

Quality Committee 05.08.2025

Tue 05 August 2025, 14:00 - 16:00

Agenda

14:00 - 14:05 **1. Standing Items** 5 min

1.1. Welcome, Introductions & Apologies

Ceri Phillips

1.2. Declarations of Interest

Ceri Phillips

1.3. Minutes of the Quality Committee Meeting held on 24.06.2025

Ceri Phillips

📄 1.3 - Draft Quality Public Minutes 24.06.2025 CP.pdf (8 pages)

1.4. Action Log – Following the meeting held on 24.06.2025

Ceri Phillips

📄 1.4 - Quality Committee Actions following 24.06.2025.pdf (1 pages)

1.5. Chair's Action taken since last meeting

Ceri Phillips

No Chair's Actions.

14:05 - 15:55 **2. Items for Review & Assurance** 110 min

2.1. CD&T Clinical Board Assurance Report

30 mins *Adam Christian / Sarah Lloyd / Helen Luton*

📄 2.1 Quality CD&T Assurance Report 2025.pdf (31 pages)

2.2. Quality Indicators Report

30 mins *Alex Scott / Angela Hughes*

📄 2.2 - QI Covering Report August 25 (1).pdf (2 pages)

📄 2.2.2 - Quality Indicators Template.pdf (33 pages)

2.3. Invited Service Review (IRS) of Cardiff and Vale University Health Board (UHB) Mental Health Services

10 mins *Rim Al-Samsam / Tara Robinson*

📄 2.3 - Public Quality Presentation MHCB.pdf (8 pages)

2.4. Equity, Equality, Experience and Patient Safety Action Plan - Six Month Update

10 mins *Claire Beynon / Eloise Hamon*

📄 2.4.1 - QSE Cover paper. Equity Equality Experience and Patient Safety action plan. FINAL.pdf (2 pages)

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- 📄 2.4.2 - Equity Equality Experience and Patient Safety Action Plan. QSE slides Aug 2025 FINAL.pdf (6 pages)
- 📄 2.4.3 - July 2025 equity equality experience and patient safety action plan FINAL.pdf (17 pages)

2.5. Theatres Review

20 mins Paul Bostock

- 📄 2.5.1 - Theatres Together - Quality Committee - August 2025.pdf (3 pages)
- 📄 2.5.2 - Theatres Together_improvement plan _21 July 2025 V1.0.pdf (17 pages)

15:55 - 15:55 3. Items for Approval / Ratification

0 min

Ceri Phillips

No items for approval

15:55 - 15:55 4. Items for Noting & Information

0 min

4.1. Minutes from Clinical Board QSE Sub Committees / Safeguarding Steering Group (SSG) / IP&C Group

0 mins Jason Roberts

- 📄 4.1.1 - CD&T - QSE Minutes 26.6.25.pdf (15 pages)
- 📄 4.1.3 - IPCG minutes 18.03.25.pdf (8 pages)

15:55 - 15:55 5. Items to bring to the attention of the Committee

0 min

Ceri Phillips

15:55 - 15:55 6. Agenda for the Quality Committee Private Meeting

0 min

Ceri Phillips

- Private Minutes & Actions
- Any Urgent / Emerging Themes – Verbal (Confidential Discussion)

15:55 - 15:55 7. Any Other Business

0 min

Ceri Phillips

15:55 - 15:55 8. Review of the Meeting

0 min

Ceri Phillips

15:55 - 15:55 9. Date & Time of Next Meeting

0 min

Ceri Phillips

16th September 2025 at 2pm via MS Teams

15:55 - 15:55 10. Declaration

0 min

Ceri Phillips

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

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Held on 24th June 2025 via MS Teams

To view the meeting: [CAVUHB Quality Committee 24.06.2025](#)

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Rhian Thomas	RT	Committee Vice Chair / Independent Member – Capital & Estates
In Attendance		
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
Jason Roberts	JR	Executive Nurse Director
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Matt Phillips	MP	Director of Corporate Governance
David Fluck	DF	Executive Medical Director
Angela Hughes	AH	Assistant Director of Patient Experience
Claire Beynon	CB	Executive Director of Public Health
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Louise Denham	LD	Food Vale Co-Ordinator – Public Health
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Yvonne Hyde	YH	Head of Nursing for Infection Prevention & Control
Tara Cardew	TC	Head of Patient Safety
Observers		
Amy English	AE	Deputy Regional Director - Llais
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Steve Riley	SR	Independent Member – Local Community
Mike Jones	MJ	Independent Member – Trade Union
Lauranne Cullen	LC	Regional Director for Llais
Paul Bostock	PB	Chief Operating Officer

QC		ACTION
25/06/001	<p>Welcome & Introductions</p> <p>The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.</p>	
25/06/002	<p>Apologies for Absence</p> <p>Apologies for absence were noted.</p>	
25/06/003	<p>Declarations of Interest</p> <p>No declarations of interest were raised.</p>	
25/06/004	<p>Minutes of the Committee meeting held on 13.05.2025</p> <p>The minutes of the Committee meeting held on 13.05.2025 were received.</p> <p>The Committee resolved that:</p>	

	a) The minutes of the meeting held on 13.05.2025 were approved as a true and accurate record of the meeting.	
QC 25/06/005	<p><u>Action Log following the Meeting held on 13.05.2025</u></p> <p>The Action Log following the Meeting held on 13.05.2025 was received.</p> <p>The Committee resolved that:</p> <p>a) The Action Log from the meeting held on 13.05.2025 was noted.</p>	
QC 25/06/006	<p><u>Committee Chair's Actions</u></p> <p>No Chair's Actions were raised.</p>	
Items for Review & Assurance		
QC 25/06/007	<p><u>Deep Dive – Nationally Reportable Incidents (NRIs)</u></p> <p>The Deputy Regional Director – Llais (DRD-L) asked what prompted the deep dive topic.</p> <p>The CC responded that the Cabinet Secretary was aware of the larger than usual number of NRIs, and the Committee wished to analyse and understand the situation.</p> <p>The Assistant Director of Quality and Patient Safety (ADQPS) introduced the paper to the Committee and highlighted the following:</p> <ul style="list-style-type: none"> • In 2024, 153 NRIs were recorded in the UHB. • Until mid-2023, NRIs were incidents associated with what was perceived to be initially levels severe or catastrophic harm. In 2023, Wales introduced a new category of NRIs to include all incidents that would be reported through a Perinatal Mortality Review Tool (PMRT) process. • 34% of NRIs were now from MMBRACE cases, leading to an uplift in the number of reported incidents. • A paper was brought to the Quality Committee in November 2024 which detailed maternal and neonatal cases, and improvements. • Themes from NRIs included cases associated with endoscopy, never events, deteriorating patients, follow-up failures, medication safety, and infection prevention & control (IP&C) • Endoscopy: - <ul style="list-style-type: none"> ○ COVID caused delays in endoscopy surveillance for patients who required ongoing monitoring. ○ They had now eradicated this legacy backlog. They had undertaken a number of case reviews which resulted in widespread learning. • Never Events: - <ul style="list-style-type: none"> ○ The Theatre Review was published the previous month, and there were concerns around how the WHO checklist was implemented across the organisation. ○ A WHO checklist collaborative was implemented who were working through the checklist and putting in more robust methodology and responsible individuals. ○ Work had been undertaken with Medical Education around invasive procedures - e.g. a standardised process for local anaesthetic procedures was now mandated and included competency assessments. • The “Shaping Our Future Quality Excellence” (SOFQE) programme had been implemented to drive a health board wide programmes of improvement priority areas that have emerged because of patient safety incidents. This programme has a number of projects underneath. • Lost to Follow Up: - 	

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- Three tranches of work underpinned this: 1) ensuring the continuity of care for patients at the point of an outpatient appointment and appropriate subsequent care; 2) standardising referrals into the UHB; and 3) internal referral processes.
- The Deteriorating Patient
 - A revised early warning score (NEWS) 2 system would be implemented across the UHB by the end of July 2025, with training provided.
 - Work had been completed to implement a similar system in neonatal services and aim to do the same for maternity and paediatric services by Autumn 2025.
- IP&C: -
 - IP&C efforts included improving data insights to not only look at bloodstream infections and bacteraemia's.
 - They had introduced the "Brilliant Basics" communications programme, targeted at all UHB staff.
- Medication Safety: -
 - Electronic Prescribing and Medication Administration (ePMA) systems were being implemented to interrogate both prescribing and medication administration.
 - They would focus on several areas including the safe prescribing and administration of opioid medications and insulin, the eradication of omitted doses, and antimicrobial prescribing.
- For the SOFQE programme, senior responsible officers were appointed to oversee each programme, with progress reported monthly to an executive programme board.

The CC asked for regular updates on the progress of the SOFQE programme in areas such as lost to follow-up, deteriorating patient care, IP&C, and medication safety.

The Executive Nursing Director (END) responded that the NRI themes were all incorporated into the different projects, which reported into the programme board. The SOFQE programme was now embedded in the organisation and focused on learning, innovation, and transformation.

It was suggested that the CC and END meet to discuss the frequency for SOFQE Programme themes to be brought to the Committee.

The Committee Vice Chair (CVC) noted that medicines management and prescribing risks had been frequently highlighted in recent inspections and asked if the electronic prescribing implementation would address the recommendations and concerns from Health Inspectorate Wales (HIW) reports.

The ADQPS responded that the ePMA implementation would address some HIW concerns, but it wouldn't cover all issues, especially around medication storage safety. Ongoing programmes and internal audits would continue to address these areas, with a focus on UHB-wide learning through the SOFQE initiative.

The Executive Medical Director (EMD) noted the ePMA was an important safety step but only addressed part of the errors. The medication safety programme within SOFQE would include storage, medication, administration, and prescribing.

The END suggested that once ePMA was embedded, that the CVC visit a ward to see logistically how it worked.

The CC asked to what extent they were working with the improvement team.

The ADQPS responded that the improvement team were central to shaping the SOFQE programme.

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	<p>The Committee resolved that:</p> <ol style="list-style-type: none"> 1) The emerging themes from the Nationally Reportable Incidents was noted 2) The assurance provided by the improvement work associated with these themes was noted 	
<p>QC 25/06/008</p>	<p><u>Prevention of Future Deaths Update - Ref: 1051 and Ref: 1553</u></p> <p>The END introduced the item and highlighted that the Prevention of Future Deaths (POFD) was a decision that the coroner makes following a hearing, which held an organisation accountable for improvements to prevent similar issues. They had received two cases.</p> <p>The Assistant Director of Patient Experience (ADPE)</p> <ul style="list-style-type: none"> • They did not just respond to the coroner – they considered implications and embedded improvements across the UHB to mitigate future risks. • The first PFD Report related to the Silencing of Alarms at Central Monitors: <ul style="list-style-type: none"> ○ Whilst they responded to the coroner, they realised this was a risk where there was telemetry for any patients across the UHB. ○ Significant progress had been made, with new central monitoring systems and configurations in place. ○ The PFD was shared across Wales and was monitored with regular updates to the Director of Nursing (DoN) forum. • Second PFD Report related to a sad death in St David’s Hospital: <ul style="list-style-type: none"> ○ The PFD focused on fall prevention management, recognising at-risk patients, and using enhanced supervision. ○ A robust, sustainable training programme for staff had been implemented, which included risk assessments and mitigation. ○ Improvements included deploying extra-low beds and ensuring up-to-date risk assessments. ○ The work was shared on an All-Wales basis and monitored <p>The CC commented that to aspire towards quality excellence, they must ensure that learning permeated all relevant areas and not just restricted to letters from coroners.</p> <p>The CVC asked whether they needed to report all actions to the coroner for sign-off. Additionally, she asked whether they shared new practices and learning with other UHBs.</p> <p>The ADPE answered that their initial response to coroner’s letters was within 56 days of receiving a PFD, but they are not obligated to report further. However, they ensured lessons were learned from all inquests and shared this information with the All-Wales Inquest Network.</p> <p>The Committee resolved that:</p> <ol style="list-style-type: none"> a) The assurance provided by the report was acknowledged. 	
<p>QC 25/06/009</p>	<p><u>IP&C Position Update</u></p> <p>The END introduced the item and highlighted that some of the UHB’s IP&C measures were not meeting the WG reduction targets.</p> <p>The END and Head of Nursing for Infection Prevention & Control (HNIP&C) presented the IP&C Position Update which covered the goals set for various infections, the current status of these infections within the UHB, and the specific measures being implemented to improve IP&C and patient outcomes.</p> <p>The CC asked to what extent would the improvements continue</p>	

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The HNIP&C responded that the introduction of ePMA would enable better oversight of prescribing. An education tool had been developed and would be available on all PCs across the UHB and would focus on key areas like handwashing, cleaning, and prescribing.

The END highlighted the following points:

- C.diff was a national issue – the HNIP&C represented CAVUHB at a C.diff Learning Collaborative Co-Design event.
- This work was supported by executive colleagues to maintain cleaning standards despite financial constraints.
- The Chief Nursing Officer (CNO) had been preparing enhanced cleaning standards, which needed to be socialised across the organisation.
- There was an issue with medical reporting of Aseptic Non-Touch Technique (ANTT) training due to different logging systems for consultants and resident doctors. There would be a focus on ANTT training in executive reviews and plan for a full breakdown of training in the following meeting.
- There was great importance in maintaining good handwashing techniques, clean clinical standards, and proper uniform and dress codes.

The EMD highlighted that the report stated that 50% of C.diff cases were hospital-acquired, and MRSA and Staph aureus rates were high. Previously, even one MRSA case was significant. This was an urgent matter.

The EMD asked whether the UHB's visiting regimes were too relaxed, and whether they needed to limit the number of visitors, or engage with more visitors to stress the importance of handwashing and IP&C.

The HNIP&C responded that:

- All visitors were asked to wash their hands. However, due to limited staff, monitoring everybody was challenging.
- All patients should receive a C.diff information leaflet to share with their families, which provided guidance on handwashing and laundry.
- Limiting visiting times was a sensitive issue, especially since visitors often helped with patient care.
- Flow and capacity were major issues, and they lacked enough single rooms to meet demand.

The ADPE noted that during the pandemic, they used volunteers to remind visitors about handwashing and checking for infections, and suggested they utilise this approach again to emphasise public responsibility and its impact.

The HNIP&C added that there was an IP&C cell that the END chaired with Comms colleagues present to help disseminate information to the public. She noted that they could consider more campaign, e.g. Cardiff University had a campaign during the school holidays in the shopping centre.

The END concluded that it was not just about visitors, they needed staff to listen in equal measure. They must build a culture where everyone understands their role in improving infection control.

The CC asked for another IP&C update to return to the Committee in Q2.

The Committee resolved that:

- 1) The IP&C update was noted.

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QC
25/06/010

Clinical Effectiveness Committee Report

The Head of Patient Safety (HPS) introduced the report and highlighted the following:

- This was a biannual report summarising the national audits presented at the Clinical Effectiveness Committee (CEC). The report highlighted audits from the last two CEC meetings.
- Common theme was data collection challenges – e.g. the National Neonatal Audit Programme (NNAP) faced significant data collection issues in 2023, which led to over-reporting of mortality cases and under-reporting of congenital anomalies. The issues were reported to MMBRACE but beyond the deadline for amendments. They had since transitioned to BadgerNet.
- They were undertaking a project to assess resources for data collection across the UHB to support clinical teams in audits - there was good engagement from clinical teams and notable work presented
- The CEC reorganised around specialties to group and theme audits, aiding clinical boards in supporting audits and improving patient care

The CC asked what analytical support they had to translate the generated data into meaningful information.

The EMD noted that the national audits provided a lot of analysis and feedback to sites. He suggested that the real question ought to be what they were doing within those teams to address the issues raised by the national audits.

The Associate Medical Director Patient Safety and Clinical Effectiveness (AMDPSCE) noted that some themes from SOFQE appeared in their national audits. It was crucial to understand their position within these audits and use the data proactively to guide decision-making.

The CC asked how they were using that data to develop improvement schemes.

The ADQPS highlighted that:

- National audits provided prospective data such as the stroke audit and the National Hip Fracture Database. Data was accessed monthly or quarterly to drive improvements.
- Some data in the report was two years old, which didn't relate to their current position
- Across Wales, a national data resource was being developed for centralised data collection.
- The UHB did not have a centralised data analysis team at present, but some areas like the National Emergency Laparotomy Audit were well-resourced
- Clinical boards needed to monitor data continuously and have improvement plans. Clinical boards should provide assurance to CEC, not be the first point of contact for audits.

The AMDPSCE referred to the neonatology team working with infection control to reduce infection rates on the unit. This significant effort aimed to lower infection rates through various measures. This audit was well-recognised and influenced operational decision-making.

The Committee resolved that:

- 1) The assurance provided by the national audit data and some of the areas of improvement covered in the report were noted.

Items for Approval / Ratification

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<p>QC 25/06/011</p>	<p>Policies</p> <p><i>No policies for approval.</i></p>	
<p>QC 25/06/012</p>	<p><u>Regional Health Protection Partnership</u></p> <p>The Executive Director of Public Health (EDPH) introduced the report and provided the following summary:</p> <ul style="list-style-type: none"> • The public health vision focused on reducing inequalities and protecting the health and wellbeing of the local population through health protection. This element of work focused on health protection. • CAVUHB had strong relationships with local authority colleagues, particularly in environmental health and Shared Regulatory Services. • This year's plan included improving primary care relationships, developing a communications and engagement strategy, strengthening ties with the third sector, and developing and testing a pandemic response plan. • The plan had been approved by the Amplifying Prevention Board and the Strategic Leadership Team (SLT) and would be presented to the two public service boards. <p>The CC asked how they could ensure that the implementation of preventative schemes and health protection measures wouldn't increase inequalities.</p> <p>The EDPH responded that they saw more communicable diseases in deprived areas and groups, and they worked closely with those working with those groups (like the CAV Health Inclusion Service and the prisons). Their vaccination plans included health inequalities plan to increase uptake and reduce differentials.</p> <p>The Committee resolved that:</p> <ol style="list-style-type: none"> 1) The Health Protection Regional Partnership Plan was approved. 	
<p>QC 25/06/013</p>	<p><u>Vale Food Strategy</u></p> <p>The EDPH and the Food Vale Co-Ordinator – Public Health (FVC-PH) presented the paper and slides to the Committee which outlined the Vale Food Strategy. The Strategy outlined the vision for a healthy and sustainable food system in the Vale of Glamorgan (VoG), and the actions to be taken to address this.</p> <p>The EMD asked whether enough work was being done internally for staff to promote this and role model good food practice.</p> <p>The FVC-PH responded there was an opportunity to do more. Some colleagues in the public health team were working on initiatives like the Restaurant and Retail Standards to raise awareness about healthy food and its impact on our daily decisions.</p> <p>The CC asked for an update on the strategy's progress at a future Committee.</p> <p>The Committee resolved that:</p> <ol style="list-style-type: none"> 1) The Vale Food Strategy 2025-2030 was approved. 	
	<p>Items for Noting & Information</p>	
<p>QC 25/06/014</p>	<p><u>Minutes from Clinical Board QSE Sub-Committees</u></p> <p>The Committee resolved that:</p> <ol style="list-style-type: none"> 1) The minutes were noted. 	

QC 25/06/015	<p>Joint Commissioning Committee Quality Safety and Outcomes Sub-Committee Highlight Report</p> <p>The Committee resolved that:</p> <p>1) The Joint Commissioning Committee Quality Safety and Outcomes Sub-Committee Highlight Report was noted.</p>	
QC 25/06/016	<p>Internal Audit Report – Follow Up Health Roster System</p> <p>The Committee resolved that:</p> <p>1) The Internal Audit Report – Follow Up Health Roster System was noted.</p>	
	Items to bring to the attention of the Committee	
QC 25/06/017	<i>No items.</i>	
	Agenda for Private QSE Meeting	
QC 25/06/018	<p>i) <i>Minutes and Action Logs from the Private QSE Committee on 13.05.2025</i></p> <p>ii) <i>Any Urgent / Emerging Themes – Verbal Update</i></p>	
	Any Other Business	
QC 25/06/019	<i>No items.</i>	
	Date & Time of Next Meeting:	
QC 25/06/020	5th August 2025 at 2pm via MS Teams	

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Action Log - Public Quality Committee

Update for meeting 5th August 2025
(Following the meeting held on 24th June 2025)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions					
QC 25/06/007	Deep Dive – Nationally Reportable Incidents (NRIs)	For the END and Chair to discuss the frequency for Shaping Our Future Quality Excellence Programme themes to be brought to the Committee.	05.08.2025	Jason Roberts / Ceri Phillips	<i>Update to be provided during the Action Log section of the meeting.</i>
QC 25/06/009	IP&C Position Update	For ADPE and HNIP&C to discuss how best to utilise volunteers to remind visitors about hand hygiene and IP&C	05.08.2025	Angela Hughes / Yvonne Hyde	<i>Update to be provided during the Action Log section of the meeting.</i>
QC 25/06/009	IP&C Position Update	For an IP&C update to return to the Committee in Q2.	28.10.2025	Yvonne Hyde / Jason Roberts	COMPLETED - Added to the Forward Plan for October 2025's meeting.
QC 25/06/013	Vale Food Strategy	For an update on the strategy's progress to return to a future Committee.	05.08.2025	Claire Beynon / Louise Denham	COMPLETED - Added to the Forward Plan for October 2026's meeting.
Actions referred to Board / Committees					
Actions referred FROM Board / Committees					

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Report Title:	Clinical Diagnostics and Therapeutics Clinical Board Assurance Report		Agenda Item No:	2.1
Meeting:	Quality Committee	Public	X	Meeting Date: 05.08.2025
		Private		
Status	Assurance X	Approval		Information/Noting
Lead Executive Title:	Executive Director of Nursing			
Report Author Title:	Director of Nursing & Multi-professional Teams CD & T Director of Operations CD & T Clinical Board Director CD & T			

Main Report

Background and Current Situation:

This report details the arrangements, progress and outcomes taking place to improve quality, safety and patient experience within the Clinical Diagnostics and Therapeutics (CD&T) Clinical Board. It outlines the achievements and innovations leading to improved quality and care for patients. It also describes some key challenges, risks and the mitigations we have in place in order to continue into 2025/26.

The Clinical Diagnostics and Therapeutics Clinical Board provides a wide range of diagnostic and therapeutic procedures on a local, regional and UK wide basis. Collectively these services underpin, and are core components of, almost every aspect of clinical activity undertaken within the UHB.

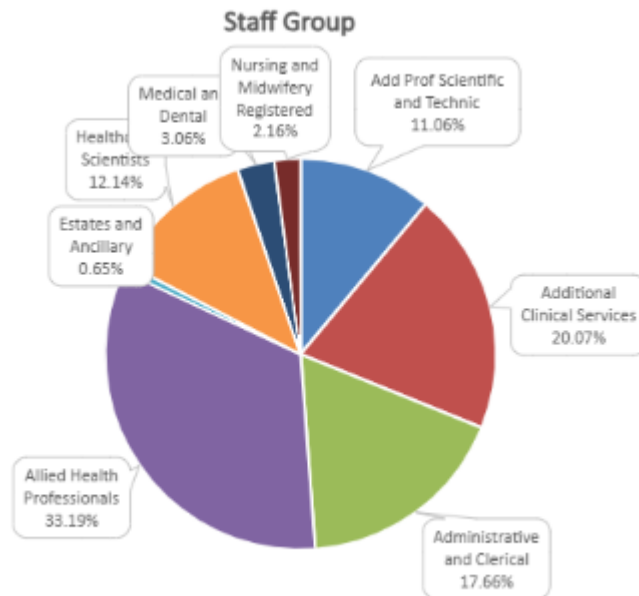
During the financial year 2024/25 the Clinical Board consisted of 6 directorates and had a budget of £149 Million:

1. Laboratory Medicine
2. Radiology, Medical Physics and Clinical Engineering,
3. Medical Illustration
4. Outpatients/Patient administration and Clinical Coding
5. Therapies
6. Pharmacy and Medicines Management (including All Wales Therapeutics & Toxicology Centre (AWTTC))

The Clinical Board also host WEQAS, Wales External Quality Assessment Scheme. An independent organization providing over 50 EQA Programmes, including external audit, performance analysis and an educational advisory service.

The Clinical Board spans diverse services and is delivered by a variety of professions. As of the 1st April 2025 here are 2775 staff in post across all professional groups.

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Quality, safety and patient experience is a core component of all we do. Over the last 12 months we have continued to embed the health and care quality standards across the clinical board in line with the duty of quality statutory guidance 2023.



This report provides assurance of the progress being made within the Clinical Board with regard to:

- The Welsh Government Quality Delivery Plan for NHS in Wales
- The Clinical Board's Operational Plan and IMTP
- Quality, Safety and Patient Experience agenda
- Management and monitoring arrangements related to risk
- Health and Care Quality Standards
- Financial and information Governance
- Organisational Development and Workforce planning
- Regulatory Compliance
- Promoting a positive culture for staff engagement, development and understanding of everyone's responsibility for safe, effective, quality care



Safe Care

The Clinical Board has an agreed agenda and comprehensive work plan for the next 12 months. The plan includes monitoring service delivery against required standards, monitoring and managing risks through the e-Datix reporting system, regulatory compliance, and the risk register.

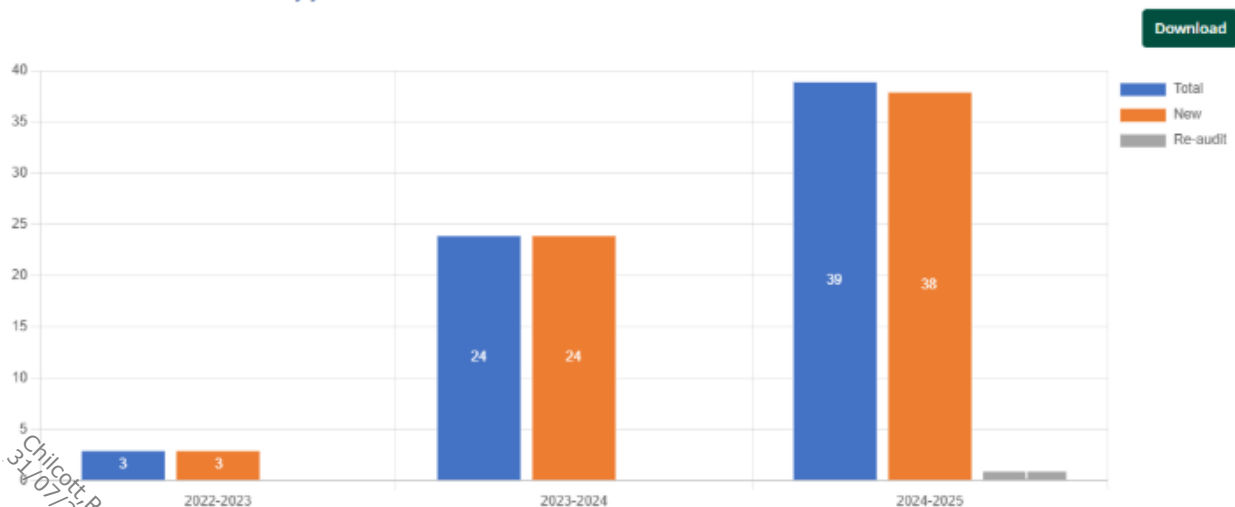
The Quality, Safety and Patient Experience (QSPE) agenda is a key priority for the Clinical Board. QSPE meetings are held monthly, with terms of reference reviewed annually. The QSPE agenda is aligned with the 6 health and care quality standards. There is good attendance and representation from across the Clinical Board.

Assurance is received through QSPE group and other formal meetings. Heads of Service and the Quality Managers in Laboratory Medicine, Radiology and Pharmacy are key members of the team and support those areas to deliver safe, effective and quality care to patients. In addition, those quality managers support the work to comply with legislation that regulate those areas. Q-pulse is a well-used electronic platform for storing policies, incidents, audits and action plans that provides assurance to the Clinical Board and our regulators. The system has recently been upgraded to a web version which should provide more functionality and visual display of data through dashboards.

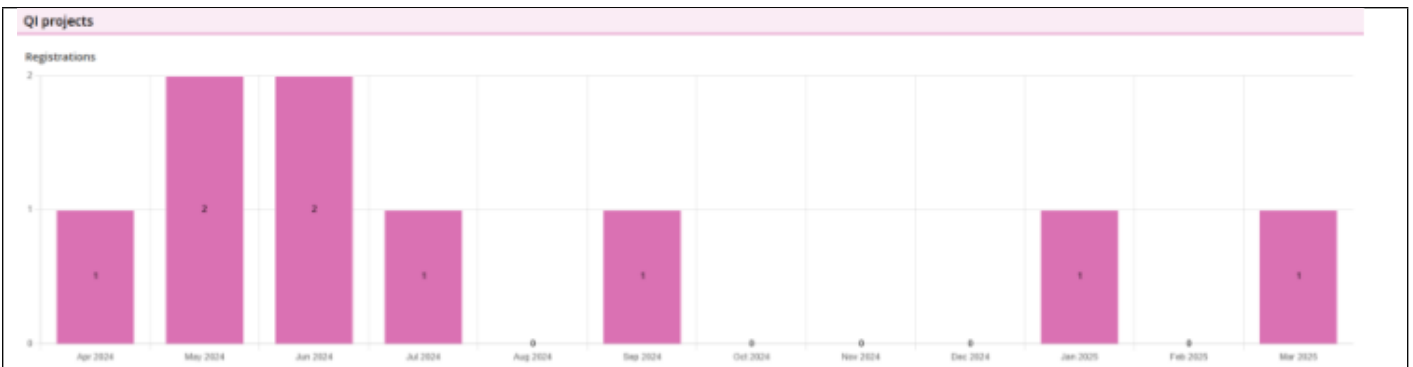
The adoption of AMAT outside of these areas needs further work to make the most of the platform. We have made more use of it to record actions from investigations and inspections and track progress against them. In the next 12 months we plan to migrate the risk registers onto the system to enable more access and transparency in relation to the risk we hold as a CB.

We have seen a steady increase in the use of AMAT for audit activity over the last few years and we had a total of 38 recorded compared to 25 in 2023/2024.

Number of new and re-audits by year



Teams continue to utilise AMAT to record QI projects, the number logged in 2024/2025 period were similar to the previous year.



Projects vary, with Biochemistry and Therapy teams registering QI projects including:

- Benefits of the use of pharyngeal electrical stimulation therapy for dysphagia in intensive care
- An evaluation of 'did not attend' rates for outpatient pelvic health physiotherapy service at CAV
- Review of nationally used cortisol assays in congenital adrenal hyperplasia
- Developing a collaborative movement, voice and swallow prehab programme for people with early Parkinson's from CAV due to complete in 2026
- Stability of porphyrins in red blood cells and plasma: implications for sample handling and storage
- The introduction of simulation as an education tool into Paediatric physiotherapy on-call training- An implementation Project

The QSPE group has sub-groups that report to it:

- Health and Safety Group meets bi-monthly. Health and safety issues, risks and incidents are discussed. RIDDOR reportable incidents are shared in this forum to ensure wider learning from events. Training compliance is also a focus.
- Regulatory Compliance group meets monthly, with a minimum of 9 meetings per year being convened. The function and purpose is to ensure governance arrangements are operating effectively, to provide high quality and safe healthcare. To provide assurance to the Clinical Board of compliance with regulatory requirements through reviewing quality indicators. There is also a quarterly review of all incidents, to identify themes and share learning.
- Research and Development group meet every 2 months. Reports on research and development activities across the Clinical Board. It provides a forum for the exchange of information on R&D issues between directorates leads. Supporting collaboration with other Clinical Boards, university research groups and other partners. It has also been used as a forum for colleagues undertaking higher academic qualifications to have a network of peers to support through their studies.

Through all groups, the aim is to identify themes and share learning from incidents, inspections, and action plans.

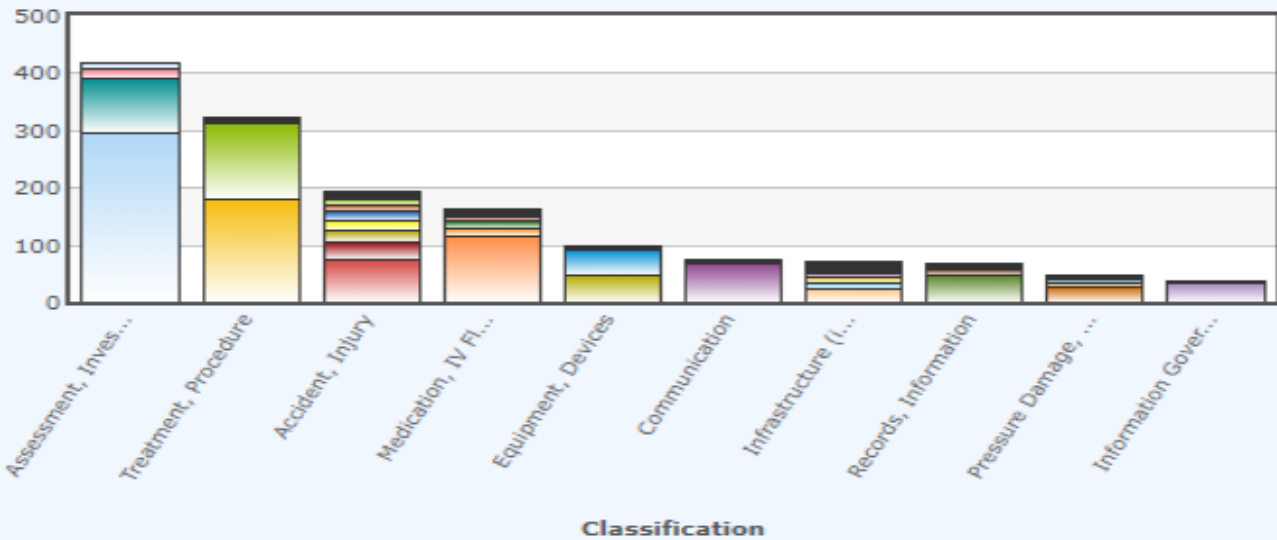
Incident Reporting

The total number of incidents reported by the Clinical Board using the RLDatix system during the period 1st April 2024 to 31st March 2025 was 1,904 compared to 1,657 the previous year, demonstrating a strong reporting culture across the board. Data is taken from RLDatix system and is from the same period.

The top 10 incident types are outlined below.

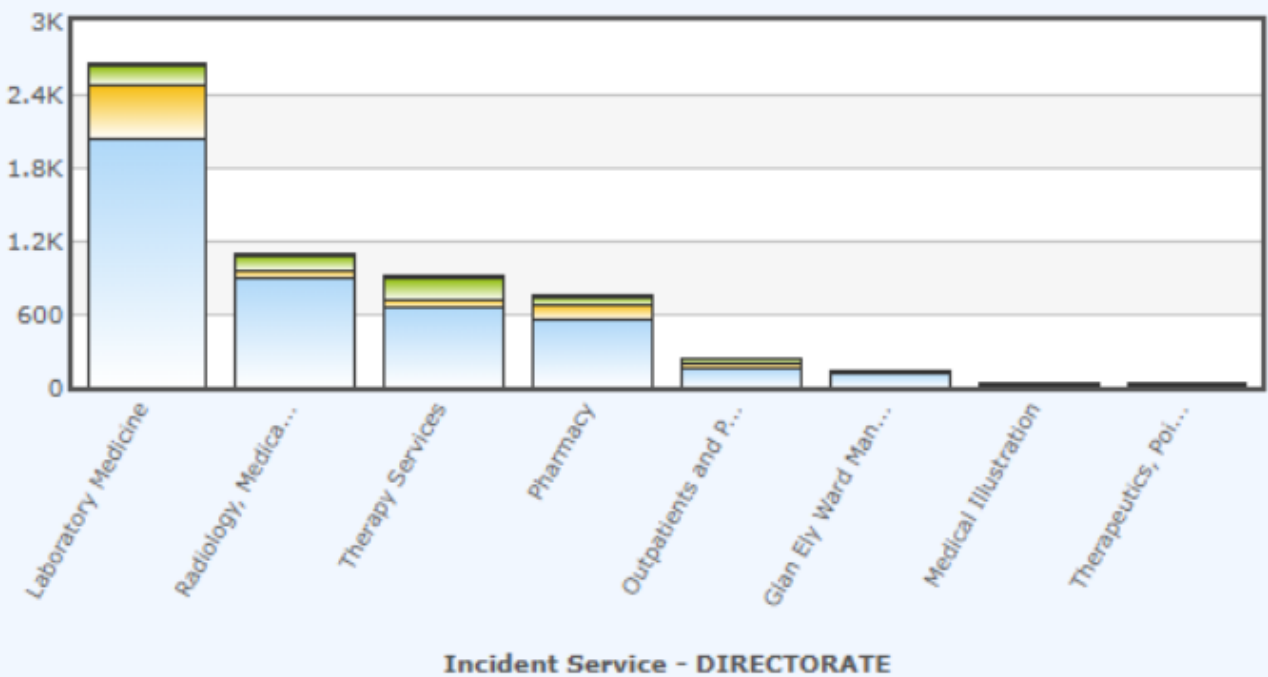
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INC_CB_TOP_02 - Top 10 by Incident Type Rolling 12 complete months (BarChart|DB)



The majority of incidents are reported under the assessment, investigation & diagnosis category - this is not unexpected as diagnostic testing would cover all of our laboratory services and Radiology, which as you can see from the graph below have the largest number of incidents reported. Closely followed by Therapies and Pharmacy.

INC_CB_SVS_01 - Incidents by Service and Type (BarChart|DB)



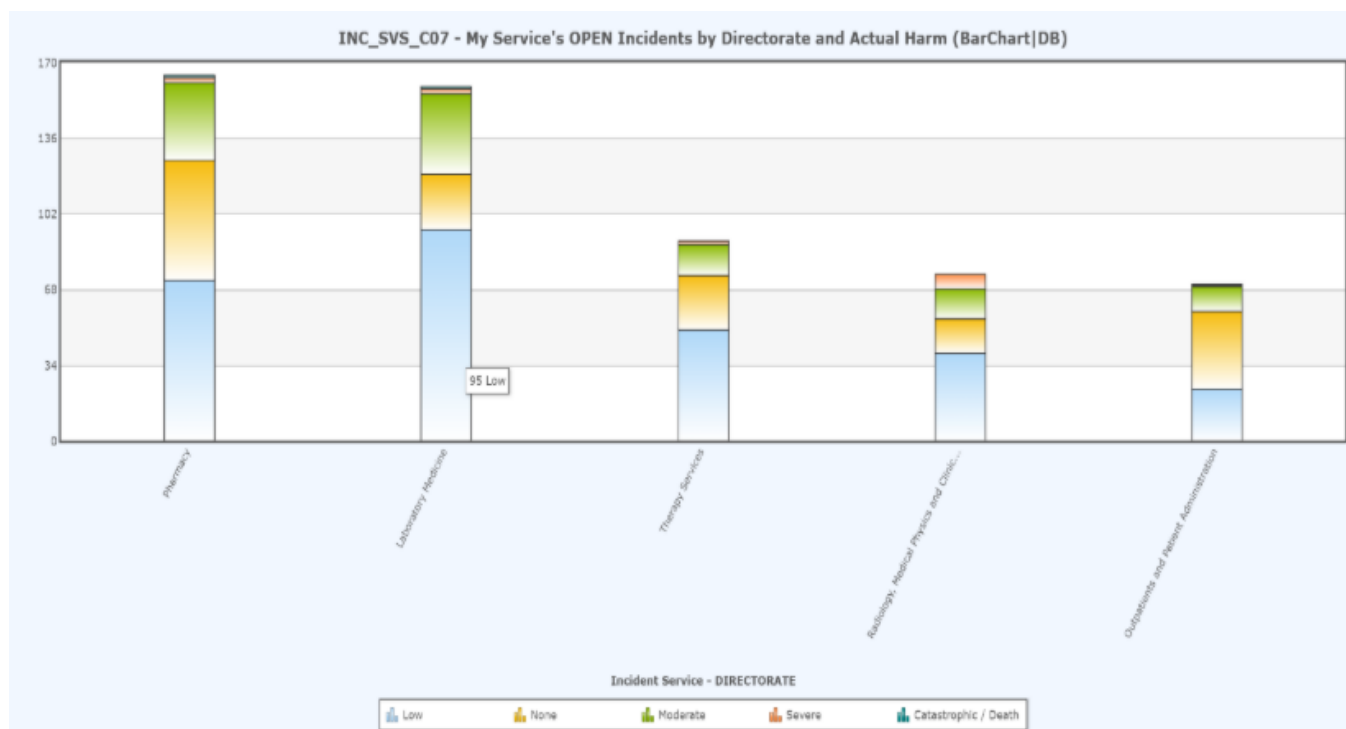
Timely closure of incidents remains a challenge for our teams; those categorised as moderate or above are prioritised. Those reported as severe or catastrophic are reviewed by the patient safety team and Director of Nursing & Multi-Professional Teams and the Lead Nurse for CD&T. Timely review and closure of incidents will continue to be a focus for the clinical board in the next 12 months working closely with the patient safety team.

A quarterly review of all incidents are discussed in our Regulatory Compliance meetings to share any learning and identify themes.

CD & T Clinical Board- Datix Management



The graph below demonstrates the current picture of open incidents based on actual harm by directorate. The vast majority of incidents reported are no or low harm and often represent a near miss.



Of the 2 incidents initially classified as catastrophic, following review they were assessed as moderate or no harm. The moderate harm incident is still under investigation and relates to information given to a patient on discharge regarding their medication.

The 15 first assessed as severe harm, 75% were re-classified following review as no or low harm. Of those that remained at severe harm, they were reported under NRI criteria. Of the low and no harm fewer than 1% were re-classified to increase the level of harm.

From the 1st April to 31st March, we reported 11 nationally reportable incidents compared to 8 in the previous 12 months.

May 2024

An issue with the way an electronic referral from a G.P was received and processed leading to a 50-day delay in the patient being seen in secondary care for a suspected cancer. The investigation identified a race condition within the Welsh Admin Portal that

	despite audit logs showing the referral had been processed it had not been transferred to Welsh Clinical Portal for onward management. The monitoring of zero status list would have identified the error and there are plans in place to ensure improved monitoring of these lists going forward. Investigation went overdue and was closed in June 2025
June 2024	During an endovascular aneurysm repair an introducer from a catheter was inadvertently left inside the vessel. During the follow up imaging the object was identified. It was subsequently successfully removed. The root cause of the incident was identified as a combination of procedural variation and inadequate counting processes. Following the review procedural updates, training improvements and recommendations to strengthen safety practices in interventional radiology have been undertaken
July and August 2024	4 patients experienced delays in receiving pathology results. Whilst there were some nuances in each case the main issue identified in the reviews lay with the workflow through the cellular pathology laboratory. Namely delays in the production of slides-microtomy. Specimens were not processed in a timely manner due to the backlog of over 4000 blocks within the laboratory at the time of these incidents. There were also delays with the reporting of the slides due to shortages in consultant pathologist workforce. To mitigate this, specimens are outsourced. This process also experienced a backlog due to the high volumes. Much improvement work has been undertaken within the laboratory to improve workflow through the laboratory to improve timelier diagnosis for patients. More detail on the improvement work is described further on in the paper.
September 2024	Deterioration in pressure damage, leading to category 4 damage whilst under the care of Podiatry. Following review, it was determined that the deterioration in pressure damage from 3 to 4 was avoidable if appropriate off-loading measures were implemented in a timely manner. The podiatry team are reviewing the potential use of a risk assessment tool to help identify off loading measures and future audits of case notes to ensure documentation of pressure damage is robust.
October 2024	Radiology reporting delay. A 136-day delay in formal reporting of a chest X-ray led to a delay in diagnosis of a patient's lung cancer and a reduction in treatment options available. In-patients plain film should be reported within one week. Due to a backlog where demand exceeds reporting capacity that was exacerbated during this period, a delay of 136 days to a formal report. The subtle abnormality on the X-ray would not have been expected to be identified by non-reporting clinicians (e.g those that made the referral and reviewed images pre-operatively). Radiology are working hard to meet the reporting demand, further reporting Radiographers have been recruited, outsourcing and WLI's have been utilised to reduce the backlog. The team are also exploring the potential for AI tools to support
October 2024	Radiology reporting error. A lung nodule was not identified on a CT scan from 2021. It was identified on a scan in 2024 leading to a delay in diagnosis of lung cancer. The lesion grew in size during the period from 1A to 1B, but surgical treatment was ultimately curative. The missed nodule was an error of perception, a common type of reporting error within Radiology globally. Errors of perception are where the abnormalities go unnoticed despite being visible. The exact cause of this remains unknown as is the case with this error. Given the time passed it was not possible to identify what human factors may have contributed to the error. Reviewing workload and workstations, interruptions have all been considered.
December 2024	A baby sustained a burn injury while attending a NYLO (Nutrition for Your Little One) dietetic and nutrition community group session. The group session was led by UHB dietitians with a private provider providing creche facilities in a community setting. The staff providing childcare were not paying attention to the baby and they reached out and held onto a hot radiator pipe. Safeguarding procedures were followed in relation to creche staff. A review of the venue and how facilities and venues are 'procured' has been undertaken by the Dietitians, including updating the risk assessments and documentation used at community groups.
February 2025	Radiology reporting error. A delay of 6 months in lymphoma diagnosis due to an unreported abnormality on CT scan. Due to a national shortage of Radiologists, imaging reports are outsourced to an external provider. The external provider did not identify on the CT scan the incidental finding of a lymph node mass. This was an error

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	of perception, i.e. the abnormality was present but not identified. The external provider has undertaken its own review and will share the case for wider learning. As above the exact cause of errors of perception are often unknown.
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The clinical board has a robust process for managing reportable incidents, supported by the Patient Safety Team. Each report is presented in QSPE to share any learning across the Clinical Board. Between 1st April and 31st March most investigations have been completed within the timescales set by the NHS Wales Delivery Unit.

Of the NRIs listed above all have been taken to re-dress.

The current position as of 14th July in the clinical board is, 3 open NRI's - one involving Biochemistry process and two in Radiology, one involving DXA scan protocols and one reporting error. All should be completed within the timescales set by Delivery unit for investigation.

Ionising Radiation (Medical Exposure) Regulations (2017) Report

The Ionising Radiation (Medical Exposure) Regulations, (IR(ME)R), provide safeguards for individuals exposed to ionising radiation from medical equipment for imaging, treatment or research purposes. The regulations set out a requirement that any accidental or unintended exposure to radiation is recorded and reported to the appropriate enforcing authority, in this case, Health Inspectorate Wales (HIW). The regulations require the employer to carry out a detailed investigation and share the outcome with the enforcing authority. The patient safety learning review template is used for these investigations and include an improvement plan to demonstrate actions taken to minimise the chance of a similar incident in future. Patients, where appropriate, are always notified of the incident and asked if they have any questions they would like addressed as part of the review.

Between the 1st of April 2024 and 31st March 2025 there were over 420,00 examinations involving ionising radiation, not including those undertaken in DEXA or Dental imaging). There were a total 66 IR(ME)R incidents, compared to 68 last year, 13 of which were reported to the HIW in line with IR(ME)R legislation, a reduction on the 21 reportable last year. Proportionally the incident rate is similar to 2023/24.

Overall incident rate occurrence is less than 0.001% of all applicable examinations.

Causes of IR(ME)R incidents are outlined in the infographic below

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RADIOLOGY ANNUAL SUMMARY

APRIL 2024 – MARCH 2025

IR(ME)R Radiation Incidents

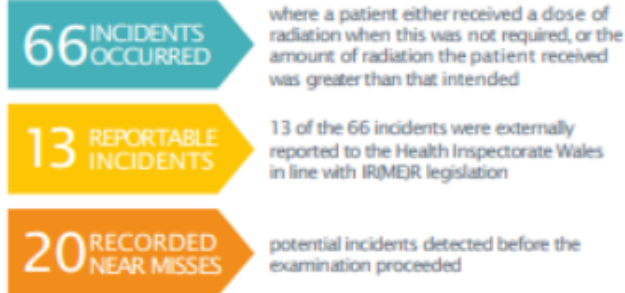


GIG
CYMRU
NHS
WALES

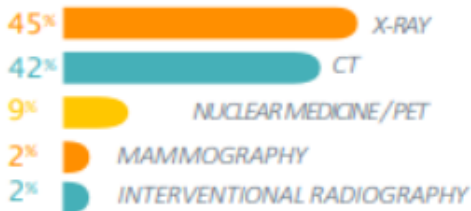
Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

Between the 1st of April 2024 and 31st March 2025 there were over 420,000 examinations involving radiation.

(Figures do not include DEXA or Dental imaging)



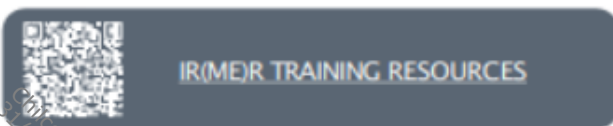
IMAGING MODALITY INVOLVED



INVOLVEMENT IN RADIATION INCIDENTS AS A PERCENTAGE OF THE TOTAL INCIDENTS/NEAR MISSES (SOME INCIDENTS WERE MULTI-FACTORIAL)

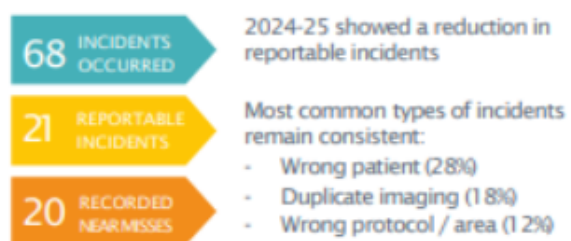


MOST COMMON TYPES OF ERRORS



IR(ME)R TRAINING RESOURCES

Comparative analysis with 2023 – 2024 data



IR(ME)R notifications to HIW April 2023 – March 2024

FREQUENT CAUSES OF THE MOST COMMON ERRORS

- INCORRECT PATIENT DETAILS** (100% were due to referrer errors)
 - ▶ Failure to confirm patient details prior to request submission
 - ▶ Multiple sets of notes present when completing referrals
 - ▶ Request not completed until the end of the ward round / clinic
 - ▶ Interruptions during the completion of referrals/handover
 - ▶ Miscommunication due to verbal requests
- DUPLICATE IMAGING**
 - ▶ Failure to review previous imaging at all points of the process – referrer, practitioner and operator
 - ▶ Area of interest covered on another modality e.g. xray pelvis requested when already covered on a CT Abdomen and Pelvis
 - ▶ Imaging already performed in another Health Board
 - ▶ System alert messages not acknowledged
 - ▶ Not asking open questions
- INCORRECT AREA IMAGED**
 - ▶ Operator failure to "Pause and Check" prior to exposure
 - ▶ Referrers requesting incorrect area to be imaged
 - ▶ Radiologist not amending requests based on clinical information prior to vetting
- INCORRECT SIDE IMAGED/OVERSCAN**
 - ▶ Inadequate review of clinical information against the protocol/vetting information
 - ▶ Miscommunication between staff / patient
 - ▶ Workload pressures/interruptions during imaging
 - ▶ Equipment issues

The above summary of all IR(ME)R incidents will be shared across the UHB.

Regulatory Compliance

The governance arrangements for regulation and accreditation is through the Clinical Board Regulatory Compliance Group which uses a combination of metrics to drive the compliance dashboard, ensuring appropriate senior management oversight, escalation of issues, and monitoring of performance.

The metrics include: the number of documents overdue review, the number of overdue audits and how many corrective and preventative action plans open. The number of open incidents and the number of change controls not closed are also monitored.

Service area	Inspection status (scheduled/ not for audit)	Document review compliance	Audit compliance	Alerts overdue to (UHW)	Overdue to (UHW)	UHW overdue to (UHW)	Number of clinical incidents	Incidents overdue to (UHW)	Number of overdue Changes	Open Changes (overdue to UHW)
Neuroradiology (UHW)	1	80%	98%	10	75	140	10	104	10	811
Non-Cellular Imaging (UHW)	1	80%	95%	10	3	120	5	110	1	302
Neuroradiology/Local Transcribe (UHW)	1	80%	98%	14	10	140	10	130	4	404
Pharmacy (UHW)	1	100%	98%	14	3	140	3	137	3	0
Immunology (UHW)	1	80%	100%	3	3	100	0	0	3	104
Genetics Cell Path (UHW)	1	95%	100%	10	10	10	3	10	0	0
Genetic Pathology (UHW)	1	80%	98%	14	80	140	0	100	0	0
Microbiology (UHW)	1	95%	100%	3	1	10	7	14	0	0
Respiratory (UHW)	1	80%	100%	3	4	10	4	11	0	0
Pharmacy (UHW) (UHW)	1	80%	98%	104	44	120	40	110	11	402
Pharmacy (UHW) (UHW)	2	80%	100%	3	11	100	3	100	2	10
Pharmacy (UHW) (UHW) (UHW)	1	100%	100%	3	11	100	0	0	1	10
Pharmacy (UHW) (UHW) (UHW)	2	80%	100%	3	11	100	3	100	0	0

Many areas in the Clinical Board are tightly regulated and subject to regular inspection and assessment against legislation, regulation and standards. In 2024/25 the following inspections took place:

HIW Inspection of Nuclear Medicine UHW against IR(ME)R regulations 15th and 16th October 2024

Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection of Nuclear Medicine at UHW. HIW reported that staff had a good awareness of their roles and responsibilities in line with IR(ME)R. Patients were treated with courtesy, kindness and respect. Effective arrangements were in place to deliver safe and effective care. There were clear lines of reporting, accountability and governance arrangements in place to maintain regulatory compliance. There were 29 recommendations including suggestions to amend documentation, recommendation for audits going forward and further detail to be added in relation to training matrix. In addition they identified an ageing estate and the route to the department as cluttered in the corridors and the road way entrance should be cleaned more frequently.

All Wales Quality Assurance of St Mary's Production Unit, October 2024

The inspection demonstrated improvement in the PQS from the previous audit. There remains some further work to improve, and the QA team have been meeting with CB outside of regulatory compliance group to monitor and track the PQS. It was also identified that the environment required improvement. New cabinets and isolators were purchased as a result of the inspection findings the plan for installation is in progress. The wider improvement for SMPU is linked to the closure of PSU in UHL and the TrAMS project.

British Standards Institute inspected Clinical Engineering, June 2024 and July 2025 two external for BSI 9001:2015 certification, both resulting in positive recommendations for continued certification.

UKAS Accreditation Biochemistry (January 2025)

Re-accreditation visits against ISO15189 2022 in Biochemistry resulted in successfully maintained accreditation. Accreditation ensures safe delivery of services, technical competence, timely, accurate and reliable results, and good quality management. The assessors recognised the expertise of the staff in the labs, the complexity of the service provided and high levels of compliance.

Feedback from QMS demonstrated plenty of conformity and competency, high levels of quality management that was well managed and led. A strong culture of quality was observed with the team

rising to the challenge set by the quality team. What was particularly encouraging to hear was that the assessors noted the commitment and passion about the job and the team's role in helping patients.

UKAS Accreditation Haematology (April 2025)

Re-accreditation visits against ISO15189 2022 standards in Haematology resulted in successfully maintained accreditation, pending completion of 2 outstanding non-conformities. 14 mandatory findings identified. Identified some findings with competence records and some slippage in QMS but identified the challenges in the team with implementation of LIMS and several secondments in place to support that project. The UKAS Quality Manager and the peer reviewers were very complimentary of the high standards of the team particularly the attention to detail in IQC, trending and compatibility were above and beyond what they have seen elsewhere.

UKAS Accreditation Cellular Pathology (April 2025)

Re-accreditation visits against ISO 15189 2022 standards in Cellular Pathology resulted in successfully maintaining accreditation. Some mandatory findings were noted none of criticality and they have been closed within the timeframes given. Noted the engagement of Consultants. The assessors noted the improvements in the workflow through the laboratory.

HTA Inspection of Stem Cell Laboratory (June 2025)

No formal report received but verbal feedback was positive on the day with only minor findings reported. Noted significant improvements that had been made with overdue audits having a plan in place to improve.

Risk Register

Directorates feedback risks during QSPE meetings and it's sub group meetings. The clinical board risk register is reviewed every 2 months and feeds into the corporate risk register.

The top risks on the risks on the risk register are summarised below:

Risk	Current Risk	Actions
<p>Estates Risks The fabric of the estate is suboptimal to delivery of modern, safe and sustainable healthcare. Significant aggregated risks across the Clinical Board Directorate risk registers including: 1. Stem Cell Processing Unit - inadequate accommodation, compressor failures, failure of supply of liquid nitrogen from the external tank. <u>Risk/ impact</u> - failure to deliver liquid nitrogen to the cryogenic freezer, delays to patients. 2. Health Records - inadequate storage capacity across departments, <u>Risk/Impact:</u> loss of security of the Health records, increased costs for off site storage 3. Insufficient accommodation for a number of clinical board services including <u>Risk/Impact:</u> Poor staff experience. Health and safety risks and inability to grow service impacting on potential for income generation 4. Repeated examples of water or sewage ingressing into clinical and non-clinical areas <u>Risk/ Impact:</u> inability to deliver services, poor staff and patient experience, health and safety concerns, damage to records in UHL main OT department</p>	<p>20</p>	<p>1. Continue to seek funding through WG for replacement equipment and HTF funds to substitute old technologies. Accommodation request submitted to use some space vacated by Cardiff Uni 2. Put in place recommendations from internal audit of medical records storage and security 3-4. Further work with Capital and Estates to develop prioritised timetabled plans to address known risks. Raise requests through accommodations working group 5. Engage with TRaMS project for proposed regional solution to Radiopharmacy and aspetics. Working through plans for PSU closure towards end of 2025/2026 6. Laboratory space identified, a/w funding agreement from WG for refurbishment works required 7. The minimum power required for scanner has been shared with estates colleagues to work through potential solutions.</p>

<p>5. The viability and sustainability of an ageing facility in PSU at UHL <u>Risk/Impact:</u> Possible closure from the regulator</p> <p>6. Insufficient space for New born screening expansion in line with WG requirements <u>Risk/Impact:</u> Risk of inability to deliver the expanding tests</p> <p>7. Electrical supply to UHL potential to fail with delays to back up supply or fluctuations in supply leading to insufficient time to power down CT scanner <u>Risk/Impact:</u> Expensive damage to CT scanner and associated downtime leading to loss of activity</p>		
<p>Equipment Risks - ageing equipment across the clinical board including:</p> <p>1. NVA 1 and NVA 2 simultaneous breakdown <u>Risk/ Impact:</u> delays to patients' treatment</p> <p>2. Air handing and chiller units - not in place, subject to regular breakdowns, affecting temperature sensitive services <u>Risk/Impact:</u> Loss of service, regulatory failure leading reputational damage, delays for patients .</p> <p>3. Air tube for lab specimens regular breakdowns and damage <u>Risk/Impact:</u> results in inability to use the system to deliver specimens causing delays for patients.</p> <p>4. Ageing equipment in Pharmacy sterile services</p> <p>5. Ageing laboratory equipment in cellular pathology laboratory: stainer, cover slipper and printmates <u>Risk/impact,</u> risk that aged equipment would not be able to be repaired following breakdown, repair contracts will no longer be provided by the supplier and spare parts may be unavailable to maintain equipment. this would lead to delays in patients diagnosis</p> <p>6. CT2 scanner is 15 yrs old and has been identified as producing poorer image quality and requiring higher dose radiation compared to other UHB scanner <u>Risk/Impact</u> - Higher risk groups have been identified as unsuitable to use CT2 and as such has placed further work on remaining CT scanner in UHW leading to longer waits, where they can't be accommodated and CT2 is used some patients have been required to be recalled due to image quality</p> <p>7. Ageing POCT blood gas devices <u>Risk/Impact:</u> devices unable to be repaired, potential data loss from older machines, connectivity issues</p> <p>8. Clinical Engineering tail lift van is overdue replacement <u>Risk/impact</u> Should this van fail there would be no other means of taking equipment to and from UHW/UHL/Field way,</p>	20	<p>1. Replacement programme commenced for NVA 1 and 2 in July 2024 and near completion July 2025</p> <p>2. Capital replacement bid to be submitted for air handling and chiller units, temporary devices to be procured to mitigate temperatures in Summer where possible (cellular pathology)</p> <p>3. Explore options to purchase new system and how best to manage future maintenance of the system with estates colleagues</p> <p>4. Engage with TrAMS project for proposed regional solution to sterile production units</p> <p>5. Capital replacement bid submitted, new auto stainer procured, awaiting installation, source a new company who would be willing to service and repair ageing equipment</p> <p>6. Scheduling adjusted, bookings reviewed daily, DRL audits. On schedule for All Wales level for Radiology Equipment, likely to be replaced by 2026</p> <p>7. POCT to contact procurement to complete tender process</p> <p>8. Support from procurement to progress with options for replacement</p>

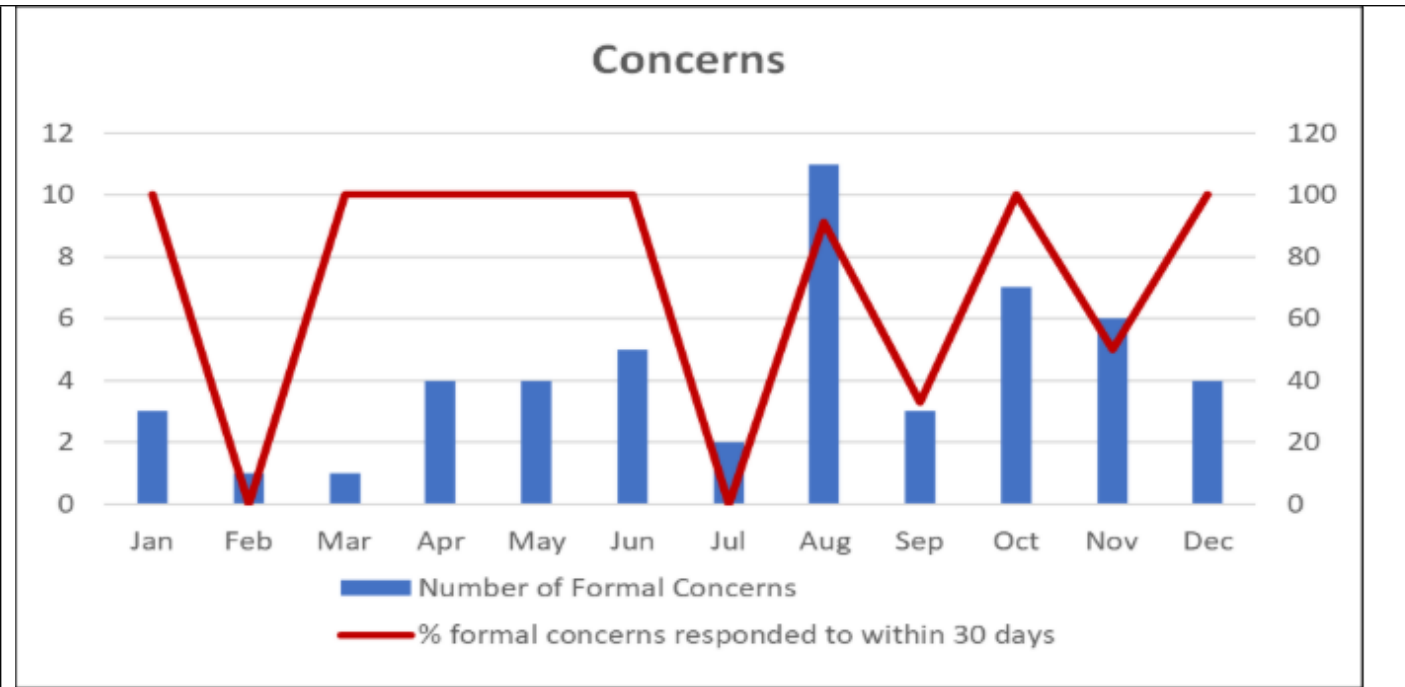
leading to delays and unavailability of equipment in clinical areas		
<p>Backlog in Diagnostics Backlog of diagnostics in Radiology and Cellular Pathology as a result of increase in demand and no increase in capacity <u>Risk/Impact:</u> - risk of increased morbidity and mortality to patients due to delayed pathways - missed/delayed cancer or critical illness diagnosis due to incorrect prioritisation - increase in concerns/complaints - adverse public reputation</p>	20	Capacity and Demand work continuing Explore opportunities across professions-reporting radiographers/ scientists Fully embed clinical prioritisation model of performance Further Develop Lightfoot dashboards across the CB Ultrasound action plan in place including review of criteria for referrals, additional sonographer training places, ongoing recruitment. Locum sonographers, WLI and enhanced payments agreed for time limited period to address backlog. Outsourcing options to reduce backlogs Exploring use of AI to triage plain film backlog Toyota work ongoing to improve workflows
<p>IT and Digital Impact from aging hardware and software, slow delivery of key IT systems, on-going stability issues (WCCIS, WLIMS, TrakCare,Telepath), connectivity issues for POCT devices Electronic requesting within the Radiology Information System (inability to address patient identification issues) only for GP and inpatient not for outpatients Lack of Radiology results notification and acknowledgement system so that unable to meet requirements of NPSA16 and unable to flag significant and expected findings Inability of PARIS to interface with the Welsh Clinical Portal</p>	16	Continue to engage with the National Programme to work towards standardisation and interoperability in order to implement more prudent and effective IT systems, e.g. LIMS and RISP Ensure representation on the Digital foundations working group to ensure digital solutions are considered as part of the 5-year digital programme



Concerns and Compliments

307 concerns were received during the period 1st January 2024 to 31st December 2024. 51 were managed through the formal concerns process and 256 were managed via early resolution. Across the year, 84.5% of formal concerns were responded to within 30 days.

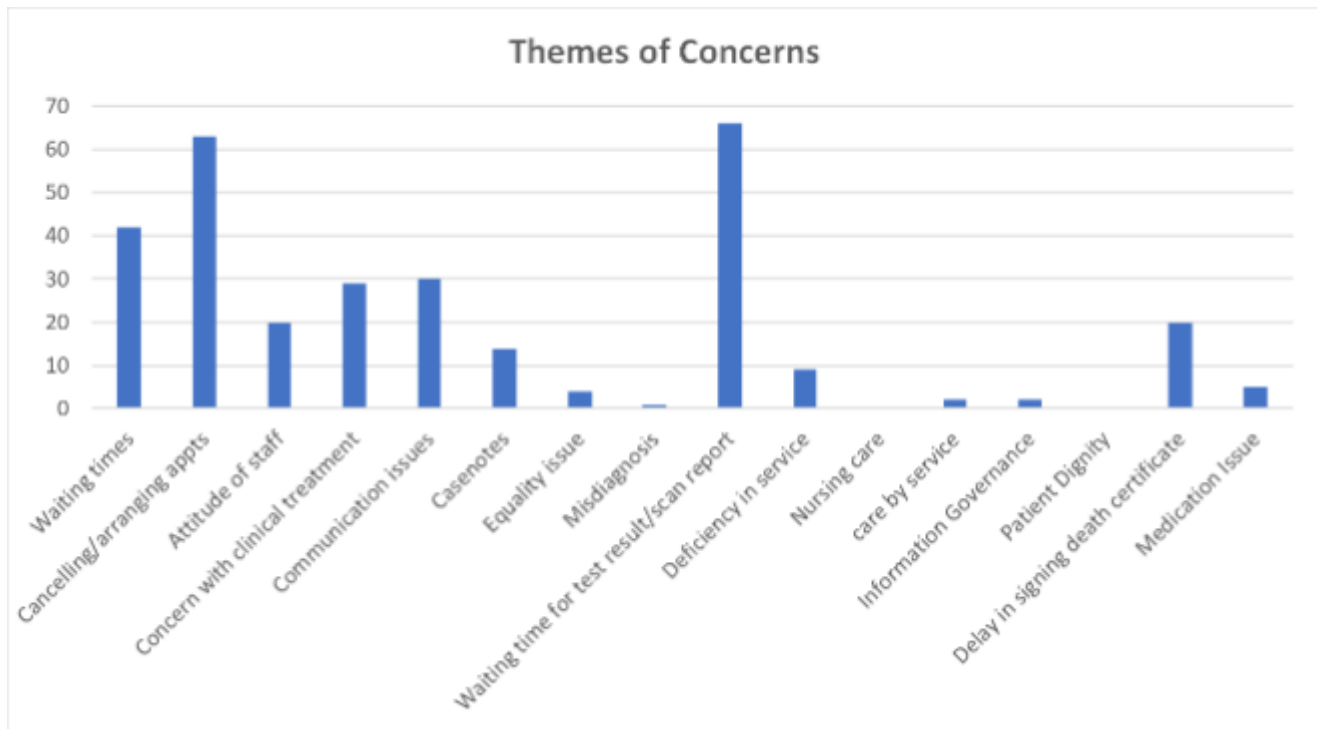
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The top 3 themes of concerns received in 2024 were:

- Waiting times for test results/scan reports
- Difficulties cancelling/arranging appointments
- Waiting times

Which were the same themes as the previous 12 months.

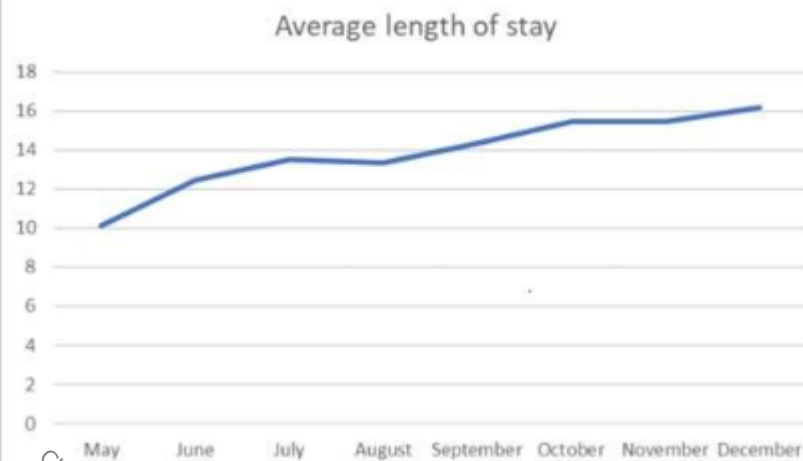
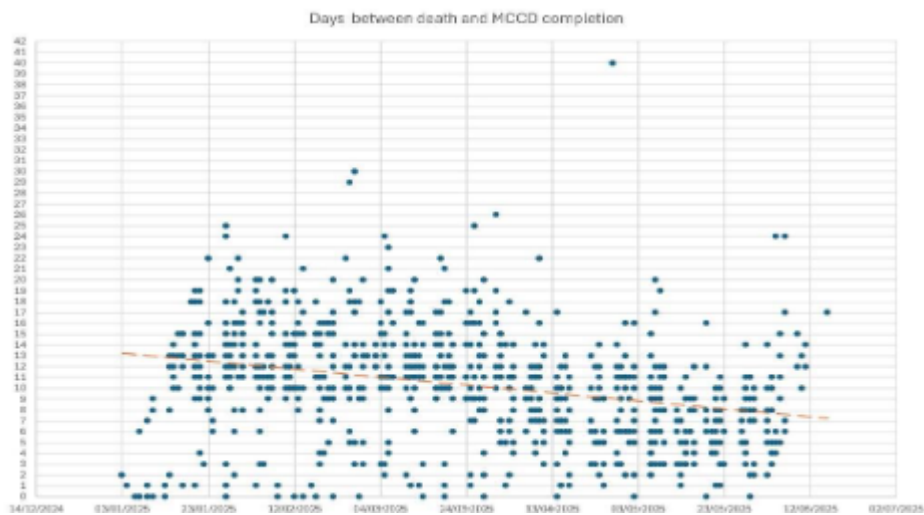
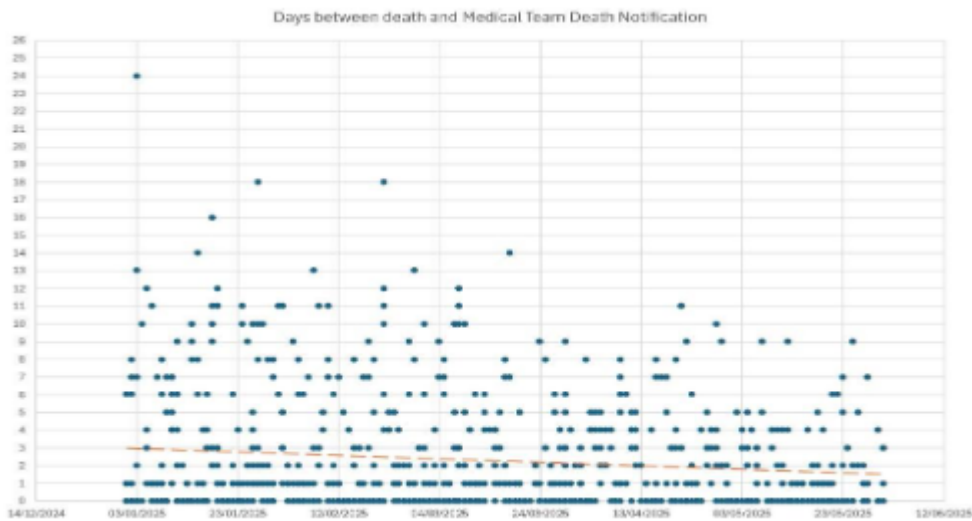


In relation to the difficulties in cancelling/ arranging appointments we are looking at how automated systems may be implemented to address these challenges and this has made some progress in the last 12 months.

Whilst over 12 months delays in completion of death certificates hasn't been a top theme it certainly was in the early part of this year for our bereavement team. In September 2024 there was a change in the Medical Examiner (ME) process leading to all deaths being discussed with the ME. A process where a QR code can be completed which notifies the ME of a death and a proposed cause of death was introduced to support timely notification. The bereavement office will then scan notes to the ME. The ME

when they have scrutinised the case will have a discussion with Doctor and the certificate can then be completed.

The graphs below indicate an improving picture in relation to timely completion of both QR code and completion of MCCD, there is further work to improve the process for bereaved families. This process has also had an impact on the length of time patients stay in our mortuary.



While the process around the ME has been a significant in its impact, it is not entirely responsible. There is an uptick in the use of direct to cremation funeral directors, the business model of the majority of these is to keep patients at local mortuaries and only collect 48 hours prior to cremation. Funeral Directors are not taking patients into their care until disbursements and other payments are made by the bereaved families arranging funerals.

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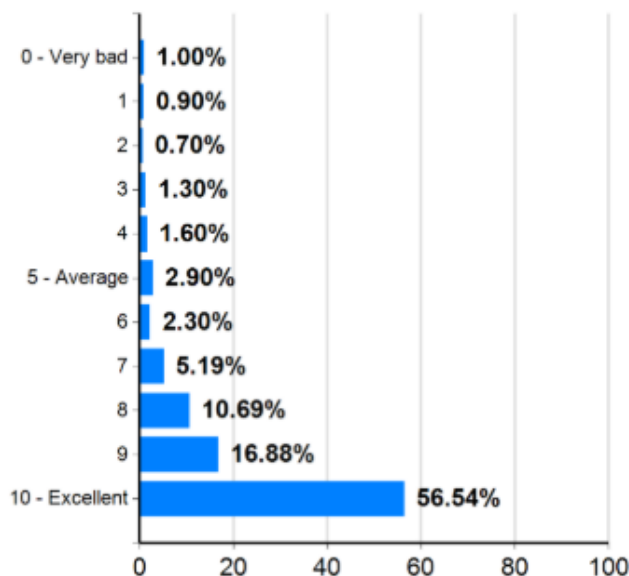
59 compliments were received within the Clinical Board within this same period. Departments are reminded to share their letters/emails of praise from patients to ensure that their compliments are recorded.

Patient Experience Data

During 12 months from 1st April 2024 to 31st March 2025 data has been collated from Civica in relation to services across Clinical Board. Largely this data comes from outpatient settings in particular Physiotherapy, Occupational Therapy and Phlebotomy clinics.

Question 5: Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?

Available Answers	Responses	Score (%)
0 - Very bad	10	1.00%
1	9	0.90%
2	7	0.70%
3	13	1.30%
4	16	1.60%
5 - Average	29	2.90%
6	23	2.30%
7	52	5.19%
8	107	10.69%
9	169	16.88%
10 - Excellent	566	56.54%
Total	1001	100%



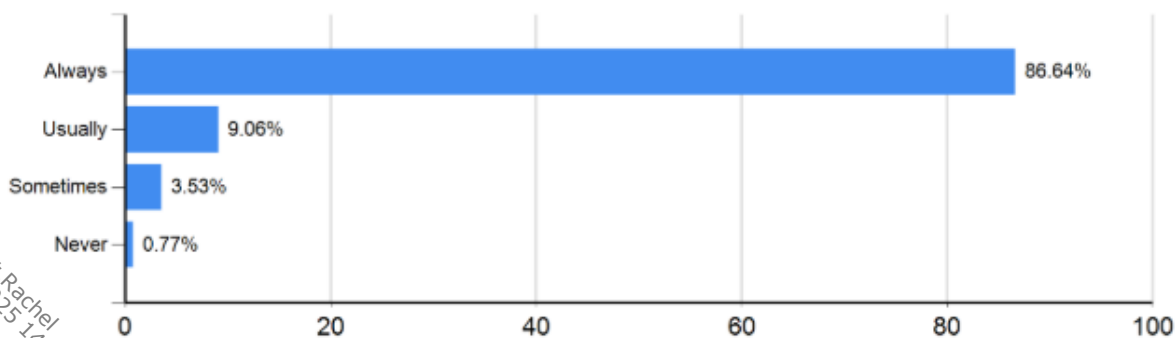
[Create new action](#)

Question 3: Were staff kind and caring?

[Create new action](#)

Available Answers	Responses	Score (%)
Always	564	86.64%
Usually	59	9.06%
Sometimes	23	3.53%
Never	5	0.77%
Total	651	100%

Score: 94%



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It is pleasing to note that the majority of patients rate their overall experience as 8 or above and that 86% replied that our teams were kind and caring always.

The word cloud below is created by collating comments taken from free text boxes in the Civica system, the larger the word the more frequent it was mentioned.

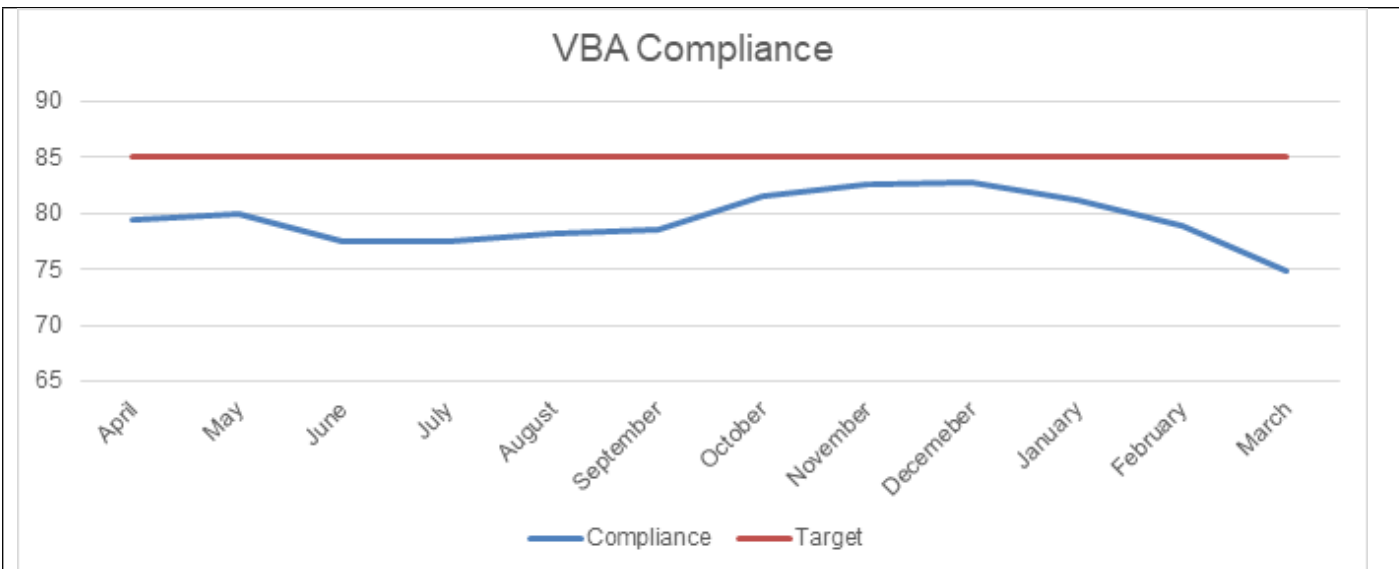


A powerful patient story that arose from a concern raised by a service user of the Podiatry Service in CRI has been shared across the clinical board for awareness and learning. The service user, who is visually impaired, experienced multiple challenges including accessing the building, the department and obtaining her Welsh Ambulance Transport home. The podiatry service explored and resolved the concern in an innovative, co-produced way. After an initial discussion with the service user, it was agreed that she would attend a departmental training day where she would share her experience to enable a greater awareness of the needs of visually impaired service users. 'Carole' was keen to use the opportunity for wider dissemination and agreed to be filmed by the medical illustration department. This video, shared across the clinical board, portrays a powerful message of the need for greater awareness of service user's vulnerabilities within and outside of the UHB. It also highlighted the need to improve the infrastructure in some of our sites, particularly for people with sensory impairments.



Workforce

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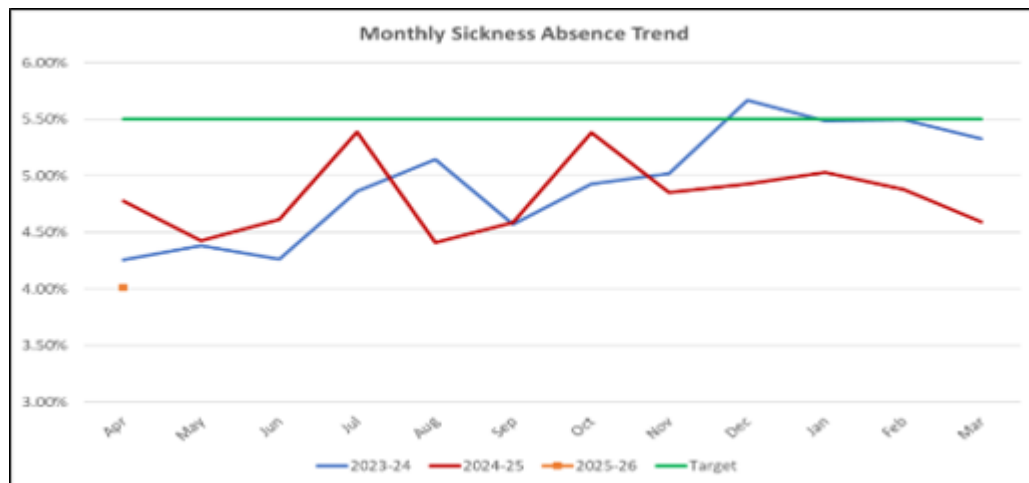


Despite an encouraging trajectory during the latter part of the year, the momentum has not been sustained, and we have seen operational pressures and the focus on delivering clinical care impact compliance, dipping to all year low under 75%. VBA remains a priority for the Clinical board and is monitored monthly with each directorate

Performance March 2025					
Turnover	Cumulative Sickness	VBA	Medical Appraisal	e-Job Planning	Stat and Mand
11.06%	4.79%	74.78%	85.71%	63.86%	86.25%

Turnover reduced to 11.06% from 11.95% reported in the same period as last year and is steadily reducing further with the current rate at 10.75%.

There has been a focus on fire training in last 12 months and current compliance is at 79.4% and improvement from a low of 72.49% in August last year.



Whilst sickness remains consistently below the UHB target the following interventions have been put in place to support colleagues managing attendance

- **Monthly Sickness Panels** established and embedded, with a targeted focus on high-impact areas; identified as 'hotspots' due to elevated sickness levels relative to WTE staffing.
- **Comprehensive case reviews** undertaken during panels, including long- and short-term sickness cases to ensure consistent and timely progression in line with policy.
- **Supportive offer extended to all Directorates** – opportunity for tailored sickness panels to assist departments in strengthening sickness management and governance.
- **Sickness panels to be appraised** following delivery in 'hotspot' areas, with scheduled roll out to other departments as improvements are embedded and sustained.

- **Training needs identified** – Managing Attendance at Work (MAAW) training sessions to be attended by managers in 'hotspot' areas.
- **Emphasis on policy adherence** – active reinforcement of meeting policy prompts, holding timely review meetings and ensuring accurate documentation of decisions and use of discretion.
- **Focus on Manager resource signposting** – clear promotion of available support tools including, Stress Risk Assessment, Occupational Health referral routes, Access to Work and flexible working pattern reviews, with a preventative focus prior to reaching formal review prompts.
- **Primary reason for absence: Anxiety, Stress and Depression (29.54%)** - To consider targeting wellbeing interventions and preventative methods to reduce impact and support sustained attendance.



There are a number of initiatives across the Clinical Board to support staff engagement and well-being. There is a fortnightly team brief, via teams, for staff to join to get updates from the Clinical Board and the wider UHB, and opportunity for teams to raise any questions or concerns.

Within therapies there has been much work on equality, diversity and inclusion led by Speech and Language colleagues.

Within the laboratories sessions on culture and leadership have been put on with support from HCPC and have been well received.

Health Roster continues to be rolled out across the clinical board, with Radiology the most recent directorate to begin implementation.

The Clinical Board are developing plans to address the results of the staff survey. The table below outlines some of the plans.

Theme	Issue	Action
Staff Engagement	At 71.2%, the CD&T staff engagement index is below the NHS Wales average of 72%.	Promote CD&T representation at Staff Survey Focus group (led by CEO), actively publicising the opportunity and facilitating time to attend. Re-energise the equality and inclusion ambassador network by convening a meeting with CD&T leadership representatives and E&I People and Culture colleagues to co-define refreshed objectives, membership and priorities.
Sexual Safety	Unwanted sexual behaviour in the workplace and a need for greater clarity, consistency and confidence in how concerns are raised and addressed.	The UHB has introduced a new <i>Sexual Misconduct Procedure</i> and ensure we have clear, supportive processes in place for dealing with any concerns. Awareness training has been developed and is available to all employees. It is designed to provide the knowledge and tools necessary to respond to concerns raised but also to foster a safe, respectful workplace. CD&T Clinical Board to support the roll out of the programme to facilitate employee attendance. CD&T Clinical Board to promote the "Speaking Up Safely" procedure, reinforcing the message that all staff are empowered to raise concerns without fear of reprisal. A toolkit is being developed to support the sexual misconduct procedure, to aid managers and staff in applying the procedure consistently and will be available on SharePoint shortly. Dedicated investigating officers who have received specific training on Sexual Harassment allegations.
Stress and 'burnout'	Staff report feeling 'burnout' due to workload pressures and service demands (2024 Staff Survey – 36% of staff reported always or often feeling 'burnt out' as a result of their work – highlighting the impact of workload and pressure on wellbeing).	Champion proactive absence management to facilitate timely staff rehabilitation and sustainable workplace retention. Seek opportunities to partner with People Services and Occupational Health teams to proactively identify and manage cases of work-related stress through targeted intervention. Embedding use of Stress Risk Assessments across 'hot spot' areas, with reinforced management support/guidance concerning early identification. Promotion of self-care and wellbeing resources (e.g. CANOPI and Wellbeing Support) in collaboration with EWS.

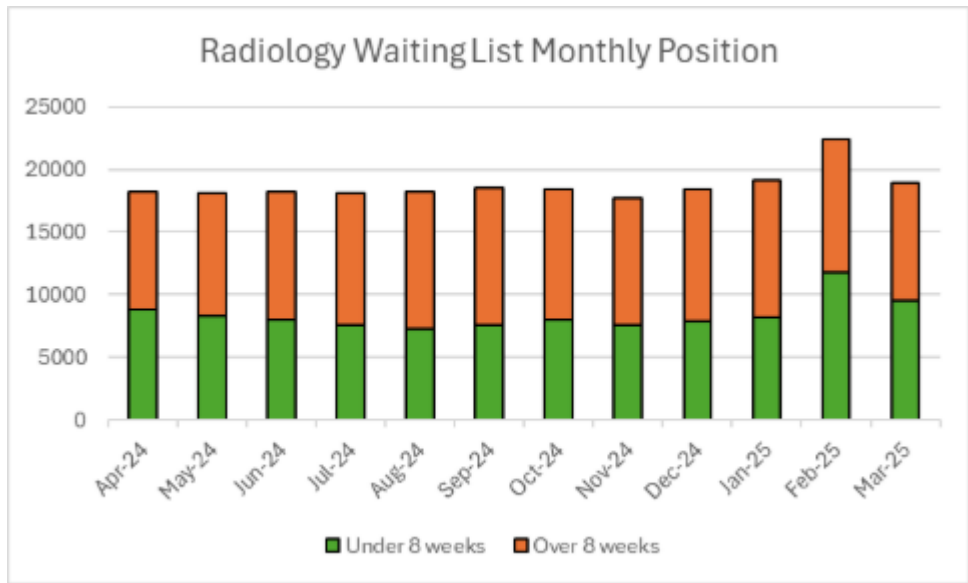
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Performance Against National Standards

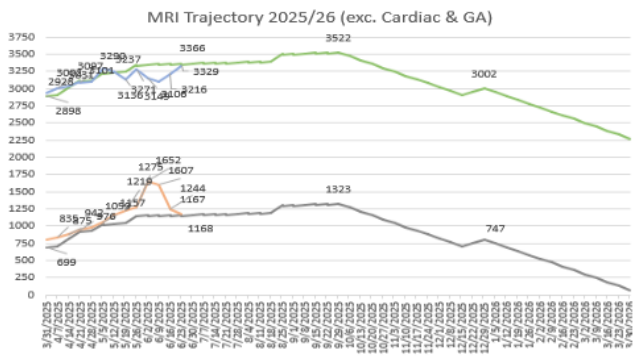
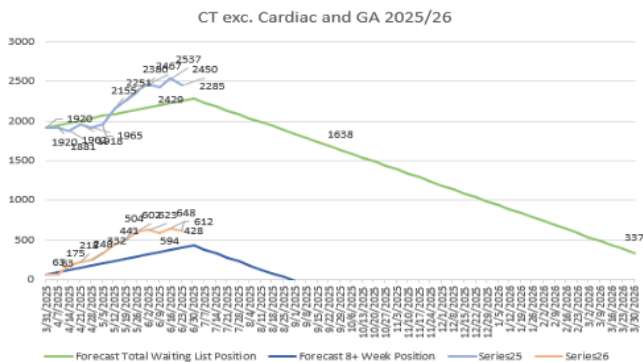
Diagnostic & Therapeutic Standards-

2024/25 has been another challenging year in terms of providing timely care to patients.



In relation to the 8-week diagnostic turnaround, the performance dipped a little over the summer after making some improvements at the start of the year. A slight improvement can be seen towards the beginning part of the year but this remains a challenging position.

Significant action has been taken in CT and MRI to reduce the number waiting over 8 weeks. The diagnostic hub at UHL increased capacity from September for CT and MRI which ran into 2024/25. But recent scanner down time is affecting the length of time patients are waiting. There is a plan to create additional capacity over the Summer. The trajectories below demonstrate where we hope to be with the additional actions in place.

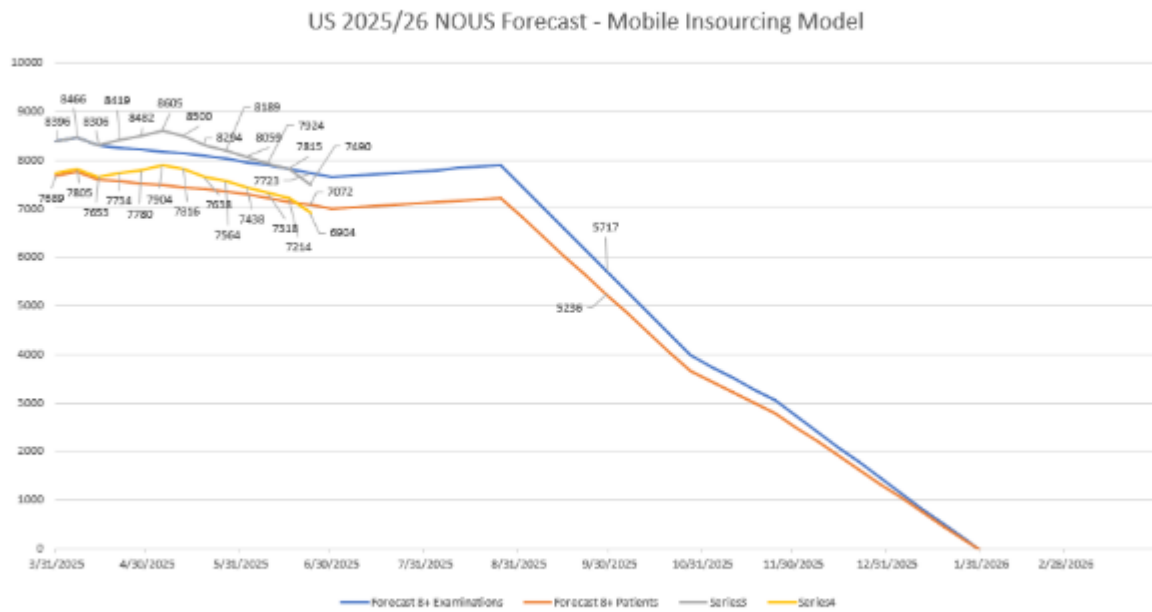


The overall waiting list is primarily due to insufficient capacity within Ultrasound. Sonographers are in short supply nationally and are difficult to both recruit and retain.

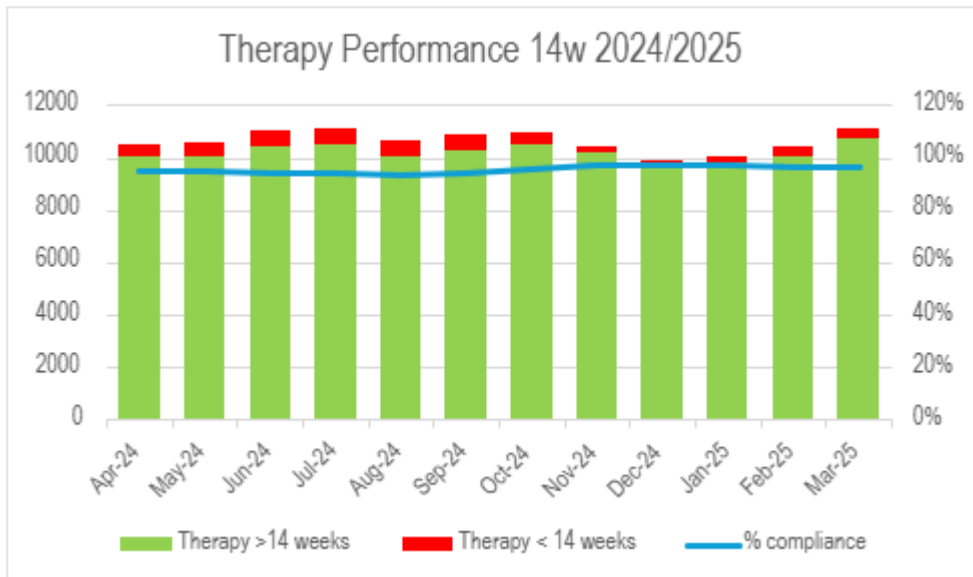
Despite adopting a robust action plan to increase the capacity for 2024/25 to improve the position, which included several initiatives, both to reduce demand and increase capacity the waiting list remains at over

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6500 patients. However, this is an improvement from over 9000 in August last year and we are on track with the recovery trajectory as the graph below demonstrates.



The 14week standard for therapies was met consistently in a number of therapeutic specialties. We have also seen an increase in Therapy referrals over the last 2 years of 10% and a 23% increase compared to pre-covid levels. This demonstrates how the service has evolved with much more focus on prehabilitation and the development of the live well service since the pandemic.



The Weight Management pathway was taken out of the performance measures. The graph below demonstrates the March 25 position

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Level 2 Weight Management



■ Breaches ■ Nbr under 14 weeks

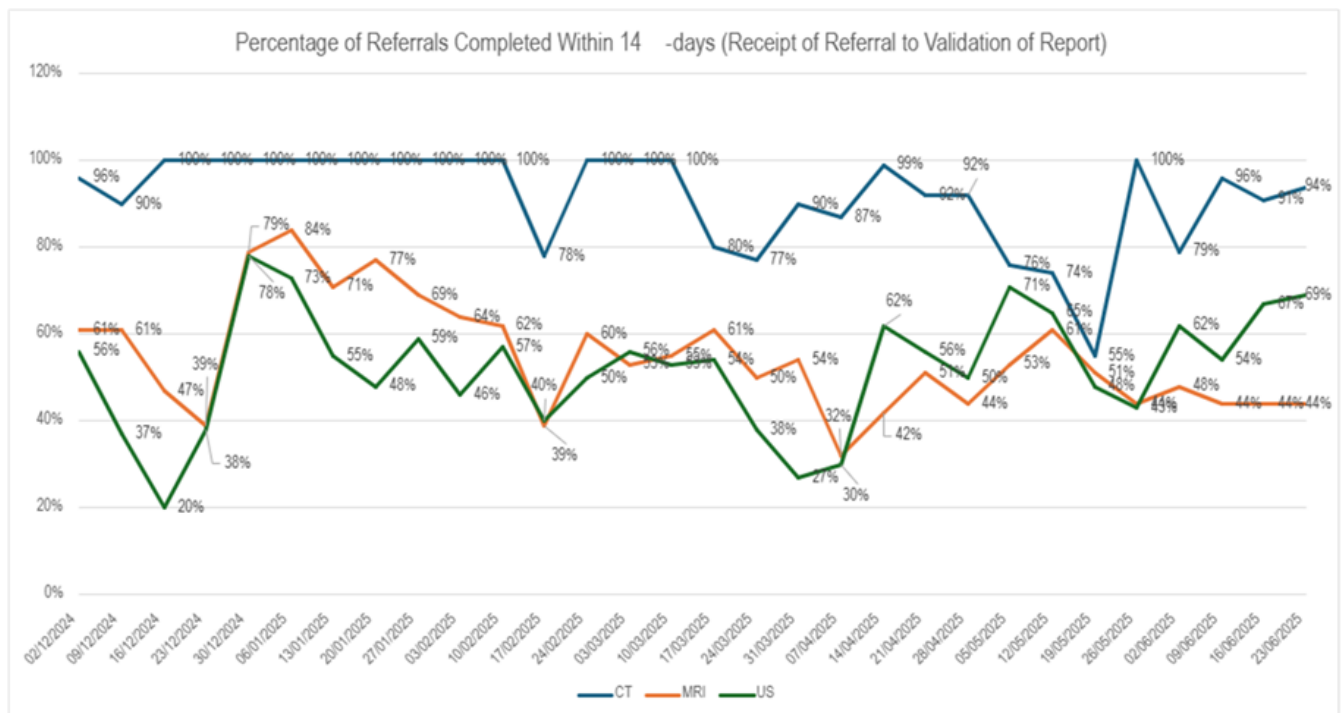
This remains an area of concern, particularly with the publicity and public demand for weight loss injectables such as Mounjaro and Wegovy. Managing public expectations around access to weight loss medications is challenging.

Cancer

Focus on improving the diagnostic pathway for patients with suspected cancer continues. The turnaround time from referral to report for CT and MRI scans is monitored closely.

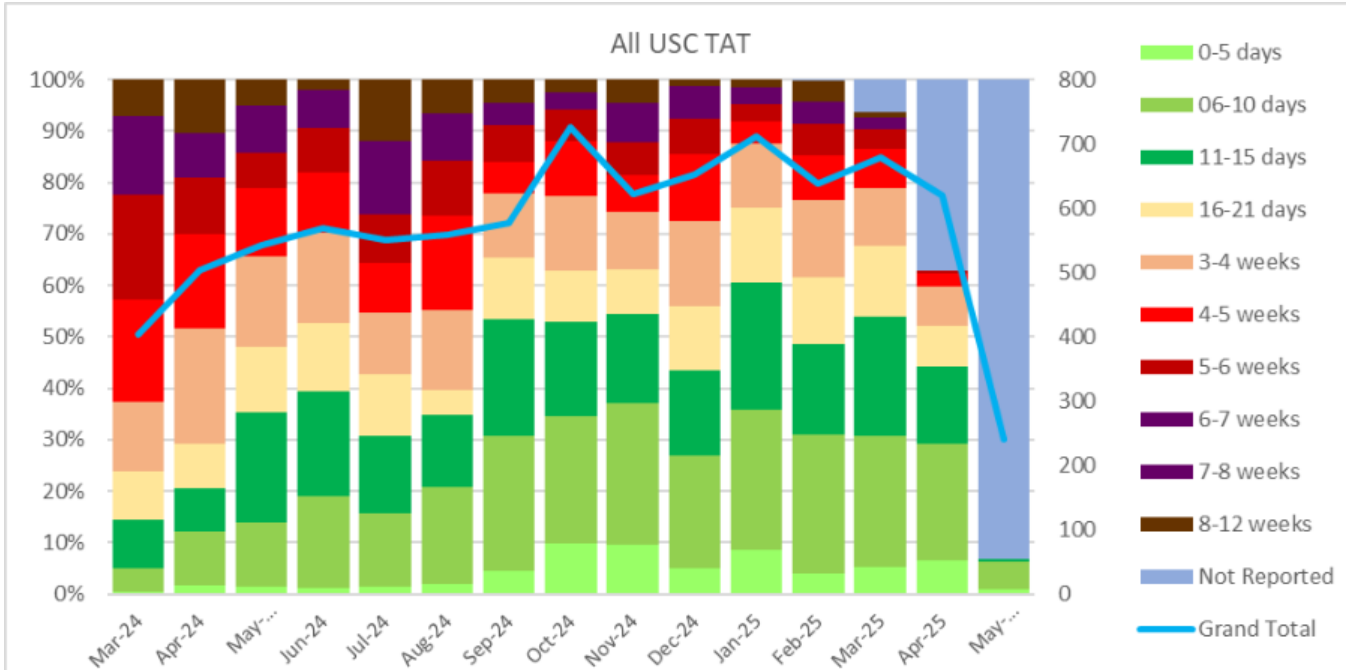
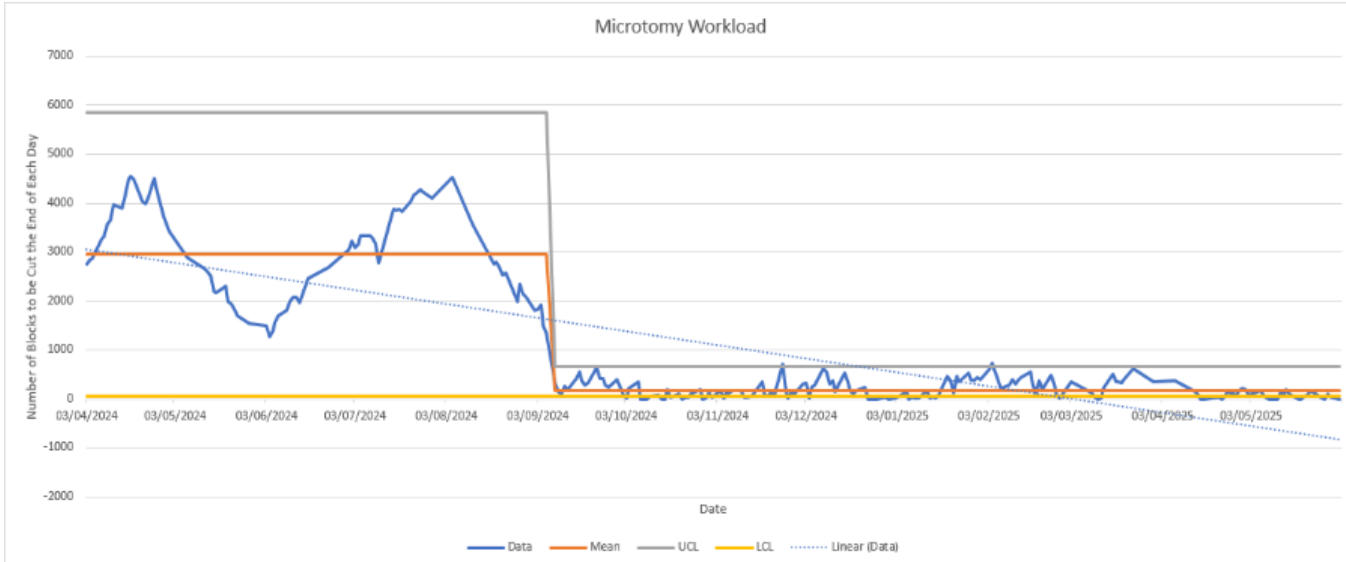
MRI is struggling to meet the 14-day turnaround time, linked more recently to scanner downtime in CAVOC, current snapshot data for the end of June, shows only 44% achieved within 14 days and still only 81% at 21 days.

CT is performing better than MRI but is not consistently meeting the target 10-day target, but as the graph below demonstrates is achieving the 14 days turnaround more consistently. As described above the ultrasound waiting time is challenging but steady improvement has been seen since April last year.



There has been much work undertaken within the cellular pathology laboratory to help improve the turnaround times for cancer diagnosis.

Within the laboratory lean working has improved the time taken for specimens to be processed and made into slides for Consultant Pathologists to make a diagnosis. As you can see from the graph below, we had a backlog of over 4000 blocks. This led to significant waits for patients. The number of blocks is monitored daily by the team and workflows in the laboratory reassigned when required to manage demand. As the graph outlines the workload has reduced significantly.



The graph above shows the turnaround time for all specimens labelled urgent suspected cancer (USC). The blue line shows an upward trend of improvement, with 50% of all USC turnaround time within 15 days. There is ongoing work within cellular pathology to further improve the time patients are waiting. We now have an additional reporting scientist and a further 2 in training.

The following section of the report outlines how each of the directorates are contributing to the 6 domains of quality and the 6 enablers



Radiology, Medical Physics & Clinical Engineering

Following some adaptations to Tendable it continues to be used within Radiology and provides assurance in relation to IPC practices.

During the last 12 months both Interventional Radiology suites have been refurbished, providing a modern and reliable environment to undertake procedures such as biopsies, IVC filter placement and treatment of brain aneurysms.

Following feedback from HEIW last year an improvement in support for Registrars has been implemented with additional support from 5-8pm now in place

Thrombectomy service went live on 1st July 2025, seeing our first patient that day. The patient attended the emergency unit and was referred for thrombectomy review at 13:33. The National Institutes of Health Stroke Scale, or NIH Stroke Scale (NIHSS), is a tool used by healthcare providers to objectively quantify the impairment caused by a stroke and aid planning post-acute care disposition. His NIHSS score was 10 on referral, indicating a moderate stroke. The Procedure started at 14:40 and concluded 15:05. The patient was discharged home 3 days later, self-caring and independent.

The Paediatric Radiology team have been working closely with colleagues from the Children's Hospital for Wales on scanning children while they are asleep. Using techniques like feed and wrap or bedtime scan avoids the need for sedation or general anaesthetic and leverages the child's natural sleepiness to allow for successful imaging.

CEDAR

CEDAR led the development of the National People's Experience Survey (PES) for Welsh Government and Patient Experience Teams last year and this was released in April this year. The PES is being used to collect patient experience data in national services, with collection ongoing in across UHB's and Trust's in Wales. The project also won the Public Involvement Award at the Health and Care Research Wales Award last year.

CEDAR is involved in a number of projects that include gathering patient experience data to evaluate services in CAV and across Wales – Cardiff Benefits Realisation, LUPUS evaluation, SWAN clinic evaluation (to name just a few) as well as things like the HAD project which is producing a tool to help reduce hospital acquired deconditioning.

Medical illustration

In the last year, over 4400 orders have come through the Print Department, with over 5 million individual sheets being handled by the team. A new addition to the services for this year, is that we can now offer bespoke duplicate and triplicate printing to enable our clinical teams who need this type of form to be able to obtain them at a fraction of the cost of using an external printing company.

Over the last year, the Design Department has seen 1435 orders for artwork come through, ranging from forms and booklets to animations, interactive reports, illustrations and poster designs.

In the last year, the Clinical Photography Department has seen almost 42,000 patients. Our Teledermoscopy service enables clinicians to view images of lesions quickly and effectively, including urgent suspected cancer (USC) referrals. This service has seen 2726 patients over the last year. It reduces the need for referrals to have a face-to-face appointment with a Dermatology Consultant, and therefore directly contributes to the decrease in Dermatology waiting lists.

To support the workforce Medical Illustration have provided protected time for the designers to develop skills in order to meet the future needs of the service. Photography clinical audits are held in line with UHB timelines, and this is used as an opportunity to hold workshops, image audits and critiques in order to facilitate the ongoing development of the team. The department's appraisal approach encourages individuals to be proactive in determining areas for their growth. The team are set objectives that will ensure their ongoing development to meet the needs of the service. A proactive approach to appraisals ensures that the team are invested in their ongoing development and feel supported.

Pharmacy

An exciting new digital system for prescribing and administering medication called electronic Prescribing and Medicines Administration (ePMA) has been introduced this year, with the Nephrology wards the first

to use the system and wider roll-out planned throughout the coming year. ePMA is a key part of the Digital Medicines Transformation Portfolio which aims to make the prescribing, dispensing and administration of medicines easier, safer, more efficient and effective, for both patients and clinicians replacing paper-based prescribing and administration records. The system has clinical decision support so will support prescribing and administration decisions where there are allergies, interactions, dosing decisions and formulary choices to promote medicines safety. The system also supports 'closed loop' supply and administration which will be developed to further enhance safety features of this system.



KidzMedz (initiative to support Children and Young people taking medicines in tablet or capsule form instead of liquids) is still ongoing with interest growing from other areas of Wales.

The Welsh Medicines Advice Service (WMAS) is undergoing a transformation where the individual Medicines Information (MI) services in Wales are attempting to work more closely together, to improve efficiency of the Medicines Information services both locally and nationally and ultimately provide information and advice Once for Wales. To enable this transformation, the WMAS has invested in a digital solution, a cloud-based contact centre called Netcall, which went live in April 2025. Not only will this system allow our MI services to work seamlessly together as a national service, we will also see for the first time, the true activity of the individual services at any point in time allowing us to better understand the service demands and allow informed workforce planning.

The SBRI challenge around safe and ethical disposal of Nitrous Oxide and Entonox medical gases was shortlisted for the Improvement and Innovation award at the Health Industry Leaders Sustainability Awards but unfortunately did not win in a competitive category.

Therapies

Therapies celebration AHP Week October 2024 focused on The Rehabilitation Model, 24 presentations over the week demonstrating and highlighting how Therapies are working within the CAV Shaping our wellbeing across the services. 111 staff participated.

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How we work; Our Rehabilitation Model

The Rehabilitation model allows us to rethink how we deliver care, delivering support closer to home and enabling us to access harder to reach population groups, whilst **working in a more effective & efficient way**. Through ensuring people access the right care, at the right time, we are able to **optimise clinician time and utilise community offerings** to ensure effective intervention, whether this be group based or specialist support



Level 1: Keeping Me... Well

Supporting people with **self care** and health generation in the community. From exercise groups such as Tai Chi, to social meets like support cafes

Level 2: Enabling Me... To Live Well

Individual or group consultations that include meaningful conversations, education, shared decision making and brief interventions to build self-care and health. Examples – Foodwise for Life programme, OAK, Manage backs

Level 3: Supporting Me... To Live Well

Providing the complex, multifaceted, group-based interventions that support sustainable strategies for health and wellbeing. Examples – Long Covid Recovery, ESCAPE pain, Back in Action

Level 4: Helping Me... To Live Well

Supporting individuals with complex needs on a one-to-one basis. Examples – 1-1 professional intervention from core therapy services and tailored individualised health treatments

Our therapy teams have been leading the way on co-production and have recently published their AHP strategic plan for coproduction. It is a comprehensive document that outlines the vision, goals, and achievements of the Allied Health Professions in promoting co-production to improve health outcomes and create an inclusive, equitable, and sustainable healthcare system.

Some of the successes so far include:

- Stepping Stones: A co-produced toolkit for people living with long-term health conditions, focusing on what matters to them and providing inclusive resources.
- Peer Support: Embedding lived experience within services and creating peer support practitioner roles.
- Waiting Well: Co-producing a charter to improve the experience of people on waiting lists, adopted by Welsh Government
- Live Well, Age Well: An integrated program to improve health within communities and reduce the risk of falls.

The plan outlines strategic goals to shape future practice and advance the evidence-base for co-production, leading to a change in practice and enabling sustainable health outcomes. Working with academic partners, therapy teams and co-production partners across Wales to spread and scale the impact of co-production.

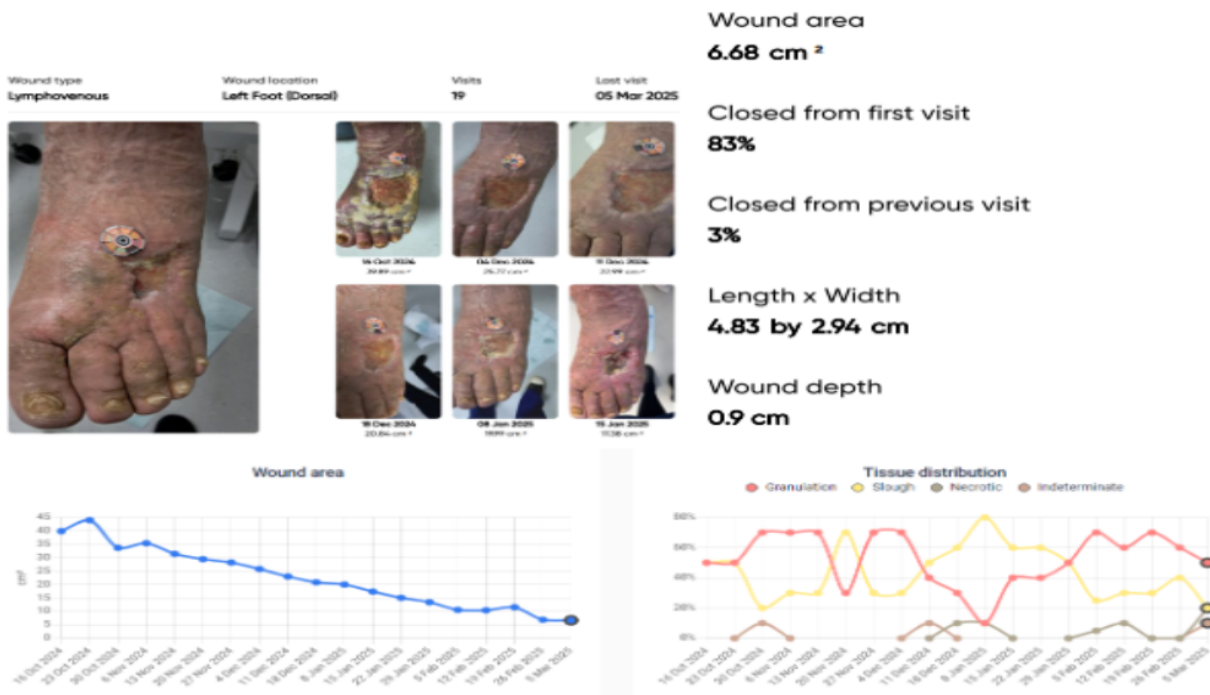
The podiatry service is currently undertaking their fourth Bevan Exemplar project with the Bevan Commission - 'A Podiatry Led Community Vascular Screening Pathway, Improving Peripheral Arterial Disease (PAD) Diagnosis and Treatment Planning within Cardiff and Vale UHB'. Through close working relationships between Cardiff and Vale UHB and the South-East Wales Vascular network, it has been identified that the Vascular Surgery department in the UHB receives a significant number of referrals that are not pertinent to urgent/routine secondary care vascular input. These patients currently have a wait of 58 weeks on the routine vascular waiting list. Without timely expert assessment and treatment planning there is potential for a higher rate of chronic complications in this patient cohort. As well as potential delays in urgent case review due to the waiting list demand. Podiatrists, as experts in lower limb assessment, are well placed to support early diagnosis and treatment of PAD. The project is examining the concept of re-direction of referrals triaged as 'routine' for lower limb PAD patients to the Podiatry team. The Podiatry service on acceptance of these referrals will provide vascular assessment and chairside vascular diagnostics. Early findings demonstrate that the wait for these appointments has reduced to 6-8 weeks. Further information will be shared on completion of the project in October 2025.

The success of the Diabetic Foot Emergency Early Triage (DFEET) clinic, a previous Bevan exemplar project, has been acknowledged this year in three awards. Finalist in the Diabetes Quality in Care awards 2024, Health Service Journal Award 2024 and winner in the Best Diabetic Foot Intervention at this year's

Journal of Wound Care Awards 2025 for our Diabetic Foot Emergency Early Triage (DFEET) clinic. Journal of Wound Care Awards 2025 - 2025 Winners This is a great accolade as there was tough competition from diabetes foot services from Italy and Singapore. The clearly tangible benefits to our patients, staff and our organisation have been recognised for spread and scale across the nation. The value and impact of this work has also been acknowledged in the Senedd in the recent motion on the vital work AHPs perform across Wales.

Quick change, a collaboratively produced interactive animation enhancing the promotion and encouragement of daily movement in children, including improving strength and balance. Developed by Podiatry and the local public health team, quick change has been launched in schools across Cardiff and the Vale of Glamorgan. A finalist in the NHS Wales Awards 2024, this work continues to extend its reach. With animations supporting pre-schoolers and early years, further work is being devised for a greater reach and to enable inclusion for those less physically able. The collaborations are also extending with new opportunities for the Podiatry Service to influence the education of the next generation of teachers within CMET. A recent visit by Dawn Bowden, MS and Minister for Children and Social Care provided an opportunity to discuss the importance of these initiatives to act for the future to support well-being and good health.

The ANCLE Café is an innovative partnership between Cardiff Metropolitan University and Cardiff and Vale UHB, delivering timely, holistic wound care in a welcoming, café-style setting. By combining clinical expertise with social connection, the Café improves healing rates, boosts patient wellbeing, and empowers district nurses and students through hands-on, multidisciplinary education. With support from the Lymphoedema OGEF programme, it promotes efficient, evidence-based care for chronic wounds and lymphoedema—reducing demand, enhancing skills, and delivering measurable outcomes. Significant improvement in healing rates, with 60% of patients healed and the remaining progressing positively on healing trajectories. 90% of patients who have attended the Café since September have had lymphoedema but only 53% of those patients were known to the lymphoedema service.



The therapy team have had success in value in health bids for 2 projects, Ambulatory feeding for Liver disease and Coeliac disease dietetic led service. Both proof of concept and will report back to QSPE when complete.

In the last year the podiatry team in collaboration with CEDAR has been running a Research for Patient Benefit (RfPB) funded feasibility study, HELPP, to develop personalised treatment pathways for relief of plantar heel pain using a sequential multiple assignment randomised trial (SMART) study design. It is hoped the outcome of this study will further support the development of efficient pathways within the UHB to improve patient reported outcomes and deliver value-based healthcare within the service. The results of the study should be available later in the year. Physiotherapy colleagues working with Psychology and

nursing have been awarded a British Heart Foundation research grant funded project for work in Cardiac Rehabilitation in Acquired Congenital Heart Defect (ACHD), we look forward to the outcomes.

Laboratory Medicine

All the laboratories within the directorate have maintained United Kingdom Accreditation Service (UKAS) accreditation to the 2022 standards. This is a great achievement. Accreditation by UKAS demonstrates the competence, impartiality and performance capability of the laboratories against national and international standards.

The mortuary refurbishment has been completed and UHW re-opened on the 12th May. The project started on the 20th of March and was anticipated to take 10 months. This led to our teams working differently and across sites for a prolonged period which came with some challenges but the care and dignity of those in their care was always a priority. The new facility is due to be inspected by the HTA in September.

The UHL facility will remain on the HTA licence and as such fulfills one of the recommendations as set out in phase 2 of the Fuller enquiry. The phase 2 report was published in July 2025 and the recommendations are being reviewed by our Mortuary Manager.

All of our laboratory teams are working hard on the implementation of the new laboratory information system (LIMS 2). There have been challenges with the implementation and delays to the roll out which has created additional work for our teams. The migration to the new system has changed and will now be by discipline rather than by health board with blood sciences due to migrate in October, leaving only a 2 month contingency before the current system is end of life. The national programme and DHCW are working through mitigations.

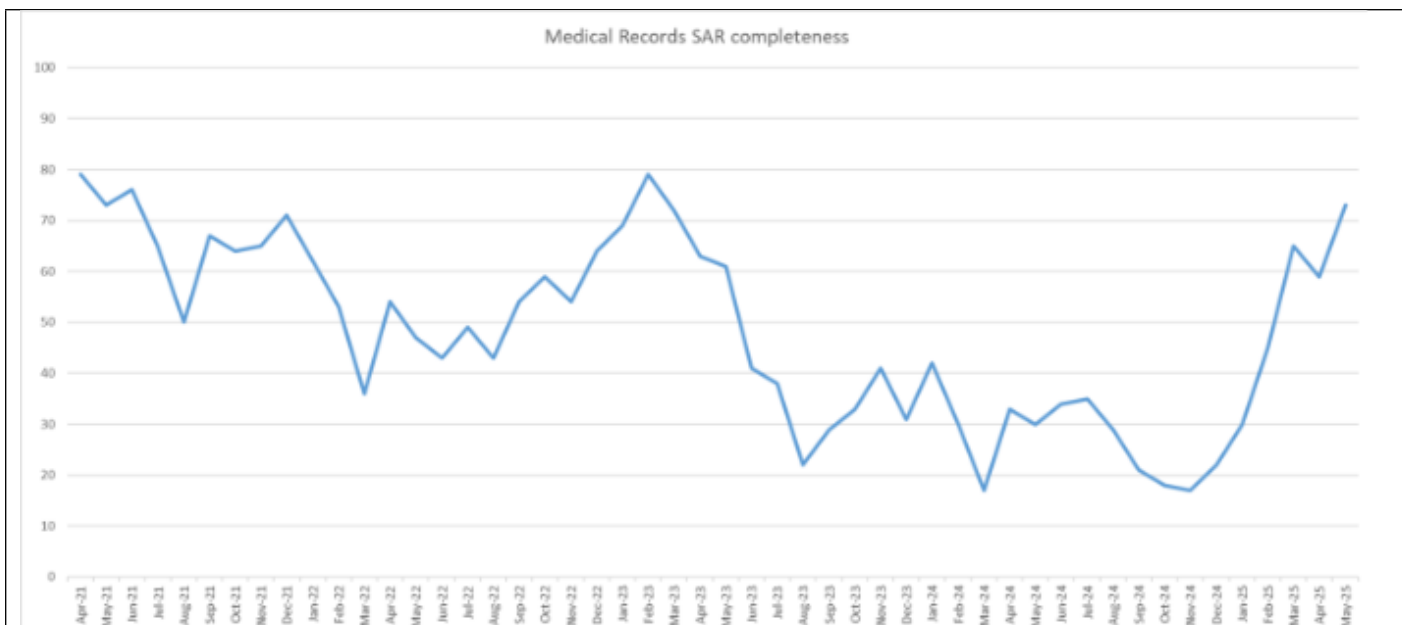
Cellular Pathology have been working with Improvement Cymru and Toyota to improve workflows through the laboratory. Historically, bottlenecks have been identified at Reception, Microtomy, and IHC, with an increased workload over the last 12 months. The team conducted a lead-time analysis and process studies, focusing on identifying bottlenecks, non-value-added tasks, and process capacities. Standardised work studies were carried out to identify the lowest repeatable cycle time, waste within the process, and abnormalities. Activities included the introduction of a float role to increase reception available time by 59% and the implementation of height-adjustable benches. The 5S methodology was applied to various areas, resulting in organised and efficient workspaces

Next Steps: include standardising the reception and booking-in process, training all staff, and developing a lab dashboard.

Health Records and Outpatient Nursing

After a very challenging period, principally due to operational constraints and increased demand, compliance with Subject Access Requests (SARs), has improved significantly. Whilst there is still much to be done to ensure all requests are completed within 30 days, the latest rate of 73% is the best achieved for over 2 years and close to the highest recorded figure of 79%. A review of case load management, coupled with a departmental reorganisation which bolstered the team's capacity, has seen an increasing trend, indicative of sustainable improvement. The anticipated implementation of a bespoke SAR system which will act as a digital front door, is expected to lead to further improvement. It should drive additional efficiencies and through much better data capture, will provide transparency of the delays in each step in the process and via the identification of common constraints to enable more precise mitigating actions to be taken.

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The Health Records Bereavements team have provided both practical support and operational insight in ensuring the effective implementation of statutory changes introduced in September 2024 related to the completion of Medical Certificates of Cause of Death (MCCDs). This has led to improvements in the time taken to complete several elements of the care after death process, helping to reduce the time taken for the bereaved to register their loved one's passing. The changes have proven a catalyst for how the team can collaborate more with other professionals and groups in the pathway, such as medical colleagues and the Medical Examiner Service. It has led to a series of changes which have been implemented or are planned. This includes inputting and updating information into a bespoke Care After Death database and with the close support and direction of the Patient Safety team, taking forward departmental and collective improvements, facilitated through weekly meetings.

In response to unprecedented staffing constraints, the department, through the support of Clinical Board Directors, embarked on further expansion of the Clinical Information Triage programme (CIT). Essentially this promotes the use of clinical information available electronically during acute outpatient consultations, rather than the provision of paper. Clinicians are encouraged to record outcomes in the UHB's designated system, or in bespoke systems if they are available. Where this is not taken up, the department offers a digitisation option (scanning). CIT therefore, acts as a key enabler in the organisation's Digital Strategy. Whilst the rapid expansion of CIT worked for the majority of unconverted specialties, for a limited number, CIT was unable to meet specific clinical requirements. The ensuing engagement process has helped identify the changes necessary to move these areas into CIT. These are being progressed, mainly through developments and the direct support of D H& I colleagues.

The department continues to try and offer opportunities to people from all backgrounds and experience. As an advocate of Project Search, the team have successfully supported several individuals, which has proven rewarding for them and the department. One, [Huw}, has gone on to take an apprenticeship position in the department; one of four apprenticeship positions that the team are currently supporting. Here is a link to Huw's story ["Huw has brought everyone closer" – Celebrating Learning Disability Week](#)

The Outpatient Nursing Team have continued with sessions linked to the Cultural & Leadership programme they embarked upon around 18 months ago with the support of colleagues in ECOD. Through this collaborative led approach, team briefings have been introduced. These have been facilitated through a consensus led change in shift times. This in itself has enabled more flexibility and improved work life balance. The Nursing team continue to try and introduce new ways of supporting services. Examples include expanding the number of nurse supported dermatology treatment sessions, along with practical input for undertaking certain diagnostic tests, such as spirometry.

Clinical Coding

Following on from the transfer of Clinical Coding to CD&T in September 2023, the coding completeness rate for 2023 /24 finished at 75.3%. Data for 24/25 has only recently been submitted and as such not verified, indications are that the completeness rate has risen considerably to 81%. This despite continued

significant recruitment and retention difficulties, along with a hike in the total episodes of care for the year; approaching 9000 or an increase of almost 6%. This would see the UHB move from the Health Board with the lowest coding completeness rate, to one of the middle performers.

Whilst this improvement represents a considerable achievement, there remains a sizeable gap to bridge before the national target of 95% is attained. The UHB is not alone in addressing these challenges, to the extent that a National Clinical Coding Improvement Initiative (CCII) has reviewed the options available. The recommendation proposed is 'partial coding'. This would see a compromise in the application of coding standards, with the trade-off being an increase in coding completeness through shorter times to code and without added financial burden. As with other Health Boards, whilst there is an acknowledgement of the argument that some coding is better than no coding, there is reluctance to adopt this option given the returns have not been tested and that it may significantly impact on the quality of coding and impair data comparisons between past and future data.

The preferred approach of the Clinical Coding department is to focus on improvement initiatives which can increase productivity without detriment to current and future staff and to coding standards. Some improvement plans build on initiatives already in traction, principally, the use of electronic information for coding sources. The team have added cataracts to the list of episodes of care they code digitally and are due to expand imminently in other areas using bespoke systems such as those in Mental Health and Obstetrics. Coding from Discharge Advice Letters (DALs) is also being explored. This digital approach has seen an increase in cases coded per hour in 24/25, particularly the latter part, and this is set to increase with the plans in place anticipated to achieve productivity rates equivalent to those suggested through enacting 'partial coding'. Amongst the other key benefits, is the ability to further increase home working roster which has already recently expanded. Through a planned 'scan to code' programme supported by Shaping Change, this is anticipated to expand further.

The creation of a new Head of Clinical Coding role and successful appointment into it in October 2024, has helped to deliver the benefits seen recently and develop the new initiatives. It has also seen the grow our own approach start to pay dividends with retention rates stabilising, the attraction of new trainee coders and the development of new and existing staff through the introduction of internal assessments. Close collaboration with DHCW's national training function will see this improve further, particularly with a new Clinical Coding Trainer role planned for the second half of the year. Along with the recent appointment of an Assistant Clinical Coding manager, much needed capacity and governance has been created to deliver the benefits seen, ensure they continue and provide confidence that those planned will be achieved.

Resource

At the end of the financial year the board reported an underspend of £549, 996 against the budget of £149,521,633. The underspend was largely driven by one off non-recurrent benefits. Work continues this year to meet our savings target and to go further through the QIEP plan. Quality impact assessments are used where appropriate to demonstrate that decisions are made through a quality lens.

Our current savings position is outlined below.

Clinical Board	Original Target	Going Further	Total Target	£m				Recurrent Green/Amber
				Green	Amber	Total	Red	
CD&T	3.76	3.00	6.76	2.30	0.71	3.01	0.90	1.51
		£m						
	Original Target Gap	0.75						
	Going Further Target Gap	3.75						

Executive Director Opinion & Key Issues to bring to the attention of the **Committee**

Appendices

n/a



Recommendations:

The Committee is requested to:

- a) Note the progress made by the clinical board to date

b) Note the content of the report and assurance given by Clinical Diagnostics and Therapeutics Clinical Board

Link to Strategic Objectives of Shaping our Future Wellbeing:

1.	 Putting People First	2.	 Providing Outstanding Quality
3.	 Delivering in the Right Places	4.	 Acting for the Future

Five Waves of Working (Sustainable Development Principles) considered:

Prevention	Long Term	Integration	Collaboration	Involvement

Quality Impact Assessment Completed?

Please place an "x" in the below boxes where relevant

Yes		No		n/a
-----	--	----	--	-----

Impact Assessment

Risk: n/a
Safety: n/a
Financial: n/a
Workforce: n/a
Legal: n/a
Reputational: n/a
Socio Economic: n/a
Equality & Health: n/a
Decarbonisation: n/a
Welsh Language: n/a

Approval/Scrutiny Route (please list all other Committees/Groups this report has been to)

Name of Committee/Group/Exec	Date:

Chilcott, Rachel
31/07/2025 14:01:08

Report Title:	Quality Indicators		Agenda Item no.	2.2
Meeting:	Quality Committee	Public	X	Meeting Date: 5/08/2025
		Private		
Status:	Assurance	X	Approval	Information
Lead Executive:	Executive Nurse Director			
Report Author:	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality			

Background and current situation:

The Quality Indicators Report offers assurance on key priorities related to quality, safety, and patient experience. It presents data up to the end of July 2025, where available, and outlines ongoing initiatives aimed at driving essential improvements. The report also includes exception reporting to identify emerging trends and concerns in quality and patient safety for the committee's review. As the indicators continue to develop, additional metrics will be introduced to evaluate the timeliness of care, as well as the equity and fairness in care delivery and health outcomes.

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

The report has primarily concentrated on the reporting of key performance metrics, while also incorporating the quality measures utilised to assess the efficacy and impact of those indicators.

In accordance with the Committee's request, the presentation has placed particular emphasis on the actions being implemented as a direct consequence of the analytical findings derived from the discussed indicators.

This emphasis has been directed towards ensuring alignment with regulatory and statutory obligations, with specific reference to:





- ✚ Health and Social Care (Quality and Engagement) (Wales) Act 2020 - Introduced Duty of Quality, Duty of Candour, and Citizen Voice Body
- ✚ NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011
- ✚ Care Standards Act 2000
- ✚ Coroners and Justice Act 2009 and Coroners (Inquest) Rules 2013
- ✚ All Wales Standards for Accessible Communication and Information for People with Sensory Loss
- ✚ WHC/2024/015: Welsh Health Circular People's Experience Framework
- ✚ National Framework for the Delivery of Bereavement Care in Wales (published in October 2021)
- ✚ Standards for Spiritual Care Services in the NHS in Wales (2010)

Recommendation:

The Committee is requested to:
 a) **NOTE** the assurance provided by the quality indicators

Link to Strategic Objectives of Shaping our Future Wellbeing:
<https://shapingourfuturewellbeing.com/>

Submitted by:
 Rachel
 31/07/2025 14:00

 Putting People First 1.	 Providing Outstanding Quality 2.
 Delivering in the Right Places 3.	 Acting for the Future 4.

Five Ways of Working (Sustainable Development Principles) considered

Pr ev e n t i o n		L o n g t e r m		Integration		Collaboration		Involvement	
--	--	--------------------------------------	--	-------------	--	---------------	--	-------------	--

Quality Impact Assessment Completed?

Yes	No – Not required for the paper but a requisite for the Quality indicators when identified and finalized
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Impact Assessment:

Risk: Yes

Several indicators have regulatory elements for compliance measurement

Safety: Yes

All indicators are monitored to identify learning and avoidance or mitigation of harm/ risk

Financial: Yes

Failure to meet regulatory and legal requirements can have a direct financial implication

Workforce: No

Legal: No

Reputational: No

Socio Economic: n/a

Equality and Health: n/a

Decarbonisation: n/a

Welsh Language: n/a

Approval/Scrutiny Route (please note anywhere else this paper has been before):

Committee/Group/
Exec

Date:

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GIG
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NHS
WALES

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



Quality Committee

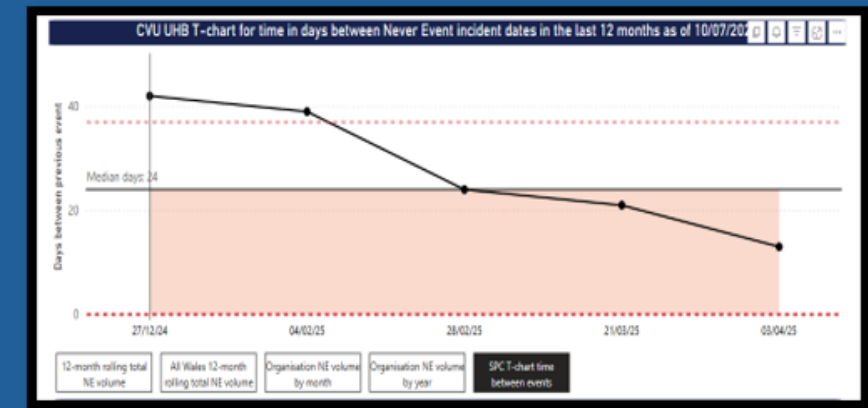
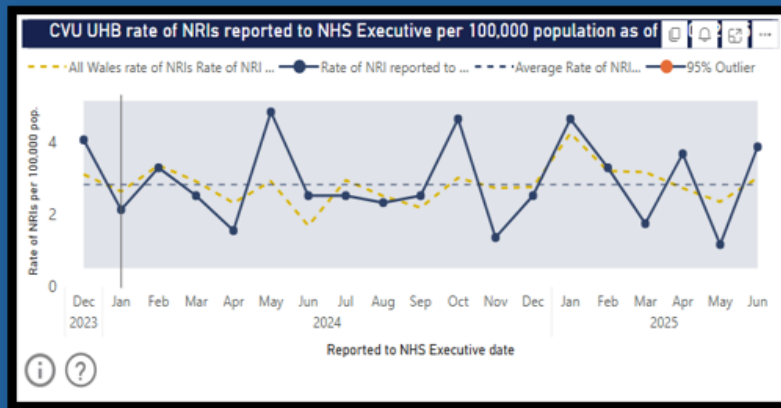
Quality Indicators and Performance Report

August 2025

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Safe Care

Patient Safety Incident Reporting



In response to patient safety learning reviews undertaken and completed in June and July 2025 a number of localised improvements have been delivered within specialist areas, these include an update of the health pathways in endoscopy to standardise investigations, flagging of critical time medications on the electronic Prescribing and Medication Administration (ePMA) system and development of a standardised protocol for the updating of patient demographics on the Patient Management System. These areas of work will continue to be monitored to completion.

Theatres Together

An improvement plan to deliver the recommendations made in the recent Theatres Review is progressing and has been shared at Board. Improvements have been divided in a number of traches with a detailed improvement plan developed around Trache one and two. Improvements include the standardisation of anaesthetic rooms, provision of children's recovery areas to be in line with the Royal College of Anaesthetists and improvements to the security of changing areas. Trache two includes a workforce and education and development review.

WHO Checklist Collaborative

A collaborative was formed in June 2025 to bring together clinicians from the perioperative directorate along with surgeons. The collaborative agree on six principles that supported the effective implementation of the WHO checklist in all settings. These included the explicit requirement for all members of the operating team to be present in the Team Brief, for anaesthetists and anaesthetic practitioners to complete the Sign In together and for no surgical instrument to be handed over until the Time Out had been completed. The collaborative is working to design a WHO checklist whiteboard that will support a team approach to these checks and will strengthen the reconciliation of prothesis. Audit of the WHO checklist is planned for August and September 2025.

Shaping our Future Quality Excellence

Shaping our Future Quality Excellence is an executive led programme to deliver UHB wide improvement projects addressing quality and patient safety priorities. Projects reporting into the project board include medicines safety, acute deterioration, infection prevention and control and lost to follow up. Updates on these projects have been provided throughout the quality indicators report.



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Safe Care

Patient Safety Incident Reporting



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Shaping our Future Quality Excellence – Lost to Follow Up

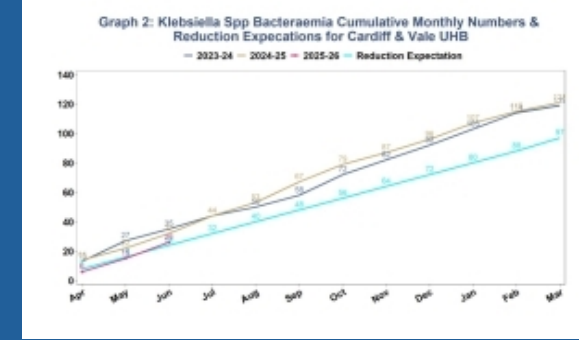
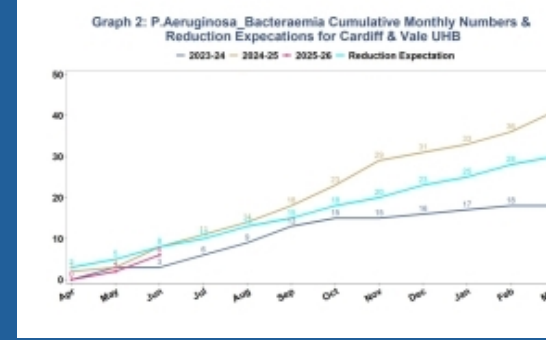
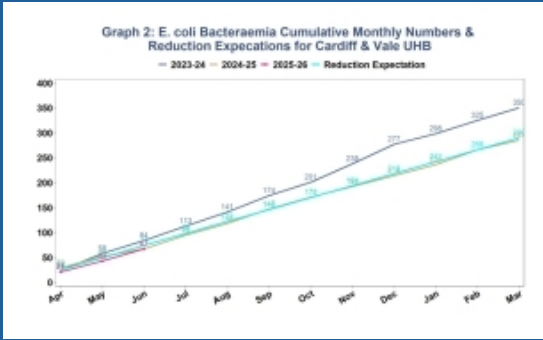
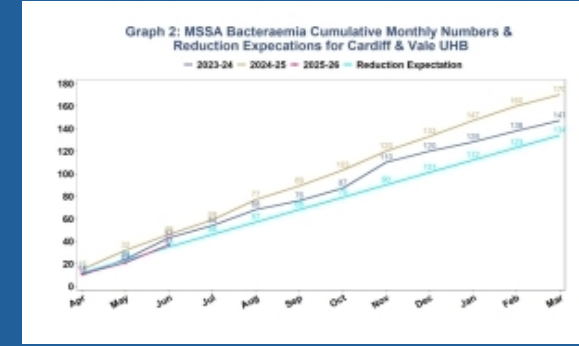
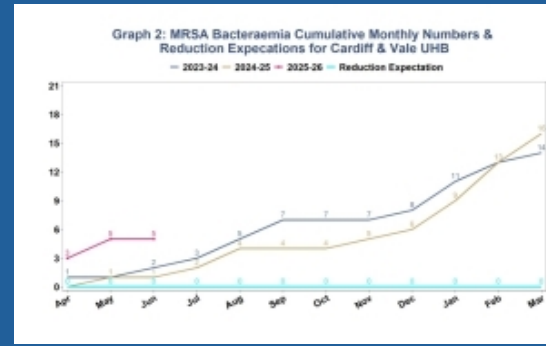
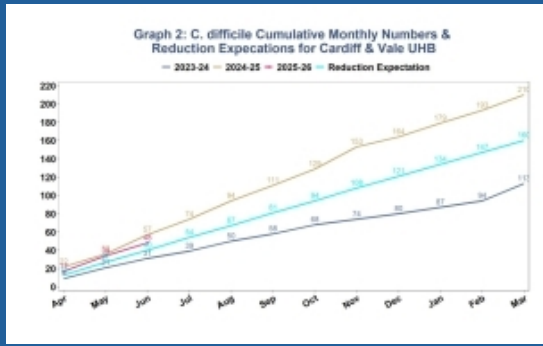
This workstream was developed in response to several patient safety incidents relating to disruption of patient clinical pathways, that resulted in delays in diagnosis or treatment.

Initial work has focused on ensuring all patients that attend outpatients have a clear outcome following that attendance, whether that be discharge, referral onto another service or follow up appointment. Governance links have been established with the Outpatients Implementation group and an exercise is underway to convert all existing patients with an undetermined outcome following an outpatient attendance to a See on Symptoms or Patient Initiated Follow Up pathway with communication being sent to relevant individuals.

An initial discussion was held with the NHS Performance and Improvement regarding digital improvement funding and a business case is in development. Subsequent work will focus on referral into the UHB followed by internal referral processes.

Safe Care

Infection Prevention and Control



Shaping our Future Quality Excellence HAI Dashboard Development

A Health Care associated Infection dashboard concept has been developed. Infection prevention and control (IP&C) data sources have been mapped and potential data sources identified, these include ICNET, Patient Management System, pharmacy, Patient Reported Outcome Measures, Datix and TheatreMan. The initial Healthcare associated infection measures have been scoped and include Methicillin Resistant Staphylococcus Aureus and Carbapenemase Producing Organisms, compliance with IP&C bundles and environmental data.

Plans for July / August 2025 include the delivery of a multi-disciplinary workshop to define the healthcare associated infection dashboard scope and measures and the development of the dashboard prototype will commence.

Gloves off and Brilliant Basics

The UHB has delivered a Gloves Off campaign designed to reduce the carbon emissions of the UHB but also to support effective hand hygiene. The Brilliant Basics campaign : Clean – Smart - Safe – Sure; the campaign reinforced the importance of the fundamental principles of hand hygiene, dress code standards, safe practice including Aseptic Non touch technique.



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Safe Care

Infection Prevention and Control



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Neonatal Unit MRSA outbreak

The UHB reported an outbreak of MRSA in the neonatal unit between 7 April 2024 and 10 March 2025. This outbreak has since closed with no new cases identified and all improvements complete or in progress. During this period, multiple neonates tested positive for MRSA despite negative admission screens. Genomic sequencing of 18 cases revealed that while most were independently acquired, 8 cases formed three transmission clusters (Cluster 1: 4 cases; Cluster 2: 2 cases; Cluster 3: 2 cases).

In response to the outbreak actions included, conducting of regular IPC audits conducted, the initiation of twice-daily cleaning as per outbreak protocol and weekly deep cleaning of bedspaces, including high dusting of pendant arms and Hydrogen Peroxide Vapour cleaning completed following decanting of Bluebell and Daisy areas. Assurance audits confirmed incubator cleaning compliance was in line with national guidance and breast pump cleaning procedure was developed. Storage capacity in the unit was increased and improved. Parents of MRSA-positive babies were notified and were screened and baby screening frequency increased from weekly to twice weekly.

OXA-48 Outbreak

The UHB reported an outbreak of OXA-48 Carbapenamase outbreak in the renal wards B5 and T5, impacting nine patients who were linked. The footprint of the renal wards was increased to ensure increased space between bed spaces and to provide additional bathroom and toilet facilities. Routine screening of all patient on admission for Carbapenemase Producing Organisms was implemented and continues as well as weekly screening for the duration of each patients' inpatient stay, and cleaning and decontamination guidance and practice were strengthened. This included the cleaning of bed frames and mattresses. The infection Prevention and Control team are working with Medstrom, medical bed company, to further strengthen the cleaning protocols and guidance in difficult to reach areas of the bed frame. No further cases have been reported since March 2025 and as a result the decision was made to close the outbreak and the closure report will be presented to the November meeting of the UHB Infection Prevention and Control Group.

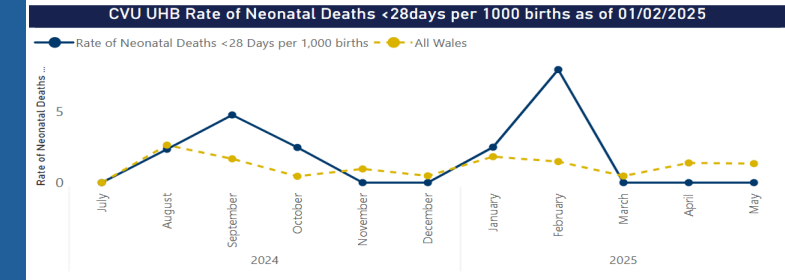
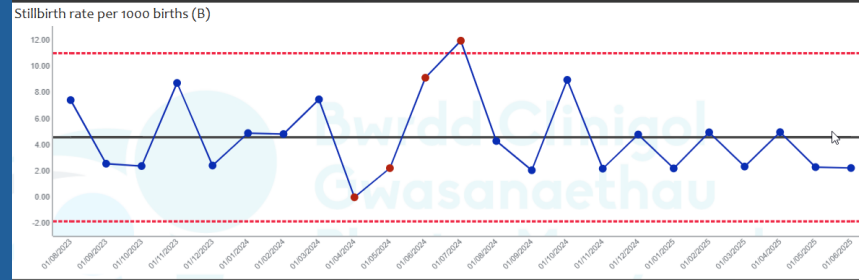
National Clostridium Difficile Collaborative

The Health Board is participating in the All Wales *C'diff* learning collaborative. The *C. diff* Learning Collaborative will support health board and trust teams across NHS Wales to identify and implement improvements that will reduce the prevalence of *C. diff*. The collaborative will provide improvement behaviour change support for teams and provide a space for collaboration and shared learning; and will ultimately aim to embed sustainable improvements that can be widely adopted at scale.

Alongside the collaborative the Health Board is also participating in a study organised by NHW Executive, the purpose of which is to understand NHS Wales staff perspectives on what is causing *Clostridioides difficile* (*C. diff.*) infections in NHS settings and identify opportunities for behaviour change interventions to reduce infections.

Safe Care

Perinatal Patient Safety (Perinatal Mortality- MBRRACE)



The UHB Still birth rate was 2.24 per 1000 births for May 2025 and a rate of 3.12 for 2025 as of 1 June 2025. This compares with a national rate of 3.8 Per 1000 births across England and Wales in 2024 as reported by the Office of National Statistics.

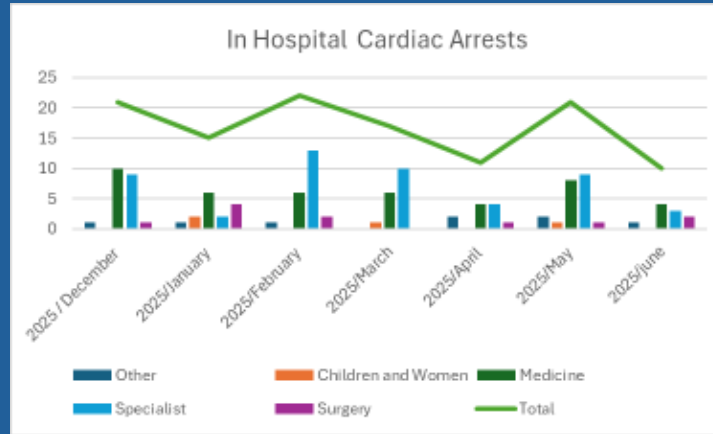
In 2023 the NHS Wales National Policy on Patient Safety Incident Reporting & Management was amended to require all the reporting of all maternal, perinatal and infant deaths regardless of whether there were any acts or omissions in care that might have contributed to the outcome. As a result, perinatal deaths have become the highest reported category of Nationally Reportable Incidents.

Between 1 April and 30 June 2025 there have been five stillbirths and late fetal losses and seven neonatal, and post-natal deaths reported. All cases will be subject to a multi professional review that will seek to identify any elements of care that might have contributed in part or in full to the outcome and take into account placental histology and post-mortem results. Three of the twelve reviews are complete, and none identify any elements of care that impacted the clinical outcome.

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Safe Care

Deteriorating Patient



Shaping our Future Quality Excellence Acute Deterioration

Welsh Government issued the Welsh Health Circular, Standardising the Management of Acute Deterioration in 2024, mandating the adoption of the National Early Warning Score 2 (NEWS 2) for the identification and escalation of acute deterioration of adults, Pediatric Early warning Score (PEWS) for children and young people and Newborn Early Warning Track and Trigger 2 (NEWTT2) for use in the post-natal setting. It was stated that the tools must be fully implemented by 30 September 2025.

NEWS 2.

The implantation date for NEWS2 is confirmed for 28 July. Clinical response plans, for News score over 7, have been finalised across all areas. Training material has been developed and being implemented. The P@RT team is delivery training, supported by practice nurse educators and posters, screen savers and comms messages have been distributed. Face to face training is being delivered along with virtual training hosted on ESR and as of 29 July 3808 people had completed the virtual training and 1700 the face to face training. A prototype of the NEWS2 chart has been drafted and is currently under review.

PEWS

The go-live is confirmed for 15th September and preparations are progressing to meet this timeline. ESR training is now live, and the clinical leads are liaising with the NHS Performance and Improvement around some elements of this resource. A prototype of the PEWS chart has been developed and is currently under review by clinical leads and relevant stakeholders to ensure accuracy and usability. Response protocols are in the process of being reviewed and refined to align with the new PEWS implementation.

MEWS

The maternity and neonatal digital system, BadgerNet will go-live on 29 July 2025. This initial rollout will not include the MEWS chart functionality. The MEWS chart is expected to be available by the end of September and so in the interim period, an alternative solution using paper-based MEWS charts will be implemented. These charts will be updated to reflect the latest MEWS criteria and ensure continuity of care and accurate clinical documentation.



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Safe Care

Deteriorating Patient



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NEWTTS

This system is now live. An audit tool will be implemented, and discussions are ongoing to conduct a lessons learned session to assess how staff are responding to the changes.

SEPSIS

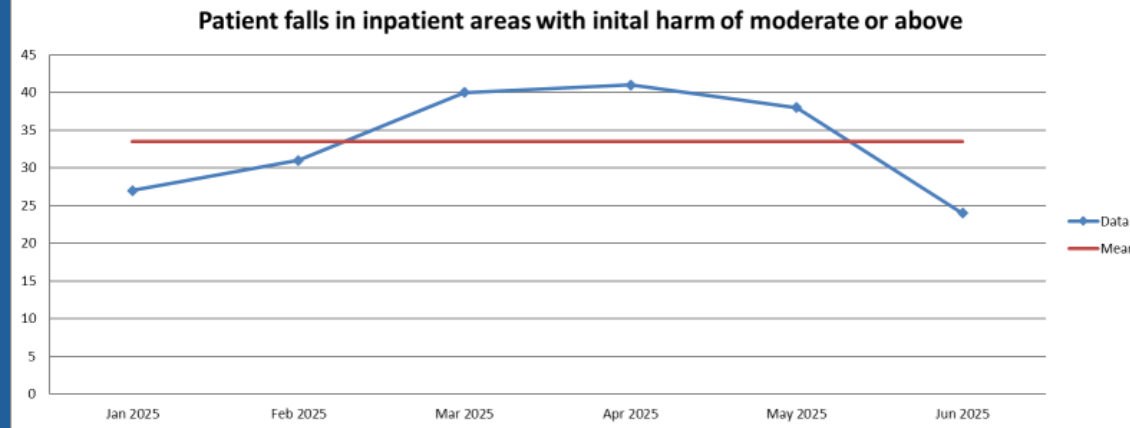
The Sepsis screening tool will go live on 28 July, alongside the implementation of NEWS2. The tool is based on the UK Sepsis Trust's adult screening tool for acute hospital settings and all Welsh Health Boards and Velindre NHS Trust will adopt this tool, with individual go-live dates, aiming for compliance with WHC/2024/035 by end of September. A sepsis learning event is tentatively planned for September, around World Sepsis Day (13 September) and safety netting advice developed by Aneurin Bevan UHB, in collaboration with the UK Sepsis Trust, is being shared across NHS Wales and will be localised for each Health Board.

Safe Care

Patient Falls



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Inpatient Falls training

An inpatient training programme to support staff in the risk assessment and mitigation of falls risk was developed in 2024 and piloted across the Medicine Clinical Board. It has been agreed that training will be rolled out across the organisation through a programme of train the trainer and the cascade training, with an aim to commence training the practice development nurses in October 2025.

During May, June and July 2025, more than 265 staff members have undertaken the falls prevention and management session. The session continues to be exceptionally well received, with an average staff rating of 4.76 out of 5. The falls prevention and management training is also incorporated into the UHB's nurse preceptorship programme.

An inpatient Multifactorial Risk Assessment (MFRA) quality audit was undertaken in June 2025. The audit demonstrated that while the individual risks were identified the documentation of mitigating actions to reduce the risk of individuals falling was poor. Areas that require further work included risks associated with medication, vision assessment and delirium screening. A method to objectively assess the quality of completed MFRAs is being considered to assist targeted support and education within the ward teams.

Community falls

A multi-agency falls workshop was held in June to map the falls response for four groups of patients in the community. Those that live independently without a telecare services, those that have a telecare response, individuals living in residential homes and those in nursing homes.

The varying falls response were mapped to identify constraints and gaps in provision. Four problem statements were identified:

- Public messaging on falls prevention, post-fall actions, and referral pathways is inconsistent and is not reaching all the intended population
- People who could benefit from Telecare are not signed up to the service
- Falls prevention and management practices across nursing, residential and domiciliary care settings are varied, with many residents being transferred to the Emergency Unit unnecessarily
- People are attending/conveyed to the Emergency Unit for minor treatments which could be provided safely at or near their home

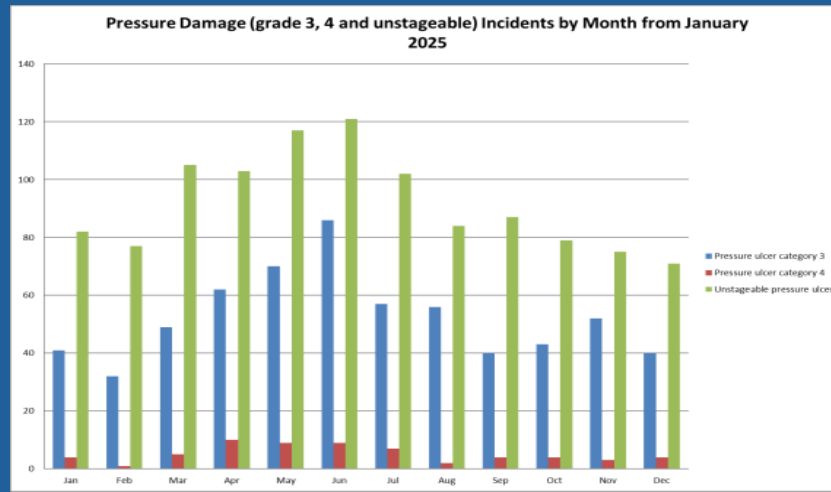
Business cases are being developed to extend the availability of non-medical fall response for patients in their homes and those in the nursing and residential homes.

Safe Care

Pressure Damage



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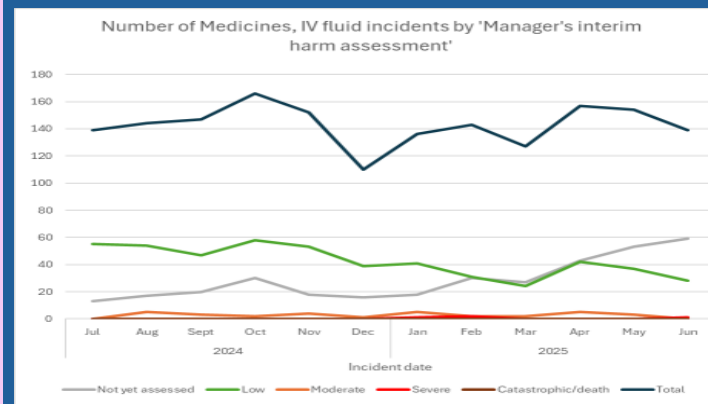


The UHB Pressure Damage Collaborative has not sat for an extended period of time, however there are plans to identify a new Chair and to reinstate the groups, which will focus on the outcome of pressure damage incidents to inform education, commissioning of equipment and quality assurance measures.

The first meeting of the collaborative will be held in September 2025.

Safe Care

Medication Safety



Medicines-related incidents reported via Datix Cymru between 1st July 2024 and 30th June 2025

Manager's interim harm assessment:

- **Catastrophic/Death:** 0 incidents
- **Severe:** 4 incidents (0.23% of Meds, IV fluid incidents)
- **Moderate:** 32 incidents (1.9% of Meds, IV fluid incidents)
- **Low:** 509 (30% of Meds, IV fluid incidents)
- **No harm:** 825 (48% of Meds, IV fluid incidents)
- **Not yet assessed:** 344 (20% of Meds, IV fluid incidents)

Note: Incidents where the Manager's interim harm assessment is 'none' are not shown on the graph (but are included in the total number of incidents)

Launch of Electronic Prescribing Medicines Administration (EPMA) system

EPMA is a key part of the digital medicines transformation portfolio which aims to make the prescribing, dispensing and administration of medicines in Wales easier, safer, more efficient and effective for patients and clinicians.

The roll out of ePMA in CAVUHB began in July, with the system going live on early adopter wards in Nephrology and Transplant (B5, A5 North and Cardiff Transplant Unit).

Over time further data will be available to monitor the safe use of medicines such as non-administration rates, closed loop administration and scanning of patient wrist bands to ensure administration to the correct patient. This data will be used to inform a quality improvement approach.

Shaping Our Future Quality Excellence (SoFQE) – Medicines Safety

Medicines safety has been adopted as one of the Project sitting within the SoFQE Programme. The project will focus on five areas associated with higher risk and where there is evidence of patient safety incidents and near misses across the UHB. These areas are:

Thromboprophylaxis - Incorrect assessment for, prescribing and administration of anticoagulants can lead to uncontrolled bleeding, thrombosis formation or death.

Opioid pain relief- Incorrect prescribing or administration can cause confusion, falls, difficulty breathing or death.

Insulin-Incorrect monitoring, prescribing or administration can cause blood sugar levels to be too high or low causing confusion, loss of consciousness or death

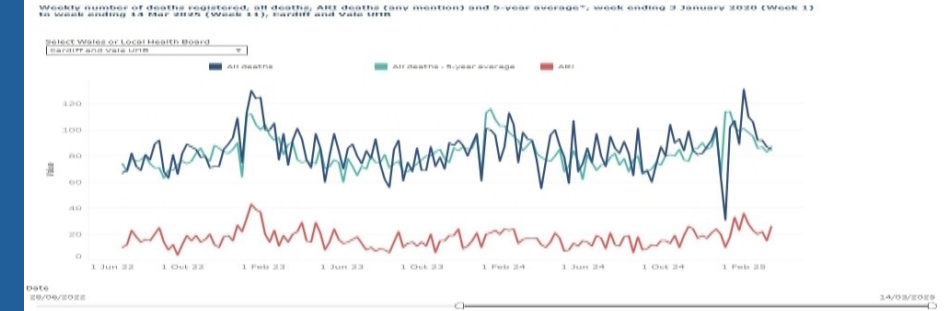
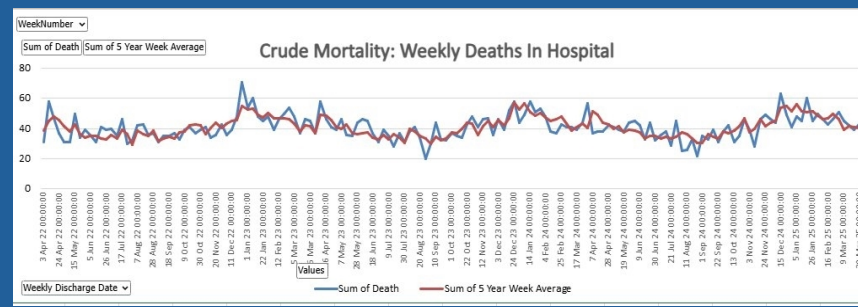
Unintentional Omitted or delayed doses -Which can cause harm as medication will not have required effect on controlling conditions which can lead to harm or death (depending on medication/condition)

Two person medication checks- Medication administration by the wrong route has occurred despite a two person check

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Effective Care

Mortality



The all-cause mortality rate across Cardiff and the Vale remains in line with the five-year average with a reduction in deaths from acute respiratory infections observed since February 2025.

Medical Examiner reviews have identified a recurring theme around the application of mental capacity. The MCA team have undertaken reviews of 59 cases over a 12 month period, contributed to four mortality and morbidity review, contributed to two adult practice reviews and lead on the development of a further review. Through their involvement they have revised the documentation and associated supporting for mental capacity assessments and have delivered associated training. The team also deliver half day training programmes of the practical application of the Mental Capacity Act and have developed two Seven Minute Briefing sessions that are being delivered to clinical teams and forums across the UHB.

The Palliative Care Team is undertaking an audit of end of life care provided to patients referred back to the UHB by the Medical Examiner. Audit outcomes include the recognition and assessment of symptoms and efficacy of symptom control. Furthermore nutrition and hydration support provided at the end of life is an emerging theme. A healthcare support worker appointed within into the palliative care team is providing support to ward staff around general care at the end of life.

The development of a standardised Mortality and Morbidity (M&M) tool hosted on the UHB governance system AMaT is complete and plans are being made to trial in endoscopy and Vascular surgery. The M&M module is included in the embedded power point presentation and will be used to strengthen governance around mortality and morbidity reviews and the associated learning:



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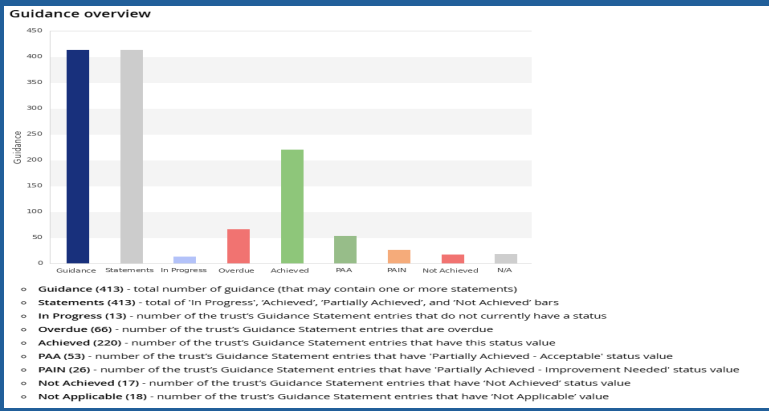
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Effective Care

Audit and Assurance



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July 2025 Clinical Effectiveness Committee Summary

Renal Registry Audit

Cardiff and Vale UHB remain within confidence intervals for key renal registry metrics with highest number of living donor transplants recorded in 10 years, with many of those patients receiving a transplant prior to starting dialysis. Registry data is 18–24 months out of date at the point of publication, however Vital Data is presented through Power BI dashboards to provide near real-time information to inform improvement work. This includes focus on the number of patient commencing renal replacement therapy without a transplant decision, demonstrating a significant improvement since 2023. The dashboard also allows monitoring of pre-emptive transplant rates. Provision of home therapies is below the 30% target, partly impacted by the high transplant rates. Increased bacteremia rate are associated with use of tunnel lines rather than fistulas, work is underway to increase fistula formation and is detailed under the heading quality statement. At present Cardiff and Vale bacteremia rates are not reported through vital data to support real time monitoring. A referral tracker is being used to monitor admission discharge and transfer between Health Boards this will support a focus on length of stay and delays in repatriation.

Quality Statement for Kidney Disease

There have been improvements in the provision of vascular access surgery with straight forward distal fistula procedures supported by two vascular practitioners and vascular access nurses. Local anesthetic waiting times have reduced to three weeks in UHW and between one and two weeks in UHL. Between 50-58% of patients receiving dialysis have a fistula with an aim of achieving 65-70%.

The Welsh Kidney Network is developing guidance for the management of Acute Kidney Injury, with a focus on the provision of care between medicine and nephrology. However, the delivery of dialysis to treat severe acute Kidney Injury falls is undertaken on ward B5 or Critical Care, reinforcing the importance of the work underway to support management of patient flow including repatriation and use of day beds.

Effective Care

Audit and Assurance



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ICNARC Audit

The UHB critical care standardised mortality ratio (SMR) is consistently below 1.0, and although the Cardiff and Vale crude mortality exceeds many peers the standardised mortality rate is at the lower end of the expected range as a result of higher-than-average acuity, with acuity of twice that of similar unit across the UK. Previous reports had highlighted issues relating to out-of-hours discharges, performance was impacted by inaccurate data recording but work to improve the accuracy of this data means that the department is no longer identified as an outlier around this indicator.

It was discussed that that submission has been suspended due to loss of 3 data clerks and as a result there is a risk of exclusion from 2025 national report, this risk is being addressed by currently using major trauma center data clerks temporarily to reduce the data validation backlog.

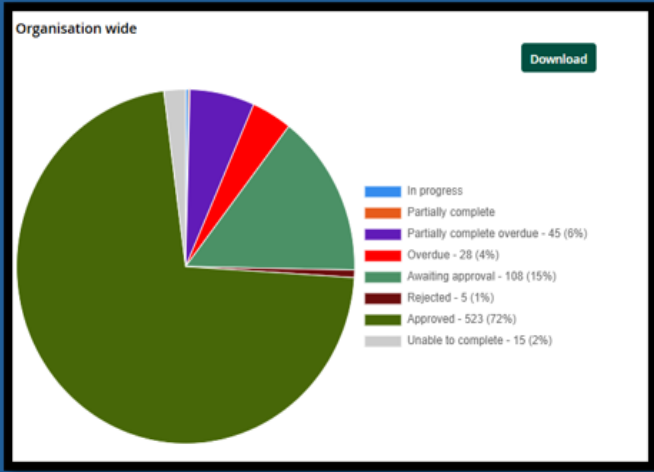
There is a manual data entry burden due to lack of digital ICU system and Incomplete data capture (e.g NEWS2 scores). Actions taken to address these challenges include urgent recruitment and training of data staff.

NICE and Health Technology Wales (HTW) Guidance

The graph on the previous slide demonstrates the uptake of NICE and HTW guidance across the UHB with the majority of statements implemented in full or to an acceptable level. A protocol is being developed to support the standardised scrutiny of statements that can not be implemented in full, that will include the development of a quality impact assessment and focus through the UHB planning process with governance oversight at the UHB Clinical effectiveness Committee.

Effective Care

External Assurance



Improvement plans associated with Health Care Inspectorate Wales Inspections and reviews are hosted on the UHB quality management System AMaT.

A planned mental health review was undertaken in the Hamadryad Community Mental health Service on 26 and 27 March 2025, and the report was published on 27 June 2025. The reported noted that the Hamadryad Community Mental Health Team supported a high number of service users who self-presented. The inspecting team observed positive and caring conversations between staff and service users. An improvement plan has been developed to address the recommendations resulting from the review and includes improvements in documentation provision of information about advocacy and recruitment and retention of staff. The full inspection report can be accessed at [20250627HamadryadCentreEN.pdf](#)

An unannounced inspection of Maple ward was undertaken on 14 15 and 16 April 2025. Throughout the inspection, the review team witnessed staff treating patients with respect and kindness and supporting them in a dignified manner. The ward's communal areas generally provided a suitable therapeutic environment, and each patient had their own bedroom with ensuite facilities, supporting their privacy and dignity. However, multiple unresolved maintenance issues, including a lack of privacy film on gym windows, compromised patient privacy and the overall quality of the patient experience. The UHB estates team are addressing the backlog of estates issues to ensure the necessary environmental improvements. Infection prevention and control review and checks are being reinforced to ensure the required standards are maintained and a structured professional judgement tool is being introduced to assess the risk of violence in patients with a programme of training for staff to support them in delivering these reviews. The full report can be read at [20250717HafanYCoedEN_0.pdf](#)

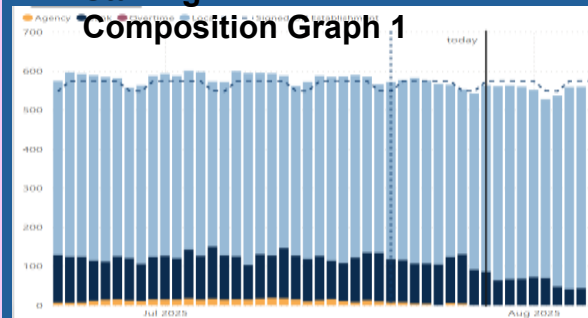
An unannounced inspection of Elizabeth Ward , St David's Hospital was undertaken on 30 April and 01 May 2025. The report will be published on 1 August 2025.



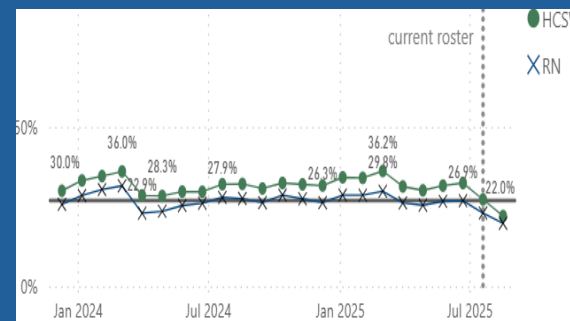
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Workforce

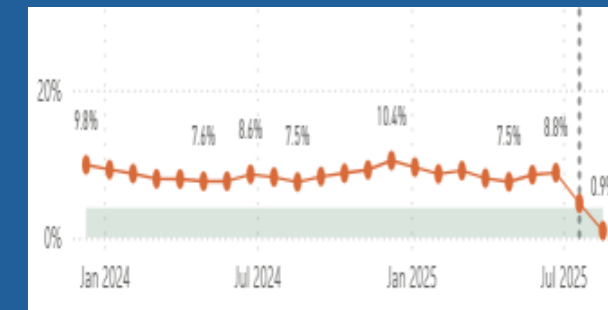
Staffing



Headroom trends Graph 2



Sickness Trends Graph 3



Nurse Staffing Levels

- **Staffing Composition Over 24 Hours – 25B Areas (Graph 1):**

This graph illustrates nurse staffing levels across a 24-hour period for acute adult and paediatric inpatient wards, specifically those designated as 25B areas under the Nurse Staffing Levels (Wales) Act. Substantive staff are shown in light blue, bank staff in dark blue, and agency staff in yellow. Over the past six months, there has been a clear reduction in agency usage, with plans in place to cease all agency staffing from 28th July, supported by tailored exit strategies for specific wards.

- **Headroom Trends (Graph 2):**

Average headroom across all areas stands at 28.6%, with the 25B wards slightly higher at 28.7%. Unavailability continues to be more pronounced within the Healthcare Support Worker (HCSW) group compared to registered nurses.

- **Sickness Rates (Graph 3):**

Sickness remains a concern across the nursing workforce. Last month, the overall sickness rate was 8.8%, with unregistered staff experiencing a higher rate of 11.3%, compared to 7.5% among registered nurses.

- **Shift Appropriateness – 25B Wards:**

Staffing levels are assessed for appropriateness on every shift. Over the past three months, 88% of shifts were deemed appropriately staffed—an improvement from 84% during the same period in 2024, indicating a positive trend in staffing adequacy.



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Patient Centred Care

Patient Experience

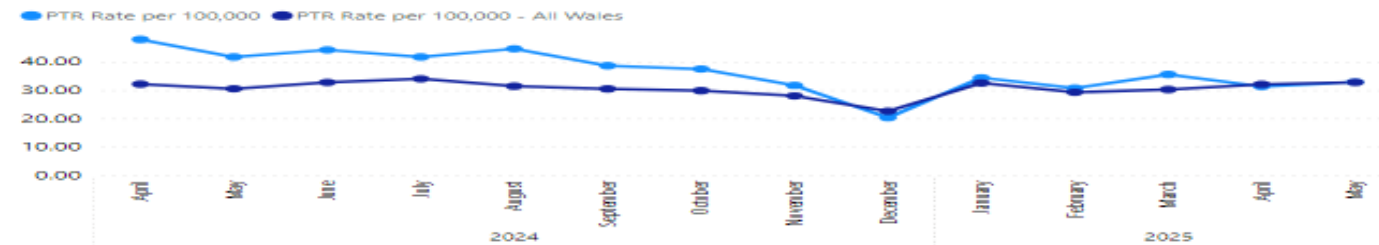


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Quality and Patient Experience

The graph presents a comparative analysis of the **Putting Things Right (PTR) concerns rate per 100,000 population** for **Cardiff and Vale University Health Board (CVU UHB)** against the **all-Wales average** over a 12-month period. **April 24 to May 2025**: The new year saw a resurgence in concern rates. Both CVU UHB and the Welsh average experienced an upward trend, with a notable spike in **January** where the rates nearly intersected in the **mid-30s**. This was followed by a slight decline and stabilisation from **March**.

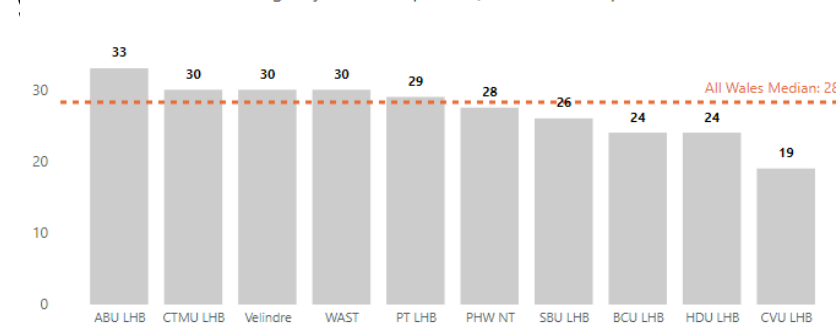
CVU UHB - PTR Concerns per 100,000 population



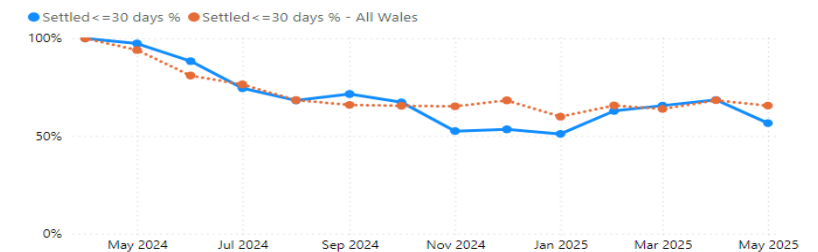
Performance

The graphs below shows the median response time to formal concerns across Wales and Cardiff and Vale UHB's current performance against Welsh Government's 75% target. A decline in response times is recognised across Wales due to the complexity of concerns and the raised awareness of AI tools in

All Wales - Median working days for a response (includes still open co...



CVU UHB - % PTR Concerns Settled in 30 Working Days - by Month o...



Patient Centred Care

Patient Experience



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Concerns Management: Monitoring and Responsive Action

We continue to monitor response times to concerns monthly to identify trends and areas for improvement.

Emerging Themes: Recurring themes are collated and shared with relevant teams to inform targeted actions. These include:

- Difficulties in booking or amending outpatient appointments
- Issues accessing the dental portal
- Extended waiting times
- Requests to expedite appointments or referrals

Action Taken: To address concerns more proactively, we have piloted a dedicated enquiries line aimed at resolving issues at the earliest opportunity. Currently, approximately 30 concerns are being processed daily through this channel.

We are actively engaging with the relevant departments to review their accessibility and to explore the implementation of multiple contact methods. This includes ensuring that all enquiries are acknowledged and actioned in a timely and effective manner.

Patient Centred Care

Patient Experience



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Deep dive into themes across MH Services –What people tell us

Key Themes in Patient Concerns

1 Access to Care & Service Coordination

- Appointments
- Transfers
- Referrals
- GP access



2 Discharge & Continuity Issues

- Discharge process
- Care planning
- Follow-up



3 Medication Access & Management

- Medication supply
- Prescriptions
- Contingency plan



4 Communication & Staff Conduct

- Information sharing
- Empathy



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Patient Reported Outcomes



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The graphs below show that during Q4 43 people contacted the Ombudsman for Wales . This represented 19% of the contacts from across Wales – During this time we had 2 partially upheld reports of the 12 across Wales . The Following themes were identified through the Ombudsman reports

Ombudsman Case Summary

Common Themes

- Clinical documentation issues
- Patient safety and risk management
- Communication failures
- Procedural non-compliance

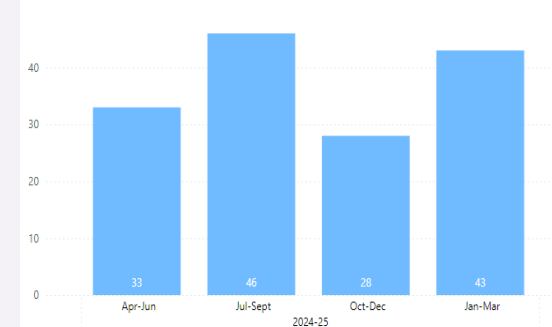
Learning Outcomes

- Reflective practice and team learning
- Emphasis on national standards
- Improved communication and coordination

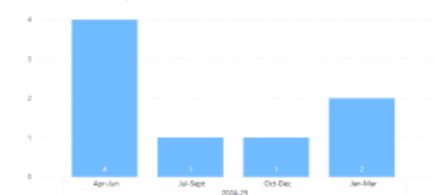
Focus Areas

- Documentation clarity
- Discharge planning
- Protocol adherence

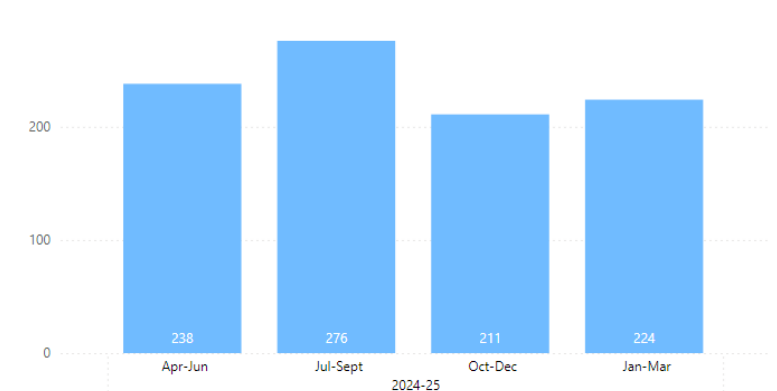
CVU UHB - PSOW - Referred to PSOW



CVU UHB - PSOW - Upheld



All Wales - PSOW - Referred to PSOW



Patient Centred Care

Patient Reported Outcomes



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Learning from Events Reports (LFERs) – Claims and Redress Cases

Reimbursement by the Welsh Risk Pool (WRP) is contingent upon formal approval of the associated learning. Payment will not be processed until the submitted learning has been reviewed and accepted.

Key Themes Identified Across Claims and Redress Cases



Failure to Recognise Clinical Deterioration

Delays or omission in identifying signs of patient decline



Failure to Escalate Concerns

Missed opportunities to escalate clinical issues to senior staff or appropriate services



Process and System Failures

Examples include patients lost to follow up and delays in results reporting



Inadequate Documentation

Particularly in relation to informed consent and clinical decision-making

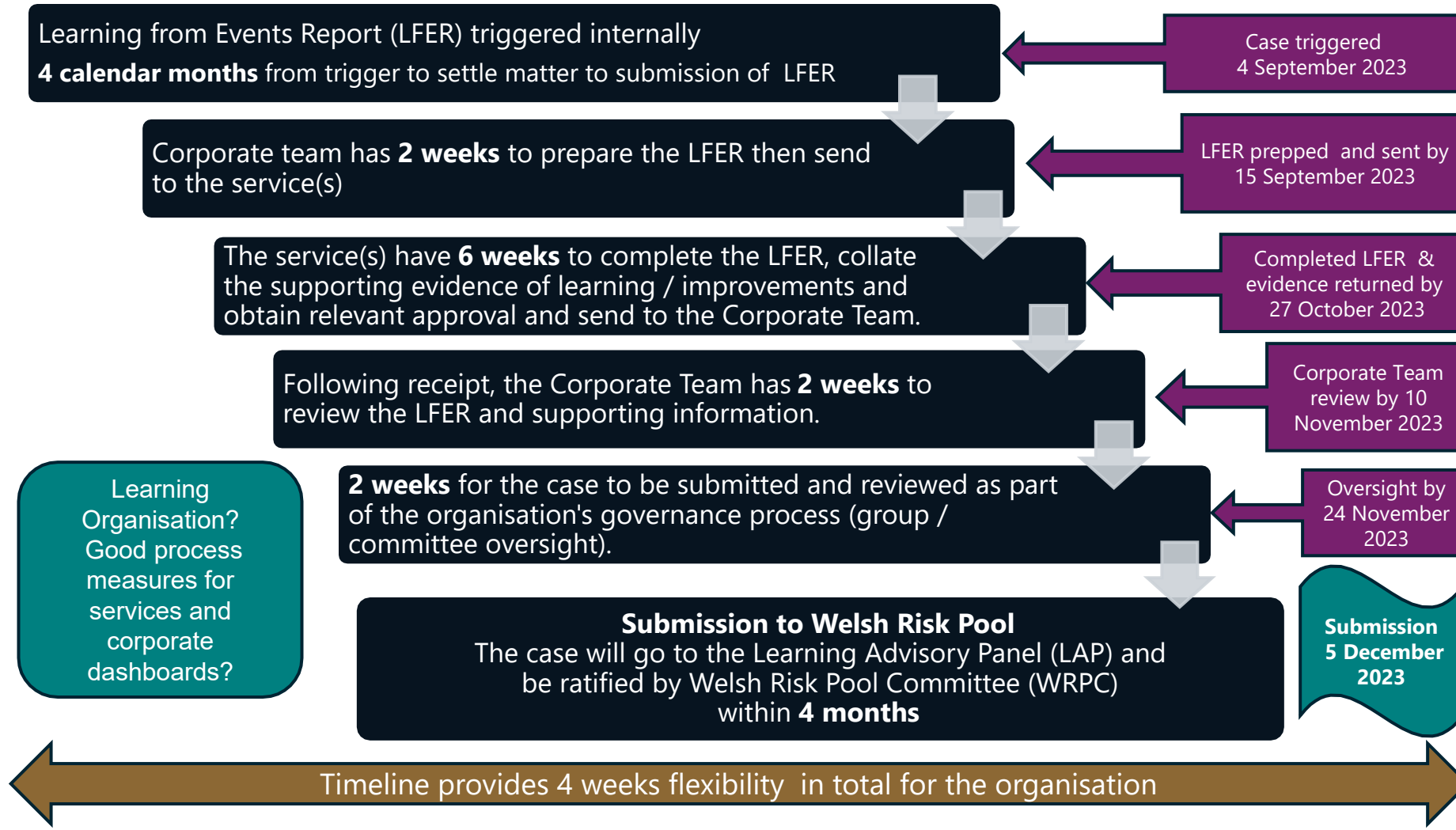


Use of EIDO Resources

Issues related to the application or understanding of EIDO patient information materials

Case WRP Ref: 12345, Health Body Ref: 111

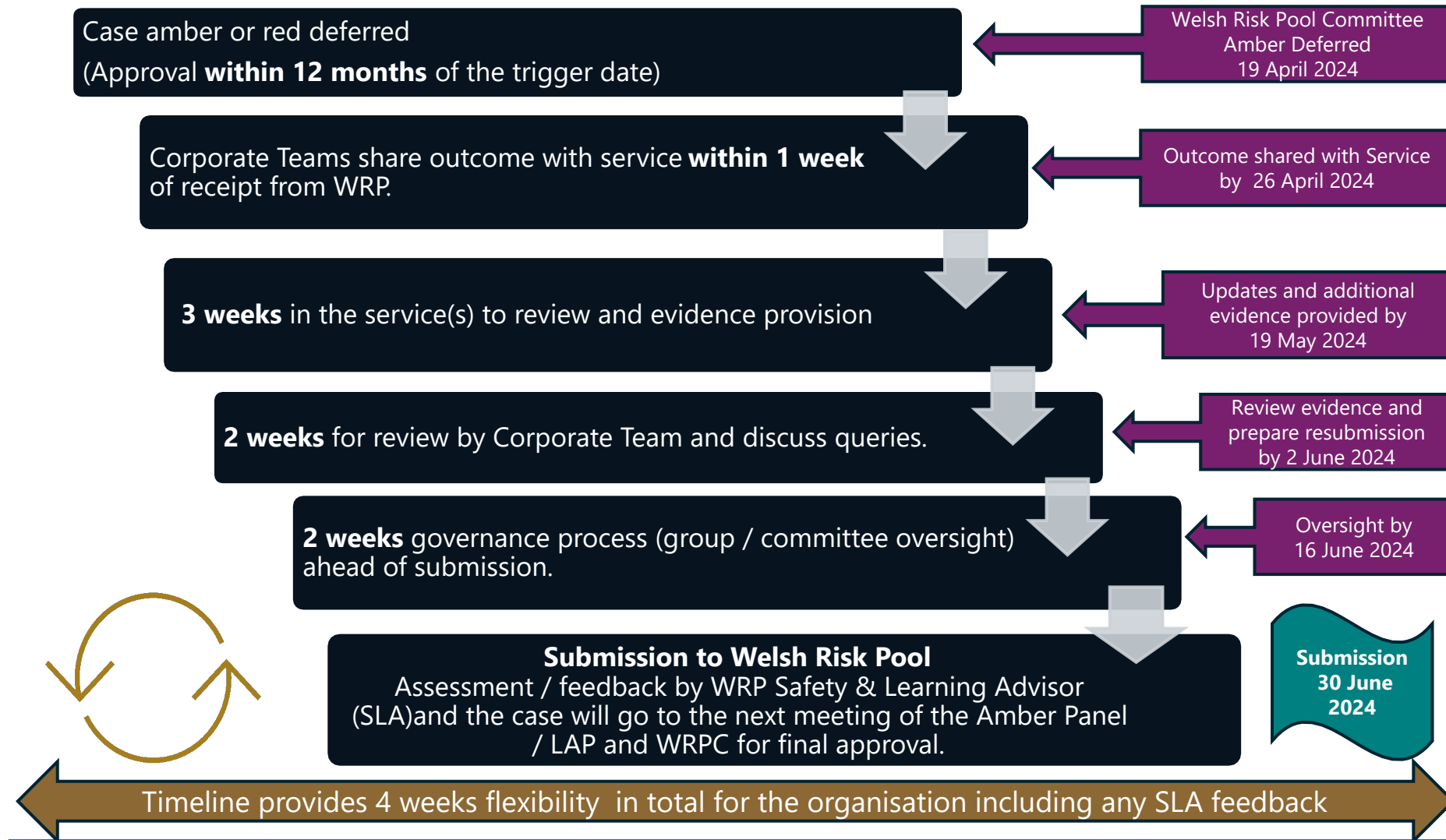
Reference: Welsh Risk Pool Case Reimbursement Procedures, version 3-1, September 2023



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Post-submission to Welsh Risk Pool

Reference: Welsh Risk Pool Case Reimbursement Procedures, version 3-1, September 2023



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Patient Reported Outcomes



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Weekly Peer review of LFER'S

Collate Themes to promote system wide learning

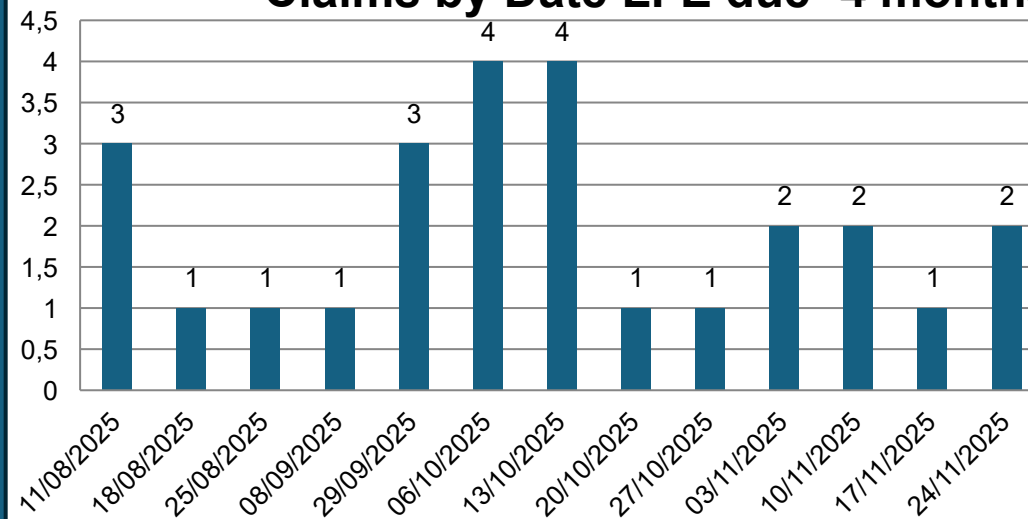
Work with the CB to complete and provide the evidence

Attend every National panel

Escalation process

Provide regular dashboards and updates

Claims by Date LFE due -4 months



	May-25	Jul-25	Sep-25
CVUHB			
APPROVE	54.9%	58.1%	
DEFER	11.8%	2.3%	
DEFER UNTIL INFO RECD	33.3%	39.5%	

Patient Centred Care

Patient Reported Outcomes



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LEARNING FROM OBSTETRIC EVENTS



Clinical Decision-Making

- Early, accurate diagnosis is critical (e.g, brow presentation, pre eclampsia)
- Escalate concerns promptly for obstetric review
- Stay alert to signs of hypoxia and maternal deterioration



Monitoring & Interpretation

- CTG interpretation and fetal monitoring are vital



Team Communication

- Clear handovers and multidisciplinary communication are essential



System Improvements

- Use structured tools (BSSO/Ts, OEWS) for triage and early warning
- Audits help track compliance and identify gaps
- Standardised PCR reporting improves consistency



Education & Training

- Reinstate MDT CTG teaching and PROMPT scenarios
- Simulation training builds emergency response skills



Learning & Accountability

- Ensure learning and action plans follow incidents

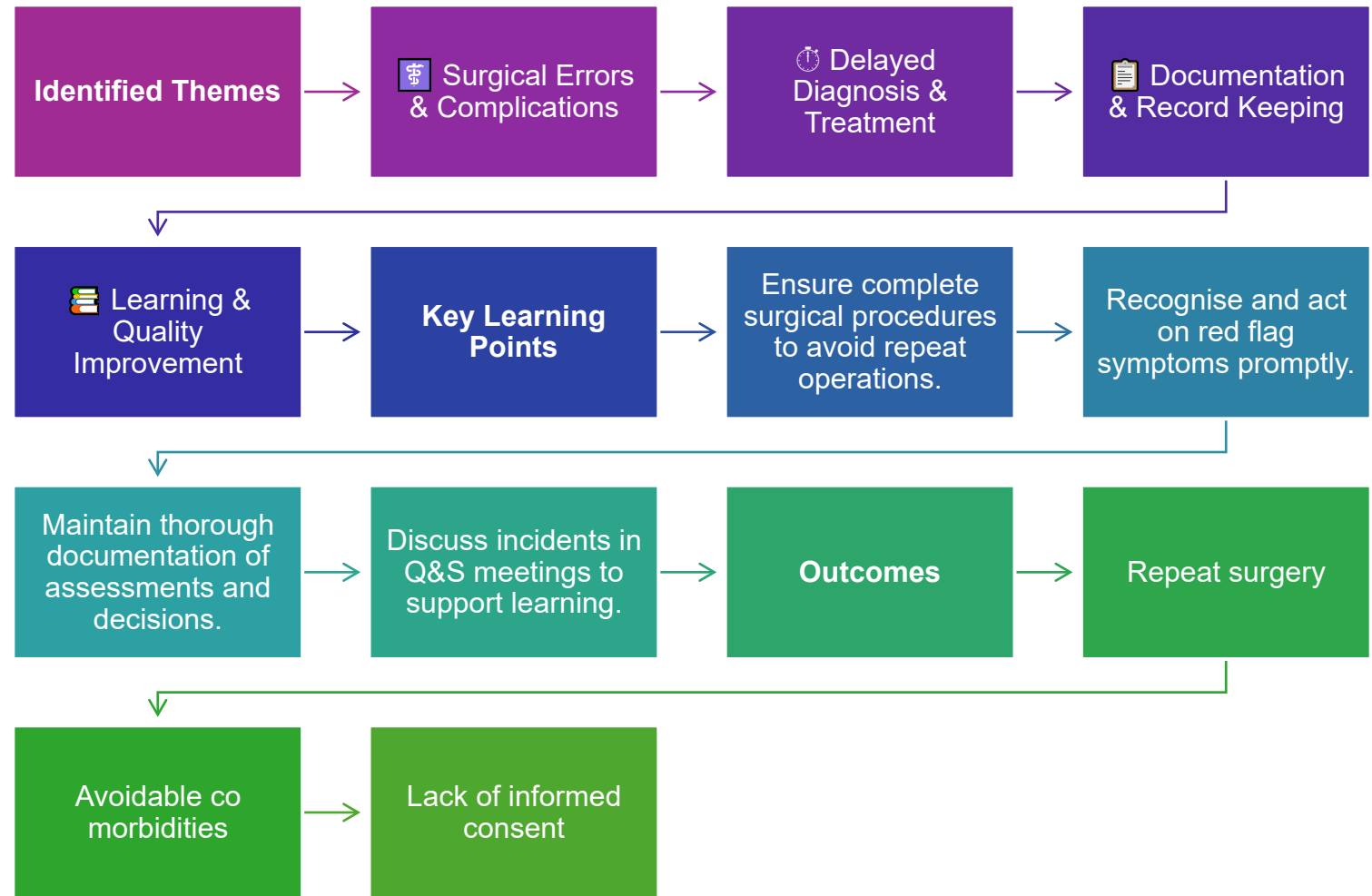
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Themes and learning identified through Surgical Concerns-Complaints and Claims



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Report	Themes Identified	Learning Outcomes
LFE NM	Issues with transcription errors, poor briefing discipline, incorrect site surgery, and inadequate marking protocols.	Reinforcement of Five Steps to Safer Surgery, process mapping to reduce transcription errors, and improved marking procedures.
LFE NC 2 1	Delays in biopsy reporting, lack of tracking via cancer pathways, and lab capacity issues.	Implementation of digital pathology, improved tracking systems, and escalation protocols for delayed results.
LFE M F	Retained surgical item due to equipment interference and swab design flaws.	Procurement of radio-opaque swabs, MHRA reporting, and interim policy updates for swab verification.

Patient Feedback

Satisfaction scores for core questions in the **Patient Questionnaire AW2**. (MH – National survey)

Sample: Based on feedback received from the SMS Random / MH cohorts between: 02/06/2024 – 02/05/2025

Clinical Board	Respondents (n)	Staff caring (%)	Feel safe (%)	Overall (%)
Children and Women's	1622	91	91	86
CD&T	5275	93	94	89
Medicine (excl EU cohort)	3911	94	94	89
Mental Health	1249	-	-	73
PCIC	-	-	-	-
Specialist Services	2724	96	95	93
Surgery	5012	94	94	90
All above CBs	19793	94	94	89

* Staff caring: *Were staff kind and caring?*

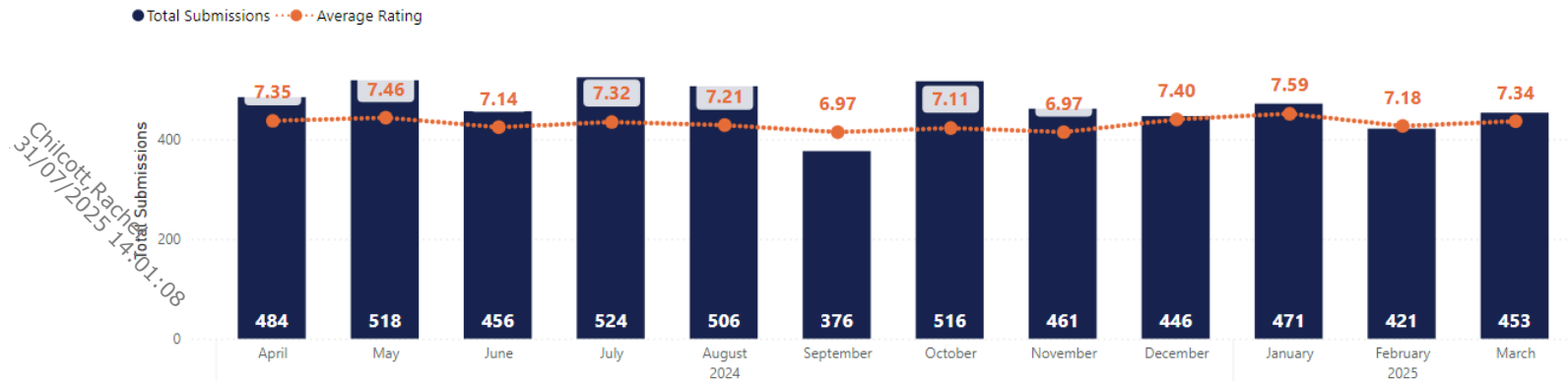
Feel safe: *Whilst in our care did you feel safe?*

Overall: *Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?*

Compliance against 85% Benchmark (for completed surveys only) between Apr-24 to Ju...

Organisation	Q1 rating	Q2 rating	Q3 rating	Q4 rating	Q5 rating	Q6 rating	Q7 rating	Q8 rating
ABU UHB	73.0%	43.2%	45.75%	71.6%	72.0%	72.7%	79.1%	73.6%
BCU UHB	81.2%	56.1%	53.63%	76.4%	75.9%	77.7%	82.5%	78.6%
CVU UHB	81.9%	46.8%	59.29%	79.9%	77.6%	81.3%	86.6%	81.4%
CTMU UHB	84.7%	45.4%	63.50%	80.0%	79.5%	83.9%	88.7%	84.5%
HDU UHB	85.0%	63.8%	58.31%	84.5%	82.5%	84.5%	88.4%	84.6%
SBU UHB	76.7%	65.1%	40.41%	67.8%	64.3%	74.6%	79.6%	73.9%
All Wales	82.7%	54.1%	58.33%	78.8%	77.6%	81.2%	86.1%	81.7%

Cardiff and Vale UHB Question 9: Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall experien...

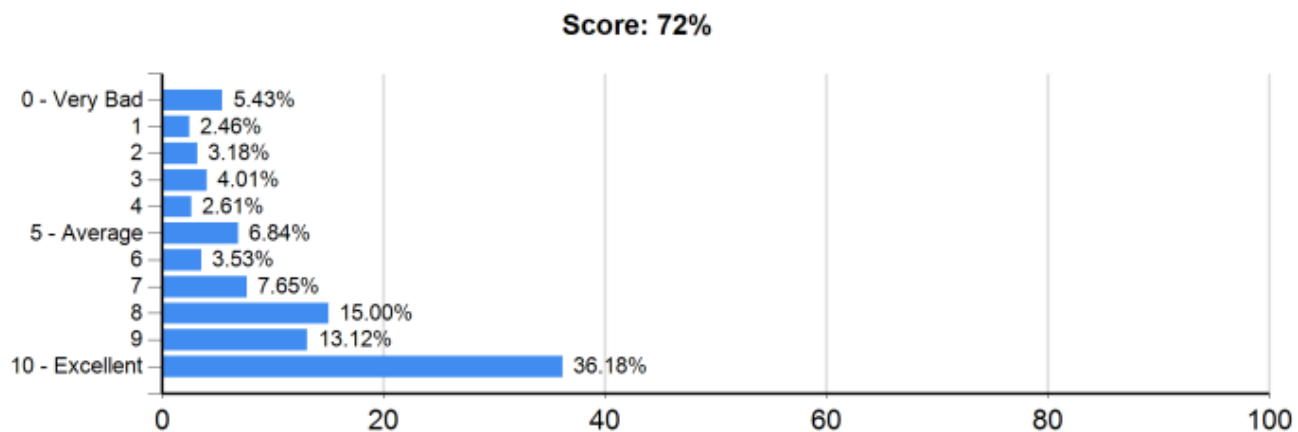


Patient Feedback

Satisfaction scores for core questions in the **Emergency Department survey**.

Sample: Based on feedback received from the SMS EU cohort between: 02/06/2024 – 02/05/2025

Cohort	Respondents (n)	Staff caring (%)	Feel safe (%)	Overall (%)
Emergency Department	5951	-	-	72



* Staff caring: *Were staff kind and caring?*

Feel safe: *Whilst in our care did you feel safe?*

Overall: *Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?*

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Patient Feedback

Satisfaction scores based on Ethnic sub-group from feedback received with the **Patient Questionnaire (AW2)**.

Sample: Based on feedback received from the SMS **Random cohort** between: 02/06/2024 – 02/05/2025

Ethnic sub-group	Respondents (n)	Overall (%)
White	14357	91
Mixed / multiple ethnic groups	260	84
Asian / Asian British	505	85
Black / African / Caribbean / Black British	271	87
Other ethnicity	154	79
I prefer not to say	370	72
All above sub-groups	15917	90

* Overall: Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?

Patient Centred Care

Patient Reported Outcomes



Enhancing Patient Experience - Autumn 2025 Initiatives

Feedback Collection & Engagement



Surveys



Robots



Multilingual Support



Community Engagement

Accessibility & Inclusion



BSL



Inclusive Design



Volunteers helping patients



Digital Accessibility

Volunteer Support



Volunteers helping patients



Dementia companions

Staff & Public Education



Training



DKAS survey



Public Awareness

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Patient Reported Outcomes



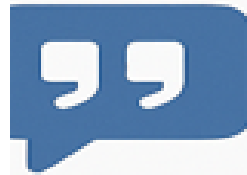
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123
digital stories
produced



Over 5,000
views on
YouTube



300+
staff requests and
a digital story
request form
developed for
'You said, we did'
feedback



Ongoing
integration
with Civica
platform



103 staff trained
in digital storytelling
(CVUHB, Velindre CC,
Cwm Taf UHB)



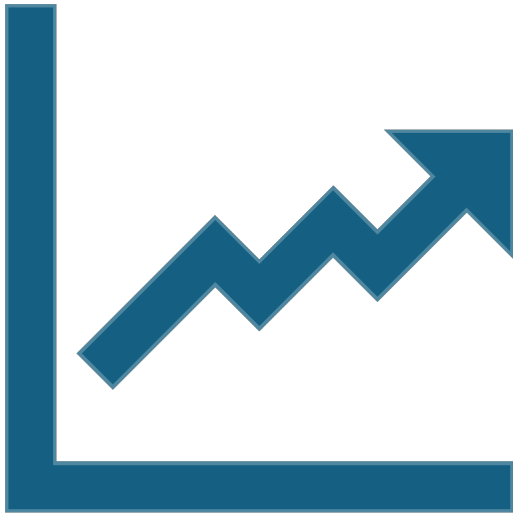
15 stories
reviewed
by Executive
Team and
Board

Top 3

Collaboration with CVUHB, Velindre CC, and Cwm Taf UHB

- Top 3 request areas: CD&T, Medicine, Specialist Services

Mental Health Clinical Board Thematic Improvement Plan Approach



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Royal College Main Findings

Quality of Risk Assessment and lack of coproduced approach safety planning

Care planning and formulation

Quality of therapeutic engagement

Continuity of Care – Referral management

Approaches to changing diagnosis and treatment approaches

Minimal contact with families

Serious Incident Review process

Defining the problem

There are in excess of 60 improvement plans across the MHCB

Within excess of 345 actions against recommendations

HIW improvement plans

Royal College of Psychiatry

Historical Improvements plans lost of time

Variety approach not identifying the themes

Identifying the smaller issues, rather than identifying and addressing the systemic issues

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Progress:

- Reviewed all improvement plans held on S drive and word and AMAT from 2022
- Mapped learning and recommendations into themes
- 5 Key themes identified
- Agreed approach with Clinical Board and discussed with Patient Safety Team
- Identified Project Lead and leads for workstreams Safety Planning and Family Engagement - 3 remaining

Key Improvement Themes:

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Safety and Risk Formulation	Care Planning	Service Provision	Safeguarding	Family Involvement
Risk of self-harm and suicide	Restrictive practice	Young persons in AMHS	Mental capacity	Patient and Family Involvement
Ultra-Lethal Compounds	Documentation	Eating Disorders	Violence/ Aggression	
Safety Planning	Risk assessment	Physical Environment		
Risk formulation	Discharge	Assertive Outreach		
	Medication Management	Commissioning Care		
	Physical Health	Neurodiversity		
	Patient Transfer	Gender		
	Referrals	EUPD Pathways		
	Care Co-ordination	Crisis Procedures		
	Trama Informed Care	CMHT Procedures		
	Assessment	Staffing		
	MDT approach	Communication Across Services		

Draft Overarching Improvement Plan

Engagement and Care Planning

Safety and Risk Formulation

Family Engagement and
Involvement

Service Provision

Safeguarding

Current Task:

Audit past improvement plans to ensure all included

Prioritise co-production approach to improvements

Identify actions that are completed or no longer relevant

Review any outstanding actions – remove expected practice, include latest updates

Review all actions to ensure they are **SMART**

Develop the Overarching plan and associated themes

Upload to AMAT

Continued greater support and scrutiny of approved recommendations in partnership with reviewer

Maintain SIRAN accreditation and share learning across Wales

Challenges:

Capacity to undertake work within the clinicians and those with lived experience

Backlog of improvement plans and impact on the Coroner process

Capacity of the Quality Team to support for reviewers

End Result:

Co-produced overarching improvement plan

Overall key improvement areas with inclusive themes

Movement away from individual plans

Improved focus and monitoring

Ensure that all actions are individual (not clustered) and adhere to SMART criteria

Evidencing impact of improvements

Continued evidence approach to review

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Next Steps

- All former improvement plans amalgamated into themed approach by February 2026
- Priority to be agreed with MHCB and Stakeholders
- Align approach with MHCB Programme Board and MHCB Strategy
- Project plan to be developed and finalised end of September
- Workstreams and stakeholders to be identified
- Identify Executive project sponsor for programme
- Agreement of approach with Shaping Change Team
- Share revised approach across the Clinical Board, local authority and with partners – Information sharing at Lived Experience and inviting participation at the Lived Experience Open Day September Shared Learning Event November
- Present at the AWSNAG- SIRAN Accreditation
- Present progress with themes at Public Facing Committee- Family Engagement work and lived experience story to be shared at next meeting

Current Panel
31/07/2025 14:01:08

Report Title:	Equity, Equality, Experience and Patient Safety Action Plan Update			Agenda Item no.	2.4
Meeting:	Quality Committee	Public	X	Meeting Date:	5/8/2025
		Private			
Status <i>(please tick one only):</i>	Assurance	X	Approval	Information	
Lead Executive Title:	Claire Beynon – Executive Director of Public Health				
Report Author (Title):	Eloise Hamon – Specialty Registrar in Public Health				

Main Report

Background and current situation:

Health inequities and inequalities are preventable, unfair and unjust differences in health between groups, populations or individuals.

The aim of this work is to deliver equitable and excellent preventative and clinical services in Cardiff and Vale University Health Board (UHB). As a provider of prevention, primary and community care, secondary and tertiary health services, we have a duty under the Equalities Act (2010) to look for and address inequalities in the access to, experience and outcomes from our services.

In 2023, a three-step process – the 3i Framework – was developed to help staff think through how their services could make a difference to reducing health inequalities. The framework together with a Support Pack was developed to assist staff with applying the framework in practice. The Health Board identified a number of initial actions that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. These 24 projects were described in the first action plan. The actions needed are organisation wide: Planned Care, Equitable Employee Experience, Unscheduled Care, Maternity Care, Prevention, Analytics, Primary Care, Representation, Mental Health and Patient Safety.

Current Situation

The Equity, Equality, Experience and Patient Safety action plan sets out the initial action areas, providing updates approximately six months on from their previous update, along with target completion dates. We will provide further updates in six months' time and hope to identify additional new actions in the next update.

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

We need to deliver equitable and excellent preventative and clinical services for the population of Cardiff and the Vale of Glamorgan.

This action plan provides six-month updates on progress across the Health Board on current projects of strategic importance to equity, equality, experience and patient safety.

Appendices:

- 1) Equity, Equality, Experience and Patient Safety Action Plan Slides
- 2) Equity, Equality, Experience and Patient Safety Action Plan (July 2025 Update)





Recommendation:

The Committee is requested to:

- a) Support the actions under way in the action plan to address health inequities in Cardiff and the Vale of Glamorgan.

- b) Acknowledge the six-month progress that has been made against the actions, including the challenges around health inequality data availability.
- c) Agree to receiving further updates in another six months.

Link to Strategic Objectives of Shaping our Future Wellbeing:

 Putting People First	X	 Providing Outstanding Quality	X
 Delivering in the Right Places	X	 Acting for the Future	X

Five Ways of Working (Sustainable Development Principles) considered

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X
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Impact Assessment:

Risk: Yes <i>Inaction in these action areas poses a risk of widening health inequalities in Cardiff and the Vale of Glamorgan.</i>
Safety: Yes <i>Patient safety actions within the action plan seek to reduce variation in patient safety and quality of reporting incidents.</i>
Financial: No
Workforce: Yes <i>Implementation of the actions in the action plan will improve the experience and health of employees in the Health Board.</i>
Legal: Yes <i>Achieving the actions in this report will facilitate the Health Board complying with the Socio-economic Duty Equality Act 2010.</i>
Reputational: Yes <i>Achieving the actions in this report will facilitate the Health Board complying with the Socio-economic Duty, Equality Act 2010, and the More Equal Wales aspect of the seven well-being goals set out in the Wellbeing of Future Generations (Wales) Act 2015.</i>
Socio Economic: Yes <i>Achieving the actions in this report will facilitate the Health Board complying with the Socio-economic Duty Equality Act 2010.</i>
Equality and Health: Yes <i>The majority of the actions in this action plan will address health inequalities.</i>
Decarbonisation: Yes <i>Reducing health inequalities in access to services will reduce demand for high value services in secondary care. Prevention is the best form of decarbonisation.</i>

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

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Quality
Committee
5 August 2025

Equity, Equality, Experience and Patient Safety **Action Plan**

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The 3I Framework

Beynon, Scott, Whiles, Hughes, Jones, and Roberts, 2023

Identify:

Acknowledge and understand the differential experience, access to health services, health inequity and inequality for local people and our employees

Output- summary of equity and excellence priorities

Intelligence for action:

Use community engagement and qualitative insights to understand lived experience and improve quantitative data collection on equity and use both sources to co-produce service improvements that deliver equity and excellence

Output- co-produced interventions based on data and evidence

Interventions tailored to need:

Integrate equity, equality experience and patient safety improvements into existing and new work programmes, staff development initiatives and policies

Output- interventions integrated into routine practice

Aim

To deliver equitable and excellent preventative and clinical services/ approaches.

The framework sets out actions each Clinical Board or Team could take on their journey to delivering equity and excellence as part of a quality approach

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Action Plan

Equity, Equality, Experience and Patient Safety

Equity, Equality, Experience and Patient Safety Action Plan

The 3I Framework

Beynon, Scott, Whiles, Hughes, Jones, and Roberts, 2023

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Next Steps

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Purpose:

The action plan sets out the initial action areas agreed in 2023, providing six month updates, along with target completion dates.



Snapshot

Equity, Equality, Experience and Patient Safety

Going well...	Difficulty with...
<p>Much progress has been made with respect to the new health inclusion model based on need- there is a nurse in place between 9am-5pm to provide EU/ward in-each. There is also a GP in place providing primary care in-reach to inclusion groups.</p> <p>The 'Amplifying Prevention' Board including the Public Health Team and Cardiff and Vale of Glamorgan Councils has aided progress in many areas including tackling obesity and working to decrease inequalities in immunisation.</p> <p>People and culture continue working on a number of initiatives to promote the UHB as an employer, aiming to build a workforce that genuinely reflects the rich diversity of the communities it serves.</p>	<p>Data availability</p> <p>Data linkage</p> <p>Data analysis</p> <p>Progress in some areas is limited/slowed by the current financial and resource climate.</p>

Next steps

The Committee is requested to:

- a) **Support the actions** under way in the action plan to address health inequities in Cardiff and the Vale of Glamorgan.
- b) **Acknowledge** the six-month progress that has been made against the actions, including the *challenges around health inequality data availability*.
- c) **Agree** to receiving further updates in another six months.

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Thank you for listening

Any questions or comments?



Equity, Equality, Experience and Patient Safety Action Plan (update July 2025)

The 3I Framework

Beynon, Scott, Whiles, Hughes, Jones, and Roberts, 2023

Identify:

Acknowledge and understand the differential experience, access to health services, health inequity and inequality for local people and our employees

Output – summary of equity and excellence priorities

Intelligence for action: Use community engagement and qualitative insights to understand lived experience and improve quantitative data collection on equity and use both sources to co-produce service improvements that deliver equity and excellence

Output – co-produced intervention based on data and evidence

Interventions tailored to need:

Integrate equity, equality experience and patient safety improvements into existing and new work programmes, staff development initiatives and policies

Output – interventions integrated into routine practice

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Introduction

People often think that tackling inequities is someone else's business, or think that it is too difficult or that they are doing all they can already.

In 2023 an [Equity, Equality, Experience and Patient Safety Framework support pack](#) was produced and released, to support individuals and teams to make a positive difference. The support pack was developed by our staff, for our staff to help tackle issues around equity, equality, experience and patient safety in Cardiff and Vale Health Board.

The aim: To deliver equitable and excellent preventative and clinical services/approaches.

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The objectives:

- To reduce variation in health outcomes
- To reduce variation in access to services
- To reduce variation in quality of services
- To have a workforce that is representative of the population, who have an equitable experience of work, career development and personal growth at CAVUHB

Cardiff and Vale University Health Board take seriously our responsibility to our patients, staff, volunteers, and community with regard to equity, equality, experience and patient safety.



Our main responsibilities as a Health Board are two-fold:

- Firstly, we are here to help people live well - from having a healthy start in life through to maintaining health in later years.
- Secondly, we are here to provide excellent care and treatment for people who need healthcare services to keep well or recover to get well.

As a provider of prevention, primary and community care, secondary and tertiary health care services, we can look for and address inequalities in the access to, experience of and outcomes from our services.

Ensuring we collect the data we need to be able to find and address inequalities is fundamental and will be supported by our digital transformation over the coming years.

We can also be a listening organisation and take the time to understand what services our communities need and co-design those services with our communities so that they are fit for purpose and drive a reduction in health inequalities. We can look after and promote the health and wellbeing of our staff in the same way that we look after our patients.

A three-step process – **The 3I Framework** – was developed to help staff think through how their services could make a difference (see Figure 1 to the right).

The Health Board identified a number of projects that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. This list is not exclusive, but guides the organisation to deliver on strategically important work. If local teams wish to make service improvements this should be supported.

This action plan sets out these initial areas of focus for Cardiff and the Vale University Health Board, providing updates six months on from the previous update.

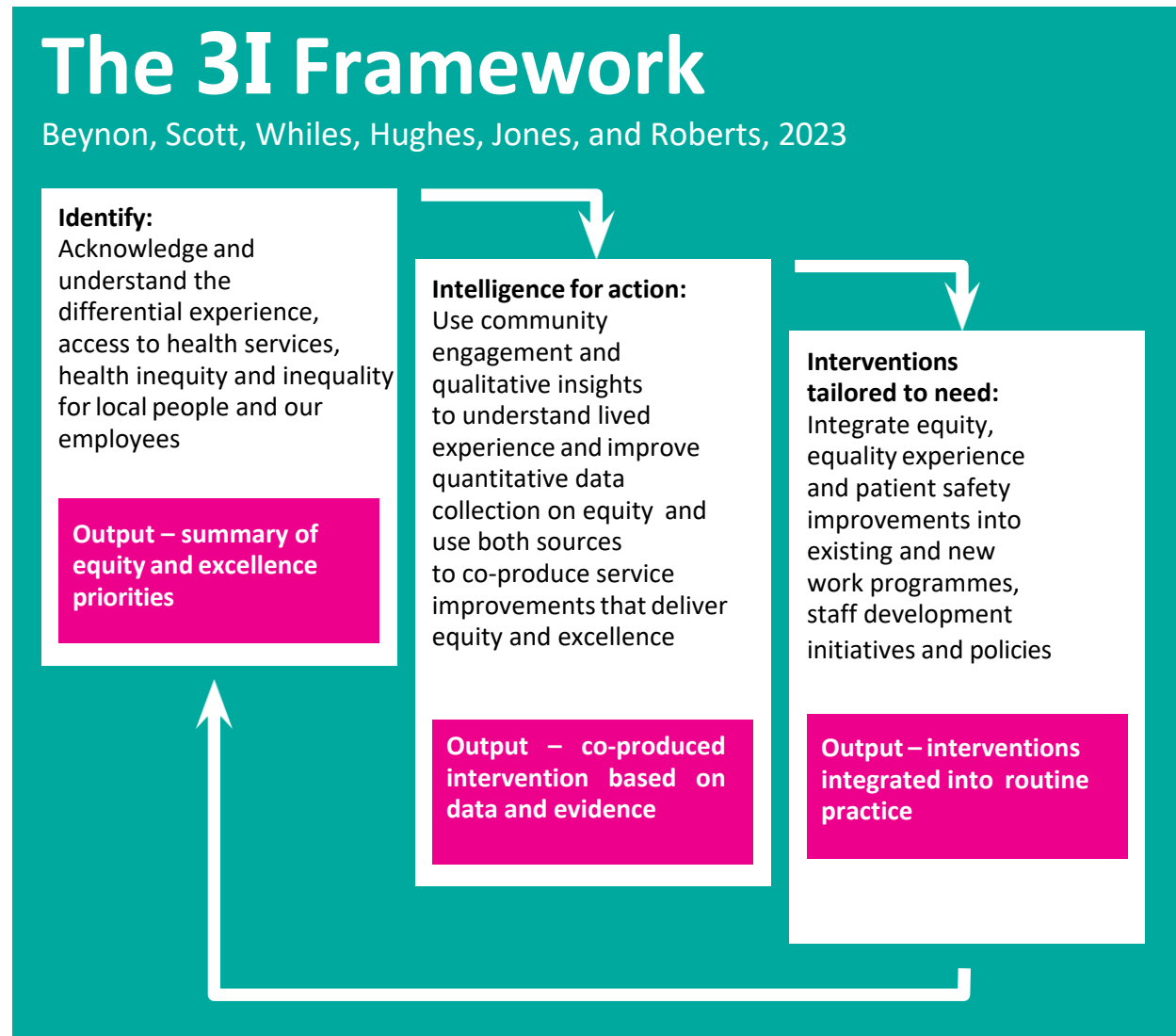


Figure 1: Three I Framework: a three-step tool to support teams in making positive changes to equity, equality, experience and patient safety in Cardiff and Vale University Health Board

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Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Planned Care	Adam Wright <i>Head of Service Planning (Operations)</i>	Examining waiting lists by postcode (Welsh Index of Multiple Deprivation – WIMD) to aid prioritisation	As per previous update- we have now received an updated analysis of our inpatient and outpatient waiting lists by Welsh Index of Multiple Deprivation (WIMD) decile. Our next step was to review the analysis undertaken within our Strategic Planned Care Programme Board to consider how it can shape our approach moving forwards. Original target date for this was Sep 2024, however unfortunately we have been unable to progress this. We set the target completion date for a further 9 months time but have still not been able to progress this. Achieving this action is likely to require an investment of additional support.	August 2025- unlikely to achieve this without additional support.	
	Steven Thomson <i>PROMS Programme Manager (Digital Health and Intelligence)</i>	Analysis of PROMs by protected characteristics	<p>Most protected characteristics are not routinely collected as part of the PROMs collection or in the Health Boards patient administration systems. PROMs are mostly very prescriptive and cannot be modified and therefore there is no opportunity to collect these. PROMs data is also not currently stored in the Cardiff and Vale warehouse with the other Cardiff and Vale data, and so cannot be linked to the PROMs data at present. To overcome this, we will be doing the following:</p> <ul style="list-style-type: none"> • Integration between Promptly and the health board has been completed and does allow data to be sent but not returned. This is the next stage and we anticipate this will be completed by the Autumn. • Work is underway to store PROMs data in the Cardiff and Vale warehouse. Target date is for current services (Dec 2025), with ongoing work as more services come online. <p>We have raised equity on a number of occasions as we are aware that some patients are digitally excluded. This new system we are using does help with this in some respects as it allows transcription from paper or over the telephone, they can be collected on a ward or waiting room via an ipad (or similar) and could be completed by a friend or relative.</p>	<p>Integration between Promptly and the health board to allow data to be returned as well as sent- autumn 2025</p> <p>Store PROMs data in the CAV Warehouse- December 2025</p>	

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Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Planned Care	Emma Cooke <i>Deputy Director of Therapies and Health Sciences</i>	Supporting Patients Whilst Waiting work	In August 2023, Welsh Government published the 3Ps Policy (Promote, Prevent, Prepare). This policy explicitly requests that all Health Boards establish a single point of contact for patients waiting for treatment. This is modelled on an established service in Hywel Dda that was set up during the pandemic. CAV UHB's single point of contact service (named locally as the Waiting Well Support Service) has been live and staffed with the majority of the funded team since January 2025. A dietician is joining the team later this month. Since January, patients on three specific pathways have been supported by the team (hernias, gallbladders and hips). Patients on two further pathways (benign gynae and knees) are soon to be onboarded.	Summer 2025	
Equitable Employee Experience	Claire Whiles <i>Assistant Director (Organisational Development, Wellbeing and Culture)</i>	Embedding and enaction of the Anti-Racist Action Plan (e.g. policy review)	The WRES Task and Finish Group has been established with organisational agreement to focus on progression and representation. A thorough analysis of data is underway to identify recruitment and progression barriers for our ethnically diverse colleagues. Meetings continue to take place with the Welsh Government. The anti-racism eLearning module has been launched on ESR, and discussions are ongoing about making this mandatory as per instruction from the Welsh Government. Additionally, anti-racism is now included as part of the Equity and Inclusion session in the First Steps to Leadership and Management programme.	Quarter 4 2025/26	
	Claire Whiles <i>Assistant Director (Organisational Development, Wellbeing and Culture)</i>	Establishing and growing Employee Resource Groups (Networks)	A proposal for relaunching staff networks has been drafted, which looks at the resource and time afforded to staff networks in addition to the governance framework around them. This proposal aims to enhance employee engagement and support across the organisation.	Quarter 4 2024/25	

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Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Equitable Employee Experience	Claire Whiles <i>Assistant Director (Organisational Development, Wellbeing and Culture)</i>	Benchmarking and progress monitoring e.g. Employers Network for Equality and Inclusion (ENEI)	Financial challenges have made taking work forward with ENEI or other external organisations difficult; however, new KPIs included in the annual plan report around equity, inclusion, and the Welsh language will mean that the Health Board can monitor progress more effectively. This will ensure that we are on track and can address any issues promptly.		Quarter 4 2024/2025
Unscheduled Care	Katja Empson <i>Consultant (Emergency Unit)</i>	Examining EU waits by demographics e.g. ethnicity to support 6 goals of urgent and emergency care	Due to organisational constraints this is not possible at present. Nevertheless, e-triage has been implemented in the department and some data on ethnicity is now being collected.	Ongoing	
	Katja Empson <i>Consultant (Emergency Unit)</i>	Analysis of frequent users by postcode (WIMD)	The Business Intelligence Department hold a Frequent Attendees report that collates by post code, which can be refreshed, but it's not currently scrutinised. This information is available for us by the frequent attenders team who work to put in place management plans for the more complex and/or high frequency attenders.		10/04/24
	Katja Empson <i>Consultant (Emergency Unit)</i>	New model for inclusion health based on need	Much progress has been made with respect to the new health inclusion model based on need. There is nurse in place during the hours of 9-5 to provide EU/ward in-reach. There is also a GP in place providing primary care in-reach to inclusion groups. Further work on the new model for inclusion health is ongoing and a further update will be provided in due course.	Ongoing	

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Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Maternity Care	Judith Cutter/ Alys Gower Consultant Midwives (Maternity)	Understanding the needs of ethnic minority people	<ul style="list-style-type: none"> Maternity Services has completed the staff-training days required as part of the Welsh Government's Diverse Cultural Competency Scheme and is working toward submission for formal accreditation in 2025. We continue to work with the Birth Partner Project to provide face-to-face sessions in the community. We are currently arranging the 2025 timetable for clinicians and specialists to attend and provide information on post-birth physiotherapy, birth experiences and public health messages. We are now expanding the Birth Partner Project sessions to involve Health Visitors. We are working with Cardiff's Women's Advocacy Network to support establishment of a peer-led network within local diverse communities. This network intends to offer peer services including breastfeeding peer support and childcare assistance; the network will work with us to ensure that women and birthing people from diverse backgrounds are able to contribute to service development. Following successful trial of face-to-face antenatal education sessions for non-English speaking families, the project has been established within the Community Midwifery programme of classes to continue on a permanent basis. We have introduced the 'Inclusivity' session which now runs as a part of mandatory training into the induction training for newly qualified midwives entering employment with the health board. 	Summer 2025	Cultural competency training days completed. Ongoing work to achieve cultural accreditation. Aim for submission in Summer 2025.

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Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Maternity Care	Judith Cutter/Alys Gower <i>Consultant Midwife (Maternity)</i>	Supporting people with obesity in pregnancy	<ul style="list-style-type: none"> We continue to provide individual support for women with higher body mass index in line with the Healthy Weight, Healthy Wales workstream and strategy group. We are currently working with Diabetic specialists to examine opportunities for enhanced care for women on GLP-1 medications, so as to ensure healthy weight management throughout pregnancy and into the postpartum period. We are working to ensure women who have had gastric surgery are included within the pathway. 	Once roll out of the new maternity informatics system is completed.	
Prevention	Suzanne Wood <i>(Reduce obesity) Consultant in Public Health Medicine (Public Health Team)</i>	Using 'Amplifying Prevention' to increase immunisation and reduce obesity	<ul style="list-style-type: none"> System connectedness has been strengthened through the establishment of a Cardiff Leadership and Enabling Change Group and a Move More Partnership Group. We are working through a governance arrangements in the Vale of Glamorgan. Progress report for the Good Food and Movement Implementation Plan shows that the majority of actions were in train during 2024/25. Consultation on the Cardiff Replacement Local Development Plan was held. Cardiff and Vale UHB submitted a response to include the priorities and commitments of the Good Food and Movement Framework. Research completed by the PHIRST INSIGHT Team enabling insight around unhealthy food advertising from young people, residents and stakeholders (key to system change) to be gathered. Unhealthy food advertising on University Hospital of Wales site bus stops restricted. In Vale of Glamorgan schools, 425 extra-curricular physical activity / sport sessions were facilitated during 2024/25, resulting in 7930 attendances/participations. The offer was based on consultation with young people. 	November 2025	<p>April 2025</p> <p>April 2025</p> <p>March 2025</p> <p>March 2025</p>

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Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Prevention	Dino Motti <i>(Increase immunisation) - Consultant in Public Health Medicine (Public Health Team)</i>	Using 'Amplifying Prevention' to increase immunisation	<p>The Vaccine Community Champions model continues to be delivered successfully at a Cardiff Secondary School, attracting interest from Public Health Wales who are keen to use the learning to develop a pre-school and pregnancy vaccine champions initiative.</p> <p>Through the Childhood Immunisations Group, we are working to understand the various strands of 'champions' including the above alongside the Immune Patrol pilot ('pupil champions'), and ad hoc initiatives in Flying Start settings ('pre-school champions').</p> <p>A recent audit against the Vaccine Literacy Standards identified several opportunities for improvement and colleagues from across the public health team and immunisation coordinators are engaging with a series of workshops led by the Behavioural Science Unit.</p> <p>Schools remain a key focus of work to increase vaccination uptake and conversations are ongoing with Cardiff Council colleagues to enable better sharing of data on uptake with schools. One action is to ensure that appropriate information sharing governance is in place and fortnightly task and finish groups are in place to progress this.</p> <p>A review (initiated by VPDP) of our Vaccine Equity Strategy is also underway and due to be completed by the end of June 2025.</p>	Ongoing	

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Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Analytics	Tom Porter <i>Consultant in Public Health Medicine (Public Health Team)</i>	Identification of potential indicators	<p>Potential equity indicators have been identified and shared with the Business Intelligence team. A Digital Service Desk request was sent on 15.04.2024 for development of a Health Equity Indicator dashboard.</p> <p>NEW ACTION JULY 2025:</p> <ul style="list-style-type: none"> Look to develop a health equity indicator dashboard in-house within the Public Health team. A discussion was held with the BI team and due to service pressures this was the agreed course of action- they will give the Public Health Team access to PowerBI licenses to develop dashboards. Initial dashboard to be developed by Tom Porter. 		15 th Apr 2024 Q2 2025/26
	Kerry Ashmore <i>Head of Business Intelligence (Digital and Health Intelligence)</i> David Thomas <i>Director of Digital and Health Intelligence</i> Dave Price <i>Head of Architecture and Analytics</i>	Development of a dashboard.	<p>Digital Service Desk request for development of a Health Equity Indicator dashboard received from the Public Health team on 15/04/24. It has not yet been allocated to a developer. Next steps will be for Public Health Team representative to work with Digital Services to produce a dashboard. We anticipate starting work on this just before Christmas and will provide a further update with respect to timescales in the New Year.</p> <p>Update July 2025: A discussion was held with the BI team and due to service pressures this was the agreed course of action- they will give the Public Health Team access to PowerBI licenses to develop dashboards. Initial dashboard to be developed by Tom Porter as per above.</p>	Q2 2025/26	

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Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Primary Care	<p>Sian Griffiths <i>Consultant in Public Health Medicine (Public Health Team, now retired)</i></p> <p>And Rebecca Lewis <i>(Principal Public Health Practitioner, Public Health Team)</i></p>	Scope how to identify unmet need e.g. cardiovascular risk	<ul style="list-style-type: none"> Additional data items are being regularly added to PHW's Primary Care Clusters Dashboard, which benefit clusters in identifying unmet need. A Place Based Planning pilot has been completed, led by regional planning and PCIC. Lessons learned are being considered and will inform future cluster planning. Cardiovascular risk assessment remains paused. <p>NEW ACTIONS JULY 2025: Continue to work to identify and address inequity and unmet need.</p> <ul style="list-style-type: none"> Work with Public Health Wales to consider the implications of implementing the Health Equity Action Framework for Primary Care. Consider local implications of the 'Prevention Based Health and Care Framework', in particular the ABCD+ programme in relation to Cardiovascular risk management. 	<p>Q4 2025/26</p> <p>Q4 2025/26</p>	<p>Complete</p> <p>Complete</p> <p>TBC</p>
	<p>Emma Holmes <i>Head of Nutrition and Dietetics</i></p>	Consider diabetes prevention programme expansion	<p>Six of the nine primary care clusters have been actively involved in the All Wales Diabetes Prevention Programme (AWDPP). The remaining clusters have not yet joined, although there had been expressions of interest. There have been challenges in recruiting staff due to delays in funding confirmation and the delays to recruitment. The team had successfully recruited 4 healthcare support workers, unfortunately more staff movement has meant that activity has paused again within one of the clusters. AWDPP outcome data has been published indicating it is a successful model.</p> <p>Funding from both Welsh Government and the Strategic Programme for Primary Care (SPPC) had been secured until March 2026. This alignment across funding streams was seen as a step forward. A business case has been drafted aimed at securing funding to replace the current patchwork of cluster-specific and national funding. There are inefficiencies and administrative burdens of the existing model. The business case advocates for a unified funding model that supports a health board-wide approach, enabling economies of scale and more equal service delivery.</p>	Ongoing	

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Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Representation	Claire Whiles <i>Assistant Director (Organisational Development, Wellbeing and Culture)</i>	Understanding current workforce demographics (Workforce Race Equality Standard)	The WRES Task and Finish Group has been established with organisational agreement to focus on progression and representation. A thorough analysis of data is underway to identify recruitment and progression barriers for our ethnically diverse colleagues. Meetings continue to take place with the Welsh Government.	Q4 2025/26	
	Jonathan Pritchard <i>Assistant Director (People Resourcing)</i>	Proactive community outreach to promote UHB as an employer	<p>Progress continues with a number of initiatives to promote employment within UHB:</p> <ol style="list-style-type: none"> 1. We have provided 4 tailored work placements for young adults with experience in the care system and the feedback was very positive. We have also partnered with a local university to conduct research into the experiences and barriers faced by care-experienced individuals in relation to employment. 2. Those with learning disabilities and/or autism. The UHB is now in its 4th year of delivering the Project Search program. This continues to play a vital role in helping young people transition from education into the world of work with dignity, purpose, and the right support, while also promoting a more inclusive and understanding workplace culture across Cardiff and Vale UHB. Departments that welcomed and supported interns this year included Portering, Catering, IT, the Central Production Unit, Colposcopy, and Laboratories. 3. Minority ethnic groups- we have sustained and strengthened our collaboration with key community organisations, aiming to break down barriers and foster trust. We have also focused extensively on secondary schools in the deprived areas of Cardiff and the Vale to inspire interest in NHS careers. We aim to build a workforce that genuinely reflects the rich diversity of the communities it serves. 4. Refugees- We have strengthened partnerships with refugee-focused organisations, including the Welsh Refugee Council. Recently, we attended a group meeting with around 15 refugees from various countries to provide valuable guidance on pathways into NHS careers. We also supported them by 	Ongoing	

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Action Plan

			<p>clarifying how their international qualifications can be converted to British equivalents, enabling them to apply for relevant positions within the Health Board. Additionally, the UHB has actively sought placements for individuals interested in gaining work experience or volunteering, helping to enhance their applications for NHS roles.</p> <p>5. There are many more examples we could share, such as developing links with the HM Prison and Probation service, organisations who support individuals experiencing homelessness and the Department of Work and Pensions, aiming to offer further support to those seeking jobs.</p> <p>6. We have partnered with UK Youth Cymru to deliver the Summer Jobs Programme, offering paid work placements to young people aged 16–20 who are at risk of violence or face significant barriers to employment. This initiative provides valuable experience, skills development, and confidence-building through supported placements across our Health Board.</p>	September 2025	
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Representation	Claire Whiles <i>Assistant Director (Organisational Development, Wellbeing and Culture)</i>	Listening to understand barriers, challenges and views	The 2024 Staff Survey results have been received, and the Equity & Inclusion team has been given access to the raw data to better understand our workforce's experiences. With the improved dashboard functionality, the survey results can now be broken down by various characteristics, providing more detailed insights.	Complete	Quarter 4 2024/2025
Mental Health	Dan Crossland <i>Director of Operations (Mental Health Clinical Board)</i>	Training and self-certification commissioned from Diverse Cymru	There are 20 service areas in the Mental Health Clinical Board undertaking training and self-certification at various stages. As of December 2023, 2 Clinical Board level trainings were completed. We were aiming for submission of the remaining service areas to Diverse Cymru for review by Q1 of 2024-25. This is now complete. We had confirmation recently that the MHCBC has won a Bronze Award with Distinction! We also had a silver award for Psychology and Psychological Therapies Directorate and a Bronze 'foundation' for our Headroom 1 st Episode Psychosis service.	Complete	2024

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Mental Health	Dan Crossland <i>Director of Operations (Mental Health Clinical Board)</i>	Development of a local strategy and framework for peer workers.	The lived experience team are developing a local strategy and a framework for peer workers.	2025	
	Dan Crossland <i>Director of Operations (Mental Health Clinical Board)</i>	Work with Police and Crisis Care Concordat to improve and understand shared ethnicity recording.	We have requested a report to cover Welsh Language compliance (would they prefer to speak in Welsh), preferred language and Ethnicity report by team. Our data set does match the police one now in terms of detail.	Complete	2024
Patient Safety	Alexandra Scott <i>Assistant Director of Quality and Safety (Patient Safety team)</i>	Understand variation in quality and patient safety reporting	The development of reporting from Datix has not progressed due to vacancies held for six months. If the position were able to be filled, this work could fully commence during 2026.	2026 onwards	
		Scope a pilot of variation in Medical Examiner Referrals by postcode	Discussed with medical examiner but they are not unable to progress. To consider potential to progress within the UHB once power BI analysis of Datix information is enabled. Until this point, this action is on hold indefinitely.	On hold	
		Undertake a baseline assessment of National audit data set to identify measures of inequity.	The work around measures of inequity in national audit is complete, however it is limited to only a few indicators relating to long term conditions. While useful, these don't provide a systems wide approach beyond these conditions.		2025

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Next Steps

Work to be undertaken to complete the actions outlined above

University Health Board to be updated of progress in six months time



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Next Steps

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Report Title:	Theatres Together – Progress Update			Agenda Item no.	2.5
Meeting:	Quality Committee	Public	X	Meeting Date:	5 th August 2025
		Private			
Status <i>(please tick one only):</i>	Assurance	X	Approval	Information	
Lead Executive:	Chief Operating Officer				
Report Author (Title):	Director of Operational Planning and Performance				

Main Report

Background and current situation:

The Theatre Together Programme is delivering on the recommendations made following the Theatre Review which took place during 2024/25. The robust and detailed review uncovered a number of concerning themes, ranging from failures of leadership practice, variable compliance with policies and procedures, and a poor culture all of which is impacting upon behaviours and psychological safety of colleagues.

This paper provides assurance on progress and highlight ongoing risks in relation to delivery against the 66 recommendations in the review. It follows an update on progress which was taken to Board Development in June which detailed the programme objectives, tranche methodology, governance arrangements, communications approach and key achievements to date. That update also detailed the ongoing risk and challenges, notably the financial impact of delivering some of the actions, and the strained capacity across clinical and operational teams due to staff absence.

An important part of the Theatres Review Programme relates to communication and there has been continued engagement with stakeholders. A meeting was held with Health Inspectorate Wales where members of the Executive Team discussed the findings, our response to date and development of the action plan. The cultural and leadership challenges in operating theatres were also referenced explicitly in the Cabinet Secretaries written statement on the escalation and intervention arrangements for the Health Board. Clear, consistent and transparent communication on the organisations progress, internally and externally, remains a key requirement as the recommendations are addressed.

The Theatre Together Programme has been working diligently through the initial tranches, namely, Foundation and High Impact. The action plan for these first two tranches is provided as an appendix to this paper. Following review at Board, this action plan will be shared with stakeholders including Health Inspectorate Wales and the Cabinet Secretary.

Progress against the Foundation Tranche has been positive with most actions complete. On reviewing the action plan each recommendation has been divided into a series of component actions. Through the process of reviewing each of the recommendations it has been noted that the scope has, in some instances, increased slightly. Whilst this is the right approach, as it ensures all the necessary actions are being implemented to deliver improvements, it does mean that some of sub-actions for the initial recommendations will take longer to complete. For assurance, the most imperative part of each of the immediate actions are being completed first.

Highlights from the Foundation Tranche include:

- **Security:** Reinstated existing TDSI access to the main theatres department.
- **WHO Checklist:** The WHO Collaborative reviewed the outcomes from patient safety incidents associated with non-adherence with the WHO checklist and co-produced a set of principles that standardised the checklist process and adherence with the checklist
- **Paediatric Recovery:** Review of the paediatric recovery bays undertaken in partnership with Children's Hospital of Wales to ensure that these areas meet the needs of paediatric patients and their families
- **Anaesthetic Rooms:** Standardised contents list for drug cupboards has been produced with Anaesthetists and Anaesthetic Practitioners
- **Cleaning:** Theatres Cleaning procedure has been reissued to all staff
- **Staff Room:** Refurbishment work due to commence in Q2.

Progress against the High Impact Tranche has been positive, whilst these actions are not due for completion until October there are a significant number of component actions which have already been achieved, and the Programme is confident in the delivery for those remaining over the coming months.

Highlights from the High Impact Tranche include:

- **Speaking Up Safely:** Staff side representatives have held safe space session in main theatres
- **Celebrate Success:** A range of initiatives have been implemented across all four perioperative areas to promote staff engagement, recognition, and wellbeing
- **People Services:** A senior advisor has been appointed to support theatres.
- **Team Meetings:** Clear expectations for engagement and meeting with teams have been set by the Theatres Management Team. Clinical Leaders are supported to meet regularly with their respective teams.
- **Team Meetings:** Quality and Safety Sessions are protected and have been changed to all day sessions with rotas arranged to ensure staff have opportunities to attend

Given the scale and number of recommendations, progress will be iterative and develop each week. All the remaining actions, particularly those relating to the Culture Tranche will be provided as part of the next update to Board. Many of these actions have completion dates in 2026 and therefore focus currently remains on the most urgent recommendations. The recommendations and actions will be added to the AMaT in the next month, this will allow for quantification of the completion rates.

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

- There has been good progress against the initial two tranches of the Theatre Review recommendations
- The action plan is provided as appendix and details the recommendations and actions for the first two tranches
- There remains operational pressure within the Surgical Clinical Board, Perioperative Care Directorate and Theatres Together Programme. Additional support is being provided to help mitigate
- The next update to Board will provide detailed actions for all recommendations and actions

Recommendation:

Quality Committee is requested to:

- NOTE** the progress on the Theatre Together Programme.

Link to Strategic Objectives of Shaping our Future Wellbeing:

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	X
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	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term		Integration		Collaboration		Involvement	
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Impact Assessment:

Risk: No

Safety: No

Financial: No

Workforce: No

Legal: No

Reputational: No

Socio Economic: No

Equality and Health: No

Decarbonisation: No

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

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Theatres Together improvement plan

Foundation and High Impact tranches

Updated 21st July 2025

Version 1.0

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Foundation Tranche (formally tranche zero)

Recommendation		Actions	Additional information	Status	Target date	Owner
1h	Explore security options to make the female changing area a more secure place to leave belongings.	Provide secure changing rooms with lockable storage for all staff	Reinstate/repair existing TDSI access to the main department.	Complete	Complete	Estates
			Additional TSDI for the female and male changing room, and the scrub room has been ordered with plans to install. Temporary TDSI passes will be provided to visitors following completion of TDSI installation.	In progress	September 2025	Estates
			Undertake an audit of the locker rooms to confirm that every person has been offered access to a locker and ensure access for all staff.	Complete	Complete	Perioperative Directorate Team
		Development of a UHB Theatres Visitors Policy	<p>The Procedure for the Management of Visitors within the Operating Environment exists and a UHB Theatres visitors policy has been developed. The Policy is being presented at the Perioperative Directorate quality and Safety Meeting for comment.</p> <p>The policy will then be shared with Corporate Governance to take through the UHB ratification process in August 2025</p>	In progress	September 2025	Perioperative Directorate Team
5g	Provide colleagues with the necessary information about patients that is pertinent to their role for maintaining safety for both staff and patients.	Develop a systems approach to ensure the communication of pertinent clinical information to relevant staff prior to commencement of a surgical procedure.	Include pertinent information about patients, including infection control information at Team Brief. Include a prompt for this in the WHO Checklist Whiteboard design.	In process	August 2025	WHO Checklist Collaborative

8a	Audit adherence to policies and procedures for consent and 'WHO Checklist,' ensure standardised application across all theatres and provide update training as required.	In partnership with the perioperative team and surgeons develop a set of principles that must be adhered to, that support a standardised WHO checklist process.	Establish a multi- professional WHO Checklist collaborative to design a programme of improvements to support compliance with the WHO checklist.	Complete	Complete	Surgery Clinical Board
			<p>The WHO Collaborative reviewed the outcomes from patient safety incidents associated with non-adherence with the WHO checklist and co - produced a set of principles that standardised the checklist process and adherence with the checklist. Communication from the Clinical Executive Team was sent to all Perioperative workforce and all surgeons on 13 May 2025 mandating the principles:</p> <p>Team brief must be attended by all members assigned to the list</p> <p>Sign in must be completed by the anaesthetist and the anaesthetic practitioner</p> <p>Time out must take place prior to commencement of the procedure and no surgical instrument must be handed to any member of the team until this has been completed</p> <p>Sign out must be completed by the whole operating team before any member of that team leaves the theatre.</p> <p>Debrief should be undertaken at the end of each operating session</p>	Complete	Complete	WHO Checklist Collaborative with Surgery Clinical Board
		Deliver the required systems and processes to ensure 100% adherence with the WHO checklist	Engagement events have taken place to embed the WHO checklist principles. These include:		Complete	WHO Checklist Collaborative with Surgery Clinical Board

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		and to provide the correct resources to support adherence	<p>Executive led WHO checklist engagement events, with all surgeons invited. Grand Round – Hosted by the Clinical Director for Perioperative Directorate around the delivery of the WHO checklist. Undertaken on 9 July 2025.</p> <p>The Director of Nursing for the Surgery Clinical Board has discussed the WHO Checklist at the UHB Senior and Lead Nurse Forum.</p> <p>The WHO collaborative wrote to all Clinical Boards Triumvirate to request that the WHO Checklist was discussed at all Clinical Board and Directorate quality and Safety sessions.</p>	Complete		
			Implementation of WHO checklist stickers to record involvement and completion at each stage of the list – to be used in the first three months of implementation to record adherence with the WHO Checklist principles.	Complete	Complete	WHO Checklist Collaborative with Surgery Clinical Board
			Procedure for Sign In stage of the WHO checklist agreed when variation exists between Theatreman and Consent form.	In progress	September 2025	WHO Checklist Collaborative with Surgery Clinical Board
		Deliver the required systems and processes to ensure 100% adherence with the WHO checklist and to provide the correct resources to support adherence	Update to WHO Checklist Policy	In Progress	October 2025	Perioperative Directorate Team

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<p>Chilcott, Rachel 31/07/2025 14:01:08</p>			WHO Checklist adherence will be subject to observational audit through August and September to inform the work of the WHO Collaborative	Planning stage	September 2025	Perioperative Directorate Team
			Co-production of the design principles for a WHO Checklist Whiteboard is complete and the draft design is to be presented at WHO collaborative	In Process	August 2025	WHO Checklist Collaborative with Surgery Clinical Board
		Deliver systems to ensure completion of consent prior to transfer to theatre	Communications have been shared to remind all staff of the requirement to ensure pre-operative checks are completed prior to the patient leaving the ward, including checking the presence of a consent form.	Complete	Complete	Surgery Clinical Board
			Theatre assistants have been informed that patients must not leave the ward without a signed consent form. In the event that a consent form hasn't been completed they must escalate to the theatre manager	Complete	Complete	Surgery Clinical Board
			Concentric E Consent Platform to be piloted in Ophthalmology and Cardiology	Planning	March 2026	Consent Lead
	Deliver strengthened digital record of theatre activity.	Introduction of Aqua theatre system as a replacement for Theatreman with associated SOP, training and audit of the system. Testing to commence in September 2025	In Process	20 January 2026	Perioperative Directorate Team	

8b	Examine the management of paediatric cases operated on in Mains Upper and determine whether the current arrangement of recovery in the adult recovery area aligns with the Royal College of Anaesthetists' Guidelines (Chapter 10: Guidelines for Provision of Paediatric Anaesthesia Services 2025). Assess the measures taken to safely manage children. Investigate what is required to fully utilise Children's Hospital for Wales to ensure that paediatric cases are operated on and recovered within Children's Hospital for Wales.	Standardised provision of Paediatric Anaesthesia services in line with Royal College of Paediatric Anaesthesia Guidelines	Undertake a Gap analysis of paediatric care against the Royal College of Anaesthetists Guidelines Chapter 10 Guideline of the Provision of paediatric Anaesthesia Services 2025	Complete	Complete	Perioperative Directorate Team
			Agree model for the delivery of paediatric surgery in main theatres that includes required education and skills and staffing requirements.	Planned	31 October 2025	Perioperative Directorate Team and Acute Child Health Directorate
			A review of the paediatric recovery bays undertaken in partnership with Children's Hospital of Wales to ensure that these areas meet the needs of paediatric patients and their families	Complete	Complete	Perioperative Directorate Team
			All required equipment has been identified, and funding support is being sought from Noah's Ark Charity.	In progress	October 2025	Perioperative Directorate Team
			A review of theatres has been undertaken to establish the most suitable for paediatric cases, ensuring room temperature can be rapidly adjusted and the necessary estates work to be undertaken to accommodate this.	In progress	August 2025	Estates
8e	Create standard operating procedures for the setup and standardisation of anaesthetic rooms throughout the department, where feasible.	Standardisation of the anaesthetic room layout and design	A standardised anaesthetic room design is being co-produced with Perioperative workforce	In progress	31 September 2025	Perioperative Directorate Team and Shaping Change
			Standardised contents list for drug cupboards has been produced with Anaesthetists and Anaesthetic Practitioners. Drug cupboards in each theatre have been labelled: Cupboard A – CDs and local anaesthetics	Complete	Complete	Perioperative Directorate Team

			<p>Cupboard B – Induction, reversals, emergency drugs, antiemetics, anti-inflammatories</p> <p>Cupboard C – Cardiovascular, analgesia, other</p> <p>Cupboard D – Antibiotics.</p> <p>Stock levels for drugs and other equipment have been agreed and will be subject to ongoing monitoring.</p>	Ongoing Monitoring	Complete	Perioperative Directorate team
			<p>A review of required equipment has been undertaken</p> <p>Equipment quotation requests have been submitted for storage trollies to replace cupboards.</p>	Complete Under review	31 September 2025	Theatres Together Team
			<p>Costings developed for environmental improvements and submitted to UHB Senior Leadership Team Meeting.</p> <p>Agreed at Senior Leadership team and to progress for discussion at Capital Management Group</p>	In progress	31 September 2025	Estates and Surgery Clinical Board
		Implement anaesthetic emergency toolboxes.	Anaesthetic emergency toolboxes are in Theatre 1, Theatre 10, and Recovery, containing emergency drugs and guidelines for anaesthetic emergencies.	Complete	Complete	Anaesthetic Practitioner – Main Theatre
8h	Standard Operating Procedures and schedules for the theatre deep cleaning rota, including weekend protocols that are standardised across all theatre suites.	Implement Standardised cleaning processes that meet the standards set out in the Perioperative Theatres Cleaning Procedure and national standards.	<p>Scope and price an initial deep clean, a one-off HPV clean and submit to Senior Leadership Team.</p> <p>Further discussion to explore the resourcing of standardised cleaning of theatres across the UHB</p> <p>Review of the operational arrangements for cleaning main theatres to align with other theatre areas within the UHB</p> <p>Develop a cleaning schedule checklist for each for individual theatre and communal areas.</p>	Complete In progress Complete Planned	31 August 2025 Complete 31 September 2025	Executive Team Perioperative Directorate Team Perioperative Directorate Team and Infection Prevention and Control Team

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			Theatres Cleaning procedure has been reissued to all staff	Complete	Complete	Perioperative Directorate Team
			Develop Options appraisal for theatres cleaning process and present to UHB Senior Leadership Team.	Presented 17 July 2025	31 August 2025	Executive Team
			Further discussion to explore the resourcing of standardised cleaning of theatres across the UHB	In progress		
		Align cleaning policy with updated CNO All Wales Cleaning policy when this is published.	Undertake a gap analysis of cleaning procedures against CNO All Wales Cleaning policy when published.	On publication of standards	Pending	
8j	Charitable bid to the Staff Lottery Fund to refurbish the staff room, including new furniture, fridges, and a dishwasher.	Refurbishment of the Perioperative Staff Room	Design of the Staff room co-produced with Perioperative workforce	Complete	Complete	Perioperative Directorate Team
			Bid to Charitable Funds Committee for staff room refurbishment agreed on 10 June 2025	Bid agreed	30 September 2025	Theatres Together Team
			Identification of an interim staff room during the refurbishment period alternative staff room	In progress	31 August 2025	Theatres Together Team
			Refurbishment work is planned for September 2025	Scheduled	30 September 2025	Estates
8i	The family room requires refurbishment. Explore options for charitable funding to improve the environment for relatives waiting. This space could also be used for staff to	Refurbishment of family room.	Develop refurbishment plan for family room	Complete	Complete	Perioperative Directorate Team
			Application made for the following: 1 x 2-seater sofa 1 x Low back chair 1 x coffee table 2 -3 upright chairs, which can be more easily moved.	In progress	August 2025	Perioperative Directorate Team

	pray or take some quiet time when not in use.		In conjunction with Capital, Estates and Facilities - contractor quotes in progress.	Planned	Oct 2025	Perioperative Directorate Team and Estates
9e	Explore how all theatres can work collaboratively to support efficiency including how Children's Hospital for Wales is staffed on Weekends and Bank Holidays		<p>Surgical wards in the Children's Hospital for Wales are staffed to accommodate surgical cases including supporting the transfer of children to and from theatre seven days a week.</p> <p>Agree model for the delivery of paediatric surgery in main theatres that includes required education and skills and staffing requirements (8b).</p>	In progress	31 October 2025	Perioperative Directorate Team and Acute Child Health Directorate

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High Impact Tranche (formally Tranche 1)

Recommendation		Actions	Additional information	Status	Target date	Owner
1b	Share the HCSW code for conduct to support individuals to be aware of the code.	Ensure that the HCSW Code of Conduct is used to support professional conversations	Re-distribute code of conduct to HCSW staff	Complete	Complete	Perioperative Directorate Team
			A review of the Values Based Appraisal process will ensure that the code of conduct is integral to the appraisals of Health Care Support Workers.	In progress	December 2025	Head of Organisational Development and Culture
1c	To share with colleagues how to raise concerns internally, share 'Speaking up Safely.' Consider support from HCPC and NMC on culture, the code and when to report to the regulator.	Promote the use of 'Speaking up Safely' to staff.	Speaking up safely highlighted to all staff via communication from the Chief Executive following the publication of the theatre review.	Completed	Complete	Comms Team / Theatres Together
			UHB Leaders who Listen engagement framework will promote awareness of the 'speaking up safely' process.	In progress	Oct 2025	AD Quality and Patient Safety
			Speaking up Safely is being promoted as part of all staff surveys and the UHB-wide screensavers.	Ongoing	Complete	Head of Organisational Development and Culture
			Staff side representative have held safe space session in main theatres for staff that work in upper main theatres.	Complete	Complete	Perioperative Directorate Team
		Consider support from HCPC and NMC on culture, the code and when to report to the regulator.	Contact the regulatory bodies to access advice on reporting to a regulator and consider how this information is shared.	In Progress	31 August 2025	Director of Nursing Surgery Clinical Board
1g	Celebrate success – feed back to the team when they receive positive feedback.	Implement a range of initiatives to celebrate success and provide feedback.	A range of initiatives have been implemented across all four perioperative areas to promote staff engagement, recognition, and wellbeing. These include:	Ongoing	Complete	Education Department and Perioperative Directorate Team

			<p>Shout-out boards have been introduced to showcase staff feedback and Greatix submissions. Student feedback is regularly shared via notice boards and social media platforms such as Facebook.</p> <p>Positive feedback and team successes are also communicated through WhatsApp groups.</p> <p>The Greatix process has been widely promoted to encourage staff participation.</p> <p>Newsletters are used to highlight good practice and achievements, and wellbeing events, including celebrations for Nurses, ODPs, and HCSW as well as events including bake sales, quizzes etc.</p> <p>The Surgery Star Awards is an opportunity to recognise individuals and teams for their efforts.</p> <p>Staff are encouraged to engage with updates and discussions via Viva Engage. Star of the month process has been positively received within Anaesthetic Practitioners and discussions are underway to t expand this to teams of the month.</p> <p>Communications about the re-runs of the Saving Lives in Cardiff TV programme has been broadened to reflect the contribution of the wider perioperative team as well as the surgeons.</p>			
	<p>Chilcott, Rachel 31/07/2025 14:01:08</p>		<p>Collaborate with the communications team to agree further opportunities to celebrate success aligned to maternity communication</p>	<p>In progress</p>	<p>October 2025</p>	<p>Perioperative Directorate Team</p>

2h	Sickness panels supported by People and Culture colleagues, to be conducted to ensure consistent approach, with regular attendance by clinical leads or deputies.	Strengthen sickness management with support from people and Culture	Regular sickness panels have been established with Theatre Managers, Lead Nurse, DON and Senior People and Culture Business Partner.	In progress	August 2025	People and Culture / Surgery Clinical Board
			People Services to meet with Theatre Managers on a weekly basis to review the previous weeks sickness cases to support with management of cases	In progress	August 2025	
			Sickness absence training/support to Clinical Leaders	In progress	September 2025	
			Sickness management forms part of the monthly Executive Reviews	Ongoing	Complete	Executive Team
2i	A senior advisor from people services should be allocated to theatres to provide consistent advice for the leadership team.	Appoint senior advisor from Peoples Services to support theatres.	A senior advisor has been appointed to support theatres. A plan is in place to continue this support when the current advisor moves to a new role in September 2025.	Complete	Complete	People and Culture
3b	Review of the workload of the clinical leaders to assess the feasibility of making them supervisory in line with their ward-based colleagues. Share with the team what is expected of the Clinical Leaders in their non-clinical time	Explore the feasibility of a supervisory clinical leaders team with clear guidance developed to ensure responsibilities articulated.	A review of staffing establishment will be undertaken to identify resource requirements to support clinical leaders in a fully supervisory role	Planned	31 October 2025	Theatres Together Team
			Develop guidance for clinical leaders to support a standardised approach to their supervisory duties	Planned	30 September 2025	Education Culture and Organisational Development Team
3c	Clearly define roles and responsibilities and ensure accountability for fulfilling	Develop a workforce structure with clear lines of reporting and responsibility	A review of Perioperative workforce structures, roles and responsibilities will be undertaken to clearly define with line	In progress	31 October 2025	People and Culture

	them across the workforce. Consider developing a training needs analysis to support the development of staff.		management and reporting/escalation arrangements.			
			A large-scale review of all education for all non-medical staff within the Perioperative Directorate will be undertaken to inform an educational strategy and a training needs analysis. That will expand access to leadership, clinical, and Level 7 education programmes and resources delivered internally to the UHB as well as national programmes of education (8m (part 1))	Planned	April 2026	Education Department and Perioperative Directorate Team
5a	Implement regular team meetings for all staff to improve communication and engagement.	Develop a department meeting structure to ensure engagement with all staff.	Clear expectations for engagement and meeting with teams have been set by the Theatres Management Team. Clinical Leaders are supported to meet regularly with their respective teams.	Complete	Complete	Perioperative Directorate Team
			Regular band 7 forums have been established.	Ongoing	Complete	
			Forums for all staff groups are currently being planned.	In Progress	31 September 2025	
			Q&S Sessions are protected and have been changed to all day sessions with rotas arranged to ensure staff have opportunities to attend	Ongoing	Complete	
			A Directorate Management Team (DMT) has been established to provide a structured weekly forum for departments to share staffing updates, operational issues, and key information, promoting consistent communication across the Directorate.	In progress	31 September 2025	

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5b	Consider reinstating the General Manager / Lead Nurse drop-in sessions on a regular basis.		General Manager / Lead Nurse drop-in sessions will be reinstated from September on a monthly basis	In progress	31 September 2025	Perioperative Directorate Team
5c	Regular meetings with General Manager, Lead Nurse, and Theatre Manager with set agenda.		Regular two to one meetings between the General Manager Lead Nurse and Theatre Manager have been re-established	In progress	Complete	Perioperative Directorate Team
5d	Regular meetings with General Manager, Lead Nurse, Theatre Manager and the Clinical Leaders.		A programme of meetings between the General Manager, Lead Nurse and Theatre Manager and the Clinical Leads is being developed	In progress	30 October 2025	Perioperative Directorate Team
5e	Consider implementing the use of team briefs across the entire suite to enhance teamwork. This approach could be beneficial in celebrating success, addressing concerns such as the impact of staff sickness in specific areas, and checking in with staff, particularly following challenging cases.	Implementation of team briefs	Undertake an exercise to map out pathways for support for theatres.	In progress	31 October 2025	Head of Organisational Development and Culture Theatre Managers
			MedTrim response was implemented in June 2025. Twenty-three members of staff have undertaken MedTrim training with further training planned. MedTrim response is supported with a protocol to standardise the implementation of de brief. Roll out has been supported by awareness raising session.	Complete	Complete	Theatres Education and Development Team.
5f	Verify who has UHB email accounts and ensure that all individuals have access. Consider alternative	Provision of emails accounts to all staff	An audit has identified that 25% of theatre staff did not have an activated email account.	Complete	31 September 2025	Perioperative Directorate Team

	means of mass communication, such as Theatres SharePoint Site, Viva Engage or Teams channels, instead of relying solely on WhatsApp.		Communications will be sent to all staff without email addresses with their login details. Communication will include promoting the benefit to staff of accessing their email account, including improved communication within the department and the potential additional benefits to the individual staff members, such as access to NHS discount schemes.			
			A department meeting structure has been developed (action 5a) to ensure engagement with all staff	Ongoing	Complete	Perioperative Directorate Team
6a	Conduct a comprehensive review of rostering practices, including an analysis of shift times and their correlation with late finishes, late starts, and early finishes. Specifically, assess the feasibility of implementing 12-hour shifts within the Recovery teams.	Undertake a review of rostering practices to identify areas for improvement	Undertake systematic review of current health rostering, to include: <ul style="list-style-type: none"> - Sign-off dates. - Requesting process. - Annual leave. 	Ongoing	Complete	Lead Nurse Perioperative with Health Roster Team
			Health rostering learning sessions have been conducted in collaboration with the Health Rostering Team and the Corporate Nursing Team to support improvements in workforce planning.	Complete	Complete	Lead Nurse Perioperative Directorate and Health Rostering and Senior People & Culture Business Partner
			Internal Audit will undertake a review of UHB health rostering	Planned	2025/26 financial year.	Internal Audit
			Existing roster templates are currently under review, with a focus on aligning list start and finish times with staff working hours.	In Progress	30 November 2025	Health Rostering Team
	Scope the feasibility of implementing 12-hour shifts	A trial of 12-hour shift patterns is being planned to explore potential benefits for	In progress	December 2025	Lead Nurse Perioperative Directorate	

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			service delivery and staff wellbeing. A draft of the 4-week roster has been prepared, providing a clearer view of how the arrangement would function in practice. The plan is to review the numbers against the establishment spreadsheet to see how this would work. Once completed the outcome of the pilot will be presented at the Nursing productivity Group			
		-	Communicate principle that 80% of AL is to be booked by December 2025 for 2026/27 as per UHB rostering policy	Complete	Complete	Lead Nurse Perioperative Directorate
8f	Consider wider use of Tendable to monitor compliance against standards and procedures including use of PPE. This would give more oversight to the Directorate and Clinical Board. IPC colleagues, Clinical Board Director of Nursing, Directorate Lead Nurse, and Decontamination Lead to support ad hoc patient safety walk around and audits against standards.	A programme of Infection prevention and control quality assurance will be developed with clear reporting and exception reporting arrangements	Perioperative directorate will develop a timetable of IP&C audits to be undertaken by Clinical Leaders. These audits will be presented at the Perioperative quality and safety and reported by exception at the Surgery Clinical Board Quality and Safety Forums and the UHB IP&C meetings.	In Progress	31 September 2025	Lead Nurse Perioperative Directorate
8m (Part 1)	Review training on offer for new starters establish if the course is transferable and does it cater for all learners.	Develop a Perioperative Education strategy that supports succession planning	Meet with the University College London to explore their Theatre Workforce Strategy	Planned	31 September 2025	Perioperative Directorate Team

	Explore working with HEI's and HEIW on commissioning a post graduate level 7 perioperative care module.		A large-scale review of all education for all non-medical staff within the Perioperative Directorate will be undertaken to inform an educational strategy and a training needs analysis. That will expand access to leadership, clinical, and Level 7 education programmes and resources delivered internally to the UHB as well as national programmes of education.	Commencing in September 2025 following completion of the workforce review	April 2026	Education Department and Perioperative Directorate Team
		Development of a new starters education programme for all professional groups	Review of new starter education programme has been undertaken, and education and competency booklets have been further developed to support this approach	Complete	Complete	
			Work has been undertaken with HEIW to agree funded places for leadership and organisational development, cardiothoracic study days and Facilitated teaching and learning education.	Complete	Complete	Education Department and Perioperative Directorate Team
			Identify a funding source for resuscitation training for ODP	In Progress	April 2026	

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Minutes of the Clinical Diagnostics and Therapeutics Clinical Board Quality, Safety and Patient Experience Sub-Committee

Held on 26th June 2025

Present:		
Helen Luton (Chair)	HL	Director of Nursing/Multi Professional Teams
Sian Jones	SJ	Directorate Manager, Laboratory Services
Alana Adams	AA	Principal Pharmacist, Welsh Medicines Information and Advice Service
Anna Burgess	AB	Digital Lead Pharmacist, Welsh Medicines Information and Advice Service
Alison Lewis	AL	Patient Safety Coordinator
Tracy Wooster	TW	Sister, Outpatients
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Debra Woolf	DW	Sister, Outpatients
Jonathan Davies	JDa	Health and Safety Adviser
Susan Beer	SB	Public Health Wales Representative
Jo Fleming	JF	Quality Lead, Radiology
Edward Chapman	EC	Head of Clinical Engineering/ Medical Devices Officer/Assistant Director of Therapies and Health Sciences
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Seetal Sall	SS	Point of Care Testing Manager
Carole O'Shea	CO	Deputy Site Superintendent Radiographer
Rhys Morris	RM	CD&T R&D Lead/Director of MPCE
Suzanne Rees	SR	Lead Nurse for CD&T
Eleanore Hobbs	EH	Genomics Implementation Support Officer (Observing)
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Adam Christian	ACh	Clinical Board Director
Sarah Lloyd	SL	Director of Operations
Becca Jos	BJ	Deputy Director of Operations
Melissa Melling	MM	Head of Medical Illustration
Vanessa Goulding	VG	Interim Head of Podiatry
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Paul Williams	PW	Quality and Safety Lead, Medical Physics
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Bill Salter	BS	Lead Staff Representative
Sandra Watts	SW	Senior Nurse for EPMA, Pharmacy
Jamie Williams	JW	Senior Nurse, Radiology
Elaine Lewis	EL	General Manager, Pharmacy
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Yvonne Hyde	YH	IP&C Team Representative
Sue Lawless	SL	Laboratory Service Manager, Haematology
Timothy Banner	TB	Clinical Director, Pharmacy

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Ruth Lang	RL	Office Manager, AWTTC
Julia Dinley	JD	Head of Speech and Language Therapy
Kate Blower	KB	Shaping Change Team

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 25/151	Welcome & Introductions HL welcomed everyone to the meeting.	
CDTQSE 25/152	Apologies for Absence Apologies for absence were noted.	
CDTQSE 25/153	Minutes of the previous meeting The minutes of the previous meeting were received. The Group resolved that: a) The minutes of the previous meeting held on 29 th May 2025 were accepted as an accurate record.	
CDTQSE 25/154	Matters Arising/Action Log The action log was received and it was noted that a number of actions had been completed. The outstanding actions were updated as follows: <i>CDTQSE 24/250 Update on new ME Process</i> The Bereavement team will present the changes to the process of how death certificates are issued in September. <i>CDTQSE24/277 Incidents Relating to Pathology Delays</i> SG will present at the next meeting. <i>CDTQSE 25/139 Drinking Water Provision in Speech and Language Therapy</i> Suzanne Rees to visit the Speech and Language Therapy department to consider their options. The group resolved that: a) The updates to the outstanding actions were noted.	KBa SG SR
CDTQSE 25/155	Review of Terms of Reference The draft updated terms of reference document was circulated. The group resolved that:	

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	a) Any comments to be submitted to HJ within 2 weeks. If no comments are received it will be presumed that there are no further changes required.	All
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 25/156	<p>Concerns and Compliments Report</p> <p>In May 2025, the Clinical Board received 44 concerns: 4 formal and 40 early resolution. There was 1 breach in response times. 1 compliment was received.</p> <p>The top themes of concerns received in May were:</p> <ul style="list-style-type: none"> • Difficulties cancelling and arranging appointments • Waiting times • Communication issues <p>The key themes of concerns received to date are:</p> <ul style="list-style-type: none"> • Difficulties cancelling and arranging appointments • Delays in signing death certificates • Waiting times <p>The top themes received to date for compliments are:</p> <ul style="list-style-type: none"> • Excellent clinical treatment • Contributions to materials e.g. articles, photographs <p>HL reported that the dietetics team are inundated with queries and complaints direct from the public relating to accessing weight loss injections. She noted that the UHB is developing a comms to help manage the public's expectations.</p> <p>KA stated that the Physiotherapy team are receiving high volumes of concerns relating to call waiting times and this is linked to the high level of vacancies in the Booking Team.</p> <p>The Group resolved that:</p> <p>a) It was noted that the Physiotherapy team will be trialling SMS messaging to see if this has any impact.</p>	
CDTQSE 25/157	<p>National Reportable Incidents</p> <p>A breakdown of the open incidents relating to this Clinical Board was circulated.</p> <p>The long overdue incident will be a priority for closure.</p> <p>A reporting error in Radiology linked to the outsourcing company will be closed out this month when the improvement plan has been finalised.</p> <p>An incident relating to a creche was a complicated issue whereby an external provider was providing the facility in an</p>	

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	<p>external venue. Learning from this incident will be brought to a future meeting.</p> <p>Physiotherapy reported an incident relating to a patient's oxygen requirement. This is being managed by Specialist Clinical Board.</p> <p>An incident relating to a potential Radiology miss is awaiting pathology results to determine whether this is the case. An initial meeting needs to be arranged to set the terms of reference for the investigation.</p> <p>2 NRIs have been reported in the last week. One relates to the reagent in Biochemistry that has impacted on PSA results which was reported at the previous meeting. This was submitted as an early warning notice to Welsh Government and it was suggested that this is reported as an NRI under Principle 3 and 4, not because of the level of harm, but due to the volume of patients involved. Principle 4 relates to wider learning.</p> <p>A similar issue has occurred with a DEXA scanner where a software setting has potentially affected some results. 70 results may have been affected but it is not yet clear if there has been any harm to patients. This was also submitted as an early warning notice to Welsh Government and they suggested that it was reported to both HIW as an IRMER incident and also as an NRI.</p> <p>The Group resolved that:</p> <p>a) Investigations are underway into both of the recent NRIs.</p>	
<p>CDTQSE 25/158</p>	<p>Duty of Candour Cases/Claims/LFERs</p> <p>JF reported that an 11-year-old attended for a PET scan. A PICC line was in situ which was to be used for the venous access to deliver the radiopharmaceutical. The correct procedure was not followed whereby the PICC line was flushed and a BM was taken prior to the radiopharmaceutical administration. The line was not flushed again after drawing the blood back, and by the time the staff member had prepared the radiopharmaceutical and went to administer this, the blood had clotted in the line.</p> <p>Support was obtained from the ward but attempts to clear the line were unsuccessful. To minimise the impact to the patient and ensure that he had the imaging required, a senior radiographer inserted a cannula and the patient managed to have their imaging ahead of their next round of treatment. Unfortunately, the patient needed a new PICC line inserted and this had to be inserted under general anaesthetic.</p> <p>A review was undertaken into the case. Although the radiographer had received some training for access and PICC</p>	

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lines through their induction training within PET, this had not been documented against competency framework and the training required significant improvement to make this a more robust process within Radiology.

The Radiographer was not overly confident to perform the procedure and had asked a core member of staff to explain the procedure for accessing PICC lines prior to undertaking the procedure. The core Radiographer should have remained present to supervise or have undertaken the procedure themselves.

Whilst not a contributing factor, an issue was identified that the cannula inserted by the senior Radiographer is outside of the scope of Radiographers, as paediatrics are not currently within the scope.

Recommendations from the review include:

Ensuring that only staff who have completed formal training (not cascade training) should access PICC lines. In the interim appropriately trained staff from the ward can be contacted to prepare and flush PICC lines if core staff are not available.

A new training pathway should be developed and introduced for Radiographer accessing of PICC lines.

Mentorship of recently trained staff to remain in place post induction training.

The total number of Radiographers trained to access PICC lines should be limited to senior core staff within PET/CT. This will allow staff to maintain skills. This may be reviewed in the future depending on clinical and service need.

The review identified that within PET, the patient has to be imaged within a certain timeframe from administering the radiopharmaceutical. Staff feel pressured to ensure they do not have to cancel patients due to the radioactivity being reduced. Potential measures to reduce this pressure on staff whilst maintaining clinical activity should be explored.

Consider expanding the scope for Radiographers to enable them to cannulate paediatric patients for Radiology procedures following appropriate training.

HL suggested that Radiographers participate in the UHB IV Access Group. JF noted that the department is looking to take this forward.

JF also noted that there is variation across the Health Board around training of access for PICC lines and Radiology has been advertised to link with the Haematology department for best practice.

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	<p>The Group resolved that:</p> <p>a) SR reported that the UHB has a Practice Development Nurse in post and will send the contact details to JF.</p>	SR
CDTQSE 25/159	<p>Risk Register Updates</p> <p>SJ reported that the temperature in Cellpath Laboratory is affecting both staff and instruments.</p> <p>The Group resolved that:</p> <p>a) SJ will request that the current risk assessment is updated.</p>	SJ
CDTQSE 25/160	<p>Patient Safety Alerts</p> <p>A Safety Memo has been circulated regarding Amphotericin and the high risk of selecting the wrong product.</p> <p>ISN 2025 02 Guedel airway recall has been circulated for staff to check if they have any affected stock.</p> <p>The Group resolved that:</p> <p>a) Where applicable, directorates to feedback on the ISN and confirm they have taken the required action.</p>	All
CDTQSE 25/161	<p>Medical Device/Equipment Risks</p> <p>EC noted that a Field Safety Notice was received from Philips relating to their Azurion R1.x and R2.x machines where a software issue could potentially result in loss of imaging functionality. JF advised that Philips will be visiting Radiology within the next month to run a software update..</p> <p>A poster has been produced that simplifies the process for staff to follow for medical device incident management reporting and EC asked for comments. Some suggested amendments were made. The aim of the poster is to raise awareness of the correct steps of the process that need to be followed, particularly in relation to reporting the incident on Datix.</p> <p>RM suggested adding a hyperlink to the post that defines what constitutes as a medical device.</p> <p>The poster suggests completion of the MHRA Yellow Card. Whilst this is encouraged, Clinical Engineering can action this if appropriate. If staff need advice they can contact Clinical Engineering.</p> <p>The Group resolved that:</p> <p>a) EC will present the poster to the Patient Safety Team meeting for further discussion and comments.</p>	EC

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<p>CDTQSE 25/162</p>	<p>Point of Care Testing</p> <p>DW noted that Outpatients need 3 scanners for new utilisers they have received, to cover UHW and UHL. SS will explore with the manufacturer if there are scanners available.</p> <p>The Group resolved that:</p> <p>a) The update was noted.</p>	
<p>CDTQSE 25/163</p>	<p>IP&C/ Decontamination Issues</p> <p>SR reported that concerns have been raised that equipment is being sent back to Clinical Engineering without being decontaminated. The cleaning of suction equipment is also an issue. EC commented that Tendable audits include a category for medical equipment that should help identify areas that can be targeted for improvement.</p> <p>HL reminded the Group of the Gloves Off Campaign and the importance of good hand hygiene.</p> <p>The Group resolved that:</p> <p>a) There were no issues to report.</p>	
<p>CDTQSE 25/164</p>	<p>Safeguarding Update</p> <p>The MCA L2 training compliance report was received for May 2025. This Clinical Board is reporting 86% compliance.</p> <p>The Group resolved that:</p> <p>a) The update was noted.</p>	
<p>CDTQSE 25/165</p>	<p>Consent Issues</p> <p>HL reported that the UHB Consent Group was held yesterday. There is a new UHB Consent Lead in post, Daniel Harrison.</p> <p>It was reported that the EIDO platform can now host local information where there is no EIDO leaflet available. These can also be translated into different languages. Documents can be added via a contact in Welsh Risk Pool and HL will share the contact details in the Teams channel.</p> <p>The Consent training compliance Report for May was circulated. This Clinical Board is reporting 76%.</p> <p>The Group resolved that:</p> <p>a) Consent training compliance within the medical staff group needs to be improved.</p>	

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<p>CDTQSE 25/166</p>	<p>Health and Safety/Staff Wellbeing</p> <p>JD provided an update from the UHB Health and Safety Operational Group. It was noted that RIDDOR incidents are higher than the national average. This Clinical Board has reported 0 RIDDOR incidents this year to date.</p> <p>A focus of the meeting related to fire safety and the changes in the response from the South Wales Fire and Rescue Service. A number of incidences of fires were discussed including a fire started by a contractor undertaking roof works and a number of incidents related to cooking in non-designated cooking areas.</p> <p>It was noted that Health and Safety mandatory training compliance has generally improved across the Health Board.</p> <p>The UHB COSHH procedures are being updated.</p> <p>The Clinical Board Health and Safety Group met this week. There is a plan by the Fire team to deliver fire training on Teams as an alternative to face to face sessions. This should help improve compliance. Face to face fire training can be provided to any areas of high-risk.</p> <p>Staff Wellbeing Resources available for all staff have been circulated across the Clinical Board.</p> <p>Focus Groups linked to the Staff Survey Results are being led by the Chief Executive. HL requested that these are promoted to staff.</p> <p>HL shared information on the New UHB Sexual Misconduct Procedure and training sessions are available to all staff.</p> <p>The Group resolved that:</p> <p>a) Departments will encourage their staff to attend the Staff Survey Focus groups.</p>	<p>All</p>
<p>CDTQSE 25/167</p>	<p>Regulatory Compliance</p> <p>SJ reported that the HTA are currently undertaking an inspection in Stem Cell.</p> <p>The HTA will also be visiting the new mortuary premises in July or September.</p> <p>Also, the HIW are inspecting Radiology next week.</p> <p>The Group resolved that:</p> <p>a) The minutes of the Regulatory Compliance Group meeting were circulated.</p>	

TIMELY

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<p>CDTQSE 25/168</p>	<p>Waiting Times Performance</p> <p>SO reported that the number of patients waiting 8 weeks or greater for a diagnostic has increased by 374 to 9534.</p> <p>Patients waiting 14 weeks or greater for Therapy input has increased by 96 to 571.</p> <p>The Group resolved that:</p> <p>a) Waiting times performance is monitored and discussed in detail in the directorate performance review meetings.</p>	
EFFECTIVE		
<p>CDTQSE 25/169</p>	<p>Feedback from UHB QSE Committee</p> <p>The minutes from the meeting held on 13th May 2025 were circulated.</p> <p>HL noted from the minutes that the Specialist Clinical Board presented their annual report.</p> <p>There was a discussion on the variance in the quality and completeness of discharge advice letters issued across the Health Board. It was noted that EPMA will hold discharge advice letters when the system becomes live. Education is being put in place for resident doctors on creating focused and relevant discharge advice letters.</p> <p>SO reported that Clinical Coding is looking at the option of making more use of discharge advice letters for coding, rather than obtaining patient records for inpatients and episodes of day care. The update provided will help provide him with some further links.</p> <p>The group resolved that:</p> <p>a) The key items from the minutes were noted.</p>	
<p>CDTQSE 25/170</p>	<p>Research and Development</p> <p>RM reported that VPAG funding has been made available for posts to be advertised for roles focusing on commercial research. There is also potential VPAG funding for Radiology to facilitate work with Cubric.</p> <p>RM has been in discussions with the National Imaging Programme and Radiology Consultant colleagues with regards to AI research. There are difficulties in accessing anonymised image data sets for AI algorithms and an All-Wales approach may help in addressing information governance issues which is impacting on research into this data. Other countries are much further forward in AI research from publicly available datasets.</p>	

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	<p>Speakers are needed for the next Clinical Board R&D Forum. EC referred to an external speaker from Oxford who delivered an interesting presentation on AI in diagnostic imaging. He will ask whether they would be willing to present this to the Forum.</p> <p>Any staff involved in research, innovation or are undertaking PhDs etc. are encouraged to join the Clinical Board R&D Group.</p> <p>The Group resolved that:</p> <p>a) Directorates to consider if there are any staff in their areas that would benefit from attending the Clinical Board R&D Group.</p>	EC
<p>CDTQSE 25/171</p>	<p>Service Improvement Initiatives</p> <p>Anna Burgess, Digital Lead Pharmacist in the Welsh Medicines Advice Service presented her MSC project related to improving Common Ailments Service Guidance for Community Pharmacists in Wales with a focus on the allergic rhinitis summary and pathway.</p> <p>The Common Ailments Service is an NHS service provided by 99.4% of community pharmacies across Wales. It allows patients to access advice and treatment for 27 minor conditions without having to visit their doctor, making healthcare more accessible and reducing the burden in general practice. Patients have a consultation with a pharmacist in a private space who will assess their symptoms and if appropriate provide free advice and treatment.</p> <p>The team at the Welsh Medicines Advice Service have been commissioned by Welsh Government to write and review the Common Ailments Service evidence-based framework and the resources that enable the pharmacist to provide this service. The formulary is available both in PDF format and via the Inform Platform produced by DHCW based on the framework. Community Pharmacists need to be able to provide the Common Ailments Service to as many patients as possible and therefore the process and solutions need to be as simplified as possible for the pharmacists to meet an increasing workload.</p> <p>The Project Framework followed the Design Council's framework for innovation. Research, stakeholder engagement, SWAT analysis and force field analysis identified the drivers, barriers and opportunities and the key challenges such as developer access and software costs.</p> <p>It was identified that the Common Ailments Service Formulary in PDF format was not user-friendly during consultations and is most often accessed via the Inform platform. Benchmarking was undertaken against other UK and international models an options appraisal was undertaken to identify how to improve</p>	

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the useability of the formulary, particularly for more complex conditions. It was agreed to focus on the pathway for allergic rhinitis as this was one of the most common ailments presented to the service.

Prototypes were developed based on user feedback. The community pharmacists using the tool will be familiar with the wordy formulary and are competent at assessing symptoms of allergic rhinitis and providing recommended treatments. The solution is therefore an aide memoire rather than a clinical decision tool and therefore is not classified as a medical device. Consideration was given of how best to make the condition summary and management pathway accessible and the preferred option was uploading onto the WMAS public-facing website.

The key lessons learned were:

The principle of starting the project with 'why?' led to stakeholder buy-in.

Iterative design and prototypes helped maintained stakeholder engagement and user-centred design principles resulted in a solution that is useful and useable.

Collaborative working with stakeholders resulted in a solution that satisfied all parties.

Whilst financial resources and access to developers restrict the development of an optimal design of a sleeker, digital solution, this lower technological summary and pathway still enhances the user experience.

SS asked if the service is target driven and if there are time pressures to see as many patients as possible. AB noted that there are time pressures on the community pharmacists, which is why it is important that the tools available can support them in navigating through these consultations in a time efficient way as possible.

She also asked if there had been engagement via Welsh Government in terms of hosting point of care testing devices. It was noted that there is currently only one which is in the sore throat component, which involves a swab at the back of the throat but there are discussions around potentially expanding the scope into the other conditions.

SO asked what project support was provided in terms of following the structures around improvement and engagement. It was noted that the Dragons Heart Institute provided sessions and there was support from the Shaping Change team and Community Pharmacy Leads across Wales.

HL asked if all 27 conditions are in this format. AB explained that not all conditions require a pathway, the plan is to develop

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	<p>pathways for the more complex conditions that have multiple treatment options. Dry skin conditions are being considered as the next area of focus.</p> <p>The Group resolved that:</p> <p>a) It was suggested that the project is submitted to National Conferences and put forward for National Awards.</p>	
<p>CDTQSE 25/172</p>	<p>Information Governance/Data Quality</p> <p>SO noted that a discussion was held in the Clinical Information Board around the use of MS forms and Power Apps. Whilst there are opportunities and benefits of using these apps, there are concerns around how the forms are being set up and being managed particularly in relation to patient information.</p> <p>Governance parameters and guidance are likely to be needed with the development of SOPs and templates etc. This issue will be discussed further at the Digital Advisory Board and Operational Delivery Group. Similar opportunities and risks have been raised relating to AI.</p> <p>The Digital Health and Intelligence team are leading work on a common demographic service to look at how key patient demographics are flowing between local and national systems.</p> <p>JF enquired if there is any IG guidance on staff using their personal devices when there are connectivity issues with the mobile devices such as tablets that are provided by the Health Board. For example, Inpatient E-referrals can be accessed on devices through Office 365 when the tablets cannot connect. SO asked JF to provide him with specific examples and he will discuss with the UHB Information Governance Officer.</p> <p>Concerns have also been raised that there is a growing expectation for staff to utilise their own personal devices for work purposes.</p> <p>The issue was also raised that the UHB procedure relating to the use of mobile devices no longer reflects the rapid advances in technology that have occurred during the last few years.</p> <p>The Group resolved that:</p> <p>a) The information governance issues were noted.</p>	<p>JF</p>
<p>CDTQSE 250/173</p>	<p>HIW/Llais Reports and Improvement Plans</p> <p>The Group resolved that:</p> <p>a) No reported or improvement plans have been received.</p>	
<p>CDTQSE 25/174</p>	<p>Policies, Procedures and Guidance (including NICE Guidance)</p>	

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	<p>The WHO Checklist letter has been circulated. JF noted that Radiology undertakes audits against the WHO checklist.</p> <p>JF asked if there is any further update around the UHB reinstating the NATSSIP Group. HL will enquire on any plans with the Patient Safety Team.</p> <p>The Group resolved that:</p> <p>a) There were no new local policies or procedures to be reviewed.</p>	HL
EFFICIENT		
<p>CDTQSE 25/175</p>	<p>Feedback from Directorate QSE Meetings</p> <p>The Terms of Reference for this Group set out the requirement for feedback to be received from directorate QSE meetings. HL requested that a record of discussions held are submitted to this group for noting.</p> <p>The Group resolved that:</p> <p>a) Directorates to consider the most appropriate format for providing their feedback.</p>	All
<p>CDTQSE 25/176</p>	<p>Clinical/Internal Audits</p> <p>The Group resolved that:</p> <p>a) There were no audits to report.</p>	
<p>CDTQSE 25/177</p>	<p>Sustainability</p> <p>The NHS Wales Sustainability Conference and Awards were held on 20th June. A presentation was being delivered on AI and evaluating its sustainability in healthcare. The CD&T Green Group held a discussion on the high levels of energy needed to run AI and how users can be smarter in their use of AI tools to help reduce energy consumption.</p> <p>In the NHS Sustainability Awards, the Gloves Off Campaign was awarded winner in the Spread and Scale category.</p> <p>Therapies staff in the community are keen to support sustainable travel by purchasing E-bikes through the Salary Sacrifice Scheme but were unaware of the fire risks and the UHB stance of not allowing them to be stored within UHB premises. This raised concerns around the risk of theft and the issue was escalated to the Clinical Board Health and Safety Group.</p> <p>AWTTC have produced a dashboard report showing the progress on their initiative in reducing the carbon footprint of inhalers in Primary Care Wales. The indicative carbon</p>	

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	<p>footprint has reduced by 16.84% from February 2024 to February 2025.</p> <p>The Group resolved that:</p> <p>a) The updated from the CD&T Green Group was noted.</p>	
EQUITABLE		
<p>CDTQSE 25/178</p>	<p>Feedback from Clinical Board Inclusion Ambassadors Group</p> <p>The Clinical Board Inclusion Ambassador Meeting was held this week. The Clinical Board's compliance against the recording of Welsh language skills on ESR is 69.83%. Staff who have not yet uploaded their level of skills on ESR are being encouraged to complete the link that has been circulated.</p> <p>RM noted that there is an issue for long-serving staff who completed this information at the time when there was only a requirement for listening and speaking Welsh skills to be uploaded, and their skills against reading and writing Welsh which are now required, have not been recorded. These staff may not realise that they need to resubmit their details.</p> <p>The welcome to Welsh and Confidence in Welsh courses are being promoted across the Clinical Board.</p> <p>SO will be engaging with the Mental Health Clinical Board for shared learning around taking forward the Equality and Inclusion agenda.</p> <p>The Group resolved that:</p> <p>a) The update from the Inclusion Ambassadors Meeting was noted.</p>	
<p>CDTQSE 25/179</p>	<p>Equality and Diversity Issues</p> <p>SO noted that Therapies are empowering their staff who have additional needs with effective support tools, particularly with a focus on staff with neurodiversity.</p> <p>He also noted that Health Records is involved in piloting work with the Welsh Interpretation and Translation Service, to provide patients requiring BSL interpreters with a community self-serve option for making bookings This is being supported by the Patient Experience Team, as it is recognised that this will involve services outside of Health Records. A meeting is being arranged to consider how to commence this work.</p> <p>The Group resolved that:</p> <p>a) There were no issues to report.</p>	

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PERSON CENTRED		
CDTQSE 25/180	<p>Patient Story – Physiotherapy</p> <p>Physiotherapy was not in attendance.</p> <p>The Group resolved that:</p> <p>a) HJ to follow up with JS if they have prepared a story to present at a future meeting.</p>	HJ
CDTQSE 25/181	<p>Patient Experience Feedback</p> <p>The Group resolved that:</p> <p>a) HL will circulate Civica reports when they are received.</p>	
CDTQSE 25/182	<p>Internal/External Awards</p> <p>The Group resolved that:</p> <p>a) There were no further awards successes to report.</p>	
CDTQSE 25/183	<p>Good News Stories</p> <p>The Group resolved that:</p> <p>a) No good news stories specific to directorates were reported.</p>	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 25/184	Regulatory Compliance Group Minutes June 2025	
ANY OTHER BUSINESS		
CDTQSE 25/185	<p>Radiology is scheduled to present its patient story at the next meeting.</p> <p>It was noted that NEWS 2 training will become mandatory for all clinical staff. Clinical staff will need to receive both the face-to-face training and undertake the ESR training module.</p>	
CDTQSE 25/186	<p>Date & time of next Meeting</p> <p>The next meeting will be held on 25th July 2025 at 10am via Teams.</p>	

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Cardiff and Vale
University Health Board

INFECTIOIN PREVENTION AND CONTROL GROUP

Tuesday 18th March 2025

Via TEAMS

MINUTES

Present:	
Jason Roberts (chair)	Executive director of Nursing
Abigail Holmes	Director of Midwifery and Neonatal Services Obstetrics & Gynaecology
Catherine Twamley	Director of Nursing SpCB
Chisom Uwaezuoke	Senior Nurse IPC
Dino Motti	Consultant in Public Health
Gavin Forbes	Consultant microbiologist, IPC doctor
Helen Bonello	Senior Nurse Professional Standards Nursing
Jane Murphy	Deputy director of Nursing
Mark Campbell	Head of Decontamination
Phillip Butterick	Epidemiologist
Rachael Daniel	Health and Safety
Rishi Dhillon	Consultant microbiologist, IPC doctor
Suzanne Rees	Lead Nurse CD&T
Yvonne Hyde	Head of Nursing IPC
Tea Racic (notes)	IPC Admin
Apologies:	
Alexandra Leyshon	Pharmacy
Claire Main	Director of Nursing OPAT
Richard Skone	Deputy Medical Director
Rhian Lewis	Interim Senior Nurse for Education, Quality and Safety MHCB
Tara Robinson	Interim Deputy Director of Nursing Mental Health Clinical Board

PART 1: PRELIMINARIES (<i>Chair</i>)		
1.1	Apologies for Absence	JR
	As noted above.	
1.2	Minutes of last meeting held on Wednesday 24 th September 2024	JR
	Minutes of the last meeting were accepted as a true record.	
1.3	Matters Arising and Action Points from 24 th September 2024	JR

	No actions arising from the notes.	
1.4.1	<p>General Acute Respiratory Illness Update</p> <p>Flu season started very early around the beginning, middle of December. Going into January, the flu has died down. Then towards the end of January was same with COVID. There are still few outbreaks. There are new updates to the General Acute Respiratory Illness guidance.</p>	YH/JR
1.4.2	<p>General MPox update</p> <p>There is no update. There are no new cases. All wales meeting is this afternoon and the health board meeting was yesterday. The health board is awaiting PPE trollies from shared services. There was an issue with the hoods that were ordered. Staff who have done Sheffield HCID PPE training continue to cascade training.</p> <p>There was an incident in England where medics went to conference. One of the attendees did not feel well and threw up during the event. He took the train back and then flew to Nigeria where he passed away and had Lassa fever. PHW colleagues did the contact training exercise.</p>	
PART 2: STRATEGIC AND OPERATIONAL DELIVERY OF THE IPC AGENDA		
2.1	<p>1. ICD Reports (UHW + UHL)</p> <p>GF reported for UHW.</p> <p>NICU MRSA Outbreak</p> <p>MRSA outbreak has been ongoing since April 2024. There are 18 cases in total and 1 bacteraemia infection. Four case were linked to previous outbreak, four cases were linked to the 2023 outbreak. There are lots of work streams ongoing at the moment, around cleaning both of the environment and of certain pieces of equipment. walk arounds have identified issues around high dust particularly. One of the main problems, however, has been around equipment cleaning. A number of pieces of equipment that are not being cleaned adequately. Outbreak group has previously discussed environmental screening and decided not to go ahead with it. Group initially decided against staff screening after some issues with a previous outbreak and staff screening, but it was decided to go back to it as purely as an epidemiological exercise.</p> <p>OXA 48 Outbreak</p> <p>OXA 48 has started back in November 2024. There are 9 cases in total, and 7 of those are linked by whole genome sequencing. There was one associated death with the outbreak. This was a patient who was known to be colonised, came into UHW septic, went to ITU and unfortunately died on ITU of a bacteraemia caused by this oxa 48 producing E coli. Number of issues noted during outbreak meetings and walk arounds and things by the IPC team. The environment on B5 is not great. Some issues around cleaning. There are lots of issues identified on some initial IP&C audits around bed frames not being</p>	GF/RD

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	<p>appropriately cleaned, mattresses not being clean, equipment not being cleaned. There were some issues around CRO screening. Recent audits have shown a significant improvement on that.</p> <p>RD reported for UHL</p> <p>PII of C. Diff on West 1</p> <p>Meeting was held on 5th March. Three cases in total which were linked. All three cases were discussed at the meeting. There are high risks for individual acquisition of C diff due to the fact of their disease and their antibiotic burden, which was deemed appropriate by the clinicians and the pharmacists on the call. There was no mortality associated with the cases. Audits have been undertaken, action plan implemented, the audits revealed areas of concern at the time around hand hygiene, commode and environment. There haven't been any further cases in several weeks, not anticipating a further period of increase instance meeting.</p> <p>2. IP&C Position Report</p> <p>IPC team has recruited for the band 6 position. IPC team continues to deliver education sessions across the health board. Cardiff and vale health board has second lowest rate in Wales. And second best performing in Wales for C. diff.</p> <p>3. HARP HCAI Performance Report</p> <p>The first graph shows CAV UHB monthly CDF numbers. Numbers have come down in the few last month but it spiked in December. Nationally there has been an increase of C. diff. multiple investigations are going on at the moment. CAV UHB has done well on MRSA. There was a blip over the last few months. There is no increase across the border. Increase for MSSA bacteraemia. CAV UHB is doing well on <i>E. coli</i>. Pseudomonas numbers have doubled compared to last year. Klebsiella same numbers as the last year.</p> <p>4. Internal Audit Report</p> <p>Only two outstanding actions from the internal audit report. Outbreak management policy has been brought to this meeting for sign off. YH has a draft annual report ready.</p>	<p>CU</p> <p>PB</p> <p>YH</p>
2.2	<p>New Guidance/application in the Health Board</p> <p>There was a notification of a listeria outbreak in England. No any new guidance in the health board.</p>	<p>YH</p>

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2.3	<p data-bbox="252 286 576 322">Clinical Board Reports</p> <p data-bbox="252 360 480 396">2.3.1 Medicine</p> <p data-bbox="252 434 1358 763">JM reported for medical clinical board. Again, the number of C. diff has gone up. E. coli has reduced by 41% to last year. ANNT core standards have remained high with average 98% compliance. PVC audits have averaged around 85%. Gloves Off campaign has been introduced in emergency and acute medicine. Medicine's cleanliness scores are low, specifically in Llandough. Bed audits remain an issue as well, largely due to frequent patient transfers and the inability to complete deep cleans as per IP and C guidelines due to operational pressures. Medical clinical group will bring an action plan within the clinical board report to the next meeting.</p> <p data-bbox="252 801 568 837">2.3.2 Surgery/Dental</p> <p data-bbox="252 875 1358 1128">CW reported for surgery clinical board. Surgery clinical board has had 0 cases of MRSA this year. E. coli has been reduced by 21%. The main concern is C. diff increase. There were 31 patients from April to December. These patients had risk factors such as over the age of 65, morbidities of the patients, multiple admissions over the last six months. They were discharged and a few days later readmitted to hospital. Number of patients had antibiotics. Good nursing ANTT compliance.</p> <p data-bbox="252 1205 624 1240">2.3.3 Specialist Services</p> <p data-bbox="252 1279 1358 1464">CT reported for specialist clinical board. Similar results for C. diff like other clinical boards. Up by 12 cases of C. diff compared to last year. Down 2 cases of MRSA compared to last year. One case MSSA less than last year. Reduction of 20 case of E. coli. doing well on Klebsiella, and Pseudomonas is up by 10 cases. Overall RCA return rate is 61%.</p> <p data-bbox="252 1496 560 1532">OXA 48 Outbreak B5</p> <p data-bbox="252 1570 1358 1720">Seven cases in total and linked by whole genome sequencing. One further patient awaiting typing. Robust Action plan focusing primarily on screening, beds and mattresses, environmental constraints and equipment. Planned expansion of footprint.</p> <p data-bbox="252 1756 1358 1973">There is currently an open NRI (ID 45048) in Haematology for Cryptococcal Meningitis. There is an ongoing joint investigation between Public Health Wales and the directorate. CB shows consistently high levels of ANTT compliance. Go live for 'Gloves Off Campaign' in Critical Care on January 20th. Significant change which will positively impact on patients and the environment.</p>	

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2.3.4 CD&T

SR reported for CD+T clinical board. Main focus of CDT is increasing ANTT compliance. There are 135 non-nursing staff that need ANTT training. A plea from our colleagues who work in medical engineering to come to the group and ask us all to remind people within the clinical boards that some of the stuff that gets sent back to medical engineering is really dirty. Tendable has been rolled out in CDT.

2.3.5 PCIC

No representative.

2.3.6 Children and Women

AJ has sent report for Children and women clinical board.

Please find attached women and children clinical board.



2.3.6 WCH IPCG
Clinical Board Feedba



2.3.7 Maternity and Neonatal

AH gave an update on maternity and neonatal. Island ward was closed last week due to norovirus outbreak. And was reopened on the weekend. PICU and NICU services are in escalation with NHS Wales Joint commissioning committee. Part of the reason is the NICU is in escalation is outlier status for NAP data. And one of them being blood borne infections in babies under born under 32 weeks. Since Jan 2023 a lot of work has been put into this. High acuity has improved and that resulted in the drop of blood borne viruses rate. NICU is no longer in outlier status. A lot of work with housekeeping around high level dust, blood gas machine, issues with the frequency of curtains being changed. Hand washing education with families. Parents are being screen if their baby is positive. Other part is for NICU to report on Caesarean Section Surgical Site Infection Surveillance. Which fed back every quarter to public health and they publish that data. Data is not where it needs to be and that is due to data collection. A lot of data is still collected through papers. Hopefully soon the digital programme will be available to capture and publish the data more easily.


2.3.8 Mental Health

No representative nor report.

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2.4	<p>ANTT Update</p> <p>Unable to get medical ANTT data. This seems to be an issue across Wales. All data is stored locally. Last health board ANTT meeting was cancelled due to low attendance.</p>	Verbal YH
2.5	<p>HCAI Delivery Board update</p> <p>The main focus of conversation was C. diff, a bit about antimicrobial stewardship. All Wales cleaning standards were discussed. They haven't come out yet.</p>	YH
2.6	<p>Antimicrobial stewardship</p> <p>Part of the antimicrobial stewardship agenda is to audit antimicrobial prescribing. It looks at what infection patients are diagnosed with and deciding to prescribe and then review within 48-72 hours. The algorithm has been updated in 2023. So, in terms of auditing the start smart and focus audit standards look at documentation, indication recorded and Is the prescription in line with the guidelines and then whether a review has been documented within 72 hours of start in that prescription? It also looks at the outcome of that review. Audits are done quarterly. Soon all the prescribing will be on Epma.</p>	RMac
2.7	<p>Tendable update</p> <p>HB gave an update on Tendable. Tendable will look into adding IPC risk assessment tool into the adult risk assessment booklet.</p> <p>Please find attached Tendable presentation.</p> <p> 2.8 Tendable IPCG Quarterly Report De</p>	HB
PART 3: CORPORATE ASSURANCE SUPPORT AND PERFORMANCE FRAMEWORK (REDUCTION EXPECTATIONS 2021/22)		
3.1	<p>Caesarean Section Surgical Site Infection Surveillance</p> <p> 3.1 CSSI 2023 Annual report - All v</p>	AH
PART 4: DECONTAMINATION AND INFRASTRUCTURE		
4.1	Decontamination Report	MC

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	<p>Decontamination team has been tasked to review all of the decontamination services that UHB currently provides. That includes STO, our services, endoscopy, community, dental, primary care, etcetera. The purpose of the piece of work is to ask the question can things be done better and can higher quality of standard be achieved? Currently paper is being developed. The three sterile service departments all maintain their accreditation to ISO 13485. Any non-conformances were raised to being closed down. The biggest risk UHB has been carrying it for at least three years is the Air handling unit that feeds the IAP room. In the HSDU we secured funding, the capital project was agreed. Plan to shut down, which is going to be the 12th for May to the 13th of June. The shutdown will be difficult but contingency plan will be used. MC attended Welsh Assembly Government decontamination group. From a capital replacement programme, funding was secured to replace the steriliser in the Hsdu. Secured funding to implement video laryngoscopy now into the Children's Hospital theatres. Nothing to report from the subgroups of the decontamination group. The STO, our service group, or the ultrasound governance group. Decontamination has a SharePoint page.</p> <p>4.2 Legionella in Water UHL – SBAR Legionella in Water UHL</p> <p>4.3 General Update on Facilities/Estates/Capital Planning</p> <p>AP sent his apologies.</p> <p>Please find attached General Update on Facilities/Estates/Capital Planning presentation.</p>  <p>4.2 and 4.3 IPCG March 2025 Paper.pp</p>	<p>AP</p>
<p>PART 5: INFECTION CONTROL POLICIES AND PROCEDURES</p>		
<p>5.1</p>	<p>5.1.1 Update on Current Position regarding Procedures for Noting</p> <p>5.1.2 Procedures and Protocols for Comment</p> <p>CJD procedure is brought for comments to the group.</p> <p>5.1.3 Procedures and Protocols for Ratification</p> <p>Outbreak procedure was brought here for ratification.</p>	<p>YH</p>

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PART 6: REPORTS FROM OTHER COMMITTEES/GROUPS

(For information only not, discussion)

6.1	Minutes of the Decontamination Group Meeting Minutes for information only.	MC
6.2	Antimicrobial Group Minutes Minutes for information only.	RM
6.3	Staff Flu Vaccination Update	DM
6.4	Water Safety Group minutes Minutes for information only.	YH
6.5	Public health Update	AA
6.6	HESG Update Health board will be reinstating HESG meetings. Minutes will be brought to IPCG.	YH

PART 7: GENERAL UPDATES/ISSUES

7.1

There are no general updates/issues.

DETAILS OF FUTURE MEETINGS

IPCG Meeting Date	Meeting times	Papers to be received by:	Papers for the meeting will be sent out by:
19/06/25	09:00-11:30	05/06/25	09/06/25

Action log
IPC team to do outbreak report.
IPC team to do a breakdown of RCA's
CB to include ANTT data for both medical and nursing staff
JR to contact PCIC and MH clinical boards
ECOD colleague needs to be included into ANTT conversations
Add HESG minutes under 6.1 section

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