Board Director of Operations provided assurance that funding would be sought to ensure adequate equipment was in place.
Workforce: Yes
Detailed within the report
Legal: Yes
Detailed within the report
Reputational: Yes
Detailed within the report
Socio Economic: /No
Equality and Health: Yes
Detailed within the report
Decarbonisation: No

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

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