Quality Committee 13.05.2025

Tue 13 May 2025, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:05
5 min

1. Standing Items

1.1. Welcome & Introductions

Ceri Phillips

1.2. Apologies for Absence

Ceri Phillips

1.3. Declarations of Interest

Ceri Phillips

1.4. Minutes of the Quality Committee Meeting held on 01.04.2025

Ceri Phillips

1.4 - Draft Quality Public Minutes 01.04.2025_cp (2).pdf (9 pages)

1.5. Action Log – Following the meeting held on 01.04.2025

Ceri Phillips

1.5 - Quality Committee Actions following 01.04.2025 (1).pdf (1 pages)

1.6. Chair's Action taken since last meeting

Ceri Phillips

None.

14:05 - 15:45
100 min

2. Items for Review & Assurance

2.1. Specialist Services Clinical Board – Assurance Report

25 mins *Mike Stephens / Tom Holmes / Jess Castle / Catherine Twamley*

2.1 - Assurance Report - Final (002).pdf (43 pages)

2.2. Quality Indicators Report

20 mins *Angela Hughes*

2.2a - Quality Indicators Report.pdf (3 pages)
2.2b - Quality Indicators Report May 25 - Copy.pdf (15 pages)

Chilcott,Rachel
08/05/2025 16:26:32

2.3. Learning from Mortality

20 mins *David Fluck / Aled Roberts*

2.3 - Learning From Mortality_010525.pdf (8 pages)

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

10 mins *David Fluck / Dan Crossland / Rim Al-Samsam*

- 2.4a - RCPsych invited review briefing paper.pdf (4 pages)

2.5. Quality Excellence Framework Board

10 mins *Jason Roberts / Ruth Jordan*

- 2.5 - SoFQE - Public Quality Committee [130525]1.pdf (5 pages)

2.6. Discharge Advice Letters (DALs)

5 mins *Aled Roberts*

- 2.6 - DALs SBAR QSE_V2.pdf (4 pages)

2.7. Board Assurance Framework (BAF)

10 mins *Matt Phillips*

- 2.7 - BAF.pdf (36 pages)

15:45 - 15:55
10 min

3. Items for Approval / Ratification

3.1. Policies

5 mins *Karen Gillespie*

i) UHB 529 - Policy for the Management of Suspected and Proven Neutropenic Sepsis in Adults

- 3.1a - Board & Committee Covering Report KG.pdf (2 pages)
- 3.1b - Neutropenic Sepsis Policy - final version 1.pdf (59 pages)

3.2. Cardiff and Vale of Glamorgan Suicide Prevention and Self-harm Strategic Plan 2025-2030

5 mins *Claire Beynon / Suzanne Wood*

- 3.2a - 20250513 QSE SPSHSP FINAL.pdf (4 pages)
- 3.2b - SPSH strategic plan 2025.pdf (28 pages)

15:55 - 15:55
0 min

4. Items for Noting & Information

4.1. Minutes

0 mins *Jason Roberts*

4.1.1. Clinical Board QSE Sub-Committees

- Medicine Clinical Board - 19.03.2025
- CD&T Clinical Board - 27.02.2025

- 4.1.1 - Minutes of the Medicine Clinical Board 19 Mar 25 v2.pdf (5 pages)
- 4.1.2 - CD&T- QSE Minutes 27.2.25.pdf (14 pages)

4.1.2. Safeguarding Steering Group - 21.03.2025

- 4.1.3 - SSG Final minutes 21.03.05.pdf (6 pages)

Chilcott,Rachel
08/05/2025 16:26:52

4.1.3. Infection Prevention and Control Group - 24.09.2024

4.1.4 - IPCG minutes 24.09.24.pdf (8 pages)

4.2. CAVUHB Primary Care Eye Needs Health Assessment (EHNA)

0 mins *Emma Cooke*

15:55 - 15:55 0 min

5. Items to bring to the attention of the Committee

Ceri Phillips

15:55 - 15:55 0 min

6. Agenda for the Quality Committee Private Meeting:

Ceri Phillips

i. *Private Minutes & Actions*

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

15:55 - 15:55 0 min

7. Any Other Business

Ceri Phillips

15:55 - 15:55 0 min

8. Review of the Meeting

Ceri Phillips

15:55 - 15:55 0 min

9. Date & Time of Next Meeting:

Ceri Phillips

24th June 2025 at 2pm via MS Teams

15:55 - 15:55 0 min

10. Declaration

Ceri Phillips

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

Chilcott,Rachel
08/05/2025 16:26:52

Minutes of the Public Quality **Committee**

Held on 1st April 2025 via MS Teams

To view the meeting: [CAVUHB Public Quality Committee 01.04.2025]

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Rhian Thomas	RT	Committee Vice Chair / Independent Member – Capital & Estates
Mike Jones	MJ	Independent Member – Trade Union
In Attendance		
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Matt Phillips	MP	Director of Corporate Governance
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
David Fluck	DF	Executive Medical Director
Angela Hughes	AH	Assistant Director of Patient Experience
Claire Beynon	CB	Executive Director of Public Health
Thomas Lancaster Kitchen	TL	Consultant Anaesthetist
Rhian Grapes	RG	Interim Senior Nurse – Trauma & Orthopaedic
Sara Williams	SW	Staff Nurse – Trauma & Orthopaedics
Clare Wade	CW	Director of Nursing – Surgery Clinical Board
Abraham Theron	AT	Surgery Clinical Board Director
Rachel Thomas	RT	Director of Operations – Surgery Clinical Board
Andy Jones	AJ	Director of Nursing/Midwifery - Children and Women's Clinical Board
Sarah Martin	SM	Research & Development Manager
Matthew Wise	MW	Locum Consultant in Intensive Care
Lisa Parry	LP	Infant Feeding Coordinator – Health Visiting
Catherine Bickerton	CB	Senior Nurse Health Visiting
Paula Davies	PD	Lead Nurse – Community Child Health
Lynne Topham	LT	South and East Cardiff Locality Manager - PCIC
Observers		
Lauranne Cullen	LC	Regional Director for Llais
Natasha Goswell	NG	Deputy Executive Nurse Director
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Akmal Hanuk	AH	Independent Member – Local Community

Chilcott,Rachel
08/05/2025 16:26:52

QC 25/04/001	**Welcome & Introductions**	**ACTION**

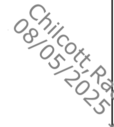
	The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	
QC 25/04/002	**Apologies for Absence** Apologies for absence were noted.	
QC 25/04/003	**Declarations of Interest** No declarations of interest were raised.	
QC 25/04/004	**Minutes of the Committee meeting held on 18.02.2025** The minutes of the Committee meeting held on 18.02.2025 were received. **The Committee resolved that:** a) The minutes of the meeting held on 18.02.2025 were approved as a true and accurate record of the meeting.	
QC 25/04/005	**Action Log following the Meeting held on 18.02.2025** The Action Log following the Meeting held on 18.02.2025 was received. QSE 24/11/009 - Equity, Equality, Experience and Patient Safety Action Plan Update - The Executive Director of Public Health (EDPH) noted that continued conversations with the Director of Digital Health Intelligence (DDHI) around how to improve equity data, and this had been suggested to Internal Audit to focus on in the following financial year. She noted that data around gender and age was good, but more data was needed around ethnicity and other protected characteristics. The Assistant Director of Patient Experience (ADPE) suggested she share survey information which had been nationally agreed across Wales, with feedback from Public Health. **The Committee resolved that:** a) The Action Log from the meeting held on 18.02.2025 was noted.	
QC 25/04/006	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QC 25/04/007	**Surgical Clinical Board – Assurance Report** A presentation was provided to the Committee on the challenges faced by the Enhanced Recovery Unit (ERU) at the University Hospital of Llandough (UHL), its background, development, and their current challenges. The Executive Medical Director (EMD) praised the great work undertaken but noted that more data was needed to demonstrate the benefits clearly. The Independent Member – Trade Union (IM-TU) asked how they managed staff given that the unit only operated three days a week. He also highlighted the difficulty in handling unexpected admissions to the unit, which complicated staffing management.	

Chilcott, Rachel
08/05/2025 16:26:52

	The Consultant Anaesthetist (CA) responded that the unit was staffed by ward staff for the three days, and that it could handle unplanned admissions if there was capacity. For unplanned admissions when the unit was closed, the fallback was the treatment transfer pathway to critical care services at University Hospital of Wales (UHW), although this was not without risk. He noted that creating beds and managing resources across different units incurred costs and affected staffing levels, highlighting the challenges in resource allocation. The Interim Senior Nurse – Trauma & Orthopaedic (ISN-TO) added that staffing was managed using an alternate week 1 and week 2 rota, which was incorporated into the overall allocated rota sent to staff. The Staff Nurse – Trauma & Orthopaedics (SN-TO) added that they had become proficient at reviewing both theatre and trauma lists to identify patients to ensure comprehensive planning. The CA noted that the number of unplanned admissions was higher than expected, which the original business case funding did not include. Currently, the project was funded by the Surgical Hub at UHL. The small unit made it challenging to measure changes in length of stay due to the diverse surgical backgrounds of patients. The EMD responded that it was important to look beyond the length of stay and outcomes of individual high-risk patients. Instead, they ought to focus on the overall performance of the entire unit. The Director of Nursing – Surgery Clinical Board (DN-SCB) noted that discussion highlighted the need to consider UHL as a site given it is where the highest acuity patients can be looked after. The Surgery Clinical Board Director (SCBD) noted that they needed to evaluate if the ERU reduced the number of patients needing transfer to UHW. He praised the Orthopaedic nurses who upskilled themselves during COVID whose care was vital to delivering the service. The DN-SCB presented the Surgery Clinical Board Assurance Report to the Committee which detailed the arrangements, progress and outcomes within the Surgery Clinical Board in relation to the Quality, Safety, and Patient Experience agenda during 2024/25. The EMD noted that whilst the mortality dashboard was a positive step forward, he noted the focus for clinical boards should be on specific areas to reduce mortality or gain a deeper understanding of it. The DN-SCB responded that the data would be available soon. The EMD asked where they needed to implement an improvement programme to monitor it through the dashboard. The DN-SCB explained that one of their current challenges was the absence of an Assistant Director for Quality and Safety, which was crucial for driving improvements and setting up standard ways of working within the Directorate. Efforts would be made this year to appoint someone. Given the four never events in 2024, the CC asked whether the actions being implemented would reduce the number of never events to zero.	

Chilcott, Rachel
08/05/2025 16:26:52

	The DN-SCB responded that they needed to adopt a radically different approach by engaging with daily practitioners, assigning responsibility for checklist parts, and establishing strong barriers. Specifically, no patients should leave the wards without a consent form. Achieving this required engagement from all staff groups. The SCBD noted that the majority of never events occurred because existing processes were not followed. The focus needed to be on engaging staff to follow these nationally established processes to prevent harm. Efforts would be made to relaunch these processes and potentially implement hard rules, although the goal would be for staff to engage willingly. The Executive Nursing Director (END) noted that it was crucial to have checking mechanisms in place throughout the patient pathway to prevent never events. The improvement work initiated by the surgery team aimed to instil accountability and responsibility amongst clinicians, and progress was being made through ongoing meetings. The EMD noted it required a cultural and behavioural shift rather than compliance. He suggested that it would be beneficial to see the plan once it was formed. **The Committee resolved that:** 1) The assurance provided by the Surgery Clinical Board QSE assurance report was noted; 2) The mitigation being taken to improve quality, safety and experience and reduce harm by the Clinical Board was agreed.	
QC 25/04/008	**Deep Dive – The Deteriorating Patient** The Associate Medical Director Patient Safety and Clinical Effectiveness (AMDPSCE) presented the Deep Dive on the Care of the Deteriorating Patient to the Committee, and summarised the following programmes of work: • National Early Warning Score 2 (NEWS2) • Treatment Escalation Plan (TEP) • Patient at Risk Team (P@RT) • Call for Concern • Resuscitation The EMD suggested that a map showing how all these services worked together and how their effectiveness was monitored would be beneficial. The AMDPSCE responded that the hope was that mapping and planning exercises would naturally occur with the implementation of NEWS2. The EMD noted it was important to get more upstream and engage with all teams early to understand and identify escalation processes with patients. The AMDPSCE responded that there was ongoing TEP work within the community, and the implementation of All Wales TEP forms would help to initiate conversations earlier and reduce unnecessary or unwarranted escalations for patients. The Senior Service Improvement Programme Manager (SSIPM) noted that the previous year, the UHB participated in the Safe Care Collaborative. This year, there would be a second collaborative focused on deteriorating patients, with visits to every UHB around the implementation of NEWS2.	


Chilcott, Rachel
08/05/2025 16:26:52

	The END explained that the goal of NEWS2 and acute deteriorating patient work was to enhance the skills of ward nurses. Success meant early detection and reducing the need for ITU or critical care. **The Committee resolved that:** 1) The assurance provided by the Implementation of P@RT and the Resuscitation service was noted; 2) The implementation of the Call 4 Concern service to meet the requirements of Martha's Rule was noted; 3) The improvement work to deliver NEWS2 and TEP with the health board wide education programmes was noted.	
QC 25/04/009	**Children Looked After Assessment Backlogs – Six Month Update** The Director of Nursing/Midwifery - Children and Women's Clinical Board (DN/MCWCB) provided a six-month update to the Committee on the backlog of Children Looked After (CAL) assessments. He noted the improvements made in processes and staffing but highlighted the ongoing challenges due to increased complexity and caseloads. The Committee Vice Chair (CVC) noted concern over the increasing number of referrals and complexity. There was a need to understand the influence CAVUHB have on assessments for patients outside of the area, and how reciprocal responsibilities were managed. The DN/MCWCB responded with the following: • The increase in cases over the past 4-5 years had been significant and largely due to communication issues. Effective communication around the 28-day notification had led to improvements. • Teams were working closely with other UHBs in Wales to recognise the importance of the 28-day assessments and to prioritise them. • However, the growing numbers and complexity remained challenging. Efforts were focused on working more effectively and efficiently to free up staff time to undertake more assessments. The CVC asked whether the measures discussed were intended to manage the performance for both children within the area and those outside of it. The DN/MCWCB responded that the measures primarily focused on those within the CAV area. He would try to obtain data by other UHBs to present next time. The END highlighted the following: • Significant progress had been made over the past 12 months in reducing the lists, despite the increasing complexity and number of young people requiring attention. • There were ongoing challenges in maintaining this progress. • Health visiting had been integrated into this effort, supported by school nurses, marking a first across Wales. • It may be useful to explore role redesign to further improve the situation • Timely assessments were important to mitigate risks. The END suggested they continue to address this issue in monthly executive reviews with the clinical board, and bring back another update to the Committee in six months. The CC expressed concern about the increase in the number of initial assessments awaiting completion within CAV which had risen from 47 in August 2024 to 99 currently.	

Chilcott, Rachel
08/05/2025 16:48:52

	In contrast, there had only been a slight increase of four outside of CAV. Whilst the number of reviews had slightly decreased, the out-of-area placements remained unchanged. The CC suggested that the progress being made was not sufficient and suggested that further internal review was needed. The EMD asked for clarity on the reasons behind the increase in workload and children in need. The DN/MCWCB responded with the following: • The reasons behind the increase were unclear. • Whilst the post-pandemic period brought significant challenges for families, the upward trend began in 2017. • The CAV CAL population was likely more significant due to the areas' demographics. • He suggested collaborating with other teams to gather comparative data from other UHBs. • The complexity of cases had increased, particularly post-pandemic, which aligned with trends seen in other dysregulated children and young people. The EMD suggested that by identifying the underlying causes, there may be alternative ways to support families more effectively. The CC suggested an update to be brought back to the Committee in six months to include data on the reasons behind the increase in workload for children looked after assessments and compare data with other Health Boards. **The Committee resolved that:** a) The contents of the paper and the actions taken to mitigate the risks associated with child health assessments was noted.	
QC 25/04/010	**Research and Development Six Month Update** The Research and Development Manager (R&DM) and the Locum Consultant in Intensive Care (LCIC) presented the research and development (R&D) six-month update, which highlighted the structure, activity, and successes of the research team within the UHB. They also discussed plans for future research and the importance of embedding research into clinical practice. The CVC asked about the commercial risk associated with not meeting the recruitment targets for both commercial and non-commercial studies, and whether it could lead to withdrawal/reduction of funding or penalties. The LCIC responded dismissed the importance of recruitment time targets set by organisations, and noted the following: • In commercial research, the primary concerns were how quickly study was set up, whether the required number of patients were recruited, and the quality of data entry. • The main risk of not meeting recruitment targets was that the company may not return for future studies. • Commercial studies often involved novel therapies for rare diseases which were more expensive, providing treatment options for patients who might not have other alternatives.	

Chilcott, Rachel
08/05/2025 16:26:52

	The R&DM explained that the financial model for commercial studies involved payment in arrears. The R&D review ensured the team had capacity for this work and plans for reinvestment into new staff or future plans. Efforts were being made to improve financial transparency and support research. Currently the risk was low. The EMD asked for feedback from the Committee on what additional information would be good to see in the research report. **The Committee resolved that:** 1) The progress made by Research to date was noted; 2) The content of this report and the assurance given by R&D was noted.	
QC 25/04/011	**Baby Friendly Breastfeeding Accreditation** The Infant Feeding Coordinator – Health Visiting (IFC-HV) presented the paper to the Committee and reported on the successful reassessment of the health visiting service for the Baby Friendly Initiative (BFI). She highlighted the achievements and plans for achieving the gold standard accreditation. The END congratulated the team on maintaining their accreditation for the past few years, and acknowledged the hard work involved. The CVC shared a personal reflection on how their baby benefitted greatly from the service between the initial accreditation and the reaccreditation period. As a new mother at the time, she had found reassurance and support provided by the service to be fantastic. The ADPE queried whether the interviews with mothers considered the diversity of the community. She highlighted the importance in ensuring that information was provided in appropriate languages and communication methods. The IFC-HV responded with the following: • Heath visitors obtained consent from mothers for the BFI assessment and ensured that diversity was considered. • Most mothers audited were diverse, with only a few requiring an interpreter. • The team conducted audits during visits to capture a broad range of mothers in the CAV area, not just typical breastfeeding mothers. • Currently, a study on breastfeeding challenges was being conducted with Cardiff Met University. • The BFI focused on population needs, and the management team used referral data to determine the need for local support groups and additional staff training. These statistics would help guide future efforts. The Executive Director of Public Health (EDPH) highlighted that the annual Director of Public Health report focused on children aged 0-5 years, with a chapter on breastfeeding. She noted that white mothers had the lowest breastfeeding uptake at around 61%, compared to 80% among the Asian population. She emphasised that breastfeeding should be a collective societal responsibility to make it a positive and comfortable experience. **The Committee resolved that:** 1) Baby Friendly would be added as a standard agenda item to the QSPE agenda and ensure data was reported through this and performance processes; 2) Additional staff resource to support the Infant Feeding Specialist Team was considered. This would enable the IF Coordinator to have ringfenced time to	

Chilcott, Rachel 08/05/2025 16:26:52

	strategically manage the Baby Friendly project and work towards achieving Gold sustainability. 3) In principle, UHB commitment to support the cost of maintaining Baby Friendly Accreditation (costs as above) 4) Staff to be provided with appropriate equipment when supporting a mother to breastfeed (small cost to service) 5) Training to upskill breastfeeding champions covering the infant feeding specialist clinic – Tongue Tie assessment course (non-accredited training £145.00, Level 3 accredited £185.00) Approx 10 staff. 6) Leadership course recommended for Infant Feeding Lead.	
	Items for Approval / Ratification	
QC 25/04/012	*No items.*	
	Items for Noting & Information	
QC 25/04/013	**Minutes from Clinical Board QSE Sub-Committees** **The Committee resolved that:** 1) The minutes were noted.	
QC 25/04/014	**Medical Records Tracking Update** **The Committee resolved that:** 1) The update was noted.	
QC 25/04/015	**Cancer Services – Audit Wales report** **The Committee resolved that:** 1) The report was noted.	
QC 25/04/016	**Smoking Cessation Internal Audit Report** **The Committee resolved that:** 1) The report was noted.	
QC 25/04/017	**Joint Commissioning Committee Quality Safety and Outcomes Highlight Report** **The Committee resolved that:** 1) The report was noted.	
QC 25/04/018	**Quality Committee Annual Report 2024/25** **The Committee resolved that:** 1) The annual report was noted.	
	Items to bring to the attention of the Committee	
QC 25/04/019	The END suggested that he would speak to the Clinical Boards to ensure that their QSE minutes are being fed into this Committee for noting.	
	Agenda for Private QSE Meeting	
QC 25/04/020	*i) Minutes and Action Logs from the Private QSE Committee on 18.02.2025* *ii) Any Urgent / Emerging Themes – Verbal Update*	

Chilcott, Rachel
08/05/2025 16:26:52

	Any Other Business	
QC 25/04/021	*No items.*	
	Date & Time of Next Meeting:	
QC 25/04/022	13th May 2025 at 2pm via MS Teams	

Chilcott,Rachel
08/05/2025 16:26:52

Action Log

Public Quality Committee

Update for meeting 13th May 2025
(Following the meeting held on 1st April 2025)

MINUTE REF	SUBJECT	AGREED ACTION	DATE BY	LEAD	STATUS/COMMENT
Actions					
QC 25/04/009	**Children Looked After Assessment Backlogs – Six Month Update**	For an update on Children Looked After Assessment Backlogs to come back to the Committee in six months – to include data on the reasons behind the increase in workload for children looked after assessments and compare data with other Health Boards.	**28.10.2025**	Jason Roberts / Andy Jones	**COMPLETED** *Added to the Forward Plan for the 28.10.2025 meeting.*
QC 25/04/010	**Research and Development Six Month Update**	Action from 01.04.2025 - for an update to come back to the Committee in six months.	**28.10.2025**	Sarah Martin / Matt Wise	**COMPLETED** *Added to the Forward Plan for the 28.10.2025 meeting.*
QC 25/04/011	**Baby Friendly Breastfeeding Accreditation**	For the Baby Friendly Breastfeeding Accreditation to be added to the Quality Committee agenda as an annual item.	**14.04.2026**	Jason Roberts / Lisa Parry	**COMPLETED** *Added to the Forward Plan for the 14.04.2026 meeting.*
Actions referred to Board / Committees					
Actions referred FROM Board / Committees					

<table>
<tr><td>Report Title:</td><td colspan="3">Specialist Services Clinical Board Quality Assurance Report</td><td>Agenda Item no.</td><td colspan="2">2.1</td></tr>
<tr><td rowspan="2">Meeting:</td><td rowspan="2">Quality Committee</td><td colspan="2">Public</td><td>x</td><td rowspan="2">Meeting Date:</td><td rowspan="2">13th May 2025</td></tr>
<tr><td colspan="2">Private</td><td></td></tr>
<tr><td>Status:</td><td>Assurance</td><td>X</td><td>Approval</td><td></td><td>Information</td><td></td></tr>
<tr><td>Lead Executive:</td><td colspan="6">Jason Roberts
Executive Director of Nursing</td></tr>
<tr><td>Report Author:</td><td colspan="6">Catherine Twamley
Interim Director of Nursing for Specialist Services</td></tr>
<tr><td colspan="7">Background and current situation:</td></tr>
</table>

This report provides details of the arrangements, progress, and outcomes within Specialist Services Clinical Board (SSCB) in relation to the quality, safety and patient experience (QPSE) agenda over the last 12 months (April 2024-2025). It highlights achievements, innovation and transformational work undertaken. It also describes key risks and their mitigating actions.

Governance structures and oversight have and continue to develop significantly. This is in alignment with the 6 domains of quality and enablers, as defined by the Duty of Quality Statutory Guidance 2023 (see visual below) and the strategic objectives of Shaping our Future Wellbeing (putting people first, providing outstanding quality, delivering in the right places and acting for the future).

The first section of the report gives an overview SSCB. It then focuses on headlines for each separate directorate. This is to depict the unique essence of SSCB and how across all areas, quality is delivered.

During the financial year 2024/25, SSCB comprised of 6 clinical directorates with associated clinical services and sub-specialties and 1 management directorate, holding a recurrent budget of £230m. There are 2035 whole time equivalent (WTE) staff in post. The

Chilcott, Rachel 06/05/2025 16:26:52

CB delivers a number of highly specialised services serving the South East region, South and mid-Wales region and wider all Wales population, as well as providing secondary care services to the local Cardiff and Vale population. These are predominantly NHS Wales Joint Commissioning Committee (JCC) commissioned. The JCC took over the function of Welsh Health Specialised Services Committee (WHSSC) on April 1st 2024. Services are structured through the directorates below:

- Critical Care
- Haematology, Immunology, Metabolic Medicine and NETs
- Nephrology & Transplant
- Neurosciences
- Cardiothoracic Services
- Artificial Limb & Appliance Service (ALAS)

The Supportive Care Service which consists of a palliative care consultant and clinical nurse specialists also sits within SS currently, the model having been developed within cardiology. It has now expanded to support renal, hepatology and also respiratory services having received funding from Welsh Government through Value Based Health Care. Currently the Supportive Care Service sits outside of a defined directorate. It is important to note however that a new strategic vision for improvement and modernisation of end-of-life care in Cardiff and Vale University Health Board (CAVUHB) will be launched in the coming months with support from MacMillan Social Finance funding. Expansion and integration of Supportive and Palliative Care services will inevitably involve increasing collaboration with PCIC and CB realignment for this service.

Previously the CB developed and had governance responsibility and oversight of the Integrated Assessment and Care Unit (IACU), 60+ beds within the Lakeside Wing Building which opened in October 2022. As part of ongoing planning work and the Acute Site Operational Programme 2024/2025 within the UHB, IACU made the synonymous transition to sit with Medicine CB in August 2024.

Discussions have been ongoing for a number of months to align Stroke Services with Neurology with a view to strengthening and improving the service. Therefore, there is a proposal to move Stroke out of Medicine CB and into the Neurosciences Directorate within SS. A task and finish group has been established in partnership with Trade Unions and People Services to work through this change and what the new structure will look like. The consultation period for those staff affected ends Sunday May 4th 2025.

This report provides assurance of the progress being made within the SSCB regarding:

- The Welsh Government Quality Delivery Plan for the NHS in Wales
- The CBs operational plan, IMTP, priority deliverables and choices
- Leadership and the prioritisation of the QPSE agenda within an open culture
- Ongoing review, monitoring, and management of risk
- Infection, Prevention and Control Annual work programme
- Health and Care Standards
- Financial and information governance
- Organisational development and workforce planning
- Patient safety culture
- Quality governance arrangements
- Promoting a positive culture for staff engagement, development and the understanding of everyone's responsibility for safe, quality care

Chilcott, Rachel
08/05/2025 16:26:52

Quality, Safety and Patient Experience

The CB 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 Datix reporting system and the risk register.

Assurance is received via the robust mechanisms which are in place such as the UHB's internal audit processes, the nursing specific dashboards to include Tendable, AMaT, the SSCB Quality, Safety and Experience (QSE) Committee and formal business, decision making and governance meetings at CB and directorate levels.

The CB received a positive internal audit report in October 2024. Key matters now being addressed are a review of terms of reference (ToR) for decision-making groups and governance forums and documentation of key actions. This has led to the increased use of action logs supported by Copilot.

The nursing dashboards used across the organisation have also been strongly adopted within SS and are discussed in more detail further on in this report.

AMaT allows all the learnings from investigations and clinical audits to be stored securely in one place and can be accessed to give assurances and demonstrate service improvement. Audits are not linked however and it can be a challenge to identify themes. The next steps for the CB are to work with the Patient Safety Team to create a CB template to assist with this.

The QSE Committee and formal business meetings have strong multidisciplinary representation and are fully minuted.

The QSE Committee is a formal and well-established group that meets every 3 weeks. It is co-chaired by the Medical Lead for Quality and Safety, Mat Davies who is a Consultant Nephrologist and the interim Director of Nursing (DON) for Specialist Services, Catherine Twamley. There is good engagement from core teams that span across each of the directorates. Standing attendees also include the Infection, Prevention and Control Team, the Health and Safety Team, the Pharmacy Team, Resuscitation Services, the Patient Safety Team and UHB mortality lead who are regular contributors to the agenda too. The CB is also fortunate to have a Band 7 QSE Facilitator in post, Tracey Vine.

In addition to the frequency with which they are convened, these meetings are rotated between days and times so that clinicians with fixed clinical commitments have opportunity to attend and contribute to the safety culture within the CB. This also allows for the general optimisation of attendance. The agenda allows each directorate to share their quality improvements and wellbeing initiatives alongside items for discussion and escalation.

Health and safety is incorporated into the QSE meeting. Previously this has been the focus of every third meeting. Moving forward it will be scheduled to synchronise more closely to the UHB Operational Health and Safety Group meetings. Other key attendees include the fire advisor and other individuals and / or departments, for example representatives from the Capital, Estates and Facilities Team, are also invited as indicated.

Chilcott, Rachel
08/05/2025 16:26:52

SSCB also have an Infection, Prevention and Control (IP&C) Group that meets bi-monthly and reports into the QSE Committee. The IP&C Group has its own formal terms of reference and is minuted with a range of stakeholders who attend in addition to a nursing and medical representative from each directorate, to ensure excellent engagement and alignment with the overarching quality and safety agenda. The aim of this approach is to

draw themes and learning opportunities together so that actions, learning and service developments can be shared collaboratively.

Nationally Reportable Incidents (NRIs) and Incident Management

Between January 1st 2024, and April 1st 2025, 21 NRIs were submitted to the NHS Executive within SSCB. Upon further review, 4 incidents were downgraded as additional information provided assurance that they did not meet the NRI criteria, 3 of these in 2025. In addition to this, a number of incidents initially graded as severe and thought to potentially be an NRI, have been investigated as a matter of urgency and subsequently downgraded. This demonstrates the thorough review process in place to ensure accurate reporting.

A total of **3 Never Events** were reported:

- Wrong route medication administered
- Misplaced nasogastric (NG) tube
- Retained object

Fortunately, the Never Events all resulted in no harm to patients.

The main themes of NRIs included:

- Assessment, Investigation, Diagnosis: 2 incidents
- Pressure Damage, Moisture Damage: 1 incident
- Treatment, Procedure: 7 incidents
- Patient/Service User Death: 3 incidents
- Equipment, Devices: 2 incidents
- Medication, IV Fluids: 1 incident
- Infection Prevention and Control: 1 incident

At the time of writing this report, the Clinical Board has **18** open NRIs, with 1**2** overdue. Notably, 2 of these overdue NRIs have been pending for over a year. The overdue NRIs are being actively managed, with specific actions taken to address the underlying issues and learning points identified in regard to the delays.

There has been an increase in open NRIs over the last year, reflecting a proactive reporting culture. This commitment to transparency ensures that all incidents are identified, escalated and addressed promptly. However, there is also variability in the number of NRIs closed each month which reflects the challenges in maintaining a consistent closure rate. The rise in overdue NRIs, particularly those pending for over a year, also underscores the complexity of some cases and the necessity for improved incident management strategies. Whilst this is being actively managed, there is a clear need for enhanced processes to prevent delays and ensure that all incidents are resolved within appropriate timeframes. It also highlights the need for ongoing efforts to streamline the review process and ensure timely resolution of incidents. To this end, a trial of a new weekly NRI and Datix checkpoint clinic is to commence from May 2025. This is a collaborative approach with the Patient Safety Team with a view to ensure the quality and timeliness of incident resolution, further strengthening our commitment to patient safety and care excellence.

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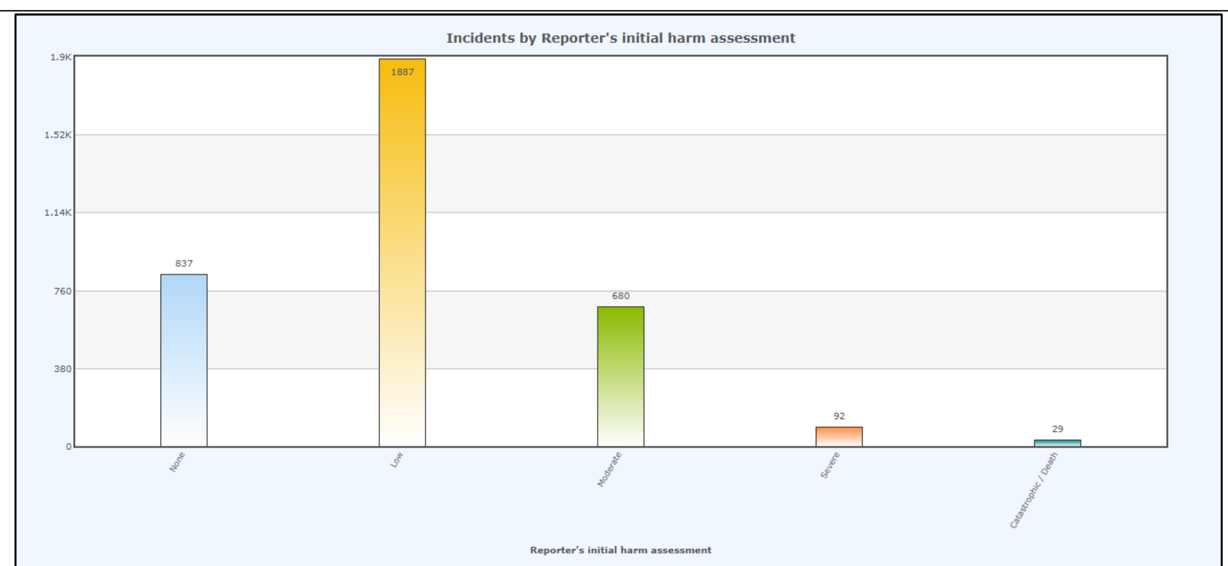
08/05/2025 16:26:52

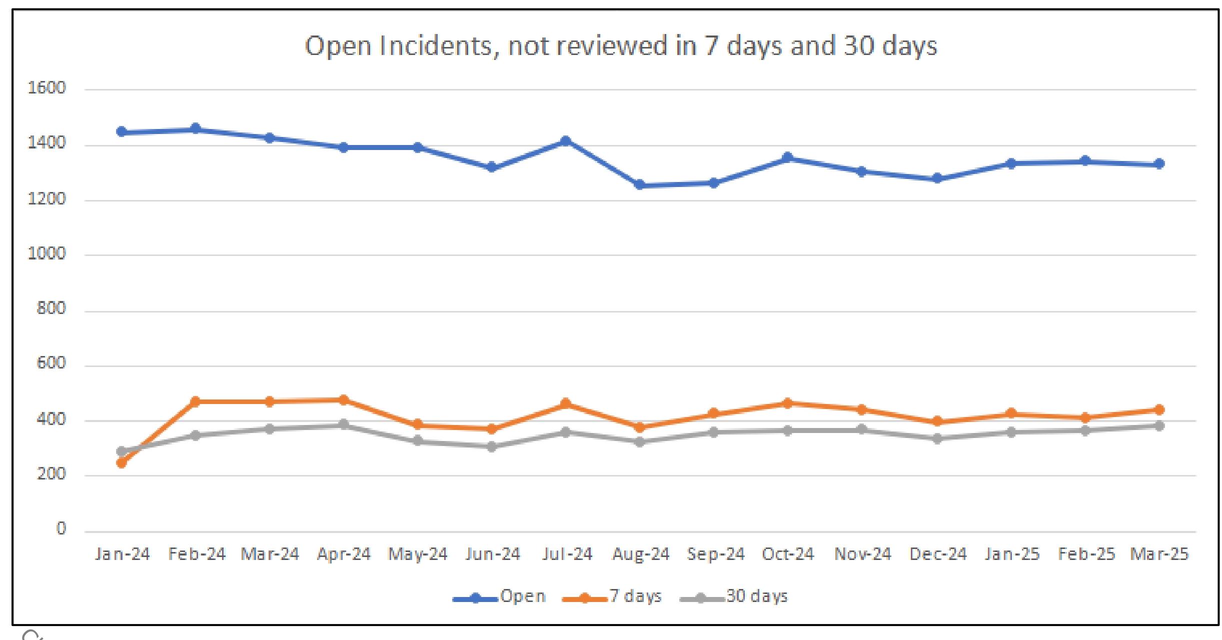
Datix/ Patient Safety Incident Management



The bar chart above provides a breakdown of incidents based on the initial harm assessment by the reporter.

- No Harm: 837 incidents were assessed as causing no harm.
- Low Harm: 1,887 incidents were assessed as low harm.
- Moderate Harm: 680 incidents were assessed as moderate harm.
- Severe Harm: 92 incidents were assessed as severe harm.
- Catastrophic Harm: 29 incidents were assessed as catastrophic harm.

This suggests that while there are many incidents, most do not result in severe harm. Upon reviewing all incidents categorized as severe and catastrophic harm, it was found thar many of them did not truly meet the criteria for these harm levels. This discrepancy highlights the need for ongoing training and calibration of harm assessment criteria to ensure accurate and consistent reporting. Immediate review of each of these and associated implications has also impacted on the timely management of true NRIs.



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The number of open incidents fluctuated over the period, starting at 1447 in January 2024 and ending at 1330 in March 2025. The highest number of open incidents was recorded in February 2024 (1459), while the lowest was in August 2024 (1254). This fluctuation indicates variability in incident reporting and management throughout the year. The data shows a significant number of incidents not reviewed within the 7-day and 30-day benchmarks.

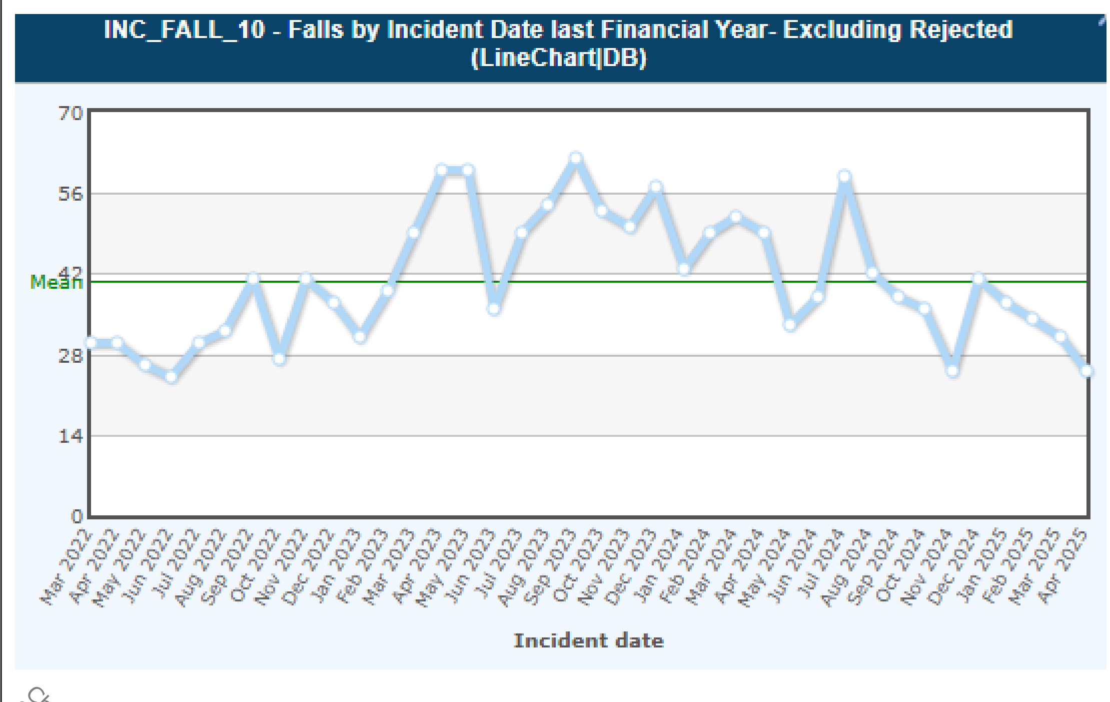
The overall trend in open incidents reflects a robust reporting culture, ensuring that incidents are consistently identified and logged. However, the data also highlights the need for ongoing efforts to improve the timeliness of incident reviews. It must be noted however that this data includes historic incidents and related challenges in regard to closure.

The arrival of the new Band 7 QSE facilitator in mid-April made a significant impact, contributing to improvements in the timeliness of incident reviews and driving progress in incident management processes. Additionally, targeted support and training is in place to address areas with the most open and unreviewed incidents, supported by the Patient Safety Team. This collaborative effort aims to enhance the skills and knowledge of the clinical staff.

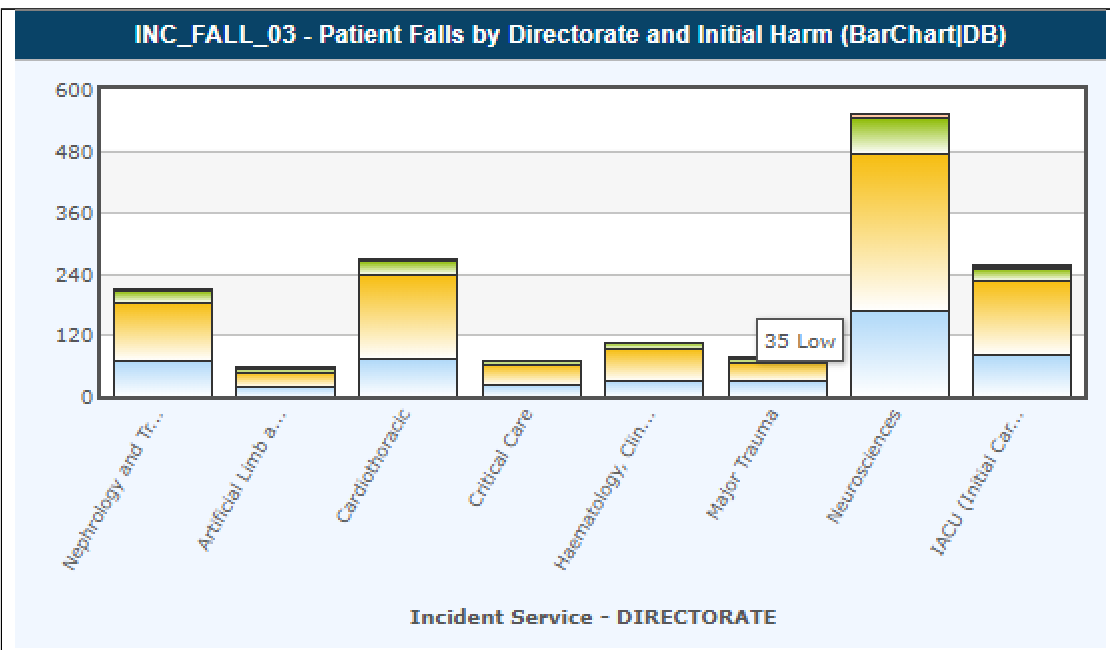
Falls

Falls are the most reported incident within SSCB. As the graph below demonstrates, there was a notable increase in numbers in 2023 into 2024. This led to education and awareness work to include wide sharing of focused review and scrutiny panel learning, which is likely to have contributed to the latter improvement in the position. A deep dive review was also undertaken in the Neurosciences Directorate where significantly more falls are reported. Previously, staffing challenges were considered a contributing factor although this is no longer the case. Their patient cohort however remains a key component. This is also a theme that is particularly relevant in Major Trauma. Consequently, a review of the establishments for these areas in conjunction with temporary staffing spend for enhanced supervision is planned to explore opportunities for more prudent working.

To note, over the last year, no injurious fall has been found to have caused severe harm and be NRI reportable to date. A patient unfortunately sustained a fall and subdural haematoma on B4N in April 2025 however. A focused review and fact finding has been undertaken and an injurious fall scrutiny meeting has been convened to review.



Chilcott,Rachel
08/05/2025 16:26:52

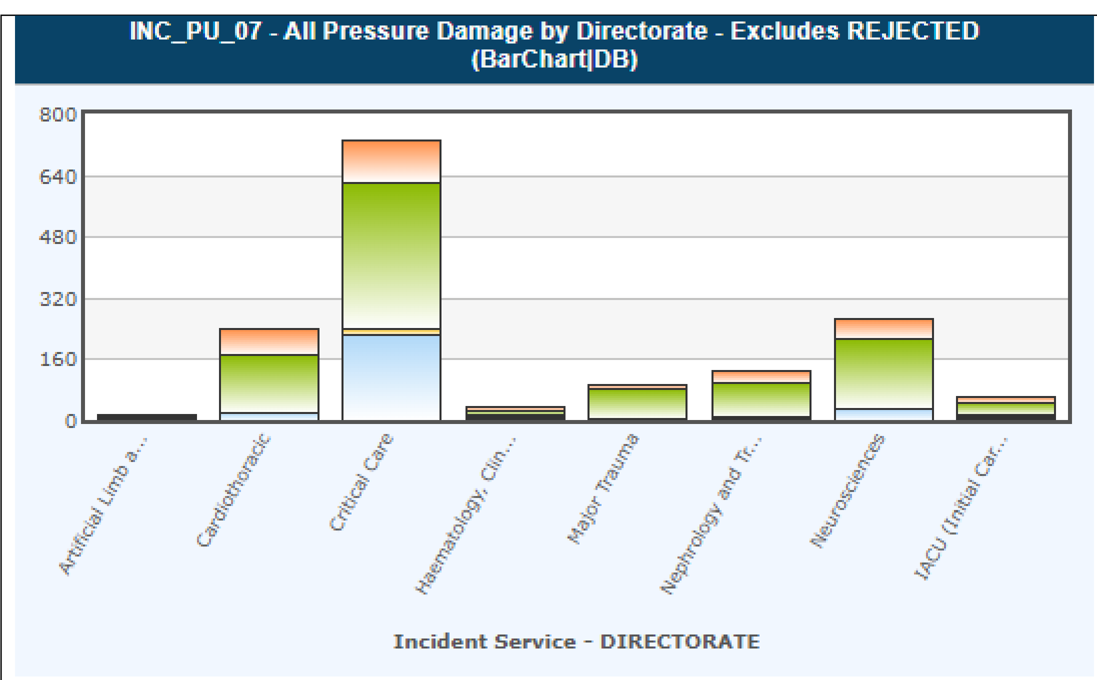


Pressure and Tissue Damage, Reduction and Prevention

Over the past year, SSCB has continued to develop and refine its pressure damage scrutiny process, which aims to reduce avoidable pressure damage through shared learning and collaborative efforts. The CB has its own Pressure Damage Scrutiny Panel. The panel's quorum consists of a tissue viability nurse, a representative from the Patient Safety Team, a senior nurse, and the Q&S facilitator.

The panel conducts focused reviews to scrutinize incidents and determine whether they were avoidable or unavoidable. This process informs the Datix system, ensuring timely follow-up and providing shared learning opportunities for the directorates and the CB. The efforts of this group have led to significant improvements in identifying and addressing pressure damage incidents. This year, only one avoidable pressure damage incident has been reported, demonstrating that the actions taken are showing positive results. Additionally, there has been a lot of cross-directorate sharing of good practice, which has further contributed to the reduction in avoidable pressure damage.

Due to recent unanticipated staff absences of quorum attendees in 2025, a backlog of cases has however accumulated. To address this, additional staff have been assigned to support the group in clearing the backlog and to enhance and make the process more resilient moving forward, without reliance on the continuous presence of specific individuals. This initiative is designed to ensure the continued effectiveness of the scrutiny panel and uphold high standards in pressure damage management.



Safeguarding

At time of writing this report, the CB currently has 16 safeguarding referrals open. This is the lowest run rate for the last 12 months. Of these, 8 relate to pressure damage (pending scrutiny panel) and 4 are historic with the health lead practitioner (HLP) no longer being in post. An AS2 is outstanding on these to indicate completed, and they have therefore been reallocated following a recent CB Safeguarding Review Clinic and validation. All safeguarding investigations are led by health lead professionals with appropriate actions taken.

There are 9 professional concerns currently open, all being progressed and managed appropriately through the correct processes.

SS CB have good mandatory safeguarding training compliance at 81 % for Adult L2 training, 70% for domestic abuse training and 77% MCA training compliance.

Safeguarding is a standing item on the QSE Committee agenda with a focussed meeting being dedicated to such at regular intervals as indicated by agenda items. These have included, for example, a focus on the procedural response to unexpected death in childhood (PRUDiC), following a delay regarding such in response to the death of a patient under 18 within the CB last year. Also, having support an audit of AS1s submitted within the CB, a senior nurse presented the results at a safeguarding focused QSE meeting and in conjunction with this and following discussion, devised an exemplar AS1 which was shared for learning and information.

Infection, Prevention & Control

SSCB are fully engaged with the expected reduction figures for all healthcare acquired infections and the associated challenges. Environmental, hand hygiene and bare below the elbow audits, in addition to IP&C audits on Tendable, are undertaken monthly to ensure standards are maintained. As aforementioned, the CB has its own IP&C Group that meets bi-monthly. The purpose of these meetings is to drive forward the UHB IP&C agenda with multidisciplinary input and assign specific responsibilities captured in our health care acquired infection (HCAI) action plan for reduction in bacteraemia, updated at every

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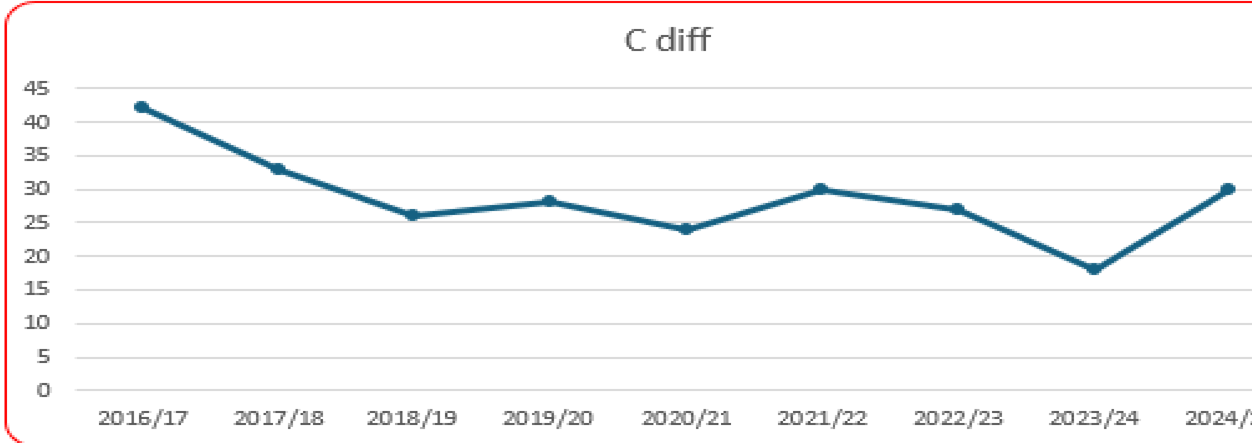
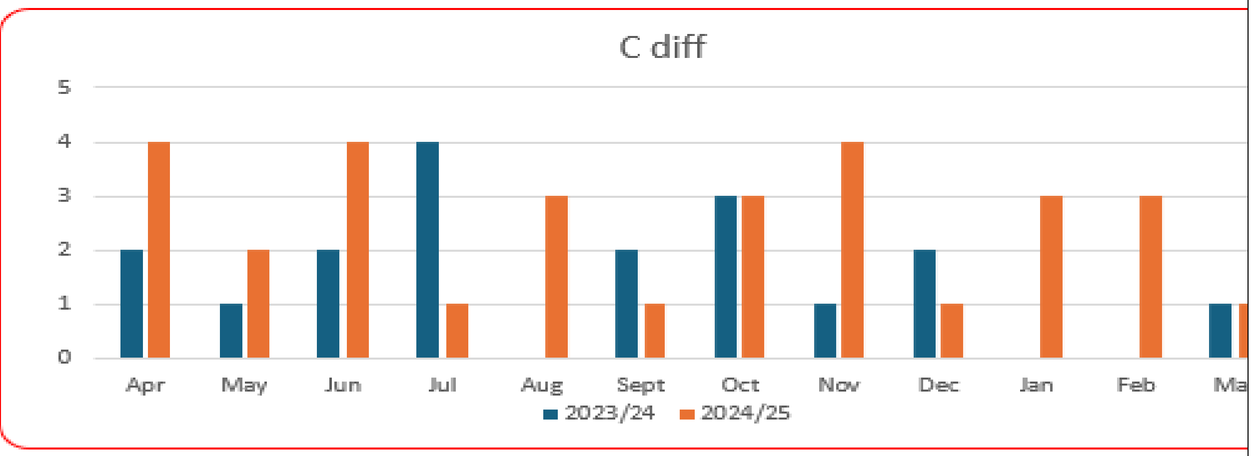
08/05/2025 08:26:52

meeting. Each directorate also takes it in turn to present something relevant for example a patient story, IP&C initiative or any IP&C related shared learning. The group then determines actions to improve outcomes. Presentations over the last year have been varied and interesting. They have included:

●RCA presentations from ward mangers
●an overview of C-difficile cases in Haematology,
●the 'Gloves Off Campaign',
●MRSA screening in Neuro,
●SOP for Decontamination of Ultrasound Transducers in Critical Care
●CRO screening
●line insertion and management,
●preparedness for MPOX

Clostridium Difficile (C. diff)





- There were a total of 30 cases for the 2024/25 financial year (Apr 24 - Mar 25), 67% more than the equivalent period in 2023/24 and 8 cases over the reduction expectation
- Hot spots were Haematology and Critical care

MRSA

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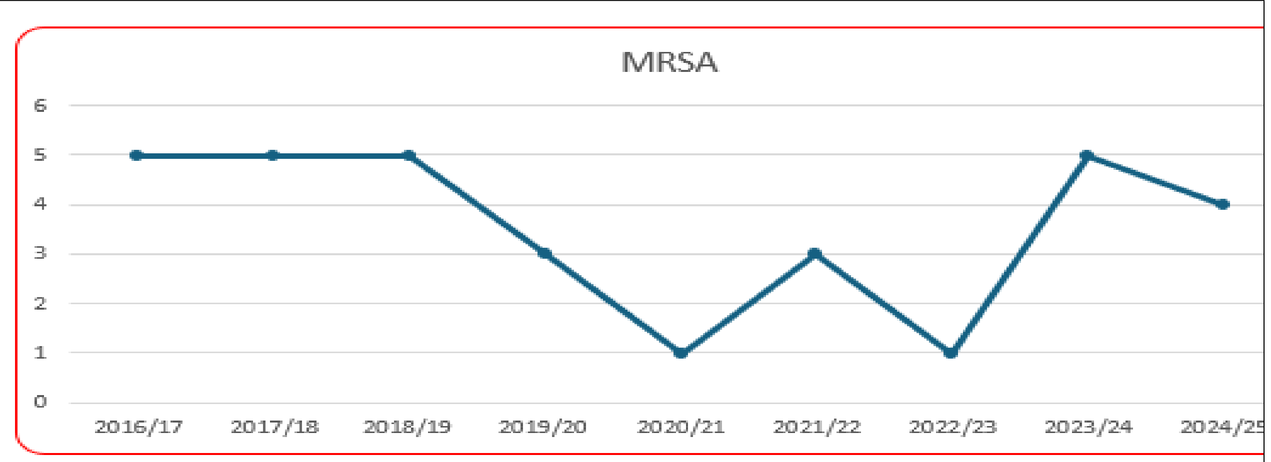
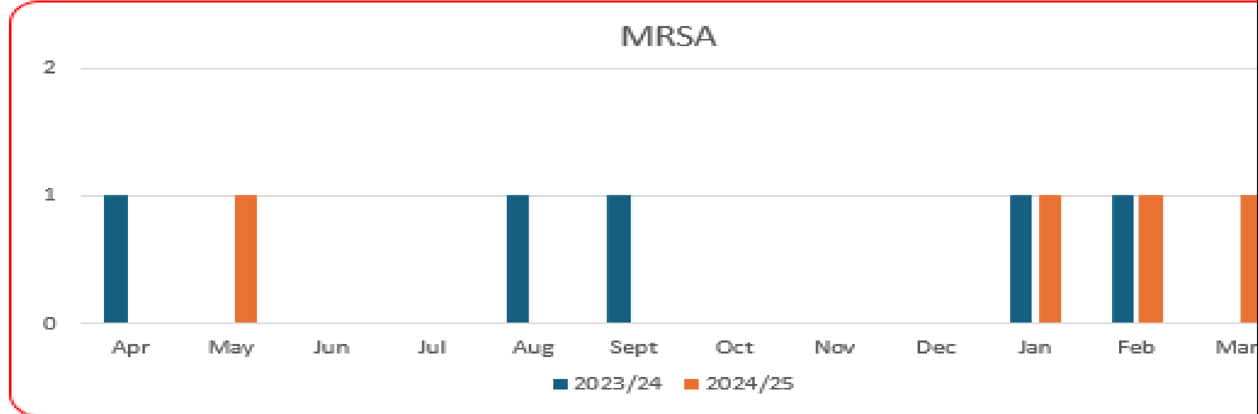
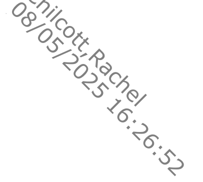
08/05/2025 16:26:52





- The total number of cases of MRSA Bacteraemia was 4 in SS CB (Apr 24 - Mar 25). This is 20% less than the equivalent period in 2023/24 but the reduction expectation for this period was 0 cases, thus the number of cases is 4 cases over.

MSSA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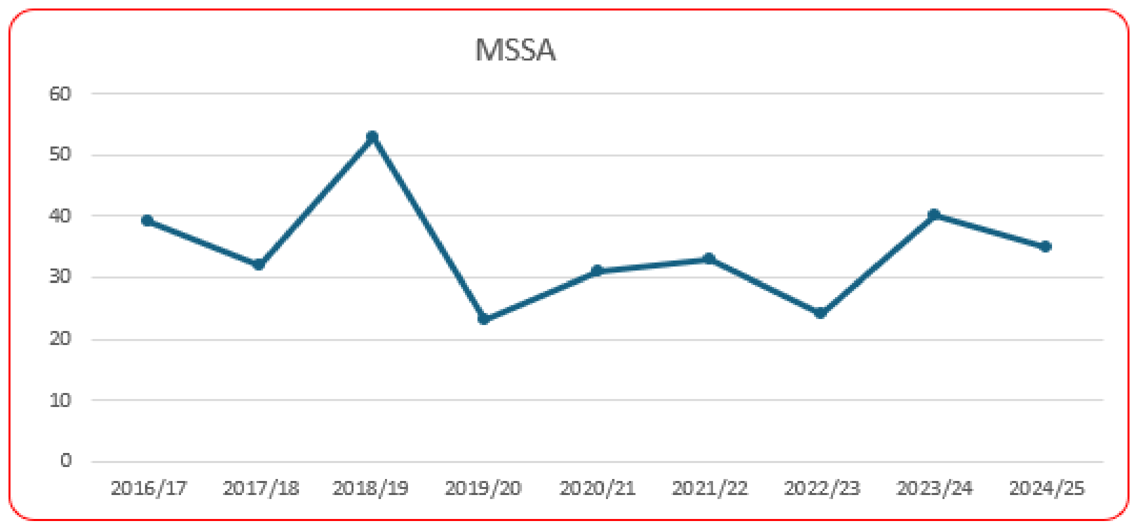
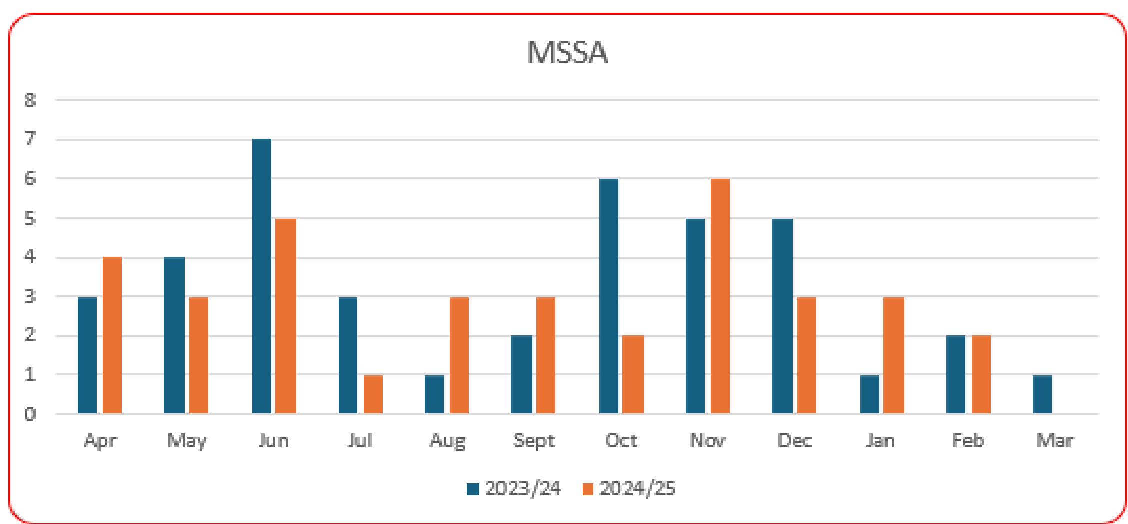




- There were a total of x35 cases (Apr 24 - Mar 25), which is 12% less than the equivalent period in 2023/24. Although the reduction expectation for this period was not met.

Bacteraemias and Nephrology

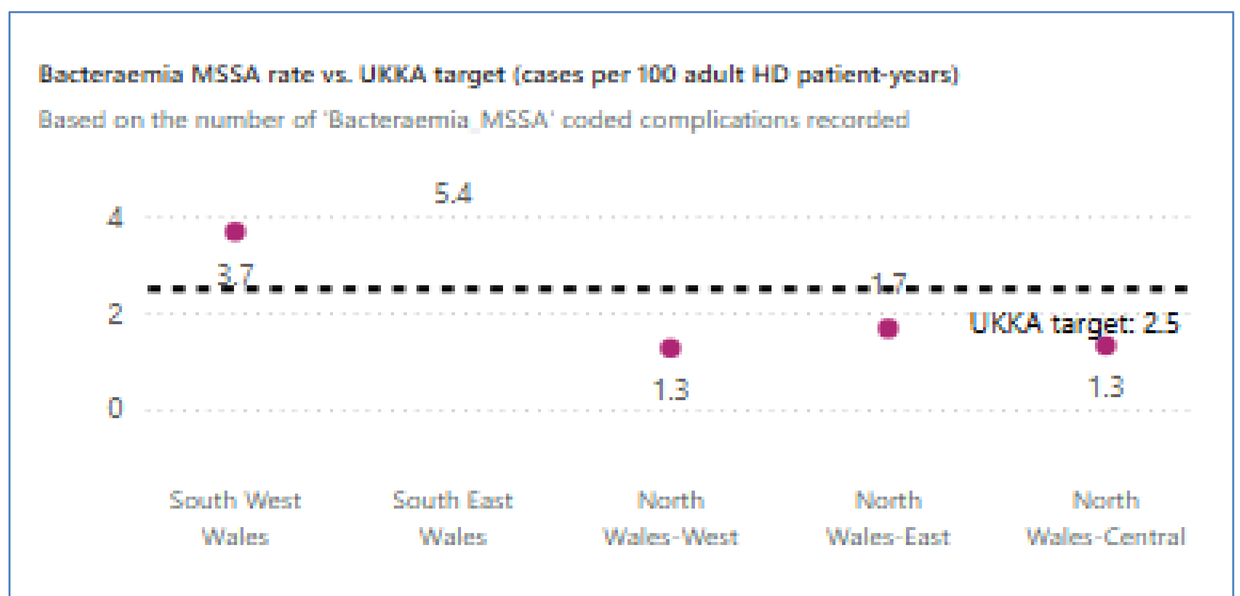
Nephrology continues to see a high number bacteraemias, particularly MSSA, associated with line infections. This is despite RCAs being undertaken, findings reviewed and actions and interventions being put in place to address any learning. It does need to be recognised that this a cohort of patients with multiple comorbidities and shared responsibility for line care. The position however has led to a full review of the patient pathway and improvements to include:

- Redesign and configuration of the treatment room on B5
- Bespoke line insertion packs
- Structured education of sterile practice to all members of staff who undertake line insertions
- Competency based learning and assessment for those supporting line insertion procedures
- Review of ANTT practice, with support from Practice Development Team
- Redesign of dialysis line care plans
- Bespoke education to ward-based staff regarding bacteraemias and implications for patients

Chilcott, Rachel
08/05/2025 16:06:53

- Review of decolonisation techniques/procedure pre and post line insertion

South East Wales remains an outlier however despite these efforts. The directorate will therefore be focusing on this and continuing work in this area with an MDT approach, to also include their independent service providers.



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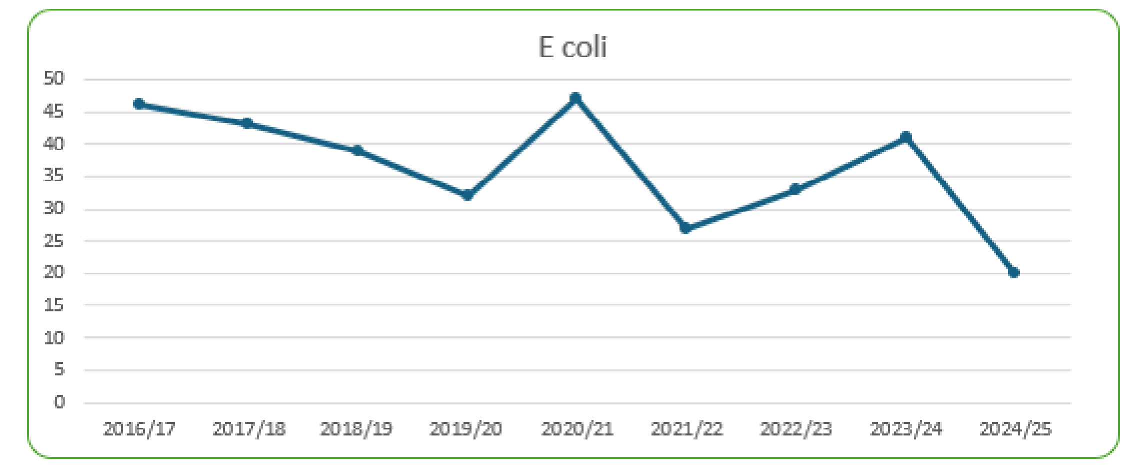

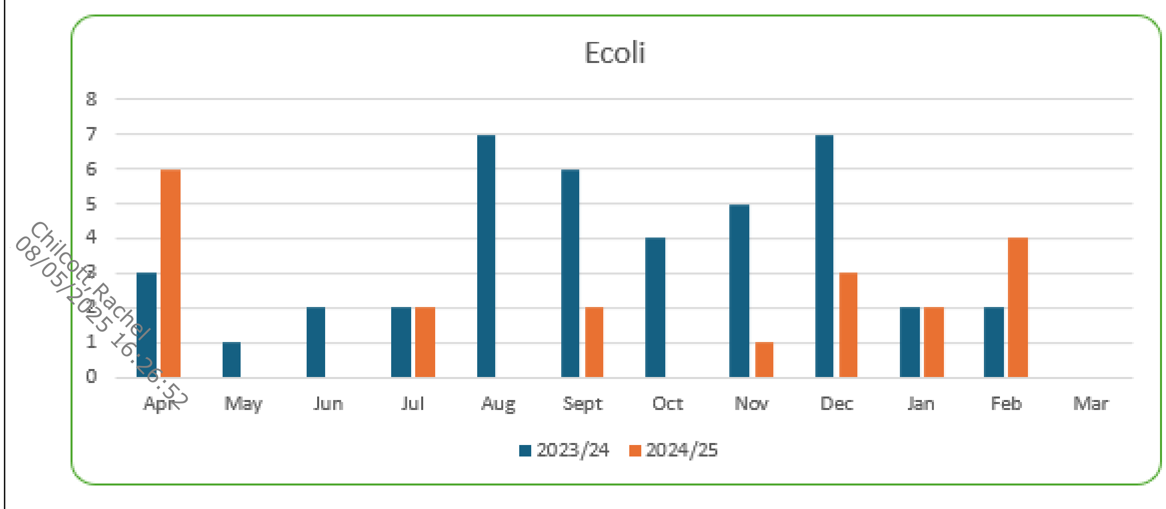

Chilcott, Rachel
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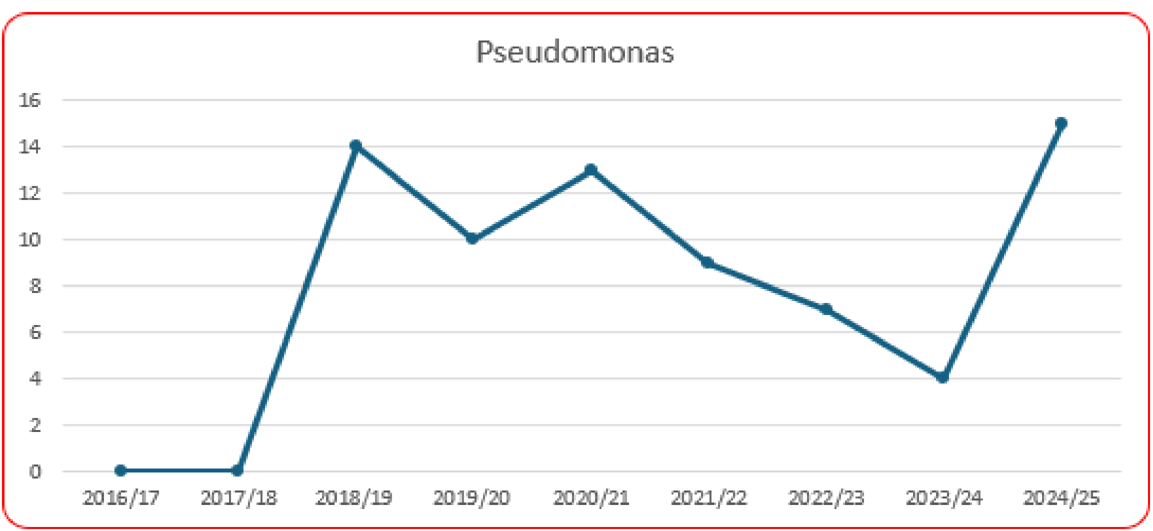
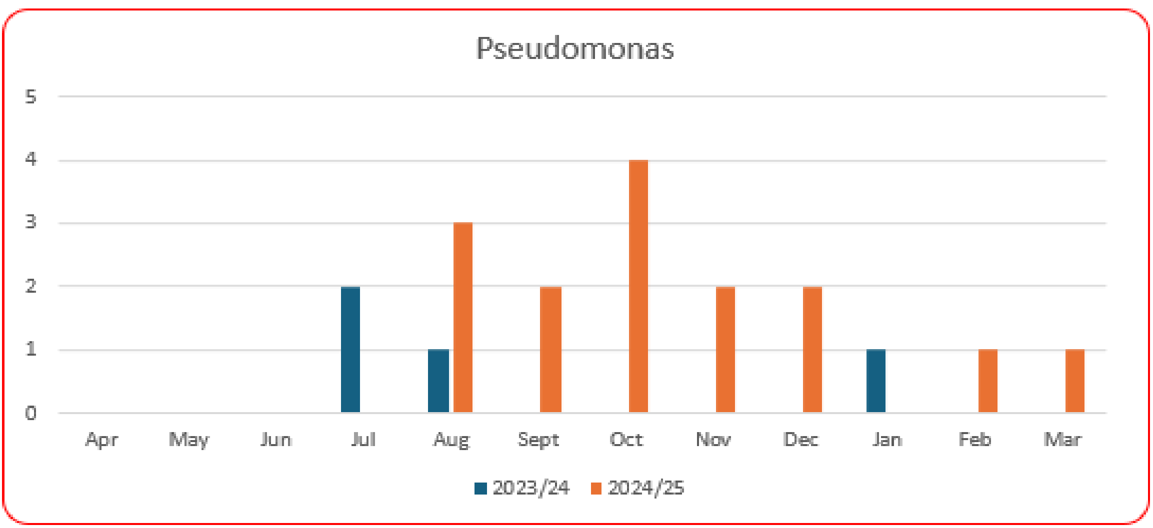
- There were a total of x20 cases for the 2024/25 financial year (Apr 24 - Mar 25), which is 51% less than the equivalent period in 2023/24.

Pseudomonas

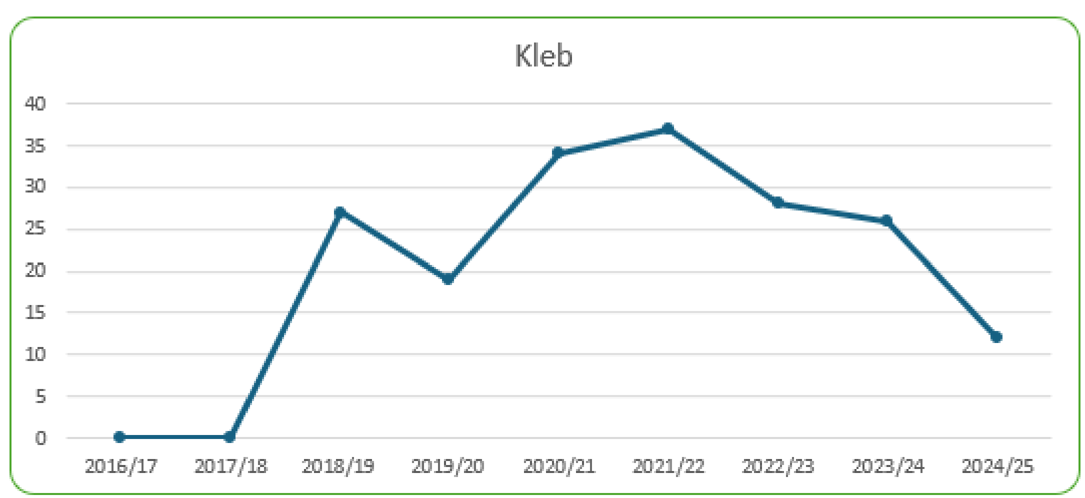


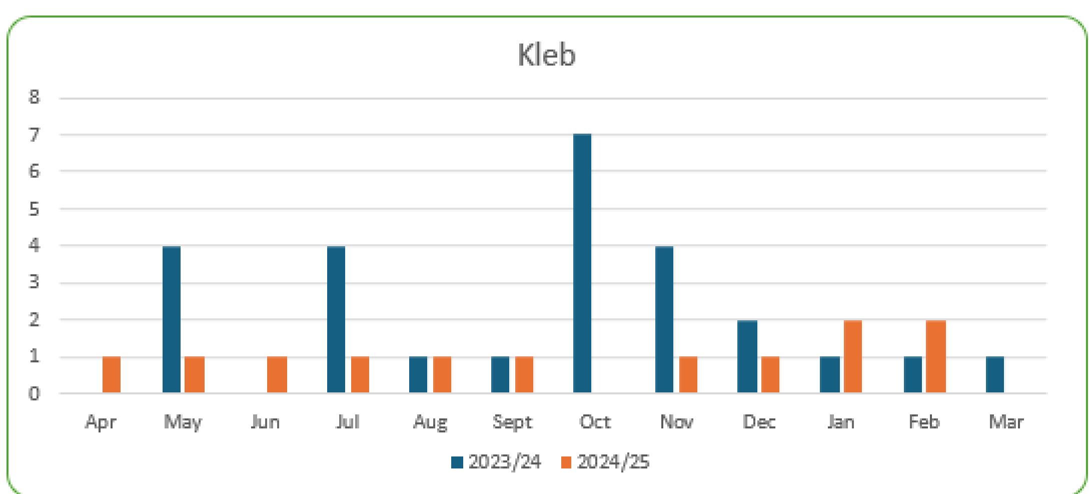


- The were a total of 15 cases (Apr 24 - Mar 25), 275% more than the equivalent period in 2023/24
- B4 Haematology (H) was a hotspot with 8 out of the total number of cases and an outbreak. The majority of these were attributed to PICC line infections however, there were no changes to practise regarding insertion or maintenance. Water sampling of the unit was undertaking, and some remedial work of outlets was undertaken where water sampling identified raised counts of Pseudomonas. Genome typing of isolates was also undertaken which showed no genomic link therefore indicating no transmission event had occurred. There have been no cases since December 2024

Klebsiella

Chilcott, Rachel
08/05/2025 16:35:52



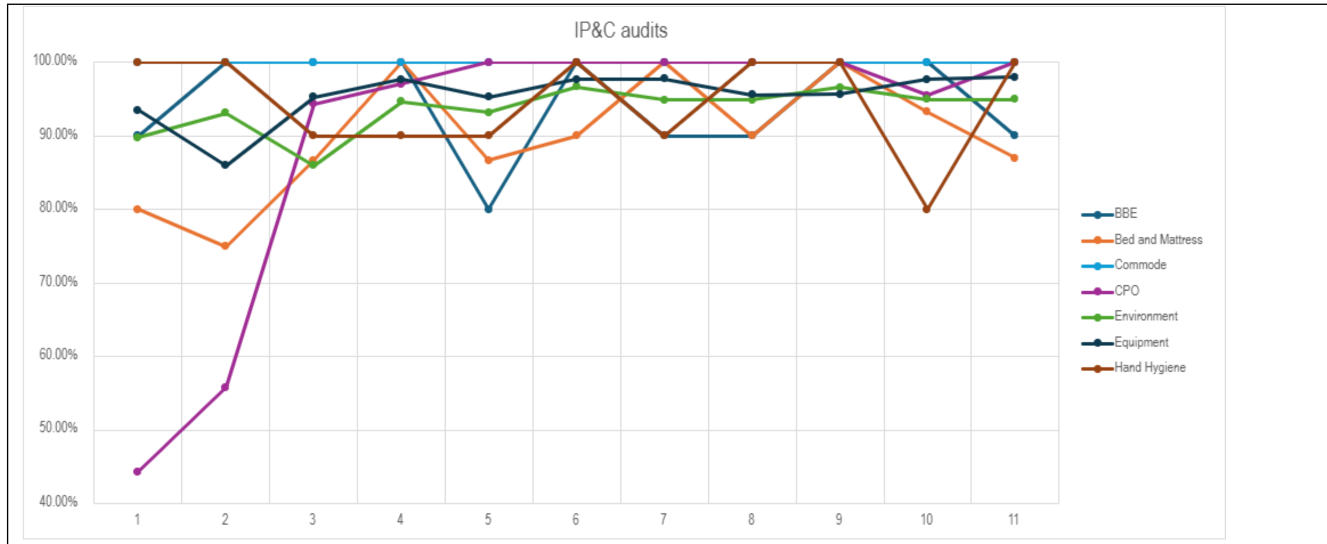


- The total number of cases (Apr 24 - Mar 25) was 12 cases, 54% less than the equivalent period in 2023/24. The reduction expectation for this period is 16 cases, thus the number of cases is 4 below the reduction expectation however

Outbreaks*:*

- Pseudomonas on B4H as aforementioned
- CRO OXA 48 on B5 Nephrology which is currently ongoing. Eight cases to date have been genomically linked indicating a transmission event. There has also been the death of a patient currently being reviewed. Several actions have been put in place. These have included admission and weekly screening of consenting patients, identifying estate issues and a plan for remedial works, regular IP&C audits and aligned practice improvement. Throughout the management of the outbreak, the clinical environment has been recognised as a potential contributing factor and as a result, with support from executive colleagues B5 will expand their footprint into A5N. This will allow for patients to be appropriately distanced from each other, meeting the 2-meter dialysis requirement and increased number of washing and toilet facilitates for patients.

Chilcott, Rachel
08/05/2025 16:26:52

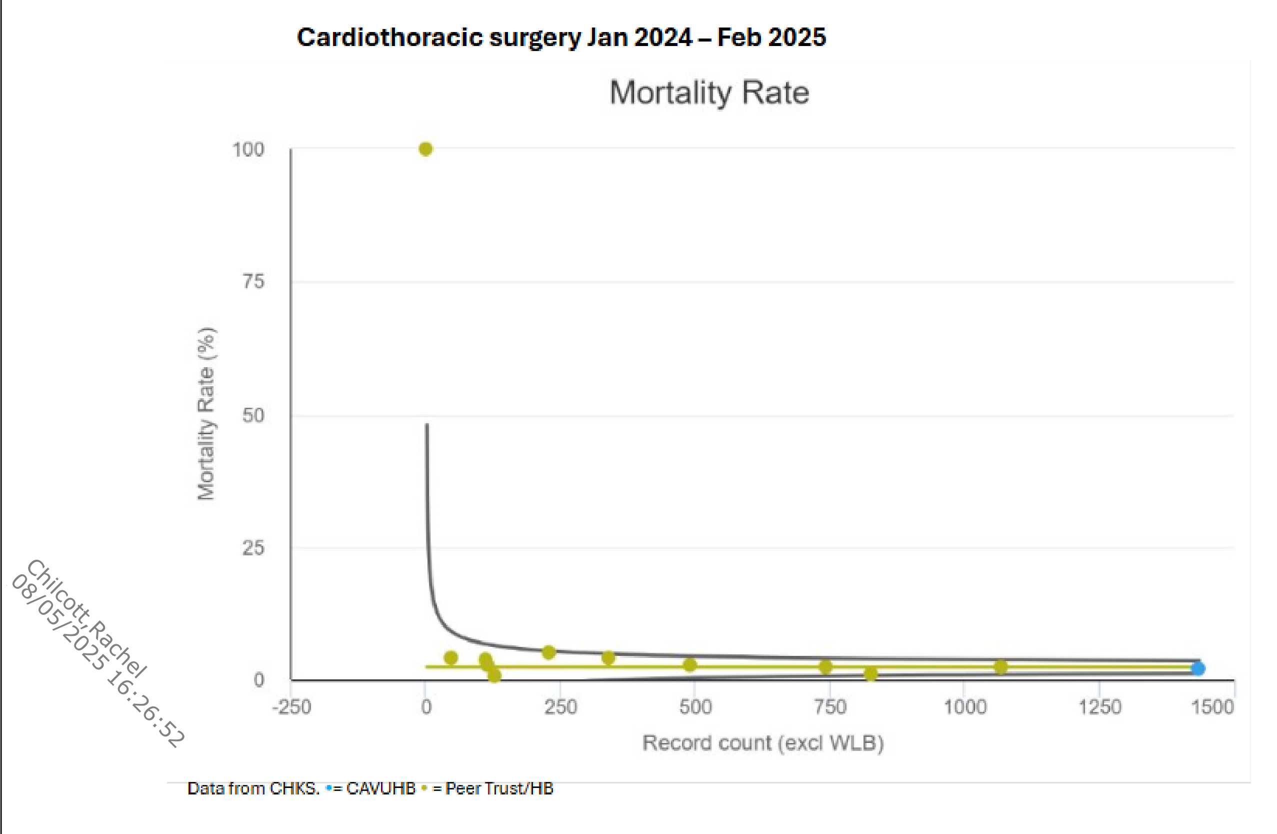


- B1 Norovirus outbreak started 18/03/25. Outbreak closed 05/04/25. On the 02/04/25 due to ongoing transmission the decision was made to close the ward. Twenty-nine symptomatic patients of which 11 were confirmed Norovirus. Nine staff were reported and a total of 49 bed days lost. It is important to note ongoing environmental concerns on Ward B1. Initial basis repairs have been undertaken whilst a PIE has been submitted with a view to longer term refurbishment.

Mortality & Morbidity

A number of areas in SSCB feed into wider audits

The UHB contributes to CHKS (healthcare Intelligence and quality improvement services) hospital benchmarking system. Mortality data can be viewed at speciality level for cardiothoracic surgery and neurosurgery, as per below.



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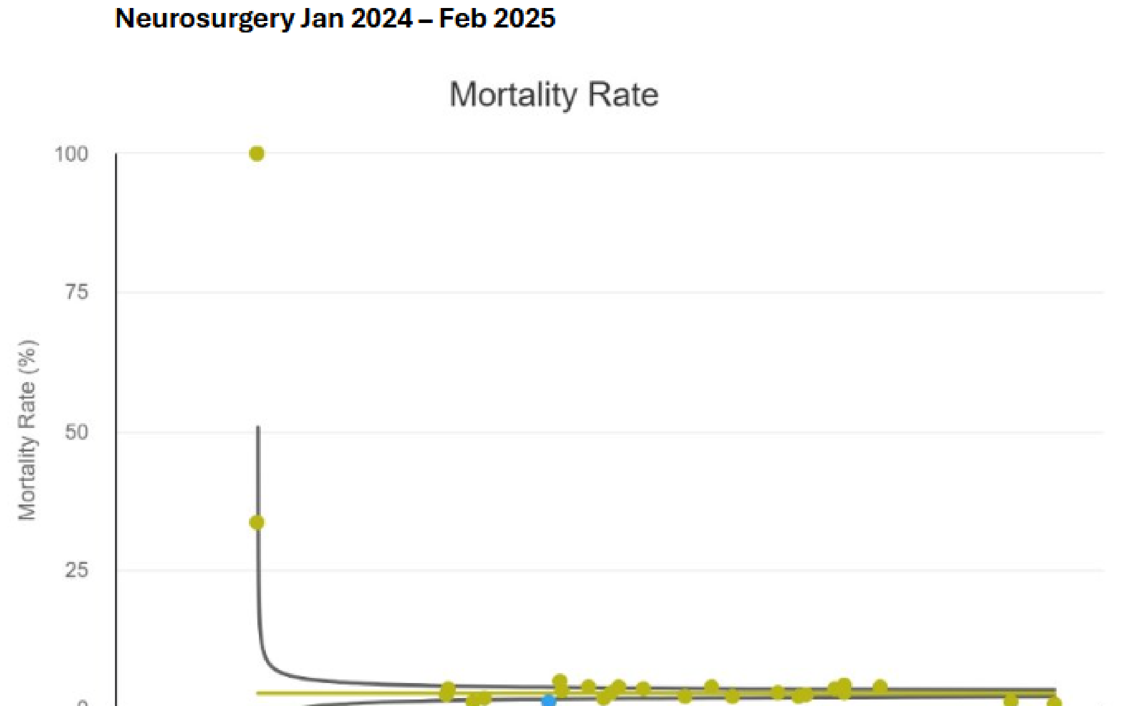
For cardiothoracic surgery we are within the expected mortality rate for the number of cases performed.



Data from CHKS. • = CAVUHB • = Peer Trust/HB

In neurosurgery, our mortality is slightly below the rate that would be expected.

Data on renal services within the UK is collected by the UK Kidney association. The most recent publication (2024) covers data from 2018-2020. Survival rates over 1-year for adult patients on Kidney Replacement Therapy (KRT) are shown below, with Cardiff and Vale UHB being within the 95% expected range for the number of KRT patients.

The full report is available at *: [26th Annual Report - data to 31/12/2022 | UK Kidney Association]*

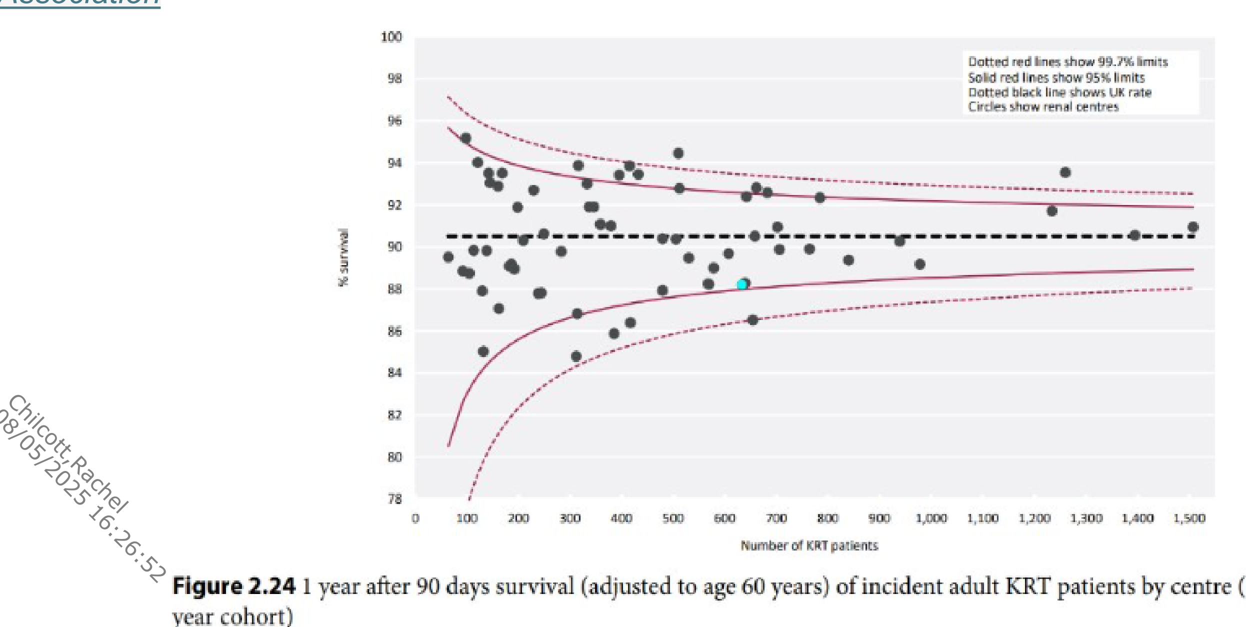


Figure 2.24 1 year after 90 days survival (adjusted to age 60 years) of incident adult KRT patients by centre (2018-2 year cohort)

Data from UK Kidney Association. • = CAVUHB • = Other centres

Chilcott, Rachel
08/05/2025 16:26:52

The Health Board participates in the ICNARC Case Mix Programme (CMP), which audits patient outcomes from all adult general critical care units in Wales, England and Northern Ireland. ICNARC collects data from patients who are likely to become, currently are or are recovering from being critically ill. ICNARC supports clinicians to identify best care for patients by facilitating improvements in the structure, processes, outcomes and experiences of critical care. ICNARC data includes all patients that are admitted to critical care, to include their physiological score which predicts a risk of death, co-morbidities and diagnosis and is shared to organisations quarterly.

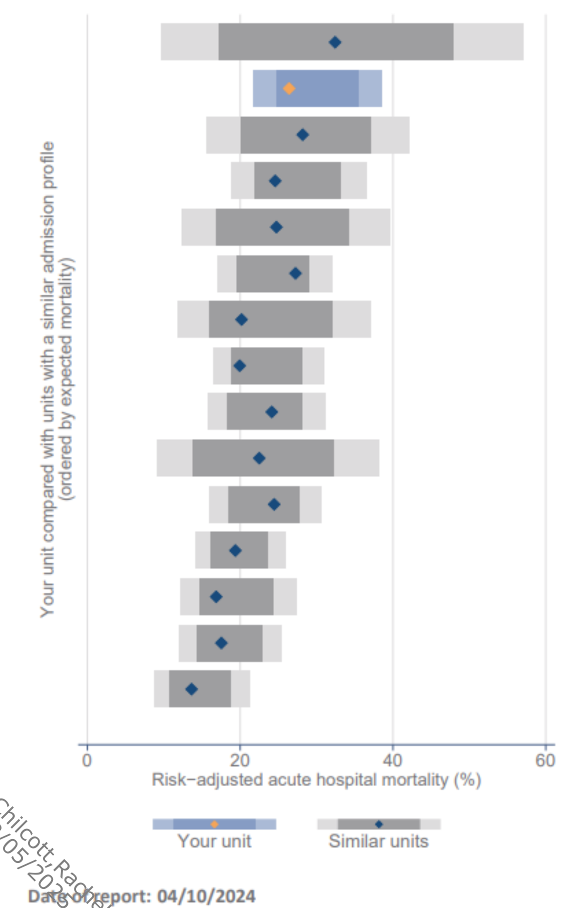
The mortality rate (26.4%) as illustrated by the orange dot, illustrates an observed mortality rate above that of 13 similar units in the comparator group for the University Hospital of Wales (UHW) Adult Critical Care Services Q1 2024-2025

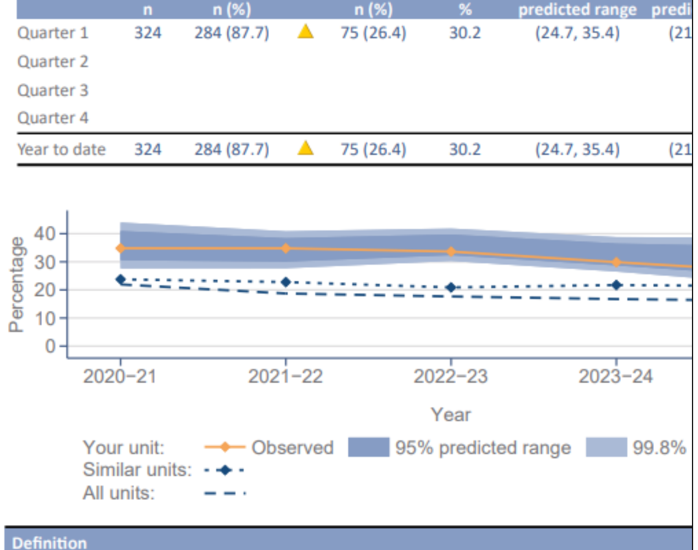
The box plot however illustrates that the UHB mortality rates is within the expected range.

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

University Hospital of Wales, Adult Critical Care Services
Quarterly Quality Report: 1 April 2024 to 30 June 2024

Risk-adjusted acute hospital mortality





	Eligible n	Complete n (%)		Observed n (%)	Expected %	95% predicted range	predi
Quarter 1	324	284 (87.7)	▲	75 (26.4)	30.2	(24.7, 35.4)	(21
Quarter 2							
Quarter 3							
Quarter 4							
Year to date	324	284 (87.7)	▲	75 (26.4)	30.2	(24.7, 35.4)	(21

Definition

- Eligible: All critical care unit admissions, excluding readmissions, patients dead on admiss admitted to facilitate organ donation
- Complete: The number and percentage of eligible admissions with sufficient data to calcu ICNARC_{H-2023} model risk prediction and complete status at discharge from acute hospita
- Observed percentage: The number and percentage of complete eligible admissions that d ultimate discharge from acute hospital
- Expected percentage: The expected percentage of acute hospital deaths, calculated as the risk of death from the ICNARC_{H-2023} model, among complete eligible admissions to your
- Predicted range: We expect a unit's observed percentage to lie within the 95% predicted out of 20 and within the 99.8% predicted range 998 times out of 1000

Chilcott, Rachel
08/05/2025 16:26:52

Date of report: 04/10/2024 21

Mortality reviews are generally undertaken either as part of local QSPE meetings or specific Morbidity and Mortality (M&M) meetings and for a number of services, such as Major Trauma and Renal, shared with the relevant networks and UK Renal Registry respectively.

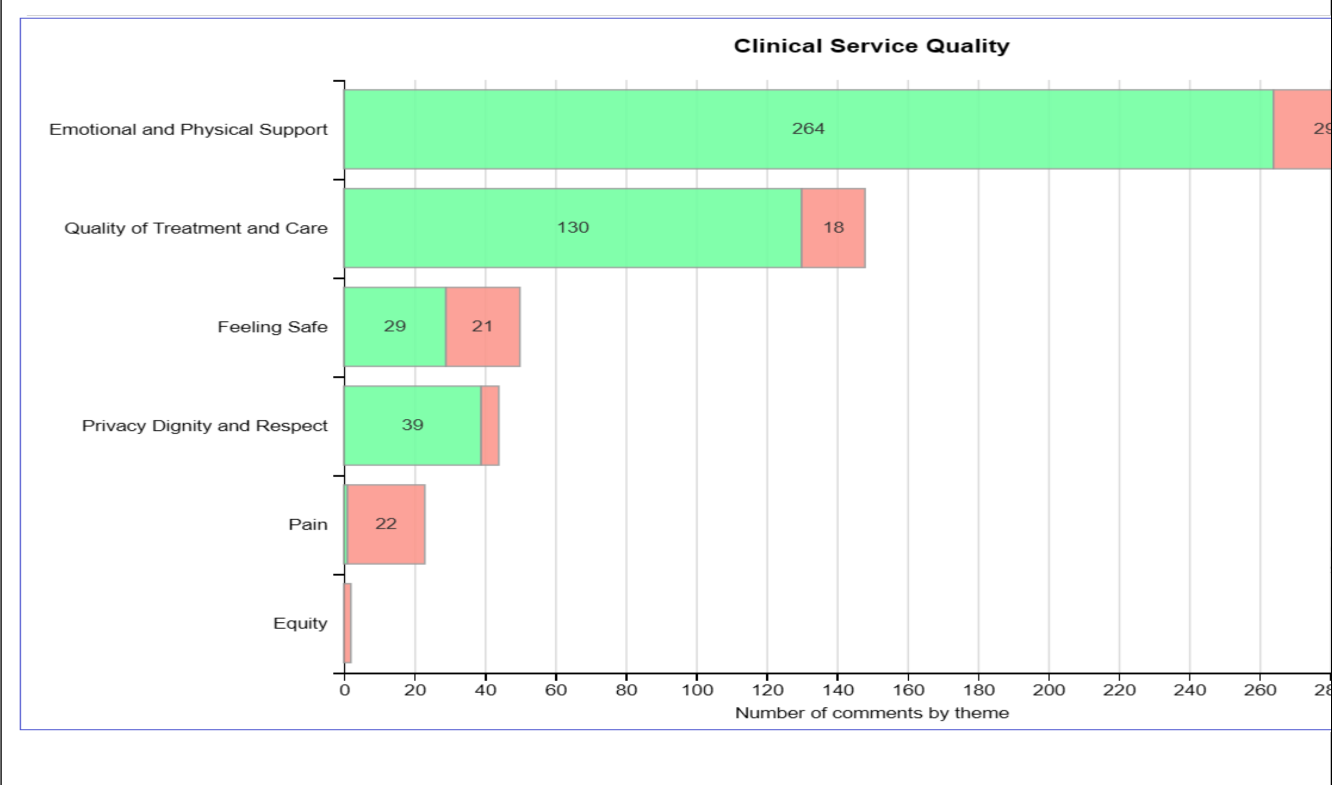
Current work is a focus on all areas to ensure each directorate is taking ownership aligned with cases, trends, and processes.

In regard to an individual case basis, as opposed to numbers of people, the CB is fully engaged and working with independent medical examiner (ME) reviews and the UHB Mortality Lead, Nick Denny, attends the CB QSE Committee meetings. The focus now is on pulling together themes to present and mortality indicators for SS, recognizing the unique nature of each clinical area.

Our CB Consultant Mortality Lead, Caroline Burford and Consultant QSE lead, Mat Davies, attend the UHB mortality screening panel meetings. These then feed into our Clinical Board QSE Committee.

Patient Experience

The graph below demonstrates comments by all themes from the 'Civica Experience Wales' platform. Positive comments are shown in green and negative in red. The first table focuses on clinical service quality themes.



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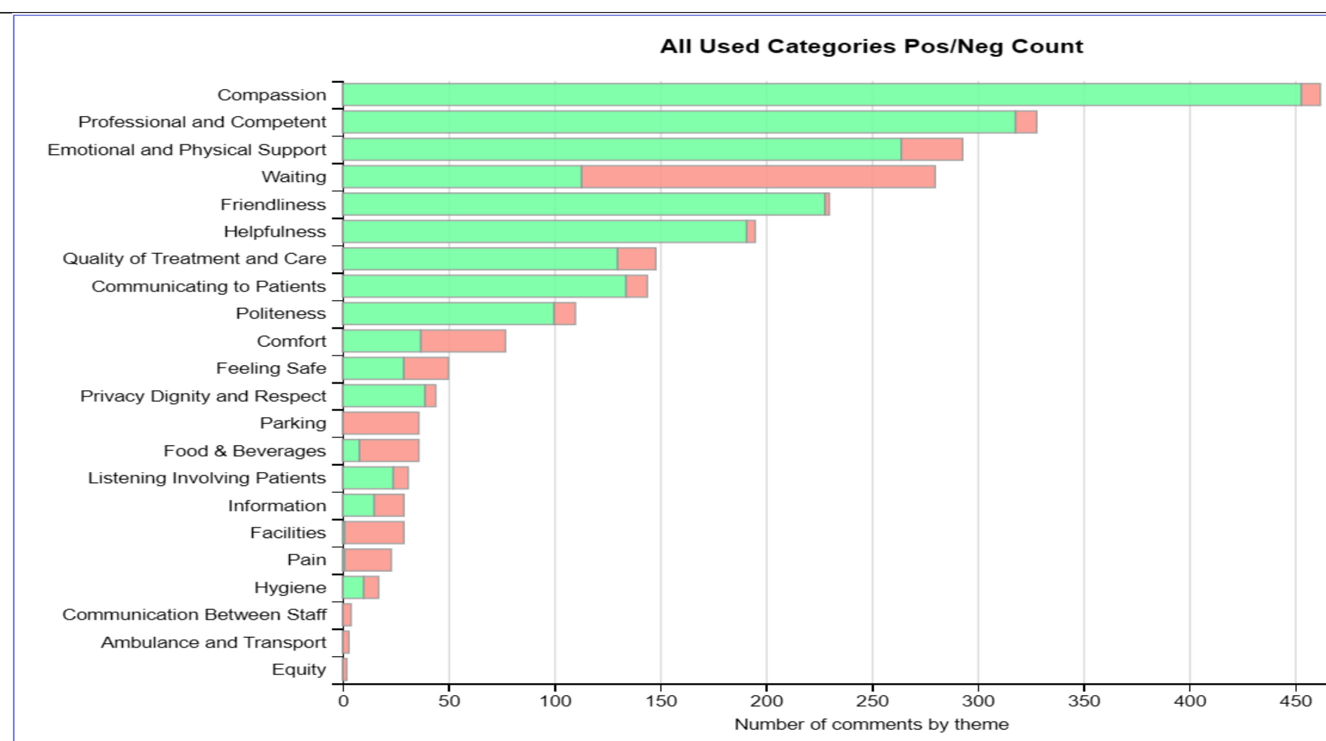
08/05/2025 16:26:52



The patient satisfaction score from any survey activity has been consistently over 90 % and between April 2024 and March 2025, a total of 37 formal compliments were also received.

Redress

Currently:
2 active cases for redress (1 potential / 1 confirmed)

Example: *Case reported as an NRI after pressure damage was identified. The patient was a long-term inpatient and was very unwell. The issues in this case largely related to a failure to document discussions had between the nurses and the patient around re-positioning whereby he was refusing assistance with re-positioning. He was not compliant with re-positioning but as this was not documented it was difficult to defend the case. The case was discussed at redress clinic and a letter of apology was sent.*

Personal Injury Claims

Over the last year 1/4/2024 to 13/3/2025

New Claims = 2
Closed Claims = 0
Active Claims at 13/3/2025 = 7

Example: *A manual handling incident sustained by a nurse working in Critical Care. At the time the claimant was lifting an unconscious patient for the X-ray machine to be placed behind their back, with 3 other members of staff. The manoeuvre involved moving the bed forward and putting the patient into a sitting position in a pulling motion using a sheet. During the manoeuvre the claimant claim to have suffered a shoulder injury. Investigation is currently ongoing.*

Chilcott, Rachel
08/05/2025 16:26:52

Monthly Serious/ RIDDOR reportable incident meetings are held between the CB and Health and Safety. Slides are presented as per an agreed template in relation to open pertinent incidents. These are also shared locally as appropriate and those with relevant, wider lessons to be learnt, are subsequently shared at the CB QSE Committee.

Clinical Negligence

There are currently 58 active claims. Loose themes are related to assessment, investigation and diagnosis but all very varied in nature. Currently 4 Welsh Risk Pool deferred cases with evidence of learning being chased and 3 new triggered.

Example of new claim:

The claimant underwent craniotomy for left meningioma on 22/10/19 after being seen by a consultant Neurosurgeon for her worsening symptoms. The claimant developed symptoms of severe headaches in around September 2021 and subsequently attended the emergency department. The claimant was only given two options, which were observation and further interval imaging or microsurgical resection. The surgery was carried out on 11/01/22. This lesion, due to its venous sinus involvement, was only incompletely resected which leaves the claimant with a significant risk of recurrence and need for further treatment. The claimant subsequently learned that the option of stereotactic radiosurgery was available and should have been recommended as a less invasive and risky treatment option for her. Alleged failure to offer radiosurgery treatment as an option, which would have bypassed the potential re-occurrence of previous complications of the microsurgical resection as it would offer management without the opening of the skull and with materially less intrusion and inconvenience to the claimant. Witness comments are currently being obtained.

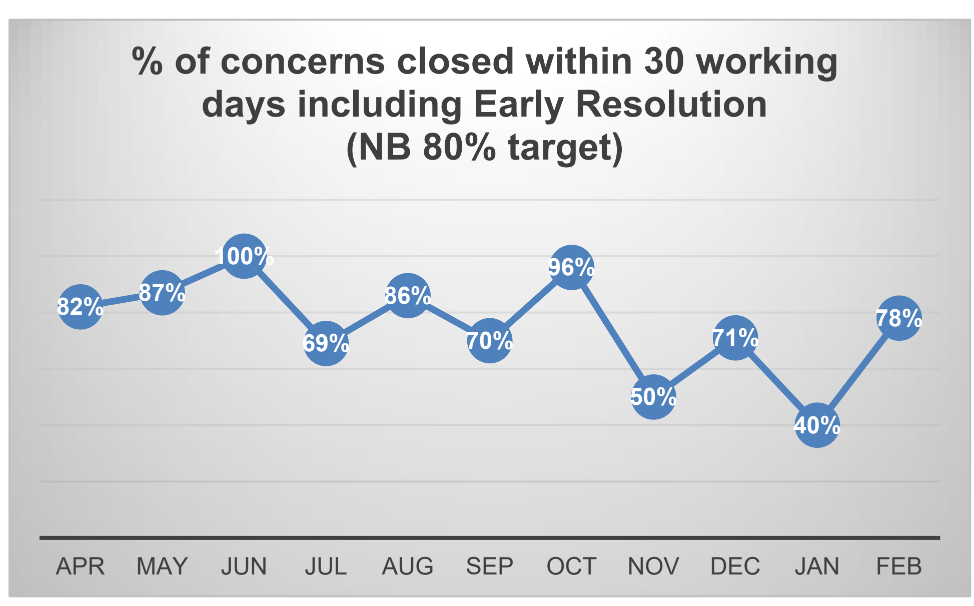
Concerns

At time of writing this report , there were 25 putting things right (PTR) concerns open in total at time of writing report with 10 out of time, to include 5 over 75 days.

Closed concerns in last 12 months:

	Specialist Services		
	Managed through PTR	Early Resolution	Total
Mar 2024	19	13	32
Apr 2024	43	12	55
May 2024	36	18	54
Jun 2024	17	15	32
Jul 2024	27	20	47
Aug 2024	13	8	21
Sep 2024	39	18	57
Oct 2024	13	12	25
Nov 2024	17	10	27
Dec 2024	8	7	15
Jan 2025	39	6	45
Feb 2025	28	12	40
Total	299	151	450

Collins, Rachel
08/07/2025 16:26:52



Themes include, care and treatment, behavior of staff and discharge from service/ follow up. Main reason for response delays are complex concerns spanning more than one directorate or even CB and multiple services and/ or teams.

Medicines Management

Antimicrobial Stewardship

The CAV UHB antimicrobial stewardship (AMS) pharmacists have continued to provide quarterly reports to SSCB, which have been discussed at the QSE committee meetings, and provide detail on how antimicrobial agents are prescribed and used across the CB. The reports are based on the results of the regular AMS audits which ward pharmacists complete, looking at compliance with good prescribing in this area, such as documenting the indication for all antimicrobial prescribing and prescribing as per guidance or microbiology advice. Areas for improvement that were highlighted in the most recent SSCB report were around documentation of the intended duration of treatment, as well as ensuring there is a review of all antimicrobial prescriptions after 72 hours of treatment.

Electronic Prescribing and Medicines Administration (ePMA) is imminently to be rolled out in SSCB with ward B5 as an early adopter. It is anticipated that documentation will be improved as a result of this process for prescribing antimicrobials on the system, and the availability of data will be much greater.

The AMS pharmacy team has also led the way on the development of a fluoroquinolone prescribing checklist, which has been implemented in the UHB because of the MHRA drug safety alert around the information supplied to patients when prescribed these agents. The antimicrobial formulary has been reviewed to ensure that fluoroquinolones only appear in our guidance where there are no other effective agents to treat an infection. the checklist is available for all prescribers to ensure that they have supplied the appropriate information to patients who need these antibiotics.

Medicines Safety

Over the last year, the Medicines Safety pharmacy team have produced reports on the trends of medicines-related Datixes for each CB, which have been shared via the SSCB QSE meeting. This enables wider learning from errors and near misses that have happened

Chilcott, Rachel 08/05/2024 16:26:53

in individual directorates within the CB and has encouraged useful discussion about reducing the risk of such errors happening in the future.

Tendable Dashboard

Tendable, the quality improvement and auditing app, has been embedded and is used across SSCB to capture live data about quality standards, patient and staff experience and the care environment. In 2024, clinical teams have used their Tendable data to inform and drive their improvement actions. For example, in preparation for the launch of 'Gloves Off' in Critical Care, the 'Green ICU Team' have used Tendable to review their waste disposal practices to ensure the clinical environment is optimised to support good clinical and environmental practices. This work is due to be captured in filming being undertaken for Climate Action Wales in Spring 2025. The inpatient Cardiology teams at UHW is also an excellent example; they have used Tendable to demonstrate 86% compliance (August – January 2025) with patients receiving information via the 'Explain my Procedure' tool and 100% compliance (August – January 2025) EIDO leaflets for their cardiology procedure. Additionally, Ward B5 piloted the All-Wales Adult Pressure Ulcer Prevention and Management Care Plan as part of their journey to Bronze Ward Accreditation. They are working collaboratively with the Tissue Viability Team to ensure that the evidence base integrates seamlessly to ensure patients receive optimum care.

The CB currently has 3 Bronze 'Ward Accreditation and Improvement' (WAI) awards reflecting their commitment to quality, safe and effective care. Owing to the specialist nature of the services delivered within the SS, several areas would require a bespoke accreditation programme to fully reflect the services delivered.

Resource

The Board reported an operational overspend of £1.579m for 2024/2025, against a target control total of £1.350m.

Headlines:

- medical £1.338 million - gaps and premium cover, average x8 WTE vacancies
- registered nurses £0.679 million - temporary staffing costs to cover sickness and vacancies
- other vacancies (Net £1.753 million) – c67 WTE across most specialities
- LTA performance £b/e – varied under/ over performance across directorates resulting in a breakeven position at year end
- secondary care drugs £1.888million – Pressure in Haematology, Immunology and Metabolic Medicine

Chilcott, Rachel
08/05/2025 16:50:53

As a CB, we have not pursued any cost savings with quality impact implications. Our Quality Improvement Program for 2025-2026 focuses on grip and control, income generation, medicines management, procurement, workforce (include improving wellbeing and availability to work) and optimizing planned care (reduction in length of stay in cardiology and improved renal theatre utilization*).*

Workforce

The CB are committed to delivering the values and behaviours of the UHB to all staff and supporting them to do the same. Key developments are detailed in the directorate specific sections of this report. Workforce reshaping is ongoing.

	Performance - March 2025								
Clinical Board	Vacancies	YTD Bank Spend	YTD Agency Spend	Turnover	Cumulative Sickness	VBA	Medical Appraisal	e-Job Planning	Stat M
SpS	6.68%	£3,478,543	£868,112	8.56%	6.78%	70.95%	87.18%	47.80%	80.

Values Based Appraisals

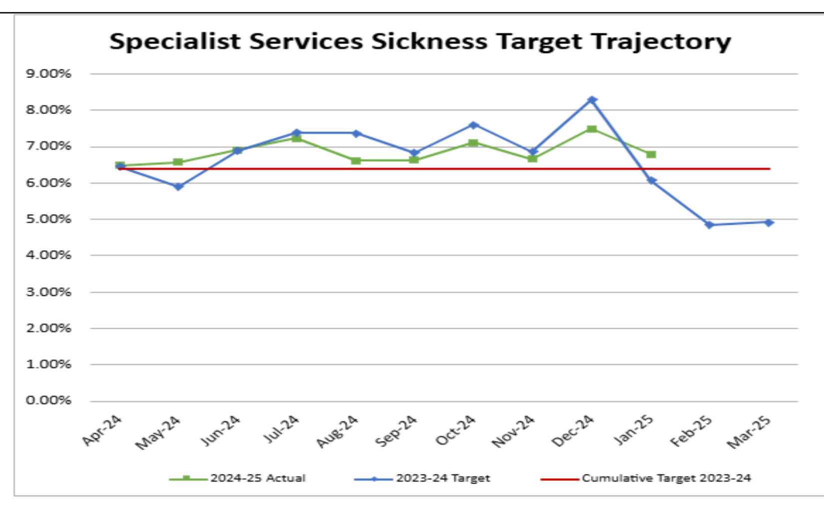
The CB has driven compliance with a notable improvement at the start of the last year. Most areas achieved compliance of 80% or over during the last year, with significant improvements in the worst performing areas, which stood at 36.81 % in March of 2024. It is recognized however that operational pressures and a focus on delivering clinical care does continue to add to this challenge. Unfortunately, the CB have seen a 7% drop in compliance between January and March 2025. VBAs are a priority for SSCB again moving into 2025-2026.

Directorates	Due Soon	In Date	Over due	Grand T	% Complete	Nur to 85
ALAS	17	70	52	139	62.59%	
Cardiac Services	60	224	110	394	72.08%	
Critical Care	106	274	112	492	77.24%	
Haematology and Clinical Immunology	34	147	70	251	72.11%	
Nephrology and Transplant	19	119	62	200	69.00%	
Neurosciences	106	126	125	357	64.99%	
Specialist Services Management	1	6	5	12	58.33%	
(blank)						
Grand Total	**343**	**966**	**536**	1845	70.95%	

Sickness management

The CB sickness trajectory is supported by an effective and evolving sickness panel led by the DON and People Services. This was instated over the last year focusing on LTS initially and now prioritizing frequent STS. This work has been supported by the spread and scale of exemplar areas (Cardiothoracic Services at 5%) and focused work, for example within the Haematology nursing workforce (14.3 % down to 4.1% at best, post focused efforts). This work is further reinforced by the CB focus on staff wellbeing.

Chilcott,Rachel
08/05/2025 16:26:52



Risks

The CB currently hold 32 red risks scored at 15 or above. Themes are, footprint capacity, environment, workforce specific services, RTTS and theatre capacity.

Each directorate holds their own risk register. These are also regularly uploaded to a CB folder on our QPSE Teams channel to be stored centrally. Newly identified risks are discussed at directorate review meetings and our CB QSE Committee to achieve a rounded perspective and to validate and support mitigation. For JCC commissioned services, risks are also captured on the JCC risk register and should be consistent. Where indicated any high scoring risks will be discussed at the CB executive review meetings.

SSCB hold risks that crosscut with other CBs, for example estates issues and liaison psychiatry and are therefore keen to embrace the refining of risk management and working towards the AMaT module work that is ongoing within the organization. We are also very supportive of moves to contributing to a unified cancer risk register and have recently shared all cancer related items for this purpose.

More detail is included in the directorate specific sections of this report regarding key risks in specific areas.

Safe, Timely, Effective, Efficient, Equitable and Person-Centered Care by Directorate

This part of the report contains a section dedicated to each of the directorates within SSCB and their services. It outlines their headlines over the last year, aligned with QPSE.

Critical Care Directorate

Recipe Book

‘The Intensive Care Environmental Sustainability Recipe Book’ is a new, practical guide designed to help Intensive Care Units (ICUs) across the UK reduce their carbon footprint by giving them the key ‘ingredients’ and ‘methods’ to cut waste and increase sustainability.

The guide features case studies from Cardiff and Vale UHB's Green ICU Team, spotlighting its experience of seeking to reduce waste, conserve energy and make financial savings.

Chilcott,Rachel
08/07/2025 16:26:5

‘People, Planet and Profit’. Each element of this triple bottom line is vital, with this recipe book providing some of the necessary tools for critical care multi-disciplinary teams to contribute to preserving a planet worth surviving critical illness for, to reduce waste, and improve efficiency.

These initiatives include:

- reusing unopened ventilation bags instead of disposing of them
- unplugging fully charged machines and installing LED lighting
- replacing medical sterile water with standard drinking water

IP&C Fortnightly ‘Walk Throughs’

These were commenced to increase engagement with the IP&C team to highlight contemporaneous issues in Critical Care. It involves the IP&C CNS, The ITU consultant IP&C lead, QSE lead, shift coordinator’s and zone leaders. The aim is to discuss current IP&C issues, identify any trends and discuss any oversights/improvement opportunities in practice.

Cardiff Critical Care Family Survey 2023/24 Results

The FS-24 Family Survey results highlight the strength of Cardiff Critical Care’s commitment to delivering not only safe, expert clinical care but also deeply compassionate and inclusive support for families during times of crisis. The overwhelmingly positive feedback reflects a culture where communication, empathy, and professionalism are embedded in daily practice. At the same time, the survey has offered valuable reflections on where Critical Care can continue to grow — particularly in ensuring consistency, enhancing emotional support, and improving the environment for visiting families. These insights will inform ongoing quality improvement across the unit, and staff are encouraged to reflect on this feedback with pride and purpose as we strive to maintain excellence in both patient and family experience.

Echo Award

The Critical Care Department has been accredited by the British Society of Echocardiography under its Echocardiography Quality Framework. Echocardiographs play a vital role in Critical Care, as they help to ensure the UHBs most unwell patients have effective access to accurate diagnosis and monitoring of certain conditions.

To achieve this accreditation, the team established minimum standards for patient reporting and reviews, conduct regular audits and peer reviews for collaborative improvement and has invested in equipment and infrastructure to ensure sustainability. The unit has also increased the number of colleagues trained in echocardiography proficiency from 5 to 17, an increase of 240%. As the only Critical Care Department in Wales and a select few in the UK, to achieve this accreditation, this demonstrates commitment to providing the highest quality care to patients AND also to the continued professional development of clinical colleagues.

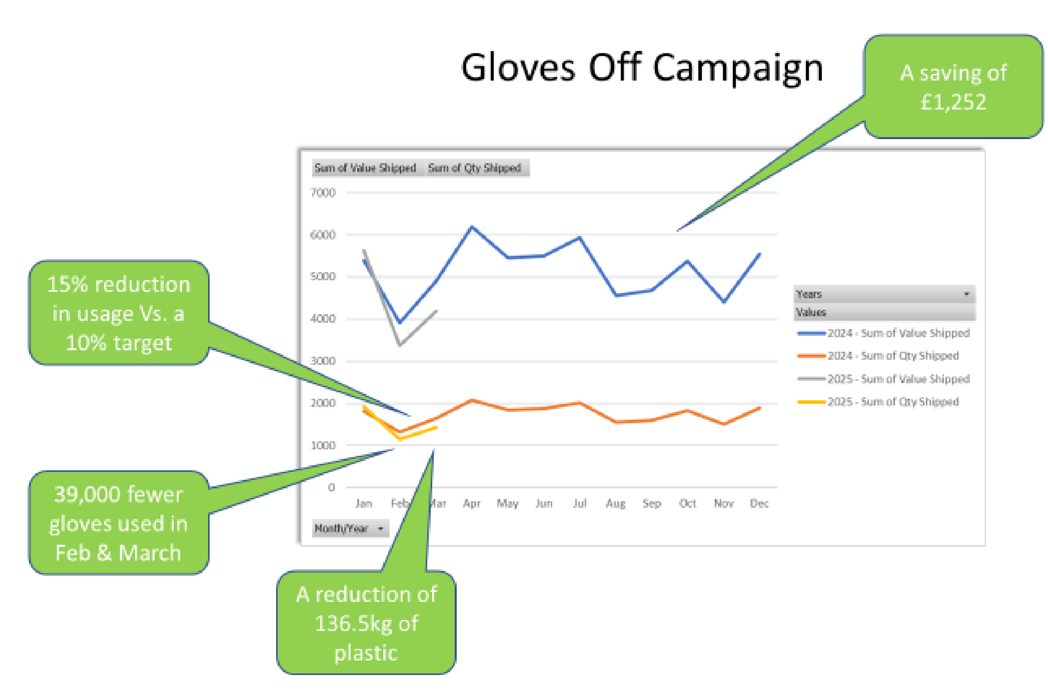
Druggle

The 'Druggle' refers to a new initiative of a drug huddle that was led on by the Critical Care Pharmacy team. This weekly meeting is designed to facilitate the sharing of learning and education regarding medication safety. It provides an opportunity for all team members to come together, discuss challenges, share insights, and ensure that everyone is aligned on best practices for handling medications. Good medication practices and prescribing are celebrated by the ‘medication star of the week’ and ‘prescriber of the week’ as well as sharing information on prescribing and medication error trends to positively share learning and improve practice. It is hoped to roll this initiative out to other areas within the CB over the next year.

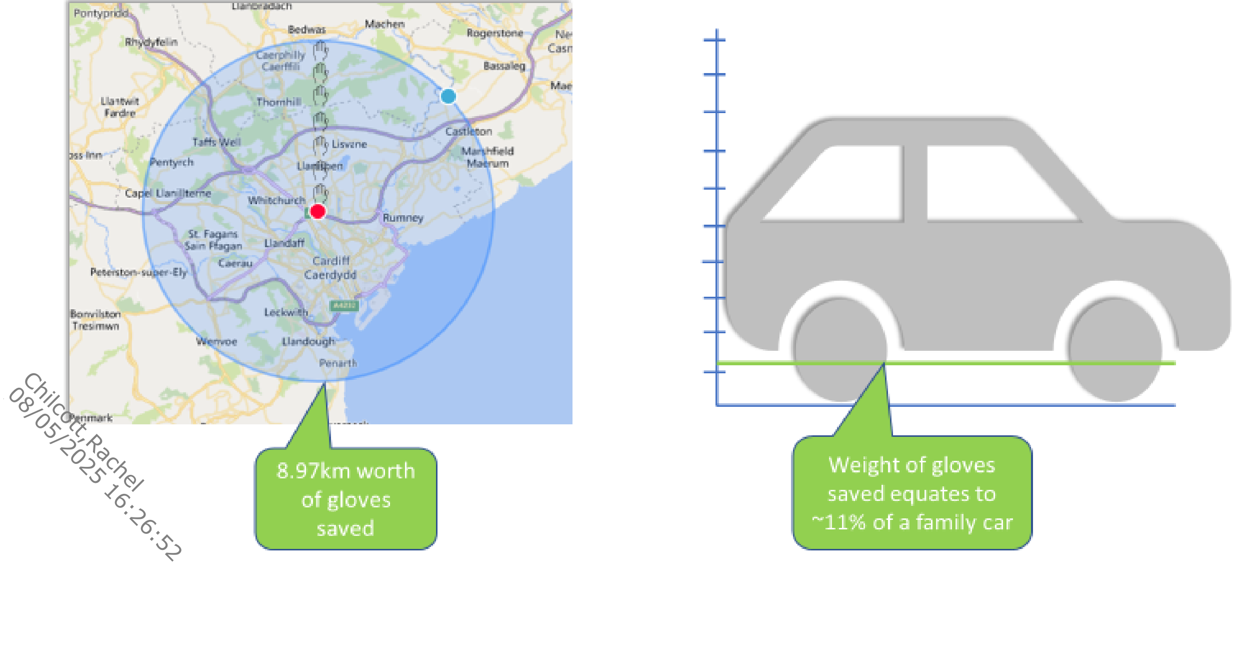
Chilcott, Rachel
08/05/2025 16:26:52

Gloves off Campaign

Critical Care launched the pilot of the 'Gloves Off Campaign' this year which has now been rolled out in two additional departments, with a UHB wide roll out planned this year. Since January, they have used 195 fewer boxes (19,200 gloves). A reduction of -550kg c02e which if you placed each glove end to end equates to 4.6 kilometers roughly from UHW to Rookwood and forecasting a saving for 24/25 of £9,000.
The team have been nominated for an NHS sustainability award for this initiative.



Comparable savings



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08/05/2025 16:26:52

Key Risks

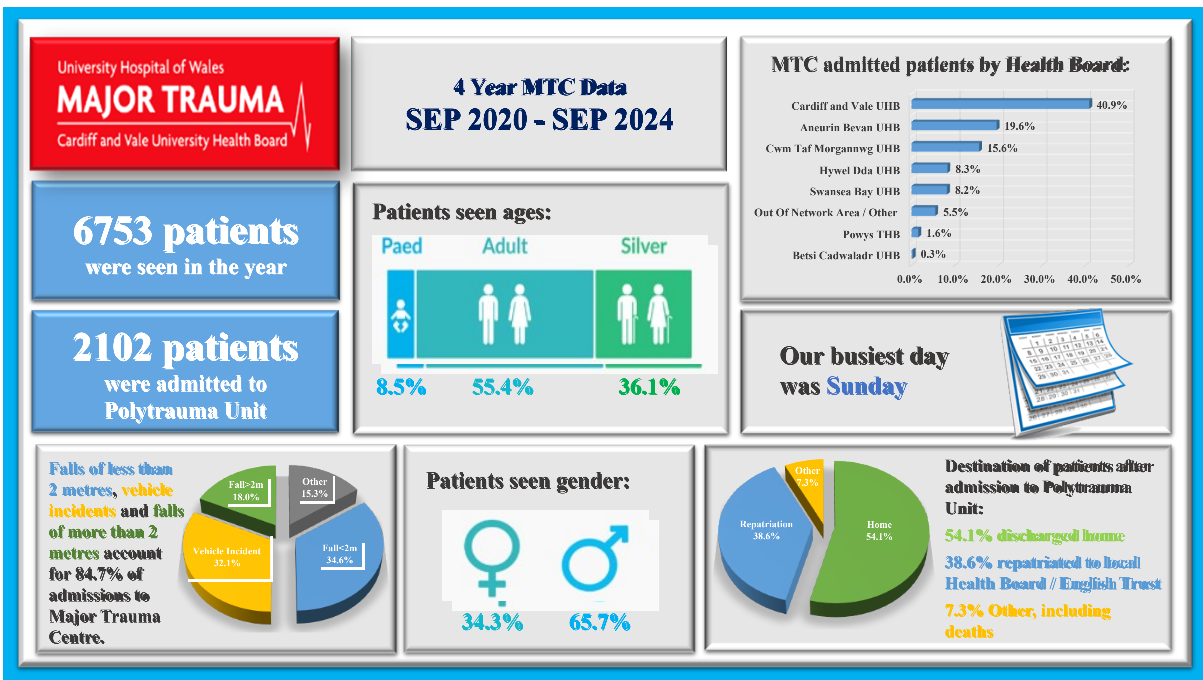
Key risks carried in the Critical care directorate are the lack of physical emergency beds to accommodate current and predicted demand (up to 2030). Delays in emergency admission to Critical Care result in avoidable deaths and impaired functional outcomes. This is captured as an extreme risk scoring 20. A business justification case in regard to this is pragmatically moving forward.

The unit also has environmental, and estates challenges captured on the risk register to include a consistent lack of cubicle space and more transient issues.

Major Trauma Centre

Activity

The Major Trauma Centre (MTC) has seen more than 7000 patients from go-live to date. The Polytrauma Unit (PTU) has admitted/treated more than 2000 patients for the same period, breakdown by Health Board (HB) is below (see infographic).
Please note these are patients who were admitted to the PTU as their first destination.



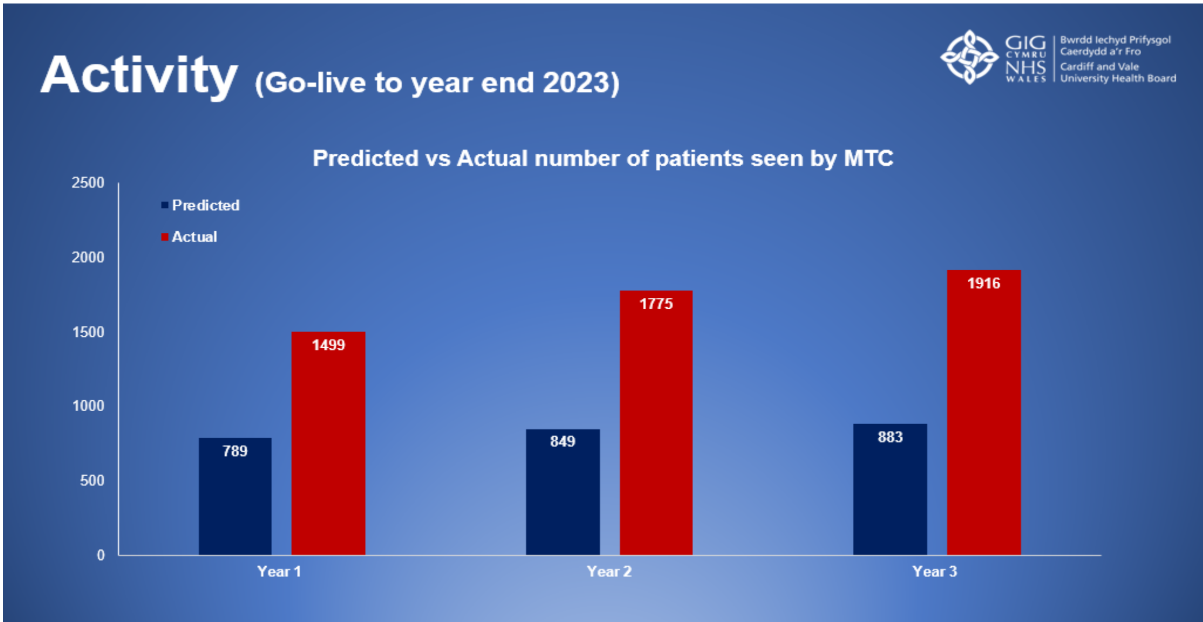
Infographic – 4-year activity data for MTC

Overwhelmingly, a large majority of patients admitted to the MTC are subsequently discharged to their home/place of residence (54.1%), with 38% repatriated back to their local HB. Whilst the MTC acknowledge the efforts made by neighbouring HBs in facilitating repatriations to support flow, the South Wales Trauma Network (SWTN) data demonstrates that there has been a significant decline in adherence to the network repatriation policy which does pose a challenge currently.

The MTC continues to see a rising number of paediatric patients who require complex rehabilitation. The teams are continuing to develop the options appraisal for a specialist rehabilitation facility within the Children's Hospital for Wales. This is an ongoing piece of work with the JCC. Scoping work has started alongside paediatric MTC's within National Health Service Executive to investigate the use of a standardised tool to assess the needs of a family, following admission to an MTC. Access to paediatric psychology remains a challenge.

The MTC lead therapist is currently undertaking a project to improve the quality of rehabilitation prescriptions. This has been tailored as an individualised patient-centric hand-held document and is being provided to patients at the point of discharge or repatriation. There is a phased implementation plan to roll this out across the whole MTC pathway, starting with PTU.

As per the business case, National Major Trauma Quality Standards, NICE guideline on Major Trauma Service Delivery (NG40, February 2016) and the Peer Review recommendations, further work is required to progress the discussions surrounding the future expansion of the PTU. This is a high-level priority for the MTC Directorate Management Team (DMT) who presented at a ‘Summit’ meeting with the Chief Executive and Chief Operating Officer in September 2024. This urgency is underscored by the fact that the actual activity levels have been twice the amount initially predicted and modeled for the MTC (see Graph 1).



Graph 1 – 3-year actual activity v predicted data

The MTC and Critical Care Directorate have initiated a modelling project with the NHS Executive Modelling Collaborative to ‘right size’ the phased expansion plan for the PTU. It is acknowledged that as the SWTN matures, the PTU has faced increasing constraints on capacity.

Trauma Audit and Research Network (TARN) data (Now National Major Trauma Registry – NMTR) was taken offline on 9th June 2023, when the University of Manchester confirmed it had been the subject of a cyber-attack. Although the NMTR was launched in April 2024, data submission from NHS Wales required a formal request to process Welsh data and NMTR only went live for Cardiff submission in September 2024.

As such it is only in the past 6 months that data has be able to be entered into NMTR (training on the new system commenced locally in August 2024) with limitations on bulk data uploads from when there was no national registry.

An SBAR (NMTR – Increase in Staffing Resource to Meet Case Submission Demand) has been submitted to SSCB highlighting staffing shortfalls in 2024 which led to a backlog of cases meaning that the national standard for submission of all eligible cases within 30 days was not being met. This is also captured on the MTC risk register. The MTC DMT have identified the need to maintain staffing within the NMTR team at 1.0 WTE data collector per

400 submissible cases and have recommended to the SSCB increasing the NMTR Coordinator team by 1.0 WTE to achieve this.

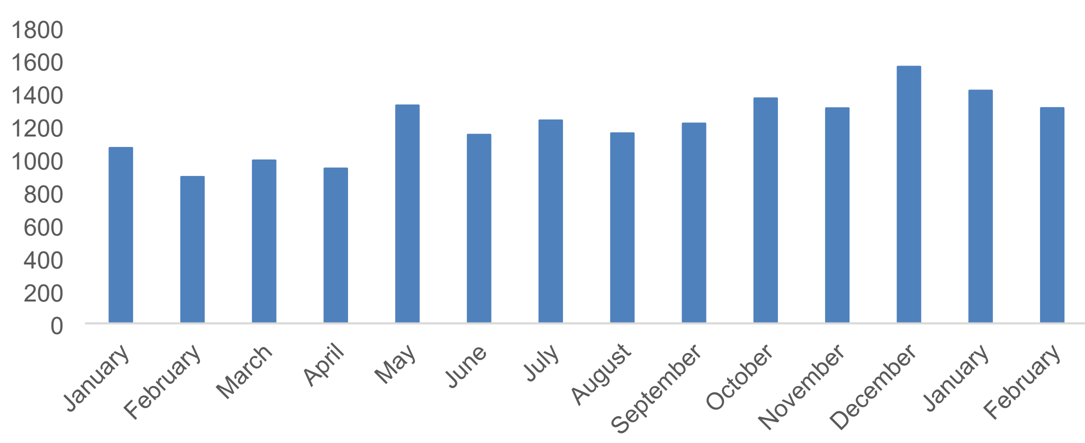
As a combined (Adult & Paediatric) MTC, UHW expects to undergo national peer-review in early 2026. NMTR data will be highly important for informing this process.

P@RT

Critical Care outreach teams have been widely implemented across developed healthcare systems to identify and manage patients who are acutely unwell or at risk of deterioration, but who are located outside of the Intensive Care Unit (ICU).

In CAVUHB, the Patient at Risk Team (P@RT) was formed in October 2021 in response to numerous national policies and guidelines, mandating the implementation of early warning scores to identify these patients as well as delivering an appropriate, timely response 24/7.

The team have become increasingly busy and are now reviewing around 1300 patients per month. 40% of these calls are out of hours (19:00-07:30 and weekends/bank holidays). Furthermore, 38.8% of all P@RT referrals are for patients with a NEWS >6. The mandated Welsh standard for responding to this more acute cohort of patients is 30 minutes. Regardless of the time of day, P@RT are achieving a response time of 14 minutes.



Whilst the core business of P@RT is responding to NEWS calls there is also demand in other domains. For example, post ICU discharge follow-up and safety netting, patients with identified acute kidney injury, safe intra-hospital transfer, hospital sepsis pathway and supporting staff managing fewer familiar therapies and interventions.

P@RT plays a particularly important role in providing equity of support across the UHB, as acute services and staff have been relocated. This is particularly relevant to the UHL site. P@RT has been able to mitigate the risk of remote out of hours airway assistance, alongside critical care support for patients awaiting transfer for escalation of care at UHW.

The team has been proactive in developing support pathways for psychiatric patients in the geographically remote Hafen y Coed hospital, in line with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) ‘Picture of Health’ recommendations. The team are a key part of the physical health strategy of mental health in-patients. They have been able to ensure hospital resources are utilised more appropriately, avoiding MEAU admissions and improving patient experience.

Call 4 Concern

P@RT went live with Call 4 Concern July 1st 2024, following the passing of Martha's law. Themes for improvement which lie outside of acute deterioration have been identified and fed back and/or escalated as appropriate.

Users Assessment of P@RT

- 95% of ward staff gave a satisfaction score of 5/5 with the service
- 67% doctors and 80% nurses felt P@RT night service had increased their wellbeing and feeling of support
- 75% of doctors and 80% nurses felt that the P@RT night service had improved timely escalation of acutely unwell patient care.

Future Plans

- Deliver accredited courses that can generate income
- Support the delivery of the NHS Executive Strategy for Acute Deterioration
- Implement NEWS2 in line with Welsh Government policy
- Implement a Medical Emergency Team (MET) to support the highest NEWS2 patients
- Support the implementation of MEWS, PEWS and NEWTTS across the UHB
- Continue to lead Wales with Call4Concern implementation strategy
- Develop advanced practitioners to support critical care, particularly in remote sites
- Support the UHB strategy for enhanced care area provision

Haematology Directorate

Risks and Developments

The directorate, with excellent support from the 'Shaping Change' team has undertaken a comprehensive review of activity and patient services delivered within the Haematology Day Centres (HDCs) at the UHW and UHL sites. HDC is the gatekeeper for Haematology and bone marrow transplant (BMT). Services provided include a front door for Haematology enabling immunosuppressed patients to avoid EU, admission avoidance through early intervention and monitoring, care closer to home and provision of highly complex chemotherapy regimens. HDC has experienced significant and complex challenges relating to staffing, overcapacity, and system and process inefficiencies leading to an increased number of Datix and poor patient and staff experience, captured on the directorate risk register. The team are committed to supporting sustainable improvements to create a safer, more efficient service to enhance quality and eradicate avoidable harm.

Key improvements from this work to date include taking forward the chemotherapy scheduler and the introduction of an additional multiple myeloma chemotherapy treatment clinic to the day centre at UHL, to support with releasing capacity at UHW. There has also been collaborative working with pharmacy colleagues to review the processes to minimise waste, both in terms of drug wastage but also chair time on the unit, because of problems with scheduling chemotherapy. An efficient patient pathway is in the process of being developed too, which will involve digitalising the entire process, from referral to administration and enable data capture on the whole journey to better plan. Right sizing and workforce reshaping is necessary to continue to progress this work as a priority.

In UHL, it has been identified that infusions and blood transfusions are being undertaken by Haematology which would be more appropriately placed in other services outside of the CB. This service creep is being reviewed as it is impacting on ABILITY To treat cancer patients in a timely manner and so a risk. There is also a direct impact on the financial cost to the directorate, as there is no recharge for these services currently. Additionally, there is an ongoing review of infusions and where these should be undertaken locally within other HBs. Currently there is limited remuneration for this work and it is impacting on the capacity and/ or delivery of appropriate treatments within Haematology. The directorate continues to explore options to repatriate these services where appropriate, ensuring person-centred care is delivered in the right place.

A key risk carried by the directorate is that CAVUHB are the only provider in Wales of bone marrow transplant (BMT) and CAR-T (cancer immunotherapy treatment) therapies. Maintaining JACIE (Joint Accreditation Committee of the International Society for Cellular Therapy) accreditation is a fundamental requirement of the JCC service specification for BMT and CAR-T and of the pharmaceutical companies who supply the products for CAR-T. Due to environmental factors related to infrastructure, the UHB is at risk of not retaining JACIE accreditation following the next inspection in 2025. If the UHB is unable to retain JACIE accreditation, the potential impact on the service could result in steps being taken to decommission BMT and CAR-T, which would fundamentally undermine the delivery of haematological cancer services for the population of South Wales. The directorate is continuing to proactively work with Capital Planning colleagues and Welsh Government to develop a new build solution to address these concerns and it is a priority deliverable for the CB.

The directorate has successfully secured a dedicated space to undertake intrathecal chemotherapy administration, as required by national guidance hence mitigating a risk that was previously captured on the corporate risk register. This was part of the benefits realised by maintaining a split footprint to obtain x4 cubicle spaces in response to IP&C risks having demonstrated improved outcomes.

The Teenage Cancer Trust (TCT) charity currently fund six roles within the Teenage and Young Adult (TYA) Service in the UHB and are in the process of developing a new operating model. The model will cease funding for the role of TYA MDT Coordinator in March 2026; decisions regarding future funding of other roles within the service are due Summer 2025. TCT are currently undergoing a feasibility study with the UHB regarding a significant refurbishment of the TCT unit to provide a modernised, fit-for-purpose and age-appropriate space for young people undergoing treatment for cancer. Workstreams in progress include service delivery, design, communications and fundraising. The outcome of the feasibility study will be presented to TCT and the uhb in July 2025. Collaboration is ongoing between the TYA clinical leads and Welsh Government, JCC and Welsh Cancer Alliance regarding updating the outdated TYA Standards for Wales seeking a review of commissioning arrangements for TYA patients in Wales. Key to inform this will also be feedback from patients and their families and the team plan to use CIVICA and feedback from the Youth Advisory Group to inform this.

Infected Blood Inquiry

The Infected Blood Inquiry was established to examine the circumstances in which patients treated by the NHS before 1996 received infected blood and blood products. The final report was published in May 2024 and the CB supported the team in preparing a robust operational response in collaboration with a wide range of stakeholders, which was informed and well received by infected and affected patients and their families.

There are currently known to be 438 individuals - either actively registered or previously registered - with the Bleeding Disorders Network Wales (BDNW) who received infected blood products. In preparation for the publication of the report, a dedicated telephone line and email address was set up by the BDNW, to facilitate the implementation of the recommendations and ensure a clear, dedicated contact process to follow. A ‘padlet’ was also developed by the team as an additional information resource and guidance. In recent months, this has resulted in a substantial increase in workload for the multidisciplinary BDNW team, particularly their single handed dedicated social worker. Work has been tireless to ensure that appropriate levels of support, aligned with the report recommendations are in place. This is not sustainable however and the CB recently attended a Management Executive Meeting to discuss the position and seek advice on the best route for external funding to support additional social work hours and capacity, predominantly to focus on supporting the compensation process for these patients.

Awards and Recognition

The Haematology Clinical Research Group (CRG) nurse manager was nominated and shortlisted for the RCN ‘Nurse of the Year’ award in relation to nurse-led research studies.

The nurse-led hemochromatosis clinic is now fully established at UHW/UHL, and the lead CNS was shortlisted and commended for her work in this area as part of the RCN ‘Nurse of the Year’ awards as a model for practice ongoing. It will be important to undertake audits as this work progresses as it will enable patients to be discharged from the hospital setting to the Welsh Blood Service, supporting care in the right place.

The Teenage and Young Adult Outreach Team were winners of the 2024 Moondance Achievement Award for 'Better Patient Experience' for the expansion of the outreach service across South Wales. In addition, the team on the Teenage Cancer Trust Unit were winners of the 'Team of the Year' in the 2024 Specialist Services Clinical Board annual staff awards.

Immunology

Workforce reshaping within the directorate has led to a revised structure for the team with a new Clinical Director role to support Immunology, Metabolic Medicine and the Neuroendocrine Tumors Service (NETs).

The Immunology Team has had a considerable number of publications and success with multiple posters and presentations. They have also been involved in several studies aligned with service development and improvement.

One example is the DART study to assess the accuracy, ease of use and acceptability of dried blood spot (DBS) sampling to monitor immunoglobulin levels of patients with antibody deficiency receiving immunoglobulin replacement therapy (IgRT). One of the main advantages of using DBS specimens is that it allows specimens to be collected in situations where standard blood collection is challenging (problems with sampling, transport, and storage) and is possible across geographical distance.

Chilcott, Rachel
08/05/2025 16:26:52

In contrast to conventional liquid blood sampling this does not require the patient to travel to a hospital or GP surgery with potential exposure to nosocomial infection. Phlebotomy staff and blood bottles are not required and transport to central laboratories is much simpler in an envelope through the post, versus the more complex time sensitive transport needed for liquid blood samples.

Collaborative work

The Immunoglobulin Forward Strategy Group is co-chaired by Professor Stephen Jolles with Chloe George from the Welsh Blood Service (WBS) and medical, nursing, pharmacy, WBS and commissioning stakeholders. This is a key group which has protected supply of immunoglobulin and ensured quality for patients in Wales for many years avoiding the serious issues which have arisen in the other nations.

Consultant Nurses, Emily Carne, created, developed, wrote, and ran the first ever UK British Society of Immunology Nursing Excellence Course (RCN accredited).

UGMedicinternational whereby the team regularly host international students in Immunology, Allergy and the laboratory.

Achievements

Quality in Primary Immunodeficiency Services (QPIDS) is the accreditation programme for primary immunodeficiency services in the UK. Services undergo a programme of quality improvement before receiving a rigorous assessment against the QPIDS standards by medical, nursing and patient inspectors. The QPIDS accreditation was awarded to the CAVUHB Immunodeficiency Centre for Wales in March 2025.

The team were awarded the Jeffrey Modell Centre Network status. The Jeffrey Modell Foundation is a global network recognising centres of excellence and linking teams across the world with 6 centres recognised in the UK. Outside of England, Cardiff is the only centre across the other 3 nations.

Professor Stephen Jolles was awarded Health Hero March 2025 with the accolade, ‘He's everything the NHS stands for and needs’.

Risks

Reduced allergy services in neighbouring Health Boards have contributed to a significantly increased number of referrals to CAV UHB. This has contributed to insufficient capacity for allergy patients on the outpatient waiting list to be seen in a timely manner, resulting in delayed diagnosis and the increased risk of anaphylaxis. Psychology and dietetic services are not commissioned and patients are unable to access these services. The team are currently supporting an all-Wales scoping exercise through the Allergy Core Oversight Group. The waiting list is regularly reviewed and out of area referrals are no longer accepted.

Nephrology and Transplant

Transplant

The financial year of 2024/2025 has seen the highest transplant activity (see table below)*:*

Chilcott, Rachel
08/09/2025 16:26:32

Donor Type	***2022/23***	***2023/24***	***2024/25***
Deceased	*78*	*87*	*87*
Live Donor	*41*	*42*	*47*
Total	*119*	*129*	*134*

This has been achieved through several measures including, but not limited to, improvement in patient education and a ‘transplant first’ approach. The directorate has also had an increase in access to general anaesthetic and local lists which has allowed a higher allocation to the live donor programme. This has supported toward mitigating the high scoring risk of theatre access for the directorate too.

The demand for other surgical activities undertaken by the directorate such as complex vascular access, nephrectomy and bilateral hernia repairs is currently 6 months, with 4 months for non-complex surgery and 2 weeks wait for local anaesthetic lists. Whilst the increase in access to theatre has improved performance in some respects, the service continues to have an unmet demand, which is proactively being managed by Directorate Management Team through continuing to work to acquire additional theatre access.

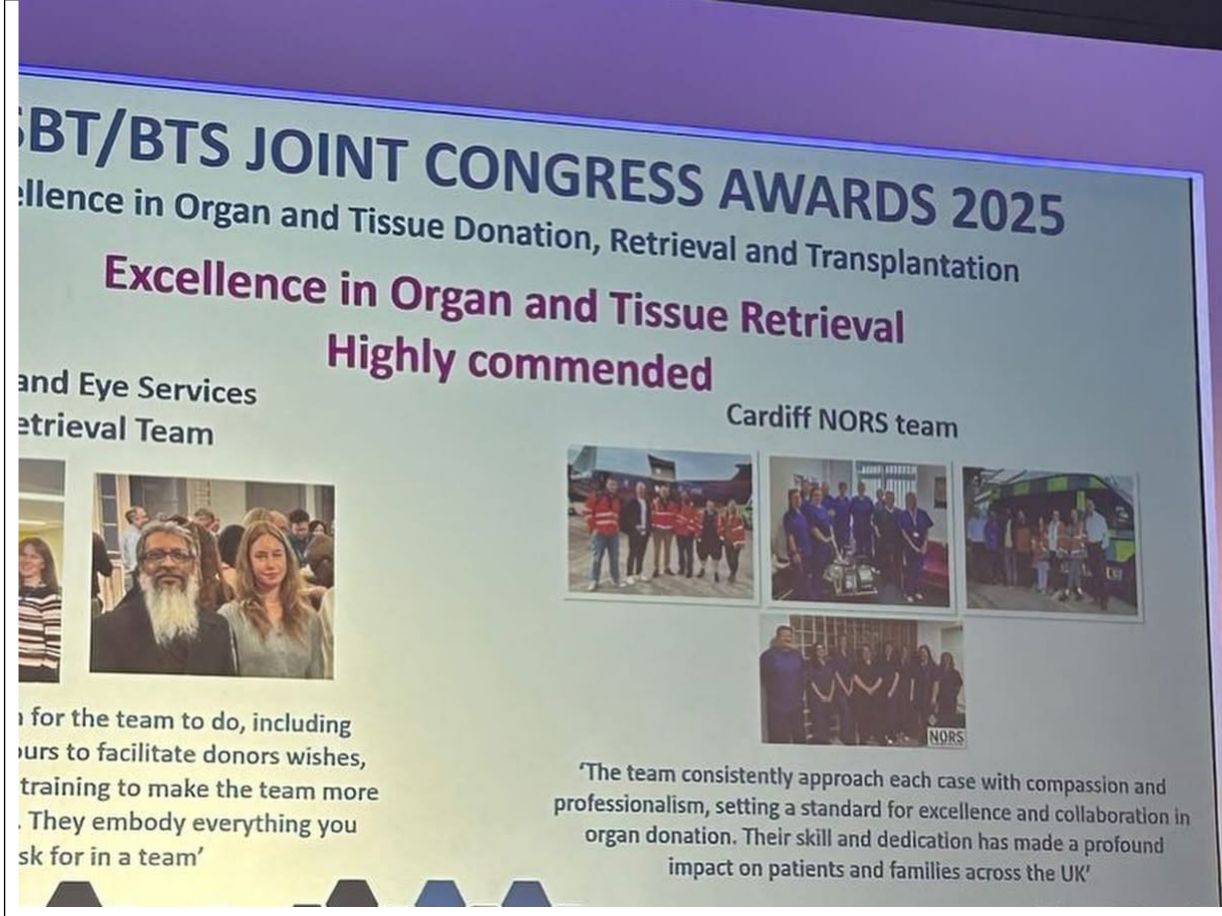
Aligned with the changed allocation of theatre access, the directorate no longer has access to day case beds at UHW, which has resulted in the 6 patients allocated to this list every Friday requiring to be accommodated on T5 (transplant ward). This continues to be a significant pressure for the clinical area due to bed occupancy, which has resulted in a number of cancellations leading to inefficiencies and a poor patient experience. There is also a significant under utilisation of these list, which will likely have a financial implication to the directorate due to the lack of access to day case beds and is captured on the risk register.

With the increase in transplantation, we have seen an increase in demand for outpatient services. This continues to be challenging and is actively managed by a number of team members within N&T. Clinics and demand are reviewed weekly, although this is an area that also remains on our risk register and is focus for the next year.

National Organ Retrieval Service (NORS)

The Cardiff NORS team were awarded the ‘Excellence in Organ and Tissue Retrieval’ at the British Transplant Society Conference in 2025. They were awarded this because ‘the team consistently approach each case with compassion and professionalism, setting a standard for excellence and collaboration in organ donation. Their skill and dedication have made a profound impact on patients and families throughout the UK’.

Chilcott,Rachel
08/05/2025 16:26:52



The Clinical Lead for NORS, Al Croose, also presented during the 4-day national conference his work in relation to establishing a structured training program for NRP, which highlights the importance of a robust education and governance framework which leads to a highly skilled and sustainable workforce.

Nephrology

The chronic kidney disease (CKD) clinical nurse specialist workforce lead on the 'Enhance' programme, which is funded through Value in Health monies. They have redesigned and digitalised patient education for those approaching renal replacement therapy. This structured approach supports patient autonomy and shared decision making. The education has a focus of 'transplant first' for those patients who are appropriate and as a result of this there has been an increase in transplantation.

GLP-1 clinics have been a desire of the directorate for the past year, with the aim of improving access to this weight loss method for patients who are approaching renal replacement therapy and improving access to transplantation. Again, through an MDT and collaborative approach this work is gathering pace and shadow clinics have commenced to skill staff to undertake this independently in the future.

Input from the Supportive Care Service continues to be routine practice within N&T. The dedicated MDT reviews all referrals and a joint clinic supports patients in decision making and symptom control. This important aspect of our service supports patients to remain at home and receive support to prevent avoid hospital admissions for symptom control.

The David Thomas Dialysis Unit MDT have developed and implemented a structure transition pathway for young adults who are planned to move into adult services who are dialysis dependent. This has allowed young adults to be empowered and engaged with their treatment, ultimately improving their understanding, engagement and health. The programme has been widely recognised and reviewed positively by both patients and staff. The programme was presented at the National UK Kidney Conference in 2024.

Neuroscience Directorate

Prolonged Disorders of Consciousness (PDOC) Phase 2

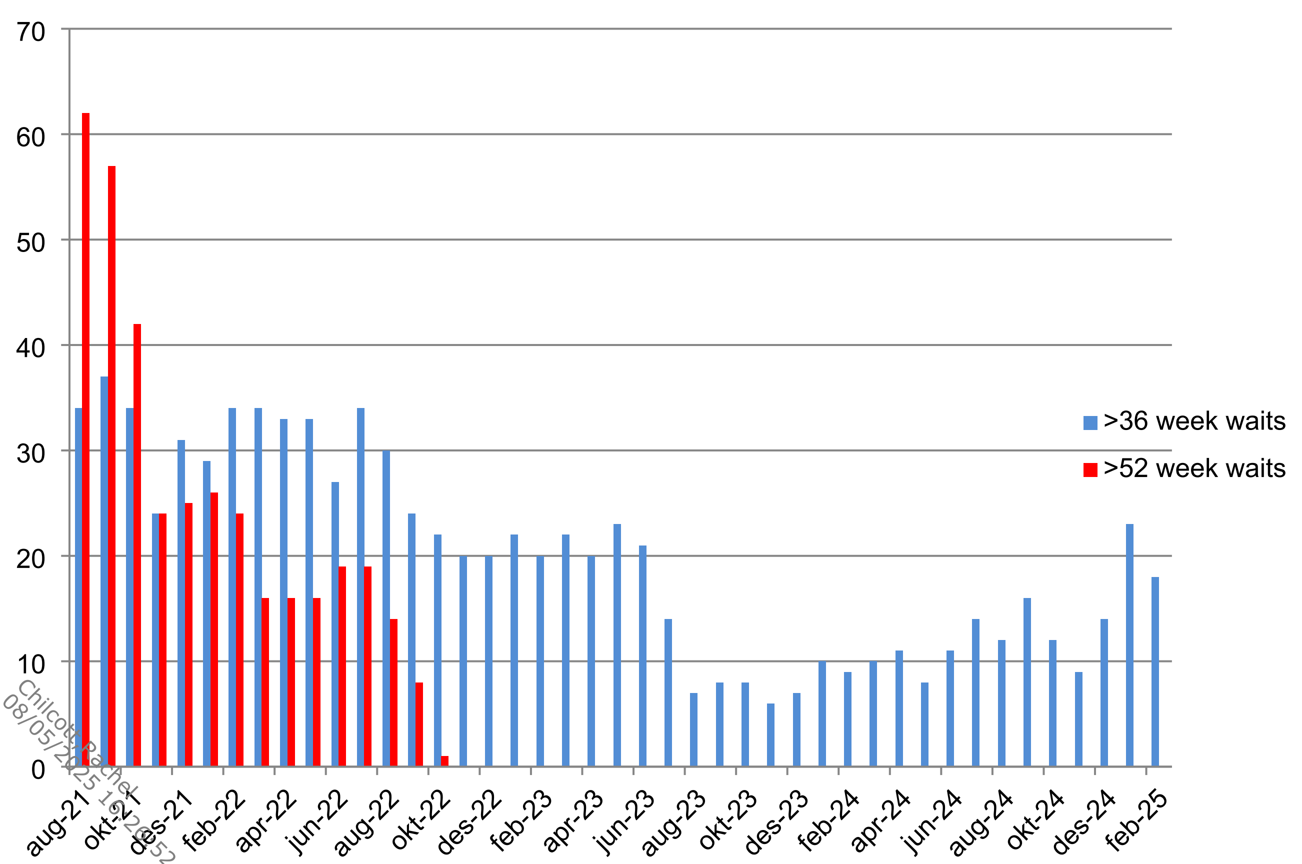
The neurorehabilitation services have been able to further develop its PDOC sub speciality following JCC investment.

The key benefits of the PDOC Phase 2 Service are:

- Equitable Service Delivery across specified regions of Wales
- Improved Patient Outcomes
- Workforce Development
- Monitoring and Reporting
- Support for Families
- Service Sustainability

Neurosurgical Performance Data:

The graph below clearly demonstrates the impact of COVID-19 resulting in extreme waits for neurosurgical intervention at its height reporting 62 patients waiting over 1 year. With a detailed recovery programme, the service has been able to implement an improvement programme.



Chilcott, Rachel
08/05/2025 15:26:52

The neurosurgical department has been able to maintain the results following the recovery programme. Currently 93% of the total neurosurgical waiting list (outpatient & Inpatient) is sat under 26 weeks, which is equal to the 92% NHS England targeted position.

Neuromodulation Service

The Neuromodulation Service includes spinal cord stimulation and intrathecal drug delivery at UHW which deliveres life changing care to patients suffering from spasticity and intractable pain.

The service current holds a success rate of over 90%, therefore ensuring the vast majority of patients within the cohort have effective pain management to improve their quality of life. Information from the Neuromodulation Society for UK and Ireland (NSUKI), which represents activity recorded in the National Neuromodulation Register for Cardiff and Vale University Health Board, demonstrate our Spinal Cord Stimulation Service is effective and performing above the UK average in improving pain and spasticity symptoms. The majority of patients reporting to be 'improved' or 'much improved'.

Workforce

The nursing workforce has been prioritized over the last 12 months within Neurosciences and this has resulted in a significantly decreased vacancy rate across the directorate. Following the success of the assistant practitioner (AP) role, overseas nurse recruitment and bespoke recruitment events, the Band 5 vacancy position has improved from 22 WTE in October 2024 to nil vacancies currently that are not aligned with a plan.

The T4 High Care Unit and nursing team has also transitioned back across from the Critical Care Directorate. This has provided an opportunity for rotation nursing posts to be considered alongside excellent training and education opportunities. It also enhances the journey for patients by making it seamless throughout their admission.

Risks

There are 2 epilepsy related risks that each score 20 on the risk register. Epilepsy Services and the risk associated with sodium valporate MHRA guidance.

The valproate risks relate to the known significant risk of serious harm to a baby after exposure to valproate in pregnancy. Valproate must therefore not be started in new patients (male or female) younger than 55 years, unless 2 specialists independently consider and document that there is no other effective or tolerated treatment, or there are compelling reasons that the reproductive risks do not apply. At their next annual specialist review, women of childbearing potential and girls should be reviewed using a revised valproate risk acknowledgement form. This will include the need for a second specialist signature if the patient is to continue with valproate and subsequent annual reviews with one specialist unless the patient's situation changes

An Action Plan has been put in place and many of these have been undertaken, for example targeting high risk patients, working with GPs for safe transfer and recruiting to a valproate coordinator post. The team are not yet fully compliant however.

The second risk is that there are are prolonged waits for review within the Epilepsy Service to include the sodium valproate, ante natal and first seizure clinics. The CB are working closely with the directorate to address this. At the last meeting it was agreed to progress with workforce reshaping and a pharmacist prescribing post, to review options to increase the number of first seizure clinics (being supported by a neurology registrar currently) to 2 per week and to review opportunities for additional consultant sessions.

Chilcott, Rachel
08/05/2025 16:26:52

Cardiac Services

Safe Care

The QSE monthly meeting is a formal and well attended multi-disciplinary forum within Cardiothoracics.

Interventional cardiology M&M Meetings take place monthly, chaired by a consultant interventional cardiologist. This is attended by the consultants, senior nurse for the Cardiac Catheter labs and trainee registrars. The purpose is to review and discuss any complex cases and mortality incidents to identify and share learning in a collaborative approach. An anonymised reporting mechanism has also been established within the Cardiothoracic Directorate to enable staff to raise concerns relating to the activity that has taken place within the cardiac catheter labs.

A weekly MDT meeting is held and attended by a cardiothoracic surgeon, consultant cardiologists from CAVUHB, other HBs and trainee registrars. The purpose of this is to discuss the suitability of patients for cardiac surgery versus less invasive procedures such as Transcatheter Aortic Valve Implantation and Percutaneous Coronary Intervention.

A monthly pacemaker device box change MDT was recently implemented by one of the device/heart failure consultant cardiologists. This was partly in response to related incidents within the directorate and the purpose is to review all patients whose device batteries are due for renewal and for a decision on appropriate management.

Successful Return of the Cardiothoracic surgery to UHW

The planned return of the Cardiothoracic Services from UHL to UHW was successfully completed in September 2024. This has eliminated the significant risks associated with services over split sites. The directorate worked in collaboration with internal and external stakeholders to safely co-ordinate and manage the return with minimal disruption to services and patient care. To support this move to UHW, interim footprint moves took place to mitigate reduced capacity. The directorate have successfully refurbished the old Discharge Lounge, located adjacent to the Cardiac Day Case Unit to support relocation of the acute coronary syndrome (ACS) Treat and Repatriate (T&R) Service. As part of the return to UHW, Ward C5 and CITU have undergone a total refurbishment to ensure the environment is suitable to deliver safe patient care. This has had a positive impact on all staff working within the cardiothoracic surgery department and this was evidenced in the way the teams worked collaboratively during and after the move.

Transcatheter Aortic Valve Replacement (TAVI) Bay

Working in collaboration with the directorate, CB and wider UHB, a ring-fenced mixed gender TAVI Bay has been created on Ward B1. The driver for this innovation was the increased waiting time for this cohort of critically ill patients, high mortality and insufficient bed capacity.

The patients are all pre-assessed 1 week prior to their admission and given all the necessary admission details. Patients are then admitted to the TAVI Bay the evening prior to their procedure for the following day and return to the TAVI Bay following their procedure. The patients are cared for by the ward nurses and early mobilisation is key to enable the patients discharge home the following day.

Chilcott,Rachel
08/05/2025 16:26:52

The TAVI Bay has had significant benefits to the TAVI programme reducing our elective pathway by a significant number of weeks. Previously there were 100 + patients who were ready for TAVI but with no confirmed date. Since go live in July 2024, there are currently 23 patients who are ready and have been allocated dates in March 2025 and 74 patients who

are currently being worked up for TAVI. The elective pathway has now reduced to 36 weeks, which is a reduction of 23 weeks since July 2024 and commencement of the TAVI bay.

Since opening the TAVI Bay, it has been possible to regularly admit 3 or 4 elective patients per list and to plan to admit 4 on most elective lists (previously a maximum of 3). Fewer elective patients are being cancelled at late notice because of lack of beds or to prioritize an in-patient as inpatient lists can also be planned more effectively.

Early mobilisation post TAVI

Early mobilisation post TAVI has been shown to have positive outcomes for patients, in that there are less reports of delirium, infection, discomfort, and hospital acquired deconditioning. It is recognized that there is no increase in vascular bleeding complications in the patients that are mobilised earlier (6 hours) compared to those mobilised at 12 hours post procedure.

It was felt that this would be a small improvement to patient care that would have a significant benefit to patient outcomes and potentially reduce length of hospital stay as indicated in the literature and at the benchmark centre.

The TAVI team worked in collaboration with the ward sister and nursing team to deliver training with them which included a blend of theoretical education sessions to evidence the benefits for patients and then bed side sessions working alongside the nursing team teaching management of vascular complications.

The results have shown that the nursing staff feel much more confident and competent when caring for patients post TAVI which has resulted in more patients being mobilised 6 hours post procedure. This has had a positive impact on the patient's length of stay and since initiation of early mobilisation training, we have seen a reduction in the patient's length of stay. In addition to this we have been able to send 2 patients' home on the same day of their procedure. It would be prudent to say that the patients suitable for same day discharge are a very small and carefully selected group of patients.

Explain My Procedure

The Cardiothoracic Directorate implemented a new initiative called 'Explain your Procedure in May 2024'. This has improved communication and evidenced based information given to patients who require cardiac procedures/ intervention or cardiothoracic surgery.

This initiative is to work towards a more varied and informative consenting process for our patients; to allow them a better understanding of how these procedures work and what the recovery & risks to these procedures are.

The expectation is that this will be used not only in the 1:1 patient setting but also to be incorporated into correspondence, leaflets and posters across the directorate to fully immerse the usage of these links and QR codes into all the resources which we have readily available to us – with the guidance of the individual areas themselves. This initiative is not a replacement for the existing processes to consent patients but an enhancement.

Chilcott, Rachel
08/05/2025 14:28:52

Other Headlines

●A right sizing project has been undertaken in collaboration with the CB and Cardiff University in response to pressure on services, capacity and environment. Cardiology bed capacity itself is also a current challenge. These constraints are also captured within the right sizing project and on the risk register.

●Planned relocation of CCU, step down Ward C3 and pacing theatre to Ward C1 and SSSU. Plans and funding finalised with work anticipated to commence mid-May 2025. This will eliminate the risks associated with current services fragmented across the UHW site and reduced cardiology bed capacity.

●The Cardiothoracic Directorate are committed to delivering the values and behaviours of the UHB to all our staff. Following recent concerns highlighted at various levels regarding the behaviours of specific staff groups, the directorate team have been working collaboratively with the CB and Executive Team to undertake an independent review of values and behaviours across the Cardiology Department. The review commenced in September 2024 and an outcome is awaited.

●The Cardiothoracic team have successfully improved the working environment for a number of teams within the directorate over the last 12 months. These include a total refurbishment of the Catheter Lab changing rooms, refurbishment of Ward B1 changing rooms, relocation and refurbishment of the junior doctor's office and successfully securing additional office space for the CNS Team. These refurbishments have been supported by the Cardiothoracic Directorate endownment funds and have had a well received with a positive impact on the staff.

●The adult congenital heart disease ACHD team were successful in obtaining a 12-month BHF funding bid to implement a biopsychosocial service to enhance engagement in physical activity in people living with adult congenital disease. This pilot innovation that commenced in September 2024 is a newly implemented exercise program for adults with ACHD in South Wales. Patients will receive individualized support from physiotherapy, nursing and psychology to help overcome the barriers and concerns about exercising with the aim of improving health and wellbeing. This has previously been unavailable to our patients who were born with the heart condition, and there is a recognized inequality of service provision compared to patients who develop heart disease in later life

Workforce

The Cardiothoracic rotational programme for new starters is going from strength to strength, being constantly evaluated to ensure it is meeting the needs of clinical areas and new staff. It has now been offered to staff who have been in post longer and missed the opportunity at the start of their service. This programme is supporting the recruitment, retention and ongoing development of nursing staff within the directorate.

In order to build and create a sustainable cardiothoracic workforce, the directorate are undertaking a benchmarking exercise to reduce the recurrent medical gaps by developing a non-medical workforce structure consisting of advanced nurse practitioners (ANPs), advanced critical care practitioners (ACCPs) and surgical care practitioners (SCPs)

The Cardiothoracic Directorate have recently appointed a 7th interventional consultant cardiologist and a locum imaging consultant cardiologist to support the increased demand on cardiology services especially within interventional cardiology and MRI for ACHD patients. Following feedback from HEIW the directorate has recently implemented a consultant of the week to provide senior decision making for the ward areas and improve relationships and training opportunities for the resident doctors.

Chilcott, Rachel
08/05/2025 16:26:52

The Physiology Department has recently appointed 3 experienced Band 7 cardiac physiologists. To improve recruitment and retention, the directorate in collaboration with the CB are currently working towards implementing a preceptorship model allowing Band 5 cardiac physiologists to work towards achieving a Band 6 on completion of competencies. The directorate are also currently working with the cardiac physiologists to look at work-life

balance opportunities in terms of the current rota frequency and training/teaching opportunities to support recruitment and retention.

Risks

The most significant risks currently held by the directorate and captured on the risk register, scoring 20, are:

- the inability to deliver cardiac surgery theatre lists to support current waiting list and in-house referrals.
- the cardiology outpatient waiting list as a consequence of demand versus capacity constraints

Work is ongoing to address and mitigate these to include continued validation and prioritization.

Artificial Limb and Appliance Service (ALAS)

Headlines

During the last year ALAS have implemented 'safety checks' with every engineer contact. This is 'making every contact count' and taking the opportunity to identify potential maintenance and/or safety issues. With 7648 repairs completed in the past 12 months, which is a high volume of opportunity to take a preventative approach to maintenance and safety.

A 'Grab & Go' scheme has been put into operation within the complex postural pathway. This involves keeping a stock of Rea wheelchairs (with required accessories such as pelvic belt and seat cushion) that can be taken to assessment appointments and issued if appropriate. This has saved time for clinicians, but also improved the quality of our service delivery for our service users by making it timelier.

In collaboration with colleagues at UHL, a wheelchair clinic has been established there for inpatients to attend. This is in the early stages, but feedback so far has been positive and early indication is that it is improving patient experience with an effective and equitable service.

A rapid response pathway has been initiated which prioritises wheelchair provision for service users who have a prognosis of less than 6 months and/ or a rapidly deteriorating condition such as Motor Neurone Disease. There have been 192 episodes of care opened under this over the past 12 months, with 44 currently live.

The is a pressure management pathway in use which prioritises referrals for service users with severe pressure ulcers (grade 3 and above or deemed to be a high risk). This may involve provision and set up of air cushions, pressure redistributing accessories for other parts of the wheelchair if needed (such as footplates, hangers, backrest, armrest, headrest) and specialist assessment of positioning in the wheelchair including use of pressure map when appropriate. This pathway has had 122 episodes of care opened in the past 12 months, with 15 currently open.

In order to achieve a person-centred approach, a pressure management therapist continues to attend wound clinic at UHW to work collaboratively with the MDT as needed for any service users that are attending the clinic.

Chilcott,Rachel 08/05/2025 16:26:52

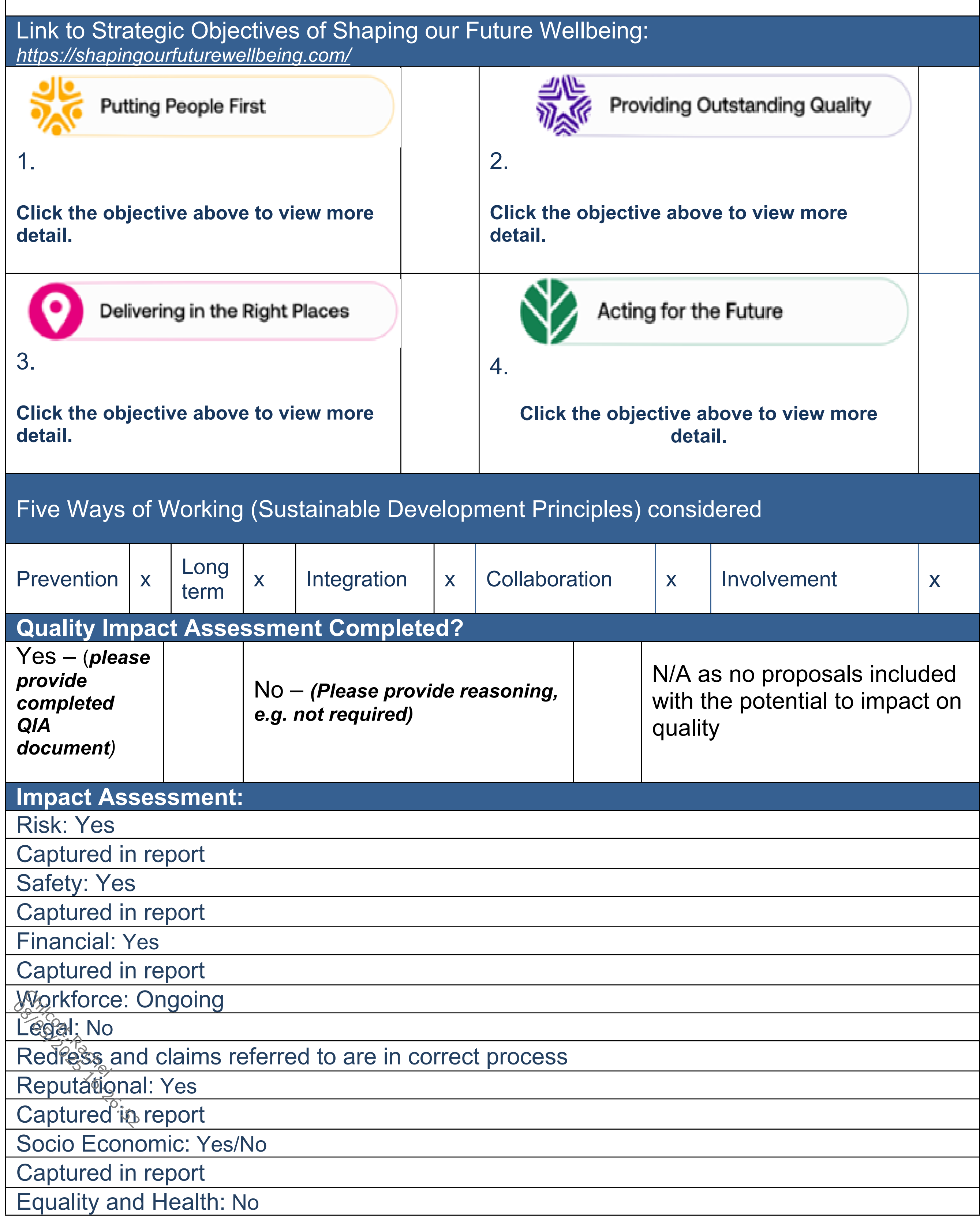
Executive Director Opinion and Key Issues to bring to the attention of the Committee:

Recommendation:

The Committee is requested to:

- Note contents and in particular, highest risk areas for SSCB to include:
  - Critical Care infrastructure
  - Maintaining JACIE accreditation in Haematology
  - Access to renal theatre lists
  - Risks aligned with Epilepsy Services
  - Cardiac surgery waiting lists

These have all previously been discussed at executive reviews and will be taken back upon request, or when the CB have a specific ask for support in managing such.



Link to Strategic Objectives of Shaping our Future Wellbeing: *https://shapingourfuturewellbeing.com/*			
Putting People First 1. **Click the objective above to view more detail.**		Providing Outstanding Quality 2. **Click the objective above to view more detail.**	
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		N/A as no proposals included with the potential to impact on quality

Impact Assessment:
Risk: Yes
Captured in report
Safety: Yes
Captured in report
Financial: Yes
Captured in report
Workforce: Ongoing
Legal: No
Redress and claims referred to are in correct process
Reputational: Yes
Captured in report
Socio Economic: Yes/No
Captured in report
Equality and Health: No

Decarbonisation: Yes	
Report exemplifies how above is being achieved	
Welsh Language: Yes/No	
Not specifically referred to within body of report but an ongoing consideration.	
Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Report Title:	Quality Indicators Report			Agenda Item no.		2.2
Meeting:	Quality Committee		Public	X	Meeting Date:	13.05.2025
			Private			
Status:	Assurance	X	Approval		Information	
Lead Executive:	Executive Medical Director and Executive Nurse Director					
Report Author:	Assistant Director of Quality and Patient Safety					

Background and current situation:

The Quality Indicators report provides assurance in relation to a number of quality, safety and patient experience priorities.

The report provides oversight of data up until the end of December with details of actions that are being undertaken to drive the requisite improvements.

The quality Indicators report will include exception reporting to bring emerging quality and patient safety issues and themes to the attention of the committee.

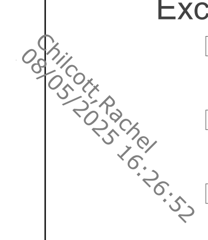
The quality indicators are continuing to develop and further indicators will be included to provide oversight of the timeliness of patient care and equality and equity of care provision and health outcomes.

Work is underway within the Health Board to review the quality indicators used to provide assurance and inform quality improvement. The development of a Quality Improvement Efficiency and Performance (QEIP) dashboard will incorporate a range of data. The quality dataset is being generated in bundles that correlate with frequently reported patient safety incidents and quality priorities. Data will be taken from a number of sources to support triangulation and would include
data relating to patient safety incidents, compliance with associate risk assessments, crude outcome data from Business Intelligence Systems (BIS), patient experience data from the CIVICA platform and Staffing rates aligned to staffing legislation.

The aim is to support a process that informs quality improvement rather than just providing a narrative around performance.

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

- **Patient Safety Incident Reporting Rates**: The reporting rate of nationally reportable incidents is 1.93 per 100,000 population, compared to a national rate of 3.29 across Wales.
- **Duty of Candour**: 269 Duty of Candour triggers were identified, with key themes including avoidable pressure damage and falls.
- **Quality Excellence Programme**: The UHB Shaping Our Future Quality Excellence programme is progressing with three main areas:
  - **Care of the Deteriorating Patient**: Implementation of the National Early Warning Score 2 (NEWS 2) tool by September 2025.
  - **Continuity of Patient Care**: Centralized referral process and prudent approach to discharge and follow-up care.
  - **Infection Prevention and Control**: Reduction in healthcare-associated infections through data-driven quality improvement.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- **Increase in Never Events**: There has been an increase in the number of Never Events reported over the last year, each thoroughly reviewed for learning and improvement.
- **WHO Checklist Collaborative**: A large-scale review of the WHO checklist aims to transition from paper-based to team safety processes, supported by a Charter with explicit roles and responsibilities.
- **Infection prevention and Control**: There continues to be an increased trajectory of C diff cases above the previous year. Aseptic Non-Touch Technique continues to be promoted to support improvements in MRSA rates. 34% of MSSA cases have been acquired in hospital, Route Cause Analysis are being undertaken for all cases to further understand the reasons for acquisition.
- **Medication Incidents Reported**: 407 medicines-related incidents were reported between January 1, 2025, and March 31, 2025.
- **Actions Undertaken**:
  - Introduction of 'Druggles' in Critical Care and Mental Health.
  - Improvement of second check processes during medicines administration.
  - Collaboration with the ePMA team for timely administration of time-critical medicines.
  - Implementation of Clozapine monitoring safety improvements.
  - Development of SOP for emergency buccal midazolam administration.
- **Mortality Dashboard**: Monitoring of mortality-related measures, including deaths per 10,000 EU attendances and inpatient deaths per 1,000 bed days.
- **Medical Examiner Reviews**: 19.9% of cases reviewed by the Medical Examiner were returned for further consideration, with common reasons being family concerns and communication issues.
- **Person-Centered Care**: Focus on patient experience and feedback, with initiatives like the DrEaMing agenda supported by volunteers and interactive touch table devices to enhance patient engagement.
- Interactive Touch Tables: Installed at three hospitals to enhance patient engagement.
- **Patient Experience**: 87% of respondents felt safe and found staff kind and caring.
- **Emergency Unit**: 69% felt listened to, and 61% found the wait time acceptable.
- **Mental Health Services**: 63% felt listened to, and 66% were satisfied with the wait time
- **Nurse Staffing Monitoring**: Staffing levels for 25B wards are closely monitored, showing a year-on-year reduction in agency use.
- **SafeCare Compliance**: 86% compliance achieved, with majority of shifts judged appropriate based on professional judgment.

Recommendation:

The Committee is requested to:

a) **NOTE** the assurance provided by the report

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

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1. **Click the objective above to view more detail.**	Providing Outstanding Quality 2. **Click the objective above to view more detail.**

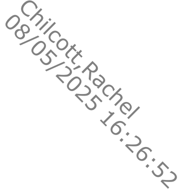
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered										
Prevention		Long term		Integration		Collaboration			Involvement	

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		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 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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Quality Indicators Report

Quality Safety and Experience

May 2025

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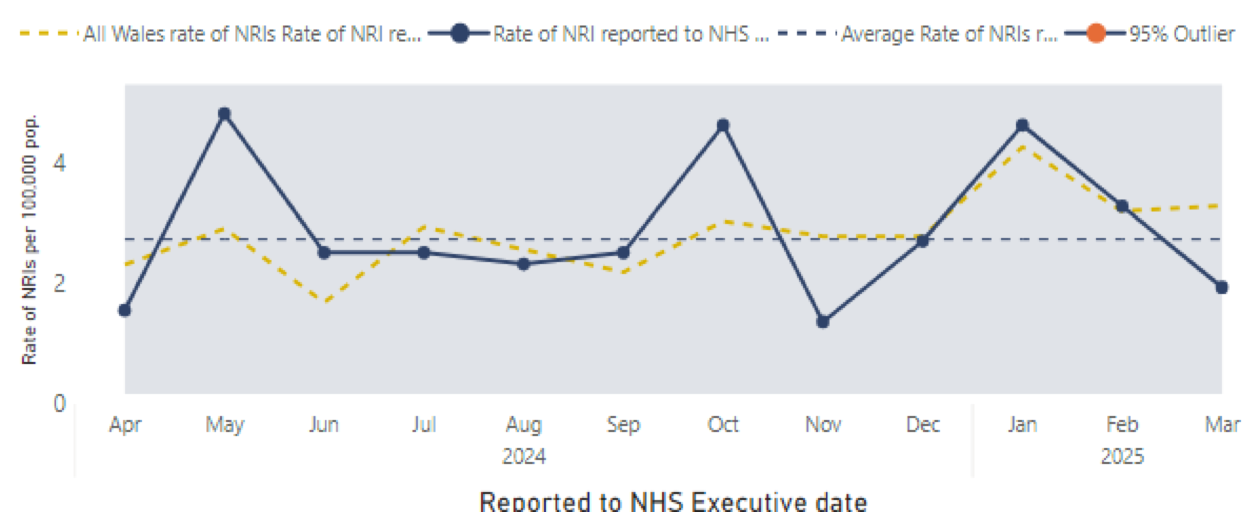
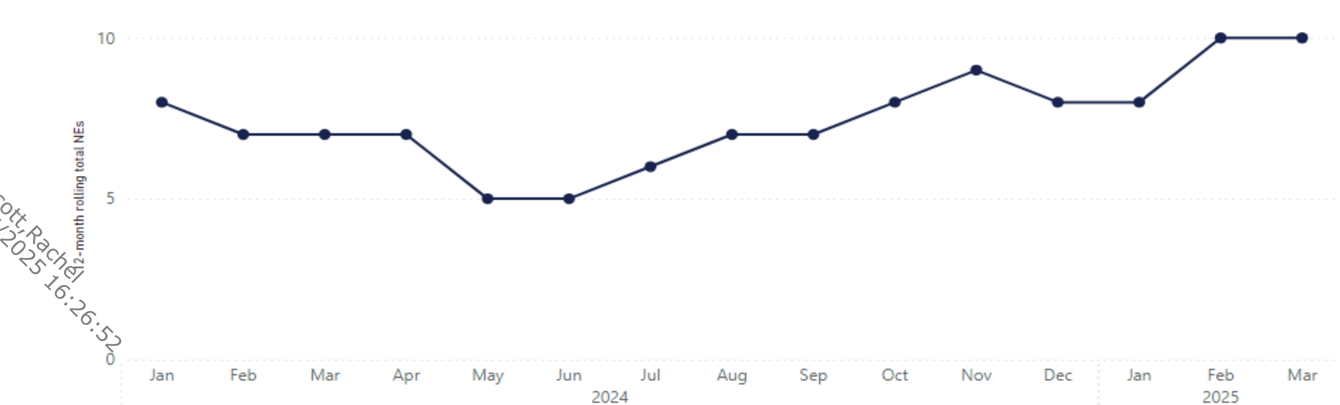
Safe Care

Patient Safety Incidents





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The reporting of nationally reportable incidents is in line with national reporting rates with a reporting rate of 1.93 per 100000 population compared with a national rate of 3.29 across Wales.

The UHB Shaping Our Future Quality Excellence programme is progressing with three programmes of work that align to themes that are emerging from patient safety incidents. These include:

Care of the deteriorating patient which will deliver the implementation of the National Early Warning Score 2 (NEWS 2) tool by September 2025 with an associated programme of education and a standardised clinical response to inpatient deterioration.

Continuity of patient care from referral to discharge will deliver a centralised referral process and prudent approach to discharge and follow up care provision of outpatients.

Infection prevention and control delivering a reduction in health care associated infections through data driven quality improvement

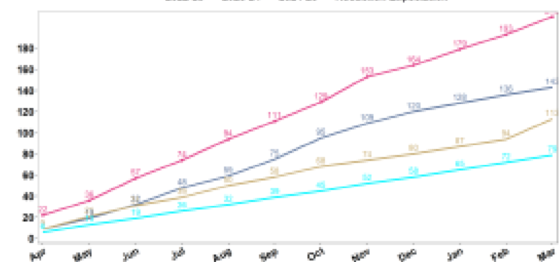
There has been an increase in the number of Never Events reported over the last year, each of these has been externally reported and subject to a thorough review to determine learning and improvement action.

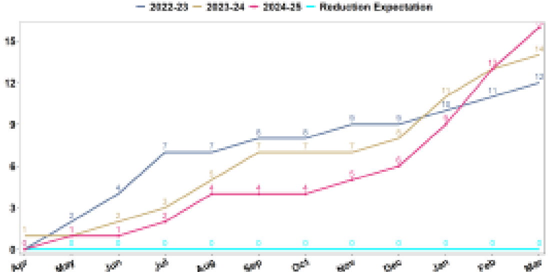
In April the WHO Checklist collaborative met to undertake a largescale review of the WHO checklist in partnership with Surgeons, Anaesthetists, Interventional Radiologists, Scrub Practitioners and Anaesthetic Practitioners.

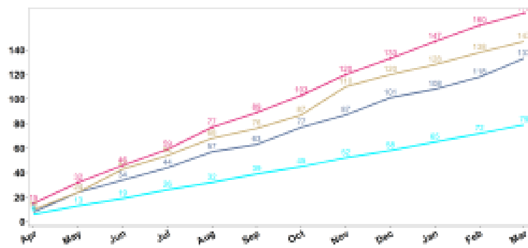
The Collaborative's aim is to move from the completion of a paper-based checklist to a team safety process where every member is engaged in the checks and planning for each surgical procedure and is fully sighted on the completion on a wall mounted whiteboard in each theatre. The revised checklist will be supported by a Charter which will include explicit roles and responsibilities. It is hoped that this will help reduce the number of reported Never Events.

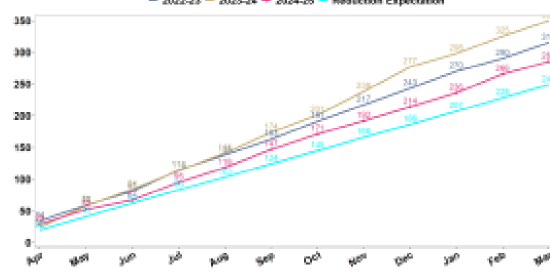
Safe Care

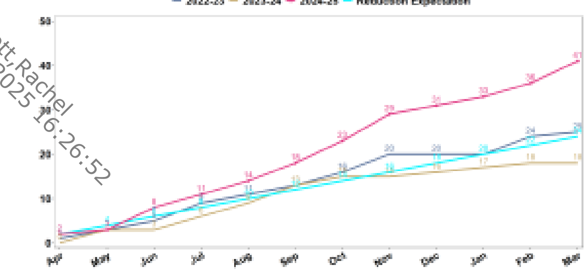
Infection Prevention and Control

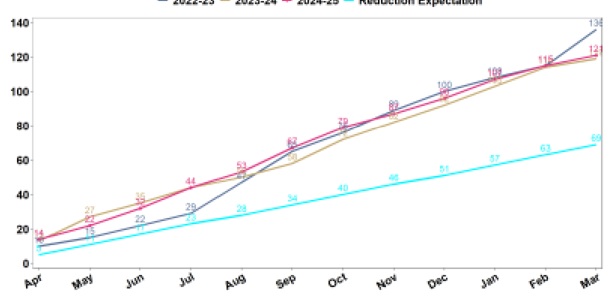












C'diff – Whilst there continues to be an increased trajectory of cases. Further analysis is being conducted to understand the trend of C.Diff cases. All appropriate actions have been taken

MRSA – Aseptic Non-Touch Technique (ANTT) continues to be promoted, and examination of cases continues to be conducted to determine further improvements. Particularly as CAVUHB rates are the lowest rate per 100,000 population.

MSSA – The reduction of MSSA has not met the reduction expectations target, with approximately 34% of cases have been acquired in hospital. Further investigation of RCAs are being conducted to understand the root cause. All appropriate actions have been taken and improvements have been made.

E.coli - There is further work required to examine the trends as CAVUHB has not met the expected reduction, despite this CAVUHB continues to have the lowest rate per 100,000 population across all acute Health Boards in Wales

Klebsiella sp. - There is continued review of cases as the trajectory remains above expected reduction targets monthly number of cases remain variable and there are slightly more cases to the equivelant period last year

Paer – There remains a continued focus on analysing the cases to understand further the root cause the numbers of cases continues to rise compared to the same period last year and CAVUHB currently has the highest rate per 100,000 across all acute Health Boards.

The gloves off campaign is being fully launched in May 2025 this will raise the profile of hand washing and adhering to IPC guidance.

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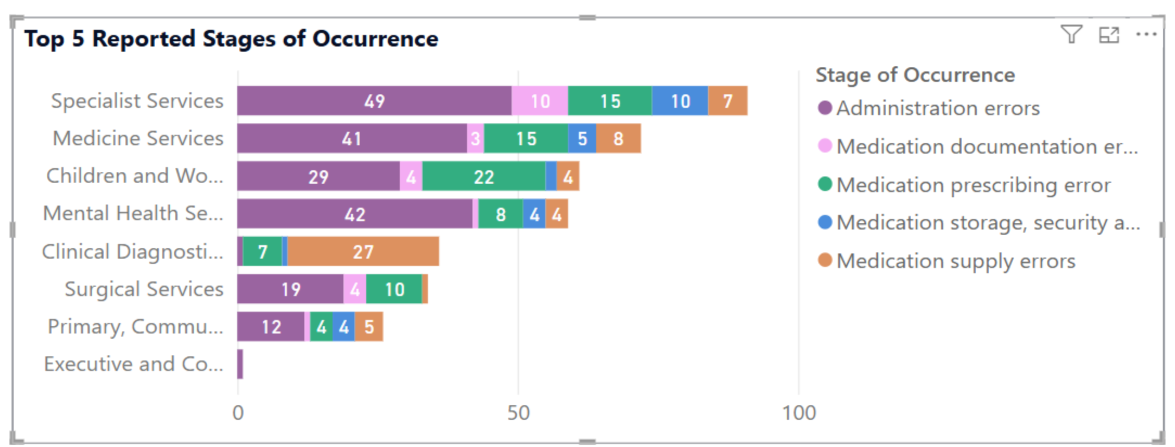
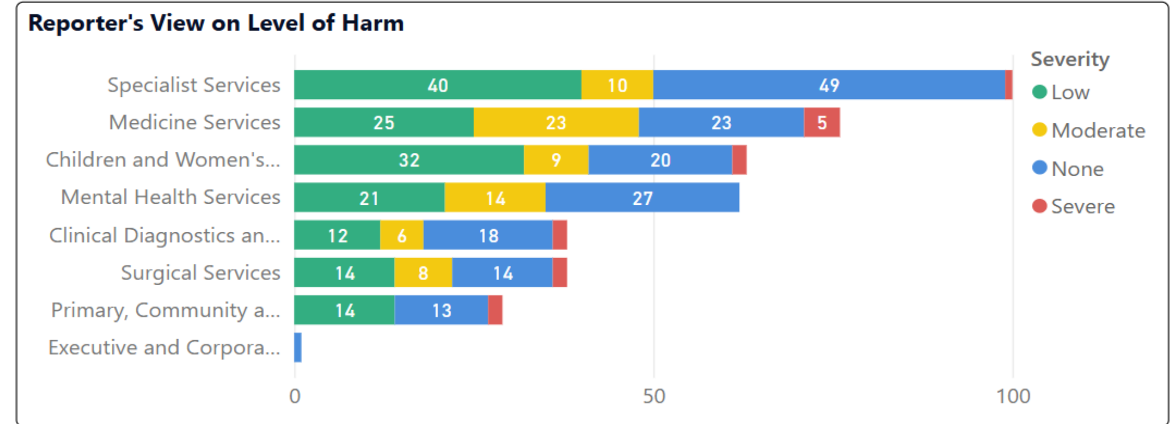
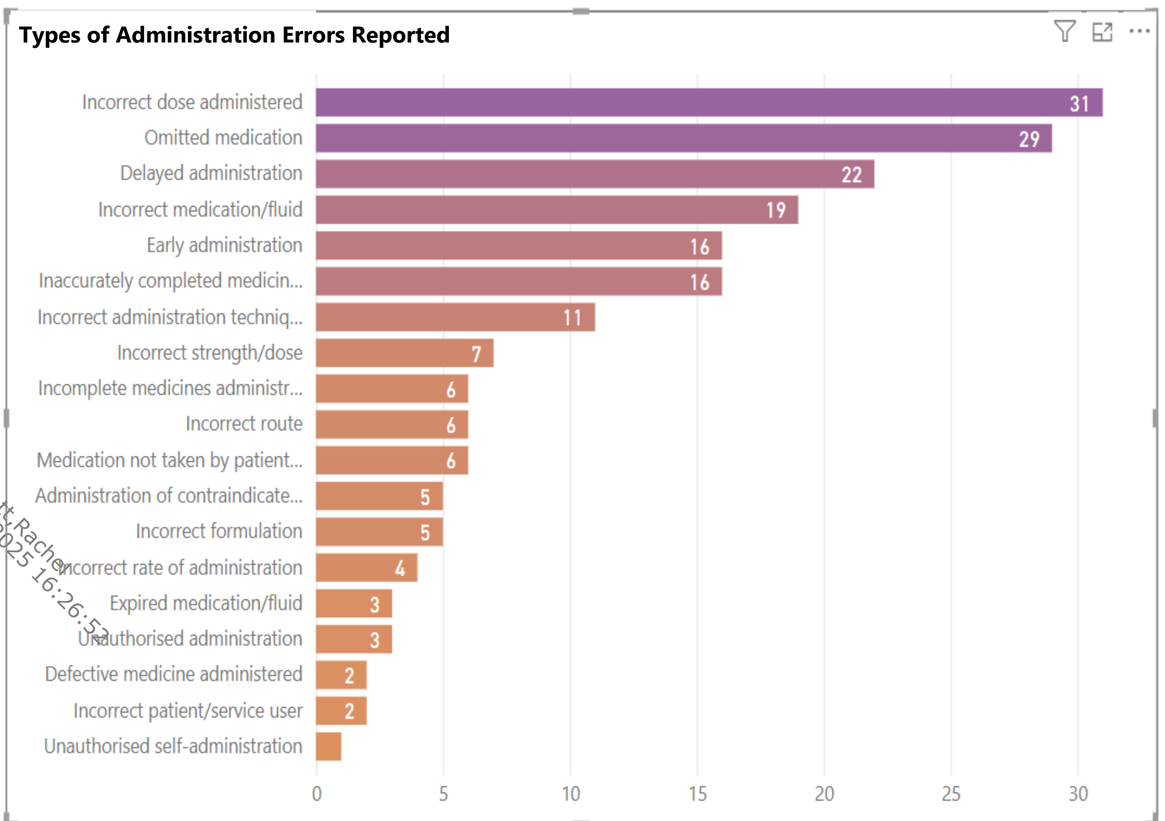
08/05/2025 16:26:52

Medication Incidents
01 January 2025 – 31 March 2025







407 medicines-related incidents were reported between 01 January 2025 and 31 March 2025.

Examples of actions undertaken by colleagues across the UHB to raise awareness of medicines-related risks and reduce harm:

- 'Druggles' introduced in Critical Care and Mental Health. These have already been in place in NNU for a number of years.
- Project to improve second check processes during medicines administration has begun (early stage at present)
- Medicines Management Memo produced and circulated regarding Paracetamol shortage
- Work undertaken in collaboration with the ePMA team to utilise system functionality in relation to improving timely administration of time critical medicines
- Medicines Safety Briefing (March 2025) produced and circulated
- Quality improvement project completed to implement Clozapine monitoring safety improvements
- History based penicillin de-labelling – CAVUHB staff involved in this All Wales work
- SOP developed for administration of emergency buccal midazolam by HCSWs in Children, Young People and Family Health Services (CYPFH)
- Increased practice educator resource to support medication administration and training in Integrated Children's Community Nursing Service (ICCNS)
- NICU and PICU working groups established to look at improving staff engagement, staff culture, process and prescribing practice. Patient Safety Forum established and bedside 5R's teaching developed for NICU. Further work underway.

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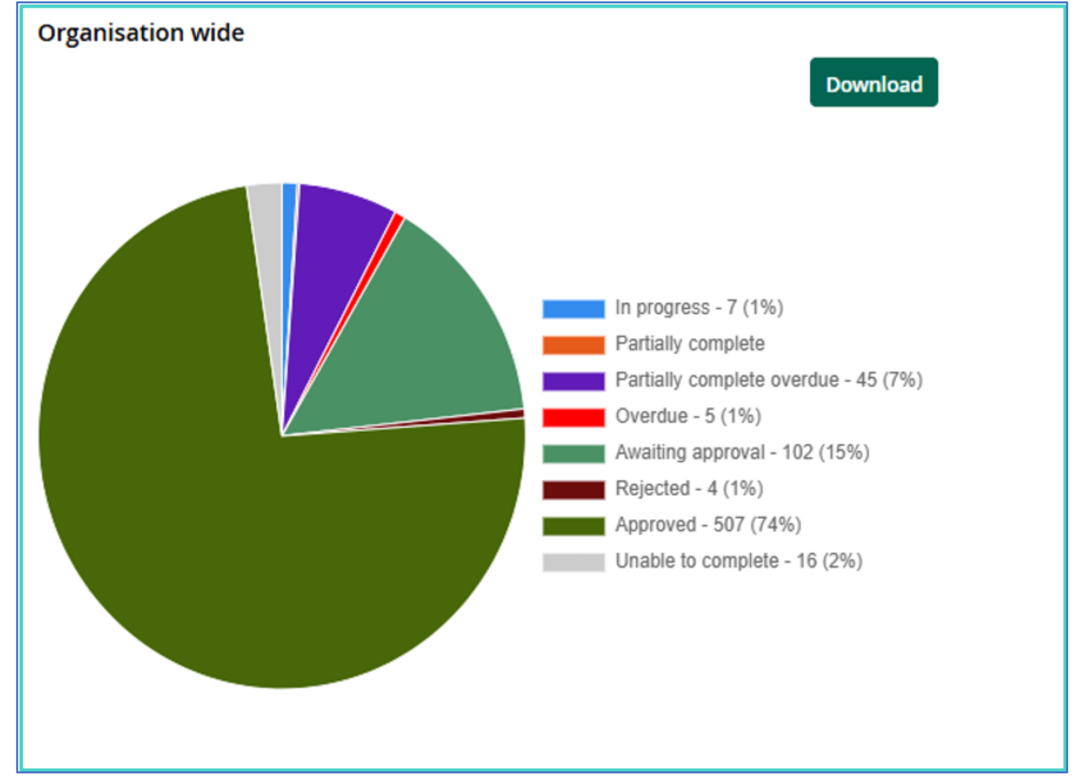
08/05/2025 16:26:52

HIW



Unannounced Inspection of Elizabeth Ward St David's Hospital
HIW undertook an unannounced inspection in Elizabeth Ward in St Dvid's Hospital concluding on 1st May 2025. The Inspection resulted in one immediate assurance recommendation, requiring improvement in Basic Life Support (BLS) training compliance amongst staff. The inspection team were complimentary of the care that they observed, but made observations relating to the ward environment and clinical documentation. The Draft report and wider improvement report are pending.

Inspection of Hamadryad CMHT Centre
A positive inspection with no immediate assurance issues
Draft report and recommendations yet to be received

Inspection of Maple Ward
A positive inspection with no immediate assurance issues
Draft report and recommendations yet to be received

Nuclear Medicine Department and Non-Medical Imaging Department
Works continues to translate all letters into Welsh and the implementation of the RIS system in Medical Physics will support automation of bilingual letters

Pregnancy testing processes for patients of child-bearing potential receiving Iodine 131 treatments being implemented

All Employers procedure documents have been redrafted and are currently being ratified

Safe Care

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08/05/2025 16:26:52

Mortality

Effective Care

WeekNumber

Sum of Death | Sum of 5 Year Week Average

Crude Mortality: Weekly Deaths In Hospital

Values

Weekly Discharge Date

Sum of Death — Sum of 5 Year Week Average

Weekly number of deaths registered, all deaths, ARI deaths (any mention) and 5-year average*, week ending 3 January 2020 (Week 1) to week ending 14 Mar 2025 (Week 11), Cardiff and Vale UHB

Select Wales or Local Health Board: Cardiff and Vale UHB

All deaths — All deaths - 5-year average — ARI

Date: 28/06/2022 – 14/03/2025

The newly developed mortality dashboard facilitates monitoring of a range of mortality-related measures including deaths per 10,000 EU attendances and deaths where patients were previously medically fit.

The number of inpatient deaths per 1000 bed days was 4.1 in April 2025. This is similar to April 2024 (4.0) and lower than April 2023 (4.9). So far this year, the number of inpatient deaths per 1000 bed days is following the expected pattern with a significant drop in deaths from the normal winter peak in December and January.

All deaths that occur in hospital or within Cardiff and Vale of Glamorgan that are not referred to HM Coroner are subject to independent scrutiny by the Medical Examiner. 19.9% of Cardiff and Vale cases reviewed by the Medical Examiner were returned to the UHB for further consideration. Comparable with return rates across Wales which vary from 17.8-25.5%

The most common reasons for cases to be returned to the UHB from the Medical Examiner were due to family concerns raised through the ME process and issues with communication regarding patients' care.

Cases returned from the ME with significant concerns are discussed at a fortnightly multidisciplinary scrutiny panel and learning is fed to clinical and non-clinical teams.

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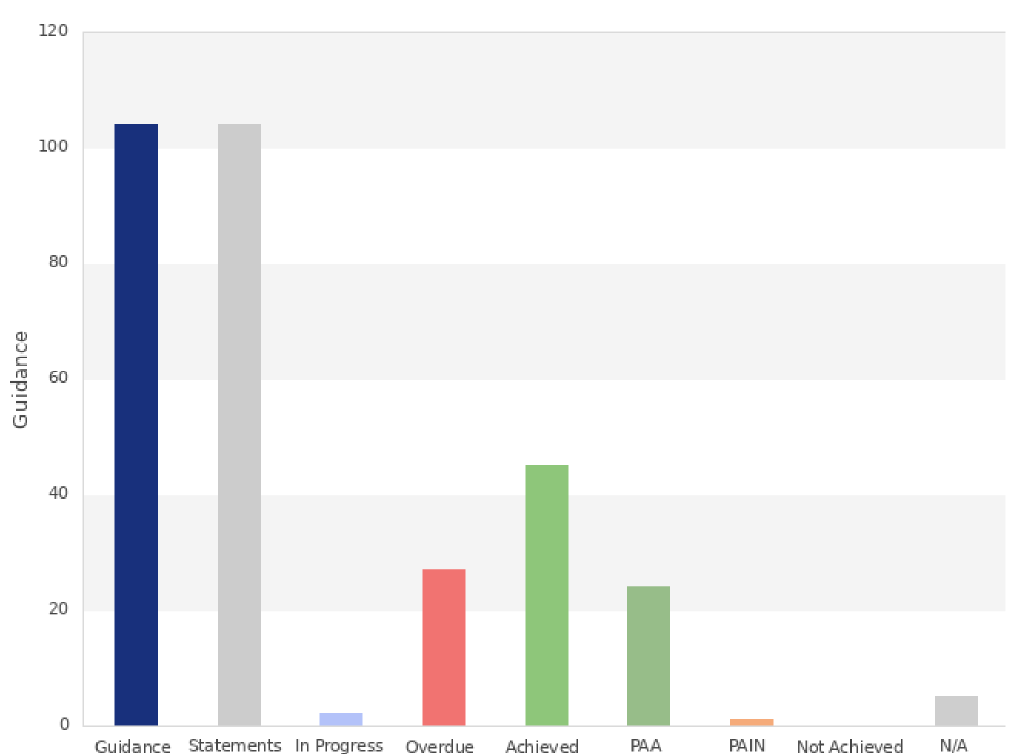
Effective Care

Guidance overview



104 pieces of NICE and Health technology Wales Guidance have been circulated in the past 12 months with the majority implemented in full or to an acceptable status.

- **Guidance (104)** - total number of guidance (that may contain one or more statements)
- **Statements (104)** - total of 'In Progress', 'Achieved', 'Partially Achieved', and 'Not Achieved' bars
- **In Progress (2)** - number of the trust's Guidance Statement entries that do not currently have a status
- **Overdue (27)** - number of the trust's Guidance Statement entries that are overdue
- **Achieved (45)** - number of the trust's Guidance Statement entries that have this status value
- **PAA (24)** - number of the trust's Guidance Statement entries that have 'Partially Achieved - Acceptable' status value
- **PAIN (1)** - number of the trust's Guidance Statement entries that have 'Partially Achieved - Improvement Needed' status value
- **Not Achieved (0)** - number of the trust's Guidance Statement entries that have 'Not Achieved' status value
- **Not Applicable (5)** - number of the trust's Guidance Statement entries that have 'Not Applicable' value

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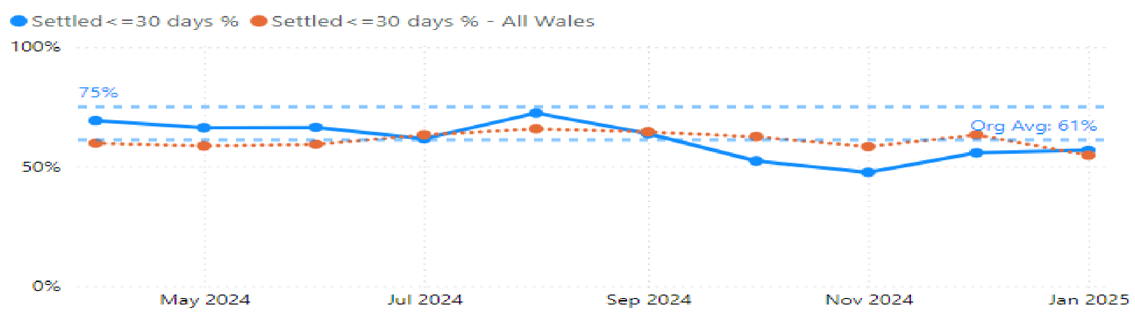
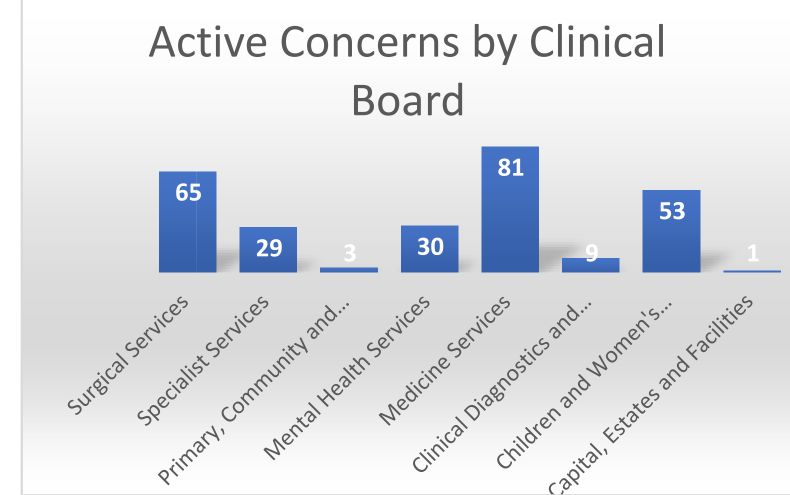
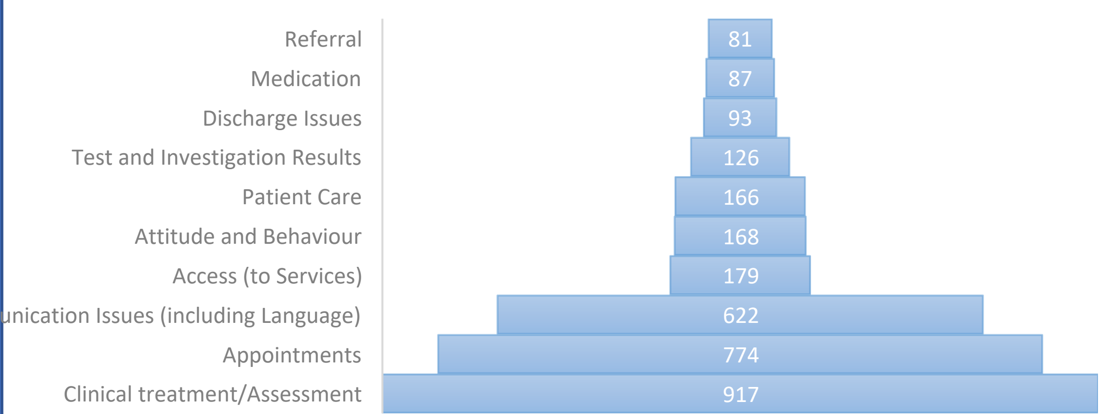
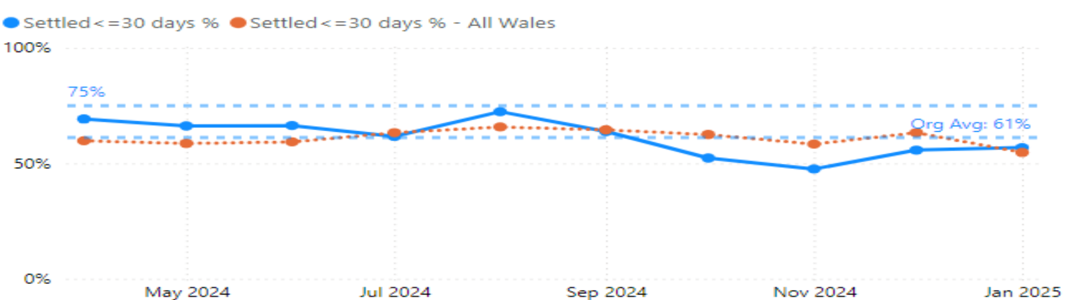
Patient Experience

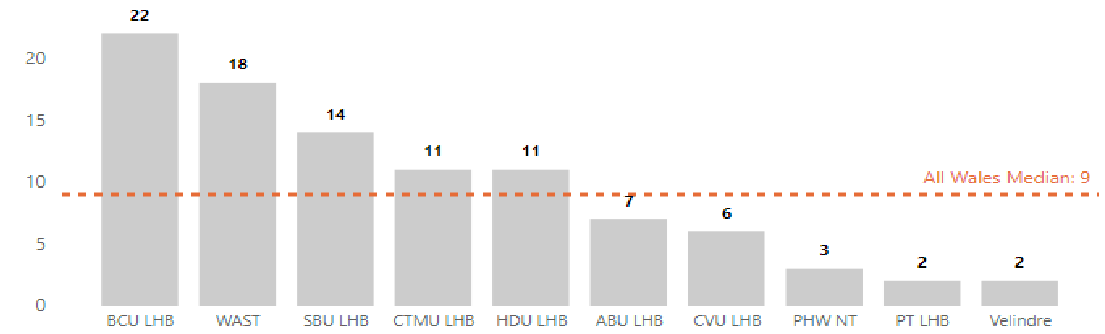




Person Centred Care







Key Updates:

- Since April 1st, 2023, 50,623 incidents have been reported across the Health Board.
- Since April 1st, 2023, we have triggered the DOC on 269 occasions.

Themes and Trends for Triggered Duty of Candour:

- Avoidable pressure damage
- Avoidable falls
- Patients lost to follow-up
- Failure to prescribe or administer appropriate medication
- Administration of incorrect medication
- Missed opportunities to diagnose

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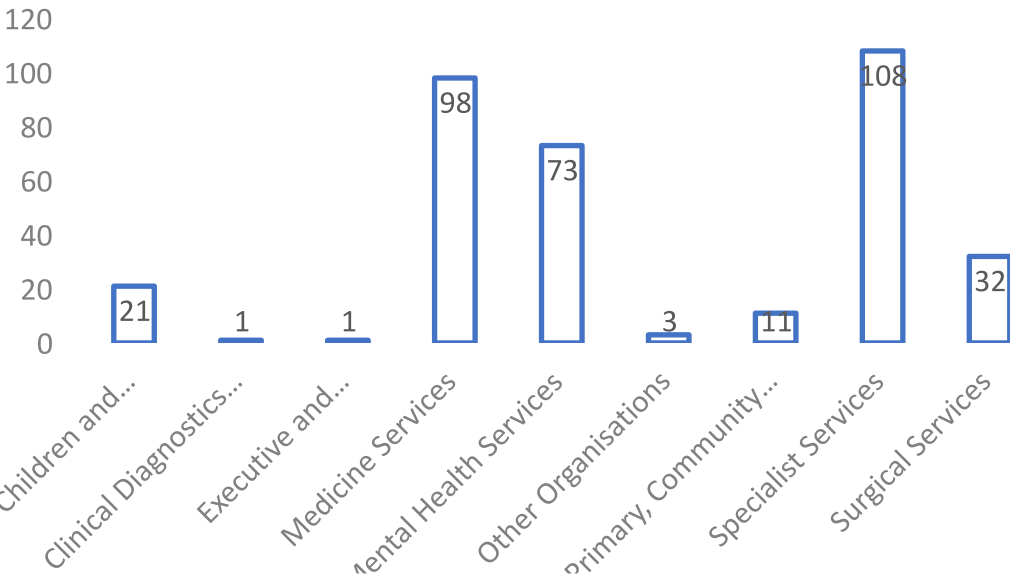
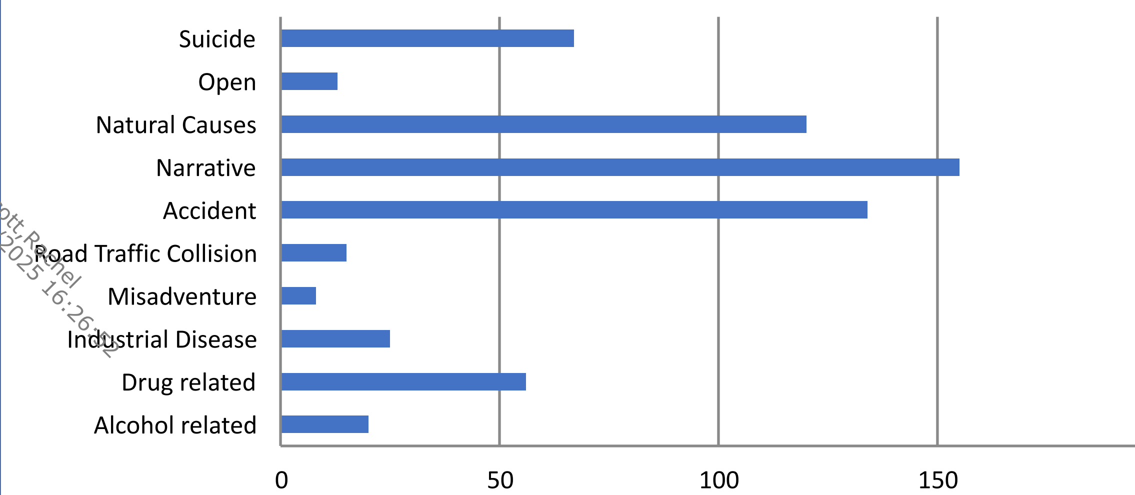
Person Centred Care





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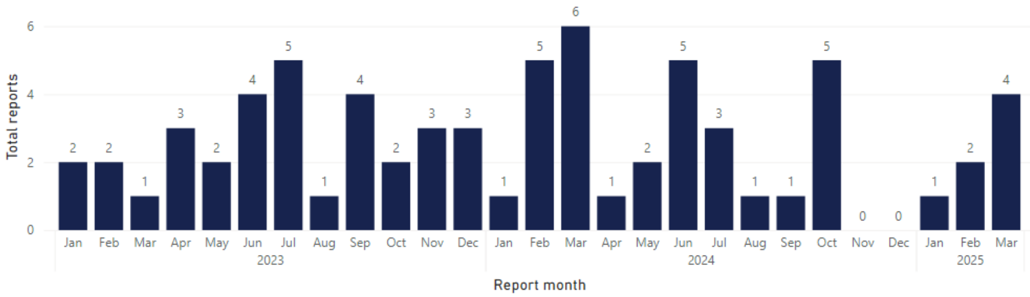

We have been issued with 3 Prevention of Future deaths-For context across Wales since January 23 there have been some 26 PFD's issued

One related to a death in custody the update was shared through the QSE committee where a detailed improvement plan was implemented -the focus of the PFD was multifaceted and included enhanced communication between hospitals and HMP, Improved communication between partners regarding people with complex needs, improvement skills in identifying the deteriorating patient, Policy and procedural issues regarding refusal of food and fluid policy, consideration of mental capacity and GP establishment. This case was discussed with the improvement plan in the QSE Committees of May and November 2024 .

One related to the use of silencing alarms at a central monitor without visually checking the patient whilst we have responded to the PFD IT was agreed this had implications across the health board and we have scoped addressing the functionality of telemetry with central monitors across the UHB this was also shared across Wales as it pertained to any health Board. This work is being checked through the Directors of Nursing Meetings.

The most recent PFD was issued in relation to a sad death in St David's Hospital - *Evidence was taken from nurses at St David's that there remains a lack of confidence in both qualified nursing staff, healthcare assistants and healthcare support workers in the use of and implication of risk assessments around falls, and the use of and importance of enhanced supervision and the Enhanced Supervision Document. The Coroner expressed concern that unless more training is provided and refreshed frequently, there is a risk of future deaths occurring, particularly given the cohort being nursed at that hospital and the turnover of staff.*

This PFD also has implications across the UHB and we will be responding with the organisational actions being taken

Patient Experience -You Said We Did

Feedback	Source	Action
It was identified by the Prehab2Rehab Team that the DrEaMing agenda (Eat, Drink Mobilise within 24 hours after your surgery) could be supported by volunteers.	**Patient Experience Team**	We developed a role with a volunteering pathway to support the Prehab2Rehab journey. The Project is in its first phase – with 13 applicants (including those with lived experience of surgery themselves) being interviewed in April to start in June. They will be on the surgical wards championing the DrEaMing aims; prompting, supporting and encouraging patients to Drink, Eat and Mobilise post-surgery, while being a friendly face and company.
Received feedback from patients and wards about boredom and engagement.	**Patient Experience Team**	We have 3 Interactive Touch Table devices; one at St David's Hospital, one at Llandough Hospital and one at Lakeside Wing UHW. Staff Feedback March 2025: *"The screen has been invaluable for the day hospital over this past period where it's been based with our OT colleagues. It's really helped the well-being of those that have used it and allowed us to engage patients that wouldn't have been able to do so with the resources we have. It is used daily by staff to help groups & 1:1 work. It's so amazing to use with our patients there. Allowing us to support patients with all sorts of disabilities to engage in material based on the screen and internet as well. The touch screen and ability to move the screen to so many angles, heights etc.. is so good. Its been particularly good at helping us engage those with dementia and the physical disabilities that often come with this."*

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Person Centred Care

Patient Experience - CIVICA

AW2, TT(A) Survey

SMS sent: 29800

Survey responses: 5328

Response rate: 18%

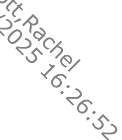
Bedside responses: 270

89% were satisfied with their overall experience.

AW2 Survey results

Based on **5,328** partial/full survey completions (1st January – 31st March 2025 discharges).

- Whilst in our care did you feel safe? **87%** of respondents answered 'Always'.
- Were staff kind and caring? **87%** of respondents answered 'Always'.
- Did you feel that you were listened to? **77%** of respondents answered 'Always'.
- Were you able to speak in Welsh to staff if you needed to? **32%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- From the time you realised you needed to use this service, was the time you waited: **69%** of respondents answered 'Shorter than expected' or 'About right'.
- Were things explained to you in a way that you could understand? **80%** of respondents answered 'Always'.
- Were you involved as much as you wanted to be in decisions about your care? **77%** of respondents answered 'Always'.
- **90%** were satisfied with their overall experience.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Person Centred Care

Patient Experience - CIVICA

Emergency Unit Survey

SMS sent: 11941

Survey responses: 1546

Response rate: 13%

74% were satisfied with their overall experience.

Emergency Unit Survey results

Based on **1,546** partial/full survey completions (1st January – 31st March 2025 discharges).

- Did you feel that you were listened to? **69%** of respondents answered 'Always'.
- Were you able to speak in Welsh to staff if you needed to? **38%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- From the time you realised you needed to use this service, was the time you waited: **61%** of respondents answered 'Shorter than expected' or 'About right'.
- Did you feel well cared for? **64%** of respondents answered 'Always'.
- Were things explained to you in a way that you could understand? **72%** of respondents answered 'Always'.
- Were you involved as much as you wanted to be in decisions about your care? **66%** of respondents answered 'Always'.
- **74%** were satisfied with their overall experience.

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08/05/2025 16:26:52

Person Centred Care

Patient Experience - CIVICA

Mental Health Survey

SMS sent: 5065

Survey responses: 348

Response rate: 7%

75% were satisfied with their overall experience.

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08/05/2025 16:26:52

Mental Health Survey results

Based on **348** partial/full survey completions (1st January – 31st March 2025 discharges).

- Did you feel that you were listened to? **63%** of respondents answered 'Always'.
- Were you able to speak in Welsh to staff if you needed to? **30%** of respondents answered 'Always' (based on those who answered with a response other than 'Not applicable').
- From the time you realised you needed to use this service, was the time you waited: **66%** of respondents answered 'Shorter than expected' or 'About right'.
- Did you feel well cared for? **58%** of respondents answered 'Always'.
- Were things explained to you in a way that you could understand? **63%** of respondents answered 'Always'.
- Were you involved as much as you wanted to be in decisions about your care? **57%** of respondents answered 'Always'.
- **75%** were satisfied with their overall experience.

Efficient Care

Nurse Staffing Levels

Chillcott, Rachel
08/05/2025 16:26:52

Nurse Staffing Levels Monitoring – 25B Wards

•Staffing levels continue to be closely monitored against the approved establishment.

•The infographic shows nurse staffing data for 25B wards, in line with the **Nurse Staffing Levels (Wales) Act 2016**.

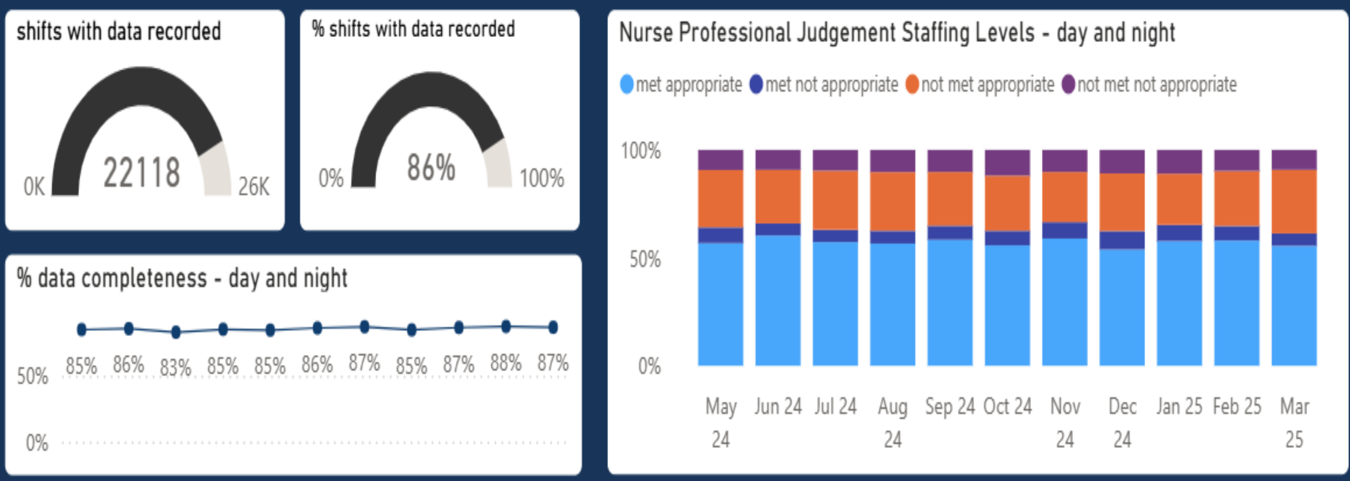
•Data reflects total staffing levels over a 24-hour period for the previous month and future predicted position.

•Temporary staffing use is highlighted, with **agency shifts shown in yellow**.

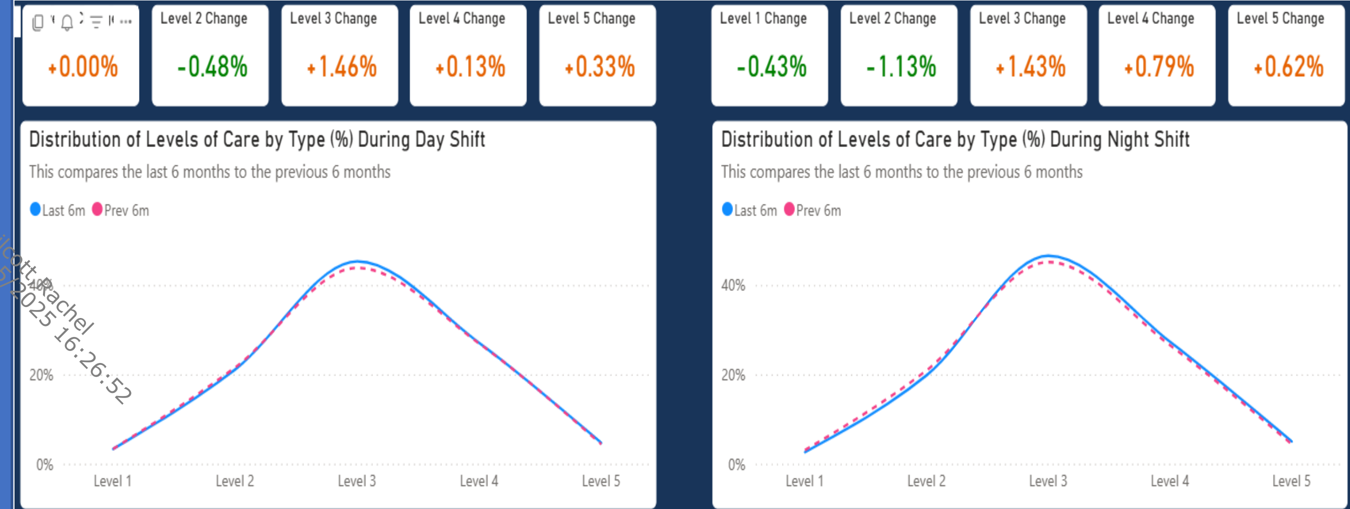
•A **year-on-year reduction** in agency use has been observed.

Efficient Care

SafeCare Compliance & Shift Appropriateness



Patient Acuity (Last 6 Months)



- **SafeCare** is now active in most inpatient areas.
- Over the last 12 months, **25B wards achieved 86% compliance**.
- SafeCare is updated at the **start of every day and night shift**, reflecting the professional judgment of the **Nurse in Charge**.

- **Shift Appropriateness (Based on Professional Judgment):**
- ✅ **83%** of shifts were judged **appropriate.**
- ⚠️ **6.72%** of shifts were **not appropriate**, even when rosters were met.
- ❌ **10.16%** of shifts were **not appropriate** and **rosters were not met.**

- Majority of patients on 25B wards are assessed as **Level 3** (Welsh Levels of Care).
- Data shows a **gradual shift in acuity**, with a **slight increase in Level 4 and Level 5** patients.
- This indicates a **rise in patient complexity and care requirements.**

<table>
<tr><td>Report Title:</td><td colspan="3">Learning from Mortality Paper - Corporate Quality and Safety</td><td colspan="2">Agenda Item no.</td><td colspan="2">2.3</td></tr>
<tr><td rowspan="2">Meeting:</td><td colspan="2" rowspan="2">Quality Committee</td><td>Public</td><td>X</td><td rowspan="2">Meeting Date:</td><td colspan="2" rowspan="2">13.05.2025</td></tr>
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<tr><td>Status:</td><td>Assurance</td><td>X</td><td>Approval</td><td></td><td colspan="2">Information</td><td></td></tr>
<tr><td>Lead Executive:</td><td colspan="7">Executive Medical Director</td></tr>
<tr><td>Report Author:</td><td colspan="7">AMD Patient Safety and Clinical Effectiveness</td></tr>
<tr><td colspan="8">Background and current situation:</td></tr>
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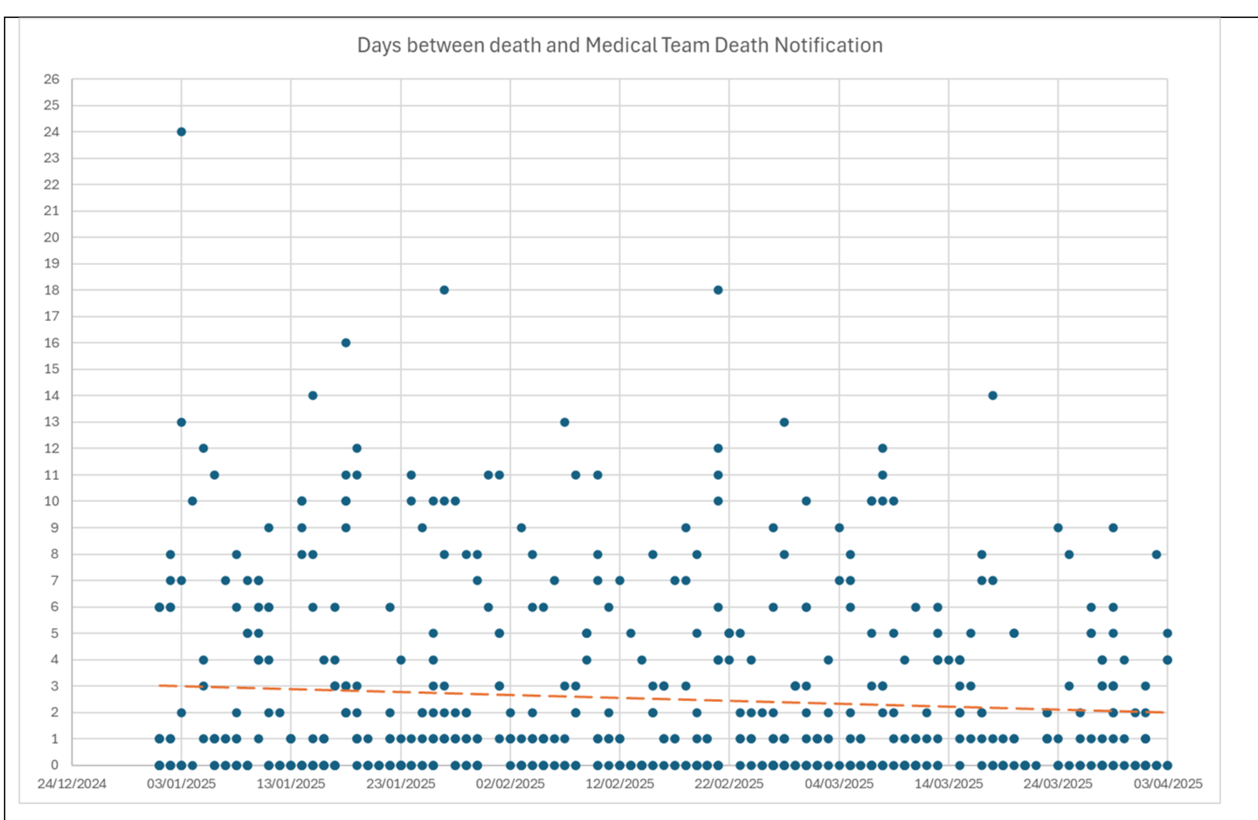
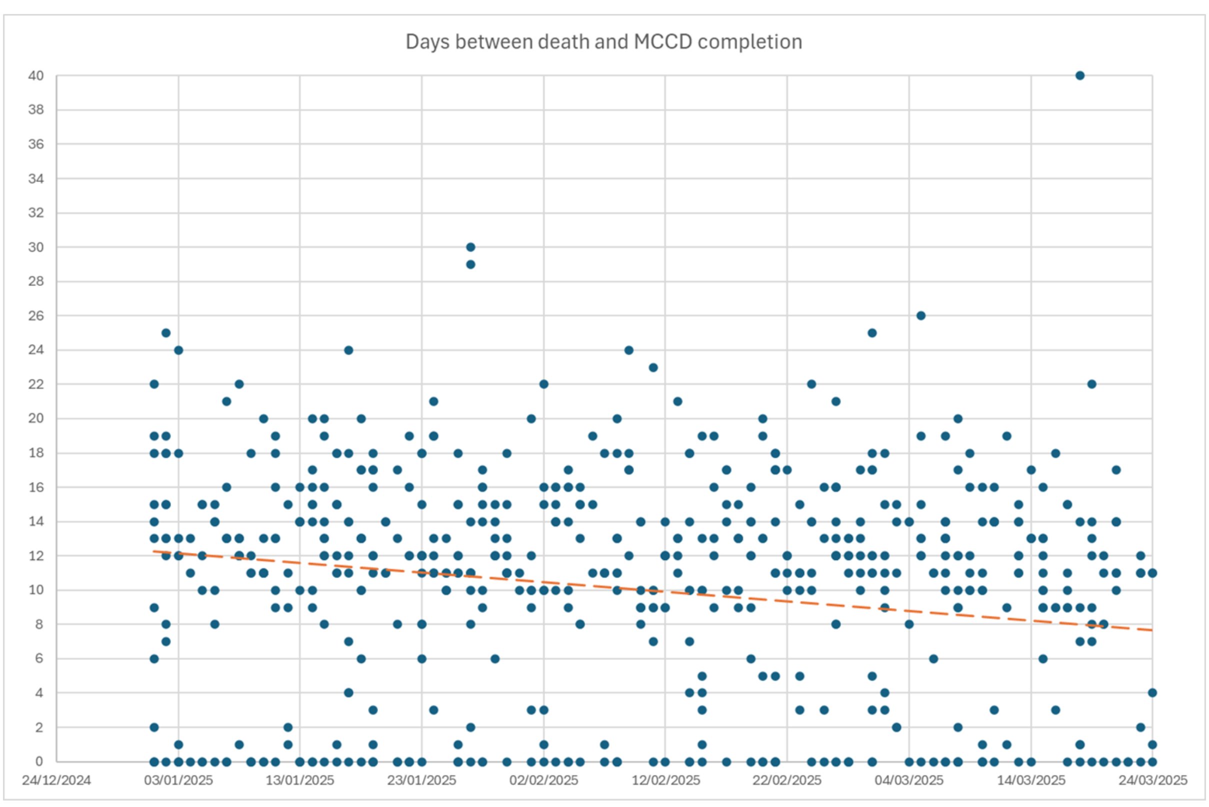
The importance of learning from deaths attained significance within Health systems stemming from a number of high-profile events within the UK – Harold Shipman (Shipman Enquiry 2003), Gosport Memorial Hospital (The Gosport Independent Panel, 2018), and The Francis Inquiry into the Mid Staffordshire Foundation Trust (Francis Report, 2013) to name 3 examples. In September 2024 the Medical Examiner service (MES) in Wales became a statutory service providing independent scrutiny of all deaths in hospital or in the community not referred to the Coroner. The Cardiff and Vale mortality scrutiny systems have evolved to feed information reliably to the MES and the Coroner, to sieve and sort referrals returning from the MES, and to ensure that any learning from mortality generates improvement and where necessary change in practice within our health systems.
There are 25-60 deaths per week across CAV inpatient hospital sites varying seasonally. There are approximately the same number of deaths per week outside of the acute hospital setting.

Care after death process

Previously a paper based system, in the summer of 2024 a QR code was introduced which digitalised the recording of a death to the MES. A digitalised copy of the last spell of the hospital (paper based) patient health record is shared with the MES and scrutiny of the death is undertaken by the Medical Examiner (ME). For community deaths, the MES can access GP digital systems to aid the scrutiny process. Following agreement of the cause of death with the MES the Qualified attending practitioner (QAP) will complete the Medical Certificate for the Cause of Death (MCCD). A QAP must be a registered Medical Practitioner (i.e. F2 or above).

Nationally, there has been significant media attention on the length of time taken to issue death certificates following the introduction of the Medical Examiner Service. The patient safety team meets weekly with bereavement office and medical records teams to monitor and improve the care after death processes within the UHB. The graphs below show the trend in times between deaths and the Medical Team Death Notification (where the clinician provides a proposed cause of death to the Medical Examiner), and between deaths and the MCCD being completed.





The graphs show the improving turnaround times within CAV (red trend line) in the reporting of a death to the ME, and the time from a patient's death to the production of an MCCD. There continue to be significant outliers influencing the data. This data is continually being refined and would benefit in the future from one single digital system serving ME referrals, Coroner referrals and a digital MCCD.

Chilcott,Rachel
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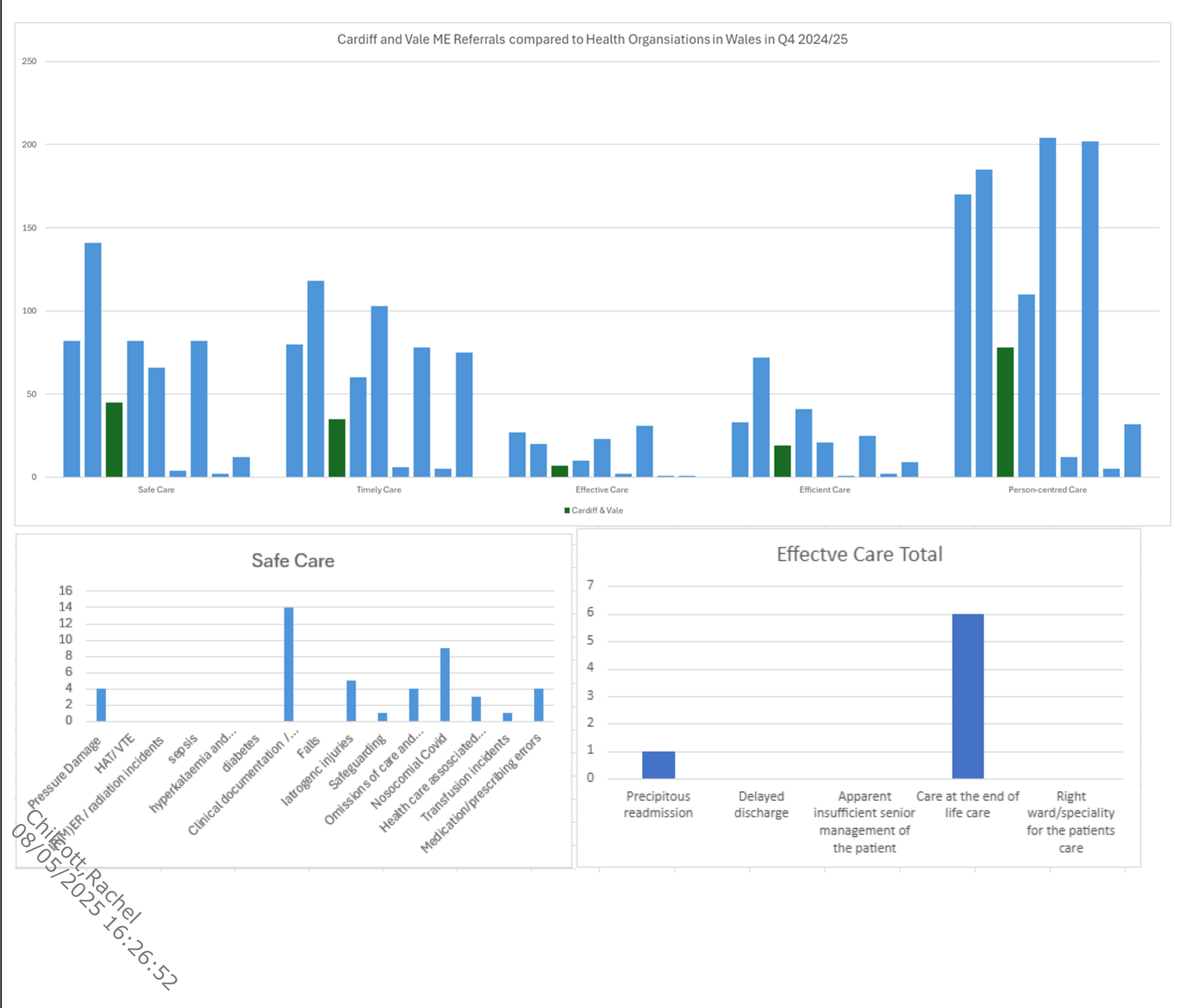
<u>Medical Examiner Referrals</u>

The ME will make a referral to the UHB if any further scrutiny of the death is advised. It is the decision of the UHB as to what level of scrutiny is required upon receipt of the referral into the UHB. The current MES referral rate for deaths in CAV is 22% (MES, Quarter 3 data

24/25). Current Coroner referral rates are stable for both UHW and UHL sites -34% of all deaths are reported to the Corner (National figures, Coroners Statistics 2023, MOJ).
The UHB has set up a Mortality pre-scrutiny panel led by the Assistant Director of Patient Safety and the Associate Medical Director for patient safety and clinical effectiveness, the Organisational Learning Facilitator for Mortality Reviews and the Head of Safety, Quality and Organisational Learning. This panel sieves and sorts the ME referrals to determine the level of further necessary mortality review. A number of these reviews are not considered for further review and are logged thematically – e.g. failure of countersigning of DNACPR forms. If a death is considered to require further scrutiny internally the Death is discussed at a Mortality Scrutiny Panel. Invited to this panel are members of the pre-scrutiny panel as well as Clinical Boards representative (DoN and Q&S Lead), members of the Resuscitation team, Resuscitation service and other relevant mortality leads. In this panel decisions are made as to what further level of scrutiny is required – this may be discussion in a Departmental Mortality and Morbidity meeting, a specific case review, a review within a GP Surgery environment and whether that review is documented (and where) or brought back for the attention of the Mortality Panel. A view is also taken as to where the learning of the review is presented.

Since September 2024 all deaths that occur both in inpatient settings and in the community receive independent scrutiny from the Medical Examiner unless they are referred to HM Coroner, 22% of all cases are referred back to CAVUHB for further consideration. The Medical Examiner categorises referrals to the health organisations in Wales under the six domains of quality. The UHB received less referrals than any other University Health Board in each category, with the exception of Powys UHB.



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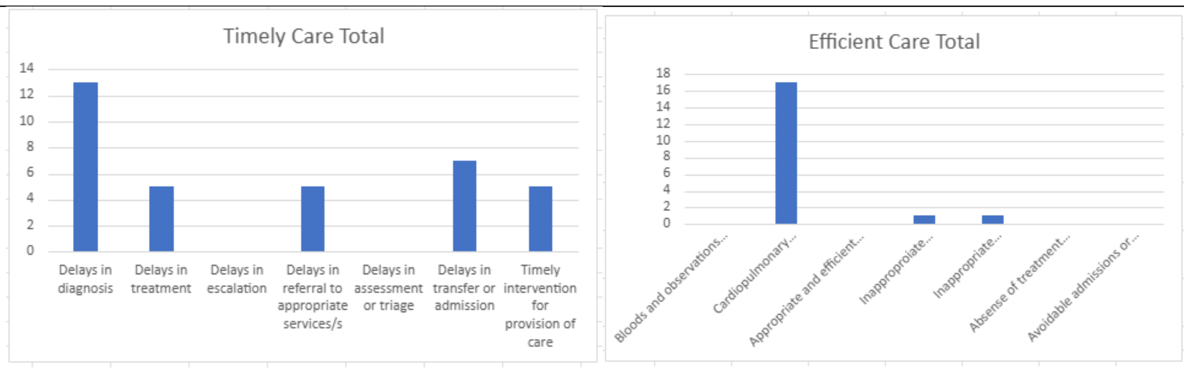
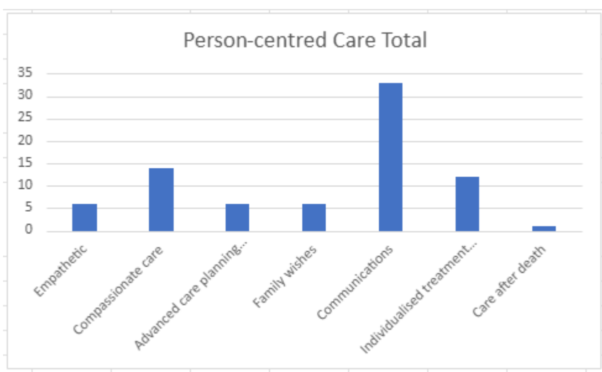




Person centred care was the greatest reason for referral with communication with the patient and their family dominating this category. Clinical documentation also forms the most common reason for referral under the safe care domain.

The timely completion of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions and the accurate completion of the paperwork including the signature of the consultant consistently features as a common reason for ME referral.

Learning from Mortality Group

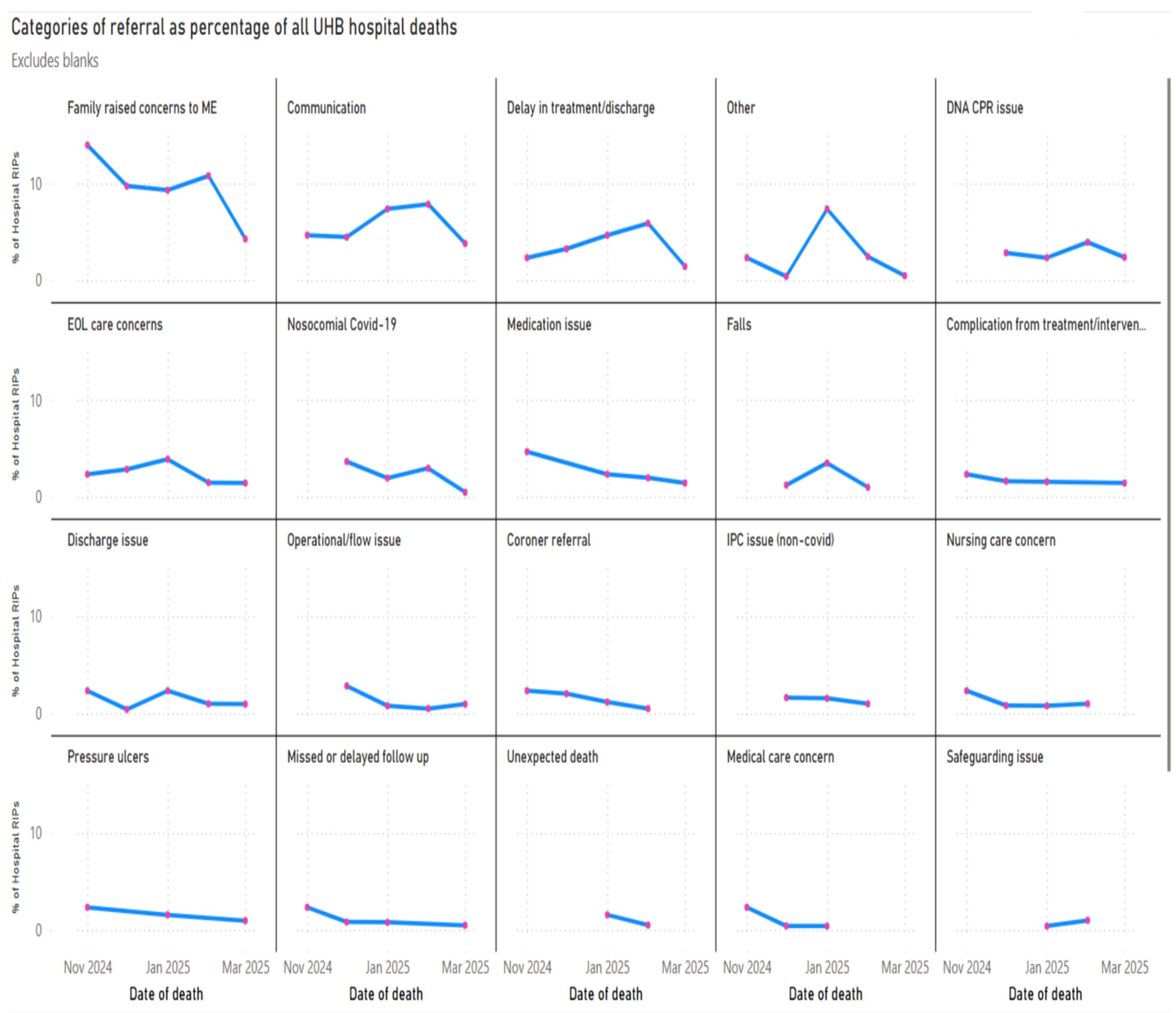
The Learning from Mortality Group is a safety group which meets every 2 months. Clinical Board representatives from every CB are invited, as well as representatives from Public Health, the Bereavement team, Inquest team and Medical Records and other interested parties. Themes form the Mortality Scrutiny panel are discussed and the Care after death process monitored. Tier 1 mortality trends are considered and Clinical Boards are encouraged to track mortality data and discuss trends and movements in their tier 2/3 mortality data at the meeting. Links have been made with Learning difficulties team (CAV and SBUHB) and Homelessness Service (Dr Ayla Cosh) to ensure learning from mortality reviews are shared with services supporting these high risk groups, and that any feedback from these services on care provision is fed back to CAV service providers. A report from the Learning from Mortality Group is provided to the Clinical Safety Group annually.

Morbidity and Mortality Review

Morbidity and Mortality reviews occur widely within the UHB though with varying approaches and often little documentation. There is currently heath board wide work ongoing, coordinated from the patient safety team and the learning from mortality group, to standardise M&M process and record outcomes within an AMAT module. This work is commencing within Vascular and Endoscopy services.

Progress and Learning

Graphical representation of the themes emerging from the initial scrutiny of ME referrals is demonstrated below. Within this data, themes emerging as common from Mortality Scrutiny include adequate assessment of Capacity, and Mental Capacity Act related concerns, "lost to follow up" associated concerns, the recognition and management of deteriorating patients and the care of patients and decision making at the end of life.



Capacity and MCA

The scrutiny process has identified the documentation of issues relating to capacity assessment and the mental capacity act, consent in the context of a lack of capacity and adherence to Safeguarding policies to be major learning points for our systems. This has led to increased educational efforts, often targeted at areas identified in reviews, on the theme of consent and mental capacity act, aimed at multidisciplinary teams. Also there have been efforts to signpost clinicians to appropriate educational material on ESR and internal educational resources.

Chilcott,Rachel
08/05/2025 16:55:5

The MCA Team have been involved in the Mortality Screening Panel since its second meeting in June 2024. The team's contribution includes scrutinising the SBARs based on ME report findings to identify whether a more detailed record review is required. Findings are then fed back through panel discussion to identify organisational learning, and the team

contribute to relevant review processes where MCA practice is a key part of the learning required.

Over this 11 month period, the MCA team have reviewed the records for 42 cases - these record reviews are usually detailed and often lead to further activity through involvement in other review processes, with team statistics indicating that the average case takes 2.2 hours of MCA team time.

As well as contributing to the mortality process' objectives, the MCA team have gained significant benefit from our collaboration, gaining rich information about the broader picture of MCA compliance in the UHB, and directing team priorities for training and resources.

Review themes have identified frequent instances whereby patients are treated as if lacking capacity to make independent decisions during admission but with no reference to the MCA requirements being considered, with varying degrees of harm as a result. This valuable information would otherwise not have been highlighted as both the advisory work of the team & annual audit processes only cover cases where clinicians have identified that the MCA should be applied to their patient's case.

After themes were noted of failure to assess capacity when the threshold was met and poor-quality documentation, short-form training with accompanying posters has been developed for 'When to Assess Capacity' and 'Documenting Capacity Assessments'. This has allowed concise and effective feedback through multiple forums to highlight key learning and direct staff to more comprehensive resources and training available.

Emerging themes of failure to recognise and/or act on self-neglect concerns prompted the team to expand our knowledge in this area, and self-neglect now forms a significant portion of both our organisational and regional work. Multiple different Self Neglect and the MCA training resources have been developed and delivered in the past year, including multi-agency work, contribution to national guidance and there continues to be considerable resource dedicated ot improving practice & staff support in this area.

Management of the Deteriorating Patient

Delays in diagnosis, treatment, referral and transfer or admission featured under the timely care domain and have been used in conjunction with data from patient safety incidents to inform the UHB Shaping Our Future Quality Excellence programmes focusing on ensuring the timely identification and escalation of deteriorating patients and the continuity of patient care provision form referral to discharge. Work is already underway within the organisation to increase advanced care planning in the community, adopt the new All Wales treatment escalation plan (TEP), and regularly review DNACPR decisions in the inpatient setting. Together with the implementation of, and education associated with, NEWS-2. At the same time the organisation is tasked to implement NEWS-2, the latest iteration of the National approach to the identification and escalation of the deteriorating patient. The target for implementation of NEWS-2 is the end of September 2025. Both these significant areas of work will impact on the quality of care of the deteriorating patient reducing referrals from the ME in relation to recognition, management and escalation of the deteriorating patient.

Lost to Follow Up

Lost to follow up may include the identification of an abnormal finding which is not acted upon, a patient lost to outpatient or surveillance follow-up, delayed investigations of concerning symptoms These all appear as recurrent themes within mortality reviews. Lost to follow up as a theme has also been adopted as a workstream within Shaping our Future Quality Excellence which will improve health systems in providing continuity of care when investigation and surveillance is required.

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08/05/2025 16:26:52

End of Life Care

The Wales Quality Statement for Palliative and End of Life Care was published in 2022 and sets a standard for how and where people will access safe effective person centred and timely care. To support delivery of these standards, a project is being undertaken to evaluate end of life care provision from the viewpoint of the bereaved. An end-of-life audit tool has been developed to identify areas of poor end-of-life care - for example uncontrolled symptoms, basic human needs unsupported; inequity of access; lack of honest compassionate communication; over-medicalised vs reversible clinical factors not addressed; carer isolation/overwhelm; lack of compassionate care etc that are contrary to the standards set out in the Quality Statement. All referrals from the Medical examiner are being audited to extrapolate themes. The Symptoms Early Warning Score (SEWS) assessment chart, is emerging as an area that requires additional focus. SEWS should be used to assess patients at the end of life to support the recognition of agitation, pain and respiratory symptoms and to standardise the response to ensure optimal symptom control. Educational resources will be developed in response to the findings of the ongoing audit and there are plans to extend the audit to the community over the coming year.

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

Recommendation:

The Committee is requested to:

a) Acknowledge this summary of Mortality Scrutiny being undertaken within CAV UHB
b) Recognise the learning efforts and partnerships in place to embed learning arising from mortality scrutiny and subsequent internal UHB review

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**	x	Providing Outstanding Quality 2. **Click the objective above to view more detail.**	x
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered

Prevention		Long term		Integration		Collaboration	x	Involvement	x

Quality Impact Assessment Completed?

Yes – (***please provide completed***		No – ***(Please provide reasoning, e.g. not required)***		Not required

Chilcott, Rachel
08/05/2025 16:48:53

QIA document)				

Impact Assessment:	
Risk: No	
Safety: No	
See descriptions of reviews of thematic outputs from mortality scrutiny	
Financial: No	
Workforce: No	
Legal: No	
Reputational: No	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Welsh Language: No	
Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

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08/05/2025 16:26:52

<table>
<tr><td>Report Title:</td><td colspan="3">Invited Service Review (IRS) of Cardiff and Vale University Health Board (UHB) Mental Health Services</td><td>Agenda Item no.</td><td colspan="2">2.4</td></tr>
<tr><td rowspan="2">Meeting:</td><td colspan="2" rowspan="2">Quality Committee</td><td>Public</td><td>X</td><td rowspan="2">Meeting Date:</td><td rowspan="2">13.05.2025</td></tr>
<tr><td>Private</td><td></td></tr>
<tr><td>Status:</td><td>Assurance</td><td>X</td><td>Approval</td><td></td><td>Information</td><td></td></tr>
<tr><td>Lead Executive:</td><td colspan="6">Medical Director</td></tr>
<tr><td>Report Author:</td><td colspan="6">Dan Crossland – Director of Operations – Mental Health Clinical Board</td></tr>
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Background and current situation:

Introduction This briefing paper provides a summary of the background, contents, and actions taken following an Invited Service Review (IRS) conducted by the Royal College of Psychiatry for Cardiff and Vale University Health Board (UHB) in July 2024.

Background During the COVID-19 pandemic, specifically in 2021 and 2022, Cardiff and Vale mental health hospitals experienced a higher than expected number of suspected suicides. This prompted the UHB to request an independent review from the Royal College of Psychiatrists.

Methodology The review followed a three-phased approach:

1. Reviewing clinical records to assess the standard of care.
2. Conducting interviews with staff and stakeholders.
3. Reviewing investigation reports and other key documents.

Main Findings The review identified several key themes:

Risk Assessment
The review highlighted issues with risk assessments, noting that risk tools had a positive predictive value of less than 5%. It emphasized the need for dynamic assessments sensitive to changing presentations and information from friends and families.

Care Planning and Formulation
Deficiencies in care planning were noted, with a need for a more varied MDT skill mix in reviews, supervision, appraisal, mentoring, and regular audits.

Therapeutic Engagement
The review stressed the importance of therapeutic relationships between patients and nursing staff, recommending regular 1:1 sessions.

Continuity of Care
The review found issues with communication between referring and receiving teams, exacerbated by COVID-19.

Diagnosis and Treatment
The need for careful consideration when changing diagnoses and treatment approaches was highlighted.

Chilcott, Rachel
08/05/2025 16:26:52

Mental Health Act
The review noted instances of "de facto" detention of informal patients and recommended adherence to the Code of Practice.

Observation Levels
The review emphasised that observation should be part of a comprehensive risk

management plan and should involve meaningful engagement with patients.

Response to Family Concerns
Minimal contact with families was noted, with COVID-19 restrictions cited as a contributing factor.

Serious Investigations
The review found variability in the quality and length of investigation reports and recommended a standard approach.

Recommendations and Actions The review team made several recommendations, many of which focused on ensuring the implementation of existing policies and practices, continuity of care, adherence to the Code of Practice, and sufficient time and expertise for staff to engage with patients and their families.

Conclusion The review highlighted the need for improvements in risk assessment, care planning, therapeutic engagement, continuity of care, diagnosis and treatment, adherence to the Mental Health Act, observation levels, and response to family concerns. The MHCB has initiated, completed or is in the process of implementing multiple actions to address these issues and improve the quality of mental health services.

Key actions are listed below:

1. **Risk Assessment**
The Mental Health Clinical Board (MHCB) has revised its risk assessment processes for all secondary care patients, implementing the Welsh Applied Risk Research Network (WARRN) tool in preference to the previous FACE tool which has been removed. This includes increased trainers, 2-day training sessions for hundreds of staff, and refresher training. We are at 98% compliance with training.
The MHCB has also worked with partners to roll out Suicide Awareness and Mitigation training (SAMT) and associated clinical tools. Transfer of the documentation onto the PARIS electronic record has been signed off, the next phase is roll out to teams to allow routine delivery. We are leading this work in Wales and are the only UHB to have procured and agreed the SAMT tool.

2. **Care Planning and Formulation**
Care planning spot audits have highlighted the need for clear local guidance.
The MHCB has issued priorities for inpatient standards, including formulation-based risk assessments and Care and Treatment Plans within 72 hours of admission. Regular audits and skill mix reviews are ongoing to identify gaps in practice and training. A skill mix review of inpatient staff is being conducted to ensure sufficient psychological skills at all levels.

3. **Therapeutic Engagement**
The MHCB is determined to achieve Quality Network for Inpatient Working Age Adults (QNWA) accreditation and is working to ensure correct staffing levels to meet therapeutic engagement standards. A therapeutic training and support program is being developed to enhance therapeutic and compassionate language, relationship-centred care, and motivational interviewing. An audit program will monitor the completion and quality of 1:1 support sessions. The QNWA standards can only be met by investment into the staffing establishments to meet the baselines set by the QNWA. An investment case is being finalised for the first stage of this staffing model.

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08/05/2025 16:26:52

4. **Continuity of Care**
The MHCB has overhauled its previous 'sleeping out procedures' and is working to improve continuity of care through board rounds coordinated by community teams. Efforts are being made to address national and local shortages in Consultant Psychiatry cover. A new

'Outlier' policy has been developed to ensure appropriate staffing and active communication during peak times.

5. **Mental Health Act / Diagnosis and Treatment**
Medical staff have been reminded to refrain from writing statements that may be construed as de facto detentions. Family engagement and involvement are being prioritized through a family engagement project. Consideration of s5(2) and s5(4) has been incorporated into the Mental Health Act training program.

6. **Observation Levels**
The MHCB has updated its Observation Policy to include enhanced therapeutic engagement during observation. An audit program will monitor the completion and quality of support sessions. SafeCare software is being used to match staffing levels with patient needs in real-time.

7. **Serious Investigations**
The MHCB has seen significant improvements in its investigation process and has received the first accreditation in Wales from the Serious Incident Response Accreditation Network (SIRAN). Terms of reference are agreed at initial meetings and are flexible to cover all relevant points. Families are met prior to finalizing terms of reference to include their concerns. Staff undertaking investigations receive training and administrative support

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

Actions have been taken against all of the recommendations, the majority of issues have been addressed with the outstanding recommendations relating to the Quality Network for Inpatient Working Age Mental Health Services (QNWA) standards, skill and staff mix, and multidisciplinary staffing.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

Due to these changes in practice there are potential implications for:

- Staffing model
- The funded Nursing Establishment in inpatient wards to achieve the baseline QNWA standards

Recruitment to senior clinical roles and MDT roles to support the inpatient establishment to adhere to good cultural, clinical and procedural expectations.

Recommendation:

The Committee is requested to:

a) **NOTE** the content of this report.

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

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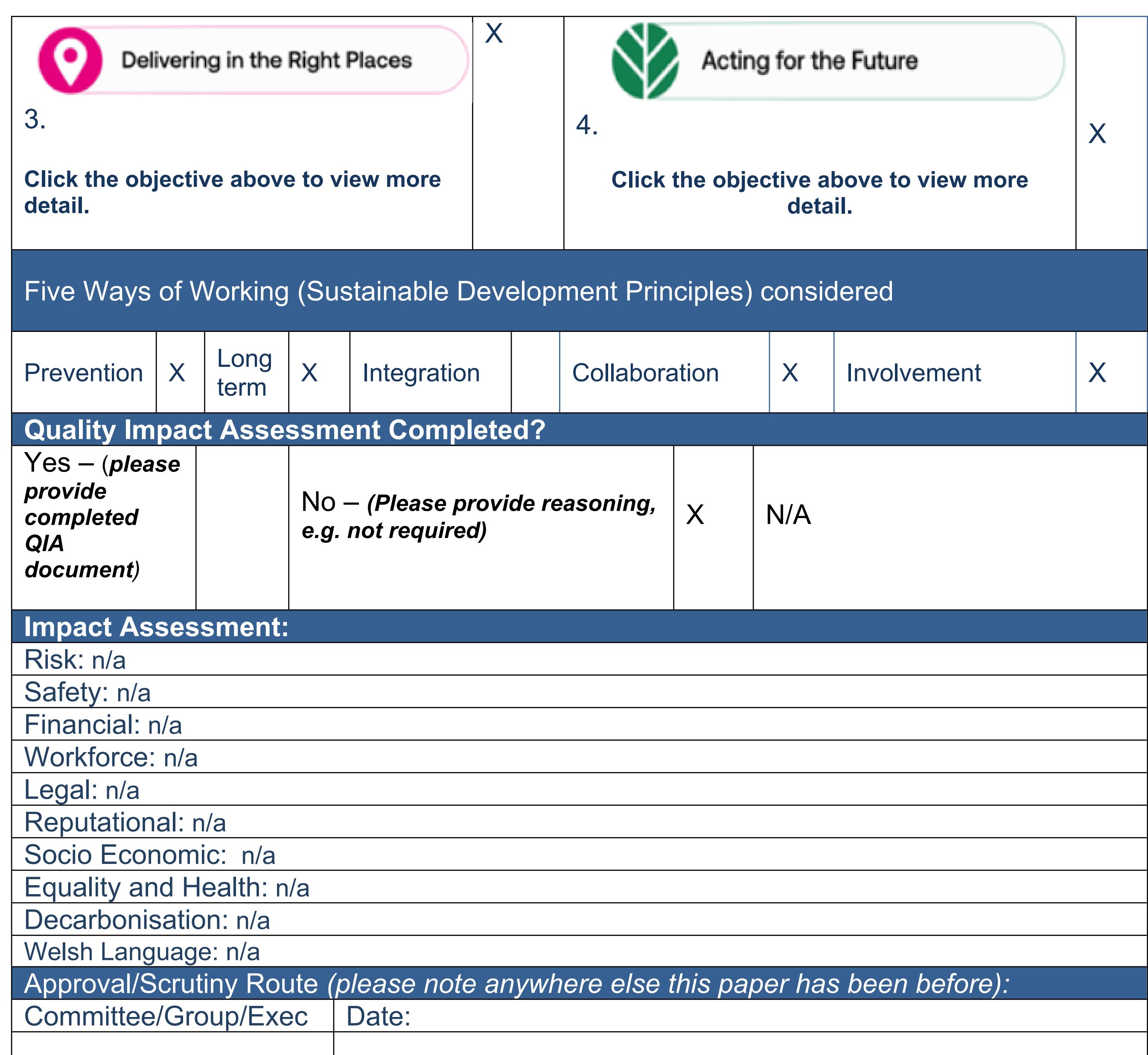

Delivering in the Right Places 3. **Click the objective above to view more detail.**	X	Acting for the Future 4. **Click the objective above to view more detail.**	X

Five Ways of Working (Sustainable Development Principles) considered									
Prevention	X	Long term	X	Integration		Collaboration	X	Involvement	X

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***	X	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 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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08/05/2025 16:26:52

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board
Shaping our Future
Quality Excellence

What is the purpose of Shaping our Future Quality Excellence programme?

Shaping our Future Quality Excellence (SOFQE) is a Health Board-wide programme to create a system and culture for quality in its broadest sense.

The programme will be the strategic vehicle by which we deliver Cardiff and Vale UHB's *main effort* of eradicating avoidable harm, in all its forms, including:

- Harm to patients.
- Harm to colleagues.
- Harm to our resources.
- Harm to future generations.
- Harm to our reputation.

Chilcott,Rachel
08/05/2025 16:26:52

Our organisational mission and purpose is to 'Eradicate Avoidable Harm' - but what is avoidable harm?

Avoidable harm refers to unintended or unexpected harm that could have been prevented. It occurs when incidents of harm could probably or totally have been avoided through timely intervention or adherence to evidence-based practices and governance. It is harm that could have been mitigated with better processes, guidelines or delivery. Examples of different types of avoidable harm can be seen in the table below. This is not intended as an exhaustive list.

Types of Avoidable Harm	Examples
Harm to patients	Medication errors, hospital acquired infections, surgical complications, falls and fractures, pressure ulcers, excess waiting times, pathway variation.
Harm to our workforce	Unsafe working environments, lack of training, burnout, unnecessary employee investigations, bullying and harassment.
Harm to our resources	Waste, unnecessary tests, treatments or procedures; over ordering of stock, inefficient staff allocation and rostering, underutilising digital systems.
Harm to future generations	Unnecessary or excess carbon emissions, excess travel, inequitable access to services, excess waste incineration.
Harm to our reputation	Negative interactions, inappropriate values and behaviours, system failures, actions that damage trust.

Chilcott,Rachel
08/05/2025 16:26:52

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Cardiff and Vale University Health Board

Board

Strategic Portfolio Executive Steering Group

Shaping Our Future Quality, Value and Sustainability Strategic Portfolio Board

Shaping Our Future Quality Excellence Programme Board

Executive Quality meeting

Intelligence sharing & advice

Quality Management System Project
SRO: Dr Aled Roberts
Project Manager: Jo Harrall

Hospital Acquired Infections Project
SRO: Dr Richard Skone
Project Manager: Jade Barber

Lost to Follow Up Project
SRO: Mr David Scott-Coombes & Catherine Wood
Project Manager: Jess Jones

Acute Deterioration Project
SRO: Dr Abraham Theron
Project Manager: Sue Hostler

Chilcott,Rachel
08/05/2025 16:26:52

Programme Board

SRO: Jason Roberts/ meets monthly

Manage and coordinate the project teams to ensure delivery of milestones and outcomes.

Determine the strategic direction for quality and prioritise programmes and projects related to stated outcomes within the strategy

Quality Management System Project

Scope:
Building a system for quality for the UHB, to include:
- The system, processes and architecture of a Quality Management System
- Structures and flows including roles and responsibilities
- Delivery of a system that allows quality control

Hospital Acquired Infections Project

Scope:
Developing a baseline dashboard to provide timely and consolidated data and then driving improvement in Healthcare Acquired Infection practices.

Lost to Follow-up Project

Scope:
- Address the issue of follow-up patients becoming ‘lost’ within the Health Board system, who as a result, are at risk of suffering preventable unintended or unexpected harm.

Acute Deterioration Project

Scope:
- Implementing strategies, including those listed in 'Standardising the management of acute deterioration' (WHC/2024/035) to improve the recognition and response to physical deterioration.

Chilcott,Rachel
08/05/2025 16:26:52

Report Title:	Discharge Advice Letters - SBAR				Agenda Item no.	2.6
Meeting:	Quality Committee		Public	X	Meeting Date:	13.05.2025
			Private			
Status:	Assurance	X	Approval		Information	
Lead Executive:	Executive Medical Director					
Report Author:	AMD Patient Safety and Clinical Effectiveness					
Background and current situation:						

A Discharge Advice Letter (DAL) is a clinical document for the communication of information on transfer of care of an individual from the inpatient hospital setting. A DAL describes the diagnoses and care provided to individual patients during their hospital stay, the treatments provided, and the medications added, changed, or stopped during the inpatient spell. The DAL should provide accurate information on salient investigations undertaken, critical information for the patient and GP, and any necessary follow-up within the system. Many problems are known to exist across NHS systems regarding the completion of DALs, the quality of information within a DAL, and the physical sending and receipt of a DAL. It has become clear that there are multiple, cross system, digital, cultural, historical, interdependent, issues at play.

A DAL task and finish group was established in November 2023 and the following statements begin to describe the issues identified, and extensively investigated within the Group:

- A DAL is automatically generated but may not be populated with any information e.g. in the planned care setting.
- DALs are not generated from “non-admitted” areas e.g. Emergency Department (ED) and same Day Emergency Care (SDEC) settings, where differing solutions are currently in place which may not result in the automatic push of a DAL to the GP, e.g. the production of a “DAL on demand”.
- “DALs in draft”– a DAL may be populated but not signed off and therefore delayed or not sent.
- The quality of DALs is hugely variable, and often include results of investigations fully copied and pasted from elsewhere within Welsh Clinical Portal (WCP).
- DALs are held within WCP and therefore within Digital Health Care Wales (DHCW), and any feed with respect to DAL completion rates necessitates a request to DHCW.
- Many General Letters are generated and sent in lieu of, or as well as, DALs – this introduces risk as letters arrive at different times into GP systems, and there may be subtle (or significant) differences in the content of the DAL and the content of the General (discharge) letter.
- A number of clinical areas will print a copy of the DAL for a patient to take home. This practice was more widespread historically but is not now routine practice across the Health Board.

Background

Chilcott, Rachel
08/05/2025 16:26:52

The GMC states in Good Medical Practice[1] that a Doctor must contribute to the safe transfer of patients between healthcare settings. A DAL is a means of communicating vital information, ongoing plans and actions, on the transfer of care of a patient from the hospital inpatient setting. A template of this digital document is automatically generated in WCP when a patient is admitted into an inpatient setting, and has the utility to list relevant medication changes which are cross checked by Pharmacy colleagues prior to sign off. A

fully signed off DAL is automatically "pushed" via the Welsh Clinical Communications Gateway (WCCG) to the patient's registered General Practice where processes are in place to ensure that any action for the General Practice including any change in regular medication, is enacted. Increasingly, cluster pharmacists are taking responsibility for the actions arising from a DAL communicated to General Practices.

WCP sends its DALs in .XML format so that the 2 GP systems in use in Wales (EMIS and INPS) can directly import the structured data. This is not the case for general letters which arrive in GP surgeries in PDF form. In some inpatient areas a DAL will be printed for the patient to take with them on discharge.

When a DAL is signed off by an approved clinician, it is pushed through WCCG and on to the GP Surgery within 4 hours if there has been Pharmacy review or within 17 hours if Pharmacy have not signed off (if adjustment is needed to medications they then can be made by Pharmacy in the extra time available). A manual "DAL on demand" can also be created in WCP, and is often used in non-admitted areas (e.g. SDEC areas), and transmitted through WCCG as soon as it is signed off by the clinician completing the document.

1 - GMC – Good Medical Practice
Paragraph 44 "You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:
a. share all relevant information with colleagues involved in your patients' care within and outside the team,"

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

Assessment of available Data – Size and Scope of the problem

The size of the DAL problem can be defined in terms of volume and/or quality. It is not possible at this time to use AI or any other means, to digitally assess the quality of a DAL. In March 2022 – data from DHCW suggests that 50% DALs were not sent.

In terms of DAL quality data from Pharmacy colleagues in the community suggest that 1 in 31 DALs received had an issue which required contacting the hospital to resolve.
In 2023 there were 167 Datix recorded from Primary Care which were DAL related. The main themes of these Datix were DAL not completed or delayed, DAL in draft and DAL inaccurate or vital information omitted.

A DatixWeb search stretching back to 2005 reveals 1100 records where the terms "clinical portal", "WCP", "EU Workstation" and "Generic Letters" were utilised. This is a crude measure but reflects the prominence of communication on transfer of care within CAV patient safety events.

In 2023, 23 calls were made to the UHW Pharmacy team in relation to DALs – 2 queries from community Pharmacists in relation to DAL issues and 21 calls from members of the public querying lack of instructions in relation to Medicines or lack of a DAL at discharge. An update from DHCW on DALs not sent in 2023 is being processed and cleansed. 66,391 DALs were sent in 2023 across CAV. 19% of these were created manually. The time taken to obtain and cleanse this data highlights the difficulty in obtaining data on DALs given the necessity to liaise with DHCW in order to obtain the data for C&V patients.

Work is underway within the Digital team to work up "DALs Sent" and "DAL in draft" dashboards for clinical teams, revisiting work that was in progress prior to the pandemic. However, this work will be superseded by the DAL being constructed in the Cardiff and Vale electronic prescribing and medicines administration (ePMA) system (ePMA via Nervecentre currently preparing for clinical implementation)). A DAL in the CAV ePMA will mean that

Whilcott, Rachel 08/05/2025 08:25:52

CAV will "own" its own DAL data, enabling the ability for CAV, Directorate, Ward and Consultant level DAL productivity dashboards to be produced.

The following broad themes have been discussed and agreed as workstreams that would optimise the completion of a DAL containing appropriate, patient centred data, with actions to facilitate efficient transfer of care on discharge from hospital. The working group that has produced these principles has representatives from Medical and Nursing teams, Pharmacy, Primary care, Resident Doctor and Digital colleagues.

- Establish a ward standard that a DAL is completed before a patient is discharged
- Establish a ward standard that patients are provided with a copy of their completed DAL on discharge
- Increase priority of DALs in daily workstreams – daily board rounds, patient safety checklists, education and awareness within Clinical Boards and Directorates in order to prioritise DAL completion
- Education and awareness to Consultants and Resident Doctors of the importance of the DAL being an accurate representation of inpatient care with clarity of prescribing on transfer of care.
- Ensure Standard Operating Procedures are in place for the completion of absent DALs, DALs in draft, DALs requiring clarification on request, etc. Time should be routinely set aside for the Team or Consultant of day/week as "failed DAL completion time" etc.
- Establish automated or standard information within DALs arising in planned care areas.
- Consider digital support through DAL production within ePMA, to optimise DAL performance completion and quality – e.g. routine "DAL in draft" reporting mechanisms, DAL in draft alerts to clinicians, development of an automated quality metric to monitor DAL quality etc. Action underway with digital team to scope potential for DAL completion dashboards arising within ePMA.
- Governance – Clinical Boards to embed DAL performance metrics within Quality and Safety meeting structures which will be interrogated at performance reviews

Immediate actions

- Align discharge processes in Medical and Surgical SDECs – EU Workstation discharge letter, with "DAL on Demand" for medication reconciliation.
- Use a DAL solely to document discharge from hospital from an admitted area in preference to a general letter. Cease the use of a Clinical note on WCP documenting an inpatient admission.
- Generate detailed action plan to address recommendations
- Raise awareness of incomplete or unsent DAL as a clinical safety risk on transfer of care with all Clinical Boards – recommend DAL provided to patient at point of ward discharge
- Education to Resident Doctors on topic of importance of accurate and timely DAL completion for optimised transfer of care (delivered by PCIC/Pharmacy)

Recommendation:

The Committee is requested to:

a. **NOTE** the content of this report.

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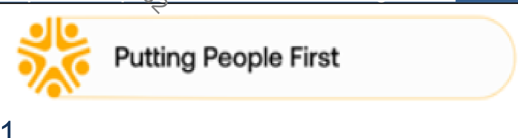
Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

 1.		2.	yes

Click the objective above to view more detail.		**Click the objective above to view more detail.**	
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Future 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term		Integration	X	Collaboration		Involvement	

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		Nil required

Impact Assessment:
Risk: Yes
Risks of incomplete or poorly completed DAL defined in paper
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: Yes
DAL issues are high profile and regularly represented in Datix received within clinical boards
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Chilcott,Rachel
08/05/2025 16:26:52

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Board Assurance Framework

Updated 27 Mar 25

Chilcott,Rachel
08/05/2025 16:26:52

Introduction

The Board Assurance Framework (BAF) is the tool and document that seeks to articulate what strategic risks an organisation has identified that will, if not addressed, prevent it from delivering its strategy.

There is no definitive format, and it is intended that the below pages present in as clear a manner as possible the alignment between CAVUHB's 4 strategic objectives, the strategic portfolios that are led by the Executives in order to turn the strategy into delivery over the course of the strategy, the strategic risks that have been defined to best articulate the major themes that could prevent the delivery of the strategy, and the Board's Committees that are charged with seeking assurance on and scrutinising the delivery of each strategic objective.

While each strategic risk aligns to a Committee, the risks themselves are applicable to all 4 strategic objectives and have a whole organisation perspective and impact. Each has a risk appetite as determined by the Board.

Each risk seeks to identify the potential cause and effect of a manifestation of the risk becoming an issue. This 'uncontrolled' assessment makes use of a simple 5 x 5 scoring guide for likelihood against impact:

Likelihood / Impact	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Severe (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Moderate (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare (1)	1	2	3	4	5

Each risk is then assessed for the different controls and assurance measures or mechanisms that are in place, as well as identifying where there may be gaps in these facets. Once these have been applied a new assessment, using the above scoring system again, is then made.

However, the BAF is not a definitive mechanism or science. It is a vehicle for the organisation to articulate and expose some of the strategic level impacts on delivering the strategy, and for the Board and Committees to pull through and scrutinise those elements that are appropriate.

Finally, the BAF seeks to articulate the activity taking place relevant to each risk for assurance.

This document looks to capture and present this information so that the Board and members of the public can see all of the above information, the trends in scoring, the actions being undertaken and every change made to the document between one Board meeting and the next through the use of track changes.

Chilcott, Rachel
08/05/2023 16:26:52

Strategic Framework

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Strategic Framework						
Strategy	Putting People First	Providing Outstanding Quality			Delivering in the Right Places	Acting for the Future
Strategic Portfolio	Shaping Our Future People & Culture	Shaping Our Future Population Health & Place Based Partnerships	Shaping Our Future Quality, Value & Sustainability	Shaping Our Future Clinical Services	Shaping Our Future Infrastructure	Shaping Our Future Generations
Strategic Risk Theme	People	Quality			Digital	Sustainability
		Health Equity			Infrastructure	
Committees	People and Culture Committee	Quality Committee			Digital and Infrastructure Committee	Finance and Performance Committee
		Mental Health Committee				
	Audit & Assurance					

Chilcott, Rachel
06/05/2025 16:26:52

Strategic Objectives

Strategic Objectives			
Putting People First	**Providing Outstanding Quality**	**Delivering in the Right Places**	**Acting for the Future**
We will be a great place to train, work and live, where we listen to and empower people to live healthy lives. By 2035, colleagues would recommend us a great place to work, our workforce will reflect the diversity of our communities and more people will be living healthier lives.	We will provide outstanding services which are equitable, timely and safe, where people are treated with kindness and are supported to achieve the outcomes that matter to them. We will have reduced inequities in prevention, improved access to clinical services and clinical outcomes.	By 2035 we will be using real time integrated data to inform joint decision making and multi-disciplinary team working, giving people access to and ownership of their data to enable them to manage their health and wellbeing. We will be well on our journey to provide care in the right place, in facilities that are fit for purpose, flexible and promote recovery.	We will work to ensure that what we do today does not compromise the wellbeing of our future generations. We will protect the environment and develop and use new technologies, treatments and techniques to provide the best possible health outcomes and sustainable health care into the future. By 2030 we will have reduced the Health Board's carbon footprint by 34% and will have increased our research and clinical innovation activities.
People will feel valued, developed, supported and engaged. We will have an inclusive culture where the diversity of the Health Board's people will be representative of the Health Board's local populations. Through our integrated population health improvement programme, we will enable and empower people to live healthy lives and reduce their risk of ill health.	Focus on minimising inequity in healthy behaviours, preventative services, access to clinical services, and health outcomes, to reduce current unfair, unjust differences experienced by people in the community Deliver outstanding quality of care every time - from the most complex care for the most critically ill to routine care that prevents and protects against ill health and disease – addressing physical and mental health needs. Achieve the best outcomes for patients in line with what matters most to them, their families and carers. Develop the Health Board's approach to continuous quality to improvement and make the best use of the Health Board's resources.	To achieve digital maturity enabling the Health Board to connect and communicate, supporting shared decision making in the planning and delivery of health care services. Refresh and deliver the Health Board's programme for creating integrated health and care facilities in our local communities where people can access the information and support they need under one roof. With Cardiff University and NHS partners, develop the Health Board's plans for ensuring hospitals providing acute care are fit for the future. Develop more shared infrastructure with public and private sector partners to get best value for the Health Board's investment.	Develop and expand the Health Board's research, teaching and innovation portfolios in collaboration with Cardiff University and other partners. Contribute to the development of and adopt cutting-edge and novel treatment, techniques and technologies where they deliver improved patient outcomes and improved value. Maximise the Health Board's contribution to the foundational economy Deliver the Health Board's carbon emissions targets and fully support active and sustainable travel for staff and visitors to patients. Promote, reward and embed successful waste reduction as part of our quality programme of continuous improvement.

Chilcott,Rachel
08/05/2025 16:26:52

Risk Overview

What will prevent Cardiff and Vale University Health Board from delivering its strategy?
If any of the below risk themes cannot be controlled, then the strategic objectives are unlikely to be met.

Strategic Risk	Risk Appetite / Target Risk	Gross Risk *(no controls)*	Net Risk *(after controls)*	Trend	Context	Executive Lead(s)
Quality	Cautious 10	25	15		Our ultimate priority - to continuously, reliably, and sustainably meeting the needs of the population that we serve. Our organisation will focus on delivering assurance on the six domains of quality with the ultimate aim of providing outstanding care to our patients. We will strive to deliver Safe; Timely; Effective; Efficient; Equitable and Person-Centred Care.	Exec Dir Nursing Exec Medical Dir Exec Dir AHPs and Health Science Chief Operating Officer
Health Equity	Open 12	16	12		One of our two statutory responsibilities as a Health Board is to improve the health and well-being of our local population. The overall aim of our strategy is: 'Working together, we will help improve lives so that by 2035 people are healthier and unfair differences in health outcomes are reduced.' The goal is to improve health outcomes by reducing inequity in indicators of healthy behaviours and increasing the use of preventative services and access to clinical services.	Exec Dir Public Health
People	Open 10	20	16		The most important asset of any organisation. Through the delivery of the People and Culture Plan, our strategy will be delivered with a key focus on these core People risks: Attract, Recruit, Retain | Culture | Wellbeing	Exec Dir People

Chilcott, Rachel
08/05/2025 16:26:52

Risk Overview

Digital	Cautious **20**	**25**	**20**		Data is integral to our strategy. It empowers informed decision making about what we need to do, why, when and how we perform. Delivering our digital and data transformation road map will introduce actionable insights and capabilities that enable clinicians and patients in any setting delivery of safe, high-quality care, improving productivity, efficiency and communication through person centric digital solutions. The security, management and accessibility of data is essential.	Dir Digital
Infrastructure	Open 10	**25**	**20**		The Health Board has the largest hospital in Wales, a footprint across dozens of locations and integrated service locations with key partners. We must shape our future infrastructure to ensure facilities are fit for the delivery of modern healthcare, intelligent integration takes place with partners and the service is delivered in the right locations for our population.	Exec Dir Finance
Sustainability	Cautious 10	**20**	**15**		Sustainable, efficient services are a legal requirement, improve quality and ensure a sustainability of service for now and future generations. By articulating the strategy through the integrated mid-term plan and the proper alignment of resources and consideration of the environment the Health Board will meet its statutory duty and ensure value in delivery.	Exec Dir Finance

Risk Appetite			
Avoid	Avoidance of risk and uncertainty is a key organisation objective	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (VFM)
Minimal	Preference for ultra-safe delivery options which have a low degree of inherent risk and only for limited reward potential	Seek	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward	Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

Chilcott, Rachel
08/05/2025 16:26:52

Strategic Risks – Quality

Strategic Risk	Strategic Portfolio	Exec Leads	Committee	Date Added
Quality	Shaping our Population Health and Place Based Partnerships	Exec Dir Nursing | Exec Medical Dir | Chief Operating Officer Exec Dir Therapies and Health Science	Quality	30 Sep 24

Risk

Delivering outstanding quality and eliminating avoidable harm is the ultimate priority of the Health Board, however, constraints associated with . The Health Board must assure itself that it has suff Capacity, capability, governance and leadership to deliver measurable success across each of the six domains of quality impacts on the ability to deliver quality all the time and for the entire population.

Cause	Impact
Safe – avoiding harm to service users and staff Risk to delivering safe care is increased due to demand pressures, workforce shortages, aging physical estate, lack of digital technology and variation across the organisation.	**Safe** The UHB continues to see a number of same cause patient safety incidents where the harm to patients is potentially avoidable. These incidents include health care associated infections, failure to ensure continuity in clinical pathways and Never Events. The health, safety and welfare of our staff is not universally maintained.
Timely – providing care within an appropriate timescale to avoid harmful delays Ability to deliver timely care is significantly impacted by the backlog of referrals following the covid-19 pandemic and the mismatch between demand and recurrent capacity within many clinical services	**Timely** Long waiting times for planned care and diagnostics means care is delivered at inappropriate timescales with a potential consequence of progression of disease, worsening wellbeing and associated psychosocial impact on patients and families. Care is ultimately costlier to provide.
Effective - providing services based on scientific evidence and refrain from providing treatments and services that do not benefit patients Ability to deliver effective care is impacted by workforce pressures, outdated systems and process, particularly related to digital technology and aging physical environments. The challenge in accessing real time data to track care against a robust evidence base means that the organisation is dependent on retrospective data to inform its response to quality risk	**Effective** Benchmarked data associated with national clinical audits demonstrates that we don't universally benchmark in the top 30% of organisations nationally for performance and outcomes. The pressure on estates, workforce capacity and wellbeing will impact on our ability to provide care in line with evidence base.
Efficient - avoiding waste that does not add value to the patient or the desired outcome Risk to delivering efficient care is caused by outdated systems and process, particularly related to digital technology and aging physical environments and workforce efficiency.	**Efficient** The Health Board is not meeting some of its productivity and efficiency ambitions, including in relation to outpatients and length of stay. Care may be being delivered which does not provide value to the patient, wider population and health economy. Care can be duplicative and wasteful. Care is often delivered with a disproportionate focus on intervention vs prevention. Constraints around workforce availability results in a reliance on non UHB staff to provide core .
Person Centred - providing care that is respectful and responsive to patient's values and needs In order to deliver reduce the risk of not delivering person centred care the organisation must seek understanding of our population, empower patients, seek options to receive feedback and develop a responsive culture.	**Person Centred** The Health Board is striving to deliver care that meets the patients right to empathy, compassion, privacy, dignity and respect. In some areas patient experience is below our ambition, for example in the Emergency Department which is below the 85% target in all but one measure. The Health Board is seeking to ensure patients and families views are sought and play a role in improving services.
Equitable - Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life We embed equality and human rights in our health care system. We design services that meet the needs of our local population.	**Equitable –** Our health outcomes between different population groups (e.g. most deprived and least deprived and different ethnic groups indicate that we have more work to do on this aspect of quality. We have developed an 'Equity, Equality and Patient Safety Framework for the Health Board' this describes a framework for change, provides examples of best practice from across

Chilcott,Rachel 08/05/2025 12:26:52

Strategic Risks – Quality

		the world, and finally outlines the key actions each Clinical Board has committed to. For example, our data collection of protected characteristics is poor, and each Clinical Board will need to make improvements in this area. Using a co-production approach supports equity.	
Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 10

Controls	Assurances
Safe – Corporate Quality and Safety team have oversight of all UHB patient safety incidence, the Duty of Candour supports systematic scrutiny of all incidents reported as having caused moderate harm and above. Quality and safety Committee and the groups that report into the committee provide oversight of emerging trends. The clinical safety group brings together the clinical boards and clinical advisory groups to support the development of strategy and policy to deliver quality aligned to current risk. **Timely**- Planned Care programme and Operational Performance meetings delivering on plans to reduce waiting times. Patients prioritised in line with Health Board criteria – Urgent and Emergency Care; Cancer and Time-Critical; planned (in referral order). Recovery plans being developed for diagnostic long waits such as endoscopy and non-obstetric ultrasound. **Effective –** The Clinical Effectiveness Committee provides oversight of national clinical audit outcomes and improvements and implementation of NICE and HW guidance. Clinical Boards are bringing an overview of their local arrangements to providing continuous focus of national audit data and use it to transform clinical pathways as has been done in stroke and hip fracture. **Efficient –** operational programmes in planned care and urgent and emergency care focused on delivering best practice. Benchmarking and use of GIRFT central to programme. Productivity and Efficiency ambitions in place and monitored. **Person Centred –** Value Based Healthcare programme supporting projects and programmes focused on delivering value to patients. **Equitable –** We monitor performance against the actions outlined in the Equity, Experience and Patient Safety Framework and Action Plan. This goes to Quality Committee every six months. Our Cardiff and Vale Health Inclusion Service (CAVHIS) supports the most vulnerable people experiencing 'cliff edge' health inequalities, but there is more to do to support this population and reach out to the next level of people experiencing health inequalities. Investment has been agreed to support this expansion. Implementation of this Business Case will need to be reviewed periodically.	• Clinical Board Performance Meetings • Integrated Performance Report • QSE • Clinical Effectiveness Committee • Clinical Safety Group • Risk registers • Executive Reviews • CIVICA • Benchmarking Information (Clinical) • Get It Right First Time • Peer Reviews • HIW and external assurance • Equity, Equality, Experience and Patient Safety Framework and Action Plan at Quality Committee • Assurance of CAVHIS Business Case Implementation in 2024/25

Chilcott,Rachel
08/05/2025 16:26:52

Progress against the implementation of our co-production approach will also be important for improvements to equity.	
Gaps in Controls	**Gaps in Assurances**
Lack of funding available for deliver planned care performance standards recurrently Both the clinical safety group and the clinical effectiveness groups are relatively new forums, and the Clinical Board quality and Safety governance needs to mature further to deliver a quality management system. Many local improvements aligned to patient safety incidents are within the gift of the clinical boards t facilitate, however there are complex health board wide or national improvements for example delivery of scan for safety, implementation of a medical device register, whole system approach to observation and escalation that are dependent on resource Poor data collection on protected characteristics across the organisation.	• Approach to Quality Statements • Quality Outcome Framework • Resource for widespread health board wide improvements • Data improvements that will improve data monitoring of protected characteristics at the local level e.g. National Data Repository, a Population Health Management System for Wales and use of the NHS App in Wales

Risk Post-Controls and Mitigation			
Impact: 5	Likelihood: 3	Net Risk: 15	

Actions			
What	**Lead**	**By**	**Update**
Deliver stroke improvement plan to address quality concerns in acute stroke pathway	PB	31/03/25	• Business case approved for stroke model, funding to be released from Q4 2024/25 • Delays in recruitment for agreed stroke post
Develop 6 goals workstream four objectives to transform continuity of care, hospital flow and length of stay	PB	31/05/2025	• UHB launch of Reducing Time In Hospital in November – completed • 6 goals programme reframed for 25/26 to include two workstreams, one focused on secondary care and one primary. Detailed plan developed and will be signed off in Q1
~~Develop plan to winter to ensure primary and secondary care systems are equipped for increased pressures~~	~~PB~~	~~31/10/24~~	~~• Additional winter capacity is open in UHL. Significant operational pressures~~
Develop and deliver improvement plan for cancer and long waiting patients, including a plan to reduce diagnostic waiting times.	PB	31/03/25	• Delivery against revised trajectories is monitored internally and by WG • Challenging position in select specialities including ophthalmology

Philcott, Rachel 08/05/2025 10:26:52

Strategic Risks – Quality

Develop and deliver long term proposal for ITU capacity – Strategic Outline Case in production	PB	31/03/25	• SOC in development and due to WG in March 2025 • Interim plan for releasing capacity on 3rd floor in progress through discretionary capital programme – relies on moving cardiology
Development of a Quality Outcomes Framework- To support a data informed approach to quality	JR/ RS	31.06.25	• Meetings underway with corporate teams to agree quality indicators • Work to extrapolate data relating to patient safety incidents commenced • Plan to develop a first draft by Q1 with digital support by June 2025 • Publication of a UHB mortality dashboard
Launch of Quality Excellence Programme Board	JR	31.10.24	The Programme Board has now commenced with the second meeting taking place in January 2025 and an agreed focus on the development of a quality management system and IP&C and a third priority relating to follow up of patient care in Q1
Development of the Quality prospectus to populate the quality academy – Up skill staff across the clinical boards in patient safety review technique, Iimprovement planning and clinical governance	JR	31.03.25	• PSLR training developed • Improvement plan training in development • Human factor prospectus planning • DevelopemntDevelopment of a quality academy • Accredited audit training in place
Monitoring of the Equity, Equality, Experience and Patient Safety Action Plan and progress against actions by Clinical Boards	CB	Every six months	• Paper for Quality Committee on progress against the action plan. • Early discussions with Public health around equity measures as part of the quality outcome framework
Implementation of the co-production framework in Cardiff and Vale	TBC		

Chilcott,Rachel
08/05/2025 16:26:52

Strategic Risks – Health Inequity

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Health Inequity	Shaping our Population Health and Place Based Partnerships	Executive Director of Public Health	Quality	29 July 2021

Risk
There is a risk that lack of investment in prevention, primary care and community services coupled with a deterioration in the wider determinants of health will adversely impact our statutory duty to improve the health and well-being of our local population and our strategic ambition to reverse the historic trend in widening inequality in life expectancy for men and women living in Cardiff and Vale.

Cause	Impact
• People in the most deprived areas die earlier on average and live more of their lives in poor health; this is well recognised and deeply entrenched, but it is preventable. • People living in poverty are getting sicker and accessing services later. For the most deprived groups, EU attendances are nearly twice as high and emergency admissions more than double that the least deprived. • In 2021 the *undiagnosed* diabetes rate was double for those in the bottom Indexed of Multiple Deprivation (IMD) quintile compared to the top. This presents a challenge for the NHS in finding those with an unmet need for healthcare. • Greater illness and poorer access to care (the inverse care law) contribute to worse health outcomes. This impacts directly on the gap in life expectancy between the most and least deprived groups. • Our organisation has set the strategic intention to shift spending from reactive care in hospitals to more prevention and proactive care in the community setting – but secondary care has attracted a greater share of NHS spending, meaning that prevention, primary care and community services have received a smaller share. This must be addressed for the sustainability of the organisation. Locally we call this left shift, a 'shift upstream' towards prevention. • Spending on prevention, and in primary and community settings had a superior return on investment when compared with acute hospital services. • There is strong evidence that areas that invest more in prevention and community care see 15 per cent lower non-elective admission rates and 10 per cent lower ambulance conveyance rates together with lower average activity for elective admissions and EU attendances.	• We can reduce premature mortality, reduce social disparities, and reduce the absolute time in ill health. This in turn reduces the burden on the Health Board and social care while enabling our population to be more productive in our working lives, so strengthening the local economy. This is the desired outcome for individuals, families and the public purse. • Risk factors interact and multiple aspects of disadvantage come together, increasing the disease burden and widening equity gaps. • The key population groups with multiple vulnerabilities include: - Some minority ethnic groups, especially some people in Black and Asian populations - People living in (or at risk of) deprivation and poverty - People in insecure/low income/informal/low-qualification employment, especially women - People who are marginalised and socially excluded, such as people who are homeless and other inclusion health groups • Areas with higher unemployment have greater incidence of suicide; and people living in the most deprived areas experience the largest increase in mental illness and self-harm. • Health inequalities are estimated to cost £3-4 billion annually in Wales through higher welfare payments, productivity losses, lost taxes, and additional illness • The total annual cost associated with inequality in hospital service utilisation to the NHS in Wales is estimated to be £322 million, equivalent to 8.7% of the total hospital service expenses, driven largely by higher service use among people living in the more deprived areas compared to those living in the least deprived (PowerPoint Presentation (nhs.wales)) • There is a moral and financial sustainability imperative to address health inequalities in our Health Board.

Chilcott,Rachel
09/05/2023 16:26:52

Strategic Risks – Health Inequity

- Changing both the distribution of resources and the operating model to deliver integrated, preventative care closer to home are the strategic priorities of the organisation as described in the strategy, because they are derived from the changing needs of the population.
- Health inequalities are well documented across the UK, with a recurrent pattern of worsening outcomes linked to factors such as deprivation and ethnicity; these inequalities are evident for many chronic and acute conditions.
- Health inequalities arise in three main ways:
- structural issues, e.g. income, employment, education and housing
- unhealthy behaviours due to the envirnoment, social norms and income levels
- inequitable access to, or experience of, services, which can be a result of discrimination due to inaccessible services, public information or healthcare sites that may be relevant/pertinent to particular needs.
- Differential experience of the wider determinants of health across the life course mean that disadvantage experienced in childhood is often compounded and exacerbated through adult life, and often passes inter-generationally.
- The 'Inverse Care Law' has been recognised for over 50 years, with those experiencing disadvantage consistently experiencing more challenges in accessing health services. Inequity of access to healthcare continues to be evident in Cardiff and the Vale of Glamorgan.
- The UHB also has a role as a care provider, employer and regional Anchor Organisation to positively impact the wider determinants of health for employees, patients and residents and to advocate for improvements to the wider determinants of health with other statutory partners.
- Lack of capacity to deliver evidence-based interventions at scale to tackle health behaviours e.g. smoking, diet, physical activity, alcohol, that drive the huge disparities in health outcomes we see across Cardiff and Vale.
- Lack of capacity to undertake more substantial work on the wider determinants of health with partners.
- Lack of investment in prevention, primary and community services, e.g. health visitors (UK staff shortages) and public health consultants (Faculty recommends 15 for a population of 500,000).

Uncontrolled Risk			
Impact: 4	Likelihood: 4	Gross Risk: 16	Target Risk: 12

Chilcott, Rachel
08/05/2025 16:26:52

Strategic Risks – Health Inequity

Controls	Assurances
1. Statutory duty • The Health Board has a~~two~~ statutory dut~~ie~~ys: ~~to break even and~~ to improve the health and well-being of the local population. ~~Reducing health inequalities supports both requirements.~~ • The Socio-economic Duty places a legal responsibility on public bodies in Wales when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. • **2. Role as an Employer** • In our Equality, Inclusivity and Human Rights Policy, we have an active programme, which sets out the organisational commitment to promoting equality, diversity and human rights in relation to employment, and ensuring staff recruitment is conducted in an equal manner • Our Strategic Equality Objectives and Plan 'Shaping our Inclusive Culture 2024-2028, has a number of key delivery objectives and is premised on the basis of embedding equality, diversity and human rights, and Welsh language, into UHB business processes. • All our Executives have taken up a leadership role as an Inclusion Ambassador covering different characteristics, including those specified in the Equality Act 2010 Staff have been signposted to resources to help them to cope with the cost-of-living crisis **3. Our Strategy and Plans** • The refreshed UHB Strategy 'Shaping our Future Well-being' shines a light on the issue of equity at the strategic level • The Cardiff and Vale long-term public health plan 2024 – 2035 sets out how the UHB intends to achieve its ambitions of increasing life expectancy, reducing inequity and shifting more focus to prevention • 'Shaping our Inclusive Culture 2024-2028' is closely aligned with the UHB Shaping our Future Well-being. • Through our PSB and RPB plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB have further identified collective actions. • The future UHB organisational direction agreed at the recent rapid planning event supports the 'shift upstream' by committing to develop an Integrated Community Health System, underpinned by care pathways that begin with prevention; prevention is a 'brilliant basic' • The establishment of a Strategic Diabetes Programme Board is a key element to reducing health inequalities and has an aim to identify those with undiagnosed diabetes in areas of deprivation across Cardiff and Vale. 4. **Public Health Priorities to reduce health inequalities** • As a team we have agreed three immediate priorities that will influence health inequalities (and other work that we will need to bring forward when capacity allows):	Board papers Committee papers to Quality Committee e.g. updates on Equity, Equality, Experience and Patient Safety Framework. Committee papers to People and Culture and Quality and Safety Committees e.g. updates on Welsh Language Standard. Risk Registers Integrated Performance Report Papers to SLB

Chilcott,Rachel 08/05/2025 16:26:52

Strategic Risks – Health Inequity

- preventing obesity (focus 0-5 years) - reducing smoking rates (dependent on a new business case) - increasing levels of vaccination (using an outreach model to reduce inequity in uptake).			
Gaps in Controls		**Gaps in Assurances**	
		Monitoring data (e.g. on protected characteristics) Population Health Management System to reduce inequalities by identifying those at risk	
Risk Post-Controls and Mitigation			
Impact: 4	Likelihood: 3	Net Risk: 12	

Actions			
What	**Lead**	**By**	**Update**
Embed a 'Socio-economic Duty' way of thinking into strategic/operational planning, *beyond* complying with our statutory duty, and to always consider the unintended consequences of our actions	Claire Beynon/ Rachel Gidman	2024/25	• We plan to strengthen the strategic response to the Socio-economic Duty, ensuring actions are systematically applied. • The EHIA process is being reviewed on an All Wales basis with the view of creating a Once for Wales approach. C&VUHB will contribute to the development and implementation. The Health Board are also exploring opportunities as to how the EHIA process can be better embedded into governance processes and to make the process more user-friendly. • Our UHB will continue to work collaboratively with our stakeholders to shape our services and culture.

Chilcott,Rachel
08/05/2025 16:26:52

Strategic Risks – Health Inequity

Within the UHB and through our PSB and RPB partnerships, develop and deliver a suite of focused preventative actions to tackle inequalities in health	Claire Beynon	March 2025	• We will continue to work with PSB and RPB partnerships on three areas where we can make a significant impact on reducing health inequalities: smoking, vaccination and obesity. The Amplifying Prevention Board, held jointly with Local Authority partners, provides governance oversight of this collective action and works to remove any blocks to collective action. • The Head of Equity and Inclusion is a member of the Public Sector Equality Network, improving the collaboration between public sector organisations in the area. • We have been delivering are restarting a second round of MMR vaccines catch-ups directly in schools with lower uptake to reduce barriers to access and reach groups less engaged with the childhood immunisation schedule to protect education from the impact of a Measles outbreak as this would exacerbate health inequalities. This outreach approach is being extended to reach other communities where uptake is lower. Additionally a data sharing agreement with Cardiff Council will support a more targeted, timely and intelligence driven approach and enable a more active role played by schools in monitoring and promoting vaccination. • TheA Health Improvement Officer has taken up post and is developing community profiles as part of the an action plan to work to address the health inequalities experienced by ethnic minorities and boost our understanding and ability to engage and build trust.. This is a joint position with Cardiff Council and the UHB. As part of the investment in health protection and immunisation, we are recruiting to further positions to enhance our ability to deliver focused actions to reduce the gap across the socio-economic gradient and different communities. • An 'Equity, Equality, Experience and Patient Safety' action plan was developed, covering 24 initial actions across the Clinical Boards that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. This was approved by Board in May 2024. Progress on the actions is reported to Quality Committee on a 6-monthly basis. The most recent update in November 2024 commented on the successful establishment of face to face antenatal education sessions for non-English speaking families as part of the community of midwifery programme of classes, and highlighted various awards won by teams with respect to the equality agenda such as the 'project search' program, designed to support young adults with learning disability/autism in gaining employment which was recognised with awards at the Project Search awards in Blackpool and the National HR awards in London. Work continues to meet targets in the existing plan, especially in relation to data collection. Additionally, work seeking to identify any additional new actions to add to the plan has begun. A further update will be provided in 6 months time. • A vaccination van has been procured by the Health Board and it is being deployed in areas of lower uptake and to support outreach efforts and to offer opportunistic vaccination in the context of large community gatherings. The community delivery model of vaccination is continuing, and the distance radius and focus is being reviewed to further enhance the proximity of the offer.

Chilcott, Rachel 08/05/2025 16:26:52

Strategic Risks – Health Inequity

Improve the routine data collection in relation to equality and inequity across the UHB.	Claire Beynon	March 2025	There are improvements that need to be made in the routine collection of protected characteristics in order to support the introduction of new indicators. This will need to be addressed by each Clinical Board. Patient feedback is essential to improving service quality. Since October 2022, the UHB has collected most routine feedback via electronic surveys, accessed by SMS link, QR code and URL. We currently survey up to 1000 patients who have attended an outpatient appointment or following discharge as an inpatient every day; this includes the Emergency Unit (200), Mental Health (200) and the routine survey which randomly selects from all other clinical areas (600). As part of ongoing development, the routine survey has been translated into the top ten most frequently used languages, including BSL, English and Welsh. All surveys also collect information on protected characteristics, although this is not compulsory. A range of methods is used to gather feedback with the aim of ensuring all patients have the opportunity to contribute, including: • Website hosted surveys • Kiosk surveys • Tablet surveys • Postal surveys and paper-based feedback forms • Telephone surveys • SMS surveys • Focus groups • Patient stories • Bespoke The All Wales Peoples Experience Framework will be launched in 2025/26. At the same time there will be a roll out of an all wales national survey which will be translated into different languages to enable accessibility.

Chilcott,Rachel
08/05/2025 16:26:52

Strategic Risks – People

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
People	Shaping our People and Culture	Rachel Gidman	People and Culture	30 Sep 24

Risk

If we do not have the right people, the right culture and a healthy, effective workforce then we will not be able to provide the services to the population that we are required to and on which people depend.

Cause	Impact
1. Attract Recruit Retain • The increased demand across the NHS and Social Care has left a shortage in some professions and the sustained pressures have impacted negatively on wellbeing and retention. • National shortages in some professions have made it difficult to attract people with the right skills/experience and in the numbers required. • Attraction, recruitment and retention is also being affected by the negative image that is portrayed that NHS staff do not receive the right remuneration for the work that they do. The Industrial Action over the last couple of years has not helped the national reputation of the NHS as an employer. • People now think differently about work and what is important to them.	• Higher levels of sickness absence • Lack of management capacity to support staff appropriately; - Higher levels of turnover; - Low morale and poor staff engagement; - Increased reliance on temporary workforce e.g. bank, agency, locums, etc; - Reduced capacity to undertake appraisals, identify development needs, and focus on talent management and succession planning. - Lack of capacity to upskill and develop our current workforce. - Reduction in uptake of student training places and higher attrition rates, resulting in a reduction of graduates. • Potential negative impact on quality of care & safety. Inability to expand services as required due to lack of staff with the relevant experience, skills, etc.
2. Culture • There is a belief within the organisation that the current climate is high in bureaucracy and low in trust. • Staff reluctant to engage with the case for change as they are overwhelmed with system pressures, change and ongoing demands. • Staff are not feeling involved in, or understanding the part their role plays for the case for cultural change due to lack of communication filtering through all levels of the UHB. • Additional complexities as colleagues continuously respond to the challenges of the pandemic, making involvement in, and response to change complex and challenging.	• Staff morale may decrease • Increase in absenteeism and/or presenteeism • Difficulty in retaining and recruiting staff • Potential decrease in staff engagement • Increase in formal employee relations cases / respect and resolution • Transformation of services may not happen due to staff reluctance to drive the change through improvement work. • Patient experience ultimately affected. • UHB credibility as an employee of choice may decrease • Staff experiencing fatigue and burnout making active and positive engagement in change challenging and buy-in difficult to achieve. • Existing inequalities exacerbated • Not realising the opportunities within workforce sustainability

Chilcott,Rachel
08/05/2025 16:26:52

Strategic Risks – People

<table>
<tr><td colspan="2">3. Wellbeing

• Lack of integration and understanding of importance of wellbeing amongst managers
• Impact upon manager wellbeing of balancing staff and service needs
• Conflict between demands of service delivery and staff wellbeing
• Exposure to psychological impact of increasingly complex and challenging demands of care
• Inability to deliver care to required standard due to short staffing (moral injury / moral distress)
• Ongoing demands over an extended period of time
• Cost of living
• Financial climate</td><td colspan="2">• Values and behaviours of the UHB will not be displayed due to high pressure environments, and potential for exacerbation of existing poor behaviours
• Operating on reduced staff levels in clinical areas due to sickness absence and/or staff shortages
• Mental health and wellbeing of staff will decrease, existing MH conditions exacerbated
• Clinical errors will increase
• Staff morale and productivity will decrease
• Job satisfaction and happiness levels will decrease
• Increase in sickness levels
• Patient experience will decrease
• Increased referrals to Occupational Health and Employee Wellbeing Services (EWS)
• Increased referrals for higher level psychological support
• UHB credibility as an employer of choice may decrease
• Potential exacerbation of existing health conditions
Impact on retention (negative) and attraction of staff into healthcare</td></tr>
<tr><td colspan="4">Uncontrolled Risk</td></tr>
<tr><td>Impact: 5</td><td>Likelihood: 4</td><td>Gross Risk: 20</td><td>Target Risk: 10</td></tr>
</table>

Chilcott, Rachel
08/05/2025 16:26:52

Strategic Risks – People

Controls	Assurances
• The People and Culture Committee provide more scrutiny and assurance to Board. • People and Culture Plan in place with a robust governance structure monitoring delivery against the agreed priorities.. • Monthly Executive Review meetings with Clinical Boards • Strategic oversight meetings, e.g. NPG, MWAG and introduction of MPG (Medical Performance group) • Cardiff and Vale UHB refreshed strategy: Shaping Our Future Wellbeing • Talent management and succession planning framework • Values based recruitment / appraisal • Strategic Equality Plan • Anti-Racist Action Plan • Workplace Race Equality Standards (2024) • Welsh Language Standards • Patient experience score cards • Raising concerns procedure/Speaking up Safely. • Widening Access Framework • New Starter Surveys and Exit Questionnaires/interviews • Nursing Staff in Post Forecasting to identify potential risks in advance • Adoption of consistent, evidence-based approach to Culture and Leadership via the NHSE Culture and Leadership Programme Staff survey	• Robust monitoring of People and Culture Plan KPI's at the People and Culture Committee and Board. (1) • Quarterly IMTP/Annual Plan updates to WG. • WG JET and IQPD • Effective partnership working with Trade Union colleagues (WPG, LNC, LPF). • Internal Audit on Staff Wellbeing, Culture and Values (Sept 2022) report (3); • Engagement of staff side through the Local partnership Forum (LPF) (1) Matrix of measurement now in place which will be presented in the form of a highlight report to Committee (1) • Internal monitoring and KPIs within the OH&EHWS (1) • Wellbeing champions normalising wellbeing discussions (1) • VBA focussing on individual wellbeing and development (1) • Successful retention of the gold (and platinum) Corporate Health Standard awards via the 'Enhanced Status Checks' in March 2023 • Substantive funding identified to maintain on a permanent basis the enhanced EWS service from April 2023 • Development of a new and permanent OD Manager - Wellbeing and Engagement role • Taking Care of Carers Audit and Action Plan to become part of Business as usual (3) • Internal audit on Staff Wellbeing, Culture and Values (September 2022) Report and implementation of Management Actions (3) • Trade unions insight and feedback from employees (2) • Working with HEIW as part of the Financial Wellbeing (FWB) task and finish group to develop a FWB strategy for NHS staff in Wales (2)
Gaps in Controls	**Gaps in Assurances**

Chilcott,Rachel
08/05/2025 16:26:52

Strategic Risks – People

Agreed Retention Plan for all staff. Retention & OD Lead for the UHB • Workforce supply affected by National Shortages. No leadership / management principles as a UHB (currently align with HEIW compassionate leadership principles) • No organisational cultural dashboard • Staff shortages / industrial action leading to movement of staff and high demand for cover • Transparent and timely Communication especially to staff who do not have digital access • Continued increase in manager referrals to Occupational Health • EWS seeing an increase in staff presenting with more complex issues, including a rise in referrals needing a wellbeing check due to the presentation of high risk in the referral • No Colleague Health and Wellbeing Framework	Capacity to respond to requests for cultural and transformation work Effective measures of culture / engagement • Organisational acceptance and approval of wellbeing as an integral part of staff's working life balanced against demand and flow • Awareness and access of employee wellbeing services, particularly for staff without email / internet access • Clarity of signposting and support for managers and workforce

Risk Post-Controls and Mitigation			
Impact: 4	Likelihood: 4	Net Risk: 16	

Actions			
What	**Lead**	**By**	**Update**
Consult, finalise and launch the Widening Access framework.	Jonathan Pritchard	January 2025	• Presentations and consultation undertaken with Staff Representatives and Clinical Board Management Teams. • Follow up meetings with Clinical Board managers arranged to identify work placements/opportunities. • Local areas of deprivation / community hubs identified and programme of visits for 2025 developed. •
Agreed Retention Framework to support retention for all staff groups, aligned to HEIW Principles and HEIW Nurse Retention Plan.	Claire Whiles	~~March~~May 2025	• The All Wales self-assessment was due on the 31 March 24. The organisation completed and submitted. ~~• A UHB Retention Framework is in development to support retention across the UHB. This will be available for engagement and inputQ4 2024/25 due to a focus on Staff Survey engagement across the UHB.~~A review of 3 frameworks in development identified cross-cutting themes. This has resulted in the

Gillett,Rachel
08/05/2025 16:26:52

Strategic Risks – People

Attract, Recruit and Retain is one of the key three themes of the People and Culture Action Plan which is monitored on a monthly basis to ensure good progress.			development of an over-arching framework including retention, health and wellbeing and organisational development. This will be consulted upon in March and April, and presented in May 2025 for approval. • Retention and OD Lead part of HEIW Community of Practice to ensure learning across Wales brought into UHB.
To develop management and leadership development where compassionate and inclusive leadership principles will be at the core of all the programmes.	Claire Whiles	MarchJune 2025	• Management programmes continue to be delivered and evaluated using the Kirkpatrick model (introduced Q1 2024) • Compassionate Leadership masterclasses developed via 'train the trainer' session with Professor Michael West. Delivered regularly. Ongoing review and evaluation in place. • General Manager leadership and management programme engagement completed. Focus group held with General Managers October 2024. Programme delivery to commence November 2024. Audience widened to all General Managers over two Cohorts.General Manager programme postponed due to action taken regarding non-essential training. Resume April 2025. • A leadership development pathway is in development and will be aligned with UHB objectives and organisational need. Leadership post recruitment November 2024 was unsuccessful, post to be reviewed and readvertised FebruaryApril 2025. • We plan to identify leadership and management principles in Q4 2025 - partially dependant on recruitment to Leadership and Management post.Working closely with HEIW to align leadership principles to 4-nations work on leadership and management competencies. Focus on management development April-June 2025, focus on managing attendance and wellbeing. • All programmes underpinned by compassionate and inclusive leadership principles. Planned work with HEIW and Professor Michael West to identify monitoring and evaluation measures to underpin development and cultural imporvement work. • Compassionate Leadership Pledge has been signed by the Board. Roll-out plan in development to support meaningful adoption at a local level, exploring tie-in to team assessment and ward accreditation. • Thorough TNA will be required to support effective leadership and management development. Looking at Management Passport for all managers to ensure underpinning knowledge. • Proposal for experiential leadership programme for managers at Band 7 level submitted toagreed by HEIW for consideration. Proposal for CAVUHB to pilot and evaluate.

Chilcott,Rachel
08/05/2025 16:26:52

Strategic Risks – People

Equality, Diversity and Inclusion	Claire Whiles	March 2025	• Monitor the delivery of the Strategic Equality Objectives and Plan through annual reporting. • Equality Policy has been reviewed and updated, to be shared with Stakeholders for comment January 2025 prior to further consultation and engagement.
Welsh Language Standards being implemented.	Claire Whiles	March 2025	• Continue to improve capture of Welsh language skills data through 'making every contact count' approach (i.e. Staff Survey roadshows). • Resolve the three Standard Enforcement Investigations currently open with the Welsh Language Commissioner. • Continue to communicate and deliver Welsh language learning opportunities with Dysgu Cymraeg Caerdydd.
Inclusion - Nine protected Characteristics	Claire Whiles	March 2025	• Development of UHB's LGBTQ+ Action Plan, stage one engagement underway with representatives from LGBTQ+ network. • Initial meeting held with Welsh Government to develop actions following the Health Board's Workforce Race Equality Standards Report. UHB's Anti-racist Action Plan to be reviewed once WRES actions agreed. • Follow up meeting with Welsh Government scheduled for February 2025 to discuss next steps with WRES.
Commissioning model / whole team approach introduced in People and Culture to ensure managers / teams can request support / advice / guidance and training which is delivered / supported by the most appropriate team / individuals and/or external partners. Includes representation from ECOD, People Services, Wellbeing Services, Equity and Inclusion.	Claire Whiles	~~March~~June 2025	• ~~The commissioning process is under review and will be strengthened to support a 'digital front door' into People and Culture. This will ensure effective allocation, response and evaluation.~~People and Culture Team working in collaboration with HEIW and Professor Michael West to review and improve culture and leadership programme implementation, monitoring and evaluation. Measures to be established and lessons learnt internally and via NHS England to be under-taken. • P&C MDT established and reviewing organisational requirements in interim. • Priority cultural work currently identified and allocated by Chief Operating Officer, EDofP&C and appropriate Executive Directors. Elements of work paused due to Service Review requirements. • ~~Organisational Development Framework to support delivery of the People and Culture Plan to be developed Quarter 4 2024/25.~~A review of 3 frameworks in development identified cross-cutting themes. This has resulted in the development of an over-arching framework including retention, health and wellbeing and organisational development. This will be consulted upon in March and April, and presented in May 2025 for approval.
The People and Culture Team will identify insights from workforce data, including themes emerging from EWS, OH, People Svcs, Culture work and Staff Survey, to shape	Claire Whiles	~~March~~June 2025	• Developments required to P&C Dashboard to ensure include all relevant measures, e.g. OH and EWS KPIs. Working with HEIW to improve dashboard reporting.

Chilcott, Rachel
08/05/2025 ...

strategic and operational response to themes / emerging trends. This will also be informed by working in collaboration with Clinical Boards.			• OH KPIs regularly reported to WG and KPIs adjusted to align with Welsh Government guidelines (i.e. calendar days). • Internal audit of OH Services postponed due to department re-location, to commence Q1 2025~~planned for Q4 2024/25~~ • NHS Wales Staff Survey 2024 ~~engagement and completion with increase in participation from 21.4% to 27%.,~~results received and analysis under-way. Communication and engagement plan in place for 2025/26 • ~~Investigating implementation of~~ OPAS database to be inplemented within~~into~~ EWS to support effective reporting and user experience. ~~To be implemented April 2025.~~Licences to be procured in April 2025. •
1. Enhance communication methods across UHB - Social media platform - Regularity and accessibility of information and resources Improve website navigation and resources	Claire Whiles	~~March~~May 2025	• ~~Draft H&WB Framework to be discussed with stakeholders, to come back for formal adoption by UHB. Influenced by HEIW Wellbeing Principles and AWMGS Framework.~~A review of 3 frameworks in development identified cross-cutting themes. This has resulted in the development of an over-arching framework including retention, health and wellbeing and organisational development. This will be consulted upon in March and April, and presented in May 2025 for approval. • To establish wellbeing area within Viva Engage
2. Training and education of management - Integrate wellbeing into all parts of the employment cycle (recruitment, induction, training and ongoing career) Enhance training and education courses and support for new and existing managers	Claire Whiles	~~March~~June 2025	• Colleague and Manager wellbeing included in all management and leadership programmes, induction. • Will be included within leadership and management principles development and leadership programme development as above. • Management training under review and refresh to focus on wellbeing and keeping people well at work. Training to commence April 2025, supported by digital learning. • Leadership development and talent role to be advertised April 2025, role will enable distinct focus on development of existing and future leaders and managers. • ~~Organisational Development Framework development to support managers with cultural improvement, including wellbeing, inclusion, retention, performance.~~
Wellbeing interventions and resources to be evidence based, targeted, reviewed and evaluated.	Claire Whiles	~~March~~June 2025	• EWS continue to offer evidence based interventions and review and enhance offer, e.g. Spring; EMDR • ~~Evaluation of wellbeing interventions to be improved through implementation of H&WB Framework~~A review of 3 frameworks in development identified cross-cutting themes. This has resulted in the

Chilcott,Rachel 08/05/2025 16:26:52

Strategic Risks – People

			development of an over-arching framework including retention, health and wellbeing and organisational development. This will be consulted upon in March and April, and presented in May 2025 for approval. Will contain sections on data driven decision making, and monitoring and evaluation. • Improvement required across UHB to ensure consistency of offer, e.g. Trauma response / psychologist intervention / evidence based practice. • Staff Fast Track Trauma Pathway under review due to increase in waiting times, draft paper for initial consideration ~~February~~ April 2025. • Trauma Risk Management (TRiM) proposal presented at Senior Leadership Board for feedback, business case in development for presentation ~~Februar~~Quarter 1~~y~~ 2025. • Review of EWS and OH service based upon direction of 'Brilliant Basics' to align to organisational priorities and support reduction in waiting times.

Chilcott,Rachel
08/05/2025 16:26:52

Strategic Risks – Digital

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Digital	Shaping our Future Digital Services	Director Digital and Health Intelligence (D&HI)	Digital and Infrastructure	4 October 2022

Risk
CAVUHB has legacy and deficit in human resources, skills and capability, infrastructure, applications and informatics. The digital estate has grown but the supporting resource has not. Without resourcing our Digital and Data transformation plans and Roadmap we risk the achievement of our SOFW objectives

Cause	Impact
CAVUHB IT and digital services are known to be historically underfunded resulting in a legacy and deficit in infrastructure, applications and informatics capability that has built up over at least a decade (e.g. our core applications for UEC, inpatients and outpatients were developed in-house c20 years ago). There are plans to rectify these issues however they are unachievable with the current resource (people, finance) allocation We have some capability in human resources but insufficient capacity or funding to execute the digital and data transformation plans and road map. Existing resources are fully consumed with tactical short-term on the day-to-day urgency of UHB operational needs Recruitment of suitably skilled D&HI staff is a national challenge as well as affecting CAV. This often requires the use of interim agency support in key areas, especially whilst we continue with legacy solutions as we are tied to old technologies. This of itself diminishes further our existing capacity as resources need to be familiarised with the technical environment and then supervised. Historically CAV has looked to provide much of its core IT and digital services inhouse. This is not always necessarily the optimum route however 'legacy lock' and the resource to support forward plans keeps us where we are. Meanwhile with new initiatives the technical estate grows and the gap between what we have and what we can support/refresh widens.	Colleagues need mobile, scalable, agile solutions that enable data collection and sharing. This is unachievable whilst we are locked into legacy. Legacy Lock makes improving our cyber posture more challenging (e.g. securing our data) The impact of not managing this risk is that the improvements in safety, quality, outcomes, productivity and financial efficiency that staff and patients expect from D&HI cannot be fully realised, therefore putting at risk the deliverability of the SOFW Strategy.

Chilcott, Rachel
08/05/2025 16:26:52

Strategic Risks – Digital

Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 20

Controls	Assurances

• Digital strategy approved by Board in 20/21 with roadmap for 21/22/23 - these will be refreshed by April 2025
• Roadmap to support the strategy shared with DHIC covering 2024/27 - these will be refreshed by April 2025 as part of the Digital Foundations PBC work
• Digital components described in IMTP – focussed on in year national and clinical board priorities
• £466K is being invested by CAVUHB in the development of a Digital Programme Business Case (PBC) to seek All Wales Major Capital Funding alongside a Business Justification case (BJC) for phase 1 of the 5 annual phases. This work will complete in 12 months.
• The work will deliver a clear trajectory, costs and plans on how CAV will achieve its target of HIMSS[1] Level 3 in pursuit of its intention towards a modular EPR, consistent with national and regional initiatives. The capabilities the PBC and business justification cases will describe are harmonious with and would segue into any nationally agreed and funded EHR solutions through interoperability and concordance with the "All Wales" Infrastructure review.
  ○ Work is expected to begin Oct/Nov 2024.
  ○ This follows positive discussions with WG IIB and NHS CDIO,
	• All Controls are shared and discussed with the DHI Committee which meets quarterly.
	• The Digital Foundations case was scrutinised and approved by the Investment Group and Strategic Leadership Board.
	• The Director D&HI shared the intentions of the Digital Foundations investment case and updated WG's chief digital officer, whilst the DoF has discussed with IIB Lead. Both are supportive of approach and our intentions
	• Recruitment and procurement is underway for the resource to produce the PBC and BJCs
	• Risk register articulates the risks of not being able to deliver digital solutions to support delivery of healthcare (1)
	• Internal audit report highlights the risk in delivering digital strategy citing the investment challenges that will prevent full implementation.

Gaps in Controls	Gaps in Assurances
Current annual discretionary funding is insufficient to cover the maintenance upkeep of the core infrastructure and there is no headroom for innovation	Unable to currently provide assurance that the finance will be provided

Risk Post-Controls and Mitigation			
Impact: 5	Likelihood: 4	Net Risk: 20	

Chilcott, Rachel
08/05/2025 16:26:52

Strategic Risks – Digital

Actions			
What	**Lead**	**By**	**Update**
Internal investment case to support the Digital Foundations case approved	Director of DHI	Sept 25	Programme Business Case completed and shared with WG setting out detailed roadmap plans and the associated costs, funded accessed by annual Business Justification Cases to WG's Major capital budget. Statement of works produced against which a suitable external partner will be sought
Additional resources brought in on a temporary basis (12 months) to support the Digital Foundations programme	Director of DHI	complete	Enterprise Architect and additional programme manager roles on-boarded Both EA and senior PM positions filled internally;
Presentation of Digital Foundations case to DHIC, SLB and wider organisation	Director of DHI	complete	Wider communications plan to share with the organisation how the digital foundations challenges will be met; work with clinical and operational leads to ensure alignment with current and future service delivery plans. The Digital Foundations programme referenced and discussed at the Senior Management Rapid Planning Event held in December; an agreed output is to communicate the programme more widely across the organisation to include all Clinical Boards and Corporate areas to ensure wide understanding of plans to improve digital solutions and the data which is collected, reported and used.

Chilcott,Rachel
08/05/2025 16:26:52

Strategic Risks – Infrastructure

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Infrastructure	Shaping our Future Infrastructure	Exec Dir Finance	Digital and Infrastructure	12 November 2018

Risk	
There is a risk that the condition and suitability of the UHB estate, IT infrastructure and Medical Equipment impacts on the delivery of safe, effective and prudent health care for the patients of Cardiff and Vale UHB. The condition of facilities within our main hospitals and some community facilities are impacting on our ability to continue to provide the full range of services and provide the r would like to commission from us. This is as a result of insufficient funding and resource to bring the estate up to the required condition in a timely way.	
Cause	**Impact**
• Significant proportion of the estate is over-crowded, not suitable for the function it performs, or falls below condition B (assessed regularly on an all-Wales basis by NHS Shared Services Partnership). • Investment in replacing facilities and proactively maintaining the estate has not kept up the requirements, with compliance and urgent service pressures being prioritised. • Lack of investment in IT also means that opportunities to provide services in new and efficient ways are not always possible and core infrastructure upgrading is behind schedule. • Insufficient resource to provide a timely replacement programme, or meet needs for small equipment replacement • Lack of timely decisions regarding the development of strategic business cases required to address the significant estates challenges we face.	• The health board is not able to always provide services in an optimal way, leading to increased inefficiencies and costs. • Service provision is regularly interrupted by estates issues and failures. • Patient safety and experience is sometimes adversely impacted. • IT infrastructure not upgraded as timely as required increasing operational continuity and increasing cyber security risk • Medical equipment replaced in a risk priority order where possible, insufficient resource for new equipment or timely replacement • Staff facilities needed to support good staff wellbeing are inadequate in many areas.

Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 15

Chilcott,Rachel
08/05/2025 16:26:52

Strategic Risks – Infrastructure

Controls	Assurances
• Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate, which is fit for purpose, efficient and is ‘future-proofed’ as much as possible, recognising that advances in medical treatments and therapies are accelerating. This is being updated. • Statutory compliance estates programme in place – including legionella proactive actions, and time safety management actions. • The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure. • The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP/annual plan, with regular oversight of the programme of discretionary and major capital programmes. The 2024/25 Capital Plan will be submitted for Board with the IMTP • Medical Equipment prioritisation is managed through the Medical Equipment Group and there is a process in place for rapid decision making if there is a urgent need to replace a piece of equipment. This part of the Capital Management Group agenda. • Business Case performance monitored through Capital Management Group every month and Finance & Performance Committee at each meeting, every month. • Welsh Government has asked all NHS organisations to provide a prioritised capital programme using a weighting framework developed by the Infrastructure Investment Board. The submission date is 31st March 2024. The Health Board’s submission has been scrutinised and approved through the internal governance mechanisms and is coming to the Board on 28th March for oversight. • Discussion with Welsh Government regarding the Shaping Our Future Acute Hospital Programme Business Case is ongoing. We presented to a special Infrastructure Investment Board prior to Christmas where there was agreement to progress testing of options, including a phased approach to developing on the current UHW site. The scope of this work, which is being led jointly with Cardiff University, is currently being finalised for approval by Welsh Government. • In accordance with the prioritised plan the Board approved and submitted to Welsh Government the Tertiary Tower Business Case and the Vascular MTC Theatres Business Case. The Tertiary Tower Electrical Supply business case was approved by Welsh Government and the capital works is progressing. This will remove a single point of failure in the electrical system and provide greater resilience. The Vascular MTC Theatres business case is currently being updated to reflect that the original equipment supplier has withdrawn. A new supplier has been identified but the financial case will need to be updated to reflect the preferred solution, and any changes to costs due to the passage of time since the business case was originally approved. The business case for	• The estates and capital team is in constant dialogue with WG and continues to present business cases to secure the necessary capital to address the major short/medium term service estates issues. This has proven successful in the closing months of the financial year A significant amount of end of year funding has been secured, as in previous years, and this has enabled capital investment in critical digital infrastructure in particular. • The statutory compliance areas are monitored every month in the Capital Management Group to ensure that the key areas of risk are prioritised and reporting of estates risks to the Health and Safety Committee has been strengthened(1) • The Executive Director of Strategic Planning and the Director of Capital, Facilities and Estates meet regularly with the Welsh Government Capital Team to review the capital programme and discuss the service risks (3). • Regular reporting on capital programme and risks to Capital Management, Management Executive and Finance & Performance Committee (1) (2) • IT risk register regularly updated and shared with DHCW (2) • Health Care Standard completed annually (3) • Medical equipment risk registers developed and managed by Clinical Boards, reviewed at UHB medical equipment group (1) (2) • Finance and Performance Committee continue to oversee the delivery of the Capital Programme (1) • Timely decision making in relation to the Shaping Our Future Hospitals Strategic Outline Case (3)

Chicott,Rachel
08/05/2025 16:26:52

the BMT, haematology, complex cancer and cancer research hub has been submitted to Welsh Government and a team made up of the three partners (Cardiff University, Velindre NHS Trust and Cardiff and Vale Health Board). • Welsh Government has also provided funding to enable the demolition of the Links Building at CRI which presented a health and safety risk. Additional car parking will be provided temporarily on the space created whilst the longer-term plan (subject to business case approval) for the Health and Wellbeing Centre at CRI comes to fruition.	
Gaps in Controls	**Gaps in Assurances**
• The current annual discretionary capital funding is not enough to cover all of the priorities identified through the risk assessment and IMTP process for the estate and digital infrastructure and medical equipment replacement services which requires the need to prioritise investment and resource allocation based on assessed level of risk and alignment with strategy and IMTP priorities. • In year requirements further impact and require the annual capital programme to be re-prioritised regularly. • Traceability of Medical Equipment • The Welsh Government current capital position is very compromised due to size of budget compared with estimated need which will impact significantly on the Capital Programme of the UHB. Not all business cases in the Welsh Government capital plan will be deliverable and the UHB needs to be mindful of the potential reputational risk of delays between OBC and FBC approvals with supply chain partners.	• The regular statutory compliance surveys identify remedial works that are required urgently, for which there is no discretionary capital funding identified, requiring the annual plan to be re-prioritised, or the contingency fund to be used. • Medical equipment is also subject to regulatory requirements, and therefore requires re-prioritisation during the year. • Despite the substantial end of year capital, the recurrent position remains unchanged. • Full condition surveys of all buildings have not been carried out so not possible to fully understand the condition of the estate.

Risk Post-Controls and Mitigation			
Impact: 5	Likelihood: 4	Net Risk: 20	

Actions			
What	**Lead**	**By**	**Update**
Risks to infrastructure which have been identified are developed into robust plans for mitigation. These are prioritised through our annual planning work and identified	Geoff Walsh	Annual plan	The discretionary capital is prioritised to meet our annual plan. Prioritised plan is signed off by CMG and SLB and Board. Significant risks or financial requirements are raised regularly with Welsh Government to support when necessary.

Chilcott, Rachel
08/05/2023 16:26:52

Strategic Risks – Infrastructure

Where estate is no longer required for the provision of care or services a programme of decommission, disposal or demolition is undertaken to minimise the estate and infrastructure which the Health Board needs to maintain.	Geoff Walsh	Annual plan	Decommission priorities – Denbeigh and Carmarthen house and Rookwood decant & reprovision Disposal plans – Whitchurch and Rookwood sites Demolition plans – Linc building CRI
A condition survey will be undertaken to understand in detail the status of the Health Board estate with a view to inform a future investment priorities and estate needs.	Geoff Walsh	December 2025	The scope and plan for the condition survey have been shared with and supported by Welsh Government. Funding is pending and this work is anticipated to be undertaken in the next 12 months.
An acute infrastructure group is overseeing the short – medium term priorities and a programme of work is progressing Shaping Our Future in the Community Programme Board oversees the capital infrastructure requirements for community based care and a prioritised business case pipeline is in place. This work dovetails with the RPB 10 year capital plan and the Cardiff PSB Asset Management Group.	Geoff Walsh	Ongoing	The group continues to meet to oversee the priorities and development of a number of business cases that have been prioritised to ensure they progress in a timely way to address significant infrastructure risks.

Chilcott,Rachel
08/05/2025 16:26:52

Strategic Risks – Sustainability

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Sustainability	Shaping our Future Generations	Exec Dir Finance	Finance and Performance	1 April 2022
Risk				
If the organisation cannot produce a balanced 3-year plan or a balanced IMTP in any year it will breach its statutory financial duty and will be limited in the ability to deliver on the strategy and so the services to the population that the organisation serves. If the organisation cannot protect the environment and take the steps required of it regarding waste, carbon footprint and other deliverables, it will not be an efficient service and will jeopardise the health of future generations.				

Cause	Impact
The UHB has to manage its operational budget. In the absence of a 3 year approved IMTP the UHB works to One Year Operational Plans from year to year. These still require significant savings achievements within each financial year irrespective of a deficit year end projection. Decarbonisation: • The UHB has to achieve 16% and 34% emission savings from a 2018/19 baseline by 2025 and 2030, respectively, aligned with Welsh government targets. Additionally, the "Shaping Our Future Wellbeing" strategy targets a 40% reduction in directly controlled emissions by 2027. • In the last calculated emission report, total emissions increased by 7% to 217,000 tonnes, while emissions under our control reduced by 7%. CAVUHB is not on track to achieve the 16% reduction target set by the Welsh government for 2025. To meet the aims outlined by UHB in the strategy, we must reduce emissions under our control by 10% annually starting since 2023/24. Climate Impacts:	Breach of statutory duties, escalation. Unable to deliver a balanced year-end financial position. Reputational loss. Inefficient or reduced service delivery Decarbonisation: • UHB will not achieve its targets for decarbonisation in its current pathway and this will render UHB answerable to Welsh Government. • Reputational loss due to not achieving Shaping Our Future Wellbeing" strategy's target of 40% reduction in directly controlled emissions by 2027. • If the yearly emission reduction pathway is not designed and followed it will lead to risk of spending more at a later time to meet the set-out targets. Climate Impacts: • Initial sift of evidence and analysis shows that, given Cardiff's growing older population along with increased climate impact, vulnerability in the region is set to rise. This translates into more hospital admissions, increased patient flow, and ultimately, increased healthcare delivery costs for UHB. • Operationally, given the aging assets and assets exposed to weather events, there will be increased physical impacts on UHB's assets. • As comprehensive risk assessment has not been conducted, and a climate adaptation plan to mitigate the risks is not in place, UHB's understanding of its climate risks is limited and capacity to adapt are limited.

Chilcott, Rachel
08/05/2025 15:26:52

• The world has breached the 1.5°C pathway set by the Paris Agreement in 2024. Growing evidence shows that the magnitude of climate impacts is increasing day by day, and Cardiff is projected to be one of the most affected cities in the UK. The Welsh government has made it mandatory for UHB to submit an annual qualitative report on climate adaptation. • Currently, UHB has not undertaken a comprehensive assessment of current and future climate risks. This renders UHB vulnerable to unidentified climate risks that have a direct impact on healthcare delivery and its financial situation.	

Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 10

Controls	**Assurances**
Additional expenditure is being authorised within the governance structure and the UHB Scheme of Delegation. Financial Plan submitted to Welsh Government in March 2024 explaining inability to deliver financial balance over the three-year period 2024-2027. Themed Savings programme managed through fortnightly Sustainability Board chaired by CEO aligned to the National Value and Sustainability Board Decarbonisation: • A decarbonisation action plan is in place to deliver decarbonisation actions aligned with the NHS Wales Decarbonisation Strategic Delivery Plan 2021-2030.	The financial position is reviewed by the Finance & Performance Committee which meets monthly and reports into the Board (1) Financial performance is a standing agenda item monthly on Senior Leadership Board with escalation to Management Executives Meeting (1) Financial performance is monitored by the Management Executive (1). Assurance from internal audit annual review of core financial controls including budgeting and planning. Sustainability Programme Board in place, chaired by the Chief Executive. Additional measures implemented IY as set out in actions below

Gillcott, Rachel 08/05/2025 16:26:52

• SusQI has been implemented to embed sustainability in Q&I projects. • The Welsh Government has mandated yearly reporting, such as Decarbonisation Co-Ordination Reporting and Emission Reporting, along with all other health boards in Wales. Climate Impacts: • The Welsh Government has made it mandatory to report qualitatively on progress regarding climate adaptation. • A task and finish group has been established to identify pathways for climate risk assessment and climate adaptation pathways. • Initial conversations are being held with the MET Office to collaborate and conduct a comprehensive Multi-Risk Assessment, starting with the impacts of heatwaves on our operations.	Decarbonisation plan is developed annually and overseen by Finance and performance committee
Gaps in Controls	**Gaps in Assurances**
Decarbonisation: • The current financial landscape doesn't allow UHB to meaningfully develop plans to hit NHS Wales targets or the targets set out by the strategy. • Given the complexity of decarbonisation actions across various departments of the UHB, there is a lack of continuous, robust monitoring. This would require the reestablishment of a digital climate change program dashboard, setting of qualitative and quantitative KPIs aligned with targets, and a seamless data collection process for all decarbonisation actions. • Sustainability needs to be embedded in decision-making. • The business plan template needs to capture sustainability from decarbonisation and climate risk perspectives and should be given appropriate weight. Climate Impacts:	Work will be undertaken to workshop the decarbonisation plan and delivery in December 24 Decarbonisation and Climate impacts: • A working group or delivery group needs to be established, comprising staff who are owners of decarbonisation actions, to highlight progress and barriers.

Chilcott,Rachel
08/05/2025 16:26:52

Strategic Risks – Sustainability

- Given the nascent stage of climate adaptation in UHB, it needs more resources to be properly explored and established. As climate risk exacerbates all existing risks, it ultimately strains UHB's finances in the future if not acted upon appropriately now.
- Climate Impacts needs to be included in appropriate risk registries, and risk thresholds needs to be set.

Risk Post-Controls and Mitigation

Impact: 4	Likelihood: 5	Net Risk: 20

Actions

What	Lead	By	Update
Savings plan for 2024/25 implemented.	Catherine Phillips	End FY	Further schemes are being progressed to improve the expenditure run rate entering 2024/25. A wide-ranging set of measures applying moratoriums to a wholesale spectrum of expenditure has been implemented. Any derogations from this will require Exec level approval. An Exec programme team has been established and will meet daily for the rest of the FY to oversee this enhanced grip and control/
The~~A~~ 25/26 Quality Improvement and Efficiency ~~Savings~~ Plan is presented today~~required~~. ~~Work will be carried out across the organisation and coalesced at the fortnightly sustainability programme board (SPB) and reported to Finance and Planning Committee~~.	Catherine Phillips/ Paul Bostock	March 2025	SLB and SPB work and plan delivery issues identified the need to undertake the rapid planning event and work more strategically with the leadership team of the organisation to work on long term sustainability. This will support next years plan and the future model of delivery for the organisation. As part of the annual plan a quality improvement plan will be developed and implemented to deliver the 2025/26 savings programme. A monitoring function for all plan aspects is being developed and will be introduced at F&P Apr 25
~~The outcomes of the rapid planning event held Dec 24 will be coalesced into 25/26 savings plan and also longer-term work on financial sustainability~~	~~Catherine Phillips~~	~~Mar 25 and longer term~~	
The emission gap between the health board's current emission pathway and targets set by the Welsh government and the	Catherine Phillips	September 2025 ~~and longer term~~	**Currently a ~~Sustainability~~Sustainability Program Board is being established to review and monitor progress of decarbonisation actions.**

Chilcott,Rachel 08/05/2025 16:26:52

Strategic Risks – Sustainability

SOFW strategy is widening. Hence, the emission reduction targets, and pathway need to be reviewed.			

Chilcott,Rachel
08/05/2025 16:26:52

Report Title:	Neutropenic Sepsis Policy			Agenda Item no.	3.1
Meeting:	Public Quality Committee	Public	X	Meeting Date:	13/05/2025
		Private			
Status:	Assurance	Approval	X	Information	
Lead Executive:	Executive Medical Director				
Report Author:	Acute Oncology Clinical Nurse Specialist				

Background and current situation:

The National Confidential Enquiry into Patient Outcome and Death Report (NCEPOD 2008) and National Chemotherapy Advisory Group (2009) highlighted the organizational risk associated with not having a policy to address oncological emergencies such as Neutropenic Sepsis.

The Health Board does not currently have a policy for the management of patients who present with suspected neutropenic sepsis. The Acute Oncology Service was tasked with the development of a policy in line with the National Institute for Health and Care Excellence (NICE) guidance.

This document will aim to ensure all patients who are admitted with suspected neutropenic sepsis have the correct treatment commenced in accordance with national guidelines: NICE guideline [CG151].

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

Recommendation:

The Board/Committee are requested to:

a) . Review the policy for final approval

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

Objective		Objective	
Putting People First 1. **Click the objective above to view more detail.**	Y	Providing Outstanding Quality 2. **Click the objective above to view more detail.**	Y
Delivering in the Right Places 3. **Click the objective above to view more detail.**	Y	Acting for the Future 4. **Click the objective above to view more detail.**	Y

Five Ways of Working (Sustainable Development Principles) considered

Prevention	Y	Long term	Y	Integration	Y	Collaboration	Y	Involvement	Y

Quality Impact Assessment Completed?				
Yes (see below)				

Impact Assessment:
Risk: No, if policy not approved, will enter onto risk register for organization
Safety: No, not applicable
Financial: No, not applicable
Workforce: Yes – will require education re: policy attached, AOS are committed to providing continuing education to upskill wider workforce. Also available on Hospital HealthPathways.
Legal: No, not applicable
Reputational: No – however risk associated with not having standardized policy to manage neutropenic sepsis as per previous NCEPOD, NCAG and NICE recommendations
Socio Economic: No
Equality and Health: Yes (see appendix 8)
Decarbonisation: No, not applicable to clinical policy
Welsh Language: Yes - If necessary for clinical policy, will require health board support to translate key information as per Welsh Language Standards however not aware of other CAV bilingual clinical documents

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/ Exec	Date:

Chilcott,Rachel
08/05/2025 16:26:52

Reference Number: *UHB 529* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *n/a*

POLICY FOR THE MANAGEMENT OF SUSPECTED AND PROVEN NEUTROPENIC SEPSIS IN ADULTS

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will:

Ensure that the risk of neutropenic sepsis is managed appropriately.

Ensure all patients with suspected or proven neutropenic sepsis are treated appropriately.

Comply with national evidence-based guidelines on the management of neutropenic sepsis (NICE 2012).

Policy Commitment

This document provides guidance on the prevention and treatment of suspected and proven neutropenic sepsis.

- To ensure all patients who are admitted with suspected neutropenic sepsis have the correct treatment commenced within one hour of admission in accordance with national guidelines.

- To ensure all patients receiving systemic anti-cancer treatment are educated about the signs and symptoms of neutropenic sepsis and know how to contact the health board.

Supporting Procedures and Written Control Documents

Other supporting documents are:

- *C&V UHB Antimicrobial guidelines* - CAV UHB Antimicrobial guidelines (Microguide) - Access CAV Microguide via CAV intranet/ SharePoint or via Eolas Medical app.
- *Velindre Cancer Centre (VCC) Neutropenic Sepsis Policy-* *http://nww.velindrecc.wales.nhs.uk/document/358487*
- *UKONS triage tool - https://www.ukacuteoncology.co.uk/information-hub/ao-guidelines#*
- *NICE guidelines- https://www.nice.org.uk/guidance/cg151/chapter/1-Guidance*
- *C&V UHB Inpatient sepsis screening and action tool - **Appendix 1***
- *Haematology Sepsis Pathway and Tazocin PGD – **Appendix 2***
- NEWS scoring system - **Appendix 3**
- *Oncology Chemotherapy alert card - **Appendix 4***
- *MASCC scoring tool- **Appendix 5***
- *Early discharge criteria – **Appendix 6***
- *Post exposure to infectious diseases – **Appendix 7***

Chilcott,Rachel
08/05/2025 16:26:52

- *Equality and Health Impact Assessment* – ***Appendix 8***

Scope

This policy applies to all of our staff in all locations including those with honorary contracts.

Equality and Health Impact Assessment	An equality and health impact assessment (EHIA) has been completed and this found there to be a positive impact.

Policy Approved by	Quality Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Quality Committee
Accountable Executive or Clinical Board Director	Executive Medical Director

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governanc Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept.]*	*State if either a new document, revised document (please list main amendments). List title and reference number of any documents that may be superseded*
2			

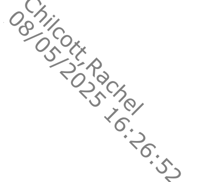
Chilcott,Rachel
08/05/2025 16:26:52

Purpose and Summary of Document:

To ensure a safe, standardised evidence-based approach (adhering to NICE guidance) for the prompt assessment and initial clinical management of adult patients (>16 years of age) with potential Neutropenic Sepsis (NS) who present to the health board. To ensure all patients with suspected neutropenic sepsis receive antibiotics within an hour of arrival at the healthcare setting.

It is imperative that those working in front line services without an extensive knowledge of Systemic Anti-Cancer Therapy (SACT) have the knowledge and confidence to recognise and promptly initiate treatment of NS. This will ensure a reduction in morbidity and mortality for patients presenting with NS whilst recognising that NS is a "time-dependent condition". The Acute Oncology Service (AOS) will provide education to front line staff on NS.

All of the Wales Cancer Network patients receiving SACT will have been issued with an information card detailing their regimen, hospital number and immediate contact details for advice 24 hours a day. This policy provides a concise guide of what needs to be achieved during the first hour of presentation with suspected NS and subsequent 48 hours and will support clinicians in the recognition and initiation of prompt and appropriate clinical management.


Chilcott,Rachel
08/05/2025 16:26:52

Contents

1.0 Introduction 5

2.0 Definitions 6

3.0 Roles and Responsibilities 7

3.1 Medical Director 7

3.2 Ward/Departmental Managers 7

3.3 Ward and departmental Staff 7

3.4 Medical Teams 8

3.5 Clinical Committees....................8

4.0 Patient and Carer education and antibiotic prophylaxis 8

4.1 Patient alert cards 8

4.2 Antibiotic prophylaxis....................9

5.0 Initial Assessment 9

5.1 Diagnostic Tests 11

5.2 Initial Treatment....................11

5.3 Risk Assessment Scoring (Solid Organ malignancy only) 11

5.4 Monitoring 12

5.5 Follow up Assessments....................12

5.6 Use of GCSF in Neutropenic Sepsis 12

6.0 Neutropenic Sepsis Flowchart 13

7.0 References....................14

8.1 APPENDIX 1. Inpatient Sepsis Screening Tool. 16

8.2 APPENDIX 2. PGD. HAEMATOLOGY USE ONLY. 18

8.3 APPENDIX 3. NEWS-2 32

8.3 APPENDIX 4: Example of an Oncology Chemotherapy Alert Card 34

8.4 APPENIDIX 5 – MASSC Scoring – ONCOLOGY PATIENTS ONLY. ...35

8.6 APPENDIX 6: Assessment for early discharge: Oncology Patients ONLY....................36

8.7 APPENDIX 7. Post exposure to infectious diseases....................37

8.9 APPENDIX 8. Equality & Health Impact Assessment 38

Chilcott,Rachel
08/05/2025 16:26:52

1.0 Introduction

Patients with neutropenia can develop life-threatening, rapidly progressive infection and sepsis.

Neutropenic sepsis (NS) can occur in patients with haematological and solid organ malignancy and be a fatal complication of cytotoxic chemotherapy given for malignant or non-malignant conditions. A mortality rate of approximately 5% has been reported in patients with solid tumors undergoing cytotoxic therapy (Naurois et al. 2010).

Several reports have highlighted the risks of NS and have made recommendations to develop systems for urgent assessment and organisational level policies for the management of neutropenic sepsis (NCEPOD 2008, NCAG 2009).

Neutropenic sepsis must be considered an acute emergency requiring prompt identification and treatment (Naurois et al. 2010). With correct and rapid responses, morbidity and mortality can be improved (Crawford 2004, Larche et al. 2003 and NICE 2012).

This policy is based on the National Institute for Health and Care Excellence (NICE) guidance 2012. [Neutropenic Sepsis: Prevention and Management of Neutropenic Sepsis in people with cancer]. A review of the guideline in 2020 resulted in minor changes to the use of fluoroquinolones only.

Chilcott,Rachel
08/05/2025 16:26:52

2.0 Definitions

Sepsis	A life-threatening organ dysfunction due to deregulated host response to infection. It should be considered whenever there is an acute deterioration, raised NEWS-2 score
Neutropenia	Moderate neutropenia: neutrophils ≥0.5x10^{9}/L and < 1x10^{9}/L Severe neutropenia: neutrophils < 0.5x10^{9}/L
Neutropenic Sepsis	Clinical signs of infection, and/or a temperature ≥ 38°C (or ≤ 36°C), in the presence of moderate or severe neutropenia (< 1x10^{9})
Sepsis 6	IV antibiotics IV fluids Oxygen Blood cultures Lactate Hourly urine output (**See appendix 1**)
NEWS-2	National Early Warning Score 2 (**See appendix 3**)
SACT	Systemic anti-cancer therapy
AKI	Acute kidney injury
MASCC Risk Index	Multi-national association for supportive care in cancer scoring system - ***For use in patients with solid malignancy only*** (**See appendix 5**). MASCC < 21 suggests *high risk* MASCC ≥ 21 suggests *low risk*

Chilcott, Rachel
08/05/2025 16:26:52

3.0 Roles and Responsibilities

This section outlines the roles and responsibilities of all staff involved in promoting the highest standard of practice in relation to neutropenic sepsis. It is the responsibility of health care professionals involved in the management of patients with potential NS, to familiarise themselves with the content of this policy. This includes staff working across care settings in primary care (out of hours, GP's) secondary care (A&E, Acute Receiving Units), third sector, independent sector and all those involved in the care and management of oncology patients.

3.1 Medical Director

The Medical Director has overall responsibility in ensuring the organisation adheres to the standards set out in this clinical guideline. The Medical Director also ensures all medicines are handled in a safe and secure manner and has oversight of antibiotic stewardship.

3.2 Ward/Departmental Managers

Department managers and Ward managers are responsible for:

- Implementing the clinical guidance for the management of neutropenic sepsis and monitoring compliance in their clinical area
- Ensuring that any sepsis related clinical incidents are reported via the UHB incident reporting system.
- Taking any remedial action where needed
- Ensuring all staff for whom they have responsibility have undertaken essential training appropriate to their role
- Investigate non-compliance with essential training sessions
- Support ward staff in completion of the iv antibiotic process competency assessment packages

3.3 Ward and departmental Staff

All ward and departmental staff have a responsibility to:

- Adhere to all UHB clinical guidance for the appropriate management of a patient with suspicion or confirmation of neutropenic sepsis
- Complete the UHB approved sepsis training relevant to their position and role in a timely fashion
- Complete clinical one-to-one iv antibiotic PGD competencies relevant to their role (where applicable)

Chilcott, Rachel
08/05/2025 16:26:52

- Work within the professional scope of their registered bodies
- Report any sepsis related clinical incidents via the UHB incident reporting systems
- Report all clinical incidents or events, and near misses, to the nurse in charge

3.4 Medical Teams

All doctors have the responsibility to:

- Adhere to all UHB clinical guidance, policies and procedures for the appropriate management of neutropenic sepsis
- Ensure documentation adheres to the local and national coding guidelines
- Ensure all sepsis related clinical incidents and events, and near misses, are reported via the UHB clinical incident reporting system
- Keep up to date with current UHB guidelines ensuring early recognition, management and treatment for suspected sepsis, including prompt prescribing of antibiotic cover where appropriate

3.5 Clinical Committees

Acute Oncology Steering group
Medicine Q&S
Acute Medicine Q&S
Haematology Q&S
Corporate Medicines Management Group
Quality Committee

4.0 Patient and Carer education and antibiotic prophylaxis

4.1 Patient alert cards

Alert information cards will be given to all patients on commencement of systemic anti-cancer treatments, including for non-malignant conditions, advising and educating them on the symptoms and signs of infection and sepsis. The cards will contain details for 24-hour emergency advice on triage and admission. All patients will be provided with a thermometer and instructed in its correct use.

Example of the alert cards in **Appendix 4**

Chilcott, Rachel
08/05/2025 16:26:52

4.2 Antibiotic prophylaxis

Patients and their carers will be instructed on the use of prophylactic antimicrobials and given information on potential side effects and interactions with their cancer medications. Necessary prophylaxis will differ dependent on the patient's diagnosis and treatment. Treatment schedules will be initiated by the Oncology/Haematology teams.

5.0 Initial Assessment

Suspect neutropenic sepsis if the patient is receiving or has received anti-cancer treatment in the last 6 weeks and the patient is unwell, has signs or symptoms of an infection, or a temperature over 38°C or under 36°C.

All patients with suspected neutropenic sepsis must be seen and assessed urgently. If possible, the patient should be admitted to a cubicle, but prompt assessment and treatment is a higher priority than isolation. The same principles apply in neutropenic sepsis if suspected in an inpatient.

Initial clinical observations include:

- Temperature
- Pulse
- Blood pressure
- Respiratory rate
- Oxygen saturations on air, and on oxygen
- Level of consciousness

Results of observations will be recorded on the NEWS2 charts. The NEWS2 score will be reported immediately to the admitting doctor or senior nurse. If this is not possible and there is concern, escalate via the NEWS 2 escalation procedure.

Undertake a full history and thorough clinical examination. Initiate appropriate antibiotic treatment within ONE HOUR of presentation with suspected neutropenic sepsis.

<u>Do NOT wait for blood count results before starting antibiotics.</u>

Commence the Sepsis Six pathway first hour responsibilities (See appendix 1).

STANDARD - IV antibiotics will be administered within 60 minutes of presentation

Chilcott, Rachel
08/05/2025 16:26:52

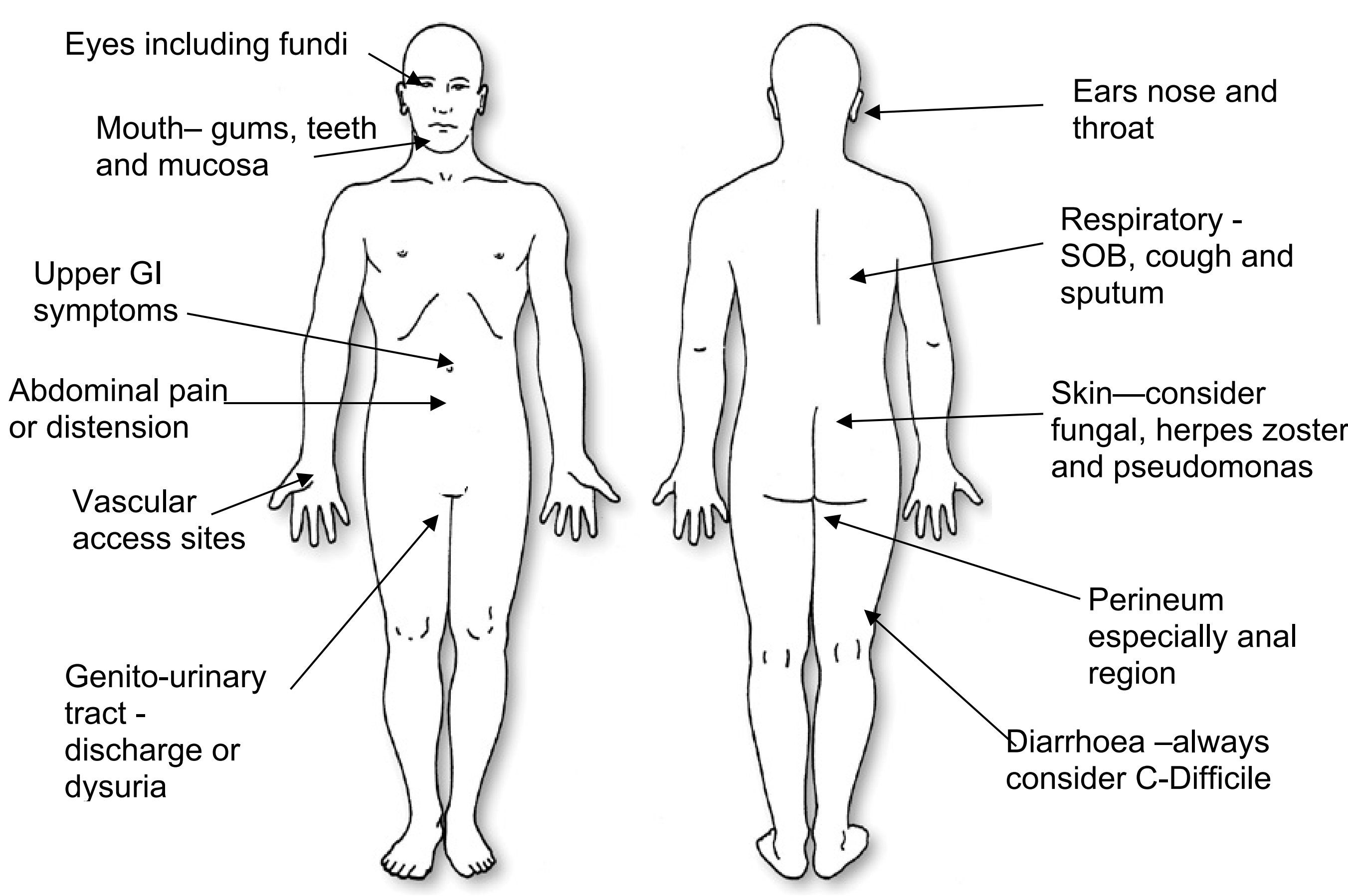
A detailed history should include:

- Time of onset of symptoms including fever or rigors
- Timing of fever or rigor in relation to line flushing
- Any recent blood products

- Nature of current or recent chemotherapy/systemic anti-cancer treatment
- Prior prophylactic antibiotics
- Concomitant steroid use (Which may mask signs of infection, including fever)
- Recent surgical procedures
- Details of known allergies

A detailed examination includes:

- Ears, nose and throat
- Cervical, axillary and inguinal lymphadenopathy
- Skin
- Respiratory and cardiovascular systems
- Abdomen and perineum
- Other systems as directed by symptoms
- Assessment of any indwelling lines and catheters



Chilcott,Rachel
08/05/2025 16:26:52

5.1 Diagnostic Tests

Initial test to confirm the diagnosis should include:

- FBC
- Renal and liver function
- Coagulation screen
- C-reactive protein
- Lactate (arterial or venous)
- Blood cultures (before antibiotics are given) **(Central line and peripheral)**
- Chest X-ray
- Blood sugars

5.2 Initial Treatment

Do NOT wait for blood count results before starting antibiotics.

Refer to Micro Guide for Treatment Options.

In Haematology where the Piperacillin-Tazobactam (Tazocin) Patient Group Directive (PGD) has been approved and implemented - nurses who have been assessed as competent can initiate first dose administration in line with a strict inclusion/exclusion criterion.

PENICILLIN ALLERGIC ADVICE

- Document the nature of the allergy

Refer to Micro Guide for Treatment Options.

5.3 Risk Assessment Scoring (Solid Organ malignancy only)

The Multinational Association for Supportive Care in Cancer (MASCC) scoring index is a risk assessment for identifying low-risk febrile neutropenic cancer patients and is validated for use in solid malignancy by NICE (2012) and Klaterskry (2000).

The MASSC risk tool can be used by a healthcare professional familiar with and competent to use it, and applied within 24 hours of presentation, basing the risk on presenting features (NICE 2012). The Acute Oncology Service (AOS) can provide advice on MASSC scoring.

The score **DOES NOT APPLY** in Haematology patients.

The MASSC scoring system appears in **Appendix 5.**

Chilcott, Rachel 08/05/2025 16:26:52

5.4 Monitoring

Patients with neutropenic sepsis should be examined daily and the following investigations undertaken:

- NEWS monitoring
- Full blood count
- Renal and liver function
- Coagulation screen based on clinical assessment
- Serial C-reactive protein
- Repeat blood and other cultures if fever persists (consider fungal and viral screens)
- Reassess the patient's risk of septic complications using MASSC, if appropriate.

5.5 Follow up Assessments

Review patient's clinical status daily and consider changing antibiotics from iv to oral after 48 hours of treatment in patients whose fever has settled quickly and who are low risk of complications. (See **Appendix 6** for early discharge criteria)
Change antibiotics to appropriate targeted therapy in liaison with Microbiology if a source of infection is identified.

Seek advice from senior colleagues and from medical microbiology and virology for patients whose temperature is not settling, or who are deteriorating clinically despite maximal therapy.

5.6 Use of GCSF in Neutropenic Sepsis

Peg filgrastim should not be used for the treatment of neutropenic sepsis. However, if a patient is not responding to appropriate antibiotic management and developing life threatening infection (such as severe sepsis, pneumonia or invasive fungal infection) then administration of GCSF can be considered (Crawford et al. 2010, Aapro et al 2006) after discussion with Oncology/Haematology.

Chilcott, Rachel
08/05/2025 16:26:52

6.0 Neutropenic Sepsis Flowchart

NEUTROPENIC SEPSIS FLOW CHART

Suspect Neutropenic Sepsis if patient has received anticancer treatment within the last 6 weeks and has signs or symptoms of an infection and/or a temperature of over 38 or below 36 degrees

↓

Take blood cultures (Line if applicable and peripheral - before antibiotics administration if possible).
FBC, Renal and liver function, Coag, CRP, Lactate, Blood sugar.
Chest X-ray
Send any other indicated specimens for MC&S

↓

Obvious source of infection?

No → Give antibiotics without delay - do not wait for blood results.
Refer to microguide for treatment options

Yes → Refer to microguide for treatment options.
Give antibiotics without delay - do not wait for blood results.

Antibiotics within an hour

1 HOUR

→ Screen for Sepsis and implement the Sepsis 6 (where appropriate)

Chilcott,Rachel
08/05/2025 16:26:52

7.0 References

Aapro, M.S. Cameron,D.A., Pettengell, R., Bohlius, J., Crawford, J., Ellis, M., Kearney, N., Lyman, G.H., Tjan-heijnen, V.C., Walewski,J., Weber, D.C., Zielinski, C. (2006) European Organisation for Research and Treatment of Cancer (EORTC) EORTC guidelines for the use of granulocyte-colony stimulating factor to reduce the incidence of chemotherapy-induced febrile neutropenia in adult patients with lymphomas and solid tumours. *European Journal of Cancer.* 42 (15), pp 2433-2453.

Amgen. Neulasta Summary of Product Characteristics. [Accessed 18/12/2024] Available at: http://www.medicines.org.uk/EMC/medicine/11783/SPC/NEULASTA/

Crawford, J., Dale, D.C., Lyman, G.H. (2004) Chemotherapy Induced Neutropenia: Risks, Consequences & New Direction for Its Management. *Cancer*, 100 (2), pp 228-237.

Crawford, J., Caserta, C., Roila, F. (2010) Hemotopoietic growth factors: ESMO Clinical Practice Guidelines for the applications. *Annals of Oncology*. 21 (5), pp 248-v251.

Klatersky J., Paesmans, M., Rubenstein, E.B., Boyer, M., Elting, :., Feld, R., Gallagher, J., Herrstedt, J., Rapoport, B., Rolston, K., Talcott, J.(2000) The Multinational Association for Supportive Care in Cancer (MASCC) risk index: A multinational scoring system for identifying low risk febrile neutropenic cancer patients. *Journal of Clinical Oncology*, 18 (16) pp 3038-3051.

Larché J, Azoulay E, Fieux F, Mesnard L, Moreau D, Thiery G, Darmon M, Le Gall JR, Schlemmer B. Improved survival of critically ill cancer patients with septic shock. Intensive Care Med. 2003 Oct;29(10):1688-95. doi: 10.1007/s00134-003-1957-y. Epub 2003 Sep 12. PMID: 13680115.

Naurois J., Novitzky-Basso, I., Gill, M.J., Marti, F.M., Cullen, M.H., Roila, F. (2010) Management of febrile neutropenia: ESMO Clinical Practice Guidelines. *Annals of Oncology,* 21 (5), pp 252-256.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD). (2008) For better, for worse? A review of the care of patients who died within 30 days of receiving systemic anti-cancer therapy.
[Accessed 18/12/2024] available at:
https://www.ncepod.org.uk/2008report3/Downloads/SACT_report.pdf

National Chemotherapy Advisory Group (NCAG) (2009) Chemotherapy Services in England: Ensuring quality and safety. [Accessed 18/12/2024] available at: https://webarchive.nationalarchives.gov.uk/20130104173757/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_104500

National Institute for Health and Clinical Excellence (NICE) (2012) Neutropenic sepsis: prevention and management in people with cancer (CG151) London: National Institute for Health and Clinical Excellence. [Accessed 18/12/2024] available at: https://www.nice.org.uk/guidance/cg151

Chilcott, Rachel
08/05/2025 16:55:52

Prytherch DR, Smith GP, Schmidt PE, Featherstone PI. (2010) ViEWS - towards a national Early Warning Score for detecting adult inpatient deterioration. Resuscitation 81. 932-937.

Sandoz. Zarzio Summary of Product Characteristics. [Accessed 19/12/2024] Available at Zarzio 30 MU/0.5 ml solution for injection or infusion in pre-filled syringe - Summary of Product Characteristics (SmPC) - (emc)

Salisbury, S., Ramsay, M., Noakes, K. (2006) Immunisations against infectious disease. Department of Health 2006.

Chilcott,Rachel
08/05/2025 16:26:52

8.1 APPENDIX 1. Inpatient Sepsis Screening Tool.

SEPSIS SCREENING TOOL ACUTE ASSESSMENT — **AGE 16+**

PATIENT DETAILS:

DATE: TIME:
NAME:
DESIGNATION:
SIGNATURE:

01 START THIS CHART IF SEPSIS IS SUSPECTED
Factors prompting screening for sepsis include:

- ☐ NEWS2 has triggered
- ☐ Carer or relative concern
- ☐ Recent chemotherapy / risk of neutropenia
- ☐ Patient looks unwell
- ☐ Evidence of organ dysfunction (e.g. lactate >2mmol/l)
- ☐ Assessment gives clinical cause for concern

YES

CALL FY2+ TO COMPREHENSIVELY RISK ASSESS

Measure lactate and calculate NEWS2 using latest vital signs

Always interpret vital signs and NEWS2 in context of medical history, medications and response to treatment

02 IS NEWS2 7 OR ABOVE?
OR IS NEWS2 5 OR 6 AND ONE OF:

- ☐ Any one NEWS2 parameter with score of 3
- ☐ Mottled or ashen skin
- ☐ Non-blanching rash
- ☐ Cyanosis of skin, lips or tongue
- ☐ Deterioration since last assessment
- ☐ Deterioration since recent intervention
- ☐ Lactate > 2 mmol/L OR known AKI

YES

HIGH RISK

START SEPSIS SIX

NO

03 IS NEWS2 5 OR 6?
OR IS NEWS2 1-4 AND ONE OF:

- ☐ Any one NEWS2 parameter with score of 3
- ☐ Mottled or ashen skin
- ☐ Non-blanching rash
- ☐ Cyanosis of skin, lips or tongue
- ☐ Deterioration since last assessment
- ☐ Deterioration since recent intervention

YES

MODERATE RISK

1. Send full set of bloods including VBG
2. Consider discussing with a senior decision-maker
3. If antimicrobials needed, ALWAYS give within 3h

I have prescribed antimicrobials ☐

This patient does not require antimicrobials as:
- I don't think this patient has an infection ☐
- Patient already on appropriate antimicrobials ☐
- Escalation is not appropriate ☐
- Other________________

NAME: GRADE:
DATE: TIME: __ __ : __ __

NO AMBER CRITERIA = FY2+ TO CONSIDER ANTIBIOTICS/ OTHER DIAGNOSIS
ALWAYS REASSESS IF PATIENT DETERIORATES OR SITUATION CHANGES
DOCUMENT RISK ASSESSMENT IN MEDICAL NOTES

UKST ADULT INPATIENT 2024 1.0 PAGE 1 OF 2

Chilcott, Rachel
08/05/2025 16:26:52

SEPSIS SCREENING TOOL - THE SEPSIS SIX

AGE 16+

PATIENT DETAILS:

DATE: **TIME:**

NAME:

DESIGNATION:

SIGNATURE:

COMPLETE ALL ACTIONS WITHIN ONE HOUR

01 INFORM SENIOR CLINICIAN

NOT ALL PATIENTS WITH RED FLAGS WILL NEED THE 'SEPSIS 6' URGENTLY. A SENIOR DECISION MAKER (ST3+ or equivalent) MAY SEEK ALTERNATIVE DIAGNOSES/ DE-ESCALATE CARE.

TIME: ☐☐:☐☐

02 GIVE OXYGEN IF REQUIRED

START IF O_2 SATURATIONS LESS THAN 92% - AIM FOR O_2 SATURATIONS OF 94-98%
IF AT RISK OF HYPERCARBIA AIM FOR SATURATIONS OF 88-92%

TIME: ☐☐:☐☐

03 SEND BLOODS INCLUDING CULTURES

BLOOD CULTURES, VBG, BLOOD GLUCOSE, LACTATE, FBC, U&Es, LFTs, CRP AND CLOTTING. LUMBAR PUNCTURE IF INDICATED. CONSIDER RAPID PATHOGEN ID

TIME: ☐☐:☐☐

04 GIVE IV ANTIBIOTICS, THINK SOURCE CONTROL

MAXIMUM DOSE BROAD SPECTRUM THERAPY (CONSIDER ESCALATION IF ALREADY ON ANTIBIOTICS)

CONSIDER: LOCAL POLICY /ALLERGY STATUS /ANTIVIRALS

EVALUATE NEED FOR IMAGING/ SPECIALIST REVIEW TO HELP IDENTIFY SOURCE

IF SOURCE AMENABLE TO DRAINAGE ENSURE ACHIEVED AS SOON AS POSSIBLE BUT ALWAYS WITHIN 12H

TIME: ☐☐:☐☐

05 GIVE IV FLUIDS

GIVE BOLUS OF 500mL OVER 15 MINS IF LACTATE > 2mmol/L OR SBP < 90 mmHg. REPEAT IF NO

IMPROVEMENT, IF NO IMPROVEMENT AFTER SECOND BOLUS CALL SENIOR (ST3+) TO ATTEND

TIME: ☐☐:☐☐

06 MONITOR

USE NEWS2. MEASURE URINARY OUTPUT: THIS MAY REQUIRE A URINARY CATHETER
REPEAT LACTATE AT LEAST HOURLY IF INITIAL LACTATE ELEVATED OR IF CLINICAL CONDITION CHANGES

TIME: ☐☐:☐☐

IF WORSENING/ NOT IMPROVING AFTER ONE HOUR – ESCALATE TO CONSULTANT
REASSESS NEWS2 AT LEAST EVERY 30 MINS

RECORD ADDITIONAL NOTES HERE:
e.g. allergy status, arrival of specialist teams, de-escalation of care, delayed antimicrobial decision making, variance from Sepsis Six

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UKST ADULT INPATIENT 2024 1.0 PAGE 2 OF 2

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08/05/2025 16:26:52

8.2 APPENDIX 2. PGD. HAEMATOLOGY USE ONLY.

Patient Group Direction for the administration of Piperacillin/tazobactam in suspected neutropenic sepsis within the **Haematology Directorate**

PGD review date	
Time of next review	3 years from above date
Expiry date	
Name of Medicine	Piperacillin/ tazobactam
Professionals to which PGD applies	Registered nurses working at Band 6 or senior band 5 employed within the Haematology Directorate at Cardiff & Vale University Health Board who have demonstrated competency
Clinical Director for Haematology / Specialist services	Dr Raza Alikhan Dr Thomas Holmes/ Dr Mike Stephens
On behalf of Cardiff & Vale University Health Board **Service Director for Pharmacy and Medicines Management**	Mr Timothy Banner 1/11/23
Medical Director	Professor Meriel Jenney 1/11/23
Executive Nurse Director	Mr Jason Roberts 01/11/2023

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08/05/2025 16:26:52

Clinical Condition	**Patient presenting with suspected untreated neutropenic sepsis**
Criteria for Inclusion	Patients who have received systemic anti-cancer treatment (oral, subcutaneous or intravenous chemotherapy) within the last 4 weeks and presenting suspected neutropenic sepsis, with any one of; pyrexial, hypotensive, tachycardia, hypothermic unwell or NEWS greater than 3. Patient known to be neutropenic due to pre-existing disorder (eg. bone marrow failure, cyclical neutropenia, leukaemia etc.) Patients receiving systemic immunosuppression following an allogenic bone marrow transplant Note: pregnant patients **may** be treated under the PGD if appropriate
Criteria for exclusion	Anaphylaxis or type 1 allergic reaction to penicillin, cephalosporin or betalactam containing antibiotic (eg. dizziness, shortness of breath, wheezing, bullous skin eruptions, swelling of eyes, lips, hands or feet and angioedema) Unable to ascertain allergy status Patient refusal Patient <14 years old Patient weight <40 kgs Patient receiving high dose methotrexate >1g/m^2
Seek further advice	Patient must be reviewed by medical team within 1 hour of presentation Contact medical team for urgent review if any of exclusion criteria are met May reduce excretion of methotrexate

Description of treatment	
Name of medicine	Piperacillin with Tazobactam combined 4.5g
Legal status of Medicine	POM (Prescription Only Medication)
Form	Powder for solution for infusion
Strength	4.5g in 50ml Sodium Chloride 0.9% when reconstituted
Dosage	4.5g
Total daily dose	Only first dose to be given under PGD
Route of administration	Intravenous infusion to be given over 30 minutes
Frequency of administration	Only first dose to be given under PGD
Duration of treatment	Only first dose to be given under PGD
Total treatment quantity	Only first dose to be given under PGD

Adverse reactions	See current BNF Diarrhoea Rash Vomiting
Written & verbal advice for patient/carer	Verbal information to be given to the patient
Follow up	Relevant medical team to review patient within 1 hour, prescribe aminoglycoside antibiotic if indicated within 1 hour and review blood results when available to make ongoing treatment decision/prescribe further doses
Arrangements for referral for medical advice	Refer to appropriate Doctor as required (ward/unit)
Records of administration for audit	Record following on applicable patient documents: description, quantity and time of administration signature of person administering medicine any adverse events Use Piperacillin/tazobactam PGD sticker on 'stat' dose prescription chart

Chilcott, Rachel
08/05/2025 16:26:52

	(see appendix 2)

Professional qualifications	NMC Registered Nurse
Training	Completion of Anaphylaxis training Competent in intravenous drug administration Completion of PGD competence framework and assessment, updated annually (See appendix 1)

<table>
<tr><td>Continuing education</td><td colspan="3">Maintenance of personal education as outlined by NMC and legislation.

Recognise own limitations and act accordingly.

Demonstrates competency to initiate treatment, supply or administration of the medicine to which the PGD relates</td></tr>
<tr><td rowspan="2">Signature of individual accepting responsibility and accountability to perform this PGD

Register to be maintained electronically</td><td>Name</td><td>Date</td><td>Signature</td></tr>
<tr><td></td><td></td><td></td></tr>
</table>

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08/05/2025 16:26:52

Individual Record of Competence in using Patient Group Directive (PGD)

Neutropenic Sepsis Algorithm for
Piperacillin Tazobactam 4.5g PGD & Meropenem 1g PGD

Nurse's Name ____________________ Signature/ Date _______________________

Assessor's Name __________________ Signature/ Date ___________________

Assessors must have relevant cancer nursing experience and have demonstrated their own competence in using this PGD

Date assessed as competent to administer intravenous medication:

Date completed ILS/ ALERT/ Anaphylaxis similar:

Before you attempt to work according to a PGD, you must:

- Have been deemed competent to administer intravenous medication at Cardiff and Vale UHB
- Completed Anaphylaxis training /ILS/ ALERT/ Similar of care of the unwell patient • Be able to identify which patients meet the inclusion criteria
- Be able to follow up and provide continued care of the patient following administration of Piperacillin-Tazobactam under the PGD or Meropenem PGD
- Know how to correctly document use of the PGD
- Be able to identify patients who are excluded from the PGD and how to manage them safely
- Be authorised by name under the current version. i.e. be on the register for this PGD

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08/05/2025 16:26:52

Individual Record of Competence in using Patient Group Directive (PGD)
Neutropenic Sepsis Algorithm for
Piperacillin - Tazobactam 4.5g PGD & Meropenem 1g PGD

Completion of this document demonstrates you have the appropriate skills and knowledge to work under this PGD. It should be completed with the guidance of your mentor and retained for future reference. Once you have completed it, you can be added to the PGD register.

A PGD, signed by a doctor and agreed by a pharmacist, can act as a direction to a nurse to supply and/or administer prescription-only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription (RCN 2006).

The prescription and administration are documented on a pre-prepared sticker, which must be placed on the stat side of the drug chart.

Defining the clinical situation

Define suspected neutropenic sepsis?

Who needs to be informed that you have given first line Piperacillin-Tazobactam

Within what time scale should a doctor prescribe second line antibiotics for the patient?

A patient identifies they are allergic to Penicillin. Where would you look to confirm your decision to give (or not) Meropenem under the PGD?

If there is no documented allergy status or plan to administer IV Meropenem as an alternative to Piperacillin- tazobactam what would your actions be?

What is anaphylaxis?

What initial management would you instigate is anaphylaxis occurred?

Where would you look for sides effects of Piperacillin Tazobactam 4.5g or Meropenem 1g?

List your next steps following administration of Piperacillin Tazobactam 4.5 PGD or Meropenum 1g PGD:

A patient arrives on the unit from home at 01.15. They are 10 days post chemotherapy and have a temperature of 38.5°C, respiratory rate 30 rpm, heart rate 121 bpm, blood pressure 75/48mmHg, oxygen saturations 91% on air. What action would you take?

A patient arrives on the unit from home at 16.30. They had a bone marrow transplant 3 months ago and are currently taking systemic immunosuppression. They have a temperature of 38.2°C, respiratory rate 18rpm, heart rate 85 bpm, blood pressure 100/52mmHg, oxygen saturations 97% on air. What action would you take?

You assessing a patient prior to commencing the PGD pathway. The patient reports a rash in childhood with penicillin. What action would you take?

You assessing a patient prior to commencing the PGD pathway. The patient reports some wheezing after taking penicillin tablets. What action would you take?

When checking the patients allergy patients' allergy status prior to commencing the PGD pathway, the patient reports a rash when they have previously received Meropenem. Where would you look for advice and what action would you take?

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08/05/2025 16:26:52

Individual Record of Competence in using the Patient Group Directive (PGD) for the administration of intravenous Piperacillin - Tazobactam 4.5g PGD & Meropenem 1g

I confirm that I have the required skills and knowledge to use the above named PGD

Nurse's name/signature: ________________________________ Date: ____________

I have assessed the nurse named above as having the required skills and knowledge to use this PGD

The above nurse has:

- **Successfully completed this workbook**
- **Attended a 1:1 training session**
- **Been observed in clinical practice successfully apply the Sepsis pathway and initiating Piperacillin – Tazobactam 4.5g IV PGD and Meropenem 1g IV**

Assessor's name/signature:______________________________ Date: ____________

Assessors must have relevant nursing experience and have demonstrated their own competence in using this PGD

Date assessed as competent to administer intravenous medication:

____

Practical Sign off for:
Individual Record of Competence in using Patient Group Directive (PGD) Neutropenic Sepsis Algorithm, Piperacillin - Tazobactam 4.5g PGD,

Name of Nurse:

Objective	**Mentor Sign off, comment & date:**	**Nurse Sign off:**
Correctly identifies sepsis and initiates Neutropenic Sepsis Pathway • Can demonstrate knowledge of inclusion criteria		
Undertakes First hour duties as per Sepsis 6 • Can provide rationale for excluding specific tasks if not complete • Escalates for more support when required		
Correctly identifies if patient should be excluded or not from Piperacillin-Tazobactam 4.5g IV PGD and meropenem 1g IV PGD • Checks allergy status • Age • Weight • Consent		
Able to access Welsh Clinical portal and identifies where allergy status is documented		
Informs medic and nurse in charge • Escalates for urgent assistance if required • Requests review within 60 minutes		
Correctly prepares Piperacillin – Tazobactam IV 4.5g/ meropenem IV 1gfor administration • Via IV infusion		
Administers Piperacillin – Tazobactam IV 4.5g/ meropenem IV 1g and documents correctly • Document of drug chart • Document on pathway • Document audit		
Monitors patient for side effects, and reviews Sepsis 6		
Can identify the following reference points: • Antibiotic Prescribing in Penicillin Allergy Poster • Copy of PGD • BNF		
Comments:		

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08/05/2025 16:26:52

Assessors must have relevant nursing experience and have demonstrated their own competence in using this PG

Tazocin® (Piperacillin/ Tazobactam)	4.5g	I.V.	Within 60 minutes of arrival	Given as per PGD. no contraindications Nurse print __________ Nurse sign __________

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08/05/2025 16:26:52

Written by: Haematology Sepsis Group, Approved by: Haematology QSPE 18/07/2023 Review date: July 2025

Haematology Oncology Neutropenic Red Flag Sepsis Pathway

For all patients aged 14 years and over, presenting with **suspected** neutropenic sepsis (neutrophil count <0.5x10^9L).

Neutropenic sepsis should be suspected in any **unwell** Haematology, Oncology or Bone Marrow Transplant (BMT) patient regardless of whether they are having current treatment or not.

Addressograph

Staff member completing form:

Date:______________________________________

Name:______________________________________

Designation:__________________________________

Signature:___________________________________

Is an end of life pathway in place? Yes☐ No☐ Advanced Directive in place for refusal of treatment? Yes☐ No☐

Is escalation clinically inappropriate? Yes☐ No☐ If yes to any of above discontinue pathway

Key Points

Pyrexia or Fever may not always be present

Treat as a medical emergency.

Give first dose antibiotics **as soon as** possible and within 60 minutes of arrival/ recognition

Do not wait for a neutrophil count before giving first dose of antibiotic (use PGD)

ASSESS

Time:____

A: Inclusion criteria

☐Patient has received anti-cancer treatment within last 4 weeks

☐Patient is known to be neutropenic due to pre-existing disorder

☐Patient receiving systemic immunosuppression following bone marrow transplant

B: Suspected Neutropenic Red Flag Sepsis (tick all that apply)

☐Pyrexia of 38°C or above (or recent history of pyrexia)

☐Clinical suspicion of infection (rigors)

☐Cold Sepsis symptoms (temperature below 36°C and septic symptoms)

☐NEWS of 3 and above with suspicion of infection

If patient meets any ONE inclusion criteria from A & any ONE inclusion criteria from B initiate Sepsis 6-

Contact on-call medical team. Time contacted:__________ Dr/ANP Name:______________ Bleep:_______

Sepsis 6 Delivery to be completed within **1 hour** of positive assessment	Date	Time	Signature
1. Administer oxygen – aim to keep saturation >94% (88-92% if at risk of CO_2 retention)			
2.Take blood cultures – take peripheral and CVC cultures if possible, culture other sites as clinically indicated (sputum, viral throat swab). Consider CXR			
3. Give IV antibiotics – as UHB protocol. Consider PGD use if trained. Ensure allergy status is reviewed			
4. Give IV fluids – if hypotensive and/or lactate >2mmol/l, 500ml stat. Repeat if clinically indicated to maximum of 30ml/kg. Consider PGD use if trained (250ml)			
5. Check lactate and bloods –FBC, Clotting, G&S, U&E, LFT, Magnesium, CRP and blood glucose. If venous lactate is >4 call CCOT. Repeat after fluid resuscitation			
6. Measure urine output – Complete fluid balance chart hourly Consider urinary catheter, urinalysis , if positive for nitrates send MSU/CSU			

Neutropenic sepsis pathway version 3 Written by: Haematology Sepsis Group. Approved by: Haematology QSPE 18/07/2023 Review date: 07/2025

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Haematology Oncology Neutropenic Red Flag Sepsis PGD

Piperacillin with Tazobactam 4.5g IV

Sodium Chloride 0.9% 250ml fluid bolus IV

CHECK ALLERGY STATUS . IF ALLERGIC TO PENICILLIN, CEPHALOSPORIN OR OTHER BETA-LACTAM ANTIBIOTCS, CONSDER MEROPENEM PGD (Page 3)

Step 1 Inclusion Criteria

Piperacillin with Tazobactam 4.5g IV

☐ One inclusion criteria from A & B met (page 1), consider Piperacillin with Tazobactam 4.5g IV via PGD

Sodium Chloride 0.9% IV 250ml Bolus

☐ One inclusion criteria from A & B met

PLUS TWO OF:

☐ Systolic blood pressure <100mmHg
☐ Heart rate >110bpm
☐ Capillary refill time >3 seconds
☐ Fluid loss e.g. diarrhoea, bleeding
☐ Not passed urine in past 12 hours

Step 2 Exclusion Criteria

Piperacillin with Tazobactam 4.5g IV

☐ Allergy to penicillin, cephalosporin or other beta-lactam antibiotic
☐ Unable to ascertain allergy status
☐ Patient receiving high dose methotrexate >1g/m²
☐ Patient refusal
☐ Patient <14 years old
☐ Patient under 40kg

If exclusion criteria met, consider eligibility for meropenem (page 3)

Sodium Chloride 0.9% 250ml bolus

☐ Suspicion of fluid overload:
- respiratory distress
- positive fluid balance >2Litres
- weight gain >10% during admission

☐ Known left ventricular impairment
☐ Chronic kidney disease + dialysis
☐ Patient <14 years old
☐ Hypersensitivity to intravenous fluids
☐ Patient refusal
☐ Patient under 40kg
☐ Patient pregnant

Step 3

If patient meets inclusion criteria in Step 1 and NO exclusion criteria identified in Step 2 give:

☐ Piperacillin with Tazobactam 4.5g IV **AND/OR**
☐ Sodium Chloride 0.9% fluid bolus 250ml IV using PGD sticker

Step 4

I discussed with nurse in charge and informed Dr.............................on bleep ....
of the clinical situation at..............AM/PM.

☐ I have requested a medical review within 60 minutes for further antibiotics
☐ I have documented administration via PGD on the drug chart using the appropriate sticker

Step 5

Haematology registrar opinion obtained from................................ at ....
Form completed by nurse .... at ....
Nursing delay exceeding 60mins? Why:
Medic delay exceeding 60mins? Why:
IV access device used: ☐ PICC ☐ Hickman ☐ PVC ☐ Other:_____________

IF AT ANY POINT PATIENT SHOWS SIGNS OF SEPTIC SHOCK (NEWS >6, SYSTOLIC BP <90mmHg), **ESCALATE CARE IMMEDIATELY TO APPROPRIATE MEDIC AND PATIENT AT RISK TEAM FOR URGENT CLINICAL REVIEW. NOTIFY SPECIALITY SPR ON-CALL**

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Haematology Oncology Neutropenic Red Flag Sepsis

Patient Reassessment and Medical Review

RE-ASSESS PATIENT
Time:____

☐ Repeat observations/ NEWS assessment following Sepsis 6 Care Duties and review

If after delivering the Sepsis Six, patient still has:

- ☐ Systolic blood pressure < 90mmHg
- ☐ Reduced level of consciousness despite resuscitation
- ☐ Respiratory rate over 25 breaths per minute
- ☐ Lactate >4mmol/L or not reducing
- ☐ Patient clearly critically ill at any time

ESCALATE – CALL PATIENT AT RISK TEAM AND SPECIALITY SPR

MEDICAL REVIEW
Time:____

Name: **Position:** **Bleep:**

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08/05/2025 16:26:52

8.3 APPENDIX 3. NEWS-2

(updated NEWS charts will be place across the UHB from June 25)

Addressograph

NEWS CHART

Ward / Dept

Score	1	2	3

Parameter	Range
Date	
Time of Observation	
Frequency of Observations	
Respiratory Rate	≥25
	21-24
Accept < ……… / >………	12-20
	9-11
Signed:	≤8
O2 Saturations	≥96%
Accept < ……… / >………	94-95
	92-93
Signed:	≤91
Inspired Oxygen	
Temperature	≥39.1
	38.1-39
	36.1-38
	35.1-36
	≤35
	≥220
Blood Pressure	210-219
	200-209
Note record both systolic and diastolic pressures but use systolic only to score	190-199
	180-189
	170-179
Note: In atrial fibrillation measure the BP manually	160-169
	150-159
	140-149
	130-139
	120-129
Accept systolic BP of ………. For this patient	111-119
	101-110
	91-100
	80-90
	70-79
	60-69
Signed:	50-59
	40-49
	≥131
Heart Rate	121-130
	111-120
Accept Heart rate of ……..bpm for as normal for this patient	101-110
	91-100
	81-90
	71-80
	61-70
	51-60
Signed:	41-50
	≤40
Neuro	Alert
	Voice
	Pain
	Unresponsive
Consider Glasgow Coma Score if any Neurological concerns	
NEWS total score	
OBS Performed by Initials	
Qualified Nurse Initials	

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08/05/2025 16:…:52

Cardiff and Vale Resuscitation Service

APPENDIX 3. NEWS-2 – Escalation.

NEWS CHART

	Physiological Parameters	3	2	1	0	1	2	3
A	Respiratory Rate (bpm)	≤8		9-11	12-20		21-24	25
B	O2 Saturations (%)	≤91	92-93	94-95	96			
	Any supplemental Oxygen		YES		NONE			
C	Systolic BP (mmHg)	≤90	91-100	101-110	111-219			220
	Pulse (BPM)	≤40		41-50	51-90	91-110	111-130	131
D	CAVPU score	C			ALERT			VPU
E	Temperature (°C)	≤35.0		35.1-36.0	36.1-38.0	38.1-39.0	39.1	

Concern about a patient should lead to escalation, regardless of the score.

NEWS	MINIMUM MONI-TORING	ALERT	REVIEW
Score 0-2	12 Hourly	If concerned inform Nurse in Charge (NIC)	
Score 3-5 **3 = THREAT!**	4 Hourly Increase frequency dependant on patient response	Inform Nurse in Charge, then immediately inform designated nurse/doctor	Review in 1 hour. SBAR
Score 6-8 **6 = SICK!**	1 Hourly	Inform Nurse in Charge, then immediately inform most senior designated nurse and doctor	Review within 30 minutes. SBAR
Score 9+ **9= NOW!**	30 mins	Inform Nurse in Charge, then Call Resuscitation Team via 2222	Immediate SBAR

The Nurse in Charge of each shift must ensure that the designated nurse/doctor names and bleep numbers are updated and clearly displayed on a Patient Status at a Glance Board (PSAG).

Frequency of Observations are increased in relation to the patients condition.
If there is any concern, please escalate regardless of the NEWS score.

RED FLAG SEPSIS SCREENING

Use Sepsis Screening & action tool if NEWS is 3 or above and suspicion of infection plus any ONE of the following Red Flags

- ☐ Responds only to voice
- ☐ Systolic BP≤ 90mmHg (or drop from > 40 from normal)
- ☐ Heart rate > 130 per minute
- ☐ Respiratory rate ≥ 25 per minute
- ☐ Needs oxygen to keep Sa02 ≥ 92%
- ☐ Non-blanching rash, mottled, ashen, cyanotic
- ☐ Not passed urine in last 18 hours
- ☐ Urine output less than 0.5 mls/kg/hr
- ☐ Lactate ≥ 2 mmols/l
- ☐ Recent chemotherapy

RED FLAG SEPSIS - Start Sepsis 6 pathway NOW

NEWS version 2. Resuscitation Service 11/20

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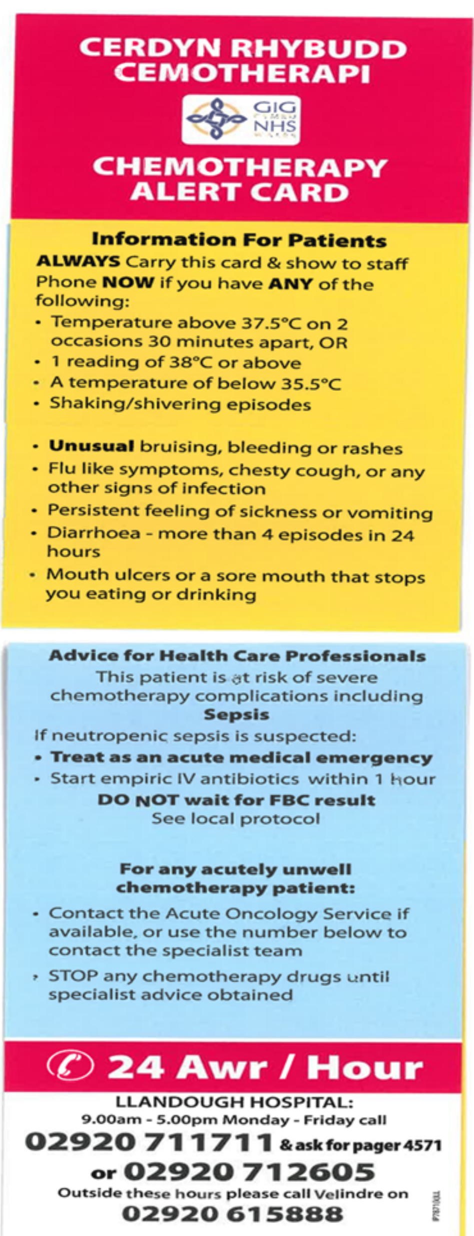
08/05/2025 16:26:52

8.3 APPENDIX 4: Example of an Oncology Chemotherapy Alert Card



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08/05/2025 16:26:52

8.4 APPENIDIX 5 – MASSC Scoring – ONCOLOGY PATIENTS ONLY.

Characteristic		Score
Age	≥ 60 years	0
	< 60 years	2
Patient dehydrated, requiring fluids?	Yes	0
	No	3
Patient systolic blood pressure	Systolic BP <90mmHg	0
	Systolic BP ≥90mmHg	5
Does the patient have COPD?	Yes	0
	No	4
Does the patient have a solid tumour or no previous fungal infection in a haematological malignancy?	Solid tumour <u>or</u> no previous fungal infection in a haematological malignancy	4
	Haematological malignancy with previous fungal infection	0
Does the patient have symptoms related to this infective neutropenic episode?	None or mild symptoms	5
	Moderate symptoms	3
	Severe symptoms	0
Was the patient already an inpatient before this episode of infective neutropenia?	Admitted with this episode	3
	Already an inpatient	0

Patients with a <u>score of < 21 = HIGH RISK</u> of complications (consider IV antibiotic therapy)

Patients with a <u>score of ≥ 21 = LOW RISK</u> of complications. (consider oral antibiotic therapy and early discharge if fits criteria-see appendix six)

Note: scoring attributed to 'symptoms related to this infective neutropenic episode' is not cumulative; therefore, the maximum theoretical score is 26.

MASSC <21=HIGH RISK

Review microbiological cultures and sensitivities; seek advice from microbiology if needed. Consider IV to PO switch after 48 hours of treatment in patients whose risk of developing septic complications has been reassessed as low.

Consider discharge for this group of patients after patients' risk of developing septic complications has been reassessed as low.

MASSC ≥21=LOW RISK

After switching to oral antibiotics, consider discharge if the patient remains afebrile and stable for 24 hours, and fits early discharge criteria (See appendix six). Review microbiological cultures and sensitivities; seek advice from microbiology if needed.

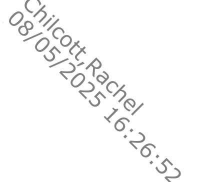
8.6 APPENDIX 6: Assessment for early discharge: Oncology Patients ONLY.

Criteria for early discharge:

There is evidence to support early discharge in **low risk** patients after a **minimum of 24 hours in hospital** (Naurois et al. 2010). They must be clinically stable, symptomatically better and meet the criteria for early discharge (See below).

For low risk patients who are clinically stable and symptomatically well, if the following criteria are met you can consider early discharge:

- Does the patient have someone at home to support them?
- Does the patient have access to a telephone?
- Does the patient have access to transport if required?
- Does the patient live within a 30 minute travel time from the hospital?
- Is the patient registered with a GP surgery or health centre?



8.7 APPENDIX 7. Post exposure to infectious diseases

If you suspect a patient has come into contact with an infectious disease you can contact the Microbiology or Virology department at UHW for advice if you have any concerns. There is somebody available from both departments to provide telephone advice 24 hours a day, 7 days a week. Out of hours the service is provided via a non-resident on call system. Urgent queries out of hours should be dealt with immediately. Non-urgent queries should be dealt with during working hours of the next working day.

Advice regarding treatment can also be sought using the Green book, Immunisations against disease. Available from:

https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

If the patient has been admitted to VCC and they have been in contact with an infectious disease please isolate the patient, contact Microbiology or Virology department at UHW for advice and inform the infection control team.

8.9 APPENDIX 8. Equality & Health Impact Assessment

Equality & Health Impact Assessment for

MANAGEMENT OF SUSPECTED AND PROVEN NEUTROPENIC SEPSIS POLICY (EXCLUDES PATIENTS WITH HAEMATOLOGICAL MALIGNANCY)

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
  - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
  - Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required[1]
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

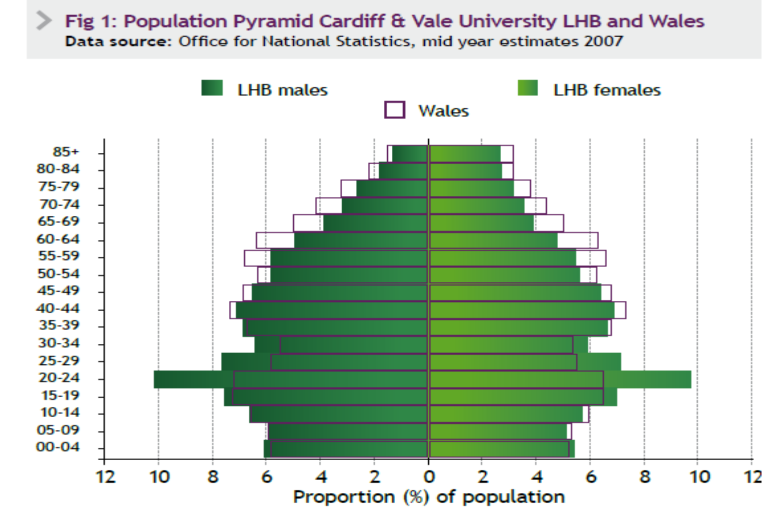
1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	*MANAGEMENT OF SUSPECTED AND PROVEN NEUTROPENIC SEPSIS POLICY*

[1] http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,73860407,253_73860411&_dad=portal&_schema=PORTAL

Chilcott,Rachel
08/05/2025 16:26:52

2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Haematology Dr Jonathan Kell Jonathan.kell@wales.nhs.uk (EHIA Assessment completed by Diane Parry) Acute Oncology – Dr Juliette Lewis Jones Juliette.Lewis-Jones@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	To provide a rationale and practical framework for the treatment and care of patients with NS. -Assist clinical staff with diagnosing NS -Initial management of patients with suspected/confirmed NS -Clinical management of patients with confirmed NS -To comply with NICE guidelines on NS
4.	Evidence and background information considered. For example • population data • staff and service user's data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages	Cardiff & Vale University Local Health Board (LHB) area is the smallest and most densely populated LHB area in Wales, primarily due to Wales' capital city: Cardiff. 72.1 and 27.9 percent of the LHB area population live within Cardiff and the more rural Vale of Glamorgan respectively

Chilcott,Rachel 08/05/2025 16:26:52

	Population pyramids are available from Public Health Wales Observatory[2] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[3].	 • The UHB's usual arrangement with regard to consultation was followed (ie. 28 days on the intranet). No comments were received. • As part of good practice other policies from different organisations were considered. • Stakeholders engaged in the policy development(ns working group) • NICE guidelines considered • Data protection

Chilcott,Rachel
08/05/2025 16:26:52

[2] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[3] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

		• Microguide • Prescribing guides
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	The policy applies to all UHB staff involved in the care of patients with NS. Applicable to patients aged 16 and over.

7. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 16; • between 16 and 65; and • over 65	• Between 16 and 65 • Over 65 • No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an	• Mitigates under 16	n/a

Chilcott,Rachel
08/05/2025 16:26:52

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	adverse impact against any group of individuals in respect of age.		
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	The UHB is aware from its demographic information that it employs staff who have disabilities as defined within the Act. As such, the Policy has been made accessible to staff in both electronic and paper copy.	n/a	n/a

Chilcott,Rachel 08/05/2025 16:26:52

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	There appears not to be any impact on staff regarding gender. No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of	n/a	Policy put out for consultation within the organisation

Chilcott,Rachel 08/05/2025 16:26:52

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	individuals in respect of gender.		
6.4 People who are married or who have a civil partner.	There appears not to be any impact. No documented evidence found from the assessment review of the information available on the date the search was performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of sexual orientation.	n/a	Policy put out for consultation within the organisation

Chilcott,Rachel 08/05/2025 16:26:52

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	There appears not to be any impact.	n/a	n/a
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There appears not to be any impact regarding race, nationality, colour, culture or ethnic origin. No documented evidence found from the assessment review of the information available on the date the search was	Whilst there doesn't appear to be any impact, if a member of staff was known to have difficulties with the written word, good management would dictate that alternative arrangements be made,	All departments to be aware of their staff profiles. Policy put out for consultation within the organisation

Chilcott,Rachel
08/05/2025 16:26:52

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	performed to suggest that there are any statements, condition, rules or requirements which could potentially exclude or where applied cause an adverse impact against any group of individuals in respect of race	such as individual meetings. Members of the public would be supported by staff or family members as appropriate	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	It is unlikely to be any impact on staff regarding their religion.	n/a	n/a

Chilcott,Rachel 08/05/2025 16:26:52

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	There appears not to be any impact on staff or patients.		Policy put out for consultation within the organisation
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	Bilingually patient information leaflets are available for patients. This is in line with our current Welsh Language Scheme and the future Welsh Language Standards. The leaflets are available in one the leaflet should be bilingual in one single document English on one side and Welsh on the other side.	n/a	Policy put out for consultation within the organisation

Chilcott,Rachel
08/05/2025 16:26:52

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	The aim of the 'active offer' is that staff should ask for the language choice (of either Welsh or English) of the patient. The language choice should then be integrated into the patient's treatment. In other words the patient could request their treatment be in Welsh. If we are unable to provide a fully Welsh language service for the patient, we should then aim to maximise the coverage of treatment and care in Welsh for them using		

Chilcott,Rachel
08/05/2025 16:26:52

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	the staff and resources we already have.		
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There appears not to be any impact	n/a	n/a
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	There appears not to be any impact on staff, and this policy has a positive impact on people on low income as the policy is applicable to all people.	n/a	Policy put out for consultation within the organisation

Chilcott,Rachel
08/05/2025 16:26:52

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	People who speak other languages other than Welsh or English will be impacted positively as the policy refers to issues of language accessibility. There are no other groups including Carers or risk factors to take into account with regard to this Policy.	n/a	Policy put out for consultation within the organisation

8. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	The aim is to standardise care for patients with NS based on national evidence based guidelines	n/a	n/a
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention	As a policy, there will be no impact.	n/a	n/a

Chilcott,Rachel
08/05/2025 16:26:52

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
(eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	• May enable patients with NS to go home sooner	n/a	n/a

Chilcott,Rachel
08/05/2025 16:26:52

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces	For this policy, there will be no impact.	n/a	n/a

Chilcott,Rachel 08/05/2025 16:26:52

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	Positive impact for patients with NS potentially being able to go home sooner		

Chilcott,Rachel
08/05/2025 16:26:52

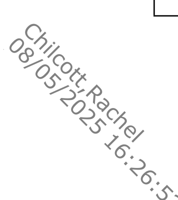
How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	Welsh Government Policy		

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	The positive impacts of the policy are that patients will get a standardised evidence based approach to their management to comply with NICE guidelines and it will enable eligible patients to go home sooner. Has the potential to improve morbidity and mortality rates from NS by getting their treatment sooner. Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this policy.

Action Plan for Mitigation / Improvement and Implementation

	Action	**Lead**	**Timescal e**	**Action taken by Clinical Board / Corporate Directorate**
8.2 What are the key actions identified as a result of completing the EHIA?	None	n/a	n/a	



	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As there has been potentially very limited impact identified is unnecessary to undertake a more detailed assessment.	n/a	n/a	

	Action	**Lead**	**Timescale**	**Action taken by Clinical Board / Corporate Directorate**

8.4 What are the next steps?
 	
Some suggestions:-
• Decide whether the strategy, policy, plan, procedure and/or service proposal:
  o continues unchanged as there are no significant negative impacts
  o adjusts to account for the negative impacts
  o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)
  o stops.
• Have your strategy, policy, plan, procedure and/or service proposal approved
• Publish your report of this impact assessment
• Monitor and review
	On reviewing this policy minor positive changes have been made. The EHIA has been consulted.
	
	When this policy is reviewed, this EHIA will form part of that consultation exercise. This EHIA will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required. The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).
		Dr Parry
		Dr J Kell
		Dr Juliette Lewis - Jones
			6 months
			
			3 years	

Chilcott,Rachel
08/05/2025 16:26:52

Report Title:	Cardiff and Vale of Glamorgan Suicide Prevention and Self-harm Strategic Plan 2025-2030				Agenda Item no.	3.2
Meeting:	Quality Committee		Public	X	Meeting Date:	13/05/2025
			Private			
Status:	Assurance		Approval	X	Information	
Lead Executive:	Executive Director of Public Health					
Report Author:	Consultant in Public Health Medicine / Principal Public Health Practitioner					

Background and current situation:

Introduction

Every death by suicide is a tragedy that affects individuals, families and the wider community, and has long-lasting effects on the people left behind. For every death by suicide there are many more people who attempt suicide. Self-harm, too, has devastating consequences and whilst more than half of people who die by suicide have a history of self-harm.

The reasons for suicide and self-harm are multi-faceted, influenced by social, cultural, biological, psychological and environmental factors present across the life course. Suicide is a significant public health and social inequality issue, yet suicides are preventable. There is well-established evidence that outlines the effective preventative action to tackle the underlying risk factors and interventions that can be put in place to address suicide and self-harm. The strategic plan has been produced, building on from the progress made since the previous 2021-2024 strategy, and outlines the commitment and collective action to be taken over the next five years to ensure suicide prevention and self-harm remain high public health priorities.

Background

In Cardiff and Vale of Glamorgan, there were 56 deaths registered from suicide, recorded in 2023, of which 39 were in Cardiff and 17 in the Vale of Glamorgan (Office for National Statistics, 2024a). When examining most recent 3-year aggregated data, in 2021/23 the age standardised suicide rate in Cardiff was 10.4 per 100,000 people and in the Vale of Glamorgan was 12.4 per 100,000 people aged 10 and over and whilst each Local Authority is below the rate for Wales (13.1 per 100,000), the ambition is to reduce the rates of death by suicide considerably.

Self-harm is a risk factor for suicide and most recent data for 2020-22 shows there were 822 emergency admissions for residents of Cardiff and Vale of Glamorgan aged 10 and over for which self-harm was recorded. Whilst the age-adjusted rate of emergency admissions for self-harm have fallen considerably since 2017/19 (please refer to the full strategy document for further information), we still need to address the issue of self-harm specifically as rates remain higher for residents of the Vale of Glamorgan compared to Cardiff, and higher for females compared to males.

Note: Self-harm can be difficult to define, categorise and measure in particular because self-harm, as a widely stigmatised activity, is often concealed and may never be recorded. Self-harm that is recorded tends to be more serious (e.g. incidents requiring hospital admission) and is likely to be the tip of the iceberg.

Chilcott,Rachel
08/05/2025 16:24:52

Strategic Plan development

In October 2024, Cardiff and Vale University Health Board Public Health Team hosted a stakeholder engagement workshop at Cardiff Castle inviting a wide range of partners and members of the public (those with lived experience) to come together to co-produce our refreshed Strategic Plan and first year delivery plan for 2025-26. The event was attended by

35 participants from across Cardiff and Vale University Health Board (CAVUHB), Local Authority, Third Sector, Public Health Wales and Welsh Government, voluntary sector and individuals with lived experience including those bereaved by suicide. There was also an option for those unable to attend in person to join online to participate in the engagement process as well as access to a MENTI evaluation form to ensure contributions and feedback was gathered and used to inform the strategic plan development. A video summarising the engagement workshop is being produced and will be shared when available.

At this time, the national Suicide Prevention and Self-Harm strategy was out for consultation and a summary of responses released, which was used to inform and ensure our local strategic plan is aligned to the national agenda and identified priority objectives.

A draft strategic plan was prepared using the information gathered, which was shared and approved with a 'Strategic plan refresh task group' of the Suicide Prevention and Self-Harm Steering Group.

Between February to April 2025, the draft document was released for consultation where partners and members of the public (those with lived experience) were invited to comment (using MS Forms). Twenty responses were received and this feedback has been considered and the draft strategic plan updated accordingly to produce the final version. The national Suicide Prevention and Self-Harm Strategy was released in April 2025 and the local plan has been cross-referenced with this to ensure it continues to align with the national agenda for suicide prevention and self-harm.

The final Strategic Plan (Appendix A) has been approved by the Suicide Prevention and Self-Harm Steering Group, as well as the Regional Lead for Suicide Prevention and Self-Harm within NHS Executive as subject expert, and endorsed by the Regional Partnership Board.

The attached Strategic Plan holds the vision:

By 2030, we will empower individuals across Cardiff and Vale of Glamorgan: to be capable of having compassionate conversations about mental health, suicide and self-harm; to understand how and where to access the most appropriate help at a time when it is needed for themselves or others at risk of or affected by suicide and self-harm; to have Support services that are readily available and accessible to all (including preventative services), providing person-centred care.

There is commitment from a range of stakeholders and partners across Cardiff and the Vale of Glamorgan over the next five years to:

- reduce the rate of deaths from suicide, including reducing access to the means and methods of suicide;
- improve data and evidence relating to suicide prevention and self-harm and to apply this to local interventions;
- raise the profile of talking about mental health and wellbeing, and suicide prevention and self-harm as everybody's responsibility, including by developing a competent workforce;
- provide effective interventions at the stage of prevention, intervention and crisis which is available and tailored to individuals;
- work together (across organisations and communities); and hold each other accountable for progress on this agenda.

Chilcott, Rachel
08/05/2025 16:26:02

The plan is structured under eight priority objectives, as listed in Table 1, and aligned to the national agenda. During engagement and consultation, there were strong views that Self-Harm and Co-production were stand-alone objectives, and so the local plan reflects this.

Table 1: Eight objectives to deliver action across Cardiff and the Vale of Glamorgan.

Objective 1: Contribute to the robust evidence base for suicide prevention and self-harm, drawing on a range of local data, research and information. Develop robust infrastructure at local and South East Wales regional level to facilitate the analysis and sharing of data/information to focus resources and drive action.
Objective 2: Co-ordinate cross-sectoral action which collectively tackles the drivers of suicide and reduces access to means to suicide.
Objective 3: Deliver rapid and impactful prevention, intervention, and support to those groups in society who are the most vulnerable to suicide and self-harm through the settings with which they are most engaged.
Objective 4: Ensure an appropriate, compassionate and person-centred response is offered to all those who self-harm, have suicidal thoughts, or who have been affected or bereaved by suicide, promoting effective recovery and reduced stigma.
Objective 5: To reduce the risks of self-harm in our population.
Objective 6: Increase skills, awareness, knowledge and understanding of suicide and self-harm amongst the public, professionals and agencies who may come into contact with people at risk of suicide and self-harm by the delivery of effective training.
Objective 7: Responsible communication, media reporting, and social media use regarding self-harm, suicide and suicidal behaviour.
Objective 8: To apply co-production principles in all that we do to prevent suicide and self-harm.

Annual action plans will accompany the Strategic Plan, with the first-year action plan for 2025/26 included in the document to ensure focussed action builds on previous work established and key partners will take forward to make the desired progress.

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

1. Cardiff and Vale University Health Board plays a significant role in co-ordinating the work outlined in the Strategic plan.
2. The first-year delivery plan for 2025/26 shows the range of partners who have responsibility in progressing this agenda and delivering on action.
3. Local action has and continues to feed into national work on this agenda. The national strategy was released in April 2025 and the local plan aligns with this vision.

Recommendation:

The Committee is requested to:

a) APPROVE the Cardiff and Vale of Glamorgan Suicide Prevention and Self-Harm Strategic Plan 2025-2030 and first-year delivery plan 2025-26.

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**	X	Providing Outstanding Quality 2. **Click the objective above to view more detail.**	X

Chilcott, Rachel
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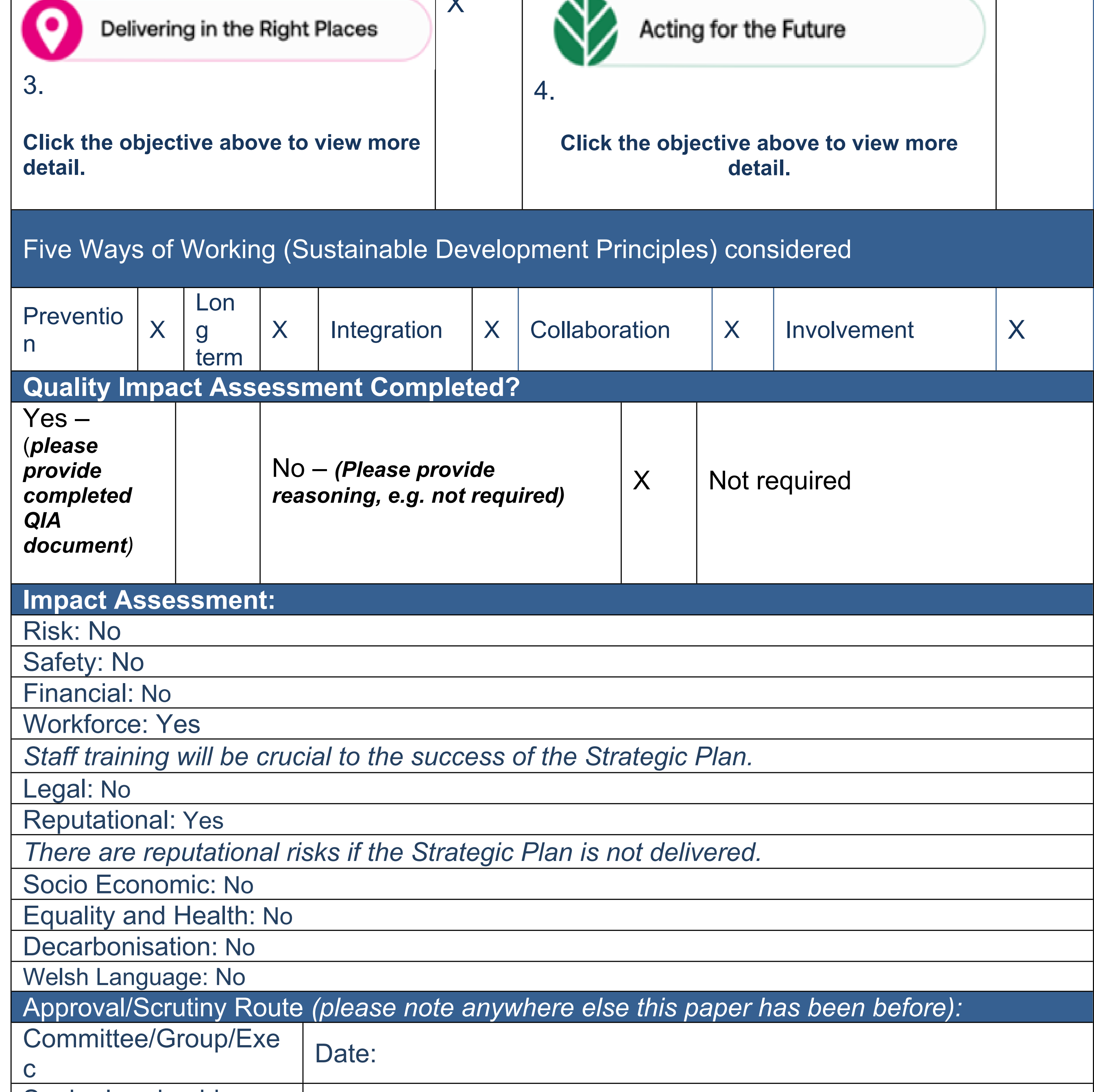

3. Delivering in the Right Places Click the objective above to view more detail.	X	4. Acting for the Future Click the objective above to view more detail.	

Five Ways of Working (Sustainable Development Principles) considered

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Quality Impact Assessment Completed?

Yes – (*please provide completed QIA document*)		No – ***(Please provide reasoning, e.g. not required)***	X	Not required

Impact Assessment:
Risk: No
Safety: No
Financial: No
Workforce: Yes
Staff training will be crucial to the success of the Strategic Plan.
Legal: No
Reputational: Yes
There are reputational risks if the Strategic Plan is not delivered.
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:
Senior Leadership Board	3 April 2025

Chilcott,Rachel
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Cardiff and Vale of Glamorgan Suicide Prevention and Self Harm Strategic Plan
(2025-2030)

Fostering compassionate conversations and support for suicide prevention and self-harm.

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Suicide and Self-harm
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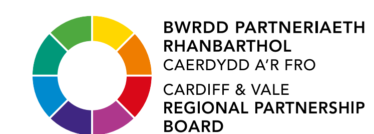

Contents

Foreword	**3**
Sources of support while reading this document	**3**
Introduction	**4**
Our Vision	**5**
Governance	**6**
The population of Cardiff and Vale and their health needs	**6**
Priority areas for action: 8 objectives	**11**
Successes from the previous strategy	**17**
Delivering the strategic plan - year 1 delivery plan (2025/26)	**18**
References	**24**
Source of information	**25**
Appendix A: data analysis	**26**

Chilcott,Rachel
08/05/2025 16:26:52

Foreword

This is the second Suicide Prevention and Self-Harm Strategic Plan that Cardiff and Vale of Glamorgan have produced, and will run from 2025 to 2030 as a continuation of the work we are proud to have started since the last (2020-2024). Recognising the current difficult economic climate we live in, post-pandemic, and the complex multiple factors that are linked to suicide and self-harm, it continues to be a vital component of our strategic plans and programmes to collectively address this.

Preventing suicide and self-harm cannot be achieved alone and it remains the responsibility of each of our organisations to address these issues. We have developed this plan in partnership, consulting with a range of organisations and those with lived experience, with endorsement from the Regional Partnership Board. We have listed co-production as a stand-alone objective (one of eight objectives) in recognition that if we are to prevent suicide and address self-harm among our population this will be an essential approach.

We are grateful to the work of our colleagues who have helped to develop this plan. We all acknowledge that behind the statistics quoted is a person lost to suicide and the devastating impact this has to their families and our communities.

Claire Beynon
Executive Director of Public Health
Cardiff and Vale University Health Board

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Sources of support while reading this document

If you are finding things difficult to manage or dealing with significant challenges, sources of support in Wales can be found at Get Help Now - SSHP. The Samaritans listening line can be contacted 24 hours a day, for free, on 116 123, by email on jo@samaritans.org or visit www.samaritans.org to find your nearest branch. Welsh Language Service for Samaritans Cymru can be reached via 0808 164 0123 between 7-11pm.

Other support is available from C.A.L.L Mental Health Helpline for Wales via 0800 132 737 or email: Call@helpline.wales or the NHS help for suicidal thoughts page. Support is available around the clock, every day of the year, providing a safe place for you, whoever you are and however you are feeling.

Media coverage of suicide related issues should adhere to the Samaritans' Media Guidelines because of the potentially damaging consequences of insensitive reporting. These guidelines have been followed for the terminology applied throughout this document.

If you have been affected by a suspected suicide death, support is available through the National Advisory and Liaison Service for Wales, telephone: 08000 487742, or email: support@nals.cymru. Help is at Hand Cymru can be accessed online for more information after a sudden death.

A range of organisations, dataset and resources are referenced throughout this document, Section 11 provides further information about these.

Introduction

Every death by suicide is a tragedy that affects individuals, families and the wider community, and has long-lasting effects on the people left behind. For every death by suicide there are many more people who attempt suicide. Self-harm, too, has devastating consequences and whilst more than half of people who die by suicide have a history of self-harm, self-harm may or may not be a sign that someone is feeling suicidal. The term self-harm is referred to throughout this document as:

"Self-harm is defined as intentional self-poisoning or injury, irrespective of the motivation or apparent purpose of the act and is an expression of emotional distress".

This definition is taken from the National Institute for Health and Care Excellence (2022).

The reasons for suicide and self-harm are multi-faceted, influenced by social, cultural, biological, psychological and environmental factors present across the life course (World Health Organisation, 2024). Suicide is a significant public health and social inequality issue, yet suicides are preventable. There is well-established evidence that outlines the effective preventative action to tackle the underlying risk factors and interventions that can be put in place to address suicide and self-harm.

Context for the strategic plan

The plan has been developed in partnership between Cardiff and Vale University Health Board (CAVUHB), Local Authority, Third Sector, Public Health Wales and Welsh Government as well as in consultation and engagement with those with lived experience (bereaved by suicide), recognising that commitment and collective action is required to address suicide and self-harm across Cardiff and the Vale of Glamorgan. This plan builds on the progress made since the 2021-2024 strategy (CAVUHB, 2021a) and sets out the approach that will be taken over the next five years to ensure suicide prevention and self-harm remain high public health priorities.

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The Cardiff and Vale of Glamorgan Suicide Prevention and Self Harm Steering Group has been in place for a number of years and is well established. The Group includes representation from local services and organisations, and takes a lead on monitoring the progress of local delivery plan developments, as well as playing a lead role at the regional advisory groups and contributing to national actions and agendas.

This strategic plan is aligned to wider strategies underway:

- The national Suicide Prevention and Self Harm Strategy for Wales, to ensure local action is part of the wider activity taking place across Wales with an overall ambition for reducing deaths from suicide, and the impact of suicide and self-harm.
- The Mental Health and Wellbeing Strategy for Wales. Suicide and self-harm are not diagnosable mental health conditions and most people who die by suicide are not known to NHS mental health services, although it is recognised that having a mental health difficulty is a risk factor for suicide and self-harm; both are behaviours in response to emotional distress caused by factors including (but not limited to) mental and physical health conditions, addiction, poverty and financial strain, bereavement, job losses and relationship breakdowns.
- This plan is set in the context of the Well Being of Future Generations Act (2014) which aims to improve the social, economic, environmental and cultural wellbeing of our population.

As this strategic plan spans 2025-2030, it is important that it is an active document, aligned to new and emerging information, data, insights and evidence-base to be refreshed regularly in order to remain relevant. The first-year delivery plan (2025-26) will ensure action is implemented, with subsequent annual action plans for 2026-2030.

Our vision

By 2030, we will empower individuals across Cardiff and Vale of Glamorgan: to be capable of having compassionate conversations about mental health, suicide and self-harm; to understand how and where to access the most appropriate help at a time when it is needed for themselves or others at risk of or affected by suicide and self-harm; to have Support services that are readily available and accessible to all (including preventative services), providing person-centred care.

This vision applies to ALL ages* and spans the full geographical area of Cardiff and Vale of Glamorgan, aiming for equitable access to support.

**For a description of the changing risks and intervention points throughout the life course, please refer to Section 10 of the Suicide Prevention and Self-Harm Strategy for Wales, 2025 to which our local approach aligns with.*

There is a focus on working with those with lived experience to ensure our response is informed, whilst recognising that engagement with children and young people must be carefully managed.

There is commitment from a range of stakeholders and partners across Cardiff and Vale over the next five years to:

- reduce the rate of deaths from suicide, including reducing access to the means and methods of suicide;
- improve data and evidence relating to suicide prevention and self-harm and to apply this to local interventions;
- raise the profile of talking about mental health and wellbeing, and suicide prevention and self-harm as everybody's responsibility, including by developing a competent workforce;
- provide effective interventions at the stage of prevention, intervention and crisis which is available and tailored to individuals;
- work together (across organisations and communities); and hold each other accountable for progress on this agenda.

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08/05/2025 16:26:52

We will deliver this against a number of priority areas (aligned to national action), as set out in the next chapter.

We will know that this has been achieved when:

- By 2030, the rate of deaths from suicide is reduced (from a baseline of 10.4 per 100,000 people in Cardiff and 12.4 per 100,000 people in the Vale of Glamorgan in 2021/23).
- There is an established protocol for the coding of all suicide and self-harm incidents applied to by key organisations involved in data collection, to enable active surveillance to respond and inform decision making and subsequent action.
- There is available training on suicide prevention and self-harm to ensure people feel competent to raise these topics when they come into contact with individuals that require information, signposting and support.
- A workshop is held annually bringing together key partners to progress the suicide prevention and self-harm agenda in Cardiff and Vale.
- Communications campaigns are delivered and evaluation metrics suggest wide reaching content to target audiences.
- A self-harm prevention pathway is in place across Cardiff and Vale, accessible for all.
- Local services provide person centred support, equitable for all.
- A bereavement support pathway is in place across Cardiff and Vale, accessible for all.
- Key organisations pledge support to addressing suicide and self-harm, as identified in key strategies and plans.

Governance

The Cardiff and Vale of Glamorgan Suicide Prevention and Self Harm Steering Group will hold the oversight of the strategic plan. The annual delivery plans will detail the tasks required for each financial year between 2025-2030, listing the responsible lead with reporting arrangements established on a quarterly basis to the Steering Group.

The Steering Group will report progress against the strategic plan and delivery plans to the Regional Partnership Board (RPB), who endorse this plan.

Local activity is also fed into the South East Wales Regional Suicide Prevention and Self-Harm Forum, reporting to the National Programme Board that will measure progress in Cardiff and Vale against the national strategy and action plan, as part of national accountability structures.

The population of Cardiff and the Vale of Glamorgan and their health needs

Based on 2023 Office for National Statistics data, the population for Cardiff is estimated at 383,536 and for Vale of Glamorgan is estimated at 134,733 totalling 518,269 with the overall population expected to grow rapidly by 2030 (Stats Wales, 2024). Cardiff has a younger population than most other areas of Wales, in part because of the large number of university and further education students studying in the city; whereas, the age structure in the Vale of Glamorgan is similar to the rest of Wales. The Cardiff and Vale of Glamorgan Population Needs Assessment – CAVRPB conducted by the Regional Partnership Board (2022) states that approximately 50% of Cardiff's population live in the 50% least deprived areas, while for the Vale of Glamorgan, 65% live in the 50% least deprived areas, recognising the established inequalities in health across the geographical area.

Additional points to note from the 2022 Needs Assessment include:

- Cardiff has a considerably more ethnically diverse population than other parts of Wales.
- Cardiff is an initial accommodation and dispersal centre for asylum seekers.
- Access to mental health and counselling services were one of the most commonly identified gaps in available services that would improve wellbeing, stated by both residents and professionals.

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Population-level statistics on deaths by suicide in Cardiff and the Vale of Glamorgan

As well as data on the general population, two sources of data exist to present the trends in deaths from suicide and suspected suicide and have been analysed to allow us to further understand the specific population groups who may be at increased risk of suicide.

1. **Office for National Statistics data:** reports annually on the rates of registered death by suicide, using the date of registration (rather than date of death) following an inquest by a Coroner. An inquest generally results in a delay until the death is officially registered and so the actual occurrence of those deaths may have been months or years prior. These data are presented as 3-year aggregated data and are also age-standardised to allow for comparisons between areas.

2. **Real Time Suspected Suicide Surveillance (RTSSS) data:** has been established in Wales since April 2022 and collects information about deaths by suspected suicide, data includes notifications received from the four Welsh Police Forces and British Transport Police (BTP) as well as additional information from NHS Executive, Welsh Clinical Portal system and Network Rail. Reports are produced monthly for the purpose of updating the monthly operational group, and annually (published online). Whilst it is more timely data than official statistics, the data have not gone through the coronial system and are used as indicators only.

Whilst it is helpful to access Office for National Statistics data on deaths registered from suicide, using RTSSS data allows the Cardiff and Vale of Glamorgan Suicide prevention and self-harm Steering Group to respond quickly to emerging patterns and to routinely monitor suspected suicides on a more regular basis. For these reasons, RTSSS data (using the latest national report 2023/24) has been analysed, along with the views of stakeholders gathered during the development of this plan, and summarised below to identify the needs of our local population and inform where to focus our efforts to address the gaps that exist. For further information on data analysis, strengths and limitations please refer to: Annual Report: Deaths by suspected suicide 2023-24 - Public Health Wales (Public Health Wales, 2024).

Where data exist for Cardiff and Vale of Glamorgan, these have been included. Where there are gaps for specific populations at local authority level, but relevant data exists for Wales from the latest RTSSS annual report 2023/24, we have included this.

Office for National Statistics data

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In Cardiff and Vale of Glamorgan, there were 56 deaths registered from suicide, recorded in 2023, of which 39 were in Cardiff and 17 in the Vale of Glamorgan (Office for National Statistics, 2024a).

Note: Office for National Statistics data apply 3-year aggregated data. In this section we use a rate per 100,000 people, called the European Age Standardised Rate (EASR) which is 'age standardised' to allow better comparison between areas. Confidence intervals around the EASR assess how likely it is that any difference between rates (in different areas, or for different age groups) is due to chance. If the confidence intervals for two figures do not overlap, we consider it statistically much more likely that there is a 'real' difference between the figures (i.e. the difference is not just due to chance).

Figure 1 shows the rate of suicides since 2017/19. In 2021/23, the age standardised suicide rate in Cardiff was 10.4 per 100,000 people and in the Vale was 12.4 per 100,000 people aged 10 and over and whilst each Local Authority is below the rate for Wales (13.1 per 100,000), differences are due to chance rather than any real difference between the rates for suicide across these areas. By comparison, latest data on the age-standardised suicide rate was 8.8 per 100,000 in the United Kingdom and 10.2 per 100,000 in European Union countries in 2021 (World Health Organisation, 2025).

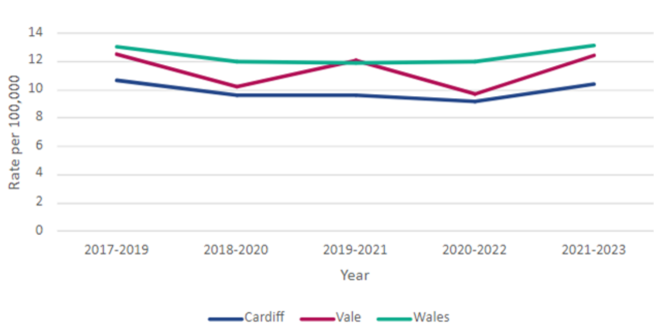

Figure 1: Age-standardised suicide rates per 100,000 population for Cardiff and Vale of Glamorgan local authorities and Wales (2017-2019 to 2021-2023).
Source: Office for National Statistics, 2024b. Suicides in England and Wales by local authority - Office for National Statistics

NOTE: Death statistics are compiled from information supplied when deaths are certified and registered.

Additionally, data is available by sex (as shown in Figure 2) by date of registration, which shows rates of suicide remain higher among males than females. Analysis of 2023 data by age-group (Figure 3) continues to highlight where efforts must focus to reduce rates among key age groups in our population.

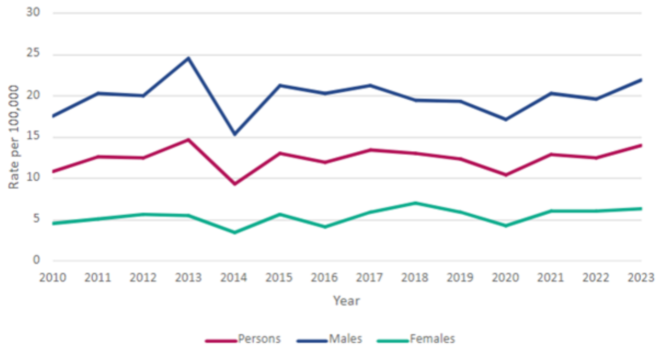

Figure 2: Age-standardised suicide rates per 100,000 population by sex, for Wales, 2010 to 2023 registrations.

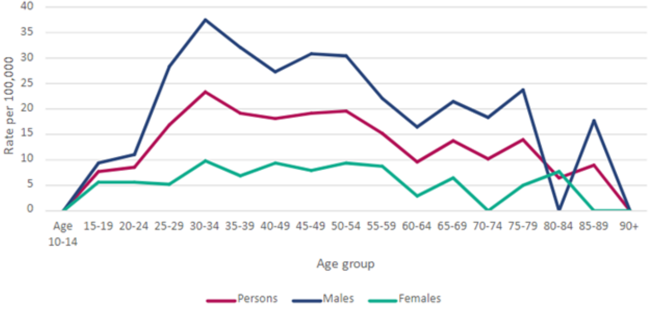

Figure 3: Age-specific suicide rates per 100,000 population by five-year age group, Wales, 2010 to 2023 registrations.

Real time surveillance

The RTSSS annual report ([Public Health Wales, 2024](#)) has identified the following across Wales:

- The rate of suspected suicides was 10.3 per 100,000 for Cardiff and Vale University Health Board which was not statistically significantly different from the all-Wales rate (12.4 per 100,000).
- There were a higher number of deaths among those living in the most deprived areas, 15.8 per 100,000 in 2023/24. The rate in the least deprived area was 8.6 deaths per 100,000.
- Males accounted for 76% of suspected suicides, which is similar to the rates in 2022/23 and therefore men continue to be a high priority area for continued action.
- The highest rate of suspected suicides was in males aged 35-44 years, followed by males aged 45-54 years. The rates were higher in males compared to females in all age groups.
- The highest rates in females was among the 35-44 years age group, followed by the 25-34 years age group.
- The highest rate of suspected suicide was in people where employment status was recorded as unemployed (126.7 per 100,000). This was at least 12 times higher than in any other employment status group.

Appendix A provides further information.

Population-level statistics on self-harm in Cardiff and the Vale of Glamorgan

Self-harm is a risk factor for suicide and most recent data for 2020-22 shows there were 822 emergency admissions for residents of Cardiff and Vale of Glamorgan aged 10 and over for which self-harm was recorded.

Note: Self-harm can be difficult to define, categorise and measure in particular because self-harm, as a widely stigmatised activity, is often concealed and may never be recorded (CAVUHB, 2021b). Self-harm that is recorded tends to be more serious (e.g. incidents requiring hospital admission) and is likely to represent 'the tip of the iceberg'.

The rate for self-harm related emergency admission in Cardiff and Vale of Glamorgan from 2020-22 was 58.3 per 100,000 people aged 10 and over, and then:

- For Cardiff the EASR was 56 per 100,000
- For Vale of Glamorgan the EASR was 69 per 100,000
- For Wales the EASR was 119 per 100,000
- For men in Cardiff and Vale the EASR was 41 per 100,000

Chilcott, Rachel
08/05/2025 16:26:52

- For women in Cardiff and Vale the EASR was 77 per 100,000.

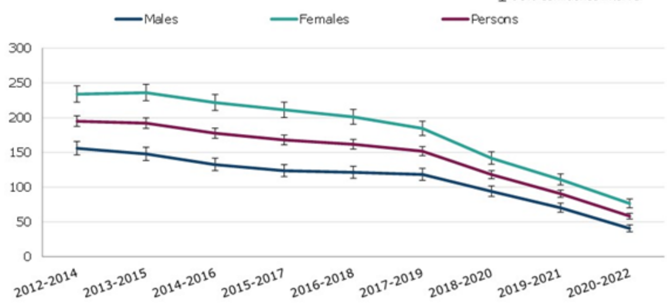

Figure 4: Self-harm emergency admissions for Cardiff and Vale UHB, 2012-2022.
Source: Mid-year population estimates (MYE), Office for National Statistics (ONS)
Patient Episode Dataset Wales (PEDW), Digital Health Care Wales (DHCW). **Produced by Public Health Wales Observatory, 2024.**

Figure 4 above shows that, consistent with figures for Wales and the UK (see: CAVUHB, 2021b), rates are consistently higher in females compared with males. We can be confident that the differences between rates for men and women are not due to chance, which leads us to focus our attention on self-harm prevention and action more so with females. The national Suicide Prevention and Self-Harm Strategy highlights that self-harm is most prominent amongst young girls between the age of 15 to 19 years; the strategy also notes under-reporting due in part to people's reluctance to access medical or psychological services for treatment which are important points to consider when analysing available data on this topic.

Figure 5 below suggests that the age-adjusted rate of emergency admissions for self-harm have fallen consistently since 2017/19, we can be confident the differences between the rate in the Health Board and the differences between national age-adjusted rates are not due to chance, though we still need to address the issue specifically as it remains higher for residents of the Vale of Glamorgan compared to Cardiff.

Note: these are admissions, and an individual may have been admitted more than once.
[Data on age-specific rates for emergency admissions for self-harm was not available and therefore has not been included.]

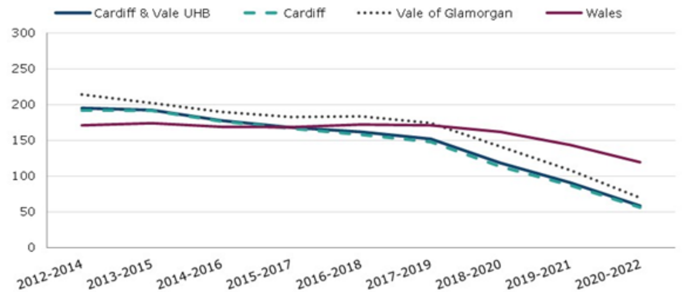

Figure 5: Self-harm emergency admissions for Cardiff, Vale, and Cardiff and Vale UHB, and Wales, 2012-2022.
Source: Mid-year population estimates (MYE), Office for National Statistics (ONS)
Patient Episode Dataset Wales (PEDW), Digital Health Care Wales (DHCW). **Produced by Public Health Wales Observatory, 2024.**

Gaps in supporting people across our population

Population groups facing higher risks of suicide or self-harm have been identified in the previous strategy and continue to be a focus of our work. These are listed below with further detail available in the previous strategy supplementary information document (CAVUHB, 2021b).

- LGBTQ+
- Black, Asian and minority ethnic people living in Cardiff and Vale
- Asylum seekers and refugees
- Those with diagnosed mental health difficulties*
- Those experiencing bereavement due to suicide*

There are also some themes around risk and vulnerability that cut across general population and vulnerable/at risk groups:

- The role of carers

- Substance misuse
- Unemployment and risks by occupation*

RTSSS data has identified and established emerging trends and highlighted where we need to extend our attention to, some of which overlap with the previous population groups/risk factors listed above (indicated by *).

It is worth noting that, as suicide and self-harm are complex issues, the list is not exhaustive and regular monitoring and evaluation of the RTSSS data will keep knowledge up to date and promote timely action in response to any emerging trends.

The most common associated factors among people who died from suspected suicide across Wales (Figure 6, n=350) (identified from the RTSSS annual report, Public Health Wales, 2024) are outlined below.

- A mental health condition, which was reported in 63% who died from suspected suicide. This has increased since 2022/23 (170/359, 47%) which Public Health Wales suggest could be a real increase in people who were reported to have had a mental health condition, there could be better reporting, or it could be due to improved cross checking of data with other sources.
- A history of previous self-harm, which was reported in 53% (in 2022/23 it was 49%).
- Family and/or relationship issues were reported in 26% (in 2022/23 it was 19%).
- Those known to mental health services (in the past 6 months prior to death), which was reported in 29% of deaths by suspected suicide. Forty five percent were not known to mental health services and for 26%, it was unknown whether they were known to mental health services so it is possible that the percentage of people who were known to mental health services was underestimated or overestimated. A similar figure was reported in 2022/23. From these data you cannot conclude what is meant by 'known to mental health services' There is not yet enough information to determine how people were known to services.
- Those known to the Police (at any point in their lives prior to their death), which was reported in 65%. The most common reason for being known to the police as for being suspected/convicted of a crime (37%). This was higher in 2022/23 (74%). From these data you cannot conclude what the risk of suicide was in someone who was suspected/convicted of a crime, was a victim or witness of a crime, or was a vulnerable person, as denominator data were not available.

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Refer to Appendix A for further information.

From these data you cannot conclude what the risk of suicide was in someone who had a mental health condition or history of previous self-harm, or any other associated factor, as denominator data were not available (which is the number of people in the whole population who have each associated factor). Additionally, it is important to acknowledge that individuals may be counted in more than one of the factors listed above and there are multiple contributing factors (not a single risk factor) associated with a suspected suicide.

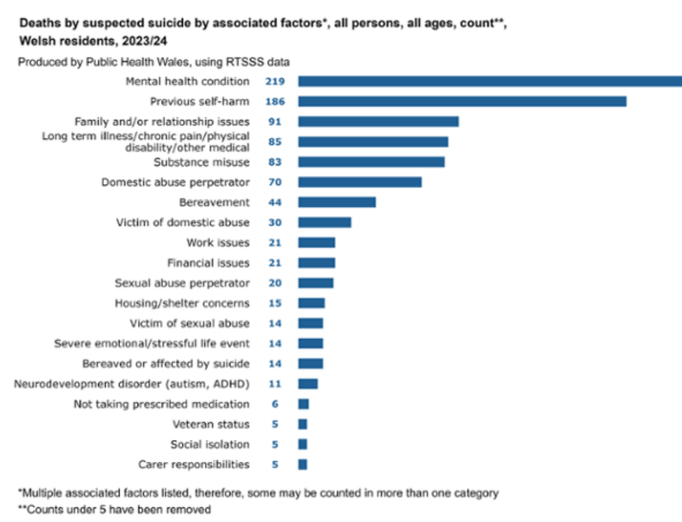

Figure 6: Deaths by suspected suicide by associated factors, across Wales, 2023/24.

Analysis of the RTSSS data allows us to highlight the higher risk of suicide among some population groups and to focus local preventative action and intervention accordingly, to direct vulnerable people to sources of support.

Priority areas for action: 8 objectives

Eight objectives have been identified as part of the Welsh Government Suicide Prevention and Self-Harm Strategy and used as part of consultation processes throughout the development of this plan, with agreement from partners that they are the objectives we will work to. Each Objective is described in turn, setting out the strategic action to be taken over the duration of this plan.

Objective 1: Contribute to the robust evidence base for suicide prevention and self-harm, drawing on a range of local data, research and information. Develop robust infrastructure at local and South East Wales regional level to facilitate the analysis and sharing of data/information to focus resources and drive action.

Current situation

Current sources of data and information for suicide prevention and self-harm available at Cardiff and Vale of Glamorgan level has been referenced earlier in this document but also includes:

a. Monthly reporting on suspected deaths from suicide (Real Time Suspected Suicide System (RTSSS) data, produced by Public Health Wales). The RTSSS task group continually review and highlight challenges and concerns and as the RTSSS contains confidential and sensitive data, this is shared to a closed membership group (including the Health Board and Public Health Wales representatives). The South East Wales Regional Lead identifies and presents information to the Steering Group (by theme) to aid local response/action on a monthly and quarterly basis.
b. Quarterly training reports to monitor the numbers of individuals from Cardiff and Vale who have completed training as listed on the National Training Framework Hub (Suicide prevention and self-harm Cymru, 2024) by job title and organisation, and used by the Steering Group for analysis.

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During consultation and engagement stages with partners, it was identified that data are collected relating to suicide and self-harm to inform action by individual services (such as hospital admission data, data from specialist services and third sector organisations, Emergency Department data, NHS 111 press 2 data, Police data) but how this is coded varies by organisation. Also, as data are not shared between organisations on a shared database, this is potentially limiting the analysis, decision making and action that follows at monthly and quarterly RTSSS task group meetings. Improving the coding and use of data will progress the ability of Cardiff and Vale of Glamorgan Suicide Prevention and Self Harm Steering Group and service providers to act rapidly and effectively. It is vital to share lessons learned from local reviews of incidents with those who can respond to support the local community and ensure learning contributes to action at both local as well as regional and national level.

Where we want to be

- Establish and apply consistent coding of data entered among those key partners responsible for data collection, to assist with meaningful analysis.
- Strengthen information sharing from established data reporting mechanisms to local Steering Group to identify any themes, trends and enable decision making and responses to occur in a timely manner.
- Form an all-age Rapid Response Group (RRG) in response to any death by suicide or cluster of deaths as part of surveillance.
- Contribute local insights to both local and national research on suicide prevention and self-harm to feed into the robust evidence base available at regional, national and UK level.
- Continue to conduct research as part of Health Board Research and Development divisions and share learning with Steering Group and regional and national networks.

Note: For the purpose of this document we will apply RTSSS data on suspected suicides for access to timely data to inform decision making and action, as opposed to Office for National Statistics data on registered deaths by suicide.

Objective 2: Co-ordinate cross-sectoral action which collectively tackles the drivers of suicide and reduces access to means to suicide.

Current situation

Recognising that changes in circumstances throughout the life course (such as financial pressures, housing, poverty, relationship breakdowns) cause individuals to consider suicide, highlights the importance of tackling the wider determinants of health, which can only be achieved by working collectively and collaboratively between organisations and agencies to address suicide risk, and by taking a community-based, poverty-informed approach (for example with housing to reduce stressors to individuals).

The current approach to supporting individuals affected by suicide and self-harm holds a focus in specialist and hospital settings however the benefit of a multi-sectoral approach to reaching all population groups facing higher risk is recognised. The focus of prevention activity must therefore shift to action taking place in local communities, and although this has started this will be achieved by continuing to work in partnership across sectors to recognise contributing factors and drivers of suicide and self-harm (the wider determinants of health – social deprivation, isolation, and not solely poor mental health) and ensuring individuals in priority groups are identified early, and once identified, are supported as part of services they already engage with (many of which will not be Primary or Secondary Care health services but community-based) to promote better outcomes. Examples include extending prevention responsibilities to employers, and educational settings, and making full use of the scope of voluntary sector services.

Chilcott, Rachel
08/05/2025 16:26:52

Where we want to be

- Use this plan to support the wider agenda and cross-over to wider strategies aligned to: Clinical Boards within the Health Board; Local Authority; and as part of the Regional Partnership Board. This will promote suicide prevention and self-harm as "everybody's business" and hold wider agencies to account for making progress with reducing the rate of deaths from suicide.
- Collaborate with agencies, such as housing and Department for Work and Pensions, to reduce stressors to individuals.
- Work with Welsh Government, Social Services, Local Authorities and the Third sector in collaboration to ensure:
- Public services and their workforce play a role in recognising signs/symptoms of suicide and self-harm among individuals they provide services to (specifically those population priority groups) and take opportunity to signpost to appropriate services.
- Individuals at vulnerable points in their lives can access support when required, and this support extends to the individuals support network, where appropriate.
- Learn from best practice in ways of working from those with lived experience, as well as across the UK and Finland, to understand develop a collaborative response to suicide prevention and self-harm in Cardiff and Vale of Glamorgan.
- Use surveillance mechanisms (RTSSS) and local intelligence (for example from South Wales Police; Fire and Rescue Services) to determine any patterns of frequently used locations and intervene with relevant partners to identify primary drivers and evidence-based interventions to reduce access to means.

Objective 3: Deliver rapid and impactful prevention, intervention, and support to those groups in society who are the most vulnerable to suicide and self-harm through the settings with which they are most engaged.

Current situation

Lots of welcome attention and recognition has been given to the importance of positive mental health and wellbeing and developing resilience on an individual and community level, specifically since the COVID-19 pandemic, and is documented in strategic programmes and areas of work by partners as covered in Objective 2 as intended action.

Shifting action to PREVENTING suicide and MANAGING self-harm by early intervention supports individuals and communities of all ages to effectively manage their health and results in better outcomes and is where efforts should focus.

Additionally, access to RTSSS data has recognised priority population groups (Public Health Wales, 2024) where some of this prevention and intervention activity is needed. Namely among:

- Individuals living in more disadvantaged areas of Cardiff and Vale of Glamorgan;
- Males ages 35-44 years and 45-54 years;
- Females age 35-44 years and 25-34 years;
- Individuals who are unemployed and face risks by occupation;
- Individuals with diagnosed mental health issues;
- Individuals experiencing bereavement due to suicide;
- Individuals with a history of previous self-harm;
- Individuals experiencing family and/or relationship issues;
- Individuals known to mental health services;
- Individuals known to the police.

NOTE: Whilst priority groups have been identified to engage with this does not refer to priority access to support services.

Where we want to be

- Strengthen the prevention agenda by improving the health and wellbeing of residents of Cardiff and Vale of Glamorgan through promoting and supporting access to healthy lifestyles services/ activities, such as physical activity and social prescribing.
- Map settings already engaged with the priority groups and identify staff working in these settings to receive basic suicide awareness training module (for example to upskill staff working at Job Centres to raise awareness and knowledge and ensure appropriate signposting for individuals that present in crisis to local support services. See Objective 6 for more details on training).
- Explore ways to reach those individuals from identified priority groups who don't engage with settings/services to ensure they receive prevention messaging and education (as outlined in Objective 6), specifically for males who are affected by unemployment as data suggests specific work is required with this group. As well as those priority groups listed above, ensure action is taken to support the following population groups facing higher risk of suicide and self-harm:
  - LGBTQ+
  - Black, Asian and minority ethnic people living in Cardiff and Vale
  - Asylum seekers and refugees
  - Those with diagnosed mental health difficulties
  - Those experiencing bereavement due to suicide
  - The role of carers
  - Substance misuse
  - Unemployment and risks by occupation.
- Work in co-production with educational settings (linked to the Healthy Schools Scheme and South Wales University Mental Health Partnership), Children and Adolescent Mental Health Services (CAMHS), school in-reach and school nursing to ensure children and young people (and parents) have access to information and education on mental health, suicide prevention and self-harm.
- Work in co-production with services supporting young people and adults with adverse childhood experiences (ACEs) and trauma to ensure they have access to information and education on mental health, suicide prevention and self-harm
- Guided by the Trauma-Informed Wales Framework, ensure any support or services delivered through our plan are trauma-informed and compassionate.
- Monitor and revise the list of priority groups as they evolve during the life course of this plan to ensure we are working with the latest evidence.

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08/05/2025 16:26:52

Objective 4: Ensure an appropriate, compassionate and person-centred response is offered to all those who self-harm, have suicidal thoughts, or who have been affected or bereaved by suicide, promoting effective recovery and reduced stigma.

Current situation

Cardiff and Vale University Health Board (CAVUHB) and Local Authorities commission services along with third sector and charitable organisations providing suicide prevention and self-harm and bereavement support services, as listed on DEWIS Cymru.

Interventions to support individuals, families and communities at risk of, and/or affected or bereaved by suicide and self-harm are in place however we must improve the co-ordination of the services available as well as provide equitable access across the geographical area.

Where we want to be

- Support service users and those who care for them to contribute constructively to planning their own care and for them to be aware of the resource available to them.
- Service providers encourage and enable appropriate and effective referral and transition between services to ensure those at risk are supported by the most appropriate service, including transition between child and adult services.
- Service providers update their delivery approach in line with evidence and best practice to deliver safe, compassionate, trauma-informed and person-centred care in response to specific needs of the service user (and those who care for them) with equitable coverage (by location and format) that is easy to access and where possible, consideration of the gender balance of support staff, across Cardiff and Vale of Glamorgan.
- Provide effective crisis support and bereavement support across Cardiff and Vale of Glamorgan.

Chilcott,Rachel
08/05/2025 16:26:52

This objective aligns to Objectives 2 and 8 requiring collaboration between services, to provide a joined-up approach for service users facilitating the individual journey between services where applicable.

Objective 5: To reduce the risks of self-harm in our population.

Current situation

Self-harm covers a vast range of behaviours, all of which carry risk. Consultation and engagement with stakeholders identified the need for self-harm to hold equal footing to suicide in this plan and whilst it is weaved through each objective, specific information is outlined here.

It is recognised that stereotypes exist with regards to what self-harm is and there is a need to amend this and broaden general understanding.

Whilst the focus is on preventing self-harm in the first place, the objective also focusses on ensuring individuals who self-harm, regardless of intent, are provided with compassionate, person-centred support with a focus on safety (self-harm management and harm reduction without risking normalising this behaviour). There are examples across the UK that we can learn from and apply in Cardiff and Vale on this. Recognising that individuals want to feel listened to, feel valid and be able to consider solutions and know how to access support into pathways is key. Moving individuals through services quickly to reduce risks of developing dependence on services also requires attention.

Where we want to be

- Recognise self-harm and effective approaches to prevent self-harm, prevent repeated self-harm behaviour (by responding well to individuals following first attempts) and help individuals to exit or reduce the harm/frequency (including effective wound management; safety planning).

- Improve access to mental health support and social support.
- Learn from self-harm prevention pathways across the UK and implement for Cardiff and Vale (involving those with lived experience to shape this); Focus on new approaches including self-care and wellbeing support, with a goal to focus support programmes tailored to the reasons rather than the actions (trauma-informed approach).
- Understand the methods of self-harm and how these differ by ages (for example between children and young people and adults).
- Clinical Safety Group (as part of the Mental Health Clinical Board) to assist exploring training needs of health staff supporting individuals who present with self-harm, including those working in non-mental health areas (e.g. Emergency Unit staff).
- Raise awareness of resources, self-help guides, websites and helplines available (such as Silver Cloud, STEPIAU website, PAPYRUS, Kooth, Head above the waves, Self-Harm UK) and extend the available resources to support those surrounding the individual (as well as the individual themselves).

Objective 6: Increase skills, awareness, knowledge and understanding of suicide and self-harm amongst the public, professionals and agencies who may come into contact with people at risk of suicide and self-harm by the delivery of effective training.

Current situation

Training is available across Cardiff and Vale of Glamorgan as part of the National Training Framework (Suicide Prevention and Self-Harm Cymru, 2024) and there is open-access to this training (online and in person). Training is also commissioned by CAVUHB and Local Authorities; plus, charitable organisations deliver training to relevant individuals/partners. This includes: basic awareness training (emphasising the importance of everyone being able to spot the signs linked to suicide and self-harm and ensuring they are equipped with relevant training to be able to offer support to those in need); general training; and specialist training (such as for those in Emergency Departments). Co-ordinating training would more effectively and strategically apply resources, enhance the offer and uptake of training to appropriate audiences to facilitate compassionate conversations, and connect the preventative approach to suicide and self-harm. This links with Objective 2, which supports a shift to prevention in communities facilitated by ensuring communities receive training and support to respond effectively, including crisis intervention. When individuals, and in particular males, increasingly seek help, this will ensure we are more skilled at recognising and responding accordingly.

Additionally, it is vital to update and revise training content to keep it up to date with the latest approaches. This will empower individuals to feel competent and capable of putting the training into practice.

Where we want to be

- Review who is commissioned to provide training across Cardiff and Vale of Glamorgan and for what purpose, to identify gaps in training provision and content (aligned to the national training framework).
- Promote the national training framework for suicide prevention and self-harm among professionals in contact with individuals at risk of suicide and self-harm. This includes medical AND non-medical professions as part of early prevention and intervention, as well as supporting those bereaved by suicide.
- Monitor who has completed training, to date, to identify gaps in potential workforce/individuals who would benefit from training.
- Provide support to health and social care professionals regularly engaging with individuals affected by suicide and self-harm to prevent burn out and de-sensitisation.

Chilcott,Rachel
08/05/2025 16:26:52

Objective 7: Responsible communication, media reporting, and social media use regarding self-harm, suicide and suicidal behaviour.

Current situation

We strive for the population of Cardiff and Vale of Glamorgan to know how to look after their physical and mental health and wellbeing, and where to turn to for support with their mental health (for themselves and others) at intervention and crisis point. It is essential to deliver communication campaigns with careful, consistent messaging. Raising awareness of positive mental health and wellbeing and of suicide prevention and self-harm will build resilience among individuals and communities to deal with life situations; allow individuals to be clear on what support services are available and when it is suitable/appropriate to access; as well as feeling confident to have compassionate conversations with others.

Due to this being a sensitive topic, Cardiff and Vale of Glamorgan communications must align to national and UK action, which also strives to make it more acceptable to talk about these topics. There is an advocacy role to Welsh Government and Public Health Wales requesting to hold partners and the media to account for content shared (for example on social media) and active monitoring of mis-information.

Where we want to be

- Deliver a communications plan (aligned to national content) that is culturally-aware and delivered in a range of formats and languages, to raise awareness of suicide prevention and self-harm to target audiences and encourage compassionate conversations on these topics.
- Promote local support services that are available to individuals and families, to facilitate access to and the use of the most appropriate source of support at the right time among potential service users. Specifically, promote the '111 press 2' service as a recognisable source of support at crisis point.
- Media partners are required to consistently apply 'Responsible reporting in the media guidelines', as produced by the Samaritans.

Chilcott, Rachel
08/05/2025 16:26:52

Objective 8: To apply co-production principles in all that we do to prevent suicide and self-harm.

Current situation

Echoing the call for cross-sectional action in Objective 2, there are excellent examples of working in co-production such as between Local Authorities and the third sector to co-produce local support services. There remains inconsistency in funding as an on-going challenge for continuous service planning/development which requires attention.

Whilst data insights are valuable, it was evident during the consultation stages of developing this plan that there should be a greater focus on working with those with lived experience to inform service planning and delivery. A range of voices from across Cardiff and Vale of Glamorgan, including the groups at particular high-risk, must be listened to.

Where we want to be

Previous objectives have discussed the need for support services to update their delivery approach (Objective 4); provide effective crisis support and bereavement support (Objective 4); implement self-harm prevention pathway (Objective 5) and resources. All are required to do so by identifying and engaging with those most vulnerable and tailoring their support to their specific needs.

- Build trust with local communities that we could engage more fully with, that would benefit from awareness, information and support on suicide prevention and self-harm (those in most disadvantaged communities, LGBTQ+ communities, ethnic minority communities, neuro-diverse populations).
- Develop support services and resources in all aspects of lived experience engagement and inclusion, from opinion seeking through to fully coproduced works.
- Consult and connect with identified lived experience contacts to establish an engaged, and growing, population of people with lived experience who can, alongside service providers, offer insights into gaps and good practice within support services through a variety of means, including workshops and surveys.

Successes from the previous strategy

Examples of good practice in Cardiff and the Vale of Glamorgan

The development of a mental health admission proforma was created to reduce the need for children and young people to repeatedly share their distressing stories, which can be upsetting and traumatic. Previously, children and young people presenting through the Paediatrics Emergency Department (ED), had to explain their mental health crisis multiple times to different professionals before seeing the crisis team. To address this, various groups such as the Medical team and Nurse Practitioners audited notes, gathered information and feedback from children and young people then developed a mental health proforma to improve the patient journey. The proforma follows the patient through from Admission in Paediatrics ED to Discharge by the crisis team with a safety plan. This is based on work already developed by other hospitals that was adapted to meet service and patient needs within our area. Teaching and development of use of the proforma is on-going and it has educated staff on the assessment information that is helpful when assessing children and young people admitted in mental health crisis.

"The document allows a multi-disciplinary team approach to care to provide the best outcome from admission to discharge of such children and young people".

Mental Health Clinical Nurse Specialist for Acute Child Health, Cardiff.

The **Jacob Abraham Foundation** is a charity established in Jacob's memory dedicated to raising awareness and reducing stigma around mental health, as well as providing support to adults in South Wales that experience suicidal thoughts and behaviours. The Foundation attended our Suicide Prevention and Self-harm engagement workshop in October 2024 to ensure those with lived experience have a voice in shaping the next strategic plan.

Chilcott, Rachel
08/05/2025 16:26:52

The Foundation follows three objectives:

- Intervention: providing 1-2-1 counselling for anybody who is experiencing suicide thoughts or attempts; educate communities by signposting to local support.
- Prevention: providing free Suicide Awareness Brief Intervention training and workshops for young people (40-minute youth workshops in after-school clubs and colleges; 8-week wellbeing and mindfulness programme).
- Postvention: providing support for those affected by suicide (immediate support, advice and monthly groups).

A client described the service:
"Thank you so much for letting me talk in a safe, non-judgemental environment. I couldn't and didn't know how to help myself. I didn't know what to do. Your actions have no doubt saved me".

What can we learn from elsewhere?

Finland in the late 20th century was a country with particularly high rates of death by suicide with over 30 deaths per 100 citizens. Now the rate has decreased considerably, to 13 deaths per 100,000. This may be due to several factors such as increased education in the recognition in depression, and the new generation of antidepressants, as well as improvements in outpatient care and the reporting on deaths by suicide in a neutral way within the media. The Suicide Prevention Strategy in Finland involves several key components:

- **Mental health integration** into primary care services to ensure early identification of individuals at risk.
- **Public awareness campaigns** to reduce stigma and increase understanding of mental health issues.
- **Training professionals** in suicide risk assessment and intervention.
- **Collaboration** across sectors (such as healthcare, social services, education) to create a supportive environment.

We will continue to learn from how other countries are working to address suicide and self-harm and apply this to local action.

Delivering the strategic plan: year 1 delivery plan (2025-26)

	Planned action	Outcome measure	Lead	Timescale
Objective 1 - Establish a robust evidence base for suicide prevention and self-harm in Wales, drawing on a range of data, research and information; and develop robust infrastructure to facilitate the analysis and sharing of information to focus resources, shape policy and drive action.				
1.1	Attend the following meetings to provide updates on Cardiff and Vale perspective, to understand local situation, trends and to inform local action: a. monthly South East Wales RTSSS operational meetings b. quarterly South East Wales regional forum Feedback information from the above meetings to the Steering group to apply information gained (e.g. relating to trends) and to inform local action; refresh delivery plans in response to latest information/content from these meetings	Attendance at monthly and quarterly meetings; Steering group minutes; delivery plan refreshed	a. NHS Executive Suicide Prevention and Self-Harm (SPSH) Regional Lead b. Cardiff and Vale University Health Board (CAVUHB) Public Health Team Lead	31 March 2026 (and through the life of the plan)
1.2	Hold quarterly Steering Group meetings (for statutory services) to monitor trends emerging from data, identify and implement mitigation actions (to include missed opportunities to intervene); record and update delivery plan accordingly	Attendance of monthly meetings; Delivery plan updated	Steering group Chair and members	31 March 2026 (and through the life of the plan)
1.3	Establish an Expert Advisory Group (to include third sector partners) to ensure all partners are actively contributing to this agenda	Attendance of monthly meetings; Minutes of meetings	Steering group Chair and members	31 March 2026
1.4	Circulate clear communication (video) to upskill key partners on suicide prevention and self-harm data to increase understanding of the caveats to local level data and interpretation	Communications/Video circulated to key partners	NHS Executive SPSH Regional Lead	30 June 2025
1.5	Hold a workshop with multi-agency partners, local service providers and those with lived experience to: a. review the patient journey and how services are currently collecting and recording data within their organisation; b. explore consistency in data coding and protocols; c. share learning from NHS Emergency Departments protocols on how information/data is managed and coded throughout the patient experience (from admission to discharge) to improve overall patient experience; d. discuss the needs for and development of a 'Mental Health passport' as a resource held by the individual to document the management of their wellbeing, safety plan, access points should they require it	Workshop held and summary report prepared outlining best practice and next steps	Workshop – facilitated by CAVUHB PHT Involvement from: NHS Executive SPSH Regional Lead; CAVUHB Public Health Lead, Police, Mental Health Clinical Board, Emergency Department, Psychology, Cardiff University Research Lead	31 March 2026
1.6	Support and engage with the national Suicide Prevention and Self Harm Research Centre and actively look for opportunities to engage in on-going research	Research project plan and research findings shared with Steering Group members	Research and Development Lead, Mental Health Clinical Board	31 March 2026 (and through the life of the plan)
1.7	Study the Self Harm data collection at Emergency Departments in Cardiff and Vale UHB hospitals and use data to inform action, as part of a dissertation project underway	Research project plan and research findings shared with Steering Group members	CAVUHB PHT Lead	31 March 2026 Timescale
1.8	Develop an all-age Rapid Response Group (RRG), as required, to respond to local incidents, to compliment National guidance	Outcome measure RRG formed and process in place, minutes of meetings available	Mental Health Lead South Wales Police, support by NHS Executive Regional Lead	31 March 2026

Chilcott,Daniel
08/05/2025 16:26:52

	Planned action	Outcome measure	Lead	Timescale
Objective 2 - Co-ordinate cross-Government and cross-sectoral action which collectively tackles the drivers of suicide and reduces access to means of suicide.				
2.1	Review the steering group membership to ensure wide reaching and cross-organisational representation	Terms of Reference; Core Membership updated	Steering group Chair and members	30 September 2025
2.2	Advocate for equitable public health input to the suicide prevention and self-harm agenda across Wales to ensure this remains a national public health priority and for consistency in the approaches applies across Wales (regardless of geography)	Record of requests made to Welsh Government/Public Health Wales	Steering group Chair and members	31 March 2026
2.3	Attend SE Wales regional meetings to learn from and share best practice (consider wider learning opportunities from UK and internationally such as Finland) Feedback from regional/national meetings to the Steering group and Clinical Boards; explore how to share best practice to wider networks to enable all partners to benefit from this information	Attendance at SE Wales regional meetings Content of Steering Group meetings includes Wales/UK learning	Steering group representative	31 March 2026 (and through the life of the plan)
2.4	Share best practice in relation to suicide prevention and self-harm with Steering Group for them to consider how this will be incorporated into local practice, including the national guidance/SBAR protocol on reducing access to means, when available	Evidence summary provided to Steering group	CAVUHB Public Health Team	31 December 2025 (and through the life of the plan)
2.5	Advocate for this strategic plan to be aligned to wider plans, including: - Mental Health Clinical Board IMTP (Integrated Medium-Term Plan) - Local Authority Corporate plans - Safeguarding Board plan Monitor the approach taken at national level for calls to merge the Mental Health and Wellbeing Strategy with the National Suicide Prevention and Self Harm Strategy and consider how locally these strategies align	Strategic plan referenced in wider partnership plans	Steering Group Chair and members	31 March 2026 (and through the life of the plan)
2.6	Work with and support partner organisations and agencies in the development of their own strategies, to ensure they align to this overarching strategic plan, including voluntary sector plans Act as the overarching lead to support the partner organisations and agencies to implement their local strategies as a co-ordination role	Suicide prevention and self-harm is referenced and actions are included in partner's strategies and action plans	NHS Executive SPSH Regional Lead	31 March 2026 (and through the life of the plan)
2.7	Mental Health Clinical Board to share with Steering Group plans for improving information sharing with other services that provide mental health support to those who have identified history or are at risk of suicide and self-harm (e.g. prison service)	Plans provided to Steering group by Clinical Board Recommendations provided to other services by Clinical Board	Mental Health Clinical Board Lead	31 December 2025
2.8	Host an annual workshop to bring together partners, those with lived experience and service providers, local communities to share examples of best practice and local insight and progress made on this agenda and to tackle drivers	Workshop held and findings shared to Steering Group members	Steering group Chair and members	31 March 2026 (and through the life of the plan)
2.9	Engage with BTP (British Transport Police), South Wales Police (Specialist crisis negotiators), Fire and Rescue Services and pro-actively work with them to identify locations of concern and put effective measures in place	Regular communications and contact established	Steering Group Chair and members, British Transport Police, South Wales Police, Fire and Rescue Service	31 March 2026 (and through the life of the plan)
2.10	Apply national guidance, when available, on Locations of Concern to review how Cardiff and Vale manage locations of concern	Update report shared to Steering Group	NHS Executive SPSH Regional Lead; CAVUHB Public Health Team	31 March 2026

Chilcott, Rachel
08/05/2025 16:26:52

	Planned action	Outcome measure	Lead	Timescale
Objective 3 – Deliver rapid and impactful prevention, intervention, and support to those groups in society who are the most vulnerable to suicide and self-harm through the settings with which they are most engaged.				
3.1	Map and identify priority groups that would benefit from prevention education and messaging; identify the organisations and settings used by these groups, as identified by the RTSSS insights as they emerge (rapid prevention), using trauma informed ways to connect with people. Link with staff working at the settings identified to receive training in suicide prevention and self-harm (See Objective 6 re: training), for example Cardiff City Football Club, community development	Mapping exercise conducted and report available Training analysis report shared with Steering Group members	CAVUHB Public Health Team; Cardiff and Vale Mental Health Forum	31 March 2026 (and through the life of the plan)
3.2	Encourage community organisations to establish links with local mental health support services such as Kooth, to signpost/refer individuals for support Establish links with Job Centres and Citizen Advice Bureau in response to emerging data showing trends among those unemployed Establish links with Cardiff City Football Club Community Foundation to develop pathways for referring at-risk individuals to local mental health services	Progress reports and updates shared with Steering Group and support services	Steering Group Chair and members; Department for Work and Pensions (Job Centres); Cardiff City Football Club Community Foundation	31 March 2026
3.3	Explore the potential to integrate all suicide prevention and self-harm services available across Cardiff and Vale (such as those commissioned by the Health Board and Local Authorities and delivered by charitable organisations) in co-production using insight from lived experience/ service users to shape the delivery of each service and ensure each service is fit for purpose	Minutes from exploration meeting Existing service protocols updated to reflect findings Statutory services guidelines in place	Co-production Lead, Mental Health Clinical Board supported by NHS Executive Regional Lead	31 March 2026 (and through the life of the plan)
3.4	Use Expert Advisory Group to conduct mapping and scoping exercise of current provision, establish criteria for service delivery, analysis of referral activity to provide an overview of the service provision offer Advocate for all organisations to work towards quality standards (on a voluntary basis) to ensure high quality service activity is in place	Mapping and scoping exercise report	Expert Advisory Group (when established)	31 March 2026 (and through the life of the plan)
3.5	Link in with Eating Disorder services (local and national provision) and programme of work led by NHS Executive to keep up to date on action Link with the new Mental Health Strategy to ensure cross-reference action between this strategic plan and the work of the Mental Health Strategy	Record of request made to Eating Disorder services from NHS Executive Regional Lead Reference to this strategic plan in Mental Health Strategy and action plans	NHS Executive SPSH Regional Lead Mental Health Clinical Board Steering Group Chair/ members	31 March 2026
3.6	Mental Health Clinical Board and Children and Women Clinical Board to share with Steering group the plans for improving the transition between children to adult mental health services	Plans provided to Steering group by Clinical Boards and confirmation of specific actions to address this issue	Mental Health Clinical Board Lead; Children and Women Clinical Board	30 September 2025
3.7	Postvention – NALS (National Advisory and Liaison Service) support is in place and accessible for anyone bereaved by suicide or suspected suicide (as part of all Wales Welsh Government funded service) Support the national exercise of mapping and scoping all suicide bereavement services in Wales, and ensure findings from this exercise are applied to local practice	Quarterly reports produced by Expert Advisory Group and shared with Steering Group	NHS Regional Executive Lead Steering Group members	31 March 2026
3.8	Learn from examples in Northumbria to the 'One is too many' approach taken to reduce deaths by suicide among military veterans	Learning shared with Steering group and local partners	Veterans NHS Wales	31 March 2026

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08/05/2025 16:00:5

	Planned action	Outcome measure	Lead	Timescale
Objective 4 - Ensure an appropriate, compassionate and person – centred response is offered to all those who self-harm, have suicidal thoughts, or who have been affected or bereaved by suicide, promoting effective recovery and reduced stigma.				
4.1	Map provision of local support services at the point of intervention for suicide and self-harm and identify gaps in provision by geography, accessibility (e.g. by high risk groups such as neurodivergence, refugees and asylum seekers, drug and alcohol; at risk groups that may not come to our attention; by needs, e.g. language, format); engaging with service providers and service users to ensure adaptations to local provision is made Review the scope of the support service provided at crisis point to consider the support offer for the family around the individual	Mapping exercise and findings report produced	CAVUHB Public Health Team	31 March 2026
4.2	Explore and gather insights from youth outreach and disability inclusion programmes to identify barriers to accessing mental health support for young people (for example via Community Forums working with young people engaged in sport) to aim to improve mental health service accessibility	Insights gathered and reported to the Steering Group	Cardiff City Football Club Community Foundation	March 2026
4.3	Promotion and use of the National Advisory and Liaison Service (NALS) Cymru to ensure everyone across Cardiff and Vale are aware of and can access appropriate support if they have been affected by suicide or suspected suicide Promote local services such as The Hangout, the adult sanctuary, 111 Press 2 Service providers to ensure service is being used appropriately, monitoring appropriateness of signposting into this support	Bereavement support pathway promoted as part of communications campaign Communications campaign analytics Feedback report from local service providers to Steering Group	CAVUHB Communications Lead Local service providers; Platfform	31 March 2026
4.4	Continually develop local protocols, using evidence-based practice and NICE guidance and including insight gained (e.g. from those with lived experience and service providers) and implement these protocols into local practice for Health Board and Local Authority commissioned suicide prevention and self-harm services	Protocols and guidance developed	Local service providers	31 March 2026
Objective 5 - To reduce the risks of self-harm in our population.				
5.1	Consider new approaches for tackling self-harm, learning from examples across the UK Work in collaboration to improve self-harm pathways and access across Cardiff and Vale	Approaches analysed and presented to the Steering Group	Public Health Team, Cardiff and Vale UHB	31 March 2026
5.2	Understand existing mental health services that support Self-Harm: Conduct an exercise to understand what support and provision is available and what pathways look like, identify gaps and ways to address self-harm and ensure appropriate support (for all ages) To consider: effective wound care management; safety planning and risk assessment	Report produced and shared with Steering Group	Mental Health Clinical Board; Dermatology Department	31 March 2026
5.3	Explore training needs of health staff supporting individuals who present with self-harm, including those working in non-mental health areas (e.g. Emergency Unit staff)	Training options analysed and recommendations made to the Leads for each clinical area	Clinical Safety Group, Mental Health Clinical Board	31 March 2026
5.4	Explore the role of 'peer support workers' as a local approach	Approaches analysed and presented to the Steering Group	Mental Health Clinical Board	31 March 2026
5.5	Raise awareness of resources available to support individuals and their families/support network on self-harm, as part of Communications approach	Resources available and promoted as part of communications plan	Communications Lead, CAVUHB	31 March 2026

Chilcott,Rachel
08/05/2025 16:25:52

	Planned action	Outcome measure	Lead	Timescale
Objective 6 – Increase skills, awareness, knowledge and understanding of suicide and self-harm amongst the public, professionals and agencies who may come into contact with people at risk of suicide and self-harm.				
6.1	Map the suicide prevention and self-harm training that has been delivered in Cardiff and Vale in the past 12 months with a view to: - Identify organisations delivering training and providing funding for training - identify the organisations that have completed training - explore any gaps in uptake of the training offer by organisation/professional groups - use findings to promote uptake of training to any organisations currently under-represented	Mapping exercise completed and recommendations shared with the Steering group	CAVUHB Public Health Team	30 September 2025
6.2	Review who is commissioned to provide training across Cardiff and Vale of Glamorgan and for what purpose, to identify gaps in training provision and content (aligned to national training framework)	Review completed and recommendations shared with the Steering Group	CAVUHB Public Health Team with support from national Public Health Wales and NHS Executive Leads	31 March 2026
6.3	Strengthen the evaluation methods of available training to allow for analysis of: - who has been trained (job title/organisation) - the impact the training has had to knowledge and skill level of NHS participants, and where possible to evaluate of wider participants (non-NHS) Advocate for training providers to include evaluation methods of training and to share analysis with the Steering Group; Establish agreements with training organisations to report into the Steering Group with anonymous post-course evaluation feedback to ensure quality training is being provided	Training analysis report circulated to Steering Group on a quarterly basis Requests made to training organisations and evaluation reports provided as a result	Public Health Wales (national) Steering Group Chair and members	30 June 2025
6.4	Apply the findings from the national training needs analysis (conducted in 2022/23 by Public Health Wales) to Cardiff and Vale, including roll out of training: a. 'Basic suicide awareness module' promoted to all (Health colleagues including Occupational Health roles via ESR; statutory organisations via national training hub) b. 'Suicide prevention training among those bereaved by suicide' promoted among those partners working with individuals bereaved by suicide c. 'Train the trainer module' promoted to Mental Health Clinical Board d. Self-Harm e-learning promoted to all (due to launch 01/03/25)	List of available training across Cardiff and Vale reported to the Steering Group	Training co-ordinator aligned to NHS Executive CAVUHB Communications Lead	30 June 2025
6.5	Deliver appropriate diversity and mental health training in line with the National Training Framework, with a focus on increasing the training delivered among: - Organisations that priority groups are in contact with, once identified - Organisations supporting diverse communities - Organisations supporting minority ethnic communities Explore funding opportunities to ensure voluntary sector involvement in the breadth of training available	Training analysis report circulated to Steering Group on a quarterly basis	Local training providers; Department for Work and Pensions (Job Centre staff); Steering Group	31 March 2026 (and through the life of the plan)

Chilcott,Rachel
08/05/2025 16:26:52

	Planned action	Outcome measure	Lead	Timescale
6.6	Distribute the Education Wales guidance 'Responding to issues of self-harm and thoughts of suicide in young people' and National Training Framework to staff working in educational settings, aligned to the Healthy Schools Scheme (Whole System Approach) and University Mental Health Partnership; extend this to Adult Education colleges; Those providing services to those not in education, employment or training (NEETS) including voluntary organisations	Healthy Schools Leads and Interim Director of Student Life to provide details of specific statistics/case studies to the Steering Group	(Healthy Schools Leads); Interim Director of Student Life (Cardiff University)	31 March 2026
6.7	Advocate for national resources on suicide prevention and self-harm and for materials to be available in accessible formats, languages, including: - resources for parents outlining advice for supporting a child who is self-harming	Resources developed and available for local use	Steering Group Chair and members	31 December 2025
Objective 7 - Responsible communication, media reporting, and social media use regarding self-harm, suicide and suicidal behaviour.				
7.1	Develop a communications plan (aligned to national activity) to: - raise awareness of available training for health professionals, non-health professionals (workplaces), public, community groups and leaders, educational setting staff and voluntary sector (Value in the Vale to support promotion of training) - normalise talking about mental health, suicide and self-harm, as a preventative action - raise awareness of support available to the public, with a focus on when and how to access the relevant support at the most appropriate time - promote the distribution of national and local public awareness mental health campaigns - circulate the Regional Safeguarding Board 'Suicide Risk and Guidance' document to Council staff who see or speak with the public on a regular basis on how to manage a risk of suicide when speaking to an individual	Communications plan developed and implemented	Communications Lead, CAVUHB; Value in the Vale	30 June 2025
7.2	Deliver a communications campaign aiming to increase the awareness and knowledge of the 111 press 2 service and the options available for someone needing support (at prevention, intervention, crisis, bereavement stages), targeting different sources of social media and offline content	Communications campaign delivered Statistics/analytics of campaign to be provided to the Steering group	Communications Lead, CAVUHB	30 December 2025
7.3	Raise awareness of Self Harm awareness day (01/03/26) Promote the ESR module on self-harm among relevant partners who will benefit from receiving this training Promote services that are available to support those affected by self-harm Link with NHS Executive SPSH Communications Lead to align local communications activity with national campaigns and events	Analytics from communications campaigns	Communications Lead, CAVUHB	31 March 2026
7.4	Share information to parents about the training and resources available to promote positive mental health and wellbeing, suicide prevention and self-harm using existing communication channels from educational settings to parents	Number of schools and universities receiving information from Healthy Schools Leads/University Mental Health Partnership	Healthy Schools Leads; Interim Director of Student Life (Cardiff University)	31 March 2026
7.5	Gather individual stories from those affected by suicide and self-harm/lived experience as part of campaign content	Campaign content includes case studies to be provided to the Steering group	Communications Lead	30 June 2025
7.6	Advocate to Welsh Government for the role of legislation (as well as guidance) for responsible reporting by the media on the topic of suicide and self-harm, to include: - monitoring misinformation and promoting online safety	Record of requests made to Welsh Government by the Steering group	Steering group Chair and members	31 March 2026

	Planned action	Outcome measure	Lead	Timescale
Objective 8 - To apply co-production principles in all that we do to prevent suicide and self-harm.				
8.1	Consult and connect with identified lived experience contacts to establish a population of people with lived experience, alongside service providers, to gather insight into gaps and good practice within support services by conducting workshops and surveys. To include identifying and engaging with those most vulnerable – i.e. those in most deprived communities, ethnic minority populations, LGBTQ+ and social housing.	Consultation activity conducted (e.g. workshop held) Evaluation report from surveys and insight gathering exercises Record of engagement events held and summary report on findings	Lived Experience Manager	31 March 2026

References

Cardiff and Vale University Health Board. 2021a. Cardiff and Vale Suicide and Self-Harm Prevention Strategy 2021-2024. Available at: cavuhb.nhs.wales/files/public-health/key-publications/ssh-strategy/the-cardiff-and-vale-of-glamorgan-suicide-and-self-harm-prevention-strategy-2021-24/. Accessed on: 03 December 2024.

Cardiff and Vale University Health Board. 2021b. Cardiff and Vale Suicide and Self-Harm Prevention Strategy 2021-2024 supplementary material. Available at: cavuhb.nhs.wales/files/public-health/key-publications/ssh-strategy/the-cardiff-and-vale-of-glamorgan-suicide-and-self-harm-prevention-strategy-2021-24-supplementary-information/. Accessed on: 03 December 2024.

DEWIS Cymru. Available at: Dewis.wales. Accessed on: 03 December 2024.

NICE, 2022. Self-Harm: Assessment, Management and Preventing Recurrence. Available at: Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE). Accessed on: 03 December 2024.

Office for National Statistics. 2024a. Suicides in England and Wales - Office for National Statistics). Accessed on: 11 December 2024.

Office for National Statistics, 2024b. Suicides in England and Wales by local authority - Office for National Statistics. Accessed on: 11 December 2024.

Public Health Wales. 2024. Annual Report: Deaths by suspected suicide 2023-24 - Public Health Wales. Accessed on: 11 December 2024.

Public Health Wales Observatory. 2024. Self-harm admissions data (using mid-year population estimates (MYE), Office for National Statistics (ONS), Patient Episode Dataset Wales (PEDW) (DHCW). Cardiff: Public Health Wales Observatory.

Regional Partnership Board. (2022). Cardiff and Vale of Glamorgan Population Needs Assessment 2022-2027. Available at: cavuhb.nhs.wales/files/population-needs-assessment-2022-27/. Accessed on: 03 December 2024.

Suicide Prevention and Self-Harm Cymru. 2024. National Training Framework Hub. Accessed on: 11 December 2024.

Stats Wales. 2024. Population estimates by local authority and age. Accessed on: 20 December 2024.

World Health Organisation (2024). Factsheet: Suicide. Available at: Suicide. Accessed on: 03 December 2024.

World Health Organisation (2025). Age-standardised suicide rates per 100,00 population. Available at: Age-standardized suicide rates (per 100 000 population) Accessed on: 27 February 2025.

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Sources of information

A range of organisations, data sets and resources have been mentioned throughout this strategic plan and information is provided below to explain each as well as the link to access more information online, if required.

National Institute for Health and Clinical Excellence, also referred to as NICE, helps practitioners and commissioners get the best care to people by producing useful and usable guidance for health and care practitioners, such as the 'Self Harm: assessment, management and preventing recurrence' guidance for children, young people and adults who have self-harmed.

Office for National Statistics (ONS) is the UK independent producer of official statistics and hold responsibility for collecting and publishing statistics related to the economy, population and society at national, regional and local levels. The Office for National Statistics reports annually on the rates of registered death by suicide, using the date of registration (rather than date of death) following an inquest by a Coroner. The Office for National Statistics data apply a rate per 100,000 people when presenting statistics, called the European Age Standardised Rate (EASR) which is 'age standardised' to allow better comparison between areas.

Public Health Wales is one of the 11 organisations which makes up NHS Wales and is the national public health agency in Wales. Public Health Wales works to protect and improve health and wellbeing and reduce health inequalities for the people in Wales. Public Health Wales have established the Real Time Suspected Suicide Surveillance (RTSSS) since April 2022 to improve the quality of data and intelligence to inform prevention work. It collects information about deaths by suspected suicide. Data includes notifications received from the four Welsh Police Forces and British Transport Police (BTP) as well as additional information from NHS Executive, Welsh Clinical Portal system and Network Rail.

Chilcott, Rachel
08/05/2025 16:26:52

The Suicide Prevention and Self-Harm Cymru Training Hub is a platform for anyone looking for training and development opportunities tat can help them, their communities, or their workforces, to develop their awareness, understanding and skills in relation to the management and prevention of suicide and self-harm.

The Well Being of Future Generations (Wales) Act is about improving the social, economic, environmental and cultural wellbeing of Wales. The Act gives a legally-binding common purpose (7 wellbeing goals) for national government, local government, local health boards and other specified public bodies and details the way in which specified bodies must work, and work together to improve the wellbeing of Wales. It will make the public bodies listed in the Act think more about the long-term, work better with people and communities and each other, look to prevent problems and take a more joined-up approach.

The World Health Organisation, sometimes shortened to WHO, is the United Nations agency that connects nations, partners and people to promote health, keep the world safe and serve the vulnerable, so that everyone, everywhere can attain the highest level of health.

Appendix A

The RTSSS annual report (Public Health Wales, 2024) has identified the following key points across Wales.

Deaths by suspected suicide by Health Board

The rate of suspected suicides was 10.3 per 100,000 for Cardiff and Vale University Health Board which was not statistically significantly different from the all-Wales rate (12.4 per 100,000) although it was statistically significantly lower than the rate for Hywel Dda University Health Board.

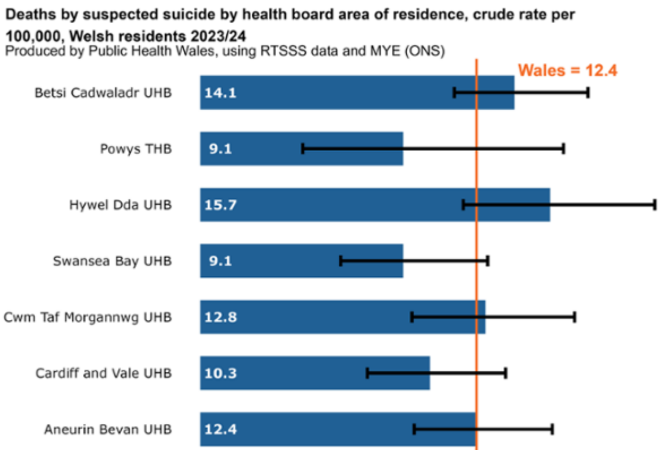


Figure 7: Deaths by suspected suicide by Health Board area, 2023/24.

The rates referred to are crude rates as they are most suitable to inform action, which is one of the aims of the RTSSS. A crude rate is the number of suspected suicides occurring in a population over a specific time period, expressed as the number of deaths per 100,000 of the population. Both the numerator (number of events) and denominator (mid-year population estimate) are based on the same geographical area and should be based on the same time period, however, 2020 mid-year estimates were used as these were the latest available for lower super output areas.

Chilcott,Rachel
08/05/2025 16:26:52

Areas of deprivation

The rate of suspected suicides in 2023/24 was statistically significantly higher in residents in the most deprived areas compared with the all-Wales rate and with the rate in the next most deprived and least deprived areas. Whilst this is all-Wales data, from the population needs assessment for Cardiff and Vale, we are aware that there are areas of Cardiff and Vale among the highest deprived areas in Wales and therefore can assume the above trend is reflected for Cardiff and Vale suspected deaths by suicide.

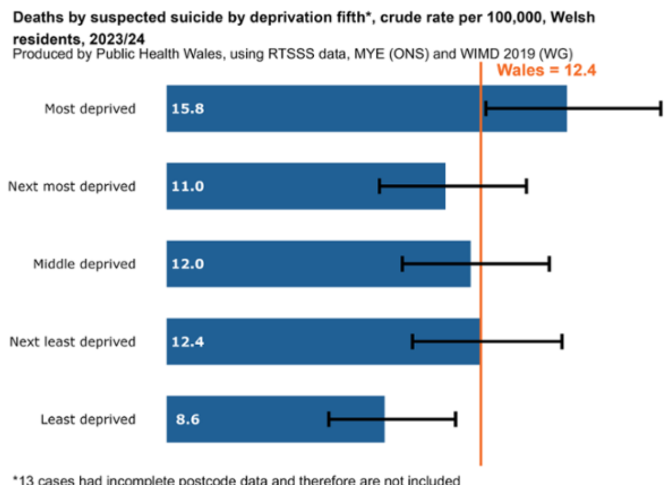


Figure 8: Deaths by suspected suicide by deprivation fifth, 2023/24, across Wales.

Gender and Age

Males accounted for 76% of suspected suicides, which is similar to the rates in 2022/23 and therefore men continue to be a high priority area for continued action.

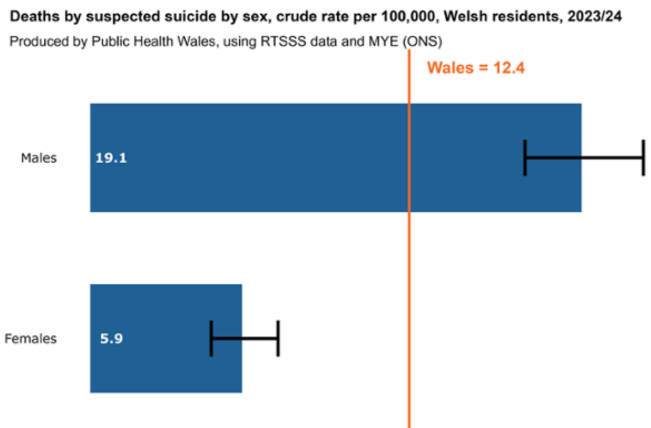


Figure 9: Deaths by suspected suicide by sex across Wales, 2023/24.

The highest rate of suspected suicides occurred in males aged 35-44 years (35.6 per 100,000, 95% CI 27.3-45.5 per 100,000), followed by males aged 45-54 years (24.6 per 100,000 95% CI 18.2-32.5 per 100,000). The rates were higher in males compared to females in all age groups. The highest rates in females was among the 35-44 years age group (12.1 per 100,000, 95% CI 7.6-18.3 per 100,000) followed by the 25-34 years age group (9.5 per 100,000, 5.7-14.9 per 100,000).

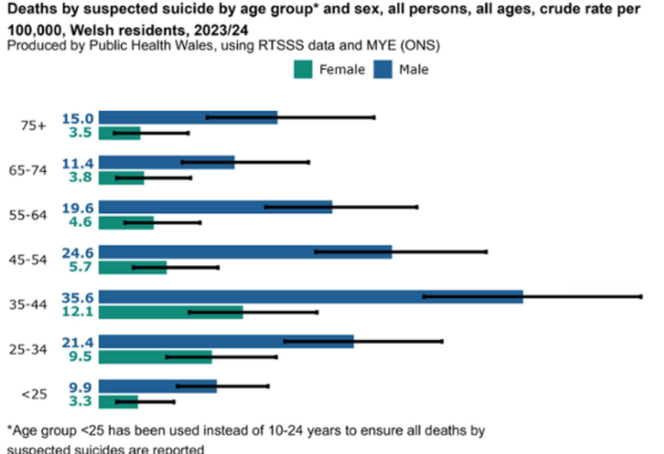
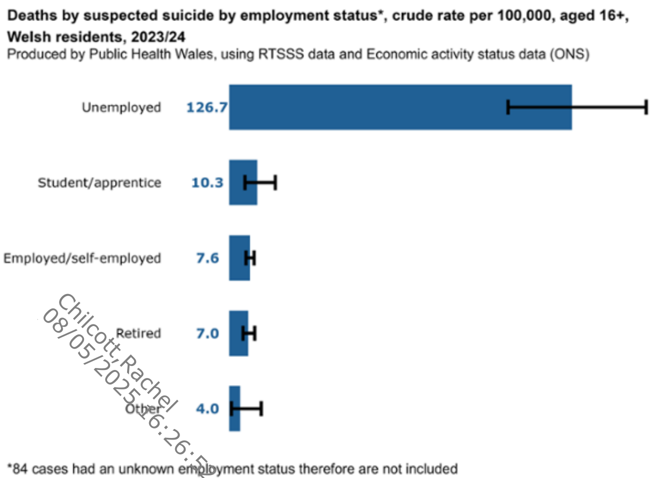


Figure 10: Deaths by suspected suicide by age group and sex across Wales, 2023/24.

Employment status

The highest rate of suspected suicide was in people where employment status was recorded as unemployed (126.7 per 100,000, 95% CI 103.1-154.2 per 100,000). This was at least 12 times higher than in any other employment status group.



Chilcott, Rachel
08/05/2025 16:26:5

Figure 11: Deaths by suspected suicide by employment status, across Wales, 2023/24.

Gaps in supporting people across the population

Population groups facing higher risks of suicide or self-harm have been identified in the previous strategy supplementary material document (CAVUHB, 2021b) as:

- LGBTQ+
- Black, Asian and minority ethnic people living in Cardiff and Vale
- Asylum seekers and refugees
- Those with diagnosed mental health difficulties
- Those experiencing bereavement due to suicide

There are also some themes around risk and vulnerability that cut across general population and vulnerable/at risk groups:

- The role of carers
- Substance misuse
- Unemployment and risks by occupation.

Since, RTSSS data (Public Health Wales, 2024) has identified and established emerging trends.

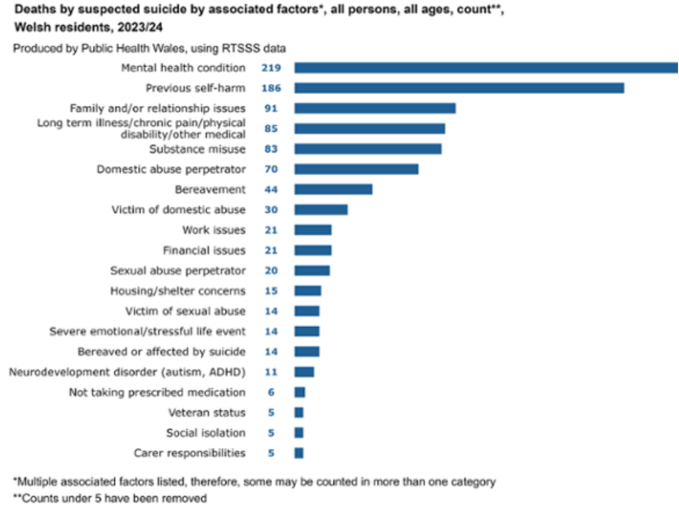


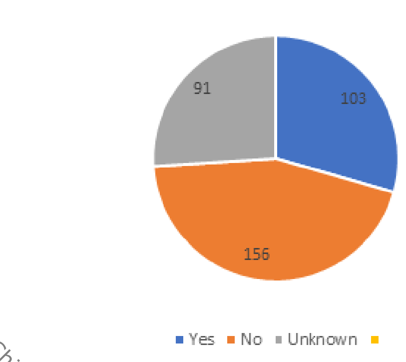
Figure 12: Deaths by suspected suicide by associated factors, across Wales, 2023/24

The most common associated factors among people who died from suspected suicide across Wales (Figure 6, n=350) (identified from the RTSSS annual report,

Public Health Wales, 2024) are outlined below.

- A mental health condition, which was reported in 63% who died from suspected suicide. This has increased since 2022/23 (170/359, 47%) which Public Health Wales suggest could be a real increase in people who were reported to have had a mental health condition, there could be better reporting, or it could be due to improved cross checking of data with other sources.
- A history of previous self-harm, which was reported in 53% (in 2022/23 it was 49%).
- Family and/or relationship issues were reported in 26% (in 2022/23 it was 19%).
- Those known to mental health services (in the past 6 months prior to death), which was reported in 29% of deaths by suspected suicide. Forty five percent were not known to mental health services and for 26%, it was unknown whether they were known to mental health services so it is possible that the percentage of people who were known to mental health services was underestimated or overestimated. A similar figure was reported in 2022/23. From these data you cannot conclude what is meant by 'known to mental health services' There is not yet enough information to determine how people were known to services.

Deaths by suspected suicide by whether known to mental health services (in the past 6 months prior to death), (count = 350)



Chilcott, Rachel
08/05/2025 16:26:52

Figure 13: Deaths by suspected suicide by whether known to Mental Health Services, by count, across Wales in 2023/24.

- Those known to the Police (at any point in their lives prior to their death), which was reported in 65%. The most common reason for being known to the police as for being suspected/convicted of a crime (37%). This was higher in 2022/23 (74%). From these data you cannot conclude what the risk of suicide was in someone who was suspected/convicted of a crime, was a victim or witness of a crime, or was a vulnerable person, as denominator data were not available.

Deaths by suspected suicide by reasons previously known to police, all persons, all ages, count*, Welsh residents, 2023/24
Produced by Public Health Wales, using RTSSS data

Reason	Count
Suspected/convicted of a crime	129
Victim of a crime	57
Vulnerable person	55
Witness of crime	13
Other	43

*Some may be counted in more than one category

Figure 14: Deaths by suspected suicide by reasons previously known to police, across Wales, 2023.24

From these data you cannot conclude what the risk of suicide was in someone who had a mental health condition or history of previous self-harm, or any other associated factor, as denominator data were not available (which is the number of people in the whole population who have each associated factor). Additionally, it is important to acknowledge that individuals may be counted in more than one of the factors listed above and there are multiple contributing factors (not a single risk factor) associated with a suspected suicide.

Minutes of the Medicine Clinical Board Quality, Safety & Experience Committee Meeting Held on 19 March 2025 14:30 – 16:00, Via MS Teams

Present:	
Katja Empson	Consultant/ Clinical Board Director (Chair)
Jane Murphy	Director of Nursing
Barbara Davies	Deputy Director of Nursing
Nicholas Denny	Organisational Learning Facilitator, Mortality Lead
Aneurin Buttress	Consultant Respiratory Physician/ Clinical Director
Sian Rowlands	Head of Quality and Clinical Governance
Katherine Prosser	Quality and Governance Lead
Cath Evans	Patient Safety Facilitator, Patient Safety Team
Wayne Parsons	Lead Nurse Integrated Medicine
Mark Davies	Consultant, Acute Medicine
Dave Mcrae	Lead Pharmacist, Medicine
Sarah Wright	Clinical Nurse Specialist, Infection Prevention and Control
Claire O'Keeffe	Senior Nurse, Integrated Medicine
Harriet Foley	Senior Nurse, Integrated Medicine
Lowri Warren	Senior Nurse, Acute and Emergency Medicine
Beth Jones	Senior Nurse, Specialised Medicine
Holly Cotterrall	Ward Manager, East 8, UHL
Secretariat	
Sheryl Gascoigne	MCB Secretary/ Project Support Officer
Apologies:	
Claire Main	Director of Operations for MCB and Unplanned Care
Hannah Mastafa	Deputy Director of Operations
Jesse Ayertey	Deputy Director of Operations
Lyndsey MacDonald	Consultant Emergency Medicine/Clinical Director
Sharon Jones	Consultant, Rheumatology/ Clinical Director
Ceri Richards-Taylor	Lead Nurse, Integrated Medicine
Dave Pitchforth	Lead Nurse, Specialised Medicine
Marianne Jenkins	Consultant Nurse Practitioner
Sam Hughes	Professional & Practice Development Nurse
Liz Vaughan	Professional & Practice Development Nurse
Angela Jones	Senior Nurse, Resuscitation Service
Molly Baker	Service Improvement Manager
Derek King	Clinical Nurse Specialist, Infection, Prevention and Control
Chisom Uwaezuoke	Clinical Nurse Specialist, Infection Prevention and Control
Hibaq Musa	Clinical Nurse Specialist, Infection Prevention & Control, Corporate Nursing

Item No	**1. Standing Items**	**Action**
MCBQSE/ 2025/17	**Welcome and Introductions** – were undertaken. **To receive the minutes of the previous meeting held on 19/2/25** – the minutes were accepted as an accurate account of the meeting. **Action Log** – was updated. **Declarations of Interest** – none declared.	
2. ITEMS FOR REVIEW AND ASSURANCE		
MCBQSE/ 2025/18	**Patient Story** delivered by Holly Cotterrall, Ward Manager, Ward East 8 East 8 has had two Court of Protection cases which are time consuming to work through. The support that SR gives to staff working through these cases is much appreciated. **Case 1, TP, aged 94, 290 days from admission on 8/5/24** May 24 – medically fit 5/9/24 – Best Interest Meeting took place	

Chilcott,Rachel
08/05/2025 16:26:52

	14/2/24 – bed held 19/2/24 – TP moved to interim placement 19/3/24 – OT statement filed Numerous home visits were trialled, however, too many of these failed. This lady has now left hospital and is in a care home. **Case 2, JW, aged 80, 324 days from admission on 29/4/24** *(as of 19/3/25)* 16/5/24 – medically fit 31/7/24 – Best Interest Meeting took place 16/10/24 – social care needs assessment 30/1/24 – bed held at a nursing home paid for by C&VUHB. 24/3/24 – Court date (directions) JW is resistant to going into a care home and wants to go home. Therefore, a home assessment will take place. 24hr live-in care is being explored. The patient is likely to remain on the ward for a few more months. **The group resolved/ Action**: each Court of Protection case is different. A meeting regarding DTOC is taking place and examples of some of the experiences here could be taken to that meeting.	Katja Empson
MCBQSE/ 2025/19	**Compliment for Ward East 2, UHL** - an acute CNS for heart failure followed up on a patient on East 2. The family expressed their gratitude for the care and compassion the patient received whilst on the ward. **MCB Concerns** - 74 open concerns. 45 overdue. 3 concerns over 100 days old. Themes are communication; inappropriate discharge; lack of respect. **Family feedback Medical Examiners Reports** – all to note for information. **The group resolved/ Action:** all to note for information.	

MCBQSE/ 2025/20	**Infection Prevention and Control (IP&C)**
	51 days since last MRSA bacteraemia (UHL E6)
	15 days since last MSSA bacteraemia (Heulwen)
	12 days since last *C difficile (UHW C7)*
	16 days since last *E. Coli* bacteraemia (UHL E2)
	49 days since last *Pseudomonas* bacteraemia (UHL E2)
	14 days since last *Klebsiella* bacteraemia (W2)
	
	• Norovirus outbreaks on C7; A2; East 4 and East 6.
	• Covid on A7 and B7.
	• Therefore, there are 7 seasonal outbreaks affecting 28 patients, 1 member of staff and 10 bed days lost.
	• C. difficile outbreak Lakeside Wing, Ground Floor 2 meeting completed, awaiting closure.
	• DMT scores – all MCB wards remain compliant for the last 4-week period.
	• HCAI reduction goals – There were new cases of all reduction goal organisms except Pseudomonas and Klebsiella in February.
	• MCB position based on same period 2023-2024:
	    o 66% increase with *Pseudomonas.*
	    o 48% increase with *C. difficile.*
	    o 33% increase with SAUR Bacteraemias
	    o 16% Increase has been seen *with Klebsiella*
	    o 41% reduction with *E. coli.*
	• There are 13 outstanding RCA's.
	
	The group resolved: the current IP&C position is compromising safe flow in the hospital and getting patients to the right place.
	Actions from discussion: to note the above.	

MCBQSE/ 2025/21	**Discharge Advice Letters (DAL)**, update delivered by Dr Aled Roberts A Task and Finish Group has been in place for the past 6 months. Work is ongoing with PCIC, particularly regarding medicines reconciliation. Approximately 20% to 30% of discharge letters do not get to the relevant GP's and some are left in draft	

Chilcott, Rachel
08/05/2025 16:26:

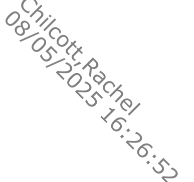
	form. This risk is being held by the organisation. There is a risk of not having a DAL and if there is a DAL and a letter, inaccuracies may occur. An educational package has been developed to highlight what DALs look like in terms of quality. Work will be undertaken regarding managing the discharge advice letters in directorate settings. ePMA will ensure a standard process is followed and discharge advice letters will be included. There is a SharePoint page for further information and information is in the resident doctor handover documentation. **The group resolved**: to note the above. **Actions from discussion**: KE will share a link for further sharing.	Katja Empson Completed
MCBQSE/ 2025/22	**MCB Assurance Report** **The group resolved**: this is for information and noting.	
3	**ITEMS FOR APPROVAL/ RATIFICATION**	
MCBQSE/ 2025/23	**National Reportable Incidents (NRIs)** – there are 21 open NRI's. **Integrated Medicine**: 6 (1 breached closure date) **Specialised Medicine**: 10 (8 breached closure date) **Emergency & Acute Medicine**: 5 (1 breached closure date) A never event has recently been reported and is subject to Coroner's Inquest. **NRIs for closure**: **Specialised Medicine** **ID54515** relating to Endoscopy A 25-year-old with complex learning disability needs was diagnosed with colon and liver cancer in March 22. His family raised a formal concern on 3/2/24. • In April 21 the patient was referred to Gastroenterology as he had rectal bleeding. Following vetting by a consultant, it was advised the patient should be reviewed in clinic potentially for IBD. A month later a telephone call was arranged, however, the patient was living in a nursing home, which at that time was unable to take calls noting this was during the Covid-19 pandemic. • In July an in-person appointment was arranged for the patient with his mother present. All investigation options were discussed. It was considered the patient would not be able to tolerate the preparation for a colonoscopy. • Following treatment discussion at a further clinic appointment it was agreed that a CT scan should be requested rather than an invasive procedure. There was a delay in arranging the CT scan. Radiology declined the scan advising that a colonoscopy should be arranged as this was considered the best pathway. • A request was submitted for the patient to undergo a Colonoscopy under general anaesthetic. Due to the Covid pandemic at the time, theatre space was reduced, and the patient was placed on the waiting list. • In March 24 the patient was admitted with increased bleeding and underwent a CT scan where a tumour was found along with extensive liver metastases. • The patient died on 24/3/25 **Learning** The scan request was not viewed for several months. Despite being chased up, the scan was declined by Radiology on the basis a colonoscopy is the gold standard diagnostic tool. The referrals for scans are now electronic and referrals are all documented. The Patient Safety Learning Review concluded treating/diagnosing sooner would not have altered the outcome. The need for demand and capacity within the Endoscopy Service was highlighted especially for GA capacity. People who cannot tolerate GA are on a longer waiting list. **Recommendations** • Look into demand and capacity within the Endoscopy Service. • Re-look at surveillance procedures. • Communication of expectations and options could have been better. • An ongoing action plan is in place in Endoscopy relating to ongoing NRIs. • Learning from the case has been shared within Directorate QSEs, MCB QSE. • Link in with the learning disabilities team to see how best to help this cohort of patients.	

Chilcott, Rachel
08/05/2025 16:26:52

	Integrated Medicine **ID69720**, refers to an injurious fall. The case is now subject to a Coroner's inquest. In August 2024 a lady was admitted to UHL with worsening left sided hip pain and sacral pain. The lady had a background history of renal carcinoma and following an MRI found to have bone metastases. On the day of transfer to UHW for planned work up for orthopaedic surgery, the lady sat on a stool falling on the ward which resulted in a fractured neck of femur. The patient was transferred to UHW as planned and required extensive medical work up before being able to go to theatre including blocks to prevent significant bleeding and the development of a PE. Sadly the patient had a cardiac arrest and passed away whilst in theatre, before surgery commenced. **Learning** - The patient had capacity and chose to sit on the stool; however, the stool should not have been in that area. - A risk assessment has taken place, and all stools have been removed from wards and kept in the storeroom. Some stools have been condemned. - A lessons learnt statement has been submitted to the coroner's office. - The fall contributed to the fracture, however, did not contribute to her death as the patient had other significant co-morbidities and diagnosis. **The group resolved**: to note the above.	
MCBQSE/ 2025/24	**Learning from Events** **Injurious fall CN/UHL/DCIQ1204 –** claim ongoing. **The patient was an 83-year-old** female admitted August 2022 following a stroke and transferred to SRC where the incident took place. Previous history included falls and had recently been diagnosed with dementia. Notes indicated the Claimant had cognitive impairment and could be 'impulsive'. An offer of settlement has been made, however, not accepted yet. **Incident***:* the Claimant was taken to the toilet. It was alleged that whilst unattended, she fell back onto the toilet seat sustaining injuries to her back. The Claimant was seen by a doctor the next day, following a phone call from the ward nursing staff advising she had hurt her back the day before. X-ray reported a compression fracture of the vertebrae. The Claimant was discharged home October 2022. **Conclusion:** liability was denied, however, due to vulnerabilities in the case a Part 36 offer of £4,000 was made. **Learning***:* • Experts felt it would have been unwise to leave the patient unattended whilst on the toilet because she was at risk of impulsivity which may result in a fall. • The Ward use Safety Briefings to highlight the importance of balancing the need to wherever possible allow patients privacy to use the toilet against their risk of falling and not to leave a patient unsupervised if they have any reservations about the risk of falls due to factors such as impulsivity for example. • Reflections were obtained from the staff involved. • Introduction of checking list to identify faulty call bells for reporting to Estates. • Routine checks (3x week) on call bells and toilets/bathrooms for clutter and unnecessary equipment that could restrict access or make unsafe. • There was a challenge in producing the evidence for Welsh Risk Pool, which SRC record on their whiteboard then erase the info from the whiteboard.	
4	**ITEMS FOR NOTING AND INFORMATION**	
MCBQSE/ 2025/25	**Patient Safety Alerts/MDAs/ISNs** Urgent Field Safety Notice: Intubation ORAL/NASAL Endotracheal Tube Safety Memo – UHW Portering system change and Major Haemorrhage Protocol Safety Memo – Self Neglect. **Actions from discussion:** - KE will share with the group information on time critical medication.	

Gilbert, Rachel
08/07/2025 16:32:52

	- KE will liaise with Richard Marsh regarding the issue of the number of mental health patients and older people that are entering MEAU and the length of wait in MEAU. This needs to be looked at to see how best to improve the pathway with the suggestion of ward-to-ward admission.	Katja Empson
MCBQSE/ 2025/26	**Medicine Services: 01/10/24 – 31/12/24 Medicines related incidents reported via Datix.** Total number of incidents reported is 82. The top reported stages of occurrence are: Administration errors = 32 Medication prescribing error = 20 **The group resolved**: for noting.	
MCBQSE/ 2025/27	**Minutes from Directorate QSE Groups and Chairs Reports/Exceptions**: • Acute & Emergency Medicine minutes 11/2/25 • Integrated Medicine, UHW (await minutes) • Integrated Medicine, UHL, minutes 6/2/25 (next meeting May 2025) • EUG last meeting 18/12/24 (minutes shared February QSE meeting). Next meeting to be confirmed. **The group resolved**: to note the above. **Action from discussion:** none	
MCBQSE/ 2025/28	**Minutes from QSE Sub-Groups:** • IP&C 03/01/2025 (next meeting May 2025) • H&S last meeting 5th February 2025 (await minutes) • Medicines Governance and Access Group last meeting 17/1/25 (await minutes) • Professional Nursing Board last meeting 10/2/25 (await minutes). **The group resolved**: to note the above. **Action from discussion:** none.	
MCBQSE/ 2025/29	**Feedback from UHB QSE Committee** **The group resolved**: to note the above **Action from discussion:**	
5. ANY OTHER BUSINESS/ DATE AND TIME OF NEXT MEETING		
MCBQSE/ 2025/30	**Inquest Team** – HM Coroners have taken on several additional Assistant Coroners. The Inquest Team have taken on more legal colleagues. There is now increased emails and queries from these areas, increasing the workload. The MCB Team have not increased in capacity. It would be appreciated if staff are asked to provide a statement for the coroner, that this should be completed as soon as possible. **Falls Education** – SH and LV have carried out a falls programme in UHL and this will be rolled out in UHW. Training is for one day and will cover risk assessments. **Sam Davies Ward and C4** – have done work around line and standing blood pressure which is a requirement of NICE guidance for everyone over 65 years of age. Work carried out at Sam Davies Ward will be brought to a future MCB QSE meeting. **Date and time of next meeting** – 16 April 2025 14:30 Teams meeting	Kath Prosser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08/05/2025 16:26:52

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

Held on 27th February 2025

Present:		
Helen Luton (Chair)	HL	Director of Nursing/Multi Professional Teams
Sarah Lloyd	SL	Director of Operations
Becca Jos	BJ	Deputy Director of Operations
Vanessa Goulding	VG	Acting Head of Podiatry
Rhys Morris	RM	CD&T R&D Lead/Director of MPCE
Susan Beer	SB	Public Health Wales Representative
Melissa Melling	MM	Head of Medical Illustration
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Alison Lewis	AL	Patient Safety Coordinator
Rebecca Carnegie	RC	Blood Transfusion Laboratory Manager
Edward Chapman	EC	Head of Clinical Engineering/ Medical Devices Officer/Assistant Director of Therapies and Health Sciences
Vicky Cummings	VC	Haematology Quality Manager
Carole O'Shea	CO	Deputy Site Superintendent Radiographer
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Emma Holmes	EH	Head of Dietetics
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Adam Christian	AdC	Clinical Board Director
Jonathan Davies	JD	Health and Safety Adviser
Jo Fleming	JF	Quality Lead, Radiology
Suzie Cheesman	SC	Nurse Advisor, Medicines Management
Bill Salter	BS	Lead Staff Representative
Sandra Watts	SW	Senior Nurse for EPMA, Pharmacy
Seetal Sall	SS	Point of Care Testing Manager
Sue Lawless	SL	Laboratory Service Manager, Haematology
Jamie Williams	JW	Senior Nurse, Radiology
Elaine Lewis	EL	General Manager, Pharmacy
Suzanne Rees	SR	Lead Nurse for CD&T
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Yvonne Hyde	YH	IP&C Team Representative
Tracy Wooster	TW	Sister, Outpatients
Debra Woolf	DW	Sister, Outpatients
Timothy Banner	TB	Clinical Director, Pharmacy
Sian Jones	SJ	Directorate Manager, Laboratory Services
Paul Williams	PW	Clinical Scientist, Medical Physics
Ruth Lang	RL	Office Manager, AWTTC

Chilcott,Rachel 08/05/2025 16:26:50

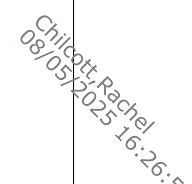
Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 25/040	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 25/041	**Apologies for Absence** Apologies for absence were noted.	
CDTQSE 25/042	**Minutes of the previous meeting** The minutes of the previous meeting were received. **The Group resolved that:** a) The minutes of the previous meeting held on 29th January 2025 were accepted as an accurate record.	
CDTQSE 25/043	**Matters Arising/Action Log** The action log was received and it was noted that a number of the actions had been completed. The outstanding actions were updated as follows: *CDTQSE 24/250 New Medical Examiner's Process* The presentation from the Bereavement Team on the changes to the process of how death certificates are issued will be deferred to the next meeting. *CDTQSE 24/277 Pathology Delays* It was agreed that the learning from incidents relating to Pathology delays will be deferred to a future meeting, as a number of the incidents linked to other services are awaiting closure. *CDTQSE 24/279 Operation POET* BJ will present an update to the meeting in March on the learning from the Operation POET exercises. It was agreed that she will also link the recent business continuity issues experienced in this Clinical Board to this discussion. *CDTQSE 25/009 CT2 Risk Assessment* CO to send a copy of the CT2 risk assessment to HL. *CDTQSE 25/009 Health Surveillance Issues* Health Surveillance issues in Medical Illustration are being progressed.	**SO** **SG** **BJ** **CO**

Chilcott,Rachel
08/05/2025 16:26:52

	CDTQSE 25/023 Service Improvement Projects KB to share an overview of service improvement projects that are being undertaken within this Clinical Board. **The group resolved that:** a) The updates to the outstanding actions were noted.	**KB**
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 25/044	**Concerns and Compliments Report** In January 2025, the Clinical Board received 43 concerns; 6 formal and 37 to be resolved through early resolution. There were 0 breaches in response times and 6 compliments were received. The top reasons for concerns this month relate to: • Delays in issuing death certificates. This theme accounted for 35% of the total concerns received. • Waiting times for test results/scan reports • Difficulties cancelling/arranging appointments **The group resolved that:** a) Delays in issuing death certificates are linked to the new changes to the Medical Examiner's process and the delays are not only in terms of the administrative process in Health Records but relate to a wider UHB pathway. The delays are also impacting on the Mortuary team in terms of the increased lengths of stay.	
CDTQSE 25/045	**National Reportable Incidents** The NRI report was received which summarises the open cases. 81055 is a new NRI linked to a radiology miss not identified by the outsourcing company. This case will be investigated and its status may be downgraded from an NRI depending on the biopsy results. The incident will be used as a learning opportunity and the outsourcing company is expected to have similar learning process in place as those used in internally within the UHB. **The Group resolved that:** a) A number of the incidents on the report are nearing closure.	

Chilcott,Rachel
08/05/2025 16:26:52

CDTQSE 25/046	**Duty of Candour Cases/Claims/LFERs** The Clinical Board is reporting 2 Duty of Candour cases outside of the NRI process. The first case involves the care of a PICC line insertion in Nuclear Medicine resulting in the patient needing to have another PICC line inserted. This case is being investigated and reviewed. The second case involved a paediatric patient in Physiotherapy Outpatients who sustained a fracture. It is not considered that this is a result of defective equipment but this case is under investigation. **Learning from Events Reports following Claims** HL reported on 2 events. In the first case it was alleged that there was a failure to identify the subtle changes in osteolysis between two images of a patient with metal on metal hip replacement taken seven months apart. The findings were extremely subtle and there were complexities in interpreting the images in the context of the patient's presentation. However, the Expert Report stated that although the changes were subtle, on the second MRI scan in the context of the reason for performing the scan, they had progressed and should have been identified on the report. The second case involved a patient who was diagnosed with right hydronephrosis during pregnancy and was born with bilateral kidney dysplasia. The patient had multiple follow ups and scans from birth to adolescence, showing progressive kidney issues. There was a miscommunication in 2006 where the local team was incorrectly informed that the right kidney was normal and consequently there was no follow up from the renal team. The patient developed chronic renal failure at aged 16, requiring dialysis and eventually a kidney transplant. A legal claim was filed in 2022 alleging that the miscommunication contributed to the patient's condition worsening. Expert advice concluded that the interpretation of the scan in 2005 was incorrect. The difficulty with this case is that the patient lived in West Wales and not all images were undertaken in Cardiff and Vale. The case was not able to be discussed in REALM due to the poor quality of the residual images taken at that time and that the IT systems have changed several times, which meant they were rendered unsuitable for a learning case. **The Group resolved that:**	


Chilcott,Rachel
08/05/2025 16:26:52

	a) Reporting errors are a known phenomenon in Radiology and errors of perception constitute for the majority of errors in radiology reporting. The reasons for their occurrence are largely unknown but appear to be related to how human perception can fail during complex tasks. b) It is difficult to identify a root cause when there is a lengthy time period involved.	
CDTQSE 25/047	**Risk Register Updates** Becca Jos stated that the laboratory leads and Project Manager for the new LIMS System need to review the risk and scoring of the new LIMS system as the All Wales implementation is behind schedule. A risk assessment is being produced in Health Records relating to the end of life scanner. He noted that there is support for funding a replacement. Sarah Lloyd requested that Radiology review the risk relating to the PACS system and review the scoring. The system experienced significant downtime earlier this week and this is becoming a frequent occurrence. SL has been tasked to produce a paper for Senior Leadership Board on the specific incident that occurred this week and this will be shared at the next QSE Meeting. AC advised that the Fujifilm team are undertaking a root cause analysis and will submit a report and AC has also requested a meeting. **The Group resolved that:** a) The risk register updates were noted.	**Labs** **AC** **SL**
CDTQSE 25/048	**Patient Safety Alerts** **The Group resolved that:** a) There were no patient safety alerts received.	
CDTQSE 25/049	**Medical Device/Equipment Risks** EC noted that funding for the scanner in Health Records has been agreed and funding has also been successful for other pieces of equipment within the Clinical Board. EC queried if the NR fit issue in Radiology has now been resolved. CO will check and feedback to EC. 2 Phillips Azurian alerts have been received. One relates to the risk of patients that might fall off the mattress due incorrect placement of mattresses on the plinth. The other relates to the risk of finger entrapment during manual movements of the patient tabletop. Risk assessments and actions have been completed.	**CO**

Chilcott, Rachel
08/05/2025 16:26:52

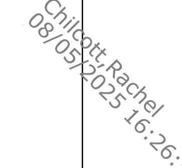
	EC noted that funding has been secured from Welsh Government to procure beds. **The Group resolved that:** a) The updates on the alerts were noted.	
CDTQSE 25/050	**Point of Care Testing** **The Group resolved that:** a) There were no matters pertaining to Point of Care Testing to report.	
CDTQSE 25/051	**IP&C/ Decontamination Issues** HL reported that IP&C colleagues have undertaken audits across areas within Radiology. The department achieved 100% compliance against bare below the elbow. The environmental scores were acceptable with the lowest score at 84%. It was noted that some general estates issues/infrastructure issues raised. **The Group resolved that:** a) The updates on IPC issues were noted.	
CDTQSE 25/052	**Safeguarding Update** HL advised that the Clinical Board has a new Safeguarding link., Stephanie Ashmore. The Single Unified Safeguarding Report was circulated. Mental Capacity Act Level 2 training compliance was noted. The Clinical Board is reporting 87.6% compliance. AHP and Nursing staff are reporting above 85%. Medical colleagues are reporting 60%. HL with check with AdC whether all the clinicians listed are required to undertake the training. **The Group resolved that:** a) Departments will check that only staff that are required to undertake the training are listed.	**HL**
CDTQSE 25/053	**Consent Issues** Nursing/AHP staff are reporting 68% compliance. Medical staff compliance needs to be improved.	

Chilcott,Sophie
08/05/2025 16:26:52

	The Group resolved that: a) Departments will have difficulties defending claims when consent training has not been completed.	
CDTQSE 25/054	**Health and Safety** KA reported that the security issues relating to TDSI in the CRI are still not resolved BJ agreed to follow this up. BJ reported that estates works are planned imminently outside the fire exit of the hydrotherapy pool. There will be a defined period where the fire exit route will need to be diverted through the reception area which is inadequate and a risk should a fire occur in that area. This is being reviewed by the Fire Officer and Health and Safety team. The Physiotherapy team received short notice of this work and there are concerns around the risk assessment that has been undertaken and the suggestion that less patients will need to be present, which will result in cancellations. SL expressed her dissatisfaction around the cancellation of patients and will follow this up. Pharmacy experienced a significant flood this week following the spell of wet weather which breached the measures that Estates had put in place following the previous flood. The robot room was totally flooded and unsatisfactory for the staff working in the room. There is a long-term plan around replacing the roof but this will not be completed before the end of March. RC asked if there was an update on the laboratory roof replacement . It was noted that SJ has been following this up to reach a resolution. **The Group resolved that:** a) The update on health and safety issues were noted.	**BJ** **SL**
CDTQSE 25/055	**Regulatory Compliance** HL provided feedback from the last meeting. The LIMS implementation work is impacting on the quality metrics for the laboratories. It was noted that UKAS are inspecting Haematology and Cellpath in April. **The Group resolved that:** a) The minutes of the meetings are shared with this group.	
TIMELY		
CDTQSE 25/056	**Initiatives to Improve Access to Services** SO has been liaising with the Telecoms team to address the recurring difficulties of getting through on the phone lines to the	

Chilcott,Rachel
08/05/2025 16:26:52

	Bereavement Office, which has been a common theme of early resolution concerns. Within Radiology, work is also being undertaken around the telephone lines to help the booking teams manage the volume of calls. The procurement team are providing support in setting up a contract which is progressing, but is not as quick a solution as first anticipated. **The Group resolved that:** a) The initiatives to try to address managing call volumes in Radiology and the Bereavement Office were noted.	
CDTQSE 25/057	**Waiting Times Performance** BJ reported that there are 9926 patients waiting over 8 weeks in Radiology. Waiting times for MR and CT are continuing to perform well. The backlog in Ultrasound has significantly reduced by 525 in January and whilst there is still progress to be made, efforts are ongoing. AC reported that in terms of Plain Film reporting, Emergency and GP work are prioritised. The longest waits have reduced and there are plans to outsource some work. In Therapies, Speech and Language Therapy have reduced their 14-week breach position to 37. Within Therapies, the areas of concern are: - Dietetic Paediatrics, where there are longstanding issues but recruitment is ongoing which will provide support. - Paediatric Occupational Therapy is reporting a slight increase in its breach position, however recruitment is progressing. - Pelvic Health, whilst an area of concern is reporting significant improvement in reducing its 14-week breaches. Physiotherapy Adults have reduced their waiting time breaches to 23. Cellular Pathology has made significant efforts to achieve the timely turnaround time of results, and are now managing their workload. The Group resolved that: a) Waiting times performance is monitored and discussed in detail in the directorate performance review meetings.	


Chilcott, Rachel
08/05/2025 16:26:52

EFFECTIVE		
CDTQSE 25/058	**Feedback from UHB QSE Committee** **The group resolved that:** a) The minutes of the previous meeting held on 18th February 2025 are not yet available.	
CDTQSE 25/059	**NICE Guidance** **The Group resolved that:** a) There was no guidance to share.	
CDTQSE 25/060	**Research and Development** A CD&T R&D Forum will be held on 1st April at 12 via Teams. All staff are welcome to join the event. A Pharmacist will be sharing her experience of First Into Research Fellowship and her rapid literature review. In keeping with the theme of literature review and evidence appraisal, a colleague from Cardiff University will present on her experience of a change in career into systematic review in Medicine. RM to forward the invitation to SL. **The Group resolved that:** a) The date of the R&D Forum was noted.	**RM**
CDTQSE 25/061	**Service Improvement Initiatives** KA reported that KB is supporting a programme of work relating to the integration of Children's Therapies into Adult Therapies and embedding the rehab model and operating model within those services. There are workstreams linked to this programme such as streamlining clinics so the focus is on the child. Also, how to make best use of the Keeping Me Well website. SO reported that meetings are being held with colleagues in Digital Health Intelligence around digitisation and scanning to support the Coding team with remote working to manage the coding backlog. Wider discussions include the use of the electronic document and records management systems within the Health Board and the benefits of scanning not just for acute records being scanned but also for other images. Good progress will come from this work with support from Executive colleagues. HL noted that the Shaping Change Team will be providing support to Blood Transfusion relating to their QMS system. **The Group resolved that:**	

Chilcott,Rachel
08/05/2025 16:26:52

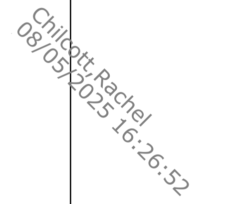
	a) The Therapies team will present their programme of work to a future meeting when this is completed.	
CDTQSE 25/062	**Information Governance/Data Quality** There is support, interest and challenge from Executives around the destruction of records. Focus will be placed on addressing the backlog of records that have been retained beyond their retention period, mainly due to the embargo. A destruction programme, which will include clear protocols will be required to assess the approach needed, as this will have resource implications for this to be undertaken across the Clinical Board and wider Health Board. The plan is to link in with the Information Governance team to ensure proper processes for destruction are in place and identify if there is any shared learning from other Health Boards. SO also noted that retention of records and how records are stored on and offsite will also be part of this work. **The Group resolved that:** a) It was noted that there is agreement from the corporate level in the Health Board to outline how this work can be taken forward.	
CDTQSE 25/063	**HIW/LLAIS Reports and Improvement Plans** KA reported that the HIW report in Mental Health will have a direct impact on Therapies services. The action plan is being driven by the Mental Health Clinical Board. **The Group resolved that:** a) A summit is being held and Therapies are linked into this work.	
CDTQSE 25/064	**Policies and Procedures** **The Group resolved that:** a) There were no new policies and procedures to receive.	
EFFICIENT		
CDTQSE 25/065	**Exception Reports from Directorates** **The Group resolved that:** a) There were no exceptions raised from directorates.	
CDTQSE 25/066	**Clinical/Internal Audits** A report on clinical and internal audits was shared highlighting the activity recorded on the AMAT system against this Clinical Board.	

Chilcott,Rachel
08/05/2025 16:26:52

	HL encouraged directorates to review the report and close out any overdue work. Action plans need to be submitted where requested. **The Group resolved that:** a) Directorates will review the report and request for leads to progress with actions where required.	
CDTQSE 25/067	**Waste and Sustainability** **The Group resolved that:** a) The next Clinical Board Sustainability/Green Group will be held in April.	
EQUITABLE		
CDTQSE 25/068	**Feedback from Clinical Board Inclusion Ambassadors Group** SO reported that the Group is in need of a refresh and the Clinical Board will ask the UHB Equality Adviser for a steer on direction going forward. Thoughts are also being given to widening out the membership of the group to Directorate Leads/Equality Champions. **The Group resolved that:** a) Discussions on how best to take the group forward will be progressed.	
CDTQSE 25/069	**Equality and Diversity Issues** **The Group resolved that:** a) There were no issues to report.	
PERSON CENTRED		
CDTQSE 25/070	**Patient Story – Podiatry** VG presented a Podiatry patient story based on a duty of candour case. The patient was an 81-year-old individual living alone but with family living nearby. Their medical history included lymphedema, bilateral leg ulceration, anxiety, and a history of prostate cancer. The patient was under the care of the District Nursing team and received regular visits from carers. It was documented that the patient was not adhering to the recommended advice from the District Nursing team, such as choosing to sleep in a recliner chair out of personal choice instead of elevating their lower legs. The patient was mobilising with a zimmer frame and has a shuffling gait. In April of last year, the district nursing team referred the patient to the	

Chilcott, Rachel
08/05/2025 16:26:52

	Podiatry team for foot ulceration to the hallux (big toe), which was deemed superficial at the time, with no issues identified with the heels. A treatment plan was put in place and the District Nursing Team continued with their care. In May, a further referral was made by the District Nursing team, indicating that the patient had developed heel pressure damage, suspected identified as suspected deep tissue injury. However, prior to the Podiatry team visiting, the patient was admitted to hospital with cellulitis. The patient was seen on the ward by Podiatry on 17th May and it was identified the patient had a category or grade 3 pressure ulcer to the plantar surface of the foot. This was infected and it was recommended that the patient was for a period to be non-weight bearing. The patient was reviewed again and it was noted that the infection had resolved. Given the extent and location of the ulceration on the foot, the patient was deemed suitable for transfers only. The patient was followed up at home on discharge from hospital and advised to free float their feet in a recliner chair. The patient had a form of temporary shoe and was under the care of the District Nurses at this point and the plan was for Podiatry to review the patient 4 weeks later. At the next appointment on 5th August, deterioration was noted. The pressure damage had evolved into a category or grade 4 ulcer and there was a central area of exposed bone. Clinical features were consistent with osteomyelitis, or bone infection. Antibiotics were arranged, but it was identified that there were no offloading measures in place. The patient's shuffling gait likely contributed to the deterioration of the wound. Due to general decline, the patient was admitted to the hospital and reviewed by Podiatry. It was recommended that the patient continue with some mobilising to prevent deconditioning. The patient was reviewed by Podiatry on discharge home and continuing with treatment for osteomyelitis. A bespoke heel cast was made, and guidance was provided to the district nurses. The patient was reviewed again in September and it was at this appointment that Podiatry were able to discuss the outcome of the Primary Care Pressure Ulcer Scrutiny Panel. A verbal apology was provided to the patient and the Duty of Candour process was explained. The patient was subsequently readmitted due to an AKI. An investigation was conducted and the case was presented to the Primary Care Scrutiny Panel. It was determined that the evolved pressure damage was avoidable and that moderate harm had been caused to the patient. The reasons included insufficient offloading measures being instigated. There were no updated individual risk assessments including the purpose T assessment. There was also inadequate documentation to support any discussions or informed consent with the patient regarding offloading measures.	


Chilcott, Rachel
08/05/2025 16:26:52

	A duty of candour was triggered, and the case was discussed at a Redress Panel. Podiatry acknowledged their omissions in care and it was agreed that an apology should be issued to the patient and their relatives. This particular incident highlighted challenges in trying to offload a plantar foot wound or pressure ulcer as there were limited options available to the patient due to their medical conditions. In terms of learning, the key issues highlighted were the importance of having discussions with the patients and relatives around their clinical condition and significance of the treatment options. Evidencing discussions with patient and relatives with accurate documentation and ensuring risk assessments are conducted and updated. Consideration and awareness need to be given to alternative offloading options. The learning from this incident has been shared with the clinical team. The case has been discussed in the Podiatry QSE Meeting and a critical review has been undertaken of the care provided. With regards to the outcome, the patient and their relatives accepted the apology. BJ asked if MDT involvement is challenging when the patient is seen at home. VG acknowledged that this poses a challenge. There is monthly support from Medicine and Microbiology but there are ongoing challenges with obtaining medical support. **The Group resolved that:** a) It was suggested that the presentation is provided to Medicine to state the case of why their support is needed. b) HL will check whether the UHB Ulcer Pressure Group is being reinstated.	 **HL**
CDTQSE 25/071	**Initiatives to Promote the Health and Wellbeing of Patients and Staff** HL reported that the staff survey results at Health Board level have been circulated. The Group resolved that: a) When the breakdown of the results are available at directorate level, the Clinical Board will produce an action plan to address issues raised.	
CDTQSE 25/072	**Any Initiatives Relating to the Promotion of Dignity** **The Group resolved that:** a) There were no initiatives to report.	

CDTQSE 25/073	**National User Experience Framework/Feedback from Patient and Service User Surveys** **The Group resolved that:** a) HL will circulate the patient feedback from surveys that she has received.	 **HL**
CDTQSE 25/074	**Staff Awards and Recognition** No suggestions have been received on how the Clinical Board can recognise its staff. **The Group resolved that:** a) Discussions will be held by the Senior Management Team on how this can be taken forward.	 **SMT**
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 25/075	There were no items to report.	
ANY OTHER BUSINESS		
CDTQSE 25/076	Nothing further to report.	
CDTQSE 25/077	**Date & time of next Meeting** The next meeting will be held on 24th March 2025 at 1pm via Teams	

Chilcott,Rachel
08/05/2025 16:26:52

Safeguarding Steering Group Meeting
Friday 21st March 2025
Via Teams

Present:

Linda Hughes-Jones	Head of Safeguarding, C&V UHB	Corporate
Simon Dring	(On behalf of Angela Stephenson) EPRR Manager	Corporate
Pippa Johnson	Mental Capacity Specialist Practitioner	Corporate
Natasha Goswell	Deputy Executive Nurse Director	Corporate
Jason Roberts	Executive Nurse Director	Corporate
Faye Protheroe	Bereavement Lead Nurse	Corporate
Helen Whalley	Deputy Bereavement Nurse	Corporate
Claire Wade	Director of Operations for Patient Flow	Surgery
Barbara Davies	Deputy Director of Nursing	Medicine
Jane Murphy	Director of Nursing	Medicine
Ceri Richards Taylor	Interim Deputy Director of Nursing	Medicine
Lisa Waters	Senior Nurse, Quality Safety & Education	PCIC
Beverley Oughton	Senior Nurse	Specialist
Alys Gower	Consultant Midwife	W&C
Paula Davies	Lead Nurse	W&C
Annette Blackstock	Interim Assistant Director	PHW

	PART 1: PRELIMINARIES *(Chair)*	**ACTION BY**
1.1	**Welcome**	
1.2	**Apologies for Absence** David Murray-Dickson, Nicola Johnson, Bethan Williams, Ceri Lovell, Claire Biddlecombe, Jeff Morgan, Judith Cutter, Cath Twamley, Chloe Evans, Sarah Pippen, Diane Walker, Adele Watkins, Andy Jones, Andrew Crook	
1.3	**Approval of SSG Minutes from the previous meeting**	
1.4	**Action Log Review:** **Action: Review of SSG ToR and CB attendance**	
	PART 2: STRATEGIC DIRECTION AND SERVICE IMPROVEMENT	
2.1	**Clinical Board Reports** **Medicine** – Specialist training L3 attendance has improved. Open adult cases have had an increase the last two months. CR-T will feedback the figures to her team and discuss review of cases that may be closed following discussion with Local Authority (LA) **Surgery/Dental** – not shared **Specialist Services** – MCA / Consent training is low for the medical / dental staff which will need to be highlighted. There has been a significant drop in open health adult cases and professional concerns with cases being closed. **CD&T** – Not present	

Chilcott, Rachel
08/05/2025 16:26:52

	PCIC – Overall statutory compliance with safeguarding sits at 86% which is a 4% increase from last year. Language line - The ipad is used in CAVIS and looking at ways to integrate it to the rest of the service. The cost in PCIC for the year was £221,987 Children and Women – Level 3 training for children attendance has increased. There are a few tricky S47 cases ongoing, staff are attending the trauma training to help staff's wellbeing. Language line – ipad's are being used with staff that feed into CAVIS. The costs for January was £33,684. There is a need for face to face interpreters so a mixed model would be useful. Patients placed out of area – will be reporting on a quarterly basis as of April. Staff safeguarding supervision attendance is monitored. **Mental Health** – not in attendance **Children & Women-** Data shared. Training figures remain at a steady rate. **Training Schedule 2025-** Discussion held Power Point Presentation shared accompanied by the Safeguarding Dashboard. SAFEGUARDING TRAINING for ssg [Autosaved].pptx **Action: Arrange meeting for Escalation Process for children < 18 years of age on S136 transferred by police to Hafan Y Coed** **Action: Contact both Cardiff and Vale LA for data demonstrating rejected referrals due to no consent obtained**	
2.2	**Medicine Clinical Board Audit of AS1s feedback presented by Ceri Richards-Taylor** Audit feedback of Medicines Clinical Board As1s submissions. Audit undertaken 5th November 2024. 20 randomly selected AS1s from October 23 – October 24 considered. **Strengths included** : Clear documentation around referral reasons, clear picture of clinical presentation, consent established in 18/20 As1's, sufficient information to determine risks. **Areas of improvement included** – family history needs further exploration, poor documentation around repeat referrals, a few forms poorly completed – a little information around rational for referral and patient/ family consultation. The audit will be shared with MCB and ward teams. **Action: Review Executive Leads, Medical Directors and DONs Group 2 & G3 VAWDASV training**	
2.3	**MCA/ DoLS Assessments Court of Protection (CoP) update presented by Chloe Evans** MCA Newsletter Quarter 3 2024-2025.pdf 7 Minute Briefing Self Neglect.pdf It has been confirmed by Welsh Government that funding will continue for 2025/26.	
2.4	**Consent Lead Update presented by Chloe Evans** The Consent Post is currently out on TRAC, advertised as Band 7, 3 days a week post.	
PART 3: ORGANISATIONAL PERFORMANCE AND EFFECTIVENESS		
3.1	**School Nursing Health Assessment SOP** Deferred	May 25

Chilcott, Rachel
08/05/2025 16:26:52

PART 4: GOVERNANCE		
4.1	**Feedback from CIW/HIW/Estyn Rapid Review of Child protection Arrangements presented by Linda Hughes-Jones** Recommendations from the JICPA and Rapid Review to be completed by May 2025 discussed: - Midwifery safeguarding supervision – Supervision sessions are being provided by the Safeguarding Midwife and Safeguarding Nurse Advisor to ELAN, ward based and community midwives. - Documenting cases notes on PARIS SOP to be completed - An Audit of safeguarding group supervision will be completed for 2024/25 - Safeguarding Team are highlighting the requirement of consent and the quality of information included in the referrals at all supervision opportunities - Rapid review focused on health practitioner's attendance at child protection conference, this work is on-going - GP's attending conference, shared with PICIC **Action**: **Monitoring of referrals rejected due to no consent to be undertaken by the safeguarding team and reported at each meeting**	
4.2	**Update on the Children Looked After Service and feedback in relation to the continuity of records for adopted children** Deferred	May 25
4.3	**PCIC Update** Deferred	May 25
4.4	**MAPPA Update** Deferred	May 25
PART 5: REPORTS/ MINUTES FROM OTHER GROUPS/COMMITTEES		
5.1	**UHB Annual Report 2023/24** - published **Police Updates** – not in attendance **RSB Updates** – - Cardiff CS are ready to go live with the digital MARF but Vale are not currently in agreement on regional digital MARF. - RSB has ratified the "was not brought" document. It will be in circulation once translated. - Pilot of MARAC until end of March 2025:– the meeting has moved as a region, to weekly MARAC's for Vale and Cardiff with no daily discussions. - Regional safeguarding data sharing solution - Possible police information, health and LA shared on one page as "One single view of safeguarding". This is an IT project across the UHB and both LAs. - Current Safeguarding Reviews: 4 APR in progress, 4 CPR, 5 MAPF, 1 OWHR, 3 SUSR. There are 2 reports to be published and are awaiting translation out for translation. New referrals agreed are 1 CPR and 1 APR . - The PRUDIC document has been sent out to the Directors of Nursing for sharing. This was due to delays in cases being highlighted to Safeguarding previously. - Fabricated or Induced Illness procedure is in the process of being updated	
5.2	**NHS Safeguarding Network Update from Annette Blackstock:**	
PART 6: FOR INFORMATION		

Chilcott, Rachel
08/05/2025 16:26:52

6.1		
PART 7: ANY OTHER BUSINESS		
7.1	• Terms of Reference Safeguarding Steering Group signed off for 2024 • Internal Audit Safeguarding Final Report 2024. • UHB Safeguarding allegation concern 2021 • Annual Safeguarding Maturity Matrix July 2024 • SSG Attendance from Clinical Boards • Cardiff and Vale University Health Board 3 Year Safeguarding Training Strategy • PHW PRUDiC process for Young People on adult wards • Professional Concerns questionnaire https://forms.office.com/e/QuC4K2WMfj • SUSR implementation October 2024 • Reporting concerns – C&V RSB • Right Care Right Person, South Wales Police • Guidance re CDM	
PART 8: KEY MESSAGES FROM MEETING		
PART 9: NEXT MEETING OF THE UHB SAFEGUARDING STEERING GROUP		
	22/05/2025 **24/07/2025** **30/09/2025** **25/11/2025** **Dates for January 2026 and March 2026 to be confirmed**	9.30-11.30

ACTION LOG

MINUTE POINT	ACTION 21st March 2025	PERSON RESPONSIBLE	TIMESCALE
1.4	**To review the SSG TOR and CB attendance** CD&T Allied Professionals not represented, JR to meet with Emma Cook Contact both Cardiff and Vale LA for data demonstrating rejected referrals due to no consent obtained	**Jason / Linda** **Linda**	**May 2025** **May 2025**
2.1	**Clinical Board Reporting** Language Line - CR-T to contact Angela Hughes to gain benefits / disadvantages of using the ipad / language line. Arrange meeting for Escalation Process for children < 18 years of age on S136 transferred by police to Hafan Y Coed	**Ceri Richards-Taylor** **Linda**	**May 2025**
2.2	LHJ to bring the poster of the role of the HLP to SSG (Medicine completed) and leaflets for patients on what a safeguarding referral means (mental health completed) Surgery Audit of AS1's to be brought back to SSG	**Linda** **Clare Wade**	**May 2025** **May 2025**

MINUTE POINT	ACTION 23rd January 2025	PERSON RESPONSIBLE	TIMESCALE
2.1	Health Assessment Standard Operational Procedure will be brought to the SSG and shared at the Children & Women Clinical Board Quality & Safety Meeting. Vicarious Trauma Training or Counselling to be considered for the school nursing service. Feedback of the discussion to come back to SSG Complete recommendations for RSB regarding CP arrangements	Paula Davies / Andy Jones PD/ AJ PD/AJ	**May 2025** **May 2025** **May 2025**
2.2	**Clinical Board Reports** VAWDASV Group 2 & 3 training with the DONs CBs to consider Medical Staff compliance with safeguarding mandatory training. Promoted by the Executive Medical Director	 LHJ/ JR/ ECOD LHJ	 **May 2025** **May 25**

Chilcott, Rachel
08/05/2025 16:26:52

2.3	**PCIC Safeguarding Audit** Changes to AS1 reporting if consent is not obtained or rationale not provided, referral will be rejected. UHB to monitor the number of rejections	Linda H-J	**May 25**

Rolled over from previous meetings

MINUTE POINT	ACTION 22nd November 2024	PERSON RESPONSIBLE	TIMESCALE
3.4	Further update to the SSG in March 2025	Dr Bethan Caryl Williams	**July 2025**
4.1	CIW/ HIW/ Estyn Rapid Review of Child Protection Arrangements		
4.1	Feedback from Q4 24/5 of professional attendance at Review CPC and Core Groups	Paula Davies	**May 2025**
4.1	Feedback from and progress made with all recommendations	Paula Davies/ Anna Mogie/ Andy Jones	**May 2025**
4.1	Monitoring of referrals rejected due to no consent to be undertaken by the safeguarding team and reported at each meeting	Linda	**May 2025**
5.1	a) Consideration to be given to an appropriate platform to share the learning from NRI reviews Alex Scott to be invited to May SSG b) LHJ to meet with AS to discuss the use of AMAT in the safeguarding team for safeguarding review actions	Alex Scott	**May 2025**

MINUTE POINT	ACTION 30th July 2024	PERSON RESPONSIBLE	TIMESCALE
3.2	Digital pathway or app to be introduced.	Andy Jones/ Zoe Roberts/ Adele Watkins	**July 2025**

	ACTION 17th March 2023		
2.1	Undertake rolling programme of evaluation of training on a 6-12-months basis. (Feedback on training)	**On-going** NJ safeguarding team	**Sept 2025**

	ACTION 25th November 22		
3.6	BW to feedback to the SSG the continuity of records for adopted children when resolved	Bethan Williams	**On hold**

Chilcott,Rachel
08/05/2025 16:26:52

INFECTION PREVENTION AND CONTROL GROUP

Tuesday 24th September 2024
Via TEAMs
MINUTES

Present:	
Jason Roberts (chair)	Executive director of Nursing
Abigail Holmes	Director of Midwifery and Neonatal Services Obstetrics & Gynaecology
Andrew Poole	Capital Planning, Estates and Facilities
Andy Jones	Director of Nursing WCH
Barbara Davies	Director of Nursing MCB
Catherine Twamley	Director of Nursing SpCB
Chisom Uwaezuoke	Senior Nurse IPC
Dino Motti	Consultant in Public Health
Gavin Forbes	Consultant microbiologist, IPC doctor
Gareth Simpson	Estates Manager (North) Capital Estates + Facilities
Helen Bonello	Senior Nurse Professional Standards Nursing
Jane Murphy	Deputy director of Nursing
James Hughes	Senior Health Protection Nurse Health Protection Team
Laura Hodges	Lead Nurse T&O
Mark Campbell	Head of Decontamination
Mark Doherty	Director of Nursing MHCB
Phillip Butterick	Epidemiologist
Rachael Daniel	Health and Safety
Rishi Dhillon	Consultant microbiologist, IPC doctor
Sian Griffiths	Consultant in Public Health Medicine
Suzanne Rees	Lead Nurse CD&T
Victoria Daniel	Infection Control Scientist
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
Rhiain Lewis	Interim Senior Nurse for Education, Quality and Safety MHCB
Tara Robinson	Interim Deputy Director of Nursing Mental Health Clinical Board

PART 1: PRELIMINARIES *(Chair)*		
1.1	Apologies for Absence As noted above.	**JR**
1.2	Minutes of last meeting held on Wednesday 26th June 2024 Minutes of the last meeting were accepted as a true record.	**JR**
1.3	Matters Arising and Action Points from 26th June 2024 No actions arising from the notes.	**JR**
1.4.1	General Acute Respiratory Illness Update YH gave an update on acute respiratory illness. There are no updates on the acute respiratory illness guidance, it remains same as the last winter. CAVUHB has 8 wards affected., 7 in UHW and 1 in UHL. MPox/HCID YH reported that there is an All Wales HCID task and finish group which meets every two weeks. Topics discussed at the meeting were general plan for Wales, PPE etcetera, Personal protective equipment trollies will be placed in EU, MEAU in CAVUHB. Maternity and paediatrics will probably have trollies but that will be confirmed shortly. Two members of staff from CAVUHB will go to Sheffield for training and will do cascade training for staff. YH is charring CAVUHB HCID preparedness group meeting. there were two meetings tow date and they are well represented. Departments are developing their pathways. SG reported that Mpox has been declared as a public health incident of international concern in central Africa. There has only been one case in Sweden.	**YH/JR**
PART 2: STRATEGIC AND OPERATIONAL DELIVERY OF THE IPC AGENDA		
2.1	1. ICD Reports (UHW + UHL) GF reported MRSA outbreak on neonatal unit. Since April 24 there were 13 cases.one of the babies subsequently developed MRSA bacteraemia. WGS tells us there were 5 independent acquisitions, and there are three clusters. Three cases are linked to the outbreak in 2023, and two other clusters of two patients each. There was an initial meeting in July where storage and cleaning blood gas machine were identified. Actions have been put in place and SOP for cleaning of breast pumps is being developed. Staff screening will commence shortly. RD reported there was a period of increased incidents of C. diff in West 2. There was an initial meeting in August. Five cases in total	**GF/RD**

Chilcott,Rachel
08/05/2025 16:26:42

	and two cases were lined by whole genome sequencing. An action plan and training have been put in place. Another meeting has been scheduled for the next week. 2. IP&C Position Report CU reported IP&C position report from April to end of August 2024. IPC team has advertised for Band 7 role. This is now in recruitment process. Band 6 post will then go out shortly after. IPC teams continue to deliver education and support students in their spoke placements. Tb and Needlestick procedure are being brought to this meeting for approval. IPC team continue to attend required meetings. 3. HARP HCAI Performance Report PB reported there has been an increase in C. diff cases. However, this not only in CAVUHB, other health board are seeing the same increase. There was an increase in Staph aureus as well, particularly MRSA. CAVUHB had a reduction in number of *E. coli.* THE NUMBER OF Klebsiella cases is the same as the last year. There has been a large spike in Pseudomonas cases. 4. Internal Audit Report The only thing that was outstanding from Internal audit report were the procedures, which have been sent out for comments and will be in date then. YH has sent the Terms of Reference to JR. YH has done a draft for Annual IPC plan.	 **YH/CU** **YH/PB** **YH**
2.2	New Guidance/application in the Health Board This was discussed in section 2.1.2.	**YH**
2.3	Clinical Board Reports 2.3.1 Medicine BD reported on Medical clinical board report. At the moment medical clinical board is appearing to be on target for MSSA, *E. coli*, Klebsiella. ANTT is 100 percent compliant in core standards from June to September. PVC audits are showing improvement. Period of increased incidents meeting was held for East 2. Lots of actions have been put in place. The PPDN's plan continues to be a blend of ward-based assessors and central assessment sessions. A back to basic's approach has been adopted including HCSW's and other members of the multi-disciplinary team such as PVC care and dressing changes and the required ANTT technique. Improvement has been reflected within the ANTT IP&C audits.	

Chilcott, Rachel
08/05/2025 16:26:22

	The substantial endoscopy plan within the Clinical Board was discussed and how this would potentially impact on decontamination services. Clinical Board to link in with the decontamination services to ensure they are fully cited. At the last decontamination meeting held 2nd July concerns were raised regarding a major decontamination issue secondary to a water leak which resulted in no AER processes working within Endoscopy UHW. This impacted on patients requiring USC procedures booked into the department, and escalated appropriately through relevant departments. The negative pressure cubicles on Ward A7 have recently been upgraded to support with any potential Monkey Pox cases. 2.3.2 Surgery/Dental LH reported for Surgery clinical board that trajectory for C. diff cases isn't going in the right direction. There were 15 cases since April compared to last year when there were 4 cases. There was a period of increased incidents of C. diff on B6. Surgery clinical board has met with IPC team and Public health Wales. There was one case of MRSA in August. Tendable audits have showed that equipment audits are not good. There is working going on to improve the audits scores. Practice developing nurses are working to support ANTT face to face assessment. Legionella was detected in SSSU theatre 6, plan for flushing and retesting has been put in place. HSDU sterilisation paper submitted. 2.3.3 Specialist Services CT reported for Specialist clinical board hotspots was C. diff, there were three cases in August. There was one case of MRSA in May. Reduction expectation on target for *E. coli* and Klebsiella. Ongoing Specialist IP&C group meetings with good MDT engagement and cross directorate representation. Positive and overall improved levels of compliance across the CB with Hand Hygiene and BBE. Introduction of weekly 'Druggle Round' in Critical Care – a ward round with an MDT approach, particular focus on antibiotic use. Introduction of a fortnightly IP&C ward round in Critical Care with the objective of education and support. This is also an MDT approach to review any identify any existing or potential IP&C challenges. For example, focussing on specific infections and reviewing opportunities to isolate and/ or mitigate. Ongoing work in relation to MSSA line related bacteremias continues in N&T as a hot spot area (x5 to date Apr-Aug 24). Not an outlier in regard to numbers and position aligned with national increase and	

Chilcott, Rachel
08/05/2025 16:26:52

	also increase in number of patients with lines. Important to note lines also subject to management in IR, dialysis units, other hospitals. Focus on decolonisation and line related care. 2.3.4 CD&T SR reported for CD+T. ANTT compliance is improving, the difficulty is getting assessors but the number is increasing as well. CD+T have started to use Tendable in outpatients and radiology. There were IPC reviews as well. Pharmacy has been flooded on two occasions which has affected business continuity but there are no IPC risks. Ongoing renovation work at UHW mortuary services with reduced capacity – for awareness raising only here. Several months of ongoing work remains. 2.3.5 PCIC There was no report for PCIC clinical board. 2.3.6 Children and Women AJ reported for children and women health clinical board. Last year there was 40% increase in C. diff cases. There were no cases of *E. coli* this year. There was one case of MRSA. Progress in terms of HPV cleaning around that C diff compliance at the moment is 86%. It was 17% last year. Clinical board is ensuring all staff are ANTT compliant. Data is currently unreliable, PDN's are collecting data locally but no reliable registry. Challenges in ensuring action plans need to be completed on Tendable within 3 weeks following IP&C audits. Poor results from CRO audits. All patient should have a CRA (clinical risk assessment) documented in the notes regarding MRSA/CRO screening. Education escalated, staffing pressures have meant unable to release attendees in CRO/MRSA screening teaching arranged for maternity staff. Ongoing work to consider broader opportunities to reduce reported poor clinical outcomes/harm from infection (NNAP report). 2.3.7 Mental Health MD reported for mental health clinical board. There was Covid on East 16, East 14. There was a D&V outbreak but it is now resolved. ANTT compliance is low but there is working going on to increase compliance. There ongoing audits and joint audits with IPC.	
2.4	ANTT Update The ANTT data on ESR is not accurate. It is hard to break down by staff group as well. PPDN's have reported this issue through the CAV	**Verbal YH**

Chilcott,Rachel
08/05/2025 16:26:52

	ANTT group. Data needs to be imputed manually and it is problem nationally.	
2.5	HCAI Delivery Board update HCAI delivery group has been set up since pre Covid 19 and it was chaired by one of executive directors of nursing at that time. The format is changing and directors of nursing and medical directors are to attend. The first meeting is in the next few weeks.	**YH**
2.6	Tendable update HB gave Tendable update. Tendable is implemented across 250 CAVUHB locations and there are over 1270 registered users. There is an increase in IPC Team audits being undertaken between this reporting period June-August 2023-2024. This is mirrored by ward-based audits being undertaken. Please find attached Tendable presentation. 2.6 IPCG Quarterly Report June - Augus	**HB**
PART 3: CORPORATE ASSURANCE SUPPORT AND PERFORMANCE FRAMEWORK (REDUCTION EXPECTATIONS 2021/22)		
3.1	Caesarean Section Surgical Site Infection Surveillance There new Caesarean Section Surgical Site Infection Surveillance report is not out yet.	**AH**
PART 4: DECONTAMINATION AND INFRASTRUCTURE		
4.1	Decontamination Report Departments that are ISO accredited had their surveillance audits and recertification audits. The audits results are positive. The highest risk we're carrying in decontamination continues to be the air handling unit that feeds the clean room within the Hsu in UHW.	**MC**
4.2	Legionella in Water UHL – SBAR	**AP**

Chilcott, Rachel
08/05/2025 16:28:52

	In terms of water sampling for the last quarter, there's been a focus on Pseudomonas rather than Legionella.in total there was 236 samples for pseudomonas was 236 samples compared to 38 for legionella. Overall for this quarter, legionella had a 58% pass rate Pseudomonas was at 94%. A lot of capital work has been completed in the last 12 months. Cleaning standards funding has been agreed. Please find attached Legionella in water presentation. 4.2 IPCG September Paper.pptx	
PART 5: INFECTION CONTROL POLICIES AND PROCEDURES		
5.1	5.1.1 Update on Current Position regarding Procedures for Noting 5.1.2 Procedures and Protocols for Comment Outbreak procedure will be sent for comments prior to the next IPCG. 5.1.3 Procedures and Protocols for Ratification TB and Needlestick procedures have been brought to this meeting for approval.	**YH**
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 Staff vaccination will start on 1st of October. Staff vaccination will be in CAVUHB facilities instead of mass immunization centre.	**DM**
6.4	Water Safety Group minutes Minutes for information only.	**YH**
6.5	Public health Update SG updates that Annie Ashman is the new deputy director of Public health and she will attend future IPCG meetings.	**SG**
PART 7: GENERAL UPDATES/ISSUES		

Chilcott, Rachel 08/05/2025 16:26:53

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:
18/12/24	**10:30-13:30**	**13/12/24**	**16/12/24**

Action log
JR to contact PCIC clinical board.
JR to send the minutes of the HCAI delivery board as part 6 of the agenda.

Chilcott,Rachel
08/05/2025 16:26:52