Public Quality, Safety, & Experience Committee

Tue 28 November 2023, 14:00 - 17:00

MS Teams

Agenda

14:00 - 14:10
10 min

1. Standing Items

10 mins

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 25.10.2023

Ceri Phillips

1.4 QSE Public Minutes 25.10.2023.pdf (6 pages)

1.5. Action Log - following the meeting held on 25.10.2023

Ceri Phillips

1.5 Public QSE Action Log.pdf (2 pages)

1.6. Chair's Action taken since last meeting

Ceri Phillips

14:10 - 15:10
60 min

2. Items for Review & Assurance

2.1. Medicine Clinical Board - Assurance Report

30 minutes

2.1 Medicine Clinical Board QSE Assurance Report Nov 2023 final.pdf (19 pages)

2.2. Quality Indicators Report - Deep Dive on Mortality

20 minutes *Jason Roberts / Meriel Jenney*

2.2 Mortality deep dive - Nov 2023 final.pdf (23 pages)

2.3. Outstanding Actions from the Ombudsman's Annual Letter

10 minutes *Jason Roberts / Angela Hughes*

2.3 Psow Ombudsman for QSE (003) final.pdf (8 pages)

15:10 - 15:15
5 min

3. Items for Approval / Ratification

3.1. Healthy Eating Standards for Hospital Restaurant and Retail Outlets

5 minutes *Fiona Kinghorn*

- 3.1a QSE Paper November 2023 Final.pdf (4 pages)
- 3.1b Healthy Eating Standards for Hospital Restaurant Retail Outlets Temp Revision Nov 2023 (002).pdf (15 pages)

15:15 - 15:30
15 min

4. Items for Noting & Information

4.1. Minutes from the Clinical Board QSE Sub-Committees

5 mins *Jason Roberts / Meriel Jenney*

a) PCIC - 26.09.2023

b) Children & Womens - 26.09.2023

c) Specialist - 02.10.2023

- 4.1a PCIC QSE Minutes 26.09.2023.pdf (9 pages)
- 4.1b CW QSE Minutes 26.09.2023.pdf (12 pages)
- 4.1c Specialist QSE Minutes 02.10.2023.pdf (6 pages)

4.2. Child Practice Review Report

10 mins *Jason Roberts*

- 4.2a CVSB CPR 052019 Report.pdf (13 pages)
- 4.2b CVSB CPR 052019 Action Plan.pdf (4 pages)

15:30 - 15:30
0 min

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

Ceri Phillips

15:30 - 15:30
0 min

6. Agenda for the QSE Private Meeting:

Ceri Phillips

i) Private Minutes

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

iii) Prison (Confidential Discussion)

15:30 - 15:30
0 min

7. Any Other Business

Ceri Phillips

15:30 - 15:30
0 min

8. Review of the Meeting

Ceri Phillips

15:30 - 15:30
0 min

9. Date & Time of Next Meeting

Ceri Phillips

Date: TBC

Via: MS Teams

15:30 - 15:30
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]"

Unconfirmed Minutes of the Quality, Safety & Experience Committee

Held on 25th October 2023

Via MS Teams

Chair:		
Rhian Thomas	RT	Committee Vice Chair / Independent Member – Capital & Estates
Present:		
Akmal Hanuk	AH	Independent Member – Community
Mike Jones	MJ	Independent Member – Third Sector
In Attendance		
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Abigail Holmes	AH	Director of Midwifery and Neonatal Services
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Kinghorn	FK	Executive Director of Public Health
Meriel Jenney	MJ	Executive Medical Director
Mathew King	MK	Interim Assistant Director of Therapies & Health Science
Matt Phillips	MP	Director of Corporate Governance
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
Francesca Thomas	FT	Head of Corporate Governance
Observers		
Nathan Saunders	NS	Senior Corporate Governance Officer
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Ceri Phillips	CP	UHB Vice Chair / Committee Chair
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences

QSE 23/10/001	**Welcome & Introductions** The Committee Vice Chair (CVC) welcomed everyone to the meeting in English & Welsh.	**ACTION**
QSE 23/10/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 23/10/003	**Declarations of Interest** No declarations of interest were raised.	
QSE 23/10/004	**Minutes of the Committee meeting held on 26.09.23** The minutes of the Committee meeting held on 26.09.23 were received. **The Committee resolved that:** a) The minutes of the meeting held on 26 September 2023 were approved as a true and accurate record of the meeting.	
QSE 23/10/005	**Action Log following the Meeting held on 26.09.2023**	

	The Action Log following the Meeting held on 26.09.2023 was received. It was noted that two actions in progress (QSE 23/04/007 and QSE 23/03/007) would have updates provided in today's meeting. **The Committee resolved that:** a) The Action Log from the meeting held on 26.09.2023 was noted.	
QSE 23/10/006	**Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QSE 23/10/007	**Quality Indicators Report** The ADQPS presented and summarised the Quality Indicators Report and coinciding slides to provide assurance in relation to a number of quality, safety, and patient experience priorities. The report is available to view in detail alongside the papers received for the Public QSE Committee on the 25/10/2023 for Agenda item 2.1. Regarding the falls prevention work, the CVC asked what work had been undertaken over the previous 3 years. The ADQPS responded that: - The COVID pandemic had interrupted work undertaken on the falls framework which had started in 2019/2020. Social distancing had interrupted simulation training for real-time incidents and events, and a Falls Lead had only been recruited around 3 months prior. - Within the previous 12 months, the UHB had refreshed the entire agenda of the Falls Delivery Group to focus on several key areas of the strategy. - The national picture had changed dramatically over the previous 18 months – e.g. the UHB had worked in partnership with Health Technology Wales to develop fall sensors. The EDPH highlighted that accessibility across C&V for falls preventative work within the helped the UHB's strategic intent on keeping people healthy at home. She added that this type of intervention at scale would start to impact on outcomes. The ADPE continued with the report and provided the Committee with a summary of the Quality Indicators Report around Patient Experience and Concerns. The IM-C highlighted the large amount of work being undertaken by a small team to analyse the data, and asked if they would receive further help. The ADPE responded that they had been in discussions with Cedar around the analysis of feedback. She added that discussions had been had nationally around Civica, and that CAVUHB might be a little further ahead in their analysis in comparison with the national picture. The IM-C asked if there was a possibility to use patient walkrounds as a means to obtain staff feedback. The ADPE responded that the data presented at this meeting was just a snapshot of the wider portfolio of feedback they had received. She explained that they undertook environmental walkrounds with Estates colleagues in which they speak to staff, as they aimed to be more proactive, rather than just waiting for complaints or incidents. The SSIPM stated that they had recently established the Patient At Risk Team (PART) which was embedded within the organisation, and whether they had yet received any feedback on this team. She added that as part of the Ward Accreditation Improvement	

	Programme, they collated staff voices on the wards which was reported via the Tendable audit. The ADPE responded that there had been concerns over the name 'call for concerns' in Wales, and it had been changed to 'call for clinical concerns' on the posters. She explained that there had been a low number of calls around feedback on the team, but that it was still early days. The EMD added that they had recently invested in PART to make it a 24/7 service, and that there was further communications work to be done. **The Committee resolved that:** a) The assurance provided by the quality indicators and the actions underway to drive the necessary improvements was noted.	
QSE 23/10/008	**Children & Women's Waiting List Update** The COO presented the report which provided an update on the volume of waiting lists within the Children & Women Clinical Board, and highlighted that: - This group of services had seen a huge increase in demand. - The Mental Health Summit held in September with Primary Care, Children & Young People and Adults Mental Health to talk through some issues and agree a way forward. - Significant efforts had been made to address some of the demand and to increase capacity. - The number of Children Looked After across C&V had increased to 1400, compared to 1280 pre-COVID. - The number of patients waiting for initial health assessments, and the backlog of assessments, had both decreased, and there had been some progress made within the eating disorders waiting lists. - They were unsure how long this demand would continue for. Regarding Children Looked After, the END added that: - The number was being monitored through Executive Oversight and their monthly meetings with Clinical Boards; - They had put resource in to try and reduce this number, and whilst they had halved the backlog of health assessments, there was still a considerable amount of work to do. The CVC asked how feasible it was as a mitigation to ask nurses / health visitors to complete one of the two annual assessments, as these teams were already under significant pressure. The END responded that there was an overlap between the health visitors and the Flying Start health visitors (who focused on this group of children). They were undertaking a whole system review to see what could be done to relieve some of their work to free up the health visitors to undertake these assessments. The EDPH commented that the increased awareness of neurodevelopmental disorders within communities had contributed to demand. In addition, she stated that there had been increased emotional mental health issues within the community due to the larger societal and socio-economic challenges at play (especially post-COVID), and she did not see the demand abating for several years. Regarding surgery and outpatients, the COO summarised the challenge they faced: - General Paediatrics Surgery had been commissioned by WHSSC, and everything else (Orthopaedics, ENT, etc) was commissioned by the Health Board - WHSSC had requested for a contract to deliver 36 week waiting times for surgery (maximum 1 year), while other patients had waited much longer.	

	- The UHB made the decision that they could not have some patients waiting 3-4 years whilst general surgical patients were treated quicker by WHSSC, which had resulted in the UHB being placed into escalation with WHSSC - A conversation was had the previous Monday with WHSSC on how to achieve a more equitable service - They wished for no children to wait longer than 2 years by December, in line with ministerial ambitions. They could not give more capacity to WHSSC at the expense of other Health Board patients. - For outpatients, the UHB had enough capacity. For surgery, they were working from a clinical priority perspective, regardless of speciality and starting with the longest waiters. - WHSSC had asked the UHB to review the patients on the waiting lists, however they had been clear that this would be done from a clinical priority perspective. The EMD added the following: - Because they were the Children's Hospital for Wales (CHfW), more complex patients came from elsewhere. - They had been having clear and open discussions with WHSSC, and the same was needed with other Health Boards in a collaborative effort to get this right. - Fundamentally, some of the challenges were around the workforce and the difficulties in recruiting and retaining staff. The COO stated that overall, the waiting lists had reduced, and by the end of March 2025 no children would wait over 2 years for surgery, regardless of their specialty. Conversations were needed around how to fairly allocate the capacity they had, and to be clear on the criteria for accepting patients from other Health Boards. **The QSE Committee resolved that:** a) The content of the paper and the actions taken to mitigate the risks associated with child health assessments was noted.	
QSE 23/10/009	**Maternity Thematic Review** The END and DMNS presented the report which summarised the key themes and findings from a number of recent reports, to demonstrate the actions being taken to make improvements to the organisation. The report is available to view in detail alongside the papers received for the Public QSE Committee on the 25/10/2023 for Agenda item 2.3. The IM-TS noted that staffing issues were highlighted when he visited the post-natal ward the previous week. He asked whether they had offered staff the opportunity to retire and return, or if staff could use bank once they retired. Additionally, he asked if the UHB captured the reasons for midwives leaving the organisation once they had achieved a Band 6 role. The DMNS agreed that they had significant staff shortages, and responded that: - This year they had increased their commissioning and had employed 35wtes. - The majority of their midwives did retire and return, and they had explored other roles that they could come back to (e.g. elective work) to build flexibility within the workforce. - Andy Jones had undertaken a large piece of work around why midwives have left, and he had obtained a huge amount of data. They had looked at how to make Cardiff an attractive place to stay for their career, as many students had relocated after their two years had finished once they had received their Welsh bursary. The COO highlighted that this was a 2-3-year programme, and while they still had a lot of work to do, they were aware of what work was needed. The CVC asked for a periodic update to return to the committee. The END explained that the Maternity Neonatal Oversight Group met monthly, and the first meeting was two weeks prior. He confirmed that they would bring regular reports to	

	this Committee, and they had agreed that they would a bring 6-12 monthly summary to the Board. **The QSE Committee resolved that:** a) They would continue to have oversight of maternity and neonatal services, and noted the report.	
QSE 23/10/010	**Specialist Clinical Board Assurance Report** - South Wales Trauma Network Verbal Update The COO provided a verbal update, and summarised the following: - A formal review of the Major Trauma Centre (MTC) had been postponed until Q4 next year, which would be led by WG and the Trauma Network. - As a result of demands, they had created capacity potentially at the risk of some other services the UHB would provide. - Some of the funding excluded from the business case they have had to request back – for example, they had insufficient radiology resource. - The team would attend the Senior Leadership Board (SLB) in November to provide an update. The COO suggested that the team come to the QSE Committee to provide an update on what the MTC had achieved over the previous 3 years, and on their future plans. The CVC responded that she would speak to the UHB Vice Chair outside of the meeting to determine what the most appropriate governance route would be to review this work. The CVC asked whether there were any risks or challenges in light of the formal review being postponed until the following year. The COO responded that they were aware of the hotspots, particularly in imaging radiology, however they were able to provide the service. **The QSE Committee resolved that:** a) The South Wales Trauma Network Verbal Update was noted.	
	Items for Approval / Ratification	
QSE 23/10/011	**Policies -** Interoperative Cell Salvage Policy and Procedure The EMD provided assurance that they had just been inspected by the Human Tissue Authority (HTA), and that their policies were not highlighted as an issue. **The QSE Committee resolved that:** 1) The Intraoperative Cell Policy and Procedure was approved; 2) The full publication of the Intraoperative Cell Salvage Policy and Procedure in accordance with the UHB Publication Scheme was approved.	
	Items for Noting & Information	
QSE 23/10/012	**Minutes from Clinical Board QSE Sub Committees** Clinical, Diagnostics & Therapies Minutes for 14.07.2023 & 22.09.2023 **The QSE Committee resolved that:** a) The minutes from the Clinical, Diagnostics & Therapies Meeting from 14.07.2023 and 22.09.2023 were noted.	
QSE 23/10/013	**Items to bring to the attention of the Board / Committee:** No items were raised.	
QSE 23/10/014	**Agenda for Private QSE Meeting**	

	i) Private Minutes *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*	
QSE 23/10/015	**Any Other Business** The IM-C asked for a verbal update around the increased rates of sepsis, as there seemed to be a growing concern. The EMD responded that the PART team enabled a clear pathway for patients who had deteriorated (which included sepsis), and they had recently advertised for a Clinical Lead for Sepsis who would lead the Sepsis Group. The EMD noted that there were no immediate causes of concern which had been brought to her attention. The IM-C highlighted that the Chief Medical Officer had referred to the culture, and that when people present to A&E, they were sometimes not being investigated as they struggled to express their symptoms. He suggested that this be picked up by the People and Culture Committee. The EMD responded that they were working hard to be transparent through Freedom to Speak Up (F2SU) and raising concerns. The EMD suggested that the cultural issue would be to support the workforce through these challenging times.	
	Date & Time of Next Meeting: 28th November – tbc - via MS Teams	

Action Log

Quality, Safety & Experience Committee

Update for meeting 28 November 2023
(Following the meeting held on 25 October 2023)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions Completed					
QSE 23/03/007	**Specialist Clinical Board Assurance Report – re: South Wales Trauma Network**	To provide the Committee with an update with regards to the WHSSC funding for South Wales Trauma Network review and associated actions.	**25.10.2023**	Paul Bostock/Guy Blackshaw	**COMPLETED Updated in October 2023**
QSE 23/04/007	**Children & Women's Clinical Board Assurance Report**	To revisit the waiting list issue identified in 6 months' time to provide more assurance to the Committee. A full Clinical Board assurance report was not required.	**25.10.2023**	Jason Roberts	**COMPLETED Updated in October 2023**
Actions in Progress					
QSE 23/07/009	**MBRRACE Update**	For a matrix report to be provided to the Committee to include the MBRRACE report.	**09.01.2024**	Meriel Jenney / Jason Roberts	**Update in January 2024**
QSE 23/09/009	**Looked After Children – Assessment Backlogs**	For a 6-month update on the Assessment Backlogs for Looked After Children to be provided to the Committee.	**05.03.2024**	Jason Roberts	**Update in March 2024**
QSE 23/07/014	**Cardiff and Vale University Health Board Hepatitis (B and C) Joint Recovery Plan 2023-25**	For an update on the Hep B & C Joint Recovery Plan to be provided in 12 months' time.	**July 2024**	Fiona Kinghorn	**Update in July 2024**
Actions referred to Board / Committees					

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions referred FROM Board / Committees					
AAC 4/7/23/013	**Regulatory Compliance Tracking Report**	Some of the Patient Safety Solutions had been on the tracker for some time and should be taken to a future Quality, Safety & Experience (QSE) Committee meeting to provide assurance.	**28.11.2023**	Matt Phillips	**Update in November**
UHB 23/05/015	**Integrated Performance Report: QSE**	For mortality data assurance to be provided to the Board at a Board Development session following a deep dive at the QSE Committee meeting in November.	**28.11.2023**	Meriel Jenney	**Update in November**

Report Title:	QSE Medicine Clinical Board Assurance Report				Agenda Item no.	2.1	
Meeting:	QSE Committee Meeting		Public	x	Meeting Date:	28th November 2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Executive Nurse Director						
Report Author (Title):	Quality and Governance Lead						

Main Report
Background and current situation:

This report details the clinical governance arrangements within Medicine Clinical Board in relation to Quality, Safety and Patient Experience (QSPE). It sets out achievements, progress and planned actions to maintain the priority of QSPE. It is aligned to the UHB's Shaping Our Future Well Being Strategy 2015 – 2025, that underpins the development of our service, and the Quality, Safety and Patient Experience Framework 2021-2026.

Medicine Clinical Board offers high quality clinical care for people with multiple, complex health needs, minor injuries and serious disease. It includes services for the wider regional and Welsh population such as Infectious Diseases, Welsh Gender, Stroke, Diabetes, Dermatology and Gastroenterology. The Clinical Board also provides emergency and secondary care services to the local Cardiff and Vale population.

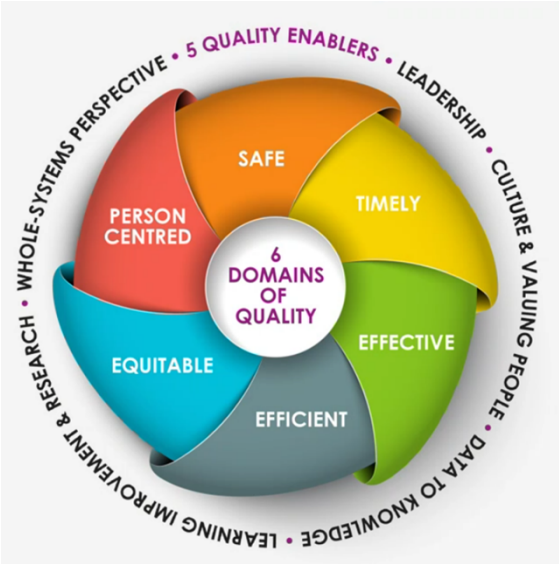
The Clinical Board has a current workforce establishment of 1715.77 WTE staff in post which includes: 770.31 WTE Registered Nurses, 511.68 WTE Health Care Support Workers, 189.31 WTE Admin and Clerical, 205.77 WTE Medical and Dental staff, 13.8 WTE Additional Prof Scientific and Technic, 511.68 WTE Additional Clinical Services, 15.87 WTE Allied Health Professionals, Student 1, and 8.04 WTE Health Care Scientists. It has an inpatient bed base of 538, three Day Units and several outpatient suites.

Secondary to the diversity and high activity provided across the Clinical Board, it is essential that robust governance and risk management arrangements are in place to reduce the risk of harm to our staff and service users.

The aim of the Medicine Clinical Board in summary is to:

- Ensure there is a process in place to continually monitor and review its risk register, acting to mitigate quality and safety risks on an ongoing basis;
- Maintain an open culture of improving quality, safety and patient experience across all teams and all staff;
- Promote a positive culture of staff engagement, development and understanding of everyone's responsibility for safe, quality care and
- Foster a culture of psychological safety within Medicine Clinical Board in order to promote collaboration, trust, innovation and personal growth.

Quality, Safety and Patient Experience (QSPE) is the highest priority for the Clinical Board and its governance structures and oversight has developed significantly. The Clinical Board Director, Director of Nursing and Head of Quality and Clinical Governance lead the agenda which is aligned to the six Domains of Quality as defined by the Duty of Quality Statutory Guidance 2023. This report is set out under each of these Domains.



Clinical Board QSPE Committee meetings are planned every month, and are well represented by medical, nursing and managerial staff across all Directorates, as well as other multi-disciplinary colleagues from across the health board, all of which take an active part in the meetings and shape the overall agenda. The Committee Terms of Reference and Work Plan are reviewed annually and it is supported by sub groups covering Infection, Prevention and Control (IP&C), Health and Safety and Medicines Governance and Access.

Each Directorate holds monthly Quality and Safety Groups, and further work is underway to strengthen these agendas and their reporting to the Clinical Board QSPE Committee. The Clinical Board governance structure provides further levels of assurance and escalation by the presentation of a Quality, Governance and Risk Highlight Report at every monthly formal Board meeting.

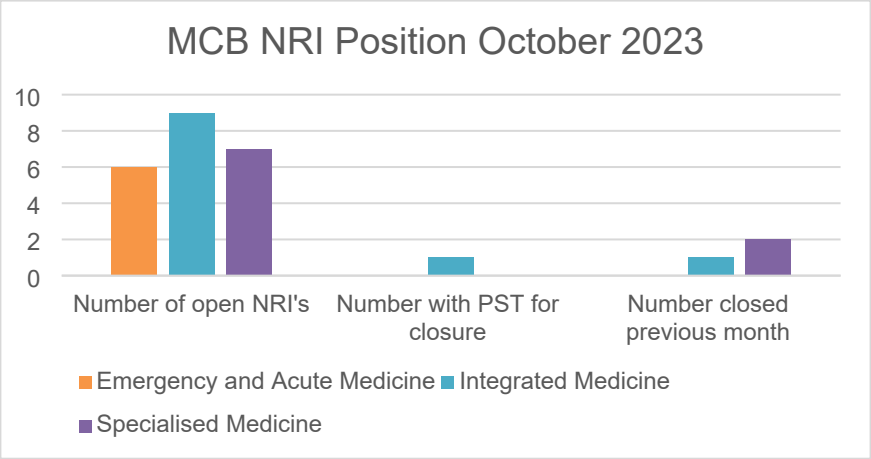
Safe Care

Patient Safety Alerts/Internal Safety Notices

The Clinical Board has a robust management system in place for Patient Safety Alerts, working in conjunction with the Patient Safety Team. An identified member of staff is responsible for all alerts received, and for their dissemination and tracking of actions where applicable. All alerts and notices are shared at both Clinical Board and Directorate QSPE meetings.

The Clinical Board recognises that a review of its compliance with national guidance is required and plans to undertake this with clinical leads by the end of the year.

NRI (National Reportable Incident) Management

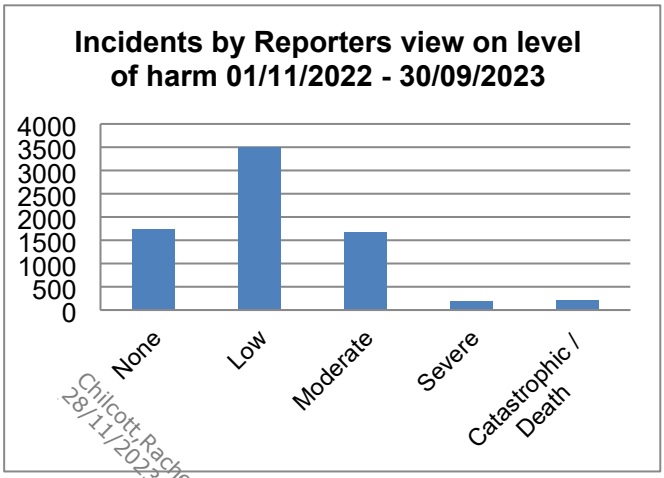


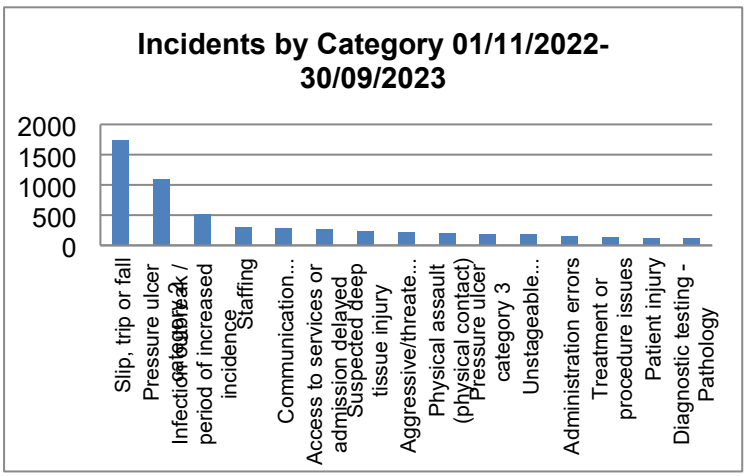
The Clinical Board is currently investigating 21 NRIs:

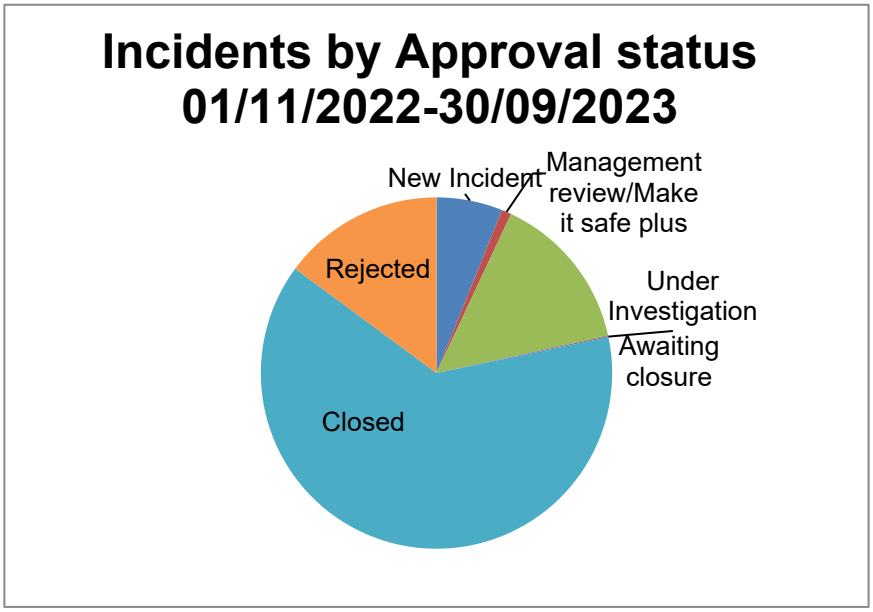
- One potential delayed Thrombectomy for Stroke
- One potential missed diagnosis and potential Thrombectomy for Stroke
- One delay in recognising a sick patient
- Four Covid-19 potential healthcare acquired death
- Five Gastroenterology delays for treatment, surveillance and cancer diagnosis
- One delay in Gastroenterology review and treatment
- One missed specimen for a cancer diagnosis Dermatology
- One PRUDiC (Procedural Response to Unexpected Deaths in Childhood) and potential error in discharge
- One delay in treatment Emergency Medicine
- One potential misdiagnosis Emergency Medicine
- Two potential lost to follow up with a cancer diagnosis ECAS (Elderly Care Assessment Service) and Acute Medicine
- One delay in referral to Obstetrics and intrauterine death
- One lost to follow up Interstitial lung disease

The Clinical Board is committed to ensuring that NRIs are closed within timescales set by NHS Wales Delivery Unit to ensure patients and their families receive feedback in a timely manner.

Patient Safety Incident Management



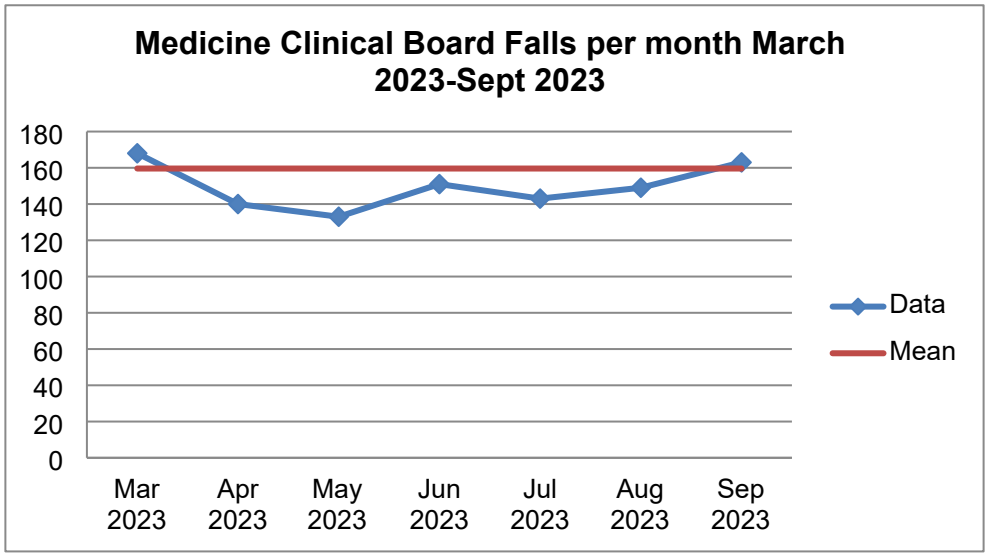




The Clinical Board demonstrates an open reporting culture with high numbers of incidents reported, the vast majority of incidents result in no or minor harm. The Clinical Board acknowledges the challenges for timely closure of Datix, and continues to focus on those reporting severe or catastrophic harm. In addition, bespoke individual support is being provided to those incident managers with significant Datix queues, with designated Super Users across all Directorates.

Falls

Falls remain one of the most reported incidents within the Clinical Board via Datix Cymru. The Clinical Board reported 133 – 169 falls per month for the period 01st March 2023 to 30th September 2023. This is an improvement for the same time period for the previous year where 142 -219 falls were reported.



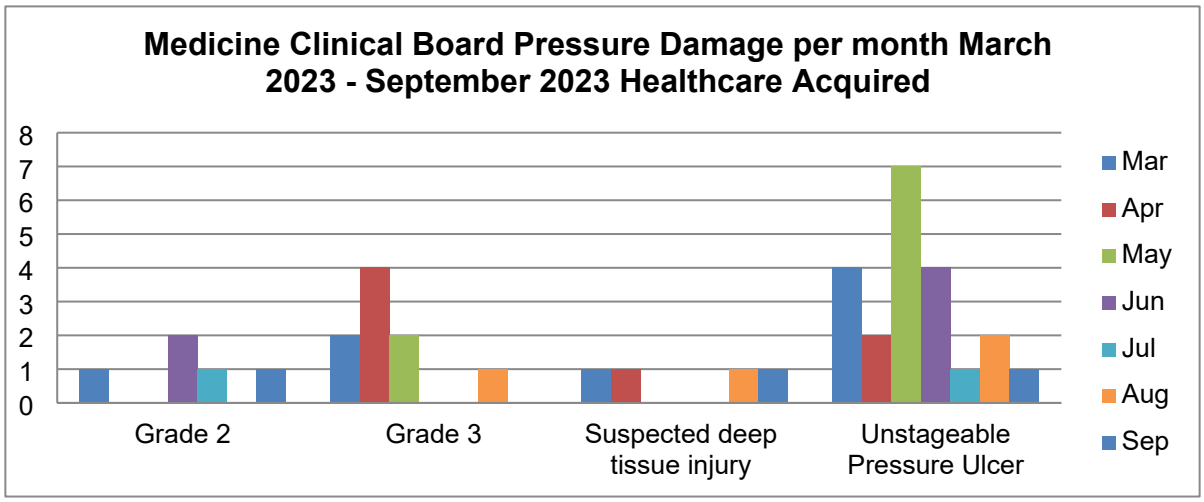
For this time period the Clinical Board reported 9 injurious injuries, 3 of which were reported to the Delivery Unit where it was agreed there were acts or omissions which contributed towards the fall and injury. These included the lack of multifactorial risk assessments to inform a patient's plan of care and a lack of clear handover regarding a patient's known high falls risk.

Aligned to the UHB Falls Delivery Group work, the Clinical Board is rolling out interactive spread and scale falls training for all staff. This includes falls training specific to individual areas, lying and standing blood pressure, and factors contributing to patient falls. Staff are taken through the Procedure for the Prevention and Management of falls and the terminology to ensure it is understood. The difference between anticoagulants and antiplatelets, delirium and cognitive impairment as well as Hover jack simulation training is also discussed.

A recent Falls Management review project undertaken by key falls leads within the Clinical Board, to support junior clinicians, sought to understand why we think falls are a problem. Falls are common, and there are lots of reasons why people fall, with many different consequences. Taking themes identified from previous NRIs, the work focused around education with UHB Falls Delivery contribution, a review of previous quality improvement projects in relation to falls, and revival of the existing falls proforma. Feedback regarding the use of the Falls Proforma included extra/duplication of documentation for nursing staff, whether it would replace clinical notes documentation and lead to confusion with the possible launch of the Falls Assessment Form. Initial feedback from junior clinicians was extremely positive, finding the tool extremely helpful. A trial of the falls proforma is being undertaken at UHL which will be resubmitted to the Falls Delivery Group for further consideration. It will also be used for further education including induction, and discussed as part of the All Wales National Falls Group. In addition, forming part of the Health Board's 6 Goals, Lakeside Wing Wards 1 and 2 are part of the Get Up, Get Dressed, Get Moving campaign to reduce deconditioning and associated patient falls risk whilst in hospital.

Pressure and tissue damage reduction and prevention

The Clinical Board continues to learn from all avoidable and unavoidable healthcare acquired pressure damage. The Clinical Board's Pressure Damage Learning and Scrutiny Panel is well embedded and supports Ward Sisters/Senior and Lead Nurses to engage in the decision making, and identification of learning to share more widely across the Clinical Board.



From 01st March 2023 to 30th September 2023 the Clinical Board reported 18 cases of avoidable healthcare acquired pressure damage as NRIs. This is a slight increase from the same time period last year where 11 avoidable healthcare acquired pressure damage cases were reported. The increase has in part been attributed to focus on the timely completion of the pressure damage focused reviews.

The Focused Pressure Damage reviews and subsequent discussion at the Clinical Board's Learning and Scrutiny panel, identified key learning and themes around timely and accurate mattress selection, heel off loading, TVN (Tissue Viability Nurse) advice, the completion of Purpose T risk assessments in line with best practice and documentation to reflect a patient's reluctance for

intervention. Significant work is being undertaken to improve overall education around pressure damage prevention and treatment across the Clinical Board with the support of Practice Educators and the Tissue Viability Team.

Improvement is monitored via Tendable (Tendable is an electronic tool which enables staff within clinical areas to undertake specific Core Standards or Care Specific audits and monitor compliance with key requirements) with Clinical Board oversight. In September overall, the Clinical Board reported 90.3% for the correct treatment, interventions and documentation for pressure damage. Areas of excellent compliance were noted in the areas of C4 Stroke, West 2, Sam Davies Ward and SRC (Stroke Regional Centre) who consistently report 100%. For those areas where improvement is required, action plans have been put in place with Senior and Lead Nurse oversight to monitor improvement.

Safeguarding

All safeguarding referrals relating to community concerns, or raised against staff working within the Clinical Board are subject to the required level of investigation and scrutiny to ensure safe care is provided. Investigations are led by Health Lead Professionals (HLP), with appropriate actions taken and shared more widely if required. The Clinical Board is currently investigating 21 safeguarding referrals, 3 of these relate to avoidable healthcare acquired pressure damage. The Clinical Board has key links with the Safeguarding Team to ensure openness and transparency, and safeguarding remains a standing agenda item on the QSPE Committee agenda.

Work is currently being undertaken within Emergency Medicine and the creation of Cyfannol; a multi-agency safeguarding hub located within the Emergency Unit to support those vulnerable patients visiting the Unit.

The Clinical Board has implemented Safeguarding review clinics led by the Head of Safeguarding and the Director of Nursing. This requires each HLP to discuss their open cases and any issues preventing closure to enable timely closures and learning from referrals.

Infection, Prevention and Control

The Clinical Board is fully engaged with the expected reduction figures for all healthcare acquired infections and the challenge this brings to promote safe and clinically effective care. Environmental, Hand Hygiene and Bare Below the Elbow, in addition to IP&C audits on Tendable are undertaken monthly to ensure standards are maintained.

The Clinical Board IP&C Group has been re-introduced and meets bi-monthly. The purpose of these meetings is to drive forward the UHB Infection, Prevention and Control agenda within the Clinical Board with multidisciplinary input and assign specific responsibilities. The Terms of Reference include the review of care delivered to ensure it is safe, timely, effective, efficient, equitable, person centred with governance measures in place. Shared learning from all healthcare acquired infections and investigations forms part of the QSPE and IP&C Group agenda, with the Group determining actions for improvement, working collaboratively across the multidisciplinary team to deliver action-based outcomes to improve patient safety.

From 01st April 2023 – 30th September 2023 the Clinical Board reported 64 healthcare acquired infections.

Clostridium Difficile

17 incidents of C. *Difficile* were reported for the Clinical Board from 01st April 2023 – 30th September 2023. Based on the same period in 2022 – 2023, a 27% increase has been noted. The

investigations and discussion with Infection, Prevention and Control identified the increased use of antibiotics and acuity of patients is a significant contributory factor to the increase noted.

The Clinical Board is committed to improvement initiatives around reducing antimicrobial resistance. It has an Antimicrobial Lead Consultant supporting antimicrobial stewardship (AMS) initiatives. Antimicrobial pharmacist / microbiologist led ward rounds in areas focus on the reduction / cessation of broad-spectrum antibiotics and prompt IV to oral switch. The ARK (Antibiotic Review Kit) chart is in use and has a dedicated section for antimicrobial prescribing and forces a review and revise approach at 72 hours. Pharmacist led audits of in hospital antimicrobial prescribing against the recommended standards are conducted on a quarterly basis and provide benchmarking. The latest audit results show improvement in some areas (92.3% adherence to guidance on average) but there is still room for improvement around recording of indication, review within 72 hours and only 50% of antibiotic prescriptions had a duration / review date recorded. These audits are fed into our QSPE structures.

MSSA

8 incidents of MSSA were reported for the Clinical Board from 01st April 2023 – 30th September 2023. The investigations and discussion with Infection, Prevention and Control identified causes secondary to PVC/CVC, chest/cardiac and urinary/renal. Practice Development Nurses plan to address ANTT (Aseptic Non-Touch Technique) compliance with a blended approach, focusing on ward-based assessors and central assessment sessions to improve standards.

MRSA

1 incident of MRSA was reported for the Clinical Board in September 2023. This is the first case since July 2022. Early review suggests this may have been community acquired.

E Coli

27 incidents of E Coli were reported for the Clinical Board from 01st April 2023 – 30th September 2023. Investigations and discussion with Infection, Prevention and Control have identified these as mainly attributed to urinary/renal and biliary/abdomen sources. Based on the same time period in 2022 – 2023, a 30% increase is noted.

Klebseilla

9 incidents of Klebseilla were reported for the Clinical Board from 01st April 2023 – 30th September 2023. Based on the same time period 2022 – 2023 a 0% increase has been seen. The investigations and discussion with Infection, Prevention and Control identified these were predominately urinary and biliary sources.

Pseudomonas

2 incidents of Psuedomonas were reported for the Clinical Board from 01st April 2023 – 30th September 2023. The investigations and discussion with Infection, Prevention and Control identified these to be PVC/CVC sources.

The Clinical Board continues to see clusters of patients and staff testing positive for Covid-19 resulting in Covid-19 Outbreaks and Incidents. In line with Delivery Unit changes for healthcare acquired Covid-19 deaths, to date the Clinical Board have investigated two inpatient deaths and presented to the UHB Covid-19 scrutiny panel where it was agreed that there were no acts or omissions causative or contributory of the patient's death.

Staffing

Nurse staffing remains one of the highest Clinical Board risks. Mitigation includes posts advertised in a timely manner with the authorisation of vacancies reviewed efficiently. Recruitment events are undertaken, with ongoing overseas recruitment, adaptation programmes, student streamlining and staff return to practice. A staff risk framework is completed daily by the Clinical Board and shared at daily OPAT UHB meetings. The new exit questionnaire has to date not picked up any themes.

Medicine Clinical Board consists of 1715.77 WTE staff. The Clinical Board currently has a 10.50% turnover rate and cumulative sickness rate reported for September as 6.51% which is noted to be an improvement. The current Registered Nurse vacancy factor across the Clinical Board is 12%. There has been active, ongoing recruitment alongside generic recruitment, student streamlining and overseas nurses.

Some examples of staff experience feedback in Tendable include:

1. 87.5% colleagues reported they could take a break during their last shift
2. 100% colleagues reported they had enough clinical items/equipment available to do their jobs effectively
3. 100% colleagues report they were satisfied with the standards of care they provided during their most recent shift
4. Examples where staff have reported they were not satisfied with the standard of care they have been able to provide on a particular shift and struggled to take a break secondary to pressures within the clinical area at the time.

The Clinical Board inpatient wards are reviewed against the All Wales Nurse Staffing acuity data. Health Roster Standards and Measures are in place with Safecare (Safecare is a tool used to monitor how many staff are on the ward and identifies gaps and risks, as populated by each clinical area) completed twice a day and monitored for compliance. An example taken from CAV Nursing Safecare Dashboard for September:

Work continues within the Clinical Board looking at different roles and workforce models to release the Registered Nurses' time and ensure the workforce is fit for purpose. This may challenge the current traditional model of the nursing workforce however the difficulties in recruiting Registered Nurses is widely recognised, so exploring different workforce models is necessary in order to keep our patients safe.

Trainee grade staffing provides challenges year to year, but the risks resulting from trainee gaps are mitigated as far as is possible by the Workforce Hub. These risks are challenging given the un-commissioned bed base open and the need to appropriately staff these areas.

The importance of staff appraisal cannot be underestimated. The Clinical Board and Directorates are working hard to improve compliance with Values Based Appraisal and pay progression. This is currently being reviewed by the Clinical Board to improve compliance. The current position is as follows:

Emergency and Acute Medicine	54.39%
Integrated Medicine	65.31%
Specialised Medicine	66.93%
MCB Management	44.44%
Clinical Board Total	**62.42%**

Medical Staff Appraisal **84.78%**

Staff engagement

The Clinical Board is fully engaged with the UHB's values and behavours and has strategies in place to manage staff who fail to meet the expected standard. The Clinical Board supports the UHB's commitment for talent management and leadership and recognises the importance of creating the right vision and environment for change to enable teams to improve the experience of patients and staff. Some examples of this include:

- Tara Rees won Nurse of the Year and the Advanced and Specialist Nursing Award from the Royal College of Nursing Wales
- Dr Benjamin Jelley Clinical Audit Champion
- Ward Sister Suma John was invited to present at Chief Nursing Officer Conference.
- Cystic Fibrosis Pharmacy Team runners up at Welsh Pharmacy of the Year Awards

The Clinical Board recognised success at its Celebration Event held in September. Many excellent examples of innovative practice were shared demonstrating improvements in the quality and safety of the care we provide. Winners included the Medical Same Day Emergency Care team for partnership working and the Stroke Clinical Nurse Specialist Team for Team of the Year.

Mortality reviews

Mortality reviews are routinely undertaken by Directorates in line with the All Wales Checklist. A proportion of Mortality Level 2 reviews undertaken are shared at Directorate Quality and Safety meetings as a means of shared learning and to take forward improvements. The Clinical Board engages fully with the Independent Medical Examiner review process and sits on the UHB Mortality Group with feedback shared at Clinical Board QSPE meetings. The Clinical Board is working with the Patient Safety Team to review and strengthen its processes around mortality reviews.

The Clinical Board has utilised the Business Intelligence System to develop an Emergency Unit (EU) mortality dashboard. This allows further analysis of our mortality data, including mortality around sepsis, stroke and breaches of 8 and 12 Hours. Going forward the Clinical Board intends to routinely capture its mortality data across the Clinical Board to increase scrutiny, learning and improve assurance.

National Audit

Whilst there are pockets of good practice in taking forward learning gained from national audits and undertaking local clinical audits, the Clinical Board recognises this is an area for improvement. Each Directorate has an Audit Lead and the Clinical Board intends to undertake a review of these roles and its processes around national and local clinical audit before the end of the current financial year. This will focus on developing an annual audit plan for the Clinical Board that incorporates audits linked to its patient safety priorities, ensuring that the Clinical Board is learning from the benchmarking of performance that national audit provides, and developing improvement plans where appropriate.

The Clinical Board has presented to the UHB Clinical Effectiveness Committee on the National Audit of Inpatient Falls and Sentinel Stroke National Audit Programme (SSNAP) and examples of the local clinical research/audits undertaken are:

- Assessment of Blood Pressure (BP) Measurements of Older People in Hospital (including postural BP concordance)

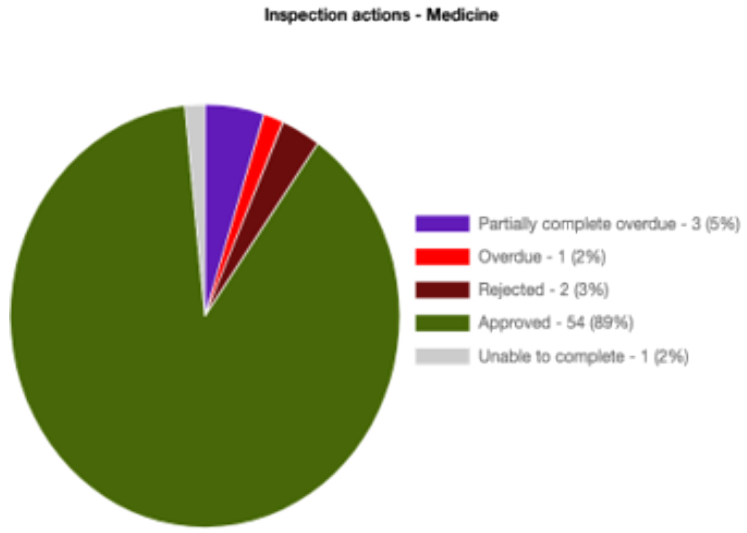
- ❖ Assessment of Hyperglycaemia in Patients Taking Steroids
- ❖ Lupus staff and service user evaluation
- ❖ Post-colonoscopy Colorectal Cancer JAG (Joint Advisory Group) Quality Assurance Standard
- ❖ Society of Acute Medicine Benchmarking Audit 2023

AMaT (Audit Management and Tracking) is key to this area and the Clinical Board has been driving the use of this system not only for audit, service evaluation and quality improvement but also to store and monitor its improvement plans relating to Healthcare Inspectorate Wales (HIW) / Community Health Council (CHC) / Health Education and Improvement Wales (HEIW) visits, NRIs, Concerns / Claims and Service Improvement.

The following inspections / visits have taken place within the Clinical Board and all improvement plans are stored on AMaT and presented at QSPE Committee:

- HIW: Emergency Unit, A7 (Gastroenterology), WAST and Patient Flow
- HEIW: Gastroenterology and Integrated Medicine
- CHC: Alcohol Treatment Centre, Emergency Unit, St David's

Three walkrounds have been conducted within the Emergency Unit following the HIW visit that took place in June 2022, providing assurance around actions taken. The below AMaT chart demonstrates current progress with actions following HIW inspections.



Patient Safety Advancements

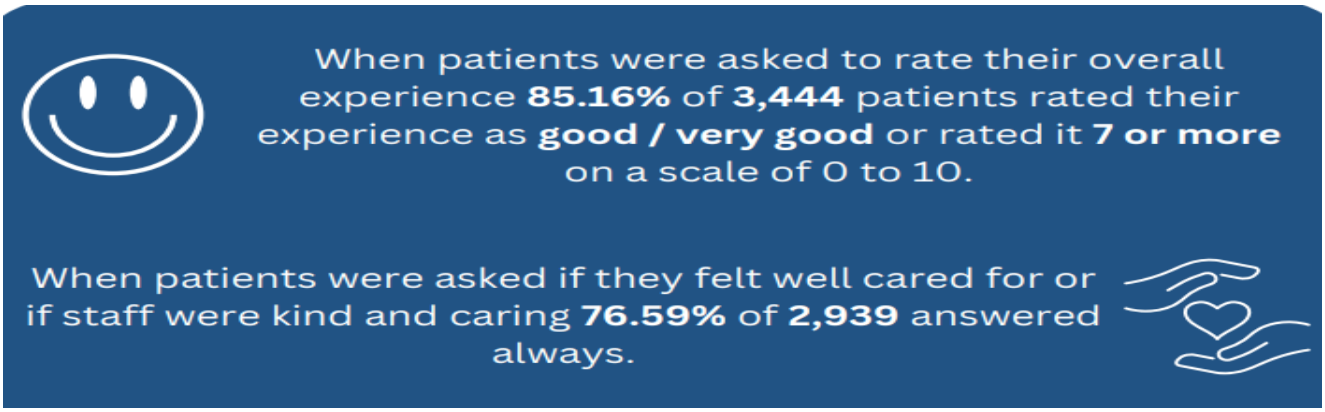
The Stroke Service is now using the Brainomix e-stroke Artificial Intelligence decision tool for stroke imaging across the UHB. This is a huge step forward in the stroke pathway, and we are the first Health Board in Wales to reach this stage of implementation. This supports doctors by providing real-time interpretation of brain scans to help guide treatment and transfer decisions for Stroke patients allowing more patients to get the right treatment in the right place at the right time. In addition, the Visionable One Pre-Hospital Video Triage for Stroke launched in September. The virtual triage project is focused on supporting WAST clinicians with pre-hospital advice and triage for suspected stroke patients which aims to improve patient outcomes, patient satisfaction and reduce mortality associated with Stroke.

A business case is currently being progressed to support a Respiratory Ambulatory Care Unit (RACU) model based in UHL. A RACU model represents a forward thinking, patient centred model of delivering care which has proven to be successful in other areas of the UK. RACU will facilitate joined up care based on 'home first' avoiding harm, waste and variation empowering people and delivering outcomes which matter to patients. It will also serve to offer a sustainable service which

provides the right care, in the right place first time and be central to managing demand and capacity within the Respiratory team. Patients discharged from an inpatient respiratory ward or under the care of a Respiratory Consultant can be followed up in RACU which has been evidenced to significantly reduce length of stay, leading to a potential reduction in inpatient beds.

Person Centred Care

Since the launch of Civica Once for Wales Patient Experience platform in October 2022, as at the end of August 2023, 19,852 patients within Medicine Clinical Board have been contacted. 21% of these patients presented via the Emergency Unit. Within this time period a response rate of 20% was received. Examples of responses are noted below:



A selection of comments left by patients within Medicine Clinical Board:

> Prompt referral by GP to MEAU at Llandough.A very long wait (busy day following Bank Holiday) but kind and professional care. Transferred to Heath Hospital 2 days later , stent fitted and discharged the following day. All very efficient.

> From the time I entered the A&E waiting area I felt very comfortable and relaxed in the surroundings. I was called for treatment very promptly within 20 mins of arriving and the whole treatment analysis process to having X-rays to final physiotherapist consultation was very professional.

> The system as a whole took too long to get a colonoscopy. I was told in April/early May by my GP they recommended I have a colonoscopy ASAP after my stool samples results. I then had to see two different consultants before I was referred for a colonoscopy. The earliest urgent appointment was end of June. Got my diagnosis of Crohn's disease the same day. So the system as a whole had too many barriers and hoops but I do understand the reasons behind and pressures on the NHS.

Concerns

Concerns between 01st March 2023 – 30th September 2023

The management of concerns remains a key priority for the Clinical Board. Tracker meetings across all Directorates are well embedded and captured via the Clinical Board tracker database. This system provides overview, prompting timely responses and actions when delays are identified. Other actions to improve the management of concerns include training for Investigating Officers, improved partnership working with the Patient Experience Team and early closure of concerns.

The Clinical Board aims to resolve all concerns by Early Resolution with contact from the relevant Ward Sister/Charge Nurse/Manager, Senior/Lead Nurse or clinician. From 01st March 2023 – 30th September 2023 the Clinical Board has responded to 247 concerns managed through Putting Things Right and 324 via Early Resolution. This is an improvement from the same time period the previous year where a total of 926 concerns were responded to. The themes and trends relate to communication, waiting times for referral/appointments, insufficient/incorrect treatment or assessment. Overall compliance for both Putting Things Right response and Early Resolution was reported as 61% on 12th October 2023; this is a slight deterioration from the same time period the previous year where 82% compliance was reported. Focused work is continuing around the timely completion of all concern's responses.

Case reviews are undertaken as part of Directorate Quality and Safety Groups to share any potential learning and themes. 'Learning from Events' and feedback from Welsh Risk Pool are shared at Clinical Board QSPE to inform shared learning and improve outcomes.

Patient Experience

All areas of the Clinical Board are engaged with the Patient Experience Framework.

The Clinical Board shares a patient story and compliments at Clinical Board QSPE each month to share good practice, highlight areas for improvement and learning outcomes. An example of a compliment recently shared at QSPE:

'On behalf of myself and my husband I would like to recommend Ward Sister Sarah Fergusson for the highest award the NHS can give, together with the amazing team on C4 Stroke Unit. My husband suffered a major stroke early February, the ambulance arrived within 8 minutes and the Emergency Unit had thrombolysis treatment ready promptly when he arrived. Michael was transferred to the Stroke Unit where he received exceptional care under the guidance of Dr Tom Hughes. When Michaels condition deteriorated it was Dr Hughes swift action in alerting surgeons and arranging a craniotomy procedure. This undoubtedly was the reason for my husband's amazing progress, and possibly instrumental in saving his life. Dr Hughes was extremely generous with his time, and was there for me to contact whenever I had any concerns.

Following surgery my husband spent 2 months on C4 where he received the highest level of care and support. The amazing leadership of Ward Sister Sarah Fergusson seemed to inspire a wonderful caring attitude in all her staff. Through difficult times when my husband suffered frightening nightmares, confusion and mental conflict the staff were tireless with their reassurance and understanding.

I should also mention Dr Shetty, who also inspired my husband and gave him hope of recovery through the principles of neuro-plasticity, and the work of the Early Discharge Team who have given such care and support since his discharge at the end of March.'

Timely Care

Emergency Unit

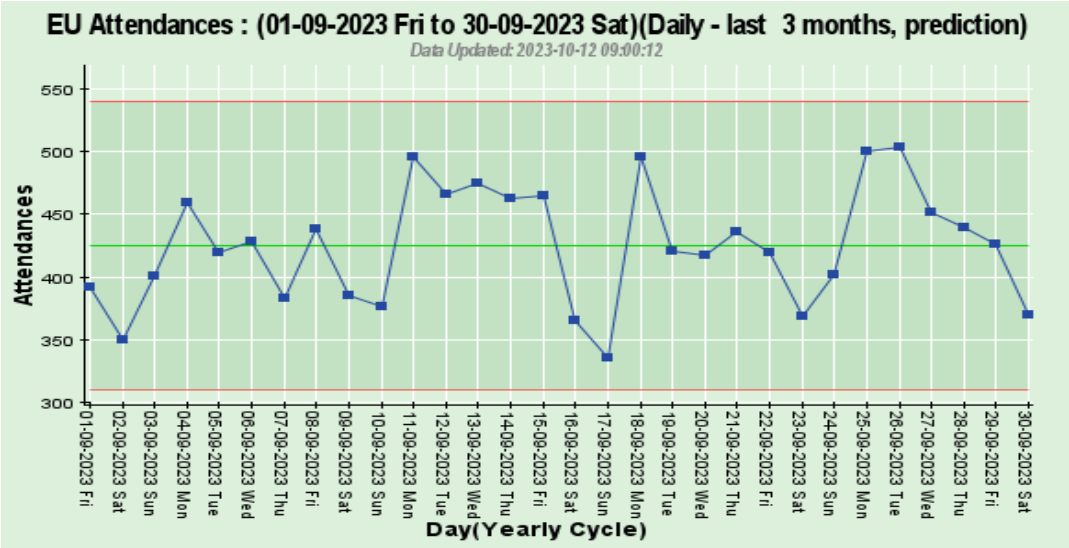
Significant transformational work is being progressed across the Emergency Unit (EU) footprint. The relocation of Acute Medicine has provided EU with the opportunity to reassess its footprint and associated clinical model. This will improve patient care, staff well-being and engagement and overall delivery of emergency care. Part of this re modelling includes the opening of both adult and paediatric Clinical Decision Units. These will provide emergency observational care for both adults

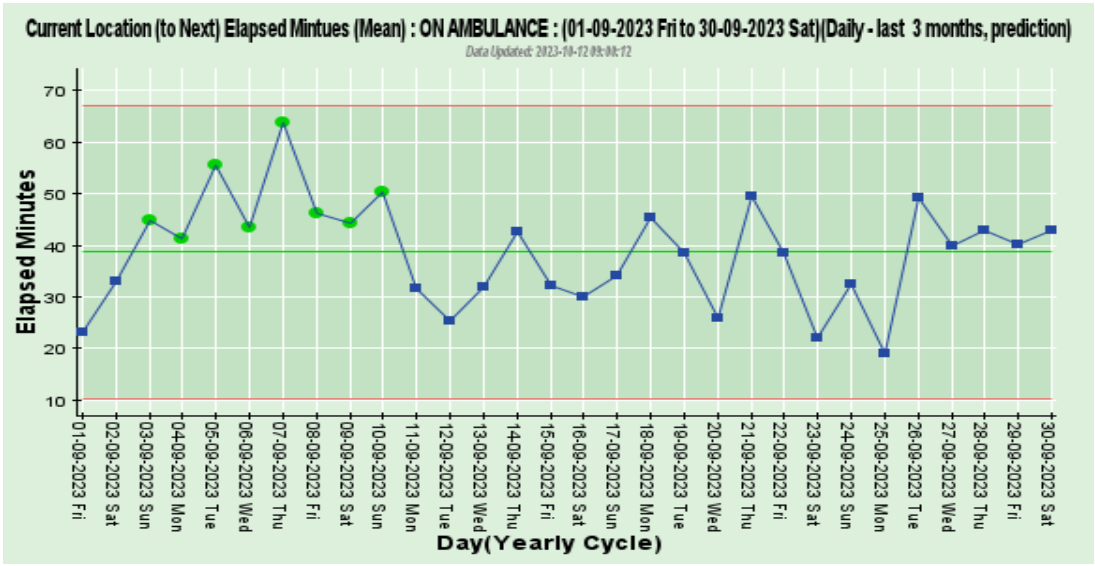
and paediatrics up to 24 hours, ensuring continuity of care, improved patient flow, reduced transfers and reduced admissions.

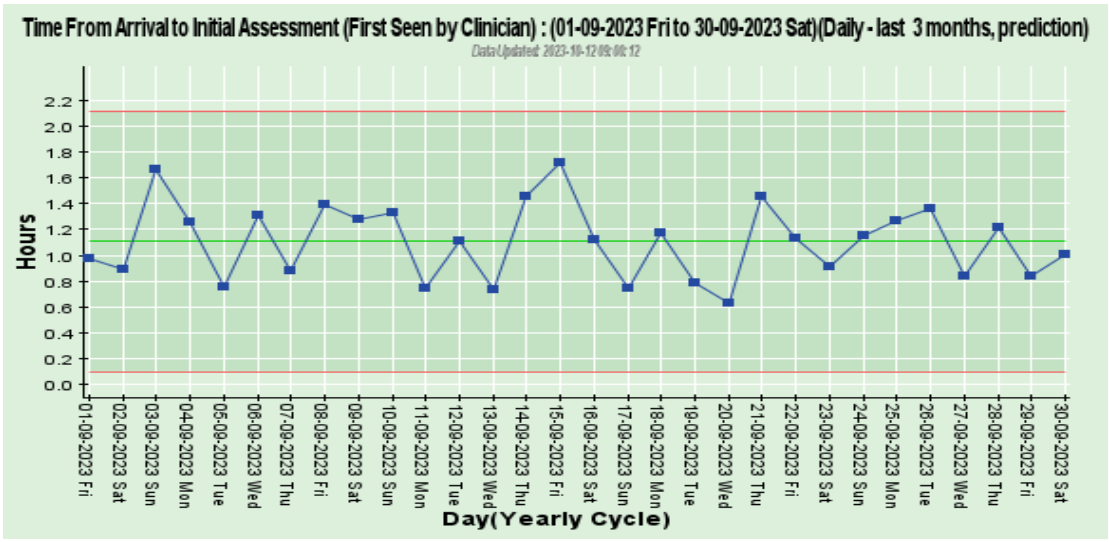
The EU 'front door model' is being revamped to support senior decision makers to provide RATZ/Streaming and Redirection from 08:00 – 00:00 daily. This area will be front loaded with senior decision makers to facilitate rapid triage, assessment, early decision making and treatment initialisation of ambulatory and minor injury patients who should be in the department for no more than 4 hours. This new area is fundamental to the efficiency and safety of the ambulatory areas, ensuring patients access the right care from the right place. Without this function there is a significant risk the ambulatory areas remaining congested and clinically unsafe.

Digital transformation work to enable task and workflow management within EU is progressing. This includes the development and integration of an Emergency Department Patient Management System to compliment the current EU Workstation. The system is a bespoke model specifically designed to manage the patient database, performance metrics, work flow and escalation procedures for both adult and paediatric patients within EU. The implementation of this system is critical to support efficient processes to deliver high quality patient care and will enhance the ability of EU to achieve both performance and quality and safety metrics.

E-Whiteboard allows areas to better manage patients referred from EU. It highlights patients in the area, clinical urgency and current status. This is currently used by Medicine and Surgery and will shortly expand to General Paediatrics. This allows for safer referral processes and audits of process.







Assessment Unit

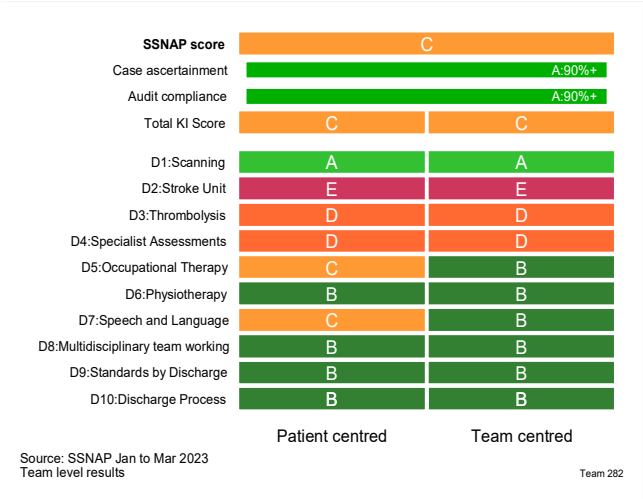
Since relocation of its assessment units, the Clinical Board is currently reviewing the new model, recognising that some patients have highlighted poor patient experience within the new footprint, specifically on A1L. The team is identifying how it can improve ways of working to reduce the time patients wait to be seen and to avoid over congestion in the waiting area which has been a recent common theme.

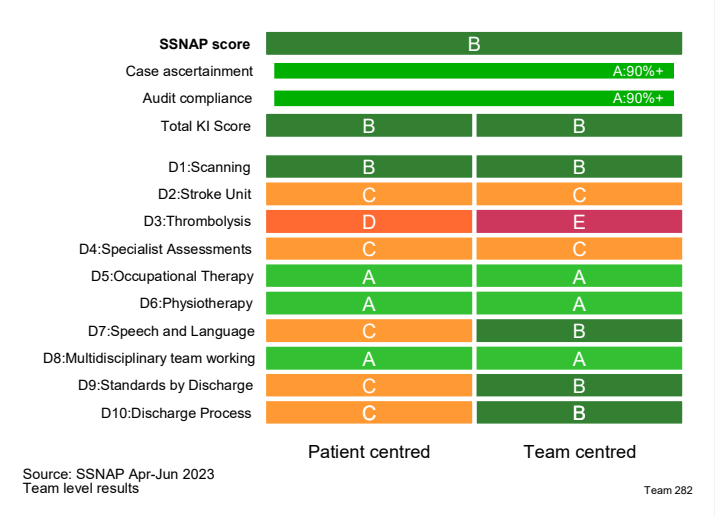
Welsh Nursing Care Record

The roll out of the Welsh Nursing Care Record continues within the community hospitals, improving efficiency and bolstering patient safety and quality of care. The Welsh Nursing Care Record allows the streamlining of administrative processes for our healthcare staff allowing more time to focus on patient care.

Stroke

SSNAP and Stroke Performance Monitoring UHW for January – March 2023 reported a SSNAP score C, this has improved from April – June 2023 to B.





Improvement has been noted in Door to Ward timeliness with patients reported as arriving on the Stroke Unit UHW at 67.9% in September with the median time reported as 03:52 hours. 80.5% of patients were seen by a Stroke Consultant within 24 hours, 91.0% by a Stroke Nurse within 24 hours and 83.3% received a swallow screen within 4 hours of presentation. Improvement opportunities remain around the scanning of patients within an hour of arrival which was reported as 46.7% for the time period April – June 2023, and the number of patients thrombolysed which was reported as 7.5% for the same time period.

Stroke Performance monitoring includes:

- Individual patient breach analysis
- Monthly Directorate and Clinical Board Executive reviews
- Monthly touchpoint meetings with NHS Executive around the specific improvement plan for Door to CT and Thrombolysis rates
- Quarterly SSNAP reports
- Stroke QSPE meetings

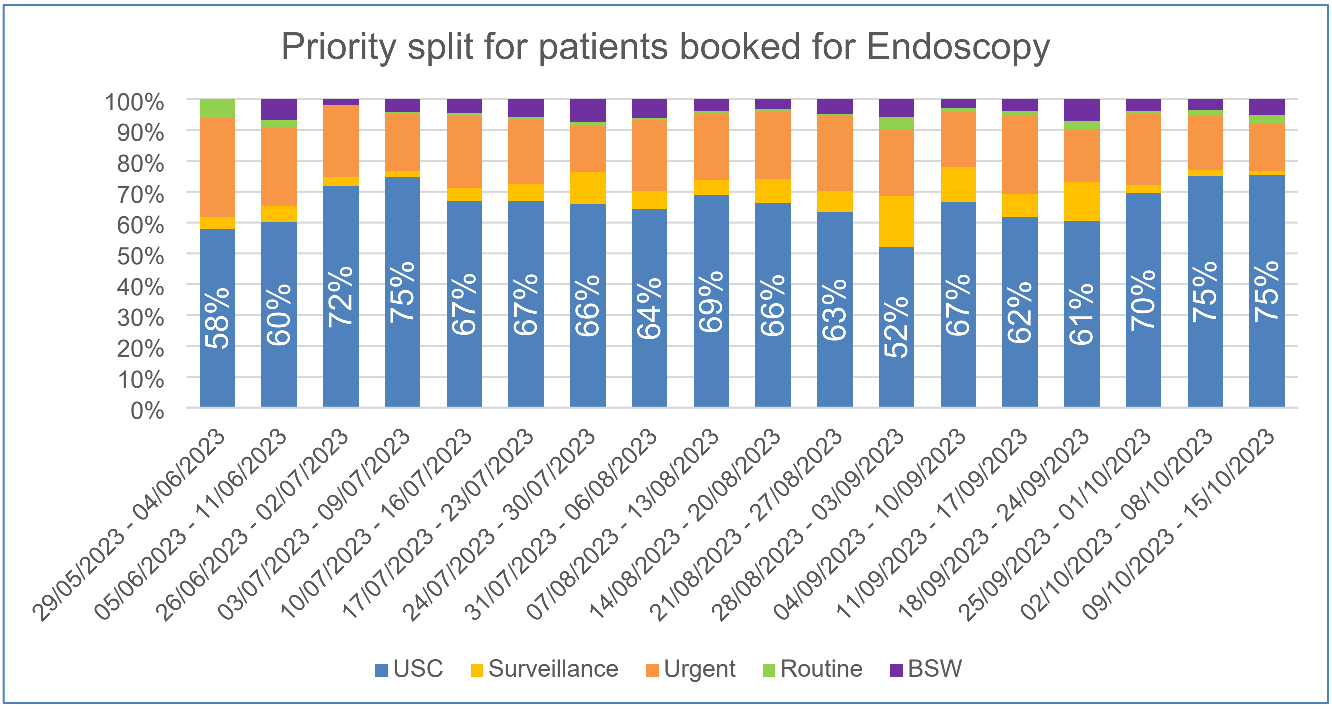
Endoscopy and Gastroenterology

Following the Covid-19 pandemic, the Endoscopy and Gastroenterology service has been under significant pressure to schedule patients for a variety of endoscopic and colonoscopy procedures secondary to:

- Reduced capacity throughout the pandemic as a result of Covid-19 guidance (AGP generating procedures) affecting the total number of patients that could be scheduled
- Changes to cleaning protocols during the Covid-19 pandemic delaying theatre capacity and turnaround (protocols have now returned to pre COVID cleaning standards which are proportionate and safe)
- Suspension of non-essential procedures in the initial stages of the Covid-19 pandemic increasing the backlog of patients
- Lack of capacity in the endoscopy units, currently being right sized through the endoscopy expansion business case
- Global demand or patients exceeding available capacity
- Nursing workforce shortage pre Covid-19 which allowed for staffing of 3 theatres rather than the 4 in operation for the last 12 months at UHL.

In 2021, as a result of the risks recognised surrounding the Endoscopy service, an overarching action plan to manage and mitigate the risks was developed, some of these actions remain open. Currently (October 2023) the Endoscopy department has over 6,000 patients on surveillance, diagnostic, therapeutics or Bowel Screening Wales (BSW) waiting lists. Secondary to the current

capacity and demand constraints the service has had to prioritise varying demands. Currently the focus is on the Urgent Suspected Cancer (USC) patient cohort.



Four of the Clinical Board current NRIs relate to Gastroenterology delays for treatment, surveillance and cancer diagnosis with Patient Safety Learning Reviews in progress. The Gastroenterology team is currently reviewing the overarching action plan with weekly meetings to ensure appropriate actions are defined, progressed and monitored via AMaT and Directorate/Clinical Board QSPE structures.

Efficient Care

E-Triage

Emergency Medicine are in the process of implementing e-Triage for patients presenting to the Emergency Department, it is anticipated that this will be in place before the end of the current financial year. E-Triage will allow patients to enter their demographics and history into e-Triage tablets and be asked simple, easy to read questions which react in real-time to take an accurate and safe clinical history. This process takes approximately 3-4 minutes to complete which safely reduces Emergency Department waits. The clinical history provided by the patient is auto-triaged aligned to the Manchester Triage System identifying those patients who need to be seen clinically first. If a patient flags as a medical emergency staff are alerted immediately to take appropriate action.

6 Goals

As part of the Health Board 6 Goals, Lakeside Wing Wards 1 and 2 are participating in the Get Up, Get Dressed, Get Moving campaign to reduce patients deconditioning whilst in hospital, with great engagement from all multidisciplinary team members.

The education needs of staff are being reviewed, linking in with falls, enhanced supervision and Dementia work including staff and patient questionnaires to aid in identifying and reducing knowledge gaps, and improving engagement. The addition of Tendable audit ‘End PJ Paralysis’ will also support our clinical areas and patients for falls prevention and deconditioning.

The Clinical Board have 7 wards that are ready for Bronze Ward Accreditation. Ward C4 Stroke Bronze Pathway commenced 28th September 2023.

Nursing Team	Tendable Core Standard and Core IPC Audit	Target	Tendable Care Specific Audit	Target	Tendable Senior/Lead/Midwife Audit	Target	Safecare Census Frequency %	Target	Ready for Bronze Pathway	Bronze Pathway Start Date
East Eight Ward Llandough - LE8	92%	83%	83%	50%	100%	50%	87%	80%	Ready	
C4 South - Stroke/Medicine	100%	83%	100%	50%	83%	50%	93%	80%	Ready	28 September 2023
East 6 Ward Llandough - LE6	100%	83%	100%	50%	83%	50%	81%	80%	Ready	
Sam Davies Ward Barry - SAM	100%	83%	100%	50%	67%	50%	83%	80%	Ready	
West 2 Ward Llandough - LW2	100%	83%	100%	50%	67%	50%	89%	80%	Ready	
East 4 Ward Llandough - LE4	92%	83%	100%	50%	50%	50%	91%	80%	Ready	
Older Persons Acute Medical Unit - A1S	100%	83%	100%	50%	50%	50%	96%	80%	Ready	

EU has secured funding for a Junior Clinical Fellow to support the creation and embedding of Hospital Health Pathways. These provide secondary care clinicians with access to a suite of localised pathways, reflecting the agreed pathways within the UHB and promote standardised ways of working to reduce duplication, inconsistency and confusion promoting a prudent approach to care.

Equitable Care

The Clinical Board recognises the challenges presented, particularly around technological advancements and biologic therapies to meet NICE Guidelines and deliver equitable care. For example, as a result of technological advancements in Diabetes management, new NICE Guidelines will set out a requirement that Hybrid closed loop systems (Insulin pumps) are offered as an option for people with Type I Diabetes who experience difficulty managing their condition. Accounting for the current resource of the pump team within Diabetes, the anticipated increase in the number of patients qualifying for the new technology, and the requirements which should be followed before commencing this treatment, the Clinical Board currently cannot comply with these Guidelines, and there will be an increase in the waiting list for pump therapy.

The Cystic Fibrosis (CF) team are working with Value Based Healthcare regarding bronchiectasis care and the patient journey through our services. This involves plotting care between all healthcare professionals in both primary and secondary care. It is presenting to the British Thoracic Society in December on re-designing the Bronchiectasis service around what patients want within a clinical care setting. As Cystic Fibrosis has been considered an exemplar they have been invited to work with WHSSC and the Lead CF Pharmacist around Clinical Outcome Measures looking at drugs versus value for money from high cost drugs such as CFTR modulator therapies.

The local paediatric population has increased, as has the expected standards of care due to the Paediatric Emergency Unit now delivering the Paediatric Major Trauma Centre service for South Wales. The new improved larger Paediatric Emergency Unit will bring the department in line with national capacity requirements for paediatric emergency units and acute paediatric assessment units.

CLINICAL BOARD GREATEST RISKS

The Clinical Board's highest risk, scoring 25, relates to Gastroenterology and endoscopy waiting times and cancer surveillance. As already referenced, there is an extensive waiting list resulting in patients waiting a significant amount of time for appointments, in some cases between 1 – 3 years, and there is a significant risk harm will come to patients as evidenced by the reported NRIs. The Endoscopy Action Plan to manage and reduce the risk is being reviewed and updated and includes clinical validation of the waiting list however further more sustainable measures are required to

satisfactorily reduce the risk such as increased capacity and a digital solution to support the management of waiting lists.

The Clinical Board also holds high risks around stroke and timely thrombolysis and thrombectomy treatment as already detailed in the report and contained within the Board Assurance Framework.

Other high-level risks relate to:

- Speciality components of Gastroenterology – service with single handed operator (Home Parenteral Nutrition) (20↔)
- Rheumatology – increase in patients waiting over 52 weeks (20↓)
- Staffing – Nursing and Medical (16↓)
- EU flow (15↓)

Recommendation:

The Committee is requested to:

a) NOTE the assurance provided by the Medicine Clinical Board in this report and the steps being taken to improve quality, safety and patient experience across Medicine.

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	√	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	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
As outlined in report.
Safety: Yes
As outlined in report.
Financial: Yes
There can be a financial impact connected with inadequate quality and safety standards as a result of legal claims. Improving standards can lead to an increase in expenditure whether for staffing or digital / equipment solutions. Financial penalties can also be imposed where required standards are not met.
Workforce: Yes
As outlined in report.

Legal: Yes	
As above.	
Reputational: Yes	
There is a reputational risk for the Clinical Board and the organisation when quality, safety and patient experience is not satisfactorily delivered.	
Socio Economic: No	
Equality and Health: Yes	
As outlined in report.	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Cardiff and Vale UHB Mortality					Agenda Item no.	2.2.1
Meeting:	QSE Committee		Public	X		Meeting Date:	28th November 2023
			Private				
Status *(please tick one only):*	Assurance	X	Approval			Information	
Lead Executive:	Executive Medical Director						
Report Author (Title):	Interim Head of Safety, Quality and Organisational Learning and Assistant Director of Quality and Patient Safety						

Main Report

Background and current situation:

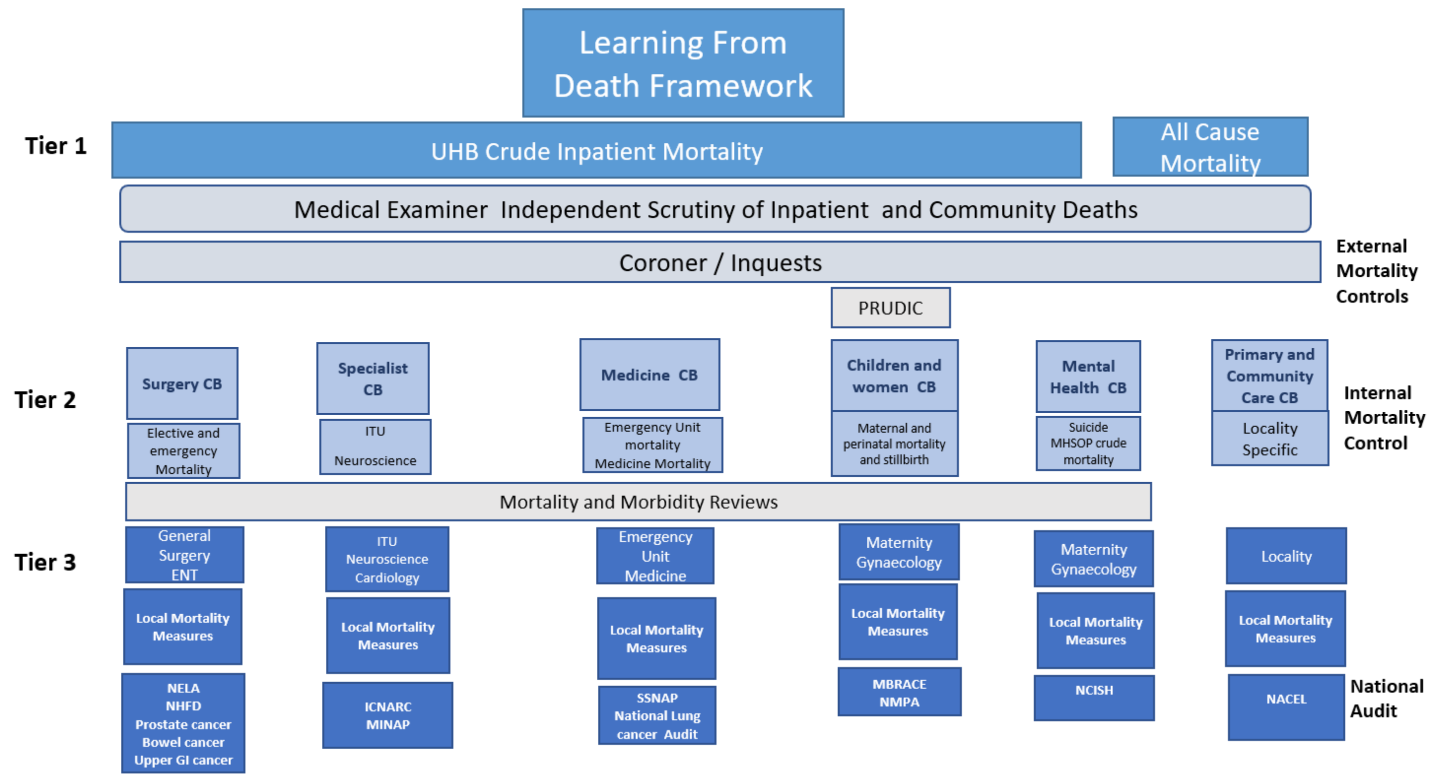
Background:

Mortality rates are an important measure of the safety of a healthcare service. At organisational level, mortality rates can indicate significant population wide impacts, such as the impact of Covid-19. However, this measure is not sensitive enough to identify variation in individual populations or services. It is therefore, important that mortality information is accessible and is subject to ongoing scrutiny as part of the quality and safety processes at all levels within the organisation. This paper sets out the key sources of mortality information and how it is used to ensure the safety of the services provided by the Health Board.

In November 2022 the Quality Safety and Experience committee agreed a three-tier approach to monitoring mortality across the UHB.

Tier 1 – Health Board level Indicators
Tier 2- Clinical Board level Indicators
Tier 3- Specialty Level Indicators

Since November 2022 the UHB Learning from Mortality group has matured to provide greater oversight and scrutiny of these mortality indicators and Clinical Board Quality and safety functions are starting to monitor and review tier 2 indicators.



Statistical Reporting of Mortality

Many of the sources of mortality data include comparison with other healthcare organisations. This benchmarking is valuable in assessing how the Health Board's services are performing, however it is important to consider the methodologies used to achieve this comparison

The following glossary of statistical reporting definitions will support understanding of condition specific and department specific mortality throughout the report

<u>Crude Mortality</u>
Crude mortality measures the actual number of patients who have died and was used to monitor increases in mortality rates above the previous five-year average throughout the Covid pandemic.

<u>Observed mortality</u>
Observed mortality is the percentage of patients that have died over a given time period and is calculated by dividing the number of deaths by the number of patients. This can be useful in identifying variation in mortality rates within a department or organisation over a period of time but does not support comparison with other originations.

<u>Adjusted Mortality</u>
Adjusted mortality refers to mortality rates that are adjusted to take into account the predicted risk of deaths by considering several factors including the comorbidities and age of patients. Risk adjusted mortality allows organisations' with differing patient populations to be compared with one another.

In order to make meaningful comparisons between services or organisations, some form of risk adjustment is required to account for variation in patient populations. For example, Cardiff and Vale UHB are a major trauma center, provider of level three critical care services and neurosurgery and therefore critical care mortality should be adjusted before it can be compared to critical care outcomes in a district general hospital.

Funnel Plots

A funnel plot is a scatter graph that supports more accurate interpretation by superimposing control limits around datapoints. These limitations are reported as two or three standard deviations (SD) either side of the mean. In the funnel graphs illustrated in this report the Y axis illustrates the mortality rate and the X axis the number of procedures or clinical cases care for in an organisation. An organisation that is scattered widely from the mean represents wider variation. Scatter points that are sitting outside the second or third SD control limits indicate special cause variation and should be subject to enhanced scrutiny to understand the reasons for the mortality rate.

Box Plots

A box plot is a method to graphically demonstrate the organisation's position within their second and third quartile and sometimes whiskers or lines are included either side of the box plot which represents the first and fourth quartile.

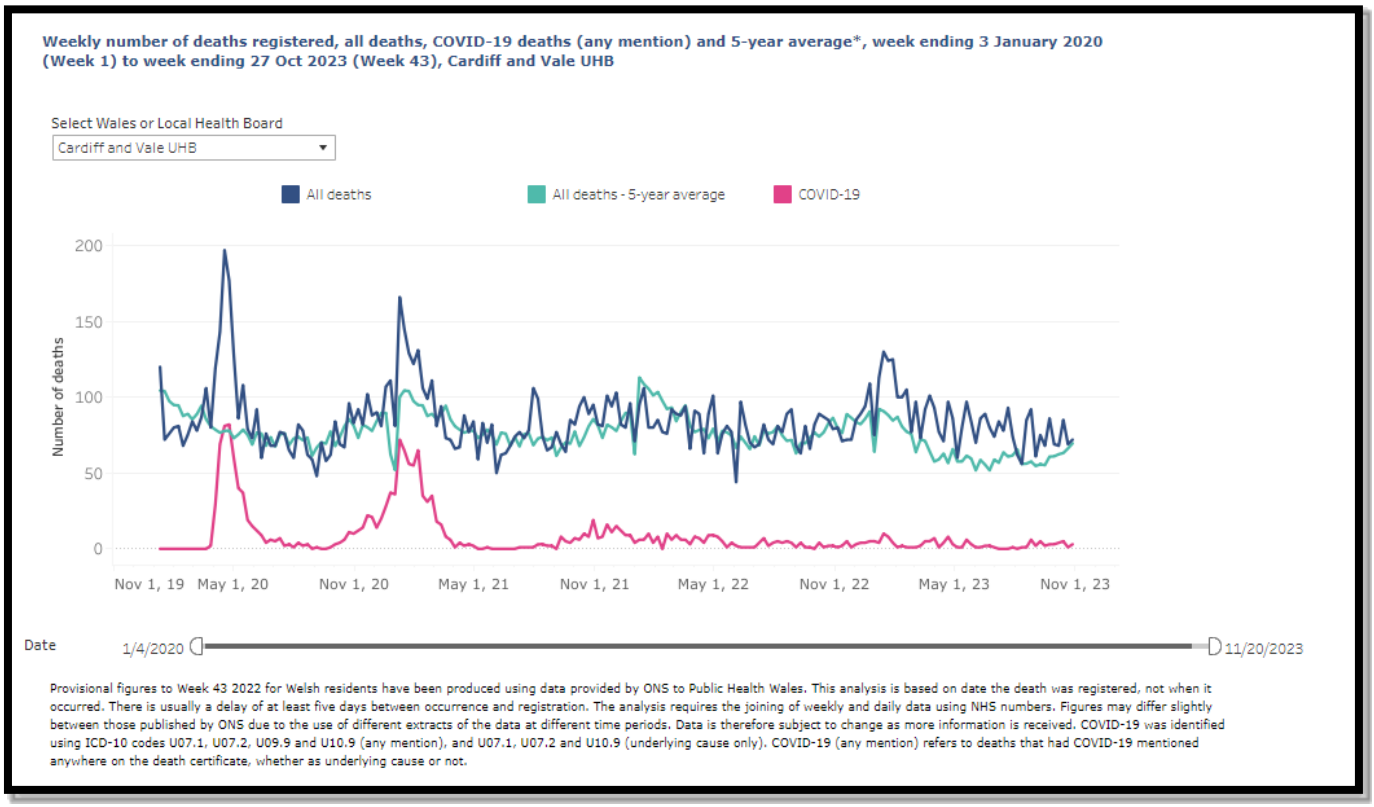
Tier 1 indicators:

Crude mortality may hide significant differences between sub-groups e.g. age, gender or ethnicity that can be important indicators of inequalities in health. In addition, crude mortality might not be sensitive enough to identify changes in mortality rates in a single specialty. The impact of Covid was significant enough to show an increase above the five-year average and can identify seasonal changes in mortality due to influenza or respiratory illness. Crude mortality can provide assurance as part of the stratified approach described.

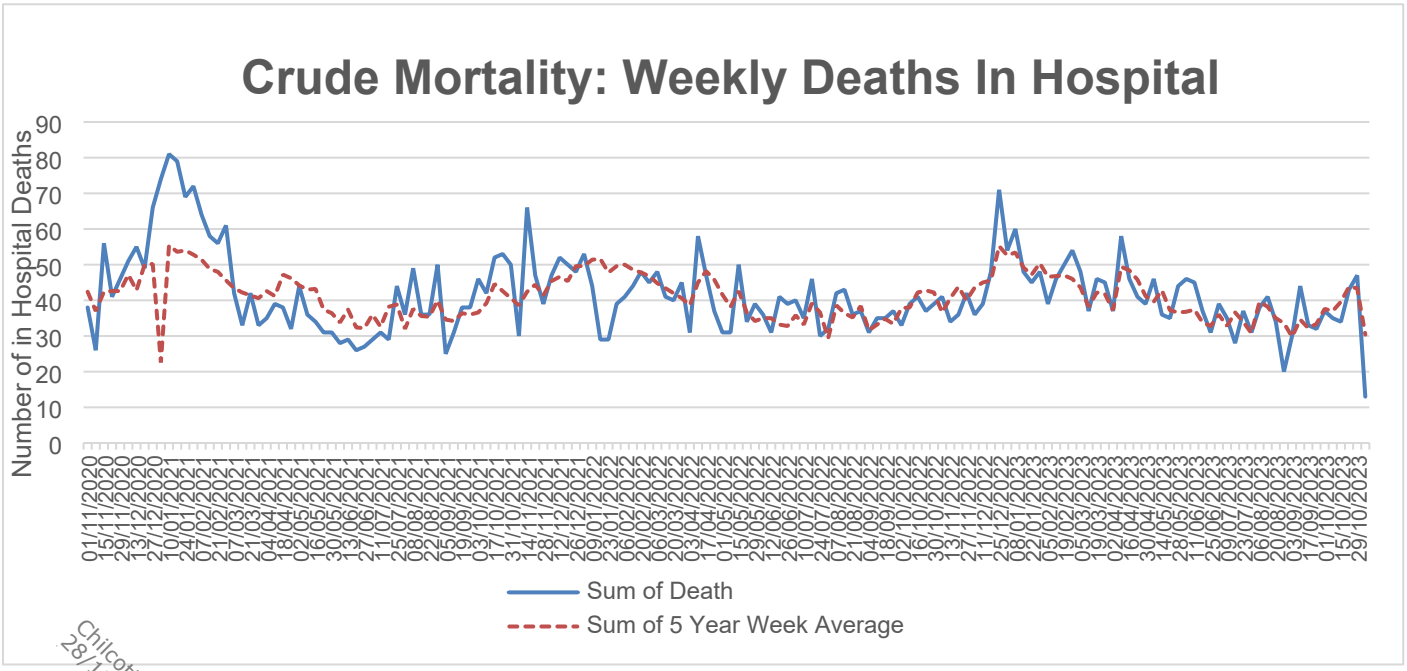
Crude mortality compares the number of deaths across the entire population to the average for the same reporting period over the previous five years and supports identification of trends above or below this average. The measurement of all-cause crude mortality was useful from the outset of Covid as a measure of excess deaths relating to Covid.

The crude all-cause mortality chart below 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. An increase above the five-year average has been noted across wales since January 2023.

Cardiff and the Vale of Glamorgan all-Cause Mortality



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 reported week. The solid blue line demonstrates the rolling crude inpatient mortality rate compared to the 5-year average for the same reporting week (dashed red line), with the exception of March 2020 and December 2020 to February 2021, the first and second waves of Covid-19. Inpatient crude mortality continues to track the five-year average



Chilcott Rachel
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Tier 2 indicators:

The identification of Clinical Board mortality indicators supports the proposed approach to mortality oversight. Learning from mortality can be achieved by identifying trends in mortality data that supports additional actions and scrutiny. These measures will include:

- Systematic reporting of mortality at Clinical Board Quality and Safety meetings or a similar forum.
- Triangulation of information from the Medical Examiner where increases in mortality rates are noted, e.g. if stroke deaths are observed to increase, thematic reviews of Medical Examiner referrals relating to this specific patient group should be undertaken to identify any contributory factors.
- Case note reviews will be considered to provide assurance in the absence of other patient specific clinical reviews.
- Presentation of mortality themes and trends at the Health Board Learning from Mortality Group to support organisational learning.

Children & Women Clinical Board

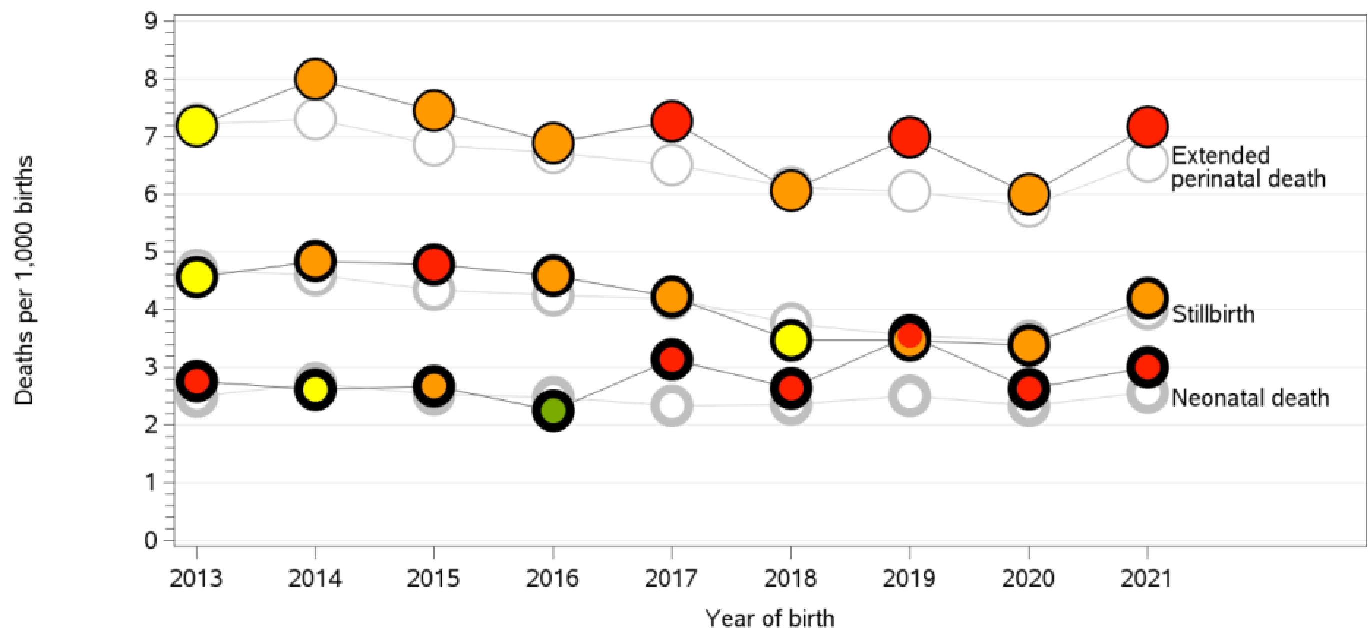
Perinatal mortality
Perinatal and maternal mortality is primarily captured through the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) audit programme. MBRRACE publish recommendations from analysis of national data, with the reporting period 2019-2021, published in October 2023. These recommendations are used to inform processes and practices within the Health Board's maternity and neonatal services.

MBRRACE publishes neonatal and still birth mortality rates for each participating NHS Trust and Health Board, with neonatal mortality defined as deaths of babies born live but who die within 28 days of birth, and stillbirth as intrauterine deaths that occur from 24 weeks gestation onwards.

Stabilised & adjusted mortality by year of birth (all deaths)

Stabilised & adjusted mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

Due to updates to the data and improvements to the statistical methodology used, these results might differ slightly from those in previous reports.



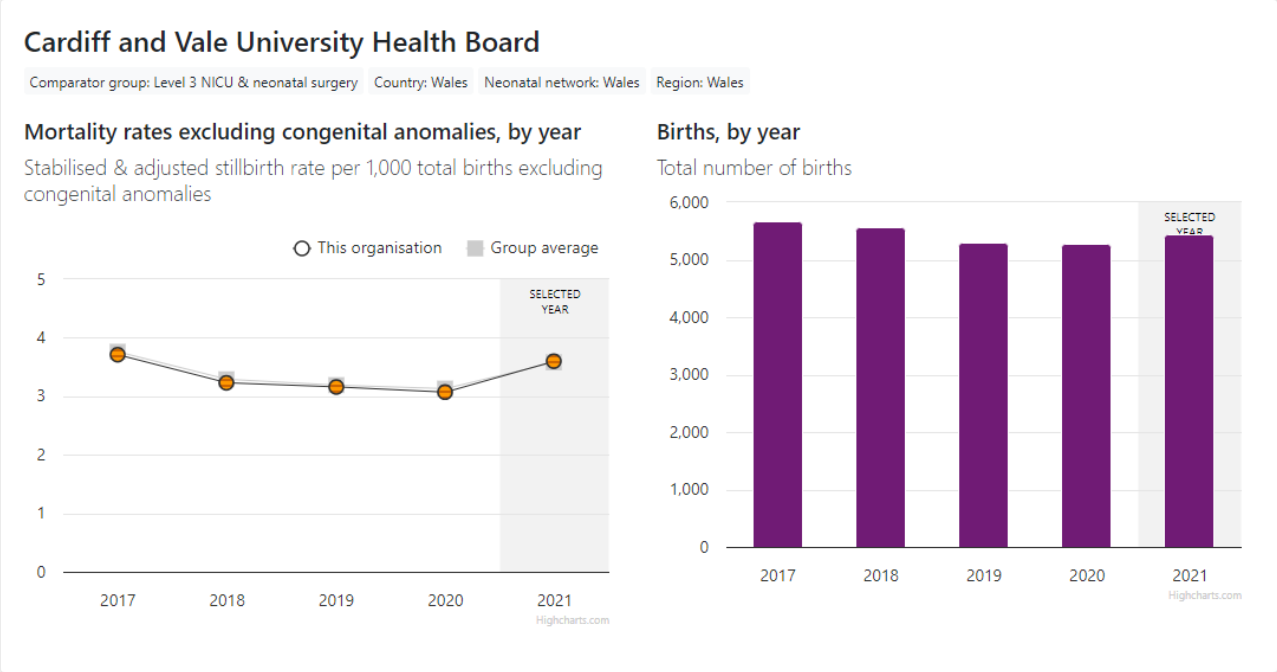
The most recent MBRRACE publication reports that Cardiff and Vale UHB neonatal mortality (2021) has an adjusted neonatal mortality rate of 3.00 per 1000 births, with the expected range of 2.05 to 4.43. Despite being within the expected range the neonatal rate is noted to be 5% higher than the comparator group average.

The perinatal mortality tool programme supports a standardised perinatal mortality review across NHS maternity and neonatal units in England Scotland and Wales. The process supports multi-disciplinary review of circumstances and care leading up to every stillbirth and neonatal death.

The outcome of the 2021 Perinatal Mortality Review Tool (PMRT) reviews for neonatal deaths in the UHB have demonstrated that UHB review outcomes are in line with national rates. These reviews have supported learning and improvement around the management of thermoregulation, infection prevention and control and hypoglycemia has also supported the development of a maternity improvement plan to reduce the risk of hypoxic- ischaemic encephalopathy.

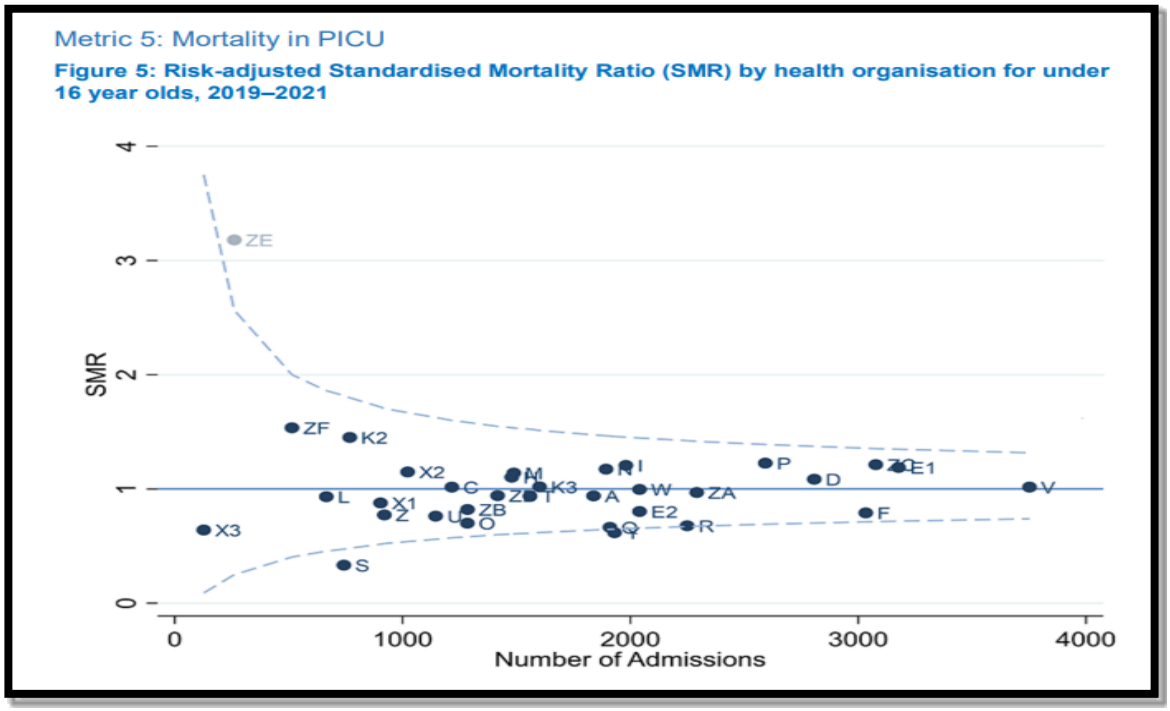
PMRT outcomes	**National March 2020-February 2021**	**National March 2021-February 2022**	**C&V 2021**
A – No issues with care identified	55% (1434)	50% (1400)	50% (8)
B- Care issues that would have made a difference to the outcome	28% (721)	31% (867)	31% (5)

C- Care issues that might have made a difference to the outcome	14% (357)	14% (394)	19% (3)
D- Care issues which were likely to have made a difference to the outcome	3% (83)	4% (124)	0%



Stillbirth rates in Cardiff and Vale UHB are within 5% of the comparator group average, with a rate of 4.20 per 1000 total births within the expected range of 3.23 to 5.39 and a comparator average of 4.01 still birth per 1000 births. As Cardiff and Vale UHB hosts a fetal medicine service, it cares for patients who are carrying babies known to have congenital fetal abnormalities. These abnormalities are often incompatible with life, so a more representative comparison of mortality rates is achieved with the exclusion of congenital anomalies. This measure gives a stillbirth rate of 3.60 per 1000 total births within an expected range of 2.94 and 4.4 per 1000 births (comparator average 3.58).

Paediatric Intensive care Unit
Additional mortality data are collected regarding children cared for on Paediatric Intensive Care as part of the national Paediatric Intensive Care Audit. The most recently published data (2019-2021) shows the risk-adjusted Standardised Mortality Ratio (SMR) for the Noah's Ark Paediatric Intensive Care Unit is within the expected range for the number of admissions and in line with the national mean:



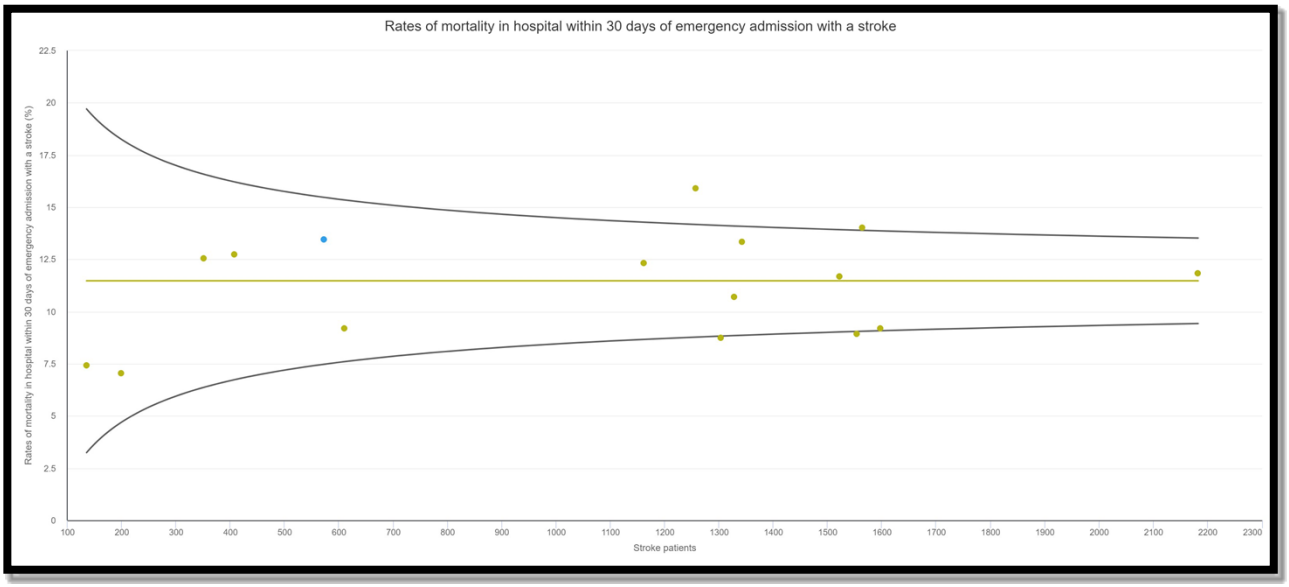
●***C*** = *Cardiff and Vale UHB.*
https://www.picanet.org.uk/wp-content/uploads/sites/25/2023/03/PICANet-State-of-the-Nation-Report-2022_v1.0-09Mar2023-pub.pdf

Medicine Clinical Board

The development of a Medicine Clinical Board mortality dashboard will support greater oversight and scrutiny of Tier 2 mortality indicators and will support the ability to cross reference of quality indicators including sepsis management with the tier 2 indicators including mortality relating to, EU, Major Trauma Centre, stroke, sepsis and mortality amongst patients who are medically fit for discharge.

Stroke
The timeliness of care in the hours immediately following a stroke are key in improved survival rates and outcomes. This is illustrated by the improving survival rates noted nationally amongst patients who have an intracerebral hemorrhage (12% of all strokes) where survival rates have increased from 29% to 33% in the past ten years, largely due to access to specialist care. The stroke mortality reported below is for the period August 2022 to August 2023.

30-day inpatient mortality following a stroke



● = *Cardiff and Vale UHB,* ● = *Peer Health Board/Trust*

UHB mortality for the period August 2022 to 23 illustrates that stroke mortality is within the expected range however, above the mean The Health Board performance around the timeliness of admission to the acute stroke unit has improved since the beginning of the year with 57.3% of patients admitted within four hours between April and June 2023 compared with 34% in January to March and a further improvement to 67.9% observed in September.

80.5% of patients were seen by a stroke consultant within 24 hours between April and June 2023 with a further improvement observed in September (87.1%).

89.9% of patients were seen by a stroke Nurse within 24 hours between April and June 2023 and a further increase to 91.9% in September 2023.

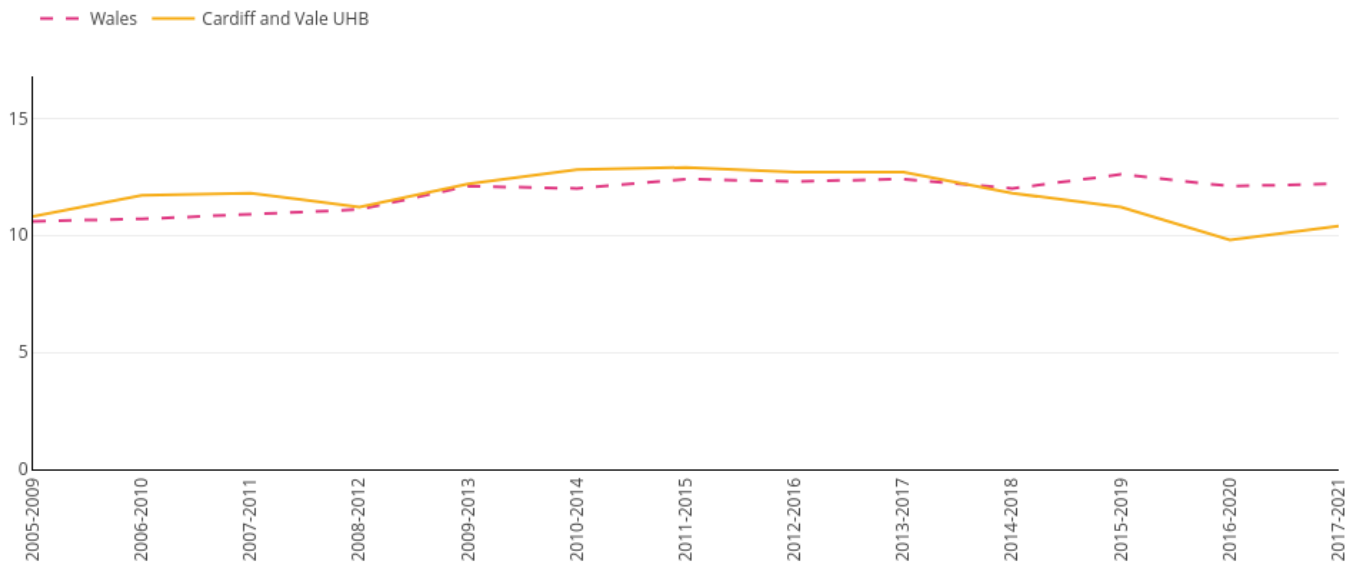
68.7% of patient receiving a swallow assessment within four hours of admission between April and June 2023 with a further improvement to 83.3% in September 2023.

Work to improve timely access to thrombolysis is underway.

Mental Health Clinical Board

Suicide*:*
Population rates of deaths by suicide can be calculated either by date of registration of death or date of death. The Public Health Wales Observatory currently uses the PHOF tool (which is due to be updated in December) to give an indication of the trends using date of registration PHOF_Dashboard.knit (shinyapps.io). The graph below shows Suicide rates in Cardiff and the Vale of Glamorgan have been comparable to those across Wales since 2005, but more recently, the rate has shown a reducing trend in Cardiff and Vale UHB. The Observatory are also collating data reported by date of death, however, this data will not be available until December 2023.

Figure: Suicides, EASR per 100,000, persons, Wales, Health Board, 2005-2009 to 2017-2021
Produced by Public Health Wales Observatory using PHM & MYE (ONS)

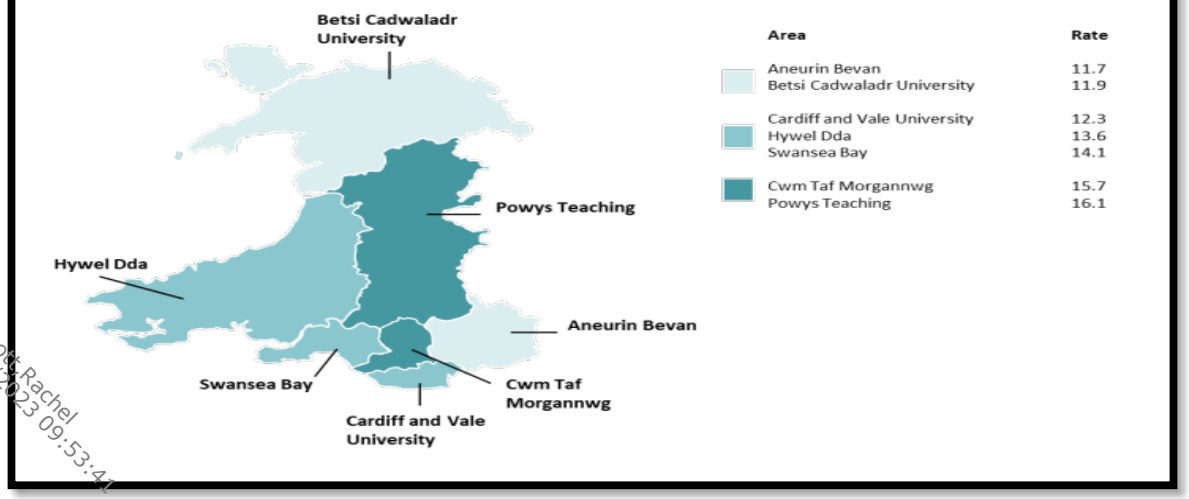


UHB Suicide rates are also captured through the National Confidential Enquiry into Suicide and Safety in Mental Health (NCISH). NCISH reports suicide rates across all UK nations and reports on themed topics. Suicide rates in Wales per 100 000 population are higher than in England and Northern Ireland but have been decreasing since an observed rise in 2017.

Between 2010-2020 28% of individuals who died by suicide were under the care of mental health services or had been recently discharged. Of these patients 23% were noted to have missed their last appointment with services and 12% had not taken their medication as prescribed.

The map below shows data from the most recent report published in March 2023. Cardiff and Vale UHB rates of suicide are 12.3 per 100,000 population in 2010-2020 compared with the UK rate of 11.2 per 100 000 population for the same period.

Figure 1: Rates of suicide per 100,000 population, by Health Board of residence (average rate 2018-2020)



The introduction of suicide awareness and mitigation training programme in 2022-23 assists staff working with people experiencing suicidal thoughts to understand the various risk factors, communicate in a compassionate way and agree a safety plan with the individuals. This programme is to be extended beyond mental health Clinical Board.

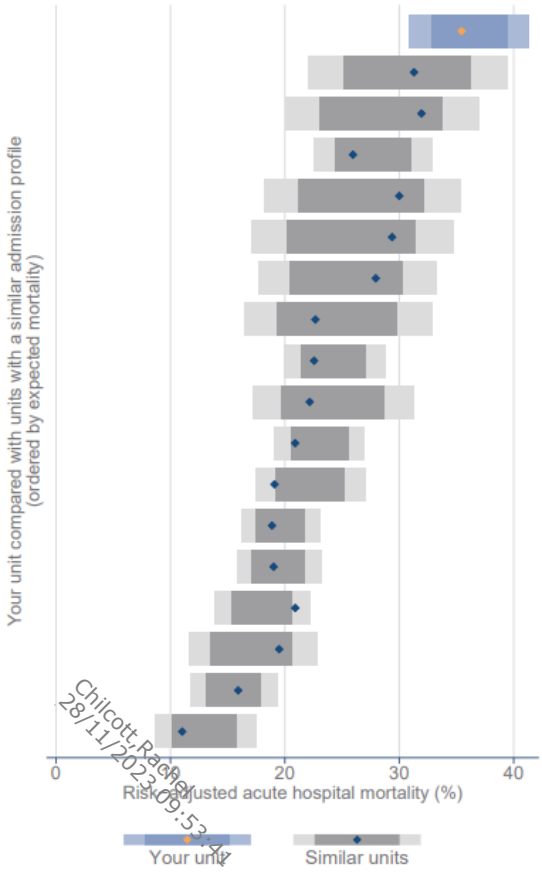
The UHB participates in a multi-agency suicide prevention forum that support work to reduce deaths from suicide recognising that the majority of these deaths by suicide occur in the population who are receiving care from mental health services.

Specialist Services Clinical Board

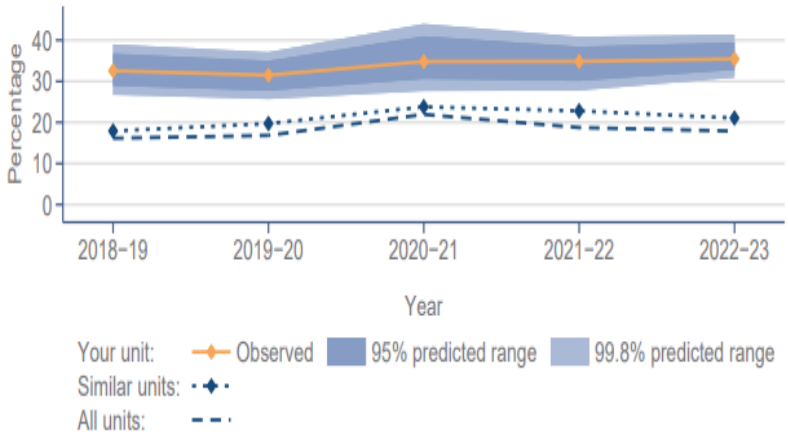
Intensive Care Unit
The Health Board participates in the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme (CMP), which audits patient outcomes from all adult general critical care units in Wales, England and Northern Ireland.

The mortality rate (35.4%) as illustrated by the orange dot illustrates an observed mortality rate above that of similar units in the comparator group for the period April 2022- March 2023, however the box plot illustrates that the UHB mortality rates is in line or below the expected percentage of 36.2% and within the expected range of 32.8- 39.4%.

Variation in observed rates between originations can be accounted for by the differences in the case mix, acuity and morbidity of the patients compared for the UHB compared with critical care units in the comparator group.

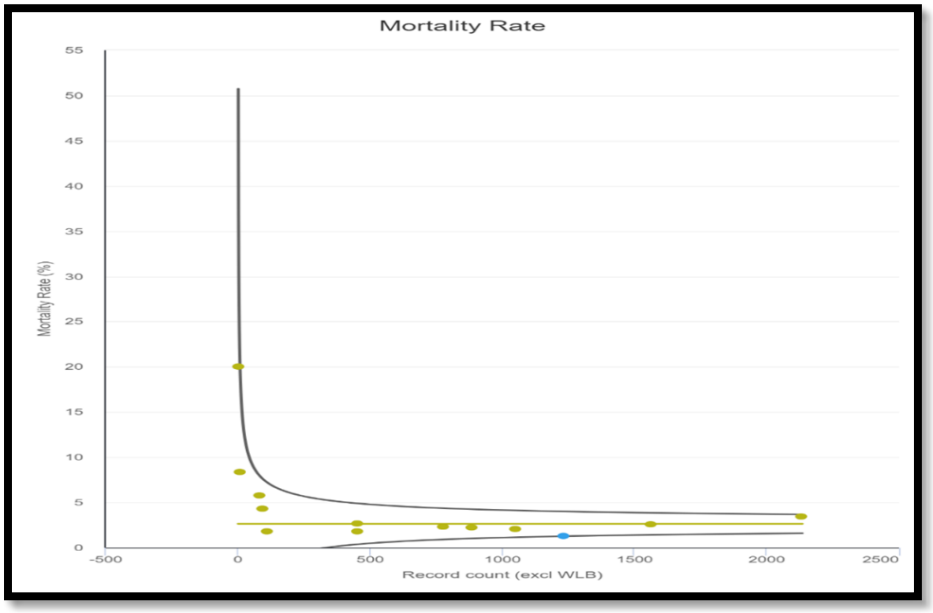


	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range
Quarter 1	274	257	35.8	36.8	(30.7, 42.5)	(27.4, 46.0)
Quarter 2	253	239	36.4	38.4	(32.0, 44.4)	(28.6, 48.0)
Quarter 3	322	274	31.8	34.5	(28.7, 40.0)	(25.6, 43.3)
Quarter 4	306	223	38.6	35.2	(28.7, 41.3)	(25.3, 45.0)
Full year	1155	993	35.4	36.2	(32.8, 39.4)	(30.9, 41.4)



Cardiothoracic Surgery
The Health Board has access to and contributes data to the CHKS system. This allows mortality rates, among other data, to be benchmarked against comparable NHS Health Boards and Trusts. Mortality rate data can be viewed at specialty level – funnel plots for cardiothoracic surgery and neurosurgery are shown below.

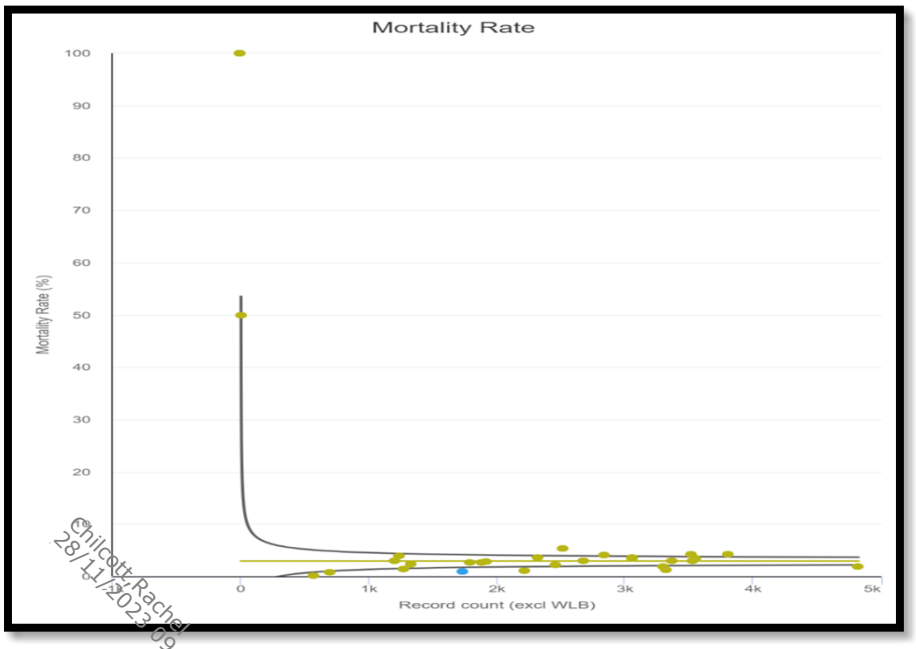
Cardiothoracic Surgery:



Data from Sep 22 – Aug 23, the most recently available peer group data.
● = Cardiff and Vale UHB, ● = Peer Health Board/Trust

The above plot shows that the mortality rate for cardiothoracic surgery is within the expected range for the number of cases undertaken and is lower than peer comparators with similar case numbers.

Neurosurgery*:*



Data from Sep 22 – Aug 23, the most recently available peer group data.
● = Cardiff and Vale UHB, ● = Peer Health Board/Trust

The mortality rate for neurosurgery is lower than expected for the number of cases, indicating better than average performance among the peer comparison group for the reporting period September 2022 to August 2023.

Renal services:
Data on renal services within the UK is collected by the UK Kidney Association. The most recent publication (2023) covers data from 2017-2020. 1-year survival rates for adult patients on Kidney Replacement Therapy (KRT) are shown below, with Cardiff and Vale UHB being within the 95% expected range for the number of KRT patients.

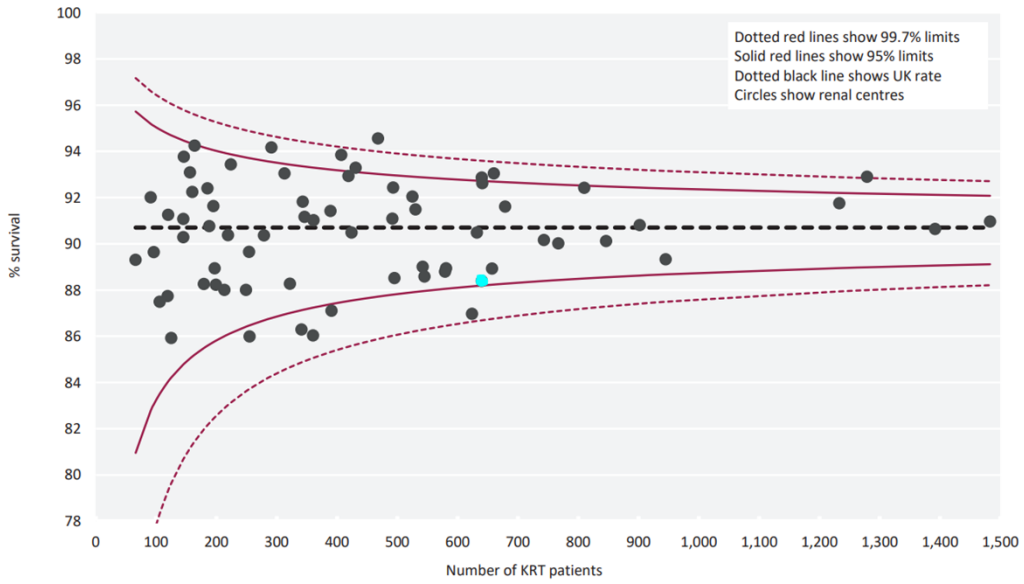


Figure 2.24 1 year after 90 days survival (adjusted to age 60 years) of incident adult KRT patients by centre (2017–2020 4 year cohort)

● = *Cardiff and Vale UHB,* ● = *Peer Health Board/Trust*

Surgery Clinical Board

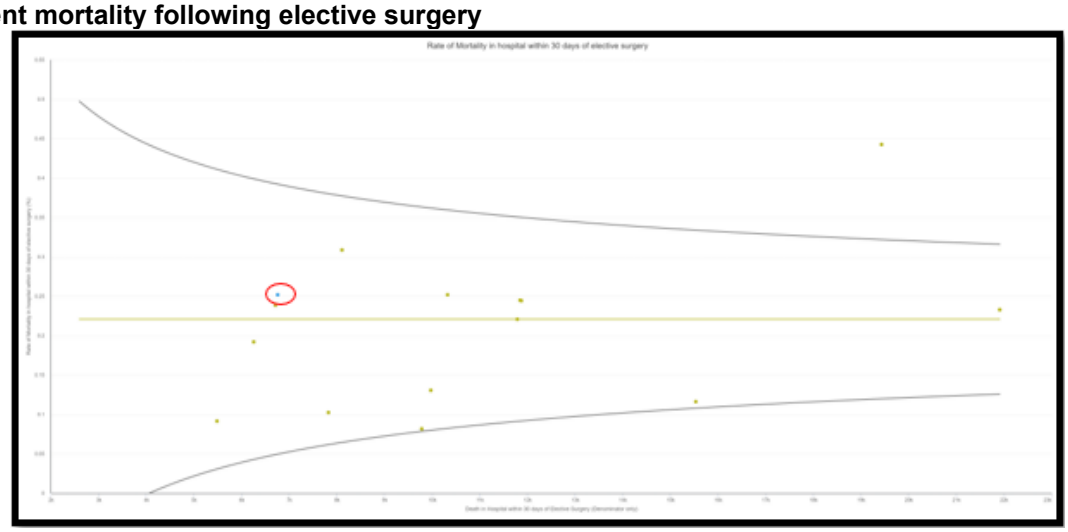
There are two Surgery Clinical Board Tier 2 mortality indicators identified, 30-day inpatient post elective and non-elective surgery. To provide context around each of these indicators a number of Tier 3 indicators have also been reported.

Thirty-day inpatient non-elective surgery mortality is better understood when considered in conjunctions with emergency laparotomy surgery mortality, post-operative hip fracture mortality, mortality and post-operative vascular surgery mortality.

While consideration of bowel cancer, and oesophageal gastric cancer mortality support wider understanding of thirty-day inpatient elective surgery mortality.

Elective Surgery Mortality

30-day inpatient mortality following elective surgery



● = *Cardiff and Vale UHB,* ● = *Peer Health Board/Trust*

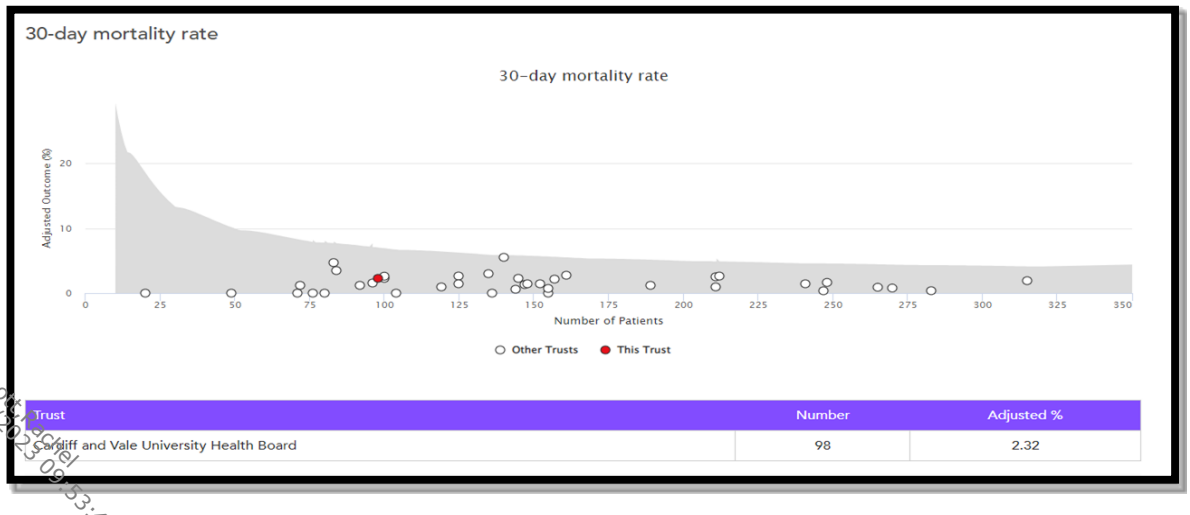
The UHB thirty days post elective surgery mortality is compared with the Acute Trust Peer, a group of fifteen health organisations across England and Wales that are comparable in size and service provision, that includes Manchester University NHS Foundation Trust, University Hospitals of Bristol and Western, Royal Free London NHS Trust, Sheffield Teaching Hospitals Foundation Trust and Guys and St Thomas NHS Foundation trust. The reporting period is August 2022- August 2023. The funnel plot demonstrates that the UHB is close to the mean for the peer group and well within the expected range.

National Oesophageal Gastric Cancer Audit:

The National gastric cancer audit evaluates the quality of care provided to patients with oesophageal gastric cancer and patients with oesophageal high grade dysplasia.

UHB adjusted 30-day mortality for the period April 2018 to March 2021 is 2.32% compared with 1.5% nationally and adjusted 90-day mortality is 2.49% compared with 3.1% nationally.

19.6% of patients in 2019-2021 in Cardiff MDT are diagnosed as an emergency admission compared to 12.5% nationally despite the increased number of patients presenting with advanced disease progression, the proportion of patients with a plan for potentially curative treatment is in line with national rates as is the proportion who have a plan for non-curative treatment.



Trust	Number	Adjusted %
Cardiff and Vale University Health Board	98	2.32

Trust	Number	Adjusted %
Cardiff and Vale University Health Board	98	2.49

National Bowel Cancer Audit 2020-2021:

The National Bowel Cancer Audit evaluates the quality of care provided to patients diagnosed with bowel cancer.

The NHS England Bowel Cancer Screening Programme and Bowel Screening Wales were paused locally for infection control and clinical safety reasons during the first wave of the COVID-19 pandemic in March 2020 and had a significant impact on the number of patients being diagnosed with all referrals coming via either the GP or as an emergency admission during this period. The impact of this period of the pandemic on the two-year mortality is not yet recorded in the National Bowel Cancer Audit.

Cardiff and Vale UHB two year adjusted mortality rate is 24.8% while overall two year all cause mortality for this national patient cohort remained at 32%

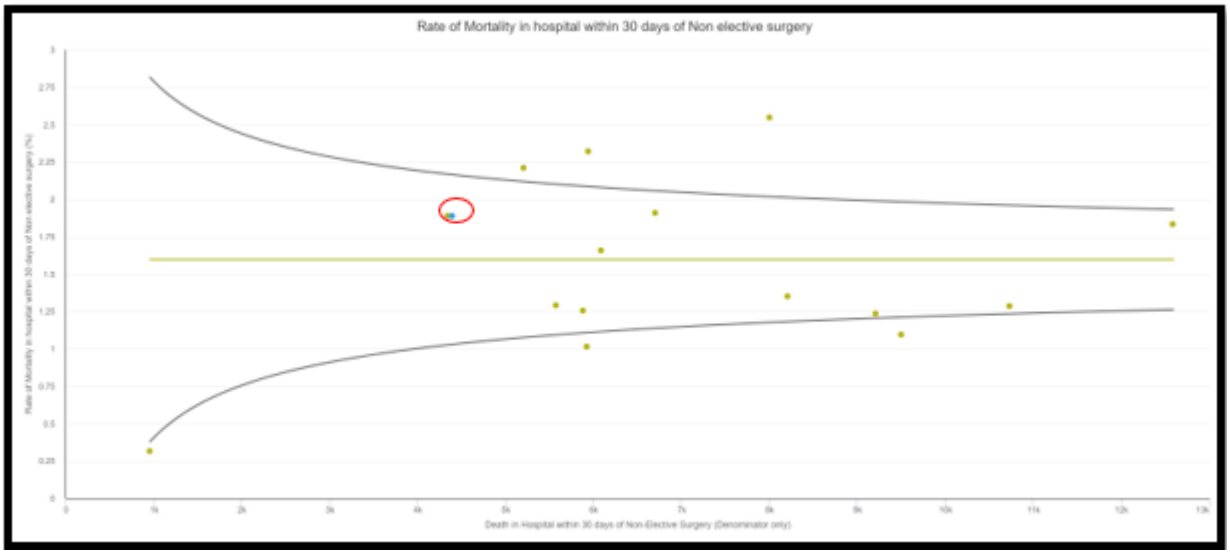
43% of patients in 2020-21 were recorded as being ASA grade 2 compared with 52% nationally and 38% ASA grade 3 compared with 31% nationally. During the reporting period the numbers of patients being deemed as potentially curative and undergoing major resection was 82% in line with the national rate and 80% of patients had laparoscopic surgery attempted compared with 67% nationally and 60% of patient receiving adjuvant chemotherapy in line with national rates.

Non-elective Surgery Inpatient Mortality:

Non-elective surgery is reported using the same methodology and peer group as elective surgery. UHB mortality is noted to be above the mean for this period although remains within the expected reporting range. To further explore this performance a review of individual mortality cases has been undertaken.

During the period August 2022- August 2023 83 patients died in hospital within 30 days of non-elective surgery undertaken in general surgery and surgical sub-specialties. While this is above the national average it remains within the expected range.

30-day inpatient mortality following non-elective surgery



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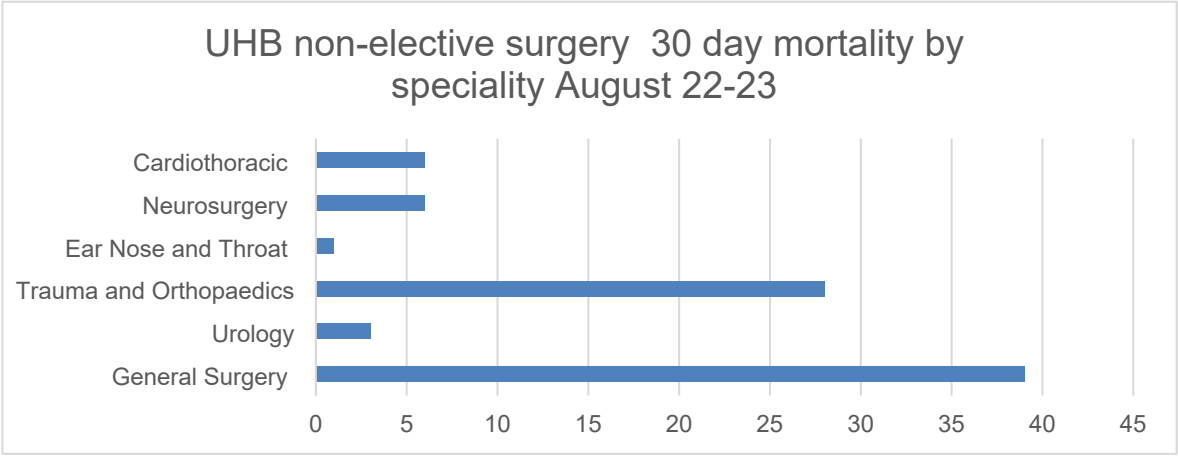
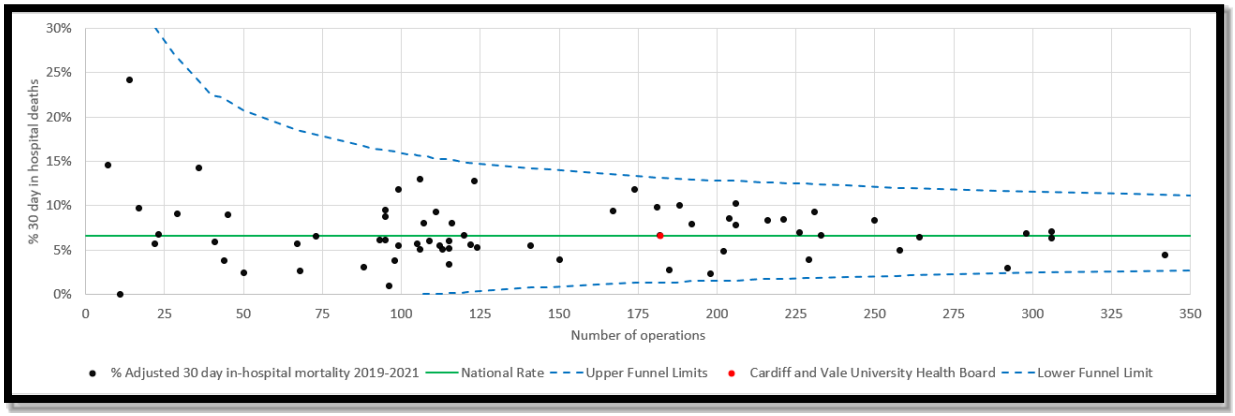


Of the eighty-three patients that died following non-elective surgery between August 2022-2023 thirty-nine case were classified as general surgery with the majority of these surgical procedures relating to either lower limb amputations or lower limb vascular procedures.

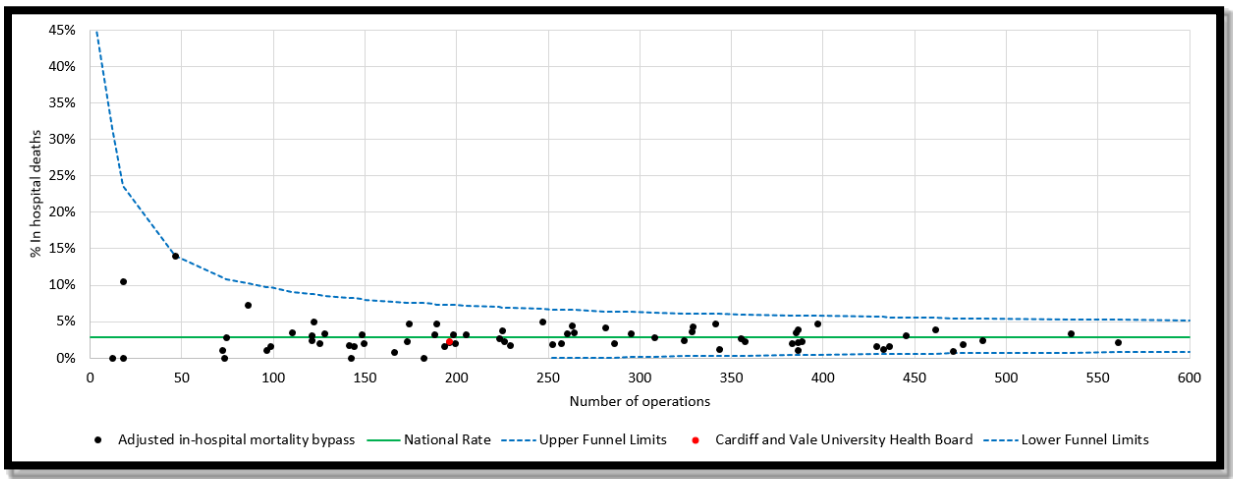
In the period 2019-2021 the national 30-day inpatient mortality rate following an amputation was 6.6% while the UHB adjusted mortality rate was 6.7%.

National Vascular Registry and % inpatient mortality following an amputation 2019-21



Nationally inpatient mortality following a lower limb bypass is 1.8% and Health Board adjusted mortality is 2.2%.

National Vascular Registry and % inpatient mortality following bypass surgery 2019-21



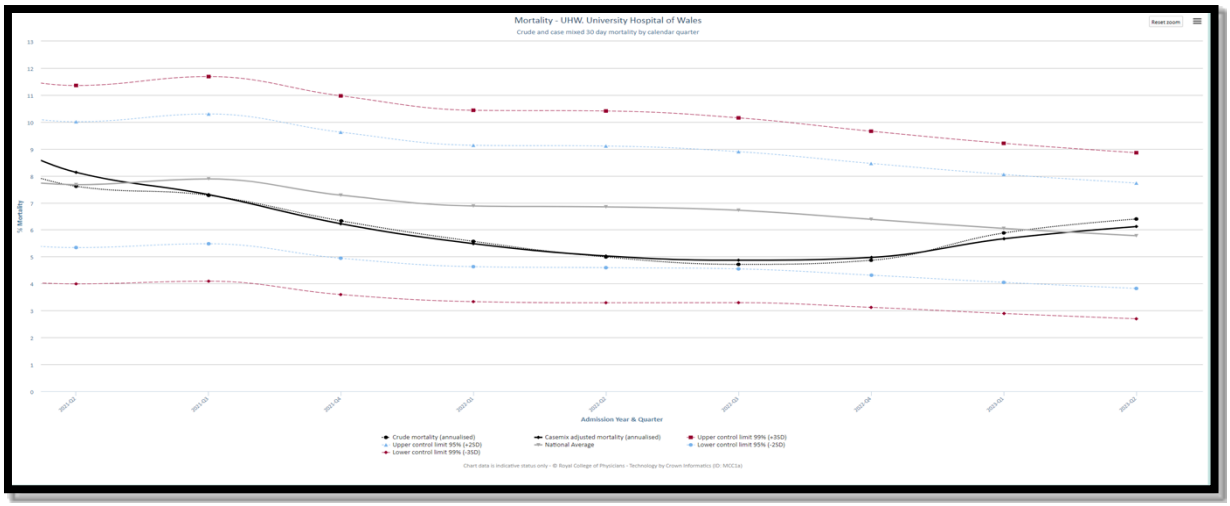
A further eight non-elective surgery patients died following emergency laparotomy surgery, and a further five as a result of acute cholecystitis and pancreatitis.

The National Emergency Laparotomy Audit reports national 30-day mortality for the period December 2020 to November 2021 of 8.7% while the adjusted mortality rate for Cardiff and Vale UHB is 6.4%.

During this period unplanned admission to critical care was 1% compared to the national rate of 3% and unplanned admission to theatres was 4% compared to the national rate of 5%. More recent quarterly report which demonstrate performance between January and March 2023 demonstrates similar performance relating to unplanned admission to critical care however unplanned return to theater was 12% compared to 8% nationally but mortality rates are not yet reported for this period.

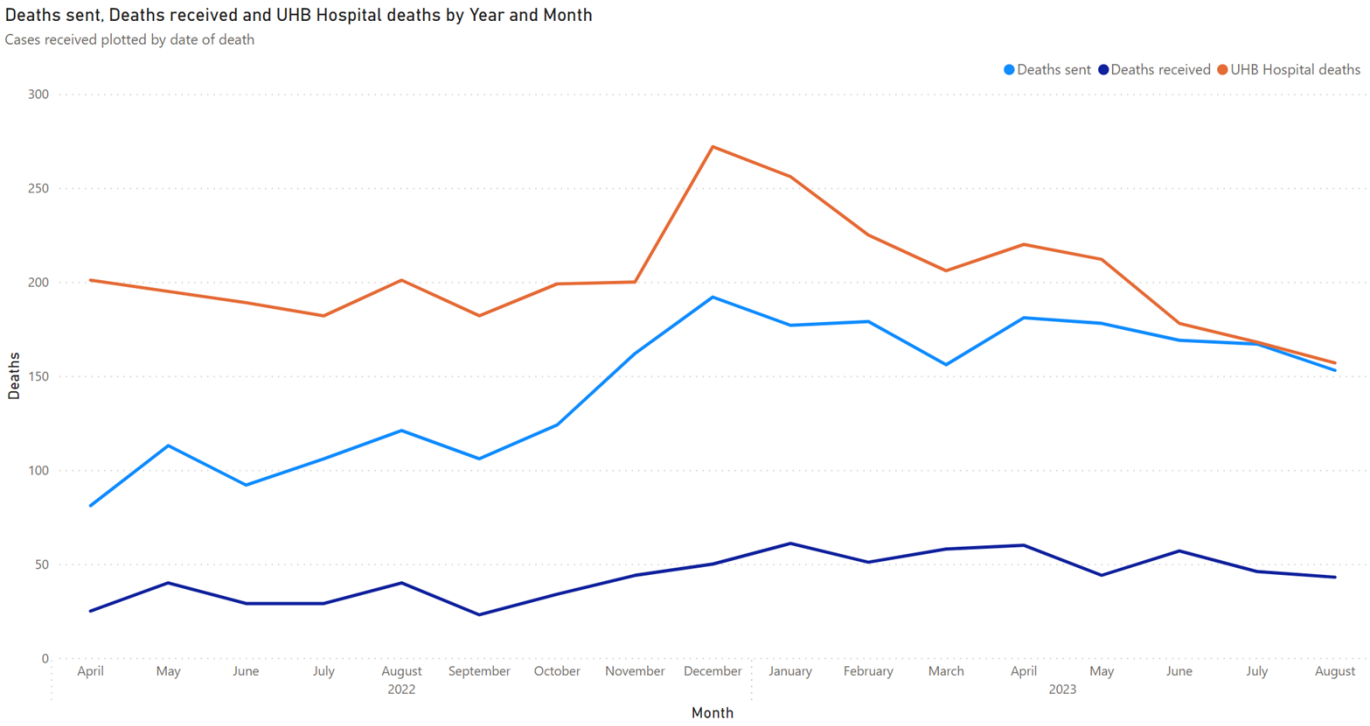
A further twenty-eight non-elective surgery patients died following non-elective trauma and orthopedic procedures and 18 of these relating to fractured neck of femur, a procedure associated with higher mortality often relating to the frailty of the patients sustaining such an injury. UHB adjusted 30-day mortality associated with hip fracture has been well below the national average since March 2023 but has increased since April 2022 to be in line with the national average.

National Hip fracture database 30-day post fracture mortality



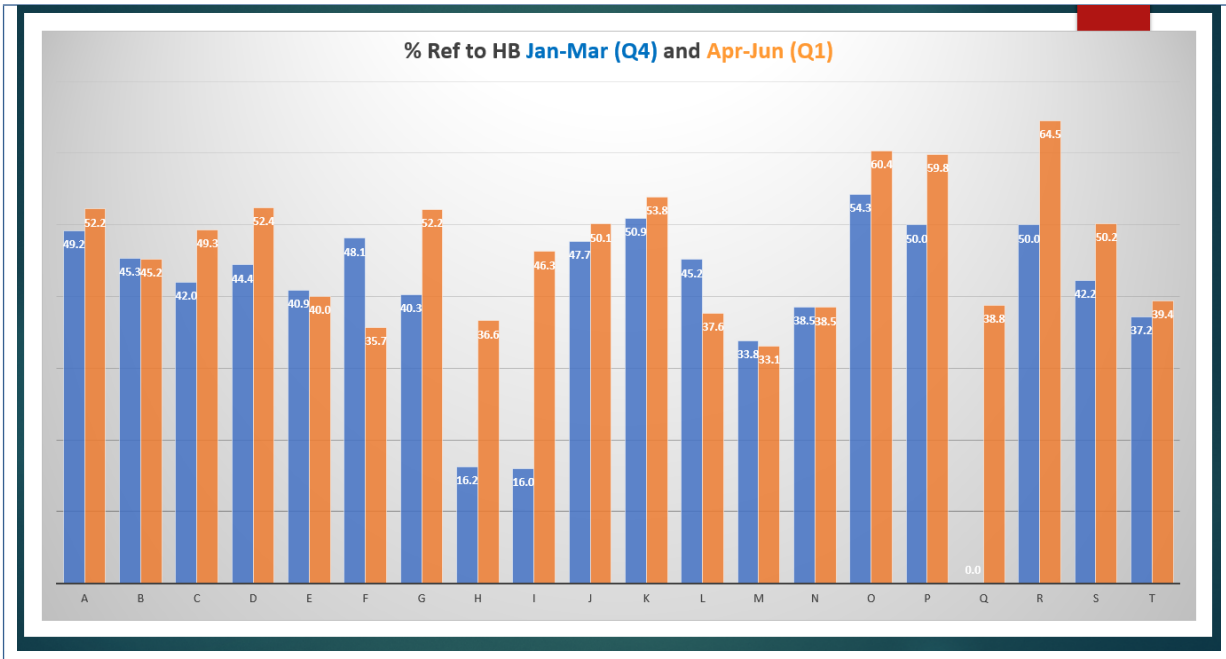
Medical Examiner and learning from mortality:

As part of the implementation of the Medical Examiner process within the Health Board, the capacity within Medical Records for scanning and sending notes to the ME has been increased. This increase has allowed the Health Board to achieve close to 100% of deaths being sent to the Medical Examiner for scrutiny. It should be noted that it would not be expected that 100% of deaths are sent as some require direct referral to the Coroner rather than to the Medical Examiner.



The Learning from Mortality Group (previously the Mortality Review Group) has oversight of the Medical Examiner process within the Health Board to ensure that all deaths within the scope of the ME service are sent.

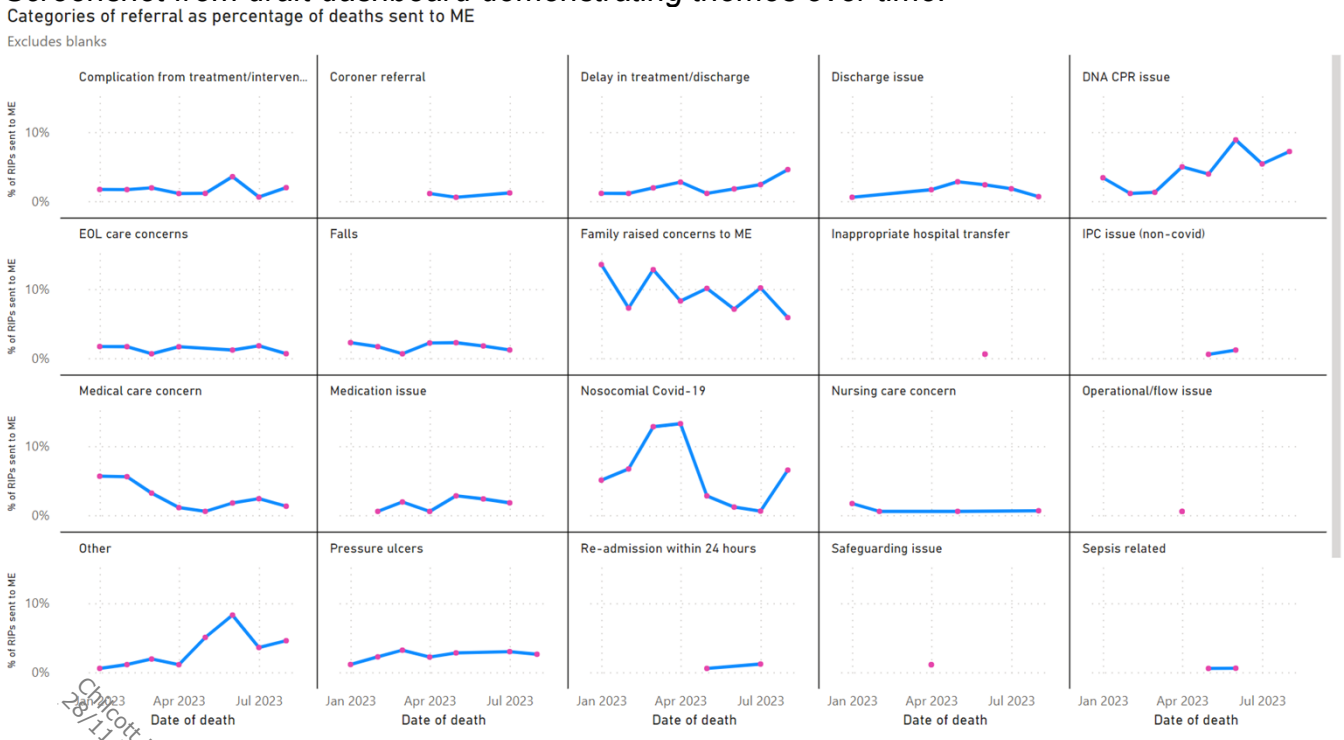
The table below illustrates that rates of ME referrals to the UHB raising questions around care of family concerns is similar to sites across Wales with 33% of ME reviews relating to UHW (M) and between 37-39% of ME reviews relating to UHL (T) being subject to referral back to the UHB in quarter four of 2022/23 and quarter one of 2023/24.



A pilot project is underway at University Hospital Llandough to streamline the process for sending cases to the Medical Examiner. This allows medical teams to provide key information to the Medical Examiner using an electronic form, with an aim to reduce the time taken for the process to be completed and improving the experience for bereaved families.

A system for identification of themes and trends from Medical Examiner referrals is in development and the Patient Safety & Quality department is working with the Digital Directorate to make this information available to Clinical Boards in real time.

Screenshot from draft dashboard demonstrating themes over time:



The themes identified from Medical Examiner referrals are fed into relevant workstreams, such as the national working group for DNACPR and a group improving the use of treatment escalation plans at the end of life. Themes are reported to the Health Board's Learning from Mortality Group, which includes representatives from Clinical Boards as well as the Medical Examiner service.

DNACPR remains one of the most common reasons for ME referral across Wales with concerns relating to issues including failure to counter sign forms and delays in completion of DNACPR documentation. Themes are being collated nationally to inform DNACPR education and policy and locally the outcome of the ME reviews are fed into the UHB resuscitation group.

Covid 19 infections contracted within a health care setting remain a common cause for ME referral. All cases will be subject to an investigation as part of the National Covid-19 investigation process. Learning from the investigation programme led to the development of Safe to Move a framework to risk assess the movement of patients between wards. This framework is currently being updated to reflect the most current guidance and in response to ongoing Covid-19 investigations.

Family concerns are collated and shared with wards and Clinical Boards to support improvements which have included difficulties in communication over the first waves of the pandemic.

ME referrals relating to falls and pressure damage are managed through the UHB patient safety processes, reported and investigated through the Datix system and where necessary reported nationally.

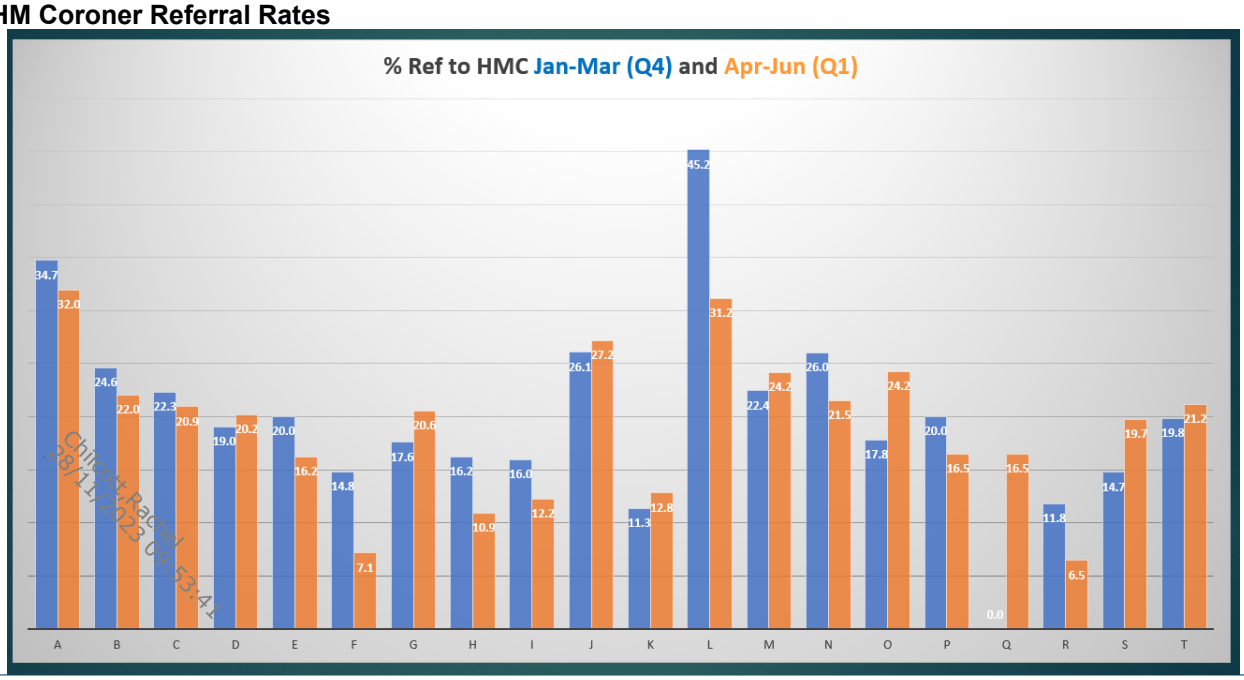
A multi professional medical examiner scrutiny panel is being convened to provide oversight of referrals relating to complications in treatment and medical care issues. The purpose of the panel will be to consider the referral and to agree a proportionate approach to further investigation.

Mortality and Morbidity Reviews
Morbidity and mortality (M&M) meetings have a central function in supporting services to achieve and maintain high standards of care. The Royal College of Surgeons has developed guidelines to ensure that these forums function in a way that is open and inclusive, supports learning, improvement and candor. A health board wide M&M review is planned and will be reported into the UHB Learning from Mortality group to support an effective and standardised approach.

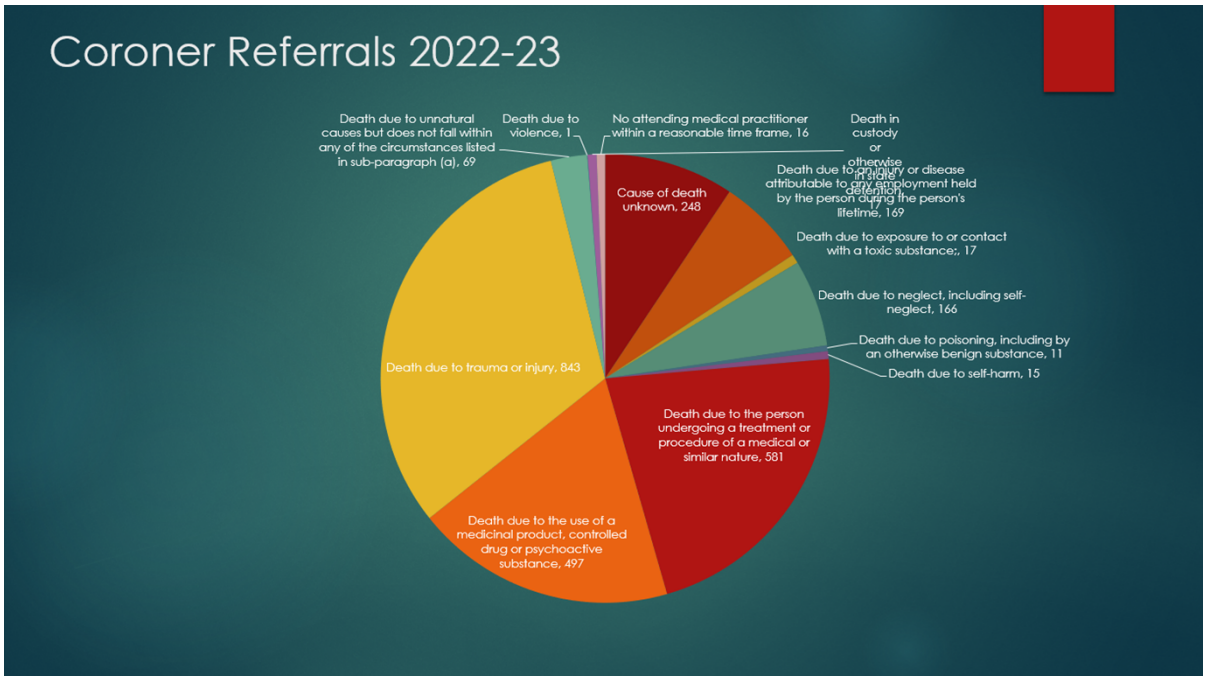
Coroner cases:

Referral rates to the His Majesty's Coroner are in line with national rates with between 22-24% of deaths being referred from UHW (M) and between 19 and 21% of cases referred from UHL (T).

HM Coroner Referral Rates



National Reasons for Coroners Referrals 2022-23



Forward plan:

Work to further develop the mortality and morbidity processes within the Health Board continues. Key priorities for the next 12 months include:

- Full establishment of the internal Medical Examiner Scrutiny Panel, which will enhance the review of deaths sent to the Health Board from the ME.
- Scoping the mortality and morbidity review processes within clinical specialities to highlight areas of good practice and areas for development.
- Making information from the ME process available to Clinical Boards and Directorates through the development of regular reports and an interactive dashboard.
- Contributing to the development of the all-Wales mortality Datix Cymru module.
- Providing education and resources to support staff in the death certification process.
- Exploring how data from the Medical Examiner process can be combined with other sources, such as socioeconomic depravation data to understand and address health inequalities.

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

The UHB crude inpatient mortality remains in line with the five-year average.

The 2019-21 UHB neonatal mortality rate is 5% higher than the average amongst its peer group however is within the expected range. The neonatal PMRT outcomes demonstrate that in three cases (19%) there was learning that might have affected the outcome and there were no cases where there was learning that directly impacted the outcome.

The UHB stillbirth rate for 2021 was 4.2 per 1000 births and 3.6 per 100 births when congenital anomalies are excluded. These rates are in line with the comparator peer group.

Suicide rates in Cardiff and the Vale of Glamorgan were 12.3 per 100 000 population in 2018-2020 and had noted to have fallen below the Welsh rate in recent years.

Intensive care mortality rates are within the expected range; however, the case mix means that a higher observed mortality rate is reported.

Both cardiothoracic surgery and neurosurgery remains within the expected range and below the national mean.

Thirty-day elective surgery inpatient mortality is close to the mean and within the expected range.

Thirty-day non-elective surgery inpatient mortality is above the mean but remains within 2 standard deviations. A review of six months of mortality cases associated with non-elective surgery demonstrated that vascular surgery, emergency laparotomy surgery and hip fracture surgery are the most common cases of death. National audit performance demonstrates that adjusted mortality rates within each of these specialties is in line with national rates.

The Medical Examiner is now providing independent scrutiny of close to 100% of inpatient deaths and will working toward reviewing all community deaths in 2024.

Referral rates from the ME back to the UHB is in line with national rates as are referrals to HM Coroner.

The development of a UHB medical examiner scrutiny panel will support robust oversight and consideration of ME referrals

A planned review of Morbidity and Mortality groups will support a standardised approach to scrutiny across the UHB.

Recommendation:

The Committee is requested to: **NOTE** the assurance provided by the UHB mortality rates reported

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		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/No
Safety: Yes/No
Financial: Yes/No
Workforce: Yes/No
Legal: Yes/No
Reputational: Yes/No
Socio Economic: Yes/No
Equality and Health: Yes/No
Decarbonisation: Yes/No

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

Report Title:	To discuss the outstanding actions from the Ombudsman's annual letter			Agenda Item no.	2.3
Meeting:	Quality Safety and Experience Committee	Public ★		Meeting Date:	28/11/2023
		Private			
Status *(please tick one only):*	Assurance		Approval	Information ★	
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Assitant Director of Patient Experience				

Main Report
Background and current situation:

The Public Service Ombudsman for Wales annually writes to each Health Board in Wales and provides an overview of trends, performance and key messages arising from activity in the Ombudsman's office over the previous year. The letters are published on the Ombudsman's website

A copy of the letter which is published on the PSOW Website Annual Letters section on website

The Annual letter was present to Board in September 23 and this paper outlines the further compliance with action

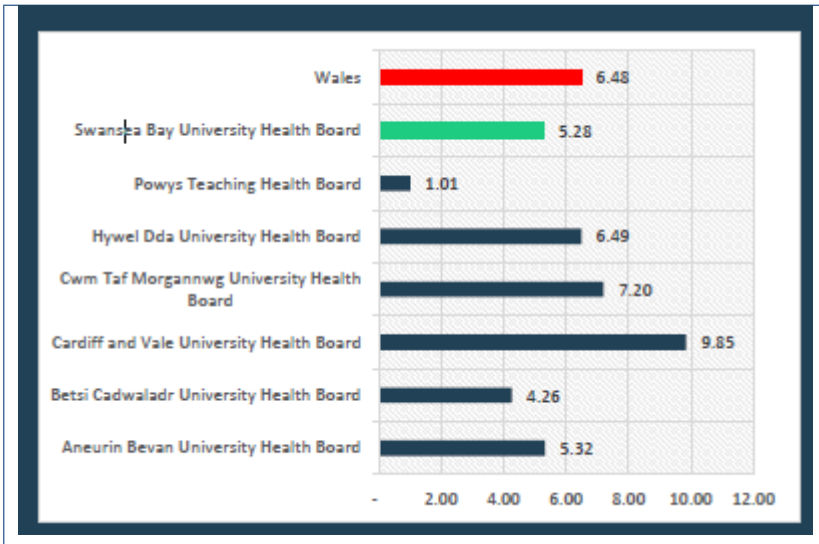
- *Update my office on how the Health Board has complied with the recommendations in our report: Groundhog Day 2: an opportunity for cultural change? by 1 December 2023.*

For Background the date from the Annual letter demonstrated that the Health Board was below the average for complaints received and investigated with Health Board average adjusted for population distribution.

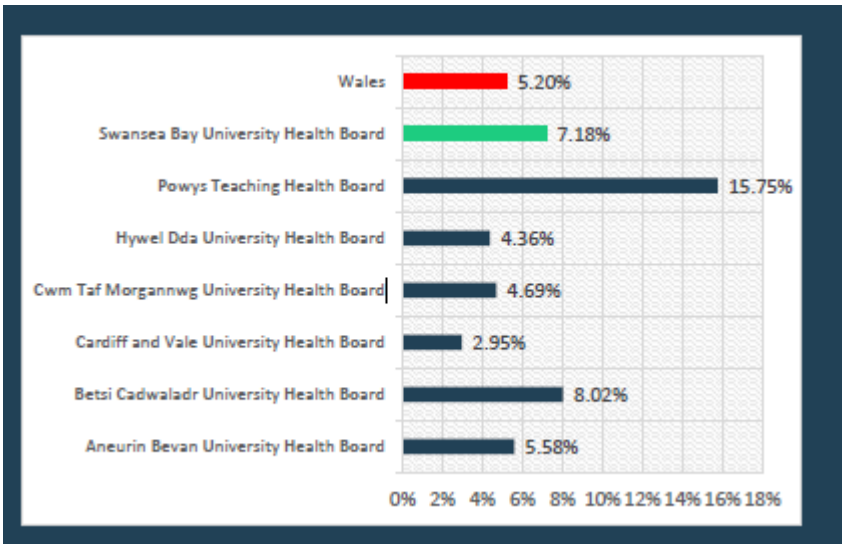
Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	166	0.28
Betsi Cadwaladr University Health Board	225	0.33
Cardiff and Vale University Health Board	137	0.28
Cwm Taf Morgannwg University Health Board	134	0.30
Hywel Dda University Health Board	104	0.27
Powys Teaching Health Board	23	0.17
Swansea Bay University Health Board	137	0.36
Total	926	0.30

This is particularly pleasing when considered in the context of the numbers of concerns the Health Board received in relation to other organizations. We received some 4866 in this period and the percentage of people who approach the Ombudsman is 0.66% of people who raise concerns with the Health Board.

This graph shows the volume of complaints received by Welsh Health Boards themselves in 22/23, adjusted by per 1,000 population.



This graph shows the volume of complaints received by PSOW about Welsh Health Boards in 22/23, as a proportion of all the complaints closed



Annual Letter actions

In response to the annual letter the Health Board was asked to take the following actions and these will be reported in detail through the Quality Safety and Experience Committee

- ***review the resources available to your complaints team-reviewed in this paper***
- ***review arrangements for accurately compiling complaints data reviewed in this paper***
- ***consider whether the option to provide staff investigating complaints with independent medical advice, is considered on a case by case basis***
- *reflect upon the lessons highlighted in this report when scrutinising their performance on complaint handling*
- *ensure that lessons learned from the PSOW's findings and recommendations are included in their Health Board's annual report on the Duty of Candour and Quality-**will be included***

The further actions are

Further to this letter can I ask that Cardiff and Vale University Health Board takes the following actions:

- *Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place. -Completed*
- ***Update my office on how the Health Board has complied with the recommendations in our report: Groundhog Day 2: an opportunity for cultural change? by 1 December 2023.***

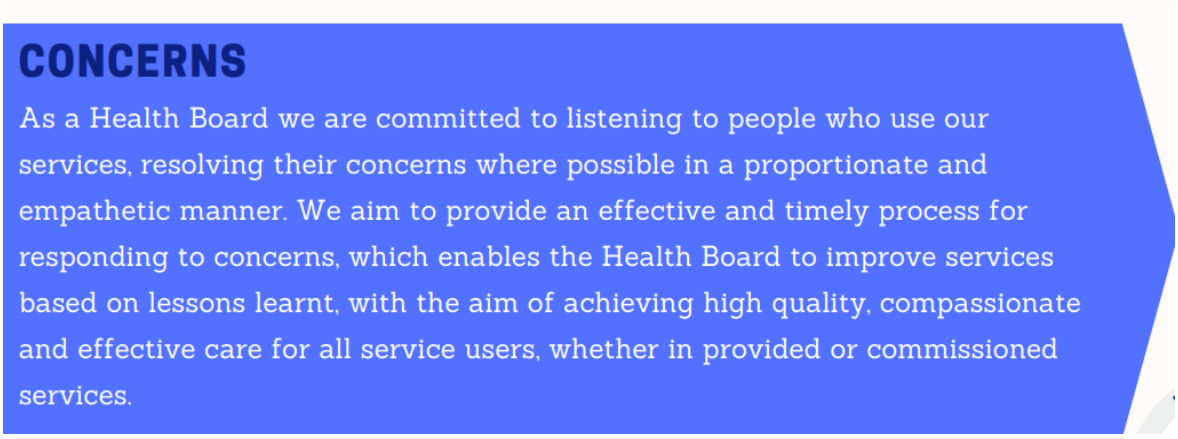
- *Continue to engage with our Complaints Standards work, accessing training for your staff, fully implementing the model policy, and providing complaints data.*
- *Inform me of the outcome of the Council's considerations and proposed actions on the above matters at your earliest opportunity.*

The Ombudsman has been advised of the Board Meeting date and the review of the organisation's compliance with the recommendations in the report Groundhog Day 2: an opportunity for cultural change? This review will be shared through the Quality Safety and Experience Committee and the Ombudsman's office advised as per the request.

- *Update my office on how the Health Board has complied with the recommendations in our report: Groundhog Day 2: an opportunity for cultural change? by 1 December 2023.*

Responses

- ***review the resources available to your complaints team-reviewed in this paper***



In order to achieve the aspiration, we have for a number of years contacted all complainants to agree the questions for investigation, this personal contact provides an opportunity to acknowledge and listen to concerns and the explain the process. We realised how confusing the redress process can be for people to understand so with every formal acknowledgement we provide a fact sheet explaining the process.

We have an SOP as below

Formal Concerns - Responsibilities of:

- **Concerns department**
- **Directorates**
- **Investigation Officer (IO)**

The Concerns Department will: -

- **On day of receipt, share the concern with the agreed identified directorate concerns leads within The Clinical Board.**
- **All concerns received via email will receive an automated acknowledgement, however, these should all be followed up with personal contact and a formal acknowledgement.**

Any letters that have come via post or any other means (not received via the mailbox) need to be acknowledged within 2 working days, including date of receipt.

- **Contact the complainant asap and agree the questions for the investigation and obtain consent* where appropriate.** ***consent is obtained to share the information with the complainant <u>not</u> to investigate the concerns therefore this should not cause any delay in the investigation.***
- **Send the complainant a letter outlining the questions (within 5 working days)**
- **Provide the directorate with a draft template which will detail the agreed questions (within 5 working days)**
- **Support Investigating Officers in obtaining comments from other areas, including external bodies.**
- **Review all final draft concern responses sent from the IO within 2 working days (If questions are not considered to be answered Concerns Co-ordinator will return response to the IO specifying additional information required)**
- **Draft reviewed to HOC or ADPE within 2 working days.**
- **Submit final draft from IO, once reviewed by Concerns Team, to Director of Nursing for final review and sign off.**
- **Advise the complainant if there will be a delay (outside timescales) explaining the reason for the delay, which must be provided by the IO**
- **Attend the weekly tracker meeting and update information and take actions as required during the meeting.**
- **Provide performance information to Clinical Board**
- **Support/arrange concern meetings in cases where a written concern response has not been provided**
- **Inform the IO if a meeting following the submission of a formal response has been requested and liaise with the family when dates and attendees have been provided by the Directorate.**
- **Produce a CD and issue the letter drafted by the Investigating Officer following a meeting**

The Directorates will: -

- **Review and consider how they wish to manage the concern.**
  E.g. – Should concern be redirected – if so this needs to be confirmed within 2 working days to ensure that the relevant area/clinical board is given sufficient time to investigate and respond in line with the PTR regulations
- **Initial consideration should be given as to whether this can be resolved under early resolution, (within 2 working days, including day of receipt) however, if there is an allegation of harm within the complaint; this <u>cannot</u> be managed informally and will require a formal response.**
- **Inform Concerns Team via email if informally managed following discussion with the complainant. Ensure outcome is clear in an e-mail to concerns Team or via completion of an Early Resolution Template**

- **Appoint an Investigation Officer –** ***It is good practice for IO to contact the complainant to inform them of their plans to investigate and to maintain openness and transparency***

The Investigating Officer (IO) will: -

- **IO to identify and request information required from all relevant parties including comments from other Clinical Boards and these should be incorporated into the response prior to submission to the Concerns Team. Comments should be requested as soon as possible.**
- **Consider if a meeting with the complainant/family would be appropriate to be followed up with a letter outlining discussions/actions agreed at meeting and concluding on Breach of Duty etc. (as per PTR regulations)**
- **IO to provide weekly updates to the directorate complaints Co-ordinator or directorate representative who will be attending the weekly tracker meeting. Update to include: - confirmation that concern will be responded to within set time scales and any problems which is hindering a timely response (within timescales) and identification of any appropriate additional support required to complete concern response.**
- **If there is a prolonged delay in providing a response the IO should contact the complainant to discuss the delay and agree a reasonable timescale or a date for a further update.**
- **Provide a full response to all questions identified on the template**
- **To include information re Breach of Duty+/- causation if known (i.e. did we do something wrong, did we omit to do something or did we do something that we should not have done). If a breach is identified, the response needs to include lessons learned, action taken/changes implemented to prevent a reoccurrence.**
- **IO to attend any follow up meetings requested and identifies and obtains availability of other attendees to share with the Concerns Team.**
- **Ensure lessons learnt learned are shared with relevant staff across the CB**

Draft responses should be completed within 20 working days and submitted to Cav Concerns mailbox - Cav.Concerns@wales.nhs.uk. This ensures that there is sufficient time for any appropriate review, any queries/amendments to be addressed.

The concerns team staff are a mixture of clinical, non-clinical and administrative staff. The teams are supported by 2 solicitors to advise re redress and a weekly redress panel. This is a fragile team due to the numbers of concerns raised and the high standard we expect of personal engagement with people who raise concerns. In every formal concern a meeting is offered to discuss the response. We rely upon the placement within the team of redeployed staff who for a period of time are unable to work clinically and they spend some time with the team they bring their clinical expertise and when they return to their workplaces they have a greater knowledge and understanding of the concerns process. The core team members have a high individual case load and provide a robust quality assurance process for concerns. We have one Ombudsman lead who also addresses the concerns for MS and MP concerns who reports directly to the Assistant Director of Patient Experience.

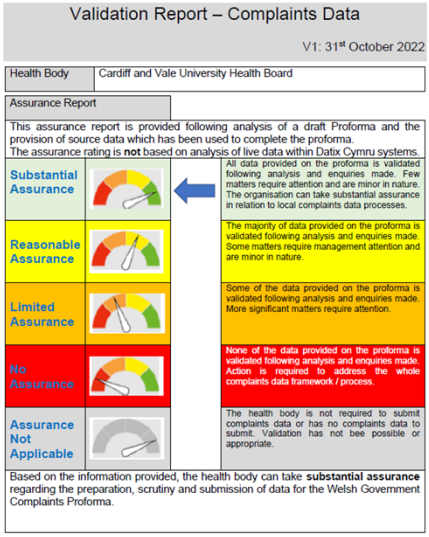
review arrangements for accurately compiling complaints data

The Welsh Risk Pool, at the request of Welsh Government, have undertaken a validation exercise of the 2022-23 Q2 and 3 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.



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.

We have continued to receive substantial assurance for our complaints data- this is achieved by on going weekly audits of the records to ensure the data is accurate.

Update my office on how the Health Board has complied with the recommendations in our report: Groundhog Day 2: an opportunity for cultural change? by 1 December 2023

To respond to this action, we considered the two reports

Annual-Report-and-Accounts-2022-23-19-07-2023-Auditor-signed.pdf (ombudsman. Wales)

Groundhog-Day-2-Report

As an organisation we have reflected upon the content of the reports and are keen to identify any learning opportunities. The consensus view was appreciation for the training provided by the Ombudsman in relation to the Complaints Standards authority which post-dates PTR- Putting Things Right but mirrors the elements of effective complaints handling and communication as embodied in both processes.

The report comments upon some key themes

A lack of openness and candour - clear evidence of maladministration or service failure not identified during local investigations
A lack of objective review of clinical care and treatment
Importance of timeliness and good communications
Acting fairly and proportionately – the need for robust investigations

The Health Board does make personal contact and keep people informed, if we think there is or may be a breach in the duty of care and / or qualifying liability we will consider if this can be addressed internally or if an external jointly instructed expert review is required. We will engage an independent clinical view where it is deemed appropriate to do so. The process for managing concerns is predicated by open and honest personal communication with people.

Points that would be helpful for Ombudsman to consider in any future reports may be:

- Organisations acknowledge the benefit of investing in independent expertise where appropriate. However, it would not be proportionate or financially viable for them to seek independent expert opinions on all or most cases. It would also cause unnecessary delays in responding to concerns.
- It would be helpful if the Ombudsman referenced in their annual reports the good practice identified by their independent experts.
- It would be helpful if the Ombudsman could provide explanations for the cases not investigated - this may also highlight good practice across organisations.

The Ombudsman's office will be provided with a copy of the paper

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

The recommendations and review of the resources available to the Complaints Team and the compliance with the *recommendations in the report Groundhog Day 2* as outlined in the report note the fragility of the concern/ complaints team.

Recommendation:

The Board is requested to: Note the the contents of the report

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		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

The review of compliance with recommendations will be undertaken
Safety: Yes
The Ombudsman provides an independent scrutiny of cases
Financial: Yes
The ombudsman can offer financial redress to people raising concerns
Workforce: Yes/No
Legal: Yes/No
Reputational: Yes/
There is significant reputational risk from Public interest reports
Socio Economic: Yes/No
e *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link:* *The Socio-economic Duty: guidance | GOV.WALES* *(If this has been addressed in the main body of the report, please confirm)*
Equality and Health: Yes/No
Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so. *Useful guidance on the completion of an EHIA can be found at the following link: EHIA toolkit - Cardiff and Vale University Health Board (nhs.wales)* *(If this has been addressed in the main body of the report, please confirm)*
Decarbonisation: Yes/No
Has consideration been given to the delivery of proposals in accordance with NHS Wales Decarbonisation Plans. If so, please confirm the detail of issues considered and plans made. *(If this has been addressed in the main body of the report, please confirm)*

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

Report Title:	Update of Healthy Eating Standards for Hospital Restaurant and Retail Outlets				Agenda Item no.	
Meeting:	Quality, Safety & Experience Committee		Public	x	Meeting Date:	28/11/2023
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Executive Director of Public Health					
Report Author (Title):	Principal Public Health Practitioner					

Main Report

Background and current situation:

Background

Cardiff and Vale University Health Board (UHB) formally adopted the Healthy Eating Standards for Hospital Restaurant and Retail Outlets in December 2015 and it remains the only Health Board in Wales implementing this approach, whereby a minimum of 75% of the food and drink on offer in our restaurants and retail outlets are classed as healthier options. This has been noted as best practice by the national Healthy Weight Healthy Wales Implementation Board and Steering Group members regularly engage with other Health Board areas to highlight the positive steps taken and share learning through development.

The *Healthy Weight Healthy Wales* strategy includes actions on creating healthy food and drink environments, with hospitals seen as a key setting in which to promote healthy options. Following the recent consultation on healthy food environments, new measures will shortly be in place which will revise how the nutritional contact of food is measured, limit the sale of sugary drinks and place restrictions on advertising high fat, sugar and salt food and drink products.

The Healthy Eating Standards for Hospital Restaurant and Retail outlets apply to all UHB-run restaurant and retail food outlets. In order to monitor compliance with the Standards, a robust audit process is in place and the workstream is driven by a Steering Group comprised of key stakeholders from across the UHB including Catering, Facilities Management, Dietetics, Procurement and Public Health.

Current Situation

Our latest audit across all outlets was in 2021, when average compliance was at 81% across all categories - hot food, cold food, drinks and snacks and confectionaries.

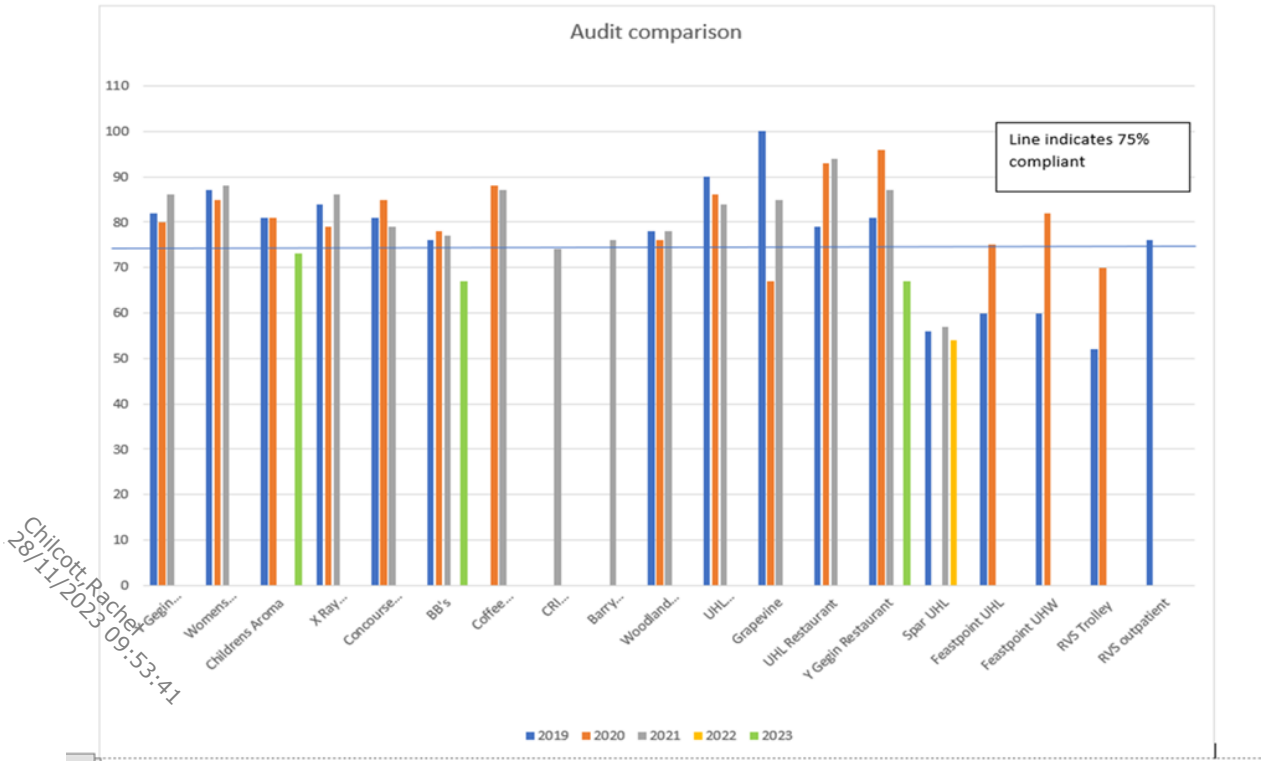
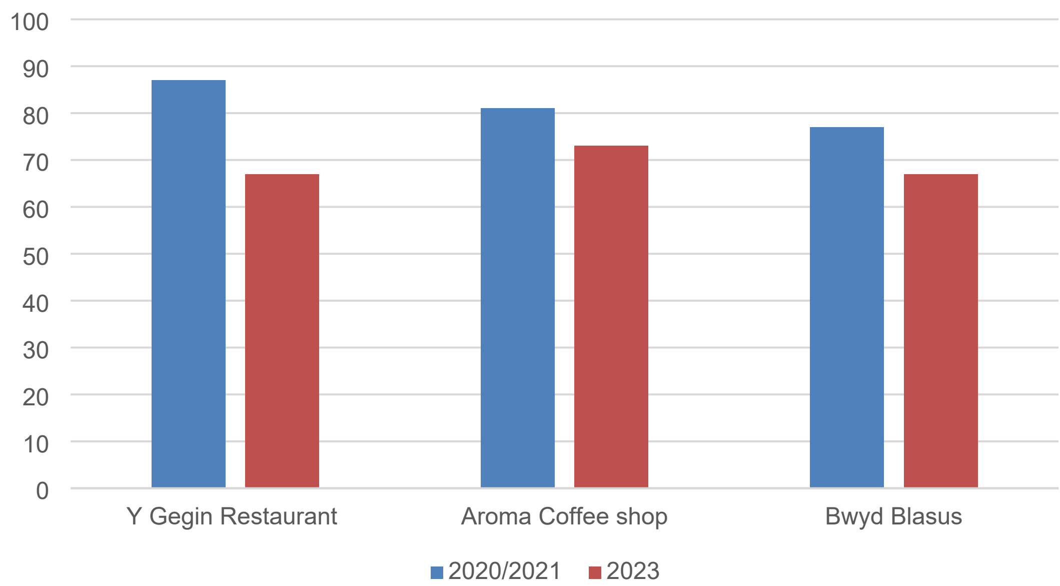


Fig.1: Graph to show audit comparison including 2023 recent audit results

We have postponed carrying out a full audit as we are developing a digital audit tool, which unfortunately, is delayed due to challenges with the software but we hope to launch the new tool by the end of the financial year.

Since 2021 however, there has been a decline in the number of compliant products for sale, see Fig 2, below. A recent mini audit on 3 of the outlets showed a marked decline in compliance, in particular due to the increase in less healthy snacks, confectionary and drinks that have been made available for sale.

Fig 2 : Graph to show comparison of 3 UHB outlets 2020/2021 with 2023



Therefore, in discussion with the Corporate and Estates Department and in recognition of the current challenges we face in providing a healthy and sustainable restaurant and retail model, we have agreed to put in place temporary arrangements which will revise the overall compliance requirements including financial challenges downwards. For the next 12 months, we will audit against an overall compliance of 60% as opposed to 75%. However, vending will remain at 75% compliance – this provision is being monitored closely as a new supplier is due to go live this autumn.

We will monitor and review this arrangement on a quarterly basis and have put in place additional governance measures to link with the Head and Deputy Head of Catering on a monthly basis to monitor compliance. Results will be reported through the Nutrition and Catering Steering Group.

The Public Health Team will focus on the completion and roll out of the new digital audit tool along with work to identify purchasing trends and developing appropriate behavioral science interventions to continue to promote the healthy choice as the easy choice.

These standards do not apply to inpatient food provision, which must currently comply with the Welsh Government All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2011).

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

Due to the current financial pressures faced by Catering colleagues in the Corporate and Estates Department, it has been agreed to revise the overall compliance required by the Standards downwards as a temporary measure and will monitor on a quarterly basis.

This paper provides assurance that we are continuing to progress with this agenda and are working closely with Capital, Estates and Facilities to monitor the situation. During this temporary arrangement, the Public Health team will focus on

developing new approaches to behavioural change and will prepare for implementing any changes from Welsh Government under the *Healthy Weight Healthy Wales* strategy, including nutritional analysis, potential restrictions on the sale of sugary drinks and high fat, sugar and salt products and the links with healthier advertising policy changes, continuing to make the healthy choice the easy choice for all.

Recommendation:

The Committee are requested to:

- NOTE the temporary changes to the Standards and the plan to be back up to the original compliance of 75% by December 2024.

- APPROVE the revised Standards (in Appendix)

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

1. Reduce health inequalities	x	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		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
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	x	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/~~No~~

- A potential risk is not returning to our original compliance and the number of unhealthy products on sale will increase

Safety: Yes/No

Financial: Yes/~~No~~

- Running at a loss will increase the risk of the UHB having to subsidise the retail catering provision or that prices will have to increase significantly to offset this

Workforce: Yes/No

Legal: Yes/No

Reputational: Yes/~~No~~

- There is a reputational risk as we are currently the only health board in Wales with these measure in place, but might lose momentum if return to a great number of unhealthy products

Socio Economic: Yes/~~No~~

• If prices continue to increase, it become more challenging for staff on lower incomes to be able to purchase a healthy and nutritious meal during their shift
Equality and Health: Yes/~~No~~
• We will be increasing the inequity gap due to price increases as well as limiting access to healthy and affordable food for staff during their working day
Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Nutrition and Catering Steering Group	Circulated for approval November 2023.
Quality, Safety & Experience Committee	28th November 2023

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Healthy Eating Standards for Hospital Restaurant and Retail Outlets

Date of issue: December 2014
Updated: November 2019 (& October 2021, following Internal Audit), September 2023

NOTE: REVISIONS MADE TO REFLECT TEMPORARY ARRANGEMENTS FROM 1.10.23
TO BE REVIEWED BY 30.09.2024

UHB Steering Group members:

Andrew Poole, Head of Estates & Facilities, Capital, Estates & Facilities

Andrew Pritchard, Deputy Head of Catering, Capital, Estates & Facilities

Calum Shaw, Environmental Sustainability Improvement Manager, Strategy and Planning

Carl Sealy, Retail Team Manager, Y Gegin, UHW

Chloe Barrell, Public Health Practitioner, Public Health Team

Darren Bradbury, Retail Team Manager, UHL

Heidy Arnot, Staff Health Dietitian, Dietetics Services

Helen Griffith, Senior Public Health Practitioner, Public Health Team

Illiass Dadda, Procurement Business Officer, Procurement Services

Jacqueline Prosser, Senior Catering Team Manager

Joanne Jefford, Dietetic Catering Lead & Nutrition & Dietetic Manager, UHL

Marie Price, Clinical Lead for Public Health Dietetics, Dietetics Services

Rhianon Urquhart, Principal Public Health Practitioner, Public Health Team

Simon Williams, Head of Catering, Capital, Estates & Facilities

Stepfanie Burgess, Retail Manager, Concourse, UHW

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FOREWORD

Cardiff & Vale University Health Board is committed to improving the health and wellbeing of our staff as well as our local population. Cardiff & Vale UHB formally adopted Healthy Eating Standards for Restaurant & Retail Outlets in December 2015 to improve the food offer for staff, visitors and patients attending our hospital sites. The Standards apply to all UHB-run restaurant and retail food outlets, and we audit each outlet to monitor and ensure compliance with the Standards. We are the first Health Board in Wales to adopt this approach, making the healthy choice the easy choice for customers.

We are continuously improving the availability, range and affordability of healthy options offered at our UHB-provided hospital restaurants and cafes in order to make the healthy choice the easy choice. We hope that you will help us make Cardiff and Vale UHB a healthier place to work and take the opportunity to make positive changes to improve your health.

Fiona Kinghorn

Executive Director Public Heath

BACKGROUND

Being a healthy weight has become one of the most effective ways to reduce the risk of long-term health conditions such as diabetes, heart disease and cancers. However, in our current environment it is difficult to achieve this as our food provision has developed in a way that prioritises convenience over health.

Despite widespread knowledge regarding the benefits of maintaining a healthy balanced diet, increasing urbanisation, a more fast-paced way of life and increased production of processed foods has led to a gradual shift in the dietary habits of the UK population. As a result, individuals are eating less fruit and vegetables, oily fish and dietary fibre, but instead are consuming a greater proportion of energy-rich foods high in fat, salt and sugar [1].

In Cardiff and Vale, only 39% of adults report eating the recommended 5 portions of fruit and vegetables a day, and over half (57%) are overweight or obese[2].

VISION

We are committed to caring for people, taking preventative measures to keep people well and influencing healthier food provision. We have a public duty to act now and ensure the Wellbeing of Future Generations[3] and work hard to be an exemplar in empowering people to make healthier choices.

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[1] World Health Organisation (2020) Healthy Diet. Available at: Healthy diet (who.int)

[2] StatsWales. Adult lifestyle by health board [updated July 2023] Available at: Adult lifestyles by local authority and health board, 2020-21 onwards (gov.wales)

[3] Future Generations Commissioner for Wales. Well-being of Future Generations (Wales) Act 2015. Available at: Well-being of Future Generations (Wales) Act 2015 – The Future Generations Commissioner for Wales

As outlined in the Cardiff and Vale UHB Shaping our Future Wellbeing Strategy[4], our lifestyle behaviours are influenced by the environment in which we live and work and how able we feel to make changes. Cardiff and Vale University Health Board (UHB) is one of the largest NHS organisations in the UK, providing healthcare services for over 490,000 people living in Cardiff and the Vale of Glamorgan. To improve the future health and wellbeing of our population we will create an environment in which individuals have a sense of personal responsibility for their health and are supported to adopt behaviours, which reduce their risk of poor health. Cardiff and Vale UHB has a responsibility to ensure provision of opportunities to access healthy food and drink within the workplace, to positively contribute towards the health and wellbeing of the 16,000 staff it employs, supporting them to be fit and healthy to offer the best service to patients and reduce staff sickness. As well as our staff, we welcome approximately 200,000 patients and visitors per year onto our sites. Supporting staff, patients and visitors to make healthier food and drink choices requires strategic co-ordination and the collaboration of Retail Catering Services, Dietetic Services, Procurement and the Local Public Health Team. A Steering Group was established in 2013 to implement the current 'Hospital Restaurants and Retail Catering Outlets Food Standards'.

LARGE SCALE CHANGE

Supporting people to change their dietary habits is a gradual process that requires long-term thinking and a shift in the way we procure sell and prepare food. We recognise this and continue to work collaboratively with our health board colleagues and food industry partners to identify and address changes in the wider system that enable us to make healthier choices more accessible and sustainable. In order to do this, we present a set of Standards that require executive commitment to ensure implementation.

The Standards drive our ambition to normalise a healthy food environment, changing peoples' expectation of restaurant and retail food provision on hospital sites to one that represents and promotes wellbeing. As part of our commitment to the national obesity strategy, Healthy

[4] Cardiff and Vale UHB. Shaping Our Future Wellbeing: Cardiff And Vale University Health Board Strategy to 2035. Living Well, Caring Well, Working Together. Available at: SHAPING-OUR-FUTURE-WELLBEING-STRATEGY_FINAL.pdf (shapingourfuturewellbeing.com)

Weight: Healthy Wales[5], we will continue to implement strict criteria that supports people to achieve and maintain a healthy weight.

REQUIREMENTS:

The Standards ensure that staff, visitors and patients are encouraged and supported to eat well, with healthy* options widely available, and a significant reduction in the quantity of energy-dense, high fat, high sugar and high salt food and drink products.

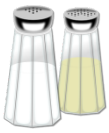
All UHB Restaurant & Café Outlets

Due to the current financial challenges faced by the UHB, the overall compliance will be revised downwards, requiring a 60 – 40% split in favour of healthy options. This is for a period of 12 months and will be monitored on a quarterly basis, with a view to returning to the overall compliance of 75% across al UHB-run restaurants and retail outlets.

	A minimum of **60%** of the quantity and range of items available for customers to purchase within each product category must be classed as healthier.
	**Only healthier food and drink items can be promoted**, e.g. at till point, in special offers/meal deals, in window displays and via other promotional activities. Products that are not classed as 'healthier' cannot be promoted.
	A **healthier hot meal must be available for purchase as the cheapest** hot meal option available and promoted as such, for example, the 'deal of the day'.
	**Whole fresh fruit must be available** for purchase at all meal times, that it is cheaper for the customer to purchase than the majority of confectionary items, and that it is included as an option in all meal deals.

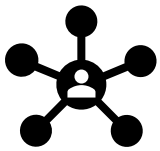
[5] Welsh Government. Healthy weight strategy: Healthy Weight Healthy Wales. Available at: https://gov.wales/healthy-weight-strategy-healthy-weight-healthy-wales

*Food and drink products are classified 'healthy' in accordance with the Food Standards Agency Traffic light system. See page 10.

	The **nutritional information of all** products to be **displayed to the customer**, as per the FSA traffic light system[6].
	**Free drinking water is readily available** to all restaurant users and location of drinking water highlighted to customers at till point.
	**Salt must not be provided at tables** – sachets must be available at service counter only.
	**Ensure compliance with the** EU Food Information for Consumers Regulation 1169/2011[7]

External Retail Provision

In recognition of the current challenges to provide a healthy and sustainable retail model and to attract high quality suppliers, from October 2023 we will be implementing the following criteria for all retail shops:

	A minimum of 55**%** of the quantity and range of items available for customers to purchase, must be available, with a view to increase compliance to 60% within an agreed timescale.
	All non-UHB outlets will be required to participate in a network/nominate a 'Champion' to discuss progress and opportunities to improve the healthy retail food environment.

[6] Food Standards Agency. Check the Label Guidance. FSA:2020. Available at:https://www.food.gov.uk/safety-hygiene/check-the-label

[7] European Commission. Food information to consumers – legislation. EC: 2016. Available at: https://ec.europa.eu/food/safety/labelling-and-nutrition/food-information-consumers-legislation_en

	All vending machines must comply with the 75/25% split in favour of healthy options. Branding must support health promoting messages. All existing and new vending contracts must agree to the above as outlined in contractual agreements.

These standards do not apply to inpatient food provision, which must currently comply with the Welsh Government All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2011)[8].

[8] Welsh Government. All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients. WG:2011 [cited 2021 October 07]. Available at: All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2011)

COMPLIANCE WITH THE STANDARDS

In order for food and drinks to be classified as healthier and included within the 60% range they must not have high levels of fat, saturated fat and/or sugar as defined by FSA. The audit process will measure compliance within the following categories - *Table 1: Criteria for 'healthier' food and drink products by category*

Restaurant & Café Outlets	Product Category	Examples	Criteria
	Hot food	Hot meals, cooked puddings, microwavable ready meals, etc.	Must **NOT** be high in fat, saturated fat or sugar as defined in table 2
	Cold food	Sandwiches, salads, cold pasties/sausage rolls, cereals, etc.	
	Snacks and confectionary	Crisps, sweets, nuts/seeds, cereal bars, fresh fruit, fruit pots, cakes, biscuits, ice cream, etc.	Must **NOT** be high in fat, saturated fat or sugar as defined in table 2, unless fat or sugar is naturally occurring in the product
	Drinks	Hot chocolate, coffee drinks (e.g. lattes, cappuccinos), flavoured water, carbonated drinks, fruit juice/juice drinks, milk based drinks, etc.	1. Must **NOT** be high in fat, saturated fat **or sugar** – as defined in table 3 (36) 2. Must **NOT** contain **any** 'added sugars', except for the following products provided there is no more than 5% 'added sugars' and the dairy based drinks are based on skimmed, 1% or semi-skimmed milk: - Flavoured milk - Milk based drinks, e.g. iced coffee drinks - Yoghurt drinks - Dairy smoothies (36) 3. **No carbonated drinks are permitted** except: - Carbonated water - Carbonated pure fruit and vegetable juices

Restaurant & Café Outlets	Product Category	Examples	Criteria
			- Pure fruit and vegetable juices diluted with carbonated water (if contains a minimum 50% fruit or vegetable juice) (36)
Retail outlets / Convenience Store	Groceries	**Chilled/fresh foods:** cheese, spreads, fresh milk, deserts, etc. **Ready meals:** fresh/frozen pre-packaged lasagnes, pizzas, burgers etc. **Perishable foods:** bread, eggs, flour, etc. **Non-perishable foods:** pasta, rice, tinned vegetables, tinned/packet soups, jam, pasta/curry sauce, etc.	Must **NOT** be high in fat, saturated fat or sugar as defined in table 2

MONITORING THE STANDARDS

Products will be audited based on the Food Standards Agency guidance for determining whether products are low (green), medium (amber) or high (red) (table 2)[9].

The information needed is the amount of fat, saturated fat and total sugar per 100g.

If the portion/serving size of the product is more than 100g or 150 ml, you will also need:

- Amounts of fat, saturates, (total) sugars and salt **per portion** (can be calculated using per 100g/ml information and portion size).
- Criteria for red (HIGH), amber (MEDIUM) and green (LOW) as set out below.

Table 2: Criteria for 100g of food

Colour Code	*Low*	*Medium*	*High per 100g*	*High per portion*
Fat	≤ 3.0g/100g	> 3.0g to ≤ 17.5g/100g	> 17.5g/100g	> 21g/portion
Saturates	≤ 1.5g/100g	> 1.5g to ≤5.0g/100g	>5.0g/100g	> 6.0g/portion
Total Sugars	≤ 5.0g/100g	> 5.0g to ≤ 22.5g /100g	> 22.5g/100g	> 27g/portion
Salt	≤ 0.3g/100g	> 0.3g to ≤ 1.5g/100g	>1.5g/100g	>1.8g/portion

[9] Food Standards Agency. Guide to creating a front of pack (FoP) nutrition label for pre-packed products sold through retail outlets. FSA: 2016 [cited 2021 October 07] Available at: https://www.food.gov.uk/sites/default/files/media/document/fop-guidance_0.pdf

Table 3: Criteria for drinks (per 100ml)

Note: Portion size criteria apply to portions/serving sizes greater than 150ml

Colour Code	*Low*	*Medium*	*High per 100g*	*High per portion*
Fat	≤ 1.5g/100ml	> 1.5g to ≤ 8.75g/100ml	> 8.75g/100ml	>10.5
Saturates	≤ 0.75g/100ml	> 0.75g to ≤ 2.5g/100ml	> 2.5g/100ml	> 3g/portion
Total Sugars	≤ 2.5g/100ml	> 2.5g to ≤ 11.25g/100ml	> 11.25g/100ml	> 13.5g/portion
Salt	≤ 0.3g/100ml	>0.3g to ≤0.75g/100ml	> 0.75g/100ml	> 0.9g/portion

Exceptions

Processed products containing natural fats or sugars, directly pertaining from foods known to have health benefits, including fruit, vegetables, nuts and seeds are exempt unless they have added sugar or fat.

Added sugars: sugars from fruit will not be taken in to account when assessing sugar levels, unless the product has added sugar (or a sugar derivative including honey, glucose syrup, etc.) as an ingredient. For example, a product containing dried fruit may exceed the bought-in product specification for sugar, however if they have no added sugar then the product is acceptable. Acceptability will be determined by the ingredients list, which will reference any “added sugar”.

Added sugars: fats from nuts and seeds are not taken in to account when assessing fat content, unless the product has added fat from an additional ingredient. For instance, if a cereal bar contains nuts and seeds and no additional vegetable oil or other fat source it will be acceptable.

EVALUATION AND GOVERNANCE

- The Steering Group oversees the implementation of the Standards and monitors compliance. The Steering Group reports into the UHB Nutrition and Catering Steering Group, 3 times per year.
- In addition to audit data, we collect feedback from customers using customer surveys.
- Sales data is reviewed by the Steering Group and used to inform healthier product selection, and monitor sales
- Nutrition training and regular updates on the standards are provided for catering staff to increase knowledge of the importance of healthier food provision and support implementation of the policy.
- All outlets (restaurants, cafes, retail outlets, trolleys and vending machines) across the UHB will be audited on a quarterly basis by representatives from Catering, Public Health and Public Health Dietetics. Regular spot checks will also be carried out throughout the year to support the audit process and maintain the requirements of the standards
- Audit results will be calculated and fed back to:
    - Restaurant & Retail Hospital Food Standards Steering Group
    - Nutrition and Catering Steering Group
    - Cardiff & Vale Public Health Team monthly performance management meetings
    - Capital & Estates performance meetings and Operational Service Board

SUSTAINABILITY

The Steering Group is committed to supporting the Health Boards aim to reduce its carbon footprint by identifying measures to reduce food waste, avoid unnecessary use of plastics and offer more sustainable food choices.

References:

1. World Health Organisation (2020) Healthy Diet. Available at: Healthy diet (who.int) [accessed 2 November 2023].

2. StatsWales. Adult lifestyle by health board [updated July 2023] Available at: Adult lifestyles by local authority and health board, 2020-21 onwards (gov.wales) [accessed 2 November 2023].

3. Future Generations Commissioner for Wales. Well-being of Future Generations (Wales) Act 2015. Available at: Well-being of Future Generations (Wales) Act 2015 – The Future Generations Commissioner for Wales [accessed 2 November 2023].

4. Cardiff and Vale UHB. Shaping Our Future Wellbeing: Cardiff And Vale University Health Board Strategy to 2035. Living Well, Caring Well, Working Together. Available at: SHAPING-OUR-FUTURE-WELLBEING-STRATEGY_FINAL.pdf (shapingourfuturewellbeing.com) [accessed 2 November 2023].

5. Welsh Government. Healthy weight strategy: Healthy Weight Healthy Wales. Available at: https://gov.wales/healthy-weight-strategy-healthy-weight-healthy-wales [accessed 2 November 2023].

6. Food Standards Agency. Check the Label Guidance. FSA:2020. Available at:https://www.food.gov.uk/safety-hygiene/check-the-label [accessed 2 November 2023].

7. European Commission. Food information to consumers – legislation. EC: 2016. Available at: https://ec.europa.eu/food/safety/labelling-and-nutrition/food-information-consumers-legislation_en [accessed 2 November 2023].

8. Welsh Government. All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients. WG:2011. Available at: All Wales Catering and Nutrition Standards for Food and Fluid Provision for Hospital Inpatients: (nhs.wales) [accessed 2 November 2023].

9. Food Standards Agency. Guide to creating a front of pack (FoP) nutrition label for pre-packed products sold through retail outlets. FSA: 2016. Available at: https://www.food.gov.uk/sites/default/files/media/document/fop-guidance_0.pdf [accessed 2 November 2023].

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

PCIC CLINICAL BOARD
MINUTES OF THE QUALITY, SAFETY & EXPERIENCE GROUP
HELD AT 11 AM ON 26TH SEPTEMBER, 2023, 11 AM
Venue: MS TEAMS

Attendees	
Anna Mogie (AM)	Deputy Director of Nursing (Chair)
Helen Kemp (HK)	Deputy Clinical Board Director (Chair)
Clare Evans (CE)	Assistant Director Primary Care
Lisa Waters (LW)	Senior Nurse for Quality and Education
Clare Clement (CC)	Head of Medicines Management
Tanya Balch (TB)	Locality Nurse, North & West Locality
Kate Roberts (KR)	Vale Interim Lead Nurse
Carol Preece (CP)	Lead Nurse, South & East Locality
Helen Earland (HE)	Clinical Operational Lead, GP Out of Hours
Jayne Gay (JG)	Clinical Manager, Out of Hours
Andrea Rich (AR)	Lead Nurse, Palliative Care
Ruth Cann (RC)	Consultant Nurse Older Vulnerable Adults
Victoria Whitchurch (VW)	Head of Operations, Mass Imms
Ellen Davies (ED)	Clinical Nurse Specialist in Infection Prevention & Control
Nicola Robinson (NR)	Head of People and Culture
Theresa Blackwell (TB)	PCIC Business Manager
Louise Thomas (LTho)	Quality & Safety Officer

Apologies	
Anna Llewellin	Director of Nursing
Lisa Dunsford (LD)	Director of Operations

Gneeta Joshi (GJ)	Community Director of Clinical Governance
Sarah Griffiths (SG)	Head of Primary Care
Jane Brown (JB)	Head of Dental and Optometry
Lynne Topham (LTop)	Locality Manager, South and East Locality
Rachel Armitage (RA)	Quality and Safety Manager
Rhys Davies (RD)	North West Locality Manager
Helen Donovan (HD)	Locality Lead Nurse, North & West Locality
Neil Morgan (NM)	Vale Locality Manager
Lorna McCourt (LMc)	Staff Side Trade Union Representative
Rebecca Gill (RG)	Senior Nurse, Primary Care
Janice Aspinall (JA)	Health and Safety Representative

ITEM NO.	TITLE	ACTION
09/23/01	AM welcomed everyone to the meeting.	
09/23/02	Apologies of absence were noted as above.	
09/23/03	No declarations of interest were raised.	
09/23/04	Minutes The minutes of the meeting held on 25th July, 2023 were accepted as an accurate record. There were no other matters arising.	
09/23/05	Action Log Please refer to item 5.	
09/23/14	AM welcomed Stephen Allen (SA), Regional Director for CAV, Llais to the meeting and invited him to deliver his presentation earlier than scheduled on the agenda. SA explained that Llais (formerly CHC) was formed as of 1st April, 2023. Llais must demonstrate its independence from health and social care services, demonstrate that it is a trustworthy and inclusive body, showing that everybody living in Wales has equal parity and a voice of equal strength. Llais was established within the 2020 Engagement and Equality Act and was set up to have a local, regional, national footprint; work will be carried out over the next twelve months examining cluster levels and needs within each neighbourhood. The role of CHC was carried over to Llais and has been condensed into three areas which are engagement, representation and advocacy and they now cover	

	health and social care. Visiting continues under the new Welsh Assembly Government statutory guidance issued and is referred to as 'access to premises' across the whole of health and social care services. SA noted that the main reason for Llais' existence is to engage with the public regarding their opinion on health and social care services and access in their area. Volunteers are free to choose which pieces of work they deliver, i.e. visiting, online feedback, representation or engagement. The Health Board and Local Authorities must pay due regard to the representation made by Llais under point 15.2 of the regulations. Llais' role in relation to the service change process is to ensure engagement is sufficient, processes are being followed and to ensure that everyone is engaged with those they should be engaging with. Three priority areas for LLais are stranded patients (delayed transfers of care), unscheduled care and the management of dental waiting lists. SA noted that Llais would want to help with issues that prevent health staff carrying out their roles, i.e. the situation District Nurses are faced with when accessing patients residing in the Crystal Glen area. Llais would like the Health Board to signpost staff and patients to them in order to develop processes and encourage co-production, helping the body to understand key service areas that can be looked at via an independent framework. Visits will be announced although 'on the day' visits can be carried out. Llais can visit any service that is commissioned by the NHS or Local Authority via the health and social care budget. It can also visit people's homes to enquire about care packages being received and can liaise with private providers regarding findings. Providers are obliged to respond to Llais whose aim is to add value to the work already being carried out. Reports will note the good practice being carried out as well as what may not be working so well. SA will share the template that is being used for announced and on the day visits so that the PCIC team can offer advice and support to their colleagues and independent contractors. AM thanked SA for presenting to the PCIC QSE group.	SA
09/23/06	<u>Patient story (AR)</u> This patient story forms part of a quality improvement project (the Informal Carer Project) that the palliative care team had dealt with. The deceased patient's family had quoted "The process has been completely reactive and it should have been proactive." AR explained that palliative patients and their families are supported in relation to their preferred place of care and preferred place of death. It can be quite a protracted process to discharge a palliative patient out of hospital, discharges often fail and patients are readmitted. Many informal carers (those taking care of a patient at home) are not prepared for what they are about to undertake at home or the demands of a rapidly deteriorating patient, and this can contribute to the readmittance of a patient. The palliative team has developed a standardised, structured process and information resource to be used by health care professionals to guide the conversations needed and the way in which informal carers are prepared for	

discharge. It acts as a communication tool between the hospital and the community care health care professionals.

A discharge package has been devised which structures the discharge process, informs and supports the informal carer, improves the informal carer's ability to make informed choices about caring at home, to be more prepared for the unpredictable aspects of care and to reduce episodes of crisis, avoiding the possibility of readmission to hospital.

The patient was an 82 year old lady who had been married for 58 years, had two supportive daughters and a close, extended family. Her daughter was her power of attorney for finance, health and welfare. The patient had been unwell in hospital and was deteriorating. It was clear that that her life was coming to an end with a prognosis of less than six weeks. She wanted to spend her remaining time at home with her family and did not want to be in hospital. The patient was extremely unwell and bedbound when she was discharged home (she was discharged before the new initiative was implemented).

The patient story is told by her informal carers, the husband who lived with the patient, and two daughters who did not. They all attended a meeting with a doctor on the ward who informed them of the patient's disease progression and the poor prognosis of just a few weeks. The two daughters spoke with the doctor alone after the meeting and informed him that they had the power of attorney for both their mother (the patient) and their father who was already frail. They asked to be included in all future discussions and decision making but afterwards had stated that they felt pushed away. They were told that both their parents had capacity and would be dealt with directly. Consequently, much of the information was passed to the patient and her husband. The daughters stated that their mother would agree to anything as long as she could go home, and the husband later reported that he could not retain all of the information as he was so emotionally involved. The patient's notes also incorrectly documented that the patient was living with one of the daughters (and the daughter's name was incorrect).

The family received two phone calls on the day of discharge, one from Pharmacy about the blood thinning injection that was usually administered by the patient (which the family felt they did not have insight into how the extremely unwell patient was supposed to administer), and the other phone call informing them that the patient would return home at 3 pm on that day. The family have since stated that they felt they did not receive clear, up to date information, especially as the patient was deteriorating daily. The daughters left their father on his own with their mother on the first night as they did not appreciate her needs. The husband felt extremely upset when he was on his own and felt helpless when his wife could not breath and he could not move her; he just held her. Following on from the patient's first night back at home, the daughters stayed the following nights as well as all day.

The family provided examples of MDT members not having insight into the situation. Some of the patient's equipment was suitable for her the previous 7 – 10 days, but not since she had deteriorated, e.g., she was transported home from hospital in a wheel chair in usual transport, was left in her chair and informed her carers would put her to bed. The family expected the patient to be brought home in an ambulance assisted by someone. The slide sheets for the patient's bed had been delivered to home but the family did not know how to fit them. They spoke with the care agency who informed them they would be shown how to fit the sheets when they visited. The care agency was expecting the patient to be able to get from her chair to the bed; they did not realise how unwell she was until they

	arrived. They informed the family that they could not manually lift the patient into bed so the family had to lift her themselves. The bed lever had to be changed, the incontinence pads were the wrong size and the mattress was made of foam. Medication was sent home in one big bag, mixed with injectables. The family contacted the ward asking for an explanation of the medication. They noted that the nurses were very helpful and explained what medication should be taken when. The family expected the carers to administer the injections, but found out from the carers that this was not the case. The family queried why there was no blister pack and was told that they should have asked for one. They were also in receipt of a letter from a dietician with inappropriate wording asking the patient if she was eating well since returning home, if she needed to continue with supplements stating that her case would be closed should she not respond within four weeks. This reinforced the family's belief that the healthcare professionals were not aware their loved one was dying. No advice or demonstrations were offered upon hospital discharge, the family was left to work things out for themselves. The daughters and granddaughters changed incontinence pads using their own technique. The family did not have contact numbers for the care agency, district nurses or community palliative care service. It was assumed upon discharge that they would have these numbers. The situation improved when the family contacted the care agency and district nurses. The district nurse liaised with Out of Hours who contacted community palliative care on call. The daughter noted that she had the insight to say the words 'end of life' when initiating conversations via telephone which definitely helped. The family were happy to look at each section of the Informal Carer Project after their loved one passed away. They reflected that the pack would have been extremely helpful to prompt necessary conversations prior to their loved one's discharge. It would have made them more aware of what lay ahead after discharge and they would have understood the carers' role. The document is individually tailored to each patient and an up to date list of contact numbers is included, also relevant to each patient. Equipment is now provided for the entire illness trajectory with all relevant instructions provided. Discharge medication is listed. Written information regarding moving a patient in bed, transferring to a commode and how to change an incontinence pad is provided along with QR codes directing to videos. Ongoing education is being provided for ward staff. The six pilot patients have been followed up and the families of patients who took the resource home reported it to be extremely useful. It was noted that the resource isn't yet available in Welsh, but the videos are. SA had left the meeting but noted in the Teams chat bar that this is the type of information Llais would love to hear about and it was suggested that AR shares the presentation with him. AM thanked AR for sharing the fantastic work which has been done and noted how the project will result in a real improvement for families supporting their loved ones wish to die at home. AR will share the electronic document with lead and senior nursed for them to read and comment on.	AR AR

09/23/07.1	OOH Business Report Further to item 7.1, HE noted that OOH is undergoing a deep dive into capacity and demand on services that sit under the CAV 24/7 umbrella.	
09/23/07.2	N&W Locality Business Report Assurance has been provided relating to the administration of Denosumab and its monitoring by the bone clinic. A SOP is being developed and will be brought to the next meeting for sign off.	HD
09/23/07.3	Vale Locality Business Report Many of the outstanding repairs at Broad Street have now been rectified.	
09/23/07.4	South and East Locality & HMP Business Report There was nothing further to add to item 7.4.	
09/23/07.5	Medicines Management. CC noted that the Health Heroes award is now open to independent contractors following on from a recent incident that took place in a community pharmacy. The PCIC team recognised the outstanding actions of a pharmacist who had been involved and supported a member of the public who became unwell when attending the pharmacy and queried why the award was not open to independent contractors. As a result, the pharmacist was presented with the Health Heroes award and independent contractors can now be nominated for the award.	
09/23/07.6	Palliative Care The Hospice team is going out to recruitment. This will hopefully enable the palliative care team to reopen commissioned beds which have been closed due to staffing capacity.	
09/23/07.7	Primary Care HIW have carried out an immediate assurance visit to a GP practice in relation to IP&C which is currently being worked through. Western Vale Family Practice has been awarded GP Practice of the Year with nominations being received by several patients. The award will be acknowledged in the newsletter and detail has been passed to the Comms team for inclusion in Chief Exec Connects. Recognition was given to the optometrist who recently identified a patient's corneal ulcer, saving their sight as a result. Significant work has been carried out in the Community Dental Service shifting capacity from approximately 45% to 80%. AM referred to privacy and confidentiality when attending Teams meetings and noted that VW and her team have drafted a SOP in relation to this. HK noted that RA is also drafting a paper on this matter and noted that it would be useful for the SOP to be shared.	VW

	AM noted that an internal audit is being carried out on all PCIC governance processes including QS&E.	
09/23/07.8	Mass Vaccination Centre (MVC) report VW has produced a guide about setting up a Teams channel. This work was carried out following on from a previous page being set up as a public page, not a private page. VW will share.	VW
09/23/08	Risk Register The next deep dive is scheduled on 3rd October 2023. RA has emailed business unit leads requesting that their tab on the centralised corporate risk register is updated. Business unit risk registers are not corresponding with the corporate register. AM explained that there is a separate tab on the corporate register that should be updated by business unit leads.	ALL
09/23/09	Business Continuity The last UHB Business Continuity meeting was stood down due to operational pressures. TB asked the group to check the S drive to ensure plans are up to date, indicating their review date on the front sheet.	ALL
09/23/10	PCIC Quality report There are currently no open NRI's however, there is one IRMER which is planned to be closed by the end of October 2023. It has been identified that previous IP&C data presented at PCIC QSE meetings was set against Health Board data and not PCIC data; therefore, this has not represented an accurate data set. The IP&C team is working closely with epidemiologists in PHW to identify accurate information in order to highlight areas that need addressing. This will allow a more accurate data set for PCIC. LW and ED are identifying any key themes that require further work in terms of education. Medicines Management now sits under a different title on Datix system. Due to this, only one pharmacy incident has been received since the change was made in comparison to 83 incidents the previous month, 60 of which related to community pharmacy. Further discussion is ongoing with the Datix team to clarify where the community pharmacy incidents will sit. This will be fed back at the next Q&S meeting. HK requested that 'learning from death' is added as a subdivision header within the PCIC Quality report so that both the mortality review process and the coronial process are covered. AM suggested that consideration could be given to a newsletter similar to the one produced by CTM at a future date. LW drew the group's attention to the wonderful compliments recently received. Datix IDs 20390 and 28595 were noted. LW explained that the nurse education team provides continuous support regarding wound care education and management, dressings selection and identification of pressure damage and grading. Item 10b 'alleged IG breach' referred to the legal requirements for the issuing of prescriptions and highlighted that the GP did not breach any regulations.	LW

09/23/11	Removal from the Medical Performers list on grounds of lack of activity September 2023 HK referred to item 11 noting that the paper was drawn up by the PCIC governance team. The MPL is managed by Shared Services on behalf of Health Boards but decision making is made by the PCIC governance team on recommendation of the Responsible Officer. Please refer to item 11 for further detail. It was agreed that item 11 could be signed off at PCIC level and forwarded on appropriately.	
09/23/12	IPC update The Cdiff RCA return rate remains at 100%. A European point prevalence survey looking at antibiotic usage in care homes will be completed between October – November. Wales will take part; the IP&C team is waiting to hear if CAV will participate. Teams are being encouraged to take up the offer of flu and Covid immunisation.	
09/23/13	Primary Care contractors HIW Inspection, IP&C requirements It was noted that it is unclear what the HIW inspection regime is for Primary Care contractors in relation to IP&C. The service is commissioned as part of a national contract with GPs; the contract states that GPs need to have appropriate IPC but does not direct or specify what guidance should be followed. Practices should be supported and provided with clarity on what the expectation is. It is hoped that there will be further clarity by the next meeting.	
09/23/15	SOP – Cold Chain Breach (Draft) Rebecca Stringer has developed a SOP for procedures dealing with cold chain breaches within GP practices (please see item 15). CC will read the SOP to ensure that it ties in with pharmacy processes and feed back to RS. The last quarter saw £14k worth of immunisations wasted. Processes will be discussed with the practice manager and lead nurse of practices who repeatedly breach, and a framework will be developed to potentially enable costs to be recouped by the Health Board where negligence is identified as a recurring issue. All practices have been offered data loggers.	CC
09/23/16	Safeguarding Ask DP to provide a formal report or update at the next meeting.	LTho
09/23/17	Annual audit plan LW thanked all who had contributed to the annual audit plan and requested that business unit leads ensure their plans are up to date.	
09/23/18	Dementia programme This item will be discussed at the next meeting scheduled on 28th November, 2023.	

09/23/19	Patient quadrant spreadsheet AM reminded the group to log any patient experience work/information on the patient quadrant spreadsheet.	
09/23/20	Any Other Business HK assured the group that the number of incomplete and unsent DALS (electronic discharge letters) are being dealt with at Health Board level and are actively being worked upon. CP reported that the South locality was visited by the NMC this morning and feedback was positive.	
PART 2	The Group noted the papers submitted for information.	
Date and time of next meeting: 28th November, 2023 at 11.00 am.		

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 26th September 2023 at 8.30am
Via Microsoft Teams

Present:		**Title**
Andy Jones	AJONES	Director of Nursing, Children & Women's Clinical Board
Alison Lewis	AL	Patient Safety Facilitator
Angela Jones	AJ	Senior Nurse, Resuscitation Service
Emma Bramley	EB	Quality & Safety Lead, CHFW Directorate
Siwan Jones	SJ	Clinical Nurse Specialist, IP&C
Becci Ingram	BI	General Manager, CYPFHS Directorate
Martin Edwards	ME	Asst Clinical Director, CHFW Directorate
Janice Aspinall	JA	H&S Lead Staff Side Representative
Laura McLaughlin	LM	Risk Manager, O&G Directorate
Abigail Holmes	AH	Director of Midwifery, Children & Women's Clinical Board
Catherine Wood	CW	Director of Operations, Children & Women's Clinical Board
Samuel Barrett	SB	General Manager, CHFW Directorate
Natalie Vanderlinden	NV	Designated Education Clinical Lead Officer (DECLO)
Tina Freeman	TF	Senior Nurse, CHFW Directorate
Suzanne Davies	SD	Senior Nurse, CHFW Directorate
Karenza Moulton	KM	Lead Nurse, CHFW Directorate
Lois Mortimer	LM	Head of Midwifery, O&G Directorate
Jane Jones	JJ	Clinical Director, CYPFHS Directorate
Rim Al-Samsam	RS	Clinical Director, CHFW Directorate
In Attendance		
Carris Bude	CB	Practice Educator, CHFW Directorate (Item 2.1 only)
Rachel Weston	RW	Staff Nurse, Paediatric Critical Care, CHFW Directorate (Item 2.1 only)
Nichola Davies	ND	Ward Manager, Paediatric Critical Care, CHFW Directorate (item 2.1 only)
Debbie Jones	DJ	Deputy Head of Quality Assurance
Apologies:		
Alison Davies	AD	Lead Nurse, CYPFHS Directorate
Anthony Lewis	AL	Clinical Board Pharmacist

Item No	Agenda Item	Action
CWQSE/ 2023/146	**1.1 Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2023/147	**1.2 Apologies for Absence** **The CWCBQSE resolved:** a) The apologies given were noted.	
CWQSE/ 2023/148	**1.3 Minutes of the previous Q&S Meeting held on 27th June 2023** The minutes of the meeting were agreed to be an accurate record **The CWQSE resolved:**	

	a) The minutes were noted and agreed	
CWQSE/ 2023/149	**1.4 To note and update the action log of the meeting of 27th June 2023** The action log was noted and updates provided. **The CWQSE resolved:** a) Action log to be updated and final version circulated for noting of updates.	**KH**
CWQSE/ 2023/150	**Presentation – Pressure Ulcers in Paeds Critical Care** CB and RW were welcomed to the group and provided an update on the tissue viability work that has been carried out within PCCU. There was an increased of hospital acquired pressure ulcers/worsening of pressure ulcers on the unit during the last winter period. The background to the work was provided, there has been increased education and a RW has been identified as the Tissue Viability Special Interest Working Group Lead for the Unit. Benchmarking has been undertaken with other PCCU centres and also Adult ITU regarding care plans in place. Lack of adequately trained staff/doubling up of patients/support to agency nursing were significant areas which impacted on the inability for nurses to maintain 100% of the patients receiving 4hourly turns/cares. A number of recommendations were identified and a PCC Skin Integrity pathway was developed, and has been implemented, which has been developed in conjunction with the purpose T assessment tool. Education on the products to use and the importance of moving through the products as this develops has been undertaken by all staff on the unit. Thanks, were expressed for the comprehensive work has been undertaken and it was noted that this was very assuring to see. Agreed that this should also be shared and presented at the next Q&S Meeting with WHSSC and UHB NMB meeting to share the excellent work that has been undertaken. Discussion ensued with regards to silicone pads and it was noted that they are single use for each patient, but can be washed and reused on different areas of the individual patient. It was noted that following implementation of this work, there has been a reduction in the number of incidents being reported, however it was noted that work is ongoing with regards to the turn team leading towards the winter period as it is felt that this will make a big difference to pressure relief for patients. Plan is in place for review of Grade 3/4 to ensure timely robust reviews and investigations are progressed **The CWQSE resolved:** a) The update was noted and agreed that the presentation would be shared for information and onward sharing. b) Presentation to be shared at the next Q&S Meeting with WHSSC c) Presentation to be shared at the next UHB NMB Meeting.	**EB** **AJONES/KM**
GOVERNANCE LEADERSHIP & ACCOUNTABILITY		
CWQSE/ 2023/151	**2.1Health & Care Standards Directorate QSE Exception Reporting** The detailed report was shared for information and an update was provided on the key highlights from the report.	

2.1.1 CYPFHS Directorate Report

- HPV Immunisation programme has commenced, with catch up clinics arranged for October and November 2023.
- Fluenz programme has commenced, and the Band 3 HCSW's are supporting. Catch up clinics will be undertaken at Shire Newton and Rover Way as this has previously been successful.
- ND continues to be a significant risk, due to the number of patients waiting. Transformation work is ongoing in order to improve the waiting times.
- CCNS continues to be a risk, and discussions are ongoing with regards to potential respite beds in the hospital footprint to help relieve some of the immediate risks.
- Work ongoing within Welsh Government with regards to the Healthy Child Wales Programme and review of Special Schools as there has been an increase in special schools' placements. Discussions have taken place with Head of the Western federation in Cardiff in terms of the way they operate and the expectations of the school nurses into the special schools and how the service can work differently to increase the amount of support the nurses can provide.
- Ongoing H&S threat with regards to patient at Ty Hafan. UHB are aware of the situation. Requests have been made by the mother to meet to discuss the release of the patient records and the post mortem. Further discussions to take place outside of the meeting regarding next steps.
- HV workforce remains a significant risk and work is ongoing with regards to sustainability of the two teams (Generic and Flying Start).
- Work ongoing with Adult Mental Health regarding recently reported NRI at Hafan y Coed.
- LAC review of caseloads has been undertaken and there have been improvements regarding the overall numbers reducing for initial health assessments and reviews, however there continues to be a backlog of which work is ongoing to address specifically for under 5's which continues to be the biggest risk.
- LD service, number of appointments have been made to the team and the risk assessment will be reviewed in light of this.
- Launch of the Hangout for C&YP which is provided by Platform, Mental Health and Social Change Charity. The service has been very well received and an excellent example of early intervention and prevention.
- Goleuddy Service, which was initially set up to support earlier discharge of CYP who are blocked in the CHFW. Team leader has left and also vacancies within the team. A risk assessment is being undertaken and meetings are taking place with the Local Authority.
-

Timely Access

- Achieved 93% for Part 1a compliance in Emotional Wellbeing and Mental Health and a reduction in the waiting list from 186 to 104 patients waiting in August. Increase in referrals leading up to Christmas are anticipated following the return to school.
- Achieved 0% for Part 1b compliance, on track to make 5% improvement in September. Whilst the compliance is at 0%, there has been a reduction in waiting list and the longest wait is currently at 20weeks. Once backlog of patients resolves, it is hoped that the compliance position will further improve.
- Part 2 dip in compliance in August, however this was due to a number of outstanding CTP's, which are being managed.
- For ND, there were 2134 patients awaiting assessment. Triage clinics will be commencing soon to manage the backlog, however it is anticipated that the waiting list is likely to significantly increase, with the longest wait being at

	153weeks. It was noted that whilst there was a significant number of children awaiting triage, the numbers have now significantly improved which provides assurance of reduction in the risk. • LAC – reduction in numbers waiting for an initial health assessment which has reduced to 109 waiting. 0% compliance for number of patients seen within 28days in August. **The CWQSE resolved:** a) The report provided was noted for information and key highlights and actions were recorded.	
CWQSE/ 2023/152	**2.1.2 CHFW Directorate Report** • 5 open NRI's at present, x1 anticipated to be downgraded following receipt of results from microbiology. X3 reports are nearing completion. • NICU/PICU continue to be the areas of greatest risk and work is ongoing to mitigate risks as they arise. • Main Datix incidents themes in month relate to lack of suitability of untrained staff and unexpected admissions to NICU. • Winter plan has been shared across the CHFW, outlining the plans to maximise patient flow and resources. • VBA week held in July which increased compliance significantly and a further focused week is planned in the coming weeks. • Tissue viability work is ongoing and a Paediatric Scrutiny Panel is being developed and SOP has been shared through Directorate Q&S for comment/ratification. • MRSA Outbreak on NICU and there have been no further MRSA cases reported. Further meeting scheduled this week which is hoped will close down the outbreak. An improvement plan has been developed and work is ongoing on the actions outlined. Increase in Klebsiella noted has been reviewed and confirmed that the cases are not linked. The only linked cases were from a set of twins. • IP&C RCA's completion has significantly improved, and work continues to complete the final outstanding cases. • Tendable Audits have scored 96% overall. CRO audits have been poor and discussions are ongoing as to how these can be improved going forwards. • Reduction in medication Datix incidents across August 2023, and work continues to monitor this. • Deputy and Senior Nurse Professional Nurse Forums continues, along with QR codes and monthly newsletter. Facebook page continues as a communication platform. • Several winter planning meetings have been arranged to update all staff on the winter planning process across the CHFW • New Trial Study has commenced for a drug for children with Cystic Fibrosis and currently the unit is the only UK centre with this trial running at present. Positive feedback has been received from the pharmaceutical company on the trial set up. • Patient Story shared for MTC Patient – YouTube video, outlining their pathway from PICU to Neurorehab pathway. • Shared decision-making document developed for PICU in line with the process used within NICU. AJONES requested a copy of this. • Concerns main theme for informal concerns remains as waiting times for blood tests and surgery waits. 9 formal concerns are progressing. • Vacancies and recruitment process continue across all areas. Streamlining closed, and 9 newly qualified staff have applied. Quality Lead Nurse post for NICU is progressing.	

	Timely Access • 246 waiting between 36-52 weeks for new outpatient appointments, with only 12 patients requiring a date which is a significant reduction of appointments. These patients who remain without a date require clinical guidance and are in the process of being booked as priorities • Waits for General Paediatrics outpatients remains high due to demand. There are currently x2 consultant posts being progressed. • Outpatients utilisation process is being progressed to ensure full utilisation is offered to all services to increase capacity. • No children waiting over 36weeks for a new Cardiology appointment. There are currently 267 children in the new outpatient pathway, 163 of which have appointments and 104 now require appointments to be booked. • Waiting Targets are expected to increased due to consultant workforce shortage. • Endoscopy – 96 children on the waiting list, 83 of which are over the 8-week target. A new theatre list is being progressed which is anticipated will significantly help reduce the waiting list. • Paediatric Surgery - 236 children waiting over 36 weeks, and 131 waiting over 52 weeks. Some of the challenges relate to PICU HDU beds post operatively, 11 cancellations in July due to staffing pressures. • No children waiting over 52weeks for a new outpatient appointment for Paediatric Surgery and the longest wait is 40weeks with an appointment, the longest wait without an appointment is currently at 16weeks. It was acknowledged the significant shortage of staff across NICU and PICU and the Health Board have agreed 15wte internationally educated nurses to help support and mitigate the risks within the service. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded. b) Shared decision-making tool for PICU to be shared with the Director of Nursing outside of the meeting.	**EB**
CWQSE/ 2023/153	**2.1.3 O&G Directorate Report** • Foodwise app is now live and further plans to review the outcome measures with Digital Cymru Team. • Smoking cessation officer appointment being progressed • Perinatal MH – awaiting psychologist role advertisement to go live. • Breastfeeding guardian approved and is being progressed • Birth partner project supporting antenatal classes • Baby Loss Awareness Week taking place between 9th – 15th October. • PGD's for oral contraceptive pill, depo and implant is being reviewed as a generic template has been released by Public Health Wales. • Staff vaccinations have commenced for Flu and COVID. • 163 incidents reported in August, 800 open incidents at the time of this report which are currently being worked through. Investigations x7 for Gynaecology, x2 of which are NRI, x22 for Obstetrics, x8 of which are NRI • Theme of the month for August relates to Hyponatremia. Some learning shared with AB UHB (following rapid review case undertaken relating to a patient who was out of area). • X1 tissue damage reported in Gynaecology for August. Reviewed and reported as Grade 1. • X2 Falls reported for August. No ongoing concerns • 8 medication errors reported for August within Obstetrics. • Ongoing work with Gap and Grow implementation	

	• Funding agreed for mural outside antenatal clinic as part of communication work with the theme of inclusivity. • Number of digital projects ongoing, including new Maternity Dashboard, and accessibility of risk and governance information. • Recruitment is ongoing across a number of areas. 33wte midwives commenced in September 2023. • Executive Nurse Director has agreed to be the executive breastfeeding sponsor. • Birth partner project has been very successful however funding has now been withdrawn. Discussions are ongoing to review alternative funding resource. • PROMPT compliance currently at 75%. Queries were raised with regards to the plans to achieve the target set. It was noted that there needs to be an ongoing All Wales discussion as it has been noted that some Dr's are attending (as part of rotation) who are already out of compliance, and this should be agreed that it is a responsibility of the initial Health Board they are with, similar to an All Wales passport for mandatory training. • Ethnically diverse care to be added to the report as a standing item to update on the work that is being undertaken. **Timely Access (taken directly from Directorate Report)** RTT update for Quarter 2 (end of Sept position); 156 weeks Quarter 2: Currently 9 without TCI's 104 weeks Quarter 2: Currently 239 without TCI's 52 weeks Quarter 2: Currently 34 who have future OPA's Urgent Pooled: Current wait is 2/3 weeks (on target) Diagnostics: Forecasting 11 by the end of September waiting +8 weeks No cancer updates available. Agreed to be followed up outside of the meeting. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded. b) Cancer update to be shared c) Ethnically diverse care to be added as standing item update in Directorate report	**LMc/LM** **LMc**
CWQSE/ 2023/154	**2.2 New Risks to be considered for the Clinical Board Risk Register** X2 new risk assessments being completed for addition to the Directorate/Clinical Board risk registers. • Fragility of consultant workforce within the CYPFHS which is impacting a number of areas, specifically in relation to safeguarding child protection rota and SARC and a risk assessment is being developed which will be shared • Fragility of consultant workforce within PICU from February onwards to be reviewed and considered It was agreed that the risk assessments will be shared at the next meeting. It was requested that the updated Directorate Risk Registers to be shared by the middle of October in readiness for the next Clinical Board submission	**BI** **SB**

	The CWQSE resolved: a) New risks noted. Risk Assessments to be shared at next meeting. b) Updated Directorate Risk Registers to be shared outside of the meeting.	**ALL**
SAFE CARE		
CWQSE/ 2023/155	**3.1 Patient Safety Update** Overview shared with regards to the current position for the Clinical Board. There are 13 NRI's open for the Clinical Board, with x6 overdue. It was acknowledged with regards to the pressures with time constraints and the importance of timely completion and review of learning for the family. Patient Safety are reviewing the current process and how the team can help support. These ideas will be presented shortly. It was noted that new incidents require review within 7 days and the importance of review was reiterated to ensure that timely review is undertaken and incidents are moved on within the process. All areas were asked to ensure that the new incidents are reviewed and progressed/actioned. Requested that all 2022 incidents are reviewed and closed/actioned by the next meeting. Patient Safety Learning Review (PSLR) Tool training is being developed and will be shared as soon as possible. **The CWQSE resolved:** c) Update report was noted. d) Directorates to review all 2022 incidents and close/action appropriately by the next meeting.	**ALL**
CWQSE/ 2023/156	**3.2 NRI/PSLR/Closure Forms for discussion/exception reporting** **SBAR, PSLR & Improvement Plan – RF (Datix Ref 21344)** Post-natal re-admission, patient diagnosed as suffering a subarachnoid haemorrhage. The background to the case was provided (full detail included within the SBAR and PSLR). The outcome of the investigation noted the following issues: Issue 1. Discharged without Labetalol Issue 2. Level of review by Doctor on the OAU Issue 3. No follow up visit organised Issue 4. Incorrect telephone advice Conclusion on terms of reference and specific review questions - The injuries suffered by the patient may not have occurred with different postnatal management of her chronic hypertension. **Recommendations** • All postnatal readmissions should have a senior obstetric review in line with BSOTS guidance. • All patients need discharge communication. • Review of discharge processes from UHW to the community and primary care. It was noted that the discharge summary was incomplete, therefore GP not aware/understand the need for more urgent appointment for review/monitoring. • Case to be shared for learning Discussion ensued and it was agreed that there were a number of areas of	

	miscommunication throughout the pathway of care. Queries were made as to how the service can ensure that these actions are embedded into practice. It was noted that work is ongoing with regards to compliance of the BSOTS guidance and reviews are being undertaken to ensure that discharge summaries are regularly being completed and this is being monitored through the risk and governance processes (for those cases that are discussed at Clinical Risk). It was noted that there is an audit that is currently being undertaken around discharge documentation which is being monitored and actioned through AMaT. The report was approved for sharing with the family and for progression to closure. **SBAR, PSLR & Improvement Plan – CR (Datix Ref 23789)** Delay in clinical assessment for a patient with a ruptured ectopic pregnancy. The background to the case was provided (full detail included within the SBAR and PSLR). The outcome of the investigation noted the following issues: Issue 1. Inappropriate management of Pregnancy of unknown location (PUL) Issue 2. Failure to recognise and escalate signs of hypovolemia. Issue 3. Unsafe transfer to C1 Gynaecology. Conclusion on terms of reference and specific review questions – the patient's care was adversely affected by the absence of clear referral pathways between PAS and Gynaecology. When she presented with signs of haemodynamic instability this was not recognised by emergency staff and not escalated appropriately. As a result, it is likely that her care was delayed; that she was exposed to avoidable risk by unsafe transfer between clinical areas and emergency surgery while clinically unstable. **Recommendations:** • Ensure that clear written guidance is produced for referral of patients from PAS to C1 Gynaecology including a written summary to accompany patient/upload on Welsh clinical Portal (WCP) to ensure that medical information is available to the ward staff and medical staff. • Local EPAU guidance to be updated to clarify process for management of PUL by non EPAU clinicians. • Patient journey and case discussion for emergency Gynaecology junior staff and ED staff. • WAST paramedic update about atypical presentation of haemodynamic instability in young women. The final report will be shared with the EU Department, OPAT team and WAST to share lessons learnt from the case. Once shared through Directorate Q&S it was agreed that the report could be approved for sharing with the family and progression to closure. **The CWQSE resolved:** a) The cases were noted and approved. b) Cases to be progressed for sharing with the family and closure process to Welsh Government. c) Case CR to be shared with EU Department, OPAT team and WAST to share lessons learnt from the case.	**LMc/AL** **LMc**

CWQSE/ 2023/157	**3.3 NRI/PSLR/Closure Forms for noting/exception reporting** **(cases have been discussed as part of the NRI/RCA Governance Sub Group Meetings)** • SBAR, Improvement Plan & Closure Form – Patient RR (Datix Ref 15524) • SBAR, Improvement Plan & Closure Form – Patient LC (Datix Ref 32954) • SBAR, Patient Safety Learning Review Tool – Patient KJ (Datix Ref 23561) • SBAR, Birth Injury Tool – Patient SR (Datix Ref 18320) • SBAR, RCA & Action Plan – ML (Datix 25392) • SBAR, RCA & Action Plan – CF (Datix 27205) • SBAR, RCA & Action Plan – AC (Datix 16881) • SBAR, RCA & Action Plan – RD (Datix Ref 5514) • Final Improvement Plan – CL (Datix Ref 11182) All the cases were noted for information, and sharing of lessons learnt. The cases have been discussed in detail as part of NRI/RCA Governance Sub Group. There were no specific exceptions to note for this meeting. Notes from the meeting will be shared for information. **To note the Final Improvement Plan – MG (Datix Ref 6551) – Deferred.** *Postscript – The final improvement plan will be shared for information following sign off by Specialist Services Clinical Board as the actions/improvement plan developed will be led by Neurosciences Directorate. There were no specific actions for the Maternity department following the investigation.* **The CWQSE resolved:** a) The cases were noted. b) NRI/RCA Governance Sub Group Minutes from 12th September to be shared for information at the next meeting.	**KH**
CWQSE/ 2023/158	**3.4 Personal Injury Claim for noting** **Learning from Events Personal Injury Claim - PI/UHW/DCIQ/1313** The case was shared for information and for onward dissemination to share and note lessons learnt and findings from the claim. **The CWQSE resolved:** a) The case was noted.	
CWQSE/ 2023/159	**3.5. Infection Prevention Control Update Report** The report was shared for information. • X1 C Diff and x1 E Coli bacteraemia for Pelican in August • No cases reported for September from Tier 1 organisms The new reduction targets are included within the report. • Target 6, current position 2 – C Diff • Target 0, current position 1 – MRSA • Target 8, current position 3 – E Coli • Target 4, current position 2 - MSSA • Target 0, current position 1 – Pseudomonas • Target 4, current position 3 – Klebsiella 7 outstanding RCA's for the Clinical Board (x5 for CHFW / x2 for O&G). Audits are ongoing, with the next joint audit on Owl Ward with housekeeping, estates and the senior nursing team. There is a planned audit for November within	

	Maternity services. Poor compliance with CRO audits and risk assessment has been shared with the areas. Thanks, were expressed to Rainbow Ward who have implemented CRO risk assessment sticker which has been effective, with the latest audit results significantly improved. All were asked to ensure that there is a winter plan in place and that all are aware of the respiratory pathway. Any inpatient with respiratory symptoms is required for a PCR and isolation. LFT's are not recommended. Promoting staff vaccination for COVID/Flu and ensuring appropriate stock levels and fit testing for staff, to ensure preparedness in readiness for the winter. KM noted that further discussion will be required outside of the meeting in relation to the respiratory pathway and possible impact to the current winter plan Safe to move guidance has been circulated for information. KM noted that this is not transferable directly for Paediatrics and further discussions are required as to how this can be adapted for implementation. **The CWQSE resolved:** a) Update noted. b) KM/SJ to discuss respiratory pathway outside of the meeting c) KM/AJONES to discuss the safe to move guidance for Paeds	**KM/SJ** **KM/AJONES**
CWQSE/ 2023/160	**3.6 Safeguarding** No issues to note for this meeting. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/161	**3.7 Patient Safety Alerts (internal/external)/Welsh Health Circulars** • Safety Memo - Oxygen Flowmeters • Safety Memo - Falls Sensors • ISN 2023 004 - Defibrillator pad placement • AWMSG Endorsement - All Wales Paediatric Asthma Management and Prescribing Guidelines • Roche Field Safety Notice • NatPSA_2023_009 - Synthetic opioids and heroin overdoses • Safety Memo - Calcium Gluconate • ISN 2023 005 - Amiodarone pre-filled syringes The alerts were noted and have been disseminated widely across the Clinical Board. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/162	**3.8 NICE Guidance – Update on Progress** The latest statement of compliance activity was shared with the group for information and request for review of any actions to be completed as it was noted that there are a number that are overdue. DJ noted that if there are any specific concerns, or the need for additional support all were asked to contact Clinical Audit team. **The CWQSE resolved:**	

	a) Update noted. b) Review of all overdue statements of compliance to be undertaken and update of actions to be undertaken	**DMT's**
TIMELY CARE		
CWQSE/ 2023/163	**4.1 Paediatric Same Day Emergency Care (PSDEC)** The update was noted for information and outlines the change from the Children's Assessment Unit to the Paediatric Same Day Emergency Care (PSDEC) Unit to align to other SDEC units across the Health Board. CAU has been compared to surgical and medical SDEC in Adult services and have aligned the Paediatric SDEC to this. This will then align to the Children's Hospital Alliance and their Paediatric same day emergency care work, allowing the service to work nationally with the. This has been shared widely with Paediatric ED and are aware of the change being taken forward. The Clinical Board are fully supportive of this change, and will provide clarity to how the PSDEC service differs to that of the Paediatric CDU work that is being taken forward by Paediatric ED. **The CWQSE resolved:** a) Update noted. b) The change of name was supported.	
CWQSE/ 2023/164	**4.2 Directorate concerns & assurance update** Discussed as part of the directorate reports. Thanks, were expressed to all for the significant ongoing work undertaken, specifically with the progression of 100-day concern responses. **The CWQSE resolved:** a) Update noted.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2023/165	**5.1 NRFit Changeover** Shared for information. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/166	**5.2 Doctrina – Welsh Risk Pool Learning Advisory Panel Newsletter** Shared for information. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/167	**5.3 Drug Safety Update – Reminders on Fluoroquinolones & methotrexate and valproate** Shared for information. **The CWQSE resolved:** a) Update noted.	

CWQSE/ 2023/168	**5.4 EIDO Quarterly Update – April -July 2023** Shared for information. Information sheets and support for consent is available in a number of different languages. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/169	**5.5 CSSSI Report – Quarter 1 2023** Shared for information. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/170	**5.6 Child Death Review Report** Shared for information. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/171	**5.7 Sibling sexual behaviour: A summary guide to responding to inappropriate, problematic and abusive behaviour** Shared for information. **The CWQSE resolved:** a) Update noted.	
ANY OTHER BUSINESS		
CWQSE/ 2023/172	**Duty of Candour Process – Nationally Reportable Incidents (NRI)** Shared for information and onward dissemination. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/173	**Paediatric Resus Practitioner** This issue has been added to the Health Board Risk Register **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2023/174	**Health Contribution to the ALNET Act** Paper will be shared at the next meeting for further discussion. **The CWQSE resolved:** a) Paper to be shared at the next meeting	
CWQSE/ 2023/175	**6.1 Date and Time of Next Meeting** Tuesday 24th October 2023 (H&S Focus Meeting), 8.30am, Microsoft Teams	**ALL to note**

Minutes of the Specialist Services Clinical Board
Quality, Safety and Experience Committee

2 October 2023 9:30-11am

Via MS Teams

Chair:		
Claire Main	CM	Director of Nursing, Specialist Services
Present:		
Angela Jones	AJ	Senior Nurse, Resuscitation
Colin Gibson	CG	Consultant, Clinical Engineer ALAS
Ceri Phillips	CP	Lead Nurse, Cardiac Services
David Thomas Edward West	DTW	Consultant Critical Care
Gareth Jenkins	GJ	Directorate Manager, Haematology
Helen Thomas	HT	Lead Pharmacist for Specialist Services Clinical Board
Jane Morris	JM	Senior Nurse PART
Jo Clements	JC	Lead Nurse, Critical Care
Jordan Wilmer	JW	Service Manager for Non-malignant Haematology, Immunology and Metabolic Medicine
Keith Wilson	KW	Consultant Haematologist
Laszlo Szabo	LSz	Consultant Transplant Surgeon
Lisa Higginson	LH	Lead Nurse, Nephrology and Transplant
Lisa Simm	LS	Service Manager, Neurosciences
Lewis Whitehorn	LW	Service manager, Cardiac
Mike Stephens	MS	Interim Clinical Board Director Specialist
Rachael Sykes	RS	Assistant Head of Health and Safety
Sian Williams	SW	Senior Nurse, Cardiothoracics
Richard Parry	RP	Q&S Facilitator Specialist Services
Secretariat		
Natasha Bevan	NB	Pa for Specialist
Apologies:		
Bethan Ingram	BI	Senior Nurse, Teenage Cancer Trust
Claire Mahoney	CM	CNS Infection Prevention & Control
Tracey Skyrme	TS	Head of Inquests
Niamh Sully	NS	Patient Safety
Nicola Carter	NC	Service manager, Haematology
Jessica Castle	JCa	Director of operations for Specialist Services

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Item No	Agenda Item	Action
1.1	**Welcome & Introduction**	CM
1.2	**Apologies for Absence**	
1.3	**To review previous minutes** Mat D chaired the last meeting, last minutes with him to review will share as soon as finalised.	
1.4	**NRI – Presented by Paul Rogers** Complex case from 2021 where a wheelchair user fell out of the wheelchair. Whilst works were carried out on the chair there was a failure to notice the missing belt which could have prevented the extent of the injuries. The order was placed for the belt but due to availability of other parts this carried on being held Unfortunately due to the injuries sustained and subsequent complications the user has had a BKA. This is jointly investigated with Swansea Bay where the inpatient care took place. A formal review took place after this which highlighted a series of recommendations. Paul Rogers presented these to the group. As a result of this a significant review of processes was undertaken including checklists of review of orders. CM thanked Paul for the work undertaken and the learning undertaken. It was also acknowledged that this had an impact on the staff involved as the service user is a long-term client and continues to be supported in the service.	
1.5	**Updates from Directorates** LH provided the N&T updates – biggest challenge highlighted was the continual water leaks which have been escalated through estates and clinical board Haematology – Ward move B4 to move up to C5, GJ to meet up with estates today however looking to move in Friday after a few water tests etc. Cardiac- CP provided the update, ongoing capacity issues as well as issues with office space. 6 teams now without an office and although in touch with Estates no update as of yet. CM and Ceri P to pick up outside of this meeting.	

	ALAS- PR mentioned Rookwood site and the fact that they have raised a concern about a safe exit from the site, wheelchair users have their road tests there but now concerned with it being busier due to the MVC Neurosciences- LS also touched on Rookwood hopefully able to move outpatient activity completely from there within the next few weeks. CC – DTW – site issues this morning issues accessing psych services for a sectioned patient so that continues to be a problem. Messages of the month was discussed and how it's been a huge success– CM asked if Tom and Hayley could also present this to the group at a later date. Jane Morris – PART JM informed the group that 24/7 service started yesterday, few teething problems working through so all the ward teams know who to call. Will feedback if any problems. 2nd Anniversary for PART today.	
	Safe Care	
2.1	**Open Nationally Reportable Incidents** RP ran through the open ones currently, looking to close open NRI for patient JD this afternoon, after the meeting. **Potential NRI's** New one – patient had a bleed and passed away, family reported that the patient was under the care of Neuro and already a record of mdt, looks like the patient has been lost to follow up. .	.
2.2	**Closure Forms** RP ran through and presented 2 closure forms to the group. ID18570 - NRI investigation outcor The 2 closure forms are attached here Discussions took place within the group around these 2 cases. **The GROUP resolved:** This has been great to show what gaps we have in the processes so now we can address the issues, super helpful for all. We will continue to bring these here to this forum. CM thanked RP as this is a huge amount of work	RP ID13127 Signed NRI Investigation Outco

Commented [CM(aVU-ID1]: We will need the details of these added and the closure forms. Can you link in with Richard to close this please

Commented [NB(aVU-SS2R1]: Closure forms added

Commented [NB(aVU-SS3R1]:

2.3	**Alerts / Patients Safety Notices** The following notices which have been disseminated to the Group from last time, to share as appropriate. All saved on SharePoint. Diphtheria in Asylum seekers Study day next week **The GROUP resolved:** • All documents shared at this meeting to be shared within the Directorates.	LfE In152962 NIN 2021 229 for DU.doc
2.4	**Healthcare Associated Infections** No HCAI report received – Claire Mahoney not on the call.	
2.5	**Health Care Standard 2.9 Medical Devices** Colin Gibson – ALAS informed all that he would be happy to present at the next available meeting.	
2.6	**Health and Safety** RS informed the group of a previous incident that occurred with batteries catching fire, this has been thoroughly investigated. And procedures put in place to prevent this happening again. D Walker ref - PI/ROOK/DCIQ920 The Claimant a Health Care Support Worker (HCSW) was transferring a reduced mobility patient with the help of another HCSW colleague, the move was undertaken by using a wooden slide board to transfer a patient from the bed to a shower chair. The Claimant was holding the patient's legs guiding her across the wooden slide board onto the shower chair. It was alleged that although the brakes were on, the chair moved away from the wooden slide board during the manoeuvre. Subsequently, the claimant took the full weight of the patient, causing her to sustain an injury to her lower back injury. The incident occurred in November 2019. **Issue** **Action** Shower chairs and equipment with problems around maintenance and repair.	

	Due to the age of the building (1932) it had become challenging to manage patients with specialist physical needs due to the building layout and the limitations this presented. Issues around manual handing compliance and patient preference despite risk assessments in place. 1a. On move of the unit all chairs were replaced with new ones. (Competed) 1b. New and improved equipment provided. (Underway) 1c. Improve procurement procedures for accessing and replacing chairs. (Underway) 1d. Dedicated specialist repairer being sought for specialist spinal chairs (Completed) 2a. Spinal unit moved to a dedicated new spinal & rehabilitation unit to UHL. (Completed). 2b. More space in bathrooms and shower areas. (Competed) 3a. Practice development nurse now in post to support clinical staff (Completed) 3b. Staff re-orientated and further supported to new working area (Competed) 3c. Update manual handling training. (See compliance) 3.d. Regular meetings regarding incidents/QSE & H&S meetings. (To follow) 3.e Input from (H&S) to support with further manual handling. (Completed) 3.f Audits in place as part of learning process (Audit Completed and Action plan being worked jointly H&S & Ward)	
2.7	**Risk Register** As a board we have a number that are out of date and don't reflect the issues. MD and CM ask each directorate to share their live systems on the channel so they can review what they have, Aaron fowler and team will assist then with anything further.	All

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	Action: teams to add their risk registers on to teams' channel	
	Governance, Leadership and Accountability	
3.1	**Feedback from UHB QSE** RS – presented to the group the update on the last meeting	RS
	Items to be Recorded as Received and Noted for Information by the Committee	
4.1		
5	**Any Urgent Business**	
	CM reminded all to access their vaccines to protect themselves, patients and colleagues. Will share the data once received at the next meeting.	
6.	**Date & time of Next Meeting**	
	26.10.2023 9:30am via Teams	

Bwrdd Diogelu Caerdydd a'r Fro
Cardiff & Vale Safeguarding Board

Child Practice Review Report

Cardiff & Vale of Glamorgan Safeguarding Board
Concise Child Practice Review

Re: *CVSB CPR05/2019*

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

Legal Context

A Concise Child Practice Review was commissioned by Cardiff and Vale Regional Safeguarding Board on 22nd February 2020, on the recommendation of the Child and Adult Practice Review Subgroup in accordance with the Guidance for Multi Agency Child Practice Reviews 'Working Together to Safeguard People (Volume 2)'. The criteria for this Concise Child Practice Review are met under s3.4 of the above guidance issued under the Social Services and Well Being (Wales) Act 2014.

The criteria for child/adult practice reviews are that the child / adult has:

- Died or
- Sustained potentially life-threatening injury or,
- Sustained serious or permanent impairment of health or development

In accordance with the guidance, the criteria for a Concise Child Practice Review was met, as Toby was found murdered during August 2019. A Concise Child Practice Review was commissioned.

During August of 2019, Toby's body was discovered at an Industrial Unit in the Vale of Glamorgan. He had been fatally stabbed. Four individuals were subsequently convicted of murder, and three individuals were found guilty of manslaughter.

Toby was 17 years old at the time of his death, in the prior months there had been multiple concerning incidents including significant violent threats to Toby and his family, one incident included the sighting of a firearm. On at least two occasions Toby attended A&E with significant injuries which he disclosed had been sustained during assaults. Agencies

suspected that Toby was involved in the supply of drugs and criminal activity such as being involved in threatening behaviour with weapons. Information had also been provided to Children's Services that Toby was involved in County Lines drug distribution.

In addition, it is recorded, despite efforts to engage Toby he left mainstream education prior to statutory school leaving age.

Information provided from individual agencies highlights safeguarding concerns, including involvement and continued risk of child criminal exploitation (CCE). It appears that this information was not adequately shared between individual agencies.

Initial strategy discussions were held (following a red RAG rating by Children's Services), but they did not identify that Toby was at risk of significant harm and agreed that a well-being assessment should take place. This decision was reviewed by a single agency without considering history of concerns and multi-agency knowledge was not capitalised on. As a result, no care and support needs were identified.

It is unclear how Toby became involved in the distribution of drugs and whether he was trafficked between areas to supply drugs. Regardless of this, Toby was a child and the safeguarding measures in place to protect him were inadequate.

Key:

MARF - Multi Agency Referral Form.

RAG Rating – cases are sometimes rag rated (red, amber, green) indicating levels of concern / risk.

CCE - Child Criminal Exploitation.

CSE - Child Sexual Exploitation.

MASM - Multi Agency Safeguarding Meeting.

MDT - Multi Disciplinary Team.

Support 4 Families – A Children's Services Early Help Team, which provides early intervention and prevention services which aim to avoid families escalating to statutory services. The service works to ensure that families and young people receive the right help, at the right time and at the right level.

Think Safe – A Children's Services exploitation team, working with young people at risk of and who are experiencing sexual and criminal exploitation.

Well-Being Assessment – The local authority has a duty to offer an assessment in relation to any child where it appears that the child may have needs for care and support in addition to or instead of the care and support provided by the child family'.

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

Safeguarding during Adolescence

Between October 2017 up until his murder on the 28th of August 2019, Toby came to the attention of South Wales Police (SWP) on twenty occasions. Some of these contacts related to Toby being the victim of assaults and threats (involving knives and guns) which appeared to escalate in seriousness and severity. Others were in relation to involvement in criminal activity involving drugs, gangs, knives and as a passenger in the theft of cars. Toby was also identified as potentially being involved in County Lines. He had also been reported as a missing person. He disclosed on more than one occasion that he was using cannabis and that he felt unable to report threats/ assaults due to fear of repercussions. Intelligence showed that the individuals Toby was associating with had been heavily involved in criminal activity for some time. Toby's parents reported that they had been threatened with a gun from an individual who posed a threat to Toby, in addition they had their own concerns in relation to a change in his behaviour and what he was potentially involved in. Five days before his murder his family were threatened that their house would be burned down if Toby's whereabouts were not disclosed.

Public Protection Notices (PPN) used to share information by the Police with other organisations could have been completed on 12 occasions in respect of Toby and his interactions with SWP. PPNs were completed on 4 occasions, but on only two of those occasions were the PPNs shared with other agencies. The only conclusion that the reviewers could draw was that it appears that Toby's vulnerabilities were not recognised as he was not yet an adult.

In April 2018, Police submitted a PPN to Children's Services regarding an ongoing feud with another individual and threats to Toby including a video of his phone being smashed. As a result of this incident Toby was later placed on a Youth Referral Order, again his vulnerability was not recognised.

Between the 18th of March until the 28th of August 2019, Children's Services received information from the Police, Toby's parents and a third party that Toby was involved in drug use and supply, County Lines, being a passenger in stolen cars and driving illegally. It was acknowledged that Toby was involved with weapons and that his family had been threatened with a firearm. Despite this, there does not appear to have been any progression to look at multi-agency or historical concerns which may have demonstrated Toby was at risk of significant harm.

Information Sharing & Early Intervention

The review has identified that there were missed opportunities for all agencies to share information throughout the process. In October 2017, Police were involved after Toby was 'beaten up' by a gang of boys which left him with significant injuries including facial fractures. At that time Toby also shared that he had been threatened with a knife a week earlier, however no PPN was submitted by Police and no MARF was made from Health.

Prior to this in September 2017, following Toby's attendance at A&E, a MARF was submitted by Health itemising relevant safeguarding concerns, including the possibility that Toby was dealing drugs. Children's Services have no record of receiving this MARF. Toby's GP and school nurse were notified and the school nurse attempted to make contact with Toby.

In December 2017, Education documented that Toby had not attended tuition for 4 weeks. A letter was sent to his parents, but no follow up action was taken.

In April 2019, the family had moved house in an effort to minimise the risks of violence and threats to themselves and their home.

In May 2019, Toby and his parents met with the Support 4 Families support worker. It was at this time that Toby's parents raised that they were extremely worried for their children's safety (both Toby and his sibling) and were shocked when they were informed that information had been received that Toby may be involved in County Lines. All parties accepted that Toby had become an angry young person over the past 12 months.

At this point, the level of support that was being offered to Toby was on a voluntary basis and our records state everyone at the meeting agreed that the case could be closed.

Case recordings show that individual agencies were aware of numerous serious incidents in which Toby had been involved. This information was either not shared, inadequately shared or previous incidents were not compared and considered. It would seem that the escalation in criminal behaviour, known associations with others involved in crime, threats to Toby and his family, and the possibility of exploitation were not considered holistically at this time.

Disengagement from Education, Employment & Training

A positive that came out of the review, was the involvement of the Youth Worker attached to the school that Toby was referred to earlier whilst at high school, who appeared to have a positive input. However, once that support ended there was not the opportunity for Toby to be rereferred. The importance of the role of Youth Worker must not be underestimated, they are specifically trained and skilled to work with young people and could be the one key professional in the individual's life who are able to develop a positive relationship, identify concerns and engage the relevant professionals.

Reporting Concerns

Toby's parents reported that they did not know where to turn when they were concerned about Toby. In the Learning Event, it was acknowledged that professionals and members of the public (family, friends, associates) need to be aware of how they report safeguarding concerns, and the option to report anonymously through Crime Stoppers or other advice organisations.

In addition, if professionals share information and do not feel appropriate action has been taken, they need to be able to challenge decision making and escalate their concerns when required. In addition, Cardiff & Vale regional Safeguarding Board have a multi-agency escalation policy that can be used to resolve professional disputes.

Similarly, members of the public can follow individual agencies complaints procedures should the need arise.

Adolescent Safeguarding Considerations

Age can play a part in whether an individual is perceived as at risk. After the age of 16 there can be a tendency to not see the child when criminality and associated behaviours become an issue.

At this age there is a greater need for effective multi-agency chronology building including associations and escalation of criminality and risk. This should be alongside professional curiosity and appropriate professional challenge.

There should be consideration via the assessment process to ensure access to the appropriate support from key agencies. This is particularly important where parents/carers are seeking help for their adolescent child. Assessment should be holistic and consider sign posting to the appropriate agencies.

Recognising parents and children as the 'experts' in their own lives and listening to their voices is integral to managing and reducing risk.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the SAB and its member agencies and anticipated improvement outcomes: -

Agency Improvements in Practice

All practitioners who attended the Learning Event have shared their views on how practice has improved within their agencies since the tragic event of Toby's murder. Some actions have already been taken to improve practice in the time that has elapsed and these are listed below:

- **PPN Submission / Rationale**

Improvements are in place to ensure the appropriate submission and sharing of Public Protection Notices (PPN). It is now mandatory within South Wales Police for a PPN to be submitted for any child brought into custody, including those attending voluntary interviews. Any young person (aged 10-17) brought into custody is also offered access to a Custody Youth Worker. The receipt of high risk PPNs for young people result in an immediate response from Children's Services, MASH (Multi-agency Safeguarding Hub) assessment and a multi-agency plan. Child exploitation flags are used on the South Wales Police (SWP) system to identify concerns and direct officers to other individuals associated with a young person. Following continuous professional development days (CPD) on child exploitation, there is more awareness that all young people involved in an incident need to be included on a PPN and consideration given that involvement in criminality may be exploitation of vulnerabilities and therefore a clear safeguarding concern. In addition, there has been a restructure within South Wales Police to ensure a consistent and coordinated response to child criminal exploitation (CCE) across the force area, which will provide sufficient capability and capacity to investigate and disrupt CCE and to safeguard victims.

Arrests of young people in the South Wales Police (SWP) area are now reviewed by Youth Justice Service (YJS) staff who will request that arresting officers submit a PPN for those under 18 years of age, if one has not already been completed. Where SWP become aware that there is intelligence about the associations of young people which are of concern, a PPN

is requested and this is shared with MASH for assessment, discussion and intelligence sharing. Young people with suspected links to County Lines and other criminality can be seen by the St Giles Trust staff whilst in custody and offered support.

The Youth Justice Service (YJS) has developed a consistent way of recording contacts with children and young people, there are flags on their system for those involved with the Prevention Service and the Referral Order process has changed. Visits to children and young people involved with the YJS can now take place in more varied community settings to increase accessibility and engagement.

Since June 2021, Cardiff has taken part in a national pilot whereby the National Referral Mechanism (NRM) decision making process is devolved to Local Authorities. 10 Authorities are taking part nationally. The NRM decision process allows professionals to review evidence and information and then conclude as a panel whether they believe a child has been/is being exploited.

The NRM decision making panel is made up of core voting members who include senior staff from Local Authority (Children's Services), Health and Police. A representative from the Independent Child Trafficking Guardian (ICTG) service is also mandatory at panels but does not have decision making capabilities. In Cardiff, the social work case manager is also invited to present the case and submit any evidence for decision making but is not required to make decisions regarding the NRM. By building local mechanisms the quality and timeliness of decisions has improved, as well as improvements and increased connectivity between existing safeguarding mechanisms and the NRM process.

- **Information Sharing between Agencies**

Since 2016, there has been a Multi-Agency Safeguarding Hub (MASH) in Cardiff where all MARF referrals are received. Improvements have been made and now child exploitation meetings are held where the VOLT (victim, offender, location, theme) model is used for all types of exploitation, allowing professionals to identify victims and offenders, and to map and understand the associations and vulnerabilities within groups.

There is improving knowledge of criminal exploitation and an expectation that professionals from all agencies will look at the history of a child or young person and the context of an incident. Where cases are escalated, there is now an expectation that an analytical chronology will be compiled to enhance professionals' understanding of the child or young person and their situation.

Over the past year Cardiff City Local Authority and partners have developed the SAFE framework (Safeguarding Adolescents from Exploitation). An exploitation screening tool has been created and shared with all staff alongside a clear referral pathway in relation to exploitation for individual cases (exploitation strategy meetings/high risk panels/mapping analysis in conjunction with the police).

In a wider context work is being completed around school curriculum development, an exploitation training matrix for staff and development of the MISPER protocol. An action-focused SAFE partnership group is held monthly highlighting and responding to thematics from individual meetings and locality focus groups which then reports into the Children and Young People's Recovery Board.

- **Disengagement from Education, Employment & Training**

New safeguarding systems are now in place which allows all involved professionals to communicate concerns. These are triaged by a designated safeguarding lead who can assign tasks and ensures that safeguarding concerns are flagged up and escalated promptly. Education now has a 'Fresh Start Panel' to support children and young people who are moving between schools. The panel enables the needs of the child or young person to be identified and strategies to be put in place to support them through the transition process. Each child or young person has an Individual Development Plan (IDP) which includes the views of the child or young person and their parent / carer. There is a 'Fair Access Panel' (FAP) which supports children and young people with behavioural/emotional/social difficulties to move to alternative provision. 'Team Around the School' is now in place where there is a link for the secondary school and feeders from Children's Services who are available to support.

- **Attendance at Accident & Emergency Department**

Since November 2019, the C&V University Health Board has a Violence and Prevention Team based in the Accident and Emergency Department (A&E) who engage with patients who have been / are suspected to have been assaulted. The team has now increased its remit to include children and young people, and staff can refer to the team for immediate support and follow up of victims of assault. Their work includes reporting to Police, referrals to Children's Services and direct intervention work with children and young people. The team can also refer on to appropriate outside agencies for prevention and disruption work, including addressing involvement in different types of criminality.

There is now an adolescent documentation card (Blue Card) in use within the A&E Department, which prompts adult trained staff who see young people aged 16/17 years of age where drugs / alcohol are a factor, to the correct safeguarding procedures to be followed. Flags are added to the PMS electronic record system for domestic abuse, child sexual exploitation (CSE) and child criminal exploitation (CCE). The Blue Cards are reviewed within the regular Adolescent Safeguarding Review Meetings, where any additional vulnerabilities are assessed in conjunction with the young person's (PARIS) electronic records and the submission of appropriate MARFs can be checked.

Health staff receive training on County Lines and child exploitation as part of Level 2 and Level 3 study sessions, including information on indicators of exploitation and this forms part of the holistic safeguarding approach. Health staff are based in MASH and attend all relevant multi-agency meetings to provide information, and form part of the assessment and planning for those cases discussed.

- **School Nursing Service**

The School Nursing Service now has two Emotional Wellbeing Nurses in post (October 2021). They are from a school nursing background and are supporting children and young people who are not in mainstream schools. The nurses pick up any A&E attendances and safeguarding concerns for those pupils in alternative education provision and offer follow up support. The team are forging links with alternative education establishments to ensure effective information sharing for those children where there are concerns. Working relationships are being developed with staff in A&E, Education and the School Nursing Service to improve the support offered to children and young people.

Recommended Actions

1. **Safeguarding during Adolescence:**
   Cardiff and Vale Safeguarding Board to provide a multi-agency feedback event for this CPR to disseminate information for the wider workforce.

   Cardiff and Vale Safeguarding Board to further develop the training matrix to include specific training on safeguarding concerns that arise during adolescence.

   The Cardiff and Vale Safeguarding Board must ensure that the need to safeguard young people is promoted and strengthened. Professionals need advice and training on how a young person develops to understand risk and consequences.

2. **Information Sharing and Early Intervention**
   Children's services must consider the impact of exploitation on siblings as part of referral and assessment

   Cardiff and Vale Safeguarding Board must review the current support available for young people at risk of exploitation, building upon the Safeguarding Adolescents from Exploitation (SAFE model in Cardiff). Resources, advice and support services must be promoted to the public more widely.

3. **Disengagement from Education, Employment & Training**
   Where there are concerns around a young person, it is essential that education is always part of the safeguarding considerations. This is particularly important where a young person is educated outside of mainstream school placements.

4. **Reporting Concerns**
   All agencies must ensure appropriate follow up by referrer when they make a referral in relation to a young person at risk and consider appropriate professional challenge if they do not agree with the decision making.

5. **Adolescent Safeguarding Considerations**

   All agencies involved in strategy discussions and meetings considering young people at risk of exploitation, must consider any relevant historical information, mapping of associations and identified escalations in concerning behaviours, held by their own agencies. This mapping/ history must then be considered jointly by all involved agencies, for decision making and planning.

Statement by Reviewer(s)	
REVIEWER 1	**REVIEWER 2** ***(as appropriate)***
Statement of independence from the case *Quality Assurance statement of qualification*	**Statement of independence from the case** *Quality Assurance statement of qualification*
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference
Reviewer 1 *(Signature)* **Name** *(Print)* Nicole Devonish **Date** ……	**Reviewer 2** *(Signature)* **Name** *(Print)* Louise Young **Date** ……

Chair of Review Panel (Signature)	……
Name *(Print)*	Melanie Roach
Date	

Appendix 1: Terms of reference

Child Practice Review process

To include here in brief:

- *The process followed by the Safeguarding Board and the services represented on the Review Panel*
- *A learning event was held and the services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

The Child Practice Review Panel included representatives from Police, Education, Children's Services, Health, Youth Justice Service and the St Giles Trust The multi-agency timeline attached considers involvement and events between the period of 1st August 2017 to 28th of August 2019. However, some historical information going back to 15th August 2012 was considered by the panel. Due to the time between the incident, the criminal proceedings and this review, many of the staff who had direct involvement with Toby and his family have moved on.

The Learning Event was held virtually on 20th January 2022 due to the constraints placed upon services resulting from the Covid-19 pandemic. The Learning Event included practitioners from all of the above services.

Toby's parents requested to use this pseudonym throughout the report.

The family were contacted prior to the learning event to talk to the reviewers about their experiences of working with agencies. These comments were discussed with professionals at the learning event. A further meeting was held with family prior to publication of this report. The following paragraph represents the family's view of Toby. Toby was a much-loved son and brother, an integral part of his family whose loss continues to be acutely felt. He was a loving son, a 'practical joker.' Whilst his parents recognise that Toby was engaging in some negative and illicit activity, they also highlight that he wanted to protect them from repercussions to the lifestyle he was part of, and despite their efforts and request for support and assistance from agencies, it was not always forthcoming or adequate. Toby's parents do not want another family to suffer the loss of a child in the way they have.

☐ Family declined involvement

Terms of Reference for a Child Practice Review (Concise)

Re: CPR 05/2019

Introduction

A concise child practice review will be commissioned by the Regional Safeguarding Board (RSB) in accordance with the Social Services & Well-being (Wales) Act 2014, Working Together to Safeguard People: Volume 2. A concise child practice review will be undertaken where abuse or neglect of a child is known or suspected and the child has:

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health or development; **and**

the child was neither on the child protection register nor a looked after child on any date during the 6 months preceding –

- the date of the event referred to above; or
- the date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

Terms of Reference

The terms of reference agreed for this review are:
The timeframe for the review will be **26th March 2018 – 02nd June 2019**
The following services will produce a timeline of significant events of its involvement with the Child, for the timeframe above.

- SWP
- Health
- Education
- Cardiff Youth Justice Services
- Social Services

A merged timeline will then be produced.

Core Tasks (for a concise practice review)

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.

- Examine inter-agency working and service provision for the individual and family.

- Determine the extent to which decisions and actions were individual focused.

- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.

- Take account of any parallel investigations or proceedings related to the case.

- Hold a learning event for practitioners and identify required resources.

Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the *Review Panel* in accordance with guidance for concise and extended reviews.

- Agree the time frame.

- Identify agencies, relevant services and professionals to contribute to the review not already requested by the Case Review Group, produce a timeline and an initial case summary and identify any immediate action already taken.

- To consider the recognition of response to and impact of Criminal Exploitation and the specific vulnerabilities of this case.

- Produce a merged timeline, initial analysis and hypotheses.

- Plan with the reviewer/s a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.

- Plan with the reviewer/s contact arrangements with the individual and family members prior to the event.

- Receive and consider the draft practice review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.

- Agree conclusions from the review and an outline action plan and make arrangements for presentation to the Case Review Group and the RSB for consideration and agreement.

- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

Tasks of the Regional Safeguarding Children Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.

- *Review panel* completes the report and action plan.

- RSB send Report and Action Plan to relevant agencies for final comment before sign-off and submission to Welsh Government.

- Confirm arrangements for the management of the multi-agency action plan by the Case Review Group, including how anticipated service improvements will be identified, monitored and reviewed.

- Plan publication on RSB website.

- Agree dissemination to agencies, relevant services and professionals.

- The Chair of the RSB will be responsible for making all public comment and responses to media interest concerning the review until the process is completed.

For Welsh Government use only

Date information received ……..

Date acknowledgment letter sent to SAB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	

Bwrdd Diogelu Caerdydd a'r Fro
Cardiff & Vale Safeguarding Board

CPR ACTION PLAN

Re: CPR5/2019

No.	Recommendations	Actions needed	Responsible	Timeframe	Outcome
1.	**Adolescent Safeguarding Considerations:** Cardiff and Vale Safeguarding Board to provide a multi-agency feedback event for this CPR to disseminate information for the wider workforce. Cardiff and Vale Safeguarding Board to further develop the training matrix to include specific training on safeguarding concerns that arise during adolescence. The Cardiff and Vale Safeguarding Board must ensure that the need to safeguard young people is promoted and strengthened. Professionals need advice and training on how a young person develops to understand risk and consequences.	Multi-agency workshops to be held, face to face and virtually to disseminate the learning. As part of the continuing development of the Exploitation Strategy, specific training is provided. To ensure that all future training includes advice on understanding risks, consequences and the vulnerabilities for young people, particularly for those aged 16. CVSB website to provide resources for professionals/children and their families in relation to criminal exploitation and to ensure links and signpostings are made to other social media platforms in relation child exploitation, to provide support and advice.	Delivery Group and the Business Unit. Panel members to facilitate. CVSB Exploitation Strategy Task and Finish Group. Delivery Group Business Unit	November 2023 December 2023 December 2023 December 2023	
2.	**Information Sharing and Early Intervention** Children's services must consider the impact of exploitation on siblings as part of referral and assessment	Add prompts to eclipse (ICS system) where siblings need to be considered	Children's Services	December 2023	

	Cardiff and Vale Safeguarding Board must review the current support available for young people at risk of exploitation, building upon the Safeguarding Adolescents from Exploitation (SAFE model in Cardiff. Resources, advice and support services must be promoted to the public more widely.	Update SAFE guidance, tools and briefings to include consideration of siblings Develop messages for practice on considerations of siblings Include a domain into audit tools around the risk to siblings in assessments/referrals and consideration of whether the sibling should have an assessment in their own right Partner agencies to share relevant resources, for embedding within the regional exploitation strategy, which is currently under review, and for those to be uploaded to the CVSB website for access by professionals and the public	Cardiff Children's Services /SAFE Team CVSB Business Unit Children's Services All partner agencies and CVSB Business Unit	To begin November 2023 and continue	
3.	**Disengagement from Education, Employment & Training** Where there are concerns around a young person, it is essential that education is always part of the safeguarding considerations. This is particularly important where a young person is educated outside of mainstream school placements.	Ensure multi-agency representation at the FAP (or various panels) where children not in provision, on reduced timetables or on EOTAS packages are discussed, to enable a 'line of sight' of these young people and a basis to enable escalation of concerns. Provide regular opportunities for family engagement in discussions and decisions. Explore a range of	Education and Children's Services. Delivery Group to oversee QA Work.	September 2023	

		methods for engagement to ensure the information is as accessible as possible.			
4.	**Reporting Concerns** All agencies must ensure appropriate follow up by referrer when they submit a MARF in relation to a young person at risk and consider appropriate professional challenge if they do not agree with the decision making.	Children's Services to ensure the referrer is informed of the decision and outcome of submitted MARFs. Agencies to be reminded of their responsibility to liaise with Children's if they have not received a decision outcome within 10 working days.	Delivery Group	February 2024	
5.	**Adolescent Safeguarding Considerations** All agencies involved in strategy discussions / meetings considering young people at risk of exploitation, must consider relevant historical information as well as mapping of associations and identifying escalations in concerning behaviours. This mapping/ history must then be considered jointly by all agencies, rather than just by singular agencies	Ensure that the new multi-agency chronology, which is under development, is used at strategy discussions/meetings to inform decision making. Regional Safeguarding Board to consider use of multi-agency chronologies for child protection conferences.	CVSB Partner Agencies CVSB	December 2023 September 2023	.